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An investigation into whether the level of experience affects the way that CMHNs assess the level of risk from clients.

MSc Practice Development (research route)

Contents

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Declaration

No portion of the work referred to in the research has been submitted in support of another qualification at this or any other university. I declare that the content contained is the authors own work.

Abstract

This was a small scale study that focussed on whether the level of experience affected the way that Community Mental Health Nurses (CMHN) assessed the risk of violence from their clients. Ethical approval was gained and 22 participants took part in the study. A mixed method approach was adopted utilising a quantitative phase followed by a qualitative phase of data collection. Each were separately analysed and the results were, that regardless of level of experience, the CMHNs believed that they were the best at assessing risks compared to all other Multidisciplinary Team members. Further, the more experienced the staff member the more control they tried to impart on the perceived risk situation, whereas the less experienced members of staff tended to withdraw and allow other members of staff to deal with the situation. Finally it was found that although training was found to be important in helping the staff to identify and manage risks; observation of live situations that were well managed was more influential in their interpretation of how they should react. The more experienced staff utilising more 'life skills' experience than the less experienced.

These finding will have an impact on training and on the future recruitment of staff to community positions.

1. Introduction

The theme to be explored in this small scale study is the way risk factors associated with patient contact are identified and prioritised. This will require examination of policy and individual accounts concerning risk in the mental health field. For any small scale study it would be too great a task to focus on the whole area of risk, therefore this study will examine one specific area; the way that staff assess the risk of violence posed to them by their clients. This is specifically focused on mental health and in particular the risks that clients pose to staff working in the community.

This specific component is important due to many factors; however, the initial driver is that there were two incidents in a local trust, where the risk posed by clients has been found to be underestimated. In both instances a full risk assessment had been completed, however, the area of risk to others was brief and inconclusive. Both incidents led to staff being held against their wish in the client's home.

For many years risk has been managed in in-patient units and the focus of risk assessment has been skewed to the risk of suicide and the care offered in in-patient units. The need to assess risk is not in question, the manner that it is conducted and its integral parts, is. Violence by the mentally ill has for the last 50 years been generally managed by a legal framework and custodial supervision (Barnes & Bowl 2001). The closure of several large forensic units has placed a strain on individual Trusts to care for and manage their violent clients. Ultimately, many do leave hospital and live in the community, where community staff support and monitor them. Equally, many clients return to mental health units when relapsing and the community staff act to coordinate a return to community living.

Over the last 40 years there has been a shift in emphasis in care for the mentally ill from a hospital to a community setting. This has resulted in the closure of around

100,000 beds (Houses of Commons Health Select Committee, 1994) and the development of care in the community to its present status. This culminated in London closing 60% of the in-patient beds it had in 1991, which is more startling when it is considered that the major bed closures brought about by resettlement had been conducted pre 1991.

This has led to a change in care being offered and an emergence of problems generally dealt with inside institutions. It has meant that many initiatives needed to be developed to deal with adverse incidents, and to comment on the approach adopted to care in the community.

Past policy change to risk has often been seen as almost a knee jerk reaction to bad press. An example of this was the reaction to the first major inquiry into the care provided by a health and social services department. This involved an examination of incidents where a person with a mental health problem murdered a community worker, and was reviewed by Spokes *et al* (1988). It investigated the murder of Peter Gray, a social worker who worked with the deaf in Hampshire. The inquiry found that staff perceived this as a singular and random incident, which is now recognised as naiveté, but also identified that it was a structural problem that required some solution. From this inquiry the early shape of the Care Programme Approach (Department of Health 1991) were muted and developed.

Historically this case did not foresee the size and gravity of the trend it was the first of, and it can be said that managers at the time operated in isolation. The managers supported an ethos of non-reporting of violent incidents, often imbuing blame on the workers, which consequently led to underreporting and the worker being trapped in a

vicious circle of having a problem but having nowhere to take it. This was an underpinning factor in Holloway's (1994) opinion as this reflected the high failures of psychiatric care, and was to get worse with the reporting of next the major inquiry into a staff murder, by Bloom-Cooper *et al* (1995). This investigated the murder of Georgina Robinson, an occupational therapist in Torbay, Devon. It pointed to ill judgement of misapplied care by management and workers, and found evidence where the patient's parents and friends were not listened to, concluding that the incident was preventable. The major recommendation was that there is a need to address the deficiencies in the mode and manner of communication between the parties involved, and re-emphasised the need to have a structured approach and system that reflected some accountability.

The Government, after trialing the Care Programme Approach, (Department of Health, 1991), produced a structural programme of individual patient care that was based on the amalgamation of the American system of Case Management and the recently introduced Care Management. Its aims were to ensure that clients being discharged to the community were adequately followed up and that there was a system of assessment and review in place. This was to avoid clients 'falling through the net' and being lost to the system. This was unfortunately implemented too late for the above people, however, the later inquiry led to modifications to the Care Programme Approach, and the publication of *Building Bridges* (Department of Health, 1995) in response to the inquiries. This attempted to define severe and enduring mental illness and clarify arrangements for interagency working and emphasised the need for risk assessment to be built into any assessment. This important legislation, however, was not without its critics, in particular the case

management angle, something savaged by Marshall (1995) who referred to this as dubious practice, and inferred the first step towards 'big brother'.

There is little or no identifiable evidence of different professions sharing information and working in partnership pre *"Building Bridges"*, and there remained little evidence of such partnership after its implementation. Therefore, further policy and guidance was needed to draw the professions together and address the risks of continued working in isolation.

Policy-wise the Government devised operational guidance to aid the implementation of the White Paper *Modernising Mental Health Services* (Department of Health 1998), in which Frank Dobson, Secretary of State for Health, stated that there is a need

"To ensure that patients who might otherwise be a danger to themselves and others are no longer allowed to refuse to comply with treatment they need"

The fact that it took such a long time before the Government decided that it was sensible to monitor attacks on NHS staff in order to reduce the violence aimed against them is indefensible. The startling speed with which policy and reform occurred following this admission underlines that bureaucracy can, when needed act quickly. The global ideals of this paper were reinforced by Alan Milburn, Secretary of State for Health, who was anecdotally credited for suggesting that 'care in the community' was synonymous with 'couldn't care less in the community'. He advocated for services to become safe and sound, where the mental health services protected the public and the patients. This statement reflected the ideology that was starting to evolve, where staff needed to get their own systems in place to address safety.

The advent of *A First Class Service* (Department of Health 1999a) set the standard for monitoring quality, but more importantly for the use of clinical governance to focus on professional self-regulation, quality and lifelong learning. Governance aims to include local level service providers that can produce locally arrived at guidance and standards that reflect the needs of the local services in general.

This development of governance has led to reform and change: has created new tiers of management to oversee the process of standard monitoring; and to the reaffirming of the importance of risk. This momentum, instead of being propelled by inquiry findings, was probably fuelled by the fear of litigation. The government had identified that they were ultimately responsible for policy that cared for the mentally ill, and they found themselves in the position of having to shift the responsibility away from the policy makers and on to the policy enforcers.

This optimistic time in the Government's policy making, however, still lacked true focus on community care workers. The Government continued to advise what could and should be done, but without providing the necessary means to do so. They ignored the fact that proffering broad brush promises meant that others had to devise a way of achieving the promise, without extra financial support. Consequently the messages were diluted and the focus detracted from the community workers and back onto in-patient services.

Reflecting back to 3 years previous to a *"First Class Service"* the *Inquiry into Homicides and Suicides by Mentally Ill People* (Royal College of Psychiatrists, 1996) concluded that in the 33 months preceding the inquiry, there had been some 39 cases of homicide by a person with a mental health problem. Problematically, the cases identified were not categorised into discrete bands, i.e. care staff, relative, and partner. Failing to do this avoided a need to address the problem systematically and led to

vague directives for staff to press charges against patients who attacked them and for a need to reform the Mental Health Act (Department of Health 1983), something it has still not been able to do. A further response by Government to reduce the fact that people who work with the mentally ill may be in danger, was to attempt to normalise the offence of homicide. Information that supports their argument is presented for example by The British Psychological Society (2000), who identified that of the homicides committed; only 5% of them are committed by the mentally ill, therefore 95% are committed by the sane.

It was only with the use of policy driven, standardised monitoring of practice that the problem of staff assaults became quantifiable. With no Governmental intervention, professional organisations decided to act. Professional organisations identified' and clearly defined, the specific aspects needed to assess the risks clients pose; *Safer Working in the Community* (National Health Service Executive & Royal College of Nursing 1998) and *Stopping Violence Against Staff Working in the NHS* (Department of Health 1999b). Each supported the use of 'zero tolerance' of violence towards staff, and set targets to reduce and stamp out violence. Underpinning this was the encouragement of staff to prosecute people who assault them, *Crime and Disorder Act* (Department of Health 1998), and to address the issue of none reporting which skews figures and could hide the true level of the problem.

This skewing of figures would not be so bad if true accurate figures for violence against community staff existed. The then nursing regulatory body, The United Kingdom Central Council (2001) in their published review in to the prevention and management of violence in the year 2001, openly admitted that community services were still under researched for the risks associated in working with the mentally ill.

This argument is continued when the Department of Health (2002 a) issued figures that for the time period of 2000/2001 the number of violent or abusive incidents in the health service had risen to 84,273, from 65,000 in the period 1998/1999. These figures contain no true breakdown of community mental health violent incidents, but targets to reduce the incidence of violence by 30% by the end of 2004 (Department of Health 2002 b) were continually hindered by continued under reporting of incidents, thus making it difficult to establish the true level violence. In addition there is an anecdotal belief that coping with a certain amount of aggression is part of the job of a nurse (Department of Health, 2002 a). To put this into prospective the government openly admit in mental health care and the care of learning disabled, the figure for such incidents is two and a half times the average for each trust. They however, neglect to identify where these figures relate to in terms of in-patient or community.

The under reporting by nurses and the acceptance of some aggression flies in the face of the nurses own code of conduct (Nursing and Midwifery Council (NMC) 2002). The NMC argue that they do not require healthcare professionals to put themselves or their colleagues at risk for the sake of the patient.

1.1 Literature Search

The literature search utilised a variety of methods: search of databases (Medline and CINHAL) an extensive search using various search engines (Google and MSN), and a manual trawl of policy document (Department of Health and local trust directives). The key words in the search were; violence, aggression, community mental health nurse, risk, perception, experience and experiential. The level of evidence aimed to identify all articles and commentary papers published with a reference to at least one of the key words. This search yielded a great deal of information, but on reading the identified articles, the articles tended to focus around violent incident and structured ways to assess the risks. Little information was available on factors affecting the CMHNs' assessment of violence. There were no direct studies on whether the level of experience of staff affected the assessment of violence. However, there were some factors identified from the literature that did identify the gravity of the situation that the CMHN works within; and that other authors have suggested that assessment of the level of experience of staff conducting risk assessments should be carried out.

This dearth of research around the CMHN and the risk of violence necessitated the literature to be examined in detail for reference to factors that are important in assessing the risk of violence. Further, this approach required a somewhat systematic approach for analysis of the literature in order to identify the threads of information that may be influential in the community workers area of work and for factors that need to be considered within the study.

Over the last 30 years John Monahan and Harold Steadman devoted seemingly timeless effort into identifying ways to predict violence. They focused on the level of dangerousness that the individual displayed and linked this to past events. Yet

throughout their time they were unable to establish a meaningful measure. Their efforts only came to fruition with the development of the Macarthur Foundation and their pivotal work on the Interactive Classification Tree Method (ICT) (Monahan *et al* 2000).

In the Macarthur Violence Risk Assessment study (Steadman *et al* 1998) the ICT was piloted on a mix of 939 male and female patient's between 18-40 years of age. They were assessed on 106 risk factors in hospital and monitored for 20 weeks after discharge.

The sample had a variety of diagnoses (schizophrenia, bi-polar problems, personality disorder and drug and alcohol problems), and, following the initial assessment, were placed in one of three groups (high risk, low risk no classification). The results were very interesting. Of all the people discharged 18.7% committed a violent incident in the follow up period. This, however, neglected to identify the diagnosis of the individual or which group (high risk, low risk no classification) they came from, but later links the level of violence to the environment that they returned to. The results were startling in that they discovered that the violence committed by those discharged was similar to violence committed by people in their neighbourhood in respect to style (hitting) and location (home). The major finding was that those discharged with a substance misuse problem were significantly more likely to commit a violent act than those without. This study however, must be viewed sceptically as it was conducted in the suburbs of Pittsburgh using a narrow age band of participants. Further it had an inclusion criterion of only comparing English speaking individuals.

The relation of this study to the research question is quite clear; there are several factors that were identified that should influence assessment. Also that there is a link

between hospital and community for violence occurring in both areas, and finally that clients may be affected by the environment that they live within in respect to the violent act they commit.

To focus more on clinician predictiveness Mulvey & Lidz (1998) studied a model of conditional prediction in the United States of America. The aim of the study was to compare the accuracy of the predictions of lay people to mental health workers as to future violence by identified individuals. The study used an emergency room of a hospital to identify and engage participants. They were assessed for the possibility of repeated violence and followed up for 6 months.

The results of the predictions were very similar, with both groups indicating that alcohol/ drug misuse would be a contributory factor in violence. Similarly they predicted that non-adherence to prescribed medication would lead to a predicted 29% of the sample committing a violent act. This did not occur, with less than half of that figure having non-adherence to medication as contributor to a violent act.

This study was innovative and simple, but had many flaws. The major flaw was that many refused to take part, and most participants came from one area of the city. Further it cited the age-old clichés that past violence and alcohol/ drug misuse are synonymous with future violence. This bias was in no way addressed and no effort was made to investigate the level of violence existent in the neighbourhood as Steadman *et al* (1998) had. Therefore the figures have a limited use to shaping clinical practice. However, what should be taken from the study is that there is a need to understand where the person lives and their life style in order to assess and ultimately predict the risk of violence more accurately. It further addressed the facts that stereotyping people because they do not necessarily conform to service demands

(taking medication) is not such an important factor in assessing violence as thought of by participants. The level of experience here ranges from lay people (with an unknown background in assessing risks) to staff who frequently come into contact with violence. The similarity in their results suggests that experience should not play too great a role in accurate assessment of violence.

Clinical predictiveness of violence was studied on an inpatient unit in Israel. Haim *et al* (2002) compared the predictions of psychiatrists with those of nurses. They involved 308 participants of which 33 were violent in the 9 month study period. The proportion of correctly predicted violence was 84% for the psychiatrists and 82% for the nurses, and there was no significant difference between the two groups. At first glance this looks remarkable, yet on closer inspection there were several doubts placed upon the results. People, who the staff were unclear as to whether they would be violent again (i.e. possibility of being violent unknown), were removed from the study. Further there was no control on how people were managed; and subsequently it was unclear how many potentially violent incidents were curtailed by intervention. The fact that the study did yield a high accuracy rate must not be ignored, and that different professions rated in a similar way is promising. This does once again have to be accepted with care, and examination of training and the medical model utilized in Israel considered when deliberating over the results. A more important comparison would have been with other professions (i.e. social workers) and including staff with a variety of time in office and from different aspects of psychiatric care.

These predictive studies have so far focused on the identification of core themes implicit in those who go on to commit a violent act, and on the way that different

people (a range of professionals and lay people) predict the possibility of violence. These studies are generally reliant on information from standardized measures that have proven efficacy in assessing the risks of violence in forensic populations (HCR-20, Webster *et al* 1997, V-RAG, Harris *et al* 1993 & PCL-R, Hare 1991). Few studies have taken the approach of not using a standardized measure to influence predictiveness, and have been based on a non-forensic population. Further even less focus on community care and the practice and decision making on CMHNs. From the few studies that purely look at clinician opinion on factors that may affect violent incidents, and that do not utilize any of the above tools for comparative controls there were only 2 available studies.

These two pivotal studies, Doyle (1996) and Murphy (2004) both explore how CMHNs assess risks from clients, and both identify enigmatic factors associated with a gut reaction that becomes pervasive in establishing opinion.

On a micro level, Doyle (1996) used an ethnographic approach employing interview and questionnaire to collect data. The analysis was conducted in a qualitative way using a predominantly narrative presentation. This analysis accessed the in-sider perspective and gained rich information. He used only 8 CMHN subjects in two trusts: four subjects from a forensic workplace and four subjects from a generic workplace to identify the different emphasis that CMHNs placed on risk assessment. The results showed that the different working environments that individuals were practicing in affected their interpretation of risk. Forensic workers (working in a team based approach) emphasized the importance of historical factors as the most important factor in assessing risk. The generic workers (working in an autonomous

approach) emphasized the importance of current factors in assessing the risks. Within the study experience was identified, but was an unmeasured variable.

Doyle's (1996) study indirectly identified that the way risk was assessed may be affected by the team/ environment you work within, and that CMHNs may have different opinions about how to assess the risk of violence.

Murphy (2004) similarly examined how CMHNs assessed the risks from clients, however, adopted a phenomenological approach (an approach based on understanding the meanings events have for persons being studied (Patton 1991)), in order to ascertain meanings to how people assessed risk. The methodology reflected this approach by using questionnaires and focus groups that were analysed qualitatively by identifying trends. This study had 16 participants, all generic CMHNs from one trust. It found that the participants identified a need to have an accurate history as a priority as this enabled the development of a sharing therapeutic relationship with clients. The studies pinpointed that people who they had found to be violent tended to have difficulty in developing therapeutic relationships and had responded adversely to change. They also highlighted that there was a belief that experience made risk assessment more accurate, and Murphy (2004) had indicated that this was an area that was in need of further investigation.

This dearth of information on CMHNs assessment of violence generated many questions.

1.2 Questions:

What is it that makes risk assessment accurate?

Is it the education of the assessor?

Is it to do with the environment of work?

Does the management strategy affect the decision-making?

Will the experience of the assessor improve the accuracy?

Could it be enigmatic factors (gut reactions)?

Is it due to recent exposure to risk situations?

The questions raised have an affect on the way that we practice and develop our skills, and are important factors when addressing the issue of risk, however, to address all of them identified would be too great a task for a small study. Therefore narrowing the investigation to the experience of the assessor was proposed. This needed to take into consideration the environment and management of risk, and also to explore personal factors that influence decisions about the beliefs about the level of risk. It was to be conducted in the community mental health field, as this is the area of limited investigation. This leads to a question of "Does the level of experience affect the CMHNs assessment of risks?"

There are several ramifications of linking experience to practice. If the study identifies that risk assessments are dependant on the experience of the practitioner. Then this could produce some further questions:

Will this affect the job description of those wanting to work in this area?

Will it alter the roles workers adopt in the area until experience is acquired?

Will it affect the balance between senior and junior members of staff and lead to elitism?

These problems aside, the importance of such a study is many fold: It could lead to the sharing of good practice; Demonstrate what experience was valuable; Identify management styles that are effective in skill development and practice; May affect the

way junior members of staff are allowed to practice; Involve an increase and redesign of supervision.

The importance of this study is that it will examine the role that experience has on decision-making and on assessing risk. It will have implications for staff, carers, users and managers, and could be influential in decisions about recruitment.

1.3 Aim

- To discover if the level of experience of the CMHN affected the way that they assessed risks.

1.4 Objectives

- Identifying personal experiences (inside and outside of the work environment) that affected the assessment of risk, and
- Identifying actuarial factors associated to risk, and reporting emergent patterns of participant responses.

2. Methodology

2.1 Research Design

The study is going to explore the factors that CMHNs believe are important to them when assessing the risk of violence from clients. It will explore the factors that have led them to practice in the way that they do, and things that have influenced their decision-making in risk situations. It is a follow up to a previous study that I conducted where the findings indicated that a more in depth exploration of specific risks and actions of staff associated with the risk of violence from clients was required. The previous study identified some staff behaviours that occurred when assessing general risk, but did not probe in any depth the underlying beliefs about why they acted in the way that they did. Further it neglected to investigate more into where they gained their decision-making ability.

In order to explore this, the design must identify a group of people who have been in a situation where they believed they could be at risk of a violent act, and identify how they coped and what influenced their behaviour. The design of the study is also influenced by my personal philosophy of being a pragmatist and a personal need to utilise a mixed method approach. This, I believe, will provide firstly the opportunity to quantitatively measure some components of risk and then secondly qualitatively explore in depth specific issues that come out the first phase.

2.2 Pragmatic principles and personal philosophy

Being a Pragmatist influences my method of personal inquiry, as I believe that actions and beliefs are based on a problem solving adaptation to the environment. This environment that we engage in, demands the use of understanding and not merely the use of the senses (Searle 1998). Mead (1863-1931) described pragmatism as involving

human conduct that is symbolic in allowing an understanding of gestures and responses. These symbols need to be seen as being based in common language that will reflect the meaning of 'self'. This image is inextricably linked to beliefs both psychological and psychic that affect an individual, and this belief of self is regarded as society. To clarify the principle further Blumer (1969) argues that humans act rather than react to construct a social action. The underlying beliefs that drive the act are personally important. These beliefs drive behaviour that will cause reactions and effect within any social structure.

For pragmatists to conduct inquiry there is a need to satisfy these principles and be able to generate a diverse level of discourse. This can ultimately lead to the generation of exposing feelings (Knight 2002).

This will consequently provide the opportunity to examine how beliefs and actions are displayed within the culture of an inquiry, and if they are harmonious (cognitive dissonance theory, Festinger 1957).

Pragmatic research has to focus on the real world. It needs an impetus that moves researchers away from the "sole consideration of knowledge and knowns to a discourse centred on knowings and meanings" (Tashakkori & Teedlie 1998 p52).

To be able to achieve this level of discourse I believe that the use of mixed methods of inquiry would be necessary. To many (Tashakkori & Teedlie, 1998, 2003) these would equate with pragmatism. Dewey (one of the founders of the American pragmatic philosophy school) argued that a pragmatist's view is that knowledge is not necessarily universal and that it is something possessed at an individual level. This individual level lends itself to 'insider' (emic, Schwandt, 2001) investigations.

This approach I believe provides me with a framework that meets my personal desire for structure and clear reporting, whilst allowing me to investigate and use the language of the informants. The pragmatic approach means that I am not shackled by one perspective of how to investigate, both in size and in depth. Whether my philosophy was influenced by the job of being a nurse, or was in built is questionable. There is a general rejection of one scientific method and one framework that solely underwrites inquiry. The nature and principle is that it is social in source, using procedures that are most effective. Tashakkori & Teedlie (1998) advocate for the rejection of using only one measure and forward the mixed method approach, qualitative and quantitative in regulated fashion. Bernstein (1983) argues that mixed or multiple method approaches are needed for a social inquiry that was investigating the understanding of human subjects and their actions, from a particular perspective related to the situation in place. This provides the researcher with the scope to use any warrantable method, thus providing the opportunity to utilize a method that will open up interpretive dimensions if so desired. What matters is not the origin of the idea but the outcome yet to be realised and measured (Kaplan 1964).

An important factor within this approach is the relationship between the "knower" and the "known" ('Epistemology' Guba 1990 p.18), and raises the question, 'What is warrantable or even acceptable knowledge?' Bryman (1992) argues that this relationship (epistemology) underpins the divide between quantitative and qualitative research

"Qualitative research typically involves an in-depth and holistic approach, through the collection of rich narrative materials using flexible research design" (Polit, Beck & Hungler 2001, p469), whereas,

"Quantitative research lends itself to precise measurement and quantification, often involving rigorous and controlled designs" (Polit, Beck & Hungler 2001, p469),

It is important to understand how the researcher is related to those being researched; where the study is conducted and the structure, will affect the relationship. On a personal level, I have no problems with conducting a study in my own area of work and thus being almost grounded in it, but similarly I could conduct another study away from here and accept being almost independent. This situation could invariably occur in different phases of one study.

Personally, there is a need for me to adhere to some structure; this is probably fuelled by my fear of anarchy and the desire to know where I am up to with things at any one time. This means that when I explore what sort of methodology to use, I can see that running concurrent processes would be difficult for me. Thus I believe that for my own personal beliefs I would need to adopt a sequential process of separating out the methods and using the data to further influence the next stage.

Values are important at this point, (axiological considerations) and their relationship to the inquiry, particularly in relation to a pragmatic inquiry. An acceptance that methods of collecting data have limitations is important, and in particular that when you utilize mixed methods you are somewhat neutralizing this effect (Creswell *et al*

2003) and enhancing the strengths of both. This enhancement may lead you to take what could be considered, an inordinate amount of time over a study.

Cherryholmes (1992) stated

"For pragmatists, values and visions of human action and interaction precede a search for descriptions, theories, explanations, and narratives. Pragmatic research is driven by anticipated consequences. Pragmatic choices about what to research and how to go about it are conditioned by where we want to go in the broadest sense" (p13).

Personal values play a large part in the pragmatist's decision as to what and how to research, and this is often demonstrated in the research question used. These personal values are steeped in the personality of an individual and have been affected by many forces, in particular personal experience, however, it must be remembered that,

"There can be no better or more natural way of justifying a method than with respect to the scientific appointed tasks that are in view for it" (Rescher 1977, p3).

2.3. Personal Pragmatic Philosophical Needs

Ultimately, all of the philosophical questions need to be tied with how we are to obtain information and the methodology is dependant on what the question is. This allows the researcher from a pragmatic position to select a method that not only fits with their personal view of how a study should be conducted, but also to use

whichever method they believe will best fit the parameters of the inquiry. This notion fits with the ‘use what works’ ideology.

Personal experience of conducting studies involving staff where risk is the focus provides me with an understanding that it can be approached in a variety of ways. For example, in my last study the design used a phenomenological approach because this was what best fitted the questions.

In each study there is a need to look at the context of the environment and within this, examine the nature of reality and what really counts as evidence (ontological perspectives, Guba 1990). It is clear that in some situations there is clear unambiguous evidence, however, in others there are unclear ambiguous assumptions. Acceptance of the reality that there is a breadth of information attainable, that can be presented in various ways, allows me to somewhat ‘sit on the fence’ and agree with disparate philosophies. I believe that an investigation on the experiential factors around risk issues directs a researcher to have to quantify what is going on and then to have to explore why; an approach a pragmatist may adopt.

This approach is neither new nor novel. Although seeming abstract to research, unearthing the way that we arrive at a decision can be seen in many forms of research and philosophy. Even in Taoist teaching, “ *things in their original simplicity contain their own natural power, and are easily spoiled when the simplicity is changed”* (Hoff 2003 p10) there are essential personal values.

Although appearing descriptive in nature, it does provide the opportunity to explore how individuals naturally perceive themselves in their environment. Working with people in their own environment and engaging them in open discourse may avoid the confusion related to having to think too abstractly outside their normal environment, and provide a truer picture of how things are.

A further personal philosophy is that the language and the structure of research needs to be transparent, and avoid conversations laden with jargon. This will allow the research to be open to a wider audience that does not require a dictionary to decipher some of the phraseology. These criteria are undoubtedly linked to producing an enquiry that examines the content of the speech of individuals, but linked with this there is a personal need to gain the collective opinion. This demands a structure that will have to work on two levels. On one level collecting information from a large number of people, which can produce an overall opinion of an inquiry. Then secondly, narrowing the field to find out more detailed information from individuals. This offers the opportunity to compare individuals to the wider group, thus demanding an approach that embraces both qualitative and quantitative methodology.

Personal beliefs about the methodology for this study mean that if there are two phases of data collection, then they need to be conducted separately. Splitting it in this fashion avoids being overwhelmed, ensures that the whole story is looked at and that an impulsive leap for one measure, before knowing what is needed, is avoided.

The method I feel most comfortable with is a staged design involving two separate phases: the collection of quantifiable data and analysis, then the collection of the

qualitative data, analysis and then comparison of findings (sequential explanatory design, Creswell *et al* 2003).

This structure would almost provide two separate studies in one, however, in this case part of the analysis of the first phase will be integral in selection of participants for the second phase. Therefore, there is a dependence on this structured sequential approach. This analysis would identify individuals that would best demonstrate the range of opinion from the population of the study. This provides the opportunity to select participants that would best answer the question set (purposeful sampling), and involve them in more detailed qualitative inquiry in the next phase. The instruments used for the quantitative investigation is a questionnaire, and the instrument for the qualitative investigation is individual interview.

A structural point is made by Lewis Carroll (1939), in his assertion to read things through and be methodical

"Begin at the beginning and don't allow yourself to gratify mere idle curiosity by dipping in to the book, here and there" (p 1116).

2.4. Developing the Research Question

I have been receiving regular requests for advice on the issue of risk from colleagues and managers. This culminated in the development of two small-scale research studies that I conducted in the trust, focusing on *"How CMHNs assess the risk of violence from their clients"* (Murphy 2004), and *"Assessing the risk of violence from clients"* (Murphy 2005).

They involved a small number of subjects and yielded some vague but interesting results in relation to historical factors and gut reactions, the latter, none of the subjects felt able to adequately define. Importantly the identification of this enigmatic sign did in some circumstances act as a warning to the nurse of a perceived threat of violence, but in others it did not.

Within the first study there was an attempt to identify the local language and concepts used to name their experience (emic perspective, Schwandt 2001), whilst trying to also quantify some natural facets of the enquiry. However, the results did not satisfy me as they touched all the bases of what was felt to be important, but added little in the way of substance that would relate to practice.

The second study, although published later, was a pilot study looking at similar questions to the first, similarly identifying the emic perspective. This provided the information that made the first published inquiry feasible, identifying that there were factors that nurses felt uneasy with, but were unable to conceptualise in an articulate manner.

On reflection, although an attempt to be true to my personal philosophy was made, I feel that the lack of experience and the guidance provided by colleagues diluted the methodology. The focus became linked to policy frameworks and influenced by the supervisor's personal philosophy. A major lesson learnt from this was that I needed to accept other people's comments, but not necessarily alter the way a study is conducted.

The studies ultimately left me with questions rather than answers, something that I find difficult to accept. It has therefore led to the exploration in more detail of a specific strand of the original research. This strand, 'experience' is important, and was not fully explored. Experience is difficult to quantify, yet managers throughout the country demand levels of experience in order to make people eligible for new roles within the profession. But what is experience and how is it developed? What do you need to have seen, heard or believed to develop this experience, or is it purely a matter of time in a role? In my opinion time in role does not equate to experience, merely time served.

This research needs to examine the detail of what experience is. Then relate this to the issue of assessing violence from clients in the area originally explored in my research. This will ultimately provide a more coherent account of the experiences that develop the skills of community nurses in assessing this risk.

These experiences are pivotal in the study as this is the area that other studies have always omitted. What, how and when we become experienced is important. Equally so is what the experiences are and where we obtained them. Therefore, the study will address the question of;

Does the level of experience of the CMHN affect the way that they assess risks.

2.5. Sample for questionnaire:

The sample is a sub-set of the population (Robson 2001). The population for this study are CMHNs in the Trust. The sample to be used is the CMHNs of one of the districts of the Trust.

The Trust has only recently become an amalgamation of three other Trusts (now referred to as directorates). Within these directorates policies and procedures for research exist that are slightly different to each of the others. In order to reduce the process of having to apply to all three the sample is only taken from one. The population of this one directorate is 38 staff. Therefore, narrowing the sample in this way means that within the time constraints of the study, the research is viable.

A factor that needs to be considered is that the people who respond must be representative of the people who did not respond (or were not selected for part of the study). Therefore, care is required in examining the questionnaires to see if they are from all the teams involved, and a cross section of the level of experience. A very low response rate is usually a sign that only certain types of people are responding, which may lead to substantial response bias and misleading data (Wilson & Javed 2005).
(Inclusion criteria for the study are in appendix 1.)
Permission to approach and use the time of respondents was gained from the community team manager (copy of letter in appendix 2.). This included:
Attendance of a presentation about the study
Reading information sheet on study (see appendix 3.)

Reading and completing consent form (see appendix 4.)

Completion of the questionnaire (see appendix 5.)

If selected for interview, (interview inclusion criteria, see appendix 6.) both an agreed venue and time to take part in the interview (interview schedule, see appendix 7.)

Attendance at the presentation of the final results

2.6. Questionnaire:

One of the major problems with questionnaires is the response rate (Robson 2001). Czaja & Blair (1996) suggest that to improve the response rate to the questionnaire, it will need to be a valid measure of the research question that will elicit accurate information and will need the cooperation of the respondents.

The questionnaire needs to be designed to be user friendly. It will need to be of sufficient length to answer the research question. Response is improved if the questionnaire is; short, of value to the individual, clearly thought through and well presented (Robson 2001). A copy of the questionnaire is in the appendix.

In an attempt to increase response rate, Czaja & Blair (1996) argue that the researcher needs to send the questionnaire to the named individual, and enclose a copy of the introduction sheet. It will need a stamped addressed envelope and a date to be returned by. After one week the individual will be followed up with further correspondence to enquire on the questionnaire.

Careful wording to aid understanding and avoiding a specialist knowledge test are key to a good questionnaire (Robson 2001). The questionnaire developed addresses this point by using a mixture of unambiguous questions, both open and closed, and aims to

elicit opinion about how risk assessments are influenced by experiences both in and outside of work.

2.7. Data analysis of questionnaire:

This is the first stage of analysing the data where the information from the questionnaires are organised into a data set using SPSS. The data will be presented in a descriptive way utilising scatter graphs and comparative ratios, and will identify the way that groups of staff respond to specific questions. This information will be further analysed to establish if there was any variance between means using Oneway ANOVA test.

The analysis will use specific questions in the questionnaire to identify clusters of respondents that have varying levels of experience in relation to working as a CMHN. It will also group together those who have been assaulted and in a situation where they believed that they were at risk of violence.

As an important contextual, point the final area of analysis is that respondents need to be able to identify accurately, factors associated with the risk of violence. This is important as these factors are instrumental in all risk training courses and are evidenced (Dolan & Doyle 2000). This will provide the clustering of those that can be used for interview and those not. From those that can be used for interview the respondents will be categorised according to the amount of time served as a CMHN, so as to give the range required. People for interview will be selected from all points of this range.

2.8. Sampling for interviews:

This phase is reliant on the analysis of the questionnaire and relies on identifying individuals that present a range of experience. Therefore, purposeful sampling is used to identify typical representation. It allows the selection of individuals that represent different perspectives, but also ones that are accessible (Creswell 1998) and who would be informative (Morse 1991). This obviously means that prior knowledge of the sample is needed, but also that the analysis of the questionnaire is accurate (Maycut & Moorhouse 1994). It is important that respondents have experienced assault at some level and have knowledge of some key actuarial factors.

2.9. Interview:

The interview will only be conducted once the questionnaires have been analysed, and the individual has agreed to take part. The analysis of the questionnaire will act as a way of selecting the participants for the interview phase. The structure of the interview provides what Patton (1991) suggested, that questions can provide a *"framework that respondents express their own understandings in their own terms"* (p.290). Thus not necessarily answering the question in the way that we felt they should, but how they wanted to. Therefore, exploring their experiences in an open and frank manner.

The style of interview will be semi-structured so information can be delved for below the surface, and explore attitudes, behaviours and experience ((Bowling 1997). Importantly, there is a need to gain the trust and establish a rapport with the respondent, thus gaining a guided conversation (Loffland & Loffland 1995). Further this will, if conducted tactfully, uncover rich information that can be examined from a

personal viewpoint (Bowling 1997), therefore, gaining their perspective (Marshall & Rossman 1995).

Within the interviews, an audio recording will be made and notes taken. Wisker 2001, argues this is distracting but better than relying on memory which is foolish. Supplementary questions are used to explore in more detail individual answers (Maykut & Morehouse 1994). This will provide in-depth information, or the contextual issues relevant to the experiential event (Patton 1991).

2.10. Rationale for approach:

Credibility in qualitative studies tends to be linked to the identification of accurate descriptions of an individual's experience (Sandelowski 1986). This may be difficult for a pragmatist to accept as the only evidence. Using only questionnaires even in their loosest form will limit the information that can be provided, and understood. However, with an additional measure of interviews, the information from the questionnaires could be presented back to develop themes, and this may start to address the need for accurate descriptions, and add validity to the evidence gained.

2.11. Data analysis for interviews:

The main drive here is to produce a coherent account of the experiential factors involved in risk assessment in the words of the respondent (Dey 1993). The method will involve the coding of the transcribed interviews in order to establish themes (Huberman & Miles 1994). These themes will be then categorised further to establish the relationships between them (Dey 1993).

The analysis will involve listening to the audio recordings many times and reading the transcription, this will aid an understanding of the contextual setting that the respondents are from, and develop a feel for their view (Burnard 1991).
The manual coding of the data will use the Huberman & Miles (1994) approach. They advocate for categorisation of similar data and use of memo notes on the relevant site. This style will allow the grouping of similar data and enable cross matching (Kruger 1998), easing the management of the analysis. Kruger (1998) further identifies that this approach will help the identification of commonalities, linked to each respondent. Ultimately this will lead to an opportunity to report verbatim accounts of experience, actions and feelings. This will then be able to be cross-matched to where the respondents are positioned on the continuum of experience.

2.12. Ethics:

"In the development of defensive rules and procedures we have somehow forgotten exactly from what ***harms we are protecting our patients, students and staff****"* Johnson (2004).

This statement sums up a concern that I have about the present system of trying to get ethical approval for research. We commonly make things more elaborate and complicated in order to try to placate a research ethics committee that have little in common with those who are being researched. Effectively nursing research is being made more difficult to conduct and more bureaucratically managed out of the profession

To argue this point does not dismiss the need to have approval or to have ethics underpinning a study. It merely reflects the concern about political correctness that has been foisted onto us novice researchers. It clearly accepts that there is a need for rules and the need to protect individual's rights, but that if we continue to impose further restrictions on the present system, then research will be strangled out of existence from the practicing nurse. The process of narrowing research to a limited field and a need to have such a tight methodology that can have little generalisability antagonises this problem. This means that research can have a narrow use and an even more narrow understanding. Leaving it possibly useful to the few and nonsense to the masses.

The Royal College of Nursing (RCN) guideline (RCN 2004) on nurse research advocates autonomy and the practice of beneficence and non-malevolence (doing good and no harm). This approach is, however, quite narrow and ignores the wider picture of society. Research can affect not only the subjects being researched and the researcher, but also all those involved in the life of those being researched. In my opinion this narrow view therefore demands that close scrutiny of the methodology can become the primary focus of ethics, and miss the opportunity to identify the benefits more globally. Johnson (2004) argues that this narrowing and focusing on methodology has become a distraction from what the research is actually trying to do.

Therefore, ethics needs exploring in a wider spectrum, and because of this I will detail the ethical considerations utilising the Social Research Association (SRA 2003) ethical guidelines.

2.12.1. Obligation to society

By providing a clear structured schedule with specific rationales for methods to be employed reduces possible misinterpretations of the study. This openness further protects society from the production of misleading results caused by misrepresentation of the findings.

2.12.2. Obligation to funders and employers

There are common interests for the study with the employers and funders, and there will be no attempt to produce something that will purely act to advocate the funders perspective. A mutual respect between employers and researcher is needed, with an acceptance that the researcher has an exclusive professional and technical domain over the integrity of the data. Care will be taken not to pre-empt results as no guarantees will be entered into with the funders as to what will be found. This will maintain the quality and ethical standard required for research in society.

2.12.3. Obligation to colleagues

There is a need to promote confidence in the study, but care will be taken not to exaggerate the impact of the findings. Clear information about the methods and adherence to ethical principals will ensure that respect for colleagues in terms of avoiding the creation of risks. The production of valid data and upholding the principal of producing a faithful representation of the findings that is open to scrutiny will be made.

2.12.4. Obligations to subjects

There is no obligation for subjects to take part in the study, and there is no special right for the researcher to coerce participation. This study is seeking new information and therefore, cannot use existing data, however, the data produced for this study will be used solely for this study.

The study will be based on freely given consent with no obligation to take part. Further, participants can withdraw from the study at any time without reason. By providing a clear and detailed account of the study the participants should be able to make a choice based on the evidence, and should understand the implications of participation. Should they require more detail a contact point will be left for them to contact the researcher directly. To support this a signed consent form is to be used which will also reiterate the obligations of all parties and that participation is voluntary. The design aims to allow the inclusion of as many people as possible in the first phase, with the main exclusion criteria being that they do not wish to take part. Confidentiality of records will be maintained, and recordings will be coded using a key that is accessed by the researcher. This key will be securely stored, and access for the researcher needed for the identification of participants chosen by purposeful sampling of the second phase.

All information will be computer stored and will be encrypted to protect identification by others.

2.13. Summary of ethical principles

There are several responsibilities that need consideration. The study has to be open and clear so that it does not "*hide behind any notion of subordination, compliance and*

obedience to justify avoiding personal responsibility for what is done as part of a research study" (Royal College of Nursing 2004).

There is a need to consider the impact that the study will have on its participants, and also those who may witness the study being conducted. It is important that participants are treated with respect and that the research is conducted with the participants rather than on them (Royal College of Nursing 2004). This is addressed by making the initial stage of the research proposal as inclusive as possible and then sensitive purposeful sampling used later. There is no coercion involved as the process requires participation as voluntary, and personal autonomy is addressed by:

- Providing clear unambiguous evidence and information about the proposal. This will allow the participant to balance the issues and have enough information in order to make a choice.
- Not applying any pressure on participants when making a choice.

3. Data Analysis

3.1. Analysis of quantitative data (PHASE1)

This stage of the study utilised questionnaires. There were 35 sent out and 22 returned. Each of the 22 returns had a consent form completed, that had been returned in a separate envelope.

The first stage of analysis was to develop a data set, which was entered onto the SPSS software package once all the data had been collected. This required some initial considerations when devising the questionnaire. This meant that the questionnaire was constructed in such a way that specific questions could be coded for quantifiable measurement. The other questions were in place for inclusion criteria for the next phase of the study and for influencing the microstructure of the next phase. Even though this was done, on examining the returned questionnaires, there was the occasional question that was left blank for no apparent reason, but this was something that I had expected. This expectation guided the software package choice of SPSS, as it will only compute averages on data that is present. The data was entered into the package and values for each variable assigned.

Before attempting analysis, a cross matching exercise of checking the data against the computed data took place. This was to ensure that the data had been entered correctly. A final check using simple frequency checks was completed on the columns to identify if there were any clear anomalies.

The first part of analysing the data was to describe the sample. This is shown in table 1.

Table 1. To show composition of sample

Age	18-24	25-34	35-44	45-54	55+
	0	9	5	8	0

Sex	Male	Female
	5	17

Qualifications	Registration only	Diploma	Degree
	8	3	11

Type of practice	Community Team	Assertive Outreach Team	Crisis/ Intensive Home Treatment Team
	15	2	5

Time in Practice	Student nurse	< 5 years since qualifying	> 5 years since qualifying
	0	5	17

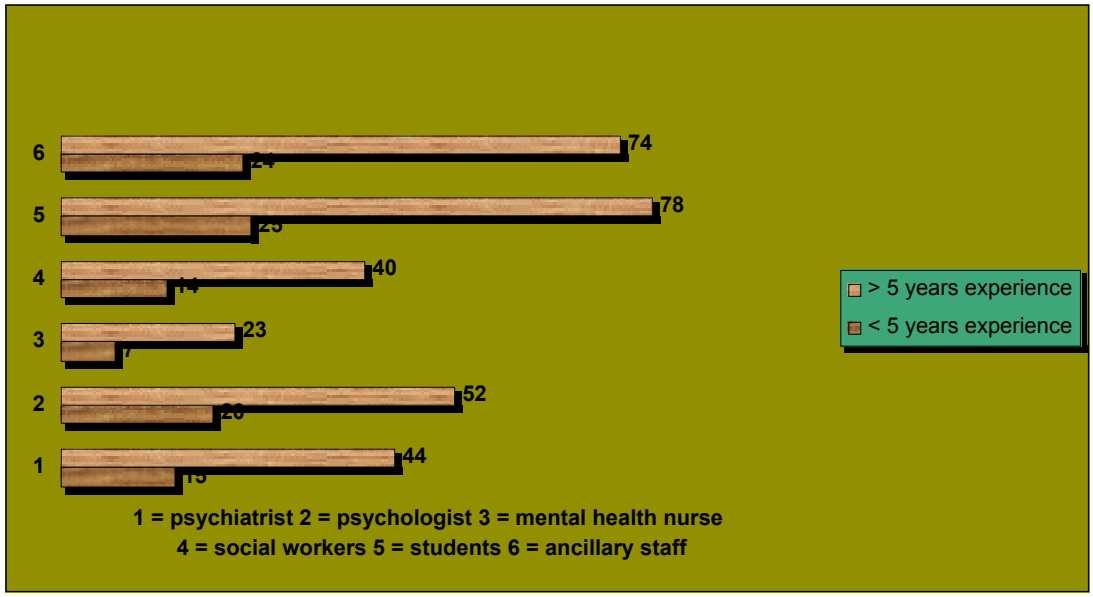
The sample is in an age band of 25-54 years of age and with more than 3 times more females responding than males. Generally it is required to have at least 3 years post registration experience (if not a student) to be eligible to work in the community in this directorate. The sample was representative of the ratio of sexes.

The type of qualification was interesting as the respondents that identified registration only, were in the older age band (45-54) and the crisis/ intensive home treatment team had the highest ratio of younger members and the highest ratio of respondents with degrees.

The type of practice level were reflective of the ratios of staff to each team, but the team with most staff with < 5 years experience was the crisis/ intensive home treatment team which was not a true reflection of all the team compositions.

In analysing the data there is a need to return to the focus of the study (to examine whether the level of experience affected the way that CMHNs assessed the risk of violence).

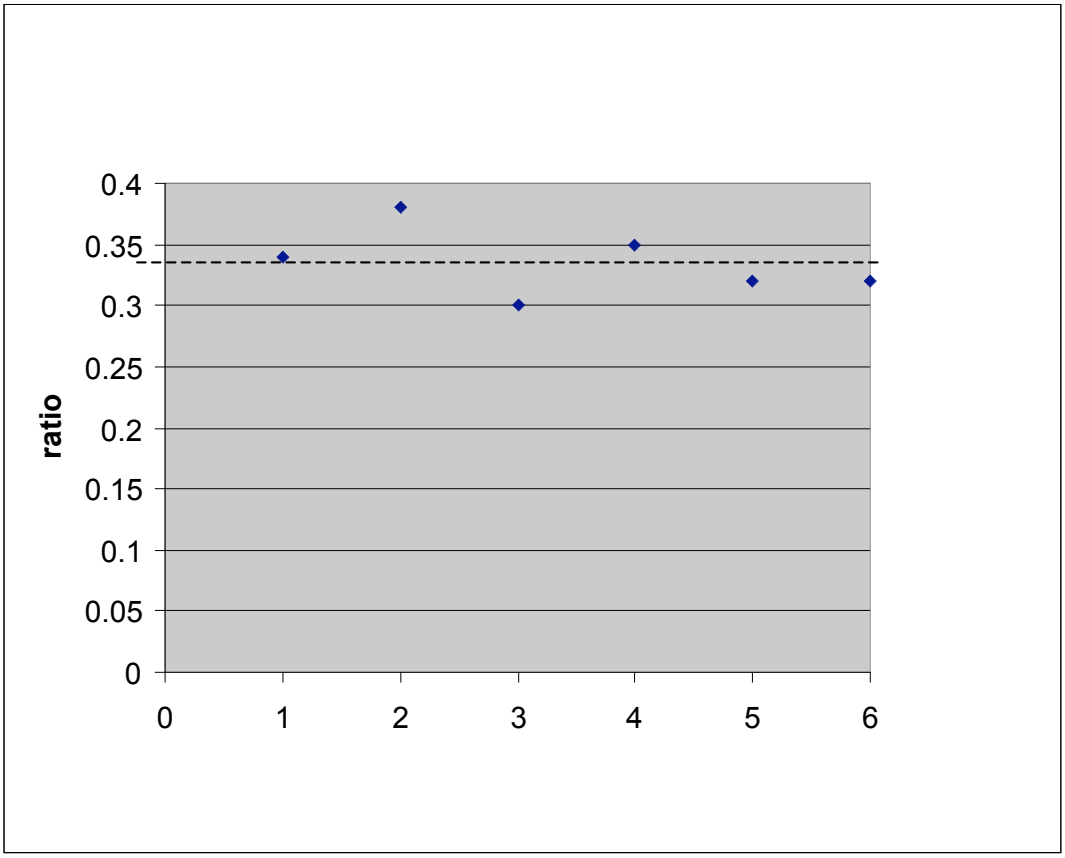
Chart 1. To show the comparative results of how CMHNs perceived the capabilities of other professions to assess risk.



To interpret this box there is a need to understand the way that respondents ranked the various professions. The lower the score entered, the better the respondent believed that the professional assessed risk.

From this it is clear that mental health nurses are believed to be the best at assessing the risk and students are the worse. This is the same for both level of experience of staff respondent. To examine this in more depth, and to establish if this had a similar pattern over all the variables a scatter graph would need to be plotted and a line placed at the mean to show variance of scores from it. Before this could be done there was a need to transform the data into a similar comparable form. Initially conversion into percentages was considered, but rejected, as the number of respondents was very low. Therefore, conversion to a ratio between the 2 sets of data for each variable was done. The results are seen in Graph 1.

Graph 1. To show the how the ratio scores are compared to the mean score.



What is clear is that the ratios are similar in presentation (range 0.3 – 0.38), and were closely grouped around the arithmetic mean of 0.335.

To establish how closely related the sets of data were, they were statistically measured for variance using a one-way ANOVA test. To conduct this the data was returned to its raw form and analysed through SPSS. The findings are in Table 2 and 3.

Table 2. To show the results from Oneway ANOVA test of the variance of scores for the way each group (,5 years and >5 years experience) rated each professions ability to conduct risk assessments.

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Psychiatrist	Between Groups	.655	1	.655	.408	.530
	Within Groups	32.118	20	1.606		
	Total	32.773	21			
Psychologist	Between Groups	3.422	1	3.422	1.523	.231
	Within Groups	44.941	20	2.247		
	Total	48.364	21			
MHN	Between Groups	.009	1	.009	.019	.892
	Within Groups	9.082	20	.454		
	Total	9.091	21			
SW	Between Groups	.772	1	.772	.626	.438
	Within Groups	24.682	20	1.234		
	Total	25.455	21			
Student	Between Groups	.334	1	.334	.188	.669
	Within Groups	35.529	20	1.776		
	Total	35.864	21			
Ancillary	Between Groups	.772	1	.772	.282	.601

	Within Groups	54.682	20	2.734		
	Total	55.455	21			

Table 3. To show descriptive information on how each group of staff (<5 years and >5 years experience) rated each professions ability to conduct risk assessments.

Descriptives

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
psychiatrist	<5years	5	3.0000	1.22474	.54772	1.4793	4.5207	1.00	4.00
	>5years	17	2.5882	1.27764	.30987	1.9313	3.2451	1.00	5.00
	Total	22	2.6818	1.24924	.26634	2.1279	3.2357	1.00	5.00
psychologist	<5years	5	4.0000	1.58114	.70711	2.0368	5.9632	2.00	6.00
	>5years	17	3.0588	1.47778	.35841	2.2990	3.8186	1.00	6.00
	Total	22	3.2727	1.51757	.32355	2.5999	3.9456	1.00	6.00
MHN	<5years	5	1.4000	.89443	.40000	.2894	2.5106	1.00	3.00
	>5years	17	1.3529	.60634	.14706	1.0412	1.6647	1.00	3.00
	Total	22	1.3636	.65795	.14028	1.0719	1.6554	1.00	3.00
SW	<5years	5	2.8000	1.09545	.48990	1.4398	4.1602	2.00	4.00
	>5years	17	2.3529	1.11474	.27036	1.7798	2.9261	1.00	4.00
	Total	22	2.4545	1.10096	.23473	1.9664	2.9427	1.00	4.00
student	<5years	5	5.0000	1.22474	.54772	3.4793	6.5207	3.00	6.00
	>5years	17	4.7059	1.35852	.32949	4.0074	5.4044	2.00	6.00
	Total	22	4.7727	1.30683	.27862	4.1933	5.3521	2.00	6.00
ancillary	<5years	5	4.8000	1.64317	.73485	2.7597	6.8403	2.00	6.00
	>5years	17	4.3529	1.65609	.40166	3.5015	5.2044	2.00	6.00
	Total	22	4.4545	1.62502	.34646	3.7341	5.1750	2.00	6.00

The result are clearly identifying that there is no significant variance, between the two groups of staff in the way that they believe other professions assess the risk of violence. The scores are compared to the standard cut off of 5% or less for

significance (no significance if 0.05 or greater) (Hicks 1990). This cut off is referred to in some literature as the critical value (Polit1996), however, commonly when referring to critical values, 0.05 (95%) and 0.01 (99%) provide degrees of significance that the results are compared to (Polit 1996).

The next stage of analysis was to focus on the factors that were felt to be most important in assessing the risk of violence. The respondents were provided with 21 statements, each an identified factor associated with violence in the mentally ill. They were asked to identify the 5 most important factors. This information was collated in a table (Table 4.).

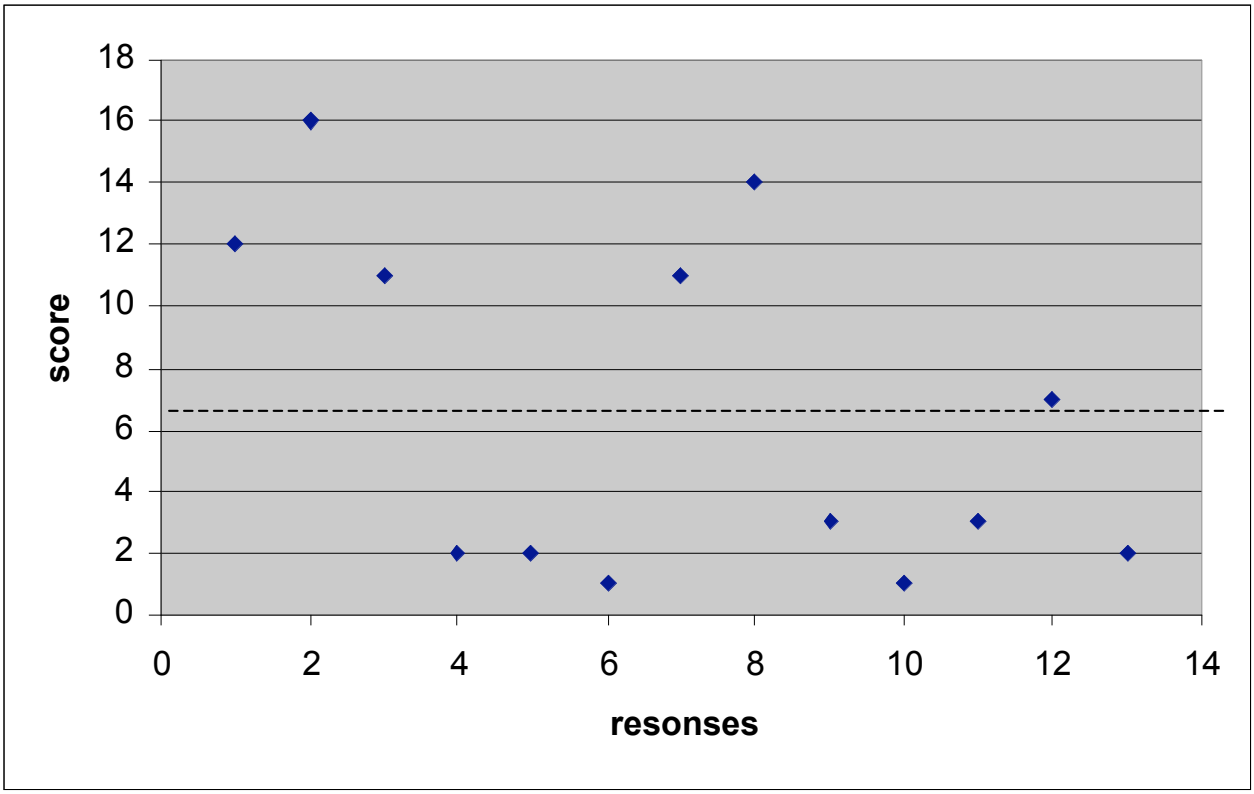
Table 4. To show the results of all scores for the indicators of risk of violence.

Variable	Score > 5 years	Score < 5 years	Total
Impulsive behaviour	12	3	15
Past history of violence	16	5	21
Reported violent incident in last week	11	4	15
Diagnosis of schizophrenia	0	0	0
Male patient	2	0	2
Poor education	0	0	0
Unemployed	0	0	0
History of physical illness	0	0	0

Violent home environment	2	2	4
Stressful relationship	1	0	1
Making threats to harm people	11	5	16
Irritable	0	3	3
Unmarried	0	0	0
Age under 40	0	0	0
Alcohol / drug misuse	14	3	17
Environmental stressors	3	0	3
Recidivist personality	1	0	1
High level of anxiety	3	0	3
Confused state	7	0	7
Convictions for non-violent crime	0	0	0
Resistant to treatment	2	0	2

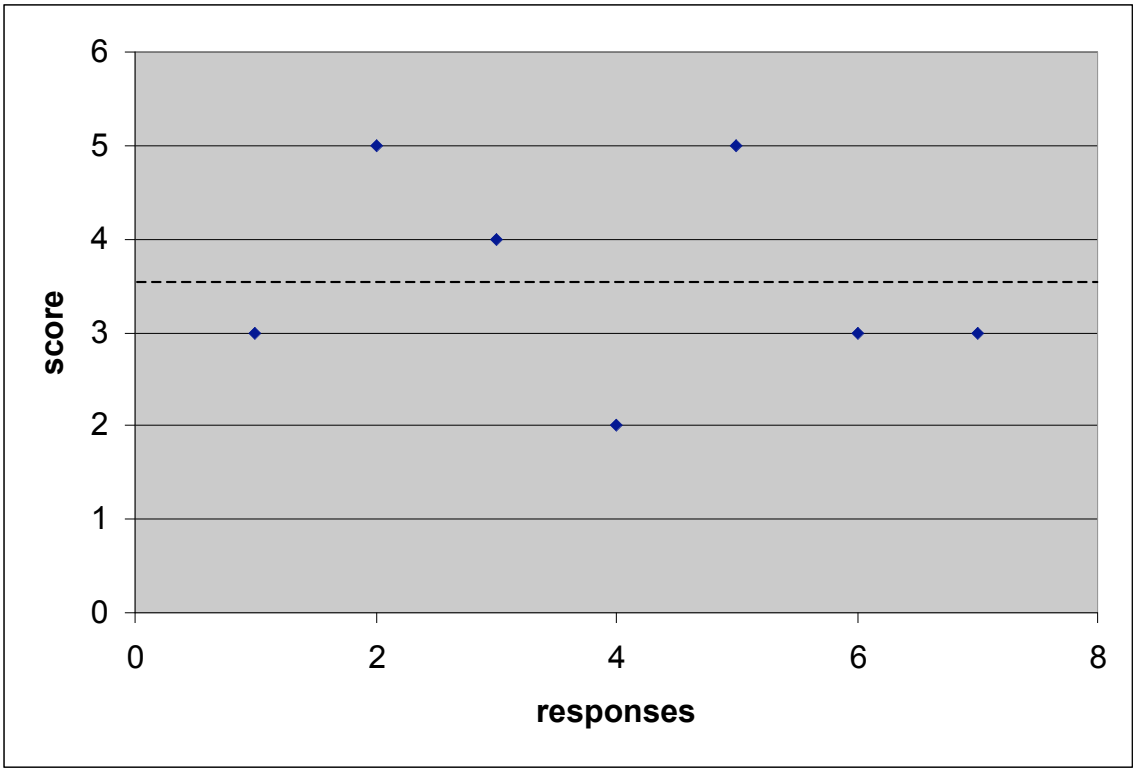
To enable the data to be compared there was a need to separate it in to the 2 groups of experience. This is then presented in scatter graphs, and a mean line is entered for both sets of data. This is shown in Graphs 2 & 3.

Graph 2. To show how the spread of scores compared to mean for factors important in assessing the risk of violence (>5 years experience).



The mean score was 6.29 and is indicated by the dotted line on the graph. The graph appears to show that the scores are quite uniform around the mean, however, this needs to be compared to the other group of staff scores in graph 3.

Graph 3. To show how the spread of scores compared to mean for factors important in assessing the risk of violence (<5 years experience).



The mean score was 3.6 and is indicated by the dotted line on the graph. As in the previous graph the score do appear to be uniform around the mean, but this is not conclusive. Therefore a Oneway ANOVA test was used to see if there was any variance from the data. This is shown in table 5.

Table 5. To show the results of Oneway ANOVA test on how both sets of staff (<5 years and >5 years experience) identified factors important in assessing the risk of violence.

ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	56.196	8	7.025	7.634	.001
Within Groups	11.042	12	.920		
Total	67.238	20			

The conclusion can be made that there is significant variance (0.01) between the factors identified as important by each group of staff. There is no attempt to say whether one group identified factors that were more important as all the factors in the question used were reported as important (Shaw *et al* 1999).

There were clearly 5 factors felt by the respondents to be most important:

- ✓ Impulsive behaviour
- ✓ Past history of violence
- ✓ Reported violent incident in last week
- ✓ Threats to harm people &
- ✓ Alcohol/ drug use

These factors were at least twice as likely to be selected as the next highest scoring factor. It is clear that the 2 groups did identify all these factors but with different proportionate levels.

The next area of analysis that was needed was the level at which respondents were able to accurately identify if being in what they potentially believed was a risky situation. This was compared to if they subsequently did actually get assaulted.

Of the 22 respondents only 11 had been assaulted, but these 11 had all identified that they believed that at the time they were at risk of being assaulted. Of the other 11 respondents, 6 had believed that they had been in a situation where they believed that they may be assaulted, but were not assaulted. This is interesting when the data is separated into experience groups (Table 6.) Inserted in brackets are the ratios of variable to number of respondents in each group.

Table 6. To show data collected for assaults, being at risk and level of experience.

Experience	Number of respondents	Believed at risk assault from client(s)	Assaulted	Believed situation could have been handled better
< 5 years	5	4 (0.8)	3 (0.6)	1 (0.2)
> 5 years	17	13 (0.76)	8 (0.47)	8 (0.47)

It is clear that both groups reported that they believed that they were at a risk of assault at a similar level, but that being actually assaulted following this belief was a lower ratio for the more experienced staff. Further this group were more likely to believe that the situation could have been handled better. This has presented a theme

that will be explored in the next section of data collection. When the data is further examined it is clear that of the 5 male respondents, 4 had been actually assaulted (Female 17 respondents and 7 assaults).

A Oneway ANOVA test was conducted on all the scores for the staff members believing to be at risk and being assaulted (Table 7).

Table 7. To show results from Oneway ANOVA test of the variance of scores for the way that believing to be at risk varied to being assaulted.

ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1.136	1	1.136	8.333	.009
Within Groups	2.727	20	.136		
Total	3.864	21			

The results are conclusive that there is a significant variance (0.009), indicating that there is not a link between believing to be at risk and being assaulted. This factor will be examined in more detail in the next phase of the inquiry.

The final area of analysis was to compare the way that both staff groups (<5 years and >5 years experience) reported 'being at risk of assault, being assaulted and believing the situation could have been handled better'. The results are compared for variance using Oneway ANOVA test (see table 8.).

Table 8. To show the results of Oneway ANOVA test on how both sets of staff (<5 years and >5 years experience) reported being at risk of assault, being assaulted and believing the situation could have been handled better.

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Handled better	Between Groups	.173	1	.173	.705	.411
	Within Groups	4.918	20	.246		
	Total	5.091	21			
At risk	Between Groups	.005	1	.005	.025	.876
	Within Groups	3.859	20	.193		
	Total	3.864	21			
Assaulted	Between Groups	.065	1	.065	.238	.631
	Within Groups	5.435	20	.272		
	Total	5.500	21			

Considering that there was significant variance in believing to be at risk and being assaulted, these results show that there is no significant variance between the two sets of staff making this report. Therefore it is fairly safe to conclude that the staff reported in a similar fashion to the questions, but did not believe that purely believing to be at risk necessarily led to assault.

3.2 Purposeful sampling for second phase

The criteria for inclusion are in the appendix (appendix 6). From the analysed questionnaires and utilising the data presented in table 3, it is clear that 11 people could possibly be involved in the second phase.

Comparing these respondents completed questionnaires to the inclusion criteria identified that 2 of the > 5 year experience group had not met the criteria. One only identified one experiential factor, and the other left Question 8. blank.

This left 9 respondents (3 from < 5 years experience and 6 from > 5 years experience). To ensure that all the areas of workplace were represented, the remaining 9 respondents were separated into workplace origin.

The < 5 years experience had one from the community team and two from intensive home treatments. These two were of the same age group and academic achievement. One was randomly selected.

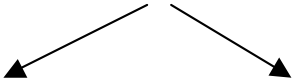
The > 5 years experience had one respondent from assertive outreach and intensive home treatments. There were 4 from the community team. The person selected was the only one who did not leave any section blank in the questionnaire, and was the only person from the 45-54 age band.

3.3 Qualitative analysis (PHASE2)

Primarily a decision was needed as how to order the interview data. Initially consideration was given to utilise NUD*IST software (Qualitative Solutions and Research 1997) as a form of 'filing cabinet' to order and manage it. This option was rejected as NUD*IST still requires the data to be coded for themes, input into the system, recoded and then considered for analysis. This would have effectively doubled the time needed to order and prepare data for analysis. NUD*IST is best used where large amounts of data need managing (e.g. >100 interviews) and is of less use where small amounts of data are used (in this case 5 interviews). However, it would be of use if the study were longitudinal in structure and may in the future be rerun. In this scenario a matrix would already exist and allow relatively quick comparison of data. The analysis used, utilised the method advocated by Huberman & Miles (1994) and Wolcott (1994). They suggested note making throughout whilst reading the transcripts, and supplementing these notes with memos in the margins and reflective comments. This helps to identify the words and the metaphors used, and enables the establishment of rich information, and the production of a narrative account.
This account can highlight actual responses and give a subjective gauge to the strength of feeling. It will also provide the opportunity to compare and identify differences between the participants.
The following main themes emerged from this process, with specific branches:

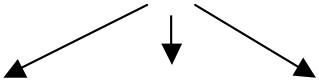
3.31 Themes

1. *The situation that occurred*



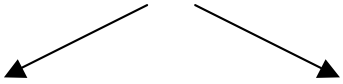
Coping strategy employed *Experience used to deal with the situation*

2. *Believed reason for the assault*



Staff influences *Client influences* *Personal influences*

3. *What helped after the assault?*



What has changed in your approach *How do you now feel about the assault?*

Each of the themes identified originally branched off into many other smaller subcategories, which in my opinion over analysed the words used and complicated the arguments made. Therefore a decision was made to leave the themes as indicated above so as to allow a clearer narrative account.

Two of the interviews were with people who had less than 5 years experience and three with people with more than 5 years experience. In the narratives, comparisons between the answers of each group are presented and the relevant group identified in brackets. Each interview lasted at least 30 minutes and was transcribed prior to analysis.

3.32. The situation that occurred.

The situation in which both groups of participant found themselves involved, were assaults within the hospital. These situations varied from taking somebody into hospital that was being detained to encountering a client that had become drunk. Each of the scenarios that were described had similar themes where control was required in the management of the situation.

> *I suppose looking from the client's perspective we represented a service that he was very much disenfranchised from and had years and years of grief in using (>5 years)*

This sentiment was similar in all the situations identified, in that the client was seen as almost a victim, and the participant who generally worked on a one-to-one basis with the client, appeared to move allegiances from the client to colleagues.

3.33. Coping strategy employed

The coping strategy differed within the groups. Emphasis was placed on self-protection. This varied from individual to individual: on confronting a violent situation, immediately sounding alarms and preparation to restrain the client (<5 years). This approach did not mean that the participant would be resolving the situation, merely that they would have other staff who if needed could resolve the situation.

The more experienced utilised a more balanced approach where a measured assessment was made

> *...make a hasty retreat, and you take yourself away from the environment and then make decisions (>5 years).*

This more measured approach identified a clear delineation between immediately asking for help and establishing what had actually just happened. This difference is further clarified in the final subcategory of this theme.

3.34. Experience used to deal with the situation

There was a difference in how the situation was coped with.

The more experienced (>5 years) participant became more involved in the management of situation

I think that at the time when the assault happened there was only the 3 staff, from the ward, it was only when we decided to set the alarms off that a lot of other staff came to help us out (>5 years)

ultimately taking more of a leading role in attempting to resolve the assault, yet in this instance not averting it.

The less experienced (<5 years) participant took less control. In fact one account highlighted grave reservations about the actions being taken by less experienced staff

erm the nurse in charge, who hadn't been qualified that long, had ok'd it for the police to kind of take off the handcuffs, and then there was a kind of disagreement between a couple of other staff, a couple of the NAs because the qualified nurse had said well take the locks off as well, because this patient couldn't take his tablets……. I didn't really say anything because I wasn't working on the ward, I was more of an observer really (<5 years)

this either lack of confidence or abdication of responsibility was a theme within this category. The less experienced participants felt that they knew what they should do, and were able to draw on experiences that if implemented may have resolved the incidents. Yet there was no use of the experience

but I didn't anticipate that in any way, the severity of the incident (<5 years)

This anticipation to act was thematic particularly in the more experienced group. They all highlighted that experience of assault was beneficial in knowing how to avoid it, and that there is a need to learn from this and alter practice

> *you have a sort of intuition or a feeling to who is potentially volatile and while your on the periphery of that situation you take stock of what is going on (>5 years)*

They also highlighted that experience in coping with situations where assaults happen, is gained through observing

> *good and bad ways of handling a situation, then taking what you think you would do and then putting it into action the next time the situation crops up (> 5 years)*

The ability to analyse their actions was missing in the less experienced participants. Their experiential influences were based heavily on training and its importance, however, acknowledging learning from other assault situations, they still described text book responses

> *I stood back and adopted a non-threatening stance, trying to look least threatening* (<5 years)

3.35. Believed reason for the assault

This theme started to reveal what influences the participants felt were responsible for the situation they found themselves in. It identified 3 subcategories, all playing a prominent role in the beliefs of the participants as to why they were assaulted.

3.36. Staff influences

The participants identified that commonly the assaults were a consequence of others actions or interventions. The less experienced had frequently found themselves in a situation where decisions were made without consultation that left them in a perilous situation

> *the client was inappropriately placed, he should have been moved to another ward, but the move had been blocked. He knew he was due to move, and this was preparation for discharge, he found out he wasn't moving and came into the office where I was (<5 years)*

This passing on of information and not assessing the consequences affected not only the less experienced participants. A statement from a more experienced participant who was assaulted highlighted that other staff actions left them in a similar position

> *I think the fact that he'd been drinking, erm and that the observations obviously weren't done properly, because I think he was left in a room on his own with his dad, who in the morning had brought him some alcohol in. Erm and I kind of felt like I was just left to mop up somebody else's mess really (>5 years)*

Once again the situation that led to the assault was not of their making and was a consequence of others actions.

3.37. Client influences

There were several factors identified that were under the control of the client, particularly the use of alcohol. In some the diagnosis of schizophrenia and personality disorder, however, more interestingly the lack of self-control. In each case the behaviour was predictable and the client had acted violently in the recent past.

> *he had already kicked someone on the way in and had threatened other staff that something was going to happen* (< 5 years)

> *known to be angry and wanting people to have it* (>5 years)

On each occasion the client was felt to be ill, but in some way sign posting what was going to happen and not trying to stop it themselves. This actually formed the basis on which the clients were arrested by the police and charged for assault (on 1 occasion from each group). This identification that the client had to shoulder some of the responsibility for the assault was apparent across the accounts of all participants.

3.38. Personal influences

There was a different picture presented from the two groups of participants about the level of personal influence. The less experienced believed that the assaults were not due to anything they were doing and were more so

> *a bystander* (<5 years)

In exploring their recollections they identified that they had the knowledge to assess the situation and were trained in the techniques to deal with violence, however, could not see how any of their actions could be a contributory factor. The more experienced were more reflective. They were in a situation where they believed they had to take some control, therefore influenced the outcome in someway. Their need to act placed them in the front line and meant that they could not be a bystander

> *He was actually at the door of the smoke room, so there was a lot of other patients around and he was just kind of swinging punches all over (>5 years)*

This also led to more self-analysis of how they had coped personally and what they may have done if they could revisit the situation again

> *I think what I would probably have done differently was maybe communicated to the other staff better, kind of what our plan was, because there was me and another member of staff from the ward, and then obviously people could hear, so people started to appear, but erm there was only us two that actually knew what we were*

trying to do, and knew what, so I mean I guess that was a big part of it, and if the other staff had known what are plan was and what we were trying to do then they might not have chipped in a bit (>5 years)

This really demonstrates that the more experienced participants still look at personal influences and try to evaluate the actions taken. They further consider changes to practice.

This is not to say that the less experienced participants do not self-analyse situations. It does indicate that there is a difference in the way that the two group of participants attribute responsibility for the situation, and the less experienced see themselves more a victim.

3.39. What helped after the assault?

There was across the board support and some form of debriefing. This varied from directorate to directorate; however, it did explore the incident and responses made by staff. The difficulty remains that all the participants had no long-term help to deal with the assault.

3.310. What has changed in your approach?

The less experienced participants emphasised more tangible things than the more experienced

an appreciation of risk history and past history knowledge of past history being the best predictor of future and it'll always stick in my mind (<5 years)

and

> *I'm very aware about where I'm sitting and also what am I doing in there, is it safe to go in, you know that sort of 10 second risk assessment that we all do, is it safe to go into the room, and try and, especially when you see people in home, you know try and not be as challenging as possible (<5 years)*

These useful techniques do vary form the more global a less specific approach of the more experienced participants

> *there is a lot to be said for years served in any job that you do, to gain experience and yes you can gain a great deal from speaking to others and reading material but there is no substitute for actual experiential learning, and sort of shaping the way you interact with people based on your past experiences of interacting with people and I think it comes with many critical experiences as well when things don't necessarily go according to plan or not going the way that you always feel comfortable with because although I think they are harder lessons to learn I think they are lessons that stick, lessons that your more likely to adapt what you do from* (>5 years)

This reinforces that violence has many facets and they are not always that clear. They reaffirm that there is not necessarily one thing that you should do, but many things in order to practice more safely.

3.311. How do you feel about the assault?

This theme sums up the overall picture that all the participants reported. There was no real difference in what they felt

> *Frustrated (both client and staff) at being put in the situation* (<5 years)

> *Angry with the lack of support* (<5 years)

> *I felt pretty angry about it to be honest (>5 years)*

Each participant felt that the situation was avoidable and that the responsibility was commonly out of the hands of the staff that were faced with the initial situation. Frustration with management was focussed generally on the case management of the client and the lack of sharing of information. The lack of actions of others to resolve the situation before it became what they found themselves in has led to the more experienced participants linking training

> *you need the ability to apply that knowledge into a practise sense, and I think that sometimes that training courses actually get you to move from that A to B* (>5 years)

with practice. The less experienced participants remain less creative, and more hurt by the assault. This is probably because the assaults were more recent and from the accounts more violent.

4. Discussion

The aim of the study was

- to discover if the level of experience of the CMHN affected the way that they assessed risks.

It was intended to achieve this with consideration of the following objectives:

- identifying personal experiences (inside and outside of the work environment) that affected the assessment of risk, and
- identifying actuarial factors associated to risk, and reporting emergent patterns of participant responses.

Care was needed as the study could easily have focused on the clients, and this may have distracted from the discovery of experiential factors.

Risk assessment is an inexact science, and there are many variables that need controlling in order to make some sense of the experiences of individuals trying to assess the risks (Allen 1997).

Risk is such a large area to investigate. Even when the area is narrowed down to examining the effect of experience on assessing risk, there remains so much that has not been covered. There are a number of things that were deliberately not controlled (narrowing the population to purely Community Psychiatric Nurses (CPN) in title), but also controlling the area of investigation (2 levels of experience). The rationale for not controlling the population to CPN in title only was due to CPNs now having various titles that are more reflective of role, yet continuing with the same job description. In essence all the CMHN posts are what used to be referred to as CPN posts, as they were taken from the natural pool of community nurses and allocated

new titles. The roles remain the same as they were, but the staff are grouped together for purpose of audit and Government directive.

The need to look at experience, and limit it to the 2 groups was firstly an element of exploring how long I believed it took to become experienced in the role. Secondly because the ethics committee considered 3 or more bands of level of experience may be problematic due to the possibility of insufficient numbers of participants that would be categorised in these bands. A decision in hindsight I agree with.

The main findings were that:

- regardless of level of experience, the CMHNs believed that they were the best at assessing risks compared to all other Multidisciplinary Team members.
- that there were similar opinions about what were risk factors gave differing emphasis on which were the most important. A clear example is that the less experienced group identified that the ‘making threats’ factor was most important, and that ‘confusion’ was not considered a factor associated with risk. The more experienced group believed that ‘making threats’ was fourth most important and that 8.5 % of participants believed that confusion was an important factor in risks.
- Although training was found to be important in helping the staff to both identify and manage risks, the quality was believed to be derived from observation of live situations that were well managed. The more experienced staff utilising more ‘life experience’ than the less experienced.
- The level of experience had an effect on how perceived risks of violence situations were managed. The more experienced were more pro-active and

involved, whereas the less experienced allowed others to take control. Both approaches yielded similar results.

- Both groups had a belief that colleagues were mostly responsible for the assaults that occurred. They similarly identified that communication to them, being an outsider, was poor. Importantly the violence had an element of a signpost that it was about to happen.
- There was no significant difference between the groups in identifying what they believed to be a risk of violence situation, and then being subsequently assaulted. In fact the assaults that occurred with these participants happened outside of their normal working environment.

Looking more closely at each of these findings provides some detailed information that may shape practice.

There was an expectation when comparing how the level of experience affects the way that violence is assessed, that there would be a difference between the two groups. This on the whole was borne out, but before exploring this in more depth it has to be said that there was one similarity found in the way that they assessed the ability of others to assess the risk of violence. Here both groups generally agreed on who assessed the risk best (CMHNs) and worst (Ancillary Staff). The results are fairly uniform when plotted in a graph and show a similar comparative ratio. These findings are probably not that reflective of the level of experience affecting the decision-making. Both groups will have worked as a mental health nurse for more than three years and will have had a great deal of contact with the identified groups. Therefore having an opportunity to develop an opinion on there ability to do something will

have been developed throughout that period. Further with the more recent trend to provide student nurses with longer placements and give them more responsibility in the last year of training, the less experienced group will have had more working contact with various disciplines than in the past. This would possibly equalise the contact experience with other staff, placing them in a similar position to the more experienced group to provide a judgement on others' ability.

What was expected was that there would have been some statistical significance in the way that the groups responded. This was almost found (that there was no difference) but it did not reach the necessary level. The similarity was expected as each of the community posts are fairly specialised; yet work within a similar framework. Job descriptors are similar and type of person (level of work experience, educational level, problem solving ability and personality) selected for such a post is also similar.

There were many differences in the way that the two groups responded to the rest of the questions. When exploring how the level of experience affected decisions about what were the most important factors in assessing the risk of violence, there were some major differences.

Although having a general agreement that there were five key factors (impulsive behaviour, past history of violence, reported incident in the last week, threat to harm people and alcohol/ drug use) from the twenty-one choices, this was the only similarity. The comparative ratios for theses scores between the two groups were different and there were many others scores for other factors that were chosen only by one group.

It was expected that there would be some difference between the groups as they work with differing clientele with a slightly differing emphasis on aspects of care (more difficult to engage people in the assertive outreach team, more crisis resolution work

within the crisis/ intensive home treatment team), but not to the level that was found (significant difference 0.001).

When exploring experiential factors, it became clearer in the interview phase that the more experienced staff were utilising factors experienced in and outside of work to assist their judgement of potentially violent situations. This group admitted to learning by mistakes made by themselves and others. They also said that training had helped, but placed more emphasis on their own life experiences. The less experienced staff focused mainly on training as an influential factor for decision-making.

It is unclear whether the less experienced staff utilised experiences from outside of the work environment to aid judgements. Whether this was due to having faced less life experiences (generally they were from the younger end of the scale of the sample population), or because they came into nursing without having other jobs, remains unclear. What could be said is that the less experienced staff may have had contact with the profession and clients in a less medically governed environment, and where the essence of care is multidisciplinary team based, with risk viewed from a positive angle. What is important is that this is information that has not been either discussed or explored in other studies in relation to assessing risks, especially for the less experienced staff who Finnema *et al* (1996) argues are more at risk due to their lack of experience.

The more experienced staff will possibly have had contact with clients under a more medical model approach and where less emphasis was placed on team working, autonomy being the key word. Therefore, making decisions independently and problem solving in difficult situations was more commonplace. This was evident when exploring how they reacted in a potentially violent situation. The less experienced staff stood back and allowed the people in charge to take control. The

more experienced had a tendency to assess the situation and if they believed it was necessary, exert some control. The outcome of both actions was that an assault still occurred, posing the question of 'was the decision influenced by a positive outcome in the past?' Unfortunately this was not measured in specific detail, but is something that could be looked at in future.

This issue of 'to act or not to act' was seemingly related to the level of experience of the participant. But, was this experience or the response to the environment they found themselves in? Perhaps the more experienced staff had worked independently for so long that they were not used to team working in the same way as the less experienced. This is not to say that the more experienced cannot work as team members, more so that they make decisions as to what role they will adopt in a given situation. If that approach were thought to need a team approach then that would be used; however, this is not as flexible as first seen, as the more experienced staff would ultimately decide how they were going to act. This reinforces the argument that they would take some control, as they had learned from the past. The more experienced staff could argue that incidents had occurred in the past that they had witnessed, and they were utilising an approach they had either used or seen work. Ultimately both levels of experienced staff were fairly equally decisive in that the more experienced acted and the less experienced did not act. Thus both making personal choices on the evidence that confronted them.

A major problem with this variable approach is that complacency and over-confidence could become evident. It is fine learning from the past, but there is a need to share information (communication is vital in the management of any potentially violent situations, Leibia 1980, Lion 1983, Cahill *et al* 1991, Blair 1991,). Being able to diffuse a situation alone could portray a rose tinted picture of individual clients, and

indirectly place pressure on other workers to adopt the approach used when the regular member of staff is not available. This could place pressure on the unaccustomed staff member to diffuse a situation that could only be done by someone who had developed an interpersonal relationship with the client. This approach if continually adopted could be conceivably be seen as arrogant.

Over-confidence or arrogance has been cited in the past as a reason for violence (Gudjonsson G.H., Rabe-Hesketh S. & Wilson C. 2000), however, care is needed to establish what arrogance is. This present study clearly identified that arrogance, of the participants, probably did not play a part in any of the violent incidents experienced. In fact what appears to be happening is that tried and tested practice is being used, but outside of the area where it was traditionally used.

Another important finding was that there was some 'signposting' of intent for violence. This is something that John Monahan throughout the 1980s advocated in his belief that violence was predictable, yet this whole topic remains an unproven belief. The fact that staff believed that violence may occur suggests that they are looking at the actuarial factors, however, they were only citing these facts on cases that culminated in violence. It would have been interesting to establish how often they had identified such factors and violence had not occurred. For this to happen there is a need for the participants to be able to reflect on practice (Schon 1983). The more experienced group appeared more reflective in action. They were more likely to consider actions taken in the past and use these to influence practice. This is quite surprising as what would have been considered was that the less experienced group, having reflective practice as an element of training. But is this reflection? The more experienced staff seem to have learned from past events, but this is not necessarily being reflective, especially as they have once again ended up in the same situation of

a potentially violent environment, and having to utilise learned coping strategies. Therefore, I believe that they have ended up in this situation due to their own over-confidence of being able to manage whatever confronts them, and are not necessarily that reflective.

The less experienced staff are clearly outside of their normal boundaries and are adopting a learning position. They do actually seem to reflect as they return to the only knowledge available, training.

In the analysis of event, the less experienced group readily identified others who were responsible for their situation. This is a common approach adopted by someone who feels that on reflection they were assaulted through no fault of their own. This responsibility is an important factor and needs to be taken in context with the other comments about 'others influence on the situation'.

It is clear that in each of the assaults there were other factors at play that were outside the control of the individual. These factors were not only the mental health of the client, but also the actions of colleagues. The actions of colleagues were an unknown variable prior to the assault, but were evident as soon as the situation commenced. Here experience seems to once again take control, especially in the less experienced group. They were willing to allow someone who was in charge at the time take control. This maybe because they had not realised that violence would ensue, or they believed that their responsibility for the care of that client had been handed over. The more experienced group were not willing to allow this to happen. Whilst they were present they remained in control and would not abdicate responsibility until they were willing to do so. Yet who has the expertise? It is accepted that the community staff have knowledge of the client and have an interpersonal relationship with them, but they are outside of their normal working environment and the client is clearly outside

of their boundary for care. What is needed is some evidence of being able to manage novel situations, which were the incidents that participants were engaged in. This situation where community staff accompanies and support clients admitted to wards has only recently become an issue. Changes proposed and only recently acted upon, (Department of Health 2000) to the role and responsibility of a care coordinator, in this case the CMHN, has led to an increased involvement and more continued intervention. In the past clients admitted to an in-patient unit would have been discharged from a CMHNs' caseload, being reallocated on discharge from hospital. The more 'hands-on' and seamless service has opened up a new area for client interface. Yet, all staff will have worked within an in-patient unit, and will have been trained in risk assessment within such an area. Then why is this a problem, especially for the less experienced staff that will have worked more recently within an in-patient area? The probability is that they have taken on new roles and have engaged in a different interpersonal relationship. This is not to say that the staff have forgotten what to do, more so that they are in a novel situation where they are drawn to either act in the interests of the client, colleagues or self. In response it became clear that the less experienced avoided decision making to some degree, and the more experienced worked in an autocratic fashion for self.

The probability is that the more experienced have simply experienced more life events of this nature and subsequently continue to use what works. This pragmatic view is further reinforced by their behaviour being shaped by consequences. The less experienced staff probably rely at present on systems and protocol. But will this change with time? I believe that it will, and that with time the less experienced staff will start to adopt some of the practices of the more experienced staff. You may argue

that they are simply adapting to the practice that is used by most staff, but when does this occur and what has to happen for it to take place?

Does an old dog learn new tricks? The more experienced acknowledge information from training and hold it in esteem. They however, choose to act and react in the way the see fit. It is not necessarily the case that the more experienced do not fall back on training, more so that they have a range of armoury available to them. If they chose an inappropriate strategy they can use this to learn from. The less experienced have fewer weapons to access, and personally I believe they revert to the default of training. Once again this is not necessarily the wrong response, and is possibly the only response they have available to them.

This is supported by the information gleaned from the responses from questions about the belief of being at risk of assault, actually being assaulted and whether the situation could have been handled better. Here it became apparent that the more experienced staff were both assaulted slightly less frequently and yet still believed that they could have handled the situation better.

The reasons for this response in some ways have already been discussed (confidence to accept responsibility and self analysis of past events to influence present ones), yet not fully. The assault area is probably less because of the experience of past events and awareness of intuitive triggers that alert and prepare them to resolve a situation. The handling better is difficult. On one level it suggests that there is deeper reflection and self-analysis of the situation. However, I believe that it is due to the amount of time being in post exposing them to more incident reviews and frequent changes in policy in dealing with incidents. They are also generally more senior to the less experienced staff and therefore have to investigate and analyse issues in more depth.

This approach does not allow for abdicating responsibility and the belief that it was solely the fault of others.

From this there are several import factors that will need to be addressed in practice. I believe that

- There is an argument for CMHNs' to have greater than 5 years experience
- Training should remain central for updating of risk information
- There is a need for a wider remit on training around the environments where violence occurs, as most assaults occurred outside of the community nurse's normal working environment

This indicates that in job descriptions there will need to be an amendment for level of experience. At present for a person to work in the community as a bank/ agency worker, there is no level of experience indicated. For a person to apply for an 'F' Grade post there is a minimum of 2 years experience required, but none necessary in a community setting. This 'F' Grade section is where the entire less experienced group were drawn from, with several of them having had 1 or 2 years experience in that post.

The training remains central as all level of experienced staff accepted that they referred to training issues during any risk decision-making.

The final rationale for change is the most important. As most assaults occurred outside of the community nurse's normal working environment there would be a need for more emphasis in communication skills (between in-patient and community). Here there would be a need to update community staff on the risk management process that was in place within the in-patient units. This could be achieved by altering the risk

training schedules to include risk management protocol and practice in the community nurses risk training.

The main problems that came out of the study were that there was initial suspicion as to why I was exploring such area, and the participant's difficulty in expressing experiential beliefs. Whether they believed that it might be seen as a weakness in their practice, too hurtful and experience or not trusting the agreement to maintain confidentiality I am unsure. What is clear is that from what was said, there were experiential factors affecting individual practice, but for whatever reason the participants would not divulge fully what they were.

5. Conclusion

These findings are important in identifying that the differently experienced groups identify and manage risk with similar levels of success. Yet they have a different approach in the face of risks and have different factors that they would prioritise in assessing the risks. They both interestingly identified some experiential factors that were felt to be important, in particular, observing others good management of risk. The findings are also important in that assaults occurred outside of the CMHNs' traditional client face to face working environment. This environment is now beginning to shift to incorporate areas where the assaults took place into the CMHNs' working environment. Further that if the assaults tended to occur only outside of what may be viewed as 'the area of expertise', and then the change in working environment would require some extra training. Obviously the combination of skills and training have provided staff with the ability to work safely and have confidence in their normal traditional working environment, but when they step outside of this, there is insufficient experience and expertise to manage the situation.

The level of learning that has occurred because of the assaults is debateable, with the traditional approach being adopted to identifying where responsibility for their demise sits. Thus, condemning other's practice, and importantly identifying some management issues for change. Communication of what is to happen and what to do was lacking. Further the allowance of a member of staff to be either present and avoiding involvement or someone from another team taking over the management of a situation in an environment where expertise is with the ward based staff. Each questions the CMHNs' presence in the situation. Therefore, 'was the staff in the wrong place at the wrong time?' No! The CMHNs' were right to be present, but

should have been briefed on procedures and actions that they could take. Their presence may if used correctly have aided the smooth transfer of care.

The final important point to conclude on is that regardless of what actions the CMHNs' took, they indicated that others inappropriate actions placed them at risk. What has to be said though is that their action/ in action did have an affect on what ensued.

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Appendix 1.

Inclusion criteria for study:

INCLUSION CRITERIA FOR STUDY

❒ Any mental health nurse who is currently working in the community setting.

❒ The nurse needs to be either training toward qualification of be qualified as a mental nurse.

❒ The person will need to be on a placement in the community.

❒ The person needs to be agreeable to take part in the study.

❒ Participants need to be English speaking.

Appendix 2.

Consent and approval correspondence (hard copies only)

Letters from community service manager, (allow staff to be used in study)

Service director, (sponsoring study)

Consent from Trust research Board

Consent from Ethics Board

Consent for University ethics panel

Appendix 3.

Information sheet:

INFORMATION SHEET

The following information should be read carefully as it will identify the stages and responsibilities of the study.

Title: ***An investigation into whether the level of experience affects the way that CMHNs assess the level of risk from clients.***

Researcher: Neil Murphy (Lecturer Practitioner, Moorside Unit, TGH.)

The study will involve nurses working as CMHNs in a community setting, and has the support of your managers to use both your time in work and suitable NHS accommodation. The study is part of an MSc in Practice Development that I am attending at Manchester Metropolitan University.

The research study will have two phases of data collection. The first phase will involve the completion (by all who take part) of a questionnaire that will take approximately 20 minutes. The questionnaire will be sent to all staff and will need to be completed by all the staff that are willing to take part in the study. Once completed it should be placed in the envelope provided. If for some reason the envelope is missing you can return it to the address below.

This phase will take one month to complete. The second phase, will commence at the completion of the first phase, and will involve an interview. The people selected for interview will be selected according to criteria solely for use in this study, and will be identified by the researcher. Only five participants will be interviewed, believing that in total, they will represent a cross section of experience of those taking part. The interviews should take about 60 minutes and will be conducted at a site agreed between participant and researcher.

It must be made clear that if you agree to take part then you may only be asked to complete the questionnaire phase, however, you are still welcome to attend the final feedback session. Once all the data has been collected I will feedback the results to those who took part before completing the final write up.

Please note that you are under no obligation to participate in this study. You have every right to decline to answer questions or terminate your participation at any point during this study without having to provide a reason. Should you choose to withdraw

from this study, audiotapes of our conversation will be erased and information obtained from you will be destroyed.

To protect your identity all information that you would provide will be coded and stored in a secure location. I will hold the key to the coding system employed and will be the only person able to identify you from the information provided. It must be made clear that should your answers raise issues of malpractice, I will have to breech this arrangement and report to the Trust management.

Participating in this study should benefit individuals by providing them with information on what is deemed to be best practice in assessing risk, and provide an opportunity to air opinions and views on best practice. This information will be drawn together summarised in a final report that will be presented to all participants.

There is a need to advice all participants that this study may in the future be put forward for publication in an appropriate journal.

Neil Murphy Lecturer Practitioner
Room 62
Moorside Unit
Trafford General Hospital
M41 5SL

Tel: 0161 746 2108.

Appendix 4.

Consent form:

Title: An investigation into whether the level of experience affects the way that CMHNs assess the level of risk from clients.

INFORMED CONSENT FORM (version1. 23/12/04)

Principle Investigator: Neil Murphy (Lecturer Practitioner) Bolton, Salford &Trafford Mental Health NHS Trust

My name is Neil Murphy. I am a student at The Metropolitan University of Manchester completing an MSc in Research Development. The purpose of this research is to establish the level to which being an experienced CMHN affects the way that risk assessments are completed. The aims are to identify good practice and share this within the field of mental health nursing.

As part of my research study I intend to have two phases of data collection. The first phase will involve the completion (by all who take part) of a questionnaire that will take approximately 20 minutes. This phase will take one month. The second phase, will commence at the completion of the first phase, and will involve an interview that will be audio taped with only five participants, taking approximately 60 minutes. For this phase, each participant will be chosen by myself, believing that in total, they will represent a cross section of experience of those taking part.

It must be made clear that if you agree to take part then you may only be asked to complete the questionnaire phase, however, you are still welcome to attend the final feedback session. Once all the data has been collected I will feedback the results to those who took part before completing the final write up.

Please note that you are under no obligation to participate in this study. You have every right to decline to answer questions or terminate your participation at any point during this study without having to provide a reason. Should you choose to withdraw from this study, audiotapes of our conversation will be erased and information obtained from you will be destroyed.

To protect your identity all information that you would provide will be coded and stored in a secure location. I will hold the key to the coding system employed and will be the only person able to identify you from the information provided. It must be made clear that should your answers raise issues of malpractice, I will have to breech this arrangement and report to the Trust management.

Participating in this study should benefit individuals by providing them with information on what is deemed to be best practice in assessing risk. There is a need to advice all participants that this study may in the future be put forward for publication in an appropriate journal. There are no expected risks for participants. Please return the completed form in the envelope provided by 14th February 2005.

If you have any questions or concerns, please feel free to contact me on:
Telephone 0161 746 2108 or E-Mail Neil. Murphy@Trafford.nhs.uk

Participants name (please print) _____

Signature _____

Date _____

Appendix 5.

QUESTIONNAIRE

Ref No:

An investigation into whether the level of experience affects the way that CMHNs assess the level of risk from clients.

Please tick appropriate box:

Age: ❒18-24 ❒ 25-34 ❒ 35-44 ❒ 45-54 ❒ 55+

Sex: ❒ Male ❒ Female

Qualifications: ❒ Registered Nurse ❒ Degree ❒ Diploma

Type of Practice: ❒ Community ❒ Assertive Outreach ❒ Intensive home treatments

Time in Practice: ❒ 0-24months ❒ 25-36 months ❒ < 5 years since qualifying
❒ >5 years since qualifying

(Please tick the appropriate boxes)

1. How accurately do you believe that Mental Health Professionals assess the risk of violence from their clients?

❒ Very accurately
❒ Moderately accurately
❒ Accurate as by chance
❒ Less often than by chance

2. Of the following professions, rank them in order (by placing a number over the box at the side of the profession) of whom you believe assess the risks of violence from their clients best?

❒ Psychiatrists
❒ Psychologists
❒ Mental Health Nurses
❒ Social Workers
❒ Student Mental Health workers
❒ Ancillary staff

3. Which 5 of the following indicators would you believe were the best indicators that a client may be presenting a risk of violence? **(tick only 5 boxes)**

- ❒ Impulsive behaviour
- ❒ Past history of violence
- ❒ Reported violent incident in last week
- ❒ Diagnosis of schizophrenia
- ❒ Male patient
- ❒ Poor education
- ❒ Unemployed
- ❒ History of physical illness
- ❒ Violent home environment
- ❒ Stressful relationship
- ❒ Making threats to harm people
- ❒ Irritable
- ❒ Unmarried
- ❒ Age – under 40
- ❒ Alcohol and drug misuse
- ❒ Environmental stressors
- ❒ Recidivist personality
- ❒ High level of anxiety
- ❒ Confused state
- ❒ Convictions for non-violent crime
- ❒ Resistant to treatment

4. If you believed you were at risk of violence from your client what would you immediately do? **(tick only one box)**

- ❒ Talk to the client in the treatment and try to diffuse the perceived problem
- ❒ Make a special note in the clients records
- ❒ Leave the situation and consider your next steps
- ❒ Remain in the situation and contact police
- ❒ As soon as the client left the room or there was a chance to leave, depart the scene
- ❒ Confront the client
- ❒ Make an excuse to leave

5. Have you ever been in a situation where you believed you were at risk of violence?

- ❒ Yes (go on to next question)
- ❒ No (Go to question 11)

6. Were you actually assaulted? (either physically or verbally)

- ❒ Yes
- ❒ No

7. Considering the event, do you believe it could have been handled better?

- ❒ Yes
- ❒ No

8. What factors do you believe contributed to the event? **(list up to 3)**

1……

2……

3……

9. What life experiences influenced your decision to react the way you did?

……
……
……
……
……

10. What work experiences influenced your decision to react the way you did?

……
……
……
……
……

11. Are you a better practitioner because of the events experienced?

- ❒ Yes
- ❒ No

12. Do you believe that the level of experience is important in assessing the risks that clients pose?

- ❒ Yes (go on to next question)
- ❒ No (go to question 14)

13. How long do you believe it takes for someone to become experienced enough to accurately assess the risk of violence from clients? **(tick one box)**

❒ 0-24months ❒ 25-36 months ❒ < 5 years ❒ >5 years

14. What experiential factors do you believe are important for a practitioner to accurately assess the risk of violence from their clients? (list up to 3)

1……

2……

3……

15. Do you believe that risk training provided by the Trust was beneficial in helping you to assess the risks client presented?

❒ Yes
❒ No

16. Is there any further information you would like to present concerning how experience has affected your ability to assess the potential dangers form clients? **(continue overleaf if needed)**

Thank you for completing this questionnaire. Please place it in the envelope provided and return in the internal mail.

Appendix 6.

Inclusion for interview:

INCLUSION CRITERIA FOR INTERVIEW

❒ Has been assaulted.

❒ Has been in a situation where the person believed they were at risk of violence.

❒ Identified that three of the answers given to Qu.3 are identified in Qu.8.

❒ Can list 3 experiential factors that are important to accurately assess the risk of violence.

❒ Nurse working in a community placement

Appendix 7.

Interview schedule:

INTERVIEW SCHEDULE

Thank you for you participation.
This interview will last about 60 minutes.
It is a semi-structured interview.
I ask your permission to record the content, but I will also make notes as we talk.
If at any time you feel that you do not want to continue, please tell me and we will stop.
There is no obligation to take part, and this is part of piece of research into how experiences affect the way you assess the risk of violence from your clients.
If after the event you decide that you want your data removing from the study please contact me and I will comply with your wishes.
If you would like a copy of the recording I will provide you with one.

Questions:

1. **Have you ever been assaulted by a client?** (Specify: verbally or physically)

Was this on an in-patient unit or in a community setting? How long ago did the last one happen? Did it affect you in someway?

2. **Did you report it?**

Do you think it should have been reported? How was this done? Did you follow a formal procedure? What were your feelings about reporting it?

3. **What do you believe were the factors that contributed to the event/s?**

Can you explain? Were they foreseeable in your mind? Were you forewarned in some way but still carried on? Was it due to the mental state of the client? Was it due to the issue you were talking about? Was it caused by something else? (specify)

4. **How did you react?**

Did you try to diffuse the situation? Did you try to escape? Did you have to use reasonable force? Why did you do what you did?

5. **On reflection what experiences helped you during the event?**

Was there something you had leaned in/outside of work? What was this? Was there something you had seen someone else use in a similar situation? Was it something you have tried before? Tell me about what you did? Was it as a result of training in/outside of work or in C&R?

6. **On reflection what experiences helped you after the event?**

Was there something you had leaned in/outside of work? What was this? Was there something you had seen someone else use in a similar situation? Was it something you have tried before? Tell me about what you did? Was it as a result of training in/outside of work or in C&R?

7. **Over time has your skill in assessing risk improved?**

What specific factors improved your skills? At what time do you believe that you could assess these risk factors well? How long had you been training/ practicing?

8. **In what way did risk training help you with the event?**

Was it the theoretical factors that helped? Was it the actuarial factors that helped? Was it some practical skills? Did risk training not help at all? Do you think that anyone can assess these risk factors without training?

9. **What advice would you give to other colleagues facing similar events?**

Re read the text box.

If later you decide that you want your data removing from the study please contact me and I will comply with your wishes.
If you would like a copy of the transcription I will provide you with one.

Thank you again for your participation in this interview.

Appendix 8.

Appendix 9.

Journal Article

Introduction

It is surprising that the risk posed by clients has had little research conducted within a community arena. The community although in some way acknowledging that clients are on the whole more stable and less floridly ill, is still the area where relapse and subsequent episodes of illness re emerge.

For many years risk has been managed in in-patient units and the focus of risk assessment has been skewed to the risk of suicide and the care offered in in-patient units. The need to assess risk is not in question, the manner that it is conducted, its focal point and its integral parts, is. Violence by the mentally ill has for the last 50 years been generally managed by a legal framework and custodial supervision. This framework and puritanical approach has been challenged by an increased awareness to respect human rights and the influence of external agents such as advocacy workers and independent legal representation.

Although advocating for patient rights, this new patient friendlier service has, on occasions, made elemental mistakes and left community workers to pick up the pieces at short notice due to hurried self-discharge. The dilemma is that patients are discharged whilst still mentally relatively unstable into a community setting, with the risk of violence, not having been either fully assessed or measured.

Few studies have attempted to assess how Community Mental Health Nurses (CMHNs) assess risks of violence in a community setting. Doyle (1996) found that CMHNs assessment of risk may be influenced by the environment that they practice

in (forensic or generic field), and that different fields placed a different emphasis on the 'value' of risk. Murphy (2005) found that CMHNs in the generic field commonly relied on 'gut reactions' and changes in presentation in assessing risks from clients. This proposed study focused on how community mental health nurses assessed the risks of these clients, however, took an unusual and important approach of examining if the level of experience of the worker affected the way this assessment was conducted.

Methodology

Aim: To discover if the level of experience the CMHN affected the way that they assessed risks.

Sample: Community mental health nurses from a variety of teams within one directorate.

The design used a mixed method approach (quantitative questionnaire and the qualitative interview) that was introduced in a sequential way (Creswell *et al* 2003). The rationale was that the quantitative element would assess the entire sample and the qualitative would purposefully select key participants to explore some of their decision making in more depth.

Ethical and local trust permission was sought and granted. Participation was purely voluntary with the acceptance that anyone could withdraw at anytime.

Results

The way that risk was prioritised was different as the less experienced staff tended to identify active behavioural components of risk rather than the symptom components identified by the more experienced staff. A clear example is that the less experienced group identified that the 'making threats' factor was most important, and that

‘confusion’ was not considered a factor associated with risk. The more experienced group believed that ‘making threats’ was fourth most important and that 8.5 % of participants believed that confusion was an important factor in risks.

The level of experience had an effect on how perceived risk of violent situations was managed. The more experienced were more pro-active and involved, whereas the less experienced allowed others to take control. Both approaches yielded similar results. Where an assault took place on the member of staff, both groups had a belief that colleagues were mostly responsible for the event. Similarly they identified that communication to them, being an outsider, was poor. Importantly on reflection the violence had an element of a signpost that it was about to happen.

There was no significant difference between the groups in identifying what they believed to be a risk of violence situation, and then being subsequently assaulted. In fact the assaults that occurred with these participants happened outside of their normal working environment.

The more experienced staff modelled positive actions by others in handling risky situations. Utilising these actions successfully led to gaining of experience in handling potentially risky situations. They also were able to relate many actions to how they had coped in life events both inside and outside work. The less experienced were more reliant on elements of risk training and in risky situations defaulted to almost trained responses. They found it difficult to identify experiential factors that truly affected their practice in assessing risk.

Conclusion

It is clear that the level of experience of the CMHN does affect the way that risk is assessed, however, this experience does not necessarily relate to better practice or an increase in quality. The fact that the less experienced staff defaulted to an almost

trained response is positive as they relied upon the evidence that had been presented in risk training. This however, does rely on the quality and content of the training provided.

The more experienced staff did practice slightly differently. They took more control and tended to view risk related events in a broader way. This could be simply that they have experienced more risk events in various environments in practice. The study did find that life events did play a part in this group's assessment. It is often overlooked that life outside of work is fraught with risks and these have an affect on decision making in stressful events.

It was interesting that the less experienced group found it difficult to identify any life events that may have influenced their practice. Whether this is totally true is unclear, but I do believe that an element of trust is needed by participants to disclose this sort of information and the more experienced staff did appear more able to trust the researcher to represent their reports factually.

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