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Issues in acute psychiatric inpatient services: staff experiences of suicide and risk-assessments

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Total Word Count

	Main Text	Appendices, references, tables and figures	Total
Thesis abstract	151	-	151
Literature review	6726	6292	13018
Research paper	7955	7216	15171
Critical appraisal	3636	889	452
Ethics	5479	2304	7783
Total	23947	16701	40648

Thesis Abstract

This thesis presents four chapters: section one: systematic literature review; section two: empirical research paper; section three: critical appraisal; section four: ethics application. The systematic literature reviews offers a summary of risk-to-self (e.g. self-harm and suicide) risk-assessment tools validated for acute psychiatric inpatient settings. Sixteen reports were included in the review and ten psychometric properties of 15 risk-assessment tools were appraised using a quality rating system. The empirical study qualitatively explores the experiences of clinical psychologists who have had a patient die by suicide whilst working in acute psychiatric inpatient settings. Six participants' experiences were analysed and interpreted using 'Interpretative Phenomenological Analysis' (IPA). The critical appraisal synthesises the finding of the systematic review and empirical study, and offers a deeper exploration of clinical recommendations and limitations of the reports. The final section includes the ethics application for the empirical study, the approval letter and supplementary documentation used to conduct the research.

Declaration

The present thesis has been research and written as part of the Doctorate in Clinical Psychology, Division of Health Research at Lancaster University, UK. The research, review and accompanying material presented is the author's own, except where reference to others' work has been cited. This work has not been submitted elsewhere for the award of another degree or academic award.

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Section 1: Systematic Literature Review

The quality of the psychometric properties of risk-to-self assessment tools validated on acute psychiatric inpatient samples: A systematic literature review

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Abstract

Introduction: Risk-assessment plays a central role in working with patients in mental health settings. A proportion of patients who die by suicide were admitted to an acute inpatient psychiatric service and died within three months of admission, with the majority being classified as no or low-risk to themselves at their final contact with services. Against guidance, many structured risk-assessment tools in use are not peer-reviewed or validated for use within a specific setting or with a specific patient group. The systematic review aims to identify, and quality appraise, peer-reviewed self-harm and suicide risk assessment tools validated for adult psychiatric inpatient populations.

Method: This study offers a systematic literature review of risk-to-self assessment tools validated on adult acute inpatient samples. The electronic search was conducted through Medline, PsycInfo, CINHAL and Web of Science databases. The review appraises the quality of the psychometric properties of risk-to-self assessment tools using pre-defined criteria developed by Terwee and colleagues (2007) for assessing health-status outcome measures and questionnaires.

Results: Sixteen reports were selected for review which identified 15 unique risk-to-self assessment tools. Quality ratings (positive, intermediate, negative) were awarded across ten quality criteria per risk-assessment tool.

Conclusions: The review supports existing recommendations that risk-assessment tools are only a supplemental tool that can help clinicians and patients have more meaningful discussions or provide insight into potential problems.

Introduction

Risk-assessment plays a central role when working with patients¹ within mental health services. Clinicians often assess multiple domains of risk, including risk-to-others, risk-from-others and risk-to-self (e.g. Royal College of Psychiatrists; RCP, 2010; 2016). The following review will examine the domain of ‘risk-to-self’ whereby people are at risk of self-harm with or without the intent to die by suicide (National Institute for Clinical Excellence; NICE, 2004; 2011). Risk factors for self-harm and suicidal behaviour are varied and can include thinking about suicide (suicidal ideation), the deliberate destruction of one’s bodily tissue with or without lethal intention (suicidal behaviour or ‘non-suicidal self-injury: see Favazza, 1996; Nock, 2010), or indirect concepts such as hopelessness (Beck et al., 1974).

Globally, suicide accounts for 1.4% of deaths annually (World Health Organisation, 2021) and remains a significant national public health concern in the UK and equates to 6,500 deaths annually (Office for National Statistics, 2019). The annual report by ‘National Confidential Inquiry into Suicide and Safety in Mental Health’ (NCISH, 2022) shows there were 18,268 suicides by people within 12 months of receiving mental health care in the UK between 2009-2019. This accounted for 27% of all general population suicides, and approximately 9000 of those had been seen within seven days. It is thought that around half of people who die by suicide have previously self-harmed (Foster et al., 1999) and so self-harm is thought of as a key predictor of suicide (Carroll et al., 2014). Tsiachristas et al. (2020) suggest there could have been around 220,000 presentations of self-harm in English hospitals in a single year, with an estimated cost of £128.6 million to the NHS. Around 1 in 25 people who self-harm will go on to die by suicide within five years (Carroll et al., 2014). However, not all self-harm is done with the intent to end one’s life, known as non-suicidal self-injury (NSSI; Favazza & Rosenthal, 1993;

¹ The term patient is used for consistency, but may refer to clients and service users.

Nock, 2010). People who engage in NSSI can have many other complex motivation to do so, such as a coping behaviour for emotional or psychological distress (O'Connor et al., 2018) and so NSSI prevalent but distinct issue from attempting suicide (Mars et al., 2014). Suicide reduction is a key mental health priority for the National Health Service (NHS) in the UK, outlined by the 'Five Year Forward View' (NHS Long Term Plan, 2019) and their 'Zero Suicide Strategy', with risk-assessment of key predictors of suicide (e.g. self-harm) (Graney et al., 2020) a part of that. Health Education England have worked closely with the 'National Collaborating Centre for Mental Health' and NHS to provide self-harm prevention and reduction frameworks for public use (2018).

Risk-management is a key part of clinical practice internationally and is commonly done through structured assessment (RCP, 2016). In the USA, risk assessment strategy advocates for the widespread use of risk-assessment tools and categorisation into low and high-risk groups (Office of the Surgeon General (US), 2012); whereas countries such as the UK and Australia use risk-assessment as a part of a broader psychosocial assessment of needs (Graney et al., 2020). Structured risk-assessment is not recommended to be used to predict suicide or self-harm (NICE, 2011). There is a difference in opinion as to whether risk-assessments can adequately predict suicide or self-harm, but an extensive systematic review of the evidence shows that it is not appropriate to categorise people into high or low risk groups as they are not sufficient predictors of behaviour (Large et al., 2017). This is no better illustrated by the fact that 88% of mental health patients who died by suicide in the UK in 2019, had been classified as no or low-risk at their final contact with services (NCISH, 2022).

Graney et al. (2020) collected information from 85 NHS trusts and found that over 150 examples of risk-assessment were given, many of which were locally derived. Of the 85 tools analysed, 85% were structured assessments, and 97% of those directed clinicians to predict future suicide or self-harm behaviour or categorise patients into low-high risk groups despite the evidence and guidance against

doing so (NICE, 2011; Graney et al., 2020; Large et al., 2017). Descriptive studies have shown that risk-assessments used in the NHS, vary widely and are predominantly locally derived (NCISH, 2018). Locally derived risk-assessments are used to guide intervention or care and are generally not evaluated by peer review, which could mean clinicians are in danger of using unreliable or invalid means of assessing risk accurately. The RCP (2010, pg. 11) advises clinicians against using risk-assessment tools that have not undergone psychometric validation and other studies (e.g. Ryan et al., 2010) share this consensus. Despite this, structured assessment tools are very commonplace in clinical practice as part of risk-assessments. The NCISH's report on the use of risk assessment in clinical settings (2018), reported the benefits of using risk-assessment tools according to clinicians. They described risk-assessment tools as helpful for having meaningful conversations with both patients and colleagues. Many felt risk-assessment tools identified areas of risk that could be incorporated into risk management plans, were a way of keeping broader risk-assessments up to date, and were valuable as an 'aide memoir' when making clinical judgements.

It has been shown that the type of risk-assessment tool used varies depending on the setting, as the needs of each population is different (Graney et al., 2020). Psychiatric inpatient wards are populated by the most high-risk and acutely unwell patients, in an environment characterised by high bed occupancy, frequent staff turnover and poor morale (Cleary, 2011). Suicidal behaviour in inpatient psychiatric wards is common and particularly prevalent during admission or within the first two to three weeks after discharge (NCISH, 2022; Chung et al., 2019). Completed suicide during psychiatric inpatient admission, or within three months of admission accounted for 27% of all mental health patient suicides in 2019 (NCISH, 2022). NSSI is also a frequent occurrence in inpatient settings (James et al., 2012). This is partly due to a high association between self-harm and mental health difficulties, and inpatient settings are tasked with providing a safe environment for those unable to keep themselves safe

from harm (Bowers et al., 2005). The review also suggests that the restrictive nature and environmental factors associated with inpatient settings further contribute to a higher likelihood of people self-harming (James et al., 2012).

Some descriptive and systematic reviews have shown the different types of risk-assessment tools being used in UK mental health settings (e.g. Harris et al., 2019; Hawley et al., 2006; Higgins et al., 2005; Graney et al., 2020; NCISH, 2018) but they mostly demonstrate the variety of assessments being used in various mental health settings. While they have clinically valuable information, they do not provide any assessment or conclusions on the quality of those tools. The reviews also look at risk-assessment tools that cover multiple risk domains including risk to and from others. They also review multiple mental health settings (i.e. one measure can be used in forensic, community and inpatient) but rarely focus on one risk domain or mental health service, so it is difficult to select the best tool for different categories of risk. Many risk-assessment tools are validated in the literature, and their psychometric properties assessed, however, to our knowledge there is no comprehensive list or consensus of accepted risk-assessment tools for psychiatric inpatient settings and there are no reviews that assess risk-assessment tools that have been specifically developed for, or validated on a psychiatric inpatient population. It is imperative to fill this gap in the literature due to the widespread use of risk-assessment tools for clinical decision making and prediction of suicide or self-harm behaviours (Graney et al. 2020; NCIHS, 2018) and because psychiatric inpatient settings have their own needs and particularly high risk levels (Cleary, 2011; James et al., 2012).

This systematic review aims to identify and evaluate the psychometric properties of risk-assessment tools for a specific risk domain (risk-to-self), in a specific setting (acute psychiatric inpatient). It aims to strengthen the literature in this area by moving the literature away from making recommendations for broad use of risk-assessment tools for multiple purposes in multiple settings.

Objectives

- Identify risk-to-self assessment tools that are validated on an acute psychiatric inpatient population
- Assess the psychometric quality of the risk-assessment tools using predefined quality criteria for reliability (internal consistency, reproducibility: agreement and reliability), validity (content, criterion, construct and predictive), floor/ceiling effects and interpretability (Terwee et al., 2007)
- Identify implications for future research and make recommendations for clinical practice

Method

Design

This quantitative systematic literature review was conducted following PRISMA guidelines (Page et al., 2021). These systemic principles were used to guide the researcher in searching, screening and selecting reports for review to appraise the quality of the psychometric properties of risk-to-self assessment tools, validated on acute psychiatric inpatient populations. A tool developed for the appraisal of health-status questionnaires (Terwee et al., 2007) was used to assess the quality of the psychometric properties of each risk assessment tool.

Search Strategy

The article search was conducted in the EbscoHost database and included Medline, PsycInfo and CINHALL from inception to 2nd October 2021. An English language and age filter (>18 years old) was applied to the EbscoHost database search. The electronic database Web of Science was also searched from inception to 2nd October 2021 with an English language filter applied. Grey literature was not searched as peer-reviewed publication was part of the inclusion criteria.

A combination of keywords were used in the search procedure to identify risk-to-self assessment tools and acute psychiatric inpatient populations. Table 1 defines the areas of interest for this review with an accompanying search strategy.

The initial screening procedure was performed by two independent reviewers (CL and AA). Articles were screened by title and abstract by the lead reviewer (CL) for initial eligibility using the inclusion and exclusion criteria. A second reviewer (AA) checked a small proportion ($n = 200$) of the search results to verify the screening process. Discrepancies were discussed between the two reviewers for consensus. When the eligibility of an article was not clear by title and abstract, it was included in the full-text article retrieval. The lead reviewer retrieved and conducted the full-text article review for final inclusion.

The lead reviewer conducted additional Google Scholar citation searches from identified reports following the original article search and by searching for keywords such as ‘inpatient’ and ‘risk assessment’. Secondary searches were completed by 15th November 2022. In addition, two independent reviewers (JK and LW) offered supervision for verification or clarification around articles.

Inclusion and exclusion criteria

Reports were included if they reported psychometric properties (e.g. validity, reliability) of risk-assessment tools for risk-to-self (including suicidal ideation, intent, behaviour and attempts and self-harm) on adult populations (18 and over) in acute psychiatric inpatient samples. Reports had to be written in English using untranslated assessment tools. Translated tools require additional validation to ensure content validity remains when making them culturally appropriate in another language (Acquadro et al., 2014), and it was outside the scope of the review to ensure that validation had been carried out. Reports had to be peer-reviewed for the tools to be considered validated for an acute psychiatric inpatient setting.

Reports were excluded if they were solely validated on child and adolescent or older adult populations (under 18 or over 65 years old). Studies were not included when risk assessment tools were used as part of an experimental design or for any other purpose than validating the tool for the target population.

Data Extraction

The lead reviewer extracted information and data using pre-designed extraction tables (Tables 2 & 4). Table 2 is a descriptive summary table that includes the name and description of the risk assessment tool, the risk-to-self domain measured, and whether the assessment tool was developed specifically for inpatient use. The reviewer also located the original papers for risk-assessment tools when included reports had inadequate information around utility and scoring of the risk-assessment tool. Further quality assessment of the psychometric properties of the risk-assessment tools was put into a pre-designed extraction table (Table 4) and included ten quality criteria: reliability (internal consistency, reproducibility: agreement and reliability), validity (content, criterion, construct and predictive), floor/ceiling effects and interpretability. Terwee et al (2007, pg. 40) was used as a template in creating the table for the quality criteria rating. Discrepancies or inconsistencies were clarified with a third reviewer (LW).

Synthesis and assessment of the quality of psychometric properties

The quality of the psychometric properties of each risk-assessment tool was assessed and rated using pre-defined criteria set out in the Terwee et al. (2007, pg. 39) paper. Refer to Appendix 2 for complete rating criteria for each domain. This quality criterion was developed to appraise the properties of health status questionnaires, and is composed of nine psychometric properties: content validity, internal consistency, criterion validity, construct validity, reproducibility ('reliability' and 'agreement'),

responsiveness, floor/ceiling effects, interpretability. A commonly examined psychometric property in risk-assessment tools is predictive validity as many tools endeavour to predict risk in order for clinicians to try and prevent it in the future (NCISH, 2018). While recommendations outlined in the introduction (e.g. NICE, 2011) discourage the use of risk-assessment as a predictive tool, it is still of interest to understand how many tools were designed with this purpose in mind. This will additionally establish whether they are effective in their purpose, particularly if this is a contentious issue within the literature. The decision was taken to develop appropriate quality criteria for 'predictive validity' that was complementary to the existing quality criteria (Terwee et al., 2007). Researchers used the existing rating criteria for 'responsiveness' as the blueprint. The existing criteria and additional literature around predictive validity in outcome measures (e.g. Hosmer et al., 2013) was utilised to ensure the newly created criteria was comparable to the nine others.

Extracted data was given a positive (+), intermediate (?), negative (-), or missing (0) rating after assessing each of the ten domains. These ratings were awarded using explicit benchmarks for each domain as set out by Terwee et al., (2007). The criteria was pre-defined and varied for each psychometric property (please refer to Appendix 2 for detailed rating criteria). Ratings were synthesised into Table 4.

Results

The initial search yielded a large number of potential reports ($n = 13,024$). Figure 1 summarises the search identification, screening and inclusion process in accordance to PRISMA recommendations (Page et al., 2021). After duplicates were removed, 11,902 reports were screened by title and abstract. Sixty-two full text reports were sought for retrieval and assessed for eligibility. Two reports could not be retrieved and 12 reports were eligible for inclusion. The secondary citation search and Google Scholar search identified a further 21 reports for screening and 12 full-text reports were assessed for eligibility

(Figure 1). The secondary search found four eligible reports (Beck et al., 1985; Beck et al., 1974; Block-Elkoulby et al., 2021; Barzilay et al., 2020). Sixteen eligible reports were included in the final total.

Study Characteristics

The sixteen reports identified 15 unique risk-to-self assessment tools which are summarised in Table 2. For clarification, some reports included two risk-assessment tools within the same report, while some risk-assessment tools were included in more than one report. Refer to Table 3 for summary.

Fourteen suicide risk-assessment tools were identified. They included: SCI: Suicide Crisis Inventory (Galynker et al., 2017; Barzilay et al., 2020); SCI-2: Suicide Crisis Inventory v. 2 (Block-Elkoulby et al., 2021); SCS: Suicide Cognitions Scale (Ellis & Rufino, 2015); B-SCS: Brief Suicide Cognitions Scale (Rudd & Bryan, 2021); SIS: Suicide Intent Scale (Mieczkowski et al. 1993 ; Beck et al., 1985); INQ-15: Interpersonal Needs Questionnaire (Mitchell et al. 2017); SIS-MAP: Scale for Impact of Suicidality – Management, Assessment and Planning of Care (Nelson et al., 2010); SBQ-R: Suicidal Behaviours Questionnaire-Revised (Osman et al., 2001); ASIQ: Adult Suicidal Ideation Questionnaire (Osman et al., 1999); LRFL: Linehan Reasons for Living Inventory (Osman et al., 1999); RoSP: Risk of Suicide Protocol (Grey et al., 2021); DSI-SS: Depressive Symptom Index-Suicidality Subscale (Stanley et al., 2021); STS-3: Suicide Trigger Scale v. 3 (Yaseen et al., 2014); BHS: Beck Hopelessness Scale (Beck et al., 1974; Beck et al., 1985).

Two self-harm risk-assessment tools were identified. They included: RoSP: Risk of Suicide Protocol (Gray et al., 2021) and HCR-20: Historical Clinical and Risk Management (O’Shea et al., 2014). It must be noted RoSP also assesses suicide risk and the HCR-20 is primarily a violence risk-assessment tool for forensic settings. It was included in the review as the report specifically aims to

validate items for assessing self-harm in psychiatric inpatient populations, although its primary purpose is not to assess for self-harm.

Twelve risk-assessment tools were validated in the United States, two in the United Kingdom (RoSP; Gray et al., 2021; HCR-20; O’Shea et al., 2014) and one validated a risk-assessment tool in Canada (SIS-MAP; Nelson et al., 2010). Sample sizes ranged from 50 – 504 participants. Two reports had mixed samples that included psychiatric inpatients and outpatients (Barzilay et al., 2020 (44% inpatient); Bloch-Elkouby et al., 2021 (25% inpatient) and four reports did separate analysis for each patient sample (Rudd & Bryan, 2021; Osman et al., 2001; Gray et al., 2021; Beck et al., 1974). In these instances only analyses for psychiatric inpatient samples were assessed and rated.

Quality Ratings

Table 4 presents the summary of quality ratings for each risk-assessment tool under the ten quality criteria domains: Content validity; internal consistency; criterion validity; construct validity; reproducibility (agreement and reliability), responsiveness, floor/ceiling effects, interpretability and predictive validity (Terwee et al., 2007). Three risk-assessment tools (SIS; SCI; BHS) have two sets of ratings as they were included in two reports.

All risk-assessment tools scored at least one positive rating in one criteria, with the exception of the HCR-20 which scored no positive ratings. Five of the highest rated tools achieved positive ratings across three domains (B-SCS; INQ-15; ASIQ, LRFL, DSI-SS). Five tools scored positive ratings across two domains (SCI: Barzilay et al., 2020; SCI-2; SIS-MAP; RoSP; BHS: Beck et al., 1974) and five tools scored one positive rating (SCI; Galynker et al., 2017; SCS; SIS: Mieczkowski et al., 1993; SBQ-R; STS-3).

Content Validity

Content validity is the extent to which the domain of interest set out in the report (e.g. suicidal ideation, suicidal behaviour) is comprehensively sampled by the items in the risk-assessment tool (Terwee et al., 2007). Only six reports included content validity, with three (LRFL; RoSP; BHS: Beck et al., 1974) scoring a positive rating. A positive rating was awarded for clear descriptions of the measurement aim, target population and concepts being measured and item selection as well as having target population and experts involved in item selection. The 12 reports that scored '0' likely did not report on content validity as they were not the original developers of the risk assessment tool so did not report the original authors' methods of developing the scales. No reports scored an intermediate rating for lacking a clear description or doubtful design but three reports scored a negative rating (B-SCS; SIS-MAP; SCI-2). A negative rating was awarded when there was no target population involvement, which meant service users were not involved in developing the risk assessment tool.

Internal Consistency

Internal consistency is the extent to which items in the risk-assessments are intercorrelated, and therefore measure the same construct (Terwee et al., 2007). Thirteen reports were given a rating for internal consistency. Five reports were awarded a positive rating (SCS; B-SCS; SIS: Mieczkowski et al., 1993; LRFL; BHS: Beck et al., 1974) for having acceptable Cronbach's alphas (between 0.70 and 0.95) and factor analyses were performed on an adequate sample size. Three reports were awarded an intermediate rating. Two were rated intermediate (INQ-15; SBQ-R) as they reported acceptable Cronbach's alphas but did not include a factor analysis, so scored an intermediate rating as opposed to a negative rating. The other (RoSP) scored an intermediate rating as they only described their ratings as 'good or excellent' but did not adequately report the data. Additionally four reports scored negatively

due to Cronbach's alpha levels above 0.95 (SCI: Galynker et al., 2017 ; Barzilay et al., 2020 ; SCI-2; ASIQ).

Criterion Validity

Criterion validity refers to how well tools relate to a 'gold standard' tool or measure (Terwee et al., 2007). There was no evidence of a definitive 'gold standard' in the literature, but in line with guidance a tool could be allocated a positive rating if authors made a rationale that validating measures were to an appropriate standard. The reviewer considered arguments for each report, for example, the tool was considered common for use as a measure in studies around suicide. Eleven reports included criterion validity, two of which scored a positive rating (B-SCS; DSI-SS) as they proposed a rationale for the use of their validating measures as well as having a correlation with the 'gold standard' of 0.70 or over. Nine intermediate ratings were given as the reviewer felt there was no convincing argument made that the correlations they did use in the report were related to a 'gold standard' tool or measure (SCI: Barzilay et al., 2020; SCI-2; SCS; HCR-20; SBQ-R; ASIQ; LRFL; BHS: Beck et al., 1974). No negative ratings were given and the remaining seven reports scored a '0' as there was no information on criterion validity.

Construct Validity

Construct validity is the extent to which scores on the risk assessment tools relate to other measures in a manner that is consistent with theoretically derived hypotheses concerning the concepts that are being measured (Terwee et al., 2007). Thirteen reports included construct validity. Seven reports were awarded a positive rating (SCI: Barzilay et al., 2020; SCI-2; B-SCS; INQ-15; ASIQ; LRFL; DSI-SS). A positive rating was awarded when around 75% of hypotheses pre-defined in the introduction

were confirmed after analysis. Five intermediate ratings were awarded as pre-defined hypotheses were not reported, although they showed good construct validity (SCI: Galynker et al., 2017; SCS; SIS-MAP; SBQ-R; BHS: Beck et al., 1974). One measure (HCR-20) scored negatively in this criteria, however, the tool is primarily designed as a measure of risk-to-others and subscales were being investigated for their potential to predict self-harm, so could not meet construct validity.

Reproducibility (Test-Retest Reliability)

Agreement.

Agreement is the extent to which scores on repeated measures are close to each other showing test-retest reliability (Terwee et al., 2007). All reports scored a '0' as no risk-assessment tools were used on more than one occasion with the same sample.

Reliability.

Reliability is the extent to which a sample of patients can be distinguished from each other despite measurement errors (Terwee et al., 2007). Two positive ratings were given (SIS-MAP; ASIQ) as the ICC or weighted Kappa was 0.70 or above in a sample of at least 50 participants. Three intermediate ratings were given (B-SCS; RoSP; BHS: Beck et al., 1974) as it was considered the reports had a doubtful design or method such as an undefined time interval between tests. A further two reports were awarded a negative rating (SCS; SCI-2) for an ICC or weighted Kappa below 0.70 despite an appropriate design. Eleven of the 18 reports did not provide information on reliability.

Floor/Ceiling Effects

Floor/ceiling effects are the number of respondents who achieved the lowest or highest possible score (Terwee et al., 2017). Only four reports included floor/ceiling effects. Three positive ratings were given (SCI: Galynker et al., 2017; Barzilay et al., 2020; INQ-15) as less than 15% of respondents scored the highest or lowest possible scores. One report (STS-3) scored a negative rating as over 15% of participants' scored the lowest or highest scores possible. The remaining 14 reports did not report floor/ceiling effects.

Interpretability

Interpretability refers to the degree to which qualitative or clinical meaning is given to the quantitative scoring of the risk-assessment tool (Terwee et al., 2017). Five reports included clinical or qualitative interpretability of scores with one positive rating (SIS-MAP). A positive rating was awarded as scores were presented for at least four relevant subgroups of patients. Four intermediate ratings were given (INQ-15; SBQ-R; STS-3; BHS: Beck et al., 1985) as they did not give qualitative interpretations or only provided two categories to divide scores into. There was no defined criteria for a negative rating in this criteria so the remaining 13 ratings were '0'.

Responsiveness

Responsiveness is the ability of the risk-assessment tool to detect clinically important changes over time. All reports scored a '0' as none of the reports included risk-assessment tools that were tested over time.

Predictive Validity

Predictive validity is the degree to which scores on a tool are related to a specific outcome (i.e. suicidal behaviour, self-harm) at some point in the future (Frey, 2018). A positive rating was given if 'area under the curve' (AUC) was equal to or greater than 0.8. The reviewer chose 0.8 as the benchmark as it is considered 'good' (Frey, 2018; Hosmer et al., 2013). An intermediate rating was given if the design, method or interpretation of data was unclear and a negative rating was given if results showed AUC below 0.8.

Reports conducted predictive analyses for suicidal behaviour (SB), suicidal ideation (SI), suicide attempts (SA) and self-harm (SH) or a combination of these, therefore some reports have multiple ratings. The results include 26 ratings, rather than 18, for this criteria.

Six reports were awarded a positive rating (SCI-2; RoSP; INQ-15; STS-3; SBQ-R; ASIQ). The SCI-2 scored positively for predicting SA, as did RoSP; ASIQ and STS-3, though the STS-3 rating was for a reduced item subscale. The INQ-15 scored a positive rating for SI and SBQ-R scored a positive rating for SB. Six intermediate ratings were awarded (SCI: Galynker et al., 2017; SCS; BHS: Beck et al., 1985; SIS: Beck et al., 1985) due to them inadequately reporting data, which meant it could not be rated under the positive or negative criteria. Nine negative ratings were awarded (SCI: Barzilay et al., 2020; SCI-2; HCR-20; LRFL; RoSP; STS-3). The SCI scored negatively for SI, SB and SA, the SCI-2 scored negatively for SI and SB. The LRFL and STS-3 scored negatively for SA. The HCR-20 and RoSP scored negatively for SH. Five reports did not provide an analysis for predictive validity (B-SCS; SIS; Mieczkowski et al., 1993; SIS-MAP; DSI-SS).

Discussion

The results presented in this review assessed the psychometric quality of 15 risk-to-self assessment tools validated on acute psychiatric inpatient populations from 16 reports. Quality was

assessed through a rating system across ten criteria set out by Terwee et al. (2007). These included content validity, internal consistency, criterion validity, construct validity, reproducibility (agreement and reliability), interpretability, floor/ceiling effects, responsiveness and predictive validity.

Five of the most highly rated tools (B-SCS, INQ-15, ASIQ, LRFL, DSI-SS) assessed suicide risk, scoring three positive ratings. Taking all intermediate and negative ratings into consideration, the INQ-15 could be considered the highest quality risk-assessment tool out of the included tools as it had the most positive ratings and no negative ratings. However, these tools scored five other negative, intermediate, or '0' ratings, and therefore no tool had a majority of positive ratings to be considered psychometrically robust. This logically concludes that no risk-assessment tool is, therefore, 'fit for purpose' for being used clinically in an acute psychiatric inpatient setting.

Generally, the risk-assessment tools had good internal consistency and construct validity but had lower ratings in other criteria such as 'reproducibility' and 'interpretability'. Therefore, they are likely to be measuring the risk constructs (suicidal ideation and suicidal behaviour) but overall do not have good test-retest reliability for inpatient samples of patients and do not provide clinically useful results after scoring.

Overall, the poorest quality risk-assessment tools for use in inpatient settings were the BHS, SIS and HCR-20. The BHS (Beck et al., 1974) was the only one of these tools to score two positive ratings for content validity and internal consistency. The four reports that contributed to the rating of the BHS and SIS may have been rated poorly as they did not report on many of the criteria set out by Terwee et al. (2007) or could not meet a positive rating despite reporting. For instance, only one negative rating was awarded across the four reports. The reports are dated between 1974-1993, and since then the reporting of validation studies have improved with clearer guidance for standardisation (e.g. COSMIN; Mokkink et al., 2018). Had these tools been developed or validated on inpatient samples more recently,

they may have more positive quality ratings. However, this review cannot conclude that these risk-assessment tools are valid or appropriate for use in psychiatric inpatient populations. Conversely, the HCR-20 is a violence risk-assessment tool developed for forensic settings (Webster et al., 1997), therefore, it is unsurprising that it was not validated for predicting self-harm in inpatient settings, scoring negatively for construct validity and predictive validity.

While internal consistency was one of the more positively rated criteria, several negative and intermediate ratings were awarded. For example, the SCI (Galynker et al., 2017; Barzilay et al., 2020) and SCI-2 scored negatively due to very high Cronbach's alpha values (>0.95). The reports themselves define this as excellent internal consistency, suggesting each subscale correlates with the construct being measured. However, literature has shown that a high full-scale internal consistency may indicate item redundancy, suggesting there could be unnecessary or duplicated items in the scale (Hulin et al., 2001). As previously mentioned, intermediate ratings were given to the INQ-15 and SBQ-R as they did not conduct a confirmatory factor analysis. Factor analysis is important in validating the internal consistency of the full scale by confirming that the risk-assessments are related to pre-defined theoretical constructs and appropriately selected items (Floyd & Wideman, 1995; Allen, 2017). Without this, the INQ-15 and SBQ-R may have reliable scales, but they lack the confirmation or validation that these scales do in fact relate to their theoretical underpinnings (e.g. perceived burdensome and thwarted belongingness in INQ-15).

Criterion validity, or the extent to which the risk-assessment tools related to a gold standard measure, was one of the more challenging criteria to assess. It relied heavily on the reviewer's judgment and subjective opinion to award a rating. There is little in the way of consensus around a 'gold standard' for the assessment of suicidality and self-harm, rather a collection of well-established and commonly used scales (e.g. Columbia Suicide Severity Rating Scale: Posner et al., 2008; Beck Depression

Inventory: Beck & Steer, 1984), therefore the reviewer accepted tools as ‘gold standard’ if reports offered a rationale for their choice of comparative measure. The appraisal was further complicated because the risk-assessment tools measure different domains of suicidality and self-harm and often use diverse theoretical paradigms to underpin the development of the tools. For example, the SCS and B-SCS assess suicidal ideation through the theoretical concept of ‘hopelessness’ (e.g. Weishaar & Beck, 1992), whereas the DSI-SS assesses suicidal ideation through direct questions about suicidal thoughts and suicide planning. This makes for difficulty in rating the tools, but it is also impossible to draw direct comparisons of the criterion validity of similarly rated tools due to the diverse nature and theoretical underpinnings of the tools. This is likely true for many health-status questionnaires, which calls into question the utility and purpose of this criteria. Unfortunately, unlike other criteria, Terwee et al. (2007) offer very little insight into the rationale around the development of this criteria or guidance in decision-making, which is a real limitation for users.

Construct validity was widely reported and generally awarded positive or intermediate ratings. Intermediate ratings were primarily awarded due to a lack of pre-defined hypotheses in the reports. Without pre-defined hypotheses, there is a high risk of bias as it is possible that low correlations in reports can be explained away, as opposed to concluding that a tool is not valid (Terwee et al., 2007). Aside from the HCR-20, which did not show construct validity, all the other risk-assessment tools reported on content validity showed adequate correlations to other measures, which is a strength for the risk-assessment tools validated on inpatient populations. However, the ones that were rated as intermediate (SCI: Galynker et al., 2017; SCS; SIS-MAP; SBQ-R; BHS: Beck et al., 1974) should be looked at with caution as there is a chance of bias in the report.

Predictive validity was reported in all but four reports (B-SCS; SIS-MAP; DSI-SS; Beck et al., 1974) and in line with findings in previous studies show that the risk-assessment tools are not adequate

in predicting a variety of risks (SA, SH, SB). Therefore the review findings cannot recommend that the risk-assessment tools should be used as a means of predicting or categorising risk. This is an important conclusion considering the high prevalence at which this happens in clinical practice (Large et al., 2017; NCIHS, 2018). SIS-MAP did not report predictive validity as it was a tool developed to help clinicians decide on the type of care may need during active episodes of suicidal behaviour or self-harm, and SIS (Mieczowski et al., 1993) was a paper dedicated to a factor analysis of the tool.

The most frequently reported criteria (i.e. did not score a '0') were internal consistency, criterion validity, construct validity, and predictive validity. The remaining quality criteria (content validity, reliability, interpretability, floor/ceiling effects) were not widely reported. In the case of 'content validity' and 'reliability' the reviewer assumes this is due to many reports being additional validation studies to the original papers and therefore do not report information from the development of the tool. This highlights a real lack of consistency in reporting the validation of risk-assessment tools. This is particularly problematic due to the clinical nature of the tools and adds a burden on clinicians and services when trying to select appropriate, evidence-based, tools for use with patients and opens them up to using tools that may not be appropriate for their patient group.

The SIS-MAP was the only paper to describe detailed qualitative interpretations of the scores. Clear qualitative interpretation provides clinicians with useful clinical information when using the tool. A lack of interpretability is surprising as one could presume clinical utility and usability would be an important part of developing a tool to use with patients, on the other hand, clinical cut-off scores may not be particularly useful considering most measures have no predictive validity.

It is worth noting that three measures (SCI; SIS; BHS) were included in two reports and, therefore, have two sets of ratings. Consideration was given to using the most conservative ratings, however, a comparison shows that due to the prevalence of '0' or intermediate ratings, no report showed

a particular positive bias over one another despite a difference in ratings and so the reviewer opted to show all ratings. Nevertheless, it does show the importance of standardisation in conducting validation studies and reporting psychometric properties as assessment of quality could potentially vary widely from report to report, and clinicians could have different perspectives on the quality of a tool depending on the report they have read.

By collating the risk-assessment tools, this review also shows an apparent lack of tools developed for the assessment of self-harm and validated on psychiatric inpatient populations, despite the high prevalence seen in these settings (James et al., 2012). This is surprising as NSSI is a well-researched and well known problem in the UK (e.g. Nock, 2010; James et al., 2012), and the intricate links between self-harm and risk of suicide are also well known in the literature (e.g. Carroll et al., 2014). Finally, descriptive information shows that very few of the 15 risk-assessment tools were developed specifically for an inpatient setting. So, it can be concluded that these specialised, high-risk settings are relying on risk-assessments that are not validated or appropriate for their clinical population.

Key Strengths and Limitations

This review is the first to offer a systematically collated list of risk-to-self measures validated on acute inpatient populations. It goes beyond existing reviews by using a well-established quality criteria to evaluate those measures. The review attempts to honour the specific and complex needs of inpatient settings as it did not evaluate the psychometric properties of the risk-assessment measures and then generalise to other mental health settings.

The review is limited in its scope due to the nature of conducting a largely independent systematic review for a doctoral thesis. The reviewer acknowledges that assessing the quality of the risk-assessment tools does not fully assess the methodological quality of the report itself. The most appropriate tool for looking at the risk of bias in health-status measures would be the checklist

developed by the COSMIN study (Mokkink et al., 2018). The checklist allows reviewers to rate a number of domains from ‘inadequate’ to ‘very good’ and presents an accessible and succinct table to show the overall methodological quality of reports, however, the checklist is extremely long and did not feel appropriate for scope of this review. The reviewer searched for other well-established but briefer methodological appraisal tools, however, to their knowledge none could be found that had been developed for health-status questionnaires.

Additional limitations of the review lay within the quality criteria itself. Terwee et al., (2007) acknowledge that some criteria can be opinion based and are open to interpretation, therefore it would be plausible that a different review team would come up with different ratings. Health-status questionnaires vary greatly, and so the quality criteria did not fully assess all domains of a risk-assessment and so the reviewer had to add their own additional ‘predictive validity’. While the reviewer was guided by literature in developing the rating criteria and sought supervision, it has not gone through the rigorous development of the other rating criteria due to the scope of the review.

Recommendations for future research and clinical implications

The range of ratings for the risk-assessment tools points to a lack of good quality risk-assessment for inpatient populations. Appropriate risk-assessment tools must continue to be developed for inpatient populations, but existing tools should also be validated for this population. The breadth and variety of tools being used in UK mental health settings leads to an assumption that clinicians working in inpatient settings could be using several risk-assessment tools that may not be appropriate for that population. Considering the central role these assessments play in clinician decision making despite recommendations not to do so, it is imperative that clinicians have good quality options (RCP, 2016;

Graney et al., 2020). In addition, research priorities should centre around validating tools for self-harm as this systematic review could find very little that met the inclusion criteria.

The quality of risk-assessment tools may also be influenced by the reporting of the tools. The ratings show many criteria were under-reported, or lacked clear and concise designs, pre-defined hypotheses, or did not report specific data making it difficult to rate something positively. Researchers need to follow reporting guidelines as a means of standardising reports that involve psychometric properties. Using quality criteria such as Terwee et al. (2007) or the COSMIN checklist (Mokkink et al., 2018) may help authors to make appropriate interpretations of their results. For example, SCI and SCI-2 were considered excellent for internal consistency, but the literature states an extremely high Cronbach's alpha suggests problems in the item selection (Hulin et al., 2001). Similar was seen in the evaluation of predictive validity in reports, as authors were able to omit robust analysis in favour of data to support their claims, which were in contrast with the rating criteria.

The review found a particular lack of service user involvement in the development of risk-assessment tools. This is an essential improvement in the future development of tools to be of the highest quality, however, there are barriers to this as resources can be limited to recruit and properly compensate service users for their involvement, so there is a balance to be had between service user involvement and not developing the tool at all.

Conclusions

No risk-assessment tool validated on psychiatric inpatient populations demonstrates good overall quality. Many do show good internal consistency and construct validity which indicates they have been carefully developed to measure the intended construct. The review supports existing NHS guidance (NICE, 2011) that risk-assessment tools are supplementary tools that can facilitate conversations

between clinicians and patients or provide information for broader biopsychosocial assessments (Graney et al. 2020; RCP; 2019).

There is a distinct lack of risk-assessment tools for self-harm that are validated on inpatient populations, and a greater lack of psychometrically robust and validated risk-assessment tools created purposively for inpatient settings.

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Appendices

Appendix 1

Author Instructions for Archives of Suicide Research Journal

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.

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Appendix 2

Quality rating criteria: Terwee et al. (2007, pg. 39)

Table 1
Quality criteria for measurement properties of health status questionnaires

Property	Definition	Quality criteria ^{a,b}
1. Content validity	The extent to which the domain of interest is comprehensively sampled by the items in the questionnaire	+A clear description is provided of the measurement aim, the target population, the concepts that are being measured, and the item selection AND target population and (investigators OR experts) were involved in item selection; ?A clear description of above-mentioned aspects is lacking OR only target population involved OR doubtful design or method; -No target population involvement; 0No information found on target population involvement.
2. Internal consistency	The extent to which items in a (sub)scale are intercorrelated, thus measuring the same construct	+Factor analyses performed on adequate sample size (7 * # items and ≥100) AND Cronbach's alpha(s) calculated per dimension AND Cronbach's alpha(s) between 0.70 and 0.95; ?No factor analysis OR doubtful design or method; -Cronbach's alpha(s) <0.70 or >0.95, despite adequate design and method; 0No information found on internal consistency.
3. Criterion validity	The extent to which scores on a particular questionnaire relate to a gold standard	+Convincing arguments that gold standard is "gold" AND correlation with gold standard ≥0.70; ?No convincing arguments that gold standard is "gold" OR doubtful design or method; -Correlation with gold standard <0.70, despite adequate design and method; 0No information found on criterion validity.
4. Construct validity	The extent to which scores on a particular questionnaire relate to other measures in a manner that is consistent with theoretically derived hypotheses concerning the concepts that are being measured	+Specific hypotheses were formulated AND at least 75% of the results are in accordance with these hypotheses; ?Doubtful design or method (e.g., no hypotheses); -Less than 75% of hypotheses were confirmed, despite adequate design and methods; 0No information found on construct validity.
5. Reproducibility		
5.1. Agreement	The extent to which the scores on repeated measures are close to each other (absolute measurement error)	+MIC < SDC OR MIC outside the LOA OR convincing arguments that agreement is acceptable; ?Doubtful design or method OR (MIC not defined AND no convincing arguments that agreement is acceptable); -MIC ≥ SDC OR MIC equals or inside LOA, despite adequate design and method; 0No information found on agreement.
5.2. Reliability	The extent to which patients can be distinguished from each other, despite measurement errors (relative measurement error)	+ICC or weighted Kappa ≥ 0.70; ?Doubtful design or method (e.g., time interval not mentioned); -ICC or weighted Kappa < 0.70, despite adequate design and method; 0No information found on reliability.
6. Responsiveness	The ability of a questionnaire to detect clinically important changes over time	+SDC or SDC < MIC OR MIC outside the LOA OR RR > 1.96 OR AUC ≥ 0.70; ?Doubtful design or method; -SDC or SDC ≥ MIC OR MIC equals or inside LOA OR RR ≤ 1.96 OR AUC < 0.70, despite adequate design and methods; 0No information found on responsiveness.
7. Floor and ceiling effects	The number of respondents who achieved the lowest or highest possible score	+≤15% of the respondents achieved the highest or lowest possible scores; ?Doubtful design or method; -> 15% of the respondents achieved the highest or lowest possible scores, despite adequate design and methods; 0No information found on interpretation.
8. Interpretability	The degree to which one can assign qualitative meaning to quantitative scores	+Mean and SD scores presented of at least four relevant subgroups of patients and MIC defined; ?Doubtful design or method OR less than four subgroups OR no MIC defined; 0No information found on interpretation.

MIC = minimal important change; SDC = smallest detectable change; LOA = limits of agreement; ICC = Intraclass correlation; SD, standard deviation.

^a + = positive rating; ? = indeterminate rating; - = negative rating; 0 = no information available.

^b Doubtful design or method = lacking of a clear description of the design or methods of the study, sample size smaller than 50 subjects (should be at least 50 in every (subgroup) analysis), or any important methodological weakness in the design or execution of the study.

Tables and Figures

Table 1.

A table summarising the search terms used in database searches, categorised by area of interest.

Area of Interest		
Risk-to-self	Assessment Tool	Target Population
Search Terms (suicid* OR self-harm* OR NSSI OR SSI OR risk* OR self-poison* OR self-injur* OR self-neglect* OR self- mutilat* OR self-inflict*)	(measure* OR screen* OR tool* OR form OR assessment* OR evaluation* OR indicator* OR criteria* OR survey* OR questionnaire* OR factor* OR checklist OR rating* OR inventor* OR index OR survey OR scale* OR psychometric*)	(psychiatr* OR mental health) N1 (inpatient* OR in patient* OR ward* OR acute OR unit* OR intensive care OR PICU)

Table 2.*Descriptive summary table of risk-to-self assessment measures*

Risk Assessment tool	Risk domain measured	Was the tool developed for inpatient population? (Y/N)	Original paper for tool
SCI-Suicide Crisis Inventory <i>(previously known as STS: Suicide Trigger Scale)</i> <i>(Galynker et al., 2017; Barzilay et al., 2020)</i> <i>Description</i>	Short-term SB (Suicidal Behaviour)	Y	Galynker et al., (2017)
	<i>The SCI, formerly known as the Suicide Trigger Scale (STS), is a 49-item assessment tool designed to determine near-term suicide risk. Entrapment (13 items), panic dissociation (9 items), ruminative flooding (7 items), emotional pain (4 items), and fear of dying (3 items) are the five subscale components of this scale. The other 13 items contribute to the overall SCI score but do not fit into any of the five subscales. The items are assessed on a five-point scale ranging from not at all (0) to extreme (4) by self-report. The participants are asked to rate the items when they felt the worst over the last several days.</i>		
SCI-2: Suicide Crisis Inventory v. 2 <i>(Bloch-Elkouby et al., 2021)</i> <i>Description</i>	Short-term SB	Y	Bloch-Elkouby et al. (2021)
	<i>The SCI-2 comprises 61 items divided into five dimensions (Entrapment, Affective Disturbances, Loss of Cognitive Control, Hyperarousal, and Social Withdrawal), rated on a 5-point Likert scale ranging from 0 (Not at all) to 4 (Extremely).</i>		
SCS: Suicide Cognitions Scale <i>(Ellis & Rufino, 2015)</i> <i>Description</i>	Suicidal Ideation (SI)/Hopelessness	N	Rudd et al., 2008 (unpublished)
	<i>The SCS is an 18-item self-report tool developed to assess suicidal ideation and thinking. Statements compatible with the suicidal schemas of unbearability and unlovability appear in the items. The items are rated on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree). The tool is</i>		

graded by adding up the ratings from each item, with scores ranging from 18 to 90.

**B-SCS: Brief
Suicide Cognitions
Scale**

(Rudd & Bryan,
2021)

Description

SI/Hopelessness

N

Rudd and Bryan (2021)

The B-SCS is a 6-item self-report scale that was developed to measure the suicidal belief system using items originally developed for the SCS, capturing enduring or identity-based hopelessness embedded in core beliefs about one's self as unlovable, one's emotional experience as unbearable, and one's life problems as unsolvable (i.e., the suicidal belief system elements), resulting in persistent vulnerability for the emergence of acute suicidal crises. Unlovability, unbearability, and unsolvability are all represented by two items each in the B-SCS. Likert-scaling (1–5) is used in B-SCS, and scores are derived by adding the keyed replies, yielding a value between 6 and 30.

**SIS: Suicide Intent
Scale**

(Mieczkowski et
al.1993 ; Beck et al.,
1985)

Description

Suicidal Intent

N

Beck et al. (1985)

The SIS comprises of 15-items scored from 0-2 to assess the severity of suicide attempts, taking into objective and subjective aspects of the person's suicide experience.

**INQ-15:
Interpersonal Needs
Questionnaire**

(Mitchell et al., 2017)

Description

Distress due to SI

N

Van Orden et al. (2012)

The 15-item INQ is a self-report tool that was created for research purposes and examines suicidality-related notions such as perceived burdensome and thwarted belongingness. It may be useful when clinicians feel a patient does not want to discuss suicidal thoughts or behaviours openly.

**SIS-MAP: Scale for
Impact of
Suicidality –
Management,
Assessment and
Planning of Care**

Severity of suicide risk

Y

Strivastava and Nelson (2008)

(Nelson et al., 2010)

Description

The SIS-MAP is a 108-item scale that uses a structured clinical interview to categorise the degree of suicide risk for treatment planning and admission to inpatient or outpatient mental health services. The overall scale consists of eight subscales that represent the important risk factor domains (demographics, psychological, comorbidities, family history, biological, protective factors, clinical ratings/observations, and psychosocial and environmental difficulties). The questions are either 0-1 or Yes/No, and they involve risk and resilience elements related to suicide risk. Outpatient care is required for scores 13-23, and scores over 33 suggest that patients may require inpatient admission. For results that lie between the two clinical cutoff levels, clinical judgement is necessary.

HCR-20: Historical Clinical and Risk Management
(O'Shea et al., 2014)

Violence; validated for self-harm (SH) N Webster et al. (1997)

Description

The HCR is a 20-item structured clinical guide used to assess the risk of violence in psychiatric and forensic populations. The instrument has a three-part temporal emphasis, which includes: ten historical variables ('H' Scale), looking at a history of violent behaviour and attitudes, employment, relationships, mental and personality disorders, and antisocial behaviour; five clinical variables ('C' Scale), highlighting recent or current problems with psychosocial, mental health, and behavioural functioning; five risk management factors ('R' Scale), encompassing relevant past, present, and future considerations with regards to living conditions, employment, and relationships. The HCR-20 prioritises cases into three categories: low/routine, moderate/elevated, and high/urgent. A low/routine grade indicates that the individual does not require any extra interventions or monitoring. Moderate/elevated risk indicates special management and increased monitoring is needed. The high/urgent prioritisation requires immediate action, which could include hospitalisation.

SBQ-R: Suicidal Behaviours Questionnaire-Revised
(Osman et al., 2001)

SB N Osman et al. (2001)

Description

The SBQ-R is a psychological self-report questionnaire designed to identify risk factors for suicide in adolescents and adults. The four-item questionnaire asks about four constructs within the suicidal behaviour domain: lifetime ideation and attempt, recent frequency of ideation, suicide threats, and self-

assessed likelihood of future suicidal behaviour. The four items are rated on Likert scales of varying lengths, resulting in total scores between 3 and 18.

ASIQ: Adult Suicidal Ideation Questionnaire
(Osman et al., 1999)
Description

SI N Reynolds (1991)

The ASIQ is a 25-item self-report with a 7-point rating scale for each item. It has a built-in score system. When there is a risk of suicide, the ASIQ can be utilised during admission interviews or therapy to take appropriate preventive action. The ASIQ generates a total score, as well as a T and percentile score. When you compare the entire score to a cut-off, you can identify who needs to be evaluated further for suicide risk.

LRFL: Reasons for Living Inventory (Linehan version)
(Osman et al., 1999)
Description

SI and SB N Linehan et al. (1983)

The Reasons for Living Inventory is a 48-item self-report tool that assesses a variety of adaptive attitudes and expectations for living if suicide is being considered. There are six subscales in the inventory: Survival and Coping Beliefs (e.g., "I believe I can find a purpose in life, a reason to live"), Family Responsibility (e.g., "My family depends on me and needs me"), Child-related concerns (e.g., "I want to watch my children grow"), Fear of Suicide (e.g., "I am afraid of death"), Fear of Social Disapproval (e.g., "I am concerned about what other people think of me. The 48 items are graded on a six-point scale, with one being "not at all significant" and the other being "very important". Higher scores represent more reasons to live.

RoSP: Risk of Suicide Protocol
(Gray et al., 2021)
Description

SH and SA N Gray et al. (2021)

The Risk of Suicide Protocol (RoSP: Snowden and Gray, 2020) assesses 20 risk indicators across four domains (History, Current Clinical, Current Problems, and Current Thinking) to generate a thorough risk assessment of a person and a risk management plan to mitigate or eliminate suicide risk. The RoSP consists of 20 factors that the clinician assesses before determining the level and nature of safety planning and clinical intervention required for the service user based on suicide risk.

DSI-SS: Depressive Symptom Index-Suicidality Subscale
(Stanley et al., 2021)

SI N Joiner et al. (2002)

<i>Description</i>	<i>The DSI-SS is a four-item self-report measure of SI severity that has occurred in the last two weeks. Each item is rated on a 4-point scale ranging from 0 to 3. There are different anchors for each DSI-SS component. Item 1 anchors, for example, include: 0="I have no plans to commit suicide," 1="I have suicidal thoughts on occasion," 2="I have suicidal thoughts the majority of the time," 3="I've always considered murdering myself." The responses are added up, and larger scores (range: 0–12) indicate more severe SI.</i>		
STS-3: Suicide Trigger Scale v. 3 <i>(Yaseen et al., 2014)</i>	SA (validated for post-discharge SA)	N	Yaseen et al., (2014)
<i>Description</i>	<i>The Suicide Trigger Scale v.3 was designed to measure the construct of an affective 'suicide trigger state' which is hypothesised to precede a suicide attempt. The STS-3 is a 42 item assessment battery with 3 response categories (0 = not at all, 1 = somewhat, 2 = a lot).</i>		
BHS: Beck Hopelessness Scale <i>(Beck et al., 1974; Beck et al., 1985)</i>	SI/Hopelessness	N	Beck et al. (1974)
<i>Description</i>	<i>The Beck Hopelessness Scale (BHS) is a 20-item self-report questionnaire that assesses three primary aspects of hopelessness: feelings about the future, motivation, and expectations. It assesses the extent to which the respondent has pessimistic views about the future. It could be used to assess suicidal risk in depressed people who have attempted suicide. It can be administered and scored by paraprofessionals, but only clinically trained professionals who can use psychotherapy interventions can interpret it.</i>		

Table 3.

Summary of the quantity of included reports and risk-to-self assessment tools identified in the systematic search

	Reports	Risk-assessment tools	Risk-assessment tools found in two or more reports	Reports containing two or more risk-assessment tools
Quantity	(<i>n</i> = 16)	(<i>n</i> = 15)	(<i>n</i> = 3)*	(<i>n</i> = 2)**

Notes: * Beck Hopelessness Scale; Suicide Intent Scale; Suicide Cognitions Scale

** Osman et al. 1999; Beck et al., 1985

Table 4.*Table of quality ratings for risk-to-self assessment tools across quality criteria*

Tool	Reproducibility (test-retest)					Reliability	Agreement	Interpretability	Floor/Ceiling Effects	Responsiveness	Predictive Validity
	Content Validity	Internal Consistency	Criterion Validity	Construct Validity							
SCI ^a	0	-	0	?	0	0	0	+	0	? (SB)	
SCI ^b	0	-	?	+	0	0	0	+	0	-(SI), -(SB), -(SA)	
SCI-2	-	-	?	+	-	0	0	0	0	-(SI), -(SB), +(SA)	
SCS	0	+	?	?	-	0	0	0	0	? (SA)	
B-SCS	-	+	+	+	?	0	0	0	0	0	
SIS ^c	0	+	?	0	0	0	0	0	0	0	
SIS ^d	0	0	0	0	0	0	0	0	0	? (SI/SA)	
INQ-15	0	?	0	+	0	0	?	+	0	+(SI)	
SIS-MAP	-	0	0	?	+	0	+	0	0	0	
HCR-20	0	0	?	-	0	0	0	0	0	-(SH)	
SBQ-R	0	?	?	?	0	0	?	0	0	+(SB)	
ASIQ	0	-	?	+	+	0	0	0	0	+(SA)	
LRFL	+	+	?	+	0	0	0	0	0	-(SA)	
RoSP	+	?	0	0	?	0	0	0	0	-(SH), +(SA)	
DSI-SS	0	+	+	+	0	0	0	0	0	0	
STS-3	0	0	0	0	0	0	?	?	0	-(SA), +(SA*)	
BHS ^e	+	+	?	?	?	0	0	0	0	0	
BHS ^f	0	0	0	0	0	0	?	0	0	? (SI/SA)	

Notes. += positive rating; ? = intermediate rating; - = negative rating; 0 = no information

^a (Galynker et al., 2017) ^b (Barzilay et al., 2020) ^c (Mieczkowski et al.1993) ^d (Beck et al., 1985) ^e (Beck et al., 1974) ^f (Beck et al., 1985)

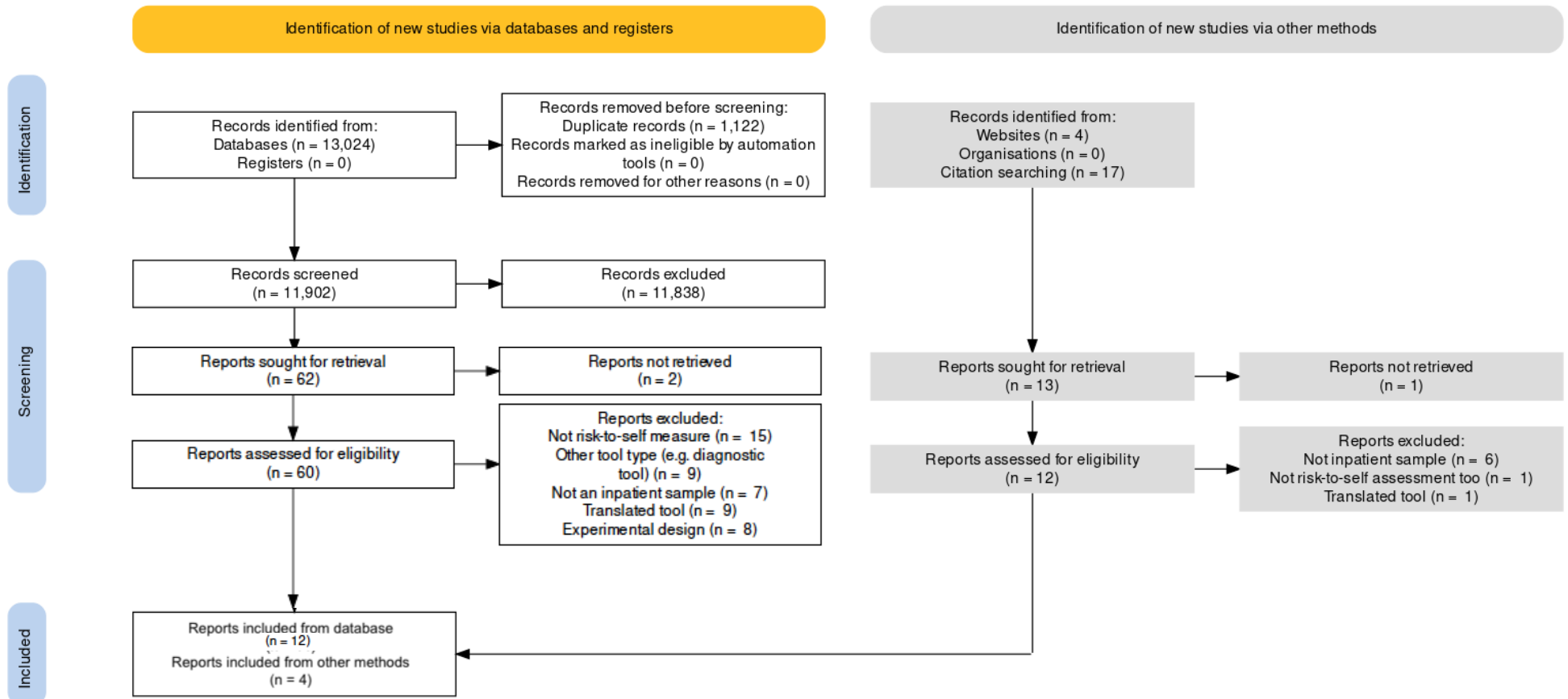
* = Referring to reduced item subscale (items 2, 4, 7, 23, 27)

SB = Suicidal Behaviour; SI = Suicidal Ideation; SA = Suicide Attempts; SH = Self-Harm.

SCI = ; SCI-2 = ; SCS = Suicide Cognitions Scale; B-SCS = Brief Suicide Cognitions Scale; SIS = Suicide Intent Scale; INQ-15 = Interpersonal Needs Questionnaire; SIS-MAP = Scale for Impact of Suicidality – Management, Assessment and Planning of Care; HCR 20 = Historical Clinical Risk Assessment; SBQ-R = Suicidal Behaviours Questionnaire-Revised; ASIQ = Adult Suicide Ideation Questionnaire; LFRL = Linehan Reasons for Living Scale; RoSP = Risk of Suicide Protocol; DSI-SS = ; STS-3 = Suicide Trigger Scale v. 3; BHS = Beck Hopelessness Scale.

Figure 1.

PRISMA flow diagram



Section 2: Empirical Paper

Clinical psychologists' experiences of patient death by suicide in psychiatric inpatient services: An IPA study

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Division of Health Research, Lancaster University

Year 2022

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Prepared for *Clinical Psychology & Psychotherapy*

Abstract

Introduction: Suicide is a global and national health concern that costs the National Health Service around £14 billion a year. A significant proportion of mental health patients who die by suicide were admitted to acute inpatient psychiatric services, who often work with the most high risk patient groups. The death of a patient by suicide can have long lasting personal and professional consequences for staff working in inpatient services. Clinical psychologists hold a unique role within inpatient services but little is currently known about patient suicide impacts this staff group. The study aims to explore the experiences of clinical psychologists who have experienced the death of a patient in inpatient services.

Method: Six clinical psychologists who had experienced at least one death of a patient while working in inpatient services were interviewed using semi-structured interviews. Qualitative data was analysed using Interpretative Phenomenological Analysis

Findings: Participants experiences were interpreted and organised into three superordinate themes. Initial shock: Dealing with personal feelings in a professional space; After the shock: self-evaluation, scrutiny and reflection; and The lasting phase: Remembering to learn

Conclusions: Clinical psychologists who experience a patient suicide in an inpatient setting are likely to feel intense emotions, including shock and sadness. Psychologists can move forward into a position of personal and professional growth with appropriate support, a sense of being valued by the organisation, and space to reflect. Without adequate support, psychologists may experience personal and professional ramifications such as leaving their roles or prolonged distress. The findings demonstrate how clinical psychologists' specific training and expertise as reflective-scientist practitioners, notably formulation and reflection skills, play a significant role in the process psychologists go through when a patient dies by suicide.

Introduction

Suicide accounts for 700,000 deaths a year, or 1.4% of the world's population (World Health Organisation, 2021). Suicide remains a major national public health concern in the United Kingdom (UK), accounting for 6,500 deaths annually (Office National Statistics, 2019). The key findings of the annual report by the 'National Confidential Inquiry into Suicide and Safety in Mental Health' (NCISH; 2022) show that there were 18,268 suicides by people within 12 months of receiving mental health care in the UK between 2009 and 2019, accounting for 27% of suicide in the general population.

The National Health Service (NHS) in the UK is responsible for the majority of mental health care in the country, spending around £14 billion in 2020-21 (NHS England, 2021), with suicide prevention set as a key priority (NHS Long Term Plan, 2019). Psychiatric inpatient hospitals, in particular, provide care to patients experiencing acute mental health crises and significant risk to themselves, including self-harm and suicide (Bowers et al., 2009). In the UK, during 2009-2019, 29% of mental health patient suicides (5218) occurred during inpatient admission, post-discharge or during crisis home treatment, with patients¹ most at risk within two weeks of discharge (NCISH, 2022; Chung et al., 2019), illustrating the burden of suicide on acute services.

Experiencing suicidality and completed suicide in inpatient settings can be burdensome for staff, both personally and professionally, with long-lasting consequences (Awenat et al., 2017). In Awenat et al.'s paper, staff feared blame for a patient death, and many reported taking leave from work due to anxiety. The research investigating the specific phenomena of workplace

¹ The term patient is used for consistency, but may refer to clients and service users.

death related to suicide in inpatient settings is limited (Sandford et al., 2021) and primarily focuses on nurses (e.g. Takahashi et al., 2011; Bohan & Doyle, 2008). However, multi-disciplinary teams with distinct functions characterise psychiatric inpatient hospitals (Royal College of Psychiatrists; RCP, 2019). Inpatient psychologists play an increasingly key role in assessing and formulating a patient's psychological needs and delivering appropriate psychological intervention (RCP, 2019; NHS Long Term Plan, 2019). According to the British Psychological Society (BPS; 2021), psychologists play an important role in risk management by assessing and formulating crises, planning for safety, problem-solving and psychoeducation. Psychologists must have an extensive set of competencies in inpatients settings addressing basic social needs, and promoting social connection with structured and psychosocial intervention (Wood et al., 2022). Psychologists' unique role and skillset in meeting these needs are also highly valued (Wood et al., 2019). While psychologists are increasingly vital in delivering inpatient treatment, staffing levels have not expanded in line with demand, further burdening psychologists with an increased workload and stress (Ebrahim, 2021; Raphael et al., 2021). Additionally, psychologists are highly likely to experience a patient suicide during their careers (Trimble et al., 2000). Despite their critical position and high exposure to acute risk, and their specific role within inpatient care, little is known regarding the impact of patient suicide on psychologists (BPS, 2021; RCP, 2019).

Alongside their direct patient work, psychologists often collaborate with the rest of the team, providing training, consultation, and reflective practice (BPS, 2021; RCP, 2019). When a serious or traumatic event occurs, such as a patient's death, guidelines recommend that psychologists conduct debriefings or follow-up support to promote staff members' psychological well-being (BPS, 2021). Psychologists are in a unique position because they are expected to help

both patients and colleagues while sharing the same difficult experience. Therefore, it is critical to investigate how a patient's death by suicide affects psychologists, given that research suggests it can lead to adverse personal and professional outcomes for other staff groups (Awenat et al., 2017).

While there is limited literature on the impact of suicide on staff in inpatient settings, there is a wealth of literature around death in the workplace that indicates potential outcomes for staff. The impacts vary widely depending on the healthcare setting and how expected the death is (e.g. Anderson & Gaugler, 2007; Meller et al., 2019), making it necessary to investigate each healthcare setting individually. A 2020 national survey (summarised in Mc Donnell et al., 2022) captures the experiences of people affected by suicide. Sixty percent of those who had experienced four or more suicides were health professionals, despite only 2% of participants reporting a patient-related suicide, demonstrating the prevalence for staff. Twenty-three percent of those who had lost a patient to suicide said the loss had a "Major Impact" on them. While professionals reported fewer adverse health-related and social life events than family members, negative health and social consequences were still widespread. For example, according to qualitative data in the study (McDonnell et al., 2022), one mental health professional suffered from persistent anxiety and low mood for 18 months following the death, with frequent sleep problems and feelings of guilt and grief. This resulted in time off work, demonstrating that the impact on healthcare professionals can be both personal and professional.

In contrast, a qualitative study looking at psychologists' experiences of suicide in a range of healthcare settings showed they were reluctant to recognise any personal impact of the suicide and did not question their practice due to feeling that suicide was out of their control (Darden & Rutter, 2011). Furthermore, nurses and care assistants working in residential aged or palliative

care, where patient death is commonplace and expected, had positive reactions following a patient's death (Anderson & Gaugler, 2007). This included professional and personal emotional growth resulting from successful death processing in these contexts (Papadatou et al., 2002). Conversely, healthcare staff have been shown to experience negative psychological responses, such as compassion fatigue, vicarious trauma, and burnout (Meller et al., 2019). Responses to a patient's death can be akin to those of family caregivers and are common among healthcare professionals who work directly with their patients (Boerner et al., 2015). A systematic review by Sandford et al. (2021) found shock and sadness to be a common initial reaction across disciplines, despite the circumstances. Ting et al. (2006) found that after a patient's suicide, mental health social workers experienced avoidance, intrusion, and added themes of professional incompetence, responsibility, and isolation. Patient suicide can have serious personal and professional consequences for healthcare workers, including stress reactions, emotional distress, and self-doubt (Castelli Dransart et al., 2017). The current body of literature demonstrates a spectrum of adverse but also positive outcomes for staff following a patient's death; thus, we cannot make any assumptions about psychologists' experiences in inpatient settings and should explore their unique experiences.

Proposed Research

Research has been crucial in shedding light on protecting healthcare staff in the aftermath of patient death (e.g. suicide 'postvention'; Kinman & Torry, 2021). Research shows that the workplace setting or context plays a central role in how patient death may impact staff (e.g. Anderson & Gaugler, 2007) and the varying healthcare professions or circumstances of the death (e.g. Meller et al., 2019). Therefore, research must continue to address and understand the issues

for specific staff populations to refine and enhance support to staff following the death of a patient in line with the NHS Long Term Plan (2019) priorities. This research aims to explore the unique experiences of practitioner psychologists working in psychiatric inpatient wards following the death of a patient by suicide. The research objectives are as follows:

- Understand the experiences of psychologists and how they respond following the death of a patient by suicide in an inpatient setting.
- Identify the processes and events that contribute to any psychological impact experienced by psychologists following the death of a patient by suicide.
- Provide clinical recommendations to inpatient services around the needs of psychology staff following a patient death by suicide.

Method

Design

Given that reaction to death is a complex phenomenon and unique experience for individuals, the research adopts a qualitative approach to focus on the meaning a phenomenon might hold for a participant and its ability to reveal how one experiences the theme under investigation (Willig, 2008).

Little is known about practitioner psychologists' experiences of suicide in psychiatric inpatient settings, so the research aims to preserve the participants' individual experiences and perspectives with a phenomenological approach (Hefferon & Gil-Rodriguez, 2011).

Interpretative Phenomenological Analysis (IPA) was selected over other qualitative methods as it allows for an in-depth, exploratory analysis of a homogenous group (Smith, Flowers & Larkin,

2009), in contrast to studies that have investigated these experiences simultaneously across multiple staff groups (e.g. Meller et al. 2019; Cleary, 2011).

Experiential data on participants' psychological responses to patient death by suicide, including cognitive, affective, and meaning-making processes, provides an in-depth look at how clinical psychologists in inpatient settings perceive these events over time (Smith, 2011).

Through IPA's double hermeneutic stance, which embraces the researcher's interpretative role throughout the study, a conceptualisation of participants' sense-making is generated (Smith & Osborn, 2003).

Ethical approval was granted by the 'Faculty of Health and Medicine Research Ethics Committee' at Lancaster University².

Procedure

Participants

Due to the idiographic nature of qualitative research, it is generally agreed that a modest sample size of three to six people is sufficient (Smith, 2004; Smith et al., 2009); hence researchers sought six participants minimum.

Participants were purposefully chosen to ensure sample homogeneity to better understand practitioner psychologists' experiences with patient suicide in a psychiatric inpatient setting (Smith et al., 2009). A comprehensive recruiting method was adopted, applying inclusion and exclusion criteria related to the specific characteristics necessary for this study to achieve fair homogeneity (Pietkiewicz & Smith, 2014).

² For full details of the ethics application, including risk management, refer to Section 4.

To be included, participants were required to be qualified practitioner psychologists (Clinical, Counselling, Forensic) who work or have worked in a secure psychiatric inpatient setting in the UK. Participants experienced at least one patient death by suicide, within three months of their discharge. Patients are at a high risk of suicide immediately after discharge, (NCISH, 2022) therefore psychologists are likely to have had recent contact with them before they died. Participants had to be at least 18 years old and fluent in English. There was no upper age limit.

Participants were excluded if their only experience of patient death occurred within the last year, or more than six years ago. This ensured participants had temporal distance from the event (Elliot, 2012) and ensured the participants' experience was relevant to the current NHS context and environment. Previous studies helped define the upper time limit (e.g. Castelli Dransart et al. 2014). In addition, participants were excluded if there were ongoing investigations relating to the patient's death, as this was deemed a present experience and would make it difficult to fully explore the psychological impacts on participants as per the study's aims.

Recruitment and Selection

Potential participants were purposively sampled through targeted advertisement in psychology networks and forums. Members were encouraged to forward the advertisement to their contacts as a further means of snowball sampling. A recruitment poster³ was made to describe and advertise the study to potential participants and included a contact email. The advertisement was forwarded to an acute inpatient psychology network by a researcher (LW), and members were asked to share it with peers who fit the inclusion criteria. The advertisement was also shared on a private Facebook group for UK Clinical Psychologists. Once candidates

³ For full documentation used in recruitment and participants interviews refer to ethical approval in Section 4.

responded, they were emailed a participant information sheet and screened for inclusion and exclusion criteria. All candidates had the opportunity to ask questions about the study. Eligible candidates were selected on a first-come, first-serve basis to reduce selection bias. An interview was scheduled once participants completed and submitted the consent form. Eight candidates came forward and six took part in an interview. One candidate did not meet the inclusion criteria due to the patient death being too recent, and one could not proceed due to scheduling difficulties.

Data Collection

Data was collected through 45-60 minute, flexible and interviewee-led semi-structured interviews (Pietkiewicz & Smith, 2014). Due to COVID-19 restrictions on face-to-face meetings, interviews were remote via encrypted video-conferencing software. The lead researcher developed an interview schedule with open questions and prompts to help guide the interview³ (Pietkiewicz & Smith, 2014). Participants were asked for feedback during the interview to ensure all key issues were covered. Questions were adapted as the interviews progressed to ensure the research remained interviewee-led. Participants were provided with a debrief³ via email at the end of the interview. The debrief included phone numbers participants could call if they needed additional emotional support following the interview, although no participants required this. In preparation for analysis, the researcher transcribed the audio recordings verbatim (Appendix 2).

Data Analysis

The data was analysed using an Interpretative Phenomenological Analysis (IPA) framework, in-keeping with the phenomenological method and attempting to understand the participant's meaning-making of their experience. To arrive at superordinate and subordinate themes, the

principal researcher went through a cyclical procedure (Smith et al., 2009). After each interview and throughout the analytic process, the researcher kept a reflective diary to record anything noteworthy and to contain any interpretations or emotional responses before doing an in-depth analysis (Appendix 3). The researcher immersed themselves in the transcripts with repeated reading to actively engage with the "participant's world", noting anything of interest and paying particular attention to the participants' explicit meaning-making before moving on to interpretations and early themes (Smith et al., 2009; Appendix 2). Initially, the researcher utilised a spreadsheet to organise and arrange the early notations into potential emergent themes, allowing them to verify their understanding of the data through supervision (Appendix 4). Next, the researcher utilised thematic maps to aggregate themes and began to piece together a cohesive analysis of the participants' diverse experiences (Appendix 5). The ultimate categorisation of findings into superordinate and subordinate themes was guided by thematic maps, which illustrated both common and conceptually diverse experiences, supported by participant quotes.

Reflexive Statement and Epistemology of Researcher

At the time of writing, the researcher was a 30-year-old white, cis-gendered female working as a trainee clinical psychologist in the NHS. The researcher reflected on her own experiences as a Clinical Psychology Trainee working in an acute inpatient setting. She thought critically in supervision about what led her to want to capture staff experiences and understand the processes involved when losing a patient by suicide. This process enabled the researcher to comprehend her personal experiences of suicide outside of her professional function, and a loss in the workplace (unrelated to suicide) may lead to assumptions when designing interview

questions. Additionally, as new views and understandings of an experience evolved during the investigation, this method allowed the researcher to stay open and inquiring (Haynes, 2012).

The research was conducted from a critical realism epistemological standpoint (Bhaskar, 2013). This viewpoint argues that participants' reality is built around their own experiences. It also assumes that an effect is created by several factors interacting together rather than by a single cause (Archer et al., 1999). From this vantage point, the researcher realised that the only way to comprehend the death of a patient is through the personal narratives of those who have experienced it, as there is no objective understanding of the universe and several valid accounts are conceivable (Maxwell, 2012).

Findings

Participants identified as male ($n = 2$) and female ($n = 4$) between the ages of 31-44. All participants identified as White British and had worked in NHS trusts across England. All participants were qualified clinical psychologists. Participants had worked in the NHS for nine months to ten years. Participants experienced between one and four deaths of a patient by suicide.

[Insert Table 1]

Findings, organised into three super and subordinate themes, demonstrate that psychologists' experiences after the death of a patient can be thought of as a process occurring over time. Theme one, 'Initial shock', describes the early phase of finding out about the patient's death, how they felt and how the delivery of the news and the support around them impacted their initial responses. Theme two, 'After the shock', describes the process of understanding what happened and broader reflection on professional issues. It discusses where the reflective process takes place and challenges to this process. The third theme, 'The lasting phase', focuses on

enduring emotions, how participants remember their patients and how they use their experiences for personal and professional learning and change. Themes are summarised in Table 2.

[Insert Table 2]

1. Initial shock: Dealing with personal feelings in a professional space

This theme describes the participants' experiences after learning that their patient had died, and how their responses evolved early on. These responses were influenced by the duration of time since they last worked with their patient, and a sense of leadership support.

Regardless of the circumstances surrounding the suicide, all participants described feelings of 'shock' and 'sadness,' followed by a feeling of 'numbness'. Four participants also expressed a desire to resume their normal routine, which reflects the fast-paced inpatient work culture.

“It was very sad ... but I’d say the nature of the environment is that we all just move on because there’s something else, everyone’s in crisis technically”. (Joe)

The strength of the connection with the patient and the length of time since they last saw them mitigated the intensity of the participants' initial reactions. Danielle, for example, had worked closely with her patient and had only seen them days before learning of their death. These participants had raw visceral reactions, becoming tearful and upset. They described a range of emotions and distress that emerged throughout the day, which could adversely impact their work.

“I needed a bit of flexibility, particularly on the day I found out ... I got the email in the morning and I was supposed to go and see a patient but luckily she didn’t want to. I went to the loo and just burst into tears so I wasn’t in a great frame of mind to be going into sessions”. (Eleri)

Conversely, Emma described a diffused sense of distress when the person died a while after discharge, potentially due to no longer having direct professional input, which could feel protective.

“one thing I’ve noticed is the time between working with someone and them passing away seems to correlate a bit with how distressing it is. It would’ve been so much more difficult had it been immediate, because it would’ve been very difficult to argue that the things he was going through weren’t evident to me at the time. There’s sort of a wish they weren’t feeling that at the time [of discharge] and things got much worse, which I think is a psychological trick that we do to make ourselves feel better.” (Emma)

Participants were able to adopt a more logical and analytical approach to the circumstances, given some time between seeing the individual and learning they had died. Due to the detachment from the person and incident, emotions and thoughts tended to seem less distressing, resulting in less disruption to the day ahead. In these instances, participants were more likely to feel 'frustration' or 'anger' towards other professionals or the service. Though reactions to deaths occurring post-discharge tended to be focused on professional matters, this could be intertwined with delayed personal sentiments of 'anguish' or 'guilt', so no participant was immune to some degree of sorrow.

All participants discussed a lack of policy or procedure for informing staff of a patient death, which resulted in them being told in various ways. Some participants were told directly, in a planned and intentional manner, by supervisors or managers:

“On the Monday morning I came in and reception staff were very cagey ... so I went up to my office and my supervisor was in before me, which was unusual, and he said ‘oh, can I speak to you?’. (Becky)

Other participants were told indirectly. Some were told by email which could feel “brutal” and “blindsiding” as the communication could feel “practical” and “matter-of-fact”. One participant was accidentally informed by a colleague, resulting in high levels of distress. Being told indirectly led to a sense of abandonment by leadership and a feeling of being undervalued.

The quality of leadership and team support made a difference in how difficult the participants' experiences were. Danielle was expected to support other colleagues, which made her feel as if her distress was not acknowledged, leading to feeling undervalued as a professional. This was comparable to Becky's experience with a lack of emotional validation and communication, which she stated impacted how she felt valued in her team and ultimately led to her resignation.

“It was like the emotional impact didn’t matter, I just felt like people really didn’t care ... in part why I ended up leaving that post because they didn’t value communication and staff value wasn’t great”. (Danielle)

When supervisors or colleagues recognised participants' personal emotional needs, they felt valued as professionals. Joe, for example, saw his experience as containing since he felt well supported by his co-workers, allowing him to informally support other employees despite his own sadness. On the other hand, most participants had to advocate for their own needs. They did so to cope personally and professionally, but this could lead to increased dissatisfaction and frustration toward the service.

2. After the shock: self-evaluation, scrutiny and reflection

The second theme describes the process participants take as they piece together what happened to their patient and their role in it. It explores how professional feelings and the

work environment influence the reflective process, and the avenues and barriers to support throughout this phase of their experience.

a. Information gathering, external scrutiny and self-evaluation

After learning their patient had died by suicide, participants wanted to learn more about the circumstances surrounding the death. However, unless a patient died during admission, there was often limited information, which could lead to feelings of guilt or doubt about their professional activity concerning that person. In response, a process of gathering information to try to understand the suicide would commence, often guided by reflection on final contacts with the patient and a review of notes. This became an early stage of self-evaluation for several participants, driven by a sense of professional anxiety over whether they had done the correct thing or missed something crucial.

“I suppose selfishly, maybe not selfish, but with both deaths there was that thing like, oh my gosh, have I done everything I was supposed to do? I think I went back on both the records and looked through my notes and was thinking is this comprehensive enough?”

(Eleri)

Participants were routinely asked to participate in 'serious incident' investigations, and coroner's court reports were frequently requested. The experiences varied but could feel more difficult when it was the first time, and there was little guidance around the process. Becky was apprehensive because she did not know how much information to share, so had a 'bad experience' with no guidance, while Danielle felt informed by her employer's legal team. This alleviated her fear of being summoned to court, demonstrating how professional support altered anxiety levels. Although this form of external 'scrutiny' was unpleasant for many, perhaps fearing judgement, it was often considered a valuable element of further self-evaluation. The process

pushed them to focus constructively on their role as clinicians in the person's care, consequently, all participants felt relieved they had taken the time to make comprehensive notes, prompting them to make thorough record-keeping a priority throughout their careers.

“I would have expected it to be more anxiety-inducing because there’s a sense of your decisions being questioned. In this case it happened to be an extremely thorough piece of work so I was quite happy to say I felt it was a good account and we had made the best efforts to take in account this person’s needs” (Joe)

Looking back on the work while writing the report also facilitated the internal processing of the death. The more comprehensive the assessment and formulation, the easier it was for participants to believe that they had done everything they could for that person, resulting in a more emotionally contained experience. Formulation was used as a contextual backdrop to the suicide, which reduced personal guilt regarding their patient's death. Appreciating the complexity of their patient's life through formulation allowed participants to feel greater acceptance over the suicide.

“In your work you want to empower patients and collaborate with them, not be this parental restrictive figure ... we knew his risk was high but he was keen to manage things on his own and he didn’t want any more therapy ... I think he was as ready as he could have been to leave the ward, and yes we could have kept him for longer but I think that risk would have always been present” (Eleri)

Due to the limited amount of time with the patient and the resulting lack of formulation prior to discharge, Leigh had reservations about the service's decision to discharge. Despite minimal involvement, he felt "quite responsible" and frustrated with the system without the formulation.

“there were a lot of question marks about what was going on for him [patient] and there was a only a tentative hypothesis and formulation to share.” ... “it was felt the risk had gone down ... but there was so much we didn’t know about her, we didn’t have a clear formulation.” (Leigh)

Leigh's experience demonstrates how a lack of formulation can damage the self-evaluation process, leading to internal blame, unanswered questions, and professional frustration.

b. Ruminating and reflecting on the path to acceptance

Following the initial information gathering and self-evaluation was a period of thinking more broadly about professional issues concerning patient suicide. This included participants' views about the inpatient service's functioning, their role and positioning as a psychologist in the service, and patient wishes versus risk. Participants' reactions varied depending on the difficulty of the initial responses and the level of support they received, and tough professional experiences could lead to more negative internal processes.

“Most of the process is through what I would kindly call ‘reflection’, but in reality might be rumination of just like going over something that’s driven by guilt probably in the first instance. So, yeah, just engaging in a ruminative, guilt fuelled process of dissection.”
(Emma)

Many spoke about cultural and practical challenges that obstruct reflection and processing of traumatic events in inpatient settings, particularly for the wider team.

“What we have a habit of doing is, something bad happens and staff are in tears and it’s just like ‘you okay?’. ‘Yeah I’m okay’. Have a cup of tea, okay, bye and carry on and do your group in ten minutes” (Joe)

Debriefings are frequently conducted after a patient dies by suicide and provide an opportunity for the team to come together and discuss what happened, and are a more formal type of reflection in inpatient settings. However, five people said the debriefs were “unhelpful”, and everyone agreed that the culture of inpatient settings made debriefs “practical” and “dehumanising” rather than the space for mutual processing and reflection that they could be. Becky described teams as 'defensive,' and Leigh summarised the barriers to team reflection:

“there’s a lot of fear around reflecting because nobody wants to think about the things that have gone terribly wrong ... people are so tied to the idea that they need to save and rescue people, it goes back to feeling like I’ve done something wrong and ultimately closes down a lot of conversations and the willingness to kind of go there” (Leigh)

There was a sense that actively engaging with the emotional aspects of what happened and attempting to navigate through it, rather than disregarding it, was a feature of psychologists' training and not common practice among other professionals. This could be difficult for participants whom all wanted to engage in some form of processing.

“I think everyone has to put some degree of armour on, but I think as a psychologist, we have to be willing to go there ... it’s part of our training to reflect on our thoughts and feelings, which perhaps other professions, it’s not in their training or culture to do that ” (Leigh)

As psychologists working in teams that were often defensive in the face of tragedy, all participants relied on supervision as their primary source of support and reflective space. The less support the service provided, the more critical supervision was to explore their emotional responses and professional growth. From the perspective of a lead psychologist in an inpatient

service, Emma emphasised the necessity of supervision, providing instances of good supervision qualities that helps people stay in their roles.

“what people need I think is a system which is so containing that when they go through this process themselves, what’s internalised is a sense of trust and capability, that’s what holds them and guides them” ... “We had someone in the team who just started and had two people die in a couple of months, he hadn’t had that trust imbedded in him yet. So he left. So it’s something we provide that’s an internal function” (Emma)

3. The lasting phase: Remembering to learn

The third theme explores some of the participants' enduring feelings and their perceptions of how they had altered personally. Participants described a variety of ways they used the death of a patient as a learning opportunity for professional development to honour their patients' memories and strive to improve experiences for patients and colleagues in the future.

a. Enduring sadness. remembering and personal impact

All participants remembered or thought about their patients long after their deaths with some sense of sadness. Those who had ‘containing’ experiences and were supported throughout that time, or were more established in their roles, experienced lower long-term personal impact and a greater focus on professional development. Participants who had distressing early experiences of the death, such as Danielle and Becky, remembered the person more frequently and with a stronger sense of sadness. In these circumstances, longer-term impacts were centred on personal transformations or carrying the individual with them in their daily activities to honour them as a

person. Personal growth could involve rediscovering coping methods or practising better self-care.

“I still think about him all of the time. I wrote poems occasionally, still do as well, even nearly three years down the line. He’s stayed with me more like a friend when they’ve died ... he loved hikes and stuff. So if I’m doing something like that, I always think about him and I sort of give him a little nod, like you can just see it through me. So yeah, I think about him a lot” (Becky)

Joe explained how he preferred to compartmentalise his experiences in a work environment because it was too difficult for him to talk 'shorthand' or find understanding from others in his personal life, which other participants echoed. Some participants lost empathy for friends’ work problems, which seemed trivial in comparison.

“I talked to my friend [who was] launching a new product and it got a setback and how that was the most horrible stressful thing. And you’re thinking, right? ... you haven’t got a clue what it’s like to work in the NHS with suffering and misery. I just remember feeling quite aggrieved” (Leigh)

Emma also spoke similarly about waning empathy, comparing her job to her friends and recognised her threshold for what she felt was a ‘real’ problem had lessened over time.

“a bad day at the office can be somebody being found hanging, you know, that’s not like a bad day at someone else’s office and it can be quite difficult to feel like there’s a shared understanding.” (Emma)

Perhaps due to the sense of shared understanding in an inpatient setting, none of the participants indicated diminishing empathy for their patients. While the culture enabled participants to

separate themselves and maintain empathy in their work life, it appears to come at a personal cost.

b. Professional growth

Despite their experiences with suicide leading some to leave their jobs, every participant continued to work with high-risk patients. Leigh recounted making a conscious decision to stay in crisis work and accept the risk of patient death to stay true to his professional values.

“this is the price you pay, this is part of it, in order to do work that is meaning and important you have to come into contact with some of that stuff”. (Leigh)

Emma also felt that staying true to her values allowed her to navigate patient death throughout her career. Strong professional values were inextricably linked to personal values, allowing participants to continue working in acute care.

“what guides us is ultimately what is the decent thing to do as a human being, not a decent psychologist but a decent person ... and if we’ve done that we can navigate patient deaths more easily” (Emma)

Participants were reminded of the potential repercussions of poor mental health after experiencing patient death by suicide, which further motivated them to continue with high-risk work. As a result, most participants have utilised their experiences to make practical and tangible changes in services or take on service development roles to honour their patients. Joe, for example, went on to create a new service pathway after recognising the need for change:

“I feel hopeful and passionate about the work we do in this setting, because the other option is to say, well someone could die any time so let’s not do the work so we make the best opportunity to give people a chance to not have that as the outcome” ... “being able

to say from experience we need to iron this out and we need to be better at this and that”.

(Joe)

Danielle used her negative experience of being told accidentally about her patient to develop practical measures to help prepare the service to inform staff of a patient death in the future.

“we developed a checklist, nothing major, but it’s got people in the whole team and prompts for who might be informed so you can tick them off”. (Danielle)

Participants establish a strong professional identity as a result of working in an acute hospital culture, making it harder to leave. Emma thought it would be difficult to change roles because she found frequently responding to crises "addictive" and "exhilarating." Participants thrive on the fast pace, take pride in a "tough" identity, and feel a sense of belonging in a unique shared experience that unites them with colleagues.

“We know our jobs are mad, we know it could be way easier. We know we’ve got this crazy messed up job that every day we’re like why the hell do we do this? But it’s really hard to leave ... it’s almost like people wear it as a badge of like, you know, like we’re tough. That’s not always a good thing as it could easily tip into bravado, so it’s balancing that.” (Emma)

Guilt and anxiety drove participants to develop a deeper understanding of themselves professionally. This allowed them to acknowledge “their own stuff”, allowing participants to free themselves from feeling stuck within those thoughts and feelings. Danielle was able to acknowledge that she did not feel integrated in her team and made proactive changes, whereas Leigh began to think more deeply around his power and professional responsibilities and how to better leverage his position to influence decision making.

“When we’re positioned as this expert, I found that quite paralysing, and it’s kind of noticing when you get in positions like that. Trying to step outside of that and say with the best will in the world there’s no way you can fix it all ... I got closer to those in a position of influence or the decision-makers, so when I do have concerns I can flag them up and be more open about saying ‘I’m not sure’” (Leigh)

Discussion

The findings shed light on clinical psychologists' experiences in inpatient settings after a patient dies by suicide. The themes represent the personal journey of clinical psychologists, framed by 'phases' that signify the passage of time. The findings show psychological responses, reflective processes, and long-term implications of patient suicide, similar to the literature (e.g. Awenat et al., 2017; Anderson & Gaugler, 2007) around death in the workplace such as emotional distress and self-doubt in the form of self-scrutiny (Castelli Dransart et al., 2017). The study’s novel findings are that these experiences have been interpreted through the prism of intertwined personal and professional identities or ‘selves’. Furthermore, it suggests clinical psychologists use their specific skillset and training (e.g. supervision and formulation) to help process a patient death. Systemic factors such as the culture in which participants work, and the support they receive following a patient death, shape their personal and professional responses. These experiences then influence internal processes of reflection and personal and professional development. Although authors such as Awenat et al. (2017) discuss professional and personal growth, they are often discussed as discrete phenomenon rather than influential to each other (Woodward, 2014).

A range of initial emotional responses, particularly shock and sadness, were experienced by all participants, which was anticipated from the literature on patient death in healthcare

(Sandford et al., 2021; Castelli Dransart et al., 2017). However, the intensity of emotional distress participants experienced depended on systemic factors. For example, the less time between their last contact with their patient, the more distress participants felt when hearing the news. The more integrated and supported they felt in their work-place when going through difficult processes such as writing coroners' reports, the more confident and emotionally contained they would feel in their professional work (e.g. Sandler, 2009).

Some literature (e.g. Sandford et al., 2021) touches on staff feeling undervalued through a lack of support after the death of a patient, and this research sheds light on some other ways this can happen. The delivery of the news was meaningful for participants, and poor experiences were often preceded by a lack of service preparation for these circumstances. Feeling as though they were dehumanised when being informed led to participants feeling undervalued as professionals, creating additional distress unrelated to the person who died. Participants who felt emotionally contained and supported were able to experience positive professional and personal growth due 'successful death processing' (Papadatou et al., 2002), while more difficult experiences could lead to negative psychological responses like compassion fatigue (Meller et al., 2019), further supporting the literature. However, in contrast to the literature, compassion fatigue was directed at friends and family rather than patients.

Bennett-Levy's (2006) cognitive model of therapist development can be used as a supportive framework for the findings. The three main systems in the 'DPR model' are declarative (conceptual knowledge), procedural (skills), and reflective. The reflective system is given a central role in the model as it allows therapists to reflect on their declarative knowledge and procedural abilities in a dynamic and ever-evolving way (Bennett-Levy, 2006) through a cognitive mechanism known as "perceptual learning" (Bransford et al., 1989). In the DPR model,

the reflective system compares current and past experiences, analysing the information before transferring it back to the other systems to facilitate new understandings, adding to the therapist's development and expertise. Within the DPR system, all information is processed through two schemas: the 'self-schema' (the non-therapist self) and the 'self-as-therapist schema', which is an identity that therapists (including psychologists) develop during training and beyond, with both continually influencing each other (Bennett-Levy, 2006).

We can consider the DPR model when thinking about participants' reflective experiences that are integral to themes two and three. For example, participants question and evaluate the professional-self and their clinical work through clinical notes and formulation to form an understanding of why their patient died by suicide (Theme 2). They also utilise clinical supervision, formal debriefs and informal support from colleagues as a form of reflective practice (BPS, 2021; DCP, 2019). Participants turn to their clinical work (clinical notes and formulation) conducted through procedural and declarative systems and use the reflective system (self-evaluation and supervision), which ultimately impacts their professional and personal selves (therapist and non-therapist schemas) (Bennett-Levy, 2006). This is an unsurprising finding to emerge as it is central to clinical psychology training to develop as 'reflective-practitioners' (see Hanley & Amos, 2017) alongside 'scientist-practitioners' (Amos & Hanley, 2017; pg. 8. BPS; 2019) which is the development of theoretical knowledge and therapy skills.

Participants who had access to multiple forms of support and reflection went through a more emotionally containing process that tended to develop the professional-self in positive ways. Participants were able to integrate learning from the death of their patients to develop stronger professional values, which acted as a motivation to implement positive and tangible changes in their workplaces (McCann et al. 2013). This included service development, or simply

solidifying their commitment to working in acute care despite its ongoing challenges (Theme 3b). Those who felt less valued and supported were more likely to experience personal growth as a means of self-care and healing, as was illustrated by Becky, who re-engaged with rewarding hobbies. This is consistent with Charlemagne-Odle et al. (2014), who found psychologists would often make positive experiences following work-related distress.

The importance of supervision and reflective skills for professional development and emotional containment has been widely written about, particularly in regard to trainees (e.g. Woodward et al. 2015; Fleming & Steen, 2013; Sheikh et al., 2013). These findings illustrate how this skillset in the professional-self comes to life in a real clinical context and can protect psychologists in the face of difficult circumstances, such as the death of a patient. The quality of assessment, clinical notes and formulation served as protection from triggering difficulties in the personal-self relating to the death. While no participants were immune from any impact on the personal-self, those who felt they lacked support and necessary reflection at the time of their patient's death experienced the most personal difficulty. While participants describe other professions as defensive, clinical psychologists want to engage emotionally with difficult events such as patient death, and possibly need to in order to continue positively in their jobs.

These findings demonstrate the potential for positive professional growth and tangible change through 'successful grief experience' and is expected from the findings on growth across other healthcare professionals (e.g. Anderson & Gaugler, 2016). However, what is reiterated here is that personal growth relied on emotional containment and support early in the process. This is primarily found in supervision for psychologists, but participants point out many missed opportunities for staff support which can ultimately lead to a sense of being undervalued. This is

crucial as participants in the study who felt less valued and supported were more likely to leave their jobs.

Strengths and Limitations

This paper offers a novel exploration of the unique experiences of clinical psychologists who have experienced the death of a patient by suicide in a psychiatric inpatient setting in the UK. To prevent a bias in sampling, participants were accepted in the order they contacted the researcher. However, all participants were White British and fell into a relatively limited age bracket. The research acknowledges the findings' limited cultural perspective which would have been enriched by a more diverse sample. While the sample size was adequate for the study, it did not reach 'data saturation' (Chamberlain, 1999) whereby no new information came to light in the transcripts, so there are potentially missing experiences, although some literature does not believe this is the true aim of IPA (e.g. Hale et al., 2008)

The findings show participants move through a process that ultimately allows them to stay within their roles. However, the nature of self-selection of participants and awareness of the topic to be discussed may have skewed the sample to people who ultimately had a successful process following the death of their patients. Therefore, it cannot be concluded that the findings in this study reflect the experiences of people who may have left their careers as a result of experiencing a death, as highlighted in Emma's interview.

IPA offers a flexible and open approach to data collection, privileging individual meaning-making, which allows for a thorough consideration of participants experiences that allows them to guide their own narratives. A key strength of this research is that it allows clinical psychologists' valuable experiences to be understood in order to make positive and practical improvements to current working practices in inpatient services. Novel findings of this study

highlight the complex interplay between personal and professional selves when a patient dies by suicide in inpatient settings, which can have a range of consequences in multiple aspects of a clinician's life. Furthermore, the findings show how appropriate preparation for, and support after, a suicide can mitigate longer-term negative outcomes for professionals.

Clinical Implications for Practice and Future Research

The key clinical implications from the findings are that clinical psychologists utilise their specific professional skillset to protect the personal-self following the death of a patient by suicide. Without acceptable assessments and formulations, participants lacked the contextual framework and professional safety to understand what had happened to their patients leading to distress. Training programmes must promote working practices, such as assessment and formulation, thorough clinical note-taking and strong reflective-practitioner skills. While the integration of clinical psychology into inpatient services is still relatively new, services must allow psychologists to practice in line with their professional skills and values to mitigate future distress.

Despite its prevalence, findings demonstrated a lack of preparation for patient suicide in inpatient settings. One key suggestion from participants and literature is that policy is integral to mitigating traumatic experiences and negative outcomes for professionals (Thompson & Lund, 2009). Furthermore, findings show appropriate support for staff, such as supervision, mitigates adverse outcomes and fosters an environment that creates the potential for personal and professional growth and transformation. Inpatient settings often have the means of creating this space during commonly held debriefs. However, the findings show debriefs often become practical, factual meetings that do not allow for reflection and sharing experiences within teams.

This seems a missed opportunity for all staff, particularly when they do not have the same skillset psychologists fall back on as protective measures in the face of distressing experiences. While there were mixed experiences, most participants found debriefs unhelpful. Gibbons et al. (2019) found debriefs that felt insensitive or persecutory to staff could be damaging and this was reflected by participants describing them as ‘inhumane’, showing the need for adequate guidelines when holding debriefs following patient suicide.

Future research would benefit from looking closely at the experiences of those who had left their jobs as a result of patient death to understand the differences in their experiences and more closely identify the key factors that lead to that outcome.⁴

Conclusions

This study shows psychologists who experience the death of a patient by suicide in psychiatric inpatient settings are likely to experience strong emotions, particularly shock and sadness. Through good support, a sense of being valued by the organisation and space to reflect, psychologists are able to move into a place of growth and acceptance around the death of their patient. When this process is successful it enables psychologists to undertake powerful personal changes, enhanced understanding of the self as a professional and motivates psychologists to make active changes and improve services. A difficult experience can lead to psychologists feeling a prolonged sense of sadness around the loss which can have professional consequences such as having to leave their role. The findings highlight how the unique training and skillset of clinical psychologists as reflective-scientist practitioners (BPS, 2019), particularly formulation and reflective skills, plays a prominent role in the process psychologists go through beyond the death of a patient by suicide.

⁴ See Section 3: Critical Appraisal for a detailed exploration of clinical implications and recommendations.

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Appendices

Appendix 1

Guidelines for Publication for Clinical Psychology & Psychotherapy Journal

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a meeting or symposium.

Data Protection: By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at <https://authorservices.wiley.com/statements/data-protection-policy.html>.

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Clinical Psychology & Psychotherapy aims to keep clinical psychologists and psychotherapists up to date with new developments in their fields. The Journal will provide an integrative impetus both between theory and practice and between different orientations within clinical psychology and psychotherapy. *Clinical Psychology & Psychotherapy* will be a forum in which practitioners can present their wealth of expertise and innovations in order to make these available to a wider audience. Equally, the Journal will contain reports from researchers who want to address a larger clinical audience with clinically relevant issues and clinically valid research. The journal is primarily focused on clinical studies of clinical populations and therefore no longer normally accepts student-based studies.

This is a journal for those who want to inform and be informed about the challenging field of clinical psychology and psychotherapy.

Submissions which fall outside of Aims and Scope, are not clinically relevant and/or are based on studies of student populations will not be considered for publication and will be returned to the author.

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2. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Research Article: Substantial articles making a significant theoretical or empirical contribution (submissions should be limited to a maximum of 5,500 words excluding captions and references).

Comprehensive Review: Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies (review submissions have no word limit).

Measures Article: Articles reporting useful information and data about new or existing measures (assessment submissions should be limited to a maximum of 3,500 words).

Clinical Report: Shorter articles (a maximum of 2,000 words excluding captions and references) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e. be innovative).

3. PREPARING THE SUBMISSION

Parts of the Manuscript

The manuscript should be submitted in separate files: main text file; figures.

File types

Submissions via the new Research Exchange portal 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) or LaTeX (.tex) formats.

If submitting your manuscript file in LaTeX format via Research Exchange, select the file designation “Main Document – LaTeX .tex File” on upload. When submitting a Latex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as “Main Document - LaTeX PDF.” All supporting files that are referred to in the Latex Main Document should be uploaded as a “LaTeX Supplementary File.”

Cover Letters and Conflict of Interest statements may be provided as separate files, included in the manuscript, or provided as free text in the submission system. A statement of funding (including grant numbers, if applicable) should be included in the “Acknowledgements” section of your manuscript.

The text file should be presented in the following order:

1. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's [best practice SEO tips](#));
2. A short running title of less than 40 characters;
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4. The authors' complete institutional affiliations where the work was conducted (Institution Name, Country, Department Name, Institution City, and Post Code), with a footnote for an author's present address if different from where the work was conducted;
5. Conflict of Interest statement;
6. Acknowledgments;
7. Data Availability Statement
8. Abstract, Key Practitioner Message and 5-6 keywords;
9. Main text;
10. References;
11. Tables (each table complete with title and footnotes);
12. Figure legends;

Figures and appendices and other supporting information should be supplied as separate files.

Authorship

On initial submission, the submitting author will be prompted to provide the email address and country for all contributing authors.

Please refer to the journal's [Authorship](#) policy in the Editorial Policies and Ethical Considerations section below for details on author listing eligibility.

Acknowledgments

Contributions from anyone who does 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, including the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s). Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the [Conflict of Interest](#) section in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Abstract

Enter an abstract of no more than 250 words containing the major keywords. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.

Key Practitioner Message

All articles should include a Key Practitioner Message of 3-5 bullet points summarizing the relevance of the article to practice.

Keywords

Please provide five-six keywords (see [Wiley's best practice SEO tips](#)).

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1. The journal uses US spelling; however, authors may submit using either US or UK English, as spelling of accepted papers is converted during the production process.
2. Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

References

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. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

For more information about APA referencing style, please refer to the [APA FAQ](#).

Reference examples follow:

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](https://doi.org/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=Vja83KLOXZs>

Endnotes

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Appendix 2

Sample transcript with initial notes and interpretations

Transcript	Initial notes	Reflections and Interpretations
<p>Speaker 1: [00:16:04] <i>And you said a little bit about feeling quite kind of numb on that first one that you wanted to get on with your day. Can you tell me a bit more about the impact of that news at that time?</i> [00:16:18][14.2]</p>		
<p>Speaker 2: [00:16:20] So I do think this is where the two slightly differ, because I think the first one definitely, definitely affected me personally more, I think partly because it was umm. Yeah, it was my first experience of suicide and also because I had literally I must have seen him hours before and I think it was within twenty four hours that he did it. And I remember so I was thinking a lot. About him, and I like so because he came up to see me at the lunch table and asked when the psychiatrist was coming, and I thought about that a lot, because then when he I saw him sitting on the ward and he just looked like he was plotting something, so. I thought I thought about him a lot, I didn't really feel any emotion straight away, I think that took a little while to hit. I think fear actually I think shit was my first. It's like I have got no idea what this means, like I don't know, I don't understand anything about this sort of process. I very quickly had legal services on the phone, emailed to me saying I was going to need to write reports for the coroner and stuff. So I think that was probably my first one first feeling. And then when that subsided a little bit, most of what you would sort of expect, like sadness, guilt, the proper going over, because I remember I didn't think that he was going that weekend. And if I'd known like I was like if the psychiatrist had just come and spoken to the rest of the MDT, I would have, because I said to the nursing that it'd been a really hard session. And I thought that we're making progress. But I still thought he was very, very, very high risk of suicide and like, why didn't that message get through? So, yeah, a bit of anger as well, because I did, on the one hand, sort of felt there was this narrative about it being inevitable. You know, we couldn't have kept him here for any longer. He would have done it as soon as we had let him out anyway vs.. But that's the point of us like we are a hospital, like we are meant to keep people for as long as we think that</p>	<p>Slightly different impact</p> <p>First oen affected me personally My first experience of suicide</p> <p>Saw him hours before, I was thinking a lot about him because he came up to me</p> <p>I thought about that last meeting a lot</p> <p>He looked like he was plotting Thought about him a lot</p> <p>Emotion took a while to hit</p> <p>First emotion fear Didn't know what it meant Legal services called and emailed – reports and coroneers</p> <p>When fear subsided sadness, guilt Going over things</p> <p>If the psychiatrist had spoken to MDT</p> <p>I still thought he was very very high risk of suicide</p> <p>Anger; why didn't the message get through Narrative of his suicide being inevitable vs. this is the point of the hospital</p>	<p>IMPACT – first one affected her more personally and was first experience of suicide.</p> <p>Took some time off after a few weeks</p> <p>TIME – saw him hours before so it feels quite close</p> <p>REMEMBERING – thinking about him, ruminating on what she saw</p> <p>EMOTIONS – took time to hit. Fear was an early emotion because of the not knowing what was going to happen – fear of process and scrutiny of work or the consequences of a suicide (UNPREPARED)</p> <p>PROCESS – legal services called and instructed her to prepare a report for coroners Going to the funeral was helpful as she got to learn about him and his family.</p> <p>EMOTIONS; after a while – sadness, guilt, ruminating on the last interactions Funeral – devastating, helpful (2nd patient) anger over reversed decisions, more muted feelings as felt more distant (TIME)</p> <p>CLINICAL JUDGEMENT – I knew he was high risk but lack of COMMUNICATION to team when psychiatrist making decisions about leave</p>

is that clinical risk. And I very much sort of carried on that week. I think it was the week after so I did to end up taking time, I took a couple of days off that same month. And then it was actually on the day, because I was allowed to go to his funeral, and I think that's when the emotional impact sort of hit me the most, which didn't help because my I got a phone call. I drove into work trying to prep myself for the fact that I was going to go to his funeral later that day and then got a phone call to say that my cat had been hit by a car when I got to work. So I was just a mess. It's just an emotional mess. But going to the funeral was really helpful, even though it was devastating because I saw so much I tried to ask about his family and his life, but obviously you learn much more about him as a person so I sort of and I saw his daughter, which was devastating. I wrote a lot of poems as well. So, yeah, with the with the second one. I think similar sorts of things, particularly when I read about the event sort of leading up to it having happened, I said I've had quite a lot of systemic input. It looked as though a lot of plans that we'd put in place had been reversed. So, again, that was a lot of that sort of anger in terms of why is what? Like, we knew that that would be a massively high risk situation, but just slightly more muted. So I think a lot of the same emotions, but just it felt like a little bit more distant. [00:20:41][261.0]

I carried on that week, took a couple of days off that same month

Went to his funeral, the emotional impact hit me

An emotional mess
Funeral was helpful, seeing his family was devastating

Learned more about him

Wrote a lot of poems

Similar emotions for second one
Systemic plans had been reversed

Anger – why? We knew he was high risk

Felt more distant

CULTURE – narratives that if something is going to happen it will 'carrying on' for the week
RISK – conflicts of detaining people against their will

COPING – writing poems, going to the funeral, taking time out

Speaker 1: [00:20:42] Yeah, OK. And what do you think that was attributed to that that distance? [00:20:47][4.5]

Speaker 2: [00:20:49] I think it was partly because I hadn't seen him face to face for a while. And partly I don't think there was something about the first one. That's just connected. I don't know the first ones sorry, the second ones I was at the direct work didn't go on as long, so I didn't actually have that many sessions with him. And also with the first one, the sessions were just way more intense, I think, where he wouldn't really say anything. So there was a lot of sort of long pauses, silences. He'd give me a lot of meaningful looks. And I I felt that, yeah, I think that was a deeper so I felt a deeper connection with the first one. [00:21:40][50.8]

Emotions more distant because hadn't seen him face to face in a while

Worked with first one for longer
Sessions more intense

Pauses, silences, meaningful looks, deeper connection

TIME – not seeing that person face to face made it feel more distant
Connection with patient was different as had fewer sessions

Connection brought about by intensity of the work

Speaker 1: [00:21:44] And. I think you touched on this a little bit already. One of the questions about your understanding or your impression of how the patients were doing before the incident.

So I think the person you touched on and said if they would have come to you he's too high risk. So can you tell me a little bit more about that? [00:22:06][21.8]

Speaker 2: [00:22:08] Yeah. So he let's say he he was very, very **classically overcontrolled personality** so that the the instant it brought him into hospital was **a very unforeseen, very violent event, which we sort of made sense of because of his overcontrolled coping style.** When we looked at his history, there was just the months and months and months and months of **sitting on really intense emotions** and then it sort of exploding. And I think I sort of got that sense in all sessions as well, I didn't **I didn't believe that he wasn't feeling things** and a lot of **the nursing team put it down to the medication** that he was on. So they were sort of saying **he was quite lethargic.** He was he wasn't he didn't use any facial expression, which they were putting down to medication. And I was putting down to overcontrolled controlled style and. But we were sort of noticing **he he was becoming more unkempt** and, yeah, in that last session, he he **he thumped the table** and I said, well, I think I think, you know, you seem as though You're quite angry. And I remember he said to me, I've been angry for the past three months. And I said, but **it's really interesting because you haven't actually shown that if I asked any of my colleagues, we would not know that you had been simmering on the anger,** which he seemed really, really shocked by. But then immediately after, it was the **first time I'd seen sort of not tears in his eyes, but wetter than normal.** And again, I took that as a very good sign because **I thought he wasn't going anywhere.** And I thought that that was therapeutically a positive sort of thing.

First person over-controlled
Came in in unforeseen
circumstances

He was sitting on intense
emotions

I didn't believe he wasn't
feeling things

Nurses put it down to
medication – I put it down to
overcontrolled

He became more unkempt

Saw new emotion from him –
anger

Differences in staff about reasons for
someone's behaviour

She spotted signs that he was
neglecting his personal care more

Appendix 3

Sample of reflective notes after interview

I felt particularly struck by him saying he didn't have the language to communicate outside of the job - friends talk about meeting and he experienced death.

I got the sense he had 'good' experiences and he just thinks it's important to be present for staff. There was a thought that he felt it was his job to support the staff? He is the source of ~~the~~ picking up the pieces.

A sense that no blame from the service, they were not surprised by the plan.

Also struck me about pace of debrief / aftermath reflects the day to day.

Close to person - there was remembering
more removed - more questioning.

I felt a sense of relating -

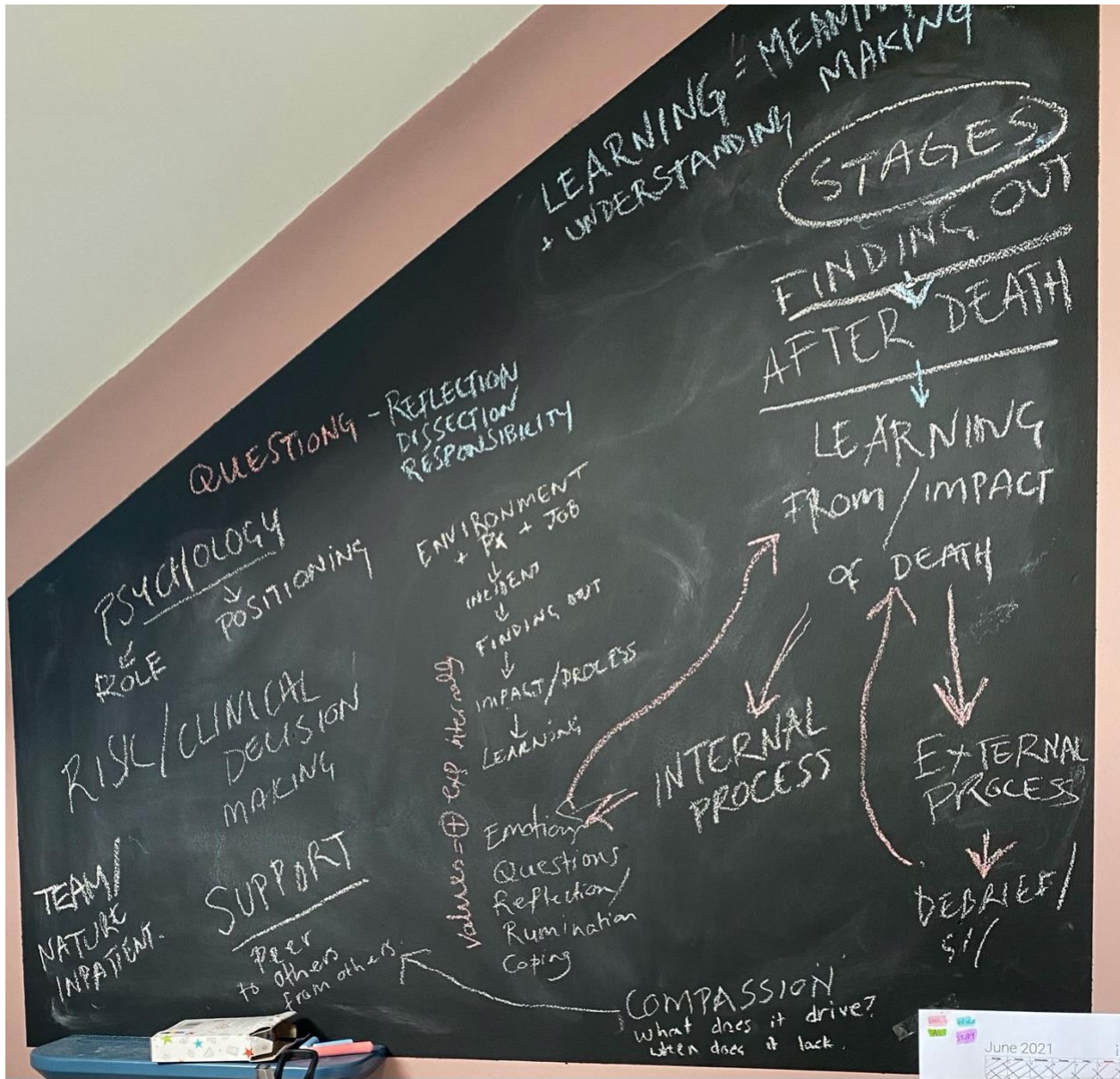
Appendix 4

Sample of initial grouping and organisation

POSITION/USE OF PSYCHOLOGY IN SERVICE		SERVICE/TEAMS		CULTURE/NATURE OF INPATIENT	
Separation from wider team/half in-out	5	Move on quickly/carry on	8	Fast paced/Px moved through	8
Used incorrectly/lack of understanding	4	Fearful/anxious/defensive/avoidant	5	medical model	5
Collaborate with Px/Empower	4	High staff turnover/shifts	4	Unique culture/Hard to understand	4
Advocate for Px	4	Feel uncared for/forgotten	4	Pressure to discharge	4
Works in conflict/contrast to service	3	Impact of leadership	3	Abandoning	4
Changing/Questioning position post death	3	burnout	3	Difficult environment	3
Power/expertise/influence	3	Open/genuine/trust	3	Armour/defense	2
Decisions made w/o psych	3	High team demands	2	Px Move wards	2
Expected to fix	2	Emotions not validated	2	Dehumanising	2
Connected to team	2	Reactive vs proactive	2	Chosen profession/style of working	2
Spread thinly		Changing/Growing +		Supervision as a negative	
Questioning the service		Takes action		Need evidence of risk	
		Emotionally disconnected		Can't eliminate all risk	
				Dark humour	
		Creating more psych posts		Doesn't listen/won't change	
		Compartmentalise		Narratives around suicide	
RESPONSIBILITY				Shared Language	
personal responsibility	3			Open	
teams responsibilities (to fix/rescue)					
to be helpful	3				
to drive change/influence	2				
Connection & time acts like a mediator?		Internal Processes?	(P5 for possible internal process)		
		(may want to split common emotions down)			
EXPERIENCE OF Px DEATH				AFTER DEATH	
FINDING OUT		EMOTIONS			
Told by email	3	shock/surprise	6	DEBRIEFS	6
Not informed at the time/indirectly	3	sadness/upset	9	Window of opportunity	3
Difficulty informing correct staff	3	anger	5	No debrief	2
Told by colleague	4	frustration	4	Negative/unhelpful experience	3
Empathy/Compassion to others		numb	3	Arranged quickly	2
Support/empathy from others	6	guilt	3	Practical/factual	2
Minimal empathy	2	anguish	2	Disrespectful	2
Service response/policy/process in place	3	brutal		People who not involved	
Matter of fact		devastating		Externally run	
				Explore emotions	
		QUESTIONING	3		
		trying to understand what happened	4	REFLECTIVE PRACTICE	
		what could I do differently	4	bonding	
		decision making (services)	3	done independently	
		decision making (myself)	5		
IMMEDIATE IMPACT/RESPONSE		family context			
Unprepared/New	3				
Remembering Px	4	was I/anyone helpful?	3		

Appendix 5

Thematic maps



Tables

Table 1.

Summary of participant demographics (n=6)

Age	Gender	Ethnicity	Location	Deaths experienced in inpatient setting	Years qualified at time of first death	Job title and NHS banding
31-43 (<i>M</i> age=36)	Female (<i>n</i> =4), Male (<i>n</i> =2)	White British (<i>n</i> =6)	London; Hampshire; South West; Midlands	1-4 (<i>M</i> =2.8)	1 – 10 years (<i>M</i> =4.3 years)	Ward Psychologist 8a; Clinical Psychologist 7- 8a; Consultant Clinical Psychologist 8c; Highly Specialist Clinical

Table 2.

Summary of superordinate, subordinate themes and contributing transcripts.

Superordinate themes	Subordinate themes	Contributing transcript
Theme One: Initial shock: Dealing with personal feelings in a professional space	-	Becky Joe Emma Leigh Eleri Danielle
Theme Two: After the shock: self-evaluation, scrutiny and reflection	Information gathering, external scrutiny and self-evaluation	Eleri Danielle Joe Leigh
	Ruminating and reflecting on the path to acceptance	Emma Joe Leigh
Theme Three: The lasting phase: Remembering to learn	Enduring sadness, remembering and personal impact	Joe Becky Leigh
	Professional growth	Leigh Joe Danielle Emma Becky



Section 3: Critical Appraisal

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2022

Critical Appraisal

The previous chapters of this thesis have explored issues around suicide and self-harm in psychiatric inpatient settings. The first chapter was a systematic literature review and quality assessment of risk-to-self measures (self-harm and suicide) that are clinically validated for use with a psychiatric inpatient population. Chapter two offers a qualitative exploration of psychologists' experiences of the death of a patient by suicide whilst working in inpatient settings through the methodology of 'Interpretive Phenomenological Analysis (IPA).

This third section aims to appraise the first two sections critically. It will offer an overview, discuss the results presented, and delve deeper into clinical recommendations. The critical appraisal also provides personal reflections on a number of contextual and ethical considerations taken into account.

Synthesis of findings: Issues around risk in psychiatric inpatient settings

The systematic literature review included 16 studies which were identified from pre-determined inclusion criteria. From the 16 studies, 15 risk-to-self measures were included for quality appraisal using Terwee et al.'s (2007) criteria for health outcome questionnaires. The review concluded that while the majority of the risk-to-self measures had good internal consistency and construct validity, none of them were determined to have good overall quality across all, or most, of Terwee et al.'s (2007) criteria.

The empirical study was conducted with six participants who were qualified clinical psychologists and had experienced at least one death of a patient by suicide while working in an inpatient setting. Participant data obtained from semi-structured interviews was analysed using Interpretive Phenomenological Analysis (IPA; Smith et al., 2009). The researcher took an interpretive role (Smith & Osborn, 2003) to make sense of participants' in-depth personal and

professional experiences of the deaths of their patients which resulted in the emergence of three superordinate themes: Initial shock: Dealing with personal feelings in a professional space; After the shock: Self-evaluation and reflection; The lasting phase; Remembering to learn. The findings discussed the range of reactions and responses participants experienced in the initial days and months after the death of their patients and the contextual factors that impacted on their personal journey through that time. While the context of participants' experiences differed, with different outcomes for the individual, the findings showed similarities in the shock and sadness they felt after the death of a patient. Additionally, they all utilised their specific skills as psychologists in order to process and understand the death of their clients, particularly in their use of formulation and reflective-practitioner skills (e.g. Hanley, 2017; BPS, 2019).

While the findings have been previously discussed in-depth for both individual chapters, I felt it important to think about how risk-assessment is essential to consider in relation to the experiences of clinical psychologists, and potentially other staff in inpatient settings. The empirical findings put the personal experiences of the participants at the heart of the analysis. However, the in-depth nature of the interviews meant that participants discussed a lot of 'service-level' processes that impacted their feelings and responses about their work. Issues around risk-assessment were considered concerning clinical decision making, particularly when thinking about discharging patients from inpatient settings. Guidance already directs services to make thorough risk assessments before discharging patients (e.g. Royal College of Psychiatrists; RCP, 2016; 2010), and is an ongoing process during admission. However, examples given by participants on how risk assessment is used within services suggested clinicians and professionals across their services are using the tools at their disposal but often with a great deal of uncertainty around the 'real' risk which could be anxiety-provoking for clinicians. For

example Jo and Becky discussed experiences of their patients who died by suicide as being ‘under the radar’ in terms of risk at discharge, as well as services making quick risk-assessment to allow patients to go on leave and they harm themselves during this time. Jo and Leigh discussed ‘quick decisions’ and a ‘get-in-get-out’ approach to risk assessment and discharge, hinting at the idea that services may be using limited risk assessment methods, i.e. only using discussion amongst professionals, or solely relying on outcome measures. Findings of the review, guidance and literature (e.g. NICE guidelines, 2011; Graney et al., 2020; Large et al., 2017) all recommend that risk assessment tools are certainly not appropriate to use in isolation and so the qualitative experiences of clinicians give an idea of how important this in terms of potential consequences to patients and staff. When perceived level of risk is inaccurate patients may go on to harm themselves both in and out of hospital, and when that happens as discussed in the empirical chapter, there are far reaching and long term consequences for staff on both a personal and professional level.

During the process of writing both chapters, I was struck at the lack of consistency in guidance around risk assessment or appropriate methods of risk assessment for psychiatric inpatient settings. This was reflected in participants’ reporting of clinical decision making or risk-assessment processes in their respective services. While there certainly is guidance and multiple approaches for conducting risk assessment (e.g. British Psychological Society, 2021), as shown in the review there is no standardised national approach specific to psychiatric inpatient settings for assessing risk, and it is up to each service to create their own guidance. Inconsistency in clinical decision making and risk assessment is an important issue to consider for psychiatric inpatient services, as the qualitative findings in the empirical study show that a perceived lack of care and planning for patient risk can leave clinicians feeling frustration and anger towards their

work places. In addition, it leaves the door open for feelings of personal blame and guilt to permeate through the whole organisation, which ultimately ends in a fearful and defensive workforce that is ultimately negative for both staff and patients.

Further exploration of clinical recommendations

Recommendations in the empirical study suggest that a sense of preparedness would have been helpful to participants in helping them cope with the aftermath of a patient suicide, particularly after their first experience. Many participants felt a lot of anxiety about what would happen, what processes would look like, and what would happen to them as professionals. Emma discussed seeing colleagues leave their jobs as they were not adequately prepared for the death of a patient by suicide. As stated in the literature, suicide is prevalent and there is a relatively high likelihood that psychologists will experience this at some point in their career (NCISH, 2021; Awenat et al., 2017). While robust and clear policy and procedures in each service is suggested as an appropriate way to mitigate some anxiety and help staff through this process should they have to, during the research, I was able to reflect with my supervisors and fellow trainees on issues of patient or client death and felt that our subjective experiences were that we would not be prepared for an experience like that, and it was not part of our curriculum to think beyond potential risk. Examining the syllabus, I also discovered that there were no specific sessions dedicated to working in high-risk crisis services such as psychiatric inpatient settings and this seems like a missed early opportunity to prepare psychologists for the more challenging aspects of the job. A lot of time goes into thinking about risk, and risk assessment, but not so much thought goes into what happens to psychologists if their patients do go on and follow through on

their high risk thoughts and behaviours which can occur in community services as well as inpatient.

A review carried out by Leane et al. (2019) looked at studies of trainee psychiatrists who had encountered patient suicide. As psychologists regularly work alongside psychiatrists, it was felt some of their findings were applicable and relevant to psychologists. In particular they found that 44% to 96% of trainees were trained in suicide risk assessment but only 10% to 47% had any training on procedures to follow after a patient died, but those who had something as simple as a 90-minute workshop on these issues felt this to be very useful (Leane et al., 2019; pg 145). Darden and Rutter (2011) summarise literature around graduate mental health programmes for psychotherapists and also conclude that therapist postvention, or post-suicide review have minimal consideration or resources devoted to these issues despite numerous recommendations to do so. Training and preparation are seen as central to adaptive coping following patient death by suicide (e.g. Chemtob et al., 1988; McAdams & Foster, 2000). If we consider that services are not preparing staff for patient death, reviews such as this show that clinical psychology trainee programmes could play an early preventative part in making difficult experiences easier for trainees, either during training or later in their careers, and this could be done in simple ways alongside existing training around risk, particularly as some evidence shows that trainers of therapists already feel that intervention and postvention training is inadequate (Sudak et al., 2007)

Additional reflections on choosing appropriate methodology

The primary aim of the empirical study was to examine the experiences of clinical psychologists following the death of a patient by suicide in inpatient settings. Additional objectives included understanding these reactions by examining psychological responses both at

the time of the death by suicide and in the days and weeks that followed. As was previously mentioned in Chapter 2, Interpretative Phenomenological Analysis (IPA) was chosen as a phenomenological method to protect the participants' unique experiences and views because little is known about practitioner psychologists' experiences of suicide in psychiatric inpatient settings (Hefferon & Gil-Rodriguez, 2011). This method embraces the researcher's interpretative role throughout the study through a double hermeneutic stance to conceptualise the meaning-making of participants' experiences (Smith & Osborn, 2003). The approach is considered as appropriate when attempting to provide an in-depth analysis and exploration of complex processes or phenomena and to shed light on the varied nature of human experience, which is another comment on the strength of IPA for this particular research topic (Creswell, 2013). It is thought to be particularly useful for examining subjects like pain and grief that are not only complex but possibly ambiguous, nuanced and emotionally laden (Smith & Osborn, 2015).

For this investigation, alternative qualitative methods were considered. Social constructivist grounded theory (Charmaz, 2014), accepts that each person's definition of "truth" is specific to them (Andrews, 2012), and also acknowledges the significance of socially constructed realities. However, grounded theory aims to "develop a general concept or theory" (Castillo, 2018, p. 84) rather than focusing on the lived experience related to a phenomenon. Given that the experience of patient death by suicide for the psychologists in an inpatient setting has received relatively little attention in the literature, it was decided that the research should focus on revealing and unearthing those experiences on a personal level before attempting to understand them from a theoretical standpoint. Therefore, it did not seem appropriate to employ this strategy for the purposes of this study. In addition, narrative methodological approaches were taken into account because they too share the fundamental belief that individuals create their own reality and

knowledge based on their central role in a larger societal context. Participants' language is closely examined in order to understand how their story affects their evolving experience. While both grounded theory and narrative methods provide rich data and explore experiences, IPA maintains an emphasis toward studying the particular lived experience of a phenomena and the meaning that individuals attribute to experiences. The individual experience, rather than an investigation of the event itself, was prioritised in the study's aim and objectives, rendering IPA the appropriate approach in light of those goals.

For instance, a strength when utilising IPA to analyse the data, I paid attention to how participants talked about the cultural setting in which they worked, particularly when it came to management and operational concerns before and after their patients died by suicide. In many cases, participants did not explicitly state why they considered these topics were important to discuss in relation their own experiences, but by taking an interpretive approach, I was able to move beyond the 'event' or 'description of what happened' and uncover personally significant concepts regarding the participants' perceptions of their own sense of value (or lack thereof) as individuals and professionals.

Ethical and quality considerations

Ethical considerations

When working with human participants, ethical considerations are central to considerations when designing and conducting research. This research was planned with these considerations in mind by completing an ethics application, which was approved by the Lancaster University, Faculty of Health and Medicine ethics panel (see Section 4). This study involved sensitive and potentially distressing discussion around suicide so there was a great deal

of focus on protecting participants at all stages of recruitment and interview. Participants were prepared for this pre-interview by giving each potential candidate an information sheet which was transparent around the nature of the interviews. Due to the sensitivity of the topic each candidate was given the opportunity to email any questions beforehand and were given time to think about whether they wanted to participate. Inclusion criteria also served to protect the interests of participants by requiring that a year had passed before they could participate, to allow for participants to have some emotional distance from the death of their patient. Of course, one cannot assume that after a year, an event such as a death by suicide will be easy to talk about so the interviewer prepared with the supervisor to be mindful and plan for emotional distress that could arise during the interviews. This was a useful and necessary part of the preparation as a participant became visibly upset during interview. The interview was briefly paused and the participant was offered a break, which they declined so the interview proceeded. Some additional time was taken at the end of the interview to ensure the participant was feeling okay and to offer some additional support which they did not feel they needed.

Supervision was used to manage any emotional responses I may have felt to the content of the interviews but no significant emotional distress was experienced. Useful resources and contacts were prepared to signpost all participants through a debrief sheet, should they need additional support once the interview was over, and they were invited to get in touch if they had found the interview particularly difficult. This was encouraged as a form of feedback in ensuring the emotional safety of future participants, however, no participants reported any lasting distress after the interviews had concluded.

The audio recordings of the participants' interview were stored securely and final transcripts remain anonymised with participants only identifiable by a pseudonym. Direct

quotations within the report remain anonymised and participant's permission was sought at interview to use direct quotations. All participants were given a time-limited opportunity to withdraw their data from the research. Time limitations were given for withdrawal as the nature of IPA meant that it would be difficult to completely ensure that an individual's data was not included in interpretations once analysis had begun.

Language and Terminology

According to the Royal College of Psychiatrists (RCP, 2020, pg. 8):

“The reporting and handling of suicides is important both at the level of emotional and social sensitivity to the bereaved, and as a public health issue. Clinicians, organisations, and the media should familiarise themselves with the media reporting guidelines”.

Due to the academic nature of the thesis, I felt it was important to be factual and direct when referring to terminology relating to suicide. However, I also looked to guidance from organisations like Samaritans UK (Samaritans, 2020) to ensure that the language being used was appropriate and avoided using biased or assumptive expressions often heard in public discourse. For instance, common phrases such as "they committed suicide" originated from a perspective that saw suicide as an individual's immoral or criminal act rather than the result of someone experiencing emotional suffering or mental health issues (Olson, 2011). A neutral alternative that is less judgmental and neutralises a position towards the person is to use phrasing such as "they died by suicide."

Despite the fact that the participants were professionals in the context of this research, I noticed that their language felt less "blunt" and was more indirect or humanising when talking about suicide (e.g., "when 'it' happened," "passed away," "the family lost a loved one"). While using the phrase "died by suicide" in an academic writing context may be appropriate, it is important to

consider how findings may need to be presented or distributed to a variety of audiences, and that using "neutral" language might be disrespectful or offensive in itself to those who have been impacted by suicide. For instance, the term "died by suicide" has been criticised for possibly dehumanising or removing a person's agency in suicide, while the phrase "took one's own life" has been criticised for avoiding the word "suicide" and potentially contributing to the stigma and shame surrounding the topic (see Galasiski & Ziórkowska, 2020). When investigating or discussing topics surrounding suicide, it is crucial to recognise the complexity of the subject and strike a difficult balance between respect, humanity, and factual facts. To do this, researchers should employ constant reflection and published guidance.

Quality Assurance

As briefly discussed in limitations in Section One, the review is limited in its scope due to the nature of conducting a largely independent systematic review for a doctoral thesis and so I had to make some difficult, but strategic decisions around quality appraisal. The psychometric properties of risk-to-self measures validated within the 16 studies were quality appraised (Terwee et al., 2007), but risk of bias or quality of the methodology of the studies themselves was not appraised. I would like to take an opportunity to further reflect on my decision making around this.

The most appropriate tool for looking at the risk of bias in health-status measures would be the checklist developed by the COSMIN study (Mokkink et al., 2018), presented as an accessible and succinct table to show the overall methodological quality of reports. However, as touched upon, the checklist consists of 92 items which would need to be considered for 16 reports, so the decision was made that this was not within the scope of an individual literature review for a thesis submission (see Boland et al., 2017; Chapter 1). The next step was to look for

well-established but briefer methods of quality appraisal, such as the ‘Critical Appraisal Skills Programme (CASP)’ checklist, however, their checklists are not designed for studies that develop health-status questionnaires or similar. It was not felt that a self-developed checklist would be a valid method of quality appraisal. Any precedent within published literature was searched for to justify the exclusion of quality appraisal of the studies themselves. Some reviews that present quality appraisal of health-status questionnaires/outcome measures but no additional methodological quality appraisal were found (e.g. Zuccala et al., 2019; Modini et al., 2015). Finally, the conclusions of the review were that no risk-to-self measures had high quality psychometric properties overall and none were explicitly recommended for clinical use by the review, and so additional methodological quality appraisal would not change the overall conclusions presented.

Developing a thesis during COVID-19

The empirical study's development stage and methodological features were constrained because it was prepared in the first few months of the COVID-19 lockdown in 2020. S There should be some form of service user input when conducting a psychological is good practice study of any kind, especially when it relates to healthcare (see NIHR, 2014). It would have been preferable if service users had been included in the development of the study questions, objectives, and interview schedule; but, due to numerous limits on everyone's personal and professional lives at the time, this was extremely difficult to do. During a healthcare crisis, it might have been inappropriate to burden stakeholders or service users. Instead, participants were able to provide input regarding the depth and breadth of topics covered because the IPA method takes a semi-structured approach to interviews, ensuring that the research was as participant-led as possible (Smith et al., 2009).

It is worth noting that the COVID-19 pandemic was and continues to be a prolonged global phenomena that significantly affected and transformed the daily lives of the majority of people. Although it can and should be presumed that this new social context has indirectly influenced research participants' experiences, it is not possible to quantify or characterise that in this work. However, it raises the intriguing philosophical question: How might participants' experiences of a patient's death by suicide have evolved over time if society had remained mostly unchanged during the study period?

Despite the fact that interviews began later in the pandemic, they had to be conducted online using video conferencing software due to ongoing legal restrictions on in-person contact. In terms of recruiting participants, this did have some benefits because remote interviews were more accessible, time-saving, and convenient (Gray et al., 2020). This was especially beneficial for the participant group since it allowed them to engage without adding to their already busy schedules while they were still actively working in the NHS under extremely stressful conditions. This extra convenience made it possible for the research to find participants from all around the UK rather than just a small local area, which would have been difficult otherwise. Some researchers began focusing more intently on the potential advantages or challenges to this change as qualitative research was compelled to transition to a primarily digital form during COVID-19 (e.g. Gray et al., 2020; Archibald et al., 2019; Howlett, 2022). Participants generally had positive opinions of their experiences, notably the efficiency of using online platforms despite any potential technological difficulties. Both researchers and interviewees discovered that rapport-building was still feasible, although it is currently unclear how this affects the collecting of data and the following interpretation or analysis of findings until research explicitly comparing in-person and remote interviews is produced.

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Section 4: Ethics Application

Michaela Ann Lagdon

Doctorate in Clinical Psychology (2018 cohort)

Division of Health Research, Lancaster University

2022

Application for Ethical Approval for Research

Faculty of Health and Medicine Research Ethics Committee (FHMREC)
Lancaster University

for additional advice on completing this form, hover cursor over 'guidance'.

Guidance on completing this form is also available as a word document

Title of Project: Clinical Psychologist's experiences of patient suicide in inpatient services

Name of applicant/researcher: Caela Lagdon

ACP ID number (if applicable)*:

Funding source (if applicable)

Grant code (if applicable):

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [\[link\]](#).**

Type of study

Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, two and four of this form**

Includes *direct* involvement by human subjects. **Complete sections one, three and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM Trainee Clinical Psychologist; DClinPsy

2. Contact information for applicant:

E-mail: c.lagdon@lancaster.ac.uk

Telephone: 07969497166

Address: Lancaster University

3. Names and appointments of all members of the research team (including degree where applicable)

Caela Lagdon; Clinical Psychology Trainee

Dr James Kelly ; ClinPsyD, Research Lecturer & Principal Clinical Psychologist

Dr Lisa Wood ; ClinPSyD, Research Lecturer

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the [FHMREC website](#))

PG Diploma Masters by research PhD Thesis PhD Pall. Care
PhD Pub. Health PhD Org. Health & Well Being PhD Mental Health MD
DClinPsy SRP [if SRP Service Evaluation, please also indicate here:] DClinPsy Thesis

4. Project supervisor(s), if different from applicant:

Dr. James Kelly; Research Supervisor

Dr. Lisa Wood; Field Supervisor

5. Appointment held by supervisor(s) and institution(s) where based (if applicable): Research Lecturer & Principal Clinical Psychologist; Lancaster University; Research Lecturer, UCL

SECTION THREE

Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

Suicidal behaviour in psychiatric wards is common and is particularly prevalent soon after admission. The impact of death on staff in a variety of health care settings has been widely studied and the results vary dependent on context. The impact can vary from positive grief responses through to burnout and stress.

This research will explore inpatient psychologists experiences of the death of a patient by suicide and hopes to inform inpatient psychology services and the wider service in being able to support staff after an incident of suicide.

The researcher will remotely interview 4-8 psychologists about their experience and analyse the results using Interpretative Phenomenological Analysis (IPA), which helps to preserve the meaning-making of individuals in a specific situation.

The method for analysis works through four probing stages, returning through the stages as each participant's data is explored, finally reaching major and minor themes.

2. **Anticipated project dates (month and year only)**

Start date: December 2020

End date: June 2021

Data Collection and Management

For additional guidance on data management, please go to [Research Data Management](#) webpage, or email the RDM support email: rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

Inclusion:

- Adults aged 18+ who work, or have worked, in an acute mental health hospital and experienced at least one death of a patient by suicide.
- Worked as a qualified clinical psychologist at the time of the patient death.
- English language speakers due to budget and time restraints in obtaining appropriate translation
- UK based

Exclusion:

- Participants who are involved in any ongoing legal proceedings or inquest or internal investigation in relation to a suicide. To accurately explore the whole experience of staff members it is essential that the participants are not in the middle of the incident.
- If the suicide of a patient occurred under a year ago, or over six years ago. This ensures the suicide occurred under a current context of NHS inpatient working and provides temporal distance from the incident.

Potential participants will be asked screening questions before commencing interview to ensure they meet inclusion/exclusion criteria

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

Purposive, snowball sampling will be used to recruit Psychologists with experiences of working with someone who has committed suicide in an inpatient setting. An electronic version of the advertisement describing the broad details and contact number and email for the study will be distributed by the researcher and supervisors to their network of peers who have worked in the field and snowballed from there. Participants will express interest using the details on the advertisement. If this does not yield enough participants the advertisement will be posted on a separately create social media account (Twitter) to widen the chances of reaching people who do, or have, worked in inpatient services. The advert will also be posted into a private clinical psychology Facebook group. Appropriate participants will be taken on a first come, first serve basis and once the required number of participants is obtained we will turn interested participants away. Before providing information sheets and consent forms for the interested participants, it will be made clear that there are screening questions which must be asked before proceeding. Using screening questions early will avoid wasting participant and researchers time. They will be thanked for their interest either by email or over the phone depending on their original method of contact.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

Data will be collected through flexible and interviewee-led semi-structured interviews (Pietkiewicz & Smith, 2014) conducted via video conferencing software (i.e. Microsoft Teams) by the researcher. An interview schedule with prompts will be used to guide the interview. Basic demographic data will be collected and screening questions to ensure the suitability of the participant before interview. Audio recordings and anonymised data will be stored on an encrypted flash drive and destroyed after transcription.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

Electronic, audio or visual data will be securely stored on a password protected laptop and transferred to Lancaster University (LU) secure One Drive account. Files will be password protected and can only be accessed by research team members employed by LU. Any hard copies of transcripts and associated notes from analysis will be stored in a locked filing cabinet. Data will also be deposited in Lancaster University's institutional data repository. Lancaster University uses Pure as the data repository which will hold, manage, preserve and provide access to datasets produced by Lancaster University research.

7. Will audio or video recording take place? no audio video
a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.
Yes, any data that needs to be transferred or temporarily stored will be on an encrypted flash drive and then transferred onto a LU encrypted OneDrive.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Audio or visual data will be securely stored on a password protected laptop and transferred to LU secure One Drive account. Files will be password protected and can only be accessed by research team employed by LU. These will be kept up to the point of examination and destroyed once examination is passed, in case recordings need to be checked. The recordings will not be kept after August 2021 on completion of the course.

Anonymised electronic transcripts will also be destroyed after examination, no later than August 2021. Any printed transcription with handwritten notes from the researcher will be destroyed immediately after scanning and storing electronically. We would keep these for 10 years, on institutional data repository – as stated in 8a

Electronic consent forms will be stored separately from raw data and retained for 10 years. Paper consent forms will be scanned and destroyed immediately.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

Data will also be deposited in Lancaster University's institutional data repository and will be shared on request only. Lancaster University uses Pure as the data repository which will hold, manage, preserve and provide access to datasets produced by Lancaster University research.

8b. Are there any restrictions on sharing your data ?

Due to the small sample size and specific criteria for participants (i.e. specific event in a specific work role), even after full anonymization there is a small risk that participants can be identified. Therefore, supporting data will only be shared on request. Access will be granted on a case by case basis by the Faculty of Health and Medicine.

9. Consent

a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law?

b. Detail the procedure you will use for obtaining consent?

Potential participants will only be contacted in the first instance if they have expressed interest in participating by responding by phone or email to the advertisement.

Formal consent will be taken prior to the interview starting. Interviews will be conducted remotely so participants will be sent an information sheet with a consent form. Participants will have to check all the relevant boxes, and electronically sign and date these forms and return to the researcher before the interview takes place. The researcher will give the participant an opportunity to ask questions around consent at the beginning of the interview. If a participant does not have access to an email account, the researcher will read the information sheet and consent form and ask for verbal consent for each item before proceeding with the interview.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

The study will involve discussion of sensitive issues around death and suicide. There may also be discussion around the circumstances and events before and after the death. There is potential for this to be an emotional experience for the participant, causing psychological discomfort. The researcher aims to fully inform the participant about the nature of the interview before it takes place. This will allow participants to be prepared for potentially difficult topics in advance. The researcher will provide the participant with a number of contacts for different support services appropriate for them should they experience discomfort or distress which will be available on the debrief form. The distress protocol will be followed in the case of any psychological distress during interview. The researcher will look for signs of distress such as crying or shaking. The interview will be stopped and the researcher who is a health professional will assess the participants mental health status. If the participant is able the interview will continue, if they do not the interview will be terminated. With consent, the researcher will encourage the participant to contact their GP or support them to contact their GP or other health care professional. With further consent the researcher will offer a follow up call.

Participants are welcome to withdraw their participation from the study at any point before and during the interview. Participants may subsequently withdraw their data up to 2 weeks following their interview as the data collection and analysis happen simultaneously. Numbers of appropriate places of support are noted on both the information and debrief sheets in case of distress.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

The researcher may experience psychological discomfort from listening to participants' personal stories/experiences. The researcher will follow the Distress Protocol and will schedule regular support and supervision from the research supervisor. Should the researcher experience further psychological discomfort beyond the realms of supervisory support, they will contact LU counselling services for additional support.

The interviews will take place remotely and the researcher will only use their University email address and a mobile number specifically for research purposes. The researcher will not give out personal details at any time and will not use any personal contact details or mobile phone for research purposes.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There may be no direct benefit to participants for taking part in the study, however, some may find it a positive experience to simply share their experiences, or to contribute to research which aims to better inform how to help people in a similar situation in the future.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

Participants will be entered into a prize draw for a £30 Amazon voucher. Interviews are done remotely, therefore no out-of-pocket expenses will be offered.

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?

b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

The researcher will adhere to BPS: Code of Human Research Ethics (2014) as well as LU guidelines when referring to confidentiality and anonymity whilst completing the study.

Anonymity: The researcher conducting the interviews will also be transcribing the data which will limit the amount of people who know the identity of the participant. Transcripts will not include real names of people and places and no identifiable data (e.g. name, age) of the participant will be attached to any raw data. Data will be identifiable to the researcher via a participant number. Any transcription that is included in the final paper will remain anonymised with a pseudonym. The only identifiable data, including name and demographics, will be found on the consent form. This form will be stored separately from the transcribed data so that participant numbers cannot be matched.

Confidentiality: Will sign confidentiality agreement. The researcher must conduct the remote interview in an empty room. This space may be in the researchers own home or in a booked LU space to ensure members of the public do not enter the room accidentally during the interview. Participants will be asked to find a quiet, private space for interview to protect their confidential information.

The participant has the right to ask the researcher to leave information out of the transcript.

Only the researcher, supervisors and regulatory authorities will have access to the full transcripts.

Limitations of confidentiality: Any information shared with the researcher that indicated the participant is or has engaged in behaviour that poses a significant risk to themselves, to others or significant risk from others may have to be shared with relevant authorities (e.g. police).

A sample of the transcripts will be seen by examiners as part of thesis examination, therefore it may not be possible to keep all raw data completely confidential. Anonymised quotations will be used during the write up of the research which means specific things the participant can be seen by the public reading the published paper. The participant will be informed of these limitations prior to interview.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

Due to COVID-19 it has not been possible to conduct a focus group prior to the design of the study and interview questions. Instead, each participant will be asked for some feedback at the end of the interview. This will inform the content of the interviews as they go on and will monitor the level of distress participants are experiencing.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

The research makes up part of a doctoral thesis and will also be published in an academic journal.

Relevant clinical findings/recommendations may be shared with inpatient services that the researcher and supervisors have contact with.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

.....Column Break.....**SECTION FOUR: signature**



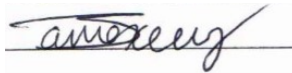
Applicant electronic signature:

Date

19/11/20

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review

Project Supervisor name (if applicable):
discussed 19/11/2020



Date application

Submission Guidance

1. Submit your FHMREC application by email to Becky Case (fhmresearchsupport@lancaster.ac.uk) as two separate documents:

i.FHMREC application form.

Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*

ii.Supporting materials.

Collate the following materials for your study, if relevant, into a single word document:

- a. Your full research proposal (background, literature review, methodology/methods, ethical considerations).
- b. Advertising materials (posters, e-mails)
- c. Letters/emails of invitation to participate
- d. Participant information sheets
- e. Consent forms
- f. Questionnaires, surveys, demographic sheets
- g. Interview schedules, interview question guides, focus group scripts
- h. Debriefing sheets, resource lists

Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submission deadlines:

i. Projects including direct involvement of human subjects [**section 3 of the form was completed**]. The *electronic* version of your application should be submitted to [Becky Case](#) **by the committee deadline date**. Committee meeting dates and application submission dates are listed on the [FHMREC website](#). Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.

ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. [**Section 3 of the form has *not* been completed, and is not required**]. Those involving:

- a. existing documents/data only;
- b. the evaluation of an existing project with no direct contact with human participants;
- c. service evaluations.

3. **You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application**

Research Protocol

Clinical Psychologist's experiences of patient suicide in inpatient services

Introduction

In-patient suicide

Globally, suicide accounts for approximately 800,000 or 1.4% of deaths annually (WHO, 2020). Suicide remains a significant national public health concern in the UK and equates to 6,500 deaths annually (Office National Statistics, 2018). Suicide that occurs in psychiatric inpatient care compromises approximately 9% of these death (NCHIS, 2015).

Suicidal behaviour in psychiatric wards is common and is particularly prevalent soon after admission. In-patient mental health wards are populated by patients who are acutely unwell within an environment characterised by high bed occupancy, frequent staff turnover and poor staff morale (Cleary, 2011). Staff well-being is a UK Department of Health (2009) priority known to present particular challenges for mental health staff and their employers.

Work – related death in healthcare

The impact of death on staff in a variety of health care settings has been widely studied and the results vary dependent on context. Studies investigating nurses and care assistants working in settings where patient death was expected and frequent, such as residential aged care or palliative care, showed staff may display positive grief responses after the death of a patient including professional and emotional growth due to successful grief processing (Anderson & Gaugler, 2007; Papadatou et al., 2002). Conversely, research shows healthcare staff can experience negative grief responses including compassion fatigue, vicarious trauma and burnout

(Meller et al., 2019). Grief symptoms can be akin to those experienced by family caregivers are common among direct care workers after patient death (Boerner et al., 2015). Ting et al., (2006) found avoidance and intrusion, as well as additional themes of professional incompetence, responsibility, isolation, and justification were indicated amongst mental health social workers after client suicide.

Impact of suicide on inpatient staff

Awenat et al., (2017) explored the experiences and attitudes of staff when working with suicidal inpatients and found that the professional and personal effects in the aftermath of a patient death by suicide ‘transcends all levels of seniority’ within the organisation, with long lasting effects. At times staff felt blamed or feared being blamed for a patient death and there were reports of many staff becoming anxious and taking leave from work. This particular paper predominantly focused on how staff worked alongside suicidal inpatients rather than the experience of the loss itself, and research into the specific phenomenon of work-place grief in relation to suicide in inpatient settings is extremely limited.

Much of the literature from inpatient work focusses on the experiences of nurses, therefore the unique experiences of psychologists will be explored to extend the research for inpatient settings. Given that loss is quite a rich, complex phenomenon and can be a unique experience for each individual, a qualitative approach was adopted because of its focus on the meaning a phenomenon might hold for a participant and its ability to bring to the surface how one experiences the theme under investigation (Willig, 2001).

Research has been crucial in shedding light on ways of protecting staff in the aftermath of patient death but due to contextual differences in settings (Cleary, 2011) it is important to look

closely at the specific phenomena of inpatient suicide to understand helpful future interventions for inpatient staff. After the ‘New Ways of Working for Applied Psychologists’ NHS programme in 2007, clinical psychologists are able to work more strategically and psychologically with whole teams.

Proposed Research

This research will explore inpatient psychologists experiences of the death of a patient by suicide and hopes to inform inpatient psychology services and the wider service in being able to support staff after an incident of suicide.

Aims

Primary

Explore the experiences and perspectives of psychologists working in inpatient psychiatric hospitals after a patient dies by suicide.

Secondary

Use the experiences of Psychologists to identify strengths and weakness of current processes in inpatient services and be able to provide recommendations for best practice around the needs of staff after a work-related loss.

Objectives

- Identify any common areas of impact for Psychologists following a death by suicide
- Identify which aspects of service practice contribute to positive or negative experiences for Psychologists following a death by suicide.

- Be able to provide recommendations for best practice to inpatient services around the needs of staff after a work-related loss

Proposed Method

Participants

This research requires a minimum of 4 and maximum of 8 participants, aged 18 or over, who have experienced death of a patient by suicide. They should currently be working or have worked in a secure inpatient mental health service and qualified clinical psychologists at the time of the suicide. The suicide should have happened at least one year and a maximum of six years prior to the interview, with no ongoing investigation or legal proceedings taking place. This time frame will allow participants to have some temporal distance from the event but will ensure the experience took place within a relevant and current NHS working context (Elliot, 2012).

Participants will be recruited using an advertisement (Appendix 1) that will be emailed to known contacts to the supervisors and will be asked to distribute this among current or ex-colleagues who may be interested. The advertisement (see Appendix 1) will be distributed on as a means of snowball sampling. Should this method not yield enough participants the advertisement will be distributed through the researcher's social media channels, specifically twitter and specific closed Facebook groups for health professionals. Due to the idiographic, nature of qualitative study there is a consensus that a small sample size is adequate (Smith, 2004). Larger sample sizes may lead to loss of 'subtle inflections of meaning' during analysis (Collins & Nicolson, 2002) and after 12 participants data saturation can occur (Turner et al, 2002). A modest sample of 4-8 participants has been chosen primarily for pragmatic reasons, due to the limited timescale of the thesis project being undertaken by the researcher and limited resources in being able to

support the transcription of a larger number of participants. Due to the timescale of the project the researcher would like to allow for in-depth and thorough analysis of each transcript and has chosen the sample size to ensure that due care and attention is paid to each participant's interview whilst gathering an adequate amount of data.

Materials

An initial advertisement has been developed which can be distributed both electronically and as hard copies. The research requires an interview schedule (see Appendix 5) for the interviewer and an audio recording device for later transcription. All participants will have access to an information sheet (Appendix 3) informing them about the nature of the study as well as consent and debrief forms (Appendices 2 & 4).

Procedure

Once consent has been acquired from participants, data will be collected through flexible and interviewee-led semi-structured interviews (Pietkiewicz & Smith, 2014) conducted remotely via secure video conferencing software or telephone by the researcher. An interview schedule with prompts will be used by the researcher to guide the interview. Participants will read the information sheet and digitally sign the consent form prior to interview, or verbally consent over the telephone should they lack access to appropriate technology. Every participant will be provided with a debrief post-interview (See Appendices 2, 3, and 4). The researcher will then transcribe the audio recording verbatim in preparation for analysis.

Design

The research is a qualitative study with a phenomenological approach as it aims to preserve the participants' perspectives and voice through a flexible interview (Hefferon & Gil-Rodriguez, 2011). Experiential data around the participants' cognitive and emotional responses and meaning making processes relating to experiencing of patient loss by suicide, will offer an in-depth insight into how inpatient staff interpret these experiences over time (Smith, 2011).

Proposed Analysis

In keeping with the phenomenological approach and endeavouring to explore the participant's individual meaning making of their experience, Interpretative Phenomenological Analysis (IPA) will be carried out on the transcribed data (Smith, Flowers & Larkin, 2009). The method adopted for analysis is a cyclical process whereby the researcher works through four probing stages, returning through the stages as each participant's data is explored, finally reaching super-ordinate and subordinate themes as the final result (Smith, Flowers & Larkin, 2009).

The stages are as follows:

- *Stage 1: Reading and re-reading*

This stage involves the initial encounter with the data and aims to allow the researcher to immerse themselves within the transcripts. By repeated reading the researcher can actively engage with the "participant's world". It is recommended that the researcher write any initial ideas or connections in note form and place to one side to allow complete focus on the data.

- *Stage 2: Initial noting*

This stage offers open and exploratory analysis of the text, examining semantic content and the use of language. The researcher notes anything of interest and pays close attention to the participant's explicit meaning. This process has no close rules to follow and combined with Stage 1 allows for a deep familiarity with the data, enabling the researcher to identify some of the participant's meaning making surrounding an issue.

- *Stage 3: Developing emergent themes*

Here the researcher shifts from working primarily within the transcript into working with the notes. Emergent themes should feel more focused and capture an understanding of the participant's perspective. The themes will be greatly reduced from the initial notes but should still capture complex meaning and detail in terms of patterns and connections.

- *Stage 4: Searching for connections across emergent themes*

This stage is the process of grouping emerging themes together into super-ordinate themes by identifying patterns between them. It may also be useful to search for polarisation within the themes as well as similarities.

Practical Issues and Quality Assurance

The research will take place in the context of COVID-19, with changing restrictions on movement. To ensure the practicality and safety of both the researcher and participants, all interviews will be conducted by video conferencing software (Microsoft Teams). We will have to ensure consent is gained electronically via email.

Although IPA is a creative process with few set rules it is important for the researcher to consider quality and validity throughout. The researcher will consider four flexible and broad principles set out by Yardley (2008). The researcher will be sensitive to the context of the study

from selecting appropriate participants through to analysis. Yardley also proposes that the researcher shows transparency and coherence throughout the paper by including full descriptions of processes and decisions made in the write up. The researcher will file data in a way that it would make it possible for someone to be able to follow a chain of evidence for the whole process (Yin, 1989). Yin suggests an auditing process, therefore the researcher will provide a transcript to their supervisor to compare against initial codes, checking that notes have validity against the transcript.

Stiles (1993) presents a case for the researcher declaring their orientation and any personal connections to the research. This allows the reader to be able to fully understand the hermeneutic and narrative approach to analysis, putting them in the researcher's perspective and context. As the researcher has experience of working in an inpatient setting, and experienced loss in the workplace, they will present their perspectives in a reflexive section. This approach also compliments Yardley's transparent approach to validity and quality control in a qualitative process.

Ethical Considerations

The study will involve discussion of sensitive issues around suicide and potential negative outcomes this has had on the individual both personally and professionally. This could be an emotional experience for the participant, causing psychological discomfort. The researcher aims to fully inform the participant about the nature of the interview so that they can be prepared for potentially difficult topics and minimise any negative experiences. The researcher will provide the participant with a number of contacts for different support services appropriate for them should they experience discomfort or distress. The participant

will be informed of their right to withdraw at any time should the interview become too difficult to continue. Should the participant express this, the researcher will terminate the interview immediately. Should this occur, the researcher would follow the distress protocol (Appendix 6).

The researcher may experience psychological discomfort from listening to participants' personal stories/experiences. The researcher will access regular support and supervision from the research supervisor in accordance to the distress protocol (Appendix 6). Should the researcher experience further psychological discomfort beyond the realms of supervisory support, they will contact LU counselling services for additional support.

The video recording of the participant's interview will be stored securely on the LU one drive, and any data that needs to be transferred here will be done so using an encrypted pen drive only accessible to the researcher. Final transcripts will remain anonymised, with participants only identifiable by a pseudonym or number. Direct quotations within the report will remain anonymised. Any quotes that put the participant at risk of being identified will not be reported. Only the researcher, supervisor and regulatory authorities will be able to gain access to any of the recordings or raw transcript data. Recordings will be destroyed after examination of the thesis and transcripts and data analysis will be stored securely for 10 years, after which period will be destroyed by LU. The data will not be used for any other purpose than the proposed study at any time during or after the study.

Timescale

December – January: Recruitment

January – February: Interviews

February – April: Transcription and Analysis

April – June: Final write up

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Appendices

Appendix 1

Study Advertisement

**DOCTORATE IN CLINICAL
PSYCHOLOGY RESEARCH**

Lancaster University
Doctorate in
Clinical Psychology

**HAVE YOU
EXPERIENCED THE
DEATH OF A PATIENT
THROUGH SUICIDE IN
AN INPATIENT
SETTING?**

*We are looking for Clinical
Psychologists who would be willing
to share their experiences through
a remote interview*

**FOR MORE INFORMATION PLEASE
CONTACT:
C.LAGDON@LANCASTER.AC.UK**

You can be entered in a prize draw
to win a £30 voucher for
participating

Appendix 2

Consent Form

Study Title: Staff experiences of patient suicide in an inpatient mental health service

We are asking if you would like to take part in a research project that aims to understand the experiences of staff on inpatient mental health wards that have experienced a patient dying by suicide, and how this may have impacted on both their personal and professional lives.

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Caela Lagdon. Email: c.lagdon@lancaster.ac.uk

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study
2. I confirm that I have had the opportunity to ask any questions and to have them answered.
3. I understand that my interview will be video recorded and then made into an anonymised written transcript.
4. I understand that video recordings will be kept until the research project has been examined.
5. I understand that my participation is voluntary and that I am free to withdraw at any time before and during interview, without giving any reason, without my medical care or legal rights being affected.
6. I understand that once my data have been anonymised and incorporated into themes it will not be possible for it to be withdrawn, and therefore I can withdraw my data up to 2 weeks after my interview.
7. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published; all reasonable steps will be taken to protect the anonymity of the participants involved in this project.
8. I consent to anonymised information and quotations from my interview being used in reports, conferences and training events.
9. I understand that the researcher will discuss data with their supervisor as needed.
10. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator may need to share this information with their research supervisor.
11. I consent to Lancaster University keeping electronic transcriptions of the interview for 10 years after the study has finished.
12. I consent to take part in the above study.

Name of Participant _____ **Signature** _____ **Date** _____

Name of Researcher _____ **Signature** _____ **Date** _____

Appendix 3

Participant Information Sheet



Participant Information Sheet

Staff experiences of death by suicide in an inpatient setting

My name is Caela Lagdon and I am conducting this research as a clinical psychology trainee for a doctoral thesis at Lancaster University, Lancaster, UK

What is the study about?

The purpose of this study is to explore the experiences psychologists have following the death of a patient by suicide, in an inpatient mental health setting. The research aims to find out the specific impact of a death by suicide and explore how the service impacted that experience following the incident. Ultimately, the study aims to be able to help inform services about the best way to support staff following a death in the workplace.

Why have I been approached?

You have been approached because the study requires information from people who are aged 18+, who are or were qualified psychologists working in an inpatient mental health service and have experienced at least one death of a patient by suicide. The incident(s) you have experienced will have been between 1-6 years ago.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part or not. If you decide to take part and change your mind part-way through or at the end of the study, you have the right to withdraw at any point with no explanation required. All data collected at that point would be destroyed and you will not be included in the research.

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

If you decide you would like to take part, you would be asked to schedule a time for a 45-60 minute interview with me remotely **via Microsoft Teams**. I will ask you to provide some basic details and then ask you a series of questions around your experiences. The interview will be recorded throughout.

Will my data be identifiable?

The information you provide during the interview is confidential and anonymous. The data collected for this study will be stored securely and only the researchers conducting this study will have access to this data:

- Audio recordings will be destroyed and/or deleted once the project has been submitted for publication/examined.
- Hard copies of questionnaires will be kept in a locked cabinet.
- The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself will be password protected.
- At the end of the study, hard copies of consent forms will be scanned. The electronic files will be saved on a computer for ten years. At the end of this period, they will be destroyed.
- The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.
- All your personal data will be confidential and will be kept separately from your interview responses.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a my research supervisor, or third party such as the emergency services where appropriate. If possible, I will tell you if I have to do this.

What will happen to the results?

The results will be summarised and reported in a doctoral thesis and may be submitted for publication in an academic or professional journal. This means that the results may be published and available for the public to read.

Are there any risks?

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

Are there any benefits to taking part?

Although you may find participating interesting and you are willing to share your experiences, there are no direct benefits in taking part.

Who has reviewed the project?

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

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

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

Caela Lagdon: c.lagdon@lancaster.ac.uk

Dr. James Kelly: j.a.kelly@lancaster.ac.uk

Complaints

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

Dr Bill Sellwood: (01524)593998
b.sellwood@lancaster.ac.uk
Health Researcher; Faculty of Health and Medicine
Lancaster University
Lancaster
LA1 4YG

If you wish to speak to someone outside of the Department of Psychology, you may also contact:

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

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

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance.

Samaritans: Tel: 116 123

www.Samaritans.org

Website: <https://supportaftersuicide.org.uk/resource>

If you are still currently working in the NHS you can ask to speak to your trusts staff wellbeing team.

Appendix 4

Debrief Sheet

Debrief

Experiences of staff in inpatient services following a patient death by suicide

Thank you very much for taking part in my research. The data you contributed will help me to complete my doctoral thesis, which is focussed on exploring the experiences of staff working in inpatient services following a patient death and aims to improve experiences for staff.

What happens now?

A transcript of our interview will be typed up in the weeks following our meeting. In the **two weeks** following interview, you may still choose to withdraw from the study if you no longer wish your data to be used. If this is the case, please contact me via the most convenient method. After this **two week** period, the transcript will be analysed and collated together with other interview transcripts and I will be unable to extract and delete your individual data. If you would like a lay summary of the results, I would be happy to send this to you upon the study's completion. Please let me know if you do require this summary so I can make a note and ensure that I send it to you.

What if I need to speak with someone following interview?

I hope you found the interview to be a positive and interesting experience. If, however, the experience has brought up difficult feelings, or left you feeling distressed, I would encourage you to contact one of the services listed below:

Samaritans: Tel: 116 123

www.Samaritans.org

Website: <https://supportaftersuicide.org.uk/resource>

If you are still currently working in the NHS you can ask to speak to your trusts staff wellbeing team.

Finally, if you have any further questions, or want an update on the research, please feel free to contact me using the details provided:

c.lagdon@lancaster.ac.uk

Thank you again for taking part, your input was invaluable.

Appendix 5

Interview Schedule

1. **Please could you tell me a bit about your role in the inpatient service you work/or did work in?**

Prompts: How long did you work there? What sort of work do you do? How long have you been qualified? Do you work with a team?

2. **Can you tell me about your role in the service and the type of work you were doing with the patient who had died by suicide?**

Prompts: Were you working directly/indirectly?

3. **Thinking about when the patient died, how was the experience for you?**

Prompts: Emotional aspects? How did you find out? What did you do? Did you seek support.. in work, out of work?

4. **How have you been able to make sense of the patient committing suicide?**

Prompts: Was it avoidable? Inevitable?

5. **Can you tell me about the longer term impact of the death on you?**

Prompts: Emotionally, professionally, personally. Has it changed how you feel about work? Has it had lasting impacts on you at all?

6. **What did you need following the incident and were those needs met?**

Prompts: Did you need support from work? From colleagues? Out of work support?

7. **What was your experience of management or the service following the death?**

Prompts: Support put in? Attitude towards you/others? Service processes put into action?

8. **How would you want things to be the same or different for people if this happened again?**

Prompts: Level of support? Changes or improvements to the service?

General prompts

Describe that in more detail? How did that feel? Going back to...? To clarify...

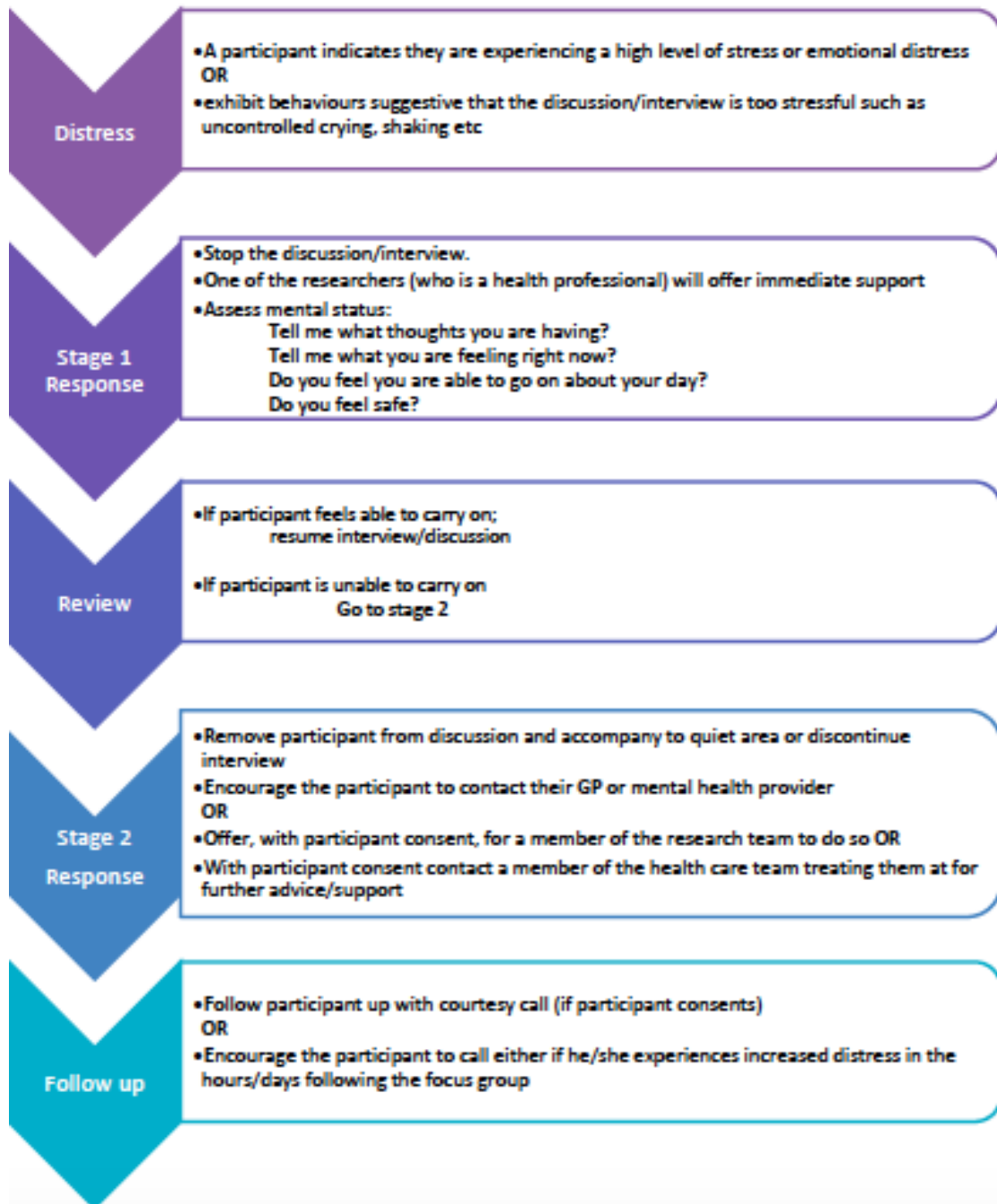
Tell me more about that/them... In what ways did that affect you/impact you...

That sounds interesting, can you say more...

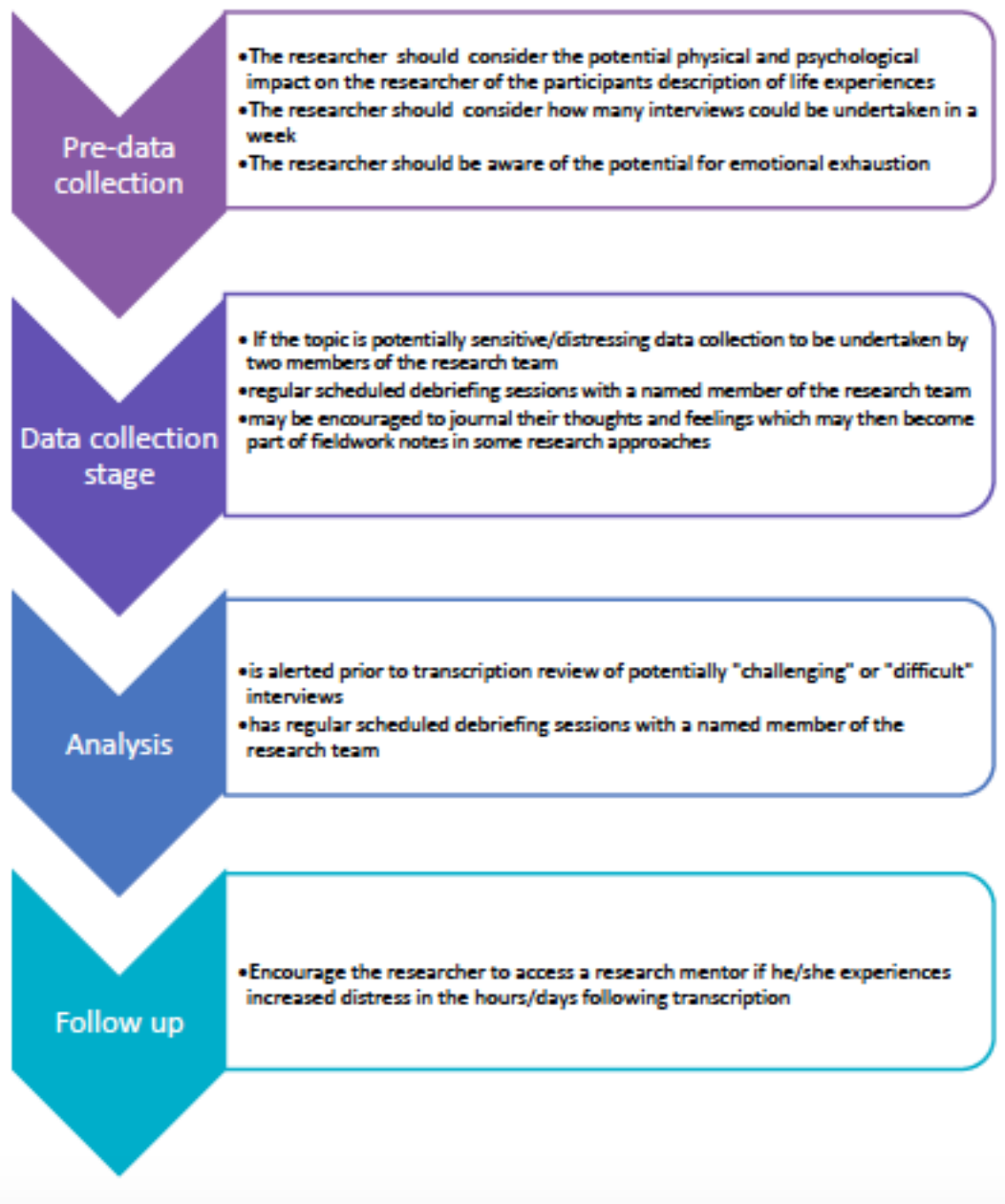
Appendix 6

Distress Protocols for Researcher and Participants

Distress Protocol 1: The protocol for managing distress in the context of a research focus group /interview
(Modified from : Draucker C B, Martsolf D S and Poole C (2009) Developing Distress Protocols for research on Sensitive Topics. Archives of Psychiatric Nursing 23 (5) pp 343-350)



Distress Protocol 2: The protocol for managing distress in the context of a research focus group /Interview management
McCosker, H. Barnard, A. Gerber, R (2001). *Undertaking Sensitive Research: Issues and Strategies for Meeting the Safety Needs of All*.
Forum: Qualitative Social Research, 2(1)



Appendix 7

Letter of Ethical Approval



Applicant: Caela Lagdon
Supervisor: Dr James Kelly
Department: Division of Health Research
FHMREC Reference: FHMREC20069

26 January 2021

Re: FHMREC20069
Staff experiences of suicide on an inpatient mental health ward

Dear Caela,

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

As principal investigator your responsibilities include:

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

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

Email: fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

A handwritten signature in black ink, appearing to read "ABeap".

Annie Beauchamp,
Research Ethics Officer, Secretary to FHMREC.