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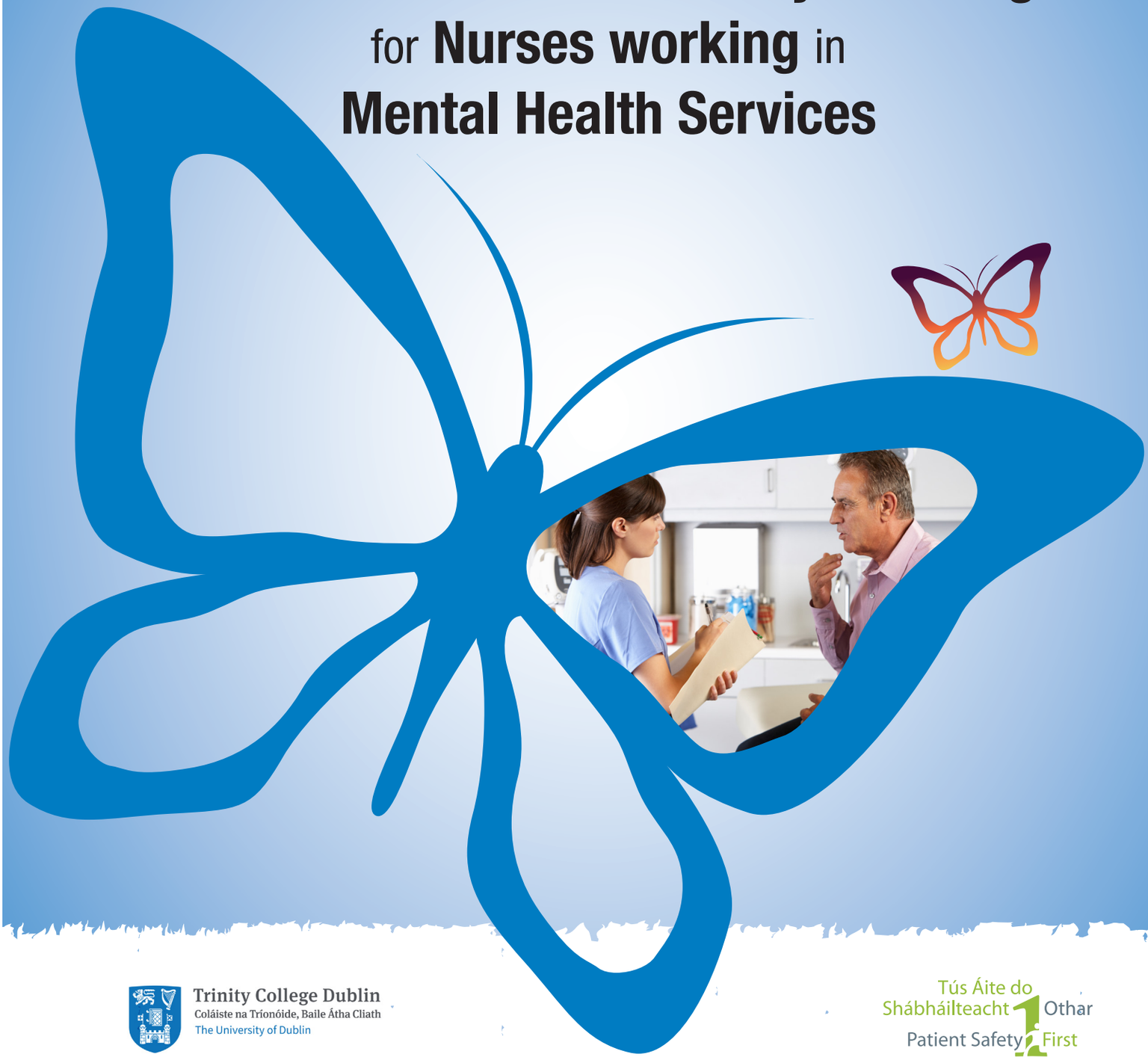
Office of the
Nursing & Midwifery
Services Director

Best Practice Principles
for
Risk Assessment and Safety Planning
for **Nurses working** in
Mental Health Services



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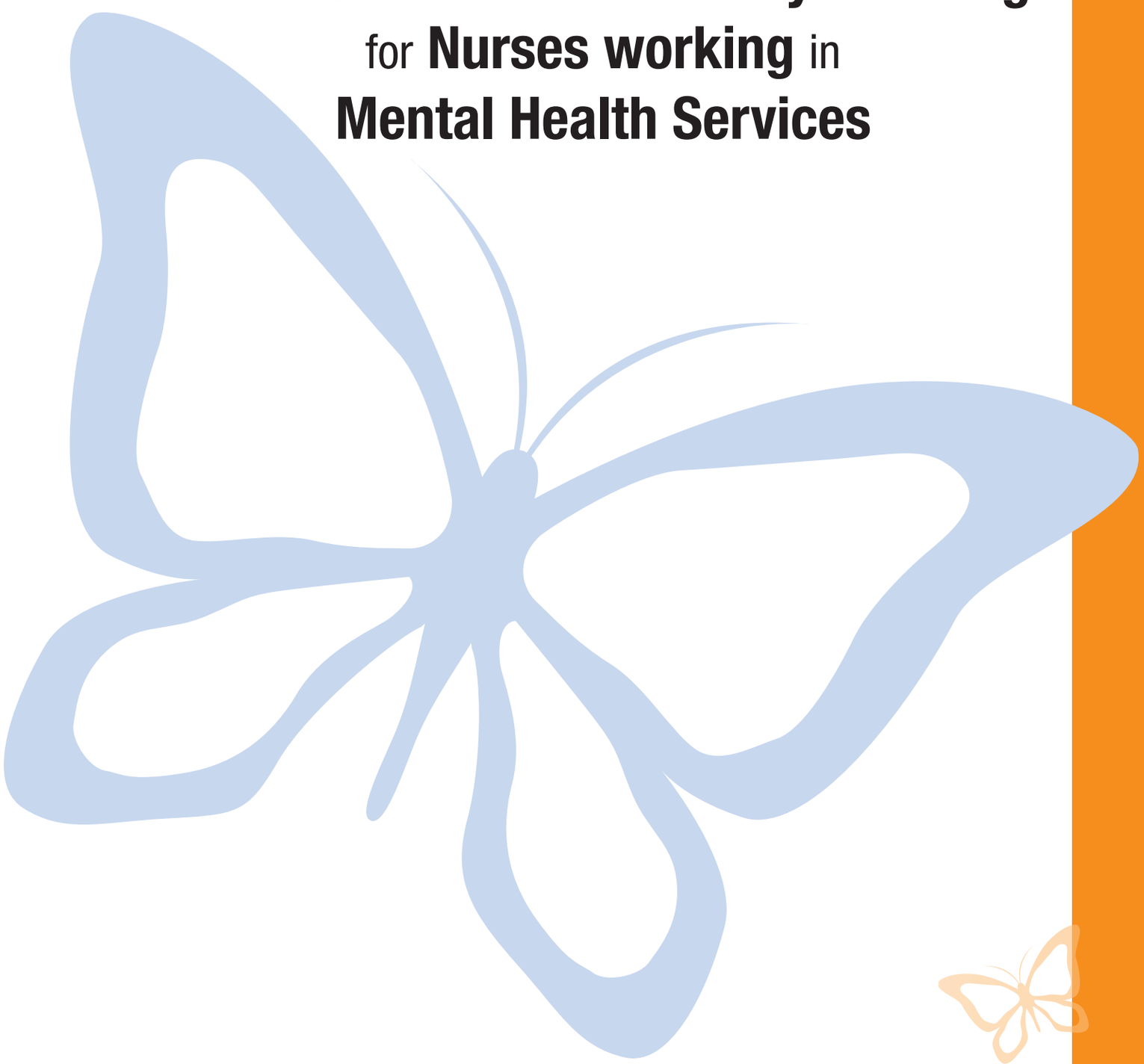

'When people assert control over their own lives and make their own decisions, they also take on responsibility for the consequences of their decisions. Often, as service providers, we want to protect people from failure. We know, or at least think we know, what is best. We do not like to see people fail-both because of the pain it may cause to the person, but also because of the pain and feelings of failure we may experience. Sometimes when psychiatric survivors decide to make changes in their lives, they may not succeed. And, like other people, they may have a right to take risks. And sometimes they succeed, surpassing all expectations' (Walsh, 1996:88).

Foreword

It is with great pleasure we present these Best Practice Principles for Risk Assessment and Safety Planning. These principles provide evidence-based guidance for all nurses working in clinical practice in the Mental Health Services nationally. The clinical role and responsibilities of the nurse has developed significantly to meet the changing nature and context of mental health care. Risk assessment and safety planning constitutes a significant component of the role of every nurse working in a recovery focused way in contemporary services and is particularly significant for those working in specialist and advanced practice roles in areas such as Liaison, Self Harm, Suicide Crisis Assessment and Community Mental Health. These principles are a resource for all nurses and provide a benchmark for the delivery of care.

This document and these principles relate to the specific area of risk assessment and safety planning of an individual's care. It is internationally accepted that risk and safety planning is an integral part of a standardised, comprehensive mental health bio psychosocial assessment of care which every individual will have when accessing mental health services. However, the profession requires a more in-depth knowledge and expertise in the area of risk assessment and safety planning. How risk is defined, classified and responded to needs to be evidence-based and consistent across all clinical settings and locations where care is being delivered nationally.

The Office of the Nursing & Midwifery Services Director (ONMSD) in partnership with Area Directors of Nursing commissioned a piece of research to provide evidence to inform clinical practice, mental health nursing policy and the development of education programmes in the this area: *Risk assessment and safety planning within mental health nursing services: an exploration of practices, policies and processes (Higgins et al. 2015)*. These 20 key principles have been developed as an outcome of this work, and now provides nurses with evidence based guidance for clinical practice. These Best Practice Principles for Risk Assessment and Safety Planning should underpin nursing practice and will improve the quality and safety of care provided to service users and their families through enabling the application of research into practice, reducing variation in practice and assisting with clinical decision making.

We would like to acknowledge all those who contributed to this publication, including the service users, family members and clinicians. Their willingness to read and comment on these principles is much appreciated. We extend our appreciation to Professor Agnes Higgins and her team in the School of Nursing & Midwifery, Trinity College Dublin for their work.

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Introduction

Risk assessment and safety planning is one of the 'highest profile tasks of mental health practitioners' (Woods 2013: 807) and a central component of mental health nursing in Ireland today. The manner in which risk is assessed and safety assured in mental health services are issues of concern to all stakeholders, including people who use services, family members, practitioners, general public and policy makers. The need for services to be driven by a quality and safety agenda is reflected within *A Vision for Change* (DoH&C 2006). A whole-systems approach towards safety management and quality control is detailed in *Quality Framework, Mental Health Services in Ireland* (MHC 2007), while statutory regulations around risk management procedures are laid out in Article 32 of the Mental Health Act 2001 (Approved Centres) Regulations (2006). Risk assessment and safety management in mental health services has been more recently addressed by a guidance document contending that safety is a shared responsibility and that risk, while impossible to fully eliminate, can be mitigated through good policies, processes and procedures (HSE 2009).

In recent years, Irish health policy has positioned mental health within a recovery-oriented framework (DoH&C 2006; MHC 2007; MHR 2012; HSE 2014), reflecting an intention to include recovery-oriented care as a key component of clinical nursing practice. Mental Health Reform (2012) identified the following as key building blocks of a recovery orientated approach: partnership, listening, hope, choice and social inclusion. Another aspect of a recovery oriented approach is the ability to engage with therapeutic or positive risk taking; which may *'….involve the person taking on new challenges leading to personal growth and development*' (Slade 2009:177). At the same time, positive risk taking must be balanced with the service users and wider publics' right to be guarded from unwanted negative outcomes (Morgan 2000). Balancing what may appear, at times, to be competing or conflicting demands requires nurses to have knowledge, skill and confidence in the area of risk assessment and safety planning.

Encouraging and supporting the person to be involved in the risk assessment and safety planning process can be therapeutic for the person and help the person's recovery. Listening and hearing the person's story can also facilitate the process of engaging and help the nurse to see the person beyond the risk behaviour (Morrissey 2015). In addition, it helps the nurse to acquire a greater understanding of the person's perspective of risk, the meaning they attach to risk within their lives as well as enabling explorations of possible solutions and strategies for personal safety and well-being. Enabling the person to engage in the process of safety planning requires a two-way dialogue that takes an honest and open approach to discussing the purpose and process of risk assessment and safety planning.

The aim of this document is to provide an evidence-based guidance document for nurses in the specific area of risk assessment and safety planning. The document consists of 20 key principles that should underpin nursing practice in the area of risk assessment and safety planning. It is important to note that risk assessment and safety planning does not take place in isolation but is part of a more comprehensive recovery-oriented mental health assessment and recovery plan.

Principles for best practice in risk assessment and safety planning

Principle 1: Service users should be active participants in their assessment and safety planning process

A key component of a recovery oriented approach is the involvement of service users in co-constructing their personal care and safety plan. Service user engagement and input is critical if the risk assessment and safety plan is to be person-centred (HSE 2009). Involvement of the service user ensures a more accurate assessment of risks and vulnerabilities, better understanding of service users' perspectives on risk and safety, and greater ownership of the process and care plan (Higgins *et al*. 2015; Langan and Lindow 2004). Full engagement is not always possible, and staff may be required to make decisions around safety for the service user, especially if they are in the early phase of their recovery journey, and are acutely unwell. At these times it may be unhelpful and unrealistic to have expectations of service users that they cannot meet (Boardman & Roberts 2013; Carr 2010; Slade 2009). In such an event this should be documented and every effort made to re-engage the person in collaborative dialogue as soon as possible. In addition, it is essential that the nurse continues to treat the person with dignity and respect, keeps the person fully informed, and conveys an expectation of future involvement and recovery.

Research indicates that many service users are not aware that their risk is being assessed, managed and documented, while others report that they are aware of the *fact* that the health professional is formulating an opinion about their 'illness' and level of risk without their involvement (Mental Health Reform 2013; Faulkner 2012; Carr 2010; Langan & Lindow 2004). The language used to discuss risk with service users is also important as language often influences thinking and subsequent action. While the language of risk and risk management dominates the policy and clinical practice culture, risk language may alienate service users as they prefer to speak of personal safety and ways of keeping and promoting their safety (Langan & Lindow 2004).

Principle 2: A trusting relationship between the service user and all those involved in providing their care is the best foundation for effective care and safety planning

Risk assessment and safety planning is a relational process that is rooted in the therapeutic dialogue and involves getting to know the individual rather than a process of procedures and check lists. It is also a process which requires the nurse to engage with the person while

working within best practice parameters and policy. A helping relationship is built with care, compassion and respect. Each therapeutic relationship is unique and may be influenced by many different factors. Every interaction with the service user is an opportunity for the nurse to undertake risk assessment and safety planning by engaging into a supporting relationship and offering help to reduce the person's distress at that time. The process of engagement in risk assessment and safety planning has the potential to enable the person and the nurse to feel a sense of connection; create a space for exploration and further understanding of distress and open a space for dialogue and reflection on possible options and solutions for positive risk taking. Conducting risk assessment and safety planning with the service user requires the nurse to be able to connect with the person and demonstrate a willingness and ability to develop and remain connected with the person at risk, while recognising there are no certainties or guarantees.

Principle 3: A comprehensive risk assessment requires a non-judgemental and positive attitude towards the service user

Engaging in a discussion about risk with service users can be experienced by nurses and service users as challenging and anxiety provoking. Such responses can impact on how nurses relate to service users and have the potential to hinder the development of a trusting working relationship. Attitudes held by nursing staff towards service users at risk, together with their knowledge, skill and sensitivity are likely to influence their working relationship and hence the experiences and outcomes of a comprehensive risk assessment. Staff with negative attitudes may find it difficult to respond with hope and in a helpful, compassionate and creative way. Each person's experience of recovery and risk is unique and will reflect in any given moment their experience of themselves and their world. Conducting a risk assessment is therefore different with each service user and will vary according to the context of the interaction and the nature of the relationship. Nevertheless, all risk assessment interactions need to be based on a model of respect and facilitation as opposed to asking a series of standardised, impersonal questions often in the format of a checklist.

Principle 4: A Risk assessment is an integral part of the person's overall mental health assessment and recovery plan

Risk assessment and safety planning does not take place in isolation, but is part of the person's overall biopsychosocial assessment and recovery/care plan. The safety plan developed as an outcome of the risk assessment process should be aligned closely with the broader context of the person's wellness and recovery, being mindful of the interrelationship between risk, personal learning and ongoing recovery. This will help integrate and support continuity of care which is essential for effective risk and safety planning.

Principle 5: Structured clinical judgement is considered the best approach towards risk assessment

The reason for conducting a collaborative risk assessment is to gather information to form an overall picture of the person, place the person on a continuum of risk, inform a plan to support the person and nurse maintain safety, and promote the potential and priorities of the service user. There are three main approaches to the assessment of risk in clinical practice: unstructured clinical judgement, which relies upon intuition to carry out an assessment (often described as 'impressionistic' or 'first generation' approaches); actuarial methods which uses empirically validated tools and instruments to measure risk (often described as 'second generation' approaches); and structured clinical judgement. Structured clinical judgement uses a combination of clinical judgement and actuarial methods (tools, checklists or an *'aide memoir'*) to assess an individual's risk and is considered the best approach towards risk assessment. Structured clinical judgement takes the form of engaging with the person to explore risk as well as protective factors, and includes multiple perspectives, such as the person, family/carer and other practitioners.

Principle 6: Risk assessment and safety planning should adopt a strengths-based approach and acknowledge protective factors

Risk assessment and safety planning must be built on the recognition of the service user's strengths. The identification of protective factors is integral to a strengths-based approach to risk assessment and safety planning. Protective factors are personal strengths, skills and resources available to the person that they can use or be supported to use as part of their care and safety plan. Protective factors can arise from within the person, from support networks and environmental context (a list of protective factors is provided in Appendix II). Protective factors may be identified by the individual themselves or through collaborative dialogue with their mental health team, family members and/or carers. It is only through a comprehensive assessment of the person's protective factors or strengths may the person be encouraged to go on and take positive risks. In taking a strengths based approach toward risk assessment and safety planning, nurses may reflect upon a service user's past achievements and coping mechanisms, and explore with the person how he/she can best make progress with the use of current resources, support structures and personal strengths available at a particular point in time.

Principle 7: Therapeutic or positive risk should underpin risk assessment and safety planning processes

Positive risk is about 'weighing up the potential benefits and harms of exercising one choice of action over another, identifying the potential risks involved (i.e. good risk assessment), and developing plans and actions (i.e. support for safety) that reflect the positive potentials and stated priorities of the service user (i.e. a strengths-based approach). It involves using

'available' resources and support to achieve the desired outcomes, and to minimise the potential harmful outcomes' (Morgan 2011: 6). In the context of recovery oriented practice, therapeutic or positive risk is a process which promotes the self-determination, autonomy and freedom of the service user while taking into account the safety needs of everyone involved. No action is entirely free of risk; positive risk taking acknowledges the inherent risk of all options and seeks to choose risks which will support the service user's autonomy, and life goals. Slade (2009:177-178) is of the view that 'the goal of eliminating all harmful risks is both damaging and an illusion..[as]..can be unintentionally counterproductive, by reducing skills in risk self-management, and reduce the extent to which people develop skills at taking responsibility for their own actions'. The role of the nurse is to engage and work with the risk, in ways that balance risks with opportunity for personal development and learning, while minimizing harmful consequences. As the promotion of recovery inherently rests upon an individual's ability to act, think and advocate for themselves in a positive capacity, recovery and therapeutic or positive risk taking goes hand-in-hand with a recovery based approach to risk assessment and safety planning.

Principle 8: A comprehensive assessment of risk includes consideration of risks posed by service users to themselves and others; as well as risks posed to service users by others and 'iatrogenic risks'

Risk in mental health service provision is an inherently broad topic, both in terms of who the risk is perceived to be directed towards and the types of risks that are deemed worthy of assessment and management. Stakeholders in the provision of mental health services have been found to focus almost entirely on the risks posed by service users to themselves and others, while mostly ignoring the risks posed to service users by others or by the mental health services that they use (Ryan 1998; Busfield 2004). In a recent study exploring the practices, policies and processes around risk and safety management within mental health nursing in Ireland, risk to self (by suicide or self-harm) and risk to others (by violence) were disproportionately emphasised clinical nursing practice (Higgins *et al.* 2015). In order to capture a balanced and comprehensive assessment of risk, assessments should include consideration of: risks posed by service users to themselves; risks posed by service users to others; risks posed by others to service users; and 'iatrogenic risks' or risks posed to service users as a result of their engagement with the mental health services (see Appendix I for examples of each).

Principle 9: A risk assessment and safety plan must include consideration of risk factors

A number of risk factors may impact on the person's safety including personal, organisational and relational factors. Risk assessment practices in mental health often overplay personal risk factors at the expense of organisational and relational factors (Langon 2010). Careful exploration of all risk factors in context of protective factors can be helpful in determining with the service user the level of risk they present. Personal factors are focused

on the person and are frequently classified as static or dynamic. Static risk factors, otherwise known as non-modifiable risk factors, are risk factors which are unlikely to change in a person's life. Demographic status, aspects of one's personal history, personality attributes, socio-economic factors, early onset risk factors and co-morbid substance abuse are largely unchanging aspects of a person's past or present life which may increase their risk of running into negative outcomes. Dynamic factors, otherwise known as modifiable risk factors, capture the fluctuating nature of the person's environmental and internal capacity to manage risk. They fluctuate in intensity and severity and are amenable to change.

Such factors include situational triggers relevant to a person's life, social factors, a sudden or gradual deterioration of mental state, reoccurrence of previous 'trigger' circumstances, poor treatment adherence, disengagement with therapeutic alliance or services. Dynamic factors are highly contextual and must be considered in light of the broader context of a person's current life, social ties, access to resources and past experiences. Organisational or environmental factors are those that relate to the wider context in which care is being delivered, such as: inconsistent or inequitable approaches to care and safety planning; policies and practices that discourage individuality, collaboration and positive risk taking and availability, accessibility, and acceptability of support and care pathway options within and outside services. Relational factors are embedded within the service user-nurse relationship and may manifest in the following manner: lack of skill and knowledge of staff; negative attitudes of staff or staff reacting to own fears; inconsistent expectations and practices of practitioners and authoritarian of dismissive approach towards safety planning.

Principle 10: Risk assessment and safety planning is a dynamic continuous process rather than a static or once-off event

Risk can change within short time periods and can fluctuate in accordance with the individual's circumstances and mental health status; therefore, risk assessment should be carried out as an ongoing process rather than a static or once-off event.

Principle 11: Risk assessment and safety planning is best completed in the context of multidisciplinary involvement

Risk assessment and safety planning 'does not fall exclusively within the domain of any single profession or discipline… as people require a spectrum of services and supports' (HSE 2009:11); therefore collaboration between all professionals within a multidisciplinary team is essential. Multidisciplinary teams in mental health settings may comprise nurses, social workers, psychologists, psychiatrists and therapists of various types (occupational, art, etc.). Each profession has its own skillset and perspective which can be used to support a comprehensive approach to risk and safety planning. It is important to be mindful of the different perspectives, strengths and knowledge that each discipline may bring to the safety planning process. Seeking opinions from members of the multidisciplinary team can result in

unique insights, innovative recommendations, and enhance the quality of clinical decision making and the safety planning process. However, at all times the service users' voice should be central.

Principle 12: Risk assessment is only effective if it is followed with a safety plan

A risk assessment is only as good as the safety plan that is formulated as an outcome of the assessment process. Research indicates that there is often a disconnection between the risk assessment process and the development of a safety plan. Gilbert *et al.* (2011) and Woods (2013) found that despite risk assessments being completed by nurses, the safety planning step was omitted or the strategies identified to support the person's safety did not correspond with the risk identified. The development of a safety plan following the identification of risk is a critical step in meeting the objective of supporting the person and the nurse to maintain safety, while promoting the potential and priorities of the service user. Once the crisis has resolved, the nurse in collaboration with the service user should develop an advanced crisis/safety plan for the future. In the event of the person experiencing a future crisis, having a crisis plan that identifies strategies, including who to contact or who not to contact can be of significant benefit to the person and others.

Principle 13: Safety plans involve developing flexible strategies aimed at promoting positive risk, preventing negative events or if this is not possible, minimising the harm caused.

A safety plan should aim to capture a summary of the risk identified, formulations of the situations in which identified risks may occur, including warning signs, factors that may escalate the risk and strategies to be taken by practitioners and the service user in response to risks identified. The strategies identified should be aimed at: promoting positive or therapeutic risk taking, preventing negative events from occurring or, if this is not possible, minimising the harm caused. In addition safety plans should endeavor to identify the potential benefits and drawbacks of choosing one action or another, with all actions being ultimately directed towards an individual's recovery (Boardman and Roberts 2013). Safety plans should also include a clear statement of who is responsible for carrying out specific tasks in the plan. Ideally, a timeline for the review and possible re-assessment should be constructed in advance and laid out in the safety plan. In addition to mapping future review timelines, safety plans should detail who on the team will carry out the review and/or re-assessments. Service users should have a copy of the safety plan, be asked to indicate their agreement with the plan.

Principle 14: To enable effective communication the safety plan needs to be clearly documented

Documenting the risk assessment process and safety plan is important for continuity of care and communication with the team and service user. At all times documentation should be available to the service user. Documentation is also part of professional accountability and provides information to enable nurses to record interventions, note changes in the level of risk or protective factors and provides information for ongoing review. In the event of a subsequent crisis or possible readmission to the service, documentation helps by identifying effective and non-effective interventions or other influencing factors that were considered important. Documentation is also required in any review process and in the event of a negative outcome for the service user or other person.

Principle 15: It is good practice to involve family/significant others where possible

Research and policy literature suggests that family members and others can be pivotal in people's recovery journeys and can support people to successfully manage or reduce risk behaviours. The inclusion of family members, carers and significant others are an aspect of best practice in the *Risk Management in Mental Health Services: Guidance Document* (HSE 2009). Factors which are unique to the individual and his or her life circumstances may become more identifiable through the input of families and carers. In addition to emotional support, family members can provide practical and other on-going supports such as housing and financial assistance, that act as protective factors in the person's life (Boardman & Roberts 2013). Family/carer involvement needs to occur within the context of service user informed consent. Nurses also need to be mindful that while family and significant others can be a potential protective factor they can also be a risk factor; therefore involvement can sometimes be counterproductive within the safety planning process.

Principle 16: Risk assessment tools are best used in conjunction with other risk assessment and safety planning activities

Risk can never be fully estimated or eliminated, however with the correct use of empirically validated tools, in addition to clinical judgement, some insight into the likelihood of a particular negative outcome occurring may be gleaned. Screening or assessment tools are designed with general populations in mind, not individuals, hence they cannot be relied upon to accurately predict future events (Royal College of Psychiatrists 2008). Screening for potential risk is not an end in itself, but should inform future safety plans and actions. Regardless of the type of tool that is used, the tool must be used in its entirety and in accordance with the guidelines for use. Individual questions must never be removed from or altered within a tool; because the tool's predictive value is only valid for the tool in its full and complete form. While tools are helpful they are only of value if used in conjunction with

other assessment and safety planning activities, and underpinned by a commitment to collaborative and recovery-oriented relationships and supports.

Principle 17: Risk assessment and safety plans should be reviewed regularly with the person and multidisciplinary team

As risk assessment and safety plans are developed at a particular point in time, they reflect an awareness of the potential for change in the level of risk and strategies to maintain safety over time. Therefore, they are required to be reviewed regularly as part of the care planning process with the person and multidisciplinary team in order to accommodate changing circumstances and contexts. The primary objective of reviewing risk assessments and safety plans is to complete a thorough examination of what has worked well and what needs to be modified or updated in accordance with the service user's identified needs. While remaining flexible, ideally, a timeline for the review and possible re-assessment should be constructed in advance so that they are not simply amended as a reaction to a crisis or as a matter of routine (Department of Health UK 2007). It is important that the multidisciplinary team are mindful of possible circumstances, situations or particular times in the person's life that might influence their risk and protective factors, thus reducing or increasing potential risks. In such situations a review of the safety plan outside the normal agreed timeframe is required. In keeping with the principle of collaboration and the dynamic nature of a safety plan service users and family members should be able to request a review at any time.

Principle 18: Information shared by service users is confidential within the team and only disclosed when required by law or professional guidelines.

Information shared by a service user should, by and large, be kept confidential within the team, as nurses are legally obligated to ensure that personal information is not disclosed in an unauthorised manner and without service user informed consent. However, there are some instances wherein disclosure of information is required by law or advisable from an ethical perspective. It is best practice to inform the service user of instances whereby their information must be shared with outside authorities or public services. In these situations, the level of disclosure should be limited to information necessary to convey the perceived threat to personal or public safety, as further information can be shared as and when needed.

Principle 19: Risk assessment and safety planning occurs in the context of organisational and professional policies and guidelines

Risk assessment and safety practices within mental health are influenced by organizational policies and procedures. Nurses need to be mindful of how these may inform local practice and ensure that risk assessment and safety planning are in line with the broader guidelines,

aims and recommendations of organisational policies and guidelines. Equally, organisational policies need to take account of positive risk and support a recovery and co-produced orientation towards risk and safety planning. In addition, nurses need to keep abreast of policies or guidelines published by the regulatory bodies such as Nursing and Midwifery Board of Ireland or the Mental Health Commission.

Principle 20: Ongoing education and supervision is essential for competent practice in risk assessment and safety planning

Research demonstrates a significant correlation between education in risk assessment and safety planning and the subsequent undertaking of risk assessments and the development of safety plans (Higgins *et al.* 2015). Education in risk and safety planning is essential for all nurses working in the area of mental health. Ongoing education and supervision ensures that nurses keep abreast of new frameworks, policies, tools and skills required for competent, caring, compassionate and reflective practice.

Appendix 1: Risk classification and examples

Risk can be classified into the following four categories:

Risk the person experiencing the mental health issue may pose to themselves.	Risk the person experiencing the mental health issue may pose to others.
Risk others may pose to the person experiencing the mental health issue.	Risk to the person from engaging with the mental health system or what can be termed 'iatrogenic risks'.

Examples of risk to self:

- Deliberate or unintentional harm to self -suicide, self-harm (including repetitive self-injury), self-neglect and substance misuse.
- Loss of social and financial status arising from mental health mental health status such as loss of employment, loss of accommodation, loss of supports (family/friends/other relationships); loss of custody of children, loss of reputation.
- Risk to physical, psychological and sexual health as a result of engaging in risk behaviours, such as substance misuse, sexual risk behaviours.

Examples of risk to others:

- Violence, aggression, verbal or physical assault.
- Sexual assault or abuse, harassment, stalking or predatory intent.
- Property damage including arson.
- Neglect or abuse of children or adults for whom care is being provided.
- Behaviour that could be thought of as reckless or high risk to others, such as drink driving.

Examples of risk from others:

- Physical, sexual and emotional abuse by others.
- Financial abuse or neglect by others.
- Victimization and harassment (in own home and public: name calling, having objects thrown, having offensive graffiti written on the walls).
- Being treated unfairly in the workplace,
- Losing accommodation or having difficulty getting accommodation.

Examples of iatrogenic risk:

Risk to the person from engaging with the mental health service may be associated with:

- Diagnosis and labelling
- Erosion of identity and self-esteem; loss of autonomy and voice, institutionalisation
- Stigma and discrimination
- Emotional trauma associated with detention, seclusion, restraint
- Negative attitudes and controlling behaviours of staff
- Violation of human rights
- Health problems associated with side effects of medication
- Experiencing harassment within the service

Appendix II: Protective factors

- Personal: Capacity and willingness to understand distress; sense of potential to change; level of optimism, self-esteem, sense of personal control; ability to use adaptive coping mechanisms; communication and assertiveness skills; willingness to talk about emotions and feelings; previous positive experience of managing crisis and risk potential; collaboratively agreed crisis plan.
- Support networks: Family support (and willingness/ability to access such support); friends and other networks (e.g., work colleagues/religious groups/social media/volunteering); interests and activities; involvement in the community; other important attachments (e.g., pets, gardening); engagement with mental health services; previous positive experiences of engaging with services during periods of crisis.
- Environmental: Living in stable accommodation; having financial security; availability, acceptability, diversity and flexibility of mental health service; availability and accessibility of informal mental health supports (e.g., peer support, advocacy groups, etc.).

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