Psychiatric risk assessment and management: an exploration of clinical perceptions, knowledges and attitudes existing within the context of risk

by

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Thesis
Submitted to Flinders University
for the degree of

Doctor of Philosophy
College of Nursing and Health Sciences
October 2017

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ABSTRACT

Risk assessment and management (RAM) is a significant part of everyday clinical practice. Risk in psychiatric settings usually means the avoidance of adverse events (e.g. aggression, absconding). As such, professionals seek to prevent negative outcomes for patients, staff, and the public through RAM. Overall, there is a lack of robust research about how RAM is conceptualised and understood by clinicians working in acute inpatient psychiatric settings. This study examines the issues facing health professionals in undertaking RAM, and investigates their perceptions, knowledge, and attitudes towards RAM, as well as the enablers of, and barriers to, RAM practices.

Using a case study approach (Yin 2014) in Stage One, 14 multidisciplinary mental health professionals participated in semi-structured interviews. A thematic model (Braun & Clarke 2006) was used to analyse the data. The themes provided a rich description of how clinicians specialising in mental health manage risk, and how RAM is integral to, and underpins all, clinical practice. Focused practice was considered important, and the purpose of RAM was to minimise risk – to ensure the safety of patients, staff, and visitors. Predicting risk behaviours was essential to the expert clinician. Clinicians identified a number of difficulties they encountered when attempting to predict risk – yet most were confident in their predictions. Experience, clinical knowledge of risk factors, and an “inner knowing” enhanced predictive confidence and were integral to this process.

RAM was considered to be everybody’s responsibility. Confusion about roles and task specificity, as well as legal and ethical issues, were identified. Clinicians also considered effective communication between clinicians, and towards patients, to be essential for risk assessment. However, opinion was divided. If done well, this promoted feelings of support and protection; if not, the potential for unsafe practice resulted. Staff considered that effective communication skills promoted therapeutic relationships and required patient and family input. These themes, together with other enablers of, and barriers towards, RAM will be presented and contextualised within notions of “risk”. The implications of these findings for clinical practice, including contemporary assessment practices, roles, and responsibilities will also be considered. Stage Two is a document analysis of key sources and draws on the work of Karppinen and Moe (2012), Prior (2003), and Smith (1984). The theoretical work on risk by Ulrich Beck (1992) and Anthony Giddens (1990), and Isabel Menzies' (1960), were then applied to the findings of Stage One and Two.

Two key points emerged from this analysis. Firstly, notions of risk within mental health settings are socially-constructed through stereotypes about patients diagnosed with a mental illness, legal prescriptions, ethical guidelines, public health policy, and the institutional and bureaucratic culture of the organisation; mirroring what Beck refers to as “risk society”. Together, these socially-constructed factors interact with clinical knowledge and experience to constitute the core of psychiatric practice in this setting. As a consequence, I have argued in this thesis that the care plan of the patient is primarily concerned with the management of risk, and that RAM and the Recovery Framework, which underpins mental healthcare, cannot coexist.

DECLARATION

"I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text."

Georgia Geller

ACKNOWLEDGEMENTS

First and foremost, I would like to extend my sincere thanks and gratitude to my extraordinary supervisors Doctor Julie Henderson and Professor Eileen Willis. Their wisdom, support, and guidance through this journey have been gratefully received. I feel extremely honoured and privileged to work beside them and I have profound appreciation for their thoughtful input and teamwork that have allowed me to expand my thought processes during challenging times. My Assistance Dog “Miss Coco” also extends her thanks – our supervision sessions were delightful and I know that she appreciated the supportive environment that Julie and Eileen extended to us.

It is acknowledged that Professor Eimear Muir-Cochrane and Dr Adam Gerace supervised the PhD candidature from 2009 until 2012. The work in this thesis on risk evolved from a body of work on risk and risk assessment undertaken by these supervisors.

Continuing, I extend further thanks to the Directors’ of Nursing and clinicians of the research site that participated in this study. Their thoughtful insights, dedication to furthering knowledge, and commitment to research enabled me to tease apart the complexity that exists within the clinical environment. I appreciate the time, effort, honesty, and sharing of your experiences. I admire your dedication toward your work and the tenacity each and every one of you expressed in order to make a positive impact and to enhance the care provided to the patients.

A special mention also goes to Doctor Robert Muller. Thank you for taking time out of your day to discuss with me the nuances of risk theory, the recommendations of other theorists to provide further insight and understanding and for providing valuable insights into the theoretical tenets of this thesis. Your vast experience and knowledge was further utilised in the many hours you spent also editing this thesis. I am forever indebted.

Similar accolades go to Doctor Amanda Muller and Doctor Louise Roberts. Thank you for listening and supporting me through this journey. Special and heartfelt thanks are also extended to a dear friend and honorary sister, Maha Alshammari. It has been a delight to go through this roller coaster of a journey with you by my side.

Your unwavering support and faith in my ability has not gone unnoticed. You have taught me a lot about your culture, and together, I hope that we continue to bridge the divide, promote harmony, and encourage other Saudi women to further their education. Truly Maha, you are a trail-blazer!

My family deserve a special mention. Gary, Taylor, Maddyson, Henry, and Owen, thank you for your unwavering support during my periods of monotone answers and silence whilst I remained engrossed in research and writing. Thank you for all the help you have given; without this, I do not believe completing this thesis would have been possible. Your understanding and support of my deteriorating health and eventual need of a wheel-chair is truly amazing. I would be lost without you all!

Likewise, my sister, RN Claudia Cristea. To know that I can call on you day or night and have you by my side during periods of sadness, joy, or anything in-between is awesome. Your unwavering loyalty and friendship will be treasured always. To my darling Kelly - the “long black’s” and “extra-large” fries make my day! Doctor Alisa Voss, your text messages of support from Queensland and gentle encouragement, together with advice, have been gratefully received – I would be lost without you.

Finally, I am honoured to include my Assistance Dog Miss Coco Chanel here. But for her, I would not have completed this thesis. She was instrumental in providing me with the confidence when I had none, she allowed me to speak up for myself in the face of adversity and, more importantly, she does (and continues to) mitigate the symptoms of my disabilities. Notably, her presence in my personal and working life enabled the veil of pretence and duplicity to be lifted, exposing the truth; allowing only those with integrity and honour to be by our side at the end of this tumultuous journey.

1 SITUATING RISK ASSESSMENT AND MANAGEMENT WITHIN THE CONTEXT OF ACUTE PSYCHIATRIC CARE

> *Clinical risk assessment stems from the activities of medical and mental health practitioners and is an approach rooted in individual diagnostic techniques geared towards identifying individual personality factors and situational triggers for behaviour. These kinds of assessments are retrospective not prospective and have a poor record of prediction (Walklate & Mythen 2011, p. 103).*

This introductory chapter provides a brief background of risk assessment and management (RAM) within the context of acute psychiatric care, together with an outline of this research study. The chapter also offers a general summary of the thesis and my journey throughout. The thesis initially sought to examine RAM from the clinician's perspective, and to develop an understanding of the issues facing health professionals in undertaking psychiatric risk assessment and management by examining their perceptions and knowledges of, and attitudes towards, RAM together with identifying the enablers and barriers experienced within the clinical setting. A significant part of everyday clinical practice is RAM (Muir-Cochrane & Wand 2005). In acute psychiatric care settings, risk usually means the prevention of adverse events (e.g. absconding, aggression, suicide) (Kettles 2004; Muir-Cochrane & Mosel 2008b). The psychiatric assessment and management of risk is essential and forms a significant component of clinical healthcare, which not only aims at reducing the incidence of adverse events experienced by staff, but also, by patients. Healthcare professionals in these settings attempt to quantify and measure risk both formally (e.g. through the use of tools, formal assessment) and informally (e.g. in interaction with patients), while dealing with the inexact nature of prediction (Raven & Rix 1999), requirements for legal and procedural accountability, and the Recovery Framework for clients.

Despite the importance of RAM to daily clinical practice, the research has so far only focused on assessment methods such as actuarial versus clinical judgement approaches, and the types of risk encountered in mental healthcare. For example, the risk assessment and management of psychiatric patients has been explored in great detail in the literature (see: Morgan 2000; Muir-Cochrane & Wand 2005;

Raven & Rix 1999); however, most of the literature is concerned with issues of prediction, prevention, and accuracy within the contexts of self-harm, suicide, aggression, and violence, as opposed to other equally important risks such as absconding, risk of falls, and client self-determination. On the other hand, there is only scant literature considering healthcare staff perceptions and attitudes towards risk assessment and management, although these contribute to, and form, a large component of clinical care.

Due to the risky behaviours that some patients may exhibit, for example, violence, aggression, and substance abuse, the research to date has focused on specific risk behaviours. Clinicians then integrate these findings into their RAM practices, and yet, they apply this to the entire range of risk behaviours exhibited. For example, clinicians may integrate the findings of research dealing with aggression into their RAM practices, and then apply this more broadly to patients at risk of absconding. The variables are completely different, and clinicians may have a difficult time delineating between the two or applying suitable preventative strategies (Zeleznik & Frank 2001). In addition, the risk behaviours identified in psychiatric settings omit other important risks for the client; this includes the risks associated with physical frailty or loss of social networks. I contend here that RAM as an approach employed by clinicians, focuses on specific risks to the detriment of overall patient well-being. Despite these limitations, risk assessment and management of psychiatric patients is necessary to ensure that the delivery of mental healthcare is both safe and ethical (Muir-Cochrane & Wand 2005). This is because risk assessment in psychiatric settings is the “building block” that is required to be in place before care can be implemented.

This study investigates how RAM is conceptualised and understood by clinicians working in acute inpatient and community psychiatric settings. In particular, this research focuses on the acute care setting, investigating the main issues that clinicians see as influencing their practice, and the ways in which they work together when assessing and managing risk. Initially, I wanted to see how risk might be managed, and to explore the therapeutic care that is offered. However, I have found that care is limited to the management of risk. This finding is consistent with the theoretical work of Beck (1992) and Giddens (1990) on “risk society”, and Menzies’ (1960) notion of the management of risk in clinical settings.

1.1 The journey

Initially, when I began this PhD journey in 2009, I extended a concept that I explored in my Honours research project, “A retrospective analysis of absconding behaviours in acute care psychiatric in-patients”, to the overall notion of psychiatric RAM. In psychiatric RAM, absconding is one of the main risk behaviours that clinicians seek to identify and manage. As a Registered General Nurse (but not a Mental Health Nurse), this topic interested me on a number of levels. I had spent many years working in both acute care and acute psychiatric settings. The care that I delivered to patients in both settings was transferable, but there were key distinctions between the two, and the subsequent care delivered to clients. I was interested to explore psychiatric acute care settings in greater detail. Secondly, I was interested in this broad area as, during my Honours research, I identified a particular risk behaviour (absconding), and established that dealing with mental health patients can be “risky”. In this present study, I wanted to see how clinicians constructed and managed this risk. Thirdly, the diagnosis of a mental illness as a secondary diagnosis was common in acute care wards, and similarly, in mental health settings, co-morbid health conditions existed with a primary diagnosis of a mental illness. I was concerned because there are implications from a risk management perspective – general nursing and psychiatric nursing are different specialties and there seemed to be a clear divide between physical health and mental health care without recognition from healthcare professionals of the significant overlap between the two. I believe that because of this overlap, each specialty needs to be cognisant of both, because there are very real risks in relation to physical health, just as there are real risks in mental health. Fourth, as little was known about RAM from a qualitative perspective, I was keen to delineate the clinicians’ perspective to assist healthcare professionals to improve their practice, and ultimately, to improve care delivery to the patient. Finally, I was interested in how clinicians managed risk, given the way legislation frames mental healthcare, which impacts on the patient at a number of levels.

Throughout the initial stages of the research I discovered that little was known about how clinicians perceived RAM as a concept, or what their perceptions about this were in everyday practice. There is an abundance of research available as to how clinicians should “do” RAM (see: Alnutt et al. 2010; Gilbert, Adams & Buckingham 2011; Godin 2004; Lamont & Brunero 2009; van de Sande et al. 2011a), but little related to how they perceive RAM or what knowledge they might draw upon to assist in their decision-making to assign a risk status to the patient they are assessing. This is important, as the assessment will ultimately affect the management of the identified risks, and subsequently, care delivery. I had initially intended to develop an understanding of the issues facing health professionals in undertaking psychiatric risk assessment and management. The specific objectives of the research were to: examine the perceptions, knowledges, and attitudes of mental health professionals in relation to psychiatric risk assessment; and to explore the barriers and enablers experienced by a multidisciplinary team in relation to effective psychiatric risk assessment and management practices. Developing an understanding of the issues facing health professionals in undertaking psychiatric risk assessment and management became the first aim of this thesis.

I also discovered that the framework for RAM in psychiatric settings, to which clinicians must comply, was one of legal prescriptions, ethical guidelines, and policies. Subjecting the findings to sustained analysis allowed me to establish the framework that clinicians operate within, in particular the legal and ethical frameworks, together with the state of play in the Australian mental healthcare system to enable a deeper understanding and conceptualisation of the findings. Critically exploring the relevant legislation together with the legal and ethical frameworks that influence RAM, and contextualising this within the Australian mental healthcare system, became the second aim of the thesis.

When I started the process of interviewing clinicians, I also began to see that many ideas around risk were socially-constructed by the participants. Although it needs to be acknowledged that very real risks do exist, it seemed from the interviews, that the process of risk assessment itself was actually creating risk. Hence, the third aim of the thesis led me to tease apart the ways in which risk is real or perceived, or socially constructed.

While I had originally intended to develop an understanding of the issues facing health professionals in undertaking psychiatric risk assessment and management, I found that the research participants generally considered that managing risk was equivalent to care delivery, which is the core tenet of this thesis. As a General Registered Nurse working in acute intensive care and emergency departments, I was familiar with assessing for risk – but my assessment of the patient in an acute care setting took a holistic approach, with risk being only one small component of the nursing plan. It seemed that there was a clear distinction between general nursing and psychiatric nursing and is delineated at the end of this chapter (*see* 1.4.1- 1.4.3).

As a result of the distinct differences described in section 1.4, there are clear overlaps between “risk” and “care”. I contend that nursing should focus on the person as a whole – their mind, spirit, body, and environment – which are present in Nursing Care Plans (*see* 1.4.4). In this thesis, I argue that in psychiatric settings, the care plan is distinctly different to that in acute care settings. I have found that the RAM tool used by psychiatric clinical nurses is, in fact, a tool to assess both risk and the actual Nursing Care Plan. This is despite mental health nursing being based on the Recovery Framework (Australian Health Ministers' Advisory Council 2013) through actions that are meant to focus on the client’s capacity for self-management, self-determination, empowerment, and hope through the nurse’s advocacy. The Nursing Care Plan is viewed as an alternative to the biomedical model where the main emphasis is on pathology, deficits, and dependency. Assessing for risk in its purest form seems to be at odds with this framework; in response, I argue that RAM and recovery cannot coexist. Similarly, RAM seems to be at odds with general nursing, whereby a patient’s cognitive and mental state is not viewed in isolation, but rather, as one aspect that needs to be attended to, in addition to their physical needs, in order for the person to return to an overall state of well-being. As risk management now becomes the care plan, there is no assessment or therapy for the patient’s physical health or their psychiatric health and well-being. I argue that the therapeutic exercise in acute psychiatric care is simply a case of managing the risk. It appears that a number of socially constructed factors interact with clinical knowledge and experience to constitute the core of psychiatric practice in this setting. A critical comparison of psychiatric care plans with acute care medical care plans became the fourth aim of this thesis.

In addition to the overall aims of the thesis, the questions I sought to answer included: Why, in acute care nursing, do there exist patient “care” plans and why, in psychiatric acute care, are they referred to as “risk management” plans? What part does “care” play in risk management? I was also concerned to understand where “recovery” sits within risk management and how managing risk leads to recovery for the patient (or not)? Certainly, the minimisation of psychiatric risk will obviously ensure the safety of the patient (as there *are very* real risks to the patients and the public); however, does the focus on risk minimisation promote recovery from mental illness? Doesn’t the process of risk assessment itself create risk? Are there issues besides the management and assessment of risk that should form part of the patient's therapy, such as, consideration of physical symptomologies that occur within the context of suffering from a mental illness, capacity to perform ADLs, or the client's self-determination? RAM seems to leave little scope for the consideration of these issues.

1.2 Purpose of this thesis

Throughout my journey, the objectives of this research have changed significantly. The original aims and objectives of the research remain the same; however, upon reflection on the early findings of the research, wider reading, and critical analysis, additional aims were formulated as further gaps were identified. The purpose of this thesis became not only to develop an understanding of the issues facing health professionals in undertaking psychiatric risk assessment and management, but also to describe what happens around risk and to provide a critical commentary on risk within the context of the holistic approach to psychiatric care. With the addition of these further aims, this thesis will allow clinicians to "see" that a focus on risk, at the expense of therapy, may be detrimental to patient recovery. The overall aims of the thesis are to:

- ***Aim 1*** - Develop an understanding of the issues facing health professionals in undertaking psychiatric risk assessment and management.

- ***Aim 2*** - Explore the barriers and enablers experienced by a multidisciplinary team in relation to effective risk assessment and management practices.

- ***Aim 3*** - Critically explore relevant legislation together with the legal and ethical frameworks that influence RAM, and contextualise this within the Australian mental healthcare system.

- ***Aim 4*** - Illuminate the way in which risk is socially constructed in acute care psychiatric settings.

- ***Aim 5*** - Critically compare psychiatric care plans to acute care medical care plans within the context of risk management, and use this knowledge to comment on the way risk has been conflated with care. This last aim draws upon sociological accounts of risk as outlined by Beck (1992), Giddens

(1990), and nursing scholar Menzies (1960).

1.3 Thesis framework

I have argued in the preceding sections that risk within mental health settings is socially constructed through stereotypes of patients diagnosed with a mental illness, legal prescriptions, ethical guidelines, public health policies, and the institutional and bureaucratic culture of the organisation. I consider that these social constructions take place in what Beck (1992) refers to as “risk society”; socially constructed factors interact with clinical knowledge and experience, and constitute the core of psychiatric practice in this setting. As a consequence, I argue that the care plan of the patient is primarily the management of risk.

The framework of this thesis has been carefully designed to take the reader on a journey that presents the key concepts and findings of the study, and allows them to see how I have drawn the conclusions that I make, in addition to meeting the identified aims and objectives. This section provides an outline of the thesis argument.

Chapter Two, is a theoretical exploration of Beck (1992) and Giddens’ (1990) key ideas on risk, together with Menzies’ (1960) study on the management of anxiety in healthcare settings. First, I introduce the theory of social constructionism and the notion of “risk”, as this sets the scene for the thesis argument. I argue that risk is a socially constructed phenomenon, and I believe that it is important from the outset to theoretically establish the phenomena that are occurring within the clinical setting. After establishing risk as a social construction, I explore Beck, Giddens, and Menzies key ideas on risk and anxiety. These ideas theoretically establish the ways in which clinicians use defence mechanisms to manage client risk, and how they form socially constructed ideas about risk and “risky patients”. This chapter also contributes to meeting the thesis’ fourth overall aim and moves the reader towards a theoretical understanding of the ways in which risk is socially constructed in acute care psychiatric settings.

Chapter Three provides a historical account of mental healthcare from the 18th century to modern-day practice and provides a segue from Chapter Two, Risk as a Social Construct, to Chapter Four, which examines the contemporary clinical literature available on risk assessment and management (RAM). This chapter also intends to bridge the divide between theoretical notions and what is happening in "reality". The importance that has been placed on RAM in contemporary mental healthcare can be understood through the examination of past practices and development. As such, this chapter is a sociological account of mental healthcare and the mental healthcare system where patients have progressed from being defined as "bad to mad". In this way, the occasions of deviant behaviour have gone from sin, to crime, to illness/madness, to risky behaviours.

In Chapter Four, the relevant literature is reviewed in order to examine RAM in the clinical psychiatric setting, what is currently known about risk practices, how risk plays out in the clinical setting, which issues pertaining to risk exist in the acute care inpatient psychiatric setting, and to establish the gaps in knowledge. This review of the literature contributes to meeting the first aim of this thesis. Notably, one important finding is that RAM originated from forensic settings; and this finding supports the theoretical propositions made in Chapter 3, that psychiatric conditions have transitioned from badness to madness (Hewitt 2008, p. 187).

The methods used to conduct the interviews (Stage One) and to analyse the legislative discourses (Stage Two) are then outlined in Chapter Five. Stage One was designed by drawing on the case study methods of Yin (2014, p. 50), and employs a thematic analysis framework as outlined by Braun and Clarke (2006). A convenience sample of healthcare professionals (*n*=14) who worked within a multidisciplinary clinical team on a psychiatric ward were interviewed in order to examine how they understood RAM. The interview questions were designed to enable an in-depth discussion of the topic. Then, in Stage Two, I used the work of Karppinen and Moe (2012), Prior (2003), and Smith (1984), to selectively analyse relevant documents that served to inform and frame clinical actions and patient care.

The findings of the study are presented over three chapters (Chapters Six, Seven, and Eight). Chapter Six steps off from Chapter Three by examining the Australian legal and ethical frameworks that clearly influence the clinicians who participated in the study which, in turn, results in tension and anxiety for them. Informed by Chapter Three, and the findings of Chapters Seven and Eight, Chapter Six examines the relevant legislation together with the legal and ethical frameworks that influence RAM, provides critical commentary, and contextualises this within the Australian mental healthcare system. This chapter also presents:

- A common South Australian nursing care plan used in acute care hospitals;
- *And* the research site's risk assessment and management tool:
    - as identified by participants to be the care plan they use;
- An identification and critical analysis of the similarities and differences in these care plans.

I argue that using RAM tools, such as checklists, acts to keep the client at arm's length from the clinician. Such tools act as defence mechanisms, transferring responsibility for safety from the clinician to the tool which, in effect, is the care plan. The patient's care plan is based on their risk score which is at odds with the National Mental Health Recovery Framework (Department of Health and Ageing 2013).

Chapter Seven is the first of two which present data from the interviews and describes in detail some of the issues facing health professionals when undertaking RAM. It also identifies the attitudes of health professionals towards risk assessment, as well as the enablers and barriers identified by the participants that exist in relation to effective risk assessment. This chapter also identifies the themes that arose from the interview data: the definition of RAM, the practices of risk assessment and management, the purpose of risk assessment and management, and predicting risk, as described by the participants.

Chapter Eight is the second of two chapters presenting data from the interviews. In this chapter, I present the barriers and enablers to RAM. These include the participants' responsibilities within RAM, associated communications, and RAM training and education. Interestingly, the participants also identified the ward culture as impacting on RAM and this finding is important in establishing how risk is constructed and managed on the ward.

Chapter Nine examines these findings using the theoretical lens of the risk theorists, Beck (1992) and Giddens (1990), and the insights of Menzies (1960). This chapter serves a number of purposes. Drawing on these theories and insights, the chapter brings together, into a cohesive whole, the previous chapters of this thesis, while at the same time, the aims of the thesis come together to create the thesis argument. Secondly, the notion of risk is teased out and I discuss the ways in which risk as a social construct has been illuminated within the previous chapters, thus finalising the third aim of this thesis. Thirdly, a robust discussion of the issues facing health professionals in undertaking psychiatric risk assessment and management is undertaken in order to develop a deeper understanding of the phenomenon, and to clearly identify what this means for clinical practice. This discussion includes a consideration of the data that was previously presented in terms of the legislative framework that clinicians operate under, but are powerless to change; this meets the first and second aims of the thesis. Nursing care plans are examined in this context. Finally, the tension between risk and recovery is examined as are the implications for nursing practice.

Chapter Ten concludes the study and makes a number of recommendations based on the research findings. I draw conclusions here on the basis that the unpacking of risk assessment and the management of risk “has potential applications in supporting clinical learning, collaborative work with patients”, and organisational social constructs (MacNeela et al. 2010, p. 1305). The assessment and management of risk are often “obscured from view”, most likely because of the intuitive component that clinicians apply when assessing and managing for risk (MacNeela et al. 2010, p. 1305). This may then give credence to rehabilitation and personal empowerment for both clinicians and patients (MacNeela et al. 2010, p. 1305).

1.4 Definitions

Prior to concluding the chapter, to provide contextual clarity for the reader for the rest of this thesis, key concepts and distinct differences are now explored. These are: Acute Care, the differences between Registered and Psychiatric Nurses and their roles, Mental Illnesses and, Nursing care plans from the perspective of Registered Nurses in the acute care setting as opposed to the psychiatric setting.

1.4.1 Acute Care

Acute care is defined by the Australian Institute of Health and Welfare (AIHW) as the care in which the primary clinical purpose or treatment goal is to:

- *manage labour (obstetric);*
- *cure illness or provide definitive treatment of injury;*
- *perform surgery;*
- *relieve symptoms of illness or injury (excluding palliative care);*
- *reduce severity of an illness or injury;*
- *protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function;*
- *perform diagnostic or therapeutic procedures*

(AIHW 2014b, p. 1).

1.4.2 Registered and Psychiatric Nurses

Registered Nurses can be classified as general nurses and psychiatric nurses (AIHW 2014a), although this delineation is not reflected in the national registration of nurses. General nursing can be thought of as a specialty required for the short-term nursing care of medical and surgical patients with chronic or acute diseases in acute care settings, or long-term care out in the community. Mental Health (or Psychiatric) Nursing is considered to be another specialty of nursing care. Mental health nurses care for patients of all ages with a mental illness or mental dysfunction, and are concerned with the prevention and care of mental illnesses. Whilst primarily using the bio-medical model, the care provided is underpinned by the Recovery Framework, which in its broadest terms goes beyond the medical model to focus on the psychosocial arena, so that the client is able “to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues” (Department of Health and Ageing 2013, p. 4).

1.4.3 Mental illnesses

Mental illnesses are presumed to be medical conditions that cause a disorder in a person’s thinking or behaviour. Mental illnesses, as well as being psychological and emotional, are often physical in manifestation, which can include tachycardia, headaches, and epilepsy (Townsend 2014). In addition, the side-effects of some psychiatric medications can include postural hypotension, tachycardia, tremors, gastro-intestinal disturbance, and sexual dysfunction (Townsend 2014). I argue that there is a significant overlap in symptomology for the patient, and both general and mental health nurses need to be trained to recognise this and incorporate both psychological and physical aspects into the care they provide. Indeed, the physical risk factors of psychiatric patients can also include the presence of physical disabilities, the aging process, decreasing independence with Activities of Daily Living (ADLs), risk of falls, and incontinence.

1.4.4 Nursing Care Plans

These plans require nurses to identify both the patient’s risks and other issues that may be evident, and incorporate the patient’s cognition, physical observations, nutritional requirements, comfort and pain levels, and sleep patterns. By identifying these areas and changes within the patient’s physical states (which includes identified risks), the nurse is able to plan and provide care that is “holistic” in nature as opposed to simply managing risk.

1.5 Conclusion

This chapter has introduced the problems of risk assessment and management in psychiatric acute care settings. The purposes of the study, and the questions posed, have been presented. A brief overview of the theoretical framework and methods used in this study has been offered, together with the research significance and implications for clinical practice.

This thesis will now take the reader on a journey in which I argue that socially constructed factors interact with clinical knowledge and experience to constitute the core of psychiatric practice in this setting. An analysis of risk and the contexts therein provides opportunities for health professionals to examine and deconstruct their traditional roles, additionally allowing the exploration of ways to “help people”, respect the human distress evident, whilst acknowledging the complexities that exist within professional responses (Buchanan-Barker & Barker 2005). This is the whole crux of the thesis.

The next chapter presents the argument around risk as a social construct and presents the key ideas of the risk theorists, Beck and Giddens, as well as Menzies who explores the ways in which clinicians use defence mechanisms to manage client risk. This thesis uses social theory to understand the wider context of risk with the contention being that we are living in “risk society”, and that risk has become an inherent part of modern (capitalist) society. As it is important to contextualise RAM in the clinical setting in order to establish how this notion of “risk” is played out in the institutional setting, I intend to demonstrate how risk, and subsequent anxiety, play out theoretically in the clinical environment by first presenting Beck’s “risk society”, Giddens’ key ideas around risk which add to Beck’s theory, and then I operationalise these ideas in the clinical setting by using Isabel Menzies within the context of clinician anxiety being a manifestation of Beck’s “risk society”. This chapter will then create a thorough understanding for the reader of the underpinning ideas that allowed me to reach the conclusions drawn in this thesis.

2 RISK IN THE THEORETICAL SENSE

2.1 Introduction

Chapter One has introduced the reader to the outline of this thesis. As stated, my observations resonated with theories associated with the idea of "risk society", and the notion that risk has become an inherent part of modern (capitalist) society (Beck 1992). In this chapter, I argue that risk is a socially constructed phenomenon. I then introduce the reader to social constructionism and the notion of "risk" as viewed by social constructionists. This will provide the reader with the underlying perspective through which I have written this thesis, and establish what is occurring in the clinical setting.

To allow the interpretation of the patterns and meanings of risk, varying risk theories can be utilised as conceptual frameworks (Krimsky 1992). Alternatively, risk theories (for example, those of Beck and Giddens) seek to look at how notions of risk become embedded in the fabric of modern society. Theories of risk may be applied to all aspects of society, and these theories claim to offer explanations for social crises, and to provide a lens through which to understand risk and the apparent inconsistencies related to this (Debrix 2004).

Proponents of various risk theories contend that there are numerous social responses towards risk (Slovic et al. 2007), with risk and risky behaviours being socially constructed, subjectively experienced, and individually assessed. While being infrequently applied to mental health, these perspectives enable institutional practices and individualised clinical responses towards risk and risk assessment and management (RAM) to be understood (Moon 2000). These perspectives also provide a medium through which to understand, explain, and predict risk, and to provide a framework to allow for an understanding of social rules and rituals that are practiced in the clinic. These perspectives are utilised in this thesis as a way of understanding and finding meaning for what is happening in the clinic and to promote a shift in orthodox thinking; in this case, in clinical mental healthcare practice. Moreover, risk perspectives provide a conceptual framework which assists in the interpretation of the data. For example, if one were to consider the notion that risk is a social construct which is inherently negative, and then proceed to examine the Recovery Framework (patients must take a risk in order to recover), the clinical outcome for the patient, based on clinical reflection, may look very different (Bird et al. 2014; Corrigan, Druss & Perlick 2014).

Specifically, this chapter is devoted to the key ideas of Beck (1992), Giddens (1990), and Menzies (1960), which theoretically establish the ways in which clinicians use defence mechanisms to manage client risk, and also how clinicians form socially constructed ideas about risk and “risky patients”. Throughout this thesis, I use Beck’s ideas to establish that “risk society” is played out in the mental healthcare arena in Australia. I then use Giddens to explore ideas about “risk society” that Beck does not, primarily around Giddens’ idea that risk can exist as a possibility (as played out in the “Recovery Framework”) and his ideas around globalisation, such as the “mutual causal links among technology, institutional structures, beliefs and social behaviour” (Georgantzas, Katsamakas & Solowiej 2009, p. 1). Nevertheless, there are also contrasting positions that these theorists take, such as that of the mitigation of risk. For Giddens (1994c), mitigation depends on developing relations of trust which is also enhanced in advanced modernity, whereas Beck (1992), in contrast, cannot see how risk can be mitigated at all.

To tease these ideas out a little further, trust is fundamental to the institutions that exist in modernity (Giddens 1981). It is vested in a system rather than in individuals. Trust means that the individual does not need to have mastery in an “expert” system. Rather, trust becomes the link between faith and confidence in the system (Giddens 1990). Trust can then be defined as an individual’s confidence in the person or system being reliable (Giddens 1994c). When applied to risk, trust allows the reduction or minimisation of dangers and is balanced with “acceptable risk” which then provides security (Giddens 1994c). In terms of RAM, this becomes a tool used in an expert system. Risk and recovery become a reflexive monitoring of behaviour whereby social practices are consistently monitored, examined, and subsequently reformed once more information comes to hand (Giddens 1991a). During this process, the characteristics of the behaviours are altered (Giddens 1991a).

In other words, a risk assessment or management tool is reflexive in nature and becomes a symbol of an expert system as a way of managing uncertainty. The defining feature of the expert system is the holding of expert knowledge as opposed to lay knowledge – thus, creating a knowledge divide (Wynne 1996). This means that, as knowledge is acquired, the expert system's performance is expected to increase (Grzymala-Busse 2012). As such, the knowledge base increases, new rules are created, and if those rules interfere with the old rules, the system is subsequently modified (Grzymala-Busse 2012). The risk assessment or management tool symbolises this divide and provides a means to modify the rules and the system (Wynne 1996).

Beck (1992) and Giddens (1990) have argued that the increasing atomisation and individualisation found in contemporary western societies generates a lack of trust and, with it, increasing levels of anxiety and uncertainty. This anxiety is also played out in the clinical setting. It is not only the patients who are anxious, so too are the clinicians. In drawing on the work of Menzies (1960), I also argue that one of the manifestations of "risk society" within the clinical setting is the way in which clinicians generate a set of defence mechanisms against the clients they care for. These defence mechanisms arise out of anxieties about risk that are socially constructed through the institutional, organisational, and cultural processes of RAM, and through the various practices that surround the management of institutional care.

The depersonalisation and categorisation of the patient and their behaviour is one such defence mechanism, aimed at minimising the individual clinician's anxiety, and as a way of mitigating potential risk. The use of nursing rituals, such as employing a checklist approach to care, is another example of a defence mechanism which transfers responsibility for safety onto the tool rather than to the individual. In a psychiatric ward, these rituals may consist of risk assessment forms (checks and counter-checks), or the locking of ward doors. However, these rituals are now defunct as mechanisms of care. Their purpose is purely a bureaucratic response to the manifestations of "risk society" that reside in the clinical setting.

2.2 Constructs of risk: Social constructionism as a methodological epistemology

> *An epistemological approach to risk also makes it possible to argue that disciplinary investigation of risk is likely to yield insights into the epistemology of disciplinary practice just as much as disciplinary perspectives are likely to tell us particular things about the epistemological approach to risk (Althaus 2005, p. 580).*

2.2.1 Methodological epistemology

Ontology is considered to be the world in question (Wand & Weber 1993), whereas epistemology is the understanding and nature of knowledge (Hirschheim, Klein & Lyytinen 1995). Together, they constitute a person's worldview. Crotty (1998) stated that "what is" (ontology) and "what it means to know" (epistemology) can be placed alongside each other. Each informs the other as well as wider theoretical perspectives. When using a constructionist world view, there is a blurring between ontology and epistemology because the constitution of a reality depends upon a particular person and their viewpoint. This means that from this perspective, constructions are considered to be the ontological element of realities. In other words, people's experience of the world cannot be separated from their ways of knowing. In this way, epistemology and ontology underpin theoretical perspectives and methodology; providing a context for logic, allowing one to design and articulate the research criteria. When applied to the concept of risk in this thesis, I argue that risk is socially constructed in the realm of the clinician, although there are indeed, very real risks. These will be teased out throughout this journey.

From this premise, I contend that there are no hard and fast rules and, as such, have decided to focus on theoretical risk perspectives framed within the social constructionist paradigm as my methodological epistemology. Using social theories of risk framed within a social constructionist methodology provides a structure through which to consider the generative mechanisms which underlie notions of risk (Renn 1992). Social theories of risk can also address illogical conclusions and the empirical inadequacies of research which are derived from observation, experience, and experimentation, particularly when searching for meaning (Adam & Van Loon 2000). This means that social theories of risk bridge and connect the research to theory, and this allows the broadening of perspectives and the consideration of alternative interpretations, which then provides an informed and sustained critique (Adam & Van Loon 2000, p. 23). This is important as the concept of risk, and what constitutes risk, can be obscured in the clinical setting.

Social epistemologies can be thought of as a set of approaches, with the epistemology providing a philosophical grounding “for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate” (Maynard 1994, p. 10, cited in Crotty 1998). Schwandt (2003, p. 307) considered social constructionism as an invitation to “play with the possibilities and practices that are made coherent by various forms of relations”. Constructionism rejects the notion of objective truth – instead, meaning and truth exist within engagement, with realities that appear apparent within the person’s world (Crotty 1998). Put simply, truth and meaning come out of an individual’s reactions to their world. From this philosophical basis, meaning is constructed by the individual and, as a consequence, may differ from person to person – although only marginally, because there are, in the main, shared social constructions of risk. Risk, from this perspective, can be understood as a social construct, as a “perceived risk”, although there may be slight differences from person to person. This means that risk does not exist in or of itself, unless it is first identified as such.

I contend here that social meaning is constructed within a social context, rather than in isolation. As defined by Crotty (1998):

> *… all knowledge and therefore meaningful reality as such, is contingent upon human practices being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context (Crotty 1998, p. 42).*

In groups, there exist “collective understandings” whereby individuals *construct knowledges* as opposed to them *discovering* or *finding* knowledge. When these ideas are applied to risk, it can be conceptualised as being relative to the social context, and “can only be reconstructed from the beliefs and rationalities of the various actors in society” (Renn 1992, p. 70). As a result, individuals accept these constructs into their belief system, adding to the collective whole. This means that beliefs about risk are a “social invention” (Speed 1991, p. 400).

The basic premise within this epistemology is that risk is self-referential, and individuals develop cognitive frameworks, models, and concepts over time and through experience, that enable them to make sense of their experiences, with constructions occurring out of new experiences as they arise (Schwandt 2003). Theorists positioned within this perspective suggest that these social constructions incorporate both the person's historical as well as their social positioning; for example, from the perspective of their gender, profession, ethnicity, or class. The individual's interpretations are made within an environment of practices, languages, and shared understandings (Schwandt 2003). As such, the individual experience is "ideological, political, and permeated with values" (Schwandt 2003, p. 308), reflecting their position within society. As a consequence the "risk is never fully objective and knowable outside of belief systems and moral positions" (Lupton 1999, p. 29).

2.2.2 Theorists and theoretical positioning

With this overarching umbrella of theoretical positions, varieties of social constructionism abound and those described as social constructionists can draw from structuralist positions. This is where Beck and Giddens fit into the schema. Under the umbrella of social constructionism, structuralism, as defined by Milner (1991), is:

> *… centred in the search for constraining patterns, or structures, which claim that individual phenomena have meaning only by virtue of their relation to other phenomena as elements within a systematic structure (Milner 1991, p. 61).*

Broadly speaking, structuralist positions examine cultural hierarchies, structures, and categories in order to define and understand risk within a social context (Lupton 1999, pp. 25-6). However, Giddens (1984, p. 25) theorised that "neither structure nor action can exist independently". He argued that there is a definite tension between structure and agency, the individual and society, between the individual's autonomy and the social constraints of society on their behaviour. Beck (1992) took a slightly different approach, arguing that modern society is characterised by the breaking down of traditional structures leading to greater self-reliance and individualisation (Beck 1992).

Whilst deviating from the discussion slightly, it is important to note that structuralism is consequently a systematic way of understanding “the fundamental structures that underlie all human experience and therefore all human behaviour and production” (Tyson 2006, pp. 209-10). This argument suggests that human behaviour is shaped by the larger social institutions that form society. From this conceptual understanding, it can be theorised that the world exists at two fundamental levels, one visible, the other invisible (Giddens 1991b). The visible, or explicit, world relating to a clinical setting would include policies and procedure manuals, whereas the implicit, or invisible, aspects would include the socially constructed norms and collective understandings about how to “do things” on the ward, including interpretations of policies and procedures.

One such structuralist position is the critical structuralist approach. As interpreted by Lupton (1999, p. 26), proponents of this perspective (for example Weber, (1958) position themselves by critiquing the power that social *institutions* wield over individuals; the effect being to reduce their capacity for autonomy and agency. The critical structuralist perspective focuses on the disorder evident within a chosen society and the associated social inequities, as well as a consideration of social conflict, using examples to highlight the necessity for social change to occur (Lupton 1999). This view is adopted by two major risk theorists, Ulrich Beck and Anthony Giddens, although their views differ from older critical structuralist approaches, such as that of Marx (1971), and they differ in their arguments around risk. Marx argued that class is the major organising principle of society, whereas Giddens and Beck see risk as the major organising principle. Nevertheless, risk is now the centrepiece of modern society, with society adjusting to an environment that it has never previously encountered (“risk society”) (Hewitt 2008). These theories attempt to explain how risk has become central to modern society, how it has an impact on everyday life, and how it has been the result of historical social responses toward risk.

2.2.3 The proliferation of risk definitions

The differing perceptions of risk leave no clear guidance (Althaus 2005), which is illustrated by Fischhoff, Watson and Hope (1984, p. 124) who stated that, in the past, risk has been defined in a variety of ways, and that arriving at a definition is “inherently controversial”. As Ekberg (2007, p. 353) contends: “[t]he different understandings of the origins and impact of risk have led to a proliferation of contested, competing or conflicting risk definitions”.

From this, it is important to consider how risk is defined by Beck to foster a base upon which to build a definition of risk. Using this theoretical base, Chapter 6.3 will analyse the proliferation of risk definitions apparent in documentary sources and then will proceed to consider the overall discourse. Continuing from a theoretical framework however, risk, as defined by Beck is:

> *… a systematic way of dealing with hazards and insecurities induced and introduced by modernization itself. Risks, as opposed to older dangers, are consequences which relate to the threatening force of modernization and to its globalization of doubt. They are politically reflexive (Beck 1992, p. 21).*

For Beck (1992, p. 13), risk is seen as catastrophic, and is another word for danger or hazard, and these risks are considered to be “irreversible threats to the life of plants, animals and human beings”. However, he considers that there is a difference in risk in and of itself to that of public perceptions; it remains unclear whether risks have “intensified” over the years, or whether it is only our view of these risks that has changed (Beck 1992, p. 55). He contends that risks are “social constructs which are strategically defined, covered up or dramatized in the public sphere with the help of scientific material supplied for the purpose”, and it is this that may explain our socially constructed perceptions that risks have increased (Beck 1996, p. 4).

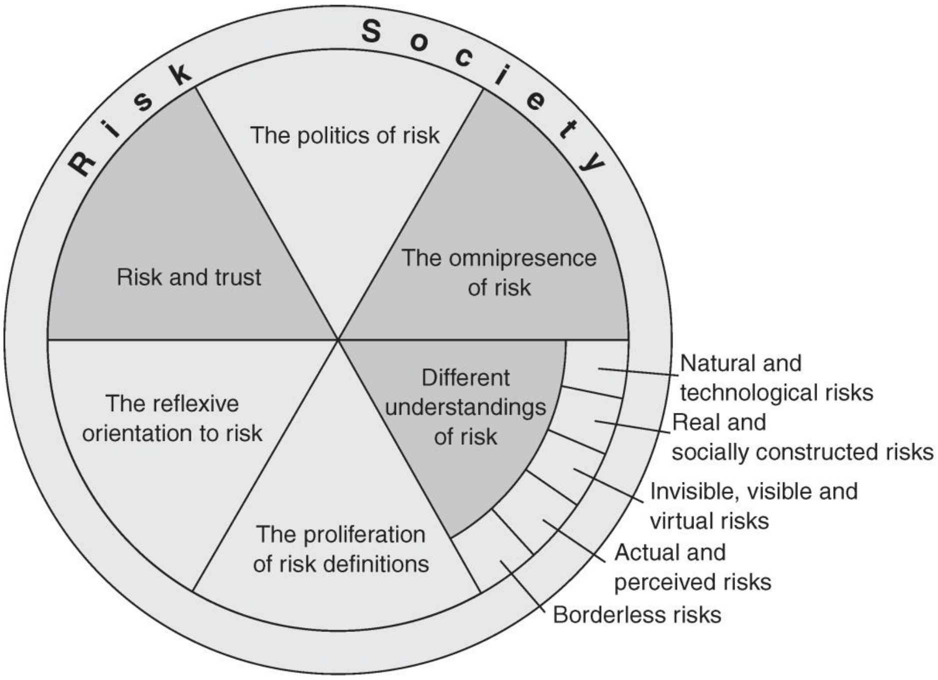
Althaus (2005, p. 568) contended that definitions of risk which are oblivious to “the philosophical debate or to other disciplinary perspectives may, at times, confuse the notion of risk”. This has been illustrated by Kramer et al. (1997, p. 337), who considered terms such as risk, and the risk factors employed in clinical settings, as being used inconsistently, which can mislead research and foster miscommunication. If the analysis of the data in this study is to be logical and rigorous, then a clear clinical definition of risk is necessary (both in Stages One and Two). Moreover, perceptions of clinical risk and the identification of inherent risk must also be related to the definition of risk to be used because, as Beck (1992, pp. 149-50) contended, arrival at a definition is shaped by “the specific rules, institutions and capacities that structure the identification and assessment of risk in a specific cultural context". This is "risk society", or a society now organised around risk.

This point cannot be highlighted enough. The problem becomes that, in a healthcare setting, and in the literature around RAM, risk is interpreted as a concrete reality – not, as I contend here, as a social construction. The pull of the "risk society" is evident, and yet, clinicians that work in this system are oblivious to this reality.

2.3 The "Risk Society"

> *[a] particular set of social, economic, political and cultural conditions that are characterised by the increasing persuasive logic of manufactured uncertainty and entail the transformation of existing social structures, institutions and relationships towards an incorporation of more complexity, contingency and fragmentation (Adam & Van Loon 2000, p. 5).*

As will be explored in the following sections of this chapter, in Beck's (1999, p. 147) conceptualisation of "risk society", society may be thought of as a range of intersecting and merging parts: politics; the omnipresence of risk; different understandings of risk ("natural and technological risks", "real and socially constructed risks", "actual and perceived risks"); the proliferation of risk definitions; and the reflexive orientation to risk and trust (Ekberg 2007, p. 345). "Risk society" is clearly illustrated in Figure 1:



Beginning with the omnipresence of risk and travelling in a clockwise direction, each parameter adds to the previous one, ultimately culminating in the final parameter, the politics of risk. In the politics of risk, risk is a function of power and a catalyst for social transformation.

Figure 1: "Risk Society"

Reproduced directly from Ekberg (2007, p. 345)

As can be seen in Figure 1, in this way, a society becomes more reflexive as it perceives itself to be a "risk society". It could be said then that if society is faced with a future that appears threatening, this then influences current action, generating more actions to decrease perceptions of risk or to decrease the risk itself, and this becomes a self-perpetuating cycle. Beck (1999) seeks to extend, combine, enhance, and critique many of the existing theoretical approaches and perspectives. The "risk society" considers the divergences and convergences, the limitations and strengths of these, concluding that:

> *… the ethos of wealth creation that characterized industrial modernity has been overshadowed by an ethos of risk avoidance, class consciousness has been displaced by a risk consciousness and the increased awareness of living in an environment of risk, uncertainty and insecurity has become a major catalyst for social transformation (Ekberg 2007, p. 345).*

Building from the work of earlier theorists, Beck has created a paradigm shift and considers the omnipresence of risk being one of what he terms “reflexive modernisation” which is explored later in this chapter. The core characteristic is Beck’s postulations that in “risk society”, society has become increasingly vulnerable when faced with unpredictability, and when faced with this unfamiliarity, risks are manufactured in an attempt to control the future, both near and distant (Beck 1992). There appears to be interplay between the identification and measurement of risk that concurrently relies on the institutional management of these, which often fails. These risks emerge from the collapse of values, traditions, norms, and customs. “De-traditionalisation” essentially allows the dissolution of safety and security (Beck 1992). In this way, there arises a collective consciousness of insecurity, anxiety, and uncertainty; and so, the omnipresence of risk becomes the core characteristic of “risk society” (Beck 1992).

This leads us to the notion of shifting from modernity, with “risk society” being seen as the reconstruction of this. To accommodate this shift, political and institutional reforms are necessary, but are centred around gaining or acquiring new knowledge and avoiding risks (be they real or manufactured) (Beck 2000). This move is best exemplified by Ekberg:

> *… the shift in emphasis from natural to technological risks, the shift from a realist to social constructivist perspective on risk, the increasing gap between actual and perceived risk, the progression from invisible to visible to virtual risk and finally, the change in the spatial, temporal and demographic distribution of risk, giving rise to a new category of borderless risks. It is these salient features of risk in the risk society, rather than the presence of risk itself, that legitimate the claim that the risks of the risk society are exceptional (Ekberg 2007, p. 347).*

From this reflexive shift, Beck (1992) considered that there emerges different attitudes towards risk, with heightened sensitivities towards risk events that now have social and political consequences. They are no longer a random product of nature; instead, they are unintended consequences that are unique to this era, arising from the accumulation of knowledge and the manipulation of events. Central to this argument is the concept of real and socially constructed risks which is explored elsewhere. Importantly, however, it is Beck’s contention that these are “open to social definition and construction” (Beck 1992, p. 23). Not surprisingly, attempts are then made to predict the probability of risk occurring. This disconnect occurs due to competing powers and the notion of expert opinions; and so the construct of competing political, social, and commercial powers emerges (Beck 1999). This is further complicated by the proliferation of definitions of risk, which receive sustained examination later in this thesis. To extend the concepts touched upon here, this notion of “risk society” can be better understood by examining Beck’s arguments on the interplay between individualisation, reflexivity, and modernity. These will be considered below.

2.4 Individualisation

Beck’s theory of “risk society” derives firstly from his observation that modernity is characterised by increasing individualisation (Beck 1992). He argued that contemporary societies are characterised by heightened levels of individualisation that allow unrestricted personal experimentation and innovation free from the constraints of traditional social mores and norms (Beck 1992). The flip side of this is that the individual is also set adrift from traditional communal supports. This leads to increased anxiety, and feelings of risk and dangers that are now very much a personal responsibility (Beck 1992).

For Beck (1992), individualisation is on the rise due to the increasing breakdown of traditional communal relationships. This then results in the individual having to rely increasingly on their own resources. This “novel personal experimentation and cultural innovation [occurs] against a social backdrop of risks, dangers, hazards, reflexivity, and globalization” (Elliott 2002, p. 298). Beck (2009, p. 3) theorised that risk “defines a social relation, a relation between at least two people; the decision-maker who takes the risk and who thereby triggers consequences for others, who cannot, or can only with difficulty, defend themselves”.

As such, individualisation is also associated with anxiety. The cultural experience of anxiety refers to the feelings of anxiety that individuals experience as a result of changes in social behaviour or in the underpinning ideas of a society, or in other words, cultural experiences of anxiety arise in the face of rapid social change and also the breakdown of traditional social mores and norms (Beck & Beck-Gernsheim

2002; Warner 2006). Anxiety can create a mobilising force in which the individual is propelled into some kind of action to manage the anxiety they feel in the face of change, in order to reduce feelings of anxiety; this is a key point to consider when examining the work of Isabel Menzies (1960) later in this chapter. Increasing individualisation does not however mean a lack of control or a licence to abandon all norms. Individuals are constantly being pushed to self-regulate given the new social norms, being a change in the philosophical construct of corporate control, reducing government regulation, and increasing self-regulation. The *response* by the institutions and individuals in order to gain more control, is to increase control through surveillance, regulation, and bureaucracy (Beck & Beck-Gernsheim 2002).

2.5 Reflexivity

A risk averse society is associated with reflexivity which is seen as an unintentional side-effect of modernity (Lupton 1999). Reflexivity means, for Beck (1999, p. 74), a relationship of “reflex and reflection”, with individuals and society redefining (once new knowledge is acquired) standards of safety, responsibility, and control within the context of potential dangers. Reflexivity is essentially a circular relationship, one between cause and effect whereby each affects the other. Through self-reflection on the situation, there arises growing awareness, critique, the weighing up of alternate methods of solutions, and then “reform” (Beck, Bonss & Lau 2003). This goes back to Beck’s ideas of “risk society”, and is the same cycle of risk, solution, and then risk in the solution (Beck 1994). Beck, Bonss and Lau explained:

> *… there is no longer ‘one best way’ to solve every problem, but rather several equally valid modes of justification that operate simultaneously. Such a loosening up of the foundations of rationality could lead to a multitude of alternative optimization strategies and/or to an expansion in scientific and technical knowledge (Beck, Bonss & Lau 2003, p. 16).*

However, the end result is that there becomes a greater need to manage the possibilities of multiple uncontrolled risks. Risk becomes a self-perpetuating cycle and this means that individual social life is transformed, because new knowledge is acquired and other knowledges are revised. The revision of knowledge comes about because they are put in place in response to perceptions of risk. For example, locking a door in a ward is a reflexive response to a perception that a patient might abscond (a risk), is dependent upon the clinician’s assessment of perceived risk from the patient, and this becomes a “mental construct” (Beck, Bonss & Lau 2003, p. 14). From this, the criteria for a reflexive society, which are centre stage in “risk society”, are illustrated by Beck, Bons and Lau (2003, p. 22) in

Figure 2:

Figure has been removed due to copyright restrictions.

Figure 2: “Reflexive Modernization”

Reproduced directly from Beck, Bons and Lau (2003, p. 22)

Beck (2008) examined reflexive society through its institutions (which form part of its structures), and the institution of society that will be examined for the purposes of this thesis is the healthcare system, with the National Safety and Quality Health Service (NSQHS) Standards driving healthcare quality and safety systems as well as improving healthcare quality in Australia (Australian Commission on Safety and Quality in Health Care 2015). The healthcare system’s responses to risk involve communicating the presence of risk. As alluded to previously, such communications of risk include locking ward doors (implying safety concerns) and physically restraining patients. These inherent actions are reflexively managed within the cultural and/or societal norms that they reside within.

2.6 Different understandings of risk: Real and socially-constructed risks – actual and perceived risks

> *The outside world itself knows no risks, for it knows neither distinctness, nor expectations, nor evaluations, nor probabilities – unless self-produced by observer systems in the environment of other systems (Luhmann et al. 2005, p. 6).*

There are different kinds of risks, both actual and socially constructed. For example, an actual attempted suicide would constitute a real risk; however, a clinician predicting the patient to be at risk of violence could be considered a socially constructed risk dependent upon the clinician's perceptions. Hinging upon socially constructed perceptions of risk are the increasing uncertainties that arise as "a result of human intervention in nature and society" (Tsoukas 2005, p. 44), and the growing perceptions of risks and the resulting reflexivity and anxiety. The reflexive society (a key feature of the "risk society"), within which clinicians and institutions are located, requires constant assessment and prediction (Beck 1999; Lupton 1999; Marshall 1998). The monitoring of risk and its subsequent management has the ability to influence social action (Beck 1999).

Risk also represents a "worst case scenario" (Beck 1992). However, reflexivity is a response to, and a means of, reducing anxiety about risk through seeking information. For example, the clinician must choose between various predicted patient outcomes which are shaped by the clinician making the decision, the society in which they reside, the institution within which the decision is being made, and how this risk is perceived at the social, institutional, and personal levels. As a consequence, the individual's perceptions, knowledges of, and attitudes towards risk are shaped by culturally-assigned values, originating from society or the institution which, in turn, shape that of the institution and other individuals.

2.7 Giddens' ideas about risk: filling in the gaps

Giddens agreed with the conceptualisation of Beck's "risk society"; however, he focused on notions of risk, rather than risk itself. This is linked to his idea that risk has not increased; rather, perceptions of risk and the increase of new manufactured ones have (Giddens & Pierson 1998).

2.7.1 Ideas about risk and trust

Giddens theorised that there is no increase of risk in modern times; there is only an increase in *perceived* risks (Lupton 1999, p. 81). He agreed with the basic conceptualisation of Beck's "risk society"; however, he was also concerned with personal dispositions (Giddens & Pierson 1998). Giddens (1999a) sees risk as inextricably bound with trust, always related to security and safety, and always associated with personal responsibility. This is important in the clinical setting because, for example, clinicians are bound by professional codes of practice and ethics which promote personal responsibility among other aspects.

He suggests that although risk is not by any means something to be minimised, it is always infused with negative connotations (Giddens 1999a); hence, risk always refers to the avoidance of an unwanted outcome (Giddens 1999a) and always exists as possibility (Giddens & Pierson 1998; Luhmann et al. 2005). The viewing of risk as positive occurs through the utilisation of "bold initiatives" in the countenance of a problematic future (Giddens 1999a; Giddens & Pierson 1998). Giddens' idea of positive risk aligns with the Recovery Framework used in mental healthcare today and ties in with the notion that reflexivity leads to a more active creation of one's self (Giddens 1991a). I pick up on his ideas in later chapters.

By using Giddens' theoretical position that risk can exist as possibility for positive outcomes, as opposed to Beck's position of risk as negative and catastrophic, there is scope to maintain a balanced approach between egotism and altruism (individual freedom vis-à-vis collective responsibility). In fact, Denzin (2001) suggested that broadly speaking, these approaches contribute to evaluative research by aiding the researcher in identifying definitions and then perceptions, and this then allows the various views to be explored, contrasted, and compared. From this premise, when exploring the notion of recovery, Beck’s approach would mean there could be no recovery, because risk is bad; whereas, if one was to take a risk in order to recover, then for example, a person diagnosed with agoraphobia would have to “take a risk” such as going outside, which would be negative and catastrophic for them, but would allow recovery and then freedom, as Giddens would allude too.

2.7.2 Globalisation according to Giddens

Globalisation is an important aspect of our understanding of risk. For both Beck and Giddens, heightened concerns with risk are associated with the new era that we have moved into (*advanced modernity* for Giddens and *risk society* for Beck). However, it should be noted that globalisation is only one aspect of *advanced modernity* and *risk society*. Beck contends that risk is ever-present in Western society. The omnipresence of risk in “risk society” is dynamic and also “trans-systemic, trans-national [and] trans-disciplinary” (Beck 2006, p. 340). This notion of risk slices through language, culture, systems, and religions, overturning priorities and creating contexts for action between groups (Beck 2006). Globalisation means that one force affects the other. As risk is considered omnipresent, in principle, the cause and subsequent consequences of risk cannot be limited to location, as it is by its very nature “de-localized” (Beck 2006, p. 333) and arises out of communication technologies. For example, risk is present even when we are a long way from it because one sees this on the news, TV, or an IPad. Strikingly, with the advent of new technologies, we know as it happens that a risk is occurring, even if it is an earthquake in Brazil.

Globalisation may also be thought of in terms of internationalisation, liberalisation, universalisation, or modernisation (Beck 1999; Luhmann et al. 2005; Lupton 1999). Modernisation, in a risk approach, refers to the changes and adaptation of societies over time which are transformed through knowledges, arising through risk experiences and the methods developed for coping with these; contributing to the growing perceptions of risks and the need to manage these (Featherstone, Lash & Robertson 1995; Slevin 2000). Advanced modernity is concerned with the change and adaptation of societies resulting from transformation through knowledges, arising through risk experiences and the association of ways developed for coping with these. As such, modernity and globalisation contribute to growing perceptions of risks and the need to manage these (Featherstone, Lash & Robertson 1995; Slevin 2000).

Giddens (1999b) argued that globalisation undermines people's sense of security and stability while, at the same time, escalating their consciousness of risk. Further, Giddens (1990, p. 64) defined globalisation, as "the intensification of worldwide social relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice versa". In other words, heightened concerns with risk (and the resultant anxiety) are a product of globalisation (Beck 1999; Luhmann et al. 2005; Lupton 1999). In Giddens' lecture series on the "Runaway World", he discussed the effects that globalisation has on individuals in society:

> *… [w]e are the first generation to live in this society, whose contours we can as yet only dimly see. It is shaking up our existing ways of life, no matter where we happen to be. This is not - at least at the moment - a global order driven by collective human will. Instead, it is emerging in an anarchic, haphazard fashion, carried along by a mixture of economic, technological and cultural imperatives. It is not settled or secure, but fraught with anxieties, as well as scarred by deep divisions. Many of us feel in the grip of forces over which we have no control. Can we re-impose our will upon them? I believe we can. The powerlessness we experience is not a sign of personal failings, but reflects the incapacities of our institutions. We need to reconstruct those we have, or create new ones, in ways appropriate to the global age (Giddens 1999c, p. 5).*

Primarily, this is where Giddens fits for this thesis. His ideas are able to promote clinical reflection in direct conjunction with the insights of Menzies' theorising about anxiety as a means of defence; and provide me with a further tool through which to interpret the research findings.

Extending this idea, an application of Giddens would look at the risk assessment tool as a symbol of expert knowledge that clinicians place trust in, and this perspective would also support Menzies' work in relation to clinician anxiety. Thus, globalisation as theorised by Giddens is able to consider the idea of anxiety, which then fits with Menzies' theory. First, Giddens (1999c) identifies the escalation of risk consciousness to be a product of globalisation, and then determines one of the consequences of this to be increased anxiety, which fits with Menzies' theoretical contentions quite nicely. He then considers globalisation in the context of “de-traditionalisation”, a process that occurs in healthcare settings touched on previously in this section, which ironically creates further anxiety:

> *… [t]raditions are always properties of groups, communities or collectivities. Individuals may follow traditions and customs, but traditions are not a quality of individual behaviour in the way habits are. What is distinctive about tradition is that it defines a kind of truth. For someone following a traditional practice, questions don't have to be asked about alternatives. However much it may change, tradition provides a framework for action that can go largely unquestioned. Traditions usually have guardians - wise men, priests, sages. Guardians are not the same as experts. They get their position and power from the fact that only they are capable of interpreting tradition's ritual truth (Giddens 1999c, p. 13).*

Giddens (1999c) argued that when people follow a traditional practice, it negates the need to question alternatives; while Menzies argued that the use of tradition and rituals is a way to alleviate anxiety. Tradition provides the framework for action, and this can go unquestioned. This provides stability and also has the ability (if against a stable background) to construct self-identity. That said, going through the process of de-traditionalisation, whereby everyday life becomes less informed by “tradition for the sake of tradition”, clinicians sit in a world awash with risk and anxiety (1999c). They are bound by tradition which engenders not only a framework, but a sense of stability, and yet they are faced with the process of de-traditionalisation as a result of globalisation. The outcome of this is massive ongoing healthcare reform and restructuring; which impacts upon clinical practice. The side-effect of this creates further uncertainty as the fragility within our social system is identified; we feel exposed and vulnerable (Giddens 1999c). For example, increased social mobility may induce a pandemic; economic uncertainty in one country influences another country; and technological developments occurring in one region can create transnational risks. The movement towards changing designs of healthcare, evidence-based practice, and healthcare restructuration include educational restructuring for healthcare professionals, theory development, transnational research networks, legislative changes, and new competency standards in response to the increase in chronic conditions and the prevention of adverse events (Joint Commission: Institute of Medicine 2011; Stevens 2013). For clinicians, the heightening of perceptions of risk allows institutions to enforce risk mitigation strategies which directly affect the patient, although Giddens (1994b) does argue that scientific enquiry (evidence-based practice in healthcare), using knowledge collected through systematic and careful observation, will enable the generation of theories in relation to causal relationships; put simply, as a way of managing risk.

2.7.3 Manufactured uncertainties

One aspect of globalisation has been the emergence of what Giddens (1999a) termed “manufactured risks”. As stated previously, according to Giddens, there is no increase of risk in modern times; there is only an increase in *perceived* risks (Lupton 1999). Because risk is socially constructed, what is and what is not a risk has created a level of uncertainty within society (Giddens 1999d). In order to manage this in the healthcare environment, clinicians manufacture uncertainties (Crawford 2004).

Manufactured uncertainties refer to “new risk profile[s]” arising as “outcome[s] of socially organised knowledge” and society’s inability to calculate actuarial probabilities for every risk contingency (Best 2003; Scambler 1998). Paradoxically, when more knowledge is obtained, more uncertainty will occur (Lacy 2005). As such, the more knowledge accumulated about a particular risk, the more choices exist and more decisions have to be made in order to assuage the perceived risks. Anxiety arises as a response to these perceptions of increasing risk.

Giddens’ view is that risk concerns have arisen as a result of the generation of new ideas. The result has been a “heightened sensitivity to issues of danger” resulting from extrapolation from past experiences (Lupton 1999, p. 47). Manufactured risks (or uncertainties) occur in those situations when individuals or institutions lack the historical experience and knowledge about a risk that they are confronting (Giddens 1999b). Conversely, manufactured risks (or uncertainties) can also occur when one has collected too much knowledge.

Giddens (1999b, p. 184) described manufactured uncertainties as being based on scenario thinking: “the as-if construction of future possible outcomes”. Beck (1999, pp. 78, 112), in contrast, referred to them as a combination of more unawareness (knowledge not yet obtained), more knowledge (now obtained), and reflexivity (having to decide), and as a consequence of the formation (or invention if you will) of new types of risks. This means that there exist self-referential systems which create the risks upon which they are based (Giddens 2011).

2.7.4 Risk Assessment

Crawford (2004) considered the concept of the “risk ritual” in order to manage (control) anxiety in the medical culture (explored in greater detail in Section 2.8 of this chapter). This medical culture is characterised by a seemingly abundant flurry of warnings about health hazards that could affect people (Crawford 2004). Equally, there is an outbreak of advice by healthcare professionals aimed at protecting individuals from these hazards (Crawford 2004). This contemporary view features a “health consciousness” which then acts to define the working and living environments which spawn organisations to exact regulatory control (Crawford 2004). However, the evolving insecurities precipitate an “out of control” spiral of anxiety, and subsequently, control measures are then implemented as a reaction to this spiral (Crawford 2004). Crawford (2004) contended that the “risk ritual” that evolves serves as one way of managing these hazards in healthcare. He argued that:

> *… health, as throughout contemporary social life, western scientific and technical rationality, in the context of a predatory global capitalism, cannot deliver the security it promises. The dream of security is confounded by the insecurity of contemporary social conditions and, ironically, by insecurity generated by efforts for protection (Crawford 2004, p. 506).*

Crawford’s (2004) contentions fit with Giddens’ theoretical postulating when he identified that “[r]isk assessment involves weighing up and choosing among various possible courses of action according to their predicted outcomes” (Giddens 1991, cited in Lupton 1999, p. 76) which, in itself, can be a very “risky affair” (Giddens 1991a). Giddens and Pierson (1998, p. 101) warned that there are inherent distinctions between the concepts of danger, hazard, and risk, and yet, while there may be distinct differences between these terms, they are used so interchangeably, and each person and/or organisation has a different interpretation of these, that they become difficult to separate. Indeed, one is left to wonder where the distinction actually lies. For Giddens and Pierson (1998, p. 101), risk is considered to be the "active assessment of future hazards". To illustrate this division between "danger", "hazard", and "risk", Lupton (1993, p. 425) conceptualised risk as a concept that not only has multiple meanings, but which is also "ideologically loaded". Lupton contended that:

> *… risk discourse is often used to blame the victim, to displace the real reasons for ill-health upon the individual, and to express outrage at behavior deemed socially unacceptable, thereby exerting control over the body politic as well as the body corporeal (Lupton 1993, p. 425).*

To attempt to distinguish between the concepts of danger, hazard, and risk, Crawford (2004, p. 507) explained that "dangers are problems and problems the birth of solutions". When this is applied in health education, it becomes a "pedagogy of danger" (Crawford 2004, p. 508). Crawford (2004) identified this disconnect, as being "the danger of danger":

> *… [t]he modern 'imperative of health' is to identify dangers in order to control them. Which dangers and which controls, however – individual, corporate, governmental – and the perceived adequacy of control are at the heart of the volatile political economy and ideology of health. There is an increasing gap between perception of danger and efficacy of practice – political, medical or personal. The gap spells a new kind of danger: a destabilization of the precarious balance that channels anxieties into ideologically preferred or sanctioned solutions … there is a paradox at the center of the individualizing bias of health promotion: while the effort to increase individual protection certainly preoccupies a health conscious public with personal lifestyle changes and medical monitoring, that very preoccupation continues to heighten awareness of dangers generally. Conversely, the experience of endangerment from environmental or workplace hazards engenders both an investment in individual protections and a sense of their limits (Crawford 2004, p. 512).*

From this, the concept of hazards seems to fit with contemporary politics and can be viewed as a feature of public debate, and also as a key dimension in Beck's "risk society" (Beck 1992; Crawford 2004). This is likened by Crawford (2004) as the hazards being a "culture of fear" which is almost intangible in nature, rather than something more definitive (Crawford 2004, p. 508). Crawford (2004, p. 513) considered risk to be "a kind of knowledge about potential hazards (or, more broadly, harms and benefits), a way of ordering their magnitude". From this, clearly, healthcare professionals' are motivated to not only acquire the knowledge of potential hazards (risk), but also, healthcare has become synonymous with considerations of potential dangers. As such, healthcare professionals become “gate keepers” who aim to provide appropriate care to patients, which include “educating” them to the potential healthcare risks, dangers, and hazards that the patient may be exposing them to. Crawford (2004) illustrates how this might look in modern-day healthcare practice:

> *… [m]otivating ‘at-risk’ people to give up behaviors that are psychologically useful, socially supported, peer-pressured, habitual, or to adopt behaviors that require continuous effort over a lifetime and continuous fine-tuning, compels the messenger to shake loose defenses by whatever scare tactics can be devised. The humane goal of reducing future suffering, a professional obligation, authorizes extreme measures. Health promoters and advertisers must continually discover new ways to subvert the human longing to feel safe and the penchant for discounting danger (Crawford 2004, p. 509).*

2.8 Anxiety: One manifestation of the “risk society”

> *… the contemporary risk climate is one of proliferation, multiplication, specialism, counterfactual guesswork, and, above all, anxiety … (Elliott 2002, p. 294).*

As Beck and Giddens contend, the institution (and for the purposes of this thesis, the inpatient ward) is bound together through a range of socially constructed practices. Inherent within any institution, a paradox of incalculability and un-decidability may arise (Scott 2000). To reiterate, risk is inseparable from the background of uncertainty and probability, but is nevertheless, a mobilising force (Giddens 1999d); meaning that this incalculability must be transformed into calculations of risk (Beck 1997). This mobilising force, on an individual level, has the ability to create anxiety as people move from crisis to crisis, and this generates displacement strategies that enable the promotion of a higher degree of security (Scott 2000). Giddens (1990) theorised that the social system of people is founded on employing rules, and these rules are reproduced by way of routines and rituals either knowingly or unknowingly. The need to adhere to these rules and rituals becomes a mobilising force and a means of reducing anxiety (Giddens 1984). This mobilising force moves in to a cyclical motion between excessive anxiety and the demand for control:

> *… [t]he danger of danger, however, is that politics motivated by insecurity continually threaten to explode the boundaries of that management. Insecurity is an experiential state prone to displacements, contagion and amplification. Ulrich Beck's prediction of a politicized 'solidarity motivated by anxiety' (1992: 49) has become a boardroom nightmare. The problem is an unstable cycle of excessive anxiety and excessive demands for control; that is, anxiety and control outside authorized parameters of concern and action. At stake is a loss of confidence in the orderliness of danger and therefore the efficacy of normative and normalizing protections (Crawford 2004, p. 512).*

In applying theories of risk to healthcare settings, including the concept of normative and normalising protections, Isabel Menzies (1960) provided a particularly useful adjunct to the overall argument. She was highly regarded as an adult and child psychoanalyst in the Kleinian tradition, but equally, was highly regarded as an organisational consultant and researcher in nursing and healthcare in the 1960s (Barnett 2008). Her research interests were varied however, and her research ranged from motorcycle riders, central heating, and children's lolly eating habits. Her methodology (gained from her background in psychoanalysis) was considered to be "field work", now known as action research, and this level of observation was considered to be a new methodology in her time (1930-1960) (Barnett 2008), which was well before the social critique of institutions. She considered the unconscious and organisational dynamics of observation, applying this to groups, institutions, and individuals, and her:

> *… now famous work on nursing and the defensive use of hierarchies in an attempt to deal with the anxiety surrounding illness and death is relevant to the current NHS and to other organizational structures hiding behind apparent rationality (Barnett 2008, p. 332).*

Barnett (2008, p. 333) stated (from personal conversations) that Isabel Menzies "was disappointed at how little structural change occurred in most hospitals", despite such ground-breaking research and her well-known papers. In 1960, using what is now known as "action research", Menzies studied 70 nurses in addition to senior medical and lay staff in a large general teaching hospital in London. The initial aim of the study was to develop new methods to be applied in the conduct of nursing tasks. However, what was discovered through this study were high levels of distress, tension, and anxiety exhibited by nursing staff. As a result of the initial findings, the study became more ethnographic in nature and was altered in order to gain an understanding of the nature of this anxiety and to explore the reasons for its intensity.

2.8.1 Menzies theory

2.8.1.1 Outline

Menzies (1960) theorised that social organisations are influenced by a number of factors that interact with each other. These include relationships, technologies, and the needs of members for social and psychological satisfaction, notwithstanding their need for support when dealing with anxiety. The struggle against anxiety can lead to individuals developing defence mechanisms that are socially constructed, and heavily influenced by organisational structures, and the culture and function of an organisation. These become an externalised reality and one way to unconsciously manage anxiety. For example, ward routines, which can be seen by others as a reality, become part of the ward’s structure. Menzies (1960) argued that many rituals, such as ward routines, undertaken by nurses to manage risk are designed to reduce clinician anxiety. She allows us to see what risk looks like in the clinical setting and that anxiety is a self-reflexive cycle (as I have diagrammatically conceptualised in Figure 3). This means that manufactured uncertainties, as theorised by Giddens (1994b) and described by Crawford (2004), play out as anxiety in the clinical setting. This anxiety then leads to the development of tools to assess risk, and these are intended to decrease anxiety but actually lead to increased anxiety. It could be argued (although not explicitly identified in Menzies’ study) that the tools (or as Menzies hypothesised, “checks and counter checks”) could contribute to manufactured anxiety achieved by framing a patient’s experience through a risk lens.

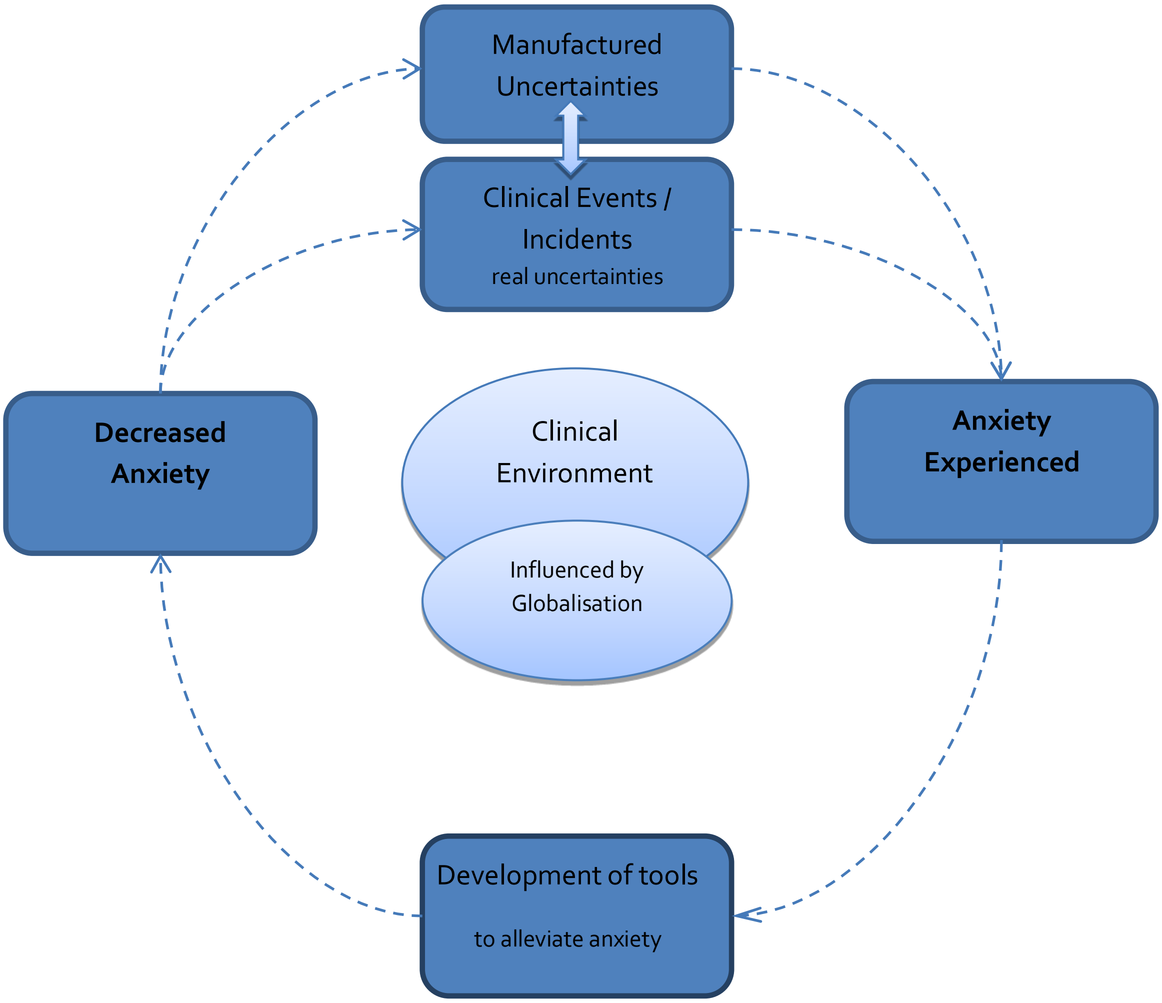


Figure 3: Social systems as producer of, and defence against, anxiety

Source: Original conceptualisation from the work of Menzies (1960) and Beck (1999)

When considering the concept of risk in the context of healthcare and the identification of such, this results in anxiety being generated within clinical professionals when it cannot be measured or planned for (Menzies 1960). From this position, anxiety within the individual clinician is felt resulting from the socially constructed risks, as explored earlier in this chapter. Menzies' theory resonates with Lazarus, a social psychologist who published a series of papers in the 1990s on coping and emotions (Folkman & Lazarus 1990; Lazarus 1993; Lazarus 1990). Lazarus (1993) theorised that the core of anxiety is uncertainty. Feelings of uncertainty produce strong drives to objectify the source of anxiety, and this externalises the threat with the objective being to reduce the feeling of uncertainty. However, the problem with this is that once the "threat" has been assuaged, another takes its place, since the threat is existential (Strongman 1995, pp. 8-9) and resonates with Beck's notions as well. Likewise, Menzies (1960) suggested that displacement strategies are used by clinicians as a means to relieve the anxiety they feel (Menzies 1960), and their defensive practices arise to protect themselves from blame. This takes the form of institutional and individual clinical risk practices (Warner 2006, p. 232). As will be explored in depth later in this thesis, some of the ritual displacement strategies which reduce the need for decision-making (Philpin 2002) include the "handover" ritual. The handover ritual allows nurses to convey, at the time of the handover, judgements about a patient's demeanour or personality (even though this is a prohibited act), but this prohibited knowledge is disguised through carefully discussed wording (Evans, Pereira & Parker 2008), the creation of a task list (Philpin 2002) and, in addition, supervisory task allocation; all of which serve to protect the practitioner from stress (O'Brien & Davison 1993). From this, I argue that RAM is a strategy of risk displacement which is aimed at reducing levels of perceived risk, and concurrently, the levels of anxiety experienced by the clinician.

Menzies' work in this area informs this thesis in a meaningful way. The section below firstly introduces the reader to a very brief summary of Menzies' findings in her study. Then, her findings that are of particular relevance to this thesis are considered. These significant findings are: the avoidance of change, nursing rituals and routines, depersonalisation, institutional practices, tools that transfer responsibility, and the simultaneous interaction of defence systems (Menzies 1960).

2.8.1.2 Menzies' key findings

Central to the argument of this thesis are the key findings of Menzies. The description of these allows the reader to gain further understanding as to how clinicians operate in the clinical setting. Menzies' (1960) findings hold true in this current climate (see Figure 4) despite her research being nearly 60 years old, including:

Findings	**Modern Day Operationalisation**
Splitting up the nurse-patient relationship.	○ *The core of anxiety lies with the nurses' relationship with their patient.* ○ *When the nurse becomes closer in their relationship, levels of anxiety within the nurse will increase. By increasing patient-load, essentially the nurse is offered protection from anxiety due to the emotional distance toward the patient this increase of load promotes. (p. 101)*
Depersonalisation, categorisation and denial of the significance of the individual.	○ *The task list system inhibits the development of the nurse-patient relationship and leads to anxiety. (p. 101)*
Detachment and denial of feelings.	○ *A nurse must develop adequate professional detachment from the patient. (p. 102)*
The attempt to eliminate decisions by ritual task-performance.	○ *Decision-making creates uncertainty of outcome and creates conflict and anxiety. (p. 103)*
Reducing the weight of responsibility in decision-making by checks and counter-checks.	○ *Reducing the final committing decision and this postponing action (and as such the resultant feeling of being anxious) by implementing counter-check procedures.* ○ *This might take the form of checking and counter-checking medication dosages prior to administering this to the patient. (p. 104)*
Collusive social redistribution of responsibility and irresponsibility.	○ *Nurses attempt to split off aspects of themselves from their personality and project them onto other nurses.* ○ *They use this denial to protect their own personal identity. (p. 104)*
Purposeful obscurity in the formal distribution of responsibility.	○ *"the formal structure and role system fail to define fully enough who is responsible for what and to whom" (p. 105)*
The reduction of the impact of responsibility by delegation to superiors.	○ *In a hospital setting, tasks seem to be forced up the hierarchy so responsibility for performance can be denied. (p. 106)*
Idealization and underestimation of personal developmental possibilities.	○ *To reduce anxiety, nurses seek assurance that the nursing staff are competent and responsible. If that premise holds true (albeit their perception), then all nurses must be competent and responsible, are idealised and as a result do not require personal development. (p. 107)*
Avoidance of change.	○ *Change becomes an excursion into the unknown, requires a commitment to unpredictable future events, and this then evokes anxiety and doubt.* ○ *This is now endemic and seen as the "ideal" in management. (p. 108)*

Figure 4: Interpretation of Menzies Key Findings

Reproduced directly from Menzies (1960) key findings with original interpretation

Some of Menzies' key findings relevant to this thesis will now be explored.

2.8.2 Avoidance of change

In Menzies' study, nurses tended to cling to familiar tasks even when those tasks ceased to be appropriate or relevant (Menzies 1960). Change was initiated by these nurses only at the point of crisis. Anxiety and the uncertainties that surround change, as well as the perceived consequences of the change, inhibited the nurses' planning and decision-making processes. Change implies the unknown and its future consequences cannot be completely predicted. This, in itself, can produce feelings of doubt and anxiety for clinicians. Yet, Menzies found that the hospital (i.e. the work organisation) required flexibility for nurses dealing with sick leave, the proportion of acute patients, and the subsequent fluctuating workload. Despite this, the need for flexibility co-existed with remaining rigid in what they did; which then became a “reiteration of the familiar”. They clung to the familiar, and initiated change only when in crisis (Menzies 1960, p. 109). Menzies (1960) theorised that by ensuring familiarity, constructive planning and decision-making are inhibited. However, it must be acknowledged that since the advent of “evidence-based practice” (EBP), the initiation of change is present although, with this change, the redistribution of “blame” now rests with the research available to date (Guyatt et al. 2002; Leape, Berwick & Bates 2002). In this way, while unfamiliar practices are emerging, if anything goes wrong, then the blame is left squarely on the research findings, and the organisation or regulatory body who demand EBP, rather than the individual nurse (Wachter & Pronovost 2009).

2.8.3 Rituals and routines

As touched upon previously, rituals and routines are a central aspect of contemporary healthcare settings (Crawford 2004). Menzies (1960) argued that nursing rituals and routines were developed by clinicians to control the anxiety that they experience, which included aspects of controlling safety on the ward (a socially constructed defence mechanism) ultimately to control risky behaviours exhibited by patients (Crawford 2004; Mosel 2011b). These social practices were developed and became part of institutional practices (Mosel, Gerace & Muir Cochrane 2011; Mosel et al. 2010). These findings can be aligned with Giddens' (1994c) central concept that routines, and the reproduction of these, form a reflexive process which serves to promote “ontological security” (Giddens 1979). In other words, Giddens' theorised that there is a basic need for individuals to have “a sense of continuity and order in events, including those not directly within the perceptual environment of the individual” (Giddens 1991a, p. 243). It is a prerequisite for self-identity and agency and contributes towards an understanding of the self (part of the reflexive process) and becomes a narrative (Krolikowski 2008). “To be ontologically secure is to possess, on the level of the unconscious and practical consciousness, ‘answers’ to fundamental existential questions which all human life in some way addresses” (Giddens 1991a, p. 47).

2.8.4 Depersonalisation

Nurses depersonalised their patients in the face of anxiety, detached from and denied their feelings, avoided change if possible, and felt deprived of personal satisfaction (Menzies 1960, pp. 101-13). The result of this were attempts to eliminate decision-making by undertaking task-performance rituals (for example, by “reducing the weight of responsibility” in the decision-making process by instigating “checks and counter-checks”), and became a means of “collusive social redistribution of responsibility” by nurses (Menzies 1960, pp. 101-13). These checks and balances were the methods employed in order to reduce the anxiety felt by clinicians in the hospital setting and were used as a social defence system. However, these methods, while facilitating the avoidance of anxiety, did little to actually modify or reduce it (Menzies 1960). This indicates that some nursing interventions in current-day practice may be formulated to avoid anxiety rather than being based on evidence or on being of value to the patient (de Klerk 2012; Lawlor 2009; Smith & Allan 2010).

2.8.5 Institutional practices

The institution creates a number of practices in order to minimise risk and its negative consequences (for the institution) (Menzies 1960). Ultimately however, these risk practices and subsequent actions by individuals require decision-making. As a consequence, the patient is affected by these decisions, which are actually aimed at assuaging the personal feelings of the clinician and to avoid “social chaos and individual breakdown” for them (Menzies 1960, p. 118). Attempts are then made by the institution and the clinician to modify the patients’ behaviour if it is perceived to be risky by the clinician. This preoccupation with the assessment of risk and danger in Australian mental healthcare, coupled with anxiety, can lead to “control and containment approaches to behavioural problems rather than supportive management" (Parker, Kilroy & Hirst 2009, p. 48). This circular pattern of containment and anxiety alleviation then feeds into each other.

Menzies' findings are particularly important when considering the nature of risk and the complexities associated with this, particularly in a hospital (institutional) setting. This is relevant for this research, as there is a need to understand the motivations behind clinicians' behaviours, and to anticipate the resultant actions. This also includes understanding how clinicians work within this and other frameworks (such as the Recovery Model) (Warner 2006, p. 233). Requiring further exploration is whether clinicians who implement these ritualistic practices understand the origins of these rituals, or whether they simply follow the lead of others.

2.8.6 Tools that transfer responsibility

Tools such as risk assessments are useful for guidance in a profession as they transfer the responsibility to the tool rather than to the individual (Menzies 1960). For example, a checklist approach has the ability to discourage clinicians from thinking laterally (Sawyer 2005). Menzies (1960) considered these aspects when she examined why nursing rituals are ineffective. The rituals are defunct in their utility and become actions that illustrate the bureaucratic nature of the organisation, rather than being about the patients. In a psychiatric ward, these rituals may consist of risk assessment forms (checks and counter-checks), the locking of ward doors, and care structuring. However, if one considers the locking of ward doors – this communicates to patients and staff that a risk exists (Luhmann et al. 2005). This risk remains until the doors are unlocked.

2.8.7 The simultaneous interaction of defence mechanisms

Depersonalisation and categorisation of patient behaviours are two examples of defence mechanisms that directly apply to the assessment and management of risk, also interacting with each other simultaneously, as identified by Menzies. In fact, this can be seen in the contemporary literature that considers risk in clinical settings (see:Carroll 2009; Lamont & Brunero 2009; Langan & McDonald 2008; Langan

2008; Petrila & Douglas 2002, p. 75), as well as in the variety of approaches taken towards risk (for example: actuarial risk assessment). For example, a patient is categorised according to their “disease”, after which the patient then ceases to be a person. Rather, they become a group of characteristics based on the behaviours that represent the disease (Menzies 1960). In the latter, this relies on levels of statistical significance and a range of pre-determined categories assigned to each patient’s behaviour which then determines the level of risk. Moreover, the reliance on static factors (which include previous history of behaviours, age, diagnosis, and gender) (Muir-Cochrane & Wand 2005) adds another dimension to this categorisation. This is in keeping with Castel’s (1991, p. 288) theory that “[o]ne does not *start from* a conflictual situation observable in experience, rather one *deduces* it from a general definition of the dangers one wishes to prevent”. As a result, risk is calculated on the basis of a systematic form of pre-detection.

One can posit further that the use of actuarial forms is self-referential (Luhmann et al. 2005) whereby the use of such documents creates a need for risk, because if there is no risk, there is no need for actuarial science. So, when there is risk awareness, there arises scientific awareness. It is easy to see this link when considering another defence mechanism identified by Menzies (1960, pp. 99-105) which she identifies as “detachment and denial of feelings” followed by attempts to “eliminat[e] decision-making by ritual task performance”. Filling out risk assessment forms is one such ritual that not only feeds into risk as being self-referential, but which also enables the clinician to depersonalise and objectify the client. Decision-making also implies some level of uncertainty of outcome. Menzies (1960) suggested that the responsibility for decision-making can be reduced (as another anxiety-relieving defence mechanism) by implementing checks and counter-checks. This can again, be linked back to assessment approaches (e.g. actuarial).

2.9 Conclusion

The perspective presented in this chapter attempts to provide the theoretical guidelines to make sense of risk within society (Debrix 2004). Risk theories, from a social constructionist position, have the potential to provide a contextualised understanding of risk and its implications, and of risk behaviours, within social, cultural, political, and economic contexts.

The use of risk theorists (Beck and Giddens), as well as Menzies' findings, provides an ideal background towards understanding the issues faced by healthcare professionals. However, one should consider that Beck and Giddens' theories contain abstract perspectives that have not been operationalised nor empirically tested (Lupton & Tulloch 2002, p. 319). Menzies (1960) is useful for this purpose as she explores the social defence mechanisms of nurses within their clinical environment. The identified socially-influenced defence mechanisms are present as an element within the structure, culture, and mode of functioning of this environment. These defence mechanisms are an external reality, arising through agreement and collusive interaction between members of the organisation. Accordingly, Menzies' research can be utilised in this thesis when examining the defence mechanisms that exist in the context of anxiety (for example, actuarial tools, locking of doors, and risk aversion), which can then be further understood through the application of risk theory. As such, Beck considers the language of risk as always being social, and the perception of risk itself as creating anxiety.

Through this lens, the analysis of risk perceptions, knowledges, and the attitudes that clinicians have towards risk will be realised. These theories can illuminate established codes of practice in institutions and allow them to be challenged. As well, the disclosure of subjective and biographical experiences will be included and an account of how the incorporation of these experiences can be projected to the future offered (which includes how desired possibilities may be actualised) (Adam & Van Loon 2000). The use of these theoretical positions informs this thesis in a meaningful way and allows a consideration of how risk and its assessment are socially constructed within mental health settings. As such, these theories guide this current study and provide a context grounded in logic, and which directs the research towards specific conclusions (Crotty 1998), accounting for the dynamic variables, case-specific influences, and the contexts that surround risk assessment, risk management, and risk behaviours. These findings may then aid effective clinical practice designed to be of benefit to the patient (Doyle & Dolan 2002; Mosel, Gerace & Muir-Cochrane 2009; Woods & Lasiuk 2008).

To conclude, as Ewald contends:

> *… [i]n everyday language the term 'risk' is understood as a synonym for danger or peril, for some unhappy event which may happen to someone; it designates an objective threat … nothing is a risk in itself; there is no risk in reality. But on the other hand, anything* can *be a risk; it all depends on how one analyzes the danger, [and] considers the event (Ewald 1991, p. 199).*

I will now move onto the next section of the thesis, where I establish the state of play in mental healthcare. This is a sociological account of the history of mental healthcare, interpreted through the theoretical tenets that I have presented in this chapter.

3 SOCIOLOGICAL DISCOURSES AROUND MENTAL HEALTH AND “RISK” IN THE CLINICAL SETTING: FROM BADNESS TO MADNESS TO RISKINESS

3.1 Introduction

The importance placed on RAM in contemporary mental healthcare can be understood through an examination of past practices and development. Historical notions of risk, rather than constructions of mental health and mental healthcare, tell us very little about today’s risk, because it is not risk that has changed, it is instead society that has changed. Society has moved into an era in which “risk” has come to dominate our decision-making processes in every aspect of our lives, although there is one caveat, according to Beck (1992); through rapid technological development, we have transformed into a society where the balance of risk has shifted from natural risk to human-induced and human-created risk.

Natural disasters can be generally thought of as being produced by a non-human force (a pre-given arising from the “gods”) such as an earthquake, whereas human-induced or created risk implies that there is human agency in the creation of the risk, such as the rise of technological, chemical, industrial, and nuclear dangers (Beck 1996; Elliott 2002). These can be thought of as manufactured and external risks, and could include for example, pollution and crime. Other such examples might be a flood (natural disaster), war (manufactured), or the possibility of a stock market crash (manufactured uncertainty). In the case of manufactured risks, human agency is high when both producing and mitigating these issues. Decision-making is also key and societal intervention transforms hazards into something that can be calculated, yet paradoxically, becomes a defensive attempt in order for social institutions to avoid new problems; such as through the high regulation of the nuclear power industry as a result of disaster which saw the industry abandon its plans of expansion because of social concerns (Beck 1994). This means these risks are “dependent on human decisions, created by society itself, immanent to society and thus non-externalizable, collectively imposed and thus individually unavoidable” (Beck 2014, p. 181).

This chapter focuses on historical constructions of mental health and the mental health patient over the last 300 years, rather than directly on constructions of risk, although as will become clear here, risk comes into play in the last historical stage (“risk society”). In this chapter, I argue that the patient has transformed from a state of badness to madness to being a “risk”. Over time, the apparent deviant behaviour of the mental health patient has shifted from being labelled as a sin, to a crime, to illness/madness (Conrad 1975, 1992), and finally to risky behaviours. This analysis provides the background to the way in which risk plays out in the contemporary clinical setting in the following chapters, as a transition from “badness” to “madness” to “riskiness” that I extrapolate in this chapter using the theoretical interpretations examined in Chapter 2. As illustrated below, Table 1 outlines the social forces and incidences that have produced these shifts over time:

Table 1: Historical constructions of mental health and the mental health patient

Source: Original conceptualisation

Transition	**1700-1900**		**1900-1970**	**1970-2016**
Identified social forces	o Impact of industrialisation on concentration of populations o Poverty o Loss of community		o Rise of medical science o Invention of population health o Rise of the welfare state (post-war) o Rights of citizenship fully affirmed (1967)	o The beginning of the decline of the welfare state and the rise of neoliberalism o Deinstitutionalisation (changing of paradigm – risk of mental illness is not contained – but in the community) o Increasingly global economy and rapidly increasing globalisation o Unfolding post-industrial society underpinned by neoliberal ideology o Risk pooling and individualisation of risk
Definition of behaviour	o Sin (badness)	o Crime	o Illness (deviant / mad)	o Risk (badness)
Agent of social control	o Church	o Legal System	o Medicine	o Medicine and the legal system
Custodial institution	o Church	o Alms-house (Church)	o Asylums	o Clinics and the community (family)
Containment	o Control of non-productive behaviour (e.g. alcoholism)		o Sanctuary for the weak	o Management of risk
Changing Labels	Badness (Sin) → Crime →		Illness ↳ Madness →	Riskiness →

The table represents the three eras that are presented in this chapter, each one corresponding to changes in the overall social configuration of people with a mental illness within the Western European context. The first period extends from 1700 to 1900. During this period, mental illness was equated with “badness” and heralded a transition from “gaol” as the custodial institution to the establishment of lunatic asylums in Western society which transformed “sin” to that of “illness / madness”

(Fabrega 1991; Scull 1977). The second section covers the years between 1900 and 1970 and describes the transition of mental illness from “badness” to “madness”. During this time, mental disorder evolved to being conceptualised by society as an illness. The “risk society” is then considered as the third era, and dates from the early-to-mid 1970s to the present. This era evolved within the mental healthcare arena, manifesting itself in practices that deal with the calculation of patient risk or danger, whereby consumers/patients are seen to pose a risk due to their “risky behaviours”. In the final sections of this chapter, psychiatric RAM in its current form is examined, in addition to developments within the consumer movement and the shift in mental health service delivery. Uncertainties and anxieties that stem from contemporary modernity are also unpacked, which reveal Beck’s concept of reflexivity as a perpetual cycle in the context of changing nursing practice.

3.2 Badness equals Sin and Crime: Social deviance and mental disorder (1700-1900)

> *An analysis of theory and research in social psychology reveals that while methods of research are scientific in character, theories of social behavior are primarily reflections of contemporary history. The dissemination of psychological knowledge modifies the patterns of behavior upon which the knowledge is based. It does so because of the prescriptive bias of psychological theorizing, the liberating effects of knowledge, and the resistance based on common values of freedom and individuality. In addition, theoretical premises are based primarily on acquired dispositions. As the culture changes, such dispositions are altered, and the premises are often invalidated (Gergen 1973, p. 309).*

3.2.1 Badness, the Church and the Industrial Revolution

For the purposes of this thesis, I am situating this chapter within the Australian context and its historical backdrop. From this perspective, the history of mental health constructs and risk in mental healthcare stems primarily from Great Britain (GB) and from South Australian colonial life. In GB, badness was associated with very specific groups of people from the early modern period through to the Industrial Revolution (early 1700s to early 1900s) in which there were mass migrations of people from the countryside to the cities looking for work as the countryside became increasingly “swallowed up” by land-owners, increased mechanisation of large-scale agriculture, and the Enclosure movement, among other developments (Landes 2003). This meant that there were push and pull factors, such as unemployment and poverty (push) and new opportunities and the search for stability (pull) (Landes 2003). The standards of living were generally poor, with food and nutrition also being poor, with chronic hunger and malnutrition common (Scull 2005).

In this era, Christianity dominated constructions of morality despite the dissolution of the Church’s role in civil society which rendered the Church’s response to the indigent unworkable (Scull 2005; Weber 1958). Not only was the Church’s land redistributed because of the clash between them and the state, but also, the Church’s funds were reduced, and charity was curtailed (Scull 2005). The reduction of funds available to help the poor affected the attitudes of people’s dependence on aid; although this change in attitude did not disappear immediately (Scull 2005). Ironically, due to this situation, societal views began to shift and charitable deeds diminished while issues of “worthiness” to receive aid arose (Scull 2005). In addition, the population of GB doubled between 1700 and 1800, and by 1900 had nearly doubled again (Scull 2005). This increase in population, and the increased mechanisation of agriculture, created an “army of vagrants, beggars, and idlers, no longer needed on the land” (Scull 2005, p. 12). The rise of science had the most profound effect which superseded the Church along with the shift from agriculture to industrial production. In this way, there were two social forces, one in the realm of ideas and the other creating social and industrial change (Scull 1977).

This was the era of the Industrial Revolution. The revolution created a middle class of industrial owners and professions, as well as the creation of factories and child labour (Scull 2005). The birth of trade unionism occurred along with the Protestant work ethic thereby buoying the revolution (Weber 1958). Foucault (1965) suggested that, in this era, those considered to be “mentally ill” were the marginalised populations; and it can be seen that the social structure of this time greatly affected the definition of madness (Ahmed 2013). Without exploring the “multiplicity of ideas” that surround the notion of “madness” (Midelfort 1981), “mental disorder” was a label that was ascribed to particular people who were judged to be socially deviant and considered to be “bad” (Foucault 1965; Giddens 1993). The recognition of social deviance is described as an attempt by those powerful elements in society to control persons displaying deviant tendencies and those who challenged the moral values of the bourgeois class, meaning those behaviours that fell outside of orderly social life (Erikson 2011). This is reflected in the writings of Henry Fielding, who in 1751, mused in his book “An Enquiry Into The Causes Of The Late Increase Of Robbers”:

> *… the introduction of trade … hath indeed given a new face to the whole nation, hath in great measure subverted the former state of affairs, and hath almost totally changed the manners, customs, and habits of the people, more especially of the lower sort (Fielding 1751, pp. B,6).*

In other words, people who did not conform to class values were ascribed a level of deviancy (Foucault 1973). The deviant tendencies are difficult to describe given that deviance, in itself, is only defined as deviant behaviour when “the sanctions governing conduct in any given setting seem to be contradictory” (Erikson 2011, p. 208). Deviance can be thought of as conduct that should be minimised or addressed because of the label conferred to it by social control agencies (Erikson 2011). The social audience seeks to control one of its member’s behaviours, but this process of selection is intricate, and historically, may be based on a very small number of deviant tendencies (or sometimes a single one) that are “set within a vast context of proper conduct” (Erikson 2011, p. 209).

3.2.2 Social order

One form of control was detention in an asylum, although asylums came about due to the slow construction of deviance as mental illness (which is considered later in this chapter) (Scull 2005). However, the asylum was initially intended to be established as an institution in which “the threatening army of idle vagrants and beggars could be confined and kept under surveillance” (Scull 2005, p. 13). During the rise of the asylums, they were first known as an “almshouse” (in the 17th century) where “no efforts were made to classify inmates [sic] according to the (supposed) underlying causes of their pathology” (Scull 2005, p. 16). Instead, they served to confine troublesome and/or dangerous lunatics (Suzuki 1992). Nevertheless, this control over certain parts of the population was an attempt to maintain social order

(Erikson 2011) and, although a contentious issue (as we now know that people with identifiable clinical symptoms of mental illness are more than just this), Giddens (1993, p. 144) identified the “mentally disordered” as those who may be unable to acknowledge the “complex conventions” that exist within institutions or broader society.

In a “lived” example of deviance and/or dangerousness, and to demonstrate the lineage of “risk” in mental health, in 1872 Dr. Clouston clearly highlighted the ease with which a person could be detained in a lunatic asylum:

> *[l]ess than fifty years ago, the question of sending an insane patient to a lunatic asylum was a very simple one. It was determined solely by the fact of the patient's being dangerous to others or to himself, chiefly by the former consideration (Clouston 1872, p. 96).*

In some ways, “dangerousness” was the discourse of the Victorian era; women, sex, the disease of consumption, alcohol, gambling, vagrants, and the unemployed were all considered to be “dangerous” (Fielding 1751; Scull 2005). I argue here that the same groups (and many of the same issues) are now considered in the discourse of risk because this is the current discourse through which ideas are framed. Some of these notions are further illustrated below, when Dr. Clouston (1872) extended his thinking in his advocacy against detention in lunatic asylums by weighing up the various forms of insanity that meant automatic detention in an asylum. He clearly illustrated the disparity between the classes in addition to the moral climate of the time: “Among the rich, such cases need never be sent to asylums. Among the poor, no cases are often so much benefited by asylum regimen and treatment” (Clouston 1872, p. 98). The whole point in this chapter is that there has been a shift from sin to risk, and this shift was influenced by the societal view that class determined the levels of “sin” assigned:

> *In any sort of mental disturbance, if the circumstances of the patient be such that they manifestly aggravate it, or if no proper attendance can be got, or if the patient have evidently not sufficient food, there can be but little question about sending him to an asylum … I shall briefly go over the different groups into which Dr. Skae divides insanity. His first group is congenital insanity, comprising idiocy and the various degrees of imbecility … The next group, that of epileptic insanity … is a tendency to great violence and excitement after the fits ... The insanity of masturbation comes next ... The same observations apply to hysterical insanity in*

> *the female, and to the short attacks of mania that sometimes occur at puberty (insanity of pubescence) in both sexes. In the case of puerperal insanity, everything depends on the intensity of the symptoms and the circumstances of the patient … Among the very rich, almost no cases of puerperal insanity need be sent to asylums; but they must often be sent from home, under the care of proper attendants. Among the very poor, on the contrary, I believe nearly every case would get better much sooner, and more satisfactorily, if sent to asylums … In the case of senile insanity, all must depend on the violence of the symptoms and the circumstances of the patient. Among the rich, such cases need never be sent to asylums. Among the poor, no cases are often so much benefited by asylum regimen and treatment (Clouston 1872, p. 98).*

In the asylums, “deviants” or “madmen” were handcuffed, chained, and sometimes beaten (Scull 2005). Medical opinion during this era was that these “madmen” could only be controlled using fear (Scull 2005). This control by fear and the public opinion of the time was exemplified by Dr. Clouston in 1872 (who actually took an “enlightened” stance), when he weighed up the benefits of institutionalisation versus in-home care:

> *At home, the patient is placed in his usual circumstances, is not disturbed and confused by unusual and unknown ways and surroundings. He has the care of relatives, whose affection and solicitude may make up for all the skilled attendance in the world; whose persistence may be a match for even insane obstinacy; whose watchfulness has none of the eye-service of the hireling in it; and whose forbearance is the result of higher motives than rules and regulations. He has no fellow-patients to irritate or annoy him; he is not lost in a crowd. He is treated as an individual, and gets sympathy for small ailments that he would get nowhere else. … The disadvantages of home-treatment are, on the other hand, the want of special rooms and appliances; of skilled attendance and supervision; of means of controlling sudden outbursts of violence; the usual abundance of means of committing suicide; the impossibility of making friends understand and guard against the cunning and method that are so often found in madness; the difficulty of giving food and medicines, and of making the patients take proper out-door exercise; the absence of medical help in sudden emergencies; and the absurd fear of the insane which those not accustomed to them often have. Then there is the great difficulty of properly disposing of the patient at night, and giving him proper attention without keeping him awake by over-much watching. In many cases, there is a strong dislike to those nearest and dearest to the patient, and an extreme impatience of control by any relative or friend … But, perhaps, the greatest disadvantage of all in an asylum is the damage and discredit that are supposed to result to the patient from his having been an inmate of one. This is unquestionably a most serious matter to most persons. It results partly from a popular prejudice, and partly from the known fact of the tendency of insanity to recur in many cases; so that it is thought the patient ‘cannot be trusted’ again (Clouston 1872, p. 97).*

3.2.3 The Transition

According to Porter (1987) and Foucault (1965) (despite their disagreement about the timing), the previous era started to metamorphose into the “great confinement” that swept across Europe in the latter part of the 17th century through to the 18th century; becoming firmly established by the 19th century. Confinement within an asylum for those who were considered deviant or bad served a social purpose in that they were segregated and then integrated into institutions, which severed any interaction with wider society (Foucault 1965). Porter (1987, p. 64) went as far as to say that capitalism was also a driving force in the “explosion” of asylums as “no diseases were so lucrative as the nervous kind”, the implication being that it was a humanizing act to define the sin/crime as an illness and to promote “care” for the mentally ill.

Those who were assessed as displaying deviant behaviours (some being constructed as mental disorders) were incarcerated in asylums along with the poor, the “work shy”, the homeless, and a range of criminals, and were ostracised from society (Crowe & Carlyle 2003). They were not clinically diagnosed as “mad”; instead, they were removed from society because they were “bad”. So, madness became the new badness. The lunatic asylum then became a “culturally legitimate alternative” for society to cope with “disruptive” citizens (Scull 2005). Scull (2005) convincingly argued that, within this era, the increasing numbers of individuals certified with a mental illness, or “insanity”, was because the government provided facilities, such as large asylums, in order to accommodate the various “misfits”, who at other times in history would not have been considered “crazy”, but would have nevertheless resided on the margins of society. In this situation, the “mentally ill” now came under the control of the legal system.

3.3 Madness in the 19th and 20th Century: Transitioning to illness

In the previous era, through governmental discourses, dangerous classes and individuals were identified; the identification being based on judgements about their living conditions and the moral climate of society at the time (Lupton 1999). Throughout this era, a shift occurred from “badness” to “madness”, and madness now also became a form of danger (Hewitt 2008, p. 187). This shift culminated in various forms of legislation; for example, in Britain, the Lunatic Acts of 1845 provided the medical profession with a central role in the treatment of the mentally ill (Scull 2005). This shift meant that the discourse of madness allowed the removal of “bad” people to be extended to “misfits” (Scull 2005), and could be seen as a means to assure the protection of those classes seen to be at risk of “contamination” by dangerous groups or individuals (Lupton & Miller 1999). These individuals were placed in lunatic asylums, which then became known as institutions of containment (Crowe & Carlyle 2003; Hewitt 2008; Morrall & Hazelton 2000) or custodial warehouses (Scull (2005).

In the 19th and 20th centuries, “a profound shift in the cultural understanding of madness took place” (Scull 2005, p. 91). Madness was now associated with the rise of the medical sciences and psychiatry in the latter quarter of the 19th century and throughout the first three-quarters of the 20th century (until the mid-1970s). The power of these sciences and the growing strength of, and faith in, science (psychiatry, penicillin, space travel, and the automobile, as well as distance transmission technologies such as the telephone, the television, and radio) gave institutions associated with these sciences tremendous power, particularly over those who approached them for services or assistance (Beck 1992; Foucault 1965; Scull 2005).

The “rise” of the medical profession also played a role in the context of defining “madness” (Scull 1977; Sherry 2003). No social groups assumed responsibility for these “outcasts” in the asylum “until the mid-19th century, when” under the “gaze” of the medical profession, “various types of phenomena” within these individuals in the institution were recognised and then descriptively categorised (Crowe & Carlyle 2003, p. 20; Scull 2005; Scull 1977). Through the descriptive categories, the notion of madness then came into being as a definitive mental illness (Foucault 1965; Foucault 1973).

In other words, Rosenberg (2006, p. 121) contested that the medicalisation of deviance came about through society’s predisposition to “re-categorize sin(s) as pathology(ies) and to consign the management of such conditions to appropriately certified practitioners”. From this, the re-classification of deviant behaviours (from the 19th century through to now) has fallen into the psychiatric domain of “clinical responsibility” (Rosenberg 2006, p. 123; Scull 2005; Scull 1977). Yet, deviance in and of itself is not a “discrete and objective thing”; rather, it is “place”, “time”, and “class-specific” (Conrad 1992; Rosenberg 2006, p. 122). That said, the controversy continues still to this day surrounding the categorisation of diseases that “promise” to explain emotional pain and deviant behaviours (Conrad 1992; Rosenberg 2006).

The first part of the 20th century also brought about another profound shift and the first small movement towards “risk society” that would be fully realised half a century or more further on. The dominant thinking about risk (including the risks of mental illness) became increasingly about statistics and probabilities and, as a consequence, risk became more science-based (Castel 1991). This is the key to explaining how mental illness shifted from “badness” to “madness”. With the rise of the “psy” sciences (but not domination – this would come from the 1970s onwards) and the domination of medical science, this era increasingly saw scientific studies and measurements of mental health, but from a medical perspective (Foucault 1973). So, it is the combining of the dominant medical science with actuarial science that gave rise to the change from badness to madness (Castel 1991). Although it is important to note that this was just the beginning, it was only from the mid-1980s that the focus shifted from assessing for danger to that of actuarial risk prediction, which is described in the next section of this chapter (McSherry 2004).

This meant that risk was beginning to be seen as being manageable “through human action and the “myth of calculability”” (Shakya 2009, p. 26). It would seem that, in this era, symptoms were designated within a medical system or framework such as a “disordered manifestation” of a “diseased brain” (Scull 2005, p. 219), while characteristics (distinctive traits) were more likely to be designated through a checklist approach which became increasingly prominent in the following era. Castel (1991, p. 288) theorised that this approach no longer addressed individuals. Instead, there existed only factors and statistical correlations of heterogeneous elements. The mode of surveillance was one of systematic pre-detection. Castel (1991, p. 288) suggested that it was no longer necessary to manifest symptoms that could be deemed abnormal or dangerous. Instead, it was simply enough for the individual to display characteristics that were identified as risk factors.

Actuarial risk assessment tools started to be developed in response to what is now known as *adverse events* committed by the mentally ill (Scull 2005). Noted however, these adverse events were identified by family members, and police, etc., arising in part because of the legal requirements of the public, police, and healthcare workers that was emerging as part of the process (Grotto et al. 2015; Scull 2005). For example, Rosenberg argued that:

> *… [m]edicine in general and psychiatry in particular remain boundary managers: border examining and certifying transit documents in an unceasing battle over depression and anxiety, sexuality and addiction. Psychiatry remains the peculiar legatee of such problems, an obligate participant in every generation's particular cultural negotiations—a kind of canary at the pitface of cultural strife. It is by no means the only player. Civil and criminal courts, welfare officers, media commentators, a variety of other specialists—not to mention patients and families— all play a role (Rosenberg 2006, p. 129).*

These risk assessment tools were based on the science of probability and the accumulation of data in order to make generalised predictions of whether a mentally ill patient would "commit" such an "offence" (Godin 2004). From this, formalised systems of risk management in hospitals arose through the embodiment of danger from those diagnosed with mental illnesses that were capable of violent and unpredictable behaviour (Lupton 1999). This notion stems from the previous era with the divorce of mental illness from behaviour beginning to be realised (Davies et al. 2006). This means that previously, behaviours were considered deviant and consequently "bad". In this period (because of the interconnection between the social forces of medical domination and actuarial techniques), the behaviours were still considered to be deviant, but the person was "measured" to define them as "ill" (or not) and to be confined (or protected). Once deviant tendencies were identified, an assessment of who is "at risk" occurred (Crowe & Carlyle 2003; Foucault 1965; Foucault 1973; Morrall 2000). Crowe and Carlyle (2003) suggested that the risk present was situated within the individual. However, the decision as to whether the individual may be deviant or "not normal" rested with the medical profession, whereby the:

> *… psychiatrist has been the designated trustee of those social and emotional dilemmas that can plausibly—and thus usefully—be framed as the product of disease … [including] the precise definitions and appropriate clinical and social responses to somatic ills as well … Since its origins as a specialty in the 19th*

> *century, psychiatry has been a definer of boundaries, a delineator and designated manager of the normal and abnormal, and thus unavoidably a key participant in this never-ending debate. At the same time it has suffered from a recurrent status anxiety—one might call it procedure envy, or organic inferiority. Psychiatry has been chronically sensitive to its inability to call upon a repertoire of tightly bounded, seemingly objective, and generally agreed-upon diagnostic categories based firmly on biopathological mechanisms … Psychiatry remains the legatee of the emotional, the behavioral, and the imperfectly understood (Rosenberg 2006, p. 124).*

Yet ironically, the blame for the potential risks presented by the individual lay with the healthcare professional (Crowe & Carlyle 2003). This is because clinicians were seen to have a social responsibility to ensure the safety of the public at large (Scull 1977). So, in an organic and abstract sense, one could say that "society" sought to set up a method of control to ensure that it was protected from the "harmful" effects of deviancy (Erikson 2011). This notion demonstrates the divorce of mental illness from behaviour because, although a person was sick, they could not be held responsible for their behaviour, and thus, were to be protected in an asylum; the prevailing thought was one of public safety, morality, and control (Castel 1991; Conrad 1992; Davies et al. 2006; Erikson 2011; Foucault 1965).

I argue here that *disease* turns out to be an entity outside of its manifestation within the person (Rosenberg 2006). This view became culturally pervasive in the late 19th century when progress at this time provided "a series of intellectual building blocks" emphasising "disease as a discrete entity" heralding an "objective store of tools, procedures, models and data" to delineate measurable and precise terms; as the brain is an organ, the mind is contained within the brain, and in this way, "mental illness" became a "product of brain disorder" (Rosenberg 2006, p. 126; Scull 1977). As such, these theories were then widely used to explain the variety of self-destructive and socially stigmatising behaviours, which were categorised within legislation (Rosenberg 2006). These notions are supported by Rosenberg, when he so powerfully states:

> *… [s]ince the 19th century, we have come to think of disease in terms of specific entities—entities defined and legitimated in terms of characteristic somatic mechanisms. Since the last third of that century, we have expanded would-be disease categories to include an ever-broader variety of emotional pain, idiosyncrasy, and culturally unsettling behaviors. Psychiatry has been the residuary legatee of these developments, developments that have always been contested at*

> *the ever-shifting boundary between disease and deviance, feeling and symptom, the random and the determined, the stigmatized and the value-free … The use of the specific disease entity model will always be a reductionist means to achieve necessarily holistic ends, both in terms of cultural norms and the needs of suffering individuals. Bureaucratic rigidities and stakeholder conflicts structure and intensify such boundary conflicts, as do the interests and activism of an interested lay public (Rosenberg 2006, p. 120).*

3.4 Riskiness from 1970 to the present – Back to badness: Risky behaviours and risky patients within the context of the "risk society"

3.4.1 Overview

The concept of risk as being embedded within society is associated with advanced modernity (Giddens 1990) or "risk society" (Beck 1992). These are two formulations of the same era (the contemporary era). In contemporary society, riskiness becomes a new form of "badness". This new form of "badness" fits very precisely with the contemporary, punitive, surveillance, "securitised" society which is increasingly emerging. Importantly in this era, the discourse places the "consumer as a risk" within the context of "risk society". This is not necessarily because the "consumer" is more of a risk than a consumer of products and services (who was not labelled as a consumer) in previous eras, but because this is the way the consumer is framed within the discourses that characterise "risk society" (from the mid-1970s to the present).

3.4.2 Institutional risk

Institutions conceptualised as a communal structure (a locus where people gather) permeate society and, as a result, dominate them (Beck 2000; Giddens 1981); so, it stands that institutions hold a level of control over the defining of risk, including the identification and assessment of risks within society (Beck 1999). Giddens (1991a, p. 28) suggested that reflexivity is part of advanced modern society (Giddens' temporal equivalent of Beck's "risk society"). Individual social life is transformed because new knowledge is acquired and other knowledges are revised. Reflexivity is important here because it is through reflexivity that we have the ability to make such predictions (through iteration and folding of ideas into themselves as reflection, rather than in a linear fashion), however inaccurate they may be.

The reflexive institution in which clinicians are located requires constant risk assessment and prediction. The “modernising” tendency is one of increasing control through governing or governance and the latest manifestation of this is to “govern” risk (Mol & Spaargaren 1993). In this way, “the reflexive monitoring of actions is a permanent feature of social life” (Mol & Spaargaren 1993, p. 449) and perceptions, knowledges, and attitudes about risk exist within a paradox of un-calculability and un-decidability. Deviance and/or adverse events fit quite naturally with this concept of reflexive monitoring, and create anxiety in the face of the paradox of un-calculability and un-decidability (Castel 1991; Godin 2004; Menzies 1960).

The institution in this instance is the healthcare system (a collective structure considered to be abstract in nature) (Beck 1992). The healthcare system’s response to risk involves communicating the presence of risk. Such communication of risk includes a policy of locking ward doors (which in itself implies safety concerns), physical restraint of patients, and the increasing presence and authority of actuarial (risk assessment) forms. The perceptions, knowledges, and attitudes of clinicians are shaped by the institution and the personal disposition of the particular clinician (*see below*), and these then affect the risk assessment of the patient. Manufactured uncertainties (as explained in Chapter 2) arise from this, which then alter the management of risk. Risk assessments are performed within an environment of institutional control whereby agents of the institution must be appropriately trained, acquire competence, and be deemed as capable of operating within particular institutional work processes (Beck 1999). Beck added that “risk is always culturally constituted and, as such, is always imbued with culturally-determined values” (Beck 1999, p. 135). The languages, practices, ideas, symbols, and values that are associated with a particular culture assist with negotiation and “making sense” of the world at large on varying levels (Rowe 2000, p. 309).

Dangerousness (which could be considered a risk within the context of mental healthcare) is conceptualised by Giddens (1991a) as representing behaviour not accommodated within the boundaries of normal behaviour and which can be seen by clinicians as unpredictable and possibly harmful. When an individual seeks to move away from traditional norms and forms of governance, the structures they operate in may attempt to regain control by implementing stricter policies and procedures as a reaction. Patient behaviours are ultimately viewed by the clinician or institution as desirable or undesirable, depending on their positioning in relation to the risk, their perceptions thereof, and the influences that surround this (Luhmann et al. 2005). This is conceptualised around perceptions of uncertainty for both the institution and the clinician. Uncertainty exists within the aspect of future potential loss, and increases in the face of new knowledge (Luhmann et al. 2005; Luhmann, Rasch & O'Neil 2002). The potential loss may then be either a consequence of the decision (the risk of the decision), or an external factor (danger), depending on the clinician’s assessment of this. The clinical decision could be based solely on an event, be associated with the fear of making a clinical decision, or be due to the consequences of a previous poor clinical decision. From this, it follows that risk assessments should not be made purely within the context of calculation, but instead, should be made within the context of a mediated environment in which there is a range of inputs (Adam & Van Loon 2000).

This reflexive response is evident in the mental healthcare arena and can be demonstrated through formal policies, the implementation of formalised risk assessments, and stricter documentation of evidence. As Lupton (1999, p. 73) stated, institutions affect individuals and their lives, while individual actions do little to shape institutions. These types of formalised prescriptions for action can then lead to a preoccupation with risk – with attempts made to reduce these risks to “acceptable” levels – arising from the mobilising force of anxiety. It makes sense then that Beck and Giddens both suggested that research must be conducted to establish how risks are perceived, experienced, and legitimated within each society and/or culture (Adam & Van Loon 2000; Beck 1999; Giddens & Pierson 1998).

3.4.3 The modernisation of risk in mental healthcare: the actuarial mindset

> *Risks ... induce systematic and often irreversible harm, generally remain invisible, are based on causal interpretations, and thus initially exist only in terms of the (scientific or anti-scientific) knowledge about them. They can thus be changed, magnified, dramatized, or minimized within knowledge and, to that extent, they are particularly open to social definition and construction (Beck 1992, pp. 22-3).*

Castel (1991) suggested that, in modern times, there has been a departure from the traditional notion of the individual in mental healthcare and social work. The individual is now understood as a combination of factors that risk is composed of. To consider this in the context of the actuarial mindset, the “essential component of intervention” does not take place through the relationship between mental healthcare providers and the patient; rather, it is mediated through a collection of factors that are deemed to produce generalised risk (Castel 1991). This establishes “flows of populations” upon which actuarial risk predictions are based (Castel 1991). As such, these risk predictions are based on the science of probability and the accumulation of data in order to make generalised predictions. Castel (1991) suggested that “post-modern” society has produced a new formula with which to administer its population.

There has been a slow evolution of mental healthcare practice towards systems of healthcare checks which, by default, can make individualised care and interactions between clinicians and patients “almost dispensable” (Castel 1991; Godin 2004). This approach shifts the focus to the accumulation of facts (for example, observations about behaviours displayed) rather than looking at the patient as a person. From such observations, the notion of “dangerousness” (in which Castel (1991) considers dangerousness to represent a designation of targeted preventative medical strategies) has moved to the notion of risk, which represents a shift from badness to madness to now riskiness.

Paradoxically, dangerousness, or risk, is assumed to be embodied within the patient who may be capable of unpredictable, if not violent, action (Castel 1991). In this way, perceptions, knowledges, and attitudes about risk exist within a paradox of un-calculability and un-decidability (Castel 1991). As previously mentioned, deviancy, or, adverse events, naturally fitted with this concept of reflexive monitoring, and created anxiety in the face of the paradox of un-calculability and un-decidability (Castel 1991; Godin 2004; Menzies 1960). Castel (1991, p. 283) theorised that, strictly speaking, “there can only ever be imputations of dangerousness, postulating the hypothesis of a more or less probable relationship between certain present symptoms and a certain act to come”. Following this logic, risk is not necessarily embodied within the individual; instead, it must be a combination of abstract factors which then render the occurrence of behaviours that are undesirable more likely or more probable (Castel 1991).

3.4.3.1 Institutionalised risk predictions

RAM has “taken a central position in the delivery of contemporary mental health services” (Crowe & Carlyle 2003, p. 19). Ironically, in an attempt to eradicate risk completely, the construction of new risks occurs, and these new risks then require preventative interventions (Castel 1991). However, these concepts and prescriptions are generally followed without a great deal of critical thought and are adhered to because it is perceived that this is “the way the system works” (Crowe & Carlyle 2003, p. 19). In classical psychiatry, risk represents the embodiment of danger of those diagnosed with mental illnesses that are capable of violent and unpredictable behaviour (Lupton 1999). From these perceptions of danger, clinicians then consider potentialities and the types of risk behaviours that may arise. An exploration of how to eliminate the risks presented by these individuals then occurs. This however, is based on the observation and assessment of present symptoms followed by the prediction of future behaviours (Lupton 1999). Importantly, blame is placed on the individuals, together with assigning liability to the clinician for the predictive errors that were made in order to transfer responsibility away from the institution (Hewitt 2008). From this analysis of the observation and assessment, statistical (or actuarial) risk predictions are then utilised in these settings (Slovic et al. 2007). Ironically, in an attempt to eradicate risk completely, the construction of new risks occurs, and these new risks then require preventative interventions (Castel 1991). Crowe and Carlyle (2003, p. 22) identified four types of risk within clinical risk assessment, and indicated that these are the risks that mental health professionals and institutions focus on. These types of risks (and/or risk behaviours) include “risk of progression of illness; risk of deliberately induced self-harm; risk of unintentional self-harm; risk of intentional or unintentional harm to others” (Crowe & Carlyle 2003, p. 22). However, when focusing on these risks, the onus is on the clinician to assess, evaluate, and decide upon the patient’s thoughts and actions (Crowe & Carlyle 2003). This then dictates the “degree of control” that the clinician and the associated “institution can exert” upon the “risky” patient (Crowe & Carlyle 2003). The legitimation of a wide range of institutional and governmental interventions then takes place (Crowe & Carlyle 2003).

In healthcare, where evidence-based practice is the foundation of clinical practice, advances in science and technology must be taken into account. Of importance is the fact that in Beck’s risk analysis, science and technology contribute “significantly to the creation of modernisation risks” (Mol & Spaargaren 1993, p. 441); although, the predictive accuracy of risk tools varies (Hanson & Morton-Bourgon 2009). Nevertheless, science and technology play crucial roles in the perception of risk, as these perceptions are then reflexively managed by the clinician based on new knowledge being acquired, which is then reflected upon by the clinician.

There are numerous ways in which RAM as a nursing practice in mental health has been conceptualised; however, it is generally characterised as being a set of interchangeable steps. These steps include the context that the risk is being assessed in; identifying the risk; analysing the risk (formally); evaluating the level of risk posed; identifying and evaluating the existing risk controls; implementation of nursing interventions designed to reduce the level/s of risk and reflection for improvement; communication; consulting; monitoring and regular review (adapted from: Fealy & Story 2006a, 2006b; O'Connor et al. 2004). These steps in clinical practice are fluid, iterative, and adaptable to circumstance. Notably, McSherry (2004) described mental health risk instruments, such as the Violence Risk Appraisal Guide (VRAG) and the Historical/Clinical/Risk-20 (HCR-20), as tools that focus mainly on historical variables as opposed to individual ones. Indeed, she identified the variables that could be considered, any of which are dynamic rather than static. These include pre-existing vulnerabilities, social and interpersonal factors, state of mind, situational triggers, and personality constructs (McSherry 2004, p. 2). This ties in with Menzies’ (1960, p. 104) notion about rituals in nursing care acting as a defence against anxiety. These rituals, such as ticking a box, are further considered in the contemporary literature (Godin 2004). Beck (1992) argued that the institution and the clinician bring their own view of what constitutes a risk, which is socially constructed within their dominant organisational culture. This suggests that the values of the dominant culture are present within risk assessments conducted in psychiatric healthcare, which further influence clinical practice.

At the same time, past experiences of risk can adversely affect current perceptions of risk; for example, perceptions of risk may become heightened or conversely diminished (Colson et al. 1985; MacKay, Paterson & Cassells 2005; Montes-Berges & Auguston 2007). So, as clinicians engage with, and become more familiar with, a particular situation, the perceived risks are diminished (Colson et al. 1985; Montes-Berges & Auguston 2007). This suggests that clinicians with less experience will be more risk averse, and their practices will be different to clinicians who perceive there to be no risk. Conversely, experienced clinicians may perceive higher risks due to their past experience (MacKay, Paterson & Cassells 2005). These fluid processes are shaped by changing perceptions, knowledges, and attitudes which are influenced by both historical and sociocultural constructs. From this premise, individual assessors then bring a different lens through which they view clinical risk assessments, which influences practice and the resultant interventions that are devised by the clinician.

Sawyer (2005) suggested that risk can influence service provision and its parameters, including how the patient-clinician relationship is structured in the clinical setting. The organisation in which the clinician operates influences these perceptions of risk (Beck 1992). When considering Beck’s (1992) perspective, it may be suggested that the institution holds a greater level of control over the definition of risk, and the clinician is influenced by these institutional definitions of risk. These definitions shape the identification and assessment of risk within that institution (Beck et al. 2008) and clinicians will then shape their practices to the edict of the organisation. Concurrently, assessment and evaluation occurs within that of the dominant culture and the culture’s attributes of normality (Crowe & Carlyle 2003). In this way, when viewing risk assessment as a process, the context of the risk, the identification and interventions, and so forth, are argued to have been informed by socially constructed practices. This implies that these may not necessarily be designed to be of benefit to the patient.

3.4.4 The role of structural change in service delivery

3.4.4.1 Deinstitutionalisation

Mental health services have undergone marked changes over the last 60 years. Central to these changes is the process of deinstitutionalisation. Deinstitutionalisation started as a policy measure from the mid-1990s resulting in the social integration of patients with a mental illness (Giddens 1990; Lupton 1999; Morrall & Hazelton 2000) through attempts by mental health policy-makers to reduce the duration and use of inpatient treatment (Fisher et al. 2001). Deinstitutionalisation consisted of two related aspects, “the transfer of individuals from the hospital to the community and the transfer of the state psychiatric hospital’s functions to alternative community-based settings” (Fisher et al. 2001, p. 1052). However, Lamb and Bachrach (2001, p. 1042) considered deinstitutionalisation as involving more than the changing of the place of care; this also included social processes that nevertheless had “secondary consequences”. In Australia, new challenges have arisen through the refocusing of community-based roles for health professionals, while at the same time, having to also maintain essential roles within inpatient settings (O'Brien, Maude & Muir-Cochrane 2009, p. 80). Critical to the argument of this thesis is that through this process of deinstitutionalisation, heightened concerns for safety and security were voiced within the community (Piat 2000; Wolff 1986), demonstrating the specific mental health consequences of the social shift towards Beck’s “risk society”. This also indicates a further shift in Australian society towards risk aversion, another consequence of the “risk society”.

3.4.4.2 The Recovery Model as the underpinning framework

An alternative view of risk is proposed by Giddens who introduced the idea of “risk as possibility” as opposed to the notion that risk is a negative concept (Giddens 1999d; Giddens & Pierson 1998). In practical terms, this might mean that risk could be allowed rather than forestalled. This is an important notion to consider in a growing consumer movement postulating that a recovery approach (known as "the Recovery Framework") should be an integral aspect of mental health practice (Barkway 2009a). This approach necessitates patients taking a risk in order to recover while working in partnership with mental health clinicians. Nevertheless, it is still focused on "minimising the disability" in order to "live well despite their condition" (Barkway 2009a, p. 257).

In mental healthcare, risk usually represents a range of potentially adverse events that need to be avoided (Giddens 1999d; Kettles 2004; Lupton 1999). This is reflected in various institutional mental health policies and legislation (for example: *Guardianship and Administration Act 1993; Mental Health Act 2009; Nursing and Midwifery Practice Act 2008*). Notably, Giddens (1994a) suggested that these policies are dependent upon notions of risk that arise through actuarial predictions (*see* Section 3.4.3). McSherry (2004) contended that the rise of actuarial instruments that assess for risk have altered the concept of "dangerousness" to one of probabilistic thinking. Moreover, the emphasis then on the clinical assessment of "dangerousness", and then aligning this with probabilistic thinking, also incorporates issues such as social policy and legal judgement and definition, rather than diagnosis (Giddens 1994a, 1994b; McSherry 2004). However, this focus on "statistical association" leads to alignment with historical and collective variables rather than individual needs and individual differences (McSherry 2004).

Castel (1991, p. 288) extended this concept, suggesting that these preventative policies no longer address individuals. Instead, there exist only factors and statistical correlations of heterogeneous elements and, as a result, the mode of surveillance is one of systematic pre-detection. Ironically, in the attempt to lessen risk to an absolute minimum, the construction of new risks occurs, which then requires preventative interventions (Castel 1991). This means that in terms of measurement, there is no longer an individual because it is about means, averages, and modes (population statistics, public health, etc.); however, in terms of social practice, the individual is supreme in the "risk society" (Beck 1992). Without the safety zone of community, the individual is left to fend for themselves with all the associated anxieties (Beck & Beck-Gernsheim 1996; Menzies 1960).

In mental healthcare, RAM is concerned with the minimisation of risk, which takes the form of the minimising of risk behaviours predominantly through reflexivity (Crowe & Carlyle 2003; Giddens 1994c; Muir-Cochrane, Holmes & Walton 2002; Muir-Cochrane & Wand 2005). In order to minimise the risks that may be present, risk practices exist within hospitals (an institution) that are designed to minimise these perceived risks. These practices do not appear to be in the interests of the patient, but instead may only be in the interest of the institution to minimise and/or manage risk, and certainly not in the spirit of the framework of the Recovery Model (Barkway 2009a). Regardless, as is consistent with the idea of "risk society", these practices seem to have been designed to decrease risk to a quantifiable level, possibly to the edict of the institution. The power and knowledge held by the institution (and its agents) can then be controlled and managed through technologies of surveillance, enforcement, and discipline (Beck 1999). This demonstrates "risk society" whereby the institutions are managing risk adequately, simply because the perception throughout society is that they are managing it adequately (Benn, Brown & North-Samardzic 2009).

3.4.5 Consumerism and Patient Care

> *People do a lot of consuming without necessarily thinking about themselves as consumers, but at certain historical moments they can also acquire a voice and identity as consumers (Brewer & Trentmann 2006, p. 1).*

The idea of consumerism in general crosses over from the previous era into "risk society", with the era of healthcare participation (autonomy and citizenship) emerging between 1963 and 1979, and which continues today; although the meaning of consumerism and the subsequent "construction of the patient-consumer has significantly altered over time" (Mold 2010, p. 511). While patients may "have operated as consumers" well before the term "consumer" became extensively used within healthcare – essentially meaning payment for medical services provided – the discourse surrounding patient consumerism began in earnest in most English-speaking countries in the 1960s and 1970s as a result of the coalescence of patient groups advocating for patients' rights (Irvine, Henderson & Petersen 2002; Mold 2010, p. 507; Tomes & Rosenberg 2006).

In the late 20th century, the idea that patients could be consumers of healthcare began in earnest, not just because of the growth of organised consumer movements that had an impact on the delivery of public healthcare services, but also because of the proliferation of consumer goods throughout society and the economic shift from a production-based society (in which we used to make things) to a consumption-based society (Hilton, Trentmann & Soper 2008). To illustrate how this shift has played out in the social sphere, we used to be socially judged by our occupation (what do you do for a living?), whereas now we are judged by our purchases and status (where do you live?; do you have a swimming pool?) (Andrews & Withey 2012). Echoing participatory mechanisms such as trade unions and democratic processes, consumer groups in healthcare were concerned with visiting rights, quality of accommodation, and poor treatment and waiting times (Gorsky 2006). This provided a more collective form of negotiation, and was considered more effective than individual negotiation (Gorsky 2008). However, consumerism is not all positive. The negative side is the "user-pays" philosophy that accompanies consumerism which leads to disadvantage for those who cannot afford to pay (Gray et al. 2015).

While the consumer movement grew, it was also in the 1970s that a change in social attitudes and hierarchies occurred (Mold 2010). There arose a "backlash against professional society" whereby people began to question the authority and power of professions, including the medical profession (Perkin 1990). This allowed a shift in the consumer movement for groups to emerge that were patient-led as opposed to doctor-led, and this assisted in challenging the paternalistic assumptions that were evident in healthcare around this time (Perkin 1990). Furthering their cause was that the public's trust in the medical profession was being undermined (Stacey 1978). The public began demanding a need for more information about medical issues and also for better healthcare services (Deakin et al. 1995), noting that at this time "consent for procedures was rarely sought, patients were not always told what condition they were suffering from or what their prognosis was, and they had little input into decisions about treatment" (Mold 2010, p. 508). The language of "consumerism" was used in order to promote public participation, which was underpinned by the idea of individual self-determination and patient autonomy (Hilton 2003).

Moving to the 1980s, a greater understanding of market-based consumerism occurred; however, changes in policy development represented a shift away from participatory action, and moved patients towards a notion of proxy-consumers who operated in a quasi-market (Mold 2010). What this meant was that, with the changing landscape of healthcare policy development, individual patients still did not have any power to make decisions; instead, the choices about “purchasing” healthcare services for the patient was delegated to their agent; for example, their General Practitioner (Le Grand 1991). The General Practitioner would then act as their proxy in a quasi-market (Le Grand 1991). However, the activities of patient-consumer groups during this time suggested that they considered that further reform was required and that consumers, rather than their proxies, be afforded greater decision-making for their health (Mold 2010).

In the late 1990s, the idea of greater patient involvement took hold (Mold 2010). Milewa (2004) contended that despite the emphasis placed on patient participation, it did not effectively increase the patient’s voice. In fact, it seemed that the patient’s voice became even more fragmented at both the local and national levels. In addition, increased healthcare system complexity, in tandem with a lack of coherence, actually reduced the patient voice (Baggott 2005). These developments, which continue today, have “had an impact on the ongoing construction of the patient-consumer” (Mold 2010, p. 512).

While the label of “consumer” has taken hold, and very prominently in mental healthcare, there is evidence to suggest that currently consumers are uneasy with this label in the context of healthcare (Clarke, Smith & Vidler 2006). This is because, as Clarke and Newman (2007) have contended, patients do not consider themselves to be consumers or customers when it comes to healthcare. The 21st century has also brought about problems with applying the concept of consumerism to healthcare. The issues that remain include aspects such as the power gap between patients and doctors, the limitation of patient choice, and the withholding of information by those “in power” (Clarke & Newman 2007; Greener et al. 2003).

Another way of viewing this concept of the patient-consumer is that calling the patient a "consumer" itself is part of the problem, as every movement has a counter-movement (Clarke & Newman 2007; Greener et al. 2003). One could posit that in response to a consumer world where the consumer has some power, institutions and governments have responded by removing consumer power through re-establishing themselves (institutions and governments) as "experts" through such "scientific" measuring procedures (Foucault 1965; Foucault 1973). Expert knowledge structures and the wielding of such power allow for the movement to positions of power and the movement back to that of a "professional society" (Mold 2010). Further, this begs the question of agency; has the patient-consumer been constructed or shaped by themselves, or have they been constructed or shaped by others? As Mould so eloquently stated:

> *… [p]aradoxically, as government attention to the patient-consumer increased, the actual role played by independent patient-consumer groups seemed to diminish. The shifting meanings ascribed to the patient-consumer, and the changing nature of the groups representing their concerns, should therefore, raise doubts about any authority that claims to know what patient-consumers 'really' want (Mold 2010, p. 518).*

Despite such concerns, today the label "consumer" dominates in most of the mental healthcare literature and is applied to those diagnosed with a mental illness (Rogers & Pilgrim 2014). For the purposes of this thesis, the conventional use of "consumer" as opposed to "patient" was considered, although the tension that still remains with the assigning of such labels must be identified (Kleinman 1980; Tomes 2006; Tomes & Rosenberg 2006). The terminology of "patient" was decided upon for the purposes of this thesis due to the analysis that was undertaken throughout this thesis to reflect the social forces that exist and the movement toward the term "consumer" only in the latter part of the history of mental health (Kleinman 1980; Morrison 2013; Tomes 2006; Tomes & Rosenberg 2006). It is outside of the scope of this thesis to explore further the tensions that exist; only to acknowledge that it does exist, and to offer a justification as to why the label of "patient" is primarily used in this thesis.

3.5 Risk and Reflexivity: The link to personal anxiety

> *Given that individuals have no means available to them to determine the uncertainties which place them "at risk", all aspects of life represent a potential source of anxiety. If, in the face of pervasive and yet unknown "threats", we are witnessing not the resolute triumph of risk (i.e. probabilistic analyses) over uncertainty (cf.Reddy 1996) but the divisive character of the political distribution of risk, understanding how individuals (and groups) are dealing with indeterminacy is of foremost importance (Hier 2003, p. 14).*

When applied to the mental health setting and the changing landscape of healthcare in general, it is easy to see why reflexivity is an important theoretical concept to consider. In fact, Menzies suggested that "[t]he characteristic feature of the social defence system … is the orientation to helping the individual avoid the experience of anxiety, guilt, doubt, and uncertainty" (Menzies 1960, p. 109). Using such avoidance strategies, a reflexive response not only causes change, it also has the potential to generate anxiety.

These views are reinforced by Lupton (1999) who suggested that hazards and dangers are conceptualised in contemporary society as risks and, as such, we may wish to control these (although we can have little control). Rosenberg also considered the reflexive nature of people and culture, stating that:

> *… [t]oday's fashionable evolutionary psychology adds a metahistorical style of biological reductionism to our culturally available store of mechanism-oriented and determinist explanations for behavioral and emotional pathologies (as well, of course, as the "normal"). But there remains an historical irony … As a culture we are relentlessly reductionist in presuming somatic (and ultimately genetic) causation for behavior, yet at the same time we are reflexive, critical, and relativist in our approach to existing disease classifications and therapeutic modalities. We have never been more aware of the arbitrary and constructed quality of psychiatric diagnoses, yet in an era characterized by the increasingly bureaucratic management of health care and an increasingly pervasive reductionism in the explanation of normal as well as pathological behavior, we have never been more dependent on them (Rosenberg 2006, p. 130).*

The concepts outlined above are important for the purposes of this thesis, whereby clinicians may experience anxiety in a clinical setting when faced with uncertainty

(Menzies 1960). Uncertainty exists as an unquantifiable future potential loss (Luhmann, Rasch & O'Neil 2002). The potential loss may then be either a consequence of the decision (the risk of the decision) or an external factor (danger) which hinges upon an individual’s assessment of this (Luhmann et al. 2005). Risk is not independent of the observer. Instead, risk is dependent upon the observer’s attributes (situational characteristics, their personality, or their role within society) (Luhmann et al. 2005). Risk estimation and assessment remains socially context-bound.

In mental healthcare, absconding is one such risk behaviour that clinicians seek to minimise. In Australia, Mosel, Gerace and Muir-Cochrane (2010) and Mosel et al. (2010) have identified through statistical analysis a profile of patients that are likely to abscond. Their findings aligned with the scientific consensus of the generally accepted profile of an absconder being a young male, involuntarily detained in a psychiatric unit, who is diagnosed with Schizophrenia. This latest research could then produce more choices for the clinician when caring for the patient, and ultimately, more decisions must be made when attempting to assess and manage the patient’s absconding risk which is framed within institutional policy; although, absconding remains a very real risk to both the patient and the public. The focus of this research on risky absconders adds to the “archive” about risk, which adds to heightened perceptions of risk, again demonstrating reflexivity in action.

3.6 The perpetual reflexive loop

The omnipresence of risk and the notion of globalisation are key ideas that are important to consider for this thesis. As a whole, nursing practices have consistently evolved (arguably as a result of these experiences with risk), and will continue to do so (Toman & Thifault 2012). Changing technologies, the internationalisation of nursing, national registration for healthcare professionals, and a focus on the professionalisation of nursing, are all contributing factors which have an impact upon, and which shape, Australian nursing practice (Toman & Thifault 2012).

Healthcare and nursing education have evolved at a rapid rate precipitated by policy and legislative changes, economic change, expanding technologies, the movement towards population-based care, internationalisation, interdisciplinary education, and a requirement for evidence-based practice (Roche et al. 2012; Toman & Thifault 2012). These could be the micro-social effects of globalisation in tandem with the omnipresence of risk, and it is these that influence the clinical workforce. I argue that nursing and other healthcare professionals are operating under a particular historical set of circumstances known as “risk society”. Within this social configuration, risk is ever-present because it is constantly focused upon; however, perceptions of risk are socially constructed (Beck 2000; Luhmann et al. 2005). In fact, Rosenberg stated that:

> *… [s]o long as medicine in general and psychiatry in particular remains our designated manager of such problems, specific disease categories will always be an indispensable tool in the performance of that social role. So long as we ask medicine to help in doing the cultural work of defining the normal and providing a context and meaning for emotional pain, we will continue to fight a guerilla war on the permanently contested if ever-shifting boundary dividing disease and deviance, feeling and symptom, the random and the determined, the stigmatized and the deserving of sympathy. (Rosenberg 2006, p. 135).*

As such, the mental health system in “risk society” shapes how risk is clinically defined which concurrently underpins perceptions of clinical risk that happens through a perpetual reflexive loop.

3.7 Conclusion

Social views have changed and risk perceptions have become increasingly heightened. Attempts have then been made to reduce these perceived risks, which have culminated in Australia becoming increasingly risk averse in mental healthcare (Fisher & Hatton 2009; O'Hagan 2004; Slovic et al. 2007). To date, the mentally ill are still associated with calculations of danger, and attempts are made to control (or eliminate) the perceived risks by the institution. The main mechanism through which this is achieved today in mental healthcare is RAM. I argue that this is because we now live in “risk society”, and institutions, and by default individuals, frame everything around risk. When society changes so dramatically (as has happened with the emergence of “risk society”), the entire psychology of the individuals who live in that society changes, and for Beck, the transition to “risk society” is as significant as the shift from feudalism to capitalism was in the 17th century (Anievas

& Nisancioglu 2013).

The contextual nature of this chapter sets the framework for the rest of this thesis, with the next chapter (Chapter 4 examining the contemporary (scientific) literature in order to explore RAM in clinical psychiatric settings, to establish what is currently known about risk practices, how risk plays out in the clinical setting, what issues pertaining to risk exist in the acute care inpatient psychiatric setting, and to establish the gaps in knowledge. An important link is made here in relation to the context set out in Chapter 3, that psychiatric conditions have transitioned from badness to madness (Hewitt 2008, p. 187).

After the methods are outlined in Chapter 5, the findings will be presented over three chapters (Chapters 6, 7, and 8). Again, there is a very direct link between Chapter 6 and the current chapter by looking at the intersection of the relevant legislation, the legal and ethical frameworks, and the tools that are used in mental healthcare, that inform and influence RAM, and the societal setting in which mental healthcare takes place and how mental illness is framed in this “risk society”. Providing such context has indeed been one of the main aims of Chapter 3.

Through a set of interviews with mental healthcare professionals, Chapters 7 and 8 then take the above link between legislation, frameworks, and tools, and the societal context of the “risk society” into the ward setting itself to explore how health professionals actually work with and perceive RAM. Chapter 9 then explores these connections and contexts through the themes drawn out from the literature, but particularly through the work of Beck (1992), Giddens (1990) and Menzies (1960) to demonstrate the main contention of the thesis – that mental healthcare is increasingly focused around risk management, but that this is incompatible with the main operating framework, the Recovery Framework, under which the mental health care system claims that it operates. The final chapter will then conclude the thesis.

4 EXAMINING MENTAL HEALTHCARE AND RISK ASSESSMENT AND MANAGEMENT IN THE CLINICAL SETTING

4.1 Introduction

4.1.1 Contextualising “clinical psychiatric risk” in the contemporary literature

This chapter contextualises risk in the clinical setting and examines how it is played out by exploring the contemporary literature on risk assessment and management (RAM) practices in psychiatric settings. In addition, the mental healthcare setting in Australia is described. This selective literature review aims to identify what Australian mental healthcare consists of, as described in the contemporary literature, what is currently known about these practices, and then considers risk in the clinical setting. Notably, while RAM is informally conducted by clinical staff on a daily basis, from an organisational context, it has now become both a formal and historically informal process of decision-making for the clinician (Alnutt et al. 2010; Vinestock 1996). This includes the use of RAM tools, policies, and procedures that are integrated through in-service education, regular meetings, and ward rounds. RAM is conceptualised as a formalised process by the clinician for balancing the probable consequences of decisions (Kettles et al. 2004; Vinestock 1996; Woods & Lasiuk 2008) and making clinical judgements. This process then validates the decision-making process for the clinician (Morgan 2000) and informs their clinical practice, which then shapes the care for the patient. However, it should be acknowledged at the outset that there is a large body of knowledge in relation to RAM planning, with a significant part of the published literature in the area originating from forensic settings (Hartvig et al. 2011; Kumar & Simpson 2005; Lewis & Webster 2004). As such, many of these research studies (the most relevant of which will be described) are not applicable to an acute care psychiatric inpatient environment. Complicating matters even further, Howells, Day, and Thomas-Peter (2004, p. 394) have contended that there remain methodological difficulties associated with validating methods of risk assessment to “mentally disordered offenders”.

4.1.2 Contemporary understandings of RAM in clinical settings

RAM in mental health has been identified as a significant part of everyday clinical practice (Godin 2004; Higgins et al. 2016; Muir-Cochrane & Wand 2005). It usually represents a way of assessing/identifying a range of potentially adverse events (i.e. a negative outcome that needs to be avoided) and then working to manage the situation/person to minimise the adverse events that may occur (Higgins et al. 2016; Kettles et al. 2004; Muir-Cochrane & Wand 2005).

In clinical practice, effective RAM relies on information that must be collected by the clinician with enough detail to include any risk factors that may need to be minimised (Government of South Australia 2010). Risk factors are defined as “[t]he responses to the symptomatology of the disorder, pre-morbid patterns of behaviour and circumstances that alone or in combination lead to an increased risk” (Mental Health Division: WA Department of Health 2008, p. 36). Effective RAM must also consist of a care plan that addresses the identified risks (Vinestock 1996, p. 4). The identified risks must also be assessed (identified) regularly and managed in order to comply with mandated policies and procedures (for example: Alnutt et al. 2010). Indeed, the nature of a person presenting with a mental health problem can be identified as a risk due to the behaviours they exhibit. As RAM aims to minimise such risks, an understanding of the dynamics and precipitators of adverse events are also important (Muir-Cochrane & Mosel 2008a).

While RAM is informally conducted by clinical staff on a daily basis, RAM has now also become a formal process of decision-making for the clinician (Alnutt et al. 2010; Vinestock 1996). This includes the use of RAM tools, policies, and procedures that are integrated through inservice education, regular meetings, and ward rounds. RAM is conceptualised as a formalised process by the clinician for balancing the probable consequences of decisions (Kettles et al. 2004; Vinestock 1996; Woods & Lasiuk 2008) and making clinical judgements. More clearly stated, this process then validates the decision-making process for the clinician (Morgan 2000) and informs their clinical practice, which then shapes the care for the patient. As such, RAM practices consist of a number of fluid and iterative steps, directed towards achieving a specific aim.

4.1.3 Exploring heterogeneity

Mental health settings are not homogeneous (Palinkas et al. 2015). Clinical diversity (variability or differences of patient characteristics) exists in tandem with diverse social settings which are unique in and of themselves (BootsMiller et al. 1997). Likewise, there is also methodological diversity (Klassen et al. 2012). I contend in this chapter that the diverse nature of research sites, participants, and methodological processes all affect the research outcomes of the situations examined and that, for the purposes of this chapter, the diverse nature of society (even workplace culture) must be considered when analysing the research available to date (Dinmohammadi, Peyrovi & Mehrdad 2013). Kumar and Simpson (2005) noted that RAM originated from forensic settings and that the patient population is different when comparing forensic to adult general psychiatric settings. Forensic patients will have already offended and so risk assessments are aimed at reducing the risk of reoffending (or recidivism) rather than perhaps avoiding a violence risk assessment based in a general adult psychiatric setting. Kumar and Simpson (2005) have contended that violence is less common in a general psychiatric setting when compared to a forensic population. Approaches to RAM and the nature of assessed risk will differ and, as such, most of the research available to date may not be applicable to adult psychiatric settings. Lindqvist and Skipworth (2000) supported these claims, adding that forensic psychiatry is oriented towards risk assessment and omits the traditional role of medicine, which is to treat and care (Lindqvist & Skipworth 2000). The focus is simply on risk (Undrill 2011). As such, risk management, the treatment, and the rehabilitative aims that are focused upon in general adult psychiatric settings may not be met in forensic settings due to the nature of the setting (Lindqvist & Skipworth 2000).

These differences in the settings are also highlighted by Kent-Wilkinson (2010) who defined forensic psychiatry as encompassing the clinical and scientific expertise that exists within a legal context that embraces correctional and criminal matters. General adult psychiatry, while concerned with such, focuses on very different aspects, and is centred around consumer Recovery Models instead. As a consequence, there are broad gaps in knowledge related to RAM in mental health settings; in particular, a paucity of mental health literature that considers the ways in which clinicians assess risk (Littlechild & Hawley 2010).

4.1.4 Gaps in knowledge

I have determined in this chapter that there is a lack of robust research about RAM practices in acute care psychiatric settings and, most tellingly, little consideration of RAM from the clinician's perspective. This is an important gap in knowledge, as the care decisions of the patient rests with the on-duty clinician, and it is RAM that drives the care of the patient. Yet, we know little about what and who influences the clinician, and what knowledge they draw upon to make a clinical judgement or how they arrive at the answer. I argue that the answers to these questions can be found in this literature, in the legislation (via document analysis), and in the interviews undertaken for this study, where there is a complex interplay between elements of "risk society", organisational influences, and clinical decision-making. I further argue that mental healthcare in Australia is synonymous with RAM; in this way, psychiatric care is all about managing risk.

4.2 Method

This selective literature review examines clinical RAM practices in acute care adult psychiatric settings, exploring contemporary issues surrounding clinicians who undertake RAM in acute care psychiatric wards. Originally, this review was intended to be a systematic literature review to increase the power of the findings by pooling the results and establishing generalisability (Bowman 2007; Mulrow 1994). However, as was clear from the outset (from 2010), limiting the literature to acute care psychiatric settings was not enough for the purposes of this thesis. This limitation also became apparent when a more recent selective review on the effectiveness of risk assessment was published by Wand in 2012, who stated that "[a] systematic review was not possible given the paucity of studies evaluating the effectiveness of risk assessment in mental healthcare" (Wand 2012, p. 2).

Literature from the period 2000-2017 has been selectively reviewed. A timeframe of 10 years was deemed appropriate due to the changing face of mental healthcare including funding, changing models of care (specifically the introduction of a recovery orientation), the process of deinstitutionalisation, and to keep pace with care delivery and was then updated upon submission of the thesis (Arya 2011; Henderson et al. 2011; JBI 2014; Page 2008; Papadopoulos & Rheeder 2000).

Search words and their variants included risk and/or assessment and/or management and/or mental health and/or psychiatric and/or nurs*. The articles that met the inclusion criteria were peer reviewed, written in the English language, and dealt with the assessment and management of risk in adult acute care psychiatric settings. When the results yielded 0-200 articles, all were examined in their entirety and inclusion/exclusion criteria were applied. When the results yielded 201-500 articles, all the abstracts were examined and inclusion/exclusion criteria were applied, as well as refining words added to the original keywords. These refining words were “acute care”. This ensured the completeness of the search. When the results yielded over 500 articles, a refining search commenced, and the results of this search were examined in their entirety (all abstracts were examined and inclusion/exclusion criteria applied). Articles that dealt with community psychiatric settings or risk more generally, but which were relevant to risk assessment and management in an acute adult setting, were included.

Over 2,000 titles and citations were reviewed, including polemic articles, empirical research, and literature reviews. There were 55 articles retrieved that met the inclusion criterion. Often, the studies referred to legislation from the country of origin. In the review that follows, links to recent Australian and overseas legislation, where relevant, is used to provide a context. Each article was judged for trustworthiness, which included dependability, credibility and, and transferability (Graneheim & Lundman 2004). The credibility of each article was then assessed as either unequivocal, credible, or unsupported (Leslie & Finn 2004). Articles that contained quantitative data were ranked in terms of levels of evidence (*see* Table 2) to further support this review (JBI 2009; Leslie & Finn 2004, p. 99).

Table 2: Levels of Evidence (Quantitative)

Source: Informed by JBI (2009) and Leslie and Fin (2004)

Levels of Evidence	Description of Evidence
Level 1	Obtained from reviews published of all Randomised Control Trials (RCTs)
Level 2	Obtained from properly designed RCTs
Level 3 (1)	Obtained from well-designed control trials (randomisation absent)
Level 3 (2)	Obtained from comparative studies (randomisation absent; control and allocation present)
Level 3 (3)	Obtained from comparative studies (historical controls present)
Level 4	Obtained from case series

As can be seen in Appendix A, there are three distinct settings: acute psychiatric care, community psychiatric care, and forensic care. Risk assessments will, by their very nature, be different due to the vastly different environments. As a result, the heterogeneity principle comes into play (BootsMiller et al. 1997). Basically, this indicates a sense of incomparability between the three environments and the risk assessments and the variables that are applied to these. When the principles of heterogeneity are evident, it will be clearly identified on every relevant occasion in this thesis.

4.3 Themes

Five main themes were identified in the literature: (1) Definitions of risk assessment and management; (2) Types of risks; (3) Factors that influence risk assessments; (4) Formal and informal risk assessment and management approaches; and (5) Interventions. Within each theme, a focus is on the issues that confront clinicians in day-to-day acute care psychiatric practice.

4.3.1 Definitions of risk assessment and management

There were only scant definitions of risk assessment and risk management in the reviewed literature. When defined, most remained context-bound to the behaviour being assessed. In addition, many papers failed to provide an explicit definition of what they meant by risk assessment. The underpinning focus of identifying these adverse events, as well as the risk factors/behaviours that were found to have caused the adverse events, was that they were to be minimised (Bhui et al. 2001; Campion et al. 2008; Quirk, Lelliott & Seale 2006; Thompson et al. 2008; Thurston 2003; Welsh & Lyons 2001).

In the clinical sense, while risk was defined in very few papers, the framework of risk assessment and risk management was more prevalent. In a critical literature review by West (2001, p. 32), risk assessment was defined as “a combination of an estimate of a target behaviour occurring with a consideration of the consequences of such occurrences”. West advised that the identification and analysis of these hazards must occur first, and must be aimed at reducing the probability of their occurrence. This includes the recognition of risk factors (including behaviours) that may then predict an increase of the probability of a negative outcome (West 2001). West applied this definition to the risk of violence. Once risk assessment is contextualised to violence, risk assessment becomes the evaluation of the likelihood of individuals committing acts of violence. The development of the interventions to reduce or manage the likelihood of violence then becomes risk management.

Bishop and Ford-Bruins (2003, p. 204) more generally defined mental health assessment as “collecting information about a whole person in order to make a judgement”. This is within the context of nurses’ perceptions of mental health assessments. However, Kelly, Simmons, and Gregory (2002) were more specific when they defined risk assessment to be “the process of assessing the individual patient against the specific risk profile developed for the individual as well as against other known general risk factors such as substance abuse, and active delusions and hallucinations” (2002, p. 209). The function of the risk assessment is to alert the clinician to the need for action to protect the patient or community. The diagnosis of the patient informs the risk assessment (and the treatment plan). The clinician does so by way of activating a risk management plan, which is essentially a nursing care plan (or the treatment). Similarly, Muir-Cochrane et al. (2011a) considered that the purpose of risk assessment was to keep the patient safe, with risk management being a preventative tool. Unfortunately, this study focused on the purpose of risk assessment as opposed to explicitly defining this from the outset.

Alternatively, Langan (2008) investigated risk assessment practices from both a mental health perspective and a patient perspective. Interestingly, Langan (2008) identified that patient participants were able to define risk and RAM in this study, but unfortunately the researchers did not explicate these findings. Notably, they found that clinician and patient participants had difficulty with verbalising concepts of risk. For example, clinicians referred to risk in terms of “early warning signs”, whereas the patients’ perspective of risk was measured in the context of the risk that they had posed or could pose to other people. It is clear that the definition of risk is important because this establishes the context and a gauge through which to assess behaviour.

4.3.2 Identifying and assessing types of risks

There were a diverse range of risks that emerged in the literature. The most common risks cited were violent or aggressive incidents (Bhui et al. 2001; Campion et al. 2008; Lepping et al. 2009; Quirk, Lelliott & Seale 2006; Thurston 2003), the availability of illicit drugs (Cleary et al. 2009; Quirk, Lelliott & Seale 2006), and absconding (Cleary et al. 2009). The diversity of risk assessment is demonstrated in the following studies.

In one study (Quirk, Lelliott & Seale 2006), patients were faced with forced intimacy (due to closed ward environments) and/or placed in an institution against their will; in more simple terms, they are detained against their will and this was seen as a trigger for absconding or other “subversive” tactics. Alternatively, Bhui et al. (2001, p. 567) found that dissatisfaction with the “hotel aspects” of the ward were identified by patients as a trigger for violence. Other triggers included food, television, noise, crowding, and a lack of quiet areas (Bhui et al. 2001).

Interestingly, dilemmas related to RAM were also evident when a smoke-free policy was implemented in one hospital in Australia (Campion et al. 2008). In this study, six key informants were interviewed and the data were analysed using a realistic evaluation. Empirical data were also obtained in relation to incident and clinical indicator reporting over a twelve month period (six months pre-intervention, a six week trial, and four months post-intervention). Incidents were generalised in this study to include assault, aggression, and seclusion. Concerns were reported by staff related to their belief that increases in aggression in this acute care mental health unit were a direct result of the smoking ban, and staff perceptions were supported by the increased number of incidents. Linked to this were concerns related to their mandated responsibilities (duty of care). Specifically, during the time of the ban, healthcare professionals were unable (on occasion) to locate patients, primarily because they were smoking away from the campus and abiding by the “no smoking” policy of the site. Given these concerns, the smoking ban was terminated after six weeks. This became a divisive issue among the staff. Some staff members felt that some risks had been reduced now that patients in this research setting could be easily located. They felt relieved that their supervisory and safety duties could be resumed. Others remained concerned with the known risk factors of passive smoking, and their continuing obligation to observe inpatients when smoking onsite. Notably, a discussion centring on their duty of care towards the smoker is absent in this paper. The findings were inconclusive in this triangulated study as to whether the slight increase in aggressive incidents and the increase in incidents of seclusion (rising from an average of 20 per month pre-trial to 46 during the 6 week trial) were directly related to the implementation of the smoking ban. Notably, the research failed to address the patient’s physical health related to smoking.

Another factor that may present a risk in terms of violence and aggression is the area of illicit drugs and unwelcome visitors. Quirk, Lelliott, and Seale (2006) cited numerous events whereby unwelcome visitors threatened staff members and they also examined the issues of drug use and drug dealing on these wards. Not surprisingly, these events were identified by staff as a problem. Remarkably, while staff in this study (Quirk, Lelliott & Seale 2006) acknowledged that contact with family and friends was important, the participants felt that this communication directly influenced ward life. Family visits often resulted in conflict, resulting in high levels of violence and aggression. However, a gap in the knowledge on this remains and I highlight here that *there is little consideration about what knowledges acute care mental health professionals draw from to manage these issues, and what evidence is available to effectively manage these risks*.

4.3.3 Factors that influence risk assessments

There were a number of factors that were found to influence risk assessments in the papers examined. These are factors such as responsibilities, staff factors, organisational factors, and time. These factors will now be extrapolated within each sub-theme.

4.3.3.1 Responsibilities

The very nature of mental healthcare and subsequent clinical practices are guided by the scientific paradigm, which considers risk assessment as a way of gaining control of the environment through prediction, and is seen to dominate contemporary mental health practice (Littlechild & Hawley 2010). This scientific paradigm, being the “biomedical model”, is the most dominant approach to illness and health in Western societies (Jenkins 2014). The model is founded on scientific approaches which use objective methods to treat and diagnose health problems, in addition to claiming to offer superior ways of understanding health and illness (Ishikawa, Hashimoto & Kiuchi 2013; Walsh 2004). Significantly, this paradigm can be linked to the assertions made in Chapter 3.

This idea has also been supported previously in this chapter, when the diagnosis of the patient was identified as directing not only the risk assessment but also the treatment (being the risk management of the patient). It is not surprising then, that the notion of risk assessment, which is entrenched in actuarial predictions, fits with the biomedical model whereby the management of the patient is focused on risk, and once the illness can be identified and treated, so too, the risk the patient poses to society is then minimised. As such, these concepts are closely aligned (Baker et al. 2014).

Given the dominance of the medical model, risk assessment falls within the realm of the responsible doctor and the nurse. This observation was reinforced when Lewis and Webster (2004) considered the two main professions who undertake RAM tasks in the clinical setting, and who publish the most amount of RAM literature available to date, being psychiatrists, psychologists, and more recently, nurses; although there are more professions that are beginning to publish in this area (Heilbrun 1997; Rozanski et al. 2005).

Lewis and Webster (2004) further noted that nurses have an interest in performing risk assessments. This contention was supported in a study of mental health nurses' (*n*=14) perceptions of mental health assessments (Bishop & Ford-Bruins 2003). Bishop and Ford-Bruins (2003) provided a historical context, suggesting that nursing assessments functioned to act as a data collection service to justify or assist the determination of a medical diagnosis for the patient. From this, nurses collect data for the doctor, who then makes the diagnosis. Nurses are now also required to use these standardized assessment tools (Dolan & Doyle 2000). Of concern, however, is that risk assessments can vary between individual professions, even when they are using the same tools (Littlechild & Hawley 2010). This is a concern as it is likely that the assessment and management of the patient becomes fragmented. In response, I pose the following question: could it be that each profession has different mandated responsibilities within the realm of RAM, or that they have a different focus when caring for and managing a patient's healthcare needs?

Likewise, Muir-Cochrane et al. (2011a) found opposing views of "who is responsible for risk assessment and management". While formally, it was the doctor's responsibility during the working day, it was the nurse's responsibility after hours and on weekends. This prescriptive but contradictory approach towards RAM creates numerous tensions on the ward, and together with shared accountability, leads to reluctance on the part of nurses to undertake this role. This reluctance is framed within the notion of punitive measures and the confusion that surrounds these contradictory practices, primarily in relation to accountability issues and the "fear of getting it wrong".

From this fear and contradictory practice, there has been a shift for nurses to move towards nursing diagnosis. However, Crowe and Carlyle (2003) contended that nursing care is still based on "dominant psychiatric ideologies". These dominant ideologies, firmly entrenched in the biomedical model of disease, are at odds with nursing theories which are to treat the patient in a holistic manner, which means that the disease is only one small part of the healing process, and social needs also contribute towards the patient improving and being able to live a fulfilling and meaningful life (Nursing & Midwifery Board 2016). Crowe and Carlyle (2003, p. 19) questioned how nurses can meet their "socially mandated role as guardians of those who pose a risk to others to ensure that [their] practice represents [their] espoused therapeutic responsibilities”. From these prescriptive mandates and the disconnect between the biomedical model and the holistic model, nurses consistently grapple with their role within the dominant medical model, while being “trapped in an anachronistic relationship with psychiatric medicine” that still exists in most healthcare settings (Buchanan-Barker & Barker 2005).

The dominance of the medical model in mental healthcare also poses a number of other risks for the patient (O'Donovan & Gijbels 2006), particularly in relation to their disempowerment, loss of personhood (depersonalisation), and danger from other patients (Quirk, Lelliott & Seale 2004). This means that there appears to be no choices, because the medical model dominates and the patient may be treated in a depersonalised way because of how the medical model operates. Health professionals’ personal safety is also at risk in these settings. This arises from the volatile nature of the environment and the social climate within, in addition to the violence and aggression that may be exhibited by some patients (Quirk, Lelliott & Seale 2004). Regardless, health professionals are still mandated to operate within this framework. This means that, effectively, health professionals are at risk, but their concern is lower – they have to operate in this environment because it is their job which is governed by both legal and ethical frameworks. As a result, this could also lead to the disempowerment of the health professional.

Health professionals’ perceptions of personal risk to themselves are exemplified in a study by Quirk, Lelliott and Seale (2006), who found that staff were concerned with the consequences of intervening when a risk became apparent. They often ignored the behaviour if the consequences of intervening were perceived to be worse. Staff grappled with competing responsibilities, such as how to respect the rights and freedoms of voluntary patients while containing involuntary patients; how to meet the accommodation needs of those patients in an acute phase of their illness as opposed to the rehabilitative phase; how to prevent voluntary patients engaging in activities that are antisocial or criminal; and how to prevent outside influences detracting from care while concurrently maintaining links with the community in order to prepare for discharge. Unfortunately, with the complex interplay between interactional and contextual factors within the study site, strategies to solve or mitigate these issues were not clearly stated in this study.

Similarly, Undrill (2011) contended that risk assessments can be used as a method to justify restrictions that diminish staff autonomy, such as those placed on a patient. The reasons for this include, firstly, a consideration of the patients' best interests - how do clinicians know? Secondly, coercion (a key aspect of risk management) may damage the therapeutic relationship between the clinician and patient. Thirdly, risk assessment is likened to "reputation management". For the clinician, this means endeavouring to avoid the coroner's court, while for the organisation, robust RAM protocols ensure that their legal obligations are met.

This argument is supported by Wand (2012), who suggested in his selective review of the effectiveness of risk assessment, that the focus on risk assessment has had a "negative impact on clinical practice, patients, and the public" (Wand 2012, p. 2) leading to a "culture of blame", which may also lead to coercive practices and policies. In doing so, this demonstrates a lack of understanding of the complex nature of patient admission and the complexities that arise in the clinical setting. This suggests that the role assigned to health professionals is fraught with difficulties. Issues such as grappling with conflicting roles within dominant medical and psychiatric models, the presence of risk behaviours on the part of the patient, together with the consequences of these (or ignoring them), have an effect on the fulfilment of clinician obligations, and the potential for a risk averse culture to emerge.

Price (2014), (an independent consultant) however, attempted to shift this paradigm. In this polemic and challenging evidence-based practice paper, Price aimed to convince nurses to discuss risks with patients, to share the decision-making, and to support patients through the decision-making process. This challenge is prefaced with the statement that despite the range of risk variables psychologists identify, nurses need to be able to describe risks to patients in a straightforward manner and then discuss them together as a team. Despite such a convincing argument, there remains little change within the contemporary literature that reflects nursing feeling comfortable discussing such matters with patients (Higgins et al. 2016).

4.3.3.2 Staff factors

The reviewed literature points to the fact that RAM practices are influenced by a number of factors related to staff or the staff-patient interaction. Recurring issues associated with the clinical knowledge of the professional, “tuning in”, the complexity of interactions and consideration of possibilities by clinicians, were considered frequently. The literature examined the importance of clinicians knowing the patient, and this included a range of aspects such as their medical history, their history of violence, clinician and patient belief systems, and consideration of the personal impact that the mental illness has had on an individual level (Baker et al. 2014; Buckingham, Adams & Mace 2008; Grotto et al. 2015; Trenoweth 2003; Welsh & Lyons 2001; West 2001). These were seen as important aspects of RAM that could also affect assessments of risk (Buckingham, Adams & Mace 2008; Trenoweth 2003).

There is also a complex interaction between situational factors and the individual’s predispositions (Gerace, Curren & Muir-Cochrane 2013; West 2001), and the unstated knowledge of clinicians of the risks and the variables that exist, which can influence a clinical judgement (Gerace, Curren & Muir-Cochrane 2013; Welsh & Lyons 2001). Likewise, MacNeela et al. (2010) considered nursing assessments in mental health settings to be characterised by assumptions about patients. While the literature failed to determine whether these affect RAM practices, the gathering of patient information was implicated as a variable in risk assessment.

For example, Murphy (2004) considered nurses’ assessments of violence, finding that past knowledge of the patient, and past clinical experience left community nurses feeling confident in their assessment of violence, although they did not use “formal risk assessment instruments” in their daily practice (p. 409). The factors associated with violence were also explored in this study, with two recurrent themes emerging: the importance of “gut feel” and the training needs of staff. This “gut feel” was identified by one participant in this study as an inner alarm when in contact with the patient in the environment (Murphy 2004, p. 411) which then feeds into the concept known as intuitive decision-making.

“Gut feel” and knowing the patient were also identified as important by mental health nurses in a study by Bishop and Ford-Bruins (2003), who studied nurses’ perceptions of mental health assessments. Participants in this study, located in an acute care psychiatric setting in New Zealand, described the dominant factors in their assessment as knowing the patient and “gut feel”:

> *…. [g]enerally I have already made up my mind about what is going to happen by how that person behaved rather than what they say. I have got to this stage by watching other people go through that process since I have been here and checked what works for other people and what hasn’t worked (Bishop & Ford-Bruins 2003, p. 206).*

This notion of “gut feel” was also present in a study by Hutchinson, Lovell, and Mason (2009), who interviewed 12 multidisciplinary team members who worked with sex offenders with a learning disability in a community setting. The multidisciplinary team was comprised of social workers (*n*=5), nurses (*n*=3), psychologists (*n*=2), one psychiatrist, and one case manager. The authors found that risk assessments did not differ according to these professionals. Interestingly, all of the participants relied on “gut feel” in their assessments of risk. The key question professionals asked themselves was “is it safe to do this?” This is an important finding, as the notion of “gut feel” is seen to dominate the nursing literature, but has limited applicability to medical research, particularly in light of the dominance of the medical model of care, as previously mentioned.

Past experience influenced staff-patient interactions in another way. Nurses in the study by Murphy (2004) also considered that previously being a victim of violence affected their perceptions of future violence as well as their experiences which served to increase vigilance about potential risks or increased their confidence, through feeling that this would never happen again. This experience also seemed to fuel their “gut feel”. The findings of this study imply that the assessment of risk is affected by personal experiences. This may then lead to patients being labelled inappropriately as violent. Similarly, this study was related to perceptions of violence as opposed to perceptions of RAM. Nevertheless, perceptions of violence may influence RAM practices.

Alternatively, in a study that used observational methods and questionnaires, patients stated that when they considered staff to be authoritarian, this was a trigger for patient violence (Quirk, Lelliott & Seale 2004). Clinical assessment and management of risk were affected, with Bhui et al. (2001) suggesting that clinicians make “subjective and impulsive judgements” about patients’ behaviours without exploring their causes. In such cases, the interpretations of the patients’ behaviours by staff may be incorrect.

The individual cognitive behaviours of clinicians can also be considered within the context of bias. Carroll (2009) examined the struggle by clinicians with probabilistic thinking (attempting to predict future events), and personal experience (for example, past interactions with violent patients). This type of thinking and experience may lead a clinician to take heed of irrelevant factors. Ultimately, these detract from the clinicians’ ability to accurately assess and manage risk. Other aspects that influenced RAM included the quality of judgements, recent adverse incidences, confirmation bias, hindsight bias, ignoring relevant and contextual factors, being socially influenced, cognitive dissonance, and group thinking (Carroll 2009).

These are known as common heuristic biases and have a “synergistic effect on the likelihood of error” (Carroll 2009, p. 193). For example, it is more likely for a clinician to ask “what has happened to me in the past?” which then leads them to consider, on that basis, “what, from those experienced possibilities, is more likely to happen?” There are only a limited range of possible risks. Also affecting the accurate assessment of risk is the concept of group thinking. This is theorised to be a process that mediates the social members of a group to strive for unanimous thinking, which often overrides the realistic appraisal of existing risks (Carroll 2009).

Another point raised in the research is the influence that a range of settings have on RAM. One such example is described by Thurston (2003). Using a case example, he compared behaviours in an acute care facility to those in a community setting. On admission to an acute care facility, patients often displayed aggression and destructiveness. Thurston (2003) found that this behaviour did not evoke guilt in the patient, as opposed to the guilt they expressed when acting in this manner in a community setting. From this, Thurston (2003) proposed that the patient did not develop or learn from these episodes. Arguably, this implies that the setting may influence patient perceptions and consequently their behaviour, and then, the risk assessment of that patient would differ depending on the setting, being either acute care or out in the community. However, some level of caution is necessary here as this is only a single case study.

4.3.3.3 Organisational factors

The literature reviewed also points to the fact that RAM practices are influenced by a number of organisational factors. Petrila and Douglas (2002, p. 471) suggested that risk assessment practices vary in different organisations, even from ward to ward or individual to individual. This supports early statements regarding heterogeneity and unique social settings and their influence on RAM practices. The assessment of risk within organisations was examined in one study which further highlighted the variances between risk assessments conducted in different organisations, as well as the wider sense of heterogeneity (BootsMiller et al. 1997). Lepping et al. (2009) surveyed British, Swiss, and German acute care psychiatric ward managers. They found that British wards were statistically more likely to perform a documented risk assessment on patients. In the countries that had lower levels of compliance in performing risk assessments (Germany and Switzerland), the ward managers also demonstrated lower levels of satisfaction with risk assessment procedures. This indicates the effect of culture on the organisation.

Likewise, in a study by MacNeela et al. (2010), 59 mental health nurses were interviewed in relation to nursing assessments in the community and the hospital. It was found that the environment shaped the purpose, character, and method of assessment. The setting appears to be an important and influential aspect of RAM for clinicians as well as patients.

These varying practices may however, place the organisation at risk legally and this was clearly a limitation to the managers participating in a study by Clancy and Happell (2014) who identified that it was this that influenced the development of their risk practices. Fear of litigation was another decisive factor for organisational development around risk (Clancy & Happell 2014, p. 3181). To reduce this risk, Petrila and Douglas (2002, p. 471) advised that risk assessment should be created within the contexts of “coherent organisational approaches” and “prevailing professional standards”. These approaches and standards include designing policies in consultation with experts in “release decision making” (Petrila & Douglas 2002, p. 471) (releasing the patient from care), and explicit clinical documentation of the risk assessment performed, including the conclusion and the procedures and tools that were used to make the decision. They considered that institutional commitment is necessary, noting that risk assessments based on unstructured or clinical judgements alone do not meet prevailing standards or professional norms. They again demonstrate “what should be done” in RAM rather than “what is being done”. From this point, there appears to be a number of polemic articles stating how RAM should be implemented in the clinical setting. However, when RAM in the clinical setting is examined, there are practices which do not necessarily conform to the identified standards.

Clinical education is another key aspect of RAM within organisations. Petrila and Douglas (2002), Cleary et al. (2009), and Lepping et al. (2009) suggested that education enables the recognition of “at risk” behaviours, the development of effective clinical practices, and may be used as a means to reduce work-related stress. Specifically, in this study, Lepping et al. (2009) found that when training and education were in place, ward managers were more satisfied with the general management of aggression and violence. Notably, they found that 100% of British ward managers had protocols in place for when staff had to deal with violent patients, as opposed to 61% and 59% of German and Swiss ward managers respectively.

While Lepping et al. (2005; 2009) have been the only published studies investigating education and training across countries within the time period sampled, Murphy (2004) found that all participants (*n*=16) in their study on how nurses assess the risk of violence, believed that mandatory training should be provided and should include changes to policy and legislation as well as new developments in risk assessment. The participants considered training to be a key aspect of being able to accurately assess risk. Alternatively, Higgins et al. (2005) found that, out of 45 mental health trusts in England, only half provided training in the standard risk assessment forms that assessed the risk of violence. This seems to indicate that knowledge and training is important for clinicians, and is suggestive of the idea that the setting and the education provided are important components of RAM. However, while over half of the healthcare organisations in this study provided training for healthcare professionals, many did not attend the training sessions provided (Higgins et al. 2005). These findings are no different some 12 years later, when Higgins et al.

(2016, p. 165) reported statistically significant differences “in relation to training in risk assessment and self-reported confidence in conducting risk assessments. A higher proportion of those with training in risk assessment were conducting risk assessments compared to those without training”. Strikingly, they found that those participants who had received training also had statistically significant self-reported confidence in developing safety plans, although they were less confident about involving stakeholders and family members than they were when liaising with police and other healthcare professionals (Higgins et al. 2016).

Lepping et al. (2009) also explored the management of violent incidents with ward managers. They found that most British ward managers were able to discuss violent incidents in a structured way, while only half their counterparts (Swiss and German) could do the same. Likewise, debriefing and counselling services for staff involved in violent incidents were offered by most British wards, while only half of Swiss and German wards did the same. The authors suggested, as an outcome of their study, that structured discussion seems to be of importance in RAM practices.

Petrila and Douglas (2002) found that the education provided by the organisation needed to focus on specifics, enabling clinicians to correctly document how a risk assessment was done, what risk factors were considered, why the decision was made, and which interventions were implemented. The purpose of this was to avoid litigation (Petrila & Douglas 2002). They further noted that staff must have access to the current thinking available in the field of risk assessment. This notion of access is also evident in Cleary et al’s (2009) selective review. However, for the purposes of this chapter, it is difficult to make generalisations based on the findings of these articles due to their selective nature. Nevertheless, selective reviews are useful adjuncts when combined with other studies, and aid in increasing the power of findings (Bowman 2007).

Resources also emerged as an important aspect. Resources in organisations refer to aspects such as staffing numbers, the availability of organisational guidelines and protocols, and the availability of alarm buttons or emergency telephone numbers (Lepping et al. 2009). In relation to the availability of resources, Lepping et al. (2009) found that there was a reduced perception of difficulty related to violence and aggression by staff. Likewise, levels of training and the quality of training also contributed to these perceptions, as did the availability of guidelines and standards, although staffing numbers had no effect on perceived levels of safety. This particular finding is worth noting.

In a study by Emmerson et al. (2007), communication was also encouraged prior to ward rounds by requesting staff to identify patients “that may be potentially at risk of being aggressive”. This allowed increased levels of peer support, which was linked to lowering overall assault rates on staff. Alternatively, Trenoweth (2003) found that nurses perceived lower levels of risk when they were supported by a skilful team and were able to draw upon their knowledge of the patient. This allowed them to intervene successfully. From these studies, it would seem that staffing support levels and knowledge of patients facilitate effective responses by healthcare professionals towards potentially violent situations.

Interestingly, nursing clinicians (*n*=125) participated in a study by Martin and Daffern (2006) which considered “personal safety and confidence when managing inpatient aggression in a forensic” hospital in Australia. This study found that perceptions of safety were supported by organisational factors which allowed clinicians to feel more confident when managing inpatient aggression. However, this study failed to specifically identify what these organisational factors were, although they considered compliance with policies and procedures as one factor that influences clinicians’ feelings of confidence and safety. Martin and Daffern (2006) contended as a result of their research, that complying with policies and procedures provided a skilful and experienced workforce. They further found that if there is a large attendance of staff for training and education in aggression management, this supported confidence in managing aggressive inpatients. Teamwork, leadership, good communication, and staff support were also identified as supporting confidence within the clinical setting.

Safety was another factor considered in a study by Bishop and Ford-Bruins (2003). The participants in this study considered that the “predominant ward culture” was centred on “managing safety and risk”. Opinion was divided however as to whether this culture was inevitable and an integral aspect of patient care, or whether it negated the principles of the Recovery Model, which is centred on aspects such as encouragement and empowerment as opposed to the medical model, both of which have been previously addressed. Nevertheless, these participants did not dismiss the importance of maintaining a safe environment. Rather, they attempted to balance the unpredictability of the patient against the safety of staff and other patients.

4.3.3.4 Time

Further factors that affect RAM included limitations on time and the conscious processing power required regardless of which RAM approach is used. In order to effectively assess and manage risk, clinicians need time to assess the patient, and to absorb and consider all of the variables that exist in order to implement evidence-based interventions. This was suggested by Carroll (2009) as being a sometimes unrealistic expectation of clinicians, although expected by organisations, with time being a prominent recurring issue throughout the literature examined. Notably, Clancy and Happell (2014) found that lack of time impacted on the clinician’s ability to utilise evidence-based practice, an issue which is of major concern.

A study by Hutchinson, Lovell, and Mason (2012) found that multidisciplinary clinicians struggled when assessing for risk, as a significant amount of time was required to successfully complete this process. The lack of time to spend with patients has also been identified by Bishop and Ford-Bruins (2003) as impeding holistic assessment. They posited that this may be one reason why the medical model (with psychopharmacology and pathophysiology being the major focus) still dominates psychiatric settings in the Australian context (Sarris et al. 2014). Fluidity of staff and high patient turnover also detract from therapeutic clinical practice (inherent in previously established therapeutic care relationships) (Quirk, Lelliott & Seale 2006). However, it should be noted that, one of these studies was a selective review on the contemporary evidence (Carroll 2009), with Bhui et al’s (2001) study focusing on managing violence, and Quirk, Lelliott, and Seale’s (2004) focusing on how patients managed risk in a volatile environment in one institution. Thus, it is difficult to draw conclusions due to the diverse nature of these studies.

Specifically, the pressures of time were noted as influencing RAM practices in a study by Thompson et al. (2008). In this study, they found that when nurses were placed under time pressure, risk assessment decisions were affected. For example, with a reduction in time, nurses were less likely to intervene, and they also appeared to have a reduced ability to detect need. The variables included nursing performance, decision thresholds, and the ability to distinguish between signals of clinical risk and the non-contributory (irrelevant) information misinterpreted as warning signs. Nursing performance in this study referred to a decision made which is correct. This determines whether the nurse takes action when faced with a patient that could be at risk of a critical event occurring. Decision thresholds were based on clinical nursing experience and their individual approaches to risk that created a variable action threshold or decision tendency. That said, the consequences that nurses feel once the decision is made is also variable and within the context of the “duality of error”. For example, they may feel that they missed an opportunity to act, or some may err to intervene, although the subjective nature of determining the risk in the first place comes in to play in these instances. However, the participants in this study included both community and acute care nurses and the study was focused on acute care situations rather than distinctive psychiatric acute care situations.

4.3.4 Formal and informal risk assessment and management approaches

This theme encapsulates a debate within the literature in relation to the strengths and weaknesses of various dominant approaches to assessing risk. One limitation of this approach is that many of the articles are related to violence, which is only one aspect of overall risk assessment.

4.3.4.1 Unstructured clinical judgement

Doyle and Dolan (2002, p. 650) referred to unstructured clinical judgement as involving “professional opinion” or judgements “where there is complete discretion over which information should be considered and there are no constraints on the information the assessor can use to reach a decision”. One reason suggested for risk evaluations conducted in acute care psychiatric settings being largely “unstructured” is that empirically validated risk factors were developed for forensic patients (Hartvig et al. 2011). The advantage of the clinician using their professional judgement is that a number of factors which are specific to the patient being assessed can be considered. These factors include the patient’s situation (for example, their personal support team), the environment (for example, the hospital ward), and the interaction between these variables and the knowledge and experiences of the clinician (Grotto et al. 2015; Kumar & Simpson 2005; Trenoweth 2003; Woods & Lasiuk 2008).

One component of clinical judgement is intuition. Earlier, there was a discussion of “gut feel”, but this was in the context of the influences of RAM. This section examines the dominant approaches to RAM, with intuition being a component of unstructured clinical judgement. In a study by Bishop and Ford-Bruins (2003), which investigated perceptions of mental health assessment among 14 mental health nurses, the participants considered intuition as being integral to their assessment. In this study, “[a]ssessment may be seen as collecting information about a whole person in order to make a judgement” (Bishop & Ford-Bruins 2003, p. 204). The participants described the importance of intuition and ranked it as “being equal if not superior value to researched and formal tools” (Bishop & Ford-Bruins 2003, p. 207). Likewise, Carroll (2009) investigated intuitive decision-making used by clinicians when assessing and managing risk. However, Carroll (2009) stated that intuitive decision-making (which is based on feelings of “what is right”) may be biased. Intuitive decision-making in this instance refers to neuropsychological system responses that are based on habits deriving from cognitive associations. Bias may occur; particularly as intuitive decision-making contains an emotional aspect and deviates from appropriate, fair, and balanced decision-making. On this premise, Carroll suggested that if this is not considered in a mindful way, unbalanced, unfair, and inappropriate decisions will occur. Carroll (2009) reported that rational decision-making is dependent on slow, neutral cognitive processes, all of which require mindful effort. To reduce the biases that may be evident, and to constrain and structure the decision-making process, a series of steps were then outlined by Carroll (2009, p. 197), including optimising the context; defining the question/s; clarifying the goal/s; gathering the information (using structured risk assessment tools); making the decision/s; planning for the worst outcome/s; learning from these outcomes; and estimating the levels of confidence in the decisions made. Carroll recommended a combined risk assessment approach which is intuitive and structured.

There are a number of other criticisms of unstructured clinical judgement, as being overly-subjective and based on personal impressions (Doyle & Dolan 2002, p. 651). Further, these clinical risk predictions are only slightly higher than chance (Doyle & Dolan 2002). This finding is supported by Petrila and Douglas (2002) who noted that subjective clinical judgement is a characteristic of most clinical decision-making. However, the validity and accuracy of such a method is unmeasurable due to this subjectivity and, as such, they do not recommend this in the assessment and management of risk. Likewise, Lewis and Webster (2004) found that clinicians may over-estimate the risk of violence if they base their predictions solely on this unvalidated method. Unstructured clinical approaches are also not recommended as they rely on subjective conclusions rather than on the gathering of objective data (Petrila & Douglas 2002; West 2001). On the other hand, Hutchinson, Lovell, and Mason (2012) found that multidisciplinary healthcare professionals considered both formal and informal risk assessments to be subjective:

> *Assessments can be subjective and negatively value loaded, they are not meaningful unless followed by plans of action that take note of risk assessment (P7)... Trust your instincts ... check them out; awareness, people tell you what you want to hear, risk is in the eye of the beholder (P2) (Hutchinson, Lovell & Mason 2012, p. 56).*

It is also worth noting that assessment can change the outcome. From this premise, it is then difficult to assess how “correct” clinicians may be (Doyle & Dolan 2002).

4.3.4.2 Actuarial assessment

Actuarial assessment uses empirical research on risk factors associated with adverse events (Gunenc, O'Shea & Dickens 2015; Kumar & Simpson 2005; Trenoweth 2003). This relies on the static or historical characteristics of the individual being assessed in order to make a prediction about future behaviours. These static variables include previous history of behaviours (e.g. substance abuse, childhood behaviours), family circumstances, age, diagnosis, and gender (Douglas & Skeem 2005; Hartvig et al. 2011; Lindsay et al. 2004). Predictive judgements are then made which are based on explicit and fixed rules, and these judgements are based on data empirically associated with the risk being assessed (Doyle & Dolan 2002). Petrila and Douglas (2002) posited that actuarial decision-making eliminates clinical judgement by using pre-existing equations and scores to determine the level of risk. Petrila and Douglas (2002) contended, as a result of their review, that this approach was found to be 10% more accurate than clinical predictions.

Undrill (2011) supported the over-performance of assessment tools in comparison to clinical judgements, although acknowledged that actuarial methods have been criticised in the past. One such criticism has been the notion of false positives and negatives. A false positive implies that the risk was predicted to happen, and did not, while a false negative means that a risk was predicted not to happen, but actually did (Undrill 2011). Lindqvist and Skipworth (2000) stated that patients are at risk when being assessed through actuarial methods. If the patient scores a high actuarial risk score, then their freedom will be restricted (being detained against their own volition) “because of guilt by statistical association” (Lindqvist & Skipworth 2000, p. 320). Likewise, a “reassuringly” low score may mean that the patient is discharged despite the concerns the clinicians may have. Likewise, Hart, Michie, and Cooke (2007) advised caution to be used by clinicians when using these tools to make inferences about patients’ risk of violence.

While originating from forensic settings (Lewis & Webster 2004), actuarial measures have also been used by nurses (Bishop & Ford-Bruins 2003). Some of the actuarial measures (commonly known as risk assessment tools) include the Violence Risk Appraisal Guide (VRAG), Historical Clinical Risk 20 Version 2 (HCR-20), and the Behavioural Status Index (BSI). However, Hart, Michie, and Cooke (2007) suggested that these measures and their ensuing accuracy are based primarily on large samples and are not person-specific, and moving this focus changes how risk is conceptualised in the clinical setting. Another problem is that this approach may ignore “crucial case-specific, idiosyncratic factors”, and further, does not consider cross-cultural diversity. At the same time, the over-reliance on static risk factors (which are unchangeable) leads to predictions that are passive (Doyle & Dolan 2002, p. 651; West 2001). Clinicians may also need extensive training in using these instruments (Doyle & Dolan 2002).

It should also be noted at this juncture, that most violence risk assessment tools are not designed to be applied to the general population (Wand 2012). Instead, these tools have been developed to be applied to high-risk offenders in the forensic sector. If there are attempts to apply these tools to the general population, Wand (2012) has contended that this could lead to interventions that are overly-coercive, and which may be inaccurate.

The legal aspects of the identified actuarial measures should also be considered in this context. Petrila and Douglas (2002) found that courts do not necessarily admit these in cases of litigation. This could be because these tools do not meet the legal standards of scientific evidence, given that the margin of error is actually incalculable (Hart, Michie & Cooke 2007). Moreover, Petrila and Douglas (2002) found that the US Supreme Court declined to endorse a legal position which could mandate the use of actuarial tools in the assessment of risk. The Court stated that, in fact, actuarial tools may harm court proceedings due to the weaknesses evident in the tools, although the Court noted that they are reasonably reliable. The use of actuarial tools in legal proceedings has also been considered by Lewis and Webster (2004). They found as part of their selective literature review, that jurors are more influenced by clinical opinions, with actuarial evidence being less persuasive. Similarly, clinicians in a community study by Hutchinson, Lovell, and Mason (2009) doubted the effectiveness of risk assessment instruments. They further found that failed predictions of risk have the potential to lead to political and public scrutiny. Similarly, Webb (2012) considered the use of tools by clinicians as “risky” and of possible detriment to the clinical experience and judgement of clinicians. This point is exemplified by Gunenc, O’Shea and Dickens (2015) who attempted to use the HCR-20 to find a link between risk factors for aggression and verbal aggression. Despite a large sample size of *n*=613, they arrived at the conclusion that “there may be other important predictors of verbal aggression that are not captured by the HCR-20” (p. 319). They went further by concluding that essentially, this means that the static data collected by the HCR-20 is unable to accurately distinguish between those who do or do not engage in aggressive verbal interactions.

So, the function of this method is prediction; the paradox is that, in mental health settings, risk assessment has to be linked closely to management and prevention (Doyle & Dolan 2002). Notably, risk management becomes the care plan of the patient; this improves patient outcomes, seemingly preventing adverse events. West (2001) has argued that dynamic factors such as patient mood or inebriation are more telling and predictive. Over time, these states can change. This then affects the assessment of risk on, potentially, a daily basis. West (2001) stated further that consideration must also be given to dimensions of severity and frequency when assessing for risk. This implies that clinicians must rely on the gathering of data, not only from the patient but also from collateral sources because the patient may minimise their symptomology or the frequency of occurrences. West considered information to be the key, with decision-making without information considered as a clinical gamble.

These contentions by West (2001) are further supported by a study by Trenoweth (2003) which reported that nurses draw on their knowledge of the patient through observation of their behaviour and body language and the recognition of general risk factors that may trigger a risk behaviour. For example, in Trenoweth’s study, triggers for potentially violent behaviour included the presence of particular nurses, anger at being detained against the patient’s will, or a refusal to grant the patient leave from the ward. Likewise Buckingham, Adams, and Mace (2008) found that clinicians weighted dynamic factors, such as intent, higher when assessing for risk; for example, committing self-harming behaviours that were intended to cause death. It would seem from this that a combination of static and dynamic factors assist clinicians in their risk assessments.

4.3.4.3 Structured clinical judgement

To expand this argument, there is debate as to which method is superior, actuarial risk assessment or structured clinical judgement, with evidence lacking one way or the other (West 2001; Woods & Lasiuk 2008). Each approach requires mental health professionals to obtain full knowledge of the patient, both individually and as a member of a group (Godin 2004). The clinician is required to abstract this knowledge in order to make a fully-informed prediction about future behaviours (Godin 2004). Baker et al. (2014) and Kumar and Simpson (2005, p. 332) considered structured professional (clinical) judgement to be when a clinician is informed “by the risk factor literature, considers the presence and meaning of particular risk factors relevant to this person, and formulates the risk on that basis”. Woods and Lasiuk (2008) suggested that rather than solely using unstructured clinical judgement, or actuarial risk assessment, current practices for assessing risk should be centred around a combination of both approaches. Gerace, Curren, and

Muir-Cochrane (2013) found that tools provided a snapshot of a situation and also enabled a structured approach to be taken. Clinical judgement was then applied in order to formulate decisions.

In contrast, Moore and Hammond (2000) stated that statistical methods of prediction are more accurate than clinical judgement. This lack of agreement identified by Lamont and Brunero (2009) in the literature was also explored by Petrila and Douglas (2002). They stated that when assessing risk, there appears to be no consensus on which is the superior method, although they found that unstructured clinical judgement is inferior. Despite this, studies have demonstrated that actuarial tool performance is enhanced when used in combination with clinical judgement, although the confidence of predictions is correlated with the quality of the data used for the risk assessment (Lewis & Webster 2004). There is also a large body of knowledge that provides information for clinicians to use; I note here as a key point that *there still remains little research on whether clinicians actually incorporate evidence into their practice.*

Nevertheless, West (2001) and Carroll (2009) suggested that structured professional judgement (which incorporates actuarial assessments) combined with clinical judgement has proven to be valid and useful; their rationale being that this utilises the best features of the clinical and actuarial approaches. These defined guidelines and empirical knowledge are integrated into assessment, prediction, management, communication, and prevention tasks (West 2001). From this, a “rapid, intuitive judgement” is made.

Similarly, in a study by Muir-Cochrane et al. (2011a), in which 15 multidisciplinary healthcare professionals completed a risk assessment based upon a clinical vignette and were interviewed afterwards, the healthcare professionals used multiple interdependent factors, including a risk assessment tool (invalidated), to provide an overall picture of the risks that were present. Structured clinical judgement involved the tool to guide the assessment, and the collection of information such as recording their observations of the patient, their physical interactions with the patient, and collecting this information from other healthcare professionals, the police (where relevant), and families/caregivers. Once pieced together, this presented an overall picture.

In a triangulated study (*n*=46), Buckingham, Adams, and Mace (2008) examined how clinicians make risk judgements and provide a comprehensive framework of risk and clinical knowledge when assessing risk. This included the areas that clinicians draw on, such as state of mind, personal details, and history, and demonstrated the notion of combining clinical judgement with intuitive practice. Buckingham, Adams, and Mace (2008, p. 301) subsequently developed a mind map (*see* Figure 5) outlining this framework as a result of interviewing mental health practitioners from varying disciplines. This mind map is notable and relevant for the purposes of this chapter as it illustrates the various aspects that clinicians considered when assessing for risk. This map demonstrates the intricacies in RAM in a way that many studies have failed to do. In this map, risk as the focal node is the central point, with specific risks extending from this point, and clinicians then identifying risk factors. They considered static cues (or historical influences) and argued that this can be “dehumanizing actuarial data”. The participants in this study considered historical influences as part of risk assessment; however, they were more focused on current influences, with the primary consideration being the patients’ “intention to execute a risk behaviour” (p. 306) and “unintentionally relayed signs” (p. 307) during the assessment, including appearance and behaviour. In this way, a subjective component in this knowledge structure seems to exist, although it should be noted that there is always a subjective element when looking into the future. Due to the participants’ lack of dependence on historical factors alone, the authors argued that having identified this aspect in decision-making allows the development of a valid risk screening decision support system that factor in these aspects. The major specific risks found by Buckingham, Adams, and Mace (2008) included “past episodes of risk, family history of risk”, “life history” of risk, and current intention to be risky. Buckingham, Adams, and Mace (2008) noted however, that individual reactions to risk by clinicians were another important factor. This factor affected their assessment of risk, and yet, the systematic incorporation of tangible cues would further improve risk assessment. However, there was little agreement by clinicians as to what these would be.

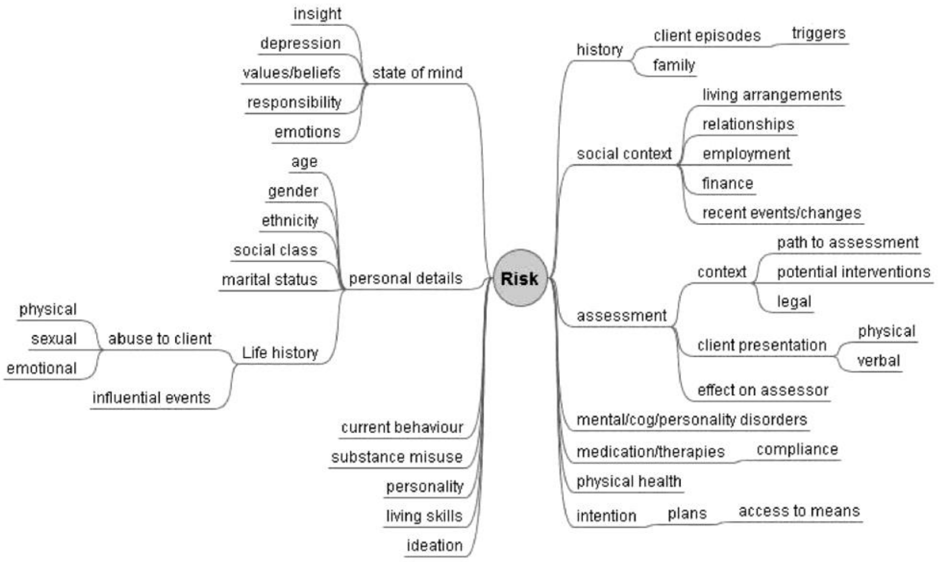


Figure 5: Mind Map of Risk

Reproduced directly from Buckingham, Adams, and Mace (2008, p. 301)

4.3.5 Risk Management (Interventions)

Risk management becomes the next step for patient care after clinicians have assessed for risk. As such, “risk management” now becomes conceptualised as the interventions that are needed in order to reduce the risks that have been identified for the patient. In this way, risk assessments are used primarily to identify risk, but also to develop and inform risk management strategies (or interventions) (Hutchinson, Lovell & Mason 2012). To illustrate this point, a randomised controlled trial conducted over forty weeks on four acute care psychiatric wards found that daily risk assessments (*n*=597) “led to significant reductions in the number of aggression incidents”, including clinicians’ need to rely on seclusion as an intervention to reduce risks to patients and staff (van de Sande et al. 2011b, p. 476). van de Sande et al. (2011b) suggested that the reason for this is that this procedure had the potential to foster team awareness of behavioural escalation. Evidence-based interventions have the potential to improve clinical practice. Again, I identify here another key point relevant for this thesis in that *there has been little research published that has examined whether clinicians currently access or implement these interventions in their practice*. Consequently, there is little to draw from for the purposes of this chapter.

The information available in the selected literature included structural aspects offered as a means of control for staff, which consisted of locking the ward doors to contain patients (to prevent absconding) or to prevent unwanted visitors from entering (Cleary et al. 2009; Grotto et al. 2015; Quirk, Lelliott & Seale 2006). Of note was the study by Quirk, Lelliott and Seale (2006) in which visits to the local zoo to reduce incidences of violence and aggression (Antonysamy 2013) and special observation to manage risks of absconding were conducted (Cleary et al. 2009; Gerace, Curren & Muir-Cochrane 2013; Grotto et al. 2015; Quirk, Lelliott & Seale 2006). Quirk, Lelliott, and Seale (2006) found that a high proportion of health professionals' time was spent managing adverse events. Interestingly, in the aforementioned study by Antonysamy (2013), weekly visits to the local zoo were scheduled over a 12 month period in an attempt to reduce violence, aggression, and absconding. While the reporting of this intervention has significant limitations, and there may be many other determining factors, it cannot be ignored that violence and aggression reduced over this time by 25%, the average length of stay reduced from 90 to 30 days, and the seclusion rates and staff sickness rates also reduced significantly during the period of the intervention.

Emmerson et al. (2007) developed a protocol to manage behaviours through medication, as well as implementing educational strategies related to error chains to encourage communication. The error chain in healthcare refers to when adverse events occur because of only a single error being made. Instead, the event is due to a multiple series of errors (Emmerson et al. 2007). The reduction of error chains, in this study, was achieved by developing protocols and implementing educational strategies designed to be used as a means of controlling aggression. Bhui et al. (2001) found that patients suggested a separate ward for other patients who were perceived to be violent or aggressive in order to reduce the levels of risk associated with these behaviours.

Interventions were also considered by Cleary et al. (2009) within the context of feelings of powerlessness and lack of control felt by patients and, by default, their families/significant others. They suggested that these feelings hampered the initiation of a therapeutic relationship and subsequent engagement with the patient, citing this as a significant barrier towards effective care. To decrease these feelings, they suggested interventions that would enable patients and families to become more familiar with the mental health system. This means being aware of the ward rules and regulations, explaining restrictions that had been put in place, and educating patients on their legal status and rights, the roles of staff, and the layout of the ward.

The availability of a therapeutic space was also cited as a measure for managing the negative transference of patients’ emotions and actions (Bhui et al. 2001; Thurston 2003). Patients also suggested other strategies such as punching bags, more televisions and separate rooms, quick resolution by staff when altercations occur, reassurance provided by staff thereafter, therapeutic conversation and self-disclosure by healthcare professionals, and communication after incidents (Bhui et al.(2001). Patients claimed that staff would intervene too soon, and that measures of control and restraint were used all too frequently, which detracted from the therapeutic process (Bhui et al. 2001). This finding was similar to that of Baker et al. (2014) who suggested that this can lead to therapeutic disengagement by patients.

Interestingly, nursing clinicians (*n*=125) who participated in a study by Martin and Daffern (2006) considered that proactive strategies to de-escalate or prevent inpatient aggression increased their confidence in managing aggression. These interventions included PRN medication, adequate assessment, empathy, rapport, and counselling. However, the factors that detracted from this confidence were individual perceptions, such as believing that the patient was under-medicated, or the medical staff misunderstanding aggression management protocols. Similarly, Gerace, Curren, and Muir-Cochrane (2013) found in their study that multidisciplinary healthcare professionals cited interventions such as allocating male staff, supervised activities, avoidance of triggers, and family support when managing risks. However, it should be mentioned that the interventions cited were in the context of a clinical vignette and, as such, were case-specific.

4.4 Discussion

This thematic analysis of the contemporary risk assessment and management literature focusing on acute care adult settings revealed that risk assessment is a multilayered iterative process. There were multiple definitions of RAM in the literature, although risks such as the risk of violence are often considered in isolation from other risk and management considerations. Despite this, the empirical literature does identify the diversity of risks that exist for both the patient and the staff. RAM is conceptualized to be influenced by a number of factors, including clinical responsibilities, staff factors, organisational and ward factors, and one specific barrier, that of time. The recent literature addresses the approaches taken towards RAM, building on the work which began in this area in the year 2000, focusing on the strengths of each in the clinical setting, together with looking at the interventions available to minimise risk. What emerges from this literature is that global and local understandings of risk are layered over the more specific aspects such as clinical practices, with risk being the central point. Each layer informs and influences the others.

4.4.1 Local evidence

Notably, only six acute care psychiatric RAM studies (*see* Appendix A) originated from Australia. Without sustained and focused Australian research, the nature of clinical RAM within an acute care psychiatric context “cannot be accurately assessed, nor can local practice standards be defined” (Mosel, Gerace & Muir-Cochrane 2010, p. 178). There remains a critical need for a local understanding of RAM within specialised settings; hence, there is an explicit gap in the knowledge. None of the studies examined comprehensively what knowledge of RAM clinicians draw upon to aid their practice. Rather, the literature identifies the types of risks present and the interventions that are available, but fails to investigate whether these are used by clinicians in their practice. The literature also fails to consider clinicians’ attitudes and perceptions to RAM in acute care settings.

4.4.2 Type of risks

It is important to identify the type of risks that clinicians seek to assess and then manage. The literature has mainly focused on the assessment of risk, and in particular violence, but is largely silent on the management of violence. In addition, the individual types of risk are absent from the literature when examining them in conjunction with specific minimisation strategies. Nevertheless, the type of risks and risk factors specifically identified in the literature included violent or aggressive incidents (Bhui et al. 2001; Campion et al. 2008; Lepping et al. 2009; Quirk, Lelliott & Seale 2006; Thurston 2003), the availability of illicit drugs (Cleary et al. 2009; Quirk, Lelliott & Seale 2006), and absconding (Cleary et al. 2009; Grotto et al. 2015). While only a limited range, these studies have the potential to inform clinicians and to aid with their practice.

Although risk behaviours need to be individually explored further within the literature due to the uniqueness of each one, there remains scope to not only identify the risk behaviours that clinicians seek to assess and manage, but also to analyse and conceptualise these as a cohesive whole. Links can also be made which assist clinicians in the clinical setting. For example, aggression can be triggered by the social milieu (Bhui et al. 2001) or the locking of the doors in the ward (Higgins et al. 2016; Muir-Cochrane et al. 2012), whereas absconding may be triggered when there are fewer staff available on the ward and perceptions of risk are heightened with less staff support (Grotto et al. 2015; Mosel, Gerace & Muir-Cochrane 2010; Trenoweth 2003). These examples demonstrate the multi-factorial complexities that exist when attempting to assess and manage risk within pre-defined frameworks.

4.4.3 Approaches available

The literature suggests that a structured approach combining static, dynamic, and future risk factors (inclusive of details and context) is the best approach. This means that static and dynamic factors are considered when using clinical judgement and/or intuition for assessing and managing risk. In addition, clinical judgement and intuition relies on a large number of factors that are specific to the patient being assessed, the situation and environment that the assessment is taking place in, and the interactions that may occur between variables (Gunenc, O'Shea & Dickens

2015; Kumar & Simpson 2005; Trenoweth 2003; Woods & Lasiuk 2008). That said, this approach should include all multidisciplinary healthcare members together with the patient (Vinestock 1996). However, a lack of evidence still remains. Of the studies included in this review, there is an acknowledgment that static (unchangeable, such as a history of risk behaviours) and dynamic (potentially changeable; for example, substance abuse) factors are overlooked in RAM, while complexity abounds in relation to these factors, situations, and individual predispositions (for example: Buckingham, Adams & Mace 2008; Carroll 2009; Carroll, Lyall & Forrester 2004; Dolan & Doyle 2000; Doyle & Dolan 2006; Gilbert, Adams & Buckingham 2011; Mosel et al. 2010; Muir-Cochrane et al. 2010; Muir-Cochrane et al. 2011b; Price 2014; Vail et al. 2012). Consequently, it was difficult to draw conclusions from the evidence being examined, due to the focus on behaviour being examined rather than assessing and managing risk across a broad spectrum of acute psychiatric care.

Regardless, intuitive decision-making by clinicians appears to dominate the literature. The majority of the studies that considered this advocated a combination of intuition and clinical judgement due to bias being evident when using only an intuitive approach. However, many of the participants in the studies reviewed used intuitive approaches as part of their clinical practice. From this, one may conclude that RAM can be viewed as an art rather than a science (Kumar & Simpson 2005). As an alternative, other literature centred upon what clinicians should do to enable effective RAM practices, as opposed to what studies support effective RAM practices (Petrila & Douglas 2002; Price 2014; West 2001; Woods & Lasiuk 2008). The articles reviewed provide a framework for RAM in acute care psychiatric settings. For example, Moore (2000) suggested that the central role of clinicians in mental healthcare is the assessment and management of risk. There should be no short-cuts in the decision-making process. The incorporation of a comprehensive “check list approach”, together with various RAM strategies, should occur even if previously undertaken for the same patient.

This notion is supported in other literature in this review which has demonstrated that standardised risk instruments are being used in the clinical setting on a more frequent basis (Doyle & Dolan 2002; Hart, Michie & Cooke 2007; Lindsay et al. 2004; Petrila & Douglas 2002; Samuels, O'Driscoll & Bazaley 2005; Undrill 2011;

Webb 2012; Welsh & Lyons 2001), although structured clinical judgement seems to be of more use in the clinical environment, rather than actuarial assessment or unstructured clinical judgement on their own. Wand (2012) supported this and suggested the use of a multi-disciplinary approach using an integrated framework that incorporates the more complex dynamics as opposed to only clinical experience or actuarial information. This may then reduce incidents of aggression and violence in the clinical setting. To achieve this, structured professional judgement requires consideration of the individualised knowledge of the patient, knowledge of the risk factors, and professional experience (Wand 2012).

Normative decision-making models can also be usefully considered at this juncture. These models can be useful as they assist in describing optimal thinking standards, acting to maximise the utility of these decisions. These models use probability in order to predict “the conditional probability of an event given the occurrence of another event, and is the underlying model used in actuarial risk assessments in a number of fields” (de Klerk 2012, p. 9). At this point however, it should be mentioned that the check-list approach should be viewed as being fluid, iterative, and adaptable to circumstance. What aids this approach would seem to be the additional use of actuarial measures.

Having evidence-based understandings of the frameworks surrounding RAM is necessary. The factors within RAM must be consistent and flexible, and should also account for the dynamic variables, case-specific influences, and the contexts. Consideration of these factors is necessary and critical for effective clinical practice in a range of settings (Clancy & Happell 2014; Doyle & Dolan 2002; Mosel, Gerace & Muir-Cochrane 2010; Woods & Lasiuk 2008).

4.4.4 Perspectives and influence of risk assessment and risk management

This review also considered that environments shape human behaviour (BootsMiller et al. 1997) and that acute care settings are unique (Kumar & Simpson 2005). Yasini (2009) extended this by suggesting that “[r]isk assessment and management need to be put in political and epidemiological perspectives” (p. 156). This viewpoint was reinforced by Murphy (2004, p. 412) who considered that “practice is influenced by the awareness of risk". This suggests that clinical practices may not incorporate these (and other) perspectives. Moreover, these perspectives might also be influenced by a large number of variables that are identified within these themes.

The awareness of risk is one such variable. This awareness can be influenced by factors such as the definition of risk assessment, varying approaches towards the assessment and management of risk, mandated requirements, patients, time, risk perceptions, and the organisation. Intrinsic within this process are stakeholders (who are often not considered). However, stakeholders may also influence RAM practices. These influences can, in turn, influence the RAM process and affect clinical practice.

Measures of risk can be both objective and subjective. Objective data can be thought of as being empirically-based. In the context of risk behaviours, for data to be objective, the behaviour must be measurable and must be complete in the definition to then "allow clear observations of the measures of the behaviour" (Groth-Marnat 2009, p. 105). Alternatively, subjective data can mean "self-experienced" (Kim et al. 2010, p. 952). Depending on the definition, objective or subjective measures are then applied to the risk being assessed. However, when objectively measuring a risk, a clinician's experience may also come into play. This means that when risk is first defined and interpreted at the individual and organisational level, it is then assessed and managed differently depending on the measures applied. As a result, perceptions of risk may be negatively influenced. For example, if a clinician has been a victim of violence, then their confidence in recognising potential risks may be affected, or they might increase their vigilance towards potential risks (Murphy 2004). Patients may then be labelled (e.g. as violent) and, in this way, clinical practice may be influenced from the outset.

The lack of time and the pressure this creates were also raised in the contemporary literature. However surprisingly, there were very few papers that examined these aspects of assessing and managing risk. Yet the limitations of time and the unrealistic expectations of organisations on clinicians' time are frequently referred to in the literature on acute psychiatric care RAM, but also in relation to healthcare in general. The consequences of lack of time for the patient include influences on decision-making (Clancy & Happell 2014; Thompson et al. 2008), the inability to consciously process all of the information necessary to then make a decision (Carroll 2009), the inability to comply with policy and recommendations (best practice) (Yarnall et al. 2003), and being unable to develop and implement complex interventions (Campbell et al. 2000). Lack of time for health professionals can also lead to the under-treatment of depression for the patient (Hirschfeld et al. 1997), may interfere in communication between healthcare professionals and the consumer/patient (Stead et al. 2003), and may also affect the implementation of culturally competent care (Johnson et al. 2004).

The literature identified other considerations, such as multidisciplinary teams working together. While at a seemingly individual level, it is worth considering the organisational influences that can have an impact on this. One example is a report commissioned by the Mental Health Commission Ireland (Byrne & Onyett 2010). This report included a research study that analysed 100 key stakeholders' responses using a thematic analysis. Individuals were grouped according to the professional bodies they belonged to. The groups of professional bodies that participated in this study included advocacy/voluntary organisations, academic/research organisations, and specialist health services.

One of the questions posed to the respondents was "[i]n the Irish experience, what are the barriers and facilitators to MDT [multi-disciplinary teams] working" (Byrne & Onyett 2010, p. 69). The barriers that were identified through thematic analysis were staffing issues (*n*=61), training/preparation for team working (*n*=39), understanding/knowledge of other professional roles (*n*=39), dominance of the medical model (*n*=37), professional balance (*n*=31), communication (*n*=24), lack of resources (*n*=20), leadership issues (*n*=18), "professional elitism" (*n*=20), and mutual respect (*n*=18). These themes indicate that in order for multidisciplinary teams to work effectively, staffing levels and the availability of resources in organisations need to be addressed, as does the pervasive "dominance of the medical model" and "professional elitism". Similarly, the training needs of healthcare professionals should also be carefully considered. The areas worthy of close attention for organisations are communication and leadership skills.

These dominant themes that existed as a barrier towards multidisciplinary teams working together are also evident in a number of other studies. Bishop and Ford-

Bruins (2003) found, for example, that nursing roles remain unclear in multidisciplinary teams, with nurses relying on the initial assessments of medical staff, rather than their own. Yet, nurses were found in this study to play an integral role in multidisciplinary teams due to their sustained contact with the patient and, as a consequence, were more intimately involved in their care. This finding is reinforced by Lewis and Webster (2004), who indicated that risk assessment is becoming a multidisciplinary task, rather than a task for a single professional group. Davies et al. (2006, p. 1098) argued that professions within forensic settings are “simultaneously interdependent and competing for power, status and resources. The tension between these two states puts relationships between professions into constant flux”. This is important in that an adverse event may be understood in a different way by each participant of a differing profession, and risk blindness may occur in the organisational context when there are differing frames of reference to risk assessment without considering the frames of reference of other professions (Davies et al. 2006). This highlights the disconnect between the biomedical model versus the holistic care that nurses hope to provide; and this comes with the different focus in terms of “care” each healthcare professional has when interacting with patients. The disconnection and differing focus ultimately influences the assessment of risk and subsequent management of risk – stemming from the differing perspectives of each field of healthcare.

One other area of organisational influence is the identified need for clinical education, which was perceived in the literature examined here to be a key component of effective RAM. Education in documentation and formal RAM training were viewed as the most crucial aspects, with structured collaboration between health professionals enhancing this process. Comprehensive policies and procedures that are adaptable to the environment are also important in this process (WHO 2010). While these policies and procedures have been identified as affecting assessment and management within this review, there has been little exploration from a clinician’s perspective, despite their legal obligations. It is clear there is a need for education, training, and continual support, particularly when applied to the containment of patients. Health professionals should also be building skills in counselling, negotiation, and communication.

4.4.5 Interventions available

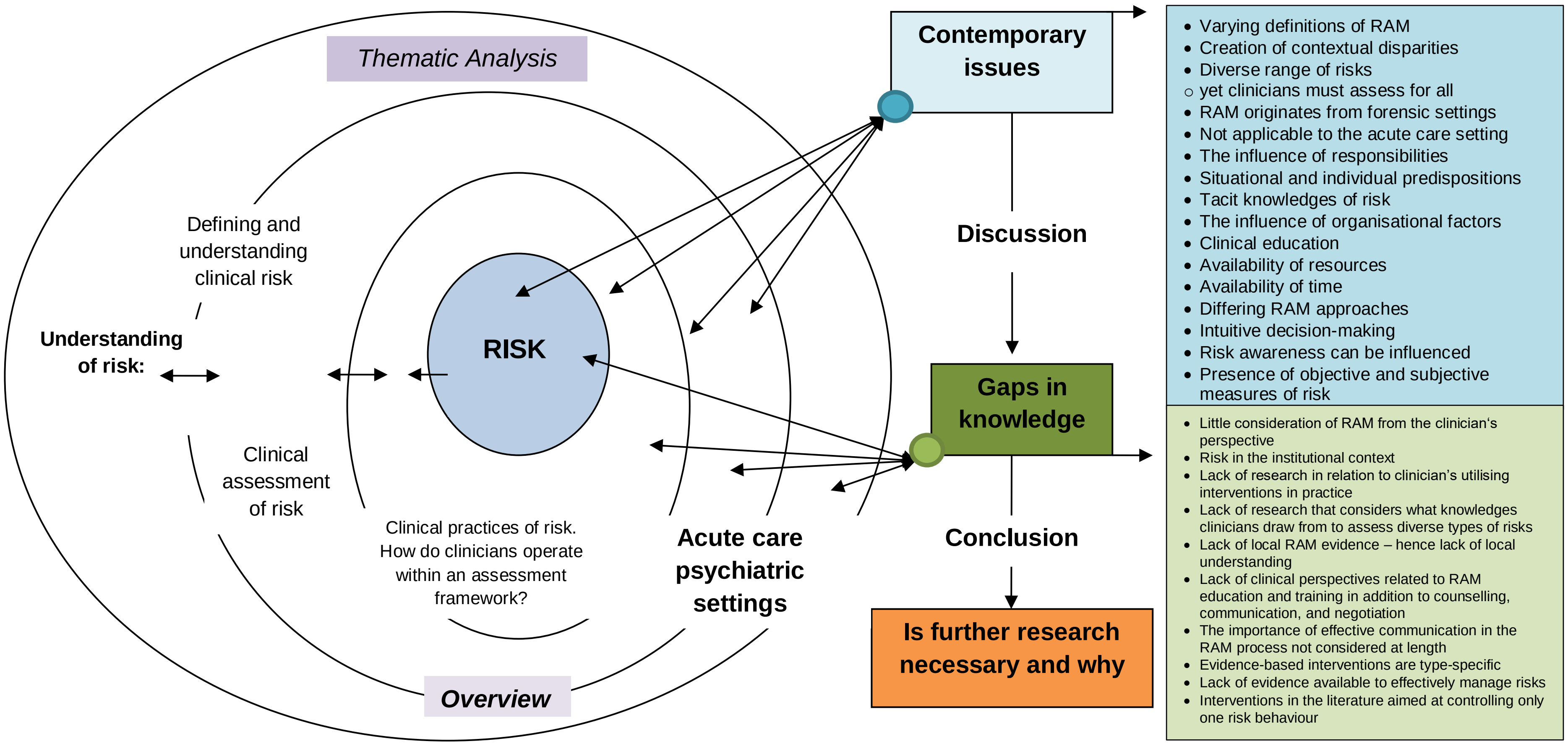
Interventions or, strategies featured prominently in the literature in keeping with the framework developed by Moore (2000) as previously described. Interventions and strategies described in the literature were purposely implemented in order to reduce or manage adverse events and minimise risk. The interventions ranged from communication with staff through to changing the physical structure of the ward. However, the interventions identified were largely aimed at controlling aggression and preventing absconding.

Communication was an important intervention, yet it is not afforded importance in many of the studies. Effective communication has the potential to decrease perceptions of risk, and this then changes the management of risk behaviours (Trenoweth 2003). Effective communication can enhance the therapeutic relationship with the patient as well (Chant et al. 2002). However, the communication can be either therapeutic or detrimental to patient care, which depends on what information is being relayed and the purpose behind the communication. Bhui et al. (2001) examined this, to some extent, when they considered patients’ views after a violent incident. Patients’ suggestions such as therapeutic conversation, effective debriefing after violent incidents, and decreasing control and restraint strategies were noteworthy, although to date, these remain untested for their efficacy. Nevertheless, some of the interventions suggested by patients in this study are based on contemporary evidence and enhance the therapeutic aspects of the interaction (Blasi et al. 2001; DiMatteo 1994; Novack 1987). Time is however an important consideration within this context. Time does factor significantly when implementing interventions, especially when clinicians spend a large proportion of their day assessing and managing risks. It is not difficult to imagine the amount of time required to implement effective strategies, promote therapeutic care, and create therapeutic space, while at the same time, continuously monitoring and managing other risks as they arise.

4.5 Limitations

Overall, there were many issues raised within the literature of specific relevance for clinicians undertaking RAM. However, many articles focused on only one aspect of mental health RAM (for example, violence or self-harm/suicide and concepts of dangerousness). As such, it was difficult to draw firm conclusions due to the focus of each study. Moreover, the literature implied that the RAM of psychiatric inpatients was “about making defensible decisions”, suggesting that these decisions be clinically defensible, logically defensible, and medico-legally defensible (Clancy & Happell 2014; Holdsworth & Dodgson 2003; Vinestock 1996, p. 3). Often, these papers were not based on gold standards of evidence (systematic reviews or randomised controlled trials) (Christ 2014). Rather, they were expert-based, single issue (such as the behaviour being researched was violence, aggression, or absconding for example), or qualitative. It is not surprising then, that what emerged were papers that identified what should be done in RAM, as opposed to what is being done. This review has however allowed some of the issues that face health professionals to be identified, as well as the current perceptions, knowledges, and attitudes of health professionals to be explored in relation to risk assessment and risk management, in addition to the barriers and enablers experienced by health professionals. In addition, this review informs the aims and objectives of this thesis.

The conceptual summary developed (*see* Figure 6) illustrates the findings of this selective review, describing and outlining these. The core concept is “risk”. Risk is encapsulated by global (outside of the country) and local (inside the country) understandings of risk, which shape and define the understandings of clinical risk by clinicians and organisations. The clinical assessment of risk in an acute care setting is underpinned by these understandings, but at the same time, clinical assessments of risk can influence global and local understandings of risk, as evidenced by the arrows that move in a two-way manner. Clinicians in an acute care psychiatric setting then operate within a risk assessment framework which shapes their clinical practice at an individual and/or team level. However, clinical risk practices have the potential to influence risk assessments. This thematic analysis has focused on the clinical practices of risk and has aimed to identify the contemporary issues that are evident within the literature. The gaps in knowledge have been identified which indicate that further research is required. The contemporary issues and gaps in knowledge identified as a result of this literature review are briefly summarised in Figure 6 and have been subjected to sustained examination in the themes presented in this chapter.



- Varying definitions of RAM
- Creation of contextual disparities
- Diverse range of risks
  - ○ yet clinicians must assess for all
- RAM originates from forensic settings
- Not applicable to the acute care setting
- The influence of responsibilities
- Situational and individual predispositions
- Tacit knowledges of risk
- The influence of organisational factors
- Clinical education
- Availability of resources
- Availability of time
- Differing RAM approaches
- Intuitive decision-making
- Risk awareness can be influenced
- Presence of objective and subjective measures of risk

- Little consideration of RAM from the clinician's perspective
- Risk in the institutional context
- Lack of research in relation to clinician's utilising interventions in practice
- Lack of research that considers what knowledges clinicians draw from to assess diverse types of risks
- Lack of local RAM evidence – hence lack of local understanding
- Lack of clinical perspectives related to RAM education and training in addition to counselling, communication, and negotiation
- The importance of effective communication in the RAM process not considered at length
- Evidence-based interventions are type-specific
- Lack of evidence available to effectively manage risks
- Interventions in the literature aimed at controlling only one risk behaviour

Figure 6: Conceptual framework of the thematic findings

4.6 Conclusion

There remains a lack of robust research about RAM practices in acute care psychiatric settings. Overall, there is little consideration of RAM from the clinician's perspective, and particularly from Australia. Current conceptualisations, understandings by multidisciplinary healthcare professionals, which knowledge base they draw from, and what the issues are for clinicians that affect their practice in terms of assessing and managing risk have been examined, but with little depth. Moreover, there is little exploration about what helps, and what does not help, clinicians' practice when undertaking RAM. For example, there is a paucity of research that considers what knowledges clinicians draw from to assess diverse types of risks. There were also limited clinical perspectives related to RAM education and training, and the importance of effective communication in the RAM process was not considered at length. Of further note was that while the literature was relevant to acute care psychiatric settings, many did not include these settings in their studies (Bowers et al. 2002).

Broadly, the findings of the review indicate that the varying definitions of RAM remain problematic for clinicians, with perceptions of risk being influenced by many factors. Mandated responsibilities influence clinical practice; however, therapeutic roles may be difficult to fulfil in this context. Time is further identified as a specific hindering influence in RAM practices. Of concern is that the research studies examined remain context-bound in looking at specific behaviours. This is problematic when clinicians are required to assess and manage all of these risk behaviours in acute care settings. The limited findings of this review have a number of potential practical outcomes. Importantly, these findings can be compared to other studies and serve to inform the findings of this thesis. A thorough understanding of RAM aids in the development of clinical competencies that underpin decision-making practices (Mosel et al. 2010).

This review has been designed to fill, in part, the gaps in knowledge. The next chapter will now describe the methods used in this thesis to understand the issues of RAM, how it is perceived, the knowledge required, how it is arrived at, and what are the enablers and barriers experienced in relation to effective RAM practices. The methods used to design the interviews are also outlined, including the thematic analysis framework used to arrive at the conclusions.

5 METHODS

5.1 Introduction

5.1.1 Overview

This chapter discusses the research problem, and the aims and objectives of this thesis, as well as providing an overview of the research design, ethical issues, and methods used in the collection and analysis of the data (Liamputtong 2007; Liamputtong & Ezzy 2006). Two areas of inquiry are explored:

- Stage One: An exploration of multidisciplinary clinician perspectives on RAM; and;
- Stage Two: A document analysis of the regulations and legislation that influence and frame the care that clinicians provide to patients.

5.1.2 Design

To reiterate, this study has been constructed by drawing upon the methods of Yin (2014, p. 50), and employs a thematic analysis framework for Stage One and a document analysis for Stage Two. The thematic analysis framework developed by Braun and Clarke (2006) was determined to be the most useful for Stage One and served to identify the common themes that were identified from the interviews with clinicians. Then, using the work of Karppinen and Moe (2012), Prior (2003), and Smith (1984), Stage Two selectively analysed the relevant documentation that serves to inform and frame clinical actions and patient care. For ease of reading however, the findings of Stage Two (Chapter 6) are presented before the findings of Stage One (Chapters 7 and 8). This approach allowed my analysis of the data to "enhance the richness and depth of enquiry" (Lambert & Loiselle 2008, p. 228).

5.1.3 Framework of this chapter

First, the aims and objectives of this research study are described. The development of the research problem as illuminated through my thesis journey will be discussed. Then, the study design will be outlined to provide the reader with a clear idea of what this research is all about. This discussion delineates the stages of the research study. From this, the methods employed in Stage One will be explored. The purposive sampling techniques used, and the conduct of the interviews, will be clearly explained. Next, the participants for the study are described to provide the reader with the ability to contextualise their place in the social system within which they operate. This is followed by an overview of the ethical issues that are relevant to this study followed by a discussion of how the data were analysed. Next, the innovative methods of research used in Stage Two are examined. These sections consider the selection of the data (sampling techniques) and how the data were analysed. From this, issues of rigour in research in both stages are considered, and then the overall limitations of the study are explored.

5.2 Aims and objectives

5.2.1 Research Problem

Significant gaps in knowledge about psychiatric RAM have been identified, particularly in Australia. There is a lack of robust research that identifies the issues that clinicians face when undertaking risk assessment, including their perceptions and knowledge of the process. Moreover, methods of assessment and current practices to reduce risk behaviours are often not based on evidence, but instead, on widely-held beliefs (Bowers et al. 2002; Haglund, Von-Knorring & von-Essen 2006; Melvin, Hall & Bienek 2005; Muralidharan & Fenton 2006). The purpose of this research is to develop an understanding of the issues facing health professionals in undertaking psychiatric risk assessment and management, to describe what happens around risk, and to provide a critical commentary on risk within the context of the holistic approach to psychiatric care. In broader terms, this research examines the issues that pertain to psychiatric risk assessment and risk management from a multidisciplinary clinical perspective in Australia.

5.2.2 Aims

This research study aims to develop an understanding of the issues facing health professionals in undertaking psychiatric risk assessment and management. The overall aims of this thesis are to:

Aim 1

Develop an understanding of the issues facing health professionals in undertaking psychiatric risk assessment and management.

Aim 2

Explore the barriers and enablers experienced by a multidisciplinary team in relation to effective risk assessment and management practices.

Aim 3

Critically explore relevant legislation together with the legal and ethical frameworks that influence RAM, and contextualise this within the Australian mental healthcare system.

Aim 4

Illuminate the way in which risk is socially constructed in acute care psychiatric settings.

Aim 5

Critically compare psychiatric care plans to acute care medical care plans within the context of risk management and use this knowledge to comment on the way risk has been conflated with care.

5.2.3 Meeting the Aims of the Research

The research design that is described in the next section of this chapter (*see* Figure 8) encompasses all aspects of this research study and has enabled me to meet the aims and objectives of this research in a methodical and logical manner.

The findings of the document analysis (Stage Two) are described in Chapter 6 and the findings of the interviews conducted (Stage One) are explored in Chapters 7 and 8. These findings and resulting clinical implications are contextualised and considered in Chapter 9 framed within the theoretical perspectives previously considered (*see* Chapter 2). Conclusions and cross-conclusions are then drawn (*see* Chapter 9). Implications for practice have also been identified and considered during these stages in the research process and are considered in this chapter.

5.3 Research Design

5.3.1 Outline

This study was designed drawing on the methods of Yin (2014, p. 50). This study also utilised a thematic analysis framework as outlined by Braun and Clarke (2006) and a document analysis adapted from the work of Bowen (2009), Karppinen and Moe (2012), Prior (2003), and Smith (1984). A case study approach was adopted as this lends itself to researching a problem through a range of different methods. De Massis and Kotlar maintained that:

> *… case study research is particularly appropriate to answer how and why questions or to describe a phenomenon and the real-life context in which it occurred … In addition to choosing a specific type of case study design, different philosophical traditions can be embraced in conducting a case study … (De Massis & Kotlar 2014, pp. 16-7).*

Social constructionism (*see* Chapter 2) can be seen to fit well with this approach whereby “knowledge is constructed through the creation of concepts, models, and schemes to make sense of human experience” (De Massis & Kotlar 2014, p. 17). A case study approach allows me to make sense of the findings by exploring the construction of a range of schemas and what influences the participants' construction of risk in the clinical sense.

5.3.2 Case study approach as a method of inquiry

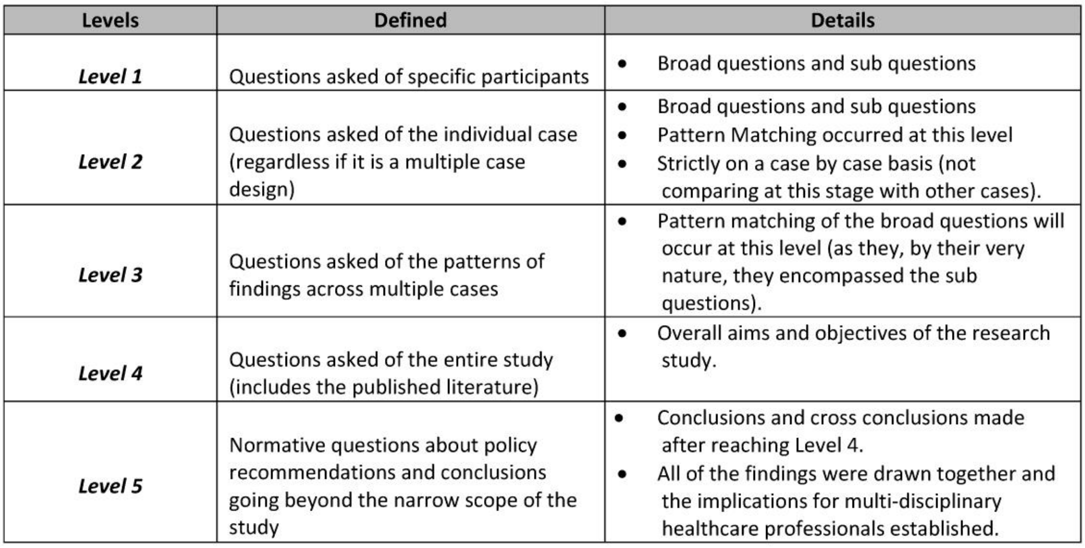
The case study approach enables insight and understanding of the "unexamined", is able to produce knowledge that is context-dependent, the nuances of reality are exposed and I can meaningfully understand human behaviour in the context of my research aims and objectives (Flyvbjerg 2006; Shaban 2004; Soy 1997). As such, this approach is useful "for exploratory and descriptive case studies" (Yin 2014, p. 1) in addition to a detailed exploration of "[h]istory and previous behaviour[al] patterns" (Burns & Grove 2005). The case study method has been demonstrated as being stable, unobtrusive, and exact, also enabling a rich source of descriptive information that is theory-dependent (Elo & Kyngäs 2008; Hancock & Algozzine 2015; Vaismoradi, Turunen & Bondas 2013). Furthermore, it also allows for the retention of meaningful and holistic characteristics that occur in real life, and is the preferred method when behaviours are unable to be manipulated (Yin 2014). Yin (2014, pp. 12-3) defined a case study as a practical examination that "investigates contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident".

Yin (2014, pp. 12-3) contended that this approach is suited to unique situations where there may be "more variables of interest then data points", and benefits "from the prior development of theoretical propositions to guide data collection and analysis". In particular, the case study approach may be used to explore and describe situations that have occurred in real life, and is not limited to sources of evidence that include detailed and direct observations (Yin 2014). This is ideally suited to the purposes of this research.

Yin (2014, pp. 46-55) and Tellis (1997, p. 1) suggested that when a case study approach is used for multiple cases, the evidence may be more compelling, and therefore, more robust. For this to be the case, however, there must be a rich theoretical framework. By doing this, there is the potential for generalisation to occur towards new cases. In addition, external generalisability may be achieved if there are common conclusions between cases. Of particular importance in this approach is that the research design can be modified upon encountering information, while continuing to collect the data. This then allows for the alteration or modification of the original design to occur (*see* Section 5.7). Nevertheless, the greatest concern identified for this method has been the lack of rigour, as there is little foundation for generalisation to occur, although Yin argued convincingly that there is little foundation for this criticism. This has been explored briefly in this section, and is further addressed in Section 5.6.

Importantly, case studies “are designed to bring out the details from the viewpoint of the participants” (Tellis 1997, p. 1). This is an important consideration when choosing a method of inquiry and is particularly appropriate for this research study. Consideration of the theoretical framework chosen for this research study (outlined in Chapter 2) is therefore necessary.

Yin (2014, pp. 72-5) outlined five levels of questions the researcher must ask in order to accurately reflect the researcher’s line of inquiry and to aid in the collection and analysis of the data (*see* Figure 7). These levels of questions are intended for the researcher, as opposed to the participants, and assist in determining the direction of the research. These questions, particularly Levels 1 and 2, occur in the data collection phase, and are reflected in the case study protocol (*see* Section 5.3.3). Levels 3-5 occur when the data has been collected and is being analysed. These levels and how they directed the data collection and supported the analysis of the data are illustrated in Figure 7:



Levels	Defined	Details
Level 1	Questions asked of specific participants	- Broad questions and sub questions
Level 2	Questions asked of the individual case (regardless if it is a multiple case design)	- Broad questions and sub questions - Pattern Matching occurred at this level - Strictly on a case by case basis (not comparing at this stage with other cases).
Level 3	Questions asked of the patterns of findings across multiple cases	- Pattern matching of the broad questions will occur at this level (as they, by their very nature, they encompassed the sub questions).
Level 4	Questions asked of the entire study (includes the published literature)	- Overall aims and objectives of the research study.
Level 5	Normative questions about policy recommendations and conclusions going beyond the narrow scope of the study	- Conclusions and cross conclusions made after reaching Level 4. - All of the findings were drawn together and the implications for multi-disciplinary healthcare professionals established.

Figure 7: Levels of questions

Reproduced from directly from Yin (2014, p. 74)

Of particular importance in the analysis of the data is that it must take place simultaneously with the data collection (Munhall 2007). In doing so, one informs the other and becomes an iterative process (Hartley 2004; Munhall 2007). This iterative process is demonstrated when considering the five levels of questions. These levels of questions, described by Yin (2014, pp. 72-5), reflect my line of inquiry and serve to aid in the collection and analysis of the data. These are Levels 3-5 which are particularly relevant for the analysis. A multi-perspective analysis of the data took place throughout this stage, embedded within the application of the levels of questions. This allowed for a consideration of the voice and perspectives of the participants, as well as the perspectives of the groups of participants and the interactions between them (Tellis 1997, p. 2). For a high quality analysis to occur using a case study approach, there are four principles identified by Yin (2014, p. 137) that must be applied. First, all of the evidence must be attended to; second, rival interpretations must be addressed; third, the most significant aspects of the case should be analysed; and fourth, prior expert knowledge should be utilised, which includes a demonstration by the researcher of the current thinking about the topic. These principles have been applied in the analysis of this data, and are reflected throughout all the chapters of this thesis. Consideration of the existing literature must also be utilised and this reflects adherence to the fourth principle above. This strategy was used to enhance the analysis, and served to raise questions about whether the current findings are consistent with the research published to date (Hartley 2004). This examination and questioning of the findings assisted my research, and allowed me to consider alternative interpretations, and to ensure rigour.

Finally, the ways in which case study methods play a major part in meeting the aims of this thesis will now be outlined, starting with a reiteration of the aims of the thesis.

- ***Aim 1*** - Develop an understanding of the issues facing health professionals in undertaking psychiatric risk assessment and management.
- ***Aim 2*** - Explore the barriers and enablers experienced by a multidisciplinary team in relation to effective risk assessment and management practices.
- ***Aim 3*** - Critically explore relevant legislation together with the legal and ethical frameworks that influence RAM, and contextualise this within the Australian mental healthcare system.
- ***Aim 4*** - Illuminate the way in which risk is socially constructed in acute care psychiatric settings.
- ***Aim 5*** - Critically compare psychiatric care plans to acute care medical care plans within the context of risk management, and use this knowledge to comment on the way risk has been conflated with care.

As a bounded case of what happens in one selected psychiatric ward, the case study method meets Aims 1, 2, and 4 of the thesis by developing the reader’s understanding of the issues, and the enablers and barriers, faced by health professionals in undertaking RAM, in addition to demonstrating how risk is socially constructed in particular ways in acute care psychiatric settings.

In addition, the mental healthcare system is constrained and enabled at the same time by legislation and ethical frameworks, but also by the organisational culture of the particular venue(s) in which mental healthcare is enacted on a daily basis. The bounded nature of the case allows an exploration of exactly how the legislation and ethical frameworks affect practice on a day-to-day basis on the ward. As well, by working with a single bounded case, a detailed overview can be provided of how the legislation and ethical frameworks are operationalised within and outside of the selected venue, so that the case venue can then be placed within the context of the wider Australian mental healthcare system, thus fulfilling Aim 3 of the thesis.

Finally, each mental healthcare venue has specific psychiatric care plans which are unique to the venue, although having many commonalities across the sector nationally. Having a bounded case allows for a direct comparison of psychiatric care plans with the acute care medical plans used in the public hospital sector. In this way, the 'use' of the psychiatric care plans will be placed in stark contrast to more general care plans, thus showing how risk, in the psychiatric setting, has been conflated with care. In this way, Aim 5 of the thesis will be fulfilled.

5.3.3 Protocol

The case study approach requires a protocol to be developed. By doing so, an exemplary case study approach can be achieved which is informed by Stage One of this study which seeks to explore, understand, and provide critical commentary on the perceptions, knowledges, and attitudes of clinicians. Likewise, as Stage Two seeks to examine the discourse that frames the participants' actions and constructs their reality, the development of this protocol has allowed me to "move from *source* to *fact*", and reveals the fundamental structures that clinicians operate within (Karppinen & Moe 2012). In this way, this research will inform and enable effective risk assessment and risk management in psychiatric inpatient units. The criteria of this is considered by Yin (2014, pp. 20-40) to be a significant, explicit attention towards the distinction between the phenomena and the given context in which a complete collection of relevant evidence is achieved, and where the researcher gives appropriate consideration to alternative perspectives.

The case study protocol developed by Yin considers five necessary aspects; "a study's questions; its propositions, if any; its unit(s) of analysis; the logic linking the data to the propositions; and the criteria for interpreting the findings" (Yin 2014, p.

20). Yin (2014) noted however that when a phenomenon is being explored, there does not need to be any research or theoretical propositions. From this, a case study protocol for this research study has been developed in accordance with Yin's guidelines, which includes the aforementioned aspects of research design. The case study protocol is tabulated below (*see* Table 3) and discussed throughout this chapter.

Table 3: Case Study Protocol

Source: Informed by Yin (2014, p. 20)

Method | Procedures	Thesis Section	
Study questions (overview of project)	Chapter 3 - Sociological discourses around mental health and "risk" in the clinical setting: from badness to madness to riskiness Chapter 4 - Examining mental healthcare and Risk assessment and management in the clinical setting Chapter 5.2 - Aims and objectives	
What is to be explored	Appendix F: Interview Protocol and Questions	Appendix H: Document Analysis: Data Selected
The purpose of the exploration	Chapter 1.2 - Purpose of this thesis	Chapter 5.2 - Aims and objectives
Study questions	Appendix F: Interview Protocol and Questions Appendix G: Thematic Patterns Exemplar	Appendix H: Document Analysis: Data Selected
Propositions & linking of data to propositions	**N/A**	
Unit (s) of analysis	Chapter 5 - Methods Appendix B: Participant Demographic Form Appendix F: Interview Protocol and Questions Appendix H: Document Analysis: Data Selected Appendix I: South Australian Mental Health "Assessment Order" Appendix J: Acute Mental Health Risk Assessment Tool Appendix K: Clinical Procedures Used On the Ward Appendix L: Standardised Risk Assessment Form For Community Mental Health Services Appendix M: South Australian Acute Mental Health Risk Assessment Tool Appendix N: Research Site: Mental Health Risk Management History	Appendix O: Research Site: Mental Health Risk Assessment Appendix P: Research Site: Risk Assessment as a Guide Appendix Q: Acute Care Nursing History & Assessment Form Appendix R: MUST Tool Appendix S: Braden Scale Appendix T: Falls Risk Assessment Tool Appendix U: Research Site: Mental Health Risk Management Plan Appendix V: Research Site: Mental Health Risk Management History Appendix W: Acute Care Nursing Care Plan Exemplar Appendix X: Acute Care Basic Observation Chart Exemplar
Data collection	Chapter 5.4.5 - Data Collection	Chapter 5.5.3 - Data Selection
Field procedures	Chapter 5.4.1 - Overview	Chapter 5.4.5 - Data Collection
Criteria for interpreting findings	Chapter 5.4.7 - Data Analysis	Chapter 5.5.4 - Data Analysis
Criteria of a successful exploration	Chapter 5.6 - Establishing and maintaining rigour in qualitative research	

5.3.4 Rigour

The trustworthiness of the findings was also considered as part of the research design. As will be explored in Section 5.6, issues such as the credibility of the findings, fittingness, transferability, auditability, dependability, and confirmability are explored at length. An audit trail was established, the steps of the analysis are clearly described, and the phases of this thematic analysis are systematically outlined. As such, this study meets the standards for rigorous, accurate, credible, and meaningful research (Aroni et al. 1999; Koch & Harrington 1998).

5.3.5 The stages of the research

On the following page, Figure 8 represents the research design in brief and demonstrates the steps taken in this research process. Initially, an analysis of the historical discourse was undertaken in addition to a review of the contemporary literature (*see* Chapters 3 and 4). This in-depth exploration led to the formulation of the research question that aimed to address the most pressing gaps identified to explore the issues evident for clinicians that work within multidisciplinary teams and practice within Australia. In Stage One, a research site was then selected (an acute care setting that also provided community services), ethics approval obtained, and participants recruited. Staff members at the research site, including the Directors of Nursing, were supportive of the research. In Stage Two, contemporary documents such as the policies and procedures of the research site, legislation, and best practice guidelines were examined to gain further understanding of the participants' responses and to allow for critical commentary about RAM in psychiatric settings.

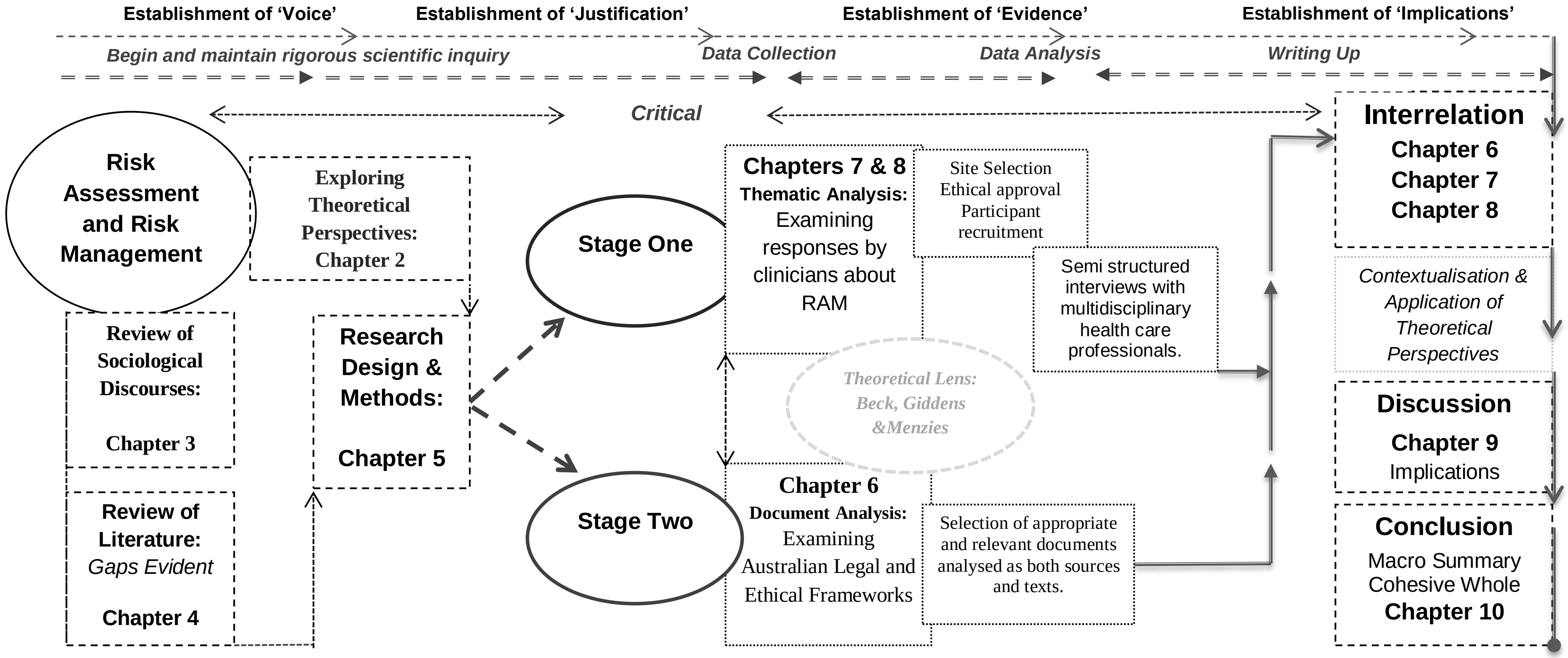


Figure 8: Research Design

Source: Original Conceptualisation

5.4 Stage One

5.4.1 Overview

Multidisciplinary care teams are deemed to be a practical necessity that allow for optimal coordination among clinicians and serve to achieve clearer communication with patients which enhances their recovery (Borras et al. 2014). As multidisciplinary healthcare is considered to be best practice, I chose to use a purposive sample of healthcare professionals (*n*=14) who worked within a multidisciplinary clinical team on a psychiatric ward for Stage One of this study. Semi-structured interviews were used to elicit data from the purposive sample and the professions that made up the sample included nurses, doctors, and allied health staff who worked together as a multidisciplinary team at the research site. Clinicians were interviewed in order to examine how they understood RAM. Protocols (interview questions) were designed to enable a rigorous approach to the in-depth analysis (*see* Chapters 7 and 8). The semi-structured interviews were a minimum of 90 minutes duration, and the interview format was carefully designed to elicit the maximum amount of information. Theoretical perspectives were also applied during the analysis (*see* Chapter 2).

The interviews conducted were part of a larger research project funded through a seeding grant received from Flinders University in 2008. The purpose of the overall project was to explore the risk assessment practices of the multidisciplinary mental health service in one large South Australian hospital. This larger study aimed to provide baseline data about the current clinical decision-making practices of the multidisciplinary team; a comprehensive understanding of the issues facing staff in undertaking risk assessment practices; and to direct future research on, and practice in, risk assessment with people with a mental illness across all wards and services of the hospital.

5.4.2 Description of the setting

The setting used for the study is an acute care public hospital of over 300 beds in a metropolitan area in an Australian capital city. The ward selected specialises in caring for people with physical and mental health problems that are aged over 65 years. The Director of Nursing was supportive of this research project and participation was promoted within the organisation as an important aspect of in-service education. This demonstrated the staff's commitment toward nursing research. The Director of Nursing agreed to the research project in order to improve the risk assessment and management processes on the ward.

5.4.3 Sampling method

A purposive sample of healthcare professionals (*n*=14) who worked within a multidisciplinary team was used in order to examine perspectives of risk. While a purposive sample is economical, time-saving, and convenient, there is the potential for bias as it is less representative of the target population and the generalisability of the findings may be limited (Yoon & Horne 2004). For the purposes of this research, I believe that the benefits of using this method of sampling outweigh the limitations. The data and the information sought to answer the research question would not have been possible using techniques such as probability sampling due to funding limitations, the timeframe, and the target population in relation to the research questions posed (Popay, Rogers & Williams 1998).

To increase credibility, an appropriate population was defined and a selection made of those who met the inclusion criteria; basically, any mental health professional who was part of the care team on the identified ward (Lunsford & Lunsford 1995). This meant that a purposive sampling technique was used and I recruited clinicians who were information rich. Pope, Mays, and Popay (2007) argued that this is a measure of quality in qualitative research and this further serves to justify my rationale for using a multidisciplinary sample. The exclusion criterion was "any health professional that was not part of the healthcare team on the ward". The participants explicitly consented to being part of the study, which is a core requirement of the National Health and Medical Research Council (NHMRC) (2007) and is explored at length later in this chapter.

The research study focuses on a particular environment and the sample is homogeneous in nature. This is further supported by the NHMRC (2007, p. 27) who stipulate that in qualitative research, rigour "should not be judged on sample size". Nevertheless, to reduce potential bias and increase credibility and fittingness, the recruitment of participants was rigorous. For example, the Director of Nursing at the research site and associated staff made announcements in team meetings and through leaving recruitment leaflets in the lunch room in addition to distributing these during handovers to increase the sample size. Data saturation was an important consideration during the recruitment phase and:

> *… entails bringing new participants continually into the study until the data set is complete, as indicated by data replication or redundancy. In other words, saturation is reached when the researcher gathers data to the point of diminishing returns, when nothing new is being added (Bowen 2008, p. 140).*

From this, recruitment ceased after 14 participants had been interviewed as there was no new information being added during the interviews and data saturation had been achieved.

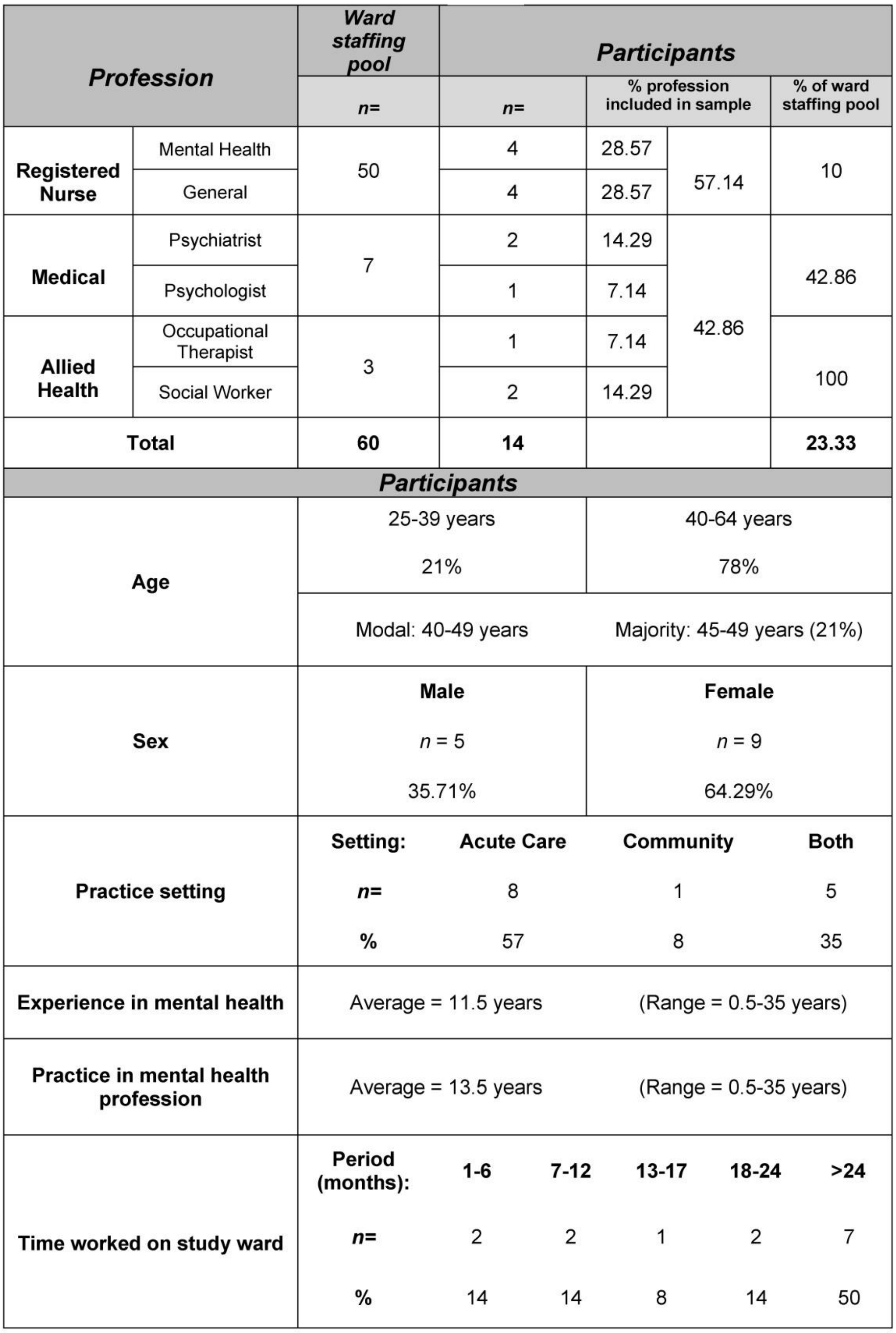
5.4.4 Describing the purposive sample

> *Qualitative researchers closely engage with the research process and participants and are therefore unable to completely avoid personal bias. Instead researchers should recognize and clarify for readers their identity, credentials, occupation, gender, experience and training. Subsequently this improves the credibility of the findings by giving readers the ability to assess how these factors might have influenced the researchers' observations and interpretations (Tong, Sainsbury & Craig 2007, p. 351).*

As Tong, Sainsbury, and Craig (2007) identified, it is essential for me to provide the readers of this thesis with a description of the occupation, experience, and gender of the participants as this serves to add further to the credibility of the research findings. The participants recruited included mental health and general nurses, psychiatrists, psychogeriatricians, occupational therapists, and social workers. Table 4 (*see below*) shows that all allied healthcare staff associated with the ward were interviewed (*n*=3); however, proportions of medical staff and nursing staff interviewed were 43% (*n*=3) and 10% (*n*=8) respectively. While the sample included a broad range of professions, the majority of the participants were nurses (registered, clinical, and mental health). Most of the participants were aged from 45-49 years, with 36% of the participants being male and 64% female. They worked only in the acute care setting. The descriptive demographic analysis concluded that clinicians who participated in this research study had on average 11.5 years of experience in mental healthcare and had practiced in this form of care for an average of 13.5 years. In addition, 50% of the participants had worked on the ward for over 2 years. Of the participants, 57% worked only on the ward, 8% worked in the community (under the ward's directorate), and 35% worked in both the acute care ward and in the community. The Director of Nursing of this ward considered the community staff to be an "integral part of the inpatient service as both case managers and inpatient allied health staff" (2012, email, 8 February). Risk assessments are conducted on the ward on a daily basis, and on a quarterly basis in the community.

Table 4: Demographics of participants in the study

Source: Original



Profession		***Ward staffing pool***	***Participants***			
		n=	***n=***	**% profession included in sample**		**% of ward staffing pool**
Registered Nurse	Mental Health	50	4	28.57	57.14	10
	General		4	28.57		
Medical	Psychiatrist	7	2	14.29	42.86	42.86
	Psychologist		1	7.14		
Allied Health	Occupational Therapist	3	1	7.14		100
	Social Worker		2	14.29		
Total		**60**	**14**			**23.33**

Participants

Age	25-39 years 21%	40-64 years 78%
	Modal: 40-49 years	Majority: 45-49 years (21%)
Sex	**Male** *n* = 5 35.71%	**Female** *n* = 9 64.29%

Practice setting	**Setting:**	**Acute Care**	**Community**	**Both**
	n=	8	1	5
	%	57	8	35

Experience in mental health	Average = 11.5 years	(Range = 0.5-35 years)
Practice in mental health profession	Average = 13.5 years	(Range = 0.5-35 years)

Time worked on study ward	**Period (months):**	**1-6**	**7-12**	**13-17**	**18-24**	**>24**
	n=	2	2	1	2	7
	%	14	14	8	14	50

5.4.5 Data Collection

5.4.5.1 Recruitment and interview process

Participants were recruited via a letter distributed to all healthcare professionals on the selected ward (*see* Appendix D). This letter offered a description of the study including the anticipated outcomes. The involvement of participants was outlined, including that their participation was voluntary, with participants free to withdraw from the study at any time. Confidentiality and financial issues were also clearly stipulated. This form clearly stated that there would be no payment for participation; rather, participation would be considered as part of the ward's clinical education program.

Appointments were scheduled at times which were suitable to both staff members and the Director of Nursing, and were located in a quiet room at the hospital. When the participants arrived at their scheduled interview time, the letter previously distributed to all staff was again supplied and the participants were requested to read this prior to giving consent (by signing a standard consent form) (*see* Appendix D). At this point, the demographics form was also completed (*see* Appendix B). The participants were reminded that they could withdraw from the research study at any time. Semi-structured interviews were conducted during the months of June and July 2009 at the hospital. Interviews were transcribed by a transcription service, with appropriate confidentiality agreements in place. The transcribed interviews were then uploaded into QSR: NVivo version 8-9 by the researcher.

5.4.5.2 Interview method

Semi-structured interviews have been identified as a useful mode of data collection when observation of participants is not possible (Yin 2014). This mode of enquiry has the ability to provide a large amount of historical (static) information, whereby the researcher can control the questions in order to obtain the maximum amount of information (Creswell 2003, p. 186). However, using interviews as a research technique also has limitations. For example, the research conducted is outside of the natural setting, bias may be evident through the views of the participants and the researcher being present, and not all participants are as articulate and perceptive as others (Creswell 2003; Liamputtong & Ezzy 2006). Nevertheless, due to the nature of the research site and the ethical issues that surround the collection of this data (*see* Section 5.4.6), interviews were identified as the most appropriate means of obtaining the required information (Creswell 2003, p. 186). Although participation was voluntary (using self-selection as a mode of participation), there were multiple professionals within the study sample. This ensured that multiple viewpoints were evident and, as a result, any potential bias was minimised. The use of semi-structured interviews as a data gathering tool has been validated by Hutchinson, Lovell, and Mason (2012). In their study of the difficulties of risk assessment experienced by community practitioners, they considered semi-structured interviews as the “preferred data collection instrument”, as it enabled the researchers to directly engage with the participants of their study.

5.4.5.3 Content and context of semi-structured interviews

Semi-structured interviews (audio-taped) were conducted with mental health professionals. The questions (*see* Appendix F) were centred on the perceptions, knowledge, attitudes, and the barriers and enablers of psychiatric risk assessment and management. The questions were subjected to review by my supervisors at Flinders University and by the Director of Nursing of the research site. Each question was constructed to elicit the maximum amount of information and to answer the research questions posed. The semi-structured nature of the questions enabled the initial responses to be pursued in greater depth (Mays & Pope 2006). After refinement of the questions to address the feedback, an interview protocol was designed which can be seen in Appendix F. The protocol included the opening statements to be used by the interviewer, the research questions, prompts (transition messages), and the requirements for the interview environment (a quiet on-site location).

Areas covered in the interview were:

- *Responsibility for risk management*
- *Attitudes to risk assessment and management*
    - *Processes and purposes for conducting risk assessments*
- *Risk assessment practices in the ward/team*
    - *Confidence in developing risk management plans*
    - *Knowledge and skills required for effective RAM*

An example of a question with prompts is:

- *How important is risk assessment in your day-to-day care of patients?*
    - *Prompts:*
        - *How does this affect your care of the patient?*
        - *What is the role of risk assessment in patient care? Real, ideal?*

The data were recorded with a digital voice recorder and a Livescribe Smart Pen. Livescribe Smart paper was also used to make reflective notations during the semi-structured interview. These reflective notations were then uploaded into QSR NVivo as a “memo” in the program, which is considered by Creswell (2003, p. 190) to aid analysis, if the memo is referenced during the analytical process. This enabled a more detailed and descriptive account to occur. Transcriptions of the interviews into hard copy then occurred. The process of participant validation ensured the rigour of the findings (Jackson, Daly & Chang 2004).

5.4.6 Ethical Considerations

The use of human participants in research must be ethically appropriate with approval to be given by an Ethics Committee that is closely associated to the researcher and/or the research site. This means that the research must also include informed consent and confidentiality provisions (Liamputtong 2007; Liamputtong & Ezzy 2006). For example, the benefits for the participants should outweigh the risks and there should be the same outcomes, merit, and respect for all participants (NHMRC 2014). However, it is recognised that research “and the compilation or analysis of statistics, are important for providing information to help the community make decisions that impact on the health of individuals and the community” (NHMRC 2001, p. 1).

In this study, ethical standards were adhered to, and participants’ privacy and rights to confidentiality were respected at all times. Ethics approval was gained from the Flinders University Social and Behavioural Ethics Committee in accordance with the NHMRC Guidelines (2007). Potential conflicts of interest within the organisation, institution, and between the participants and the researcher were considered within this framework, with none being identified (NHMRC 2007). The requirements of consent for participants were also adhered to (NHMRC 2007, pp. 19-24). This research did not require the identification of participants in any reporting of results and the transcripts were de-identified prior to analysis.

The NHMRC (2007) provides further guidelines in relation to the identification of data. Data may be collected, stored, and disclosed in three ways, through individually identifiable data, re-identifiable data, and non-identifiable data. For the purposes of this research, while the data will be termed non-identifiable, I also had the capacity to re-identify the data if I needed to. However, the ability to de-identify and re-identify data has been acknowledged within the NHMRC statement as enhancing the contribution that this research can make. For example, should any information become available that may affect the well-being and safety of the participants during the interview, the researcher can act in an appropriate manner to ensure that the participants are not affected. Alternatively, if a participant, after viewing their transcripts, chooses to withdraw some part, or all, of their data, the researcher is able to do this easily. However, it was anticipated that the information that was collected would not have any bearing on the well-being and safety of the participants.

The semi-structured interviews were audio-recorded and transcribed. They were then assigned a random number, Participant 1, 2, 3, etc., and given a fictitious name that reflected their occupation to contextualise the findings for the reader of this thesis. Recordings were saved on to a computer hard drive with the corresponding number. The participants were also asked to complete a basic demographics form (*see* Appendix B), in which they were asked only to provide their age (in ranges), gender, profession, qualifications, as well as their time worked on the ward, total service in mental health, total service in the profession, and their role on the ward. The same corresponding number was then assigned to this form to allow links to be made and to aid with further analysis. The data were uploaded into Excel spreadsheets (*see* Appendix C) from which descriptive statistical analysis (mean, mode, and proportion) was undertaken. Once the data were transcribed, each participant was offered the opportunity to review their transcript. Those who chose to do so were required to read and sign Clauses 8 and 9 of the consent form, if they agreed.

The researcher adhered to the Flinders University ethical research requirements (Flinders University 2010). All the collected data complied with Flinders University maintenance of research records, data storage, and retention requirements (Flinders University 2010). Data were stored on the researcher’s work station at Flinders University in a locked filing cabinet. Electronic media were stored in a password-encrypted external hard drive kept in the same locked filing cabinet. Data will be kept for the maximum period as stipulated by Flinders University, being five years. The data will then be destroyed in a safe and secure manner “in line with University policy of the time” (Flinders University 2008, p. 2).

5.4.7 Data Analysis

5.4.7.1 Thematic analysis as a qualitative method

Braun and Clark (2006, p. 79) identified that thematic analysis “is a qualitative method utilised for identifying, analysing and reporting patterns (themes) within data”. This method has the ability to organise and describe data in a rich, meaningful, and detailed way, explaining social phenomena and focusing on deep understanding. This understanding is achieved by developing analytical categories (or themes), moving from an inductive to a deductive approach (Jackson, Daly &

Chang 2004; Mays & Pope 2006). These approaches seek to examine the interconnectedness within the data and then to identify relationships between these themes (Pope, Mays & Popay 2007; Schneider et al. 2013). By analysing the patterns within the text, the ability to “make sense of others’ sense-making” is realised (Attride-Stirling 2001). Thematic analysis as a method for Stage One is well suited as it has direct application and relevance to clinical practice (Banning 2005; Fereday & Muir-Cochrane 2006; Joffe & Yardley 2004; Raine, Sanderson & Black 2005).

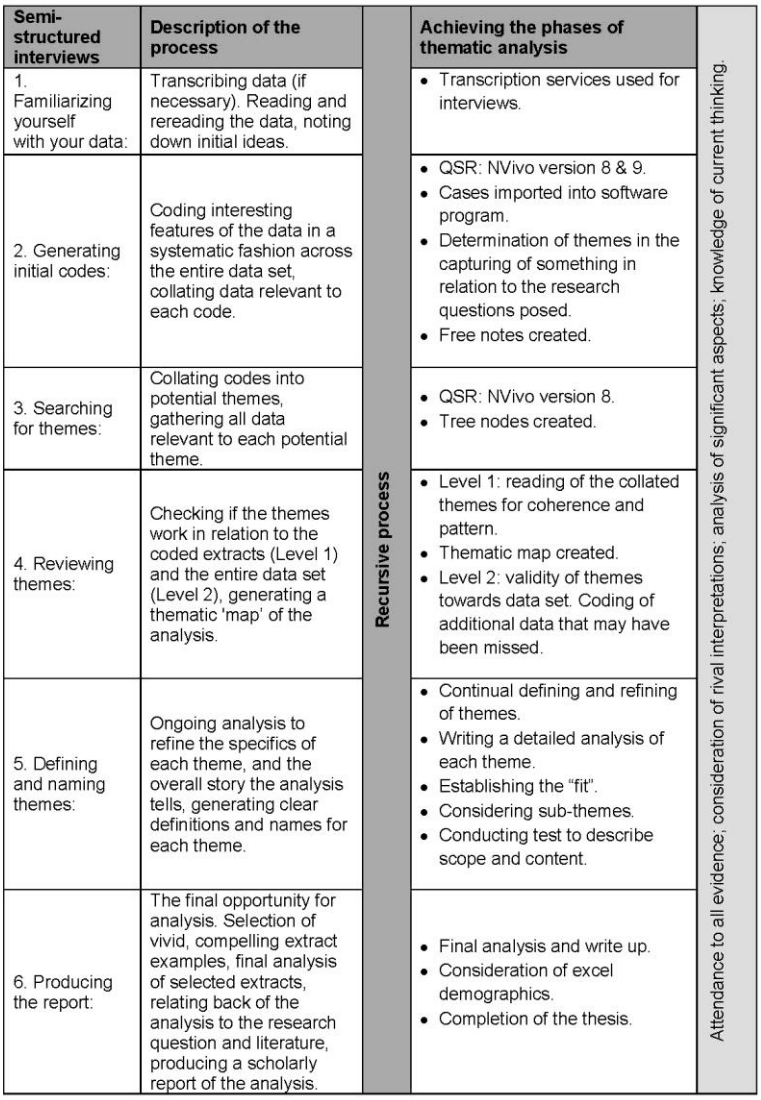
Thematic analysis has been identified by Braun and Clark (2006) as a valid and foundational method that can be employed in order to identify, analyse, and report upon the themes that appear within the data. This form of data analysis has been previously used in research on psychiatric RAM. Specifically, Hutchinson, Lovell, and Mason (2012) used the framework developed by Braun and Clarke to consider professional approaches towards risk assessment in the context of professions working with people with a learning disability that had a background of sex-offending behaviour, albeit in a community setting.

This method is also ideally suited as a constructionist method, when one is seeking to examine ways in which realities, meanings, and events operate within society (Braun & Clarke 2006). The theoretical tenets of the research of Ulrich Beck, Anthony Giddens, and Isabelle Menzies presented in Chapter 2, centre upon social theories of risk and provide the framework for the methods used in this research study. The thematic analysis method is effective in providing a rich account of risk assessment and risk management.

Braun and Clarke (2006) considered the advantages of thematic analysis as providing accessible results, allowing for the summation of key ideas which exist within a large data set and the enhancement of flexibility. Thematic analysis also provides a description of the data and is ideally suited when working within a social constructionist paradigm. Further insights can be made when using this method, which permit broader social interpretations in addition to the individual (psychological) level of interpretation. However, thematic analysis is not without its limitations. Braun and Clarke (2006) identified these as primarily being concerned with the method’s narrow scope of interpretive power (unless used within an existing theoretical framework). By using risk theory, this research overcomes such limitations.

5.4.7.2 The phases of thematic analysis

The semi-structured interviews conducted and the documentation collected were thematically analysed using the phases of thematic analysis developed by Braun and Clarke (2006, p. 87) (*see* Figure 9):



Semi-structured interviews	Description of the process		Achieving the phases of thematic analysis	
1. Familiarizing yourself with your data:	Transcribing data (if necessary). Reading and rereading the data, noting down initial ideas.	Recursive process	• Transcription services used for interviews.	Attendance to all evidence; consideration of rival interpretations; analysis of significant aspects; knowledge of current thinking.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.		• QSR: NVivo version 8 & 9. • Cases imported into software program. • Determination of themes in the capturing of something in relation to the research questions posed. • Free notes created.	
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.		• QSR: NVivo version 8. • Tree nodes created.	
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.		• Level 1: reading of the collated themes for coherence and pattern. • Thematic map created. • Level 2: validity of themes towards data set. Coding of additional data that may have been missed.	
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.		• Continual defining and refining of themes. • Writing a detailed analysis of each theme. • Establishing the "fit". • Considering sub-themes. • Conducting test to describe scope and content.	
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.		• Final analysis and write up. • Consideration of excel demographics. • Completion of the thesis.	

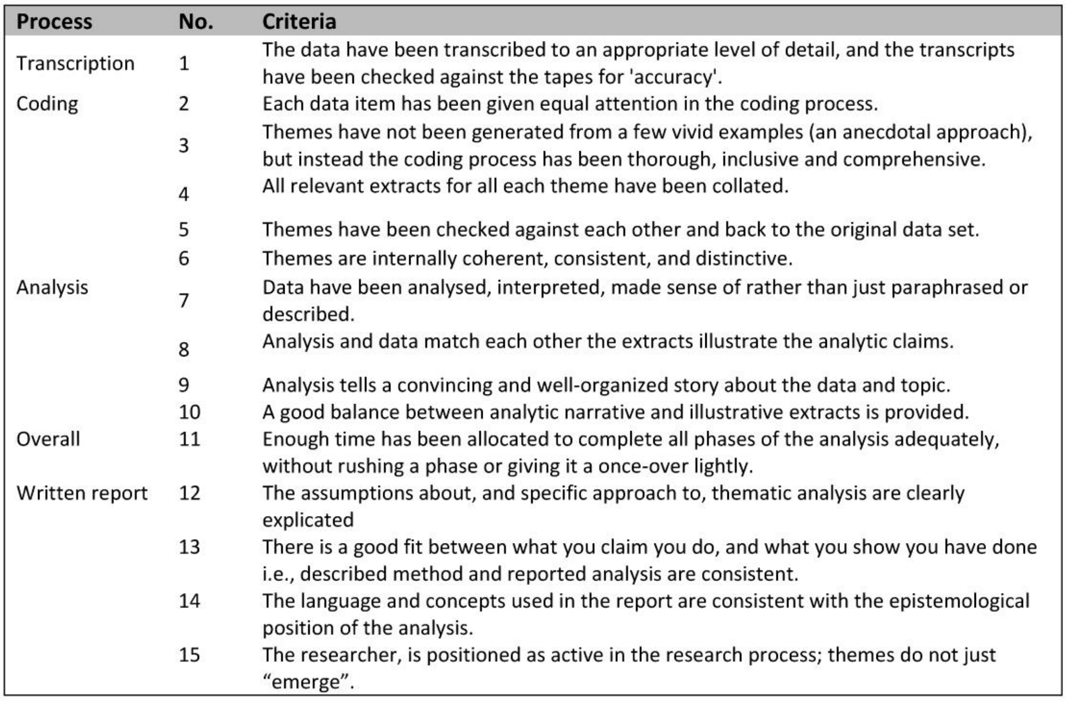
Figure 9: Phases of Thematic Analysis

Source: Adaption from Braun and Clarke (2006, p. 87)

Braun and Clarke (2006) suggested that during these phases, there is a consideration of both latent levels (ignoring a pre-existing framework/interpretive) and semantic levels (explicit); in addition to an inductive thematic analysis versus a theoretical (deductive) thematic analysis. A theoretical thematic analysis is driven by the theory of the research study and is semantic in nature.

An inductive approach was used in this analysis, as it has the ability to provide rich and descriptive results, and also aids in investigating and analysing the world of the participants, which is preferable to basing the analysis only on the literature available to date (Bishop & Ford-Bruins 2003). This means that the researcher does not fit the data around a pre-existing coding framework and has flexibility when working with the data set. Flexibility allows the entire data set to be analysed and, as such, may provide further unrelated findings that may be of importance. To ensure that the theoretical framework and the lens through which the research findings are viewed would not be "clouded", the thematic analysis in this study was conducted at both a semantic (overt) and a latent (covert) level. Importantly, the latent level has been determined by Braun and Clarke (2006) as being constructionist in nature. This allowed for the identification and examination of the underlying theoretical assumptions, ideas, and conceptualisations that shape and inform "the semantic content of the data" (Braun & Clarke 2006, p. 84). A deductive approach was encompassed in the process. This approach provided a more detailed analysis and enabled further consideration of more aspects within the data. Using both approaches (the deductive approach to a lesser extent) can then adequately meet the overall research objectives (Bishop & Ford-Bruins 2003).

Braun and Clarke's (2006, p. 96) criteria for an exemplary thematic analysis was adhered to, as shown in Figure 10:



Process	No.	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
Analysis	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
	7	Data have been analysed, interpreted, made sense of rather than just paraphrased or described.
	8	Analysis and data match each other the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organized story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated
	13	There is a good fit between what you claim you do, and what you show you have done i.e., described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher, is positioned as active in the research process; themes do not just "emerge".

Figure 10: Criteria for the Exemplary Thematic Analysis

Reproduced directly from Braun and Clarke (2006, p. 96).

5.4.7.3 Computer assistance

The data analysis was aided by a computer-assisted qualitative data analysis program described in detail in this section. Such programs *assist* in the analysis of the data, and provide a convenient means through which to capture and sort the data (Liamputtong & Ezzy 2006, p. 274), enabling efficient and flexible storing, coding, and retrieval of data. NVivo version 8-9 aided in establishing the thematic framework, the cases (interviews), the associated memos (reflective notes), and document text were coded into free nodes. Tree nodes were then created which became the overall themes. The useful "query" function of NVivo was also used. The query allowed a text search of specific words or phrases within the transcripts. This allowed a series of checks and counter-checks to occur to ensure that the context of the interview was not lost in the process of coding. As an adjunct to QSR: NVivo version 8-9, the Microsoft Office Excel 2010 software program was used to analyse the participants' demographic information. The spreadsheets were then imported into NVivo for analysis and comparison.

5.5 Stage Two

5.5.1 Overview

> *[Documents] … are forms that externalize social consciousness in social practice, objectifying, reasoning, knowledge, memory, decision-making, judgments, evaluation, etc., as the properties of formal organization or discourse rather than properties of individuals … The simple properties of the documentary or textually mediated forms of social organization involve the dependence upon, and exploitation of, the documentary capacity to crystallize and preserve a definite form of words detached from their local historicity. The appearance of meaning as a text, that is in permanent material form, detaches meaning from the lived processes of its transitory construction, made and remade at each moment of its course (Smith 1984, p. 60).*

This study now shifts to that of following a "chain of action" which is centred around documents "because it is texts that coordinate people's activity across time and place within institutional relations" (DeVault & McCoy 2006, p. 21). Adapted from the work of Karppinen and Moe (2012), Prior (2003), and Smith (1984), Stage Two analysed relevant documentation that served to inform and frame the clinical actions of the participants, and arguably, to influence the care that patients would receive. Smith (1984, p. 62) went so far as to contend that these textually mediated forms of instructions objectify knowledge and decision-making processes "distinguishing what individuals do for themselves from what they do organizationally or discursively". This becomes (in a way) a form of monitoring by the organisation and can be seen to be one component of self-reflexivity for the individual (Prior 2003).

Smith (1984) reasoned that conducting a sound and rigorous analysis of documents has the ability to illuminate, or make visible, the otherwise hidden phases of organisational processes that are otherwise inaccessible. As such, one can identify the documentary dependence on practices that provide continuity and coordinate order in the organisation (Smith 1984). From this, it is important to highlight here that the documents selected were considered to not only be "primary sources" which served to represent the "facts" (and as such, operated as a descriptive function), but were also analysed as "texts", whereby they became a social product that can have consequences; in other words, they functioned as a set of rules for action (Prior 2003; Smith 1984). This means that the distinction between the documents as a “source”, as opposed to a “topic of study” must be made (Karppinen & Moe 2012). By doing so, and staying true to the social constructionist perspective, the discursive power of government and other policy actors is revealed. Document analysis now can be considered as an appropriate next step after conducting the interviews (Karppinen & Moe 2012, p. 10; Smith 1984).

This meant that Stage Two of this study became a sustained analysis of relevant documents (*see* Appendix H) that framed the participants’ responses and understandings of psychiatric risk. This added further depth and understanding to the participants’ responses in the interviews. The legislative discourse surrounding the Australian legal and ethical frameworks that influence the clinicians who participated in the study were examined and contextualised within the Australian mental healthcare system (*see* Chapter 6). In this way, this adds further weight to my assertion that I have provided an accurate account of the participants’ reality, thus enhancing the validity of the research, and its capacity to have a positive impact on both academic and policy debate (Karppinen & Moe 2012).

5.5.2 Exploring the method

> *It can be argued that documentary research does not even constitute a method, as it does not say anything about how one uses documents … However, this does not free us as researchers from the requirement to explain our interest and how we use which texts when we analyse documents (Karppinen & Moe 2012, p. 14).*

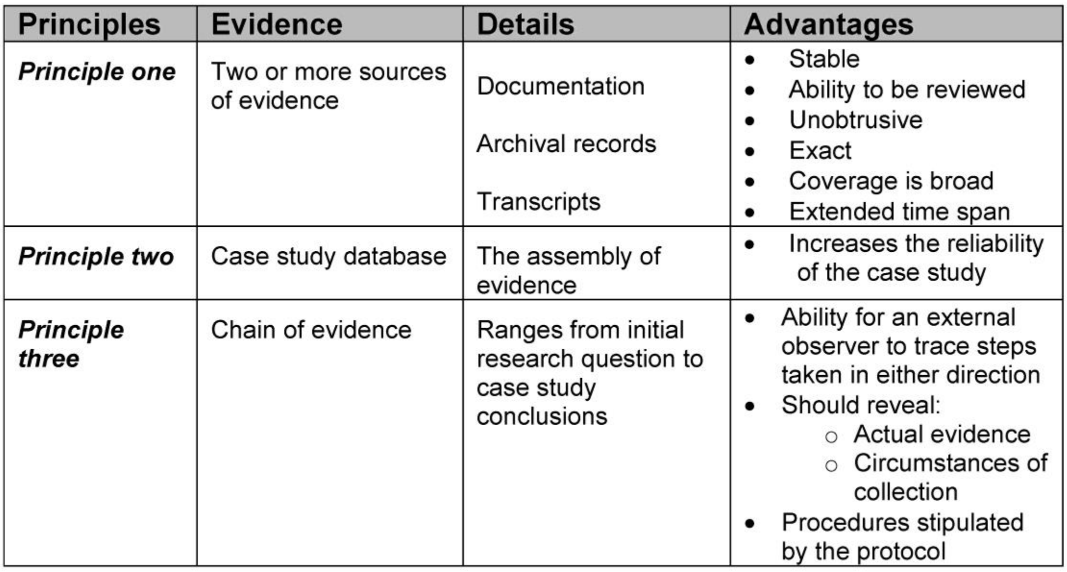
From the outset, the distinction must be made between the literature reviewed in Chapters 3 and 4 to that selected, analysed, and presented in Chapter 6. As Karppinen and Moe (2012) contended, the methodological challenge remains when attempting to delineate the distinction between research literature and documents. For the purposes of this study, documents are considered to be those that are an objective source of data around which clinicians frame their clinical responses. The documents are considered to be publically accessible or accessible to the clinicians interviewed in Stage One. This means that, in addition to legislation, policies, and procedures being selected, contemporary clinical research studies were also included with the argument being that these also serve to influence the discourse around risk and to guide policy-makers, particularly when considering core practice requirements that surround evidence-based practice.

Bowen (2009) stated that the critical aspect of the analytical feature of document analysis becomes the method. This method becomes one of “finding, selecting, appraising (making sense of), and synthesising data contained in documents” (Bowen 2009, p. 28). The relevance of the documents is considered critical to ascertaining if they apply to the research problem and purpose, considering if this document can contribute toward the issues being explored in the research, and whether it fits with the conceptual framework of the research study (Bowen 2009). This fits with Yin’s (2014) case study approach whereby Bowen interpreted this to mean that the:

> *… qualitative researcher is expected to draw upon multiple (at least two) sources of evidence; that is, to seek convergence and corroboration through the use of different data sources and methods. Apart from documents, such sources include interviews, participant or non-participant observation, and physical artefacts … By triangulating data, the researcher attempts to provide ‘a confluence of evidence that breeds credibility’ … (2009, p. 29).*

5.5.3 Data Selection

The collection and recording of the documents and relevant content was carefully structured using the principles of data collection; a necessary requirement of the case study protocol design. Yin (2014, pp. 83-100) and Tellis (1997, pp. 7-9) identified the following principles to aid data collection:



Principles	Evidence	Details	Advantages
Principle one	Two or more sources of evidence	Documentation Archival records Transcripts	• Stable • Ability to be reviewed • Unobtrusive • Exact • Coverage is broad • Extended time span
Principle two	Case study database	The assembly of evidence	• Increases the reliability of the case study
Principle three	Chain of evidence	Ranges from initial research question to case study conclusions	• Ability for an external observer to trace steps taken in either direction • Should reveal: ○ Actual evidence ○ Circumstances of collection • Procedures stipulated by the protocol

Figure 11: Principles of data collection

Exploring the principles of data collection as theorised by Yin (2014, pp. 83-100) and Tellis (1997, pp. 7-9).

By using the above principles, the case study approach has the ability to determine the construct validity (credibility) of the method (Yin 2014). Moreover, it should be noted that no single source of evidence is more advantageous to use than another (Tellis 1997). Rather, these sources may be complementary to one another, or they can be used in tandem. However, multiple sources of evidence should be used, *if they are relevant to the study* (Tellis 1997).

Karppinen and Moe (2012, p. 10) considered that “the activities of governments, regulators and other policy actors are always bound up with discursive power”, and it is this framework of meaning that is part of the public domain that has the power to change social reality. This means that the social reality of the participants must be contextualised within this discourse to allow a rigorous mode of inquiry, reveal the hidden narrative, and to illuminate and explain the courses of action of the clinicians interviewed. The sampling strategy was purposive and pragmatic (Prior 2003), and I have deliberately chosen and analysed documents that contribute:

> *… to the governing of a certain area of social life as 'intellectual machinery' that renders the world thinkable and amenable to regulation … Events need to be transformed into political language, and furthermore into information, reports and position papers. And although necessary, these can never be neutral – they are always bound to specific values and political rationalities. From this perspective, policy documents can be analysed as discourse, much in the same way as communication scholars analyse newspaper stories, for instance, with an interest in the narratives and metaphors used in the documents, or the way they portray some courses of action as commonsensical and others as nonsensical (Karppinen & Moe 2012, pp. 10-1).*

In this way, documents were selected that had the ability to influence decision-making processes as well as those that contained factual information about the process of RAM. The selected documents provided me with an advantage in that they were produced under "natural" conditions and, in a sense, I had not "affected" the documents that were being collected (Karppinen & Moe 2012). In this way, these documents represented the "facts", while the literature considered in Chapters 3 and 4 offered me a way to interpret the findings described in Chapters 6, 7, and 8 in an authentic way (Karppinen & Moe 2012). The documents selected are summarised in Appendix H.

5.5.4 Data Analysis

> *… as researchers of the inert text it would undoubtedly be of considerable help to us if we could appeal to a set of generally accepted rules about evidence to demonstrate that our scrutiny of document content was done 'in the right way' and to the highest standards - rules that would help establish that our ultimate claims are valid and reliable. Unfortunately, no such body of rules exists. That is not to say that there are no rules … only that their status is always contested (Prior 2003, p. 147).*

The selection and subsequent analysis of the documents is considered to be appropriate when thematically analysing the data collected from the interviews in Stage One (Karppinen & Moe 2012, p. 10). As such, I critically analysed the documents and viewed them as objective sources that reflect why clinicians act in certain ways and that have the ability to reveal organisational structures (Karppinen

& Moe 2012). Importantly, during the analysis, the social aspects surrounding the document allowed me to grasp not only the meaning and intent of the document, but also the significance around this (Karppinen & Moe 2012).

As the documents are used as sources, it was not my intention to consider in depth the language of the chosen documents (although as will be revealed later, it was explored to some extent). Rather, using the tenets of social constructionism, the discourses and themes, the problems they present, and the consequences of such (which to some extent explains why clinicians manage risk in certain ways) are considered. I used a funnel approach to demonstrate how the social forces have contributed to not only legislative and policy framework design, but also how they informed and shaped the actions of clinicians; and so became a repository of expert knowledge (Bowen 2009; Prior 2003). From this, the documents analysed in Chapter 6 functioned in specific ways. Firstly, documents were selected that provided data to contextualise the ways in which the clinicians operated. Secondly, the documents functioned to provide supplementary data and became a valuable addition to this knowledge base.

According to Bowen (2009), analysing documents is an iterative process. This analysis required me to perform a superficial examination once the relevant documents had been retrieved from the public sphere, after which a thorough examination led to the interpretation of the content. This initial analysis provided me with a crude overview in order to identify relevant and meaningful passages of text. The first pass allowed me to collect the pertinent information relevant to the study. Then, a more focused and careful review and re-reading of the data occurred. The characteristics of the data were identified which were then integrated to capture the phenomena. The data were then evaluated to establish meanings and their contribution to the issues being explored (Bowen 2009). The content of the documents were further analysed to ensure that they were aligned to the conceptual framework of the study. Bowen (2009, p. 34) contended that when evaluating and analysing documents in this way “empirical knowledge is produced and understanding is developed”. As such, this process functioned as a complementary method to that of Stage One, offering another source of data through which to make meaningful interpretations of the interviews, allowing me to provide a critical commentary. This iterative process is demonstrated in Table 5 and Appendix H.

Essentially, the first step in the document analysis process was to find a strict template to abide by for this kind of analysis. I quickly came to the conclusion that no such plan existed; therefore, I would need to identify the themes in the documents through more of an intuitive process, utilising tenets of Braun and Clark's (2006) approach previously described in Chapter 5. I decided that the best way to start this process was to notate and analyse the documents through the identification of keywords.

I began by reading each text a number of times, looking for within-document themes that would repeat themselves throughout each individual document within each category (care plans, government documents, and so on). This involved looking for metaphors, phrases which held meaning associated with the topic of investigation, and indeed, keywords. Such instances were colour-coded in the text according to categories, and then cut-and-pasted into separate documents, again according to these categories. By following this process, it became apparent that documents around RAM and risk management within the metal healthcare field were based on a number of key concepts. These are (in an alphabetical but non-meaningful order):

Table 5: Document Analysis

Source: Original analysis

Clinician/Clinical Environment	Diagnoses & Acts	Integral Organisational Aspects	Overall Requirements
Actuarial	Absconding/ers	Carers	Audit
Admission	Anxiety	Clients	Complete
Adverse	Behaviour/s	Clinician	Data
Anxiety	Disorders	Commonwealth	Decision
Assessment	Emotions	Community	Duty
Care	Events	Countries	Evidence
Complete	Factors	Court	Experts
Data	Forensic	Decision	Forms
Dilemmas	Harm	Duty	History
Discharge	Health	Education	Incidents
Duty	Incidents	Evidence	Information
Education	Injury	Experts	Law
Emotions	Low/Moderate/High	Factors	Management
Ensure	Mentally	Forms	Offence
Events	Neglect	History	Order
Evidence	Problems	Incidents	Plan
Experience	Psychiatric	Information	Policy
Factors	Risk	Law	Powers
Forms	Suicide	Low/Moderate/High	Procedure
History	Support	Management	Score
Incidents	Thoughts	Offence	Standards
Information	Trust	Order	Warrant
Intuition	Violence	Plan	
Knowledge		Police	
Law		Policy	
Low/Moderate/High		Powers	
Management		Practice	
Observation		Procedure	
Offence		Review	
Order		Risk	
Plan		Score	
Police		Standards	
Policy		Treatment	
Practice		Warrant	
Pressure			
Problems			
Procedure			
Psychiatric			
Review			
Risk			
Score			
Situation			
Standards			
Support			
Tacit			
Time			
Treatment			
Trust			
Warrant			

These types of categories allowed me to establish the themes that were arising from the texts, who or which organisation they could be attributed to, and the context of each theme. This then made it possible, not only to see which themes had arisen from the texts, but also to see what had not emerged, or what information was being excluded. In addition, it was also possible then to see the anomalies, inconsistencies, and contradictions in the documents, particularly in the policy-related documents, whether they be government or institutional policies. This, of course, became particularly useful when using the work of Menzies (1960).

The next step in the data analysis was to create a ‘map’ from the categories/themes that emerged from Step 1 to demonstrate the connections between the themes and who, or which organisations, was using or contributing to this information. This was an important part of the process as it brought the data from the documents closer to what was happening in practice, this allowing for more of a picture to emerge of the on-the-ward practice of RAM, as well as the politics that surround it.

The above process provides an overview of the interpretive approach used for the document analysis. Being interpretive, it was thus absolutely critical to ensure that rigour was, and could be, maintained. The following section explores how this took place throughout the document analysis, but also for the entire data analysis process for this thesis.

5.6 Establishing and maintaining rigour in qualitative research

5.6.1 Criteria for rigour

Descriptive and exploratory research needs to be based on sound evidence when seeking to present data to be interpreted and understood (Gross Portney & Watkins 2000). Establishing and maintaining rigorous research (or “trustworthiness”) is necessary (Kitto, Chesters & Grbich 2008; Koch 2006, p. 976; Tobin & Begley 2004). If undertaken appropriately, the findings then have the capacity to be strong and meaningful (Gross Portney & Watkins 2000). However, this is becoming extremely complex, particularly in the field of healthcare, which now uses many research designs, methods, and diverse approaches (Kitto, Chesters & Grbich 2008).

A rigorous mode of investigation has been demonstrated throughout each section of this chapter, from explicitly outlining the research design, through to clearly identifying the data sources and the scope of the study. However, it is also necessary to demonstrate this further, in order to explicitly (rather than implicitly) reveal the varying components of rigour. Importantly, for Stage Two, Prior (2003) identified six areas of consideration to establish the validity of this type of analysis:

> - *Researching the inert text requires one to attend to issues of reliability and validity*
> - *Issues of reliability and validity in turn require that we state at the outset of the research project what, exactly, we are seeking to achieve and what is to be included in the field of study*
> - *Selection (and exclusion) of documentary materials should be in accordance with the principles established in the preceding point*
> - *In those instances where documentary materials have to be sampled, a thorough justification for the sampling procedures needs to be provided*
> - *Indexing and coding of data need to be executed in a rigorous and unbiased manner*
> - *Whilst drawing conclusions from data, always pay special attention to data that apparently fail to confirm one's claims and generalizations*
>
> *(Prior 2003, p. 163).*

Drawing from the literature, Table 6 below shows the criteria of rigour for Stages One and Two, outlines in brief the associated research strategies, and the tools/techniques used to achieve a trustworthy study. This table demonstrates the qualitative strategies used to establish and maintain scientific rigour for this study: credibility, auditability, fittingness, and confirmability.

Table 6: Criteria of rigour

Source: Adapted from Tuckett (2008; 2004); Jackson, Daly, and Chang (2004, p. 149); Koch (2006, p. 977); and Kitto (2008).

Criteria		Research Strategy	
Trustworthiness	***Defined***	***Outlined***	***Technique used***
Credibility	Truth of findings - judged by participants and experts in the field	Audio recording Livescribe recording and notations Reflection Transcription Thematic analysis (log) Auditing Dissemination of findings	Member validation Peer review Purposive convenience sample Purposive pragmatic sample Audit trail Conferences/publications/in-service presentations
Fittingness/ Transferability	Accurate account of the participants' reality (can use literature to refute or support the concepts emerging) - described in detail to allow evaluation of significance	Data display Literature review Theoretical considerations Historical analysis Dissemination of findings	Purposive convenience sample Purposive pragmatic sample Rich description Comparisons to literature Conferences/publications/in-service presentations
Auditability/ Dependability	Accountability - audit trail of the questions; raw data; steps of analysis; interpretation	Audio recording Livescribe recording and notations Transcription Establishment of chain of evidence Phases of thematic analysis (log) Auditing Dissemination of findings	Peer review Audit trail Conferences/publications/in-service presentations
Confirmability	Findings - reflection of the implementation of credibility, fittingness, and auditability	All of the above	Audit trail - documentation prepared for closer scrutiny if required
Transparency			

5.6.2 Credibility

For research to be credible, the researcher must demonstrate that they have been rigorous, transparent, and ethical in conducting the study (Koch 2006; Sandelowski 1986). Sandelowski (1986, p. 30) suggested that a “qualitative study is credible when it presents such faithful descriptions or interpretations of a human experience that the people having that experience will immediately recognise it from those descriptions or interpretations as their own”. Credibility can be referred to as the most appropriate and meaningful interpretation of results in relation to the study (Jackson, Daly & Chang 2004). Credibility may also refer to the variables (qualities or attributes, as distinct from the quantitative variables) and the relationships between them (Jackson, Daly & Chang 2004).

Yin (2014) also considered credibility when using a case study approach. He suggested that there are four strategies that are available to increase credibility:

- *Multiple sources of evidence (which encourages converging lines of enquiry)*
- *Establishment of a chain of evidence*
- *Findings subject to peer review*
- *Pattern matching*

(Yin 2014, pp. 98-125).

These considerations are evident in the developed case study protocol and the exploratory framework developed as an analytical strategy. Trellis (1997, p. 14) also supported this approach as being credible, stating that: Yin has “designed protocols [for] conducting the case study, which enhance the reliability and validity of the investigation”. To ensure the credibility of this research, the ethical issues are described in Section 5.4.6. The relevance and accuracy of the measurements have been previously described (truthfulness), and this includes participant validation. In addition, an audit trail was established to increase the reliability of the findings and to ensure consistency (*see* Table 6) (Creswell 2003).

Reflexivity, and being self-reflexive, is also necessary when establishing the credibility of research, and aids in reducing bias (Creswell 2003; Koch & Harrington

1998; Liamputtong & Ezzy 2006). The issues that the researcher was reflexive towards included her preferences, values, consideration of the constructions that informed her practice, and her affinity with data sources. This includes the participants, the theories, and the design of the research; her experiences and ability to conduct the research; and her personal qualities. In this study, this was aided through the input of annotations and memos when coding in QSR: NVivo version 8 and 9 after the update was released (Liamputtong & Ezzy 2006, p. 273). Critical reflection regarding my part in this process was also undertaken throughout the research. Such critical reflection included a range of aspects, such as overall broad reflection on the data, the minutiae of applying the theoretical perspectives, in-depth analysis of my personal viewpoint, examination of the participants' worldview, and exploration of the social norms and mores that existed within the organisation as a whole, and within the document analysis and the re-evaluation of personal objectivity.

5.6.3 Fittingness/Transferability

To evaluate fittingness in qualitative research, Sandelowski (1986, p. 32) suggested that the "study meets the criterion of fittingness when its findings can "fit" into contexts outside the study situation and when its audience views its findings as meaningful and applicable in terms of their own experiences". In this research study, the site was chosen because it provided a multidisciplinary team that was committed to research, had a strong RAM focus, and used a risk assessment tool in their daily practice. Documents were pragmatically selected when it was clear that these informed the participants, provided them with an "expert knowledge base" or when they were legally-bound to adhere to these. While this research study is not generalisable per se, it does have the potential to be contextualised into other settings. The accuracy of the data sources and sample size was also an important consideration, particularly in terms of achieving rigour. The nature of this research required participants to be selected in order to enable illumination of "the phenomenon being studied" (Sandelowski 1986, p. 31). A small sample size (*n*=14) of mental health nurses was used in a study by Bishop and Ford-Bruins (2003) who considered nurses' perceptions of mental health assessments. The major assumption of their research study was the social context of the participants, whereby interactions with others had the ability to create their reality within the clinical context. The role of these researchers was to “try to discover and understand the world of the participants” (Bishop & Ford-Bruins 2003, p. 205). Bishop and Ford-Bruins (2003) also considered that their sample size was adequate to achieve data saturation. Likewise, data saturation in this study was established. Notwithstanding these aspects, the fittingness of the research will also be demonstrated when discussing these research findings (*see* Chapter 9) in reference to the previous research.

One criticism may be that the sample is not a fair representation of the wider population (Kitto, Chesters & Grbich 2008; Lunsford & Lunsford 1995). However, in qualitative research “any subject belonging to a specified group is considered to represent that group. Anyone's experience, if well described, represents a ‘slice from the real world’” (Sandelowski 1986, p. 32). Nevertheless, it is necessary that the findings can fit within the contexts that appear outside of the study’s environment, and is meaningful and applicable towards the audience and their experiences (Sandelowski 1986). From this viewpoint, participant validation, analysis of relevant documents, peer review, dissemination of findings, and comparison to the contemporary literature were undertaken in order to achieve this component of rigour (see Chapter 9).

5.6.4 Auditability/Dependability

A decision trail is central to the demonstration of auditability (Koch 2006; Sandelowski 1986; Tobin & Begley 2004) and can be used as a mode of transparency (Aroni et al. 1999). Audit reduces the possibility of errors and can be used to address the limitations and biases that are outlined in the section on confirmability (Koch 2006; Sandelowski 1986). An audit trail for the analysis of the findings of this study has been established (*see* Figure 9).

5.6.5 Confirmability: Bias and limitations

“Confirmability is achieved when the auditability, truth value, and applicability are established” (Sandelowski 1986, p. 34). The data must be engaged with, rather than detached from, when seeking the truth (Sandelowski 1986). The findings should stand by themselves, regardless of the subjective stance of the researcher. This then ensures that the findings are “clearly derived from the data” (Tobin & Begley 2004, p. 392).

Some of the bias evident for me as a result of regular reflection on the progress of this study included prior knowledge of the literature, my work in psychiatric mental health units as a Registered Nurse, and discussions held with senior academics at Flinders University and the Directors of Nursing in a large South Australian acute care hospital. Each chapter of this thesis has been structured to address, and account for, bias. Addressing the bias and the limitations of this research also ensures that the findings are truthful and meaningful. One way to enhance credibility and reduce bias is constant comparison within the data (as outlined in the framework developed by Braun and Clarke). In this study, I constantly referred to documents, transcriptions, recordings, and notations while looking for comparisons and patterns. This was in addition to regular reflections on potential bias within the comparisons themselves. The patterns that were established from the data and the subsequent development of themes are presented as examples in Appendix G and Appendix H.

5.6.6 Dissemination of findings

The dissemination of findings is an important component of the research process in order to communicate the results, as it is of little use or value to the scientific community if the findings remain unknown (Polit & Hungler 1999). Dissemination further establishes the rigour of the research study and becomes part of the audit process. For example, Kieser and Leiner (2009, p. 516) suggested that advancing knowledge for practice is likely to occur when there are four inter-related activities when conducting research. Firstly, the research question must be clear in order to consider and situate the multiple dimensions of reality. Secondly, representation of the main aspects of the phenomena being studied must occur. Thirdly, the use of appropriate methods in both the research design and data collection which are able to answer the research question is required; and fourthly, dissemination of the research findings and obtaining the differing perspectives of academics and practitioners should occur.

Waddell (2001) lamented that high quality and rigorous research is being conducted but not utilised in clinical practice. She identified basic applied research, including practical summaries and clinical applications, as a preference for clinicians. The communication channels they use to obtain this are conferences, reviews, the Internet, and academic journals. Dissemination enables the accessing of information, and this develops the knowledge base by way of sharing (Starkey & Madan 2001). The research findings for this study were disseminated to clinicians by way of in-service presentations at the hospital site, conferences (Mosel 2011a, 2011b; Mosel, Gerace & Muir Cochrane 2011), a final thesis dissertation defence (2012), and through published articles (Muir-Cochrane et al. 2010; Muir-Cochrane et al. 2011a).

5.7 Limitations

This study was intended to be conducted in two phases at the outset. The first phase was intended to be the conceptualisation of risk in the clinical setting. The next step was to identify a risk behaviour in a clinical setting, and then to analyse the case notes of Aboriginal and Torres Strait Islander patients who abscond. The findings of this would then have been applied to the conceptualisations of risk in the clinical setting. However, as the first phase of the study progressed, there was more recruitment and interviewing than had originally been predicted and the analysis was also more time-consuming. In addition, it became clear that further sustained investigation of the framework that clinicians operated under was required. As a result, the analysis of the interviews was supported by the addition of a document analysis to ensure a greater understanding of the impact of the policy, legal, and organisational contexts of risk construction as well as the context in which decision-making around risk occurs. As such, this became the second stage of the research study in order to fit with the theoretical tenets described in Chapter 2, and the interviews of the clinicians became the first stage of the study. The appendices for this thesis support the density of the analysis undertaken, particularly when moving from a deductive approach to an inductive thematic analysis.

5.8 Conclusion

The aims of this research, and the justification of the methods used have been presented in this chapter. A comprehensive discussion on the issues of rigour, inclusive of validity and reliability, together with the ethical components of the study, has been addressed. The research methods identified in this chapter have been argued to be the most appropriate way to meet the stated aims of this research.

The next chapter steps off from Chapter Three by examining the Australian legal and ethical frameworks that influence the clinicians who participated in the study which, in turn, resulted in tension and anxiety for these clinicians. Drawing on the findings of Chapters Three, Seven, and Eight, and as described in this chapter, Chapter Six will examine the relevant legislation together with the legal and ethical frameworks that influence RAM, provide critical commentary, and contextualise this within the Australian mental healthcare system. Then, the following two chapters will present the findings of the methods as outlined here. The first of these chapters centres on clinical RAM practices, while the second focuses on other areas within RAM that are considered to be important. Both include the identified themes that arose from the application of Braun and Clarke’s (2006) framework, and will allow for meaningful interpretations and conclusions to be drawn through the lens of risk theory.

6 EXAMINING AUSTRALIAN LEGAL AND ETHICAL FRAMEWORKS: ORGANISATIONAL CULTURE, DISCOURSE, TOOLS, AND CONSEQUENCES

> *So long as we ask medicine to help in doing the cultural work of defining the normal and providing a context and meaning for emotional pain, we will continue to fight a guerilla war on the permanently contested if ever-shifting boundary dividing disease and deviance, feeling and symptom, the random and the determined, the stigmatized and the deserving of sympathy (Rosenberg 2006, p. 135).*

6.1 Introduction

This findings chapter steps off from the selective review of the contemporary literature on risk assessment and management (RAM) (Chapter 4) and informs the following chapters (Chapters 7 and 8). This chapter presents a document analysis which examines the relevant legislation together with the legal and ethical frameworks that influence RAM (the discourse), and provides a critical commentary, contextualising this within the Australian mental healthcare system. This meets Aim 3 of the thesis. The frameworks and legal prescriptions described here extend to the research site, and demonstrate the environment within which clinicians work while highlighting the contradictory discourses that are present which should not (theoretically at least) co-exist in the same sphere. This chapter also allows the reader to understand the framework that the research participants operate under, in addition to meeting Aims 2 and 3 of the thesis, which are to develop an understanding of the issues facing health professionals in undertaking psychiatric risk assessment and management, and to explore the barriers and enablers experienced by a multidisciplinary team in relation to effective risk assessment and management practices. As will become clear in Chapter 9, I argue that this framework is socially constructed and representative of Beck’s (1992) “risk society”, demonstrating how risk is constructed in the light of legal and policy requirements. This is represented in Figure 12 which considers the social context of risk and RAM in mental healthcare, examining the discourse, and the subsequent power of this discourse, through a stepped approach.

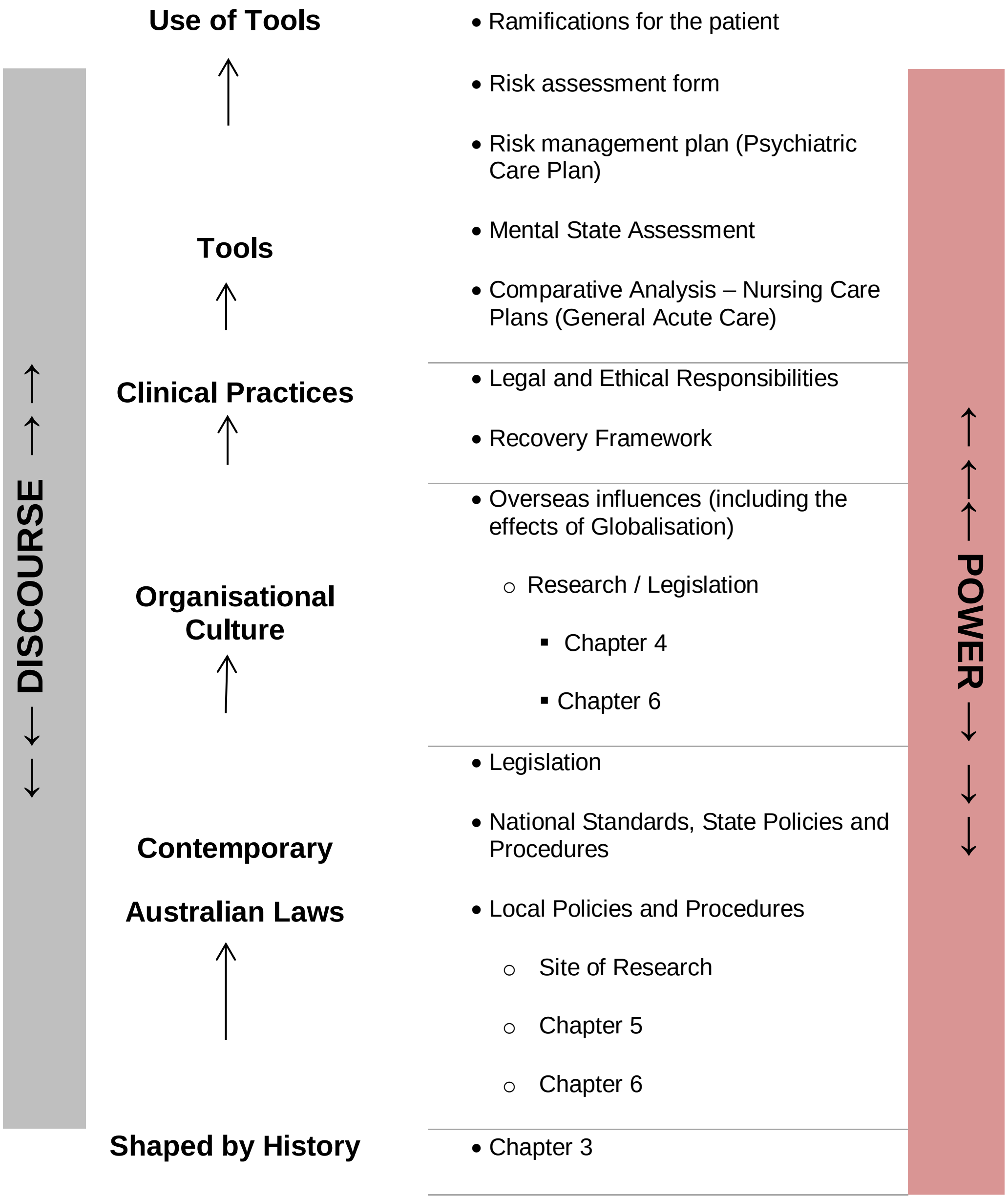


Figure 12: The Social Context of Risk and RAM in Mental Healthcare

Source: Original

Figure 12 illustrates the structure of this chapter which explores the relevant legislation together with the legal and ethical frameworks that influence RAM, and to contextualise this within the Australian mental healthcare system (*see* Appendix H).

The purpose of this chapter is to clearly identify the existing frameworks that have an impact upon psychiatric clinical practice and then to contextualise this at an organisational level. The underpinning premise is that the discourse is created by the organisational culture which influences the tools. This is then enacted in particular ways which creates ramifications for the patient. Initially, the contemporary legislation including the South Australian Mental Health Act (*2009*) will be explored, as it is this legislation which underpins both the organisations involved in mental healthcare and the actions of individual clinicians who work within the system (by dictating their general understandings of risk, and what influences their definition of risk). This legislation, as presented in Appendix H, provides a clear illustration of the transition described in Chapter 3 from “badness” to “madness” to risk management, which is now conceptualised as “dangerousness”.

This figure then demonstrates how the analysis moves to the policies and procedures which are directly influenced by the current legislation (*see* Appendix H). These documents (as depicted in Appendix H) are considered both to be *texts* and *sources*. As such, this document analysis considers contemporary clinical literature that includes a range of aspects, such as the prevailing definition of risk, followed by an overview of the organisational factors which influence RAM. Then, the clinical practices are considered, examining the clinicians’ legal and ethical responsibilities together with the Recovery Framework within which clinicians must work. In this section of the chapter, I argue that the prevailing discourse does not exist comfortably in the same sphere as the existing Recovery Framework as the two are highly contradictory. These competing aspects of the legal responsibilities and the Recovery Framework are considered in this context. From this foundation, history and the contemporary legislation then shape the prevailing organisational culture. The effects of globalisation become apparent as a result of these laws, as they open the profession up to global movements of workers and international ideas which act to directly affect local organisational cultures. These organisational cultures, in turn, affect the tools used in mental healthcare (for example RAM), and the culture associated with particular healthcare organisations then dictates how the tools are used (*see* Appendix H). Ultimately, how these tools are used has direct ramifications for how the patient is treated.

6.2 Contemporary Australian Legislation

The historical origins of mental healthcare and subsequent risk from a sociological perspective have been previously examined in Chapter 3. I argue that these influences have shaped the legislative requirements that are present in the Australian healthcare system today. This legislation clearly indicates the transition from badness to madness, and now, back to a new kind of badness, which is risk. Initially, the South Australian Mental Health Act (*2009*) is explored in the context of the discourse of risk, as this legislation directs both the organisation and the clinicians who work within the system. The national standards, policies, and procedures associated with RAM are then considered, in addition to those used at the research site.

6.2.1 The Mental Health Act: Transitioning to a new kind of "badness"

Mental healthcare in Australia stems primarily from the Mental Health Acts of the various Australian states (which have been formulated based on overseas influences); for the purposes of this thesis; when the Mental Health Act is referred to, I am referring to the South Australian Act (Glover-Thomas 2011; Gray et al. 2010; King & Robinson 2011). Kettles (2004) suggested that within mental healthcare policies and procedures, risk primarily refers to negative outcomes and usually represents a range of potentially adverse events that need to be avoided. As such, it is argued that Australian legislation is focused and driven by the idea of harm minimisation, as opposed to being rights-based (Gray et al. 2010). Similarly, Glover-Thomas (2011, p. 585) argued that "risk determines the nature, duration and extent of a patient's engagement with mental health services". It could be argued that safety is built into hospital and provider policies and procedures across the industry on a global basis, and this stems primarily from the creation of legislation that aims to create safety for the organisation (Undrill 2011). The notion of risk being identified with adverse events, in the South Australian context, is exemplified when a person is detained in a psychiatric facility against their own volition, under the Mental Health Act, if:

> a. *the person has a mental illness; and*
>
> b. *because of the mental illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition), or for the protection of others from harm; and*
>
> c. *there is no less restrictive means than a detention and treatment order of ensuring appropriate treatment of the person's illness.*
>
> *(*Mental Health Act 2009*, pp. 17-8).*

It is argued that this political discourse, infusing mental health law with a risk agenda, is a response to a public safety agenda arising from homicides committed by the mentally-ill (Glover-Thomas 2011). Mental health acts within Australia are state-based, although there is a move towards uniformity. In Gray et al.'s (2010) comparison of Australian and Canadian mental health acts, they found that most mental health acts include these sub-criteria for involuntary detention as mechanisms for ensuring the safety of the patient, reducing the risk to the patient, and also ensuring public safety. Through this, it is clear that mental illness is associated with being a “risky” individual. Risk is considered to be bad and must be forestalled. The risk a person poses to the public is further identified within this legislation, whereby Part 1, Section 3 of the Mental Health Act defines a patient “at large” as being a patient that has been detained under this Act, but:

> a. *the patient has not been taken into, or remained in, the care and control of treatment centre staff, or an authorised officer or police officer, after the making of the order and before admission to a treatment centre; or*
>
> b. *the patient has left a treatment centre in which he or she was being detained, or the care and control of treatment centre staff, without leave of absence under Part 5 Division 5; or*
>
> c. *the patient has been granted leave of absence from a treatment centre under Part 5 Division 5, but has not returned to the centre or been taken into the care and control of treatment centre staff or an authorised officer or police officer by the expiry of the leave or after cancellation of the leave.*
>
> *(*Mental Health Act 2009*, pp. 7-8).*

An illustrative example of a South Australian Mental Health “Assessment Order” is presented in Appendix I. This commonly used order is completed when detaining a patient against their own volition for 24 hours pending further review. The patient is then either transferred to a mental health facility as an inpatient, or is assessed in the community. This form requires a mental health practitioner to be a registered psychologist, registered nurse, social worker, or registered occupational therapist who is employed or engaged by a mental health service to make a clinical judgement as to whether the person requires immediate treatment if they “appear” to have a mental illness. The clinician is legally required to detain a person against their own volition in the interests of safety (protecting the person or general public from harm) in order to prevent potential risky outcomes from happening (*Mental Health Act 2009*, pp. 17-8).

Being “a risky individual” is further illustrated through the use of the terminology “at large” present also in Australian Commonwealth legislation, the Crimes Act *(1914, p. 52)* in reference to prisoners. It could be that the terminology in the Mental Health Act (*2009*) is “borrowed” from this act and is suggestive of the “prison state” of the detained mentally-ill patient, demonstrating the transition from “badness” through to “madness” to “risk”. This Act states that a:

> ***‘prisoner unlawfully at large’*** *means a person who is at large (otherwise than because the person has escaped from lawful custody) at a time when the person is required by law to be detained under a provision of a law of the Commonwealth, including Divisions 6 to 9, inclusive, of Part IB (*Crimes Act 1914*, p. 52).*

Likewise, this terminology is continued in the Law Enforcement (Powers and Responsibilities) Act (*2002*), last amended on 5 November 2014. Section 102, “Power to arrest persons who are unlawfully at large”, allows the following:

> *(1) A police officer may, with or without a warrant, arrest a person if the police officer suspects on reasonable grounds that the person is a person who is unlawfully at large.*
>
> *(2) A police officer who arrests a person under this section must, as soon as is reasonably practicable, take the person, and any property found on the person, before an authorised officer to be dealt with according to law.*
>
> *(3) The authorised officer may, by warrant, commit the person to a correctional centre, to be kept in custody under the same authority, and subject to the*

> *same conditions and with the benefit of the same privileges and entitlements, as would have applied to the person if the person had not been unlawfully at large.*
>
> *(4) In this section, a reference to a person unlawfully at large is a reference to a person who is at large (otherwise than because of escaping from lawful custody) at a time when the person is required by law to be in custody in a correctional centre.*
>
> *(5) Inmates of correctional centres who are unlawfully at large may also be arrested under section 39 of the Crimes (Administration of Sentences) Act 1999.*
>
> *(*Law Enforcement (Powers and Resonsibilities) Act 2002*, pp. 51-2).*

The person diagnosed with a mental illness who is ordered to be detained for their own or others' safety is likened in legislation to persons who are deemed to be criminals under Australian legislation. This clearly highlights the conclusions drawn by Olstead (2002, p. 636) who stated that persons diagnosed with mental illness, become involved in a transition from "badness", "… deliberately commit crimes …", to "madness" which, when translated, means not only *mad* but also *bad*. Olstead (2002, p. 636) argued that this statement on madness represents "our repugnance and hatred for the mentally ill".

Of particular note is that while risk is utilised in the Mental Health Act (*2009*) as a key factor in detaining a person against their will for compulsory mental health treatment (i.e. risk of harm to self and others), in this Act, risk in itself remains undefined. Interestingly, the assessment of risk is left to the authorised officer who is determined as being a mental health clinician, ambulance officer/paramedic, medical officer/flight nurse of the Royal Flying Doctor Services of Australia, or a police officer. This finding is no different than the findings by Glover-Thomas in their empirical study conducted in the United Kingdom:

> *… [u]nfortunately, while such definitions clarify the 'abstract' concept of risk, what actually constitutes a 'risk factor' 'in practice' is left to the discretion of decision-makers to determine in accordance with their professional judgment and experience. The Mental Health Act neither defines risk nor delimits the scope of factors pertaining to it. This highlights a tension between promoting a degree of pragmatism, essential to mental health practice by not prescriptively fettering decision-making, and providing clarity in such decision-making through prescriptive, and consequently easily predictable, criteria. Moreover, clear criteria also promote more effective rights protection … (Glover-Thomas 2011, p. 587).*

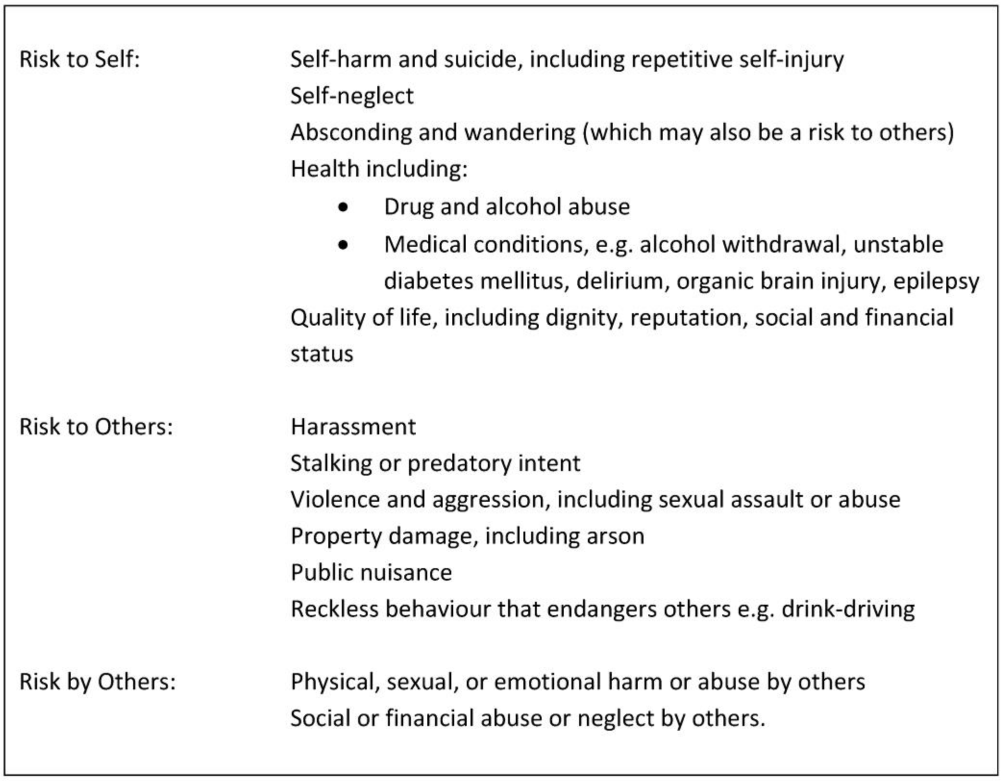
To return to South Australia, this means that what constitutes a risk is based on the judgement of the officer, and this can provide scope for errors in judgement. Another aspect that may influence an officer's judgement is their own value system. For example, in a study by Scott et al. (2011), who interviewed 46 community mental health professionals, they found that treatability was "very ill-defined". This concept was explored further by these participants in relation to detaining a person for treatment. One participant stated that it was "… wrong to take somebody in just for detention. Wrong morally and wrong legally" (Scott et al. 2011, p. 166). The study demonstrated that there is incongruence within health professionals' explicit values (from their occupational position and training) and their implicit values (their social attitudes, personal values, and moral judgement). These values and the influence they have on the officer, ultimately decide a person's detention status. It could be argued that this is almost a case of values determining a person's detention status.

6.2.2 **Standards, Policies, and Procedures**

6.2.2.1 Overview

Szmukler (2003) argued that risk assessment within the services that offer mental healthcare is problematic due to the conflicting notions of dangerousness and illness. The denial of rights is one such example, whereby the persons who are considered dangerous (but have committed no offence and have no diagnosis of mental illness as yet) are afforded protection via legal norms which prohibit preventive detention and promote liberty; whereas, those diagnosed with a mental illness are subsequently denied the luxury of these legal norms.

Australian national standards and state policies and procedures are set against this backdrop of inequity and use of prohibitive detention; for example, it is clearly demonstrated in the Risk Management and Clinical Risk Management Guidelines for the Western Australian Health System (Department of Health 2008). This policy outlines examples of clinical risks in mental health (see Figure 13) which, under the South Australian Mental Health Act (*2009*), would constitute a detention order being issued:



Risk to Self:	Self-harm and suicide, including repetitive self-injury Self-neglect Absconding and wandering (which may also be a risk to others) Health including: • Drug and alcohol abuse • Medical conditions, e.g. alcohol withdrawal, unstable diabetes mellitus, delirium, organic brain injury, epilepsy Quality of life, including dignity, reputation, social and financial status
Risk to Others:	Harassment Stalking or predatory intent Violence and aggression, including sexual assault or abuse Property damage, including arson Public nuisance Reckless behaviour that endangers others e.g. drink-driving
Risk by Others:	Physical, sexual, or emotional harm or abuse by others Social or financial abuse or neglect by others.

Figure 13: Examples of clinical risks in mental health

Reproduced directly from the Department of Health (2008, p. 8).

6.2.2.2 National Standards for Mental Health Services

While risk remains largely undefined in contemporary legislation, the Australian Government's National Standards for Mental Health Services defines risk to be:

> *The chance of something happening that will have a (negative) impact. It is measured in terms of consequence and likelihood (Commonwealth of Australia 2010b, p. 40).*

and risk assessment as:

> *[t]he process of identification, analysis and evaluation of a risk (Commonwealth of Australia 2010b, p. 40).*

Not surprisingly, the definition of risk management in these national standards focuses on the mitigation of harm for the mental health service:

> *[i]n health care, designing and implementing a program of activities to identify and avoid or minimise risks to patients, employees, visitors and the institution; to minimise financial losses (including legal liability) that might arise consequentially; and to transfer risk to others through payment of premiums (insurance) (Commonwealth of Australia 2010b, p. 40).*

Standard 2.11 requires Australian mental health services to conduct a:

> *risk assessment of consumers throughout all stages of the care continuum, including consumers who are being formally discharged from the service, exiting the service temporarily, and/or are transferred to another service (Commonwealth of Australia 2010b, p. 10).*

The risk assessment framework and what should be included in a risk assessment is not identified in these standards. The standards do, however, specify that the assessment is to be made using accepted methods and tools (Standard 10.4.1), and that the service must conduct a review of the treatment, care, and recovery plan if [the patient is] at risk of harm to self or others, is detained or removed from detention, or is about to exit the mental health service (Standard 10.4.5). These clearly indicate that there is a lack of agency on the part of the “risky” individual and the individual is being restricted as their “fate” is in the hands of an “unspecified expertise” (i.e., the tools and the institution that uses these tools). This bears similarities to institutionalised regulation, as considered by Beck and Beck-Gernsheim (2002), whereby institutions respond to risk in order to gain more control, and implement measures to achieve this either through surveillance, regulation, or bureaucracy (Beck & Beck-Gernsheim 2002).

6.2.2.3 National Practice Standards for the Mental Health Workforce

The National Practice Standards for the Mental Health Workforce (Department of Health: Victoria 2013) outlined the requirements of individual practitioners by delineating the values, attitudes, knowledge, and skills required of each profession, including nursing, occupational therapy, psychiatry, psychology, and social work.

Standard 1: Rights, responsibilities, safety, and privacy

Adding to the contention of institutional regulation is Standard 1: Rights, responsibilities, safety, and privacy (Department of Health: Victoria 2013, p. 12). This standard (Section 9) requires practitioners to conduct effective individualised risk assessments throughout the care continuum that consider people and their environment; yet, what is an effective risk assessment remains unspecified.

Standard 5: Access

Standard 5.9 requires collaboration with people in order to generate a recovery plan that will address the key risk issues for the patient; but, as will be seen throughout this thesis, collaboration rarely occurs. Standard 5.14 states that practitioners, where appropriate, conduct risk assessments that take into account “mental state, suicidality, self-harm, violence and risk of harm to others” (Department of Health: Victoria 2013, p. 15).

Standard 6: Individual Planning

Assessing for the triggers of risk of harm to self and others, including suicidality, is also required in Standard 6.13, in addition to risk factors in the patient’s family and extended environment (Standard 6.14). These practice standards define risk in terms of there being a chance that an incident that occurs will have a negative impact. The measures applied are “consequence” and “likelihood”. Risk assessment is defined in these standards as the process of “identifying, analysing and evaluating a risk” (Department of Health: Victoria 2013, p. 24).

Clearly, in these standards, the implication is that risk refers to an adverse event and is considered to be an unwanted consequence for the patient. These standards imply that it is up to the clinician to take control of the patient’s healthcare in a paternalistic manner, and that clinicians should collaborate with “people” to generate a recovery plan for the patient. Notably, the standards do not require the clinician to collaborate *with the patient*.

6.2.2.4 Implementation Guidelines for Public Mental Health Services and Public Hospitals

Stepping off from the National Practice Standards, the implementation guidelines for public mental health services and public hospitals aim to continually improve mental healthcare quality for all Australians (Commonwealth of Australia 2010a). There is recognition within these guidelines of social and cultural diversity, which is reflected not only in the make-up of mental health patients and carers, but also of mental healthcare professionals. The contemporary evidence and practice standards for nurses clearly demonstrate that social and cultural diversity is one of the cornerstones of effective healthcare in Australia (Alvarez et al. 2014; Mosel et al. 2010; Nursing & Midwifery Board 2016; Paternotte et al. 2014; Purnell 2014).

Criterion 2.1 of these guidelines (Commonwealth of Australia 2010a) outlines the promotion of safety within a mental health service for staff, visitors, patients, and carers. National safety priorities need to be met which includes an individualised analysis of risks that are specific to the individual mental health service. The mental health service must ensure that they have policies and procedures in place that will ensure the safety of all people that are in the setting, taking particular care of those who are vulnerable. Again, the relevant policies and procedures include provisions to minimise the risk of suicide and self-harm, as well as for risk identification and management.

Criterion 2.11 requires that the mental health service should undertake “regular risk assessment of patients to ensure their correct health status” (Commonwealth of Australia 2010a, p. 12). As well, this must be done in a “timely manner”. The rationale in this instance is to minimise the risk of harm to others and themselves. These guidelines also identify that the greatest risk for patients is during a care transfer or at a time of transition between settings; here, risk profiles are being refined. The mental health service must be able to provide evidence that these standards have been met by providing written policies and procedures, documented risk assessments, and risk management reports. Criteria 10.3.6 and 10.3.7 consider involuntary admission. These guidelines require that the mental health service should encourage voluntary status as long as this status does not pose a risk to the staff, the patient and other patients, carers, or visitors (Commonwealth of Australia 2010a).

Risk assessment is again revisited in Criterion 10.4 (Commonwealth of Australia 2010a). Evidence that appropriate information has been collected by the mental health service must be provided. The appropriate information that must appear in the patient's health record (part of the assessment, review, treatment, and recovery process) includes the level of risk that the patient presents to both themselves and others. As well, it is stipulated that culturally-appropriate suicide and risk assessment tools should be used.

6.2.2.5 South Australian Community Sector

The *Adult Community Mental Health Services: Model of Care* (SA Health 2010, p. 11) frames the community sector of mental health care. The model of care described here outlines:

Text removed due to confidentiality.

This comprehensive document provides not only the guiding principles, but the patient pathways, operational guidelines, and national standards expected of South Australian community mental health services, and provides a clear framework that the services and clinicians must adhere to. This represents the local framework that clinicians must operate under.

All mental health services must use standardised risk assessment documentation which includes a physical health assessment. The key service components in the assessment process include a focus on the person; demonstrated resilience; holistic approaches; identification of co-morbidity; and a current and historical analysis of risk to others and self (SA Health 2010, p. 41). These components appear to encompass holistic healthcare which is more in line with the Recovery Framework (*see* Section 6.4.3). The service must audit and ensure that risk assessments are undertaken and conducted in a timely manner. Risk assessments are made within the context of aiming to reduce “adverse events, suicide and deliberate self-harm in mental health services” (SA Health 2010, p. 46). The service must also ensure that the strategies are incorporated into the patient's care plan (risk management plan). As well, the strategies within the risk management plan must be implemented, and the plan be communicated to the patient. Strikingly, such strategies are absent, and the onus is put on the clinician to decide what these are.

6.2.2.6 Acute Care Sector

To provide an example of the acute care sector's risk assessment policies, Policy EDM P2-02: Admission, care, utilisation and discharge in acute mental health in-patient units is used (Department of Human Services 2002).

> *This policy emphasises the need to fully outline the reasons for considering admission to hospital, and describes how priorities will be determined, in order to lead to more purposeful interventions and optimal use of limited in-patient resources. Any need for prolonged hospitalisation will be assessed from the perspective of what value is added by continued hospitalisation and what alternatives might meet [patient] needs in a more effective way. Relevant standards from the National Standards for Mental Health Services 1996 are identified throughout the policy to assist in reflecting the principles that should guide all planning and decision making in acute mental health inpatient units, and the specific criteria against which services should be audited (Department of Human Services 2002, p. 5).*

The policy is prescriptive and focuses heavily on risk and draws on the Commonwealth and State Strategic Directions, National Standards for Mental Health Services (1997), the Mental Health Act (*2009*) and the Guardianship and Administration Act (*1993*). This focus on risk is exemplified in this policy where it acknowledges the right of a patient not to have others involved in their care as long as there is no imminent risk to the patient or others. Imminent risk features significantly in this policy's criteria for instability, and yet, imminent risk remains undefined. Similarly, "[t]he aspects of risk and safety are paramount in determining priorities for admission" (Department of Human Services 2002, p. 14). Priority One is determined to be life-threatening behaviours or "perceived severe category of risk of dangerousness to self or others (for example, possession of means, clear intent)"; Priority Two is the "[p]resence of psychiatric illness or disorder requiring immediate intervention AND life-threatening ideation BUT WITHOUT clear means at present time"; Priority Three is the "[p]resence of psychiatric illness or disorder requiring urgent intervention AND community treatment alternatives have failed to stabilise the situation". This policy also discusses risk assessment and risk management. It is clear that the focus is on the risk to the patient and others, while it omits the *physical* health and well-being of the patient:

> *… The acute phase of a psychiatric illness or disorder can contain a large number of potential risks. It is the comprehensive and competent assessment and management of risks that is the skill most necessary in mental health professionals dealing with acute psychiatric illnesses.*
>
> *… Formal risk assessment will ensure the treating team considers observation and management strategies that are appropriate for each consumer. It is recommended that each in-patient unit have systems in place that ensure that significant deviations from the suggested strategies are documented, in addition to the rationale for their use.*
>
> *… Risk management aims to minimise the likelihood of adverse events within the context of the overall management of an individual, to achieve the best possible outcome, and deliver safe, appropriate, effective care.*
>
> *(Department of Human Services 2002, p. 17).*

Interestingly, this policy, while requiring the South Australian Acute Mental Health Risk Assessment Tool (*see* Appendix J) to be used in clinical practice, also acknowledges that this tool has not been fully validated. Moreover, the tool referred to in this policy is required to be an aid to assisting with clinical judgement. Clinical judgement is considered in this policy to be the primary tool. These tools are considered later in this chapter.

6.2.3 **Examining the policies and procedures of the research site**

6.2.3.1 Description of health service

The research setting is an acute care public hospital of over 300 beds in a metropolitan area in an Australian capital city. The hospital specialises in caring for older people and veterans. The selected ward specialises in caring for people with physical and mental health problems that are aged over 65 years. In this ward setting, multidisciplinary team members include both general and mental health nurses, social workers, psychiatrists, doctors, psychologists, and occupational therapists. The inclusion of multidisciplinary team members in this study has been previously addressed in Chapter Section 5.4.4. Due to the professional skill mix of the team, not only can this ward cater for primarily mental health issues but also for minor physical illnesses.

6.2.3.2 Clinical Procedures

The clinical procedures that staff on this ward are required to adhere to are presented in Appendix K; these align with the South Australian Policy EDM P2-02: Admission, care, utilisation and discharge in acute mental health in-patient units (Department of Human Services 2002). These clinical procedures are prescriptive and focus significantly on risk. Interestingly, in these clinical procedures, the risk management plan aims to minimise adverse events, but in addition, to “deliver safe, appropriate, effective care”. On examination of these clinical procedures, essentially, the risk management plan becomes a nursing care plan which, in a general acute-care setting, provides a comprehensive guide “to patient care within a specific scenario” (Koutoukidis, Stainton & Hughson 2013, p. xx). Strikingly, the ward’s risk management plan (i.e. care plan) seemingly applies to those acute care patients with physical illnesses as well. There is however some scope to record some level of detail on this form under the category of “risk of poor or deteriorating functioning”; but this is left to clinical discretion. This section (as quoted directly from Appendix K), aims to measure:

Text removed due to confidentiality.

As will become clearer throughout this thesis, there is no scope for the consideration of comorbidity and physical health status, despite the overarching standards previously discussed. Instead, the only aspect that requires documentation is risk of harm to self or others and the potential to cause harm, although it must be clarified that there is scope to record other objective and subjective data in the patient’s case notes.

6.2.4 The provision of care versus the controlling of risk: organisational issues

The tension between the duality of the provision of care while controlling for risk, takes place through policies and procedures, primarily at the organisational level, which are framed at the state and/or national level. Brown and Calnan (2013) suggested that while previously “proceduralism” was at odds with the medical approach, now the legal-procedural and the medical are no longer competing paradigms. This means that the medical approach has now aligned itself with the legal one. Essentially, with the emergence of litigation, the social constructs of the medical profession and concepts such as paternalism and responsibilities such as duty of care, legal proceduralism has now planted itself firmly within the medical arena as a protective mechanism.

There still exists a gap between the risk approach and the recovery approach, most strikingly in its day-to-day implementation (Brown & Calnan 2013, p. 244). This is clearly evident when considering the varying practices of RAM, as discussed in Chapters 4 and 6 of this thesis, which ironically may place the organisation at risk in a legal sense. To reduce this risk, Petrila and Douglas (2002, p. 471) advised that risk assessment should be created within the contexts of “coherent organisational approaches” and “prevailing professional standards”. These approaches and standards include concepts such as designing policies in consultation with experts in “release decision-making” (Petrila & Douglas 2002, p. 471) (releasing the patient from care), and explicit clinical documentation of the risk assessment performed, including the conclusion and the procedures and tools used to make the decision. Petrila and Douglas (2002) considered that institutional commitment is necessary, noting that risk assessments based on unstructured or clinical judgements alone do not meet these prevailing standards or professional norms. Nevertheless, they again demonstrate “what should be done” in RAM, rather than “what is being done”. This means that there seems to be a number of polemic articles stating how RAM should be implemented in the clinical setting. However, when RAM is actually examined in the clinical setting, there are varying practices which do not necessarily conform to the identified standards. What is being done is affected by many levels of contingency, while what “should” be done is not.

6.3 The overseas influence: Defining and understanding risk in the clinical sense – connecting the organisational culture with the written discourse and the hidden assumptions

As indicated in Section 6.1 of this chapter, adding to the examination of contemporary clinical risk literature in Chapter 4, this document analysis now steps off from this examination in Chapter 4 to consider key documents in a different way and to tease apart what the general understandings of risk in the clinical sense are using the literature available to date. This means that the institutional conceptualisations of risk and RAM are now considered as part of this analysis. These conceptualisations are evident in the clinical literature (the sources: *see* Chapter 5.5.3) through which clinicians also gain knowledge and insight into risk and RAM, which then subsequently frames their definitions and interpretations, ultimately serving to shape their actions towards the patient. This is in keeping with the framework of this chapter illustrated in Figure 12. The important areas for the purposes of this document analysis include the prevailing definition of risk, followed by an overview of the organisational factors which influence RAM. This section presented here is vital to this document analysis as it examines the literature that further influences the general understandings of clinical risk in acute-care adult psychiatric settings, comparing this to key policies and legislation. I argue that, in this way, these documents all have the potential to influence both organisational and individual actions when identifying these risks. The flow-on is that these risks must be minimised. As such, safety is built-in to hospital and provider policies and procedures across the industry on a global basis (Muir-Cochrane & Mosel 2009; Undrill 2011).

One key aspect of the institutional definition of risk is that it is strongly based on the notion of adverse events, which is the organisational culture prevalent in the West. Identified adverse events in mental healthcare institutions include, but are not limited to, violence, aggression, absconding (leaving the hospital/ward without permission or while detained under mental health legislation), suicide and self-harm, and substance abuse (Muir-Cochrane & Mosel 2009). To support my assertion that this document analysis must consider such aspects through a different framework, Carroll (2009) suggested that in order to conduct thorough risk assessments, the *context* of risk assessment must first be defined. It could also be argued that what is meant by using the terminology of *risk* must be identified and defined. To extend this concept, the context of risk assessment and its definition will be difficult to identify and articulate unless the concept of risk is explicitly defined, and this must be contextualised within the mental healthcare arena (for this thesis). The absence of these definitions has the potential to affect clinical practice, as perceptions of risk are subjective (Trenoweth 2003), and benchmarks are clearly absent for clinicians seeking to base their practice on evidence. This is no different to the absence of definition in the contemporary legislation and is not such a surprising finding for this chapter. I argue at this juncture that if risk remains undefined, it cannot be effectively assessed or managed as it is based upon unspoken assumptions; and this argument provides even more reason to explicitly define the concepts that are being analysed and interpreted.

To further complicate matters (while adding weight to the previous argument), the contemporary literature remains context-bound to the behaviour being assessed and fails to provide an explicit definition of the concept of risk. This leaves out many forms of risk because of the first part of the equation “an act of harm”, and begs the question, why would risk only be about “harm”? This leaves out any sense that risk may be something inherent in the way the system or the facility operates, which may be a risk for the patient. In the United Kingdom, the Department of Health (2007) has developed *Best Practices In Risk Management* for mental health professionals who work with patients. These guidelines underpin risk assessment in all mental health settings across the United Kingdom. The definition of risk, as stated in these guidelines, is:

> *… [t]he nature, severity, imminence, frequency/duration and likelihood of harm to self or others; a hazard that is to be identified, measured and ultimately prevented (Department of Health 2007, p. 57).*

Risk factors should also be considered in this context, and are defined as:

> *… [a] condition or characteristic assumed to have a relationship to the potential to harm another person or self (Department of Health 2007, p. 57).*

Comparatively, this bears similarities at a local level whereby a practice manual for mental health professionals published by the New South Wales Justice of Health (Alnutt et al. 2010) defines risk according to the Department of Health (2007) guidelines. Alternatively, the Risk Management and Clinical Risk Management Guidelines for the Western Australian Health System define risk as:

> *… [t]he chance of an event occurring that will have an impact upon values, goals or intentions. It is assessed in terms of repercussions and likelihood (Department of Health 2008, p. 36).*

These guidelines extend further, defining risk assessment to be:

> *… [a] gathering of information and analysis of the potential outcomes of identified behaviours, identifying specific risk factors of relevance to an individual, and the context in which they may occur. This process requires linking historical information to current circumstances, to anticipate possible future change (Department of Health 2008, p. 36).*

Langan (2008) clearly demonstrated how clinicians and patients have difficulty with this concept of “risk”, and this discourse is important to consider in this chapter. Langan (2008) found that the patient participants were able to define risk and RAM in their study, but Langan did not discuss the patients’ responses in detail. Lanagan does discuss that notably, while the participants were able to define risk, they had difficulty verbalising concepts of risk. Clinicians’ in Langans’ study referred to risk in terms of “early warning signs”, whereas the patient participants’ perspectives of risk were measured in the context of the risk that they had posed or could pose to other people. This indicated that the patient participants were also influenced by the prevailing discourse that they are, in fact, “risky”; a notable finding in this chapter. That said, obviously some patients are indeed at risk or pose a risk to themselves or others (under specific circumstances); however, with the current discourse, *there appears to be no other way to think about the situation except that they will do something dangerous.* The current thinking does not allow for alternative lines of thought, such as what the risk is for the patient if they do not “participate in their risk management plan”, and where the institutional obligation is in this instance.

Bending this discourse slightly to further meet the aims of this thesis, Murphy (2004) attempted to understand the terms of risk (rather than to define this), identifying the four factors of risk as being:

> 1) *risk to self;*
> 2) *risk to others;*
> 3) *risk of neglect; and*
> 4) *risk of vulnerability.*
>
> *(Murphy 2004, p. 410).*

For the purposes of this document analysis, risk of neglect and vulnerability appear to refer to the obligations of the mental healthcare system as opposed to the dangerousness of the patient. Lamont and Brunero (2009, p. 29) then defined risk factors to be “the specific circumstances that may adversely influence behaviours and involve a complex integration of idiosyncratic and environmental circumstances”. This is an interesting twist in that there appears to be a slight movement away from prevailing notions of dangerousness, and an acknowledgment of the complexity surrounding mental illness, in addition to the institutional obligation. Strikingly, these possible risk factors likely relate to the operationalisation of risk for the purposes of an empirical study, rather than to the theoretical treatment of risk. At this juncture however, a distinction should be made that these are institutional definitions of risk, as opposed to the sociological and theoretical definitions of risk, which are considered in Chapters 2 and 3 of this thesis.

6.4 Discourse around Clinical Practices

6.4.1 Legal and Ethical Responsibilities

The very nature of mental healthcare is framed within legal and ethical responsibilities and this discourse guides and binds clinicians by not only various legislation and policies in relation to RAM (Australian Health Ministers 1992; Commonwealth of Australia 2002; *Guardianship and Administration Act 1993; Mental Health Act 2009;* WHO 2003), but also, through the prevailing clinical literature founded upon the concept of “Evidence Based Practice”. This means that clinical practices are guided by the scientific paradigm, which considers risk assessment as a way of gaining control over the environment through prediction, and which is seen to dominate current-day mental health practices (Littlechild & Hawley 2010). This scientific paradigm, or the “biomedical model” in mental healthcare practice, is the most dominant approach to illness and health in Western societies. This model is founded on scientific approaches, which use objective methods to treat and diagnose health problems, in addition to claiming to offer superior ways of understanding health and illness (Walsh 2004). This idea is supported in practice, as seen previously in this chapter; the diagnosis of the patient is identified as directing not only the risk assessment but also the treatment (being the risk management of the patient). It is not surprising then, that the notion of risk assessment (which is entrenched in actuarial prediction as explored in Chapter 4), the biomedical model, and the legislative requirements are so closely aligned.

Likewise, it is important to consider that each profession has different mandated legal and ethical responsibilities within the realm of RAM; this is an important distinction to make when considering the notion of multidisciplinary healthcare teams. For example, MacNeela et al. (2010) interviewed 59 mental health nurses who practiced either on the ward or in a community setting. These participants were very aware of their legal responsibilities and saw risk behaviours as those that justified institutional care. This concept was illustrated when one participant stated that most “people would say in a court of law they were a danger to themselves and other people (FG8)” (MacNeela et al. 2010, p. 1303).

Scott et al. (2011) found that psychiatrists were more inclined to detain their clients, because the risk their clients posed seemed to be of greater significance than their right to freedom. In addition, the psychiatrists in this study were more likely to strategically protect themselves from blame, with a detention order that they issued being a “safer” option. This idea is also supported by the findings of Petrila and Douglas’ (2002) selective review in which it appears that risk and the protection of the patient and others is the reason the individual is placed in a secure facility. Petrila and Douglas (2002) also suggested that legally-precise documentation has the ability to decrease legal liability. All of these factors can be considered as having major influences on RAM. I argue here that these findings demonstrate the influence that such discourse has on the formulation and implementation of legislative and ethical requirements.

6.4.2 Identified Variables

Other variables assessed in RAM include social aspects such as the personal dispositions of staff, legislative requirements and mandated responsibilities, and unique social settings such as the ward (i.e. heterogeneity), which can also influence RAM. Gunstone provided a broad equation that considers some of these factors:

Autonomy/safety decision (risk management)

=

[(Worker’s tolerance + policies, procedures, legislation + worker’s definitions) + (risk assessment)]

(Gunstone 2003, p. 294).

This equation was developed by Gunstone (2003) as a result of interviewing multidisciplinary mental health professionals. Mental health workers’ tolerance refers to situations that are affected by past experience. Awareness by the workers of legislation, policies, and procedures also affected their risk decisions. These areas framed their definitions of what (in the case of this study) constituted self-neglect. The decisions they made, based on these aspects, affected the decisions that impacted upon a patient’s safety needs or their autonomy in the community.

However, the wider spread of stakeholders are absent from this equation, and yet they can also affect the assessment and management of risk. Stakeholders include patients, carers, families, healthcare professionals, and the public at large (Ryan 1998, cited in Gunstone 2003). Each stakeholder will hold a broad, multi-dimensional definition of risk, possibly reflecting differing agendas, but ultimately influencing psychiatric RAM (Ryan 1998, cited in Gunstone 2003). Moreover, given this point, it could be considered that comprehensive policies and procedures should be adaptable to the environment (Smith & Allan 2010).

6.4.3 The Recovery Framework

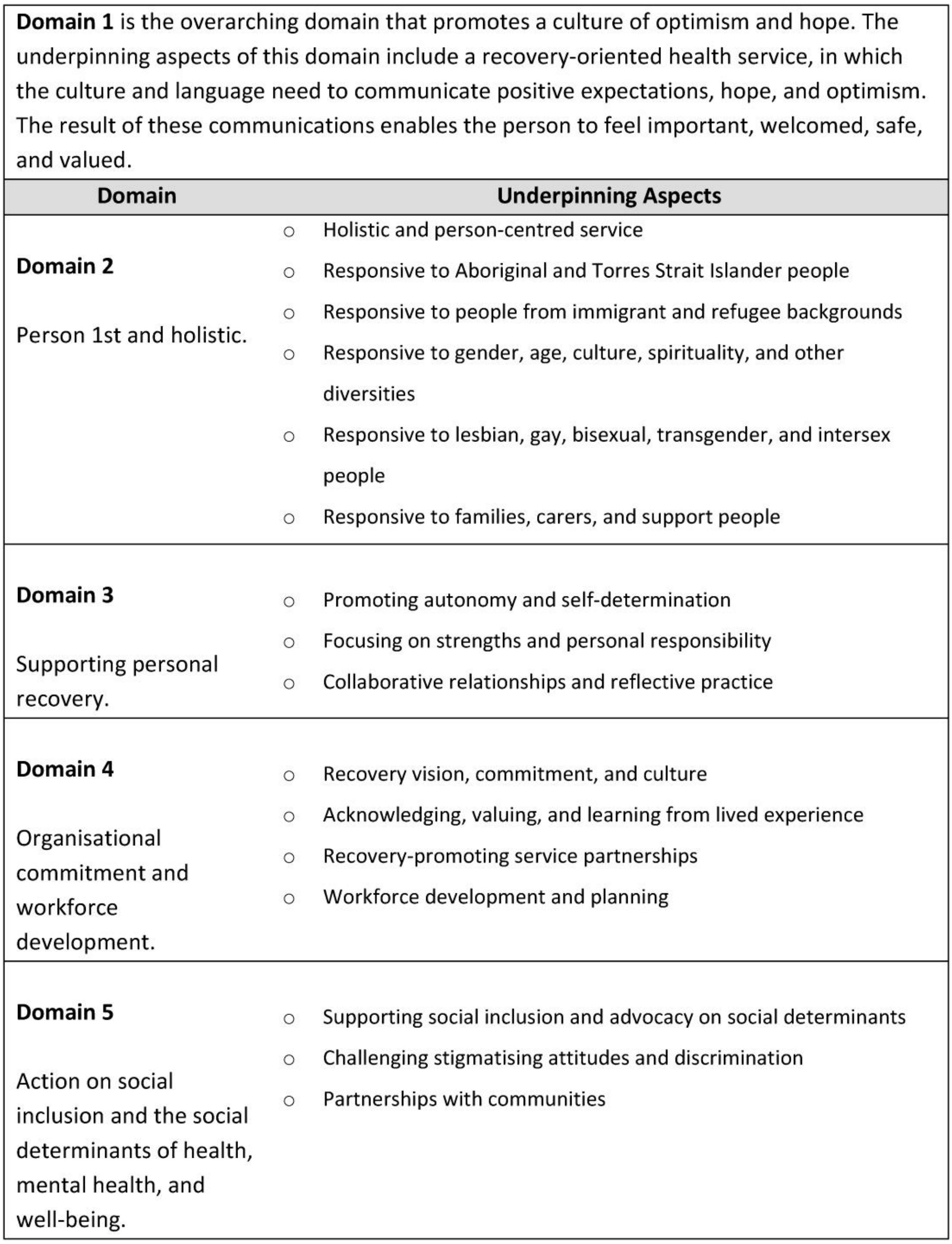
Next, this document analysis will consider the concept of the “Recovery Framework”. Figure 12 frames the conceptualisation of the “Recovery Framework” as adding to the discourse surrounding risk and RAM, and yet, this further muddies the already dirty waters. Rather than risk being defined as an adverse event, as is the prevailing discourse so far in the preceding sections of this chapter, Kumar and Simpson (2005, p. 329) defined risk as “the possibility of beneficial and harmful outcomes and the likelihood of their occurrence in a stated time scale” which lead to the mitigation of risk. This deviates from Beck’s theory that risk is seen as catastrophic and moves closer to Giddens’ notion that risk can exist as a form of possibility. The key features of Kumar and Simpson’s (2005) definition include a consideration of the likelihood of different outcomes occurring and a consideration of the benefits as well as the potential harms. This could be considered, in this context, as a contingency model although, more realistically, it could be argued that this model does not serve the dominant discourse that exists around risk.

This alignment with contingency in plain terms implies that “this might happen”, that one “cannot predict the future”, and that risk prediction is an inexact science (Kumar & Simpson 2005). This is important when considering the fact that mental healthcare in Australia is centred on the Recovery Framework. It could be argued that the Recovery Framework is not compatible with the dominant risk discourse, but is highly compatible with this contingency model. For example, the Minister for Mental Health in the state of Victoria, the Hon. Mary Woolridge, in the Ministerial Foreword of the Framework for Recovery-Oriented Practice (Department of Health 2011), considered recovery from mental illness to be a self-defined journey, with the focus being on strong partnerships between the patient, significant others, and healthcare providers through collaboration and careful negotiation. The Recovery Framework, as outlined in this document, identifies a need to balance risk which promotes risk tolerance, in addition to acknowledging that risk-taking (within ethical boundaries) can lead to empowerment:

> *… [g]iven that a recovery approach involves promoting people's choice, agency and self-management, a degree of risk tolerance in services becomes necessary. As such, services can empower people – within a safe environment and within the parameters of duty of care – to decide the level of risk they are prepared to take as part of their recovery journey. In supporting people's recovery efforts, it is necessary for services to articulate the threshold of risk appropriate to the particular service setting. Accordingly, services should consider providing guidance, training and support to staff on how to reconcile flexibility and responsiveness to people's unique circumstances and preferences with appropriate risk management obligations. This involves working with the inherent tension between encouraging 'positive risk taking' and promoting safety (Department of Health 2011, p. 3).*

To extend this concept, Wand (2012) suggested that there is a "double standard" between those not diagnosed with a mental illness compared to those who are. Patients who have been diagnosed are unable to exercise their choice to take a risk or to make choices that are potentially self-defeating, as the interventions implemented by clinicians are designed to protect the patient from harm. He further went on to say that when patients are denied the "dignity of risk", they are then denied opportunities to learn from their mistakes, and then to ultimately recover. This essentially means that the Recovery Framework requires the "consumer" to take risks in order to recover; however, because their care is strongly controlled through RAM, they are not *enabled* to take these risks which would, under the Recovery Framework, enhance their recovery. This means that, because of the tight restrictions, risk management seeks to manage the risks before they occur leading to the question of how a patient can take a chance (or risk) if they are prevented from doing so at the outset and on an ongoing basis.

This is clearly at odds with the Australian national Recovery Framework, which directs all mental health services and jurisdictions to implement the Recovery Framework (Australian Health Ministers' Advisory Council 2013). The domains of recovery-oriented practice and service delivery that guide practitioners and service providers are as follows:



Domain 1 is the overarching domain that promotes a culture of optimism and hope. The underpinning aspects of this domain include a recovery-oriented health service, in which the culture and language need to communicate positive expectations, hope, and optimism. The result of these communications enables the person to feel important, welcomed, safe, and valued.

Domain	Underpinning Aspects
Domain 2 Person 1st and holistic.	○ Holistic and person-centred service ○ Responsive to Aboriginal and Torres Strait Islander people ○ Responsive to people from immigrant and refugee backgrounds ○ Responsive to gender, age, culture, spirituality, and other diversities ○ Responsive to lesbian, gay, bisexual, transgender, and intersex people ○ Responsive to families, carers, and support people
Domain 3 Supporting personal recovery.	○ Promoting autonomy and self-determination ○ Focusing on strengths and personal responsibility ○ Collaborative relationships and reflective practice
Domain 4 Organisational commitment and workforce development.	○ Recovery vision, commitment, and culture ○ Acknowledging, valuing, and learning from lived experience ○ Recovery-promoting service partnerships ○ Workforce development and planning
Domain 5 Action on social inclusion and the social determinants of health, mental health, and well-being.	○ Supporting social inclusion and advocacy on social determinants ○ Challenging stigmatising attitudes and discrimination ○ Partnerships with communities

Figure 14: Illustrating the Discourse Surrounding Recovery-Oriented Practice

Reproduced directly from the Australian Health Ministers' Advisory Council (2013, p. 32).

6.5 Tools

As introduced previously (*see* Section 6.1), driven by the data collected from the interviews and the documents in the preceding sections of this analysis, this section considers:

- One acute-care nursing care plan commonly used in South Australian acute-care hospitals (*see* Appendix Q); and
- The risk assessment and management tool used at the research site (*see* Appendix O)
    - Identified by the participants as the “care plan” used at the research site.

To allow the reader to see the foundation upon which these care plans are built, the South Australian Acute Mental Health Risk Assessment Tool, the Standardised Risk Assessment Form for Community Mental Health Services, and the South Australian Acute Mental Health Risk Assessment Tool are first considered. After this, the care plans are analysed. The similarities and differences between these care plans are identified and then critically analysed. From this analysis, Menzies’ (1960) contentions related to the use of nursing rituals, such as employing a checklist approach to care as an example of a defence mechanism, are considered. The transferring of responsibility for safety onto the tool rather than the individual is then examined within this context.

6.5.1 Formalised RAM

Through the discourse previously discussed, and the organisational culture that has arisen through it, the organisation has the power to dictate which tools are used in relation to psychiatric risk assessment and risk management. From an organisational perspective, formal risk assessment is considered to be a way to ensure a considered summary of potential risks, while risk management is a way of minimising the likelihood of adverse events. The South Australian Acute Mental Health Risk Assessment Tool (*see* Appendix J), which incorporates a risk management plan, is as follows:

Text removed due to confidentiality.

6.5.2 South Australian Standardised DOH Community Risk Assessment Form

The Standardised Risk Assessment Form for Community Mental Health Services (SA Health 2014) is included in Appendix L. The risk assessment focuses on the patient's overall safety "including current risk to self or others, and other potential hazards". The patient's history of violence, assault, or forensic attendance is focused upon when assessing for risk of harm to others. The history of response to treatment is also assessed as is the patient's attitude to, and engagement with, treatment. As is consistent with Glover-Thomas' (2011, p. 587) findings, "what actually constitutes a "risk factor" *in practice* is left to the discretion of decision-makers to determine in accordance with their professional judgement and experience". Glover-Thomas (2011) suggested that without clear criteria, the protection of patients' rights will diminish.

6.5.3 South Australian Acute Mental Health Risk Assessment Form

The South Australian Acute Mental Health Risk Assessment Tool is illustrated in Appendix M. This form contains exactly the same components as the community assessment form. However, interestingly, clinical judgement is identified which can subsequently affect the risk score:

Text removed due to confidentiality.

6.5.4 Care Plans

Now that the foundation has been teased apart, in this section a sustained analysis of two care plans will be undertaken. Arising from the analysis of how the tools are used in mental healthcare settings, this section meets the fourth aim of the thesis which is to provide a critical comparison of care plans. Driven by the data collected from the interviews, and from the documents in the preceding sections of this analysis, this section presents the care plans commonly used in South Australian acute-care hospitals and the "care plans" used at the research site. The similarities and differences between these care plans will be identified and then critically analysed. The use of nursing rituals such as employing a checklist approach to care, as an example of a defence mechanism which transfers responsibility for safety onto the tool rather than the individual, as theorised by Menzies (1960), is examined within this context. I argue here that the use of the RAM tool acts to keep patients at arms' length, is developed in a way that patients cannot understand (and this takes the power away from the patient), and that their care is based on their risk score which is at odds with the National Mental Health Recovery Framework (Department of Health and Ageing 2013).

What will be argued here is that the care plan is a risk plan, or in other words, that care in mental health is reduced to risk assessment and audit. Firstly, a broad description of the tools is presented. Then, each form (or tool) is placed side-by-side with the equivalent form used in general settings (these forms are presented as Appendices). Subsequently, the similarities and differences between these forms will be identified and then critically analysed.

6.5.4.1 Nursing History, Assessment, and Care Plan in the acute care sector

In the general acute-care sector, "Nursing History and Assessment" is a vital aspect of patient care, which becomes a tool for the nurse through which care for the patient is planned (*see* Appendix Q). From this, another form is completed, the "Patient Care Plan", which records observations made by nurses and addresses the holistic nature of patient recovery (*see* Appendix W and Appendix X).

6.5.4.2 Risk Assessment and Management Tool: Risk management as care

On the acute-care psychiatric ward, the risk assessment tool is based on the South Australian Acute Mental Health Risk Assessment Tool (SAAMHRAT) (*see* Appendix M) (Department of Human Services 2002). The organisation acknowledges that the tool has not been fully validated. Instead, they consider this as "a guide and an aid to assist experienced clinician judgement, not replace it. Clinical judgement is the primary tool" (Department of Human Services 2002, p. 17).

The health service of this research site developed a hybrid version of the SAAMHRAT after a lengthy analysis of critical incidents. The tool was then refined through an auditing process. Furthermore, audits in relation to staff compliance in completing the tool are carried out every three months. Consideration and extrapolation of this tool appears in this section. The risk assessment tool (*see* Appendix O) is used in tandem with the risk management tool (*see* Appendix U), which becomes the care plan for the patient.

6.5.4.3 Comparing patient-consumer history and assessment

The next section juxtaposes the forms used in the research site to the commonly used nursing and history assessment tools found in the general acute-care sector. To preserve anonymity, all these forms have been de-identified for the purposes of this analysis.

Psychiatric risk management history and risk assessment forms

The first three forms (*see* Appendix N, Appendix O, and Appendix P) illustrate how the risk management history of the patient is documented, how the assessment tool which scores the level of risk the patient poses to the self and others is used, and how the risk assessment guide is intended to direct clinicians to the numerical score that they should assign to the patient. These forms become a de-facto equivalent of an acute-care general nursing assessment of a patient when they are initially admitted to the ward.

As depicted in the Appendices, clinicians at the research site initially record the risk history of the patient. The form prescribes that significant risk events should be the focus, in addition to the patient's risk of falls and risk of injury related to a disability. Once the risk history is collected, then the clinician is required to complete the risk assessment form. They do this by assigning a numerical value that, when totalled, determines the overall risk that the patient presents during their admission at the research site. Clinicians are directed to the risk assessment guide when assigning the numerical value of risk. The categories in this guide are:

Text removed due to confidentiality.

Interestingly, there is minimal focus on functioning, support, and attitude, whereas the focus becomes, with this particular form, the risk of harm to self or others, with ample space to add additional risk scores based on other individual risks not otherwise identified, which include sexual disinhibition, falls, impulsivity, intrusiveness, substance misuse, and poor judgement. There is no associated Falls Assessment form, nor a form for physical assessment, despite the national standards requirements previously described.

General acute care nursing history and assessment forms

The general acute care nursing history and assessment form (*see* Appendix Q) used for patients is explored below. The associated forms, if relevant to the patient, are also presented here. These include the MUST Tool (*see* Appendix R), the Braden Scale (*see* Appendix S), and the Falls Risk Assessment tool (*see* Appendix T). All these forms direct general nurses in the patient's care.

Initially, the general nurse completes the nursing assessment using the "Fundamentals of Care", and considers:

Text removed due to confidentiality.

Then, the MUST Tool is completed as a linked document which further informs the care plan (*see* Appendix R). The MUST tool considers a person's risk of malnutrition and can improve patient recovery and decrease the length of stay in hospital (Strikeberg & French 2009). This tool considers a patient's Body Mass Index, their weight loss over 3-6 months, and their nutritional intake over the past 5 days. It incorporates elimination, continence, and skin integrity. These scores are added together, the overall score is determined, and the management of the patient in terms of nutrition is directed by the calculated risk score.

The Braden Scale is also used and the associated score is calculated and becomes a linked document which further informs the care plan (*see* Appendix S). The Braden Scale is used to prevent pressure ulcers, and considers the following risk factors in determining the level of risk that a patient has to developing a pressure ulcer in order to protect the integrity of their skin (Baulch 2009). The risk factors include: activity, sensory perception, mobility, friction and nutrition.

A Falls Risk Assessment (*see* Appendix T) is also used in general acute-care settings and care plans, considering the person's current medications, medical history, and cognitive, sensory, or musculoskeletal impairments (as these can increase a person's likelihood of falling and injuring themselves) (Randle 2009). The Falls Risk Assessment allows for the consideration of postural drops in blood pressure (which can cause dizziness), in addition to a person's judgement regarding their physical ability. This form also includes actions to take to mitigate the risk of falls based on the risk assessment completed. The associated score must be calculated and further informs the care plan.

Risk Management: the care plan for acute care psychiatric patients

As depicted in Appendix U and Appendix V, clinicians at the research site now formulate the care plan for the psychiatric patient, which is heavily informed by their clinical judgement as stipulated in the various legislative directives previously examined in this chapter. This care plan must be based on the patient's collected risk history, the completed risk assessment, and the multidisciplinary assessments conducted upon admission.

6.5.4.4 General acute care nursing care plans

The general acute-care nursing care plan used in acute-care hospitals in South Australia is explored below. The associated forms, if relevant to the patient, are also considered here. Initially, the general acute care nurse will consider the patient's risks and/or issues that are identified upon admission (*see* Appendix W). A discharge plan will be formulated at this point in time. The patient's needs are also considered, including the domains of dignity/respect/privacy, personal needs, and psychological/social and environmental needs.

The next form is the care plan attachment which allows the daily recording of the patient's health status, and includes the following areas: cognition, observations, nutrition/hydration, elimination/continence, skin integrity, mobility, hygiene/self-care needs, comfort/pain, rest/sleep, and other patient requirements. In addition to this (and on a daily basis), a MUST score is calculated (which further directs the care) (*see* Appendix R), a Pressure Injury Risk Assessment (Braden Scale) (*see* Appendix S), and a Falls Risk Assessment (*see* Appendix T) are conducted. These tools have been previously presented, while the other presented here at this juncture, is a basic Observation Chart which records a patient's vital signs and further directs the care provided (*see* Appendix X).

6.6 Connecting the organisational culture with the discourse, the tools created as a result, the ramifications for the patient, and the notion of power

The forms discussed in the preceding section used for collecting the patient's history, assessing for risk, and managing the patient-consumer in both general and psychiatric acute-care hospitals have been presented (*see* 6.5.4), and will now be critically explored. From the perspective of risk assessment in psychiatric care, one cannot discount the fact that there are other tools that clinicians use in addition to risk assessment, including psychosocial assessments; for example, the Mental State Assessment. This assessment includes the patient's history, general assessment, motor behaviour, mood and affect, thought processes and content, sensory and intellectual processes, abnormal sensory experiences or misperceptions, judgement and insight, self-concept, and physiological and self-care considerations (Evans & Brown 2012). Regardless of these points, the risk assessment drives the risk management of the patient, and the risk management plan *is* the care plan for the patient. In terms of assessment, psychiatric illness is strongly associated with chronic physical illness in addition to shorter life expectancy

(Evans & Brown 2012). For example, patients with schizophrenia are at risk of developing the following:

> *1) weight gain and obesity;*
>
> *2) diabetes;*
>
> *3) hyperlipidemia;*
>
> *4) prolongation of the QT interval on the ECG;*
>
> *5) prolactin elevation and related sexual side-effects;*
>
> *6) extrapyramidal side-effects, akathisia, and tardive dyskinesia;*
>
> *7) cataracts; and*
>
> *8) myocarditis*
>
> *(Marder et al. 2004, p. 1334).*

While noting that the majority of mentally ill patients hospitalised in acute-care psychiatric settings in South Australia are diagnosed with schizophrenia (AIHW 2012; Mosel, Gerace & Muir-Cochrane 2010), in this context, Marder et al. (2004) suggested that patients' BMI be recorded before every medication initiation or change. They further suggested that the management (interventions) should be as follows:

> *… closer monitoring of weight, engagement in a weight management program, use of an adjunctive treatment to reduce weight, or changes in a patient's antipsychotic medication. If a patient is taking a medication that is associated with a higher risk for weight gain, the mental healthcare provider should consider switching the medication to one with less weight gain liability (Marder et al. 2004, p. 1336).*

Likewise, Marder et al. (2004) urged mental health providers to be aware of the symptoms of diabetes, by monitoring for the presence of these on a regular basis. This also applies to monitoring for extrapyramidal side-effects, akathisia, tardive dyskinesia, cataracts, and myocarditis. The risk management history form and the risk assessment tool leave little room for such monitoring (as opposed to general acute-care nursing forms). Without the ability to document changes in the patient's health status, such as through the use of these forms and tools, the patient in the psychiatric setting may be at risk of developing chronic physical illnesses. Moreover, as these changes in the patient's health remain largely unnoticed, this ultimately affects the risk management plan which directs the care of the patient.

As such, the physical observation of the psychiatric patient is as important as the psychiatric assessment. Unfortunately, when comparing the care plans of psychiatric and general acute-care settings, there is little scope for clinicians in psychiatric settings to record such observations. General acute-care nursing plans consider many more domains for the patient (and could be considered more holistic in nature). Moreover, nowhere in either the risk management or the risk assessment form is it considered whether the patient has driven their own care, which is a mandate of the Recovery Framework, although it needs to be acknowledged that this lack of patient voice is also present in acute-care general settings. The omission of physical health certainly implies the notion of, and focus on, dangerousness, as opposed to the very real physical complications that can occur as a result of mental illness.

Interestingly, the focus on the "forms" as seen in both general and psychiatric settings resonates closely with the theoretical formulations of Menzies (1960), who suggested that the use of nursing rituals, such as employing a checklist approach to care, are examples of defence mechanisms which transfer responsibility for safety onto the tool rather than to the individual clinician. Given that there is such a focus on these forms, and that there is an organisational expectation that these be completed in their entirety, it would seem entirely plausible that clinicians would be focused on completing them to avoid litigation, and to transfer the responsibility of patient deterioration to the organisation rather than taking the responsibility on themselves.

Further, it seems clear from the analysis of these tools that they have been developed in such a way that patients do not understand them (which takes the power away from the patient). The major disparity is, however, that the patient's care is based on their risk score which is at odds with the National Mental Health Recovery Framework (Department of Health and Ageing 2013). This adds further weight to the argument that the current prevailing discourse and the Recovery

Framework are incompatible and therefore cannot coexist.

6.7 Concluding Comments

This analysis has concluded that the risk assessment tools and the risk management of the patient (which becomes the care plan) are sorely inadequate, with a potential for deleterious physical effects as a result. As well, the tools transfer responsibility away from the clinician, which could mean that clinicians do not need to justify why they have neglected to consider the physical consequences *as there is no space on the forms in which to write their observations*. This has clear ramifications for the patient because it is the tool that is used, and the manner in which the tool is used, that dictates the care they receive. For the psychiatric patient, the focus is purely and simply on risk in the truest sense of the word, risk of harm to self or others, and nothing more.

To complicate already complex matters, the sources and texts analysed here also demonstrate that there are multiple definitions of risk. These documents further identify the diversity of the risks that exist for both the patient and the staff, which subsequently influences the definition and interpretations of the risks that are identified. Likewise, the arguments made in previous chapters in relation to “risk society”, and the historical transition from “badness” to “madness” to “dangerousness” is further evident not only in the definitions of risk in the contemporary literature, but also in this analysis of Australian legislation that extends to the organisation. The overarching framework that has been examined here is one that both the organisations and the clinicians operate within and it is clear that this ultimately directs the care the patient is provided with. Against this backdrop, the following chapter steps off from this critical analysis by thematically considering the perspectives of clinicians in relation to risk and RAM in one South Australian clinical setting.

7 THE PRACTICES AND PURPOSE OF RISK ASSESSMENT AND MANAGEMENT: THE PERSPECTIVE OF CLINICIANS

7.1 Introduction

7.1.1 Synopsis

This chapter is the first of two that present data from the interviews, describing in detail some of the issues facing health professionals when undertaking risk assessment and management (RAM). It also identifies the attitudes of health professionals towards risk assessment, as well as the enablers and barriers identified by the participants that exist in relation to effective risk assessment. Central to the argument of this thesis is that these findings indicate that RAM is the cornerstone of mental health practice and is not limited to nursing practice. The medical profession and allied health also use RAM to underpin all their clinical practice. RAM is considered to be the only way to minimise risks in order to ensure the safety of patients, staff, and visitors. RAM tools are used to provide care for the patient and function as the care plan that nurses, doctors, and allied health staff use to guide them in care provision.

To “set the scene” for this chapter, a theoretical caring trajectory on acute care psychiatric wards (*see* Figure 15), reproduced from the work of Hummelvoll and Severinsson (2001, p. 161), visually illustrates how patients are admitted to a ward and then theorises how the focus of this admission is to deal with the short-term needs of the patient. Hummelvoll and Severinsson (2001, p. 161) identify clearly in this figure that theoretically, clinicians attempt to engender patient insight into their psychiatric diagnosis, the implications, the treatment, and the necessity for medication (if prescribed). While the aims for care in the acute phase of illness indicate a recovery focus, it is noted in Figure 15 that the holistic care of the patient and the Recovery Model are absent in assessment and diagnosis. Instead, RAM (the initial treatment) comprises the main aspects of this acute care admission. This caring trajectory reflects the trajectory present on this ward and in the community setting.

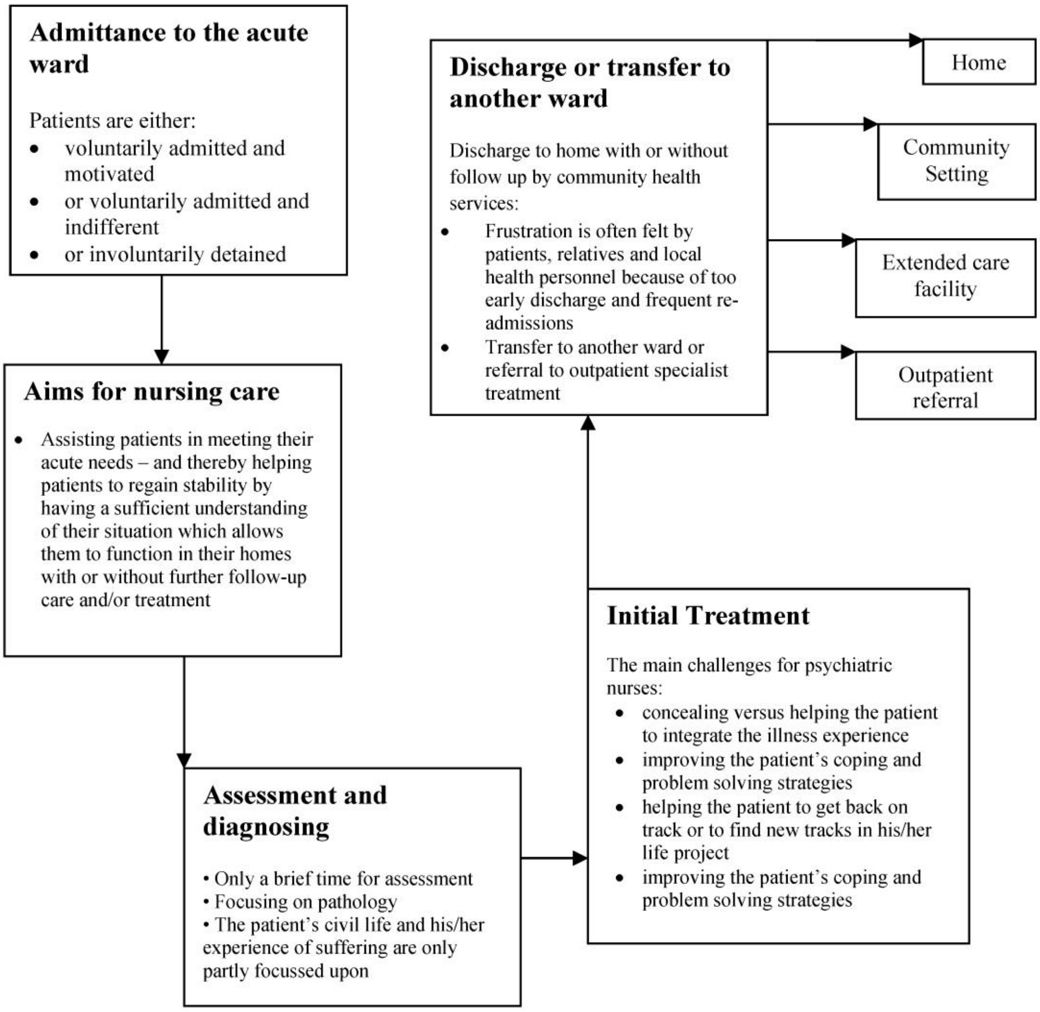


Figure 15: Theoretical Caring Trajectory

Reproduced directly from Hummelvoll and Severinsson (2001, p. 161)

Using Figure 15 as a platform to theoretically consider the findings, this current study was conducted within a unique ward providing community and inpatient care by mental health and general nurses, and doctors and allied health professionals. Both the patients' mental health and physical needs were attended to on the ward. The participants recruited included mental health and general nurses, psychiatrists, psychogeriatricians, occupational therapists, and social workers. Collectively, they had an average of 11.5 years of experience in mental healthcare and over 50% had worked on the ward for over 2 years.

The multi-disciplinary team members were required to undertake daily risk assessments which then informed the care the patient received, and in fact, this risk assessment form informed the risk management form. The risk management form became the care plan for the patient on a daily basis until discharged from the ward; and both the risk assessment form and the risk management form were kept in the front section of the patient’s case notes. This form was based on the ward’s Risk Assessment Clinical Procedures (*see* Appendix K) and, on admission, the assessment was completed by the admitting medical officer and nurse while the risk management plan was developed by the doctor and nurse, with input from allied health staff. That said, according to the ward policy, doctors had to complete the form between the hours of 9am and 5pm on weekdays. On weekends, the risk assessment was completed by the mental health nurse in charge of the ward with the on-call medical staff being contacted for further input.

All team members were then involved in the daily risk assessments which contributed to the daily risk management “care” plan. Given the patient demographics (being that of patients aged in their 60s and above), in addition to receiving psychiatric care from the psychiatrists, psychologists, and nurses, occupational therapists and social workers had an integral role in patient care, and this care then extended out to the community setting once the patient was discharged to their home. This took the form of occupational therapy, with the goal being to enable patients to participate in everyday life activities, and social work to assist the patients to manage their day-to-day lives.

7.2 Findings

The themes described in this chapter are: Defining RAM; Practices of RAM; The purpose of RAM versus purposeful RAM tasks; and Prediction as described by the participants. These themes will now be discussed.

7.2.1 Themes

7.2.1.1 Defining risk and RAM

Risk was not explicitly defined by the participants and reflects what was found in the literature in relation to clearly of defining RAM (*see* Chapter 4.3.1). However, throughout the interviews and upon review of the transcripts, risk was clearly defined by the participants in accordance with the risk assessment clinical procedures of the research site and the organisational risk assessment tool; and this is similar to what was found in the literature reviewed (*see* Chapter 4.3.1). RAM was also conceptualised by the participants in accordance with the forms (*see* Appendix O, Appendix P, Appendix U and Appendix V), again, similar to that of what was found previously (*see* Chapter 4.3.1).

Broadly speaking, all interviewees expressed a general understanding of risk with the consensus being that risks were adverse events that may result in a patient harming themselves or others. The range of risk behaviours articulated by the participants included absconding, suicidality, risk of harm to others (e.g. aggression), and risk of falling. This thinking was clearly in line with the clinical procedures and RAM tool of the research site (*see* Appendix O):

Text removed due to confidentiality.

The risk assessment guide (*see* Appendix P), which was included as an integral section of the RAM tool, explicitly defined risk behaviours which were categorised in Figure 16 as follows:

Image removed due to confidentiality.

Figure 16: Defined Risk Behaviours

Reproduced directly from Appendix P

Other individual risks were identified as intrusiveness (to others); impulsivity; poor judgement; sexual disinhibition; substance misuse; and falls. The range of scores that clinicians could assign (based on their clinical judgement) appears in Figure 17:

Image removed due to confidentiality.

Figure 17: Risk assessment guide of the research site

Reproduced directly from Appendix P, p. 3 (De-identified)

How risk and RAM were defined in the context of the policies and procedures of the ward is clearly illustrated in the following excerpts of the interviews with the participants. Interestingly, many of the participants discussed and defined risk using examples as opposed to providing a formal definition of risk. This finding is important as it demonstrates the nature of ostensive definition use, by conveying meaning through the use of examples:

> *RMHN Joel: … if I can just give you an example, we had a patient in the secure ward and she had dementia and it wasn't documented about her habit of sneaking up behind people and hitting people with her handbag, she had a handbag with a really long handle, but it was only when her family said it's what she puts in her handbag, at least two to three bottles of hair shampoo to make it heavy it increases the level of risk to everybody in the ward. One little snippet of information from a family member which sort of added to our assessment the risk from this woman, so never overlook the contribution from family members…*
>
> *Psychiatrist Nancy: … for example with this gentleman who is knowing risk of violence towards the wife but if we know that this man has never been violent towards his wife in the presence of his son we know this is a protective factor initially at least then the son should be there when he meets with his wife – this is the best way to prevent this is a protective factor we can enhance at any time as opposed to risk factors that sometimes we can't address.*

Clinicians considered that RAM was a necessary, albeit complex process. While describing the complexity, the participants then arrived at their definition of RAM (which was in keeping with the policies and procedures of the organisation). Interestingly, the transcripts revealed that there was limited attention to levels of patient functioning; for example, how they managed their day-to-day activities such as showering and dressing themselves, and their personal interests such as how they occupied their time in a positive and productive way. Instead, the overwhelming focus was on “risky” behaviours:

> *RMHN Lucy: … you need to know what the risks are, you have a duty of care to the patient, the client, to be aware of what the risks are and manage them as best you can. Knowing if the person’s got the capacity to make the decisions and take those risks, if they can weigh it all up and they know what the risks are … you’re assessing their moods, mental state, domestic functioning, their risk, their suicidal tendencies, their lack of functioning, everything …*
>
> *RMHN Joel: … (RAM is) … absolutely vital for everybody’s safety, if something goes wrong if you’ve got your plan and your assessment documented it’s a basis of your accountability, it’s a basis of evaluation, is there something we can do to improve this, also if the patient re-presents you can go back to the risk assessment and the more comprehensive it is the more useful it’s going to be …*
>
> *Psychiatrist Nancy: … in old age there is three main factors and history is one of them … in old age someone who has dementia you could really deal with something completely new - someone who has never been aggressive can become aggressive …*

7.2.1.2 Practices of risk assessment and management

RAM was perceived to be integral to clinical mental health practice. The participants described how they would like to practice in an ideal way, and how they conceptualised this “ideal practice” in the clinical environment. Extrapolated in this theme is the clinician’s desire to be able to quickly assess mental state, determine the presence of risk factors, and then, after discussion with family and other professionals, goals and strategies to reduce risk would be logically formulated. From this, they identified that current practices could be improved. Issues such as clinical experience, time, complexity of information, and a complex range of risk factors were identified as barriers to ideal practice. Time was considered as essential for tailoring care plans, completing risk assessments, and developing relationships with patients. Not surprisingly, the participants spoke of a significant lack of time available to perform these tasks. The following strategies aimed at minimising risk were identified by the participants:

- establishing therapeutic relationships;
- effective senior support; and
- appropriate tools.

Risk Assessment Form: Tools as structure

As a standard approach on the ward, risk assessments were conducted on every patient upon admission and then daily during their stay on the ward. Nurses, and allied health and medical staff considered the risk assessment tool to be a vehicle to logically consider and assess the information collected in their practice. It was seen as a means of communicating risk, accurately reflecting up-to-date information and the medical requirements of the patient. Many participants viewed this as an excellent starting point:

> *OT Daniel: … it's definitely there as a way to work through a difficult situation or circumstances … with a degree of structure to enable [and] facilitate your thinking about the issue.*

Overall, nurses and medical staff considered the Risk Assessment Form as an extremely important tool in their everyday practice. It was viewed as a succinct way of organising information, alerting other staff to the risks that are present, enabling clinicians to gain a different perspective (from other team members), prioritising, and providing visual cues. The form was also seen to benefit the patient:

> *Psychologist Vera: … these kind of tools that we have are very valuable actually because it gives me a structured way to get … immediate information that's absolutely necessary … whereas if you're just relying on yourself to ask these questions it's a lot harder … so it's just a nice structured way to make sure you're doing the best thing for the patient, you're doing the best thing for your service, and if there's a gap you can quite clearly see there's a gap …*

This tool was also viewed as a form of effective communication. The form was accessible to all staff and provided an "at a glance" overview of the level of risk, the care that had been planned, and the previous "care" provided to the patient. The "care" provided took the form of notes made in the Risk Management Plan section of the form (*see* Appendix U). This also allowed staff to make a strong argument to other team members, justifying one's position on the risk present and the care planned. The form was also used as a means of gaining input from other staff members on their assessment of risk and served to promote reflection and discussion. Following a structured thought process in relation to risk assessment allowed for a more considered care plan for the patient. The form was also used as a means of obtaining organisational support (i.e. higher staffing numbers):

> *SW Frank: … having a risk assessment in paper … you've got more of an argument to actually get assistance for that patient where otherwise you're just talking about his risk and you've got nothing really in writing that you can show them …*

RMHN Mandy and RN Phillip were cautious about using the RAM tool in their practice. Similarly, RN/RMHN Katy was particularly reflective, considering that too many healthcare professionals had too much input into the risk management plan. She considered that the intent behind the changes in this plan may disadvantage the patient and could be aligned with "care" discontinuities:

> *RN/RMHN Katy: I guess there's … too many chiefs and not enough Indians as the old saying goes, and one person might do it and then another person might come on and add or change and it might not necessarily be in the client's best interest.*

A small number of participants voiced their concerns that the assessment could, at times, be seen as "risky" for the patient as the participants could formulate opinions based purely on the risk assessment. This stereotyping could be considered as "dangerous" for the patient and has the potential for inappropriate treatment to be provided as a result of this stereotyping. From this, differing opinions of what was appropriate care arose. Within this context, the participants requested that, as a result of these interviews, that clinicians in future should be careful what they write in clinical notes, as this can sometimes detract from effective care. RN/RMHN Katy reflected on what was actually written on these forms, remembering incidents when staff did not appear to think about what they were writing. Concern was expressed when observing that some staff did not look at these forms. Nevertheless, while cautionary, this participant considered this form to be a useful tool, if used for its intended purpose:

> *RN/RMHN Katy: To some degree it's a bit of a label … they do need them [risk assessments], they're an important thing … we just need to be very careful what we write on them … I mean these go with the client … to other places … all staff [should think] before they write things on them.*

Further concerns were voiced by RN/RMHN Katy about the negative judgements made by staff that could be to the detriment of the patient. During the interview, she asked that, in this thesis, I specifically raise this issue and to highlight to clinicians that they be careful when making notes on the risk assessment form, as these notes can influence the patient's care in future admissions, which might lead to labelling or stereotyping of the patient:

> *RN/RMHN Katy: One person might do it and then another person might come on and add or change and it might not necessarily be in the client's best interest. To some degree it's a bit of a label, I think that's a pretty heavy thing to have a risk assessment for someone and they do need them, they're an important thing but I think we just need to be very careful what we write on them.*

The participants also considered the gathering of collateral information about the patient. They said that they believed care must be taken when gathering collateral information in order to avoid unnecessarily influencing the assessment of risk. Importantly, RMHN Lucy warned of the danger of making a judgement when gathering sensitive information about the patient as this can be viewed as detrimental to effective patient-centred care.

> *RMHN Lucy: The danger I guess is that people get a bit judgemental if there's a, like child abuse, even domestic violence sometimes people can get a bit he's always been like that. It's keeping it in perspective but generally I would say it's useful, you can kind of see if there's patterns there or certain triggers that make it all be an issue.*

RN Gail considered that the paperwork and the limited amount of time available were barriers to effective care, while RN/RMHN Katy considered further that risk assessment forms were potentially disempowering for nurses, as they could not formally complete this tool on the initial admission. According to ward policy, doctors had to complete the form during the hours of 9am and 5pm on weekdays. All nurses in the study considered this to be a prohibitive organisational policy that detracted from their autonomy. Their unanimous view was that it would be more efficient to complete the risk assessment form when a patient was first admitted to the ward, even if it was outside of business hours.

Access was deemed to be an important aspect for practice. This was divided in terms of the accessibility of forms (the availability of the completed assessments), access to staff (MDT) who offered additional skills and knowledge with which to manage and assess risk, and access to support services for the patient and their family. When assessment forms (succinct plans) were available to team members, effective risk management occurred. In addition, participants noted that when they had access to more experienced staff, and these staff members were available to consult, the participants felt assisted and supported. Access to support services for the patient and their family further enhanced care practices. Overall, these three areas of access ultimately minimised risk and were perceived to enhance the quality of care provided to the patient.

Real versus ideal RAM practices

The participants also spoke about how they would “like to” practice in the clinical setting and then went on to discuss what actually happened in reality. The participants perceived RAM to be a logical systematic process that was integral to clinical practice. The goals of care included aspects such as reducing the risk number to a “safer” level, gaining insight, and reducing the risk of falls:

> *RN Jack: … need a logical approach … I’ve got this information and I’m going to check it all out … establish goals of care and strategies to meet those goals and I need to be able to monitor what’s happening all the time, see whether those goals are being achieved or whether that strategy is working …*

The participants described what ideal practice might look like in RAM and how it existed within the clinical environment. This included the ability to quickly assess mental state and to determine the presence of risk factors, and doing so while relating to the patients. Information gathered in interviews with patients, their families, and other professionals would then be considered in a logical manner to establish goals and strategies. This would be achieved through formal evaluations (the risk assessment tool). Consistently monitoring the changing environment would also be necessary:

> *Psychiatrist Nancy: So, the way I do it is by collecting as much information as possible; talking to as many people as possible involved in the patient care; always assessing the environment (the risk assessment will vary depending on the environment) ... what we provide here, for instance, can't be provided in a nursing home, even if the patients are quite similar.*

Upon analysis of the data, the participants considered that these identified practices were ideal, yet were at times not done in reality. The participants were clear that in their daily practice, they lacked the ability to perform all of the aforementioned conceptualisations of what constituted ideal practice. For example, they felt that they lacked the time to meet procedural requirements (such as paperwork), which included formal RAM evaluations:

> *RMHN Joel: … comprehensive assessment taking up to an hour before you can go and start your work, considering there's four or five patients and some days six, so six risk assessments …*

Their inability to practice in an ideal way was compromised not only by meeting procedural requirements, but also being presented with information that was complex in nature. The static (historical) factors were considered as mitigating aspects and detracted from the dynamic aspects (what was actually happening to the patient). This was in addition to lacking the time that was required to collect this complex information:

> *OT Daniel: [History is] just one factor, a person may have no history but then there's a whole series of circumstances which put the person at acute risk and if they're in place they continue to be so … it's kind of different from individual to individual …*

This complexity was also exacerbated when the participants identified the range of risk factors they needed to consider. This included suicidal and homicidal ideation, declining ADLs (Activities of Daily Living), and wandering (absconding). OT Daniel clearly identified this complex range:

> *OT Daniel: In terms of discharge plan [sic] from the hospital to home in assessing risk … a person's ability … to complete ADLs, for example, falls risks, risks of safety related to leaving things on stoves, pots and pans, risk of wandering, absconding, risk of harm to others in their social networks …*

The qualities a clinician must possess in order to effectively assess and manage risk were also discussed. These identified qualities included being committed towards RAM as a care plan, being compassionate and empathetic towards the patient (facilitating understanding), and being flexible, accountable, and analytical. Five participants discussed effective RAM within the context of being committed to this process which led to positive outcomes for both staff and patients. Commitment and consistency to reducing risk then enabled effective risk assessment practices:

> *GN Martha: Facilitating good risk management is the tool we use to start with and diligent staff are all standing by the protocols which are all in place, working as a team and being aware … assisting each other.*

When assessing and managing risk, senior staff support was seen as a positive aspect of the workplace and aided in their practice (RMHN Lucy and Psychiatrist Nancy). Although RN Jack expressed concern about senior staff appearing to get “bogged down” with administrative tasks, the view was that the support by senior staff in the assessment and management of risk was best practice. RN Jack further noted that the lack of individualised care for patients, and the lack of consistency, affected the team’s commitment to reducing risk, and that this could be viewed as a “ticking the box” approach.

The participants regarded compassion and empathy as necessary to understanding the patient’s personal situation and history. This allowed for an insight into the patient as a person. This was considered to be ideal practice, and was used as a way of minimising risk in their practice:

> *SW Jennifer: To minimise risk … connect, listen to the person, understand [the] situation … Look at family, relatives, supports around … engage with supports if [there are] none around.*

Flexibility was also considered to be valuable when assessing and managing risk. This ranged from being flexible over time to being flexible within the profession. Likewise, they considered that becoming multi-disciplinary within one’s practice was vital:

> *OT Daniel: Risk management changes … tailor its frequency to what's actually happening with client so [it] will decrease over time … or may go up if patient becomes suicidal …*
>
> *SW Frank: … you've got to be able to investigate the situation and look for yourself and see things, you've also got to be a little bit multi-d in yourself I think because even as a social worker you need to have knowledge about OT stuff and a bit about psychiatry.*

The participants also considered that they should be accountable towards the patient and the organisation. Non-maleficence, mindfulness, and reflective practice were intertwined in this professional requirement of accountability. These were considered to be important in clinical practice and aided the effectiveness of RAM:

> *SW Jennifer: … effective risk management is reinforce[d] by incorporating it into daily practice … Being mindful you are accountable to client to organisation and that you have done everything in your power for that client.*

Having excellent analytical skills also fostered effective RAM. For clinicians, this meant they had the ability to investigate and evaluate the patient's level of functioning. The subsequent analysis drew from all of the aforementioned aspects:

> *OT Daniel: You need to be able to know your sources of information and draw on those appropriately … You need to have good analytical skills but you also need to use your intuition as well … you need to be very good at reading body language.*

The clinicians' viewed the above as appropriate and necessary in their clinical practice. They then considered how they acquired these skills. They considered that all of the above qualities were refined through experience, knowledge, and supportive environments:

> *GN Martha: So, [clinicians] really need to be very aware, educated and supported in having a broad concept of the awareness of the risk because it's quite a serious matter … it's a matter of life and death, it's not just whoops I didn't think of that, you know you've got to be very diligent, very accurate, very aware and educated and supported … If a staff member is new on a ward or if they're new to the industry they need to be supported in formulating these tools and not just left to their own devices, both for their professional support and for the safety of their clients as well.*

Individual practices ranged from daily risk assessments to only documenting when considered necessary. This was despite the policy of the ward that stipulated daily risk assessments. This proved to be a contentious issue and will be discussed later in this thesis:

> *SW Frank: I guess if I heard things like … any things like a client feeling worthless or helpless, if I saw their ADLs declining and I found that life was more difficult for them. If they were making any comments of suicidal ideations or homicidal ideations, even if they're very passive I would probably more inclined to do one. If I thought there was any kind of re-occurrence of their mental health issue … I might do a risk assessment in that time for accountability to myself as well that I've actually put something in writing about the risk and I've documented the risk … I might have verbalised it to my colleagues but I think it's also good to put it in writing.*

SW Frank's responses were similar to those from the majority of participants. This indicated that they relied on their clinical judgement in their daily practice. Conclusions drawn meant that clinicians considered that these experiences assisted their decision-making processes. SW Frank exemplifies the majority of responses:

> *SW Frank: If you're working with a client who has been a low risk for a very long time, unless there's some reason why I have to do a risk assessment, their situation's changed, or they're telling me things that would warrant me to do one, then I probably wouldn't do one.*

Conversely, for the less experienced staff who rely heavily on formal risk assessments as a means of structuring care and less so on clinical judgement, the variability of practice can lead to confusion at best and unsafe practice at worse. For example, RMHN Joel relies on the risk assessment form and assumes that all staff document relevant information. As is demonstrated throughout this chapter however, this is not necessarily the case:

> *RMHN Joel: It's an essential tool … before I had any contact with the patient, when I know my allocated patients, I will re-read the risk assessment for that patient, if I hadn't been here for two days or I've got on a late and I'd last been on an early, anything could've happened in that period and I need to just update myself before I go near the patient. So, it's an essential tool, it's a good starting point.*

With less experienced staff relying on the risk assessment tool (which is sometimes the only way in which the risks that are present to staff and patients are communicated), it is clear that lack of documentation can cause safety and care issues. Lack of documentation was identified by one community nurse as not being ideal in healthcare settings because it does not allow the carer to monitor the patient’s progress. This seems at odds with the identified preoccupation with risk demonstrated by the participants of this study and the organisational RAM mandates of the research site:

> *RMHN Lucy: They’re done every 3 months [in the community] or, if there’s something major, then that would be updated … it does get documented in the daily notes, but not under [a] risk assessment heading which is probably a bad practice.*

However, there was also confusion over who was responsible for formally completing the risk assessment. In reality, the assessment of risk was generally undertaken informally. Hospital policy states that it is to be completed primarily by the doctor. However, most nurses interviewed considered that they were capable of formally completing these assessments, and often would do so after hours. At times, this was a divisive issue among the participants. Psychiatrist Nancy reflected on this:

> *Now, what happens in reality, it is still done informally … is still done by one person not in consultation and is not multi-disciplinary as much as it should be. It is not communicated appropriately. I still believe apart from writing on a piece of paper … talking to the person and at least one of the nurses is very important … not just writing but also communicating … I still [am] not good at that.*

Not only did Psychiatrist Nancy reflect on this divisive issue, she also conveyed a number of issues associated with risk assessment. She was able to identify that there seemed to be ineffective communication between team members. This meant that despite such claims of a multi-disciplinary approach being taken on the ward, it could be done better (in her opinion). This interview identified that she struggled with these issues and did not know how to rectify them.

Time

Not surprisingly, time was an important issue for the participants, which further supports the general consensus of what has been previously examined (see Chapter 4.3.3.4). Most spoke of the lack of time available to them for assessing and managing risk in their practice. They were very clear that they took risk assessment seriously, but struggled with the responsibility they had in terms of RAM and how time impacted upon their decision-making:

> *RMHN Lucy: … but having time to actually think, to actually sit down and think, hold on, stop the frame, let me just weigh this up and think about it.*

There were many facets to this, particularly as the participants struggled to tailor individualised care plans while operating within time constraints. The participants had difficulty including every aspect of assessing and managing risks within a limited timeframe. They mentioned their tiredness throughout the day while being so busy; their inability to find time in the day to reflect on and weigh up varying options; the worry that they may miss something; and their struggle to have time to read the previous assessment of management plans when coming on shift, despite the verbal handover. Organisational expectations weighed heavily on their minds when they could not fulfil all of these requirements in the allocated time provided. Some examples of these tasks included medication management, counselling the patient, engaging in team meetings, performing daily risk assessments, and formulating “care” strategies (also known as risk management planning). From this, however, was the view that allowing time for patients to recover was considered important for quality patient care. The participants considered this when tailoring care plans, yet faced difficulties when a finite amount of time was available:

> *OT Daniel: If you’ve got time, sometimes you need to reserve your judgment a little bit and let things unfold.*

The lack of time participants felt which impinged on their inability to tailor a care plan for the patient also extended to when they spoke about time spent with the patient. They mentioned the importance of observation in order to be able to read body language, observe behaviour, and note compliance. This was commonly termed as "knowing the patient" which was seen as being important for therapeutic treatment and reducing risks, and was seen as part of best practice:

> *GN Martha: There's minimal time … there are so many different participants in the role of recovery … but we invite the client to let us know what it is that they would like to have put in place, to have assistance within their individual goals for their own recovery …*

Strategies to minimise risk

Strategies to minimise risk were another vital aspect for clinicians. This is because such strategies were actually the care that the patients received. From this, formal risk assessments clearly identified risk factors, alerted staff, and allowed strategies to be formulated to minimise these factors:

> *RMHN Lucy: You can't necessarily get rid of risks, but you need to know what they are … there may always be a risk of something or other that you can't get rid of … but if it's identified and people know that that's the risk then … that's sometimes as good as you can get.*

The participants were able to identify the variety of strategies they practiced to minimise risk (*see* Table 7). Some of the risks the participants sought to minimise included falls, self-harming behaviours, and absconding. Importantly, the participants identified the value of a dynamic patient risk assessment in which changes can be made, which demonstrated that the strategies/interventions were with effect; meaning that risks were minimised. However, the strategies identified were not consistent when the data was analysed. The participants identified many strategies that they used in their practice, with no apparent pattern and illustrates the formal and informal approaches examined in Chapter 4.3.4. This lack of consistency serves to highlight the variability of individual practice, but does not mean that participants do not use all of the identified strategies in their practice. Strikingly, RMHN Lucy acknowledged the variability of RAM, with the clinician formulating strategies dependent upon the risk identified. Interestingly, the best available evidence on risk assessment was not considered by the participants during the semi-structured interviews.

Table 7: Strategies to minimise risk

Source: Findings from Stage One

Overall Strategy:	Specific Strategy
Inclusion	Include all people involved in patient’s care (Psychiatrist Nancy). Include security staff (Psychiatrist Francesca). Utilisation of outside services – ASIS (Assessment and Crisis Intervention Service) and SAPOL (South Australian Police) (Psychologist Vera). When monitoring a patient in the community, a nurse and psychiatrist attended. Should a specific issue be identified, then a health professional specialised in that area would be included (OT Daniel).
Staffing and skill set	High staffing numbers were used to deal with perceived high levels of risk. At the same time, skill levels within these numbers were considered (Psychologist Vera; RN Phillip).
Patient specific	Know the patient (RN Gail). Know triggers – collateral information (RMHN Joel; Psychiatrist Nancy; RN Phillip). Be pre-emptive (RN Phillip). Use of PRN medication (RN Phillip). Diversion – calming actions (RN Gail). Negotiation (Psychiatrist Nancy). Increase insight (Psychiatrist Nancy). Connect with the patient (RN Gail). Ensure the clinician is perceived by the patient as safe (GN Gail). Address psychiatric problems (Psychiatrist Nancy). Ethical considerations (RMHN Mandy). Consider non-medication alternatives (RMHN Nancy).
Environment	Creation of a supportive environment “depending on what’s beneficial for the person, the client will accept as beneficial for their treatment” (OT Daniel). Observation of the patient including supervision of visitation if high-risk to protect visitors (RN Gail; RMHN Mandy; RN/RMHN Katy). Engage patient with the environment (Psychiatrist Nancy). Wear duress alarm (Psychiatrist Francesca).
Access	Ensure access to a risk management plan is available to all clinicians (OT Daniel). Share information with all staff in order to create awareness of risks present (RMHN Lucy; Psychiatrist Francesca).
Documentation	Ensure that all risks are documented (RMHN Lucy). Read previous notes – including previous admission history (RMHN Joel; Psychiatrist Nancy; Psychiatrist Francesca).
Education	Educate the patient – ensure patient knows the risk management plan (OT Daniel; RN Phillip). Consider risk factors (Psychiatrist Nancy).

From Table 7, the individual strategies that the participants used to minimise risk were categorised to reflect the overall strategy. Firstly, the participants sought to use inclusion as an overall strategy. Within this, they considered the inclusion of staff, patients, and carers who were involved in a patient's care as one way of minimising risk. They also considered using outside services to be of further benefit. Alternatively, patient-specific strategies were also used, including gaining knowledge of the patient and their triggers, and the collection of collateral information, in addition to medication administration and diversion techniques. The environment could also be used as a strategy. The specific strategies here were identified as the creation of support by staff within the environment, observation of high-risk patients limited to within this environment, and encouraging patient engagement with, and within, the environment. Consideration of the staffing skills mix, in addition to high staffing numbers, was viewed as another strategy to minimise risk. Accessibility, documentation, and education were identified as effective strategies which highlighted the importance of information to minimise risk. From these strategies, patient care was refined and enhanced. The participants spoke of various aspects that enhanced their practice, and they felt this enhanced the care they received and also, achieved personal satisfaction feeling that they were caring for patients in a beneficial way. These aspects are explored below.

Enhancing practice

Therapeutic relationships with family

Families seemed to be a key source of support in assisting clinicians to assess a patient's risk. As such, building rapport with families was considered to be vital by RN Jack, while other participants (RN Phillip, SW Jennifer, Psychologist Vera, RN Jack, and SW Frank) noted that this was important and beneficial towards patient care. This relationship was primarily formed in order to gain collateral information from family members.

RN Jack and RMHN Mandy also discussed therapeutic relationship development with patients, and Table 7 identified how clinicians attempted to achieve this. However, the impetus was, again, to gather information. The participants mentioned difficulties in developing these relationships with patients. Patient capacity was identified as a barrier in these instances. That said, the participants articulated varying ideas of relationships, yet the findings demonstrated a disconnect between what clinicians thought they were achieving to what was actually occurring in the "therapeutic relationship" (such as power differentials), as well as levels of paternalism, rather than the patient fully engaging and participating in the decision-making process. While building a therapeutic relationship is viewed as enhancing practice by these participants, patient agency seemed to be largely omitted:

> *RN Jack: They're not involved in deciding what the strategies are; in that sense, they're told what they are and they need to understand … this is what we're doing for you because …*

Policy and Procedures: Tools that guide

Over half of the participants interviewed considered clear policies and procedures (not necessarily in relation to RAM) as being important and valuable in their daily practice. Formalised policies and procedures enabled structure and clear guidelines and provided an "early warning system" that alerted clinicians to potential problems.

However, while generally viewed in a positive way, many of the doctors, nurses, and allied health professionals qualified their responses. For example:

> *OT Daniel: So, policies and procedures can again alert you to important things and important steps to follow, but policies and procedures are always secondary I think to clinical judgement and things such as your intuition and integrity.*

Alternatively, RMHN Lucy considered that it was important to know where to *find* the policies and procedures of the ward. RN/RMHN Katy and SW Frank expressed low levels of frustration. They wanted the policies and procedures to be flexible and adaptable in order to reflect individual situations/patients:

> *RN/RMHN Katy: [I] don't think it's best practice [mandatory risk assessments for all admissions], that's my own personal thoughts. I don't think everyone needs a risk assessment.*
>
> *SW Frank: Procedures are there to guide [you] when to do them [risk assessments] … but [procedures] should be allowed to be altered if need be …*

7.2.1.3 The purpose of risk assessment and management

This theme examines the participants' responses and found that RAM underpinned clinical practice. They considered that the purpose of RAM was to minimise risk, ensuring the safety of patients, staff, and visitors. This was in keeping with the clearly outlined policies and procedures of the research site. However, upon further exploration, it became clear that purposeful RAM tasks were most prominent (exemplifying the "tick a box" approach), rather than being able to clearly identify the overall purpose of RAM. Not surprisingly, the tool (risk assessment and management forms), consideration of static and dynamic states, safe environments, and legal requirements were discussed within this context.

The interviews reflected how important RAM was for clinicians. They not only perceived it as important in their daily practice, but also considered it to be important for the patient in order to ensure that "care" would be provided effectively. Likewise, they considered purposeful clinical practice to be important. The participants reasoned that RAM underpinned their overall practice:

> *Interviewer: So you think it [risk management] underpins what you actually do when you care for the patient?*
>
> *RN Jack: Well, it has to, otherwise you're just putting band-aids on things, so yes for me it is; without this, you can't do anything.*

The overall purpose of RAM was underpinned by task-oriented RAM practices that were designed to minimise risk. The participants considered that RAM and completing the tool as two ways of identifying and managing risk to ensure patients and staff were kept safe (i.e. harm prevention). In other words, the analysis revealed that the purpose of RAM was aimed at minimising risk primarily to ensure the safety of the patient, staff, and visitors:

> *GN Martha: Basically to keep the client safe, to keep the staff safe, to keep other clients safe, and to determine the medication protocol … in assistance with nursing staff, doctors, and psychiatrists … [important] to get the protocol correct because different risks can determine a need for different medications …*

The participants spoke of considering risk factors and protective factors within this context. Moreover, they considered that they had a duty of care to incorporate and consider these aspects in their practice. This drove their purpose:

> *Psychiatrist Nancy: I think only in the last couple of years, we have come to the structured way of identifying risk … before, we always looked at risk factors or we looked at protective factors, but be we didn't have this structured way and we didn't have this multi-disciplinary approach to risk …*

One purposeful task was to use the RAM tool as a means to structure their thinking about risk. The purpose of RAM was operationalised in what the participants were actually doing. This structured thinking enabled the participants to protect not only the patient, but also their family, and other staff:

> *SW Frank: … to triage your clients and to re-vouch your workload.*
>
> *Psychologist Vera: A quick and easy way to identify risk and to rate risk, rather than again relying on clinical judgement, which we can all be flawed depending on how tired you are …*

The participants regarded the risk assessment tool as a snapshot in time, recognising that it revealed little about the patient who was dynamic and evolving. Despite this, staff also highlighted the perceived benefits of using the tool:

> *RN/RMHN Katy: … they are important because you get instant history. I think that's why too [when] everyone comes in, we do one … like automatically everyone goes on daily, it's just a given that that happens and then we get to know them a little bit and then they'll go to weekly …*

Yet it was evident from the responses that risk assessment in the latter part of the patient's admission process was not as important. This begs the question of why the patient is being discharged when their risk assigned assessment "number" has not changed. If one goes by what the participants are suggesting, that risk management is the care plan, then the risk assessment score should have been reduced as the risks are then being effectively managed. This either means that risk assessments are not taken seriously and a "tick a box" approach is being used, or the patients have not improved and pose a risk to self or others. This is a striking finding, particularly as RN/RMHN Katy also highlighted this dichotomy:

> *RN/RMHN Katy: … I just question towards, especially towards the end of their admission, and we all know they're going, and they're going to be discharged in a few days; I question why we're still ticking them off and they're still on sixty minute visuals [observations] …*

Not surprisingly, the clinicians also considered that while the purpose of RAM was to minimise risk to benefit the patients, they were nevertheless bound by strict legal requirements. This resulted in a shift of purposeful risk assessment from a patient-centred role towards mandated responsibilities, and this served to reinforce the role of legislation in the construction of risk:

> *RMHN Lucy: From our point of view … I suppose it's an arse-covering exercise to a degree …*
>
> *OT Daniel: … it's obviously there for legal reasons, covering our backsides …*

While mandated responsibilities to complete a risk assessment were seen to be driven by policy, the participants acknowledged that situational factors also need to be considered. This means that clinicians considered their own judgement to be equally important. Practicing in an autonomous way, while at odds with the mandatory requirements, was seen to be necessary:

> *SW Frank: I think that they're important, but you've also got to use your own common-sense as well about when risk assessments need to be done … risk assessments are something that you can do anytime ... if you see anything which has you concerned, then you should be able to do a risk assessment. There are procedures there to guide clinicians about the best times to do them but … there are times where they need to be altered for particular situations …*

Many of the clinicians interviewed focused on reducing risk behaviours to acceptable levels. This is in line with the overall aim of eliminating or minimising the risks that are present. Yet, RMHN Lucy was comfortable with risk and acknowledged that they are always present:

> *RMHN Lucy: I assess that risk as best I can and being able to know what is manageable and what is not manageable, there are risks in everything and we all have to live with it. It's knowing what you can and can't do … that's fine for us, the practitioners, who document that and say the risks are huge … however, here's how we can best manage them. It's the crux of what we do ...*

Surprisingly, specific safety issues evident on the ward were mentioned by only two participants, although safety was broadly discussed by all. This culture of safety is also considered in the literature reviewed (*see* Chapter 4.3.3.3). RN Jack spoke about this within the context of safety for the patient. They discussed the impact that verbal threats had on staff and how this may disadvantage the patient when assessing their risk level.

GN Martha discussed two different areas of safety. The first was about the actions which may jeopardise the safety of clients. This was described in terms of staff having less tolerance, no gentleness, and no empathy, and ruling in a "despotic" manner, which could be interpreted that focusing on risk actually works against care provision. This participant considered that these attributes of staff were more likely to bring about reactive behaviours (anger and aggression) in patients:

> *GN Martha: I find that all of those things I've just mentioned can bring an anger response, a defence response from clients and they're adults, they've lived their whole life demanding respect of themselves and I think they rightly deserve it. I don't think anyone needs to be overpowered, perhaps the only time that's necessary is when someone is being extremely aggressive and they've lost control and need to be held down and injected. However, I've noted that a lot of aggressive behaviours can be minimised by staff interaction.*

GN Martha also described a safe environment. The examples she used to highlight what made the ward a safe environment included using emergency alarms, and correct staffing numbers and skills mix. These all engendered feelings of safety:

> *GN Martha: We have our emergency alarms which gives you a feeling of safety in case you're barricaded … specifically … the environment enables safety, the staffing is accurate for the clientele and is reassessed shift by shift and accommodated if need be.*

Staff were able to clearly articulate the main purposes of RAM, but the discussions were particularly rich when describing the tasks involved. Often, “doing a risk assessment” meant using the tool, despite the interviews reflecting that clinicians were assessing for risk mentally, rather than formalising their assessment on a piece of paper for others to see. They then framed their answers about their reasons and purpose when assessing risk within this context on the form (tool) specified for the assessment of risk. RAM is considered as the “building blocks of care” (RMHN Joel), so it makes sense that their focus is structured in this concrete way. Nevertheless, patient care in relation to RAM seemed to be an evolving process that encompassed both formal and informal assessments and subsequent management of the risks posed by these patients.

7.2.1.4 Prediction

Predicting risk was seen to be essential both as part of the risk assessment and for risk minimisation. Although most of the staff interviewed were confident in their predictive ability, they identified a number of difficulties which they encountered when attempting to predict risk, including:

- the onus being on them rather than on the form
- the organisational reliance on experience
- their reliance on tacit knowledge

The participants considered that experience and clinical knowledge of risk factors enhanced predictive confidence. Experience and knowledge appeared to be integral to this process. Intuition, or an inner knowing (tacit knowledge), was also important, and experience and knowledge enabled intuitive skills to be developed. That said, professionals acknowledged the need to predict which risks might be in place, and the problems with this:

> *Psychologist Vera: [Looking at past history is] critical … you just can’t [predict risk] without it … you really struggle …*

Nonetheless, most were confident in their predictions, and the participants perceived this confidence in many ways. Confidence arose when clinicians knew the patient, a task accomplished by asking direct and challenging questions. Their confidence was improved when they were familiar with the organisation (knowledge of RAM policies and procedures), being aware of the available services and the existing care plans that were in place. Experience further enhanced this confidence and allowed the participants to define risk, and to identify risks and risk factors. Different levels of experience and complementary skills were noted as being beneficial for the patient. This further served to aid their predictive abilities:

> *Psychiatrist Nancy: The area of skills is based on experience and if you don't have enough experience, it is based on asking and talking to others. So, learning from their experience …*
>
> *RN/RMHN Katy: … I need to have information, I can't just have someone just walk in, I need to have information about the client before I can do a risk assessment, so if I've got that information, then I'm very confident to do one.*

How one was to gain experience was also discussed. Many interviewees referred to years of service as the gaining of experience. Furthermore, life experience was seen to be a useful adjunct:

> *RMHN Lucy: So, the first time you ask somebody do you feel like harming yourself, you kind of have an out-of-body experience and kind of see yourself asking them thinking "how random is that to be asking that kind of question?" So yeah, just having the confidence to know what to ask and then to know what to do with the information, and a lot of that comes with experience …*

On the other hand, Psychiatrist Nancy noted that those less experienced clinically can still effectively assess and manage risk. She considered that less experienced clinicians could still draw from their life skills and experiences, and identified this as being valuable:

> *Psychiatrist Nancy: I think that everyone comes with knowledge, with skills, with experiences, which is valuable … I don't see it as different or that one is more important than the others …*

Access to experience and knowledge also enabled the intuitive skills of the less experienced clinicians to be developed. This could be aligned with an inner knowing (RN Jack, RN Gail, RMHN Lucy, Psychiatrist Nancy, Psychologist Vera, and RN/RMHN Katy). This sense of inner knowing allowed confidence in predictions to be further developed:

> *RMHN Lucy: You kind of need to know your client, you need to know how to do like the initial risk assessment, you need to know what to ask, you need to know what information you need, you need to know how to conduct an assessment and the things that are listed on your risk assessment … you may not be [able to] do that separately … some new staff don't necessarily appreciate that, they have their paperwork, correct that bit and go on to the next bit of paper … it's sort of knowing how to do a complete assessment of the situation.*

Intuition was identified as important, as this enabled the risks present to be further minimised. The participants considered that it could be achieved by predicting (intuitively) the evolving dynamics of the patient. Intuition and body language seemed to go hand-in-hand:

> *OT Daniel: You need to have good analytical skills, but you also need to use your intuition as well; you need to be very good at reading body language.*

The intuitive component was seen to alert the participants to important aspects and assisted them to predict risk. This can be seen as a form of tacit knowledge. Two clinicians were able to clearly articulate intuition: SW Frank considered this inner knowing which was described as "feeling like there was a risk". This prompted them to complete a formal risk assessment. GN Martha also discussed body language, and factored this aspect into an intuitive knowing:

> *GN Martha: Instinct, you need to have a lot of instinct, and this is where a lot of, you know, you can't learn a lot of things out of a book so therefore life skills and having an awareness of reading body language …*

However, two (RN Jack and Psychiatrist Nancy) participants spoke about the difficulties they experienced when attempting to predict risk. RN Jack discussed this within the context of receiving mixed messages of risk from the patient:

> *You have to weigh it up and say, initially you said you're going to kill yourself … so I've got to take you at your word … the longer I stand with you, the more I see that you're doing behaviours that protect yourself, like you're eating and you're sleeping well … so it impacts on my overall risk assessment.*

Psychiatrist Nancy discussed difficulties predicting in terms of unrealistic expectations from other team members and the organisation:

> *… it is very hard to predict this, though other people expect us to predict risk, it is quite unrealistic in terms of prevention …*

This implies that the onus was on them, rather than on the form, when assessing and managing risk. RN Jack had only 0.8 years of experience working in mental health (although 25 years of experience as a Registered Nurse), while Psychiatrist Nancy had 12 years of experience working in mental health as a psychiatrist and 25 years working in her profession. This indicates that, regardless of clinical experience, difficulties in predicting risk can still exist.

After this, GN Martha, RMHN Lucy, Psychiatrist Nancy, RMHN Nancy, and Psychiatrist Francesca then discussed the importance of sound clinical knowledge, understanding the illness and identifying risk. This assisted with predicting risk. The knowledge that the participants considered essential when assessing and managing risk included:

- ➢ *Knowledge of illness (psychiatry)*
- ➢ *The medication*
- ➢ *Alcohol issues*
- ➢ *The influence of diagnosis on risk*
- ➢ *Broad awareness of holistic views*
- ➢ *At risk of*
  - o *medical*
  - o *psychological*
  - o *emotional*
  - o *hydration*
  - o *nutrition*
  - o *social*

- *Awareness of what you can ask*
- *Protective factors*
- *Using the risk assessment as a tool*

Interestingly, Psychiatrists Nancy and Francesca, Psychologist Vera, and RN Phillip spoke explicitly about the importance of knowledge of the illness, the need to understand the illness, and how this influences risk. In their opinion, one way to minimise risk was for participants to adopt a preventative strategy (i.e. addressing psychiatric problems). These factors all aid in assisting with prediction. SW Jennifer saw training as one way of gaining this knowledge. However, Psychologist Vera felt that generic training did not account for all of the differing levels of experience. This is explored further in the next chapter.

7.3 Conclusion

The findings in this chapter indicate that intrinsic to the process of RAM was the direct clinical aim of forestalling risk. This was defined by the participants as being the minimisation of patients' risk behaviours. They represent areas such as knowledge, practices, strategy, prediction, and the forestalling of risk. Clinicians undertook a structured process in order to assess and manage risk. Accurate data is required, and was collected throughout the process. They were then required to predict the risk which was aided by the risk assessment tool. Intrinsic to the process was the direct clinical aim of forestalling risk. Overall, minimising risk as a general notion was clearly identified by the participants as being the minimisation of patients' risk behaviours.

Purposeful RAM tasks were seen to underpin the participants' practice and, in these tasks, the overall purpose of RAM was realised. In the current environment, legally mandated requirements resulted in tension and anxiety, which was further compounded by lack of time. Predicting risks was also difficult, however was aided by developing intuitive skills and having access to experienced clinicians and clinical knowledge. Role confusion was also a source of anxiety, but was mitigated by purposeful task assignments. The participants clearly considered their everyday

RAM practices to be less than ideal. Predicting risks was also difficult; however, was aided by developing intuitive skills and having access to experienced participants and clinical knowledge.

This chapter has predominantly explored what clinicians did in terms of clinical RAM practices, which were driven by purpose and definition and which required necessary predictions of risk to be made as a core aspect of their practice. However, there are other essential areas that exist within the effective assessment and management of risk in a clinical environment. The next chapter will present the other connected themes that are considered to underpin effective RAM practices. These connected themes existed while the participants navigated through the clinical environment.

8 COMMUNICATION, ORGANISATIONAL CONSIDERATIONS, AND CLINICAL RESPONSIBILITIES ASSOCIATED WITH RISK ASSESSMENT AND MANAGEMENT

8.1 Introduction

As previously described, daily risk assessments were completed on the ward and it was this assessment that informed the care the patient received. The risk management plan was identified by the participants to be the care plan. Both the risk assessment form and the risk management form were kept in the front of the patients' case notes. This form was based on the ward's Risk Assessment Clinical Procedures (*see* Appendix K) and the Risk Management Plan (*see* Appendix U) and was the form that the clinicians used to record the goal/plan/treatment that the patient received during their stay on the ward. Patient case notes were also used by all clinicians to extrapolate further information. In other words, risk is the primary focus of care for clinicians practicing on this ward and in the community setting.

While the previous chapter presented the practice and purpose of RAM as perceived by the participants, including their definition of risk and RAM and the focus on clinical practices, other aspects were identified by the participants as important. These included the participants' responsibilities within RAM, associated communications, and RAM training and education. Interestingly, the ward culture was also identified by the participants as having an impact on RAM, and this finding is important in establishing how risk is constructed and managed on the ward. This identified "culture" is consistent with the notions postulated by Giddens and Beck.

In this chapter, I present the barriers and enablers to risk assessment and management (RAM). First, a detailed description of the participants' perceptions of their responsibilities within RAM is presented. Next, there is a consideration of the communications associated with RAM and the culture of the ward as viewed by the participants. How they perceive the organisation in relation to RAM and their associated training and educational requirements is then explored. Finally, a conceptual conclusion is presented.

8.2 Findings

8.2.1 Themes

8.2.1.1 Responsibility

Responsibility for risk assessment was discussed with the participants and many considered RAM to be the responsibility of all parties; and is considered at length in Chapter 4.3.3.1. Confusion about roles and task specificity, as well as legal and ethical issues, were identified. The participants established levels of responsibilities that extended to the patient, primarily within the context of including them in the process of RAM, providing information from their own perspective, and expressing fears. The participants spoke of the importance of collaborating with other team members, and they considered themselves to be responsible for making this happen. Collaboration was seen to enhance patient care and to minimise risk. The participants discussed their perceptions of their overall responsibilities in relation to RAM. One important aspect of their role was collaborating with team members. The participants then considered the role of patients within RAM. Tensions towards roles and overall responsibilities did exist, and these are considered within this theme.

Perceptions of clinical roles and intrinsic responsibilities

Clinical practice and the participants' roles were considered by all the clinicians. Although it was clearly stated by most that "good" practice was dependent upon levels of experience, the assumption made by the clinicians was that the greater the level of experience, the better their clinical practice was. That said, the majority of the participants considered that all clinical staff were responsible for RAM as part of good practice:

> *RMHN Lucy: … Everyone has got a responsibility, the client has got a role, the case manager, my senior, my team manager, the doctor, the institution has, they're responsible … [otherwise it] falls over …*
>
> *SW Jennifer: Everyone [is responsible for risk management]. Not one person's responsibility. If I see something, I need to ensure some action is taken … doesn't matter who fills out the form …*

Some staff struggled with the responsibility that was assigned to them. This was primarily based on the distinction between nurses, doctors, and allied health staff. Allied health staff considered that although the final responsibility for assigning levels of risk rested with medical and nursing staff, they were also in fact required to contribute and recognise the risks that are present. Although this differed according to professional discipline (for example, an Occupational Therapist may focus more on a patient's risk of falling as opposed to a nurse who may consider whether they were an absconding risk):

> *RMHN Joel: [Nurses] have that legal responsibility for their patient … you can't say "oh but the consultant [psychiatrist] missed that point but I knew it and didn't do anything about it" … we all have a responsibility.*

The participants spoke about the importance of, and their responsibility for, collaboration with team members, considering each profession as integral to enhancing the care provided (communicated by way of RAM). This included aspects such as each team member being aware of what the patient's risk status was (sharing the information around), and this was seen to minimise risk through enhancing the care provided to the patient. This meant that all of the team were required to review not only the risk assessment and risk management forms, but also the case notes as well:

> *GN Martha: Well, we work collaboratively as a team to recognise the risk; however, the doctor's assessment becomes a more medical and a more neurological ... but the nurses, it's more behavioural, physical interactive on the floor, what works best for how to do ADLs and how to feed them …*

Tapping into experience (from each profession; for example, nursing, medicine, social work) enabled the patient to receive appropriate care; and these influences were briefly explored in Chapter 4.3.3.2. This took the form of counselling, medication, lifestyle management, and improvement of physical limitations. The participants considered that multidisciplinary input and different points of view enabled well-balanced care. Relating well to the multidisciplinary team was also important as it enhanced the above and created a good working environment (which then fed into effective communication).

Familiarity between team members and working collaboratively were also seen as important by the participants. It was noted that some only communicated with other members of the same profession, which is a situation that can impede collaboration. Knowledge of other professions, including their role within the organisation, enabled the participants to become multidisciplinary, as they had the outside knowledge of different professions that could be incorporated into their own practice:

> *RMHN Joel: I really like working in a multi-d setting, not just doing the paperwork, actually doing the interviewing with the patients, I'll sit in and actively participate. So, when they joint assessments a lot of bouncing off, "what do you think here, is this too high, is this too low", two brains are better than one. Theoretically, and I suppose legally, the consultant psychiatrist knows more about these things than the psych nurses or the registered nurses, but we might see things that the doctor or the interviewing nurse has missed.*

The participants were also very clear that gathering collateral knowledge about the patient was an integral part of their practice. Collaboration was viewed as vital in this process in order to minimise risk and establish therapeutic care. The participants were responsible for obtaining the clinical documentation on the patient in order to gather background information. This included using sources such as past personal history and previous hospital admissions. The participants stated that obtaining documentation identified the patients' cycles of behaviour. Keen awareness and observation of not only the patient, but also the milieu of the ward, was also a potential source of information. This included undertaking mental state assessments, both formally and informally. Through collaboration, changes that reflected medical deterioration could be identified. The gathering of such information through collaboration (both observations and documentation) was also necessary in order to ascertain the "circumstances" about what has happened/is happening:

> *OT Daniel: It's just one factor, a person may have no history, but then there's a whole series of circumstances which put the person at acute risk …*

A "collaborative history" seems then to be of importance in clinical practice. This meant collecting information from whatever sources were available to them; for example, from family members, police officers, and other team members. Collaborative history (i.e. gathered through collaboration) not only encompasses circumstances, but is aided by a keen understanding of the illness itself:

> *RN/RMHN Katy: If you have no understanding of dementia then, you're not going to [provide appropriate care]…, so that's why it's always that that multi-d thing, because someone there knows about dementia, someone there knows about bipolar … so, I think to do them the very best we can would be a multi-d approach.*

This understanding is further facilitated by information-sharing with professionals (which also reflects the levels of change in patients' risk status), predominantly in the form of knowledge-sharing, verbal handovers, and up-to-date documentation. Psychologist Vera noted that risk assessments are always changing; hence, continual updates from all sources are necessary. This accumulation of information raises confidence in predicting risk, noted RN/RMHN Katy. However, RMHN Lucy stated that history, illness, and the environment cannot necessarily be separated in the assessment of risk:

> *RMHN Lucy: I think some new staff don't necessarily appreciate that, they have their paperwork, correct that bit and go on to the next bit of paper and it's sort of knowing how to do a complete assessment of the situation.*

This brings up notions of seeking advice and tapping into experience. SW Frank indicated that there needed to be a purpose and understanding as to why the information is being gathered. Understanding and purpose is an important aspect of collaboration and effective risk assessment.

The sources used to obtain this information (fostered through inclusive or collaborative environments) included team members, patients, families, carers, significant others, social workers, and the police (SAPOL). SW Jennifer indicated that this has the potential for a greater diversity of risk information to be gathered:

> *SW Jennifer: Doesn’t matter who fills out the form, but information is given from everybody.*

The participants also considered that in order for this to happen, they must be familiar with the other professions. This need for familiarity was expressed in every interview conducted. The clinicians considered that it allowed the patients’ risk history, triggers, and patterns to be noticed:

> *Psychologist Vera: So we, the whole team, get to know about everyone who is allocated goes through risk management, so the whole team are aware of new referrals and what their risk is. And it’s done in that multi-d team setting, so we’re able to get other input from other professionals on the team, which is great.*

As such, collaboration with team members enabled the effective gathering of information. Once gathered, it was essential to include the knowledge accumulated when assessing and managing risk. Underpinning this was the idea that there was no point in collecting the information if you did not use it. The participants considered that, as part of their role, they were responsible for ensuring collaboration. The ultimate benefit to the participants was to minimise risk and to enhance the recovery process for the patient.

While it was acknowledged that everybody contributed equally to the assessment, and that the management of risk and collaboration were vital, the interviews reflected very clearly that certain tasks were assigned to specific people and is no different to the findings in the literature reviewed (*see* Chapter 4.3.3.1). So, while the assessment and management of risk was everybody’s responsibility, it became the responsibility of certain people in their role at the institution to complete the necessary paperwork. For example, in the context of completing the risk assessment form on a daily basis based on the levels of risk assignment, the risk management plan was then completed. The risk management plan became the care plan:

> *Interviewer: So the nurses don't do them every day [formal risk assessment and management]?*
>
> *RN Jack: No. They're supposed to be done, the actual documentation of risk management is done by a doctor every day; we, nursing staff tend to write things first, and we write the care plan, the nursing care plan but this bit, the actual risk assessment is a medical officer's job.*

This is a new finding that has previously not been examined in literature to date.

However, there was also a measure of role/task confusion. This depended on who was on the shift and whether it was a weekday or the weekend (a comparison of the differences in care plans are analysed in Chapter 6.5.4 and are illustrated in Appendix Q and Appendix U). The extract below clearly demonstrates the complexity of this situation and highlights the potential confusion when navigating through the clinical environment:

> *RN Jack: Whoever is the director of chief medical officer [is] responsible [overall] for mental health in the hospital … I suppose that obviously gets delegated to DC to make sure that it happens … You don't actually apply [doing a risk assessment] to RNs because they can do them with an RPN but only RPNs can do them … we only do them on the weekends … in practice ... the procedure is that medical officers are responsible to do risk assessments on a daily basis, but weekends when there are no medical officers around … then the mental health nurses are responsible and they can do them with, in collaboration with, an RN or an EN for that matter … Generally speaking, we do them in collaboration with a primary nurse … So, if you're the primary nurse for Joe Bloggs, and if you're not an RPN, you can come to me and say this needs to be done ...*

From other participants' perspectives (RN/RMHN Katy; Psychiatrist Francesca), each person's role was categorised within a concrete set of tasks. For example, these participants identified physiotherapists as being responsible for managing the risk of falling. Nurses were to observe the patient for signs of agitation, reactions towards medications, and family visitation. Doctors were responsible for writing up the RAM plan and doing a full assessment. The members of the multidisciplinary team were responsible for contributing to the assessment and identifying what they perceived as risk. Despite such role allocation, the nurses in this study considered that they were fully responsible for undertaking RAM (both on weekdays and weekends) and were frustrated that the policy dictated that medical staff were to complete these forms.

Interestingly, the role of legal discourse in risk construction and the associated ethical issues were raised within the context of role responsibilities, which is a slight twist to what was previously examined in Chapter 4.3.3.1 and 4.3.3.3. This was a complex field which clinicians had to navigate through. Responsibility towards RAM was identified by the participants as not only a legal responsibility, but also as a moral one, a new finding:

> *RMHN Joel: … every registered psych nurse, every registered general nurse … they have that legal responsibility for their patient, and you can't say "oh but the consultant missed that point, but I knew it and didn't do anything about it", we all have a responsibility.*
>
> *OT Daniel: … then of course, you've got your administrative guys who are obligated to develop [a] tool … some procedures … and make them consistent.*

Policies within the legal context were also explored. The complexity again was described by the clinicians, although some participants considered RAM to be policy-driven in order to fulfil organisational legal responsibilities:

> *Psychologist Vera: Risk assessment, my knowledge of it is limited in terms of where it comes from other … it's a top down [approach] …*
>
> *Interviewer: So you think it's coming from the top, you're being told to do it?*
>
> *Psychologist Vera: Yes I think so, that's basically in terms of putting into practice, making it policy, then yes, I would say so.*

Inclusion versus collaboration: participants' perceptions of patients' and families' roles and responsibilities

RAM required everybody to make a fundamental contribution within practice and was an important aspect of effectively assessing and managing risk in clinical practice. The analysis of how multidisciplinary team members work together within the context of RAM revealed collaboration in its truest sense of mutual respect, and acknowledgement and utilisation of the resources and skills that each bring to the relationship.

Overall, the participants engaged both directly and indirectly, and they considered engagement and negotiation to be a form of collaboration. Direct engagement included explaining care strategies that were in place. This, however, highlights to the patient the limited range of choices they have. Indirectly engaging the patient was identified as explaining care strategies to the family/carer. This attempt to gain support from the family and/or the carer presented a united front to the patient. Indirect engagement assumes that the patient lacks the capacity for insight and is unable to make decisions for themselves. The participants were clear that engaging the patient in their care had the ability to foster insight. Once insight had been established, compliance with the care regime could occur. This also had the ability to minimise risk. Engaging relatives or carers in the patient's care also reduced risk:

> *Psychiatrist Nancy: Another way to minimise the risk is always talk to the relatives or to the carers – they might like to bring in something from home or whatever could be actually a helpful thing, when in fact, this increases risk for some reason – so in fact to involve them also – explaining the risk and what we are doing.*

Seen in another way, while responsibility for RAM was seen to primarily reside with the participants, these levels of responsibility to effectively assess and manage risk did extend to a lesser degree to include the patient and their family and/or carers in this role as well:

> *SW Jennifer: … consumers and carers [should be] involved in risk assessment … [the consumer] has a right to be involved if able to … They [the carers] have knowledge and history of the client. They know the context …*

However, a dichotomy existed whereby participation by the patient was ambiguous. The participants reflected that this encouragement was contingent upon the insight the patient had. As such, clinicians placed qualifying statements in their answers that it is always based on the patient's capacity to engage and take responsibility in order for this to occur:

> *RN Jack: … a lot of people we have on the secure unit are significantly cognitively impaired, you're not going to get them to be able to sit down and discuss their risk management plan.*

Most of the interviews reflected that the participants considered most patients as unable to act responsibly. The clinicians considered that it was not appropriate to include them in this process in their professional opinion. This supporting role for patients and families only included providing a collaborative history, assisting participants to identify what will and will not work in terms of interventions for the patient, and the context of the admission. Primarily, what emerged in the analysis was that patient involvement in RAM took the form of using questions and information gathering during the initial admission and other subsequent assessments:

> *OT Daniel: I still think it primarily rests on the roles of health professionals to take responsibility for the risk management … so you might get the cooperation of say a family member … but how far can we assume …*
>
> *RMHN Lucy: … speaking to the patient and getting information from them, getting their view … and it's not being afraid to ask very direct questions, questions that you would socially, you would normally, not think of asking.*

Nevertheless, including family, carers, and friends in the RAM process aided the collection of essential collateral information and was considered to be best practice. As considered by SW Jennifer, family and carers have not only the knowledge and history of the patient, but they can also provide context. From this, it is clear that the patient's role in RAM is quite limited. RAM was a linear process of healthcare professionals asking the patient questions, and patients then feeding back their responses to the participants:

> *Interviewer: So it's a collaborative relationship?*
>
> *RN/RMHN Katy: It is and it should be, and it's not per se, they don't see their risk assessments … but it's not something we actually sit there and do with them …*

Interestingly, the act of listening was considered in the interviews. Clinicians considered this to be a form of collaboration with the patient. It was evident that the clinicians considered this to be a useful strategy and another way of minimising risk and establishing therapeutic care. Therapeutic care was further established by listening to patients' fears and eliminating these from the environment:

> *GN Martha: We're to listen and broadly learn and bring in the whole historical picture of where this person's coming from … you can't say "get over it and get on with it", this is real to them. So, transforming my reality into theirs then enables me to see where they're coming from, from their particular point of view, from their reality … we invite the client to let us know what it is that they would like to have put in place, to have assistance with in their individual goals for their own recovery; however, I really don't know how much each individual nurse does enable the client to participate.*
>
> *RMHN Joel: I think their opinions and their feelings and their fears need to be respected and if there's something they're afraid of, for example, something that triggers a psychotic episode or a panic attack and we just sort of blithely ignore it and we put that person [at risk], we increase the chances that the person has a bad day and that can often rub off on other patients too, we're not doing our job properly, so we need to listen to the patients. They have a right to be involved in their own care as much as possible.*

In this way, risk assessment was viewed as a positive by the participants in order to minimise triggers that promoted inappropriate or risky behaviour. Alternatively, risk minimisation was achieved by the participants listening in order to gather collateral information. Collaboration in this way was considered to be collecting data with which to identify risks, and also, the gathering of data included how were the risks "managed" previously:

> *RN Jack: How long is a piece of string, sorry. It should be in theory, but it's asking for facts … from anywhere.*

However, rather than an equal partnership between the professional and the patient, the participants embedded messages about the healthcare professionals' levels of responsibility. This was done by the clinicians in order to ensure that the patients understood why various risk management strategies were in place. In this way, a patient could gain an insight into their mental health condition:

> *SW Frank: I might try and be very inclusive with that and let them know the outcome of it and let them know my thoughts because I don't think there's anything to hide. You can say this sort of indicates to me that we're at a medium risk here and I'm a little bit concerned about you and if you can articulate that to the client, it can be very beneficial.*
>
> *Psychologist Vera: They also need to have an understanding of what its purpose is, why it's being done …*
>
> *GN Martha: I firmly believe that empowering someone to be their own barometer in life is the best recovery, the best way for recovery.*

As time progressed on the unit, the participants stated that the patients were invited to participate in their own recovery, which was considered by the participants as being beneficial for the patient:

> *RMHN Lucy: … you work with them on a relapse prevention plan.*
>
> *GN Martha: However, a lot of our clients really aren't in that situation of being able to do that especially on initial admission, but as time goes on, the recovery model is to invite them to participate in their own recovery, their own progress, positive goal towards depleting all these behaviours, etcetera.*
>
> *Psychiatrist Nancy: Part of helping the patient to really participate in the whole management - even if the patient is not capable initially at least - it should still be somehow engaged in an indirect way through his family in this case some type of strategies to use formally ... any type of way is depending on the circumstances but any type should be tried to engage a patient - more engage patient in playing the role more likely to succeed …*

This included assessing and managing their individualised risk. The participants viewed this as encouraging the patient to take some form of responsibility for their actions which were viewed as being beneficial to their recovery. However, when the participants spoke about involvement, it was also about providing a range of choices:

> *RMHN Lucy: … they have the responsibility in their care planning as well ... okay, if you feel like taking a tablet you must do this, you must phone this number first or you must try and do this …*

RMHN Lucy stated that the responsibility for care was placed on the healthcare professionals, with patients and family merely supporting this. This finding reflects a limited range of choices that the patient has and could be interpreted as a manifestation of a power differential. This can be aligned with one participant's claim of "power and despotic rule" (GN Martha) on the ward:

> *RN Jack: They're not involved in deciding what strategies are, in that sense they're told what they are, and they need to understand that it's part of the therapy relationship …*

This notion of empowerment within the context of depletion links back to the aforementioned concept of power. It is certainly aligned with the provision of a limited range of choices aimed at producing a range of acceptable behaviours. Not surprisingly, it is also centred on the fundamental aspect of minimising risk.

In summary, history engenders an awareness of risk. This awareness then enables the participants to meet the patients’ needs. The use of history then becomes “current armoury” (RMHN Joel) while collateral information provides a “picture on who that person has been in the past” (RN Gail) and evokes feelings of confidence when involved in the process of prediction. Hence, this is about process *and* the specific type of data the participants collect assisted through collaborative environments and can be linked to what has been previously found in terms of “structured discussions” that is important in RAM practices (*see* Chapter 4.3.3.3).

The inclusion and engagement of patients as fostered by the participants in collaboration with team members can now be diagrammatically represented in Figure 18. This provides a visual representation of how the participants achieved inclusion and collaboration with team members, patients, families, and carers in the clinical setting. Level 1 indicates the starting point, being observations about the patient. These progress to the second level once the observations are made, now becoming interventions. This is an iterative process; each informs the other and are changeable according to circumstance.

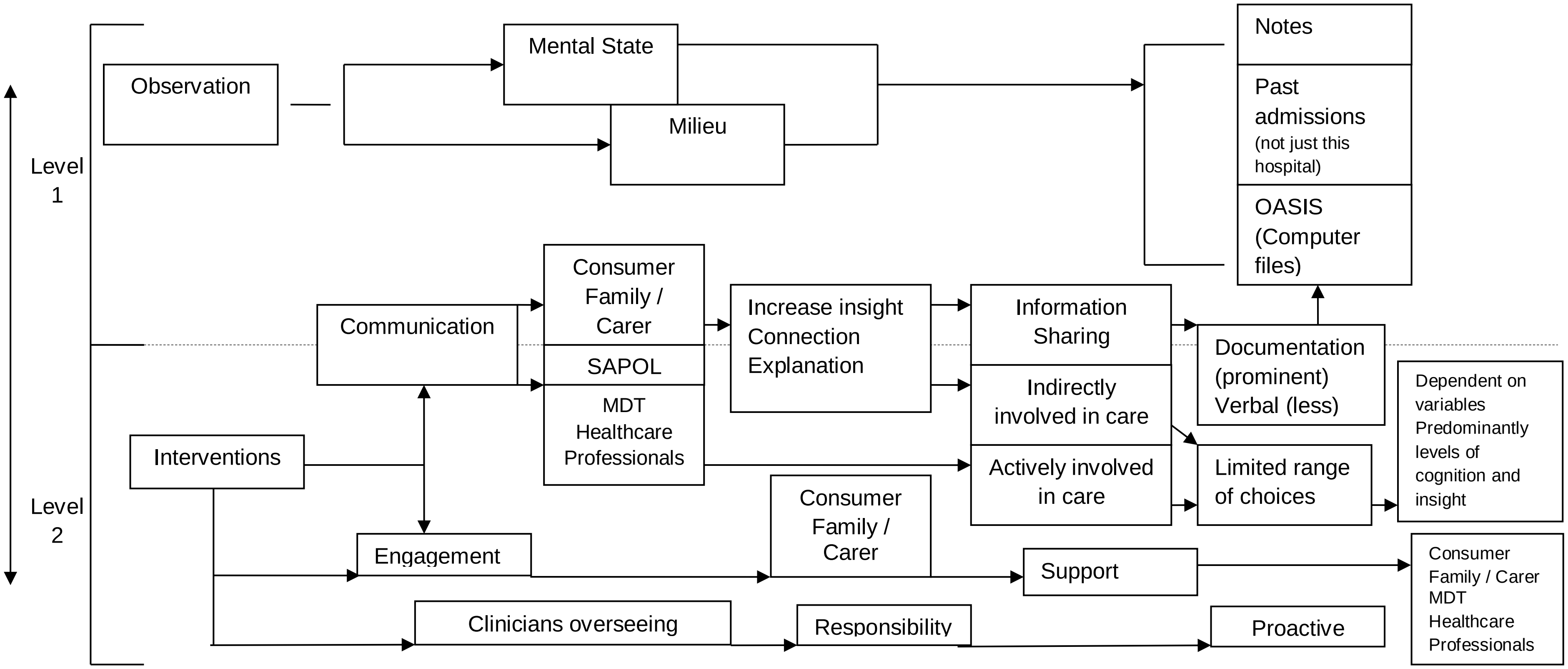


Figure 18: Patient inclusion and engagement by participants

Source: Findings Stage One

8.2.1.2 Tension on the ward

> *RJ Jack: This is what we are supposed to do for this fellow is this, and this is what the plan says, but nobody is doing it, so what's the point?*

While collaboration and responsibility were viewed as important aspects on the ward, it was evident from the interviews that there was a lack of cohesion between staff members which resulted in tension and disquiet. Lack of consistency and lack of individualisation of care were the main issues raised by a small number of participants. For example, RN Jack highlighted that while every patient on the ward was supposed to have a risk management plan, this only lasted for a week or two and then was not undertaken after that. However, this was not mentioned by the other participants. Nevertheless, this suggests that there are issues around individualised care (or the lack thereof), consistency, and lack of support in some areas:

> *RN Jack: [It is a] problem [because] while you know what is likely to work, it is not individualised – no consistency …*

This lack of individualised care is highlighted in GN Martha’s observation that some staff behave in a “despotic” manner towards patients. This was alluded to previously in the above section. Nevertheless, this quote provides a powerful statement and reflects the clinician’s feelings about some of the staff on the ward and the impact this has on both clinicians and patients:

> *GN Martha: … some staff have less tolerance, have a less gentle approach, have a less empathetic determination of situations, and some staff use power and despotic rule …*

Equally, RMHN Joel stated that “risk assessments [should be] comprehensive, relevant and updated [however] that’s not always the case”. A number of participants (RN Jack, Psychiatrist Francesca, and RN/RMHN Katy) identified a lack of teamwork on this ward (for example, not talking enough as a team and a lack of senior support), and expressing frustration with this situation. Other participants

(Psychiatrist Nancy, Psychiatrist Francesca, and Psychologist Vera) considered "forgetting other staff members will use this" as the main reason for this lack of consistency. This could be why Participant RN Jack stated:

> *So, you've got some people who are pushing it and supporting it, and other people who are just letting [it go] and fall.*

RN Jack, Psychiatrist Francesca, and RN/RMMHN Katy also noted an inconsistency of care between professionals who were not aware of each other's assessments. An example of this would be doctors not completing the appropriate forms, which was the primary medium used to inform other staff of risk levels and the management plan that was in place. This was reflected in the frustration that staff members (other than the medical staff) felt. Despite the ward policy, the onus was on them to ensure that the forms were completed as per the policy, or they felt that they needed to complete the forms themselves, despite "breaking" ward policy:

> *RN/RMHN Katy: … checking up and chasing the doctors to fill it in [the risk assessment form] …*

RMHN Joel struggled with staff members' unrealistic expectations of prediction, while RMHN Lucy noted that some staff were afraid to talk to the rest of the team. Psychiatrist Nancy stated that risk assessment and risk management were not always done as well as they could be, often being more in response to a crisis rather than as a preventative measure. The illustration below summarises the content of the incongruity that was present in the interviews:

> *RN/RMHN Katy: … I think it is the multi-d thing, I don't think we do it quite that well, we do at ward round because that's the only days that everyone's sitting there, the other days when the doctors just come to do the daily ones; ideally, it's supposed to be done with the nurse that's looking after the patient, but that doesn't always happen, we can improve that.*

8.2.1.3 Communication

Communication was seen to be vital when assessing and managing risk and was briefly considered in Chapter 4.3.3.3. However, opinion was divided as to whether this was performed effectively on the ward. The modes of communication that the participants used, effective communication skills, and the information shared were seen to be important for minimising the risks that were present and for facilitating agency. Effective communication assisted with successfully obtaining collateral information, and effective communication skills were considered to be vital.

A large number of staff in this study considered communication as integral to not only effective practice, but as beneficial for the ward as well. Effective communication skills, and the information shared, were seen to be important in order to minimise the risks that were present and to facilitate agency. However, opinion was divided as to whether this was done well on the ward. If done well, this promoted feelings within the participants of support and protection. Some of the participants referred to the importance of effective communication with patients' families:

> *RMHN Joel: … one little snippet of information from a family member … added to our assessment the risk … so never overlook the contribution from family members … there might be vital information there.*

They also discussed various aspects, such as modes of communication, the advantages of effective communication (which incorporated a range of skill sets) and the information they shared with others in order to effectively assess and manage risk:

> *RMHN Joel: Mutual respect is important too and listening to other members of the care team is vital and that happens pretty well in psych settings. Like five fingers of a hand, work well together.*

Modes of communication

The participants stated that the predominant modes of communication were written and verbal. Written methods referred to documentation which consisted of referrals, nursing notes, and the assessment tool. Verbal methods included collaboration with the team, and talking with the patient and family at various levels. Collaboration with staff occurred in team and clinical meetings as well as on a daily one-to-one basis. Talking to the patient and family aided the participants in identifying issues that the patient were struggling with and obtaining collaborative information (triggers, patterns, and changes in behaviour). The rationale provided for these methods of communication was identified by SW Frank as being “able to easily identify what the associated risk is”. Observations of risk were also communicated through talking and writing. This has been diagrammatically represented in Figure 19:

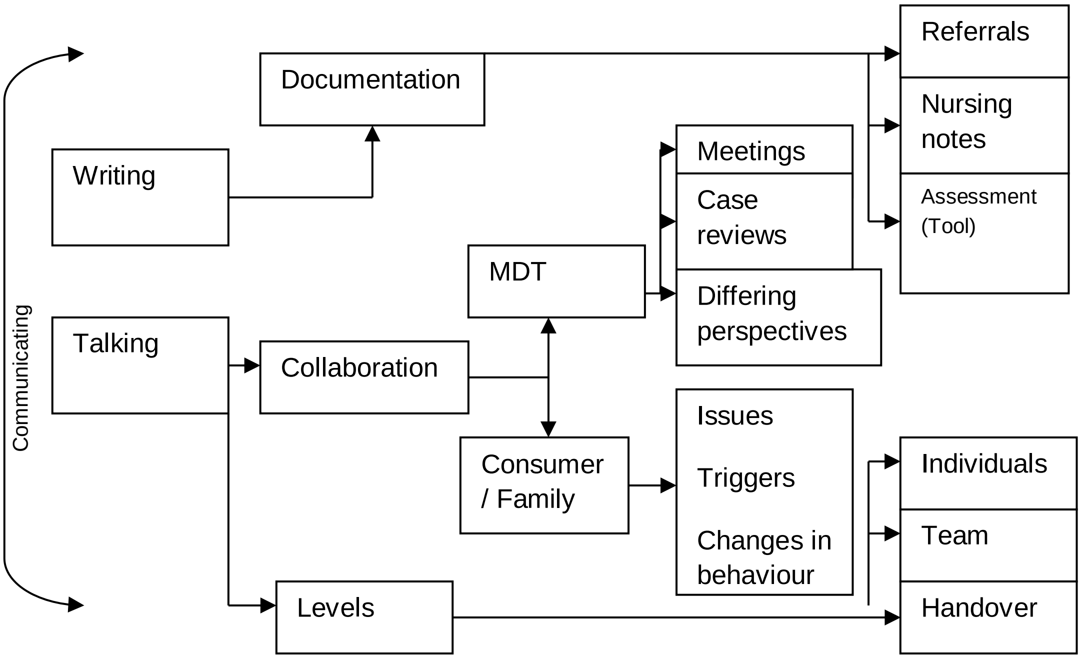


Figure 19: Modes of communication

Source: Findings Stage One

Through these two modes, the participants considered risk to be effectively assessed and managed. The end result was aimed towards effectively caring for the patients and promoting a safe environment for patients, staff, and visitors. The information shared by the participants in these forms of communication included:

- *issues patients were experiencing (e.g. struggling with negative emotions)*
- *collaborative history (e.g. triggers and patterns)*
- *understanding of illness*
- *any changes in a patient’s risk behaviour*
- *concerns about patients*
- *propensity for violence*

Effective communication

Effective communication skills were considered to be vital by the participants. The participants did not necessarily identify the components of effective communication, but they were able to demonstrate it in discussions of how they cared for the patients. The participants considered that if they “possessed” these skills, then one could discuss difficult issues with patients or with family members, such as the triggers or changes in behaviours, in order to investigate a situation. Similarly, being proactive and seeking advice from team members in order to gain understanding was underpinned by effective communication skills. From the data, these effective communication skills included: being approachable, showing mutual respect, and the practice of active listening. GN Martha considered an environment which incorporated effective communication gave staff “a feeling of support and reassurance”. Alternatively, lack of confidence in communication with staff was observed by RMHN Lucy. However, she also indicated the autonomous aspects of their roles and the level of experience they have:

> *RMHN Lucy: … some people can be afraid to talk to the rest of the team and there’s nothing wrong with nipping out … phoning somebody and saying look, this is where we’re at, I kind of think this, this and this, what do you reckon or what’s your view and what’s your opinion … speaking to one of the doctors, speaking to one of the nurses, especially from other professions, you get a completely different view on it … so knowing who in the team has maybe more experience in that, or maybe somebody to tap into their knowledge.*

Opinion was divided as to whether this was conducted effectively on the ward. Psychologist Vera considered the assessment of risk (and by default effective communication) as a requirement of senior staff i.e. “from the top down” and, as such, it would be difficult in this case to effectively communicate. RN/RMHN Katy stated that “I don’t think we talk enough as a team about them” and had to “chase doctors” for assessments to be done. She went on further:

> *I guess it’s the nature of the ward, it was in built into us that when we first started here that risk assessments were so important, so without thinking about it, you know it has to be done … it’s my job at intake to let the team know who’s on daily and who needs their risk assessment done or at ward round, we discuss whether they can go to weekly or whether they stay on daily … and part of our handover is that everyone has to mention the client’s risk assessment …*

Fear was considered to be one aspect which impinged on effective communication. This was in the context of conflict within the team. RMHN Lucy considered this:

> *I make sure everything is documented, share the information around and that's probably the main one is to make sure that people are aware and are not afraid to face them to another member of staff or to another … I'm worried about this …*

Not only does this participant encourage effective communication, but she also advocates for greater agency for other staff members. Psychiatrist Nancy expressed difficulty in effectively communicating risk to others, acknowledging that documentation is one small aspect, and that talking to the patient and other staff members was equally important. This was reinforced by RN/RMHN Katy who felt that the doctors did not seek nurses out in order to assess risk collaboratively.

8.2.1.4 Ward culture

Although a minor theme, ward culture was integrated into many other themes. The participants considered the culture on the ward to be supportive, and through this support, they were able to integrate RAM into their daily practice in a meaningful way. RAM was able to be integrated through collaborative relationships, support, and education.

> *RMHN Joel: … and five minutes conversation and you come up with a consensus, so teamwork, mutual respect is important too, and listening to other members of the care team is vital, and that happens pretty well in psych settings.*

This notion was present in almost every interview, and explicitly in three. RAM has been promoted effectively on the ward and has become ingrained into the environment and the ward culture:

> *RN Jack: … it was in-built into us that when we first started here, that risk assessments were so important, so without thinking about it, you know it has to be done …*

However, the current focus on legally-mandated requirements placed the participants in a position of feeling anxious and prone to blame and is briefly considered in Chapter 4.3.3.1. This finding provides a clear link to the idea that patients with a mental health issue are never fully cured. Instead, they are only in a holding pattern or have their illness “under control”:

> *RMHN Lucy: … I think as well that nobody wants to be the one to say yes, I think that person is safe …*

8.2.1.5 Training and education

The participants considered training and education to be important, as it assisted in effectively assessing and managing risk. This is a key aspect that was explored in Chapter 4.3.3.3 that enables the recognition of risk behaviours. Just under half of the participants felt that the organisation fully met their educational needs. In addition, the participants considered the organisation to be responsive to suggestions/initiatives for improving care delivery. GN Martha identified the organisation as being responsive to decreases in the delivery of care, and saw it as willing to address this reduction:

> *I’ve noticed on the ward that if there’s an unspoken and noted reduction in the delivery of standards, then education is brought in accordingly … which is beneficial ...*

In addition, five participants considered the organisation as supporting and meeting their educational and training needs. This is a useful finding, particularly for the research site. While this finding is not necessarily transferable, it certainly means that some of the team considered that they have had their needs met:

> *GN Martha: The education development support on this ward is just phenomenal and its ongoing continually on the ward as well as specialised information educational sessions weekly here. Plus, they also offer an in-house mental health course that all staff can attend … They have violence training etcetera, so everything is covered, it's really the individual [dependent upon] having an attitude of learning and growing and appreciating support, stepping up, and asking questions … it's all here, it's just fantastic.*
>
> *SW Frank: I do think we've had quite a lot of training to do this [risk assessment] well …*
>
> *OT Daniel: Our ongoing training in risk management and related areas, such as suicide, is now becoming more mandatory and routinised [sic], certainly at the moment and in the past there's been deficiencies, so it works both ways, but it's improving …*

Alternatively, RN/RMHN Katy did not feel that their educational needs had been met. Nevertheless, many of the participants who mentioned the training and education stated that the training occurred monthly, but also stating that training happened on a daily basis, albeit informally. Listening to staff needs was also important and the participants felt that this organisation did listen to their training and education requests. However, four participants were also careful to state that new staff needed more training over and above the mandated requirements. This aspect can be aligned with the themes: 7.2.1.2 – Practice, and 7.2.1.3 – Purpose.

8.3 Conclusion

RAM was perceived by the participants to be everybody's responsibility. The participants were very clear that the knowledge of the patient and access to this information was crucial and allowed their risk assessments to be more effective. Their attitude towards the organisation was positive, and the organisation was seen to promote RAM in terms of mandated requirements for clinicians to adhere to. The participants considered that good communication assisted effective RAM practices, with RAM training and education further benefitting their RAM needs. Clinical experience also aided their risk assessments. However, some barriers were identified, which included role and task confusion and a lack of cohesion between team members. The participants were concerned about the patient's capacity to engage, which limited the patient's role in RAM. This resulted in the patient having only a limited range of choices.

Upon examination of these themes, which sit within assessing and managing risk in a clinical setting, issues facing health professionals were then identified. RAM was integral to clinical mental health practice; however, it was identified as a complex process that involved not only the collection and analysis of information, but also working within an environment involving collaboration with other disciplines, patients, and family members. In this way, risk and its construction in mental healthcare emerged. The interviews reflected multidisciplinary collaboration, identified as a key responsibility which enabled clinical practice within the context of RAM to be refined and improved. The participants considered effective communication between clinicians, as well as between clinicians and patients, to be essential for risk assessment. Strategies to minimise risks included establishing effective therapeutic relationships, providing access to senior support, and using the risk assessment tool. The participants also believed that effective communication skills promoted therapeutic relationships and enabled patient and family input. The organisation was considered to be supportive to staff in meeting most of their needs.

The next chapter will examine the findings of the last three chapters through the theoretical lens of the risk theorists, Beck (1992) and Giddens (1990), as well as the insights of Menzies (1960). Drawing on these theories and insights, the chapter will then bring together, into a cohesive whole, all of the chapters of this thesis. The aims of the thesis finally come together to create the thesis argument, including identifying the issues facing health professionals undertaking RAM, and teasing out the notion of risk, illuminating this as a social construct among other important aspects identified.

9 DISCUSSION

9.1 Introduction

9.1.1 Synopsis

Through the journey of writing this thesis, I have come to the conclusion that there are some very real risks, but there are also many risks that are socially constructed through policies and by tradition and culture. I discovered in the interviews that risk management is actually the care plan. In this chapter, I will develop a critical commentary. This chapter serves a number of purposes. Using the theoretical lens of the theorists Beck (1992) and Giddens (1990), and the insights of Menzies (1960), this chapter brings together the previous chapters with the aims of the thesis finally coming together. Secondly, the notion of risk is teased out and I discuss the ways in which risk as a social construct has been illuminated within the previous chapters, thus finalising the third aim of this thesis. Thirdly, a robust discussion of the issues facing health professionals when undertaking psychiatric RAM will be developed in order to understand, and to clearly identify, what this means for clinical practice.

The chapter is presented in three sections which are aligned specifically to meet the overall aims of the thesis. This discussion includes a consideration of the data that was previously presented in terms of the legislative framework that clinicians operate under, but are powerless to change; this meets the first and second aims of the thesis. Care plans are examined in this context. Finally, the tension between risk and recovery is examined. Throughout this chapter, I draw comparisons to “risk society” and argue that this is, indeed, playing out within the clinical setting.

Figure 20 demonstrates how these three areas contribute to the ways in which risk is managed in addition to how psychiatric care plans are developed based on these risks.

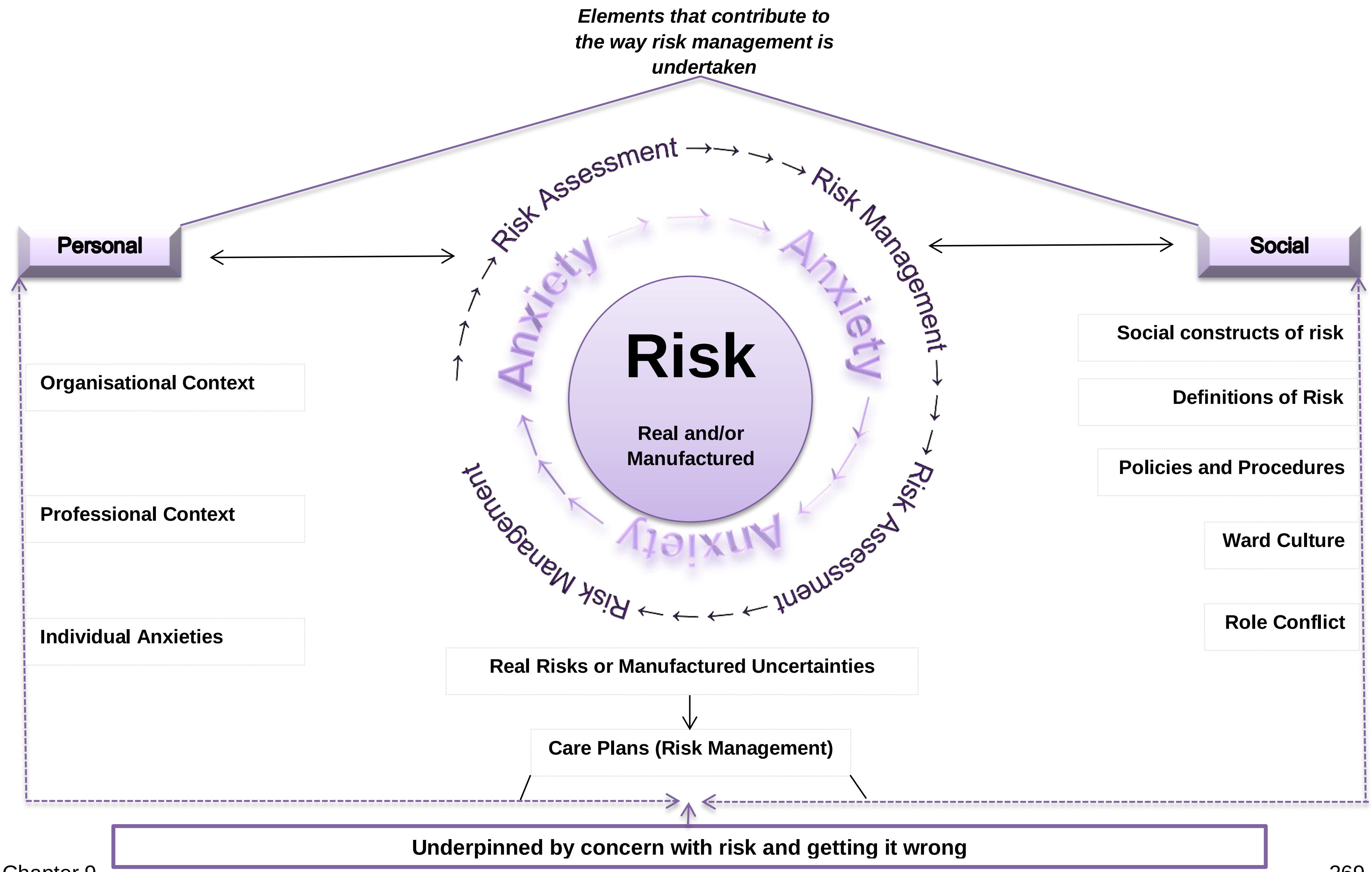


Figure 20: Risk management and the elements

Source: Original Concept

9.2 The social constructs of risk

> *Although the criminal justice system and the healthcare system have fundamentally different social functions, there are areas of common purpose, and even common interest. Both are charged with the responsibility to protect members of the community from harm, although, arguably, this responsibility is more ambiguous for health than for the criminal justice system (Howells, Day & Thomas-Peter 2004, p. p. 392).*

This section illuminates the social constructions of risk from the perspectives of Beck, Giddens, and Menzies. To reveal and tease apart these constructions, data from the interviews, the Australian legislation, and the ethical frameworks are examined through the lens of risk theory. The real risks that the clinicians discussed are explored and are then compared to manufactured risks and uncertainties. Institutional anxieties are also considered, together with the policies and procedures of RAM within the institutional setting, which is clearly a cultural reflection of Beck and Giddens' theoretical postulations about risk. The conduct of RAM within a legal framework is notable and reflects a growing international trend of the construction of the mentally-ill as dangerous within legislation (O'Brien 2010).

9.2.1 Social deviance means the construction and definition of risk

Risk society is about how society organises itself in response to either real or perceived risks. The medicalisation of social deviance is an issue worthy of exploring in the context of this thesis. The changes in legislation (explored in Chapter 6) have redefined mental healthcare, particularly in relation to treatability. Medical treatment has been redefined to mean the alleviation or prevention of a disorder or its manifestations and/or symptoms (Scott et al. 2011). Consequently, the condition itself may not be treatable; however, the effects, which may include harm to others or risk of violence, can be. Combined with the expansion of medical knowledge and the “re-medicalisation” of conditions (largely anti-social conduct), the achievement of social control remains (Scott et al. 2011). The focus becomes one of making clinical assessments based on dangerousness, and then is based around issues such as social policies and legal judgements (McSherry 2004). For example, predictors of violence are not simply mental illness. Instead, the predictors include pre-existing vulnerabilities, state of mind, substance abuse, situational triggers, social and interpersonal factors, and personality constructs (McSherry 2004). So, it is important to determine a theoretical definition of risk that clinicians in the study would operate under.

Beck (1999, pp. 149-50) suggested that a number of questions should be asked and considered prior to arrival at a definition. The most relevant questions for the purposes of this thesis are: who will "define and determine the harmfulness of products, the danger, the risks"? Once this is decided upon, then one must ask "[w]here does the responsibility lie"? This approach involves examining the knowledges related to the dimensions of the risk, the causes, and the actors involved.

When defining risk for the purposes of this thesis and assigning responsibility, consideration should then be given to concepts such as power and control, which is in keeping with the theoretical perspectives described in this chapter. For Giddens (1996), power is in the hands of experts who hold the knowledge. Likewise, Slovic (2007, p. xxxvi) suggested that "[w]hoever controls the definition of risk, controls the rational solution to the problem at hand". The choice of definition for the purposes of this thesis is the expression of one's views in relation to the importance of the situation being considered. There may however, be differing opinions as to what constitutes an adverse event (hazard) (Fischhoff, Watson & Hope 1984). Conflicts then arise when individual measures of objectivity and subjectivity are applied, and arguably, cause anxiety when undertaking risk management in the context of psychiatric care. Fischhoff, Watson, and Hope (1984) suggested that individuals rarely arrive at the same conclusion. This means that clinicians could also rarely arrive at the same conclusion. An exercise of judgement must then occur and must depend on the decisions that individuals make (Beck 1999; Fischhoff, Watson & Hope 1984). From this, in order for:

> *… deliberative decision-making to proceed, it must be complemented by comparable conceptual analyses of the other consequences. With a clear set of concepts, it is possible to begin making the hard trade-offs between risks and net benefits (which may include any positive value attributed to risk itself) … (Fischhoff, Watson & Hope 1984, pp. 127-8).*

For this reason, the definition and responsibility for the decision of assigning risk must be based on the prevailing definitions that are represented in the legislation which the participants in this study would use to frame their definitions. Likewise, for the purposes of this discussion, the responsibility for risk assessment is also based on the prevailing social mores and norms. Beck (1992) argued that definitions of risk are shaped by institutions and cultural contexts. To build on this, the participants in this study are shaped by institutional policies (with clinicians using policies as tools), specific risk forms designed by the institution, which would be a document used as a tool, and the Mental Health Act (*2009*), being the legislative requirements. These have an impact on the determination of risk of the patient, and the patients then have to live with what clinicians "have to" adhere to. This is important because, as Ewald (1991) stated, risk can only be defined in terms of the attempts to control it (for example, through legislation, policies, tools, and regulations). Without these, there is no risk (Ewald 1991). This is represented when considering clinical risk decisions which are choices that exist among a range of other options.

I argue that risk is socially constructed, institutionally defined, and framed by legislation, which is then individually assessed by the clinician. While Stage One of this study allowed the participants (clinicians) to define risk in their own terms, the essential underpinning notion is that, in simple terms within the clinical setting, risk is defined as the likelihood that an adverse event may occur while the patient is hospitalised (Muir-Cochrane & Wand 2005). The rationale for this position is that, in mental healthcare, the minimisation of risk is necessary in order to protect the patient, the staff, and the public from harm (Mosel, Gerace & Muir-Cochrane 2010). An adverse event is defined as an incident instigated by the patient in which harm can result, while harm is defined as damage or injury to the patient or staff that may be physical, mental, or moral.

This is an important definition to arrive at because this study does not consider risk within the context of (for example) occupational health and safety or workplace hazards, and the definition of risk in this context excludes other definitions, representing the dominance of the legal framework. Rather, this research is concerned with the harm that can result from the actions of the patient on the self and other patients, the staff, and the public. Risk in the context of this study is presented as a range of potentially adverse events that need to be avoided

(Giddens 1999a; Kettles et al. 2004; Lupton 1999; Muir-Cochrane & Wand 2005). The next step arising out of this for clinical practice is the management of “hazards and insecurities” as a result of human intervention (Muir-Cochrane & Wand 2005, p. 2).

9.2.2 The existence of real risks or manufactured uncertainty?

Beck (1997) argued that it is necessary to look at hazards or dangers as being different to risk. The key point that dominates here is that risks are real, but a focus on risk and assessment creates anxieties and identifies (or in other words, manufactures) potential risks which may or may not manifest *despite* actuarial or clinical predictions. Extending upon this, Moon (2000, p. 247) characterised dangerousness as an unacceptable risk and, “in the case of mental illness, dangerous behaviour is that which cannot be accommodated within the rules (and risks) of “normal” behaviour and which is also both unpredictable and potentially harmful”. This means that in Western society, risk has replaced the notion of dangerousness. Scott, Doughty, and Kahi (2011) reasoned that it is this Western approach that has allowed clinicians to deal with uncertainty in the mental health context. They extended this argument by suggesting that:

> *… [w]e cannot do anything about the speed of social change, the increasing inability of politics to restrain the operations of global power, the gradual withdrawal of social safety nets, and the individualisation of responsibility for planning and action. However, we can deflect the ontological fears these social changes raise onto technical processes for managing uncertainty on a personal scale (Scott, Doughty & Kahi 2011, p. 190).*

This brings into play the “management” of those diagnosed with a mental illness (and who are subject to regular risk assessments) through a number of mechanisms (Godin 2004); and this reflects a shift from therapeutic consciousness to one of risk consciousness (Scott, Doughty & Kahi 2011). Certainly, this reflexive thinking which requires one to rely on expertise and technical problem-solving is a reflection of “high modernity” (Giddens 1991a), and this notion is clearly demonstrated when considering a Clinical Risk Assessment and Management manual produced by the Government of New South Wales as a justification for increased training in clinical

RAM:

> *… [w]hile the base rate of suicide is higher than that of homicide, the impact of homicide on the community is far greater than suicide. There are more victims, the public interest is greater, the incident adds to the stigmatisation of people with mental illness by the public through the media, and Mental Health Services are criticised despite adequate performance in other areas. We would argue that these are significant reasons for Mental Health Services to build on their Risk Assessment and Management skills … The link between violence and mental illness has been the source of much debate. Prior to the late 1980s, it was strongly believed that no association existed between the two. However, since this time, studies have continually found at least a minor association, though this is not without controversy (Alnutt et al. 2010, pp. 5-6).*

Previously, modern daily life was no more hazardous or “risky” previously; it was simply a case of how it was viewed (Beck 1997). Once society attempted to control and move towards providing a future of “predictable security”, risk then became a political issue (Beck 1997). In this way, there was an impetus to bring about societal interventions, primarily through targeted decision-making. Elliot (2002, p. 295) explained that society was then able to transform unknown risks into risks that could be calculated (that is, predicted). This means that “risk society” is about the “rational control” of individual risks, ranging from illnesses and accidents to the threat (or risk) of war (Elliott 2002; Scott, Doughty & Kahi 2011). It is clear then from the work of Beck (1992, 1997; 1996) that while there is no certainty (or uniformity) in diagnosing risk in people that have mental health issues, there can be a recognition of a “generalised but in-specific danger” (Moon 2000, p. 247) that becomes an intrinsic aspect of “risk society”. This intrinsic aspect, when contextualised in the form of a mental health risk assessment can be thought of as a response to the ever-changing nature that is risk, and perhaps, a governmental way of imposing order and attempting to manage diversity (Moon 2000).

I would argue that the pervading aspects of social control, the management of anxiety, and the melding of risk and danger muddies the water when it comes to treating those diagnosed with a mental illness, because risk may not manifest on the basis of prediction. The nature of “risk society” has confused clinicians in such a way that it seems that doing a risk assessment and then managing the identified risks means that it will improve the patient’s care (Alnutt et al. 2010; 2005). In fact, Sawyer (2005) suggested that risk alters the structure of the clinician-client relationship as well as the parameters of service provision. However, with such a focus on risk assessment, even clinical RAM manuals acknowledge small levels of risk, and it is surprising that care provision would be influenced in this way because of these small risks:

> *… [w]e know that there is a real increased risk of serious harm to others by the mentally-ill, though it is small. The advent of increased use of illicit drugs has made this a much more real issue (Alnutt et al. 2010, p. 5).*

This focus on risk, rather than on treating the symptoms of mental illness, is clearly concerning, yet is even acknowledged in clinical RAM training manuals:

> *… [r]isk factors are mostly unrelated to mental illness symptoms. Empirically derived risk factors are most commonly applicable to populations not individuals. Risk within the inpatient setting fluctuates, often on a minute by minute basis. It is important to undertake formal risk assessment and implement management strategies when observable changes in a patient suggestive of an increase in the risk of violence begin to emerge (Alnutt et al. 2010, p. 11).*

Alnutt et al. went further with their argument:

> *… [f]or this reason, to focus only on a person's mental state at the time of assessment, is to risk missing other perhaps more relevant factors. Indeed, only treating a patient's mental illness symptoms without addressing the other criminogenic risk factors may not significantly reduce the patient's risk for violence. This is likely a common error made by mental health professionals inexperienced in risk assessment and management (Alnutt et al. 2010, p. 21).*

So which is it? Treating the mental illness and endangering a patient's recovery, or reducing their propensity for violence, despite the statistics demonstrating that only a very small percentage are violent? (Alnutt et al. 2010). To this end, Sawyer (2005) suggested that when interventions are formulated purely on the basis of risk, there is less likely to be a therapeutic response. For Castel (1991), this also meant that patients would perceive themselves as a risk that requires management, rather than as an individual deserving of care. Furthermore, a focus on risk management creates not only an emphasis on administrative tasks (as Menzies, [(1960) theorised), but also creates real risks for the patient. Brown and Calnan (2013), for example, suggested that when patients are perceived to be risky, then the quality of the information the patient divulges is limited, which can impede recovery from *mental illness*. I maintain here that in relation to risk monitoring, while Australian mental healthcare position statements are about recovery in the context of positive risk-taking, they are simply unable to coexist in the legislative framework as it stands today. I consider this legislative framework in the next section.

9.2.3 Centrality of risk to legislation and practice standards

> *OT Daniel: So, policies and procedures can again alert you to important things and important steps to follow, but policies and procedures are always secondary I think to clinical judgement and things such as your intuition and integrity.*

The policies and procedures that are used in the research site of this study are influenced by a national framework that acts at both the federal and state levels. The policies are influenced by “legislation, standards, policies, guidelines, operational circulars”, national directives, and safety priorities and strategies (Department of Health 2008, pp. 2-4). Based upon sustained examination in this thesis, conceptually, RAM in Australian mental health-care looks like this:

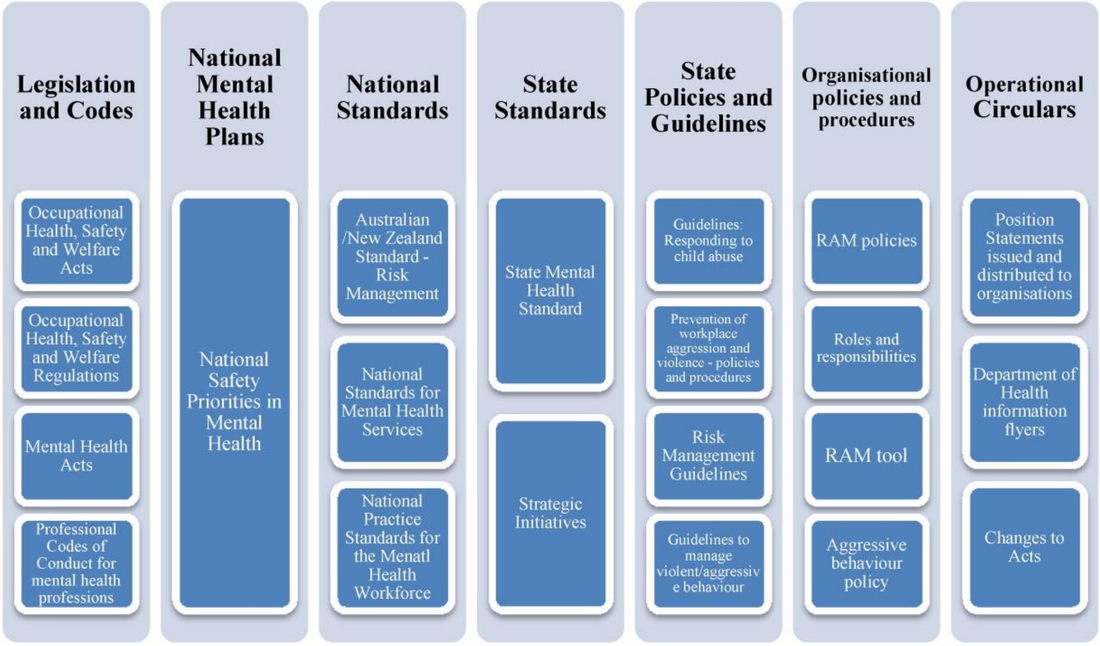


Figure 21: Conceptualising RAM in Australian mental healthcare

Adapted from the Department of Health (2008, pp. 2-4)

The interviews demonstrated that perceptions of RAM were primarily influenced by organisational policies and procedures. The ward's risk assessment policy (*see* Appendix K) was very clear regarding each team member's role and responsibilities in this process. Policies and procedures were considered by clinicians as a structured way to provide clear guidelines and were viewed as an early warning system. It was pleasing to see such clear guidelines, as practice can be influenced by risk awareness in the context of formal policies (Murphy 2004). Legalism and managerialism existed within this framework, with clinicians expressing frustration at the lack of flexibility and adaptability. Nevertheless, the accessibility of this documentation aided the management of risk. The organisational policies and procedures, as described by the participants, were clearly influenced by the national framework as depicted here, and they also illustrate Becks' conceptualisation of risk society, whereby "risk has become the central way in which human agents and modern institutions organize the social world" (Elliott 2002, p. 299).

Importantly, Sawyer stated that:

> *… [t]he formal priorities of patient care as outlined in policy documents and service brochures, in many cases, thus take second place to the substantive needs of the organisation (Sawyer 2005, p. 293).*

This means that the reliance on policies and procedures on the ward reflects the prevailing attitudes of the mental healthcare system. Nevertheless, Saxena et al. (2007) were careful to note that mental health policies "are essential for coordination of services and activities to improve mental health and reduce the burden of mental disorders". I argue that these must include protective mechanisms to ensure that human and civil rights are upheld. This exemplifies the dichotomy that exists in Australia because of the risk averse nature of, and the focus on risk in, the legislation. For example, The Australian College of Mental Health Nurses (ACMHN) Standards of Practice considers the legislative requirements in Standard 8:

> *… [t]he Mental Health Nurse's practice incorporates and reflects common law requirements, relevant statutes and the nursing profession's code of conduct and ethics. The Mental Health Nurse integrates international, national, local and state policies and guidelines with professional Standards and competencies (ACMHN 2016, p. 1).*

Similarly, the National Practice standards for the Mental Health Workforce (Victorian Government Department of Health 2013, p. 11), which applies to nurses, occupational therapists, psychiatrists, psychologists, and social workers, states that mental health practices should be recovery-oriented, aligned with complementary standards, and be “within the boundaries prescribed by national, professional, legal and local codes of conduct and practice”. In addition, the Model of Care: Principles, Patient Pathway, Operational Guidelines and National Standards (Government of South Australia 2010, p. 21) clearly delineates the pathway a patient follows within the South Australian Mental Health Services, stating that the patient and carer “will be directly involved in planning their own care”. This model of care clearly deviates from the findings of this current study which may suggest the over-riding nature of legislative requirements. For example, the risk assessment must:

> - *Focus on the person and the issues that impact on their functioning within the environment – not solely the issues relevant to the nature of the illness …*
> - *Include psychiatric, psychosocial and social functioning domains, including an analysis of risk to self and others, both current and historical …*
> - *Include an examination and information on general physical health …*
>
> *(Government of South Australia 2010, p. 41).*

The findings are clear – a physical assessment is not included in their standard risk assessment tool. Similarly, the divorce between illness and risk still occurs (Davies et al. 2006). Unfortunately, as is explored later in this chapter, when legislation, and policies and procedures strictly focus on risk, therapeutic interactions decline and it is argued that this focus then fails to improve health outcomes. Moreover, the practice standards of professions that work in mental health could not possibly be adhered to in their truest sense, because the ethical requirements of the mandate are in direct competition with the legislative requirements.

9.2.4 Aligning the conflicting professional role with blame

> *RMHN Joel: … and five minutes conversation and you come up with a consensus, so team work, mutual respect is important too and listening to other members of the care team is vital …*

Giddens (1999a) saw risk as being inextricably bound with trust, always related to security and safety, and always associated with personal responsibility. The findings of this study suggest that the clinicians felt an individual responsibility towards minimising risks on the ward, and that the culture of the ward created anxiety because of the conflicting messages transmitted through the written procedures compared to what was occurring "in reality". Yet the clinicians were very clear about their role in relation to RAM, more so than the participants in a previous study (Bishop & Ford-Bruins 2003). One of the reasons for this could be the very clear RAM procedures of the ward in which they work, which unmistakably delineates the professional role that doctors and nurses play in the assessment of risk in this organisation (*see* Appendix K). However, as will be explored later, the culture of the ward prevailed and confusion and anxiety arose for the participants as to what their professional role was in relation to RAM on the ward.

Interestingly, when Cleary and Edwards interviewed patients who considered the nursing role to be

> *… promoting independence, advocating, coordinating care, counselling, solving problems, providing information with explanations and guidance, answering questions, assessment, support, helping to plan the day, communicating, interacting in a social way and providing practical assistance (Cleary & Edwards 1999, p. 474),*

the clinicians in this study saw their role as similar to this and the interviews revealed that the organisation was supportive towards clinicians, but expected high levels of personal accountability. Reference was made to individual professional and legal responsibilities; however, there was potential for blame to arise which then prevented them from using their professional judgement in a manner that encouraged autonomy and accountability. Yet, autonomy and accountability is a requirement of their practice and contributes to the personal assigning of blame. Both Littlechild and Hawley (2010) and Kingston et al. (2004) found that nurses perceived this culture as promoting blame and as being punitive in nature. A culture of blame contributes to defensive practice (Higgins, Hurst & Wistow 1999), and the contemporary literature has considered this issue together with the resultant distrust and anxiety that ensues for clinicians (Cordall 2009; Higgins, Hurst & Wistow 1999; Kingston et al. 2004; Mullen 2002; Prins 2005, p. 643). The outcome of such anxiety is an emphasis on documentation that consequently increases the volume of paperwork and detracts from therapeutic interactions (Higgins, Hurst & Wistow 1999).

This research study has also found that tensions existed on the ward as to who would formally complete the risk assessment tool, despite the written policy, as the culture of the ward was completely different to the procedural requirements of each team member. This added to the stressors of this complex process. On the ward during weekdays, only doctors were permitted to formally complete the initial risk assessment form. After hours, experienced nurses were permitted to formally complete the form, but if it was complex, on-call medical staff were to be contacted (*see* Appendix K). This bears similarities to Walklate and Mythen's findings, who stated that:

> *… [t]he presumption of risk as both uniform and unifying reinforces the power of expert knowledge based on risk assessment tools that not only mask what it is that those professionals actually do, but renders silent other voices claims for what is doable (Walklate & Mythen 2011, p. 109).*

In reality, at all times, both doctors and nurses informally assessed and managed risk, and this was a divisive issue among clinicians, particularly when there was an "increasing expectation on all mental health professionals to identify, appraise and manage risk" (Masson et al. 2008, p. 13). Clinicians in this current study defined that the primary role of the doctor was to assess for risks, while multidisciplinary staff were to manage these identified risks, but procedurally, nurses could assess for these risks as well. One should not be surprised at the tensions that surround risk assessment as a result, when the roles can be changed depending on the time of day.

Nurses have historically faced significant challenges in establishing their position, status, and identity, moving away from being a "hand maiden" to the doctor.

Catanzaro (2002, p. 21) stated that many nurses and doctors, and even the public, perceive “nursing practice as being inferior and subordinate to physicians’ practice”. There is little wonder then, that tension exists on the ward when faced with such arbitrary decrees. Competing levels of status and autonomy are also evident in other research studies. For example, Langenbach et al. (1999) found that junior doctors were responsible for initiating risk management strategies in the main, with nurses contributing to this decision-making process on occasion, while Bishop and Ford-Bruins (2003) found that assessments were conducted primarily by doctors, with nurses having little input. Bureaucracy on the ward was seen as the main contributing factor towards this.

This means that there are unresolved tensions between clinicians working in this environment. Davies et al. (2006) found that doctors, who wielded the most (social) power and had the highest status bestowed through the medical model, rejected the notion that there could be alternative frameworks of care, focusing purely on the “eradication” of the patient’s illness. Interestingly, in the same study, the nurses adopted a criminogenic perspective and were seen to be responsible for any security lapses; as such, they “had the greatest direct professional interest in managing safety” (Ward et al. 1999, p. 1101). This meant that the patient’s “crimes”, or social deviance, were caused by their mental illness, as opposed to a different perspective, such as the offending (or deviant behaviour) being caused by a personal disposition that may co-exist with a mental illness (Davies et al. 2006). The consequences for patients may mean overly restrictive environments, as nurses attempt to navigate through this tension, perhaps implementing further restrictions as a social defence strategy (Menzies 1960). Likewise, psychiatrists may attempt to protect themselves from criticism by detaining clients (ranking the risk of harming self or others higher than personal freedom) as one way to alleviate their anxieties (Scott et al. 2011). An alternative perspective outlined by Mulder (2011, p. 606) proposed that “[d]octors construct patients as a source of threat to their professional standing and may not always act in their patients’ interests”. Undrill (2011, p. 69) went further, stating that risk assessments are “essentially reputation management” and that clinicians cannot reliably know what is in their patient’s best interests. With the range of differing perspectives, one issue remains; risk assessments may amplify anxieties rather than reduce them (Brown & Calnan 2013; Mulder 2011). As such, they should be curtailed.

While legally mandated requirements did place clinicians in a position of feeling anxious and being prone to blame, this is not to suggest that the ward should become a blame-free culture. Cordall (2009, p. 32) suggested that while the evolution of a “just” culture has occurred whereby RAM is “founded on both evidence-based and safe practice”, for clinicians, reality would suggest that “risk assessment still remains a “risky business””. So, while I have argued that there are difficulties (in that clinicians cannot predict risk in every instance), they should (and do) bear some level of responsibility should “something go wrong”. It goes against the grain to suggest that clinicians should have a blasé attitude towards keeping vulnerable patients safe as they have a duty of care that they must uphold. But, within this context, it is important to consider that, in the face of blame, there is a potential for risk aversion. Wand (2012, p. 3) suggested in this instance that risk aversion “then becomes responsibility aversion whereby clinicians act from fear of legal ramifications”, and this is the antithesis of what the spirit of the law intended. Undrill (2007) specified that, in addition, there are situations in which clinicians may act in this way because they are afraid to fail, and this will be at the expense of the patient’s well-being. However, as the findings indicate, in the face of the support and collaboration that exists for clinicians on this ward, together with the clear guidelines outlined by the organisation, this risk aversion may be mitigated (Cordall 2009).

Regardless of this, legal responsibilities were important and clinicians considered this to be a small, but necessary, aspect of their overall practice, although I would argue here, following from the previous assertions, that clinicians in this study may not realise how much importance they actually attribute to their perceived legal responsibilities. Clinicians primarily considered that they had a duty of care to protect staff, visitors, and patients. Alexander (2006) suggested that rule constructions on the ward arise from clinical legal responsibilities, but that deleterious patient responses towards the implementation of these limitations may be mitigated through communication. The findings of this study suggest that ethical and legal tensions exist, which impact on clinicians’ obligations to fulfil their ethical and legal responsibilities, while at the same time, knowing that these responsibilities could detract from patient-centred care. It would seem that they view the same events from their own professional frame of reference (Davies et al. 2006). This is aligned with Benn, Brown, and North-Samardzic’s contention that:

> *… [b]y placing responsibility for risks in the hands of institutions, industrial society creates a system of rules to manage the impact of these risks (Benn, Brown & North-Samardzic 2009, p. 1655).*

9.3 Agency within the context of practice norms

As established in the previous chapters of this thesis, RAM is an essential aspect of acute care admissions, yet in the literature published to date, clinical practices and understandings in acute care settings have rarely been considered. One aim of this study was to provide an understanding of the issues facing health professionals when undertaking RAM. The objectives were to examine their perceptions, knowledges, and attitudes of risk assessment, together with the enablers and barriers of effective RAM.

This section creates an understanding of the issues facing health professionals when undertaking RAM against the backdrop of risk as a social construction, and broadly considers why mental health practitioners conduct risk assessments and then seek to manage risk, i.e. the practices and purpose of RAM and how this is done is framed through clinical responsibilities and the communication that exists within the RAM process.

Firstly, the organisational context will be considered which includes an exploration of the aims of care and the enablers and barriers of this care in the framework of RAM. Secondly, the professional context will be explored. This includes a consideration of what the prediction of risk really looks like in the psychiatric clinical setting, consideration of collaboration with team members and patients, and communication within the setting. Finally, individual anxieties will be explored, looking at rituals and training as two key areas that have arisen from the findings. These three areas frame the findings and allow the issues facing health professionals to be identified, extrapolated, and then discussed in the context of what this means for both the patient and the clinician, and for care delivery for the individual, the organisation, and the healthcare system.

9.3.1 The Organisational Context

9.3.1.1 The Aims of Care

Overall, risk assessment was perceived by clinicians as a logical systematic process designed to minimise risk. RAM required the assessment of a range of risk factors that aimed to ensure the safety of patients, visitors, and staff. RAM was perceived by the participants to be legally and policy driven. Risk assessment encompassed many areas, and knowledge of each area complemented RAM practices and became the care plan for the patient. The attitudes towards RAM were varied; however, most clinicians considered RAM to be a useful process that benefitted the patient and enabled structured thinking. However, RAM practices were negatively affected when there was a lack of senior support, and when responsibility for RAM varied within each profession.

9.3.1.2 Enablers and Barriers towards "Care" – a.k.a. Risk Assessment and Management

RAM was enabled through various mechanisms, including collaborative relationships; clinical experience and knowledge; sound clinical documentation, education, and training; the establishment of therapeutic relationships with patients and families; organisational and senior staff support; the availability of time; and effective communication together with intuitive abilities. However, a number of barriers were encountered in clinical practice towards RAM. The identified barriers were the complexity of information; the lack of time; role confusion; mandated and legal responsibilities; policy driver perceptions of RAM; unequal partnerships between patients and clinicians; and the labelling of patients.

9.3.1.3 A Cohesive Whole

> *RN Jack: This is what we are supposed to do for this fellow is this and this is what the plan says, but nobody is doing it, so what's the point?*

Many of the tensions on the ward have been considered in other sections of this chapter. However, three main issues that were identified in the findings are worthy of further discussion. These issues were a lack of consistent individualised care for the patient, lack of senior support, and the notion of “chasing staff”. A lack of consistent individualised care for patients, which feeds into a lack of senior support, will be considered first. RN Jack highlighted that while every patient on the ward was supposed to have a risk management plan, this often lasted only for a week or two and then was not done after this. This is at odds with the policy-driven nature of the ward. Nevertheless, this interview reflected a level of frustration at the lack of individualised care afforded to the patient, the lack of consistency in the care they received, and the lack of senior support in the organisation. Alexander and Bowers (2004) suggested that rigid organisational structures prevent clinicians from providing individualised care to the patient, with the absence of rule clarity and consistency being linked to patient aggression.

Senior support also aided effective RAM practices, aiming to minimise risk and risk behaviours. Clinicians in this study considered staff as being unable to provide the extra time, or extra staff, to support RAM practices, yet senior support has been demonstrated to assist effective RAM. Lack of senior support is also not to be dismissed, as the lack of support in this area has the potential to create high levels of stress in clinicians (Hummelvoll & Severinsson 2001). That said, providing support to junior staff is difficult considering the high amounts of administrative tasks that senior clinicians have to undertake (Higgins, Hurst & Wistow 1999). Certainly, in a supportive environment, it would be conceivable that consistent individualised care would be fostered rather than hindered.

Clinicians in this study also identified time as a barrier towards effectively assessing and managing risks. They considered that they lacked the time to be able to create individualised care plans, and that the complexity of information compounded this barrier. The availability of time for clinicians is important in any clinical environment. The lack of time can be one of the biggest barriers for clinicians when assessing and managing risk, and can prevent them from fulfilling their clinical role in its entirety (Pinikahana & Happell 2004). One major reason for this lack of time (and the availability of fewer resources) has been the changing patterns of service delivery (Breeze & Repper 1998). Similarly, in a study by Cleary and Edwards (1999), nurses attributed a lack of time to staffing numbers. Other factors that influence the availability of time include patient acuity, documentation requirements, and unplanned activities (Cleary & Edwards 1999). There are numerous consequences resulting from lack of time. For clinicians, this may lead to stress and burn-out (Hummelvoll & Severinsson 2001; Pinikahana & Happell 2004).

Another factor that can accompany stress is lack of support for clinicians, including a lack of staffing (Happell, Pinikahana & Martin 2003; Hummelvoll & Severinsson 2001). The inability to reflect and weigh up options when pressed for time has also been identified as a major concern as this affects not only the care the patient receives, but also, affects the clinician on a personal level as well (Higgins, Hurst & Wistow 1999). From the perspective on the patient, this may lead to a limited depth and quality of therapeutic care which is fostered by the nurse-patient interactions (Cleary & Edwards 1999; Higgins, Hurst & Wistow 1999). The consequences of a reduction in therapeutic engagement has the potential to intensify patient reactions in relation to ward rule enforcement, and the result is increased intention to resort to aggressive behaviour or to abscond (Alexander 2006). Other less severe consequences include boredom (Higgins, Hurst & Wistow 1999).

Concurrently, patients have identified the time available to clinicians as an important aspect of their recovery (Breeze & Repper 1998). However, in a study by Cleary and Edwards (1999), patients acknowledged the demands placed on nurses, and considered staffing ratios, workloads, responsibilities, and high patient numbers as contributing to the lack of time available for nurse-patient interactions, although patients would have liked more time with the nurses. Limited time has been identified by Hall (1996) as favouring the biomedical model, which leaves little time for clinicians to evaluate patient problems, and to take a therapeutic stance to promote healing (for example, looking at self-image) (Hummelvoll & Severinsson 2001). Interestingly, Higgins, Hurst, and Wistow (1999) found that nurses frequently feel tension when wanting to allow patients sufficient time to recover, while being pressured to free up beds. The lack of time can also be aligned to comments by the clinicians that they have to “chase” doctors to get them to fill out the risk assessment forms, while one clinician (a doctor) admitted that they had difficulty in effectively communicating risk to others. This phenomenon could be reconciled with an “us against them” attitude and is a common cause of frustration seen in many clinical settings (Ashworth 2000). For example, a participant in a study by Kingston et al. (2004, p. 38) stated that “I don’t see why we have to chase them [doctors] up; they’re a separate entity. They’re lacking with [sic] discipline, and they’re lazy ... generally it’s the Medical Officers that let the side down”. This conflict has the potential to create significant stressors within the clinical environment (Pinikahana & Happell 2004).

The inability to act as a cohesive whole is certainly one aspect that needs to be considered at this research site, given the potential consequences that this can have for both the patient and the clinician. While the roles and responsibilities of clinical staff are clearly delineated in the risk assessment policy of the ward (*see* Appendix P), the clarification of these in the workplace should be more explicit in light of the interviews. If there is greater clarity in roles and responsibilities, and staff work to fulfil these roles, then “seamless” holistic consistent patient care will occur. In this way, Higgins, Hurst, and Wistow considered that:

> *… [o]pportunity and commitment are needed to foster multidisciplinary team working and development. The aim should be to produce integrated multidisciplinary patient records as a matter of routine in order to reduce the need for nurses to chase other professionals and enable nurses to spend more time with patients (Higgins, Hurst & Wistow 1999, p. 60).*

9.3.2 The Professional Context

9.3.2.1 The Difficulties of Predicting Risk: A Case for Manufactured Uncertainties

> *RMHN Lucy: You kind of need to know your client, you need to know how to do like the initial risk assessment, you need to know what to ask, you need to know what information you need, you need to know how to conduct an assessment and the things that are listed on your risk assessment … you may not be [able to] do that separately … it's sort of knowing how to do a complete assessment of the situation.*

On the surface, the findings of this study have concluded that clinicians considered themselves to be confident in their prediction of risks. This confidence was achieved through knowledge of RAM procedures; for example, being aware of available services, the existing patient care plans in place, and the risk factors that existed. This confidence was enhanced through clinical experience and skills. However, as this study did not measure the accuracy of their predictions, it is unknown as to whether they were accurate or not. Yet, although clinicians stated in their interviews that they were confident in making predictions, Littlechild and Hawley (2010) considered predictions surrounding RAM procedures as being based on the principle that the world is fully knowable and understandable. Cause and effect can be determined through the observation of events, and this notion of control and predictability underpins contemporary RAM decision-making. Yet logically, one can deduce that the world is *not* fully knowable and understandable. So, it follows that confidence in predictions clearly does not guarantee their accuracy.

Most clinicians in this study considered that clinical experience aided predictive abilities, a finding similar to that of Murphy (2004). However, less experienced clinicians also considered themselves to be confident in making these predictions, arguing that their life experiences contributed to this confidence. This idea is also supported by Adams and Van Loon (2000) who contended that risk calculations are extrapolated from past experiences. This means that clinicians confidently base their predictions on experience when encountering risks that they are familiar with. Yet, Menzies (1960) argued that when familiarity with the situation at hand is evident, then constructive planning and decision-making are inhibited, arguably creating a risk for the patient rather than protecting the patient from risk. In this way, familiarity may lead to a loss of objectivity, which is a concerning outcome.

One can then consider this from a risk contingency perspective. As the world is *not* fully knowable and understood, then what are the consequences for the patient when clinicians are unfamiliar with the risks? Mullen (2006) and Menzies (1960) argued that the focus on prediction creates anxiety, while ironically, even full and complete risk assessments fail to incorporate all of the variables and will (because of this) never be accurate. From this perspective, there is the potential for clinicians to manufacture uncertainties due to their inability to calculate actuarial probabilities for every risk contingency and to assuage their anxiety (Best 2003; Lacy 2005; Scambler 1998).

This link with anxiety is also present when considering the intuitive component evident in clinical decision-making, which is arguably informed by familiarity. Clinicians in this study identified that intuitive decision-making aids RAM predictions. Murphy (2004) explored intuition at length with nurses. The “gut feel” when linked to experience is cognitively assimilated, and the result is a feeling of unease. Murphy (2004) proposed that “gut feelings” can have objective factors that seem to be arbitrarily attached, with presentation of the patient together with changes in the environment being linked to clinical perceptions that are then attributed to the patient. Alternatively, Scott et al. (2011) argued that this “gut feel” about a patient is most generally negative and related not only to assessing the risk the patient poses to others, but the “gut feel” is also linked to the difficulties that the patient has caused for healthcare services. This subjective emotional reaction could be quietly damaging to the patient in many ways, particularly in a restrictive sense. It would seem that if clinicians operate from a purely intuitive sense, then they may miss the very “real risks” that are present, manufacturing other arbitrary ones instead. Brunton (2005) argued convincingly that critical thinking skills should replace intuitive predictions to promote clinical competence in relation to risk assessments. Likewise, Godin (2004, p. 349) stated that “[t]he practitioner’s knowledge of a patient is infrequently detailed enough to make a fully reasoned prediction about the patient’s future behaviour”. A number of “false positives” may occur, with the result being increased coercion and unnecessary restriction of civil liberties for the patient

(Petch 2001). That said, Brunton (2005) is careful to note that intuition can assist in identifying the initial issues, and structured risk assessments can improve the reliability and validity of RAM decision-making. It is then argued that clinicians need an evidence-base and that this should use guidelines that are underpinned by a systematic analysis of the research literature (Littlechild & Hawley 2010). To date, there is little systematic research available in relation to RAM in acute care psychiatric settings.

9.3.2.2 Effective Communication and Collaboration: Where does the patient fit?

While the clinicians perceived all clinical staff to be responsible for RAM, they saw that one major responsibility in this process was to collaborate with team members. The benefits of collaboration, particularly in the arena of mental healthcare, are enormous and those who benefit include stakeholders such as mental health clinical teams, emergency department staff, courts, police, patients, carers, and significant others (Department of Health and Ageing 2009). The Department of Health and Ageing (2009, p. 68) considered collaboration to be a key component that “can make a significant difference to the immediate and longer-term outcomes for the person involved”. This is supported by Life Without Barriers’ (2008, p. 8) guiding principles. In these principles, they encourage one to recognise each individual’s knowledge and experience. When these notions are combined, this has the ability to “provide patients, carers and their families with greater opportunities for increased quality of life” (Life Without Barriers 2008, p. 8). Collaboration then has the ability to foster patient recovery. The benefits of collaboration between team members are best reflected in a Victorian Government Department of Human Services document:

> *… [a] collaborative therapeutic partnership between mental health staff, the patient and their families and carers also assists with a patient’s management of and responses to illness. Collaboration relies on families and carers and mental health staff acknowledging and respecting the skills and resources that each brings to the working relationship (Victorian Government Department of Human Services 2009, p. 26).*

Clinicians in this current study viewed collaboration as a means of respecting the skills and knowledges of others and to promote patient recovery. They identified that teamwork with other members of staff had the potential to alert them to as yet unidentified risks. Alaszewski (2006) argued that experienced clinicians are considered as a resource for the less experienced clinicians. When facilitation of effective communication occurs, the less experienced clinicians will learn more and team members will be better supported (Cleary & Edwards 1999). Effective teamwork has the potential to contribute to positive patient-clinician interactions. Hummelvoll and Severinsson (2001) contended that the differing views of clinicians have the ability to add to a much wider perspective of the complex situations patients are faced with. In Cleary and Edwards' (1999) study, the settings for sharing information as part of a team environment occurred in handovers, case reviews, and in morning meetings. The settings in this current study are no different.

However, Cleary and Edwards (1999) pointed out that it is difficult to balance patient care and interaction with professional development activities, which occur informally when sharing information about the patient. However, formal or informal professional development activities are important in any clinical environment in order to keep abreast of the changing face of healthcare and the current focus on quality improvement (Gunn & Goding 2009; Mazmanian, Davis & Galbraith 2009; Stewart & Carpenter 2009; Watts 2010). It could be argued that while it is important to strike a balance between patient care and professional development, as the latter essentially detracts from the time spent with the patient, but is nevertheless essential. Professional development has the ability to improve clinical competency, and also assists with clinicians' ability to form effective therapeutic relationships, not just with patients, but also with members of their own team (Gunn & Goding 2009; Watts 2010). There is also the potential, when fostered through collaboration, for clinicians to develop differing but complementary skills outside of their area of expertise. Most strikingly, the availability of professional development has been identified by Watts (2010) as a key motivator to increase job satisfaction, which then reduces staff turnover and shortages.

While collaboration was considered to be essential in practice, there were a number of barriers to teamwork. These barriers included lack of time, limited commitment to RAM, and a lack of consistency. Furthermore, the sense of teamwork failed if senior staff did not support it. The lack of cohesion within the collective group caused tension. Collaboration occurred primarily with other team members, and then with the family; however, the patient lacked the same consideration. As a consequence, care was often inconsistent and ineffective which could lead to the disempowerment of staff and patients (Janner & Page 2008). Likewise, Ryan-Nicholls and Haggarty (2007) stated that healthcare services cannot be effective if patients are involved in only a limited way in the decision-making process.

Clinicians in this study considered gathering collateral information about the patient as a major component of their clinical role, which was important for the assessment of risk and best practice (Littlechild & Hawley 2010). Collaboration is seen to be important in this process and clinicians considered that greater amounts of information about the patient could be collected when collaborating with other clinicians. The significance of patients, and *including* them in this process, was also considered as a dynamic factor aiding the assessment and management of risk. It would seem that this should be a core component of best practice in reference to RAM practices. However, the findings of this study suggest that clinicians collaborated more with other healthcare professionals than with patients. They were also very clear about how important it was to collaborate with family members. Reference to collecting information from the patient, however, was notably absent. This is a striking discovery, in that the notion of “collaboration” was used by every participant and they viewed collecting information as a form of “collaboration”. I argue here that this is not collaboration, and for this to be so, it must promote a therapeutic alliance (Colson et al. 1988). With the patient notably absent, this then amounts to no more than a data gathering process used as a means to accurately predict risk. For the patient, the findings indicate that they were merely the passenger and were being led in the direction in which the clinicians wanted to go.

According to the participants, collaboration led towards the effective assessment and management of risk, and was enhanced through effective communication. Staff in this study used two modes, verbal and writing, and yet communication can incorporate other strategies to convey and receive messages, such as verbal and non-verbal cues, the environment, absorptive capacity, perspective, decoding ability, and language (Dewatripont & Tirole 2004). These internal and external factors influence clinician-patient communication (Tay, Hegney & Ang 2011). However, the highly developed skills that are necessary for effective communication to take place were not articulated in the semi-structured interviews, although the participants acknowledged that effective communication skills are essential. This level of significance is reiterated by Brown et al. (1999, p. 824) who suggested that communication skills are “the most important determinant of patient satisfaction with care” and that this satisfaction “is the primary determinant of personal decisions to use health plans and hospitals”. Similarly, effective communication has the potential to improve “the quality of care delivery”. Not surprisingly, the research suggests that ineffective communication is still a potent barrier present in healthcare settings today (Chant et al. 2002; Tay, Hegney & Ang 2011).

It can be seen from the data that the skills the participants seemed to consider as being effective were being approachable, having mutual respect, and actively listening. The research suggests instead that effective communication skills include “listening, hearing, explaining, rephrasing, repeating, checking out meaning, making space for conversation and discussion” (Grover, Treasure & Schmidt 2000, p. 197) as well as “personal awareness of the likely barriers to effective communication” (Fallowfield & Jenkins 1999, p. 1594). While the skills identified by the participants encompassed some of these, the findings suggest that the participants focused on data collection rather than on therapy.

Of interest is a systematic review by (Tay, Hegney & Ang 2011) which considered the factors that influence effective communication. One finding in particular seems to be of relevance:

> *… [e]vidence suggests that when nurses focus more on performing tasks than communication, their conversations with patients tend to concentrate more on giving and collecting information. In addition, nurses who lack respect for and a genuine interest in understanding patients’ concerns further inhibit communication (Tay, Hegney & Ang 2011, p. 158).*

This finding is worthy of consideration as the participants in this study have focused much of their time and effort on gathering collateral information (in more rudimentary terms, data collection). Nevertheless, the clinicians considered that effective communication engendered feelings of support and reassurance. However, the benefits of effective communication can be more than this, including complete and accurate data collection (leading to accurate diagnosis), satisfaction with the care received, decreased patient distress and anxiety, greater patient insight, less confusion for both the patient’s family/carer and the multidisciplinary team, and finally, clinicians may experience less stress and greater job satisfaction (Fallowfield & Jenkins 1999; Maguire & Pitceathly 2002).

Not surprisingly, the participants stated that there was the potential for unsafe practice if communication was not effective. The benefits outlined above certainly suggest that there is potential for this to occur if communication is of a substandard nature. It is also interesting to note that RMHN Lucy considered fear as having an impact on communication. This finding is similar to that of O’Daniel and Rosenstein (2008) who suggested that fear can exist even in collaborative/collegial environments. Some types of fear could include, fear of confrontation, fear of retaliation, or even fear that nothing will change (O'Daniel & Rosenstein 2008). The organisational culture could also be a factor. However, it would be difficult to conclude that the organisation instils fear given the overall findings. This phenomenon could be reconciled with an “us against them” attitude and is a common cause of frustration seen in many clinical settings (Ashworth 2000).

Empowering the patient and the clinician is important within this context. Clinicians in this study considered that communicating with the patient was a way of allowing the identification of issues and obtaining collateral information. They were careful to note that effective communication promoted therapeutic relationships and patient/family input. Yet, it remains unknown as to whether effective communication was present on the ward given the limitations of this study. This is important to consider if the communication is to flow in both directions. Clinicians have the scope to communicate their concerns to the patient while maintaining a recovery focus. Similarly, patients could be encouraged to communicate what interventions have worked for them in the past. This could be beneficial as this recognition of the risks that exist can be one way of minimising risk (Beck 1999).

9.3.3 Individual Anxieties

9.3.3.1 Task Performance Rituals Means Purposeful Tasks

> *RMHN Lucy: I assess that risk as best I can and being able to know what is manageable and what is not manageable, there are risks in everything and we all have to live with it. It's knowing what you can and can't do … that's fine for us the practitioners who document that and say the risks are huge ... however the guy's got capacity … here's how we can best manage them. It's the crux of what we do really …*

The participants were clear that the overall purpose of RAM was to minimise risk, and this meant ensuring safety for patients, staff, and visitors on the ward. These findings are similar to other current conceptualisations of RAM (Muir-Cochrane & Wand 2005). However, the clinicians did not necessarily articulate the overall purpose of RAM; rather, the purpose of RAM was operationalised into purposeful RAM tasks. Hummelvoll and Severinsson (2001, p. 157) stated that "[k]nowledge can, per se, remain hidden in the tasks nurses perform until they have the possibility to systematically reflect on practice". Similarly, Kempster, Jackson, and Conroy (2011, p. 320) considered the concept of purpose being viewed as "an aim or objective which guides action – achieving a goal in a particular context". The goal of risk assessment is to achieve the minimisation of risk, and this means that the task at hand must be implicitly related to a purpose.

To extend this concept further, Kempster, Jackson, and Conroy (2011) posited that the notion of purpose can be quite complex, and is shaped by institutional structures and organisational requirements. The emphasis then is placed on "socially desirable ends", in this instance, the minimisation of risk. Menzies (1960) considered a number of aspects of this when she theorised that clinicians attempt to eliminate decision-making by undertaking task performance rituals. The result of this, according to Menzies, was a collusive social redistribution of responsibility. When purpose is present, motivation follows (Kempster, Jackson & Conroy 2011). In conjunction with this notion, the mobilising force of anxiety can lead to a preoccupation with risk, and it is theorised that attempts are made by individuals to reduce risks to "acceptable" levels (Beck 1992). It is clear from the interviews in this current study that clinicians were committed to RAM, and were then motivated towards achieving a common goal. Purposeful tasks actually drove RAM.

9.3.3.2 Impact of training on reducing anxiety about risk assessment

> *GN Martha: The education development support on this ward is just phenomenal and its ongoing continually on the ward as well as specialised information educational sessions weekly here. Plus, they also offer an in-house mental health course that all staff can attend … They have violence training etcetera, so everything is covered, it's really the individual [dependent upon] having an attitude of learning and growing and appreciating support, stepping up and asking questions … it's all here, it's just fantastic.*

Both formal and informal education was seen to be important to the clinicians and the organisation and formed a large part of clinical practice. While Cleary and Edwards (1999) noted that formal education detracted from direct patient care, they added that formal and informal education (in the form of interaction with colleagues) had the potential to improve clinical confidence and to encourage communication with patients. The findings of this current study also indicated that access to clinicians was considered a resource for the less experienced, and this type of informal education should not be overlooked within the organisation. The organisation was perceived by the clinicians as being responsive to their education needs and this is one way to develop risk competency (Murphy 2004). Access to this formal and informal education could be considered as responsive and reflective by clinicians and the organisation (Alaszewski 2006),which may suggest that actuarial and "managerialist" approaches are diminishing (Langan 2009).

While it is acknowledged that some risks cannot be predicted, Littlechild and Hawley (2010) contended that the importance of adequately training clinicians in RAM should never be underestimated. However, they added that risk assessment training should include aspects such as holistic practice, evidence-based predictors of risk, and professional decision-making. Alaszewski (2006) went further and suggested that reflective and responsive clinical practice, underpinned by the professional development of clinical judgement together with therapeutic and analytical skills, is imperative in developing and maintaining risk competencies. However, overall, the findings of this current study would suggest that more attention be afforded to issues such as patient participation and time management, while at the same time, attempting to diminish the culture of blame.

9.4 Care plans

This section provides a natural segue and argues that care delivery is considered to be synonymous with risk management, resulting in vast differences between acute care nursing care plans and risk management plans. This critical comparison builds upon Chapter 6 which explored the differences and similarities between the two and the overlapping symptomologies, arguing here that a risk management plan does not meet the needs of the psychiatric patient when looked at holistically and when applied to the findings of this thesis. Also explored are the tensions between risk and recovery, the Recovery Framework, and the dichotomy between these in the context of care plans, and what this means for the patient and the clinician.

9.4.1 The Risk Assessment Tool: Risk Consciousness Rather Than Therapeutic Consciousness

> *The cardinal purposes of risk assessment revolved around naming the risk with anticipated frequency and severity, and developing strategies to minimize* [sic] *its occurrence (Hutchinson, Lovell & Mason 2012, p. 59).*

9.4.1.1 Risk and Safety

Surprisingly, the clinicians did not explicitly discuss safety as a concept. Rather, safety was entangled within the notions of purpose and purposeful tasks and became the norm within their professional role and as a norm of the organisation. Higgins, Hurst, and Wistow (1999) identified that clinicians must always maintain a safe environment on psychiatric wards; although, there is a need to balance the safety of staff and other patients with patient unpredictability. The task of clinical staff is to make a determination as to what is an acceptable or an unacceptable risk (Carson 1994; Vinestock 1996). Risk assessment tools may also provide a feeling of safety creating both scientific and risk awareness (Beck 1999). Using the tool is a way of transferring responsibility to the tool rather than to the individual, which can also create a personal feeling of safety (Luhmann et al. 2005; Menzies 1960). In addition, the formation of structure within the organisation, achieved by using a structured tool, also engenders feelings of safety for clinicians (Menzies 1960). Certainly, the lack of staffing noted by the clinicians is important when considering the notion of safety. This may explain the current focus by clinicians on the tool and the absence of explicit discussion regarding safety which was often an unspoken goal driving the purposeful tasks.

9.4.1.2 Risk Assessment: An "Organisational Attempt to Tame Anxiety"

RAM formed a large part of the clinicians' practice and was perceived to be a logical systematic process. In contrast, Undrill (2007, p. 294) viewed RAM as a "neurotic organisational attempt to tame anxiety". The clinicians described the ideal logical and systematic process as conducting a mental state assessment on the patient to determine the patients' risk factors, establishing goals and strategies to minimise risk, while at the same time, being able to relate to patients and families in order to aid this process. Risk assessment is described in the literature as a staged process (Hollins 2010, p. 217) which is reflected in the tools used at the research site. Determining the risk factors and then minimising these risks, for example: violence, absconding, suicide, self-neglect, tension, anxiety, and self-harm, are considered of "paramount importance". By reducing these risks through therapeutic interventions aid in both patient recovery and the reduction of adverse events and outcomes (Gilbert, Adams & Buckingham 2011; Whitehead & Mason 2006). This would seem to be an enormous task when clinicians are confronted with a complex range of risk factors that must be considered when balancing safety versus autonomy for the patient (Alaszewski 2006). Similarly, clinicians are confronted with a plethora of published studies that, at best, consider RAM in the context of a single risk behaviour or, at worst, suggest that RAM practices are not supported by appropriate studies (*see* Chapter 4). This complexity has been acknowledged by a number of researchers (Gilbert, Adams & Buckingham 2011; Leiba 2000; Mosel et al. 2011;

Muir-Cochrane et al. 2011a; Muir-Cochrane & Wand 2005). Giddens (1991; cited in Lupton 1999, p. 76) demonstrated this complexity, stating that “[r]isk assessment involves weighing up and choosing among various possible courses of action according to their predicted outcomes”, which can be a very “risky affair” (Giddens 1991a). Beck (1992) suggested that risk assessment can represent a “worst case scenario”.

The findings of this study indicate that the clinicians would ideally like to perform a systematic, logical RAM process and that this is influenced by the organisation’s expectations of their professional role. In everyday practice, clinicians were unable to meet these ideal practices. They lacked the time to complete the necessary RAM paperwork, and were faced with a range of complex information that they must assess. Furthermore, Quirion (2003) and Godin (2004) argued that a systematic risk assessment process leads an organisation away from patient-centred care. The therapeutic relationship with the patient could be marred if clinicians focus on gathering information from outside sources rather than focusing on the patient. Undrill (2007) argued that this extends the amount of information collected during a patient’s presentation. This can be superfluous and can impact on clinical decision-making, adding too much complexity and being of only marginal utility.

Menzies (1960) described nursing routines and rituals as a means to allay anxieties. In the framework of RAM practices, it is conceivable that clinicians feel anxious because they are unable to meet perceived ideal RAM practices. A cycle may potentially begin with further routines and rituals being established by clinicians in order to alleviate their anxieties. It is interesting to note that rigidity may result in clinicians being unable to provide individualised nursing care. Furthermore, the absence of clarity and consistency about ward rules for patients is linked to patient aggression (Alexander & Bowers 2004). If the tensions between realities versus the ideal are too pronounced, the consequences for the organisation can be increased interpersonal conflict and sick leave, and an inability to retain staff (Hummelvoll & Severinsson 2001).

Despite being unable to practice in an ideal way, the clinicians were still able to articulate the personal qualities they needed to have in order to effectively assess and manage risk. This included a personal commitment towards RAM, and being able to be compassionate, empathetic, flexible, accountable, and analytical. These qualities could be considered within the context of the principles of best practice in managing risk as outlined by the Department of Health:

> *… [r]isk assessment involves working with the service user to help estimate each of these aspects. Information about the service user's history of violence, self-harm or self-neglect, their relationships and any recent losses or problems, employment and any recent difficulties, housing issues, their family and the support that's available, and their more general social contacts could all be relevant. Risk management then involves developing one or more flexible strategies aimed at preventing the negative event from occurring or, if this is not possible, minimising the harm caused. Risk management must include a set of action plans, the allocation of each aspect of the plan to an identified profession and a date for review (Department of Health 2007, p. 13).*

It would seem that being compassionate, empathetic, flexible, accountable, and analytical are essential in order to meet these best practice principles. If aspects of accountability are not met, confidence by patients in care standards that are consistent with modern standards is reduced, and this has a negative impact on public confidence in the Australian mental health system (Department of Health and Ageing 2009). Nevertheless, these key qualities were identified by clinicians as being able to be refined through experience, knowledge, and supportive environments. These are important in the clinical setting and clinicians considered that these could be learned qualities that would allow clinical judgement to be developed. Webb (2012) however, questioned whether there is a theory-practice gap whereby clinicians are expected to transfer clinical knowledge to the current patient situation regardless of their unique characteristics and individual needs. In contrast, Murphy (2004) found that participants considered experience to enhance the clinical decisions made in relation to assessments of risk.

Despite the importance placed on experience, knowledge, and the environment by clinicians, they did not identify what their conceptualisation of clinical judgment was. Tanner identified good clinical judgement to be:

> *… a flexible and nuanced ability to recognize salient aspects of an undefined clinical situation, interpret their meanings, and respond appropriately. Good clinical judgments in nursing require an understanding of not only the pathophysiological and diagnostic aspects of a patient's clinical presentation and disease, but also the illness experience for both the patient and family and their physical, social, and emotional strengths and coping resources (Tanner 2006, p. 205).*

From this, it would seem that clinical experience and knowledge, and a supportive clinical environment are important in this process. Structured clinical judgement has been identified by the Department of Health (2007) as the most effective approach to *violence*-based RAM, yet it is also applied to other risk behaviours. However, for structured clinical judgement to be successful, “the clinician’s discretion is seen as a vital element – especially in relation to formulating the assessment of risk and preparing risk management plans based on the risk factors identified” (Department of Health 2007, p. 20). One important aspect of structured clinical judgement is the requirement to make “an assessment of clearly defined factors derived from the research” (Department of Health 2007, p. 18). However, as illustrated in Chapter 4, RAM is generally contextualised within a single risk behaviour. For clinicians, it would be difficult to base assessments on research, when the available published research only applies to one risk factor, and does not encompass the growing range of risks and risk factors seen in the clinical environment such as violence, aggression, substance abuse, absconding, and access to weapons to name but a few. This is also acknowledged by the Department of Health (2007).

Another important aspect of structured clinical judgement is the risk assessment tool that is used (when completed in tandem with clinical discretion). The site of this study used a risk assessment tool based on the South Australian Acute Mental Health Risk Assessment Tool (Department of Human Services 2002); however, this tool has not been fully validated (Muir-Cochrane et al. 2011a). It is considered as “a guide and an aid to assist experienced clinician judgement, not replace it. Clinical judgement is the primary tool” (Department of Human Services 2002, p. 17). While attempting to maintain best practice standards, clinicians are faced with using a tool that is not fully validated and, as a result, must rely more heavily on clinical judgement than they perhaps should.

I would argue from the findings that it is no wonder that RAM is difficult to practice in an ideal way on the ward. Considered in this context, the findings of this study have identified that when clinicians used clinical judgement, and considered that the behaviour did not warrant a risk assessment, the RAM form was not completed. In addition, the clinicians sometimes documented risk assessments in the clinical notes rather than on the risk assessment form. However, less experienced staff on this ward relied on up-to-date risk assessments to aid their decision-making, and the form was often the first reference point for *all* staff when obtaining up-to-date information. Gilbert, Adams, and Buckingham (2011) also found variability in their evaluation of RAM processes on four adult psychiatric wards. This variability was linked to confusion in recording the collected information. The study did not consider the ramifications of less experienced staff relying on up-to-date information; although, it was acknowledged that risk assessments recorded elsewhere in clinical notes is “obviously dangerous” (Gilbert, Adams & Buckingham 2011, p. 5).

Clinical judgement is then a core component of clinical decision-making. Clinical decision-making is based on knowledge acquired from different sources (Alaszewski 2006). Encoded knowledge refers to knowledge gained through documents, embodied knowledge is gained through reflection on individual cases and is used intuitively, embrained knowledge is based on cognitive and conceptual skills, and embedded knowledge is based on shared routines successfully used in the past (Benner 1984; Lam 2000; Schön 1988). However, Alaszewski (2006) suggested that RAM places a heavy emphasis on encoded knowledges. With the variability of practices on the ward, it is no wonder that less experienced clinicians rely heavily on documentation to assist with their decision-making. The lack of documentation which is based on experienced clinical judgement only serves as a disservice to these staff members. The lack of documentation and recording of risk information in clinical notes, rather than on the risk assessment tool, may also not comply with the National Practice Standards for the Mental Health Workforce (Department of Health: Victoria 2013). Standard 10 requires that clinical records of treatment and support be “comprehensive, factual and sequential” in order to “promote continuity of care across settings, programs and time”. The omission of a risk assessment for less experienced staff and the recording of information in different places could lead to confusion for these staff at best and unsafe practice at worst.

Risk aversion should also be considered. Luhmann (1981, 1991; 2005; 2002) theorised that the existence of risk (a truth) is based on familiarity. He suggested that risk perceptions diminish once clinicians become familiar with a situation. This indicates that clinicians with less experience will be more risk averse, and their practices will be different to clinicians who perceive there to be no risk. If this holds true, and the findings of this study certainly indicate that there is greater perceptions of risk when clinicians are less experienced, then this may lead to added anxiety and rigid routines and structures that will ultimately affect the patient (Menzies 1960). Similarly, Beck (2000) and Giddens (1999d) considered risk to be a product of human action and subsequent decision-making.

9.4.1.3 Therapeutic care

Bishop and Ford-Bruins (2003, p. 212) explored risk assessment in an acute psychiatric ward and found that assessment encompassed the following aspects:

- Knowledge – of the patient, the signs and symptoms and having clinical experience rather than theoretical knowledge.

- Skill set – gathering information using formal and informal tools, observing the patient, using intuition and documenting findings; as well, the “system” can impact on the skill set both positively or negatively.

- Roles – there are numerous roles that a clinician can assume, and values and beliefs can impact/influence that role.

- Attitude – the attitude of the patient and the clinical staff can further impact assessment while the “system” impacts the attitude in a positive or negative way.

Organisational norms are also focused on these factors, and most likely reflect significant anxiety being experienced by individual clinicians. The clinicians in this study perceived risk assessment to be enhanced when using a risk assessment tool, and in addition, the tool was seen as a way to logically consider and assess the information collected from the patient and their carer or family. This tool was also seen as a way to enhance communication between staff members. While the tool used at the research site has not been fully validated, and is secondary to clinical judgement, the utility of this tool was not lost on the clinicians. This finding is in keeping with the current focus of structured clinical judgement whereby the utilisation of a risk assessment tool has the ability to synthesise clinical RAM practices. That said, filling out risk assessment forms can be considered as a social defence mechanism that not only feeds into risk being self-referential, but also enables depersonalisation of the patient and allows for detachment of feelings by clinicians (Luhmann et al. 2005; Menzies 1960). Similarly, the acquiring of knowledge of risk arises through the experience of risk. It could be argued that, in this instance, clinicians have developed ways of coping with these uncertainties by focusing on completing the risk assessment tool (Featherstone, Lash & Robertson 1995; Slevin 2000).

The clinicians were careful to note that using the tool on its own may disadvantage patients. They considered this tool to be risky in terms of staff labelling patients from the documentation that was attached to them. The documentation also had the potential to disadvantage them in future admissions. This finding tallies with Langan and Lindow's (2004) and Godin's (2004) findings. Langan considered this in depth, stating that:

> *… [p]rofessionals possess significant power over the construction of service users' identities and values, discriminatory attitudes and decision-making biases affect what is seen and therefore recorded (Langan 2009, p. 480).*

Overton and Medina (2008) considered that the diagnosis of a mental illness allows the perpetuation of stigma, and creates new barriers in relation to receiving treatment, with stigma originating from "the very people in the mental health field who are expected to offer help to persons with a mental illness" (p. 146). In Cleary and Edwards' (1999) study, clinicians identified judgemental attitudes as impeding the nurse-patient interaction, which then detracted from therapeutic engagement and care. Self-stigma is also important. Overton and Medina (2008) recommended that clinicians listen to the patient while empathising with their experiences and avoiding the use of "belittling" words such as "compliance" and "resistance". By doing so, the patient's self-stigmatisation may be reduced. Langon (2009) went further, suggesting that while acknowledging the impossibility of excluding bias altogether, the development of reflective practice, professional supervision, and peer review ensures the scrutiny of the judgements made and of the decision-making process. As such, there seems to be a divorce of mental illness from behaviour. Mental illness appears to be "treatable", whereas the behaviour is not treatable and it is this which is managed. Davies et al. (2006, p. 1102) also found that mental illness and behaviour exist as separate entities. It would seem that RAM is focused on the behaviour, with little focus on the actual illness. I would argue that this may mean that there is little therapeutic intervention in relation to the *illness* as opposed to the *behaviour*. With this absence, and the fact that the behaviour is most likely to be a symptom of the illness, how can the patient be therapeutically assessed and subsequently managed? Where is the care?

9.4.2 Patient Treatment = Risk Management

> *RMHN Lucy: You can't necessarily get rid of risks, but you need to know what they are … there may always be a risk of something or other that you can't get rid of … but if it's identified and people know that that's the risk then … that's sometimes as good as you can get.*

From the outset of this section, it is critical to note that in a report published in 2012:

> *… [a]bout 41% of all mental health-related separations did not have a procedure recorded. It is likely that the procedures provided to admitted patients during these mental health-related separations were not able to be coded using the existing procedure classification system. The administration of mental health-related medications, for example, are not explicitly defined in the classification system* (AIHW 2012, p. 14).

This is indicative of the biomedical model of disease, which focuses primarily on the "physical" illness rather than the mental illness (Lupton 1997). Yet, despite the absence of such data (AIHW 2012, p. 14), Snowden (1997, p. 33) defined risk management as "the process of systematically focusing on methods of reducing both the severity and frequency of recognized [sic] adverse clinical risks for each individual patient". The lack of data is compelling and reflects the lack of regard and an absence of concern with therapeutic care for such patients. This lack of therapeutic care is reflected in this current study, and formal risk assessments were perceived to be effective and considered to be therapeutic in that they allowed effective strategies to be put into place. These strategies were put into place by clinicians in order to be able to minimise the risks present for patients, families, and staff, and a reduced score meant that the patient was "recovering". At the same time, changing risk assessments were important and reflected that the strategies/interventions were effective, although the “system” or organisational expectations always seemed to influence RAM practices:

> *SW Jennifer: … effective risk management is reinforce[d] by incorporating it into daily practice … being mindful you are accountable to client to organisation and that you have done everything in your power for that client.*

Interventions (a.k.a. risk management) in current practice have been considered in Chapter 2 of this thesis. In this chapter, it has been suggested that interventions in nursing practice may have been formulated in order to alleviate anxiety rather than being based on evidence (Menzies 1960). Wand suggested that:

> *… [c]linicians become anxious about the risk management tools they are given, and then work to reduce this anxiety by discharging their share of the risk (Wand 2012, p. 3).*

Regardless of this, the interventions that are implemented are rationalised by clinicians as a way to minimise risk for the patient, the staff, and the general public.

According to the Department of Health (2007), clinical experience and knowledge of the patient needs to begin by first considering the patient’s own perspective. Breeze and Repper (1998; 2007) considered patient perspectives in two studies. If a nursing intervention was considered by patients as being less controlling, but at the same time skilful, then this was received positively by the patients and impacted in a positive way on their behaviours. For example, they were less likely to abscond or behave aggressively. A limited range of choices, or being “forced” through persuasion or threats (e.g. restraint) was considered by patients to be counterproductive. Furthermore, patients stated that while they understood that some of their requests would be denied, it would be more acceptable if delivered with explanation and respect. These aspects feed into a concept known as empowerment. Hokanson and Hawks (1991) considered empowerment skills as necessary for nurses. These skills include knowledge, concern, effective communication, trust, courtesy, respect, and caring.

Despite this, it is clear that risk management is still about minimising risk:

> *… [t]he purpose of risk management is not only to contain the risk but also to minimise it. Therefore, risk factors that are amenable to treatment should be targeted for intervention (Farrington, Jolliffe & Johnstone 2008, p. 70).*

It stands then, that in order to manage risk, the risk factors need to be identified initially. The complexity of assessing for, and then managing, risk is highlighted when considering, for example, that risk factors are often associated with the risk of violence (Pinals, Tillbrook & Mumley 2009). Pinals, Tillbrook, and Mumley identified these risk factors for violence to include:

Select Factors Associated with Increased Violence Risk

Static Variables

Age
Sex
Intelligence/neurological impairment
History of violence/criminal behaviour
History of childhood abuse/Domestic violence
Psychopathy

Dynamic Variables

Neighbourhood context
Stress/Social support
Victim availability and specificity
Substance abuse/dependence
Comorbid mental disorder (with substance abuse)
Threat/control-override (TCO) symptoms[2]
Command hallucinations[2]
Violent thoughts
Anger

[2] Although the available data regarding these factors are equivocal, some studies found support for their association with increased violence risk.

Figure 22: Risk Factors for Violence

Reproduced directly from Pinals, Tillbrook and Mumley (2009, p. 61)

Alternatively, a risk profile for an absconding patient has been established by Mosel, Gerace, and Muir-Cochrane (2010). This study has established that young men and women aged in their 20s, diagnosed with schizophrenia, in close proximity to their detention orders being extended to their first 21-day detention order, were at higher risk of absconding than other patients in the hospital population.

While to date, the reasons for absconding have not been established and this is considered a multi-factorial phenomenon (Bowers, Jarrett & Clark 1998; Bowers, Alexander & Gaskell 2003; Bowers et al. 1999; Mosel, Gerace & Muir-Cochrane

2010; Mosel et al. 2010; Muir-Cochrane & Mosel 2008a). However, it is important to note that the establishment of profiles is a contentious issue, with Wand (2012, p. 6) arguing that the profile of an individual “is biased toward identifying only negative characteristics”. Howells, Day, and Thomas-Peter (2004) likened approaches to the treatment of violence as differing markedly between the healthcare system and the criminal justice system, but have argued that these differences should not exist. Instead, they ascribe these as being differences in the philosophies, cultures, and organisational histories of the systems rather than the “characteristics, functions and explanations of the violent behaviour itself” (Howells, Day & Thomas-Peter 2004, p. 392).

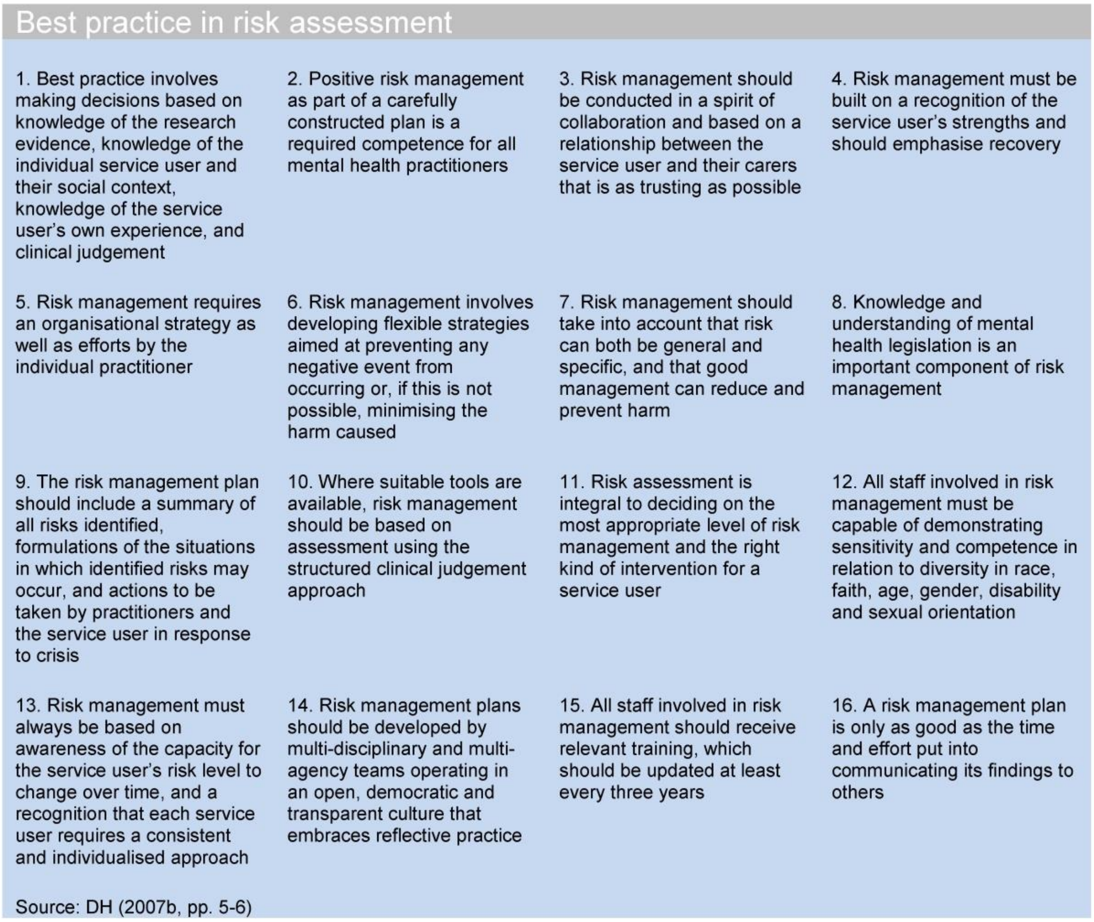
As demonstrated in these examples, clinicians are expected to assess and manage a broad range of risk behaviours, each with their own cluster of static and dynamic variables. However, Muir-Cochrane and Wand suggested a broad range of risk management strategies that may assist the clinician in this process:

Image has been removed due to copyright restrictions.

Figure 23: Stages of the Risk Management Cycle

Reproduced directly from Muir-Cochrane and Wand (2005, p. 9).

Other risk management strategies of note include education and training for carers in order to improve the recognition of the risk behaviours and the delivery of efficacious treatments (Dickens 2010). Clinicians in this study identified a diverse range of risk management strategies that they used in their practice. That said, these clusters, being inclusion (of the patient, outside resources, and other staff), staffing and skills set, knowing the patient (including the triggers), the creation of supportive environments, and accessibility of information are very broad, as they need to be. Chaplin et al. clearly delineated what is considered to be best practice in RAM (*see* Figure 24 below). Again, the divorce between mental illness and behaviour is recognised.



Best practice in risk assessment

1. Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience, and clinical judgement

2. Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners

3. Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible

4. Risk management must be built on a recognition of the service user's strengths and should emphasise recovery

5. Risk management requires an organisational strategy as well as efforts by the individual practitioner

6. Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused

7. Risk management should take into account that risk can both be general and specific, and that good management can reduce and prevent harm

8. Knowledge and understanding of mental health legislation is an important component of risk management

9. The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis

10. Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach

11. Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user

12. All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation

13. Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach

14. Risk management plans should be developed by multi-disciplinary and multi-agency teams operating in an open, democratic and transparent culture that embraces reflective practice

15. All staff involved in risk management should receive relevant training, which should be updated at least every three years

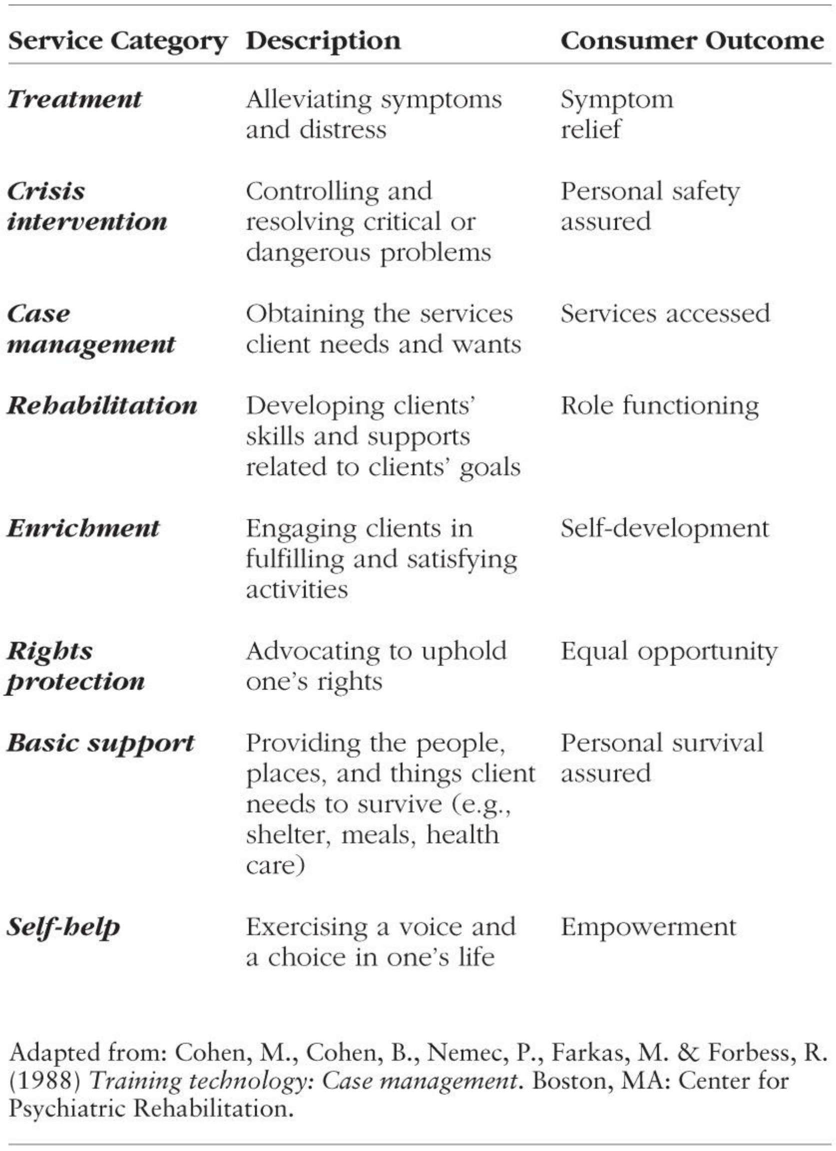
16. A risk management plan is only as good as the time and effort put into communicating its findings to others

Source: DH (2007b, pp. 5-6)

Figure 24: Best Practice in Risk Assessment

Reproduced directly from Chaplin et al. (2012, p. 282).

On the other hand, Anthony (1993, p. 524), a proponent of the recovery approach to care, looked at "Essential Client Services in a Caring System", which is quite different to the more "traditional" caring trajectory previously considered in this chapter. The contrast is clearly evident when comparing Figure 24 (above) to Figure 25 (below). Anthony considered that the system needs to consider alleviating the symptoms, resolving dangerous problems (arguably managing risks), upholding human rights, and providing basic support services.



Service Category	Description	Consumer Outcome
Treatment	Alleviating symptoms and distress	Symptom relief
Crisis intervention	Controlling and resolving critical or dangerous problems	Personal safety assured
Case management	Obtaining the services client needs and wants	Services accessed
Rehabilitation	Developing clients' skills and supports related to clients' goals	Role functioning
Enrichment	Engaging clients in fulfilling and satisfying activities	Self-development
Rights protection	Advocating to uphold one's rights	Equal opportunity
Basic support	Providing the people, places, and things client needs to survive (e.g., shelter, meals, health care)	Personal survival assured
Self-help	Exercising a voice and a choice in one's life	Empowerment

Adapted from: Cohen, M., Cohen, B., Nemec, P., Farkas, M. & Forbess, R. (1988) *Training technology: Case management*. Boston, MA: Center for Psychiatric Rehabilitation.

Figure 25: Essential Client Services in a Caring System

Reproduced directly from Anthony (1993, p. 524).

From the two examples above, it can be seen that since the 1990s, there has not only been a shift away from patient-focused care, but that risk management now predominantly encompasses crisis interventions. These findings support the ideas of Sawyer (2005) who contended that a patient's treatment plan has now been replaced by a management plan which is solely focused on control and supervision, including an "unequivocal" association with the containment of risk.

9.4.3 Patient Discharge: The Tension between Risk and Recovery

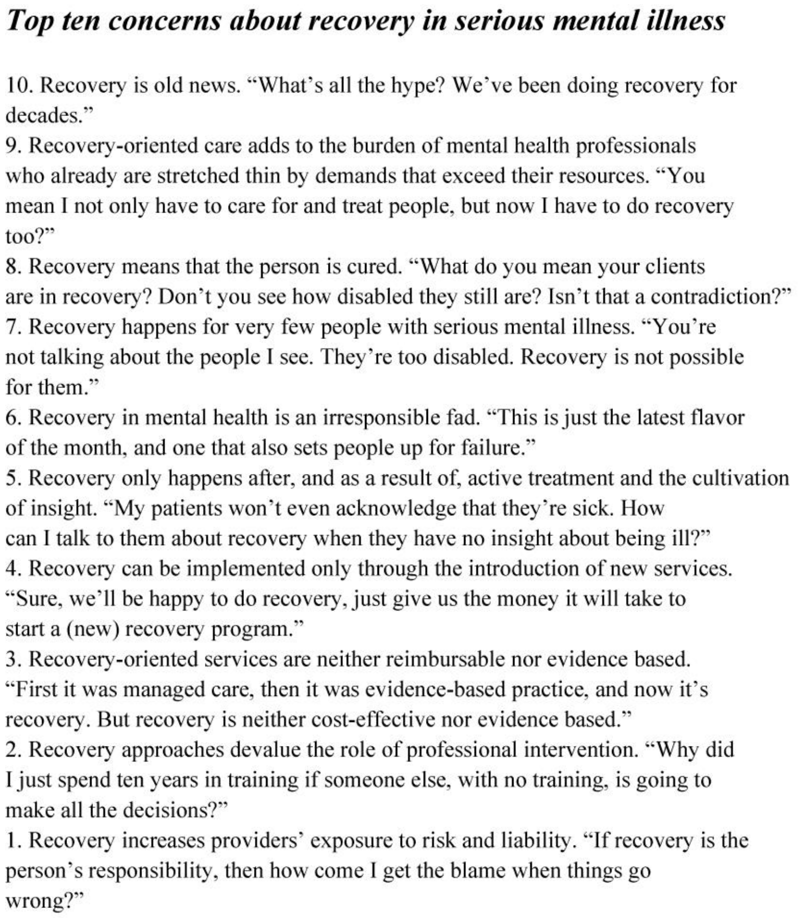
> *Recovery is what people with disabilities do … Recovery is a multi-dimensional concept: there is no single measure of recovery, but many different measures that estimate various aspects of it (Anthony 1993, p. 528).*

There is only limited research into what the term “recovery” actually means (Leamy et al. 2011). The ACMHN defines recovery to mean:

> *… a personal process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying life through the development of new meaning and purpose as the person grows beyond the effects of psychiatric disability (ACMHN 2016, p. 28).*

Slade (2009, pp. 35-40) argued however that there are two “versions” of recovery: clinical and personal. Clinical recovery has the following key features: an observable and objective outcome, determined by the clinician (not the patient), with the definition of recovery not varying between patients. On the other hand, personal recovery is a continuing journey that moves from surviving to growing, from disengagement to engagement, and has many routes, each of which is individual to each person. This does not involve a cure. It is interesting to note that while Slade (2009, p. 39) considered personal recovery to have “high ecological validity … it makes that operationalisation of the concept and empirical investigation problematic”. Slade provided a compelling argument that clinical recovery and personal recovery could be incompatible primarily because, for clinical recovery, there must be an abatement of symptoms, whereas personal recovery does not require this. Similarly, Slade argued that symptoms in mental illness are not altogether “bad”, in fact, mental illness can co-exist with high achievement, while recovery can be more about the “relationship” with the symptoms.

In this thesis, recovery to the clinician means the abatement of “risky” behaviours. Furthermore, it has been established that there is a divorce between mental illness and behaviour. There now seems to be a dichotomy when considering the Recovery Framework in this context. Are we talking about recovery from a mental illness, or recovery from “bad behaviours”? I would argue, for the purposes of this thesis, that recovery for clinicians is about stopping “bad”/”risky” behaviours. These issues are considered by Davidson et al. in Figure 26 below, listing the top ten concerns about recovery in serious mental illness:



Top ten concerns about recovery in serious mental illness

10. Recovery is old news. "What's all the hype? We've been doing recovery for decades."
9. Recovery-oriented care adds to the burden of mental health professionals who already are stretched thin by demands that exceed their resources. "You mean I not only have to care for and treat people, but now I have to do recovery too?"
8. Recovery means that the person is cured. "What do you mean your clients are in recovery? Don't you see how disabled they still are? Isn't that a contradiction?"
7. Recovery happens for very few people with serious mental illness. "You're not talking about the people I see. They're too disabled. Recovery is not possible for them."
6. Recovery in mental health is an irresponsible fad. "This is just the latest flavor of the month, and one that also sets people up for failure."
5. Recovery only happens after, and as a result of, active treatment and the cultivation of insight. "My patients won't even acknowledge that they're sick. How can I talk to them about recovery when they have no insight about being ill?"
4. Recovery can be implemented only through the introduction of new services. "Sure, we'll be happy to do recovery, just give us the money it will take to start a (new) recovery program."
3. Recovery-oriented services are neither reimbursable nor evidence based. "First it was managed care, then it was evidence-based practice, and now it's recovery. But recovery is neither cost-effective nor evidence based."
2. Recovery approaches devalue the role of professional intervention. "Why did I just spend ten years in training if someone else, with no training, is going to make all the decisions?"
1. Recovery increases providers' exposure to risk and liability. "If recovery is the person's responsibility, then how come I get the blame when things go wrong?"

Figure 26: Top ten concerns about recovery in serious mental illness

Reproduced directly from Davidson et al. (2006, p. 642).

Davidson et al. went further, identifying the pervading concerns of clinicians:

> *… [d]oesn't honoring the choices of someone with an acute or severe mental illness involve abandoning him or her to the ravages of the illness, often to the streets? Doesn't this amount to leaving a vulnerable population of people "to rot with their rights on" (20)? Finally, providers ask, how can you tell us to promote client choice and self-determination on one hand while holding us responsible for adverse events on the other? Doesn't increasing client choice increase provider risk? (Davidson et al. 2006, p. 647).*

Although it would seem that clinicians focus on minimising risk to the detriment of therapeutic considerations, the findings of this thesis suggest a pragmatism whereby clinicians consider that risk is always present. They reconcile themselves with this and try to balance these opposing notions. It was clear in this study that the clinicians considered that the risk assessment was a snapshot in time, and situational factors such as the milieu, need to be considered at this juncture. This is in keeping with Giddens' (1999d) and Luhmann's theories (2005), whereby risk can exist as possibility and is not necessarily bad. Wand (2012) suggested that risk management must move from a focus on simply assessing the patient. Therapeutic interventions should support recovery by focusing instead on a patient's strengths (Wand 2012).

The findings of this study indicate that clinicians believe that they collaborate with patients and consider them to be responsible for their care as much as their capacity allows. The clinicians considered collaborating with the patient as empowering for them, which then fostered patient recovery. However, when examining the notion of collaboration discussed in the preceding section, it is clear that patients were included but not collaborated with, although collaboration can be aligned with inclusion in certain instances. Clinicians included patients in their care through information gathering, to then allow care plans (risk management plans) to be developed. Families were also included in this process as they provided the context of the admission. Rydon (2005) found that a clinical understanding of the nature of the illness underpinned this collection of information, not only to minimise risk, but also to benefit the patient and the care they received. However, this is at odds with the Victorian Government Department of Human Services (2009) who consider inclusion to be patient participation through allowing these perspectives to be heard and then attempting to incorporate these into policy, research, and the care provided. This can then influence "the way mental health services are delivered" (2008, p. 4).

The clinicians did mention the importance of listening to the patient (as one aspect of including the patient in their care). However, the interviews demonstrated that listening to the patient was not designed to influence care delivery; rather, this was done in order to eliminate the patients' fears and to gather further collateral information which the clinician could use to create an individualised care plan. This allowed the avoidance of triggers for the patient. This elimination of triggers was beneficial for the patient as they did not suffer any distress (either from the trigger or the behaviour thereafter). The side benefit of this for the clinicians was that the emotive actions from the patient were not transferred to the milieu, and this prevented triggers occurring for other patients. Yet, the clinicians' ultimate goal was to reduce risk within an environment that consistently sought to minimise risk and potential litigation. Choices were then provided for the patient, but were dependent upon a number of variables, but the patient's right to be involved in their own care was often limited. Instead, the patients were integrated into a group of health-care professionals who sought to gain knowledge in order to care for the patient appropriately.

Inclusion of the patient was also considered within another context by the clinicians, that of providing information to the patient about their levels of risk. The provision of this information was considered important for the clinicians in order to foster understanding with the patient and perhaps to gain further insight. This seemed to indicate that the clinicians attempted to reduce risk by engendering an understanding in the patient as to why the risk minimisation strategies were in place. This involvement was an attempt by the clinicians to encourage patients to take some form of responsibility for their own recovery, although the clinicians were careful to note that diminished capacity was of concern. This notion of "responsibilisation" (Langan 2009) and self-management of behaviour has the potential to be detrimental for the patient if they are unwilling to act accordingly, with Langan (2009) suggesting that the end result could be coercion and control from clinicians, which is perceived to be a justifiable result if the patient is non-compliant.

Nevertheless, the patients' right to be involved in their own care was advocated by most clinicians, although this involvement was within the context of the patients' roles and responsibilities. Breeze and Reppers (1998) found that patients were not responsible for negotiating a care plan; rather, one was presented to them. The patients in their study had difficulty complying, feeling that it was unrealistic, and stating that this then led to coercion or force. However, recognition of differing roles and responsibilities when operating within an "environment of shared risk" is also acknowledged by Life Without Barriers (2008, p. 8). Yet, there has been limited discussion in the literature as to whether patients should be aware that they are the subject of risk assessment, although there is currently a movement towards greater transparency (Langan 2009).

To achieve involvement, the clinicians also attempted to engage the patients and their carers. This meant that the clinicians explained key strategies in order to provide a limited range of care choices, or to gain support from the family. These again were aimed at minimising risk. Patient perspectives did not appear to be considered at this point of intersection. However, it is difficult to ascertain whether the clinicians did factor these perspectives into care planning. Hence, one could not conclusively say that gaining these perspectives influenced the assessment or management of risk (the care plan). The role of patients in this instance was limited to the communication of concerns and the voicing of problems encountered.

The lack of agency in these instances can be reconciled with the social inequities (Beck 2007; Giddens 1981) that patients may experience within this environment of care. Moreover, the tension between the minimisation of risk, patient involvement, and professional imperatives can contain a number of contradictions (Langan (2008). For example, novice clinicians may manufacture uncertainties (Beck 2000), while at the same time, the premise behind the Recovery Model (Barkway 2009b, p. 257) is that patients must be able to take risks in order to recover. However, as a result of the manufactured uncertainties, patients may be met with resistance from clinicians and thus, patient recovery may be impeded.

The above is at odds with the Victorian Government Department of Human Services (2009, p. 26) who considered that patients should be part of an equal partnership/relationship with healthcare professionals in their “assessment, treatment or support”. Similarly, one of the main guiding principles of Life Without Barriers (2008, p. 8) is that healthcare professionals need to value the “choices patients make”. Breeze and Repper (1998) found that a subtle version of control is used to restrict the patient’s voice. Patients stated that they had no say in their care, and instead, a care plan was presented to them. The lack of input during this time led to unrealistic expectations being placed on the patients. They became non-compliant and this resulted in clinicians forcing/coercing the patient to comply (in order to implement the care plan). Overt measures of “rebellion” from the patient could be violence or absconding, whilst covert measures may result in refusal to engage (Breeze & Repper 1998). Patients may then be constructed as “difficult” (Breeze & Repper 1998) leading to a clinical obligation for clinicians to “take control”, regardless of the ensuing struggle (Breeze & Repper 1998). The subtle control exerted by these clinicians could be compared to Menzies’ (1960) findings, theorising that this is an attempt by clinicians to control anxiety-provoking situations.

When applying these considerations to the current study, it could be argued that an aspect of hidden control operates when the participants provided healthcare that consisted of limited choices/no input. This may be quite unconscious on the clinicians’ behalf; however, the findings strongly suggest that there is not an equal partnership between the clinician and patient. There remains a lack of evidence exploring whether there is an equal partnership between these individuals and the organisation, although it is probable that this relationship is also inequitable. Luhmann (2005) suggested that individual agency may only occur if it is free of the structure in which it resides. This means that it is possible that the structure within which the clinicians and patients are embedded does not allow for individual agency for either party. It could then be argued that the structure does not allow agency for the clinicians who must operate within the confines of structural rules and mandates. Likewise, the patient is contained within a structure that may not recognise the value of their knowledge when it comes to their own treatment. Beck (1996) highlighted a potential dilemma that focuses on lack of agency (although his theorising is different to Luhmann’s) in his discussion of reflexive modernisation. In this, he explored how, on one hand, people must take responsibility, yet on the other hand, are not afforded the agency to do so. In this current study, clinicians are required to accept responsibility for assessing and managing risk, while patients are encouraged to take responsibility for their own recovery. This may provoke more anxiety for both the clinicians and the patients.

Clinical paternalism and ethical mandates should also be considered within this context. Alaszewski (2006, p. 7) suggested that risk management “involves identifying and balancing outcomes [and] safety versus autonomy”. Ethical principles including beneficence, justice and also contribute (Wallace 2001, pp. 19.29-19.30). When considering beneficence, autonomy, and non-maleficence within the context of mental health and RAM, it is easy to see the dilemmas that exist for clinicians. On one hand, they must do no harm and promote self-determination, yet they also need to act for the greater good (protecting the patient and also other staff and patients). Similarly, the distribution of power, as theorised by Giddens (1984), suggests that clinicians retain the balance of power due to the monopoly they have in terms of communication and ward rule construction (Alexander 2006). Perhaps it is no wonder that inequitable relationships exist within this clinical environment. It must be acknowledged that on this ward, there are acutely unwell patients at risk of harm to self and others, and many of the patients being cared for have limited decision-making capabilities. That said, Alexander (2006, p. 550) suggested that this may be mitigated if clinicians “made greater efforts to set the rules within a therapeutic context”. Protecting the best interests of the patient has the potential to be efficacious (Cleary et al. 2009).

From this, it is clear that patient and family collaboration is a necessary aspect of policies and RAM practices; however, there is a paucity of research that considers patient involvement in RAM. Patient participation is acknowledged as providing a first person account which is able to make a genuine and important contribution in the gathering of knowledge relevant to their care and well-being (Cowling et al. 2006). Patient participation is supported nationally, with patients being recognised as being able to participate in decision-making in relation to their treatment and care, and as having significant input into the planning and delivery of staff training as well as planning policies and services (Australian Health Ministers 1992, 1995, 1998; Commonwealth of Australia 1997, 2002; National Consumer and Carer Forum of Australia 2004). Patient participation in healthcare and education is also supported by other commentators (Muir-Cochrane (2001); Gallant, Beaulieu & Carnevale (2002); Mcallister & Walsh (2004); Lathlean et al. (2006); Long et al. (2008); and Storm, Hausken & Mikkelsen (2010)). Mosel, Gerace, and Muir-Cochrane (2010) suggested that when clinical practices include discussion with patients about ward structures, the nature of admission, and treatment, then the incidence of risk behaviours, such as absconding, may be reduced.

Langan (2008) found that risk could only be assessed and managed at the point of intersection of therapeutic collaboration. While this view was shared by many of the participants in their study, they acknowledged that, in their everyday practice, they did not share the results of their risk assessment with the patient, nor were patients aware that any risk assessments were taking place (Langan 2008). Similarly, while openness in the discussion of risk was seen as useful by clinicians, Langan (2008) found that this was dependent upon a complex interplay between the quality of the relationship established, the disengagement or stigmatisation of the patient, the confidence of the professional in broaching the subject, and fear of personal safety (Langan 2008).

The findings of this current study indicated that patient involvement seemed to be influenced by the individual practices of the clinicians. While the clinicians considered that they were collaborating with patients, this involved inclusion, which is an important distinction to make. Collaborating with patients is important, and is in keeping with the Recovery Framework. The Recovery Framework can be aligned with Giddens' and Luhmann's theorising that risk can exist as possibility; however, for more risk averse clinicians, this may be what is preventing them from true collaboration. The possibility of including, and then collaborating with, patients would be worthwhile in this instance, with a focus by clinicians on the nuances that exist between the terms "including" and "collaborating". Langan and Lindow (2004) argued that while clinicians agree in principal to involving patients in their care, few translated this into action. The effective management of risk requires patients to be active in this process, with their omission reflecting a dismissal of patients' psychosocial problems (Alexander 2006). This is suggestive of Sawyer's (2005) contentions that it is no longer clear what actually constitutes ethical mental health practice or policy. As such, there remains a need for "patient involvement training" for clinicians that includes patient perspectives and is based on the Recovery Framework as part of best practice (Barkway et al. 2012; Department of Health and Ageing 2009; Langan 2008).

9.5 Conclusion

> *On the research side of the matter, scientists ought at least to consult with clinical colleagues, develop their research in clinically meaningful and helpful ways, and communicate this information to practitioners through clear channels (Douglas, Cox & Webster 1999, p. 178).*

This study has identified a number of issues and implications for clinical practice in relation to RAM. Clinical RAM practices were clearly articulated by clinicians; however, the findings demonstrated therapeutic concerns and some level of frustration with the barriers, thus preventing clinicians from practicing in an ideal way. The history of the patient engendered an awareness of the risk/s they posed which enabled the clinicians to meet patients' needs. The use of history then becomes "current armoury" (RMHN Joel), while collateral information provided a "picture on who that person has been in the past" (RN Gail) and evokes feelings of confidence when predicting risk. RAM then is about process *and* the specific type of data that clinicians collect. Collaboration was highlighted as being vital on the ward both for clinicians and patients, although the notions of "including the patient" and "collaborating with the patient" were clearly different. The prediction of risk, and the associated challenges, was a key issue raised, as was the lack of time which detracted from patient-centred care. Regardless, the organisation was supportive of training needs.

Nevertheless, there was a clear integration of RAM practices on the ward that appeared to be evidence-based. The clinicians demonstrated high levels of autonomy in their practice, although there were high levels of risk aversion, which can be aligned with Beck and Giddens' theorising of risk society. In addition, Menzies' theories of social defence mechanisms were evident. Issues such as legalism, "responsiblisation", and "managerialism" existed in this context, with clinicians seeking to balance these with therapeutic care. Navigating around these issues was particularly difficult and demonstrated their pervasive nature, particularly because what has been established here is that the process of risk assessment actually creates risk.

9.6 Implications for practice

Meeting the aims and objectives of this thesis together with the appropriate dissemination of the findings may impact upon practice by encouraging collaboration between health researchers and clinicians, and may also encourage deep reflection on risk as a social construction, thereby enhancing the development of reflective practice (Barbour 2000). This study also has the potential to promote evidence-based practice, as the research process (through the interviews) has the ability to promote reflection, which can then influence clinical decision-making and clinical behaviour. This will obviously impact upon the care that the patient receives. This research may also aid clinicians by facilitating evidence-based nursing interventions within Australia (Barbour 2000; Barbour & Barbour 2003; Bowers, Jarrett & Clark 1998). The unpacking of risk assessment and the management of risk has potential applications in supporting clinical learning, collaborative work with patients, and organisational constructs. The assessment and management of risk are often obscured from view, most likely because of the intuitive component (MacNeela et al. 2010, p. 1305). This may then give credence to rehabilitation and personal empowerment for both clinicians and patients (MacNeela et al. 2010, p. 1305).

The next chapter will provide an executive summary, an overview of the limitations of the research, and will conclude the thesis.

10 NEW UNDERSTANDINGS

Such conflicts surrounding the ontological status—and thus social legitimacy—of behavioral and emotional ills have been endemic since their widespread articulation well over a century ago (Rosenberg 2006, p. 123).

To conclude this thesis, I highlight the manner in which the findings presented here offer new approaches to healthcare professionals in the ways they undertake risk assessment and management (RAM). This thesis is intended to promote deeper thought, and greater reflection and recognition of the ways in which RAM may promote criminogenic thinking as opposed to a Recovery Framework by clinicians. In this chapter, I consider a new way of understanding that has developed as a result of viewing risk and RAM through a different lens and the limitations of this research.

10.1 Conceptual Summary

This thesis has taken the reader through a journey about the construct of risk in the context of psychiatric care. This notion of “risk” has been argued to be socially constructed by way of stereotyping patients diagnosed with a mental illness, and has been present in legislation, ethical guidelines, public health policies, and the institutional and bureaucratic culture of the organisation.

Firstly, I presented the theoretical lens through which I interpreted the findings of this research study. I argued, through the theory of social constructionism, that risk was a socially constructed phenomenon, establishing that this is what is played out in the clinical setting. I considered the defence mechanisms and the ways in which clinicians use these and, in this way, these also add to the social construction of risk. The language of risk was seen to always be a social construct, and that perceptions of risk can create anxiety both in the clinician and the patient.

After this, I was able to bridge the divide between theoretical postulations and how these were played out in the clinical setting by exploring the history of mental healthcare from the 18th Century to now. By creating this understanding through the examination of past practices, what was revealed was a transition from “badness” to “madness” to the notion of risk in mental healthcare being constructed as a form of danger to be minimised. As established in this chapter, we now live in “risk society”, and institutions and (by default) individuals, frame everything around risk. Society has changed dramatically and, as a result, the entire psychology of the individuals who live in that society changes. For Beck, this means the transition to “risk society”.

The contemporary literature was then examined, which revealed the current state of play of RAM in mental healthcare. What was found was a lack of robust research about RAM practices in mental healthcare, and strikingly little consideration of this from the clinicians’ perspective. This paucity of research enabled the identification of the research problem, and the aims and objectives of this study were generated in order to fill this significant gap in the research.

In order to reach the aims and objectives of this thesis, this study was designed using unique and innovative methods. I argue that those described were the most appropriate way to meet the stated aims. A rigorous mode of inquiry was described and an audit trail established.

The first of three findings chapters was then presented. As a result of my journey thus far, I drew on the findings of Chapters Six, Seven, and Eight, selecting and examining the relevant legislation together with the legal and ethical frameworks that influence RAM, provided a critical commentary, and contextualised this within the Australian mental healthcare system using the contemporary literature. I found in this document analysis, that risk assessment tools and the risk management of the patient in psychiatric care (which becomes the care plan) are sorely inadequate. This reliance on the forms (tools) transferred the responsibility of decision-making away from the clinician which served to alleviate their anxieties. Importantly, the data revealed that the risk management plan of the patient actually becomes their care plan, and has the potential for deleterious physical effects as a result. The diversity of risk was identified and it was found that this diversity influences the interpretations of risk.

The perspectives of the clinicians were then examined in Chapters Seven and Eight.

It became clear that the direct clinical aim of the participants who were part of the multidisciplinary healthcare team was to forestall risk. In this way, the clinicians aimed to minimise patients' "risk behaviours". The participants clearly described the anxiety they felt, but mitigated these anxieties by engaging in purposeful tasks. Overall, RAM was integral to clinical practice, but it was identified as a complex process that involved not only the collection and analysis of information, but also working within an environment of collaboration. In this way, risk and its construction in mental healthcare emerged.

I then moved on to consider what all this means, particularly for clinicians, patients, significant others, policy-makers and so on. From these considerations, what I was able to establish in Chapter Nine was that the process of these assessments, and the attempts at managing those identified, actually created risks.

Conceptually, I have summarised the findings in this thesis diagrammatically in the next section (*see* Figure 27), which demonstrates how these findings are related to risk, and how they fit together. From the theoretical lens applied to the findings of Stage One, the themes and sub-themes sat within three iterative layers centred on the concept of risk. These layers included understandings of risk, the clinical assessment of risk on the ward as applied to the environment, staff, consumers, and visitors, and the clinical practices in relation to assessing and managing risk. Predominantly, "Layer 1: global understandings of risks", remains hidden on many occasions, but nevertheless will shape the participants' overall risk assessments and the subsequent management of risk. More explicitly, somewhere between Layers 1 and 2 is the legal and organisational context together with the ward culture, and this is where the findings of Stage Two fit. This is because, for the clinicians, risk in this context is understood as existing according to institutional and legal constraints. Layer 2 is the participants' assessments of risk in the clinical setting, while Layer 3 consists of the clinical practices, the aim of which is to minimise the identified risks that are present for the consumer, the staff, and the public. The findings generally sit within (or overlap) Layers 2 and 3. Examples are provided in this conceptual summary which relate to the research study's aims and objectives. For example, RAM is perceived by the participants to be everybody's responsibility. The participants were very clear that knowledge of the consumer and access to this information was crucial and allowed their risk assessments to be effective. Their attitude towards the organisation was positive, and the organisation was seen to be generally supportive of RAM. The participants considered communication to assist effective RAM practices, with RAM training and education further benefitting their RAM needs. Clinical experience also aided their risk assessments. However, a number of barriers were identified, which included role and task confusion and a lack of cohesion between team members. The participants were concerned about the consumer's capacity to engage, which therefore limited their role in RAM. This resulted in the consumer having a limited range of choices. From the findings of Stage One and Two, and a sustained investigation into the concept of "risk society", the historical origins of risk and RAM and clinical literature available to date, the issues facing health professionals were then identified.

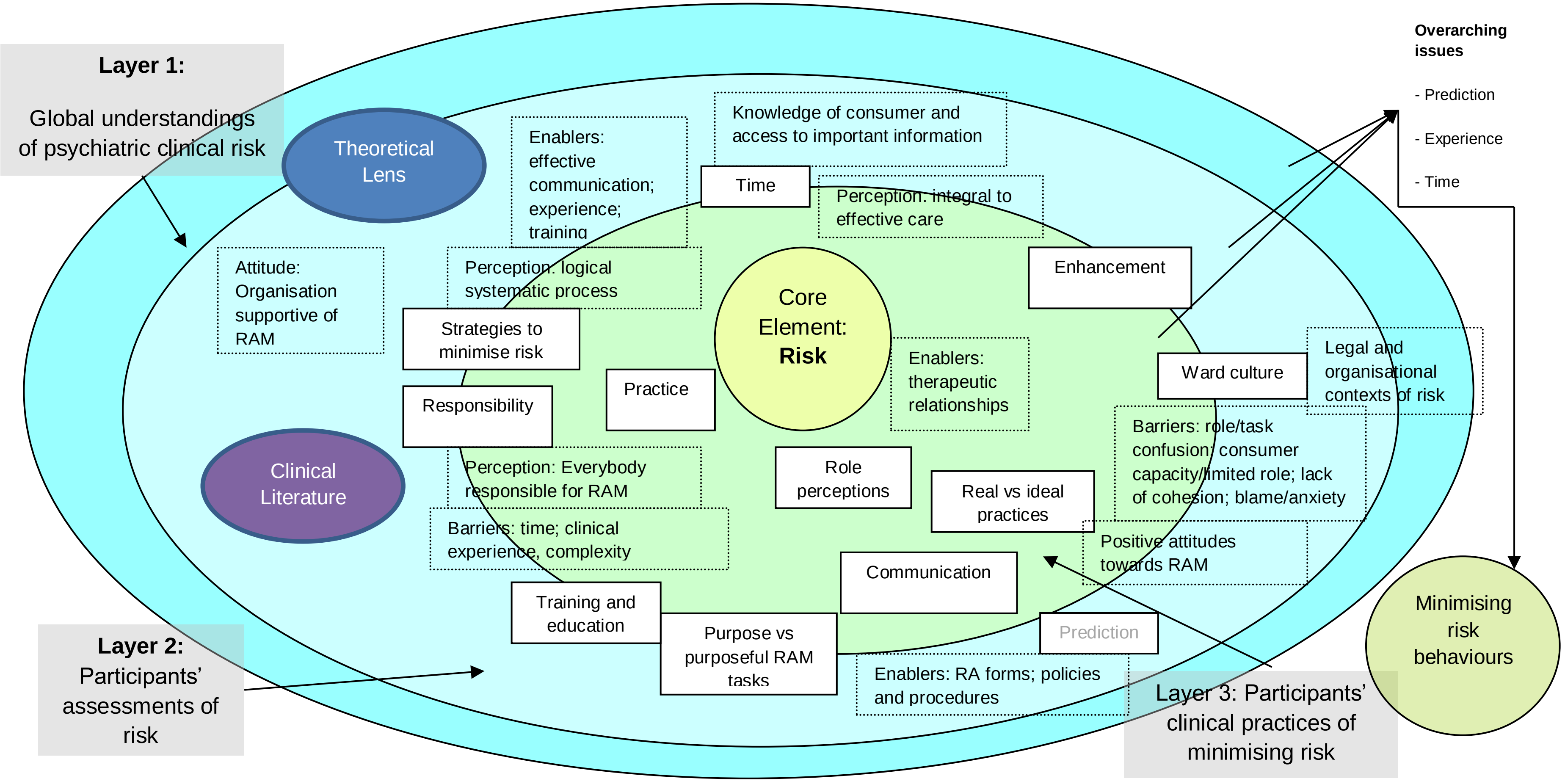


Figure 27: Conceptual Summary

Source: Original

10.2 “Risk Society”

This thesis established that “risk society” has indeed manifested in the clinical environment. In this way, the medicalisation of social deviance has evolved and has redefined mental healthcare as we see it today. This manifestation is now seen to be the management of symptoms and serves to undermine the diagnosis of the patient. The notion of dangerousness, as conceptualised by Beck, is now considered to be viewed as a risk and this has allowed clinicians to deal with this uncertainty. This thesis has described the societal attempts at control aimed at providing predictable security in the clinical setting and, as Beck has theorised and which is evident here, has become a political issue. These concepts described by Beck are unmistakable and seen in both the legislative and policy discourse, through to the clinicians’ perspectives on risk and RAM.

10.3 The Organisational Context

Clinical paternalism, legislative requirements, and ethical mandates were seen to drive how the organisation operated and directed their policies and procedures, while RAM became an organisational attempt to tame anxiety. As such, the balancing of the outcomes of safety and autonomy is tricky. Yet, the distribution of power is clearly in the organisation’s hands, and clinicians are mandated to adhere to the policies and procedures set forth by the organisation. It would seem that the therapeutic context of care is absent from these legal and procedural requirements, and instead, is left in the hands of clinicians who seek to minimise risk and to transfer responsibility away from themselves. More strikingly however is the finding that organisational expectations require clinicians to assess a broad range of risk behaviours, yet each (organisational expectations, clinician and patient behaviours) have their own cluster of dynamic and static variables. It is clear that best practice in RAM does not necessarily transfer into clinical settings, and that the divorce between mental illness and behaviours is still apparent.

10.4 Patient Care Plans

One critical finding of this study is that managing risk meant, for the clinicians, that they were providing clinical care, and it was in this way that the risk management tool actually became the care plan for the patient. While it is acknowledged that there exist very real risks, this thesis has established that many of these are in fact manufactured, and function as ways of alleviating anxieties, rather than being therapeutic for the patient. These are then rationalised as being the first imperative in order to minimise risks to patients, staff, and the general public, and the use of these tools promotes feelings of safety which is engendered by the creation of both risk and scientific awareness. In this way, this becomes a form of “risk consciousness” rather than “therapeutic consciousness” and, as such, the tension between risk and recovery is real, and is of concern from the perspective of the patient.

10.5 A New Way of Understanding

This research stems from a local imperative, a global priority, and a number of theoretical perspectives. There is a lack of robust research that identifies issues that clinicians face when undertaking risk assessment, including their perceptions and knowledge of the process. Moreover, the methods of assessment and the current practices used to reduce risk behaviours are often not based on evidence, but instead on widely-held beliefs (Bowers et al. 2002; Haglund, Von-Knorring & von-Essen 2006; Melvin, Hall & Bienek 2005; Muralidharan & Fenton 2006). As such, the purpose of this thesis has been to develop an understanding of the issues facing health professionals in undertaking psychiatric risk assessment and management, to describe what happens around risk, and to provide a critical commentary on risk within the context of the holistic approach to psychiatric care. The aims of the thesis were not only to develop this understanding and to provide a critical commentary, but also to explore the clinical barriers and enablers of RAM, explore the legislative and ethical frameworks that exist around RAM, to consider the social construction of risk, examine nursing care plans, and to comment on how risk has been conflated with care. The findings which have been presented over three chapters present new understandings and offer clinicians a new way of approaching RAM in clinical settings.

Importantly, this thesis has added to the body of knowledge by identifying that:

- Risk is, and still remains, a social construct;
- RAM is always bound with the historical aspects of madness;
- Risk assessment takes place within a broad cultural, social, and political context with a complex interplay between the human desire to blame, views of mental illness, public safety mandates, and socio-economic factors;
- Risk cannot be effectively predicted;
- Anxieties that arise from real risks or manufactured uncertainties affect the care the patient receives;
- Transparency of risk assessments are non-existent to the patient;
- The patient is generally not involved in RAM processes;
- It remains unknown as to whether RAM is based on clinical judgement alone or whether it is based partly or fully on prejudices/biases;
- The tensions that play out are beyond the influence of clinicians and patients alone;
- Risk management is the care plan, but cannot co-exist with the notion of healing or the Recovery Framework.

10.6 Limitations

10.6.1 Socio-historical

Before proceeding further, it must be pointed out that in this thesis, I did not intend to provide the differing positions of socio-historical theorists. Where, for example, Porter (1987) criticised the work of Foucault (1965), who contended that the "Great Confinement" (lunatic asylums) arose in the 18th century, while Porter asserted that this happened in the 19th century. Nor do I consider the challenge by Scull (2005) to the work of Foucault (1965), criticising that his work contains only French-sourced materials. Rather, the major focus of this chapter is on risk society contextualised within the mental health arena, with the other eras presented briefly here in order to "skim" over the broad socio-historical factors in mental healthcare that can lead us to an understanding of mental healthcare in risk society.

It is also important to be aware that the underpinning premise of this chapter is that "not all madness is socially constructed, however cultural expectations certainly impact on how madness is expressed and understood" (Ahmed 2013, p. 4). The historical constructions of mental healthcare and mental illness presented in this thesis are considered not as "indisputable facts, but rather a telling of non-fictional stories", which then allows one to consider the gaps in knowledge in an objective and more complete way (Ahmed 2013, p. 13).

10.6.2 Issues of heterogeneity

Issues of heterogeneity still abound within the context of this thesis, particularly where risk assessment practices vary in different organisations, even from ward to ward or from individual to individual. Likewise, patient population groups are different and vary in the same way as risk assessments, as do staff on the ward as well. For these reasons, while the methodology and methods of this research have been clearly described and justified, the findings here may not necessarily be transferable to other settings.

Finally, it is hoped that this thesis might allow clinicians to "see" that the focus on risk, at the expense of therapy, may be detrimental to patient recovery. I now conclude with the musings of Rosenberg (2006) in the context of risk, mental illness, and the care the patient receives:

> *… [the] line between disease and willed misbehavior or culpable self-indulgence—or idiosyncratic emotional discomfort—will not easily be agreed upon, while the cultural and bureaucratic need to create such boundaries will hardly disappear. Meanwhile individual men and women, lay and professional, act out complex and not always consistent agendas shaped by personal, familial, generational, and social locational realities … Billions of dollars and many thousands of lives have been altered by deeply felt and widely disseminated assumptions … Are such behaviors the symptoms of a chronic disease (with a biochemical and perhaps genetic substrate) that demands treatment? Or are they crimes to be punished? (Rosenberg 2006, pp. 122-3).*

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12 APPENDICES

Appendix A: Literature Included In Selective Review

Total	Per Cluster	Article	Summary	Nature
Adult Acute Care Psychiatric Risk Assessment and Management Studies				
1.	**1.**	Antonysamy, A 2013, 'How can we reduce violence and aggression in psychiatric inpatient units?', *BMJ Quality Improvement Reports*, vol. 2, no. 1, pp. 1-3.	Implementation of three interventions to reduce violence and aggression on the ward as a risk management strategy.	Triangulated. Credible. Sample not identified. Acute care psychiatric. UK.
2.	**2.**	Bishop, D & Ford-Bruins, I 2003, 'Nurses' perceptions of mental health assessment in an acute inpatient setting in New Zealand: A qualitative study', *International Journal of Mental Health Nursing,* vol. 12, no. 3, pp. 203-212.	An exploration of mental health nurses' perceptions of mental health assessments.	Qualitative. Credible. Semi-structured interviews mental health nurses *n*=14. Acute care psychiatric. New Zealand.
3.	**3.**	Bhui, K, Outhwaite, J, Adzinku, F, Dixon, P, Mcgabhann, L, Pereira, S & Strathdee, G 2001, 'Implementing clinical practice guidelines on the management of imminent violence on two acute psychiatric in-patient units', *Journal of Mental Health*, vol. 10, no. 5, pp. 559-69.	Implementation of new clinical practice guidelines on two wards, focused on risk of violence. Discussion of clinical practice guidelines on managing imminent violence.	Triangulated. Credible; L.4. *n*=37 violent incidents; *n*=8 service users. Acute care psychiatric. UK.
4.	**4.**	Campion, J, Lawn, S, Brownlie, A, Hunter, E, Gynther, B & Pols, R 2008, 'Implementing smoke-free policies in mental health inpatient units: Learning from unsuccessful	Implementation of a smoke-free policy in one acute care mental health unit. Explores aggressive incidents within the context of risk assessment and management.	Triangulated. *n*=6 interviews; descriptive statistics comparison risk incidences. Acute care psychiatric. Australia.

Total	Per Cluster	Article	Summary	Nature
		experience', *Australasian Psychiatry*, vol. 16, no. 2, pp. 92-97.		
5.	**5.**	Emmerson, B, Fawcett, L, Ward, W, Catts, S, Ng, A & Frost, A 2007, 'Contemporary management of aggression in an inner city mental health service', *Australasian Psychiatry,* vol. 15, no. 2, pp. 115-119.	Risk management of aggression and injuries in one hospital. Explores the profiles of consumers likely to be aggressive and other variables.	Quantitative. L. 3.3. Pre Post Strategy. *n*= 17.42 aggressive incidents per month pre; 13.0 post (significant). Acute care psychiatric. Australia.
6.	**6.**	Gerace, A, Curren, D & Muir-Cochrane, E 2013, 'Multidisciplinary health professionals' assessments of risk: How are tools used to reach consensus about risk assessment and management?', *Journal of Psychiatric and Mental Health Nursing*, vol. 20, no. 6, pp. 557-563.	An exploration of the role of risk assessment tools in one acute care psychiatric hospital.	Qualitative. Credible. *n*=14. Acute care psychiatric. Australia.
7.	**7.**	Grotto, J, Gerace, A, O'Kane, D, Simpson, A, Oster, C & Muir-Cochrane, E 2015, 'Risk Assessment and Absconding: Perceptions, Understandings and Responses of Mental Health Nurses', *Journal of Clinical Nursing*, vol. 24, no. 5/6, pp. 855-65.	Nurses experiences were explored within the context of patients that absconded. The paper focused on absconding risk assessment and management strategies.	Qualitative. Credible. *n*=11. Acute care psychiatric. Australia.
8.	**8.**	Hartvig, P, Roaldset, J, Moger, T, Østberg, B & Bjørkly, S 2011, 'The first step in the validation of a new screen for violence risk in acute psychiatry: The inpatient context', *European Psychiatry,* vol. 26, no. 2, pp. 92-99.	Validates structured clinical risk assessments for inpatient violence.	Quantitative. Tool validation. L.3.3. Acute care psychiatric setting. Norway.
9.	**9.**	Higgins, N, Watts, D, Bindman, J, Slade, M & Thornicroft, G 2005, 'Assessing violence risk in general adult psychiatry', *Psychiatric Bulletin,* vol. 29, no. 4, pp. 131-133.	Establishes current risk assessment practices in relation to harm in general adult psychiatry.	Qualitative. Credible. *n*=45. Acute care psychiatric. UK.
10.	**10.**	Higgins, A, Doyle, L, Downes, C, Morrissey, J, Costello, P, Brennan, M & Nash, M 2016, 'There Is More to Risk and Safety Planning Than Dramatic Risks: Mental Health Nurses' Risk Assessment and Safety-Management Practice', *International Journal of Mental Health Nursing*, vol. 25, no. 2, pp. 159-70.	Explores risk assessment and risk management from the perspective of mental health nurses and investigates how nurses conceptualise risk including how they engage with risk assessment and planning for safety.	Quantitative. L.4. *n*=381. Descriptive statistics, including frequency distributions, means, and standard deviations. Acute care psychiatric. Ireland.

Total	Per Cluster	Article	Summary	Nature
11.	**11.**	Langan, J 2008, 'Involving mental health service users considered to pose a risk to other people in risk assessment', *Journal of Mental Health*, vol. 17, no. 5, pp. 471-81.	Investigating how mental health professionals assess risk, and the involvement of consumers in this process.	Qualitative Credible. Users *n*=13; MHP *n*=46. Acute care psychiatric. UK.
12.	**12.**	Lepping, P, Steinert, T, Needham, I, Abderhalden, C, Flammer, E & Schmid, P 2009, 'Ward safety perceived by ward managers in the UK, Germany and Switzerland: Identifying factors that improve ability to deal with violence', *Journal of Psychiatric & Mental Health Nursing*, vol. 16, no. 7, pp. 629-35.	An evaluation of ward safety over three countries. Explores risk assessment and management in the context of aggression - efficacy of standards, training and methods used to reduce risks.	Quantitative. L.4. Switzerland *n*=81; UK/Wales *n*=4; Germany *n*=9. Acute care psychiatric. 4 countries.
13.	**13.**	Modai, I, Hirschmann, S, Hadjez, J, Bernat, C, Gelber, D, Ratner, Y, Rivkin, O, Kurs, R, Ponizovsky, A & Ritsner, M 2002, 'Clinical evaluation of prior suicide attempts and suicide risk in psychiatric inpatients', *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, vol. 23, no. 2, pp. 47-54.	Establishing models for decision-making related to suicide risk. Clinically tested four models regarding the influence previous suicide attempts had on clinical decision making using a series of discriminant analyses.	Quantitative. L.4. *n*=250 psychiatric inpatients; *n*= 40 psychiatrists. Acute care psychiatric. Israel.
14.	**14.**	Moore, E & Hammond, S 2000, 'When statistical models fail: Problems in the prediction of escape and absconding behaviour from high-security hospitals', *The Journal of Forensic Psychiatry,* vol. 11, no. 2, pp. 359-371.	Explores absconding behaviour - risk, within the context of predicting problematic behaviours in mental health settings. The difficulties with statistical methods are identified.	Quantitative. L.4. *n*=44 / control *n*=5133. Acute and extended care psychiatric. UK.
15.	**15.**	Muir-Cochrane, E, Gerace, A, Mosel, K, O'Kane, D, Barkway, P, Curren, D, & Oster, C 2011, 'Managing risk: Clinical decision-making in mental health services', *Issues in Mental Health Nursing*, vol. 32, no. 12, pp. 726-734.	An investigation into risk assessment practices within a multidisciplinary acute care psychiatric service.	Qualitative. Credible. *n*=15. Acute care psychiatric. Australia.
16.	**16.**	O'Donovan, Á & Gijbels, H 2006, 'Understanding psychiatric nursing care with non-suicidal self-harming patients in acute psychiatric admission units: The views of psychiatric nurses', *Archives of Psychiatric Nursing,* vol. 20, no. 4, pp. 186-192.	Examines findings of one study that attempted to gain understanding of nursing practice pertaining to consumers that self-harm in absence of suicidal ideations.	Qualitative. Credible. *n*=8 interviews. Acute care psychiatric. Ireland.
17.	**17.**	Quirk, A, Lelliott, P, & Seale, C 2006, 'The permeable institution: An ethnographic study of three acute psychiatric wards in London', *Social Science & Medicine*,	Research investigating the psychiatric institution through participant observation and the parameters that exist within.	Qualitative. Credible. Participant observation and interviews. *n*=26 interviews with patients, patient

Total	Per Cluster	Article	Summary	Nature
		vol. 63, no. 8, pp. 2105-2117.		advocates and staff. Acute care psychiatric. UK.
18.	**18.**	Quirk, A, Lelliott, P & Seale, C 2004, 'Service users' strategies for managing risk in the volatile environment of an acute psychiatric ward', *Social Science & Medicine*, vol. 59, no. 12, pp. 2573-2583.	Research investigating the psychiatric institution through participant observation and the parameters that exist within.	Qualitative. Credible. Participant observation and interviews. *n*=26 interviews with patients, patient advocates and staff. Acute care psychiatric. UK.
19.	**19.**	Thompson, C, Dalgleish, L, Bucknall, T, Estabrooks, C, Hutchinson, Am, Fraser, K, De Vos, R, Binnekade, J, Barrett, G & Saunders, J 2008, 'The effects of time pressure and experience on nurses' risk assessment decisions: A signal detection analysis', *Nursing Research,* vol. 57, no. 5, pp. 302-311.	Considers clinical experience in relation to time pressure and nurses' risk assessment decision making.	Quantitative. L.4. *n*=95 UK nurses; *n*=50 Netherlands; *n*=50 Australia; *n*=50 Canada. Acute care (psychiatric and general). 4 countries.
20.	**20.**	Thurston, I 2003, 'Developing the therapeutic alliance in acute mental health care', *Psychoanalytic Psychotherapy,* vol. 17, no. 3, pp. 190-205.	Considers therapeutic alliance in mental health care using case examples in reference to risk assessment and case management.	Qualitative. Clinical Case Illustration. Credible. *n*=1. Acute care psychiatric 'day stay' hospital. Acute care psychiatric. UK.
21.	**21.**	Trenoweth, S 2003, 'Perceiving risk in dangerous situations: Risks of violence among mental health inpatients', *Journal of Advanced Nursing*, vol. 42, no. 3, pp. 278-87.	Investigates how nurses assess the risk of violence in mental health settings as part of their clinical practice. Skills, mechanisms and cognitive processes are explored in this study.	Qualitative Credible. *n*=10. Acute care psychiatric. UK.
22.	**22.**	van de Sande, R, Nijman, HL, Noorthoorn, EO, Wierdsma, AI, Hellendoorn, E, Van Der Staak, C & Mulder, CL 2011, 'Aggression and seclusion on acute psychiatric wards: Effect of short-term risk assessment', *British Journal of Psychiatry*, vol. 199, no. 6, pp. 473-478.	A clustered randomised controlled trial conducted over 40 weeks on four acute care psychiatric wards. This study aimed to investigate short term risk assessments compared to the number of aggressive incidences and seclusion as an intervention.	Quantitative. L.2. *n*=597. Acute care psychiatric. Netherlands.
Community Psychiatric Risk Assessment and Management Studies (may include references to adult acute care)				
23.	**1.**	Godin, P 2004, ''you don't tick boxes on a form': A study of how community mental health nurses assess and manage risk', *Health, Risk & Society,* vol. 6, no. 4, pp. 347-360.	Clinical risk assessment and management practices of community mental health nurses are examined.	Qualitative. *n*=20 interviews. Credible. Community psychiatric. UK and Wales.

Total	Per Cluster	Article	Summary	Nature
24.	**2.**	Gunstone, S 2003, 'Risk assessment and management of patients whom self-neglect: A 'grey area' for mental health workers', *Journal of Psychiatric and Mental Health Nursing,* vol. 10, no. 3, pp. 287-296.	Investigates the perceptions and experiences of risk assessment management of mental health workers situated in a community setting. Focused on self-neglect.	Qualitative. Interviews with mental health community workers. UK.
25.	**3.**	MacNeela, P, Scott, A, Treacy, P & Hyde, A 2010, 'In the know: Cognitive and social factors in mental health nursing assessment', *Journal of Clinical Nursing,* vol. 19, no. 9-10, pp. 1298-1306.	A study of mental health nurses in clinical and community psychiatric settings that aimed to develop social and cognitive understandings in relation to mental health nursing assessment.	Qualitative. Credible. Mental health nurses (focus groups) *n*=59. Ireland. Acute and community psychiatric.
26.	**4.**	Murphy, N 2004, 'An investigation into how community mental health nurses assess the risk of violence from their clients', *Journal of Psychiatric and Mental Health Nursing,* vol. 11, no. 4, pp. 407-413.	Outlines community violence risk assessment by examining nurses' understandings of violence, perception and awareness.	Qualitative. Credible. *n*=16 questionnaire; *n*=16 focus group. Community mental health care. UK.
Forensic Risk Assessment and Management Studies				
27.	**1.**	Gunenc, C, O'Shea, LE & Dickens, GL 2015, 'Prevalence and Predictors of Verbal Aggression in a Secure Mental Health Service: Use of the HCR-20', *International Journal of Mental Health Nursing*, vol. 24, no. 4, pp. 314-23.	This study examined the HCR-20 and the relationship of verbal aggression with risk factors for aggression to establish which factors of the behaviour could be predicted.	Quantitative. *n*=613. Item outcome analysis. L.4. Forensic mental healthcare. UK.
28.	**2.**	Hart, SD, Michie, C, & Cooke, DJ 2007, 'Precision of actuarial risk assessment instruments', *British Journal of Psychiatry,* vol. 190, no. 49, pp. s60-s65.	This paper evaluates two risk assessment instruments to evaluate individual and group risk estimates. This compares recidivism to non-recidivism.	Quantitative. Tool validation. L.3.3. Forensic mental healthcare. Europe.
29.	**3.**	Hutchinson, J, Lovell, A & Mason, T 2012, 'Managing risk: A qualitative study of community-based professionals working with learning-disabled sex offenders', *Journal of Psychiatric and Mental Health Nursing,* vol. 19, no. 1, pp. 53-61.	This qualitative study interviewed 12 multidisciplinary clinicians in the community that worked with sex offenders who had learning disabilities within the context of risk assessments.	Qualitative. *n*=12. Credible. Interviews with multidisciplinary community team members. Community forensic.
30.	**4.**	Kelly, T, Simmons, W, & Gregory, E 2002, 'Risk assessment and management: A community forensic mental health practice model', *International Journal of Mental Health Nursing,* vol. 11, no. 4, pp. 206-213.	The development of a RAM community forensic mental health practice model.	Qualitative. Credible. Practice model creation. Community forensic. Australia.

Total	Per Cluster	Article	Summary	Nature
31.	**5.**	Martin, T & Daffern, M 2006, 'Clinician perceptions of personal safety and confidence to manage inpatient aggression in a forensic psychiatric setting', *Journal of Psychiatric and Mental Health Nursing,* vol. 13, no. 1, pp. 90-99.	Considered clinical perceptions in relation to safety and confidence when managing inpatient aggression.	Triangulated. L.4. Credible. Questionnaire. Mental health nurses *n*=125. Australia. Forensic hospital.
Literature Reviews / Informative / General articles or studies relevant to risk / Risk Assessment and Management in adult acute care psychiatric settings				
32.	**1.**	Baker, J, Sanderson, A, Challen, K & Price, O 2014, 'Acute Inpatient Care in the Uk. Part 2: Managing Risk', *Mental Health Practice*, vol. 18, no. 1, pp. 21-7.	A brief update that considers the methods that are generally used in acute mental health settings in the United Kingdom to assess and contain risk.	Selective Review: Credible. Acute mental health care settings. United Kingdom.
33.	**2.**	Buchanan-Barker, P & Barker, P 2005, 'Observation: The original sin of mental health nursing?', *Journal of Psychiatric and Mental Health Nursing,* vol. 12, no., pp. 541-549.	A review of historical dimensions of ‘observations’ within the context of mental health RAM.	Selective Literature Review: Credible. Mental health care settings. World-wide review.
34.	**3.**	Buckingham, C, Adams, A & Mace, C 2008, 'Cues and knowledge structures used by mental-health professionals when making risk assessments', *Journal of Mental Health*, vol. 17, no. 3, pp. 299-314.	Identifies cues used for clinicians to make risk judgements, and exploring these within concepts such as suicide, self-harm and harm to others.	Triangulated Credible; L.4. *n*=46. Implied clinicians who work in a range of acute care psychiatric settings. UK.
35.	**4.**	Carroll, A 2009, 'How to make good-enough risk decisions', *Advances in Psychiatric Treatment*, vol. 15, no. 3, pp. 192.	Article that explores decision making within the context of risk and applies contemporary psychological evidence to the common dilemmas of risk assessment and management within clinical environments.	Qualitative. Selective review on contemporary evidence. Credible. Implied Acute care psychiatric. World-wide review.
36.	**5.**	Clancy, L & Happell, B 2014, 'Tensions of Difference: Reconciling Organisational Imperatives for Risk Management with Consumer-Focused Care from the Perspectives of Clinicians and Managers', *Journal of Clinical Nursing*, vol. 23, no. 21-22, pp. 3177-87.	Explored the impact of risk assessment and management with the delivery of mental health care from the perspective of clinicians (and included mangers) across a range of disciplines and practice settings in Australia.	Qualitative. *n*=43. Credible. Interviews with multidisciplinary team members. Large mental health service. Australia.
37.	**6.**	Cleary, M, Hunt, G, Walter, G & Robertson, M 2009, 'Locked inpatient units in modern mental health care: Values and practice issues', *Journal of Medical Ethics,* vol. 35, no. 10, pp. 644-646.	An exploration of locking inpatient psychiatric units including common risks and practice issues.	Selective Review. Credible. Acute care psychiatric. World-wide review.

Total	Per Cluster	Article	Summary	Nature
38.	**7.**	Crowe, M & Carlyle, D 2003, 'Deconstructing risk assessment and management in mental health nursing', *Journal of Advanced Nursing,* vol. 43, no. 1, pp. 19-27.	A deconstructive analysis of the concepts of risks, risk assessment and management, historical context and the impacts of these on both mental health nurses and consumers.	Selective Review. Credible. Acute care and community. World-wide review.
39.	**8.**	Douglas, K & Skeem, J 2005, 'Violence risk assessment: Getting specific about being dynamic', *Psychology, Public Policy, and Law,* vol. 11, no. 3, pp. 347-383.	Considers changing risk dynamics within the context of the risk assessment of violence. Identifies and delineates risk status, risk state, contemporary measures and important risk factors.	Selective Literature Review: Credible. Mental health care settings. World-wide review.
40.	**9.**	Doyle, M & Dolan, M 2002, 'Violence risk assessment: Combining actuarial and clinical information to structure clinical judgements for the formulation and management of risk', *Journal Psychiatric Mental Health Nursing,* vol. 9, no. 6, pp. 649-657.	Explores risk assessment and management approaches to violence in relevant to psychiatric settings. Advantages of each approach are considered, including the use of risk assessment tools.	Selective Review. Credible. Community. World-wide review.
41.	**10.**	Kumar, S & Simpson, A 2005, 'Application of risk assessment for violence methods to general adult psychiatry: A selective literature review', *Australian & New Zealand Journal of Psychiatry,* vol. 39, no. 5, pp. 328-335.	A ten year literature review on risk conceptualisations in different disciplines and discusses the origins of risk assessment and management within the context of general adult psychiatry.	Selective Review. Credible. Community. World-wide review.
42.	**11.**	Lamont, S & Brunero, S 2009, 'Risk analysis: An integrated approach to the assessment and management of aggression/violence in mental health', *Journal of Psychiatric Intensive Care,* vol. 5, no. 1, pp. 25-32.	Critical discussion of risk assessment practices pertaining to effective assessment and management of aggression and violence in psychiatric settings.	Qualitative. Credible. Critical Review. Psychiatric. World-wide review.
43.	**12.**	Lewis, AH & Webster, CD 2004, 'General instruments for risk assessment', *Current Opinion in Psychiatry,* vol. 17, no. 5, pp. 401-405.	A selective review that is focused on consumers exhibiting violence, considers risk assessment instruments that can facilitate effective risk assessment within this context. Examines key risk assessment themes that have emerged in 2003.	Qualitative. Credible. Selective review. World-wide review.
44.	**13.**	Lindsay, W, Murphy, L, Smith, G, Murphy, D, Edwards, Z, Chittock, C, Grieve, A & Young, S 2004, 'The dynamic risk assessment and management system: An assessment of immediate risk of violence for individuals with offending and challenging behaviour', *Journal of Applied Research in Intellectual Disabilities,* vol. 17, no. 4, pp. 267-274.	A field trial of a risk assessment tool - measuring aggressive incidents.	Quantitative. L.4. *n*=45 reliability instrument. Intellectual disability setting. UK.

Total	Per Cluster	Article	Summary	Nature
45.	**14.**	Lindqvist, P & Skipworth, J 2000, 'Evidence-based rehabilitation in forensic psychiatry', *The British Journal of Psychiatry,* vol. 176, no. 4, pp. 320-323.	Considers forensic psychiatric rehabilitation that is relevant to these settings. This is contextualised around one risk behaviour - violence.	Qualitative. Credible. Selective review. World-wide review.
46.	**15.**	Littlechild, B & Hawley, C 2010, 'Risk assessments for mental health service users: Ethical, valid and reliable?', *Journal of Social Work,* vol. 10, no. 2, pp. 211-229.	Evaluates and critiques risk assessment tools using empirical research originating from NHS Mental Health Trusts in England.	Critical tool evaluation: Credible. Can be utilised in acute care settings.
47.	**16.**	Petrila, J & Douglas, K 2002, 'Legal issues in maximum security institutions for people with mental illness: Liberty, security, and administrative discretion', *Behavioral Sciences & the Law,* vol. 20, no. 5, pp. 463-480.	Legal issues such as litigation to the right to treatment, laws regarding restraint and seclusion and risk assessment policies are explored.	Qualitative. Selective Review. Credible. Implied acute care psychiatric. World-wide review.
48.	**17.**	Price, B 2014, 'Discussing Risk with Patients', *Nursing Standard*, vol. 31, no. 33, pp. 53-62.	Aims at nurses continuing professional development and examines the components of risk, use of risk assessment tools and decision making guidelines of relevance to mental health practitioners.	Selective theoretical review. Qualitative. Credible. Acute care and Community psychiatric. World-wide review.
49.	**18.**	Samuels, A, O'Driscoll, C & Bazaley, M 2005, 'Combining clinical and actuarial methods to assess and manage risk in a New South Wales forensic psychiatric setting', *Australasian Psychiatry,* vol. 13, no. 3, pp. 285-290.	Describes a new risk assessment approach (pilot) in a forensic psychiatric unit and the implementation of risk management strategies.	Qualitative. Credible. Literature review and tool pilot in 30 bed ward. Forensic psychiatric. Australia.
50.	**19.**	Undrill, G 2011, 'Calling time on risk assessments', *Journal of Psychiatric Intensive Care,* vol. 1, no. 1, pp. 1-6.	An editorial article that considers risk assessment as a global and local notion. This is contextualised around aspects such as strategies for prediction, the evaluation and ethics of actuarial measures, and the movement from risk to safety.	Editorial. Credible. Contextualised around risk assessment and suicide. Global.
51.	**20.**	Wand, T 2012, 'Investigating the evidence for the effectiveness of risk assessment in mental health care', *Issues in Mental Health Nursing*, vol. 33, no. 1, pp. 2-7.	A selective review that investigates the effectiveness of risk assessment, as well as generally reviewing the topic of risk assessment, in addition to a discussion of the literature available on risk assessment.	Qualitative. Credible. Literature review and discussion. World-wide review.
52.	**21.**	Webb, L 2012, 'Tools for the job: Why relying on risk assessment tools is still a risky business', *Journal of Psychiatric and Mental Health Nursing*, vol. 19, no. 2, pp. 132-139.	Theoretically examines the use of risk assessment tools and decision making guidelines of relevance to mental health practitioners.	Selective theoretical review. Qualitative. Credible. Acute care and Community psychiatric. World-wide review.

Total	Per Cluster	Article	Summary	Nature
53.	**22.**	Welsh, I & Lyons, C 2001, 'Evidence-based care and the case for intuition and tacit knowledge in clinical assessment and decision making in mental health nursing practice: An empirical contribution to the debate', *Journal of Psychiatric & Mental Health Nursing,* vol. 8, no. 4, pp. 299-305.	This study aims to examine how nurses use knowledges and standardised measures when assessing risks, and considers how this informs the management plan.	Qualitative. Credible. *n*=8. UK.
54.	**23.**	West, A 2001, 'Current approaches to sex-offender risk assessment: A critical review', *British Journal of Forensic Practice*, vol. 3, no. 3, pp. 31-41.	A critical review of literature related to the risk assessment of sexual offenders.	Critical Literature Review: Credible. Implied clinical Acute care psychiatric practice. World-wide review.
55.	**24.**	Woods, P & Lasiuk, G 2008, 'Risk prediction: A review of the literature', *Journal of Forensic Nursing,* vol. 4, no. 1, pp. 1-11.	A selective literature review on risk assessment and management, current practices, historical influences and reflections on some of the key issues raised.	Selective Literature Review: Credible. Mental health care settings. World-wide review.

- Each article was judged for trustworthiness, encompassing credibility, dependability and transferability (Graneheim & Lundman 2004).
- The credibility of each article was then assessed as unequivocal, credible or unsupported (Joanna Briggs Institute (JBI) 2014)
- The articles that contained quantitative data were ranked in terms of levels of evidence, with:
    - Level 1 being evidence obtained from review of all Randomised Control Trials (RCTs),
    - Level 2 evidence from at least one properly designed RCT,
    - Level 3 (1) well designed control trial without randomisation,
    - Level 3 (2) comparative study without randomisation but with control and allocation,
    - Level 3 (3) comparative study with the control being historical, and
    - Level 4, being evidence obtained from case series (Joanna Briggs Institute (JBI) 2014; Leslie & Finn 2004).

Appendix B: Participant Demographic Form

Optional questions about you

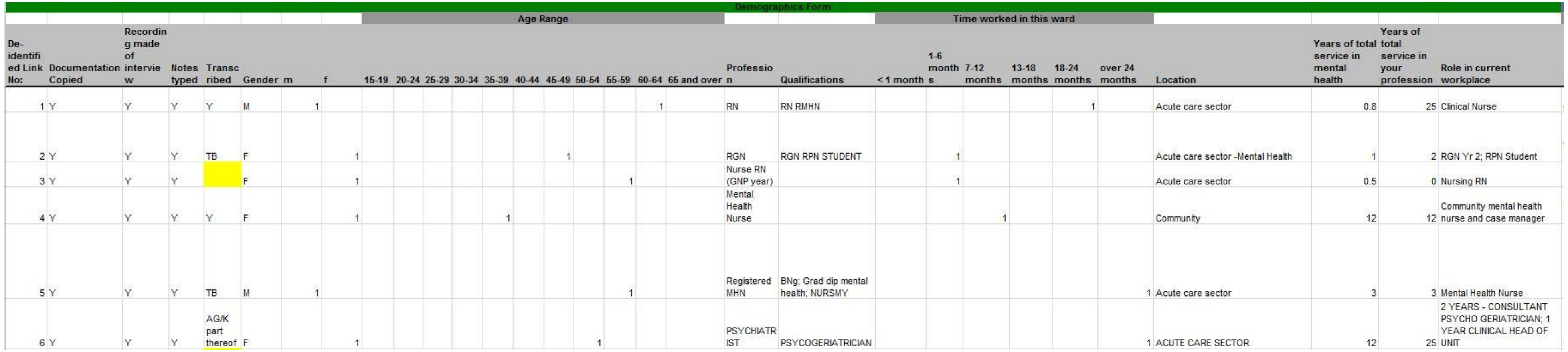
Could you take a few minutes to fill this form out to tell us some general information about yourself? This form is non identifiable. All records containing personal information will remain confidential and no information which could lead to identification of any individual will be released. Your identity will not be disclosed in the event of any publication arising from this study.

You are not obliged to fill this out. If you do, please feel free to answer only the questions you are comfortable with.

Age	Please circle: 15-19 20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65 and over
Sex	Please circle: Male / Female
Profession	
Qualifications	
Time worked in this ward	Please circle: Less than 1 month; 1 – 6 months; 7 – 12 months; 13 – 18 months; 18 months – 24 months; over 24 months
Location	Do you currently work in the: Acute care sector / Community / Both
Years of total service in mental health.	
Years of total service in your profession	
Role in current workplace	Please describe:

Thank you for taking the time to answer this.

Appendix C: Data Input Exemplar



Demographics Form

								Age Range													Time worked in this ward									
De-identified Link No:	Documentation Copied	Recording made of interview	Notes typed	Transcribed	Gender	m	f	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65 and over	Profession	Qualifications	< 1 month	1-6 months	7-12 months	13-18 months	18-24 months	over 24 months	Location	Years of total service in mental health	Years of total service in your profession	Role in current workplace
1	Y	Y	Y	Y	M	1											1		RN	RN RMHN					1		Acute care sector	0.8	25	Clinical Nurse
2	Y	Y	Y	TB	F		1							1					RGN	RGN RPN STUDENT		1					Acute care sector -Mental Health	1	2	RGN Yr 2; RPN Student
3	Y	Y	Y		F		1									1			Nurse RN (GNP year)			1					Acute care sector	0.5	0	Nursing RN
4	Y	Y	Y	Y	F		1					1							Mental Health Nurse				1				Community	12	12	Community mental health nurse and case manager
5	Y	Y	Y	TB	M	1										1			Registered MHN	BNg; Grad dip mental health; NURSMY						1	Acute care sector	3	3	Mental Health Nurse
6	Y	Y	Y	AG/K part thereof	F		1								1				PSYCHIATRIST	PSYCOGERIATRICIAN						1	ACUTE CARE SECTOR	12	25	2 YEARS - CONSULTANT PSYCHO GERIATRICIAN; 1 YEAR CLINICAL HEAD OF UNIT

Appendix D: De-Identified Participant Recruitment Letter

You are invited to participate in a research project:

“Managing risk: clinical decision making”

Investigators:

De-identified to protect the anonymity of the research site.

What this project is about?
This project is an exploratory study designed to investigate the risk assessment practices of the multi-disciplinary mental health service [redacted] Hospital.
The research will provide baseline data about the current clinical decision making practices of the multi-disciplinary team; provide an understanding of the issues facing staff in undertaking risk assessment practices and direct future research and practice into risk assessment and management of people with a mental illness across all wards and services of the hospital; support future training initiatives.

How will I be involved?
If you agree to participate you will be asked to discuss how you make risk decisions and then your perceptions of risk and experience of risk management more generally. There are no right or wrong answers, and your assessment will be used for no other purposes except this research.
The total interview time will be no longer than 90 minutes, and may be shorter.
Participation is voluntary and you are free to withdraw at anytime without prejudice. In the event that participation causes you any personal distress you may withdraw and you will be offered the opportunity to debrief with the counselling service for employees within your organization. The business cards for the counselling service will be provided at the meeting and any subsequent meetings. The Department of Health provides its employees with free access to this service.
There will be no personal financial benefit to the investigators for the conduct of this research. All payments received will be deposited into a specific account and used for salaries of personnel who are involved in this research, infrastructure costs and for funding further research projects.

Who will interview you?
If you agree to participate, you will be interviewed by researchers of Flinders University.

How will confidentiality be maintained?
Your name or any identifying material will be removed from the interview transcripts by a qualified transcriber (a person provided from a pool of transcribers within Flinders University who has also signed a confidentiality agreement).
All records containing personal information will remain confidential and no information which could lead to identification of any individual will be released. Your identity will not be disclosed in the event of any publication arising from this study. To comply with Government rules and guidelines, your records must be allowed to be viewed by representatives the Research and Ethics Committee or other regulatory bodies for the purposes of auditing, in association with this study. The information collected as part of this project in the form of records, transcripts will be remain in a secure area of Flinders University, School of Nursing & Midwifery for a period of 15 years after which they will be destroyed.

How can I find out more information?

Recruitment
By contacting [redacted]
[redacted]

Questions about the research project
By contacting [redacted], or email [redacted]. Alternatively you are welcome to speak to the [redacted] if you would like further information or have any concerns

Phone: [redacted]
Fax: [redacted]
Email: [redacted]

Ethical aspects
Flinders University Social and Behavioural Research Ethics Committee has approved the research. If you have any concerns regarding ethical issues please contact the Secretary Sandy Huxtable

Phone: (08) 8201 5962
Fax: (08) 8201 2035
Email: Sandy.Huxtable@flinders.edu.au.

Other
The study has also been approved by the Human Research Ethics Committee of the [redacted]. Should you wish to discuss the study with someone not directly involved, in particular in relation to matters concerning policies, information about the conduct of the study, or your rights as a participant, you may contact [redacted] of the Human Research Ethics Committee at the [redacted]

Phone: [redacted],
Fax: [redacted]
Email: [redacted].

Appendix E: Consent Form: Participants

CONSENT FORM FOR PARTICIPATION IN RESEARCH

I …... being over the age of 18 years hereby consent to participate as requested in the project Information sheet and Letter of Introduction for the research project on: ***Managing risk: clinical decision making in aged mental health services***

I have read the information provided.

1. Details of procedures and any risks have been explained to my satisfaction.

2. I agree to audio-recording of my information and participation.

3. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.

4. I understand that:

   - I may not directly benefit from taking part in this research.
   - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
   - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
   - I may ask that the recording/observation be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
   - My participation in the project will have no effect on my employment.

5. I agree to the tape/transcript being made available to other researchers who are not members of this research team, but who are judged by the research team to be doing related research, on condition that my identity is not revealed.

6. I have had the opportunity to discuss taking part in this research with a family member or friend.

Participant's signature……………………………………Date…………………..

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…………………………….…………………….................

Researcher's signature…………………………………..Date…………………….

NB: *Two signed copies should be obtained. The copy retained by the researcher may then be used for authorisation of Items 8 and 9, as appropriate.*

---

7. I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.

Participant's signature……………………………………Date…………………..

8. I, the participant whose signature appears below, have read the researcher's report and agree to the publication of my information as reported.

Participant's signature……………………………………Date…………………..

Appendix F: Interview Protocol and Questions

Interview Protocol

We would like to ask you a few questions about risk assessment and risk management as it happens at this workplace. We are particularly interested in your thoughts about this aspect of your work.

CLARIFYING STATEMENT: To help us understand your answers, could you let us know which location you are referring to, i.e. Acute inpatient or community care when you answer these questions. [Note allied health have roles in both the community and inpatient services]

Interviewer will explain that participant has conducted a risk assessment and spoken about how undertook that assessment (in the previous part of the interview). We are interested in their responses to a number of *broad* questions about risk assessment and management in their workplace.

Interview questions

1. How confident are you in conducting a risk assessment and developing a risk management plan?

2. What do you think about risk assessment and management?

    a. How do you conduct risk assessments?

    b. What do you think is the purpose of conducting risk assessment and management?

    c. How is risk assessment used in daily practice?

    Prompts:
    i. How important is risk assessment in your day to day care of patients?
    ii. How does this affect your care of the patient?
    iii. What is the role of risk assessment in patient care? Real, ideal?

3. What knowledge and skills are required for effective clinical risk assessment and management?

    Prompts:

    a. Policies and procedures
    b. Clinical experience
    c. Therapeutic relationship
    d. Attending courses
    e. Team work / communication / culture

4. How important is the risk management tool? (*clarify:* which tool are they discussing)

    Prompts:

    a. Do you use it in your daily practice
    b. How does this affect your care of the patient?

5. What supports effective risk management in your workplace, and what is preventing it?

Prompts:

- a. Colleagues
- b. Work environment
- c. Policies and procedures
- d. Support provided
- e. Senior staff
- f. Client acuity
- g. Degree of illness

6. How does risk management change over time during the period of a patient's care?

7. How useful is a person's history in predicting risk?

8. What are the roles and responsibilities of different people/professionals involved in risk assessment?

Prompt:

- a. What do you think is the role of the
  - a. Doctor
  - b. Patient
  - c. Family
  - d. Other staff

9. What strategies do you use to minimise risk?

10. Who do you think is responsible for risk management in this service?

11. What role do you think the client can play in risk management?

Appendix G: Thematic Patterns Exemplar

1st level coding		**Raw Data: GN Martha**	**Raw Data: RMHN Lucy**	**2nd level coding**	
Tree Node	***Free Node***			***Tree Node***	***Free Node***
The consumer, family or carer	Including the consumer	We encourage that. I firmly believe that empowering someone to be their own barometer in life is the best recovery, the best way for recovery, however a lot of our clients really aren't in that situation of being able to do that especially on initial admission, but as time goes on the Recovery Model is to invite them to participate in their own recovery, their own progress, positive goal towards depleting all these behaviours etcetera.	Assuming they've got capacity the patient has the responsibility in the risk assessment or the risk management definitely. Assuming they've got capacity, assuming you're not looking at dementia or some other straight damage or something they have responsibility to manage, to stay safe, to manage as best they can within reason. Assuming they're not so depressed or maybe castronic they can't get out of bed or whatever if you work with them on a relapse prevention plan or you work with them okay if you feel like taking a tablet you must do this, you must phone this number first or you must try and do this and they agree to that, they have the responsibility in their care planning as well.	Inclusion	Including the consumer
Liberating the mind		**Review:** Personal Reflection; Dissemination of findings; Discussions with Supervisors/Academics; Member validation; Application of theoretical framework		**Liberating the mind**	
3rd level coding					
Theme		Responsibility	***Sub Theme***	Inclusion vs collaboration: Participants perceptions of consumers and families roles and responsibilities	

Appendix H: Document Analysis: Data Selected

Total	Per Cluster	Documents Selected	Summary
Defining and understanding risk in the clinical sense			
1.	**1.**	Alnutt, S, O'Driscoll, C, Olgoff, J, Daffern, M & Adams, J 2010, Clinical risk assessment & management: A practical manual for mental health clinicians, Justice of Health, Sydney,	RAM practice manual - NSW
2.	**2.**	Bhui, K, Outhwaite, J, Adzinku, F, Dixon, P, Mcgabhann, L, Pereira, S & Strathdee, G 2001, 'Implementing clinical practice guidelines on the management of imminent violence on two acute psychiatric in-patient units', *Journal of Mental Health*, vol. 10, no. 5, pp. 559-69.	Implementation of new clinical practice guidelines on two wards, focused on risk of violence. Discussion of clinical practice guidelines on managing imminent violence.
3.	**3.**	Buckingham, C, Adams, A & Mace, C 2008, 'Cues and knowledge structures used by mental-health professionals when making risk assessments', *Journal of Mental Health*, vol. 17, no. 3, pp. 299-314.	Identifies cues used for clinicians to make risk judgements, and exploring these within concepts such as suicide, self-harm and harm to others.
4.	**4.**	Campion, J, Lawn, S, Brownlie, A, Hunter, E, Gynther, B & Pols, R 2008, 'Implementing smoke-free policies in mental health inpatient units: Learning from unsuccessful experience', Australasian Psychiatry, vol. 16, no. 2, pp. 92-97.	Implementation of a smoke free policy in one acute care mental health unit. Explores aggressive incidents within the context of risk assessment and management.
5.	**5.**	Carroll, A 2009, 'How to make good-enough risk decisions', *Advances in Psychiatric Treatment*, vol. 15, no. 3, pp. 192.	Article that explores decision making within the context of risk and applies contemporary psychological evidence to the common dilemmas of risk assessment and management within clinical environments.
6.	**6.**	Department of Health 2007, *Best practice in managing risk*, Department of Health, London.	Best practice guidelines UK.
7.	**7.**	Department of Health 2008, Clinical risk assessment and management (CRAM) in Western Australian mental health services: Policy and Standards, Department of Health, State of Western Australia.	Policy and Standards: Western Australia.
8.	**8.**	Department of Health 2011, Framework for recovery-oriented practice, Mental Health, Drugs and Regions Division, Victorian Government, Department of Health, Victoria.	Victorian Government Framework.

Total	Per Cluster	Documents Selected	Summary
9.	**9.**	Kettles, AM, Moir, E, Woods, P, Porter, S & Sutherland, E 2004, 'Is there a relationship between risk assessment and observation level?', *Journal of Psychiatric and Mental Health Nursing*, vol. 11, no. 2, pp. 156-164.	Examining the relationship between enhanced observation levels and risk assessment.
10.	**10.**	Kumar, S & Simpson, A 2005, 'Application of risk assessment for violence methods to general adult psychiatry: A selective literature review', *Australian & New Zealand Journal of Psychiatry,* vol. 39, no. 5, pp. 328-335.	A ten year literature review on risk conceptualisations in different disciplines and discusses the origins of risk assessment and management within the context of general adult psychiatry.
11.	**11.**	Lamont, S & Brunero, S 2009, 'Risk analysis: An integrated approach to the assessment and management of aggression/violence in mental health', *Journal of Psychiatric Intensive Care,* vol. 5, no. 1, pp. 25-32.	Critical discussion of risk assessment practices pertaining to effective assessment and management of aggression and violence in psychiatric settings.
12.	**12.**	Langan, J 2008, 'Involving mental health service users considered to pose a risk to other people in risk assessment', *Journal of Mental Health*, vol. 17, no. 5, pp. 471-81.	Investigating how mental health professionals assess risk, and the involvement of consumers in this process.
13.	**13.**	Muir-Cochrane, E & Wand, T 2005, Contemporary issues in risk assessment and management in mental health [monograph], *Australian and New Zealand College of Mental Health Nurses*, South Australia.	Examination of contemporary RAM issues.
14.	**14.**	Muir-Cochrane, E & Mosel, K 2009, 'Research in brief: A retrospective analysis of absconding behaviours by psychiatric inpatients in one psychiatric hospital campus in Australia', Journal of Psychiatric and Mental Health N*ursing*, vol. 16, no. 2, pp. 211-213.	Analysis of absconding (one risk behaviour).
15.	**15.**	Murphy, N 2004, 'An investigation into how community mental health nurses assess the risk of violence from their clients', *Journal of Psychiatric and Mental Health Nursing,* vol. 11, no. 4, pp. 407-413.	Outlines community violence risk assessment by examining nurses' understandings of violence, perception and awareness.
16.	**16.**	Quirk, A, Lelliott, P & Seale, C 2006, 'The permeable institution: An ethnographic study of three acute psychiatric wards in London', *Social Science & Medicine*, vol. 63, no. 8, pp. 2105-2117.	Research investigating the psychiatric institution through participant observation and the parameters that exist within.
17.	**17.**	Thompson, C, Dalgleish, L, Bucknall, T, Estabrooks, C, Hutchinson, Am, Fraser, K, De Vos, R, Binnekade, J, Barrett, G & Saunders, J 2008, 'The effects of time pressure and experience on nurses' risk assessment decisions: A signal detection	Considers clinical experience in relation to time pressure and nurses risk assessment decision making.

Total	Per Cluster	Documents Selected	Summary
		analysis', *Nursing Research,* vol. 57, no. 5, pp. 302-311.	
18.	**18.**	Trenoweth, S 2003, 'Perceiving risk in dangerous situations: Risks of violence among mental health inpatients', *Journal of Advanced Nursing*, vol. 42, no. 3, pp. 278-87.	Investigates how nurses assess the risk of violence in mental health settings as part of their clinical practice. Skills, mechanisms and cognitive processes are explored in this study.
19.	**19.**	Undrill, G 2011, 'Calling time on risk assessments', *Journal of Psychiatric Intensive Care,* vol. 1, no. 1, pp. 1-6.	An editorial article that considers risk assessment as a global and local notion. This is contextualised around aspects such as strategies for prediction, the evaluation and ethics of actuarial measures, and the movement from risk to safety.
20.	**20.**	Wand, T 2012, 'Investigating the evidence for the effectiveness of risk assessment in mental health care', *Issues in Mental Health Nursing*, vol. 33, no. 1, pp. 2-7.	A selective review that investigates the effectiveness of risk assessment, as well as generally reviewing the topic of risk assessment, in addition to a discussion of the literature available on risk assessment.
21.	**21.**	Welsh, I & Lyons, C 2001, 'Evidence-based care and the case for intuition and tacit knowledge in clinical assessment and decision making in mental health nursing practice: An empirical contribution to the debate', *Journal of Psychiatric & Mental Health Nursing,* vol. 8, no. 4, pp. 299-305.	This study aims to examine how nurses use knowledges and standardised measures when assessing risks, and considers how this informs the management plan.
Legal and ethical responsibilities			
22.	**1.**	Australian Health Ministers 1992, National mental health policy, Australian Government Publishing Service, Canberra.	National Australian Policy.
23.	**2.**	Brown, P & Calnan, M 2013, 'Trust as a means of bridging the management of risk and the meeting of need: A case study in mental health service provision', *Social Policy & Administration,* vol. 47, no. 3, pp. 242-261.	Explores the role of trust in the context of risk assessment and service users' engagement and cooperation with healthcare professionals.
24.	**3.**	Commonwealth Department of Health and Ageing 2002, *National Practice Standards for the Mental Health Workforce*, Commonwealth Department of Health and Ageing, Canberra.	National Australian Practice Standards.
25.	**4.**	Gunstone, S 2003, 'Risk assessment and management of patients whom self-neglect: A 'grey area' for mental health workers', *Journal of Psychiatric and Mental Health Nursing,* vol. 10, no. 3, pp. 287-296.	Investigates the perceptions and experiences of risk assessment management of mental health workers situated in a community setting. Focused on self-neglect.

Total	Per Cluster	Documents Selected	Summary
26.	**5.**	Littlechild, B & Hawley, C 2010, 'Risk assessments for mental health service users: Ethical, valid and reliable?', *Journal of Social Work,* vol. 10, no. 2, pp. 211-229.	Evaluates and critiques risk assessment tools using empirical research originating from NHS Mental Health Trusts in England.
27.	**6.**	MacNeela, P, Scott, A, Treacy, P, & Hyde, A 2010, 'In the know: Cognitive and social factors in mental health nursing assessment', *Journal of Clinical Nursing,* vol. 19, no. 9-10, pp. 1298-1306.	A study of mental health nurses in clinical and community psychiatric settings that aimed to develop social and cognitive understandings in relation to mental health nursing assessment.
28.	**7.**	Mental Health Act 2009 (SA).	South Australian Mental Health Act.
29.	**8.**	Petrila, J & Douglas, K 2002, 'Legal issues in maximum security institutions for people with mental illness: Liberty, security, and administrative discretion', *Behavioral Sciences & the Law,* vol. 20, no. 5, pp. 463-480.	Legal issues such as litigation to the right to treatment, laws regarding restraint and seclusion and risk assessment policies are explored.
30.	**9.**	Smith, P & Allan, TH 2010, 'We should be able to bear our patients in our teaching in some way': Theoretical perspectives on how nurse teachers manage their emotions to negotiate the split between education and caring practice', *Nurse Education Today,* vol. 30, no. 3, pp. 218-223.	A consideration of ward learning environments, devaluing care and managing anxiety.
31.	**10.**	World Health Organisation (WHO) 2003, *Mental health legislation and human rights*, World Health Organisation, Geneva.	World Health Organisation directive.
		The Australian Context	
32.	**1.**	Assessment Order.	Australian Assessment order – used for detaining a patient under the Mental Health Act [*deidentified*].
33.	**2.**	Crimes Act 1914 (Cwlth).	Commonwealth Crimes Act.
34.	**3.**	Law Enforcement (Powers and Responsibilities) Act 2002 (NSW).	New South Wales Law Enforcement (Powers and Responsibilities) Act.
35.	**4.**	Commonwealth of Australia 2010a, *Implementation guidelines for public mental health services and public hospitals*, Commonwealth of Australia, ACT.	Guidelines for Australian mental health services and public hospitals.
36.	**5.**	Commonwealth of Australia 2010b, *National standards for mental health services*, Commonwealth of Australia, Canberra.	Australian standards for mental health services.
37.	**6.**	Department of Health 2008, *Clinical risk assessment and management (CRAM) in Western Australian mental health services: Policy and standards*, Department of	Clinical Risk assessment and management: Policies and Standards of Western Australia.

Total	Per Cluster	Documents Selected	Summary
		Health, State of Western Australia, Western Australia.	
38.	**7.**	Department of Health: Victoria 2013, *National practice standards for the mental health workforce 2013*, State of Victoria, Department of Health, Melbourne.	Australian practice standards for mental health workforce.
39.	**8.**	Mental Health Act 2009 (SA).	South Australian Mental Health Act.
40.	**9.**	Olstead, R 2002, 'Contesting the text: Canadian media depictions of the conflation of mental illness and criminality', *Sociology of Health & Illness,* vol. 24, no. 5, pp. 621-643.	A consideration of mental illness to criminality.
41.	**10.**	Scott, S, Jones, D, Ballinger, R, Bendelow, G & Fulford, B 2011, 'The slide to pragmatism: A values-based understanding of 'dangerous' personality disorders', *Health Sociology Review,* vol. 20, no. 2, pp. 157-171.	Understanding dangerousness.
42.	**11.**	Szmukler, G 2003, 'Risk assessment:'Numbers' and 'values', *Psychiatric Bulletin,* vol. 27, no. 6, pp. 205-207.	Analysis of risk assessment in the context of assigning numerical values.
State			
43.	**1.**	Department of Health 2008, *Clinical risk assessment and management (CRAM) in Western Australian mental health services: Policy and standards*, Department of Health, State of Western Australia, Western Australia.	Western Australian Policies.
44.	**2.**	Department of Human Services 2002, *Policy EDM. P2-02: Admission, care, utilisation and discharge in acute mental health in-patient units*, Department of Human Services, ACT.	South Australian Policy.
45.	**3.**	NSW Health 'Framework for suicide risk assessment and management for NSW health staff', <http://www0.health.nsw.gov.au/pubs/2005/suicide_risk.html>	Exemplar.
46.	**4.**	SA Health 2010, *Adult community mental health services (metropolitan regions)*, Government of South Australia, Adelaide.	South Australian Policies.
Research Site			
47.	**1.**	[redacted] Mental Health Clinical Procedure: Risk Assessment.	Risk assessment and management clinical procedures at the site of research [*deidentified*].

Total	Per Cluster	Documents Selected	Summary
Comparison of Contemporary Tools			
48.	**1.**	[redacted] Mental Health: Risk Assessment Tool.	Hybrid risk assessment tool used at the site of research. [*deidentified*].
49.	**2.**	General acute care nursing history and assessment form.	Assessment form commonly used in South Australia in general acute care settings. [*deidentified*].
50.	**3.**	Must Tool.	Associated tool used in conjunction with the general acute care nursing history and assessment form. [*deidentified*].
51.	**4.**	Braden Scale.	Associated tool used in conjunction with the general acute care nursing history and assessment form. [*deidentified*].
52.	**5.**	Falls risk assessment form.	Associated tool used in conjunction with the general acute care nursing history and assessment form. [*deidentified*].
53.	**6.**	[redacted] Mental Health: Risk Management Tool.	Hybrid risk management tool used at the site of research. [*deidentified*].
54.	**7.**	General acute care patient care plan form.	Nursing care plan form commonly used in South Australia in general acute care settings. [*deidentified*].
55.	**8.**	General acute care patient care plan attachment.	Nursing care plan attachment commonly used in South Australia in general acute care settings. This attachment is used to record patient’s observations. [*deidentified*].

Appendix I: South Australian Mental Health “Assessment Order”

Image removed due to confidentiality.

Appendix J: Acute Mental Health Risk Assessment Tool

Image removed due to confidentiality.

Appendix K: Clinical Procedures Used On the Ward

Image removed due to confidentiality.

Appendix L: Standardised Risk Assessment Form For Community Mental Health Services

Image removed due to confidentiality.

Appendix M: South Australian Acute Mental Health Risk Assessment Tool

Image removed due to confidentiality.

Appendix N: Research Site: Mental Health Risk Management History

Image removed due to confidentiality.

Appendix O: Research Site: Mental Health Risk Assessment

Image removed due to confidentiality.

Appendix P: Research Site: Risk Assessment as a Guide

Image removed due to confidentiality.

Appendix Q: Acute Care Nursing History & Assessment Form

Image removed due to confidentiality.

Appendix R: MUST Tool

Image removed due to confidentiality.

Appendix S: Braden Scale

Image removed due to confidentiality.

Appendix T: Falls Risk Assessment Tool

Image removed due to confidentiality.

Appendix U: Research Site: Mental Health Risk Management Plan

Image removed due to confidentiality.

Appendix V: Research Site: Mental Health Risk Management History

Image removed due to confidentiality.

Appendix W: Acute Care Nursing Care Plan Exemplar

Image removed due to confidentiality.

Appendix X: Acute Care Basic Observation Chart Exemplar

Image removed due to confidentiality.