

Rolfe et al.'s (Cited by Morrissey and Callaghan, 2011) three stage reflective model is used to structure this annotated bibliography.

### *Stage 1.*

The topic I have chosen from the School Research Matrix (School of Nursing and Midwifery, 2013) is "promoting health equality for marginalised groups". This topic became a point of interest for me whilst I was on placement as part of the Homecare Team in the Community Mental Health services. The Home care team provides a community service to people who are acutely ill in their own home (Norman & Ryrie, 2009). I noticed whilst updating The Risk Of Violence and Aggression (ROVA) assessment in a clients chart that there was no set tool to help verify if there were any issues surrounding the incidence of predictive factors of risk or does the documented data diminish over time. It became apparent that if a person had a risk factor attached to them then it would stick with them through their entire time using the service. The ROVA is an assessment tool that indicates if the client is at high risk or low risk of harming themselves or others. An example of a risk factor would be a past history of violence and aggression. Risk assessment is the collecting of information through processes of communication, investigation, observation and persistence that leads to interventions being put in place to manage these risks which is then known as risk management (Norman & Ryrie, 2009).

The issue came about in practice whereby I assisted in the renewing of a clients Risk Of Violence and Aggression (ROVA) assessment. Whilst completing the assessment, I noticed there was one incident whereby the client enduring a psychotic episode, physically attacked his partner. The incident occurred ten years previously. It lead me

to think: when do risks stop being risks? I began to ask my colleagues, to which no one could give a direct answer or tool to use. It then became obvious that this was a problem when assessing risk in the community. I found it hard to believe that this problem had not already been addressed in practice.

### *Stage 2.*

I considered this issue to be extremely important in the community mental health services. When risk factors are kept on a clients chart for a number of years, the person becomes labelled. This can create a stigma towards the client. I also found it dangerous, as a nurse might be alone in the clients house, without knowing if the client was still at risk of physical assault again. I knew a past history of physical violence was a risk in its self but were there certain risks that were not known to be risk factors anymore after a certain time frame? Nurses are supposed to help reduce stigma behind mental illness, but are we doing the complete opposite by holding these risk factors in the persons chart throughout their time using the service?

### *Stage 3.*

A search of the literature using key terms 'risk assessment' and 'community mental health' proved to be not specific enough. I then specified the search to 'changeable risk factors' and 'community forensic mental health' and 'risk assessment', which retrieved 5,920 citations. In due course three research articles were chosen to meet the requirements of the assessment and were most relevant to the specific problem. From reading these papers helped to further refine my problem into a question that could be studied. The rising question is: when is risk no longer a factor?

This search proved that there was a lot information out there in reference to this topic. The three articles retrieved were broad quantitative studies. Two measured the prevalence and incidence of offending, following discharge into the community forensic mental health services and identified associated risk factors (Coid *et al.* 2007, Doyle & Dolan, 2006). The third explored the application of the Structured Professional Judgement (SPJ) tool in clinical practise (Green *et al.* 2010). It is clear that this topic is of great significance and interest within the healthcare profession worldwide. The use of the Structured Professional Judgement (SPJ) tool helps direct healthcare professionals identify evidence based factors in risk assessment (Green *et al.* 2010). In terms of forensic psychiatric clients discharged into the community, the risk of re-offending is high, yet not all this sub-group re-offend again (Coid *et al.* 2007). Measures of past history and personality were proven to be important risk factors in the assessment of violence risk. Be that as it may, consideration of current dynamic factors relating to illness and risk management, were said to significantly improve predictive accuracy (Doyle & Dolan, 2006). Although SPJ tools are said to be the way forward, the availability and costs of qualified trainers need to be considered. Green *et al.* (2010) acknowledges that this piece of research does not resolve the problem but enhances understanding in clinical practice.

Green B., Carroll A., & Brett A. (2010) Structured risk assessment in community forensic mental health practice. *Australasian Psychiatry*. **18** (6). 538-541.

The earliest of papers retrieved, presents a team of Australian physicians who describe an intervention study whereby they distributed a survey to uncover the use of the Historical, Clinical, Risk Management-20 (HCR-20) tool. The team were driven by the

need to assist clinicians to appreciate the rationale for comprehensive assessments. The HCR-20 was clearly explained as a Structured Professional Judgement (SPJ) assessment tool used to assess a person's probability of violence. The appropriate survey was distributed to 12 Australian Community Forensic Mental Health Services (CFMHSs), yet only ten services responded. The exact content of the survey was not made apparent. All CFMHS members involved in the assessments were mentioned (Psychologist, 70%, psychiatrists and nurses, 60% social workers and 50% registrars).

Whilst this research piece was not too descriptive and an easy read, it failed to supply some relevant information. The sample subjects were not made noticeable in the abstract. The survey was carried out over a 12 month period without clear evidence of ethical approval. The number of assessments conducted within this period ranged from 6 to 186.

In the results it stated 70% of services provided feedback, which were multiple interviews involving two unspecified staff members. Training was said to be essential in ensuring the ramifications of a high score is properly explained and the correct care plan is then put into place. Only 9 out of the ten services provided staff training using qualified trainers. The survey data highlighted the need for training, yet it mentioned one study where the feedback from staff states that even after training had been initiated, they were still not confident in using the tool. Overall despite positive reporting on the need for training, the availability and cost of introducing qualified trainers need to be considered. An understanding of SPJ tools was made clearly significant to enhance understanding of risk as well as referral for more comprehensive assessments as required.

Coid J., Hickey N., Kahtan N., Zhang T., & Yang M. (2007) Patients

discharged from medium secure forensic psychiatry services: reconvictions and risk factors. *The British Journal of Psychiatry*. **190**, 223-229.

Concern over public safety post discharge from medium secure forensic units, has driven the need for these Forensic Researchers and Psychiatrists to conduct this study. The study was approved by the East London and City Health Authority Ethics Committee. The study follows a large, nationally representative sample of patients discharged from medium secure units to the community, to examine the incidence of re-offending, to identify risk factors for re-offending and to explore the implications for the future risk management.

The sample subjects were clearly defined in the abstract, which were follow-up patients who spent time at risk. The sample selection could be flawed as the majority of the participants were male, Black, from minority ethnic groups and not born in the U.K. This selection of people were also said to be have the highest number of previous convictions for violence in the results. Most participants were detained under the Mental Health Act 1983. Patients included were from a range of socio-economic backgrounds and geographical areas. Patients admitted to private and public sectors in these areas were included as not to underrepresent the catchment areas. Those who died during the follow-up period and had spent some time at risk were also included. Consent for the collection of data about patients was not discussed in this article. All ranges of mental disorders were included. The authors do not specify what age groups the study included, yet in the results they state risk increases for younger ages and those who were younger when first in court.

No evidence of informed consent was obtained from participants. Medical records were retrieved in an un-ethical manner as confidentiality could have been breached during the course of the study. A fault in the results can be seen as the length of follow-up varied for each participant. This lead me to question how accurate their results were as patients progressively accrue further convictions over time.

The article gave an account of previous studies. It stated they were limited by small numbers and unrepresentative samples, restriction to a single unit or geographical area or follow-up over a 2 year period. Be that as it may, the study was subject to the same limitations of the Offenders Index. Criminal convictions are recorded using an offenders name. Some offenders change their name frequently, leading to lost criminal records or inaccurate data. Missing data from the Offenders Index was estimated at around 9%, meaning rates of offending are likely to have been higher than reported. The authors suggest future studies should include studies of specific categories of reoffending. The author failed to include rates of offending while in secure services. The readmission rates of patients were unattainable during the follow-up period. Findings from the study may differ among more recent cohorts of discharged patients. This is due to the fact that patients now spend longer in medium secure services than during the year of the study.

Doyle M., & Dolan M. (2006) Predicting community violence from patients discharged from mental health services. *The British Journal*

*of Psychiatry.* **189**, 520-526.

Doyle & Dolan (2006) are two Psychiatrists who conducted an American study known as The MacArthur Violence Risk Assessment Study. It was developed to examine predictive accuracy of a range of recognized measures of violence, in patients discharged from civil and forensic psychiatric services. I found the title very informative as it immediately informed me on what the content consisted of. The abstract gave descriptive detail of the methodology, sample subjects and findings found throughout the study. A range of non-forensic and forensic patients were chosen to ensure a representative sample of discharges. It included 112 participants in the UK assessed pre-discharge and 24 weeks post-discharge. It states that in previous prediction studies of this type, that a minimum of 100 participants is found to be more sufficient in obtaining significant results. Therefore 129 people were chosen due to these research findings. 129 of the participants were discharged during the 18 month study and only 112 completed the follow-up interviews, as 6 were transferred, 2 died and 9 were lost to follow-up. The majority of the participants were men, White and had an enduring mental illness. 59% were legally detained under the Mental Health Act and 54% had a recorded criminal index offence for which they had been or were currently receiving treatment before the assessment. All in-patients were interviewed using a semi-structured interview. Nursing staff with a good knowledge of the participant were also interviewed to provide collateral information. The information given by the nurses could be questioned, as nursing staffs attitudes towards certain patients and diagnostic labels, can be prejudice.

The study was completed in five sites which included three forensic medium secure units and two non- forensic units in the North-West

of England. Representativeness of the sample was evaluated by comparing it with typical populations within the research sites against three indices: schizophrenia spectrum disorder, gender and age. The study only included people between the ages of 18-65 years of age, people who were able to provide informed consent, present on ward at time of study, were not primarily diagnosed with learning disability, were able to read and those who understood English to ensure accurate results. Community violence in the 24 week period post discharge was measured based on official records, self reports and collateral reports. Data was also extracted from the Offenders Index at the Home Office. The assessments HCR-20 and VRAG were chosen because they had demonstrated significant predictive validity in previous violence risk prediction studies.

Self-report questionnaires were distributed, giving reason to believe that the findings were not 100% accurate due to trust issues. While the main findings suggest that current dynamic factors relating to illness and risk management, can improve predictive accuracy more than past history and personality, caution needs to be taken when interpreting these results based on limitations (Coughlan *et al.* 2007).



Coid J., Hickey N., Kahtan N., Zhang T., & Yang M. (2007) Patients discharged from medium secure forensic psychiatry services: reconvictions and risk factors. *The British Journal of Psychiatry*. **190**, 223-229.

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