

**HOW MENTAL HEALTH CLINICIANS ASSESS AND MANAGE
THE RISK OF VIOLENCE FROM MENTAL HEALTH
CONSUMERS: A DESCRIPTIVE EXPLORATORY RESEARCH
INVESTIGATION**

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Statement of Originality

This thesis contains no material which has been accepted for the award of any other degree or diploma in any University and to the best of my knowledge and belief, the thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

I give consent to the copy of my thesis, when deposited in the School of Nursing Library, being made available for photocopying and loan if accepted for the award of the degree.

Jacqueline Teresa Smit

Signed:

Date:

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Abstract

The advent of deinstitutionalisation has increased the number of mental health consumers in the community. Consequently, community mental health clinicians (CMHC) now play an increasingly important role in caring for mental health consumers, which raises the question of how CMHCs maintain their safety. The overall aim of the research was to improve the safety of CMHCs when caring for mental health consumers. In light of this question, a literature search was conducted to investigate how CMHCs assess and manage the risk of violence from mental health consumers in the community. The literature search provided background information about deinstitutionalisation but also revealed there was a paucity of research about the subject of risk assessment and management by CMHCs. This research was conducted to gain an understanding of the strategies of risk assessment and management in community mental health. A descriptive exploratory qualitative research methodology was selected. The research was conducted in a community mental health centre in a metropolitan region of South Australia. Individual interviews of eleven CMHCs provided data, which was thematically analysed and interpreted. The main themes that emerged were: preparing to meet the consumer; intervention strategies for safety; and organisational management. There were several strategies that were consistently upheld by CMHCs such as gaining information about a consumer; appraisal of the environment; careful attention to exit strategies; and appropriate interaction with the consumer according to their mental state. Concurrently, the research findings raised awareness of the need for improvement in certain areas relating to: communication within the team; training requirements for CMHCs; and awareness of the policies and procedures and Work Health and Safety Standards. This research has also highlighted new areas of interest for future research.

Chapter One: Introduction

Introduction

One important aspect of community mental health care involves assessing and managing the risk of violence from mental health consumers. Assessing and managing the risk of violence is an essential skill that every community mental health clinician (CMHC) requires to maintain their safety (McKinnon & Cross 2008; Palmer 2010). There are a range of strategies which CMHCs utilise to minimise the risk of violence when confronted with potentially violent situations from consumers. In this research, the term CMHCs will be used to denote certain members of a community mental health multidisciplinary team, which includes registered nurses, social workers and occupational therapists. CMHCs from this multidisciplinary team were invited to participate in this research. My specific area of interest was to investigate the strategies to minimise the risk of violence toward CMHCs when assessing and managing consumers who live in the community.

It is important for CMHCs to gather information about the previous behaviour of consumers in order to provide appropriate care. Information can be gathered from various sources. One source of information is the consumer's case notes. Other sources are the risk assessments and alerts in the mental health documentation tool known as "Community Based Information System" (CBIS) (Government of South Australia 2011). CBIS documentation is specific to Adelaide, South Australia; the CBIS risk assessment tool forms one part of the CBIS documentation for consumers (Appendix 1). Mental health clinicians have access to CBIS for consumers who are within their designated local health network. Rural regions of South Australia have limited access. Hence the CBIS network is a confidential local network for mental health clinicians to be informed about consumers and their care.

The ability to assess and manage the risk of violence is a vital skill when employed in community mental health. As a researcher and a CMHC, I am interested in discovering how other CMHCs assess and manage the risk of violence when caring for consumers.

Having begun employment in a community mental health centre in January 2014, I consider myself to be relatively new to community mental health. CMHCs at the community mental health centre have access to the Northern Adelaide Local Health Network (NALHN) Policies and Procedures (Appendices 2 to 5) and Work Health and Safety Standards (Australian Government 2011) relating to home visit safety. The Home Visit Safety - Mental Health Procedure (Appendix 3) contains less detail when compared to the Home Visit Procedure and Staff Out of Hours / Non Return Procedure which is also under NAHLN. (Appendices 4 and 5). Despite the accessibility of the policies and procedures and Work Health and Safety Standards, I have observed a diversity of approaches toward risk assessment and management of consumers.

CMHCs are expected to be able to judge the potential for violence from consumers. Terms such as “clinical judgement”, “gut reaction”, experience and intuition are promoted by experienced CMHCs (Addis & Gamble 2004; Murphy 2004), but as a new CMHC, I was unclear what is meant by this in relation to risk assessment and management of potentially violent consumers. I was concerned that specific techniques to improve my safety and that of my colleagues are elusive and therefore may be overlooked when assessing and managing the risk of violence. Experienced CMHCs may take their knowledge and skill for granted, and be unaware of how they perform this role, and therefore they have difficulty articulating their skills to others (Brunton 2005; Murphy 2004; Palmer 2010). Unless this knowledge is identified and disseminated in the literature, the way CMHCs to assess and manage the risk of violence from consumers will remain obscure.

CMHCs routinely perform risk assessments for consumers. Murphy (2004) emphasised the importance of experience in performing risk assessments, but the knowledge and skill to achieve this was not clearly identified. Murphy (2004) discusses “clinical judgement”, “experience”, “personal impressions” and “gut feelings” which guide community mental health nurses, when assessing the risk of violence. Although Murphy’s (2004) research was relevant, it was conducted over a decade ago in the United Kingdom and only involved community mental health nurses. Furthermore, Murphy (2004) did not give sufficient insight into the strategies

involved in risk assessment and management by CMHCs. It is therefore important to identify the distinct strategies that CMHCs use when undertaking risk assessment and management of violence. Gaining insight into these strategies can support education programs for other CMHCs, and other carers of consumers. On a professional level, I was particularly interested in gaining insight into the knowledge and strategies of the CMHCs that are employed at the community mental health centre where this research was undertaken. My overall primary aim was to improve the level of safety for myself and other CMHCs when caring for consumers in the context of an Australian metropolitan setting.

There are certain guidelines that CMHCs are expected to follow. CMHCs have access to workplace policies and procedures and Work Health and Safety Standards. As part of my research, I gathered data from the participants about their understanding of these guidelines and how the guidelines influence their practice. My research analysis examined the guidelines with the knowledge and practice of CMHCs. From the discussion, recommendations for any potential improvements are made.

Context of the study

The advent of effective medications to treat mental health conditions in the 1950's and the subsequent reduction in the number of in-patient mental health beds has increased the number of mental health consumers living in the community (Bell 2003; Crowe & Carlyle 2003; Henderson et al. 2008; Holmes et al. 2006). The current mental health recovery model aims to optimise consumers' level of functioning and independence (Stanton & Tooth 2010), in accord with the Mental Health Act 2009 (Government of South Australia 2009). Current mental health legislation promotes the principle of least restrictive practice which allows consumers the freedom to participate in community life subject to their mental health status (Government of South Australia 2009). With the limited number of in-patient beds, an admission to an in-patient unit has to be carefully considered by treating teams. When consumers do require an admission to an in-patient unit, they may need to wait in the community until an in-patient bed becomes available. Consumers who present to emergency departments may be assessed and referred for follow-up by local community mental health centres

(Clarke et al. 2013; Holmes et al. 2006; Vandyk et al. 2013). CMHCs regularly visit consumers at home, and therefore CMHCs need to know how to assess and manage the risk of violence from consumers (Godin 2004; Hewitt 2008; O'Neill 2009; Palmer 2010). Some CMHCs may be inexperienced and daunted with the responsibility of appropriately assessing and managing risk (Addis & Gamble 2004; Kingsley 2010). The process of how CHMCs assess and manage the risk of violence from consumers has not been widely researched. Hence, it is appropriate that the process of CMHC risk assessment and management be examined at this point in time in an Australian context.

Statement of the research problem

As a result of deinstitutionalisation (Bell 2003; Henderson et al. 2008) CMHCs need to care for consumers in the community during acute phases of their illness (Vandyk et al. 2013). It was anticipated that this research would ultimately provide a body of knowledge regarding the safety strategies that CMHCs use in the community in an Australian context when assessing and managing the risk of violence. The findings from this research can be used to inform safer practices for all other mental health workers.

Purpose of the study and specific aims and objectives

The study aims to improve the safety of CMHCs when caring for mental health consumers.

The objectives of the study:

- Describe how CMHCs prepare for a home visit. This includes undertaking visits alone or with another colleague.
- Identify and explore the different ways the CMHCs assess and manage the risk of consumer violence.
- Identify and review:

-The Northern Adelaide Local Health Network (NALHN) organisational policies and procedures, for CMHCs related to risk assessment and management of violence.

-Work Health and Safety Standards relating to risk assessment and management of violence for CMHCs.

-Explore if CMHCs are aware of these documents and if they refer to them in their practice when assessing risks to manage potential consumer violence.

Statement of the research question

How do CMHCs assess and manage the risk of violence from mental health consumers?

Significance of the study

Safe work practices of CMHCs are supported by organisational Policies and Procedures, and Work Health and Safety Standards (Australian Government 2011). From my nursing experience as a CMHC, the level of safety in the workplace may be compromised because there appears to be obscure and inconsistent approaches by colleagues towards the assessment and management of the risk of violence when caring for consumers. As stated earlier, previous research alludes to the use of ill-defined strategies such as “clinical judgement”, “gut reaction”, “experience” and intuition (Addis & Gamble 2004; Murphy 2004). As a new CMHC, these strategies are too vague to inform my practice or improve my safety. The lack of research into the strategies that CMHC use for performing risk assessment and management, prompted this research.

Assumptions

- When choosing this research topic, I was assuming that I will gain cooperation from management and colleagues to interview a sufficient number of participants to make the data viable for thematic analysis, interpretation and discussion.

- I am assuming that my colleagues will be willing to accurately disclose their usual practice relating to the risk assessment and management of violence from consumers, even if they need to disclose unsafe practice.
- I am assuming that uncovering the strategies in risk assessment and management of violence from consumers will promote an increase in safety for CMHCs.

Glossary of Abbreviations:

Table 1.

Abbreviation	Meaning
CMHC	Community Mental Health Clinician
NAHLN	Northern Adelaide Local Health Network
CMHN	Community Mental Health Nurse
CBIS	Community Based Information System
NVCI	Non-Violent Crisis Intervention

Definition of terms

The term “risk” in this research project will be limited to refer to: risk of violence to CMHCs from mental health consumers.

The term “violence” was chosen to incorporate the concept of physical, verbal and sexual violence. The term “violence” is commonly used in the literature.

The term “consumer” shall be used when referring to a mental health consumer; an individual with a mental health illness. The term “consumer” is the currently preferred term in mental health in accord with recovery focused model of care (Government of South Australia 2009). The term “consumer” avoids the implication of being unwell which is associated with “client” or “patient”.

Summary of the thesis: outline of the content of each chapter

Chapter one introduces the context and significance of the research by discussing the issues relating to the need for CMHCs to assess and manage the risk of violence when caring for consumers. The aims and objectives have been outlined relating to safety practices. The assumptions have been stated and terms have been defined.

The second chapter presents the literature search relating to CMHCs' assessment and management of the risk of violence from consumers. The literature was assimilated, assessed and utilised depending on its academic rigour and relevance. The literature search revealed that there was insufficient research related to this topic which justified the current research.

The major research methodologies and methods are described in chapter three. The research adopted a descriptive exploratory qualitative methodology because it was considered suitable to examine the strategies that CMHCs use when assessing and managing the risk of violence from consumers. The methods included gaining Human Research Ethics Committee approval (Appendix 6) and Site Specific approval to conduct the research at the community mental health centre (Appendix 7). A Letter of Invitation (Appendix 8), Questionnaire (Appendix 9) and Participant Information Sheet including the Consent form and Withdrawal form (Appendix 10), was then distributed to participants prior to the interviews. The individual, semi-structured interviews were audio recorded, transcribed, thematically analysed and interpreted.

Chapter four presents the results of the thematic analysis and interpretation. The thematic analysis was based on the format described by Richardson-Tench et al. (2014) and Braun and Clarke (2006). The thematic analysis and interpretation gave rise to the main themes and provided insight into the strategies that CMHCs use for risk assessment and management.

The final chapter summarises the research and presents the findings. The effective strategies for the assessment and management of the risk of violence, and the areas of practice that require improvement are discussed. Following on from this, the implications for CMHCs in clinical practice are then discussed along with suggestions for future research.

Conclusion

This chapter has introduced the background, the aims and objectives and the need for this research. The literature search indicated that there has been insufficient research on this topic. The available literature alluded to somewhat vague strategies such as “experience”, “clinical judgement” and “gut feelings” by CMHCs when assessing and managing risk (Murphy 2004). This research thesis has sought to investigate the strategies that CMHCs use to assess and manage the risk of violence from consumers with the aim of improving safety. The following chapter will present the literature review relating to this research topic.

Chapter Two: Literature Review

Introduction

The research topic

The research topic has arisen from the necessity of CMHCs to care for mental health consumers in the community. The advent of deinstitutionalisation has increased the number of consumers who are cared for by CMHCs in the community (Bell 2003; Henderson et al. 2008). One aspect of care that CMHCs undertake, involves risk assessment and management of violence from consumers (McKinnon & Cross 2008; Murphy 2004; Palmer 2010). This research aimed to provide insight into the strategies that CMHCs use when assessing and managing the risk of violence from consumers living in the community in a contemporary Australian context.

The research question

The question that is being asked is, “How do CMHCs assess and manage the risk of violence from mental health consumers?” Hence the literature review will examine any relevant literature related to this topic. The literature will be organised with regard to existing knowledge, how CMHCs assess risk and then the management of risk by CMHCs. The literature review will also briefly discuss the organisational policies and procedures and Work Health and Safety Standards with regard to guiding practice for CMHCs. Implications for future research will form the conclusion of the literature review.

Searching the literature

This literature review aimed to collate information and identify the strengths and weaknesses of the current literature on the selected topic. Literature was collated from several sources and critiqued for its quality and relevance to the research topic (Polit & Beck 2008; Richardson-Tench et al. 2014). The literature search was conducted in the following databases: PubMed (Appendix 11); Cumulative Index to Nursing and Allied Health Literature (CINAHL) (Appendix 12); Scopus (Appendix 13); and a University of Adelaide Library search (Appendix 14). Key words were identified to

gain access to relevant articles. The key words that were used were based on: “community mental health”, violence, assessment, management and risk.

When the searches in PubMed, CINAHL and Scopus were completed, the titles and the abstracts of each article were examined for relevance to this research topic. Relevant articles were then selected to be included in this literature review. The PubMed search was conducted and this search revealed 546 articles; limited to 2004 revealed 332 articles; limited to humans revealed 318 articles; limited to full text revealed 293 articles, limited to English revealed 283 articles, from which the title and abstract were read, to select 27 relevant articles. The CINAHL search produced 191 articles; limited to 2004 revealed 150 articles; limited to full text revealed 69 articles from which a title and abstract selection revealed an additional 11 articles. The Scopus search revealed 239 articles and was then limited to Health Sciences to reveal 213 articles, limited to 2004 to reveal 136 articles, limited to English to reveal 115 articles, limited to Humans revealed 88 articles, and from the title and abstract selection a further 2 new articles were identified. A University of Adelaide library search was also conducted revealing 118 articles; limited to 2004 to reveal 102 articles; limited to English to reveal 81 articles, however 4 of these were repeated so the true number was 77; from the titles 15 articles were chosen and 1 additional relevant article was identified.

From the selected literature, reference lists and citation searches and unstructured searches based on the key terms were used to find an additional 9 articles. The articles were read in full and assessed and appraised for suitability (Richardson-Tench et al. 2014). During the reading, additional articles of relevance were identified from the reference lists. Information gleaned from authors in text books such as Cummins, Sevel and Pedrick (2012), Meadows (2011) and Palmer (2010) was also incorporated into the discussion.

Selection of articles

Inclusion criteria

Articles were selected if their contents related to the key words and the aim and objectives of this research topic. Hence articles that discussed CMHCs performing risk assessments and management of violence from adult mental health consumers were included. The research proposal commenced in 2014, so articles from 2004 to 2016 were evaluated for inclusion to ensure the information was current and relevant to practice. Articles from reference lists that were older than 2004, were included if the article had a high degree of relevance. Articles were limited to human, English, and in full text to facilitate accessibility. Articles were required to be of an academic standard.

Exclusion criteria

Literature that related directly to in-patient settings, forensic mental health services, intellectual disability services, youth mental health services and remote area nursing were excluded because these areas require specific approaches to the risk assessment and management of violence. Literature that discussed risk unrelated to the risk of violence toward CMHCs was also excluded.

From the literature search, a sizable number of articles were identified from the title and abstract. However, following a thorough reading and review of the selected literature, only a few articles were relevant. Many of the relevant articles were published approximately ten years ago. Some relevant articles reported overseas research, hence they lacked an Australian context. Other articles had some minor relevance but were not specific enough to the research topic to be included. Many articles discussed risk assessment in general. Authors such as Murphy (2004), Crowe and Carlyle (2003), Godin (2004), and Brunton (2005) only included community mental health nurses (CMHN); these articles were included in the discussion, hence CMHNs may be included as CMHCs in this thesis. Upon further reading, some of the selected articles proved irrelevant and poor quality. Only the articles that contributed to the research topic were included in the discussion within the literature review. From examining the available literature, it is evident that there had not been any recent

research in Australia that examined the topic of this research thesis. Hence it is significant and timely, to conduct this research to gain insight into the strategies of how CMHCs assess and manage the risk of violence to themselves from mental health consumers.

The discussion of the literature review

Chapter 1 discussed the background to this topic including deinstitutionalisation which reduced the number of inpatient beds and increased reliance upon CMHCs to provide care in the community to mental health consumers (Bell 2003; Crowe & Carlyle 2003; Henderson et al. 2008; Holmes et al. 2006). Consequently, one of the roles of CMHCs is to assess and manage the risk of violence from consumers in the community (McKinnon & Cross 2008; Palmer 2010). This review indicated that whilst there is a significant amount of literature written around the topic of risk assessment and management in general, there is little information detailing the strategies that CMHCs use to assess and manage the risk of violence from consumers. The considerations to be examined include several aspects of care such as: the preparation for a visit with a consumer; the strategies involved when assessing the risk of violence; the methods of managing the risk of violence; the use of organisational policies and procedures, and Work Health and Safety Standards; the inadequacies in the current literature; and the implications for future research, which will form the conclusion of the literature review.

Preparation for a community visit with a mental health consumer

The preparation that CMHCs undertake prior to visiting consumers is a vital part of safe practice. Adequate assessment and preparation is necessary because there is a significant correlation between some mental health conditions and the risk of violence (Doyle & Dolan 2006; Penterman & Nijman 2011; Swanson et al. 2006). Naturally, there should be attempts to prevent violence rather than just predicting it as Allnutt et al. (2013) points out, but the ability to predict violence from risk assessments remains a contentious issue (Large et al. 2014; Zhou et al. 2016). The preparation and conduct for visiting a consumer has been discussed by Cummins, Sevel and Pedrick (2012)

and Palmer (2010): CMHCs are advised to communicate their schedule to team members and assess the information available to determine the need for additional staff to support personal safety. Gathering information includes looking at any previous risk assessments and alerts that have been recorded about the consumer. Many consumers pose no threat of harm to CMHCs, but there are some occasions when there is a significant threat of violence to CMHCs (Doyle & Dolan 2002; Godin 2004; Meadows 2011; Rao, Luty & Trathen 2007). It is important that CMHCs are aware and alert to the threat of violence to achieve their maximum level of safety.

Assessment of the risk of violence

The development of risk assessment tools

Risk assessment is now standard practice for CMHCs. This practice was promoted following the number of homicides and suicides in Britain in the 1990's and risk assessment is now an integral part of community mental health care (Godin 2004). Risk assessments attempt to predict the likelihood of consumer related adverse events. The literature identified various approaches to risk assessment, including actuarial risk assessment tools, professional intuition and clinical judgement (Doyle & Dolan 2006; Godin 2004). Actuarial risk assessment tools identify a finite number of risk factors and a score of overall risk is derived which has a measure of convenience, but by their very nature, actuarial risk assessment tools can be mechanical and dehumanising (Doyle & Dolan 2002). An alternative approach is clinical prediction to assess the risk of violence, which combines the historical evidence gleaned from an actuarial risk assessment, and gut feelings which comprise of an awareness, understanding and perception of the consumer and the situation (Doyle & Dolan 2002; Murphy 2004). Actuarial tools provide a structured approach but used alone this method can be unreliable, so many CMHNS have integrated a combination of actuarial tools and gut feelings for their assessments (Godin 2004). Despite the large amount of knowledge regarding forensic mental health risk assessments, this knowledge has not been adapted to adult mental health services (Carroll 2007). For the purpose of this research, risk assessments will only be discussed from the perspective of the risk of violence toward CMHCs in adult mental health services.

Performing risk assessments

Risk assessments cannot be precise, so it is important to gain as much information as possible about the consumer to support a safe interaction (Doyle & Dolan 2002; Murphy 2004). CMHCs should check for any history of violence by the consumer, be able to detect cues toward violence, and be alert to the presence of weapons which would require a police notification (Meadows 2011). In addition, the consumer's local neighbourhood should be assessed for safety with regard to lighting, people in the vicinity, dense vegetation and the presence of potentially dangerous animals (Cummins, Sevel & Pedrick 2012). Assessing risk requires adequate preparation and CMHCs should be vigilant when interacting with the consumer and their environment.

There are specific factors that CMHCs should be aware of relating to the risk of violence from consumers. Protective factors that minimise the risk of violence include having a safe environment, strong financial support, good relationship with staff and acceptance of current treatment (Palmer 2010). On the other hand, when a consumer resists building a therapeutic alliance with CMHCs, and when there is a change in the norm for the consumer, the risk of violence increases (Murphy 2004). Rao, Luty and Trathen (2007) define violence in terms of; intent to cause harm; threatening non-verbal communication; written threats; physical assault and muggings. It was found that violence was highest in accident and emergency, psychiatry and community care settings (Health Services and Advisory Committee 1987, cited in Rao, Luty & Trathen 2007). Many risk factors for violence are related to personal and social functioning according to Sands et al. (2012) and these factors are evident when the consumer is experiencing the following situations: reduced social functioning and interaction; poor self-care and functioning; early onset of illness; history of previous violence; positive symptoms of schizophrenia; thinking disturbances such as hallucinations, thought insertion and delusions of external control; hostility; suspiciousness; anger irritability; agitation, impulsiveness and restlessness; male gender; youth; history of previous violence; antisocial personality disorder and psychopathology; cognitive impairment; substance abuse and its related factors (Sands et al. 2012) (Doyle & Dolan 2006). In addition to these factors, the dynamic factors that indicate the highest risk include immediately observable factors such as; appearance, behaviour, speech, affect and thoughts (Blumenthal et al. 2010; Sands et al. 2012) (Appendix 1). CMHCs need to

consider all the available information about the consumer including the dynamic factors that increase the risk of violence when undertaking risk assessments.

When CMHCs assimilate information from a wide range of sources they incorporate this information with gut feelings, intuition and structured professional judgement. Gut feelings are described by Murphy (2004) as an unconscious alarm that may result from negative past experiences, hence they are unscientific in their means of assessment and they can produce inaccurate predictions. The substance of nurses' intuition and gut feelings is not quantifiable and the reliance upon these cues for risk assessment is questioned by Paley (1996, cited in Godin 2004). The CMHN may not be aware of how and when they are using gut instincts and intuition (Godin 2004; Murphy 2004). Murphy (2004) discussed whether gut feelings are developed from experience, from an awareness of the environment, or noticing subtle nuances of the client that are difficult to explain. In a similar manner, Brunton (2005) asserts that when CMHNs assess for the risk of violence, they rely on gut instincts, and intuition based on experience. To strengthen their assessment skills, CMHCs incorporate structured professional judgement which is a combination of clinical judgement and an actuarial style tool hence static and dynamic aspects are also considered (Doyle & Dolan 2002; Holmes 2013; Penterman & Nijman 2011). CMHCs incorporate information about the consumer with structured professional judgement to form a holistic picture of the consumer.

Experienced CMHNs are viewed as having the ability to work intuitively, which distinguishes them from novice CMHNs who need to rely on rules (Benner 1984, cited in Godin 2004) and experienced CMHNs are able to predict violent incidents better than less experienced staff (Brunton 2005; Murphy 2004). The experienced CMHN may instinctively notice changes in the environment and presentation of the consumer (Murphy 2004). Godin (2004) explains that the more experienced CMHNs who have avoided adverse events feel justified in attributing this outcome to their intuitive judgement. Although experienced CMHNs can identify cues to alert them to the risk of violence from a consumer, it is unclear how they achieve this skill (Brunton 2005).

The literature search, revealed only a few relevant articles regarding how CMHCs performed the risk assessment and management of violence toward CMHCs.

Risk assessment tools and the influence of CMHCs

Risk assessment tools are routinely used by CMHCs. Structured risk assessment tools are now a standard part of the risk assessment process (Doyle & Dolan 2006; Murphy 2004). Godin (2004) contributed to the discussion on the assessment of the risk of violence but his research is dated and referred to CMHNs in the United Kingdom. Risk assessments tools examine many aspects of risk by consumers but they do not specifically address the risk of violence to CMHCs (Godin 2004; Holmes 2013). Some examples of risk assessment tools include the Mac Arthur Violence Risk Assessment Study (MacVRAS) (Monahan et al. 2001, cited in Doyle & Dolan 2006), the Violence Risk Assessment Guide (VRAG) (Webster et al. 1994, cited in Doyle & Dolan 2006) and the Historical Clinical Risk – 20 items scale (HCR- 20) (Webster et al. 1997, cited in Doyle & Dolan 2006). The community mental health setting which was involved in this research utilises a risk assessment tool that is incorporated into the Community Based Information System (CBIS) (Government of South Australia 2011) (Appendix 1). The CBIS risk assessment tool incorporates aspects of the risk assessment tools that have been mentioned by Sands et al. (2012) but it does not specifically identify the risk of violence toward CMHCs. Risk assessments include predictive factors such as static and dynamic risk factors as displayed in Appendix 1. Static factors are reliable indicators of the risk of violence, however, dynamic factors are more pertinent to violence risk management and in particular the consumer's perception of treatment, which is highly relevant to the risk of violence (Elbogen et al. 2006). Using the MacVRAS tool, the risk of violence was predicted prior to discharge from five in-patient facilities, hence the MacVRAS tool gave an indication of the likelihood of violence in the community (Monahan et al. 2001, cited in Doyle & Dolan 2006). Despite the usefulness of the MacVRAS tool, this tool is not used within NALHN.

The efficacy of risk assessments

There is controversy regarding the efficacy of performing risk assessments. The strong emphasis on risk can negatively impact upon the consumer's care and risk assessments do not necessarily prevent adverse outcomes (Godin 2004; Holmes 2013; Nielssen 2013; Szmukler & Rose 2013). Penterman and Nijman (2011) assert that there is no assessment tool that is suitable for every occasion. In addition, there is concern about the expenditure of time and effort required to complete risk assessments (Brunton 2005; Godin 2004). Risk assessments are performed despite the assertion that there is no clearly identified benefit (Richardson-Tench et al. 2014; Szmukler & Rose 2013), which is concerning given the emphasis in health care on evidence-based practice (Kent & McCormack 2007). Furthermore, the ethical and political issues and difficulties with risk assessments are emphasized by Crowe and Carlyle (2003) who challenge the social and medical management of consumers, arguing that risk assessments are merely a form of contemporary governance related to the fiscal needs of organisations. Risk assessments need to be useful tools to predict violence, in order to improve the safety of CMHCs. Risk assessments are an attempt at objectifying risk factors thereby reducing reliance on the judgement and experience of CMHCs (Szmukler & Rose 2013). However, risk assessments could be improved to incorporate the cues, judgement and experience of CMHC's (Buckingham, Adams & Mace 2008; Szmukler & Rose 2013). When risk assessments are augmented by the expertise of CMHCs, they will give a more helpful indication of the risks of the consumer (Godin 2004). It is vital that the investment of time and effort to perform risk assessments is beneficial in supporting safe and effective care for all concerned.

There are additional concerns about the negative outcomes from the use of risk assessments. Risk assessments are prone to false positive and false negative results according to Holmes (2013). This means predicting violence, when violence does not occur, and not predicting violence when violence does occur respectively (Nielssen 2013; Szmukler & Rose 2013). The obligation to perform risk assessments is questioned given that false negatives and false positives cause poorer outcomes which undermines the formation of trust with consumers. In addition, Hawley et al. (2010) emphasize the large investment of time to perform risk assessments. Littlechild and Hawley (2010) discuss risk assessments in general from a social work perspective;

they conclude that training in risk assessments is required to ensure they are performed adequately. Regardless of concerns about the efficacy of risk assessments, they are still performed routinely by CMHCs for consumers.

The majority of risk assessments are aimed at overall risk, and do not specifically address the risk of violence toward CMHCs. However, in the Netherlands, Penterman and Nijman (2011) researched one assessment tool which assesses known factors about consumers to predict the likelihood of violence toward CMHCs, and the predictability value was deemed fair to good. The tool comprised of a check list which has to be completed prior to attending a potentially dangerous crisis situation involving a consumer in the community. In proportion to the number of call outs, the highest rates of aggression were following call outs requested by police, family members or the consumer, when compared to call outs requested by general practitioners (Penterman & Nijman 2011). Factors which increased the likelihood of aggression toward CMHCs were identified as: drug and alcohol abuse; comorbidity of schizophrenia; antisocial personality disorder; psychosis; prior aggression; prior involuntary admissions; potential paranoid delusions; and sensory disturbances (Penterman & Nijman 2011; Rao, Luty & Trathen 2007). Other factors were related to the consumer's environment, such as social problems and the presence of dangerous people and weapons (Penterman & Nijman 2011). Their research had some limitations in that it did not assess if clinical judgement alone could have produced similar results (Penterman & Nijman 2011). Furthermore, when the assessment indicated an increased risk of violence, precautionary measures were attended, such as gaining advise from senior staff, gathering additional information about the situation and the consumer, being accompanied by another colleague, relocating the visit to another venue and obtaining police presence (Penterman & Nijman 2011). Naturally, predicting the likelihood of violence should prompt action to circumvent violence which in turn undermines the predictive ability of the test (Penterman & Nijman 2011). It is desirable that specific risk assessment tools be utilised to predict the risk of violence toward CMHCs, so that appropriate action is taken. Similar research in a contemporary Australian context would be beneficial to determine best practice in risk assessment and management.

Management of the risk of violence

Coping strategies and risk management training

The risk of violence needs to be managed skilfully and appropriately by CMHCs. Firstly, CMHCs need to acknowledge that there is a risk of violence associated with some mental health disorders and then develop effective risk assessment and management strategies aimed at violence prevention (Sands et al. 2012). To assess and manage the risk of violence, CMHCs need to have specific knowledge, skills and attitudes (Happell & Gaskin 2012; Happell, Palmer & Tennent 2011). One of these skills includes having coping strategies to overcome any anxiety and fear with regard to the risk of violence (Addis & Gamble 2004), such as the development of resilience (Edward 2005). In addition, appropriate training is required to help CMHCs make rapid decisions when assessing risk factors, and when risk factors are identified, interventions should be timely, for safer outcomes for both consumers and CMHCs (Sands et al. 2012). One intervention could be ensuring medication compliance with antipsychotic medications for consumers diagnosed with schizophrenia (Swanson, Swartz & Elbogen 2004). Further to this, it is important that CMHCs acknowledge recommendations for improvement in risk management to maximise their level of safety possible (McKinnon & Cross 2008). Although some articles discussed risk management, and Cummins, Sevel and Pedrick (2012) and Meadows (2011) recommend safety measures related to visiting consumers, limited insight was provided into the strategies that CMHCs actually use to manage the risk of violence to themselves from mental health consumers.

CMHCs require strategies to manage the risk of violence from consumers. CMHCs need to think and act in specific ways when caring for consumers (Meadows 2011). Meadows (2011) suggests how CMHCs should manage the risk of violence: CMHCs should be alert to their intuitive and emotional responses, and avoid threatening behaviour during interactions with consumers; CMHCs should be accompanied by another CMHC, unless there is confidence of a low risk of violence; escape routes should be established and utilised if necessary, followed by a request for assistance; CMHCs should be aware that restraint requires several trained people; there should be

clear standards when conducting interviews; and weapons should not be present. CMHCs should also be aware that there is an increased danger when administering medications; and CMHCs need to know how to maintain personal safety. Price and Baker (2012) discusses effective de-escalation techniques for mental health nurses which include: maintaining personal control; employing effective verbal and non-verbal skills; engaging appropriately with the consumer; knowing when to intervene; and as much as possible, ensuring safe conditions for de-escalation. When interacting with consumers, CMHCs should try to: investigate the cause of any aggression; support consumers when they express their problems; try to solve problems; be creative, flexible and tolerant; set limits on behaviour; and use a degree of authority depending upon the level of aggressive behaviour (Price & Baker 2012). The process of managing the risk of violence, involves the CMHC building rapport, employing a least restrictive practice approach and maintaining consumers' self-esteem (Price & Baker 2012). These strategies should be familiar to all CMHCs for the best outcomes for consumers.

Strategies for visiting consumers

CMHCs need to conduct home visits to consumers in accord with their local Policy and Procedure Guidelines (Appendices 2 to 5) and Work Health and Safety Standards (Australian Government 2011). Cummins, Sevel and Pedrick (2012) discuss the following management strategies for CMHCs: CMHCs must communicate their scheduled visits to supervisors and colleagues; CMHCs need to have mobile phones; they should wear comfortable shoes to allow for ease of mobility; and CMHCs need to identify themselves by wearing a name badge and having business cards; if CMHCs suspects the consumer is using alcohol or drugs they should avoid entering the consumer's home; police presence is advised if there is a perceived threat of violence; and respecting cultural practices is recommended to improve rapport with the consumer and family. In addition CMHCs should consider taking self-defence classes (Baby, Glue & Carlyle 2014; Cummins, Sevel & Pedrick 2012). The actual strategies that CMHCs use for safety that have been discussed by Cummins, Sevel and Pedrick (2012) and Meadows (2011) will be investigated in this research, along with any additional considerations and behaviour that CMHCs have when they engage with consumers.

Home visiting of consumers is a regular practice by CMHCs. Despite the inherent dangers of home visiting, home visits provide the benefit of getting to know the consumer in their own environment which provides a greater understanding of the consumer's strengths and difficulties (Cummins, Sevel & Pedrick 2012). However, CMHNs have described instances where they felt threatened, and were aware that patients toy with their fears (Godin 2004). It is necessary for CMHCs to manage their fear of violence during their interactions with consumers. One of Godin's (2004) interviews indicated that CMHNs use their mobile phones to call for help, and that they use a catch-phrase to indicate the police should be called. If there is a perceived high risk for a home visit, the home visit may be conducted with a colleague or the consumer may be asked to visit the community mental health centre.

Policy and Procedure Guidelines and Work Health and Safety Guidelines

Organisational policies and procedures (Appendices 2 to 5) and Work Health and Safety Standards (Australian Government 2011) should guide CMHCs when assessing and managing the risk of violence. The organisational management in each workplace is responsible for maintaining appropriate policies and procedures, and upholding Work Health and Safety Standards for employees which should include the provision of appropriate safety training (Australian Government 2011; McKinnon & Cross 2008). McKinnon and Cross (2008) found that despite training to deal with occupational violence, less than thirteen percent of mental health nurse respondents felt clearly confident, and eighty-one percent of incidents were not reported, due to a lack of support and inadequate follow-up. In an attempt to reduce the risk of violence, McKinnon and Cross (2008) make the following recommendations: avoid discharging consumers too early from hospital; support consumers toward medication compliance; report incidents of violence; review policies relating to occupational violence; training for mental health staff to deal with violence; placing a consumer on a treatment order when required, to enforce an admission or treatment; address workplace culture; and develop orientation packages. Policies and procedures need to be relevant and support the safety of CMHCs in accord with Work Health and Safety Standards (Australian Government 2011).

Organisational management should provide training in risk assessment and management for CMHCs (Beech & Bowyer 2004; Littlechild & Hawley 2010; Spencer & Munch 2003). Adequate training will help to develop confidence to intervene to reduce the risk of violent behaviour (Beech & Bowyer 2004). Spencer and Munch (2003) assert that safety training is an important part of skill development; hence training should include how to assess for acute symptoms, behavioural changes, medication compliance, alcohol and drug use, any orders related to compulsory care and history of violence.

Staff need to be provided with high levels of training in the management of violence and aggression, and in other key nursing areas such as risk assessment, care coordination, rapid tranquilization and effective evidence-based therapeutic interventions, including anger-management, assertiveness training, relaxation skills, problem-solving, acceptable self-expression and cognitive behavioural approaches. (Beech & Bowyer 2004, p. 35)

The work environment also needs to be considered for safety. The organisational management at the community mental health centre and CMHCs should take all reasonable measures to maintain safe work practices so that risks are eliminated or minimised in accordance with the Work Health and Safety Act 2011 (Australian Government 2011). Spencer and Munch (2003) provide information for social workers, which also applies to CMHCs; they detail several factors that need consideration, including the safe use of the work car; car maintenance, petrol supply, safe storage of keys, the removal of potential weapons, not leaving medication on display and parking safely to ensure that a rapid exit is possible. With regard to the local environment, it is important to have knowledge of any drug use and gang activities, recent violence, how social workers are viewed, safe travel routes, and how to park the car for safety (Spencer & Munch 2003). In addition, the consumer's home needs to be considered for the presence of other people, animals, illegal items, exit points, security devices, and weapons (Spencer & Munch 2003). Social workers need be aware of protocols when in imminent danger which includes: having an appropriate mobile phone with emergency numbers preprogramed into it; working with a colleague when required; having communication skills to de-escalate a situation; current non-violent self-defence training; self-awareness related to one's instincts; and an appropriate demeanour (Spencer & Munch 2003). The guidance for managing the

risk of violence by Spencer and Munch (2003) can be adopted by all CMHCs working with consumers. In accord with Work Health and Safety Standards (Australian Government 2011) organisational management at the community mental health centre and CMHCs have a duty of care to ensure that work is conducted as safely as possible.

Inadequacies in the current literature

The majority of available literature discusses the topic of risk assessment and management from a general perspective and so this is not specific to the risk of violence toward CMHCs. Guidelines for risk assessment and management of violence are described in social work and nursing text books such as Cummins, Sevel and Pedrick (2012) and Palmer (2010) respectively. However, there are only a few articles that specifically researched and discussed the practice of how CMHCs assess and manage the risk of violence to themselves from consumers, and some of these articles only refer to CMHNs (Godin 2004; Murphy 2004; Penterman & Nijman 2011). This research sought to address the inadequate amount of research relating to this topic.

Indications for future research

Many CMHCs consider their skills in risk assessment and management of violence to be based on instinct, “gut reaction”, intuition and experience (Brunton 2005; Godin 2004; Murphy 2004). It is possible that experienced CMHCs have become so accustomed to what they are doing, that they have difficulty explaining the details about the strategies they use. This lack of insight hinders dissemination of knowledge and skills to new CMHCs. Apart from the interpersonal skills of CMHCs, risk assessment tools have been devised to enhance the assessment of the risk of violence (Godin 2004; Penterman & Nijman 2011). It is desirable to gain a greater understanding about strategies that CMHCs use when performing risk assessment and management of violence from consumers. This research has attempted to understand these strategies. The results from this research can promote future activities such as action research which could be undertaken to provide effective education on risk assessment and management of violence for CMHCs, and to ensure that policies and

procedures on risk assessment and management are comprehensively written to improve safety and to be in accord with Work Health and Safety Standards.

Conclusions from the literature review

The available literature provides limited discussion on how CMHCs perform risk assessments and management of violence from consumers. Some CMHCs prefer to rely on instinct, “gut reaction”, intuition and experience for their personal safety but this seems to be an insufficient means to gauge personal safety from potentially violent consumers (Brunton 2005; Godin 2004). Current standards of practice require that CMHCs perform risk assessments and while some CMHCs find them helpful, there is contention about the benefit of risk assessments to both CMHCs and the consumer. Risk assessment and management skills are assumed knowledge and learnt on the job according to Palmer (2010). However, there is no clear understanding of the strategies that CMHCs use for risk assessment and management of violence (Brunton 2005; Murphy 2004). The current literature lacks insight into how CMHCs rely on instinct, “gut reaction”, intuition and experience to assist in the assessment of the risk of violence. Research that identifies the strategies that CMHCs use for risk assessment and management would be beneficial to the knowledge base for all CMHCs.

Chapter Three: Methodology and Methods

Introduction

This chapter lists the theoretical assumptions and describes the characteristics of quantitative and qualitative paradigms. A qualitative methodology was the most appropriate for undertaking this research. The qualitative methodologies of descriptive exploratory, phenomenology, grounded theory and ethnography were considered and the reasons for choosing the descriptive exploratory methodology are discussed. Further to this, a detailed description of the research methods is given in the second half of this chapter. The description of the methods includes: ethical considerations and ethical approval; informed consent, privacy and anonymity; the study setting; inclusion and exclusion criteria of participants; recruitment strategies; data collection; interview techniques; reliability and validity; and storage of the data.

Theoretical Assumptions

Theoretical assumptions underlie the methodologies and the subsequent generation of knowledge. The theoretical assumptions of this research include the following concepts: Ontology which is the study of existence; Epistemology which is the study of knowledge and truth; and Methodology which is a framework for conducting the research (Richardson-Tench et al. 2014; Whitehead 2013b). The two main paradigms that are used in research are quantitative or qualitative methodologies or a combination of both. The research question and reason for study determines the choice of a paradigm and methods.

Quantitative and qualitative methodologies

The selection of either a quantitative or qualitative paradigm or combination of these is dependent upon the research topic. The factors to consider when choosing a paradigm include the purpose of the research, the nature of the issue, the best fit for the research, the knowledge and experience of the researcher and the need for generalizability (Whitehead 2013b). Quantitative and qualitative research is explained in detail by Shields and Watson (2013), Whitehead (2013a), Richardson-Tench

(2014), Kermode and Roberts (2006) and Polit and Beck (2008). In brief, quantitative research is a positivist research methodology, which uses a scientific approach of objective observation, prediction and testing, and acknowledges a cause and effect relationship (Maggs-Rapport 2001 cited in Whitehead 2013b). The term determinism is used to denote that the phenomena are not the result of chance; rather, there are predisposing causes (Polit & Beck 2008; Whitehead 2013b). The quantitative approach employs terms such as “empirical-analytical” or “logical positivism” to describe the origins and belief system of this paradigm, and another term is “deductive reasoning” which is a logical thought process that moves from current knowledge to testing the subject (Polit & Beck 2008; Whitehead 2013b). Quantitative methodologies use objective, empirical methods where the research is shown to have “reliability” in that the results can be replicated, “validity” so that it actually tests what it is designed to test, and “generalizability” in that the data can be generalised to similar populations (Richardson-Tench et al. 2014). The quantitative method only allows research that can be answered by objective processes such as observation, description, measurement, correlation and analysis, explanation and prediction to determine statistical significance; to support this, variables are carefully controlled and manipulated as required (Richardson-Tench et al. 2014). The analysis of quantitative data involves inductive and deductive reasoning; the data is reduced to things of interest, a process known as “reductionism” (Fisher & Schneider 2007; Richardson-Tench et al. 2014). Quantitative methodologies reveal information about the effectiveness of interventions; it is not subjective and therefore it may not involve humans and does not allow for individual discourse (Richardson-Tench et al. 2014). Neither quantitative methodology nor a mixed method approach was used in this research; the research question required the adoption of a qualitative methodology and hence the following discussion will concentrate on the main qualitative approaches.

An alternative methodology is qualitative research. Qualitative research is a post-positive approach to research used when the topic is subjective and specific to a situation or culture; it therefore allows for research about the human experience (Pepitone 1981, cited in Whitehead 2013b). The levels of evidence for qualitative research include feasibility, appropriateness, meaningfulness, effectiveness and economic evidence (Joanna Briggs Institute 2013 cited in Richardson-Tench et al.

2014). Qualitative research adopts a naturalistic paradigm and may be either interpretive or critical in approach (Polit & Beck 2008; Whitehead 2013b). The interpretive approach may be considered a constructivist or naturalistic paradigm; it describes, explores and generates meaning within a specific cultural or situational context through employing a methodology such as phenomenology, grounded theory, ethnography or descriptive exploratory (Polit & Beck 2008; Whitehead 2013a, 2013b). The interpretive approach may describe and examine a phenomenon within a specific context via dialogue between the participants and the researcher which gives rise to meaningful reality, therefore the phenomenon may have many different meanings and possibilities, hence reality is understood to be flexible (Polit & Beck 2008; Whitehead 2013a, 2013b). Then, through a process of inductive reasoning, generalisations are derived from observations (Whitehead 2013b). In contrast, the critical approach challenges the status quo and seeks to promote change within its context (Harding & Whitehead 2013; Richardson-Tench et al. 2014). The critical approach is a post-positive approach and seeks to challenge and change the existing societal norms whilst empowering research participants, hence it is an emancipatory approach (Richardson-Tench et al. 2014; Whitehead 2013b). Another approach of critical research is feminist research which identifies and then seeks to change power structures such as gender (Whitehead 2013a). The researcher needs to consider the nature and purpose of the research and adopt the most suitable paradigm (Harding & Whitehead 2013; Richardson-Tench et al. 2014).

Qualitative research allows for the use of individual discourse to discover knowledge about the consciousness and subjective opinions of people from the population that is being studied (Richardson-Tench et al. 2014). As such, qualitative research is non-empirical and non-replicable, and therefore not generalizable to a wider population (Taylor 2006). Rather than reliability and validity which is appropriate to verify quantitative research, “trustworthiness” is adopted to evaluate qualitative research, and this is achieved by participants being accurate to their experiences, attitudes, values and beliefs which are specific to themselves, their location, time and context (Harding & Whitehead 2013; Polit & Beck 2008; Richardson-Tench et al. 2014). Qualitative research therefore provides rich insight into specific phenomenon.

In qualitative research, the participants have the knowledge that the reviewer wants to discover. Thus the participants may be part of the phenomena, environment and culture to be studied, or participants have experiences that are to be researched (Polit & Beck 2008; Richardson-Tench et al. 2014; Whitehead 2013a). The data are analysed and interpreted using one of the specific approaches suitable for qualitative research. The research in this Masters thesis aimed to understand the experiences and opinions of the participants, and individual discourse is a vital part of this research. Consequently, a qualitative methodology was chosen for this research project, because it is the most appropriate methodology to answer the research topic. There are a number of other approaches that are available within the qualitative methodology (Annells 2007; Richardson-Tench et al. 2014; Whitehead 2013a). The main approaches for qualitative research that will now be discussed include; descriptive exploratory, phenomenology; grounded theory; and ethnography.

Descriptive exploratory

The descriptive exploratory methodology has become a popular choice for research in nursing (Whitehead 2013a). The descriptive exploratory approach incorporates all the qualitative approaches and allows for a less structured approach for data collection and analysis than the traditional methods of phenomenology, grounded theory and ethnography (Whitehead 2013a). The descriptive exploratory approach does not require the theoretical or philosophical considerations that the traditional research approaches demand; the more traditional approaches demand a complex and precise adherence to the methodology with regard to the detail and exploration of the data (Whitehead 2013a). The descriptive exploratory approach is a general qualitative approach used to analyse narrative data from small purposely selected populations, using an unstructured thematic analysis (Whitehead 2013a). For this research thesis, data was recorded and transcribed from a single semi-structured face-to-face interview, and the data was then thematically analysed using a method described by Braun and Clarke (2006) and Richardson-Tench et al. (2014). The alternative qualitative approaches that are incorporated into the descriptive exploratory methodology will now be described. Ultimately, the descriptive exploratory methodology was chosen for this research.

Phenomenology

Phenomenology aims to uncover the meaning of a phenomenon that has not been previously discovered (Polit & Beck 2008; Whitehead 2013a). Phenomenology provides a rich description of the phenomenon; the description can emphasize the possibilities and impact of that phenomenon (Whitehead 2013a). Within phenomenology, specific human lived experiences are understood from the perspective of being in the person's "life-world" (Polit & Beck 2008; Richardson-Tench et al. 2014; Whitehead 2013a). Phenomenology does not give a causal explanation of the experiences; rather, the data is interpreted to provide a description of the meaning related to being a person within that particular world, where the phenomenon is understood as a whole (Polit & Beck 2008; Whitehead 2013a). In light of this, it was considered that phenomenology would not enable an exploration of how CMHCs assess and manage the risk of violence, and therefore it was not a suitable framework for this research.

Grounded theory

Grounded theory was also considered as a possible methodology for this research. Grounded theory evolved to explain human action and interaction by collecting data over time, starting from the ground up and using an inductive process which requires a very rigorous and lengthy process (Polit & Beck 2008; Richardson-Tench et al. 2014; Whitehead 2013a). There are many perspectives of grounded theory which differ in the way data are analysed and theory is derived to propose a solution to a problem or to explain the socially constructed events (Richardson-Tench et al. 2014; Whitehead 2013a). The main perspectives of Grounded theory are objectivism and constructivism from which theoretical explanations are derived (Whitehead 2013a). The question asked in this research thesis does not relate to a specific theory and therefore Grounded theory was not an appropriate methodology for this research.

Ethnography

Ethnography is the descriptive study of a cultural group with the aim of understanding their behaviour (Polit & Beck 2008; Whitehead 2013a). Cultural groups share knowledge and hold specific beliefs on relationships, and ethnography seeks to understand these cultural norms as a whole entity (Richardson-Tench et al. 2014; Whitehead 2013a). Understanding is gained over time from observing and gathering various data of the whole society (Fetterman 2000, cited in Whitehead 2013a). Ethnography involves an outsider identifying and understanding a culture that is different from their own; this practice is termed ‘fieldwork’ (Richardson-Tench et al. 2014; Whitehead 2013a). Ethnography may also include historical research where, the study examines long term change in societies to provide a point of reference for today (Polit & Beck 2008). The research topic was not an observational study and hence this methodology was also not a suitable choice.

Selecting the descriptive exploratory methodology

After considering the attributes of the various methodologies that have been briefly described, the most relevant methodology was determined to be descriptive exploratory. The descriptive exploratory methodology provided the greatest flexibility during the conduct of the research and allowed the analysis to be performed in a timely and achievable manner to complete this Masters thesis (Annells 2007; Kermode & Roberts 2006; Whitehead 2013a). The degree of freedom within this methodology, allowed the data to be collected from single interviews for each participant and thematically analysed to provide insight (Harding & Whitehead 2013). From the insight gained from this research, it is anticipated that the findings will be published and future research topics may be realised. The next section of this chapter will discuss the methods that were used to attend to the research.

Research Methods

This research examines how CMHCs assess and manage the risk of violence from mental health consumers. The available literature lacks detail about how CMHCs

manage their safety when making reference to “gut reaction”, “experience” and “clinical judgement” (Murphy 2004); this does not provide sufficient detail of how CMHCs assess and manage the risk of violence. The processes that CMHCs use must be understood to a greater extent and documented in the literature to inform other CMHCs and colleagues who work with consumers in the community context. This research may identify areas of practice that are in accord with policies and procedures and Work Health and Safety Standards and then identify other practices that need improvement. It is hoped that these research findings will promote improvements and lead to future research with the aim of ensuring that appropriate safety measures are in place for CMHCs.

Restatement of research design

The research assumed a descriptive exploratory methodology within a qualitative research framework as described by Whitehead (2013a). This methodology allowed for a rich source of data to be derived and thematically analysed from a small number of participants (Whitehead 2013a).

Ethical considerations

Ethical considerations needed to be considered in this research as discussed by Woods and Schneider (2013) and Polit and Beck (2008). When ethics approval was obtained, the researcher was permitted to advertise and explain the research at the community mental health centre. CMHC participants needed to be completely voluntary so coercion to participate was avoided. Each participant was required to request a Participant Information Sheet, which included a consent form and a withdrawal form (Appendix 10). A signed consent form was required from each participant prior to the interview proceeding. A withdrawal form was also provided in case the participant decided to withdraw from the research (Appendix 10). Confidentiality was required for CMHCs and consumers. There was a need to have psychological support available for participants in case past traumatic situations resurfaced during the interviews. The research did not include consumers as participants so there were no perceived ethical

dilemmas directly related to consumers. At the conclusion of the research, there is a requirement is that data will be stored in a secure facility for at least five years.

Ethical approval

Research approval from the relevant ethics committee was obtained prior to conducting the research (Polit & Beck 2008; Richardson-Tench et al. 2014). In this research, ethics approval from the Human Research Ethics Committee (HREC) relevant to the specific health service was obtained (Appendix 6). In addition, Site Specific Assessment approval was also obtained from management of the community mental health centre (Appendix 7) and the University of Adelaide Ethics Committee which was granted after approval from the HREC.

Informed consent, privacy and anonymity

After ethics approval was obtained, the research was announced at the community mental health centre and a letter of invitation which briefly explained the research, was made available to the CMHCs (Appendix 8). Interested CMHCs were given a questionnaire (Appendix 9) and a Participant Information Sheet which described the research in more detail (Appendix 10). Prior to each interview, a signed consent form from each participant was obtained. Confidentiality was addressed within the limitations of qualitative research via the use of a pseudonym for each participant and avoiding the use of any identifying names or places. If identifying names or places were mentioned during the interviews, the researcher altered or removed them during transcription of the data. The community mental health centre rooms provided privacy. However, the face-to-face interview of the participants meant that the CMHC participants could not remain anonymous to the researcher.

Descriptions of the study setting

The setting for the data collection was a northern metropolitan community mental health centre, located in a low socio-economic region of Adelaide (Galletly et al. 2012;

Glazbrook 2011). The interviews were held at the CMHCs usual place of employment. The interview rooms at the community mental health centre provided suitable locations to avoid interruptions.

Types of participants; inclusion/exclusion criteria

Inclusion criteria:

- Participants need to be CMHCs employed on a regular casual, part-time or full-time basis at the CMHC.
- CMHCs need to have regular contact with mental health consumers in the community setting.
- CMHCs may be any age.
- CMHCs may be any gender
- CMHCs may have any amount of experience in community mental health nursing.
- CMHCs may be at any level of employment.

Hence a diversity of experience was welcomed to add depth and richness to the data.

Exclusion criteria:

- CMHCs who are employed via a nursing agency will not be included.

Recruitment strategies

After ethics approval was granted, the research was introduced at a small number of morning team meetings at the community mental health centre. A Letter of Invitation explaining the research was provided at the meetings and in the tea room (Appendix 8). CMHCs were then invited to discuss participation with the researcher. The participants were CMHCs who were employed as CMHNs, social workers or occupational therapists at the community mental health centre. Interested CMHCs were provided with: the questionnaire (Appendix 9); a Participant Information Sheet, a consent form and a withdrawal form (Appendix 10). Participants were invited to discuss the research in more detail, and there was no coercion to participate.

Participants were advised that follow up counselling is available via the Employee Assist Program which is available to all Australian Health Employees. The preferred number of participants was eight to twelve to enable an adequate and manageable amount of data for analysis. The aim was to have a sufficient number of participants to reach saturation point for the data (Guest, Bunce & Johnson 2006). The CMHC participants were recruited from a non-probability, convenience, purposive sample (Lopez & Whitehead 2013). A quota sample within this population was not established; hence there was no determined mix of gender or age in the participants. The inclusion criteria determined that only CMHCs that were contracted employees at the community mental health centre were permitted to be included in the research (Lopez & Whitehead 2013).

Description of any collection tools

The researcher utilised the interview rooms at the community mental health centre. The researchers code locked mobile phone and iPod devices as described by Lopez and Whitehead (2013) were used for recording the interviews. The researcher's code locked personal laptop was used to transcribe the recorded interviews.

Details of data collection

The interviews were audiotaped onto both the researcher's iPod and mobile phone which created a backup recording of the data. The audiotaped recordings allowed for the interviews to be transcribed in preparation for analysis (Lopez & Whitehead 2013). The participants' identities were eliminated from the data by the use of a pseudonym. Participants were instructed to avoid referring to any identifying information such as names or locations, but if any identifying information was inadvertently mentioned during the interview, it was altered to maintain confidentiality of the CMHCs and consumers.

Description of the interview technique

The interview process required careful consideration. A pilot interview was not conducted because the questions were merely a guide for the discussion (Lopez & Whitehead 2013). The interviews were confidential, semi-structured, one-to-one, face-to-face between the interviewer and the participant (Lopez & Whitehead 2013). The interviews were conducted in a non-judgemental and non-threatening manner. At times during the interviews, the researcher used probing questions and paraphrased the comments to ensure clarity during the discussion. The length of the interviews was guided by the participants; interviews concluded when there was no longer any new data from the participant, and when the participant agreed to end the interview.

Reliability and Validity

For the purpose of evaluating the standard of this qualitative research, the use of the term trustworthiness rather than validity is considered more appropriate (Harding & Whitehead 2013; Polit & Beck 2008). Trustworthiness was achieved by meticulous transcription of the interviews, followed by a thematic analysis of the data to allow for inferences to be made (Harding & Whitehead 2013).

Storage of the data

The data was stored in a secure location with the researcher during all phases of the research process. The participants' responses were organised under the participants' pseudonyms. Following the research, the tapes and transcripts were maintained in a secure location at the University of Adelaide, School of Nursing, for a minimum of five years before being destroyed.

Conclusion

In this chapter the research methodologies of descriptive exploratory, phenomenology, grounded theory, and ethnography have been briefly described. The methodology that was selected was the descriptive exploratory methodology because it allows flexibility

to collect and analyse data in a less structured approach than the other methodologies. With the descriptive exploratory methodology, the methods that were undertaken to conduct this research have been described in detail. In the next chapter, the analysis and interpretation from the data will be presented.

Chapter Four: Analysis and Interpretation of the data

Introduction

This chapter presents the analysis and interpretation from the data. The data from the interviews was analysed to form three main themes: preparing to meet the consumer; intervention strategies for safety; and organisational management. From the three themes, numerous subthemes emerged. The themes were interpreted under the relevant headings and relevant extracts from the data were included to illustrate these themes.

Data collection and method of analysis

The data was collected from individual interviews of each participant. There were eleven voluntary participants which provided sufficient data for this research (Guest, Bunce & Johnson 2006). Note taking did not occur during the interviews because it may have caused a distraction to the discussion. The interviews took between twelve to thirty minutes duration, and participants only had one interview each. The interviews were audio recorded and transcribed word-for-word into a Microsoft WORD document on the researcher's security coded laptop, at a secure site by the researcher to promote familiarity with the data (Lopez & Whitehead 2013). The transcription was set up into a document with a margin to allow for codes and note taking during a manual analysis of the data. The participants' body gestures were not included in the transcription because they did not display any distinct behaviour that was noteworthy (Lopez & Whitehead 2013). Any identifying names were removed during transcription. The transcribed interviews were not checked by the participants due to time constraints and the meticulous attention to detail during the transcription. A copy of the transcribed interviews was also given to the research supervisor.

When all the interviews were accurately transcribed, the thematic analysis of the data commenced (Braun & Clarke 2006; Richardson-Tench et al. 2014). The data was analysed without the use of a software data tool. The data was read and re-read to ensure familiarity; theory driven codes were derived to form the units of analysis; the

units of analysis were then used to form themes; the established themes formed the basis for the discussion (Braun & Clarke 2006; Richardson-Tench et al. 2014). The themes were also reviewed during discussions with the research supervisor. Extraneous matter such as “umm”, “err”, “mmm”, pauses, repeated words and superfluous words were also removed from the quotations in the analysis and clarifications were added in brackets, to achieve the essential meaning of the statements (Richardson-Tench et al. 2014).

Demographic of Participants

The participants were invited from a community mental health centre team, which consisted of CMHNs, social workers and occupational therapists. As previously indicated, each participant was referred to as a community mental health clinician (CMHC). Quotas for participant variables were not incorporated into the research design (Lopez & Whitehead 2013). The participants who volunteered consisted of nine CMHNs and two social workers; no occupational therapists participated. The length of experience of the participants ranged from two years to over thirty years, and the majority of participants had been working in mental health for over fifteen years. Amongst the participants in this research, the variables of gender and age were not considered (Polit & Beck 2008), however both genders were represented and participants were of a wide variety of ages.

At the community mental health centre, CMHCs conduct the majority of visits with consumers in the community and discussion regarding this practice will dominate the analysis and interpretation. The community mental health centre operates as two teams, which are geographically determined, and consumers are allocated to the teams according to their place of residence. Each team has a duty worker during the day and there is one duty worker for both teams after hours. Participants from both teams were represented and no distinction was made between the teams during the analysis. The community mental health centre also provides a Walk in Service (WIS) for assessments. Safety measures for CMHCs who assess consumers at the community mental health centre include rooms that have duress alarms on the wall and under the desk, and a personal alarm. There is also a security guard at the community mental

health centre after business hours. As previously stated, the majority of visits with consumers occur in the community rather than the community mental health centre and the discussion will be dominated by how CMHCs conduct home visits.

Thematic analysis and interpretation of the data

The key points that guide the analysis of the data are dictated by the research question “How do CMHCs assess and manage the risk of violence from mental health consumers?” The key points that the analysis will examine is: how participants prepare for a home visit; the methods of assessing and managing the risk of violence; and the awareness and use of policies and procedures and Work Health and Safety Standards. The identified codes and themes were organised to establish three main themes: preparing to meet the consumer; intervention strategies for safety; and organisational management. The three main themes and respective subthemes will now be discussed.

Preparing to meet the consumer

Gathering information

When a CMHC is allocated to care for a consumer, the routine practice is to gather information about the consumer including risk factors in accord with the Home Visiting policies and procedures (Appendices 1 and 5). This information is largely gathered from CBIS which may contain the past history, current history and any alerts that have been recorded. Another local health information system is the Outcome and Assessment Information Set (OASIS), which provides discharge summaries from hospitals related to mental health and general medical information. The available information usually includes a handover if transferred between CMHCs. CMHCs may also discuss the consumer with other CMHCs. When CMHCs are aware that there is a previous incidence of violence, their research about the consumer becomes more vigilant. The CMHCs responses to this initial phase of gathering information were consistent, with the aim of gathering as much information as possible and assessing for any risk of violence in the past and present.

...the first time I am collecting a new client, we usually have a face to face handover, depending on the client situation; whether they are from one other team to us, or if they were picked up from the hospital. (...) The previous care coordinator would introduce me to the new person and go through all the risks. (Pat p. 1)

I find out about them, through however they're presented, either as a referral or through a team review, or whatever, or over the phone from mental health triage. And then, I look them up on CBIS, and read some background, and check the alerts to see if there's any previous alerts that are serious... (Max p. 1)

I have a look to see about any risks, past history, past presentations to ED's and past presentations to inpatient units. I tend to ask my colleagues have they worked with this client before. Are there any risks? Is there anything I need to know? (Mary pp. 1-2)

Well obviously you look at the referral information, to see what that contains. I have a look at other resources available to me such as CBIS and OASIS, to see what information may be recorded on that. I particularly look for alert flags, to see what that's all about which may indicate whether there may be potential aggression or violence (Kevin p. 1)

CMHCs also gather information about the consumer by contacting the referrer, relatives, friends, other sources of collateral information, and the consumer by phone. Aspects about the consumer such as gender, drug use, living conditions and location are taken into account. All the available information gives the CMHC an indication of past and current risks of violent behaviour, and an indication of any environmental risks.

...we also contact the family members, if there are any of them to contact, or friends, close friends to them, or any person that we can actually get in touch with to give us collateral information about the client. (Pat p. 2)

I find out about them, through however they're presented, either as a referral or through a team review, or whatever, or over the phone from mental health triage. And then, I look them up on CBIS, and read some background, and check the alerts to see if there's any previous alerts that are serious... (Max p. 1)

I contact the consumer and talk to them about my role, coming out to see them...do a safety check to see whether they're a smoker to see if they cannot smoke while I am there. Do they have any dogs or other animals which may be potentially dangerous? If they have, can they keep them outside? Do they have other people in the household who may be dangerous to me for whatever reason? (Kevin p. 1)

Communication within the team

Communication with team members forms a major part of the preparation to meet the consumer. CMHCs are aware that the Home Visiting policies and procedures (Appendices 3 to 5) require them to write the details about the visit on the white board and electronically via CBIS scheduler, and also have their work mobile phones with them prior to visiting a consumer. Cars also have to be booked electronically. The details about the home visits are then accessible to team members and the CMHCs can maintain contact with the duty worker. All CMHCs take their work mobile phone with them and they notify the duty worker if there are any changes to their scheduled home visits. One issue that was raised by a few CMHCs was that their work mobile phone needs to be charged up and they need to contain emergency phone numbers for rapid dialling in the event of an emergency.

We have policies here to write our name up on the white board, who we're going to see and when we're coming back. Always take my work phone which always needs to be charged. I do have my personal phone and that is a back-up, so if something happened to the work phone, or it wasn't charged, I'd have my personal phone. (Mary p. 1)

...the duty desk is always occupied by one of the staff members and through the duty, we can always communicate to say, where we are up to and if we are going to be delayed or something like that. (Pat pp. 5 & 6)

You should make sure they [mobile phones] are charged, and you can use them and that you have got numbers, and if you're really worried, it's good to have emergency numbers already on the screen ready to push in case you need it. (Max p. 3)

So then we go to initial introduction by phone, scheduling a time electronically and then the logistics of booking cars, making sure people know you are out of the building, and various white boards. (Fred p. 2)

Concerns were raised about the use of the whiteboard, mobile phones and the processes in place to deal with CMHCs returning late from a home visit. On occasions the duty worker may be busy with many other tasks, and from where the duty worker is positioned, the white board is out of direct sight. Some suggestions were discussed to deal with this issue.

I think in theory the in-out board works; in practice...not. I can think of multiple times when I've been late and either missed the time or that I've not been able to call or people are looking for people and they've got no idea. So the board's not used by everybody and nobody really has ownership of checking everybody has returned roughly on time. If the in-out thing that we have on the computers worked. That an alert was activated...or that it's...allocated to somebody as a specific duty. (...) The white board is on the opposite wall, and the duty worker might be covering someone's sick leave and juggling their own things and have the rapid response phone. (...) I would say that if we sat down, and we had a conversation, people would be, "oh when I'm duty, I always check it". (...) I think the reality of that does not fit. (Jane p. 6)

I think there is a problem around using the white board, which is definitely a very good tool, but often people will write down four or five different names and that they'll be back around five. How are we meant to know who you're going to see? Like is that the order you're going in? (...) And then if you phone the police, which of those consumer's houses are they at? So, it's a bit of a concern (...) I think that you can have text messaging set up on your computers (...) then if you need someone, you look up on the computer screen (Louise pp. 12, 13)

Several CMHCs indicated that they sometimes omit to use the white board when home visiting. There was a heavy reliance on mobile phone access, which allows contact with the duty worker for safety. On occasions, there are difficulties with the use of mobile phones; the CMHC may not have access to a work mobile phone and the duty worker may not have the correct contact number for the CMHC.

I'm a little bit slack on the whiteboard bit...don't always remember to put my name up. This morning being a point. You get ready to go out, you go out the door, but yes...people do know where I'm going. But white board, I'll be honest... not always!! But phones...I always take my work mobile phone...everyone has my number. (Bruce p. 2)

To be honest with you the white board, some days I forget, but I do inform the coordinator before I go out and I always have my phone with me and sometimes I can't answer because I'm talking with a patient, or sometimes 'cos I'm driving, or somewhere. (Joy p.11)

The mobile list for example is not up to date. I don't have a work phone at the moment because mine is broken, so I'm using my personal one. (...) and people are phone sharing (Jane pp. 7 & 8)

Determining the location of the visit

After CMHCs gather information about the consumer, a suitable location of the visit is determined. It may become apparent that the risk factors are high and that additional support is required or that a home visit is unwise. In this case the CMHC may request that the consumer present to the community mental health centre. The community mental health centre has a duress alarm system and a security guard after hours. If the consumer presents to the community mental health centre but appears irritable, the visit may be conducted in an open area such as the foyer.

If the risk is really high, we don't go by our self. But if we bring them [consumers] along to attend at the clinic and if the risk is high, we don't see them in a very enclosed area. (Pat p. 1)

There's one client that I've newly had referred to me and he's got quite a history of violence, and I've actually asked him if he can attend the clinic to see me and also attend for his depot and that way it's a more controlled environment. You can have another person there and we've also got the security and back up. (Mary p. 6)

Coming into the office is a safer option because there's a security guard around the place, we've got alarms that we could use. (...) If he's irritable, agitated you don't invite him into the consulting room. You could chat to him outside and then press the alarm (...) When you're interviewing a client you make sure that you have quick access to the door. (Joy pp. 1 & 2)

...until recently we had no security people on site, so if we are bringing in a person on site we're usually asking the team to be aware and have someone in the interview room with you, and we do have the duress alarm mechanism. (Fred p. 3)

One service which always interviews consumers at the community mental health centre is the Walk in Service (WIS). The WIS CMHCs do not use a whiteboard for internal communication for CMHC location. When two WIS CMHCs are on duty, there is informal communication between WIS CMHCs prior to assessment of consumers. Consumers walk in without an appointment and may be new to CBIS. The WIS rely on the alarm system located within the rooms of the centre and have two CMHCs if there are concerns for their safety.

Doing assessments within the centre, we just advise within our walk in team if we go down to assess someone. So we don't have a white board system within the walk-in team which can be problematic because often

we don't know if our staff are down assessing or who they're assessing, and how long they've been in there, so that can be a bit of a problem. (Louise p. 1)

From a safety point of view, we all have our own personal alarms. There's a wall alarm and an under table alarm. And if we are concerned at all, we take two staff in for an assessment. (Louise p. 3)

Code phrase

Some CMHCs establish a signal, code word or code phrase in advance of a home visit, to discretely communicate with the second CMHC in case they think they need to quickly end the visit and exit the consumer's home.

...we usually talk to each other as we go along to see our client, and we kind of give each other a signal to say this is time to leave if the person is starting to become irritable to a stage where it is no longer safe for us to remain in the house. (Pat p. 5)

...we have a code word that my colleague and I would say, so we will work out a code word that if I say it, or if my colleague says it, we will know it's time to go. (Mary p. 3)

Before you go in, if you think this may get a little out of hand, you can have a code phrase. If I say this or you say this...we retreat, withdraw (...)
It's just between the two of you on the spot. (...) It's common practice... (Bruce p. 7)

CMHCs sometimes use phrases that are obvious to advise the consumer that the visit will cease.

It's more doing pre work and discussion before you go in, so you've at least discussed if this gets to a situation where either of us is uncomfortable, we won't necessarily use a phrase; one says that "we need to stop the interview now, we will be leaving". (Fred p. 10)

...before you go into the patient's house you have to have a plan first. Like you say to them "come on let's go", if I look at you or whatever, "come on let's go, we've got to see another patient" (Joy p. 3)

Determining the need for a second CMHC, Police and Ambulance presence

Preparation includes determining the support required to safely conduct the home visit. If a consumer is known to the mental health service and known to be a low risk to violence, the home visit is usually conducted with one CMHC.

...if they're known to the service already, then I probably wouldn't take a second person. Sometimes consumers can feel a bit judged if we're taking two people. So I probably wouldn't take a second person if they're a low risk. (Louise p. 2)

If you have dealt with that person in the past and there is no risk issue, you can easily go on your own. (Pat p. 2)

CMHCs take a second CMHC for an initial assessment if a consumer is new to the mental health system. Following the initial assessment, the need for a second CMHC would be based on the CMHC's judgement and knowledge about the risk of violence by the consumer. For a mental health consumer who is considered to be a high risk of violence, CMHCs carefully plan for a safe interaction through discussions with other CMHCs. In addition to a second CMHC, the police which are also referred to as "SAPOL" may need to be present at the visit.

...if you haven't seen them before, you need to still take somebody else with you, just in case. (...) I think you need to have a good team discussion before you go out. Maybe there's other people that have previously case managed that person. You might need to assess whether you're going to need police present, and you would definitely, be looking at the alerts for all the warning signs, and any history of violence towards workers. (Max pp. 2 & 3)

If the person wasn't known to the service already, I would arrange for a second person to come with me if it's a community visit. (...) If they're considered to be a high risk of violence, then ideally you would exhaust other options before the home visit. If the home visit has to be conducted, then probably you'd contact SAPOL for support. (Jane pp. 2 & 3)

I would call SAPOL for assistance if they've got high alerts and they haven't been engaging. (...) Reading from the past history, that would indicate each time that you see a patient, whether they needed SAPOL to start with. (Joy p. 4)

Intervention strategies for safety

Contacting the consumer

After preparing for the visit the initial intervention involves a further risk assessment and a conversation over the phone with the consumer.

...we check the risks; do a quick risk assessment, asking them whether they've got any violent, fierce dogs that will attack you, whether they have any knives or whether their partner is liable to be aggressive towards the staff members... (Joy p. 1)

I usually try and make phone contact with the client first. So I ring them. I introduce myself, tell them that I'll be coming out to see them, and basically just talk about what my role will be and that I'll be the care co-ordinator. (Mary p. 1)

Assessing the environment

For every home visit, CMHCs discussed the need to assess the environment. CMHCs are aware that there may be unexpected people at the consumer's home who may increase the risk of violence.

Look of the place, are there other people there? (...) I have, with colleagues, said, "I'm not comfortable going in there", so we've backed away, and that is when you arrange for them to come into the building. (Bruce p. 6)

...if I'm going somewhere, that I don't know, I need to know who's going to be in the house. I have been once to a house that I thought was just ordinary, and when we got there, there was about fifteen people there, and it was basically a drug den and we didn't know anything about it. (Ros p. 3)

...being mindful of the environment of which the home visit would be occurring, and who's around that home visit? Whether it's in the mental health hostel, or there's other risk people there. (Fred p. 3)

In addition, CMHCs need to assess any potential safety issues and hazards with the local neighbourhood, including dangerous animals or weapons.

So look at the yard, and look at the appearance of the place, and look to see if there's any animals or anything before you go in as well, that could be a danger. (Max p. 1)

Again check the risks, if there's any sharp objects or, any dangerous guns or relative aggressive, even though the patient them self is not aggressive. (Joy p. 3)

Going to the house...before you go out ordinarily you'd be checking to make sure that there was nobody out there that wouldn't appreciate you visiting or that would be a risk or any dogs or hazards in the home. So you'd be assessing that on arrival to the house. (Jane p. 2)

On some occasions, the predicted level of risk may not be accurate and the CMHC is compelled to deal with unexpected situations during a home visit. Experience can help CMHCs to deal with potentially dangerous situations.

There was a home visit where I went with another staff member, and we were in the kitchen talking, and I looked at the other staff member who looked down to the side to where there was a table filled with hunting knives (...) I stood in front of those knives (...) so even if he wanted to (...) he couldn't have got to the knives. (Louise pp. 6 & 7)

...and quite suddenly without our hearing anybody come to the front door, the door was flung open and the screen door pushed open and two pit bulls ran out at us and thank God that I was with a very large man with large boots on who kicked the dogs across the garden and we were running back to the car. (Ros p. 6)

I've always tried to get quick access, so it's sort of hovering between the front door (...) It's all comes down to experience. Anybody can do it (...) you've got to not be frightened. (Joy pp. 4 & 5)

Respecting awareness

If a CMHC is uncomfortable with the visit proceeding, these feelings are respected by the other CMHC.

...if you go as a two up, and one person goes, "I'm feeling really uncomfortable with this", you don't go in. Even if you are driving up to it. Even before you have presented. If one of your partners goes, "oh this looks a bit iffy, I'm really not comfortable", you just don't go in. (...) because you just never know. And it's absolutely, if they feel uncomfortable, you do not talk them round. You accept that and you make other plans. (Bruce pp. 6 & 7)

...the almost intuitive things of feeling aware of danger of feeling aware of what the surroundings are like of the place (Ros p. 5)

...you retreat from a visit if you feel that there's any sort of threat there rather than proceed. (...) What I've done in the past is retreated or called the visit off, like I've gone out there and the client's been very angry, haven't gone inside. They've been talking behind the screen door, haven't gone on with the visit. (Mary p. 6)

Exit strategies

One of the safety considerations during home visits involves having a constant awareness of exit strategies in case the need arises to retreat from the consumer. All

CMHCs consciously park their car to allow for rapid egress from the consumer's home. The car is always parked in the direction that they will travel away from the consumer's house.

...if we are in a cul-de-sac, we park so that we are not facing into the cul-de-sac, we are facing out of the cul-de-sac. (...) You always have an escape plan... (Bruce p. 6)

I'll park in front of the house along the street. I won't park in the drive way. (...) It doesn't matter which place I go to, whether it's low risk or high risk, that I've got an exit that I can get back to the car if I need to. (...) I tend to not like going behind the back of houses 'cos you don't have your exit. (Mary p. 2)

When CMHCs are at the consumer's front door, they also position themselves strategically to allow quick egress from a home visit which minimises the risk of any potential assault.

I make a point never to stand directly in front of a door. I don't know why, it's just something that I've done maybe from reading crime stories (*laughs*), but I always stand at the side. (Max p. 3)

When we got to the house, I or my partner, on knocking at the door, would probably be very unobtrusively, putting our foot, against the screen door, so that nobody could charge out. I've seen this happen. They had a rolled umbrella to poke us. So we're very careful. (Ros p. 2)

All CMHCs make a rapid mental state assessment on first engagement with consumers at every visit. If the consumer is deemed to be agitated, aggressive, under the influence of drugs or under the influence of alcohol, the CMHC may leave the house and briefly engage with the consumer outside.

...home visits, is not putting yourself in any danger so you're minimising that so you retreat from a visit if you feel that there's any sort of threat there. (Mary p. 6)

You can have a bit of a chat on their doorstep and that might be all that you need to do. (...) If they're especially agitated, if they're intoxicated, you might be able to smell it or sense it or see it in their pupils or reactivity...what they're saying in their speech. They might be extremely psychotic. The minute you get there or when you get there, even how they

open up the door, how they're engaging; are they gentle and encouraging or are they really aggressive? (Louise pp. 4 & 5)

...there's an awareness of a person's rising anger, an awareness of a smell in the house. I can now identify certain drugs just by smell and I try to get out of the house. (Ros p. 4)

If it is considered safe to enter the consumer's home, CMHCs immediately establish their exit points and strategically position themselves to allow for rapid egress if required. CMHCs may need to exit the house if the consumer becomes violent and a rapid escape is required. Some CMHCs request that the front door remain open whilst others remain conscious of their exit points and observe whether the door is closed.

...modern houses are very contemporary, with the very long central corridor, and some of the corridors have a twist, which I find dangerous. I would much prefer to be in a front room, but they're always bedrooms. But I try not to have anything between me and the door. I'm also wary when I've entered, being aware that the person I'm visiting, has locked the screen door and maybe deadlocked the front door; that worries me and I'll watch. (Ros p. 3)

...it's good to be aware of the exits, to make sure the door is left open. So some consumers will try and shut the door behind you. I usually ask them to leave it open (Louise p. 6)

I always make sure that there's a clear exit to myself and my colleague. If a client ever says "oh, come through to this room", I'll actually very politely say, oh that's fine, I'm really happy just to stand here, and talk. (...) I'll make sure I'm standing near the front door so that I can get out quickly. (Mary p. 3)

Interaction with the consumer

CMHCs are aware of the potential for violence with consumers. Using refined interpersonal skills and engaging with the consumer in a respectful and polite manner is important to minimise the threat of the consumer's behaviour escalating toward violence.

I would say, the use of self is very important and I think, trying to talk in a non-confrontational manner is very important to the client. (...) I try and make them feel at ease. I'll try and make them feel listened to. (...) I'll just talk in a very nice, respectful way, and that's often worked. (Mary p. 10)

...when you have to approach them, try not to be too confrontative; try to be as relaxed as possible; back off if they appear to be irritable or angry or agitated. (Joy p. 3)

I try and put the person at ease to make it as comfortable for them as it is comfortable for me to be doing the assessment. (Kevin p. 5)

CMHCs are constantly alert to the risk of potential violence. CMHCs assess the consumer's behaviour, observe for changes in their demeanour and take appropriate action for safety.

I tend to watch people, and read their body language, and if they are looking agitated or psychotic or they're voicing things that aren't realistic and it's violence related, or their mannerisms...I'll take a step back, and reassess the situation and perhaps get supports. (Max p. 5)

...you do observe...are they agitated? Are they quite relaxed when you go in? So all the time you are painting a picture, because the picture can change quite quickly. (...) You can see somebody starting to become agitated. (Bruce p. 6)

Well, if the client's voice is getting raised and if they're getting agitated, if they're starting to argue with you and not able to negotiate with you, I would just back off, I wouldn't allow them to escalate to that situation where it became physical. (Sue p. 5)

CMHCs determine what action to take if a consumer's behaviour is escalating toward violence. CMHCs respond in an individualised manner according to the specific situation to maintain safety for everyone involved.

...at least you'd try and deescalate the situation to start with. Your first thought is safety for yourself and the other worker that you are with, so I guess it would depend on the situation... (Sue p. 3)

If there was a situation where the client escalated and myself or my colleague was there and there was pending risk there...then I would dial for assistance... (Mary p. 8)

...it's such an individual thing based on the consumer and staff member as well. We each have different ways of managing aggression. Some people are quite assertive. (...) I try and humanise myself and bring that back to reality that, I'm a person and I'm trying to help you. (Louise p. 9)

If CMHCs observe a consumer becoming increasingly agitated or aggressive and the consumer's behaviour cannot be deescalated, the home visit is terminated. CMHCs return to the community mental health centre and documents the events and then talks

with other CMHCs to determine whether to return to the consumer and if police presence is required.

...you retreat from a visit if you feel that there's any sort of threat there rather than proceed. (...) I'll document that and I'll actually refer to OH and S safety (...) and then I'll talk to my team back at the office about whether or not we should engage SAPOL [police] with that client, whether we should go out again. (Mary p. 6)

...if that person had a history of violence, and they'd already assaulted another worker and you really needed to go round to see them, I would get the police involved. I don't think I would take the risk. (...) You're putting yourself and someone else's life in jeopardy, so I'd definitely be ringing the police, and saying "would you meet us there?" (Sue p. 4)

Organisational management

There are policies and procedures regarding home visit safety and Work Health and Safety Strategies that the management of the community mental health centre are responsible to maintain. One of the aims of the policies and procedures and Work Health and Safety Strategies is to support safety for CMHCs when visiting consumers.

Dealing with potential violence

Annual educational updates require that CMHCs attend non-violent crisis intervention (NVCi) training. The NVCi training aims to educate CMHCs how to escape from a violent encounter with a consumer in a safe manner for both the CMHC and the consumer. Some CMHCs have not maintained annual updates of this training.

I've done the training...non-violent [training]. I did that a couple of years ago but I mean that's supposed to be updated every year or two. It would be good to do that here because that was for the elderly service and I haven't done any for the adults. (Sue p. 7)

...if we take the mandatory training of non-violent crisis intervention for instance, the last time I did that was five years ago. (...) I should have done it. It's hard to get to these things. (Fred p. 12)

CMHCs constantly assess the consumer's demeanour and are prepared to manage potential violence in its various forms. The presence of illicit drugs can exacerbate consumers' behaviour towards violence.

...being shouted at is a regular occurrence, so it's inevitable that [violence] is going to happen with some of our clientele. I also find that as we deal with comorbidity more, there's more and more people coming into our system on the illicit drugs so the risk of coming in contact with violence is inevitable. (Bruce p. 5)

You have to get really smart at reading people, and you can read people's body language and their tone of voice. You can read the look of their eyes. If you think "oh, oh, if he's got daggers in his eyes", you don't go near 'em (Sue p. 6)

I think we deal with very violent and aggressive people. (...) We develop strategies that allow us not to be in a position where we would be at risk. (...) It is about managing the risk rather than being subjected to it. (Mary p. 8)

Awareness and utilisation of policies and procedures

Most CMHCs stated that they were aware of the policies and procedures. However, CMHCs rely on their experience and practical orientation for the assessment and management of the risk of violence from consumers.

It's not the current method to have written policies, because they change so frequently. You would point them [new CMHCs] to the triple P site, the health network and probably to specific policy names to review them. (Kevin p. 3)

It's part of your contract to know where to find them [policies and procedures]. I suspect probably more of what happens on a day to day basis, is what people have gathered over their years of working. (Jane p. 4)

There's not an actual document that I refer them [new CMHCs] to around management of violence. (...) I think, for orientating new staff members, it's more about that practical component, especially when they're new to the team (Louise p. 8)

Some CMHCs had difficulty finding the on-line policies and procedures. A few CMHCs referred to using the policies and procedures anecdotally and some CMHCs referred to printed copies of the policies and procedures which are no longer available.

I couldn't find anything there on home visits or anything, so obviously I need to get directed to the right website. (Sue p. 5)

...so quite often it's [orientating] anecdotally, (...) I do advise them to look up policies on the computer. I always chat about how we do things. It's more verbal... (Bruce p. 4)

...for me currently I don't know where they [policies and procedures] are. So to me, they are hard to find because they are not just sitting in a paper file that I can pull out of a filing cabinet that says orientation and safe practice folders. (Fred p. 5)

The policies and procedures were criticised by a few CMHCs as being useless and onerous. Managing aggressive behaviour was viewed as an individualised response by each CMHC toward consumers and hence it is difficult to generalise how to respond to every situation.

Most Policy and Procedure documents are a bit useless and there's a lot of reading (...) and it's very hard to write down in a Policy and Procedure how to manage aggressive consumers, because it's such an individual thing based on the consumer and staff member as well. We each have different ways of managing aggression. (Louise p. 9)

Well in terms of safety, I don't use any of them [policies and procedures]. I'm aware of them, but I perceive them as useless. They don't actually deal with the realities of the situation. (...) the things that they are writing in those policies, have nothing to do with real safety. (Ros p. 4)

Yeah, I mean there's a lot of stuff on the [Policy and Procedure] site, so it's a bit onerous isn't it? (Jane p. 4)

Work Health and Safety Standards

All CMHCs considered safety to be a high priority.

Obviously the most important thing is safety; safety to ourselves and safety to our clients, and safety to all members of the community. So prior to going to visit our client, we have to go through the risk assessment. We have to make sure that we are aware of any form of issue with this particular client. (Pat pp. 3-4)

...you need to make sure that you stress the importance of being safe. So being safe for yourself, being safe for others, people that you go with, identifying the risks before you get there. (Max p. 4)

CMHCs were aware of Work Health and Safety Standards and were able to easily locate them as a consequence of orientating new CMHCs. A few CMHCs had difficulty relating the Work Health and Safety Standards to the risk of violence and others appeared vague and had difficulty locating them.

I've got all that [Work Health and Safety Standards] on my desk top and I've made sure I can find it because I've precepted a couple of students. So it's really easy to have it there. (Mary p. 5)

I am aware of where to locate OH and S policies, but how they would relate to the issue of violence or potential violence would require me to search out. (Fred p. 6)

I can discuss with them [new CMHCs] what I know about the safety, and the Occ. Health and the risk that you check on CBIS. (Joy p. 7)

I couldn't find any [Work Health and Safety Standards]. I had a look on the SA Health website and I went to safety, what's it called safety and quality? (Sue p. 5)

Conclusion

This chapter has provided a thematic analysis and interpretation of the data. This analysis and interpretation has provided insight into the many strategies that CMHCs use when assessing and managing the risk of violence from mental health consumers. The strategies involve a thorough preparation prior to meeting the consumer, a carefully planned home visit or interaction with the consumer, and an acknowledgement of the risk assessment, policies and procedures and Work Health and Safety Standards with regard to safety for all involved. In the next chapter, the research will be summarised and discussed and the direction for future research will be considered.

Chapter Five: Discussion

Introduction

This research thesis investigated the way CMHCs assess and manage the risk of violence from consumers. The literature search provided the context regarding the deinstitutionalisation of mental health services and the subsequent impact on community mental health care (Bell 2003; Crowe & Carlyle 2003; Henderson et al. 2008; Holmes et al. 2006). The literature search also revealed there was an inadequate amount of research on how CMHCs assess and manage the risk of violence in the community. This research thesis has provided insight into the strategies of eleven CMHCs who are employed at a community mental health centre in a northern metropolitan region of Adelaide. The analysis and interpretation indicated that some areas of assessment and management are performed well, whilst other areas require improvement. The overall aim of this research was to identify the current practices, discover ways to improve the level of safety for CMHCs, and subsequently to consider topics for future research.

The main themes that emerged from the data were; preparation to meet the consumer, intervention strategies for safety and organisational management. Several subthemes also emerged under the three main themes. The findings indicated that the areas of risk assessment and management that are performed well were preparing to meet the consumer and exit strategies. However, other areas of practice were not performed well and these included; communication within the team and utilising the policies and procedures and Work Health and Safety Standards to maintain safety. A discussion will now present the research findings and suggest the implications for CMHCs practice and future research opportunities.

Restatement of the problem

Deinstitutionalization of mental health facilities in the 1950s resulted in the majority of mental health consumers residing in the community (Bell 2003; Crowe & Carlyle

2003; Henderson et al. 2008; Holmes et al. 2006). Consequently, there are times when CMHCs need to care for consumers during acute phases of the consumer's illness (Vandyk et al. 2013). It is therefore essential that CMHCs assess and managing the risk of violence appropriately to maintain their safety. The guidelines for risk assessment and management are detailed in the organisational policies and procedures, Work Health and Safety Standards, SA Health on line training websites, and by authors such as Cummins, Sevel and Pedrick (2012) and Meadows (2011). This research aimed to discover the strategies that CMHCs use for performing risk assessment and management and determine if these strategies are in accordance with the available guidelines and standards.

Major findings and their significance to clinical practice and education

Preparing to meet the consumer

Gathering Information

When CMHCs gather information about consumers, their aim is to thoroughly understand consumers to promote safe interactions, which was a strategy supported by the literature (Cummins, Sevel & Pedrick 2012; Doyle & Dolan 2002; Godin 2004; Meadows 2011). All participating CMHCs attended the phase of gathering information in a thorough manner. CMHCs collate information from the referral and from CBIS, and via communication with other CMHCs and sources such as relatives. CMHCs also contact the consumer to discuss risk factors, however CMHCs should be aware that consumers do not always give accurate responses regarding the potential risk to CMHCs. CMHCs gather information from a variety of sources to determine the risk of violence from the consumer.

The assessment of the risk of violence

The methods of assessing and managing the risk of violence from consumers involves a variety of approaches. There should be a risk assessment on CBIS if the consumer has had previous interaction with the mental health system (Appendix 1). The CBIS

risk assessment considers multiple factors relating to the consumer, but is not specific to the risk of violence from consumers to CMHCs (Appendix 1). Further to this, the alert system on CBIS is available for CMHCs to record all known instances of violence. The CMHCs do not use any other formalized tools to assess the risk of violence (Doyle & Dolan 2002; Godin 2004; Murphy 2004). However, there are effective risk assessment tools available such as the MacVRAS tool (Monahan et al. 2001, cited in Doyle & Dolan 2006). Despite the efficacy of the MacVRAS tool, it is not used by in-patient services, prior to referring consumers to the community mental health centre. Alternatively, CMHCs could consider using a check-list in the community to structure the consumer's risk assessment. Penterman and Nijman (2011) found a check list to be beneficial for predicting the likelihood of violence; the use of this check list can assist with averting a dangerous situation if sufficient measures are taken to minimise the risk of violence. To enhance the check list, clinical judgement can add predictability to the risk of violence, and when combined, this is termed "Structured Professional Judgement" (Penterman & Nijman 2011). At present, a check-list as suggested by Penterman and Nijman (2011) is not used by the CMHCs: only the risk assessment on CBIS which includes static and dynamic risk factors is used (Appendix 1) along with the CBIS alert system. CMHC gather all available information about the consumer and use their clinical judgement to plan safe interactions with the consumers.

Communication within the team

CMHCs communicate with other CMHCs prior to visiting a consumer in accord with the policies and procedures (Appendices 3 to 4) (Cummins, Sevel & Pedrick 2012). CMHCs schedule visits with consumers on CBIS, and prior to leaving the community mental health centre, CMHCs write the home visit details on the white board with an estimated time of return in accord with the Home Visit Procedures (Appendices 3 to 5). Some CMHCs had safety concerns about the use of the white board. On some occasions, CMHCs forget to write their names on the white board before leaving, or they forget to remove their names when returning to the community mental health centre. The white board should be checked regularly by the duty worker to ensure that CMHCs have returned by the expected time (Appendix 5). If the CMHC has not returned by the expected time, the duty worker contacts the CMHC to check their

location and safety. In reality, the white board is rarely checked by the duty worker, hence there is a risk that a phone call to a CMHC who has not returned by the expected time may be overlooked. CMHCs rely heavily on communication via the use of the scheduler, the white board and mobile phones to support their safety.

CMHCs carry a work mobile phone to allow communication with the duty worker and to have access to emergency numbers (Appendices 3 and 4). If there are any changes to the CMHC's schedule for home visits, the information should be communicated to the duty worker. However, the mobile phone lists are not always accurate so communication between the duty worker and CMHCs can sometimes be impaired. To improve the level of safety, it was suggested that CMHCs could contact the duty worker in between home visits, to notify the duty worker of the CMHCs location. An alternative suggestion is a computer system that allows CMHCs to send a text before and after each visit to the duty worker. Relying on the team for support is crucial to CMHCs maintaining safety in the community.

Determining the location of the visit

CMHCs assess the risk of violence and then determine a safe location for visiting the consumer (Cummins, Sevel & Pedrick 2012; Doyle & Dolan 2006; Godin 2004; Meadows 2011) (Appendices 1 to 4). When consumers have previously been in contact with mental health services and are considered to be a low risk of violence, most CMHCs visit the consumer unaccompanied. The visit is always conducted with due consideration to exit strategies as described by Meadows (2011). When the consumer is considered to be a high risk of violence, CMHCs may visit with another CMHC and the additional use of the police may also be requested, which is a common strategy identified in the literature (Cummins, Sevel & Pedrick 2012; Meadows 2011); the CMHC may also decide the consumer should be seen at the community mental health centre. Additional support is organised as appropriate to maintain safety.

Code phrase

When two CMHCs visit a consumer, they sometimes create a code phrase to be used in the event that either of the CMHCs feels unsafe and wants to exit the situation. CMHCs determine the code phrase en route to the home visit. Generic code phrases related to the word “black” are suggested in two of the health services policies and procedures (Appendices 4 and 5) but this advice is not included in the Home Visit Safety-Mental Health Policy (Appendix 3), and hence CMHCs do not use a generic code phrase. Some CMHCs prefer not to use a code phrase and consider that it is more appropriate to simply inform the consumer that they are concluding the home visit and they will be leaving. The use of code phrases was not discussed in the literature and is currently treated as an individual preference that CMHCs consider en route to consumers’ homes.

Determining the need for a second CMHC and Police presence

The need for a second CMHC and police presence is determined by CMHCs after assessing the risk of violence by the consumer (Meadows 2011; Murphy 2004) (Appendices 1 to 3). When a CMHC attends an initial home visit for a consumer, a second CMHC is also scheduled to improve the level of safety and allow for the risk of violence to be assessed. Some CMHCs prefer to have an accompanying CMHC regardless of whether the consumer is low risk or high risk because consumers can be unpredictable (Cummins, Sevel & Pedrick 2012). If a consumer has alerts regarding previous violence, two CMHCs attend the visits and this may be enhanced with police presence (Meadows 2011) (Appendices 3 and 4). CMHCs regularly assess the resources required for safe home visiting based on the risk of violence by the consumer and in accord with the policies and procedures (Appendices 1 to 5) and Work Health and Safety Standards (Australian Government 2011).

Intervention strategies for safety

Assessing the environment

CMHCs make a thorough assessment of the environment prior to engaging with the consumer (Cummins, Sevel & Pedrick 2012; Meadows 2011) (Appendices 3 and 4). All CMHCs were aware of the need to be vigilant when assessing the local area for safety, to observe for the presence of weapons, or people who may be violent, or the presence of dangerous animals, as discussed by Cummins, Sevel and Pedrick (2012), Meadows (2011) and the policies and procedures for home visiting (Appendices 3 to 5). CMHCs usually visit the consumer's home but there are occasions when it is more appropriate to meet the consumer at the community mental health centre, and this is always the venue for the WIS. The community mental health centre provides the safety of a security guard, alarms on the walls and under the desks and CMHCs have a personal alarm. All CMHCs were careful about maintaining their safety when conducting assessments with consumers.

Exit strategies

There was a great deal of emphasis raised about exit strategies. CMHCs all described parking their car in a position that facilitates rapid egress from the consumer's residence, in case the consumer's behaviour is escalating toward violence (Cummins, Sevel & Pedrick 2012; Meadows 2011) (Appendix 3 and 4). Hence CMHCs avoid parking in driveways or positions where a quick exit would be difficult. CMHCs were also aware of the need to maintain an exit strategy from inside the consumer's home. CMHCs try to remain near the front of the house. However, the design of modern homes often has bedrooms at the front and living rooms to the rear of the home which is not conducive to talking at the front of the home. Hence, to facilitate rapid egress in case the consumer's behaviour is escalating towards violence, CMHCs may talk on the front porch or request that the front door be left open. CMHCs always consider their exit strategies.

Interaction with the consumer

At the commencement of each visit, CMHCs assess that the consumer has a suitable demeanour for the visit to proceed, which is a recommended approach in the literature (Blumenthal et al. 2010; Meadows 2011). CMHCs use their clinical judgement, gut reaction, experience and intuition as they assess consumers (Brunton 2005; Godin 2004; Murphy 2004). When a CMHC expresses safety concerns regarding any home visit, those concerns are respected by the accompanying CMHC, and the home visit may be cancelled or reorganised. CMHCs observe for cues in the consumer's affect and body language that would indicate an increased risk of violence as described by Blumenthal et al. (2010) and Murphy (2004). The assessment of the consumer is ongoing, because the consumer's behaviour can change rapidly (Meadows 2011; Penterman & Nijman 2011). CMHCs listen to the tone of voice and note if the consumer is becoming argumentative or agitated. If the consumer is becoming agitated, CMHCs retreat from the visit as recommended by Meadows (2011). CMHCs assess and respond to the consumer according to the consumer's presentation (Appendices 2 to 4). CMHCs request assistance from police as required (Meadows 2011) or return to the community mental health centre and discuss how to proceed with senior team members. CMHCs work cohesively as a team when assessing and managing consumers.

Organisational management

Dealing with potential violence

CMHCs are required to manage the risk of violence from mental health consumers (Doyle & Dolan 2002; Elbogen et al. 2006; Godin 2004; Price & Baker 2012). To support this role, CMHCs can attend NVCI training. The NVCI training assists CMHCs to respond to violence from consumers in a way that maintains safety for both CMHCs and consumers. Organisational management supports CMHCs to attend NVCI training on an annual basis, however, some CMHCs have not maintained annual training which may jeopardize their safety and the safety of consumers.

Awareness and utilisation of policies and procedures

The organisational management is responsible for writing the policies and procedures and to educate CMHCs how to access them on-line, in accord with best practice (Richardson-Tench et al. 2014) (Appendices 2 to 5). The safety strategies in the Home Visit Safety-Mental Health Policy and Procedure (Appendix 3) are enhanced by the safety strategies within the general Home Visiting Procedure and Staff Out of Hours/ Non Return Procedure (Appendices 4 and 5). It is important that CMHCs refer to all the health service policies and procedures relating to home visit safety. Although new CMHCs are referred to the policies and procedures during orientation, some experienced CMHCs had difficulty finding the policies and procedures on line. Some CMHCs explained that they are familiar with their practice and so they do not regularly refer to the policies and procedures. In addition, a few CMHCs considered that the current policies and procedures are not useful. One explanation for the criticism was that interactions with consumers require individual approaches, and the many situations and methods of dealing with consumers could not be adequately described in a policy and procedure document. A few CMHCs referred to their preference for printed versions of the policies and procedures which they found easier to access, but printed versions are no longer available; the policies and procedures are now only available on-line. In light of this criticism, the policies and procedures relating to home visits and assessments of consumers, needs to be examined to ensure best practice is being promoted (Richardson-Tench et al. 2014) (Appendices 2 to 5) and CMHCs need education about how to access the policies and procedures on-line.

The policies and procedures at the community mental health centre state that training occurs in home visit safety and that this training is recorded. During the course of this research, on-line training was required of all CMHCs in September 2015, regarding “Remote and Isolated Work Health and Safety Module One and Two” and this related to home visit safety routines and knowledge (Australian Government 2011). CMHCs currently learn how to conduct safe home visiting from the existing policies and procedures, from advice from other CMHCs, and from on-line training. The community mental health centre also has an Induction Orientation Checklist which is available to orientate new employees to the community mental health centre

(Appendix 15). This was not referred to by the CMHCs. The Induction Orientation Checklist refers new CMHCs to the Policy and Procedure Guidelines (PPG). Currently, orientation and safety strategies for home visits occurs at the discretion of the preceptor CMHC.

Work Health and Safety Standards

The organisational management is responsible to support CMHCs to work in an environment that is as safe as possible (Australian Government 2011). All CMHCs acknowledged the importance of assessing and managing the risk of violence from consumers to maintain their safety. Some CMHCs did not refer directly to the Work Health and Safety Standards but the concept of safety was discussed in broad terms. On some occasions, the terms Occ. Health and Safety or OH and S was used, which has now been replaced by the term Work Health and Safety. Hence CMHCs need to be updated with current Work Health and Safety terminology. In general terms, CMHCs indicated that they were familiar with the concept of safety under the Work Health and Safety Standards.

In accord with the Work Health and Safety Standards, CMHCs take responsibility to maintain their own safety and the safety of their colleagues. Experienced CMHCs orientate new CMHCs to support safe practice but only few CMHCs referred directly to the Work Health and Safety Standards. The main reference when assessing a consumer's risk was the CBIS risk assessment. When discussing safety, most CMHCs merged the policies and procedures, Work Health and Safety Standards and the CBIS risk assessments. Despite the limited reference to the Work Health and Safety Standards, there was agreement that safety was of prime importance for all CMHCs when interacting with consumers.

Improving practices

CMHCs were invited to provide their opinions about what worked well and what required improving at the community mental health centre. The issues that were raised

included; access to the policies and procedures, Work Health and Safety Standards, communication, orientation training, NVCI training, de-escalation techniques and safety strategies.

Some CMHCs indicated that the **policies and procedures** were not useful and they had difficulty locating them. The Policies and Procedures should guide CMHCs to deal with the risk of violence from consumers in a safe manner. Organisational management could encourage feedback from CMHCs regarding any safety concerns and then address these concerns within the Policies and Procedures. The Policies and Procedures could then become more relevant to CMHCs. In addition, in-service education sessions could be held to educate CMHCs about how to access the Work Health and Safety Standards, particularly for new staff.

Some CMHCs raised concerns about the **methods of communication** around home visiting. CMHCs write their proposed home visits to consumers on CBIS scheduler. In addition, CMHCs write on the white board who they are going to see and what time they expect to return. On occasions when going out, some CMHCs forget to use **the white board**, hence the team may not be easily aware of their location and expected time of return. It was suggested that the white board system be examined by CMHCs to determine if there are safer procedures that can be followed.

Another issue with communication is the **use of mobile phones**. The CMHCs rely on their mobile phones to maintain contact with the duty worker in their team. There is difficulty with this system because sometimes CMHCs do not have access to a work mobile phone and the phone contact list is not always up to date with the current phone numbers. Hence the duty worker is at times, impaired when trying to contact CMHCs whilst attending home visits. A review of who is responsible to maintain this system is essential to staff safety as well as the availability of work mobile phones.

Organisational management is responsible to **provide orientation** for CMHCs. A structured orientation program would benefit new CMHCs to improve safety. Orientation should include how to access the Policies and Procedures, how to locate Work Health and Safety Standards, and discussions with experienced CMHCs to ensure that new CMHCs understand their responsibilities and how to **remain safe when attending home visits**. It is the responsibility of organisational management to ensure new and existing CMHCs are provided with an adequate orientation to the community mental health centre and the location and use of the **duress system**.

Organisational management are required to provide **regular training** for CMHCs. Most CMHCs maintain annual training in NVCI. In addition, training in de-escalation techniques would benefit CMHCs (Beech & Bowyer 2004; Nyberg-Coles 2005; Price & Baker 2012; Spencer & Munch 2003). **De-escalation techniques** are therapeutic tools used by CMHCs when a consumer appears to be increasing in agitation and when there is a risk of violence from a consumer (Nyberg-Coles 2005; Price & Baker 2012). Unfortunately, de-escalation techniques are not routinely taught to CMHCs in NALHN. CMHCs would benefit from regular education sessions on the use of de-escalation techniques with consumers to achieve the best outcomes. De-escalation techniques could be incorporated alongside **NVCI training** which is referred to in the Home Visit Safety- Mental Health Procedure (Appendix 3). In contrast to in-patient units, when CMHCs are home visiting they do not have rapid access to additional staff and security guards, hence skills in risk assessment and management skills and de-escalation techniques need to be heightened when working in the community.

Incorporating specific assessment tools related to the risk of violence may be beneficial. The MacVRAS tool could be used to assess the risk of violence from consumers prior to discharge from in-patient units (Monahan et al. 2001, cited in Doyle & Dolan 2006). In addition, Penterman and Nijman (2011) researched one assessment tool which assesses known factors about consumers to predict the likelihood of violence toward CMHCs. At present CMHCs only use a risk assessment tool that assesses all risk factors (Appendix 1). Incorporating a specific violence

assessment tool such as the one promoted by Penterman and Nijman (2011) may prove beneficial.

Study limitations

A quota was not established to capture various lengths of experience of CMHCs. CMHCs with little experience did not volunteer to participate and hence their views were not captured in the data.

Participants were required to volunteer without any coercion. This meant that CMHCs who may have biased views on certain issues could have elected to participate and their views are then captured in the data and results.

CMHCs from only one community mental health centre were interviewed. The results may not be representative of the strategies of risk assessment and management of CMHCs in other centres.

There were no quotas for the participants in this research. It did not capture a balanced representative sample of the multidisciplinary team. From the multi-disciplinary team, the participants comprised of two social workers and the remaining nine participants were CMHCs working in mental health. There were no occupational therapists included. There was also a gender imbalance, albeit gender variables were not a focus of this research (Lopez & Whitehead 2013).

The research results were derived from a relatively small number of CMHCs working in a metropolitan region of Adelaide, South Australia and therefore the results may not be representative of CMHCs in other areas (Harding & Whitehead 2013).

Participants were only interviewed once and there was no further follow up. Participants were not provided with a transcript of their interview to check for accuracy and that the wording reflected their opinions.

Recommendations for further investigation

The research is expected to form the foundation for further research, which could take the form of an Ethnographic, Phenomenological or Action Research. Similar research to investigate how CMHCs work at alternative sites could be conducted. Ideally, in future, participants would be afforded the opportunity to review the transcription of their respective interviews to improve trustworthiness of the data. A meta-synthesis could then be undertaken to strengthen the body of knowledge in this area (Polit & Beck 2008).

Research into the use of risk of violence assessment tools would be beneficial for the safety of CMHCs. Research could be conducted into the efficacy of MacVRAS tool (Monahan et al. 2001, cited in Doyle & Dolan 2006) to determine the predictive ability of violence from consumers. Additional research could compare the benefits of using a community risk assessment tool as discussed by Penterman and Nijman (2011).

Researching what types of mental health clinicians make effective de-escalators could be beneficial. Variables such as gender, age, experience, attitudes, and personality characteristics could be examined for the degree of influence on successful de-escalation strategies (Nyberg-Coles 2005; Price & Baker 2012). The attributes and behaviour of CMHCs could be researched to provide insight and guidance to existing CMHCs and to new CMHCs on how to perform effective de-escalation techniques. Focus groups could discuss the findings of the research and an action research group could be established to implement and evaluate changes that promote the minimisation of risk of violence to CMHCs from consumers. The findings could also be used to improve the policies and procedures relating to visiting consumers with the aim of improving safety.

Focus groups could research methods of improving safety for CMHCs. Emphasis should be placed on effective methods for the provision of structured orientation

programs for new CMHCs. Researching methods to improve team communication related to maintaining safety during home visitation would be beneficial. In addition, there could be further research into improving the use of Policies and Procedures and Work Health and Safety Standards and existing training programs to promote safety.

Conclusion

The advent of deinstitutionalisation of mental health consumers has resulted in the majority of mental health consumers living in the community (Bell 2003; Crowe & Carlyle 2003; Henderson et al. 2008; Holmes et al. 2006). Consequently, CMHCs are required to care for consumers in the community which involves the assessment and management of the risk of violence from consumers (Doyle & Dolan 2006; Murphy 2004). This research thesis aimed to uncover how CMHCs approach the task of risk assessment and management. The thematic analysis and interpretation has highlighted that CMHCs use a series of strategies which assists them to maintain their safety as much as possible when interacting with consumers. These strategies were summarised under the three main themes; preparation to meet the consumers, intervention strategies for safety and organisational management. The research has provided insight into the strategies that CMHCs use to maintain their safety when engaging with mental health consumers. The findings can be used to inform Undergraduate General Nurse education and Post Graduate Mental Health education.

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Appendices

Appendix 1: Risk Assessment

Not for Case Note
*This form is to assist with collecting the consumer's mental health assessment.
 This must be entered into CBIS.*

Entered into CBIS ? Date: / /



Government of South Australia
SA Health

Consumer Name:	Assessment Date:
Given Name/s:	Assessment Time:

Mental Health Assessment
RISK ASSESSMENT (01.4000)

Focus of Care CT: Acute / Functional Gain / Intensive Extended / Maintenance / Protocol Exclusion *(please circle)*

Mode: Face to Face / Telephone / Written *(please circle)*

Participation Status: Participating / Not Participating *(please circle)*

Location of Contact: Clinic / Dwelling / Other *(please circle)*

Other registered consumers involved? Yes / No *(please circle)*

Was SAPOL present at this contact? Yes / No *(please circle)*

Was this contact specifically for Extreme Heat? Yes / No *(please circle)*

CLINICAL INFORMATION

Mental State Examination
Please enter Mini Mental Status Examination (MMSE) results here.

- * Appearance
- * Behaviour
- * Mood
- * Speech
- * Affect
- * Thought (form and content)
- * Perception
- * Cognition function
- * Insight
- * Judgement
- * Rapport.

Neurovegetative Symptoms

- * Sleep
- * Concentration
- * Energy
- * Appetite
- * Weight

Risk	<u>Assessed Level</u>	<u>Category</u>
Suicide or self-harm	High / Low / Medium/No Risk	Acute / Chronic / Immiment / Acute exacerbation
Violence or aggression	High / Low / Medium/No Risk	Acute / Chronic / Immiment / Acute exacerbation
Absconding	High / Low / Medium/No Risk	Acute / Chronic / Immiment / Acute exacerbation
Vulnerability	High / Low / Medium/No Risk	Acute / Chronic / Immiment / Acute exacerbation

L = Low (mild, limited frequency and intensity) M = Medium - (frequent but with limited intensity and H = High (frequent, intense, N = No Risk

Appendix 1: Risk Assessment: continued

*This form is to assist with collecting the consumer's mental health assessment.
This must be entered into CBIS. This form is not for inclusion in the case note.*

Risk Summary
See Attached for Prompts

*** Please enter or confirm appropriate CBIS Alerts for the safety of both consumer and your colleagues ***

NOTIFICATIONS AND MANDATORY REPORTING

Firearm / Weapon Safety Concerns? Yes / No *(please circle)*

Firearm Notification Lodged? Yes / No *(please circle)*

*** Please enter or confirm appropriate CBIS Alerts for the safety of both consumer and your colleagues ***

Children's Safety Concerns?

Are there children under 18 years old or
other dependent persons in the household? Yes / No *(please circle)*

Has Families SA been notified? Yes / No *(please circle)*

*** Please enter or confirm appropriate CBIS Alerts for the safety of both consumer and your colleagues ***

RECOMMENDATION / PLAN

Clinical Impression - key issues, working diagnosis

Management and Risk Reduction Plan - trigger/precipitating factors, early warning signs, plan to manage these (effective approaches if known), links to services and whether these have been formalised

Time taken (minutes):

Appendix 1: Risk Assessment: continued

*This form is to assist with collecting the consumer's mental health assessment.
This must be entered into CBIS. This form is not for inclusion in the case note.*

RISK SUMMARY PROMPTS:

Please explain what the identified risks are and include further details (static and dynamic factors).

This should then be formulised as a management and treatment plan (e.g. high imminent risk of self harm=admit to ward).

<p>RISK SUMMARY PROMPTS - STATIC FACTORS SUICIDE/SELF HARM</p> <p>Static</p> <ul style="list-style-type: none"> - Previous suicide attempt or self harm - Family history of suicide and/or self harm - History of serious physical illness or disability (e.g. multiple sclerosis, malignancy) - Male between 25 and 50 or over 70 years - Lives in rural setting (especially males 15 - 24 years) - History of abuse (especially sexual) - Member of a minority group - Identifies as lesbian, gay, bisexual or transgender - Migrant - CALD/Indigenous 	<p>RISK SUMMARY PROMPTS - DYNAMIC FACTORS SUICIDE/SELF HARM</p> <p>Dynamic</p> <ul style="list-style-type: none"> - Intent - Plans (preparation/rehearsal) - Settling of affairs (giving away possessions, writing will) - Thoughts (frequency/duration) - Recent suicide attempt - Suicide note - Impulsivity - Increase in Alcohol/Drug use - Problem gambling/gambling addiction - Access to means (medications/weapons/rope/poisons etc.) - Deterioration in serious physical illness - Physical pain - Psychological pain (hurt, anguish, misery) - Stress (feeling pressured/overwhelmed) - Agitation (emotional urgency) - Hopelessness (expectation that things will not get better) - Self hate - Shame - Guilt - Relationship problems/divorce/separation/custody issues - Psychotic symptoms - Command hallucinations - Recent discharge from hospital (within last 28 days) - Social isolation/lack of any support group - Unwillingness to accept help - Works in construction/mining industry - Unemployed
<p>VIOLENCE/AGGRESSION/CRIMINAL ACTIVITY</p> <p>Static</p> <ul style="list-style-type: none"> - Under 25yrs - History of violence/sexual offence - Criminal/forensic history - Conduct disorder - History of substance abuse 	<p>VIOLENCE/AGGRESSION/CRIMINAL ACTIVITY</p> <p>Dynamic</p> <ul style="list-style-type: none"> - Impulsivity - Anger - Fear/anxiety over contact with MHS - Intoxication/withdrawal - Cognitions supporting violence - Recent threats - Recent aggressive actions or thoughts - Carries weapon/access to firearms - Psychotic symptoms - Command hallucinations - Content of delusional beliefs - At risk of sexually abusing others
<p>SELF NEGLECT/EXPLOITATION/VULNERABILITY</p> <ul style="list-style-type: none"> - At risk of being sexually abused by others - At risk of domestic/family violence - At risk of being financially abused by others - At risk of self neglect - Cognitive impairment <p>ABSCONDING</p> <ul style="list-style-type: none"> - History of absconding - Poor adherence to psychiatric treatment - Frustration regarding hospital treatment - Lack of insight - Command hallucinations - Fear associated with being in hospital 	

Appendix 2: Assessment and Review of Mental Health Consumers



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SSI01016
Assessment and Review of Mental Health Consumers

This Procedure Supersedes Procedure Number/s:.....		Not Applicable <input checked="" type="checkbox"/>	
Title of Procedure/s			
Superseded:.....			
Effective date	03/2014	Next review date	03/2017
Interim Review	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Review in <input type="checkbox"/> 3 months or <input type="checkbox"/> 6 months	
Scope (Indicate those that apply <input checked="" type="checkbox"/>)	<input type="checkbox"/> Organisation Wide (OW) NALHN	<input checked="" type="checkbox"/> Service Specific (SS) <input checked="" type="checkbox"/> Division ...Mental Health <input type="checkbox"/> Clinical Area <input type="checkbox"/> Site	
Application (Indicate those that apply <input checked="" type="checkbox"/>)	<input type="checkbox"/> All Staff <input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Nursing <input type="checkbox"/> Midwifery <input checked="" type="checkbox"/> Allied Health <input type="checkbox"/> Administration	<input type="checkbox"/> Students <input type="checkbox"/> Volunteers <input type="checkbox"/> Contractors <input type="checkbox"/> Agency <input type="checkbox"/> Consumers <input type="checkbox"/> Other (please specify)	
Roles and Responsibilities			

Purpose

This procedure articulates minimum expectations for the assessment and review of consumers' status, consistent with the National Standards for Mental Health Services 2010: 'Consumers and their carers receive a comprehensive, timely and accurate assessment and a regular review of progress.' [standard 10.4];

Procedure Detail

1. Initial Assessment/Triage

Not all consumers on initial contact with the service require a comprehensive assessment, although every consumer contacting the service will receive a systematic [albeit brief] assessment even if by telephone, and this will be documented. If clinically indicated, a more comprehensive assessment by telephone or in person will be conducted.

The extent of this initial assessment/triage will however, be based on available clinical information, a systematic culturally appropriate risk assessment, and the clinical prioritisation of need. Where the initial assessment/triage process is unable to clearly identify risks or assign a clinical prioritisation, further information and/or a more detailed assessment to determine the most suitable response by mental health services should be completed.

2. Comprehensive/Intake Assessment

Where the decision is made to admit a consumer to a bedded or community service, a comprehensive assessment will be completed within twenty four [24] hours. The completion of this minimum standard assessment does not preclude clinicians from

Appendix 2: Assessment and Review of Mental Health Consumers: continued



SSI01016

Assessment and Review of Mental Health Consumers

using their discretion to apply other validated tools to the assessment process. The components of the minimum expected assessment are:

Personal Identifying Data

- Name, date of birth, gender, address, contact numbers
- Language requirements
- Specified information required for appropriate medical records management.

Presenting Problems

History of Presenting Problems

- Symptom identification
- Onset
- Severity
- Duration
- Precipitating factors.

Past Psychiatric History

- Previous symptoms, diagnoses
- Previous treatment including hospitalisations
- Current or past treatment orders.

Current and Past Medical History

- Diagnoses and treatments
- All medications including prescribed and over-the-counter preparations
- Response to treatments
- Compliance with treatments
- Adverse effects of treatments
- Allergies.

Family History of Mental Health Disorders

- Including self-harming behaviour and suicides.

Alcohol and Drug History

- Substances used and effects
- Frequency and pattern of use
- Estimates of amounts used
- Tolerance or withdrawal symptoms.

Personal and Social History

- Ethnicity and cultural background
- Developmental history [abuse/neglect/malnutrition, education, family and peer relationships, occupational history, key events in life]
- Current level of functioning and best prior level of functioning
- Responsibility for, and wellbeing of, dependants and children
- Support systems
- Legal difficulties/forensic issues.

Current Risk Assessment

- Consider issues of self harm/suicide, violence, sexual safety, ability to comply with treatment, absconding risk of absconding, level of disorganisation and vulnerability.
- Consider both active [abuse, domestic violence] and passive [neglect, inability to provide care to dependent others] risks to others.

Appendix 2: Assessment and Review of Mental Health Consumers: continued



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Assessment and Review of Mental Health Consumers

Mental State Examination

- Appearance
- Behaviour
- Conversation
- Affect
- Perception
- Cognition
- Insight
- rapport
- Judgement

Physical Assessment

All consumers admitted to a bedded service are to promptly receive upon admission, an initial nursing physical assessment comprising:

- Heart rate
- Respiratory rate
- Blood pressure
- Temperature
- Urinalysis
- Height
- Weight
- Neurological observations.

Abnormal results from a physical assessment by nursing staff are to be reported immediately to the treating medical officer (MO) or on-call MO.

All consumers admitted to a bedded service are to receive a medical examination within 48-hours. The medical examination will comprise:

- Consideration of consumer's previous medical history
- Consideration of nursing's physical assessment results
- Examination of all major systems of the body
- Ordering of further investigations or screenings required
- Orders for the range and frequency of ongoing physical observations.

All consumers admitted to community services are to promptly receive upon admission, an initial nursing physical assessment [see above]. The extent and detail of further examination should be determined by the treating team. This may include referral to a general practitioner for assessment and management of any physical problems.

NOCC Tools

- HONOS
- LSP
- K10

Specialist Assessment

Depending on the outcomes of the comprehensive assessment further specialist assessment should be considered by the treating team including;

- Falls risk
- Pressure ulcer risk
- Drug and Alcohol assessment [including withdrawal]
- Specialist Multidisciplinary assessment.

Appendix 2: Assessment and Review of Mental Health Consumers: continued



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Assessment and Review of Mental Health Consumers

Diagnosis

Working diagnosis
Differential diagnoses

To minimise duplication of assessment, available information on consumers representing to the service, or who have been partially assessed elsewhere, should be reviewed and where appropriate utilised in the formulation of the assessment.

3. Consumer and Carer Involvement

All assessments and reviews will include documented evidence of consumer and carer input into the assessment or review, and feedback to the consumer and carers [with the consumer's informed consent] re the outcomes of assessment or review. Where a diagnosis is made, the consumer and carers [with the consumer's informed consent] are to be provided with information on the diagnosis, options for treatment and possible prognoses.

4. Risk Assessment

All consumers must, at key points in their treatment, receive a risk assessment. Accurate risk assessment depends upon a high quality of history-taking, the sharing of information between services, and locating of relevant past information which may indicate areas of future risk. A comprehensive risk assessment will have input from all disciplines.

The utility of risk assessment also depends upon team processes for clinical decision-making, and the quality of the therapeutic relationship. Any tool for risk assessment is at best an adjunct to clinical decision-making and must not be a substitute for sound clinical reasoning and judgement.

Risk assessments will be reviewed/repeated:

On triage contact with the service
As part of the comprehensive intake assessment
Prior to transfer to another service, team or unit
As part of the routine clinical review process
Following significant change in clinical condition
After major treatment reviews including changes to medication regime

When any member of the multidisciplinary team feels a formal review of risk is required

Following collection of information from consumer or others which impacts the level of assessed risk.

When any member of the multidisciplinary team feels a formal review of risk is required. Following collection of information from consumer or others which impacts the level of assessed risk.

In bedded services risk assessments will be conducted:

- On admission to a bedded service
- On transfer to or from a bedded service

Appendix 2: Assessment and Review of Mental Health Consumers: continued



SSI01016

Assessment and Review of Mental Health Consumers

- At least every 24-hours in acute inpatient units, PICUs, and emergency departments.
- At least every 24-hours for the first week then no less than weekly thereafter in inpatient rehabilitation units.

The Risk Assessment is an essential part of the consumers care plan.

Where risk is identified, the care plan will address the immediate risks, their management, and future preventative actions. Care plans will take into account the context, the opportunity, means and motivation for acting upon the risk.

In bedded services, the risk assessment is to be linked to the level of nursing observation as defined in the Mental Health Directorate's *Nursing Observation* procedure. Where the nursing observation level and management plan are inconsistent with the level of risk, a clear rationale in the medical record is to be provided. When specifying level of observation, the ward environment must be considered, ie, when the unit is closed or during periods of high acuity.

Where possible, clinicians undertaking a risk assessment will ensure consumer input, and where appropriate and agreed, carer participation. This is particularly important when drafting a relapse prevention plan.

A history of risk to self and others will be documented on an 'Alert Form' placed at the front of the current volume of the medical record and onto CBIS.

5. Reassessment/Review Schedule

In community services, multidisciplinary clinical review, conducted with peers and more experienced colleagues, and recorded in the consumer's medical record, is to occur at least every three [3] months including:

- Recovery plan
- Service plan
- Outcome measures
- Medication response.

Clinical Review for consumers is to occur prior to transfer between service elements.

In bedded services, multidisciplinary clinical review, conducted with peers and more experienced colleagues, and recorded in the individual medical record is to occur:

- In PICUs as often as necessary, but at least every twenty four [24] hours.
- In acute inpatient units as often as necessary, but at least every twenty four [24] hours.
- In secure rehabilitation inpatient units at least every week.
- In open rehabilitation inpatient units and community rehabilitation centres fortnightly for the first month, then at least monthly.

6. Assessment Competency

Consistent with the National Standards for Mental Health Services, 'assessments are conducted by appropriately qualified and experienced mental health professionals' only. Consumer assessment is only to be completed by clinicians who have demonstrated competence in assessment. Clinical service coordinators, team managers and discipline leads are responsible for ensuring systems are in place for the orientation, training, supervision and oversight of all clinicians providing assessments.

Appendix 2: Assessment and Review of Mental Health Consumers: continued



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Assessment and Review of Mental Health Consumers

Hand Hygiene

The 5 moments of hand hygiene are to be complied with by all staff at all times as per Policy Directive, Hand Hygiene, Infection Prevention and Control, SA Health.

Patient ID

All staff must identify the patient at the beginning of a care episode and at each patient intervention using the 3 mandatory identifiers of 1. Correct Unit Record Number, 2. Name and 3. Date of birth as per Policy Directive, Patient Identification and Patient Identification Guideline SA Health.

Consent

All procedures involving the provision of medical treatment to a patient must be undertaken in accordance with the Consent to Medical Treatment and Palliative Care Act 1995

National Safety and Quality Health Service Standards

Standard 1 Governance for Safety and Quality in Health Service Organisations	Standard 2 Partnering with Consumers	Standard 3 Preventing & Controlling Healthcare associated infections	Standard 4 Medication Safety	Standard 5 Patient Identification & Procedure Matching	Standard 6 Clinical Handover	Standard 7 Blood and Blood Products	Standard 8 Preventing & Managing Pressure Injuries	Standard 9 Recognising & Responding to Clinical Deterioration	Standard 10 Preventing Falls & Harm from Falls
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Work Health and Safety

Program 1 Governance Accountability & Communication	Program 2 Duty of Care	Program 3 Emergency Management	Program 4 Hazard Identification & Risk Management	Program 5 Incident Reporting & Investigation	Program 6 Employee Health & Wellbeing	Program 7 Injury Management	Program 8 OHSW&M Training & Development	Program 9 Performance Review & Continuous Improvement
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risks

Rating Moderate	Risk Error leading to incorrect diagnosis and provision of care.
---------------------------	--

Evaluation / Audit

Monitoring through SLS report of incidents related to assessment.

Medical Records audit for compliance.

Legislation

Not Applicable

SA Health Directives/Policies/Guidelines

Not Applicable

Appendix 2: Assessment and Review of Mental Health Consumers: continued



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Assessment and Review of Mental Health Consumers

NALHN Policies/Procedures/Guidelines/Forms

Not Applicable

External References & Best Practice Guidelines

National Standards for Mental Health Services [2010]

Garden G, Physical Examination in Psychiatric Practice. Advances in Psychiatric Treatment, Vol.11, pp142-149. 2002.

Definitions and Acronyms

Not Applicable

Key Word Search

Admission Assessment, Risk Assessment, Mental State Assessment, Mental health Assessment,

Procedure Sponsor

General Manager Mental Health

Author

Director of Nursing, Central Adelaide Local health Network – Mental Health Directorate

Division Approval	
Name	Leonie Nowland Conrad Wareham
Position	General Manager ED Medical Services Northern Adelaide Local Health Network Mental Health Directorate
Date	18/03/2014

ADMINISTRATIVE USE ONLY	
CEO Approval for Organisation Wide Procedures	
Clinical Governance Committee Date	
Name	
Date	

Version	Effective from	Effective to	Change summary
1.0	03/2014	3/2017	Procedure translated from previous Adelaide Metro Mental Health Directorate procedure

Appendix 3: Home Visit Safety – Mental Health



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SSI01027
Home Visit Safety – Mental Health

This Procedure Supersedes Procedure Number/s:.....		Not Applicable <input checked="" type="checkbox"/>	
Title of Procedure/s Superseded:.....			
Effective date	03/2014	Next review date	August 2015
Interim Review	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Review in <input type="checkbox"/> 3 months or <input type="checkbox"/> 6 months	
Scope (Indicate those that apply <input checked="" type="checkbox"/>)	<input type="checkbox"/> Organisation Wide (OW) NALHN	<input checked="" type="checkbox"/> Service Specific (SS) <input checked="" type="checkbox"/> Division ...Mental Health <input type="checkbox"/> Clinical Area <input type="checkbox"/> Site	
Application (Indicate those that apply <input checked="" type="checkbox"/>)	<input type="checkbox"/> All Staff <input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Nursing <input type="checkbox"/> Midwifery <input checked="" type="checkbox"/> Allied Health <input type="checkbox"/> Administration	<input type="checkbox"/> Students <input type="checkbox"/> Volunteers <input type="checkbox"/> Contractors <input type="checkbox"/> Agency <input type="checkbox"/> Consumers <input type="checkbox"/> Other (please specify)	
Roles and Responsibilities	<p>a It is the responsibility of Sector Managers to ensure that this procedure is implemented and adhered to.</p> <p>b It is the responsibility of managers/supervisors to ensure that home visits are planned, that safe systems of work are in place and that risks to health and safety are regularly reviewed in accordance with risk management principles.</p> <p>c It is the responsibility of all employees to ensure that they:</p> <ul style="list-style-type: none"> wear Mental Health identification badges whenever undertaking a home visit; do not place themselves or others at risk; withdraw at any time from any home or location where there is a threat or perceived threat to their health and safety. notify their supervisor / manager and seek directions if they are concerned about their health and safety and are unable to continue with the planned home visit. report incidents in accordance with the <u>reporting and Investigating Work Health Hazards and Incidents procedure</u>. 		

Purpose

The procedure provides strategies for the elimination or minimisation of risks to health and safety associated with offsite/home visits.

Procedure Detail

1 Safe Systems of Work

- A risk assessment shall be undertaken to identify and assess potential hazardous situations prior to undertaking offsite/home visits (eg, dogs on premises, previous incidents, difficult escape routes etc).

Appendix 3: Home Visit Safety – Mental Health: continued



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Home Visit Safety – Mental Health

- b If a home visit risk assessment indicates a potential risk to health and safety, consultation shall occur with relevant employees, Health and Safety Representatives and others to develop appropriate actions / strategies to mitigate the risks.
- c If the risk assessment indicates a moderate risk or higher, two employees shall attend the home visit and other strategies shall be considered to ensure the health and safety of employees (eg, having SA Police backup, calling the consumer out of the home etc).
- d A system to track and monitor the exact location and safety of employees undertaking offsite/home visits shall be implemented (eg, In and out boards, Scheduler on CBIS, GPS phones).
- e Mobile phones shall be provided to all employees undertaking offsite / home visits and they shall be made aware of appropriate emergency numbers.
- f A strong light source and instructions on its use shall be provided for employees who are required to undertake home visits at night.
- g Reporting procedures shall be implemented to ensure that if employees do not return at the designated time, they can be traced.
- h. Consumers shall be discouraged from smoking during the home visit.
- i. Employees shall be provided with anti-bacterial cleansing gel for washing hands before and after the home visit.

2 Managing Risks

- a Consumers shall be advised of the following:
 - the expected time of arrival, and to ensure that he/she is prepared for the visit;
 - to restrain dogs and any other potentially harmful animal during the visit;
 - leave an outside light on if visits are to occur after dark.
- b A home shall not be entered if it is suspected that there is a risk to health and safety (eg, poor visibility, lack of quick exit routes, dogs that are of concern, the blinds are drawn, the client or carer does not answer the door, there are voices raised in argument on the premises etc).
- c In the event that risks to health and safety are such that the home visit is deemed unsafe, the supervisor /manager shall be notified and direction sought.
- d Cars shall be parked so as to ensure a safe, secure and quick departure (eg close to the home visit site, facing the direction to be travelled, and so that departure cannot be impeded).

3 Planning a Home Visit

- a All home visits shall be planned and any foreseeable risks managed.
- b Consumers shall be advised of the expected time of arrival and shall be directed to:
 - restrain dogs and any other potentially harmful animal during the visit.
 - leave an outside light on if visits are to occur after dark.
- c Once at the consumer's home, do not enter if there is a perceived risk, which may be demonstrated by any of the following:
 - the house is in darkness;
 - the blinds are drawn and the consumer / carer does not answer the door;
 - there are voices raised in argument etc.

Appendix 3: Home Visit Safety – Mental Health: continued



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Home Visit Safety – Mental Health

- d If a home visit cannot continue, the Manager/Supervisor shall be advised and further direction sought.
- e Cars shall not be parked in a manner that enables them to be blocked in. Cars shall be parked facing in the direction to be travelled in order to secure a quick and safe departure.
- f Ensure that all safe exits are noted and that there is no barrier between the employee and the exit.

4 Training

- a All employees required to undertake off site/home visits shall be trained in this procedure.
- b Training shall be reviewed and updated (if required) following investigation of incidents.
- c Records of training shall be maintained by the unit manager/team leader for at least five years, and shall include the following information:
 - the name of the person receiving the training and the date/s of attendance;
 - an outline of the training content;
 - the names of persons providing the training.

Training records shall be stored in the Work Health and Safety (WHS) Documentation folder by the unit manager/team leader.

5 Review of Home Visit

- a To ensure continuing employee safety and security, consultation on the home visit shall occur with the manager/supervisor, employee and Health and Safety Representative (where relevant).
- b Dangerous or potentially dangerous issues in or around the consumer's accommodation shall be reported immediately to the manager/supervisor who shall reassess the risk assessment plan, make a note in the consumer's case notes, and take appropriate action to ensure the health and safety of employees.
- c In the event that dangerous weapons and firearms are noticed, the employee shall withdraw from the home and report to SA Police via their manager/supervisor.

All WHS incidents shall be reported and recorded in accordance with the reporting and Investigating Work Health Hazards and Incidents procedure

6 Incident Reporting

- a All incidents shall be reported in accordance with the reporting and Investigating Work Health Hazards and Incidents procedure.
- b Dangerous or potentially dangerous issues in or around the consumer's living accommodation shall be reported immediately to the manager/supervisor.
- c All incidents shall be investigated and the home visit risk management process reviewed and modified where relevant.
- d Appropriate comments shall be made in the consumer's case notes and be recorded on the Community Based Information System (CBIS).
- e Where firearms / weapons are identified as a threat to consumers or others, a report shall be made to SA Police via the manager.

Appendix 3: Home Visit Safety – Mental Health: continued



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Home Visit Safety – Mental Health

Hand Hygiene

The 5 moments of hand hygiene are to be complied with by all staff at all times as per Policy Directive, Hand Hygiene, Infection Prevention and Control, SA Health.

Patient ID

All staff must identify the patient at the beginning of a care episode and at each patient intervention using the 3 mandatory identifiers of 1. Correct Unit Record Number, 2. Name and 3. Date of birth as per Policy Directive, Patient Identification and Patient Identification Guideline SA Health.

Consent

All procedures involving the provision of medical treatment to a patient must be undertaken in accordance with the Consent to Medical Treatment and Palliative Care Act 1995

National Safety and Quality Health Service Standards

Standard 1 Governance for Safety and Quality in Health Service Organisations	Standard 2 Partnering with Consumers	Standard 3 Preventing & Controlling Healthcare associated infections	Standard 4 Medication Safety	Standard 5 Patient Identification & Procedure Matching	Standard 6 Clinical Handover	Standard 7 Blood and Blood Products	Standard 8 Preventing & Managing Pressure Injuries	Standard 9 Recognising & Responding to Clinical Deterioration	Standard 10 Preventing Falls & Harm from Falls
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Work Health and Safety

Program 1 Governance Accountability & Communication	Program 2 Duty of Care	Program 3 Emergency Management	Program 4 Hazard Identification & Risk Management	Program 5 Incident Reporting & Investigation	Program 6 Employee Health & Wellbeing	Program 7 Injury Management	Program 8 OHSW&M Training & Development	Program 9 Performance Review & Continuous Improvement
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risks

Rating High	Risk Injury to staff
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Evaluation / Audit

Six monthly audits of staff incidents related to home visits

Legislation

Work Health and Safety Act 2012

SA Health Directives/Policies/Guidelines

Not Applicable

NALHN Policies/Procedures/Guidelines/Forms

Not Applicable

Appendix 3: Home Visit Safety – Mental Health: continued



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Home Visit Safety – Mental Health

External References & Best Practice Guidelines

Not Applicable

Definitions and Acronyms

Community Based Information System (CBIS)
Work Health and safety (WHS)

Key Word Search

Home Visit Safety, Community Mental health, Work Health and Safety Act, Occupational Health and Safety.

Procedure Sponsor

General Manager, Mental Health Services

Author

Director of Nursing, Central Adelaide Local health Network – Mental Health Directorate

Division Approval	
Name	Leonie Nowland Conrad Wareham
Position	General Manager ED Medical Services Northern Adelaide Local Health Network Mental Health Directorate
Date	21/03/2014

ADMINISTRATIVE USE ONLY

CEO Approval for Organisation Wide Procedures

Clinical Governance Committee Date	MM/DD/YYYY
Name	Margot Mains
Date	MM/DD/YYYY

Version	Effective from	Effective to	Change summary
1.0	MM/YYYY	August 2015	Procedure translated from previous Adelaide Metro Mental Health Directorate procedure

Appendix 4: Home Visiting Procedure



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OWI00777

Home Visiting Procedure

This Procedure Supersedes Procedure Number/s: SSI00777 Title of Procedure/s Superseded: Primary Health Care Home Visiting Procedure	Not Applicable <input type="checkbox"/>
--	---

Effective date	MM/YYYY	Next review date	MM/YYYY
Interim Review	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Review in <input type="checkbox"/> 3 months or <input type="checkbox"/> 6 months	
Scope (Indicate those that apply <input checked="" type="checkbox"/>)	<input checked="" type="checkbox"/> Organisation Wide (OW) NALHN		<input type="checkbox"/> Service Specific (SS) <input type="checkbox"/> Division <input type="checkbox"/> Clinical Area <input type="checkbox"/> Site
Application (Indicate those that apply <input checked="" type="checkbox"/>)	<input checked="" type="checkbox"/> All Staff <input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Midwifery <input type="checkbox"/> Allied Health <input type="checkbox"/> Administration		<input type="checkbox"/> Students <input type="checkbox"/> Volunteers <input type="checkbox"/> Contractors <input type="checkbox"/> Agency <input type="checkbox"/> Consumers <input type="checkbox"/> Other (please specify)
Roles and Responsibilities	<p>Risks associated with home visiting must be assessed prior to attending a patient's home.</p> <ul style="list-style-type: none"> ➤ It is the responsibility of the CEO to ensure that this procedure is implemented and adhered to. ➤ It is the responsibility of Divisional Directors, Managers, Team Leaders and Supervisors to ensure that home visits are planned, that safe systems of work are in place and that risks to health and safety are regularly reviewed in accordance with risk management principles. ➤ Individual staff have a responsibility to conduct a risk analysis for each initial home visit to determine if the service can safely be provided, and in doing so the visit does not place them at risk ➤ Staff are responsible for using the resources, systems and procedures developed by NALHN to reduce hazards and maintain personal safety for both themselves and their colleagues, including reporting incidents and near misses ➤ Individuals working in services that do not routinely provide home visiting may be required to seek management approval prior to undertaking the visit. 		

1 Purpose

The Northern Adelaide Local Health Network is responsible for ensuring employees are provided with a safe, supportive and healthy working environment in accordance with legislative requirements.

The patient's home environment is not directly under the control of staff and subsequently safety during a home visit could be compromised at any time.

This procedure aims to reduce risk to staff delivering services in the home environment by providing strategies for the control of risks associated with home visits.

Appendix 4: Home Visiting Procedure: continued



OWI00777

Home Visiting Procedure

2 Procedure Detail

2.1 Assessment

Prior to conducting a home visit, a risk assessment should be undertaken to identify risk areas and form strategies to control risks where possible. Where the risks are deemed to be significant or strategies to control risk are not available, the person completing the risk assessment should discuss with his / her manager for instruction.

2.1.1 Consent:

- Prior to the visit, verbal or written consent should be obtained where possible from the patient or guardian
- If additional staff (including students) are undertaking the visit, permission should be obtained

2.1.2 Risk assessment:

- To ascertain the level of risk, review all available information including referral details, files, reports and correspondence. Additional alerts may be identified on electronic databases including CHIS, OACIS, SAAS and SAPOL.
- Local safety checklists / tools may be available to support the risk assessment process
- Where risks are identified, the individual should consider
 - What the risks are and whether they can be controlled
 - Whether it is safe for the home visit to safely proceed
 - Which safety measures should be put in place prior to the visit

2.2 Planning:

- Clothing: consider choice of footwear and clothing to maximise safety and movement. Some jewellery and lanyards should not be worn due to the risk of entrapment and restraint
- Staff are to wear their identification badge at all times
- Phone: ensure the phone
 - Is fully charged
 - Is programmed with the list of emergency numbers
 - has sufficient coverage in the area to which you are travelling. Mobile phones provided by SA Health generally use Optus or Telstra. The following websites provide local coverage information:
<http://www.optus.com.au/network/mobile/coverage>
<http://www.telstra.com.au/mobile-phones/coverage-networks/our-coverage/>
- Personal duress (see safe work procedure (draft))
- Communication: ensure compliance with departmental requirements and work instructions so staff whereabouts, estimated time of return and / or completion of work are known.
- Cultural sensitivity: Consider gender appropriateness where cultural or vulnerability issues are identified when visiting a client alone at home. Where required, staff members may need to be accompanied by staff member of opposite gender. Theatre overshoes should be considered if staff are requested to remove their shoes. Plan for access to a face to face or telephone interpreting services for non-English speaking patients.
- Equipment: a range of equipment may be required. Before leaving for the home visit, ensure the equipment is available, clean and in good working order.
- Electrical appliances taken into patient homes must have a Residual Current Device

Appendix 4: Home Visiting Procedure: continued



OWI00777

Home Visiting Procedure

(RCD) fitted

- Personal protective equipment (PPE) must be taken on all home visits including gloves, alcohol gel and gowns. Alcohol and/or detergent wipes, and Cardio Pulmonary Resuscitation (CPR) barrier devices should also be carried. Consider cytotoxic precautions (purple gloves and sharps containers)
- Vehicle fuelled: at commencement of the visit, check the fuel gauge to see if there is sufficient fuel. As a general guide, all vehicles should have no less than half a tank of fuel at any one time.
- Each car should contain a first aid and bushfire survival kit.
- Disabled parking permits are available for use if parking may be required during patient transport
- Extreme heat: use a range of strategies including taking;
 - Copies of the [SA Health Guide to coping and staying healthy in the heat](#) booklet
 - Sufficient water to drink – 1 L for every two hours on the road
 - Pack sunscreen if planning to spend time outdoors
- Bushfire safety and survival: On a day of Catastrophic Fire Day Rating all work related activities that require travel within or through the affected area will be risk assessed. Refer to the [NALHN Bushfire Safety and Survival Procedure](#) (OWI00959).

2.3 Undertaking the Home visit:

Patients may withdraw consent at any time. Similarly, if staff feel threatened or at risk, a home visit should be aborted immediately.

Take additional precautions during periods of extreme heat including;

- park in shade and use provided windscreen and steering wheel covers
- Select rooms or spaces with good ventilation and temperature control in the patient's home
- use air-conditioning whilst in the vehicle
- remain hydrated

In other extreme conditions such as storms and heavy rain, take care when commuting.

2.3.1 Arrival

- The vehicle should be parked on the street. Do not park in driveways. Consider parking on the same side of the road in shade where possible, except where one way traffic or dead end conditions requires the vehicle to face the direction of egress.
- On leaving the vehicle, press the Global Positioning System (GPS) locator on the personal duress device if provided.
- On arrival, do not proceed if there is a perceived risk, which may include raised voices in argument, holes punched through doors, unrestrained dogs, smells, fumes and house in darkness. If available, use personal duress device to alert control room and withdraw from area.
- Keys, mobile phone and personal duress device should be kept on your person at all times
- Attention to specific location of entry and exit points from the house and property should be noted as well as the general condition of home.
- Inform patient to leave outside light on if visit is required after dark
- After knocking, move away from the door, away from any potential danger
- If the door is unanswered, ring the house number or next of kin. If these details are not available, phone the office.
- If unsatisfactory response or concern about the patient consider;

Appendix: 4: Home Visiting Procedure: continued



OWI00777

Home Visiting Procedure

be followed:

- Use personal duress device – refer to Safe Work Procedure (draft)
- If there is no personal duress device, use mobile phone – where it is not safe to state the situation over the phone the following phrases can be used to alert the Manager/staff member
 - *Please let Mr/Dr Black know that I need to cancel my appointment/home visit with him*
 - *Could you call Mr/Dr Black for me and let him know*
 - *Thanks for returning my call Mr/Dr Black*

The staff member /Manager will attempt to maintain phone contact and ascertain where the staff member is without them having to state directly, for example

- *"Are you still at the home visit? / Are you still at Mr/Mrs XXXX's house?"*

The Staff member / Manager will then alert another staff member or use another phone to contact the police by dialling 000. Remember to dial 0 first if calling from a hospital site.

2.4 Staff non-return:

If a staff member has not returned at their expected time and are more than 30 minutes late or has been reported to be more than 30 minutes late for an appointment / booking, a local action plan should be followed and may include:

- Contacting the member of staff on their mobile phone (the staff member may be holding more than one mobile phone)
- Contacting the site where the staff member is thought to be (ascertain details on when staff member left premises, level of cooperation from site and any other details that may be relevant)
- Contact the personal duress device carrier control room to trace location of the last device activation / device
- Alerting the Manager or other senior staff member if there is an unsatisfactory or no response
- Phoning the staff member's home or emergency contact person
- Contacting the police (continue to attempt to make contact with the member of staff unless advised otherwise) Ongoing communications to ascertain the status of investigations and further actions should take place between the manager and the police.
- Senior management should be made aware of escalation to the police and any progress
- Police Communications should be notified immediately if the employee has been located and their safety status confirmed

2.5 Reporting of Hazards / Incidents

2.5.1 Internal Reporting

Work Health and Safety reporting is a feature on the Safety Learning System (SLS) for the reporting of incidents that affect SA Health Workers. The Work Health and Safety WHS content is incorporated into the existing Notification form.

Work Health and Safety incidents cover:

- hazards, such as equipment faults; environmental factors
- incidents with no harm, such as something has happened but no-one was injured
- incidents with injury, such as muscular stress or emotional trauma and vehicle accidents. If

Appendix 4: Home Visiting Procedure: continued



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Home Visiting Procedure

injury is sustained by the worker, then Workforce Health Injury Management must also be notified by contacting 1800 702 264

- Notation in the client's file should provide appropriate advice for any further staff involvement
- Place an alert on the local records management system

2.5.2 External Reporting

- Where a staff member has reason to believe that a patient/person is in possession of a firearm, the manager and SAPOL must be notified. There is an obligation to report unsafe or suspected unsafe situations associated with firearms to the Registrar of Firearms. This is done by completing a "Medical Notification to Registrar of Firearms" form.
- Under Section 11 (1) & (2) of the Children's Protection Act 1993, there is a requirement that staff and volunteers associated with the delivery of this organisation's services, report to Family and Youth Health Services any reasonable suspicion of a child/young person who has been or is being abused or neglected.











The 5 moments of hand hygiene are to be complied with by all staff at all times as per Policy Directive, Hand Hygiene, Infection Prevention and Control, SA Health.

All staff must identify the patient at the beginning of a care episode & at each patient intervention using the

3 mandatory identifiers of correct Unit Record Number, name and date of birth as per Policy Directive, Patient Identification and Patient Identification Guideline SA Health.

All procedures involving the provision of medical treatment to a patient must be undertaken in accordance with the Consent to Medical Treatment and Palliative Care Act 1995

National Safety and Quality Health Service Standards

 Governance for Safety and Quality in Health Care	 Partnering with Consumers Policy Link	 Preventing & Controlling Healthcare associated infections Policy Link	 Medication Safety Policy Link	 Patient Identification & Procedure Matching Policy Link	 Blood and Blood Products Policy Link	 Clinical Handover Policy Link	 Preventing & Managing Pressure Injuries Policy Link	 Recognising & Responding to Clinical Deterioration Policy Link	 Preventing Falls & Harm from Falls Policy Link
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 4: Home Visiting Procedure: continued



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Home Visiting Procedure

Work Health and Safety								
Program 1 Governance Accountability & Communication	Program 2 Duty of Care	Program 3 Emergency Management	Program 4 Hazard Identification & Risk Management	Program 5 Incident Reporting & Investigation	Program 6 Employee Health & Wellbeing	Program 7 Injury Management	Program 8 OHSW&IM Training & Development	Program 9 Performance Review & Continuous Improvement
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risks								
Rating			Risk					
Moderate to high			Injury or death of NALHN employee due to harm arising from travelling to / from home visit or undertaking home visit					
Evaluation / Audit								
Divisions will monitor and evaluate the effectiveness of this procedure through collection and analysis of data on home visit related incidents and claims, SLS reporting, monitoring of client complaints and clinical supervision.								
Related Documents								
<p>Legislation Section 27a Firearms Act, 1977 South Australian Work Health and Safety Act 2012 Children's Protection Act, 1993 Mental Health Act, 2009 Mental Health Bill 2008 Criminal Law Consolidation Act 1935 Public Sector Act 2009 Commissioner For Public Sector Employment Guideline: Gifts and benefits</p> <p>SA Health Directives/Policies/Guidelines</p> <ul style="list-style-type: none"> SA Health 'Extreme Heat Operational Plan (January 2013 version 6.06) SA Health 'Patient Identification Policy Directive' (ref no D0228) SA Health 'Patient Identification Guideline' (ref no G0103) SA Health OHSW&IM Policy Directive <p>NALHN Policies/Procedures/Guidelines/Forms</p> <ul style="list-style-type: none"> Bushfire Safety and Survival Procedure <p>External References & Best Practice Guidelines</p> <ul style="list-style-type: none"> DASSA: Home visits Standard Procedure. Child Youth and Women's Health Service: Home visiting safety. RDNS, Home visit procedures 								

Appendix 4: Home Visiting Procedure: continued



OWI00777

Home Visiting Procedure

Definitions and Acronyms

Associated risks include (but not limited to):

Threats, assaults or harassment which may be categorised as any of the following:

- Physical violence against a staff member
- Threatening to harass, injure or kill a staff member, colleague or other person
- Sexist, racist or personally demeaning comments or innuendo
- Physical violence against objects, such as kicking, defacing or destroying property
- Unwelcoming or threatening actions including blocking access, vulgar noises or gestures and the exhibiting of offensive material
- No control over environment or people in the environment
- Any unreasonable accusations of impropriety or unprofessional conduct on behalf of staff
- Unpredictable client status e.g. intoxication and mental state at time of visit
- Threat of attack or intimidation by dogs and other animals

Environmental risks including:

- Not being familiar with the area and potential to get lost
- Car breakdown or car accident
- Hot weather
- Isolation e.g. home visiting in an area where there is no access to phones
- Rubbish, waste, rotting food and biological matter
- Uneven pathways, poor lighting, broken steps, flimsy balustrades.
- Broken furniture, soiled bedding, linen and upholstery.
- Poorly maintained electrical appliances, plumbing and equipment.
- Vermin, spiders, lice, fleas and other pests
- Potential allergens
- Poorly maintained hygiene in regard to self care, pets, and biological substances.

Standard Precautions are a series of strategies used during actual or anticipated contact.

Key Word Search	Home, visiting, firearms, personal duress device, safety, community, driving, fire
Procedure Sponsor	Karen Puvogel Divisional Director, ACRPC (Nursing)
Author	Gill Bartley, Manager Northern Community Geriatrics Service Meredith Jolly, Manager Northern Adelaide Rehabilitation Service

Division Approval			
Name	Dr John Maddison	Karen Puvogel	
Position	Divisional Director ACRPC (Medical)	Divisional Director, ACRPC (Nursing)	
Date	27/05/2014	27/05/2014	
CEO Approval for Organisation Wide Procedures			
Clinical Governance Committee Date	04/06/2014		
Name	Margot Mains		
Date	18/6/14		
Version	Effective from	Effective to	Change summary
1.0	03/2011	03/2013	New Procedure
2.0	06/2014	03/2017	Reviewed Procedure, NALHN template

Appendix 5: Staff Out of Hours / Non Return



Government of South Australia
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SSI01461

Staff Out of Hours / Non Return

This Procedure Supersedes Procedure Number/s: Title of Procedure/s Superseded:	Not Applicable <input checked="" type="checkbox"/>
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Effective date	08/2014	Next review date	08/2015
Interim Review	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Review in	<input type="checkbox"/> 3 months or <input type="checkbox"/> 6 months

Scope (Indicate those that apply <input checked="" type="checkbox"/>)	<input type="checkbox"/> Organisation Wide (OW) NALHN	<input checked="" type="checkbox"/> Service Specific (SS) <input checked="" type="checkbox"/> Division ACRPC <input type="checkbox"/> Clinical Area <input type="checkbox"/> Site
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Application (Indicate those that apply <input checked="" type="checkbox"/>)	<input checked="" type="checkbox"/> All Staff <input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Midwifery <input type="checkbox"/> Allied Health <input type="checkbox"/> Administration	<input type="checkbox"/> Students <input type="checkbox"/> Volunteers <input type="checkbox"/> Contractors <input type="checkbox"/> Agency <input type="checkbox"/> Consumers <input type="checkbox"/> Other (please specify)
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Roles and Responsibilities	Employees are responsible for communicating their movements out of the office, including car details, destination, travel details and estimated time of return. All staff can provide access to view each other's calendars. The Administration Officer is responsible for monitoring staff return. Manager and team leaders are required to follow the below process in the instance of staff non-return.
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Purpose

The Out of Hours / Non Return work procedure will ensure the safety of staff undertaking work duties off site and outside core business hours.

Procedure Detail

The Out of Hours / Non Return procedure is to be followed in the following circumstances:

If a staff member has:

- not returned at the expected time and is more than 30 minutes late as per the designated communication board and/or Outlook calendar entry
- not notified a staff member or the manager of a change in their expected time of arrival
- been reported to be more than 30 minutes late for an appointment / booking.

Action Plan:

The following responses are triggered by the designated officer or delegate in the order detailed herein. If an unsatisfactory response is obtained, the actions are escalated to the next level

1. Contact the staff member using his/her allocated mobile phone
2. Contact the house or site where the staff member is thought to be
3. Escalate to the Manager or other senior staff member if there is an unsatisfactory or no response
4. Phone the staff member's home or emergency contact person (details in the emergency

Appendix 5: Staff Out of Hours / Non Return: continued



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SSI01461

Staff Out of Hours / Non Return

contacts folder kept by the Manager, Team Leaders and Administration Officer
5. Contact the police and notify the Divisional Executive Team by mobile phone.

Process when staff under personal threat:

If the staff member is at risk of personal threat (Code Black) and cannot safely state this over the phone the following phrases should be used to alert the Manager/staff member

- Please let Mr/Dr Black know that I need to cancel my appointment/home visit with him
- Could you call Mr/Dr Black for me and let him know
- Thanks for returning my call Mr/Dr Black

The caller will attempt to maintain phone contact and ascertain where the staff member is without them having to state directly, for example,

"Are you still at the home visit? / Are you still at Mr/Mrs XXXX's house?"

The caller will then alert another staff member or use another phone to contact the police by dialling 0-000.

Documentation and Reporting:

Following resolution, the staff member is required to complete a Safety Learning System (SLS) Incident Report

The 5 moments of hand hygiene are to be complied with by all staff at all times as per Policy Directive, Hand Hygiene, Infection Prevention and Control, SA Health.

All staff must identify the patient at the beginning of a care episode & at each patient intervention using the 3 mandatory identifiers of correct Unit Record Number, name and date of birth as per Policy Directive, Patient Identification and Patient Identification Guideline SA Health.

All procedures involving the provision of medical treatment to a patient must be undertaken in accordance with the Consent to Medical Treatment and Palliative Care Act 1995

National Safety and Quality Health Service Standards

Standard 1 Governance for Safety and Quality in Health Service Organisations	Standard 2 Partnering with Consumers	Standard 3 Preventing & Controlling Healthcare associated infections	Standard 4 Medication Safety	Standard 5 Patient Identification & Procedure Matching	Standard 6 Clinical Handover	Standard 7 Blood and Blood Products	Standard 8 Preventing & Managing Pressure Injuries	Standard 9 Recognising & Responding to Clinical Deterioration	Standard 10 Preventing Falls & Harm from Falls
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 5: Staff Out of Hours / Non Return: continued



Government of South Australia
SA Health

NALHN

SSI01461

Staff Out of Hours / Non Return

Work Health and Safety								
Program 1 Governance Accountability & Communication	Program 2 Duty of Care	Program 3 Emergency Management	Program 4 Hazard Identification & Risk Management	Program 5 Incident Reporting & Investigation	Program 6 Employee Health & Wellbeing	Program 7 Injury Management	Program 8 OHSW&IM Training & Development	Program 9 Performance Review & Continuous Improvement
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risks	
Rating	Risk
High	Staff working in the community who are not monitored may be placed in dangerous situations that require a plan of action.

Evaluation / Audit
<p>Incidents are raised at business meetings and departmental meetings as they occur.</p> <p>SLS reports</p> <p>Divisional Work Health Safety (WHS) reports tabled at quarterly Divisional Governance Committee (1D5).</p>
Related Documents
<p>Legislation</p> <p>SA Health Directives/Policies/Guidelines</p> <p>SA Health Incident Management Policy Directive (ref D0162)</p> <p>SA Health Incident Management Guideline Incorporating Open Disclosure Response (ref G0075)</p> <p>Attendance Management Guideline for SA Health</p> <p>Work Health and Safety Duty of Care to all Persons Policy Directive</p> <p>Work Health and Safety Reporting and Investigation</p> <p>Work Health, Safety and Injury Management (WHSIM) Policy Directive</p> <p>Worker Health and Wellbeing Policy Directive</p> <p>NALHN Policies/Procedures/Guidelines/Forms</p> <p>Bushfire Safety and Survival Procedure NALHN-OWI00959</p> <p>Home Visiting Procedure OW100777</p> <p>External References & Best Practice Guidelines</p>

Appendix 5: Staff Out of Hours / Non Return: continued



Government of South Australia
SA Health

NALHN

SSI01461

Staff Out of Hours / Non Return

Definitions and Acronyms

Key Word Search	Safety, threat, non-return, staff out of hours, home visiting , community
Procedure Sponsor	Kirsty Delguste, Nursing Director Aged Care, Rehabilitation & Palliative Care
Author	Gill Bartley, Manager Community Geriatrics Service Meredith Jolly, Manager Northern Adelaide Rehabilitation Service

Division Approval

Name	Dr John Maddison	Karen Puvogel
Position	Director Aged Care, Rehabilitation and Palliative Care (Medical)	Director Aged Care, Rehabilitation and Palliative Care (Nursing)
Date	22/08/2014	22/08/2014

CEO Approval for Organisation Wide Procedures

Clinical Governance Committee Date	
Name	
Date	

Version	Effective from	Effective to	Change summary
1.0	08/2014	08/2015	New Procedure

Appendix 6: Human Research Ethics Committee Letter of Approval



Government of South Australia
SA Health

Human Research Ethics Committee (TQEH/LMH/MH)
Basil Hetzel Institute DX465101
The Queen Elizabeth Hospital
28 Woodville Road
Woodville South SA 5011
Telephone: 82226841

16 February 2015
AMENDED 25 FEBRUARY 2015

Ms Jacqueline Smit
Northern Community Mental Health Local Network
PO Box 400
Salisbury SA 5108

Dear Ms Smit

HREC reference number: HREC/14/TQEHLMH/250

Project title: How community mental health clinicians assess and manage the risk of violence from mental health consumers: a descriptive exploratory research investigation.

RE: Ethics Application Approval

Thank you for submitting additional information received on 15 February 2015 in relation to the above project for ethical and scientific review.

We have reviewed your response, and I am pleased to advise that your protocol has been granted full ethics approval and meets the requirements of the *National Statement on Ethical Conduct in Human Research, incorporating all updates*. The documents reviewed and approved include:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application: Low Risk Proposal for Research	AU/15/633B115	21 October 2014
Response to Request for further information	-	30 January 2014
Response to Request for Further Information	-	15 February 2015
Covering Letter		04 November 2014
Research Protocol	-	07 October 2014
CV: Jacqueline Smit	-	24 September 2014
Interview Questions	1	05 October 2014
Participant Information Sheet and Consent Form: Main	3	23 February 2015
Letter of Introduction	5	23 February 2015

Sites covered by this approval:

- **Northern Mental Health (NALHN)**

HREC approval is valid from **17 February 2015 to 17 February 2018**.

Please note that approvals are subject to annual review reports submitted every 12 months from the date of approval. Failure to submit reports may result in the HREC revoking its approval. The responsibility of submitting an annual review reporting is with the Coordinating Principal investigator.

Please note the following conditions of approval:

Appendix 6: Human Research Ethics Committee Letter of Approval: cont.

1. This HREC will act as the South Australian 'lead HREC' for the purpose of this ethics approval. Any study sites that are not listed on this letter are not covered by this ethics approval. Any SA study-sites within the public health system that wish to be added must contact the CPI, who must write formally to this HREC requesting the additional study site and a separate formal letter will be issued.
2. Annual review reports must be submitted to the HREC, every 12-months from the date of approval. Each site covered by this HREC must submit a report, and it is the responsibility of the Coordinating Principal investigator to ensure this is carried out.
3. Researchers are required to immediately report to this HREC anything which might warrant review of ethical approval of the study, including:
 - a. serious or unexpected adverse effects on participants;
 - b. proposed changes in the study; and
 - c. unforeseen events that might affect continued ethical acceptability of the project.
4. Confidentiality of the research subjects shall be maintained at all times as required by law.
5. All research subjects shall be provided with a Participant Information Sheet and Consent Form, unless otherwise approved by the HREC.
6. Adequate record-keeping must be maintained in accordance with GCP, NHMRC and state and national guidelines. The duration of record retention for all clinical research data is 15 years from the date of publication.
7. SA Health requires all institutions under its jurisdiction to dispose of research materials in accordance with the requirements outlined in the NHMRC Australian Code for the Responsible Conduct of Research.
8. A report and a copy of any published material should be forwarded to the HREC at the completion of the project.

This Committee is constituted in accordance with the NHMRC *National Statement on the Ethical Conduct of Human Research (2007)* and incorporating all updates.

You are reminded that this letter constitutes ethical approval only. You cannot commence this project until you receive site authorisation from the CEO or delegate, even if ethics approval is received.

To obtain site authorisation, a separate Site Specific Assessment (SSA) application should be made to each public health site involved in the study, through the Site's Research Governance Officer. For more information, please visit:

<http://www.basilhetzelinstitute.com.au/research/research-ethics-governance/governance-site-specific-assessments-ssa->

If University personnel are involved in this project, the Principal Investigator should notify the University before commencing their research to ensure compliance with University requirements including any insurance and indemnification requirements.

Should you have any queries about the HREC's consideration of your project please the HREC Executive Officer on 08 8222 6910 or qeh.ethics@health.sa.gov.au

The HREC wishes you every success in your research.

Yours sincerely

Professor Richard E Ruffin
Chairman, Human Research Ethics Committee (TQEH/LMH/MH)
RR:CC

cc: Alison Barr – Governance Officer NALHN

Appendix 7: Site Specific Approval



Northern Adelaide Local Health Network

Research Governance Office
Level 2, Clinical Trials Unit
Lyell McEwin Hospital
Haydown Road
ELIZABETH VALE SA 5112
Tel: 08 8182 9346
Email: nalhnrgo@health.sa.gov.au

04 March 2015

Ms Jacqueline Smit
Northern Community Mental Health Local Network
PO Box 400
Salisbury, SA, 5108

Dear Ms Smit

HREC reference number: HREC/14/TQEHLMH/250

SSA reference number: SSA/14/NALHN/6

Project title: How community mental health clinicians assess and manage the risk of violence from mental health consumers: a descriptive exploratory research investigation.

RE: SSA/14/NALHN/6 - Site Specific Assessment Approval

Thank you for submitting an application for authorisation of the above project. I am pleased to inform you that authorisation has been granted for this study to commence at the following site:

- **Northern Community Mental Health**

The following conditions apply to the authorisation of this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval to this project:

1. Notification of extensions / annual reviews granted by the lead HREC are to be provided to the NALHN Research Governance Officer (RGO).
2. Confidentiality of the Northern Community Mental Health research subjects shall be maintained at all times as required by law.
3. Researchers are required to immediately report to the NALHN RGO anything which might warrant review of site approval of the protocol including serious or unexpected adverse effects on participants;
4. Researchers are required to notify the NALHN RGO of any amendments to the protocol (summary of changes) or participant recruitment material (with tracked changes).
5. Adequate record-keeping must be maintained in accordance with GCP, NHMRC, HREC, state and national guidelines.
6. SA Health requires institutions under its jurisdiction to dispose of research materials in accordance with the requirements outlined in the NHMRC Australian Code for the Responsible Conduct of Research.
7. Notification of completion of the study at Northern Community Mental Health is to be provided to the RGO.
8. A report and a copy of any published material should be forwarded to the NALHN RGO at the completion of the project.

If University personnel are involved in this project, the Principal Investigator should notify the University before commencing their research to ensure compliance with University requirements including any insurance and indemnification requirements

Should you have any queries about the consideration of your Site Specific Assessment form, please contact me on 08 8182 9346 or nalhnrgo@health.sa.gov.au

The SSA reference number should be quoted in any correspondence about this matter.

Yours sincerely

ALISON BARR
Research Governance Officer
Northern Adelaide Local Health Network (LMH/MH/PHC)

Appendix 8: Letter of Invitation



SCHOOL OF NURSING
FACULTY OF HEALTH SCIENCES
TELEPHONE +61 8 8313 0511
FACSIMILE +61 8 8313 3594
nursing@adelaide.edu.au
CRICOS Provider Number 00123M

Date

Dear Community Mental Health Clinician

I am undertaking a research project as part of my study towards a Master of Nursing Science at The University of Adelaide. The research project will be undertaken under the supervision of Dr Lynette Cusack, Senior Lecturer, School of Nursing, at The University of Adelaide.

The aim of the research project is to gain insight into how community mental health clinicians assess and manage the risk of violence from mental health consumers.

This study is important because there is a paucity of literature available on this practice that forms an important aspect of community mental health clinicians' roles

Potential participants will receive an information sheet to explain more about this study. If you would like to participate in this study, you will be asked to complete a consent form prior to an interview. The interviews will be individual, confidential, and will be held during work time with permission by management. The interview is anticipated to take about one hour.

Should you wish to contribute to this study or to find out more about it please contact me at the email address below and I will send you an Information Sheet. You will be able to decline to answer any particular questions and to withdraw from the interview at any time. Your participation in this research is entirely voluntary.

If you are interested in participating or would like more information please email:

Jacqueline.smit@student.adelaide.au or Jacqueline.smit@health.sa.gov.au

Thank you for your consideration of this project.

For any concerns in relation to the research please contact:-

Research Supervisor: Dr Lynette Cusack at 83133593 (The University of Adelaide) or Human Research Ethics Committees as outlined below.

Best regards

Masters Student Jacqueline Smit,

School of Nursing

University of Adelaide

This research project has been approved by the Human Research Ethics Committee (TQEH/LMH/MH): HREC/14/TQEHLMH/250 and the Adelaide University Human Research Ethics Committee (Project Number HREC/14/TQEHLMH/250).

For more information regarding ethical approval of the project or any ethical concerns you can contact the Executive Officer Human Research Ethics Committee (TQEH/LMH/MH) on (08) 8222 6910 Or

The Research Branch of The University of Adelaide on 8313 5137, or by email rb@adelaide.edu.au.

J.Smit

09.03.2015

Letter of Introduction Version 6

Appendix 9: Questionnaire



SCHOOL OF NURSING
FACULTY OF HEALTH SCIENCES
TELEPHONE +61 8 8313 0511
FACSIMILE +61 8 8313 3594
nursing@adelaide.edu.au
CRICOS Provider Number 00123M

Initial Check list:

Copy of Participation Information/ Consent/ Complaints/ Withdrawal Form given: Yes / No

Consent Form signed: Yes / No

Interview Number: Date:...../...../.....Time:.....Pseudonym.....

Interview Questions:

1. Please indicate your current role:
Mental Health Nurse..... Social Worker..... Occupational Therapist
2. Please indicate your length of employment in Mental Health:
Years.....Months.....

The following questions are asked in relation to how the risk of violence from mental health consumers is assessed and managed in the community:

3. With regard to meeting consumers, can you tell me:
3a. how you prepare to meet a new consumer?
3b. how you prepare for a community visit with a consumer that is considered to be a low risk toward violence?
3c. how would you prepare for a community visit with a consumer who is considered to be a high risk toward violence?
4. Do you orientate new members of staff? Yes / No (If No, proceed to Question 5)
4a. if yes: When you orientate a new member of staff, what policies, procedures and standards do you refer them to, for community visits, or assessment and management of violence from mental health consumers in the community? (Organisational Policies and Procedures; Work Health and Safety Standards).
5. Can you tell me about any policies, procedures or standards that you use to guide your assessment and management of violence from mental health consumers in the community? (Organisational Policies and Procedures; Work Health and Safety Standards).
6. What is your opinion of this statement "it is inevitable that mental health clinicians will be subjected to violence from a consumer"?
7. Is there anything else that you would like to tell me about the different ways you assess and manage the risk of violence from mental health consumers in the community?
8. Do you have any comments about the current practice at this Community Mental Health Centre, of risk assessment and management of violence from mental health consumers in the community that you think works well or that requires improving?

Appendix 10: Participant Information Sheet, Consent Form and Withdrawal form



School of Nursing
Faculty of Health Sciences
Telephone +61 8 8313 0511
Facilimile +61 8 8313 3594
nursing@adelaide.edu.au
CRICOS Provider Number 00123M

Participant Information Sheet/Consent Form

Health/Social Science Research - Adult providing own consent

Northern Community Mental Health Centre

Title	How community mental health clinicians assess and manage the risk of violence from mental health consumers: a descriptive exploratory research investigation
Short Title	Community mental health clinicians: assessment of risk of violence
Protocol Number	HREC/14/TQEHLMH/250
Coordinating Principal Investigator/ Principal Investigator	Ms Jacqueline Smit Dr Lynette Cusack
Location	Northern Community Mental Health Centre

Appendix 10: Participant Information Sheet/ Consent Form: continued
Part 1 What does my participation involve?

1 Introduction

You are invited to take part in this research project, which is called:
How community mental health clinicians assess and manage the risk of violence from mental health consumers: a descriptive exploratory research investigation.

You have been invited because you are a community mental health clinician and you are employed by the Northern Community Mental Health Centre. A brief introduction to this research project has been provided when the research project was announced to the team and in the Letter of Introduction.

This Participant Information Sheet/Consent Form tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research. Please read this information carefully. Ask questions about anything that you don't understand or want to know more about.

In accord with ethical considerations, participation in this research is voluntary. You are under no obligation to participate. There will be no negative consequences to you if you choose not to participate or if you commence participation and then decide to withdraw from the research project. The nature of your relationship with respect to the coordinating principle investigator should not affect your decision to participate or not participate.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling me that you:

- Understand what you have read
- Consent to take part in the research project

You will be given a copy of this Participant Information and Consent Form to keep.

2 What is the purpose of this research?

This research aims to improve the safety of community mental health clinicians when caring for mental health consumers.

There is a limited amount of published literature regarding this topic. This research will add to the literature by investigating the processes that mental health clinicians use to minimise the risk of violence, when caring for mental health consumers in the community.

Investigating the process of risk assessment and management of violence, will provide the opportunity to analyse and discuss how risk is minimised and to identify if there are any recommendations to improve safety. Knowledge gained from this research can inform education, decisions regarding policy and procedures, and can contribute to published literature on this practice. This research will provide insight into this practice, but it may indicate the need for further investigations.

The limited number of in-patient beds and the principle of least restrictive practice, determines that mental health consumers are cared for in the community during various phases of their recovery. One aspect of care by mental health clinicians is the skill to assess and manage the risk of violence from mental health consumers. There is a paucity of literature expounding this skill. It is important to understand how community mental health clinicians undertake this role.

This research has been initiated by the researcher, Ms Jacqueline Smit MHN, RN. The results of this research will be used by the Coordinating Principal Researcher, Jacqueline Smit to obtain a Master of Nursing Science.

Appendix 10: Participant Information Sheet/ Consent Form: continued

3 What does participation in this research involve?

Participants will be given a consent form, which must be signed prior to commencement of the interview.

To be eligible to participate in the research you will need to meet the following criteria:

- Working as a mental health nurse, social worker or occupational therapist
- Employed by the Mental Health Community Health Centre in a casual, part-time or full-time capacity

You will be asked to participate in an individual semi-structured interview with the researcher to discuss a series of questions. The questions will be provided when you express an interest in participating, to allow you time to consider your responses. The interview will occur at a convenient time with yourself and the researcher. Your participation in this project should take no longer than one hour.

The research will use a qualitative, descriptive exploratory approach. The data will undergo a thematic analysis followed by a discussion of the findings.

There are no costs associated with participating in this research project, nor will you receive payment. It is expected that you will be able to participate in the research during your work hours.

The research has been granted ethics approval from the Human Research Ethics Committee (TQEH/LMH/MH) and the Adelaide University Human Research Ethics Committee, and Site Specific Assessment Approval from Management of the Community Mental Health Centre.

The research will be monitored by the researcher's supervisor, Dr Lynette Cusack. Any deviations from the proposed research will require approval from the Ethics Committees and Management of the Community Mental Health Centre.

Interviews will be held in a private location at the Community Mental Health Centre. There will be no personal information from which you will be identified. It is preferred that you choose a pseudonym for the interview. The interview will be audio recorded and the data will then be transcribed. Any information that could identify you or any other persons or places, will be de-identified from these records and neither your name nor any other identifying information will be used in the reporting of this study.

The data will be kept in a secure location at all times and the transcribed data will be stored by Dr Lynette Cusack, in a secure location at the University of Adelaide, School of Nursing for seven years.

4 Other relevant information about the research project

It is anticipated that eight to twelve participants will be involved in the research at the Community Mental Health Centre. There is a possibility that not everyone who expresses an interest in participating will be interviewed. If there are more than twelve community mental health clinicians interested in participating, then the first twelve applicants to respond, to the invitation to participate, will be selected.

The research will involve one Coordinating Principal Researcher and a Principal Investigator from the University of Adelaide. This research is an independent study which is not part of any other current research.

Appendix 10: Participant Information Sheet/ Consent Form: continued

5 Do I have to take part in this research project?

Participation in this research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with the researcher; professional staff; the University of Adelaide; and it will not affect your employment within NALHN.

6 What are the possible benefits of taking part?

You may not receive any benefits from this research. However, your participation will contribute to a discussion regarding the current practices to minimise the risk of violence from mental health consumers. The discussion may highlight areas for quality improvement processes in this area of practice. The research will be published in relevant journals.

7 What are the possible risks and disadvantages of taking part?

It is possible that you may feel uncomfortable discussing some aspects of how you assess and manage the risk of violence from mental health consumers.

If you do not wish to answer a question, you may request to go to the next question, or you may stop immediately. You will be able to withdraw from the study at any time.

If you become upset or distressed as a result of your participation in the research project, counselling or other appropriate support will be suggested. Access to the health services Employee Assistant Program is available for any participants who feel they need support for the issues raised during the discussion. The counselling or support will be provided by qualified staff who are not members of the research team. This counselling is provided free of charge to SA Health employees.

When the research project is finalised, the findings of the research will be presented to the Community Mental Health Centre. All care will be taken to maintain privacy and confidentiality, but you may experience embarrassment if you identify comments that were said during the interview which are quoted during the discussion.

8 What if I withdraw from this research project?

If you do consent to participate, you may still withdraw at any time. If you decide to withdraw from the project, please notify the researcher. The researcher will inform you if there are any special requirements linked to withdrawing. If you do withdraw, you will be asked to complete and sign a 'Withdrawal of Consent' form; this will be provided to you by the researcher.

If you decide to withdraw, the researcher will not collect additional information from you, although information already collected will be retained to ensure that the results of the research project can be measured properly and to comply with law. You should be aware that data collected up to the time you withdraw will form part of the research project results. If you do not want your data to be included, you must tell the researcher when you withdraw from the research project.

Appendix 10: Participant Information Sheet/ Consent Form: continued

9 Could this research project be stopped unexpectedly?

This research project may be stopped unexpectedly for a variety of reasons. These may include reasons such as the researcher being unable to complete the research project.

10 What happens when the research project ends?

When the interviews for the research project have concluded, the researcher will analyse the data and the findings will be discussed and submitted as a Masters Thesis to the University of Adelaide. The Masters thesis is expected to be concluded by the end of 2015. The Masters Thesis will be published and stored at the University of Adelaide. The results of the research will be presented at the Adelaide University, School of Nursing, Conversazione. The researcher will publish the research investigation in a peer reviewed journal. With permission from management, the findings will be presented as an in-service education session at the Community Mental Health Centre.

Appendix 10: Participant Information Sheet/ Consent Form: continued

Part 2 How is the research project being conducted?

11 What will happen to information about me?

By signing the consent form you consent to the researcher collecting and using information that you have provided for the research project.

Any information obtained in connection with this research project that can identify you will remain confidential. Any identifying information will be de-identified. A preferred pseudonym will be used and the interviews will receive a number, date and time. Any reference that identifies you, other clinicians or consumers will be de-identified to maintain confidentiality.

The data will be kept in a secure location by the researcher in a locked drawer at work or at home on a password protected USB device. Access to the data will be limited to the Coordinating Principal Investigator, and the Principal Investigator.

The data will be stored for seven years at the University of Adelaide, School of Nursing. At the conclusion of seven years, the data will be destroyed by the University of Adelaide, School of Nursing.

Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law.

The information that the researcher will collect and use from each interview, is whether you are a mental health nurse, a social worker or an occupational therapist; how long you have worked in mental health, and the discussion which is guided by the questionnaire.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified.

In accordance with relevant Australian and/or South Australian privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the researcher. If you would like a transcript of the interview, please inform the researcher who will ensure that you will be identified adequately for this purpose. The interview transcript will then be de-identified.

You also have the right to request that any information with which you disagree be corrected. Please inform the researcher named at the end of this document if you would like to access your information.

Any information obtained for the purpose of this research project that can identify you will be treated as confidential and securely stored. It will be disclosed only with your permission, or as required by law.

12 Complaints and compensation

The study has been approved by the Human Research Ethics Committee (TQEH/LMH/MH) and the University of Adelaide Human Research Ethics committee. If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the Coordinating Principle Investigator.

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

Research Approval number HREC/14/TQEHLMH/250

Appendix 10: Participant Information Sheet/ Consent Form: continued

Ms. Jacqueline Smit (Coordinating Principal Investigator)

Work phone: (08) 74854300

Mobile phone: 0424681765

Email: jacqueline.smit@student.adelaide.edu.au or jacqueline.smit@health.sa.gov.au

If you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant you can contact:

Dr. Lynette Cusack (Principal Investigator)

The University of Adelaide

Phone: (08) 8313 3593

Email: lynette.cusack@adelaide.edu.au

Human Research Ethics Committee (TQEH/LMH/MH) 08 8222 6910:

qeh.ethics@health.sa.gov.au

University of Adelaide Human Research Ethics Committee's Secretariat: (08) 8313 6028 or by email to hrec@adelaide.edu.au .

If you suffer any distress as a result of this research project, you should contact the researcher as soon as possible. You will be assisted with arranging appropriate treatment and support.

13 Who is organising and funding the research?

There is no funding for this research project.

The researchers will not receive a personal financial benefit from your involvement in this research project (other than their ordinary wages).

You will not benefit financially from your involvement in this research project even if, for example, knowledge acquired from your information proves to be of commercial value to the University of Adelaide. This research will form part of the Master of Nursing Science to be awarded upon completion by the University of Adelaide to Ms Jacqueline Smit.

Appendix 10: Participant Information Sheet/ Consent Form: continued

14 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC).

The ethical aspects of this research project have been approved by the TQEH HREC and The University of Adelaide HREC.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

15 Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the:

Research contact person (1)

Name	Jacqueline Smit
Position	Site Coordinating Principal Researcher
Telephone	Work: 08 74854300: Personal Mobile: 0424681765
Email	jacqueline.smit@student.adelaide.edu.au jacqueline.smit@health.sa.gov.au

Research contact person (2)

Name	Dr Lynette Cusack
Position	Principal Investigator
Telephone	Work: 08 8313 3593
Email	Lynette.cusack@adelaide.edu.au

For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

Complaints contact person (1)

Name	Alison Barr
Position	Northern Adelaide Local Health Network Research Governance Officer
Telephone	08 8182 9346
Email	nalhnrgo@health.sa.gov.au

Complaints contact person (2)

Name	University of Adelaide Human Research Ethics Committee
Position	Secretariat
Telephone	(08) 8313 6028
Email	hrec@adelaide.edu.au

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Participant Information Sheet/Consent Form Version 3 23/02/2015 Page 8 of 11

Appendix 10: Participant Information Sheet/ Consent Form: continued

Reviewing HREC approving this research and HREC Executive Officer details (1)

Reviewing HREC name	Human Research Ethics Committee (TQEH/LMH/MH)
HREC Executive Officer	Melissa Kluge
Telephone	08 8222 6910
Email	qeh.ethics@health.sa.gov.au

Reviewing HREC approving this research and HREC Executive Officer details (2)

Name	University of Adelaide Human Research Ethics Committee
Position	Secretariat
Telephone	(08) 8313 6028
Email	hrec@adelaide.edu.au

Appendix 10: Participant Information Sheet/ Consent Form: continued
Consent Form - Adult providing own consent

Title How community mental health clinicians assess and manage the risk of violence from mental health consumers: a descriptive exploratory research investigation.

Short Title Community mental health clinicians: assessment of risk of violence.

Protocol Number To be advised:

Coordinating Principal Investigator Ms Jacqueline Smit

Principal Investigator Dr Lynette Cusack

Location Northern Community Mental Health Centre

Declaration by Participant

I have read the Participant Information Sheet.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future care.

I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print) _____
Signature _____ Date _____

Declaration by Researcher†

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher† (please print) _____
Signature _____ Date _____

† An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature.
Participant Information Sheet/Consent Form Version 3 23/02/2015 Page 10 of 11

Appendix 10: Participant Information Sheet/ Consent Form: continued

Form for Withdrawal of Participation - Adult providing own consent

Title How community mental health clinicians assess and manage the risk of violence from mental health consumers: a descriptive exploratory research investigation

Short Title Community mental health clinicians: assessment of risk of violence

Protocol Number To be advised:

Coordinating Principal Investigator Ms Jacqueline Smit

Principal Investigator Dr Lynette Cusack

Location Northern Community Mental Health Centre

Declaration by Participant

I wish to withdraw from participation in the above research project and understand that such withdrawal will not affect my relationships with the researchers or the Northern Community Mental Health Centre.

Name of Participant (please print)	_____
Signature	_____
Date	_____

In the event that the participant's decision to withdraw is communicated verbally, the Coordinating Principal Researcher must provide a description of the circumstances below.

--

Declaration by Researcher†

I have given a verbal explanation of the implications of withdrawal from the research project and I believe that the participant has understood that explanation.

Name of Researcher (please print)	_____
Signature	_____
Date	_____

† An appropriately qualified member of the research team must provide information concerning withdrawal from the research project.

Note: All parties signing the consent section must date their own signature.

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Appendix 11: PubMed Logic Grid

Community mental health	AND Violence	AND Assessment	NOT domestic
Community mental health services[mh] OR community mental health service*[tiab] OR mental health services[mh:noexp] OR house calls[mh] OR home visit*[tiab] OR community visit*[tiab]	Violence[mh:noexp] OR violen*[tiab] OR assault*[tiab] OR aggress*[tiab] OR aggression[mh] OR dangerousness[tiab]	Risk assessment[mh] OR risk factors[mh] OR risk[tiab] OR prevention and control[sh] OR management[TW]	Domestic[tw] OR School[tw] OR gang[tw] OR spouse abuse[tw]

Search Summary:

Search (((Community mental health services[mh] OR community mental health service*[tiab] OR mental health services[mh:noexp] OR house calls[mh] OR home visit*[tiab] OR community visit*[tiab])) AND (Violence[mh:noexp] OR violen*[tiab] OR assault*[tiab] OR aggress*[tiab] OR aggression[mh] OR dangerousness[tiab])) AND (Risk assessment[mh] OR risk factors[mh] OR risk[tiab] OR prevention and control[sh] OR management[TW])) NOT (Domestic[tw] OR School[tw] OR gang[tw] OR spouse abuse[tw]) Filters: Full text; Publication date from 2004/01/01 to 2015/12/31; Humans; English

Appendix 12: CINAHL Logic Grid

Community mental health	AND Violence	AND Assessment and/or Management	NOT Domestic
MH “community mental health services” OR TI “community mental health service*” OR AB “community mental health service*” OR MH “mental health services” OR MH “house calls” OR TI “home visit*” OR AB “home visit*” OR TI “community visit*” OR AB “community visit*”	MH violence OR TI violen* OR AB violen* OR TI aggress* OR AB aggress* OR MH aggression OR TI dangerousness OR AB dangerousness	MH “risk assessment” OR MH “risk factors” OR TI risk OR AB risk OR MW “prevention and control” OR MH management OR TI manage* OR AB manage*	TX “domestic violence” OR TX school* OR TX gang OR TX “intimate partner violence”

Search Summary:

"(MH “community mental health services” OR TI “community mental health service*” OR AB “community mental health service*” OR MH “mental health services” OR MH “house calls” OR TI “home visit*” OR AB “home visit*” OR TI “community visit*” OR AB “community visit*”) AND (MH violence OR TI violen* OR AB violen* OR TI aggress* OR AB aggress* OR MH aggression OR TI dangerousness OR AB dangerousness) AND (MH “risk assessment” OR MH “risk factors” OR TI risk OR AB risk OR MW “prevention and control” OR MH management OR TI manage* OR AB manage*) NOT (TX “domestic violence” OR TX school* OR TX gang OR TX “intimate partner violenc) Full Text; Published Date: 20040101-20141231 on 2015-02-28 06:08 AM"

Appendix 13: Scopus Logic Grid:

Community mental health (ABS)	AND Violence (ABS)	AND Assessment And/or Management (ABS)	AND NOT Domestic
"community mental health center" OR "mental health service" OR "mental patient" OR "ambulatory care" OR "community mental health" OR "mental health care" OR "mental disease"	"psychiatric violence" OR "risk assessment" OR Violence OR Aggression OR "crisis intervention" OR "risk factor" OR risk	"organization and management" OR "predictive value" OR "risk assessment" OR Affect OR "clinical assessment" OR Prediction	"domestic violence" OR Gang* OR School* AND NOT forensic* AND NOT "intellectual disabil*"

Search Summary:

(ABS ("community mental health center" OR "mental health service" OR "mental patient" OR "ambulatory care" OR "community mental health" OR "mental health care" OR "mental disease") AND ABS ("psychiatric violence" OR "risk assessment" OR violence OR aggression OR "crisis intervention" OR "risk factor" OR risk) AND ABS ("organization and management" OR "predictive value" OR "risk assessment" OR affect OR "clinical assessment" OR prediction) AND NOT ALL ("domestic violence" OR gang* OR school*) AND NOT TITLE-ABS-KEY (forensic*) AND NOT TITLE-ABS-KEY ("intellectual disabil*")) AND SUBJAREA (mult OR medi OR nurs OR vete OR dent OR heal) AND PUBYEAR > 2003 AND (LIMIT-TO (LANGUAGE , "English")) AND (LIMIT-TO (EXACTKEYWORD , "Human"))

Appendix 14: University of Adelaide Library search:

“mental health services” AND “risk assessment” AND violence

Limited to 2004; English

Appendix 15: Induction Checklist

Induction Checklist for Agency Nursing and Midwifery Staff

This checklist is to ensure that the essential orientation information has been provided to agency staff at their local workplace who are engaged to undertake services at NALHN

Instructions

- > This checklist is to be completed with the CSC/Team Leader
- > For any *activity* on the checklist which is not applicable please insert "N/A" in the corresponding column.
- > It must be noted under the *completed* column whether the activity has been completed by initialling or placing a tick the *yes* column.
- > **Once the checklist is completed it must be signed by the participant and CSC/Team Leader and returned to the DNC at the end of shift** to record induction has taken place. A copy of the completed checklist must also go to the participant.

Participant Details

Surname Name: _____
First Name: _____
Agency: _____
Position: _____
Commencement Date: _____
Workplace Location (Division): _____
CSC/Team Leaders Name: _____

AHPRA Registration: _____

Is this the first time you have been oriented to NALHN
YES/NO

Upon Completion

I agree that the activities on this checklist have been satisfactorily explained to me and that I understand where I can seek clarification or further information if required in the future.

Participant Signature: _____

Date: _____

Manager/CSC/Team Leader's Signature: _____

Date: _____

Appendix 15: Induction checklist continued

Please take this form with you to the work area you are working in. It is to be completed in consultation with the CSC or Team Leader upon arrival at the ward/unit/area.

Activity	Completed	
	YES	NA
PART 1 – to be completed by the Duty Nurse Coordinator		
Hospital Plan provided		
Remind Agency staff of their obligation under the agency panel agreement in relation to confidentiality and Code of Ethics		
IT access for systems such as OACIS/EPAS		
PART 2 – to be completed in the work area		
ADMINISTRATION		
Access to NALHN PPG		
Provide advice on new/revised relevant policies		
Safety Learning System - Explain the hazard and incident/accident reporting procedure for workers and patient incidents		
Access to meals / beverages / staff areas		
Security - explain security arrangements (e.g. locker, storage of personal belongings, after-hours access, lock up times, swipe cards, security codes etc)		
Tour of work area including staff room, meeting rooms, toilets and change rooms		
TELEPHONES		
Explanation of telephone system (i.e. transfer, voicemail, pagers, switchboard, directories)		
Personal use during work time (i.e. mobile phones not to be used except during breaks)		
EMERGENCY PROCEDURES		
Emergency Procedures including –		
- Fire evacuation routes and assembly points,	- Fire alarms,	
- MET team response	- ERT	
- Duress Alarm	- Emergency Codes	
INFECTION CONTROL		
Explain the procedures following body fluid splashes and needle stick injuries, including contact details for BBFE hotline		
Cleaning processes and products		
EQUIPMENT AND SUPPLIES		
Lifting equipment (as required)		
Highlight location of - emergency trolley, drug room, linen stores and store room.		
MEDICATION MANAGEMENT		
S4 & S8 documentation		
Management of verbal/phone orders		
MEDICAL RECORDS		
Location and processes		
SUPPORT SERVICES		
Pathology, Allied Health, Imaging, Patient Transport		
WASTE DISPOSAL/SEGREGATION		
General waste		
Clinical Waste		

If you are not sure of anything please ask the CSC or Team Leader

Attachment 2