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Doctoral Thesis

A qualitative exploration of how risk is conceptualised and worked with in mental health services

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Word Count

	Main text	Appendices (inc. tables, references, abstracts, footnotes and title pages)	Total
Thesis Abstract	265	0	265
Literature Review	7,978	5, 013	12,991
Research Paper	7,943	10,845	18,788
Critical Appraisal	3,982	568	4,550
Ethics Section	5,832	2,271	8,103
Total	26,000	18,697	44,697

Thesis Abstract

This thesis explores concept of risk in mental health services via a literature review, research paper and a critical appraisal.

The literature review is a qualitative systematic meta-ethnographic study of six papers exploring therapists experiences of working with clients who are suicidal. The findings suggest therapists experience the work as emotionally demanding. Some therapists working with clients who are suicidal, fear blame or emotional discomfort which contributes to them avoiding relational closeness with their clients. The findings imply that therapists' experiences may vary, with some feeling capable of managing the emotional demands of the work and others experiencing it as overwhelming. The findings highlight the possible benefits of therapists receiving support, including regular clinical supervision.

A grounded theory (Glaser & Strauss, 1967; Charmaz, 2006) was constructed from interviews with ten multidisciplinary staff working in older adult 'functional' inpatient mental health services. The grounded theory explains how risk is narrowly conceptualised as something dangerous resulting from perceived 'mental illness'. Staff become focused on the task of risk reduction through the use of medication and electroconvulsive therapy. Potentially, the process of focusing on the task provides a form of psychological defence for staff; against anxieties, tension and distress evoked within them by their work (Menzies-Lyth, 1959). When dangerous risk is reduced occupational therapists conceptualise risk more broadly and work with risk more collaboratively with patients.

The critical appraisal extends the discussion of the strengths and limitations of the research project. The challenges of being a novice meta-ethnographer and grounded-theorist are then discussed. Clinical implications from the research paper are also addressed. A compassionate, trauma-informed and collaborative approach to older adult mental health is argued for.

Declaration

This thesis documents research undertaken between September 2016 and August 2017, in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology. The work presented here is my own, except where due reference is made. This thesis has not been submitted for the award of a higher degree elsewhere.

Signature:

Print name:

Date:

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Abstract

Objective: Mental health service users account for approximately 30% of deaths by suicide (University of Manchester, 2016). This paper aims to systematically review and synthesise qualitative research that explores therapists' experiences of working with clients who are suicidal. Understanding their experiences could provide ways of improving service design and delivery to improve the efficacy of therapy, which might reduce suicide rates among people engaging in therapy. ***Method****:* Using meta-ethnography (Noblitt & Hare, 1988) the study reviewed six papers. ***Results****:* A line of argument was developed, which suggests therapists experience the work as emotionally demanding. Some therapists, working with clients who are suicidal, fear blame and, or fear emotional discomfort which contributes to them avoiding relational closeness with their clients. The findings indicate that therapists' experiences vary, with some feeling capable of managing the emotional demands of the work and others experiencing it as overwhelming ***Conclusion*****:** How therapists respond to the experiences could have implications for the effectiveness of the therapy they provide. The findings highlight the importance of therapists being able to access a range of supports, including regular clinical supervision. Identifying ways for services to support therapists to manage the challenges of this work could improve the efficacy of therapy with suicidal clients.

Suicide can be defined as death from intentional self-harm (Andriessen, 2006). Globally, one person is estimated to die by suicide every 40 seconds, causing 800,000 deaths annually (World Health Organisation, 2014, p.2). There were 6,188 suicides in the United Kingdom in 2015, at 10.9 deaths per 100,000 population, equating to a death by suicide every two hours (Department of Health [DoH], 2012, p.10). However, the real- world rates of suicide are higher than the recorded figures, as proof "beyond reasonable doubt" is required to officially record a suicide (House of Commons Health Committee, 2017, para. 12). Notwithstanding this, suicide remains the leading cause of death among young people aged 20-34 years in the U.K., a leading cause of death in other age groups, and a major public health concern (DoH, 2012).

The ‘World Health Organisation (WHO) European Mental Health Action Plan 2013- 2020’ (2015) encourages European states to "develop and implement suicide prevention strategies that incorporate best evidence" (p.9). Despite this, only 13 European states have a national suicide strategy. In the United Kingdom, the cross-governmental strategy ‘Preventing Suicide in England’ (DoH, 2012), aims to reduce death by suicide. Two key areas of action comprise gathering research and tailoring approaches to improve mental health in specific groups. This research paper covers both. Preventing Suicide in England focuses on people with mental health difficulties as they are particularly vulnerable to suicide (DoH, 2012, p.7).

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (University of Manchester, 2016) reported that suicide rates vary among populations served by mental health services, and are complicated by inaccurate total patient numbers and a fluid clinical population (pp. 8-11). It has been estimated that a third of people who take their own lives have had contact with mental health services in the year prior to their suicide, and two thirds have attended their

general practitioner (DoH, 2012). During the period 2004-2014, 28% of suicides in the U.K. general population were among current mental health service users (University of Manchester, 2016).

Mental Health Services and Risk

The House of Commons Health Committee (2017) and the latest Preventing Suicide in England report (DoH, 2017) have urged services to improve training for mental health professionals in the assessment of suicide risk. Indeed, a major focus of mental health policy and practice in recent years has been the assessment and management of risk, including suicidal risk, among service users (Nolan & Quinn, 2012, Royal College of Psychiatrists [RCP], 2008; Tickle, Brown & Hayward, 2014). However, an increasingly instrumentalised approach to risk management and subsequent risk aversion by staff may inadvertently increase risk by prioritising the assessment over meaningful engagement and connection with the person (Vassilev & Pilgrim, 2007; Power, 2004)

A survey of multidisciplinary mental health staff by Wand, Isobel and Derrick (2015), found that most staff considered risk assessment and management as integral to good care, and had faith in a technical or ‘tick-box’ approach to risk. The evidence base suggests that a ‘tick-box’ approach is ineffective at predicting risk (Awenat et al. 2017; Carter et al., 2017). The National Institute for Health and Care Excellence (NICE) recommends that services use a psychosocial formulation informed approach to risk (Awenat et al., 2017; NICE, 2011) An investigation into perceptions of risk and recovery among clinical psychologists by Tickle et al. (2014) found they were aware of ‘recovery’ as an emerging alternative to a traditional paternalistic approach to mental health services but still worked within narrow conceptualizations of risk, and felt obliged to be risk averse due to service restrictions. Tickle et al. (2014) found that risk

was perceived as primarily physical and emanating from the client. This perception does not acknowledge the risks of iatrogenic harm such as risks from psychotropic medication, or excessive rights restrictions (British Psychological Society [BPS], 2012; Tickle et al., 2014).

A common theme in mental health policy, research and practice is the development and use of enhanced risk assessment methods (Murray, 2016). However, increasing the range of instruments purported to assess risk is unlikely to reduce the number of deaths by suicide (Awenat et al., 2017; Cutcliffe & Stevenson, 2008a, 2008b; Murray, 2016). The considerable reliance on methods of technical risk assessment in the absence of a solid evidence base is unethical and concerning (Carter et al., 2017; Wand et al. 2015). Cutcliffe and Stevenson (2008a, 2008b) argue that much of the research has focused on the identification of causal links or clinical features associated with suicide - presumably in the hope that these can be identified and reduced. Risk assessment tools have a poor evidence base, with no useful predications for clinical work (Carter et al., 2017; Owens & Kelley, 2017; Quinlivan et al., 2017a. 2017b).

Working with Suicidal Risk as a Mental Health Professional

There is a limited amount of research exploring how mental health staff experience working with risk. An area that remains particularly under-researched is the experience of health professionals working psychotherapeutically with suicidal clients. Understanding the experiences of people working directly with clients may identify means of supporting staff to work effectively and safely in that role, and in turn reduce the number of deaths by suicide

Many professionals experience that working closely with death, particularly suicidal death, generates intense discomfort (Hagen et al., 2017; Wurst et al., 2010;

Yaseen et al., 2013). This may explain why Thomas and Leitner (2005) found that some professionals adopt a traditional ‘crisis intervention’ model which takes power away from the client and does not seek to comprehend their inner emotional experience, but instead attempts to treat their ‘mental illness’ or ‘suicidality’. Thomas and Leitner (2005) propose a ‘fight or flight’ model to conceptualise how professionals respond when working with suicidal clients.

Embodying the fight response, the professional takes control of the client and removes their agency; they then proceed with actions they believe are ‘best’ for the client. In flight mode, the therapist psychologically flees the client, by not therapeutically engaging them and avoiding the issue of suicide, or by strategic avoidance, such as referring them elsewhere. Arguably, the ‘ideal’ response involves authentically engaging with the client and working meaningfully with them to try and understand their experience and promote alternatives to suicide (Thomas & Leitner, 2005). A literature review on the role of psychiatric nurses caring for suicidal people by Cutcliffe and Stevenson (2008c) argued that working with suicidal clients’ needs to be an emotional and relational endeavour, as advocated by Hagen et al. (2017), suggesting that talking and listening to the patient ought to characterise the approach.

In acute mental health services, nursing staff often have most direct contact with people who are suicidal, owing to the frontline nature of their role. Bohan and Doyle et al. (2008) and Hagen et al. (2016) found that nurses experienced working with suicidal clients as emotionally demanding and that the work often evoked emotional pain and discomfort. Moreover, Cutcliffe and Stevenson, (2008a, 2008b) found that nurses may - consciously or otherwise - seek to distance themselves from the emotional pain of the person they are working with through various strategies which may impair their ability to establish a therapeutic alliance with their client, akin to the flight response of Thomas and

Leitner (2005). Cutcliffe & Stevenson (2008a; 2008b; 2008c) have recommended that health professionals receive training to develop and channel their effort to provide emotionally and relationally connected care for suicidal patients, which in turn should reduce risk (Hagen et al., 2017; Murray, 2016). To achieve this, Cutcliffe and Stevenson (2008b) and Hagen et al. (2017) recommend the provision of training not in risk assessment, but in increasing self-awareness among professionals and the ability to manage emotional difficulties regarding death, suicide and distress.

Hagen, Hjelmeland, and Knizek (2017) claim that relational and emotional connection between clients and staff may be diminished by staff prioritising the ‘risk’ over the relationship. A predominantly risk-averse culture places unrealistic expectation on staff and service users, and excessive demands on resources (RCP, 2008; Hagen et al., 2017). This could from the focus on relational and emotional care, characterised by Hagen et al. (2017) as ‘connecting with and caring for’ the patient. Working relationally is argued to allow for connecting and the formation of a trusting bond between staff and clients, creating a foundation for collaboration. In psychotherapy, a robust therapeutic alliance has been found to be a reliable predictor of effective therapy (Ardito & Rabellino, 2011; Horvath & Dianne, 1991; Wampold, 2015).

Through the relationship the client has a safe and secure base and feels emotionally held, which allows them to connect with, share and process their "psychache" (Hagen, 2017, p.101; Murray, 2016). A large body of research supports the view that the therapeutic alliance is an important variable in facilitating therapeutic change. However, despite calls for an emotional and relational approach there is limited evidence that such an approach reduces suicidal risk. A systematic review of studies investigating the association between the therapeutic relationship and treatment outcome relating to suicidal ideation and behaviour by Dunster-Page, Haddock, Wainwright, and

Berry, (2017) found that nine of 12 studies reported at least one positive impact of high alliance between patient and professional on patient's suicidality. Furthermore, none of the 12 studies reported that a strong alliance had a detrimental impact on patient's suicidality. More research in this area is required to understand the impact of an emotional and relational therapeutic approach to risk of suicide.

Working Psychotherapeutically with Suicidal Clients

Staff working psychotherapeutically have frequent, prolonged, direct contact with clients who are suicidal. Therapists typically meet a client weekly for approximately 50 minutes, depending on the service or therapeutic modality. These sessions are likely to be emotionally intimate and are designed to address the client's emotional distress; sometimes therapy will focus on their suicidal intent, other times it may be more global. Wampold (2015) found that the most important factors in determining the efficacy of psychotherapy are the qualities and actions of the therapist. Wampold (2011, p.3) argues that whilst there are only minor differences between types of therapy, there are significant differences between "effective" and "non-effective" therapists. Wampold (n.d.) provides a list of 14 qualities that effective therapists possess. However, Wampold (2015, n.d.) did not specifically explore if the therapeutic alliance is effective in reducing suicidal risk.

From a service user perspective, clients' report that believing a therapist genuinely cares about them, which is knowable through their words and actions, is the ideal response (Thomas & Leitner, 2005), however they do not refer specifically to suicidal clients. A review of qualitative literature on counselling and psychotherapy for the prevention of suicide found that 'therapist qualities' of respect, understanding and being non-judgemental were also rated highly by clients (Winter, et al. 2014). Additionally, Winter et al. reported that clients found having their feelings validated and

accepted by therapists was essential in supporting them to process their experiences – particularly as many of them had lacked this opportunity in their past. This finding is akin to Cutcliffe's recommendation of "sitting with the person and listening" (2008b, p.8) and Wampold's (2013) finding that clients of effective therapists felt understood and trusted them. However, the review of Winter et al. (2014) is limited by including papers published only before 2007. A further limitation is that it reviewed only two papers focusing on therapist experiences of working with suicidal clients. Moreover, it does not explore what clients who are suicidal have found unhelpful.

Current Research

There are qualitative studies exploring therapists' experiences of working with suicidal clients but no recent review asides from Winter at el. (2014). If engaging some clients in meaningful therapeutic relationships can reduce their risk of suicide it is important to understand the experiences of those providing therapy, to best promote the 'ideal' response (Thomas & Leitner, 2005). Understanding these experiences could inform policy, practice and recommendations for further research. Therefore, this research aims to (1) systematically identify and critically appraise relevant qualitative studies and (2) use meta-ethnography to analyse and synthesise the results of the identified papers to understand how professionals experience working psychotherapeutically with clients who are suicidal.

Method

This study used a meta-ethnographic approach guided by Noblitt and Hare's (1988) method for synthesising qualitative studies. The defining feature of a meta-ethnography is its emphasis on interpretation rather than aggregation or summation of the data; the aim being to identify relationships between the studies regarding the research question. Noblitt and Hare (1988) identify seven phases of a meta-ethnography:

Phase 1: Getting started, Phase 2: Deciding what is relevant, Phase 3: Reading the studies, Phase 4: Determining how the studies are related, Phase 5: Translating the studies into one another, Phase 6: Synthesising translations, and Phase 7: Expressing the synthesis.

Aim 1. To systematically identify and critically appraise relevant qualitative studies.

Phase 1: Getting Started

Phases one and two involved identifying an area of interest that might be suitable for qualitative investigation (Noblitt and Hare, 1988); therapists' experience working with clients who are suicidal. Search terms were chosen through discussion with my research supervisor, and a university librarian specialising in health-related research, alongside terms used in existing literature. This step was followed by a literature search using the inclusion and exclusion criteria listed below to select appropriate studies.

Searching for studies. The following databases were searched in October 2016: MEDLINE, PsycARTICLES, PsycINFO. Using a Boolean search, the following terms and phrases were combined:

- Health Personnel Attitudes OR Psychologist Attitudes OR Therapist Attitudes OR Counselor Attitudes OR Clinical Psychologists Attitudes OR Psychotherapist Attitudes OR Psychotherapists OR psychotherapist OR therapist OR psychologist OR counselor OR counsellor OR psychologist OR psychiatrist
- Experience OR perspective OR view OR perception OR attitude OR opinion OR impact OR behavio* OR feelings OR emotions
- Attempted Suicide OR Suicidal Ideation OR Suicide OR Suicidology No

expanders or limiters were used. A total of 2,443 papers were screened for eligibility, as the search returned 104 papers on MEDLINE, 141 on PsycARTICLES and 2,198 on PsycINFO. Google Scholar was also searched using the following terms:

- Therapist OR Clinical Psychologists OR Psychotherapist Attitudes OR Psychotherapists OR psychotherapist OR therapist OR psychologist OR counselor OR counsellor OR experience of suicidal clients OR working with suicide.

Google scholar does not provide a total number of papers returned; however, the findings from the above search were exhausted and returned no additional papers (Figure 1. p.1-37)

FIGURE 1 HERE

Phase 2. Deciding what is of relevant interest: Selecting studies. For a paper to be included, the following inclusion criteria were applied: English, qualitative, peer-reviewed, must have a substantial focus on qualified health professionals' experience of working psychotherapeutically with clients presenting with suicidal risk, and must have direct quotes from participants to support results. Studies that met the inclusion criteria were then tested against the exclusion criteria. Studies were excluded if the study focused on health professionals in training, exclusively used survey findings, the participants were not working psychotherapeutically with their clients, i.e. 'talking therapy,' and where the study focused predominantly on experiences of health professionals when the client had died by suicide. Applying the inclusion and exclusion criteria left six studies remaining. See Table 1 (p.1-38) for descriptions of the studies.

TABLE 1 HERE

Phase 3. Reading the studies. In reading through the studies, the specific research question was: how do health professionals experience working psychotherapeutically with clients who are suicidal? Each paper was also quality appraised using the framework

outlined by Kuper, Lingard and Levinson (2008). These authors provide six items that readers ought to measure papers against when determining their quality. Initial evaluation enabled a systematic and critical consideration of each paper's value, but it was not used to exclude studies (Sandelowski & Barroso, 2003). See Table 2 (p.1-42) for a summary of quality appraisal findings.

TABLE 2 HERE

Aim 2: Using meta-ethnography to analyse and synthesise the results of the identified papers to understand how professionals experience working psychotherapeutically with clients who are suicidal.

Phase *4: Determining how the studies are related.* This phase involved noting frequent or salient concepts regarding the relationships between papers, and resulted in six concepts (Table 3, p.46). I adopted a social constructionist perspective when conducting the research. None of the papers stated their epistemological stance apart from Rossouw (2011) whose work was guided by a Heideggerian phenomenology. It seems a fair interpretation that each of the six papers sits could fit within the social constructionist framework applied in this current review as all the papers use the participants' own words, which express their 'reality', which can be interpreted as their perspective (Murray, 2013). Determining how the papers were related was grounded in these quotes, as well as the authors' interpretations. Interpretations in papers that appeared to go disproportionately beyond the data were not included in the analysis.

TABLE 3 HERE

Phase 5. Translating the studies into one another. Table 3 (p.1-46) illustrates how the studies were translated into one another. The contents of the cell summarise each study. Fidelity to the concepts of the original papers was maintained by using some of the

original authors' concepts the grid; in other cases, the essence of the paper is summarised. Cell entries in parentheses signify where no material contributed to the first order; meaning the concept was not frequent or significant in that paper. The key concept in each cell in each row was then translated from the original into the first order concept; for example, content from the five papers apart from Reeves and Mintz (2001) went into first order concept of 'building relationships'.

TABLE 4 HERE

Phase 6. Synthesising translations. The line of argument was synthesised from the second order interpretations, upon which the third order interpretations were founded. This process is illustrated in Table 4 (p.1-50). Importantly, steps 1-6 were not a linear process and there was much iteration and refining. Phase 7, the final phase, is 'expressing the synthesis' which is achieved through this paper and its dissemination.

TABLE 4 HERE

Results

The line of argument is that therapists experience considerable emotional demand when building or maintaining relationships with clients who are suicidal. To build and sustain the relationship, therapists need a range of supports to meaningfully engage with their clients. However, for some therapists, fear of blame and, or, of emotional discomfort contributes to them avoiding relational closeness with their clients. See Table 1. p.1-36/37 for number assigned to each paper used in results.

Building Relationships

In all six papers, the therapeutic relationship was experienced as an important part of working with clients who are suicidal. Referring to the role of the relationship, one participant commented "Creating therapeutic change with the client is relational it is something that happens together within the therapeutic relationship. That's how it

happens." (3, p.26). While papers 4 and 5 acknowledged the importance briefly, participants in the other four papers experienced a strong therapeutic relationship as foundational when working with clients who present with suicidal risk (2, 1, 3 and 5)

Despite its importance, establishing a relationship was a substantial challenge for therapists. Some attributed this experience to clients having difficulties with relational closeness and associated emotions (5). Interpreting the client's behaviour enabled therapists in (5) to pursue the relationship regardless of the challenges and to attempt to work through the client's defences against relational closeness. Conversely, some therapists in (3) disrupted the relationship by strategically avoiding the topic of suicide, (p.10) "Many clinicians have the attitude 'don't ask, don't tell'". This was an effort to manage therapists' discomfort in experiencing the emotional challenge of the work amid fear of blame and litigation.

Another challenge for some therapists was institutional pressure to conduct formalised risk assessments (2 & 6) Some participants experienced pressure to work with the 'suicidal behaviour' in an instrumentalised and reductive way without supporting the client to explore and process their feelings about why they were suicidal. Focusing on the behaviour rather than the meaning was linked to having not established a therapeutic relationship: "When the relationship is not there, that's when I start asking more direct questions" (1, p.220). Participants felt conflicted between managing the perceived risky behaviour and working authentically with the client in 2, 4 and 6: "It was about managing the risk as opposed to treating the person" (2, p.9).

Working psychodynamically meant participants in paper 5 had a unique perspective on building therapeutic relationships, given the focus on relational dynamics in that modality. Like paper 3 the participants in 5 were aware that many

clients had relational difficulties. Participants in 5 used this information to understand their experience of the clients and hypothesised that getting close to the therapist simply felt too dangerous for many clients. They also described the therapist's experience of feeling attacked or punished by the client, sometimes overtly and often passively. Interpreting the meaning of this behaviour helped participants to better tolerate 'attacks' on the relationship, allowing them to continue to try and form robust relationships with their clients.

Self-Doubt

Across all six papers therapists were affected by the intensity of this work. In 1, 3 and 6 participants questioned the meaning of their work and reported having significant doubts regarding the efficacy of therapy: "what do I achieve?" (1, p.4). In 2, 1 and 5 the process of tolerating these emotions was necessary for working effectively. Tolerating these emotions allowed therapists to connect authentically with clients without becoming emotionally overwhelmed. In all six papers, participants experienced a variety of distressing and intense feelings when working with suicidal clients, including panic, fear, and guilt. In papers 1, 2, 4 and 5 it was most intense: "I had an overwhelming sense of helplessness and hopelessness" (5, p.4).

In 6, working with clients who were questioning their own identity and meaning contributed to therapists experiencing a parallel process where they questioned their own personal and professional existence. Parallel processes occurred to some degree in all papers, except 3 where participants experienced distress but distanced themselves from the client's experience by focusing on treating the symptoms of the client's 'mental illness', or avoiding suicidal material (3, p.9): "A client dealing with hallucinations has significant problems managing their hallucinations around their suicidality because of the distorted thought processes". For these participants, medicalising clients' distress, rather

than connecting with how and why the client felt suicidal, seemed to buffer therapists from the emotional intensity.

Despite doubt stemming from the emotional and existential pressure faced by the participants there was still the potential for hope; this was most evident in 1, 2 and 5. Hope played a crucial role in the therapists' willingness to experience and connect with the emotional world of the clients while tolerating their own emotional distress: "we are human relational beings who are in communion with each other, there is hope" (2, p.7).

Hope was a standalone theme in 2 and in all three papers hope supported therapists in facilitating their clients to work through intense emotions instead of avoiding them through suicide. Conversely, in 4 some participants were dependent on their clients for hope, which risked the relationship getting caught in a hopeless cycle, as the clients had minimal hope. In papers where participants avoided or distanced themselves from the client's emotional world there was no identifiable sense of hope (4; 3). Without hope there seemed to be greater doubting of self-efficacy and the work had a more negative impact on the therapist.

Emotional Containment

Many participants reported that their clients' suicidality was related to intense hopelessness, accompanied by painful emotions they felt unable to experience without support. In those circumstances suicide was reported to provide a 'better' option, presumably in the absence of other means of coping, which therapists seemed to understand:

> What meaning does somebody's death have, what meaning does somebody's life have? Who am I to say that somebody should live, you know if they decided it really is the better thing for them, who am I to make that decision about what their life means, um, or what their death means. (2, p.11)

Working therapeutically with clients who were experiencing emotional pain so unbearable they would rather die was emotionally demanding. How therapists experienced and responded to these challenges was influenced by a range of factors, such as the therapeutic modality being used, their training, level of experience, the type of support they had and where they worked. In all papers, working with someone who was considering suicide evoked anxiety and was stressful. However, the therapists' ability to tolerate and contain the client's intense emotions varied between and within papers.

Participants in 1, 2 and 5 seemed to contain their own emotions and those that the client was not yet able to connect with and experience. Providing this emotional containment was experienced as holding hope for clients:

> I will often say to clients who are suicidal, "We're in this together, we're walking this particular path at this particular moment side by side, and yes it might feel like a dark place, it might feel like a place of crushing despair, but you're not going through it on your own. We don't know how it's going to end, we don't know where it's going to go" …. but within it, there is sometimes, just the tiniest, tiniest, tiniest speck of hope and that's something that, you know, keeps me going. (2, p.607)

Containing the intense emotions when reprieve seemed unlikely was integral for tolerating this work. Yet, in 4 the participants did not acknowledge the importance of containment and seemed to be emotionally uncontained. In 3 some therapists spoke of avoiding the topic of suicide and feeling incapable of working with clients who were suicidal. In 2, participants found the work challenging but believed that tolerating these feelings was a necessary component of working with suicidal clients. According to one participant in 5, "The most important thing is you have to care" adding that caring is

what contains the client's difficult emotions. This is not to suggest that participants who could not tolerate the intense emotions did not care. Possibly, what is being referred to is the action of caring and having the capability and support to provide that care, which allowed them to tolerate the intense emotions.

Managing Boundaries

In all papers, participants had challenges maintaining their own boundaries and respecting those of clients, psychologically and physically. Participants appeared to be tested by the challenge of holding firm boundaries, internally in terms of separating their emotions from the client's, and externally, in terms of resisting the temptation to take control of the client either through instruction or restricting their rights in some form.

Participants in 3 and 4 were deeply affected by their work, which permeated their personal and professional lives. Participants had difficulty separating their feelings from the client's. In 5 therapists experienced some of their clients' hopelessness, despair and other feelings but, overall, they distinguished boundaries between clients' feelings and their own:

> I felt at times completely useless, hopeless as a therapist and a human being, always doing and saying the wrong thing. I also had strong feelings of her dependence and panic at the degree of it. Sometimes the feelings were acknowledged by her to be hers, at other times I carried them all. (p.8)

The participants in the papers of 1, 2 and 5 were the most capable of providing boundaried care:

> She makes me want to become invasive and overpowering. I think, 'right, give your money. I'll keep all your money and give you pocket money and then we'll get you sorted out'. I feel terrifically tempted to do this. (5, p.9)

This participant is aware of her intense emotions and the temptation to act on them, yet she does not do so, but instead contains her feelings. Participants in these papers managed to tolerate intense feelings without acting on them. Tolerating intense feelings enabled them to respect the client's boundaries and manage their own. Similarly, in 1 participants had difficulty managing boundaries but they balanced their desire to control the client with respecting client autonomy and trying to preserve those boundaries.

Conversely, in 6 the boundaries were managed in ways that prevented the therapists from engaging authentically with the clients:

> Is my neck on the line? I had all these bureaucratic concerns about how responsible I have been…it brings added pressure…They are risk averse and you should protect yourself...the question of how to open up to the person without institutional investigation creates conflict for me. It interferes with spontaneous practice. That need to feel safe steers you in the way of prescriptive practice and that is not care. (p.6)

Participants experienced this approach as incongruent with their values and how they wanted to work, yet they were trying to avoid blame and preserve their job, resulting in a sense of internal conflict and frustration.

Needing Support

Therapists providing emotional containment required support: professionally, emotionally and institutionally. All six papers referred to the essential role of support when working with clients who are suicidal. Good quality supervision was noted as crucial in all papers, but was not always received. In 6 supervision was experienced by many as low quality and unhelpful. Supervision was experienced as helpful when participants could openly share their actions, experience and emotions and reflect on their work:

> It [supervision] was a release and I felt more comfortable with myself. It is part of the process of letting go; I remember asking myself what is it that I am trying to control here? What was I holding on to? And I think it was the thought that in this job I am not supposed to make mistakes. (6, p.8)

Moreover, having support from peers, colleagues and a clinical supervisor was deemed essential to tolerating the burden of responsibility and to nurturing self-awareness and one's personal emotions, "supervision was crucial…and working through all the things I did not want to own up to myself" (1, p.221).

In 6 (p.8) clinical supervision was mostly experienced as a task focused on managing and dealing with the technical approach to measuring 'risk'. This approach was reported to be a consequence of the culture of the institution where they were employed, the New Zealand District Health Board, (a free-to-access public health service). Participants in 6 found that clinical supervision focused on ensuring they had completed the associated paperwork to protect themselves and their employers from blame or liability. Therefore, supervision was experienced as a place to gain confirmation that you 'had done the right thing' rather than somewhere to consider what the client might require therapeutically, to process emotions or reflect on the impact of working with suicidal clients.

Fear of Blame and Emotional Discomfort

Fear regarding blame, guilt and 'necks being on the line' was at the forefront of therapists' minds when they worked with suicidal clients in 3, 4 and 6. Some therapists were concerned whether they had 'ticked the right boxes' which was influenced by the culture of the organisations they worked in (2, 4 & 6). These concerns limited their ability to work therapeutically with the client as they focused on the risk rather than the therapeutic relationship. Throughout the above papers, therapists were

fearful of being investigated, should their client die by suicide, which impacted how they worked. When the fear was intolerable some therapists appeared to adopt a ‘tick-box’ approach to risk, where they insulated themselves from potential blame but engaged less with the client’s emotional experience.

The perceived need to protect oneself in a culture of fear and blame seemed to generate a sense of internal conflict for several participants (3, 4 & 6). Many wanted to do what was best for the client yet found themselves in situations where they felt obliged to meet institutional demands – which they mostly experienced as contradictory to providing care. Other ways of coping involved participants seeking reassurance from colleagues which was also related to fear of litigation and blame (4).

In the three remaining papers the opposite occurred, that is, participants focused more on building a therapeutic relationship and less on the ‘risk of suicide’: “It felt really important that I did not try to work with the suicide but tried…. remained wholly with her" (1, p.220).

In 1 and 5 participants were less limited by fear of litigation and more capable of caring for the client through building the relationship, and of caring for themselves through using supports. In 1, five participants were working in private practice, six in the voluntary sector, three in academic settings and one was in the health service; in 5 this was not clarified. In 1 participants experienced intense emotions when working with suicidal clients; yet, they balanced these fears with working with the whole person. Somehow, they held the tension between understandable fears and building a relationship with the entire client, not just the suicidal part.

Discussion

The line of argument is that therapists experienced considerable emotional demand when building or maintaining relationships with clients who are suicidal. To build and sustain the relationship, therapists need a range of supports to meaningfully engage with their clients. However, for some therapists, fear of blame and/or of emotional discomfort contributes to them avoiding relational closeness with their clients. This line of argument is more than a summary of the existing papers; it provides an extended interpretation of their combined sum (Noblitt & Hare, 1988). As a result, this meta-ethnography provides a novel addition to the literature on suicide. The addition of six key concepts, combined into a line of argument, illustrates how health professionals working psychotherapeutically experience working with suicidal clients. The line of argument provides a framework that conceptualises this experience.

The findings offer novel insights into therapists' experiences of working with clients who are suicidal. They also support earlier research claiming that working with death and suicide can be emotionally discomforting (Cutcliffe & Stevenson, 2008b; Hagen et al., 2017). Furthermore, the findings show how working with suicidal clients had a significant impact upon some therapists' wellbeing (Moerman, 2012; Popadiuk et al., 2008; Roussow et al., 2011). Moreover, it was found that for some therapists working with suicidal clients was intolerable, to the point where they tried to disrupt the therapeutic relationship by avoiding the topic of suicide, adopting a 'don't ask don't tell' approach (Popadiuk, Young, & Valach, 2008, p.10). Therapists who were better able to tolerate the experience were more capable of supporting their clients through the therapeutic relationship (Moerman, 2012; Nicholl et al., 2016; Richards, 2001; Roussow et al., 2011).

To build and sustain the therapeutic relationship, and tolerate the emotional

intensity, the line of argument tells us that therapists need secure and nurturing support. In all papers, clinical supervision was experienced as central to providing 'good enough' care and processing the emotional aspects of working with suicidal clients. Where supervision was unhelpful, it was experienced as focused on the technical aspects of their work rather than their own experiences and emotions (Roussow et al., 2011, p.8). The "Care Quality Commission Supporting information and guidance: Supporting effective clinical supervision" (2013) states that clinical supervision aims to help staff to manage the personal and professional demands created by the nature of their work; it also states that this should be a priority when working with complex or challenging cases (p.5). The evidence base supporting the efficacy of supervision is small, but suggests that it is a valuable component for many health professionals (Wheeler & Richards, 2007; Spence et al., 2001).

Peer support from colleagues (Moerman, 2012, p.221; Nicholl et al., 2016), personal therapy (Nicholl et al., 2016, p.604, and in Richards (2000), potentially, the modality of psychodynamic therapy, also seemed to be important supports. Psychodynamic therapy requires working with an awareness of process relating to feelings, such as countertransference and projective identification, as well as containment (Bion, 1959, 1962). Acknowledging these - sometimes uncomfortable - feelings and being curious about what they represent is a central aspect of this way of working (Molnos, 1995). Being psychodynamically trained and working within the modality may be helpful for therapists working with suicidal clients.

The line of argument points to Thomas and Leitner's (2005) model, with therapists in the current study experiencing a mixture of 'fight', 'flight' or 'ideal' responses when working with suicidal clients. Bion's (1959, 1962) theory of containment also provides a concept for understanding therapists' experiences. According to Bion, the

therapist must contain the client's projections of intense thoughts or feelings before re-representing them to the client in less destructive interpretations. Clients may eventually internalise this experience and develop a capacity to tolerate their own emotions thereafter. In terms of the line of argument, the therapist must be able to tolerate these intense projections from clients who are suicidal, to build a therapeutic relationship.

The line of argument is supported by research into the qualities and actions of effective therapists (Messer & Wampold, 2002; Wampold, n.d.). The six concepts contributing to the line of argument illustrate how therapists who focused on relational connectedness displayed qualities and actions by effective therapists. The therapists in the current study focused primarily on establishing the therapeutic relationship; they did not avoid difficult material in therapy and they used such difficulties therapeutically; they also displayed self-awareness of their own psychological processes; and lastly, they conveyed hope and optimism.

Fear of blame and emotional discomfort was an issue for many therapists (Nicholl et al., 2016; Popadiuk et al., 2008; Reeves & Mintz, 2001; Rossouw et al., 2011). Stanley and Manthorpe (2004, p. 10) suggest that fear of blame contributes to mental health staff working at less depth and adopting a 'conveyer belt like' approach to the work,which fails to engage adequately with the needs of people using services. Understood through Thomas and Leitner's (2005) model, some therapists appear to adopt a 'flight' response by avoiding a relationship with the clients and their emotional experiences.

Considering the findings of the current study, policy makers, service managers and employers could consider moving away from a culture of blame to one where staff are accountable but are encouraged and supported to take positive risks (Stanley & Manthorpe, 2004). Moving beyond a culture of blame towards one of 'focusing on

> the greater good' has been advocated by the RCP in 'Giving up the Blame' (2007) and the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness (University of Manchester, 2016). The RCP recommends a strengths-based approach to risk, which emphasises recovery (Morgan, 2007, p.13)

A non-blame focused positive risk-taking approach would need to recognise that a narrow focus on risk, along with risk-averse staff is, at least ineffective, and at worst dangerous (Murray, 2016; Morgan, 2007). It is ineffective due to lack of an evidence base for a predominantly 'tick-box' instrumentalised approach (Murray, 2016: Owens & Kelley, 2017; RCP, 2007).

Not providing suicidal clients with effective care may be harmful, as they need and deserve effective services. In Rossouw et al. (2011) and Popadiuk et al. (2008) therapists felt restricted by an overly instrumentalised and defensive approach to working with suicidal clients, but avoided an emotional and relational approach due to fear of blame. Murray (2016) argues that patients presenting with thoughts of actions of suicide, should receive care that is "focused on reducing or tolerating emotional pain" (p.1). However, the line of argument and the evidence suggest fear of blame is preventing some therapists from providing an approach that promotes this ability in clients. Advocates for a shift in health services from 'a blame culture to a learning culture' include the current Minister for Health (DoH, 2016).

Implications for Policy and Practice

Policymakers may benefit from reviewing the focus of Preventing Suicide in England (2013), considering the findings of the current review and bearing in mind the important role of therapists for many people who are suicidal. To balance, or replace an instrumentalised 'flight' approach with an 'ideal' response, professionals require training in self-awareness, supporting them to recognise and tolerate their intense feelings and the

‘urge to act’ or ‘flight’. They would need to receive training to contain their clients’ emotions and their own. These skills are a basic requisite for using an emotional and relational approach. This would enable staff to support clients to reduce and tolerate the emotional pain, or ‘psychache’ that is causing their suicidality, and should lower risk of death by suicide. For staff to provide this type of care, they need good quality regular clinical supervision, and training in being emotionally attuned to their own needs as well as those of clients. Furthermore, it is important to consider individual or system related factors that may contribute to avoiding difficult material, such as suicide or related emotions, and factors that hamper a departure from a culture of blame.

Limitations

Including only six studies limits the generalisability of the findings; therefore, caution is needed when using them. Another limitation is the range of settings, modalities and cultures across a period from 2000 to 2015 in the six studies. Issues regarding the quality of some papers is another limitation of this study, as some studies had low clarity overall, with minimal detail on method (Reeves & Mintz, 2001; Richards, 2000), interpretations extended beyond what the data contained (Roussow, et al. 2011) and no papers considered ethical issues such as issues regarding power, or reflexivity of the researcher – all identified as key features when considering the quality (Kuper et al. 2008)

Future Research

More research into the experiences of those working psychotherapeutically with suicidal clients is required as there is a dearth of literature in this area. Future research could investigate the experiences of other health professions working with suicidal clients to compare their experiences to those in this study. Experiences of nurses have been investigated; however, psychiatrists, occupational therapists, and pharmacists are

important members of mental health services who have frequent contact with suicidal clients and their experiences are not covered in the existing literature.

Research investigating experiences of therapists in specific settings, such as community mental health teams, inpatient settings or third sector providers would also be needed to identify what factors influence experience. Additionally, how different modalities may support the therapist to work effectively with suicidal clients warrants further exploration, such as those working psychodynamically in Richards (2000). Exploring the experiences of therapists who respond 'ideally', with a view to identifying what has been helpful or unhelpful in developing those qualities and actions is also important. Future research needs to consider issues regarding quality, particularly key sample appropriateness, and overall clarity regarding what the researchers did, appropriate analysis of data, consideration of ethical issues; these are areas identified as fundamental factors of quality (Kuper et al. 2008).

Conclusion

This research aimed to improve our understanding of the experience of those working psychotherapeutically with suicidal clients. Based on these findings, it appears that therapists may experience considerable emotional demand when building or maintaining relationships with clients who are suicidal, and that to build relationships, therapists need a range of supports. However, for some therapists, fear of blame and/ or of emotional discomfort could contribute avoidance of relational closeness with clients. Despite the low number of studies reviewed, this research provides a line of argument that may be helpful for policymakers, researchers, services and therapists.

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FIGURE 1

Flowchart Diagram of Article Selection Process.

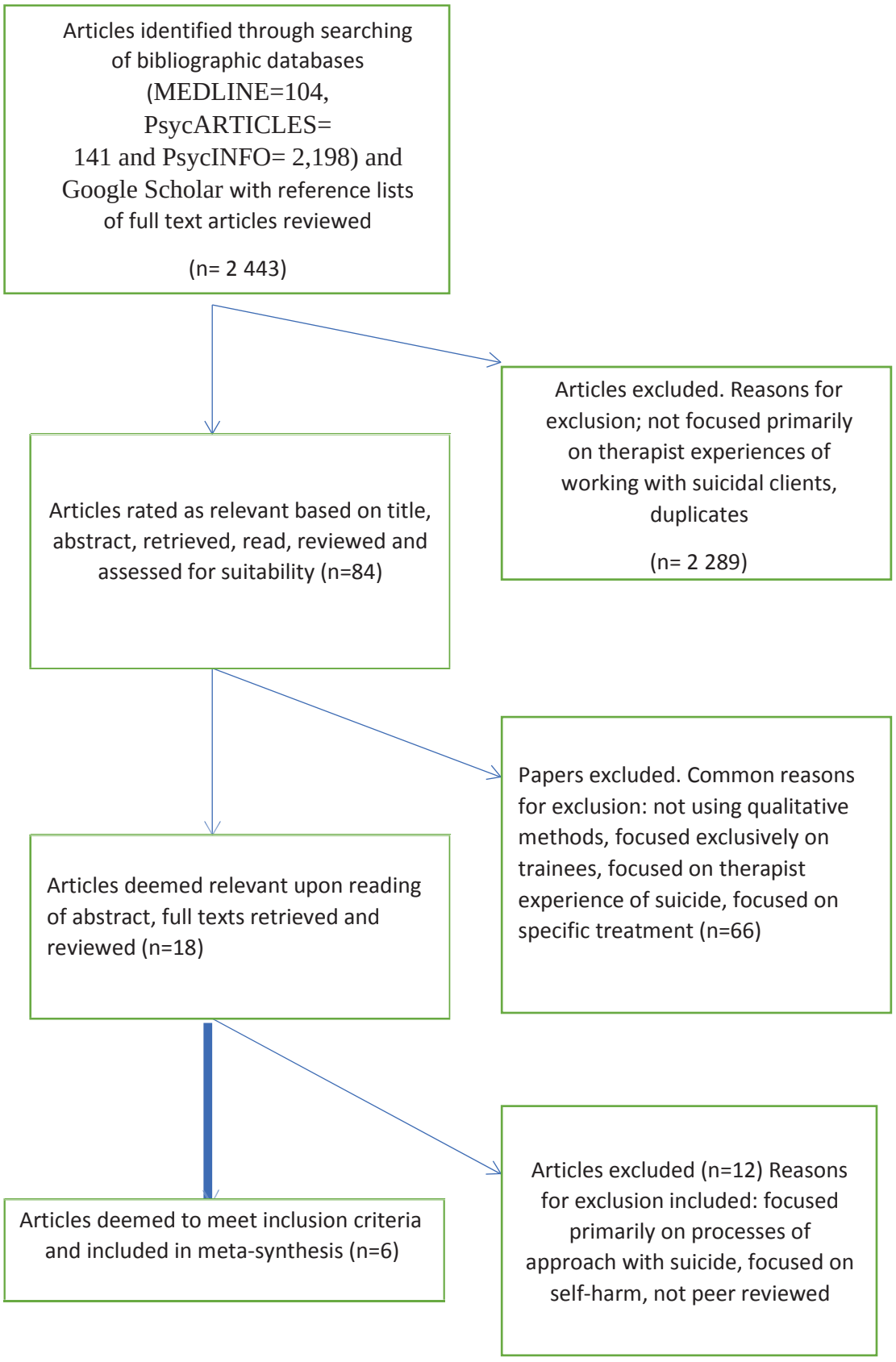

Table 1.

Description of Studies part I

	(1) **Moerman (2012)**	(2) **Nicholl, Loewenthal and Gaitanidis (2016)**	(3) **Popadiuk, Young and Valach (2008)**
Research Question/Aim	To determine how the person-centred counsellor experiences and understands the issue of risk assessment within the confines of their work ethos	An exploration of what it is like for psychotherapists who work with suicidal clients within a culture of suicide prevention.	An investigation of clinician perspectives of the therapeutic use of the self-confrontation procedure with suicidal clients.
Methodology, method of data collection and analysis	Semi-structured interviews, analysed using thematic analysis	Informal interviews analysed using narrative analysis according to Bruner's method (1990).	Focus group, followed up by individual interviews. Analysed using methods common to thematic analysis

Participants: modality of therapy, setting, age range years of experience, sample size, gender.	Seven person-centred counsellors, between four and 35 years of experience (mean 12.5), aged from 42-74 years, five females and two males, and all white, British; private practice (5), and or voluntary sector (6) and (1) in academic setting	Five with experience working as counsellors and psychodynamic therapists; two women and three men. Gestalt (2), Psychodynamic (2) and existential (1). Four previously worked for NHS, another for a charity, but all now worked in private practice.	Eight, with a minimum of three years' experience providing counselling or support to suicidal clients. Three female and five male, four master-level clinical social workers, two occupational therapists, a master-level psychiatric nurse, and a bachelor-level psychiatric nurse. Working in employee assistance program, a day program for clients with schizophrenia, and a community mental health team.

Table 1.

Description of Studies part II

	(4) **Reeves and Mintz (2001)**	(5) **Richards (2001)**	(6) **Rossouw, Smythe and Greener (2011)**
Research Question/Aim	An exploratory study of counsellors' experience of working with suicidal clients	An exploration of the experience of psychotherapists working with suicidal patients.	A study of therapists' experiences of working with suicidal clients
Methodology, method of data collection and analysis	Semi-structured interviews analysed using a constant comparative method	One hundred psychotherapists were surveyed by questionnaire with five follow-up semi-open-ended. interviews; analysed using content analysis	Hermeneutic-phenomenological methodology informed by Heidegger (1962)

Participants: modality of therapy, setting, age range years of experience, sample size, gender.	Four person-centred counsellors. Four females. Working in a health setting, voluntary sector, private practice and local authority. Aged between 40-50 years. All had or have experience of working with suicidal clients.	Five Psychodynamic or Psychoanalytic therapists. No further details provided.	13 participants aged between 30-50 years. All employed by District Health Boards. Five psychologists, seven psychiatric nurses and one psychiatrist. Seven female and six male.

Table 2

Summary of Quality Appraisal guided by Kuper, Lingard, & Levinson (2008)

	Moerman (2012)	**Nicholl, Loewenthal and Gaitanidis (2016)**	**Popadiuk, Young and Valach (2008)**	**Reeves & Mintz (2001)**	**Richards (2000)**	**Rossouw, Smythe and Greener (2011)**
Sample appropriateness?	Gave sufficient detail on demographics.	Justified method and clearly	Good detail on recruitment process and participants	Good detail on inclusion criteria but lacked clarity on recruitment	Good details of process of recruitment	Clarity on recruitment process and demographics.
Data collection appropriateness	Sufficient detail of semi-structured interviews	Sufficient detail regarding process	Clarity on rationale for method and process	Unclear who conducted interviews	Lacked clarity about selection of five interviewees	Sufficient details of process.

Data analysis appropriateness	Used thematic analysis but lacked detail	Good detail and clarity regarding choice of narrative analysis and process	Described analysis in detail but only briefly mentioned method,lacked clarity.	Very unclear, named method used but gave no details of application.	Unclear how analysis was conducted, merely stated 'content analysis'.	Analysis seemed appropriate but method was difficult to read and verbose.

Table 2

Summary of Quality Appraisal guided by Kuper, Lingard, & Levinson (2008)

	Moerman (2012)	**Nicholl, Loewenthal and Gaitanidis (2016)**	**Popadiuk, Young and Valach (2008)**	**Reeves & Mintz (2001)**	**Richards (2000)**	**Rossouw, Smythe and Greener (2011)**
Transferability of findings	Strong emphasis on experience of therapist.	Good transferability, emphasis was on experience with clear results.	Caution is needed due to lack of clarity on analysis and focus on 'self-confrontation'.	Caution is needed due to poorly formatted and difficult to read results section.	Good examples of experiences with appropriate use of quotations.	Poorly written, contains a lot of jargon and interpretation is mixed with findings.
Ethical adequacy	Lacked clarity on actions taken to address ethical issues	No mention of ethical issues or reflexivity	No mention of ethical issues	Considers impact on participants. Formal ethics unmentioned.	Inadequate focus on ethics	Addresses ethics explicitly on a range of issues with good details.

Table 2

Summary of Quality Appraisal guided by Kuper, Lingard, & Levinson (2008)

Overall clarity	Good clarity in some areas. Clarity is lacking in method and ethics.	Good clarity throughout. Inadequate ethical considerations.	Good clarity overall. Clarity is lacking clarity in analysis section.	Poor clarity overall	Reasonable clarity overall apart from method and ethics sections	Reasonable clarity in areas- lacking clarity on results and implications

Table 3.

Phase 5: Translations of Studies Into One Another

	Moerman (2012)	**Popadiuk, Young and Valach (2008)**	**Nicholl, Loewenthal and Gaitanidis (2016)**	**Reeves and Mintz (2001)**	**Richards (2001)**	**Rossouw, Smythe and Greener (2011)**
Importance of therapeutic relationship	Quality of relationship was crucial.	Relationship recognised but some emphasis on 'treating illness'.	Relationship as pivotal and a privilege	(Acknowledged but not emphasised)	Actively pursued and maintained despite 'attacks by client'.	Hampered by focus on formal risk assessment and control of risk.
Containment	Giving client a safe platform to explore and process	Therapists feeling incapable of working with clients	Recognised as testing for therapist but necessary	Participants feeling uncontained	Receptacles for the clients' unbearable feelings	Operating at a surface level with through bureaucracy

Table 3.

Phase 5: Translations of Studies Into One Another

Self-doubt	Feeling distressed and questioning efficacy and meaning of work	Unsure how to work with suicide, actively avoiding the topic	On a range of issues	Feeling inadequate and unprepared	Therapists aware of intense emotions such as hopelessness	Concerns that formalised approach is inauthentic and ineffective
Needing support	Supervision and peer support as crucial	Wanting further training to work with suicidal clients	Mixed experience of supervision, but rated it as fundamental	Reassurance seeking from others, especially supervisors	Mixed range of supports	Needing assurance from colleagues that the ‘right box is ticked’

Table 3.

Phase 5: Translations of Studies Into One Another

	Moerman (2012)	**Popadiuk, Young and Valach (2008)**	**Nicholl, Loewenthal and Gaitanidis (2016)**	**Reeves and Mintz (2001)**	**Richards (2001)**	**Rossouw, Smythe and Greener (2011)**
Managing boundaries	Balancing desire to control client with client autonomy	Struggling with emotional impact of work	Multi-dimensional awareness of boundaries personal and professional	Obsessing over client's behaviour, out of work hours	Managing emotional experiences and encouraging client autonomy	High level of bureaucratic self-protection, clashing with participants' values
Fear of emotion and blame	(Supporting client autonomy and rights)	Active avoidance of addressing suicide due to fear	Institutional pressure and culture of blame	Fearing litigation and blame	Strong tolerance for client distress	Myopic focus on 'risk' is primary focus of their work

Table 3.

Phase 5: Translations of Studies Into One Another

Explanation/ theory Second order interpretation	*Working holistically with suicidal risk can reduce risk, however the work significantly impacted the therapist.*	*Therapists' difficulties working with suicidal clients possibly diminished their ability to work therapeutically.*	*Therapists found the work intensely challenging but rewarding.*	*Organisational culture influenced approach to risk, which felt incongruent with values.*	*Working with suicidal clients evoked intense emotions. Support was essential when engaged in such work.*	*Institutional pressure to focus on risk assessments hampered the therapeutic alliance.*

Table 4.

Synthesising Translations into a 'Line of Argument'

Concepts	Second Order Interpretations	Third Order Interpretations (Line of Argument)
Building Relationships **Emotional Containment** **Self-Doubt** **Managing Boundaries**	The relationship is where the change happens. Therapists experience intense emotional pressure and self-doubt.	Building and maintaining a therapeutic relationship places considerable emotional demand on therapists.
Needing Support	Therapists require quality supervision and institutional support.	They require a range of supports to be able to engage meaningfully with suicidal clients.
Fear of Blame	Cultures of blame add to therapist's emotional burden and diminishes their willingness to connect with client.	Therapist's fear of blame/emotional discomfort may contribute to distancing from client

Appendix 1-A: Example of Initial Analysis of Paper

Paper	Key themes, first iteration	Key themes, final iteration
Moerman (2012)	*Impact of RA on* *self* Personal impact Severe Intense Immediate and long-term impact on counsellor *Emotional impact on counsellor* Years of impact "I had an overwhelming sense of helplessness and hopelessness" (p.217) Initial intense strong emotional reaction to expressions of suicidal intent Panic when client expressed suicidal intent Pervasive doubt "What do I achieve…?" (p.217) Desire for knowledge to know what to do Difficulty with not knowing what the client's going to do Desire to control the client Overpowering feelings of responsibility Bringing strong reactions to work to supervision Need for self-protection and self-awareness	**Intense emotional response to suicidal clients** **Wanting to know what to do?** **Strong and wide ranging emotional reaction** **Personal and professional fragility** **Desiring control over the client** **Essential need for self-care** **Value of professional support**

Appendix 1-A: Example of Initial Analysis of Paper

	Process of building therapeutic alliance and holding the client in the moment and considering the consequences of possible actions was often intense and lengthy and left participants feeling exhausted "Absolutely exhausted,…I think I gave a lot of energy out…in the beginning to build enough of an alliance" (p.217) *Use of language* Need for directive language when complying with organisational risk assessment procedures To avoid confusion Using non-directive language deemed appropriate when need to proceed tentatively	**Emotional cost of holding the client** **Need for sensitive but open and clear communication regarding suicidal intent**

Appendix 1-B: Author Guidelines

Author Guidelines

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in Psychology and Psychotherapy: Theory, Research and Practice are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

All articles submitted to PAPT must adhere to the stated word limit for the particular article type. The journal operates a policy of returning any papers that are over this word limit to the authors. The word limit does not include the abstract, reference list, figures and tables.

Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length (e.g., a new theory or a new method). The authors should contact the Editors first in such a case.

Word limits for specific article types are as follows:

• Research articles: 5000words
• Qualitative papers: 6000words
• Review papers: 6000words
• Special Issue papers: 5000words

3. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

4. Submission and reviewing

All manuscripts must be submitted via Editorial Manager. The Journal operates a policy of anonymous (double blind) peer review. We also operate a triage process in which

submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the terms and conditions of submission and the declaration of competing interests. You may also like to use the Submission Checklist to help you prepare your paper. If you need more information about submitting your manuscript for publication, please email Melanie Seddon, Senior Editorial Assistant at papt@wiley.com or phone +44 (0) 1243 770 108

5. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

•Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. You may like to use this template. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the Credit website for a list of roles.

• The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placedat the end of the manuscript but they must be mentioned in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be

listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.

• For articles containing original scientific research, a structured abstract of up to 250words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.

• All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professionalpractice.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

• SI units must be used for all measurements, rounded off to practical valuesif appropriate, with the imperial equivalent inparentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publishlengthy quotations, illustrations, etc. for which they do not own copyright.

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• Manuscripts describing systematic reviews and meta-analyses must be submitted in accordance with the PRISMA statement on reporting systematic reviews and meta-analyses (http://www.prisma-statement.org).

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Running Head: INPATIENT STAFF CONCEPTUALISATIONS OF RISK

Section Two: Research Paper

How do staff working in older adult 'functional' inpatient settings conceptualise risk? A grounded theory investigation.

Word count: 7,953

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Abstract

Objective Risk is the primary reason for admissions to older adult inpatient mental health settings (Royal College of Psychiatrists, 2011). In mental health services risk is often associated with 'dangerousness' from patients and many services are risk averse with limited evidence of positive risk-taking (BPS, 2012; Tickle, Brown & Hayward, 2014). Low staffing levels and low-morale among staff are reportedly common issues in acute mental health settings where there are high levels of tension and distress among patients and staff (Clarke &Wilson, 2009). There is no research exploring what risk means for staff working in this setting. Therefore, the current study aims to understand how inpatient staff conceptualise risk within older adult mental health services. ***Method:*** Data from individual interviews with ten mental health professionals working in older adult inpatient settings were used to develop a grounded theory (Charmaz, 2006; Glaser & Strauss, 1967). ***Results:*** The theory suggests risk is narrowly conceptualised as something dangerous resulting from mental illness. Medical and nursing staff focus on the tasks of reducing risk with medication and electroconvulsive therapy [ECT]. Potentially, focusing on the task of risk reduction protects staff from dealing with anxiety, distress and tension evoked by their work. When dangerous risk is reduced, some staff, primarily occupational therapists, conceptualise, and work with, risk more broadly and collaboratively. ***Conclusion:*** Based on these findings there may be benefits and risks from supporting staff in broadening their conceptualisation of risk. Older adult inpatient teams could benefit from support, training and resources to work with distress in a bio-psychosocially informed way, where risk can also be conceptualised as potentially therapeutic as well as harmful

Older adults are given fewer options of treatment than working age adults, and receive lower quality care than younger adults (RCP, 2009; Joint Commissioning Panel for Mental Health, 2013). Explicit discrimination between age related divisions in mental health services has resulted in the development of an unequal system, as reported in a review by the Commission for Healthcare Audit and Inspection (2006). An adequate mental health service includes the provision of substantive psychiatric, psychological and social input (Joint Commissioning Panel for Mental Health, 2013), however psychology and psychotherapy are under-provided in older adult services (Chaplin, Farquharson, Clapp & Crawford, 2015; Matthew Prina et al.,2014).

Older adult services are more likely than younger adult services to prescribe psychotropic medication as treatment for mental health difficulties (Maust, Kales, Wiechers, Blow & Olfson, 2016). A possible factor contributing to the difference in services is the "Understandability Phenomenon" (Blanchard, 1992) reportedly prevalent in Western culture, which suggests that depression may be perceived as an inevitable consequence of aging, despite evidence to the contrary (Bryant et al., 2012). This may lead to sense of hopelessness in older adults and professionals, where recovery from mental health difficulties is not considered possible. Treatment may focus on symptom reduction through medication without focusing on means of empowerment over their own recovery. The absence of a psychological perspective in many acute mental health inpatient settings (Clarke & Wilson, 2009; BPS, 2012b) may also mean services adopt a medicalised view of mental health. The use of biopsychosocial formulation with clients and staff in services is arguably a valuable means of introducing psycho-social factors alongside the biological (Johnstone, 2014).

Negative stereotypes regarding the benefits of therapeutic work with older adults prevail among mental health professionals, including clinical psychologists (Lee, Volans &

Gregory, 2003). However, an extensive systematic review and meta-analysis of randomised controlled psychotherapy trials for older adults with a diagnosis of depression by Huang, Delucchi, Dunn & Nelson (2015) reported that psychotherapy is an effective treatment for older adults. Francis and Kumar (2013) also reported that psychological interventions are effective for later-life depression in a review of several psychotherapies, with similar findings from Kirkham, Choi and Seitz (2016). Furthermore, cohort effects among older adults may contribute to some of this population being less willing to engage in psychotherapy due to their own alignment with the “Understandability Phenomenon" as well as stigma around requesting and receiving help for mental health difficulties, scepticism regarding the efficacy of therapy or adopting a ‘just get on with it’ attitude to distress (Brenes, Danhauer, Lyles, Hogan & Miller, 2015; Bryant et al., 2012).

Interventions to address older adults’ mental health difficulties appear to be informed by a predominantly medicalised approach to mental distress. Pitkala, Laurila, Strandberg and Tilvis (2004) studied prescribing practices for older adults in residential care and mental health inpatient units and found 87% were prescribed one psychotropic medication, two were prescribed to 66%, three were prescribed to 36% and 12 % were taking four or more. There are considerable risks to older adults from psychotropic medication as they are 3.5 times more likely than younger individuals to require a hospital admission due to side effects caused by psychotropic medications (Curkovic, Dodig-Curkovic, Eric, Kra1ik, & Pivac, 2016; Maust et al., 2016). Older adults are also at risk from medication induced hypotension or falls that result in fractures (Curkovic et a1. 2016; de Jong, Van der Elst, & Hartholt, 2013). Polypharmacy significantly increases the risk to older adults, with the risk rising greatly with the number of medications prescribed and increasing age (Curkovic et a1.2016)

Older adults are also much more likely to receive Electroconvulsive Therapy [ECT]

than younger adults (Rapoport, Mamdani & Herrmann, 2006). Usage rates of ECT over a 12- month period from 2014-2015 show that older adults received significantly higher rates of ECT than younger adults. For example, in the group 70 – 79 years, 497 people received ECT (25.2% of the overall total), compared to those aged 18 – 29 years where 78 people received ECT (4% of the overall total). The National Institute for Health and Care Excellence Guidance (NICE, 2009) recommends that ECT be administered only after all other treatment options have been unsuccessful and, or, when there is a significant risk to life. Possibly, health professionals are identifying more incidents of significant risk to the lives of older adults than younger people, hence the higher usage of ECT with older adults. The higher figure may also be a result of factors identified by Rapoport et al. (2006), such as not responding to treatment. It may also be due to the type of treatment not being suitable for the client, inadequate service provision, limited treatment options and beliefs around the suitability and nature of psychology psychotherapy for olderadults.

Risk in Older Adult Mental Health Services

There are many risk issues for this age group; they are at risk of age related physical health problems, many are vulnerable to physical, sexual, psychological, emotional and financial abuse, as well as neglect from self and others, serious losses of dignity and respect, and infringements of human rights (Francis, 2013: Pinner et al., 2011). Adverse reactions to medication and injuries from medication related falls are also significant risks for older adults admitted to inpatient units (Anathhanam, Powis, Cracknell & Robson, 2012; Gallagher, Barry & O'Mahony, 2007; Marvin et al., 2017).

Many mental health services are reported to have a culture of 'risk avoidance', primarily motivated by a fear of blame (BPS, 2012; Morgan, 2007; RCP, 2008; Sykes, Brabban & Reilly, 2015). This culture of risk avoidance operates from a narrowly constructed conceptualisation of risk as equating to 'dangerousness', which supersedes a

view of appropriate risk-taking potentially leading to positive outcomes (BPS, 2012; Tickle, et al., 2014). Risk is a complex issue, linking political and mental health agendas with human rights and individual wellbeing (Langan & Lindow, 2004, p.11; Simpson, Miller & Bowers, 2003). Amidst these interweaving threads some practitioners manage to regard risk as potentially positive, and they support service users in taking positive and therapeutic risks (Nolan & Quinn, 2012), while others aspire to promote positive risk taking but feel restricted by service constraints (Tickle et al.,2014).

In some mental health services there is an emergent culture of positive risk-taking, sometimes referred to as, or associated with, a 'recovery' focused culture (Sykes et al., 2015; Tickle et al., 2014). A culture of recovery emphasises someone's right to make mistakes, to choose 'unwisely', and to have maximum agency over their own lives despite their experience of psychological distress (Sykes et al., 2015). A recovery approach therefore embraces positive risk-taking by recognising and not infringing on a service user's human rights. In the act of acknowledging their rights, conceding autonomy and focusing on empowerment, there is reported to be a significant therapeutic value and there is growing evidence that positive risk-taking within services leads to better clinical outcomes (Felton, Wright, & Stacey, 2017). However, positive risk-taking remains uncommon in practice (Sykes et al., 2015; Tickle et al., 2014).

A grounded-theory study by Tickle et al. (2014) explored the perceptions of risk and recovery among 11 Clinical Psychologists working in a range of adult mental health settings. Tickle et al. (2014) found that psychologists were aware of the importance of developing a recovery oriented approach to their work but were working within a narrow definition of risk that superseded a broader understanding of risk as potentially positive. A key finding was that these professionals were fearful of harm due to risk, for which they could be blamed, as in the findings of Sykes, et al. (2015) and the BPS (2012). This incongruence between an awareness

of the value of recovery on the one hand, and practice that is not recovery focused on the other, was reported to be strongly influenced by a culture of risk avoidance within mental health services. Tickle et al. (2014) recommended that further research explore other professionals' perceptions of risk and recovery.

There is no research exploring how risk or recovery are understood in older adult services. From the existing research regarding older adult service provision it appears that many services adopt a medicalised approach to mental health, and that recovery oriented services and positive risk taking are likely to be uncommon. Understanding how staff conceptualise risk in an older adult inpatient setting may provide ways of supporting staff to promote recovery and incorporate positive risk taking into their services.

The Current Study

Qualitative research methods can be useful when making preliminary explorations of a poorly understood area (Forrester, 2015). Grounded theory is predominantly concerned with offering an explanatory model of the process involved with a specific phenomenon (Corbin & Strauss, 1967; Charmaz, 2006). Constructivist grounded theory offers a way to develop a tentative understanding of how risk is conceptualised (Charmaz, 2006). Through conducting an inductive exploration of this nuanced area, grounded theory provides a means to an in-depth and rich exploration of how risk is being conceptualised by staff. It also provides a way of transforming the data gathered in this exploration into a fledgling model of the process involved.

While there has been research in adult mental health services, the conceptualization of risk by health professionals in older adult services has not been researched. Clinical decision making in inpatient services is predominantly focused on understanding the risks presented by the patient, risk being the reason they are admitted (Clarke & Wilson, 2009). How risk is conceptualised will therefore be an important influence upon clinical decision

making regarding admission, treatment, and discharge. Therefore, the current study aims to explore how staff working in an older adult 'functional' inpatient unit conceptualise risk.

Method

Participants

Ten qualified health professionals working in multidisciplinary teams across three older adult 'functional' inpatient units in Northern English urban area participated. All participants had a minimum of one year's experience working in an older adult functional setting. Four registered mental health nurses, one clinical psychologist, two occupational therapists, two pharmacists and one non-consultant psychiatrist participated.

Design

Data gathered from semi-structured interviews was transcribed verbatim and analysed using a grounded theory method (Glaser & Strauss, 1967; Charmaz, 2006) informed by Charmaz (2006), with a social constructionist epistemology. This epistemological stance acknowledged the existence of multiple social realities, whilst believing that none can claim to be objectively true. Using this epistemological stance means the current theory is an interpretation of participants' meanings, rather an objective truth. My own biases and understandings will have impacted the findings, but the impact of the relationship between researcher and participants, analysis and findings are unavoidable and will influence the findings despite efforts to manage my biases (Charmaz, 2006).

Procedure

Ethical permission was granted from the Faculty of Health and Medicine Ethics Committee at Lancaster University, and permission was granted from two trusts to conduct research

Recruitment

During recruitment visits to the inpatient units, staff were provided with a participant

information sheet (See Appendix 4, p. 4-24). In the initial round of data collection, five participants working across three sites agreed to be interviewed. After preliminary analysis of the data it was necessary to interview a further round of five participants working across the same three sites. Theoretical sufficiency was achieved following ten interviews and recruitment then ceased (Dey, 1999); that is, the material gathered was sufficient to develop a theory grounded in the data.

Data Collection

Interviews lasted from 45 to 85 minutes, and used questions from topic guides as appropriate. Interviews were audio recorded, and recordings were transferred to secure storage, before being transcribed and anonymised.

Data Analysis

Line by line coding was applied to transcripts of the first five interviews. Focused coding then followed, codes were built around salient information relating to the research question (Charmaz, 2006). (See Appendices 2-A, 2-B). Quotes were used throughout the analysis and drafting of the results to keep the model grounded in the data. Applying a method of constant comparison analysis involved looking for similarities or differences between interviews, codes and categories (Charmaz, 2006). Preliminary theoretical categories were developed from the conceptual categories. This process was aided by ongoing memo-writing and freewriting (Charmaz, 2006). (See Appendix 2).

Results

This model provides a grounded theory of how risk is conceptualised by staff. The interpretation of the data used to develop the theory is informed by Menzies-Lyth's theory of social defense systems as a defence against anxiety (1959, 1961, 1961b, 1970), which in turn is informed by object relations theory (Klein 1952b, 1959). The core category of the model: 'we must reduce risk', suggests that staff initially perceive risk as something

dangerous resulting from the patient's mental illness that must be reduced. This task becomes the driving force in their work. Around this task are three other categories: risk must be reduced by medication, risk can increase in complexity, and risk can be worked with collaboratively.

One way of interpreting staff's conceptualization is that focusing on the task of risk reduction through the ritualized process of diagnose, medicate and administrate provides a way for staff to protect themselves from their own emotional responses of dealing with patients in significant distress (Menzies-Lyth,1959). In wards with restricted resources such as low staffing levels and limited psychology input, each staff member must develop ways of protecting themselves and coping with intensely demanding work (BPS, 2012, Clarke & Wilson, 2009). Their defences therefore may influence conceptualisations of risk, potentially explaining why risk becomes narrowly viewed as something to be reduced with medication and, or, ECT. Using medication and ECT may be appropriate and recommend treatments for some patients but potentially their usage and the focus on their usage by staff is disproportionate to the needs of patients.

When the initial dangerousness perceived by staff is reduced, and potentially, staff begin to feel less anxious, risk becomes conceptualised more broadly to include risk emanating from outside of 'mental illnesses. Occupational Therapists (OTs) are the main staff who conceptualise risk more broadly. Their work compliments the use of medication, namely, different sources of occupation and environmental modification which require working collaboratively with clients. OTs regard risk as potentially harmful but also potentially therapeutic. When risk is reduced to a level manageable in the community, the client is discharged from the unit. See Figure 1. (p.2-39) for a graphical depiction of the model.

Risk Must be Reduced

This core category of the model provides an interpretation of how staff conceptualise risk as something that must be reduced through a set process of treatment. During the early admission phase staff hold a narrow view of risk while they assess the dangerousness of the client. This time may be consciously, or unconsciously, anxiety inducing for staff, as they try to diagnose the patient, and identify which medication will effectively treat their risk. Menzies-Lyth (1959, 1961, 1961b, 1970) suggests that focusing on tasks protects nursing staff from having primitive anxieties evoked within them. Furthermore, she theorises that reducing the individuality of patients is another means of managing the burden of anxiety, distress and tension experienced by staff, consciously or otherwise. Focusing on the diagnosis, rather than say understanding what has happened to the person, the meaning of their distress and exploring how they are feeling and engaging with their inner world could be one way of staff protecting themselves and reducing the individuality of patients.

Within a medicalised model of mental health difficulties, many staff seem to have a narrow view of risk

> Yeah, risk, to me, would mean the chance of an adverse event happening, so umm, a person, the risk they would pose to themselves or other people in the environment around them. (Karen)

Staff do not regard risk more broadly, such as also having potential positive value, or emanating from sources other than the patient. When considering risk, concepts such as aggression or ‘dangerousness’, ‘being psychotic’ or ‘having psychosis’, are perceived to be risks coming from the client’s ‘mental illness’, are at the forefront of staff’s minds, as in this case, when asked what risk might look like “When clients are quite psychotic and hallucinate the aggression is there" (Shreya).

Danger from clients towards self and others is a key aspect of staff conceptualisations of risk, despite limited evidence that people with mental health difficulties pose greater risk to others than those without these difficulties (BPS, 2012). “You’ve got to be careful of risk of aggression, that there’s nothing that client can use as a weapon…so they can’t pick it up and throw it”(Dolly). Potentially, this perception of staff as a potentially dangerous ‘other’, in contrast to the evidence for this, could be a means of staff further reducing individuality of patients and further protecting staff from primitive anxieties evoked by the work.

Staff focus primarily on the task of risk assessment, diagnosing and medicating the patient. They do this from a narrow perception of risk as something dangerous resulting from which must be reduced by staff. Risk appears to be medicalised, and conceptualised to reside within the patient as the result of mental illness, and staff seek to reduce this risk through a process of ritualized tasks which they proceed with for each patient. Focusing on these tasks may be a way of protecting staff from daily exposure to people experiencing extreme emotional distress in the absence of adequate clinical supervision. Nursing staff are also dealing with low-morale and high levels of distress among staff resulting in high levels of absence of qualified nurses, which adds to more stress and anxiety:

> Well a lot of people on this ward are off sick with stress and anxiety, I’m speaking confidential because there isn’t enough staff to cover these things, so I mean we might put someone on 1:1 in the morning, but we try to get cover and that but there just isn’t enough staff to cover it. And you ring higher above and you get told you have to manage it? Well that’s what we’re already doing… And then we obviously get help from other ward, where there not able to release staff to help all the time, and this is every morning and every day night consistently and I know it’s like this everywhere and this not a moan but this is just talking about risk. (Naz)

Nurses reported finding clinical supervision helpful, but that they received little or none due to demands on time, “Amm, we have line management which I’ve not had for a few month now. And clinical supervision, and it’s difficult getting line management and even more so for clinical supervision”

> No, you’re supposed to have supervision, but it’s finding the time to have it, like I’m line managing junior staff and then I’m line managed but I’m not getting any supervision. I had in the past and then they left, and then I had someone else and they went off sick, and I had someone else and they moved and I’m thinking of asking someone else, that I’m thinking of approaching but they are really busy and always in meetings and I don’t know if they’ll have the time, it’s going to be difficult to get off the ward for half an hour or an hour? (Jean)

Teams seem to have a narrow focus on risk, and risk reduction. One way of interpreting this approach is that focusing on tasks limits the emotional and relational connection with the patient. Consequently, the emotional experiences of staff might be contained through preoccupation with the task. In the absence of clinical supervision and opportunity to reflect in a containing and protected process they may need to defend themselves emotionally through focusing on tasks and maintain distance.

Risk is Best Reduced by Medication

Medicalising mental health and risk contributes to a process where the ‘dangerousness’ posed by patients is managed with psychotropic medication and ECT. Working with the ‘riskiest clients’, staff regard the risk to be potent and requiring urgent action: “Their illness can get to a point where it’s so severe it’s much more difficult to treat. So, you know to get them on the road [medication] quickly, and not to delay” (Jean). Medication and early intervention are clinically recommended and helpful for many patients. It is equally important to provide patients with an approach that acknowledges the

psycho-social aspects of mental health. It appeared that there is limited consideration of alternatives to the task of administering medication, or ECT, such as trying to make sense of what is being communicated through the clients' distress and normalizing and validating their experiences. Potentially, staff avoid engaging with the individuality of patients to cope with the reality of working in an intense and demanding role. The task of medicating or providing are ECT are proceeded with an apparent certainty in their effectiveness, despite the limits of their efficacy and associated risks (Taylor, Paton & Kapur, 2015).

During the early phase of a client's admission staff seek to determine the type of risks clients pose, the type of 'mental illness' they are perceived to have and what medication will reduce the level of risk. Using psychological formulation to understand what function 'risky' behaviour might have for the person because of their life experiences seemed to be a minority approach. The lack of psychological input may be due to the limiting impact of one psychologist working across two sites and several wards. At this point of admission staff aim to rapidly reduce the severity of the risk posed by the client's mental illness, and they regard early intervention with medication to be the optimal means of achieving this aim. Staff believe that risk from within the client will decrease once they get the 'right' medication and dosage:

> We've got NICE guidance and a good body of evidence to support the use of medication, but we're not down to being able to, we're not sure what their diagnosis is, what we're treating exactly and that can take several days…. And maybe even weeks to understand, so once we got that, then it's what treatment are we going to use, and again medicines are our, fir…very commonly used….it's unfortunate that we can't say that that person will respond to that medicine, and it often is a period of giving someone a medication and seeing how they respond.(Simon)

Medication administration is something staff believe they must do, at any cost,

presumably because medication is believed to reduce risk, and staff are focused on reducing risk. It is assumed that not taking medication is going to have a negative impact on any patient: “Medication might be an issue if they don’t take their medication they’re going to deteriorate physically and, mentally aren’t they?” (Jean).

Medication can be helpful for some mental health difficulties, but it’s important that patients are given genuine choice regarding their treatments and are informed of the risks. Risks from medication rise with age, and older adults are more likely to have adverse reactions and falls caused by psychotropic medication than younger adults (Anathhanam, Powis, Cracknell & Robson, 2012; Lindsey, 2009; Taylor, Paton & Kapur, 2015, p. 479). Yet, this risk was not prominently considered. The team either minimise, or are unaware of well documented risks of harm from medication for older adults and focus on the task of reducing the risks from a person’s mental illness with psychotropic medication:

> If we have someone, who because of their mental ill health, is agitated or aggressive, the first line is non-pharmacological intervention, and all that business…if that fails then you’re in the realms of having to put hands on someone, before that, it may be possible to get them to take medicines, things like benzos, diazepam, things that have anxiolytic properties, so they will relax someone, and they will bring someone down quickly. (Simon)

The above quote refers to non-pharmacological intervention, but there was no sense of that might entail, and there was no reference to it by other staff. Clients were perceived to be unable to choose if medication would helpful or unhelpful with their own mental health difficulties as they are automatically perceived to lack insight

> And another thing is if somebody is on an oral medication, you can’t force them to take that, you know, if somebody is taking something by mouth, you can’t force them because you can’t push it down their mouth, it’s a case of them having to take

> it, or not and clozapine's one of those drugs that you have to give by injection. The problem is your dealing with people very poor insight, some of them haven't got capacity, to decide" (Jean).

Consequently, staff adopt a paternalistic medicalised approach to risk reduction. Clients are perceived to lack insight in general, due to having a 'mental illness', and their ability to make choices is undermined, particularly choices about their treatment. Choosing to decline medication is also automatically considered highly dangerous. It seems fair to hypothesise that refusing medication is considered dangerous because medication is the main resource available to the team to initially achieve risk reduction, and interrupting this task would diminish its protective quality against the distress, tension and anxiety experienced by staff. Possibly for these reasons, the team persuade all clients to take medication:

> We all tried as an MDT [multidisciplinaryteam], at the unit round, and we had her in and said we think it's best if you have this medication and she wouldn't accept it, and ehh, it was the nursing staff…and the nursing staff were getting frustrated because there was nothing they could do for her and she was getting worse and she was getting worse, and she was feeling people were out to get her, she was paranoid, there was nothing positive in the future, and she might as well not be here, and ehh, you know all the time she wouldn't accept any medication…and the staff were saying what to us, what will we do, what will we do…(Jean)

It was frequently described that the client either agrees to take the medication, or the team use encouragement, or alternatively, a complex array of legal frameworks to secretly or forcibly administer medication. This means there seems to be a lack of genuine choice for patients regarding medication:

> And in the end, we did have to treat her and there are two ways of doing that,

> obviously, if you're under section of the MHA then you can treat with a depot antipsychotic, and the other is covert administration of medication. (Simon)
>
> That's when we try covert medications, and if she's not getting any food because she's picky with her food or she might, some people are quite suspicious of the food offered to them in terms of their paranoia, in this case we'll find that covert medication is not going to work, it's not going to be successful, in which case we'll have to look at other forms, we might use regular injections to get them into that stable mood. So that's the other option they'll go for. (Shreya)

Client who have paranoia regarding their food are perceived as irrational, with these thoughts attributed to mental illness, rather than an evidence based fear of medication being hidden in their food by staff. It seems plausible to conjecture that clients might be aware of covert medication practices and may therefore be scared to consume any food or drink provided to them by staff:

> And then we amm, the pharmacist decides whether it'll be crushed or if it'll be liquid…and then we've got to think, what food do they like, 'cos if we got someone who's walking up and down…and you give 'em a sandwich, what you know they like…. something's that going to work because they like it…(Dolly)

To ensure that staff can complete the task of risk reduction they use sometimes use methods of physically restraining and forcibly injecting clients with medication. This practice is the main way to reduce risk for clients who do not want medication and are deemed to lack capacity to make this choice. Restraining clients to administer medication is an uncomfortable experience for staff who do so in the belief medication will benefit the client and reduce the risk:

> You have to give it injectable, because there is no other way of doing it, so you have to hold somebody down, which isn't pleasant…but hoping that after a few

> injections, they become amenable and happy and accept it, which a lot of clients do…many service users, you know, do, they will maybe develop a little bit more insight…and say yes…and there's also the ones that don't. (Shreya)

Medical and nursing staff believe that once risk from mental illness is reduced the team can begin the process of discharging them. One way of interpreting this process is that they focus rigidly on these tasks because medication may help some patients, but also to protect themselves and distance themselves from patients' internal experiences of psychological distress such as suicidality or psychosis. Staff have limited, or no clinical supervision, or reflective space to process or express the strong emotions evoked in them by clients, and their work.

> "Amm, we have line management which I've not had for a few months not. And clinical supervision, and it's difficult getting line management and even more so for clinical supervision…"
>
> (Shreya)
>
> When asked about reflection this participant responded "No, it's a culture of stoicism, suck it up and get on with it, if a patient's experience or narrative is distressing, at best they might find place to cry, and they may at very best, and I'm pushing it here, might explore it clinical supervision, which they don't get enough of and I don't think it's provided effectively" (Luke)

The DoH (2002) document, Mental Health Policy Implementation Guide: Acute Adult Inpatient Care Provision, highlights the importance of reflective practice, recommending protected time is allocated for such practice. However, there are many tasks that are prioritised before reflection, and it sometimes is neglected or avoided. It seems plausible that the absence of such supports for them limits their capacity to provide such supports for patients.

Risk May Increase in Complexity

Some clients experience an increase in mental health difficulties and risk after being admitted to the unit. This increase is mainly attributed by staff to result from 'self-neglect' by refusing to eat or drink, which harms their physical health and can be fatal. Working in the proximity of death can evoke strong emotional responses for many professionals. Potentially more so when the tasks staff use to reduce risk are not having the desired result and risk is increasing. If staff are using the tasks to also protect themselves from the emotional demands of their work then deteriorating physical health could increase the anxiety of staff, and the complexity of managing the risk for these clients:

> With the severity of his symptoms, we were treating him with amm antidepressants, with Lithium as well, but he wasn't fully responding, he got a little bit better…but when he was eating, food would go in his mouth and he wouldn't swallow. And the real risk for him, is that because of the mental ill health, his physical health was declining and deteriorating…and there was a real danger that we wouldn't get him better with the medicines alone and it was more likely then that he would have physical ill health. (Simon)

Staff attribute the person's refusal of food and drink to their mental illness, which the team believe to have deteriorated due to refusing medication. They do not consider other reasons for refusing food or medication, such as genuinely not wanting medication, fear of covert medication in food, or as a way of exercising autonomy in situations where staff have much of the power. There was limited evidence of curiosity about why a client might choose to refuse food or of trying to engage with a client's reason for doing so. This may be because staff would find it emotionally destabilizing to critically evaluate their primary tasks, and emotional defences. Rather than exploring why a person might behave this way, the team focus rigidly on medication, or ECT:

> So, what do you do? You have someone who's depressed, or stops eating and drinking, and often their medication too, so what do you do? You have to go down the ECT route, even if you didn't want to there is nothing else you can do? Otherwise that person will die, I've seen that too. (Jean)

On occasions when risk increases, adhere to their task, and possible defences by increasing, or varying the use of medication and/or ECT. When risk from self-neglect is reduced through this increased combination medication and ECT the team begin the process of preparing for discharge, and a process of broadening their conceptualisation of risk begins.

Risk can be Worked with Collaboratively

Risks from mental illness are initially prioritised over risks outside the mental illness; presumably this triaging is based on the perceived level of danger to the client's well-being or to others. When reducing risk from mental illness is no longer a priority, some members of the team broaden their conceptualisation of risk to consider risks emanating from outside of mental illness. The team continue to monitor risks from falls or medication but now begin to consider broader risks such as vulnerability to exploitation, or difficulties for clients using their environment safely. Within the multi-disciplinary team (MDT), occupational therapy begins to play a prominent role in managing these risks, and it is mostly they who broaden the view of risk. Medication and ECT are less central to managing the risks, as the client will have agreed, or is being forced, to engage with medication. Furthermore, the role of occupational therapist (OT) focuses on occupation rather than medication. Having broader means at their disposal they conceptualise risk moreholistically.

Occupational therapists conceptualise risk more broadly and adopt a more collaborative approach to working with risk, as described here by an OT:

> Sometimes we can manage those risks safely…sometimes you can get a care

> package and you can manage it…or you can manage the risk by adapting the environment, whether it's a rail to help them use the toilet, or equipment to help them in the bathroom there's a load of ways to support them to stay at home…(Una)

One factor contributing to OTs having a broader view of risk is that they are working with clients when the initial risk is diminished and when the client is being considered for discharge. This could evoke less anxiety for OTs, and they may have less need to protect themselves from the patients' inner distress. However, OTs work in this setting still work with people who are acutely unwell. Other factors may be that OTs conceptualise risk as resulting from several factors, such as medication, unmet psychological, social and physical needs. In doing so they focus on engaging with the person and understanding their difficulties holistically:

> So, let's say as an OT and we have a person who can't get on and off the toilet safely, without falling, then that's going to have a complete effect on you physically, because the risk of fractures, then it has an impact on your self-esteem, self-worth, if you can't toilet yourself, then how does that make you feel psychologically? So, it's a whole smorgasbord of risks….that affect the person in many ways really. (Paddy)

Moving towards discharge, OTs also conceptualise risk as something to be encouraged in terms of positive risk taking, while also minimising the likelihood of harm. Risk is no longer assumed to be dangerous or primarily because of mental illness and starts to be conceptualised as having some therapeutic value. OTs regard their role to require managing and taking risks while maximising the client's independence:

> I think over the years I've learned you can minimise risk but you can't eradicate it completely, there will always be an element of risk and it's about managing that risk and it's about positive risk taking too. And not being so risk aversive that you literally don't, you inhibit that person's independence, you want to maximise their person so they can

function as well as they can, and you also should flag up the risks as well. (Paddy)

This category suggests that risk becomes more broadly conceptualised as the team have broader ways of working with risk, and begin considering discharge. With the initial risk from mental illnesses reduced through medication, occupational therapy appears to play a central role in how the team conceptualise and work with risk. OTs typically work with risk regarding discharge, when the wellbeing of patients is improving, which may result in less intense emotions being evoked in them as professionals. The category illustrates how staff begin to work with risk using a more collaborative approach than when they are focused on risks from mental illnesses. Risk is also conceptualised as having some therapeutic value for clients, and positive risk taking is encouraged.

Discussion

The current research achieves its aim of constructing a grounded theory of how health professionals working in an older adult functional inpatient setting conceptualise risk. This model suggests that staff conceptualise risk narrowly, as something that must be reduced, believing that risk comes from mental illness and must be lowered with medication and/or ECT, even when risk increases in complexity. When risks from mental illness are perceived to reduce some team members broaden their conceptualisation to include risk that emanates from outside mental illness as well as therapeutic risk-taking. OTs are instrumental in this broader conceptualisation where risk is worked with collaboratively with clients and others, such as staff in external organisations.

Professionals working in social institutions, such as inpatient units, may protect themselves from intense anxiety, stress and feelings of loss or despair through creating unhelpful defences (Menzies-Lyth, 1959). According to Menzies, there is a cohesive, albeit unconscious, effort by most staff members through personal efforts to activate mechanisms of defence. The process of conceptualising and working with risk through following a set

process of task completion may be a manifestation of staff's efforts to defend against experiencing intense emotions evoked in response to their work. Inpatient mental health settings are often under-resourced, under-staffed and dealing with people who are very unwell (Clarke & Wilson, 2009). Persons working in these settings are expected to perform multiple competing tasks, sometimes with agency staff filling in for long-term absences, further contributing to their anxiety (Clarke & Wilson, 2009), as reported by participants in the current study.

For these staff, working with emotions which clients cannot bear, for example because of emotionally unprocessed trauma, or feeling hopeless and suicidal, could evoke anxiety, tension and stress which they respond to with a form of social defence systems. Intense emotions are also likely to be evoked where their role involves life or death outcomes. In the absence of adequate clinical supervision, applying a ritualized task-performance of risk reduction through insisting on always administering medication and, or ECT may be protective for staff. It could protect them from engaging with the individual reality of their clients beyond mental illness and perceptions of risk. Engaging with these experiences may be untenable without adequate supervision, while also attending to multiple other tasks without adequate staffing levels. Reports of multiple staff on long term sick leave due to stress in the current study, and across acute inpatient units could be related to these experiences (Clarke & Wilson, 2009)

This study is the first qualitative exploration of risk with health professionals working in older adult inpatient units. Findings from this study support research claiming that risk is often conceptualised narrowly, with the focus on harm that clients may cause (BPS, 2012; Morgan, 2007; RCP, 2008; Sykes, et al., 2015; Tickle et al., 2014). It adds to the research the concept that staff in this setting may conceptualise risk, and risk reduction, narrowly to protect themselves from distress, tension and anxiety. The core category, 'we

must reduce risk', shows that staff conceptualise risk through acutely focusing on risk reduction tasks. The focus on a narrowly defined end, that of reducing risk - dominates staff approaches to working with clients, and creates distance between the patient as an individual beyond illness or risk and staff

The second category, 'risk must be reduced by medication', suggests that staff use the means of medication and ECT to reduce risk, but also that the focus on this task may form a means of psychological collective defense. Undoubtedly, psychotropic medication can benefit some people experiencing mental health difficulties (Lindsey, 2009; Wang et al., 2005). NICE guidance for many mental health difficulties such as depression (NICE, 2011) and 'psychosis and schizophrenia' (NICE, 2015) recommend that medication is offered alongside psychotherapy, even during acute phases of psychosis in acute inpatient settings (NICE, 2015).

However, forcing all clients to take medication, and using legal powers, covert medication or restraining an elderly patient and injecting them could also be experienced as traumatic by clients (BPS, 2012; Watson et al., 2014) and distressing for staff (Bonner, Lowe, Rawcliffe & Wellman, 2002). The rigid insistence that all patients take medication to reduce risk, when older adults are at risk from many medications highlights the need for staff to broaden their understanding of risk. Furthermore, the absence of choice regarding medication for patients could indicate that this task represents some form of defence, particularly as staff become agitated when patients refuse, as mentioned in the results. Focusing on the task of administering medication, without flexibility may create emotional distance between staff and patients as it limits patient choice. Furthermore, risks from medication for this population increase with age and need to be given greater consideration.

The third category, 'risk can increase in complexity', suggests that attempts to reduce risk with medication are sometimes ineffective. There are reasons beyond mental

illness that may explain why clients ‘self-neglect’. Historically, food refusal has been used by people being oppressed as a means of communicating with their oppressors and as an attempt at reclaiming power (Buckroyd & Rother, 2008, p. 28). Knowing that staff covertly place medication in the food they provide is a credible reason to refuse to eat. It is possible that clients feeling powerless may resort to food refusal to reclaim power. When clients disrupt tasks efforts to administer medication and food it may increase

The final category, ‘risk can be reduced collaboratively’, shows that some team members conceptualise risk in broader terms, the OTs in this study. This conceptualisation comes to the fore once the initial reduction in risk is achieved. Staff then begin to work with risk in a person-centred approach, involving clients in activities and decisions regarding their treatment. This is in line with a person-centred approach as recommended in NICE guidance and within the NHS. The CQC (2016) suggests that OTs are central in supporting clients in using services, empowering them to regain their confidence and increase their ability to live successfully outside hospital. Service users report many benefits from OT supported occupation including social connectedness, normalisation, routine, pleasure and meaningful engagement (Kelly, Lamont & Brunero, 2010). Enhanced self-concept and improved mental health are reported to result from these factors (Kelly et al., 2010). Having broader means to reduce risk contributes to broader conceptualisations of what risk is, and how it can be positive.

Strengths and Limitations

The sample was relatively homogenous, as all participants worked within the same trust. The study sought to reflect the clinical reality of multidisciplinary conceptualisations, and interviews were conducted with registered mental health nurses, occupational therapists, pharmacists, a clinical psychologist and a junior-doctor psychiatrist. Thirdly, ten participants may be a low number, but theoretical sufficiency was achieved as new findings

were not being suggested in the data (Dey, 1999; Charmaz, 2006). The reliability and transferability of the findings are also limited as participants were only interviewed once (Charmaz, 2006). Furthermore, it was not possible to recruit a consultant psychiatrist, which also limits the findings as they have an influential role within a multidisciplinary team. Despite this, the data gathered provided sufficient material to model how the team conceptualise risk, and a junior doctor (ST4) specialising in older adult mental health was interviewed.

Recommendations for Future Research

This study builds upon existing research into staff perceptions of risk (Tickle et al., 2014). To complement these findings a phenomenological exploration of staff understanding of factors that influence their approach to working with risk could reveal the role of individual and systemic factors. Research could explore the concept of the focus on tasks as defences and the emotional aspects of this work. At a systemic level, it would be helpful to explore how clinical commissioning groups and trust management understand the mental health needs of older adults and staff working with them, particularly given the issues regarding long-term absences among nursing staff, which may be related to the anxieties evoked in them. Understanding the factors influencing how staff conceptualise risk could inform ways of dangerous risk reduction and increase positive risk-taking.

Clinical Implications

This study provides a grounded theory of how risk reduction may be a driving force in the mental health care system and in staff conceptualisations of risk among older adult inpatient settings. Inpatient teams might benefit from having opportunities to conceptualise and work with risk in broader ways, instead of merely a narrow focus on risk reduction through medication and ECT. Older adults have the right to a range of treatment options, like those offered to other age groups. Health professionals in this setting could benefit from

training, support and resources to recognise and reduce inequality in the type of service provided to older adults.

One alternative to current inpatient structures is to support staff to understand distress biopsychosocially, and creating a therapeutic milieu on a ward, one that embodies compassion (Appleton, Chambers and Arkley, 2016). Clarke and Wilson (2009) argue that psychology can use CBT principles to improve staff morale, create a therapeutic milieu and enhance inpatient care. The key functions of a therapeutic interactions model are supporting and facilitating conditions for emotional containment and improving staff awareness and understanding of the emotional and psychological factors contributing to distress, such as trauma (Appleton et al., 2016). Clarke and Wilson (2009) suggest that supporting staff to develop their role into a therapeutic agent rather than focusing on tasks of risk management can be achieved through consultation and reflective practice.

Working this way could support staff to conceptualise risk more broadly, as they might require less defences against the anxieties evoked, and may be able to tolerate these feelings better. This might enable them to balance the dangers and opportunities in risk. Promoting therapeutic risk-taking involves some exposure to potential harm. However, outcomes of serious harm relate to a minority of people in contact with mental health services (Appleby, et al, 2016). Approaches to risk management must consider the low probability of serious harm occurring, but also the reality that harm may occur. This would need to be balanced with the benefits of appropriate risk taking (Felton et al., 2017). Shifting towards a culture of positive risk-taking would require support throughout the organisation for staff to feel safe to take defensible risks without fear of disproportionate blame.

Clinical psychologists' core competencies of psychological intervention, service delivery, training, communication and teaching competencies along with transferrable skills mean they could be well suited to support other professions to broaden their view of risk and

enhance older adult inpatient experiences. Clinical psychologists, as reflective scientist practitioners, could provide input towards service design, alongside training, consultation and providing clinical supervision to support staff with the emotional demands of working with risk (Health & Care and Professionals Council, 2015; Care Quality Commission, 2013). In the current study, clinical supervision was provided haphazardly, or not at all, despite the Royal College of Nurses (2003) suggesting that supervision is vital for good clinical governance and risk management.

Using psychological formulation with teams can help them to develop a biopsychosocial understanding of clients' risk issues (Cole, Wood & Spendelow. 2015: Johnstone, 2014). Formulation of how teams work can also help teams reflect on their own approaches to risk, which could be a valuable introduction to inpatient teams to help them recognise patterns of behaviour between teams and patients (Roycroft et al., 2015, p. 63). Providing regular clinical supervision to other team members offers another way of supporting to staff to work effectively with risk. Clinical supervision is associated with good clinical governance and promoting good quality care, managing risks, and increasing accountability without blame (CQC, 2013; HCPC, 2015). Some teams, or individuals within teams may not welcome change or additional input from clinical psychology. Where possible it may be helpful to work collaboratively with teams to understand their needs and introduce appropriate input from psychology. It could be helpful to ensure that managerial level staff are aware of the benefits of providing staff with support to broaden risk more broadly, and ways of doing this.

Conclusion

The model provides a theory of how risk is narrowly conceptualised as something dangerous resulting from mental illness. It suggests that staff may protect themselves from strong emotions evoked by the work through focusing narrowly on tasks to achieve risk

reduction. Working in medicalised and under-resourced services, staff seek to reduce risk with medication and ECT. When dangerous risk is reduced, staff, particularly OTs, conceptualise risk more broadly and work with risk collaboratively. These findings suggest there may be benefits from supporting staff to broaden their conceptualisation of risk. Teams may benefit from support, training and resources which could create opportunities to work with distress using a bio-psychosocial and collaborative model where risk can be understood more broadly, and as a necessary aspect of recovery. Clinical psychology could support these changes through providing input towards service design, training and clinical supervision.

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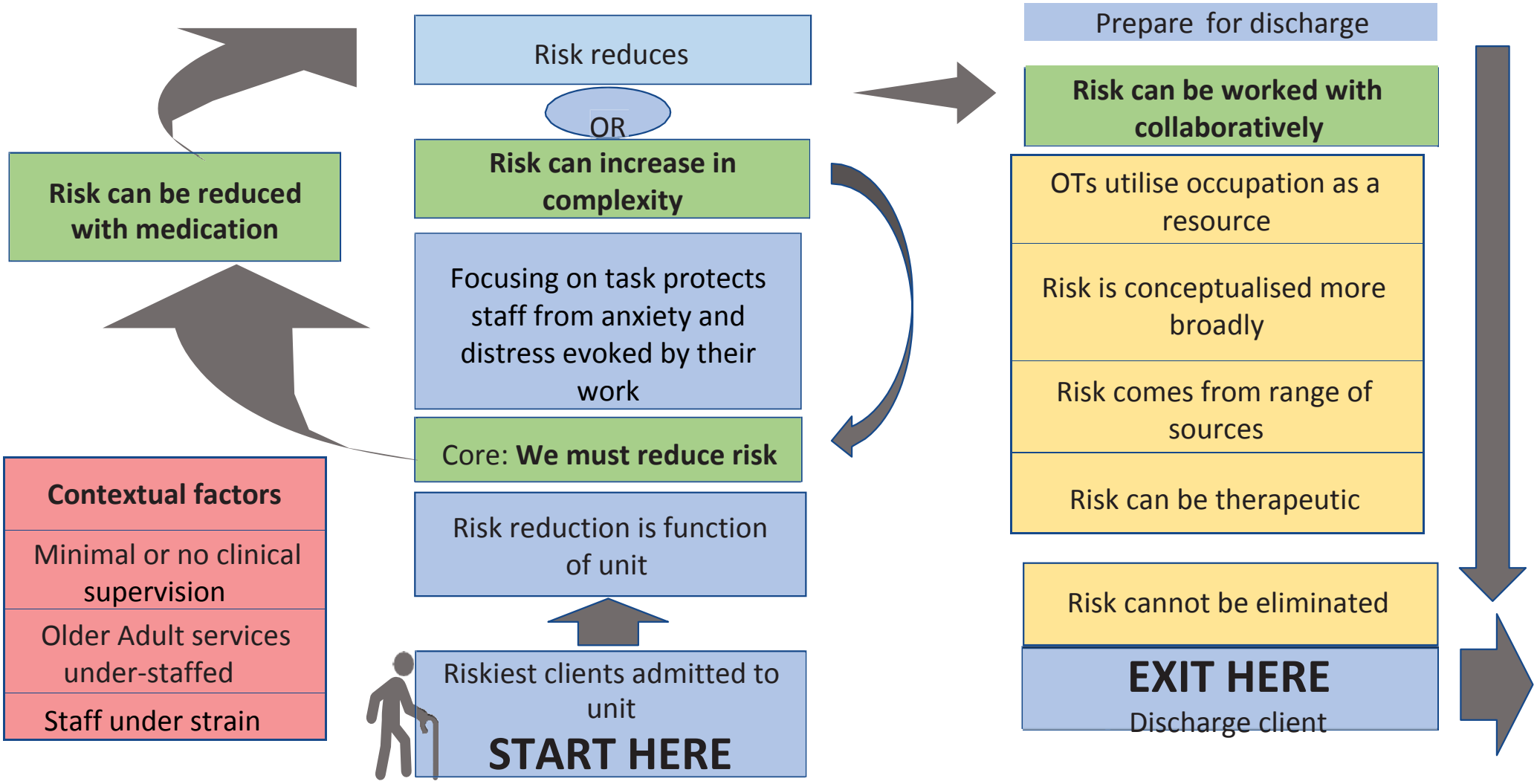
Figure 1. *Graphical Depiction of Grounded Theory*



Appendix 2-A
Example of Development from Line by Line Coding to Theoretical Coding

Transcript	***Line by Line Coding***	***Conceptual Categories***
there is difference it is different with functional…..like when I first started- this feels like job interview doesn't it?....When I first started I found that I was really shocked by the difference- in the fact that patients were going out with medication and they were getting on 'bus with the medication and they was taking it with 'em and they was handling their own money and you know, and I found it oh!.. oh it was that, it was a big change….. Right…. Let's just say I had to,…it was a transition for me to get used to that. From what I perceived to be a Adjusting to new perspective on risk risk with my working with organic patients, like you know like handling medication. It took me a while to get my head round the fact that they was you know the risks,….like obviously there was	Wanting to control Patients having unrestricted rights Finding difference a challenge Transitioning into new culture Coming to terms with new culture Adjustment	Questioning how much rights the patients should have Adjusting to culture of risk

Appendix 2-A
Example of Development from Line by Line Coding to Theoretical Coding

Transcript	***Line by Line Coding***	***Conceptual Categories***
	Positive risk taking	
t hese therapeutic risks that they was assessed before they went out you know tha a d t it was okay to obviously leave and go on the bus and soon…but am…. Yeah.	Patient's leaving the ward	
Adapting to new culture I've had to kind of adapt that because…am my head was like organic patients. I mean so that was. Yes Taking time to adjust kind of, am…..I had to get used to it,…..it took a while to get used to and like…. everything's	learning new way of working with risk Acknowledging challenge	
therapeutic risk, isn't it? I found it yea……With them going outon leave and things like that. I mean you're constantly assessing, assessing risks aren't you?	Taking risks for therapeuticgain Being vigilant forrisk	Risks are constant Hypervigilance
Yeah. I guess? Accepting patients' rights to leave When, you have informal patients and when they can go out on leave,	Monitoring and managing	
that's obviously got to be risk assessed and ……you know reviewed daily, and…..weekly and….I don't know…. Okay….I mean so it's ah……there is a constant risk?	risk Being vigilant for risk	thresholds of risk Mega-vigilance

Appendix 2-A

Example of Development from Line by Line Coding to Theoretical Coding

Transcript	***Line by Line Coding***	***Conceptual Categories***
Yeah….Well obviously everybody has their individualised on the risk don't they?		
You know what Recognising personal preference/traits works say for one person might not be the same for the other…. just because they were all	Seeing people as individuals Separating person from their diagnosis	Seeing people as unique

Appendix 2- B
Example of Line by Line Coding

Transcript	**Line by Line Coding**
Okay, so risk, in general is in the four groups isn't it? I'd class it as risk of self-harm, aggression, risk of self-neglect and risk of exploitation and vulnerability and risk of ahh….self-harm means you make sure the enviorment is safe for them, there is no harmful substance's about and you're constantly having to make sure and have to one to one sessions to analyse their mental state, are they voicing any risks or wish to harm themselves. And we do the risk history side of things, so we can put managing and planning in place, and sometimes if the risk is quite high we place them on level 1 or 2's observations. At the moment though we have everyone on zonal observations to manage the risk of falls, that kind of thing or everyone is on hourly checks. Then there is the risk in the environment, making sure that things are put away you know, where they are supposed to be. Spillages and things like that, we do have a security nurse on the ward, the one person who does an environment check on a daily basis, make sure things are put away-like the fire exit, things like that. Checking the environment is risk free and that kind of thing.	Classifying risk Discrete categories Describing risk Concrete terms Managing the physical environment Protecting service user from physical risk Ongoing assessment Monitoring Everyone is monitored managing the physical environment
Okay	
Am, risk of aggression, again we get a patient history if we can when they are admitted and the staff do a risk assessment, to class all risks under the headings of the STAR, and we put plans in place. Sometimes we will put someone who is coming with a risk aggression, and we watch them for the first week or two…and they sometimes settle in, if they have come from a nursing home….and based on the risk of aggression we review them and see what we can do about it. We do have a psychologist for the last one year and we do team formulation meetings every week for one person, once per week, and if there's something we find quite challenging and we put formulations together and plans in place then make sure all that's correct.	Standardised approach to risk assessment Initially high level of observing Formulating to understand and manage challenges

Appendix 2- B
Example of Line by Line Coding

Okay	
When patients are quite psychotic and have hallucinations and the aggression is there, once they are stabilised on a certain medication that aggression we can see that coming down and they are more amenable and things like that.	Medicating risk Making clients more controllable
Okay	
Self-neglect is a big thing for elderly patients, I think, ah even when they are depressed they are not eating or drinking very well, they are not wanting to do anything and stay in	Specific risks for this population Patients isolating
their room, that kind of presentation. So, on the ward we encourage them to stay in the lounge most of the time, if we find that someone is risk of staying in bed all the time, we have to put a robust care plan in place, to negotiate with them, maybe a couple of hours a day and increase that later on. IF they didn't have a reason to be in bed, we encourage them to socialise and do activities and things like that, and the OT staff are quite good like that, getting them active in things they are interested in.	themselves, remaining in bed Forcing client to enter other parts of ward Engaging clients to get them active
Okay	

Appendix 2- B
Example of Line by Line Coding

And we monitor their food and liquid for first three days of admission and then we see if they are improving we can discontinue, and keep them going with foods and snacks and things like that..am, medication might be an issue if they don't take their medication they're going to deteriorate physically and mentally aren't they?. So, we keep an eye on them, and if compliance is a big issue then we will think about capacity, are they taking an informed decision, that they don't want to take the medication if they are on section under the MHA, things like that, we put plans in place and maybe look at covert medication policy or injectable forms to make that compliance better. Ammm…then other things we look at is risk of falls, which is we get physio to assess them within 24hrs of admission, we have FRATS, which is a riskassessment tool, that can be completed. If there is anything in place where there are concerns then we put plans in place for them if they need a mobility aid, or if someone is completely immobile, then what kind of plans for when using a hoist. That kind of plan will be discussed as a team and we'll put in a care plan. And if someone is just walking without any aids but they are unsteady on the floor, we'll put them on, we don't' tend to use level 1 obs at the moment, we'll keep them under zonal observations. They will keep an eye on them and will know the persons' risks.	Monitoring food Watching clients food intake Assuming negative consequences of not taking medication Some clients choosing to take/not take medication Hidden, legal and physical ways of putting medication into clients body Risk of falls, standardised initial procedure
Zonal?	
Yeah, that is the space out there in day room, so someone can keep an eye on everything and be aware of the risks…	
Okay, like a lifeguard almost?	Staff observing specific physical space
Yeah, so, some patients are quite intrusive and they just walk around and go into others space and that can cause a bit of aggression, from the other side?	
Yeah	Clients aggravating and assaulting each other

Appendix 2-C
Sample of Freewriting Memo

Memo Writing 19.5.2017

Patient is admitted to ward because of a mental health related issue that is deemed too risky to be manged in the community, either voluntarily or under the MHA. During the admission, the MDT begin gathering as much information as they can to determine what the risks are. When assessing the risks, the team use the STAR risk assessment as a framework which covers a wide range of risks. Using the STAR allows for sharing clinical reasoning and providing rationale for actions. It also guides provides evidence on thinking and actions around risk. For all staff, at this stage risk assessment is mostly focused on the risks coming from within the patient. The team use the client's history, the reason for admission and their own assessments as they begin identifying the risks. The goal of identifying the risks is preventing adverse things from happening.

Staff divide risks into physical and MH risks. When thinking about MH risks staff see the risk as being inside the patient and focus on mental illness symptoms such as physical harm to self or others, self- neglect. Staff are at heightened vigilance when a new patient is admitted as the risk feels unknown. To manage the unknown/or known risks new patients can often be on 1:1 observations initially. This prevents the patient from doing any harm to themselves or others.

During the early stages of an inpatient stay patients may be quite distressed. This manifests through symptoms such as not eating, not talking, not accepting medication. For others, it can manifest through verbal and sometimes physical aggression. When a client is distressed and not engaging with treatment the team assume that the medication is the only effective treatment to offer. For any new client the team, particularly pharmacy, try and match the right medication with the person's illness. This is difficult as it's not an exact science and the pharmacists adopt a trial and error approach using an algorithm' informed by NICE guidance. They are considering three main factors when observing if medication is suitable - tolerability, side effects and efficacy. During this time staff anxiety and patient agency

is low, and the team are focused on making sure the client is taking medication, not isolating and is getting adequate nutrition

During this period staff focus on determining level of risk of new patient. They gather information from history if it exists. They liaise with the CMHT or other professionals involved in the person's care. The focus on identifying risks that exist. Team discuss key risk issues at MDT. Depending on the level of the risk staff feel they must act to reduce the risk. The risk resides in the patient but while in the ward the staff see it as their role to reduce the risk. How they act is determined by their role and the decisions made by the MDT. If the risk begins to reduce the team may reduce the level of monitoring, and the patient's degree of agency may increase slightly.

Staff have total belief that if the patient will adhere with the right medication that they will get better. Staff see medication as a way of making the patient more amenable, and less risky. Patients are given a choice regarding how they take medication, it can be orally, in tablet or liquid form, or can be given as injections but all patients are prescribed medication. If patients do not agree to take the medication it will be given to them using covert means, or by restraining them and forcibly injecting them. Patients agency decreases when they refuse medication and the team will use a range of legal tools to take power from the patient and take maximum control of their treatment. Staff regard this as an uncomfortable part of their job but feel they must be brave and do what's best for the patient. They know that if they do this as soon possible that the it's better for the patient's mental health.

Staff also are focused on non-mental health risks such as the risks of falls due to mobility issues or as a side effect of medication. When managing risks of falls staff using varying degrees of physical closeness to the patient. This may require one to two staff to try and prevent or reduce harm from falling. Staff find this stressful as it can feel impossible to always achieve this. It also uses up a lot of their time and reduces the number of staff available for other tasks during their shift. This can lead to increased risks in other areas, such as

During their stay other, non-mental health risks emanate from outside of the patient, such as physical side effects from medication. Nursing staff manage these risks.

OTs manage risks in the patient's environment and identify ways to support the patient to adapt to the risks, particularly risks at home or in the community upon discharge. They may modify the patient's home/ put in a care package to support to reduce the risk outside the ward. Identify meaningful occupation, connect the person with opportunities to reduce isolation. Other patients may also present an external risk.

For OTs risk is seen related to unmet needs, such as psychological and spiritual as well as physical. The focus is on engaging with the person and understanding their difficulties within the context of their life. OTs role is focused on trying to manage and take risks while maximising the client's independence. While preparing clients for discharge OTs may briefly liaise with community based care providers to manage and take risks. This may involve responding to risks from other services on discharge, if the care is inadequate and risky to the client. They may make safeguarding referrals to ensure the clients are protected from any risks from staff or care home issues.

Reducing risks of relapse is also managed by informing new care providers/ carers about what client likes/enjoys. During this transition, the OTs are judging what risks to focus on and how to use resources. For many clients, the OT's focus on occupation that appeals to the clients and meets their needs through connecting clients with groups and activities their community. Preventing MH deterioration due to loneliness and isolation. Their overall goal is putting supports in place to enable client to function optimally, particularly after discharge. Client agency is high.

Some patients may experience an increase in MH risk after being admitted to the ward. This can occur from neglect or through actions such as self-harm. Staff can become anxious and concerned when this happens. It can feel frustrating and they want to do something. They can also begin to doubt their current plan of treatment.

When risk increases risk of death is a concern pharmacy will alter the type of medication and/ or use increasing amounts of medication. If the risk to/from the patient increases the team may decide to administer ECT to reduce the risk. Staff hope that ECT will cause the patient to engage with treatment, ie take medication, stop self-neglecting. This risk is primarily seen as residing within the patient and due to their illness. When this risk increases staff use more of their power and the patient agency decreases.

When risk remains, high or increases they will continue to use medication and ECT until the risk is reduced. Staff- (Psychiatry) try and contain their anxiety and that of staff and families when there is high level of risk to life. This can feel difficult for the psychiatrists as they feel uncertainty. Other team members can feel conflicted and upset by reality that some clients may not get well/kill themselves. All staff are hoping that clients can benefit from their inpatient stay and recover.

Some clients may be at risk from psychotropic medication. Staff will monitor the client for side effects and let the team know if any are observed. This may be through monitoring bloods of observing significant changes, such as tremors. If this occurs the team will change the dosage or type of medication to reduce risks to client

Staff Feeling at risk

Risks to staff primarily seen as resulting from aggression from patients. The amount of risk to staff depends on the role, nurses are exposed to most risk from patients. Psychiatrists and pharmacists are exposed to less risk and mostly verbal aggression. Some staff interpreted client’s behaviours literally and feel at risk from aggressive or threatening language. Others felt anxious but focused on Interpreting client's behaviour rather than reacting to risky content. This involved staying calm when client threatens risky behaviour and trying to understand what was being communicated through the behaviour. This meant understanding the risk from the client's perspective and trying to hold the client's real needs in mind.

The most significant risk to staff is from the nature of the work and being under resourced, although this mostly to nursing staff. Understaffing and relying on bank staff contributes to nurses feeling stressed and not being able to work safely and effectively. Many nurses cope with this by going on sick leave. Some staff are offered clinical supervision which they find helpful, however this is not prioritised and occurs at most ever second month and sometimes never. Staff feel anxious about risk and want to avoid harm to patient as well as blame for not preventing risks. Staff believe it is in patient's best interests to comply with medication/ECT to reduce risk. Staff worry that they'll be blamed if a patient falls and they have not prevented it, even though they are under staffed.

Completing treatment

When the risk is deemed to be manageable elsewhere the client is discharged. Towards the discharge there is some focus is on risk outside the patient Staff are involved in the transition of care from the ward to place of discharge. In the community, there may be a risk of vulnerability to exploitation, risks from poor levels of care as well as MH risks and physical health risks. OT may be closely involved in supporting the patient to establish links in the community to support their mental health recovery and ability to remain

Different team members have different roles/approaches to working with risk

Nursing- deal with risk to themselves, work physically closely to patient, 1:1s and 'obs' to prevent falls and self-harm or suicide. OT-works closely with the patient to improve occupation.

Pharmacy-may not work with the patient, may meet them to discuss risks from medication. Deals with risk by prescribing medication.

Psychology-may not work with the patient, may work with team.

Psychiatry-may work with patient but not closely, rarely in isolation. Risk is primarily seen as within the patient.

Appendix 2-D
Author Guidelines for The Journal of Aging Studies

INTRODUCTION

The Journal of Aging Studies features scholarly papers offering new interpretations that challenge existing theory and empirical work. Articles need not deal with the field of aging as a whole, but with any defensibly relevant topic pertinent to the aging experience and related to the broad concerns and subject matter of the social and behavioral sciences and the humanities. The journal emphasizes innovations and critique - new directions in general - regardless of theoretical or methodological orientation or academic discipline. Critical, empirical, or theoretical contributions are welcome.

Contact details for submission

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One author has been designated as the corresponding author with contact details:

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All necessary files have been uploaded:

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• All figures (include relevant captions)

• All tables (including titles, description, footnotes)

• Ensure all figure and table citations in the text match the files provided

• Indicate clearly if color should be used for any figures in print Graphical Abstracts / Highlights files (where applicable) Supplemental files (where applicable)

Further considerations

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Running Head: CRITICAL APPRAISAL

Section Three: Critical Appraisal

A critical appraisal of the research, with a focus on the grounded theory combined with some reflections.

Word count: 3,989

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This thesis focuses on risk in mental health services. The literature review providesa systematic review and line of argument of how therapists experience working with clients who are suicidal. In doing so it highlights the challenges therapists' experience, and how they may benefit from a system which supports them to work effectively. The empirical paper presents a theory of how staff in an older adult inpatient functional unit conceptualise risk. This grounded theory explains how clients are admitted due to their risk being deemed unmanageable in the community, which motivates staff to focus on risk reduction. Staff view risk narrowly and focus on specific tasks of risk reduction. The model uses Menzies-Lyth's theory of social defences against anxiety (1959) to interpret how staff conceptualisations of risk may also be linked to defence mechanisms employed to manage their own anxieties evoked by proximity to human suffering and distress. Towards the latter part of a client's admission OTs begin to play an important role in preparing clients for discharge, and have various means at their disposal to reduce risk. At this stage, risk begins to be conceptualised more broadly and positively.

OTs in the current study demonstrated a biopsychosocial understanding of mental health difficulties and adopt a more holistic approach in working with clients, although only two OTs participated, which limits generalisations that can be made. The remainder of the team had a more biomedical approach to mental health. Perhaps the nature of their profession contributes to OTs having more means of working positively with risk than nurses, pharmacists and psychiatrists. The Department of Health's Essential Shared Capabilities Framework lists therapeutic risk-taking as a central value for mental health services (Department of Health 2004; Felton, Wright, & Stacey, 2017). The foundation of therapeutic risk-taking is an acknowledgement that risk is more than risk of harm, or danger (Felton, et al., 2017). OTs also recognised the potential therapeutic value of risk.

Strengths and Limitations

The study meets the criteria listed by Charmaz (2006, p.182) as requirements for a grounded theory study: credibility, originality, resonance and usefulness. Kuper, Lingard, and Levinson, (2008, p. 1) also list six items to be assessed when determining the quality of qualitative research: Was the sample used in the study appropriate to its research question? Were the data collected appropriately? Were the data analysed appropriately? Can I transfer the results of this study to my own setting? Does the study adequately address potential ethical issues, including reflexivity? Overall: is what the researchers did clear? The strengths and limitations of the current study will be discussed using an amalgamation of these generic criteria and Charmaz's (2006) grounded theory criteria as a guide.

Firstly, in terms of credibility, the data are sufficient to suppport the claims of the model (Charmaz, 2006). The sample was broad and reflects the reality of multidisciplinary working in this setting. However, the study did not involve a consultant psychiatrist. Consultant psychiatrists typically occupy the role of responsible clinician in an acute MDT, and their absence limits the findings and credibility. Another limitation regarding credibility is the number of participants. Deciding when enough participants have been recruited is a frequently debated topic (Guest, Bunce, & Johnson, 2006; Patton, 2005). When conducting a study based on grounded theory, the concept of theoretical sufficiency (Dey, 1999) is accepted by some as a means of deciding when sufficient data have been collected. In this study, the final size of the sample was determined after analysing the second round of interviews. However, it could have strengthened the data to use member-checking and validation to explore the resonance of the findings with participants. The credibility of the theory is supported by the links between the data gathered, the data analysis and the argument made. Charmaz (2006) cites originality as a requirement for a grounded theory, and it seems fair to claim that this study offers fresh insights, and

develops upon the research of Tickle et al. (2014).

Resonance and usefulness are the final criteria required of a grounded theory (Charmaz, 2006, p.182. 183). Using the criteria of Kuper, et al. (2008), usefulness could be understood as the transferability of the findings. Resonance refers to how well the study reflects the fullness of the studied experience. One of the limitations of this study is that in seeking to develop a theory it does not fully reflect the experiences of the individuals. Some of the detail shared by individuals was not represented in the model, as it did not adequately reflect the overall approach to risk. However, the findings suggest there are some differences between professions, highlighting OTs' role in working with risk more broadly.

A major limitation of the study is the use of single interviews. The limited amount of time available to complete the research was a key factor in this decision. I chose not to conduct second interviews as I was anxious that doing so would delay my work by several weeks. This is a limitation of the study, as I did not provide participants with the opportunity to further reflect on the original interview and for us to explore my initial analysis.

Furthermore, member-checking and validation was not attempted to establish the resonance of the findings which limits the credibility of the findings. This decision was made primarily because the findings may be difficult for team members to hear, as the current study argues that there is a need for change with the current approach to risk by the team. I think that sharing such views with staff needs to be done with careful consideration and in a way that is constructive and helpful. It was therefore decided to share the findings with participants once the study has been examined. This also allows for me to have more emotional distance from the topic, which will help me bring more balance to any discussions and to manage such conversations with participants constructively.

Usefulness is another domain recommended for measuring a study against

(Charmaz, 2006). Kuper et al. (2008) recommend considering how the findings of a study can be transferred to a different setting. Similarly, Charmaz asks whether a study provides interpretations that will be of use in everyday worlds (p.183). The findings of this research have 'everyday' value in terms of assisting those with power to change the system of older inpatient units. Furthermore, the findings recognise the demands on staff and give voice to participants working in an under-resourced system. Moreover, the findings speak to the concerns regarding the lack of mental health support available for older adults. The findings are useful in highlighting the potential for systemic changes and increased funding for these services. The research also recommends some practical clinical implications that may improve the team's ability to work with risk.

A central feature of the empirical paper is that there may be benefits from changing how older adult teams in inpatient settings work with risk. This is influenced by my own biases, but it is also supported by the evidence cited in the introduction, regarding inadequate service provision for older adults. It is important to acknowledge there are good reasons for services wishing to reduce risk, and to prescribe medication for patients. However, there are risks to the approach that these services take to risk, in my opinion. By working paternalistically, with a strongly medicalised approach, and viewing risk narrowly they may be limiting patients' opportunities to engage in recovery from their mental health difficulties. If a patient is informed that they have a biological illness and are sick, and that the main treatment for this is medication then they are not being provided with good enough care. Patients have a right to person-centred mental health care. Psychological formulation can help people in acute mental health settings make sense of their distress, and for teams to also understand why the person is unwell. (Clarke & Wilson, 2009; Johnstone, 2014) Without this context the person simply 'is unwell' and recovery may be less likely. Furthermore, the more a person has a biopsychosocial understanding of distress, the greater

the opportunities to recognise risks to their mental health.

The final question Charmaz asks of a grounded theory is, how does it contribute to knowledge, and how does it contribute to a better world? This model contributes to knowledge by highlighting the possible benefits from changing the way risk is conceptualised. The enabling nature of therapeutic relationships between staff and clients is absent in the initial phase of working with risk (Hagen, Knizek, & Hjelmeland, 2017; Felton, et al., 2017). Staff's limited appreciation of the importance of their relational experience with clients is highlighted most starkly by the quote from Jean:

> We all tried as an MDT, and we had her in and said we think it's best if you have this medication and she wouldn't accept it, and amm, it was the nursing staff…and the nursing staff were getting frustrated because there was nothing they could do for her and she was getting worse and she was getting worse, and she was feeling people were out to get her, she was paranoid, there was nothing positive in the future, and she might as well not be here, and amm, you know all the time she wouldn't accept any medication…and the staff were saying what to us, what will we do, what will we do…(Jean)

Hagen, et al. (2017) claim that inpatient clinical practice is increasingly instrumentalised, and that the focus on standardised practice hampers staff's ability to provide relational-emotional care for suicidal patients. One answer to the above question "What do we do?" is: we support staff to work differently. This study highlights the need to change the clinical practice in older adult inpatient care. Depending on medication and ECT to reduce risk and improve the mental health of older adults is not in line with NICE guidance and does not meet expectations of adequate service provision. Psychotropic medication also presents a significant risk to older adults (Curkovic, Dodig-Curkovic, Eric,

Kralik, & Pivac, 2016: Maust, Kales, Wiechers, Blow, & Olfson, 2016), and they are entitled to alternative ways of reducing mental health difficulties. Thus, these findings can contribute to improving the worlds of older adults experiencing mental health problems. Services could empower staff to utilise their inherent human ability to assist clients to heal, to recover, to take responsibility and to rediscover a sense of wellbeing (Hagen, et al., 2017; Muskett, 2014). Staff would also benefit from being treated as individuals, with inner emotional worlds, and given autonomy and responsibility as well as adequate clinical supervision. Providing support for staff is necessary if they are to support service users.

Why these Papers?

Risk is a major focus for mental health teams and in recent years has become a central feature of how staff and teams work with clients. In my clinical practice, I worked in an older adult community mental health team where many of the team, including the manager, believed the reason the team existed was to manage risk. I disagree. I think we are there to help people with mental health difficulties recover and find some peace in their lives. Working in adult mental health I found some of my clients were considering suicide and homicide. Initially, this felt quite overwhelming and I was anxious regarding the wellbeing of my clients and others. Fortunately, from these experiences and over time I have learned the value of working with risk in a therapeutic way. To do this, I needed good support from my team and clinical supervisors. My personal experience of mental health difficulties combined with my clinical training supported me to understand that most people respond well to being treated respectfully, and feeling emotionally contained and attuned to by mental health professionals. Some of my work and personal experiences have involved situations where the health professional has approached the ‘risk’ in a literal and instrumentalised manner. This has felt disempowering, disheartening and frustrating. In contrast, when people have worked with the person in front of them, be that me, or a client,

this has felt powerful and supportive.

As a person I value love, justice and human rights. Many of these values overlap with the values of the National Health Service: Working together for patients, respect and dignity, commitment to quality of care, compassion, improving lives and the idea that everyone counts. Within my role as trainee clinical psychologist, I hold a certain amount of power in academia, through my access to journals, and ability to publish research in influential domains. Within the healthcare system, I also possess certain skills and rights, which can be labelled as ‘power’. Using that power to improve the lives of older adults motivated me to undertake this research. Working in inpatient older adult mental health I was upset by some of the decisions that were being made due to the ‘risk’ presented by clients.

My view was that clients were being labelled as ‘risky’, and treated as dangerous without staff understanding the meaning behind clients’ behaviours. My perception was often that there was minimal risk, but I was curious as to why this view was not widely held. I tried to understand the rationale behind my colleagues’ decisions, through reflection, discussion with colleagues and clinical supervision. I also tried presenting an alternative perspective, using formulation and thinking about the person holistically. Following that placement, I remained concerned that older adults were receiving care informed by a reductive understanding of risk, and were not being provided with adequate care. In some cases, I had concerns the care was unethical. There was also some great care being provided, and from talking with individual staff it was clear there was an appetite to work differently. However, many staff were also feeling overwhelmed and staff morale was low.

Clinical Implications

For staff to conceptualise risk more broadly and therapeutically they are likely to require support to manage their own anxieties evoked by this work. One way of supporting them may be through adequate staffing levels, providing a biopsychosocial perspective on mental health, and providing adequate opportunities to safely engage in reflective practice through clinical supervision. Psychology occupied a background role in staff conceptualisations of risk. One of the wards where recruitment took place had been without a psychologist for five years, and only recruited a psychologist in recent months. Even without increased funding there are still changes that can be made at several levels. Implementing the therapeutic interactions model of Appleton, Chambers and Arkley (2016), mentioned in the discussion of the empirical paper, is unlikely to require additional funding, but would require willingness on behalf of the system and staff. Firstly, staff would need to be consulted to understand how they feel about such an approach. It would also be necessary to communicate with them regarding the importance of changing working practices and shifting from a focus on risk to a recovery oriented culture. Working with staff and understanding their needs would increase the likelihood of their engagement with the process of cultural and structural change in inpatient settings.

Recovery oriented inpatient care also needs to be trauma-informed care (Davidson et al., 2016, p. 47). Trauma survivors are likely to comprise most of the population in an inpatient setting (Davidson et al., 2016; Muskett, 2014) with approximately 80% of those admitted to an inpatient setting having experienced at least one significant trauma. Davidson et al. (2016, p.17) argue that “recovery oriented inpatient units need to be welcoming, supportive, strength-based, and person/family-centred milieu that are truly respectful of and responsive to the dignity, autonomy, and tremendous suffering of the people they are intended to serve”. A review by Musket (2014) of literature from 2000–

2011 detailing trauma-informed care in inpatient mental health settings reported that practices in inpatient settings, including coercive practice such secluding or restraining clients, are traumatic for clients, as they are physically intimidated, feel physically and emotionally in danger and the practices are disempowering. Musket (2014, p. 8) concludes that effective and safe inpatient care is trauma-informed and promotes the empowering role of the nurse–client relationship, and truly values client-centred care. A trauma-informed recovery focused on a therapeutic interactions model provides a way of working with clients that is unlikely to require additional funding (Davidson et al., 2016).

Within such an approach there is need for teams to adopt a biopsychosocial approach to mental health. Formulation offers a valuable way of supporting teams to understand mental health in a biopsychosocial and person-centred way. Formulating a client's mental health difficulties and the factors that contribute to acute mental health problems can also enable staff to reduce risk of harm. There is a robust body of evidence linking adverse childhood experiences to mental health difficulties in later life (Collins & Long, 2003; Van der Kolk, 2003). Trauma awareness did not seem to be part of the participants' approach to understanding risk. Providing education and training to the team on the broad nature of historical trauma, from emotional neglect to sexual abuse, and the various ways this can impact on someone later in life, is needed.

Working with someone's experience, if trauma is a factor, can be more emotionally demanding on staff in the short term but may benefit them in the long term (Collins & Long, 2003). A trauma-informed approach considers how the person's past affects their present. Instead of focusing on symptoms, it considers how what has happened to someone impacts on their current emotional and relational ability. However, talking about or being aware of childhood sexual abuse, violence, emotional neglect and a person's specific experiences

can be more emotionally demanding on staff (Collins & Long, 2003). Reducing these experiences to mental illness and symptoms is less demanding, in some ways, and does not require an acknowledgement of the trauma that has contributed to their presentation. Clinical supervision is necessary to reduce the likelihood of vicarious traumatisation of staff (Williams, Helm, & Clemens, 2012). Supervision also supports staff to process their own emotional responses to the clients, clients' histories and how clients behave in the present.

Critiquing the Research Process

A key frustration while conducting research was the process of interviewing staff over a single meeting and building a theory based on the information shared in that interview. In my clinical work, I observe that people need time to truly talk openly about more emotionally challenging content. Building trust requires time and experience, in this case for participants to determine whether they feel safe to speak openly in my company, and to choose whether it would be beneficial to do so. It may be the case that participants shared only one aspect of their experience.

Drawing on psychodynamic theory enables the consideration of how a single interview is limited in its potential to accurately reflect an individual's experience. From a psychodynamic perspective, people may form defences against uncomfortable or unbearable feelings. Molnos (1995, p.35) proposes an internal triangle of conflict between one's true feeling (X), which is unconscious, the conscious anxiety (A) one has about (X), and (D) the defences one forms to protect against (X). Working clinically, I will share my curiosity about a client's (X), and share observations of what appear to be (D) that are driven by (A).

Through working together with clients, we often come to a shared understanding that

more accurately reflects their true, unconscious experience (X). My current placement is psychodynamic, and I was curious about inner emotional and unconscious experiences of staff, and wondered how much could realistically and safely be shared with someone they will speak with once, maybe twice. While they were considered, no second interviews were conducted.

During the interviews, some participants spoke of their discomfort around practices such as restraint, or intense observations of clients. Encouraging some participants, I enquired further how they felt about these practices, but they justified them and I sometimes wondered if they were using these justifications as defences (D) to manage their inner emotional distress, or (X). This is conjecture and my hypothesis may be wrong. The essence of the point is a reflection on how would it feel to honestly share with a relative stranger how uncomfortable you are with certain working practices. Second interviews may have reduced the likelihood of impression management, and could have increased trust and openness and they would also have strengthened the model. With the time constraints of this study that was not practically possible.

The findings of this study have not been shared with the staff yet, and they may, or may not, feel they adequately reflect their experiences. Furthermore, the findings raise concerns about the risks of depending heavily on medication as the primary means of risk reduction. Raising these concerns could be difficult for staff to acknowledge, considering they currently have limited other means to reduce risk.

Furthermore, I was aware that some of what was being shared with staff clashed with my understanding of mental health, of what is helpful for people with mental health difficulties and my values. For example, some participants commented that there was no role for psychology during periods of acute distress. This is a view that I disagree with, and

goes against NICE guidance in terms of direct work with clients. It also suggests there may be a misunderstanding of the role of clinical psychology, perhaps due to a lack of exposure to psychologists. I felt uncomfortable when listening to the role of clinical psychology being misunderstood but did not think it was appropriate to raise my views during an interview. Therefore, I tried to continue the interviews with the genuine intention of attending to the research question, while being aware of my bias and emotional reactions. The dominant role of psychiatry and a traditional medical model in the setting contrasts with the current mode of working for clinical psychologists. A tension between some aspects of psychiatry and clinical psychology is acknowledged (BPS, 2014, p.13). While both professions share similar aims, in the NHS and older adult inpatient settings, there is dominance of a biomedical, psychiatric and pharmacological approach. During the interviews, this dominance was reflected in the language used, with people being described as ‘psychotic’ with the assumption this meant they were ‘risky’, dangerous and in need of medication. These views are not new to me, however I found it difficult to conduct a conversational interview and contain my own views, disagreements, or questions around these paradigms and practices.

During all interviews, I sought practice based examples of participants' views on risk and explained how it would assist in the development of a model grounded upon ‘what is happening here’ (Glaser & Strauss, 1967). Using intensive interviewing techniques (Charmaz, p. 28) allowed me to explore statements or topics, and gather evidence to support the participants’ views on risks. In some interviews, participants gradually began to share their frustrations with working with aspects of the system, and began asking “Do you want to me be honest?” This indicated to me an increase in trust and a truer reflection of their working practices and experiences. In other interviews, it felt quite difficult to gather examples of when someone worked with risk in the way they might have just

described. In some interviews, it was clear that the participant was not giving me any material from experience, rather it was distanced and theoretical. It did not seem appropriate to name this process, but it also felt frustrating and I was left wondering, why is that?

Final Reflections

Working as a novice meta-ethnographer and grounded theorist presented several challenges and opportunities. Choosing an epistemological and methodological approach that matched my values and research proved difficult. The main challenge was committing to a somewhat nebulous methodology that seemed only knowable through experiential learning. Having committed to grounded theory, the process of navigating the differing schools of thought regarding how to be a grounded theorist was confusing, frustrating and at times exciting. Focusing on the process of conceptualising risk felt central to understanding how teams work with risk. This curiosity and belief in the importance of this research, combined with endless patient support from my supervisors nurtured my navigation of the grounded theory material.

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Running Head: ETHICAL APPLICATIONS AND APPENDICES

Section Four: Ethics Section

Evidence of ethical applications and approval and appendices.

Word count: 5,832

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Lancaster University Ethics Application

Governance checklist

Introduction

Please complete all sections (1 to 4) below. If none of the self-assessment items apply to the project then you do not need to complete any additional LU ethics forms.

Further information is available from the FREC webpage

Note: The appropriate ethics forms must be submitted and authorised to ensure that the project is covered by the university insurance policy and complies with the terms of the funding bodies.

Name: Tom Heavey **Department**: Faculty of Health Medicine, Clinical Psychology
Title of Project: How do health professionals working in an older adult inpatient mental health unit construct the concept of clinical risk? **Supervisor** (if applicable): Dr Suzanne Hodge

Section 1A: Self-assessment

1.1 Does your research project involve any of the following?

a. Human participants (including all types of interviews, questionnaires, focus groups, records relating to humans, use of internet or other secondary data, observation etc)

b. Animals - the term animals shall be taken to include any non-human vertebrates, cephalopods or decapod crustaceans.

c. Risk to members of the research team e.g. lone working, travel to areas where researchers may be at risk, risk of emotional distress

d. Human cells or tissues other than those established in laboratory cultures

e. Risk to the environment

f. Conflict of interest

g. Research or a funding source that could be considered controversial

h. Any other ethical considerations

D Yes - complete Section 1B
D No - proceed to Section 2

Section 1B: Ethical review

If your research involves any of the items listed in section 1A further ethical review will be required. Please use this section to provide further information on the ethical considerations involved and the ethics committee that will review the research.

Please remember to allow sufficient time for the review process if it is awarded. The ethical review process can accommodate phased applications, multiple applications and generic applications (e.g. for a suite of

projects), where appropriate; the Research Ethics Officer will advise on the most suitable method according to the specific circumstances.

1.2 Please indicate which item(s) listed in section 1A apply to this project. Provide information below if ticking 's'

a D b D c D d D e D f D g D h D

a) The research participants will be NHS staff working in older adult inpatient mental health units. The majority of interviews will take place in the workplace.
b) However, some participants may request to have the interviews in a different location. If this occurs the researcher will use a lone worker policy in line with the Lancaster University Lone Worker Policy.

1.3 Please indicate which committee you anticipate submitting the application to:

D NHS ethics committee
D Another external committee

D LU FHM Research Ethics committee
D LU FASS/LUMS Research Ethics committee
D LU FST Research Ethics committee
D LU AWERB (animals)

Section 2: Project Information

This information in this section is required by the Research Support Office (RSO) to expedite your proposal.

2.1 If the establishment of a research ethics committee is required as part of your collaboration, please indicate below. (This is a requirement for some large-scale European Commission funded projects, for example.)

D Establishment of a research ethics committee required

2.2 If the research involves either the nuclear industry or an aircraft or the aircraft industry (other than for transport), please provide details below. This information is required by the university insurers.

Click here to enter text.

Section 3: Guidance

The following information is intended as a prompt and to provide guidance on where to find further information. Where appropriate consider addressing these points in the proposal.

- If relevant, guidance on data protection issues can be obtained from the Data Protection Officer - see Data Protection website
- If relevant, guidance on the Freedom of Information Act can be obtained from the FOI Officer - see FOI website
- The University's Research Data Policy can be downloaded here
- The health and safety requirements of each research project must be considered, further information is available from the Safety Office website
- If any of the research team will be working with an NHS Trust, consider who will be named as the Sponsor (if applicable) and seek agreement in principle. Contact the Research Ethics Officer for further information
- If you are involved in any other activities that may result in a conflict of interest with this research, please contact the Head of Research Services (ext. 94905)

- If any of the intellectual property to be used in the research belongs to a third party (e.g. the funder of previous work you have conducted in this field), please contact the Intellectual Property Development Manager(ext.93298)
- If you intend to make a prototype or file a patent application on an invention that relates in some way to the area of research in this proposal, please contact the Intellectual Property Development Manager (ext.93298)
- If your work involves animals you will need authorisation from the University Secretary and may need to submit an applicationto AWERB, please contact the University Secretary for furtherdetails
- Online Research Integrity training is available for staff and students here along with a Research Integrityself-assessmentexercise.

3.1 I confirm that I have noted the information provided in section 3 above and will act on those items which are relevant to my project.

D Confirmed

Section 4: Statement

4.2 I understand that as researcher I have overall responsibility for the ethical managementof theproject and confirmthe following:

- I have read the Code of Practice, Research Ethics at Lancaster: a code of practice and I am willing toabide by it in relation tothecurrentproposal
- I have completed the training and passed theassessment
- Iwillmanage theprojectin anethicallyappropriate manneraccordingto:(a)the subject matter involved; (b) the code of practice of any relevant funding body; and (c) the Code of Practice and Procedures of the university.
- On behalf of the institution I accept responsibility for the project in relation to promoting good research practice and the prevention of misconduct (including plagiarism and fabrication or misrepresentation of results).
- On behalf of the institution I accept responsibility for the project in relation to the observance of the rules for theexploitation of intellectual property.
- If applicable, I will give all staff and students involved in the project guidance on the good practiceand ethical standards expected in the project in accordance with the university Code of Practice. (Online Research Integrity training is available for staff and students here)
- If applicable, I will take steps to ensure that no students or staff involved in the projectwill beexposed to inappropriate situations.

D Confirmed

Please note: If you are not able to confirm the statement above please contact Faculty Research Support Officer and provide an explanation

Applicant: Name: Tom Heavey Date:11/82016

Supervisor (if applicable)*: Name:DrSuzanneHodge

Headof Division* Name: DrBruceHollingsworth

(or delegatedrepresentative)

You must submit this form from your Lancaster University email address, and copy your supervisor and Head of Division in to the email in which you submit this application

Please return this form along with your ethics application to Diane Hopkins

Letter of Approval from Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Applicant: Tom Heavey
Supervisor: Suzanna Hodge
Department: Health Research
FHMREC Reference: FHMREC16005

26 September 2016

Dear Tom

Re: How do health professionals working in an older adult inpatient mental health unit construct the concept of clinical risk?

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions suchas extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information. Tel:-

01542 592838
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

Dr Diane Hopkins
Research Integrity and Governance Officer, Secretary to FHMREC.

Appendix 4

Research Protocol

Project Title: How is the concept of clinical risk constructed by staff within an older adult mental health inpatient unit?

CP Trainee: Thomas Heavey.

Research Supervisor: Dr. Suzanne Hodge, Lecturer in Health Research, Division of Health Research, Doctorate in Clinical Psychology, Lancaster University, Lancaster

Field Supervisor: [redacted]

Introduction

Depression is relatively common in older adults, i.e. over 65, with 2.4 million British older adults experiencing a significantly diminished quality of life due to depression (Mental Health Foundation, 2016). Psychosis is also common in older adults with 20% experiencing 'psychotic' symptoms before the age of 85 (Mental Health Foundation, 2016) These rates are for older adults with 'functional' mental health issues and do not include people with 'organic' mental health issues such as dementia, this research is focused on the former.

The most common treatment pathway for older adults with acute or severe functional mental health issues is admission to inpatient mental health unit, either voluntarily or involuntarily (Department of Health, 2009). Inpatient units are traditionally divided into 'organic' or 'functional' units. Organic units provide care for people with dementia and functional units provide care for people with functional mental health diagnoses, such as 'depression' 'psychosis' or 'schizophrenia' (Faculty of the Psychiatry of Old Age

of the Royal College of Psychiatrists, 2011). Functional Mental health inpatient settings care for people with a level of need that is deemed to be unmanageable in any other setting (Audit Commission, 2000)

Older adults in a functional inpatient unit typically receive co-ordinated care under the Care Programme Approach. The type of care they receive is decided by health professionals in multidisciplinary team and will be dictated by their assessment of the person along with the resources that are available (Faculty of the Psychiatry of Old Age of the Royal College of Psychiatrists, 2011). Research suggests that most older adult services have fewer options of care than adult mental health services, furthermore in mental health services across all ages medication is reported to be over relied upon as a means of intervention Negative stereotypes regarding the benefits of therapeutic work with older adults have been found among mental health professionals, including clinical psychologists (Lee, Volans,&Gregory,2003.

Psychotherapy is also underutilised in older adults despite increasingly robust evidence supporting its efficacy (Huang, Delucchi, Dunn, & Nelson, 2015; Woods, 2005). People using older adult inpatient services are significantly more likely than younger adults to receive pharmacological intervention and/or ECT (Serfaty et al., 2009) . If they do not consent to treatment then it may be administered forcibly under the Mental Health Act (1983)

A Health Care Commission Review (2006) reported explicit discrimination in mental health services where the organisational division between mental health services for adults of working age and older people has resulted in the development of an unfair system, as the range of services available differs for each of these groups. Older people who have made the transition between these services when they reached 65 have said that there were noticeable differences in the quality and range of services available (Health Care Commission Review, 2006).

According to the 2014 to 2015 Electroconvulsive Therapy (ECT) Dataset from the Royal College of Psychiatrists (2015) older adults received significantly higher rates of ECT than younger adults, with over 500 older adults receiving ECT in the 12-month period compared to less than 100 younger adults. Why an older adult in distress is more likely to receive ECT than someone younger is not discussed in the literature. The National Institure for Health and Care Excellence Guidance (NICE, 2009) recommends that ECT should be used after all other treatment options have failed and/or when there is a significant risk to life. If the guidance is being adhered to it therefore follows that health professionals are identifying more incidents of significant risk to the lives of older adults than younger people. However, there is an absence of research that explains why OA are supposedly more at risk and therefore more likely to receive ECT.

A possible factor contributing to the difference in services provided to older adults is the ‘Understandability Phenomenon’ prevalent in Western culture, which suggests that depression may be an inevitable consequence of aging, despite evidence to the contrary (Bryant et al., 2012). These narrative overlaps with the view that older adults are impervious to psychotherapy which may explain the increased use of ECT. Furthermore, cohort effects within older adults may contribute to this population being less willing to engage in psychotherapy due to their own alignment with the “Understandability Phenomenon”, stigma, lack of belief in its efficacy or adopting a ‘just get on with it’ attitude to distress (Brenes, Danhauer, Lyles, Hogan, & Miller, 2015; Bryant et al., 2012)

Risk in Older Adult Mental Health Services

A national study of older people’s mental health services in the United Kingdom reported that there are many risk issues for this population, they are vulnerable to physical, sexual, psychological, emotional and financial abuse, as well as abandonment, neglect and serious

losses of dignity and respect, and infringements of human rights (Health Care Commission Review, 2009). A review of the literature exploring ageism and age discrimination in mental health care in the United Kingdom found older adults are also at risk to themselves and others, as well as risk of iatrogenic harm such as polypharmacy or a lack of options for treatment (Department of Health, 2009).

Western mental health services are predominantly preoccupied with ‘risk’ avoidance. This culture of risk avoidance operates from a narrowly constructed perception of risk. Risk in this narrow framework is conceptualised in terms of risk to others, to self and risk arising from vulnerability (Nolan & Quinn, 2012). This narrow construction does not consider risk from stigma, social exclusion or iatrogenic risk associated with treatment provided by mental health services (Tickle, Brown, & Hayward, 2014).

High profile media cases and publicised investigations into incidents of suicide or homicide involving people with mental health difficulties have contributed to mental health professionals feeling pressurised to prevent such ‘risk related’ events from happening, despite this being an unrealistic expectation. This pressure has also contributed to services being focused on risk avoidance (Tickle et al. 2014).

Services therefore have an ethical responsibility to keep people safe from the harm that services can do. Harm from services may be linked to unachievable expectations they are held to, such as preventing any negative outcomes associated with risk. Such expectation can feed into a ‘risk-averse’ culture where workers feel anxious about ending up being punished. For example, in some services professionals who fear being criticised if anything goes wrong become over-focused on insisting that people take medication, without offering alternatives. A broader conceptualisation of risk recognises the risk of such an approach, and that in reality

risk is inherent in all actions. It also recognises that positive risk taking can support service users towards and into their experience of recovery (Tickle et al. 2014)

In response to the existing ‘risk avoidant’ culture of mental health services is an emergent culture of positive risk taking within a ‘recovery’ focused culture. A culture of recovery emphasises the need to allow older adults the right to make mistakes, to make bad choices, to have maximum agency over their own lives despite their experience of psychological distress (Sykes, Brabban, & Reilly, 2015). A recovery approach therefore embraces positive risk taking by supporting service users to exercise their human rights. In the act of affording the service user respect, autonomy and empowerment there is reported to be a significant therapeutic value and there is growing evidence that positive risk taking within services leads to better clinical outcomes. However, positive risk taking remains uncommon in practice (Sykes, Brabban, & Reilly, 2015). There is a lack of research evidence about how staff conceptualise risk and recovery in older inpatient units but anecdotal evidence and a limited number of surveys suggest that many services may be risk averse.

A grounded theory study by Tickle, Brown and Hayward (2014) explored the perceptions of risk and recovery of eleven Clinical Psychologists working in a range of mental health settings. The authors found that the psychologists were aware of the importance of developing a recovery oriented approach to their work. However, they reported working within a narrow definition of risk that superceded a broader understanding of risk as potentially positive. A key finding was that these professionals were fearful of harm due to risk, for which they could be blamed, which is similar to that reported by Sykes, et al. (2015). This incongruence between an awareness of the value of recovery and practice that is not recovery focused was seen to be strongly influenced by the dominant culture of risk avoidance within mental health services. A limitation of Tickle et al.’s study was that it only looked at the experiences of clinical psychologists and they recommended that further

research should be undertaken to explore other professionals' perceptions of risk and recovery with a view to identifying ways to support staff to reduce their anxiety regarding blame, litigation and harm.

In terms of research, policy and practice, building on the exploratory work of Tickle et al., can provide a new understanding of how risk and recovery are understood and can highlight areas for improved insights into supporting people who use services. From a recovery, oriented perspective there are potentially more helpful means of dealing with clients in distress who may present with 'risk'. Such an approach involves respecting the client's choice and right to make mistakes, such as to self-injure, while being provided with a therapeutic environment and skills to develop healthy alternatives to self-injury (Sykes, et al., 2015). While there are risks associated with such an approach, the theory and evidence indicates that such an approach is therapeutic as the client feels respected and validated.

A positive risk-taking approach has been argued to lower the risk of actual harm while also promoting recovery (Sykes, et al., 2015). This approach can be implemented alongside direct therapy or having the staff as agents of therapeutic change, instead of harm, which also reduces actual risk of harm (Tickle et al. 2014). However, to inform the implementation of positive risk-taking and recovery oriented approaches in older adult services there needs to be an understanding of how the health professionals conceptualise these concepts. Using grounded theory is well suited where there is minimal knowledge regarding the area of interest and where the research aims to develop a novel theory informed by the participants' experiences (Charmaz, 2006).

The Current Study

The lack of research investigating how risk is constructed by mental health professionals in older adult inpatient teams means this area is poorly understood. Using

Method

Participants

Staff working in Older Adult Inpatient Mental Health Units. Participants will be interviewed individually and will be accepted on a ‘first come, first served’ basis.

Inclusion Criteria

Current health qualified professionals working in older adult inpatient mental health units with experience of working with clinical risk. Can be from any discipline involved in the assessment and management of clinical risk Must be English speaking.

Exclusion Criteria

Under one month’s full-time experience in an older adult inpatient mental health unit

Design

The study will employ grounded theory as guided by Charmaz (2006), which offers a systematic yet flexible method for collecting and analysing qualitative data in order to construct theory from the data itself. Grounded theory encourages an iterative process of moving back and forth between data collection and analysis using comparative methods that requires the researcher to interact continuously with their data and emerging analysis (Charmaz, 2014). Grounded Theory is well-suited to this project as it will enable the development of a theoretical model of how health professionals construct the concept of risk, elucidating the factors involved.

Service User Involvement

Consultation with staff to inform project and design topic questions.

grounded theory this study will develop a model of how health professionals define and conceptualise risk. Having a model of how they do this will enable research to explore how this conceptualisation impacts upon decision making in clinical practice. Understanding how health professionals in this setting understand and conceptualise risk could enable all stakeholders to support services to develop a balanced relationship with risk and recovery.

Procedure

Initially the ward managers will be contacted by me to discuss the research, and to gain their approval to recruit from their wards following ethical approval from Lancaster University and research governance approval from the Health Research Authority. Ward managers will be provided with participant information forms. They will be asked to let staff know that I will be attending staff meetings to introduce and discuss the project and for recruitment.

Participants will therefore be contacted by myself through attendance at staff meetings. Staff will be provided with information leaflets containing details of the research (See Appendix 2). If there not enough participants a follow up email will be provided to ward managers to circulate among the staff with the information sheet attached. A reminder email will be circulated after a few weeks, depending on uptake. (See Appendix 4)Those who express an interest in participation may do so via email or in person to myself. They will then agree a time and location for the interview.

Written consent will be obtained at the start of each interview (See Appendix 4). Interviews will mostly take place in the unit where the research is being conducted, with other interviews held in an alternative suitable location if requested. Each participant will be met individually for an interview of approximately 60 minutes. Interviews will be conducted with only the participant and interviewer present. The primary researcher will be the interviewer. The questions will be guided by the topics detailed on the topic guide in Appendix 4.

Analysis

Data will be analysed using Grounded Theory (Glaser & Strauss, 1967; Charmaz, 2014). The primary aim of grounded theory is the generation or discovery of theory (Glaser & Strauss,

1967). The study will use the principles of grounded theory described by Charmaz (2014). Theory generation is achieved through choosing a general research topic to explore: for this study it is ‘How do health care professionals in an older adult inpatient unit construct the concept of ‘risk’? Selecting a topic enables theory development from data generated through research. Data gathered is analysed at each point of data collection, e.g. after each interview, using the comparative method and theoretical sampling. This study will adopt a constructivist approach that assumes that theories do not exist to be discovered but are constructed through the research process (Charmaz, 2006). Therefore, the grounded theory from the study is regarded as interpretative representation, not an objective ‘truth’.

Charmaz (2006) identifies key principles for any Grounded Theory research that this study will use to guide analysis. Firstly, a constant comparative method will be used meaning data collection and analysis will be done simultaneously in an iterative process. Secondly, the constant comparative method is used by the researcher to develop concepts from the data by coding and analysing at the same time. Thirdly, the study will draw on data (e.g. narratives and descriptions)to develop conceptual categories. Furthermore, developing inductive abstract analytic categories will be achieved through systematic data analysis.

Subsequently, theory creation will be prioritised over description or application of existing theory. Theoretical sampling will be used, meaning coding and analysis of data will inform what data to gather next to develop a theory as it emerges. There will be variation in the studied category or process to allow the pursuit of developing a category rather than covering a specific empirical topic (Charmaz, 2006). The codes and concepts identified in the initial coding analysis will then be refined, extended, and cross-referenced to see how they can be integrated to form a theory (Glaser, 1978). Lastly, an ongoing memo writing process aims to

contain hypotheses and ideas that will be recorded during the analysis process. The memo writing will also constitute an audit trail of how the theory was developed.

Practical issues

Some interviews may take place in a suitable location outside of the participant's work place. If this occurs the Lancaster University lone working policy will be applied. The researcher will inform a colleague of their plans to meet a participant. The researcher will provide their colleague with a sealed envelope with details of where and with whom they are. The researcher will agree to call their colleague at an agreed time after the meeting. If this does not occur their colleague will be instructed to open the sealed envelope and contact the police after one hour from the agreed time. If the researcher does not call their colleague they are to return the envelope for shredding.

Ethical concerns

It is unlikely staff will become upset during the interviews as the topic is focused on their professional, rather than personal, experiences. Furthermore, how they construct risk is unlikely to be connected to strong emotional content. However, it is possible that some staff may have a strong emotional response to the questions, for example if they have worked with some risks that evoked emotions within them. Equally they may have worked on a case where harm occurred as a result of risk. If a participant becomes distressed I will use my clinical skills as a trainee clinical psychologist to contain the emotional content of the distress. Also, participants will be provided with information for supports by the researcher prior to the interview process (See Appendix 3).This sheet will guide them to appropriate supports such as their work-based supports, and also generic supports such as The

Samaritans. Should any participants reveal any information that indicates worrying work practices this shall be shared with the field supervisor, a clinical psychologist. All participants will be made aware of this safeguarding measure prior to interviews (See Appendix 3).

Data Handling and Storage

Anonymity will be ensured through the use of participant pseudonyms. Furthermore, any reference to individual's other than the participant will be anonymised. Interviews will be audio recorded using an electronic recording device. Audio recordings will be transported and transferred to the researcher's file space on the password protected, secure university server in a timely manner and then deleted from the recording devices. The audio files will be deleted once transcribed and the transcription will be stored anonymously in an encrypted file on the university server. Paper copies of consent forms will be scanned as soon as possible and stored on the university secure server for 10 years; original paper versions will be destroyed. These steps are in line with the Data Protection Act (1988) and Freedom of Information Act (2000).

Where any data has sensitive material or identifiable personal information the individual files will be password protected as an additional security measure. Any data in paper format the data will be stored securely in a locked cabinet in the researcher's home and destroyed at the end of the study. During the analysis process the storage will be at the chief investigators home address; however long-term storage will be stored electronically Department of Clinical Psychology Research at Lancaster University. The Data Custodian i.e. the person who has ultimate responsibility for managing the usage and safety of the data is my research supervisor, Suzanne Hodge. This will be done by following a procedure that has been developed by the Department of Clinical Psychology and can be found at

http://www.lancaster.ac.uk/shm/study/doctoral_study/dclinpsy/onlinehandbook/ethics_and_data_storage_advice/

Timescale

Table 1 contains the project timescale for the project.

Table 1. Timescale for SRP project 2015-2016

Date	**Project Stage**
April 2016	Prepare Ethics application to Lancaster Faculty of Health and Research Medicine (FHMREC) and IRAS submission.
August/September	Submit Ethics application to July FHMREC committee and IRAS. Continue reading on risk and Grounded Theory.
August/September	Confirm date of staff meetings and attend to promote research.
August/September	Take expressions of interest from staff. Begin introduction. Begin recruitment .Complete introduction.
October	Begin first round interviews. Analyse data.
November	Complete second round of interviews. Continue analysis.
December-January 2017	Complete analysis
January/February	Complete results and begin discussion
March	Submit draft

March	
April	
May	

Appendices

- Appendix 1: Participant Information Sheet
- Appendix 2: Consent Form
- Appendix 3: Topic Guide
- Appendix 4:Follow-up Letter

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Appendix 4-A

Participant Information Sheet

Study Title: How is the concept of clinical risk constructed by staff within an older adult mental health inpatient unit?

Participant Information Sheet

My name is Tom Heavey and I am doing this research as part of my training to become a Clinical Psychologist. I am enrolled on the Clinical Psychology Doctoral Training programme at Lancaster University.

What is the study about?

The study will explore how staff working in older adult inpatient mental health settings understand the concept of risk, and also personal recovery. By interviewing staff about their experiences of working with risk and recovery in their clinical practice I am hoping to develop a detailed understanding of how risk is defined, what it means in practice, and what factors might be involved in shaping that understanding and how it relates to recovery. Using the data from the interviews I will then develop a model of how the concept of risk and recovery are constructed in these older adult inpatient settings. This model may be used to inform further research and/or input from clinical psychology services. The results will be written up in my doctoral thesis and will also be fed back to the services involved in the research.

Why have I been approached?

Because the study requires information from health professionals who work in older adult inpatient mental health settings.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part. There are no direct benefits for you from taking part and no consequences for not taking part.

What will I be asked to do if I take part?

If you decide you would like to take part, the first step is to let me know. You can do this in person or through email, my details are below. We would then arrange a convenient time and place to meet for an interview. The interview would last between 30-60 minutes approximately. The interview can be in a private room at your workplace, or if you would prefer we can agree on another location. There may be an option for a second interview. If this occurs I will contact you to discuss this with you. If you agree to a second interview it would follow the same format as the previous one, however we may refer to the content of the initial interview.

What if decide to withdraw from the study?

If you decide to take part and then change your mind, you may withdraw from the study during the interview or up until the interview ends. After this point your data will have been pooled with data from other participants, so it may not be possible to withdraw it.

Will my data be identifiable?

The information you provide will be treated confidentially and will be anonymised. Only I and my research supervisor will have access to the interview recordings and transcripts.

Some anonymised quotes may be used in the final write-up of the research, which may be published in a scientific journal. The data collected for this study will be stored securely and only the researchers conducting this study will have access to this data:

- Audio recordings will be deleted once transcribed.

- The transcription files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and thecomputer itself password protected.
- All data will be stored electronically where possible andthe hard copies destroyed once the project is completed.
- All your personal data will be confidential and will be kept separatelyfrom your interview responses.

There are some limits to confidentiality: if what is said in the interview causes me to believe that you, or someone else, are at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you should I decide to do this.

What will happen to the results?

The results will be summarised and used in my thesis which I will produce as part of my clinical psychology training at Lancaster University. A summary of my research will also be provided to the services that take part in the study. Lastly, the research may be submitted for publication in an academic or professional journal.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

There are no direct benefits in taking part. However, your participation and the results of the report may be useful to inform future provision of supports by clinical psychology in your service. It may also influence the supports given generally to you from your service.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee, at Lancaster University.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher, or his supervisors:

Main researcher:

Tom Heavey

Trainee Clinical Psychologist

Doctorate in Clinical Psychology

Psychology Faculty of Health and Medicine

Lancaster University

Lancaster

LA1 4YG

Email: t.heavey@lancaster.ac.uk

Tel: NA

Supervisors:

Dr Suzanne Hodge

Lecturer in Health Research

Doctorate in Clinical

Faculty of Health and Medicine

Lancaster University

Lancaster

LA14YG

Email:s.hodge@lancaster.ac.uk

Tel: (0)1524592712

[redacted]

[redacted]

If you want to raise a concern or make a complaint and you do not want to report this to the researcher then please contact:

Dr Bill Sellwood

Research Director

Doctorate in Clinical Psychology

Division of Health Research

Furness Building

Lancaster University

LA1 4YG

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

Professor Roger Pickup

Associate Dean for Research

Faculty of Health and Medicine

(Division of Biomedical and Life Sciences)

Lancaster University

Lancaster

LA1 4YG

Email: r.pickup@lancaster.ac.uk

Tel: 01524 593746

What if I feel worried or upset afterwards?

If you feel worried or upset after the interview, please talk to your line manager, or someone within the service that you feel comfortable talking with. If this is not possible, you could also contact one of the resources listed below.

- Your local
- For anonymous support contact the Samaritans

Confidential support for people experiencing feelings of distress or despair.

Phone: 08457 90 90 90 (24-hour helpline)

Website: www.samaritans.org.uk

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

Appendix 4-B

Consent Form

Study title: How is the concept of clinical risk constructed by staff within an older adult mental health inpatient unit?

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the researcher, Tom Heavey, or any of the people identified on the participant information sheet.

- I confirm that I have read the information sheet and fully understand what is expected of me within this study.D
- I confirm that I have had the opportunity to ask anyquestions and to have themanswered. **D**
- I understand that my interview will be audio recorded and then made into an anonymised written transcript.**D**
- I understand that audio recordings will be kept until the research project has been examined. **D**
- I understand that my participation is voluntary and that I am free to withdraw up to two weeks after taking part in an interview withoutgiving anyreason.**D**
- I understand that after two weeks it might not be possible for my data to be withdrawn, though every attempt will be made to extract my data, up to the point of publication. **D**

- I understand that the information from my interview will be pooled with other participants' responses, anonymised and I consent to information and quotations from my interview being used in reports, conferences and training events.D
- I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator will need to share this information with his research supervisor.**D**
- I consent to Lancaster University keeping written transcriptions of the interviewfor10 years after the study has finished.**D**
- I consent to take part in the above study.**D**

Thank you for taking the time to read this form.

Name ofParticipant:_____

Signature:_____ **Date:** _____

Name ofResearcher:_____

Signature:_____ **Date:** _____

Appendix 4-C

Topic Guide

1. **What does risk mean to you?**
   - How do you recognisewhat risk is?
   - How have you learned what riskis?
   - If something is not risk related,how do you know?
   - Does your viewof risk differ to others?
   - Has your view of risk changed over time?
   - What does recoverymean to you?
   - Do you think recoveryand risk are related?
   - Does your team have ashared view of recovery?
2. **How doyou goaboutassessingormanaging risk?**
   - What might risk look like?
   - When might you begin to formally assess risk?
   - Are there steps, informal orotherwise that you go through?
   - Are there thoughts that you might have during this?
   - Are there familiar feelings youmight have during this?
   - Are there familiar actions you might go through?
   - How might any of the above differ with each situation?
   - What might stay the same?
   - What are thestrengths/weaknesses of this process?
   - What prevents the decision making from looking howyouwant it to?
   - How would you like your decision making to look?
   - How does recoveryinform this process?
   - Are there barriers to working with recovery and risk?
3. **What does risk looklike from the team/service perspective?**
   - What are the obvious risks thatyour team works with?
   - What are the less obvious risks that your team works with?
   - Are there risks that might beinvisible to the team?
   - Would you ever think the team does well with risk management, what does that look like?
   - Where might theteam do better?
   - What could the steps tothis look like?
   - What stops your team from doing better with risk?

- What role does each person in the team play in defining and constructing a ‘risk’?
- Would you ever think the team does well with recovery, what does that look like?
- Where might theteam do better?
- What could the steps tothis look like?
- What stops your team fromdoingbetterwithrecovery?
- In an ideal world what might your/teams approach to risk and recovery look like?

Appendix 4-D

Follow up Email (for Circulation by Ward Managers)

Dear recipients,

You may have met with me at a recent staff meeting, or if not, you will have received information regarding the research I am conducting. This email is a follow up email to determine if there are any further people who are interested in taking part. There is a participant information sheet regarding the study attached. If you have any questions please contact me.

Yours sincerely,

Tom Heavey

Trainee Clinical Psychologist

Lancaster University

Appendix 4-E

Health Research Authority Application Form

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
How is risk constructed in an older adult mental health inpatient ward

1. Is your project research?

(●) Yes ( ) No

2. Select one category from the list below:

( ) Clinical trial of an investigational medicinal product
( ) Clinical investigation or other study of a medical device
( ) Combined trial of an investigational medicinal product and an investigational medical device
( ) Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
( ) Basic science study involving procedures with human participants
( ) Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
(●) Study involving qualitative methods only
( ) Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
( ) Study limited to working with data (specific project only)
( ) Research tissue bank
( ) Research database

If your work does not fit any of these categories, select the option below:

( ) Other study

2a. Please answer the following question(s):

	Yes	No
a) Does the study involve the use of any ionising radiation?	( )	(●)
b) Will you be taking new human tissue samples (or other human biological samples)?	Yes	No
c) Will you be using existing human tissue samples (or other human biological samples)?	Yes	No
	( )	(●)

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

☑ England ☐
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?

IMPORTANT: If your project is taking place in the NHS and is led from England select 'IRAS Form'. If your project is led from Northern Ireland, Scotland or Wales select 'NHS/HSC Research and Development Offices' and/or relevant Research Ethics Committee applications, as appropriate.

☑ IRAS Form
☐ Confidentiality Advisory Group (CAG)
☐ National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D Offices in Northern Ireland, Scotland and Wales the CI must create NHS/HSC Site Specific Information forms, for each site, in addition to the study wide forms, and transfer them to the PIs or local collaborators.

For participating NHS organisations in England different arrangements apply for the provision of site specific information. Refer to IRAS Help for more information.

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

☐
☐
☐
☐
☐
☑

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 research e.g. NHS Support costs) for this study provided by a NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC), NIHR Patient Safety Translational Research Centre or a Diagnostic Evidence Co-operative 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 studyto 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 provides researchers with the practical support they need to make clinical studies happen in the NHS 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, you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form (PAF) immediately after completing this project filter question and before submitting other applications. Failing to complete the PAF ahead of other applications e.g. HRA Approval, may mean that you will be unable to access NIHR CRN Support for your study.

6. Do youplan to includeanyparticipantswho are children?

Yes No

○ ◉

7. Do youplanatanystage oftheprojecttoundertakeintrusive researchinvolvingadultslackingcapacitytoconsent forthemselves?

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 youplan to includeanyparticipantswho areprisonersoryoung offendersin the custodyof HM Prison Serviceor whoareoffenderssupervisedbythe probationservice inEnglandorWales?

Yes No

○ ◉

9. Isthestudyoranypart of it being undertakenas aneducationalproject?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
The student is a clinical psychology doctoral student. They will be the chief investigator.

9a. Is theprojectbeingundertakeninpart fulfilmentofa PhDorotherdoctorate?

◉ Yes ○ No

10. Willthisresearchbefinanciallysupportedbythe United States DepartmentofHealthand Human Servicesoranyof itsdivisions,agenciesorprograms?

○ Yes ◉ No

11. Will identifiablepatientdata beaccessedoutsidethecare teamwithoutpriorconsentatanystage of the project (including identification of potentialparticipants)?

○ Yes ◉ No

Integrated Research Application System
Application Form for Research involving qualitative methodsonly

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)
How is risk constructed in an older adult mental health inpatient ward

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

How do health professionals working in an older adult inpatient mental health unit construct the concept of clinical risk?

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title	Forename/Initials	Surname
	Mr	T	[redacted]

Address [redacted]

Post Code [redacted]

E-mail [redacted]

Telephone [redacted]

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

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title	Forename/Initials	Surname
	Dr	Suzanne	Hodge

Address Division ofHealthResearch

	Room C21 Furness College
	Lancaster University LA14YG
Post Code	s.hodge@lancaster.ac.uk
E-mail	01524 592712
Telephone	
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 MrTHeavey	Dr Suzanne Hodge

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
	Mr Tom Heavey
Post	Trainee Clinical Psychologist
Qualifications	Msc Applied Psychology Bsc Psychology
ORCID ID	
Employer	Lancaster University
Work Address	Doctorate in Clinical Psychology Programme Divisionof Health Research Furness College Lancaster University
Post Code	LA14YG
Work E-mail	t.heavey@lancaster.ac.uk
* Personal E-mail	t.heavey@lancaster.ac.uk
Work Telephone	07903572873
* Personal Telephone/Mobile	07903572873 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
	Dr Diane Hopkins
Address	Research Services Room B14, Furness College, Lancaster University, Lancaster
Post Code	LA1 4YW
E-mail	ethics@lancaster.ac.uk
Telephone	01524592838
Fax	01524843087

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):

Sponsor's/protocol number:

Protocol Version:

Protocol Date:

Funder's reference number:

Project website:

Additional reference number(s):

Ref.Number Description	Reference Number
IRAS PROJECT ID	214003

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.*

The issue of clinical 'risk' has become increasingly important in mental health services in the past three decades. Mental health policy and practice has become significantly focused on risk assessment and management. Two main approaches to dealing with risk have emerged, a risk aversive approach and a positive risk taking approach that supports recovery. However there is an absence of research investigating how clinicians define or develop the construct of 'risk' in practice. This research will develop a theory of how health professionals understand risk, particularly in relation to recovery, in older adult inpatient mental health settings. Understanding this process and developing a theory can inform further theory, research, policy and practise. Improving an understanding of risk can support clinicians towards positive risk taking practise and a greater empowerment of themselves and service users.

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, R&D office 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.

This study has straightforward ethical issues. We will be inviting health professionals to participate in an interview which discusses professional issues. We will not be administering any experimental treatment. An issue that could arise is that a participant becomes distressed during the interview. As a trainee clinical psychologist, I have some clinical skills to contain the distress and to direct the person to the appropriate supports. If a participant were to become distressed I would discuss this with them and assess the level of distress they were experiencing.

We would determine if it was possible to continue the interview or it we needed to discontinue. If we needed to discontinue we would then determine what measures needed to be taking, if any, to manage their distress. I would assess if they needed a referral to another support to assist them with their distress. If necessary I would contact the field supervisor, and discuss further steps that might need to be taken.

[redacted]

Also, participants will be provided with information sheets with details of supports prior to the interview process. This sheet will guide them to appropriate supports such as their work-based support and generic support such as The Samaritans.

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.*

To develop a theory that explains how mental health professionals working in an older adult functional inpatient setting construct the concepts of risk and recovery.

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

NA

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

Older adults in a functional inpatient unit typically receive co-ordinated care under the Care Programme Approach. The type of care they receive is decided by the multidisciplinary team and will be dictated by their assessment of the person along with whatever resources they are available. Research suggests that most older adult services have less options of care than adult mental health services, (DepartmentofHealth,2009).

Psychotherapy is also underutilised but particularly so in older adults despite robust evidence supporting its efficacy. People using older adult inpatient services are significantly more likely than younger adults to receive pharmacological intervention and/or ECT.

A 2006 Health Care Commission Review reported explicit discrimination in mental health services where the organisational division between mental health services for adults of working age and older people has resulted in the development of an unfair system, as the range of services available differs for each of these groups (Health Care Commission Review, 2006).

Recent years has seen an increasing awareness among policy makers, service providers and users of 'personal recovery' alongside the more traditional concept of clinical recovery. However, to support services and the people who use them with personal recovery it is important that services are supported to adopt and maintain a positive risk-taking approach and are aware of the consequences of risk aversive practise.

To support staff in older adult inpatient services we must first understand how they construct the concepts of risk and recovery. Therefore, this study will explore how they do develop and understand these concepts.

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.*

Initially the ward managers will be contacted by me to discuss the research. Ward managers will then be provided with participant information forms. They will be asked to let staff know that I will be attending staff meetings to introduce and discuss the project and for recruitment. Participants will therefore be contacted by myself through attendance at staff meetings. Staff will be provided with information leaflets containing details of the research. Those who express an interest in participation may do so via email or in person to myself. They will then agree a time and location for the interview.

Written consent will be obtained at the start of each interview. Interviews will mostly take place in the unit where the research is being conducted, with other interviews held in an alternative suitable location if requested. Each participant will be met individually for an interview of approximately 60 minutes. Interviews will be conducted with only the participant and interviewer present. The primary researcher will be the interviewer. The questions will be guided by the topics detailed on the topic guide. It is possible that some participants will be interviewed a second time. If this is the case the same procedure will be followed but the question may be informed by the content of the previous interview

Analysis
Data will be analysed using Grounded Theory (Glaser & Strauss, 1967; Charmaz, 2014). The primary aim of grounded theory is the generation or discovery of theory (Glaser & Strauss, 1967). The study will use the principles of grounded theory described by Charmaz (2014). Theory generation will be guided by the general topic of ‘How do health care professionals in an older adult inpatient unit construct the concept of ‘risk’ and recovery?

Data gathered will be analysed at each point of data collection, e.g. after each interview, using the comparative method. This study will adopt a constructivist approach that assumes that theories do not exist to be discovered but are constructed through the research process (Charmaz, 2014). Therefore, the grounded theory from the study is regarded as interpretative representation, not an objective ‘truth’.

Charmaz (2014) identifies key principles for any Grounded Theory research that this study will use to guide analysis. Firstly, a constant comparative method will be used meaning data collection and analysis will be done simultaneously in an iterative process. Secondly, the constant comparative method is used by the researcher to develop concepts from the data by coding and analysing at the same time. Thirdly, the study will draw on data (e.g. narratives and descriptions) to develop conceptual categories. Furthermore, developing inductive abstract analytic categories will be achieved through systematic data analysis.

Subsequently, theory creation will be prioritised over description or application of existing theory. Theoretical sampling will be used, meaning coding and analysis of data will inform what data to gather next to develop a theory as it emerges. There will be variation in the studied category or process to allow the pursuit of developing a category rather than covering a specific empirical topic (Charmaz, 2014). The codes and concepts identified in the initial coding

analysis will then be refined, extended, and cross-referenced to see how they can be integrated to form a theory (Glaser, 1978). Lastly, an ongoing memo writing process aims to contain hypotheses and ideas that will be recorded during the analysis process. The memo writing will also constitute an audit trail of how the theory was developed.

A14-1. In whichaspectsof theresearch process have you actively involved, or will you involve, patients, serviceusers, and/ortheircareers, or membersofthepublic?

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

Give details of involvement, or if none please justify the absence of involvement.
I discussed the research with an staff member with several years of experience working in older adult inpatient environments.

A15. What is the sample group or cohort to be studied in thisresearch? _____

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
- [ ] 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:	Years
Upper age limit:	Years

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

Current health professionals working in older adult inpatient mental health units with experience of working with clinical risk.Can be from any discipline involved in the assessment and management of clinical risk. Must be English speaking.

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

Under one month's full-time experience in an older adult inpatient mental health unit

A18. Give details of allnon-clinical intervention(s)or procedure(s)that will bereceived by participants aspartofthe research protocol. *These include seekingconsent, interviews, non-clinical observationsand use of questionnaires.*

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

1. Total number of interventions/procedures to be received byeach 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 totalwould be routine?
3. Average time takenperintervention/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
Gain consent	1-2		10	Chief Investigator
Conduct a semi-structured interview.	1-2		50	Chief Investigator

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

Around 60 minutes per interview with approximately 6 weeks between interviews, if there are second interviews.

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 asfar as possible.

With any interview regarding working in mental health there is the potential for distress. However, the content of these interviews will not be exploring non-work-related issues and will focus on participants experiences of work which they will be asked to voluntarily discuss. It is not expected that participants will become distressed.

Should someone become distress, as a trainee clinical psychologist I have some clinical skills in containing and supporting people in distress. If a participant does become distressed I will manage the situation and discuss options for supporting the participant with them in a collaborative manner.

Before the interview I will explain to participants that they can stop at any point during the interview. Should they appear distressed or burdened I will explore that with them sensitively. If they are distressed we will discuss what measures we can take, this may mean discontinuing the interview and re-arranging to meet another time. All

participants will be provided with contact details for myself or my supervisors should they wish to discuss any issues including distress after the interview.

If interviews are taken during work hours or on work premises this could be a burden for some participants. Therefore I will offer to meet them out of work hours and in an alternative location. Equally some participants may prefer to meet during work hours, I will aim to be as flexible as possible in the times I offer to meet participants in order to minimise the impact on their working or personal life.

A23. Will interviews/questionnaires or group discussionsincludetopicsthatmightbesensitive, embarrassing upsetting, oris itpossible that criminalorotherdisclosures requiringactioncould occurduring the study?

(●) Yes ( ) No

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

When discussing work practices relating to risk and mental health there is always the possibility that inappropriate conduct or illegal behaviour will be discussed. Should this occur I will seek more detail from regarding what they have said and explain to them that I am trying to ensure that everyone's welfare is being considered and supported.
If this occurs I will explain to the personmy concerns regardingwhat theyhave mentioned and that I will be discussing the issue with my research and field supervisor and other parties where appropriate. This may include the ward manager, matron or safeguarding teams depending on the issues raised. Where there is any doubt or concern I will discuss this as soon as possible with my field supervisor. As a trainee clinical psychologist, I have some experience of risk assessment and dealing with risk or safeguarding issues as they arise in one to one situations and am aware of the need to assess and act appropriately in order to protect the public.

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

There are no direct potential benefits for participants.

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

None.

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 social care or GP records, or review of medical records. Indicate whether this will be done by the direct care team or by researchers acting under arrangements with the responsible care organisation(s).*

Initially the ward managers will be contacted by me to discuss the research, gain their approval following ethical approval from Lancaster University and research governance approval from the Health Research Authority. Ward managers will be provided with participant information forms. They will be asked to let staff know that I will be attending staff meetings to introduce and discuss the project and for recruitment. Participants will therefore be contacted by myself through attendance at staff meetings. Staff will be provided with information leaflets containing details of the research. Those who express an interest in participation may do so via email or in person to myself. They will then agree a time and location for the interview.

A27-2. Willtheidentificationofpotentialparticipantsinvolvereviewingorscreeningtheidentifiablepersonal information ofpatients,service usersoranyotherperson?

( ) Yes (●) No

Please give details below:

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

○ Yes ◉ No

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

Initially the ward managers will be contacted by me to discuss the research, gain their approval following ethical approval from Lancaster University and research governance approval from the Health Research Authority. Ward managers will be provided with participant information forms. They will be asked to let staff know that I will be attending staff meetings to introduce and discuss the project and for recruitment. Participants will therefore be contacted by myself through attendance at staff meetings. Staff will be provided with information leaflets containing details of the research. Those who express an interest in participation may do so via email or in person to myself. They will then agree a time and location for the interview.

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.

Written consent will be gained from participants by the chief investigator. This will be obtained at the start of each interview.

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 have approximately up to four weeks to consider taking part. However, some participants may decide sooner that they wish to take part. After the interviews have been conducted they will not be able to withdraw their material as the study builds upon each interview and their material is likely to analysed and used within two weeks.
They will be informed of the limits of withdrawal in the participant information form and consent form.

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)*

None, as this study does not have the resources.

A35. Whatstepswould youtake ifa participant,who hasgiven informedconsent, losescapacityto consentduring the study? *Tick one optiononly.*

○ 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:

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:

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

Interviews recordings will be stored on a recording device that will be securely stored .At the earliest possible opportunity the recording will be transferred to the secure online storage at Lancaster. The files will then be deleted from the
recorder. The recordings will then be transcribed and the audio file deleted.Transcripts of interviews will be anonymised. These will be stored on a Lancaster University secure file storage facility. Paper copies of consent forms will be scanned as soon as possible and the originals will be destroyed. The electronic copies of interview transcriptions, along with the scanned consent forms, will be stored on the university secure server for 10 years following completion of the study and will then be destroyed. Electronic files will be transported securely e.g. using an encrypted memory stick or ZendTo secure software. The transportation of files using either method will be made as soon as is practicable and possible. The Doctorate in Clinical Psychology administration team will be responsible for

the storage and deletion of data once I have completed my course.

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.*

Participant anonymity will be protected by the use of ID codes in place of participants' names that will applied as soon as is practically possible. Participants will be informed that the information they give will be transported and stored in a secure manner. Ward managers or clinicians at the service where they work will have no access to the transcripts, nor will they be informed of those who have taken part. Participants will be informed that should they choose to meet hold the interview at work that they are risking their anonymity being breached through being seen meeting with the researcher.

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.*

The primary researcher will have access to the interview material. The research supervisor will have access to the transcribed interviews but these will be using pseudonyms and any identifying material will be redacted.

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?

It will be analysed on the primary researchers home computer.

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

Title	Forename/Initials	Surname
Dr	Suzanne	Hodge

Post	Lecturer in Health Research
Qualifications	Phd, Msc and BA.
Work Address	Division of Health Research, Doctorate in Clinical Psychology Lancaster University Lancaster
Post Code	LA14YG
Work Email	s.hodge@lancaster.ac.uk
Work Telephone	01524 592712
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

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

Years: 10

Months:

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 audio files will be deleted by the researcher once examination of the academic assignment has been completed. The Doctorate of Clinical Psychology administration team will be responsible for the storage and deletion of data once I have completed my course on September 1st 2017.t The data will be transferred electronically using a secure method that is supported by the University and will be stored electronically by them.

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

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 healthor 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

A50-1. Will the research be registered on a public database?

◉ Yes ○ No

Please give details, or justify if not registering the research.
It will be registered on the Lancaster University website.

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
- [ ] Internal report
- [ ] Conference presentation
- [ ] 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
- [x] Other (please specify)

Through my doctoral thesis I will be reporting the results. This is submitted as an academic task as part of my ongoing training. A summary report of the findings may also be shared with clinicians working in the teams in order to inform their practise.

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

All data will be anonymised with any identifying information removed. Pseudonyms will also be used.

A53. Will you inform participants of the results?

(•) Yes ( ) No

Please give details of how you will inform participants or justify if not doing so.
A summary report of the findings may also be shared with clinicians working in the teams in order to inform their practise. This will be discussed with teams as the findings are compiled and will be decided through discussion with them at the time.

A54-1. 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
- [ ] Review within the Chief Investigator's institution or host
- [ ] organisation Review within the research team
- [x] Review by educational supervisor
- [x]
- [ ] 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 research has been proposed to the Lancaster University Clinical Psychology Doctoral Training Programme research team who have approved the study pending ethical approval from Lancaster University Faculty of Health and Medicine Research Ethics Committee.

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: 15

Total international sample size (including UK):

Total in European Economic Area:

Further details:
This is an approximate upper figure and it is likely to be in the range of 8-12.

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.*

Based upon previous research using similar methodology and populations this number is adequate to allow for theoretical sufficiency (Tickle, Brown, Hayward, 2014).

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.

The data will be evaluated using Grounded Theory (Charmaz, 2014). Grounded theory uses six phases of analysis. In summary, the analysis is an iterative process of interviewing, analysing, developing the theory, and more interviews, analysis and theory development. The theory is rooted in the data and comes from the experiences of the participants not from a prior theoretical viewpoint. The final outcome will be theory grounded in the data that attempts to explain the process and content of how the participants construct the concept of risk and recovery.

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

[redacted]

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Commercial status:

Status:

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

If Other, please specify:

Contact person

Name of organisation	Lancaster University
Given name	Diane
Family name	Hopkins
Address	Research Services
Town/city	Room B14,Furness College,
Post code	LA1 4YW
Country	UNITEDKINGDOM
Telephone	01524592838
Fax	01524843087
E-mail	ethics@lancaster.ac.uk

Is the sponsor based outside the UK?

○ Yes ◉ No

Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.

A65. Has external funding for the research been secured?

- ☐ Funding secured from one or more funders
- ☐ External funding application to one or more funders in progress 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 responsibilityforanyspecific researchactivitiesorprocedures beendelegatedtoa subcontractor(other than a co-sponsor listed in A64-1) ? *Pleasegive details ofsubcontractors ifapplicable.*

○ Yes ◉ No

A67. Has this or a similar application been previously rejected bya 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. GivedetailsoftheleadNHSR&Dcontactforthisresearch:

[redacted]

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: 19/09/2016
Planned end date: 30/06/2017
Total duration:
Years: 0 Months: 9 Days: 12

A71-1. Is this study?

○ Single centre
◉ Multicentre

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

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ Other countries in European Economic Area

Total UK sites in study Three

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:*

- ☑ NHS organisations in England
- ☐ 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
- ☐ Educational establishments
- ☐ Independent research units
- ☐ Other (give details)

Total UK sites in study: 0

A73-1.Willpotentialparticipants beidentifiedthroughanyorganisationsotherthantheresearchsiteslistedabove?

○ Yes ◉ No

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

My research supervisor and field supervisor will be involved in the ongoing monitoring and auditing of the research. When completed it will also be submitted as part of my doctoral training programme where it will be evaluated and marked.

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. Whatarrangementswill be madeforinsurance and/or indemnity to meetthepotential legal liability of investigators/collaborators arising from harm to participants in the conduct of theresearch?

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 detailsofthe hostorganisations(LocalAuthority, NHS or other)in the UK thatwillbe responsible for the research sites. *For further information pleaserefertoguidance.*

Investigator identifier	Research site	Investigator Name

IN1

NHS site

Non-NHS site

Country: England

Forename Tom

Middle name

Family name Heavey

Email t.heavey@lancaster.ac.uk

Qualification MSc applied psychology

[redacted] isation [redacted]

IN2

NHS site

Non-NHS site

Country: England

Forename Tom

Middle name

Family name Heavey

Email t.heavey@lancaster.ac.uk

[redacted] ationM [redacted]

psychology

(MD...) BSc Psychology

Organisation name [redacted]

IN3

NHS site

Non-NHS site

Forename

Middle name

Family Name

Email

Qualification (MD...)

Country

Appendix 4-F

Letter of HRA Approval

Health Research Authority

Mr Tom Heavey

Email: hra.approval@nhs.net

04 January 2016

Dear Mr Heavey

Letter of HRA Approval

Study title:	**How do health professionals working in an older adult inpatient mental health unit construct the concept of clinical risk?**
REC reference:	**16/HRA/6136**
Sponsor	**Lancaster University**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

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

- Working with organisations hosting the research
- 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.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

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 email the HRA at hra.approval@nhs.net.
Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **214003**. Please quote this on all correspondence.

IRAS project ID	214003

Yours sincerely,

Natalie Wilson
Assessor

Email: hra.approval@nhs.net

Copy to: *Dr Diane Hopkins, Lancaster University, Sponsor contact*
[redacted]

Appendix A - List of Documents

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

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non-NHS Sponsors only) [Insurance]	1	04 October 2016
Interview schedules or topic guides for participants [Topic Guide]	Version 1	15 August 2016
IRAS Application Form [IRAS_Form_22112016]		22 November 2016
IRAS Application Form XML file [IRAS_Form_22112016]		22 November 2016
IRAS Checklist XML [Checklist_22112016]		22 November 2016
Letter from sponsor [Letter]	1	04 October 2016
Letters of invitation to participant [Optional Follow Up Email]	2	28 September 2016
Other [Statement of Activities]	2	21 December 2016
Other [Schedule of Events]	2	21 December 2016
Participant consent form [Consent Form]	2	28 September 2016
Participant information sheet (PIS) [PIS]	2	28 September 2016
Research protocol or project proposal [Thesis Protocol]	Version 1	28 September 2016
Summary CV for Chief Investigator (CI) [CV]	Version 1	15 August 2016
Summary CV for student [CV]	Version 1	15 August 2016
Summary CV for supervisor (student research) [CV]	Version 1	15 August 2016

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the *participating NHS organisations, capacity and capability* and *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: Tom Heavey

Email: t.heavey@lancaster.ac.uk

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	This is a non-commercial, multicentre study taking place in the NHS. A Statement of Activities has been submitted. This will act as the agreement between sponsor and participating NHS organisations.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical

Section	HRA Assessment Criteria	Compliant with Standards	Comments
			defence organisation covers the activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	Sponsor is not providing funding to participating NHS organisations.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	
6.3	Devices – MHRA notice of no objection received	Not Applicable	
6.4	Other regulatory approvals and authorisations received	Not Applicable	

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

This is a non-commercial, multicentre study. There is only one site-type involved in the research. NHS staff will be asked to take part in a semi-structured interview.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with

participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

Participating NHS organisations in England **will be expected to formally confirm their capacity and capability to host this research**.

- Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capacity will be confirmed is detailed in the *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* section of this appendix.
- The Assessing, Arranging, and Confirming document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

Neither a Principal Investigator (PI) nor a Local Collaborator (LC) is expected at participating NHS organisations. Sponsor does not expect research staff to undertake any specific or additional training for the study.

GCP training is not a generic training expectation, in line with the HRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

Letters of Access would be expected for research staff requiring access to participating NHS where interviews with NHS staff are conducted in clinical areas. No Letters of Access would be expected for interviews conducted in administrative offices/non-clinical areas.

Other Information to Aid Study Set-up

IRAS project ID	214003

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 4-F

[redacted]

Letter of Approval from Trust

Mr Tom Heavey
73 Nicolas Road
Chorlton
Manchester M21
9LS

Tel: [redacted]

Dear Mr Heavey

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access toconduct research through forthe purpose and on the terms and conditions set out below. This right of access commences on **08/02/2017** and ends on **01/06/2017** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as notified to us. Please note that you cannot start the research until the Chief/Principal Investigator for the research project has received an email from us confirming we have the capacity and capability to support the research and all other regulatory approvals are in place.

You are considered to be a legal visitor to [redacted] premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking researchthrough [redacted] st,you will remain accountable to your employer **Lancashire Care NHS Foundation Trust**, but you are required to follow the reasonable instructions of the relevant service manager(s) in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must actin accordance with [redacted] policies and procedures, which are available to you upon request, and the Research Governance Framework.

The Trust is committed to safegu ard ing children , young people and vulnerable adults and requires all staff and volunteers to share this commitment.

[redacted]

You are required-operate with [redacted] in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on [redacted] Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally always.

You are required to ensure that all information regarding patients remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http:l /www.dh.gov.uk/asse!t RooU04/06/92/54/04069254 .pdf) and the Data Protection Act 1998. Furthermore, you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may have led to prosecution.

[redacted] in:lemnify you against any liability incurred as a result of any breach of confidentiality or breach of the 1) data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, bleep number, email or library account, keys or protective clothing, these are returned up::>n termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NH1S organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving s6iven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider amounting to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this MHS organisation or if you are convicted of any criminal offence. Where applicable, your substantive employer will initiate your Independent Safeguarding Authority {ISA) registration in-line with th phasing strategy adopted within the NHS and the applicable legislation. Once you are ISA registered, your employer will continue to monitor your ISA registration status via the online ISA service. Should you cease to be SA-registered, this letter of access is immediately terminated. Your substantive employer will immediately withdraw you from undertaking this or any other regulated activity and you MLIST stop undertaking any regulated activity.

Your substantive employer is responsible for your conduct t during this research project and may in the circumstances described above instigate disciplinary action against you. If your circumstances change in relation to your health, criminal record, professional registration or ISA registration, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

[redacted]

[redacted]

[redacted]