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Patient perspectives of helpful risk management practices within mental health services. A mixed studies systematic review of primary research

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MR. KRIS DEERING (Orcid ID : 0000-0001-9723-5524)

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**Patient perspectives of helpful risk management practices within mental health services.
A mixed studies systematic review of primary research.**

Title page:

- i. Patient perspectives of helpful risk management practices within mental health services.
A mixed studies systematic review of primary research.
- ii. Beneficial risk management practices.
- iii. Kris Deering¹, Dr Chris Pawson², Dr Neil Summer² and Dr Jo Williams¹
- iv. ¹Mental Health Nursing Department, Faculty of Health and Applied Sciences, University of the West of England, Glenside Campus, Blackberry Hill, Stapleton, Bristol UK BS16 1DD

² Psychology Department, Faculty of Health and Applied Sciences, University of the West of England, Frenchay Campus, Coldharbour Ln, Stoke Gifford, Bristol BS16 1QY

³ Faculty of Wellbeing, Education & Language Studies School of Health, Wellbeing and Social Care, Open University, Walton Hall, Kents Hill, Milton Keynes MK7 6AA
- v. Kris Deering Kris3.deering@uwe.ac.uk +44 (0)117 32 88545
- vi. Acknowledgements: Jenny Fletcher: Senior Practitioner: Sandlewood Court, Swindon UK & Ivor Bermingham: Community Involvement Coordinator, Swindon, UK.
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Accessible Summary

What is known about the subject?

- Risk in psychiatry involves harm to self or others owing to mental health difficulties, for example iatrogenic effects of treatment, self-harm, suicide and violence.
- Risk management is a framework to minimise risks, comprising of risk assessment, generation of risk management plans, and evaluation of interventions.
- Literature has extensively explored risk management and presented a critique that its practices can lead to patient harm. However, there is a paucity of literature about what patients identify as helpful risk management practices, despite the potential for such patient views to ameliorate harm and improve mental health care.

What this paper adds to existing knowledge

- Interpersonal relationships with clinicians, and communication that keeps patients involved and informed of management processes, were found to be central to beneficial risk management practices, while patients having agency and autonomy to influence their participation was also important.
- Beneficial interpersonal relationships and connectivity in the form of patients' wider community of support was found to be influential in aiding risk management. Meaningful relationships, and particularly peer support, that maintained personal and collective identities were prevalent in the literature.

What are the implications for practice?

- Rendering risk management more visible and accessible in practice might cultivate an openness that promotes patient participation. This includes drawing on a wider network of support, for example, the patient's friends and family, as well as having advocacy utilising peer-support.

Abstract

- **Introduction:** Minimising the harm that patients pose to themselves and others, due to mental health difficulties, is a central component of risk management in psychiatry. However, risk management itself can cause patient harm, but despite this and the potentially informative value of lived experience, little is known about what patients want or expect from risk management.
- **Aim:** To review research and explore what patients consider beneficial in risk management practice.
- **Method:** A mixed-studies systematic review utilising PRISMA guidelines, alongside a convergent qualitative design to categorise findings.
- **Results:** 12 papers were identified, generating two categories of beneficial practices: interpersonal relationships and communication with clinicians; coupled with patient agency in their own risk management.
- **Discussion:** Connectivity appears important. Particularly patients feeling involved, and their voices being heard in both the identification of risks and then shaping risk management practice. Moreover, this included involvement of friends, family, and peers to widen input and supportive networks beyond clinical relationships.
- **Implications for Practice:** Risk management needs to be an accessible part of care, which is more inclusive of patient views and needs. The latter might also be aided by drawing on the patient's wider community in order to provide more effective support and risk management.

Relevance statement.

Mental health nurses engage in risk management as a function of their daily practice in most psychiatric settings. Despite many studies exploring how to assess and plan risk interventions, little is known about what risk management practices patients might value. This knowledge has significance to nursing owing to studies suggesting that its practices can be inadequate, leading to patients experiencing harm. Hence, drawing on patient views to un-

derstand what practices are helpful, may better inform how risk management might become a more collaborative part of care.

1. Introduction.

1.1: Aim of systematic review

This paper presents a mixed-studies systematic review (SR) of research published in journals, detecting beneficial risk management methods identified by mental health patients. Whilst practices may differ internationally, risk management is often an intrinsic part of most worldwide psychiatric settings (Health Service Executive, 2009). Psychiatry has customarily categorised and assessed risk as calculable harms that patients may inflict on themselves and/or others due to mental health difficulties; notably self-harm, suicide and violence (Briner and Manser, 2013; Higgins et al. 2015). Hence, risk management can comprise of a diverse combination of practises informing decision-making in the assessment and alleviation of risks, to improve safety and mental health (Gilbert et al. 2011; Royal College of Psychiatrists (RCP), 2016). This is notwithstanding contemporary definitions, which acknowledge risk management involves more than lessening deliberate harm and can include, taking calculated risks that improves quality of life (Crowe and Deane, 2018).

Despite multiple academic articles and policies advocating that patient participation is needed within risk management (DH, 2009), there are no apparent SRs which explore what patients want from its practices. Previous reviews have gravitated towards improving assessment and prediction of harm; predominately capturing and synthesising clinical views (Higgins et al. 2016). Although the latter has contributed to the assessment and amelioration of risks inherent in some mental illnesses (Ackling, 2017), there is limited understanding of what practices have utility from a patient perspective (Faulkner, 2012). This is in surprising contrast with literature which theorises management approaches that patients might value. Notably, Perkins and Repper (2016) suggest clinicians collaborating with patients improves the effectiveness of risk interventions, while more meaningful risk assessments can be produced by exploring the personal significances of risk to patients (Morrissey et al. 2018).

To further understand risk management, this paper explored primary research investigating what patients identified as beneficial practices; this was to expand knowledge on what might be helpful and advise on the direction of future research. A mixed studies approach examining qualitative, quantitative and mixed-methods studies was adopted to broaden the inclusion of investigations (Gough, 2015), while research was selected if it examined patient experiences, recommendations, or measured what they found useful. Moreover, the review was informed by PRISMA guidance for evaluating mixed-studies; this was to improve reporting, and employ rigor with the process of identifying and analysing research (Moher et al. 2009).

1.2 Current terrain of risk management

The UK Department of Health (DH), (2009) policy advises that risk management is a joint decision-making process between clinician and patient, making best use of patient strengths and aspirations, to strive for what they consider is valuable. Emphasis is not on risk prediction, rather management is informed by personal growth, whereby risk-taking is seen as part of daily living, underpinned by understanding that risk involves having opportunities to make life more satisfying (RCP, 2017). For this to occur, Reid et al. (2018) propose that this requires clinicians to share power, so that patients have active roles with navigating their own safety. This is echoed in policy, in that promoting safety is not only an end-point of risk management, but patients feel safe to engage in its practices (DH, 2009). The therapeutic relationship between patients and clinician is therefore crucial to foster patient opportunities, in the exploration of what risks are, and ways to feel safe (Felton, et al. 2018b). That said, participatory approaches are not always evident with risk management. Higgins et al. (2016) proposes owing to insufficient opportunities to contribute to risk management, patients have limited involvement with promoting their own safety. Moreover, hospital patients suggest safety overly focuses on preventing physical harm, not as they prefer, which is for safety to include promoting their quality of life (Berg et al. 2017).

Given the uncertainty of some risks in psychiatry, alongside anxieties about professional culpability, there is criticism that practitioners may utilise more risk aversive methods to prevent harm (Felton et al. 2018a). This can be in light of wider societal trends in risk avoidance, as well as misconceptions perhaps, that mental health difficulties increase risk illitera-

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cies, and dangerousness (Beeber, 2018). Moreover, tensions with risk management and therapeutic relationships might be exacerbated, as 'safety' goes beyond individual care, and includes 'other patients, staff and the general public, widening the sphere of risk' (Slemon et al. 2017:1). While it is acknowledged these situations are multifaceted, literature suggests they do shape a risk preoccupation, which some stakeholders believe is to the detriment of mental health care (RCP, 2010). There is concern that risk management is disproportionately focused on patient inadequacies, further marginalising people who experience mental health difficulties (Felton et al. 2018a). These negative perceptions not only erode therapeutic relationships but can also provoke 'dehumanising and distressing' risk management practices (Mind, 2013:12). Moreover, the abolition of such practices has been called for by the United Nations Human Rights Council (2017) - notably physical restraint, seclusion, and ward confinement (Larue et al. 2009). This has led to suggestion that patient participation needs to develop in risk management, as to identify safer clinical ways to navigate risks (McSherry, 2014).

2. Rationale and objective.

[Table 1: systematic review databases. To be placed here]

The current review of practices that patients find helpful is supported by the aforementioned impact of risk management on patients, and the understanding that patient views can improve mental healthcare (World Health Organisation, 2017a/b). A preliminary search was conducted in February/March 2018 to establish the originality of this SR. Detected papers emerged from the databases shown in table 1, and included; patient interpretations of safety, risk predication, and papers drawing on clinical views (Berg et al. 2017; Chan et al. 2016; Levin et al. 2016).

Overall, no reviews were located, suggesting an underrepresentation of not only patient voices, but also the voices of friends and family of patients who can have supportive roles within risk management (Lagan and Lindow, 2004). The closest relevant review was Eidhammer et al. (2014), which appraised patient involvement in lessening violence, but did not explore patient views on beneficial risk management practices. However, there was some relevant literature pertaining to the subject matter in the form of individual articles with a tendency to point towards more recovery-orientated practices. Such practice is a

principle of mental healthcare whereby life satisfaction is promoted irrespective of mental health difficulties (Slade and Longden, 2015). Recovery was associated with safety planning, involving taking calculated risks to promote a meaningful life; coproduction of management plans and enhancing social activities to lessen the risk of social exclusion (Callaghan and Grundy, 2018; Higgins et al. 2015; Kanerva et al. 2016; Perkins and Repper, 2016).

The literature search was directed utilising the established UK Department of Health (2009:6) definition: 'risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused'. To lessen misrepresenting findings, the SR focused on literature that explicated research related to 'risk assessment(s)' and/or 'risk management' in the text. These limitations were employed so practices identified by patients reflected current policy directions, in which risk management is a framework comprising of risk assessment, devising plans to lessen harm, and evaluation of interventions (DH, 2009).

The review explored risk in how patients determined the term, as well as traditional notions of risk in psychiatry. This was to detect practices identified by patients to have utility; for example, owing to a shared grasp of what risks are between patient and clinician, besides addressing familiar 'risks' aimed to be minimised in care. Drawing on the RCP (2016/2017) factors were risk to self; neglect, substance misuse, exploitation, abuse, self-harm and suicide. Risk to others included violence, exploiting and abuse, while offending and recidivism informed both risk to self and others.

3. Methods.

3.1: Justification for a mixed-studies review

Given the limited presence of patient perspectives in the risk management literature (Eidhammer et al., 2014), the SR employed a mixed studies design to maximise the capture of relevant studies. Moreover, it was thought to be particularly important to include qualitative and mixed-methods research that may capture patient lived experiences of practices that might be helpful.

3.2: Eligibility criteria

[Table 2: Inclusion and exclusion criteria. To be placed here]

The search limited literature to peer reviewed journal articles for academic rigour and within the last ten years in order to ensure contemporary findings. The patient population was defined by adults of working age (18 to 67), while international articles were included as risk management has global relevancy to mental health services. The inclusion criteria comprised of primary studies of patient perspectives or, measured patient views in what was beneficial, such as via a satisfaction survey. Also accepted were studies illustrating patient recommendations to develop understanding on what could improve risk management. However, papers were excluded when studies were ambiguous if patient views were collected or did not explain if the items being measured were found helpful by patients. For example, while predicting risk may have some benefit with gathering data that could lead to minimising harm, this is not to say items measured were informed, and deemed beneficial by patients, or even if predicting risk using set measures, is a helpful practice according to patient views. For the full inclusion and exclusion criteria, see table 2.

All attempts were made to locate literature, however owing to the breadth and variety of risk management practices, it is possible that some articles are inadvertently absent. However, as fig 1 shows, 60,775 duplicate citations were removed, suggesting a saturation point had been reached, in which the search would be unlikely to find different literature.

3.3: Information Sources

During 1st of April and 31st August 2018, the following health and social care databases were searched following a scoping exercise to assess if they contained full text research articles on risk management in mental health care or psychiatry, alongside studies involving patients as participants: AMED (Allied and Complementary Medicine), ASSIA (Applied Social Sciences Index and Abstracts), BNI (British Nursing Index), CINAHL Plus (Cumulative Index to Nursing and Allied Health Literature), EMBASE, Emerald, MEDLINE, ProQuest Sociology, PsycINFO, Scopus and Social Services Abstracts.

3.4: Literature Search

[Table 3: Search terms. To be placed here]

To yield more results and conduct an 'exhaustive' search of the literature, the full text of databases was scanned (Booth, 2016). A senior university librarian gave guidance to develop the accuracy of searches. 'Psychiatry' or 'mental health' signified the explored setting, while 'risk management' or 'risk assessment' denoted the practice(s) being investigated; lastly the examined population was reflected by synonyms for 'patient'. This combination was searched with a risk management practice or term denoting patient involvement, both detected in a preliminary search of the literature, or a risk factor as identified by the RCP (2016/2017). Search terms were combined using Boolean operators; AND/OR, while truncations (*) expanded searches, for example; ((mental health) OR (psychiatry) AND (risk manag*) OR (risk assess*)) AND ((service user*) OR (patient*) OR (consumer*) OR (survivor*) OR (client*)) AND (streng*) (See table 3).

3.5 Critical appraisal

Owing to the review question being novel, no studies were excluded because of methodological issues. However, to explore the future direction of research in the discussion, studies were appraised using the Mixed Methods Appraisal Tool (MMAT, Hong et al. 2018). The tool was adopted to aid the evaluation of qualitative, quantitative and mixed methods study designs, while appraising features such as researcher bias, appropriateness of measures, integration of qualitative and quantitative research, and sampling techniques (Hong et al. 2018). In addition, as the review centred on patient perspectives, the MMAT was employed primarily to assess the authenticity in how these views were interpreted (See table 4).

3.6 Synthesis and data collection process.

A convergent qualitative design was utilised, to transform all results into a qualitative format, for example statistical findings were reported using words. This approach was applied as it allows heterogeneous research to be synthesised into the same review (Pluye and

Hong, 2014). Firstly, beneficial risk management practices were inferred from the study findings, and then those that related to each other were then categorised and assigned a label to epitomise the data held by the category (Pluye and Hong, 2014). Moreover, whenever possible, patient quotations were employed in the synthesis to support findings, as well as promote the authenticity of results.

4. Results.

4.1 Study selection

[Figure 1: Literature selection. To be placed here]

Screening for suitable research (Fig. 1) commenced with removing duplications, then excluding articles when titles and abstracts did not match the inclusion/exclusion criteria. To minimise bias, this extraction process was conducted by two independent reviewers, with intermittent discussions to check progress, and ensure consistency of approach.

Most articles did not explicitly explore what patients considered as helpful from risk management, but as recommended by Sandelowski (2007), concepts under investigation can be sought in different areas of the literature. Hence, eligibility of studies was determined by reading the full text of remaining papers, by detecting sentences in the findings that indicated to what practices patients did find useful. If such data was not present, the papers were excluded. However, to account for a possible shortfall of studies, research was accepted if other perspectives, such as clinical opinion, were examined alongside patient views.

4.2 Study characteristics

12 studies fit the review criteria (See table 4). Research derived from the UK ($n = 9$), USA ($n = 2$), and USA with Denmark ($n = 1$). Forensic placements ($n = 6$) represented 50% of all settings, followed by community and outpatients ($n = 3$), then community and hospital ($n = 2$). One study by Coffey et al. (2017) drew on multiple sites. The majority of studies were qualitative ($n = 7$), owing to how patient experiences could satisfy the review question, nevertheless quantitative ($n = 2$) and mixed-method studies ($n = 3$) were also located. The Collaborative Assessment and Management of Suicidality (CAMS) was the sole risk management

framework identified that employed patient views, showing how patient participation improves risk management. However, despite a purpose of risk management, promoting safety did not appear investigated with what practices patients found helpful, while one study examined recovery. The latter verified findings by Holley et al. (2016) that the recovery concept is rarely researched with risk management practices.

4.3 Result from appraisal

Most studies employed data collection and analysis methods suitable for the study aim ($n = 10$), while some response rates appeared on the low side ($n = 2$), indicating that results may not fully reflect the patient population (Hong et al. 2018). In addition, member-checking which can comprise of participants authenticating the researcher's findings (Lincoln and Guba, 1985) was not always evident in the qualitative studies ($n = 5$). Member-checking does have limitations, notably participants can disagree with interpretations, yet may concede owing to the asymmetrical power relationships with researchers (Karnieli-Miller et al. 2009). Nevertheless, while acknowledging limitations, member-checking in this review was informed by Birt et al. (2016), involving participation beyond being asked to merely validate results. The focus herein is on patients having an opportunity to be immersed in the whole research process, in order to co-construct knowledge, and with a view to generating more meaningful findings for both participants and researchers.

[Table 4: Reviewed literature. To be placed here]

4.4 Results of synthesis

In order to report the results, the category labels generated from the literature findings will be presented as headings followed by a narrative synthesis to illustrate how the labels were determined. From the study findings, multiple categories were initially located, but because of similarities, these were amalgamated into the two shown below; this was to reflect how beneficial practices implicated clinical relationships, alongside the means patient had to shape involvement and support with risk management.

4.5 Interpersonal relationships and communication

A key finding was that interpersonal relationships and communication were important to risk management in how patients felt informed with management processes. This was consistent with the messaging in several of the policy sources referred to in section 1.2. While patients shared that the mere presence of a clinician was helpful to give comfort (Schembari et al. 2016), relationships that were able to facilitate risk management required mutual trust (Brown and Calnan, 2013; Long et al. 2012). This was signified by a link between trust and meeting patient need. Notably that their distress was understood, or when patient views were validated, for example, whilst reviewing treatment options with clinicians (Brown and Calnan, 2013);

'I ... tell her how I'm feeling and what's going on and I can say "I want to take Haloperidol because I am ill" ...I can...touch base with her... but they have to trust me. I'm not the overdosing type. They have to trust and if they trust, I'll trust them...' (Brown and Calnan, 2013: 251).

Beneficial risk management from the patient perspective was associated with the gradual cultivation of trust. This was to nurture an openness with relationships, so patients felt able to discuss risks, while staff respectfulness made troublesome topics (i.e. those delicate to the patient) easier to discuss (Lang et al. 2009; Long et al. 2012). Patient desire for sincerity and collaboration was also met when they felt listened to, even though there were disagreements (Long et al. 2012). Disputes, it seemed, were recognised by some patients as an authentic part of therapeutic relationships which openly discussed risks, especially when it might require confronting difficult issues (Dixon, 2012; Long et al. 2012). Hence, it was acknowledged that staff perseverance and commitment with maintaining interpersonal relationships, in light of disagreements, was helpful to keep dialogue open and enable a concerted management of risks (Brown and Calnan, 2013; Holly et al. 2016). This necessitated a patient awareness that risk management was a visible and approachable feature of their care, whereby patients spoke of the worthwhile, yet straightforward discussions with staff to transverse risks, accompanied by mutual cooperation, so compromises could be made (Coffey et al. 2017; Dixon, 2012);

'...I was quite happy with [compromises]...they are professionals...so I have to give it...out of respect' (Dixon, 2012:672).

Clinicians diversifying their interpersonal approach were equally helpful, involving a thoughtful curiosity with questioning, so patients gained perspectives on their risks and explored ways that might aid coping (Mckeown et al. 2016; Schembari et al. 2016). This was detected with devising safety plans with patients and facilitating learning, to make sense of past difficulties, and acquire proficiencies which could promote life-satisfaction (Holley et al. 2016). Striking however, was the study by Pulsford et al. (2013), which located beneficial practices linked to managing risks via physical means, such as seclusion, as patients did not wish to be victims of risks, notably violent acts. Still, patients identified how the closeness of therapeutic relationships, along with staff abilities of verbal negotiation, might lessen violence and aggression; while it was also advocated that clinicians were not always involved in every volatile incident, as patients were able to resolve some issues themselves (Pulsford et al. 2013; Reynolds et al. 2014).

However, despite the literature revealing several benefits of interpersonal relationships and communication, patients could be passive recipients of risk management, particularly in forensic settings (Coffey, 2012; Reynolds et al. 2014). It was suggested that staff had reservations about whether patients grasped the severity of their risks, especially to others, and this resulted not asking for their input (Coffey, 2012; Dixon, 2012). That said, patients in these studies desired relationships that discussed risks but how risks were defined appeared to conflict with staff perspectives. Instead, patients opted to speak to fellow patients to gain support, perhaps due to the reciprocity of these relationships, and a shared understanding that a loss of personal and collective identities also constituted a risk (Coffey, 2012; Dixon, 2012; Reynolds et al. 2014);

'The patients help each other, don't trust the doctors and nurses...The patients meet in the evenings and talk about what happens day-to-day, keep in touch with reality, with our reality and the outside world' (Reynolds et al. 2014: 206).

4.6 Patient agency and autonomy

While interpersonal relationships and communication aided risk management to be more inclusive for patients, agency and autonomy related to patient decision-making, along with shaping their involvement and the support they received. A common thread was that pa-

tients preferred clinicians to hold responsibility for risk management, at least initially, with patients setting the pace of gaining back control (Long et al. 2012; McKeown et al. 2016; Schembari et al. 2016). This was encouraged by clinicians, instilling a sense of hope and self-belief that patient could attain engagement with risks management (Long et al. 2012; Schembari et al. 2016);

'Progressing on the treatment pathway at your own pace...[not being] overloaded' (Long et al. 2012: 572).

Trust, it seems, not only aligned to meeting a patient need, but had an empowering value for patients. This was by patients reciprocating the trust offered by clinicians and being less hesitant with sharing concerns (Brown and Calnan, 2013; Reynolds et al 2014). Moreover, because staff validated patient accounts, risk took on an extra saliency for patients, as they could discuss issues relating more to everyday experiences (Holly et al. 2016; McKeown et al. 2016). However, opportunities for patients to exert autonomy and agency appeared conditional on the type of risk assessed. Notably, there were repercussions from risk rating violence and how patients experienced agency. For example, patients felt marginalised when rated at high-risk, as practices to minimise risk restricted life opportunities; whereas, low-risk evaluations improved agency, as patients felt more able to enact personal choices owing to experiencing less restrictions from clinicians (Coffey, 2012; Dixon, 2012). To redress the balance, patients indicated their strengths and abilities could be assessed to mitigate risks, as assessment solely on harm overlooked their qualities as people (Dixon, 2012; Long et al. 2012);

'...of course, it paints you...in your worst situation, whereas you would always like to be seen in your best situation. But that's a natural thing, because ...the whole purpose of identifying risks is to enable people in, the professions, to actually recognise improvements...' (Dixon, 2012:674).

'Being acknowledged as a person' (Long et al. 2012: 572).

Nevertheless, some patients voiced enthusiasm for assessment, significantly when relating to the prevention of suicide. They observed that assessment led to productive conversations, or further exploration that otherwise would not have been disclosed (Comtois et al. 2011; Lang et al. 2009). Moreover, alternative ways of coping that emerged from conversa-

tions aided agency, for patients developed choices in how to manage risks (Schembar et al. 2016);

'It is good to screen', 'this can save lives', and 'I felt better afterward by letting my therapist know' (Lang et al. 2009: 163).

'The feeling of being heard, taken seriously...' and *'I now know where to go, which I did not before'* (Schembar et al. 2016:221).

It emerged from the literature, that although agency and autonomy assisted patients to explore personal preferences with risk management, this was a coexistent relationship, when having the freedom to explore, and implement changes, further developed agency and autonomy (Coffey et al. 2017; Comtois et al. 2011). This coexistence appeared to cultivate more meaningful management plans and broaden opportunities to navigate risks (Holly et al. 2016; Schembari et al. 2016). In addition, patients related to agency and autonomy when speaking of the benefits of collective forms of involvement, cultivating a sense of belonging by their views enacting changes to service delivery (McKeown et al. 2016). Although, description of service delivery was inexact, it appeared to include risk management, when change linked to hospital settings, as it was felt these environments could aggravate risks of violence and aggression (Pulsford et al. 2013).

'If the physical environment were different, patients would be less aggressive' (Pulsford et al. 2013: 300).

'You'll get general managers moaning to commissioners and you think yes, I'm part of something here...you get insights into the way things work...' (McKeown et al. 2016: 573).

Given the significance of autonomy and agency with interpersonal relationship, it was also recognised that drawing on the patient's wider community could be beneficial with risk management (Holly et al. 2016; Schembari et al. 2016). Studies revealed utilising friends and family strengthened support networks, furthering patient choices to who they may speak to, while social connectivity with significant others evolved personal coping strategies (McKeown et al. 2016; Schembari et al. 2016). It was also indicated that utilising friends and family for support, rather than only services, might alleviate some feelings of social stigma associated with risk monitoring. As the narrative below shows, stigma materialised when patients were frequently visited by clinicians in the community, with patient concern that

these visits gave the impression they were somehow unusual, to those living nearby (Coffey, 2012);

'Yeah, risk [has been discussed with me]...even my family and friends. . . if I want to confide in someone, they know certain risks, risk factors and other things that could cause relapses' (Coffey et al. 2017:474).

'The more distance you feel about the relationship and it becomes difficult to ask them for help...' (Coffey et al. 2017:474).

'They may see, when you've been discharged from hospital...you get people coming to your house with briefcases, and doctors and nurses and all that sort of thing. It looks a bit funny, you know...' (Coffey, 2012:474).

5. Discussion.

5.1 Overview of findings

Despite controversies with risk management, this review found that when patients felt involved and had a voice, beneficial practices could emerge. Interwoven within the two categories found, the undertone of connectedness was identified. This was most notably within the therapeutic relationship and in terms of patients feeling invested in risk management (Holly et al. 2016; Lang et al. 2009). This was particularly evidenced when there was flexibility in exploring what risks are, alongside openness that risk management occurs as part of care (Brown and Calnan, 2013; Coffey et al. 2017). Moreover, patients felt engagement with clinicians and opportunities to explore risks was a valuable practice in itself, irrespective of how this ultimately impacted on risk outcomes (McKeown et al. 2016; Schembari et al. 2016).

Connectedness to the wider community and environment was also important, particularly, where patients had collective involvement and their views enacted meaningful changes to minimising risks (Long et al. 2012; Pulsford et al. 2013). Strikingly, a deeper understanding of the patients' lives outside of mental care developed connectedness, in particular, relating risk to everyday experiences and drawing on their wider community for support (McKeown et al. 2016; Schembari et al. 2016). This however was not always apparent in practice, yet patients appeared to have need for support to go beyond clinicians and beyond clinical risks narratives (Coffey, 2012; Pulsford et al. 2013). For example, there was value in patients

speaking to their peers, such as fellow patients, as they understood their predicaments better, while limiting the risk of losing personal and collective identities; for it was felt, services overly characterised patients in terms of risk, rather than people (Dixon, 2012; Reynolds et al. 2014).

Studies have acknowledged that tensions involving risks can lead clinicians to avoid patients, as a way of circumventing risk anxieties and concerns about culpability (Felton et al. 2018a). However, what this review adds is that when clinicians acknowledge these tensions, and offer space to negotiate, a valuable shared understanding can emerge. Acknowledgment that disagreements are not unusual, and that examining risk can be challenging, is particularly salient to beneficial risk management practice (Coffey, et al. 2017; McKeown et al. 2016). Importantly, patients expressed the value of staff perseverance with maintaining relationships despite differences. Giving time for trust to build, founded on understanding the patient's distress, and validating their views was particularly important (Brown and Calnan, 2013; Holly et al. 2016). This did appear problematic however, when violence was assessed, as patients felt this risk suppressed other risks that had more personal meaning. Although, patients suggested that there still could be consideration to their strengths and qualities as a person, even in light of past violence (Long et al. 2012; Pulsford et al. 2013; Reynolds et al. 2014). Nevertheless, patients spoke favourably when assessment related to suicide prevention, as it aided conversations and evolved personal coping strategies (Comtois et al. 2011; Lang et al. 2009). Connectivity also had a place, as literature reveals feeling a burden to significant others, may influence suicide (Cawley et al. 2019). This demonstrated the significance of involving friends and family in risk management, to show the person is of worth, while widening their support networks (McKeown et al. 2016; Schembari et al. 2016).

5.2 Recommendation for research

The appraisal adopted the MMAT to evaluate research in a mixed-studies SR, however as the review involved patient views of beneficial risk management practices, analysis focused primarily on how these views were interpreted. A potential discrepancy was a lack of detail in how interpretations were verified by participants. Given that literature criticises an absence of patient involvement in risk management (Felton et al. 2018a), it follows, at least

ethically, that patient participation is more considered when their views are utilised in research. Hence, whilst acknowledging the aforementioned limitations, it is recommended that future studies consider member-checking as characterised by Birt et al, (2016). This is so when exploring patient views on risk management, there is opportunity for patients to contribute throughout the whole study, rather than the potentially tokenistic gesture of only validating the researcher's results (Karnieli-Miller et al. 2009).

Risk was captured in more traditional terms of psychiatry in the reviewed studies, comprising of forms of deliberate harm. While this might reflect societal trends with risk involving negative outcomes, risk can be explained as the likelihood of loss or gain, of something valued (Curran, 2016), and perhaps, a shift in research is required that 'gain' is more investigated. The latter might identify how risk management can be more inclusive of the personal growth associated with recovery, whereby promoting quality of life aids patients with navigating risks (Holly et al. 2016). This resonated with some findings in the review, in which patients illustrated helpful practices that evoked recovery, such as enhancing social connectivity. However, risk management can generate obstacles for patient recovery, notably restricting involvement and decision-making (Repper and Perkins, 2016); hence to understand how recovery may coalesce with risk management, research might first explore the ways patients feel safe, so they can engage in recovery as part of risk management.

5.3 Implications for practice

Literature in the review as well as elsewhere, has illustrated patients can be excluded from risk management, or they are unaware of its existence (Bennison and Talbot, 2017; Coffey, 2012). There might be value therefore with rendering risk management more visible in practice, to increase patient opportunities to participate. Although tensions may emerge, some patients do appreciate deliberating risks can be emotive (Brown and Calnan, 2013; Long et al. 2012); this echoes staff views in some studies, in which honesty about risk, and openness about its practices might alleviate frictions (Langan, 2008). Moreover, practice may benefit by reflecting on patient connectivity; if they feel involved in risk management, and how risk management connects to their world beyond psychiatry, markedly, friends and family to widen support, while envisaging risk within their everyday experiences (Lagan and Lindow, 2004).

The review also illustrated connection to oneself as noteworthy, in order for patients to maintain authentic identities (Coffey, 2012). However, clinical duties involving public safety, besides protecting patients even from themselves, can mean the person might become lost within clinical risk narratives (Clancy et al. 2014; Heyman, 2004). Patients found peer support helpful in such circumstances, speaking to fellow patients instead of staff, as it was felt a focus on some risks were unsurmountable, particularly violence (Dixon, 2012). Nevertheless, patients desired relationships that discussed risk, albeit in different contextual lights (McKeown et al. 2016). Along these lines, there is seemingly appeal for advocacy in risk management, so the personal perspectives and interests of patients are more heard (Molas, 2016). This is also in recognition that at times, clinicians might be limited to embrace all patient concerns about risks. However, peer advocacy, if independent from healthcare organisations, could be a step towards improving patient representation in risk management (Ridley et al. 2018), while peers having had similar experiences, might better understand how managing risks may impact on patient lives (Scott et al. 2011).

5.4 Limitations of review

A review limitation was the subjectivity in how beneficial practices were inferred, although this was lessened by two researchers independently reviewing findings and reaching consensus via discussion. In addition, it is possible some articles were unintentionally overlooked in the literature search, because risk management can be adjuvant to mental health practices using different terminologies. This equally implies however, that to ensure research and practice improve risk management, risk management is clearly explicated as a practice within itself. As Reynolds et al. (2016) suggest, there is perhaps danger if risk management masquerades as a care approach without patient awareness, for misunderstandings and conflicts can arise in relation to what are suitable outcomes of mental health care between service providers and patients.

Conclusion.

Despite limitations, this review has offered an analysis of what patients identify as helpful risk management practices within mental health services. Although there was evidence of inconsistencies, findings suggest that when risk management is open and inclusive, patients do benefit. This includes nurturing relationships and channels whereby the voice of patients,

and their wider social networks, can serve to identify risks and the strategies deployed for their management. Furthermore, for risk management to truly become a collaborative part of care; education, research and mental health practitioners need to recognise that risk management should ultimately serve to improve, and therefore must be meaningful within, the lives of patients.

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Table 1: systematic review databases.

Database of Abstracts of Reviews of Effects (DARE)/
Cochrane Database of Systematic Reviews (CDSR)/ The
Cochrane Depression, Anxiety and Neurosis Review Group's
Specialised Register (CCDANCTR) National Institute for
Health and Clinical Excellence (NICE)/ NIHR Health Technol-
ogy Assessment (NIHR HTA)/ Campbell Library of Systematic
Reviews (CLSR)/ Evidence for Policy and Practice Infor-
mation (EPPI)/ Database of promoting health effectiveness
reviews (DoPHER)/ National Guidelines Clearinghouse
(NGC)/ Scottish Intercollegiate Guidelines Network (SIGN),
and Social Care Online (SCO)/ PROSPERO: International
prospective register of systematic reviews

Table 2: Inclusion/Exclusion criteria.

Inclusion.	Exclusion.
Adults patients (18 -67).	Papers exploring physical health.
Articles published between 2008 and 2018.	Research exploring the risk aetiology of mental illnesses.
Research linked to risk assessment and/or risk management.	Research exploring safety of pharmacology and therapies.
International literature using the English language.	Patients with organic or developmental disorders.
Published in peer reviewed journals.	Studies examining mental health laws and administration of involuntary treatment.
Research exploring patient perspectives or measuring patient views.	Studies exploring none psychiatric settings, such as prisons, rehabilitation, and homeless services.

Table 3: Search terms.

Setting, practice and population.	and	Risk management term or a risk in psychiatry.
'Psychiatry' OR 'mental health' AND 'risk manag*' OR 'risk assess*' 'service user' OR 'client*' OR 'consumer*' OR 'patient*' OR survivor'.		'Abscond*' OR 'abus*' OR 'activities' OR 'aggres*' OR 'alcohol misuse' OR 'collaborat*' OR 'conceptual*' OR 'crises plan*' OR 'deci*' OR 'engage*' OR 'exploitat*' OR 'forensic*' OR 'harm mini*' OR 'involv*' OR 'lived experience*' OR 'offending' OR 'participat*' OR 'positive risk tak*' OR 'protective factor*' OR 'recidivism' OR 'recover*' OR 'safe*' OR 'satisfact*', OR 'self-harm*' OR 'self-neglect*' OR 'streng*' OR 'substance misuse' OR 'suicid*' OR 'verfi*' OR 'violence'.

Table 4: Reviewed literature

Article	Exploration aim	Beneficial practices	Methods	Sample and psychiatric setting(s)	Location	Critical appraisal (MMAT)
Brown and Calnan, (2013).	'Trust' to connect risk management with needs.	Trust facilitates risk management.	Qualitative: semi-structured interviews coded using N-Vivo.	Patients ($n=8$) from community services.	UK	<ul style="list-style-type: none"> ❖ Methods suitable for study aim. ❖ Unclear if interpretations were substantiated.
Coffey, (2012).	How talk about deviance was handled.	Social integration is part of assessment, notably stigma.	Qualitative: an 'ethnomethodological stance' ($p=468$). Interviews using thematic discursive analysis.	Patients ($n=20$) in forensic outpatients, in two NHS settings.	UK	<ul style="list-style-type: none"> ❖ Methods suitable for study aim. ❖ Unclear if interpretations were substantiated.
Coffey et al. (2017).	Views of risk management and care plans.	Therapeutic relationships and discussing risks.	Qualitative component of mixed methods study: semi-structured interviews thematically analysed.	Patients ($n=33$) across four English and two Welsh NHS sites.	UK	<ul style="list-style-type: none"> ❖ Methods suitable for study aim (See protocol - Simpson et al. 2015). ❖ Interviews piloted with patient researchers. ❖ Member checking evident to substantiate interpretation.
Comtois et al. (2011).	Feasibility of the Collaborative Assessment and Management of Suicidality (CAMS).	Higher satisfaction with CAMS.	Quantitative: randomised 1-arm study part of feasibility study. Mixed effects models analysed outcome measures recurrently with same person.	Patients who completed study ($n=20$). Harborview Medical Centre, Washington.	USA	<ul style="list-style-type: none"> ❖ Methods suitable for study aim. ❖ 31.25% drop out rate impairs validity. However, research was to determine feasibility. ❖ 75% completion showing intervention tolerability.
Dixon, (2012).	Patient and clinician views of risk management.	Collaborative assessment, including vulnerabilities.	Mixed-methods: semi-structured interviews, coded using N-Vivo. A-Kappa measured agreement of risk assessment between patients and clinicians.	Patients ($n=19$) in forensic hospitals across three NHS trusts.	UK	<ul style="list-style-type: none"> ❖ Methods suitable for study aim. ❖ Unclear if interpretations of qualitative data were substantiated
Holley et al. (2016).	Impacted of risk management on recovery-oriented care.	Transparency and genuineness about risks.	Qualitative: semi-structured interviews using vignettes. Grounded theory coding.	Patients ($n=8$) across five community teams in a London NHS Trust.	UK	<ul style="list-style-type: none"> ❖ Methods suitable for study aim. ❖ Member checking evident to substantiate interpretations.
Lang et al. (2009).	Views of a routine suicide risk screening.	Patients (60 %) found screening beneficial.	Mixed methods: qualitative arm of study gathering feedback.	Patients ($n=105$). Outpatient facility in New York.	USA	<ul style="list-style-type: none"> ❖ Methods suggest a service evaluation. ❖ Unclear how feedback was analysed. ❖ Unclear if interpretations were substantiated.
Long et al. (2012).	Perspectives of therapeutic milieu.	Consistency with risk management	Qualitative: patient-led participatory research. Two focus groups thematically analysed.	Patients ($n=19$). St Andrews Healthcare - women secure settings.	UK	<ul style="list-style-type: none"> ❖ Methods suitable for study aim. ❖ Interview schedules piloted with patient researchers. ❖ Member checking evident to substantiate interpretations.
Mckeown et al. (2016).	Involvement initiatives.	Involvement and therapeutic alliance to promote personal responsibility.	Qualitative: semi-structured interviews, focus groups thematically analysed.	Patients ($n=69$). Secure hospitals in Yorkshire and Humber.	UK	<ul style="list-style-type: none"> ❖ Methods suitable for study aim. ❖ Analysis substantiated via triangulation with 'reference panel'.
Pulsford et al. (2013).	Compared staff and patient attitudes of aggression and violence.	Therapeutic relationships and negotiation reduce aggression.	Quantitative: Outcome measure using Likert scales about aggression and violence and management. Nonparametric testing analysed scale mean.	Patients ($n=26$) across three male secure hospitals.	UK	<ul style="list-style-type: none"> ❖ Methods suitable for study aim. ❖ Analysis suitable to compare two independent groups (staff and patients) when dependent variables (MAVAS) are ordinal. ❖ Measure has validity to aim. ❖ 27% response rate reduces validity.
Reynolds et al. (2014).	Patients and providers risk management experiences.	Having a voice and maintaining personal identities.	Qualitative: interviews, using grounded theory coding.	Patients ($n=?$) within one forensic secure service.	UK	<ul style="list-style-type: none"> ❖ Method of analysis is unclear. ❖ Unclear if interpretations were substantiated. ❖ No sample of participants.
Schembari et al. (2016).	Benefits of CAMS.	Problem-solving/Mindfulness/Therapist/Friends and family for support/Being listened to/Cognitive-Behavioural Therapy/Dialectical-Behaviour Therapy.	Mixed methods: Qualitative survey coded. A-Kappa measured inter-rater reliability between codes.	Patients from Harborview Medical Centre, Washington ($n=17$), Menninger Clinic, Texas ($n=17$), and community mental health services in Aarhus and Copenhagen ($n=18$).	USA and Denmark	<ul style="list-style-type: none"> ❖ Methods suitable for study aim. ❖ Good response rate of 94.2%. ❖ Analysis triangulated.

Figure 1: Literature selection.

