Understanding how mental health liaison practitioners make sense of their experiences with decisions related to life-threatening self-harm

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Thesis Portfolio Abstract

Background

Suicide prevention continues to be at the forefront of public health initiatives. Research has shown that structured assessment tools have poor predictive ability and guidance suggests that suicide risk assessment should involve clinicians making judgments about pertinent risk factors and completing a needs-led assessment. This thesis aims to look at the role of clinical judgement in practice and the factors which may impact clinicians' judgement. It also aims to explore clinician experience of making decisions regarding suicide risk assessment (SRA).

Methods

A systematic review synthesised the available evidence around the role of clinical judgement in suicide risk assessment. Databases were searched and included papers summarised. An empirical study was conducted exploring the in-depth experiences of clinicians making risk decisions. Eight liaison practitioners took part in interviews which were analysed using Interpretative Phenomenological Analysis.

Results

Nine studies met the inclusion criteria. Seven looked how clinician factors impacted risk rating and two looked at clinician experience of suicide risk assessment, with one of these papers also into current clinical practice of suicide risk assessment. There was large variability across the papers looking into clinician factors, however highlighted that clinician factors are likely to play a role in how a clinician rates risk. The empirical paper found six main themes were identified in the data: You can only do what you do can do; My team are my safety blanket; The only certainty is uncertainty; Putting my wellbeing first allows me to show up for others **;** You can't help but go back to what you've been through before; At the end of the day, you need to protect yourself

Conclusions

Clinician judgement is an under researched area, which is surprising due to the lack of predictive ability of structured assessment tools. This thesis highlights the impact clinician factors can have on risk ratings, the complexity of and variability of the risk decision process and the salient elements of a clinician's experience. Although there is further research need, this thesis has shown the importance of recognising the clinician's role in SRA.

Chapter One

Introduction

Word Count: 2186

Introduction

This initial chapter serves as an introduction to the thesis portfolio. Within this introductory chapter an introduction to the various topics within the portfolio are introduced. This includes suicide risk assessment (SRA); the role of clinical judgement in assessing risk; and the assessment of risk in an emergency department (ED) setting. The aims of the thesis are outlined, and an overview of the chapters are presented.

Suicide

Suicide prevention has been at the forefront of mental health strategy and remains a prevalent issue, with the NHS Five-Year Forward View setting a national ambition in 2016 to reduce suicides by 10% (equivalent to 482 suicides) by 2020/21 (HM Government, 2021). In 2019, there were 5,691 suicides registered in England and Wales (Office for National Statistics,2020), and suicide continues to be the biggest cause of death in men under the age of 50 in the UK. Research continues to seek better ways of predicting and preventing these deaths.

A number of psychological theories exist which attempt to understand the processes underpinning suicide. The most frequently cited of these is the interpersonal-psychological theory of suicidal behaviour (Joiner, 2005). This suggests that three components must exist in order for an individual to die by suicide: 1) the acquired capability to enact lethal self-injury, 2) the sense that one is a burden on loved ones or society (burdensomeness), and 3) the sense that one does not belong to or feel connected with a valued group or relationship (Stellrecht et al., 2006). These components suggest points of emphasis for intervention, as well as assessment.

The Integrated Motivational-Volitional Model of Suicidal Behaviour was first proposed in 2011 by Rory O'Connor and then later refined (O'Connor & Kirtley, 2018) and offers an alternative theory of suicide. This is based in the stress-diathesis model and suggests that there are three parts of the model: (1) Background Factors (Pre-motivational phase; the context in which suicide may

occur), (2) Development of Suicidal Thoughts (Motivational phase; how/why suicidal thinking emerges) and (3) Attempting Suicide (Volitional Phase; factors associated with acting upon one's thoughts of suicide).It is important the assessments of risk are grounded in the theoretical underpinnings of understanding why a person might go on to die by suicide.

Contact with Services

Associations have been established between suicide and previous contact with health services. A French study found that over 60% of individuals who had died by suicide had consulted a physician or an emergency department in the month prior to their death (Laanani et al., 2020) and it is estimated that 1 in 3 individuals who die by suicide had presented to an ED in the year prior to their death (Da Cruz et al., 2011; Gairin et al., 2003). It is clear that these settings are imperative to identifying suicide risk.

Suicide Risk Assessment

The World Health Organisation (WHO) calls for increased importance around suicide prevention and recommends this be achieved by systematic consideration of risk factors, protective factors and related interventions (WHO, 2014). The Department of Health's Best Practice in Managing Risk (2007) defines risk as relating to the likelihood, imminence and severity of a negative event occurring. The WHO also recommend that selective strategies be targeted at higher risk groups, however ambiguity then appears when attempting to determine the level of a risk an individual presents with.

There has been significant research into risk factors for suicide, with psychiatric disorders having the strongest effect on suicide rates (Chesney et al., 2014), as well as a history of self-harm (Favril et al., 2022). There are, of course, other predisposing factors, and understanding an individual's risk requires consideration of both predisposing and precipitating factors (Fazel & Runeson, 2020). These are considered to result in psychological changes, including feeling alone,

hopeless, and isolated. These changes combined with access to lethal means, allows for the possibility of suicide (Van Orden et al., 2010).

Predicting suicide typically is done by clinical judgement, however there is a significant amount of research around structured assessment tools with no validity. There is also increasing research combining these risk factors with statistical models and tools, aiming for a more precise assessment of risk. The predictive ability of these measures remains poor despite the ongoing research and development of new measures (Quinlivan et al., 2017; Chan et al., 2016) and in England, UK, although assessing risk is key aspect of clinical practice, making decisions using a tool is not recommended by national guidelines (NICE, 2022).

Whilst the structured tools lack validity, the risk factors for future suicide and the evidence base should still be considered. Courtney and McCutcheon (2009) argued that reliance solely on clinical guidelines can limit decision-making and result in erroneous outcomes and should consequently be used in collaboration with the evidence base. Current SRA practices were examined at numerous ED's (Quinlivan et al., 2014; (McClatchley et al., 2019) and results indicated that a wide range of tools are used, with the most common being a locally developed tool or proforma.

Clinical Judgement

By nature, clinical judgment means there will be variation across clinicians and multiple factors can influence decisions. For example, Berman et al. (2015) found that clinicians with higher levels of burnout and clinicians with higher caseloads were more likely to recommend in-patient treatment for suicidal patients, which suggests that clinicians under pressure become more risk averse and that there is likely a number of complex, dynamic factors interact with clinical judgement. The responsibility, however, remains with clinicians to complete a psychosocial assessment of risk, which is then used to underpin and justify their plan of action. The most common place for SRA to occur is the ED, and as evidenced above this appears to be where the research is focused on current practices. Given ED's are busy departments with high patient flow the themes of higher caseload and

risk of burnout in the staff group might be one this cohort more closely identify with. Whilst the literature has made attempts to understood processes around risk assessments in this setting such as structured tools to predict risk what is less known is the experiences of this staff group, especially given the high-risk environment.

Clinical experience, a thorough knowledge base and the ability to think critically are a few of the many skills required for any clinical decision-making process (Smyth & McCabe, 2017). Working within an ED can present challenges to how effectively clinical judgement, or clinical decision making, is carried out due to the multiple stressors and the unpredictability of the environment. Decision Making Decision theory describes the steps involved in making any decision, including recognizing that a decision must be made, understanding the goals that one hopes to attain, making a list of options, determining the consequences—both positive and negative—of each option, determining the desirability of each consequence, evaluating the likelihood of each consequence, and integrating all the information. The entire process occurs within a context or situation that may influence the options available and their consequences (Fischhoff, 1992).

There are two prominent theoretical models related to decision theories: dual-process theory (Kahneman, 2011) and Bayesian decision theory, which says decisions are almost always made under uncertainty with a probability of risk (Ellsberg, 1961). In the first theory, Kahneman proposes that there are two distinct processes: System One is automatic, intuitive, affective / emotional and involves little mental effort and System Two is more analytical, deliberate, and logical, and requires more mental effort. Bayesian decision making involves basing decisions on the probability of a successful outcome, where this probability is informed by both prior information and new evidence the decision maker obtains.

Decision-making is a fundamental concept of nursing practice that conforms to a systematic trajectory involving the assessment, interpretation, evaluation and management of patient-specific situations (Dougherty et al., 2015). Standing (2010) suggests that decision making is a complex

process that involves observation, information processing, critical thinking, and clinical judgement to select the best course of action in promoting and maintaining a patient's health. Decision-making is a dynamic process in nursing practice, and the theories emphasise the importance of adaptability and reflective practice to identify factors that impact on patient care (Pearson, 2013).

Exploring how decision making is conceptualized in nursing practice includes understanding how theory is utilized to guide practice. Payne (2015) discussed intuitive decision making, describing it as non-conscious event that's orchestrated by the mind, however analytical decision-making requires the nurse to perform a conscious, logical, and sequential thought process. Staempfi, Junz, and Tov (2012) proposed a model which provides a process whereby the nurse first approaches a critical situation, then reflects on personal knowledge, applies knowledge and skills, and implements appropriate action.

Within clinical decision-making theory, 'hypothetico-deductive reasoning' is considered the most dominant approach in health care with practice based on rationality and empirical precision (Jefford et al, 2011). This framework is formed of four stages that assist the assessor in identifying and interpreting cues and constructing and evaluating a hypothesis: Cue acquisition; Hypothesis generation; Interpretation of cues; Evaluation of hypothesis. Applied to SRA, this theory outlines clinicians assessing primary data, developing a provisional hypothesis, re-exploring and interpreting the cues before making a final evaluation.

Mental Health Liaison

Liaison psychiatry services provide immediate access to specialist mental health support for people being treated for physical health problems, most often in general hospitals and in some cases in the community. Liaison Psychiatry in the modern NHS suggests that every NHS hospital should have such a service as standard and that liaison psychiatry services can save an average hospital £5 million a year by reducing the number and length of admissions to beds (Fossey et al., 2012).

Working with suicidality

Working with individuals who have attempted suicide or self-harmed evokes a range of emotions (Hagen et al., 2007) and SRA involves complex decision making in each phase of the process. Sands (2009) found that decision making under pressure was commonly cited as a key stressor and clinicians located in the ED felt their level of responsibility was high.

Rates of burnout are high in ED settings (Hooper at al., 2010), and O'Neill et al. (2019) highlighted that liaison psychiatry practitioners working in the ED may be at risk of burnout due to experiencing high levels of distress in time pressured situations. No research has investigated the rates of burnout in this population. However, burnout is linked to poor patient safety (Hall et al., 2016; Panagioti et al., 2018) which is especially important in SRA. Given the frequency in which ED clinicians are making assessments about suicide risk, well-being is an important factor to consider.

Thesis Overview

Undrill (2018) highlights in his article titled the risks of risk assessment that this part of a clinician's role can be anxiety provoking. SRA is often a subjective and context dependent statement about an individual, and, because of the impossibility of removing uncertainty and the consequences of an adverse outcome, it can have significant implications for both parties.

This thesis aims to review the subjective aspects of SRA, particularly looking at how clinical judgement is being used and how this may impact decision making. This is especially important given the recommendations for assessments in NICE guidance as well as empirical research suggests not to solely rely on standardised structured measures. The thesis portfolio also aims to explore clinicians experience of making risk decisions, in an environment where SRA is commonplace, with the knowledge that many individuals who have died by suicide have been seen in ED in the months prior to their death.

Chapter two presents a systematic review of the existing research investigating the role of clinical judgement in SRA. Given the lack of prior knowledge around how current practices involve clinical judgement and to what extent, the aim of this review was broad and hoped to present a picture of what we know so far. Searches were carried out across four databases and were included if they directly investigated clinician judgement, if clinicians had a core profession, and if the assessment was about suicide risk. Chapter three presents a brief bridging chapter, which summarises the systematic reviews findings and explains the rationale for the empirical paper.

Chapter four presents the empirical study, which explored the lived experience of mental health liaison practitioners working in ED and making decisions about suicide risk. This study was reviewed and approved by the UK Health Research Authority (HRA) (Appendix A), as well as the Faculty of Medicine and Health Sciences Research Ethics Subcommittee, at the University of East Anglia (Appendix B). Participants were recruited via local liaison teams and the study advert (Appendix C) was sent round via email. Participants then got in touch with the researcher and were then given the participant information sheet (Appendix D) and the consent form (Appendix E). Participants took part in semi structured interviews, guided by the topic guide (Appendix F) which lasted about an hour via Microsoft teams and were then sent a debrief form (Appendix G). Interviews were then analysed using Interpretative Phenomenological Analysis. Participants experiences were presented using themes and discussed. Finally, chapter five summarises the findings of both papers, presents a critical review and discusses the future implications in both practice and research.

Chapter Two

Systematic Review

The role of clinical judgement in suicide risk assessment: A Systematic Review

This paper has been developed for submission to Archives of Suicide Research.

(Author guidelines are outlined in Appendix A)

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The role of clinical judgement in suicide risk assessment: A Systematic Review

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Abstract

Objective

Research predominantly focuses on reliability of risk assessment tools to determine suicide risk. There is limited evidence as to what extent clinical judgement plays a role in the decision-making process in clinical practice. This review aims to examine and synthesise the literature capturing how clinical judgement is used in practice, what this means for SRA and whether it is comparable to clinical tools.

Method

Searches of four databases were conducted. Studies were included if they directly investigated clinician judgement, if clinicians had a core profession, and if the assessment was about suicide risk.

Results

Nine studies met the inclusion criteria. Seven looked how clinician factors impacted risk rating and two looked at clinician experience of suicide risk assessment, with one of these papers also into current clinical practice of suicide risk assessment. There was large variability across the papers looking into clinician factors, however highlighted that clinician factors are likely to play a role in how a clinician rates risk.

Conclusions

This review highlighted the lack of evidence as to how clinical judgement is currently integrated in routine practice of SRA as well as showing that clinician factors affect the level of risk an individual is given during a risk assessment.

Keywords: Suicide; Risk assessment; Clinical Judgement;

Background

Suicide prevention remains at the forefront of national healthcare strategies, with approximately 700,00 deaths by suicide reported each year across the world (Organization, 2021). Evidence shows that in the 12 months prior to a completed suicide 87% of individuals are seen by a general practitioner and a third are seen by mental health services (Leavey et al., 2016). Therefore, successfully identifying those at highest risk of suicide during these contacts with services is crucial. However, assessing a person's risk of dying by suicide is recognised to be a complex task (WHO, 2021) with no agreed gold standard assessment, in terms of an instrument (Andreotti, 2020).

Risk assessment and management is best conceptualized as a process, rather than a single event which includes assessment, intervention, and subsequent reassessment (Oquendo, 2017). The Department of Health's Best Practice in Managing Risk (2007) defines risk as relating to the likelihood, imminence and severity of a negative event occurring. In practice, suicide risk assessment (SRA) often occurs in a single meeting between professional and individual and is carried out by multiple disciplines across a variety of settings.

Current Risk Prediction Models

Whiting and Fazel (Whiting & Fazel, 2019) examined recent reviews of suicide assessment consistently finding that the prediction of suicide is difficult and associated with uncertainty.

Much research has been conducted into identifying risk factors (Franklin et al., 2017) and into developing risk assessment tools to better recognise patients at the highest risk of completing suicide. Despite the many developed tools, the sole use of these is not recommended as the evidence suggests their predictive ability remains low (Perlman & Neufeld, 2014). Therefore, this is recommended as a support tool for clinical decision making. Indeed, Carter et al (Carter, 2017) found the positive predictive value of such risk assessments to be less than 20%. UK national guidance (NICE, 2022) does not recommend using a formal assessment tool predicting the risk of

future suicide or self-harm to make decisions about someone's care, but rather to assess risk in a needs led way.

How Is Suicide Risk Assessed Currently

Looking at current practices into how SRA is conducted, Quinlivan et al (Quinlivan, 2014) focused on emergency departments finding there was a wide range of tools used, with the prominent practice being a locally developed structured proforma (41% of the sample). Only 1 hospital (3% of the sample) reporting using only clinical judgment to assess risk. A review conducted in Scotland found that 67% of participants stated they used a suicide risk assessment tool, and similarly the most common tool was a locally developed tool or proforma (McClatchey et al., 2019).

Clinical Judgement

Decision making largely falls into two categories – clinical judgement (sometimes called clinical decision-making) and mechanical prediction. Clinical judgement refers to a clinician's expert opinion based on their information gathering and mechanical prediction refers to purely statistical calculation. Clinical judgement by nature means that there will be variation across clinicians. However, multiple factors can influence clinical judgements. For example, Berman et al. (Berman et al., 2016) found that clinicians with higher levels of burnout and clinicians with higher caseloads were more likely to recommend in-patient treatment for suicidal patients. This demonstrates numerous complex, dynamic factors interact with clinical judgement.

Rationale and Aims

Clinical judgment refers to the expertise and experience of mental health professionals in interpreting and synthesizing various pieces of information to arrive at a comprehensive understanding of a person's suicide risk. It can be interpreted and used in different ways and to the authors knowledge no one has comprehensively reviewed the many aspects of clinical judgement and how it plays a role in decision making.

Research has, and continues to, predominantly focus on reliability of risk assessment tools to determine risk. However, there appears to be limited evidence as to how much weighting is given to these assessments in clinical practice and to what extent clinical judgement plays a role in the process. This review hopes to understand what clinicians are using to assess suicide risk and whether this is a combination of structured tools and clinical judgement, or solely either of these methods.

Another area under researched is to how these tools compare to clinicians' judgement. As Fazel et al (2017) suggested, it may be that directly comparing risk tools with clinicians' judgement is not feasible, however there does not appear to be a synthesis of any attempts to do so.

Aim: This review aims to examine and synthesise the literature capturing how clinical judgement is used in practice across clinical services, and to what extent it is used either alongside structured assessment tools or instead of.

Method

This systematic review protocol was developed in line with Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA; (Moher et al., 2009)). It was registered with The International Prospective Register of Systematic Reviews (PROSPERO, https://www.crd.york.ac.uk/prospero, registration number CRD42023404051).

Eligibility

Studies needed to include mental health practitioners who assess suicide as part of their role. Studies focused only on quantitative assessment of suicide, or with no mention of clinical judgement were excluded

Inclusion Criteria:

- Participants/population includes:
    - clinicians working in mental health setting
    - clinicians undertaking risk assessment directly related to assessment of suicidality

    - clinicians who hold a recognised core profession (e.g. doctor, nurse, psychologist, occupational therapist)
- Published in English (or translated into English) since 1985

Exclusion Criteria:

- Risk assessment where suicidality is related to physical health
- Papers which solely use a quantitative risk assessment tool
- Risk assessment that does not explore suicidality
- Grey literature including unpublished thesis projects
- Reviews of literature or theoretical papers

Search Strategy and Screening

The EMBASE, PsychINFO, CINAHL, and MEDLINE databases were searched, with additional hand searches based on reference lists and citations of papers meeting the inclusion criteria. Search terms which were cross-referenced with MESH terms were: ("clinical decision" or "clinical judgement" or "professional judgement" or “clinical reasoning”) AND (suicid*) AND (assess* or risk). Searches were carried out in July 2023.

Screening and Quality Assessment

Duplicates were removed before a detailed title and abstract screen was undertaken by the first author. Ten percent of abstracts screened for eligibility were re-checked by RM (n=62) and no discrepancies were found. Remaining papers were full text screened for eligibility based on the inclusion and exclusion criteria. Twenty percent of full text articles screened for eligibility were checked independently by RM (n= 7), with 1 discrepancy being resolved by discussion.

Methodological quality of studies was assessed using the Mixed Methods Appraisal Tool (MMAT) (Hong, 2018). The MMAT is well-established and commonly used for studies adopting

quantitative, qualitative, mixed, or randomised control trial methodologies. Included studies were initially assess by HL, with thirty percent (n=3) independently assessed by RM, with 87% agreement. Discrepancies were discussed and resolved.

Data Extraction and Narrative Synthesis

Data were extracted from the studies (n=9) included: study characteristics (study aims, whether participants were clinicians or patients, assessment of suicidality), sample characteristics (sample size and source, gender, age), study procedure, and study outcomes. A narrative synthesis was conducted which explored common patterns, themes and relationships between the data. This aimed to be in accordance with the guidance by Popay and colleagues (Popay et al., 2006), which suggests first developing an idea about the review question, then to organise findings from included studies to describe patterns. The latter steps direct you to then consider the factors which may explain any difference and then to finally provide an assessment of the evidence.

Results

Figure 1 shows the study selection process. Database searches returned 935 papers (623 following removal of duplicates). Following abstract screening, 29 full text papers were screened for eligibility, 6 of which met the inclusion criteria. Additional papers were hand searched using the reference lists of screened papers (n=5), 3 of which were then included. In total 9 papers were included in the final evaluation. 2 papers used the same original participant sample (Regehr et al., 2016; Regehr et al., 2015).

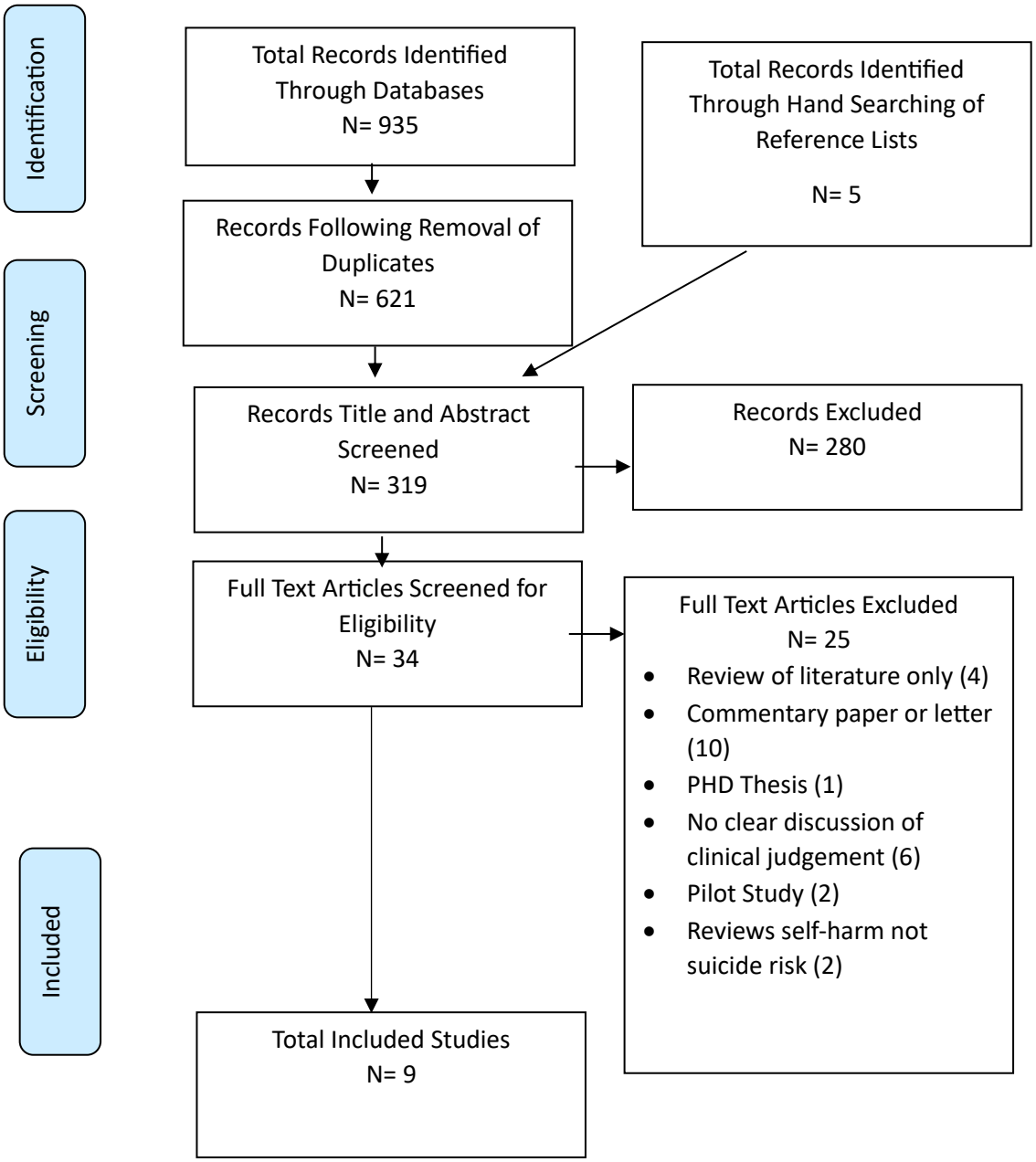

Figure 1: flow chart demonstrating process of review

Study Characteristics

Study characteristics are summarised in Table 1.

Participants

Table 1 summarises study characteristics. The studies originated in multiple countries, (USA, Germany, UK & Canada), employed a variety of study designs and participants were all clinicians working with assessment of suicide risk. Sample sizes ranged from 15 (Chunduri et al., 2019) to 400 (Gale et al., year) with a mean of 108. Mean age of participants ranged from 15 (Boege et al., 2014) (patients) to 43 (Gale et al., 2016). Four studies did not report participant age. Mean percentage of males was 35%, with a range of 14% (Sequeira et al., 2022) to 59% (Chacko et al., 2021), with two studies not reporting gender.. Most studies in this review did not report ethnicities of participants and therefore ethnicity has not been included in the study characteristics table.

Study Focus/Aims

Seven studies looked at clinician factors involved or impacting suicide risk assessment (Berman et al., 2016; Chacko et al., 2021; Gale et al., 2016; Paterson et al., 2008; Regehr et al., 2016; Regehr et al., 2015; Sequeira et al., 2022. Two studies explored clinician experience of conducting risk assessment (Chunduri et al., 2019; McClatchey et al., 2019) with McClatchey et al., 2019 additionally exploring current practices clinicians are employing in suicide risk assessment. One paper explored what cues/factors clinicians deem to be important when conducting suicide risk assessment.

Study Measures

There was significant variance in how studies assessed clinicians' judgement of suicide risk following assessment. Within the papers looking at clinician factors, one paper used a yes or no response as to whether clinicians believed the patient would go on to end their life (Gale et al.,

2016). Two papers solely used yes or no responses as to whether they would hospitalize the patient presented (Regehr et al., 2015; Regehr et al., 2016) and one paper used this as additional measure to another risk rating (Berman et al., 2016) Two papers used 0-100 scales, with one paper asking clinicians to rate risk level (Berman et al., 2016) and one paper asking how likely the patient was to die by suicide in the next 24 hours (Paterson et al., 2008). Two studies used Likert scales of risk, one paper using a 5 point scale (Chacko et al., 2021) and one paper using a 11 point scale (Sequeira et al., 2022). Two papers used an additional measure of asking clinicians to choose a treatment recommendation from three possible options (Chacko et al., 2021; Sequeira et al., 2022). One paper compared the Suicidal-Ideation-Questionnaire (SIQ) to clinical judgement, which was assessed by the clinician rating a patients risk as low, medium or high (Boege et al., 2014).

In the other papers included in this review, one study was qualitative in design. Chunduri et al. (2019) used focus groups to explore clinician experience with risk assessment. McClatchey et al. (2019) had a mixed method design, however, did not use suicide risk assessment measure.

Table 1: Study characteristics

Author	Study Objectives	SS*	Design	Sample Source	Gender	Age M(SD); Range	Assessment of suicidality (if used)	Other Measures
Berman et al., 2016	To examine how a) patients age influences suicide risk assessment and b) clinician demographics and training factors moderate clinicians' perception of risk.	260	Cross-Sectional	Mental health clinicians in USA	Male 55 (21.2%) Female 205 (78.8%)	33.64 (8.52); 22–67	Rating from 0 (not at all likely) to 100 (extremely likely)	
Chacko et al., 2021	To examine physicians' characteristics that influence management of acutely suicidal patients.	103	Cross-Sectional	Psychiatry residents and attendings in 4 academic hospitals is USA	Male 61 (59.2%) Female 42 (40.8%)	NR	What is the severity of acute suicide risk? (Likert scale from 1 to 5) & What would you do in this case? (three options)	

Chunduri et al., 2019	To explore suicide risk identification and flow of patients with differing suicide risk through the Psychiatric Emergency Service.	15	Qualitative – thematic analysis	Clinicians working in psychiatric ED of a hospital, USA	NR	NR	-	Experiences with Risk Assessment (Focus Groups)
Gale et al., 2016	To investigate whether perception of patient's suicide risk is influenced by presence of an associated emotion and to investigate any decision bias. Also to explore clinician confidence in their decision.	400	Cross-sectional	Mental health clinicians in UK	Male 152 Female 248	Drs: 41, psychiatric nurses 44, social workers 45	Prediction if patient did or did not complete suicide	
McClatchey et al., 2019	To investigate clinician suicide risk assessment practices in emergency departments, and to explore clinician's experiences of suicide risk assessment	51 (6 qual)	Mixed method	Emergency department clinicians in Scotland, UK	Male 23 (46%) Female 27 (54%)	NR	-	Survey and interviews
Paterson et al., 2008	To explore the factors influencing judgements regarding suicide risk, examine the information cues that clinicians used to inform their judgements of suicide risk, comparing them to risk factors identified by a review of the literature	63	Cross-Sectional	Psychiatrists and mental health nurses from across four Primary Care Trusts in Scotland	Psychiatrists: Male 6 (50%) Female 6 (50%) Nurses: Male 20 (40%) Female 31 (60%)	Psychiatrists: 39(7.9); 25-53 Nurses: 40(8); 20-54)	10 cm bar anchored on the left with ''no risk'' and on the right with ''very high risk'' & recommended level of observation	

Regehr et al., 2015	To examine the degree to which the previous work-related experiences of clinicians and their preexisting emotional state influence professional judgment regarding acute risk in patients presenting with suicidal ideation	71	Cross-Sectional	Social workers (final year and experienced) in Canada	Male (18%) Female (82%)	Total range: 21-78, Students: 27.42 (5.29), Experienced: 42.5 (13.56)	Would you hospitalize (yes or no), plus Beck Scale for Suicide Ideation, the Hamilton Rating Scale for Depression, and the Columbia Suicide Severity Rating Scale
Regehr et al., 2016	To identify the consistency with which social workers make determinations of suicide risk, the confidence of clinicians in their assessments, and factors influencing clinical confidence	71	Mixed method	Social workers (final year and experienced) in Canada	Male (18%) Female (82%)	Total range: 21-78, Students: 27.42 (5.29), Experienced: 42.5 (13.56)	Would you hospitalize (yes or no), plus Beck Scale for Suicide Ideation, the Hamilton Rating Scale for Depression, and the Columbia Suicide Severity Rating Scale

Sequeira et al., 2022	To investigate the uniformity of decision making around suicide risk within healthcare professionals	79	Cross-Sectional	Healthcare professionals in Canada	Male (14%) Female (86%)	34.5 (-); NR	a labeled 11-point Likertscale (0–10), with 0 being low, 5 being moderate, and 10 being high suicide risk, along with an exact percentage AND treatment decision

Study Results

Study results are summarised in Table 2. Due to limited data and the nature of the studies found, it was not possible to synthesise the data in line with the planned synthesis method. Step 2 of Popay et al. (2006) was conducted, whereby the studies were organised in a way to identify patterns. The studies with similar focuses were then grouped, and due to the variability in individual study methods, the results were then summarised and presented. Consequently, the heterogeneity in the studies identified meant it was difficulty to make draw clear conclusions from.

Variations/bias/reliability in risk assessment

Numerous studies commented on the variability of clinician risk rating. Berman et al. (2016) reported that the risk ratings for the same vignette (only changed by age) ranged from 0 – 95 out of a possible 100. Similarly, Paterson et al. (2008) using the same 0-100 scale found the average range of scores was 69.9, with a larger range being seen in nurses (compared to psychiatrists). When looking at varying degrees of risk it appeared there was more consensus regarding cases that were deemed to be higher risk (Paterson et al., 2008). The same study also looked at test-retest reliability, finding only 58% (psychiatrists) and 22% (nurses) had significant correlations. Sequeira et al. (2022) found that there was also higher uniformity across clinicians in the high-risk vignette.

Both Regehr et al. (2015) and Regehr et al. (2016) commented on the same data set, again finding variation within clinicians, with an average of 66% recommending hospitalisation and 34% recommending not. Gale et al. (2016) reported that there was a significant bias towards associating the vignette with suicide (58% suicide judgements vs 42% non-suicide judgements) despite the study being set up so the chance was only 50%.

Clinician Factors in Suicide Risk Assessment

Age: The effect of clinician age was looked at by three of the studies and two (Berman et al., 2016; Regehr et al., 2015) found similar results. Both papers reported older clinicians rated risk

higher than younger clinicians. Both papers looked at an interaction of clinician and patient age, with Berman et al. (2016) finding younger clinicians scored higher when they believed the patient to be elderly, and older clinicians rated risk of suicide higher when they believed the patient to be younger (despite it being the same vignette). Similarly, Regehr et al. (2015) found that younger clinicians were less likely to endorse hospitalisation for the younger patient. Gale et al. (2016) briefly reported that age was not associated with response regarding whether they believed the patient died by suicide or not.

Gender: Three studies looked at clinicians' gender and whether this effects how they rate risk of suicide (Berman et al. 2016; Gale et al. 2016; Sequeira et al. 2022) all reporting different findings. Berman et al. (2016) found females rated risk higher than males, whereas Gale et al. (2016) found the opposite, reporting that males were more likely to predict suicide than females. Sequeira et al. (2022) found no effect of gender on risk ratings.

Profession: There were a variety of professions so drawing similarities is difficult. Berman et al. (2016) found that licensed (vs unlicensed) professionals were more likely to endorse hospitalization and Gale et al. (2016) found doctors were more likely to predict suicide than nurses or social workers. Sequeira et al. (2022) found an effect of profession on only one out of three of their vignettes (the high-risk presentation) and reported that registered nurses were significantly more likely to choose admission than physicians or nurse practitioners.

Paterson et al. (2008) did not compare scores directly, however, when looking at the range of risk scores, found that there was a large range in both professions, with nurses having a slightly higher range (no statistical comparison reported). They also found that when looking at test-retest reliability, they found psychiatrists had greater reliability in their judgements. This study also found psychiatrists were significantly more influenced by a patient's diagnosis and suicidal ideation than nurses were.

Experience: Four papers looked at clinician experience, however how this was captured varied across studies. Berman et al. (2016) used number of patients per week and found that clinicians who reported having more patients per week than others, were then more likely to endorse hospitalisation. Chacko et al. (2021) asked clinicians to report whether they had had a previous patient die by suicide and whether they had an acquaintance outside of work die by suicide. They found that, in less senior clinicians the biggest factor affecting risk rating was knowing someone outside of clinical practice who had died by suicide and it led them to rate the risk of suicide lower than people who didn't know someone. Across all participants they found that a greater number of previous patients who had died by suicide was associated with a less aggressive treatment, indicating they felt they were lower risk. Sequeira et al. (2022) looked at two measures of experience – frequency of conducting assessments and length of experience. They found no effect of frequency of conducting SRA on risk rating, however on one vignette only (out of three; medium risk scenario) they found that clinicians with longer experience were less likely to choose admission, indicating they felt the risk was lower than those with less experience. Gale et al. (2016) looked at length of service, however found no association with response.

Work Setting: Chacko et al. (2021) found that clinicians working in an outpatient setting were associated with less aggressive treatment options (i.e. continue treatment as normal) when compared with those working in hospitals. Sequeira et al. (2022) found no effect of practice setting on risk rating.

Affective Factors: Only Regehr et al. (2015) looked at post-traumatic stress and burnout finding that higher levels of post-traumatic stress were associated with lower assessed suicide risk. However, there was no association between burnout and assessment of suicide risk.

Confidence: Four papers looked at clinician confidence (Chacko et al., 2021; Gale et al., 2016; Regehr et al., 2016; Sequeira et al. 2022). Perceived difficulty was used by Chacko et al. (2021) and they found greater perceived difficulty in assessing suicide risk was associated with less aggressive

treatment options (i.e. continue treatment as normal), indicating that the harder they found the assessment the less risk the clinician perceived. Gale et al. (2016) reported that, despite being told that there was a 50% chance that the patient had died by suicide or not, over 40% said they felt substantially or extremely confident in their decision. Sequeira et al. (2022) touched upon clinician confidence but didn't investigate how this linked with risk rating, instead focusing on what clinician factors were associated with clinician confidence. They found no relationship between clinician's gender, work setting, or frequency of conducting assessments. For the high-risk patient confidence in decision was significantly different between professions, with nurses rating their confidence higher than nurse practitioner or physician.

Clinician confidence was the primary focus for Regehr et al. (2016) and they found no association between confidence and the decision that hospitalisation was necessary. Clinicians with more experience felt more confident in their assessment of the adolescent only (not the adult), and clinicians with higher levels of burnout were significantly less confident in their risk assessment of the adolescent (again no association when looking at the adult vignette).

Clinician Experiences of Suicide Risk Assessment

Two qualitative studies (Chunduri et al., 2019; McClatchey et al., 2019) discussed themes clinicians raised about their experiences with suicide risk. Chunduri et al. (2019) discussed factors affecting clinical judgement, highlighting experience of a clinician can impact a decision. Participants felt that lack of experience could lead to underestimation of risk, that social resources, such as insurance, which is cultural to USA, may also impact the decision made. One participant described insurance not accepting a referral for admission and therefore a risk plan has to be adapted based on this rather than judgement. Participants also spoke about work culture, with some saying they felt pressure to be more cautious to avoid bad outcomes, but also pressure to discharge patients more quickly for steady patient flow – both of which would then impact risk assessment and management.

McClatchey et al. (2019) found four themes: Clinician experiences of suicide risk assessment – participants reported SRA was a common, challenging part of the role and that there was little training on this specifically. Components of suicide risk assessment – all participants discussed patient demeanour such as behavioural and interaction cues being important to the assessment and highlighted other, well-known risk factors associated with suicide. Clinical decision making – participants felt that experience was a beneficial factor in decision making and that clinical judgement is the best means of making a decision around patient outcome. Supporting clinicians - participants made recommendations for suicide risk assessment training, such as a need for tailored and focused training (rather than a tool), particularly for those who are new to emergency departments. Both studies reported a strong belief from participants that no screening or assessment tool can replace good clinical judgement and structured tools can be used as supporting rather than directing suicide risk assessment.

Current Practices in Suicide Risk Assessment

McClatchey et al. (2019) asked participants to complete a survey to investigate current practices across emergency departments in Scotland. They found that 68.8% of participants used a suicide risk assessment tool, with 51.4% reporting that it was a requirement in their workplace. Interestingly, there were seven departments with clinicians who disagreed whether it was a requirement and out of the 15 departments with more than one respondent, nine had clinicians using different tools. Of the people who did use a tool, the majority were using a locally developed proforma rather than a validated measure. Of the participants using a validated measure, the most common tool was the SAD PERSONS Scale, which has recently been found to have low sensitivity (Katz et al., 2017). It was also found that there were differences in how clinicians would approach assessment of a young person, with 37 participants saying they would assess as normal, 11 saying they would make adjustments and 3 saying they wouldn't assess.

Table 2: Study results

Author	Measure of Risk Assessment	Procedure	Clinician Factors Analysed	Study Findings
Berman et al. 2016	Risk rating Endorsement of hospitalization	Survey, Participants presented with vignette, which only differed by patient age.	- Age (of patient and clinician) - Gender - Number of patients per week - Licensed or not licensed	• Variety in risk rating: dramatically heterogeneous with a range of 0 – 95 • Patient age significantly associated with suicide risk rating. Older patient elicited higher scores than the younger patient. • Female clinicians rated risk higher than males (on both aged vignettes) • Older clinicians rated risk higher than younger clinicians (on both aged vignettes) • Interactions: Clinicians age moderated the relationship between patient age and both risk rating and hospitalization - younger clinicians rated higher for elderly vignette. Older clinicians' rated higher for younger vignette • *Female clinicians were more likely to endorse hospitalization than males (by 2.35 times)* • *More patients per week led to being more likely to endorse hospitalization* • *Licensed clinicians were more likely to endorse hospitalisation*
Chacko et al. 2021	Severity of acute suicide risk Recommendations	Survey, presented 3 hypothetical cases of acutely suicidal patients in three different clinical settings	- Clinician title (attending and residents) - Having had a patient die by suicide, - Having an acquaintance outside clinical work die by suicide, - Work setting - Perceived difficult of assessment	• In residents only, the biggest factor which affected risk rating was knowing someone outside clinical practice who died by suicide. This led to lower risk rating scores. This was not found in attendings. • Greater number of previous patients who had died by suicide and working in outpatient was associated with less aggressive treatment recommendations • Greater perceived difficulty in assessing suicide risk was associated with less aggressive clinical disposition (i.e. continue treatment as usual)

Gale et al. 2016	Prediction if patient did or did not complete suicide	Survey, presented with a vignette describing a fictitious patient with a long-term mental illness alongside a photo of the subject - 4 conditions: control (no photo), moderately happy face, moderate sadness, moderate anger	- Profession - Length of service - Confidence in decision	• Overall bias towards associating vignette with suicide (despite it being set up to be 50/50) • No significant differences across conditions, however the condition generating most 'suicide' responses was the happy face stimuli • Profession- Doctor group more likely to predict suicide than other professions • Gender – Males significantly more likely to predict suicide • Confidence – despite being told that the vignette was 50% likely to be either suicide or not, very few participants (14%) felt not confident in their decision. Over 40% said they felt substantially or extremely confident.

Paterson et al. 2008	Mark how likely to commit suicide in next 24 hours on a scale (0:low to 100:high) & recommended level of observation	Survey, questionnaire & 130 hypothetical cases (consisting of 13 bits of information), 15 cases repeated.	- Profession (psychiatrist & nurses)
			- Reliability of assessment (same case measured at 2 time points)
			- Importance of risk predictors
				• Agreement and reliability between clinicians
				  ○ Large ranges of risk scores for both professions – psychiatrists: 61.3; nurses: 78.4
				  ○ Psychiatrists agreed with each other slightly more than nurses (not sig)
				  ○ when comparing the relative degrees of risk, there appeared to be consensus regarding cases that were of relatively higher risk
				• Of the 12 psychiatrists, 7 (58%) had significant correlations between their risk predictions on test-retest. Of 51 nurses only 22% had significant correlations, showing psychiatrists had greater reliability in their judgements.
				• Both psychiatrists and nurses associated suicidal ideation with increased suicide risk, although psychiatrists were significantly more influenced by this cue; Psychiatrists were also significantly more influenced by the patient's diagnosis than nurses were
				  ○ considerable agreement between the two groups on the relative significance of other factors such as previous suicide attempts, gender, length of admission, clinical improvement, compliance and hopelessness when assessing suicide risk.

Regehr et al. 2015	Would you hospitalise (yes or no) & structured measures	Survey, questionnaires, assessment of simulated patient – one of an adolescent in crisis and one of a depressed adult	- Age - PTSD Symptoms	• Large variation across clinicians for both cases as to whether they would hospitalise or not • Younger clinicians were less likely to think the younger patient requires hospitalization, showing an effect of age • Higher levels of post-traumatic stress were associated with lower assessed suicide risk ○ burnout was not associated with assessment of suicide risk in this study

Regehr et al. 2016	Would you hospitalise (yes or no) & structured measures	Survey, questionnaires, assessment of simulated patient – one of an adolescent in crisis and one of a depressed adult	- Confidence levels & what factors affect this	• Large variation across clinicians for both cases as to whether they would hospitalise or not
				• There was no significant association between confidence and the decision that hospitalization was necessary
				  ○ experienced workers felt more confident in their assessment of risk with the adolescent in crisis
				  ○ Life stress not associated with confidence
				  ○ workers with higher levels of burnout were significantly less confident in their risk assessment of the adolescent, but burnout was not associated with confidence in the assessment of the older patient

Sequeira et al. 2022	Likert scale of risk and treatment decision	Survey, questionnaires including 3 vignettes (high, medium, low risk)	- Confidence levels & what affect this
			- Gender
			- Profession
			- Setting
			- Frequency of conducting assessments
			- Length of experience
				• Confidence levels: no effect of participant's sex, practice setting, or frequency of SRA on the confidence in their decisions
				• Risk rating: no effect of sex, clinical designation, practice setting, or frequency of conducting SRA on the participant's suicide risk rating for all 3 vignettes
				  ○ Higher uniformity across participants in the high risk vignette.
				• Treatment decision:
				  ○ On 1 vignette only (medium risk)- clinicians with longer experience were significantly less likely to choose admission
				  ○ On 1 vignette only (high risk)
				  ▪ nurses were significantly more likely than other professions to choose admission
				  ▪ Clinicians working in mental health settings were significantly more likely to choose admission than clinicians working in other settings

Table – Other Papers

Author	Procedure	Factors being looked at	Study Findings
Chunduri et al. 2019	Qualitative interviews	Clinician experience of risk assessment	• 7 themes found: Patient assessment / Suicide Risk Screen / ED psychiatrist analysis of professional risk / Affective response of ED psychiatrists / ED psychiatrist resources / Clinical management: Patient aspects / Clinical management: Systems • Participants heartily agreed that no screening tool can replace good clinical judgement and they view the role of suicide screening checklists as supporting rather than directing their decision making • Other factors affecting clinical judgement include: resources (insurance) and feeling this determines outcome, experience - tendencies of inexperienced clinicians to underestimate risk compared to more seasoned clinicians, Culture - Some said they felt pressured to be cautious to avoid bad outcomes, but they also felt pressure to discharge patients more quickly for steady patient flow
McClatchey et al, 2019	Mixed Methods study	Quantative investigation into current practices in risk assessment Qualitative exploration of clinician experience of risk assessment	• Survey: 68.6% use a suicide risk assessment tool, Is it a requirement: Yes (51.4%), No (37.1%), Don't know (11.4%) - 7 departments had clinicians who disagreed if it was a requirement, Of the people who did use a tool (n= 35), 3 were using multiple tools, 20 people were using one of 8 locally developed tools rather than validated measures; Assessing YP differently: Yes (n=37), No (n=11), I wouldn't assess a YP (n=3) • TA = 4 major themes: Clinician experiences of suicide risk assessment, components of suicide risk assessment, clinical decision making, Supporting clinicians o using a suicide risk assessment tool as an 'aide-memoire', with some discussing that they would not use the scoring system of assessment tools; experience can affect decision making (e.g. err on side of caution); clinical judgement shouldn't be replaced by tools but tools can help, awareness tools lack validity o clinicians use patient demeanour as an important assessment method - this is hard to capture in a tool and subject to clinical judgement

Quality Appraisal

The quality assessment ratings are shown in Table 3. The methodological quality of studies ranged from 43% (Regehr et al., 2016) to 100% (Buckingham et al., 2008; Chunduri et al., 2019; Gale et al., 2016). All studies had clear research aims and the data collected allowed the research question to be answered. A common theme was a lack of comparison to the population, and it was therefore difficult to ascertain whether the participants were representative of the target population. A key difficulty with assessing the quality of papers related to measures used and whether they were appropriate. This is because clinical judgement is, by definition, not a validated measure.

Table 3. Quality Appraisal

		Quality assessment of included studies									
	Quality Criteria	**Berman et al. 2016**	**Boege et al. 2014**	**Chacko et al. 2021**	**Chunduri et al. 2019**	**Gale et al. 2016**	**McClatchey et al. 2019**	**Paterson et al. 2008**	**Regehr et al. 2015**	**Regehr et al. 2016**	**Sequeira et al. 2022**
Screening Questions	S1. Are there clear research questions?	+	+	+	+	+	+	+	+	+	+
	S2. Do the collected data allow to address the research questions?	+	+	+	+	+	+	+	+	+	+
1. QUALITATIVE STUDIES	1.1. Is the qualitative approach appropriate to answer the research question?	n/a	n/a	n/a	+	n/a	n/a	n/a		n/a	n/a
	1.2. Are the qualitative data collection methods adequate to address the research question?	n/a	n/a	n/a	+	n/a	n/a	n/a		n/a	n/a
	1.3. Are the findings adequately derived from the data?	n/a	n/a	n/a	+	n/a	n/a	n/a		n/a	n/a
	1.4. Is the interpretation of results sufficiently substantiated by data?	n/a	n/a	n/a	+	n/a	n/a	n/a		n/a	n/a
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	n/a	n/a	n/a	+	n/a	n/a	n/a		n/a	n/a

3. NON-RANDOMIZED STUDIES	3.1. Are the participants representative of the target population?	?	?	?	n/a	+	n/a	n/a	?	n/a	n/a
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?	+	+	+	n/a	+	n/a	n/a	-	n/a	n/a
	3.3. Are there complete outcome data?	-	+	+	n/a	+	n/a	n/a	+	n/a	n/a
	3.4. Are the confounders accounted for in the design and analysis?	+	+	+	n/a	+	n/a	n/a	+	n/a	n/a
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?	+	+	+	n/a	+	n/a	n/a	+	n/a	n/a
4. QUANTITATIVE DESCRIPTIVE STUDIES	4.1. Is the sampling strategy relevant to address the research question?	n/a	n/a	n/a	n/a	n/a	n/a	+	n/a	n/a	+
	4.2. Is the sample representative of the target population?	n/a	n/a	n/a	n/a	n/a	n/a	?	n/a	n/a	?
	4.3. Are the measurements appropriate?	n/a	n/a	n/a	n/a	n/a	n/a	+	n/a	n/a	+
	4.4. Is the risk of nonresponse bias low?	n/a	n/a	n/a	n/a	n/a	n/a	-	n/a	n/a	-

	4.5. Is the statistical analysis appropriate to answer the research question?	n/a	n/a	n/a	n/a	n/a	n/a	+	n/a	n/a	+
5. MIXED METHODS STUDIES	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	n/a	n/a	n/a	n/a	n/a	+	n/a	n/a	?	n/a
	5.2. Are the different components of the study effectively integrated to answer the research question?	n/a	n/a	n/a	n/a	n/a	+	n/a	n/a	+	n/a
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	n/a	n/a	n/a	n/a	n/a	+	n/a	n/a	-	n/a
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	n/a	n/a	n/a	n/a	n/a	?	n/a	n/a	?	n/a
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	n/a	n/a	n/a	n/a	n/a	+	n/a	n/a	-	n/a
	Total percentage	71%	86%	86%	100%	100%	86%	71%	71%	43%	71%

Discussion

Main Findings

This systematic review aimed to explore the role of clinical judgement in SRA. There was one study looking at current practices and how clinical judgement is being used clinically. Seven papers looked at how clinician factors have an impact on SRA and the decisions they make. Two studies qualitatively explored clinician experience of SRA and how clinical judgement is part of this. One paper included a direct comparison of a validated SRA tool to clinical judgement. Variation between participants regarding risk ratings were looked at by six of the seven papers, and all found a wide variation in risk rating.

There were mixed findings regarding clinician factors, with a wide range of factors being looked at, and papers defining these factors in slightly different ways. Experience and profession were explored by the most papers (four studies respectively) with age and gender being examined by three papers. Clinician confidence was considered in four papers; however, it was not always with the primary aim of assessing how confidence impacted SRA, and clinician factors impacting confidence were reported. Other factors include work setting and affective factors.

Clinician experience of SRA and how they view clinical judgement was consistent across both papers, with clinicians viewing clinical judgement as best practice and that risk assessment measures are only useful as a support rather than a directive too.

Interpretation of Findings

Outcome of the Review

The results of this review highlight the breadth of information in this area; however, they also highlight the lack of depth into specific areas of focus. It presents an initial summary of things that may be useful to consider when discussing or conducting clinical judgement in SRA and is a first look into how clinical judgement is being integrated into practice and what clinician factors may influence the assessments and decisions being made.

It was hoped that there would be more research comparing standardized assessment tools to clinical judgement as it is conducted in practice, however this review only found one paper that described the process of comparison and the procedure of clinical judgement in enough detail to be included. This reinforces the position of Fazel & Wolf, 2017, who suggested it may be that directly comparing risk tools with clinicians' judgement is not feasible or add any additional information to the current literature.

It is reported by McClatchey et al., 2019 that the majority of clinicians reported using a tool and that in some cases this is a requirement of the department. It is unclear however to what extent these tools are used and what weighting they are given, as the follow-up qualitative data suggests that clinicians are using these to support their clinical judgements rather than as a standalone tool. This may highlight the reason for lack of studies directly comparing clinical judgement to standardized tools as this is not reflected in practice.

In the UK there is variation in how risk assessment is completed following self-harm (Quinlivan et al., 2014) and that there is variation in SRA guidelines in the emergency department (Bennewith et al., 2004). This review found only one study reviewing current practice, however it concurs with these previous studies, highlighting the variation in clinical practice in SRA in emergency departments (McClatchey et al., 2019). This review hoped to highlight those nuances and found little evidence describing current practices. Understanding the role of clinical judgement may be difficult to ascertain, as it may be being used with differing weightings alongside standardized tools, which is hard to capture in research.

Variations in Measuring Clinical Judgment

Across included studies there were different measures of SRA by clinicians, with one paper only asking for clinicians to predict whether the fictitious patient would go on to die by suicide or not (Gale et al., 2016). The two papers by Regehr et al. (2015, 2016) asked whether clinicians would hospitalize or not. This reductionist approach highlights the difficulties in applying real world practices to a controlled research setting. It poses the question as to whether clinical judgement in

SRA should be defined by a 'risk rating' or the decision of recommended intervention. Both are represented across this review.

Variation Of Risk Ratings

An important finding of this review is the variation, reliability, and bias of clinician's risk ratings, even when presented with the same information and with limited choices when rating risk. This may further add evidence to the fact SRA is a complex process, however, also suggests that patient interventions are heavily impacted by the clinician assessing them as well as the difficulties they bring to the assessment. It is known that low reliability, agreement, and accuracy is associated with greater uncertainty in the decision task (Harvey, 1995) and this may suggest that the high levels of uncertainty associated with SRA mean that finding consistency within clinicians is unlikely. There did appear to be higher consensus when the risk was higher, and this may represent less uncertainty in the decision task.

Clinician Factors

SRA is a complex, multifaceted task and is therefore, unsurprisingly, impacted by subjective factors. As highlighted, there is significant research into what factors are important to consider in predicting future suicide, however this review draws attention to the range of clinician factors which may impact SRA.

Whilst the results are described above, it is important to consider why there is such variability. Clinician age for example, looked at by three of the papers, is only one of a multitude of intersecting factors which simultaneously have an effect. The papers in this review, do not control for confounders to a real-world extent. Understanding the interaction between clinician age, experience, cultural and personal biases and their own emotional states is hard to capture. There is an added layer of complexity as decisions can be affected by external factors such as availability of resources and workplace pressures (Chunduri et al., 2019) (McClatchey et al., 2019).

Critical Review

The studies meeting inclusion criteria were often heterogeneous with different aims, and even within the same broad aim, the measures and procedures differed greatly. Samples were from different countries, and from different places of work, and therefore whilst there is a summary of results, there is little evidence for consistent findings which would confirm or deny a particular idea.

The heterogeneity of the studies, as well as the broad question, made conducting a comprehensive synthesis of the literature difficult. This review aimed to follow guidance by Popay et al. (2006), however there are other synthesis methods that may have been used, including thematic synthesis (Thomas & Harden, 2008). This method encourages the researcher to identify themes across the papers and to develop further or new explanations from these themes. However, using thematic synthesis would have placed less focus on making clearer the context and focus of each study (Lucas at al., 2007) which was an important element of the review.

Reflecting on the process of synthesising the information, an alternative option would have been to approach the data synthesis with the aim of conducting a scoping review. The aim of a scoping review is to map the extent, range and nature of the literature (Mak & Thomas, 2022), and whilst both approaches have different merits, this may have been of benefit prior to asking specific questions regarding current practices about the role of clinical judgement in SRA. Whilst the aim of this review was to retrieve evidence to answer the question of what role clinical judgement plays in SRA in practice, a scoping review would provide an overview of the current evidence around clinical judgement in SRA, perhaps as a precursor to a future systematic review.

Whilst there is significant breadth in the research question and the associated findings, this highlights an important gap in the literature. Although this review is not able to offer a synthesis and overview of current practices, it really draws focus to the dearth of literature into clinical judgement and how it is operationalised. This is surprising given the importance of clinical judgement and the belief that is continues to play a key role in SRA.

Despite the variability in the results presented, this review appears to be the first attempting to synthesise the literature around clinical judgement. One of the key findings is that clinician factors do play a role in how risk is rated. Evidence has shown that structured risk assessment tools are poor predictors of risk when used in isolation and that there should be an emphasis on incorporating clinical judgement into assessing risk in a needs-led way. Focusing on clinician led decisions, rather than a computerised or structured risk assessment tool, means that the role of the clinician should be considered as well as the risk factors they should be looking for. This review shows that variability in clinician factors such as age and profession, as well the agreeability between clinicians is impacting how an individual's risk is rated.

Research and Clinical Implications

SRA is a complex task (WHO, 2021) and the current guidance and evidence recommends assessing risk in needs led way, rather than by using a structured tool.

There remains a focus in research in how to predict and prevent individuals going on to die by suicide by using assessment instruments (Campos et al., 2023) and computer-based algorithms (such as; Lejeuene et al., 2022; Zheng et al., 2022). This is understandable given suicide is the fourth leading cause of death amongst 15–29-year-olds globally (WHO, 2021). However, risk prediction has been repeatedly shown to be ineffective due to poor predictive ability of instruments used (Kessler et al., 2020).

Hawton et al. (2022) discusses the factors leading to potential preoccupation with risk prediction and suggest a model of therapeutic risk assessment, with a more person-centred approach. Given this is the current guidance in the UK (NICE, 2011), research may benefit from moving away from risk assessment tools and focusing on how clinicians can engage with SRA in a meaningful way. However, it is noted this is not the case globally or in different settings, and other recommendations are given for SRA. For example, a report published in California, USA recommends initial screening with a validated screening tool, and then for those who meet 'medium' risk will be assessed at 'discretion of provider' (Joint Commission's NPSG, 2001). It is unlikely that in practice,

SRA is a simple as either a validated tool or clinical judgement, however this review hoped to highlight those nuances and found little evidence describing current practices. This in itself is a concern as the review found no evidence that clinical judgement is used in a consistent way by clinicians, but rather variations exist by clinician age, gender, profession meaning it is not clear whether or when clinical judgement can be used to accurately and effectively determine suicide risk.

One aspect of this, highlighted in this review, and likely why professionals continue to use structured tools, is that there is a wide variation in how clinicians rate risk. In addition, clinicians are prone to bias based on a number of personal factors such as age and gender. There is not enough evidence to confidently say how these factors influence SRA decisions, however it is important for clinicians to become aware of these. Future research should investigate further, and it may be that adaptations in clinician training are need to help them be aware of potential biases.

Conclusion

In summary, this review highlighted the lack of evidence as to how clinical judgement is currently integrated in routine practice of SRA. This is surprising given the lack of evidence to support the sole use of structured, validated assessment tools, of which there is a significant amount of literature. The drive to find a successful risk prediction model is understandable given the global numbers of suicide, however, whilst person-centre, needs led assessments are recommended and widely used, it would be useful to understand how this is being implemented. An interesting finding was the majority of papers found looked at clinician factors affecting this judgement, which is also an important consideration in SRA. The results were notably varied, with different factors being investigated, different ways of measuring clinician judgement of risk and some papers exploring clinical judgement qualitatively. This made it difficult to draw any conclusions beyond individual papers, other than the variability in which clinicians are rating suicide risk. Considering the potential implications from assessing risk further research should aim to establish what is currently happening in practice with SRA and how is clinical judgement being used and secondly what the role of clinicians' personal factors have on their assessment of risk.

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Chapter Three

Bridging Chapter

Word Count: 379

Bridging Chapter

The systematic review presented in Chapter 2 examined the available literature surrounding the role of clinical judgment in suicide risk assessment (SRA). This highlighted that demographical factors related to the clinician, such as age or profession, may have an impact on the decision that they are making. The potential implicit biases, such as age and profession highlighted in this review suggest that SRA is not a uniform process and is affected by many dynamic factors.

Another theme that emerged from this review was that little research exists exploring how clinical judgment is used in practice. Whilst the risk factors for people at risk of future suicide are well known, it is unknown how clinicians incorporate these into their assessment. This means there is a gap in the literature relating to whether they use structured assessment tools alongside a clinical interview, or whether they solely conduct an unstructured interview, patient-led, drawing in these factors as applicable to each individual.

This review identified two papers (McClatchey et al., 2019; Chunduri et al., 2019) which explored clinicians experience of conducting risk assessments. However, the focus appeared to be exploring the factors influencing how they made these decisions. There is a need for further exploration into this area, to attempt to understand the lived experience of how practitioners make sense of and understand their experiences of conducting SRA.

Specialist psychiatric input into Emergency Departments is recommended as good practice in the UK (AMRC, 2008) and guidance recommends all acute hospitals have a mental health liaison service. (NICE, 2016) Mental health liaison practitioners (MHLP) face a unique context in frequent exposure to individuals with a high level of distress, liaising with multiple services and little or no continuity following assessment. This cohort of staff are repeatedly assessing risk of future suicide at greater frequency than other mental health teams., However, little is documented about what this experience is like for these practitioners.

Therefore, chapter four presents an empirical paper which sought to build upon the limited existing research, searching for an in depth understanding of how MHLP's make sense of their own experiences of conducting SRA. The paper presents data from MHLP's across four different hospital sites in the East of England, each offering a unique insight into their lived experience of their role.

Chapter Four

Empirical Paper

Understanding How Mental Health Liaison Practitioners Make Sense of Their Experiences with Decisions Related to Suicide Risk Assessment

This paper has been developed for submission to Journal of Psychiatric and Mental Health Nursing.

(Author guidelines are outlined in Appendix B)

Word Count: 5865

(Excluding abstract & references)

Understanding How Mental Health Liaison Practitioners Make Sense of Their Experiences with Decisions Related to Suicide Risk Assessment

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Abstract

Introduction

Individuals are often seen by emergency departments or mental health services in the year prior to their death. It is therefore a key area for risk identification. Mental health liaison practitioners in emergency departments work with individuals following self-harm or suicide attempts, completing suicide risk assessment. Little is known about the experiences of these clinicians.

Aim

This study aims to develop an understanding of how liaison practitioners experience making risk decisions.

Method

Eight National Health Service mental health liaison practitioners completed semi-structured interviews. All participant interviews were transcribed and analysed using an Interpretative Phenomenological Analysis methodology.

Results

Six main themes were identified in the data: You can only do what you do can do; My team are my safety blanket; The only certainty is uncertainty; Putting my wellbeing first allows me to show up for others **;** You can't help but go back to what you've been through before; At the end of the day, you need to protect yourself.

Discussion

Identified themes reflect some of the limited previous literature. However, this is a novel insight, highlighting the impact a team can have on how decisions feel for practitioners, how they reach a point of acceptance in the limits of their role, and the underlying sense they need to justify their decisions.

Implication for Practice

Recognising the increased confidence that comes from shared decision making and the importance of recognising the impact of experience on decision are important highlights in ensuring practitioners continue to provide best care for patients.

Key Words: suicide risk assessment, liaison staff interpretative phenomenological analysis (IPA), qualitative.

Liaison psychiatry practitioners in emergency departments (ED) work with individuals presenting with possible acute mental illness, often following self-harm or suicide attempts. They provide a link between general and mental health services, offering a rage of interventions including assessment and intervention planning, case consultation and advice (Sharrock & Happell, 2001). A need to develop such services was first identified in the 1960s and 70s (Satloff & Worby, 1970). Consequently, specialist psychiatric input into emergency departments is recommended as good practice in the UK (AMRC, 2008).

Within these services mental health liaison practitioners regularly assess risk of suicide following self-harm, and thus work closely with a population where death by suicide is more likely (Geulayov et al., 2019). Suicide prevention remains a global public health issue. Approximately 800 000 people die by suicide every year, and it is the second leading cause of death among 15-29-year-olds globally (WHO, 2016).

There is a significant association between suicide and a previous attendance at ED with deliberate self-harm (Ryan et al., 1996), with Crandell et al., 2006 finding that the suicide rate was more than triple the national average for patients who were discharged from the ED after presenting with a 'suicide-related complaint'. Geulayov et al. (2019) found that the risk was particularly elevated in the first month.

It is estimated that 1 in 3 individuals who die by suicide had presented to an ED in the year prior to their death (Da Cruz et al., 2011; Gairin et al., 2003). Looking at the United Kingdom specifically in the three years between 2010 and 2012, there were 329 384 presentations for self-harm to EDs in England (Clements et al., 2016). In Scotland, records show that between 2010 and 2015, 27% of individuals who died by suicide had attended ED's within the three months prior.

Suicide Risk Assessment (SRA)

Risk assessment tools vary widely across the UK, with many hospitals using locally developed proformas, and there appears to be little consensus over the best instrument for risk assessment following self-harm (Quinlivan et al., 2014). Clinical guidelines in England (National Institute for Health and Care Excellence, 2022) do not recommend the use of risk assessment scales to predict suicide, instead a comprehensive psychosocial assessment of individual needs should be conducted. Graney et al. (2020) conducted a study looking at suicide risk assessment in the UK and found that most assessment tools aimed to predict self-harm or suicidal behaviour, despite the guidance, and the poor predictive validity of these measures. Furthermore, staff using the tools felt they did not have adequate training and that the assessment was time consuming. Positive views towards risk assessment tools were that they facilitated communication and enhanced therapeutic relationships, with a suggestion that they were used to inform and formulate care plans based on clinical judgement. This indicates that clinicians have a significant role in SRA, however little is known about their lived experience when making decisions based on clinical judgement.

Exploring practices into how SRA is conducted, Quinlivan et al. (2014) focused on ED's finding there was a wide range of tools used, with the prominent practice being a locally developed structured proforma (41% of the sample). Only one hospital (3% of the sample) reported using only clinical judgment to assess risk. A Scottish review found that 67% of participants stated they used a suicide risk assessment tool, and similarly the most common tool was a locally developed tool or proforma (McClatchley et al., 2019).

Working with individuals who have attempted suicide or self-harmed evokes a range of emotions (Hagen et al., 2017). Despite the stressful and demanding nature of this, little is known about how staff experience and perceive working with suicidal patients (Cutliffe & Stevenson, 2008). Identifying this as a need, Awenat et al. (2017) aimed to investigate the experiences of staff working with suicidal in-patients. The author's found there was a range of staff beliefs about suicidality which

had an impact on attitudes to patient care. This included seeing suicide as an inevitable feature of mental illness; and feelings of hopelessness and frustration when questioning whether they were able to support individuals who frequently self-harmed. Concerns were also highlighted from staff that, should a suicide occur, clinical records would be scrutinised, identifying them as the last professional to speak with a patient, and this would be investigated within a 'perceived' 'blame-seeking' culture. This would then leave them professionally vulnerable.

Chunduri et al. (2019) conducted a study asking clinicians, mostly psychiatrists, working at a psychiatric ED in America about their experiences when conducting SRA. There were in-depth discussions about the lack of resources, clinician experience, affective response, and the challenges of responding to competing demands. A theme from this paper was how clinicians managed worry and what mediated this. Some staff identified if due diligence is completed then they feel okay whatever outcome is arrived at. Another theme that came from this was an unrealistic expectation of preventing every suicide.

In what is thought to be the first paper investigating clinicians experience of suicide in the UK, McClatchey et al. (2019) asked ED clinicians about their experience. It appears, however, that these participants were physical health clinicians working in ED, rather than speciality psychiatric liaison clinicians. They found that clinical experience was helpful in decision making, and that clinical judgement could not be replaced by clinical tools. Additionally, they found clinicians found the process time consuming and challenging and would welcome further training.

Research has explored how risk decisions are made regarding future care following self-harm and suicide attempts. There is limited information exploring staff perspectives and how they make sense of their experiences of conducting SRA, with no evidence investigating staff who work in mental health liaison. This is peculiar as liaison staff are the cohort most commonly responsible for making decisions related to risk and are working in particularly high-risk environments given what it is known about contacts with ED prior to death by suicide.

Mental health liaison practitioners assess risk of future harm following a presentation of self-harm at the ED. The uncertainty and complex decisions they are faced with is a unique experience, yet is common practice for this population. This paper aims to be the first to explore their lived experience of conducting SRA.

Aim

This study aims to develop an understanding of the lived experience of Mental health liaison (MHL) practitioners when making risk of suicide decisions following self-harm presentation. It will explore how they manage uncertainty in these situations and how staff personally experience these circumstances. The following research question was posed: How do MHL practitioners make sense of their experiences of conducting suicide risk assessment?

Methods

Design

This study took a qualitative, , phenomenological approach to explore detailed in-depth individual experiences. Phenomenological research focuses on identifying the meanings individuals make of their experiences through accessing their interpretation. This seeks to highlight how individuals talk about and perceive their experiences, rather than describing them (Smith et al., 2022). There is an interrelationship between the interviewee and the researcher which is important for the co-cocreation of knowledge and meaning (Mills et al., 2006).

Interpretative Phenomenological Analysis (IPA) was used as this approach allows for exploration of the depth of individual experience and this study aims to elicit the deeper sense making of personal experiences. Findings will provide a unique time sensitive insight into participant's experience (Burr, 1995), rather than aiming for generalisable claims.

IPA

IPA is a qualitative approach, drawing on philosophical principles of phenomenology, hermeneutics and idiography (Pietkiewicz & Smith, 2014).. Phenomenological inquiry is an interpretative process which situates participants in their particular contexts and explores personal perspectives. IPA aims to give a voice to individual experience, by encouraging self-reflection to make sense of participants worlds (Chapman & Smith, 2002). IPA is committed to the detailed examination of the case, wanting to know in detail what the experience is like for each individual participant (Smith et al., 2022).

Ethical Approval

Ethical approval was provided by the Faculty of Medicine and Health Sciences Research Ethics Subcommittee, at the University of East Anglia (REF: ETH2324-0134) and by the Health Research Authority in England (IRAS ID: 311190).

Participants

Eight clinicians participated in interviews, all were qualified mental health liaison practitioners currently working in ED, have a core profession and were able to recall a specific scenario of assessing suicide risk. This included two male practitioners and six female practitioners, from mental health liaison teams (MHLT's) across the east of England. Due to local teams being small in staff numbers further demographic information was not reported to wanting to maintain confidentiality.

Procedure

Recruitment to the study was advertised via email to local MHLT's across East Anglia. Interested and eligible staff members read an information sheet before giving informed consent to participate. Interviews took place on Microsoft Teams.

A semi-structured interview aimed to explore novel areas of discussion, particularly around the area of making decisions. This was shaped by consulting MHL practitioners to address feasibility, acceptability, and clarity of wording. MHL practitioners consulted were not eligible to participate in the study. Interviews were transcribed verbatim, and pseudonyms were used to protect anonymity.

Analysis

Analysis followed the methodology set out in Smith et al. (2022), firstly becoming familiar with the transcripts before conducting initial coding. Each transcript was analysed individually. First exploratory comments were added, then experiential statements (ES) were developed, reflecting both the participants experience and the researcher's interpretation, before organising into personal experiential themes (PET). Then patterns were sought across the transcripts and final Group Experiential Themes (GET) were developed, with key quotes and phrases identified to ground each theme in the data. At each theme development stage, discussion was had with all authors to identify how best to capture individual experiences and ensure any researcher biases were identified. Researcher's awareness of their own experiences is a key element of IPA and ongoing reflective discussions throughout analysis ensured transparency in the process.

Results

Analysis identified six main themes. Table 1 shows the representation of participants across each GET and the related subtheme.

Table 1. Representation of participants across themes

Theme	Total	P1	P2	P3	P4	P5	P6	P7	P8
You can only do what you can do									
Putting the assessment down	8	X	X	X	X	X	X	X	X
..And after that it's out of my hands	7	X	X	X		X	X	X	X
My team are my safety blanket									
I feel reassured I am not alone	8	X	X	X	X	X	X	X	X
The responsibility can be diluted	7	X	X		X	X	X	X	X
The only certainty is uncertainty									
Some assessments are hard to let go	7	X		X	X	X	X	X	X
Risk assessment will always have an element of uncertainty	8	X	X	X	X	X	X	X	X
Putting my wellbeing first allows me to show up for others	7	X	X	X	X	X	X		X
You can't help but go back to what you've been through before	7		X	X	X	X	X	X	X
At the end of the day, you need to protect yourself	8	X	X	X	X	X	X	X	X

You can only do what you can do

This GET encapsulates participants' experience of there being limits to their role, and how honouring and accepting this boundary is a key part of their experience in making risk decisions. Participants experienced feeling that their hands felt tied at times. They explored how they have to recognise when they cannot do more for an individual and that sometimes they are not able to provide what they think a person needs. Mike summarised this, sharing "*I think one of the difficult things in liaison is when you let somebody go and you've got an idea you feel like you know what they would really benefit from, but you've got no control over what happens next*"

Putting the assessment down

Participants experience reaching a stage in the assessment where they recognise they have done all they can do and their role and responsibility comes to end. Carol describes getting "*to a point where you have to acknowledge to yourself that I am not responsible for every single person's life*". This was also highlighted by David who explained that "*my bits done, and I've done whatever the possibilities are for that person*". Katie encapsulated this idea, sharing "*I've made the decision*

now, I made it with the best intention and information I had at the time. I can't change it now". The theme highlighted that understanding "*you can only do what you can do*", which was stated by multiple participants, was important to maintain clarity and wellbeing in the role. Ellie explained this phenomena helped her with the challenges of not ruminating on a decision, sharing "*I find it a better way to cope. To think we can just do what we can do. Otherwise, we'd all be quite depressed*".

..And after that it's out of my hands

Although participants are striving to make the best decision they can, they experience significant elements beyond their control. Mike explained "*feeling forced, or feeling like we, 'should be making decisions based on resources' not on need and how that can feel sort of more morally and ethically really challenging*". This was reflected across multiple participants, with Jane stating "*no, we're not gonna be led by your resources. We're gonna be led by what the assessment outcome is*", and Carol sharing "*to my mind we've identified the need. It's their job to find and meet that need now*". This indicates a shared feeling that the assessment recommendation is separate to the ensuing plan and this can feel beyond the participants' control. Daisy explains this as a frustration with onward service provision and not being able to do more, stating "*there should have been more available. You know, that person should have been given more, you know, rather than I could have done more*" As well as service provision being a factor, David explained that "*we do let people go home because that's what they want to do and we're thinking this might not go well, but it's all about capacity and it's about consent*". There is an emotional weight attached this idea, with Carol summarising this as "*I can't promise them 100% when I send them home that everything that I've said is gonna happen will happen*".

My team are my safety blanket

Many participants spoke about the relationship they have with their team, sharing how connecting with the team provided them with reassurance and improved their confidence in decision

making. Recognising the power in shared decision making and how this changed the experience was also a key factor identified.

I feel reassured I am not alone

Participants shared the power, privilege, and comfort in not feeling alone when completing risk decisions. David begins by saying that the "*amount of experience we've got as individuals and then collectively is huge*", with Katie expanding on this sharing that "*other people have different jobs and experience and so that helps me feel confident in the decision*". There was a sense that this feeling of "*support and understanding*" (Daisy) is paramount to 'good' decision making with Daisy saying "*it's highlighted the need for the team around you and the difference that makes in making the decision*". Participants experienced team support as a necessary factor in undertaking assessments, with Stacey sharing "*having good people around you because you can't just do this on your own*". Similarly Ellie explains "*I think if we didn't have that space for being reflective… talking to other people… I think we just send everyone home and that would be that wouldn't be very good*". Participants seemed to value not being alone as an element that helps them feel okay, with Mike sharing "*I didn't feel alone afterwards, cause I could go back to my team and go wow, that was full on*" and Ellie summarising by saying "*Yeah, I think I just feel quite looked after*".

The responsibility can be diluted

A component of this GET was that a team around an individual dilutes the sense of personal responsibility a participant might feel when making a decision. Jane explains this as "*we need to get everybody on board. So it's not just me holding the risk*". Similarly, Katie explained that "*following an assessment that feels risky I feel like I can come back and have a big discussion about someone. There can be lots of names of people involved… So there's that diluting of like, it's not blame if something goes wrong, but it's like, um, accountability is diluted… a little bit*". Ellie talked about the importance of including team views and different opinions to ensure the assessment is thorough, sharing that "*particularly with these risky decisions, involving more people. So you know you're making sure that*

it's not just a decision that you're making on your own and that you're kind of consulting with all the people around that person cause sometimes that can be a complete game changer".

The only certainty is uncertainty

Feeling, sitting with and tolerating a feeling of uncertainty is a fundamental aspect of the experience of making risk decisions. Some participants highlighted it felt impossible to never let an assessment affect you, either personally or professionally; and many highlighted that they believe eliminating risk and uncertainty is impossible.

Some assessments are hard to let go

One aspect of this GET was that some experiences of risk assessment are not as easy to let go. Jane shared that "*naturally… there's always that one person that you're going to follow more than others*". This idea was mirrored by Mike who explained that sometimes "*there is a really heavy piece of work with somebody and you find that you have a real connection with that person then you're more likely to take it home and need to sort of unravel it a bit*". Participants also detailed what impact this has. Daisy shared that "*I guess you just question whether like say, whether that was the right thing and it's kind of going over, going over it a few times, kind of in your head*" and that with these type of assessments "*you kind of come back the next day and have a little look*". This experience of wanting to know the outcome of assessments that stick with you was a common phenomenon across participants. Ellie shared that "*I know what I'll be doing. I'll be checking their notes when I next come in and see what happens*" and similarly Jane said "*so it hasn't gone completely because, tomorrow I shall read up on her notes and just and then I shall be able to leave it*". Katie explained that following a particularly uncertain, what she felt to be a risky assessment "*my decision making was much more risk averse and I was much more nervous to assess children because I was still thinking a lot about her*" and Daisy commented that a previous risky decision "*makes you nervous to do other assessments*".

Risk assessment will always have an element of uncertainty

Stacey summarises this sub theme by saying that "*there's certain people who you see who you know are risky, it's just a chronic thing. And there's, there's nothing you can put in place to stop that*". Similarly, Carol shared that "*you can reduce risk to try and help people keep themselves safe. But you can't remove it completely*". David shared that despite all the plans that are made there are always times when "*you don't have all the answers and you try and pick the best option".* Daisy explains the impact of this on her, sharing "*you do have to say there is a risk and there's nothing we can do about it, and I think sometimes that's the hardest thing because it's a risk you're not gonna mitigate*". Stacey talked about the zero-suicide policy, sharing "*this zero tolerance, you know… so personally … I think is ******** ridiculous*". This belief is shared by Mike who said "*I know there's this sort of suicide strategy... Which I don't really agree with*", explaining he doesn't believe it is possible to reach this. Ellie summarised this idea, saying "*we know there's an element of uncertainty and people would disengage and things won't work out. And I think I've got to a point where I've accepted that*", highlighting that it is almost just a known fact that uncertainty is and will always be a key element of this process.

Putting my wellbeing first allows me to show up for others

Almost all participants described needing empathy, compassion and care to be able to do their job well. It was balanced with recognising the need for boundaries and taking a step back to maintain their own wellbeing. There was a sense of participants recognising what they felt they needed to make risk decisions. Carol highlighted this, saying "*I need to be in a good place emotionally. Otherwise, how can I sit and listen to everybody else? You're not going to be as empathetic*". This shows the dynamic scale of needing to care, as Jane states "*you can't do this job without empathy*", whilst also recognising the importance of being okay as Daisy states "*I think this job I think you you have to be OK*". David also highlighted this idea, sharing that he "*believes unless you've got your personal life sorted that you can't do the job the way they you need to*" and to be

able to bring "*unconditional positive regard*". Mike also resonated with this phenomenon, explaining if you stick too much to the boundaries "*you lack any compassion, you know. And so you have to find a balance*".

You can't help but go back to what you've been through before

All participants spoke about previous experiences when talking about their current experiences. It appeared to be a significant component in how participants make sense of both their decision making and how they feel about their role. Daisy highlights this idea by stating "*I think sometimes a lot of it … works on kind of your intuition and your experience*". Mike shared his feelings of learning to make these decisions and shared "*you can get to a stage where intuition does kick in….it's not cause you're tarring people with the same brush. It's just that when you see you're faced with certain things. You're like…. I know how this goes. And I feel comfortable with this*". Stacey talked about how experiences throughout her career will impact her present experience, stating "*my thoughts around the decisions that I've made would be vastly different if I'd had a lot of suicides after decisions that I'd made*". Participants reflected on how they learn to make these decisions. David highlighted that "*I don't think it's training really, it's life experience*" and Jane also reflected it's not something you can be taught and "*it takes time to learn it*".

At the end of the day, you need to protect yourself

This GET encompasses the experience of relying on and going back to the importance of documenting decisions due to an underlying fear of a negative outcome and the decision being questioned. Most participants spoke about feeling a need to justify their decisions. David summarised this being the end of his risk assessment experience, stating "*so now it's just about making sure that you've boxed everything off in a way that means that you're protected. making sure it's all documented*". Stacey explains this as "*I just go through what I've done and why I've arranged*

arrived at the decision I did arrive at. Look at what I put in place and then I just back myself up". The driver behind this phenomenon appeared to be a fear of being called to coroner's court. Carol explained this by saying "*it has to cover why you did stuff, why you didn't do stuff, what you considered, why you didn't consider… And has to be in enough detail so that if it does go to coroners court, it's there*". Katie shared this also being an element in her decision making, stating "*that might be the decider. I might think to myself how could I justify that? Could I justify this in coroner's court*".

Discussion

This study aimed to explore and gain a fuller understanding of the lived experience of MHL practitioners working in ED. Through analysis six main themes were developed: You can only do what you do can do; My team are my safety blanket; The only certainty is uncertainty; Putting my wellbeing first allows me to show up for others; You can't help but go back to what you've been through before; At the end of the day, you need to protect yourself.

All participants described recognising that there are limits to what they can do within their role, and that the steps following assessment are often out of their control. Almost all participants spoke highly about their team and the reassurance and safety that comes with shared decision making. Uncertainty is a key element of SRA and participants reflected that this is an unavoidable part of the experience and that there are times a particular assessment will stick with them. All practitioners detailed qualities and skills they believe are needed for the job, and this highlighted the balance between care and empathy for the individuals they assess and the boundaries and ability to step back which is needed for the own wellbeing. All participants spoke about how previous experiences influence their present experience, whether this was an impact on how they view a decision, or how they learnt to conduct these assessments. Justifying decisions was the final theme, with all clinicians detailing the thought process around documenting and protecting themselves against possible future scrutiny.

The current findings add novel detail regarding the experience of this population, specifically looking at personal experiences. This develops the literature beyond understanding the practicalities of what factors clinicians think about when conducting SRA.

Complimenting the results found by Chunduri et al. (2019) and Awenat et al. (2017) this study also found that participants felt totally eliminating suicide risk was an impossible task and that uncertainty was a core, irremovable feature of this experience. Another similarity identified was that, despite any future bad outcomes, there was a focus on doing what you can do within the parameters of the role, and as long as it is documented, this can mediate any potential anxiety felt.

Building on McClatchey et al. (2019) this study also highlighted the role of experience in the process of SRA. These results add to this idea, providing further detail as to how experience influences decision making processes, with past risky decisions leading to a period of more risk averse decisions, as well as experience in terms of career and length in role being the primary way of learning how to do and cope with these decisions. Previous experience with patients dying by suicide has been found to be associated with less severe treatment options (Chacko et al., 2021). Whilst this study didn't look at treatment options, participants' experience suggests the opposite phenomenon, whereby they feel more risk averse following a difficult assessment or outcome.

Awenat et al. (2017) described in-patient staff feeling concerned about potential scrutiny should a suicide occur. This was mirrored in the experiences explored in the current paper. Whilst there was no mention of a perceived blame-seeking culture in these findings, there appeared to be a culture of ensuring justification of decisions due to an underlying fear of future investigation. In an article discussing the risks of risk assessment Undrill (2018) suggested that professionals are increasingly being made accountable for what they do and they may be becoming more preoccupied with managing their own risks rather than focusing on the patients risk. This phenomenon was not present in this study, with participants focusing on accurate documentation rather than actively making recommendations that benefit themselves over the patients' needs. However, it may be that

the theme of diluting responsibility has foundations in self-protection and is also driven by a fear of repercussions.

One of the themes identified was the power and safety in team connection. Isolation is a recognised factor for burnout amongst healthcare professionals (Stebnicki, 2007) and it can be hypothesised that the phenomenon of team support identified in this study is helping to minimise risk of burnout.

Strengths & Limitations

A particular strength of the study is the novel insight into the lived experiences of mental health practitioners working in ED in the UK. The nature of the analysis allows for the researcher to interpret the participants interpretations of their own experiences. The researchers own position of being familiar with SRA allowed for authentic discussions and deeper exploration, removing the need for context and description in the interviews. Reflexivity was ensured throughout the process, however this paper offers a unique account of the experience of making risk decisions.

The study design holds both strengths and weaknesses, with a small, relatively homogeneous sample allowing for the in-depth, rich analysis of experience, but also meaning the results are not more widely generalisable. Furthermore, there was a general sense that the participant sample experienced their job positively, especially in regard to the team support, which may be unique to this sample. Recruitment was conducted across multiple teams however, so whilst this may have influenced the phenomenon identified and impact the generalisability of the study, it is important to consider for clinical implications. Future research in this area may benefit from widening the methodology to include different approaches, aiming to build upon the knowledge around clinician experience.

Critically reviewing the analysis process, the lead researcher followed IPA guidance outlined by Smith et al. (2022). A strength of the research is the thoughtful iterative approach taken which

increases validity. Braun and Clarke (2013) outline the importance of reflexivity in qualitative research and ongoing reflection throughout the process was ensured by regular supervision and discussion with the research team. There are limitations with using IPA and although guidance is suggested there is no single process when analysing data. This can leave room for both subjectivity and lack of standardisation. Another criticism of IPA is that it focuses on perception and understanding lived experience but does not seek to explain why they occur. This perhaps limits the conclusions that can be drawn. As a rebuttal to this challenge, Smith et al. (2009) suggest that the analysis used allows for an understanding of the cultural position and context of the individual which adds to the understanding of why these experiences occur.

Considering the phenomenological approach, strengths of this include the richness of the data, allowing a unique insight to examine and comprehend lived experience. This approach encompasses the complex understanding of experience, and encourages an interpretation of perspectives and meanings, unique to the person and their context. This orientation for qualitative research also has several limitations including the risk of researcher bias and remaining true to participant lived experience when grouping phenomenon themes. Phenomenology as a research approach relies on the accounts of participants and the experiences of researchers, however the critical question is whether both the participants and researchers have the requisite communication skills to successfully communicate the nuances of experiences (Tuffour, 2017). A challenge for phenomenological psychology is to translate the philosophical underpinnings into a practical and coherent approach to data collection. The guidance set out by Smith et al. (2009) discusses IPA as being influenced by the core emphases of the approach and suggest that “IPA can be seen as operating within, and attempting to further, the intellectual current of phenomenology, in the context of psychology”.

Applications to Practice

The depth of experiences in this paper highlight the complexity of the decisions these clinicians are faced with. The theme around finding safety and comfort in the team may show the importance of allowing clinicians protected time to connect, and perhaps having a more formal structure to shared decision-making would increase these feelings. We know that burnout is linked with decreases in patient safety (Hall et al., 2016) and it may be, with future research, that practitioners experience of finding a safety blanket in their team is a protective factor against burnout.

Given the inherent subjective nature of SRA, participants experience suggests that uncertainty is a factor that is unavoidable. This may be of interest to future clinical practice, especially in the context of the zero-suicide policy. If practitioners believe they can never be completely certain about an individual's level of risk, it may negatively impact them if this is what is expected of them. This idea is summarised by Bryan and Rudd (2006) who postulate that society has unrealistic expectations of professionals being able to predict suicide.

It could be that this idea ties into the other theme around protecting yourself. Whilst these findings did not explicitly discuss blame culture, there is a patient safety agenda in the UK (National Advisory Group on the Safety of Patients in England, 2013), which suggests developing a culture that avoids a predisposition of blame. This highlights the need to remove the notion of blame and move attention away from the individual, however the theme around justification suggests there may still be an element of fear of the consequences of an adverse outcome. This may be useful to understand further, again with the aim of increasing the wellbeing and resilience of this particular staff group.

Participant's found prior experience to be a key element of their lived experience in conducting SRA. Whilst these are preliminary findings, it highlights the important of recognising the impact of what a clinician has experienced before encountering individuals who are at risk of suicide. It may benefit

clinicians to have additional training to aid reflection of how their previous experiences are impacting the process of reaching a decision about risk. **Conclusion**

The current study is the first to explore the lived experience of mental health practitioners making risk decisions in ED. It has added to the understanding of clinician experience in SRA, highlighting themes which practitioners feel are core elements of their meaning-making in these situations.

The findings have highlighted the sense of limitation practitioners feel, having to accept they 'can only do what they can do'. It was also found that the team offer more than just support, they provide a source of reassurance and safety in the ability to share decision making responsibilities. Furthermore, results show that practitioners are not seeking, nor believe that it is possible to, have uncertainty eliminated. Justification of decisions was also a theme, as was reflection on the necessary skills and qualities to keep doing a good job.

More focus on recognising the importance of shared decision making may be an important area for practice, as well as incorporating further reflection and awareness of how experience affects decisions into training.

This research shows the complexity and breadth of experience of mental health liaison practitioners making clinical decisions about risk of suicide. The findings show a unique insight into the experience of these participants when making decisions about suicide and offers a discussion as to how this can be taken forward to ensure practitioners voices are not lost in SRA research.

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Chapter Five

Discussion and Critical Evaluation

Word Count: 3413

Discussion and Critical Evaluation

This thesis aimed to explore clinical judgement and clinicians' experiences of conducting suicide risk assessments (SRA) in an Emergency Department (ED) setting. This final chapter of the thesis portfolio presents an overview of the findings from each paper, offers a critical evaluation with strengths and limitations, and discusses the wider clinical and research implications. The primary researcher's reflections and a conclusion are also presented.

Summary of Findings

The systematic review aimed to summarise and synthesise the existing literature on the role of clinical judgment in SRA. Criteria for the studies to be included in the review were: clinicians holding a core profession; were working in mental health setting; and who routinely assess suicide risk. Results highlighted that there was no clear evidence as to how clinical judgement in SRA is integrated in practice, with only one paper commenting on how clinical judgement is used in ED's. A key finding was the impact of clinician factors on suicide risk rating. Although the results were broad, limiting the generalisability, it is thought to be the first paper beginning to draw together current knowledge on how clinician factors affect their judgement of risk.

This paper found similar themes to previous research, showing that there are large variations in practice, and that the most common aid to conducting SRA is a locally developed proforma. This appears to go against guidance which recommends using clinician led psychosocial, individually tailored assessment. It may be that understanding the role of clinical judgement, or how much of a decision is made by clinical judgement is difficult to ascertain This could be because it is being used with differing weightings alongside standardized tools and varying from service to service which is hard to capture given variance in clinical practice.

The review highlighted a surprising number of papers that looked at the factors which influence clinical judgement in SRA. Across the seven papers, the results showed that clinician

factors, such as age, gender, experience and profession did have an impact on risk ratings. However, the findings were inconsistent. For instance, three studies looking at clinician gender all found different results, and of three papers looking at age, two found older clinicians rated risk higher than younger clinicians and one found no effect age on risk rating. These mixed findings indicate that in relation to the clinicians' demographical factors such as age, gender, experience and profession that the literature does not show a dominant theme and that this might be a more complicated and dynamic process beyond demographical features of the clinician.

Two papers discussed themes clinicians raised about their experiences with suicide risk. Both papers discussed experience in the role as a theme and both highlighted the participants view that no screening or assessment tool can replace good clinical judgement and structured tools can be used as a guidance for clinicians. It was unclear to what extent they would use or rely on these tools, or whether it gave them a greater sense of certainty. All questions which would be useful for future research into how clinical judgement is being used in practice.

The empirical paper aimed to explore the in-depth experience of mental health liaison practitioners working in ED's. Interpretative phenomenological analysis was conducted on eight participant interviews, who were asked about their experience of assessing suicide risk. The analysis identified six main themes: You can only do what you do can do; My team are my safety blanket; The only certainty is uncertainty; Putting my wellbeing first allows me to show up for others; You can't help but go back to what you've been through before; At the end of the day, you need to protect yourself. All participants described recognising that there are limits to what they can do within their role, and that the steps following assessment are often out of their control. The role of the team in shared decision making was also a key theme, as was being able to justify a decision they had made. Participants experienced a process in which they recognised the need for boundaries and distance to maintain their ability to be empathetic, which they recognise as a key value in conducting a good

assessment. This theme, as well as acceptance of things beyond their role, may be an initial insight into how practitioners manage their own wellbeing, which is important for good clinical practice.

Extended Discussion

Suicide risk assessment is a complex task (WHO, 2014), with little consensus over the best instrument to use (Quinlivan et al., 2014). More recent research has shown that the currently developed tools have poor predictive ability (Chan et al., 2016). There is little to no research into the extent to which structured tools are being used, or how much weight is given to clinical judgement, however the limited research shows great variability in SRA practices.

Clinical guidelines in England (National Institute for Health and Care Excellence, 2022) recommend not using tools or scale that seek to predict the risk of suicide. Instead, they recommend a comprehensive psychosocial assessment of individual needs should be undertaken, which appeared to be the preferred approach by clinicians from the results from both papers. By nature, clinical judgement means there is scope for variation across clinicians, with individual factors and experiences potentially impacting the risk decision to be made. Research continues to seek a more precise, statistically informed risk tool but given ability to correctly predict risk has not improved in over 50-years of risk assessment it seems unlikely anything will be imminently produced. Given lots of literature exists exploring this topic, this thesis explored an area that is less research and attempted to further understand clinical judgement and the experiences of clinicians conducting SRA.

Despite the broad inclusion criteria of the systematic review, little evidence is published regarding how clinical judgement is being incorporated into practice, and although the papers returned in the searches suggested large variability in SRA practices, there was not enough information regarding the weight placed on clinical judgement compared with how much reliance there is on validated assessment measures. The systematic review highlighted qualitative findings stating practitioners feel there is no replacement for clinical judgment, which poses the question as

to why there is so much interest in developing accurate risk prediction models if clinicians do not feel they are of any benefit. This of course, may be due the current lack of validity in measures available, however identifying more sensitive tools does not appear to be a priority of clinicians, or what fits with the current NICE guidance (NICE, 2022).

Both papers presented in this study picked up on the notion of clinician experience being an important factor in SRA. The systematic review highlighted this as a factor which can impact the rating of risk and the empirical paper found participants' previous experience was a theme in understanding their current processes in making risk decisions.

A theme identified in the empirical paper was that SRA will always have an element of uncertainty and that striving for certainty around future risk predictions is unhelpful. There is a backdrop of initiatives to tackle this. In the UK this includes Mersey Care's board approving a Zero Suicide Policy in 2015 and were the first mental health trust to do so. More locally there is the Zero Suicide Alliance, who work in the East of England, believe that suicide is not inevitable, and following the publication of the Five Year Forward View many areas were given additional funding for suicide prevention schemes. Whilst there is universal agreement that intervention for potential suicide should be offered and processes improved, there is critique around zero suicide and the notion that better assessment or algorithms can predict risk thus placing a devastating burden on healthcare staff (Turner et al., 2020). There is then a disparity between policy and public messaging and the beliefs held by practitioners, which has the potential for an ongoing friction between what is expected by the public and NHS providers and what practitioners on the ground feel they can deliver. Given the challenges in staff recruitment and retention, this may be a small yet impactful factor in this particular staff group.

Theoretical Models

Smyth and McCabe (2017) state that clinical decision-making requires clinical experience, a thorough knowledge base and the ability to think critically. Clinical experience specifically was highlighted in

the results of both studies as being a key factor in how clinicians assess risk of future suicide. Payne (2015) discussed intuitive decision-making, and according to Benner (1984), as nurses increase their experience through the integration of memory and pattern recognition, they progress through identifiable stages and ultimately develop a deep understanding of phenomena which is then labelled as intuition. Whilst the empirical paper focused on the experience of the clinician rather than the process they went through in making a decision, intuition and experience were key ideas discussed by participants in how they will often go back to previous experiences in their mind during their assessments and within the decision making process. **Critical Review**

Findings of both papers provided valuable additions to the current literature around the role and experience of clinicians in SRA. However, both had limitations which prevent the generalisability of the results.

The findings from the systematic review highlighted great breadth but little depth into the role of clinical judgment in SRA. Whilst the results highlight clinician factors, such as profession and gender can impact risk rating, the lack of consistency in which factors were looked at and how risk rating was measured limits the conclusions that be drawn. Despite the number of papers looking at how and which clinician factors impact risk ratings, this was not a specific aim of the review. This does draws attention to the lack of research into this area and indicates how future research into this area could really benefit clinical practice. The review included papers with mixed methods, with only two papers presenting a qualitative design. This further adds to the difficulties with generalisability of the findings.

The quality of the review process undertaken was a strength of this systematic review. Having the screening and quality stage completed by a second rater, decreased the risk of researcher bias and increased the validity of the review. The number of papers and second rater reviews was high, indicating a through and robust process was undertaken. However researcher bias is always a possibility and given the breadth of the original question and the inclusion criteria, reflexivity as to

what studies met the criteria could have been improved with further reflective discussions or a reflective log highlighting any researcher bias at this stage.

The empirical paper aimed to explore the experience of mental health liaison practitioners making assessments and decisions about future risk. The study used Interpretative Phenomenological Analysis as the methodology, with the goal of gaining a deeper understanding of lived experience. IPA is based on phenomenological epistemology, which explores the subjective experience of the participant, rather than attempting to define an objective reality (Smith et al., 1999). A strength of this study was the consistency of this epistemology throughout the research process. Examples of the analysis are included in Appendix J.

A potential limitation highlighted was the small sample size. However, IPA does not encourage large sample sizes due to the phenomenological nature, with a recommendation of between six and eight for British clinical psychology doctoral programmes (Turpin et al., 2007), meaning the number of participants recruited was within this window of acceptability. The small number of participants, whilst reaching the upper recommendation for a thesis project, were from a specific region in the UK, which again limits the generalisability of the findings. Although the singular region limits wider implications due to differences in mental health prevalence and presentation across urban versus rural areas, there is consistency in the setting across the UK. All acute hospital liaison practitioners will see individuals who self-harm and are at risk of suicide. Greater participant numbers do not necessarily increase knowledge, as using IPA methodology allows for richer and more useable data (Ogden & Cornwell, 2010), meaning fewer participants are needed to reach a deep understanding of the topic.

Whilst this project was not quality assessed, it is important to consider the factors which contribute to good quality research. There are several different approaches to assess the quality of qualitative research. This includes a method set out by Yardley (2000), which presents four broad principles: sensitivity to context, commitment and rigour, transparency and coherence and impact

and importance. Another approach to demonstrating robustness of research is described by Lincoln & Guba (1985), who discuss the concept of trustworthiness of research and introduced the criteria of credibility, transferability, dependability, and confirmability to parallel the conventional quantitative assessment criteria of validity and reliability.

Smith et al. (2009) set out a chapter addressing how IPA meets these four principles. Firstly IPA demonstrates a sensitivity in the interactional nature required in data collection and that often establishing a rapport, displaying empathy and recognising interactional difficulties is imperative in obtaining good quality data. Secondly, IPA requires a high level of attentiveness to the data showing commitment, and the data analysis in inherently a rigorous process. Thirdly, transparency can be addressed by how well the researcher describes the process of recruitment and analysis and the coherence is addressed by whether any ambiguities are dealt with, whether the themes fit logically and if the study is consistent with underlying principles of IPA. Lastly, IPA aims to tell the reader something interesting, important or useful and encourages the researcher to do this. Yardley's guide is suggested for all qualitative research, however the first guide for specifically assessing the quality of IPA studies was published by Jonathon Smith (Smith, 2011). He suggests the following factors be considered when assessing whether an IPA paper is of good quality: a clear focus, strong data, rigorous, sufficient space given to the elaboration of each theme, interpretative not descriptive analysis, both convergence and divergence in data skilfully demonstrated and a carefully written paper.

Clinical Implications & Directions for Future Research

The findings from this thesis highlight the complexity of clinical judgement and experience in SRA. A key theme found in both papers was the role of clinician experience in the decision-making process. The systematic review found this to be a factor which can affect the level of risk rating an individual is given and the empirical paper found this to be a key element of participants' experience. Whilst these are preliminary findings they do highlight the importance of recognising the impact of

what a clinician has experienced before coming into contact with individuals who are at risk of suicide. Ultimately, with future research to corroborate findings, it may be useful for individuals responsible for SRA to have additional training to aid reflection of how their previous experiences are impacting the process of reaching a decision about risk.

The systematic review findings suggest that additional research is needed to provide a stronger evidence base for how clinician factors impact their evaluation of risk. This is an important area for clinical practice, as although it is not recommended for SRA to be completely objective by use of tools, there may ultimately be large variations in the recommended intervention, based on risk rating, solely due to differences in clinicians' biases.

Researcher Reflections

Prior to training I worked across various NHS mental health services, however the majority were based in forensic settings. Making decisions and judgements around future risk was at the core of many of these services, and I became acutely aware of how this process differed amongst professionals. Personally, I have always been drawn to staff experience, and have valued reflective practice spaces to bring those experiences to the forefront. It has struck me that the impact of working in mental health services was rarely talked about, and I began to think about and be more open with my own experiences of working in these settings.

I have encountered firsthand the worry of making a decision and having to sit with the uncertainty that comes with it. Writing a risk assessment that was used at a tribunal was a significantly anxiety provoking part of my career, and being called to explain my recommendations was especially intimidating. I have been incredibly lucky to have been in teams where reflecting on personal responses to the role was encouraged. Being a non-qualified member of staff meant that the risk never fully sat with me, and I recognised I relied on this a lot to ease any worries.

This reflection was something I took with me and as I moved into different roles, the risk of future violence was replaced with the risk of suicide. Again, I had experiences of making decisions, sitting with uncertainty and anxiety about whether I had made the right recommendations. During lockdown, prior to starting training, I logged into work to find an email from a patient detailing how they were going to end his life. Being in my family home, away from my team, had a big impact on how I processed this information. It made me realise the value I felt in being around other people and how, despite the wonderful supervision I received, I still felt a sense of personal responsibility. The outcome of this was positive, however the process and experience of this was significant. It was not my first encounter with a patient threatening or attempting to take their own life, however the context of this particular experience will stick with me,

This job will always evoke an emotional response and for all these reasons, I was and will continue to be interested in staff experiences of making risk decisions.

I wanted to expand my knowledge, and beginning this project I knew very little about ED and mental health liaison. It has been such a privilege in being able to learn about those services in the way that I have. As with everything, I had an idea in my mind about what the job would be like, and having suggested going to ED to a number of people throughout my career, I felt a bit guilty I didn't understand the process a bit better. Although this project was focused on suicide risk assessment, I was particularly struck with how broad the role is, and all the different presentations clinicians are working with.

Hearing the lived experience of these participant's was such a rollercoaster of emotions, and although I had expected to feel sad, I had not expected to laugh with and feel validated by this group of individuals. I learnt so much from them, reflecting on how I connected or equally didn't connect with their experience, hearing how they navigate this process and taking away ideas for my own practice. It is a unique experience and I had expected to feel certain I didn't want to work in that environment, however the passion for their job was so clear in each participant that it was infectious.

Although not a surprise, I really connected with participants' sense of frustration with service pressures, structures, and policies. I felt sad, angry and hopeless at times, alongside the participants. I reflected on the uncertainty of risk assessment and how this is something that is likely to never go away. Risk assessments will inherently be uncertain, and that 'what if' thoughts are likely to always pop up occasionally.

There is so much that I have taken from this project. Firstly, it has been an important reminder to check in with my friends and colleagues and continue to ensure personal experiences of the jobs we are in is discussed with as much emphasis as the focus of the intervention or assessment. I have thought about the participants often, especially when I am making decisions around risk and it has really changed the way I reflect on my personal limits and knowing when I have reached that point of 'you can only do what you can do'.

Conclusion

This thesis aimed to explore the role of clinical decision making and clinicians experience in SRA. A systematic review was conducted to collate the existing literate around how clinical judgment is used and with what impact, and a qualitative empirical study was completed to explore the experiences of mental health liaison practitioners when making risk decisions.

Findings from both papers highlight the complexity and variability of the factors important to this process. Although there is further research need, this thesis has shown the importance of recognising the clinician's role in SRA.

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Appendices

List of Appendices

Appendix A: Health & Research Authority Ethical Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Heather Lawrence
University of East Anglia
Norwich Research Park
Norwich
NR4 7TJ

Email: approvals@hra.nhs.uk

26 September 2022

Dear Miss Lawrence

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

Study title:	**Understanding how mental health liaison practitioners make sense of their experiences with decisions related to life-threatening self-harm**
IRAS project ID:	**311190**
Protocol number:	**N/A**
REC reference:	**22/HRA/3560**
Sponsor	**UEA Sponsor, Research & Innovation Services**

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

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

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

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

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

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

What are my notification responsibilities during the study?

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

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

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

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

Your IRAS project ID is **311190**. Please quote this on all correspondence.

Yours sincerely,
Michelle Ahmed

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Ms Polly Harrison*

List of Documents

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

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research	3	25 July 2022
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor Insurance]		01 August 2022
Interview schedules or topic guides for participants [Topic Guide]	3	25 July 2022
IRAS Application Form [IRAS_Form_16082022]		16 August 2022
Letter from sponsor [Letter from Sponsor]		01 August 2022
Letters of invitation to participant [Letters of Invitation]	2	25 July 2022
Organisation Information Document [Organisation Info Doc]	1	25 July 2022
Other [Inclusion & Exclusion]	2	25 July 2022
Other [Sponsor Insurance]	1	01 August 2022
Participant consent form [Consent Form]	2	25 July 2022
Participant information sheet (PIS) [PIS]	4	25 July 2022
Research protocol or project proposal [Protocol]	4	25 July 2022
Schedule of Events or SoECAT [Schedule of Events]		25 July 2022
Summary CV for Chief Investigator (CI) [CI CV]		25 July 2022
Summary CV for supervisor (student research) [Supervisor CV]		25 July 2022

Information to support study set up

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

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
All sites will perform the same research activities therefore there is only one site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study in accordance with the contracting expectations detailed. Due to the nature of the activities involved, organisations will be expected to provide that confirmation to the sponsor • Within 35 days of receipt of the local information pack • After HRA/HCRW Approval has been issued. If the organisation is not able to formally confirm capacity and capability within this timeframe, they must inform the sponsor of this and provide a justification. If the sponsor is not satisfied with the justification, then the sponsor may escalate to the National Coordinating Function where the participating NHS organisation is located.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other agreement to be used with participating NHS organisations of this type.	The sponsor has detailed its proposals with respect to whether any study funding will be provided to participating NHS organisations of this type in the relevant Organisational Information Document. This should be read in conjunction with the relevant Schedule of Events/SoECAT which details the cost implications of the study for participating NHS organisations.	In line with HRA/HCRW expectations a Principal Investigator should be appointed at participating NHS organisations of this type.	Where an external individual is conducting only research activities that are limited to access to staff, or staff data (in either identifiable or anonymised form), or anonymised patient data then a Letter of Access is required only if these activities will take place in NHS facilities. Where these activities will not take place in NHS facilities then no arrangements under the HR Good Practice Pack are required. This should be issued be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed). These should confirm Occupational Health Clearance. These should confirm standard DBS checks.

Other information to aid study set-up and delivery

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

Appendix B: UEA FMH Ethical Approval

University of East Anglia

Study title: Understanding how mental health liaison practitioners make sense of their experiences with decisions related to life-threatening self-harm

Application ID: ETH2122-0940

Dear Heather,

Your application was considered on 29th March 2022 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **29th September 2023**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under

evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Paul Linsley

Ethics ETH2122-0940: Miss Heather Lawrence

Appendix C: Study Advert

University of East Anglia

Understanding how mental health liaison practitioners make sense of their experiences with risk decisions

We are looking for individuals with experiences of assessing patients following a presentation to ED with significant self-harm (requiring medical intervention).

Specifically we would like to talk to those who have completed an assessment with an outcome of discharge with no immediate further support from mental services, defined as no support from services in the 72 hours following the assessment.

We are interested in hearing about your experiences, how you make sense of these, and any effect this may have on you.

What is involved?

You will be invited to take part in an interview, which will last about an hour, and will likely be over MSTeams. If you would prefer to meet in person then this will also be possible.

What will I get from taking part?

You will be contributing to a research project aimed at better understanding the roles you are in and adding to the literature around the potential effects of making these types of decisions. The aim is for the research to be published in a peer reviewed journal.

How do I volunteer to take part?

If you are interested in taking part or wish to find out more about the study please contact:

heather.lawrence@uea.ac.uk

Trainee Clinical Psychologist, Univeristy of East Anglia (UEA)

Appendix D: Participant Information Sheet

Understanding how mental health liaison practitioners make sense of their experiences with decisions related to life-threatening self-harm

Participant Information Sheet

Background and aims of the study

Research shows that managing risk of suicide is a prevalent issue for mental health services. We also know that working with individuals who are suicidal has an impact on the wellbeing and clinical practice of staff. It is highlighted that mental health liaison staff are at increased risk of burnout, due to the unique combination of working in fast paced emergency departments, with patients who are at risk of suicide and with the added layer of working within uncertainty and the levels of responsibility.

Research has focused primarily on risk assessment tools for assessing risk of suicide, however little information is known about how staff working in liaison services experience and make sense of the decisions they are making around risk.

The aim of the study is to gain a deeper understanding of how mental health liaison practitioners experience and make sense of the effect on them of making a decision to discharge a patient home following life threatening deliberate self-harm. By gaining insight into these experiences, we hope to contribute to the existing knowledge of the experiences and effects of making mental health risk decisions, as well as the support needed for this staff group.

In this research study we will use the information you tell us during the interview process. We will only use information that we need for the research study. We will only let people involved in the study know your name or contact details if they really need it, however for those who do not need to know a number or code will be used instead. Everyone involved in the study will keep your data safe and secure. We will also follow all privacy rules. At the end of the study, the anonymised transcripts of the interviews will be stored in case it needs to be checked, however this will not be identifiable. The following information will tell you more about this.

Why have I been invited to take part?

You have been invited to take part because you are working as a mental health liaison practitioner for over a year. You have also identified that you have assessed an individual who has required medical intervention following deliberate self-harm and have made the decision to discharge home without any further immediate follow up from mental health teams.

Do I have to take part?

Joining this study is not compulsory and your decision to take part will not be shared with your colleagues, or have any effect on your job role. Participation is voluntary and you are able to ask questions before deciding whether or not to participate. If you do agree to participate, you may

withdraw your data without giving a reason, however it will only be possible to withdraw up until the data is anonymised and analysed by the researcher.

What will happen if I agree to take part?
If you agree to take part in the study, you will be asked to complete a consent form, and we will ask you a few questions to confirm whether your experiences meet the requirements for the study. Following this, you will be invited to an online meeting via MSTeams, at a time which is convenient to you. If you would prefer to conduct the interview in person, this will be facilitated in line with social distancing guidelines, and in a confidential space. The interview will last about an hour, and you will be asked about your experiences and how you made sense of these. This will be a semi-structured interview, with a few ideas of topics from the researcher, however it is hoped that these conversations will be open to allow for deeper exploration of your personal sense making of your experiences.
The interview will be recorded to allow for transcription, however this will be stored securely and information will be anonymous.

Are there any potential risks to taking part?
The risks are considered low given you have been doing this role for at least a year and the interview is about routine clinical practice. However, it is possible you may find some of the discussions distressing due to the nature of the topic, should this happen then the research team will provide support within the interview, and pass on contact details of organisations which may be beneficial should you wish to seek further support.

Are there any benefits to taking part?
There will be no direct benefit to you for taking part in this research, however your participation will be contributing to our current knowledge of experiences with risk decisions.

What happens to my information?
We will need to use information from you for this research project. This information will include your name and contact details (email address) for contact purposes whilst conducting the interviews. People who do not need to know who you are will not be able to see your name or contact details, your data will have a code number instead. We will keep all information about you safe and secure. One we have finished the study we will keep some of the data (the anonymised transcripts) so we can check the results. We will write the report in a way that no-one can work out that you took part in the study.

All information will be stored on a UEA secure encrypted drive and only the researchers will have access to your data The audio recordings of the interviews will be stored on a secure UEA OneDrive until they have been transcribed and analysed and then they will be deleted. Your consent form will be stored separately to the audio recording, so as to keep your information anonymous. Transcriptions will use a pseudonym to maintain anonymity.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have. This will be interviews that are already transcribed and anonymised.

- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you

You can find out more about how we use your information:

- at www.hra.nhs.uk/information-about-patients/
- in our leaflet available from www.hra.nhs.uk/patientdataandresearch
- by asking one of the research team
- by sending an email to Ellen Paterson dataprotection@uea.ac.uk, or
- by ringing us on 01603 592431.

Will the research be published?
It is hoped that the research will be published in scientific journals or presented at conferences for the wider mental health community. You will not be able to be identified in any publications due to anonymity of the data. Anonymised quotes from your interview may be used in publications.

Who has reviewed the study?
The study has been reviewed and received ethics clearance through both the University of East Anglia FMH Ethics. (ref no. ETH2122-0940) and the Health Research Authority (project ID: 311190).

Who do I contact if I have questions about the study?
If you have any questions you would like to discuss before or after your participation in the study, please speak to the researcher (Heather Lawrence) or their supervisor (Dr Adrian Leddy) who will do their best to support you with any queries.

- Heather Lawrence, Trainee Clinical Psychologist, UEA, heather.lawrence@uea.ac.uk
- Dr Adrian Ledddy, Clinical Lecturer & Clinical Psychologist, Dept of Clinical Psychology, UEA, A.Leddy@uea.ac.uk

If you would like to make a complaint
If you have any concerns about this research or would like to make a complaint during the research process then please do get in touch and we will try to resolve this for you. If you still feel dissatisfied then please contact the Director of the UEA ClinPsyD programme, Professor Niall Broomfield n.broomfield@uea.ac.uk

Appendix E: Consent Form

Understanding how mental health liaison practitioners make sense of their experiences with decisions related to life-threatening self-harm

CONSENT FORM

Ethics Approval Reference:

	Please initial box
1. I confirm that I have read and understood the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw without giving any reason, without my employment being affected.	☐
3. I consent for the interview session to be audio recorded.	☐
4. I understand who will have access to personal data provided, how the data will be stored and what will happen to the data at the end of the project.	☐
5. I understand how this research will be written up and possibly published. I understand how my contributions in interview will be used in publications.	☐
6. I understand that absolute anonymity cannot be guaranteed due to the use of direct quotes, but that the utmost care will be taken to anonymise and remove identifying information.	☐
7. I understand that I can change my mind and withdraw my interview data without giving any reason, up until the point the data is analysed.	☐

It will be my responsibility to contact the researcher to let her know if I wish to withdraw my information.

8. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

When completed: 1 for participant; 1 (original) for researcher site file

Appendix F: Interview Topic Guide

The below is an idea of the kind of questions we might be interested in and will help to answer the primary research question. These questions have been shaped by identified gaps in the research, supervision and through PPI involvement with two mental health liaison practitioners. Interviews will be kept in line with IPA guidance and the topic guide will not be used rigidly.

PRIMARY QUESTION: How do you experience and make sense of the effect on you when making a decision to discharge a patient home following life threatening deliberate self-harm?

1. Tell me about your experience with assessing someone following life threatening self-harm and then discharging home?
2. Tell me about the occasion which comes to mind?
3. What was that process like for you?
4. How do you experience the decision-making process?
5. Tell me about any impact these types of scenarios have on you
6. How do you make sense of your experiences with these situations?
7. Tell me about your experience after you have made the decision to discharge home

Appendix G: Participant Debrief Sheet

The debrief sheet will be sent out via email to those participating in the interview via teams and will be made aware this will be sent.

Dear [participants name],

Thank you very much for attending and taking part in this research study, your contributions were very much appreciated and will contribute to the knowledge about experiences with risk decisions.

Discussing suicidality and these particular situations of your professional career may be upsetting. It is quite normal that these conversations encourage us to look more closely at our emotional reactions, which may result in feeling sad or anxious after the interview. This may not last long, or it may also have a longer impact on how you feel. If you wish to discuss this with me then please get in touch.

If you find that you are beginning to find things more difficult and are experiencing distressing thoughts or feelings then please do get in touch with Dr Adrian Leddy, Clinical Psychologist in Mental Health Liaison at NNUH on a.leddy@uea.ac.uk or Adrian.leddy@nsft.nhs.uk. He will be able to offer a supportive space or debrief to those who would like some additional support. This is a routine part of his clinical role at NNUH, and as clinical supervisor of this project he is able to provide this to all participants.

Voluntary organisations:

Samaritans: 116 123 – free helpline available all day, everyday

Suffolk Mind: 0300 111 6000

Norfolk & Waveney Mind: 0300 330 5488

NHS:

Trust staff wellbeing services

FRS: 111 option 2

If you would like signposting to local services, or you feel the difficulties are persisting, please contact your GP.

Appendix H. Author Guidelines (Systematic Review)

Instructions for authors

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal's requirements.

Contents

About the Journal

Archives of Suicide Research is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

Archives of Suicide Research accepts the following types of article: articles, reviews, brief articles.

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**Usage in 2018-2020 for articles published in 2016-2020.

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Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

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A typical paper for this journal should be no more than 4000 (article)/4500 (review)/2000 (brief article) words

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Please use double quotation marks, except where "a quotation is 'within' a quotation".

Please note that long quotations should be indented without quotation marks.

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- Brief Article – 2000 words

References

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   Abstracts should be written in the following order: Objective, Method, Results, Conclusions

   Please also include a Highlights section after the abstract. This should be three bullet points of key highlights of your manuscript. Max of 85 characters per bullet point including spaces.

Read tips on writing your abstract.

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Updated 13th April 2023

Appendix I. Author Guidelines (Empirical Paper)

Journal of Psychiatric and Mental Health Nursing Author Guidelines

1. SUBMISSION

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We look forward to your submission.

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This journal expects data sharing. Review Wiley's Data Sharing policy where you will be able to see and select the data availability statement that is right for your submission.

Data Citation

Please review Wiley's Data Citation policy.

2. AIMS AND SCOPE

The Journal of Psychiatric and Mental Health Nursing is an international journal which publishes research and scholarly papers that advance the development of policy, practice, research and education in all aspects of mental health nursing. We publish rigorously

conducted research, literature reviews, essays and debates, and consumer practitioner narratives; all of which add new knowledge and advance practice globally.

All papers must have clear implications for mental health nursing either solely or part of multidisciplinary practice. Articles which draw on single or multiple research and academic disciplines are welcomed. We give space to practitioner and consumer perspectives and ensure research published in the journal can be understood by a wide audience. We encourage critical debate and exchange of ideas and therefore welcome letters to the editor and essays and debates in mental health.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

i. Original Research

Word limit: 5,000 words maximum, excluding abstract and references.
Abstract: 200 words maximum; must be structured under the sub-headings: Introduction; Aim/Question; Method; Results; Discussion; Implications for Practice.

Accessible Summary: 250 words maximum; the purpose is to make research findings more accessible to non-academics, including users of mental health services, carers and voluntary organisations. The Accessible Summary should be written in straightforward language, structured under the following sub-headings, with 1-2 bullet points under each: What is known on the subject; What the paper adds to existing knowledge and What are the implications for practice.

Description: The journal welcomes methodologically, ethically and theoretically rigorous original research (primary or secondary) which adds new knowledge to the field and advances the development of policy and practice in psychiatric and mental health nursing.

Relevance Statement: Only papers relevant to mental health nursing practice will be considered for publication in the Journal of Psychiatric and Mental Health Nursing. We require that corresponding authors submit a statement that-in 100 maximum, sets out the relevance of the work to mental health nursing practice. If authors do not convince the Editor in Chief of this, the work will not be considered for publication.
Reporting Checklist: Required - see **Section 5**.

4. PREPARING YOUR SUBMISSION

Cover Letters

Cover letters are not mandatory; however, they may be supplied at the author's discretion.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures; COI form.

Title Page:

The title page should contain:

i. A short informative title that contains the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips).
ii. A short running title of less than 40 characters
iii. The full names of the authors
iv. The authors' institutional affiliations at which the work was carried out
v. Corresponding author's contact email address and telephone number
vi. Acknowledgements.
vii. Ethical statements.

The present address of any author, if different from that where the work was carried out, should be supplied in a footnote.

Authorship

For details on eligibility for author listing, please refer to the journal's Authorship policy outlined in the Editorial Policies and Ethical Considerations section.

Acknowledgments

Contributions from individuals who do not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

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Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) format.

The main text file should be presented in the following order:

i. Title, abstract and key words;
ii. Main text;
iii. References;
iv. Tables (each table complete with title and footnotes);
v. Figure legends;
vi. Appendices (if relevant).

Figures and supporting information should be supplied as separate files.

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- As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

- Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

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Abstracts and keywords are required for some manuscript types. For details on manuscript types that require abstracts and/or keywords, as well as how to prepare them, please refer to the 'Manuscript Types and Criteria' section.

Keywords
Please provide up to seven keywords When selecting keywords, Authors should consider how readers will search for their articles. Keywords should be taken from those recommended by the US National Library of Medicine's Medical Subject Headings (MeSH) browser list at **https://www.nlm.nih.gov/mesh/**.

References

For details on references please refer to the 'Manuscript Types and Criteria' section.

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

A sample of the most common entries in reference lists appears below. Please note that a DOI should be provided for all references where available. For more information about APA referencing style, please refer to the APA FAQ. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page one.

Journal article
Beers, S. R., & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry,* 159, 483–486. doi:10.1176/appi.ajp.159.3.483

Book
Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document
Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from http://www.youtube.com/watch?v=Vja83KLQXZs

Tables
Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote

symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

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Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

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Although we encourage authors to send us the highest-quality figures possible, for peer-review purposes we are happy to accept a wide variety of formats, sizes, and resolutions. **Click here** for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements. Figures submitted in colour may be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white.

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The following points provide general advice on formatting and style:

- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website at www.bipm.fr for more information about SI units.
- **Spellings:** should conform to those used in the Concise Oxford Dictionary.
- **Footnotes:** should be avoided.

Appendix J: Analysis examples

Exploratory Comments	Original Transcript	Experiential Statements
We – generalising – impact of team Comparison of this job to previous Good bit is a new experience – feels nice/comforting? • I – her personal experience • Then moves to we as talk about process Comfort of shared risk? Is this better? Why is shared risk better – reduction of fear of being singled out? Face consequences alone? Space to think & discuss – Reassurance of other people, Time and space – feels safer? Reassurance of other professionals opinion – checking out, reduces anxiety? The experience is not how other people maybe expect or what she maybe expected Trying – highlighting that may not always be the case Best – how do you know what's best – Restricted by… info/what they want/services – limited by certain factors … Think.. less certain? Less sure of talking about the bits that feel 'negative'/'hard'	Hmm. Erm what I think we find so good about this team, which I haven't experienced in the same way, having come from a background of working community teams and inpatient is is that a lot of the work particularly with A&E and with the very risky people is done in pairs, so that already feels, like some of that risk is shared and we'll go away into our office and have a discussion. And often there are other people in the office that we might bring in. So for example, with this lady, we spoke to our psychiatrist and and just kind of had a bit of a think through what our options were we happen to have an AMHP in the office at the time as well. So she was asking about, you know, whether she has capacity and things so so it feels quite erm.. . Even though you think everything in A&E or in hospital is all quite rushed, it also feels quite thoughtful and and, you know, trying to make the best decisions with the information we've got with what someone's telling us and what they want and and obviously what services can provide and yeah, so um, so I think that kind of limits it a bit whereas you know in a way coming from a community team where you had a caseload that you were holding	Speak on behalf of the team – group decisions Comparison of this role to previous jobs to add context **Drawing on past experiences increases confidence in a decision** Shared decision making = shared responsibility – seems big part of how this helps **Shared decision making is the most important factor in my experience** Time and availability of other staff members Reassurance from other staff members – value MDT skill mix they bring helps decision Capacity can be assessed by others to provide MDT thinking The slow thoughtful process is not what is expected from A&E
Able to move more into reflection and 'bigger picture' – links back to the idea of hope? But focusing on the patients experience rather than her own.. Limit of what you are able to do – that's the hard bit? Balance of thoughts – not just one idea, constant to and fro of it's hard but.. there are good bits – does this help mediate the difficult feelings? Privilege – driver for doing this work/ feels lucky to be doing this? Helps with lack of control – able to do something in a system that feels limited - like you 'can only do what you can do'	But yeah, I think I also kind of on reflection can see that for some people. And, you know, things will get better and others, you know, sadly, life is gonna be hard for them. And and you can only do what you can do. And I I I do find that hard to accept. But at the same time I think well, at least I'm in a place where I can help and and in such a position of privilege for that.	Focus on the patient experience instead of their own Bigger picture provides a different story to the immediate one There is a finite limit on your actions – can only do what you can do **There are some things which are out of my control which you have to accept to keep going.** Balance of good and bad part of the job I feel lucky to be doing this job – it's a privilege **I feel lucky and privileged to be able to help which is an important value to me.** Reframe it – important to do this

Table 1. Examples of developing participant Experiential Statements

Table 2. Examples of Developing Personal Experiential Themes (within participants):

Experiential Statements	**Personal Experiential Theme**
There is always a strong desire to check a person's outcome to help ease the uncertainty. I believe that being uncertain is a useful and important part of the job I allow myself to worry as I think it's normal however it is important to balance this with distance from the job to maintain wellbeing.	**Managing uncertainty**
I recognise and accept there is a limit to what I am able to change with a patient's personal context There are some things which are out of my control which you have to accept to keep going.	**Accepting what I cannot change is a key part of my experience**

Table 3. Examples pf Developing Group Experiential Themes (across participants):

Participant Personal Experiential Theme	**Group Experiential Theme**
P3: There are limits to what I am able to do P5: You can make the soundest judgements an have the poorest outcomes – acceptance P8: Accepting what I cannot change is a key part of my experience	"You can only do what you can do"
P7: Reflecting on the power of uncertainty P2: I have to accept I cannot remove risk completely P1: Acceptance that worry and stress will not go away completely	"The only certainty is uncertainty"