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Assessing Risk in Community Mental Health Services

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Introduction

Clinical risk assessment and risk management are essential aspects of the provision of effective mental health care, that have been the focus of influential inquiries, key policy and guidance developments, which have shaped standards for practice: in the United Kingdom, this has included the publication of a Best Practice in Managing Risk Framework (DH 2007), the National Confidential Inquiry into Suicides & Homicides programme (University of Manchester 2011), the National Suicide Prevention Strategy (DH 2002, 2011) and NICE guidelines (*for example*, the recently published guidelines on the longer-term management of self-harm (NICE 2011)).

Within this short chapter, a brief introduction to the systematic and collaborative process of clinical risk assessment and risk management is provided, focusing upon key stages of the process, standards and principles for effective and meaningful practice.

Defining & Considering Clinical Risk

Within community mental health services, the term ‘clinical risk’ refers to the *possibility* and *likelihood* of a beneficial or, more frequently, a harmful or undesirable behaviour / outcome occurring in response to changing personal circumstances (Alberg et al 1996, Morgan 1998, Morgan 2000), whether happening directly to the patient or being done by the patient to others (Wellman 2006: 145).

A range of key risk behaviours need to be routinely considered as an aspect of mental health assessment with the patient, which include:

- risk of harm to self: *suicide; deliberate self harm; accidental self-harm; self-neglect; being exploited / abused*
- risk of harm to others: *violence; aggression; neglect of dependents; use of weapons; arson; exploiting / abusing others*
- risk of harm to self / others: *substance misuse; offending*

Furthermore, it is important to consider the context of working within the community mental health setting, as there are a multitude of situations that may involve or lead to potentially high risk behaviours, such as lone working, working with those who are

distressed and disturbed by symptoms such as delusional beliefs and voices, or working with those who frequently disengage or harm themselves.

Clinical Risk Assessment: a systematic & collaborative process

Risk assessment is a systematic and collaborative *process* of identifying and investigating factors associated with an increased probability of specified risk behaviours occurring. This involves the systematic collection of information from different sources to determine the degree and likelihood of the identified risk, and the *patterns* of circumstances in which *risk* factors may arise (Morgan 1998: 21, Morgan 2000, O'Rourke et al 1997: 104). Indeed, the meaningful assessment of clinical risk is regarded as '*a skill* that needs to be learned, practiced and refined' (Wellman 2006: 146).

The comprehensive and systematic assessment of risk provides a basis for decision-making in practice, through which the relative merits of different options for an individual's treatment and care can be considered, with the aim of developing and implementing care plans and interventions to manage identified risks, by *minimising* their frequency and severity, and reducing the likely impact upon all concerned should untoward events occur (Snowden 1997, Wellman 2006: 147, 160). The selection of care options will always need to involve a '*balancing*' or '*weighing up*' of the possible benefits of care interventions against the risks / disadvantages for the individual concerned and significant others.

As described by Morgan (1998: 14-15, 2007), Duffy (2008: 44) and others, this process therefore involves a number of key stages:

- Stage 1: identify or re-visit the potential for risk, which will involve considering a range of risks in different circumstances
- Stage 2: conduct a systematic and comprehensive assessment of risk, which may involve the use of structured tools and will involve the consideration of known risk factors and protective factors
- Stage 3: provide a formulation of risk and summarise risk status (*this must include a summary description of risk and risk status (often expressed on a continuum from very low to high risk)*)
- Stage 4: take preventive action, which will need to be communicated through the care plan and/or contingency risk management plan
- Stage 5: evaluate the success of preventive action, which will involve continuous monitoring for judging the effectiveness of the action and for changing the action
- *the cyclical risk assessment process then continues by returning to stage 1*

The recommended approach to clinical risk assessment has been described as structured professional judgement (DH 2007): an approach which aims to combine the evidence base for risk factors with individual patient assessment, that takes account of the individual's particular circumstances, needs and strengths. The process involves the practitioner in making a structured assessment as the basis for formulating a risk management / care plan, as a multi-disciplinary and multi-agency activity that actively involves the patient and carer (Morgan 2007, DH 2007, Bouch & Marshall 2005, DH 2008).

It is important to realise that a meaningful risk assessment can rarely be undertaken by one person alone and practitioners should always try to *validate information* from a single source by seeking information from other available sources – both professional and informal, using different methods of enquiry: interviewing; observation; and data-collection from records and significant others (Butler & Lees 2000). Furthermore, it is almost always helpful to discuss the assessment and care / risk management plan with a peer or supervisor.

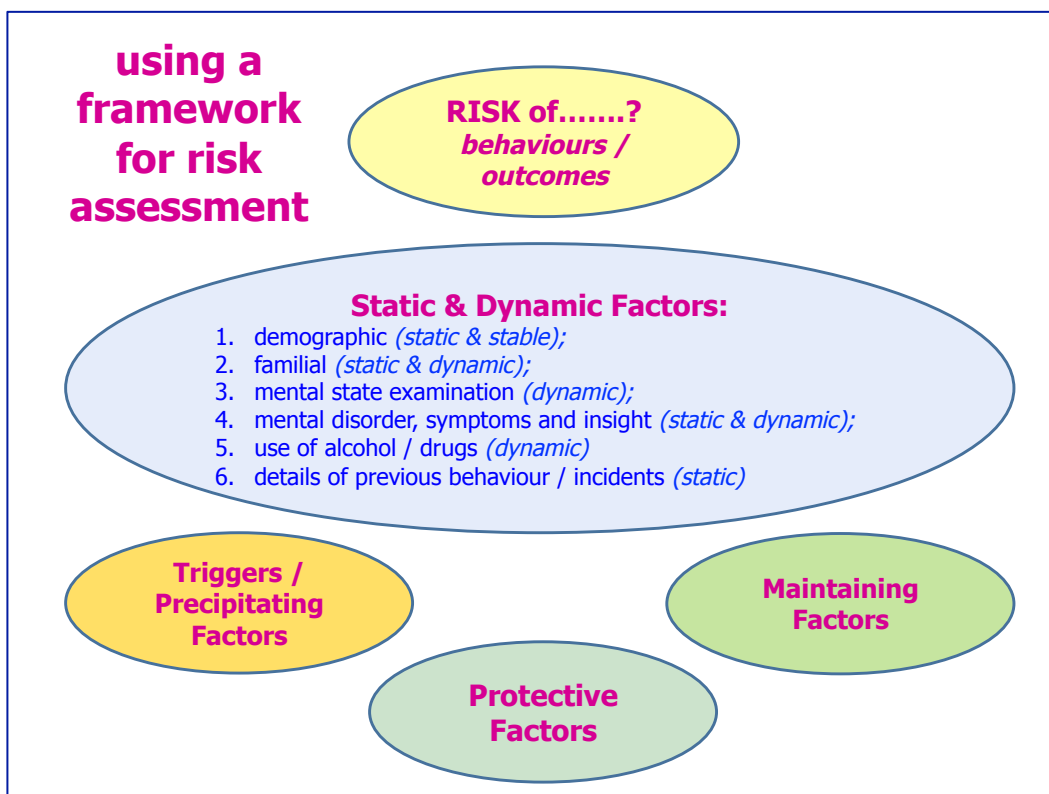
It is important to realise that whilst confidentiality is a personal right, this should not be viewed as a barrier to effective and safe practice, as it is acceptable to breach confidentiality in exceptional circumstances.

Undertaken through a collaborative approach, risk assessment and risk management planning will enable choice and maximise the person’s independence, improve consistency and transparency in decision-making and promote the targeting of resources.

Using a Framework for Assessment

Undertaking a meaningful assessment of clinical risk will be enhanced through the use of a framework, an example of which is proposed in Fig. 1.

Fig. 1: a Summary Framework for Clinical Risk Assessment



As shown in Fig. 1, clinical risk assessment will always require the consideration of: key risk issues; static & dynamic risk factors; triggers / precipitating factors (*for example, a life event*); maintaining factors (*for example, avoidance behaviour*,

isolation or a lack of problem-solving / coping skills); and importantly, protective factors.

Risk factors may be considered as personal characteristics or circumstances (DH 2007: 13-14) that are known to be associated with particular types of risk (Wellman 2006: 148-9). Bouch & Marshall (2005) provide a helpful description of different types of risk factors for suicide – a more general summary of risk factors relevant to risk of suicide and aggression / violence has been provided in Table 1. Though such factors are not necessarily causal, their presence does *assist in the overall evaluation* of a person's level of risk in the long-term.

Table 1: a Summary of Key Risk Factors

STATIC / STABLE	DYNAMIC / FUTURE
<ul style="list-style-type: none"> • fixed and historical (<i>static</i>) • long-term and enduring (<i>stable</i>) • provides an indication of the likelihood of risk behaviour 	<ul style="list-style-type: none"> • present for an uncertain length of time • fluctuate in duration and intensity • captures fluctuation in the nature of risk and informs clinical management
<p>EXAMPLES: <i>demographic:</i> age, gender, ethnic group, marital status, socio-economic status, educational attainment, employment, occupational group <i>previous history:</i> deliberate self harm, aggression / violence, childhood adversity, seriousness of previous high risk behaviour (e.g. suicide attempt that involved a more violent or lethal means and leaving a suicide note), forensic history <i>family history:</i> suicide, aggression / violence, mental illness, alcoholism <i>clinical history:</i> substance use disorder, mental disorder (depression with severe hopelessness, bipolar disorder, schizophrenia, paranoid psychosis, severe anxiety), personality disorder / traits, physical illness (especially chronic or terminal conditions and/or those associated with pain, confusion or functional impairment), persistent or poorly controlled symptoms, poor / non-adherence with treatment, previous hospitalisation</p>	<p>EXAMPLES: <i>Dynamic:</i> ideation, intent, planning, active psychological symptoms (e.g. anxiety, low self-esteem, uncontrollable anger, suspiciousness, paranoid thoughts, command hallucinations), hopelessness, impulsiveness, treatment adherence, substance use, admission and discharge, psychosocial stress (e.g. related to recent life events or relationship issues), social support (isolation), problem solving deficits <i>Future:</i> access to means, future stress, future service contact, future response to treatment, forthcoming discharge</p>

The most important risk factor is regarded as history, and so particular attention should be given to: 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 (Butler & Lees 2000).

The presence of particular known risk factors does not necessarily mean that the individual will go on to demonstrate a particular risk behaviour, but rather it is better

to consider the presence of risk factors as a series of warning signs, which may increase the likelihood of risk behaviour.

The assessment process may be complemented through the use of **specialised structured assessment tools** as an adjunct to clinical assessment. Notable examples include the Beck Hopelessness Scale (Beck et al 1974, Beck & Steer 1988), and the HCR-20 – the Historical and Clinical Risk Schedule (Webster et al 1995). 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 (Butler & Lees 2000). Use of these tools may assist the practitioner / team to *systematically evaluate and determine the seriousness* of an individual's risk, and *measure change*. However, the use of structured tools contribute only one part of the overall view of risk, and should only ever be used as *part* of the structured risk assessment approach with the patient (DH 2007: 30). In the UK, NICE (2011) recommended NOT to use *risk assessment tools and scales to predict future suicide or repetition of self-harm (NICE 2011 CG133: 1.3.11), though they may help to structure the risk assessment (NICE 2011 CG133: 1.3.13)*. In summary, whilst structured assessment tools are useful adjuncts, it is important to select these carefully, considering their validity, reliability and appropriateness.

Just as it is important to ask direct questions to identify risks and precipitating factors, it is important to remember to ask about **protective factors** and coping strategies in adopting a balanced approach to clinical risk assessment. A protective factor is regarded as *'any circumstance, event, factor or consideration with the capacity to prevent or reduce the severity or likelihood of harm to self or others'* (DH 2007: 57). A number of common protective factors and coping strategies have been summarised in Table 2.

Table 2: Examples of Protective Factors & Coping Strategies

Hopefulness	Feeling supported / having a confidante
Plans for the future	Resilient personality
Good problem solving skills	Cognitive flexibility
Having religious beliefs / a moral code	Positive coping beliefs
Positive engagement / attitude towards mental health care and support	Perception of self-control
Strong commitment to work / education	Fear of social disapproval
Being responsible for children / child-related concerns	Fear of suicide / pain
Strong social and family supports / connectedness	Lack of precipitating life events / losses

The clinical risk assessment must be documented in a meaningful descriptive form that aids team communication and supports treatment and care. This will require providing a detailed description of current risk factors and relevant circumstances (including a consideration of past and current risk factors) that are indicative of identified risk(s). It is clearly important to be specific, clear and concise, though ensuring the inclusion of sufficient descriptive detail.

The systematic assessment of risk should be concluded with a formulation of the individual's risk, as a summary statement of the presenting risk behaviours / issues, relevant risk factors, personal circumstances and protective factors, which may incorporate a summary of the person's current risk status. Perhaps put more simply, this descriptive statement should clarify what may happen, to whom, the likelihood, frequency and imminence of it occurring, the likely consequences (severity), balanced by identified protective factors and coping strategies.

The individual's risk status may be summarised as: very low (no ideas to harm self or others); low (fleeting ideas); moderate (persistent / preoccupying ideas); high (persistent or preoccupying ideas with evident planning); or, immediate (with evidence of preparatory acts). This clinical judgement will depend upon a number of key parameters: history of risk; recency of risk behaviour; seriousness of risk behaviour; frequency of risk behaviour; any actual or emerging pattern to risk behaviour; evident risk factors; ideation; intent; and, planning (see: Alberg et al 1996: 42-4, 53-4).

Managing Clinical Risk

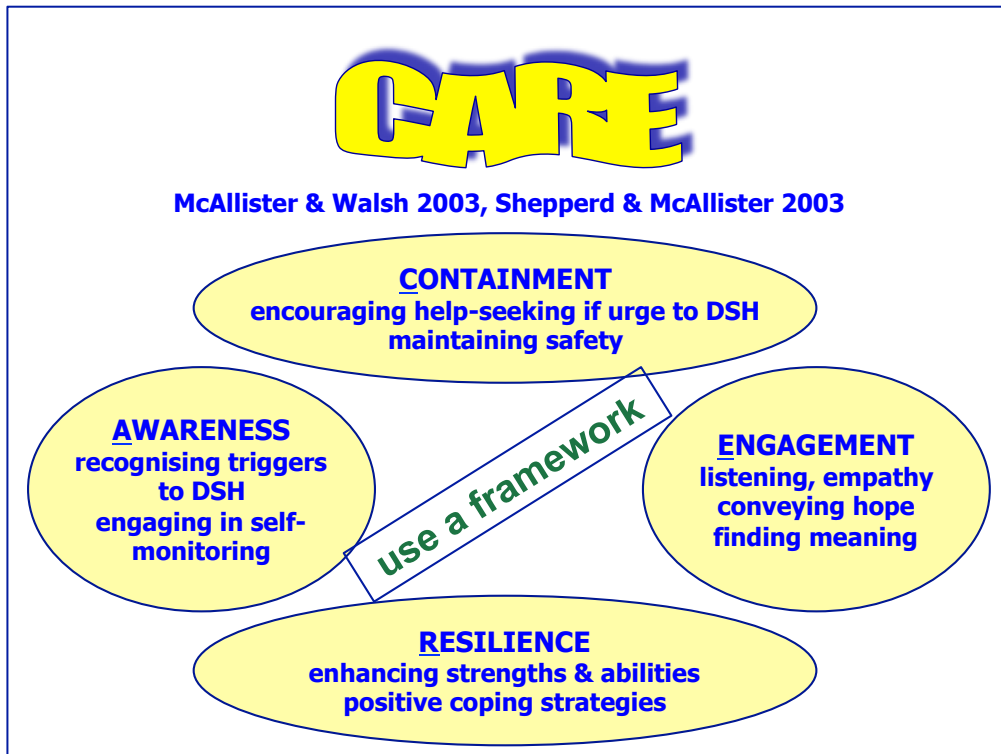
Care interventions for managing identified risks and addressing associated risk factors will need to be incorporated within a personalised care plan or contingency risk management or crisis plan.

Positive or therapeutic risk taking, more recently referred to as positive risk management, should be integral to the process of care / risk management planning (DH 2007: 8-10). This emphasises working alongside the patient, carers and other care providers to determine what is likely to work, weighing up the potential benefits and harms of possible actions, being willing to take a decision that involves an element of risk where the potential benefits outweigh the risks, in deciding upon a plan of action which is then communicated, together with the rationale, to all involved. In particular, this approach aims to support the positive potentials of the patient whilst minimising the identified risks, involves taking opportunities for less restrictive practice, and supports individual responsibility and recovery.

To illustrate, consider the helpful option of offering a talking therapy to a psychologically distressed individual – engaging the person within the therapy may cause them to experience further distress and perhaps behavioural disturbance (involving some risk behaviour) in the short term, and so it would be important to enhance the available supports and frequency of contact during the initial stages of providing the psychological intervention.

Of course, when planning how best to manage clinical risk, it will be helpful to consider the practical use of specific care frameworks or models. As one notable example, consider the use of the dynamic CARE framework as a relevant and practical tool for developing a plan of care for the person who deliberately self-harms (McAllister & Walsh 2003, Shepperd & McAllister 2003), as summarised in Fig. 2.

Fig. 2: the dynamic CARE framework for Managing Deliberate Self-harm (DSH)



Key Principles

In summary, the quality of clinical risk assessment will be enhanced through adopting the systematic and collaborative team approach of structured professional judgement, that involves validating information by consulting different sources and actively involves the patient and carer (wherever possible).

Effective practice requires the completion of a structured and well-documented assessment that forms the basis for meaningful care intervention. This will support meaningful team communication, handover and frequent care review.

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