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# Assessing and managing risk in people with severe mental illness: a practical guide

**by**
**John Butler and Gary Lees**

## Introduction:

To effectively manage risk in the community, national mental health policy has focused attention on targeting people with severe mental illness. Risk assessment and risk management are central to this enterprise. This chapter describes a practical guide for community mental health workers, developed by the authors during their involvement in the South Bedfordshire initi ative. The authors are currently working as lead community mental health nurses with adult acute mental health, one of whom was also the principle author of the local Trust's Community Care Policy (South Bedfordshire Community Health Care Trust, 1998). Both are presently involved in providing an ongoing programme of in-service training on risk assessment and risk management to mental health nurses in the Bedfordshire area. The chapter begins with some background information about risk and mental illness, an d the increasing attention given to risk assessment and management. Then, the definition of risk is discussed in relation to the present context of providing mental health care to individuals in the least restrictive environment. A practical method for the assessment of risk is then presented, based upon the development of client risk profiles. Next, the key principles of formal risk management are outlined from the perspective of the community mental health worker, with direct reference to client case mate rial based upon the direct clinical experiences of the authors. The chapter is concluded with a discussion of the problems and tensions evident within clinical risk management.

**Background:**

Over the last thirty years, care for the mentally ill has increasingly moved away from the institution and into community settings. As many more people now receive care and treatment within the community setting, professionals are faced with new challenges in effectively managing the risks presented by people with severe mental illness.

It is well known and becoming increasingly accepted that only a few mentally ill people pose real risks to themselves or others. In terms of risk:

- Swanson et al (1990), in an American study, estimated that 92% of people with a mental disorder are not violent;
- the risk for suicide or self-harm amongst the mentally ill is much greater than the risk of inflicting harm on others - up to 100 times greater for schizophrenia and up to 1,000 times greater for affective disorders (Alberg et al, 1996);
- studies of in-patient violence suggest that it is only a small number of patients who are accountable for the majority of violent acts (Crichton, 1995), with various socio-demographic factors being associated with violence – younger age groups, being male, ethnicity, low socio-economic status (Crichton, 1995; Tardiff and Sweillam, 1980);
- it is only a small number of patients that are accountable for the significant hours of direct observation in acute mental health in-patient settings;
- Lidz et al (1993) found that nurses, junior doctors and psychiatrists were able to predict violence with a reasonably high level of accuracy, and that this was enhanced by conducting formal risk assessment rather than leaving this to chance or intuition alone.

Risk assessment and risk management have gradually become more topical with the publication of a growing number of influential reports based upon numerous inquiries into serious incidents. There have been over 100 in the last 30-years. The recommendations of these reports have, in many cases, still to be fully addressed by specialist services. Most of these highly publicised reports relate to homicides by the mentally ill. They invariably highlight deficiencies in both risk assessment and risk management, and especially relate to the lack of effective communication.

Lipsedge & Bland (1997), provide a useful review of the findings of 11 such inquiries into homicides, published between 1995 and 1997. This highlights a series of: 'recurrent topics and themes which may be of

interest..... to ensure adequate assessment and management of risk'. These findings have consistently been reinforced by other inquiries (p171):

- the need to ensure that vital information is obtained, heeded and passed on to all involved parties, with risk assessment and risk management being conducted by the multi-disciplinary team, involving the consultant psychiatrist (Ritchie et al, 1994, pp110);
- the need for an adequate appreciation of the client's past history based upon full, detailed and authoritative information, which will be aided by all professional staff remaining familiar with the indicators of risk and risk management options (Main et al, 1996, pp33);
- the overriding duty to breach confidentiality and to provide information to the extent of being in the interests of a potential victim, if there is a clear risk to a member of the public (Blom-Cooper et al, 1995, pp149);
- the need to involve, listen to and respond to the needs of carers;
- the need for adequate resources - medical staffing, community mental health nurses (CMHNs), social workers, and access to in-patient beds;
- the need for accurate and effective interpretation of the Mental Health Act 1983 (House of Commons, 1983), especially Section 117 and Sections covering detention and provision for leave;
- the need to assess the client in the community if s/he is refusing or unable to attend an appointment, with the process of risk assessment being continual via face to face reviews by clinicians (Mishcon et al, 1996, pp72).

In addition to the above, it has been concluded that:

- the first referral or transfer of a patient to another team should always lead to a new clinical assessment, incorporating a risk assessment (Blom-Cooper et al, 1995, pp177);
- risk assessment should be viewed as an essential and integral part of the Care Programme Approach (CPA) (Main et al, 1996, pp32);
- a case must never be disclosed nor a patient discharged from mental health care unless the team has detailed, reliable and reassuring information about the patient's current health & welfare, and all requirements under Section 117 and the CPA have been fulfilled (Lipsedge & Bland, 1997), and;
- the development of a risk management strategy aimed at promoting the safety and security of patients, staff and the public, will need to incorporate effective communication systems, environmental assessment, an incident reporting and review system, and a continuing programme of staff training.

More recently, the National Service Framework for Mental Health (DOH, 1999) has emphasised:

- the need for formal risk assessment and risk management in providing effective care for the severely mentally ill (ibid, pp41 -51 – Standards 4 & 5); and,
- the need for health and social services to collaborate in achieving a reduction in the suicide rate by at least one fifth by 2010 (ibid, pp76 -78 – Standard 7).

**Defining Risk:**

Risk may be viewed as the possibility and likelihood of beneficial and harmful outcomes occurring within a stated time scale (Alberg et al, 1996, pp9). This 'balanced' process of assessing the likelihood or probability of various harms and benefits occurring may be illustrated in the scenario of granting leave to an in-patient. This may result in him or her not returning and carrying out further high risk beha viour, or alternatively lead to increased trust and thus compliance or collaboration within his or her own treatment.

Risk is a dynamic, ever-changing characteristic, perhaps best considered on a continuum ranging from low risk to high risk. The indiv idual will present varying types and levels of risk as an inevitable consequence of life experiences, thus moving along this risk continuum. This contrasts with the term 'dangerousness' which continues to be widely used within the literature, particularly with respect to the violent mentally ill person. It is used to refer to an individual's capacity to cause serious physical injury or lasting psychological harm. Thus, the individual is more likely to be viewed in a categorical way: as dangerous or not dang erous. It is therefore suggested that risk is likely to be a much more useful concept.

In health-care settings, a systematic and objective approach to assessment is needed, due to individual differences based upon values and beliefs. The focus is upon probability rather than certainty (Prins, 1981). Risk assessment may be viewed as the approach by which those individuals who present medium or high-risk behaviours are identified. Risk management may be viewed as the approach by which a range of action s and factors, likely to minimise the occurrence and likelihood of assessed risks, are identified and implemented. Risk assessment and risk management thus form an integrated

process, which will need to be undertaken on an ongoing basis. It will not always be possible to predict and prevent risk behaviour by mentally ill people, as risk assessment is based upon clinical judgement rather than providing guaranteed accurate predictions.

Four principle categories of harmful risks are frequently cited within the literature:

- violence and aggression;
- suicide and deliberate self-harm;
- severe self-neglect; and
- risk to children.

*Violence & Aggression*

Although often used interchangeably, these terms do refer to different behaviours and intentions: an individual can behave aggressively without violence. Aggression is a feeling or action which is hostile or self-assertive by intent, whereas violence refers to behaviour which results in injury to persons or damage to property.

*Suicide & Deliberate Self-harm*

Suicide and deliberate self-harm may be viewed as falling on a continuum with a number of stages (McLaughlin, 1993). These include (Eldrid, 1988):

- the active expression of thoughts, feelings and plans of suicide, often referred to as the 'early warning stage';
- parasuicide, defined as 'the non-fatal act of self-injury or the taking of substances in excess of the generally recognised or prescribed therapeutic dose' (Kreitman, 1987), or deliberate self-harm (Morgan, 1979) - this involves the criterion of committing a deliberate act which the individual knows will harm, but without the intent to die;
- attempted suicide, which refers to a deliberate effort to end one's life, that may have accidently failed;
- suicide, defined as 'the intentional act of self-destruction committed by someone knowing what he is doing and knowing the probable consequences of his action' (Kreitman, 1987).

*Severe Self-neglect*

The assessment of this type of harmful risk is less straightforward, as it is complicated by differences in relative standards of what constitutes self-

neglect. Alberg et al (1996) suggest that factors such as hygiene, diet, infestation, household safety, warmth and physical health should be considered as the principle areas for assessment, as each can become life threatening. Deterioration of the domestic environment or personal care may in fact be an indicative sign of deterioration in the individual's mental state.

*Risk to Children*

Many mentally ill people are also parents and as such may present certain risks to the child as a consequence of his/her potentially impaired parenting abilities. The types and levels of risk presented are likely to vary in accordance with the nature, severity and chronicity of the parent's mental health problem. Rates of mental disorder in cases of child homicide are high: 75% (Campion et al, 1988) to 100% (Bourget and Bradford, 1990) of parental perpetrators have been diagnosed as suffering from major mental illness. As with the aforementioned risks, the level of risk presented may vary from minimal to severe neglect, whether emotional, physical or sexual in nature.

**Types of Information & Tools used in Risk Assessment:**

*Actuarial Data*

This consists of factors that increase the risk of a negative outcome. For example, a man is more likely to become violent than a woman is, and being depressed increases the chance of suicide. It is important to note that with this form of data the best single predictor is only about 30% accurate, and that is usually having a past history of the risk behaviour . If a range of factors is taken into account, the accuracy can be increased.

*Anamnestic Data*

This refers to data relating to how a person behaved in the past in similar circumstances, and is more predictive than actuarial data. This kind of data is frequently gathered from a clinical interview with the client, but a well informed assessment process should include obtaining information from other sources, such as from relatives or other agencies.

*Clinical Interview*

By use of an interview, it is possible to obtain much information from the client that will add depth and meaning to the bare facts of the risk(s) presented. A framework for such an interview is presented later in this chapter. The clinical interview can, and should be, repeated with significa nt others, such as other professionals, in order to both obtain additional information and to corroborate the statement from the client.

*Risk Factors*

Whilst personal and social factors which are known to be associated with violence or suicide are not nec essarily causal, their presence does assist in the overall evaluation of a person's level of risk in the long -term. Considering the two principle risk categories of violence and suicide, the major factors associated with an increased risk are summarised in Tables 1 – 4. These should begin to alert the clinician to an increased risk. Tables 1 & 2, relating to violence or harm to others, are based upon factors identified in the literature, drawing especially on the work of Alberg et al (1996, pp42), Borum (19 96), Lipsedge and Bland (1997, pp174) and Kemshall (1999).

*Table 1: Violence or harm to others:*

| **Variables** | **Higher Risk** |
|---|---|
| Age | Younger |
| Sex | Male (if no psychotic features) |
| Living arrangements | Unstable; changeable; access or proximity to past or potential victims |
| Intelligence | Low |
| Employment status | Unemployed; casual; changeable |
| Educational attainment | Low |
| Environmental factors | Hot weather; periods of social unrest; life experience in a sub-culture condoning or expecting the use of violence |
| Physical health | Organic brain disorders |
| Mental health | Mental illness, especially psychotic depression, bipolar disorder, schizophrenia with uncontrolled symptoms (a better predictor than past history for people with schizophrenia), paranoid psychosis, anti-social personality disorder, and a history of childhood abuse |
| Mental health symptoms | Command hallucinations (if there is an history of acting on them); delusions (passivity, religious, paranormal or physical influence, persecution); thought insertion; paranoid states. |
| History of Violence / Aggression | Has an history of aggression or violence, even if this did not result in injury or was merely a series of repeated minor assaults which have escalated in seriousness but |

| | |
|---|---|
| | not led to a conviction. This is especially the case if the person has a definite plan, and the availability and preparedness to use a weapon. |
| Forensic history | Has a forensic history involving violence / aggression |
| Substance use | Alcoholism; illicit drug use |
| Time of week | Saturday |

*Table 2: Immediate risk of violence*

| **Indicators of Immediate Risk (Violence / Aggression)** |
|---|
| Speaking loudly |
| Pacing about |
| Easily evoked startle response |
| Hyper-vigilance and attentiveness |
| Clenched fists |
| Sitting on edge of seat |

Tables 3 & 4, relating to suicide or harm to self, are based upon factors identified in the literature, drawing especially on the work of Alberg et al (1996), Appleby et al (1999), Clark and Fawcett (1992), Fairlie and Butler (1994), Hawton (1987), Hawton and Fagg (1988), Kreitman (1977), Kreitman and Dyer (1980), McClure (1984), Sainsbury (1955), Schneidman (1976), Tuckman and Youngman (1963, 1968), and Whitlock (1973).

*Table 3: Suicide or harm to self:*

| **Variable** | **Higher Risk** |
|---|---|
| Age | Older and young males |
| Sex | Male |
| Marital status | Separated / divorced > widowed > single |
| Living arrangements | Living alone (social isolation); absence of children under 18 years old at home; absence of friendships |
| Employment status | Unemployed; retired |
| Socio-economic group | High or low socio-economic groups |
| Family history | History of affective disorder, alcoholism or suicide in the family |
| Physical health | Poor, especially terminal, painful, debilitating illness |
| Mental health | Mental illness, especially depression (especially 1 - 3 lifetime episodes of depression), schizophrenia, chronic sleep disorders, personality disorder, dual diagnosis |
| Mental health symptoms | Severe hopelessness; impaired concentration; severe anhedonia; severe anxiety; obsessive-compulsive features; indecisiveness; insomnia; suicidal ideation; pessimistic outlook; periods of clinical improvement following relapse; poor compliance with treatment |

| | |
|---|---|
| History of Self-harm / Suicide attempts | Has an history of deliberate self-harm or suicide attempt, especially if: attempt was made in the last year; by a more violent / lethal method i.e. hanging; leaving a suicide note; having a definite plan |
| Significant Life Events | Bereavement, especially in childhood; breakdown of intimate relationship |
| Forensic history | Has a forensic history; imprisonment, especially in the first 24-hours |
| Substance use | Alcoholism; illegal drug use |
| Time of year | April to June |

*Table 4: Immediate risk of suicide*

| **Indicators of Immediate Risk (Suicide / Self-harm)** |
|---|
| Expresses feelings of severe hopelessness |
| Expresses suicidal thoughts |
| Has a definite plan for suicide |
| Has chosen a violent / lethal method for suicide |
| Has access to the means to commit suicide |
| Makes efforts to maintain privacy for suicide attempt |
| Perceives stress as overwhelming / circumstances as unchangeable |
| Lack of social supports |
| Refusal to seek or accept help / treatment |

*Local Study of Risk Factors in Bedfordshire*

In a local audit study (Fairlie & Butler, 1994) of the coroners' records of suicides for 1991-2 in Bedfordshire (N=82), the following patterns were n oted:

- highest risk age-group was 30-39 years old;
- ratio for male to female suicides was 2.6 : 1;
- 51% of suicides were either divorced, widowed or single, and 49% were married;
- 34% of suicides were either unemployed or retired;
- the most common precipitants, recorded for 57 / 82 suicides, were:
  - breakdown of an intimate relationship (36% - especially if age <45yrs.);
  - financial problems (18%);
  - physical disability and ill-health (13% - especially if age >45yrs.);
  - bereavement (13% - especially if age >45yrs.);
- females were more likely than males to have made previous attempts;

- 34% of males and 83% of females had a psychiatric diagnosis, with depression being the most common diagnostic category (73% of those with a diagnosis);
- the most common method for suicide for males was vehicle exhaust gas (55%) and hanging (17%); and, for females, drug overdose (33%); and,
- 42% of suicides left a suicide note, a large majority of which appeared to help explain the reasons for taking one's life.

*The Role of Hopelessness*

Much research suggests that a feeling of hopelessness is central to an individual's decision to commit suicide. It appears to be both a concomitant of depression and a predictor of suicidal behaviour (Beck, 1967; 1986). It has been found to predict eventual suicide among individuals diagnosed with a major affective disorder, schizophrenia and alcohol abuse (Beck et al, 1976). Moreover, it seems to distinguish between suicidal and non-suicidal persons with the same level of depression. Hopelessness appears to be a strong predictor of suicide among persons who have made a prior suicide attempt (Dyer and Kreitman, 1984). Longitudinal studies have also shown hopelessness to be a useful long-term predictor of completed suicide. From the above, it appears that a measure of hopelessness is an essential part of any assessment of suicidal intent. Whilst this can of course be obtained by asking the client how they feel about the future, assessment rating scales are useful: the Beck Depression Inventory (BDI – Beck et al, 1961) and the Beck Hopelessness Scale (BHS – Beck et al, 1974).

*Assessment Rating Instruments*

A number of specialised tools have been developed to complement the assessment process in assisting the clinician to systematically evaluate and determine the seriousness of an individual's risk. It is thus recognised as good practice that risk assessment is supported via the use of formal validated risk assessment schedules, as an adjunct to this process of risk assessment and risk management. A variety of good examples are available like HCR-20 - Historical and Clinical Risk (Webster et al, 1995); Beck Hopelessness Scale (Beck, 1974; Beck and Steer, 1988); Beck Scale for Suicide Ideation (Beck et al, 1988). Borum (1996) presents a useful review of those instruments for assessing violence, whereas the instruments for assessing depression and parameters of suicidal intent are likely to be more familiar.

**Guide for Risk Assessment:**

It is very useful to make reference to a guide for risk assessment when conducting the clinical interview. Steadman et al (1994) produced a guide for assessing the risk of violence, suggesting that a number of variables are considered when undertaking an assessment, in order to make 'more accurate, empirically based predictions of risk' (Borum, 1996, pp947). This guide highlights four sets of factors, which would also have a useful application for the other principle categories of risk:

- dispositional - demographics, personality and cognitive variables;
- historical - family, occupational, psychiatric and forensic history;
- contextual - perceived levels of and response to stress, social supports and access to the means for violence / self-harm; and
- clinical - symptoms, diagnosis and level of functioning.

It is recommended that information is gathered from all available sources, including both formal and informal carers, by several methods of enquiry: interviewing; observation; and data-collection from records and significant others. When assessing and rating risk, Alberg et al (1996, pp42-4 & 53-4) recommended that the following are always taken into consideration:

| | |
|---|---|
| History of risk | Risk factors |
| Recency of risk | Ideation |
| Severity of risk | Plan |
| Frequency of risk | Intent |
| Pattern of risk | |

When considering the patient's history of risk, account should be taken of: relevant incidents in the past and any problems in the past year; the threat of violence or harm, whether verbal or non-verbal; and reports by others of fears for the safety of themselves or others.

When assessing risk, the use of direct questions is recommended. For example, in the case of deliberate self-poisoning or self-injury (Hawton and Catalan, 1987):

- What is the explanation for the attempt in terms of the likely reasons and goals?
- What was the degree of suicidal intent?

- Is the patient at risk of suicide now, or is there an immediate risk of further overdose or self-injury?
- What problems, both acute and chronic, confront the patient?
- Did a particular event precipitate the attempt?
- Is the patient psychiatrically ill, and if so, what is the diagnosis and how is this relevant to the attempt?
- What kind of help would be appropriate, and is the patient willing to accept such help?

**The South Bedfordshire Initiative:**

In the South Bedfordshire Community Health Care Trust, the aims of risk assessment and risk management are to:

- correctly identify the patient who presents medium or high risk behaviours, which fall along a continuum of risk from low to high;
- alert professionals / informal carers of the factors which are likely to increase the level of risk;
- identify and implement factors / actions that are likely to minimise the assessed risks; and
- support the discharge from care of those who have genuinely sustained progress, reinforcing the notion of movement along the 'risk continuum' (SBCHCT, 1998, pp12).

Risk assessment may best be summarised by considering the question: 'Might this patient in certain circumstances behave in a way(s) which is dangerous, or of risk to him / herself or to others?' The clinician is then advised to consider the nature, seriousness and likelihood of all feared outcomes: 'What exactly do I fear this patient might do, when might s/he do it, and to whom?' Framing the risk analysis in this way can help indicate the specific actions required to minimise the level of risk.

Within the Trust, this risk profiling process is closely based upon the tool developed by the Centre for Clinical Outcomes, Research and Effectiveness (British Psychological Society, 1997a): a modified version of this has been described within the Trust's Community Care Policy (South Bedfordshire Community Health Care Trust, 1998, pp12-13; 38-40; section 5.3; appendix 8). The risk profile does not dictate the way in which the assessment is carried out, this being left to the professional's discretion. However, joint assessment by two clinicians is recommended as best practice i.e. named-nurse and CMHT-member, or two CMHT-members (South Bedfordshire Community Health Care Trust, 1998). Rather than being designed as a

structured clinical interview, the items covered within the risk profile serve only as an 'aid memoire', or set of checklists, in relation to the history and recency of defined risk behaviours. The profile is used only to record information which is collected through reasonable and practical enquiry, that is, the inspection of any available letter of referral / case notes; the completion of a sensitive clinical interview with the patient and significant others.

For all patients who are subject to the higher categories of the CPA, and all those for whom one or more positive responses are given in an initial 6-item brief risk profile, the multi-disciplinary team is required to carry out and record a full risk profile. This is done through the named-nurse or key-worker, and preferably one other team-member. Particular attention is given to the following major risk types: violence, suicide / attempted suicide, self-harm, self-neglect, capacity for abuse by others, offending behaviours, substance misuse, and risk to children. It is accepted that the patient's level of risk is likely to change in accordance with the following factors: mental state, untoward events, incidents, compliance with treatments, and response to treatments (i.e. medication, psychotherapeutic approaches). Thus, risk assessment will need to be an ongoing process.

Following the completion of the full risk profile, the multi-disciplinary team discusses risk management options. It is recognised that all options will be based upon clinical judgement, with the selected option being the one that is most likely to address the identified risks. Required care interventions should be consistent with the following key principle: being the least restricting intervention necessary for risk minimisation, as judged against the assessed level of risk - harm to self, harm to others, abuse by others. The formal, three-part full risk profile incorporates:

- current warning signs (Risk Profile I & II);
- risk history (Risk Profile I & II);
- feared outcome(s) (Risk Profile II);
- factors likely to minimise risk, with an action decision and rationale (Risk Profile II); and,
- relapse and risk management plan (Risk Profile III) (British Psychological Society, 1997b; South Bedfordshire Community Health Care Trust, 1998).

The risk profile is commonly completed following the initial assessment of a new patient / client by the Community Mental Health Team. It may also be completed either upon admission to, or discharge from, an in-patient setting - especially where a succinct summary of risk factors and/or a clear risk management plan is required to be followed upon the patient's discharge.

The risk profile is also reviewed at the times of formal CPA review meetings or at times of significant change in the patient's condition (ibid, pp13).

*Developing the Relapse & Risk Management Plan*

The final and most important part of the risk profile is designed to summarise the steps to be taken in the event of: relapse, signs of relapse, to minimise risk, risk being identified or suspected. Ideally, the relapse and risk management plan is completed with the patient, following discussion with the multi-disciplinary team, and in the form of an agreed contract. A behavioural contract covers:

- the steps to be taken if patient fails to attend, or to meet other commitments;
- target signs, symptoms, and behaviours suggestive of possible risk or relapse;
- specific action to be taken in the event of risk or relapse;
- action to be taken in the event of a relative or carer no longer being able to provide support; and,
- the agreed plan, or the record of disagreement (in the event of a disagreement, arrangements should be made for the early involvement of a health or social services manager, external to the CMHT, and/or a request for a second medical opinion by an RMO ).

*Management Options*

The options for managing risk involve implementing actions designed to minimise the likelihood of future risk behaviour. These can be broadly categorised as follows:

- limiting the opportunities;
- warning potential victims;
- reducing triggers and controlling situational factors (risk factors);
- changing risk behaviour;
- monitoring and control; and,
- compulsory treatment / hospitalisation.

To illustrate these options, the following short vignettes have been included. The vignettes are based upon actual clients.

*Case Vignette No. 1: moderate depression with suicide attempts*
Julie is 23-year old woman who was initially referred by her GP to the CMHT following repeated overdoses. It transpired that Julie had made five

attempts to overdose, taking anti-depressants (SSRIs) on two occasions and paracetomol on three occasions. On three occasions, she required treatment via the local Accident & Emergency Department and although offered admission to a mental health unit on two occasions, she refused this. Julie had taken all of her overdoses in the last 8-month period, since being involved in a road traffic accident which caused her miscarriage. Although having recovered well from the accident, Julie had convinced herself that she would never be able to conceive again – and thus would not fulfil what she most wanted. She reported feeling low in mood, described becoming frequently tearful, particularly if in the company of other friends with babies or young children. During the initial sessions, she again threatened to take an overdose of paracetomol, which she had obtained for the purpose. She lives with her boyfriend, whom she described as supportive but unable to fully understand, and she works as a care assistant.

*Outcomes & Issues:*

Julie was engaged in a short series of individual sessions by a CMHN, based upon a cognitive-behavioural approach, which incorporated: problem-solving; goal-setting – short-term and long-term; identification and reinforcement of her reasons for living as opposed to dying; disputation of unhelpful thoughts and beliefs, assisted through self-monitoring methods such as a thought record; addressing the issues around the RTA and her miscarriage. Julie attended 10 sessions over a 4-month period, at which point she was discharged. Whilst she threatened two further overdoses, over the course of initial sessions, she managed to maintain self-control and did not act upon such thoughts. At one-year follow-up, she had not repeated any high risk behaviours, was engaged to be married and planning a career in health care.

Given her history of repeated overdosing, it may have been sensible to encourage an in-patient admission. However, it was reasonably decided to arrange for a period of supported community care aimed at providing Julie with a set of self-help skills, thus representing the least restrictive intervention. In view of her continued threats to overdose, this constituted a 'therapeutic risk', or the clinician's risk. Responsibility for her behaviour continued to rest with Julie. Each threat to overdose led to a further discussion of her personal goals, the likely consequences of such high risk behaviour, reinforcing the disadvantages, and emphasising the reasons for living. She did continue to have the support of her boyfriend and family.

The options taken therefore involved: Julie changing her risk behaviour, via skills acquired from engaging in a cognitive-behavioural approach; ongoing monitoring and the reinforcement of her self-control; and, addressing the situational factors and triggers which had been maintaining

her distress and behaviour – the RTA, her miscarriage and the unacceptable assumption that she would never again be able to conceive.

Whilst the CMHN was experienced, regular clinical supervision was available to help him manage the frustrations and anxieties of working with the risks presented by this client.

*Case Vignette No. 2*: *avoidant personality disorder with obsessive-compulsive features (differential diagnosis)*

Tony is a single 25-year old man who first presented to mental health services about two years ago. He works as a data-entry clerk for a local bank and lives at home with his parents, two younger brothers and an older sister. He described his main problem as having recurring negative thoughts about himself, which particularly occur whenever he is in the presence of other people. He reports a tendency to assume that others are / will think or say bad things about him, to the point that he prefers to avoid all social situations or instead will bite his cheeks and teeth together, so as not to speak. He becomes very preoccupied with these thoughts, to the point of being very indecisive and virtually unable to achieve any action without the intervention of his mother. Tony appears very tense much of the time, and on occasions will appear very impulsive and quick – he states that this is the only way he can achieve anything, because if he stops to think, then decisions or actions become impossible. Tony describes the above as a lifelong trait and has recently expressed severe frustration and hopelessness about being able to make any improvements. He has also recently been expressing suicidal ideas, of taking an overdose of paracetomol or of jumping in front of a train: he has never so far acted upon these ideas. He feels very stressed living at home: his mother is very protective of him and interfering; his father is quiet and passive; his brothers and sisters tend to criticise and demean him.

*Outcome & Issues:*

Following an attempt to work with Tony in the community setting and to resettle him into his own flat, he deteriorated further: his mood lowered further, with almost constant preoccupation with suicidal ideas; and, he expressed thoughts of self-failure, frustration, severe hopelessness and helplessness. After presenting at a Community Centre with paracetomol in his possession, shortly after contemplating jumping in front of a train, he was admitted to the local in-patient unit under Section 3 of the Mental Health Act (House of Commons, 1983). Gradually, Tony began to accept the need for admission under Section and began to improve.

Tony presented an unacceptable risk for continuing community care, being unable to fully engage in psychological treatment, and eventually

presenting a serious and imminent risk of suicide. He had also consistently refused informal admission. He is a young man with few social contacts, who displayed severe anxiety and agitation with obsessive-compulsive features, and expressed severe hopelessness about his ability to change. He thus presented several factors, which are known to be associated with an increased risk of suicide.

The options taken therefore involved: limited the opportunities for a suicidal act, by admitting him to hospital; reducing the triggers / situational factors, which included social isolation in spite of his family being there, and severe hopelessness; ongoing monitoring and control; and, compulsory treatment, due to his refusal of informal care.

*Case Vignette No. 3: anti-social personality*

Ken is a 24-year old man recently admitted to the acute admission Unit following an assault on other family members. In the Unit, he is uncooperative and aggressive towards staff. If family members visit he tends towards increased aggression. There have been a couple of incidents of violence where members of staff were injured. Ken describes considerable anxiety as his main problem and is constantly requesting time to talk to staff about how ill he is and how things would have been different if only others had behaved differently in the past. Ken's history shows a number of significant events, in particular a period of school phobia and periods of heavy alcohol and drug use. He had been unable to keep up his job having been dismissed for poor attendance and arguing with work-mates. In the cases where he had become violent, he believes that it was the fault of the other person(s) and they got what they deserved. Analysis of the incidents by ward staff revealed that Ken appeared to be choosing the times and victims carefully. Violence, unless it was against his parents, would always involve staff alone in isolated parts of the Unit.

*Outcomes & Issues:*

The first concern here is for the safety of all concerned. There is an obvious focus on aggression and violence towards his parents as well as a more diffuse risk towards staff on the Unit. The knee-jerk reaction from a number of those involved was to call for his discharge. This is a mistake. Whilst it is absolutely the case that staff on wards must be able to carry out their duties safely, discharging Ken would have put his parents at risk. Short term solutions to individual incidents might involve seclusion, medication or 2 to 1 nursing (1-1 nursing should never be the response to a violent patient as it only gives them a ready made victim in a situation that is practically guaranteed to raise tensions anyway). The longer term answer here was to

move Ken to a local secure unit where his behaviours were more controlled and boundaries were more clearly set. In addition, visits by his parents were supervised in order to give them more protection. Longer term plans involved a move to a staffed hostel rather than discharge home, with visits home dependent upon his behaviour the previous week. At that stage , if Ken should go missing from the hostel, his parents would be alerted immediately. The Police might also be informed if his last contact with the hostel staff gave rise to concerns that he was angry with his parents.

This case raises another signi ficant issue. That sometimes relatives and carers will not verbalise their real wishes for fear of upsetting the patient or for fear of further aggression. Professionals need, firstly, to give the opportunity for carers to speak without the knowledge of th e patient. Secondly, they should be prepared to overrule the stated wishes of carers if the multi-disciplinary team feels that the carers are putting themselves at longer term risk.

*Case Vignette No. 4*: *command hallucinations & self-neglect*

Wilma is a 38-year old woman who had recently moved into the CMHT's catchment area. She lives with her husband who has had to give up working in order to care for her. At initial assessment, he describes never being able to leave her alone for fear of what she might d o. The couple do not have any children and Wilma very much wants to be a mother. Wilma would remain in bed all day and eat little or nothing if it wasn't for her husband's encouragement. The worrying feature is that she hears two different voices, one tells her to harm herself and one tells her to steal a baby from a pram. Her husband stated that he had on many occasions stopped her from taking knives from the kitchen drawer and had to hide her medication because she had taken small overdoses in the past. H e also mentioned that once, while out shopping, he had been forced to physically remove her from the vicinity of a pram after she had tried to pick up the baby. Wilma admitted later that she was hearing the voice telling her to steal the baby at the time. The house they lived in was in a small row of 4 terraced houses in an isolated location. They did not have a car, but could reach the local town on the infrequent buses.

*Outcomes & Issues:*

The immediate concerns in this case are risk to children and to h erself. There is also the risk of self-neglect. The key to all the above is the fact that the husband is remaining at home with Wilma and made it clear that he never leaves her. The presence of command hallucinations that have been acted on

makes the risk of self-harm and stealing a baby high. Despite this, the members of the team that assessed Wilma were happy for her to remain at home as long as her husband continued with his commitment. Because of the isolated location of the house, it was felt that even if Wilma should leave the house alone, there would be time to put into operation the management plan. The husband had the most important role here as he would need to inform the authorities should he lose track of Wilma. Because of this, the team members also carried out an assessment of the husband's capacity to understand the issues at stake and make the needed decisions. It was agreed that he would be unlikely to fail in this. If he lost track of his wife he was to inform the CMHT and the Police as soon as possible. It would also be necessary to have some contact with the Police over this, and this could be handled in a number of ways depending on the relationship between the team and their local force, and on the perceived risk presented. The first option is only to approach them if the team loses contact with Wilma. Other options are informing the Police up front, to contact the team if there is a missing baby (without revealing the name of the client) or possibly to tell them exactly who you are worried about. The latter option would produce the quickest response, but would mean revealing information about the client that could be construed as a breach of confidentiality, given that no crime has been committed (if the client had had previous convictions for stealing babies and lived alone, the latter options would be the only ones to consider).

The other components of the plan were to begin twice weekly visits to Wilma to monitor the situation, refer the two of them to our local Befrienders service to reduce their isolation, and to set up respite care for Wilma in order that the situation didn't become too much for him.

*Further Practical Considerations for Management*

It is essential that part of the management plan for both violence and suicide be the inclusion of therapeutic activity. This should be aimed at undermining the reasons for the undesirable behaviour, and boosting reasons for more acceptable behaviour. Cognitive Behaviour Therapy (CBT) offers a number of approaches which can be effective for this (Persons, 1989).

**Concluding Discussion:**

*Risk Management*

Conducting a comprehensive risk assessment is only a part of the task. Next, it is necessary to develop a management plan. This, as might be expected, should detail the actions to be carried out in order to minimise the risk. We chose the word 'minimise' deliberately, as we feel that eliminating risk is what is aimed for, but never achieved in an absolute sense. It must, therefore, be part of the process of risk management to assess the extent to which an intervention will reduce the risk. This has to be balanced against availability of, and demand on, resources. For example, to what extent does a CMHN visiting a client three times per week reduce risk of suicide over one visit per week? Obviously, the client's individual circumstances will have great bearing in this. However, if the CMHN was carrying out a course of CBT designed to challenge the client's suicidal ideation, it is likely to have more value than more frequent visits 'just' to check on the client's mental state. The other message here is that risk reduction is not solely about controlling the client, but is also about treatment of the problem.

For a risk management plan to be effective, it should not only say what everyone involved should do, but must also spell out the 'what ifs'. The fear of what might happen will have been established from the assessment. Therefore, it needs to be decided what would constitute an indicator of the likelihood that any of these behaviours were increasing, or have already happened. Following that, a plan should be made of the action that needs to be taken in the event of any of the indicators occurring.

*Dilemma of Risk Management*

One of the dilemmas of a risk management system is the balance between usability and completeness. The system needs to be as simple as possible to avoid errors. It also needs to be practical within services that are, by and large, very busy and often short of staff. On the other hand, gathering more information increases the likelihood that the professional's decision-making will be better informed. There is no perfect answer to this challenge. Nevertheless, we do have a suggestion of a way to reduce the problem. Risk assessment protocols should be layered so that everyone contacting services gets a low-level assessment that is gathered from the usual clinical assessment carried out in the service. Where that indicates the possibility of a raised risk, a more in depth risk assessment is carried out. This concentrates effort on those with greatest need, and reduces the overall workload for the service.

*Communication*

One of the single most important factors in the team management of risk is communication. As mentioned above, one only has to read the reports of any of the recent inquiries into serious incidents to see that poor communication can undermine the best of plans. It is vital that information should be passed on to all those who need to know. This can cause difficulties because of the tension between communication and confidentiality. When it comes to life being at risk, the issue of confidentiality is something of a 'red herring'. There is no excuse for not passing information to any individual who may be at risk from not knowing. This extends beyond health and social care staff, to include anyone having contact with the client. It would be foolish to have community mental health nurses visit a client in pairs if, an hour after they have left, the housing officer or the client's GP arrives on his own.

There is often reluctance to involve the police in plans to manage risk, but they are very much part of the process. In reality, if organisations can foster good relationships with the local police force, it can lead to far more effective help for clients. For example, earlier involvement of mental health clinicians following an incident or being informed by an officer that a client with a history of suicide has been seen late at night on the canal tow path. There is of course one over-riding reason why good communication is vital. If the risks are not known, then it is not possible to provide the right services for the client and as a result of that, their care suffers.

It is perhaps obvious that communication must be understandable, and yet many practitioners will use language that others do not understand. Medical terminology in particular may not mean anything to many of those involved in the care of the client. Therefore, risks and the management of those risks must be described plainly and simply. A further point here is that descriptions should be as comprehensive and as detailed as possible in order to inform decision-making. For example: 'This man has three convictions for ABH' means far less than: 'This man has three convictions for ABH against his mother'. In turn, that is less useful than: 'This man has three convictions for ABH against his mother, all of which happened when he had been drinking heavily'. Hopefully, it is easier to construct a management plan from the latter description.

Access to the information is also crucial. Many long-term patients of mental health services have a great deal of risk information buried in a 5-inch thick folder of notes (if you're lucky). This information is not held in a useful form. It is necessary for all services to have a method for keeping risk information together in a form that is easy to access. Probably the best system is an electronic record on a networked computer system. Paper records can also achieve this aim, but it is important that as patients move

around services, new records are not started. Otherwise, there will be confusion about which is the real risk management plan.

*Multi-agency Working*

The difficulties of multi-agency working are well known. Many inquiries have identified problems, and the main reason for introducing the CPA was to attempt to overcome the difficulties. The agencies most frequently working together are health and social services, but many other agencies might be involved, for example, the criminal justice agencies, voluntary organisations, local authorities and others.

Agencies that often work together must get together and draw up joint policies and procedures. It is not sufficient just to have a joint understanding of CPA. Risk assessment must also be the same. Often the mistake can be made of thinking that using the same forms means that agencies are working together. This will not be so until the organisations involved also have a shared understanding of the meaning of risk assessment, as well as a shared understanding of each agency's role in the management of that risk. This is best achieved with joint training to complement the common paperwork and policies.

*Case Against Admission*

Often the first response to an identified suicide risk is to seek admission to an in-patient facility. This can be a mistake. That first reaction is usually prompted by the wish to preserve the client's safety. But acute in-patient units are never completely safe places to be, unless the client is placed on continuous observation. For many clients, it is possible that the quality of intervention may decrease if the ward they go to is consistently busy or under-staffed. If there is good social support from relatives and friends, coupled with an effective treatment (whether that be medical or psychological), it may well be better to keep the client at home. The reality is that they may get more support that way. There is also the possibility that being hospitalised may seem to the client to be proof of their failure and hence lead to an increase in risk.

*Clinical Supervision: coping with risk*

As stated within the guidelines for the local Trust (Butler and Suppiah, 1996, pp1): supervision may be:

> 'viewed as a structured, on-going and objective process in which a more experienced peer or more senior person maintains a negotiated contractual relationship with the individual nurse, assisting him/her to focus and reflect upon his/her professional role and clinical practice, thereby facilitating professional development. In order for supervision to be effective, it should be well-structured, uninterrupted and regular, each session being based upon a clear agenda agreed between supervisor and supervisee.'

The guidelines describe a model for the basis of supervision, based upon three distinct and inter-related areas (Hawkins and Shohet, 1990): educative; supportive; and, managerial.

Clinical Supervision is viewed as helpful for both the staff-member and for client care when there are issues of risk. This has been shown in a local audit study of clinical supervision across acute and community mental health teams in South Bedfordshire (Butler, 1999). Feeling supported (74%), stronger working relationships (63%) and gaining additional clinical insight (61%) were the most commonly reported outcomes of supervision.

Therefore, it is strongly recommended that systems for support and supervision are in place for those staff / therapists working with clients who present significant risk behaviours.

**Summary of Principles for Good Practice:**

The principles of good practice in risk assessment and risk management involve the completion of *comprehensive* assessments, developed *collaboratively* and *communicated* to all those who need to know via *user-friendly* documentation. Assessment must be undertaken as an *ongoing* process if we are to ensure the implementation of *up-to-date* and *meaningful* risk management plans.

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