RISK MANAGEMENT: AN INVESTIGATION INTO NURSES RESPONSE TO RISK PRESENTED BY PEOPLE WITH SEVERE MENTAL HEALTH PROBLEMS

BY

MAVIS ODDOYE, R.N. MSc.

SUBMITTED FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

EUROPEAN INSTITUTE OF HEALTH AND MEDICAL SCIENCES

MAY 2005
Abstract

Background

In the last few years clinical risk assessment and management in people with severe mental health problems has become a national agenda following various critical incidents reported in national confidential enquiries (Sheppard 1996, Bloom-Cooper 1996, Ritchie 1994) and the media. Evidence from previous studies suggested that nurses’ risk assessment and management practices have not been fully explored although the risk assessment and management practices of other professionals such as doctors and psychologists have been explored (Modestine 1989, Lidz et al).

Aim

The aim of this study was to explore how nurses managed risk presented by people with severe mental health problems.

Method

Data collection involved a mixed approach of both qualitative and quantitative methods in a three stage process. Stage I involved the review of a number of case notes (N=300), 150 case notes from the community and 150 case notes from the in-patient services. Gaps in the case notes reviewed led to a stage II of the study in an attempt to understand the nurses risk assessment and management practices from their point of view. Stage II of the study involved an interview with qualified nurses (N=10) in the UK, 5 participants from the community and 5 participants from the in-patients services. Following the data collection and analysis in both
stages one and two of the study the researcher believed that an international focus and perception of factors that influenced the risk assessment and management agenda and practices would be useful for comparison and learning. This therefore led to a stage III of the study which involved the collection of data through an interview process with international experts in clinical risk assessment and management and a group of clinicians and managers from two different clinical settings in the United States. The data from the case notes reviewed was analysed using Statistical Package for Social Sciences version 12 and contents analysis was used to analyse the data collected from the interviews.

Results

The major findings from the case notes reviewed showed that the community patients were more likely to have risk assessments completed with a total of 101 out of 150 completed risk assessments. Nineteen (19) patients on level 3 CPA did not have completed risk assessments. One hundred and thirteen (113) out of 150 patients had risk management plans and only 47 out of 150 patients had risk relapse plans completed. The in-patients case notes reviewed showed that only 74 out of 150 patients had risk assessments completed on admission. Only 21 out of 43 formal (detained under the Mental Health Act 1983) patients had risk assessments completed on admission. Sixteen (16) patients on level 3 CPA did not have completed risk assessment. Ninety two (92) patients had risk management plans with only 35 risk relapse plans completed.

Major findings from the interviews showed that nurses risk assessment and management practices were diverse and inconsistent with varied perceptions of responsibilities and practices. Evidence of diffusion of responsibility within the in-patient services indicated that high risk patients admitted formally (under the Mental Health Act 1983) did not have risk assessments
completed on admission. The perception of the ‘blame culture’ within the organisation hindered the completion of risk assessment, management and relapse plans.

The interviews with the participants from the United States demonstrated that risk assessment and management was very much team focused with professionals developing and using creative ways of engaging high risk patients who presented a risk to themselves and others. A standardised risk assessment tool approved by the State in which the study was conducted, and used by all the mental health facilities was perceived to be protective against litigation by the participants.

Recommendations

Recommendations for practice included a review of risk assessment and management training for nurses at both pre and post registration levels to include strong emphasis on responsibilities and communication. National Health Service Trust hospitals to introduce robust mechanisms for monitoring risk assessment and management practices to ensure that risk assessment and management practices are viewed by the professionals as a dynamic and not a static process. National Health Service Trust hospitals should address the perception of the ‘blame culture’ and the diffusion of responsibility and promote life-long learning cultures to enhance risk assessment and management practices. National Health Service Trust Boards to support clinicians especially nurses in developing creative ways of engaging high risk patients who present a risk to themselves and others.
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td></td>
</tr>
<tr>
<td>Acknowledgements</td>
<td></td>
</tr>
<tr>
<td><strong>Chapter 1</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 Rationale for the Study</td>
<td>15</td>
</tr>
<tr>
<td>1.1.1 Introduction</td>
<td>15-16</td>
</tr>
<tr>
<td>1.2 Scope of Problems</td>
<td>17-18</td>
</tr>
<tr>
<td>1.3 Political Expectations</td>
<td>18</td>
</tr>
<tr>
<td>1.4 National Strategies for Mental Health Services</td>
<td>18</td>
</tr>
<tr>
<td>1.4.1 Health of the Nation</td>
<td>18-19</td>
</tr>
<tr>
<td>1.5 National Service Framework</td>
<td>19-20</td>
</tr>
<tr>
<td>1.6 National Strategy for Suicide Prevention</td>
<td>20-22</td>
</tr>
<tr>
<td>1.7 Local Issues</td>
<td>22-23</td>
</tr>
<tr>
<td>1.8 Working Definition</td>
<td>23-25</td>
</tr>
<tr>
<td><strong>Chapter 2</strong></td>
<td></td>
</tr>
<tr>
<td>2. Literature</td>
<td>26</td>
</tr>
<tr>
<td>2.1 Introduction</td>
<td>26-27</td>
</tr>
<tr>
<td>2.2 Risk Assessment and Management</td>
<td>27-31</td>
</tr>
<tr>
<td>2.3 Suicides in People with Schizophrenia and Depression</td>
<td>31-38</td>
</tr>
<tr>
<td>2.4 Self Harm</td>
<td>38-39</td>
</tr>
</tbody>
</table>
Chapter 3

3. Research Design and Method
   3.1 Introduction
   3.2 The Research Design and Approach
   3.3 Use of Theory in the Research
3.4 Research Method and Issues 74
3.4.1 Introduction 74-76
3.5 A Sampling Frame 76-77
3.6 Ethical Consideration 77-78
3.7 Methodological Rigour 79-80
3.8 The Use of Self in Qualitative Research 80-85

Chapter 4

4. Data Collection and Analysis 86
4.1 Introduction 86
4.2. The Pilot Study 86
4.3 Stage I of Pilot Study 87
4.3.1 Design of the Semi-Structured Postal Questionnaire 87
4.3.2 Administration of the Pilot Study 87
4.3.3 Response to Pilot Questionnaire 88-89
4.3.4 Case Notes Review in Pilot Study 89
4.3.5 Second Testing of Tool for Case Notes Data Collection 90
4.4 Stage II of Pilot Study 90-91
4.5 Stage III of Pilot Study 91
4.6 Discussion of Pilot Study 92
4.7 Study I 93
4.7.1 Introduction 93
4.8 Aim of Study I 93-94
4.9 Statistical Advice 94
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.10</td>
<td>Selection of Case Notes</td>
<td>94-96</td>
</tr>
<tr>
<td>4.11</td>
<td>Gaining Access</td>
<td>96-97</td>
</tr>
<tr>
<td>4.12</td>
<td>Data Collection Process</td>
<td>97-98</td>
</tr>
<tr>
<td>4.13</td>
<td>Findings from Study I</td>
<td>98</td>
</tr>
<tr>
<td>4.13.1</td>
<td>Introduction</td>
<td>98-115</td>
</tr>
<tr>
<td>4.14</td>
<td>Discussion</td>
<td>115-118</td>
</tr>
</tbody>
</table>

**Chapter 5**

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>Study II</td>
<td>119</td>
</tr>
<tr>
<td>5.1</td>
<td>Introduction</td>
<td>119-121</td>
</tr>
<tr>
<td>5.2</td>
<td>Aim of Qualitative Data Collection</td>
<td>121</td>
</tr>
<tr>
<td>5.3</td>
<td>Interview (Self Reporting) Data Collection Process</td>
<td>122</td>
</tr>
<tr>
<td>5.4</td>
<td>The Development of an Interview Guide</td>
<td>123-124</td>
</tr>
<tr>
<td>5.5</td>
<td>Sampling</td>
<td>125</td>
</tr>
<tr>
<td>5.6</td>
<td>Purposive Sampling</td>
<td>125</td>
</tr>
<tr>
<td>5.7</td>
<td>Development of Eligibility Criteria</td>
<td>126-128</td>
</tr>
<tr>
<td>5.8</td>
<td>Selection of Participants</td>
<td>128-129</td>
</tr>
<tr>
<td>5.9</td>
<td>Interviewing Participants</td>
<td>129-130</td>
</tr>
<tr>
<td>5.10</td>
<td>Study II Data Analysis Process</td>
<td>130</td>
</tr>
<tr>
<td>5.10.1</td>
<td>Introduction</td>
<td>130-133</td>
</tr>
<tr>
<td>5.11</td>
<td>Data Analysis Process (Step by Step)</td>
<td>134</td>
</tr>
<tr>
<td>5.11.1</td>
<td>Step I (Organisation of Data and the Transcription of Individual Interviews)</td>
<td>135</td>
</tr>
<tr>
<td>5.11.2</td>
<td>Step II (Coding Process)</td>
<td>136-138</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
<td>Pages</td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>5.11.3</td>
<td>Step III (Data Filing System)</td>
<td>138-139</td>
</tr>
<tr>
<td>5.11.4</td>
<td>Step IV (Developing Categories)</td>
<td>139-141</td>
</tr>
<tr>
<td>5.12</td>
<td>Emerging Categories</td>
<td>141-142</td>
</tr>
<tr>
<td>5.12.1</td>
<td>Category I (Perception of Assessment and Management)</td>
<td>142-147</td>
</tr>
<tr>
<td>5.12.2</td>
<td>Category II (Knowledge/Types of Risk Behaviours)</td>
<td>147-149</td>
</tr>
<tr>
<td>5.12.3</td>
<td>Category III (Risk Assessment and Management Practices and Processes)</td>
<td>150-154</td>
</tr>
<tr>
<td>5.13</td>
<td>Links Between the Key Categories</td>
<td>154-155</td>
</tr>
<tr>
<td>5.14</td>
<td>The Development of Themes from Study II</td>
<td>155</td>
</tr>
<tr>
<td>5.14.1</td>
<td>Introduction</td>
<td>155-156</td>
</tr>
<tr>
<td>5.14.2</td>
<td>Content (Interpretive) Analysis</td>
<td>156</td>
</tr>
<tr>
<td>5.15</td>
<td>Summary of Community Participants Matrix</td>
<td>157</td>
</tr>
<tr>
<td>5.15.1</td>
<td>Context</td>
<td>157</td>
</tr>
<tr>
<td>5.15.2</td>
<td>Summary of Category I Matrix (Perception and Personal Views on Risk Assessment and Management)</td>
<td>158-159</td>
</tr>
<tr>
<td>5.15.3</td>
<td>Summary of Category II Matrix (Knowledge and Types Of Risk Behaviours)</td>
<td>159</td>
</tr>
<tr>
<td>5.15.4</td>
<td>Summary of Category III Matrix (Risk Assessment and Management Practices and Processes)</td>
<td>160-163</td>
</tr>
<tr>
<td>5.16</td>
<td>Summary of In-patient Category Matrix</td>
<td>163</td>
</tr>
<tr>
<td>5.16.1</td>
<td>Context</td>
<td>163</td>
</tr>
<tr>
<td>5.16.2</td>
<td>Summary of Category I Matrix</td>
<td>163-164</td>
</tr>
<tr>
<td>5.16.3</td>
<td>Summary of Category II Matrix</td>
<td>164</td>
</tr>
<tr>
<td>5.16.4</td>
<td>Summary of Category III Matrix</td>
<td>164-166</td>
</tr>
</tbody>
</table>
5.17 Comparisons of Risk Assessment and Management Practices and Processes between In-patients and Community Participants

5.18 Perception of Risk Assessment and Evidence from Case Notes

5.18.1 Knowledge of Risk and Evidence from Case Notes

5.18.2 Risk Assessment and Management Practices and Processes and Evidence from Case Notes

5.19 Discussion

5.19.1 Reliability and Validity

5.19.2 Truth Value

5.19.3 Applicability

5.19.4 Consistency

Chapter 6

6 Study III Interviews with International Experts and Clinicians from the United States

6.1 Introduction

6.2 Aim of Data Collection

6.3 Selecting Participants

6.4 Accessing Participants

6.5 Developing Interview Guide

6.6 Data Collection Process
6.7 Data Analysis Process 180
6.8 Data Reduction 180
6.8.1 Coding Process 180
6.8.2 Data Filing 181
6.8.3 Generating Codes or ‘Label’ 181
6.8.4 Developing Meaning 182
6.9 Emerging Categories from the Interviews with Participants from the United States 182
6.9.1 Category I (Perception of Assessment and Management) 182-186
6.9.2 Category II (Knowledge/Types of Risk Behaviours) 187-189
6.9.3 Category III (Risk Assessment and Management Practices and Processes) 189-194
6.10 Discussion from Study III 195-197

Chapter 7

7. Emerging Themes 198
7.1 Introduction 198
7.2 Interactive Relationship Between Emerging Themes 199
7.3 Structures for Services 200
7.3.1 Community Services 200
7.3.2 In-patient Services 200-201
7.4 Theme I (Influencing Factors) 201
7.4.1 Knowledge and Experience 201-204
7.4.2 Responsibility 204-208
7.4.3 National and Local Directives 208-209
7.5 Theme 2 (Practices and Processes) 209
7.5.1 Nursing Assessment and Decision-making (Community Services) 209-216
7.5.2 Nursing Process 217-219
7.5.3 Decision-making in Risk Management 220-223

Chapter 8

8 Discussion 224-231
8.1 Implications for Practice 231-233
8.2 Recommendations 233-235
8.3 Limitations of Study 235-236
8.4 Conclusion 237-238

List of Tables

Table 1 Risk Assessment Completed on Admission 99
Table II Patients Status and Risk Assessment Completed on Admission 100
Table III Patients Diagnosis and the Completion of Risk Assessment on Admission. 102
Table IV Evidence of Risk Management Plans 111
Table V Evidence of Risk Relapse Plans 113
### List of Graphs

<table>
<thead>
<tr>
<th>Graph</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graph I</td>
<td>Patients Status and the Completion of Risk Assessments on Admission (in-patients)</td>
<td>101</td>
</tr>
<tr>
<td>Graph II</td>
<td>Level of CPA and the Completion of Risk Assessment (in-patients)</td>
<td>103</td>
</tr>
<tr>
<td>Graph III</td>
<td>Level of CPA and the Completion of Risk Assessment (community patients)</td>
<td>104</td>
</tr>
<tr>
<td>Graph IV</td>
<td>Which Professional Assessment Patient on Admission (in-patients)</td>
<td>106</td>
</tr>
<tr>
<td>Graph V</td>
<td>Which Professional Assessment Patient on Admission (community)</td>
<td>107</td>
</tr>
<tr>
<td>Graph VI</td>
<td>Risk Behaviours Assessed on Admission for In-patients</td>
<td>109</td>
</tr>
<tr>
<td>Graph VII</td>
<td>Risk Behaviours Assessed on Admission for Community</td>
<td>110</td>
</tr>
<tr>
<td>Graph VIII</td>
<td>Legal Status and Risk Assessment and Management</td>
<td>112</td>
</tr>
<tr>
<td>Graph VIII</td>
<td>Frequency of Risk Assessments for In-patients</td>
<td>114</td>
</tr>
<tr>
<td>Graph X</td>
<td>Frequency of Risk Assessment for Community Patients</td>
<td>115</td>
</tr>
</tbody>
</table>

### List of Diagrams

<table>
<thead>
<tr>
<th>Diagram</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagram I</td>
<td>Conceptual Framework Underpinning Study</td>
<td>67</td>
</tr>
<tr>
<td>Diagram II</td>
<td>A Modified Three Stage Analysis Process</td>
<td>133</td>
</tr>
<tr>
<td>Diagram III</td>
<td>Data Analysis Process in Study II</td>
<td>134</td>
</tr>
<tr>
<td>Diagram IV</td>
<td>Emerging Categories</td>
<td>199</td>
</tr>
</tbody>
</table>
Appendices

Appendix 1  Interview Questionnaire (Guide)  240-244
Appendix 2  Modified Interview (Guide)  245-246
Appendix 3  Final – Interview Guide  247
Appendix 4  Developing Codes  248-264
Appendix 5  Developing Categories  265-275
Appendix 6  Developing Categories for Group Interview from USA  276-284
Appendix 7  Trust Risk Assessment and Management Policy  285-301

References  302-324
Acknowledgements

The researcher would like to thank:

Professor Karen Bryan and Professor Ian Robbins for their support and supervision in enabling the completion of this study.

The Florence Nightingale Foundation for the travel scholarship which enabled the researcher to visit the United States to gather valuable information which contributed to this study.

Surrey Oaklands NHS Trust for their support, patience and understanding over the last few years.
Chapter 1

1. Rationale for Study

1.1 Introduction

In the last few years various high profile incidents involving people with mental health problems discharged from institutions into the community, and the opposition to the closure of psychiatric hospitals have increased public fear of the mentally ill. Various inquiries into the deaths of members of the public have persistently indicated that professionals were failing to provide the appropriate care for people with mental health problems to stop them from harming themselves or others. Recommendations from various inquiries have also emphasised the need for good communication among all agencies to ensure that any risk identified is communicated to all appropriate professionals (Ritchie 1994, Sheppard 1996, 1997). Following the deaths of Zito, Robinson, Dewberry and others (Sheppard, 1996), the Department of Health set out recommendations in a ten point plan on the management of people with mental health problems who were deemed to be at risk to themselves and to the community (Department of Health, 1983). The ten-point plan was supposed to ensure that people with severe mental health problems were adequately supervised and supported in the community. And that those providing the services were appropriately trained to implement the care programme and to utilise the code of practice for the Mental Health Act 1983 legislation if and when necessary.

Although the ten point plan emphasised the need for training for all professionals, any training developed tended to focus on the care programme approach which is an after
care process for providing care and services for people with mental health problems, who have received either in-patient or community care from the specialist mental health services. The ten point plan did not make any reference to risk assessment training and the need for professionals to be proficient in the assessment of people with mental health problems who may present a risk to themselves or others. It appeared to have been taken for granted that all professionals, including nurses have the knowledge and skills to complete comprehensive risk assessment and implement risk management strategies effectively.

Bowis (1994) Parliamentary Secretary at the Department of Health also announced new guidance on the discharge of the mentally disordered and their continuing care in the community. This guidance stated that risk assessment must be completed before a patient is discharged from hospital into the community. The guidance also stipulated that hospital and other staff should consider before deciding to discharge a patient, whether the patient would present a risk to themselves or others in the community, or whether they could be better managed in a supportive staffed accommodation. The guidance further stated that no patient should be discharged from hospital unless those making the decision were satisfied that supervision and appropriate care was available in the community (Department of Health 1994). More recently further Department of Health guidance and policies have strongly emphasised the need for specialist mental health services to manage risk and set targets for suicide preventions (NSF 1999 and National Suicide Prevention Strategy 2002). Since then the need for effective risk management has become a focal point in ensuring the safety of both patients and the general public.
1.2 Scope of Problem

With the closure of psychiatric institutions and the NHS reforms, health care professionals are expected to identify needs/problems and to provide care using evidence based practice, knowledge and skills and to involve carers and the patient when implementing care in the community (Care in the Community 1996). The identification of risk predicting factors and their consequent management has become crucial in mental health care in the last few years. It has become more evident that professionals will be held accountable for their actions or inactions for any harm that comes to a patient whilst in their care (Carson 1989). The researcher's experience show that coroner's inquests have asked to see documented evidence of care management strategies implemented in sudden death cases on psychiatric in-patient wards. This has led to professionals expressing concerns about possible future negligence actions that may be taken by patients and their carers against the care received from the care professionals.

Authors such as Daly (1993) have asserted that in cases of suicide the court considers three factors that are crucial to the standards of care provided. These are:-

- Was the patient's suicide foreseeable?
- Was reasonable care provided and were necessary precautions implemented?
- Was treatment reliably and dependably implemented?

In the Health Service the judicial statements of duty of care states that professionals have a duty of care to all those people whom they can reasonably foresee might be harmed by the professional actions or inaction's (Carson 1989). In cases of suicide,
professionals must be able to demonstrate whether the suicide was foreseeable and whether reasonable care was taken to prevent the suicidal behaviour.

1.3 Political Expectations of Health Organisations

The removal of crown immunity and the increased independence status for the National Health Service has left many NHS Trusts open to litigation arising from patients harming themselves or others (William 1994). The introduction of the Care in the Community Act (1990) led to more people with mental illness/health problems being cared for in the community as the Government directed that Mental Health services must target the severely mentally ill when planning services (Care Programme Approach 1991). It can therefore be argued that the political expectation is that, health and social services professionals have the responsibility to protect the individual and the public from any one with a mental disorder who may present a risk. Health and social services professionals could therefore be called to account for the care provided for an individual with mental health problems following a homicide or suicide.

1.4 National Strategies for Mental Health Services

1.4.1 Health of the Nation

Mental illness was identified as one of the five key areas in the strategy for improving health (DoH 1993). The main issues set out in the government's White Paper were:-

i) to improve significantly the health and social functioning of mental ill people.
ii)) to reduce the overall suicide rate by at least 15% by the year 2000 from 1990 levels of 11 per 100,000 populations.

iii) to reduce the life time suicide rate of severely mentally ill people by at least 33% by the year 2000 (from the life time estimate of 15% in 1990 to no more than 10%).

1.5 National Service Framework

The National Service Framework (1999) set national standards and defined service models for promoting mental health and treating mental illness in five key areas: mental health promotion, primary care and access to services, effective services for people with severe mental illness, caring about carers and preventing suicides. The National Service Framework (1999) was developed in response to the government’s strategy set out in Modernising Mental Health Services to ensure:

- safe services to protect the public and provide effective care for those with mental illness at the time they need it
- sound services to ensure patients and service users have access to the full range of services which they need
- supportive services to work with patients and service users, their families and carers to build healthier communities.
In preventing suicide the National Service Framework (1999) required that:

- local health and social care communities promote mental health for all, working with individuals and the community
- deliver high quality primary health care
- ensure that anyone with mental health problems can contact local services via the primary care team or Accident & Emergency department
- ensure that individuals with severe and enduring mental illness have a care plan which meets their specific needs, including access to service around the clock
- provide safe hospital accommodation for individuals who need it
- enable individuals caring for someone with severe mental illness to receive the support which they need to continue to care and in addition
- support local prison staff in preventing suicides among prisoners
- ensure that staff are competent to assess the risk among individuals at greatest risk, develop local systems for suicide audit to learn lessons and take any necessary action.

1.6 National Strategy for Suicide Prevention

More recently the national strategy for suicide prevention was introduced to support the targets set in the White Paper – ‘Saving Lives: Our Healthier Nation’ (1998) and to reinforce the National Service Framework (1999) for Mental Health standard six, aimed at reducing the death rate from suicide and undetermined injury by at least a fifth by the year 2010. This strategy also acknowledged that suicide prevention was not the exclusive responsibility of any one sector of society, or the health service alone. It further acknowledged that people with mental health problems are a high risk group therefore
mental health services have a vital part to play in the prevention of suicide. However information available suggested that about three quarters of people who commit suicide were not in contact with the specialist mental health services (Appleby 1999). Therefore suicide prevention should be viewed as the responsibility of every one, including the general public. The suicide strategy therefore aimed to:

- reduce the availability and lethality of suicide methods
- reduce risk among high risk groups
- promote mental well-being in the wider population
- improve the reporting of suicidal behaviour in the media
- promote research on suicide prevention
- improve the monitoring of progress towards the saving lives: Our Healthier Nation target for suicide reduction.

The above government strategies aimed at improving the health of the nation have further demonstrated how vital it is for health and social care professionals to assess the needs of individuals, especially those in high risk categories to ensure that risks are identified at an early stage, and appropriate management strategies formulated and implemented effectively. It is also important to acknowledge that the emphasis on suicide reduction in the general population has been strengthened in the various government strategies such as the White Paper (1997) and the National Service Framework (1999). However, it can still be argued that there is no national risk assessment tool to support professionals' clinical judgement when assessing risk in people with mental health problems. Risk assessments are therefore inconsistent as there is no nationally agreed standard. The development of national strategies also indicate that the government will continue to monitor the care provision for people with
mental health problems by health and social care professionals in their effort to prevent self harm and harm to others.

1.7 Local Issues

In the Trust where the study was conducted the Trust Board had identified that there was an urgent need to review current documentation for all professionals and to incorporate effective risk assessment and risk management in all areas of patient care. The need for a review of current risk assessment and risk management procedures had come about as a result of an external inquiry following a serious incident in the Trust. Clinical risk management has also become a major issue for the Trust as it has to demonstrate that there are systems in place to support staff in the management of risk in order to be included in the Clinical Negligence Scheme for Trusts, which insures NHS Trusts against litigation.

Another major issue for the Trust is that currently all professional groups have their own health care records for individual patients. This means an individual patient could have two or three opened health records which do not communicate with each other. As a result of these different systems, information on risk assessment and risk management are not always accessible to all professionals involved in providing care for the patient. The current systems within the in-patient services consist of separate nursing notes, medical notes and other case notes for other professionals such as occupational therapists involved in providing the care. Community case notes are integrated in part by the professional groups, but not in all community teams. The Trust therefore is currently in the process of developing one set of integrated case notes for each patient to ensure
that all health and social care professionals have access to the same clinical information which should improve risk assessment and management practices.

1.8 Working Definitions

Risk management is a systematic process of assessment, identification and reduction of risk to people and the prevention and avoidance of untoward incidence and events (Merrett 1995). Risk is identified as the likelihood of an event which may be positive or negative occurring in response to changes in an individual's personal circumstances (Snowdon 1977). This risk can then be identified through a systematic process of examining past risk incidents in the light of current circumstances (Morgan 1998). Risk assessment therefore is a process that allows an examination of the contents and the details of past risk incidents, and its implications for the current situation. From this, predictions and judgements of the future likelihood of risk behaviour are extracted. For the purpose of this study violence will be defined as an expression of despair, through an extreme and forceful delivery of actions and emotions, inflicting harmful and damaging effects to self and others. Violence will include actual physical assault on another individual, extreme outpour of verbal or written threats and damage to property (Morgan 1998).

Suicide and self-harm are defined as the inflicting of damage or injury to self, with an intention of relieving extreme tension or distress, or drawing attention to a need for help, or causing death. This include suicidal behaviours with a planned intent, suicidal behaviours as a call for help, attention through cutting or mutilation, and abusing or addictive behaviours with the intention of inflicting harm or injury (Morgan 1998). Severe self-neglect is defined as the act of disregarding care for self, with the consequence of
serious risk to personal health and well-being. Degrees of self-neglect may endanger other people who come into contact with the individual (Morgan 1998).

The study therefore focused on the following key risk variables: suicide and self-harm, aggression and violence towards others and in addition self neglect. The rationale for including the risk of violence, self-harm and suicide in this study was due to growing recognition that suicide is the most significant consequence of psychiatric disorders and that most major psychiatric disorders carry a high suicide risk (Appleby 1992). There is also an acknowledgement that both suicide and violence carry major consequences which could lead to the loss of life (Appleby 2000). The national confidential inquiries into suicides and homicides have consistently identified factors which related to both suicide and violent behaviours leading to suicides and homicides (Appleby 1998, 2000). Evidence also suggests that mental disorders have association with violent behaviour (Wessely 1997) with Gunn (1997) suggesting the need for balance of perspective on suicide risk as the risk did not only involve individuals killing themselves but also the killing of others. It is also accepted that both nationally and internationally there is media preoccupation with harm to others by people with mental health problems (Monahan 2002). National directives and policies such as the National Strategy for Suicide Prevention (2002) and the National Service Framework (2000) have emphasised the need for suicide prevention and the prevention of harm to others by people with mental health problems. It was the combination of these factors which prompted the researcher to include the key risk behaviours namely, suicide, self harm and violence in this study as the evidence suggested that there was an association between the risk of self harm, suicide, violence and mental disorder. It was therefore imperative that this study considered the totality of the key risk behaviours associated with mental disorders.
For the purpose of this study, severe mental illness will include patients who have a diagnosis of schizophrenia, psychotic symptoms and depression with and or without alcohol related problems and are regularly in contact with the mental health services. It will also include patients admitted to the mental health services within the period of December 2000 to December 2002 and remained with the services either as in-patient or community patient for a period of two weeks or more.
Chapter 2

2. Literature Review on Risk Assessment and Risk Management

2.1 Introduction

Risk management has become a fundamental issue over the last few years following the publication of high profile incidents in England and Wales involving people with severe mental illness (Sheppard 1996). The need for professionals such as nurses to understand the phenomena of risk to enable them to manage risk has become a high priority on the national agenda as a result of the national strategies for mental health (National Service Framework 1999, National Strategy for Suicide Prevention 2002). Snowden (1997) defined risk as the likelihood of an event occurring, an event which may be positive or negative. Risk has also been defined as being fundamentally about uncertainty with variation in possible outcomes and the inability to predict with 100% accuracy the outcome of a situation (Vinestock 1996). Risk assessment therefore involves the examination of the context and the details of past risk incidents, in the light of current circumstances to extrapolate the predictions of the future likelihood of risk behaviours (Morgan 1998), whilst risk management involves the development of treatment strategies (medical, psychological, social) within a multi-professional context, involving patients, carers and significant others to reduce the severity and frequency of the identified risk (Reed 1997).

In general, the process of managing risk involved, firstly, identifying the risk presented by the patient. This could be a single risk such as suicide or a complex risk such as self -
harm and/or violence to others, or relapse of illness due to not taking prescribed medication. To identify the risk presented, the professional have to assess the patient. This assessment is based on the professional's knowledge of the patient, information given by the patient, knowledge of risk behaviours and risk predicting factors, the possible outcomes, and likelihood of the outcome if the risk is taken (National Health Service Executive 1994) before a judgement is made about the possible outcome based on the severity and frequency of the risk behaviour identified.

2.2 Risk Assessment and Management

Clinical risk assessment and management in psychiatry has become a permanent feature on the national agenda to ensure that people with mental health problems in the community or in-patients services presenting with risk behaviours are identified and the risk they present minimised. Mental health organisations in the voluntary sector such as the ZitoTrust' and 'MIND' have also expressed concerns about the care in the community for the mentally ill following a number of high profile incidents reported by the various national and local inquiries (Sheppard 1996). The confidential inquiry into homicides and suicides in England and Wales by severely mentally ill found that over a period of eighteen months, a total of 34 homicides were committed by people known to the specialist psychiatric services (Boyd 1994).

Various national inquiries into homicides have all expressed concerns about the failures by health and social care professionals to protect individuals with mental illness and the public from suicides and homicides (Bloom-Cooper 1996, Ritchie 1994). Previous editorials and studies in risk assessment and management focused on areas such as criminology and dangerousness (Pollock and Webster 1990, Monahan 1994, Gunn
1984). Recently there has been a shift and most editorials and studies have focused on risk in people with mental illness within general psychiatry (Ryan 1996, Walker 1997, Bates 1995, Thomas 1998, Lidz et al 1993, Mulvey 1994). However, the available data on risk assessment and management have focused on professionals in the field of medicine and psychology professionals with very limited information on nurses' knowledge and ability to assess and identify risk in people with mental health problems.

The various editorials focused mainly on issues such as the importance of accurate record keeping, effective communication systems, informed consent, supervision for junior staff and continued education for professionals (Merrett 1995). The editorials also gave advice and expressed opinions on how risk can be managed to avoid negligence with emphasis on the need for organisations to develop risk conscious staff to minimise the risk of high cost litigation (Merrett 1995). It can be argued that these editorials are individual views and opinions therefore not evidence based, are diverse and not scientifically validated. It has been asserted that risk can be managed effectively only if factors likely to lead to clinical accidents such as inadequate training and the supervision of staff are identified and managed by those providing the services (Bingley 1994). It has also been acknowledged that the management of risk is central to the long-term success of other initiatives directed at increasing service quality and effectiveness. The management of risk is also central to health care and is the responsibility of all direct care givers and those who manage services. It is therefore expected that mental health facilities and, in particular, acute psychiatric facilities and those that provide secure care have to manage the risk that patients may either harm themselves or others around them (Bingley 1994, Jones 1993, Greetham 1994).
Various studies and editorials criticised the inadequacies in professionals' ability to assess risk and suggested that professionals must develop clinical skills to enable them to assess risk (Modestin 1987, Morgan 1993, Ritchie et al 1994, Bloom-Cooper et al 1995). However, these authors have not specified specific skills required by clinicians or indicated whether all clinicians should be able to assess risk following a period of professional and or additional training. Others have argued that poor prediction of risks are due to risk incidents being rare and the predictions being crude as research studies continues to focus on completed events which can not be generalised as accurate predictors (Hawton 1994). There are indications that short-term and long-term risks are different and that most risk factors with exception to gender fluctuate. Evidence also suggested that other studies have focused on generalised group characteristics, which are not necessarily helpful for prediction with individuals (Hawton 1994).

Reed (1997) supported Hawton's (1994) findings and indicated that professionals have a good general understanding of risk factors, but had difficulties in bridging the gap from general risk factors to particular risk factors. The literature revealed that in relation to violence, there was a diversity of evidence which suggest that the prediction of risk differ widely on almost every point except that, professionals are not very accurate at predicting violence (Modestine et al 1988). It is suggested that in response to the professionals' poor predictive abilities, the professionals' become overcautious and restrictive in their practices (Modestine 1986, Monahan 1988, Bacon 1997). It has also been argued that risk assessment involved the concept of dangerousness and the prediction of violence and aggression Gunn (1997). However, it has been suggested that the process of prediction in risk assessment is much broader. It is a process which encompasses the identification of risk that an individual may present through a process of discussions with the individual. It involves the assessor having domain specific
knowledge of risk behaviours and risk predictors. It also involves discussions with
carers, reviewing available records and discussions with other professionals who may
have had or continue to have contact with the individual to enable a judgement to be
made about the risk presented.

Gunn (1997) also suggested that there has to be a balance of perspectives on suicide
risk as it does not only involve an individual killing themselves but also the killing of
others. There has been a number of debates on how risk assessment must be
completed. Monahan (1997) advocated that statistical (actuarial) techniques best predict
risk. He argued that statistical techniques (actuarial) have been used in criminology to
predict risk over the years whilst general psychiatry on the other hand have relied on
clinical judgement until recently. He went on to suggest that the use of actuarial
predictions in general psychiatry is not evident as most clinicians relied on their clinical
assessment to make judgements as to the level of risk an individual presented. Harrison
(1993) suggested that additional research was needed to determine the degree to which
the validity of actuarial predictions can be applied to other populations.

It is acknowledged that risk assessment and management is vital to the care provision
for people with mental illness. It is also central to the quality of care provided by health
and social services. However, to date there is no centralised directive from either the
Department of Health or the National Health Service Executives that risk training should
be mandatory for all health and social services staff who provide care for the mentally ill.
There is no standardised risk assessment and management training nationally to enable
health and social care professionals to transfer their knowledge to any area of practice
as every Trust and organisation have developed training processes to meet the
institutions needs. Until recently the internal market in health care meant there was no
sharing of knowledge, experiences and skills on risk assessment and management within the National Health Service hospitals.

Although available literature has established factors that predicted risk in people with mental illness, there has been a tendency to focus on specific diagnoses and specific risk such as suicides in depressive illness and suicides in people with schizophrenia and or violence and dangerousness in people with schizophrenia (Drake et al, 1992, Strosahl et al 1992, Gunn 1988, Monahan 1988, Monahan 1996, Gunn 1977, Wilson 1996, Steadman et al, 1970, Monahan 1980). Other aspects of risk factors such as severe neglect and exploitation of people with mental illness have been ignored. More recently the literature has begun to focus on the impact and association of drugs and alcohol misuse and risk for people with mental health problems.

2.3 Suicides in People with Schizophrenia and Depression

The Health of the Nation (1992) targeted a 15% reduction of suicides in the general population and a 33% reduction of suicides in people with mental illness by the year 2000. However, evidence from the literature indicate that not all suicides can be prevented as young men found to be in the high suicide risk group were also identified as the group least likely to seek help (Morgan 1993). The national inquiry into suicides and homicide also concluded that most suicides were committed by people who have seen their GP’s in the last three months leading to the suicide or were in contact with psychiatric services (Appleby 1999). In the late 1980’s there was a view that a population approach to suicide prevention may reduce suicide rate in the general population (Regier et al 1988). In the late 1990’s House et al (1999) suggested that the prevention of suicide should not only be focused towards the high risk groups but also
needs to include the general population. This view was supported by Regeir et al (1988) who suggested a process of public education as a means of reducing the risk of suicide. However, the current debate on suicide reduction in the general population is focusing on limiting accessibility to suicide means such as, limiting the amount of medication (paracetamol) that can be purchased at one time and reducing the lethality of carbon monoxide fumes (Department of Health 2002).

The debate about whether to target the high risk groups or the general population in suicide reduction does not appear to have influenced the national agenda as the government strategy required health care professionals to target the severely mentally ill when planning and providing services (Care Programme Approach 1999). This strategy ensured that high-risk groups are targeted even though the Health of the Nation (1993) targets included reduction of suicide among the general population. The strategy does not indicate how health professionals were to achieve these targets. Therefore achieving these targets for the high risk groups may present difficulties, especially, since professionals must be able to accurately identify those presenting high risk and demonstrate understanding of the factors that prevent suicide in this group before preventative measures can be applied in the reduction of suicide risk (Appleby 1992).

Previous studies by Barraclough et al (1974) and Morgan (1979) showed that in England drug overdose accounted for two-thirds of suicides among women and one-third among men. Drugs most commonly used were analgesic and antidepressants. Symonds (1995) also identified death by physical means such as hanging, shooting, falling in front of moving vehicles or trains, wounding, drowning, and jumping from high places. Barraclough et al (1974) and Morgan (1979) established that two-thirds of the people who committed suicide had consultations with their GP’s within the previous month and
40% had consultation with their GP's within the previous week. A quarter were out-patients who had seen a psychiatrist a week prior to the suicide. More recently Appleby (1999) has identified similar findings to that of Barraclough et al (1974) and Morgan (1978) in the confidential inquiries into homicides and suicides.

Appleby (1999) also reiterated that professionals’ ability to manage risk has not improved since the late 1970's and that they continue to fail to identify patients who are at high risk of self harm or harm to others. Appleby (1992) further argued that risk protective factors were not simply images of the risk the individual presented, but that there were circumstances which in the presence of considerable risk, act preventively without altering the risk factors themselves. Unfortunately there is no evidence to suggest that these protective factors are commonly known to professionals involved in assessing the risk. Few studies have investigated what prevents an individual from killing themselves (Appleby 1992). A comparative study between in-patients who have thought of suicide and those who have carried out para-suicide gave their reasons for living as concern for children, religion and fear of pain as the commonest reasons for not attempting suicide, with concern for children being the most powerful protective factor for high risk groups (Linehan et al 1993).

Studies dating between the 1970’s to 1999, have consistently indicated that in-patient suicide occurred either in the acute phase of psychotic relapse, first week of admission, at the time of clinical improvement or often when there were problems in planning discharge (Gale et al 1980). Studies showed that that 18% of patients died within one week of discharge, 44% died within one month, 89% died within one year, 90% died within one month of their last out-patient appointment (Roy et. al. 98). Similar conclusions have also been identified in the confidential inquiries into homicides and
suicides (Appleby 1999). Over the decades, the trend has remained unchanged with the same issues continuing to be identified as health and social service professionals continue to fail to identify individual at immediate risk of suicide (Appleby et al 1999, Barraclough 1978).

Appleby (1992) asserted that although risk-predicting factors were common in psychiatric disorders, professionals did not seem to use these factors to predict risk accurately. Thomas (1995), Monahan (1980), Gunn (1988), Steadman (1970), Drake et al (1992) and Strosahl et al (1992) identified high risk predicting factors in suicide as:- demography- age, sex, race, previous deliberate self harm, social-economic status, previous sexual assaults, mental state, suicide statements, stress, seriousness of previous attempt, severity of mental disorder, type of mental disorder, treatment available, family support, personal relationships, availability of means, time, availability of drugs and alcohol, preparatory acts, attitude towards death, declared intentions to others and suggested that these factors should be considered when assessing risk in people with mental illness.

The literature on the international perspective on suicides highlighted factors such as insomnia, impaired memory and self-neglect and anxiety symptoms, difficulty concentrating and alcohol abuse as short term risk predictors whilst hopelessness, mood cycling and history of suicide behaviour (para-suicide) were identified as long term risk predictors (Thomas 1995, Monahan 1988, 1994, Drake et al 1984, Fawcett et al 1990, Isometsa et al 1994). These authors concluded that a more direct predictor of suicide intent was the importance attached to survival and coping beliefs rather than the feeling of hopelessness, depression and negative life stresses. Positive personality features such as survival and coping beliefs were also found to have an influence on risk. Their
absence removed the important defence against suicidogenic behaviour, which made individuals' belief that suicide was the only solution. This played a major role on the individual's attitude towards suicide beliefs and intent (Strosahl et al 1992).

Other emerging theories have asserted that para-suicides may possess both a problem solving and an expressive statement of emotional pain and hopelessness components. Jonsson (1986) supported the view that a direct assessment of an individual's perception of suicide as a problem solving behaviour was valuable in the prediction of high-risk patients. A study on suicide among people with schizophrenia involving the review of clinical charts and death certificates concluded that the completed suicides were young, unemployed and unmarried with good educational background, a downward drift in social status. They had committed the suicide while depressed and feeling hopeless but not when in a psychotic state of the illness. The majority were male with chronic illness and numerous exacerbations and remissions and many had made previous suicide attempts (Strosahl et al 1984 and Drake et al 1984).

Drake et al (1984) further stated that schizophrenic patients who killed themselves had developed awareness during remission and then became unable to accept the limitations brought on by their chronic illness. This resulted in depression and hopelessness. These findings are supported by Beck et al (1975) who asserted that negative future expectations was a strong link to suicide behaviour. Strosahl et al (1992) also showed that hallucinations and delusions were not a major contributing factor to suicidal behaviour. They found that schizophrenics who committed suicide became ill at an early age, had difficulties with employment, needed longer hospitalisation, and demonstrated more negative psychosocial behaviour. All of which was supported by
Drake et al (1984) and Strosahl's et al (1992) assertion of a downward drift in social status as the illness progressed. Other psychosocial difficulties identified as having direct link to suicide behaviour include, unemployment, incapacity to work, past suicide threats, and suicide acts (Drake et al 1984, Roy 1982, Allebeck 1987). Other authors established that predictions of suicides in schizophrenic patients was difficult as only a few gave any warning of mood changes, however, they all agreed that a history of previous self harm was an important factor to consider when making decisions on levels of risk.

It has been suggested that the lack of warning signs from schizophrenics could account for why General Practitioners and psychiatrists were and are still failing to identify high risk people who go on to commit suicide as identified in the confidential inquiries and other studies (Appleby 1999, Barraclough 1988). However, these inquiries did not indicate the risk assessment training that General Practitioners and psychiatrist have had in comparison with other professionals such as nurses and occupational therapists to support their clinical decision-making in risk assessment and management. Neither did the inquiries report if the professionals assessed risk at each consultation with a patient. This suggested that the lack of standardised processes and structures including the diversity of views and opinions about risk predictors all contribute to the difficulties professionals have in assessing and managing risk. The gaps in the procedure for assessing risk leads this researcher to propose a need for further studies to explore how General Practitioners, psychiatrist, nurses and other professionals make decision about risk during consultation with their patients and to establish their knowledge base of risk assessment.
A study with 93 people measuring the severity of suicide behaviour using the schedule for affective disorders and schizophrenia suicide subscale for the Kruskal-Wallis test and the correlation between age, gender, type of affective illness, psychosis, race and mania subtype concluded that gender and psychosis were not related to suicidality (Dilsaver et al 1994). However the subtype of mania had the strongest relationship to suicidality therefore indicating that the presentation of a manic state is an indicator for careful assessment of depressive symptoms and suicidality. Neuringer et al (1974) suggested a link between suicide attempter's intent and lethality of the method chosen. However, they further indicated that men with shot gun wounds varied in their intent even though shot gun wounds have high fatality results and indicated the need for a rethink about the link between intent and lethality of methods used.

The literature highlighted the difficulties professionals have in identifying risk predicting factors and the levels of the risk presented, as intent and suicide methods could not always be relied upon as the only guide in making judgement about the levels of risk presented by the patient. Different methodologies have been used by researchers in an attempt to establish how professionals assess the risk of suicide. These have included retrospective blind chart reviews of hospital medical notes. Emergency room and psychiatric consultations, comparing patients' records following a set of criteria by two raters and interviews with clinicians to verify suicide status. Self reporting psychiatric consultation to verify suicide status, self reporting studies and questionnaires to clinicians, longitudinal study with follow-up of patients discharged from institutions. Outcomes studies, information on death and analysis of unexpected deaths amongst patients, and interviews with carers and professionals who have knowledge of the clients, (Morgan et al 1993, Monahan & Steadman 1988, Modestin et al 1992, Drake et al 1984, Grootenhuis et al, 1994, Spirito et al 1990, Pollock and Webster 1990).
Evidence from the various studies suggests that records are not a reliable method of data collection (Drake et al 1984). As such studies do not inform on the level of experience of the professionals involved in the studies or the client groups they had assessed. It also does not give any specific risk assessment tools or scales that the professionals have used in their assessment to support clinical decision making. These activities were absent from the studies reviewed therefore their effects on the outcomes could not be evaluated. Some methodologies lacked clarity about definitions of mental illness and made inadequate comparisons between groups due to difficulties in finding comparative group therefore the results could not be generalised. (Mulvey 1994, Ryan 1994, Bates 1995, Rose 1998, Steadman 1990)

2.4 Self Harm

The need to reduce self harm behaviour in people with mental health problems and the general public has become top of the national agenda with national guidelines for self-harm prevention (Self-harm Prevention 2004). Hawton et al. 2002 suggest that many acts of self-harm do not come to the attention of healthcare services therefore hospital attendance rates may not reflect the true scale of the problem. The studies also asserted that overall women were more likely to self-harm than men and concluded that self-harm can occur at any age Hawton et al., 2002, Meltzer et al 2002). However self-harm was most common in adolescence and young adulthood with only about 5% of all episodes of self-harm occurring in people over the age of 65 (Hawton et al., 2002).

The literature affirms that self-harm occurs in all section of the population (Meltzer 2002) but is more common among people on low income, single, divorced, single parents or
people with no social support. Hawton et al (2002) found that the likelihood of self-harm and the number and types of adverse events that a person reported suggest a strong association between life events and self-harm. Hawton et al (2002) further reported that most people who attended accident and emergency department following acts of self-harm met the criteria for one or more psychiatric diagnosis. He also suggested that about one-half of people who attended Accident and Emergency department following self-harm had consumed alcohol immediately preceding or as part of the self-harm episode and about one third of those who self-harm had been misusing drugs or alcohol on a regular basis with a higher rate in men (Hawton et al 2001).

2.5 Risk Assessment of Violence and Dangerousness in People with Schizophrenia and Depression

Scott (1977) defined dangerousness as an unpredictable and untreatable tendency to cause irreversible injury or destruction, or to incite others to do so. Floud (1982) argued that risk was a matter of fact, but danger was a matter of judgement or opinion. Alberg et al (1996) asserted that the term ‘dangerousness’ is often used to describe a potentially violent mentally ill person. They continued to argue that in contrast to risk, dangerousness concerned a subjective judgement made about an individual, identifying a static, enduring trait, inherent in the individual, whereas, risk was a characteristic of an individual’s response to his or her changing situation and may include more than one outcome.

Studies over the last 10 years have explored whether the risk of violence and dangerousness can be predicted (Gunn 1990, Monahan 1988). Reviews of the literature
in the 1980’s indicated that risk of violence and dangerousness could not be predicted accurately (Gunn 1988). However, Monahan (1988) argued that there was need for caution in the generalisation of the findings as the studies have focused on people released from institutions into the community, therefore the results could not be generalised. The MacArthur study (1996), on violence concluded that six homicides were committed by former patients and that most incidents of violence occurred in the first month after release from hospital. They concluded that drug or alcohol misuse combined with a mental disorder increased the risk of violence (Monahan 1996). On the prediction of violence amongst psychiatric patients Monahan (1996) indicated that it is possible to predict psychiatric patients who will become violent after releases into the community. The evidence suggested that professionals are able to predict violent behaviour in the mentally ill better through risk assessment than by chance (Lidz et al 1993). There was also a suggestion that the negative opinion about professionals’ inability to predict violence might be due to shortcomings in the way studies were conducted (Swanson et al 1990).

Other factors identified as increasing risk included refusal to continue treatment, inability to function effectively in daily life, several changes of residence, poor anger control and an impulsive personality with poor behaviour controls, violent fantasies and pervasive delusion (Monahan et al 1996). Similar findings have also been identified in the United Kingdom by the various inquiries into homicides and suicides by the mentally ill (Bloom Cooper et al 1995, Ritchie et al 1994). Studies by Steadman et al (1974) also concluded that individuals leaving institutions frequency of committing violence in the community was low, therefore the view that mentally disordered people committed more violent offences was not sustained. Research from the 1980’s until recently did not appear to support the link between violence and mental disorder. However, reviews in the literature
have indicated that there is a link between mental disorder and violence although the link is weak (Swanson et al 1990, Monahan 1992).

Wessely (1997) asserted that there is growing recognition that mental disorder has an association, albeit small with violent behaviour. He highlighted the divergent opinions regarding the link between violence and mental illness by drawing attention to criminologists and forensic psychiatrists who contradicted each other. Wessely (1997) continued to argue that such divergent views did not promote confidence in practitioner's ability to predict risk. Monahan & Steadman (1983) also argued that there was no consistent evidence to support the view that the time prevalence of criminal behaviour among former mental patients exceeds true prevalence of criminal behaviour among the general population. Therefore findings from the criminology studies could not be generalised into the general population.

Recent research has indicated that clinicians had little predictive ability concerning violent behaviour and the mentally disordered (Huxley et al 1996, Monahan 1996). In an international collaborative study involving six countries and 169 raters from different professional backgrounds, raters were asked to indicate the degree of dangerousness by reviewing 16 case histories. The outcome indicated low agreement between the raters. The evidence indicated that psychiatrist tended to rate individuals as more dangerous than the other professionals (Montandon 1984).

In an earlier study on the prediction of violence, Steadman et al (1982) investigated the accuracy of psychiatric predictions and the gains achieved from using statistical equations obtained from one study group to predict assaultiveness in two comparative groups through a retrospective analysis. They concluded that assaultive behaviour was
setting specific which implied that not all findings could be generalised. This led Montandon et al (1994) to assert that psychiatrists and psychologists were only accurate in one in three predictions of violent behaviour even though it was expected that these health professionals should be able to assess risk and take appropriate actions to manage the identified risk.

Mulvey et al (1993) compared patients rated by clinicians as potentially highly assaultive on the ward, and patients who were involuntary committed on the grounds of danger to others, with a comparative group of patients predicted by clinicians not to be assultive and patients admitted for reasons other than danger to others by reviewing charts to establish if any violence acts, seclusion for violent acts or threats of violence. They concluded that clinicians were able to predict violence in the short-term. They argued that there was a need for concern, as the concept of dangerousness did not have the same meaning for all professionals (Mulvey et al 1993). This supports this author’s view that studies on risk assessment and management must involve other professionals such as nurses as until now studies have only included doctors, psychologists and social workers.

Carson (1985) argued that the under prediction of violence may have been due to under reporting of violence incidents. Wessely (1997) highlighted the divergence between criminological and medical views on mental disorder. He argued that criminologist believe that mental illness is not a significant cause for crime, however, psychiatrists experiences, together with sound epidemiological work indicate that those charged with homicide have a higher rate of schizophrenia compared with population base rate from the local population. The literature therefore is contradictory, as criminologists have concluded that mental illness is not a significant factor in the causes of crime yet
psychiatrists have concluded that there is a higher rate of criminality in the mentally ill population than in the general population (Wessely 1997)

The behaviours identified by the various authors to predict high risk of violence included, age, sex, race, previous violence, social-economic status, substance abuse, intelligence, marital status, detailed history, substance abuse, criminal history, mental state, treatment, seriousness of previous aggressions, seriousness of mental disorder, type of mental disorder, treatment available, family support, personal relationships, employment, availability of victims, availability of weapons, availability of drugs and alcohol, declared intentions to previous victims, declared intentions to potential future victims and declared intentions to caring staff (Thomas 1995, Mulhurn 1984, Monahan 1980, Gunn1988, Steadman 1970, Drake et al 1992, Strosahl et al 1992, Dyer 1996)
The authors suggested that these factors should be considered when assessing risk in people with mental illness.

Brooks (1984) identified seven risk factors, these included the nature of harm involved, its magnitude, its imminence, its frequency, the likelihood or unlikelihood that it will occur, situational circumstances and conditions that affect the likelihood of harm occurring. He recommended that balancing the alleged harm with the nature of society's intervention should be considered when deciding whether an individual was dangerous. Binder and McNiel (1987), Monahan (1988), Steadman and Morrissey (1982) focused on the difficulties in identifying reliable risk variables. Binder et al (1987) asserted that risk-predicting factors of violence in patients are reduced two days after admission due to the effects of medication therefore past studies on violence by in-patients have been difficult.
Monahan (1988) argued that researchers in the past have designed their own risk variables and risk predicting criteria instead of replicating existing studies hence progress on further research have been hindered. Mullen (1992) highlighted various British studies such as Bowden (1991), Robertson (1983) which all concluded that patients discharged from high secure hospitals in a followed up over a 15 year period were found to have re-offended with most of the offences being violent in nature with some homicides. These authors all agreed that the most common predictor of violence in the ex-patients was the extent and types of previous convictions. Mullen (1982) suggested that the most accurate evidence on the probability of dangerousness points to previous records of violence with age as a significant factor among the young. The diagnosis of mental illness on its own was not a predicting factor. Despite the vast amount of literature on risk assessment, there is very limited empirical data on risk management and even more limited information on risk in people with mental illness within general psychiatry. Until recently the majority of the studies and editorials focussed on forensic psychiatry and criminology.

Authors such Ryan (1994), Lidz et al (1993) and Thomas (1995) suggested the need for accurate assessments but acknowledged the difficulties professionals have in assessing risk effectively as traditionally professionals have been unreliable in their assessment and prediction of risk. Lidz et al (1993) argued that problems with various studies have been due to the use of unreliable hospital records and other data collection methodologies. Various authors have also suggested that there was a need for policies and standards to support professionals in the management risk (Harrison 1997, Wilson 1996, Tingle 1997). They argued that such policies and standards must reflect the views of professional bodies such as, medical or nursing opinions and relevant specialities.
Walker (1997) and Thomas (1995) identified accurate documentation and communication as vitally important for all professionals in the management of risk. Other suggestions made by these authors included the development and use of clinical guidelines for professionals to clarify standards and ensure consistency in approach and process (Wilson 1996, Campbell 1997, Tingle 1997). These issues also gained strong support in the confidential inquiries into homicides and suicides in England and Wales (Bloom-Cooper et al 1995, Bowden 1995, Morrison 1996 and Sheppard 1996). Despite the acknowledgement of the difficulties professionals have in identifying risk in people with mental health problems, there is no national agreed guideline on the documentation of risk factors.

Limitations of these findings are that the majority of the information available are editorials. However, they all identified risk predicting factors and agreed the processes for identifying risk and developing risk plan management strategies (Wilson 1998, Walker 1997). The authors demonstrated their authority on the subject of risk assessment and management by validating each other in the identification of risk predicting factors. The evidence suggested that most of the studies had focused on the more dangerous aspects of offending behaviour, in particular, homicides, and highlighted the increase in homicidal behaviour in the mentally ill. Most of studies have been carried out on people discharged from institutions such as prisons therefore the results could not always be generalised in general psychiatry (Gunn 1977, Monahan 1988, Klassen and O'Connor 1988). The editorials did not describe any standardised format or criteria for selecting subjects, however, the studies indicated that diagnosis using International Classification of Diseases and Diagnostic Statistical Manual IV criteria have been used to select subjects and randomised methodologies have been
used to select the case note for both prospective and retrospective analyses (Modestin et al 1994, Drake et al. 1984).

2.6 When Should Risk Assessments be Completed?

Most authors agreed that suicide behaviour occurred during the acute phase of psychotic relapse, the first week of admission, one month after admission, when there was clinical improvement, when planning to discharge from inpatients, one week after discharge from in-patient care, within one month of attending out-patient, during the first year as an out-patient, or within the last month of out-patient appointment (Appleby 1992). This supported the view that risk assessments should be completed at certain critical periods in the patient’s journey through the health care system such as at the point of admission, changes in mental state before discharge and during changes in the care provision. Other authors argued that risk assessments must be continuous as observations made between when patients are seen by the medical staff and what nurses observe are crucial in clinical decision-making (Wilson 1996).

Morgan (1997) suggested that risk assessments must be completed at a point when deciding to admit a patient into in-patient care and when deciding to discharge the person who has presented some risk behaviours in the past, into the community. This suggestion is supported by the Department of Health Service Guidelines (94/27) which states that, before a patient is discharged from hospital, professionals must ensure that “any risk to the public or to the patient themselves, is minimised and is managed effectively”, and also that “no patient should be discharged from hospital unless and until, those taking the decision, are satisfied that the patient can live safely in the community”.

46
Thomas (1995), Lidz (1993) on the other hand stated that assessments must be completed on admissions, but as most professionals are aware, risk presented by patients, is not static therefore, a one off assessment on admission alone, is not enough to ensure that effective management is implemented. Gunn (1994) argued that risk assessment must be completed over short periods of time, whilst Huxley et al (1996) suggested that risk assessment should take place within a stated time scale to improve its predictive value. These authors asserted that it is easier to predict outcomes in the short term (weeks) rather than in the long term (years) and that ongoing process of risk assessment rather than a snapshot increased the predictive accuracy.

Studies on decision making have also highlighted the complex cognitive process required which enabled the professional to make a judgement based on the problem presented. It is suggested that in order to make a judgement of the risk presented the professional should be able identify important features, retrieve other information from memory and to organise the information in a meaningful (Pitz et al, 1984). They further suggested that professionals may experience difficulties in making decisions over periods of time due to the inability to retrieve information from memory.

2.7 Who Should Undertake Risk Assessments?

Department of Health and Social Security Guidelines (1984) acknowledged that assessment and after care planning could be undertaken by staff other than psychiatrists such as nurses or social workers provided they had proper training and supervision. Some studies have concluded that the content and quality of assessments by nurses are comparable with those made by trainee psychiatrists however Gardner et al (1977)
warned that any claim which suggested that there was no difference between the assessment of a psychiatrist and a non psychiatrist must be viewed with caution.

2.8 Risk Assessment Scales

Morgan (1990) asserted that assessment scales such as Beck's Suicide Ideation and Suicide Intent Beck Hopelessness Scale, Global Assessment of Functioning Scale were useful in supporting clinical assessment as they enabled the professional to make a judgement on the condition or behaviour presented. However, Morgan (1990) stated that the assessment scale were only useful if used in conjunction with clinical assessment, as the scales themselves do not predict risk. Strosahl et al (1992) examined the efficacy of self rating scales such as the Beck Hopelessness scale, Reasons for Living Inventory scale, Beck Depression Inventory, Survival and Coping Beliefs scale and Live Experience Survey as predictors of suicide intent. They found that the importance associated with survival and coping belief was a direct predictor of suicide intent. However, in practice it is not known if these scales are used by nurses as most professionals have not been trained to use them and or analyse them.

Strosahl et al (1992) and Morgan et al (1995) argued that if these scales were not used correctly they can introduce errors. Also the initial requests to patients on how to complete these scales are crucial to the responses given. For instance if a patient is asked to score using information from a week or more ago, the response may be different to if asked to respond to how they feel today. They asserted that the rating scales by themselves are not very useful as respondents do not always answer truthfully when completing such scales. They further argued that standardised risk assessment scales are only useful in detecting people at high risk of suicide and have a low
predictive power in the vast majority of people who have self-harmed, have low sensitivity and high specificity or high sensitivity and low specificity. It can also be argued that nurses tend to use the rating scales as part of their assessment process, however, many of the nurses are not trained to interpret the scores and their interpretation is therefore purely based on limited knowledge and the final score rather than analysing individual responses for meaning. It can therefore be argued that there are problems with communicating these scores to other professionals as most professionals' do not regularly use them in practice therefore may not be able to interpret them accurately. There was no evidence in the literature about how and who updates these scales.

2.9 Nursing Assessment and Risk Management

Nursing practice is based on the nursing process model which is considered to be a problem solving activity based on a particular model of human action which involved an information processing and a problem solving model (Walton 1995). The nursing process is divided into four sub processes of assessment, planning, implementation and evaluation which are related to the different aspects of decision making.

The first phase of the nursing process is the assessment which involves a critical analysis and evaluation or judgement of the status or quality of a particular condition and situation (Miller & Keane 1987). This begins with the collection of information about the patient's health status and then analysed by the nurse and a nursing diagnosis is made by identifying the patient's problem (Marriner 1983). It has been suggested that during the assessment phase (Schaefer 1974) of the nursing process the nurse searches for cues to determine where the patient is on the health – illness continuum and to predict the level of wellness the patient might reach if present health needs are met. Benner
(1984) agreed that the practitioner's knowledge and experiences were essential components of this decision making process and that the broader the nurse's conceptual knowledge base the wider the range of cues the nurses will discover and use during the deliberation of the decision-making process.

The assumption is that nurses can see their patient objectively and holistically but studies have challenged these assumptions and suggested that nurses see their patients only in specific ways. For instance on a medical or surgical wards the nurses seem to be mainly concerned with the patients physical and medical needs and not the patients psychological needs (Miller 1990). The planning phase in the nursing process is linked to the choice phase of decision making (Schaefer 1974) when alternatives are considered and the most appropriate intervention is chosen and implemented. During the intervention phase the nurse continues to search and gather additional information and reassesses the initial nursing diagnosis to determine whether the patient's condition is improving or deteriorating. The evaluation phase enables the nurse to reassess the interventions implemented and the patient's condition and situation, and then formulate a judgement on whether to continue with the interventions or to discontinue and discharge the patient from the services.

Authors such as Crow et al (1995) identified the cognitive strategies involved in nursing assessments and asserted that there was evidence that the gathering of information in nursing assessment was directed by some internally driven search process. Jacovone et al (1992) also suggested that nurses generated descriptions of physical states in the form of perceptual patterns to direct their search and expert nurses generated outward perceptual appearances which they expected to see very quickly. Prescott et al (1989) also highlighted the importance of the nurse's knowledge of the individual patient and
suggested that nurses developed specific knowledge structures for gathering and organising information about individual patients. Various authors supported this view with her assertion that knowing the patient was an inherent part of the expert nurses' clinical reasoning and that the need to know the patient as an individual was central to individualised care and that the nurses come to know the patient's typical pattern of responses and the patient as a person and use the patient's current presentation in deciding what to do (van Servellan 1982, Tanner et al 1993, Jacovone et al 1992, Corcoran-Perry et al 1990).

2.10 Decision-making and Risk Management

The fundamental principle in risk management is the ability to assess and identify the risk involved and to reach a decision on how to manage the risk effectively. Decision-making therefore involves making a judgement about the risk presented and the possible outcome, then deciding on what to do about it. Carroll et al (1990) and Pitz et al (1984) asserted that decision-making was an activity which involved a sequential process of the presentation of a problem, important features identified, other information retrieved from memory, and the information is then organised in a meaningful way. The individual then explores and classifies the decision situation to ensure they understand the relevant objectives and values, formulates the situation or behaviour presented then generates alternative solutions. The decision maker then chooses a single alternative or attribute or compares alternatives, evaluates the different benefits and makes a judgement as to what is best.

Carroll et al (1990) assertion suggested that decision makers followed a rational process of decision making which involved recognition, formulation, alternative generation,
information search, judgement or choice, action and feed-back. They established that the process involved the individual realising that a decision has to be made. Kahneman et al (1990) however, argued that decision makers did not always follow a rational process as suggested by Carroll et al (1990), but instead decision making involved a shorthand mental activity of recognition, structuring decision situations and the evaluation of preferences to produce a judgement and choice. Betteman (1979) also argued that prior learning habits and exposures reduced individuals' ability to generate alternative solutions to resolve present situations.

Pitz et al (1984) asserted that before a person can respond to the problem presented, they must understand the information and develop a representation of the problem. Johnson-Laird (1981) described this representation of a problem as a 'mental model' that related the problem to other knowledge. Johnson-Laid (1981) argued that in building the mental model, uncertain issues left by the problem such as the unpredictability of future events must be resolved or represented in a model in some way. Tversky and Kahneman (1981) and Slovic et al (1982) argued that the way in which uncertainties are represented in a mental model depends on the way a problem statement is worded, as the wording of the problem may have a marked effect on the subsequent judgement made. Payne et al (1978) and Svenson (1979) supported the view that everyone has a store of decision rules which has been developed through experience and training. The individual therefore tries to achieve a preferred outcome, objective or goal, by deciding on a preferred solution based on the repertoire they have developed through experience and training. The individual then develops a plan to achieve their preferred outcome or goal.
Payne et al (1978) and Svenson (1979) continued to assert that because we cannot hold large amounts of short-term information at once, decision-makers tend to simplify situations to enable them to formulate decisions through the limited information they can hold at one time therefore only dealing with part of the issue and not the whole issue (Newell et al 1972). It was also affirmed by Kahneman et al (1982b) that a person was more able to deal with a problem if the problem has happened before. They argued that if an event was important, the information retrieved from memory can be used accurately to assess relative frequencies. This is supported by Howell et al’s (1982) view that the more information given directly or retrieved from memory the less uncertain the person feels, therefore any task performed using such information will be performed accurately. Decision-making in risk management therefore involved critical thinking to enable the nurse to make a judgement about the risk presented by the patient. Glasser et al (1994) supported the view that knowledge was necessary in critical thinking, however it is suggested that the knowledge has to be domain specific nursing knowledge to enable the nurse to make a decision. The relevance of domain specific knowledge is also supported by Elstein et al (1990) assertion that domain specific knowledge was important to ensure successful clinical reasoning. However Yahiro et al (1994) also argued that experience was also important in decision making as it enabled the nurse to recognise patterns of behaviour and possible outcomes. They argued that lack of experience can affect a nurse’s ability to develop critical thinking skills.

Benner (1984) asserted that practical knowledge is only developed through clinical experience whilst Tanner et al (1993) and Schon (1983) acknowledged the importance of experiential knowledge in enabling the recognition of patterns and intuitive responses in expert judgement. Benner (1984) continued to assert that an expert nurse understood a situation, recognised cues and interpreted them as to what is relevant and what is not
relevant. However, to understand a complex situation, the nurse must have experienced a similar or opposing situation.

The nurse must also possess diagnostic reasoning skills and clinical decision making skills, which will indicate their level of competency. Pitz et al (1984) points out that the basis for arriving at a judgement and decision-making was the use of existing information to gain further propositions about the problem. They also supported the view that the ability to utilise the judgement process was a consequence of many years of learning and maturation. Crow et al (1995) also argued that intuition and domain specific knowledge are used without conscious deliberation when making a decision on how situations must be managed following an assessment. They asserted that nurses use an internally driven information search when making assessments and developed core ideas and opinions from clinical experiences which are generated as situations to expect. These authors agreed with Yates (1990) suggestion that general nursing assessment was about likelihood judgement.

Other authors recognised the importance of tacit knowledge (Herbis et al 2001, Broadbent et al 1986, Dienes et al 1997) and asserted that the acquisition of tacit knowledge was not dependent on the attention or awareness of learning (Reber 1989) therefore its content could not be reflected upon or examined. Herbis (2001) suggested that tacit knowledge was not consciously perceived as guiding ones actions as it worked below a subjective threshold and has complex structures therefore its contents could be ‘naïve’ or have incorrect theories that can not be examined or modified through explanation (Gaines and Shaw 1993, Berry and Broadbent 1988, Dienes and Berry 1997)
Herbis (2001) suggested that expert nurses often reported perceptions they viewed as 'intuition' when describing feelings they have about a patient but could not support those feelings by the presenting evidence. Herbis (2001) argued that these phenomena classified as 'intuition' were often tacit knowledge acquired during experience in a special domain. Various authors asserted that the unpredictability of situations, the impossibility to plan due to constant changing information as well as the necessity to recognise critical situations and to deal with them promptly required experience and intuition and consequently tacit knowledge (Herbis 2001, Benner 1984, Benner and Tanner 1987). It is suggested that tacit knowledge was similar to the heuristics developed by decision makers to enable decision makers to make a judgement based on similar experiences or prior knowledge acquired however heuristics and tacit knowledge are acquired without awareness for learning and therefore not reflected upon their use can negatively influence the decision made if the knowledge used is 'wrong'.

It is acknowledged that the fundamental principle in risk management is the ability to assess and identify the risk involved and to reach a decision on how to manage the risk effectively. Risk decision-making therefore involves making a judgement about the risk presented and the possible outcome, then deciding on the best solution. Risk management also involves uncertainties as future events cannot be predicted with one hundred percent accuracy (Huxley et al 1996, Vinestock 1996). It also involves the nurse making a mental model representation of the risk the patient is presenting by retrieving past information relating to a similar problem from memory, organising the information in a meaningful way, evaluating and integrating the information to enable the nurse to make a judgement (Johnson Laid 1981).
Pitz et al. (1984) acknowledged that the past information retrieved is only stored as a result of experiencing an event or situation and or having knowledge about the situation or event. They further suggested that judgement and decision-making processes will not be complete unless they speak to the representation of the problem stored as a result of how prior experience has been incorporated into the mental model created for the problem.

2.11 Errors Associated with Decision-making

2.11.1 Framing

It can be argued that even under normal circumstances, individual nurses dealing with complex issues do not always have the necessary or appropriate information to make the necessary decisions. Russo et al (1992) asserted that as a result of the complexities involved in decision making the human mind employed 'decision frames' or structures to keep the complex issues within dimensions and to enable the human mind to manage the issues presented. They argued that people cannot make decisions without using the framing concept and that the process of framing can also affect the outcome or the decisions made, as the individual only uses one 'frame' at a time and may therefore have a partial view of the problem or issues presented. Decisions made on a partial view of the problem presented may therefore not be as effective as decisions made with a complete view or understanding of the situation (Russo et al 1992).

Tversky et al (1974) and Kahneman et al (1974) and Thaller (1980) suggested that decision makers deal with complex, difficult and risky situations by employing limited number of pre-psychological routines known as 'heuristics'. They defined heuristics as
innate, automatic processes, operating without volition and possible outside conscious awareness which reduces complex judgmental task to sets of simpler operations. However, although these heuristics increase the rate at which judgements are made they also lead to judgement inaccuracies or errors. The three heuristics identified by Tversky et al (1974) were representativeness, availability bias and anchoring bias.

2.11.2 Representativeness Bias

Kahneman et al (1973) suggested that the process of bias originated from the way in which professionals attempt to assess an encounter in a given situation by judging how similar or ‘representative’ it is to a previous encounter. This type of decision making is sometimes effective, and enabled the professional to make a quick decision about the presented situation, by comparing the current situation with a previously similar situation.

Problems may arise when the nurses perception of similarity between the current and previous encounters are inaccurate, but still relied on the perception of similarities of the encounters as the basis upon which the decision of the identified risk is made. An example is when a nurse’s assessment of the immediate risk presented by a known violent patient does not make reference to that person’s actual current violent behaviour. Instead, a decision is made based on the nurse’s perception of how a violent patient will behave and the risk they present although that particular patient may not have presented the same behaviour. Kahneman et al (1973) and Russo et al (1992) also suggested that representative bias becomes more prominent when professionals encounter a complex and rare situation and compares that to a previous situation which presents similar characteristics.
2.11.3 Availability Bias

Availability bias is the tendency to judge an event to be more probable, the more easily it can be recalled or pictured mentally and has been generally acknowledged that vividness can influence availability (Kahneman et al 1973). Availability heuristic also enabled professionals to recall situations or events witnessed frequently or experienced easily. Applying this theory to risk assessment supports this researcher's observation that nurses tend to assess only suicide and self harm when assessing risk. This may be because nurses may be recalling situations and events involving suicides and self harm, either through their professional experiences, or the high profile cases involving people with mental health problems such as the Clunis inquiries (Sheppard 1996).

Although, issues involving homicides, violence and suicides have been widely publicised by Sheppard (1996) and Reed (1997), inquiry after inquiry have highlighted that health care professionals are failing to provide adequate care for people with long term mental illness (Ritchie 1995, Bloom-Cooper 1996). This also supported this researcher's view that there is a need for empirical studies to establish how nurses assess and identify risk as without a good assessment to identify the risks, nurses will not be able to manage the risks presented effectively.

2.11.4 Anchoring Bias

Anchoring bias is defined as a therapist's tendency to adhere to their initial assessment of a client's characteristics rather than to adjust their evaluations in response to further information received about the situation or condition (Kahneman et al 1975). In risk
management this could lead to the nurse making an incorrect judgement about the situation or condition then decide on a management strategy which may not be appropriate for the risk presented.

2.12 Knowledge and Experience

Benner (1984) and Pitz et al (1984) suggested that knowledge and experience were important in decision making as it enabled decision makers to retrieve information stored in the memory. It is also acknowledged that knowledge and experience have the ability to either help or hinder the decision making process by enabling the decision maker to retrieve information on similar problems, situations or event and to compare that information to the current presentation of the patient. This then enables the decision maker to make a judgement based on their prior experience and knowledge. It also allows a decision to be made about the current risk presented, the possible consequences if the risk behaviour continues and to decide the best possible solution based on previous similar experience. Heuristics and tacit knowledge are also crucial in decision-making as if the wrong knowledge or experience has been stored they may be used to make decisions in what is perceived as a similar situation by the decision maker, therefore making the decision made unsafe.

Researchers of clinical judgement have also implied that concepts of judgement have emerged from one of three theoretical perspectives. These are: information processing (Elstein and Bordages 1979), social judgement (Elstein et al 1982, Hammond et al 1975), and behaviour decision theory (Beach 1982, Einhorn and Hogarth 1981). All three theorists agreed that the major factors that hamper judgement accuracy are biases, the effect of amount of information and the effects of training and experience.
2.13 National Directives

Recent directives from the Department of Health (Care in the Community 1990, National Service Framework 1995, Discharged of the Mentally Disordered Offenders 1995, and Strategy for Suicide Prevention 2002) have prompted NHS Trust hospitals to manage risk effectively in people with mental health problems. There is also a national drive (National Strategy for Suicide Prevention 2002) to reduce suicides in the general population and the mentally ill which has led NHS Trust to developed local risk assessment and management policies and to monitor the effectiveness of these policies in practice.

These national and local directives and policies have highlighted the importance of risk assessment and management and brought the issues of responsibility and accountability including consequences into focus. Risk management as a decision-making process, therefore starts from an assessment phase when a judgement is made about the condition or situation presented by a patient. The cognitive process of assessment such as the recognition that there is a problem, the formulation of the problem into a mental model so it can be represented require the use of domain specific knowledge about the patient, about risk behaviours and risk indicators to form the basis on which the nurse makes a judgement about the condition or situation then decides on the best possible management strategies.

Services for people with mental illness are encouraged and expected nationally to provide a multi disciplinary approach to care. However, it is also expected that each profession (nursing, medical, and psychology) will contribute their professional specific knowledge to the process to enable the care and services provided to be effective and
comprehensive. To achieve this aim requires multi professional working and clear communication systems to allow for discussions, joint assessments and joint risk management processes. Therefore, in relation to risk assessment in mental health it will be expected that although an individual professional from a domain specific professional background, for example nursing, may complete a risk assessment independently, it will also be expected that the findings of such an assessment will be discussed with the other members of the team who are actively involved in the care provision and a joint decision is made on the risks the patient presents and the best possible solutions to manage the risks identified.

The decision-making processes and the cognitive processes involved in decision-making indicate that, for a nurse to be able to make an effective judgement and decision about the risk an individual patient presented, the nurse must have sufficient knowledge of risk behaviours, risk predictors, knowledge of the patient's background, current circumstances and the current situation. The nurse must also be able to recognise that a decision has to be made. That is, the nurse must recognise that the patient presents a risk. The risk the patient presents must then be explored to allow the nurse to gain an understanding of the situation. This may include the risk behaviours presented, the risk presenting factors, the immediacy of the risk occurring and the possible or likelihood of the outcome although according to Kahneman (1979), Payne et al (1978 and Sevenson (1979) the nurse may only be able to make such a decision if they have acquired prior knowledge of risk behaviours and risk predictors through experience and knowledge.

Nevertheless in nursing both experts and novices are expected to assess individuals to establish if they present a risk as part of the assessment process so far as the nurse is a first level nurse. Currently there is no evidence to support the effectiveness of nursing
assessments (Crow et al. 1995), neither is the profession able to assert that all nursing risk assessments are accurate as Modestine et al. (1984) indicated that other professionals such as psychiatrists and psychologists were not always accurate in the predictions of risk.

Understanding the nature of decision-making highlighted the complex nature and processes nurses followed in order to make a judgement about a situation then decide on the best possible solution. It can be concluded that the assessment and management of identified risk involved unconscious cognitive processes of recognition, formulation, alternative generation, information search, judgement or choice, decision, action and feedback. It also involved having prior domain specific knowledge about the condition or situation, experience, and the appropriate training. The need for the nurses to have prior knowledge of risk predicting factors, risk behaviours, their likely outcomes and possible consequences is imperative in enabling the generation of alternative solutions in the assessment and the management.

2.14 Conclusion

Current initiatives in the Community Care Act (1992) coupled with violent crimes committed by people with severe mental illness in the community has intensified the spotlight on community care. The important question been asked by the general public is whether the community is at risk of further violence and criminal behaviour from people with severe mental illness. Various studied have investigated the link between mental disorder and criminal behaviour. Studies by Gunn and Taylor (1984) suggested that people with schizophrenia committed violent crimes however these findings were
disputed by Lindqvist and Allebect (1990) who suggested that more non-violent crimes were committed by schizophrenics.

Studies on violence committed by people diagnosed with schizophrenia only looked at the most severe crimes and not all aspects. However, other studies have linked crime and violence with mental disorder in relation to delusional disorders (Taylor et al 1993). The literature highlighted the diversity of opinion between professionals, the various authors in risk assessment and risk management and the difficulties in estimating the relationship between mental disorder and crime (Rabkin 1979). It also indicated that risk has a number of variables which affected different people at different periods. The literature gave no clear indication as to how the risk identified could be managed effectively, except through observation and in-patient admission. There was no clear indication of what is expected from the different professionals in the management of risk in people with mental health problems except the expectation that psychiatrist should be able to assess risk in the mentally disordered for the criminal justice system.

Furthermore, information regarding nurses' role in risk assessment and risk management was scanty although in most cases nurses are usually the professionals likely to be involved in providing care for the mentally ill, either in the community, or hospitals. Evidence from the studies indicated that most of the earlier studies and majority of the current studies in risk assessment are in the field of criminology and forensic psychiatry therefore, the findings could not always be generalised for people within the general psychiatry.

The literature highlighted a dearth of studies and editorials on suicides and violence, however, there was no information on severe neglect although this is a high risk factor
for people with severe mental health problems and is one of the risk behaviours identified in the Department of Health document under supervised discharge and supervision register. Most of the studies on risk assessment have recommended the need for empirical testing of assessment scales, as these scales have been crudely tested in the past and they consequently show little generalisation effects, (Robins et al 1996).

Other recommendations have included the availability of policies and procedures/guidelines, effective communication processes and auditing processes to support professionals (Walker 1997, Wilson 1996) in their roles as key workers. Some authors suggest the development of multi-disciplinary pathways of care to help improve the problems of documentation and communication, as improving communication and documentation, are fundamental to implementing effective risk management systems, (Wilson 1996, Walker 1997, Van Liew 1997, Campbell 1997, Tingle 1997, Harrison 1997). Most of the studies have concluded with a warning about the generalisation of finding, as the studies have usually been carried out looking at specific cases, within specific environments with specific diagnoses and risk factors, i.e. suicide predictions in hospitalised para-suicides, violence in hospitalised patients.

The current debate therefore centres on how best to manage risk. It has been suggested that suicide behaviour can be best managed by developing a population strategy (House et al 1999) rather than the long running view that only the high-risk group should be targeted. However, the Health of the Nation (1992) strategy required that risk is not only reduced in the mentally ill but also in the general population. Nevertheless, crucial factors such as the links between the risk of severe neglect, exploitation and suicide or self harm behaviours have been omitted in all the studies. Also none of the editorials
discussed other risk indicators such as severe neglect and, or exploitation. This omission could probably be attributed to the fact that previous studies had focused on offenders and not patients in general psychiatry.

The view that the whole population must be targeted rather than high risk group (House et al 1997) in the prevention of suicide is supported. It appeared that the Department of Health supported this view by indicating in the Health of Nation (1994) and the New and Modern NHS (1998) document that there should be 70% reduction of suicide in the general population by the year 2010. However the studies did not identify standardised processes or structures to assist professionals in the assessment of risk in the mentally ill. There was no clear view in the literature about risk assessment training for professionals, it was also not evident as to whether only key professionals should assess risk in people with mental disorders.

The diagram below therefore illustrates the complex processes involved in risk assessment and management. It also highlights the role played by the cognitive processes such as heuristics, knowledge and experience in enabling the nurse to assess and identify the risk that a patient might present. The conceptual framework underpinning the study therefore involved an interactive process of nursing assessment, decision-making, knowledge and experience which are influenced by representativeness, framing and anchoring heuristics to enable the nurse to make a judgement about the risk presented.

The conceptual framework suggested that to manage risk presented by people with severe mental health problems, the risk presented must first be identified. The identification of risk presented by people with mental health problems is best achieved
through the process of nursing assessment which involved the identification of the patient's problems and how the problems identified affected the patient's ability to meet their needs of activities of daily living. The nurse must also have knowledge and experience of risk behaviours and risk predicting factors to enable the explorations of risk behaviours and risk predicting factors. This is then followed by a decision making process when the nurse decides whether the patient presents a risk, the specific risk behaviour presented, the risk predicting factors, and the best possible management strategies to minimise the risk. This decision-making process however is influenced by heuristics such as framing, representativeness, availability bias and anchoring by either enhancing or hindering the decision made.
This Diagram Illustrates the Conceptual Framework Underpinning the Study

Decision-making, Risk Assessment, Experience, Nursing Process and Knowledge
(The D.R.E.N.K. Triangle)
2.15 Aim of the Study:

The study investigated nurses risk assessment and management practices in people with severe mental health problems and endeavoured to understand the nurses’ perceptions of their practices.

2.16 Objectives:

- To explore nurses perception of their risk assessment and management practices
- To ascertain nurses’ knowledge of risk behaviours and risk predicting factors found in clients/patients with severe mental illness
- To identify good practices in risk assessment and management

2.17 Research Question

How do nurses manage risk presented by people with severe mental illness?
Chapter 3

3. Research Design and Method

3.1 Introduction

The purpose of this chapter is to describe and discuss the research design and the methodological considerations and give a detailed account of the 'trail' followed for the study. There will be four main sections beginning with an examination of the principles and theoretical perspectives underpinning the research design and approach including methodological rigor and ethical consideration. The second section will describe and discuss the strategies used for data collection, including the sources and nature of the data in the first phase of the study. The third section will describe, present and discuss the organisation and procedures developed for the collection and analysis of the data in the second phase of the study. The final section will then present and discuss the data collection and analysis in the third phase of the study.

3.2 The Research Design and Approach: (Principles and theoretical perspective)

Numerous studies have established the various methodological approaches of inquiry used to answer relevant research questions. Therefore the principles and theoretical perspective underlying research can be traced to two basic paradigms described as quantitative and qualitative methodologies. Conflicts and values within the different schools of Social Sciences have led to debates and their respective uses have been distinguished from one another through their basic supposition (Duffy 1985). It has been asserted that a notable difference between the two paradigms is the focus of their
analysis and the assumptions associated with each paradigm (Cormack 1996) as whilst quantitative research focused primarily on numbers, qualitative research concentrated on words. Quantitative methods have therefore often been associated with the aim of identifying and explaining causal relationships between variables and events (Duffy 1985). The positivist view therefore is developed from theory and concepts established before the study begins and does not address the subjects experiences and interpretations nor the context of the research. Alternatively qualitative methodologies derived from philosophies within social and behavioural human sciences, known as naturalist inquiry do not seek to primarily provide quantitative answers (Pope 1995). Qualitative methodologies aims to describe and understand the meanings of individual’s experiences or particular events within their natural settings based on the belief that behaviour can be understood in the context in which it occurs (Lincoln and Guba 1985). The naturalist inquiry therefore allowed the investigator to be open to all elements of the situation (Guba 1979). Qualitative researchers also argued that the focus on numbers when the subject matter of the research is the actions of human beings was inappropriate and that research on human behaviour should focus on the motivation that people have for doing the sorts of things they do.

The naturalistic approach for that reason has no initial hypothesis however concept and theories are developed from the data with the focus on lived experiences, interpretations and the meaning people attached to events or situations. Benoliel (1984) suggested that qualitative paradigm was concerned with the value of meaning and the social world from which meaning was derived with More (1991) supporting the use of naturalist inquiry when the research context was poorly understood. The rigid differentiation of qualitative and quantitative approaches as opposing traditions does not encourage interaction between the two camps but instead researchers on either side become entrenched and
often ignorant of each other’s work (Pope 1996). The view that quantitative methods aim for reliability through the use of tools whilst qualitative methods aimed for stability by understanding how people really behaved and what people mean when they describe their experiences, attitudes and behaviours had been strongly supported by authors such as Pope (1996). It can therefore be argued that qualitative and quantitative processes complemented each other rather than oppose each other. Combining the two approaches enabled the researcher to build a wider picture of the phenomena being studied. As the focus of this study was on nursing practices and perceptions of those practices, methodological triangulation was considered to be the most appropriate approach. This involved the use of both qualitative and quantitative processes of data collection within a single study to enable the researcher to depict more accurately the phenomenon being investigated.

Schatzman and Strauss (1973) asserted that qualitative approaches to research is not in the same sense as experimentation and survey approaches but rather it was an umbrella of activities in which a range of techniques may be used for gaining information. As qualitative research conveyed different meanings to different people it had caused considerable confusion and had often been misleading (Sandelowski 1986, Jacob 1988) with the underlying principle indicating that different authors focused on different aspects. It is therefore argued that the quantitative approach with its lead from the physical and natural sciences is promulgated by those who favour a systematic and objective way of gathering facts about a phenomenon whilst qualitative methodologists on the other hand, did not place emphasis on the idea of predicting human behaviours, but rather favour the understanding of human behaviour (Weber 1947).
Dingwall and McIntosh (1978) argued that nursing research has tended to take the quantitative approach. They believed that to gain access to study the problems facing the profession the researchers had needed to gain official approval from the administrators whose views and interest had had to be respected. They suggested that this resulted in nursing research defining problems in the same way as the senior administrators. Consequently nursing research has been perceived as being led by authoritarian traditions. However whilst not denying that these methods had a place, nursing had been in danger of missing a wealth of rich data, data which allowed the interpretative understanding of the phenomenon under study. This study therefore did not adhere rigidly to one specific approach as Atkinson (1995) and Sandelwoski (1994) had cautioned about restrictive and prescriptive approaches and their exclusivity. Halloway and Wheeler (1996) also suggested that methodological processes and strategies involve breaking the rules and guidelines of specific approaches. Therefore based on the philosophical nature of this study, it was felt that an eclectic approach to data collection and analysis would provide flexibility and allow for theoretical explanations.

The use of triangulation aimed to prevent biases of researchers and overcome deficiencies inherent in single methods (Denzin 1970). It has been suggested that triangulation encourages creativity, flexibility and insight into data collection and analysis as quantitative methods confirmed the findings derived from qualitative data whilst qualitative methods provided richness to quantitative data when clarifying investigations (Cowman 1993, Duffy 1987). The use of methodological triangulation was considered appropriate as it would enable the researcher to explore and validate the findings from the case notes and allow the participants to explain their practices from their point of view and the meanings they attached to their practices and perceptions. The study
further intended to establish the links between nurses risk assessment and management practices, processes and factors that influence those practices and processes, and to identify good practices. The emphasis on nursing practices and the perception of those practices influenced the research strategy and design used to address the study objectives. It was imperative that such data was collected as the evidence from the literature indicated that very little was known about nursing practices and knowledge of risk assessment and management in people with severe mental health problems within general psychiatry. The studies also showed that risk assessment and management practices had focused mainly on medical and psychology professionals (Montadon 1994, Drake et al 1984) and had not addressed nursing practices, knowledge and experiences of managing risk in people with severe mental health problem in general psychiatry.

The design of the study was based on the concept that knowledge was socially developed and the assumption that in order to understand nursing practices, views, perception and experiences, the meanings to these events must be explored. Having established the epistemology of the study, the design pointed to a collection of different research approaches using both qualitative and quantitative data collection processes as the focus was on exploring nursing practices, knowledge, experiences and the meanings they attached to these. The triangulation methodology used therefore did not have predetermined outcomes but initially focused on the recorded evidence in the patients case-notes and then followed by an exploration of the nurses' views, perceptions and their experiences and the values they attached to these. The use of triangulation also ensured that errors and biases in the data collection process were minimised by using quality data to validate and support evidence alluded from quantitative data and the complementary nature of both qualitative and quantitative methods added rigor to the study.
3.3 Use of Theory in the Research

It has been suggested that qualitative studies should be flexible to enable the inclusion of all pertinent theories and assumptions about the subject (Schatzman and Strauss 1973). They continued to assert that research need to add theoretical framework to gain conceptual entry into the subject. This was supported by De Poy and Gitlin (1993) assertion that all research began from a particular framework based on human experiences and assumptions. Therefore the framework of key areas (decision making, risk assessment and management practices, experience, nursing assessment and knowledge) to be studied was designed to form the basis of data collection for this study. These were identified from the literature reviewed and were only used in the data analysis if they emerged from the data.

3.4 Research Method and Issues

3.4.1 Introduction

The study was a combination of the use of multiple research approaches involving the collection of both qualitative and quantitative data as the main aim of this study was to obtain data about nurses’ experience and perception of their risk assessment and management practices. While it has been acknowledged that direct observation was at the forefront of qualitative research, interviewing process was also used to collect data which provided meaning from participants within a specific context. Therefore the main data collection processes used in this study were in-depth, open ended interviews with individual participants, group interview with clinicians and the collection of data through case notes analysis. The process of data collection through case note analysis and
interviews with healthcare professionals, had been widely used by researchers such as Drake et al (1984), Modestin et al (1994) and Lidz et al (1993) who advocated that data collection through these processes were reliable. However, the authors had also warned that biases such as poor record keeping may affect the result of data collected from case notes analysis as professionals did not always accurately record information or that the information recorded had not been recorded with research in mind therefore making it sometimes difficult to use the recorded information in studies. The use of interview process has also been considered to be a special mode of gathering information where the participants are human due to actions of people being complex (Schatzman & Strauss 1973). As the participants in this study were required to describe their experiences and perceptions of their practices, an interview was considered to be appropriate.

The researcher acknowledged that various nurses were involved in the assessment and management of patients in the acute in-patient setting, whilst in the community the same community nurses assessed a patient and provided the care or on occasions referred to other professionals. Therefore to limit the biases that may occur from the nurses working within the in-patient settings, the researcher identified the named nurse as the key nurse to ensure that risk assessment and management information were documented and discussed with appropriate professionals. They also ensured that risk management plans were implemented as directed through the Care Programme Approach (1994). The named nurse was also interviewed by the researcher. This allowed the researcher to compare the nurses' responses at the interview to what had been documented in the patient's case notes. The researcher sought to overcame these biases through a case notes review, followed by an interview to supplement data that were not present in the
case notes reviewed. A sampling frame was also developed for the selection of participants for the interviews to further minimise bias.

3.5. A Sampling Frame

To obtain consistencies and unbiased estimation of the population a sampling frame was developed for the participants in the UK. The sample frame for the random selection of nurses included:

- male and female
- first level registered mental nurses working within the acute and community setting
- basic qualification of Registered Mental Health Nurse (RMN)
- named nurses to a group of clients/patient's either in the community or in-patient services
- subjects worked either on day or night duty
- subjects included grades under the nursing structure of grades D, E, F, G, H.

The sampling frame for the random selection of the case notes included:

- all admissions aged between 18 years of age to 65 years
- male and female patients
- formal and informal patients from any ethnic background
- patients with a diagnosis of schizophrenia and depression with or without alcohol and substance misuse
- one or more admissions to the services, and would have received the services for two weeks or more
- admitted between December 2000 to December 2002
All names of patients who matched the categories above were included in the study. This process of case notes selection of patients applied to both in-patient and the community patients. The researcher also acknowledged that these needed to be included in the study as the grading structure did not always accurately indicate the actual responsibility of the qualified nurse. It was also recognised that there was a possibility of bias as the 150 nurses were from the same Trust. However, these nurses had been assessed and certified to be competent registered mental health nurses by a professional body (English National Board for Nurses) and have the qualifications required of all first level registered mental health nurses registered by the professional nursing body (Nursing and Midwifery Council) therefore they would be expected to abide by the professional code of practice and ethics expected of all registered mental health nurse within the United Kingdom.

3.6. Ethical Consideration

Permission was obtained from both the local ethics and the research committee in the Trust where the study was carried out, as this study included case-notes reviews, interviews and discussions with the nursing staff and the exploration of clinical practice. All staff working in the trust were informed of the research through the Trust Professional Nursing Committee. A letter was sent to all participants informing them about confidentiality issues and how the study will be conducted. The staff were advised that confidentiality will be maintained at all times and that no individual staff or study site will be identified in the study however individuals or groups of staff will be given feedback if they so wished. The nurses’ were asked for their permission to participate in the study. The researcher then agreed dates and time with the participants for the interviews. The
researcher also made herself available by visiting the clinical sites to meet with staff and to explain the research and to answer any questions that the nurses’ may about the study before the data collection commenced.

The researcher acknowledged that some staff felt threatened as they believed that their practice was being scrutinised and could possibly be reported to management. The participants were reassured of the confidential nature of the study and also a written agreement confirming that no individual professional or work area will be identified was provided. The researcher advised the participants that the only time the researcher may have to give information to a third party, i.e. ward manger, is when a patient’s life was at risk and as such by the researcher ignoring those facts will endanger the patient’s life therefore failing in their duty of care to ensure the patient does not come to any harm (Nursing and Midwifery Council 2001, formally known as United Kingdom Central Council for Nurses 1983) code of practice. It was also emphasised that should such an incident arise then the patient will be immediately removed from the study. The staff were informed that they will be informed of the results of the study and opportunities for discussions with the researcher about the overall study will be encouraged. A report will be provided to the Trust Board and this report will be made available to all staff. All information collected for the purpose of the study will be kept for a period of six months then destroyed. This will allow the researcher to answer any questions which the participants may want to ask at a later date.
Avis (1995) argued that the success of a research activity depended on the methodology used to convince others of the credibility of the research findings. One concept used by researchers to assure the research community about the authenticity of evidence from research findings is validity. However, there is also evidence to show that the process of assessing validity of research findings is different between sections of the research community (Avis 1995). Validity therefore is about the extend to which an instrument will measure what it is intended to measure (internal validity) and the extend to which the instrument will provide data which will be compatible with other relevant evidence (external validity), Burns et al (1993) and Diers (1979). Internal validity therefore related to the confidence that can be placed on a specific instrument to produce a desired outcome whilst external validity on the other hand is concerned with the extent to which research findings can be generalised to other samples and settings. However, threats such as the effects of variables external to the instrument can confuse the evidence.

Robertson et al (1984), Field and Morse (1985), Duffy (1985) and Brink (1989) have also argued that the criteria for reliability and validity can be used to assess the credibility of both qualitative and quantitative research findings. LeCompte and Goetz (1982) also argued that although qualitative research is exposed to different threats such as accurate representation arising from its interactive methods and interpretative analytical techniques, the same criteria of reliability, internal and external validity can be used to assess the credibility of quantitative research findings. Avis (1997) also suggested that the epistemological issues central to validity is how an empirical account can be shown to be an adequate representation of the phenomena. It has also been pointed out that the reliability of a measurement is a necessary but not sufficient requirement for validity.
(Polit and Hungler 1987). They argued that a measuring device that is not reliable cannot possibly be valid and that an instrument cannot validly be measuring an attribute of interest if it is erratic, inconsistent and inaccurate. Therefore to ensure reliability and validity, the research tools were piloted. The next chapter will present, describe and discuss the data collection process used in the study.

3.8 The Use of Self in Qualitative Research

It has been argued (King 1990) that interviewing within qualitative study can situate both the interviewer and the participants in a vulnerable position. King (1996) further asserted that even if there were clear guidelines for interviewing it was unlikely that the interviewee will have been in a similar situation where the focus was almost exclusively on the participants for a considerable period of time. Therefore, interviewers must decide how to present themselves and their projects as they can be influenced by who is being interviewed and where the interview was taking place.

Reinharz (1992) argued that interviewers sometimes either 'play down' or 'play up' their professional status according to who was being interviewed. However, the 'playing up, and playing down' approach is contrary to the model advocated by Oakley (1981) who suggested that interviewers should be open, responsive, engage and strive for intimacy. She proposed an interview model that used self-disclosure and the development of a potentially long-lasting relationship. King (1996) suggested that 'being yourself' was inherently problematic, but being open was viewed positively. King (1996) therefore suggested that the interviewer presentation of themselves had considerable influence upon the study.
I have worked in the Trust where the study was conducted for a member of years and have developed working and social relationships with some of the participants. However Hammersley and Atkinson (1983) assertion that there has to be some degree of both social and intellectual distance as it was this distance that created the opportunity for analytical work reinforced my awareness of the working relationship I had with the participants. I was therefore aware that my working relationship could influence the participant’s responses by either preventing them from responding truthfully to my questions or encouraging them to say things that they think I wanted to hear from their knowledge of me. I was concerned that the participant’s responses could be influenced by their fear of been ostracised by their colleagues especially if they disclosed poor practices that were happening in the teams. I was also conscious of the possibility that the interviews could resurrect emotions that may have been hidden for years about incidents that participants may have witnessed, or may say things they did not intend to say. I decided that I would deal with the situation if it became necessary to do so. However, having an 'inside knowledge' of the organisation helped me to understand what was happening in practice as I was aware that there was a Trust risk assessment and management policy and a Trust referral processes to both in-patient and the community services. I also believed that the working relationship between me and the participants created a relaxed atmosphere and encouraged the patients to be open and honest about their practices.

I was sensitive to my own feelings, views and perceptions. I decided not to say or do anything that could be misinterpreted therefore influence participants' responses to the questions. I also had an issue with self disclosure during the interviews as I believed that if I disclosed too much it may influence the responses from the participants. I therefore took a stand that I will not intentionally disclose anything in the interview that I
felt strongly about but wait to be open in the feedback. Therefore when during the interviews it became apparent that not all patients were having risk assessments completed on admission, especially formally (under Mental Health Act 1983) admitted patients. I made a conscious effort not to express any emotions such as 'surprise' or 'shock' or express any views at the time which would have influenced or affected the interviews. I decided to speak to the individuals involved immediately affect the interviews and also as part of the feedback process highlighted the poor practices to the managers and clinicians. I was also aware that some disclosures were in conflict with my own values, knowledge and experience and on occasions questioned myself away from the interviews as to why the nurses' perceptions were diverse and inconsistent. I occasionally questioned myself about why the Trust policy had not been adhered to although occasionally participants indicated that they were ware of the Trust policy on risk assessment and management. I also learnt that to define and create boundaries in research required experience, sensitivity, intuition and a strong sense of self.

During the interviewing I was conscious of creating and conducting the interviews on the guiding principles that the participants were autonomous practitioners, however this was soon called into question when one of the participants suddenly became defensive about a question on why people admitted under the Mental Health Act 1983 would not have a risk assessment completed on admission. The following excerpts demonstrates the dialogue:

Researcher: ‘The case notes reviewed showed that some patients admitted formally did not have risk assessments completed on admission, could you give me any reason why that will happen?’
Participant: ‘It does not happen on this ward, we do risk assessments on admission for every patient who is admitted to this ward. It will never happen on this ward’ I don’t think I want to answer to that.’

My immediate thought to the above response was that I had to have a degree of control as I work with participant’s to shape the interviews. I was also aware that I had to carefully word appropriate questions so that I remain neutral and not give any verbal or non verbal cues to support or encourage participant’s. I decided to restrict any direction to a minimum and refrain from interrupting or redirecting the participants despite working within a constraint time frame.

3.8.1 Interviewer Responsibility

Trust is a central issue underpinning a successful research but it has to be earned. (Reinharz 1992). To be trusted however means that the interviewer has to disclose a considerable amount of information about his or herself. The trust the participants places in the interviewer enhances the confidentiality. With this in mind, I was aware from the onset that I had to gain the trust and confidence of the participants. This was because I have worked in the Trust for a number of years in a senior position and was well known by most of the staff therefore I was initially concerned that there might be an issue about the participants trusting me. I initially questioned whether the participants would trust me enough to honestly disclose their practices without fear of recrimination. I therefore believed that I had to gain the participant’s trust and confidence. To gain the participant’s trust and confidence I made an appointment to attend one of the team’s meeting where all the professionals working within the team would be present to explain the research,
the data collection process, how and why individual's and teams would be protected through anonymising the reports and interview transcripts and what I would happen to the findings. I allowed the team members to ask questions about confidentiality and reassured all team member including the participants that their confidentiality would be maintained however, we agreed that after the interviews I would feed back and where there are issues of concerns I will highlight them immediately after the interviews to the individuals and then to the team at the feedback.

3.8.2 Developing Appropriate Guidelines

Ethical protocols guided my research process therefore after going through an introductory statement with the participants, I allowed for questions and elaborations to enhance the understanding of the participants. This was because I was aware that due to the highly personal and interpersonal nature of an in-depth interview, the process could open up issues that were sensitive. I therefore explained that if at any time the participants felt they did not want to answer a particular question, then they could 'opt out' and that they could also stop the interview at any time should they wish to. This offered the participants some degree of protection and control. As a researcher I had to be sensitive to some of the commitments of the participants and therefore agreed that during the interview process if there was an emergency and the participant was required to assist then the interview will be terminated immediately. On two occasions we had to stop the interviews to assist the ward staff to deal with psychiatric emergencies.
I also agreed that once I have transcribed the interviews I will show it to the participants to allow them to validate if the contents is what was discussed at the interview. In my opinion this enabled the participants to feel valued and involved in the research process. It also allowed the participants to reflect on their practices as having read the transcripts the participants made the following comments:

- ‘it’s not too bad’
- ‘I did not realise how bad things had got’
- ‘We need to change our practices’
- ‘I am not surprised at our lack of risk assessments’
- ‘We just have to protect ourselves’
- ‘It’s because of management, always looking for someone to blame’
Chapter 4

4. Data Collection and Analysis

4.1 Introduction

This chapter will describe and discuss the process of data collection and analysis and present the findings from the three distinct but linked stages of the thesis. Each phase of the study presented will include aims of the study, participants and the process of data collection, analysis and the findings. The first phase of the study involved the collection of quantitative data through case notes review. This phase of the study therefore commenced with a three stage pilot study of the tools to be used in the study followed by the data collection and analysis of phase one of the study.

4.2. The Pilot Study

4.2.1 Aim of the Pilot study

The aim of the pilot study was to enable the researcher to test and review the process of data collection chosen for the study to ensure validity and reliability. The two data collection processes tested in the pilot study were a semi-structured questionnaire for the interviews and the tool to collect data from the case notes review.
4.3 Stage I of Pilot Study

4.3.1 Design of the Semi-structured Postal Questionnaire

The first stage of the pilot study commenced with the testing of a 20-item postal questionnaire (appendix 1) to generate information on:-

- clinical site where the clinician is based
- respondent’s length of service
- the clinician’s knowledge on risk predicting factors
- the clinician’s knowledge of risk management
- tools used to assess risk currently in clinical area
- how interventions are planned and implemented
- whether risk assessments and management plans are documented in the patient’s case notes.

4.3.2 Administration of the Pilot Study

Before piloting the questionnaire in the clinical sites, a community mental health team and an acute admission ward were visited separately by the researcher. The purpose of the visit was to explain the aims and objectives of the pilot study and to inform the participants that their responses will be anonymous and their consent obtained. Those who gave consent consisted of 5 community psychiatric nurses and 16 nurses from the in-patient service with a nursing grade ranging from 5 grade G’s, 8 grade E’s and 8 grade D’s. The 20-item questionnaire was then sent to this convenience sample of 21 qualified staff who were requested to completed and return the questionnaire to the researcher via the Trust internal post system.
4.3.3 Response to Pilot Questionnaire

Of the 21 questionnaires sent to the qualified nurses working within the acute admission unit and to the community psychiatric nurses, a total of 16 completed questionnaires were completed and returned. The 16 returned questionnaires were from 3 nurses from the community and 13 nurses from the acute admission in-patient setting. The results indicated that the postal questionnaire process of data collection for this study was not suitable as some questions were misinterpreted or were not completed. Some gave a long list of risk predicting factors that did not correspond to the questions asked. Other respondents did not answer all questions therefore the responses could not be analysed. The researcher was not able to explore why some questions were not answered or the nurses' interpretation of the questions. The postal questionnaire process did not allow the nurses to explain their responses or allow for further exploration of the responses.

There were inconsistencies in how the identified risk was managed between the respondents. However, further exploration of the nurses' knowledge and understanding of the risk management process or an exploration of how decisions were made about interventions was not possible. The researcher therefore believed that an interview process using a semi-structured questionnaire, combined with case note analysis process, would be more appropriate as it will enable the exploration of why some questions have not been answered and allow for evidence in the case notes to be reviewed. The researcher's view of using a combination of methodology is supported in the literature which indicated that interviews and case notes reviewed had been used in previous studies.
The questionnaire was redesigned to be used in an interview to allow for the generation of discussion between the researcher and the participants. This modified interview schedule was then retested with 5 nursing staff selected randomly from the 21 respondents in the first test. The responses generated specific answers as respondents were asked specific questions. Re-phrasing the questions enabled the respondents to focus on questions being asked. The respondents were also able to ask for clarification if they did not understand a specific question. The responses indicated that the interview process was a more reliable tool to be used in this study.

4.3.4 Case Notes Reviewed in Pilot Study

The review of the case notes in the pilot study involved the random selection of eight case-notes, 4 from the in-patients settings and 4 from the community setting. Factors focused on within the case notes included were:

- evidence of application of a risk assessment tool to assess the patient?
- evidence of recorded risk assessment in the case notes
- evidence of recorded interventions implemented following the identification of risk?
- evidence of risk management plans which correlates with the identified risk

The findings indicated that the tool for data collection of information from the case notes needed to be more explicit and ask specific questions to ensure that specific data was collected. The tool was therefore redesigned and was re-tested.
4.3.5 Second Testing of Tool for Case Notes Data Collection

Twenty case notes were selected at random for re-testing of the study tool. Ten case notes from in-patients services and 10 case notes from the community services were reviewed. The findings indicated that the re-designed questionnaire and the pre-coded data sheet were reliable as it allowed the researcher to collect the specific data required. However it also indicated that minor adjustments had to be made to the pre-coded data to include factors such as when risk assessments and management plans were completed following admission for both the in-patients or to the community services.

4.4 Stage II of Pilot Study

Two research assistants were asked to retest the study tools for reliability and validity. This phase of the study was conducted in two parts, the first part required the research assistants to test the interview questionnaire by answering the questions. This was to enable the researcher to establish if the research assistants will identify any ambiguities in the questionnaire. The first test identified further ambiguities in four of the questions. The questionnaire was then modified and the same process repeated with the research assistants. The second test produced consistency in the research assistants understanding and interpretations of the questionnaire. The second part of this pilot process involved the research assistants testing the reliability and validity of the questionnaire with a convenience sample of 10 nurses working in an acute admission unit and 3 community nurses in a private psychiatric hospital. This environment was chosen because it was similar to the environment where the study will be conducted. The nurses working in this private psychiatric hospital were all qualified Registered Mental Health nurses, with nursing experience ranging between 5 to 25 years and
working at grades equivalent to G, E and D of the nursing grading structure. The hospital also catered for patients suffering from mental health problems with an age range of 18 to 75 years old. The 10 nurses were interviewed by the two research assistants who checked for the nurses understanding of the interview questionnaire and the responses given by each nurse which indicated whether the nurse understood the question or not.

The findings to the questionnaire indicated that as an interview tool, it generated the appropriate responses and the responses from the ten nurses were consistent with each other as to the understanding and meaning. Two responses under the management process of risk which needed clarification for two nurses were modified, and the two nurses were re-interviewed by the researchers. Reponses indicated understanding of the questions and the responses were consistent with the other eight respondents.

4.5. Stage III of Pilot Study

This phase involved the testing of the questionnaire for the case notes analysis by the two research assistants. This process involved the research assistants analysing the same 20 case notes independently then comparing their findings and discussing the appropriateness of the questionnaire in extracting the information required from the case notes. The findings showed that the data collected by the two research assistants were consistent with each other however, there was a need to modify some of the information on the coding sheet to correlate with the questionnaire. The coding sheet was amended in line with the research assistants' recommendations.
4.6 Discussion of Pilot Study

The tools tested in the pilot indicated that the questionnaire generated a lot of useful information however some of the information could not be used as it did not relate to the questions. The questionnaire therefore needed to be more explicit to give specific responses. This may have been due to the way the questions were asked. There was evidence to suggest that other useful questions should have been asked but these were not included in the questionnaire therefore vital information relating to how and why nurses responded to risk presented by people with severe mental health problems was not always effectively identified. The re-designed interview schedule allowed the respondents to be specific in their responses. The case notes analysis in phase I of the pilot did not allow for verification of some of the information documented in the notes. This indicated that there was a need for the questionnaire to be used for the case notes analysis to be more precise to enable the collection of appropriate information and the development of the pre-coded information sheet to allow the researcher to collect specific data. The findings from the pilot indicated that modification of the data collecting process allowed the generation of more useful and meaningful information and enabled the researcher to explore the views, perceptions and knowledge of nurses on risk assessment and risk management, including record keeping. The reliability and validity of the data collection process was increased following the testing and re-testing and the modification of the study tools therefore enabling the researcher to collect the appropriate data. Following completion of the pilot study, stage I of the study (case notes review) was commenced.
4.7 Study I

4.7.1 Introduction

Following the pilot study of the study tools, it was believed that the study tools were appropriate for the study as they would enable the researcher to collect the appropriate data. The first phase of the study therefore commenced with the collection of quantitative data through a process of case notes review. This section will therefore describe, discuss and present the data collection and analysis process and the findings from the first phase of the study.

4.8 Aim of study I

The aim of the data collection using a case-note analysis was to enable the researcher to establish nursing practices and to identify good practices through documented evidence in the case-notes based on the propositions that:

- all patients (community and in-patients services) had a completed risk assessment on admission regardless of status
- doctors and nurses jointly assessed risk for all in-patients on admission
- risk identified was routinely discussed within the team (community)
- risk of self-harm, violence towards others and severe self-neglect and drug and alcohol misuse will be the minimum risk behaviours identified for all patients
- there will be evidence of continuous risk assessment and management planning
all patients will have a risk management plan which correlates with the risks identified.

- all patients will have risk relapse plans which correlates with the risks assessment and identified needs.

4.9 Statistical Advice

Following consultation with a medical statistician it was agreed that the sample will include: 25 nurses randomly selected from the community setting, 25 nurses randomly selected from the acute in-patient setting, 6 case notes randomly selected from each of the 50 nurses case load. A total of 300 case notes were selected. This allowed for a typical nurse in the community to have a case-load of 30 patients, and a typical nurse on an in-patient acute unit to have been a named nurse to about 30 patients from December 2000 to December 2002. This process of sampling was supported by De Vaus (1997) suggestion that for a study to be statistically significant the sample size should represent 30% of the population to be studied. This researcher therefore interpreted De Vaus (1997) suggestion in deciding the sample size. As the population to be studied was a small size the researcher chose a sample size of 33% of the population to be studied.

4.10 Selection of Case Notes

The selection of case notes for review begun with the identification of all the 150 first level nurses working within the acute and community settings. The names of the 150 first level nurses were computerised alphabetically and 50 names chosen at random. These
names included names of nurses who worked on both days and nights within the in-
patient. Each community nurse was requested to provide a list of all their patients who
matched the criteria for inclusion. A computerised system was used to generate six
names from each of the case lists provided. Nurses working within the in-patient
services were also requested to provide similar information and the same process was
used to generate six names. This process generated a total of 300 case notes of
patients with a diagnosis of schizophrenia and or depression, with an age range of
between 18 to 75 years old, currently being cared for either as an in-
patient or a
community setting. The criteria for inclusion in the 300 case notes were: - all referrals to
the 25 randomly selected nurses working in the community from December 2000 to
December 2002 and patients admitted to the in-patients unit from December 2000 to
December 2002. Patient's case notes were included in the sample if they were on the list
of those named nurses. Case notes of patients were included in the sample if the patient
had a diagnosis of Schizophrenia and depression, alcohol and or substance misuse, an
aged between 18 to 75 years old with one or two previous admissions to the services
and treated either in the community or as an in-patient.

The criteria ensured that all patients seen by the mental health services who matched
the criteria were included in the study. The rationale for selecting the sample of case
notes from December 2000 to December 2002 was as a result of a pilot study carried
out by the researcher which indicated that although some of the patients on the nurse's
current case load were known to the services for one year or more. It was also vitally
important that patients already known to the services were included in the study, as
evidence from the literature by Appleby at al (1999), highlighted that most suicides
occurred within the first week of discharge from psychiatric in-patient services, within
three months of discharge or the first year after in-patient care. This suggested that most of the people who committed suicides were known to the specialist mental health services. The researcher intended to explore the nurses' practices to establish whether there was any variance or similarities in the assessment and management processes for patients already known to the services and those newly admitted patients, and if there was any differences and how this influenced the risk assessment and management decision making.

4.11 Gaining Access

The recruitment of participants for the study in the United Kingdom commenced in December 2000, with the success of the study depending on gaining access to the sites selected. The initial data from the case-notes was collected from the five community team bases and the four acute in-patient units. The participants were seen at locations convenient for them. Access to case notes and participants was therefore sought through informal discussions with the nurses within the trust where the study was conducted following approval of the study from the Trust's Professional Nursing Committee. Arrangements were then made with the five community mental health teams to meet all team members to discuss the research proposal and the purpose of the study with a view to seeking consent even before the participants had been selected. This was to allow the forging of links with the subjects and to explore how the proposed research could be mutually and reciprocally advantageous to both the researcher and the participants as suggested by Hornsby-Smith (1993). After careful negotiation of access to the case notes and participants, credibility was felt to have been established. The researcher was known in the Trust and therefore thought of as having 'insider'
status which seemed to have facilitated an unconditional access. However, this open access was later to become closed as some participants reacted negatively to the established research-participant relationship. This incident supported Honsby-Smith’s assertion that the ‘creation of barriers’ may be due to participant’s perception of external threats from intruders’. Because of this there was a need to provide appropriate reassurance to suspicious groups. The role of the researcher was therefore discussed along with expectations of the participant’s perception of the role in order to gain trust, corporation, openness and acceptances from the potential participants. The role of the researcher including the methods for data collection was outlined and issues such as how the researcher will respond to poor risk assessment and management practices were discussed and agreed between the researcher and nurses working in the Trust prior to the selection of the participants.

4.12 Data Collection Process

Case-notes were only included in the population for selection if the care co-ordinator or named nurse was a nurse. Six case notes was then selected from each of the fifty nurses whose names had been randomly selected from the population to be studied therefore generating a total of 300 case-notes consisting of patients with the diagnosis of: schizophrenia, depression and bi-polar disorder, alcohol/drug misuse and depression. The 300 case-notes also included 257 informal patients and 43 formal (sectioned) patients all selected at random. A structured questionnaire (appendix 1) was used retrospectively to analyse the contents of the 300 case-notes randomly selected from both the community and the in-patient services to establish if there was a risk assessment. When the assessment was completed, who completed the assessment.
which risk behaviours had been assessed and how often was the risk assessment completed. This was followed by the identification of evidence of collaboration on risk management plan and risk relapse plan. A Statistical Package for the Social Sciences version 12 was then used to analyse the data collected. The rationale for the data collection using a retrospective case-note analysis was to enable the researcher to explore the nurse’s knowledge of risk behaviours and risk management practices through the documented evidence in the case-notes. The use of retrospective case notes review in exploring recorded evidence in case notes had been used by various authors (Modestine 1984, Drake et al 1989) to elicit data for research purposes with health professionals. It was also believed that health records was the documentary evidence mostly used for communication across the professional groups, therefore it was thought to be important and crucial in the effective management of risk in people with severe mental health problems.

4.13 Findings from Study I (Case notes review)

4.13.1 Introduction

During the review of the case notes, ten key areas were focused on, they included: evidence of risk assessment on admission, patients status and the completion of risk assessments, patients diagnosis and the completion of risk assessment, levels of CPA and the completion of risk assessment, which professional completed the risk assessment, risk behaviours assessed on admission, evidence of corresponding risk management plans, patients status and risk management plans, evidence of risk relapse
plans and the evidence of continuous risk assessment. This next section will present and analyse the results from the 300 case notes reviewed in phase I of the study.

Evidence of Completed Risk Assessments on Admission for the 300 Case Notes Reviewed.

The 300 case-notes were reviewed for evidence of completed risk assessment on the day of admission and or accepted to both in-patients and community services. Figure 1 below showed that 74 (49%) out of 150 in-patients and 101 (67%) out of 150 community patients had risk assessments completed on patient admission. A Pearson chi-square (p<.001) indicated that community patients were more likely to have risk assessments completed on admission than inpatient services.

Table I

<table>
<thead>
<tr>
<th>Risk Assessments Completed on Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>In-patient</td>
</tr>
<tr>
<td>Community</td>
</tr>
</tbody>
</table>
Patients Status and the Completion of Risk Assessments

300 case notes were reviewed to establish if an individual's admission status made a difference to whether a risk assessment was completed on admission or not. The results in (table II) show that 154 (59%) of 257 informal patients had risk assessments completed on admission whilst 21 (49%) of 43 formal patients had risk assessments completed on admission. A Pearson chi-square (p<.223) indicated that there was no association between patients legal status on admission and the completion of risk assessments. This showed that a patient's status on admission did not affect the completion of risk assessments. The fact that a patient had been admitted on a formally under the Mental Health Act 1983 did not signify that a risk assessment will be completed.

Table II

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal</td>
<td>154</td>
<td>92</td>
<td>11</td>
<td>257</td>
</tr>
<tr>
<td>Section</td>
<td>21</td>
<td>18</td>
<td>4</td>
<td>43</td>
</tr>
<tr>
<td>Total</td>
<td>175</td>
<td>110</td>
<td>15</td>
<td>300</td>
</tr>
</tbody>
</table>
In-patient Services

Case notes from in-patients services consisted of 109 informal patients and 41 (informal) sectioned patients. The results below indicated that 54 (49%) out of 109 informal patients had risk assessments completed on admission. Only 20 (49%) formally admitted patients out of the 41 formally admitted patients had risk assessments completed on admission. The findings below from the in-patient’s services indicated that although some inpatients were admitted under the Mental Health Act 1983, almost 50% of those patients did not have risk assessments completed on admission, despite the fact that an admission under the Mental Health Act 1983, to an in-patient facility implied that the individual presented with a risk which warranted formal admission.

Graph I

Patient’s Status and the Completion of Risk Assessment on Admission.
Patient's Diagnosis and the Completion of Risk Assessments on Admission

The 300 case notes reviewed consisted of 81 patients with a diagnosis of schizophrenia, 130 patients had a diagnosis of depression and bi-polar, 65 patients had a diagnosis of alcohol/drugs and depression, and 24 patients had other diagnosis. The findings (Fig. IV) indicated that out of the 300 case notes reviewed, 53 (17%) of patients with a diagnosis of schizophrenia, 77 (25%) of patients with a diagnosis of depression and bi-polar, and 33 (11%) of patients with a diagnosis of alcohol, drugs and depression had risk assessments completed on admission. A Pearson chi-square (p<.310) showed that there was no association between a patient's diagnosis and the completion of risk assessments. A patient's diagnosis therefore did not influence the decision to complete a risk assessment and management strategy on admission.

Table III
Patient's Diagnosis and the Completion of Risk Assessment on Admission

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>53</td>
<td>23</td>
<td>5</td>
<td>81</td>
</tr>
<tr>
<td>Depression &amp; Bi-polar</td>
<td>77</td>
<td>47</td>
<td>6</td>
<td>130</td>
</tr>
<tr>
<td>Alcohol/drugs and depression</td>
<td>33</td>
<td>28</td>
<td>4</td>
<td>65</td>
</tr>
<tr>
<td>Others</td>
<td>11</td>
<td>13</td>
<td>0</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>174</td>
<td>111</td>
<td>15</td>
<td>300</td>
</tr>
</tbody>
</table>
Care Programme Approach and Risk Assessment

It is nationally required that all patients admitted to specialist mental health services should be assessed and allocated a Care Programme Approach (CPA) level which will indicate their level of needs and the potential risk they may present. The level of Care Programme Approach (CPA) identified in the case-notes and analysed were therefore as follows: From the 300 case-notes, 84 patients did not have an identified CPA level, 26 patients were on level one, 105 were on level two and 85 were on level three. The records showed that, in the in-patients services, 18 patients who had risk assessments completed did not have a CPA level indicated. However, 10 patients with CPA level one, 27 patients with CPA level two, and 19 patients with CPA level three had risk assessments completed on admission (see graph below.)

Graph II

Level of CPA and Completion of Risk Assessment

<table>
<thead>
<tr>
<th>Level of CPA at Time of Study</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Given</td>
<td>18</td>
</tr>
<tr>
<td>Level 1</td>
<td>10</td>
</tr>
<tr>
<td>Level 2</td>
<td>27</td>
</tr>
<tr>
<td>Level 3</td>
<td>19</td>
</tr>
</tbody>
</table>

Was a Risk Assessment Completed on Admission?
- Yes
- No
This indicated that 28 patients did not have any level of CPA identified at admission, 27 patients on level 2 and 16 patients on level 3 CPA did not have risk assessments completed on admission. A Pearson chi-square (p< .088) showed that the level of CPA did not have a significant impact on whether a risk assessment was completed or not. There was no association between the level of CPA and the completion of risk assessment. In the community, 16 patients did not have any level of CPA identified on admission, and as high as 19 patients on CPA level 3 did not have a risk assessment completed following acceptance to the community services.

Graph III

**Level of CPA and Completion of Risk Assessment (Community)**

![Graph showing the number of patients by level of CPA and whether a risk assessment was completed on admission.](attachment:graph.png)
It should be noted that since the data was collected, the levels of CPA have been changed nationally to two levels namely, standard and enhanced levels. The results above show that levels of CPA did not always imply that risk assessments will be completed for the individual therefore indicating that the completion of risk assessment was not dependent upon the identified level of CPA.

**Professionals Completed Risk Assessment on Admission?**

Good practice requires that consultant’s psychiatrist support nurses and junior medical staff in their attempt to identifying the risks that a patient may present on admission. It is also professionally and nationally acknowledged that risk assessment and management is more effective if it is managed by a team rather than individually. However it was evident from the data collected that different professional groups had occasionally been involved in the assessment of patients on admission. The findings however indicated that risk assessments were completed on admission as follows:

**In-patients Services**

In the in-patient services, nurses completed risk assessment on 69 (46%) occasions, doctors completed risk assessments on 33 (22%) occasions, nurses and consultant psychiatrist jointly completed risk assessments on 9 (6%) occasions and nurses and junior/duty doctors jointly completed risk assessments on 28 (19%) occasions.
Graph IV

Which Professional Assessed Patient on Admission?

The findings above demonstrate that most risk assessments were completed by individual professionals, with joint risk assessments between consultant psychiatrist and other staff taking place on 9% of the time.

Community Services

In the community, the nurses completed risk assessment on 123 (82%) occasions, doctors completed risk assessments on 14 (9%) occasions, nurses and consultant psychiatrist jointly completed risk assessments on 3 occasions, nurses and junior
doctors completed risk assessments on 9 (6%) occasions indicating that risk assessments were completed by individual professionals more often than completed jointly as recommended in the Trust policy.

Graph V

Which Professional Assessed Patient on Admission?
Risk Behaviours Assessed on Admission

National directives require that before a patient was discharged from the psychiatric services a risk assessment must be completed and appropriate risk management implemented to ensure that the individual did not harm themselves or others in the community (Department of Health 1995). The three risk behaviours identified for assessment by the Department of Health were, (a) risk of self-harm, (b) risk of violence to others and (c) risk of severe neglect. It was therefore expected that all patients admitted to the psychiatric services would have these risk behaviours assessed and any risk identified would have appropriate risk management strategies in place. The findings showed that both the community and in-patients nurses' assessed risk of violence, neglect and self harm for most patients. As evidence in the case notes showed that in-patient staff assessed the three risk behaviours (violence, neglect and self harm) for 86 (57%) patients out of the 150 patients with the community staff completing 117 (78%) assessments out of 150 on the three risk behaviours identified. The evidence demonstrated that most nurses assessed against the three key risk behaviours (violence, self harm and neglect) as recommended by the Department of Health. (See graphs below)
Graph VI

Risk Behaviours Assessed on Admission for In-patients

Key

SH - Self harm
V only - Violence
N only - Neglect
SH&V - Self Harm and Violence
SH&N - Self Harm and Neglect
SH,V, N - Self Harm, Violence, Neglect
Graph VII

Risk Behaviours Assessed on Admission for Community Patients

Key

SH - Self harm
V only - Violence
N only - Neglect
SH&V - Self Harm and Violence
SH&N - Self Harm and Neglect
SH,V,N - Self Harm, Violence, Neglect
Evidence of Risk Management Plans in the Case-notes

The evidence in the case notes indicated that 92 (61%) of patients in the in-patient services had risk management plans whilst 113 (75%) of patients in the community had risk management plans completed following admission (Table III). The result indicated that community patients were more likely to have risk management plans in place than in-patients. However, the number of risk management plans did not correlate with the number of risk assessments completed on admission. Indicating that there were more risk management plans completed than risk assessments which leads this author to conclude that some patients had risk management plans although there was no evidence of a risk assessment to support the need for those risk management plans.

Table IV

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-patient</td>
<td>92</td>
<td>58</td>
<td>150</td>
</tr>
<tr>
<td>Community</td>
<td>113</td>
<td>37</td>
<td>150</td>
</tr>
<tr>
<td>Total</td>
<td>205</td>
<td>95</td>
<td>300</td>
</tr>
</tbody>
</table>
Patients' Legal Status and Risk Management Plans

Exploring the influence of legal status from the case notes reviewed showed that 62 (57%) of informal patients and 30 (73%) formal (under the Mental Health Act 1983) patients from the in-patients services had risk management plans completed following admission indicating that some formally admitted patients did not have risk assessment completed on admission. (Graph VIII below)

Graph VIII

Legal Status and Risk Management Plans for In-patients
Evidence of Risk Relapse Plans

One of the key requirements for the Care Programme Approach (1999) is that each patient will have a risk management plan including a relapse plan agreed with the patient and his or her carers. This relapse plan is aimed at providing the patient with information on signs and symptoms which will indicate that the patient is relapsing and what actions to take. The relapse plan should also contain telephone numbers of professionals to contact to enable the patients and their carers to take appropriate actions. The evidence in the case notes reviewed demonstrated that in the in-patient services only 35(23%) of patients had risk relapse plans developed and only 47(31%) of patients in the community had risk relapse plans (see table V below). A Pearson chi-square (p<.077) indicated that there was no significant difference in the development of risk relapse plans for patients following admission and prior to discharge between community and in-patient services.

Table. V

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>missing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-patient</td>
<td>35</td>
<td>112</td>
<td>3</td>
<td>150</td>
</tr>
<tr>
<td>Community</td>
<td>47</td>
<td>103</td>
<td>0</td>
<td>150</td>
</tr>
<tr>
<td>Total</td>
<td>82</td>
<td>215</td>
<td>3</td>
<td>300</td>
</tr>
</tbody>
</table>
Evidence of Continuous Risk Assessment

Evidence from the literature reviewed showed that risk was dynamic and not static and that the risk an individual presented was constantly changing. Therefore, to manage risk effectively professionals must continuously assess and reassess patients to establish if risk behaviours have changed and to modify the management plans accordingly. The findings from the case notes showed that in the in-patient services, 89 (59%) of patients had risk assessment completed only once and 32 (21%) had risk assessments completed more than once.

Graph VIII

In-patient Services

How Many Times Has R.A. Been Undertaken?
Whilst in the community services, 98 (65%) had risk assessments completed only once with 48 (32%) having risk assessments completed more than once (See fig. X below). A Pearson chi-square ($p < .000$) indicated that there was a significant difference between the community and in-patients services in the assessment and management of risk with more patients from the community having risk assessments completed more than once following admission to the services.

**Graph X**

**Community Services**

*How Many Times Has R.A. Been Undertaken?*

![Bar chart showing frequency of risk assessments completed](image)
4.14 Discussion

The results from the 300 case notes reviewed showed that more than 67% of the community patients were more likely to have risk assessment completed with a total of (101 out of 150) completed risk assessment whilst in-patients, this was less than 50% with a total of (74 out of 150) completed risk assessments. Community nurses were also more likely to have risk assessment completed more than once during an episode of care. The evidence from the case notes also suggested that the patient's status and diagnosis did not make any significant difference in determining whether the staff completed a risk assessment in the inpatient service. As a high number of patients admitted formally (18 out of 41) in the in-patient services did not have risk assessment completed on admission despite the fact that patients admitted formally would have been expected to present a risk to themselves and or others.

Nationally the CPA is expected to be used to communicate the level of needs and risk an individual present to themselves and or others. Effective management is therefore dependent on all patients at risk having their level of CPA identified and appropriate management plans outlined. However the evidence from the case-notes showed that not all patients at risk had CPA levels identified and the risk the individual presented always reflected on their level of needs identified. The evidence also showed that 19 patients on level 3 CPA in the community and 16 patients on level 3 in the in-patient service did not have risk assessments completed on admission to the services inspite level three of the CPA requiring intensive professionals input. The evidence also suggested that most of the risk assessments had been completed individually by the different professionals, i.e., nurses with only occasional joint risk assessments completed by nurses and doctors.
The findings suggested that where joint risk assessments between nurses and doctors occurred, this tended to be in the in-patient’s services although this was still very low at only 6% of the time, whilst most community assessments were completed by individual professionals. This indicated that risk assessment and management is not always addressed through the multi disciplinary team despite the national and international agenda for the promotion of team risk assessment and management. The evidence in the case notes suggested that most patients from both the community and in patients’ services had the three main risk behaviours namely: self harm, violence and neglect assessed either on admission or during an episode of care. There was also evidence to suggest that other risk behaviours such as the risk of being exploited and the risk the individual presented to children had been considered although not in all cases. This therefore suggested that nurses are aware of the common risk behaviours recognised as a national minimum standard to be assessed for all patients.

The findings suggested that the risk management did not correlate with identified risk to ensure that any risk identified is effectively managed by the professionals caring for the patient. However, the evidence showed that the community patients were more likely to have risk management plans with 113 and 47 risk relapse plans than in-patients services with 92 risk management plans and 35 relapse plans completed. The evidence also indicated that more risk management plans had been completed then risk assessments completed suggesting there was no correlation between the risk assessments and management plans. It is therefore unclear as to what underpins the nurses’ decision in developing their risk management plans in the absence of a risk assessment. The evidence suggested that some in-patients admitted formally did not have risk management plans completed although formal admission would suggest that the patient either presented a risk to themselves or others, hence the need to identified risk and
manage the risk presented. The findings strongly suggested that more patients were likely to have risk assessments completed once during an episode of care. This indicated that risk assessments and risk management plans were not regularly up-dated and the dynamic nature of risk presented by people with mental health problems were not considered by the professionals managing the risk presented by the individuals. The findings therefore showed that a high proportion of patients presenting with high risk did not have risk assessments and appropriate management plans developed and implemented. The risk management plans were not always consistently reviewed by the professionals. The risk assessments were not always completed by the team but rather by individuals therefore there was no evidence of team decision making processes within both the community and the in-patient’s services. The next chapter will focus on exploring and understanding the nurses’ perception of their practices on risk assessment and management and its influence on the effective management of risk in people with severe mental health problems.
5. Study II

5.1 Introduction

Following the analysis of the findings from study I, it became evident that there were areas that could not be explored by the structured questionnaire data collection process therefore a second phase of the study was required to further explore the areas that the case notes review could not give sufficient or coherent information on. This led to a second phase of the study involving a qualitative approach modelled on the work of Glaser & Strauss (1967) and their view on the generation of grounded theory. This process of data analysis described the constant comparative method of the analyst comparing incident by incident in the data in the process of establishing conceptual categories which served to explain the data. Many authors have criticise grounded theory and argued that grounded theory reflected bias against the naturalism and relativism of ethnographic tradition, and favoured emerging theories as the only meaningful goal (Thorne 1991). Supporters of grounded theory however suggested that the purpose of grounded theory is to examine the effects of social behaviour which differentiates it from ethnography which involves a quest to determine why a person thinks he or she is doing what it is that he or she is doing. It also differed from phenomenology which attempts to uncover how the person articulates the experiences of what he or she is experiencing (Thorne 1991).
Grounded theory allows for the researcher to discover a conceptual framework that offers explanation of the scene under study (Stein 1985). Phenomenologist believes that there is no objective reality in the phenomenological world (Salsberry et al 1989). However in grounded theory approach working hypotheses are generated from the theory developed which can later be transferred to other settings. Lincoln & Guba (1985) suggested that grounded theory must be judged by whether theories generated enhance patient care. They asserted that theory must ‘fit’, have a ‘grab’ and ‘work’. Chenitz et al (1986) suggested that to ‘fit’ means that the categories generated must be indicated by the data and applied readily to other data. Whilst Glaser (1978) suggested that to have ‘grab’, theory must be relevant to the particular group, and to ‘work’, a theory should be able to explain what happened, predict what will happen and interpret what is happening.

Lesley (1998) asserted that during the past 35 years nursing knowledge has encompassed a plethora of views of the world. Meleis (1985) also suggested that it was importance to reflect on the epistemology of nursing knowledge, for in doing so an awareness of the knowledge required to practice safe, sensitive and competent care will develop. It further acknowledged that nursing is a practice-based discipline but is often described as an art and a science. Schultz and Meleis therefore suggested that articulating nursing epistemology was a complex task as the study of nursing knowledge must range from intuition of the experienced nurse to the systematically verified knowledge of empirical researchers. Schatzman and Strauss therefore argued that the two principle data collection methods used in grounded theory strived to ‘discover the underlying social forces shaping human action’. They further suggested that in this way grounded theory could help nursing to explain their theoretical interest in certain areas of human subjectivity. Chenitz and Swanson (1986) therefore asserted that grounded
theory offered a systematic method for data collection, organisation and analysis from the empirical world to nursing practice as it embraced multiple realities and provided an eclectic view of the ‘truth’. This researcher therefore believed that grounded theory approach was the most appropriate as it allowed for the questions to be flexible and open-ended to allow for theory development. It was also sufficiently broad to enable a thorough investigation to be carried out at the same time providing a focus to prevent the researcher from floundering.

The use of qualitative method in study II was considered to be the most appropriate method as qualitative research was interested in why people behave as they do rather than in estimating the proportion of individuals holding a particular view (Crombie et al 1998). A process of self reporting in the form of an interview was used to collect the data as it enabled the researcher to focus on the participants perceptions of the behaviour expected from them and the behaviour of others (Crombie 1998). This process of data collection also enabled the researcher to validate and collaborate the data collected in study I (case notes review) by clarifying unanswered questions identified in the case notes reviewed. It also allowed the participants to describe their risk assessment and management practices and explored their understanding and interpretations of these practices.

5.2 Aim of Qualitative Data Collection

The aim of using qualitative data collection (interviewing) process in study II was to enable the researcher to gain understanding of the participants perceptions from the participants’ frame of reference as the participants provided descriptions and explanations of their practices recorded in the case notes reviewed.
5.3 Interviews (Self Reporting) Data Collection Process

Miller et al (1997) asserted that the primary purpose of interviews was to generate data which gave authentic insight into people's experiences. Other authors argued that qualitative research can not provide the mirror reflection of the social world that positivists strive for, but they provided access to the meanings people attribute to their experiences and social world. The advantages of data collection through an interview process have been identified by various authors who asserted that interviewing method of data collection generated high response rates (Cormack 1991, Polit & Hungler 1991). They continued to emphasise that the control over the interview process lay with the interviewer who could put the interviewees at ease by the use of effective interpersonal skills and the willingness to rephrase questions as appropriate. This ensured that ambiguous or unclear questions which may be misinterpreted by respondents are clarified by the interviewer.

Qualitative interviewing therefore provided the researcher with the means of exploring participant's points of view and also provided a means of generating empirical data by asking participants to talk about the research subject. It has also been argued that interviewee's response to the interviewer are based on who the interviewer is, as well as the social categories to which the interviewer belongs, such as age and gender and as a result the interviewee may purposely mislead the interviewer in their responses (Miller et al 1997). Nevertheless, the researcher supported the use of an interview (self reporting) as the means for data collection in the second stage of the study. This enabled the exploration of the gaps and contradictions identified in stage one of the study and the explorations of complex areas that could not be explored in the stage one of the study.
5.4 The Development of an Interview Guide

This process commenced with the development of a semi-structured interview schedule. The items in the interview schedule were based on gaps identified from the case notes reviewed as the results had indicated that there were issues that could not be explored. For example, it was not possible to identify and audit the process of risk assessment and risk management in the case notes as these were not systematically recorded. It was also not possible to establish the nurses' knowledge and perception of risk assessment and risk management practices and explore the importance they attached to the risk assessment and management practices.

The eighteen-item interview schedule (appendix 1) was initially piloted with three qualified nurses working in a private acute psychiatric hospital similar to the organisation where the research will be carried out. The results suggested that the eighteen-item schedule was too long and repetitive and the participants gave the same responses without any new information. It did not encourage an active dialogue as the participants only answered to questions on the semi-structured schedule. It therefore did not allow for exploration of experiences and knowledge as was required to provide information about participants' views and perceptions about their risk assessment and management practices and processes.

The interview schedule was reviewed and further modifications made. The revised interview schedule consisted of main headings with various sub-headings to act as prompts (appendix 2). This was piloted again with another group of three qualified nurses working in the same private acute psychiatric hospital but on a different ward.
The result indicated that the researcher was adhering too rigidly to the main headings and sub-headings with all the interviewees and was not allowing the interviewee to respond spontaneously. The researcher also believed that the interviewees should be allowed to talk about their practices with minimum prompts. The responses indicated that the information generated would enable the researcher to validate the information missing from the case notes if the researcher did not adhere rigidly to the headings and sub-headings. The interview schedule was further modified to be used as an interview guide in a semi-structured interview (Appendix 3). This was considered necessary, as the semi-structured interview allowed the researcher to delve beneath the surface of the superficial responses to obtain the meanings that individuals attributed to events and the complexities of behaviours and experiences associated with such meanings.

The topic guide for the unstructured interviews therefore included:

- demographic details (area of practice)
- views of risk assessment and management
- who assessed patients on admission
- what was assessed, who was involved
- how decisions were made
- who and how risk management plans were developed and implemented
- who and how risk relapse plans were developed and implemented

This ensured that the content of the interview was mainly determined by the responses from the participants. The seven main headings covered the areas the researcher needed to further explore and to enable the validation and collaboration of the findings from the case notes reviewed in the stage one of the study.
5.5 Sampling (Participants)

Sampling is an essential aspect of any research as it enabled the researcher to select a portion of the population to represent the entire population and to ensure that the findings can be generalised (Polit et al 1997). However, in qualitative studies generalisation was not the guiding principle as the purpose was to illuminate meaning and understand the multiple realities (Polit et al 1997). In qualitative research, the researcher started by exploring who could be involved in the study to provide the information-rich data required (Polit et al 1997) with an awareness that as the data collection progresses new sampling questions may emerge. Sampling in qualitative studies therefore was emergent and capitalised on early learning to give subsequent directions. It has also been highlighted that there was no firm established criterion or rules for sampling in qualitative studies as the sampling was largely a function of the purpose of the inquiry, the quality of the informants and the sampling strategy used (Polit et al 1997). Purposive sampling was therefore be used to select participants for the study II.

5.6 Purposive Sampling

Purposive sampling is a process of sample selection in which the sample selected are based on their relevance to the research question, analytical framework and explanation or account being developed in the research rather than their representativeness. The researcher's reason for choosing purposive sampling was to enable the inclusion of the participants who could provide the best information to achieve the objective of the study. And to ensure that the participants included in the second phase of the study had been involved in the first phase of the study as it enabled the researcher to validate and
collaborate the data collected from both the case notes reviewed and the responses from the interviews. The researcher was also aware that this process of sample selection could introduce bias to the sampling selection and therefore affect the findings as participants selected through this process could be seen as participants who the researcher expected to give the answers required rather than the participants expressing their own views and perceptions. To minimise the bias this process of sampling selection could introduce, the researcher developed a staff profile (eligibility criteria) to ensure that any biases were minimised.

5.7 Development of Eligibility Criteria for Inclusion

Although the researcher postulated that purposive sampling was the most appropriate method for participant selection for the phase two of the study, the researcher also believed that it was important to use criteria to select the participants to ensure that any biases were minimised and participant's selection was not ad hoc and allowed the researcher to explain why particular subjects were selected. The following eligibility criteria were therefore developed for the selection of the community participants.

Eligibility Criteria – (Community nurses profile)

The eligibility criteria for participants from the community services included:

- must have a current case-load in the community
- both male and female staff
- registered mental health nurse
- case-notes reviewed in phase one of study
• minimum of six months community working experience

The researcher included the above profile as the initial participants in phase one of the study (case notes reviewed) had included both males and females. The researcher also required that each participant had a minimum of six months experience working in the community as the researcher believed that years of experience could highlight individuals’ experiences and knowledge and how that influences their risk assessment process and practices. The qualification of a registered mental health nurse was essential as a minimum standard for community nurses as it was a recognised qualification by the nursing professional body and all those who hold that qualification have been certified as competent practitioners. The individual must have a current case load to enable them to describe their risk assessment and management practices. This was felt necessary, as all staff must have a period of preceptorship after qualifying or moving to a new area of practice to ensure a period of consolidation of learning, (theory) and support in the new environment. The researcher was aware that there was a six-month period of preceptorship for all nurses who match the criteria at the Trust where the study was carried out. Finally, age group was also included to enable the researcher to explore whether the ages of the nurses reflected in their practices and decision making processes.

Eligibility Criteria – (In-patient services)

The eligibility criteria for participants from the in-patients services included:

• minimum six months experience in an in-patient setting
• registered mental health nurse qualification
• current named nurse to a group of patients
• case notes included in phase one of study
• both male and female staff

The above eligibility criteria were used to select the participants as it ensured that those included have similar years of experience and have had a period of preceptorship to consolidate their prior learning and support in a new environment. It also ensured that they hold the recognised registered nurse qualification and have been certified as competent nurses and therefore were licensed to practice and able to describe and explain their risk assessment and management practices. Both male and female staff were included in the initial sample as both groups of staff worked directly with patients in the in-patient and community setting, and had the same basic qualification of a registered mental health nurse and were certified to be competent clinicians by the professional body. Participants who matched the above criteria were asked if they would be willing to be interviewed about their practices to enable the researcher to explore and gain understanding of the current practices and processes and to compare their responses to the findings in stage I of the study.

5.8 Selection of Participants

Participants who agreed to participate in the second phase of the study were contacted and asked if they were still willing to participate in the interview process. The participants consisted of males and females from both the community and in-patient services. All participants had over five years of post qualification experience. Upon receipt of confirmation to participate in the study, a date and time was agreed. The researcher and
participant then met at a location convenient for the participants. All participants agreed to be interviewed at the work place.

5.9 Interviewing of Participants

The researcher met with the participants as agreed. The researcher explained the purpose of the meeting and clarified that the participants were still willing to continue with the interview and for the interview to be recorded. The researcher emphasised that the participants' team or practice area would not be identified. It was also emphasised that all data collected, from both case notes and interviews will only be kept in a locked cupboard for a period of six months after the study and then destroyed. This was to enable the researcher to revisit the raw data if needed for further work on the research report or to answer questions from the participants. Each interview lasted for about 40-45 minutes. Participants working in the community were the first to be interviewed followed by the participants working in the in-patient services. The interview proceeded in an informal, conversational format following the interview guide in varying order and not always completing it depending on the participant responses and the activities around at the time. The agenda covered: views of risk assessment and management, who assessed patients on admission, what was assessed, who was involved, how decisions were made, who and how risk management plans were developed and implemented, who and how risk relapse plans were developed and implemented. The next question was then generated from the response given by the participant. The ideas or issues raised by participants were tested out in later interviews if the opportunity arose or if the issue was worth discussing with other participants. This allowed for the amassing of data which was updated and elaborated upon rather than data collected to be analysed later. The interview guide used enabled the participants to talk freely about
their experiences, knowledge and perception of risk assessment and management practices and processes and to explore and clarify issues that were unclear from the case notes reviewed. Throughout the interviews, open-ended questions were used as they enabled the participants to elaborate on their experiences therefore generating a wealth of detailed information. The data collection was stopped when the researcher believed that key concepts have been identified from the data collected and the data has reached saturation point. The interviews were tape recorded.

5.10 Study II Data Analysis Process

5.10.1 Introduction

Various authors such as Dey (1993), Wolcott (1994), and Miles and Huberman (1994) have suggested a variety of analytical frameworks for data analysis. Some authors have focused on the importance of analysis as primarily a task of manipulating data such as coding, indexing, sorting and retrieving and from such prospective analysis which was viewed in terms of data handling, making the procedures of organisation and retrieval paramount. Other authors have focused on the importance of imagination and interpretation with the procedural and categorising task such as sorting the data seen as the preliminary work. For these authors (Coffey and Atkinson 1996) it appeared that analysis was essentially about imagination and speculation. Dey (1993) process of analysis suggested a three level process of describing, classification and connecting the data whilst Wolcott (1994) argued a rather different process of exploring and interpreting data and based his process on describing, analysing and interpreting the data. Dey (1993) process appeared to make a strong emphasis on the importance of describing the context of action, the people involved and the process in which social action is
embedded and based his analysis on the patterns and connections that emerge from the data. Wolcott (1994) on the other hand, emphasised the need to describe what, who and where things are happening, however he considered each process to have three distinctive phases with a special emphasis on analysis and also the researcher's own interpretation of what is going on, unlike Dey (1993) who emphasised on what was emerging from the data. Wolcott's (1993) description of analysis in this context differed from other authors who asserted that analysis was an all encompassing term. Wolcott's (1994) interpretation of analysis indicated that he did not consider his process of description, analysis and interpretation to be applied in its entirety in all cases.

Miles and Huberman (1994) also proposed a three staged cyclical process: a systematic process of data reduction from the interview transcriptions, the organisation and the presentation of the condensed data in a narrative text supported by extracts from the data along with visual matrices allowed for the drawing of conclusions and verifications. These different assertions and descriptions of data analysis indicated that one can not apply one approach of analysis in it's entirety but instead an eclectic approach to data analysis utilising different approaches may be more appropriate and useful. The process of data analysis in this study was therefore based on a modified framework of Miles and Hubermann (1994) as the researcher believed that Miles and Huberman's approach offered a more pragmatic and flexible approach to data analysis. However, it also envisaged that some of the philosophies of Dey (1993) and Wolcott (1994) may be incorporated in the analysis process to allow for an eclectic and flexible approach. The data analysis therefore involved a three stage process of data reduction, data organisation and display and the drawing of conclusions and verifications from the data. However, stage I and stage II of the analysis process were closely interlinked and the
process therefore moved backwards and forwards between the two stages as illustrated below.
A Modified (Miles and Huberman 1994) Three Stage Analysis Processes used in the Study

Stage 1
Data Reduction
A process of summarising, breaking down data into categories

Stage 2
Data display in a matrix

Stage 3
Conclusion and Verifications. Interpret data and draw meaning

The above three stage process illustrated the data analysis process used to analyse the data.
The diagram below illustrates the step by step data analysis process followed in the study.

**Diagram III. Step by Step Data Analysis Process**

**Step IV**

**Developing Meaning from the Data**

- Display data in a matrix
- Identify meaning/emerging themes

**Step III**

**Generating Categories**

- Group cards with similar patterns together
- Attach meaningful category label to each pile of cards
- Identify recurring data patterns

**Step II**

**Coding Process.**

- Insert appropriate description codes/labels
- Assign identification number to each data segment
- Cut and paste data segments with attached codes onto postcards

**Step I**

**Organisation and Transcription of Data.**

- Listen to the tape recorded interviews
- Transcribe interview
- Scan transcript line by line
5.11 Data Analysis Process (Step by Step)

5.11.1 Step I

Organisation of Data and the Transcription of Individual Interviews

Data reduction refers to the process of focusing, simplifying, selecting, transforming and abstracting the data (Miles & Huberman 1994) as the research draws out meaning and views from the words of the participants (Marshall & Rossman 1989). Step I of the data analysis commenced with the organisation of the raw data from the interviews. This process started with the transcription of the tape recorded interviews to enable the researcher to analyse the data. The process of transcribing the tape recorded interviews involved the playing and listening carefully to each tape to allow for the familiarisation of the data as a first priority in the data analysis process. The tapes were then transcribed verbatim. Where appropriate notations such as dots and dashes were made in the transcription to denote pauses or unfinished sentences. Following each transcription, the tape was replayed to check for accuracy. The transcripts were then checked with participant to verify that, the transcription was an accurate recollection of their responses. Three copies of each transcription were made and used as working documents. All original tapes were kept separately in a safe place to protect against loss and data protection.
Coding Process

Coding is an important aspect of the data analysis as it allowed for labelling and the retrieval of meaningful data and the identification of patterns, categories and themes and in the transcribed text. Following the transcription of the interviews each transcript was examined line by line with a series of questions such as 'what is going on here, what are the important issues or areas of interest' in mind as the researcher attempted to identify the causal conditions arising from the data (Strauss and Corbin 1990). Word or words that best described the contents was attached to the data segments. The process continued by checking the rest of the text for all possible instances of new codes. It was essential that the codes fitted the phenomenon described in the data so that it could be instantly recognised under scrutiny. During the coding process, the codes were continually reviewed by reading the data segments over and over and on occasions some of the codes were changed or fine tuned until the code fitted the data segment. The illustration below demonstrates an example of the coding process.

Why do you complete risk assessments for everybody you see?

I think the form is structured in such a way that you think about what is going on for the client when you see someone you have to reflect on what is going on and actually risk highlights for you that sort of interaction.
Could you talk me through your risk assessment and management process?

I believe it depends on the complexity of the case, what sort of need has been identified and risk .......... to be an integral part of the assessment. eh... Obviously everybody who gets referred they all have different needs and it may be needs like self-neglect, aggression, whether it is verbal or physical or whether they are a danger to themselves or others or whether they are at risk of being used by someone else. So it is good to record the assessment that reflects whatever you have identified and agreed obviously with the individual referred.

How do you manage risk? Can you talk me through the process of risk assessment and management from admission to discharge?

From admission we currently use the standard risk assessment form going through all the questions with the patient and identifying areas that there are problems and then as part of our feedback to the team we talk about risk assessment as well. We talk about any risks we have found and what the plan is for intervention and if it is necessary to put any contingency plans in place.
Each participant was allocated a unique identification number starting from 1 to 10. Number 1 was the first participant interviewed and number 10, the tenth participant interviewed. Each question asked was given a number from 1 onwards, depending on the number of questions and each response was also given a number which started from 0 onwards. The gender of the participant was attached to the identification numbers. The letter 'M' denoted male participants and 'F' denoted a female participant. For example 1.5.0.M referred to the first participant interviewed, question five and the response located in the first paragraph and a male participant. 2.1.3.M referred to the second participant, question number one and the third paragraph where the response is located and a male participant. 5.1.4.F referred to the fifth participant, the second question and the fourth paragraph where the response is located and a female participant. (See appendix 4). An index of all cards segments as well as an index for each participant was kept to allow for the identification of participant and occurrences.

5.11.3 Step III

Data Filing System

A data filing system was set by hand to ensure that every data segment for each category was easily and quickly retrieved during the analysis. Each significant data segment consisting of phrases or quote from the transcribed text was cut and pasted onto index cards which had instances of the category label it belonged to. Cards with similar data patterns were grouped together and category labels that best described them were attached. It was anticipated that this will allow for the creation of categories.
and the identification of frequencies of each category. As the process progressed the number of index cards rapidly expanded.

5.11.4 Step IV

Developing Categories

The process of coding the data segments was followed by generating categories, a process which involved the identification of data segments which could be related for the purpose of comparison. The data segments were organised by grouping segments which seemed similar or related together. The data segments were then compared within each pile to identify any interesting similarities or differences and to allow for the identification of patterns or variations in the data. Category labels which best described the contents on the index cards were identified for each pile of data segments. As this analysis progressed nine different categories were identified. These were:

- perception of risk assessment and management,
- knowledge/type or risk
- rationale for team risk assessment
- rationale for individual risk assessment
- risk management process
- risk assessment practices
- relapse plans
- status and risk assessment
- diagnosis and risk assessment
The data was critically analysed to establish if the data segments had been meaningfully grouped and to identify incidents of overlapping and to review if some categories had too many or too few segments. This review resulted in some of the categories being merged as they overlapped. Seven categories then emerged following the merging of some of the categories. The seven categories were:

- perception of risk assessment and management
- knowledge/type or risk
- rationale for team risk assessment
- rationale for individual risk assessment
- risk management process
- risk assessment practices
- diagnosis, status and risk assessment

This was rechecked and the researcher believed that some of the categories such as diagnosis and status and relapse planning had very few segments and therefore could be merged with the risk management practices as these described the risk management practices. The researcher also believed that the categories of rationale for team risk assessment and rationale for individual risk assessments described the participants risk assessment practices therefore those two categories were also merged under the category of risk assessment practices. A further review and refining of the categories identified three key categories. The three categories were:

- perception of risk assessment and management
- knowledge of risk behaviours
- risk assessment and management practices and processes
The transcripts were then given to an independent researcher to verify the codes and categories. The categories and codes generated by the independent researcher were compared with those identified by the primary researcher for validation and appropriateness. Overall both primary and the independent researcher agreed on the code and categories. However it was also noted that the independent researcher occasionally used different terminologies to describe some of the codes. For example the independent researcher used the word ‘sole’ instead of ‘individual’ responsibility. These differences were discussed between the two researchers and the meanings were clarified and agreed.
5.12 Emerging Categories

5.12.1 Category 1 (Perception of Risk Assessment and Management)

Category one described the participants views and perceptions of risk assessment and management from their subjective perspective. This category indicated that there were some similarities as well as differences in the perception of risk assessment and management between the in-patients and community participants. It also highlighted the vast diversity and inconsistency in the perceptions of risk assessment and management practices and processes between the individual participants. The responses indicated that participants had different views and perceptions about risk assessment and management and there was no consensus of opinion between the participants. For example there was a perception that all patients had risk assessment and management plans completed when admitted to the services as indicated by the following illustrations:

➢ “Yes, they all have the same assessment as I use the same standard form and format.” (1.2.0.M)

➢ “No, it should not affect my assessment. Everyone should have the same. So everyone gets risk assessment.” (2.19.0.M)

➢ “I would say during the initial assessment yes I do personally. It might not cover every aspect of risk, i.e. have you got a gun at home or more intimate question.” (4.4.0. F)
“If they have had an assessment, yes.” (5.3.0.F)

“I think it is Trust policy. We nurses are actually qualified to do it but it’s the doctors who do the risk assessment on admission.” (10.2.0. M)

“Well it should be done, it’s bad, it should have been done- you know. I can only speak for this ward, we do the risk assessment on admission, and I can’t speak for other wards.” (6.22.0.M)

One participant believed that very ill people did not always get the care they needed as the threshold for concerns amongst the professionals was diverse.

“The levels of concerns are therefore varied and highly experienced staff may not have the same concerns as those with less experience so what will concern me may not concern them. However if people who do not have concerns but high risk patients do not have patient’s harming themselves or others, then what they are doing must be correct.” (3.12.1.M)

“Only in an ideal world it would be useful to be discussed by a team but it does not happen like that. What concerns me is that the format of what triggers what concerns ---- the thresholds are not consistent.” (3.12.0.M)

Other participants believed that risk assessment and management did not happen or was not effective.
“To be honest with you, I do not think any of us do. Again that should form part of CPA discharge plan, even for in patient, but when a patient is admitted all they are interested in, is the package of care and the risk seems to be forgotten and not even mentioned. I am guilty of that as a care co-ordinator, I should say.” (2.15.0.M)

“I don’t personally think it works very well. Whereby everybody is included in doing it, R, oh it’s R’s patient wait for R to come, but if we are all made responsible…..” (9.14.0.M)

“Uh, one of the reasons might actually be, and it’s probably not a very satisfactory reason, one of the reason’s is that we don’t think about it, that’s being perfectly honest, I think the other reason is time consumption. Certainly people, like I mean, the E…. Team have 17 patients in at the moment. So the ward rounds tend to be very lengthy anyway and the risk assessment is seen to be quite a lengthy process so I think that’s why it tends to happen, and the CPA, 117 situation, when by the sheer nature of the meeting, more time is allowed within a ward round situation, anyway.” (7.13.1.F)

“Some of the nurses are not proactive in that discussion because sometimes I find the doctors are anxious if the nurses are not able to tell them exactly what is going on so that if they come for handover they are not able to say look this one does not need that observation because of a, b, c, d. If you don’t give them that information they become a bit hesitant in taking people off wards I don’t know if that has got anything to do with it?” (10.22.2.M)
Other participants believed that risk assessment and management was an individual responsibility and expect those individuals to complete the risk assessments on admission:

- “It is down to the named nurse to get the doctor’s to discuss it or make sure it’s dealt with in the first ward round. It really depends…” (7.6.0.M)

- “When it comes to that we do it individually. Like we have a named nurse who do that. If the named nurse is not here that associate nurse you know, will do it.” (9.12.0.M)

- “No it is not a team responsibility. It is individual’s decision although you talk to the team.” (2.8.0.M)

- “Only for high risk patients, but individuals have to identify high risk patients themselves first and then request for a doctor to do a joint assessment with them. Sometimes the doctors will decide they will do a DV and ask for a joint assessment with a CPA.” (1.11.1M)

- “You can discuss your own risk management plans and tell them this is what you are doing ------- because at the moment it is the individual carrying the responsibility of the risk they have identified and how they manage it.” (2.12.0.M)

- “If you are concerned about something then you obviously come back and discuss it with either the medical staff or the team at the next allocation meeting but yes it is usually our own decision in identifying risk.” (4.10.1.F)
Whilst others believed that risk assessments were completed by the team and decision about risk were made by the team:

- “It is a multidisciplinary approach so it is not only for the assessor but for the medics and the rest of the team……” (5.2.0.F)

- “Yes everyone who is assessed by any member of the team, his or her assessments are discussed here and as part of the discussion the risk assessment is also discussed.” (5.16.0.F)

- “The Trust has its own risk assessment which is multi-disciplinary and the tool that we use to do risk to determine the degree of risk. I suppose to some extent the degree of attention you pay to individual areas is determined on the nature of referral.” (3.1.1.M)

- “You may have your own ideas but you bring it to the team and say this is what you think would be the best way to deal with it and then it is open to the team to discuss but somebody else might come up with a better idea than yours but it is open to discussion and as a general agreement you draw up the plan to deal with the risk. That is how we do it in our team anyway.” (5.13.0.F)

- “If there is a risk identified every risk assessment is brought up at the allocation meeting, when we have assessed a patient we have a risk assessment form and that at the allocation meeting is presented to the rest of the team.” (4.6.0.F)
There was also a view that risk assessments were only completed to avoid blame and the participants believed that they worked in 'blame culture'.

- "At present if anyone commits suicide the immediate response will be, what did you do, not what did the team do......." (2.12.1.M)

- "We are in a blame culture. You will never be blamed for over-reacting although you might get shot at the time, but God help you if you get it wrong..........." (3.12.2.M)

It was evident from the category above that the participant held different views about risk assessment and management and although there were some similarities there was no consistency in the participants' perception and views. These differences in perception and views also influenced the participant's practices.

5.12.2 Category II (Knowledge of Risk Behaviours)

Category two highlighted the nurse's knowledge of risk behaviours commonly found in people with severe mental health problems and the risk behaviours consistent assessed on admission. The risk behaviours identified were violence, self-harm and neglect and the responses indicated that these were the risk behaviours assessed for majority of the patients on admission.

- "Well there are 4 areas, risk to self, others, potential violence and neglect. I assess those for everyone." (1.6.0.M)
• "I believe it depends on the complexity of the case, what sort of need has been identified and risk.....to be an integral part of the assessment. Eh..... obviously everybody who gets referred they all have different needs and it may be needs like self neglect, aggression, whether it is verbal or physical or whether they are a danger to themselves or others or whether they are at risk of being used by someone else. So it is good to record the assessment that reflects whatever you have identified and agreed obviously with the individual referred." (2.1.0.M)

• "Presentation of the patient, history, my own judgement at the time, my experience, knowing different types of illnesses – knowing what might be linked with certain risks and what might not." (4.5.0.F)

• "Violence, suicide, right, maybe linked to alcohol and drugs, right. A lot of them come here have a history of depression and with alcohol related, yes and whichever the first problem goes on diagnosis, and based on this too, it also lead to violence." (6.8.0.M)

There was some evidence that suggested that other participants did consider other risk behaviours such as alcohol and substance misuse and risk towards children although it did not appear to be a common practice amongst the participants."

• "My main concern used to be that they will harm themselves, but now I am concerned with them harming others. So it will be risk to themselves, others, children, risk of neglecting themselves, are they at risk of being exploited and some form of environmental risk, although that is not always appropriate in the community." (3.3.0. M)
“The risk to be assessed starts from the patients themselves whether the patient got a history of self harm and for how long and what circumstances, previous history that kind of thing and how severe it is. Is there any family or children involved in it, is the self harm also affecting other people if the person has got family, is that person also at risk to others also with the risk involved, is the risk related to any other single thing like medication or drug or alcohol or could lead to violence.” (6.1.2.M)

“I mean, I know it’s important to assess a person’s risk at the time, but I think when you are doing risk assessments you do need to be aware of history, or it’s good to be aware of history. It may not repeat itself, it may have been a one off, but I think if you’ve got that extra information, it’s got to be helpful. It’s got to be helpful.” (7.7.1.F)

“The behaviour and I think the social circumstances where they are living or support network – whether there is one or not, you have to identify or assess that so that if you felt that somebody was very depressed and suicidal and they have no support network.” (5.6.0.F)

The above category indicated that some participants considered other risk behaviours such as the social support and network available to the individual patient, the level of risk the individual presented the children and the risk of exploitation from other people due to the vulnerability of the individual.
5.12.3 Category III (Process and Practices of Risk Assessment and Management)

Initially this category was identified as two separate categories, namely, processes and practices. However, it became evident that the process of risk assessment and management could not be differentiated from the practices of risk assessment and management as the two overlapped were interconnected therefore complemented each other. This category identified the process and practices of risk assessments within the in-patient and the community setting and indicated that practices were diverse and inconsistent within the service areas. For example, all referrals to the inpatient services were seen and assessed by a doctor and a nurse usually, separately with occasional joint assessments between nurses and doctors:

- “Sometimes the patient is seen by the doctor on the ward, sometimes is seen by the nurse…….” (6.1.1.M)

- “When someone is admitted we normally, welcome the patient, make them comfortable depending on the nature of the admission, if the patient has to go on some sort of observation straight away whilst waiting for the doctor to see them…..” (6.1.0.M)

- “There have been occasions when the duty doctor will not have completed the risk assessment, in which case, it really is down to the named nurse to complete that or raise it in the first ward round whereby a risk assessment would be carried out then, and certainly when it comes to doing the CPA’s and 117 which is usually round about the time of discharge, um, the risk assessment would be repeated and sometimes we have people who are in hospital for a very long time, so they will have more than
one CPA, more than one 117 meeting, so some will actually have a few risk assessments carried out within....... carried out throughout the time of their admission.” (7.1.1.F)

➢ “When somebody’s actually referred to....... Ward, what would happen is obviously the duty doctor would be the first one to do the initial assessment to determine whether or not in fact the patient needs to be admitted. We encourage our duty doctors to complete and carry out a risk assessment on admission. Umm, they are actually, on the whole, most of them are pretty good and they will actually do the risk assessment.” (7.1.0.F)

➢ “It’s not that clear cut, some doctor’s are good at doing it and will do it automatically, some you have to prompt, and some if you’re not there to prompt them – it won’t be done. So it’s not about the patient, it’s about the doctor, and most of them are top notch, but some of them aren’t and If you happen to have a nurse on the ward who’s not very confident reminding doctors about what they are doing, it may be that the risk assessment won’t be done. It’s not dependent on the patient, it’s dependent on the doctor or the person doing the admission and that’s being honest.” (7.10.0.F)

However, all the community referrals went to a team where an individual was then allocated to complete an initial assessment including a risk assessment and report back to the team and then a care co-ordinator was allocated. However there was no systematic process for feeding back on risk assessment therefore any discussions about the risk identified within the team was ad hoc.
“You could discuss them very briefly or in details for complex cases but it is up to you and other members will ask you questions.” (1.8.1.M)

“Only for high risk patients, but individuals have to identify high risk patients themselves first and then request for a doctor to do a joint assessment with them.” (1.17.1.M)

“You can discuss your own risk management plans and tell them this is what you are doing -------- because at the moment it is the individual carrying the responsibility of the risk they have identified and how they manage it.” (2.12.0.M)

“Again, for most part it is developed by the individual and then may not be discussed with the team. So the more concerned people are, the more they discuss their concerns.” (3.11.0.M)

There were differences in perceptions about why risk assessment and management plans were not completed on occasions for patients. Some participants blamed the doctors whilst others indicated that pressure of workloads affected their risk assessment and management practices:

“To be honest with you, I do not think any of us do. Again that should form part of the CPA discharge plan, even for inpatient, but when a patient is admitted all they are interested in is the package of care and the risk seems to be forgotten and not mentioned. I am guilty of that as a care co-ordinator, I should say.” (2.15.0.M)
“I have great difficulty sometimes in presenting that to the patient, there are some things they are sometimes quite ashamed about.” (4.22.1.F)

“People on enhanced CPA also get in-depth assessment, the initial assessment is used to decide CPA level and enhanced level is always MDT but standard is not…” (1.18.1.M)

“No, not actually doing the Risk Assessment, what I am trying to say is that due to pressure of the ward when you are doing risk assessment you don’t do it as it should be done, because there is something else to be done so you are hurrying all the time.” (9.24.0.M)

“Uh, One of the reasons might actually be, and it’s probably not a very satisfactory reason, one of the reason’s is that we don’t think about it, that’s being perfectly honest, I think the other reason is time consumption. Certainly people, like I mean, the…. Team have 17 patients in at the moment. So the ward rounds tend to be very lengthy anyway and the risk assessment is seen to be quite a lengthy process so I think that’s why it tends to happen, and the CPA, 117 situation, when by the sheer nature of the meeting, more time is allowed within a ward round situation, anyway.” (7.3.1.F)

“Sometimes it is due to pressure. You are doing an admission, for instance, on ….. Ward, this morning I was unit rep, they have got three level 3’s and two level 2’s. Now everybody is doing it, take tums, every hour, so this level 2 and 3 take a long period of staff time. Admission comes, you done the admission, but you think I have
It was therefore evident from the responses above that there were differences as well as similarities in processes and practices within the Trust where the study was carried out although there was a trust policy which the Trust expected all the participants to adhere to. Category III showed that the processes in place to support the risk assessment and management practices appeared to affect practices as the different practice areas had different views and perceptions of what was expected from them.

5.13 Links Between the Key Categories

The three categories generated were linked and overlapped with each other. For instance individuals' perception of risk was based on the knowledge of risk behaviour and risk assessment processes. The knowledge of risk assessment and management and perception of risk influenced how the individual participants perceived their responsibility in the risk assessment and risk management process with the admission processes influencing the completion or non completion of risk assessment. For example in the community all referrals automatically went to the team where an individual was allocated to complete an initial assessment which included a risk assessment. Following the initial assessment the individual professional then decided whether or not to admit the patient and become a care co-ordinator or to ask the team to allocate a care co-ordinator. However, within the in-patient services referrals were admitted to the ward under the care of the consultant psychiatrist. The initial assessment was completed by a nurse and a doctor independently. The admitting nurse did not automatically become the named nurse, therefore following the initial assessment the patient may be allocated a
different named nurse to the nurse who completed the initial assessment. The processes and practices were therefore different, although there were some similarities between the inpatients and the community services even though both groups of services were working with one Trust policy and procedure. The interactive nature of perception, knowledge, processes and practices indicated that the successful completion of appropriate risk assessment and management depended upon the individual participant having the appropriate knowledge of risk behaviours and risk assessment and management processes and understand the interdependent nature of the three categories identified. The next stage following the systematic process of generating and creating categories was a process of displaying the data in a matrix to enable the identification and establishment of concepts and themes in a systematic process. A matrix of each category was developed showing the segments from the responses from the participants.

5.14 The Development of Themes from Study II.

5.14.1 Introduction

The purpose of this chapter was to illustrate the procedures followed to analyse the data as discussed in the previous chapter and to identify recurring themes from the data. The data analysis was in two stages, the first stage involved the analysis of the interviews with the community participants followed by the analysis of the interviews with the inpatients' participants. The data from these sets of interviews were analysed separately. Having identified the recurring themes and established the key emerging concepts the next stage was to make sense of the large amount of information in their context. The interviews with the community participants were the first to be analysed. This was
analysed at great length as its aim was intended to validate and or clarify omissions from the case-notes reviewed in phase one of the study. Initially all the data collected was considered to be important. Broad categories were generated from the data following the analytical process discussed in the previous chapter. These categories include the participant’s perception of risk assessment and management, participant’s knowledge of risk behaviours, the processes and practices of risk assessment and management. Three sub-categories that emerged (risk relapse management and status and diagnosis) were reviewed and because of the few data segments from these sub-categories, the sub-categories were merged with the broad category of the process and practices of risk assessment and management. All the data segments within the categories were checked against the transcriptions and were found to describe the category labels with some reasonable accuracy.

5.14.2 Content (Interpretive) Analysis

Two descriptive matrices were developed incorporating all relevant data segments from the interview transcripts and were linked to the emerging categories as appropriate. These categories were then classified according to the areas of interest during the individual interviews. The matrices were scanned and reviewed to ensure completeness of the available data and to verify the categories. Annotations in the margin were attached during the process as during the search for descriptive meaning and conceptual understanding of the data within the categories, it was imperative not to lose the meanings attached to risk assessment and management practices and processes although the reduction of the bulk of the data into the two matrices was also important. The matrices from both in-patients and community staff were summarised by condensing the data segments attached to each category to highlight the views and
issues expressed by the participants and to establish the similarities and differences within and between the two groups.

5.15 Summary of Community Participants Matrix

5.15.1 Context

Five community nurses consisting of three males and two females participated in the phase II of the study. The community nurses were all based in community mental health teams with other professionals such as: doctors, social workers, psychologists, occupational therapists. All referrals initially were sent to the team and then an individual professional was allocated the case for an initial assessment. Following the initial assessment, the assessor then presented the findings to the team and a care co-ordinator was then allocated. Usually the person who completed the initial assessment became the care co-ordinator. However, until a care co-ordinator was allocated it was the responsibility of the assessor to manage the case. The nurses who participated in the study were all care co-ordinators as case notes for phase I of the study were selected on the basis that a nurse is the care co-ordinator and therefore was responsible for ensuring that the patients on the case load had risk assessment and risk management plans completed although the individual did not always have to complete the risk assessment themselves but had to have an involvement in either the assessment or the development and implementation of a management and or relapse plan.
5.15.2 Summary of Category I Matrix (Perception and Personal Views on Risk Assessment and Management)

The perception and personal views of risk assessment and management was diverse within the community participants with each participant expressing a different view. All five participants agreed that all patients must have a risk assessment completed on admission but all five did not agree on the nature and extent of that risk assessment. Two participants (4.23.1.F) (1.18.0.M) indicated that the extent and nature of their risk assessments is based on the diagnosis of the patient, for example, a patient with a diagnosis of anxiety will not have the same risk assessment as a patient with schizophrenia. One participant (3.12.1.M) expressed concerns about the varied responses to prediction and management of risk in the community teams as there were different levels of thresholds between experienced and novice professionals with the level of threshold increasing as the professional became more experienced and that although professionals may have similar experiences and training they also had different opinions on the assessment and management of risk. One participant (3.9.6.M) also implied that if a patient was disturbed and will not engage then that patient will not get the service they require, however, if the patient was willing to engage then the patient received the services.

Another participant (4.23.2.F) indicated that she found it difficult to discuss risk assessment with psychotic and manic depressed patients but able to do so with depressed patients. One participant (1.15.0.M) asserted that risk assessment was easier to complete in the community as the patients were not as disturbed as those in acute in-patient setting therefore the community staff had time to reflect on their assessments. Another participant (2.22.0.M) stated that sometimes the teams fail to refer to risk
assessments as they should when planning the patient’s care. The above responses indicated that risk assessment and management in the community was diverse and inconsistent with individual community nurses having a different and personal view and perspective on the assessment and management of risk in people with mental health problems.

5.15.3 Summary of Category II Matrix (Knowledge and Types of Risk Behaviours)

The risk behaviours mostly assessed by the community staff were identified as the risk to self, others, potential violence, neglect, aggression, suicide ideas and thoughts, support network and the presentation of history. Four participants (4.25.1.F), (1.6.0.M), (2.1.0.M), (4.3.0.F) identified violence and aggression and behaviours that they regularly assessed with two of the four also citing self harm and self neglect. One participant (4.5.0.F) talked about the use of professional judgement, experience and knowing the different types of illness and how they could be linked, and also the use of ‘gut feeling’ and knowing when the patient is not giving you full information, and the ‘clicking’ of something in your head that tells you that you have heard this before and what the person did at the time using words such as memories, past similarities and triggers when trying to identifying risk presented by patients with mental health problems. Another participant (5.6.0.F) identified social support and support network as an area of risk that she assesses. Again this indicated that the individual community nurses explored different risk behaviours when assessing risk presented by patients with mental health problems demonstrating the varied and diversity of perceptions, opinions and views on risk assessment and management within the community participants.
5.15.4 Summary of Category III Matrix (Risk Assessment and Management Practices and Processes)

All five participants indicated that risk assessment and management was on a whole an individual professional’s responsibility with the individual responsible for identifying any concerns and high risk patients and developing management strategies. It was also the view that it was up to the individual to discuss these concerns and high risk patients with the team and occasionally the individual professional received feedback from the team when they presented the case. Two participants (2.12.1.M) (3.12.0.M) point out that if there was an incident the immediate management response is ‘what did you do’ and not ‘what did the team do’ and the participants perceived this as management blaming the individual professional. One participant (3.6.0.M) stated that the failings in the current system are due to the fact that risk assessments are the responsibility of individuals with minimal or no support from the team. Although expressed in different ways all five participants agreed that risk assessment should be discussed within the team. Four participants (2.6.0.M) (5.32.0.F) (4.10.0.F) (3.11.0.M) stated that although they completed risk assessments individually they reported their findings to the team. This however contradicted the statement made previously by participant one (1.8.1.M) that it was up to the individual professional to decide whether to discuss the risk assessment as there was no structured consistent format for this process.

However, one participant (5.2.1.F) implied that if the risk assessment and management planning was a team approach then all team members will be aware of the risk presented and it will also encourage discussion on how best to manage the identified risk. However, it was also pointed out that team discussion on risk assessment and management does not happen very often due to resources. Another participant (3.1.1.M)
also indicated that the rationale for team risk assessment and management was because it was a Trust policy. One participant (4.16.1.F) also stated that she would not be happy to manage a patient who presented a high risk of aggression and violence by herself. It can therefore be argued that most community participants perceived feeding back assessments to the team as team discussing risk assessments and management, despite the fact that individual already deciding the risk behaviour and the management strategies he or she is going to implement.

The rationale given for risk assessment and management practices was varied between the five community participants. One participant (2.13.0.M) indicated that risk assessment was completed to assure people that a risk assessment has been completed and documented regardless of the severity of the risk. Another participant (2.4.0.M) indicated that completing risk assessment helped to decide whether the patient was safe. One participant (2.12.2.M) implied that risk assessment and management was completed and documented in case there was a suicide and one was asked to write a report, or a patient committed suicide, it would reflect on that individual who assessed the patient if there was no risk assessment and the carer tried to sue or if the individual was asked for a report then they will have a record of what they had done. Two participants (3.12.2.M) and (2.13.0.M) indicated there was a 'blame culture' and that one would not be blamed for 'over-reacting' but 'God help you if you get it wrong'. One participant (4.12.0.F) stated that risk assessment and management plans needed to be highlighted more in the community as risks could be higher in the community as there was no 24 hour service unlike the in-patient services where patients were observed round the clock. Two participants (4.18.0.F), (5.26.0.F) asserted that one would concentrate on most aspects of risk for people suffering from schizophrenia then would do for people suffering from stress and anxiety, with the same participant (4.24.0.F)
stating that unless there were concerns then other staff did not have time to be concerned with individual patients risk assessments. One participant (3.13.0.M) stated that although risk relapse plans were happening they were patchy and not consistent as risk assessment and management was not given sufficient weight. Another participant (1.13.0.F) stated that risk relapse plans were only developed for patients who consistently telephoned the services stating they wanted to kill themselves, whilst another (2.15.0.M) felt that risk relapse plans were not developed although they should have been developed, with one participant (4.22.1.F) also stating that she experienced difficulties in presenting relapse plans to patients as she believed that the patients will be ashamed, especially patients with psychosis and maniac depression.

There were contradicting statements about status and diagnosis as although all five participants believed that status and diagnosis should not influence risk assessments however, some participants implied that status and diagnosis influenced risk assessment as it affected the judgements people made and how staff perceived patients (2.18.0.M) and (3. 7.0. M). One participant stated that patients with a diagnosis of anxiety did not get the same in-depth risk assessment as a patient with schizophrenia (1.18.0.M). The rationale for risk assessment and management processes cross referenced with the rationale for practice. Participants (1.5.M) indicated that current processes were due to the fact that there was a standardised risk assessment tool therefore all patients were assessed using the tool. However, another participant (2.1.0.M) stated that risk assessment was normally based on the reason given for the patient’s referral to the services. All five participants asserted although in varied ways, that most patients are referred to the team and individuals from the team are allocated by rota to complete the assessment. The assessment is then discussed with the team. All five participants (2.6.0.M), (3.11.0.M), (4.10.1.F), (1.10.1.M) and (5.2.0.F) stated that they had regular
team meetings where patients are reviewed and risk identified and management strategies highlighted.

5.16 Summary of In-patient Category Matrix

5.16.1 Context

In-patient participants consisted of 3 males and 2 females. All participants worked in the in-patient services as named nurses to individual patients. Referrals for admission to in-patient services are sent to the Responsible Medical officer (RMO) but admission assessments are completed by the duty doctor or the House Officer and the nurses on duty when the patient arrives on the ward. A named nurse is then allocated at a later date.

5.16.2 Summary of Category I (Perception and Personal Views of Risk Assessment and Management)

Four participants (6.1.20.M), (7.10.F), (8.1.0.F) and (9.1.0.M) indicated that risk assessment and management plans should be completed for all patients regardless of their status on admission. One participant (7.13.0.F) implied that this does not happen as named nurses are expected to complete risk assessments on admission and if the named nurse was not available then the risk assessment is not always completed. Another participant (10.2.0.M) also stated that although nurses were qualified to complete risk assessments the Trust policy required only doctors to complete the risk assessment on admission. The same participant (10.22.2.M) stated that nurses were not
proactive in discussing and highlighting risk assessment and management plans with medical.

5.16.3 Summary of Category II (Knowledge and Types of Risk Identified)

The types of risk behaviours identified by the five in-patient participants (8.1.2.M) (7.8.0.F), (6.1.2.M) included: risk to self, others, self-harm behaviours, patient's history, length of risk behaviours, current circumstances, and severity of behaviour. Two participants (6.8.0.M) and (8.1.2.M) identified self-harm, violence and neglect. Two other participants (6.1.2.M) and (7.7.1.F) stated that history of the patient was established as part of the risk assessment. One participant (6.1.2.M) identified the risk to children and family with the same participant (6.1.2.M) indicated the effects of alcohol, drugs and other medication as part of the risk assessment.

5.16.4 Summary of Category III (Risk Assessment and Management Practices and Processes)

All five in-patient participants implied that risk assessment was an individual responsibility. One participant (7.6.0.F) indicated that if the duty doctor did not complete the risk assessment then it was the responsibility of the named nurse to do so and discuss it with the team at the earliest opportunity at the ward round. Same participant (7.13.1.F) stated that although risk assessment was supposed to be a shared responsibility it was more the named nurse who had the sole responsibility to make sure that the risk assessments were completed. One participant (9.13.0.M) also asserted that risk assessment and management strategies were not discussed routinely with others unless an individual was interested and willing to get the notes and read themselves.
there were no routine formal discussions at handover. There were contradictions from participants as although the participants had previously stated that risk assessment and management was an individual responsibility (7.7.0.F) and (8.1.0.F) one participant rationalised team risk assessment and management as needed for when a patient was ready for discharge and that it was a trust policy. One participant (7.7.0.F) stated that risk assessment was a legal document and difficult to complete therefore a team effort was required as other professionals may have more knowledge to contribute. One participant (10.3.0.M) asserted that risk assessment must be jointly completed between nurses and doctors as nurses spent more time with patients than the doctors with another participant stating that both nurses and doctors were ‘experts’ in their field and that the two professions should contribute to the assessment and management of risk. Two participants (6.2.0.M) and (7.8.0.F) stated that the completion of risk assessments were dependent on the patient’s reasons for admission, the knowledge of the patient and the severity of the risk they presented. One participant (6.16.1.M) asserted that first admissions, psychotic patients, patients who will abscond and informal patients must have risk assessments completed immediately. Other rationales given by another participant (7.11.0.F) and (8.4.0.F) indicated that the completion of risk assessment was depended on the duty doctor admitting the patient and although some duty doctors will complete risk assessments routinely as part of the admission process others did not do so, either because they were too busy or forgot to complete the risk assessments and admission. One participant (7.18.0.M) stated that risk assessment was not ‘ingrained’ in them and that it was all about paper work which everyone hated. Another participant (9.29.0.M) indicated that sometimes it was difficult to assess patients who were not in a fit state to be assessed, for example patients admitted under section 136. Another participant (10.13.0.M) stated that risk assessment was often completed for formal patients, psychotic patients and patients with drug or alcohol problems, patients who had
been violent to others but not for informal patients such as patients with anxiety and depression or patients who have agreed to come into hospital voluntary. Two participants (7.14.0.F) and (9.22.0.M) blamed the lack of completed risk assessments on the pressure of work with one participant (9.22.0.M) stating that sometimes staff on patient's observation duties were asked at the same time to complete patient assessments including risk assessments. It was implied that this affected the quality of the observations and the quality of the assessments being completed. Most of the participants agreed that the completion of risk assessments must not be influenced by a patient's status or diagnosis and that all patients must have a risk assessment completed on admission. The risk assessment and management process described by participants was diverse although there was a Trust risk assessment and management policy. It was evident that because the perception of risk assessment and management was diverse there were inconsistencies in practices and the interpretation of Trust risk assessment and management policy.

5.17 Comparisons of Risk Assessment and Management Practices and Processes between the In-patient and Community Participants

Following the summary of the contents of the interviews for both the community and the in-patients participants it was perceived necessary to compare the finding from the interview and the findings from the case notes analysis. This was necessary to enable the identification of the links between the participant's responses and the evidence identified in the case notes.
Participants from the in-patient services mainly described risk assessment and management processes when asked for their perception and views on risk. They emphasised that risk assessment and management was a Trust policy and named nurses were expected to complete the risk assessment if the admitting doctor did not complete the risk assessment on admission. One participant indicated that risk assessments should be discussed at ward handover but believed that nurses were not proactive in feeding back risk behaviours to doctors. The in-patient participants indicated that patients with first admission, psychotic, formally admitted, patients with alcohol problems or patients who have a risk of absconding were more likely to have risk assessments completed on admission. In-patient participants also asserted that the completion of risk assessment on admission was dependent upon the admitting doctor and that not all admitting doctors completed risk assessments and that if the admitting doctor did not complete the risk assessment then the named nurse was responsible for ensuring that the risk assessment was completed. This was supported by the evidence in the case notes which showed that only 49% of in-patients had risk assessments completed on admission.

In comparison the community participants expressed concerns about the varied levels of thresholds between experienced and novices who had similar experiences and training but different opinions on the levels of risk and management of identified risk. There were concerns about the haphazard processes of CPA and difficulties in discussing risk with psychotic and manic patients and the patients who do not engage, not receiving the service they required. The community participants' perceptions of risk
management focused on practices whilst the in-patients participants focused on processes. The community participants also indicated that risk assessments were completed to assure people regardless of the severity of the risk presented by the patient and to defend practices in a blame culture. The community participants' practices were supported by the evidence in the case notes which indicated that 67% of risk assessments had been completed on admission compared to only 49% in the in-patient services. The community participants appeared to be more aware of the reasons why risk assessments were not being completed compared to the in-patient participants.

5.18.1 Knowledge / Types of Risk and Evidence from the Case Notes Reviewed

Both the community and in-patient participants identified similar risk behaviours such as risk of self-harm, risk of violence, however there were some differences in the risk behaviours identified as the ones commonly assessed. The in-patient participants focused on issues such as duration of risk behaviour, the severity, the effects of the risk behaviour on the family and the influence of alcohol and drugs misuse. Evidence in the case notes indicated that 57% of the in-patients had the risk of self-harm, violence and neglect assessed on admission. However, the community participants suggested that they relied on past similarities and the knowledge of trigger factors to identify risk behaviours. The community participants used words such as 'gut feelings', 'memories' in describing their knowledge and types of risk behaviours assessed. With the evidence suggesting that 78% of the community patients had the risk of self-harm, violence and neglect assessed on admission.
5.18.2 Risk Assessment and Management Practices and Processes and Evidence from the Case Notes

Risk assessment and management practices were diverse and inconsistent between the community and in-patient participants and although about fifty percent of patients had risk assessments completed on admission, these assessments and management plans were completed for the same reasons but from different perspectives. As stated previously, community participants completed risk assessments and management plans in order to avoid blame whilst the in-patient participants failed to complete risk assessments to also avoid being blamed. There were however, some good practices such as 18% of risk assessments, being completed jointly by both doctors and nurses in the in-patient services whilst only 6% joint completed risk assessments had been completed in the community. Most patients had risk assessments completed only once with the evidence indicating that 59% of in-patients had risk assessments completed only on the day of admission whilst community patient’s had 65% risk assessments completed only once on admission. Not all patients had risk relapse plans completed. 61% risk relapse plans were completed for in-patients and 75% risk relapse plans were completed for community patients with reasons for these practices ranging from, difficulties in assessing some patients, i.e. patients admitted on section 136, and risk assessment and management and CPA being patchy across the Trust.

In comparing the participants’ perceptions of responsibilities for risk assessment and risk management, both groups of participants indicated that risk assessment and management was an individual responsibility with the in-patient participants stating that risk assessment and management was the named nurses responsibility, and that if the admitting doctor did not complete a risk assessment then it was the named nurse who
completed the risk assessment and discussed it at the ward round. The in-patient participant’s also indicated that risk assessment and management plans were not routinely discussed. This perception of responsibility supported the evidence in the case notes reviewed which indicated that only 46% of risk assessments been completed by the in-patient nurses. Alternatively, the community indicated that risk assessment and management was an individual responsibility and that the individual was ‘blamed’ when a patient committed suicide. The participants asserted that it was the responsibility of the individual practitioner to highlight the risk if they had any concerns as risk assessment and management plans were not routinely discussed within the community teams’ meetings. There was also an indication that risk assessments were completed by the community participants to avoid blame and not necessary as good practice. Evidence from the case notes supported this view as 82% of risk assessments were completed by individuals in the community on admission compared to the 46% completed by the in-patient participants who perceived the completion of risk assessments as the medical staff’s responsibility.

It was apparent from the case notes reviewed and interviews with both the community and in-patient services participants that risk assessment and management practices and processes were diverse, individually focused with minimum team decision-making practices and processes despite the Trust implementing a policy and procedure guidance for staff. It was also evident that various factors such as knowledge, perception of responsibility and processes influenced the successful completion of risk assessment and management plans for individual patients. The diversity of the professionals’ perception and the inability to develop common approach to risk assessment and management practices appear to hinder the effectiveness of the risk assessments and management practices. The diversity and differences in approach, perception, practices
and processes therefore prompted the need for further exploration of risk assessment and management practices and processes and the perceptions of responsibility for risk assessment and management. It was believed that an international focus on risk assessment and management may provide some insight into the current risk assessment and management agenda and help to understand the issues influencing clinical practices both nationally and internationally and where appropriate learn lessons and share the lessons to support professionals in their attempt to manage risk effectively.

5.19 Discussion

The evidence from the participants' responses and the case notes reviewed showed that under the category of perception of risk, all ten participants held different views about how and who should complete risk assessment including who should have a risk assessment. The in-patient participants clearly focused on the process of risk assessment rather than good practices. The in-patient participants identified patients they perceived to be high risk for example, first admission, psychotic patients, patients admitted formally or patients at risk of absconding as those needing risk assessments completed instead of all patients admitted needing a risk assessment. It was also evident that the in-patient participants relied on the admitting doctor to complete the risk assessments on admission or the named nurse, thus if these two clinicians did not complete the risk assessment then it was likely that the patient may not have a risk assessment completed. Alternatively, the community participants did not rely on the doctors to complete the risk assessments, however they completed the risk assessment themselves due to fear of being blamed and the perception that it was the individuals responsibility to complete the risk assessment instead of completing the risk assessment.
as part of good clinical practice. The community participants used words such as ‘varying thresholds’ ‘experienced nurses’ and ‘gut feelings’ to describe their practices and reasons behind those practices. The community participants highlighted the issue about engagement and expressed concerns that patients who were less likely to engage with the services did not receive the service they needed.

The category of knowledge however, generated a much more consistent perception about the risk behaviours that all participants assessed for patients with mental health problems. All participants were able to name at least one of the three risk behaviours commonly assessed for all patients namely, violence to others, self harm and self neglect. Some participants were also able to identify other risk behaviours pertinent to the client group, such as risk to children, exploitation from others and more importantly the increased risk from alcohol and substance misuse which has been highlighted in all the confidential inquiries into homicides and suicides.

The category of risk assessment and management process and practices also highlighted some similarities and some differences in practices and processes. It was evident that both groups of participants worked in accordance with the Trust policy and procedure on risk assessment and management, however, the participants’ perceptions of the Trust expectations from them was diverse. It was evident from the responses that the participant’s perceptions of the Trust policy and procedure influenced their practices and influenced individual’s perception of those practices. Whilst the in-patients participants worked with the notion that the Trust risk assessment and management policy and procedure required that the admitting doctor completed the risk assessment as part of the admission process the community participants believed that the same Trust policy required that the individual assessing the patient completed the risk
assessment and management plan therefore the person who completed the risk assessment in the community did not need to be the participant. Having reviewed the Trust policy and procedure it was evident that the policy suggested a multi disciplinary approach to risk assessment and management. The participants' perception of the Trust ‘blame culture’ also influenced their risk assessment and management practices by ensuring that the assessments were completed, as one participant stated that completing a risk assessment will ‘cover my back’. Participants gave contradicting responses when asked about whether a patient diagnosis influenced their completion of risk assessments. Some participants stated that the patient’s diagnosis did not influence their risk assessment practices whilst others implied that the patient’s diagnosis influenced their risk assessment and management practices. For example some community participants indicated that a patient with a diagnosis of anxiety would not get the same in-depth risk assessment as a patient with schizophrenia. The responses showed that although there were more male participants, the gender of the participants did not appear to have influenced their responses as there was no consistency in their responses. The evidence also suggested that the participants’ years of experience did not significantly influence their practices.

5.19.1 Reliability and Validity

Several authors have asserted that qualitative methods are often criticised for failing to clearly address issues of validity and reliability (Le Compte & Goetz 1982, Brink 1989). Authors such as Guba & Lincoln 1981, Sandelowski 1986 have also suggested that when applying rigor to qualitative research, researchers have traditionally used terms such as ‘truth value’ ‘applicability’ and ‘consistency’ therefore this researcher used these terms to discuss the reliability and validity in the context of this study.
5.19.2 Truth Value

Researchers such as Sandelowski 1986 had asserted that a research instrument was valid when there was confidence that it measured what it was intended to measure whilst Guba and Lincoln 1981 suggested that the 'truth value' of qualitative study should be evaluated by it's credibility rather than its internal validity. They asserted that credibility could only be determined if the data and its interpretation was taken to the source and asked the participants whether they found the results plausible (Guba & Lincoln 1981) therefore implying that a qualitative study was accepted as credible if it revealed accurate descriptions of individual's experience and the people who had those experiences being able to recognise those experiences from the descriptions or interpretations (Sandelowski 1986). The researcher therefore returned to the study sites and discussed the interpretation of the study findings with four participants, two from the in-patients services and two participants from the community services to confirm the credibility of the analysis and to establish if the findings reflected the participant's experiences and perceptions of risk assessment and management within their respective clinical areas. The community participants acknowledged that the findings from the data analysis accurately reflected their experiences and reiterated the lack of support for clinicians and the blame culture that they believed affected their clinical practice. However, although the in-patient participants acknowledged that the findings reflected their experiences, they were not familiar with the word 'diffusion of responsibility'. They believed that risk assessment was the responsibility of the doctor or individual named nurses.
5.19.3 Applicability

Appleton (1995) suggested that applicability in qualitative research related to the external validity in quantitative research. Guba & Lincoln (1986) acknowledged that the idea of 'fittingness' was appropriate to describe generalisability when evaluating qualitative research. Sandelowski (1986) suggested that qualitative study whose findings 'fitted' the context outside the current research study could be described as having fittingness with further acceptability if practitioners viewed the study findings as meaningful and applicable to their experiences. Therefore the interpretation from the analysis should be applicable to other areas. Since the completion of the study the researcher has presented the study findings at the International Council of Nurses conference in Geneva where practitioners from the international nursing community found the interpretation of the analysis (blame culture, individuals instead of teams completing risk assessments) applicable to them.

5.19.4 Consistency

Polit and Hungler (1991) defined reliability as the degree of consistency or dependability with which an instrument measured the attributes it was designed to measure. Lincoln & Guba (1985) and Brink (1989) asserted that in qualitative terms this referred to the consistency, repeatability or replicability of the study and the clarity and accuracy of the final report. Guba and Lincoln (1981) suggested that the concept of auditability should be the measure of consistency in qualitative research. They asserted that the study could be judged as auditable if the reader can follow the audit trail of the research process. This study had therefore been conducted with the view of enabling the reader sufficient details and information to check the audit trail. In this study the interview was
used to explore the concept of risk assessment and management and to gain qualitative data, therefore the researcher was the data collecting instrument. The reliability of the data collected therefore depended on the capabilities of the researcher’s interviewing skills and the researcher believed that her skills increased with the progression of the study.
Chapter 6

6. Study III (Interview with International Experts in Risk Assessment and Clinicians from the United States)

6.1 Introduction

Following the data collection and analysis in both studies one and two, the researcher believed that an international focus and perception of factors influencing the risk assessment and management agenda and practices would be useful for comparison and learning. This therefore led to study III which involved qualitative data collection process through an interview with international experts in clinical risk assessment and management and a group of clinicians and managers from two different clinical settings in the United States. The MacArthur study was initiated in the late 1980’s in an effort to inform policy and decision-makers on services required for people with mental illness as the management of violence has become of central importance throughout the world and there was no evidence to support the laws and policies on which decisions about service development and service provisions are based. The evidence also suggested that the outcome of unstructured clinical assessments were also causing concerns. The MacArthur foundation network therefore decided that the way forward in improving risk assessment for community violence was not to address the process of clinical judgement but to develop an evidence-based actuarial tool that would inform the judgement as it has been well documented that statistical risk assessment was generally superior to clinical risk assessment, however there had been few attempts to develop actuarial tools for the specific task of assessing risk of violence to others among people with mental disorders (Monahan et al 2001).
6.2 Aim of Data Collection from the United States

The aim of the data collection was to:

- discuss the MacArthur violence study and its findings
- compare clinical practices between the United States and the UK
- Identify lessons to be learnt in the United Kingdom

6.3 Selection of Participants

Using purposive sampling the researcher selected participants for the third study following a review of an article in the medical journal about the MacArthur violence study in the United States. The researcher wrote to the MacArthur institute in the United States and to five clinical settings which had been involved in the MacArthur study and requested participation in the study. Three researchers involved in the MacArthur violence study and two clinical sites responded and agreed to participate in the study.

6.4 Accessing Participants

Through discussions with the participants it was agreed that the researcher will visit the United States to interview the participants from the MacArthur study at MacArthur institute in Virginia and Worcester. The two clinical sites agreed to be interviewed at Medfield and Boston. The researcher then applied for a travel scholarship through the Florence Nightingale Foundation and was awarded the travel scholarship.
6.5 Development of an Interview Guide

A semi structured interview guide was developed to enable the researcher to explore risk assessment and management practices in the United States and also to enable an exploration and discussions with researchers from the MacArthur violence study. The interview guide was designed specifically for this study as there were no previous research reports available. The interview guide consisted of 6 questions which were intended to probe the MacArthur violence study researchers and to explore their response as this type of study had been defined as an interview to get information in the respondents own words and to gain descriptions that drew out details. The questions on the interview guide included:

- The risk assessment and management agenda in the US
- Current risk assessment and management practices and processes
- What lessons can we learn from the United States?

6.6 Data Collection Process

The data collection process involved an agreement with the participants on where the interviews will take place. All participants agreed that the interviews will take place at the work place. Interview dates and times were agreed. As this was a qualitative study exploring risk assessment and management practices in the United States to inform learning, it was essential that the researcher selected participants who could articulate their experiences to enable the enhancement of the researchers understanding. The
researcher visited the United States and interviewed three researchers and visited two clinical sites who had agreed to participate in the study and interview them. Participants were interviewed in groups and all interviews were transcribed.

6.7 Data Analysis Process

As qualitative data produced rich data that needed to be systematically analysed the analysis in the third study was based on the modified Miles and Huberman (1984) used in study II. The interview data was therefore subjected to the three stage process of data reduction, data display and the drawing of conclusion.

6.8 Data Reduction

6.8.1 Coding Process

This process started with the transcription of the tape recorded interviews to enable an analysis of the data. Similar coding process as used in study II was used in study III. Following the transcription of the interviews the transcripts were read line by line and codes or 'labels' as sometimes called were attached to the data segments to allow for easy identification of those data segments at a later date. Codes of varying sizes were attached to paragraphs, sentences or words and a system for identifying and retrieving the codes at a later stage was developed.
6.8.2 Data Filing System

A data filing system was set by hand to ensure that every data segment for each category was easily and quickly retrieved during the analysis. Each significant data segment consisting of phrases or quotes from the transcribed text was cut and pasted onto coded cards, which had instances of the category label it belonged to. Cards with similar data patterns were grouped together and category labels that best describe them were attached. It was anticipated that this will allow for the creation of categories, differences and the identification of frequencies of each category.

6.8.3 Generating Codes or 'Label'

The process of coding involved the transcripts being read over and over to identify a word or groups of words that best described the content of the data segment. This process also allowed for the identification of patterns and commonalities that run through the transcripts. Generating categories involved the identification of data segments which could be related for the purpose of comparison. The data segments were organized by grouping all data segments which seemed similar or related together. The data segments were then compared within each pile to identify any interesting similarities or differences. The different data segments were compared to allow for the identification of patterns or variations in the data. These differences were discussed with another researcher and the meanings were clarified and agreed.
6.8.4 Developing Meaning

The next stage following the systematic process of generating and creating categories and subcategories was a process of displaying the data in a matrix to enable the identification and establishment of concepts and themes in a systematic process. The transcription of the interview notes were transferred onto index cards and as these grew the analysis progressed to 50. This process allowed the researcher to become familiar with the data which guided her focus so that the linkages could be followed up. The data was critically analysed and questioned and 3 categories emerged.

6.9 Emerging Categories from the Interviews with Participants from the United States

6.9.1 Category 1 (Perception of Risk Assessment and Management)

This category highlighted the different aspects of the participants' perceptions as the participants had come from different professional backgrounds with different perspectives and objectives in risk assessment and management. However, participant's responses at the interviews generated some similarities as well as some differences. In describing the purpose of the MacArthur study the participants from the MacArthur study stated that:

➢ "There were really 2 major purposes – risk assessment was one of them, hopefully at the end of the study we will be able to contribute to a better assessment of risk among persons with mental illness leaving hospitals but the other big purpose was to
learn some things that would help us form policy about persons with mental illness addressing the bigger question that has been hanging around like are people with mental illness any more likely than anybody else to be at risk to persons in the community when they are discharged.” (1.3.2)

Participants from the MacArthur study perceived risk assessment and management as part of the national policy strategy development which was driven by law and policy makers and believed that the outcome of their research will inform policy makers when making decisions about service provision for people who presented with risk and to alleviate public fears about the level of risk presented by people with mental health problems with the following illustrated statements:

➢ “The larger theoretical questions we are addressing like are persons with mental illness any more likely to engage in violence than other people – how might that be related to services that are provided after they return to the community and so forth.” (1.6.1)

➢ “All of these things drive toward better assessment also can be used to help inform everyone from law makers to people who devise policies about health care e.g., there is a general public perception that persons with mental illness represent an increased danger to that very often when you look in the newspapers you see reports of persons who have engaged in violent behaviours with a report of their mental illness alongside and increases the public perception that they are a special risk – yes they are a special risk, one that justifies special laws basically with regard to involuntary hospitalisation with regard to how you monitor people when they leave the hospital and so forth.” (1.6.1)
The participants from the clinical areas perceived risk assessment and management as much more focussed on violence and attributed the reasons for this focus on the belief that violence involved other people and attracted media attention whilst suicide only involved the individual and did not always attract much media attention:

➢ "I think one of the reasons in the USA is that violence has been focussed on more is that you are taking someone else’s life and probably the values of this country says there is not such a value placed on a person making that decision for themselves but it is when taking another person’s life. You are very fortunate if someone brought a gun back on to a Unit that they did not turn it on someone else before shooting themselves.” (2.16.1)

The clinical participants expressed concerns about the ability to predict risk and the tension between ensuring patient’s safety and restricting patients in the process of managing risk which was believed to violate individual’s right to freedom:

➢ "It is a problematic area how do you know, how can you predict the future based upon the past and how restrictive can you be without violating their rights to freedom.” (2.7.2)

There was a perception that risk assessments are influenced by the knowledge one has about a patient as that knowledge influenced the individual’s judgement when making a decision about the risk the patient presented:
“It is a tough area, we have several different types of forms that we use for risk, in one particular one you are supposed to evaluate the patient from the perspective of how they presented within the last week so it is hard not to be influenced by what you know of the patient’s history because you don’t want to say no risk, when you do in fact believe that the patient does present some risk so I guess it is difficult.” (2.8.10.)

Clinical participants also suggested that risk assessments were subjective as occasionally clinical decisions were influenced by the experiences of the professionals especially if the individual had been involved in litigations:

“Yes, it varies from unit to unit and from clinician to clinician so sometimes if you have a psychiatrist who is willing to weigh out risk benefits for certain patients to be treated in one unit and then moved to another unit where you have a psychiatrist who has had a lot of litigation against them they are very cautious so it is very subjective.” (2.9.1)

“When you were asking about why we focus on violence rather than suicide I think it is because in this country we have had a lot of high profile cases of patients with mental illness and everyone attributes the violence to the fact that the patient is mentally ill whereas with patients who are committing suicide in one sense that doesn’t make news like violence towards others.” (2.9.2)

The use of privileges to manage risk was perceived by the clinical participants to be very useful as it enabled both patients and clinicians to share the responsibilities of risk
management with the nurses having the responsibilities for ensuring that safety of patients are maintained through the use of agreed privileges:

- “Privileges are never a reward they are always based on safety they may be used as punishment but they are always based on safety and so it may be when teams are in disagreement over someone, if the patient asks for half hour privileges they may be going slower than other patients and because they don’t handle too many privileges without running into difficulties we may agree that we should give them more short blocks of time like 15 minutes at a time so that we know where they are and can they be responsible to handle them, can they get back to the unit on time, are they where they are supposed to be and if they handle them well then moving them up.” (2.11.3)

- “The nurse needs to sit down very carefully and go over with the patient whether they are safe to be off that unit for that half hour period of time and can document and hold those privileges. It doesn’t change the order but the nurse has a responsibility to make sure that the person is safe so they can still hold back on those privileges. In the old days it would have held for 24 hours.” (2.12.2)
6.9.2 Category 11 (Knowledge and Types of Risk)

This category identified risk knowledge base of all participants involved in the study. All the participants had similar views and knowledge about risk behaviours presented by people with mental health problems however, there were also some differences in the risk behaviours that the researchers identified to the risk behaviours that the clinicians believed had to be assessed. The participants from the MacArthur study had broader perceptions of risk behaviours based on evidence from the studies with suggestion that an individual’s history, age and gender played a major part in the assessment and management of risk:

➢ “There is no experimental intervention with regard to risk management and we have similar problems in this study to what you will see in much of the existing literature on risk assessment which is many of the variables that best predict future dangerous behaviour are in variant, their age, gender, past history.” (1.8.1)

➢ “Obviously some things come up and substance abuse is one of them as a variable that I suggest if you control it you may be able to reduce the rate of variable behaviour.” (1.8.2)

➢ “There were some variables that clearly seemed to correlate with higher and lower rates of violence and some of them were the sort of things that clinicians traditionally think should be targets for intervention so they included for example, compliance with treatment recommendations so subjects who were more compliant with medication and visiting actually have lower rates of violence and subjects who had more contact with care givers over a period of time had lower rates of violence, but what that
doesn't tell you is whether randomisation is involved whether the people who wouldn't be violent in the first place are the ones who complied with medication and come to their sessions or whether the medication and sessions are actually having some impact.” (1.8.4)

Both participants from the MacArthur study and clinical participants agreed that the prediction of suicide was much easier than the prediction of violence in people with mental health problems.

➢ “There is some clinical evidence which is supported by no data whatsoever that suggests that suicide is easier to predict than violence – we are better at doing it because we are clinicians and suicide is something that we assess. Here in the data for self harm, thoughts of self harm, none of the above, thoughts of self harm, attempts at self harm, attempts to actually kill themselves had a significant correlation with violence during the first 2 follow-up periods.” (1.12.1)

Clinical participants identified similar risk behaviours but with more focus on a patient's history, triggers and previous means of resolving stress, substances misuse, high risk groups such as young men and the need to consider discrepancies from one's own observations to what the patient is saying;

➢ “I think very often it feels more like an art and a constant dialogue amongst the clinical disciplines in terms of the person’s history, how they are presenting now, their current functioning, which is where ……..” (2.9.9)
“Yes you would be able to see the discrepancies from what your observation is and what the person is saying because sometimes when you do risk assessment you look at the discrepancies from what the person is presenting and what they are saying. They say one thing but may be doing something different.” (2.13.7)

“Incidents of violence & suicide are consistent with other areas. General high risk group for violence are young men, substance misuse and mental health patients.” (3.5.2)

6.9.3 Category III (Risk Assessment and Management Practices and Processes)

This category highlighted risk assessment and management practices and processes as perceived by both the participants from the MacArthur study and the clinical participants. The participants from the MacArthur study suggested that there was no evidence based process for risk management and that risk assessment and management was governed by state laws with individual state deciding to systematise the instruments used for assessing risk:

“Because issues related to prediction of risk and the consequences and failing to predict risk in this country are generally issues of state law rather than federal law so claims against psychiatrists, other clinicians, facilities for release of dangerous patients are almost always litigated in state courts.” (13.1)
Clinical participants believed that the nurses were responsible for patient’s safety, however there was a shift from individual risk assessment and management to integrated treatment plans:

➢ “... the nurses do the safety assessments and all the clinicians aren’t aware of it and it doesn’t get incorporated but it is something we are trying to work on.” (2.5.1)

➢ “We have gone away from the care planning into integrated master treatment plan. I think one of the problems for nursing is that you could have an admission that happens on a Friday afternoon and the nurse who does the initial nursing assessment is working on the 3 – 11 shift and checks all boxes, completes everything, writes everything down and then you have the master treatment planning meeting happening some time a few days later and may have a different nurse in the room who has reviewed the assessment but may not necessarily present the same level of concern or may not have spent as much time with that patient as the original nurse did.” (2.5.2)

Clinical participants expressed concerns about risk assessment and management practices and processes where for example a nurse may assess a patient on admission and have concerns about the level of risk the patient presented. However, this nurse may not be the same nurse who attended the risk management meeting therefore the level of risk or concerns presented on admission may not be expressed at the same level by the nurse attending the risk management meeting as that individual had not assessed the patient on admission. Clinical participants also emphasised that treatment plans were based on team consensus as team meetings were held regularly to discuss risk management including the allocation of privileges in an effort to manage and monitor
risk with periodic reviews on a 3 or 6 monthly basis by the care team including the superintendent of the hospital.

➢ "But what goes on our treatment plan is the whole treatment team's consensus.” (2.5.2)

➢ “On the unit you may have 1 or 2 treatment teams depending on the size and then for each of those treatment teams you generally have 2 meetings a week. One is just a general team meeting where you have a general discussion, discuss privileges and things like that and then you have what is called a treatment planning meeting and at least once a month you review every patient and have a treatment plan and a couple of times a year you do what is called a periodic review which is another treatment plan which is more comprehensive where you review all the special assessments. They are done at 3 months, 6 months and annually. For a new admission is done weekly for the first 8 weeks and then monthly.” (2.5.2)

Clinical participants also believed that the findings from the MacArthur study has had some influence on their practices as the findings from the MacArthur study had led to a review of the risk assessment forms:

➢ “Would say that the violent behaviour assessment form has certainly had some impetus from the findings of that study because of our connection with ........and the chief researchers. The violent behaviour assessment form has been done by psychology and recently our medical director has been teaching the social workers to
have a greater involvement with this and generally people tend to type this up as a full report rather than necessarily filling it all out.” (2.9.8)

The clinical participants highlighted risk assessment and management processes which ensured active participation of patients and the courts in decision making wherever necessary:

➢ “Privileges exist on our campus, passes are what happens off the campus, we made a change in that and we are changing it back to that system again but privileges can go anywhere from the person who has only privileges to be on their unit and that is a locked unit or escort by a staff member, sometimes one to one so that the first step may be to go one to one.” (2.10.8)

➢ “After escort privileges comes a destination privilege and this will involve the patient going from one area on the campus to another and then they pick up the phone and call and say I am here now and the understanding is if they don’t show up there and don’t make that phone call we will search for them but we also know that there are staff there so if they walked off the campus and called from there we would know that they still hadn’t arrived yet.” (2.10.2)

➢ “Then independent privileges which may be for a short period of time like 4, half hour periods of independent privilege, then full ground privileges when the person is checking in on the unit at least every 2 hours but other than that they are free to go to place to place. They may have employment in the coffee corner, or in a number of
other areas, we have a green house, a progressive work centre where people are actually employed and earn money as part of their rehabilitation and developing work skills.” (2.10.3)

“Even in some cases patients were turning their privileges in to safeguard them so I’m not doing well right now they were aware they were having difficulty and they would say I’m going to stay in the evening and I am not going out, could someone escort me down for the last smoke of the night and they would turn their privileges in and we would review it in rounds the next day, if the patient was more stable they would keep their privileges and it wouldn’t change but they themselves have some control and with the help of staff recognise the fact that they are having difficulties and turn their privilege level in before they did something off the unit that would put them back on a 1:1 or a C.O. or that kind of thing.” (2.12.3)

The use of coercion in the management of risk was also identified as patients were encouraged to attend health facilities to collect their state benefits which enabled the clinicians to see and assess the patient on those occasions even though the clinicians did not handle the patient’s benefits they had a responsibility to ensure that the patient had food and shelter. This arrangement also enabled the clinicians to monitor the patient’s mental state and where appropriate implement appropriate strategies.

“This centre works in teams with cases shared between the professionals. Risk assessments are evaluated every 6 months or in every team meeting. Treatment programmes are revised regularly or during any major life event.” (3.4.1)
We encourage empowerment – even allow for poor decisions to be made. People committed are those who are incompetent and refuse treatment and in some cases the courts approve medication treatment plans. Usually patients are involuntarily committed but can refuse medication unless courts have made a judgement. The courts sometimes substitute the client’s judgement.” (3.4.3)

The court will sometimes approve medication – medication will then be given against patient’s wishes. Laws allow to forcibly medicate, courts have a period of review, in-patient authorisation is usually up to 6 months.” (3.4.3)

Out-patients have guardianship which include medication review once a year or more, Judicial standards are reviewed every year. The courts will accept the judgement of medical staff in an affidavit however sometimes these are contested by patients. Once in a while a court will question a course of medication in accordance with the patient’s wishes. Most patients are voluntary, some are on probation.” (3.4.3)

We also use what we call benevolent coercion which includes probation. Guardianship are benefit from the state. Patients are then required to attend the centre for the payment of their spending money.” (3.5.1)
The responses from both the participants from the MacArthur study and the clinicians generated a lot of similarities as well as differences in the perception of risk assessment and management. The participants from the MacArthur study asserted that the purpose of their study was to inform policy which would eventually inform practice as the policy making made decision on services to be provided for people with mental health problems who present a risk to themselves and others. There was also an aim by the MacArthur study to alleviate public fears about the risk presented by people with mental health problems as the MacArthur study had indicated that people with mental health problems did not present any more risk to the public than people without mental health problems living in the community.

The clinical participants also believed that risk assessment and management in the United States was much more focused on violence as a result of public reactions to people with mental health problems and the media presentation of the risk of violence presented by this client group. Concerns were raised about the tension between maintaining patient's safety and the perceived human rights and the violation of human freedom. Some clinical participants stated that the identification of risk by clinicians was subjective and sometimes influenced by previous knowledge of the patient's history and the experiences of litigation that the assessing physician has had. Both groups of participants knowledge of risk behaviours generated a variety of variables which they believed should be considered when assessing people with mental health problems and the risk that they may present to themselves and or others. The participants from the MacArthur study identified risk variables such as age, gender, past history as well as substance misuse and compliance with service givers. The clinical participants in
addition identified substance misuse, young men, trigger factors and what had helped in the past to resolve stress that leads to an individual wanting to harm themselves or others. All participants however, agreed that suicide behaviour was easier to predict whilst violence was less predictable.

The category of risk assessment and management practices and processes also showed some similarities as well as differences in practices between the participants. The participants from the MacArthur study asserted that there was no evidence based intervention to support clinicians in their risk assessment and management practices. The participants emphasised that issues relating to risk assessment and management were governed by State laws and statues therefore each state adhered to its own regulation and processes of risk assessment and management. The participants expressed their support for the laws and statutes as they perceived the State laws and statues to be useful in protecting them from litigation. It also ensured that all clinicians working within that State used the same risk assessment tool agreed therefore the clinicians were familiar with and able to communicate identified risk with each other. The clinical participants highlighted the strong team focus in the management of risk with the description of various team meetings to discuss the risk presented by the client group and the discussion of privileges which enabled the clinicians to monitor and manage the risk presented by people with mental health problems.

The clinical participants defended the use of privileges in managing risk as being very useful as enabled the patients to be actively involved in the management of risk that they presented for example, a patient could decide to turn down her privilege to go out for 30 minutes if she believed that she was not well enough to be outside the ward environment. It appeared that the autonomy for the patient to make some decisions
about how safe she felt encouraged the patients to take some responsibilities for managing the risk they presented. The responsibility to manage risk was therefore shared although the clinicians were responsible for ensuring that the patients were safe. A clinician therefore could override a decision by a patient who believed that they were well enough to use their privileges if the clinician's evidence suggested that the patient was not well enough to go outside the hospital. It should also be noted that the decision to actively involve patients in such decision-making processes were carefully thought through within the multidisciplinary team providing the care for the patient.

Other clinical areas used other creative ways in engaging patients as their focus was on patient engagement. For example in one service patients were required to attend the centre for their state benefit, for meals or to shower at least once a day. Patients who were involved in this process of care were those client groups who otherwise will not comply with any form of intervention and lose contact with the services. The clinicians though could not dictate what the individual did with their state benefit they had the responsibility to ensure that the patient had food and shelter. It also enabled the clinicians to assess the patients whilst at the centre therefore ensuring that the risk that the individual may present to themselves or others was managed effectively.
Chapter 7

7. Emerging Themes

7.1 Introduction

This session will highlight and discuss the themes that emerged from the three studies discussed in the previous chapters. The case notes reviewed and the interviews with the various clinicians and participants from the MacArthur violence study in the United States highlighted the diversity as well as the similarities in practices between the United States and the UK. The findings suggested that researchers have continued to identify risk predicting factors to support clinical practices as well services developer and policy making in their attempt to provide safe service for people who continue to present a risk to themselves and or others. Previous studies and the findings from this study showed that risk assessment and management was a complex process which was influenced by various factors. Two key themes which influenced risk assessment and management of risk for people with severe mental health problems emerged from the results of this study. The key themes were: Influencing Factors which included (knowledge, experience, responsibility and local and national guidance) and Practices and Processes which included, (nursing assessments and decision making) in risk assessment and management. The diagram below illustrates the interactive relationship between the emerging themes.
7.2 Diagram IV  Interactive Relationship Between Emerging Themes

<table>
<thead>
<tr>
<th>Structure</th>
<th>Influencing Factors</th>
<th>Practices and Processes</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Services and In-patient Services</td>
<td>Knowledge Experience Responsibility Local and National Policies</td>
<td>Nursing Assessment and Decision-making</td>
<td>Risk Assessment and Management Completed or Not completed.</td>
</tr>
</tbody>
</table>
7.3 Structures for Service Provision

7.3.1 Community Services

The community mental health services involved in this study consisted of: 5 generic teams aligned to social services geographic service provision areas, specialist services such as community drug and alcohol service, mentally disordered offender service and assertive outreach teams. Each team was made up of multi-disciplinary professionals consisting of: nurses, doctors, social workers, psychologist, occupational therapist, community support workers, a team manager and administrative support. Each patient admitted to the community services was allocated a care co-ordinator who was responsible for ensuring that the individual patient's health and social needs were identified and met through the care programme approach. Community services in the United States who participated in the study were not linked to in-patient services but were able to refer patients for admission through the State system.

7.3.2 In-patient Services

The in-patient services consist of three acute open wards, a close supervision unit and a difficult and offender unit. The multi disciplinary team of professionals consisted of nurses, doctors and occupational therapist. Each patient admitted to the ward is allocated a named nurse who is responsible for ensuring that the patient's care needs are met whilst in hospital. The named nurse worked collaboratively with the care co-ordinator in the community and any other specialist service required for the patient to promote a speedily recovery and discharged back into the community. It was noted that the community mental health teams were closely linked to the in-patient services with the same consultant psychiatrist for the community mental
health teams being responsible for the in-patient services. Care co-ordinators visited and attended ward rounds in the in-patients units and were required to contribute to the discharge planning although it appeared this did not happen on all occasions. The results indicated that in-patient nurses expected the community nurses to actively participate in the management of the patients. However, it can be argued that this expectation was not necessarily based on best practice but mainly as a means of devolving their responsibilities to the community nurses. Structures in the United States for in-patient services are provided separately from the community services. Patients considered eligible for State service are assigned to either a hospital or day care centre. Patients can negotiate where they want to go but they are usually assigned a place to be cared for.

7.4 Theme 1 (Influencing Factors)

Responses from the interviews with the participants indicated that knowledge, experience, responsibility, national and local agendas were factors that influenced the successful or unsuccessful completion of risk assessment and management strategies for people with mental health problems. The influencing factors therefore either enhanced or hindered the assessment and or management process.

7.4.1 Knowledge and Experience

Both the responses from the interviews and the case notes reviewed demonstrated that the majority of the patients from the community and in-patients services had risk of violence, self harm and neglect assessed in over 50% of all assessments. It can therefore be deduced from the results that the completion of risk assessments were based on the extent of the individual nurses' knowledge and experience of risk behaviours and risk predicting factors. This was also confirmed by the responses
from the participants in the United States who stated that clinical decision making on the risk that a patient presented was based on the knowledge of the person’s history and the experiences that clinicians have had with litigations also influenced the decisions they made.

The evidence from the results suggested that the risk behaviours commonly assessed for all patients were, self-harm, violence and neglect and therefore it is assumed that this is because the risk of self harm, violence and neglect has been well documented in the various confidential inquiries and suicide reviews (Appleby 1998) and Department of Health policies such as the National Service Framework (1998). It has also been well publicised by the media over the last decade, and can be argued that due national and local guidance and expectations, these three key risk behaviours can be easily recalled therefore making professionals more aware of these risk behaviours in people with mental health problems and possibly enabling the professionals to store such information in their memory and use that information when assessing people with severe mental health problems. It can also be argued that responses from the clinicians in the United States implied that they also perceived that the media perception of people with mental health problems and risk influenced the public negative perceptions of mental illness and the risk of violence. Alternatively, the continuous media coverage of the mentally ill and risk ensured that clinicians remained alert to the risk factors which those client groups could present. The risk of violence, self harm and neglect also appeared to be the most common risk behaviours observed or experienced by most mental health professionals working with people with mental health problems and possibly more easily recalled therefore supporting theories such as ‘availability bias’ in which the tendency to judge an event to be more probable, the more easily it can be recalled or pictured mentally (Kahneman et al 1973). Based on the assertion by the various authors (Benner 1984, Pitz et al 1984) that knowledge and experience are important in decision making as it
enabled decision makers to retrieve information stored in the memory, it can be assumed that most professionals retrieve information on similar problem, situation or event they have experienced or have knowledge about and compared that information to the current presentation of the patient when completing risk assessments. This enables the decision maker to make a judgement on the current risk presented, the possible consequences if the risk behaviour continues and then decide on the best possible solution based on previous similar experiences and prior knowledge. Lack of knowledge and previous experience can mean that the decision maker (nurse) is unable to rely on such previous information therefore unable to make a safe judgement.

The responses from the interviews with participants showed some examples of lack of knowledge and experiences by mostly the in-patient participants in the UK who did not complete risk assessments for high risk patients such as patients formally admitted who by the nature of their compulsory admission suggested that risk assessment was imperative. Lack of knowledge, experience and the discrepancies in risk assessment and management practices was also demonstrated by all participants by the risk behaviours and risk predicting factors assessed and the fact that not all patients had the three most common risk behaviours (violence, neglect and self-harm) assessed with only one participant linking the risk of alcohol and drugs misuse to risk behaviours and risk predicting factors. The United States participants on the other hand, had identified other risk behaviours in addition to violence and self harm as they also suggested considerations for behaviours such as trigger factors, age and gender. Although not all participants acknowledged the importance of substance misuse in predicting risk behaviours it was obvious that both the UK and the United States perceived substance misuse as a major factor in predicting risk as the participants from the MacArthur study had established that mental illness alone was not a high risk factor but a combination of mental illness and
substance misuse increased the risk that an individual may present to themselves and others.

The polarisation of views and perceptions by participants were expressed through responses such as ‘not all patients required in-depth risk assessment as risk assessment should be completed for patients with a diagnosis of schizophrenia and depression and not patients with a diagnosis of anxiety’. However, there was no indication in the responses to ascertain whether a risk assessment was necessary for patients with diagnosis of co-morbidity. The limitations of participants’ experience and knowledge in risk assessment and management was supported by the evidence in the case notes reviewed which showed that risk behaviours such as violence, self harm and neglect discussed during the interviews had been assessed or recorded in most of the case notes with exception of cases where other risk behaviours such as risk to children and exploitation had also been recorded.

7.4.2 Responsibility

Evidence from studies (Maynatt et al 1975) indicated that people in groups feel less responsible for their actions than do people acting alone. Maynatt et al (1975) linked this behaviour to the combination of personal responsibility and negative outcomes which produces a unique and psychologically aversive state which is eliminated by changes in responsibility or outcome perception. Maynatt et al (1975) asserted that when an individual was confronted with implied or actual negative consequences, the individual tended to avoid conflict by diffusing and denying responsibility if possible (as in group situations) or by misperceiving the negativity of the outcomes. They suggested that in all cases the combination of responsibility and negative consequences was avoided.
Collins et al (1972) supported Maynatt's assertion on diffusion of responsibility by also suggesting that individuals reduce cognitive conflict by misperceiving the aversiveness of an outcome whereas group decision makers can deny responsibility. Collin et al (1972) affirmed that the two responses represent the same psychological phenomenon of dissonance reduction or avoidance and indicated that the ready availability of other people on whom to place responsibility would presumably make responsibility denial more probable. Collin et al (1972) therefore concluded that responsibility of diffusion was not an active group process or one that involved social interaction or exchange but simply an individual cognitive response to a potential conflict arousing situation.

The evidence from the interviews suggested that community participants working independently accepted responsibility for ensuring that risk assessment and management were completed for patients and believed that the individual professional will be blamed if anything untoward happened to the patient as the first question that the individual professional will be asked is 'what did you do to prevent this incident' and not what did the team do to prevent the incident. It was very clear from the findings that the community nurses perceived the completion of risk assessment and management as their responsibility by 82% of community nurses completing the risk assessment uni-professionally which suggested that more patients in the community had risk assessments completed than the completion of risk assessments for in-patients.

This could be further explained by arguing that in the community there was no readily availability of other people on who to place responsibility as it is an individual who saw the patient and completed the risk assessment and management strategies and then discussed their observations and decisions with other members of the team.
However, it was implied by the UK respondents that the risk assessment discussions with other members of the team was only information sharing and not comprehensive discussions and alternatives generations of possible solutions by the team. The perceptions and views of the community participants strongly supported the belief that individuals were responsible for the completion of risk assessment and management strategies instead of the good practice of teams discussing and sharing that responsibility.

In the in-patient services the responsibility appeared to be diffused with nurses blaming doctors for non-completion of risk assessments. Staff from the in-patient services on the other hand perceived the completion of risk assessment and risk management as the doctors’ responsibility and did not acknowledge that nurses also had the responsibility to complete the risk assessment jointly with the doctors or to ensure that it was completed and reviewed at critical points in the patient’s journey through the health care system. The in–patient participants also expected the allocated named nurse to complete the risk assessment if it had not been completed on admission. This meant a patient could be admitted for days before a risk assessment was completed if for instance the named nurse was off duty for a couple days.

The ward managers and other qualified staff did not seem to accept the responsibility for ensuring that risk assessments and risk management plans were completed and discussed with all professionals involved in the patients care provision. This behaviour of not accepting responsibility can be supported with the theory of diffusion of responsibility (Maynatt 1975) which asserted that people in groups feel less responsible for their actions than do people acting alone. It was very evident that in-patients felt less responsible for their actions as there were other members of staff
who could be held responsible, if risk assessment and management plans were not completed. And as suggested by Maynatt et al (1975) the above behaviours can be linked to the combination of personal responsibility and negative outcomes and the fact that when an individual is confronted with implied or actual negative consequences, the individual tends to avoid the conflict by diffusing and denying responsibility.

Diffusion of responsibility therefore appeared to be more evident in the in-patient services as the professionals within that service worked in groups compared to the community services where professionals worked independently and autonomous. It was also evident that both groups of participants attached high negativity to the consequences of management reactions to serious incidents and perceived management reaction as that of blaming the individual. It can be argued that the perception of blame culture consequently influenced participant’s behaviour in the management of risk presented by patients with severe mental health problems. The importance of completing risk assessment and management strategies had therefore not been based on good clinical practice but mainly on the avoidance of blame and the perceived consequences of blame.

The responses from the United States were varied and contradicted the behaviours observed in the UK. The clinical participants in the United States, both the community and in-patients, implied in their responses that risk assessment and management was a shared responsibility and involved everyone including the patient who was empowered to monitor their privileges. One can assume that participants from the United States did not show the extent of diffusion of responsibility as observed in the UK participants because of the support afforded to these practitioners through the State laws and statutes, therefore the clinicians were able to participate in the shared
responsibility process for risk assessment and management. It was however noted that the concern about 'blame culture' was also experienced by participants from the United States as clinicians perceived the State laws and statutes that governed risk assessment and management as being supportive as it protected them from litigations. It can therefore be argued that both participants from the UK and the United States did not complete risk assessments from a good practice point of view but instead from what the clinicians believed was expected from them.

7.4.3 National and Local Directives

In the past few years various directives from the Department of Health (care in the community (1990), National Service Framework (1995), Discharge of the Mentally Disordered (1995) and the Strategy for Suicide Prevention (2002) have prompted NHS Trust hospitals to manage risk presented by people with mental health problems more effectively. The recent national drive (National Strategy for Suicide Prevention 2002) to reduce suicides in the general population and the mentally ill has reiterated the need for NHS Trusts to effectively manage risk presented by people with mental health problems. These national and local directives have highlighted the importance of risk assessment and management and brought to focus, the issues of responsibility and accountability including consequences for NHS professionals.

In effect, the national directives and local policies have devolved the responsibilities for implementing risk assessment and management to individual professionals instead of promoting team responsibility in the community as the care co-ordinator is usually held responsible for the care an individual patient received whilst in the inpatient service, individual nurses do not accept responsibility for the completion of risk assessment and management but instead the nurses blamed each other or other
professionals. The perception of blame in both the community and in-patient services, have led to staff in both clinical areas defending their practices by either completing or not completing risk assessments for people with mental health problems for the sake of 'covering their backs' with the view that if risk assessment is not completed then one does not get blamed for an untoward incident such as suicide or homicide, or that risk assessment should be completed in case there was an incident and managers decided to investigate, then there will be an evidence of completed risk assessment. Risk assessments are therefore not completed as part of good clinical care and effective clinical risk management but instead completed as a means of defensive practice in a blame culture.

However, the participants from the United States appeared to perceive the State laws which governed their risk assessment and management practices in a more positive way as they believed it protected them from litigation. National and local agendas from both the United States and the UK appeared to develop from critical incidents involving people with mental health problems and hence the need for the MacArthur violence study to alleviate public perceptions and fears about the mentally ill and also to support clinical decision making and inform policy makers in developing appropriate services for people with mental health problems.

7.5 Theme 2 (Practices and Processes)

7.5.1 Nursing Assessment and Decision-Making

Assessment (Community Services)

The community mental health services have an open referral system with all referrals going directly to the team. One member of the team is then allocated the case for an
initial assessment and to report back to the team (see flow chart below). This individual member of the team completed the initial assessment which included a risk assessment and then decided whether the patient required services from the mental health services or needed to be referred to other agencies. On completion of the initial assessment the individual professional could either become the care co-ordinator or where appropriate another member of the team was allocated to manage the patient’s care.

Assessment (In-patient Services)

A patient is referred for in-patient admission either by the care co-ordinator in the community, any other professional in the team, a general practitioner or from the accident and emergency departments. In all cases the patient was seen and assessed by medical staff and a decision made on whether the admission is appropriate or not. Admission to in-patient service is not based on an open referral system as it is in the community. Once the patient is admitted an admitting nurse and a doctor completed an initial assessment and formulated an action plan. A named nurse is then allocated who takes over the role of co-ordinating the patient's care with all other professionals involved in the patient's care until the patient is discharged from the in-patient service.
Community Care Pathway

Patient referred to CMHT

Team member identified to complete initial assessment including risk assessment

Team member reports back to team

Patient not admitted
Report back to referrer

Patient admitted to team. Care co-ordinator identified

Care co-ordinator completes comprehensive assessment and management including risk assessment

Care co-ordinator implements comprehensive management plans including risk management plans

Care co-ordinator evaluates management plans including risk management plans

Care co-ordinator discharges patient, if management plans have been effective

Or reviews, formulates and implements new management plans

(Process continuous until patient is discharged from services)
In-patient Care Pathway

Patient referred to in-patient services by CMHT

Patient seen and assessed by medical officer and admitted

Initial nursing assessment completed by admitting nurse

Named nurse identified within 24 hours

Named nurse and care co-ordinator responsible for ensuring care management plans are reviewed in ward round including CPA meetings

Comprehensive risk assessment and management plans are formulated and implemented.

If management plans are effective, the patient is discharged following discussions in the ward round and CPA meeting. Otherwise management plans are reviewed and new plans are formulated and implemented and continuously reviewed until patient is ready for discharge

(Process is continued until patient is discharged)
Despite the close links and working relationships between the community mental health teams and the in-patient services there were vast differences in the practices and processes of risk assessment and management between the two services. The findings from the case notes reviewed also supported the themes that emerged from the interviews with the participants with the indication that 49% of in-patients and 67% of community patients had risk assessments completed on admission. 51% of formal patients in the in-patient services did not have a risk assessment completed on admission.

Rationale given by the participants for the divergence in their risk assessment and management practices and processes were varied, inconsistent with each participant giving a different view and perception of risk assessment and management therefore highlighting the diversity of knowledge, experience and perception of risk assessment and management among the participants. It was evident from the results that community participants completed more risk assessments and management strategies than the in-patient participants although it can be argued that both community and in-patient participants where first level registered nurses had completed same pre-registration nurse training programme and were deemed competent practitioners by the professional regulatory body.

Participants from the in-patient services indicated that the completion of risk assessment was dependent on whether it was the patient's first admission, patient was psychotic, patient was formally admitted, had a diagnosis of drugs and alcohol misuse, or whether there was a possibility of the patient absconding from the ward. The participants also asserted that the completion of risk assessment was dependent on the admitted doctor as the nurses perceived the admitting doctor to be responsible for the completion of risk assessments on admission. The nursing staff
did not routinely assess risk on admission and viewed risk assessments as an activity involving too much paper work and the responsibility of the admitting doctor and the named nurse. In effect, the in-patient participants blamed the admitting doctor for the non-completion of risk assessments on admission.

The community nurses on the other hand perceived the completion of risk assessment as necessary to assure managers and to defend their practices in the event of a sudden untoward incident rather than view risk assessment and management as good clinical practice and as a positive way of effectively managing risk presented by people with mental health problems. Nevertheless, both the community and in-patient participants agreed that risk assessment should be completed on admission for all patients although the participants did not agree on whether every patient admitted (community or in-patients) should have a comprehensive risk assessment. Community participants in general believed that a comprehensive risk assessment was not necessary for all patients, for example, it was perceived that patients with anxiety did not need a comprehensive risk assessment compared to a patient with a diagnosis of schizophrenia or depression.

The varied views and perceptions on risk assessment and management practices and processes by the participants supported the diversity in risk assessment and management practices observed in the case notes reviewed suggested that risk assessment and management practices were based mainly on an individual’s knowledge and experience. It also suggested that risk assessment and management practices and processes were not supported by the team but rather individuals made the decisions and implemented formulated action plans as they thought appropriate. It can therefore be argued that a decision or judgement made by an individual professional about the risk that a patient presented can be challenged as evidence
from the literature (Lidz et al 1989, Mulvey et al 1989) suggested that professionals were unreliable in identifying risk therefore the identification of risk presented by a person with mental health problems by an individual nurse without an opportunity to discuss the issues with other team members can not be accepted as reliable at all times. Other authors (Anderson 1985, Newell et al 1972) have also implied that because decision-makers can not hold large amounts of short-term information at once, decision-makers tend to simplify situations to enable them to formulate decisions through the limited information they hold at one time, therefore the process of decision-making only highlights some aspects of the situation being dealt with, whilst others are ignored therefore making the decisions made unsafe and unreliable.

The cognitive processes involved in decision-making therefore indicates that for a nurse to be able to make an effective judgement and decisions about the risk an individual patient presents, the nurse must have sufficient knowledge of the risk behaviours, risk predictors, knowledge of the patient’s background, current circumstances and the current situation. The nurse must also recognise that a decision has to be made. However, the nurse may only be able to make such a decision if they have acquired prior knowledge of risk behaviours and risk predictors through knowledge and experience (Kahneman 1979, Payne et al 1978 and Sevenson 1979). It can therefore be assumed that in most clinical environments, both experts and novices are expected to complete risk assessments as the emphasis is based on the fact the individual nurse is a first level registered nurse and not the fact that they may not have any experience or knowledge on risk behaviours or risk predictors. The practices identified in the case notes reviewed and the responses from the interviews with the participants did not support the various recommendations made in the confidential inquiries (Appleby et al 2000, Bloom-Cooper 1998) and the literature. For example, patients should be followed up in the
community, one week after discharge from hospital, and that information should be shared about the current and previous risk behaviours and risk patterns known to the professionals. Documented evidence of information sharing from the case notes was unclear, and the responses from the participants also indicated that risk assessments and management plans were not routinely shared within the teams.

Both in-patient and community participants identified the three main risk behaviours frequently assessed as: risk of suicide, risk of violence and the risk of self neglect during the interviews and the same common risk behaviours were observed to be the most common risk behaviours often assessed by professionals. The risk of violence, neglect and self harm for both community and in-patients were often assessed, other risk behaviours such as the impact of drugs and alcohol misuse and the risk of exploitation by others, the vulnerability of the patient and the association between depression and violence which has been highlighted in the literature (Monahan 2002) were not assessed or explored by both community and in-patients participants. It can be suggested that the nurses only assessed risk behaviours most commonly identified in the national policies and risk behaviours that they were mostly familiar with. The latter supports the availability heuristic in decision-making when an individual retrieves information stored in the memory through previous knowledge or experience (Kahneman 1979, Payne et al 1978). The findings also indicated that nurses do not consider the complexities involved in the process of risk assessment and management but instead relied on their basic knowledge of the three most common risk behaviours (suicide, violence and neglect) identified nationally and reported on most frequently in the media.
It can be affirmed that nursing practice should be based on the nursing process model which is considered to be a problem solving activity based on a particular model of human action which involves an information processing and a problem solving model (Walton 1995). The nursing process, separated into four subprocesses consists of assessment, planning, implementation and evaluation (Christensen et al 1990) which are related to the different aspects of decision-making.

The first phase of the nursing process is an assessment which is described as a critical analysis and evaluation or judgement of the status or quality of a particular condition and situation (Miller & Keane 1987). This begins with the collection of information about the patient's health status and then analysed by the nurse and a nursing diagnosis is made by identifying the patient's problem (Marriner 1983). It has been suggested that during the assessment phase (Schaefer 1974) of the nursing process the nurse searches for cues to determine where the patient is on the health–illness continuum and to predict the level of wellness the patient might reach if present health needs are met. Benner (1984) and Henderson (1982) both agreed that the practitioner's knowledge and experiences were essential components of this decision-making process and that the broader the nurses conceptual knowledge base the wider the range of cues the nurses will discover and use during the deliberation of the decision-making process.

The assumption is that nurses can see their patient objectively and holistically but studies have challenged these assumptions and suggested that nurses see their patients only in specific ways (Latimer 1986) for instance on a medical or surgical...
ward the nurses seem to be mainly concerned with the patient's physical and medical needs and not the patient's psychological needs (Morrison 1989, Miller 1984). It can also be argued that this also applies to mental health where most nurses appear to be concerned mainly with the patient's psychological health needs and not the physical health needs.

The planning phase in the nursing process is linked to the choice phase of decision-making (Schaefer 1974) when alternatives are considered and the most appropriate intervention is chosen and implemented. During the intervention phase the nurse continues to search and gather additional information and reassesses the initial nursing diagnosis to determine whether the patient's condition is improving or deteriorating. The evaluation phase enables the nurse to reassess the interventions implemented and the patient's condition and situation and then formulates a judgement on whether to continue with the interventions or to discontinue and discharge the patient from the services. Various authors (Crow et al 1995) have identified the cognitive strategies involved in nursing assessments and asserted that there is evidence that the gathering of information in nursing assessment is directed by some internally driven search process with Jacovone et al (1992) suggesting that nurses generate descriptions of physical states in the form of perceptual patterns to direct their search and expert nurses generated outward perceptual appearances which they can expect to see very quickly.

Prescott et al (1989) also highlighted the importance of the nurse's knowledge of the individual patient and suggested that nurses developed specific knowledge structures for gathering and organising information about individual patients. Other authors supported this view by asserting that knowing the patient was an inherent part of the expert nurses' clinical reasoning (Jenny et al 1992) and that the need to know the patient as an individual was central in concepts such as individualised care (van
Servellan 1982) and that the nurses come to know the patient’s typical pattern of responses and the patient as a person (Macleod 2090 and Tanner et al 1993) and use the patient’s current presentation in deciding what to do (Javovone et al 1992, Corcoran-Perry et al 1990)

Despite both in-patient and community nurses completing risk assessment plans uni-professionally both groups of participants also indicated that risk assessments should be completed within the multi-professional team although the in-patient nurses perceived multi-professional risk assessment and management important as it was a legal document, too difficult to complete by one person and a Trust policy. In comparison to the community team, although the community nurses believed that risk assessments should be completed by a multi-disciplinary team there was also a view that it could only happen in an ideal world with assertions that staff in the community did not have time to discuss individual cases therefore could not discuss individual risk assessments routinely unless specifically identified as high risk cases by the care co-ordinator. These views were supported by the evidence that only 61% of the in-patient and 75% of community patients had risk management plans. 59% of the in-patients and 65% of community patients had risk assessments completed only once. This clearly indicated that some patients did not have appropriate risk management plans and completed risk assessments were not reviewed or if they were reviewed they were not recorded in the case notes. This lack of adequate record keeping has been highlighted in the literature (Lidz et al 1993) hence the assertion that the use of case notes alone to gather information was not always effective therefore the use of other data collecting processes to support case notes data is imperative.
7.5.3 Decision-making in Risk Management

Carroll et al (1990) and Pitz et al (1984) asserted that decision-making is an activity which involves a sequential process of the presentation of a problem, important features identified, other information retrieved from memory, and the information is then organised in a meaningful way. The individual then explores and classifies the decision situation to ensure they understand the relevant objectives and values, formulates the situation or behaviour presented then generates alternative solutions. The decision-maker then chooses a single alternative or attribute or compares alternative, evaluates the different benefits and makes a judgement as to what is best. It is therefore suggested (Pitz et al 1984) that before a person can respond to the problem presented, they must understand the information and develop a representation for the problem. Johnson-Laird (1981) described this representation of a problem as a ‘mental model’ that relates the problem to other knowledge. He also argued that in building the mental model, uncertain issues left by the problem such as the unpredictability of future events must be resolved or represented in a model in some way.

However, authors such as Kahneman et al (1990) argued that decision-makers do not always follow a rational process but instead make shorthand mental activity of recognition, structuring the decision situations and the evaluation of preferences to produce a judgement and choice. Payne et al (1978) and Svenson (1979) also supported the view that everyone has a store of decision rules which have been developed through experience and training. The individual therefore tries to achieve a preferred outcome, objective or goal, by deciding on a preferred solution based on the repertoire they have developed through experience and training. The individual then develops a plan to achieve their preferred outcome or goal. Payne et al (1978) and Svenson (1979) continued to assert that because we cannot hold large amounts
of short-term information at once, decision-makers tend to simplify situations to enable them to formulate decisions through the limited information they can hold at one time therefore only dealing with part of the issue and not the whole issue (Newell et al 1972).

Kahneman et al (1982) also affirmed that a person was more able to deal with a problem if the problem has happened before. They argued that if an event was important, the information retrieved from memory can be used accurately to assess relative frequencies. This is supported by Howell et al (1982) view that the more information given directly or retrieved from memory the less uncertain the person feels therefore any task performed using such information will be performed accurately. It has been affirmed that decision-making in risk management involves critical thinking to enable the nurse to make a judgement about the risk presented by the patient. Glasser et al (1994) supported the view that knowledge is necessary in critical thinking, however, the knowledge has to be domain specific nursing knowledge to enable the nurse to make a decision. The relevance of domain specific knowledge is supported by Elstein et al’s (1990) assertion that domain specific knowledge was important to ensure successful clinical reasoning however, Yahiro et al (1994) also argued that experience was also important in decision-making as it enabled the nurse to recognise patterns of behaviour and possible outcomes. They argued that lack of experience can affect a nurse’s ability to develop critical thinking skills.

Benner (1984) also asserted that practical knowledge is only developed through clinical experience whilst Tanner et al (1993) and Schon (1983) acknowledged the importance of experiential knowledge in enabling the recognition of patterns and intuitive responses in expert judgement. Benner (1984) continued to assert that an expert nurse understood a situation, recognised cues and interpreted them as to
what is relevant and what is not relevant. However, to understand a complex situation, the nurse must have experienced a similar or opposing situation. The nurse must also possess diagnostic reasoning skills and clinical decision-making skills, which will indicate their level of competency. Pitz et al (1984) pointed out that the basis for arriving at a judgement and decision-making was the use of existing information to gain further propositions about the problem. They also supported the view that the ability to utilise the judgement process was a consequence of many years of learning and maturation. Crow et al (1995) also argued that intuition and domain specific knowledge are used without conscious deliberation when making a decision on how situation must be managed following and assessment. They asserted that nurses use internally driven information searches when making assessments and developed core ideas and opinions from clinical experience which are generated as situations to expect, and agreed with Yates (1990) suggestion that the general nursing assessment is about likelihood judgement.

It is therefore suggested that the fundamental principle in risk management is the ability to assess and identify the risk involved and to reach a decision on how to manage the risk effectively. Risk decision-making therefore involves making a judgement about the risk presented and the possible outcome, then deciding on the best solution. Risk management therefore involved uncertainties as future events cannot be predicted with one hundred percent accuracy (Huxley et al 1996, Vinestock 1996). It also involved the nurse making a mental model representation of the risk the patient is presenting by retrieving past information relating to a similar problem from memory, organise the information in a meaningful way, evaluate and integrate the information (Johnson Laid 1981) to enable the nurse to make a judgement. However, it has been acknowledged (Pitz et al. 1984) that the past information retrieved is only stored as a result of experiencing an event or situation and or having knowledge about the situation or event. Pitz et al (1984) affirmed that
judgement and decision-making processes will not be complete unless they speak to
the representation of the problem stored as a result of how prior experience has been
incorporated into the mental model created for the problem. Knowledge and
experience has been advocated by the various authors as two important factors in
decision-making as they enabled the decision-maker to retrieve information stored in
the memory. Knowledge and experience therefore have the ability to either enhance
or hinder the decision-making on risk assessment and management process
depending on knowledge and experience stored in the memory as a result of prior
knowledge and or experience.
Chapter 8

8. Discussion

The findings from the 300 case notes reviewed showed that out of a total of 257 informal patients only 154 (59%) had risk assessments completed on admission. The results also showed that only 21 (49%) out of 43 formal patients had risk assessments completed on admission for treatment. This indicated that not all patients admitted for treatment had risk assessment completed. The patients' status on admission for treatment, especially, formal patients who by the nature of their admission implied that they presented a risk to themselves and or others did not have risk assessment completed on admission. This suggested that patients who presented a risk to themselves and or others were not having risk assessments completed to identify the level and nature of risk that they presented. It was evident that only 53 (17%) out of 81 patients with a diagnosis of schizophrenia had risk assessments completed despite the evidence which suggested that professionals were failing to identify the high risk people with a diagnosis of schizophrenia who committed suicide due to the lack of warning signs from schizophrenia (Appleby 1999, Barraclough 1988). The findings showed that only 77 (25%) out of 130 patients with a diagnosis of depression and bi-polar and 33 (11%) out of 65 patients with a diagnosis of alcohol, drugs and depression had risk assessments completed on admission for treatment. This indicated that a patient's diagnosis was not taken into account when completing risk assessment on admission despite the national agenda for suicide prevention and reduction and the drive to reduce the risk of harm to others (National Strategy for Suicide Prevention 2002, National Service Framework 2000). The results showed that the community participants were more likely to complete risk assessment for patients than the in-patients participants with
74 (49%) out of 150 in-patients and 101 (67%) out of 150 community patients having risk assessments completed on admission for treatment despite a Trust risk assessment and management policy which stated that every patient will have a risk assessment completed on admission for treatment.

Of the 300 case notes reviewed, 84 patients did not have an identified level of Care Programme Approach in spite of the national requirement that all patients must have a Care Programme Approach level identified which is linked to the level of risk presented by the patient and the patient's level of need to enable the professionals to provide appropriate care for that individual (Care Programme Approach 1999). Sixty nine 69 (46%) risk assessments were completed by nurses in the in-patient units whilst joint assessments between nurses and consultant psychiatrist were completed on 9 (6%) occasions. Joint assessments between nurses and junior/duty doctors were completed on 28 (19%) occasions although the evidence in the literature suggested that professionals were inaccurate in their prediction of risk presented by people with mental health problems (Montandon et al 1994). One would therefore have expected that joint risk assessments would be completed between the medical and nursing staff to ensure an increase in the accuracy of the prediction of risk in people with mental health problems. In managing the risk presented by people with mental health problems 92 (61%) of the in-patients and 113 (75%) of community patients had risk management plans completed. However, the evidence from the case notes reviewed showed that only 74 in-patients and 101 community patients had risk assessments completed on admission. This clearly demonstrated that the development of risk management plans did not always correlate with the completion of risk assessments, as some patients who did not have risk assessments completed on admission had risk management plans completed. It was therefore assumed that the nurses developed risk management plans based on their previous knowledge of
the patients or having assessed the patients the nurses failed to document their assessment but developed risk management plans.

The senior medical staff did not appear to actively participate in the risk assessment and management processes, as the risk assessments seemed to be complete by the junior doctors. It was evident from the case notes reviewed that most of the junior medical staff that admitted the in-patients were inexperienced and lacked the necessary knowledge and experience as most patients did not have risk assessments completed on admission. Findings from the case notes reviewed and the interviews suggested that clinicians needed to be aware of other risk behaviours such as non-compliance with treatment programmes. The effectiveness of some treatment programmes, influence of alcohol and substances on an individual's mental state which should be considered when assessing risk presented by people with mental health problems as the combination of these factors increased the level of risk that an individual presented (Thomas 1995, Drake et al 1992).

The community participants appeared to be more proactive in the assessment and management of risk than in-patient services participants and accepted responsibility for ensuring that risk assessment and management strategies were completed. The practice of multi professional risk assessments and risk managements was underdeveloped in both practice areas suggesting poor team risk management processes and practices. The lack of acceptance of responsibility observed in the in-patient services hindered in-patients participants risk assessment and management practices as the professional group who spend more time with patients than any other professional group did not consider it their responsibility to either complete or jointly complete risk assessment and risk management plans with the admitting doctors or discuss the findings and jointly agree management plans. It was also
evident that the in-patient participants linked personal responsibilities and negative outcomes to their practices which resulted in the individual's avoiding the responsibilities. This behaviour of not accepting responsibility or avoiding responsibility is supported by the theory of diffusion of responsibility which suggested that people in groups felt less responsible for their actions than people acting alone as the ready availability of other people on whom to place responsibility made the denial of responsibility more probable (Maynatt et al 1975, Collins et al 1972). It also appeared that the in-patient participants were not prepared to support their colleagues in identifying risk and developing appropriate management strategies as they blamed each other for the non completion of risk assessments and risk management plans. The observed diffusion of responsibility behaviour seen in the in-patients participants is supported by Collins et al's (1972) assertion that the diffusion of responsibility was not a group or social interaction or exchange but simply an individual cognitive response to potential conflict arousing situation. It could therefore be assumed that the nurses cognitive response to the risk that individual patient presented was to avoid being associated with the possible negative outcome of risk and therefore be blameless of the consequences.

Understanding the process of decision-making highlighted the complex nature and processes nurses have to undertake in order to make a judgement about a situation then decide on the best possible solution. It can therefore be asserted that the assessment and management of risk involved unconscious cognitive processes such as recognition, formulation, alternative generation, information search, judgement or choice, decision, action and feedback (Pitz et al 1984, Kahneman 1990). It also involved having prior domain specific knowledge about the condition or situation, experience, and the appropriate training. The need for the nurses to have prior knowledge of risk predicting factors, risk behaviours, their likely outcomes and
possible consequences was imperative in enabling the generation of alternative solutions in the assessment and the management. However, it was also important to recognise that having prior knowledge of risk behaviours and possible solutions generated heuristics such as the availability bias, representativeness and tacit knowledge which were not verified by other colleagues as team risk assessment and management was not the norm. The lack of team risk assessment and management practices prevented the nurses from discussing their risk assessment and management practices therefore unable to have peer review of their practices. It is therefore suggested that the decisions made by these nurses could be unsafe if their decisions are based on inappropriate knowledge and experiences.

The combination and interaction of the cognitive processes such as heuristics in decision-making, knowledge and experience enabled the experienced and expert nurses to make decisions about the risk an individual presented and to develop appropriate management strategies to minimise the risk. The use of the nursing process: assessment, planning, implementation and evaluation also contributed to the decision-making process as it enabled the nurses to utilise a structured process which started with data collection. The planning phase in the nursing process could be linked to the choice phase of decision-making (Schaefer 1974) when alternatives are considered and the most appropriate intervention is chosen and implemented. This suggested that the nurse has to retrieve previous risk management strategies which have been noted to be effective in similar situations and implement, reviewing regularly and modifying the strategies as appropriate. The intervention phase enables the nurse to continue to search and gather additional information and reassess the initial nursing diagnosis to determine whether the patient's condition was improving or deteriorating. This process of reassessing implied that the nursing process was dynamic in nature and therefore was not a one off assessment but a continuous process of assessing the risk an individual presented. The evaluation
phase then enabled the nurse to reassess the interventions implemented and the patient's condition and situation and formulated a judgement on whether to continue with the interventions or to discontinue and discharge the patient from the services.

The findings from the interviews did not confirm which group of participants, (i.e. in-patient or community participants) had appropriate knowledge in risk assessment and risk management, however community participants appeared to complete more risk assessments. It was also evident that the completion of risk assessment was not based on the patient's safety, good clinical practice or effective risk management but instead risk assessments were completed to avoid being blamed. The perception of blame and the 'blame culture' had negative effect on both community and in-patients participants and hindered the completion of risk assessment and management plans as participants either completed the risk assessments to avoid being blamed or blamed others for the non completion of the risk assessments.

The findings from the interviews with the participants in the United States generated some similarities as well as differences in practices and processes. It was evident that both researchers and clinicians believed that the risk assessment in the United States was much more focused on violence as a result of public reactions to people with mental health problems and the media presentation of the risk that they presented. This could be linked to the perception of the 'blame culture' expressed by clinicians in the United Kingdom as the clinicians from both countries believed that they would be blamed for any violent behaviours that people with mental health problems presented to the public. One of the main differences between the two countries was the perceived tension between promoting safety and the denial of human rights and the violation of human freedom, as the participants from the United States were more concerned about human rights and litigation. However despite the differences in concerns about human rights and litigation both groups of participants
from the United States and the United Kingdom expressed concerns about the blame culture which affected their risk assessment and management practices.

Another difference in practices between the two countries was the support of the State Laws in the United States which appeared to govern the clinical practices and protected the clinicians from litigation. Apart from protecting the clinicians from litigation the State Laws ensured that there was one risk assessment tool used and understood by all the mental health facilities in that State, therefore when a patient moved from one facility to the other, staff in the new facilities were familiar with the risk assessment. The findings from the United States showed that risk management had a much stronger team focus compared to the United Kingdom. The patients in the United States were encouraged to actively participate in the management of the risk that they presented by empowering the in-patients to monitor how and when they used the privileges (rewards) used to manage the risk that the individual presented. The use of risk management panels within the in-patient facilities in the United States also provided additional support for the clinicians as it enabled the clinicians to discuss their concerns about high risk patients with a group of senior clinicians and managers who contributed to the development of the risk management plans. Whilst clinicians in the community developed more creative ways of engaging high risk patients who would normally not comply with treatment programmes by encouraging the patients to attend the community mental health centre for lunch or to have showers, This ensured that the patients were regularly monitored by the clinicians who assessed their mental state and the level of risk that they presented.

The findings showed that although the nurses may have had similar training, the knowledge and experiences that they had acquired determined whether risk assessment and management plans were completed or not completed. The processes for communicating the risks identified and the management plans were
also imperative and suggested the need for clear local policies on risk assessment and management processes. It was also evident that there was a need for clarification of responsibilities for both in-patients and community clinicians to ensure that clinicians were fully aware of their responsibilities in the risk assessment and management process.

8.1 Implications for Practice

The evidence suggested that risk assessment and management for people with mental health problems were ineffectively co-ordinated therefore poorly managed. The professionals managing the risk did not appear to have the appropriate knowledge and experience to support their attempts to manage the risks presented. Professionals and Trust managing boards should recognise that uncoordinated risk assessment and management practices would continue to present difficulties for professionals working with people with mental health problems. The lack of communication and team focus within many of the care teams suggested that clinicians with less risk assessment and management experience had no recourse but to work in isolation with the minimum knowledge and experience that they had. This could lead to possible errors in decision-making therefore putting both the clinicians and patients at risk. The lack of formal processes to support clinicians in risk assessment and management of people with mental health problems could have negative consequences and lead to inappropriate risk assessment and management of high risk patients. And the possibility of 'burn out' amongst the nurses as they continue to struggle to manage the risk presented by people with mental health problems. The lack of risk assessment for patients on admission, especially formal (detained under the Mental Health Act 1983) patients who by the nature of their admission suggested that they presented a high risk could raise concerns about
negligence on the part of the clinicians who will be seen as failing in their duty to provide the appropriate care that the patients required.

Lack of risk assessment and management knowledge of the varied risk behaviours that should be considered when assessing people with mental health problems suggested that high risk patients were not being comprehensively assessed therefore the risk they presented was not identified which could lead to patients falling through the 'net'. The diffusion of responsibility observed could be partly attributed to organisational structures and partly professional practices. The diffusion of responsibility demonstrated by the in-patient participants indicated that nurses were failing in their duty of care to support the management of the risk presented by people with mental health problems. Ward managers should therefore take the lead in ensuring that risk assessments and management plans are completed for all patients admitted to in-patient units and also take the lead role in pulling in other professionals to contribute to the risk assessment and management process. The community participants were also failing in their duty of care to manage risk effectively as risk assessments were not discussed with team members and a team risk management plan developed and implemented. The nurses' perception of the blame culture in the organisation influenced their practices as it prevented them from completing risk assessments and management plans. This could lead to negligible practices and litigation. The implications from these poor risk management practices could result in both the professionals and the organisation being accused of negligence as both clinicians and managers are failing in their duty of care to appropriately assess and identify risk and manage the risk presented by people with mental health problems.

The contribution from this study to the general body of knowledge therefore included the highlighting of the need for a review of both pre and post registration nurse
training to include risk assessment and management for all nurses. It has also been established that poor risk assessment and management practices are attributes from organisational cultures such as the 'blame culture' and its influence on nursing practices.

8.2 Recommendations

The findings from this study highlighted the difficulties clinicians have in their attempt to monitor and manage the risk presented by people with mental health problems. It is therefore recommended that to improve clinical risk assessment and management practices NHS Trusts could address the structural processes that guided the risk assessment and management practices by ensuring that risk assessment and management was an integral part of clinical practice. This could be achieved by NHS Trusts ensuring that;

1. all staff understand that risk assessment was a dynamic process which involved both nurses and doctors and both groups of clinicians should discuss the risk assessment with the patient and reach a consensus about the level of risk the individual presented and agree an appropriate management plan.

2. local policies should address the importance of all patients having risk assessment completed on admission regardless of their diagnosis. The completion of joint risk assessments and management by nurses and doctors should be actively encouraged.

3. clinical teams should maintain a register for high risk patients, and review these patients on a daily or weekly basis depending on the level and nature of risk the patient presented.
4. in addition to regular patient case notes reviews, all Mental Health Trust should consider 6 monthly reviews of patients records for all high risk patients by independent review panels to provide additional support for clinical teams in managing risk.

It is further suggested that NHS Trust hospitals address the blame culture that currently prevents good clinical practices by:

5. Promoting team working and decision-making to become the ethos for risk assessment and management for all patients through local policies.

6. NHS Trust management boards should develop ‘no blame’ and ‘learning organisation’ cultures to support the eradication of the blame culture.

7. Health organisations should set up local risk management groups, consisting of senior clinicians from different professional backgrounds, and senior managers to support clinicians in the risk assessment and management process.

8. Clinicians should be encouraged and supported to develop creative ways of engaging patients who otherwise may not engage with services but presented risk to themselves and others to allow for the monitoring of the patients mental state and risk status.

9. It is also suggested that patients are actively involved and empowered to contribute to the decision-making process in the management of the risk that they present where possible and appropriate.
It is also recommended that NHS Trust hospitals and nurse training institutions share the responsibilities for promoting good clinical risk assessment and management practices. This could be achieved through:

10. The promotion of regular clinical updates of research findings, especially, risk predictors to support and underpin clinical decision-making.

11. Nurse training institutions reviewing both pre and post registration training programmes to ensure that risk assessment and management forms part of the basic knowledge that qualifies every nurse to be a competent practitioner.

12. Nurse training institutions and NHS Trust hospitals ensure that the communication in the management of risk for people with mental health problems is at the top of the agenda of every nurse training institution and health organisation so that risk assessment and management is enshrined in clinical practice.

8.3 Limitations of Study

The existing literature showed that although there was a vast amount of literature available on risk assessment and management these were mainly from the forensic field with very limited literature from generic mental health. However, some key principles from the field of forensic risk assessment and management were transferable to the generic mental health field with some modifications. Studies available were specific to single risk behaviours such as violence and suicide although it has been implied that risk behaviours and predictors were inter-linked and should not be viewed in isolation. For instance, a patient with an alcohol and substance misuse was more likely to present a risk to themselves or
others therefore linking the alcohol and substance misuse with risk to self and or others. Most of the studies involved medical and psychology staff and not nursing staff therefore the researcher could not compare this study with previous nursing studies.

It was possible that the researcher could have introduced her own biases as she was familiar with the clinical environment where the study was conducted and some of the participants involved in the study. This familiarity between the researcher and some of the participants could have influenced the participants' responses as fear of disclosing too much information about poor practices could have led the participants to believe that by disclosing poor practices could lead to disciplinary actions against them or their colleagues. The researcher viewed the familiarity between herself and the participants positively as having an inside knowledge of the clinical areas allowed for open discussions about the participants views and perceptions and the participants risk assessment and management practices and processes. However, being aware of the possible biases formed part of the supervision and discussion process.

The study was conducted within one organisation therefore there may be limits about the generalisability of the findings. However, the organisation where the study was conducted was made up of three NHS Trust hospitals merged over the last few years therefore the clinicians had come together with different practices, cultures and procedures and perceptions. It was therefore accepted that the diversity of cultures and practices within the organisation would be similar to cultures and practices within different NHS Trust hospitals in the United Kingdom therefore the findings could be applicable to other NHS Trust hospitals. There is also a need for the replication of this study in other clinical settings.
8.4 Conclusion

Risk assessment and management for people with severe mental health problems has been on the international agenda for decades with the United Kingdom focusing on the risk of violence, self harm and self neglect. Various confidential inquiries into homicides and suicides have consistently identified the need for effective risk assessment and management for these high risk patient groups. International studies have also highlighted the low risk predictability by professional groups. Current processes and practices suggested that risk assessment and management strategies were not completed as part of good clinical practice but as a means of avoiding blame and litigation. The evidence from this study suggested that practitioners need to reassess the reasons for completing risk assessment and management as this study has shown that there was a remarkable lack of risk assessment for people who present a risk to themselves and others. Professionals also need to re-think their risk assessment and management practices and promote and foster team responsibility and to support each other.

The perception of blame prevented clinicians from using good clinical judgements when managing risk in people with mental health problems therefore the blame culture needs to be addressed to foster confidence in professionals' clinical decision-making. The need to improve clinical risk assessment and management must be a shared responsibility between education and practice to ensure that the learning can be transferred into practice. In conclusion, this study highlighted that risk assessment and management plans were not completed for a significant proportion of patients irrespective of their mental state and diagnosis. More community participants completed risk assessment and management plans than in-patient participants. And more risk management plans had been completed without risk assessment to
support the identified risk factors. In-patient participants risk assessment and management practices were hindered by the diffusion of responsibility which influenced the nurses' practices. In the United States, the diffusion of responsibility had been addressed by the State laws and legislation which governed the professional practices in relation to risk assessment. Addressing the process involved in risk assessment would allow for safer working practices, improve clinical outcomes and improve working environment for professionals.
Appendices
Appendix 1

Interview Questionnaire

Background

1. Which area of practice do you work in?

<table>
<thead>
<tr>
<th>Community</th>
<th>In-patient</th>
</tr>
</thead>
</table>

2. How many years of clinical experience do you have? (Please tick as appropriate)

<table>
<thead>
<tr>
<th>1 -5 years</th>
<th>6 -10 years</th>
<th>Over 11 years</th>
</tr>
</thead>
</table>

3. What is your current clinical grade? Please tick the appropriate box.

<table>
<thead>
<tr>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
</table>

4. What are your professional qualification(s)

<table>
<thead>
<tr>
<th>RMN</th>
<th>Other(s) please state</th>
</tr>
</thead>
</table>
5. Which three main risk behaviours do you consider when assessing risk in an individual with severe mental illness?

1. 
2. 
3. 

6. In your professional opinion, what do you consider to be the 5 main factors that best predict risk in people with Schizophrenia in the following: -

<table>
<thead>
<tr>
<th>Suicide</th>
<th>Violence</th>
<th>Neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
<td>3.</td>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
<td>4.</td>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
<td>5.</td>
<td>5.</td>
</tr>
</tbody>
</table>

7. In your professional opinion, what do you consider to be the 5 main factors that best predict risk in people with depression in the following: -

<table>
<thead>
<tr>
<th>Suicide</th>
<th>Violence</th>
<th>Neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
<td>3.</td>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
<td>4.</td>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
<td>5.</td>
<td>5.</td>
</tr>
</tbody>
</table>
8. Which of the following assessment scales do you use to support your clinical judgement?
Please tick the appropriate box (s)

<table>
<thead>
<tr>
<th></th>
<th>Tick</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck's Depression Inventory</td>
<td></td>
</tr>
<tr>
<td>Beck's Suicidal Intent Scale</td>
<td></td>
</tr>
<tr>
<td>Beck's Hopelessness Scale</td>
<td></td>
</tr>
<tr>
<td>Reasons for Survival and Coping Scale</td>
<td></td>
</tr>
<tr>
<td>Global Assessment of functioning</td>
<td></td>
</tr>
<tr>
<td>Others- Please State.</td>
<td></td>
</tr>
</tbody>
</table>

9. In your opinion, how should the decision on the level of risk that a patient presents be made?


10. How do you assess risk in patients with depression?


11. How do you assess risk in patients with Schizophrenia


12. Please tick the appropriate box to answer the following questions.

<table>
<thead>
<tr>
<th>Identified risk must be discussed with other members of the MDT.</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients known to have presented specific risk in the past must have risk management plans to minimise future risk.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk management plans must be incorporated in the CPA.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A multi-professional team better manages risk.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identified risk must be clearly stated in the patient's case notes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk management plans must be clearly recorded in the patient's case notes.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. In your opinion when should risk assessment be completed?

   

14. In your opinion when should risk management commence?

   

15. How often do you assess your patient(s) for risk whilst they are receiving services?

<table>
<thead>
<tr>
<th>Only on admission</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>On admission and before discharge</td>
<td></td>
</tr>
<tr>
<td>At every review</td>
<td></td>
</tr>
<tr>
<td>At every review and before discharge</td>
<td></td>
</tr>
<tr>
<td>Before discharge</td>
<td></td>
</tr>
</tbody>
</table>
16. On discharge from in-patient services, how soon should the patient(s) be followed up in out-patients or by the community services?

<table>
<thead>
<tr>
<th>Option</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>One week after discharge from in-patient service</td>
<td></td>
</tr>
<tr>
<td>Two weeks after discharge from in-patient service</td>
<td></td>
</tr>
<tr>
<td>Over three weeks after discharge from in-patient</td>
<td></td>
</tr>
<tr>
<td>Over four weeks after discharge from in-patient</td>
<td></td>
</tr>
</tbody>
</table>

17. On discharge from your service should you inform other professionals who will be involve with the patient about the risk the patient presents?

<table>
<thead>
<tr>
<th>Option</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

18. How should the risk information be communicated to other professionals?

Thank you for your time.
Appendix 2

Risk Assessment and Management

Semi Structured Interview Guide

1. Demographic Details
   - Area of work
   - Experience
   - Gender
   - Age Group (18-30) (31-40) (41 plus)

2. Understanding of Risk Assessment
   - Own definition

3. Risk Assessment
   - Who is assessed
   - When is assessments completed
   - Who completes assessment
   - How are assessments completed
   - Other professionals involvement

4. Risk Assessment Information
   - Areas/behaviours assessed and why
   - Status, diagnosis and level of CPA
   - How information is used
   - How often is information used
   - When is information used
   - Who uses information
   - Assessment scales

5. Decision making
   - Who is involved
   - How are decisions made
   - What happens to the information
6. Risk Management

- Who formulates and why
- How is it formulated
- What is included
- Risk relapse plans
- Assessments and management correlation

7. Specific examples
Appendix 3

Interview Guide

- Area of practice
- Understanding of risk assessment and management
- Practices and processes
- Risk behaviours commonly assessed
- How/who makes decisions about levels of risk and risk management
- Patients status and diagnosis
Appendix 4

Interview 1

Place of work: Community

Years of experience: 25 plus (12 in Community)

Gender: Male

1.1. Could you please take me through your risk assessment and management process?

1.1.0 We get a referral make sure it meets the criteria and then work out the nature of the referral, i.e. urgent or routine and deal with it accordingly.

1.1.1 You will assess them and then decide if you will take them on or refer to other agencies.

1.1.2 You then come back and complete the paperwork and discuss with the team what we are going to do and identify care coordinator.

1.1.3 The patients are reviewed every 6 weeks according to GP notes and you might decide to carry on and eventually discharge them.

1.2. Do you use the same assessment format for all patients you see?

1.2.0 Yes, they all have the same assessment as I use the same standard form and format.

1.3. If you did not have a standard form, will you assess everyone you see?

1.3.0 No, it is not because of the standard forms but it is because I see everyone as an individual regardless of their colour, creed and sex so everyone has to be
treated the same.

1.4. Can you elaborate more on your assessment process?

1.4.0 I use the HOPE model and then use the MDT forms in a reader friendly way. Then go into the risk assessments and if there is any concern looks out for it, for example, if the person is abusing their children, then you go to Social Services.

1.5. Why do you do risk assessments for everybody you see

1.5.0 I think the form is structured in such a way that you think about what is going on for the client when you see someone you have to reflect on what is going on and actually risk highlights for you that sort of interaction.

1.6. When you do risk assessment, what areas do you look at?

1.6.0 Well, there are 4 areas, Risk to self, others, potential violence and neglect. I assess those for everybody

1.7. How do you communicate the risk with professionals you work with?

1.7.0 I think we communicate the risk very well in this team. The first is the location meeting and the second is the clinical meeting and we have ample opportunities to actually highlight any concerns to other members of the team and we have to discuss cases and when we review cases the team gets to know what is going on.
1.8. So how often do you discuss the cases with other professionals

1.8.0 Twice per week – and every client would probably be reviewed every 6 weeks.

1.8.1 You could discuss them very briefly or in detail for complex cases, but it is up to you. And other members will ask you questions

1.9. Does every patient have a 6 weekly review?

1.9.0 Yes, or you can say this person suffers from agoraphobia so you do not have to describe any risk in detail but for example if you say that this guy has family issues, then you should elaborate a bit more and you can also bring it up in supervision.

1.10. Once you've completed your Risk Assessment, what happens?

1.10.0 Well, you do your risk assessment and discuss with the team and if they are happy, then you continue to see the client.

1.10.1 There is no formal way of presenting.

1.11. Who develops the Risk Management Plan?

1.11.0 The individual does it. Well, you say what you have done and if they agree you continue and if they do not, you alter your Plan. You say what you are going to do and if people are not happy with it, they will say.

1.12. Is every patient discussed with the team?

1.12.0 Yes, risk happens with everybody. I think it is done fairly

1.13. Can you tell me about Risk Relapse Plans

1.13.0 Yes, we do, but they are for the minority patients who are constantly on the phone or talking about killing themselves, then we formulate Risk Plans as to how to respond to these people. The form is left downstairs and everyone knows. That is only for specific people, for those who are persistently telling you they are going to kill
themselves or children.

1.13.1 For example, there is a patient of one of my colleagues who is only allowed to talk to the duty person once a day, although in the past this person had called several times. So a plan was developed with the team and it was agreed that the person can only call once per day. The patient accepted the Plan and it is now implemented.

1.14. How often are Risk Assessments reviewed?

1.14.0 Well, as I understand, they are sometimes reviewed by GP’s rota so usually you present the case every 6 weekly. In the past we did not have any Plan so only personality disorder patients were discussed at review meetings. Now everyone has the opportunity to discuss their clients at the clinical meetings when it is their turn.

1.15. Does working in the community influence the reasons why and how you assess risk for your patients?

1.15.0 I think in the ward you will be more concerned because the patients are more disturbed because they are more acute. In the community, we have time to reflect but on the wards there is no time. We therefore have time to do the Risk Assessment.

1.16. Do you do joint risk assessment with other professionals?

1.16.0 We did one the other day because we were concerned that the person was going to go home and live with his parents. The consultant and myself went to assess the patient at home, we assess him, his carer and the home environment.

1.17. Does this happen often?

1.17.0 Only for high-risk patients, but individuals have to identify high risk patients themselves first and then request for a doctor to do a joint assessment with them. Sometimes the doctors
will decide they will do a DV and ask for a joint assessment with a CPN.

1.18. In your opinion, is there a link between a patient’s diagnosis and whether they have Risk Assessment completed?

1.18.0 There should be no difference – everyone I see I complete the Risk Assessment using the standard format. The diagnosis only makes a difference in terms of how detailed you complete your risk assessment, for example, a person with anxiety who needs to join the Anxiety management group will not have the same in-depth Risk Assessment like a person who is paranoid or suicidal.

1.18.1 People on enhanced CPA also get in-depth assessment, the initial assessment is used to decide CPA level and enhanced level is always MDT but standard is not. So one person assesses, plans, and reviews.

To further explore with next participant

- Is there a standard format for risk presentation
- Is there a criteria for identifying high risk patients
- Understanding of risk relapse plan
- Views on current processes for risk assessment and management planning
- Views on the decision making processes
Ok, so the first question is about risk assessment. What I need you to tell me is to explain or describe what happens from the time someone is admitted to your ward.

When somebody’s actually referred to... Ward, what would happen is obviously the duty Doctor would be the first one to do the initial assessment to determine whether or not in fact the patient needs to be admitted? We encourage our Duty doctors to complete and carry out a risk assessment on admission. Umm, they are actually, on the whole, most of them are pretty good and they will actually do the risk assessment. There have been occasions when the duty doctor will not have completed the risk assessment, in which case, it really is down to the named nurse to complete that or raise it in the first ward round whereby a risk assessment would be carried out then, and certainly when it comes to doing the CPA’s and 117 which is usually round about the time of discharge, um, the risk assessment would be repeated and sometimes we have people who are in hospital for a very long time, so they will have more than one CPA, more than one 117 meeting, so some will actually have a few risk assessments carried out within...... carried out throughout the time of their admission.

Obviously if there is an untoward incident on the ward, then usually, the risk assessment will be reviewed and re completed then, and when I say an untoward incident ............an untoward incident meaning, perhaps something that comes out of the blue that hasn’t been covered in their initial um Risk Assessment, obviously were meant to be in psychiatry, you can’t always say people are going to behave in the way perhaps the first risk assessment will say.
7.2 So if there is no untoward incident, what happens?

7.2.1 I have to say that here on the ward, being quite honest, the risk assessments are reviewed at the CPA's and 117. They are not done as a matter of course within the ward round. Or it would be a case of so and so has been in for a couple of weeks, shall we review his risk assessment today. That's not happening, that's not happening.

7.3 Why does this happen?

7.3.1 Uh, One of the reasons might actually be, and it's probably not a very satisfactory reason, one of the reason's is that we don't think about it, that's being perfectly honest, I think the other reason is time consumption. Certainly people, like I mean, the ....... Team have 17 patients in at the moment. So the ward rounds tend to be very lengthy anyway and the risk assessment is seen to be quite a lengthy process so I think that's why it tends to happen, and the CPA, 117 situation, when by the sheer nature of the meeting, more time is allowed within a ward round situation, anyway.

7.4 So let me just clarify this. Your ward rounds and 117 and CPA meetings are held separately.

7.4.0 No, they happen together, but more time is given within a ward round for example, in a ward round a patient can be given 15 minutes, for example, whereas if they have a CPA, 117 they would be allotted half an hour.

7.4.1 OK. Some 117's do happen outside the ward rounds so I can't tell you they all happen within the ward rounds, but most of them do happen within the ward rounds and as I say they would be allocated an extra period of time because obviously there's a lot more to discuss and there's a lot more people.

7.5 Ok. So let me go back to clarify a couple of things, First of all you said the duty doctor would normally do the risk assessments.

7.5.0 Yes
7.6 If the duty Dr does not complete the risk assessment at the initial assessment then what happens?

7.6.0 It’s down to the named nurse to get the doctor’s to discuss it or make sure it’s dealt with in the first ward round. It really depends, for example if a patient comes in on a Wednesday, and the ward round’s on a Thursday, then I think it’s appropriate to wait for the ward round to do the risk assessment there.

7.7 Why, do you say it is appropriate, why is this appropriate?

7.7.0 Well because it’s better to do it with the whole team present. I have to say that I don’t, I think that Risk Assessments are legal documents, and I think that they are something that, they are something difficult to do on your own. And I think that you know that if it is at all possible it should be done within a multi-disciplinary team meeting because there are people who are going to know this patient better than we do on admission. It’s not always possible to get the level of information you need from the patient. It’s not always possible to get the notes on admission, so I think if you can deal with it in a multi-disciplinary team meeting you’re going to have more information. You’ve got a better chance of having a more thorough risk assessment.

7.7.1 I mean, I know it’s important to assess a person’s risk at the time, but I think when you are doing risk assessments you do need to be aware of history, or it’s good to be aware of history. It may not repeat itself, it may have been a one off, but I think if you’ve got that extra information, it’s got to be helpful. It’s got to be helpful.

7.8 OK. What if let’s say ......the duty doctor doesn’t do the risk assessment. What will make it necessary for a nurse to do the risk assessment before the following ward round? Would there be any reason why it has to be done urgently?

7.8.0 I think you really have to look at the reasons why the patient has been admitted. For example, if you got somebody who has been admitted who has made any attempt to harm himself or commit suicide or has committed any acts of violence to other people, or if they have put themselves or others in any form of danger or if they have hinted
they might, then I think there is an absolute need because it's not just about patients safety, it's about safety for the other clients and staff on the ward, so I think you have to assess the individual and the reasons they're coming in at the time.

7.8.1 I mean, to be honest, it should be done every time, but I'm not going to sit here and lie to you and say it's done every time, but it should be, in fact, apart from what I’ve said, I'm qualifying that it should be done every time irrespective, but I think obviously, that I would be very angry if I came in and discovered that somebody had done something pretty serious to themselves or others, that a risk assessment had not been done. I'd be seething, because I think for things like that, it's got to be done. It should be done all the time

7.9 Does the diagnosis of the patient influence whether a risk assessment is done or not?

7.9.0 It shouldn't

7.10 But does it happen and why?

7.10.0 It's not that clear cut, some doctor's are good at doing it and will do it automatically, some you have to prompt, and some if you're not there to prompt them – it won't be done. So it's not about the patient, it's about the doctor, and most of them are top notch, but some of them aren't and If you happen to have a nurse on the ward who's not very confident reminding doctors about what they are doing, it may be that the risk assessment won't be done. It's not dependent on the patient, it's dependent on the doctor or the person doing the admission and that's being honest.

7.11 Ok. What about sectioned and informal patients? Does the status influence whether a risk assessment is completed or not?

7.11.0 No, it shouldn't

No, I don’t think it’s that cut and dry. Again, I think it's all to do with the doctor. After saying that, I think that the doctor's would probably be much hotter when it comes to sectioned patients because obviously they are aware that things are much more closely scrutinised with a sectioned patient, but again, I think it doesn’t make a difference, it's
So, what if I said to you that when I looked at the case notes, one of the things that I found was that a number of sectioned patients did not have risk assessments on the day of admission. Why would you think something like that would happen?

Again, it depends who the doctor was that has done the admission as I have said already. Some doctors are great, they just automatically - they will ask for the risk assessment if it is not in the pack, others you need to prompt them to do it. There is still some disgruntlement about the risk assessment and the fact they see it as paper work, because they do identify their risk, usually within their admission documentation. However, you know, we have got the risk assessment form

Would you say the admitting nurse has some responsibilities? If yes, what are the responsibilities?

Yes, the nurse doing the admission has got a responsibility as well and this is why certainly, if it hasn't been done, then the named nurse, because although the admitting nurse should again be the one that's making sure, at the end of the day, it's the named nurse who becomes ultimately responsible for that file and for that patient, so the duty doctor should deal with all the admissions. If she hasn't, it should be the admitting nurse, but there should never be a patient without a risk assessment because the named nurse then becomes solely responsible for ensuring that that risk assessment is done and I don't agree with that because I think that's down to the doctors.

It's well to have a shared responsibility, but it does appear it's the nurses who become solely responsible, because even when it comes to the CPA's and 117's, it's the person who is doing the CPA form who says 'Risk Assessment, again there needs to be a degree of prompting.

Why does that happen?

It's more paper work. Everybody hates paper work, everybody hates forms.
7.15  But how are they going to record things?

Record in notes
Hate forms but some forms are necessary
Better to go through R.A form then to go through document

7.15.0 In writing in their notes. I hate paper work, I hate forms, but some forms are necessary and some forms are valuable and at the end of the day I'd sooner come in, flick through a risk assessment form. It's much better than having to flick through a document...

7.16  Ok that is fine. So now we have done the initial assessment. What happens with ongoing risk assessment assessments?

Happens at CPA & 117 meetings prior to discharge
Some people have more than one CPA & 117

7.16 It happens at a CPA and 117 meeting, and that would normally then be incorporated with their discharge. As I said, some people will have more than one CPA, more than one 117 during an admission, so they would have their risk assessment updated accordingly, but certainly that means that there is always a risk assessment, or there should always be a risk assessment done.

7.17  But apart from the 117's and CPA's should there be risk assessments in-between?

very rare, ongoing risk assessment

7.17.0 There should be and sometimes there are, but I have to say very, very rarely.

7.18  Why is that?

People do not think about it.
It's not ingrained
If people do regularly R.A there would be no problems
R.A is done daily but not formalised

7.18.0 Again, I think people just, I suppose it's just not that ingrained into them. I'll be honest, I don't think about it, so I think it's something that just hasn't really been ingrained into them. Again, risk assessment isn't new, well it is, and, you know, I think if people had been taught to do risk assessments on a regular basis, we wouldn't be having this problem.

7.18.1 And I think a lot of it is about .... I don't think that means that a patients risks aren't assessed on a regular basis, I just don't think it's formalised on a regular basis, so I think we do, I think we assess risks on a daily basis, people go on observations they come off observations, risks are assessed on a daily basis, they're just not formalised as often as perhaps.
So, for example, How often do you use a risk assessment to make decisions about a patient, give me examples of what you do?

Well, observations. For example, you could use a risk assessment to determine somebody's level of observations, and I have to say again, I have had observations reviewed today and people have been regarded from their obs, but a formalised risk assessment has not been carried out.

So if anything happens how would you justify from the last risk assessment and your current management plans why the observation has been regarded?

From what the doctor documents in his file. Again, this is what I'm saying. The documents in their files which they're not formalising. When I say they're not formalising, they're not using the yellow forms. So maybe that’s something again that I could feed back to my staff, that when we’re getting a doctor to review risk assessment and the observation, that he should be using the yellow form.

However, the obs need to be reviewed daily and I can’t see the doctors using the yellow form on a daily basis, and people on observation should be assessed and reviewed daily, more so than perhaps others because the mere fact that they are on observations would suggest that because of their initial risk assessment they are at a greater risk.

OK. So we have discussed a lot about assessments, How do you manage the risk you identify?

Well I think it can be done by individuals and teams, certainly when we are looking at risk management, risk management always makes me think of observations, both nurses and doctors can put patients on observations, only a doctor can actually lower or remove the observations, but they often do that with us. They don’t actually do it on their own, so I think it’s putting on obs can be a joint or individual decision, taking them off the obs and reviewing the obs I would think more often done as a joint decision.

In ward rounds we can discuss and negotiate about what we feel the level a level of obs should
be, and I think we are quite lucky; the doctors do tend to listen to the nurses. That’s not always to say they agree with us, but a lot of times they do because they respect we have seen the patient a lot more so when it comes to the management of the obs it can be nurse or doctor led, but quite often, both. I would say quite often it’s both.

7.22  Ok, alright. So apart from your ward rounds, CPA’s and 117’s, How else do you communicate with other members of the team?

7.22.0  Handovers. There’s the nursing process, but there is the handovers.

7.23  Is risk assessment discussed at every handover?

7.23.0  Risk assessment? I mean certainly if there is a change or deterioration in a patient’s mental state, then, Yes, that is discussed and remember we do Unit handovers and that’s people from ……, ……and………, so there are the optimum amount of people aware of certain deteriorations with people and I think if anything that increases safety factors because the more people that are aware the more people, do you know what I mean?, it’s like if there’s somebody down in Gershwin, then the Gershwin staff are aware .

7.23.1  Where our eyes can’t be then their eyes can be, so I think you know, having these joint handovers, although it can be a pain at times, because we’re not always ready to be there when everybody else is ready, but on the whole it works out very, very well. So, I actually think that’s quite productive.

7.24  And that’s on a daily basis?

7.24.0  It’s on a twice daily, well we have handovers actually 4 times a day, 7 O’clock in the morning, 9 O’clock, quarter past 1 and then quarter to 8 at night. So we actually have 4 handovers. The one at 9 O’clock and the one at quarter past 1 are the multi-unit handovers and we have invited junior doctors to attend that and unfortunately they don’t. So on a Monday morning you end up doing about 7 or 8 handovers.
7.25 Why don’t they attend?

7.25.0 I don’t know, but they have been invited and it’s infuriating because we plan to do handover at half-past 9, they’ve been on the ward since 9 O’clock and we are having to handover, now that is a waste of nursing resources.

7.25.1 It needs to be pushed and certainly when junior doctors are inducted, it should be mentioned as it would help us significantly, especially on a Monday morning if the doctors would come to our handover. If they’ve got the ECT or something like that to do, fine, but if they could come to the handover because, as far as I am aware, there are no clinics on a Monday morning. So they could come to the handover, because Monday is the big handover. It’s what’s happened all over the weekend because literally, I can tell you what happens to me on a Monday, then I’ve got …… and I handover to …… then the second …… I doctor will come and I have to handover to her.

7.25.2 Then the doctors come, Then Dr …. comes. Then I’ve got Dr P who’s with Cobham. Then I’ve got the …… doctor, now you look at how many – that’s four teams plus six handovers, because some of the teams have more than one doctor and they don’t always arrive at the same time.

7.25.3 You need to say to them we have 2 handovers that they are welcome to attend, the 9 O’clock in the morning or the quarter past one in the afternoon, and yes, it may mean them having to sit and wait till we’ve discussed some other patients, but if they come in there, we will endeavour to do their patients first. If they are prepared to make the effort we will reciprocate that. Ok so I mean if you could bring that up

7.25.4 And that was one of the ideas of the joint meeting as well, to cut some of the nurses work down, by having the doctors in there and there was no excuse because they’re in that office at 9 O’Clock in the morning. It’s because it will cut down on a lot of work that we do. Well, it’s really tough when you’ve got so many obs We’ve got four consultants. I know they’ve got three here, but I mean, 17 patients for ………
OK, so we have discussed risk assessment and management, what about risk relapse plan? Do you develop relapsed plans for patients being discharged from the ward........?

Certainly in the CPA there is part of the forms which allows you to look at the type of signs and symptoms that are present that would indicate that a patient is relapsing, so yes, I think we do look at, we do look at relapse plans and prevention.

But does it actually happen all the time?

On the forms that we have got now, the purple forms that we have got now, yeh, I mean I'm not so sure that it did before but certainly .....Well, certainly most of the CPA documentation, the purple documentation is completed by the care coordinators and certainly I do remember discussions where were say what are the symptoms for relapse and what are the indications, I can't say 100%, but we do look at relapse and signs and symptoms that indicate somebody is relapsing and how we would go about preventing them for no admission, or in fact, how we go about bringing them in, and making it a shorter admission.

You mentioned care coordinators, I am getting reports that sometimes the in-patient nurses expect the community staff to come in and do the risk assessment before the patients are discharged.

As part of the CPA, 117, I would expect them to do the risk assessment or be involved in it, because at the end of the day, they are taking on that patient when they go out in the community, they damn well need to be up-to-date on the risks, and the only way they can do that is by being at CPA, 117 and be involved in the risk assessment.

Do not see any problem with care coordinators completing Ra at CPA & 117 meetings
7.29 **Who should be assessing that risk before the person is discharged from the ward?**

7.29.0 I think it has to be a team effort, I think they need to be involved because generally when somebody is ready to be discharged that means they have been spending increasing periods of leave at home. Who are the people that see them at the home? – the care co-ordinators, so they can add, they have to have a big involvement in the risk assessment, it has to be a joint thing. I don’t think it belongs to one set person, but if somebody has been on a weeks leave, they are going to have more valuable input than we are for that time.

7.30 **So who should do the risk assessment before the patient is discharged from the ward?**

7.30.0 That’s dependable, if for the last two weeks before discharge they’d been on periods of extended leave you would hope the care co-ordinator will complete the risk assessment. Very often, patients are given extensive leave, you don’t normally discharge a patient without them having extensive periods of leave. You know that. They have leave and then increased leave.

7.31 **What happens if the patient’s haven’t had increased leave?**

7.31.0 They do have increased leave. And they should be maintaining that contact with the patient…..but I think it does need to be done within a multi-disciplinary team assessment and they do need to be involved in that, because I wouldn’t like to be the one doing a form, on my own saying this person is safe to go into the community.

7.31.1 I’ve never actually got somebody in to do a risk assessment. I have to say in all honesty, I have never heard of that happening. Risk assessment should happen within ward round. It should be a multi-disciplinary team discussion and obviously the care co-ordinator is going to be the one that’s out there so they do need to be involved. They shouldn’t be asked to do it on their own. It’s got to be a team discussion and it does usually happen in the ward round. I mean, …… have got a great system going. Care co-ordinators attend their ward round with their patients.

7.31.2 We find on ……, the only time we see the care co-ordinators is when it’s a CPA, 117, sometimes not even then, the teams will usually send a representative, but again, that doesn’t happen in
every team. Yeh, but if they even send a representative to the ward round, that’s quite useful because it means the information is going to go back to the community.

7.31.3 There’s nothing more annoying than Community staff complaining that the nursing staff are not keeping them up-to-date with what’s happening on ward rounds. We should not have to do that. We don’t have the time to do that.

7.32 I also understand that sometimes patients are discharged two weeks for the CPA discharge planning is done- What’s your view on that?

7.32.0 I must admit some patients have had a CPA in the community after discharge, so I’m not going to deny that, it doesn’t happen very often because we are aware obviously that is not ideal.

7.33 Why does it happen?

7.33.0 Um, because we’ve booked a CPA and the care co-ordinator for some reason has not been able to attend and hasn’t sent somebody in their place and the patient and the relatives are obviously waiting for the patient to be discharged. So there usually is a reason, I’m not suggesting it’s a good reason, but there is usually a reason. It doesn’t happen very often. Yes, it does happen on occasion

Thank you very much for your time
Appendix 5
Developing Categories

Individual Interviews with Community Participants:
Descriptive Matrix- Table 1

Category 1 Perception/Personal Views of Risk Assessment and Management

Only in an ideal world it would be useful to be discussed by a team but it does not happen like that. What concerns me is that the format of what triggers what concerns ---- the thresholds are not consistent. (3.12.0.M)

The levels of concerns are therefore varied and the highly experienced staff may not have the same concerns as those with less experience so what will concern me may not concern them. However, if the people who do not have concerns but high risk patients do not have patients harming themselves or others, then what they are doing must be correct. (3.12.1.M)

I find it quite difficult sometimes with psychotic clients, people with schizophrenia, manic depression. Depression is not so bad because usually they just start by neglecting themselves or sleeping or the biological symptoms of depression reoccur and this might be more acceptable. (4.23.2.F)

In some ways if you are disturbed and will not engage, you will not get any service, but if you are willing, you will get the service. (3.9.6.M)

To be honest with you, I do no think any of us do. Again that should form part CPA discharge plan, even for in patient, but when a patient is admitted all they are interested in, is the package of care and the risk seems to be forgotten and not even mentioned. I am guilty of that as a care-co-coordinator, I should say. (2.15.0.M)

In the ward you will be more concerned because the patients are more disturbed because they are more acute. In the community, we have time to reflect but on the wards there is no time. We therefore have time to do the Risk Assessment. (1.15.0.M)
Individual Interviews with Community Participants:
Descriptive Matrix- Table 2

Category 2 Knowledge/Types of Risk Behaviours Assessed

Well, there are four areas, risk to self, others, potential violence and neglect. I assess those for every one. (1.6.0.M)

I believe it depends on the complexity of the case, what sort of need has been identified and risk.....to be an integral part of the assessment. Eh..... obviously everybody who gets referred they all have different needs and it may be needs like self neglect, aggression, whether it is verbal or physical or whether they are a danger to themselves or others or whether they are a risk of being used by someone else. So it is good to record the assessment that reflects whatever you have identified and agreed obviously with the individual referred. (2.1.0.M)

Presentation of the patient, history, my own judgement at the time, my experience, knowing different types of illnesses – knowing what might be linked with certain risks and what might not. (4.5.0.F)

I have been in situations where I have come out of the door and I don’t know about the patient, there is gut feeling they really are capable of doing much more then they say, aggression, violence whatever but nothing that can put in black and white that indicates that, so I would ask for someone medical to see them. (4.25.1.F)

The behaviour and I think the social circumstances where they are living or support network – whether there is one or not, you have to identify or assess that so that if you felt that somebody was very depressed and suicidal and they have no support network. (5.6.0.F)

Well I would just do the same procedure, but if I identify I think because Schizophrenia – is not enhanced or is it? I am just trying to think. (5.6.0.F)
Individual interviews with community participants:
Descriptive Matrix- Table 3

Category 3  Risk Assessment and Management Processes

Only for high risk patients, but individuals have to identify high risk patients themselves first and then request for a doctor to do a joint assessment with them. Sometimes the doctors will decide they will do a DV and ask for a joint assessment with a CPA. (1.11.1.M)

You can discuss your own risk management plans and tell them this is what you are doing -------- because at the moment it is the individual carrying the responsibility of the risk they have identified and how they manage it. (2.12.0.M)

At present if anyone commits suicide the immediate response will be, what did you do, not what did the team do. They will say, well you were the last person to see the person, what were you doing when was the last time you say them, and what you observed, what did you do about the suicide identified. (2.12.1.M)

No it is not a team decision. It is individual's decision although you talk to the team. (2.8.0.M)

Again, for most part it is developed by the individual and then may not be discussed with the team. So the more concerned people are, the more they discuss their concerns. (3.11.1.M)

-------- the failings of the current system is that most risk assessments are responsibilities of individuals who may or may not have been able to consult. (3.6.0.M)

If you are concerned about something then you obviously come back and discuss it with either the medical staff or the team at the next allocation meeting but yes it is usually our own decision in identifying risk. (4.10.1.F)

Unless there is something highlighted that is very concerning. I think people
haven't got the time to be concerned about everybody's case, as a team we couldn't possibly talk about every client individually at our allocation meeting for instance on the risk assessments we have done, as there is no time. (4.24.0.F)

The thing is if you made it compulsory, then it would become an exercise for the sake of it, well I have to go or else I will be picked on or if something goes wrong they are going to say, you take the responsibility if you don't go. At the end of the day it is your choice, you make the decision. If you don't go and anything happens then you can't turn round and say....... (5.44.2.F)

Yes I think so because if I was a staff nurse on the ward, if it doesn't get done you can always find an excuse and say the manager will have to answer to somebody else, whereas if I do an assessment and I didn't do risk assessment and something comes back- it's what did you do – where was your assessment. (5.46.0.F)

Well you do your risk assessment and discuss with the team and if they are happy then you continue to see the client. (1.10.0.F)

People on enhanced CPA also get in-depth assessment, the initial assessment is used to decide CPA level and enhanced level is always MDT but standard is not. So one person assesses, plans, and reviews. (1.18.0.M)

The risk is on going – if there hasn't been a change in the behaviour then you can record it in the progress notes that risk identified on such a date remains the same or if there is change then you rewrite the form. (2.14.0)

Yes at first initial assessment but assessment is an ongoing process. We've always said you continue to assess and regularly re-assess record and monitor. (2.2.0)

I believe we do not communicate we do not identify the risk. Years ago when I was first in the community, whenever I saw a referral that said urgent, I used to run out to see them until the manager said to me why are you running around and I explained. She said to me sit down, have you discussed the risk, have you identified the risk you may face when you go to see a patient – that made me
realise what I was doing. I guess we still do it. I think risk has to be on our mind at all times. (2.17.2)

There will be an initial assessment and a further risk assessment will be triggered for any reasonably additional concern. In my case, probably 6 monthly review and any other reviews, however, any time the person expresses any concerns, a risk assessment will be triggered. (3.1.3)

The way it works here is that most people are referred to the team, and individually are allocated by rota. An initial assessment is made by one member of the team. The assessment is then discussed with other members of the team on a Tuesday and then after that there should be some form of MDT discussion on risk for anyone who goes on the enhanced CPA. (3.4.0)

If there is a risk identified every risk assessment is brought up at the allocation meeting, when we have assessed a patient we have a risk assessment form and that at the allocation meeting is presented to the rest of the team. (4.6.0)

From admission we currently use the standard risk assessment form going through all the questions with the patient and identifying areas that are problems and then as part of our feedback to the team we talk about risk assessment as well. We talk about any risk we have found and what the plan is for intervention and if it is necessary to put any contingency plans in place. (5.1.0.F)
Individual Interviews with In-patient Participants:
Descriptive Matrix- Table 4

Category 1  Perception/Personal Views of Risk Assessment and Management

Well it should have been done, it's bad, it should have been done – you know. I can only speak for this ward, we do the risk assessment on admission, and I can't speak for other wards. (6.22.0.M)

They do have increased leave. And they should be maintaining that contact with the patient.....but I think it does need to be done within a multi-disciplinary team assessment and they do need to be involved in that, because I wouldn't like to be the one doing a form, on my own saying this person is safe to go into the community. (7.31.0.F)

I don't personally think it works very well. Whereby everybody is included in doing it, R, oh it's R's patient wait for R to come, but if we are all made responsible...... (9.14.0.M)

Well, my view of the whole thing is that these things can be discussed for instance, if today we have got four patients, we can go through them discussing them, if we have got time. If we haven't got time and we can even do one patient that is fairly enough. Now, sometime we get a leeway over the weekend, not all the time, where we can give a quick handover and go through a few patients, so that all of us are aware or those on duty are aware of the patient. If somebody was to chip in as regards to Care Plan or Risk Assessment or anything that the person thinks will contribute to the betterment of the patient, then that's fine, but it doesn't happen that way. (9.17.0.M)

My feelings are that everyone who is admitted on a ward should have a risk assessment because whether informal or sectioned doesn't matter. They are here for treatment because of relapse in mental health and they agreed, the informal ones agreed to be admitted so they are not put on section and the section ones obviously someone saw the need that they should be in, they don't accept that so they are put on section, we on this ward we try our best to make sure that every risk assessment is done that the risk assessment plan is adopted. (10.11.0.M)
I think it is trust policy. We nurses are actually qualified to do it but it’s the doctors who do the risk assessments on admission. (10.2.0.M)
Individual Interviews with In-patient Participants

Descriptive Matrix - Table 5

Category 2   Knowledge/Types of Risk Behaviours Assessed

The risk to be assessed starts from the patients themselves whether the patient got a history of self-harm and for how long and what circumstances, previous history that kind of thing and how severe it is. Is there any family or children involved in it, is the self-harm also affecting other people if the person has got family, is that person also at risk to others also with the risk involved, is the risk related to any other single thing like medication or drug or alcohol or could lead to violence. (6.1.2.M)

Violence, suicide, right, maybe linked to alcohol and drugs, right. A lot of them come here have a history of depression and with alcohol related, yes and whichever the first problem goes on diagnosis, and based on this too, it also lead to violence. (6.8.0.M)

It's sometimes based on the knowledge from previous admissions – yes – it's all different and all that depends on whether you should do it tomorrow, sometimes if you feel the need to do it with a doctor we have to call the doctor back to do it. (6.15.0.M)

I mean, I know it's important to assess a person's risk at the time, but I think when you are doing risk assessments you do need to be aware of history, or it's good to be aware of history. It may not repeat itself, it may have been a one off, but I think if you've got that extra information, it's got to be helpful. It's got to be helpful. (7.7.1.F)

You remember the old white copy?.......The staff do it and then get the information. Of course they do the Hope process, assessment and joins.....so the initial assessment is to look at the criteria you know, any risk to them self and risk of absconding, any potential risk of aggression to others, to themselves, or property and the last one.....there is four, I can't remember now, abscond, self harm risk, aggression, violence to property. (8.1.2.F)
Individual Interviews with In-patient Participants:
Descriptive Matrix- Table 6

Category 3  Risk Assessment and Management Practices and Processes

There have been occasions when the duty doctor will not have completed the risk assessment, in which case, it really is down to the named nurse to complete that or raise it in the first ward round whereby a risk assessment would be carried out then, and certainly when it comes to doing the CPA’s and 117 which is usually round about the time of discharge, um, the risk assessment would be repeated and sometimes we have people who are in hospital for a very long time, so they will have more than one CPA, more than one 117 meeting, so some will actually have a few risk assessments carried out within……… carried out throughout the time of their admission. (7.1.1.M)

It’s down to the named nurse to get the doctor’s to discuss it or make sure it’s dealt with in the first ward round. It really depends, for example if a patient comes in on a Wednesday, and the ward round’s on a Thursday, then I think it’s appropriate. (7.6.0.M)

When it comes to that we do it individually. Like we have got named nurses who do that. If the named nurse is not here the associate nurse you know, will do it. (9.12.0.M)

Sometimes the patient is seen by the doctor on the ward, sometime is seen by the nurse and the relative and we carry out the normal assessment procedure – we follow the procedure, we follow the assessment to identify any risks that are involved. (6.1.1.M)

As soon as the patient is seen by a doctor, or depending on the behaviour, the nurses may decide the risk is high and put on obs until Dr. comes. (8.14.0.F)

Mostly jointly – and then notes, I mean like, they really – a duty doctor is very busy couldn’t do a joint risk assessment then the ward staff, some of the staff feel confident to do it, or depending on the urgency also, or if the patient is admitted today and tomorrow is the ward rounds and it can wait until tomorrow then sometimes staff will discuss in the ward team on duty and discuss it and do the risk assessment also. (6.13.0.M)
It is all done by the Team, because the team, when they come, we don't have a proper formal ward round any more, they come to the ward now, and sometimes they come once, it is very difficult, but when they come, the whole lot,... the social worker, sometimes the care coordinator, if you see Dr D team usually J G comes as well. (8.3.0.F)

They can't do a risk assessment. The person is in no fit state of being assessed. Now if the Dr can't assess the person or the nurses can't assess that person, there is no way of doing risk assessment. (9.30.0.M)

I think someone who comes in sort of informally and they agree to treatment and maybe they didn't see any risk involved because the person agreed to come in but someone who comes in with a form of psychosis or neurosis or whatever tends to be – yes they would. (10.14.0.M)

Admission comes, you done the admission, but you think I have got to do level 3, in the next 15 minutes so you are hurrying up to do things not to do things, just to go on the continuous. (9.22.0.M)

Uh, One of the reasons might actually be, and it's probably not a very satisfactory reason, one of the reason's is that we don't think about it, that's being perfectly honest, I think the other reason is time consumption. Certainly people, like I mean, the E.... Team have 17 patients in at the moment. So the ward rounds tend to be very lengthy anyway and the risk assessment is seen to be quite a lengthy process so I think that's why it tends to happen, and the CPA, 117 situation, when by the sheer nature of the meeting, more time is allowed within a ward round situation, anyway. (7.13.1.M)

I think the legal status does not come into it, you still have to assess the risk at that moment. What the patient says to you, the initial assessment is very important. A patient can come in and say you know, a lot of things and you know if they can come in informally and say a lot of things and say I don't need to be here, I want to go home, my husband can do a look for me, but I do not want to take medication. (8.18.0.F)

No. It doesn't. The assessment has got to be done the moment the patient comes
into hospital whether we know the patient or not, we have to do it. (9.19.0.M)

Other times we can give the feedback also during the hand over, making the feedback to whoever come and take over and also that is ongoing handover from night to days morning afternoon – keep handing over, and when you delegate jobs you the tell staff what the risk is. (6.26.1.M)

Yes, the nurse doing the admission has got a responsibility as well and this is why certainly, if it hasn’t been done, then the named nurse, because although the admitting nurse should again be the one that’s making sure, at the end of the day, it’s the named nurse who becomes ultimately responsible for that file and for that patient, so the duty doctor should deal with all the admissions. If she hasn’t, it should be the admitting nurse, but there should never be a patient without a risk assessment because the named nurse then becomes solely responsible for ensuring that that risk assessment is done and I don’t agree with that because I think that’s down to the doctors. (7.13.0.M)

The Policy is that, you need to make sure all new additions or any who come down to ……that the initial risk assessment not the detailed or thorough one, is done and I put down on the form here, to remind people risks for all admissions. So far everybody is aware and we do a …….. and before say last year we use to do it, me and the and the staff, me and the do it together – I tick it and I get the Dr to countersign it. Nowadays the Dr’s does all the writing, documentation for the patient, so far, anyway, because I have seen another of a yellow risk assessment form. (8.1.0.F)

Risk is assessed on a daily basis because obviously you have to do that on a daily basis and then it is assessed along the lines of whatever …… set yourself targets obviously, weekly, and monthly as it …. or relapses or … so it’s done like that – it is an ongoing process. (10.5.0.M)

You know we are human beings, we know we finish at 2:30pm so we want to complete it before we leave or before somebody comes at 8:30 we have got to finish it before 9:00. (9.25.0.M)
Appendix 6

Group Interviews with Participants from the United States—
Descriptive Matrix—Table 7

Category 1 Perception of Risk Assessment and Management

There were really 2 major purposes — risk assessment was one of them, hopefully at the end of the study we will be able to contribute to a better assessment of risk among persons with mental illness leaving hospitals but the other big purpose was to learn some things that would help us form policy about persons with mental illness addressing the bigger question that has been hanging around like are people with mental illness any more likely than anybody else to be at risk to persons in the community when they are discharged so in fact that actually in a lot of ways drove the study more, although all the time we were designing it we were understanding that at the end we would like to be able to take whatever factors turned out to be related to violence and turn them into some kind of a risk assessment tool. (1.3.2)

The larger theoretical questions we are addressing like are persons with mental illness any more likely to engage in violence than other people — how might that be related to services that are provided after they return to the community and so forth. All of these things drive toward better assessment also can be used to help inform everyone from law makers to people who devise policies about health care e.g., there is a general public perception that persons with mental illness represent an increased danger to that very often when you look in the newspapers you see reports of persons who have engaged in violent behaviours with a report of their mental illness alongside and increases the public perception that they are a special risk — yet they are a special risk, one that justifies special laws basically with regard to involuntary hospitalisation with regard to how you monitor people when they leave the hospital and so forth. (1.6.1)

It influences things like the public’s perception that if you have out-patient clinics or residential facilities for persons who are living in hospitals their perceptions are that those people are likely to be more dangerous to the community therefore ‘not in my back yard, not here, some place else’ so there are all those different things from laws to policies to practice in services with people with mental illness that this kind of
information can be used and results as you know indicated that the risk of violence to persons with mental illness, in the absence of substance abuse, really was no greater than for other people in the community who didn’t have a mental health history. On the other hand with substance abuse the rates increase so in that sense ........ informs policy in practice. (1.6.2)

One of the short term things we do with this form I am giving you - the special clinical review, this has been in place throughout the time but what we discovered with this one particular patient who committed suicide here was that we had this form as well as a number of other forms that focussed much more on violence history and for this particular patient there was a significant violence history as well and that tended to be the emphasis of these documents as this patient moved to a less restrictive setting, an open unit, had privileges, passes etc. so on the second page of this form. (2.7.1)

I think one of the reasons in the USA is that violence has been focussed on more is that you are taking someone else’s life and probably the values of this country say there is not such a value placed on a person making that decision for themselves but it is when taking another person’s life. You are very fortunate if someone brought a gun back on to a Unit that they did not turn it on someone else before shooting themselves. (2.16.1)

It is a problematic area how do you know, how can you predict the future based upon the past and how restrictive can you be without violating their rights to freedom. (2.7.2)

It is a tough area, we have several different types of forms that we use for risk, in one particular one you are supposed to evaluate the patient from the perspective of how they presented within the last week so it is hard not to be influenced by what you know of the patient’s history because you don’t want to say no risk, when you do in fact believe that the patient does present some risk so I guess it is difficult. (2.8.10). Yes, it varies from unit to unit and from clinician to clinician so sometimes if you have a psychiatrist who is willing to weigh out risk benefits for certain patients to be treated in one unit and then moved to another unit where you have a psychiatrist who has had a lot of litigation against them they are very cautious so it is very subjective. (2.9.1)
When you were asking about why we focus on violence rather than suicide I think it is because in this country we have had a lot of high profile cases of patients with mental illness and everyone attributes the violence to the fact that the patient is mentally ill whereas with patients who are committing suicide in one sense that doesn’t make news like violence towards others. (2.9.2)

I would say that the violent behaviour assessment form has certainly had some impetus from the findings of that study because of our connection with UMAS Medical Centre and the chief researchers. (2.9.8)

I wish I could tell you we had an easy formula to score between this and this then we would know what is going to happen and we know what to do to prevent it - I think very often it feels more like an art and a constant dialogue amongst the clinical disciplines in terms of the person’s history, how they are presenting now, their current functioning, which is where …….. comes in and we are looking for the description that leads you to whether it is a5, b6 because these are the forms that are completed on a regular basis and there is a tool that tells you how to complete this. (2.9.9)

The nurse needs to sit down very carefully and go over with the patient whether they are safe to be off that unit for that half hour period of time and can document and hold those privileges. It doesn’t change the order but the nurse has a responsibility to make sure that the person is safe so they can still hold back on those privileges. In the old days it would have held for 24 hours. (2.12.2)

Privileges are never a reward they are always based on safety they may be used as punishment but they are always based on safety and so it may be when teams are in disagreement over someone, if the patient asks for half hour privileges they may be going slower than other patients and because they don’t handle too many privileges without running into difficulties we may agree that we should give them more short blocks of time like 15 minutes at a time so that we know where they are and can they be responsible to handle them, can they get back to the unit on time, are they where they are supposed to be and if they handle them well then moving them up. (2.11.3)
Group Interviews with Participants from the United States

Descriptive Matrix- Table 8

Category 2 Knowledge and Types of Risk Identified

There is no experimental intervention with regard to risk management and we have similar problems in this study to what you will see in much of the existing literature on risk assessment which is many of the variables that best predict future dangerous behaviour are in variant, their age, gender, past history. (1.8.1)

Obviously some things come up and substance abuse is one of them as a variable that I suggest if you control it you may be able to reduce the rate of variable behaviour. (1.8.2)

There were some variables that clearly seemed to correlate with higher and lower rates of violence and some of them were the sort of things that clinicians traditionally think should be targets for intervention so they included for example, compliance with treatment recommendations so subjects who were more compliant with medication and visiting actually have lower rates of violence and subjects who had more contact with care givers over a period of time had lower rates of violence, but what that doesn't tell you is whether randomisation is involved whether the people who wouldn't be violent in the first place are the ones who complied with medication and come to their sessions or whether the medication and sessions are actually having some impact. (1.8.4)

Suicide attempt at the time of the admission was not a significant predictor of violence during the first 2 follow ups, but if one wanted to study suicide, forget about the aggression, wanted to study suicide, how does it relate to diagnostic status and all kinds of other things the capacity to do that are in that data set. (1.11.3)

There is some clinical evidence which is supported by no data whatsoever that suggests that suicide is easier to predict than violence – we are better at doing it because we are clinicians and suicide is something that we assess. Here in the data for self harm, thoughts of self harm, none of the above, thoughts of self harm, attempts at self harm, attempts to actually kill themselves had a significant correlation with violence during the first 2 follow up periods. (1.12.1)
Indeed one might find if suicide attempts are not high base rated in this group, I know that most of the patients with suicidal thoughts may have engaged in violent behaviours but it could still be it is not related to aggression in the overall study because if most of the patients who were violent didn’t have suicidal thoughts so that is the level of analysis we haven’t done. (1.12.2)

I think very often it feels more like an art and a constant dialogue amongst the clinical disciplines in terms of the person’s history, how they are presenting now, their current functioning, which is where ..........(2.9.9)

Violence is less predictable, look for triggers and predicting factors, Identify what helped in the past to resolve stresses, Some are more articulate than others and will cover up. (3.4.2)

Yes you would be able to see the discrepancies from what your observation is and what the person is saying because sometimes when you do risk assessment you look at the discrepancies from what the person is presenting and what they are saying. They say one thing but may be doing something different. (2.13.7)

Incidents of violence & suicide are consistent with other areas. General high risk group for violence are young men, substance misuse and mental health patients. (3.5.2)

Subjects who had more contact with care givers over a period of time had lower rates of violence. What they don’t tell you is, whether since there was no randomisation involved whether the people who wouldn’t be violent in the first place were the people who complied or whether the medication and the sessions had an impact. (1.8.4)
Group Interviews with Researchers from the United States-
Descriptive Matrix- Table 9

Category 3 Practices and Processes of Risk Assessment and Management

No because issues related to prediction of risk and the consequences and failing to predict risk in this country are generally issues of state law rather than federal law so claims against psychiatrists, other clinicians, facilities for release of dangerous patients are almost always litigated in state courts. (1.13.1)

Statute on those issues are state statutes and state laws control involuntary commitment of people with mental illness and it is generally the state that to the extent that there has been some movement in this area in the last couple of years, but to the extent that this has happened it has happened on a state by state basis and what I think has happened is that some number of states now have recognised the value in systematising risk assessment by using instruments that they have devised themselves or that they have taken from the literature. (1.13.2)

..... the nurses do the safety assessments and all the clinicians aren't aware of it and it doesn't get incorporated but it is something we are trying to work on. (2.5.1)

We have gone away from the care planning into integrated master treatment plan. I think one of the problems for nursing is that you could have an admission that happens on a Friday afternoon and the nurse who does the initial nursing assessment is working on the 3 – 11 shift and checks all boxes, completes everything, writes everything down and then you have the master treatment planning meeting happening some time a few days later and may have a different nurse in the room who has reviewed the assessment but may not necessarily present the same level of concern or may not have spent as much time with that patient as the original nurse did. But what goes on our treatment plan is the whole treatment team's consensus. (2.5.2)

On the unit you may have 1 or 2 treatment teams depending on the size and then for each of those treatment teams you generally have 2 meetings a week. One is just a general team meeting where you have a general discussion, discuss privileges and things like that and then you have what is called a treatment planning meeting and at
least once a month you review every patient and have a treatment plan and a couple
of times a year you do what is called a periodic review which is another treatment
plan which is more comprehensive where you review all the special assessments.
They are done at 3 months, 6 months and annually. For a new admission is done
weekly for the first 8 weeks and then monthly. (2.5.2)

This form includes after all that clinical information is placed there the psychiatrist
makes recommendations, the social worker, the nurse manager from the perspective
of all the nursing staff on the unit, rehabilitation, recommendations, psychology
recommendations (an optional thing – not all teams have a psychology member) and
this is reviewed by the medical director and our chief operating officer who is like a
superintendent of the hospital. (2.7.2)

We have a group that will come in unannounced visit a unit, talk with the patients,
talk with the staff, make sure that standards are being met and those are volunteers.
(2.8.7)

It is a tough area, we have several different types of forms that we use for risk, in one
particular one you are supposed to evaluate the patient from the perspective of how
they presented within the last week so it is hard not to be influenced by what you
know of the patient's history because you don't want to say no risk, when you do in
fact believe that the patient does present some risk so I guess it is difficult. (2.8.0)

I would say that the violent behaviour assessment form has certainly had some
impetus from the findings of that study because of our connection with UMAS
Medical Centre and the chief researchers. The violent behaviour assessment form
has been done by psychology and recently our medical director has been teaching
the social workers to have a greater involvement with this and generally people tend
to type this up as a full report rather than necessarily filling it all out. (2.9.8)

Privileges exist on our campus, passes are what happens off the campus, we made
a change in that and we are changing it back to that system again but privileges can
go anywhere from the person who has only privileges to be on their Unit and that is a
locked unit or escort by a staff member, sometimes one to one so that the first step
may be to go one to one. (2.10.1)
After escort privileges comes a destination privilege and this will involve the patient going from one area on the campus to another and then they pick up the phone and call and say I am here now and the understanding is if they don’t show up there and don’t make that phone call we will search for them but we also know that there are staff there so if they walked off the campus and called from there we would know that they still hadn’t arrived yet. (2.10.2)

Then independent privileges which may be for a short period of time like 4, half hour periods of independent privilege, then full ground privileges when the person is checking in on the unit at least every 2 hours but other than that they are free to go to place to place. They may have employment in the coffee corner, or in a number of other areas, we have a green house, a progressive work centre where people are actually employed and earn money as part of their rehabilitation and developing work skills. (2.10.3)

Nursing is very involved on a day to day basis of looking after patients and knowing them and being observant and seeing that someone is having difficulties today and just being generally aware of their clients. (2.11.1)

....... we are always trying to be observant and watch what is happening and how they are behaving because they may the only indicators we get that something is in the process of changing just by the way someone doesn’t make eye contact or their hair is in front of their face these are not good cues, let’s be a little more vigilant and watch what is happening here. (2.11.1)

We don’t try to jump to judgement we try to speak to the patient and find out what is going on it may be that it is an anniversary date they are upset about, it may be there are issues that we are unaware of - so it’s constantly being vigilant really. (2.11.2)

We have a formal process, patients do request privileges and we discuss it with the treatment team and write down what the team’s feelings are whether or not they should have privileges and what the patient may need to do in order to reach that level of privileges. (2.11.2)
This centre works in teams with cases shared between the professionals. Risk assessments are evaluated every 6 months or in every team meeting. Treatment programmes are revised regularly or during any major life event. (3.4.1)

We encourage empowerment – even allow for poor decisions to be made. People committed are those who are incompetent and refuse treatment and in some cases the courts approve medication treatment plans. Usually patients are involuntary committed but can refuse medication unless courts have made a judgement. The courts sometimes substitute the client’s judgement. (3.4.3)

The court will sometimes approve medication – medication will then be given against patient’s wishes, Laws allow to forcibly medicate, courts have a period of review, In-patient authorisation is usually up to 6 months. (3.4.3)

Out-patients have guardianship which include medication review once a year or more, Judicial standards are reviewed every year. The courts will accept the judgement of medical staff in an affidavit however sometimes these are contested by patients. (3.4.4)

Once in a while a court will question a course of medication in accordance with the patient’s wishes. Most patients are voluntary, some are on probation. We also use what we call benevolent coercion which includes probation. (3.4.5)
Appendix 7

I have received and read this document and will implement the action specified in preparation for the effective use of this procedure.

<table>
<thead>
<tr>
<th>Name of responsible person:</th>
<th>Job title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

Risk Assessment and Management in Mental Health

1. SCOPE

This policy and procedure will apply to all clinical areas within mental health.

2. POLICY STATEMENT

2.1 Risk assessment is part of an ongoing process of risk management, involving treatment interventions and reassessments by the multi-disciplinary team. It requires monitoring and supervision over a long period, with the level of input varying according to clinical need at the time. Adherence to the principles of good clinical practice avoids most pitfalls in the management of risk.

2.2 Risk assessment and management will therefore be linked to the CPA process.

2.3 Risk in the clinical sense can be defined as the likelihood of an event occurring. It is not just narrowly equated with the risk of violence but is broadened to include self-harm, self-neglect, neglect of children/dependants, accidental harm, and harm from environment. Another approach to risk is to consider the effect on the patient, and the public, and it is not inappropriate also to consider the risks to personal reputation and the standing of the clinical service.

2.4 Before a risk management plan can be considered the following aspects of risk need to be addressed:
   - Risk of what?
   - What is the severity of the risk?
   - What is the frequency of the risk?
   - Are there any specific people at risk?

2.5 It is also recommended that risk assessment and management plans should be discussed and completed jointly between medical staff and other professionals wherever possible.

2.6 This policy and procedure will be implemented within the Human rights Act 1998 legislation with specific regards to Article 8, "All persons have a right for private and family life. This right is guaranteed so far as interference is in accordance with the law, public safety.... The prevention of disorder or protection of health or morals or the protection of the rights and freedom of others"
3. PROCEDURE

3.1 GENERAL PRINCIPLES OF ASSESSING CLINICAL RISK

Make Sure That All Relevant Information is Available

A proper assessment cannot be made in the absence of information about a person's background, present mental state, and social functioning, and also his or her past behaviour.

3.2 It is essential to take account of all relevant information, whatever its source. Sources can include members of the hospital clinical team, the patient him/herself, relatives, carers, the police, probation officers, housing departments, and concerns expressed by neighbours.

3.3 Proper regard must be paid to obligations relating to confidentiality. However, wherever possible information that is relevant to forming an overall view of the case should be made available in the interests of the person and other people.

3.4 TOO OFTEN IT HAS PROVED THAT INFORMATION INDICATING AN INCREASED RISK HAS BEEN AVAILABLE BUT HAD NOT BEEN COMMUNICATED AND ACTED UPON.

4. CONDUCT A FULL ASSESSMENT OF RISK

4.1 The following all play a part in arriving at a decision about risk:

- Self reporting by the person on interview.
- Past history of the person (nothing predicts behaviour like behaviour).
- Observation of the behaviour and mental state of the person.
- Discrepancies between what is reported and what is seen.
- Psychological tests.
- Statistics derived from studies of related cases.
- Indicators of risk derived from research.

4.2 THE DECISION ON RISK IS MADE WHEN ALL THESE STRANDS COME TOGETHER – A BALANCED SUMMARY OF PREDICTION DERIVED FROM DETAILED KNOWLEDGE OF THE PERSON, THE PRESENT CIRCUMSTANCES, AND WHAT IS KNOWN ABOUT THE DISORDER FROM WHICH HE/SHE IS SUFFERING.

5. DEFINING SITUATIONS KNOWN TO INCREASE RISK

5.1 Identify the circumstances under which, based on past experience, the person is likely to pose an increased risk, and the probability of this re-occurring. Examples could include:

- When a person stops medication.
- When a person who has previously offended under the influence of drugs or alcohol starts drinking/misusing drugs again.
- When a person whose aggression has been apparent in one particular situation, e.g. in the context of a close relationship – enters another such relationship.
6. RISK OF DELIBERATE SELF HARM

6.1 PEOPLE WITH SERIOUS MENTAL HEALTH PROBLEMS ARE MORE LIKELY TO BE A DANGER TO THEMSELVES THAN TO OTHER PEOPLE.

6.2 The traditional risk factors have a low predictive value for the immediate risk of self-harm and are more useful for predicting long term risk of suicide. Therefore face to face clinical skills are of paramount importance in evaluating risk.

6.3 The importance of making tactful but direct enquiries about a person's Intentions. Asking a person about their suicidal intentions does not make suicidal behaviour more likely. On the contrary, if the person already had thoughts of suicide, he will feel better understood when the issue is raised, and this may reduce the risk. If a person has not thought of suicide, tactful questioning will not make him behave suicidally. Avoid forceful confrontation.

6.4 The most obvious warning sign is a direct statement of intent. There is no truth in the idea that people who talk about suicide do not enact it. Two thirds of suicides have mentioned their ideas, and one third have mentioned clear suicide intent.

6.5 Risk to others can be important as in the case of psychotic depression where relatives and others may be included in ideas of futility.

6.6 The assessor must decide:

- The level of risk the person poses to self or others
- Ability to give reassurance about safety (e.g. until next appointment)
- Circumstances likely to make things worse
- About how help can be made available at any times.

6.7 Some groups are particularly at risk e.g.

- young unemployed men
- attempted suicide in male teenagers – significant predictor.
- young Asian women
- young men and women misusing drugs or alcohol

6.8 The period following discharge from hospital is a time of particularly high risk of suicide, emphasising the need for well co-ordinated follow-up. The risk peaks in the first week, the highest risk occurring on the day after discharge. It therefore emphasises the need for well co-ordinated follow up with early outpatient appointment and / or key worker contact.

6.9. KEY RISK INDICATORS FOR SUICIDE:

- Old age
- Male Gender
- Divorced>widowed>single
- Unemployed/retired
- Socially isolated
- Physical illness, especially terminal, painful or debilitating illness.
- History of deliberate self harm
- Family history of mood disorder, alcohol dependency or suicide
- Bereavement in childhood
- Social classes 1 and V
- Psychiatric and personality disorder
- Substance Misuse
7. RISK OF HARM TO OTHERS

7.1 The great majority of people with mental disorder and those with learning disability present no increased danger to others.

7.2 People with a severe mental illness, such as schizophrenia or bipolar affective disorder, may present an increased risk to others when they have active symptoms.

7.3 People who have active symptoms and also misuse drugs or alcohol may present a seriously increased risk to others.

7.4 People with dissocial personality disorder by definition present an increased risk to others.

7.5 These risk factors are summative, so that, a person with dissocial personality disorder and an active psychotic illness who also misuses drugs and or alcohol may present a serious risk to others.

8. OTHER RISK FACTORS FOR HARM TO OTHERS

8.1 Specific threats made by the patient/client

8.2 Emotions related to violence, for example irritability, anger, hostility, and suspiciousness

8.3 Evidence of recent stress. In particular, loss events or threat of loss.

8.4 Evidence of any threat/control override symptoms: firmly held beliefs of persecution by others of mind or body being controlled or interfered with by external force (delusions of passivity).

8.5 Evidence of poor compliance with treatment or disengagement from psychiatric aftercare

8.6 Previous violence and/or suicidal behaviour

8.7 Presence of substance misuse or other potential disinhibiting factors, for example a social background promoting violence

8.8 Identification of any precipitants and any changes in mental state or behaviour that have occurred prior to violence and/or relapse.

8.9 Evidence of rootlessness or 'social restlessness', for example few relationships, frequent changes of address or employment

8.10 ARE THESE FACTORS STABLE OR HAVE ANY CHANGED RECENTLY?

8.11 DOES THE PATIENT HAVE ACCESS TO THE POTENTIAL VICTIMS? PARTICULARLY INDIVIDUALS IDENTIFIED IN MENTAL STATE ABNORMALITIES?

9. RISK OF RE-OFFENDING

The best predictors of future offending among mentally disordered people are the same as those for the rest of the population—previous offending, criminality in the family, poor parenting etc.

9.1 The factors influencing risk of re-offending are similar to risk of harm to others and include:
• Explicit threats
• Recent serious offence
• Previous Convictions
• Use of weapons/excessive brutality
• Lack of Remorse
• Lack of compliance with treatment
• Substance Misuse
• Impulsivity /Poor control of violent impulses
• Low self esteem
• Sexual/violent fantasies
• Severe mental illness
• Dissocial personality disorder
• Learning disability
• Family history of criminality
• Poverty/Unemployment
• Family breakdown
• Conduct disorder
• Childhood trauma

10. RISK OF SELF NEGLECT

10.1 The risk of self-neglect is usually apparent from the previous history of self-neglect, and current levels of self-care, personal hygiene, hydration, and weight loss. Physical illness and inability to seek help or treatment may also be present.

10.2 If sufficiently severe, any disorder which affects a person's physical health or mental health may result in self-neglect. Also, patients can have specific difficulties such as a lack of motivation and poor money management skills, which may lead to neglect.

10.3 The commonest risk factors for self-neglect include:
• Lack of motivation
• Lack of daily living skill
• Loss of financial control
• Dementia
• Confusional States
• Learning disability
• Severe mental illness
• Substance Misuse
• Physical Disability

11. ASSESSING RISK OF HARM/NEGLECT TO CHILDREN

11.1 The 1989 Children's Act Section 31(2) defines harm as 'injury, ill treatment or avoidable impairment of health and development that is due to a standard of care below that of a reasonable parent'. There is a duty of care to report to social services or the police if we believe that the child has suffered, or is likely to suffer, significant harm because of an act or omission by a parent. The definition is very broad and what is significant 'severity of injury, ill treatment, or avoidable impairment of health' is not rigorously defined.

11.2 Serious mental illness would appear to exert its maximum effect on children through marital discord, social adversity, and multiple changes in care takers. It has to be persistent and long-standing, chronic or relapsing, associated with significant disability, and not compensated for by other family members before it is associated with neglected abuse.
11.3 Nonetheless children may be at considerable risk from acute psychotic episodes in their parents. They are vulnerable to impairments of emotional responsiveness and attention to their needs, which result from a variety of psychiatric disorders.

11.4 Less severe illness is commonplace in the community. Depressive illness is particularly common among young mothers and is strongly associated with social deprivation. Depressive illness does affect children, particularly boys. It affects not only their current state but also their long-term development. When associated with social and marital conflict, personality disorder and other psychological problems, this illness contributes to much childhood morbidity and abuse.

11.5 Consideration for the safety and well being of children should therefore be a fundamental part of any risk assessment. A patient who is a parent should always be asked about the effects of their mental illness on their children. Specific questions should be asked about their anger and violence towards children, particularly when patients are complaining of irritability and difficulty in controlling their emotions. Escalating complaints about irritability and loss of control with children should be taken particularly seriously.

11.6 Some parents may not be able to meet the needs of their children safely on a permanent basis. However many will be able to, and many others will respond favourably to assistance.

11.7 The provision of in-patient mother and baby units and day hospitals with crèches would improve the care of seriously ill mothers and their children. Psychological treatments can help women to develop effective coping strategies with children and improve the mother-infant relationship.

11.8 Women suffering from chronic depression and chronic schizophrenia can respond to advice on the importance of physical and emotional contact with children, and can be helped to be more aware of infant development and need.

11.9 Practical, social assistance in the home and the provision of day nursery and respite care all have an important part to play in keeping families together but healthy and safe. Ideally the psychiatric team should work collaboratively with both social services and child and family psychiatrists to achieve this aim.

11.10 It is important for those involved in the care of adult patients to remember that the best interests of the child should have priority, and that confidentiality and loyalty to the adult may have to take second place.

11.11 The main categories of maltreatment of children can generally be classified into the following categories: physical abuse, sexual abuse, emotional abuse and neglect. The risk factors for each of the categories differ but there is a high degree of overlap.

11.12 The following risk factors should be considered when assessing risk to children:

- Previous history of neglect
- Children on the at risk register
- Unresolved stress
- Previous allegations/convictions
- Delays in physical and cognitive development
- Behavioural problems in child
- History of Domestic Violence
- Substance Misuse
- Mental illness
- Parental indifference, intolerance or over anxiousness towards the child
- Unemployment/poverty/debt
- Premature birth or low birth weight child
- Parental history of childhood maltreatment
- Presence of a stepparent or cohabitee in the family
- Single or separated parent or young mother
• Separated from mother for greater than 24 hours post-delivery
• Never breast fed
• Learning or physical disability in child
• Domestic Violence in the family

12. RISK OF EXPLOITATION

12.1 Some patients may present a risk of being exploited e.g. for sexual purposes, financial gain or even criminal offences. The patients most likely to be exploited are those who are suggestible, impulsive, passive and easily coerced. These may include:

• People with learning disability
• Elderly
• Adolescents
• Severely mentally ill
• Substance Misuse

13. RISK OF ACCIDENTAL HARM AND RISK FROM THE ENVIRONMENT

13.1 All care facilities are required to meet the normal health and safety standards for mental health facilities. In additions, an assessment of risk from the environment for each patient needs to be completed. The total risk will depend on the mental, physical and behavioural disturbance of the patient in its interaction with the environment.

13.2 Aspects of the patient, which may lead to accidental harm, include

• Confusion/ dementia
• Learning disability
• Falls
• Epileptic seizures
• Wandering
• Aggressive behaviour
• Suicidal behaviour
• Road sense
• Physical disability e.g. swallowing difficulties
• General frailty
• Substance misuse

13.3 Aspects of the environment which may present a risk

Is the client at risk of causing harm to self or others as a result of:

• inappropriate use of electrical equipment
• level of awareness of risk from hot water
• inappropriate use of water e.g. flooding
• level of awareness of risk combining electrical equipment and water
• level of awareness of fire risk e.g. matches, smoking in bed, extinguishing cigarettes
• level of awareness of ability to respond to the touch of, sharp objects, e.g., radiators, iron, knives
• does the client have mobility or sensory impairments, which would render general mobilising such as stairs, or walking around rooms, areas of risk?

13.4 Group/Activities Room/Workshop

• risk of ingestion of inappropriate objects i.e. clay/plasticine, aromatherapy oils
13.5 Bedroom
- is the client liable to fall out of bed?
- are the ‘bed slides’ (if used) appropriate and safe?
- does the client suffer from nocturnal epilepsy?
- would the client try to climb out of the window?
- is the client likely to lock the bedroom door?

13.6 Bathroom
- at risk of slipping/falling in the bath, shower or wet floor?
- likely to drink/eat toiletries if unsupervised?
- able to recognise safe levels and temperature of water when running a bath?
- able to recognise risk associated with sharps such as razors?
- is the client likely to lock the bathroom?

13.7 Kitchen
- able to recognise dangers such as hot cookers, kettles or toasters?
- able to understand the risks associated with using food blenders, electric knives?
- safe if the use of sharps such as knives?
- able to recognise the dangers associated with hot food or uncooked food?
- likely to eat items from the dustbin, frozen food or uncooked food?
- likely to eat or drink cleaning items?
- likely to exhibit behaviour which would put themselves or others at risk e.g.
  - pulling at the arms of staff whilst they are cooking, smashing crockery?
  - aware of the risks of broken glass, wet floors or spilt food
  - aware of the fire hazards specific to the kitchen such as flames, hot water and water, leaving pans to boil dry or leaving the gas on?

13.8 Dining Room
- recognise hot and cold food/drinks?
- able to use knife and fork without supervision?

13.9 Garden and Grounds
- is the client able to walk around without supervision or assistance?
- is the client at risk from moving traffic?
- likely to consume materials found in garden?

14. RISK MANAGEMENT
14.1 When the level of risk has been determined then risk management plan should be drawn up with the aim of reducing risk as far as possible. It is essential that the plans are well documented, the interventions are very specific and the plan is adhered to as rigidly as far as possible.

14.2 Managing immediate risk
14.3 Following assessment, the assessor(s) should consider the appropriate care setting, level of security, frequency of observations and, the optimal combination of treatments, which will minimise the risk(s).

14.4 The following aspects of management should be considered, where appropriate.
a) Care Setting

- Outpatient follow-up
- Day Hospital
- Safe House
- Admission to open ward
- Admission to a locked ward
- Admission to a secure unit.

b) Treatment plans

- Define level of supervision
- Define level of monitoring/observation
- Medication
- Key working/support therapy
- Application of the Mental Health Act 1988

14.5 Assess awareness of, and ability to access emergency psychiatric services, communicate risk to ward, rapid response service, Social Services Emergency Duty Team (if appropriate). Warn the potential victims and inform the police if deemed necessary. Inform social services if children are considered to be at risk.

14.6 If the immediate risk is such that it presents a risk to life then the RMO, team manager, and other relevant clinical staff should be informed immediately. Immediate plan of care should be devised and action should be taken to reduce the risk.

15. MANAGING LONG TERM RISK

15.1 The long-term risks can often be minimised by appropriate placement, regular contact, ensuring compliance with medication, and treatment for comorbid disorders e.g. substance misuse. If the patient fails to engage then a more assertive approach may be required.

The following aspects of management should be considered where appropriate:

a) Care setting

- Out-patient follow up
- Placement in a specialist unit
- Rehabilitation
- Long stay ward - open or secure

b) Treatment Options

- Define Level of monitoring/observation
- Medication
- Structured activities
- Supported accommodation
- Crisis plans
- Key working
- Social Work
- Explorative psychotherapy
- Specific cognitive behavioural therapies: stress and anxiety management
- Anger management
- Insight and compliance therapy
- Coping strategies for hallucinations and delusional beliefs
- Motivational interviewing
15.2 Assess awareness of, and ability to access emergency psychiatric services. Communicate risk to ward, rapid response service, social service emergency duty team (if appropriate), Warn the potential victims and inform the police if deemed necessary. Inform social services if children are considered to be at risk.

15.3 Patients who present risk to themselves or others who do not attend appointments (DNA) must be followed up. Care co-ordinators must make every attempt to contact patient (i.e. visit). The risk the patient presents must be discussed with the team and a decision should be made on the actions to take. These must be clearly recorded in the patient’s case notes.

16. Risk Assessment and Management Process (See Flow-Chart)

16.1 When a patient/client is referred to the service, an initial and/or full assessment of their mental health and social needs, including risk assessment, will be completed.

16.2 From the preliminary assessment it should be decided if the patient/client requires services from Trust.

16.3 If the patient does not require services from the Trust then a report must be sent to the referrer with advice or to the appropriate agency who may have to provide the care.

16.4 If the patient/client is admitted to the services, an initial CPA level must be agreed based on needs and the risk presented and a care co-ordinator allocated.

16.5 The risk and CPA management plan will then be formulated based on the needs and risks identified.

16.6 If the care and risk management plan is formulated by an individual professional without the other professionals involved in the care provision, the care co-coordinator/named nurse will ensure that the other professionals are fully aware of the risk management plans.

16.7 The risk management plan for high-risk patients must be discussed with other professionals involved in the care provision at all times (except in exceptional circumstances when this is not possible) and management plan(s) formulated.

16.8 The care is then delivered, changes observed, management plans reviewed as appropriate until patient is ready for discharge.

16.9 Discharge summary, CPA and risk details must be sent to referrer or GP as appropriate.

17. ROLES AND RESPONSIBILITIES

17.1 For in-patients the admitting doctor will complete the initial risk assessment. The level of risk, risk management plans, and the level of observations required should be discussed and agreed between the medical and nursing staff on admission.

17.2 The named nurse (primary nurse) in consultation with other colleagues will complete the risk assessment(s) following any incidents, change in patient’s mental state or change in risk behaviour on the ward, in the day hospital and at the point of discharge.
17.2 The named nurse (primary nurse) should ensure that the outcome of the risk assessment is discussed with the MDT as soon as it is appropriate. If there is any doubt regarding the seriousness of the risk then the named nurse (primary nurse) should consult the medical team immediately. In the absence of the named nurse, the person in-charge will ensure that changes in risk behaviours and risk management are discussed in the MDT.

17.4 For patients in the community, the care co-ordinator or the professional assessing the patient at the point of referral will complete the initial risk assessment.

17.5 The care co-ordinator is responsible for updating the risk assessments and the implementation of care plan and the risk management plan.

17.6 If the patient is a new referral then the assessor remains clinically responsible for the assessment and implementation of the initial care and risk management plans until a care co-ordinator is allocated.

18. When a patient is discharged the risk management and relapse plan(s) will form part of the CPA. Copies of these must be sent to appropriate people, i.e. GP, etc.

19. Enquiries

Enquiries should be made to ........... on 01737 272307 or ........ on 01372 20 4198
RISK ASSESSMENT & MANAGEMENT

The following risk screening questions, level of risks and risk management plans must be completed for all patients/clients referred to the service. A comprehensive risk assessment may be completed in addition to this risk screening if it is deemed necessary by the professional assessing the patient/client.

Risk of Harm to Others/Carers

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current thoughts, plans or symptoms, indicating a risk of violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current behaviour suggesting there is a risk of violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current problems with alcohol or substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant past history of violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>An expression of concern from others about the risk of violence</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Risk of Self Harm

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current thoughts, plans or symptoms indicating a risk of self-harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current behaviour suggesting there is a risk of self harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current problems with alcohol or substance misuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant past history of self-harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>An expression of concern from others about risk of self-harm</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Risk of Self-Neglect

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current symptoms and behaviour indicating a risk of self-neglect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current disabilities (mental or physical) indicating a risk of self-neglect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of financial control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current problems with alcohol or substance misuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant past history of self-neglect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>An expression of concern from others about risk of self-neglect</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Risk to Children

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current behaviour, thoughts, plans or symptoms indicating a risk to children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current problems with alcohol or substance misuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preoccupation with child pornography/fantasies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant past history of neglect or abuse of children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of domestic violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence of a single parent/step parent or cohabitee in family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A child on the 'at risk' register or in care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>An expression of concern from others about the neglect/abuse of children</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other Potential Risks

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of exploitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidental harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offending</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wandering/Absent without leave</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk from environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is patient/client a vulnerable adult?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The following is an aide memoire. It may be used to support the initial risk screening. Alternatively, a more comprehensive risk assessment can be used if it is deemed more appropriate for the patient/client group.

Full Assessment of Risk of Harm to Others/Carers

<table>
<thead>
<tr>
<th>Name of Patient</th>
<th>D.o.B</th>
<th>Date</th>
<th>Immediate Risk of Harm to Others/Carers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>Sustained anger/irritability/fear</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Violent thoughts or fantasies</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hostile or threatening behaviour</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Disinhibition</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Acting on hallucinations</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Delusions of control or fear of attack</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Litigious and misidentification delusions</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Escalating conflict with specific individual</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Acts of recent violence/arson</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Chaotic behaviour/poor social coping</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Reduced level of support</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Unresolved source of stress</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Increase in drug or alcohol misuse</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>'Active' mental illness</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Poor compliance with treatment</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Possesses weapon with possible intent to use</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Has access to potential or threatened victim</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>New patient/client or change in consultant team</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Long term Risk of Harm to Others/Carer**

| Male (16-35) | ☐ | ☐ | ☐ |
| Previous violence / arson | ☐ | ☐ | ☐ |
| Previous convictions | ☐ | ☐ | ☐ |
| Possession of weapons | ☐ | ☐ | ☐ |
| Lack of remorse or appreciation of seriousness of past incidents | ☐ | ☐ | ☐ |
| Violent/sexual fantasies (escalation: threats, acting out) | ☐ | ☐ | ☐ |
| Preoccupation with weapons/violent literature/military memorabilia | ☐ | ☐ | ☐ |
| Cruelty to animals | ☐ | ☐ | ☐ |
| Has problems controlling temper | ☐ | ☐ | ☐ |
| Impulsive behaviour | ☐ | ☐ | ☐ |
| Morbid jealousy / erotomanic delusions | ☐ | ☐ | ☐ |
| Victim of violence, sexual, emotional abuse in childhood | ☐ | ☐ | ☐ |
| Social background (family or locality) of violence | □ | □ | □ |
| Hostile relationship with carer/specific individual | □ | □ | □ |
| Evidence of rootlessness or 'social restlessness' | □ | □ | □ |
| Has a history of disengagement from services | □ | □ | □ |
| Poor compliance with treatment | □ | □ | □ |
| Personality disorder (anti-social/borderline) | □ | □ | □ |
| Severe mental illness | □ | □ | □ |
| Recent discharge from hospital | □ | □ | □ |
| Drug or alcohol misuse | □ | □ | □ |
| Concern has been expressed by others about risk of violence | □ | □ | □ |

Comments / Past incidents

<table>
<thead>
<tr>
<th>Comments / Past incidents</th>
</tr>
</thead>
</table>
The following is an aide memoire. It may be used to support the initial risk screening. Alternatively a more comprehensive risk assessment can be used if it is deemed more appropriate for the patient/client group.

Full Assessment of Risk of Self Harm

<table>
<thead>
<tr>
<th>Name of Patient</th>
<th>D.o.B</th>
<th>Date</th>
<th>Immediate Risk of Self Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Psychological distress</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Suicidal thoughts/warnings</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hopelessness/feelings of guilt</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Depressed Mood</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Current anger/agitation/humiliation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Formulated plan, attempt, preparations for death, or suicide note</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Increase in alcohol or substance use</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Acts of recent self-harm</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reduction in level of support (including medication)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>‘Active’ mental illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Poor compliance with medication</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unresolved stress (especially losses of emotional, social, physical, or financial security)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>New patient/client or change in consultant team</td>
</tr>
</tbody>
</table>

Long term Risk Of Self Harm

| Male (16-30 and 50+) |       |      | Social isolation, including estrangement, and rural location |
|                     |       |      | Being single (widowed > divorced > separated > single) |
|                     |       |      | Chronic or intermittent suicidal ideas |
|                     |       |      | Low ambivalence about dying vs. living |
|                     |       |      | Low self-esteem |
|                     |       |      | History of deliberate self-harm |
|                     |       |      | Self-injurious behaviour |
|                     |       |      | Impulsive or violent traits by history |
|                     |       |      | Recent discharge from hospital |
|                     |       |      | Easy access to lethal toxins (including prescribed medicines) |
|                     |       |      | Past and current major psychiatric illness (especially depressive) |
|                     |       |      | Personality disorder (borderline, narcissistic, antisocial) |
|                     |       |      | Alcohol or drugs misuse |
|                     |       |      | Poor compliance with treatment |
|                     |       |      | Hoarding medication |
|                     |       |      | History of disengagement from services |
|                     |       |      | Physical illness, especially terminal, painful or debilitating illness |
|                     |       |      | Family history of suicide |

299
An expression of concern from others about risk of self-harm

Comments/past incidents:
Name Of Patient........................................D.o.B...........................Date..............

Assessed Level of Risks

Immediate

<table>
<thead>
<tr>
<th>Risk</th>
<th>Negligible</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>Life Threatening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of Violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of Self-Harm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of Self-Neglect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk to Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Long-term

<table>
<thead>
<tr>
<th>Risk</th>
<th>Negligible</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>Life Threatening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of Violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of Self-Harm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of Self-Neglect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk to Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Previous Incidents/ Other identified risks (please specify):

Risk(s) Management Plan

When the level of risk has been determined then risk management plan should be drawn up with the aim of reducing risk as far as possible. The assessor(s) should consider the potential victim(s), appropriate care setting, level of security, frequency of observations/monitoring and, the optimal combination of treatments, which will minimise the risk(s). It is important, that the plans are well documented and the interventions are relatively specific. If the risk is imminent and deemed to be life threatening then notify medical staff and/or team manager

Please tick box if above risk management plan is in addition to CPA/Crisis Plan

Assessor........................................Signature.........................date......

Document drafted by:

Reviewed by:

Issue authorised by:

Date: February 2003

Next review date:


Appleby, L., 1999 Suicide within 12 months of contact with mental health services: National Clinical survey. British Medical Journal 318, 1235-1239.


Bacon, P., 1997 Assessing risk: Are we being Overcautious? British Journal of Psychiatry, 170 (suppl. 32) 30-3.1


Bonney, V., 1963 Nursing diagnosis and therapy- An instrument for evaluation and measurement.


Carroll, J S., 1980 Evaluation, diagnosis and prediction in decision making. Law and society review. 17, 199-228.

Carson, D., 1985 Dangerous people: Through a broader conception of risk and danger to better decision.

Carson, D., 1994 Dangerous people: Through a broad concept of ‘risk’ and ‘danger’ to better decisions. Expert Evidence. 3 (2) 51-69.


<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carson, D.</td>
<td>1994</td>
<td>Risk taking with special references to mental disorder services. Conference proceedings- London 29.11. 94.</td>
</tr>
<tr>
<td>D.H.S.S.</td>
<td>1990</td>
<td>Violence to staff. Report of the Advisory Committee on violence to staff. H.M.S.O.</td>
</tr>
<tr>
<td>Daly, R.</td>
<td>1993</td>
<td>Suicide in depressed patients: Medico-Legal issues. British Journal of Psychology. 163 (suppl. 20) 29-32.</td>
</tr>
<tr>
<td>De Poy, E., &amp; Gittlin, L.</td>
<td>1993</td>
<td>Introduction to research: Multiple strategies for health and human science. Mosby: St. Louis</td>
</tr>
</tbody>
</table>
Dey, I., 1993
Qualitative data analysis: A user friendly guide for social scientist. London: Routledge.

Denzin, N., 1989

Denzin, N., 1990

Department of Health 1990
Caring for people. Care programme approach for people with mental illness referred to specialist services. H SG (90) 23. London.

Department of Health 1993
The health of the nation. Key area handbook; Mental illness, London.

Department of Health 1994
Care in the community. Community Care Act. HMSO.

Department of Health 1998

Department of Health 1994
Guidance on the discharge of mentally disordered people and their continuing care in the community, NHS Executives. HSG (94) LASSL (94). London: HMSO.

De Vaus, D., 1991
Surveys in social research, 3rd edn. UCL Press, London.

Diers, D., 1979

Dilsaver, S C., Yuan-Who, C., Swann, A C., & Shoab, A M., 1994

Dingwal, R., & McIntosh, J., 1978

Dines, Z., & Berry, D., 1997
Implicit learning: below the subjective threshold. Psychonomic bulletin and Review. 4, 3-23

Drake, R E., 1986

Drake, R E., & Ehrlich, J., 1984
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field, P A., &amp; Morse, J M.</td>
<td>1985</td>
<td>Nursing research: The application of qualitative approaches. Croom Helm, Beckenham, Kent. 1-17.</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Title and Details</td>
</tr>
<tr>
<td>-----------</td>
<td>------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Gale, S., Fine, J., &amp; Talbott, J A.,</td>
<td>1980</td>
<td>A study of suicides in state hospitals in New York City. Psychiatric Quarterly, 52,</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Title and Details</td>
</tr>
<tr>
<td>-----------</td>
<td>------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Name</td>
<td>Year</td>
<td>Title</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hamersley, M., &amp; Atkinson, P.</td>
<td>1993</td>
<td>Ethnography: principles in practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tavistock: London.</td>
</tr>
<tr>
<td>Harrison, G.</td>
<td>1997</td>
<td>Risk assessment in the climate of litigation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychiatric Bulletin 22, 446-449.</td>
</tr>
<tr>
<td>Health Service Guidelines</td>
<td>1994</td>
<td>NHS Executives, HSG (94) 27.</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Title</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Kemp, V H.</td>
<td>1985</td>
<td>Concept of analysis as a strategy for critical thinking. Journal of Nursing Education. 24: 382-386.</td>
</tr>
<tr>
<td>King, E.</td>
<td>1996</td>
<td>The use of self in qualitative research, handbook of qualitative research methods. Blackwell publication.</td>
</tr>
<tr>
<td>Klassen, D., O'Connor, W.,</td>
<td>1988</td>
<td>A prospective study of predictions of violence in adult male mental health admissions. Law and Human behaviour, 12(2) 143-158.</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Title</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Little, P.</td>
<td>1979</td>
<td>The nursing care Planning System. Nursing outlook.</td>
</tr>
<tr>
<td>Male, C J.</td>
<td>1896</td>
<td>A model for teaching critical thinking; Nurse education. 11(6) 20-25.</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Title</td>
</tr>
<tr>
<td>----------</td>
<td>------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Melina, K M.</td>
<td>1982</td>
<td>Tell it as it is- qualitative methodologies and nursing research: understanding the student nurse's world. Journal of Advance Nursing 7, 327-335.</td>
</tr>
<tr>
<td>Miller, B F., &amp; Keane, B C.</td>
<td>1987</td>
<td>Encyclopaedia and Dictionary of Medicine, Nursing and Allied Health. 4th edn. W.B. Saunders, London</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Title</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>


Morrison, M., 1996 Homicides and suicides by mentally ill people: resources highlighted. British Journal of Nursing. 5(2) 70.


Mullen, P E., 1984 Mental disorder and dangerousness. Australia and New Zealand journal of Psychiatry. 18 , 8-17.

Mulvey, P E., 1994 Assessing the evidence of a link between mental illness and violence. Hospital and community psychiatry, 45(7) 663-668.

Mulvey, PE., Lidz, C W., 1984 Clinical consideration in the prediction of dangerousness in mental patients. Clinical psychology reviews, 4, 397-401.


<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Title</th>
<th>Publisher/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Executive</td>
<td>1990</td>
<td>The Care programme approach for people with mental illness referred to the specialist psychiatric services</td>
<td>HC (90)23/ Lassl (90)11. HMSO.</td>
</tr>
<tr>
<td>NHS Executive</td>
<td>1994</td>
<td>Guidance on the discharge of mentally disordered people and their continuing care in the community.</td>
<td>HSG (94) 27. Heywood: DoH</td>
</tr>
<tr>
<td>Norman, G R., &amp; Henry, M L.</td>
<td>1987</td>
<td>Expert-novice differences on recall of clinical data: resolution of paradox</td>
<td>Proceedings of the Annual Conference in Medical Education.</td>
</tr>
<tr>
<td>Norman, S.</td>
<td>1997</td>
<td>Minimising risk while maintaining standard.</td>
<td>NT Research. Vol. 2, No. 2</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Title</td>
<td>Source</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Payne, J W.,</td>
<td>1980</td>
<td>Information processing theory: Some concepts applied to decision research.</td>
<td>In Cognitive Processes in Choice and Decision behaviour, psychological bulletin, 92, 382-401</td>
</tr>
<tr>
<td>Ryan, J W.,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pope, C.,</td>
<td>1995</td>
<td>Qualitative research: Reaching the parts that other method cannot reach: An introduction to qualitative methods in health and health services research.</td>
<td>British Medical Journal. 311 (6996) 42-45</td>
</tr>
<tr>
<td>Pitz, C F., &amp; Sacks, N J.,</td>
<td>1984</td>
<td>Judgement and decision theory and application.</td>
<td>Annual review of psychology. 35: 139-163</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Reed, J.</td>
<td>1997</td>
<td>Risk assessment and clinical risk management: the lessons from recent inquiries. British Journal of Psychiatry, 170 (suppl.32) 4-7</td>
<td></td>
</tr>
<tr>
<td>Ritchie, J H.</td>
<td>1994</td>
<td>The report of the inquiry into the care and treatment of Christopher Clunis.</td>
<td></td>
</tr>
<tr>
<td>Robins, E.</td>
<td>1986</td>
<td>Psychosis and Suicide. Biological Psychiatry, 21, 665-672</td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Title</td>
<td>Publication/Source</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------</td>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Roy, A.</td>
<td>1982a</td>
<td>Suicide in chronic schizophrenia.</td>
<td>British Journal of Psychiatry. 141. 171-177</td>
</tr>
<tr>
<td>Russo, J E.</td>
<td>1991</td>
<td>Confident decision making.</td>
<td>How to make the right decision every time. London; Piakus</td>
</tr>
<tr>
<td>Ryan, S.</td>
<td>1990</td>
<td>Expertise: the basis for expert system development.</td>
<td>Advances in Nursing Science, 13, 1-10</td>
</tr>
<tr>
<td>Ryan, T.</td>
<td>1993</td>
<td>Therapeutic risk in mental health nursing.</td>
<td>Nursing standard, 7, 247, 29-31</td>
</tr>
<tr>
<td>Sandelowski, M.</td>
<td>1986</td>
<td>The Problem of rigor in qualitative research.</td>
<td>Advances in nursing science 8 (30 27-37</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Stein, P.</td>
<td>1985</td>
<td>Using a grounded theory method in nursing research. In -eninger M (Ed) Qualitative Research Method in Nursing, Orlando FL, Grunne and Stratton.</td>
<td></td>
</tr>
<tr>
<td>Snowden, P.</td>
<td>1997</td>
<td>Practical aspects of clinical risk assessment and management, 170 (suppl 32) 32-34.</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Year</td>
<td>Title and Details</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>------</td>
<td>-----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Tanner, C.</td>
<td>1987</td>
<td>Diagnostic reasoning strategy of nurses and nursing students, Nursing Research, 36, 358-363.</td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------</td>
<td>-----------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Thomas, C.</td>
<td>1996</td>
<td>Case control study of suicide by discharged psychiatric patients. British Medical Journal, 312, 1580.</td>
<td></td>
</tr>
<tr>
<td>Thorne, S.</td>
<td>1991</td>
<td>Methodological orthodoxy in qualitative nursing research: analysis of the issues. Qualitative Health Research. 1, 2, 178-199.</td>
<td></td>
</tr>
<tr>
<td>Van Liew, D J.</td>
<td>1997</td>
<td>Clinical risk management within the NHS. Nursing Times Research. 2 (2) 88-96</td>
<td></td>
</tr>
<tr>
<td>Watson, J.</td>
<td>1981</td>
<td>Nursing scientific quest. Nursing Outlook. 29, 7, 413-416</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Wessely, S.,</td>
<td>1993</td>
<td>Acting on Delusions, 1, Prevalence, British Journal of Psychiatry. 163, 69-76</td>
<td></td>
</tr>
</tbody>
</table>