JESSE K. OFORI-BULL BA Hons MSc

DEVELOPING A TRAUMA-INFORMED MODEL OF SUICIDE RISK MANAGEMENT

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Acknowledgements

My sincerest thanks go to the participants who gave their time for this project; it has been a privilege, and I hope this paper captures the essence of our conversations. Thanks to Shirley McNicholas, and the team at Drayton Park[1]; it has been inspiring to see the work you do, and thanks to Anne Cooke, whose work I have admired for a long time, and whose supervision has been a career peak. Finally, to all those who have been affected by the topic of suicide risk management; I hope this paper goes some way to advancing the field.

[1] Named with permission

Summary of the Research Portfolio

Section A is a scoping literature review, exploring the range of approaches to suicide risk management taken across Western mental health services. It outlines the historical and social influences on modern day suicide risk management practices, before characterising four key approaches in use today. For each approach, the review considers the assumptions they make about suicide and risk, the practices they tend to employ, and the way the approach positions service users and staff in relation to each other. The review goes on to consider the interactions between the approaches, and how they come together to form the overall landscape of suicide risk management in Western mental healthcare.

Section B introduces the relevance of trauma-informed approaches to suicide risk management, with particular attention to the influence of relational theories, before explicating the process of suicide risk management in one NHS trauma-informed crisis house. The study, which used a grounded theory methodology based on interviews with six service users and six staff members, identified seven key concepts. The concepts, which spanned suicide risk management processes at the individual and organisational level, constituted a core category termed *safety in relationships.*

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Section A: A Typology of Western Mental Health Service Approaches to Suicide Risk Management

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Abstract

Suicide risk management is a core function of Western mental health services. Traditionally, approaches to suicide risk management have privileged physical over psychological safety. However, some mental health service users and staff have called for alternative approaches, and research points to a changing landscape in the culture of risk management. The current paper sought to gain a broad overview of the positions taken in relation to the clinical practice of suicide risk management. The review adopted a scoping methodology and identified 29 articles that documented approaches to suicide risk management that have been put forward in Western[2] mental health settings. In reviewing the literature, four approaches were identified: The technical approach, the technical-collaborative approach, the relational approach, and the self-determining approach. For each approach, the paper explores the underlying theoretical assumptions, clinical practices, and relational processes between service users and staff. In outlining and explaining the wider range approaches, this analysis allows questioning of the taken-for-granted assumptions of mainstream services, that arguably keep services stuck, and hopefully frees up space for different approaches.

Keywords: suicide, risk management, crisis service, relational safety, organisational defences

[2] The definition of Western world, as based on that set out by the Foreign Policy Research Institute (McNeill, 1997), included European countries, the United States, Canada, Australia, and New Zealand.

Each year, an estimated 703,000 people around the world die by suicide, with a further recorded 20 suicide attempts for each one completed (World Health Organisation; WHO, 2021). In the West, management of suicide risk is a core function of mental health services (NHS England, 2016). However, it is considered one of the most demanding and "profoundly unsatisfactory" aspects of the role by many clinicians (Undrill, 2007, p.291), and only 14% of service users surveyed felt they received the response they needed during suicidal crisis (NHS England, 2016). In addition, despite research and clinical efforts, suicide statistics have remained relatively stable over the past two decades (Office for National Statistics, 2022).

Traditionally, mental health service approaches to risk have focused on clinicians calculating the probability of suicide in order to prevent it (Fitzpatrick, 2011). For instance, The Department of Health and Social Care's (2009) Best Practice in Managing Risk guidelines note that "a hazard is to be identified, measured and ultimately prevented" (p.61). Indeed, official risk discourses, such as the UK government's Zero Suicide Policy (Department of Health and Social Care, 2018, para. 7) and the World Health Organisation's factsheet on suicide prevention (WHO, 2021, para. 8), continue to emphasise that many, if not all, adverse outcomes could be avoided if standardised, scientific approaches were more rigorously applied.

Perspectives on Suicide and Risk Management: The Medical Model

The statements above can be seen to reflect the 'medical model'[3], a term coined by Laing (1971), to describe what is generally seen as the dominant approach to mental healthcare in the West (Cooke et al., 2019). The American Psychological Association define the medical model as "the concept that mental and emotional problems are analogous to

[3] Whilst generally associated to the discipline of psychiatry, Barber (2012) argues the medical model is not analogous to it.

biological problems—that is, they have detectable, specific, physiological causes (e.g., an abnormal gene or damaged cell) and are amenable to cure or improvement by specific treatment" (American Psychological Association, APA, 2023a, para. 1).

As such, the approach is typically seen to privilege physical and procedural processes (Aggett & Messent, 2019); “using clinical technologies in order to assess and contain risk by treating the ‘disorder’ that is causing it” (A. Cooke, personal communication, April 17, 2023). Indeed, Jobes (2017) asserts that one pervasive assumption within clinical practice, is that “psychotropic medications are the best treatment for suicidal people and that inpatient psychiatric care is the optimal mental health intervention of choice” (p. 208).

The medical model is credited for having driven some key improvements in community attitudes to suicide and treatment options, compared to approaches that came before; which positioned suicide as sinful and criminal (Fitzpatrick & River, 2018, p.4). Fitzpatrick & River (2018) also propose that suicide risk management from a purely medical perspective may, at times, be misaligned to the needs of those experiencing suicidality, as well as posing particular ethical dilemmas for clinicians.

Risk Management Culture and Staff Anxieties

Power (2004) proposed that under the medical model; and particularly the medico-legal system, clinicians are forced to attempt to manage the unmanageable. In doing so, they are faced with a secondary risk, namely risk to reputation, which is thought to distract from the core task of patient care. Power (2004) cautions that an over-reliance on procedural tasks can occur as a result, leading to "a potentially catastrophic downward spiral in which expert judgement shrinks to an empty form of defendable compliance" (p. 42). Bloom (2010) argues that greater reliance is also placed on authoritarian leadership, as clinicians seek certainty and security from threat.

Beyond managing reputational risks, Menzies-Lyth (1960) proposed that procedural ways of working serve to defend clinicians against the anxieties inherent in witnessing the suffering and death of patients in their care. Geller (2017) draws parallels between the defences of ritualistic and technical task performance and standardised risk procedures such as checklists and scales. Menzies-Lyth (1960) proposed that the benefit of such defences was short-lived, since they could lead to the emergence of secondary stressors, such as overwhelming volumes of administrative work and decreased job satisfaction.

Risk management practices, it is argued, should re-orient to the core activity of care provision, through which secondary, reputational, risk will be managed indirectly (Power, 2004). In order to do so, Menzies-Lyth (1960) concluded that organisations need to be designed in ways that provide psychological containment for clinicians; indeed, that "the success and viability of a social institution are intimately connected with the techniques it uses to contain anxiety" (p.78).

However, reviews of clinicians affected by service user suicide (Malik et al., 2022; Sandford et al., 2021) suggest that services, at times, continue to be seen to perpetuate these anxieties. Undrill (2007) argued that "anxiety about risk in mental healthcare settings is at currently at epidemic proportions" (p.296), and called for a cultural shift in mental healthcare that acknowledges the uncertainty inherent in suicide risk management practice.

Some of the most current and key pieces of literature in the UK, such as the NHS England Patient Safety Strategy (NHS England, 2019) and the National Confidential Enquiry (HQIP, 2022), explicitly commit to promoting psychologically safe environments in which clinicians and services can learn from critical incidents. The former states that "cultures in the NHS are too often thwarted by fear and blame. But usually [individuals] are not the real problem" (p.7). Indeed, Carroll & McSherry (2021) attest to a cultural shift towards therapeutic risk taking across the field and state that "facilitating and encouraging patients to

negotiate challenges and manage risks for themselves (drawing on assistance from services where they deem fit) is now recognized as 'best practice'" (p. 402).

Alternative Approaches to Suicide Risk Management

Theorists, such as Mary Douglas (1992), argue that Western medical constructions of risk forefront risks enacted by an individual, such as suicide, over those enacted against the individual, such as stigma and iatrogenic harm. Douglas (1992) argues that narrow Western conceptualisations of risk contribute to the 'othering' of those who embody it and block the opportunity to engage with the complex contexts in which suicides occur.

Alternatives to the medical model include the psychosocial model, of which a subset of proponents are sometimes termed 'critical' in their approach[4]. Such models have tended to forefront the role of relationships in an individual's experience of suicidality, as well as experiences of marginalisation and oppression (Mueller, 2021). As such, psychosocial approaches tend to position service users more as experts in the endeavour of suicide risk management (Marsh, 2006).

Indeed, in distinguishing psychosocial approaches from the medical model, Soper et al. (2022) highlight that "most common mental disorders ease spontaneously given time and favourable psychosocial conditions, with or without medical intervention [and, that] suicidal crises tend to be ephemeral, coming and going often within minutes" (p.146).

Psycho-social approaches to suicide are not new; Durkheimian (1879) and Freudian (1917) theories respectively positioned suicide as a societal and as a relational conflict, rather than an individual phenomenon. Theories of relational development propose that suicidality

[4] Definitions of psychosocial approaches forefront "the intersection and interaction of social, cultural, and environmental influences on the mind and behaviour" (American Psychological Association, 2023c, para. 3), and those of critical: "in the sense that there are many important criticisms that need to be made of our current approaches to issues to mental health" (Open University, 2023).

can be a crisis of attachment, in times of threat or vulnerability (Green et al., 2020). Additionally, systemic theories consider the therapeutic relationship a vehicle supporting a person's connection to the family, community, and cultural systems that ultimately sustain their sense of safety (Frey et al., 2016).

Service models, such as the therapeutic community applied these theories to practice, most notably in the 1960s and 70s, and "acknowledge[d] that a trusting relationship is a prerequisite for therapeutic change and that risk will ultimately be managed within therapeutic relationships" (Campling, 2001, p.370). As residential units became superseded by "open door" day units over subsequent decades, which some attributed to socio-political pressures on the NHS, the therapeutic community 'approach' became distinguished from the therapeutic community 'proper' (Whiteley, 2004).

Principles of the therapeutic community remain evident in the current recovery narrative more generally; ImROC, (2014) advocate for "transforming traditional risk assessment and management practices into much more collaborative, co-produced, processes" (p. 3). Indeed, the *British Medical Journal* best practice guidelines (BMJ, 2022) assert that "clinicians, patients, and their carers are calling for a paradigm shift in suicide risk assessment that moves away from 'characterising, predicting, and managing risk' towards 'compassion, safeguarding, and safety planning'" (para. 5).

Such a paradigm shift is reminiscent of the Trauma-Informed Approach (TIA; Harris & Fallott, 2001), which has gained particular prominence in recent years, and which is discussed further in the latter section of this thesis (Ofori-Bull, 2023). Crucially, TIAs propose that since much mental distress is rooted in relational trauma, in order to effectively manage suicide risk, responses should be relationally reparative (Sweeney et al., 2016). As such, TIAs advocate for suicide risk management practices that privilege psychological over physical safety (Mirick, 2022).

There have been calls from NHS mental health service users and staff for alternative approaches to suicide risk management, and some attest that the field is diversifying (Berzins et al., 2020). Whilst sometimes positioned diametrically, as medical versus alternative discourses, the range of perspectives outlined above show that such a stance is an oversimplification. The aim of the current paper is to map the range of approaches to suicide risk management that have been put forward in Western mental health settings and explore the assumptions, practices, and relational processes that underlie them.

Review Questions

- What are the different approaches to suicide risk management used in clinical practice?
    - What theoretical assumptions about risk and suicidality underlie each approach?
    - What practices do each approach draw upon in the clinical setting?
    - How are clinicians and service users positioned in relation to each other by each approach?

Positioning Statement

In naming the dominance of a broadly accepted knowledge-base, I have already taken a critical position in relation to the literature on suicide risk management. As a researcher-practitioner I have experience of working across mainstream crisis services and alternative community models. Over the years, I have become interested in the ways some knowledge bases are accepted as truths and others subjugated, both in the literature and in the clinic. Thus, I am necessarily written into the text: I seek to explore practices in line with social justice orientations and make no claims to presenting a neutral or objective account. The position taken in this paper not intended as a panacea, but rather aims to present an

underrepresented discourse and thicken the narrative that surrounds the practice of suicide risk management.

Methodology

This paper takes the form of a scoping review, with the aim of gaining a broad overview of the positions taken in relation to suicide risk management in clinical practice and identifying gaps in the literature. The review is based on methodological guidance outlined by the *Joanna Briggs Institute* (Peters et al., 2020) and the *PRISMA Extension for Scoping Reviews (PRISMA-ScR) Checklist* (Tricco et al., 2018).

Eligibility Criteria

As is typical for a review of this type (Booth, 2016), the search strategy incorporated a range of literature, both empirical (qualitative and quantitative) and conceptual, across a range of disciplines, and did not seek to be comprehensive. In order to be included, papers needed to outline a specific approach to suicide risk management taken in an adult mental health setting. The review focused specifically on individual approaches to risk management in clinical practice: population-based strategies were not included. No timeframe was imposed, due to the relative scarcity of literature pertaining to alternative approaches, and since some of what does exist grew out of the service user movement of the 1960s and 70s (Morrison, 2013). Full inclusion and exclusion criteria are detailed in Table 1.

Table 1

Literature Review Inclusion criteria

Inclusion criteria	Exclusion criteria
Paper in English language	Paper not available in English
Reference to adult mental health service users	Non-adult service user groups (e.g. child and adolescent)

Reference to the application of suicide risk management in a Western[5] mental health crisis setting	No reference to the Western mental health crisis setting (e.g. based in a non-Western country, non-clinical setting, or non-crisis setting)
Reference to an individual suicide risk management intervention	Population-based suicide prevention (e.g. media campaigns)

Search Strategy

Given that the researcher sought to explore the diversity in approaches to suicide risk management, including those that are more typically underrepresented, the literature search progressed in two stages; covering both the peer reviewed and grey literature. Search terms were identified iteratively, as outlined by Morris et al. (2016), first based on keywords identified from literature reviewed for the introduction section of this paper.

Firstly, a systematic search was conducted across four large research databases, which represented a range of disciplines; Assia, Medline, PsychInfo, and Web of Science, using the following search terms: AB(("risk management") AND (proce* OR approach* OR strat* OR practice* OR model*) AND (suicid*)).

The second stage comprised a complementary search, using Google Scholar and OpenGrey, to identify literature and positions less likely to be represented in mainstream databases. This search was based on the following search terms "suicide" AND "risk management" AND[6] ("crisis house" OR "crisis café" OR "safe haven" OR "Soteria" or "therapeutic community" OR "Open Dialogue" OR "user run" OR "crisis line"). The list of

[5] The definition of Western world, as based on that set out by the Foreign Policy Research Institute (McNeill, 1997), included European countries, the United States, Canada, Australia, and New Zealand.

[6] The list of service model specific terms was used for the Google Scholar search only (not Open Grey), given the high volume of results.

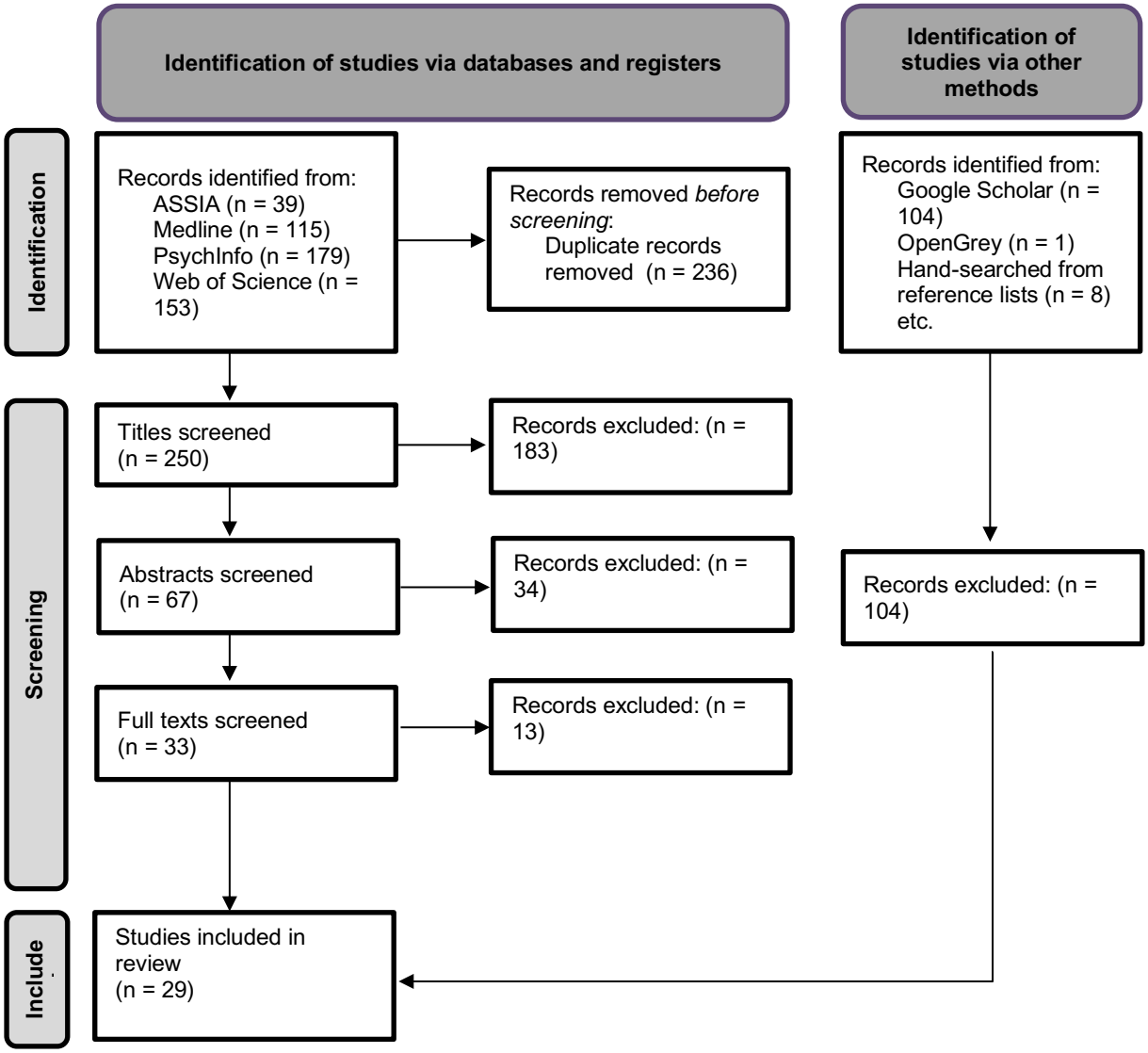
service model specific terms (such as crisis café and Soteria) were drawn from a comprehensive summary of non-statutory and "alternative" crisis services, which were typically excluded from lists elsewhere (Odejimi et al., 2020), and was collated by the International Mental Health Collaborating Network (see IMHCN, n.d.). Subsequent to the two main searches, additional data was gathered from hand searches on the reference lists of the included articles.

Data Selection

The data screening and selection process followed four main stages, as outlined in Figure 1. The initial search yielded 486 results. Following removal of 236 duplicates, 250 articles were retained, for which titles were screened and those 183 clearly not meeting criteria removed. For the remaining 67 articles, abstracts were screened and 25 removed. For the remaining 33, full texts were read and 13 articles removed. The second search and manual searches yielded 113 articles, of which 104 were screened out. The review was based on the final 30 papers.

Figure 1

PRISMA Diagram



Full details of the characteristics of the literature reviewed is outlined in Table 2. In summary, of the final 29 papers, 14 were narrative reviews (many of which featured case studies or case illustrations), 9 were cross-sectional qualitative or mixed method studies, 2 were systematic reviews, one was a rapid review, one was a meta-synthesis, one was a discussion paper, and one was a piece of grey literature.

Table 2

Literature Summary

Authors	Country	Purpose	Methodology	Findings	Major themes	Approach[7]
Bernert, Hom & Roberts (2014)	USA	To identify and review clinical practice guidelines and resource documents in suicide prevention and risk management	Systematic literature review	Current guidelines address similar aspects of suicide risk assessment and management, but significant discrepancies exist. A lack of consensus was evident in recommendations across core competencies, which may be improved by increased standardization in practice and training.	**Assumption**: Biomedical; Suicide risk as a science; Suicide is preventable; Suicide is located within the individual **Practices**: Based on prevention; Standardised EBRM as gold standard; Standardisation.	Technical
Bloch-Elkouby & Barzilay (2022)	USA	To propose that the principles of Alliance-Focused Training are integrated into practices of safety planning and suicide risk management.	Narrative review and case report	Establishing an effective therapeutic alliance with suicidal patients may enhance patients' adherence to the safety plan, promote a sense of affiliation and agency, and improve their interpersonal functioning.	**Assumption**: Acknowledgement of interpersonal trauma **Practices**: Attending to relational dynamics; Augmentations to EBP - SPI Alliance-focussed training – mindfulness/metacognitive skills **Relationships**: Opportunities for relational repair – lead to self-reg	Technical-Collaborative
Coffey, Cohen, Faulkner, Hannigan, Simpson & Barlow (2017)	UK	To examine what patients, family members, and workers say about risk assessment and management and explore the contents of care plans.	Cross sectional qualitative	Participants have contrasting priorities in relation to risk. Patients see benefit in discussions about risk, but cast the process as a worker priority that may lead to loss of liberty. Relationships with workers are key to family members and patients; however, worker claims of involving people in the care planning process do not extend to risk assessment and management procedures for fear of causing upset. Workers locate risk as coming from the person rather than social or environmental factors, are risk averse and appear to prioritize the procedural aspects of assessment.	**Assumptions:** Underlying pathology **Practices:** Based on prevention **Relationships:** Involvement is seen to be a challenge; Staff feel self-protective; Service users feeling isolated	Technical

[7] The term approach has been used to refer to the four overarching categories that emerged out of the literature; these were termed the technical, collaborative, relational, and self-directed approaches. Each approach is based on themes emerging out of the literature analysis; related to the theoretical assumptions, clinical practices, and relational processes identified between service users and clinicians. Each approach is explicated in Table 2 and detailed in the review section.

Deering, Pawson, Summers & Williams (2019)	UK	To review research and explore what patients consider beneficial in risk management practice.	Mixed studies systematic review	Connectivity appears important. Particularly patients feeling involved, and their voices being heard in both the identification of risks and then shaping risk management practice.	**Assumptions**: Forefronts relational trauma **Relationships**: Relationships as key mechanism of change	Relational
Deering, Williams & Williams (2022)	UK	To outline several critical risk theories and explore their application to risk concerns in mental health care.	Narrative review	Clinical concerns seemed to involve difficulties with uncertainty, holding onto expertise, and the othering of patients through risk. These concerns suggest the patient voice might become lost, particularly within the backdrop of clinical fears about blame.	**Relationships:** Involvement is a challenge for clinicians; Staff feel blamed and shamed for failure to predict risk	Technical
Espeland, Hjelmeland & Knizek (2021)	Norway	To explore how professionals working with suicide prevention experience the influence of the national guidelines on mental healthcare, and to gather recommendations for which steps to take next.	Cross sectional qualitative	Participants had an ambivalent view on risk assessment—it may be a tool, but it may also compromise other important aspects in prevention. Moreover, the possibility of liability has resulted in the need for self-protection. Instead, the participants recommended a relational approach to suicide prevention.	**Relationships:** Staff concerns re medicolegal	Technical
					Assumptions: Forefronts the role of relational trauma **Practices:** Attending to relational processes **Relationships:** Relationships as key mechanism of change	Relational
Evans, Edwards & Chick (2022)	UK	To identify the barriers and facilitators to implementing relational and environmental risk management approaches that address suicidality in inpatient mental health services.	Rapid review	Approaches included but were not limited to special observation, zonal nursing, relational security, locked doors (in response to absconding), no suicide contracts, and environmental safety.	**Assumptions:** Underlying pathology; Located within the individual **Practices:** Physical or procedural; Increased anti-ligature points, locked doors, and observations (particularly after incidents); Safety planning, restricting access to means, crisis contacts **Relationships:** Staff concerns regarding medicolegal; Policies as a result of critical incidents	Technical
Felton, Repper & Avis (2018)	UK	To explore mental health professionals' experiences of tensions (between providing acceptance and support for an individual's recovery through the therapeutic relationship	Case study	Findings suggested that risk dominated decision-making to such an extent it defined the way service users were understood and treated. A distant relationship between professionals and service users helped to create and maintain this situation. There needs to be a greater focus on	**Relationships:** Service users positioned as dangerous and vulnerable – tension in sharing responsibility; Distance in the relationship	Technical

		and enacting restrictions) in the context of decision-making.		service users' subjective experiences in the decision-making process to challenge the definition of people with mental health problems as risky.		
					Practices: Telling a story and receiving validation / processing emotion **Relationships:** Relational repair; Emotional and narrative proximity supports trust and understanding; Dilemma in integrating with wider technical culture	Relational
Fischer & Ferlie (2013)	UK	To explore and explain escalating contradictions between two modes of clinical risk management which resisted hybridisation. Longitudinal case study data is presented, showing contradiction and escalating contest between ethics-orientated and rules-based systems in a high-commitment mental health setting, triggering a crisis and organisational closure.	Narrative review and case study	Interactions between local conditions of strong ideological loading, high emotional and personal involvement, and rising rules-based risk management are seen as producing this contest and its dynamics of escalating and intractable conflict.	**Assumptions:** Forefronts relational trauma **Practices:** Psychological over physical containment – therapeutic interaction (clinicians, and peers); Community meetings; Introduction of restrictive practices led to organisational crisis / closure **Relationships:** Relationships as key mechanism of change – single most important factor; Service users as peers; Democratic decisions (regarding risk)	Relational
Fitzpatrick & River (2018)	UK	To outline criticisms of current approaches to the care of persons who are suicidal.	Narrative review and case illustration	Presented examples of alternative models of care (including a befriending crisis house) that challenge the current framework, and make recommendations regarding service design.	**Relationships**: Service users report feeling impersonal and superficial	Technical
					Relationships: Based on clinicians' beliefs - Limited to cases deemed lower risk.	Technical-Technical-Collaborative
					Assumptions: Attends to socio-political context (poverty, xenophobia) **Relationships:** Not sufficient to neutralise institutional context	Relational
					Assumptions: Fundamental right to autonomy, extending to right to end life; Expicitly non-medical. **Practices:** Befriending crisis house; Listening - Non-interventive	Self-Determining

					Relationships: Some limitations - Legally bound, stay length; Staff as befrienders – not professionals. Staff support is cornerstone	
Grant & Lusk (2015)	USA	To propose the adoption of the therapeutic risk management of the suicidal patient (TRMSP; augmenting clinical risk assessment with structured instruments, stratifying risk in terms of both severity and temporality, and developing and documenting a safety plan) to improve suicide risk assessment and management within multidisciplinary systems of care.	Narrative review	The TRMSP may serve as a foundation for building a standardized, collaborative, stepped-care approach that patients, individual providers, and the health care system can all benefit from.	**Assumptions:** Risks are calculable; Suicide is preventable **Practices:** Based on prediction – stratifying & structured instruments; Standardised EBRM as gold standard; Standardisation, for MDT consistency **Relationships:** Privileges staff responsibility	Technical
Guyers (2020)	UK	To present a new communicative model for managing risk of suicide. The RISK framework can be used in conjunction with traditional problem focussed approaches to increase the collaboration between healthcare professionals and patients when creating a safety plan.	Narrative review and case illustration	Using this model allows the healthcare professional to curiously ask how the person has kept safe for this long (Resources), how much they know already about how they have done this and what they would notice if the thoughts of attempting suicide were absent or managed (Increments). Next, the framework considers how might the resources discussed be best shared with others (e.g. professionals, family) and who or what else outside of the room might be able to help the increments (Sharing). Finally, in this framework, the professional aims to understand how all of the above ensures the individual keeps their existing expertise at the forefront of the difficulties they are experiencing (Knowledge).	**Practices:** Solution-focussed and narrative approaches **Relationships:** Deepened exploration / alliance during safety planning	Technical-Collaborative
Hawton, Lascelles, Pitman, Gilbert, & Silverman (2022)	UK	To propose a person-centred approach to suicide risk assessment, formulation, and management, including collaborative safety planning.	Narrative review and case illustration	A move towards therapeutic risk assessment, formulation, and risk management, including collaborative safety planning, could help clinicians develop a more tailored approach to managing risk for all patients, incorporating potentially therapeutic effects as well as helping to identify other risk reduction interventions.	**Assumptions:** Suicide risk as a science (implicit); Underlying pathology **Relationships:** Staff curtailed conversations re suicide; Organisational pressures regarding trickle down	Technical
					Practices: Person-centred style; Skills to cope, shared exploration; Less	Technical-Collaborative

					delineation between assessment and management; Formulation based	
Just, Palmier-Claus & Tai (2021)	UK	To explore inpatient staff's understanding and implementation of positive risk management.	Cross sectional qualitative	Understanding and implementation of positive risk management was dependant on multiple factors, including staffs' beliefs about mental health, levels of worry and anxiety, and amount of experience and seniority. Staff were more likely to use positive risk management with service users that they perceived as being trustworthy and less risky. Use of positive risk management was reliant on the support practitioners received, how able they were to view situations from multiple perspectives, and the degree to which they felt able to prioritize positive risk management.	**Assumptions:** Involvement a challenge; Service users usually not involved; Distance in relationships; Staff dissonance - unsure whether helping or harming	Technical
					Practices: Staff reflexivity during risk assessment and safety planning **Relationships:** Emotional demands on staff, sitting with uncertainty; Based on clinicians' beliefs - Limited to cases deemed lower risk, and where support is available	Technical-Collaborative
Margolis, Meyer & Louw (1965)	UK	To delineate the dilemma, within a therapeutic community, of maintaining a philosophy which stresses interpersonal relationships, and at the same time requires a set of suicide precautions which emphasises physical-environmental-isolation factors.	Case study	The ward staff arrived at and agreed to, new precautions, which feel more appropriately consistent with the unit's philosophy. The provision of a helping person constantly in attendance rather htan the isolation and restrictions previously thought necessary, is felt to have more therapeutic potential for the suicidal patient.	**Practices:** Psychological over physical containment therapeutic interaction (clinicians, and peers); Fidelity to model – recovery. **Relationships:** Empower service users to keep self safe. Service users as peers; Dilemma in integrating with wider technical org culture; Unsettled by incidents/investigation	Relational
Morrissey & Doyle & Higgins (2017)	UK	To examine the discourses that shape nurses' understanding of self-harm and explore strategies for working in a relational and a recovery-oriented manner.	Narrative review	Biomedical discourse has led to the development of largely unhelpful strategies to eliminate self-harm, often in the absence of real therapeutic engagement, which can have negative outcomes for the person. Attitudes towards those who self-harm amongst mental health nurses can also be problematic, particularly when those who hurt themselves are perceived to be attention seeking and beyond help. This, in turn, has a negative impact on treatment outcomes and future help-seeking intentions.	**Assumptions:** Biomedical **Relationships:** Self-protective – staff sometimes disagree with practices.	Technical

					Assumptions: Relational as an adjunct to technical; Focus on principles of the recovery model; Sui as meaningful (communicating the unspeakable); **Practices:** Positive risk taking / harm minimisation over elimination Person-centred style; Skills to cope, shared exploration; Self-reflection **Relationships:** Shared responsibility; Emotional demands on staff, sitting with uncertainty. The therapeutic alliance as a precondition to risk management.	Technical-Collaborative
Perkins & Repper (2016)	UK	To propose a recovery-focused approach to risk and safety and what this might look like in practice.	Narrative review	A recovery-focused approach to risk based on co-produced safety plans that enable people to do the things they value as safely as possible and shared responsibility for safety. Four key principles of a recovery-focused approach to promoting safety, autonomy and opportunity are proposed.	**Assumptions:** Focus on principles of the recovery approach **Practices:** Augmented safety planning; restrictive practices at times	Technical-Collaborative
Pollock, Armstrong, Coveney & Moore (2016)	UK	To examine the nature of the support offered by Samaritans services and describe the current caller centred approach taken in relation to best practice across the service and explore the views and experiences of Samaritans volunteers and callers.	Cross-sectional mixed-methods	Suicidality was seen by both callers and volunteers as sometimes a way of coping with a long term state or way of being. All claimed to incorporate the policy of self determination into their support, albeit with a tendency to 'err on the side of life' in cases where intervention is an issue. Volunteers hope that providing support at a critical moment can help callers to step down from attempting suicide in favour of a life affirming option.	**Assumptions:** Fundamental right to autonomy, extending to right to end life; Explicitly non-medical. **No repercussions** **Practices:** Crisis line; Listening - Non-interventive; **Relationships:** Substitute loved one; Some limitations - Legally bound, call/stay length; Sus chose to disclose identity; Organisational pressures demand more interventive approach; Staff as befrienders – not professionals; No judgement. Unconditional. Staff support is cornerstone	Self-Determining
Prytherch, Cooke & Marsh (2021)	UK	To explore service-users' experiences of risk management in both hospital services and a trauma-informed crisis house	Cross sectional qualitative	Four themes were developed. In the first two ('The Medical-Custodial Approach: They Only Think About Physical Safety' and 'Coercion is Counterproductive') participants described hospital as being dominated by a medical-custodial approach, which they said was ineffective in managing long term safety and	**Assumptions:** Trauma (inc. relational trauma) is central to the experience of suicidality for many **Practices:** Psychological over physical containment – therapeutic interaction (clinicians, and peers); Telling story	Relational

				could exacerbate distress. In the next two themes ('Talking Heals' and 'Relationships as Risk Management') the crisis house was described as using a relational approach to risk management that enabled women to maintain some freedom, privacy and control and was felt to be more effective long term.	and receive validation / repair; No restrictive interventions **Relationships:** Averse to power-over; Service users take a lead in risk decisions. Service users as peers; Narrative proximity enhances trust	
Roush, Brown, Jahn, Mitchell, Taylor, Quinnett & Ries (2018)	USA	To determine the frequency of suicide risk assessment and management practices and the association between fear of suicide-related outcomes or comfort working with suicidal individuals and adequacy of suicide risk management decisions among mental health professionals	Cross-sectional qualitative	Approximately one third of mental health professionals did not ask every patient about current or previous suicidal thoughts or behaviors. Further, comfort, but not fear, was positively associated with greater odds of conducting evidence-based suicide risk assessments at first appointments and adequacy of suicide risk management practices with patients reporting suicide ideation and a recent suicide attempt.	**Practices:** Physical or procedural; Safety planning, restricting access to means, crisis contacts	Technical
Rozek, Tyler, Fina, et al. (2022)	USA	To explore the current use of best practices and contraindicated interventions for suicide prevention in community settings.	Cross-sectional qualitative	The majority of both mental health clinicians (89.7%) and mental health allies (67.1%) endorsed using at least one evidence-based practice. However, of those who endorsed using evidence-based interventions, ~40% of both mental health clinicians and allies endorsed using contraindicated interventions as well.	**Assumptions:** Biomedical **Practices:** Physical or procedural; Safety planning, restricting access to means, crisis contacts	Technical
Sacks & Iliopoulou (2017)	UK	To explore how the staff of a well-established home treatment team experience risk.	Cross-sectional qualitative	The discussions revealed the different ways that professional identity can impact on risk management. The findings have the potential to help staff to work in a more self-aware way and to help teams develop more effective procedures.	**Relationships:** Distance – client seen as risky (self-perpetuating); Service users not responsible for their actions; Procedures diffuse staff anxieties and uncertainty	Technical
Slemon, Jenkins & Bungay (2017)	Canada	To argue that within current psychiatric inpatient environments, safety is maintained as the predominant value, and risk management is the cornerstone of nursing care. Practices that accord with this value are legitimized and perpetuated through the safety discourse, despite evidence refuting their efficacy, and patient perspectives demonstrating harm.	Narrative review	Four exemplars of risk management strategies utilized in psychiatric inpatient settings are provided. The use of these strategies demonstrates the necessity to shift perspectives on safety and risk in nursing care. We suggest that to re-centre meaningful support and treatment of clients, nurses should provide individualized, flexible care that incorporates safety measures while also fundamentally re-evaluating the risk management culture that gives rise to and legitimizes harmful practices.	**Practices:** Close observations, seclusion, door locking and defensive nursing practice **Relationships:**– Tension in sharing responsibility with service users; Distance in relationships; Staff dissonance – unsure whether helping or harming; Self-protective – disagree with practices at times	Technical

Svensson (2022)	Sweden	To explore patient safety strategies used in psychiatry and determine how they construct the notion of preventable harm.	Scoping review	The strategies that are supported in the literature to achieve safer psychiatry mainly arise from linear cause-effect models and rely on staff performance, competence, and compliance. Contemporary safety science acknowledges the performance variability of everyday normal work and sees risk as the dynamic migration of these daily activities. The field of psychiatry has not yet included this view of safety in the strategic actions to reduce preventable harm.	**Assumptions:** Risk is calculable. Risk is dynamic, but is generally positioned as static.	Technical
Tickle, Brown & Hayward (2014)	UK	To explore the views of clinical psychologists towards the concepts of 'risk' and 'recovery' and to set those views against the context of mental health services.	Cross sectional qualitiative	Participants' ability to work in a recovery-oriented manner seemed to be limited by the way in which services perceived and responded to risk. Narrow conceptualizations of risk as related to harm and danger seen in this study contribute to a sense of needing to be risk averse. However, the implications for practice included ideas about what might increase the possibilities for adopting recovery approaches across disciplines.	**Relationships:** Staff feel blamed and shamed for failure to predict	Technical
					Assumptions: Focus on principles of the recovery model	Technical-Collaborative
Turecki, Brent, Gunnell, et al. (2019)	Canada	To contribute to the literature on improving risk assessment, for example, by using computer testing and genetic screening, in order to reduce the number of deaths by suicide.	Narrative review	Prevention is key to reduce the number of suicide deaths and prevention efforts include universal, selective and indicated interventions, although these interventions are often delivered in combination. These interventions, combined with psychological (such as cognitive behavioural therapy, caring contacts and safety planning) and pharmacological treatments (for example, clozapine and ketamine) along with coordinated social and public health initiatives, should continue to improve the management of individuals who are suicidal and decrease suicide-associated morbidity.	**Assumptions:** Underlying pathology / MI **Practices:** Computer profiling; genetic screening; psychological therapies; pharmacolocial therapies	Technical
White & Morris (2019)	Australia	To explore the conviviality between practices of narrative therapy and the emerging field of critical suicide studies.	Narrative review	We expose some of the thin, singular, biomedical descriptions of the problem of suicide that are currently in circulation and attend to the potential effects on distressed persons, communities, and therapists/practitioners who are all operating under the influence of these dominant understandings. We identify some cracks in the dominant storyline to enable alternative	**Assumptions:** Biomedical descriptions are thin and singular; Located within the individual	Technical

				descriptions and subjugated knowledges to emerge in order to bring our suicide prevention practices more into alignment with a de-colonizing, social justice orientation.		
					Assumptions: Alternative descriptions and subjugated knowledges; alignment with a de-colonizing, social justice orientation; Away from death prevention, towards life worth living. **Practices:** Incorporating narrative questioning into risk management, inc. safety planning	Technical-Collaborative
Wortzel, Matarazzo & Homaifar (2013)	USA	To present a broad overview of a model for achieving therapeutic risk management of the suicidal patient that involves augmenting clinical risk assessment with structured instruments, stratifying risk in terms of both severity and temporality, and developing and documenting a safety plan.	Editorial	These elements are readily accessible to and deployable by mental health clinicians in most disciplines and treatment settings, and they collectively yield a suicide risk assessment and management process (and attendant documentation) that should withstand the scrutiny that often occurs in the wake of a patient suicide or suicide attempt.	**Assumptions:** Risks are calculable; Priority risk is to withstand scrutiny **Practices:** Based on prediction – stratifying & structured instruments; Based on prevention **Relationships:** Staff concern re medicolegal; Self-protective – disagree with practices; Policies as a result of critical incidents	Technical
Zortea, Cleare, Melson, Wetherall, & O'Connor (2020)	UK	To explore the psychosocial factors associated with increase and reduction of suicide risk and common elements of clinical assessment and interventions for suicide.	Meta-synthesis	Research shows that psychosocial interventions involving clinical assessment, tailored crisis response and safety plans, and follow-up contact can significantly reduce suicide risk and the odds of future suicidal behaviour.	**Assumptions:** Suicide risk as a science; suicide is predictable; underlying pathology/MI. **Practice:** Structured clinical judgement approach and clinician-led safety planning	Technical

As is outlined in the guidance for a scoping review (Peters, 2020[8]), since the aim is to map the research landscape rather than undertake a systematic synthesis, critical appraisal was not formally conducted for this review. However, Lincoln and Guba's (1985) criteria of credibility, transferability, dependability, and confirmability were considered throughout data extraction and analysis, in order to gauge a general sense of how data quality compared across the four key approaches.

Sources were generally considered of moderate to high quality across the approaches, with the exception of one service evaluation (Pollock et al., 2016), which was seen to lack some credibility since reference to suicide risk management constituted a particularly small proportion of the overall paper. However, the source was retained, since it was one of very few in its category and that data which was available was seen to add value to the overall review.

In addition, one of the papers (Margolis et al., 1965) was particularly dated, however was one of the only examples specifically documenting suicide risk management in a service of its kind (therapeutic community). Anecdotal evidence, including discussion with experts in the field and informal research of similar services, suggested that despite the cultural changes since its publication, the service and risk management approach presented in the paper remain broadly relevant today; as such, the article was also retained.

Data Analysis

Data analysis followed the procedure outlined by Peters (2020). For each of the final 29 articles, key findings related to each of the secondary research questions (the approach's assumptions, practices, and positioning of service users and staff) were extracted and charted into an Excel matrix. Based on the data extracted and following a recursive process which

[8] Peters (2020) proposes that "critical appraisal or risk of bias assessment is generally not recommended in scoping reviews because the aim is to map the available evidence rather than provide a synthesized and clinically meaningful answer to a question" (p.2124)

compared the data across papers and across the secondary questions, the four overall categories were identified, which more broadly addressed the main research question.

Data from individual articles were not always exclusively linked to one approach; some research spanned multiple approaches (e.g. those looking at peoples' experiences of hospital and a crisis house; Prytherch et al., 2020), where this was the case, it has been outlined in the table (Table 2). As is customary in a scoping review (Peters, 2020), data analysis was not intended to synthesise, but rather map the literature true to its original form. The results of the analysis are presented narratively below and summarized in Figure 2.

Review

The four key approaches to suicide risk management which emerged from the analysis, have been mapped out as and termed, for the purpose of this thesis, the *technical*, *technical-collaborative*, *relational*, and *self-directive* approaches. The terminology was partly inspired by an editorial by Aggett & Messent (2019) which referred to *technical* and *relational* risk discourses in one child and adolescent community mental health team.

However, the current review was interested in exploring the breadth of approaches to suicide risk management across mental healthcare more generally. In explicating each approach, consideration has been paid to the key theoretical assumptions, clinical practices, and relational processes between service users and clinicians, since these were the areas of greatest relevance to the overall thesis.

Although grouped discretely for the purpose of this paper, the literature did not always map neatly into the four groups. For example, some literature refers to an approach which combines technical-collaborative and relational practices or assumptions. As such, the groupings should be considered a preliminary and flexible framework, rather than a mutually exclusive and exhaustive list.

Figure 2

Typology of Approaches to Suicide Risk Management

	The Technical Approach	**The Technical-Collaborative Approach**	**The Relational Approach**	**The Self-Determining Approach**
Theoretical Assumptions	Medical and biological explanations of suicide Evidence-based suicide risk management is the gold standard	More broadly bio-psycho-social explanations of suicide Suicide risk management should incorporate the recovery principles	Relational and trauma-based explanations of suicide Suicide risk management should provide psychological over physical containment	Contextual (and explicitly non-medical) explanations of suicide; namely that individuals are lacking access to adequate social support. Suicide risk management is achieved indirectly; through talking and access to social support
Clinical Practices	Practices tend to be physical and procedural Practices include: Manualised safety planning (including restricting access to means); observations, and restrictive interventions (including environmental and physical restraint)	Practices tend to augment technical practices with therapeutic alliance-focussed techniques Practices include: Manualised safety planning, incorporating: alliance-focussed, narrative, and solution-focussed therapy techniques; and psychological formulation	Practices tend to forefront opportunities for relationally reparative interactions Practices include: Psychologically-informed one-to-one sessions; democratic decision-making regarding risk; and exclusively non-restrictive practice	Practices tend to be non-interventive (to some degree) Practices include: Befriending; and listening services
Relational Positions	Staff are generally seen to hold greater expertise and responsibility than service users	Staff are generally seen to hold greater responsibility, expertise is seen to be more shared	Staff and service users are generally seen to share responsibility and expertise equally, or for	Service users are generally seen to hold ultimate responsibility and expertise ("a fundamental right to

	Relationships are secondary to specific procedures	Relationships are a precondition; facilitate engagement	service users to hold more Relationships as the key mechanism of change	autonomy, which extends to the right to the end of life") Relationships are non-clinical and supportive

The Technical Approach

The first approach to emerge out of the analysis, and that which was represented by the largest body of literature across the highest-impact journals (Turecki et al., 2019; Zortea, et al., 2020), documented what is referred to here as a technical approach to suicide risk management. This approach, tended to be associated, though not always, to mainstream mental health services; such as mental health inpatient wards, and community and crisis teams. Some of the literature was somewhat older (Bernert et al. 2014; Grant & Lusk, 2015) than that of other approaches in similar settings, however, this was not exclusively the case (Evans et al., 2022; Svensson, 2022), suggesting that the approach remains influential today.

Theoretical Assumptions

One of the distinguishing features of the technical approach was its often-implicit perception of suicide risk as a science (Wortzel et al., 2013). Some of the more recent literature argued against historical conceptualisations of risk prediction; for example, that static cause-effect models lack validity. However, newer conceptualisations remained within the scientific frame; for example, that "contemporary safety science" highlights the dynamic nature of suicidality and risk management (Svensson, 2022, p.245).

The literature typically drew on a medical discourse, and as such another key assumption of the technical approach appeared to be that suicidality reflected an underlying pathology, either implicitly or explicitly named as mental illness (Coffey et al., 2017; Turecki

et al., 2019). For example, "The approach we propose is aimed at reducing suicide in patients with psychiatric disorders as a group" (Hawton et al., 2022, p.2).

An omnipresent theme across the technical literature was clinicians' concern about being subject to medico-legal action as a result of decisions they had made (Espeland et al., 2021; Evans, et al., 2022; Wortzel et al., 2013). Fears about legal action were often seen to trickle down to clinicians from the wider organisation (Hawton et al., 2022; Just et al., 2021). For instance, as a result of enhanced regulations following critical incidents and investigations (Evans et al., 2022). Throughout the organisation, technical approaches to risk management could be seen to convey that a priority for risk management is "[to] withstand the scrutiny that often occurs in the wake of a patient suicide or suicide attempt" (Wortzel et al., 2013, p.324).

Clinical Practices

Within the technical approach, the standardised use of "evidence-based practice" (Bernert et al., 2014, p.588) is often seen as the gold standard for suicide risk management (Grant & Lusk, 2015). Whilst there appears to be a lack of consensus as to which practices are evidence-based, assessment practices tended to focus on risk-factors and structured instruments (Grant & Lusk, 2015; Wortzel et al., 2013), and all the management practices in question were physical or procedural (Roush et al., 2018; Rozek et al., 2022). In the inpatient setting, three key components were identified as "removal of ligature points, reduction in absconding, and skilled inpatient observation" (Evans et al., 2022, p.2). In outpatient settings, procedures centred around manualised safety planning, which involved restricting access to means, and the provision of crisis contact numbers (Evans, et al., 2022; Roush et al., 2018; Rozek et al., 2022).

Whilst heavily weighted towards psychiatry, the technical approach was apparent across a range of disciplines, including psychology and occupation therapy (Bernert et al.,

2014; Morrissey et al., 2017; Rozek et al., 2022). Indeed, one key argument for the standardisation of risk management practices was to prevent silos in care and promote consistency across multi-disciplinary settings (Bernert et al., 2014; Grant & Lusk, 2015).

Another reason for standardisation was that technical risk management practices were seen to be robust in the face of scrutiny; recommendations following critical incidents or investigations tended to advocate for further enhancement of the aforementioned physical procedures and practices (Evans et al., 2022). Indeed, clinicians referred to implementing practices with which they disagreed; including physical restraint, in order to protect themselves from the threat of blame or legal action (Morrissey et al., 2017; Just et al., 2021; Slemon et al., 2017, Wortzel et al., 2013).

Of note, practices which were at times positioned as suicide risk management, were related to other factors, including organisational factors; such as the use of locked doors due to staff shortages, and relational factors; such as physical restraint resulting from staff-patient conflict (Slemon et al., 2017).

Relational Positions

In literature associated to the technical approach, clinicians were seen to hold the majority of responsibility for suicide risk management process (Grant & Lusk (2015), compared to service users, who they considered not to; "patients are not responsible for their own actions" (Sacks & Iliopoulou, 2017, p.67). Service users were often seen by clinicians as conjointly dangerous and vulnerable (Just et al., 2021). Clinicians' reports seemed to speak to a fundamental tension in sharing responsibility with service users positioned in this way (Felton et al., 2018; Slemon et al., 2017). "Practitioners appeared conflicted, not trusting service users to take positive risks but also knowing that positive risk taking was essential to recovery" (Just et al., 2021, p.1905).

As a result, clinicians reported sometimes curtailing conversations about suicide (Hawton, et al., 2022) due to fear of causing upset; "I want to protect the individual from the knowledge of their illness and that they can be a risk to themselves or to the others" (Coffey et al., 2017, p.476), and service users' involvement in the risk management process was often considered a challenge (Deering et al., 2022) and a rarity (Just, et al., 2021). Service users often considered themselves passive recipients of instructions; "[safety and risk] was their conversation, not my conversation" (Coffey et al., 2017, p.474). Where service users were not involved in conversations around suicide risk, they spoke of being more inclined to feel a stigma associated towards the topic; as though suicide is a conversation best avoided (Prytherch et al., 2021). As a result, some service users spoke of feeling isolated and unable to reach out to clinicians for help when needed (Coffey, et al., 2017).

Some of the literature particularly highlighted a cycle of distancing between staff and service users, whereby a lack of communication contributed to staff feeling uninformed and thereby perceiving of the service user as at greater risk of suicide (Felton et al., 2018). Further, staff were inclined to maintain emotional distance from service users they perceived as at higher risk, which one case study concluded "creates the very conditions that enable them to be constructed as objects of risk in the first place" (Felton et al., 2018, p.1145).

One consistent feature across the technical literature, was clinicians' experiences of dissonance in relation to suicide risk management practice; many described wondering whether their actions were likely to ultimately help or harm those under their care (Just et al., 2021; Slemon et al., 2017). Some service users reports suggested that the technical approach served as a lifeline at a point of despair (Evans et al., 2022), others noted that approach did not meet their needs; at best feeling impersonal and superficial, and at worst re-enacting traumas and causing iatrogenic harm (Deering et al., 2022; Fitzpatrick & River, 2018; Zortea, et al., 2020).

In addition, whilst the practices associated to the technical approach were seen, by staff and service users, to diffuse clinicians' anxieties and uncertainties to some extent (Just, et al., 2021; Sacks & Iliopoulou, 2017), it was a common experience for clinicians to feel inversely blamed and shamed for making ‘inaccurate’ calculations (Deering, et al., 2022; Tickle, Brown & Hayward, 2014).

The Technical-Collaborative Approach

The second approach to emerge out of the analysis, and that which is represented by the second-largest body of literature, took that is referred to here as a technical-collaborative approach to suicide risk management. The term technical-collaborative referred to the tendency for literature in this approach to be based on technical practices and forefront the involvement of and collaboration with service users and their carers in the process. Whilst generally referring to similar settings as the technical literature; namely, mainstream mental health settings, the technical-collaborative literature tended to be published slightly more recently (Bloch-Elkouby & Barzilay, 2022; Hawton et al., 2022).

Theoretical Assumptions

One key assumption of the technical-collaborative approach was an explicit focus on principles of the recovery model (Morrissey et al., 2017; Perkins & Repper, 2016; Tickle et al., 2014). In applying the recovery model to the context of suicide risk management, literature in this approach fore-fronted the development of shared understandings, between service users and staff, of a service users’ experience of suicidality, as well as shared responsibility for their safety (Perkins & Repper, 2016).

Indeed, suicidality was often seen as meaningful, for example, "an embodied means of communicating thoughts, feelings and experiences" (Morrissey et al., 2017, p.39). Consistently, the literature tended to draw more broadly on bio-psycho-social explanations of

suicide, and fore-fronted the development of shared understandings, rather than seeking to implement any one particular explanation (Fitzpatrick & River, 2018; Guyers, 2020).

Suicide risk management was generally seen to move intentionally away from risk avoidance and towards safety and opportunity (Perkins & Repper, 2016). Proponents of the narrative view argued that greater attention to the qualitative aspects of suicidality enabled suicide risk management to "move away from a narrow focus on death prevention, towards co-creating a world worth living in" (White & Morris, 2019, p.11). In line with these values, the technical-collaborative approach tended to advocate for positive risk taking, and harm minimisation over absolute elimination of risk, sometimes explicitly; "[the approach] accepts that someone may need to self-harm at some point" (Morrissey et al., 2017).

Whilst aiming to adhere to the principles of the recovery model, the literature made frequent reference to the limitations of doing so fully, due to a wider organisational alignment to a more technical approach (Hawton et al., 2022); for example, when working with a service user under the conditions of a community treatment order which might limit a service users' choices around medication (Tickle et al., 2014). As such, practices tended to be centred around technical-collaborative safety planning and recovery planning, specifically, as detailed below.

Clinical Practices

In practice, the technical-collaborative approach appeared to augment some of the evidence-based risk management practices identified in the technical literature, with techniques for enhancing therapeutic alliance and service user participation (Bloch-Elkouby & Barzilay, 2022; Perkins & Repper, 2016). Often, the basis of the technical-collaborative

approach was the use of the Stanley-Brown safety planning intervention (SPI[9]; Stanley & Brown, 2012); a manualised tool, intended for completion with service users.

One typical approach for enhancing the SPI integrated techniques from alliance-focussed training, such as mindfulness-in-interaction and meta-communication (Bloch-Elkouby & Barzilay, 2022). Other interventions integrated the use of formulation models (Hawton et al., 2022) drawing on the 5Ps (MacNeil et al., 2012), and solution-focussed and narrative approaches (Guyers, 2020) to deepen the exploration of the service user's story and guide conversations around safety planning; for example as "have you noticed when these suicidal thoughts have the upper-hand? Are there occasions where you have the upper hand?" (White & Morris, 2019, p.10).

Some literature also advocated for the use of *Wellness Recovery Action Planning* (Copeland, 2002) or *Personal Recovery Planning* (Perkins and Rinaldi, 2007); manualised tools intended to support a person to identify early coping skills and crisis planning, for once the peak of a person's crisis had subsided, and in planning for future crises (Perkins & Repper, 2016). In addition, some of the literature referred to clinicians drawing on self-reflexivity and heuristics to support decision-making during suicide risk management which did not feature in the technical approach (Hawton et al., 2022; Morrissey et al., 2017)

However, whilst advocating for self-reflexivity and service user participation wherever possible, there was generally an assumption that these more relational aspects of practice were with the intention of engaging service users in the risk management process, and must be accompanied by procedural practices, rather than as interventions in and of themselves; "exploring meaning is only effective if followed by a safety management plan"

[9] "The basic components of the SPI include (a) recognizing warning signs of an impending suicidal crisis; (b) employing internal coping strategies; (c) utilizing social contacts and social settings as a means of distraction from suicidal thoughts; (d) utilizing family members or friends to help resolve the crisis; (e) contacting mental health professionals or agencies; and (f) restricting access to lethal means." (Stanley & Brown, 2012, p.256).

(Morrissey et al., 2017, p.39). In a similar vein, references to suicide risk management beyond safety planning acknowledged that restrictive practices, such as involuntary hospitalisation, are, at times inevitable and ultimately beneficial (Morrissey et al., 2017; Perkins & Repper, 2016).

Relational Positions

Literature associated to the technical-collaborative approach generally alluded to staff holding the greatest responsibility, similarly to the technical approach, though service users were considered to be more active collaborators; "staff cannot make someone safe" (Perkins & Repper, 2016, p.102). The therapeutic alliance was generally positioned as a necessary condition for facilitating engagement in suicide risk management, more so than was apparent than that associated to the technical approach (White & Morris, 2019) and particular reference was often made to service users' expertise in lived experience (Morrissey et al., 2017)

Proximity in the relationships between staff and service users was sometimes seen to help staff to feel more informed about service users' experiences of suicidality, and less anxious about the unknown (White & Morris, 2019). For service users, in addition to aiding engagement in safety planning, alliance-focussed techniques such as mindfulness enabled them to more deeply explore and gain insight into their experiences of suicidality, which supported the safety planning process (Bloch-Elkouby & Barzilay, 2022).

The literature also noted a number of barriers to implementing more collaborative ways of working, including clinicians' beliefs about and experience in managing service users who are experiencing suicidality, their perceptions of the service user they are working with as trustworthy and risky, and the culture and support available in the organisation (Fitzpatrick & River, 2018; Just, et al., 2021). Reference was also made to the dilemma service users are faced with when engaging with such an approach; "service users are expected to learn to

manage their own care and recover whilst simultaneously being the focus of suspicion and doubt in relation to their risk status." (Coffey et al., 2017, p.480).

The Relational Approach

One of the smaller bodies of literature, and one less widely implemented in practice, takes what is referred to here as a relational approach to suicide risk management. Whilst apparent within some statutory mental health settings, the approach tended to be isolated to specific services, which were sometimes seen as more specialist or 'alternative', including a crisis house and therapeutic community.

Theoretical Assumptions

A distinguishing feature is that literature associated to the relational approach fore-fronted the role of relational trauma in suicidality. Relatedly, relationships were the key change mechanism in and of themselves and as such considered one of, if not the single, most important features of suicide risk management (Deering et al., 2019; Espeland et al., 2021; Fischer & Ferlie, 2013), this was distinct from the technical-collaborative approach in which the relationship were primarily seen as an aid to engagement. Another overriding assumption in the relational literature was that all service users retain a relatively high degree of autonomy, which it is the task of the service to build upon (Slemon et al., 2017).

Clinical Practices

Suicide risk management practices sought to provide psychological rather than physical containment, and privileged the provision of spaces for therapeutic interaction, including one-to-one meetings with allocated clinicians, peer support, and community meetings for whole service users and staff groups (Fischer & Ferlie, 2013; Margolis et al., 1965; Prytherch et al., 2021). Restrictive interventions, such as restraint and seclusion, were, as a rule, not used. Instead, service users were encouraged to take the lead in decisions

around risk. A central focus of the relational approach was the opportunity for service users to tell their stories and receive validation and relational repair.

One dilemma that was clear across the relational literature was the task of maintaining a relational stance within a wider organisation and culture which is more technically-oriented (Felton et al., 2018; Margolis et al., 1965). Risk incidents and investigations appeared to be particularly unsettling, since failings were more likely to be attributed to the approach, and at times the regulations imposed as a result (such as the introduction of seclusion and searches) were seen to undermine the philosophy on which they were built (Fischer & Ferlie, 2013; Margolis et al., 1965).

In one case, such changes were seen to trigger an organisational crisis and closure (Fischer & Ferlie, 2013) in another (Margolis et al., 1965) moving away from such precautions was seen to support the service's recovery. Hence, this subsection of literature advocated for fidelity to the relational model and cautioned against hybridisation, particularly in settings of greater emotional and relational intensity, such as residential units. The relational literature spoke to the complexities of deviating from culturally dominant approaches, and argued that relational approaches within individual services are "not sufficient to neutralise the institutional contexts in which the therapeutic relationship is embedded" (Fitzpatrick & River, 2018, p.196).

Relational Positions

The relational literature makes more explicit reference than that of the prior approaches to the potential for service users to experience re-traumatisation as a result of "power-over" relationships in the mental health setting (Morrissey et al., 2017; Prytherch, et al., 2021). As such, role of the clinician was seen as to empower the service user to keep themselves safe.

In some cases, decisions around suicide risk management (such as whether to seek medical treatment for self-harm) were decided democratically; with all members of the service voting in community meetings (Fischer & Ferlie, 2013). Gaining narrative proximity was seen to help service users and the clinicians and others supporting them to develop trust and understanding in each-other (Felton et al., 2018).

Some service users reported that the balance of trust in their own autonomy and support was central to maintaining a sense of agency in their safety: "You can take [an overdose], but we'll support you not taking it. Whereas if it was in hospital it's like I want to take an overdose but I physically can't do it" (Prytherch et al., 2021, p.7).

The Self-Determining Approach

The final approach, and one which was represented in very little literature, is what is termed the self-determining approach to suicide risk management. In contrast to the prior approaches, the services to which this body of literature referred were non-statutory, these were a befriending crisis house and crisis line (Fitzpatrick & River, 2018; Pollock, et al., 2016).

Theoretical Assumptions

The central distinguishing feature of this approach was explicit support of a fundamental right to autonomy, which extended to the decision to end their life. Whilst aiming to ultimately prevent deaths by suicide through the provision of emotional support, services spoke of taking a non-interventive stance to service users disclosing suicidality (Fitzpatrick & River, 2018; Pollock, et al., 2016).

Another distinguishing feature of the approach was the explicit acknowledgement that they were not medical nor mental health services. The approaches generally took a contextual explanation to suicide; namely that service users did not have access to adequate social support (Pollock et al., 2016).

Clinical Practices

Whilst services taking this approach are bound to disclose if they feel someone is at immediate risk, in some cases, service users are able to choose whether or not to disclose their identity, such that they can be sure that emergency interventions (for example contacting emergency services) cannot not be actioned without their consent (Pollock et al., 2016).

One particular issue, in a similar vein to that of the relational approach, appeared to be in navigating collaborative relationships with services taking other approaches. One part of the literature spoke to the challenge of growing as a service and the invitation into the wider support network (as a referral partner), and the subsequent need to accord with wider policies which may affect their ability to maintain a self-determination approach (Pollock et al., 2016).

More recently, part of the approach, namely the telephone crisis line, has become more interventive, in seeking personal information in order to notify emergency services if they feel someone is at immediate risk, though at this point service users maintain the right to decline. Given the paucity of research on the approach, little is known about how such changes may impact the functioning of the approach.

Relational Positions

Clinicians take the role of befrienders, rather than medical professionals, and at times were positioned as stepping in to offer the support of a loved one when one was not available (Fitzpatrick & River 2018; Pollock, et al., 2016). In practice, clinicians offered a space for service users to speak about the unspeakable and to be received without judgement.

The approach is built on principles of unconditional support, which is exemplified through service users being able to access the service without the need of a referral from a professional. However, the services acknowledge some limitations that are imposed in practice, for example around length of time available for each phone call or stay.

Nonetheless, some service users report that the approach was able to meet some needs (such as sharing without fears of repercussions) in a way that statutory services cannot (Pollock et al., 2016). In parallel, the support offered to clinicians, either from peers or supervisors, was often referred to as a cornerstone of the approach and superior to that in other settings (Fitzpatrick & River 2018; Pollock, et al., 2016).

Discussion

Summary and Interpretations

The findings above explicated a breadth of approaches that emerged out of the clinical practice literature; the picture is in broad agreement that the medical model remains highly influential in mainstream mental health settings. The technical approach, in particular, aligns with many of the same assumptions about suicide risk management as a medical-scientific endeavour. However, in outlining and explaining the wider range approaches, this analysis allows "questioning of the taken-for-granted assumptions of mainstream services, that arguably keep services stuck, and hopefully frees up space for different approaches" (A. Cooke, personal communication, April 17, 2023).

Alongside each other, in the order presented, the four approaches could be seen to crudely reflect a continuum; in facilitating lower to higher levels of service user autonomy, and in being targeted towards managing higher to lower perceived risk of suicidality. Such a picture would align with recommendations from the trauma literature; that in order to remedy the black and white extremes that sometimes feature in the experience of trauma survivors (Herman, 1992), approaches to risk management should not be unilateral. Crisis houses, for example, are considered a means of promoting the sense that small crises can be managed before they escalate (Harris and Fallot, 2001). However, the review further highlighted the well-documented dominance of the technical and technical-collaborative approaches and the relative lack of relational and self-determining approaches as alternatives.

One point, which appeared particularly prevalent in the literature, was how the different approaches co-exist and interact. As mentioned in the last paragraph, the four approaches appear, to some extent, to exist along a continuum. Indeed, aspects of the more relational approaches seem able to be successfully integrated with technical approaches in some instances; such as the technical-collaborative practices of joint safety planning (Bloch-Elkouby & Barzilay, 2022).

However, data from the relational approach highlights some fundamental differences in the approaches. Namely, the imposition of technical practices into relationally-oriented residential services was at times seen to undermine the principles on which relational approaches were built and was proposed to have lead to organisational crises. This appeared particularly be the case for residential services; in which interactions between staff and service users involved greater relational and emotional intensity (Fischer & Ferlie, 2013; Margolis, 1965), compared to the aforementioned technical-collaborative approaches which were implemented in outpatient settings.

From the perspective of Menzies-Lyth (1960), the imposition of more procedural ways of working could be seen as an organisational defence, resulting from a lack of containment from the wider organisation. As such, the subsequent crises could be seen as the result of secondary anxieties arising out of the defences in question. The findings could be seen to attest that in order to survive, particularly for services implementing a relational approach in residential settings, fidelity to the relational principles should be upheld across the organisation. References to psychological safety in key policy documents and frameworks, such as the aforementioned NHS Patient Safety Strategy (NHS England, 2019) in the UK, for example, could contribute to more widespread support of the model within wider, more technically oriented organisations.

Limitations and Recommendations

Given the limited scope of the current review, there were a number of areas of investigation which were not able to be pursued.

Firstly, the review was unable to capture the full range of service models, particularly those that are more understudied; such as crisis cafes and user-run crisis houses, since their approaches to suicide risk management tended to not be specifically articulated in the literature. Primary research into the suicide risk management practices across settings such as these would be of great value. The four approaches explicated in the current paper could also serve as a framework against which other service models could be mapped. For example, a review of the literature that is available on these services; albeit not specific to suicide risk management per se, could compare their assumptions, practices, and/or relational processes to those outlined in the approaches above, in order to inform the landscape further.

Secondly, in assessing the quality of papers included in the review, Lincoln and Guba's (1985) criteria were deemed helpful in identifying those with lower credibility. Whilst deemed sufficient, given that quality appraisal is not generally recommended for scoping reviews of this kind (Peters, 2020), Hannes' (2011) guidance for the inclusion of qualitative research in Cochrane systematic reviews notes that they are open to wide-ranging interpretation. Hannes (2011) suggests quality assessment should be augmented with the technical rigour of a formal quality appraisal checklist. As such, the Critical Appraisal Skills Programme (CASP) Checklists (Critical Appraisal Skills Programme, 2018), for example, which raise key questions relating to a study's validity, results, and clinical relevance, would be considered a conscientious addition for future research.

Finally, whilst the choice to take a scoping approach, for example, served the research aim to map the practice landscape broadly, it did not allow for any systematic synthesis of the data. Meta-analyses and meta-syntheses were not considered appropriate to the current review, given the breadth of the topic and settings covered. However, systematic

methodology could be valuable in following up some of the findings from the current study; for instance, a meta-synthesis of clinicians' experiences of containment in therapeutic communities. Similarly, a meta-analysis of crisis-house outcomes, for example, would enable the conceptual findings discussed in the current paper to be linked to specific outcomes.

However, drawing on such positivist methods could be expected to privilege more technical approaches (Marsh, 2006), and miss data of relevance by the relational and self-directive approaches. As such, and in keeping with the aims of the current thesis in explicating the full range of clinical approaches, research spanning a range of methods is indicated.

Conclusion and Implications

The approaches presented above speak to the presence of a range of approaches to suicide risk management. Whilst discrete categories are an oversimplification of a complex landscape, they are intended as one framework on which further discussion can be based. Whilst the review sought to map the approaches in current use; the findings highlighted the wider cultural and temporal context in which they are embedded. The literature spoke to a shifting landscape, in which clinicians and services are constantly implementing and de-implementing approaches. It is hoped that in presenting the approaches in the way they have been, taken-for -granted assumptions can be explored in order to support this process. As Fitzpatrick & River (2018) attest, we are "less concerned with promoting [a particular] model as the approach of choice as we are in using evidence from existing services to foster dialogue on alternative suicide intervention program and service models" (p.197).

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JESSE K. OFORI-BULL BA Hons MSc

Section B: Safety through Relationships: A Trauma-Informed Model of Suicide Risk Management

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SALOMONS INSTITUTE
CANTERBURY CHRIST CHURCH UNIVERSITY

Abstract

Trauma-informed approaches (TIAs) are considered, by some, to be of great relevance to the practice of suicide risk management. TIAs propose that since much mental distress is rooted in relational trauma, responses should be relationally reparative. This view contrasts, in some ways, with mainstream approaches to suicide risk management, which tend to privilege physical over relational safety. The potential value of trauma-informed has grown in prominence in recent years and has become increasingly emphasised in NHS policy. However, there is very little guidance on how to understand, conceptualize, and engage in trauma-informed suicide prevention in practice. The current study sought to develop a grounded theory model of suicide risk management in one trauma-informed crisis house, based on interviews with six service users and six staff members. The findings identified a core concept of safety through relationships, which spoke to the centrality of service users being able to develop meaningful relationships with staff members, in which they were able to share their experiences of suicidality and receive emotional containment. The findings also highlight the complexities for staff and the service in implementing this approach. The paper concludes with considerations of the findings in the context of current research and practice.

Keywords: trauma-informed, suicide, risk management, relational safety, crisis house

Trauma-informed approaches (TIAs) developed in response to research on the effects of adverse childhood experiences (ACEs; Hughes et al., 2017), and are considered, by some, to be of great relevance to the practice of suicide risk management (Mirick et al., 2022). Suicide is one of the outcomes most highly associated with an individual's exposure to ACEs; some research suggests that multiple and severe adversities can lead to up to a thirty-one times increased likelihood of an individual attempting suicide (Angelakis et al., 2019; Dube et al., 2001).

Trauma-informed approaches, which have been extensively documented elsewhere (Harris & Fallot, 2001; SAMHSA, 2014; Sweeney et al., 2016), seek to: 1) realise the widespread impact of trauma and understand paths for recovery; 2) recognize the signs and symptoms of trauma in patients, families, and staff; 3) integrate knowledge about trauma into policies, procedures, and practices; and 4) actively avoid re-traumatization (SAMHSA, 2014, p.9).

Crucially, TIAs propose that since much mental distress is rooted in relational trauma, in order to effectively manage suicide risk, responses should be relationally reparative (Sweeney et al., 2016). Trust and collaboration are seen, by some, to be fundamental in supporting those who have experienced trauma at the hands of powerful others, and who are more likely to have developed aversive reactions to hierarchical authority (Manning, 1989). Indeed, positive relationships with clinicians in the mental health setting have been consistently associated with reduced patient suicidality (Dunster-Page et al., 2017; Dunster-Page et al., 2018).

As outlined in the prior section (Ofori-Bull, 2023), trauma-informed, and relational approaches more generally, contrast, in some ways, with mainstream approaches to suicide risk management, which tend to privilege physical over relational safety.

Suicide risk management in these settings can, at times, pose particular challenges to the therapeutic relationship (Slemon et al., 2017). In line with Menzies-Lyth's (1960) findings (documented in the prior section; Ofori-Bull, 2023), some mental health staff have reported needing to distance themselves to protect against secondary trauma (Cieslak et al., 2014), and to alleviate tensions between their personal values and the organisational risk management culture (Felton et al., 2018).

Further, Loukidou et al. (2010) argue that clinicians in mainstream mental health settings are, at times, required to adopt a 'custodial' role in order to uphold patient safety; for example, when using restrictive practices, such as physical restraint and seclusion. Service users have referred to such approaches as harmful and retraumatising at times (Slemon et al., 2017), and some researchers have suggested that when overused they can increase risk in the longer term (Jordan & McNiel, 2019).

It is generally accepted in clinical practice that restrictive approaches to risk management are a last resort, in instances where a need for short-term safety overrides potential implications for longer term recovery (Butterworth et al., 2022). However, the trauma-informed literature, and the review preceding this paper (Ofori-Bull, 2023), highlight that, in practice, relatively few alternatives to mainstream services are available for individuals experiencing mental health crises.

The potential value of TIAs to mental healthcare has grown in prominence in recent years and has become increasingly emphasised in NHS policy (NHS England, 2019a). However, reviews highlight a lack of centralised strategy, legislation, or funding commitment, and call for development of the evidence-base (Emsley et al., 2022), of which suicide risk management has been highlighted as a particularly understudied area (Nizum, 2020; Procter et al., 2022; Saunders et al., 2023).

Application of Relational Theories to Suicidal Crises

Whilst pan-theoretical in nature, trauma-informed approaches have been greatly informed by relational theories (Sweeney et al., 2016). For instance, Green et al. (2020) propose that suicidality can be the result of a crisis of attachment.

Attachment theory posits that infants' relationships to their caregivers are fundamental to the development of healthy psychological development (Bowlby, 1969). Bowlby (1969) suggests that effective caregiving should provide a balance of 1) a *secure base*, from which a child can explore, and 2) a *safe haven* to which they can return when needing protection.

Infants develop attachment behaviours, such as crying and reaching out, as a means of maintaining proximity to the caregivers on whom they depend for survival. Crucially to the current thesis, these behaviours are particularly activated in times of crisis, when the individual needs safety and protection (Bowlby, 1969).

When responded to sensitively and consistently, children are generally seen to develop positive views, or 'internal working models' (Ainsworth et al., 1978), of themselves and others (i.e. develop a 'secure attachment style'), which increases their capacity to tolerate distress and navigate the world independently (Adams, 1994).

Individuals whose attachment needs have been consistently unmet; those who have experienced relational traumas such as abuse and neglect, have been found, on a population level, to tend towards one of three insecure attachment styles (Ainsworth, 1970; Hazan & Shaver, 1987), based on the extent to which the caregiver is responsive and consistent.

Organised insecure attachment styles, which are seen to depend on the extent to which an individual has learned to pursue or avoid their caregiver, are termed 'anxious', 'avoidant' respectively. 'Disorganised' attachment refers to the adoption of an incoherent pattern of preoccupied and dismissive behaviours, and is generally thought to occur as a result of

experiences of more severe neglect or abuse, where a child has not been able to establish an organised means to accessing care (Main, 1986).

Crucially, attachment patterns, whilst amenable to intervention to some extent, have been found to generally predict the ways a person relates to themselves and others into adulthood (Hazan & Shaver, 1987), and insecure attachment has consistently been associated with suicidality (Zortea, 2021).

Application of Relational Theories to the Therapeutic Alliance in Crisis Settings

Ma (2007) highlights that the way in which an individual experiences suicidality, and in particular their tendency to seek help, often depends on their particular attachment style. Some theorists argue that services act as substitute attachment figures (Bowlby, 1988), and in order to provide relationally reparative experiences, need to be attuned to an individual's attachment needs (Wilkinson, 2003).

Those with a dismissive style are generally seen to benefit from interventions which support them to verbalise feelings and communicate these with others (more of a safe haven), whereas those who experience more preoccupation are thought to benefit from approaches which support them to develop trust in their independence (more of a secure base; Ma, 2007).

In addition to attachment theory, the precedent, related and highly influential object relations theory (Klein, 1946), is considered of great relevance to studies of suicide risk management. Object relations theory is sometimes seen to offer particular insight into the process of disorganised attachment, which is that most highly associated with suicidality (Twomey et al., 2000).

Object relations theory (Klein, 1946) posits that when an infant's expressions of distress are consistently responded to, they build trust that they will be soothed within a reasonable timeframe and develop a representation of the self and other as 'good enough'.

Prolonged adversity, such as abuse and neglect, in which an infant's needs are repeatedly unmet, may disrupt the integration of pain and soothing, since the infant cannot be sure whether the latter will come, leading to representations of the self and others which are split into extremes of 'good' or 'bad'. Schechter et al. (2022a) explain that such unintegrated states can leave a person vulnerable in later life to "sudden shifts into extreme states of suicidal desperation, with difficulty evoking soothing introjects" (p.123).

Further, Campbell (2008) highlights that in working with service users who have developed these templates, clinicians can be invited into similarly extreme positions, such as the role of rescuer or executioner, which serve to reinforce the maladaptive pattern of relating. Yaseen et al. (2017) proposed that clinicians positioned in such roles experience conflicting emotions towards the client, which they found predicted post-discharge suicides; they hypothesised that this was through processes of overinvolvement and rejection.

Relational approaches to suicide risk management argue that by recognising the impact of a service user's experiences of trauma, clinicians are more able to notice relational patterns in the therapeutic alliance, such as preoccupation, avoidance, or splitting (Green, 2022). As a result, clinicians can reorient their own responses to them (Mirick, 2022; Schechter et al., 2022b), which is in turn associated to reduced client suicidality (Barzilay et al., 2020; Perry et al., 2013).

Indeed, Yakeley & Burbidge-James (2018) proffer that crisis states offer rare opportunity to access the underlying triggers and internal states that underpin a person's suicidality, in the absence of their everyday defences. If understood and managed relationally, such insights can inform and enhance a person's understanding and suicide risk management in the longer term.

Schechter et al. (2022b) refer to the "painstaking, iterative process" (p. 147) by which clinicians in the crisis setting can act as a relational container (Bion, 1962); “taking within

them the full extent of the [client's] feelings in order to return said feelings in a safer, tolerable form" (Gomez, 2017, p.45) "In doing so, the [client] also introjects a containing object who can deal with anxiety, this containment is the root of mental stability" (Trevithick, 2011, p.407).

Relational Containment at the Organisational Level

Seager (2006) highlights that, just as service users need relational containment from the clinician, clinicians need relational containment from the organisation. However, traditionally, relational practices have been siloed within psychotherapy pathways, amid the wider dominance of medical service models (Seager, 2006).

Indeed, Bloom (2010) argues that traditional mental health crisis services often function as 'traumatised systems' in which "entire systems become organised around the recurrent and severe stress of trying to cope with a flawed mental model based on individual pathology" (p.140). Rather, trauma-informed approaches, it is argued, should be implemented across all levels of the organisation (Bloom, 2010).

Trauma-Informed Approaches in the Crisis Setting

Over the past decade, TIAs to crisis care have grown rapidly. Recent reviews (Nizum, 2020; Saunders et al., 2023) suggest that TIAs can deliver a range of positive outcomes, including service user satisfaction and reduced use of restrictive practices. Whilst research capturing suicidality-related outcomes is extremely limited, Procter et al. (2022) found that out of four TIAa reviewed, two led to reduced suicidality, with the other two finding no difference compared to treatment as usual.

The literature also speaks to wide variation in the approaches taken to trauma-informed crisis care (Nizum, 2020). Rather than a prescribed set of practices and procedures, trauma-informed approaches tend to forefront six key principles; safety, trust, peer support,

collaboration, empowerment, and culture (SAMHSA, 2014). Low fidelity to TI principles has been associated with a higher incidence of risk incidents occurring (Nizum, 2020).

However, Mirick (2022) attests "there is very little guidance on how to understand, conceptualize, and engage in trauma-informed suicide prevention in practice" (p.170). As such, the current paper seeks to explicate a model explaining how suicide risk is managed in an NHS trauma-informed crisis house, as an example.

Research Question

How do service users and staff describe the process of suicide risk management within a trauma-informed crisis house?

Methodology

Research Design

The research adopted a grounded theory methodology, following the procedures outlined by Charmaz (2006), due to its exploratory nature, since little is known about the process of trauma-informed suicide risk management. As is common in studies of this kind (Charmaz, 2006), the investigation took a critical realist position (Bhaskar, 2013), which assumes that objective truths exist in the 'real world' and are filtered through an individual's perception of it. As such an individual's insights (in this case, participants' statements about suicide risk management) are thought to contain valuable information about the reality of the process, as well as the meaning they attached to it (Allman et al., 2017).

Participants

The sample was formed of twelve participants[10]; six service users and six clinicians who were purposively sampled based on them having experienced receiving or delivering

[10] Sampling was based on the principle of theoretical sufficiency, which Dey (1999) defined as the point at which an adequate depth of understanding is reached. The data were considered to have reached an adequate depth, as judged against the five criteria outlined in Nelson's (2017) conceptual depth scale (Conceptual Depth Assessment in Appendix N).

trauma-informed suicide risk management in the crisis house. A mixed sample was chosen, to explore the multi-level processes outlined in the TIA literature (Bloom, 2000; Harris & Fallot, 2001; Mirick, 2022).

Given the small size of the research site, individual demographics have not been reported. However, of those willing to disclose their demographic information (n=8), all identified as women, and the average age was 38, with a range of 28 years. Participants represented greater diversity in ethnicities than the UK population figures (of whom, ~18% represent the global majority; Office for National Statistics, 2020), and less than those in the local area of Camden, London (~40% global majority; Office for National Statistics, 2020).

Inclusion and exclusion criteria (see Table 3) were largely based on ethical considerations, and were assessed (including issues of risk and capacity) by the recruitment team at the crisis house, as outlined in the procedure section below. Whilst the inclusion criteria stated that participants users could be current or past service users or staff members (within five years of their last involvement with the crisis house), all service user participants who took part were current residents and all staff participants were employed by the crisis house at the time of interview.

Table 3

Inclusion Criteria

Inclusion Criteria	**Exclusion Criteria**
Accessed or employed by the service in the past 5 years	Last accessed or employed by the service over 5 years ago
Has capacity to consent to involvement	Lacks capacity to consent to involvement
Not expressing suicidal intent at the point of approach and interview	Expressing suicidal intent at either the time of approach or interview

Taking part not expected to place themselves or others at risk of harm Has either left the crisis house (approached via ongoing support group) or been at the crisis house for over a week	Taking part expected to place themselves or others at risk of harm Has been a resident at the crisis house for less than one week during their current stay

Service Context

Drayton Park (named with permission; see Cooke, McNicholas & Rose, 2019; Killaspy et al., 2000) is a trauma-informed women's[11] crisis house in North London, comprising of 12 individual en-suite rooms, a shared kitchen/dining area, lounge, and private garden. The all-female staff team consists of two project managers, 17 project workers from a range of professional backgrounds, and a small number of administrative, domestic, and kitchen staff. The staff team are generally representative of the ethnic diversity of the local community. The house is also able to accommodate up to four children with their mothers. Referrals are received from women themselves, their families, GPs, and other mental health professionals. Preliminary evidence suggests that there is significant overlap in the demographics of those accessing inpatient hospitals and Drayton Park, in terms of history of self-harm and admission, with 78% of those who have stayed at Drayton Park having stayed in an inpatient hospital previously (Killaspy et al., 2000).

At the start of their stay, every woman is supported to collaboratively develop an 'agreement plan', which outlines the support she will receive during her stay, and attends to suicide risk management, including the actions for which she will be responsible and those to be taken by staff. Women are encouraged to take an active role in their care. Women who are currently considered to be at high risk of violent behaviour, who require medical

[11] Trans-inclusive (Hart, 2018).

detoxification for substance use, or who are unable to engage in a safety plan and need constant supervision are not able to be offered a place. Every resident is allocated two keyworkers for the duration of their stay, who are responsible for maintaining contact and supporting her throughout the day. Women are offered two one-to-one sessions daily, with one of their keyworkers wherever possible, and a once-weekly support group. The latter of which remains open to access indefinitely after their stay. Individual psychological therapy and massage are also offered. The target maximum stay is 28 days.

Materials

Data were generated from in depth semi-structured interviews, which covered participants' experiences of receiving or delivering suicide risk management at the crisis house, the aspects of suicide risk management they found most helpful, and any changes they have noticed in themselves or their clients (for the purpose of understanding the process of risk management rather than as an outcome in itself).

The initial topic-guide (Appendix H) was loosely based on the client change interview (Elliot, 2010) from the field of change process research (Greenberg, 1986), and sought to investigate the intra- and inter-personal processes that participants experienced during the process of suicide risk management. Over the course of the interviews, amendments were made to the topic guide to follow more specific lines of questioning, in line with the grounded theory principles of theoretical sampling (Charmaz, 2006).

Procedure

In line with prior research and also guidance on ethical suicide research (Lakeman & Fitzgerald, 2009), service user participants were identified and approached in the course of their care. Recruitment was undertaken by two service managers (who were responsible for assessing risk and capacity for potential service user participants), in consultation with the service user's keyworker if they were a current resident, who shared the study poster

(Appendix B) and sought consent for the lead researcher to make contact. For staff participants, the lead researcher attended staff meetings, and circulated the study poster by email; interested parties were invited to share their contact details directly.

Consenting individuals were then contacted by the lead researcher who conducted a screening (see Appendix F), shared the participant information sheet and consent form (Appendices C & D), and arranged the interviews. Interviews were conducted at the crisis house, or via video consultation, by agreement of the researcher and participant. Interviews were recorded digitally, then transcribed and analysed by the lead researcher using the NVivo digital software package (QSR International, 2023).

Ethical Considerations and Quality Assurance

The research project was reviewed and approved by the London – Stanmore NHS Research Ethics Committee (approval letter in Appendix I).

In line with principles of trauma-informed research (Edelman, 2023), participants' wellbeing was of paramount concern throughout the research process. Interviews were conducted by a trainee clinical psychologist, experienced in supporting individuals during suicidal crises and who was working under the supervision of two senior clinicians; a consultant clinical psychologist/Clinical Director of the Doctoral programme, and the manager of the crisis house. Thorough screening and debrief processes were conducted with each participant, and a distress protocol developed in case participants experienced significant levels of distress, though the latter was not needed (see Appendices F & G for full details of these processes).

Given that the research was conducted on a single, small site, particular attention was paid to issues of confidentiality. The researcher was careful to inform participants that taking part would not affect their employment or the care they received, and that all data would be carefully anonymised before being shared with the wider research team, including the crisis

house manager. Careful amendments have been made to many of the quotes in the results section, such as removal of particular details, uses of language, and designations to individual participants, in order to protect the anonymity, whilst maintaining the integrity of the data.

The researchers also sought to forefront participant involvement in the research process. Service-user consultants were consulted whilst refining the research documentation and interview guide; in particular around the terminology of risk and safety and the potential impact of the interview process on participants. Service user involvement was based and quality assessed on the 4Pi standards (Faulkner et al., 2015).

Charmaz (2014) urges researchers to consider four key quality assurance criteria in the research process; credibility, originality, resonance, and usefulness, as outlined in the table below (Table 4).

Table 4

Charmaz's (2014) Quality Assurance Criteria

Quality Assurance Criteria	**Evidence**
Credibility	Academic and clinical consultation/ supervision; memo-writing (Appendix M) and bracketing interview (Appendix A); data triangulated from multiple sources; systematic methods of enquiry following Charmaz (2000)
Originality	Literature review (Ofori-Bull, 2023); understudied area in the trauma-informed care evidence base
Resonance	Service user consultation; feedback summary; multi-level interviewing

Usefulness	Model applicable to clinical practice; suggestions for further research

Data Analysis

In line with the principles of grounded theory, as outlined by Charmaz (2000), and in particular the process of theoretical sampling as outlined above, data analysis proceeded concurrently with data collection in order to explore the concepts as they arose out of the interviews. The analysis process followed the three iterative stages of coding outlined by Charmaz (2006; initial, focused, and theoretical coding); which progressed from the raw data to higher levels of abstraction. Constant comparisons were drawn throughout, between codes and categories, and within and between datasets, to explore nuances in the relationships between them.

As part of the theoretical sampling, and in line with guidance from Charmaz (2014), data was analysed as it was collected. After analysis of the first four interviews, the interview schedule was amended, to focus on the most significant issues. The amendments specifically sought to explore examples of interactions between staff and service users that participants had found helpful or unhelpful (as outlined in italics in the interview topic guide (appendix H). Consultation was sought from clinical and academic supervisors at this stage, and towards the latter stages of theory development after all interviews had been completed. In particular, supervisors informed the expansion and collapsing of some categories, and in supporting the lead researcher to consider issues and potential biases raised in the bracketing interview (outlined in appendix A).

Decisions about data collection were largely based on the principle of theoretical sufficiency, which Dey (1999) defined as the point at which an adequate depth of understanding is reached. The data were considered to have reached an adequate depth, as

judged against the five criteria outlined in Nelson's (2017) conceptual depth scale (Conceptual Depth Assessment in appendix N); range, complexity, subtlety, resonance, and validity, which were each rated on a scale of one to three, representing a low to high degree of conceptual depth (see Table 3 in Appendix N).

The concepts that resulted from the analysis appeared to be related to each other in complex ways, drew on a rich conceptual language, and resonated with existing literature as well as making sense in the applied context. As such, the latter four criteria were rated as highly satisfied. Given that concepts sometimes drew on data gathered predominantly from one group (for example, staff members' experiences of anxiety), the range was at times more limited, and was therefore rated lower.

Given that service user and staff interviews addressed the same research question that there was significant conceptual overlap between data sets which enhanced to the richness of the categories, the datasets were presented together. Memo-writing (memo extract in Appendix M) was used throughout to document thoughts and feelings about the data, to enhance the depth of the analysis.

Results

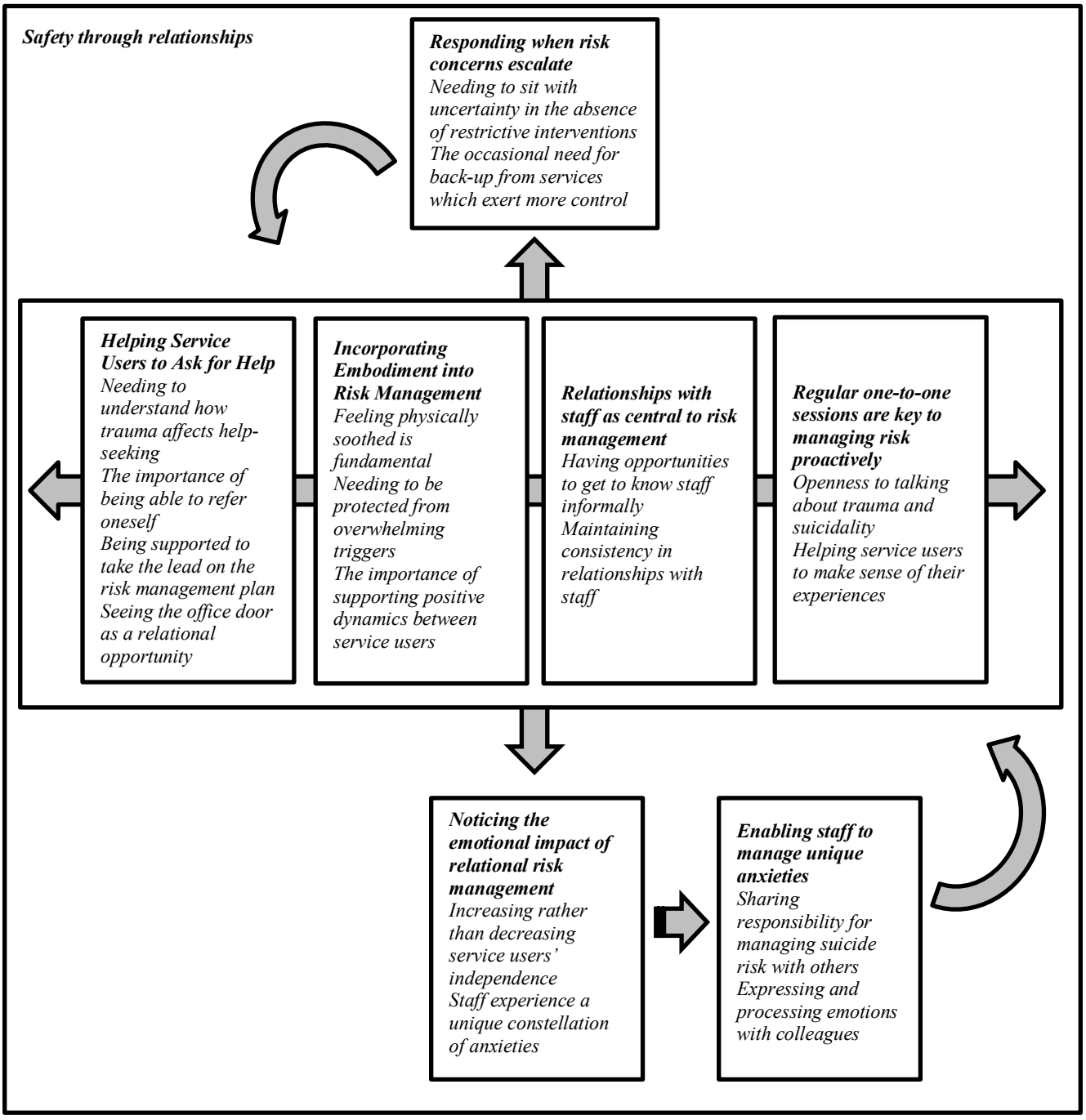
Findings were suggestive of a core concept which has been termed *safety through relationships,* comprising of seven categories, which have been presented visually in Figure 3 and explicated below.

The first group of concepts (*helping service users to ask for help; incorporating embodiment into risk management; relationships with staff as central to risk management; and regular one-to-one sessions are key to managing risk proactively*) reflected a network of processes related to relational containment at the individual-level; between service users and staff. A second group of concepts (*responding when risk concerns escalate; noticing the emotional impact of relational risk management; and enabling staff to manage unique*

anxieties), reflected organisational-level containment and wider social processes, which extended beyond the direct interactions between staff and service users, but fed back into them (as depicted by the cyclic arrows).

Figure 3

Safety Through Relationships: A Model of Trauma-Informed Suicide Risk Management



A summary of the number of service users and staff participants contributing to each theme is outlined in Table 5.

Table 5

Table of Themes

Theme	Service Users	Staff
Helping Service Users to Ask for Help		
Needing to understand how trauma affects help-seeking	4	5
The importance of being able to refer oneself	2	4
Being supported to take the lead on the risk management plan	5	6
Seeing the office door as a relational opportunity	2	2
Incorporating Embodiment into Risk Management		
Feeling physically soothed is fundamental	3	4
Needing to be protected from overwhelming triggers	4	3
The importance of supporting positive dynamics between service users	2	2
Relationships with staff as central to risk management		
Having opportunities to get to know staff informally	4	3
Maintaining consistency in relationships with staff	4	4
Regular one-to-one sessions are key to managing risk proactively		
Openness to talking about trauma and suicidality	5	5
Helping service users to make sense of their experiences	2	3
Responding when risk concerns escalate		

Needing to sit with uncertainty in the absence of restrictive interventions	2	5
The occasional need for back-up from services which exert more control	2	4
Noticing the emotional impact of relational risk management		
Increasing rather than decreasing service users' independence	2	6
Staff experience a unique constellation of anxieties	0	5
Enabling staff to manage unique anxieties		
Sharing responsibility for managing suicide risk with others	2	5
Expressing and processing emotions with colleagues	1	4

Helping Service Users to Ask for Help

A number of residents believed that their experiences of trauma had affected the way they sought help during suicidal crises, with some reporting a lack of trust in others, and in their own abilities to keep themselves safe. Participants noted that services could also play a role in the help-seeking dynamic. Helpful processes in trauma-informed suicide risk management, included: needing to understand how trauma affects help-seeking, the importance of being able to refer oneself, being supported to take a lead on the risk management plan, and seeing the office door as a relational opportunity.

Needing to Understand how Trauma Affects Help-seeking

Some service users reflected on having experienced cycles of rejection and overinvolvement in other settings, which seemed reminiscent of their experiences of trauma,

and which they believed aggravated risk during suicidal crises. In order to feel contained, participants spoke of needing the balance in services, being available and maintaining boundaries, to be more consistent and individualised.

"[In mainstream mental health services], there's this kind of push and pull between withholding care and heavy-handed use of it … they don't see how they feed that dynamic … [at the crisis house] even when they don't immediately have beds, they keep in contact with you, check how you're doing … help you to find some other way" (Service User)

"Some women are more forthcoming than others … because of what they have experienced… if someone feels like a burden and struggles to ask for help, then when she does you have to respond quickly" … "[For others] you have to be clear about what you can and can't do … and you have to follow through on what you promise" (Staff)

The Importance of Being Able to Refer Oneself

A number of service user participants noted how important it was that they could refer themselves to the crisis house and how this had been an important first step in starting to take an active role in managing their own suicide risk. Staff felt that when service users accessed the service in this way, they were already committed to helping themselves.

"Everyone is coming from the same place, that they want to take an active role in their recovery" (Staff)

"I could just call before it got to that point, and that's just so different" (Service User)

Being Supported to Take the Lead on the Risk Management Plan

Service users were seen to hold more responsibility for managing their own suicide risk at the crisis house, compared to psychiatric inpatient settings. Many staff and service users identified the agreement plan as an important and collaborative endeavor; clearly explicating each party's responsibilities empowered service users in the suicide risk management process.

"Women know they're more responsible for keeping themselves safe, we're here to support that" (Staff)

"I'm sure they [care plans] do exist [in hospital]. You [as a service user] just don't know about it, so how are you supposed to do it" (Service User)

Seeing the Office Door as a Relational Opportunity

Service users also identified that they felt more comfortable to approach staff during suicidal crises than they sometimes had in other settings. The staff office, in particular, was seen as an access point at all hours. Similarly to the referral process, participants noted that whilst staff were sometimes unable to help immediately, this was generally communicated with transparency and they were invited and supported to wait, and as such did not feel rejecting.

"There's always someone there to talk to when you need to … in hospital, if you ask for help, it's "meds and bed"" (Service User)

"We do have an office … it's not so much off limits, sometimes [service users] just need to talk something through" (Staff)

Incorporating Embodiment into Risk Management

Participants noted that one of the major differences in how suicide risk is managed at the crisis house is that risks in the physical environment, such as sharps and ligature points, are not removed to the extent they are in hospital settings. Despite having some degree of access to means, suicide risk was seen to be managed, through: feeling physically soothed is fundamental, needing to be protected from overwhelming triggers, the importance of managing dynamics between service users.

Feeling Physically Soothed is Fundamental

The crisis house setting was often referred to as a soothing place to be; soft furnishings, artwork, and a private garden contributed to an overall sense of safety in the house and enabled service users to feel trusted to manage their own safety.

"Here you have the space to feel safe … hospital is a mental assault" (Service User)

"It's important that [service users] can feel at home here" (Staff)

Service users also spoke of the embodied experience of trauma and suicidality. They expressed that feeling physically soothed; for example, by soothed home-cooked meals and holistic therapies, enabled them to tune into their bodies in order to monitor and manage their suicide risk.

"When you're feeling physically soothed, it frees up energy to manage the emotional side of it all, rather than cutting off from it" (Service User)

Needing to be Protected from Overwhelming Triggers

Whilst some physical risks remain present in the house, many service users saw the crisis house as a protected space, away from triggers such as gender-based violence, and alcohol and drugs. Some contrasted this to previous experiences in hospital, such as experiencing or witnessing violence on the wards, which they felt had inadvertently aggravated their suicide risk.

"Voices and shouting are some of my biggest triggers, I'd take the risk my life elsewhere over being in that environment" (Service User)

"There's no alcohol, that's important for it feeling safe" (Staff)

The Importance of Supporting Positive Dynamics Between Service Users

Peer relationships were seen as fundamental to suicide risk management. Service users and staff spoke of a sense of community in the crisis house setting, and the value of service users supporting each other in moments of suicidal distress.

"Everyone's in different places, but have got some things in common … you keep each other safe" (Service User)

Some service users felt that one contributing factor was that service users were often less sedated as a result of receiving less medication, and therefore more able to interact with and support each other.

Peer dynamics were also seen to at times be triggering and even aggravate suicide risk if not appropriately managed. Participants spoke of instances in which staff had supported residents to work through relationship difficulties and sometimes managed separations.

"Sometimes women get triggered by each other, like when one person is talking a lot about suicide … you can't stop that from happening, you just have to help them work it out between them" (Staff)

Relationships with Staff as Central to Risk Management

Many participants named relationships with staff as one of the most central aspects of the crisis house's approach to suicide risk management. Two of the key factors that were seen to contribute to positive relationships were; having opportunities to get to know staff informally, and having consistency in the relationships with staff.

Having Opportunities to Get to Know Staff Informally

Shared facilities in the house, including the kitchen and lounge in which staff spent time, were seen to contribute to a less pronounced power hierarchy between staff and service users, and make it easier for service users to develop trust and have meaningful interactions. Both staff and service users saw suicide risk management as a constant endeavor throughout the day.

"You see each other all the time, so you can pick up on those little cues and tell when there's something going on" (Staff)

Service users also perceived staff as wanting to develop genuine relationships, which helped them to speak more openly about their experiences of trauma and suicidality.

"You know they don't have to be in there [the dining room], so they're spending time with you by choice … especially after talking about something shameful, it just shows you that it's actually okay to talk about" (Service User)

"It doesn't make you feel "less than"; like, there's no "us and them" mugs in the kitchen" (Service User)

A number of service users also linked their experiences of suicidality to gender-based violence (GBV) and spoke of finding it easier to relate to staff who were also women.

Maintaining Consistency in Relationships with Staff

Service user and staff participants felt that having consistent keyworkers laid the groundwork for meaningful risk management, since they were able to develop a shared understanding of the person's triggers and needs. Staff could then hold these, in mind in moments of distress.

"They'll have an allocated worker … You'll get a sense of her over time and what helps" (Staff)

Some participants, who had used the crisis house on more than one occasion, spoke of recovery as a long-term process and valued the consistency across stays. They contrasted this with experiences of recurrent hospital admissions which felt repetitive with no sense of progress. Another noted that lifelong access to the weekly support group had helped them to take positive risks, such as leaving the crisis house at an earlier point than they would have in an inpatient setting, since they knew they had somewhere to come back to.

"I used to spend about half of the year in hospital. Here, you're not starting from scratch each time … I've needed to be here so rarely" (Service User)

Regular One-to-one Sessions are Key to Managing Risk Proactively

One-to-one sessions were often referred to as one of the most meaningful encounters. Some participants explained that whilst these may touch on experiences of trauma, much of the time they did not. However, a number of residents did speak of having disclosed experiences of trauma in these sessions, often for the first time, and named the process of disclosure and the support they received as a key to understanding and managing their suicidality. The key features of the one-to-one sessions were; openness to talking about trauma and suicidality, and helping service users to make sense of their experiences.

Openness to Talking about Trauma and Suicidality

One service user spoke of how experiences of trauma had driven some of the negative views she held about herself and others, and how validation from staff inspired a strength she continued to draw on during suicidal crises.

"It was the first time I had ever told anyone [an experience of trauma] had happened … [a staff member] said "I believe you", and something shifted" (Service User)

"Sometimes they'll want to talk about something really serious, they never have to, sometimes they just want to chat … it's important that they can do both" (Staff)

Service users also spoke of feeling able to speak more openly about experiences of suicidality in the crisis house setting, without fear of repercussions.

"Sometimes [in other settings], it can feel a bit like a tick-box exercise. Here, it feels like if you want to talk they're there for it" (Service User)

Helping Service Users to Make Sense of Their Experiences

One service user mentioned that hearing themselves speak out loud about their experiences of trauma and suicidality enabled them see things in a different light, and to feel more empowered in their responses.

"I realized while I was talking [suicidal thoughts] through, that it was bigger than I had realised, and that I needed to do something about it". (Service User)

Staff spoke of feeling able to better understand a person's triggers and needs.

"Sometimes it's helpful for both of us … [Giving an example of a risk incident]: "I can see why that was triggering for you"" (Staff)

Responding When Risk Concerns Escalate

Participants highlighted the absence of restrictive practices in the crisis house, and spoke of service users being encouraged instead to draw on self-soothing and communication.

Needing to Sit with Uncertainty in the Absence of Restrictive Interventions

Service users in particular, felt that having a space which was free of external restraints enabled them to exercise greater self-restraint.

"[Staff] aren't on top of you. They're there if you need them, but they give you the space to calm yourself down … [a staff member] asked me what I needed, and I said "lavender oil please", and I managed to bring myself back down with it" (Service User)

"We'll encourage them to bring things in to dispose of, like razors and ligatures, but a lot of the time you're working with the ambiguity" (Staff)

The Occasional Need for Back-up from Services which Exert More Control

Participants also acknowledged that the crisis house was not enough for everyone at all times. Staff saw colleagues from traditional services; namely psychiatric inpatient settings, ambulance services, and on-call managers as an essential back-up in cases where a service user did not feel able to keep themselves safe at the crisis house.

"Sometimes people can't keep themselves safe, and they need to be in hospital" (Staff)

"One time, someone needed to go into hospital … they called an ambulance" (Service User)

Noticing the Emotional Impact of Relational Risk Management

Participants noted that in the crisis house balanced being available and supporting service users to take an active role. In this way, service users felt a greater sense of independence. Staff spoke of a unique constellation of anxieties which arose from supporting this process.

Increasing Rather than Decreasing Service Users' Independence

Some participants believed that having access to the crisis house gave service the option to exert choice in how risk was managed, where they otherwise may not have had the opportunity.

"She might say "I want to start going out more" … we talk through the risks and make a plan with her … I'm not telling her" (Staff)

Some participants spoke of service users gaining a sense of independence in how they managed their suicide risk, which they felt disproved some commonly-held assumptions that approaches forefronting relational safety can lead to over-dependence.

"I think just knowing it's there means you feel like you need it less … it disproves the theory that it will cause over-dependence" (Service User)

Staff Experience a Unique Constellation of Anxieties

Whilst staff were seen to tolerate distress well and maintained a sense of containment in the house, they spoke of specific anxieties which were invoked in managing suicide risk in this way. They spoke of tensions between needing to be ready to act quickly, whilst sitting and waiting with ambiguity.

"All the time, it's like "what am I about to walk into" … Once [previously, whilst working in a psychiatric inpatient setting], I walked into someone's room to find that they had tied a ligature, and in a split second you have to act" (Staff)

"Here, you're waiting for someone to answer the door, or to call at the time they agreed to … you worry" (Staff)

A number of staff members spoke of at times feeling being personally affected, which they attributed to spending more time with, and having less distance from residents.

"You are more personally affected. I look at my nephews who are the same age as some of the women were [at the time of a trauma], and I want to protect them" (Staff)

Enabling Staff to Manage Unique Anxieties

Alongside noting the unique anxieties that came with managing risk through relationships, staff felt that these were best contained in two ways: firstly, by sharing responsibility for managing suicide risk with others (service users, immediate colleagues and external parties) and secondly by expressing and processing emotions with colleagues.

Sharing Responsibility for Managing Suicide Risk with Others

One of the most central factors for staff, in managing the anxieties associated to suicide risk management, appeared to be informal communications in the office, which were seen as central to the team's cohesion and shared decision-making.

"It's like an open dialogue space in the office … you are never on your own" (Staff)

A number of service users were aware that staff sometimes communicated with each other in this way. Those who did mention it, felt this open approach was helpful in managing risk collaboratively, and appreciated not having to repeat themselves.

"You know that the staff tell each other what's going on for you, but it doesn't feel gossipy, it feels safe … it helps that they know what's going on for you, it means you don't have to keep having the same conversation" (Service User)

In addition, sharing the responsibility for suicide risk management with service users was seen to help. Staff valued the explicitness of the care agreement, since it left little room for miscommunication. It also invited other parties, such as residents' loved ones and other services, into the frame.

"When you see it on paper, you realise that you don't have to do it alone" (Service User)

Many staff members spoke of the importance of working cohesively with mainstream services (such as community mental health teams, the crisis team, and inpatient settings), and felt that trauma-informed ways of working brought value to the process of suicide risk management.

"Some women feel safer to re-start medications here … it's like trauma informed medication management" (Staff)

Expressing and Processing Emotions with Colleagues

Staff noted that in addition to seeking practical support from colleagues, having relationships in which they could express and process the unique anxieties was imperative to their ability to continue working in this way.

"We're a very expressive team … it's okay to have emotions in the office, that's important" (Staff)

One staff member also noted that containment in the office largely depended upon the extent to which conversations followed trauma-informed principles, and spoke particularly to the principle of choice.

"Sometimes it can be quite overwhelming when there's a lot of conversation about trauma in the office … you need to check in with each other … and choose whether you're in a place to engage with that" (Staff)

Of particular note, many staff members considered the senior management available without fail, for practical and emotional support.

"No matter what, you know [the staff management team] are always available for you to talk things through, and that is containing" (Staff)

"They always seem pretty together … well supported" (Service User)

Discussion

Summary and Interpretations

The model of suicide risk management, based on a core category termed *safety through relationships*, centred around two groups of interlinking concepts.

The first group of concepts (*helping service users to ask for help; incorporating embodiment into risk management; relationships with staff as central to risk management; and regular one-to-one sessions are key to managing risk proactively*), built upon the individual-level literature base (Bowlby, 1969, Klein, 1946).

At its core, this group of concepts spoke to the centrality of service users being able to develop meaningful relationships with staff members, in which they were able to share their experiences of suicidality and receive emotional containment. Many of the processes described by service users and staff echoed the theories outlined earlier; largely that staff were able to sit with the distress that service users were experiencing, such that it could be transformed into something manageable (Bion, 1962).

The findings suggested that a trauma-informed lens supported service users and staff to also recognise how relationships, including experiences of trauma, may have impacted their experience of suicidality, and as such equipped them with the tools to take a relational approach to managing their suicide risk. Staff spoke of at times being able to recognise and respond to service users in individualised ways, as indicated by the literature (Ma, 2007); in providing a secure base to those experiencing more preoccupation (for example, in supporting them to engage in self-soothing), and a safe haven for those experiencing more avoidance (for example, in supporting them to tune into and talk about their feelings).

Further, from an object-relations perspective (Klein, 1969), the trauma-informed approach could be often seen to occupy a middle-ground in delivering suicide risk management, between the extremes of overinvolvement and rejection that service users spoke

of having experienced in mental health settings, and which have been well documented elsewhere as, at times, re-enacting service users' past experiences of trauma (Herman, 1992).

Crucially, the findings highlighted that there were limits to the care the crisis house was able to offer. For example, that beds and staff were sometimes not immediately available. One of the key factors that seemed to be raised across this section of the model, is that in being able to access some level of support, whether it be during a telephone call or in the weekly support group, service users sometimes felt supported *enough*, such that these experiences were not experienced as catastrophic.

In taking a 'good enough', albeit imperfect, position, theorists such as Schechter et al. (2022a) suggest that services can support service users to integrate the unintegrated states, mentioned earlier, that are theorised to underpin the experience of suicidality.

The latter group of interlinking concepts (*responding when risk concerns escalate; noticing the emotional impact of relational risk management; and enabling staff to manage unique anxieties*), built on the organisational-level literature base (Bloom, 2010; Menzies-Lyth, 1960), highlight the complexities for staff and the service in implementing this approach.

The findings suggested that staff experienced some unique anxieties as a result of engaging with distress to the extent they did in order to offer relational containment. From an organisational defences' perspective (Menzies-Lyth, 1960), many of the protective mechanisms that are seen to operate in more traditional services; such as 'focus on technical competence', and 'ritualistic task performance' (Menzies-Lyth, 1960) are more absent in the trauma-informed model. Similarly, it could be theorised, that secondary anxieties, such as 'high volumes of bureaucratic work' and 'absence of close working relationships' are less at play.

In line with Menzies-Lyth's (1960) recommendations, and Bloom's (2010) model of organisational containment, staff tended, in response to these unique anxieties, to draw on relational ways of managing, which centred on sharing responsibility for suicide risk management with service users, engaging in open dialogue with colleagues and leaders, and processing the emotional aspects of the work.

Limitations and Recommendations

The research drew on a small sample, within a single site, and as such presents one example of trauma-informed suicide risk, as opposed to a global panacea. In addition, given the purposive sampling method, the voices presented in this paper likely represent those of parties who are interested in the topic of trauma-informed suicide risk management and therefore well matched to the model. However, the trauma-informed literature advocates for service users to be able to choose from a range of service options. As such, the views of those with greater investment are not considered unreasonably biased.

In addition, whilst collapsing data from service users and staff was seen to bring some benefits; namely in adding richness to the concepts, since there was significant overlap between them, it also limited the opportunity to draw out some of the potentially more nuanced processes within the groups individually in this model. For example, whilst the findings indicated that open dialogue in the office was key to the suicide risk management process, the depth of enquiry was limited. Further research is certainly indicated, as is that looking at service users' wider relationships, for example with peers and loved ones.

Of particular note, this model and the paper reviewed previously (Ofori-Bull, 2023) have spoken to the complexities of trauma-informed and other relationally-oriented services operating in and interacting within a wider, more technically-oriented organisation. Fischer & Ferlie (2013), suggested that hybridisation between service models could be particularly challenging in instances of heightened emotion, such as suicide risk management in

residential settings. Further research on the organisational level processes related to the topic of suicide risk management; such as stakeholder involvement, policy development, and organisational responses to critical incidents, is also indicated.

These findings should be read in acknowledgement of the positions of the research team, as proponents of relational and trauma-informed ways of working. In approaching the literature from a critical realist position (Bhaskar, 2013), the authors have been necessarily written into the text. A number of steps were taken, as outlined in the method section, to promote transparency in the research process. However, in developing a more comprehensive literature base, the field would benefit from a range of approaches; measures of outcomes such as suicidality, and service user and staff satisfaction are needed, though since outcome studies privilege short-term processes, the field would also benefit from further process-based qualitative and/or longitudinal approaches.

Finally, whilst trauma-informed approaches to aim to improve the experiences of individual within organisations (Mirick, 2022), Herman (1992) highlights that in order to be truly trauma-informed, social systems must move beyond models that locate distress within individuals, to challenging the social causes of the traumas and suicidality themselves. As such, this research should be considered alongside that looking at wider socio-cultural explanations of trauma and suicidality, and approaches to their prevention (Mueller et al., 2021).

Conclusion and Implications

In explicating a trauma-informed model of suicide risk management, the current paper sought to contribute to the wider 'paradigm shift' towards trauma-informed approaches to healthcare (Sweeney, 2016).

Of note, the current model exists within a trauma-informed whole-service model. Whilst intended to inform suicide risk management in mental health settings more generally,

careful consideration should be given to the process of implementation elsewhere. Trauma-informed guidance suggests that when implementing trauma-informed approaches, services should forefront the 6 principles outlined above (SAMHSA, 2014). Such consideration could mean the difference between, for example, a service user being offered a one-to-one session versus feeling obligated or coerced to attend.

A number of barriers have been identified in introducing trauma-informed approaches to traditional mental health settings. These include reluctance to shift from biomedical causal models of distress, confusion and apprehension in introducing changes to practice beyond reduction of restrictive practices, and lack of support from the wider organisation, as well as "the historical underpinnings of psychology, including behaviourism with its erroneous assumptions that empathy and compassion reward bad behaviour" (Sweeney et al., 2018, p.326).

As such, implementing such a model in other settings, such as more traditional mental health settings, could be expected to benefit from widespread trauma-informed organisational change (Burke & Litwin, 1992; Saunders et al., 2023). Given the fundamental role of policy in organisational change, the research feels timely, since "some of the most current and key pieces of literature in the UK, such as the NHS England Patient Safety Strategy (NHS England, 2019b) and the National Confidential Enquiry (HQIP, 2022), explicitly commit to the promoting trauma-informed and psychologically safe environments" (Ofori-Bull, 2023, p.8).

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JESSE K. OFORI-BULL BA Hons MSc

Section C: Appendices

APRIL 2023

SALOMONS INSTITUTE
CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix A – Bracketing Interview

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Appendix B – Study Poster

Dear residents and staff of Drayton Park,

Would you like to be involved in research?

We are exploring how people can be supported to stay safe from suicide in ways that are trauma-informed*.

I am looking to interview women who have accessed the crisis house, and staff members, about their experiences and views on the support they've received or provide. Our aim is to help services improve the ways they support people in suicidal crisis.

If you think you might like to take part, **please let a staff member know** if you are happy for them to share your contact details with me. You can also **contact me directly** if you prefer:

j.oforibull327@canterbury.ac.uk

01227 927070 - Please leave a voicemail for 'Jess Ofori-Bull, on the Drayton Park Crisis House project', including your phone number, and I will return your call as soon as I can.

Wishing you all the best for now,
Jess Ofori-Bull, Trainee Clinical Psychologist

*Please note, you absolutely do not need to know about trauma informed care to take part in this research. However, if you are interested, here is a definition and a link to find out more... Trauma-informed care seeks to:

- Realize the widespread impact of trauma and understand paths for recovery;
- Recognize the signs and symptoms of trauma in patients, families, and staff;
- Integrate knowledge about trauma into policies, procedures, and practices; and
- Actively avoid re-traumatization.

https://www.candi.nhs.uk/about-us/ci-trauma-informed-organisation

Appendix C - Participant Information and Consent Forms – Service User

Developing a Trauma-Informed Model of Suicide Risk Management in the Mental Health Crisis Setting

My name is Jess Ofori-Bull and I am a trainee clinical psychologist at Canterbury Christ Church University. I am carrying out this research as part of my studies, under the supervision of Anne Cooke (Canterbury Christ Church University) and Shirley McNicholas (Drayton Park Women's Crisis House) and we would like to invite you to take part.

This research project has been reviewed and approved by the London - Stanmore NHS Research Ethics Committee.

What is the research about?

We are looking at how women are supported to stay safe in the crisis house setting. Previous research looked at people's experiences of crisis house care compared to hospital and found some key differences. We are now hoping to take this a step further by interviewing crisis house staff and service users to understand how suicide risk can be managed in ways that are trauma-informed.

Am I eligible to take part?

We are looking to interview six women who have accessed the crisis house service and six staff members. In order to take part, you must:

- Be over 18 years of age;
- Have accessed the crisis house in the past 5 years;
- Not be currently in crisis or planning to end your life.

Because of the sensitive nature of the interviews, we have a few steps to ensure that people taking part are as safe as can be. We would encourage you to please not participate if you expect that talking about your experiences of suicide risk management is likely to lead to significant distress.

Do I have to take part?

No. Taking part is entirely voluntary – you do not have to take part. Whether you take part or not, the service you receive from the crisis house will not be affected. If you agree to take part then change your mind, you can ask for your data to be withdrawn up to 4 weeks after the interviews. You do not need to give a reason. After this time, it may not be possible to delete your data, since it may have been included in the analysis/report. However, wherever possible we will try to help.

What will I be required to do?

The research will involve a one-to-one interview with a trainee clinical psychologist, where you will be asked about your experiences and views about how women are supported to

stay safe from suicide in the crisis house. The interview can take place at the crisis house, via video-call/telephone, or at another location which we can agree together. It will last between 60 and 90 minutes, which will include time for introductions at the start and a debrief at the end (to think about how you found the interview, how safe you are feeling, and what support you are able to access if you need to). £10 is available to those taking part, to cover expenses - you do not need to produce a receipt for this and you can choose whether you would like it in cash or vouchers.

What are the potential benefits and risks?

People have different reasons for taking part in this research project, including wanting to contribute to mental health research and practice, and as an opportunity to make sense of and take an active role in their care.

Talking about suicidal crises you have experienced and how this was managed can also be distressing or uncomfortable. You will not have to talk about anything that you would prefer not to during the interview. At the start of the interview we will think together about how you might be able to let me know if you are in distress or need anything – e.g. a break, or to skip a question. You can also stop the interview at any time. I will also be looking out for your wellbeing and at points I may ask how you are doing. At the end of the interview we will have time to debrief. Crisis contact details are available below and I will remind you of these at the end of the interview.

If I were to become concerned, based on something said during the interview, that you or someone else may be at risk of significant harm, then wherever possible I will raise my concerns with you and support you to stay safe (for example, contacting loved ones or crisis support) with your agreement. If this was not possible, then I would have a duty to break confidentiality and inform someone else (for example, emergency services), to manage the immediate risk of harm. With your consent, we will let your GP and other members of your care team know that you are taking part in this study so they can support you if needed.

Crisis Contacts

- Samaritans (free telephone and text service available all day and night): 116 123.
- Emergency Services (free to phone): 999

What are the Covid-19 safety measures?

Interviews will adhere to government and NHS guidance on social distancing and safety measures that are in place at the time. If you have any questions or concerns about this, please do let us know.

How will we use information about you?

We will need to use information from you for this research project. This information will include your:

- Name

- Date of birth
- Contact details
- GP details
- If you are happy for us to, we will also record your age, ethnicity, and socio-economic status for monitoring purposes.

People will use this information to do the research or to check your records to make sure that the research is being done properly. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from www.hra.nhs.uk/patientdataandresearch
- by asking one of the research team
- by sending an email to jo327@canterbury.ac.uk, or
- by ringing us on: 01227 927070 (Please leave a voicemail for 'Jess Ofori-Bull, on the Drayton Park Crisis House project', including your phone number, and I will return your call as soon as I can).
- by contacting our data protection officer (Robert Melville) on: dp.officer@canterbury.ac.uk

What will you do with my interview data?

The interviews will be digitally audio recorded. After the interviews, conversations will be transcribed and analysed by the study lead/interviewer (Jess Ofori-Bull). All interview data will be anonymised before being shared with the wider research team (which includes the crisis house manager) and any details that could identify an individual (such as particular use of language) will be changed. After transcription, recordings will be deleted immediately. The audio recordings themselves will not be published.

A research report will then be written, which will be submitted for educational purposes and published publicly. A summary of the findings will also be written for everyone who has taken part (it's anticipated that this will be available by August 2023). At times in the reports, we will include anonymous quotes from the interviews to help illustrate the points we make.

What if I would like to make a complaint about the research?

If you have any concerns about the research, please do let me know, my email address is at the end of this information sheet. If I am unable to resolve the issue or if you would like to speak to someone outside of the research team, please contact Fergal Jones, Research Director, at Salomons Institute of Applied Psychology: fergal.jones@canterbury.ac.uk or 01227 927110.

Any questions?

If you have any questions about this project, please do get in touch. My email address is **jo237@canterbury.ac.uk**.

Thank you for reading

CONSENT FORM

If you would like to take part in this project, please complete the consent form below and return it to Jess Ofori-Bull (Trainee Clinical Psychologist) by email: jo327@canterbury.ac.uk.

Three copies of this consent form will be kept: one for you, one for your clinical records, and one for the research file.

		Please initial
1.	I confirm that I have read and understand the information sheet for this study.	
2.	I have had the opportunity to ask any questions, and that these have been answered satisfactorily.	
3.	I understand that my personal information will be kept strictly confidential, unless researchers become concerned that I am or someone else is at significant risk.	
4.	I give consent for my GP, and other members of my care team [please state who else here: _____] to being informed that I am taking part in this study.	
5.	I agree for the interview being audio recorded. Recordings will be used for analysis but will not be published.	
6.	I agree for my pseudonymised data, including written quotes, to be published.	
7.	I confirm that my participation in this study is voluntary. I have not been pressured or coerced into taking part and I understand that I can ask for my data to be withdrawn up to 4 weeks after the interviews, without giving a reason.	
8.	I confirm that I meet the below criteria: • I am over 18 years old • I have accessed Drayton Park within the past 5 years • I do not currently have plans to end my life • I understand the interview will ask about my experiences of being supported during a suicidal crisis and I do not expect to experience significant distress as a result of taking part.	
9.	I would like to receive a summary of the research findings (optional).	

Participant Name:	**Date:**	**Signature:**
Researcher Name:	**Date:**	**Signature:**

Appendix D - Participant Information and Consent Forms – Staff

Developing a Trauma-Informed Model of Suicide Risk Management in the Mental Health Crisis Setting

My name is Jess Ofori-Bull and I am a trainee clinical psychologist at Canterbury Christ Church University. I am carrying out this research as part of my studies, under the supervision of Anne Cooke (Canterbury Christ Church University) and Shirley McNicholas (Drayton Park Women's Crisis House) and we would like to invite you to take part.

This research project has been reviewed by the London - Stanmore NHS Research Ethics Committee.

What is the research about?

We are looking at how women are supported to stay safe in the crisis house setting. Previous research looked at people's experiences of crisis house care compared to hospital and found some key differences. We are now hoping to take this a step further by interviewing crisis house staff and service users to understand how suicide risk can be managed in ways that are trauma-informed.

Am I eligible to take part?

We are looking to interview six women who have accessed the crisis house service and six staff members. In order to take part as a staff member, you must:

- Be over 18 years of age;
- Have worked at the crisis house in the past 5 years.

Because of the sensitive nature of the interviews, we have a few steps to ensure that people taking part are as safe as can be. We would encourage you to please not participate if you expect that talking about your experiences of delivering suicide risk management is likely to lead to significant distress.

Do I have to take part?

No. Taking part is entirely voluntary – you do not have to take part. Whether you take part or not, your work at the crisis house will not be affected. If you agree to take part then change your mind, you can ask for your data to be withdrawn up to 4 weeks after the interviews. You do not need to give a reason. After this time, it may not be possible to delete your data, since it may have been included in the analysis/report. However, wherever possible we will try to help.

What will I be required to do?

The research will involve a one-to-one interview with a trainee clinical psychologist, where you will be asked about your experiences and views about how suicide risk is managed in

the crisis house. The interview can take place at the crisis house, via video-call/telephone, or at another location which we can agree together. It will last between 60 and 90 minutes, which will include time for introductions at the start and a debrief at the end (to think about how you found the interview, how safe you are feeling, and what support you are able to access if you need to). £10 is available to those taking part, to cover expenses - you do not need to produce a receipt for this and you can choose whether you would like it in cash or vouchers.

What are the potential benefits and risks?

People have different reasons for taking part in this research project, including wanting to contribute to mental health research and practice, and as an opportunity to make sense of and take an active role in the development of suicide risk management practices.

Talking about suicide risk management may also be distressing or uncomfortable. You will not have to talk about anything that you would prefer not to during the interview. At the start of the interview we will think together about how you might be able to let me know if you need anything – e.g. a break, or to skip a question. You can also stop the interview at any time. I will also be looking out for your wellbeing and at points I may ask how you are doing. At the end of the interview we will have time to debrief.

As with all research of this kind, if I were to become concerned, based on something said during the interview, that you or someone else may be at risk of significant harm, then wherever possible I would raise my concerns with you and offer support. If this was not possible, then I would have a duty to break confidentiality and inform someone else (for example, emergency services), to manage the immediate risk of harm.

Crisis Contacts

- NHS confidential staff support line, operated by the Samaritans (free to access from 7:00am – 11:00pm, seven days a week): 0800 069 6222.
- Samaritans (free telephone and text service available all day and night): 116 123.
- Emergency Services (free to phone): 999

What are the Covid-19 safety measures?

Interviews will adhere to government and NHS Trust guidance on social distancing and safety measures that are in place at the time. If you have any questions or concerns about this, please do let us know.

How will we use information about you?

We will need to use information from you for this research project. This information will include your:

- Name
- Contact details

- If you are happy for us to, we will also record your age, ethnicity, and socio-economic status for monitoring purposes.

People will use this information to do the research or to check your records to make sure that the research is being done properly. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from www.hra.nhs.uk/patientdataandresearch
- by asking one of the research team
- by sending an email to jo327@canterbury.ac.uk, or
- by ringing us on: 01227 927070 (Please leave a voicemail for 'Jess Ofori-Bull, on the Drayton Park Crisis House project', including your phone number, and I will return your call as soon as I can).
- by contacting our data protection officer (Robert Melville) on: dp.officer@canterbury.ac.uk

What will you do with my interview data?

The interviews will be digitally audio recorded. After the interviews, conversations will be transcribed and analysed by the study lead/interviewer (Jess Ofori-Bull). All interview data will be anonymised before being shared with the wider research team (which includes the crisis house manager) and any details that could identify an individual (such as particular use of language) will be changed. After transcription, recordings will be deleted immediately. The audio recordings themselves will not be published.

A research report will then be written, which will be submitted for educational purposes and published publicly. A summary of the findings will also be written for everyone who has taken part (it's anticipated that this will be available by August 2023). At times in the reports, we will include anonymous quotes from the interviews to help illustrate the points we make.

What if I would like to make a complaint about the research?

We would encourage anyone with concerns about the research to contact us directly, and we will try our best to help. My email address is jo237@canterbury.ac.uk. If I am unable to

resolve the issue or if you would like to speak to someone outside of the research team, please contact Fergal Jones, Research Director at Salomons Institute of Applied Psychology, at fergal.jones@canterbury.ac.uk or 01227 927110.

Any questions?

If you have any questions about this project, please do get in touch. My email address is **jo237@canterbury.ac.uk**.

Thank you for reading

CONSENT FORM

If you would like to take part in this project, please complete the consent form below and return it to Jess Ofori-Bull (Trainee Clinical Psychologist) by email: jo327@canterbury.ac.uk

Three copies of this consent form will be kept: one for you, one for your clinical records, and one for the research file.

		Please initial
1.	I confirm that I have read and understand the information sheet for this study.	
2.	I have had the opportunity to ask any questions, and that these have been answered satisfactorily.	
3.	I understand that my personal information will be kept strictly confidential, unless researchers become concerned that I am or someone else is at significant risk.	
4.	I agree for the interview being audio recorded. Recordings will be used for analysis but will not be published.	
5.	I agree for my pseudonymised data, including written quotes, to be published.	
6.	I confirm that my participation in this study is voluntary. I have not been pressured or coerced into taking part and I understand that I can ask for my data to be withdrawn up to 4 weeks after the interviews, without giving a reason.	
7.	I confirm that I meet the below criteria (those marked with a * only apply to those who have accessed the service, and will therefore be speaking about their own experiences of suicidal crisis): • I am over 18 years old • I have worked at Drayton Park within the past 5 years • I understand the interview will ask about my experiences of supporting people during a suicidal crisis and I do not expect to experience significant distress as a result of taking part.	
8.	I would like to receive a summary of the research findings (optional).	

Participant Name:	**Date:**	**Signature**
Researcher Name	**Date**	**Signature**

Appendix E – GP/Professionals Letter for Service Users

Dr [xxx]
[Surgery address]

Salomons Institute for Applied Psychology
Lucy Fildes Building,
1 Meadow Rd,
Tunbridge Wells
TN1 2YG
Tel: 01227 927070
Email:

Dear Dr [xxx]

Re: Research Study: Developing a Trauma-Informed Model of Suicide Risk Management in the Mental Health Crisis Setting
REC/IRAS Project ID: 303743
[Service user participant name and address]

[SU participant's name] has kindly agreed to take part in a research project entitled: Developing a Trauma-Informed Model of Suicide Risk Management in the Mental Health Crisis Setting. This is a qualitative project and will involve [SU participant's name] taking part a single interview exploring their experiences of being supported to stay safe from suicide during their stay at Drayton Park Crisis House.

The study, reviewed by London - Stanmore REC, is being conducted by myself, Jess Ofori-Bull (chief investigator and trainee clinical psychologist), Anne Cooke (academic research supervisor, clinical director and principal lecturer, Doctoral Program in Clinical Psychology), and Shirley McNicholas (external research supervisor, service manager and women's lead, Camden and Islington NHS Foundation Trust).

Drayton Park Crisis House are in a gatekeeping and recruitment role for this study, and [SU participant's name]'s participation has been agreed by the leadership and clinical team. [SU participant's name] has received a copy of the participant information sheet, a copy of which is enclosed for your information. Should you have any questions regarding this study, please do not hesitate to contact me by email (j.oforibull327@canterbury.ac.uk) or telephone (01227 927070 - Please leave a voicemail for 'Jess Ofori-Bull, on the Drayton Park Crisis House project', including your contact details, and I will return your call as soon as I can).

Yours sincerely,

Jess Ofori-Bull
Chief Investigator
Trainee Clinical Psychologist
Salomons Institute for Applied Psychology, Canterbury Christ Church University

Appendix F – Screening/Debrief Questions

Screening and Debrief Questions

Screening Questions

- In the interview, we'll be talking about some difficult experiences, and my priority is making sure that you are as safe as possible, so I'm going to ask some questions about how you're doing at the moment if that's okay.
- How have you been feeling lately?*
- Do you have any current plans to end your life?*
- Do you think that taking part in this interview might cause you significant distress?
- Do you have any concerns about taking part?
- Talk through the participant information sheet (PIS) will containing information about the research/interview process, potential risks of taking part, issues of confidentiality and data protection, rights to opt-out or withdraw, and contact details in case of concerns/complaints.
- Invite to sign the consent form
- Do you have any questions or concerns related to the information sheet or the consent form?

At the start of the interview

- * If there is a delay between screening and interview (for example, where a participant requests to take part at a later point in time), the asterisked questions above will be repeated.
- the interview might cover some distressing experiences
- If you were to become distressed how might I know? and how it might it be most helpful for me to support you?
- It's important that you know you can stop the interview at any time - if you need to stop or a break, how would you let me know?

Check-ins during the interview

- How are you feeling?
- Are you okay to continue?
- Do you need a break?

Debrief questions

- How did you find the interview?
- I'm mindful that we've been talking about some difficult experiences, how are you feeling at the moment?
- How intense are the suicidal thoughts at the moment?
- Do you have any plans to end your life?
- Do you have any concerns how you might feel after we've finished?
- Direct to crisis contacts on PIS.

If the researcher believes the participant is distressed at any point, the process will be paused to support them. If they are experiencing significant levels of distress, the researcher will offer support as per the distress protocol, sensitively advise that they do not take part in the research at this time, and terminate the process.

Appendix G – Distress Protocol

DISTRESS PROTOCOL

(based on guidance (Draucker, Martsolf, & Poole, 2009) in line with that used in prior research in the crisis house; Prytherch, 2018):

In case of participants experiencing significant levels of distress, the researcher will stay with the participant until a satisfactory plan is made to keep them safe. This might involve:

- Staying with the participant and talking with them/planning how to stay safe (referring to their safety plan if they haven one);
- Planning follow up debrief sessions (either with the lead researcher or a research supervisor who has extensive clinical experience in mental health services);
- Supporting them make contact with loved ones;
- Supporting them to access health services (e.g. crisis telephone contacts detailed on the PIS, the crisis house, GP, A&E).
- If the researcher were to be concerned that a participant was at risk of significant harm as a result of something said in the interview, and the participant did not agree to a plan to keep them safe, the researcher would need to break confidentiality in order to alert the appropriate services (e.g. emergency services).

Appendix H - Interview Topic Guide

Interview Schedule

*NB for staff interviews: Change "you" to "service users"

- Rapport building: Anything that particularly interested you to take part? What are your hopes for the interview?
- Please could you tell me about how you* were supported to stay safe from suicide at the crisis house?
    - What, if anything, do you think was helpful about how you* were supported?
    - What, if anything, do you think was unhelpful about how you* were supported?
    - How, if at all, did the …[each of the below]… impact your* safety?
        - Setting of the crisis house
        - Staff at the crisis house
            - *Are there any specific interactions that stand out to you that helped you stay safe?*
            - *What worked well / what worked less well in that interaction?*
        - Specific ways of working [and policies]?
- Were there things about the nature of your* particular difficulties, or things you had experienced in the past, that influenced the way you needed to be supported?
- What is most important to you about how services help trauma survivors to stay safe during suicidal crisis?
- What, if any, impact does the crisis house's approach to safety have on you*?
    - What, if any, changes (positive or negative) have you* experienced since you started accessing the crisis house?
- What helps you* to manage your safety since leaving the crisis house?
- Additional question for staff only: How does the crisis house support you to manage suicide risk?
- Is there anything else you would like to say about how women are supported to stay safe at the crisis house?

Appendix I - HRA Ethics Approval Letter

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Appendix J - R&D Approval

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Appendix K - University Approval

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Appendix L - Coded Transcript Extract (Anonymised)

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Appendix M - Abridged Research Diary (Memo)

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Appendix N – Conceptual Depth Assessment

The data were considered to have reached an adequate depth, as judged against the five criteria outlined in Nelson's (2017) conceptual depth scale; range, complexity, subtlety, resonance, and validity, which were each rated on a scale of one to three, representing a low to high degree of conceptual depth (see Table 3).

Table 3

Conceptual depth scores

Conceptual depth criteria	**Score: Low (1), medium (2), or high (3)**
Range (A wide range of evidence can be drawn from the data to illustrate the concepts)	1
Complexity (The concepts must be demonstrably part of a rich network of concepts and themes in the data within which there are complex connections)	3
Subtlety (Subtlety in the concepts is understood by the researcher and used constructively to articulate the richness in its meaning)	3
Resonance (The concepts have resonance with existing literature in the area being investigated)	3
Validity (The concepts, as part of a wider analytic story, stand up to testing for external validity)	3
Total	13

The concepts that resulted from the analysis appeared to be related to each other in complex ways, drew on a rich conceptual language, and resonated with existing literature as well as making sense in the applied context. As such, the latter four criteria were rated as highly satisfied. Given that concepts sometimes drew on data gathered predominantly from one group (for example, staff members' experiences of anxiety), the range was at times more limited, and was therefore rated lower.

Appendix O - End of Study Report for Participants and Ethics Committee

End of Study Letter

Safety through Relationships: A Trauma-Informed Model of Suicide Risk Management

Jesse K. Ofori-Bull BA Hons MSc
A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

Acknowledgements
My sincerest thanks go to the participants who gave their time for this project; it has been a privilege, and I hope this paper captures the essence of our conversations. Thanks to Shirley McNicholas, and the team at Drayton Park; it has been inspiring to see the work you do, and thanks to Anne Cooke, whose work I have admired for a long time, and whose supervision has been a career peak. Finally, to all those who have been affected by the topic of suicide risk management; I hope this paper goes some way to advancing the field.

Research Summary
Trauma-informed approaches are considered, by some, to be of great relevance to the practice of suicide risk management. Trauma-informed approaches propose that since much mental distress is rooted in relational trauma, in order to effectively manage suicide risk, responses should be relationally reparative. The potential value of TIAs to mental healthcare has grown in prominence in recent years and has become increasingly emphasised in NHS policy. However, there is very little guidance on how to understand, conceptualize, and engage in trauma-informed suicide prevention in practice.

The current study aimed to develop a grounded theory model of suicide risk management in one trauma-informed crisis house, based on interviews with six service users and six staff members. Service-user consultants were consulted whilst refining the research documentation and interview guide; in particular around the terminology of risk and safety and the potential impact of the interview process on participants. The findings will contribute to the wider knowledge-base on trauma-informed approaches to healthcare, of which suicide risk management is an understudied area.

Findings
The overarching concept that came out of the research was “safety through relationships”. Service users being able to develop meaningful relationships with staff members, in which they were able to share their experiences of suicidality and receive emotional containment was identified as the cornerstone to trauma-informed suicide risk management. The findings also highlight the complexities for staff and the service in implementing this approach.

As shown in the diagram below, the results found that trauma-informed suicide risk management:

- *Helps service users to ask for help*
- *Incorporates embodiment into risk management*
- *Sees relationships with staff as central to risk management*
- *Offers regular one-to-one sessions are key to managing risk proactively*
- *Responds when risk concerns escalate*
- *Notices the emotional impact of relational risk management on service users and staff*
- *Enables staff to manage unique anxieties*

Illustrative Quotes

"[In mainstream mental health services], there's this kind of push and pull between withholding care and heavy-handed use of it … they don't see how they feed that dynamic … [at the crisis house] even when they don't immediately have beds, they keep in contact with you, check how you're doing … help you to find some other way" (Service User)

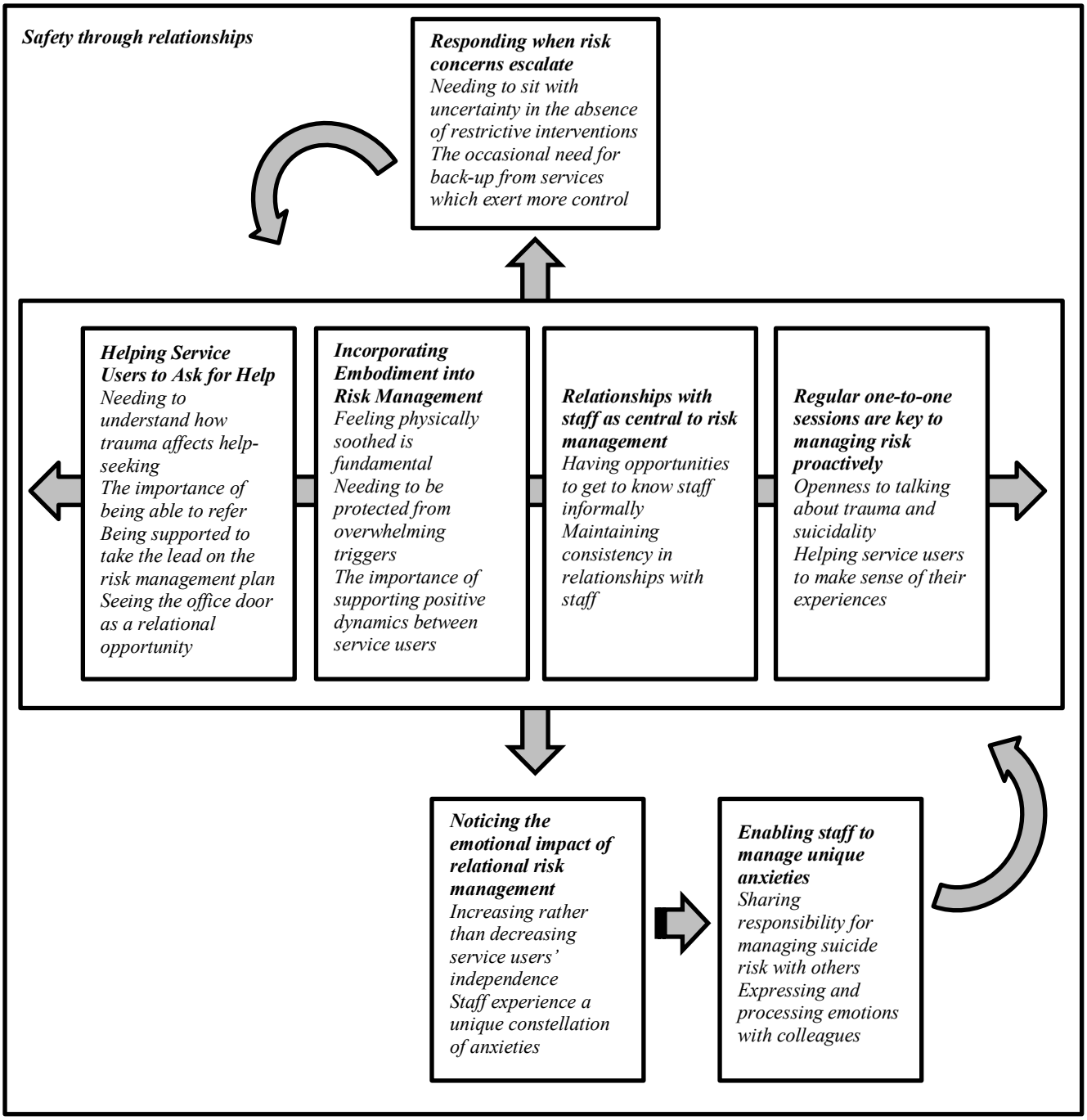
"Women know they're more responsible for keeping themselves safe, we're here to support that" (Staff)

"When you're feeling physically soothed, it frees up energy to manage the emotional side of it all, rather than cutting off from it" (Service User)

"Everyone's in different places, but have got some things in common … you keep each other safe" (Service User)

"We're a very expressive team … it's okay to have emotions in the office, that's important" (Staff)

"I used to spend about half of the year in hospital. Here, you're not starting from scratch each time … I've needed to be here so rarely" (Service User)


Safety through relationships
Responding when risk concerns escalate
Needing to sit with uncertainty in the absence of restrictive interventions
The occasional need for back-up from services which exert more control
Helping Service Users to Ask for Help
Needing to understand how trauma affects help-seeking
The importance of being able to refer
Being supported to take the lead on the risk management plan
Seeing the office door as a relational opportunity
Incorporating Embodiment into Risk Management
Feeling physically soothed is fundamental
Needing to be protected from overwhelming triggers
The importance of supporting positive dynamics between service users
Relationships with staff as central to risk management
Having opportunities to get to know staff informally
Maintaining consistency in relationships with staff
Regular one-to-one sessions are key to managing risk proactively
Openness to talking about trauma and suicidality
Helping service users to make sense of their experiences
Noticing the emotional impact of relational risk management
Increasing rather than decreasing service users' independence
Staff experience a unique constellation of anxieties
Enabling staff to manage unique anxieties
Sharing responsibility for managing suicide risk with others
Expressing and processing emotions with colleagues