Service user perspectives and experiences of risk assessment and management in an acute psychiatric setting: A critical ethnography

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Thesis submitted to the University of Nottingham for the degree of Doctor of Philosophy

JUNE 2021

Acknowledgements

Funding for this doctoral study was awarded from the School of Health Sciences, University of Nottingham, for which I am so thankful. I am also grateful to have received a small grant from the School of Health Science's public engagement fund with which I set up my Service User and Carer Advisory Group (SUCAG), and a bursary prize from NIHR CLAHRC East Midlands that covered my research travel costs.

I have been supported throughout this journey by my academic supervisors Dr Nicola Wright and Dr Anne Felton, and latterly by Prof Richard Morriss – thank you so much for your support and encouragement.

I am also grateful to Prof Patrick Callaghan who has been an amazing mentor since I first started out in research, to Dr David Charnock who provided clinical supervision throughout the intensive period of fieldwork, to Owen Butler at the Disability Support Team, to members of my SUCAG, to staff who kept me sane at the Community Mental Health Team, and to colleagues at the Association of Mental Health Peer Researchers. Further thanks are due to my examiners, Dr Julia Terry and Dr Gary Winsip, and to Dr Fiona Moffatt, who chaired my viva.

I owe a debt of gratitude to my participants, both the staff who were so welcoming and accommodating of me, and the service users who shared so much of their personal experience of risk with me - it was an honour to hear your accounts and I hope the research presented here does you justice.

Finally, I am so thankful to my family, to Jude, Kezia and Essie, who have sacrificed so much for me so that I could spend five years on this research project – thank you so much for your patience and for your encouragement.

Abstract

Service user perspectives and experiences of risk assessment and management in an acute psychiatric setting: A critical ethnography

Background:

Many mental health policy documents state that involving service users in conversations about risk is important to improving quality of care and promoting recovery. However, a scoping review of the literature revealed limited evidence of service users having a role in the assessment and management of risk. It suggested that service users are unaware, uninvolved, and ill-equipped for, risk assessment and management; particularly in acute psychiatric inpatient settings. The power of staff to define, document, and manage the risks that matter are key factors in explaining service user experience.

Research question:

How do mental health service users experience risk assessment and management in an acute psychiatric inpatient setting?

Methods:

Data was generated by a service user researcher via four months of intensive, overt, non-participant observation of life on one acute psychiatric ward (47 service users; 35 staff), including formal meetings (ward rounds; community meetings; handovers; one-to-ones) and informal spaces, and via semi-structured interviews (11 service users; 11 staff).

Findings:

1). Risk is a "sensitive" and "emotive" experience that can be "difficult" for service users to discuss openly.

2). An "honest sharing" of the individual's experiential knowledge is required to enhance their self-knowledge (identify triggers) and develop new knowledge (coping skills) towards independent coping.

3). Service users feel distant from aspects of formal risk assessment processes and from the knowledge formed, resulting in feelings of powerlessness.

4). Clinical knowledge is prioritised over experiential knowledge in various ways.

5). To counterbalance this perceived power-disparity, service users are seeking more *involvement*, framed as opportunities to contribute their experiential knowledge.

Discussion:

This research contributes to our understanding of risk as a form of experiential knowledge, and risk assessment and management as epistemic activities. It explores conflicting epistemologies operating in the setting (clinical vs experiential), and the power dynamics involved, which contribute to service users experiencing forms of epistemic injustice. How epistemic justice can be recovered through an interpretivist approach to service user testimony and a coproduction approach to knowledge and power is outlined. That risk documentation can be used (as boundary objects) to navigate these issues of knowledge and power within the setting will be discussed. Implications for practice are that risk processes should be made transparent, one-to-ones routinely initiated by staff, and ward round preparation encouraged. Risk documentation should be co-constructed, to enable service user narratives to be centred in acute psychiatric inpatient risk assessment and management.

Contents (by main headings)

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Glossary:	**Abbreviations and key terms**
A&E	Accident and Emergency hospital department
AMHP	Approved Mental Health Professional
ASSIA	Applied Social Sciences Index and Abstracts (database)
AWOL	Absent Without Leave
BAME	Black And Minority Ethnic background
BP	Blood Pressure
CAMHS	Child and Adolescent Mental Health Services (up to age 18 years)
CINAHL	Cumulative Index to Nursing & Allied Health Literature (database)
CPN	Community Psychiatric Nurse
DoH	Department of Health and Social Care, England
ECG	Electrocardiogram
ECT	Electroconvulsive Therapy
Epistemic Injustice	Harm done to a person in their capacity as a knower
Epistemic Subject	Individual as a knower, reasoner, meaning-maker
Epistemology	The philosophical study of *knowledge*
ET	English Translation
EUPD	Emotionally Unstable Personality Disorder (diagnostic label)
Experiential Knowledge	Truth learned from direct, personal experience with a phenomenon
GP	General Practitioner (Primary Care)
HCSW	Heath Care Support Worker
HO	Handover: Observational fieldnote of a staff handover meeting
Inf	Informal conversation with a participant
IV	Interview: Formal semi-structured interview with a participant
Le grand renfermement	The Great Confinement (French; Foucault)
Le regard médical	The medical gaze (French; Foucault)
LGBTQIA	Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexual and/or Ally
MDT	Multi-Disciplinary Team
MEDLINE	Medical Literature Analysis and Retrieval System Online (database)
MeSH terms	Medical Subjects' Headings (standardised search terms)
MHA	Mental Health Act 1983/2007 status (informal, section 2, or section 3)
MHSOP	Mental Health Services for Older People (typically aged 65+)
Naïve Positivism	An uncritical, standard view of science (objectivity, neutrality)

NHS	National Health Service, UK
NICE	The National Institute for Health and Care Excellence, UK
Ontology	The philosophical study of what constitutes *reality*
PIS	Participant Information Sheet
PRN	*pro re nata* (Latin) - medication dispensed *when necessary* by nursing staff
PsychINFO	Abstracts in the field of psychology (database)
RCPsych	Royal College of Psychiatry, UK
Risk to others	Typically violence, aggression, homicide (see section 1.1.1)
Risk to self	Typically self-harm, suicide (see section 1.1.1)
Risk assessment	The process of identifying, estimating, and evaluating the nature, importance, and severity of risk (see section 1.1.2)
Risk management	The process as to how to practically deal with identified risk (see section 1.1.3)
RITB	Recovery In The Bin, a grassroots service user-led collective, particularly advocating for a critical stance towards mental health *recovery*
Standpoint Theory	The position of the inquirer makes a difference to knowledge-claims
SU	Service user
SUCAG	Service User and Carer Advisory Group for the project
SUPER	Service User Perspectives and Experiences of Risk (the acronym for this study)
Thick description	Rich descriptions and interpretations of a social context (Geertz)
TTO	Medication *to take out* on discharge
verstehen	*understanding* as aim of qualitative research (German; Weber)
WR	Observational fieldnote of a ward round
1-to-1	Observational fieldnote of a staff-service user one-to-one meeting

Chapter One: Introduction

This thesis presents a piece of doctoral research undertaken to explore service user perspectives and experiences of risk assessment and management in an acute psychiatric inpatient setting. This critical ethnographic research was conducted by a current mental health service user who has personal experience of the phenomena of interest. This thesis will argue that, whilst many mental health policy documents state that involving service users in conversations about risk is important to improving quality of care and promoting recovery, there is limited evidence of service users having a role in the assessment and management of risk, including in inpatient settings.

Through a combination of observations and interviews conducted on one acute psychiatric inpatient ward, it will be found that even though it is sensitive and difficult, service users are wanting to honestly share their experience of risk. This will be shown to be a form of experiential knowledge that service users feel staff need to know in order to provide tailored support to individual service users. As will be seen, risk assessment and management are framed as epistemic activities in which service users gain support with enhancing self-knowledge (identifying triggers) and developing new knowledge (coping skills) towards independent coping. This thesis explores the conflicting epistemologies operating in the setting (clinical vs experiential knowledge), and the power dynamics involved, which contribute to service users experiencing forms of epistemic injustice in risk assessment and management. How epistemic justice can be recovered, particularly through the co-construction of risk documentation, is detailed. It is hoped that this work will contribute to the involvement and empowerment of service users in risk assessment and management.

In **this introductory chapter,** the reader will be introduced and orientated to the key notions of *risk*, *risk assessment,* and *risk management* and how they are typically conceptualised in the context of mental health research, policy, and practice. *Acute psychiatric inpatient wards* will be defined and the central role of dynamic risk assessment and management within that context will be outlined. The researcher's position in relation to the study will be described and a personal rationale will be given as to why this research study was undertaken. **Chapter two** provides the empirical rationale for the study, based upon a scoping review which demonstrates that service user accounts of the phenomena of interest are limited, and that the current evidence suggests that service users are unaware of, uninvolved in, and ill-equipped for, risk assessment and management across different settings, including acute inpatient care. The rest of the chapter then explores the wider theoretical, policy, and practice evidence to ascertain why this may be the case, with a focus on the role dynamics of power play in constructions of risk in inpatient settings.

The philosophical assumptions underpinning the study are explored in **chapter three**. Critical (as opposed to conventional) ethnography as the chosen methodology is defined and justified and the methods used to generate data are detailed. Attention is given to the issue of reflexivity and to the researcher's own standpoint. Ethical considerations in the design and conduct of the study are also outlined, alongside markers of quality in ethnographic research. **Chapter four** introduces Attenborough Ward (a pseudonym) as the acute psychiatric inpatient setting of the study. The chapter will outline the physical and social environment, and the key people and their roles within the setting. It will also detail key service user-staff interactions, will reflect upon the spaces where these interactions occur, the function of the interactions on the ward, and any particular connections to risk assessment and management.

The findings presented in **chapter five** explore in-depth service user perspectives and experiences of risk and risk-processes on Attenborough Ward. These findings centre on the various forms of knowledge operating within the setting (experiential vs clinical), the power disparities between them, the impacts of those disparities upon service users in terms of feelings of powerlessness, and potential means of counterbalancing those disparities through tangible service user involvement, particularly in risk documentation. The discussion in **chapter six** will then contextualise the findings within the existing evidence-base, theory, and practice guidance. Risk as a form of experiential knowledge and expertise from the service user perspective will be outlined, and risk assessment and management as epistemic activities will be explored. Service user experiences of epistemic injustice and how epistemic justice can be recovered for service users will be discussed. Power-dynamics operating within the specific setting will be considered, and service user conceptions of empowerment in risk assessment and management will be outlined. Finally, how risk documentation can be used (as boundary objects) to navigate these issues of knowledge and power within the setting will be discussed. In **chapter seven** the thesis concludes with consideration of the unique contribution of the study, its strengths and limitations, implications for practice, and future work.

1.1 The research topic

1.1.1 Risk and Safety

The clinical literature in mental health typically divides risk into three broad categories of *risk to self*, *risk to others* and/or being *at risk* (DoH 2007/9; NICE 2011; 2015; RCPsych, 2010; 2017). Risk to self means that there is concern (from the individual and/or from another's perspective) that the individual may come to some harm from themselves by their own actions. Typically, in a mental health context, risk to self means there are concerns around the individual ending their own life (suicidal thoughts, feelings, intent, plans, and/or attempts) and/or concerns around self-harm (such as self-injury by cutting or by poisoning) (NICE 2011; RCPsych, 2010). By contrast, risk to others indicates that there is concern that other people may come to some harm from the individual themselves. In the context of mental health policy and practice, these concerns typically centre on violence and aggression as they pertain to mental disorder (such as from the mental health impacts of dependence upon drugs and/or alcohol, or mania associated with bipolar, or psychosis/schizophrenia), however the rare risk of homicide is also a factor to consider under risk to others (NICE 2015; RCPsych 2017). Moreover, individuals can also be at risk, meaning that they are in a social situation in which they could come to some harm. Being at risk may mean the individual is vulnerable in some way (self-neglect, for example), or that they might come to harm from others (DoH 2007/9).

A body of literature on *safety planning* originated with a focus on managing suicidal thoughts in particular, where suicide prevention has been framed as an issue of safety (Ferguson et al, 2021). Safety in mental health has been conceived from two distinct but overlapping perspectives, environmental safety, and psychological safety (Berzins et al, 2020). Environmental safety emphasises aspects of the physical space (such as a hospital ward) that helps to keep individuals physically safe from harmful events (Berzins et al, 2018; 2020). Psychological safety emphasises feelings of security, protection, and wellbeing, and the absence of psychological harm, fear, and distress (Wood & Pistrang, 2004; Jones et al, 2010; Stenhouse, 2012; Muir-Cochrane et al, 2013; Berzins et al, 2020; Culter et al, 2020). Psychological safety can be fostered by feeling physically safe in the environment, but there is also an emphasis upon service users developing therapeutic relationships with staff as a means of nurturing feelings of safety (Cutler et al, 2020).

1.1.2 Risk assessment

In mental health policy and practice, the clinical literature describes risk assessment as the process of identifying, estimating, and evaluating the nature, importance, and severity of risk (RCPsych, 2010; 2017). The assessment process thus incorporates risk identification (what exactly are the risks?), risk estimation (how much risk?), risk prediction (how likely is the risk?), and risk evaluation (overall, how problematic is the risk?) (Hansson et al, 2014); these are sometimes described under the generic term of making *risk judgements* (Coffey et al, 2017). Risk assessment involves generating a *risk-definition*, which is a description or statement of the exact risk posed, such as the category of risk (risk to self, risk to others and/or being at risk) and its precise form (Langan & Lindow, 2004). In a mental health context, a risk definition is often accompanied by a *risk-narrative* (Felton et al, 2018), which is an account of events which provide the rationale for the risk-definition. Risk-narratives can be verbally communicated in spoken word (such as by staff in handover talk from one shift to the next shift; Millar & Sands, 2013) and/or written down in documentation (such as in electronic patient notes and risk assessment documents; Coffey et al, 2019).

Good practice guidance in risk assessment suggests that it should have a holistic and biopsychosocial focus upon needs and related risks (NICE 2015; RCPsych 2010; 2017). It should also take a person-centred approach that should move beyond generic descriptions of diagnoses and/or risk-categories to explore the specific risks for the individual. Mental health professionals are typically situated as the *risk assessor* leading the assessment process in the form of asking questions of the service user (Coffey et al, 2019). Thus, good practice in risk assessment is seen to require a degree of staff-service user engagement, dialogue, and interaction.

1.1.3 Risk management

In the clinical literature, risk management is the process as to how to practically deal with identified risk – how are the issues raised going to be managed? (NICE 2015; RCPsych 2010; 2017). It typically involves identifying achievable goals and the practical steps needed to fulfil them as they pertain to identified risk. Risk management implies notions of coordination, administration, responsibility, and accountability for meeting identified goals (RCPsych 2017). Mental health professionals have traditionally been situated as the *risk manager*, coordinating and administrating the management process, and possessing overall responsibility (O'Rourke & Bird, 2001). They have thus been seen as liable for blame for any mismanagement. More recently, risk management has been framed as "how is the individual going to be supported to manage their risks?" (Boardman & Roberts, 2014). There is also an emphasis upon producing a risk management plan. According to good practice, risk documentation should incorporate the risk-definition, risk-narrative, and risk management plan (Perkins and Repper, 2016).

Safety planning is a related term that features in the literature, where there has been a specific focus on managing suicidal thoughts and feelings in particular (Ferguson et al, 2021). Here the plan is written with the aim of enabling people to get through difficult times with suggestions as to how the individual can keep themselves safe in a future crisis. Whilst safety planning was an intervention that was initially focussed on suicide prevention, suicide is framed as an issue of safety rather than using the language of risk. Thus, some theorists and practitioners use safety planning as a synonym for risk management but as their preferable term (Perkins & Repper, 2016).

1.1.4 Contested issues

The language of risk has been framed as problematic (Boardman & Roberts, 2014; Perkins & Repper, 2016). As will be unpacked in the next chapter, some have argued that there needs to be a whole shift of discourse and focus away from risk towards "promoting safety and opportunity" (Boardman & Roberts, 2014, p2). Risk has been seen to have potentially negative connotations, with associations of potential for harm, as something to be avoided, and tied to the actions of others (Hamilton et al, 2007). It has been argued that the language has the potential to be stigmatising and that the language of safety makes for an easier and more productive approach (Boardman & Roberts, 2014; Perkins & Repper, 2016; Callaghan & Grundy, 2018). It is also important to consider who makes risk-judgements, who gets to formulate risk-definitions, and who constructs the overall risk-narrative, and to question whether these issues matter. It is important to reflect upon whose risks matter in mental health care and why. Furthermore, it is important to understand how risk-definitions and risk-narratives are elicited, and in what context too. As will be argued in the next chapter, service user perspectives have received little attention.

1.2 Acute psychiatric inpatient wards

Acute psychiatric inpatient wards provide 24-hour, intensive, psychiatric and nursing care and support for adults (typically aged 18-65) who are experiencing significant and distressing mental illness/disorder/difficulties that requires urgent or immediate care and treatment (Bowers et al, 2005). They offer general psychiatric care, rather than being a kind of specialist service (such as an eating disorder unit, for example) although they can function as a step towards more specialist care and support. Being an *inpatient* ward means that people will leave their home environment to reside on-site while receiving care, treatment, and support. Referrals to acute psychiatric care are managed by mental health professionals, such as staff within community Crisis Resolution and Home Treatment Teams, Psychiatric Liaison Teams (situated in hospital Accident and Emergency departments), or by professionals involved in *Mental Health Act 1983/2007* assessments (RCPsych, 2010).

1.2.1 Acute psychiatric wards and risk

Staff working on acute psychiatric inpatient wards see risk and acuity as interrelated factors that constitute the core rationale for an admission (Bowers 2005; Bowers et al, 2005). As a rationale for inpatient admission, being a risk to self means that there are concerns that it is highly likely that the individual will take action to follow through on any expressed suicidal intent, enact any concrete plans, and thereby take steps to end their own life (NICE 2011; RCPsych 2010). Alternatively, the self-harm is of such a degree that it might become dangerous and life-threatening to the individual (NICE 2011; RCPsych 2010). Similarly, being at risk means that the individual's vulnerability is to such a degree that it is highly likely that they will come to harm in their current social situation (DoH 2007/9). Moreover, admission as a risk to others means it is considered highly likely that others will come to harm from the individual as it pertains to their mental disorder (NICE 2015; RCPsych, 2017).

Acute psychiatric inpatient ward staff emphasise the *dynamic* nature of risk assessment and management within the setting, meaning that the issues can change and develop over time (Jones et al, 2020). They emphasise the need for constant monitoring and ongoing documentation of risk (Coffey et al, 2019). Whilst individuals arrive with issues of risk and acuity that brought them onto the ward, their understanding as to why they have been admitted may evolve over time (Langan, 2008). Similarly, it is acknowledged that individuals can develop further concerns around risk during their admission on the ward (Quirk, 2004; Cutler et al, 2020). Staff emphasise that risk assessment and management is enacted from admission through to discharge (Jones et al, 2020).

Individuals in the community may believe themselves to be a risk and/or at risk and may have requested a crisis admission from staff, or been offered one voluntarily by staff, and they are referred to as being *informal* (Ashmore & Carver, 2017). Being informal means that individuals are free to leave the ward whenever they so choose. Alternatively, individuals may have been brought involuntarily under the *Mental Health Act 1983/2007* who are referred to as being *detained*. Individuals can be detained initially for a period of assessment, and they could subsequently be further detained for a period of treatment. Similarly, informal service users can be temporarily detained on the ward to allow staff time to set up a *Mental Health Act 1983/2007* assessment if required. Thus, for those detained their admission is compulsory, their detention involuntary, based on the risk-judgements of others, among other factors (Akther et al, 2019). Risk has become a key factor in both informal admissions and in decisions to detain (Bowers et al, 2015; Ashmore & Carver, 2017).

1.3 The position of the researcher

As will be outlined in the methodology chapter (see chapter three), the research paradigm within which this study has been conducted requires a high degree of reflexivity (Pillow, 2003; Shaw, 2010). This entails critically scrutinising the identity, role, privileges, and power relations of the researcher (Beresford, 2005), towards the participant groups who are the focus of the study (service users and staff), towards an acute psychiatric inpatient ward as the social setting in which the study is conducted, and towards risk assessment and management as the phenomena of interest. The narrative will now move into the first person. From the outset it is important to articulate who I am as an individual and how my personal experiences have led me to undertake this research study.

Whilst I appreciate my identity as a husband, a father, a friend, and a member of a faith-community, in this research I foreground my identity as both a *mental health service user* and as a *lived experience researcher*. At the same time, I recognise the privileges of being a university-educated, white, heterosexual, now middle class, cisgender male, living and working in a developed country. I recognise that this places me in a position of socio-economic and socio-cultural privilege, and it situates me in a position of power in relation to, for example, people from LGBTQIA groups and minoritised ethnic groups (Beresford, 2005).

1.3.1 A service user

My ongoing, intentional, and voluntary engagement and involvement with mental health services means that I currently see myself as a service user. Whilst some use the term survivor, particularly in relation to "surviving the psychiatric system" (Stickley, 2006), I personally choose to engage with the system and thus I prefer to see myself as a user of mental health services and have done since 2007. Terminological debates surrounding how to describe recipients of mental health services have been long reflected in, and continue to feature in, the literature (Andreasen, 1995; Fischer, 2020). Whilst some dislike the term service user and prefer to be called a patient (Simmons et al, 2010; Dickens & Picchioni, 2011), the term service user does lack some of the connotations of patient (which might imply passivity, situated within a biomedical model) and will be the preferred term throughout.

1.3.1.1 Experiences of distress and of diagnosis

I live with my own experiences of mental distress; again, I recognise that different people have different preferences as to how they describe experiences which can also be framed and referred to as mental illness, or mental disorder, or mental health problems, challenges, difficulties, or difference. I also recognise that different models can underpin the different terms employed by professionals (with mental illness suggesting a medical model, although not necessarily bio-reductionism; Huda, 2019) and by those with the lived experience (Sayre, 2000; Barnes, 2011). I personally adopt a pro-choice approach as to how individuals frame their own experiences. For this study, it is important to acknowledge that, based on my own lived experience, I am a *knower* of mental distress (Faulkner, 2017) with all that that entails. I am also pro-choice towards accepted solutions, such as psychopharmacological (I take the antipsychotic Clozapine) and/or psychotherapeutic approaches (I value the Talking with Voices approach) to issues identified, where these are collaboratively agreed upon rather than imposed. I would thus adopt a biopsychosocial approach towards my experiences of distress and would reject bio-reductionism (Engel, 1981). However, I acknowledge that this is a different stance towards psychiatry compared to, for example, people who would position themselves as intentionally anti-psychiatry (e.g., Szasz, 1961).

I also live with a diagnosis. Upon my third acute psychiatric inpatient admission in 2007 I was eventually given a diagnosis of *paranoid schizophrenia*, although I prefer to use the more generic *psychosis* in my public discourse as I feel it has less cultural baggage. I have experienced this diagnosis as stigmatising. I have lived with both a societal and an internalised stigma based on the perceived dangerousness around the label schizophrenia (Huggett et al, 2018), particularly feeling that I have at times been judged to be a *dangerous mental patient* (Stuart, 2006). For instance, when I was first diagnosed someone within my social circle asked my wife whether she was now fearful of living with me (she was not). My wife was also asked whether I was safe to still volunteer as a youth group leader working with children (I was). I also find lazy media reporting of violence and homicides in relation to schizophrenia/psychosis at times frustrating and upsetting, as I feel it reinforces the negative stereotype of dangerousness in the public mind (as per Gwarjanski & Parrott (2018) with recent US findings), whilst fuelling my own internalised stigma. I acknowledge that living with these experiences, this diagnosis, and disability places me in a position of social disadvantage and marginalisation; however, I will argue that is not a deficit when it comes to the methodology underpinning the research process.

1.3.1.2 Experiences of acute psychiatric inpatient admission

I also have lived experience of the kind of social setting in which the study was set, having been admitted to five different acute psychiatric inpatient wards, although not the ward in which the study was set. My first acute psychiatric inpatient admission was in 2007 and I have experienced six admissions, ranging from a stay of two weeks to four months, on both mixed gendered and single gendered wards. Even though I was there as an informal service user, I felt that the threat of detention was always lurking in the background if I was not compliant, and a consultant once said that they would look to use detention if I did not agree to treatment. Also, I did not really know what my rights were as an informal service user (as per Ashmore & Carver, 2017) and assumed I could only leave once I was better, hence it felt like a *de facto* section. I had, however, voluntarily, and willingly sought admission and was (eventually) prepared to engage in suggested treatment plans, even if at times it felt coercive. As an informal service user, then, I acknowledge that my experiences of admission will have been different compared to those who have been detained under the *Mental Health Act 1983/2007* (Katsakou et al, 2012; Akther et al, 2019).

1.3.1.3 Experiences of inpatient risk assessment

As a service user with experience of admission on different psychiatric wards, I have also directly experienced the phenomena of interest, which I will for now refer to as risk assessment. Each time, upon admission I would have an initial conversation with a nurse, which I now, with the benefit of hindsight, recognise to be a risk assessment. I was seeing and hearing the voices of three evil men who were conducting painful experiments on me. They were tormenting me and telling me to harm my loved ones, and also to kill myself, and I was terrified. I also felt that this was not the kind of life that was worth living. I acknowledge that this fear and distress led me to seek admission as *a place of safety*. Furthermore, I was experiencing and holding beliefs about things that staff judged to be not real, although was very real and frightening to me. On each occasion I was asked in detail about the men, their commands and how I felt about them, and whether I felt I would act upon them. I was also asked about the emotional impact of the men in terms of suicidal thoughts and intent. Staff would routinely revisit these questions in both one-to-ones and during ward rounds. I was thus experiencing an ongoing assessment of risk to myself and risk to others.

On two occasions I was told that safeguarding would now have to be involved, but that it was standard procedure. I was struck by the fact that on other admissions that standard procedure was not operationalised. Over time, I realised that if I self-censored my responses I might have a different outcome and people might be less concerned about me and/or about my family. Also, I did not know what safeguarding meant, and I was not told. My wife would later tell me that a social worker had phoned to ask her a lot of questions. I felt that staff had gone behind my back. I thus felt that risk assessment had been deliberately covert, and I could not understand why. I felt judged; that they thought I was that dangerous mental patient. The questions they asked me were intrusive and upsetting, which was made worse by the fact that I did not understand why they were asking the kind of questions they were asking of me. I assumed that it was to inform therapy, but it seemed to make no difference to my day-to-day care. Whilst I was there voluntarily, it still felt controlling, and that I had to comply.

1.3.1.4 A personal rationale

As part of my reflexivity, it is thus important to openly acknowledge from the outset that I have personally experienced risk assessment negatively - as covert, intrusive, traumatising, and controlling. This is the initial perspective that I brought to the study. However, I wanted to see how other mental health service users had experienced acute psychiatric inpatient risk assessment and management. I felt that having had lived experience of both the setting and phenomena of interest, and being transparent about that, that I might be able to build up a trust and rapport that might enable me to understand other service users' experiences.

1.3.2 A lived experience researcher

In addition to being a service user I also identify as a *lived experience researcher*. As such, I have always sought to use my personal experience of mental distress to inform research management, design, and conduct (Faulkner, 2004). I came into research via a training course for mental health service users and carers run in early 2011, as preparation for involvement in a National Institute of Health Research-funded programme grant (which I worked on from 2012-2016). This programme of research was focussed on service user involvement in mental health care planning. I began to develop an academic knowledge-base around the role of risk assessment in care plans and care planning (Grundy et al, 2016; Callaghan & Grundy, 2018). Whilst working on this study I also experienced two acute psychiatric inpatient admissions, the experience of which I felt were enhanced by my new knowledge, setting new expectations for my involvement during those admissions. Thus, my service user and lived experience researcher pathways inform one another.

1.3.2.1 Not just a researcher

I have sometimes been asked by colleagues why I do not simply identify as "just a researcher." I will argue that lived experience constitutes a form of knowledge and expertise that is distinct from that derived from an academic knowledge-base alone (Faulkner, 2017). I will also argue that my position or standpoint as a service user with lived experience of the kind of setting and phenomena of interest will inevitably, and – importantly – *helpfully* inform how I see and interpret that social world (Rose, 2017), and also how I engage with participants within the setting, and how they then engage with me. Thus, my use of the term lived experience researcher highlights the contribution of the experiences that I have been through (as explicitly outlined above) to the role that I am adopting. This thesis, then, represents an example of a service user-led and user-controlled (albeit under supervision) research study (Faulkner, 2004).

1.3.2.2 The power of the researcher

At the same time, as a *researcher* I recognise the power I possess, and may be seen to possess, by being university-educated, by working within the academy in mental health research, and by virtue of conducting a research study (Rose & Kalathil, 2019). This inevitably places me in a power-relation toward my participants (Beresford, 2005), and particularly with the service user participants. Thus, whilst I might perceive myself to be a peer towards the service user participants, by virtue of having had similar experiences, that is no guarantee that I will be received as a peer. It will thus be important to consider further how I present myself to participants, and to consider how I may be perceived by them (Fine, 1993), throughout the life of the data generation phase of the research, and then to further consider that role within the analysis phase too. This will require continual, critical reflexivity about my identity, power, privilege, and unconscious bias and inevitable blind-spots (Shaw, 2010).

1.4 Summary

Notions of risk and safety, and of related risk assessment, risk management, and safety planning seem to have fixed meanings in a mental health care context. Risk is also an interrelated part of acute psychiatric inpatient admissions. This thesis seeks to explore service user perspectives on risk assessment and management within these settings. That the researcher is a service user with lived experience of the phenomena and settings of interest will be framed as an asset. The power and privilege of the researcher has been highlighted, that power must be wielded to enable the participants' voices to be heard. It is hoped that that is what will be achieved throughout this thesis.

This introduction then has set the foundation for the more detailed exploration of theory, policy, legislation and practice around risk that will be discussed in the literature review that will be presented in the next chapter, where the empirical rationale for the study will be delineated.

Chapter Two: Literature Review

This chapter reviews the relevant literature relating to service user experiences of risk assessment and management in acute mental health inpatient settings. It starts by presenting a scoping review which demonstrates that service user accounts of the phenomena of interest are limited, and that the current evidence suggests that service users are unaware of, uninvolved in, and ill-equipped for, risk assessment and management across different settings. The rest of this chapter explores the wider theoretical, policy, and practice evidence to ascertain why this may be the case. In particular, this chapter focuses on staff-service user power dynamics. Namely, that staff possess overall definitional power to define the risks that matter, the power to manage risk, and to create risk-narratives. How staff have come to possess such power and the impact this has upon service users will also be considered. Next, the literature on service user involvement in decision-making will be surveyed, both to evidence what *should* be happening in risk assessment and management, and to consider potentially *why* this is not being operationalised from a service user perspective. Finally, the literature on service user empowerment and recovery will be considered. The chapter concludes with the rationale and justification for the PhD study undertaken.

2.1 Finding the voice of service users: an initial scoping review

A scoping review of the literature following the Arksey and O'Malley framework (2005) was adopted because there were no previous literature reviews of any kind focussing on mental health service user accounts of their experience of risk assessment and management in any setting. Scoping reviews can be a precursor to conducting a full systematic review of the literature. Scoping reviews are, however, useful in and of themselves, particularly in examining the extent, range, and nature of prior research activity and to identify gaps in the existing literature (Arksey & O'Malley, 2005).

2.1.1 Identifying the search question

The scoping review addressed the question: *What do we know about service user perspectives on and experiences of mental health risk assessment and management?* Keywords and Medical Subjects' Headings (MeSH terms) were identified, and a broad search strategy was developed in consultation with a Health Sciences librarian (see **figure 1**).

(service user.mp. OR patient.mp. OR ((service* adj3 user*) or consumer* or patient* or inpatient* or in-patient*).mp.) AND (risk assessment.mp. OR risk management.mp. OR safety planning.mp.) AND (mental health.mp. OR mental disorders.mp. OR mental health services.mp.) AND ((perspect* or attitude* or experien* or view* or understand* or percept* or preconcept* or misconcept* or perceive* or belie* or account* or respons* or evalu* or feel* or opinion* or thought* or value* or idea or emot* or expect*).mp.)

Figure 1: Search terms

2.1.2 Identifying relevant studies

MEDLINE, PsychINFO, ASSIA, and CINAHL, which are four of the most widely indexed databases relating to the topic-area, were searched. This was then complemented by a search using Google Scholar, followed by incremental searching of the bibliographies.

2.1.3 Study selection

A set of criteria were developed to include or exclude identified studies from the searches. Inclusion criteria were:

- peer-reviewed articles
- empirical studies of any design – quantitative, qualitative, or mixed methods
- focussed on adults aged 18-65 years
- any community, day or inpatient mental health setting
- published within the last 25 years (from 1996)
- in the English language
- any geographical location

Exclusion criteria were:

- studies of risk not relating to mental health (such as learning disabilities)
- studies not related to a mental health setting (such as social care)
- non-peer reviewed articles such as opinion pieces, editorials, theses, and dissertations
- studies focusing on children or adults over the age of 65 years
- studies published prior to 1996
- studies not written in the English language

The rationale behind the study selection criteria was to maintain a clear focus on the experience of risk for service users within mental health services. The decision to include any empirical study design maximised the potential to collect diverse service user perspectives regardless of whether they were from quantitative (e.g., surveys), qualitative (interviews; ethnography) or mixed method research. Any mental health setting was incorporated to allow for comparisons and contrasts between different contexts (e.g., community; acute inpatient; forensic). Adults aged 18-65 are often identified in mental health research and policy as a distinct population, and receive particular services, compared to children and adolescents (CAMHS) or older adults (MHSOP). The timeframe reflects the changes in mental health policy that have taken place in the past 25 years and allows for any evolution in practice to be traced over time. During this period there have been significant shifts in how care is provided in a mental health context (e.g., increasing focus on care in the community) and the involvement of service users in their own care. The decision to restrict the search to papers in the English language was a pragmatic one.

The database searches were initially conducted in December 2016 and were repeated in September 2019 and in December 2020; the results of that final search (December 2020) are reported. The database searches produced a total of 1647 hits, with 11 duplicates. After title and abstract screening, 31 relevant articles were identified. Full articles were then sought and reviewed. At this stage 13 papers were excluded: seven studies reported mental health service user experiences, but were not explicitly related to risk, risk assessment or risk management; two were not empirical studies (one was a briefing document, the other a Trust policy document); one paper was a near duplicate of another included study, adding nothing further to the data; one paper was focused on social care; one did not focus on mental health, but rather on intellectual (learning) disabilities; and finally, one paper focussed on the design of a risk measure, but with no clear focus on the service user perspective in its design or subsequent psychometric testing. Therefore, 18 studies were deemed eligible for inclusion in the scoping review. For clarity, this process is summarised in a PRISMA-ScR flow chart in **figure 2** (Tricco et al, 2018).

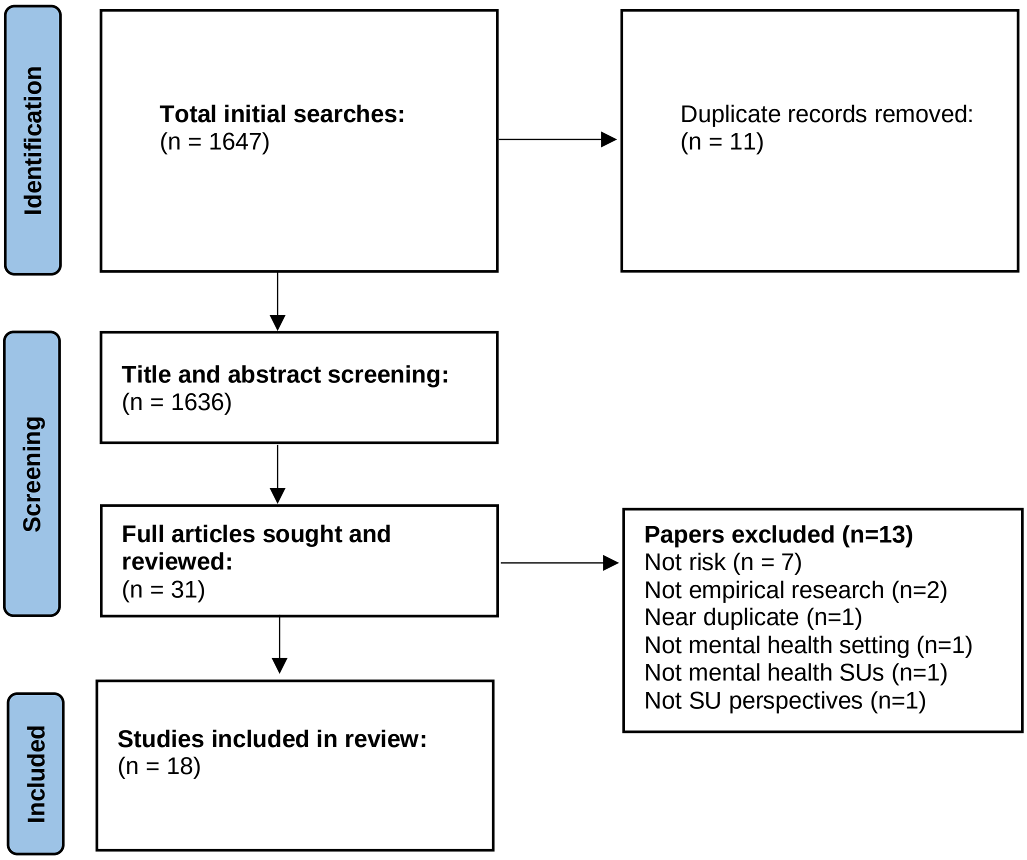


Figure 2: PRISMA-ScR flow diagram

2.1.4 Charting the data

The 18 papers included in the scoping review were then charted. Data was extracted relating to: author; year of publication; title; geographical location; setting/population; design/methods; and any comments on the paper, such as sample size and the focus of study. The final table is presented here in **figure 3**:

Author	Date	Title	Location	Setting	Design/ Methods	Comments
Berzins et al	2018	Service user and carer involvement in mental health care safety: raising concerns and improving the safety of services	UK	General community	Quant Survey	Focus on raising risk/safety concerns
Berzins et al	2019	A qualitative exploration of mental health service user and carer perspectives	UK	General community	Qual Interviews	13 SUs, exploring risk/safety concerns

		on safety issues in UK mental health services				(11 with prior experience of inpatient care)
Buckingham et al	2015	Integrating service user and practitioner expertise within a web-based system for collaborative mental-health risk and safety management	UK	General community	Mixed Interviews Focus Groups Software development	Co-design of an online decision support system
Coffey et al	2017	Ordinary risks and accepted fictions: how contrasting and competing priorities work in risk assessment and mental health care planning	England and Wales	CMHT	Qual Interviews Care Plan reviews	33 SUs, overlap of risk assessment and care planning
Coffey et al	2019	Recovery-focussed mental health care planning and co-ordination in acute inpatient mental health settings: a cross national comparative mixed methods study	England and Wales	Acute inpatient (current)	Mixed Survey Interviews	36 SUs, care planning, risk assessment, and recovery
Cutler et al	2020	Nurses' influence on consumers' experience of safety in acute mental health units: A qualitative study	Australia	Acute inpatient (retrospective)	Qual Interviews	15 SUs, experience of risk/safety and nursing care
Dixon	2012	Mentally disordered offenders' views of 'their' risk assessment and management plans	England	Forensic (current)	Qual Interviews	19 SUs, focus on risk documentation
Ganzini et al	2013	Trust is the Basis for Effective Suicide Risk Screening and Assessment in Veterans	USA	Service for veterans in the community	Qual Interviews	34 SUs – focus on suicide risk
Heyman et al	2004	Forensic mental health services as a risk escalator: A case study of ideals and practice	UK	Forensic (current)	Qual Case study	10 SUs and involved staff
Kroner	2012	Service user involvement in risk assessment and	Canada	Forensic (current)	Quant	Outcome measure testing

		management: The Transition Inventory				
Langan	2008	Involving mental health service users considered to pose a risk to other people in risk assessment	England	Acute Inpatient (retrospective)	Qual Interviews	13 SUs – focus on risk to others
Peterson et al	2011	If You Want to Know, Consider Asking: How Likely Is It That Patients Will Hurt Themselves in the Future?	USA	Acute inpatient (prospective)	Quant	Measuring predictive utility of self-perception of self-harm
Quirk et al	2004	Service users' strategies for managing risk in the volatile environment of an acute psychiatric ward	England	Acute inpatient (current)	Qual Ethnography Qualitative Survey responses	Focus on informal risk management
Reynolds et al	2014	Playing the game: service users' management of risk status in a UK medium secure forensic mental health service	UK	Forensic (current)	Qual Observation Interviews	Focus on risk management
Roaldset & Bjorkly	2010	Patients' own statements of their future risk for violent and self-harm behaviour: A prospective inpatient and post-discharge follow-up study in an acute psychiatric unit	Norway	Acute inpatient (prospective)	Quant	Measuring predictive utility of self-perception of violence/self-harm risks
Ryan	1998	Perceived Risks Associated With Mental Illness: Beyond Homicide And Suicide	UK	General community	Mixed Interviews Survey	Focus on risk definition
Ryan	2000	Exploring the risk management strategies of mental health service users	UK	General community	Qual Interviews	22 SUs, focus on informal risk management
Skeem et al	2013	The utility of patients' self-perceptions of violence risk: Consider asking the person who may know best	USA	Acute inpatient (prospective)	Quant	Measuring predictive utility of self-perception of violence

Figure 3: Scoping review table of the 18 included papers

Seven studies had a quantitative research design. Of these, five studies (Ryan 1998; Roaldset 2010; Peterson 2011; Kroner 2012; Skeem 2013) were concerned with developing actuarial measures of risk, arguing that service users themselves could accurately predict their future risk, and that service users' self-perceptions could add predictive utility to existing measures of risk. A further study (Buckingham 2015) explored risk items for an online decision support system. Berzins et al (2018) conducted a survey on service user's ability to raise risk or safety concerns or complaints.

Eleven studies had a qualitative research design or core component. Four of these were with community-based service users: Ryan (2000) with self-identified service users, Ganzini (2013) with US Veterans, Coffey et al. (2017) with service users explicitly under Community Mental Health Teams, and Berzins et al (2019) interviewing community-based service users, but including exploring aspects of their experiences of inpatient admission in relation to issues of risk and safety where relevant; three of the included studies were focussed on forensic settings (Heyman 2004; Dixon 2012; Reynolds 2014); only four included studies were with service users on acute psychiatric inpatient wards, three during their admission (Quirke 2004; Coffey et al, 2019; Cutler et al, 2020) and one on discharge (Langan, 2008).

The four included studies on service user accounts of risk assessment and management in acute psychiatric inpatient settings focussed on: service users developing their own risk management strategies particularly around interpersonal conflict on inpatient wards (Quirke, 2004); the retrospective experiences of service users who have been in an acute psychiatric inpatient setting and who had been judged to be a risk to others and were recently discharged; their involvement in risk assessment or otherwise was explored (Langan, 2008; see also Langan & Lindow's (2004) grey literature report); experiences of collaboration or otherwise in care planning as a part of risk management (Coffey et al, 2019); service user perspectives on the roles of nurses in the experience of risk and safety on acute psychiatric inpatient units (Cutler et al, 2020). In addition to these four studies, Berzins et al, (2018; 2019) identify a role for service users in identifying safety concerns and raising complaints about environmental and psychological safety, including in inpatient contexts. No study has yet sought to address the entire experience of risk assessment and management in the whole course of admission, from clerking-in to discharge, in an acute psychiatric inpatient setting.

2.1.5 Collating, summarising, and reporting the results

From the included studies, the literature we do have on service user perspectives and experiences of risk assessment and management across all settings indicates that service users are generally unaware of, uninvolved in, and ill-equipped for, risk assessment and management in mental health settings.

2.1.5.1 Unaware

The scoping review identified that mental health service users are mostly *unaware* of risk assessment and of the contents of risk documentation. In forensic settings patients have a general awareness of risk assessment being conducted (Dixon, 2012), whilst in acute psychiatric inpatient settings service users appear to lack that overall awareness (Coffey et al, 2019). Service users on acute psychiatric inpatient wards are largely unaware of being risk assessed and of staff-service user risk assessment interactions even occurring (Langan, 2008; Coffey et al, 2019). In all settings service users are also largely unaware of the contents of risk assessment and management plans, with service users not contributing to their construction (Langan, 2008; Dixon 2012; Coffey et al, 2019).

Service user unawareness of risk assessment and management in an acute psychiatric inpatient setting has been framed as problematic (Langan, 2008; Coffey et al, 2019). It is argued that service users *should* be aware of the contents of risk assessment and management plans (Langan & Lindow, 2004). Furthermore, it is suggested that staff have an ethical duty to inform service users of any risk-judgements made about them, and of any risk-narratives formulated about them, particularly if they are viewed as a risk to others (Langan & Lindow 2004; Langan, 2008). It is also intimated that service users *should* be aware of risk assessment happening on the ward (Coffey et al, 2019).

2.1.5.2 Uninvolved

Included studies in the scoping review also report that service users feel that they play no active role in formal risk assessment and management activities across all settings, forensic (Dixon, 2012; Reynolds, 2014), community (Ganzini, 2013; Coffey et al, 2017), and acute psychiatric inpatient (Langan, 2008; Coffey et al, 2019). Service users in acute psychiatric inpatient settings suggest that their role in formal risk assessment and management is largely limited to answering staff questions (Coffey et al, 2017); thus service users thus feel that they contribute their perspective only in so far as they are asked direct questions about it. Service users in an acute psychiatric inpatient setting feel uninvolved in decision-making around risk (Coffey et al, 2019) and, overall, they feel that professional risk-judgements are privileged over their own point-of-view (Langan, 2008). Service users in acute psychiatric inpatient settings also report a lack of routine collaboration and involvement in care planning, including in care planning for risk (Coffey et al, 2019). Service users also report being uninvolved in the construction of the contents of risk documentation and feel uninvolved in documentation processes (Langan, 2008; Coffey et al, 2017; Coffey et al, 2019).

As with service users being unaware, their non-involvement in risk assessment and management in an acute psychiatric inpatient setting has been framed as a problem (Langan & Lindow, 2004; Langan, 2008; Coffey et al, 2019). Studies have been particularly set against a policy context on service user involvement (outlined below) in which it is emphasised that service users *should* be involved in all aspects of their care and treatment, including risk and its assessment and management in all settings, including acute psychiatric inpatient settings (Langan, 2008; Coffey et al, 2019). Furthermore, whilst staff routinely reported collaboration and involvement, this contrasted with service user accounts which pointed to a lack of involvement in risk management (Coffey et al, 2019). This raises the question as to what involvement might mean to different parties and whether there are different conceptions at play within the setting, or whether other factors account for this discrepancy. In this instance, Coffey et al (2019) have found that some service users in acute psychiatric inpatient settings themselves *desire* involvement in risk assessment and management, and particularly in care planning for risk.

2.1.5.3 Ill-equipped

In terms of risk management, the scoping review identified that service users in acute psychiatric inpatient settings feel ill-equipped to deal with their own concerns regarding risk (Quirk, 2004). Quirk (2004) argues that some service users take their own initiative in developing their risk management strategies particularly for dealing with interpersonal risks around violence and/or aggression that they encounter on the ward itself. This initiative-taking may indicate that some service users desire a more active role in formal risk management. Some service users are looking to staff for protection and a sense of safety as a strategy for managing risk (Quirk, 2004). Furthermore, service users feel that risk management strategies are not taught to them by professionals on the ward, which contributes to the experience of feeling ill-equipped (Quirk, 2004).

Feeling ill-equipped has also been framed as problematic, and service users *should*, it is argued, be equipped by staff to manage their concerns around risk (Quirk, 2004; Langan & Lindow, 2004). What this particularly emphasises is that service users when they arrive onto an acute psychiatric inpatient ward may already have concerns around risk that they feel are entirely missed by staff. Furthermore, service users may develop risk concerns during their whole experience of admission that they feel are not picked up upon by staff (Quirk, 2004). Moreover, it appears that these missed concerns leave service users feeling that they themselves have to manage these risks on their own and entirely without staff support. It is not clear why, when staff consistently emphasise dynamic risk assessment, that these concerns are missed. This may illuminate different priorities in risk assessment and management, or it might highlight different categories or definitions of risk from different perspectives (Ryan, 2000). This again highlights the issue as to who gets to define the risks that matter within the context of acute psychiatric inpatient admission.

2.1.6 Summary

The scoping review has highlighted three core themes that summarises service users' experiences, that they are unaware of, uninvolved in, and ill-equipped for, risk assessment and management, including in acute psychiatric inpatient settings. In the absence of empirical data, the wider theoretical, policy, and practice literature will now be explored to try to understand how these situations might arise in practice. An argument will be developed that two particular dynamics of power (the power to define risk; and the power to manage it) are at play in current risk assessment and management practice, based upon staff's power to create risk-narratives in acute psychiatric inpatient settings. How staff have come to possess the power to define and the power to manage will be considered, along with the potential impact upon service users in these acute psychiatric ward-settings themselves. We will then turn to the literature on involvement and empowerment of service users (often raised as antidotes to such power dynamics) to consider what these *should* look like in practice, and how and why the failure to achieve service user involvement and empowerment may have arisen. How service users' own risk-narratives have ended up being excluded in risk assessment and management will also be considered.

2.2 Power to define

Mental health professionals have the power to construct a service user's risk. To do so, staff can create, pass on, and document a narrative account of that risk in spoken or written form (Felton et al, 2018). That narrative can act as a rationale for staff's overall risk-judgement and risk-definition and constitutes the basis for a risk management plan (Langan & Lindow, 2004; Langan, 2008). These risk-narratives centre around staff interpretations of service users' behaviours, expressed emotion, and their talk, that can then be framed as causes for concern in terms of risk from a staff perspective (Felton et al, 2018).

2.2.1 Power to define and clinical processes

In the context of acute psychiatric inpatient settings, staff are involved in a number of different clinical processes that they frame as a core part of risk assessment: observations (Insua-Summerhays et al, 2018), handovers (Olasoji et al, 2018), and documentation (Coffey et al, 2019). These processes will be considered in turn, to consider how staff are positioned in a power-role in the construction of risk-narratives, which may account for service user non-involvement.

One key clinical process that contributes to staff's power to define is observations. Observations refers to the act of watching a service user, at a frequency and proximity determined by risk, to keep service users physically safe (Hamilton & Manias, 2007). Through observation, staff can also construct a service user's overall *presentation* whereby professionals interpret service users' behaviour, expressed emotions, and their talk via focussed observations (Hamilton & Manias, 2007; 2008). In the context of acute psychiatric inpatient settings, staff consistently perceive observations as a core means of identifying risk and risk severity (Insua-Summerhays et al, 2018). Service users emphasise a lack of engagement and communication by staff in both night-time (Veale et al, 2020) and daytime (Insua-Summerhays et al, 2018) observations, emphasising the experience of being watched, but with minimal interaction. Some staff see their third-party perspectives on service user's talk and behaviour as providing them with valuable "mental state in action" and emphasise that professionals are trained to make such clinical interpretations (Hamilton & Manias, 2007). Whilst service users highlight a lack of meaningful interaction (Insua-Summerhays et al, 2018), it is not clear whether they are seeking to contribute their own interpretations, perceptions and narratives of risk in this process, nor whether they are aware of risk-narratives that are being constructed by staff through observations. If they are aware of the process, it is also unclear whether service users want access to these narratives. Where observations take the form of watching without meaningful interaction, it is clear that the process attributes to staff significant power to define risks; this may contribute towards the privileging of their own interpretations.

Handover is another process operating on acute psychiatric inpatient wards through which staff identify and communicate risk (Millar & Sands, 2013). In handover-talk "relevant information" about service users is communicated from staff working on the past shift to staff starting on the next shift. Handover-talk can include how service users have presented during the previous shift and in previous studies staff report that this may include communication around risk (Millar & Sands, 2013; Olasoji et al, 2018). This notion of relevant information is constructed by staff themselves. As with observations, staff pass on accounts and interpretations of service users' behaviour, expressed emotion, and their talk. For Olasoji et al, (2018) service users in acute psychiatric inpatient settings have an awareness of handovers taking place and desire to know what is being passed on about them. In particular, service users want to clarify what the issues are from their own point-of-view, but currently feel they have no opportunity to do so (Olasoji et al, 2018). It is not clear if the issues include their own concerns around risk. It is clear, however, that handover again privileges staff interpretations and narratives, and may exclude service users, who may be seeking to have a voice in the process (Olasoji et al, 2018). Staff again possess the overall power to create a service user's risk-narrative.

Documentation is another key process through which staff possess significant power to define risk through the construction of risk-narratives, in this case in written form (Coffey et al, 2019). Risk documentation can take the form of electronic patient notes which are updated shift-by-shift and constitute a key part of staff's dynamic risk assessment in an acute psychiatric inpatient context (Langan, 2009; Kahn et al, 2014; Higgins et al, 2016). Documentation can also take the form of paper documents such as care plans that may incorporate risk (Higgins et al, 2016; Coffey et al, 2019; Rio et al, 2020) and/or separate risk assessment and management plans (Higgins et al, 2016; Coffey et al, 2019). The literature suggests that risk documents typically capture a formal summary-statement of risks in written narrative-form derived from the risk assessment, which constitutes the basis for a management plan (Langan, 2009; Higgins et al, 2016; Coffey et al, 2019; Rio et al, 2020). Scope for service user involvement (see below) has been emphasised, particularly centring on psychiatric inpatient care planning for risk (Coffey et al, 2019; Rio et al, 2020). Coffey et al, (2019), however, found that service users in such settings felt that risk assessment and management plans were often not actively discussed with them. As the scoping review has shown, service users in acute psychiatric inpatient settings are largely unaware of the contents of these risk assessment and management plans, and service users feel that they do not contribute to their construction (Langan, 2008; Coffey et al, 2019). Staff again possess considerable power to define risks and justify risk-judgements, through the construction of risk-narratives, typically excluding service users themselves from the process.

It is important to consider how and why mental health professionals have been invested with such definitional power, and particularly the power to construct risk-narratives. One key reason is that risk has been framed as a *science* that requires a form of skill and expertise. As such, it invests professionals with knowledge and expertise that lay-persons do not possess. This, then, justifies the central role of the professional in risk assessment and might explain the absence of the lay perspective.

2.2.2 The science of risk prediction and expertise

Tracing the historical development of risk assessment and management, Covello and Mumpower (1985) found that modern risk analysis has its roots in both mathematical theories of probability (particularly as applied in actuarial science), and in scientific methods of observation and experimentation conducted with the aim of identifying causal links between adverse effects and hazardous conditions, particularly as it relates to human health. Given these historic roots, it is perhaps not surprising that early theorists on the philosophy of risk analysis sought to situate risk assessment in the domain of the natural sciences, and as sharing its scientific methodology (Covello & Mumpower, 1985). From the perspective of Starr et al (1976), for example, risk analysis is concerned with "the predictive evaluation of future risks" as a matter of mathematical probability (Starr et al, 1976, p631). As *objective risks*, they exist independently of observers in the real world, they can be objectively measured, and then the class of risk or its severity (negligible; low; moderate; high; or excessive) is determined by a statistical calculation (Starr et al. 1976). Such objective risks are distinguished from the subjective, or *perceived risk*, of the lay public who play no role in defining true risks. It is this science of prediction that grants the power to define risk.

This is the philosophical context in which the development of quantitative measures for predicting various risks has arisen (Szmukler & Rose, 2013; Ayhan et al, 2021). Introducing quantitative measures in risk assessment would seem to strengthen the science of risk analysis. Whilst quantitative measures can be used on an individual basis in clinical practice (RCPsych, 2017) this may give the impression that such measures are predicting whether the individual themselves will engage in harmful future behaviour. Actuarial measures are designed to capture the extent to which the individual shares population-based risk factors – that is, those factors that have been found in populations that correlate to an increased degree of risk (Ayan & Ustün, 2021). Whilst it might be agreed that completed suicide is at the extreme high-end of risk to self and homicide is at the extreme high-end of risk to others there is a lack of consensus around what likelihoods the terms low/moderate/high risk pertain to (Ayan & Ustün, 2021). Furthermore, since measures can produce false positives and/or false negatives it is commonly argued in guidance documents that measures cannot be used as stand-alone tools (DoH 2007/9; RCPsych, 2017), rather that they need to be incorporated into *structured clinical professional judgement* in risk assessment (Szmukler & Rose, 2013; Callaghan & Grundy, 2018).

Even within the quantitative paradigm, however, there is a growing body of evidence to suggest that obtaining service users' perspectives can be helpful in risk analysis. The argument is that service users themselves can accurately predict their future risk, and that service users' self-perceptions could add predictive utility to existing measures of risk that thereby emphasises the importance of talking to the service user about risk (Peterson 2011; Kroner 2012; Skeem 2013; Callaghan & Grundy, 2018). There is some evidence that service users are willing and able to provide sensitive information about themselves to inform clinical assessment via the completion of quantitative measures (Peterson 2011). The issue as to who is involved in the design of such measures (for example the selection of domains and items) has become important since it is recognised to have impacts upon their content validity (Connell et al, 2018); suggesting that measures might not always capture the issues that are important to service users themselves, with an argument that service users should thus be involved in the design of measures (Grundy et al, 2019).

When risk analysis is framed as the science of risk prediction it grants those involved in making such predictions a form of expertise. For Starr et al (1976) risk assessment is seen as the expert work of a technologist who makes purely statistical calculations. The technologist then presents their objective findings to societal decision-makers, and if there is a gap between the assessed risk and benefits of the technologist and the perceived risk and benefits of the public, then that gap is evaluated and resolved by the decision-makers "using the science" (Starr et al, 1976). Risk identification and estimation (the realm of the technologist) are deliberately divorced from risk evaluation (where policymakers are deciding what to do with the information). These two forms of expert knowledge, that of the risk scientist and that of the policymaker, exclude the lay public from both domains.

In the arena of mental health, professionals typically identify and estimate risk, and then *they* evaluate and thus decide what to do with that knowledge (Hansson et al, 2014). Within the term structured clinical professional judgement in risk assessment (Callaghan & Grundy, 2018), the *clinical-professional* aspect highlights a difference of perspective from non-clinical professionals, and also from non-professional lay-persons, that emphasises the 'clinical' dimension – the training, knowledge, and expertise of the individual clinician making the judgement. That it is a *structured* judgement suggests that it is the opposite of an unstructured or potentially random approach. Instead, the judgement is structured by a knowledge of the evidence-base and clinician experience, that guides the process of gathering information (Hamilton & Manias, 2007; RCPsych, 2016; Callaghan & Grundy, 2018). Whilst structured it is a less rigid approach than simply using a quantitative measure and algorithm and relies on an individual's judgement. Thus, it could be argued that mental health professionals have power to define risk by virtue of their clinical knowledge and expertise, whereby they are trained to make interpretations of service users' *presentation* (their behaviour, expressed emotion, and talk) and then to document their conclusions (Hamilton & Manias, 2007).

The notion of risk analysis as the science of risk prediction has, however, been challenged. Douglas and Wildavsky (1982) have argued that the selection, prioritisation, estimates of problem-size, levels of acceptability, choice of assessment methods, how costs-benefits analysis operates, and acceptable timeframes surrounding risk are all based upon social values. Their *cultural theory of risk* suggests that it is a collective, social construct. Risks do not exist 'out there' in the world independently of the observer, and they are not facts to be discovered, they are created or constructed by social groups for certain social purposes (Kendra, 2007; Boholm & Corvellec, 2011; Felton et al, 2018). All perception of risk is social and rooted in cultural values or bias, and no observer is free from bias. All observation is perspectival, and is filtered through our pre-existing theories, such that no observer is unbiassed or value-free (Kuhn, 1962). As such, the distinction between objective risks and perceived risks breaks downs; there are just different risk perceptions from different perspectives (Hansson, 2010; Hansson & Aven, 2014). Similarly, distinctions between fact-based and value-based activities breaks down; all observation is value-based.

When risk is accepted as a social construct that serves particular social purposes (Douglas, 1985; Kendra, 2007; Boholm & Corvellec, 2011; Felton et al, 2018), then it is important to re-consider who has the power to define it and why. Professional power has been based upon professionals themselves possessing clinical knowledge and expertise concerning the science of risk prediction, but this is now undermined in the cultural theory of risk. Instead, the perspectives and narratives of service users themselves may have, or should have, more relevance in how risk is constructed. Why the issue of definitional power matters will be considered next. It will be argued that the creation of risk-narratives can impact upon a service user's identity and could potentially contribute to the stigmatisation of the individual.

2.2.3 Risk narratives and risk-identity

In creating risk-narratives staff are not only providing a rationale for their risk-judgements, they also thereby have the power to construct a *risk identity* for mental health service users, including service users in acute psychiatric settings (Langan & Lindow, 2004; Langan, 2008). There is a possibility that risk becomes embodied in the mentally ill person who is seen as the chief actor in creating dangerous events (Coffey et al, 2017; Felton et al, 2018); the individual themselves is then perceived to be a risky person, or, more technically, a *risk object* (Felton et al, 2018).

The creation of a risk identity through the production of risk-narratives (verbal or written) has the potential to construct individuals as Dangerous Others (Douglas, 1992; Kendra, 2007; Boholm & Corvellec, 2011). There is already considerable stigma around diagnostic labels, and their perceived association with levels of dangerousness (Huggett et al, 2018), particularly around schizophrenia/psychosis (Huggett et al, 2018) and personality disorders (Sheehan, 2016), and around psychiatric hospitalisation itself (Sowislo et al., 2017). This is despite significant anti-stigma campaigns and improvements in television and film portrayals of mental illness and in media reporting (Henderson et al, 2020). Staff's risk narratives may contribute to stigmatisation, by reinforcing negative social stereotypes (Huggett et al, 2018); the role of public fears will be considered further below. Risk-narratives may also contribute to stigmatisation by influencing staff attitudes towards the risk object in both current and future care and treatment (Felton et al, 2018). If the individual is seen to be a high risk, then that might impact upon how staff then work with that individual, based upon social stigma in the guise of a risk discourse (Kendra, 2007).

Whilst staff's construction of service users as risk objects in mental health practice has been explored (Felton et al, 2018), it is not clear whether this has any impact upon the service user experience, such as whether service users actually experience stigmatisation as a result. It is known that for some service users the language of risk in itself is not understood to be a moral judgement upon an individual's character (Coffey et al., 2017), but there is recognition that being judged to be risky could be stigmatising (Boardman & Roberts, 2014; Perkins & Repper, 2016). In forensic services an over-focus on *static risks* (such as past offending behaviour, which cannot change) over *dynamic risks* (such as current mental state, which can change) is felt to negatively impact upon the identity of forensic patients. There is limited evidence on how service users themselves perceive their identity in relation to risk and risk narratives.

It has been argued that if service users cannot access staff's risk narratives (Langan & Lindow, 2004; Langan, 2008), including the narratives recorded in risk documentation (Coffey et al, 2019), then they cannot challenge inaccuracies that may have contributed towards conceptions of their identity as risk objects. This lack of access to risk-narratives has been framed as ethically very problematic (Langan, 2008). People may have been judged to be a risk to others and potentially a safeguarding concern and yet they may be oblivious to that (Langan & Lindow, 2004; Langan, 2008). It is argued that service users should be aware of whether they are judged to be a risk to others and should have access to staff's risk-definitions and risk-narratives. Thus, an ethical case has been made for service users to have access to staff's narratives.

Where staff possess power to define, then this will also impact upon their role as *gate-keepers* to acute psychiatric inpatient admission. This role is made all the more difficult by a lack of beds and resources, where individuals deemed to be high risk and have high acuity need to be prioritised in admission decisions (Bowers et al, 2005). Judgements of risk-severity, associated levels of distress, and/or acuity of mental disorder, are involved in decisions as to whether individuals defined to be a risk to self will be admitted (Bowers et al, 2005). Stigmatising staff attitudes that see people as attention-seeking or wasting staff time, compared to others deemed worthy of admission, can be involved in decisions to refuse admission (Rogers & Dunne, 2011; Lloyd et al, 2018). Such judgements can impact upon service user identity and influence care and treatment going forward. Again, service users should have access to staff's risk-narratives as a means of challenging such stigmatisation.

2.3 Power to manage

In addition to the power to define risks, staff also possess considerable power to manage risk in acute psychiatric inpatient settings. It will now be argued that staff's risk judgements, risk-definitions, and risk-narratives can also have an impact upon the management of high-risk service users. In particular, it will be argued below that staff can be overly controlling in risk management, with a tendency towards a custodial, rather than therapeutic, risk management approach.

Mary Douglas' cultural theory of risk argues that the construct of risk represents something that transgresses a socially defined line of normalcy, which is cast as a moral defect (Douglas, 1992). The defect is seen as belonging to a category of people who are to be kept apart so that an In-group identity can be preserved against the Other (Douglas, 1992). Similarly, for Foucault, the asylums functioned to segregate the mad in spaces where associated dangerousness could be contained and controlled (Foucault, ET 1989). Foucault asserted that in the seventeenth and eighteenth centuries madness became associated with animalistic traits and all things bestial, and as a result the mad were viewed as a social danger. As a social danger the mad needed to be disciplined, brutalized, and chained. Hence this period saw *le grand renfermement* (the Great Confinement) in which the mad, categorised together with the poor and the idle (and hence the immoral and anti-social), were confined and segregated from society in places where they could be put to work (such as the workhouses) so that they could at least contribute something to society. In the modern period, Foucault argues, whilst the chains have gone, power is still exercised over the mad (now distanced from the poor and idle using the discourse of *the mentally ill*) through surveillance and the moral treatments of the Asylum, which are fundamentally a form of social control, but that internment has now assumed a medical character (Foucault, ET 1989; 1994).

One key reason that staff have come to possess the power to manage risk is through the role ascribed to them in mental health legislation. The development of the legislation will be considered and the power-role of professionals over service users will be delineated.

2.3.1 Mental health legislation and containment/control

The *Mental Health Act 1959* was introduced at time when a process of deinstitutionalisation was beginning to be implemented. This policy aimed to reduce hospital admissions, and particularly the long-term stays associated with the old Asylums (Martin, 1984). This legal framework was designed to make treatment voluntary as much as possible, and it gave us the notion of the *informal* patient or service user (Ashmore & Carver, 2017). It also sought to provide a legal framework determining the conditions for compulsory detention, now defined as a medical rather than a judicial decision. As medical treatment advanced, and interventions such as Electroconvulsive Therapy (ECT) and psychopharmacological treatments (such an antipsychotics) began to be widely used in psychiatric practice, it became particularly important to consider whether such medical treatments could be imposed by professionals against the person's wishes, an issue which the current form of the *Mental Health Act 1959* gave no steer or guidance (Turner et al., 2015). Hence, in the *Mental Health Act 1983* the amendments gave the conditions for detention for assessment and the conditions for treatment. Detention for assessment was based upon evidence of a mental disorder/illness (broadly defined) combined with concerns about *the health or safety of the patient*, or concerns around *the interests* of the patient, or for the *protection of other persons*. The focus was still on the rights and protections of persons with mental disorders (Turner et al, 2015).

The Code of Practice: Mental Health Act 1983 (1999) was written to delineate how the Act was to be operationalised. It introduces the language of risk in terms of risk to self (self-harm, suicide) and risk to others (homicide, violence). It asserts that when professionals are considering the health or safety of the patient, and the protection of others (the original language of the *Mental Health Act 1983*) an obligation is being placed on professionals to assess and manage these risks. Risk to self is clearly related to the concepts of personal health, of safety, and of the best interests of the patient, whilst risk to others is associated with the concepts of public protection. Thus, the Act is understood to relate to individuals who cannot keep themselves safe, such that it is in their best interests (defined by others) to be detained, or to individuals who need to be detained to protect the public from harm. The amendments in the revised *Mental Health Act 1983* (2007) introduced concern for *patient wellbeing and safety* into what are termed the fundamental principles of the Act itself. Similarly, these fundamental principles incorporated a concern for public safety and hence protecting and keeping the public safe. Thus, as legislation has been framed, it grants professionals significant power in the management of risk and safety.

There have been significant concerns, however, about how staff have wielded this power, and it has been argued that mental health professionals have been overly controlling in their assessments and management of risk, as evidenced by rising detention rates (Szmukler, 2010). Szmukler has consistently argued that the *Mental Health Act 1983/2007* has become a means of containment with the unrealistic aim of total risk elimination and that service users are being discriminated against and their rights denied by staff (Szmukler, 2010; 2019; 2020). Whilst the 1959 iteration of the Act was initially formulated as a framework for the protection of the rights of patients (Martin, 1984; Turner et al, 2015), it has become a means of social control (Szmukler, 2020). The latest review of the *Mental Health Act* also suggests that risk adverse, defensive, and cautious professional practice is a key factor that lay behind the rising numbers of those being detained under the Act (DoH, 2018).

2.3.2 Public fear, professional responsibility, and blame

Factors other than the science of risk prediction and expertise are at play in professional risk management. Instead, public fears and blame towards risk managers account for risk averse practice that leads to custodial acute psychiatric inpatient risk management (DoH, 2018).

Foucault argued that public fear drove the desire for the containment of the mad and dangerous other. What Foucault termed the Great Fear underpinned the rationale for the containment of the mad, which he describes as "a fear formulated in medical terms but animated, basically, by a moral myth" (Foucault, ET 1989, p192). In the new psychiatric asylums Foucault argues that the doctor features "as a juridical and moral guarantee, not in the name of science" (Foucault ET 1989, p257) and acts as "a *guardian*, to protect others from the vague danger that exuded through the walls of confinement" (Foucault ET 1989, p195, original emphasis). The psychiatrists of the asylums are thus playing a moral, rather than a medical or scientific, role. This has been somewhat reflected in professional good-practice guidance that argues that the risk assessments of psychiatrists constitute a form of "ethical reasoning" (RCPsych, 2010).

High profile homicides by people in contact with mental health services in the early 1990s generated a degree of fear and anxiety in the general public. The public's risk perception was driven by the media coverage of these events (Phelan et al, 2000); these homicides impacted upon public attitudes around the dangerousness of the mentally ill (Huggett et al. 2018). The public's risk perception resulted in a prejudicial stereotype of the dangerous mental patient (Corrigan & Watson 2002); this was associated with an over-inflation of the number of homicides committed by the mentally ill in the public mind (Callaghan & Grundy, 2018).

Despite the influence of anti-stigma campaigns (Henderson et al, 2020), Huggett et al (2018) argue that in public perception different levels of dangerousness are assigned to people with different diagnostic labels and that has resulted in a perceived hierarchy of labels that results in a hierarchy of stigma for service users; this hierarchy is particularly focussed on psychosis/schizophrenia and personality disorders which are most associated with dangerousness in the public mind (Huggett et al. 2018; Sheehan, 2016). Incumbents are thought to *be* the thing they are labelled ("mad" and "dangerous"), and this forges a separation of Us versus Them. The undesirable characteristics reduce the status of the Other in the eyes of the labeller; this situates Them in a downward placement within a status hierarchy (Link & Phelan, 2001). Link and Phelan (2001) argue that power is thus essential to the social production of stigma, such that it functions to keep people down, keep people in, and keep people away (Bos et al, 2013). Madness and dangerousness thus provided a rationale for segregation and containment in the public mind.

The public's fear of the dangerous other (or their risk perception) became a key factor that professionals now had to take into consideration when weighing issues of public safety (DoH 2007/9). At the same time, the public situated professionals as risk managers with responsibility for risk assessment and management, with total risk elimination as the desired societal outcome, achieved through the science and expertise of risk prediction (O'Rourke & Bird, 2001). Furthermore, when these responsible individuals fail to protect the public there is socially legitimised blame (Douglas, 1994). Fear of blame, combined with a feeling of being solely responsible for risk, can lead to risk averse and overly controlling risk management (DoH, 2018). A further implication of this is that professional risk assessment and management practice may be concerned only with risks for which mental health professionals will be held accountable; thus, the power to assess and manage may thereby narrow the focus of assessments.

This discourse of fear, dangerousness, and control has led to a narrow focus on public safety and service users' as risk to others in public discourse. However, families bereaved by suicide and inquests into suicides of those with contact with mental health services (Appleby et al, 2019) has meant that risk to self has not been lost in the risk discourse. Again, mental health professionals are positioned as risk managers with responsibility to keep safe those service users judged to be a high risk to self, either by virtue of self-harm and/or suicidality, with blame attributed for failures to keep people safe (RCPsych, 2010; NICE 2015). The power to manage is reflected in decisions as to whether service users have mental capacity to manage themselves. Services thus have a tendency to focus on high consequence/low frequency events (homicide and completed suicide), thereby narrowing the focus of assessments (Ryan, 2000). This, in turn, creates a deficit model of assessment practice, that has no recognition of strengths or assets, but that focusses on hazards or problems.

How this works out in inpatient risk management will now be considered; the argument presented is that nursing staff have a tendency towards custodial approaches to inpatient risk management. The impacts upon service users will then be explored.

2.3.3. Custodial inpatient risk management

Nurses working in acute psychiatric inpatient settings report a tendency towards custodial rather than therapeutic risk management (Cutler et al, 2020). This is seen in staff justifications for locked-door units (Huber et al, 2016), for restrictive practices such as restraint (McKeown et al, 2019) and seclusion (Muir-Cochrane & O'Kane, 2018). Drives to enhance environmental safety and to nurture psychological safety in inpatient settings over the past decade, through a sustained commitment to reduce restrictive practices through interventions such as Safewards (Bowers et al, 2014; Higgins et al, 2018), have largely led to service users feeling safer in such settings. A custodial tendency towards risk management is still seen, however, in wider clinical processes operating on wards, such as observations and documentation processes, that are framed as risk management strategies.

Nurses report how observations can centre on using the power of surveillance to control service users' behaviour in terms of risk, such that risk management becomes the sole aim of observations (Hamilton & Manias, 2008; Mullen, 2009; Insua-Summerhays et al, 2018; Veale et al, 2020). Insua-Summerhays et al (2018) have emphasised that therapeutic engagement during one-to-one observation can be compatible with, and can even enhance, its risk management aims. They argue, however, that counterproductive power dynamics inherent in observation need to be overcome via engagement and dialogue. Hamilton and Manias (2008), however, argue that the power inherent in surveillance is important in controlling and thereby minimising self-harm and suicide-behaviours.

In terms of producing documentation, nurses state that accountability in care planning processes and in the resulting care plans frequently serves an organisational need to manage risks (Rio et al, 2020). Thus, staff emphasise a key role for risk assessment and management within the core purpose of ward rounds (Cappleman et al, 2015) and risk management is also seen as a core part of handover communication (Millar & Sands, 2013). Instead of therapeutic engagement with service users in care planning, risk management becomes the sole focus of accountable care (Rio et al, 2020).

Overall, staff appear to be making decisions or judgements as to whether service users can be involved in risk assessment and management in acute psychiatric inpatient settings (Coffey et al, 2017). Staff perceive that denial of illness and a lack of insight, metacognitive deficits, and stigma from others and from self, can all hinder the engagement of service users on acute psychiatric inpatient wards (Polacek et al, 2015). The key factors as to whether an individual might be invited to participate in risk assessment and management seem to be the acuity of their condition and/or them not presenting as highly distressed. Furthermore, staff are also making judgements as to an individual's risk (what the risks posed are; how severe they are, etc.). Such risk judgements implies a system based on professional decisions, constructed by staff themselves, reflecting values they see as desirable (Dixon 2012; Felton et al, 2018). As the scoping review has shown, service users feel that professional opinions are privileged throughout risk assessment and management (Langan, 2008).

It may be that acutely unwell and/or highly distressed service users in acute psychiatric inpatient settings will not want to be part of their risk assessment and management. It may be that service users in these settings feel that there are times when decisions can be taken out of their hands. However, service users often conceive of paternalism or tokenism as negatives and as far from ideal (Thompson, 2007; Majid, 2000). This may suggest that service users might be unhappy with such decisions being made on their behalf. Certainly, this has the potential to exclude service users who may want to be part of the process. Polacek et al. (2015) suggest that staff's engagement on acute psychiatric inpatient units is crucial as they argue that it is interconnected with both the physical and psychological safety of service users and professionals on the ward. They assert that through engagement nurses can attend to a service user's sense of psychological safety (Polacek et al., 2015), although they do not explicitly tie this to formal risk assessment and management processes. It will be important to consider, then, what contributes to this paternalistic power dynamic in the acute psychiatric inpatient setting, and whether or how it can be overcome.

Another power dynamic at play concerns service users feeling like they have to adopt a passive role in order to achieve a quicker discharge from services. Forensic patients at times deliberately adopt a passive role as an attempt to take charge of their admission experience (Heyman 2004; Reynolds 2014). Whilst the ability to express righteous anger is important in some service user definitions of empowerment (Rogers et al, 1997; Chamberlin, 1997) there is evidence that forensic patients feel that they have to manage their anger and frustrations in case these are interpreted by staff as risks (Heyman 2004; Reynolds 2014). Service users view staff as again having definitional control over whether behaviours get interpreted as risks. In these instances, forensic patients take charge by "playing the game", by not challenging authority, and deliberately adopting a passive role to try and achieve a quicker discharge (Heyman, 2004; Reynolds, 2014). It is not known if service users in acute inpatient psychiatric settings feel a similar pressure to comply, or to adopt a passive role.

We do know that service users develop a range of active and passive risk management strategies during their inpatient admission. Ryan (2000) identified managing the environment and making decisions based on previous experience of risk and thinking in advance about how they might handle future risk situations. Quirk (2004) also suggested that service users on an acute psychiatric ward have an array of management strategies including: avoidance; implicit reliance on staff; seeking active protection from staff; absence of resistance to formal observations; de-escalating other service users; seeking protection from others higher in the pecking order; risk assessing other patients themselves; communicating concerns to staff; seeking discharge; and even absconding. These strategies are, however, seemingly learned and implemented outside of formal risk assessment and management processes on the ward (Quirk, 2004), they are not taught by professionals themselves. Furthermore, Jones et al (2010) found that service users avoid other service users perceived to be dangerous, that they keep themselves to themselves, that they seek protection from staff, and value peer-support with other service users, as means of staying safe. This suggests that service users may want to play a more active role in formal risk management.

Thus, custodial rather than therapeutic risk management can be the focus of practice in acute psychiatric inpatient settings. Implications are that decision-making can be paternalistic, and service users can be left to devise their own strategies for managing their own risk or safety concerns. Whilst there is not the space to discuss fully in this thesis, it should be noted that alternative models for the care of people with acute mental distress do exist outside of statutory services. For example, therapeutic communities (Spandler, 2009), Open Dialogue forums (Razzaque & Wood, 2015), and crisis houses (Sweeney et al, 2014; Whitmore, 2017). In these settings there is often a greater emphasis on shared responsibility for risk and a sense of collective management of issues raised. Peer support and group therapeutic activities are associated with strong emotional bonds which results in an alternative vision of what being a community means.

2.4 Service user involvement

The concept of *service user involvement* has often been framed as a potential antidote to the privileging of staff perspectives. Involvement is seen to introduce the service user's own perceived risk and it emphasises a role for service users' narratives within clinical processes and documentation. The policy and good practice guidance around involvement provides a helpful context in which to think about service user un-involvement in current risk assessment and management, including in acute psychiatric inpatient settings.

2.4.1 Models of involvement

Since models of citizen involvement were first formulated (Arnstein, 1969), definitions of involvement have foregrounded notions of *participatio*n (Storm & Edwards, 2012; Dahlqvist-Jönsson et al., 2015), of *shared decision-making* (Slade 2017; Aoki, 2020), and of *collaboration* (Majid & Gagliardi, 2019). Involvement thus emphasises that service users have a role to play and that they should be taking part, particularly in the realm of making decisions. Furthermore, the relationships developed between staff and service users are central to conceptions of involvement. Participation has been conceptualised as a continuum: staff providing explanation; consultation; partnership; and user control (Hickey & Kipping, 1998). In this model, being informed what is going to happen is the least ideal, with user control as the peak ideal. An alternative continuum has been presented as: paternalism; professional as agent; shared decision making; and the person's own informed decision-making (Thompson, 2007). Thus, an individual's ability to make decisions has been particularly foregrounded in models of involvement.

Models of participation also centre power to make decisions. For Arnstein, for example, service user empowerment is the primary goal of citizen participation, such that seizing control becomes the true aim of citizen engagement (Arnstein, 1969). Arnstein presents an adversarial model of power dynamics whereby the have-nots are wrestling for control over a finite amount of power with those who already hold it (Tritter & McCallum, 2006). This model downplays opportunities for collaboration and shared decision-making since the pinnacle is citizen control (Tritter & McCallum, 2006). In Arnstein's model, empowerment is about power grasping, thus since no other group can grant that power or authority, the have-nots must grasp it themselves. It has thus been argued that only individuals can truly empower themselves (Connelly et al, 1992). Others have, however, emphasised the value of a power-sharing approach.

In the context of risk and mental health, a body of literature, including on the operationalisation of legislation (*Code of Practice*, 2015; DoH, 2018), other government policy (DoH, 2007/9 is much cited), and good-practice recommendations for services (NICE, 2004; 2011; 2015), and for psychiatrists in particular (RCPsych, 2010; 2017), and other guidance documents on best practice (O'Rourke & Bird, 2001; Langan & Lindow, 2004; Boardman & Roberts, 2014) consistently suggests that service users *should* be involved in risk assessment and management. Common themes throughout these guidance documents are that professionals should work together with service users to identify risk, planning together regarding how to manage it, and to co-construct the documentation that records the plan.

Since 1990, the concept of service user involvement in mental health care has been a consistent feature of the policy of different UK governments, initially focussed on the process of care planning and the production of care plans (DoH 1990; 1994; 1999; 2008). This established the notion that service users should be involved in decisions regarding their care and treatment, should have a role in identifying needs and goals, and should be involved in drawing up plans. A particularly influential policy document, *Best Practice in Managing Risk* (DoH 2007/9) applied the notion of involvement in the arena of risk assessment and management. It asserts that service users should be involved in identifying risk, planning to manage it, and have a role in documenting the issues. It advocates that involving service users in conversations about risk is important to improving the quality of care and promoting recovery.

The notion of the involvement of service users in risk assessment and management was introduced into the fundamental principles of the revised *Mental Health Act 2007*. A revised *Code of Practice* (2008) referred to this as the *participation principle*. This principle was further developed in the latest *Code of Practice* (2015) which refers to the fundamental joint principle of "empowerment and involvement" in the operationalisation of the *Mental Health Act 2007*. In the revised *Mental Health Act 2007*, involvement entails obtaining, listening to, and taking into consideration, the views and wishes of patients. There is also a particular focus on various mechanisms for obtaining and foregrounding the views and wishes of service users when they lack the capacity to be able to articulate them for themselves. These mechanisms include advanced statements (§1.8), advice via informal, family carers (§1.11) and via advocates (§1.12). Moreover, there is an emphasis upon documentation in terms of accurately recording service user's choices and views, and explicitly documenting differences of opinion (§1.9). Thus, involvement has been focussed on service users having a voice in all decisions made under the *Mental Health Act 2007*, including risk assessment and management decisions.

Much good practice guidance has taken up the language of involvement in risk assessment and management. Langan and Lindow (2004) argue that service users should be "fully involved" in risk assessment and management, without really defining what that means. They do suggest that service users should be involved in identifying risks and in relapse planning and management planning. NICE guidelines suggest that risk management of violence and aggression should "involve service users in all decisions about their care and treatment" with the aim of developing "care and risk management plans jointly with them" (NICE, 2015, p18). Psychiatrists are also seen to have a responsibility to "involve the patient in safety planning" (RCPsych, 2017, p25) and service users have a key role "in identifying their own triggers that might precipitate a crisis and in planning to keep safe" (RCPsych, 2017, p23). In risk assessment and management, then, there has been an emphasis upon staff and service users working together to identify risks and to plan together on how to manage risks. Thus, NICE guidelines, for example, assert that when assessing the risk of repetition of self-harm or risk of suicide, the aim of risk assessment is to "develop a care plan and a risk management plan in conjunction with the person who self-harms" (NICE, 2011, p21).

The putative benefits of involvement in risk assessment and management identified in policy and guidance are that it improves: the quality of the assessment and of the resulting management plan (DoH, 2007/9; RcPsych, 2010; 2017); the robustness, effectiveness, and practicality of plans (DoH, 2007/9; RcPsych, 2010; NICE, 2015); the accuracy of contents (RcPsych, 2010; NICE, 2015); that it enhances recovery (Boardman & Roberts, 2014); and that it reduces risk and enhances safety (Langan & Lindow, 2004; Langan, 2008; Boardman & Roberts, 2014).

2.4.2 Involvement, documents, and service user risk-narratives

The production of risk documentation has consistently been suggested as a means of formally capturing the service user risk-narrative (NICE 2004; 2011; 2015; RCPsych 2017; 2010; Boardman & Roberts, 2014; Coffey et al, 2019). For instance, the Royal College of Psychiatrists have argued that the "assessment should include a patient's narrative about their own risk" (RcPsych, 2017, p24). Similarly, Langan and Lindow (2004) argue that documentation should be "completed with" service users, and they should be able to "add their own account and explanation of events to the written record" to enhance accuracy (Langan & Lindow, 2004, p22). Thus, capturing a summary statement in first-person language, from a first-person point-of-view has been suggested as a feature of best practice (Boardman & Roberts, 2014; Perkins & Repper, 2016).

Formally documenting the service user perspective has been particularly emphasised when there is potential for disagreement around an individual's risk (Langan & Lindow, 2004; Langan, 2008). Thus, in working with risk to others there has been an emphasis upon ensuring that service user perspectives of interpersonal conflicts are explicitly sought and that staff perspectives are not relied upon alone (Langan & Lindow, 2004; Langan, 2008). Similarly, Perkins and Repper (2016) argue that "there are always two sides to one story" and that it is vital to obtain and document the service user perspective and not just rely on professional interpretation of risk. They suggest that there needs to be an aim to reach a *shared understanding* of the issues, recognising that risk is always a matter of perspective and perception, where there is potential for disagreement and diverging points-of-view (Perkins & Repper, 2016).

2.4.3 The variables of involvement

As has been shown, the included studies in the scoping review suggest that service users feel uninvolved in formal risk assessment and management within acute psychiatric inpatient settings. This lack of involvement could be attributed to individual, and/or relational, and/or organisational variables (Bee et al, 2015; Lovell et al, 2018).

2.4.3.1 Individual variables

At the level of the individual, Bee et al (2015) have argued that any involvement in decision-making is predicated on service users themselves having a desire and motivation to influence care. In the context of acute psychiatric inpatient settings, there is a wealth of literature suggesting that service users have consistently desired greater involvement or participation in the overall decision-making about their care and treatment throughout their inpatient admission (Storm & Davidson, 2010; Wright et al. 2015; Laitila et al. 2018). In these settings service users also consistently report a desire for greater involvement in decision-making processes and spaces, including in ward rounds (Cappleman et al., 2015), handover communication (Olasoji et al., 2018), care planning (Coffey et al., 2019), in raising safety concerns or complaints (Berzins et al., 2018; 2020), and in admission and discharge decision-making (Wright et al, 2015).

Another individual variable to consider is that, for meaningful involvement to occur, service users must possess the ability to identify and express need from their point-of-view (Bee et al, 2015). A lack of insight, high distress, and acuity of condition have been suggested as factors that impede engagement in acute psychiatric inpatient settings (Polacek et al, 2015). It is not clear whether service users want to, nor can express, their needs in the context of inpatient risk assessment and management.

2.4.3.2 Relational variables

At the relational level, involvement in decision-making has been predicated on staff engaging service users in decision-making (Lovell et al, 2018). Engagement has been defined as both an external process (engaging with) and an internal state (*being* engaged in) experienced by the individual (e.g., desire, willingness, enthusiasm, emotional investment) and expressed in observable behaviour (e.g., verbal contributions) that exceed mere meeting attendance, and may be visible in non-verbal cues (e.g., body-language, focus, and attention) (Bright et al, 2014). Engagement requires a relational connection and is co-constructed by both parties through ongoing interaction and professionals also need to be engaged in the relationship (Bright et al, 2014). Thus, disengagement is not a patient problem that is their sole responsibility (Bright et al, 2014); thus, the disengaged should not simply be left to be uninvolved. The role of the professional is to facilitate engagement and develop the kind of therapeutic relationship that fosters it in an inpatient setting (Polacek et al, 2015). Polacek et al (2015) have argued that such engagement is important to staff and service users in developing a sense of safety in an acute psychiatric context.

Another relational variable centres around staff communication and providing service users with enough information to be involved (Storm & Edwards, 2012; Bee et al, 2015; Lovell et al, 2018). A lack of information provision in inpatient settings has consistently been raised as a factor that inhibits service user involvement in decision-making (Laitila et al, 2018). The spaces where service users are seeking greater information provision include: at admission (Chevalier et al, 2018); in ward rounds (Milner et al, 2008;

Cappleman et al, 2015); and in detention processes (Katsakou et al, 2012; Akther et al, 2019).

Involvement in risk assessment and management assumes that staff and service users have a common language. Some tentative reasons for service user unawareness of risk assessment and management have been offered that suggests that there might not be a common language. Over two decades ago, Tony Ryan argued that mental health service users generally might not use risk language, which is more of a professional discourse (Ryan, 2000). It is not clear, however, whether this means that risk has no meaning to service users, or whether it is an irrelevance from their perspective. By contrast, back in 2008, Joan Langan suggested that inpatient staff themselves might not explicitly use the language of risk in service user-staff interactions. Langan was concerned with staff interactions with service users who are viewed as a risk to others, which could be a particularly difficult subject for inpatient staff to broach (Langan, 2008). Storm & Davidson (2010) also found that there was confusion amongst service users in acute psychiatric inpatient settings about what the term involvement in relation to treatment and/or care planning actually meant.

It has also been argued that service user involvement in decision-making requires that professionals elicit, respect and value service user perspectives and that service users feel that their points-of-view are valued by staff (Bee et al, 2015). Similarly, involvement has been predicated on staff recognising and respecting service user-led needs and that service users believe that their needs are being taken on board and addressed (Lovell et al, 2018). Thus, eliciting service user perspectives is not an end in itself; their points-of-view and their needs must be respected, taken seriously, and acted upon, by staff.

Involvement also requires collaborative working relationships. Whilst research has particularly focussed on inpatient care planning as an intervention that could enhance service user involvement in risk assessment and management, with the relational process of collaborative care planning being particularly valued by service users (Laitila et al., 2018; Reid et al., 2018; Terry & Coffey, 2019), service users report a lack of routine collaboration and involvement in care planning for risk (Coffey et al, 2019).

2.4.3.3 Organisational variables

In organisational terms, service user involvement in decision-making is seen to require an organisational culture where opportunities for negotiation are available and accessible to service users (Bee et al, 2015). Social spaces such as ward rounds and one-to-ones may be important forums for negotiation around risk. What kind of support service users need in order for such forums to be available and accessible spaces for negotiation will be important to consider. Furthermore, service user involvement in decision-making requires an organisational culture whereby time and resources are available to enable person-centred, individualised care (Bee et al, 2015; Lovell et al, 2018) and to develop therapeutic relationships (Molin et al, 2016; Cutler et al, 2020).

A further organisational factor centres on documentation processes, which must be able to operationalise dynamic risk assessment and management of service user concerns. Higgins et al, (2016) argued that inpatient documentation typically lacked space for service user’s perspectives or commentary. Similarly, Coffey et al, (2019) argued that documentation and information technology on acute psychiatric inpatient wards were too inflexible to allow for service user contributions. Risk management plans or safety plans had very little coverage in the literature identified in the scoping review (Coffey et al, 2017; 2019) so it is not clear whether these are important to service users. There is also limited data on the construction of risk documentation and whether service users are looking to be involved in this process.

Involvement in risk assessment and management is a central concept in legislation, policy, and guidance. However, the scoping review has shown that service users do not believe or feel that they are involved. Individual, relational, and organisational variables may account for a lack of involvement. How service users themselves construct the notion of involvement in risk assessment and management will be an important consideration.

2.5 Service user empowerment

Empowerment of service users has been suggested in the literature as a potential antidote to staff decisional control in risk management (*Code of Practice,* 2015; DoH, 2018). Empowerment is conceptualised as a care philosophy outworked in a practical process (Linhorst et al, 2002). As a process empowerment helps individuals to exert more influence over their own health, care, and treatment by increasing their confidence, capacities, and competencies (Bee et al. 2015; Castro et al. 2016). It is also conceived as an outcome whereby the individual gains more control over issues that they themselves define as important, such that individuals feel, and believe themselves to be, empowered (Castro et al. 2016; Lovell et al, 2018). It is characterised as an enabling process that leads to personal change, self-determination, and autonomy, and it is understood to offer a sense of mastery in life, an integrated sense of self, and improved quality of life (Castro et al, 2016).

The participation principle outlined in the *Code of Practice* (2015) refers to the fundamental principle that combines the notions of "empowerment and involvement" in the operationalisation of the *Mental Health Act 2007*. There is an assumption that by eliciting the perspective of the service user in all decisions made under the *Mental Health Act 2007* that that will necessarily empower that individual. In government policy, *Best Practice in Managing Risk* suggests that "when it is done properly – using the principles of involvement, working together and individualised support – risk management is empowering rather than disempowering for the service user" (DoH 2007/9, p22). Similarly, in good practice guidance, one of O'Rourke and Bird's (2001) overarching guiding-principles is that "effective risk assessment and management, which actively involves the user in the process can, and should be, empowering" (O'Rourke & Bird, 2001, p2). There is an emphasis on empowerment as an outcome of good risk assessment.

2.5.1 Variables of empowerment

As with involvement, empowerment rests on individual variables whereby the service user is willing to influence their care (Lovell et al, 2018). Langan and Lindow (2004) helpfully distinguish involvement and influence. Just because a service user might be present and contributing somewhat at a decision-making forum does not mean they have been given any decisional power or control. Langan and Lindow's (2004) good practice guidance argues that it is important that professionals check with service users as to whether they *feel* that they have influence. They argue that influence is generally based upon service users being articulate and determined, and on their mental state at the time of the interaction. Furthermore, they suggest that influence largely depends upon individual professional initiative (Langan & Lindow, 2004). Empowerment implies influence, and there is an important emphasis upon finding out whether the individual themselves feels and believes themselves to be empowered.

Empowerment further requires interpersonal variables, with professionals displaying a recognition and understanding of the power differentials that are inherent in the organisational priority to managing risk (Rose et al., 2002). Best practice emphasises that risk assessment and management strategies and any resulting documents should be *coproduced* (Boardman & Roberts, 2014; Perkins & Repper, 2016). Coproduction theory has particularly emphasised unmasking the operations of power, authority, hierarchies, and existing structures of accountability that operate within the specific context in which parties are seeking to coproduce together (Clark, 2015; Carr & Patel, 2016). A key relational factor is a willingness from staff to relinquish power and control (Bee et al. 2015). Inpatient staff report that service users should be empowered to be partners in risk management and to play a key role in enhancing safety (Rimondini et al, 2019). Service users in acute psychiatric inpatient wards are particularly aware of them and us power dynamics operating in the setting (Chevalier et al, 2018), with detained patients feeling that mental health professionals "have power over them" (Katsakou et al, 2012). These interpersonal power differentials are also experienced by service users in ward rounds (Wagstaff & Solts, 2003; Cappleman et al, 2015) and in observations (Hamilton & Manias, 2008; Insua-Summerhays et al, 2018). Thus, service users in acute psychiatric inpatient settings seem particularly sensitive to interpersonal dynamics of power operating in the setting, and, overall, they already feel powerless.

Empowerment requires a positive organisational culture that encourages and consolidates service user autonomy (Bee et al. 2015). There is some evidence to suggest that service users feel that their overall experience of acute psychiatric inpatient care *should* empower them (Akther et al, 2019), particularly in terms of restructuring their sense of selves for coping when they return to daily life (Koivisto et al, 2004). There is an expectation that the inpatient ward will foster a sense of autonomy and empowerment (Hopkins et al, 2009; Akther et al, 2019). There is, however, also evidence to suggest that service users can experience acute psychiatric inpatient wards as evoking a sense of powerlessness. Previous service user-led research has found that service users can perceive and experience acute psychiatric inpatient units as an untherapeutic space, and that this can evoke a general feeling of powerlessness amongst service users themselves (Rose et al, 2015). Thus, the culture and emotional environment of the ward are important variables.

Here again, acute psychiatric inpatient wards could learn from other ways of doing or being a community. The principles and values underpinning therapeutic communities, for example, emphasise a more democratic and empowering way of being community together (Spandler, 2009), based again on a greater emphasis on shared responsibility for developing a culture of safety, and a sense of collective management of issues raised. Therapeutic communities (Spandler, 2009), Open Dialogue forums (Razzaque & Wood, 2015), and crisis houses (Sweeney et al, 2014; Whitmore, 2017) also give good models of what it looks like for staff to relinquish power, attempting to reduce them-and-us dynamics, and working towards meaningful coproduction. Thus, there are good models of helpful practice, albeit outside of statutory services.

2.6 Recovery-oriented practice

2.6.1 Recovery principles and mental health

Recovery has been framed as a movement, an overarching philosophy, a set of values, or a paradigm, that informs practice in mental health (Slade, 2012; Storm & Edwards, 2013). It is also conceived as a goal or outcome of care (Lovell et al, 2018). The recovery movement began as a grassroot, user-led movement that challenged notions of clinical recovery, and that distinguished *recovery from* mental illness (rooted in a biomedical model focussed on overcoming symptoms and upon a cure) versus *recovery in* mental illness (rooted more in approaches to trauma or addiction) (Davidson et al, 2005; Davidson & Roe, 2007). The concept of recovery often suffers from a lack of conceptual precision and clarity. One early and influential definition described recovery as:

> "…a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness." (Anthony, 1993, p527)

The notion of recovery has often been described metaphorically as a personal, and individual journey (Slade, 2012).

Various attempts have been made to summarise recovery principles. Leamy et al's (2011) much cited model of recovery uses the acronym CHIME to summarise the principles of: Connectedness, Hope and optimism, Identity, Meaning, and Empowerment. In recovery ideology, active participation has now become essential to the recovery journey, and it also becomes a means of supporting an individual's recovery (Storm & Edwards, 2013). Collaboration is similarly seen as a recovery way of working. A shift of focus from pathology, illness, and symptoms towards an emphasis on health, strengths, and wellness in person-centredness becomes a recovery-orientation (Storm & Edwards, 2013). Similarly, notions of empowerment, taking control and making choices are now integral to notions of personal recovery (Storm & Edwards, 2013). In addition to risks and needs, recovery now adds a focus on and consideration of goals and aspirations that are defined by the service user rather than by services (Lovell et al, 2018). Recovery ideology, in particular, emphasises the existing strengths of the individual, rather than problems or deficits (Storm & Edwards, 2013).

The notion of recovery-oriented professional practice in acute psychiatric inpatient settings has received some exploration (e.g., Chen et al., 2013; Waldermar et al., 2016), including on professionals working with patients involuntarily detained (Wyder et al, 2013). However, acute psychiatric inpatient wards are consistently presented as a particular challenge to implementing recovery principles and processes (Storm & Davidson, 2010; Storm & Edwards, 2012; Waldemar et al., 2016), with involuntary detention posing significant problems (Wyder et al, 2013). Risk is seen to pose difficulties for collaborative, recovery-working (Storm & Edwards, 2012).

In terms of legislation and policy, the participation principle that was introduced in the *Code of Practice* (2008) now embedded the language of recovery in the operationalisation of the Act. This new principle was an attempt to acknowledge and address the dynamics of power at play in the process of applying the Act, but it did not self-consciously address a tension between using the Act to control dangerousness (risk to others) or distress (risk to self) and using it to promote recovery. Similarly, *Best Practice in Managing Risk* (DoH 2007/9) emphasised a core principle that risk assessment should be based on a service user's "strengths" and should emphasise "recovery" (principle #4). This policy document acknowledges a tension between a strengths-based, recovery-informed approach on the one hand, and the possibility of security, restrictive practice, and ultimately detention, on the other hand. Professional guidance also emphasised that risk management plans should be completed with "a focus on recovery" (RCPsych, 2017, p5). The latest review of the legislation is still wrestling with this tension. It has argued that four fundamental principles should guide its operationalisation: Choice and Autonomy, Least Restriction, Therapeutic Benefit, and the Person as an Individual (DoH, 2018). These aims and objectives are designed to inculcate recovery principles and basic human rights into actual legislation (DoH, 2018).

2.6.2 Recovery vs risk paradigms

Recovery has been conceptualised as a paradigm that potentially stands in conflict with a risk paradigm that is focussed on control and containment (e.g., Waldemar et al., 2016; Felton et al, 2018). Wyder et al. (2013) argue that, even under condition of detention, offering hope, building relationships, and offering control wherever possible can promote recovery, and that detention and enforced treatment should be framed as staff "using temporary coercion to restore power and agency" (Wyder et al, 2013, p579). Similarly, Perkins and Repper (2016) argue that the ultimate purpose of admission is never protection, prevention of harm, and treatment, but to "enable people to re-gain their self-control so that they can get on with their lives and pursue their aspirations" (Perkins & Repper, 2016, p107). To that end, they argue that there needs to be a shift of discourse and focus away from "assessment and management of risk" towards "promoting safety and opportunity". They, and others, argue that the language of safety may make for an easier and more productive approach (Perkins & Repper, 2016; Callaghan & Grundy, 2018). Thus, recovery is seen to redefine the overall purpose and focus of acute psychiatric inpatient admission, and of the use of the *Mental Health Act 2007* to detain and treat, supported by a change of discourse away from risk to safety.

An additional element of recovery-oriented practice is that there needs to be a "shared responsibility" for safety (Boardman & Roberts, 2014; Perkins & Repper, 2016). This shifts the traditional perspective where professionals are viewed as risk managers with sole responsibility for risk, to a model where professionals and service users co-manage issues of safety and share responsibility for the issues raised. This also repositions the locus of blame, with the hope that risk averse professional practice can be reduced, and positive risk-taking enhanced. Furthermore, the role of safety planning is particularly emphasised; documentation again thus becomes a central feature of centring the views and wishes of the individual in their recovery-focussed safety planning (Boardman & Roberts, 2014; Perkins & Repper, 2016).

Recovery ideology requires an organisational commitment to its ideals and particular consideration of the context of its implementation; Pilgrim (2009) thus makes a strong case for ethnographic approaches that can explore the social context in-depth and the barriers and facilitators to embedding recovery ideals in practice within the social setting. Waldemar et al. (2018) found that service users in acute psychiatric inpatient settings experienced recovery-oriented practice when they felt accepted and protected, seeing the ward as a place of safety, and thereby nurturing feelings of safety. They also found, however, that service user perceptions fell short of the professional ideals of recovery-oriented practice in that there were limited opportunities for meaningful dialogue or personal talk with staff, with service users feeling observed and assessed from a distance (although not mentioning risk assessment explicitly), rather than staff enquiring about their true feelings (Waldemar et al, 2018). Similarly, service users felt that they had limited choice and influence, with treatment centred on medicine. Furthermore, service users in these settings felt that they were often in the dark, confused, and uninformed about the goal of admission, the rationale for treatment, whether they were judged to be making progress, or the criteria for discharge. These knowledge deficits meant that they did not experience admission as recovery-focussed or as providing a sense of personal recovery (Waldemar et al, 2018).

Both notions of risk and recovery evoke definitions of what it means to be a good citizen. Douglas argued that "the vision of the good society" (Douglas 1992, p37) is sustained when the social boundaries between the In-group and the Other are maintained. Thus, definitions of risk and recovery evoke definitions of what it means to be a society. For Foucault, confinement took what was useless to society (the poor, the idle, the mad) and made them profitable through work in their confinement (Foucault, ET 1989). The moral treatments of the early asylums similarly were attempts to rehabilitate the mad back into society. Through confinement, surveillance, and treatment, the mad and dangerous Other could be restored to society (Foucault, ET 1989). Definitions of risk, then, also evoke definitions of what it means to be a good citizen. Foucault's notion of neoliberal governmentality is important here (Foucault, ET 1991); Foucault argues that governments construct, define, and guide a population and then works towards their security and wellbeing. In modern neoliberal government, power is exercised through the willing consent of individuals and their self-government. Those who are deemed a risk are those who have failed in their responsibility to take care of themselves and can no longer function independently as they ought (Foucault, ET 1991). The mad and dangerous Other is in essence a failed citizen. Thus, risk assessment and management in mental health services could be seen to further a neoliberal agenda, ensuring that failed citizens are confined until they can be transformed.

There has also been a growing concern amongst service users themselves that the concept of personal recovery has also been co-opted by professionals to serve the neo-liberal agenda (RITB, 2019; Rose, 2014; Harper & Speed 2012; Morrow & Wessler 2012). The user-led movement *Recovery in the Bin*, for example, are particularly concerned with how recovery has become focussed on getting off benefits, getting back into work, with a level of resilience that enables people to function well in society (RITB, 2019). Thus, rather than being a discourse of liberation, concepts of recovery have been understood to serve the same political agenda as concepts of risk, with the same underlying dynamics of power, control, and social conditioning. The key issue again is who gets to define the concepts of risk and recovery.

2.7 Summary

Whilst it has been suggested that service users might not use risk language (Ryan, 2000), it is not clear what language they do use. It is also unknown how service users feel about the language of risk. It is not known whether service users feel that their own risk concerns are considered in risk assessment and management. Whether risk language features in service-staff interactions is an important issue that merits further study. Moreover, there is a lack of clarity as to how the language of risk relates to that of safety in the context of acute psychiatric care from a service user perspective.

Whilst staff perceive risk assessment as being central to their work, it is unclear why service users are largely excluded from meaningful discussions about risk. Further research is warranted into why this might be the case from a service user point-of-view in the context of inpatient care. It is also unclear whether service users have or desire access to staff risk-narratives about themselves in inpatient care. If they do want to see their documentation it is unclear how this should be operationalised in an inpatient context from a service user perspective. It is also not clear whether service users are unaware of the wider staff risk processes operating on the ward (e.g., observations), and whether they know which processes constitute staff's risk-work. If service users are unaware, it is also unclear how they feel about this and whether that impacts negatively on service users themselves. Furthermore, it is not known what the benefits of being aware might be from a service user point-of-view, nor what the barriers and facilitators to awareness might be. It will be important to consider the contextual factors that might contribute to service user unawareness.

An evidence-base as to what an active role in risk assessment and management might look like from a service user perspective in acute psychiatric inpatient settings is lacking. Furthermore, service user perspectives on and experiences of involvement and non-involvement in risk assessment and management also need further exploration. It is not clear what involvement in risk assessment means to service users and the barriers and facilitators to this within the inpatient setting from a service user perspective. It is also not clear what service users want in terms of risk management in an inpatient setting, nor what service user involved risk management might look like, nor what the perceived benefits of such involvement might be, nor what the specific barriers and facilitators to this might be in an inpatient context. Given the lack of perceived involvement in risk assessment and management it is also not clear what impact this has on service users' experience of inpatient care and treatment.

The evidence of service users developing their own risk management strategies leans towards a notion that service users are looking to staff for more assistance with managing risk or safety concerns. It is not clear, however, what kind of strategies they would like to develop, nor in what context or manner that they should be learnt or taught. It is also not clear why the formal processes on the ward are not seen to assist service users to manage these risks and why they might be omitted from staff's dynamic risk assessment. More research is needed into service user's attitudes towards risk documentation. It is not clear if service users want to see such documents. If they do want to see their documentation, it is unclear how they might be helpful to them. It is not clear if they feel that their voice is represented in professional documentation, and whether that matters to them. It is also not known what function they think that these documents fulfil from a service user perspective. It is also unclear how they might be involved in the writing-up of such documents, if at all. It is also unknown what difference this involvement might make to them.

It will be important to consider the dynamics of power operating in the social setting, and in different interactions. It is also important to consider the impacts these dynamics have upon service users themselves. It will also be important to consider how service users themselves think they can be empowered in this social setting. It is also important to consider what factors might contribute to the disempowerment of service users in risk assessment and management within this particular context, and how these factors might be overcome. It is also not clear what recovery-focussed risk assessment and management might mean to service users themselves, nor whether that is even a priority for them. It is unclear whether service users have recovery-goals in risk management. It is also not known whether service users perceive or experience the tensions between recovery and risk-containment priorities or models of care or paradigms in an inpatient setting. It is not known if service users want to co-manage issues of risk/safety, to share responsibility, or to engage in coproduction within this social setting.

The scoping review has shown us that service user perspectives on risk assessment and management have been largely marginalised. Whilst it is known that service users feel unaware of, uninvolved in, and ill-equipped for, risk assessment and management, it is not known how service users conceive of involvement and empowerment within the acute psychiatric inpatient context. We can start to see that we need a methodological approach to these issues that is sensitive to how risks and risk-narratives are constructed from different points-of-view. It will be important to consider how service users themselves conceptualise important concepts such as risk, safety, involvement, and empowerment in the context of an acute psychiatric inpatient setting. It will also be important to consider how service users themselves construct the processes of risk assessment and risk management within the social setting. A methodology is also required that is open to exploring dynamics of power in the operation of risk assessment and management processes. Moreover, a methodology that considers the specific social context of service user-staff risk interactions and wider processes of risk assessment and management is required. Furthermore, methods that can probe the service user perspective and experience in-depth are needed, as there are so many unanswered questions in this regard.

Chapter Three: Methodology, Design and Conduct

This chapter will provide a detailed outline of the methodology and methods of the study, giving justification of decisions made, and will consider issues raised in study management, design, and conduct. It will begin by introducing social constructionism and standpoint theory as the philosophical orientation of the study. It will then give a rationale for the methodological approach of critical ethnography as an appropriate way to address the research question, aims, and objectives, which will be outlined. The reasons for observations and interviews as methods of data generation will be given (the what and the why), before detailing research processes that were conducted in the field (the how). Abductive ethnographic analysis, as the chosen approach to data analysis, will be described and defended. Ethical considerations in the design and conduct of the study will be explored, before concluding with a discussion of assessments of quality in qualitative research and in this study particularly. It is hoped that the reader will see that the approach is credible and dependable, laying a foundation from which to critically appraise the description of the study setting (chapter four) and the study findings (chapter five).

3.1 Methodology

3.1.1 *Philosophical orientation: Social constructionism with a standpoint perspective*

As has been shown in the previous chapter, definitions of risk have been heavily influenced by empiricism and positivism (or a standard view of science), which see risk as an objective reality which can be measured (high; medium; or low) and upon which, it is argued, predictions of future behaviour can be made with varying degrees of precision. From this perspective, when we observe the world around us, if our ideas *correspond* to that reality then we've *discovered* a truth, and that truth exists independently of ourselves; our perspective is irrelevant. However, if we always filter our observations through our theories, then our observations are never value free and we cannot be unbiased observers. We have seen that it is important to consider how risk is defined, who gets to define it, and what impact this has.

An interpretivist approach is warranted by the proposed study, which looks at risk as a social construct, from the perspective of mental health service users. Interpretivism covers a broad spectrum of positions which all aim to achieve an empathic understanding of what Weber (ET 1949) in the German tradition termed *verstehen* (understanding) of an actor's meaning, which is assumed to be constructed through social interaction (Benton & Craib, 2001). Social actors confront a "pre-interpreted world", that is, a world ordered according to the meanings that constitute it (Schutz, 1953). Knowledge is thus gained through the interpretation of these meanings. I am therefore interested in gaining an empathic understanding of the social world of mental health service users in relation to risk, and its assessment and management, in the context of an acute psychiatric inpatient setting.

Thinkers within one form of interpretivism, social constructionism, argue that the external world makes no demands as to how it is to be described and thus there is no single reality; arguably we all create our own view of the world (Berger & Luckmann, 1967). Meaning is not sought in its correspondence with an external reality, instead all knowledge is socially *constructed* rather than discovered, and interpretations of experience are all that one can know (Berger & Luckmann, 1967). This approach highlights that all knowledge is perspectival and that truth is historically and socially contextual (Kuhn, 1962), there is thus no such thing as an impartial observer. The position has been accused of philosophical relativism (Benton & Craib, 2001), which posits that there is no universal, objective Truth, and that all truth-claims are necessarily subjective. Furthermore, relativism accords all points of view an equal status (they all have a truth-quality) such that there are no standards by which one point of view can be preferred over another. However, the challenge of philosophical relativism to social constructionism can be overcome by a standpoint epistemological approach, which is the approach adopted in this study.

Many thinkers from a variety of different perspectives have argued that the goal of social inquiry should be the emancipation of the oppressed (Marx & Engels ET 1888; Habermas ET 1972; Bhaskar 1986). That knowledge claims express power relations, organised into knowledge regimes, has been stressed by thinkers such as Michel Foucault (Foucault, ET 1989). Similarly, Marxist ideology critique (developed by Marx and Engels in the mid-1800's) and later standpoint feminism (rooted in the women's rights movement of the 1960-80's, see Hartsock (1983) for example) have been seen as parallel perspectives on the importance of recognising power and oppression in the construction of epistemological claims – thus despite their many differences women and the proletariat have still been seen to share some common contextual features (namely they are oppressed and marginalised) which grant them epistemic privilege (Hartsock, 1983).

In these perspectives the position or *standpoint* of the inquirer makes a difference to epistemology, as there is no view from no-where (Benton & Craib, 2001). Standpoint epistemologies stress the importance of epistemological communities which have shared knowledge, standards, and practices (Nelson, 1993). The key insight from these perspectives is that epistemic privilege should be given to socially marginalised groups whose voices are drowned out by oppressive hegemonies. Distance from the centre of social power, it is argued, gives an ability to critique, challenge and disrupt that centre from which they are excluded (On Bar, 1993). Alternatively, experiencing multiple layers of oppression (e.g., black, female, homosexual, and a mental health service user) are seen to give greater epistemic authority to challenge the centre of social power that does not include them (On Bar, 1993).

Some versions of standpoint epistemologies seem to conceive of a single power-centre which oppresses and marginalises, but this notion has been criticised for its simplicity, instead we should conceive of multiple hegemonies; and similarly, the assumption of homogenous epistemological communities has been questioned (Benton & Craib, 2001). Furthermore, within standpoint epistemologies the construction of epistemological claims is contingent upon oppressive power, such that epistemic privilege is dependent upon there being an oppressor over the marginalised (On Bar, 1993). Moreover, if proletarianisation or egalitarianism are achieved where do the liberated oppressed then stand in relation to the centre of power? However, their empowerment would not necessitate that they themselves become oppressors, only that they would lose their epistemic privilege. Nevertheless, a sophisticated standpoint epistemology that addresses these complexities can be seen to provide a way to overcome the problem of relativism in social constructionism by offering good reasons for preferring one standpoint over another, namely that preference should be given to the marginalised (Benton & Craib, 2001).

As has been shown in the literature review, previous work on risk in different social settings has emphasised that it is a social construct (Kendra, 2007; Boholm & Corvellec, 2011), including in the field of mental health (Corbett & Westwood, 2005; Felton et al, 2018). As a social construct, we have seen that, through the process of objectification and othering, mental health service users come to be seen as risk objects and mental health professionals as risk managers (Felton et al, 2018). The operation of *power* in this construction process has been highlighted (Kendra 2007), such that risk objects are seen to need to be controlled. The discourse of risk has been used to marginalise certain social groups on the basis of their Otherness, which is conceptualised as a perceived danger or threat (Lupton 2013). The mentally ill are thus defined as in need of control to reinforce the social and moral order of society (Douglas, 1992). Risk has become embodied in the mentally ill person who is seen as the chief actor in creating dangerous events (Coffey et al, 2017; Felton et al, 2018). In such a context, being deemed to be a risk places an individual within an oppressive system which seeks to contain and control, particularly if a risk-judgement is made that an individual should be admitted to an acute mental health setting. The literature review has already highlighted how the service user voice has been almost entirely side-lined in this field, which can be seen as further evidence of marginalisation. A standpoint perspective granting mental health service users epistemic privilege is in order.

3.1.2 The author's standpoint revisited

In chapter one I gave a detailed account of my dual position as both *service user* and *researcher*. I have experienced first-hand what it is like to be admitted to acute psychiatric inpatient wards. From a standpoint perspective, the fact that I am a mental health service user myself who has experienced stigma and marginalisation, rather than being an irrelevance to be discarded, or a problem of bias, is in fact a key reason I can challenge the dominant knowledge regime. I became interested in this topic because of my own experience of risk assessment which I have found traumatising, stigmatising and oppressive. Traumatising, because I have sometimes had to answer extremely personal questions to complete strangers, sometimes repeatedly, without seeing any personal benefit from having done so. Stigmatising, because being judged to be risky has felt like an indelible slur on my character. And oppressive, because I have often not realised that I have been risk assessed and have felt disempowered by the whole experience. I wanted to do this work to impact upon and improve others' experiences of risk assessment – my rationale has thus been emancipatory, a view that strengthens the case for a standpoint epistemological approach. Therefore, in some senses I have approached the topic and the field as an insider.

I have also acknowledged my identity privileges, unconscious bias and inevitable blind-spots this leads to. I have particularly noted the power I possess by being a researcher. As a result, to many service users on the ward I would be an outsider to them, even though we have, to some extent, other shared experiences. From the outset I was committed to working hard to ensure that I really hear the perspectives of seldom heard groups who may be present on the ward.

Thus, because of my epistemological standpoint, as a service user myself who has experienced marginalisation and disempowerment, I am well placed to challenge the dominant knowledge regime, to see and unmask the operations of power and oppression, and to really hear and document the voices of the oppressed. At the same time, I need to be wary of the power and privilege that I possess by working as a researcher.

3.1.3 *Methodology: Critical ethnography*

This study seeks to explore service users' perspectives and experiences of risk assessment and management in an acute psychiatric setting from the standpoint of a lived experience researcher. An ethnographic methodology that is interested in social actors' meanings within social settings was chosen for this purpose. A *critical ethnography* that is particularly interested in dynamics of power and oppression was selected. To see the rationale for this, I will first outline conventional ethnographic approaches, before delineating the unique focus of a critical ethnography and its suitability for exploring the setting and phenomena of interest.

Conventional ethnography is a qualitative research methodology that seeks to provide a detailed description of the symbolic world of a distinct social group in their natural setting (O'Reilly, 2005). It is focussed on the interactions and interpretations of a culture-sharing group; that is, a group who share common values, beliefs, behaviours, and language. It traditionally generates/constructs data via multiple methods in a relatively undirected way, over an extended time-period, involving direct and sustained contact with social actors, within the context of their daily lives (O'Reilly, 2005). Whilst discussions of ethnography often reduce the methodology down to its key methods it is important to note that different philosophical orientations inform different forms of ethnographical research.

Early ethnographies, rooted in social anthropology (e.g., Malinowski 1922) and sociology (e.g., Park & Burgess (1921) of the Chicago School), were *realist ethnographies* reflecting a positivist paradigm. They sought to be an objective account of a cultural group, told by an omniscient narrator in the third person, claiming to be without bias or political agendas, presenting interpretations from the points of view of the subjects (the ethnographer's views being irrelevant), looking from the outside in, seeing culture as something alien, primitive, exotic, deviant, or other (O'Reilly, 2005). The rise of the interpretivist tradition, and particularly social constructionism (outlined above), led to arguments that there were multiple social worlds, that cultures were social constructions, and that there was no such thing as an impartial, unbiased observer. Among other things, this brought about a more reflexive style of ethnography that considered the subjectivity of the ethnographer (Davies, 2008) and a more philosophically considered approach to the methodology. Furthermore, political shifts in the 1960s to 1980s saw the emergence of feminist critical theory, novel applications of Marxist theory, and a rise in political activism, which led to the development of an approach to ethnography termed critical ethnography (Thomas, 1993).

Unlike conventional ethnography, critical ethnography is not content with merely describing a social group in their social situation (a criticism of the early realist ethnographies; Madison, 2012). Critical ethnography seeks to transform situations of oppression and emancipate the oppressed through exposing the ways in which participants are oppressed, considering what life could be like without such constraints, and outlining how that alternative vision could be achieved (Thomas, 1993; Carspecken, 1996; Madison 2012). It is attuned to issues of unfairness and injustice, exposing hidden agendas, power centres, and knowledge regimes, and seeks to address repressive influences and expressions of social domination (Madison, 2012) and to explore avenues of resistance (Thomas, 1993). Thus, critical ethnography compliments the standpoint orientation and emancipatory approach adopted.

Whilst Madison (2012) uses an advocacy metaphor to describe critical ethnography, and Thomas speaks of critical ethnographers raising their voice "to speak *to* an audience *on behalf* of their subjects as a means of empowering them by giving more authority to the subjects' voice" (Thomas, 1993 p4, original emphasis) even this model could be said to be oppressive (the notion of "subjects" is quite telling). Rather, the collaborative nature of the work and the emphasis on the co-construction of meaning should be emphasised (Carspecken, 1996), which in critical ethnography is understood as an attempt to grant equity to all parties (both researcher and participant). Critical ethnography is thus unashamedly both a political and a value-driven position which seeks to bring about societal change (Thomas, 1993).

Like other recent forms of ethnography, critical ethnography is reflexive; but critical ethnography asks us to consider our positionality in terms of acknowledging our own power, privilege, and the imposition of our own biases (Madison, 2012). Critical ethnography does not mandate a standpoint epistemological approach (Carspecken is a pragmatist, for example), it should be clear, though, how the chosen methodology fits with a standpoint approach that seeks to give epistemic privilege to the oppressed.

There are limited models of critical ethnographies in mental health. Bransford (2006) presents a brief critical ethnographic case-study of social workers in managed mental health care settings. Bransford explored how social workers exercised their professional authority within a particular social setting (managed mental health care settings). Using a combination of participant observation, in-depth interviews, document analysis, and focus groups with social workers (n=17) across two study sites, Bransford utilised critical ethnography to expose operations of professional power and authority as serving organisations and driven by policies, rather than expressing the underlying values of social work practice. Bransford's work focuses on the power holders (social workers) rather than their clients, but nevertheless provides a good model of critical ethnography in practice.

Ethnography, as an iterative and exploratory approach, allows social meanings to be co-constructed over time, and is particularly useful when studying an area where little is already known (O'Reilly, 2005). Ethnography is open to the unexpected, can probe tacit knowledge, the taken-for-granted assumptions, and can explore the impact of context upon the social group. In observations, a critical ethnography explores "the tactics, symbols, and everyday forms of resistance" of the social group which they "*enact* but of which they do not speak" (Madison, 2012, p98, original emphasis). Critical ethnography is focussed on describing systems of oppression, and for envisioning alternative ways of being in the social context.

A critical ethnographic methodology from a standpoint perspective is thus well-suited to exploring the phenomena of interest within a particular social setting. The literature review has shown how little is known about service user perspectives and experiences of risk, and its assessment and management. Whilst there is a wealth of literature on professional perspectives, service user perspectives are marginalised. Furthermore, the little that is known about service user experiences implies that risk assessment and management can be disempowering. I thus wanted to explore both the setting of an acute psychiatric ward in-depth, and the experiences of service users within the social setting, with a view to giving voice to service users.

3.2 Research question and objectives

The purpose of the study was to describe and explore mental health service users' perspectives and experiences of risk, its assessment and its management, in an acute inpatient setting. It was thus conducted with a view to understanding service users' experiences of these particular phenomena. The research primarily addressed the question: "How do mental health service users experience risk assessment and management in an acute mental health setting?"

The objectives of the study were:

1. To explore the ways in which service users construct and interpret risk, risk assessment and risk management.
2. To describe the social practices of risk in the social setting.
3. To examine the contextual factors which shape risk processes in the setting from the service user perspective.

To explore these objectives, I set out to conduct a critical ethnography of an acute mental health ward to explore and understand service user experiences of risk assessment and management, using data generation methods of observations and interviews. I will now turn to explore the rationale for these particular methods for addressing these objectives.

3.3 Data generation: Theory, methods and procedure

3.3.1 *Data generation: Methods and their rationale*

Instead of the common phrase data collection I use the term *data generation* to emphasise the active role of both participants and researcher in the co-construction of data (Hammersley and Atkinson, 1995).

As outlined above, ethnography is typically conducted over an extended time-period, involving direct and sustained contact with social actors, within the context of their daily lives, generating/constructing data via multiple methods (O'Reilly, 2005). Data generation aimed to produce a *thick description* (Geertz, 1973) of the social group and their situation in relation to the phenomenon of interest. This took the form of exploring: everyday concepts, meaning and motives; social action and interactions; and accounts of the phenomenon of interest delivered by social actors (Blaikie, 2007). This study utilised two data sources: overt, non-participant observation and semi-structured interviews. The combination of these two data sources lent rigour and robustness to the findings, whilst allowing for multiple constructions of the phenomena of interest (Bransford, 2006).

3.3.1.1 *Overt, non-participant observation*

In observational fieldwork the researcher in one way or another enters the social environment of participants with a view to understanding daily lives and activities (Schensul et al., 1999). Observations can consider how social actors interact with their physical and social environment, or in their natural setting (Angrosino & Rosenberg, 2011). Activities, behaviours, conversations, relationships, hierarchies, and so on, that might not be verbally articulatable by participants in an interview can be observed in action (Mason, 2002). Moreover, self-reports of attitudes and behaviours can be compared and contrasted with what is observed in the field (Jerolmack & Khan, 2014). Philosophically, observations are epistemologically significant because meaningful knowledge can be tacit, unseen, or hidden, but still enacted (Mulhall, 2003; Allan, 2010). Whilst the term observation may emphasise the process of generating data through what is visually seen, the importance of *engaged listening* in ethnographic research has also been helpfully highlighted (Forsey, 2010). What is seen and heard from participants in the social context is then described and recorded in fieldnotes (Mulhall, 2003; Tjora, 2006).

The researcher entering the social setting can take a number of different forms. Gold (1958) identified four observational roles that can be adopted in the field (complete observer; observer-as-participant; participant-as-observer; or complete participant). These have been challenged for being too simplistic and for privileging the notion of participation (Davies, 2008). For this study, the stance of the observations was non-participant, meaning that I did not adopt an existing social role within the setting. (Although it has to be acknowledged that I was ascribed some kind of role by members of the social setting; see reflexivity below). A participant approach had been considered (for example, I could have adopted a peer-support worker role) as this might be seen as a way of giving something back to the ward as a token of appreciation for granting access and supporting the study. However, a non-participant stance was adopted, not as an attempt to try to achieve neutrality or objectivity (this was not a realist ethnography), but simply to avoid confusion regarding my role on the ward, and my purpose for being there. The observations were *overt*, meaning that participants were made fully aware that a research study was being undertaken.

Intensive observational fieldwork was conducted on one acute mental health ward over a period of four months. I observed the setting five days per week and each observation session lasted approximately seven hours duration. Observation spaces/interactions were selected with regard to the likelihood that risk would be discussed, assessed, and/or managed, and that surrounding activities would be enacted. These included larger group interactions (such as ward rounds) and smaller group interactions (such as one-to-ones between a staff member and a service user). Informal spaces, such as lounge, dining areas, and entry/exit to the ward, were also observed to allow for unexpected perspectives upon risk outside of more formal settings. Intimate care and private spaces (such as bedrooms and bathrooms) were not observed, to maintain service users' privacy and dignity. Most of these meetings occurred during early, mid, and late staff shift patterns (described in the next chapter), so that the weight of observation was on those shifts, although some nights were observed. Ward rounds were regular meetings that were observed week-by-week. Observing other meetings (such as discharge meetings) depended on service user turnaround on the ward. Observation sessions aimed to include all individuals in the observational field during the session, numbers varied according to the type of space and the kind of interaction being observed.

Observations can be "unfocussed and vague" (Mason, 2002) thus I wanted a guiding framework or some observational foci whilst I got used to conducting observations. Thus, the nine ethnographic observational dimensions described by Reeves et al. (2008) were noted. These included:

- space: the physical layout of the place(s)
- actor: the range of people involved
- activity: a set of related activities that occur
- object: the physical things that are present
- act: single actions people undertake
- event: activities that people carry out
- time: the sequencing of events that occur
- goal: things that people are trying to accomplish
- feeling: the emotions expressed

This ensured that sufficient breadth and depth of observations were routinely recorded whilst gaining familiarity with the setting. In addition, the particular focus of a critical ethnography added dimensions of power and resistance (Bransford, 2006). As I became more familiar with the spaces/interactions of interest observations progressed from the descriptive, to more focussed and selective.

The data source took the form of written observational field-notes using pseudonyms, following guidance of how to make high-quality ethnographic fieldnotes (Mulhall, 2003; Tjora, 2006). Fieldnotes were initially handwritten on site, notes were mostly taken contemporaneously, particularly during formal interactions of interest (e.g., ward rounds and one-to-ones). Whilst I was able to capture these interactions in writing, I obviously could not capture features of talk such as non-lexicals (err or ums). I was aware that notetaking can be perceived to be threatening (Hammersley & Atkinson, 2007) but I also wanted to ensure that participants understood when conversations were on the record, particularly in informal conversations. I was also concerned about my own memory recall. Thus, I would often ask for permission to note down comments during any informal conversations at an appropriate moment in the conversation. Fieldnotes were later typed-up and stored securely on a password protected computer.

3.3.1.2 *Ethnographic interviews*

In ethnography, interviews can elucidate the data generated/constructed through observational fieldwork (Mason, 2002). In critical ethnography interviews are key as they are understood to *democratise* the ethnographical research process, allowing participants' own voices to be heard explicitly and giving them a chance to challenge the conceptions of the researcher (Carspecken, 1996). Interviews can explore participant's reports on external reality (e.g., what they do) and their reports on internal reality (meaning; opinions; attitudes; feelings). Ethnographic interviews probe cultural meanings and allow for the exploration of the social construction of the phenomenon of interest from the participant's point of view and in their own phraseology (Sorrell & Redmond, 1995).

Face-to-face, semi-structured interviews were conducted with eleven service users and with eleven mental health staff working on the ward (see sampling below). Individual interviews were chosen over focus groups; given the potentially sensitive nature of the topic (Michell, 1999) I thought it would be easier to manage potential participant distress one on one. All the interviews aimed to last no more than 90 minutes. For service users, the mean length was 52.39, with a range of 36.02 – 70.22; with staff the mean length was 41.50, with a range of 29.19 – 64.04.

When little is known about a phenomenon of interest, interviews can also be a particularly suitable means of exploring a topic in-depth (Tod, 2010). As service users neared discharge, the interviews thus allowed for the in-depth exploration of their perspectives and experiences of risk assessment and management throughout their whole admission within the social setting. Interviews were also conducted with staff, the rationale being that they could illuminate upon the organisational and bureaucratic context (Bransford, 2006), and could bring a professional perspective to the phenomena of interest, such as how staff conceived of service user involvement in risk assessment and management.

Rather than being constrained by a fixed, structured set of questions to be rigidly and dogmatically followed, a *semi-structured* interview approach was adopted (Silverman, 2000; see **figure 4**). As "conversations with a purpose" (Mason, 2002), a semi-structured topic guide offered a focus to guide the discussion around the phenomena of interest, using a set of questions asked of participants, whilst allowing flexibility around the order of the questions posed and how they are phrased. This allows the conversation to be adapted to the participants' own accounts, agendas, and points-of-view (Tod, 2010), which the interview was attempting to centre and give voice to. Similarly, open questions were utilised to encourage depth and detail in responses as much as possible. Paraphrasing, sense-checking, and closed follow-up questions were techniques used to ascertain that their perspective was being understood.

Service users:	Staff:
Risk definitions Please tell me what is your understanding of the term risk?	**Risk definitions** Please tell me what is your understanding of the term risk?
(If mentioned) What differences, if any, is there between the words risk and safety? If you have a preference for one of these words, please state which one and your reasons for this preference.	
(If mentioned) What's your understanding of positive risk-taking?	(If mentioned) What's your understanding of positive risk-taking?
Do you think you have been treated as a risk? In what way? How do you feel about that?	
What do you feel are the differences in perceptions of risk between service users and staff?	What do you feel are the differences in perceptions of risk between staff and service users?
Why do you think staff do risk assessment? Who do you think it benefits?	How much at risk do you feel in your job? How does that impact upon your work?
Risk assessment and management What do you think service user involvement in risk assessment and management looks like?	**Risk assessment and management** What do you think service user involvement in risk assessment and management looks like?
What helps you to share any risk/safety concerns that you may have? Do you think you have been risk assessed? In what way? What concerns, if any, do you feel have not been addressed by staff?	What, in your view, are the main purposes of risk assessment? Describe how it feels asking personal questions in risk assessments? Please tell me how you share your assessment with service users? If you do not share your assessment with service users, please explain your reasoning for this.
What do you think is the best approach to managing risk? What aspects of risk management do you find most effective? Examples?	What do you think is the best approach to managing risk? What aspects of risk management do you find most effective? Examples? (If mentioned) How do you manage positive risk-taking?
How do you feel about your risk assessment/care plan/recovery plan? Do you agree with what's in your risk assessment? Why, or why not?	How do you feel about your risk documentation? Patient notes? Risk assessments? Care plans? Recovery plans?

Figure 4: Interview topic guides

Unlike interviews conducted outside of the context of a social setting, ethnographic interviews were conducted with knowledge of participant’s social situation. This meant that self-reports of attitudes and behaviour could be compared with observations (Jerolmack & Khan, 2014). Interviews began with service users on 15/11/2018 after approximately six weeks of intensive observations. Interviews with staff began on 18/12/2018. I had thus already spent considerable time observing service user interviewees’ ward rounds, and often a one-to-one as well. Over time I felt that I had already built up a rapport with service users that can be helpful for opening-up the conversation in interviews (Fontana & Fray, 1994).

I sought permission from all participants to audio-record the interview. In one instance, a service user was very uncomfortable being audio-recorded, in that case a contemporaneous hand-written transcript of the conversation was made. Interviews were transcribed verbatim (more below).

3.3.1.3 Documents excluded

I had expected risk documents (either explicit risk assessment documents, or risk sections of care plans) to incorporate first-person risk summaries from service users. It was also my expectation that some service users may have seen their risk documentation and be able to comment upon it. I therefore sought and received ethical approval to obtain risk documents. Eight service users gave informed consent for their risk documents to be reviewed. However, all the documents retrieved incorporated third-person summaries from the professional perspective, with no space for or inclusion of first-person comments from service users. Similarly, service users reported that they had not seen their risk documentation and therefore could not comment upon them. The decision was therefore taken not to include these documents in the analysis as they did not contribute to the service user voice on risk assessment and management in acute, inpatient settings. Service user perspectives and expectations of risk documentation (generated from the observations and interviews) were still incorporated into the findings.

3.3.2 Data generation: procedures

3.3.2.1 *Eligibility criteria*

In terms of the general inclusion criteria, the study included service users who were currently admitted on the ward and staff members who were currently employed on the ward. Individuals had to be aged between 18 and 65 years of age, which was the age range of patients admitted to the ward itself. Exclusion criteria for observations were where a consultee (more below) did not advise that a service user who lacked capacity to give consent should take part in the study; participants who were highly distressed were also excluded from observations. Exclusion criteria for interviews were individuals who lacked capacity to give informed consent (as judged by myself in collaboration with ward staff) and those who could not communicate in the English language. Recruitment and consent procedures will be discussed below.

3.3.2.2 *Site selection and negotiating access*

The ethnographic study took place on a single acute inpatient mental health ward located within a hospital site in the Midlands (which will be described in detail in the next chapter). As little was known about the experience of service users regarding risk assessment and management in acute psychiatric settings, this justified the general setting of study. A single site was proposed, as it allowed the researcher to explore in-depth the unique ecology of the ward (Long et al, 2008); rigour in qualitative research being demonstrated by depth of description and interpretation, rather than by numbers of sites (Geertz, 1973). As I have previously been admitted to five different psychiatric wards these were excluded from my site selection (I would have been particularly cautious around consenting a staff member if they had been part of my care team previously. Although this issue was not encountered in the field).

Conversations with the NHS Trust about hosting the potential study started in August 2017. Negotiating access was complicated by a lack of clarity as to who ultimately could grant access, the senior staff on the ward, or the Trust's Senior Leadership Team. I had had the ward in mind as a potential study site and approached, and met with, the then ward manager to discuss the study (18/09/17) who was very keen to support it. I then had a phone conversation with the ward consultant (28/09/17) who stated that he too would be happy for ward rounds to be observed. I had thus spoken to who I considered to be the key ward-based gatekeepers (Long et al, 2008).

I was then also invited to a meeting of the Trust's Senior Leadership Team (16/10/17) to briefly present the study to them, who made some helpful suggestions. It was apparent that they wanted a stake in granting access. Following this meeting, the Clinical Director suggested meeting to discuss as and when my plans became more concrete. Thus, as the study neared Research Ethics Committee clearance, myself and one of my supervisors met with the Clinical Director (15/06/18) to go through the study processes in detail. The Trust's Senior Leadership Team then confirmed that they were happy for the ward to host the study as detailed in the protocol (20/06/18).

At this point I encountered two further access problems. First, the then ward manager informed me (23/07/18) that he had left his post. So, I then met with the new ward manager (24/08/18) to renegotiate access, and thankfully she too was happy to proceed. She then emailed information about the study (including the observation PIS) to all ward staff. She also invited me to attend a staff meeting on the ward (19/09/18) to answer any questions about the study with the senior ward staff and some of the wider team, and to begin taking consent from staff one-to-one. Second, at that staff meeting, I was informed that the consultant psychiatrist would be off on long-term sick leave, but that the ward psychiatrists would be covering, until a locum consultant could be appointed. Thus, the study formally launched (19/09/18) with some uncertainty as to whether consultant-led interactions would be observable; however, this was resolved when the new locum consultant consented to take part in the study observations (08/10/18).

3.3.2.3 *Data generation period*

The ethnographic study took place on the ward over a four-month period. Following a two-week period of intensive acclimatisation, data generation processes commenced 01/10/18 and were completed 01/02/19. A four-month period of intensive observations fits well with an ethnographic approach, which as we have seen, is often conducted over an extended time-period (Ockley, 2012). It also mitigated against the *Hawthorne effect* (which posits that people will behave differently if they know that they are being observed) four months allowed staff and service users sufficient time to acclimatise to my presence, such that I could observe the natural setting (Ockley, 2012). Furthermore, four months allowed adequate time to build up an in-depth description of the ward, and to observe all the different kinds of interactions and spaces of interest. Between 05/11/2018 and 12/11/2018 only essential staff were allowed onto the ward due to a diarrhoea and vomiting bug, thus observations were paused.

3.3.2.4 Sampling

Sampling in ethnography is typically influenced by the number of participants in the group(s) under investigation and within the specific setting of the study (Ockley, 2012). Again, it is important to remember that rigour in qualitative research is demonstrated by depth of description and interpretation (Geertz, 1973), rather than by mere numbers of participants. Thus, obtaining a thick description of service users' perspectives and experiences of risk assessment and management was the overriding concern in deciding upon the sample size.

A key factor in observational sampling was that the ward had 24 beds. 48 service users were initially recruited to the observations study throughout the four-month period of observation; however, one participant decided to withdraw, thus 47 were retained. 45 participants were willing and able to provide a brief account of their concerns around risk during informal conversations as part of the consenting process (often prefaced with the response ‘my risks are…’). Thus, it became clear that a range of different risks were incorporated in the service user observational sample (see **figure 5**).

Service users: n=47

Gender:	**Ethnicity:**	**Age:**	**MHA status:**
Cis male: 28	White: 45	18-25: 18	Informal throughout: 25
Cis female: 18	BAME: 2	26-40: 11	Detained to Informal: 22
Trans female: 1		41-55: 14	
		56-65: 4	

Self-identified risks:
Depression and suicidal thoughts: 14
Suicidal thoughts and self-harm: 10
Suicidal thoughts and substance misuse: 6
Suicidal thoughts and hearing voices: 4
Suicidal thoughts and alcohol: 2
Suicidal thoughts, alcohol, and aggression: 2
Suicidal thoughts and eating disorder: 1
Substance misuse and aggression: 1
Unique threat: 5
Undisclosed: 2

Figure 5: Observations sample – service users

In total 35 staff members were recruited to the observations study, with no withdrawals (see **figure 6**). This included six irregular staff who came onto the ward for a specific Mental Health Act Assessment meeting (an Approved Mental Health Professional (AMHP) and independent psychiatrist) or who were covering ward rounds whilst a locum was being appointed (two cover psychiatrists) or were appointed to lead a specific ward round (a Community Psychiatric Nurse (CPN)/Care Coordinator), or who came onto the ward occasionally but played an important role in ward rounds and one-to-ones (an Assessment Practitioner). The remaining 29 consisted of almost every full-time member on the staff team (minus some night-shift staff), and one regular bank staff member who was a Health Care Support Worker (HCSW). These staff were mostly consented throughout the first five weeks of recruitment.

Staff: n=35

Gender:	**Ethnicity:**	**Roles:**
Cis female: 23	White: 26	Ward Manager: 1
Cis male: 12	BAME: 9	Charge Nurse: 2
		Nurse: 13
		HCSW: 6
		Locum Consultant: 1
		Psychiatrists: 3
		Students: 3
		Irregular staff: 6

Figure 6: Observations sample - staff

In terms of time spent conducting observations, five days of observation per week allowed sufficient time to observe the different interactions of interest, whilst allowing time to type up field-work notes, for ongoing preliminary data analysis week-by-week, and time for reflexivity. Each observation session lasted approximately seven hours duration, which allowed sufficient time to observe the different interactions of interest and minimised the emotional burden of ethnographic work upon myself (McQueeney & Lavelle, 2015).

Ethnographic sampling can also be considered at the level of the key spaces/interactions of interest observed. The following key interactions were observed:

- 61 ward rounds for 30 different service users, including 13 discharge meetings
- 9 service user-staff one-to-ones
- 5 care planning interactions
- 3 community meetings
- 2 *Mental Health Act* assessment meetings
- 43 staff morning meetings/handovers
- 12 other staff handovers

Thus, a range of spaces/interactions were incorporated in the observations, which will be outlined in further detail in the next chapter.

Eleven service users were recruited to the interview study using purposive sampling (see **figure 7**), to incorporate some of the different kinds of risks identified during observations. This sample size enabled the in-depth exploration of the service user perspective.

Service users: n=11

Gender:	**Ethnicity:**	**Age:**	**MHA status:**
Cis male: 5	White: 11	18-25: 3	Informal throughout: 5
Cis female: 6	BAME: 0	26-40: 3	Detained to Informal: 6
		41-55: 4	
		56-65: 1	

Self-identified risks:
Depression and suicidal thoughts: 4
Suicidal thoughts and hearing voices: 2
Suicidal thoughts, alcohol, and aggression: 2
Suicidal thoughts and self-harm: 1
Suicidal thoughts and eating disorder: 1
Unique threat: 1

Figure 7: Interview sample – service users

Eleven staff agreed to be interviewed, who were purposively sampled so that staff from different roles were incorporated (see **figure 8**). This provided sufficient depth to probe risk and its social context from a staff perspective (Bransford, 2006).

Staff: n=11

Gender:	**Ethnicity:**	**Roles:**
Cis female: 7	White: 8	Ward Manager: 1
Cis male: 4	BAME: 3	Charge Nurse: 2
		Nurse: 3
		HCSW: 2
		Psychiatrists: 3

Figure 8: Interview sample - staff

3.3.2.5 Recruitment

Recruitment materials consisted of: posters (see Appendix 2) containing general information about the observation study and my contact details, displayed on noticeboards around the ward prior to the study and then throughout; Participant Information Sheets (PISs; Appendix 4) were left around the ward and given to participant groups; and informational presentations were delivered at staff/morning meetings and at community meetings of service users on the ward prior to the study and at various points throughout.

The initial approach to staff regarding the study observations was made directly by me. Staff were informed of all aspects pertaining to participation in the study via information sessions during morning meetings on the ward. An email was also sent to staff via the ward administrator so that I did not need to access staff email addresses. I also approached staff members to invite them to consider taking part in the interview study, again an email was also sent to all staff via the ward administrator, and the PIS was given out to staff by me in person.

The first approach to service users on the ward was from a member of staff who gave a brief verbal outline of the study and a poster. Service users were then asked for permission by that staff member for the researcher to approach them to tell them more about the study, and to give them a PIS. For the interview study, I approached service users directly to invite them to consider taking part in the study.

3.3.2.6 Observations

The observations were *overt*, meaning that participants were made fully aware that a research study was being undertaken. This was achieved by me always being visible and identifiable by a name-badge during observations. A photograph of myself, with contact details, was displayed on all study materials. All observation sessions (with the proposed exception of the admission meetings) were advertised at least 24 hours in advance. Finally, immediately prior to an observation session, observation-in-session notices were put up in the area to be observed.

In terms of process, observations began with a two-week acclimatisation period during which I began consenting participants, and I got used to life on the ward without taking detailed observational fieldnotes. This also entailed that staff and service users could acclimatise to my presence on the ward too. When observations formally began, I started by observing the informal spaces on the ward (lounge, dining areas, and entry/exit to the ward) so that staff and service users could again acclimatise to my presence. I then began to include the larger group interactions, including ward rounds and handovers. After I felt that the staff and service users were more comfortable with and trusting of me, I then began to include the more private one-to-ones between staff and service users.

3.3.2.7 Interviews

Interviews with service users were conducted as they neared discharge. Nearness to discharge was often talked about both in ward rounds and one-to-ones with service users, and also in handovers between staff. Thus, I had a good indication as to when service users would be likely to be leaving the ward, and thus when to invite them to consider participation in an interview. Interviews all took place on the ward, either in the clinic room or the visitors room. The clinic room was not an ideal setting, as it was associated with medical reviews, but meant a conversation could be had without interruption. The visitors room was better in terms of the environment, as it had comfy sofas and a coffee table, giving the room a more relaxed feeling, but was more open to people interrupting. Interviews were conducted after tea-time, when formal interactions on the ward were less likely, and the clinic room was also less likely to be in use.

Interviews with staff were conducted either in the clinic room, the staff room, the MDT room, or in a staff office just off the ward. Interviews with the ward manager, the psychiatrists, the activities coordinator (an HCSW), and with another HCSW could be booked in during a quiet period in their working hours. Other nursing staff could only be interviewed before or after their working hours. Both of these factors contributed to staff interviews often feeling rushed.

3.4 Approach to data analysis

3.4.1 *Preparing for data analysis*

From the observations, fieldnotes in the form of day-logs were typed up to produce a legible record of the daily observations, ensuring that each log represented a copy of the data recorded in the field. These were anonymised fieldnotes using assigned pseudonyms. Then, one-to-ones, ward rounds, and handovers were identified from the day-logs and were also cut-and-pasted into separate documents. Similarly, informal conversations were identified, including the surrounding contextual observations, which were also copied into a separate document. Finally, prior to interviewing service user participants, case studies across the different forms of interaction, were also produced. This opened-up different ways of viewing the data: by shifts, by interaction, and by an individual's overall experience.

As part of my disability support plan, I was able to utilise an approved and secure transcription company who transcribed each interview verbatim. Since representing spoken language in writing is in itself an interpretative process (Davidson, 2009), each interview transcript was checked against the original audio file, occasionally adding missed non-lexicals (ums and ers), noting pauses, identifying words that had been logged as inaudible, and using italics to note emphasised words or phrases. In addition to recognising my role in co-constructing meaning in the production of these transcripts, this process also served to heighten my familiarity with the interview data.

Having worked with both paper transcripts and qualitative data analysis computer software on previous projects, for this study I decided to work with paper transcripts as, for me personally, I find it heightens familiarity with the data. I printed off copies of the transcripts with wide margins and sentence spacing.

3.4.2 *Abductive ethnographic analysis*

The overall approach to analysis followed an abductive ethnographic research strategy (Blaikie, 2007; Mason, 2002; Priest et al., 2002). The aim of an abductive logic of enquiry is, first, to gain an *understanding* (verstehen; Weber, ET 1949) of social life in terms of social actors' accounts, interpretations, meanings, motives, and intentions within the social context (or first-level constructs); and second, to produce a technical account from the lay one (second-level constructs), ideally represented in language that deviates from the original accounts as little as possible (Blaikie, 2007). This is a good methodological fit, as an abductive research strategy entails ontological assumptions that posit multiple social realities, socially constructed by social actors, and epistemological assumptions whereby knowledge is derived from social actors' everyday concepts and meanings (Blaikie, 2007). Another key rationale for employing this research strategy is its insistence that social scientific accounts are derived from, are consistent with, and loyal to, lay accounts; both to evidence an adequate grasp of participants' social world, and to retain the integrity of their social world (Ong, 2012), thus centring and foregrounding the voice of participants. For a critical ethnography, it was important to develop theory and elaborate it iteratively, in line with its overall aims and concerns.

The emerging corpus of observation and interview data was repeatedly read and re-read, from literal (taking words in their most basic sense), interpretive (looking for creation of meaning), and reflexive approaches (considering the researcher's role in constructing data) (Blaikie, 2007). To this process was added a critical lens, which looked for expressions of power, oppression, and resistance.

Having conducted some preliminary analysis during data generation, at the end of data generation I began to formally code all of the accumulated data. My approach to combining the data was as follows: I decided to begin by coding the service user interviews and then moved onto the informal conversations with service users (or the *talk to me* data). I then did the same with the staff data and compared and contrasted these data sets. I next coded the service user-staff interactions (or the *talk to one another* data) and compared and contrasted these with the reported accounts. Finally, I coded the handovers (or the *talk without* data).

Data was typed up on University of Nottingham computers and backed up to the University servers. The analysis was conducted by me, with ongoing feedback from the supervisory team at monthly academic supervision meetings.

3.4.2.1 Developing themes

As I coded the transcripts, I noted issues or topics that were mentioned frequently, and these were captured as keywords in the margins of the transcripts. During this process I also kept a research journal (more below), recording all the keywords along with summary statements as to what these might mean to participants (noting also my own reflections upon interpretations of meaning, and tracing any evolution in my understanding). Whilst exploring and noting commonalities between participant's perspectives, I also noted differences between how participants understood or experienced the different keywords and any discrepancies. I also made a note as to which transcripts contained the keywords, which also helped gain a sense as to how prevalent certain keywords were.

My initial coding framework was to consider how risk, risk assessment, and risk management were constructed by service users across the whole dataset. This was a helpful beginning, but it produced a number of disparate themes. In order to assist with the organisation of the keywords, I wrote them all down on post-it notes; this enabled me to see how keywords might relate to one another as themes and how the ideas could be grouped together, whether themes could be collapsed and where tensions in perspectives might remain.

As I was clustering post-it notes together, five overarching clusters, which all cut across the data, predominated early on; one on documentation, one on interpersonal communication, one on service user (un)involvement, another on dis/empowerment, and one on issues of knowing/knowledge. As I explored these, what I began to see was that the issue of knowledge was central to all the other identified clusters of keywords. The role of knowledge initially centred on knowledge that service users lacked (their knowledge deficits), and also knowledge that service users wanted or needed to learn. Into this cluster I then brought post-its on what service users wanted staff to know and then the knowledge service users already possessed, which I saw was rooted in their experience. Thus, I was beginning to see how important this notion of knowledge was to service users. Service users' desire to share their knowledge and experience with staff became theme 1, the risk-experience. I next observed a similar cluster of keywords from the professional perspective, and their views as to what knowledge they valued, how they obtained knowledge, and what knowledge they felt service users needed to obtain (theme 3, clinical knowledge). I was then able to compare these different forms of knowledge and firm-up these identified themes.

Within this cluster of knowledge-based keywords were the barriers and facilitators to service users sharing what they wanted staff to know; these reinforced the emotions and sensitivity of the experience being shared (subsumed under theme 1, the risk-experience). They also made me consider the importance of the interpersonal dynamics underpinning the sharing of this risk-experience (which became theme 2, honest sharing); thus, interpersonal communication was subsumed within this wider concern about sharing knowledge. I also explored the possible reasons as to why service users might possess their knowledge deficits (subsumed under theme 3, as this was an impact of clinical knowledge). I thus had three key themes at this point, all focussed on different forms of knowledge and knowledge-sharing.

I next considered where and how these different forms of knowledge intersected. I began to see how hierarchies of knowledge were operating in the study setting and how this was tied to issues of power. On the one hand, I began to see that service users' feelings of powerlessness was tied to their knowledge deficits of staff processes and perspectives (under theme 3). On the other hand, that staff's knowledge was prioritised over service user's knowledge in different ways and that certain forms of service user knowledge might be downplayed to mere beliefs (theme 4, power disparities). Having uncovered these power disparities, I finally considered how service users felt that they might be counterbalanced. This is where I felt the documentation theme fit best as it was seen by service users as a potentially involving and empowering process, if it incorporated the service user perspective and was formulated in collaboration with service users (tangible involvement, theme 5). Documentation was a key means of navigating these issues of knowledge and power.

3.4.3 *Rigour and the research journal*

Ethnography is as much about the ethnographer as it is about the participants. Those personal characteristics of the ethnographer that cannot be changed (that is, those inevitable influences) have the potential to influence how people behave, what they choose to say, and how they chose to present themselves to the researcher. Similarly, how the researcher chooses to selectively present themselves (in how I dress, speak, and in introducing myself as a service user) will have an influence on others in the field. Furthermore, these characteristics will play a role in shaping the entire research process itself, from beginning to end (Goodwin et al., 2003). The reflexive process was recorded in a research/reflexive journal, which aimed to make transparent the assumptions that guided every stage of decision-making (Davies, 2008). However, the goal was to move beyond a mere descriptive account and to produce an analytical one in which my values were thoroughly scrutinised (Aranda, 2006). Critical ethnography asks the researcher to consider their positionality in terms of acknowledging their own power, privilege, and the imposition of their own values (Madison, 2012). Whilst being criticised as an exercise in narcissistic introspection (Aranda, 2006), it was important to produce a reflexive account that considered issues such as the sociological gaze of the ethnographer (Germov & Poole, 2011), why certain data was chosen, and how data could be interpreted (Davies, 2008). Therefore, the reflexive journal was important to demonstrate the robustness, rigour, and transparency of my whole approach to the entire study (more below).

3.5 Ethical considerations

Post-War condemnation of Nazi atrocities conducted in the name of research led to the formulation of the Nuremberg Code in 1947 and then the first Declaration of Helsinki in 1964, which stipulated a set of ethical principles for the conduct of medical research (Fischer, 2006). As a result, a number of ethical principles guide and shape all modern research activity including the principles of: beneficence, non-maleficence, informed consent, confidentiality, respect, and justice (HRA, 2020; Edwards & Mauthner, 2012).

This section will outline how these ethical concerns were addressed in the design and conduct of the study.

3.5.1 The impact of the methodology on ethics

Unlike other methodologies, a critical ethnography has been argued to have a number of in-built norms that guide the research process (Thomas, 1993; Madison, 2012). The critical ethnographer must value freedom and justice and oppose oppression and unfairness (Thomas, 1993). Foucault argued that "there is something in critique that is akin to virtue" (Foucault, ET 2007 p43); that is, the very act of social critique is a moral act. Whilst Madison's advocacy metaphor (speaking on behalf of 'subjects') might itself imply an oppressive approach (Madison, 2012), other notions of collaborating with participants and co-constructing meaning entail an ethical responsibility to attempt to foster equity between parties that the critical ethnographer must take seriously (Thomas, 2003). A critical ethnography can never be accused of being a voyeuristic desire to pry into people's lives simply for the researcher's satisfaction; or of being an academic exercise to simply further the career of the researcher; rather it seeks to do good to participants.

Critical ethnography seeks to not only describe situations but to transform social situations and it therefore has the potential to transform the lives of disenfranchised social groups (Thomas, 2003). However, in this study it was always stressed to potential participants that there was no guarantee that the study would help them personally. Furthermore, in critical ethnography, the potential that the researcher might become uncomfortable or distressed whilst in the field, take on epistemological significance and can be used to shed light upon potential power dynamics operating within the field (McQueeney & Lavelle, 2015). Finally, a critical ethnography will not seek to exploit a social group (Thomas, 2003), it was therefore crucial to be sensitive to issues of harm, distress or burden, and the misuse of my own power, as will be explored below.

3.5.2 Ethical permission

The study required formal ethical approval from an NHS Research Ethics Committee, as well as Research Governance approvals from the Research and Development (R&D) department of the host NHS Trust. The study was granted ethical approval from East of England – Cambridge Central Research Ethics Committee on 18/07/18 (ref. 18/EE/0154; see Appendix 1).

3.5.3 Voluntary participation

I explained to all potential participants that whilst the ward had agreed to support the study, individual participation remained entirely voluntary. I emphasised that service users could decide not to participate without their care and treatment being affected; similarly, that staff could decline to take part without it impacting upon their job situation. I was mindful of the issue of not exploiting a captive audience and of not abusing my own power as researcher to coerce anyone into participation (Jordan, 2012); this was demonstrated by me always putting the needs of the participant before the needs of the study, by immediately accepting an individual's decision to withdraw, and by observing non-verbal cues indicating any form of discomfort. My role as researcher, study information, and reminders of participant freedom to withdraw at any time were repeated at the start of every observation session.

3.5.4 Withdrawal from the study

Whilst individuals were given the opportunity to opt-out of particular observation sessions (see below), they also had the freedom to withdraw from the entire study at any time, without needing to provide an explanation. If this occurred, it would be explained that field-notes made up until that point could not be erased from the study and may still be used in the anonymised final analysis, but that no further data would be collected from that individual. One service user participant in the observations study decided to withdraw before any observation data had been generated. If they later happened to be present during an observational session of an informal space around the ward it was emphasised to them that their interactions were not being included in the study session in line with their wishes.

3.5.5 Participant Distress

Observation is a relatively unobtrusive method of data generation, as no interventions are involved, and it does not interrupt the broader dynamics of the setting. In this study I was observing activities that would otherwise take place within that environment, much as a visitor to the ward might do. The risk of associated harm was therefore minimal. However, it is recognised that the experience of being observed might make individuals feel uncomfortable; although evidence shows people acclimatise to the researcher's presence on the ward (O'Reilly, 2005). As outlined above, observation sessions would rotate through different ward areas and different kinds of interactions so that no individual or group feels that they are being observed excessively. I was also sensitive to signs of discomfort (such as heightened agitation or becoming tearful) from individuals in the observational field. If individuals did raise concerns or wished to opt-out of an observation session, depending on the circumstances and the nature of the concerns, I would either: stop making notes on that individual and inform the individual of that, but continue to observe the area; move to another area; or stop observation altogether and re-schedule.

Interviews around sensitive subjects obviously have the potential to cause distress. It was recognised that risk may be a sensitive subject area. I developed a distress protocol (see Appendix 9) and ensured that the participant was supported both during (by the researcher) and after the interview (by staff or other sources of support), and provided a debrief sheet (Appendix 10). Interviews were to last no longer than 90 minutes to avoid burdening the participant. The interview topic guide was devised so as to not immediately explore sensitive areas nor to end on distressing subjects (see **figure 4** above).

3.5.6 Consent

It was important to devise a model of consent that would be acceptable to participants, that would be judged to be ethical given the participant groups, that would be comfortable for the researcher, and feasible in the setting. An opt-out model of consent is common for observational studies (Moore & Savage, 2002; Denscombe, 2010; Hegney & Chan, 2010), including those conducted in hospital settings (Murphy & Dingwall, 2007; Houghton et al., 2010). However, given potential issues around the mental capacity of some of the service users on the ward, I felt that obtaining written informed consent for ongoing interactions to be observed, followed by ongoing verbal checks, would be more acceptable all round, as outlined below.

3.5.6.1 Individuals with capacity to consent to observation and interview

The *Mental Capacity Act* (2005) specifies that capacity relates to one decision at a time. The usual care team assessed capacity to treatment/admission, however capacity to study participation would need to be assessed as a separate issue. Capacity to consent to study participation was judged by me, in collaboration with the nurse-in-charge and one of the ward psychiatrists, and the outcome recorded (see Appendix 3). I explained the details of the study and provided a PIS (Appendix 4), ensuring that the participant had sufficient time (approximately 24 hours) to consider participating or not. I answered any questions that the participant had concerning study participation. All participants who were judged to have capacity to give consent to take part in the study provided written informed consent. The Consent Form (Appendix 6) was signed and dated by the participant before they entered the study.

Informed consent was collected from each participant with capacity to consent to study participation before they took part in any aspect of the study (including any aspect of study observations and interview). One copy of this was kept by the participant and one was kept by me.

3.5.6.2 On-going consent to observation

Having provided written consent to observation, at the beginning of each observation session, I verbally checked that participants present were happy to be observed during that particular observation session. Individuals could opt-out of an observation session, this could be communicated to me directly, or indirectly via staff or family-members. Individuals had the freedom to decide whether to opt-out of a particular observation session, or to withdraw from the entire study.

3.5.6.3 Observation of individuals lacking capacity to consent

It is important that individuals should be treated fairly in research, including in establishing inclusion criteria and in recruitment to a study (Faulkner, 2004; Edwards & Mauther, 2012). Thus, as a principle of justice, service users who could not consent to study participation were not automatically excluded, and steps were taken to explore their perspectives and experiences, if at all possible. Therefore, a *consultee model* was developed for the observations. Following the capacity assessment (Appendix 3), if a service user was judged to lack capacity to consent to take part in the study, steps were taken to identify a *personal consultee* (someone unconnected to the research who knows the potential research participant in a personal capacity and is able to advise on the person's wishes and feelings) – this could be a friend or family member. They were identified and approached during their visit to the ward. The service user must have regarded them as an appropriate person to act as a consultee. In one instance I spoke to the mother of a service user, and in another case, I spoke together with the mother and partner of a service user, none of whom felt that their family member would be inclined to participate.

If, after all reasonable steps to identify a personal consultee failed, *a nominated consultee* was approached (someone who is unconnected with the management of the research, appointed by the researcher, to advise the researcher about the person's wishes and feeling in relation to the project). This would be a health-care worker who had no connection with the management of the study, and their view would be sought by myself. Understandably, no health-care worker on the ward, however, felt comfortable advising me about a person's potential wishes and feelings in relation to the project unless they were already known to services. In one instance, I spoke to someone's CPN who was attending for a ward round who advised that the service user was unlikely to want to participate. In two further cases, attempts were made to identify a personal, and then a nominated, consultee, but these could not be found; however, one individual later regained capacity, was re-assessed, and was consented to the observations study.

Consultees were provided with information about the research project via a consultee PIS (Appendix 5) and were given the opportunity to discuss it and their role as consultee. All consultees must have been able to understand their role and be willing to undertake it. They would be asked to sign a consultee advice form indicating their view allowing the service user to participate in the study. It would be explained that the researcher would always verbally check whether the service user is happy to be observed during an observation session, and that written informed consent would be obtained from the service user as soon as they regained capacity to give such consent to take part in the study.

3.5.6.4 Observation of admission meetings

The only proposed exception to the consent model adopted above was the observation of admission assessments (or clerking-in); where a model of verbal assent, followed by retrospective written consent (based upon precedent in emergency medicine, e.g., Foëx, 2001) would be adopted. However, I was unable to observe any admission interactions or clerking-in of service users – this was a result of a combination of often not being in the right place, at the right time, or participants saying that they did not want me to observe, or my own feeling of discomfort about approaching potential participants who were obviously in great distress.

3.5.7 Participant anonymity and confidentiality

It was stressed that all personal information would be handled in confidence, with the exceptions being that any safeguarding concerns about the individual or others are raised. I worked within Trust safeguarding protocols in terms of how such concerns would be acted on. Any identifying features of individuals were removed from field-notes and the interview transcripts. Each participant was assigned a pseudonym as opposed to an ID number which I feel de-humanises the individual. The document linking participant details to pseudonyms, audio-files, and written transcripts was stored on a password protected computer. Any hard copies of interview transcripts, handwritten field-notes or typed-up observations were stored in a locked unit. It was made clear that only members of the research team (myself, plus supervision team) had access to the anonymised data and that anonymised quotations from the various sources might be used in the final analysis.

3.5.8 Researcher wellbeing

As well as being potentially distressing to participants, it was important to acknowledge from the outset that the proposed study could also have had an emotional impact upon me (Johnson & Clarke, 2003). The stress and strain of qualitative work can be both physically and emotionally demanding for any researcher (Campbell, 2002). I managed my emotional wellbeing through two key means, journaling and clinical supervision.

3.5.8.1 Journaling and emotional processing

Kinard (1996) suggests that the challenges of undertaking sensitive research forms part of the researcher's reflexive journal. Furthermore, in critical ethnography, negative emotions aroused in the field, within the researcher, can take on epistemological significance and can be used to shed light upon potential power dynamics operating within the field (McQueeney & Lavelle, 2015), such that it would be important to recognise and interpret these emotions; this would also need incorporating into the reflexive journal. Keeping a journal that incorporated my own thoughts and feelings about being in the setting, and the emotional impact that people's accounts were having on me, was a helpful means of processing my own emotions regarding what I observed and heard.

3.5.8.2 Clinical supervision

A supervision arrangement was set up so that I would have someone to debrief with, particularly during the intensive period of fieldwork. This was outside of my academic supervision team. I refer to this as *clinical supervision* to differentiate it from academic supervision. Dr David Charnock from the School of Health Sciences agreed to be my clinical supervisor. I met with him once immediately prior to the acclimatisation ward visits, twice during the period of fieldwork, and then again during the data analysis phase. Meetings intentionally took place outside of the study setting and were held at the University.

Meeting just prior to the acclimatisation visits enabled me to voice my anxieties around beginning fieldwork. I was concerned about how staff would view me, whether enough service users would consent to take part, and whether I would be seen as an intrusion. I was also wrestling with imposter syndrome and doubting my capabilities to do the research. It was also helpful to talk about the anticipated emotional labour of ethnographic research and how I planned to look after myself during the period of fieldwork. Moreover, I was mindful of the potential to be triggered or retraumatised by virtue of being back in the kind of social setting that I had experienced aspects of negatively in the past. Talking about this was not only helpful in terms of my reflexivity, but also for my own emotional wellbeing.

It was really helpful to meet for clinical supervision during the busy period of fieldwork itself. In these two supervision sessions, I took the opportunity to discuss particular cases that had had an emotional impact upon me. Whilst it was a real privilege to be hearing service user accounts of their risk, and to be present in ward rounds and one-to-ones with them, at times I heard and witnessed things that I found personally unsettling. For instance, during one ward round a service user asked me to intervene and advocate for them, and I was unable to. This was made all the harder by this service user expressing that she was being treated unfairly by staff there and that nobody was on her side. I felt angry, but powerless. Talking about that in clinical supervision helped me to process that emotion. It was also helpful to talk about a restraint I had witnessed, and the forced medication that I knew was taking place. I found it personally beneficial not to bottle things up, but to talk about what was concerning me.

The data analysis phase was also an emotionally intensive period of work, and it was also beneficial to meet for clinical supervision at this time. Whilst it may have appeared that I was merely engaging with interview transcripts and observational fieldnotes, this work evoked memories and emotions that were also important to process. As will be seen, I was exploring forms of injustices that service users experienced on the ward, and I wanted to talk about how that was resonating with my own experiences, not only for the purposes of reflexivity, but again for my own sense of wellbeing. In a number of cases, I had seen service users on their journey towards discharge, but some cases felt unresolved, and I was left ruminating about them and what may or may not have happened to them; again, it was helpful to talk with someone about that.

This process of clinical supervision was a helpful means of maintaining my emotional wellbeing at key phases of fieldwork, facilitating reflexivity and enabling me to have someone I could talk to about the emotional challenges of the work.

3.5.9 Patient and Public Involvement

I set up a *Service User and Carer Advisory Group* (SUCAG) using a small grant I was awarded from the School of Health Sciences' public engagement fund. The SUCAG consisted of two service users and one carer. I initially consulted the group about acceptable models of assent/consent. They agreed that an opt-out model of consent would not be feasible or acceptable given that there might be issues around the mental capacity of service users on the ward. Similarly, Trust staff that were consulted also had issue with an opt-out consent model. Thus, on the basis of this feedback, the models of consent outlined above were devised. Talking to the carer member of the SUCAG was invaluable in terms of understanding what it might be like for a carer to act as a personal consultee and the subsequent relational issues that this might cause them. In two further meetings, the SUCAG also reviewed and commented upon the PISs, consent forms, and recruitment poster, picking up on issues such as long and sometimes clumsy sentence structures, lack of clarity of the research process, and issues around defining risk, assessment, and management for the purposes of the PISs.

3.6 Quality

The rigour of the study has to be judged appropriately by the standards of the study methodology (Richardson, 2000; Tobin & Begley, 2004; Tracy, 2010). Thus, assessments of quality must cohere with the ontological and epistemological underpinnings of the research paradigm.

3.6.1 Reflexivity

It is important to consider my own role within the data generation, analysis, and co-construction of the findings. Reflexivity entails a consideration of how I understand my position or standpoint, how I presented myself to others, the role I may have been ascribed to play by others in the setting, and the influences these may have played throughout the research process.

3.6.1.1 Reflexivity and observations

My role in the study observations was non-participant, meaning that I did not play an existing social role in the social setting. However, I will inevitably have been ascribed some kind of role by participants, and I also sought to present my own understanding of my role to participants as well.

Unlike the management, nursing, administrative, domestic, and support staff on the ward (who each wore different coloured T-shirts by role), I was clearly not in a uniform.

Unlike the service users, I was dressed in smart/casual clothes – smart black shoes, plain black trousers, a short-sleeve shirt, and a jumper. I did not, however, wear a tie, or a suit jacket, like the male psychiatrists, as I felt that was too formal and might alienate me from service users, contributing to power dynamics. I always had my university lanyard around my neck. I often felt like an outsider in relation to both participant groups. Altogether this meant that it was not obvious what my role was on the ward, and hence I would constantly need to explain who I was and what I was doing (a feature of my ethics too).

Each time I arrived onto the ward I was given my own alarm and access fob. The access fob, in particular, indicated that I was being treated by staff like another staff member (an insider) rather than a visitor. At times, staff wanted to entrust me with minor tasks, such as momentarily watching the cleaning products or the food trolley (which I had to decline), which also suggested a sense of trust. Furthermore, the Activities Coordinator introduced me in Community Meetings as "one of the team," indicating a sense of acceptance and an 'insider' status from a staff perspective.

I wanted to position myself as a lived experience researcher. As the sponsor's office at the University would not allow me to indicate this position on PISs (it was deemed "personal information") I had to verbally construct this identity with each participant. I had decided in advance how much of my own lived experience I was prepared to disclose. At the first Community Meeting I described myself as a service user researcher, but many of the individuals that I am referring to as service users did not know what a service user was. I often unpacked lived experience by saying that I had had "my own experiences of inpatient admissions", and that "I have my own mental health difficulties". I was often asked about my diagnosis and my own experiences of admission, indicating a sense of shared experiences. I was not asked about my own risks.

When ward management introduced me to new staff or to visiting Trust staff, I would often be introduced as "the researcher working on the ward." This is also how I was introduced to the locum consultant when they started. Near the beginning of the study, one staff member commented that they had googled me, another that they had checked out my Twitter account, and one staff member had read some of my previous research. I thus felt that being seen as a researcher granted me a sense of credibility in the eyes of the staff. I felt this was helpful in terms of how they engaged with me.

I also positioned myself with staff as a lived experience researcher. I was initially concerned about how staff might feel about a service user doing this kind of research. However, there were many times when staff were making jokes about service users or making negative comments about their behaviour, and this indicated to me that staff were unlikely to be modifying their talk or behaviour in my presence. At the same time, there were a couple of instances where the Ward Manager apologised to me for "the way things were said" in handover. This perhaps positioned me as an outsider who might be making moral judgements upon the staff team.

When the Activities Coordinator introduced me in community meetings as "one of the team," this posed problems for me in terms of negotiating my identity with service users. I wanted to stress that I was not on ward staff, and that study participation or otherwise would have no impact upon their care and treatment. Since I had an access fob I would also at times be asked to let women into the female wing or grant entry/exit to the ward (which I obviously could not do).

Service users also commonly referred to me as the researcher. On a number of occasions, I overheard a service user-participant encouraging another service user to take part in the study, saying "you should really talk to Andrew about that" or "I'm sure the researcher would be interested in that". This positioned me as someone to talk to, and who would listen to them. This was encouraging to me as I was often concerned that my presence was an intrusion. Staff also commented on the rapport that I had with service users. I felt that I had to negotiate my identity more with service users in that I often had to emphasise that I could not advocate on their behalf or make any comment in ward rounds.

3.6.1.2 Reflexivity and interviews

The ethnographic interviews with service users were built upon an already established sense of rapport, created via everyday interactions, and limited self-disclosure, fostered during prior observations. Whilst critical ethnography positions interviews as a collaborative space that seeks to grant equity between researcher and participant, I found this hard to actualise.

With staff interviews, I was concerned that my lived experience/service user position might incline staff towards socially desirable responses, particularly around their views on service user involvement. However, I felt that my established position as the researcher was helpful in terms of fostering a sense of credibility. I also felt that I had achieved a kind of insider status that created a sense of equity between us.

3.6.1.3 Reflexivity and analysis

I was keenly aware of the power I possessed in the co-construction of findings. Prior to the formal coding work of data analysis, I re-scrutinised my own experiences, perspectives, and presuppositions so that these were laid out as explicitly as possible in my journal. Where identified codes cohered with my own perspectives and experiences, I would look for multiple attestations to the theme as a check against imposing my own values onto the data. Having identified a theme, I would also look for discrepant perspectives and experiences that might not fit the narrative being constructed. In this way, I allowed the data to challenge my preconceptions, noting surprising findings that did not meet my initial expectations. Throughout, I wanted to do right by my participants, both the service users, but also the staff too, who had been so generous to me during the study. I was also aware that the thesis will eventually be in the public domain, but as far as possible I did not allow that to paralyse the analysis, or to soften my critique. Whilst exposing dynamics of power, I did not want to be unduly harsh and as far as possible I tried to ascribe good intentions to staff, specifically noting where issues were more down to the organisational or bureaucratic context.

3.6.2 Dependability and credibility

The notion of data saturation was deemed inappropriate for the study paradigm (O'Reilly & Parker, 2012), instead the aim was to produce a *thick description* (Geertz, 1973) of the study setting through in-depth, intensive observations and interviews. Whilst some might argue that the quality of the study could have been strengthened by a multi-site study, I would argue that the depth and detail provided about a single site enables us to draw appropriate conclusions about the phenomena of interest. Neither the intensity nor the length of time spent on observations are themselves marks of quality (Tracy, 2010), however an intensive, four-month period of observation did allow me to build rapport, trust, and to establish my ethnographic self, all of which enabled me to build a thick description of the social context.

The aim of sampling in this study was not to attain statistical representativeness, rather it was to observe and speak to individuals who could enable the production of a thick description of the phenomena of interest in the social setting. A strength is that staff members from a range of different roles took part in both the study observations and the interviews. It was disappointing that the Locum Consultant did not want to be interviewed, but obviously that was within her rights. Similarly, service users with a range of different kinds of risk took part in the study.

Whilst rejecting all various notions of triangulation with their positivistic underpinnings (Blaikie, 1991; Hammersley, 2008), the combination of different data sources (the study observations and interviews) did add depth to the findings and allowed for comparisons and contrasts between what people say and what people do within the particular social context.

Observation of the key different spaces around the ward (apart from bedrooms or intimate care) and different forms of interaction also added depth to the findings, allowing me to construct almost the whole process of risk assessment and management. Whilst the consent processes were in place, one limitation is that I was unable to observe any admission (or clerking in) interactions of service users for reasons already recounted. Another limitation was that introducing the study to potential participants was inevitably framed by the PIS (see Appendix 4) which could have constrained participant's ideas about risk. However, it will be shown that some service users shared specific unique threats, identified by them as a form of risk, which suggests that some were able to conceive of their own ideas and definitions of risk beyond that of the study documentation.

The ethnographic interviews with staff and service users were all conducted after having spent a considerable amount of time observing on the ward. As such, I had built up relationships with participants prior to the interview interactions.

Some would argue that the ethnographer's reflexive diary should be considered as a data source. I took the decision not to do so, as I was already concerned about being overwhelmed with data, although this could be considered a limitation.

3.7 Summary

This chapter has provided a detailed account of, and rationale for, the methodology and methods of the study. It has situated the study in relation to social constructionism and standpoint theory as the philosophical orientation of the research. It has been shown that standpoint theory invests my own position as a lived experience researcher with epistemological and power significance. This chapter has also identified critical ethnography as a highly appropriate methodological approach, given its emphasis on illuminating dynamics of power and oppression operating in a particular social setting, and transforming social settings to benefit the lives of the marginalised and oppressed. The chapter has also detailed the process by which observations and interviews were undertaken within the social setting. It has also addressed ethical considerations, particularly around models of consent.

The research was conducted with the overall aim of addressing the question: “How do mental health service users experience risk assessment and management in an acute mental health setting?” Using abductive ethnographic analysis, findings have been generated which illuminates the service user perspective and experience of the phenomena of interest, which will be discussed in chapter five. Before this, a thick description of the acute psychiatric ward in which the study was set has been generated, which is detailed in the next chapter.

Chapter Four: Setting Description

This chapter will present a detailed description of the specific ward in which the study was set, which I will refer to using the pseudonym *Attenborough ward*. It will outline the physical and social environment, and the key people and their roles within the social setting. It will also detail key service user-staff interactions and will reflect upon the spaces where these interactions occur and the function of the interactions on the ward. How interactions serve risk assessment and management purposes will be a key concern of the chapter, to provide a thick description of the processes involved. This chapter provides the social context within which to frame the Findings on service user perspectives and experiences of risk assessment and management, which will be detailed in chapter five.

4.1 Introducing Attenborough ward

Attenborough Ward is situated in a hospital complex serving a predominantly white, working/middle-class, rural borough of approximately 114,500 people, situated in the Midlands. The hospital complex includes a main reception, a restaurant, a coffee shop run by volunteers, a cash point, and a prayer room and chapel. There is a free NHS WiFi connection throughout the hospital. The complex accommodates an Accident and Emergency Department, Children's Services, Maternity, Occupational Therapy, Physiotherapy, and various General Health wards.

Attenborough Ward is part of the on-site Mental Health Unit. On the ground floor, the Unit houses the local Crisis Resolution and Home Treatment Team, the Psychiatric Liaison Team (who attend A&E), Psychiatric Outpatient clinic rooms, medical staff offices, and a main reception. On the first floor are two inpatient wards, one for older adults aged 65 and over, and Attenborough ward itself. These wards are accessible by a staircase or via a lift. Attenborough Ward serves adults aged 18-65. It is a mixed-gendered ward of 24 beds, with two female bays (of five beds each), two male bays (of five beds each), and then four male side rooms. It is an acute psychiatric inpatient ward, as defined in the Introduction.

4.2 The service users

At any one time there could be a maximum of 24 service users on the ward – 10 female, and 14 male service users. Given the nature of the ward, service users were admitted due to both the acuity of their condition and any associated risks. Service users may be struggling with suicidal thoughts/intent and/or self-harm. Or they may be dealing with the mental health effects of alcohol or substance misuse, for which service users would be admitted for a detox. Service users could also be vulnerable due to their social circumstances. In terms of diagnosis, service users were commonly diagnosed with depression, bipolar disorder, schizophrenia/psychosis, eating disorders, and personality disorders. Service users could be informal, or they could be detained under the *Mental Health Act 1983/2007* initially for assessment (section 2) and could subsequently be detained for treatment (section 3).

4.2.1 A typical day for service users

At **06:00** the door to the whole Mental Health Unit downstairs is unlocked for the cleaners; at this point service users can take leave off the ward (status permitted). To be granted leave service users would have to be fully dressed, this was a hospital-wide policy with the stated aim of protecting patient dignity.

Between **08:00-08:30** breakfast is served in the dining room, where cereals, toast and spreads are available, brought up to the ward by catering staff. Service users were encouraged to attend breakfast either dressed in their day clothes, or in a dressing gown over pyjamas, this was due to the fact that it is a mixed-gendered ward. Unlike other mealtimes, staff did not go round the ward to announce breakfast, leaving service users to lie-in uninterrupted if they wanted to.

Around **11:00** most weekdays, a sweet trolley staffed by volunteers that goes round all the wards on-site, would usually arrive onto Attenborough ward. It sells sweets, chocolates, fresh fruit, soft drinks, bottled water, newspapers, and magazines. This was important to service users both for the snacks and also for the reading material, particularly if service users were not granted leave.

From **10:00-12:00** scheduled morning activities include:

Arts and crafts on Monday mornings, led by a volunteer who is an arts teacher from a local college, who facilitates craft activities in the dining room.

On Tuesday and Thursday mornings there is a music group held in the dining room. The two facilitators work for a provider of adult education, and their job involves working with various groups in the local community to provide musical courses. A file with copies of lyrics to various popular songs is kept on the ward, with service users then requesting their favourite tunes. The facilitators lead the singing, taking turns to play an acoustic guitar, with service users singing along or listening in. This was very popular with service users, who enjoyed the singing. On two occasions I observed service users becoming obviously distressed, and who later told me that a particular song had really resonated with them due to its personal significance to them.

There were no scheduled activities for Wednesday or Friday mornings, but the Activities Coordinator was around and could give access to art and craft supplies, stored in a locked cabinet in the dining room. The dining room tended to be a space where people did their own arts and crafts activities, such as knitting or crochet (under supervision). If people had no interest in crafts, they tended to gravitate to the lounge.

At **12:00** dinner is served in the dining room. Menus are on a two-week rotation (including vegetarian and vegan options), and service users fill in their preferences for their meals the day before. Meals come up to the ward in a hot-food trolley from catering. An HCSW usually goes round the ward to announce that it is dinnertime, and staff (usually the HCSWs) hand out meals on trays to service users once they are seated.

From **14:00-15:00** an arranged afternoon activity is an exercise group, run on alternate weeks on either a Tuesday or a Thursday afternoon. The facilitator is a mental health nurse by background and a personal trainer. To take part, service users complete a physical health questionnaire, which the Activities Co-ordinator asks one of the ward psychiatrist’s to sign. The group completes a combination of circuit training activities and yoga postures. There were no other scheduled afternoon activities.

During the afternoon, more people would typically locate themselves in the lounge to watch television. There is an open bookcase with various games and jigsaw puzzles, and another with various DVDs, which service users can access at any time. There was often a jigsaw puzzle on the go on a table which service users might take turns to work on.

From **17:00** supper is served in the dining room, again from a hot-food trolley from catering; sandwiches can also be requested by service users to eat later in the evening and stored in the staffroom fridge.

17:30-20:30 are formal visiting hours, but staff can accommodate visits at other times if visitor's phone ahead and check with staff. Depending upon their leave status, service users might spend some time off the ward with family or friends during this time. Alternatively, they could find a table in the dining room to sit around or meet in the Visitor's Lounge.

After supper, a staff member was usually able to facilitate games of pool amongst service users, or between service users and the staff-member. Pool cues, balls, and chalk were stored in the staffroom. These tended to take place after the MDT room was not in use by staff. Female service users were allowed to come up to the area to play pool during this time.

From **22:30** the downstairs door to the whole Mental Health Unit is locked overnight (leave is denied and requests for discharge after this time are discouraged, but staff do have a key if required).

At **00:00** the kitchen is locked (but it can be unlocked if service users later request a hot drink). The television in the lounge is programmed to automatically shut down as an encouragement for service users to go to bed, but it can be manually overridden by staff.

4.3 Regular ward staff

4.3.1 Staffing and roles

During the period of the study observations, the ward was being run by an interim Ward Manager (who is a senior mental health nurse) and two senior Charge Nurses. There were ten permanent nursing staff and one long-term vacancy (this went down to nine nurses and two vacancies when someone resigned to take up a post elsewhere towards the end of the observations). There were 12 HCSWs and four long-term vacancies. One HCSW was a Trainee Nursing Associate who had recently started a university course. Bank staff were taken from a regular pool of about six staff; this meant that bank staff were well-known to the staff team and to service users.

Whilst I was on the ward, medical care on the ward was mostly overseen by a Locum Consultant Psychiatrist, who was covering whilst the regular ward Consultant was off sick. Under the Locum Consultant, there were also three Psychiatrists working on the ward.

Other regular staff included an Activities Co-ordinator (an HCSW by background), an Environmental Co-ordinator, and a Ward Clerk. There was no Occupational Therapist, or a Clinical Psychologist, or a Peer-Support Worker working on the ward during my time there.

The management, nursing, administrative, domestic, and support staff on the ward wore a uniform consisting of a different coloured T-shirt by role. The Ward Manager, Charge Nurses, Staff Nurses, and the Activities Coordinator all wore a black T-Shirt, the Trainee Nursing Associate was in grey, the HCSWs in light blue, an Environmental Co-ordinator in dark pink, a Ward Clerk in yellow, and domestic staff in light pink. A poster with all this information was displayed on a noticeboard near the front entrance.

4.3.2 Shifts and work

Staff could work Early (07:00 – 15:00), Mid. (09:00 – 17:00), Late (13:30-21:30), or Night (21:15 – 07:30) shifts.

On any given shift there would be two nurses and two, or ideally three, HCSWs. On a ward round day, another nurse (working 9-5) would be responsible for documenting discussions and decisions in ward rounds. Nursing duties within the Nursing Office consisted of various forms of administration, such as: entering a "patient summary" on the system for each service user during each shift (see below), entering summaries of any one-to-one interactions (see below), managing referrals for service users' ongoing accommodation, or referrals to other units, booking-in community mental health workers for attending ward rounds, liaising with bed management regarding any recent discharges or impending admissions, arranging *Mental Health Act 1983/2007* assessments or tribunals, typing-up a handover shift summary (see below), liaising with pharmacy, taking telephone calls, and uploading physical copies of documents onto the system. Nurses were also responsible for medication rounds (see below), and observation duties (more below) could be shared between nurses and HCSWs.

The Locum Consultant, and ideally two of the other Psychiatrists, would be present at the doctor's handover or "morning meeting" (more below), and would attend ward rounds (more below). In addition to this, the ward Psychiatrists would also do some of the more complex physical health checks, such as ECGs, and would take detailed "patient histories", and conduct "mental state examinations." BP, bloods, or taking samples could be managed by Nursing or trained HCSWs, or phlebotomists would come onto the ward for more regular blood tests on Tuesday mornings.

The Activities Co-ordinator (working 09:00-17:00, Monday to Thursday) oversaw the music and exercise groups, crafts, games and puzzles, gardening, special events on the ward, and outings off the ward. The Environmental Co-ordinator (working Monday to Friday 09:00 – 13:30) was responsible for the ward's physical setting, and a Ward Clerk (working Monday to Friday 09:00-17:00) supported the Ward Manager. The Early cleaning shift (07:30-13:30) is covered by a regular domestic worker (the evening cleaning shift (16:00-19:00) was covered from a pool of cleaners).

An Assessment Practitioner attended most ward rounds on Mondays and on Fridays. She was a representative from the Trust's bed-management team. She was also available for one-to-one appointments with service users to discuss issues around housing and benefits, particularly to enable smooth discharge back into the community, and to try to avoid unnecessary delays in discharge.

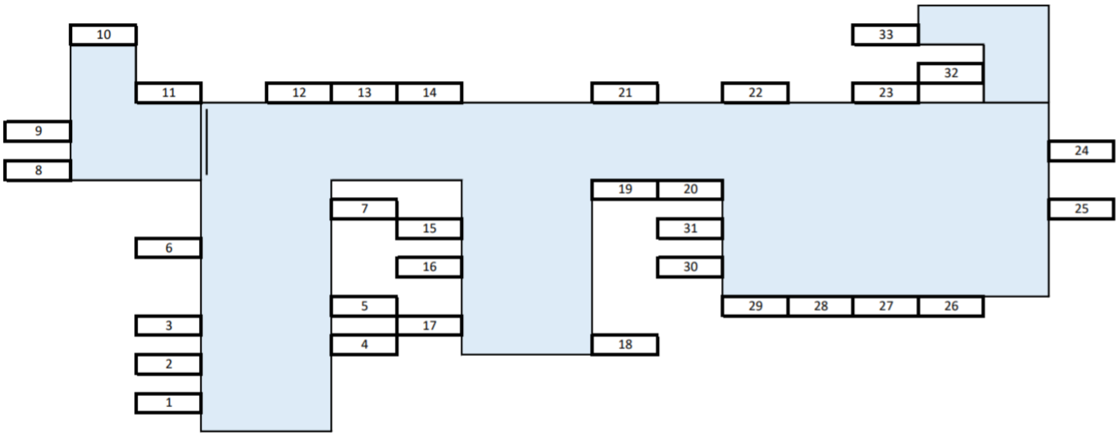
A Smoke-Free Worker aimed to help service users to stop smoking, who works Tuesdays and Thursdays; she was responsible for monitoring physical health in relation to smoking, to offer help and advice, and low-level psychological input to support smoking cessation.

Two Pharmacists would visit the ward (one on a Tuesday, another on a Thursday), particularly to offer advice to staff around medications. They could attend the doctor's handover, where their input might be sought, particularly around combinations of different medications, or side-effect management.

On Wednesday afternoons someone from the hospital Chaplaincy would often come onto the ward to talk to service users about their spiritual needs; they could provide religious texts, offer prayer/meditation support, and could also facilitate visits to the on-site prayer room and chapel.

A Feedback Volunteer came onto the ward on Wednesday afternoons to assist service users in completing the Trust's feedback form evaluating their services, if they wanted to. The Activities Coordinator emphasised the importance of this, as a means of collating feedback from service users who might not be vocal at Community Meetings (see below). Service user feedback on staff performance and on the ward-environment was important to staff, and they were keen to learn how to improve the whole admission experience.

4.4 The physical environment



Corridor:

1: Admin Office

2: Nursing Office

3: Dining Room

4: Ladies Lounge

5: Clinic Room

6: Kitchen

7: Manager's Office

Female Wing:

8: Shower

9: Bathroom

10: WC/Bay

11: Bay

Corridor:

12: Cupboard

13: Storage

14: Lounge

15: Male Shower

16: Male Shower

17: Laundry

18: Cleaners

19: Cupboard

20: Meds Clinic

21: Male Bay

22: Male Bay

23: Disabled WC

24: Side-room

25: Side-room

26: MDT Room

27: Side-room

28: Side-room

29: Bathroom

30: WC

31: WC

Staff Wing:

32: WC

33: Kitchen

Figure 9: Floor plan of the ward

Entry/exit to the ward (by room 1) was via a staff-member's key-fob, and access to the female wing and the staff wing were also enabled via the key-fob. Rooms 5 and 20 were kept locked, but they could be accessed by staff via key when needed. Rooms 9, 15, 16, 17, and 29 were kept locked and could only be accessed via staff keys, hence service users would have to request access to these rooms. Similarly, the cupboards (rooms 12, 18 and 19) could only be accessed via staff keys. Room 13 was a storage cupboard for those belongings that were considered prohibited, but which could be requested for use by service users and used under supervision.

4.5 Key Interactions

4.5.1 Mealtimes

Mealtimes in the dining room (room 3) were rare occasions when all, or a large proportion of, the service users would be together in one social space, much less so for breakfast (08:00), but particularly for dinner (at 12:00) and supper (at 17:00). It was recognised that mealtimes might be a cause of anxiety for some service users. Service users could request to eat on their own in the Ladies Lounge (room 4), this would only be granted by staff if there were issues around paranoia or social anxiety; this was provided for two service users during my observations. In one other instance staff would sit in the Ladies Lounge with a service user who had an eating disorder to try and create a better environment for her, but also to monitor and subsequently document her food and fluid intake. Other than for those reasons, hot meals and utensils could not be taken out of the Dining Room and staff particularly ensured that utensils were returned to them.

4.5.2 Medication interactions

Medication rounds occurred throughout the day for the dispensing of scheduled medications. At each medication round two nursing staff would set up within the Meds Clinic (room 20) for the medication round, opening the top-door of a stable door and leaving the bottom door shut. The morning medication round would commence around 08:30 after breakfast had been served. Usually, an HCSW would go around the ward and ask relevant service users to queue up for their morning medications. Similarly, at midday, two nursing staff run the medications clinic for service users to queue up, where applicable, often prompted by an HCSW. In the afternoon, medications can also be dispensed at 14:00 and 16:00, as these are not the more regular dispensing times then medications were dispensed by two nursing staff and typically taken by one of them to individual service users. Regular night-time medications are dispensed from 22:00, which again service users queue up for at the Clinic Room. When dispensing, staff had a medication chart detailing the name of a medication and dose. One nurse would dispense, the other check the details. The chart had a service user's photo (taken on admission) stapled to the top right-hand corner, this was to concretely identify the individual, instead of having to ask them for their date-of-birth.

Service users would queue down the corridor. Only depot injections would be given in the Clinic Room itself when the top-door of the stable-door would also be shut (these were not part of the study observations to protect individual's dignity and privacy). A small minority of service users particularly objected to queueing-up for medications and were concerned about issues of confidentiality. Staff tried to maintain a sense of personal space between service users as they queued.

If a service user was taking a new medication, staff would routinely explain what the new tablet was called and what it was for. There were three instances where a service user had not known that they had been started on a new medication, which appeared to cause some initial unease. There were also particular service users who would express that they felt that they did not need the medication, but they took it anyway. Furthermore, there were cases when service users "refused" (this was the staff terminology) to take medication. In these instances, informal service users would have this documented on the medication chart itself, and this would feature in the next handover, and particularly in the doctor's handover, and would be brought up in the service user's next ward round. Detained individuals would be moved from oral to depot;

this would also be the case if staff suspected that detained individuals were secreting oral tablets.

In addition to the dispensing of scheduled medications, service users could also be prescribed PRN (from the Latin *pro re nata* meaning “when necessary”) medication. PRN was typically prescribed when it was anticipated that service users might have periods of agitation or distress, or for pain, or for insomnia. If already prescribed, PRN could be requested by service users according to circumstance or need. Service users would often have to request PRN either by catching a staff member in or around the Clinic Room, or by approaching a staff member directly, or by knocking on the Nursing Office door. Alternatively, service users might already be in an interaction with a staff member (such as a ward round or one-to-one) and they may be offered their PRN based on their presentation. PRN could typically be requested at any time of the day, although 02:00 is the latest that a sleeping tablet would be dispensed.

Staff attitudes towards PRN dispensing varied. For some nursing staff, since it was already prescribed for the individual, if the individual felt they needed it, then staff reasoned that it should be dispensed; any subsequent concerns about a perceived over-reliance on, or misuse of, PRN should then be an MDT matter, rather than a decision of the individual dispenser. Some nursing staff stated that other coping strategies should always be explored with the individual prior to being given PRN, with PRN seen as “a last resort.” Some stated that their PRN dispensing would be dependent upon the individual’s presentation and whether there was a clear clinical justification. Many service users felt that they were rarely offered the opportunity to explore alternative means of coping, although some had been offered one-to-one time prior to obtaining PRN. A minority reported feeling disbelieved by staff when their request for PRN was denied.

Following a decision to discharge, staff would have to sort out the individual’s medication, referred to as TTOs (meaning “to take out”). Staff would liaise with pharmacy to ensure that at least a seven-day supply of TTOs were dispensed. Of the 13 discharge meetings observed (more below) in 12 instances the individual had to wait on the ward for their TTOs to be dispensed by pharmacy and brought up to the ward. These individuals were typically waiting two to three hours for their TTOs. In one instance, staff wanted a quick discharge, and were less concerned about the individual’s “concordance” with medications, and so the individual was given a prescription-note to take to a community pharmacy. Some PRN medications (such as benzodiazepines) were not prescribed in TTOs, and service users had expected them to be, causing some concern to three discharged individuals observed. They were left feeling that they had not been adequately prepared for discharge in that respect.

4.5.3 At the Nursing Office

The Nursing Office (room 2) has three desks, two with desktop computers, a whiteboard, filing cabinets with blank templates of various documents, and a shelving unit storing patient notes in files and learning resources for staff. A safe in which service users’ money or bank cards could be safely stored was located here – this was to protect items in safe storage. On the whiteboard are written service users names in rows (from the occupant in bed 1 to the occupant in bed 24) and columns with: the service user’s name, “electronic records patient number” (for access to a patient’s records on the system), *Mental Health Act 1983/2007* status and review dates, estimated date of discharge, observation-level, leave status, and named nurse and keyworker (see below). Due to the sensitive nature of this information, staff were very reluctant to invite service users into the office, and so interactions were held at the threshold to the office or taken to the Visitor's Room or Clinic Room opposite.

Nursing staff had a considerable amount of administrative responsibility (outlined above). When staff were making phone-calls the door to the Nursing Office would be kept closed, the stated rationale being due to confidentiality. Similarly, if staff did not want to be interrupted in their administrative work the door would be closed. This meant that, more often than not, the Nursing Office door was closed during the working day. The main exception to this was during the night shift, when the door largely remained open throughout the shift, as the volume of telephone interactions was much reduced. The main impact of this for service users was that if they had a need, and no staff was available elsewhere on the ward, they would usually have to knock on the door for any assistance. They would then have to wait until a staff member could attend to them and come out of the office-area to discuss their need. At times agitated service users felt that they were left waiting, thereby adding to their distress.

4.5.4 Entry/exit

As a locked ward, service users would have to be let off the ward by staff via a key fob. One of the main reasons service users knocked on the Nursing Office door was to request leave. However, as lighters, lighter fuel, matches, cigarettes, papers, tobacco, or filters, belonging to service users were stored in the Administrative Office (room 1; to ensure that no smoking of cigarettes happened on the ward) staff based there also managed requests for a cigarette break.

Informal service users had no restrictions on leave so could come and go as they pleased during the day (although if they were spending too much time off the ward staff would question whether their admission was beneficial). Conditions of leave for every service user were recorded on the whiteboard in the Nursing Office and was based upon their *Mental Health Act* status. Leave status and conditions of leave for service users who had been on the ward for some time, were well known to staff, otherwise staff would have to go and check the board prior to granting leave. Staff would remind individuals of their conditions of leave (such as length of time off the ward) prior to allowing them out. There is also a small garden on the ground floor which can be accessed with staff, which does not count as leaving the ward for the purposes of *Mental Health Act* status.

Some service users would be asked "Do you feel safe to leave?" Over time, it was observed that this was particularly asked of service users who were commonly regarded by staff as a risk to self. This question was also asked if individuals had recently been seen by staff to be obviously distressed – sometimes staff checked whether the individual wanted some downtime on the ward instead, or a one-to-one to talk. In one case, I observed a nurse having a brief one-to-one with an individual who had just been made informal to check where he would go, how long he would be, and whether he could "keep himself safe."

Some service users would be subject to "safety checks" on their return to the ward. Staff referred to safety checks for the process of looking into people's bags to see what their contents were. It became clear that not every service user was subject to safety checks on their return from leave. One individual who was known to bring items onto the ward with which she might injure herself had her bags checked whenever she returned to the ward. Similarly, where there was a concern that someone might (deliberately or unintentionally) bring cigarettes, or illicit substances, or alcohol onto the ward, they would also have their bags checked. Staff were also checking for other "contraband" items, such as nail files, scissors; batteries; nail polish/polish remover; large amounts of papers etc; long leads, chargers, and earphones – these needed to be handed in to staff for storage. A poster listing items to be given to staff was displayed on the inside of the Patients' Storage Cupboard door (room 13); all of which were identified by staff as items that people might harm themselves with in some way, or that might pose an environmental issue (e.g., papers). These checks would be complemented by environmental checks of bedspaces (led by the Environmental Coordinator) conducted at least once a month, and once I observed a police sniffer-dog team come onto the ward to check for illicit substances.

4.5.5 Ward rounds

Ward rounds were MDT meetings that service users were invited to attend largely for the purpose of making decisions about ongoing care and treatment. 61 ward rounds were observed for 30 different service users, with the meetings ranging from 3 – 57 minutes (mean 17.36). They were held on Mondays, Tuesdays, Thursdays, and Fridays in the MDT Room from approximately 10:00 to around 15:30. Typically, six to seven service users would be seen in a day. Each individual was allocated a 30-minute time slot, although these ward round slots could overrun. Attempts were made for service users to be generally seen on the same day each week, at roughly the same time, where possible. Times were displayed on the whiteboard opposite the Nursing Office so that individuals and any accompanying guests had a rough idea as to what time they would be seen and their place in the queue. Staff might also want to check-in with individuals at other times, meaning a service user might have more than one ward round in a week. Individuals could request to see the consultant at other times, for instance, if informal service users requested discharge, it was ward policy that this should be handled in an MDT setting, if at all possible.

The MDT Room (room 26) is quite a tight space, it has a computer desk at which the nurse responsible for documenting the ward round would be sat. Then there are eight other chairs around the room. There was an unspoken rule as to who sat where. One of the chairs was typically designated by staff as "the patient's chair." It was different from the rest in that it had a waterproof covering, and staff reported that that was due to some service users experiencing issues with incontinence. The chair was also situated by the door to allow ease of access or departure. One service user also commented on there being a demarcated patient chair, saying "it's piss-proof", adding that it contributed to a feeling that service users were "being treated like kids". Directly opposite would be "the Consultant's chair" and then the other attending psychiatrist would be seated directly next to her.

The ward rounds typically involved a core group of three staff members consisting of the Locum Consultant, another Psychiatrist, and a Staff Nurse (n=22). However, one (n=8) or two (n=6) or three (n=3) additional staff could also be present, who would be either another Psychiatrist, another Nurse, and/or the Assessment Practitioner. In the periods where there was no Locum Consultant, again there was a core group of three staff members consisting of two Psychiatrists and a Staff Nurse (n=14) but one additional staff member (n=7; either a Nurse or the Assessment Practitioner) might also be in attendance. Staff regarded each core group as "essential staff" and stated that they constituted the minimum number of staff required for the ward round to function. Where numbers exceeded the core of three staff present, and particularly when they were at the higher end, service users were sometimes asked whether they were happy with who was present.

During the period of observation, I never saw a HCSW present at a ward round (although I was informed that they could be invited to attend). In addition, some service users had an existing relationship with a community mental health worker, and they too could be invited to ward round. I observed two Social Workers and seven CPNs attend ward rounds (one attended twice). These staff were typically invited either to offer an account of events leading up to admission, or to ensure a smooth discharge, often including agreeing to do a follow-up with the service user within seven days. Nine service users also brought a family member and/or a friend along to support them.

In the ward rounds in which the Locum Consultant was present (n=44), the conversation was typically directed by either herself (n=21), or by the other Psychiatrist present (n=4), or between the two of them (n=4). By direction I mean that they posed questions to the service user, commented on their responses, fielded the individual's questions, offered advice, and proposed treatments and solutions. It is noteworthy that on eight different occasions the Locum Consultant referred to the encounter as an "interview" and a few service users referred to it as being like "a job interview." In these instances, the role of the Staff Nurse was largely limited to typing up the notes on the computer. However, in 13 cases the Staff Nurse present (either one of the senior nurses or a long-standing and experienced Staff Nurse) played a more active role. This was seen in them asking questions of the service user and contributing their advice or perspective throughout. Similarly, when the Assessment Practitioner was present, she too played a very active role in the discussion. This made the interaction feel like more of a Multi-Disciplinary Team meeting (which is how nursing staff framed all of these interactions). In the periods where there was no Locum Consultant (n=17), the conversation was typically directed by the Psychiatrist (n=10), but again there were instances in which the Staff Nurse present (n=7) played a more active role.

Two approaches to the observation of ward rounds were conducted, in one approach I was already in the room when the service user entered and remained there when the individual left (n=30), and in another approach I entered the room with the service user and then accompanied them out afterwards (n=31).

The first approach enabled me to see how staff briefed one another before the individual entered the room and then how they debriefed afterwards. Initial summaries about a service user (n=8) were given because, either the Locum Consultant had just started, or because the individual themselves were new to the ward. There were occasional instances in which a brief progress update was given (n=5) prior to the ward round. In 17 instances, however, there was no prior conversation of relevance. There were also limited instances of de-briefing (n=11). Thus, in 19 instances there was no subsequent conversation of relevance.

The second approach enabled me to observe how service users experienced ward rounds more closely. A number of participants reported "feeling anxious" either to a family member waiting with them, or to me directly, immediately prior to a ward round. On a few occasions service users were forewarned about the number of staff that would be present and told that they could ask for some to leave if they wanted (although I never saw a service user say that they wanted that). After the ward rounds, service users often reported that they had felt intimidated either by the numbers present or by the manner of the Locum Consultant. I also observed five cases of staff following-up service users in different ways due to distress caused by the ward round conversation. In two instances we left the ward round meeting with the service user in obvious distress and the staff nurse also left the room and came to check that the individual was okay. In one other instance, the nurse came out and gave a brief verbal handover to an HCSW, asking them to spend time with the individual, again because they were in obvious distress. In two further instances, service users were directly followed up after the day's ward round session was completed to arrange a time for one-to-one sessions to discuss what had happened in the ward round itself.

In terms of preparing for ward rounds, four people brought prepared notes with them. One service user brought both a poem to read out and a summary list of her feelings to a ward round. Another came with a list of questions and a summary statement of her condition to read aloud. A third brought a list of issues to raise to one ward round and a summary statement to read out to the next. Finally, the fourth individual twice wrote down a summary statement which she handed over to the psychiatrist for him to read out. With those who had brought a list of questions or issues to raise, the leading professional would ask them what questions or issues they had, and these would be gone through point-by-point. With those who had brought summary statements, they would either read them out or pass the statement on for the psychiatrist to read out, usually towards the beginning of the interaction. Staff would then ask for permission to include them in the notes (they could be uploaded onto the system). It was not obvious, however, that the summaries shared were then guiding the subsequent conversation.

Typical features of ward rounds included the exploration of mood/feelings, often asking individuals to rate their mood on a scale of 1-10. Mood was tracked in the course of the admission in cases where service users expressed: feeling low with suicidal thoughts and/or intent, and/or with self-harm, and/or with an eating disorder, and/or were experiencing withdrawal effects of alcohol or substance misuse, and/or were being impacted by voices, and/or were struggling with sleep, and/or were aggressive towards staff or other service users. Thoughts of harming self were explicitly probed in direct questions, including whether individuals felt they had reasons to live (what staff referred to as "protective factors"), and whether they had a positive plan going forward and/or felt hopeful about the future. The impact of sleep, diet, activity, and engagement with staff were also monitored and routinely explored by staff in ward round in relation to mood.

Another typical feature of ward round was exploring the circumstances leading up to, and reasons for, admission. Staff routinely asked individuals to give an account of their social circumstances prior to admission and the chain-of-events leading up to admission. Often service users had a clear recollection of events. Others had a hazy sense as to what had happened, but they could see there was a clear rationale for their admission and for them remaining on the ward for support and treatment. However, some did not believe that they should be treated, often commenting that they "were taking up a bed" unnecessarily. At times, a community mental health worker had been invited to the ward round to offer *their* account of events leading up to admission and to present *their* case as to why the individual should remain on the ward for ongoing assessment. Staff also often asked the individual directly as to why they thought they had been admitted. In these instances, discussions often turned to whether the person believed they were ill (framed as an issue of insight, particularly associated with psychosis) and whether they felt they needed treatment (in the form of medication). It is these individuals who were often detained under the Mental Health Act first for assessment, and then often for treatment.

Interestingly, these discussions rarely explicitly featured the language of risk, even though from handovers, one-to-ones, and the occasional ward round pre-briefing, it was clear that staff and service users regarded many of these issues (such as suicide and self-harm) as risks. In the Findings chapter, I will consider the significance of the Locum Consultant asking a Psychiatrist to "screen for risk." I will also consider how service users used the language of risk in ward rounds as a means to challenge authority.

Of the 61 ward rounds observed, 13 were explicitly discharge meetings. These meetings were the final ward round before the individual would be discharged from the ward. These meetings ranged from 3-25 minutes (mean 9.06). 12 of these meetings were planned discharge meetings, meaning that staff and service users had been working towards an estimated date of discharge, and it was now agreed that discharge would take place. However, one was unexpected to the service user and was only announced to them at the ward round itself, this informal service user was discharged due to him breaking "the terms" of his admission (he had drunk alcohol whilst on leave, but he had been admitted for a detox). During these meetings mood and thoughts of harming self were again explored, along with readiness for discharge, and whether the individual felt safe to be discharged, including staff pronouncements that they felt the person was indeed safe for discharge. Whether the individual was being discharged to safe accommodation was also checked. Other practical arrangements around medication dispensing (TTOs), planning who would conduct the seven-day follow-up in the community, noting Crisis Team contacts, and waiting for a discharge summary, were also discussed.

4.5.6 One-to-ones

On admission, every service user was assigned a "named nurse" (or sometimes referred to as the "primary nurse") and a keyworker (either another nurse, or a HCSW). These staff allocations were written up on the patient-information whiteboard in the Nursing Office. These staff would be responsible for offering a service user time and space with them individually in a private setting (referred to as one-to-ones). There was an expectation that one of them would meet with their allocated service user at least once a week, meeting either in the Clinic Room (room 5) or the Ladies Lounge (room 4). Staff were expected to arrange times with individuals for these interactions. There was also an expectation that service users should know who their allocated staff were. (Some said publicly in Community Meetings that they did not know who their named nurse was, others mentioned that to me in the course of my observations, and during interviews). In addition to planned conversations, service users could also spontaneously request one-to-one time, either with their named staff (if they were on shift, and if they were known to service users) or with another staff member. This was often initiated on the basis of a need, or because they were anxious, or if they were distressed.

I observed nine service user-staff one-to-ones, with a range of 2-24 minutes (mean: 8.22). Two of these were planned meetings, one to risk-manage following how a problematic ward round had gone the previous day, another to risk-manage self-harm (see Findings for more detail). Two were initiated by staff to follow-up with individuals following a ward round which had caused obvious distress. Another was initiated following a service user being made informal, to check on him prior to him taking leave. One was to check everything was fine just prior to a service user's discharge. Three were spontaneous requests from service users for one-to-one time, where individuals had taken initiative to knock on the Nursing Office door to ask for help and assistance.

Unlike ward rounds, where the explicit use of the term risk was restricted to securing particular purposes (either staff "screening for risk" or service user's challenging authority; see next chapter), risk-language was a more common feature of the one-to-one discussions I observed. In two cases, risk-management strategies were explicitly being passed on by staff to service users. In another, a service user was concerned about appearing to be a risk in ward round due to how she communicated there. Service users also expressed concerns regarding what was being documented about them in terms of risk. These issues will be explored more in the next chapter.

There was considerable variation in provision of one-to-ones with some service users saying they happened frequently, others that they had not been offered any such time. There were also differing views as to who initiated these, with most service users feeling that they had to request one-to-one time.

4.5.7 Community meetings

Community meetings were planned sessions which all service users were invited to, and were encouraged to, attend. It was primarily to give service users a chance to provide verbal feedback to staff about their ongoing experience on the ward. Other than mealtimes, this is the only occasion in which all service users might be together in one social space. This was seen as an opportunity for service users to get-together as a community. These meetings were facilitated by the Activities Coordinator, with one of the nurses, and an HCSW in attendance. The meeting was held in either the Dining Room, if directly after lunch, or in the Lounge if later in the afternoon. I was told that community meetings would happen every week on a Wednesday afternoon. In fact, these meetings were held sporadically, depending on the availability of the Activities Coordinator, such that, if she was too busy, or otherwise engaged, these meetings would not be held.

In addition to the community meeting in which I was first introduced to the ward during my acclimatisation visits, I formally observed three community meetings. These meetings lasted for 19, 12, and 26 minutes, respectively. These would begin by the Activities Coordinator introducing the other staff present (including myself) and to explain the purpose of the meeting in terms of obtaining verbal feedback. The group would also be told that a Feedback Volunteer came onto the ward on Wednesday afternoons to assist them in individually completing the Trust's feedback form evaluating their services, if they wanted that. The Activities Coordinator then informed the group of any upcoming special events (which, during my observation period included a Halloween evening, and a Christmas period of events). She then reminded the group of the regular planned activities on the ward, and of the arts, crafts, and games available.

Following the introduction, discussion would be opened-up to the group by asking an open question, "How are people finding their time on the ward?" or "How are you all finding things here?" Individuals generally shared environmental concerns, such as the toilets being unclean, the plastic-covered bed-mattresses being uncomfortable, the poor quality of the vegetarian food, doors making too much noise as night-staff conducted observations, and concern about being able to smell cigarette smoke in the toilets. This last issue was flagged as an "environmental risk" (and had already been discussed by staff in handover) and the Activities Coordinator announced that staff would be routinely checking the bedspaces. The group was assured that other matters would be shared with the relevant staff (domestic, for the toilets; catering, for the food; night-staff, for observations). Other areas were said to be out of staff's control (the mattresses). Other issues raised were about ward processes, particularly around who to share concerns with. The Activities Coordinator talked about the named nurse system, and some service users expressed that they did not know who their named nurse was, and staff said they would check.

Minutes were taken of the meeting by the Activities Coordinator who would type-up an anonymised account of the meeting, to be displayed on the noticeboard in the Dining Room entrance. These would indicate both bullet-points as to what was discussed and who was responsible for actioning any points raised. I checked these minutes against my own notes of the interactions and there were no missing items.

4.5.8 Handovers

At the beginning of each shift (approximately 07:00; 09:00; 13:30; and 21:15), a staff member from the previous shift would lead a handover meeting for staff starting the next shift. Handover notes would have been typed up by a staff member at some point during the previous shift using a standard A4 template, which incorporated: the service user's *Mental Health Act* status (e.g., informal; Section 2; Section 3), their observation level, their leave status (e.g., general, or general escorted), their diagnosis, any issues over a seven-day period, including any identified risks, and how the individual has been over the last shift. Handover would begin with presenting the individual in bed allocated number one through to the individual in bed allocated number 24.

The "morning meeting", or sometimes referred to as "the doctor's handover", was the longest and most detailed handover meeting. 43 morning meetings were observed, with a range of 18-73 minutes (mean: 41.14). It was attended by the most staff, including the Ward Manager, the Nurse-in-Charge, the Locum Consultant, the Psychiatrists on shift, the Ward Clerk, and other nursing and support staff, including the Activities Coordinator.

I only noted the handover details of service users who had consented to take part in the observations. Identified risks would be repeated by staff in handover over a seven-day period, meaning I had time to consent individuals before their initial risks dropped off the handover discussion. Handover was the clearest indication as to how staff conceived of an individual's risk. Initially handover would pass on an individual's reported and perceived risk on admission. Any risks encountered during admission would then feature in the handover discussion over a seven-day period. Staff were also concerned with how individuals had "presented" (the staff terminology) over the last shift. This would often feature staff interpretations of how service users had seemed, but it might also include passing on things that had been said. At times, staff might disagree with one another about an individual's presentation. The handover often identified administrative tasks for nursing staff to follow-up, or for issues to be discussed in ward round, or flagged need for one-to-one time.

4.5.9 Observations

Staff reported that the level of observations for each service user are decisions made by nursing staff initially on the individual's arrival and then throughout their admission. Staff based their decisions on the views of referring agencies (such as Community Crisis Team or Psychiatric Liaison in A&E), in addition to their own "initial assessment of risk" during their admission discussion (or clerking-in). This involved an assessment of whether an individual is a risk to themselves (largely concerns about suicidality and/or self-injury), a risk to others (concerns around violence and aggression), or at risk from others (concerns about vulnerability). Where the risks are low, service users would be assigned to general observations, where the risk was higher, service users would be assigned to intermittent observations, and where the risk was high, they would be assigned to one-to-one observations. Every individual's level of observation was reported in all handovers. Where a service user was admitted overnight on intermittent or one-to-one observation, the observation level would be discussed and reviewed during the handover to the early shift. Staff reported that they aimed to downgrade the observations level "as soon as they felt it was safe to do so".

The minimum level of observations for all service users on the ward is hourly checks referred to by staff as *general observation*. This was a task that could be completed by nursing or support staff, including any bank staff on shift. Every hour a staff member would be assigned responsibility for checking every area on the ward and every bedspace. They would also refer to the noticeboard in the Nursing Office to check who was out on leave. As the staff member moved around the ward, they would note down the exact location of each individual at that time, and they could record any concerns on a standard template attached to a clipboard. Service users were ordered on the template by bedspace number (1-24). During the day, whilst I had no access to the female corridor, I often observed staff knocking on the doors to the male bays prior to entering and I always observed staff knocking on the side room doors before entering. Typically, staff would say something like "I'm just checking you're okay." Other than that, I observed limited interactions during these clinical observations. Overnight, general observations continued every hour, with the staff member quietly entering the male bay to check each bedspace. Side rooms could be checked by unlocking the opaque glass windows on the doors to look directly in, or by opening the door slightly. At times staff also used a dimmed torchlight.

The next level of observations is *intermittent observations*, which are recorded every 10 minutes when the individual is awake. These could be lowered to every 30 minutes when the individual is asleep, which staff reported would be based on their clinical judgement. More intensive observations are one-to-one observation *within eyesight*, and one-to-one observation *within arms' length*. In each instance, individuals would typically be in their bedspace or side room. In within eyesight observations the staff member observing could sit by the door to the side room, or towards the end of the bedspace, as long as they remained within eye contact of the individual at all times. Arms' length observations meant that the staff member literally had to be always within touching distance of the individual. Given the closeness of these observations, which would be in place when the individual showered or used the toilet for example, male staff would be assigned to observe male service users and female staff to observe female service users one-to-one.

Zonal observations were undertaken by staff members when, in very rare circumstances, a female service user with complex needs had to be placed in a male side-room. This happened in one instance, where staff felt it was both for the benefit of the lady herself and for the benefit of the other ladies in the female dormitories. A staff member would have to stay located near the area (or zone) when the lady was in the side-room. This was both to ensure that she did not enter any of the male bedspaces or side-rooms and that none of the males entered her side-room. Similarly, when workmen were on the ward fitting anti-barricade doors throughout the ward, zonal observations were initiated, and a staff member had to situate themselves in the zone in which the work was taking place.

4.5.10 Documentation processes

The Trust use a web-based electronic care record system which provides a single-source of information about individual service users. The system can be accessed throughout the Trust by all relevant staff. The system was designed to replace handwritten patient files. All permanent staff working on the ward have access to the system.

During every shift, a "patient summary" will be entered on the system. Staff reported that they use an acronym "MONITOR-SP" as a mental aid to completing the summary: Mood/Mental state; Observation level; Note appearance; Individual time; Therapeutic activity; Other needs; Risk; and then the more recently added: Smoke free and Physical health. Thus, any one-to-ones (individual time) would be factored into the shift summary. Risk was also a key factor in each shift summary, informed by one-to-ones, ward rounds, and/or any incidents.

Service users are asked to fill-in a standard Care Plan template near admission, staff referred to this as a Recovery Care Plan to differentiate it from the Nursing Care Plan. I observed five initial care planning interactions. During these interactions, the Recovery Care Plan could be filled in by the individual themselves (n=4), or a staff member could sit with them and write down the responses on the individual's behalf (n=1). The document particularly included space to record the service user's "needs" and their "goals" from their perspective, and also included preferences for communicating with family members. This document would then be scanned and uploaded onto the system. No service users observed were asked about their risks when completing this document. Staff say that the Recovery Care Plan then informs the Nursing Care Plan, which is also routinely updated on the system. Staff reported that these might be reviewed with service users in one-to-ones; this was not observed in one-to-ones, and no service user interviewed, or spoken with informally, had seen their Nursing Care Plan.

Staff conceived of the Risk Assessment as a dynamic document, containing a summary of the individual's risk, populated as the "patient summary" was updated on the system. The final version of this is then used in the Discharge Summary produced for the service user, any relevant community support staff (such as CPN or Social Worker) and/or General Practitioner. It includes specific sections on risk to self, risk to others, and vulnerability. Staff reported that any statements of risk were written in the third person and from a third-person perspective. The first-time service users would potentially see this document was at the moment of them leaving the ward upon discharge, when they would be given the document in a sealed envelope to take home with them. There was an expectation that any issues raised subsequently would then be handled by a community mental health worker or by a GP, depending on whether the individual was being discharged to secondary or primary care. No service user had seen this document prior to discharge.

4.6 Summary

This chapter has provided a detailed description of Attenborough ward and some of the key service user-staff interactions in various social spaces on the ward. Handovers, ward rounds, one-to-ones, observations, and documentation processes have been detailed, including their role within risk assessment and management in the social setting. In the next chapter I will consider how service users themselves experienced risk assessment and management, and their perspectives around these phenomena of interest.

Chapter Five: Findings

The previous chapter has demonstrated that Attenborough ward was a hive of social activity with several practices and routines in place to facilitate the assessment and management of risk. The findings reported in this chapter, will illuminate the service user perspective and experience of this phenomena and in doing so, will elevate the voice of a marginalised group. As identified in Chapter 2, service user perspectives on risk assessment and management are largely missing from the current evidence base. Following the analysis process articulated Chapter 3 (section 3.3.2), the findings will present data from the semi-structured interviews and observations. The various interactions from which quotes are reported in the text are identified with abbreviations:

- semi-structured interviews (IV)

and observations, including:

- informal conversations (inf)
- ward round interactions (WR)
- staff-service user one-to-one interactions (1-to-1)
- and staff handovers (HO).

All quotations will be given in speech marks, with any observational comments in square brackets, and any omissions signalled with … . All names given are pseudonyms, and generic staff roles (such as HCSW, or Senior Nurse) are used so that particular staff members (such as the Activities Coordinator, Ward Manager, or Charge Nurses) cannot be identified.

The development of themes has already been outlined (chapter 3, section 3.4.2.1). The resultant findings (over-arching themes identified in bold), that will be presented in this chapter are:

1). Risk is a recognised key factor in acute psychiatric inpatient admission, yet service users argue that sharing their *experience* of risk (**the risk-experience** for short) can be sensitive and emotionally difficult for them to discuss openly.

2). Service users suggest that talking about risks requires an **honest sharing** of the individual's risk-experience (their experiential knowledge) in a comfortable setting with the aims of letting staff know about their risk-experience. The aims of such sharing are so that service users can receive individualised support with identifying "triggers" (enhancing self-knowledge) and developing coping skills (new knowledge) towards independent coping.

3). At the same time there is a parallel process operating whereby staff gather knowledge around risk through "screening" in ward rounds, staff observations of service users, and interaction with them (**clinical knowledge**), which staff say is informed by service user's experiential knowledge. Service users, however, feel distant from aspects of this process and from the knowledge formed, resulting in feelings of powerlessness.

4). There are also perceived (and observed) **power-disparities** between these two forms of knowledge which are at play in this setting, where clinical knowledge is prioritised over service users' experiential knowledge in various ways. Some service users, in particular, believe that they have to master the legal/professional discourse of risk in order to secure their rights and obtain power.

5). To counterbalance this perceived power-disparity, service users are also seeking more and **tangible involvement** (framed as opportunities to contribute their experiential knowledge) in sharing their concerns throughout their time on the ward.

The focus of the findings, therefore, is on the various forms of knowledge operating within the setting and the power disparities between them.

5.1 The risk-experience

Whilst all service users on Attenborough Ward recognised that risk was a key factor in their admission, they argued that sharing their *experience* of risk (the **risk-experience**, for short) can be sensitive and emotionally difficult for them, but which they feel staff need to know.

5.1.1 Risk and admission

As discussed in the sampling outlined in chapter three (see **figures 5-8** above for sample details), of the 47 service user participants who took part in the study observations, 45 were willing and able to provide a brief account of their concerns around risk. These informal conversations were often prefaced with the response "my risks are…" These participants stated that they had come onto the ward due to a risk of some form. Denise, alluding to a suicide attempt that she would later go on to describe to me in some detail, summed up how she had been admitted in these terms:

> "I risked everything. I risked my life, the, me growing up with my daughter, I risked my job. Everything just spiralled out of control and the risk then was just, it was just endless, do you know what I mean? I mean I risked everything, I risked everything - that brought me here." (Denise IV 35-40)

Denise frames risk as an action that she took that then led to her admission to hospital. Whilst Denise emphasises her sense of agency involved, seen in the repetition of "I risked…", there is also a sense of her being overwhelmed by her circumstances. Risk is framed as a situation that seemed like it had no end, and that there was no relief in sight, which is seen as leading to her suicide attempt. The spiral metaphor conveys the sudden sense of powerlessness that overwhelmed Denise, whereby she felt that she had no control over anything in her life. The notion of being "brought" to hospital also suggests a sense of passivity. Denise thus saw risk as a key factor in her admission, which was tied to a sense of powerlessness. Most participants who described their risk as a form of self-harm and/or suicide attempt (often in terms of 'risk to self') conveyed an experience of feeling overwhelmed by their life-circumstances.

The majority of participants also believed that the other service users on the ward were there largely due to issues of risk as well. For example, Abigail stated:

> "Most of the people in here are at risk, of one form or another. Whatever, whether it's self-harm, or taking drugs or, you know, anything." (Abigail IV 296-298)

Similarly, Samuel said:

> "Because in one way or another we're a risk either to ourselves or to others, like, that's how we've ended up here. We've all got our own demons to face." (Samuel IV 27-28)

Risk is thus clearly seen as a key criterion for admission onto the ward, and each individual is seen to be dealing with their own concerns around risk. Risk can also take various forms, Abigail highlighted concrete examples as self-harm and substance misuse, Samuel described two broad categories of risk - risk to self or risk to others. The individual themselves can pose a risk (seen in Samuel's phrase "we're a risk…") and thus there is a sense of agency expressed here, or individuals can be "at risk" or vulnerable in some way. The phrase "that's how we've ended up here" also again suggests passivity and implies a loss of personal control. The ward becomes the space where the individual directly confronts these demons/risks.

5.1.2 Risk-experience and emotions

In addition to feeling powerless and/or overwhelmed, participants emphasised other emotions that lay at the core of their experience of risk, specifically feeling threatened and/or fearful. Kate, for example, said:

> '"I feel at risk and under threat because people were wearing colours to try and make me fit in with them, when I don't want to." She tells me her husband said that she "wasn't wearing the right colour", and so they had fallen out over it.' (Kate inf 02/11/18)

Kate identified an external issue in relation to the behaviour and expressed opinion of others who were trying to compel her to assimilate to a particular dress-code, which is seen as a particular form of "threat" to Kate. This threat is tied to a feeling of being "at risk." Kate argues that this issue accounts for the breakdown in the relationship with her husband, alluding to his collusion in the experience of threat. The notion of wearing coloured clothing is a unique and very specific form of threat, which contributed to Kate feeling particularly vulnerable and feeling that others are out to harm her. Whilst the threat lay outside of the ward environment, Kate still feels at risk and under threat. Similarly, Gareth's experience of risk had a fear at its core:

> 'Gareth briefly explained the circumstances that brought him onto the ward as: "I don't remember much, I just remember spiders everywhere, and running away from my house, not even dressed properly." He also says that: "My fear is my risk. I was scared of the spiders, and the government was out to get me, so I lashed out at police, and somehow ended up here."' (Gareth inf 15/10/18)

For Gareth, it is the fear itself (rather than his clothing or his lashing out) that he identified as the risk that brought him onto the ward. From Gareth's perspective, this fear accounted for his attire and his lashing out at police. Gareth thus perceives the risk as an emotional reaction to a very specific external situation. Again, whilst the threat is external to the ward, the fear is still very present.

Other similar examples to Gareth's were: Preston stated his risk was that he was being "persecuted by a secret government agency" (Preston inf 01/10/18), one of Ash's risks was that he was receiving "threatening messages" from the lampposts flashing in the streets around his house (Ash inf 08/10/18), and Dominic said that he's "a multi-millionaire" and that "people want to kill me for the money" (Dominic inf 14/11/18). In each instance, there was a specific threat, located in an external situation, which caused fear and anxiety, and which was viewed as a risk. All participants, then, identified some form of emotional response to their life-circumstances, whether that be feeling powerless and overwhelmed, and/or scared and fearful, as a core part of the experience of the risk described – or what will be referred to as the *risk-experience* for short.

A number of service users also described their desired outcome of being on the ward in terms of developing a feeling of safety. This is captured well in this quote from Silas:

> “My risk is that I took an overdose and I just feel suicidal. I was just so overwhelmed and I couldn’t keep myself safe.” I ask what it’s been like on the ward, he says “It’s given me a bit of time away from all the stress, which has helped a lot. I’m here for a bit of respite and am starting to feel less stressed out and I do feel safe here now. And I know when I’ll feel safe enough to return home.” (Silas inf 30/11/18)

Emotions are again interrelated to the risk described, which is connected to an inability to maintain a state of safety. Admission is framed as a period of time away from the external stressors and a respite, again implying a period of relief away from something difficult. As a result, the ongoing feeling of stress is lessening, and Silas is starting to feel safe on the ward. This feeling of safety is seen as a prerequisite for discharge and thus as a desired outcome of admission. Many service users similarly described a journey from feeling at risk to feeling safe again; for instance, Leah stated:

> “I would say that the admission has helped me feel safe again. I can see that I was severely at risk and needed to come in here, because I was just really distressed and overwhelmed, and traumatised, really. But I’ve moved on now, and I think everyone can see that I’m not a risk anymore. But it’s a real healing process, but, yeah, I feel safe and secure again, which is all I could have wanted, really.” (Leah, IV 156-159)

This further highlights the emotions of the risk-experience and also that of the desired outcome of safety.

Whilst the risk-experience was acknowledged to be a key factor in admission, talking about any concerns around risk could also be difficult. Participants argued that this again was because of the raw emotions involved. For instance, Maria put it in these terms:

> ‘“Risk of suicide or of hurting yourself is a really emotionally sensitive area, so it’s hard to let people in so that they can know what you’re thinking and feeling, and what you’re going through, with all the difficulties you’ve been experiencing.” After a long pause, she added: “But you have to let someone in so that they can help you.”’ (Maria inf 04/10/2018)

There is a perceived heightened sensitivity around the issue of suicide or self-injury that makes it “hard” to talk about with other people. In particular, Maria asserts that it is difficult for the individual facing such a risk “to let people in”, which implies allowing or permitting someone else to enter the inner world of the individual and to share something of that sensitive space with another. The perceived result of allowing such entry is that others can then gain a form of knowledge about the individual. This knowledge is focussed on their inner world, on their thoughts and feelings, which are interrelated to the external circumstances that they are currently experiencing, which positions Maria as a *knower* of distress. Letting someone in, then, requires telling them about the thoughts and feelings, thereby giving testimony to inner knowledge to another. Letting someone in also means that they can then know that the individual’s present situation is understood by them as “going through” unpleasant “difficulties”, and thus how they themselves see, interpret, and experience their circumstances. This knowledge of what the individual is experiencing thus incorporates personal interpretations of their situation, and their thoughts and feelings about their situation, which may help to explain why the individual may want to harm themselves and/or take their own life.

Maria felt that it would be advantageous to let someone in, to give someone that permission, so that she could get help and support; this is framed almost as a precondition (“you have to let someone in…”) of receiving help, otherwise there’s an implication that other people will not know *how* to help. Thus, what will be termed as *experiential knowledge* is otherwise unobtainable unless the individual is willing to talk about it, or give testimony to it. The heightened sensitivity that is felt around the subject of risk does imply that raw emotions can themselves be a barrier for service users having such conversations about painful thoughts, feelings, and interpretations of circumstances, and thereby sharing their experiential knowledge. Thus, discussions around risk of suicide and self-injury are not emotionally detached, but emotionally charged conversations. This is, therefore, an internal barrier that has to be overcome in an interaction with another, if it's going to be possible "to let someone in" and to share this experiential knowledge.

Like Maria, many participants were looking to share their experiences with staff, but similarly found it difficult to do so because of the emotions involved. For instance, Carol in a one-to-one stated:

> "It's hard to talk about this stuff, it's upsetting. Because self-harm, suicide, it's a big trauma, but then confronting that risk again, it's another trauma, thinking about what you've done and what you've put others through." (Carol 1-to-1, 22/11/2018)

Carol thus emphasised the traumatising impact of confronting her risks of self-harm and suicide and the impact it has had on others. Similarly, when asked about his risk Spencer stated:

> "There's so much I need to tell you, but it's so raw right now [he becomes a little tearful] I just can't talk about the risks at the moment." (Spencer 1-to-1, 27/11/2018)

To summarise, whilst risk is recognised as a core criterion to hospitalisation, service users argued that it is difficult to talk about due to the raw emotive core of the risk-experience. Risk is experienced as a feeling of being overwhelmed or powerless and/or fearful or threatened that renders it a particularly "sensitive" issue to talk about. This sensitivity can be experienced as an internal barrier that needs to be overcome. It is also acknowledged that service users are positioned as *knowers* of their risk-experience and they need to share, or give testimony to, their experiential knowledge otherwise it is unobtainable. A key reason for sharing is in order to receive help and support on the ward, which is seen as a space for directly confronting such issues, in order to feel less of a risk and to reobtain a feeling of safety.

5.2 Honest sharing of experiential knowledge

Service users suggest that talking about risks requires an *honest sharing* of the individual's risk-experience (experiential knowledge) in a comfortable setting. The main aims of honest sharing around risk are letting staff know about the issues so that the person can then receive individualised support with enhancing self-knowledge ("triggers") and developing new knowledge ("coping skills") towards independent coping, thus framing the encounter as an epistemic one (emphasising 'knowledge'). This section will thus develop the epistemological argument around the central notion of service user's experiential knowledge.

5.2.1 A comfortable setting for honest sharing

One-to-ones were seen as spaces for expressing the difficult feelings that can be associated with the risk-experience. For example:

> 'Following a one-to-one with Caroline (senior nurse), which Bella did not want me to observe due to "the sensitive nature" of what she wanted to talk about, Bella, looking teary-eyed, came out of the ladies lounge and came up to me directly, saying: "You know, it's only in these one-to-one sessions that I've really shared my trauma, my risks, and I've cried, and got all that emotion out of my system. It's been so hard, but I've learnt to let my guard down and to trust Caroline. I feel like I could tell her anything now and she'd get me."' (Bella inf 01/11/18)

Trauma implies some form of experience that has been deeply distressing, which Bella associates with her risk, and which is interrelated to painful emotions. In addition to talking, one-to-one time gave Bella the space to process all of her emotions, which is seen as a useful end in itself. Bella has felt guarded, which again alludes to an internal barrier that can inhibit communication and the formation of relationships, which are necessary for the sharing of experiential knowledge. One-to-one time has thus been seen as an important context for building this trusting relationship in order to foster the sharing of experiential knowledge.

Many service users talked about the vital importance of honesty in communication around risk and safety (or *honest sharing* for short). Talking about one-to-ones, Julia stressed the need for honesty in these terms:

> "Honesty, so that patients are really actually disseminating information about how they feel in their own safety zone, their own vulnerabilities. Making real connections with the staff so that they can talk about what is most concerning to them. And therefore, the staff would then be able to assess what the risks actually are for that particular patient." (Julia IV 277-283)

Julia associates honesty with developing interpersonal relationships with staff. These relationships are characterised by "real connections", where "connections" implies the sense that there is some form of a shared common outlook, with "real" highlighting a genuineness to the relationship. The result of developing such relationships is that the individual feels that they can honestly share information about the inter-relationship between their feelings and personal circumstances ("how they feel in their own safety zone"). A "zone" normally implies a space or an area, which here refers to the internal state of safety, but which has parameters or boundaries. Once again, sharing risks involves inviting staff into the internal world of the individual, so that staff can understand the individual parameters or extent of the individual's state of safety.

Carol similarly emphasised how one-to-one interactions in particular enabled her to feel comfortable enough to be open and honest. Carol expressed this during a one-to-one with Faith, her named nurse, which she had following a ward round which Carol had described as "particularly challenging":

> Carol: I really hate the ward rounds.
>
> Faith: Why is that?
>
> Carol: It's hard to talk about this stuff, it's upsetting. Because self-harm, suicide, it's a big trauma, but then confronting that risk again, it's another trauma, thinking about what you've done and what you've put others through.
>
> Faith: That must be tough.

> Carol: I only really feel comfortable sharing stuff here, and being open and honest about what I've done and what I'm going through. And I get that you need to know this shit, and I do trust you now, and these times really help, but you don't want to air your dirty laundry in public, do you? Cos this is really private stuff. (Carol 1-to-1, 22/11/2018)

Carol distinguishes between relatively public and private spaces, which is interesting in the context of an ethnography and highlights the importance of both the environment and the social dynamics of different spaces and forums on the ward. Carol strongly dislikes and disapproves of talking about personal and private issues in front of other people in the ward rounds (implying that it is a public space). One-to-ones provide a more "comfortable" setting for honest sharing, as it is a more private space. Risk of self-harm and suicide is associated with trauma and hence with an experience of distress, that impacts upon the individual and others, but which is seen as a private matter that requires sharing in a private space. The metaphorical idiom of "dirty laundry" also adds a sense of needing privacy or secrecy and quite possibly gives a negative connotation to what is aired. To face up to, and deal with, that risk is described as an additional trauma, such that thinking about past actions, and also their impact upon others, is a further distressing and traumatic experience to undergo. Hence, for Carol, because risk is such an emotionally charged issue it is more appropriately discussed one-on-one in a private space. Since Carol now trusts Faith, she now feels comfortable confronting these issues and sharing her experience in a one-to-one setting, where she feels she can be transparent and honest about her experience. Moreover, Carol recognises that this is a form of knowledge that is helpful for Faith to know.

A number of service users, like Carol, argued that one-to-one interactions were preferred spaces for sharing concerns rather than in the ward round. Denise stated:

> "I think [you could be more involved in sharing concerns around risk] by having more sort of one-to-one sessions with the nurses, but not in the ward round. Like just having five minutes, if you had five minutes every day with somebody that you knew you were going to talk to every day, that you knew that you could just go and say that to, that, that would be easier than having to do it in the ward round. Or having to wait, because feelings change day to day, and like you say, so the ward round itself can be quite intimidating anyway." (Denise IV 635-643)

Denise has a sense that the ward round is a place where she feels that she *has* to share, almost as an obligation. Denise also feels that the ward round is an intimidating space (this was a common concern of most service users), and, for her, one-to-ones are a context where it is comparably easier to share her feelings and concerns. Intimidation alludes to dynamics of power, which could limit the ease of communication, present in the ward round setting, that are perceived to be absent in a one-to-one. Rather than having to wait for the weekly ward round, Denise is looking for short, daily, one-to-one interactions, where she can approach a designated staff member with her concerns.

Contextual factors, particularly staff busyness, were seen to limit one-to-one interactions, because they had to be initiated and requested by service users themselves. This is well summed-up in Samuel's assertion:

> "I think one-to-one time with staff is crucial, and that doesn't happen enough. But getting to know your named nurse, building up trust with them. Most of the time, they're really busy, and I have to take the lead in asking for it. I think if I wasn't a confident person, then I'd be forgotten. I feel people do get forgotten." (Samuel IV 175-178)

One-to-ones are framed as interactions that are largely not planned, but which have to be requested. A number of service users stated that staff were so busy that the initiation for requesting one-to-one time with a staff member rested with the service user themselves. Asking for such time is seen to require a sense of confidence, and there is an impression that unconfident or shy service users will not initiate these interactions, and thus will be forgotten by staff.

Trusting relationships, developed over time, are seen to be fostered particularly in one-to-one interactions. Developing such relationships are a means of overcoming the internal barriers that make such communication challenging. Staff busyness means that service users feel that these interactions have to be requested, which could be quite challenging for some service users to initiate. Overall, these one-to-ones are seen as more comfortable spaces for the honest sharing of service users' experiential knowledge around their risk.

5.2.2 Honest sharing and enhancing self-knowledge

One of the main aims of honest sharing around risk is letting staff know about the issues so that the person can then receive individualised support with enhancing self-knowledge ("triggers"), which frames the interaction as an epistemic one. Service users talked a great deal about triggers, the importance of identifying them, and of letting staff know about them. For example:

> 'Following a two-to-one with Kelly (nurse) and Karina (HCSW), Danielle told me: "Thinking about triggers was a real eye-opener for me, I got to know myself a lot better, the things that really stress me out and could put me at risk of harming myself again."' (Danielle, inf 15/11/18).

The notion of triggers is related to a form of knowledge, which is focussed on knowing the kind of events that could cause such a feeling of stress, that, in this instance, it might then lead to risk of self-harm. Triggers thus emphasises the interplay between external events (the stressors) and internal reactions (the stress felt). Understanding the triggers is described as getting "to know myself a lot better" because these stressors and the reactions to them will be unique to the individual. Thus, identifying triggers is seen as a form of enhancing self-knowledge. For Danielle this was particularly enlightening, implying that perhaps she had not thought about these particular issues before, and that perhaps staff had introduced this notion to her, with beneficial results in terms of enhanced self-knowledge.

Service users were looking to staff to help them identify their triggers; for instance:

> 'Following a one-to-one session between Angela and Mike (nurse), Angela explained to me what she hoped to get out of one-to-ones in these terms: "I'm just looking to staff to help me identify triggers, and to help manage the risks, to learn to cope." She tells me that she needs to do this because "I need to be in control here, to face up to all of the difficulties."' (Angela inf 22/10/18)

Angela is wanting to deal with all "the difficulties" in her life and in order to accomplish this she is looking to staff for specific forms of help and assistance. In particular, she is looking to have interactions with staff whereby they can assist her in identifying triggers, which is then tied to the subsequent management of the risks, implying an interconnection between triggers and risks. Staff support with managing the risks that Angela is seeking takes the form of new learning with the aim of coping with the issues raised. The goal of trigger-identification for Angela is seen to be for her own benefit, namely that she can then take on a sense of control over her difficulties. Enhanced self-knowledge is thus seen as an important part of empowering the individual in a situation where they may have felt overwhelmed and out of control.

Service users also felt that they should let staff know about their triggers in order to receive individualised support:

> "It [service user involvement in risk assessment] should be based on the individual, not just on a general diagnosis. So, you need time and space to actually sit down and say this is what anxiety feels like for me, and these are the triggers, and these are the kind of things that make me paranoid, that make me feel unsafe, things like that…" (Samuel IV 229-232)

For Samuel, his feelings of unsafety are related to the experiences of anxiety and paranoia. These issues could manifest themselves in unique ways for him, that would not be captured with a generic diagnostic description. He is thus looking for an adequate opportunity to sit down with a staff member (implied in "sit down and say…") and outline precisely how he experiences anxiety, what are his particular triggers (again, these are seen as unique to him), and which events might make him become paranoid, all of which could contribute to him feeling unsafe; the implication being that this experiential knowledge is also important for the staff member. This means that Samuel can feel understood as an individual, and he can then receive person-centred care and support around his particular issues of risk and unsafety.

Staff also talked about the importance of service users developing such self-knowledge in one-to-ones, hence also emphasising the epistemic nature of the interactions. Staff often referred to this aspect of their work as "working with" the individual; for instance, Dr Abebe stated:

> "It's [involvement in risk management] things like letting them know – developing their Care Plan, sitting down with them to make them know about things like relapse signatures and things like that, working with them – what can they do if perhaps they are beginning to feel like perhaps they are getting unwell and things like that." (Dr Abebe, psychiatrist; IV 192-198)

The relapse signatures that Dr Abebe refers to are a set of early warning signs, tailored to the individual as a form of self-knowledge. The focus on "what can they do" suggests that service users are being taught how to recognise their signs of relapse and then identify what preventative steps they might take to avoid it. The framing of the interaction, which moves from "letting them know" to the slightly more forceful sounding "to make them know", suggests that this is seen as a crucial form of knowledge from the professional perspective. Whilst there is a sense of partnership-working expressed in the language of "sitting down with" and "working with" the individual, the emphasis is more on a one-sided impartation of knowledge that implies more of a teacher-pupil relationship and power dynamic.

One-to-ones, then, are seen as private spaces for sharing knowledge, with clinical knowledge (e.g., relapse signatures) being taught with an aim of enhancing self-knowledge and moving towards independent coping, thus they are epistemic encounters.

5.2.3 Honest sharing and developing new knowledge

Staff suggested that it was also important for service users to learn coping strategies, and service users were looking to learn them. For instance:

> 'Following a one-to-one session that Faith had with a service user, she told me: "Learning coping strategies and psychoeducation are a really important part of

> risk management." Faith says that that is what she particularly enjoys about one-to-one work, because she says, "as the saying goes, 'Knowledge is power'."' (Faith, nurse, inf 23/11/18)

Faith emphasises education and learning, and thus the acquisition of knowledge and skills, set within the context of a one-to-one relationship. "Strategies" suggests plans or interventions, that are taught with the aim of helping the service user to cope with (or successfully endure through, or even overcome) a difficulty, which in this context is the particular risk. "Psychoeducation" has a particular evidence-base underpinning it, but it implies more of a learned body of knowledge. The education aspect suggests a didactic knowledge transfer from the professional to the service user, suggesting a power dynamic at play. The individual then gains knowledge and understanding that is focussed on their mental state or mental health condition. Faith argues that these inter-related forms of knowledge are necessarily empowering the individual, implying that the more that the individual knows the more control they will have over their risks. One-to-ones are seen as important spaces for such a didactic knowledge transfer; again emphasising the epistemic nature of the interactions.

Service users were also looking to develop coping strategies and were looking to staff in order to acquire these. Samuel expressed this desire in these terms:

> "[Regarding risk management] I'd like to have an actual plan of action, where you agree, like, goals, I suppose, and then you actually learn some coping strategies from the staff, because surely they've seen lots of patients with these different conditions, they must know about the kind of things that could help. But again, it's doing it in an individual way." (Samuel IV 366-369).

Coping strategies are understood to be a form of knowledge passed on from the staff to the service user with the aim of reaching agreed goals. For Samuel, this knowledge is understood to be rooted in staff's clinical experience of working with various kinds of service users. Samuel reasons that because staff have seen a large number of service users over time, all with various different mental health conditions, that that means they must have acquired the knowledge as to what could potentially help people. Thus, he is looking to staff in order to acquire such know-how from them. Interestingly, this is not, then, seen as text-book knowledge (like psychoeducation), but a form of experiential knowledge that staff have gained through clinical experience. It is a form of knowledge obtained through engaging with service users and their own experiential knowledge. Such knowledge is seen as a key to providing individualised support and care, in the form of targeted, individualised coping strategies, that speaks into the experiential knowledge that has already been shared by the service user.

As examples of how such knowledge acquisition worked in practice, excerpts of study observations from two one-to-ones will be presented. First, an observation of a one-to-one between Miles and Emily (nurse) is presented. Struggling with a drug and alcohol addiction which was fuelling depression and suicidal thoughts (which he described as "a risk to myself"), Miles had talked about taking his own life following a particularly difficult ward round. The next evening Miles had a one-to-one with Emily:

> Miles: I'm glad you didn't let me leave yesterday. I switched to my old coping mechanisms.
>
> Emily: You need to break that chain. Going out to get drunk and throw yourself under a lorry?
>
> Miles: I'm finding a better way to cope…

> Emily: Write down how you were feeling yesterday, including before the MDT meeting and afterwards. List the negatives – drink, drugs, homelessness. List all that, and then how you would change that.
>
> Miles: The pro's and con's of each situation?
>
> Emily: Yes, like a traffic light system: red, amber, green. Three columns. Red: alcohol; amber: doing your coping mechanism not to go into red. You need to work out how to do that. Talk to staff, AA [Alcohol Anonymous meetings], drug and alcohol support in the community. Look at that in the future…
>
> Emily: Write down about your childhood, and then consider whether you want to discuss that. You have to go through that dark place to deal with it…
>
> Emily: But you need to write about what happened last night and think about what you could have done differently. Think about the triggers and your reactions.
>
> Miles: I need to find a different way to drugs and alcohol… (Miles 1-to-1 23.11.18)

Miles situates old coping mechanisms in relation to a reliance on alcohol, tied to a concrete plan to die by suicide, which suggests that people's existing means of successfully enduring or overcoming difficulties are not always healthy or productive. Emily's talk of the need to "break that chain" suggests that she sees this as a problematic pattern of behaviour that needs to be successfully terminated; hence there would need to be some unlearning as well as learning new skills.

Emily offers Miles a mental template to frame a broader process of self-reflection that incorporates all "the negatives" of his life-situation, and broader coping mechanisms that he could adopt back in the community. This process of self-reflection is encouraged as a means of helping Miles to "work out" for himself how to cope better in future. Emily is thus supporting Miles to obtain a form of self-knowledge whereby he can learn how to reduce his suicide risk.

A more hands-on example of how such knowledge acquisition worked out in practice can be taken from another one-to-one interaction. During Chloe's first one-to-one with Fiona (nurse), Fiona produced a blank sheet of paper, drew two columns, and encouraged Chloe to write down the positives and negatives of her situation. Chloe did this exercise, and then Fiona reviewed the columns and concluded:

> Fiona: [Looking over the positives] Education – you didn't do that alone; you're part of a community. Friends – there's more than one there too. Family – they're there to support you. [Looking to the negative] The issue is with yourself. How do you feel about that?
>
> Chloe: I need to change myself, how I see myself.
>
> Fiona: Why didn't you say <u>we</u> need to change?
>
> Chloe: Because it's about me – I need to change.
>
> Fiona: So, write that down with the highlighter.
>
> [Chloe writes with a highlighter pen: I need to change]
>
> Fiona: How do you feel about that?
>
> Chloe: It's going to be hard.

> Fiona: It’s small, little steps – not a marathon – small, little steps towards changing who you are. When you feel a self-harm urge, you need to think of those positives.
>
> Chloe: So, when I’m feeling that, I can think about that.
>
> Fiona: I encourage you to write out this – positives and negatives – whenever you feel this. Try writing a diary over the weekend… (Chloe 1-to1, 23.11.18)

Both Chloe and Fiona perceive that underlying the risk of self-harm is a feeling or urge that needs to be managed. Fiona suggests a cognitive strategy for overcoming that urge whenever it is encountered, in the form of drawing to mind and reflecting upon “the positives” that Chloe has herself identified. Furthermore, as a means of further self-reflection Fiona advises keeping a diary. Through this reflective writing-exercise a number of positives are identified in Chloe’s life-situation as well as potential sources of support from her own point-of-view. Thus, in this instance self-reflection enables coping, facilitated by a staff member.

In both of these examples, it is clear that a collaborative relationship is being fostered, whereby service users can openly express their thoughts and feelings around their risks. Both Miles and Chloe are being encouraged to embark on a process of self-reflection with the aim of enhanced self-knowledge, moving towards coping independently. In both instances various forms of writing-exercises are suggested as concrete support strategies. In Chloe’s case, the writing-exercise is enacted within the one-to-one encounter itself, whilst Miles is given a mental template to go away and think through for himself. In both instances there is unlearning to do (old coping mechanisms; a negative sense of self) as well as new learning to take onboard. Both staff members are focussed on supporting service users not only during their time on the ward, but also preparing them for life back in the community. Coping strategies are clearly being taught by staff, with encouragement to adopt them, but with no sense that these are being imposed. Whilst similar coping strategies are suggested (writing exercises) they are tailored to the individual’s own situation. These provide good examples, then, of how knowledge acquisition works in one-to-ones, with their emphasis on both enhanced self-knowledge and new knowledge in the form of tailored coping strategies, which service users need to acquire as they move towards independent coping.

5.2.4 Honest sharing and knowledge deficits

One-to-ones were thus seen as a comfortable setting for sharing experiential knowledge with the aims of letting staff know what the issues are, so that they can then receive individualised support. However, some service users felt that they had knowledge deficits around the wider processes of risk assessment operating on the ward that hindered open and honest communication. Samuel, for example, had some concerns around sharing risks with staff:

> “Like do I have to share things there [at ward round] or could I share it in a one-to-one? But if I share it in a one-to-one will the doctors then know about it? Like, who shares what with who?” (Samuel IV 259-262)

Samuel is unclear whether there is an obligation to share during the ward round or whether he could only share things in a one-to-one setting. Furthermore, he is unclear whether doctors would obtain the requisite knowledge if he only shared within a one-to-one encounter. This highlights a lack of clarity around wider knowledge-sharing processes within the staff team, which could have an impact on the sharing process on the part of the service user.

Jacob felt that this knowledge-deficit around the wider staff processes might hinder interactions between service users and staff members:

> "I think people need to know, to understand, you know, what levels of risk are perceived to be, and how, how that can affect people's care and expectations and things. I think overall, just a lot more communication around it [risk], I think. I think if you had that, more communication, you'd get, you'd be more likely to get an honest response, if people understand what, you know, why it's being, questions are being asked, and what their response is going to be." (Jacob IV 529-537)

Jacob is concerned about how staff might typically respond to what is shared by service users. He is looking for knowledge around perceived levels of risk and how staff might respond to different levels of risk-severity and how that might impact upon ongoing care and treatment. He is also seeking knowledge around the rationale behind the different questions that are being asked by staff of service users. Such knowledge deficits are seen to potentially hinder open and honest communication. This shows an awareness that how *staff* interpret risk is a factor at play in such interactions and introduces a notion that there is another process operating on the ward in which risk is viewed from a staff perspective. These processes will now be outlined.

5.3 The role of clinical knowledge in risk assessment and management

At the same time as service users are sharing their experiential knowledge, there is a parallel process operating whereby staff gather knowledge around risk through: "screening" in ward rounds and interactions, and clinical observations (clinical knowledge). Staff say this process has to be informed by service users' experiential knowledge, but service users feel distant from aspects of this process and from the knowledge formed, resulting in feelings of powerlessness.

Risk assessment was seen by service users as a staff activity, which they *assumed* that staff were conducting in order to keep people safe; thus, Gareth stated:

> "I think it's [risk assessment] just one of the things that you assume they're going to do, really. You do come in and you do assume that, they don't know much about you, and they're going to try and suss you out – I can't think of anything against that." (Gareth IV 203-206)

For Gareth, staff were seen to have a knowledge-deficit in terms of not knowing much about the individual themselves when they arrive onto the ward. Risk assessment is seen as an acceptable means whereby staff attempt to gain more knowledge about the individual through investigative processes (implied by "they're going to try and suss you out") of some kind. There is thus an association between risk assessment and getting to know the individual. It is "assumed" that some kind of process of knowledge-gathering is in operation; this implies a belief that risk assessment is happening without necessarily there being concrete proof that that is actually the case, suggesting a lack of knowledge of the part of service users. It will be demonstrated that most service users feel distant from aspects of this knowledge-gathering process, and particularly from the overall knowledge formed as a result, leading to feelings of powerlessness.

5.3.1 Clinical knowledge and "screening for risk"

Aside from one-to-ones, which have already been described in some detail, staff argued that one of the main ways in which they found out about service users and their risk was through interactions with service users, and particularly within the weekly ward round. The Locum Consultant often referred to this form of interaction as "an interview," implying a formal meeting for the purpose of having a conversation in which questions are posed and answers sought, as part of a consultation or evaluation. This frames the conversation as an interaction between an interviewer and an interviewee, and that implies that the agenda and the flow of the discussion is led by the former. Similarly, some service users described ward rounds as being like "a job interview" which further alludes to dynamics of power at play in the discussion being had.

Interestingly, aspects of this conversation were sometimes framed as "screening for risk." The language of "screening" was used by the Locum Consultant in ward rounds of screening for psychotic symptoms, mood symptoms, and depression; thus, in these instances questions are being asked to detect a potential health problem, to ascertain what particular condition an individual might have and how unwell an individual might be, from a biomedical perspective. What is interesting is that the same terminology was used for assessing risk. Thus, during one ward round the consultant asked one of the medics:

> "Can you screen for risk?" (CP WR 30/10/18).

The Psychiatrist responded with questions exploring the length of admission thus far, the reasons that brought the individual into hospital from their own perspective, thoughts of harming self, others, whether mood had improved, and what was the individual's plan going forward. During an earlier ward round the same doctor had been asked:

> "Do you want to go through the risk issues?" (CP WR 22/10/18).

The Psychiatrist then explored thoughts of harming self, and whether the individual had a positive plan going forward. Screening for risk, then, implies that there are set questions that need to be asked in order to ascertain risk (comparable to identifying symptoms) to discover what risks are posed and how risky an individual might be.

The language of screening implies that risk, instead of being seen as a subjective experience with a raw emotional core, is instead seen as an objective reality that can be identified and quantified through the use of a screening-test. In epistemological terms, the language of screening implies that identifying risk is thus seen as a science and a form of medical expertise, constituting a learned body of clinical knowledge. This body of knowledge informs the screening process, which thus constitutes a method for gaining clinical knowledge around risk, which filters the service user account, sifting for relevant information from which a clinical knowledge of risk can be formulated. Other than one-to-one medical reviews, and *Mental Health Act 1983/2007* assessments, the ward round constitutes the main space where psychiatrists are dominant and where this biomedical language and perspective is clearly present.

Dr Abebe argued that whilst the doctors did have "set questions" to ask service users, they also had to be responsive to service user's individual needs:

> "Yes, you have to have some set questions regarding risk and things like that, and then also you have to go with the patient's needs. Patient A might have certain needs, that even if you use your set questions, it will not fit for Patient B, so you have to be a bit flexible and just work with each patient as you see them." (Dr Abebe IV 144-151)

This suggests that the screening method of asking set questions to ascertain risk is only one means of knowledge-gathering, the other being to "work with" the individual service user. This highlights a perceived limitation of the screening method of asking set questions, which might not flag up the service user's individual needs. It also highlights the importance of a person-centred approach to risk assessment, that is flexible, and individualised, and which thereby constitutes more than simply running a screening-test.

In the context of the ward round, one service user stated that staff were *reading* into the responses from service users:

> "I think a lot of the questions [about risk] that they ask you, they are asking you questions about how you're feeling, but within that they are going deeper in to it to see where you are, and what you're, how you actually are. So, they can read a lot more into your answers than what you actually, just the 'yes' or 'no' answers that you're giving." (Denise IV 462-468)

Even when service users are giving closed answers to particular questions, Denise thinks that staff have an ability to "read a lot more" into the responses given as part of the process of going deeper into the service user's experience. This suggests that more is conveyed in the conversation than the actual verbal responses. Staff are thus seen to be able to interpret service users' responses in order to know something more about them, without the service user actually articulating it themselves. This further suggests that staff can intuitively gain a form of knowledge about a service user's risk without them having to verbalise it. This stands in tension with the approach that sees experiential knowledge as otherwise unobtainable unless the service user is willing to honestly share it. The notion of staff reading service users is further articulated in reference to clinical observations, which will now be outlined.

5.3.2 Clinical knowledge of risk and staff observations

In addition to ward round interactions, staff were also obtaining knowledge about risk through clinical observations, the processes of which have already been described in some detail (see chapter four, section 4.5.9), at this point it is important to note how staff and service users conceived of this process in this setting. Some staff saw clinical observation primarily as an internal, cognitive process; thus, Kelly, for example, put it in these terms:

> "It's [observational risk assessment] just stuff going off in your head like constantly. Without – it's almost like subconscious…" (Kelly, nurse; IV 142-145)

And again:

> "But like, I think in most nurses' heads, it's [observational risk assessment] just constantly. And you might not even think, right, I'm assessing their risk now, because you just sort of do it automatically." (Kelly, nurse; IV 161-165)

The notion of observational risk assessment happening "in your head" implies an internal cognitive process that occurs without the use of external, physical aids such as a proforma or scale. The suggestion that this is almost "subconscious", emphasises that this is seen as a deep-rooted internal, cognitive process, but suggests a lack of conscious awareness or reflection at the time. Similarly, the suggestion that this is done "automatically" implies that it occurs without conscious thought or attention. Moreover, this internal cognitive process operates "constantly", suggesting that it occurs continually over a time-period (implying a whole nursing shift) and it is not limited to certain formal activities or processes during that timeframe. For Kelly, this notion that clinical observations are an internal cognitive process is projected onto others' nursing practice too, such that this is seen as something that occurs "in most nurses' heads". Risk assessment is thus an internal cognitive process of gathering information through which nurses can then formulate a clinical knowledge of risk.

From a psychiatrist's perspective, Dr Khan also emphasised risk assessment as an internal, cognitive process:

> "[Risk assessment] becomes like – I wouldn't say innate, but it becomes so ingrained that, you know, you're not being able to describe it when you're assessing." (Dr Khan, psychiatrist; IV 69-73)

Whilst not being "innate", in that it is an acquired knowledge and skillset, Dr Khan argues that risk assessment does become "ingrained", implying that it is firmly fixed and established in the mind of the practitioner. Risk assessment becomes so deeply embedded and so routine that it becomes difficult to articulate what that assessment actually entails. This notion of risk assessment as an internalised knowledge thus crosses staff roles, informing both nursing and psychiatrist's work.

From the service user perspective, clinical observation was defined by a number of service users as an activity by which staff again *read* situations, and particularly read service users' body-language, to ascertain risk. This is well summed-up in this statement from Denise:

> "So, they'll be, even though we're not saying anything, they will read a lot of our body language, our expressions, and things like that. So, I, I guess it's going on everywhere all the time, so where-ever we are, or whatever we're doing, we're being risk assessed." (Denise IV 442-447)

This reading of service users' body-language was considered by service users to be the core component of staff's observation, rather than it being an opportunity for meaningful interaction:

> "I guess, you do see some of the staff going round with their clipboards, doing their headcounts. Maybe they're assessing risk then? But then they don't ask you anything, well, sometimes they might ask 'Are you okay?' or something like that, but it feels just like when a colleague at work asks you, you know, when they ask, but they don't really want an answer from you, it's just politeness. The staff don't actually talk to you then, but I guess they're writing something down." (Samuel IV 140-145)

It is noticeable to Samuel that staff are performing some kind of administrative task, as highlighted by noticing that they have their clipboards. It is quite telling, however, that Samuel refers to observations as "headcounts" which implies that observation is centred on simply counting the number of people present on the ward, to check that everyone is there who should be. Samuel also queries whether headcounts is part of risk assessment and is not sure as to whether they are documenting risk at that point. This uncertainty arises because Samuel feels that there is no meaningful interaction during this observational process. Samuel thus experiences a sense of distance from this staff process that is operating on the ward.

This observational approach as reading situations and individual behaviours was felt to have limited utility as it could not give insight into how service users themselves were feeling in terms of risk:

> "The staff here don't, you know, they'll sort of stick, they'll stick their head in the room and say are you okay every hour, or whatever, however often it is. But

> that, that's the sort of limit of most of my interactions with them really. Unless I go and speak to them for a specific reason. So again, unless I went and told them something, they wouldn't know if I felt particularly risky or not really. They wouldn't have a clue." (Jacob IV 184-193)

Jacob implies that had he not initiated interaction with staff, they would have a knowledge deficit when it comes to his risk and risk severity. Thus, from the service user perspective, clinical observations were seen as potentially meaningful opportunities for regular interaction with staff, for the purpose of sharing concerns. Instead, clinical observations are seen as a superficial form of interaction and, without meaningful conversation, they are seen to be useless in terms of assessing service user's risk.

Finally, staff argued that there was also a good rationale for not sharing their internalised knowledge with service users at times. A case was usually made in terms of not wanting to increase service user distress. Kelly was also concerned about the discussion potentially undermining the therapeutic relationship:

> "You know, if I'm assessing someone's risk in my head, they might be upset if they – they might think I don't trust them. So, if someone says, 'Can I go out?' And I'm thinking in my head, right, how has this person been this morning? What happened last time they went off the ward? Then, well if I ask them questions, then they might think, 'Well, why does Kelly not trust me?' That might sometimes break down the rapport that you might have between the patient." (Kelly, IV, 312-324)

Thus, for Kelly there was some justification for not verbalising this internal knowledge and in keeping it to herself; the decision to share such knowledge, then, rested with Kelly herself.

Staff's approach to gathering clinical knowledge around risk is seen by both staff and service users as an internalised knowledge. Whether that is a subconscious process going on in the mind, or a reading of service users through observation, both parties emphasise that this knowledge is constructed in staff's own mind, with little meaningful interaction involved. This again stands in tension with a view of experiential knowledge that is seen as otherwise unobtainable unless openly shared by the service user themselves. This suggests that these are potentially competing epistemologies operating on the ward, experiential knowledge and clinical knowledge. This tension will now be explored and it will be shown that clinical knowledge tends to take precedence over experiential knowledge and that this contributes to service user disempowerment.

5.3.3 Clinical knowledge and service users' experiential knowledge

In interviews with staff, all staff members emphasised the importance of *involving* service users in risk assessment and risk management, with a view to obtaining their perspectives. For example, Kimberly is seeking a balanced perspective that avoids being overly restrictive or stringent in risk management as achieved via staff utilising their own experience, and also taking onboard the perspectives of the service user themselves, thus:

> "So how do we manage those [risks] without being too restrictive? And sometimes it can, as I said it before, it can impede recovery if we are too stringent. It's a very fine balance isn't it? And that's often done on experience and, as I say, it's done with perspectives of the service user as well. So, we have to take onboard what the service user says. We don't want to, we don't want to

> impede their recovery in any way, and we don’t want to be too stringent.” (Kimberly, senior nurse; IV 619-632)

The notion of staff’s own “experience” implies a form of clinical expertise developed over time within the clinical setting; this again implies that it constitutes a form of experiential knowledge and is developed in clinical practice. At the same time, this has to be balanced against service user perspectives, and the implication is that the absence of this may lead to staff being overly controlling. This further suggests that service user perspectives are potentially quite powerful, in re-balancing the power dynamic, helping staff not to impose their own perspectives.

Similarly, Kelly emphasised the importance of meaningful interactions with service users:

> “I think involving the patient gives you a feel for the risks around the patient because without involving the patient and talking to them you don’t know what’s happening in their head and you might think this patient’s fine, but if you haven’t spoken to them you don’t know how they’ve been managing at home or what’s been going on, so yeah it’s important to involve them.” (Kelly nurse; IV 534-542)

There is raised, then, the possibility of staff misinterpreting a service user’s mood, thereby implying limitations of clinical observation. In particular, staff are understood to have a knowledge deficit that can only be overcome by asking the service user whether they are fine or otherwise. The notion of gaining “a feel” suggests the development of a knowledge and understanding of the risks from the service user’s perspective that are not necessarily comprehensive, but adequate for making a judgement. Only by meaningful interaction can staff acquire knowledge of whether the service user is managing, or what their interpretation of their situation is.

Staff and service users may have different interpretations of risk and of whether the risk is manageable or otherwise, thus, Sara argued:

> “I think it’s [involvement] about discussing it [risk] with the patient, and within the team, all together as an MDT, in ward round. I think, like I said, my interpretation of a risk might be very different to the patient’s, and I think it’s important to take what, on board what they’re saying. Our patients have lived with their illnesses, a lot of them for a number of years. And they, they may be able to manage that risk, whereas I might be like well, I’m not quite sure, that’s quite a high risk.” (Sara, senior nurse; IV 541-552)

That “patients have lived with their illnesses” implies that they are thus understood to have lived experience of a mental health condition, and by virtue of living with that condition over time, they are seen to have developed their own sense of risk severity and as to whether or not they feel they can manage a risk. Here lived experience is thus synonymous with experiential knowledge. Therefore, staff assert the importance of including service user perspectives upon risk due to their lived experience constituting a form of lived expertise.

All staff members, then, emphasised the importance of gaining service user perspectives on risk, and they argue that has to be achieved through meaningful, verbal interactions. This emphasis upon explicit verbal interaction to obtain service user interpretations, then, stands in tension with a view of risk assessment that sees it as a form of internalised knowledge, and of reading service users. The reading approach suggests that staff can make judgements without explicit interaction around risk, but staff seem to suggest potential limitations of that approach, and the need to speak to service users directly to obtain their point-of-view.

5.3.4 Distance from clinical knowledge formed and powerlessness

Whilst staff are emphasising the importance of incorporating service user perspectives upon risk, in different ways service users themselves expressed a sense of distance from aspects of the clinical process. In particular, service users felt distanced from the knowledge formed and the risk-narratives constructed through that process. For example, Jimmy stated:

> "They've barely mentioned risk assessment, which is odd when you think about how important it is here, but I think it's deliberate. Maybe they think we just don't need to know, but I want to know." (Jimmy inf 19/11/18)

Whilst risk assessment is seen as an integral part of being admitted to the ward, Jimmy states that staff rarely talk about it explicitly, which is counterintuitive to him. Jimmy believes that withholding the risk assessment is a deliberate strategy on their part, to withhold that knowledge. Jimmy believes that staff may think that risk assessment is a form of knowledge that is irrelevant to service users, whilst Jimmy himself wants to know what they know. Similarly, Mickey asserted:

> "They don't share their thinking with you, so you don't know how risky they think you are or how they've come to that conclusion" (Mickey inf 16/11/18)

Mickey argues that the thought-processes involved in making an assessment of risk is not being shared with him. As a result, Mickey has a knowledge-deficit in terms of how staff conceive of his severity of risk, and he does not know the process through which they have come to that view. Thus, Mickey expresses a sense of distance both from the processes of gathering knowledge and from the resulting knowledge and risk-narrative formed.

In particular, service users expressed a sense of distance from their risk assessment documentation, and no service user participant had seen such a document. For instance, Chloe stated:

> "I just think I need to be shown it [the risk assessment document]. Yeah, it'd be nice to actually know what people are writing. And then you could also help them [staff] change it so that it makes more sense and that it's more accurate, I guess" (Chloe IV 423-427).

Chloe is thus seeking to know what has been recorded in writing and desires to be shown the actual document itself. This desire to see the document is expressed quite strongly as a "need", as something of crucial importance to her. She believes that if she could see this, she could assist in making changes to the document that could improve the coherence and accuracy of the risk-narrative. This implies that staff may have documented a risk-narrative that is inaccurate and/or that does not make sense from Chloe's perspective. For Samuel, this lack of knowledge regarding the documented staff perspective is fuelling a sense of distrust:

> "I need to see it [a risk assessment document]. I need to know what they're saying about me, and I don't. And it only adds to my paranoia, because they could be saying absolutely anything about me" (Samuel IV 380-382).

Samuel underscores a lack of knowledge which he is seeking to gain, so that he knows precisely what staff are saying about him and his risk-narrative. Again, there is a sense that the staff perspective on, or opinion of, Samuel could be wrong or untrue from his perspective. Furthermore, for Samuel seeing the documentation would be beneficial:

> “For me, that [seeing risk documentation] would be really positive, because at the moment I don’t know what’s going on, I don’t know what they’re thinking, so I’ve got no control” (Samuel IV 414-415).

Again, Samuel is emphasising a knowledge-deficit, in terms of not knowing what staff are thinking and narrating, and as a result he states that he has no control over what is happening to him.

Overall, service users were looking for the processes of risk assessment and the resulting knowledge formed to be made more explicit to them. Thus, Samuel argued:

> “I think it’s important that we know what’s actually going on, they [staff] don’t need to pussy-foot around us, or keep us in some kind of bubble. I feel we need an open and honest discussion about what’s really going on. I’ve got nothing to hide. So, I wouldn’t have a problem with it [risk assessment] being more noticeable at all.” (Samuel IV 169-173)

Whilst Samuel attributes good motives to staff in terms of them wanting to protect service users from further distress, he argues that there needs to be openness and honesty on both sides. The notion of “what’s actually/really going on” implies activities that are not currently transparent but that need to be made more noticeable in order to gain a more realistic appraisal of the situation. This requires that service users obtain a knowledge of staff activities, rather than them being unnoticeable, and to have an open, explicit and direct discussion about the issues.

It has been shown, then, that there are competing epistemologies operating within the setting. On the one hand, there is the experiential knowledge of service users, which needs to be shared with staff in order to receive individualised support. This knowledge-base can be improved through enhanced self-knowledge (triggers) and through acquiring new learning (coping skills) from staff, framing these interactions as epistemic ones. Staff say that they value experiential knowledge, since it is based upon lived experience of mental health problems developed over time. At the same time, staff are attempting to gather clinical knowledge of risk, based upon clinical experience, and also with screening suggesting the utilisation of a learned body of clinical knowledge. Whilst staff say that this clinical process has to incorporate service users’ lived experience, service users themselves feel distant from aspects of this process, and from the knowledge formed. This sense of distance leaves service users feeling disempowered. This perceived power-disparity will now be the focus of the next parts of the findings now developed.

5.4 Power-disparity between forms of knowledge

There is also a perceived (and observed) power-disparity between these two forms of knowledge which are at play in this specific setting, as seen by: service users feeling that staff perspectives are prioritised over their own perspectives; staff’s dismissal of certain risks/threats through minimisation or pathologisation; some service users believe that they have to master the legal/professional discourse of risk in order to secure their rights and obtain power; and service users feeling that a strategy of deliberate passivity is fostered by staff decisional control over the process.

In keeping with the methodology of critical ethnography, then, this part of the findings will explore the perceived, and also observed, power dynamics operating within this social setting. In particular, it will highlight the power disparities between staff’s clinical knowledge and service user’s experiential knowledge. It will expose the means through which service user perspectives are downgraded as a form of knowledge and how clinical knowledge is given prominence. The account will begin with service users' assertions of feeling that staff perspectives are given prominence.

5.4.1 Prioritisation of staff perspectives

In a number of different ways, service users articulated they felt there was a power disparity between the two forms of knowledge operating in this setting, the staff's clinical knowledge and the service user's experiential knowledge. Service users argued that staff prioritised their own perspective over and above the service user perspective. Thus, Samuel stated:

> "It [service user involvement in risk assessment] should be based on the individual, not just on a general diagnosis. So, you need time and space to actually sit down and say this is what anxiety feels like for me, and these are the triggers, and these are the kind of things that make me paranoid, that make me feel unsafe, things like that. I think the one-to-ones are good, but I don't think they're building up an overall picture of things from my point-of-view. It's all their point-of-view." (Samuel IV 229-234)

Whilst Samuel valued one-to-one time with a staff member, which he saw as an opportunity for a person-centred approach, ultimately, he felt that risk assessment was too generic. Furthermore, he felt that staff were prioritising their own perspective over his, such that one-to-ones were not contributing towards building up a summary of the issues from Samuel's own perspective. This sense that staff were prioritising their own perspectives was raised by service users in various ways, as will now be shown.

5.4.2 Staff's dismissal of certain risks/threats

This perceived disparity was expressed by a number of service users as feeling that their own concerns around risk were being dismissed. As has been shown above, a number of service users frequently felt fearful and threatened and had identified specific and unique external threats as risks to themselves. In informal conversations after their ward rounds, some service users expressed that they believed their threats were not being taken seriously:

> "*I am* at risk – I'm fearful and I'm scared, and they're just not listening. I'm not being taken seriously." He also says that "they won't let me talk, they shut me down, and go off-topic whenever I talk about these things" (Gareth inf 23/10/18)

Gareth believes that his fears render him vulnerable to harm, and he is currently feeling fearful, but feels that staff have a different topic or focus of their conversation than he does, and that these are prioritised over his own. This raises the question as to whose knowledge is most important and whose perspectives set the agenda for discussion. Similarly, Kate said:

> "They're so dismissive. People *are* wearing colours to try and make me fit in, and they're just not listening. An injection is not going to change this situation." (Kate, inf, 02/11/18)

Kate thus believes that she is not being listened to, and that her experiences are being dismissed by staff. Staff's power to define issues of risk leave service users feeling dismissed and that their own experiential concerns are not being taken seriously and have no power to direct the conversation. Gareth and Kate (and others) thus experience epistemic injustice, or the dismissal of their knowledge.

Preston provides an example where he has come to re-assess his claim that the government was persecuting him, in these terms:

> "I'm no longer a risk to myself, because I now know that I'm not being persecuted by a secret government agency." … When asked about his experience of admission, he said: "I just wish staff had validated my fears, because whilst the belief wasn't true, the fears were. And staff can't always know what is truth, with a capital 'T', so maybe a bit of humility might help too." (Preston inf 01/10/18)

Preston now claims that the government is not persecuting him any longer, and that this new knowledge has removed his risk. Preston still wishes that staff had validated his fears and taken them seriously. Preston makes an interesting point regarding the limitations of staff perspectives in terms of them not always being able to ascertain objectivity about a situation. The need for humility implies an existing sense of self-confidence on the part of the staff. Thus, the impact of these service users' underlying fears not being explicitly addressed means that they are left feeling dismissed, that their risks are not being taken seriously, and their perspectives are thereby invalidated, thereby contributing to their disempowerment; they experience epistemic injustice and marginalisation.

From the observations of ward rounds it was seen that these fears that service users had identified as risks to themselves were being explored to some extent, in that questions were asked about them. Gareth provides a typical case example as to how these issues of threat were handled by staff. By way of reminder, this is how Gareth initially conceived of his ongoing risk:

> "I don't remember much, I just remember spiders everywhere, and running away from my house, not even dressed properly." He also says that: "My fear is my risk. I was scared of the spiders, and the government was out to get me, so I lashed out at police, and somehow ended up here." (Gareth inf 15/10/18)

Gareth's fear of the spiders was explicitly addressed by staff during ward round:

> Caroline (senior nurse): Your Mother's concerns were that you were not going to football because of spiders there?
>
> Gareth: Yes, but I'm more scared of being beaten-up
>
> Caroline: Why would you fear that?
>
> Gareth: You would know better than me… (Gareth WR 23/10/18)

Gareth is fearful and scared and staff are asking about these fears and also probing the rationale behind them to some extent. Interestingly, the issue of the spiders is introduced as the mother's concern, already implying that a close family member thinks that there may be something untoward about the issue of the spiders. These fears appeared to be explored in an attempt to prove how "unusual" these experiences were:

> Caroline: Do you think anything about that is unusual? And that these are unusual thoughts? We feel the medication will help you.
>
> Dr Singh (consultant): And that it will shorten your time with us.

And again:

> Dr Singh: We feel you are still unwell –

> Gareth: I'm not unwell, I'm taking up a bed and I don't understand why I'm still here.
>
> Caroline: We've talked about your unusual beliefs.
>
> Dr Singh: And drinking your own urine is not normal behaviour. And do you remember walking in the streets bare foot?
>
> Gareth: Yeah, I do.
>
> Dr Singh: The way you are feeling at the moment, I feel that this is because you stopped taking your medication… (Gareth WR 23/10/18)

Gareth's fears are framed as an unusual experience and as interrelated to unusual thoughts and unusual beliefs. Thoughts and beliefs focus on Gareth's internal world and thus on things that exist in Gareth's mind. His subjective reality is being set against a standard or norm from which staff can assert whether something is commonly held to be true or is otherwise unusual. Gareth's experiential knowledge has been downgraded to *beliefs*, with an emphasis upon his private beliefs or opinions, with their unusualness introducing a sense that these ideas are somehow irrational, which paves the way for them being more easily dismissed.

These unusual beliefs are seen to underpin behaviour that is "not normal." These behaviours have, however, been de-contextualised. Gareth had previously attributed his walking bare foot to his fleeing his house in fear of the spiders; for him, his risk is bound up with that experience of fear, which is more important to him than notions of self-neglect. Furthermore, he was drinking his own urine because he did not trust the water-source on the ward. Interestingly, whilst practical solutions were later discussed for addressing this issue (purchasing bottled water) the underpinning fear was not addressed at all. This focus upon a deviation from the norm was an attempt to locate the risk solely in relation to Gareth's mental state. For instance, in the de-brief following Gareth's ward round, staff said:

> Caroline: These spiders and conspiracies, very bizarre.
>
> Dr Singh: Yes, and a very fixed delusion, but obviously that will pass once we get the antipsychotic back into his system. (Gareth WR 23/10/18)

Gareth's fears have been minimised and reduced to a delusion, to bizarre beliefs; again, his experiential knowledge has been reduced to belief or opinion. These beliefs situate the risk in relation to his internal mental state, the proposed solution to which is an antipsychotic; the underlying sense of fear around the external threat is not acknowledged. It is thus easy to see, then, why some service users might feel that their perspectives upon risk are being dismissed.

Other ways in which service user's perspectives upon risk might be dismissed by staff were highlighted in observations of handovers, where conversations centred on notions that certain service users will "always be a risk", seemingly no matter what staff might do. For example, this interaction occurred over a morning meeting handover regarding Maggie:

> Caroline (senior nurse): Maggie had a one-to-one with staff last night, saying she will overdose if going off the ward, and with intention to self-harm.
>
> Dr Singh (consultant): She is one of those who sabotage the treatment plan. I think she will always be a risk. How do we proceed?
>
> Micah (nurse): She has to be accountable for her own actions.

> Dr Singh: Should we discharge her?
>
> Caroline: She is due ward round on Thursday
>
> Dr Singh: She will always be a risk
>
> Micah: But there *are* key social issues
>
> Dr Singh: She's EUPD, they're fully concentrated on themselves… (Maggie HO 23/10/18)

Maggie is seen to embody a diagnosis ("she's EUPD"; meaning that she has been diagnosed with Emotionally Unstable Personality Disorder), which seems to underscore the consultant's view that "she will always be a risk," suggesting that Maggie also embodies what might be termed a risk definition. Maggie's expression of distress is thus reframed as deliberately obstructing the treatment plan. Micah introduces the notion of accountability, seeing Maggie as thus responsible, liable or answerable for her own actions in terms as to whether or not she acts upon her expressed intent; this further implies that in this instance Maggie herself, and not staff, would be to blame if she acted on her desire to overdose whilst off the ward. Discharge then seems to be raised by Dr Singh as a potential intervention that might teach Maggie the desired accountability. Caroline's suggestion that they wait until the next ward round seems to be dismissed by Dr Singh with her repeated belief that Maggie will "always be a risk". However, Micah has concerns regarding Maggie's social situation, which might make discharge problematic at this point. The conversation then continues:

> Dr Singh: She's EUPD, they're fully concentrated on themselves, no concern for her children. EUPDs will harm themselves when put on informal, these people deliberately say these things about wanting to see the children –
>
> Micah: It's game-playing, isn't it?
>
> Dr Singh: I would be on my best behaviour in front of a Social Worker, but she said that she was not eating for three weeks for effect
>
> Micah: Suggest she stay on general and we therapeutically risk it. Suicide is not an immediate risk, maybe accidental, but she needs to take therapeutic responsibility for her actions. She has the capacity and consent to receive love bites on her cheek, which she wants to explain to staff. She should be on general obs, subject to ongoing risk assessment. (Maggie HO 23/10/18)

Maggie's diagnosis of EUPD is raised as an explanation for her actions (and for those of other "EUPDs"), and Maggie is thus seen to again embody the diagnosis, such that her identity is reduced to this diagnosis; this again seems to underpin the consultant's belief that "she will always be a risk". Her diagnosis means that Micah sees Maggie as being manipulative (game-playing), thereby questioning her motivations and downplaying her expressed distress, in the belief that suicide is not an immediate risk (from a staff perspective). Maggie's activity with a male friend when she last took leave is raised as evidence that she has mental capacity and would thereby be legally responsible for her own actions off the ward. Maggie's expression of distress and her view upon her risk have been entirely reframed on the basis of her diagnosis; her risk has been pathologised and, in this instance, seen as an intrinsic part of Maggie's identity, as part of a disordered personality, rendering her a risky individual no matter what staff do.

Pathologisation was one means through which staff filtered service user accounts of their subjective experience of risk. If diagnosed with personality disorder the painful experience can be reframed, by questioning motives and downplaying the expressed distress, since the individual will "always be a risk" no matter how staff respond. Alternatively, experiential knowledge might be downgraded to mere beliefs or opinion, which when treated as unusual and abnormal, paves the way for them to be dismissed as delusion. As a result, service users felt that their perspectives on risk were being dismissed, and their fears invalidated.

5.4.3 Mastering the legal discourse of risk to obtain power

It is striking how often service users talked about risk to self and risk to others, which came up in numerous informal conversations and the formal interviews, which mirrors its use in policy, legislation, and professional discourse. Interestingly, this language was rarely used by staff or service users in the context of the ward round. Where service users used this language in ward rounds, it was in the context of asserting their legal rights. In the context of Liam's first ward round, he was querying the rationale for his Section under the *Mental Health Act*:

> Dr Singh: …There's a concern about you not wanting to stay, and we don't want to keep people against their will –
>
> Liam: That was because I was told I could leave whenever I wanted. When I tried to take some leave to clear my head – suddenly I was Sectioned, when I was not a harm to myself or to anyone else.
>
> Dr Singh: How do you feel about staying here now?
>
> Liam: I will only stay informally, I don't want to be locked down here... (Liam WR 22/10/18)

He also described his mental state upon admission as:

> Liam: I only came in as a courtesy to the staff. How come I was section-able then, if I wasn't section-able in the community? I wasn't a suicide risk at all.
>
> Dr Singh: Suicidal thoughts are not the only factor we take into consideration when we section someone… (Liam WR 22/10/18).

Liam's language mirrors that of legislation and policy and is used to challenge the legitimacy of his detention, and to assert his legal rights. In a context where Liam is questioning his section, he appears to be using some pre-existing knowledge to challenge the way he has been treated. What this example demonstrates is that there is a form of language that may need to be mastered if service users are to obtain power and challenge authority.

The legal language of risk is further seen to provide know-how of the system that can empower service users. This is seen in this statement from Jimmy which was expressed in a one-to-one with Adam (nurse), which was in preparation for a ward round to be held later that day:

> "Jimmy: My advocate told me the lingo so that I now know how to survive the system – Section 2, Section 3, and all that – and it's really helped me assert my rights. Cos when you read me my rights, I wasn't in the right headspace.
>
> Adam: I can understand that.
>
> Jimmy: But I now get that I'm not a risk to myself or to others, the only risk is that of vulnerability, and I think we can all agree on that, and now that that's clear, I think we can all move forward together." (Jimmy 1-to-1, 27/11/18).

Whilst Adam had explained to Jimmy was his rights were under his Section upon admission, Jimmy felt that he was not in the right state of mind to hold that information. Instead, he had had the support of an independent advocate. For Jimmy, understanding "the lingo" implies a language that initially felt alien and perhaps full of jargon, but mastering that language gave him a knowledge of "the system", which he feels has helped him to assert his rights. It appears that it has also given Jimmy some clarity around his risks and where there is a shared agreement about them between himself and staff. This again emphasises risk as a discourse that can empower service users who feel powerless, and that mastering that language can help assert their rights.

5.4.4 Strategy of deliberate passivity

Some service users felt that if they adopted a passive role and were subservient to a professional agenda upon risk that they could then achieve an early discharge. This implies a situation where service users are not being empowered by staff, but they are using what power they have in deliberately acquiescing to staff's overall power and control. Furthermore, service users are using their knowledge to anticipate what might be framed as concerns from a staff perspective. Julia, for example, was navigating a role between refusing to be passive in some regards and the adoption of a passive stance in other areas. She refused to accept the Locum Consultant's perspective upon her condition in these terms:

> Julia: I'm not just going to go with her diagnosis, her risk assessment, or her treatment plan, for the sake of an easy life, because it's wrong.
>
> Caroline (senior nurse): What is it that you disagree with in particular?
>
> Julia: That I have a subtle psychosis. That I'm delusional. That I need to take an antipsychotic. If something's so subtle does it really fit the diagnosis?
>
> Caroline: It's not really my place to say, but I can see why that would be frustrating. (Julia 1-to-1 30/11/18)

Julia argued that she would not adopt a passive role in relation to accepting the Consultant's overall approach, particularly in relation to whether she was unwell or not. However, Julia felt that she had to modify her communication style in order to be viewed as less of a risk:

> Julia: I've calmed down now, but I'm really worried that I've given her [the consultant] more ammunition against me.
>
> Caroline: What do you mean?
>
> Julia: I think I'm being too aggressive and too assertive in my ward rounds, and that that's feeding her idea that I'm too risky, too hostile, and that that's feeding her idea that I'm unwell. (Julia 1-to-1 30/11/18)

Julia was concerned that her communication style had given the consultant more support for her case that Julia was unwell and at risk. In linking assertiveness with aggression, Julia is implying that standing up for your rights could be inter-related with a hostile communication style, and which could be interpreted negatively from a staff point-of-view. Julia is thus using her knowledge to anticipate what might be framed as concerns from a staff perspective. Julia fears that her communication style is both informing the consultant's risk assessment, whilst also providing a rationale for the consultant's diagnosis. She thus concluded:

> “I think I need to modify my approach, to try and stay calm, and communicate more calmly and more clearly” (Julie 1-to-1 30/11/18).

This is, then, a form of adopting a passive role in order to negotiate risk whilst on the ward, where staff perspectives, interpretations and decisions have most power.

Other service users expressed similar views regarding feeling the need to adopt a passive role in order to secure a quicker discharge. For example, in Gareth’s final one-to-one with staff prior to discharge, he shared a key lesson that he had learned from his admission:

> “As I learnt about those worries, those concerns, I realised that I needed to take those on board, and to be subservient to the agenda of the staff here. That if I did that, then people would worry less, would see me as less of a risk, a concern, and a cause for anxiety. I think I sussed out the psychiatrist quite well in that regard, and so got a good result in terms of a quicker discharge. So yeah, that was good, that was a good lesson learned.” (Gareth 1-to-1 16/11/18)

Thus, in order to be seen as less of a risk or concern, Gareth felt that he had to suss out the psychiatrist, implying that he found out or discovered or gained knowledge of what her perceived agenda was. Then, Gareth reasoned that he had to be subservient to professional instruction, and he saw doing so as a means to an early discharge. Similarly, in interview Gareth expressed the same sentiment:

> “I kind of came to my senses and realised that the only way that I’m going to get around this situation is through cooperation. And the only way you can do that is by being (pause) I’m not exactly subservient, but to take a back seat and let them say what they want to say and respond to that. There was absolutely no way I could contribute my own experience.” (Gareth IV 366-371).

Gareth felt that he had to cooperate with staff, which seemed to take the form of allowing staff to set the agenda and to respond to their perspective, rather than contributing his own perspective and experience. Thus, Gareth used his power to choose to adopt a passive role as a means of navigating professional views of his risk and thereby securing discharge.

5.5 Tangible involvement to counterbalance the power-disparity

To counterbalance this power-disparity, service users are seeking more opportunities for *involvement* (contributing their experiential knowledge) throughout their time on the ward; this involvement: needs to be tangible; is focussed on co-constructing risk documentation; and is focussed on securing more power/control over the process and the outputs, rather than on any concept of recovery (which is dominant in staff perspectives). In line with the critical dimension of this ethnographic approach, it will now be considered how these power dynamics and disparities which are operating in this setting can be overcome. Service users had their own ideas as to how to counterbalance this power-disparity in very concrete ways, which will now be considered.

5.5.1 Involvement needs to be tangible

Service users constructed involvement in terms of wanting more opportunities to convey their experiential knowledge. They wanted to ensure that their perspective or testimony was passed on to the staff, and suggested very tangible means of practically doing this, including preparing notes for attending ward rounds and completing scales and/or forms.

A number of service users used written notes as a means of sharing their perspective in ward rounds:

> "Maybe if you have written down what you need to say beforehand, that could make it easier [to talk about risk], because you can - then you know that you've mentioned everything that you need to say. Whereas if you just go in without anything, then you tend to get - you tend to not be able to address your concerns as easily. Because they just kind of talk at you." (Chloe IV 170-176)

Having prepared notes to bring to ward round is seen as a means of making it easier and more comfortable to talk about risk in the ward round setting. It is also seen as a way of ensuring that all of the service user's issues have been raised. Without such preparations Chloe argues that it is harder to have your concerns addressed and that the conversation becomes very one-sided. This again alludes to dynamics of power operating in the meeting, with many service users feeling intimidated, as have already be seen. Written notes are thus a tangible way of ensuring that the service user can contribute their perspective and risk-narrative quite concretely, and thereby re-balancing the power dynamic.

Suggestions to improve involvement in sharing concerns around risk centred on tangible outputs through which service users could more concretely pass on their perspective and risk-narrative to staff. Some service users suggested that individuals could be asked to complete a scale to help identify their risk and risk severity. Jacob argued:

> "If you could give somebody a scale and say look, on a scale of one to ten, if you're, if you're experiencing thoughts of suicide, or thoughts of self-harm, or thoughts of harming someone else, or thoughts of, you know, whatever it might be, how likely are you to act on those things? I, I think a lot, a lot of people would be able to, even quite unwell people would be able to give you some idea of how safe or unsafe they were." (Jacob IV 339-347)

This is framed as a helpful means of conveying the service user's inner thoughts, and their sense of the likelihood of acting upon their concerns around risk. This is put forward as a useful means of identifying what the issues were from the service user perspective. Jacob argues that completing a scale could thus involve a large number of service users, even those who are quite unwell, helping them to convey their own concerns around risk and safety.

Leah had been on other wards where service users had been asked to complete a form prior to taking leave off the ward:

> "I have been on other wards where, when we've wanted to go out somewhere, like patients have been able to fill out their own Risk Assessment form before they go off the ward. And like fill in like questions like, is this patient at risk of like any of the following things? Like returning with contraband items or anything like that. And then like write down like what we're wearing and things like that. So, like on other wards I know that that's something that they've let patients do themselves." (Leah IV 334-344)

Service users could thus document their own risks prior to taking leave, with an opportunity for honest sharing of potential risks foreseen upon their return to the ward, such as bringing contraband items back with them. Furthermore, the document would address the risk of not returning to the ward at all (the risk of going AWOL probably underpins the suggestion of noting down what someone is wearing). Again, this is a tangible suggestion for incorporating more of the service user perspective in ongoing conversations around risk.

Jacob suggested that there could also be non-verbal ways of communication that could indicate that someone feels at risk:

> “I think risk changes, and people’s level of safety changes, for different reasons, at different times. So, I think some way of people being able to say I feel acutely at risk now, without necessarily having to physically go to someone and have a conversation. So, I don’t know whether there are like, whether there’d be a form you could, without speaking to someone, hand in to somebody, or, or, you know, we talked about that wristband thing [people wearing a wrist-band to indicate if they felt unsafe], or whether there was that, you know, something people could use as a physical sign, as a way of very simply saying, you know, I’ve got, I’ve got a problem, I feel at risk right now. As opposed to, as opposed to having to go and verbalise something.” (Jacob IV 355-368)

This suggestion arises out of the perception already considered above that service user-staff one-to-one interactions have to be requested and initiated by service users, some of whom would struggle to do so. Rather than having to initiate a verbal conversation, Jacob suggests that service users could hand in a form, or wear a wristband, or display a sign, to non-verbally communicate their need.

5.5.2 Involvement and co-construction of risk documentation

Service users emphasised not only the importance of seeing their risk documentation, but also the importance of being involved in its co-construction. Sebastian described an ideal document that he referred to as a “care and support plan” in these terms:

> So yeah, [your care and support plan could include] probably you rating high-level and low-risk of certain things. Maybe just what you know about your risk, what you’ve been doing about it. And yeah, just there's no other person involved, but asking you personally.” (Sebastian IV 326-329)

Clearly Sebastian sees a document that outlines care and ongoing support as an important thing. This suggestion incorporates the notion of identifying risks and rating their severity from the service user’s perspective. It also gives the opportunity to record the service user’s knowledge of their risk and their responses to risk thus far, and to contribute their own risk-narrative. Being asked “personally” alludes to the importance of staff asking the individual themselves explicitly and directly about risk.

For Julia, risk documentation would include the two perspectives of service users, on the one hand, and service providers, on the other:

> “Well, it would have two sections. It would have one where we have agreed upon risks that both patient and the provider, the service provider agree are risks. And then another section where the service provider may have separate thoughts. And the patient signs it so that there's a buy-in and there's a way – and it delineates how these risks are going to be reduced by both groups of people.” (Julia IV 527-534)

Thus, the document would incorporate agreed upon risks, and yet leaves space for expressing disagreement or different points-of-view. Julia also sees both parties having a role in risk reduction, with the strategies for dealing with the issues being clearly delineated in writing. Julia sees signing the document as an expression of “buy-in”, which implies a willingness to engage with the plan. Again the emphasis is upon having everything clearly documented on paper, that the service user sees and contributes to the risk-narrative.

For many service users, the co-construction of risk documentation was not just about producing an output as an end-goal, but that involvement was constructed as a process in itself:

> "I think it's imperative that it's [risk assessment documentation] got your involvement, your involvement in it, and you know that it's a working, a working document that's being looked at, and has not just been filled in and sat somewhere. It may not, it may well be being used as that, but I think unless that's being portrayed to us, then it's not got a lot of point. Because they know what they're doing anyway, it's, we who don't." (Denise IV 800-808)

Rather than being filed away, Denise argues that the risk assessment document should be used as a working one, implying that it is a work in progress that can be revised and updated over time, with the involvement of the individual throughout. Such a document, Denise argues, should be routinely revisited with the service user themselves. Denise was unsure whether the existing documentation was being used as such by staff (again highlighting an aspect of the hiddenness of the process) but argued that it needed to be presented to service users as a working document, so that service users have a knowledge of what is happening in regard to risk assessment, otherwise the document is seen as pointless from the service user perspective. If presented as such to service users, such a document would give helpful knowledge as to what is happening.

Samuel, similarly, described an ideal risk document, with an emphasis upon writing down the specific issues in the service user's own words:

> "It would note down exactly what the issues are. You could write out what your fears are, what your worries are, in your own words, get the issues down on paper. Like, this is what paranoia looks like in my experience, blah, blah. And then you write down how those things are going to be dealt with, put the goals there, put the coping strategies there. Like, they've asked me before things like 'how do you normally keep yourself safe?' – you could put that down. And any new strategies could be put down. And then it's actually reviewed, like maybe in the ward round. And you could feel if you're making progress, or where the ongoing battles are. That would really help me, and I'm sure it would help the staff too." (Samuel IV 404-412)

Thus, the document incorporates the issues from the service user's perspective, with an emphasis on the service user themselves writing down what the issues are for them, contributing their risk-narrative. This would thus present the issues in first-person language, from the service user's own perspective, rather than it being summarised in the third-person language of an onlooker. It would also record agreed upon goals, and new and existing coping strategies for maintaining safety. Again, the importance of reviewing such a document is emphasised, here in a more formal sense. Such a review of the document in the ward round is seen as a helpful means of actually tracking progress with the issues, and then highlighting what remains to be worked on. Such a document would first and foremost be of use to Samuel himself, and secondarily to staff.

The co-construction of risk documentation was seen as both an output (a completed document) and a process (a working document) that is seen as a key means of conveying service user's experiential knowledge as a risk-narrative. The emphasis on conveying their experience of risk in their own words was important to many service users as a means of empowerment. If used as a working document, some service users saw this not as a meaningless bureaucratic exercise, but as an important means of documenting knowledge and tracking progress, thereby centring experiential knowledge throughout the whole process of admission and granting power to that perspective.

5.5.3 Focus on securing more power, rather than on any concept of recovery

When staff emphasised the outcomes of service user involved risk assessment and management, they stressed the importance of recovery as an over-arching goal. Thus, Sara argued:

> "I do feel patient involvement is the best way. Every step of the way. It [risk assessment and management] has to be about them, because ultimately, it's their recovery, and their goals to achieve. It's not mine. I'm just here to help them on the way." (Sara, senior nurse; IV 573-579)

Sara depicts the service user as on a journey, with involvement being important with every step, and with recovery as its implied destination. Recovery and reaching goals are paralleled, and both are seen to belong to the individual service user, and emphatically not to the staff member. The staff member is positioned as a helper, which suggests a position of standing alongside the service user, offering support. Risk assessment and management are contextualised as a recovery way of working, and as such it has to be focussed on the individual and their recovery-goals.

Emily, similarly, emphasised the end-goal of recovery in enabling service users to self-manage their risks via the passing on of coping strategies:

> "Poor copers really need to learn the skills to self-manage their risks" regarding passing on strategies, she says "it's about giving back a bit of power, and helping to shine a bit of light into their situation" and says that "things won't change if they're not in the driving-seat of their recovery." (Emily, nurse, inf 23/11/18)

Passing on coping strategies is seen to empower and enlighten the individual so that they can self-manage their risks. "Poor copers" implies a deficit that can be overcome with learning skills that presumably leads to people becoming successful copers. The language of "giving back" power implies that someone or something has taken power away from the individual in the first place and staff are now counteracting that (hence they are seen as the solution and distanced from the problem). To "self-manage" is associated with personal recovery, of which the individual service user needs to take charge, otherwise that state will not be obtained. Recovery is thus the overall end in view when staff are passing on coping strategies.

What is interesting is that recovery was almost entirely absent from service users' discourse around why they wanted to be involved in the process of sharing their concerns around risk. Instead, their focus was on securing more power and control in a situation in which they felt powerless:

> "I'm just looking to staff to help me identify triggers, and to help manage the risks, to learn to cope." She tells me that she needs to do this because "I need to be in control here, to face up to all of the difficulties." (Angela inf 22/10/18)

It is implied that Angela's difficulties have made her feel powerless and out of control. Angela thus desires to be in control and sees enhancing self-knowledge (triggers) and learning new knowledge (coping strategies) from staff as a means of securing control again. Being in control again is thus the desired ultimate outcome of this whole process.

Samuel thought that the co-construction of risk documentation would be empowering:

> "It [co-construction of risk documentation] makes this whole process more of a shared one, like it would involve you more, if you could see what you're dealing with, how you're going to deal with it, you could own the process a bit more. You could bring it to ward rounds, you could discuss it, amend it, and tick off things as you go, yeah, that would be empowering, actually." (Samuel IV 427-431)

The emphasis, then, is on sharing the process, with it being more of a partnership and less one-sided. This sharing of the whole process is seen as an important facet of involvement. Having a written document enables the service user to see the documented risks and also to have a stake in how those risks are going to be managed. All this would foster a sense of ownership over the whole process, emphasised in the repetition of "you're" in "what *you're* dealing with" and "how *you're* going to deal with it" (not "what they"). When the document is used as a working one, with formal reviews, where progress can be demonstrated and amendments to the plan can be negotiated, this, for Samuel, would be empowering. Thus, securing more power and control over the whole process is the focus of service users' desire for involvement.

5.6 Summary

There are a number of different epistemologies operating within this social setting. Importantly for this study, there is the experiential knowledge of the service user – as a *knower* of distress – incorporating their thoughts, feelings, and interpretations of their circumstances, with a raw emotional core that can make it difficult to share. Service users are looking to convey this knowledge in a comfortable, one-to-one setting in order to receive individualised help and support from staff, framing these as epistemic encounters. Learning about triggers can be seen as a form of enhancing self-knowledge, whilst concepts like relapse signatures are rooted in more of a learned body of clinical knowledge that is passed on by staff. Similarly, service users are looking to develop new knowledge in the form of coping strategies; these can be rooted in knowledge developed in staff's clinical experience of working with service users or can also be a form of learned knowledge (e.g., psychoeducation). Staff are also gathering knowledge through screening (a form of learned clinical knowledge) and observations (largely defined as an internalised knowledge). Finally, there is also the legal framework around risk, which constitutes a form of knowledge that some service users feel they have to master in order to assert their rights.

Not all of these epistemologies are given equal prominence. Service users feel that there are power disparities between these different forms of knowledge. Service users feel distant from the processes of gaining clinical knowledge of risk and from the resulting knowledge and risk-narratives formed by staff through those processes. In particular, service users feel that in various ways staff's clinical knowledge is given priority over their experiential knowledge. This is achieved by pathologising their fears and/or behaviours and may include downgrading their experiential knowledge to mere beliefs, resulting in epistemic injustice and marginalisation. However, service users can see that these dynamics of power can be overcome through tangible means of passing on and recording the service user perspective, particularly focused on co-constructing risk documentation, seen as both an outcome (a completed document) and a process (a working document that is under constant review). The focus for service users, rather than being on any concept of recovery, is more on securing more power and control over the process and outputs, so that service users can feel like they are contributing their experiential knowledge throughout their time on the ward. In these ways service users can reclaim the power that they feel they have lost and can begin to feel safe again.

Chapter Six: Discussion

This study contributes to our understanding of the competing epistemologies (theories of knowledge) operating in an acute psychiatric inpatient ward and the degrees of power attributed to them by different parties (service users and staff). In particular, the study sheds light on the ways in which service users see themselves as knowers, reasoners, and meaning-makers (or epistemic subjects) by virtue of their lived experience and expertise. It also reveals that service users see risk assessment and management as involving epistemic activities, in which service users want to contribute their experiential knowledge, and that they are seeking opportunities to achieve this throughout their inpatient admission.

In this chapter the findings considered in the previous chapter will be situated within the existing evidence-base, theory, and practice guidance, and the key ideas will be discussed in detail. The discussion will begin with an exploration of risk as a form of experiential knowledge and expertise from the service user perspective. Then, risk assessment and management as the epistemic activities of *hermeneutics* and *giving testimony* to risk-experience will be explored. Service users as seeking epistemic support in the form of new learning (coping skills), enhancing self-knowledge, and transforming self-knowledge will also be explored. Moreover, individual, interpersonal, and procedural barriers and facilitators to the honest sharing of the risk-experience in the specific social context will be discussed.

Epistemological and power tensions of risk assessment and management in an acute psychiatric setting will be unpacked, and especially service user experiences of epistemic injustice and how epistemic justice can be recovered for service users will be discussed. Further power-dynamics operating within the specific setting will be considered, and service user conceptions of empowerment in risk assessment and management will be outlined. Finally, how risk documentation can be used to navigate these issues of knowledge and power within the setting will be discussed. Throughout the argument the novel contributions of the study will be highlighted.

6.1. Risk, experiential knowledge, and expertise

This study makes a significant contribution to our understanding of risk from the service user perspective as a form of experiential knowledge and expertise. It thus adds to our understanding of how experiential knowledge itself is conceived by service users and how service users seek to utilise it in a specific social setting in the context of risk assessment and management. This section will consider the personal experience of risk as a form of experiential and embodied knowledge, interpretations, and feelings of safety as a form of experiential fulfilment and thus the goal of admission, and the related notion of service users' experiential expertise.

6.1.1 The risk-experience as experiential knowledge

In this study, *experiential knowledge* has a central place in what are framed as the epistemic activities of the honest sharing of risk (risk assessment and management) from the perspectives of service users. Experiential knowledge has been defined as "truth learned from personal experience with a phenomenon" (Borkman, 1976, p445), and it is "based on wisdom and know-how gained from personal participation in a phenomenon" (Borkman, 1976, p446). Service users in the study undertaken emphasised the personal experience of risk (or *risk-experience* for short), seeing it as a response to life-circumstances with an emotional core. It is a situated perspective (Faulkner, 2017), in that it is particular to the individual's own situation and circumstances. The findings have shown that the interplay between external events (the stressors) and internal reactions (the stress felt) is perceived, interpreted, and experienced uniquely by the individual. It is also embodied knowledge (Abel and Browner, 1998), meaning that it is based on personal perceptions of bodily experiences and sensations. Service users emphasised an emotional core to risk that centred around feelings of powerlessness or of being overwhelmed, and/or feeling threatened or fearful. Whilst previous research has highlighted how professionals view risk as a key rationale for inpatient admission (Bowers, 2005; Bowers et al, 2005), this study also shows that service users view their risk as a key factor for admission too. Thus, service users arrive onto the ward feeling at risk or vulnerable, and/or a risk to self, and/or a risk to others, which fundamentally has experiential meaning for service users.

For the individual, their perspectives have the "certitude" (Borkman, 1976) or "epistemic authority" (Dawney, 2011) of "knowledge." The service user perspective is a form of knowledge of what the individual is undergoing, in terms of their thoughts and feelings, and how they themselves see, interpret, and experience their life circumstances. It is a knowledge of the inner world of the individual and knowledge of their embodied experience. In the context of health, it is a facet of what has been termed "patient knowledge" (Pols, 2014), as it is a form of knowledge derived from the whole experience of being a patient or service user (Baillergeau & Duyvendak, 2016). Importantly, it is a form of "knowing otherwise" (Walklate & Mythen, 2011) that is a different form of knowledge compared to the dominant theoretical/scientific narrative of risk. As such, knowing otherwise introduces another narrative, one that highlights gaps of perspectives in the dominant narratives, which for Walklate and Mythen (2011) is rooted in the experience of the victim of domestic violence risk, but which, based on my findings, can be applied to risk-experience more generally. Knowing otherwise emphasises a unique epistemic perspective that cannot otherwise be obtained, and thus service users bring a different narrative, perspective, and form of knowledge.

Service users saw experiential knowledge not as propositional knowledge gained from experience (as per Borkman, 1976) but more like Abel and Browner's notion of embodied knowledge as the raw sensory data combined with the particularistic meanings attached to such sensory data by the individual (Abel and Browner, 1998). In the study undertaken it has been shown that particularistic meanings are attached not only to the emotions felt but also to the wider external circumstances too. Service users were looking to share their particularistic meanings in terms of what self-injury or paranoia, for example, might look like for them an as individual. Service users asserted that sharing these particularistic meanings would enable person-centred care rather than care rooted in generic diagnoses or formulations.

For some service users their particularistic meanings surrounding their risk-experience meant that risk was seen as a unique form of threat. Here we return to the experiences of Gareth and the spiders, Kate and the colour-coding of clothing, Preston and government persecution, Ash and the lampposts' communication, and Dominic's fear of being killed for his millions. In each case these unique experiences and interpretations of external circumstances were still causing fear and anxiety leading to feelings of threat, interpreted as by the individual as a risk. In each case, service users wanted staff to understand the particulars of their experience and to validate their emotions.

Service user accounts of their risk-experience are thus central to understanding experiential knowledge in this context. For Borkman (1976), the three key attributes of experiential knowledge are: 1) that it is pragmatic (what works) rather than theoretical;

2) it is oriented to here-and-now action rather than theory-building; and 3) that it is holistic and total rather than segmented by a particular underpinning discipline. This might give the impression, however, that individuals simply navigate through a list of practical problems requiring pragmatic solutions. In the study undertaken, whilst service users were solutions-focussed, in terms of wanting to learn to cope in the here-and-now, the support they were seeking had to fit within the particularistic meanings attached to their experience (as per Abel and Browner, 1998), applied to their risk-experience. Instead, another term of Borkman's (1976) is helpful, namely that experiential knowledge has *experiential fulfilment* as the end-focus, rather than achieving scientific outcomes. Rather than merely seeking pragmatic solutions, service users were working towards a sense of experiential fulfilment, which in this context, as we have seen, is to achieve a sense of safety.

6.1.2 Experiential fulfilment and safety

This study emphasises that interpretations and feelings of safety also form a key part of service users' experiential knowledge in the context of risk assessment and management. We have seen that the risk-experience is perceived by service users as a key factor for admission, such that service users arrive onto the ward feeling at risk or vulnerable, and/or a risk to self, and/or a risk to others, as fundamentally experiential categories with an emotional core. In this study, feelings of fear and distress are thus associated with feeling vulnerable, at risk, and under threat. This study adds to the literature on service users' expectations and experience of inpatient wards as a "place of safety" or refuge (Hopkins et al, 2009; Molin et al, 2016; Chevalier et al. 2018). Service users expect to develop a sense of physical and psychological safety whilst on the ward (Berzins et al, 2018; 2020). Service users place emphasis upon the role of risk assessment and management in "keeping patients safe" during their admission, as professionals do too (Bowers, 2005). Importantly, service users in this setting also perceive their own feeling of safety as a key factor for discharge (Tyler et al, 2021). Service users are looking to feel safe again and are looking to build relationships with staff that will enable this (Cutler, 2020). In the current study, it is *through* the sharing of experiential knowledge around the risk-experience that service users can begin to feel safe again. This study frames the admission journey as a move away from the risk-experience towards the experience of safety as the expression of experiential fulfilment. Thus, notions of safety constitute service users' experiential fulfilment and thus as the goal of risk assessment and management for them.

6.1.3 Experiential knowledge and experiential expertise

Within this research service users possessed a form of *experiential expertise* in accordance with Borkman's (1976) conceptualisation. Since service users attribute high epistemic authority to their experience as a form of knowledge, they could be legitimately called experts *in* their own experience (Faulkner, 2017). Similarly, the term experts *by* experience underscores the notion that experiential knowledge is the source of, and thus grants, a form of expertise and experiential authority (Noorani, 2013). The domain of this expertise is as broad as the range and depth of the experiences underpinning it (Baillergeau & Duyvendak, 2016). In this respect, service users possess what is termed high *self-epistemic authority* (Stasiuk et al., 2016). Thus, in this study service users saw themselves as best placed to give voice to their risk-experience as experiential knowledge. This coheres with previous research that suggests that service users are "the best expert" in mental health care planning (Laitila et al, 2018). Similarly, service users are “best placed” to suggest interventions to improve the safety of services due to their expertise from experience (Berzins et al, 2018).

Borkman’s own emphasis is that experiential expertise refers in particular to “competence or skill in handling or resolving a problem through the use of one's own experience” (Borkman, 1976, p446). In this respect, we have seen that service users experience an inability to apply their current experiential knowledge and expertise to manage their risk-experience. Service users have a knowledge deficit in this regard. There is a tension, in that whilst service users see themselves as possessing experiential knowledge and lived expertise in relation to their risk-experience they do not possess the knowledge to be able to put that into practice. Thus, as will be seen, service users are seeking forms of epistemic support, one aspect of which centres on enhancing self-knowledge, thereby recognising service users’ inner resources. Staff assist in the application of knowledge through strategies of service user self-reflection. Furthermore, service users also felt that they have a lack of opportunity to enact the knowledge that they do have. Specific procedural knowledge deficits will be considered in detail below.

From the service user perspective, this knowledge deficit does not undermine or compromise their broader experiential expertise nor their claims to experiential knowledge and self-authority. Instead, service users are looking to utilise their experiential knowledge in the honest sharing of their risk-experience, to obtain new knowledge in the form of person-centred coping skills. From their perspective, they thus retain their overall status as expert *in* their own experience and as the best expert in sharing their experiential knowledge in their own estimation. Whilst staff said that they valued service user lived expertise, it was not always granted high epistemic authority when compared to staff knowledge and expertise.

6.1.4 Summary: Experiential knowledge and expertise

This research makes a significant contribution to our understanding of experiential knowledge and expertise in the sharing of risk-experience in the context of acute psychiatric inpatient wards. It argues that notions of risk and safety are rooted in an experiential and embodied form of knowledge, including both the raw sensory data and the particularistic meanings attached to such sensory data in the context of the service user’s circumstances. Thus, service users are looking to share their risk-experience as they journey away from the experience of risk and towards the experiential fulfilment of feeling safe again. This experiential knowledge grants a form of expertise, the domain of which is as broad as the range and depth of the experiences underpinning it. Thus, service users see themselves as best placed to share their risk-experience.

6.2 Risk assessment and management as epistemic activities

This study also makes a significant contribution in our understanding of service users as *epistemic subjects* (knowers, reasoners, meaning-makers; Fricker, 2007) who engage in what are framed as the *epistemic activities* of sharing risks (risk assessment and management). In this section the following argument will be discussed: that service users’ contribution centres on *hermeneutics* (interpreting and making sense of things) and *giving testimony* (passing on knowledge to others), (Fricker, 2007); and that service users are seeking forms of epistemic support from staff in the form of new knowledge (coping skills), enhancing self-knowledge, and potentially transforming their self-knowledge. Engagement in these epistemic activities thus centres on making sense of, and conveying to others, personal risk-experiences which to service users have the high epistemic status of knowledge.

6.2.1 Experiential hermeneutics

One way in which service users acted as epistemic subjects was in the hermeneutics of interpreting and making sense of their experience (Fricker, 2007). All service users had come to an "emotive judgement" (Zinn, 2006) that they were unsafe, or vulnerable, or under threat. They felt and perceived themselves to be either a risk to themselves, or to others, or to be at risk in some way. Many recognised that their risk-experience was a key factor in both their own admission to the ward and in others' admission too. They also felt that they were well placed to make such emotive judgements and interpretations of their experience. One of the unique aspects of the study undertaken is that it was often those experiences that would be labelled as delusion or not recognised as a risk by staff, that had experiential significance as risk to service users themselves. Thus, how service users themselves make sense of their risk-experience is crucial. Service users were also working towards the experiential fulfilment of feeling psychologically safe again, which would be a key prerequisite for discharge from a service user point-of-view. Again, service users felt they were best placed to make interpretative judgements about their psychological safety. Thus, service users applied experiential hermeneutics as they journeyed from feeling at risk to feeling safe again.

6.2.2 Giving testimony to risk-experience

Service users saw their experiential knowledge as a form of knowledge that needs to be verbalised and articulated. It thus involves a form of epistemic testimony as the individual passes this knowledge on to others (Fricker, 2007). Such experiential and embodied knowledge is also perceived as a form of knowledge that is otherwise unobtainable unless the individual is willing to give testimony about their risk-experience, because it grants access to the inner world of the person. Service users argued that staff need to have this form of knowledge in order to provide individualised, person-centred help and support with risk. There also has to be a testimonial fit between solutions proposed and the experience expressed (Abel & Browner, 1998) in order to provide a sense of experiential fulfilment (Borkman, 1976).

This study has shown that service users were seeking to contribute their experiential knowledge throughout the inpatient admission experience. Service users framed this as an honest sharing of their risk-experience. In addition to the importance of ongoing interpersonal communication with staff, this study has shown that service users also suggested tangible means in which they could contribute their experiential knowledge. As has been seen, suggestions of tangible ways of communication included completing a form that could include risk-identification and risk-severity from the service user perspective. A further novel contribution of this work is that non-verbal means of communication were also suggested, such as handing in a form, wearing a wristband, or displaying a sign, to indicate need regarding risk. Furthermore, service users felt they could be more adequately prepared for ward rounds, as they wanted to have a greater role in setting the agenda of discussion. By bringing prepared notes as to what *they* wanted to contribute to the discussion service users felt that their perspective might have a greater role in guiding the conversation. Moreover, service users wanted their perspectives recorded in documentation with any risk issues noted down from their own perspective and in their own words. Service users were seeking opportunities for tangibly contributing their testimony

The ability to contribute experiential knowledge was the primary way in which service users conceived of *involvement* in risk assessment and management. As was detailed in the literature review, involvement in risk assessment and management has been well-defined in legislation operationalisation guidance (*Code of Practice*, 2015), policy (DoH, 2009; 2018), professional guidance (RCPsych, 2010; 2017) and standards (NICE 2004; 2011; 2015), and other good practice guidelines (O'Rourke & Bird, 2001; Langan & Lindow, 2004; Boardman & Roberts, 2014). However, as has been shown, research into service user perspectives on and experiences of involvement and non-involvement in risk assessment and management have been limited (Langan & Lindow, 2004). Models of service user involvement have tended to emphasise participation as a move away from paternalism and tokenism towards empowerment to make one's own decisions (Arnstein, 1969; Hickey & Kipping, 1998; Thompson, 2007). Previous research has also highlighted the importance of the service user's "knowledge contribution" for shared decision-making (Storm & Edwards, 2012; Aoki, 2020), and that professionals need to elicit, value and respect the service user perspective for genuinely collaborative, participatory deliberation and decision-making (Bee et al. 2015; Lovell et al, 2018).

In this study, service users' focus was on collaborating with staff in order to give testimony to their risk-experience. This honest sharing gave service users a number of perceived benefits, namely, to feel heard, understood, and validated, to process emotions, to have a sense of buy-in and control over the process, and also over what is documented. In addition, service users perceived that the knowledge shared could also assist staff to provide tailored help and support. An important contribution here is that a core part of involvement, then, was staff helping service users to articulate their testimony. By contrast, non-involvement meant that service users felt they could not contribute their testimony, or that their testimony was dismissed, or that staff perspectives took precedence.

6.2.3 Epistemic support from staff

Service users primarily framed the support they were seeking from staff in epistemic terms (Fricker, 2007). Service users were looking to share their experiential knowledge with professionals so that staff could provide new knowledge in the form of person-centred coping strategies. Unlike previous studies which found that service users on acute settings felt left to devise their own risk management (Quirke et al, 2004) or safety strategies (Jones et al., 2010), this study found that service users perceived that staff did pass on certain coping strategies, and this was observed in action within service user-staff one-to-ones. We have seen that this process could involve the unlearning of current unhelpful strategies (such as a reliance on drugs and/or alcohol) where what was unhelpful was collaboratively negotiated and agreed upon rather than imposed by staff. This process also involves new learning of better means of coping in the form of new knowledge and skills. Learning to cope highlights the here-and-now focus of this knowledge for service users, and also its pragmatic aims in terms of what works for the service user (as per Borkman, 1976) as subjectively perceived by the individual living through the risk-experience. Again, there has to be a testimonial fit between the accepted solutions and the underlying risk-experience expressed.

Another key finding of this study is the epistemic work on enhancing service users' self-knowledge. As has been shown, this took a number of different forms. Mostly, service users were looking to staff to assist in identifying triggers. Previous research on the work of identifying and documenting triggers has framed this as an important part of collaborative working in risk assessment that helpfully informs risk management (Perkins & Repper, 2016; Higgins et al, 2016). In the study undertaken service users were seeking help in the hermeneutical task of making sense of their experience, in terms of the specific interplay between external events (the stressors) and internal reactions (the stress felt) in their unique risk-experience. This hermeneutical task was framed as the service user getting to know themselves better, as a means of discovering the issues within oneself. This situates the service user as a knower and meaning-maker (Fricker, 2007) who is well placed to interpret their situation and thus this work attributes high self-epistemic authority to the service user (Dawney, 2011; Norrani, 2013). Service users were looking to identify their triggers and they perceived that they needed to inform staff of their specific stressors in order to receive individualised support.

A further significant finding is that staff worked with some service users in order to transform their self-knowledge. Using the case of Chloe, we saw that in that instance staff were challenging her negative sense of self. Staff were helping Chloe to see positives in her life-experience as a means of overcoming her risk-experience of self-injury. As has been shown, this was achieved through a self-reflection exercise, enacted within a one-to-one, passed on by staff as a particular coping strategy. Again, this work attributes a high self-epistemic authority to the individual service user (Dawney, 2011; Norrani, 2013) and assumes that they are well placed to make sense of their life-circumstances and their self-identity. This is an interesting case as it suggests that service users can revise their experiential knowledge, that in a sense they can be wrong and in need of correction (Prior, 2003). Coming to a realistic self-appraisal combined with a re-interpretation of their situation, was negotiated collaboratively, and was the result of self-reflection rather than imposition by staff. Chloe already saw her self-injury as problematic, was seeking support in the form of coping, and already saw that her self-knowledge was in need of transformation. Again it is important that Chloe herself revised her experiential knowledge on the basis of her own self-reflection. This study emphasises the epistemic and experiential nature of this collaborative work.

6.2.4 Summary: Epistemic activities

This study makes an important contribution to understanding how service users framed the honest sharing of the risk-experience. It centres the epistemic activities of making sense of, and giving testimony to others, service users' experiential knowledge. Involvement is constructed by service users in an acute psychiatric inpatient setting as the ability to articulate and contribute their knowledge of the risk-experience. Service users are looking to communicate with staff in both verbal, and non-verbal means, to indicate need regarding risk. Service users conceived of sharing their risk-experience as a means of helping staff to offer epistemic support in the form of learning new ways of coping, enhancing self-knowledge, and potentially transforming self-knowledge.

6.3 Barriers and facilitators to honest sharing of experiential knowledge in epistemic encounters

6.3.1 Individual, interpersonal, and procedural barriers

A number of contextual barriers and facilitators to the honest sharing of experiential knowledge in the particular social setting were identified from the service user perspective. In this section we will consider the individual and internal barriers that can inhibit the sharing of the risk-experience, and the interpersonal and procedural barriers and facilitators to honest sharing within the specific context of inpatient care.

First, this study makes an important contribution in terms of highlighting the internal barriers within service users themselves that inhibit honest sharing. In addition to framing risk in experiential terms, service users in this study also emphasised the emotional dimensions to talking about risk, in terms of the personal difficulties involved in sharing experiential knowledge. They asserted that having such conversations could be difficult, distressing, or even traumatising. For them, these raw emotions at the core of the risk-experience and the perceived sensitivity around risk can constitute personal barriers that need to be overcome for honest sharing of risk. Similarly, there might be a sense of guardedness that could inhibit communication. This study coheres with previous research showing the importance of developing trust with staff as key to beginning to open-up a conversation (Bowers, 2005; Gilburt et al, 2008; Molin et al, 2016). Regular service user-staff one-to-ones in a private setting are important to facilitating the development of trust. As previous research has highlighted, a sense of felt trust and judgements of trustworthiness draw on experiential knowledge (Zinn, 2008).

Second, there are relational and interpersonal barriers to the honest sharing of the risk-experience. The findings of this study chimes with a wealth of previous research which highlights the importance of staff building therapeutic relationships with service users in acute psychiatric inpatient settings (Molin, 2016; Deering et al, 2019). These findings also fit with previous research which suggests that nurses often appeared to service users as too busy for meaningful interaction (Stenhouse, 2011; Terry & Coffey, 2019; Culter et al, 2020). Service users felt that the onus was on themselves to initiate and request one-to-one time with a staff member. Previous research has highlighted the importance of relationships in the work of engagement (Bright et al, 2014), including in providing physical and psychological safety for staff and service users in the context of acute psychiatric care (Polacek et al., 2015). In the study undertaken, service users were looking to staff to initiate engagement in the form of setting up these one-to-one encounters. There was also a concern that a lack of service user confidence could mean some service users get forgotten; again, emphasising the need for staff to initiate engagement. As has been shown, means of non-verbal communication were suggested as potential ways to make asking for help easier. Furthermore, service users felt that opportunities for interaction, and thus for building relationships, were missed. As prior research also suggests, staff's clinical observations are a potential opportunity for meaningful engagement (Jones et al, 2000; Insua-Summerhays et al., 2018; Veale et al, 2020), here applied to asking service users about their risk.

Third, service users expressed that they had a number of procedural knowledge deficits that could inhibit communication. Information provision has been theorised as a key part of service user participation in shared decision-making in services generally (Storm & Edwards, 2012; Castro et al, 2016). In the context of acute psychiatric inpatient wards, prior research has highlighted a lack of information provision on the ward generally (Laitila et al, 2018), and particularly in the context of admission (Chevalier et al, 2018), or of detention under the *Mental Health Act 1983/2007* (Katsakou, 2012; Akther et al, 2019), and also around ward rounds (Milner, et al, 2008; Cappleman, 2015). In the study undertaken, there was a lack of clarity around knowledge-sharing and communication within the staff team as to who shares what with whom, which could impact upon the communication of service users. As with prior research, there was a knowledge deficit around the whole process of risk assessment and management on inpatient wards (Langan, 2008; Coffey et al, 2017), in terms of staff's perceived levels of risk and how staff might respond to different levels of risk-severity, and how that might impact upon ongoing care and treatment. Similarly, as with previous research (Ganzini, 2013) service users wanted to understand the rationale behind different questions being asked by staff of service users, and again these issues might hinder open and honest communication.

These procedural knowledge-deficits contributed towards the overall sense that staff's risk assessment was a form of *hidden* knowledge. Service users expressed a sense of distance both from the processes of staff gathering knowledge and from the resulting knowledge formed by staff. Rather than it being an *assumed* activity, service users were looking for processes to be made explicit and transparent to them. In particular, service users were looking to know what was being documented about them, and to understand staff rationales, and they wanted to contribute their own perspective. Thus, a novel contribution of this study centres on staff's risk-work being open and transparent to service users, who need an understanding of processes, and who are seeking opportunities to contribute their perspective throughout those processes.

6.3.2 Summary: Contextual factors

Building upon prior work that has focussed upon the importance of interpersonal relationships within acute psychiatric inpatient settings, this study identifies two further barriers to the honest sharing of risk, the internal and emotional barriers within service users themselves, and process or procedural barriers.

6.4 The epistemological and power tensions of inpatient risk assessment and management

Research has tended to focus on the function of experiential knowledge *within* hermeneutic communities and thus amongst groups of peers (e.g., self-help, Borkman, 1976; or ante-natal groups, Abel & Browner, 1998). In this study, we have seen what happens when experiential knowledge crosses between hermeneutic communities, from the service user to staff members.

This section will consider the value of service user's experiential knowledge for staff, and the role of medical or clinical knowledge in their risk assessment and management. It will be argued that service users experience epistemic injustice when these different forms of knowledge (experiential and clinical) intersect, and that staff perspectives are given greater epistemic authority. It will be shown how the role of a standard view of science (or naïve positivism) contributes to the epistemic marginalisation of service users in risk assessment and management. Furthermore, service users' experience of epistemic injustice will be discussed, particularly focussed on staff's dismissal of unique threats and through pathologisation. Finally, this section will consider how epistemic justice can be recovered for service users through an interpretivist approach to their hermeneutics and testimonies, and a coproduction approach to knowledge and expertise in the context of risk and safety. The core issues of knowledge and power, which constitute the novel findings of the current work, that are operating within the social setting in risk assessment and management will thus be unpacked and discussed in detail.

6.4.1 Staff value service user's experiential knowledge

As with service users, staff also conceived of risk assessment and management as involving epistemic activities. In particular, staff said that they valued service users' experiential knowledge, and recognised that such knowledge needs to be verbalised and articulated by service users to them. Staff also saw service users' lived experience as constituting a form of lived expertise, which service users can draw upon in order to ascertain risk severity and to make judgements as to whether they feel that they can manage the identified risk. Service users and staff also recognised that mental health professionals gain important knowledge from their clinical experience. In particular, the clinical experience of working with a wide range of service users over time is understood to underlie the provision of tailored help and support in the form of coping strategies.

6.4.2 Risk as a learned body of medical knowledge

This study highlights a major epistemological tension regarding how a learned body of medical knowledge operates in the social setting. In relation to risk assessment and management, this is seen in notions of relapse signatures and psychoeducation (Lyman et al, 2014; Motlova et al, 2017). These concepts are focussed on the mental state or mental health condition or disorder from a clinical perspective. Whilst service users' embodied knowledge is experiential, staff's clinical knowledge is theoretical. These clinical concepts are presented as a form of knowledge and understanding that are important for service users to learn. From a professional perspective, one-to-ones are framed as epistemic encounters whereby a didactic knowledge-transfer takes place, but it has been shown that the interaction is more of a teacher-pupil one, with its inherent power dynamic and disparity.

Risk as a form of medical knowledge is particularly evident in the notion of "screening for risk" in the context of the ward round. The language of screening implies that identifying risk is a science and a form of medical expertise, akin to identifying symptoms via a screening tool, and thus constituting a learned body of clinical knowledge. This body of knowledge informs the screening process, which thus constitutes a method for gaining clinical knowledge around risk. This filters the service user account, sifting for relevant information from which a clinical knowledge of risk can be formulated. This is a case of Foucault's notion of the "medical gaze" in action. In *The Birth of the Clinic* (ET 2003) Foucault develops the notion of *Le regard médical* (the medical gaze) in which doctors filter in parts of the patient's presentation and narrative that fits into the biomedical paradigm and they filter out the non-biomedical. Foucault argued that this results in doctors viewing the patient's physical body separately from their identity as an individual person, thereby dehumanising the individual. Foucault also argued that this approach makes medicine doctor orientated. Thus, the individual patient's personal experience or perspective (what we are terming experiential knowledge) becomes less important than the doctor's judgement and formulation. Foucault argued that the *Clinique* (teaching hospital) reinforces this *regard médical* in its medical practice and perpetuates it through its system of medical education (Foucault, ET 2003). How this contributes to epistemic injustice will be considered below.

In this study staff were seen as formulating clinical knowledge on the basis of an internalised reasoning. Similarly, Carel and Kidd (2014) argue that every patient-clinician encounter involves a tacit epistemic assessment. The notion of *reading* service users was mentioned by both staff and service users. This reading constitutes part of what staff conceived as a form of internalised knowledge. Hamilton and Manias's (2007) ethnographic study of nursing observations on a psychiatric ward emphasised the notion of observations as "invisible work." They asserted that observations were constructed by nurses as an aural and visual process, with the nurse's gaze drawing on medical knowledge (symptoms, absence of symptoms, and mental state in action) and tacit notions of normality. Nurses valued a third-person perspective, since being a third party to a service user's talk was seen to provide important knowledge in relation to mental state and to the service user's coping-ability in different social situations. Nurses argued for the importance of discretion as an observational tactic. Hamilton and Manias (2007) argued that nursing work and skill would become a subjugated knowledge if the invisible work of observations was not recognised by professionals. For Hamilton and Manias (2007) such invisible work was thus constructed positively.

From the service user perspective, this conception of knowledge, however, underlies the sense that risk assessment feels like a hidden knowledge. Service users have no access to staff's own inner world. There is thus a sense of distance from the knowledge formulated. Service users were thus looking for such invisible work to be made visible to them. Furthermore, as with previous research, there was a sense that staff control if, and when, to share such knowledge with service users (Langan, 2008; Coffey et al, 2018) which clearly contributes to the feeling of disempowerment for service users.

6.4.3 Epistemic injustice of service users when different forms of knowledge intersect

When these forms of knowledge intersect, what has been shown is that there is a hierarchy of knowledge operating in the social setting. This is seen particularly in instances where service users feel that their perspectives are being dismissed. In these instances, it has been shown that a service user's experiential knowledge gets degraded to mere beliefs. This study, then, makes an important contribution to our understanding of service users' experiences of epistemic injustice, as the devaluing of their experiential knowledge and expertise, in risk assessment and management in this acute psychiatric setting.

Epistemic injustice is a harm done to a person in their capacity as an epistemic subject (a knower, a reasoner, a meaning-maker) by undermining their capacity to engage in epistemic activities (Fricker, 2007). Miranda Fricker (2007) introduced two key forms of epistemic injustice. *Hermeneutical injustice* undermines the capacity of the epistemic subject to interpret and make sense of their experience (Fricker, 2007). It may involve judgements that a service user's interpretations of their experience are too difficult to understand and to make sense of, are insufficiently articulated, or too subjective (Carel & Kidd, 2014; Crichton et al, 2017). *Testimonial injustice* undermines the capacity of the epistemic subject to pass knowledge onto others in the form of testimony (Fricker, 2007). It may involve judgements that a service user's testimony to their experience is cognitively unreliable (confused or irrelevant), emotionally or existentially unstable (they are too emotional or distressed), or poorly communicated (Carel & Kidd, 2014; Crichton et al, 2017). On both counts the individual may be seen as psychologically compromised by their illness or distress such that it hinders their capacity to accurately interpret, describe, and report their experiences (Carel & Kidd, 2014). As a result, service users are epistemically marginalised, with their perspectives not worthy of epistemic consideration. Thus, whilst we have seen that service users are engaged in the hermeneutics of interpreting and making sense of their experience and are seeking to give testimony to their risk-experience, service users experience both hermeneutical and testimonial injustice in risk assessment and management.

6.4.4 The role of naïve positivism in epistemic injustice

In the context of risk assessment and management, a standard view of science, or what we might more theoretically term a naïve positivism, allows clinicians to claim a scientific objectivity that privileges their perspectives and expertise as having high epistemic authority (knowledge and evidence) when compared to certain service user points-of-view. Claims to objectivity, science, neutrality, dispassionateness, and learned expertise all give rise to attributing staff perspectives with greater epistemic authority and thereby contribute to service user epistemic marginalisation in risk assessment and management. This standard view of science rests on a number of naïve assumptions to which we will now turn in order to undermine staff claims to greater epistemic authority, and to begin to reclaim epistemic justice for service users.

In naïve positivism scientific observation is seen as a completely value-free process. As the literature review outlined, early theorists on the philosophy of risk analysis saw risks as existing independently of the observer in the real world which can be observed, discovered, and objectively measured via a statistical calculation (Starr et al. 1976). As we have seen, on this view scientific observation is value-free and the introduction of any kind of epistemic values are biases that should have no place in risk assessment, which concerns itself with identifying objective risks (Starr et al. 1976). With developments in the philosophy of science (Chalmers, 2000), post-positivists reject this fact-value dichotomy and argue that it is impossible not to introduce certain epistemic values in the practice of science, including that of risk analysis (Thompson, 1990; Shrader-Frechatte, 1991; Hansson, 2010). Hansson and Aven (2014), however, still want to distinguish between fact-based activities (weighing evidence and exploring the knowledge base) and value-based activities (broad risk evaluation; the decision-makers review; final decision) in risk analysis. It has been argued, though, that the role of epistemic values in risk identification and risk estimation have been under-emphasised by theorists, assigning them to considerations of risk evaluation alone (Thompson, 1990; Shrader-Frechette, 1991). Thus, as the literature review discussed, Douglas and Wildavsky’s (1982) cultural theory of risk argues that risk is a socio-cultural construct, such that the selection, prioritisation, estimates of problem-size, levels of acceptability, choice of assessment methods, how costs-benefits analysis operate, and acceptable timeframes, are all products of social values. At the very least this implies that the notion of objective risk is not as unproblematic as naïve positivism assumes. This begins to undermine the privileging of staff perspectives in risk assessment and management based on a claim to greater objectivity.

Naïve positivism also situates risk assessment in the domain of the natural sciences, and as sharing its scientific methodology, thereby privileging its findings as *evidence* and *knowledge* (Starr et al. 1976). This underpins the privileging of certain styles of evidencing and presenting testimonies (Carel & Kidd, 2014), where clinicians present the science and evidence and service users are then seen as sharing anecdotes and stories, downgrading the epistemic authority of their testimony to mere beliefs (Rose, 2019). Starr et al (1976), for instance, argued that knowing about societal perceived risk was only important to the technologist when considering how to advise decision-makers regarding how to correct lay perspectives with the science. However, with the rejection of the fact-value dichotomy there has been considerable debate as to whether risk analysis can be regarded as a form of science (Thompson, 1990; Shrader-Frechatte, 1991; Hansson, 2010). In a seminal contribution to the sociology of knowledge, Berger and Luckmann (1966) argue that even the very concept of objective knowledge itself is a socio-cultural construct whereby certain ideas are externalised and objectified, and then internalised and institutionalised, as real by a social group. At the very least all this complicates distinctions between objective knowledge and subjective beliefs based upon claims to being science. This further undermines the privileging of staff perspectives in risk assessment and management based on a claim to being the science and opens up the possibility of re-evaluating service user anecdotes as forms of evidence and knowledge.

In naïve positivism the observer is seen as distanced and unbiassed, and thus as neutral and objective (Chalmers, 2000). Such notions underpin the privileging of third-person psychology and third person reporting over first-person testimony and reporting when these different forms of testimony and hermeneutics intersect (Carel & Kidd, 2014).

When third person and first-person testimonies intersect, what we see is that first-person testimony becomes subjective, by devaluing the mode of knowledge-production (experience) when compared to the scientific method (Rose & Kalathil, 2019). The rejection of the fact-value dichotomy makes claims to objective observation problematic, as all perspectives are situated and value-laden and none are epistemically pre-theoretical (Kuhn, 1962; Chalmers, 2000). Thus, it could be claimed that clinicians are simply introducing a different subjective perspective. In making the case for the epistemic authority of claims rooted in experience, Beresford has argued that "the greater the distance between direct experience and its interpretation, then the more likely resulting knowledge is to be inaccurate, unreliable and distorted" (Beresford, 2003, p4). Thus, from this perspective the notion of distance is problematic and far from ideal. Again, the privileging of staff perspectives in risk assessment and management based upon claims to neutral observation is called into question.

In naïve positivism distance and objectivity are ideally accompanied by a dispassionate perspective (Chalmers, 2000). This also reinforces the privileging of third-person psychology and third-person reporting, as service user accounts are seen as undermined by being emotionally or existentially unstable (they are too emotional or distressed) and communicated in a far too emotive style (Carel & Kidd, 2014). Zinn, however, has highlighted how reliance on the feeling of trust, intuition (gut-feelings), and emotional judgements, in risk assessment draw heavily on experience-based knowledge (Zinn, 2008). Professionals also rely on such resources in their decision-making (Zinn, 2008). Zinn argues that such knowledge is tacit and pre-rational, which stands "in between" rational (e.g., weighing evidence) and non-rational (belief, hope, faith) approaches to risk and as such do not render such judgements as irrational (Zinn 2008). Thus, testimonies articulated in an emotive style should still be heard. Furthermore, staff cannot claim privilege for their knowledge in risk assessment and management based upon notions of dispassionateness.

If the rejection of a fact-value dichotomy has implications for our view of the observer and the observed, it also has implications for related notions of *expertise*. As we have seen in the literature review, for Starr et al. (1976) risk analysis is the domain of the technologist, but risk evaluation (what is to be done with expert knowledge) is the domain of another expert, namely the societal decision-maker. The perspective of the risk analyst is value-free, the decision-maker makes a value-judgement in implementation, but the lay-person is excluded from both fields of expertise (Starr et al, 1976). Whilst Hansson and Aven (2014) define broad risk evaluation as a values-based activity they nonetheless regard it as a risk expert task. Risk assessment is, thus, the domain of the scientist, the clinician, the expert. The objectivity and neutrality of scientific experts has, however, been criticised. Beck (1992) acknowledges that whilst there is a greater public reliance upon risk experts in modernity (what he calls "the risk society"), there is also an uncertainty and distrust of the expert that undermines their expertise in the public mind. Douglas and Wildavsky (1982) suggest that since scientists are not immune from cultural bias, neither in estimating risks nor in judging their acceptability, they are unable to distinguish scientific from political issues (a false dichotomy in their view), which enables risk to be politicised. Claims to objectivity in risk expertise are thus problematic. Therefore, claims to privilege staff perspectives based upon notions of scientific expertise are again called into question, and service user lived expertise can be re-evaluated.

When different forms of expertise intersect, previous research has argued that even if service users are granted a form of experiential expertise, that expertise will be downplayed when contrasted with clinical expertise (Rose, 2019). For instance, service user's expertise might be limited to the domain of self-care (Prior, 2003), or to within a particular hermeneutic community (the self-help group (Borkman, 1976), or antenatal group (Abel & Browner, 1998)). When Tuckett et al (1985), for instance, introduced the notion of lay expertise in the context of medical consultations they often put quotation marks around the term "expert" when describing a lay contribution. This is because service user's expertise can be based upon what Prior (2003) calls "wrong knowledge" in terms of urban myths or pseudoscience (as defined by the standards of positivism). In this study epistemic injustice leads to some service users feeling entirely dismissed in the realm of risk assessment and management.

What staff in this study acknowledged was that it was also possible to come to wrong knowledge on the basis of misreading the service user, not understanding the service user's point-of-view. Even though staff may have developed a form of experiential knowledge by working with different kinds of service users, and even though they may have seen similar situations multiple times, in any one individual case they may be wrong. Thus, any reading of a service user's presentation via observations needs to be checked with the service user themselves. The notion that the service user is best placed to testify to their experience should not be undermined by such naïve positivistic assumptions about knowledge and evidence.

Carel and Kidd (2014) argue that epistemic authority and expertise are then mutually reinforced by the institutions in which clinicians work. Thus, clinicians are afforded epistemic privilege and high epistemic authority in service user-clinician encounters since they occupy an authoritative procedural role in epistemic exchanges. This was observed in the current study in ward round interactions that were sometimes framed by the locum consultant as an "interview." This was also evident in documentation processes on the ward. This authority is further seen in staff's decisional control as to which testimonies and interpretations to act upon, when enough evidence is presented, when a specific issue has been given enough time and attention, and when an issue is settled (Carel & Kidd, 2014); this again came through quite strongly in ward rounds. Staff have come to adopt this position of power by virtue of their training and expertise. This is mutually reinforced by the institutions in which they work, as they privilege certain styles of articulation or communication in terms of what is the accepted discourse, and thereby reinforce high professional epistemic authority and expertise (Carel & Kidd, 2014). Similarly, these institutions privilege certain styles of evidencing and presenting testimonies, such as favouring the science over the anecdote, and third-person reporting over first-person testimony. This study provides accounts for how risk assessment and management processes reinforce professional power and serve to epistemically marginalise service users.

6.4.5 Examples of epistemic injustice in risk assessment and management

The current research provides evidence of *how* the epistemic injustice of service users operates in the practice of risk assessment and management in an acute psychiatric inpatient setting. Two key means of the epistemic marginalisation of service users are presented, including the dismissal of unique threats, and the attribution of risk-responsibility on the basis of pathologisation.

6.4.5.1 Epistemic injustice and the dismissal of unique threats

In the cases of Gareth and the spiders, Kate and the colour-coding of clothing, Preston and government persecution, Ash and the lampposts' communication, and Dominic's fear of being killed for his millions, I have argued that these are unique forms of threat interpreted by the individual as risks. Using Gareth as a case example, we have seen that staff conceived of such experiences as delusions on the basis that the spiders were "not real." Beliefs about things that are not real were of interest to professionals filtered through the medical gaze as indicators of mental disorder from a biomedical point-of-view. This disorder may suggest a need of medication and may also be perceived as an indicator of risk, constructed from a professional perspective, and framed by legislation (*Mental Health Act 1983*/2007).

Gareth suffered hermeneutic injustice since his experiential knowledge of the spiders was downgraded to the epistemic status of mere beliefs on the basis of their unusualness. These unusual beliefs were associated with what was judged to be abnormal behaviour. Sanati and Kyratsous (2015) have theorised that professional judgements in regard to a person's "epistemic irrationality" (particularly a combination of perceived "irrationality, bizarreness, and incomprehensibility") can lead to a misattribution of true statements and non-delusional beliefs as delusional, because epistemic irrationality is generalised to other beliefs of the individual. Sanati and Kyratsous (2015) also assert that a negative social perception or negative stereotype of the "delusional patient" comes into play that allows them to be epistemically marginalised. In the study undertaken, this occurs in practice as the rational clinicians' expert perception of Gareth's epistemic irrationality undermined Gareth's meaning-making as the spiders were judged to be not real and thereby he was not making sense to staff. As a result, Gareth also suffered testimonial injustice as his fear and distress was downplayed, his construction of risk as threat was discounted, leaving him feeling that his perspective was being dismissed; he was epistemically marginalised.

By contrast, the spiders made complete sense within Gareth's own experiential hermeneutics and testimony, similar to Ritunnano et al. (2021) who found that meaning can be found within what is commonly taken to be incomprehensible or meaningless by professionals. The spiders were generating a fear which constituted the emotive core of his experience. Gareth's fear meant that he experienced the spiders as a form of threat. As a result, Gareth viewed the spiders as a risk that was making him feel unsafe. He was expecting staff to assist him with the related fears and was looking to staff to validate his feelings. He could not understand why staff were dismissive of his testimony. This chimes with previous research suggesting that the care of people diagnosed with psychosis did not reach their "inner world" (Koivisto et al, 2004).

6.4.5.2 Epistemic injustice and the attribution of risk-responsibility

Using Maggie as a case example, we have also seen that people diagnosed with Emotionally Unstable Personality Disorder (EUPD) tended to have their identity reduced to the diagnosis, which they are seen to embody (as "EUPDs"). As a result, Maggie was seen to embody a risk definition ("she will always be a risk"). On this basis Maggie was perceived to be game-playing (manipulative) and obstructive. Staff were thereby questioning Maggie's motivations, downplaying her expressed distress and suicidality, and reframing her view upon her risk entirely on the basis of her diagnosis. At the same time staff attributed moral accountability to Maggie based on the belief that she knew what she was doing. Kyratsous and Sanati (2017) have theorised that ascribing moral responsibility is the application of an "epistemic condition", since the individual must "know" and "be aware" of what they are doing in order to be in control of it, and thus culpable for it. They argue that professional judgements about "manipulation, awareness and control" can lead to over-interpreting motives and intentions. Behaviours are then interpreted on the basis of the negative stereotype.

In the case of Maggie, staff distanced themselves from culpability and justified withdrawal of support; and we see Kyratsous and Sanati's (2017) theory actualised in practice. Thus, pathologisation was the means by which Maggie was epistemically marginalised. This occurred in Maggie's absence within handover communication. Previous research has highlighted the important role of handovers in risk communication (Miller & Sands, 2013), but this study emphasises that such communication should avoid judgemental and pathologising language. This study also chimes with previous research suggesting that once a service user is diagnosed with a personality disorder those individuals feel that staff perceive them to be "time-wasting" (Rogers & Dunne, 2011). In the context of such negative staff attitudes, Rogers and Dunne (2011) have argued that it is important that the service user has "a voice" and retains "a stake" in decision-making.

6.4.6 Recovering epistemic justice in risk assessment and management

The aim of a critical ethnography is not simply to describe a group of people in a social setting, but to consider how oppressed and marginalised groups can be emancipated (Thomas, 1993; Carspecken, 1996). In this instance, the professional desire for objectivity and neutrality contributes to epistemic injustice. In exposing such injustice, we cannot now remain neutral. As I have argued, standpoint theory grants *epistemic privilege* to socially marginalised groups whose voices are drowned out by oppressive hegemonies (On Bar, 1993). The marginalised are able to critique, challenge and disrupt that social centre from which they are excluded (On Bar, 1993). Thus, service users' experiential knowledge must now be centred within the social setting, and there must be a bias towards their voice being heard. I want to suggest two approaches from the literature that can be applied, in order to grant such epistemic privilege to service users: first, an interpretivist approach to service user testimony and hermeneutics; and second a coproduction approach towards knowledge and expertise in relation to risk and safety.

First, this research would support the call for an interpretivist approach to service user testimony and hermeneutics. Whilst a biopsychosocial model has been framed as potentially illuminating the "emotional climate" of the clinical relationship (Borrell-Carrió et al. 2004), if the model is approached using a positivistic philosophy of science that is focused on verification and objectivity then that can mean that a service user's meaning-making is still devalued (Borrell-Carrió et al. 2004; Benning, 2015). Instead, Yakeley et al. (2014) have argued that, irrespective of the relative value of a biomedical model for identifying and managing mental disorder in psychiatry (which they uphold), service user perspectives and experiences should be approached through the lens of interpretivism. Whilst problematising a realist ontology (reality is out there to be discovered) and a positivist epistemology (concerned with verification or falsification), interpretivism is focussed on how meaning is constructed (Schutz, 1953; Winch, 1958). There has thus been a call for a "narrative approach" to service user accounts of risk (Felton & Stickley, 2018), where narrative means attending to what is here being referred to as service user testimony. An interpretivist approach would be a helpful step towards providing testimonial and hermeneutical justice for the individual, centring the service user's hermeneutical meaning-making, and recovering the epistemic self-authority and expertise of the individual to tell their testimony.

Second, this research would also support the call for a coproduction approach to risk assessment and management (Boardman & Roberts, 2014). Coproduction aims to flatten the hierarchy of knowledge arguing for a complementarity between different forms of knowing, where, for example, *lay knowledge* (non-medical, non-technical knowledge) is as valid to coproduction as *clinical knowledge* (Tritter & McCallum, 2006). Thus, experiential knowledge would be seen to complement clinical experience-based knowledge and knowledge-by-training or education. This entails explicitly acknowledging dynamics of power, by unmasking the operations of power, authority, hierarchies, and existing structures of accountability as a move towards genuine power-sharing (Clark, 2015; Carr & Patel, 2016). This means that, in particular, professionals need to relinquish some of their power and control (Bee et al. 2015). Furthermore, in coproduction, people are also seen to have different fields of expertise and competence based upon their different forms of knowledge, outworked in different forms of skill (e.g., clinical, administrative, self-help) (Carr & Patel, 2016). This means that expertise by learning does not trump any other form of expertise. Thus, coproduction could be a means of recovering the notions that service users are experts *by* experience (as a legitimate source of knowledge) and experts *in* their own experience, and thus best placed to give testimony to their risk-experience.

6.4.7 Summary: Epistemic injustice

In this study, we have seen what happens when service users' experiential knowledge crosses between hermeneutic communities, from the service user to staff members. That a learned body of medical or clinical knowledge takes on greater epistemic authority, on the basis of naïve claims to objectivity, science, neutrality, dispassionateness, and learned expertise. Service users then experience hermeneutical and testimonial forms of epistemic injustice through dismissal and minimisation of their unique threats (downgraded from knowledge to unusual beliefs), and through pathologisation in attributions of risk-responsibility ("EUPDs" know what they are doing). However, epistemic justice can be recovered if we take an interpretivist approach to service users' hermeneutics and testimony and take a coproduction approach to knowledge and expertise within risk identification and co-management.

6.5 Further dynamics of power and *empowerment*

Some service users had a sense that staff had overall decisional control over risk assessment and management and took deliberate steps to counterbalance this. This section will begin by discussing how some service users could adopt the role of deliberate passivity and moderating emotion as means of navigating unhelpful dynamics of power, based on their knowledge of staff perceptions. Service users' conception of empowerment will be considered, and it will be seen that it particularly centres on their ability to contribute their experiential knowledge throughout their admission. It will be seen that this focus was not related to notions of recovery but to securing more power and control over the process. How the legal language of risk and knowledge of the legal framework can help service users regain power will also be considered.

6.5.1 Deliberate passivity

In the light of staff decisional control, some service users felt that if they adopted a strategy of deliberate passivity, they could achieve a quicker discharge. This was expressed as subservience to the professional agenda. In these instances, cooperation with staff was framed as allowing staff to set the agenda and to respond to their perspective, rather than service users contributing their own perspective and experience or themselves setting the agenda. This chimes with previous research, that found that service users felt they had to "play the game" to achieve a quicker discharge in both forensic (Heyman 2004; Reynolds 2014) and in acute inpatient settings (Coffey et al, 2017). This also coheres with previous research that found that staff are making decisions as to whether individuals might be engaged in risk assessment and management or otherwise, rather than seeking service user views and preferences from the outset (Coffey et al, 2017). This could be avoided by staff relinquishing overall decisional control, power-sharing with service users, and allowing service user testimony to help set the agenda.

6.5.2 Moderating emotion

Whilst the ability to express righteous anger has been seen as a core feature of service user definitions of empowerment (Rogers et al, 1997; Chamberlin, 1997), the current study also found that some service users felt they had to tone down how they expressed themselves. If assertiveness could be perceived as a hostile communication style it could also thereby be seen as evidence of risk from a staff perspective. This led some service users to modify their communication style as a result. This again demonstrates how certain styles of testimony are perceived to be acceptable within the social setting, favouring a calm and measured communication style over an angry or aggressive style of testimony; here constructed from the service user point-of-view. Thus, once again some service users felt they had to adopt a more passive role, in terms of how they expressed themselves, in order to achieve a quicker discharge. If all risks were transparent and explicit to all involved this power-dynamic could be avoided, as service users would not have to anticipate what might be recorded as risks by staff.

6.5.3 Empowerment

This study adds to our knowledge of service user perspectives on empowerment in an acute psychiatric inpatient setting, and uniquely in the context of risk assessment and management. As with previous research, this study suggests that service users believe that acute psychiatric inpatient care *should* empower them (Koivisto et al, 2004; Hopkins et al, 2009; Akther et al, 2019). Service users are in a situation in which they already felt fundamentally disempowered (Rose et al, 2015), and they are sensitive to them-and-us power differentials operating in the setting (Chevalier et al, 2018). In this study, empowerment was important to service users in terms of their journey from their risk-experience towards feeling safe again, enabling the move towards experiential fulfilment. Empowerment has been framed as a recovery principle (Davidson et al. 2005; Leamy et al. 2011; Storm & Edwards, 2013) and staff particularly emphasised how they were working in a recovery-oriented way. Interestingly, and contrary to my expectations, recovery was almost entirely absent from service users' discourse around why they wanted to be involved in the process of sharing their concerns around risk. Instead, service users' focus was on securing more power and control in a situation in which they felt powerless. This in itself is a novel, but significant finding.

In this study, notions of empowerment centred on service users being able to contribute their experiential knowledge throughout the inpatient experience. Staff could empower by enabling service users to articulate their experiential knowledge, thus giving them a voice in a situation in which they felt voiceless. Empowerment also entailed information provision (Chevalier et al, 2018; Akther et al, 2019), particularly in terms of procedural knowledge around staff's risk assessment and management. Overall, there was a general desire to know what is happening in terms of how staff themselves are perceiving and responding to risk. Service users wanted to be asked directly and explicitly about their risk. They wanted the processes to be visible and transparent. They wanted to know what their risks were perceived to be and how those conclusions had been formulated. They also wanted to see their risk documentation and to check it for accuracy and coherence from their point-of-view, and they wanted the opportunity to contribute and document a first-person summary of the issues from their own perspective. Empowerment thus focused on service users being able to make sense of, and give testimony to, their risk-experience throughout their admission. Empowerment also focussed on service user's knowing staff perspectives and perceptions of risk.

One final contribution to service user empowerment in the context of risk assessment and management was around service users being able to assert their rights by employing the language of risk. Risk was also seen as a language that had to be mastered that gave a knowledge of the system, as a means of holding staff to account, challenging decisions, and asserting legal rights. As with previous research, there was an emphasis upon the importance of information provision and the timing of such information provision (Katsakou et al, 2012; Akther et al, 2019). There was also an emphasis on access to independent advocates, which chimes with prior research on the importance of advocacy (Stomski et al, 2017). Where service users had such knowledge, they felt empowered in employing it.

6.5.4 Summary: Empowerment

Some service users had a sense that staff had overall decisional control over risk assessment and management. They thus took deliberate steps to counterbalance this, by adopting a passive role towards staff agendas or moderating emotion so as not to be viewed as a risk. By contrast, service user empowerment could more helpfully counteract these power dynamics. Empowerment for service users centred on being able to give testimony to their risk-experience. This was not tied to notions of recovery, but on securing more power and control in a situation in which they felt powerless. Knowledge of the legal framework could also be empowering for service users in enabling them to assert their rights.

6.6 Using documentation to navigate issues of knowledge and power

This final section will discuss service user perspectives towards risk documentation. It will be shown that documents have the potential to help navigate the kinds of issues around knowledge and power that have been detailed. It will also be shown that service users want to see their documentation, and they want to be involved in co-constructing their contents. It will be argued that documents can function as *boundary objects* enabling collaboration and coproduction, even though parties may have different epistemologies, discourses, and informational purposes.

6.6.1 Service users and their risk documents

In this study it has been shown that service users assumed that staff would be documenting risk. However, they expressed a sense of distance from their risk assessment documentation, and no service user participant had seen such a document. Similarly, as we have seen, staff also said that they did not routinely show service users the risk documentation. This fits with previous research suggesting that risk assessments and management plans are often not actively discussed with service users (Coffey et al, 2019). Given how risk documentation processes were perceived to be hidden from service users I had expected that documentation would be irrelevant to service users, however, this was far from the case. As has been shown, many service users expressed a desire to see their documentation. Service users were concerned that staff may have documented something that is inaccurate and/or that does not make sense from their own perspective. Previous research has argued that sharing documentation can enhance transparency, ongoing dialogue, and for checking accuracy of contents (Kahn et al, 2014). For service users, seeing documentation was another form of seeking to gain control over the process.

Another significant finding of this research is that service users were looking to co-construct their risk documentation, which they framed as both a process (a working document) and an output (a completed plan). Higgins et al (2016) have argued that risk documentation needs to be designed to operationalise policy emphasis on dynamic risk assessment. Similarly, Coffey et al. (2019) have suggested that inflexible documentation and information technology on acute psychiatric inpatient wards do not enable collaborative working. Langan (2009) has thus argued that recording service users' views on risk, their strengths, and risk management strategies could enable collaborative working and improve information quality. Similarly, Higgins et al (2016) have argued that documentation needs to allow space for service users' commentary, including perspectives on triggers, protective factors, positive risk-taking opportunities, and risk management strategies. The current study suggests that this is what service users are wanting from the documentation too. Service users want to contribute a summary, first-person testimony from their perspective and in their own words.

6.6.2 Documents as boundary objects

Service users expected the documentation to function as a means of negotiating risk, and to further collaborative working in risk management. In theoretical terms, they were looking for documentation to function as a boundary object between themselves and staff. Susan Leigh Star's work on boundary objects was rooted in an understanding of scientific cooperation, whereby groups of scientists from different disciplines can work together whilst not having good models of each other's work, having different methodologies and methods, and different audiences, goals and time frames for their work (Starr, 1988). For Starr, boundary objects enabled such cooperation. Her insights were not just applicable to groups of scientists, but her analysis of Berkeley's Museum of Vertebrate Zoology showed how groups of professionals from different disciplines and lay-amateurs could all successfully cooperate using boundary objects too (Starr & Griesemer, 1989). Thus, this is a useful model for how staff from different disciplines as part of a Multi-Disciplinary Team (such as psychiatrists and nurses) can cooperate with service users in risk assessment and management, using documentation.

A boundary object "sits in the middle" of a group of agents who may have heterogenous viewpoints yet seek to cooperate (Starr, 1988). Boundary objects are "both plastic enough to adapt to local needs and constraints of the several parties employing them, yet robust enough to maintain a common identity across sites." (Starr, 1988, p251). As such "they have different meanings in different social worlds but their structure is common enough to more than one world to make them recognizable" (Starr & Griesemer, 1989, p393). Boundary objects thus "both inhabit several intersecting social worlds… and satisfy the informational requirements of each of them" (Starr & Griesemer, 1989, p393). To put this in the terms of the current study, we could argue that boundary objects enable heterogeneous agents with different epistemologies expressed in different discourses to collaborate. Thus, whilst risk documentation may serve different purposes for staff and service users, documents could enable collaboration. Furthermore, such work does not give precedence to one form of knowledge or discourse over another, thereby enabling coproduction.

Starr argued that there are different types of boundary objects "depending on the characteristics of the heterogeneous information being joined to create them" (Starr, 1988, p251). One such boundary object is paper forms which constitute "methods of common communication across dispersed work groups" (Starr, 1988, p254). Service users envisaged a paper form that could be completed allowing them to summarise their risk-experience in their own words. Thus, being able to document their own perspective was seen as an empowering end in itself. Service users also argued that such a summary statement could also inform staff's approach to risk. Whilst staff have their own informational requirements (which may vary between psychiatrists and nursing staff, for example), this summary statement was seen to be potentially useful to different staff groups too. In particular, the summary statement could help both parties to negotiate coping strategies as they together plan the management of identified risks. The document would thus record triggers, existing coping strategies, new coping strategies, delineating responsibility for risk-reduction.

The document could also be a useful means of opening-up the conversation around risk identification and perceived risk severity, where there was the possibility of disagreement. One service user argued that such disagreement between parties should be transparently and explicitly documented in the proposed shared risk document. This would explicitly highlight differences in perception and in the definition of the issues to be worked upon. A coproduction approach would then not give precedence to one summary statement over another. Instead, it would highlight unresolved issues to be negotiated and reviewed going forward. Thus, service users did not think that their experiential knowledge expressed as a first-person summary trumped other forms of knowledge in the setting, only that they wanted to ensure that their perspective was articulated, validated, and heard throughout their inpatient admission, including in documentation. They saw the documentation as a means of implementing cooperation, collaboration, and negotiation of issues. Instead, service users themselves were treated as a boundary object (Meier, 2015), as different staff groups worked with their testimony for their own ends.

To save this from becoming a meaningless bureaucratic exercise, service users were looking for the risk documentation to be a working document. As a working document it would be routinely revisited and revised collaboratively throughout the experience of inpatient admission. In the social setting of this study, producing the current risk documentation was divorced from any service user involvement in writing an initial Recovery Care Plan near to admission. Producing risk documentation could, however, fit within existing care planning processes. Although care plans were not always reviewed with service users, a formal review of the proposed risk documentation was important to some. Whilst risk documentation could initially be coproduced in a one-to-one setting, service users suggested the more formal reviews could take place in the ward round. These constituted *boundary spaces* where such work should be operationalised, from a service user perspective; these were the safe spaces for the work of coproduction.

6.6.3 Summary: The role and value of documents

This study makes a significant contribution towards our understanding of the role and value of risk documents to service users in contributing their experiential knowledge as a form of testimony within this setting. Documents could helpfully function as boundary objects that enable collaboration and coproduction, even if they serve different informational needs for involved parties; they could thus help navigate the issues of power and knowledge that have been identified.

Having highlighted the value of experiential knowledge in the epistemic interactions of the whole process of risk assessment and management, the next chapter will outline the implications for practice and for future research.

Chapter Seven: Conclusion

The aim of this study was to explore mental health service user perspectives and experiences of risk assessment and management within an acute psychiatric setting. Whilst the research idea came from the researcher's prior experiences of risk assessment (experienced as covert, intrusive, traumatising, and controlling), the scoping review presented in chapter two demonstrated that service user perspectives are marginal, and that service users are generally unaware of, uninvolved in, and ill-equipped for, risk assessment and management in mental health settings. The combination of empirical (in the form of the literature review) and lived experience provided a strong rationale and impetus for the study.

A critical ethnographic approach combining methods of observations and interviews enabled the study objectives to be met and facilitated the exploration of how service users construct and interpret risk and risk processes within the study setting, Attenborough Ward. Attenborough Ward has been shown to be a hive of social activities and practices related to the assessment and management of risk. Service user experiences of these have been explored and the importance of different forms of knowledge (experiential versus clinical), power and the impact of these on individuals identified. These findings have been situated in the wider literature on epistemologies, epistemic practices, forms of epistemic injustice, and the recovery of epistemic justice for service users. In this final chapter the unique contribution of this thesis will be summarised, the strengths and limitations of the research outlined, and implications for practice and future research considered.

7.1 Contribution

This study makes a number of novel and important contributions to our understanding of service user perspectives and experiences of risk assessment and management in an acute psychiatric setting. For service users it is their risk-experience that they are seeking to share which has the form and authority of experiential *knowledge*. Such knowledge also grants a form of lived expertise; together such knowledge and expertise situate the service user as best placed to give voice to their risk-experience.

The research undertaken further contributes to our understanding of service users as epistemic subjects who engage in what are framed as the epistemic activities of hermeneutics and giving testimony in the honest sharing of risk; the contextual barriers and facilitators to which have been delineated. The study illuminates upon the forms of epistemic support that service users are seeking from staff in the form of learning new ways of coping, enhancing self-knowledge, and potentially transforming self-knowledge.

This study has also shown that service users experience hermeneutical and testimonial forms of epistemic injustice when different forms of knowledge (clinical vs experiential) intersect. Epistemic justice can, however, be recovered through an interpretivist approach towards service user hermeneutics and testimony, and through a coproduction approach to knowledge and expertise.

Further dynamics of power operating within the social setting have been exposed, and empowerment has been defined in relation to the ability for service users to articulate and give testimony to their risk-experience in both verbal and written forms. The role and value of risk-documents have been demonstrated to be particularly significant to service users and can be a helpful means for navigating these issues of knowledge and power.

7.2 Strengths and limitations

7.2.1 The study design

The ethically informed recruitment and consent processes of this study were a key strength, which sought to be just and inclusive, ensuring that informal and detained service users had the opportunity to participate, with avenues for attempting to incorporate the perspectives and experiences of those who lacked capacity to give consent to participate in study observations (via the consultee assent model). Ethnographers seeking to conduct their research on acute psychiatric inpatient settings (or similar settings where people's mental capacity may play a factor in recruitment and consent) can be assured that the models of consent delineated are acceptable to both staff and service users and administratively feasible within the clinical setting.

The combination of observational and interview methods was another strength, as it allowed for the in-depth exploration of participant's perspectives and experiences, to compare and contrast reported behaviour with enacted behaviour, to check interpretations with participants themselves, and to explore the unique culture of the ward.

A strength in terms of the study's sampling was that both the sample of the study observations and the interviews incorporated a range of service users from different backgrounds and different risk-experiences, and also a range of staff with different roles on the ward, enabling the generation of a thick description of the setting and of the phenomena of interest. Similarly, another strength was that the observational sample incorporated a range of interactions covering almost all the formal spaces on the ward that constitute the whole process of risk assessment and management.

The keeping of a research journal was important in all phases of the study. It incorporated decisions and their rationale in study design and recorded reflections during data generation fieldwork. It was also useful in scrutinising presuppositions prior to analysis and in developing themes. All of this process was an aid to reflexivity (more below), and in demonstrating robustness, credibility, and quality. Journaling was also important in terms of processing emotions experienced prior to, and during fieldwork in particular, but also in the data analysis phase. Furthermore, the establishment of a clinical supervision arrangement with someone outside of the academic supervision team, was also important to both reflexivity and maintaining wellbeing. Journaling and clinical supervision are examples of good practice for any ethnographer. However, they may be particularly beneficial for lived experience researchers exploring topics and settings that they themselves have prior personal experience of.

The study's Service User and Carer Advisory Group were also an invaluable source of insight in the study set-up phase. Whilst engagement with the group was consultative, they provided help and support with the contents of study documentation, and in agreeing the models of consent. Thus, Patient and Public Involvement was another significant strength of the study and is a key recommendation for anyone embarking on doctoral research, although funding does need to be sourced to enable this, in line with best practice.

In terms of limitations, for the observations it was not possible to observe any admission (or clerking-in) interactions directly. Furthermore, whilst the production of observational field-notes during ward rounds, handovers, and one-to-ones was contemporaneous with those meetings, it was obviously not possible to incorporate the kind of details you would obtain from an audio transcript (e.g., non-lexicals). However, given the existing administrative burden of the study, I felt that it would not be feasible to obtain consent for audio-recording these interactions. For the interviews, it was disappointing that the

Locum Consultant declined to be interviewed, but that was well within her rights. Another perspective that was not included in either observations or interviews was that of family members, or informal carers, which might be considered a limitation. However, incorporating carer perspectives would add further power dynamics (e.g., carer vs service user and/or carer vs staff) and these merit study in their own right.

A further limitation was that risk documents were not analysed. Whilst ethical approval to obtain risk documents had been sought, and consent from some service users obtained, and some documents retrieved, I had expected that they would incorporate first-person risk summaries from service users, but instead they were all third-person summaries. Similarly, I had expected that service users would have seen their risk documentation and might be able to comment upon it, however this was not the case. I therefore took the decision not to incorporate these documents in the analysis process to remove an additional layer of complexity from the process and to maintain a clear focus on the service user voice.

7.2.2 Further thoughts on reflexivity

I have shown that I tried to position myself within the study setting as *a researcher with lived experience*. A key strength of the study was that my lived experience fostered a sense of rapport and trust with service user participants that might not have been there than if a professional, for example, approached the study. I have noted where findings challenged my preconceived ideas as an attempt to show that I did not merely see a reflection of myself in the data generated. For instance, I had expected that many service users would feel that the language of risk was in itself an entirely disempowering discourse, and perhaps a stigmatising one too (Callaghan & Grundy, 2018). Contrary to my expectations, service users used the language of risk, risk to self and risk to others, and at times even used the terms to assert their rights and challenge detention.

My own standpoint as a service user allowed me to empathise with the service users in this study. Whilst I have experienced my own reality feeling dismissed, I had not had the theoretical framework in which to place this experience until now. I deliberately withheld describing some service users reality as a "delusion", even though staff used such language. This is largely due to my own lived experience of feeling that my sense of reality was being dismissed by such labelling during my own stays as in an inpatient ward myself. Delusion was not a term used by these participants themselves, and I was particularly interested in how service users themselves construct their reality in the form of testimony. I could empathise with the fears being expressed, although up until now I would not have conceived of these fears and threats in terms of risk. This is an area, though, where I feel my own position as a service user researcher had an impact upon both the data generation and analysis phases. It is a clear example of where my own standpoint as someone who has lived through similar experiences in a similar setting enabled me to see the issues in a different light, from a different perspective from the professionals, from the service user point-of-view, constructed as a novel finding.

7.2.3 Transferability

The events and interactions that were observed in the setting are by their very nature ones that cannot be reproduced (Smith, 2018). In one sense the staff group observed within the study were a unique group of people, each staff member bringing their own experience, training, and values, and coming together to create a particular staff culture (Quirk, 2004). Similarly, the senior staff set the tone and feel of the ward and expectations from staff. Another factor was that the Consultant working on the ward during observations was a locum, covering a period of sickness of the regular ward Consultant Psychiatrist. Such factors are non-transferable to other settings. Mixed gendered wards are not as common as single-gender wards in the UK. However, staff working in all inpatient psychiatric settings have a duty to assess and manage risk, to carry out observations, to formally review care and treatment (ward rounds are the standard means of this), to handover to other staff, to care plan, and to document risk. These forms of staff's risk-work are transferable to other acute psychiatric inpatient settings.

The group of service users observed within the study were also a unique cluster of individuals. Each service user had their own individual testimonies, including those with unique forms of threat interpreted as risk. Some of the broader features of risk would be transferable to service users in other acute psychiatric inpatient settings, where risks to self (self-harm, suicide), risks to others (substance misuse, alcohol, aggression), and being at risk (vulnerability, self-neglect) are common. Similarly, service users across settings may have other fears and anxieties that might indicate unique threats to them. Furthermore, service users, knowingly or otherwise, experience aspects of staff's risk-work, by being observed, attending ward rounds, and potentially having one-to-ones and completing documents.

7.3 Implications for practice

Service user hermeneutics and testimony to their risk-experience have been marginalised and excluded from risk assessment and management in an inpatient setting and they need to be centred, heard, validated, and documented. Service users should be able to share their risk-experience throughout their admission. Staff should seek to involve and empower service users by helping them articulate their testimony to their risk-experience throughout the inpatient admission. How this can be practically implemented will now be considered.

All risks from the service user perspective should be acknowledged by staff. Service users may express unique forms of threat that are generating fear and a feeling of risk, and it is important that these are not dismissed. It is important that staff validate these fears and work with service users to address them. Service users should be able to formulate these risk-experiences in documentation. Staff should ask service users explicitly and directly about their risk. For instance, the question could be framed as "Are you going to harm yourself?" or "Do you feel that you are a risk to yourself?" or "Do you feel that you are a risk to others?" or "Do you think people are safe around you?" Similarly, service users could be asked "Is there anything that is making you feel unsafe?" or "Is there anything that is making you feel vulnerable or threatened?" Staff should avoid euphemisms (e.g., "Are you having any dark thoughts?").

Service users may possess some knowledge deficits around risk assessment and management processes and procedures operating on the ward, and they expect risk processes to be visible and transparent to them. Thus, service users should understand the role and function of one-to-ones, of ward rounds, of observations, and of documentation. The role and function of these processes could be briefly explained in writing, for example as part of an induction or welcome pack which could be given to service users on arrival to the ward (This should be coproduced with service users on the ward to ensure it provides the kind of information they themselves are looking for and in a way that is accessible to them). A verbal explanation could also be given during the first enactment of each process, checking for understanding at the time or whether further explanation might be required in future.

Service users value interpersonal relationships with staff developed through one-to-one time to feel able to honestly share their risk-experience. If adopting a named nurse system, service users should know who their named nurse and keyworker are; their names could be written in the induction/welcome pack, and reinforced verbally by staff, for instance during the first few ward rounds. Furthermore, service users are looking to staff to initiate these interactions, and thus staff should plan for regular one-to-ones with service users. One-to-ones should occur in a private space to enable honest sharing and epistemic support. During busy periods when the Nursing Office door is closed, instead of having to knock on the door, service users could approach a designated staff member out on the shop floor whose role is to address any need (practical or emotional) that service users may have. Moreover, non-verbal means of communicating need for one-to-one support for risk should be supported, for instance service users suggested that they could hand in a form, or wear a wristband, or display a sign on their door, to communicate their need.

Staff should explicitly and transparently elicit, respect, and act upon service user views of risk in ward round. Staff should consider power dynamics in ward rounds, such as factors that might intimidate (e.g., numbers present, strangers present), and how these might impact upon communication. This might involve each staff member considering whether they have a clear rationale for being present in an individual's ward round, otherwise should they be there. Service users should be given sufficient time to consider whether they are happy with the proposed ward round configuration and should be able to suggest alternative configurations. Other means of levelling power dynamics might mean the psychiatrists slightly dressing-down (e.g., no power suits) or being on first-name terms with service users if that is preferred by service users. Service users may also need support to prepare for their ward round and may find preparing written notes helpful, which could be facilitated by staff in one-to-ones. A pro forma could be developed to assist service users in their preparation for ward rounds, which should be coproduced with service users. Any written notes brought to ward rounds by service users should guide the conversation and set the agenda for discussion. Ward rounds should at least begin and end with the service user perspective.

Observations should be seen as potential means of therapeutic engagement and interaction, thus emphasising conversation with service users. Service users want to be discreetly, but directly and explicitly asked about their feelings and their risk. Any reading of a service user's presentation by staff should be verbally checked with the service user themselves. Any causes for concern arising from the observation process should be shared directly with the service user. In terms of education, healthcare staff need to be taught that nursing and psychiatric observations do not constitute objective knowledge (in the naïve positivist sense) just because they are performed by staff. Similarly, staff need to be aware of their knowledge deficits in observations in relation to the inner world of service users. Whatever value the biomedical model may have in guiding observations (and this is a contested area of mental health practice), observation-practice is a key area in which an interpretivist approach to service user testimony needs prioritisation.

Handovers should avoid pathologising and/or judgemental language or interpretations of behaviour. Staff should talk about service users as they would if the service user themselves were present. Again, any reading of a service user's presentation that is being handed over by staff should have been verbally checked with the service user themselves beforehand. In order to keep the service user perspective central, service users could be offered the opportunity to share what *they* would like to be handed over, such as through passing on a short, written statement of their current experience. If service users express any worry or concern about what might be handed over about them, staff should share transparently as to what will be handed over.

In terms of documentation, there again needs to be an emphasis in healthcare education that professional constructions of risk in documentation do not constitute objective knowledge (in the naïve positivist sense) just because they are written by professionals. Service users should be able to contribute a summary statement of their risk from their perspective and in their own words in a specific risk document. The risk document should also record triggers, existing coping strategies, new coping strategies, and should delineate responsibility for risk-reduction. The document should also be signed by the service user as an expression of buy-in. Documentation should be enabled and completed in one-to-ones between staff and the service user. The document should then be formally reviewed in ward rounds, to ensure that it is a dynamic document and to avoid a file and forget culture. Any differences of perspective should be explicitly acknowledged and documented.

Community meetings are important spaces where service users on the ward can be together as a collective. Acute psychiatric inpatient wards could learn from other ways of doing or being a community, such as therapeutic communities (Spandler, 2009), Open Dialogue forums (Razzaque & Wood, 2015), and crisis houses (Sweeney et al, 2014; Whitmore, 2017), where there is often a greater emphasis on shared responsibility for risk, and a sense of collective management of issues raised, with a strong emphasis on peer-support. Furthermore, they provide good models of staff relinquishing power, opening-up the potential for meaningful coproduction. To foster such an ethos, more regular community meetings need to be held, with the aim of fostering a sense of group cohesiveness, and these meetings need to be seen as an organisational priority. Meetings could be facilitated by service users, agendas set by the community, and more actions taken by service users themselves. Issues covered should be more than the environmental, with a focus on emotional peer-support and group therapeutic activities.

7.4 Future work and research

As the focus of the current study was on service user perspectives and experiences of risk assessment and management in an acute psychiatric setting, one key perspective that was not explored at all was that of family members, or informal carers. Family members could attend ward rounds, and they might accompany service users on leave off the ward or come onto the ward to visit informally. It would be interesting to explore whether carers play a role in involving and/or empowering service users in the honest sharing of risk in an inpatient setting. It would also be important to see how carers might use their own lived experience, and their own knowledge of the service user, in risk assessment and management, and whether that expertise is utilised by staff. It would also be important to know what needs carers have, or what they want to be taken account of, in the risk assessment and management of their loved ones. Thus, I would like to conduct a qualitative study of carers perspectives.

In addition to this, I would also be interested to research further service user perspectives on risk documentation. I would be interested to see whether their involvement in co-constructing a risk-plan as a working document that is reviewed over time, makes a difference to their overall experience of risk assessment and management within the setting. I would also be interested in exploring service user views about their discharge summaries once they have left the ward.

As well as future research, I believe that the findings of this study need to be embedded in the education and development of mental healthcare staff. I would like to develop a training module that synthesises the key messages of this study, that could be delivered in the University training of future nurses and psychiatrists, and also as part of current staff's ongoing continual professional development.

7.5 Overall Conclusion

This research has made significant contributions towards our understanding of service user perspectives and experiences of risk assessment and management in an acute psychiatric setting. This contribution is both theoretical (around epistemologies, epistemic activities, and experiences of epistemic injustice) and practical, in terms of concrete changes that can be made to clinical practice. It is my hope that this research will contribute towards service users' risk-narratives of their risk-experiences being central to risk assessment and management in inpatient settings; that marginalised voices will now be heard throughout the admission experience.

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Appendices

1: Letter of Ethical Approval

2: Recruitment Poster

3: Capacity Assessment Form

4: Participant Information Sheet (Observations study)

5: Participant Information Sheet (Observations study: Consultee)

6: Consent Form (Observations)

7: Participant Information Sheet (Interview study)

8: Consent Form (Interviews)

9: Distress Protocol

10: Interview Debrief

APPENDIX 1: Letter of Ethical Approval

East of England - Cambridge Central Research Ethics Committee
Royal Standard Place
Nottingham
NG1 6FS

18 July 2018

Prof Richard Morriss

Division of Psychiatry and Applied Psychology

School of Medicine, University of Nottingham

C20 Institute of Mental Health, Triumph Road, Nottingham

NG7 2TU

Dear Prof Morriss

Study title:	**Mental Health Service Users' Perspectives and Experiences of Risk assessment and management in an acute inpatient setting: A critical ethnography**
REC reference:	**18/EE/0154**
Protocol number:	**18012**
IRAS project ID:	**241853**

Thank you for your letter of 10 July 2018, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Mental Capacity Act 2005

I confirm that the committee has approved this research project for the purposes of the Mental Capacity Act 2005. The committee is satisfied that the requirements of section 31 of the Act will be met in relation to research carried out as part of this project on, or in relation to, a person who lacks capacity to consent to taking part in the project

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

The Committee has not yet completed any site-specific assessment (SSA) for the non-NHS research site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. We will write to you again as soon as an SSA application(s) has been reviewed. In the meantime no study procedures should be initiated at non-NHS sites.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants	FINAL v1.0	16 April 2018
Copies of advertisement materials for research participants [Study poster]	FINAL v1.1	04 July 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor insurance]		26 July 2017
Interview schedules or topic guides for participants [Draft interview topic guide (Service users)]	FINAL v1.0	16 April 2018

Interview schedules or topic guides for participants [Draft interview topic guide (Staff)]	FINAL v1.0	16 April 2018
IRAS Application Form [IRAS_Form_01052018]		01 May 2018
Letter from sponsor [Letter from sponsor]		16 April 2018
Other [Observations notification poster]	FINAL v1.0	16 April 2018
Other [Protocol for assessing service users' capacity to consent to observations]	FINAL v1.0	16 April 2018
Other [Observation capacity assessment form]	FINAL v1.0	16 April 2018
Other [Interview distress protocol]	FINAL v1.0	16 April 2018
Other [Interview debriefing sheet]	FINAL v1.0	16 April 2018
Other [Analysis framework for all documents]	FINAL v1.0	16 April 2018
Other [Contact form to receive study findings]	FINAL v1.0	16 April 2018
Other [Observations notification poster]	FINAL v1.1	04 July 2018
Other [Trust Safeguarding policy]	FINAL v1.1	04 July 2018
Participant consent form [Consent form: Observations]	FINAL v1.0	16 April 2018
Participant consent form [Consent form: Observations; Admission meeting]	FINAL v1.0	16 April 2018
Participant consent form [Consent form: Interview]	FINAL v1.1	04 July 2018
Participant information sheet (PIS) [PIS Observation study]	FINAL v1.1	04 July 2018
Participant information sheet (PIS) [PIS Observation study; for consultee]	FINAL v1.1	04 July 2018
Participant information sheet (PIS) [PIS Observation study: Admission meeting]	FINAL v1.1	04 July 2018
Participant information sheet (PIS) [PIS Interview study]	FINAL v1.1	04 July 2018
Research protocol or project proposal [Study protocol]	FINAL v1.1	04 July 2018
Summary CV for Chief Investigator (CI) [CI CV]		16 April 2018
Summary CV for student [PI CV]		16 April 2018
Summary CV for supervisor (student research) [CI CV]		16 April 2018

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports

- Notifying the end of the study

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

User Feedback

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

HRA Training

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

18/EE/0154	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

pp. S. O'Neil

Dr Lydia Drumright Chair

Email:NRESCommittee.EastofEngland-CambridgeCentral@nhs.net

Appendix 2: Recruitment Poster

Mental Health Service Users' Perspectives and Experiences of Risk

Would you like to take part in a research study aiming to improve service users' experiences of risk assessment and management on the ward?

At the moment there is a research study being carried out on this ward. From time to time a researcher will be taking some notes based on his observations of the ward. Staff, service users, or visitors will **not** be identifiable in these notes. The researcher would like to talk to you about observing *your* actions and interactions on the ward.

If you would be happy for your actions or interactions being observed, please let Andrew know, otherwise he will not include your actions or interactions in his observation-notes.

If you would like further information or would like to discuss any details personally, please get in touch with Andrew in person, in writing, by phone, or by email:

Andrew Grundy, B316 Postgraduate Research Office, B Floor, School of Health Sciences, Queen's Medical Centre, NG7 2HA.

Work mobile: 07480262394

Email: andrew.grundy1@nottingham.ac.uk.

Appendix 3: Capacity Assessment Form

Mental Health Service Users' Perspectives and Experiences of Risk in an acute inpatient setting

CAPACITY ASSESSMENT FORM

Service User's Name: ________________ **Date of assessment:**

Assess Capacity:

Can the person *(free from undue pressure)*

• Understand information about the study?	Yes ☐ No ☐
• Retain the information? *(for long enough to make a decision)*	Yes ☐ No ☐
• Use it to make a decision?	Yes ☐ No ☐
• Communicate the decision?	Yes ☐ No ☐

If yes to all – person has capacity. If no to any – person lacks capacity

Person has capacity: **Yes** **No**

If **yes**, ask service user if they are willing to take part, and take formal consent.

If **no**, contact relative/friend/carer, seek consultee agreement and assent to observations.

Appendix 4: Participant Information Sheet

Participant Information Sheet (Observation study)

(Final Version 1.1: 04.07.2018)

IRAS Project ID: 241853

Title of Study: Mental Health Service Users' Perspectives and Experiences of Risk in an acute inpatient setting

Name of Researchers: Andrew Grundy; Dr Anne Felton; Dr Nicola Wright; and Prof Richard Morriss

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.

The researcher will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

Many mental health policy documents state that involving service users in conversations about 'risk' or 'safety' concerns is important to improving the quality of care and promoting recovery. However, there is growing evidence to suggest that this does not occur.

The purpose of this study is to explore service users' experiences of 'risk' or 'safety' concerns whilst being on the ward. Concerns about 'risk' might include:

feeling vulnerable

having distressing thoughts

self-injury

money problems

housing issues

anger/aggression

fear of others

or anything else that might be troubling the individual and/or other people.

We are particularly interested in 'risk assessment' and 'risk management' on the ward. 'Assessment' is the process by which these 'safety' concerns are identified, which may be recorded in a risk assessment document and care plan. 'Management' is how the individual is supported in dealing with these issues, which may include writing a safety management plan.

Why have I been invited?

You are being invited to take part either because you are currently a service user on the ward, or because you are a mental health professional working on the ward in which the study is taking place.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. For service users, this would not affect your legal rights nor the standard of care you receive. For staff, this would not affect your legal rights nor your job situation on the ward. If you decide not to take part your actions or interactions on the ward will <u>not</u> be recorded in the researcher's observation-notes.

What will happen to me if I take part?

An experienced researcher from the University of Nottingham would like to spend approximately six months on your ward observing the ward staff and service users. He will spend some time observing informal spaces on the ward, such as the lounge and dining area.

With the permission of service users and ward staff, he will also observe more formal meetings, such as:

community meetings

staff meetings

staff handovers

ward rounds

one-to-one care planning meetings

and discharge planning meetings

He will be observing different shifts at different times (weekdays, weekends, mornings, afternoons, and evenings/nights).

The focus of the observations will be on how service users themselves talk about their 'risk' or 'safety' concerns, how they experience ongoing risk assessments in various different meetings, and how they experience managing these concerns whilst being an inpatient on the ward.

You will not have to do anything different to what you would normally do. The researcher will not interfere with your or any others' daily activities on the ward, although you can of course talk to him. It will always be made clear where and when an 'observation session' is taking place, giving 24 hours' notice.

We would like to ask for your permission to observe your actions and interactions on the ward by asking you to sign a consent form. After signing the consent form, the researcher will always check with you whether you are still happy to be observed during an 'observation session'. For example, you can always say whether you do not want to be observed for a period of time or during a particular meeting.

Whilst making his observations of the ward, he will be taking some written notes. However, individuals (service users, staff or visitors) will not be identifiable in his notes and these will be kept confidential. The 'observation session' will not be audio or video recorded.

Expenses and payments

Participants will not be paid to participate in the study and there will be no travel involved.

What are the possible disadvantages and risks of taking part?

Every effort will be made to ensure that you are as comfortable as possible with the observations.

What are the possible benefits of taking part?

We cannot promise the study will help you personally but the information we get from this study may help improve the way inpatient care is provided to NHS service users in the future.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. The researcher's contact details are given at the end of this information sheet. If the researcher cannot address your concerns please contact the chief investigator whose contact details are also at the end of this information sheet.

If you remain unhappy and wish to complain formally, service users can do this by contacting: Patient Experience Team, Moorgreen House, Highbury Hospital, Nottingham, NG6 9DR, (0115) 993 4542, complaints@nottshc.nhs.uk.

Staff can complain formally by contacting: Research & Innovation Office, Nottinghamshire Healthcare NHS Foundation Trust, Duncan MacMillan House, Porchester Road, Mapperley, Nottingham, NG3 6AA, RandIenquiries@nottshc.nhs.uk.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all personal information about you will be handled in confidence.

Your information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named below) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:
https://www.nottingham.ac.uk/utilities/privacy.aspx

Whilst the researcher is making his observations of the ward, he will be taking some notes. These notes will be typed up and will only be looked at and stored by authorised persons from the

University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

Where possible information about you which leaves the ward will have your name and address removed and a unique code will be used so that you cannot be recognised from it, however sometimes we need to ensure that we can recognise you to link the research data with your medical records so in these instances we will need to know your name and date of birth. We will also need this information if we need to follow up your medical records as part of the research, where we may need to ask the Government services that hold medical information about you (such as NHS Digital, the Office for National Statistics, among others) to provide this information to us. By signing the consent form you agree to the above.

Your contact information will be kept by the University of Nottingham for one year after the end of the study so that we are able to contact you about the findings of the study and possible follow-up studies (unless you advise us that you do not wish to be contacted). This information will be kept separately from the research data collected and only those who need to will have access to it. All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Although anything you might tell the researcher during his observations of the ward is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, it will be necessary to report this to the appropriate persons on the ward.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw from the entire study at any time, without giving any reason, and without your legal rights being affected. A service user's standard of care would not be affected, neither would a staff member's job situation on the ward be impacted by a decision to withdraw from the study. If you withdraw we will no longer collect any information about you or from you but we may keep some of the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. However, as much as is feasibly possible, your data (such as direct quotes) would be removed from the study. After this, we will not take any notes of your interactions, even if you are physically present in an 'observation session'. To safeguard your rights, we will use the minimum personally-identifiable information possible.

What will happen to the results of the research study?

At the end of this research, the results will be made available in reports and in academic papers. When we write up the results, all personal details will be removed so that no-one will know who you are. We may use direct quotes from your interactions but no real names will be used. If you would like to receive a summary of the results then this can be indicated on the consent form.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and the researcher is being funded by a scholarship from the School of Health Sciences, University of Nottingham.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by East of England – Cambridge Central Research Ethics Committee (Ref: 18/EE/0154).

Further information and contact details

If you would like further information or would like to discuss any details personally, please get in touch with the researcher, Andrew Grundy, in person, in writing, by phone, or by email:

Andrew Grundy, B316 Postgraduate Research Office, B Floor, School of Health Sciences, Queen's Medical Centre, NG7 2HA.

Work mobile: 07480262394

Email: andrew.grundy1@nottingham.ac.uk.

The details of the chief investigator are: Professor Richard Morriss, Division of Psychiatry and Applied Psychology, School of Medicine, University of Nottingham, C20 Institute of Mental Health, Triumph Road, Nottingham, NG7 2TU, (0115) 8230427, richard.morriss@nottingham.ac.uk.

Thank you very much for reading this information and considering whether you would like to take part in this study.

Appendix 5: Participant Information Sheet for Consultees

Participant Information Sheet (Observation Study; CONSULTEE)

(Final Version 1.1: 04.07.2018)

IRAS Project ID: 241583

Title of Study: Mental Health Service Users' Perspectives and Experiences of Risk in an acute inpatient setting

Name of Researchers: Andrew Grundy; Dr Anne Felton; Dr Nicola Wright; and Prof Richard Morriss

Invitation

Your relative (it could also be a friend or someone you care for, but for brevity this document will use the term 'relative') is being invited to take part in a research study. Before you decide whether you agree to their participation it is important for you to understand why the research is being done and what it will involve.

The researcher will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information.

Who can act as a consultee?

Where people cannot take the decision to consent to be involved in a research project then a consultee must be appointed. A consultee can either be 'personal' or 'nominated'.

A personal consultee is someone unconnected with the research who knows the potential research participant in a personal capacity and is able to advise on the person's wishes or feelings. This can be a friend, family member or court appointee.

A 'nominated' consultee' is someone unconnected with the research, appointed by the researcher, to advise the researcher about the person's wishes and feeling in relation to the project. This can be a health-care worker but they must not have any connection with the study. Before a nominated consultee is appointed, the researcher will take all reasonable steps to identify a personal consultee.

What is the role of the consultee?

The consultee advises the researcher on what the participant's wishes and feelings would be if they were able to consent for themselves, and on whether they should take part. The consultee does not give consent, only advise. The responsibility to decide whether the participant should be entered into the research lies ultimately with the researcher. Consultees will be provided with information about the research project and will be given the opportunity to discuss it and their role as consultee. All consultees must be able to understand their role and be willing to undertake it.

What is the purpose of the study?

Many mental health policy documents state that involving service users in conversations about ‘risk’ or ‘safety’ concerns is important to improving the quality of care and promoting recovery. However, there is growing evidence to suggest that this does not occur.

The purpose of this study is to explore service users’ experiences of ‘risk’ or ‘safety’ concerns whilst being on the ward. Concerns about ‘risk’ might include:

feeling vulnerable

having distressing thoughts

self-injury

money problems

housing issues

anger/aggression

fear of others

or anything else that might be troubling them and/or other people.

We are particularly interested in ‘risk assessment’ and ‘risk management’ on the ward. ‘Assessment’ is the process by which these ‘safety’ concerns are identified, which may be recorded in a risk assessment document and care plan. ‘Management’ is how your relative is supported in dealing with these issues, which may include writing a safety management plan.

Why has my relative been chosen?

Your relative is being invited to take part because they are currently a service user on the ward in which the study is taking place.

Does my relative have to take part?

We would like you to think very carefully about whether or not this person would have wanted to join the study. If your opinion is that he/she would have decided to take part, you will be given this information sheet to keep and be asked to sign a declaration form indicating your view allowing your relative to participate in the study. If you later decide that he/she no longer wishes to take part, please inform us and he/she will be withdrawn from the study. You do not need to give a reason and it will not affect the standard of care your relative receives. If you decide that your relative would not like to take part their actions or interactions on the ward will not be recorded in the researcher’s observation-notes.

What will happen to my relative if they take part?

The researcher would like to spend approximately six months on the ward observing the ward staff and service users. The researcher will spend some time observing informal spaces on the ward, such as the lounge and dining area.

With the permission of the service users and the staff present, the researcher will also observe more formal meetings, such as:

community meetings

ward rounds

one-to-one care planning meetings

and discharge planning meetings

He will be observing different shifts at different times (weekdays, weekends, mornings, afternoons, and evenings/nights).

The focus of the observations will be on how service users themselves talk about their ‘risk’ or ‘safety’ concerns, how they experience ongoing risk assessments in various different meetings, and how they experience managing these concerns whilst being an inpatient on the ward.

Your relative will not have to do anything different to what they would normally do. The researcher will not interfere with their or any others’ daily activities on the ward, although they can of course talk to him. It will always be made clear where and when an ‘observation session’ is taking place, giving 24 hours’ notice.

We would like to ask for your views about whether or not your relative would want the researcher to observe their actions and interactions with ward staff and other service users on the ward. The researcher will always check whether your relative is happy to be observed at the start of each ‘observation session’. For example, they can always say whether they do not want to be observed for a period of time or during a particular meeting.

Whilst making his observations of the ward, the researcher will be taking some written notes. However, individuals (service users, staff or visitors) will not be identifiable in his notes and these will be kept confidential. The ‘observation sessions’ will not be audio or video recorded.

As soon as your relative regains capacity to give consent to take part in the study, they will be asked if they would like to continue to be part of the study and will then be invited to sign a consent form. If they decide that they would not have liked to have been part of the study, then they will be asked whether they are happy for the information collected so far to be used in the analysis, otherwise, as much as is feasibly possible, their data will be removed from the study.

Expenses and payments

Participants will not be paid to participate in the study and there will be no travel involved.

What are the possible disadvantages or risks of taking part?

Every effort will be made to ensure that your relative is as comfortable as possible with the observations.

What are the possible benefits of taking part?

We cannot promise the study will help them personally but the information we get from this study may help improve the way inpatient care is provided to NHS service users in the future.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. The researcher’s contact details are given at the end of this information sheet. If the researcher cannot address your concerns please contact the chief investigator whose contact details are also at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting: Patient Experience Team, Moorgreen House, Highbury Hospital, Nottingham, NG6 9DR, (0115) 993 4542, complaints@nottshc.nhs.uk.

Will their taking part in this study be kept confidential?

Yes. We will follow ethical and legal practice and all information about your relative will be handled in confidence.

Whilst the researcher is making his observations of the ward, he will be taking some notes. These notes will be typed up and will only be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. Everyone will have a duty of confidentiality to your relative as a research participant and we will do our best to meet this duty.

All information which is collected about your relative during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named below) is the Data Custodian (manages access to the data). This means we are responsible for looking after your relative's information and using it properly. Their rights to access, change or move their information are limited as we need to manage their information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard their rights we will use the minimum personally – identifiable information possible.

You can find out more about how we use their information and to read our privacy notice at: https://www.nottingham.ac.uk/utilities/privacy.aspx

Whilst the researcher is making his observations of the ward, he will be taking some notes. These notes will be typed up and will only be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to your relative as a research participant and we will do our best to meet this duty.

Where possible information about your relative which leaves the ward will have their name and address removed and a unique code will be used so that you cannot be recognised from it, however sometimes we need to ensure that we can recognise your relative to link the research data with their medical records so in these instances we will need to know your relative's name and date of birth. We will also need this information if we need to follow up their medical records as part of the research, where we may need to ask the Government services that hold medical information about your relative (such as NHS Digital, the Office for National Statistics, among others) to provide this information to us. By signing the advice form you agree to the above.

Your relative's contact information will be kept by the University of Nottingham for one year after the end of the study so that we are able to contact them about the findings of the study and possible follow-up studies (unless you advise us that you do not wish them to be contacted). This information will be kept separately from the research data collected and only those who need to will have access to it. All other data (research data) will be kept securely for 7 years. After this time their data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain their confidentiality, only members of the research team given permission by the data custodian will have access to their personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that your relative could not be identified) but if we need to share identifiable information we will seek their consent for this and ensure it is secure. They will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect their confidentiality.

Although anything your relative might tell the researcher during his observations of the ward is confidential, should they disclose anything to us which we feel puts you or anyone else at any risk, it will be necessary to report this to the appropriate persons on the ward.

What will happen if I do not want my relative to carry on with the study?

Your relative's participation is voluntary and you are free to withdraw them at any time, without giving any reason, and without their legal rights or standard of care being affected. If you withdraw your relative, then you will be asked whether you are happy for the information collected so far to be used in the analysis, otherwise, as much as is feasibly possible, their data will be removed from the study. To safeguard their rights, we will use the minimum personally-identifiable information possible.

What will happen to the results of the study?

At the end of this research, the results will be made available in reports and in academic papers. When we write up the results, all personal details will be removed so that no-one will know who you are. We may use direct quotes from your relative's interactions but no real names will be used.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and the researcher is being funded by a scholarship from the School of Health Sciences, University of Nottingham.

Who has reviewed this study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect participant's interests. This study has been reviewed and given favourable opinion by East of England – Cambridge Central Research Ethics Committee (Ref: 18/EE/0154).

Further information and contact details

If you would like further information or would like to discuss any details personally, please get in touch with the researcher, Andrew Grundy, in person, in writing, by phone, or by email:

Andrew Grundy, B316 Postgraduate Research Office, B Floor,
School of Health Sciences, Queen's Medical Centre, NG7 2HA.

Work mobile: 07480262394

Email: andrew.grundy1@nottingham.ac.uk.

The details of the chief investigator are: Professor Richard Morriss, Division of Psychiatry and Applied Psychology, School of Medicine, University of Nottingham, C20 Institute of Mental Health, Triumph Road, Nottingham, NG7 2TU, (0115) 8230427, richard.morriss@nottingham.ac.uk.

Thank you very much for reading this information and considering whether you would like your relative to take part in this study.

Appendix 6: CONSENT FORM (Observations)

Consent Form – Observations (Final Version 1.0: 16.04.2018)

Title of Study: Mental Health Service Users' Perspectives and Experiences of Risk in an acute inpatient setting

IRAS Project ID: 241853

Name of Researchers: Andrew Grundy; Dr Anne Felton; Dr Nicola Wright; and Prof Richard Morriss

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number 1.1 dated 04.07.2018 for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I agree to my actions and interactions on the ward being observed by the researcher as set out in the information sheet. I understand that he will be making some notes during his observations. ☐
5. (optional) I would like to be informed of the findings of this research and agree to my name and email/address being added to a mailing list that will be used solely for the purposes of sharing the findings of this research. ☐

6. I agree to take part in the above study.

__________________________	________________	________________________
Name of Participant	Date	Signature
____________________________	________________	________________________
Name of Person taking consent	Date	Signature

2 copies: 1 for participant; 1 for the project notes.

Appendix 7: Participant Information Sheet

Participant Information Sheet (Interview study)
(Final Version 1.1: 04.07.2018)

IRAS Project ID: 241853

Title of Study: Mental Health Service Users' Perspectives and Experiences of Risk in an acute inpatient setting

Name of Researchers: Andrew Grundy; Dr Anne Felton; Dr Nicola Wright; and Prof Richard Morriss

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.

The researcher will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

Many mental health policy documents state that involving service users in conversations about 'risk' or 'safety' concerns is important to improving the quality of care and promoting recovery. However, there is growing evidence to suggest that this does not occur.

The main purpose of this study is to explore service users' perspectives and experiences of 'risk' or 'safety' concerns whilst being on the ward. Concerns about 'risk' might include:

feeling vulnerable

having distressing thoughts

self-injury

money problems

housing issues

anger/aggression

fear of others

or anything else that might be troubling the individual and/or other people.

We are particularly interested in 'risk assessment' and 'risk management' on the ward. 'Assessment' is the process by which these 'safety' concerns are identified, which may be recorded in a risk assessment document and care plan. 'Management' is how the individual is supported in dealing with these issues, which may include writing a safety management plan.

Why have I been invited?

You are being invited to take part either because you have been a service user on the ward and you are now nearing discharge, or because you are a mental health professional working on the ward in which the study is taking place.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. For service users, this would not affect your legal rights nor the standard of care you receive. For staff, this would not affect your legal rights nor your job situation.

What will happen to me if I take part?

If you do decide to take part, we would like you to take part in one individual interview. This will last approximately up to 90 minutes and will be carried out by an experienced researcher from the University of Nottingham. We will ask you for your views on and experiences of risk/safety concerns. We will also explore your perspectives on risk assessment and its management whilst you have been on the ward (service users), or working on the ward (staff).

The interview will be carried out face-to-face at a time that is most suitable for you, in a private room on the ward. With your permission, the interview will be audio recorded. We record interviews because it is hard to take notes of what people say, listen carefully and think all at the same time. We also do this to help us remember exactly what people said and to make sure that all their comments are available for the research. After the interview, the recording is typed up by the researcher and any identifying features that might be mentioned during the interview are removed from the transcript, and then the audio-file is destroyed.

If you are a service user, you will also be asked whether we have your permission to access sections of your medical notes, where it is relevant to you taking part in this research. We will also ask your permission to obtain copies of your risk assessment, care plan and recovery plan. Any identifying features will be removed from the copies we obtain. You can still take part in the interview even if you do not give your permission for us to look at these documents.

Expenses and payments

Participants will not be paid to participate in the study and there will be no travel involved.

What are the possible disadvantages and risks of taking part?

Many people enjoy sharing their views in interviews, but sometimes people can feel upset if they talk about something distressing that has happened to them or to others. If this happens the researcher interviewing you will ensure that you are supported both during and after the interview.

What are the possible benefits of taking part?

We cannot promise the study will help you personally but the information we get from this study may help improve the way inpatient care is provided to NHS service users in the future.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. The researcher's contact details are given at the end of this information sheet. If the researcher cannot address your concerns please contact the chief investigator whose contact details are also at the end of this information sheet.

If you remain unhappy and wish to complain formally, service users can do this by contacting: Patient Experience Team, Moorgreen House, Highbury Hospital, Nottingham, NG6 9DR, (0115) 993 4542, complaints@nottshc.nhs.uk.

Staff can complain formally by contacting: Research & Innovation Office, Nottinghamshire Healthcare NHS Foundation Trust, Duncan MacMillan House, Porchester Road, Mapperley, Nottingham, NG3 6AA, RandIenquiries@nottshc.nhs.uk.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all personal information about you will be handled in confidence.

Your information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named below) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:
https://www.nottingham.ac.uk/utilities/privacy.aspx

If you join the study, the data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

Where possible information about you which leaves the ward will have your name and address removed and a unique code will be used so that you cannot be recognised from it, however sometimes we need to ensure that we can recognise you to link the research data with your medical records so in these instances we will need to know your name and date of birth. We will also need this information if we need to follow up your medical records as part of the research, where we may need to ask the Government services that hold medical information about you (such as NHS Digital, the Office for National Statistics, among others) to provide this information to us. By signing the consent form you agree to the above.

Your contact information will be kept by the University of Nottingham for one year after the end of the study so that we are able to contact you about the findings of the study and possible follow-up studies (unless you advise us that you do not wish to be contacted). This information will be kept separately from the research data collected and only those who need to will have access to it. All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Although what you say in the interview is confidential, should you disclose anything to us, which we feel puts you or anyone else at any risk, it will be necessary to report this to the appropriate persons on the ward.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw from the entire study at any time, without giving any reason, and without your legal rights being affected. A service user's standard of care would not be affected, neither would a staff member's job situation on the ward be impacted by a decision to withdraw from the study. If you withdraw we will no longer collect any information about you or from you but we may keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally-identifiable information possible.

What will happen to the results of the research study?

At the end of this research, the results will be made available in reports and in academic papers. When we write up the results, all personal details will be removed so that no-one will know who you are. We may use direct quotes from your interview but no real names will be used. If you would like to receive a summary of the results then this can be indicated on the consent form.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and the researcher is being funded by a scholarship from the School of Health Sciences, University of Nottingham.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by East of England – Cambridge Central Research Ethics Committee (Ref: 18/EE/0154).

Further information and contact details

If you would like further information or would like to discuss any details personally, please get in touch with the researcher, Andrew Grundy, in person, in writing, by phone, or by email:

Andrew Grundy, B316 Postgraduate Research Office, B Floor, School of Health Sciences, Queen's Medical Centre, NG7 2HA.

Work mobile: 07480262394

Email: andrew.grundy1@nottingham.ac.uk.

The details of the chief investigator are: Professor Richard Morris, Division of Psychiatry and Applied Psychology, School of Medicine, University of Nottingham, C20 Institute of Mental Health, Triumph Road, Nottingham, NG7 2TU, (0115) 8230427, richard.morriss@nottingham.ac.uk.

Thank you very much for reading this information and considering whether you would like to take part in this study

Appendix 8: CONSENT FORM (Interviews)

Consent Form – Interviews (Final Version 1.1: 04.07.2018)

Title of Study: Mental Health Service Users' Perspectives and Experiences of Risk in an acute inpatient setting

IRAS Project ID: 241853

Name of Researchers: Andrew Grundy; Dr Anne Felton; Dr Nicola Wright; and Prof Richard Morriss

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number 1.1 dated 04.07.2018 for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the interview will be audio-recorded, that anonymous direct quotes from the interview may be used in the study reports, and that the audio-file will be destroyed after the interview has been transcribed. ☐
5. (optional) I give permission for authorised individuals to access relevant sections of my medical notes where is relevant to my taking part in this study.
6. (optional) I give permission for authorised individuals to obtain copies of: my risk assessment; care plan; and recovery plan. I understand that all identifying features of these documents will be removed prior to analysis. ☐
7. (optional) I would like to be informed of the findings of this research and agree to my name and email/address being added to a mailing list that will be used solely for the purposes of sharing the findings of this research. ☐
8. I agree to take part in the interview study. ☐

____________________	_____________	__________________
Name of Participant	Date	Signature
____________________	_____________	__________________
Name of Person taking consent	Date	Signature

2 copies: 1 for participant; 1 for the project notes

Appendix 9: Distress Protocol

Mental Health Service Users' Perspectives and Experiences of Risk in an acute inpatient setting

Interview distress protocol:

If a participant appears to become distressed during the interview, the researcher will:

1. Acknowledge that talking about problems can be distressing.

2. Encourage the participant to take a break from answering questions.

3. Offer support by reassuring participant that they do not need to answer a question(s) if they do not wish to.

4. Ask if they would like to continue with the interview or prefer to stop.

If they prefer to stop then:

5. Finish the interview and offer to return at another day/time.

6. If the participant withdraws their consent to participate in the study then this will be recorded in writing.

If the interview continues:

7. Take time at the end of the interview to talk informally, and encourage the participant to access further support dependent on their level of distress, such as meeting with their named nurse (for service user) or supervisor (for staff).

8. If the participant has any questions or requires reassurance about the research they should be encouraged to contact the researcher or the lead supervisor (details on Debriefing Sheet and Participant Information Sheet).

Appendix 10: Debrief Sheet

Mental Health Service Users' Perspectives and Experiences on Risk in an acute inpatient setting

Interview debriefing sheet

I would like to take this opportunity to thank you for taking part in this interview. The information you have given me is very valuable and I appreciate your time.

The purpose of this interview was to gather information about how risk assessment and management on an acute mental health ward can be improved.

The views and ideas that you have provided me with are extremely useful.

I hope that taking part in the interview has been interesting, although I also appreciate that talking about personal experiences can be difficult.

If you would like to contact me at a later date about any queries or concerns that you may have about your taking part in this research, please do not hesitate to contact me in person, in writing, by phone, or by email:

Andrew Grundy, B316 Postgraduate Research Office, B Floor, School of Health Sciences, Queen's Medical Centre, NG7 2HA.

Work mobile: 07480262394

Email: andrew.grundy1@nottingham.ac.uk.

The details of the chief investigator are: Professor Richard Morriss, Division of Psychiatry and Applied Psychology, School of Medicine, University of Nottingham, C20 Institute of Mental Health, Triumph Road, Nottingham, NG7 2TU, (0115) 8230427, richard.morriss@nottingham.ac.uk.