Risk and the regulation of communication in relation to service users' and providers' experiences of forensic mental health care

Volume 2

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Table 2. Gender of participants interviewed

	Gender	
	Number	percentage
Male	14	54
Female	12	46
Total	26	100

Table 3. The age range of participants who were interviewed

Age Group	Number
18-23	0
24-29	6
30-35	7
36-41	5
42-47	3
48-53	2
54-59	1
60-65	2
66-71	0
Other	0
Total	26

Table 4. Professions of service providers interviewed

Profession	Number	Percentage of health care professionals
Occupational Therapist	3	10.5
Psychologist	1	5
Art Therapist	1	5
Nurse Manager	4	21
Doctor	3	10.5
Health Care Assistant	4	16
Advocacy worker	1	5
Secretary	1	5
Social Worker	1	5
Nurse	5	16
Total	24	99

Table 5. The ethnicity of research participants interviewed

Ethnic Origin	Number
White British	9
White Irish	
Other White	2
Mixed	
Indian	
Pakistani	
Bangladeshi	
Other Asian	1
Black Caribbean	1
Black African	7
Black British	1
Chinese	
Other	5
Total	26

Appendix 2: The levels of security / pathway of care within the forensic service at the beginning of the study

Located within the Hospital

Located within the secure unit			Located outside the secure unit	
Medium Secure PICU Male	Medium Secure Acute/Rehab Male	Medium Secure Acute/Rehab Male	Medium Secure Womens Ward Stand alone	Low Secure Stand alone ward
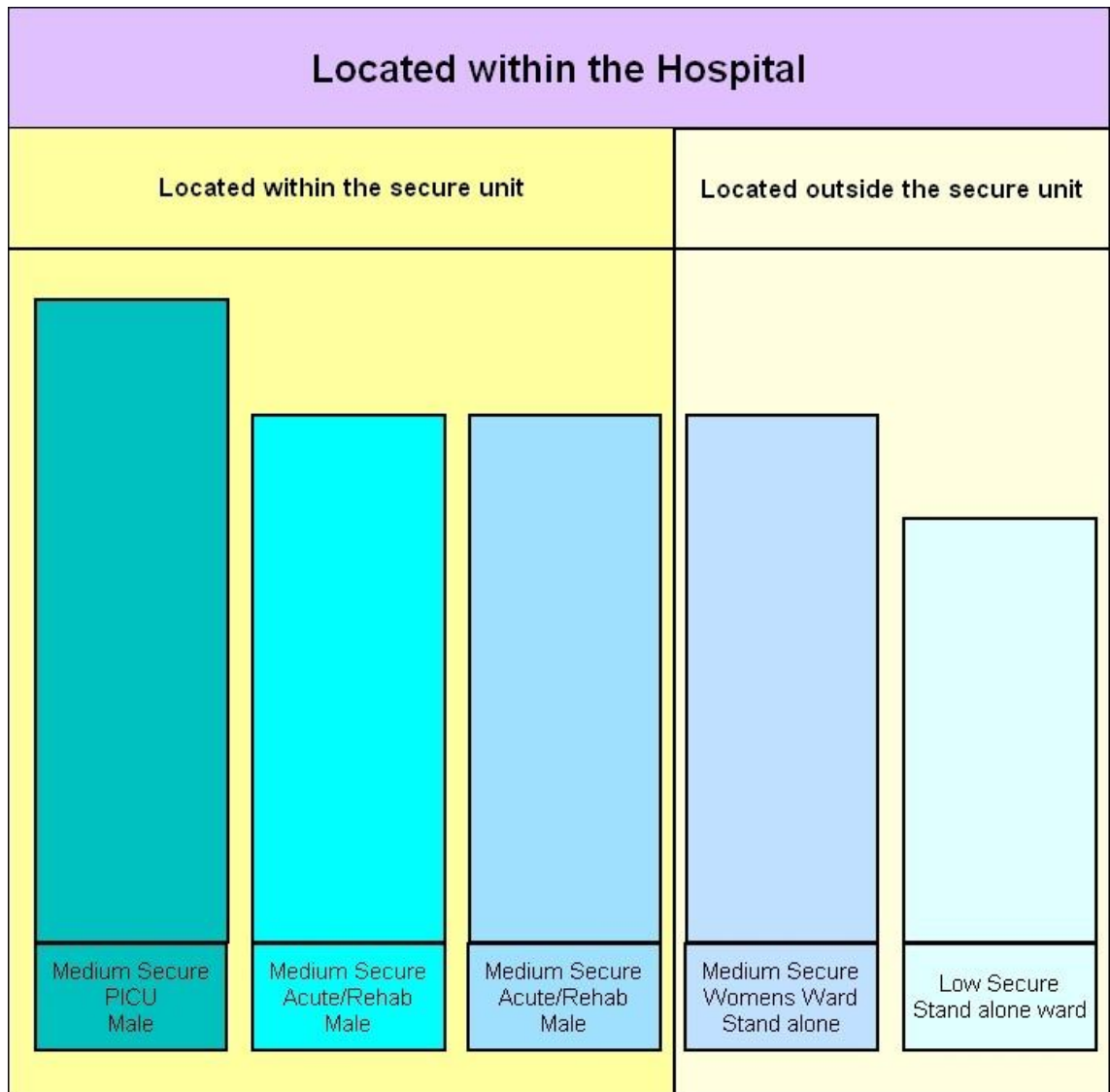
Appendix 2 (b): Levels of security / pathway of care within the forensic service at the end of the study
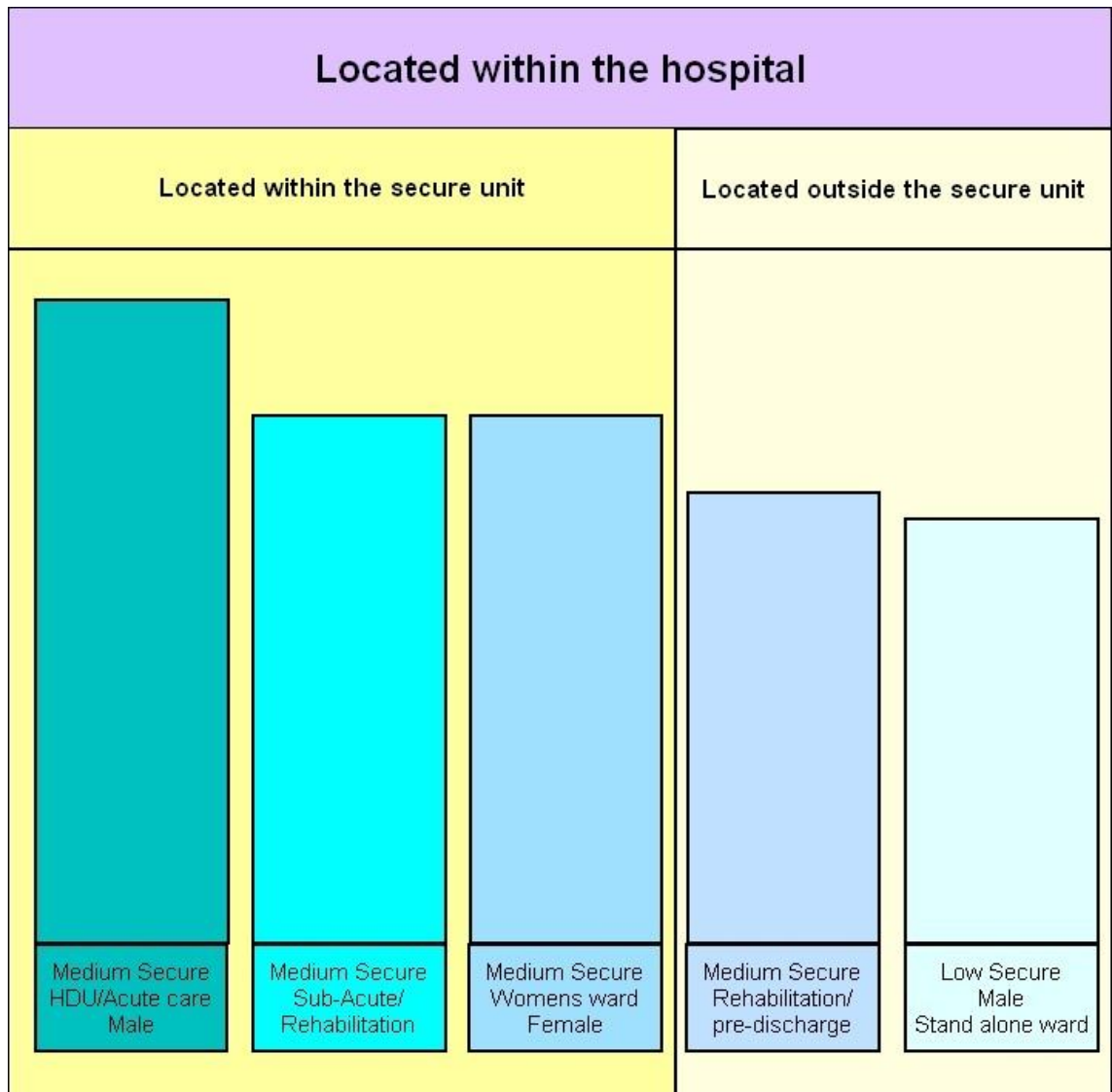
Appendix 3 (a): Initial interview topic guide: Service provider interviews

Role

- What is your role in the forensic service?
  - What is your interest / contribution to the service? What areas of the service have you been involved with?

- What do you find particularly challenging or rewarding about your role?

- What do you believe to be the main aim of the service?
  - How did you learn about the service aims?
  - Are the service aims consistent with your professional goals and beliefs?

- How do you know if the aims of the service are being achieved?

- Have the aims always been the same? If not how have they changed?

  - Over what time frame?
  - What has influenced this process?

- In your opinion what influences how the service functions?

- Do you feel you influence how the organisation works?

  - If so then how?

- Who do you believe to be the key stakeholders in the organisation?
  - What makes them key stakeholders?

Care Pathways

- What would be the ideal service user progress through the service?

- How would you describe the typical progress through the service?

- Can you give some examples of when the forensic mental health service works well / not so well?

- What helps the service to work well?

- What hinders service functioning?

- What happens on a day to day basis in the service?

- What do you see as being the main risks in the/ to the service?

  - How are they controlled?
  - What happens if they are not controlled / managed?

- Can you describe a situation / scenario where risk has been managed well / not so well?

Service User Involvement

- How is the service user involved -in their care, in the development of the service?
  - Can you give some examples?
  - How well has this worked?

- What happens when a service user is admitted to or discharged from the service?

Is there anything else that you want to say about the role that you do or the service that you have not been asked about?

Thank you for taking part in the study.

Appendix 3 (b): Interview topic guide, as developed through theoretical sampling. Service provider interviews

Service

- Please tell me about the [name of unit]?
    - How does it function?
- What are the service aims?
    - have the aims always been the same? If not how have they changed?
    - over what time frame?
    - what has influenced this process?

- In your opinion what influences how the service functions?
    - What helps the service to work well?
    - What hinders service functioning?

- Do you feel you influence how the organisation works?
    - If so then how?

Role

- What is your role in the forensic service?
    - what is your interest / contribution to the service? What areas of the service have you been involved with?

- What do you find particularly challenging / rewarding about your role?

- Who supports you in your work?
    - How do they support you?
    - Are they part of your team? If not, what caused you to work together?

- What do you find hinders your work?

- Has the homicide inquiry report affected the way that you work?

Care Pathways

- What would be the ideal service user progress through the service?

- How are decisions made to move a service user through the service?

- How would you describe the typical progress through the service?

- Can you give some examples of when the forensic mental health service works well / not so well?

Risk

- What do you see as being the main risks in the/ to the service?

  o How are they controlled?
  o What happens if they are not controlled / managed?

- Can you describe a situation / scenario where risk has been managed well / not so well?

Service User Involvement

- How is the service user involved -in their care, in the development of the service?
  o Can you give some examples?
  o How well has this worked?

- What happens when a service user is admitted to or discharged from the service?

Is there anything else that you want to say about the role that you do or the service that you have not been asked about? Thank you for taking part in the study.

Appendix 3 (c): Interview topic guide. Service user interviews

- What happens day to day in the service?

  - o What do you do in a typical day / what is your daily routine?
  - o What is good about your day, what is not so good?

- Have been on other wards in the service?
  - o If so what are the similarities and differences between them?

- How do you progress through the service to be discharged?
  - o What do you feel helps or hinders your progress?
  - o What would you like to achieve? (eg: discharge or continued detention)

- What do you believe to be the main purpose of the service?
  - o How did you learn about what the service does?
  - o What is good about the service / your stay in the unit? What is not so good?

- In your opinion what influences how the service functions?

  - o Do you feel you influence what happens in the service / your ward?

  - o If so then how?

- Who do you believe to be the key stakeholders in the organisation?
  - o What makes them key stakeholders?

- Thank you for taking part in the study. Is there anything else that you want to say about the role that you do or the service that you have not been asked about?

Appendix 4 (a): Initial observation prompt sheet.

<u>**Activities to observe:**</u>

Ward based:

- Ward round / MDT meetings
- CPA meetings
- Ward business meetings
- Ward community meetings
- Nursing hand over

Unit based:

- Advocacy meetings
- Bed management meetings
- Management meetings

<u>**Observe:**</u>

Risk assessment and management:

- Strategies for managing the balance between autonomy and safety
- The assessment and management of individual or reputational risk eg: in ward meetings and MDT discussions
- Risk assessment activities including the use of risk assessment tools

Decision making

- Decisions making regarding the balance of security and therapy
- How decisions are made
- Identify the decision makers are
- Team processes

Risk escalator / care pathways

- Risk assessments concerning service users moving up or down the risk escalator
- Management strategies.

Service user response

- Service users' views of risk management plans and risk assessments.
- Service users' views of the service
- Service users' activities, organised by staff and by the users.

Enacting of risk management plans

- Nursing / ward staff undertaking risk management activities – how do these activities relate to the planned care and MDT discussions?

- Ask the participants for their view of meetings / activities and reasons for their actions.

- Explore risk assessment and management strategies that take place within the meetings

- Ask service users for permission to read their care plans / notes relating to activities observed

Appendix 4 (b): Observation prompt sheet as developed through theoretical sampling.

<u>**Activities to observe:**</u>

Ward based:

- Ward round / MDT meetings
- CPA meetings
- Ward business meetings
- Ward community meetings
- Nursing hand over
- Service user down time
- Service user self directed activities
- Informal conversations - gossip

Unit based:

- Advocacy meetings
- Bed management meetings
- Management meetings

<u>**Observe:**</u>

Risk assessment and management:

- Strategies for managing the balance between autonomy and safety
- The assessment and management of individual or reputational risk eg: in ward meetings and MDT discussions
- Informal and formal risk assessment activities including the use of risk assessment tools
- Communication of risks eg: security breaches

Decision making

- Decision making regarding the balance of security and therapy
- Influences on decision making
- How decisions are made
- Identify the decision makers are
- Team processes
- Impact of homicide inquiry

Risk escalator / care pathways

- Risk assessments concerning service users moving up or down the risk escalator
- Risk management strategies associated with moving service users through the system
- Explore differences between wards – functioning, staff and service user groups

Service user response

- Service users' views of risk management plans and risk assessments.
- Service users' views of the service, and clinicians
- Service users' activities, organised by staff and by the users.
- Service user strategies for managing and assessing risk

Enacting of risk management plans

- Nursing / ward staff undertaking risk management activities – how do these activities relate to the planned care and MDT discussions?
- Explore any disparities – can the participant explain why there are differences between their activities and the plan of care?

Social groups

- Which service users / providers work together, or have social connections?
- Is there a social hierarchy, how is this determined, displayed?
- How do social groups function?
- How are boundaries articulated?

- Ask the participants for their view of meetings / activities and reasons for their actions.

- Explore risk assessment and management strategies that take place within the meetings

- Ask service users for permission to read their care plans / notes relating to activities observed

Appendix 5: An example of coding and concept building

Data analysis is a dynamic process in which the different types of coding, using analytic techniques and procedures freely and in response to the analytic task (Strauss and Corbin 2000). The example given below will illustrate how analysis proceeded through overlapping stages of open, axial and selective coding to develop the theory of the regulation of communication.

Extracts from interview and observational data, rather than full transcripts are used in order to preserve the anonymity of the participants.

Axial coding

Axial coding requires that the properties of categories, their dimensional range, and relationships with other categories are explored.

Table 7: The dimensions of the "management of own risk status":

Quotation	Dimensional range	Relationship to other categories
if you manage your case well, you do your risk assessment about a patient and you really address the issues, the possibilities of an incident happening will be minimized. Hence the concept of risk assessment is all that, and if incidents are minimized people really won't feel unsafe (David, manager: interview)	accepting	Addressing organisational expectations re: risk assessment.
if someone gets on your nerves and you lose your temper you've got to control your temper, you can't get angry... You've got to show them a certain amount of time that your, er, mentally strong enough to cope with difficult situations and things like that and um just comply with your medication. And after awhile then you get more and more privileges and things like that (Rubin, service user)	accepting	Regulation of communication. Non-reporting of feelings and control of emotions that could result in increased risk status.
politically you are not allowed to use your judgment now, as much as - if the patient tell you they are going to kill, that's it, don't use judgment, the patient is going to kill someone, that's it! Hearing voices, that's it! Even if I have - a lot of judgment going against - 'no, no, no, don't experiment, you are going to create problems (Martin, doctor: interview)	Frustrated / covertly defiant	Organisational expectations Expected compliance to organisational expectations. Non-compliance could result in increased risk status

|		
you have been over the top and harsh. There's no animosity from me or him. I've kept my mouth shut and engaged. I have been on the shop floor so you can write notes about me. Now you are going to be analysing me tomorrow and give me my leave back if I am good (Jason, service user: observation)	Overtly defiant	Regulation of communication & Organisational expectations Self censorship to meet organisational expectations and so manage risk status
the Unite union rep, said Well I think this is interesting that members don't feel safe enough to raise things directly through the line management. Because they're afraid that they're going to be penalised if they do. It says something about the way the management is perceived here (Max, therapist: interview)	Perceived coercion	Regulation of communication. Suppression of dissent to avoid censure.

Selective Coding

During selective coding concepts are integrated around one core category. The quotation below illustrates the interrelationships between the regulation of communication, the operation of self-forming groups and risk management.

> Barbara (HCA): *No I am not doing that anymore. I spoke to* [Jean] *about putting seven and a half hours on* [her] *time sheet. Now it's* [Barbara] *know everything! So now I am going to keep my mouth shut!* [Jean] *was very angry with me, I had to get on my knees and beg her to forgive me. We normally laugh and joke. All I said was not that lock, the other one and she was saying that I thought I knew it all.*

Barbara regulates her communication in an attempt to manage her risk status in the context of fulfilling her role requirement as a health care assistant and member of a self forming group. Barbara gives two examples of when she had been socially ostracised for reminding others to follow unit procedures in order to justify her decision not to intervene in future breaches. In one incident she intervened when a member of staff (Jean) put seven and a half hours on her timesheet, when she should only claimed for five and a half hours. I n response Jean withdrew her friendship. Later when Barbara has reminded Jean to follow the correct security procedure, Jean responded in a hostile manner.

This quotation is discussed further in section 7.4, p221
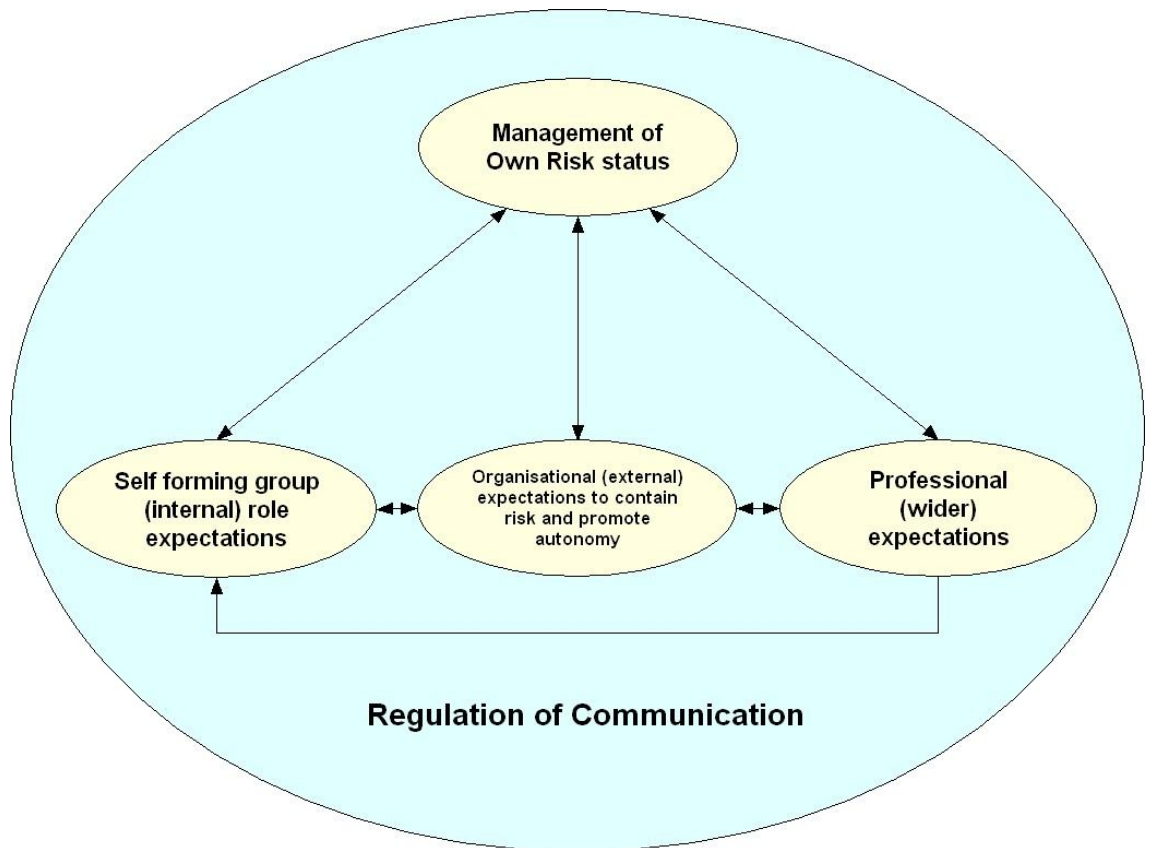
Diagram 2: The regulation of communication and the management of risk status

Appendix 6: An example of a coded observation

Discussion re: safety and hot water. How hot is hot water? Define cool down and the procedure. Possibly consider the procedure from another ward of putting milk in the cup first.

proceduralised system~

OT1 - the noise of keys is disturbing for the patients on the ward
Nurses laughed

primary / secondary adjustment

N1 - keys are part of being on a forensic ward, patients have to come to terms with that

OT1 - need to make the ward less like a prison - suggests covering keys in plastic

N2 ©- shouldn't give in to patients, just because the keys are jangly

divisions and differentiations
power and control

OT1- not about giving in, its about being compassionate

common sense care~

N0- are possible changes cost effective?

finance

OT2 if it is in out power then we should improve the environment, eg: prisons, prison officers wear trainers at night so as not to wake the prisoners
(Ns exasperated)

N0 - patients need to experience nurses walking up and down, they say they are experiencing torture. Is it unfair not to sit down and discuss this? To make it more comfortable?

N 2 ©- will this happen on all the wards?

N3- patients are paramount, keys in the night can be quite disturbing

autonomy/individual v security

N4 when staff are happy patients are automatically happy

Med 1 - I've not noticed it before [noise of keys] it's a good point

N2© we are the best forensic ward

OT1 we cannot say we are the best, we need to be like Japanese cards and always try to make ourselves better by 10% otherwise we will stagnate.

N4 keys are more important than patients

N0don't want patients to be seen as less important than keys. Run a pilot, 4 keys - OT, security, Medic, Nurse. Staff to feedback to meeting. OT to speak to patient that raised the key issue with him.

scientific system

Safety
Book not always being signed for kitchen security checks when nurses cook with patients

proceduralised system~

Poor maintenance of doors - not locking properly. But also staff, especially at night are wedging the doors open. This is a health and safety risk

Appendix 7: Sample of coded interview using Atlas-ti.

Can you tell me what your role is on the ward?

This is a really traditional role of OT, so it'd be, working with patients to achieve goals to get independence, that's the major role. Obviously being ward based and sort of assigned to your team, you do sort of managing ward environment as well. It's a very large and far reaching question, because there are all sorts of little jobs combined into one role. It could take half an hour to an hour just to describe that. But just looking at the ward environment, part of it is the physical environment and then also it is the community of the ward. I think we do a lot of joint working, definitely with the nursing staff. A little bit less with the other professionals. But things like community meetings, like what we're doing today, social events, communal meals, things like that, I think, add to the ward environment. So that's part of the role. In terms of assessment, I suppose, it's a major part, assessing people's ADL, independent living skills, risk, being a forensic ward I can't really leave that one out. For the risk, that's a shared role, very definitely. And that's me and in the ward round, CPAs, but there can be impromptu meetings, and usually if there's an element of risk we try to get two or more than two professions to come to an agreement, which does sort of back you up, or if you're anxious about something, if there's two other people saying "Well no, not really", and you talk it through, it can be a good way of... *(doesn't finish sentence)*

environmental issues

Risk assessment - formal / scientific

Can you give me an example of the sort of things you have to do in that way?

Well that can be just recently, there was a cooking session, and one of the gentlemen, [patient name], if you remember in the ward round he said himself, I'm feeling that I might do something dangerous, and before that, we noted that his mental state was not as stable as it was two or three weeks prior, and there'd been a change in medication, so there are all of these sort of little warning signs. So before he came in I said to the ward round, I'm probably going to offer to withdraw the cooking session this week because of the risk of that. But then part of you is thinking, he usually is, when you engage with him, fine. But taking that risk, in a kitchen, is slightly different to taking that risk in a corridor or in the activity room, because of the extra things. So the decision was sort of put on hold and the consultants saw him on Friday, and the nursing team on Friday, I didn't have much time to see him but I briefly saw him and there was a discussion that he's fine today, but it would be ok to cancel if there were any doubt. But definitely tools free just to be on the safe side, although we could probably have had tools if we wanted to. Then the compromise was tools free and he was absolutely fine on the day. He was a little bit hurt that we didn't think he was capable to use tools. Or safe to use tools, rather. So that is sort of a one case, really. You've got your suspicions but you need someone else's perspective to come to a safe agreement.

Risk assessment - formal / scientific
risk assessment as insitutionalisation

When you say tools you mean knives?

Yeah, sharps.

I'm interested in this thing about the cooking and the risk assessment. Can you tell me what makes you think that a patient could potentially be risky in that situation in particular. Obviously he's in different situations, so why in the cooking particularly?

Well that's where I'd be most at risk. So it's sort of self preservation more than anything else. There is literature which does outline that a lot more, accidents happen to OTs in the kitchen. It is at the back of your mind all the time, that there is a higher incidence and there is a higher risk, being in the kitchen with a patient, so you do tend to be a bit more careful about it. But there are cases where it's almost the opposite, when people are safer when they're doing something that they value or doing someone with someone they respect, and I'd like to think that I do have the respect of some of the patients. So although you are in a more potentially dangerous situation sometimes, it's less dangerous by the fact that they are doing something they value or they're doing it with someone that they value.

positive risk taking
risk & trust
risk heuristics

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