

Clinical Risk Assessment and Management

Practitioners engaged in clinical risk assessment and the development of risk management plans with service users may find the information below a useful guide:

1. Clinical Risk Assessment

It is not possible to provide an exact formula to assess risk. Rather, staff must assess risk based upon reasoned judgement and their in-depth knowledge of the service user. Although a risk assessment is based on information given by the service user themselves and a synopsis of the risk history evident on RiO, information may also be gleaned by engaging with personal networks (such as carers and friends if consent is given) and professional networks (such as other Trust teams, social services, police etc). A robust risk assessment utilises information from a variety of sources to obtain a clear and accurate picture of the risks present. Corroboration of information by multiple sources means that clinicians may be more confident in the factual accuracy of that information

1.2 Assessment of Risk of Harm to Other People

When assessing the risk of harm to others, the following areas must be considered:

- Risk Factors;
- History;
- Ideation/Mental State;
- Intent;
- Planning; and
- Formulation.

1.2.1 Risk Factors

Certain risk factors can be used in assessment to draw attention to the possibility of increased risk. The risk factors associated with harm to others as identified by research are outlined in the following table:

RISK FACTORS (HARM TO OTHERS)		
VARIABLES	HIGHER RISK	LOWER RISK
Age	Younger	Older
Sex	Male	Female
Living arrangements	Unstable, changeable	Stable
Employment Status	Unstable, changeable	Stable
Educational Attainment	Low	High
Mental health diagnosis	Clinical depression; Schizophrenia Paranoid Psychosis Personality Disorder	All other diagnoses
Substance Misuse	Alcoholism, illegal drug misuse	None

1.2.2 History

An accurate history of violent incidents is perhaps the most important information to obtain in making an assessment of risk. This information can be obtained from records and referral letters, as well as by asking service users themselves, carers and other family members. It is important to obtain past psychiatric records from other hospitals, districts, or social services departments and a full history of criminal offences should also be sought. Information for some service user's may also be obtained from the Borough Risk Management Panels.

Obtaining evidence for any of the following are also important:

- poor compliance with treatment or disengagement with aftercare;
- precipitants (such as drug and alcohol use) and any changes in mental state or behaviour which may have occurred prior to violence and/or relapse;
- recent severe stress, particularly of loss events or the threat of loss;
- recent discontinuation of medication;
- recent threatening behaviour including threats of violence/verbal threats;
- a history of intimidation (including stalking and harassment).

Information about a history of harm to others has four components: recentness, severity, frequency and pattern.

Recentness

The more recent an event or incident of harm to others, the higher the current risk. An assault upon a stranger committed today, indicates higher risk for the present than a similar incident last year, or five years ago.

Severity

The more severe an incident, the higher the current risk. Severe incidents include:

- First Degree Violence - defined as an assault which results in no detectable injury;
- Second Degree Violence - defined as an assault resulting in minor physical injuries such as bruising, abrasions or minor lacerations;
- Third Degree Violence - defined as an assault resulting in major physical injuries including large lacerations, fractures, loss of consciousness, or any assault requiring subsequent medical investigation or treatment.

Frequency

The more frequent the events or incidents of harm to others, the higher the current risk. Persistent and repeated assaults on others are very strong indicators of high risk.

Pattern

Is there a common pattern to the type of incident or the contexts in which it occurs?

1.2.3 Ideation and Mental State

What is the person thinking or feeling now? It is important to assess the service user's mental state and in particular look for evidence of the following:

- Evidence of any threat/control override symptoms: that is, firmly held beliefs of persecution by others (persecutory delusions) of mind or body being controlled or interfered with by external forces (delusions of passivity);
- Emotions related to violence e.g. irritability, anger, hostility, suspiciousness;
- Specific threats made by the service user;
- Command hallucinations, e.g. voices telling service user to attack a particular person.

1.2.4 Intent

A statement from an individual that they intend to harm another person is the clearest indication of risk and should never be ignored. Intent, whether implied or not, is the strongest and most powerful predictor of future behaviour.

1.2.5 Planning

If the person admits that they have thoughts of harming themselves or others, it is important to establish whether they have considered exactly how they might do so. This can be extracted from his or her own statements or other objective evidence. The presence of a plan as to how they harm another person indicates yet higher risk. If the person also has access to the means for carrying out that plan the degree of risk rises still higher. A person with paranoid delusions about their neighbours, who has considered exactly how they might deal with them using his kitchen knife, poses a greater risk than the person who has more vague ideas and no clear plan.

1.2.6 Formulation

Following the assessment a formulation should be made which should, so far as possible, specify factors likely to increase risk or dangerous behaviour and those likely to decrease it. It should include an appreciation of all the risk factors described above, in particular, how their interaction *might increase* risk. The formulation should aim to answer the following questions:

- How serious is the risk?
- Is the risk specific or general?
- How immediate is the risk?
- How volatile is the risk?
- Are circumstances likely to arise that will increase it?
- What specific treatment and management plan can best reduce the risk?

1.3 Assessment of Risk of Suicide/Self-Harm

Assessing the risk for suicide/self harm follows a similar process as the assessment for risk of harm to others. Once again the following issues should be examined:

- Risk Factors;
- History;
- Ideation/Mental State;
- Intent;
- Planning; and
- Formulation.

1.3.1 Risk Factors for Self-Harm (See also Suicide Prevention Strategy)

The following risk factors for harm to self and suicide have been identified in the research literature:

RISK FACTORS (HARM TO SELF)		
VARIABLES	HIGHER RISK	LOWER RISK
Age	Older	Younger
Sex	Male	Female
Marital Status	Separated, Divorced, Widowed	Married
Living arrangements	Living alone	Others at home
Employment Status	Unemployed, retired	Employed
Physical health	Poor, especially terminal, painful, debilitating illness	Good
Mental health	Mental illness, especially depression, schizophrenia and chronic sleep disorders	Good
Substance Misuse	Alcohol, illegal drug misuse	None

Once again, it should be stressed that the *level of importance of each of the risk factors will differ*, depending on the individual circumstances of the service user. Clinicians will have to use their professional judgement and their knowledge of the client to assess the risk for suicide or self-harm.

1.3.2 History of Previous Self-Harm

An accurate history of past self-harm incidents and suicide attempts is vital for the risk assessment process. The recentness, severity, frequency and pattern of these attempts should be examined as explained in 4.2.2. For example, when considering the severity of an attempt, the person alone in a house who has taken steps to avoid interruption, has attempted to hang themselves and has been rescued only by chance, is at much higher suicide risk than the person who has taken an overdose they know is not lethal and present themselves at Accident & Emergency.

Similarly, when considering the pattern of self-harm or suicide attempts, a suicide attempt may be typically made by one person at the ending of a relationship. If that pattern is now repeating itself and a relationship is now ending, this indicates a higher risk. Anniversaries of recent traumas and losses may also increase risk, usually temporarily, particularly if it leads to a sense of entrapment and hopelessness. The service user's view of anticipated events may also increase risk as they approach. It is also important to remember that substance misuse, particularly of alcohol, greatly increases risk.

1.3.3 Ideation and Mental State

An examination of the person's ideas on suicide can help assess the risk. Consider whether the person sees suicide as a solution to his or her problems. Does the person think or fantasise about suicide? How frequently does the person think about suicide and how does he or she respond to these thoughts? The greater the prominence and rigidity of these thoughts in the person's life, the higher the risk of suicide. Fleeting thoughts quickly rejected represent low risk, while persistent, intrusive and painful thoughts indicate high risk even in the absence of planning. Consider constraints on action (religious beliefs, family obligations).

1.3.4 Intent

As with the intention of harming others, a statement from the service user that they intend to kill themselves is the strongest indicator of risk and should never be dismissed. Intent, whether declared or not, is the strongest indicator of future behaviour.

1.3.5 Planning

If the person admits to suicidal ideas has he or she taken it a stage further to commence planning how to do it? How likely in the assessor's judgement is the plan to succeed? Plans to avoid detection are of particular significance. For example, if a person has continual thoughts of suicide, has the person determined that he or she will shoot him or herself when the rest of the family are away, and does the person have the means to do so, for example by owning a shotgun? If so, this would indicate a very high risk. Thoughts of suicide without any plan or without access to the means to do so carry a lower risk.

1.3.6 Formulation

Once again a formulation should be made, including an appreciation of all the risk factors described above and their interaction in increasing risk. It should aim to answer the following questions:

- How serious is the risk?
- Is the risk specific or general?
- How immediate is the risk?
- Is the risk liable to diminish fairly quickly?

- Are circumstances likely to arise that will increase the risk? And
- What specific treatment and which management plan can best reduce the risk?

It is important to mention that service user's responses should not always be taken at face value - e.g. service user's might categorically deny feeling suicidal when this is far from the case. Remember that it may be difficult to determine whether suicidal feelings are present in the face of plausible denial by the service user.

1.4 Assessment of Risk of Severe Self Neglect

Self-neglect is a common problem for people with severe and enduring mental illness. Assessing the risk of self-neglect is not a straightforward process, except in the most severe situations. It is made more complex by differences in relative standards. The areas that should be covered by the assessment process are:

- Hygiene;
- Diet;
- Infestation;
- Household Safety;
- Warmth.
- Physical Health.

1.5 Reliability of Information

Information acquired from the service user and others for the purpose of assessing risk is usually reliable, but not always. Information from known reliable sources can be given more weight than information from unknown or unreliable sources. Reliability is further bolstered when other parties corroborate information.

The sources of information must be detailed within both the Brief Risk Assessment and the Full Risk Assessment. Regardless of the source of information, every effort must be made by assessors to follow up, clarify and confirm uncorroborated information, or information of doubtful accuracy (unknown or unclear) information prior to placing greater emphasis upon it.

1.6 Risk Indicator Checklist

A Risk Indicator Checklist is included for information at Appendix 3. This checklist includes the risks as mentioned in the above but also specifies a number of other areas that may be pertinent to people with mental health problems.

2. Management of Clinical Risk

It is important that teams give careful consideration to managing the risk behaviours identified during the assessment. The risk management plan (which should be fully reflected in the care plan) should include a summary of all risks identified, formulations of situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to a crisis.

The risk management plan should be based upon the following six questions:

- How serious is the risk?
- Is the risk specific or general?
- How immediate is the risk?
- How volatile is the risk?
- What specific treatment and interventions can best reduce the risk?
- What plan of management is needed to reduce the risk?

Some helpful general risk management strategies that should be followed are:

- The need to be alert and vigilant to hazard;
- The need to be aware of the service user's history;
- The need for all team members to be aware of the results of the risk assessment;
- Consider who might be harmed, why and how and ways that the risk could be mitigated;
- Sound knowledge and understanding of mental health legislation.
- Evaluate whether current arrangements adequately address the risk and decide whether further measures need to be taken;
- Record in writing exactly what risks are thought to be present, what action has to be taken and by whom and what level of risk is being accepted for an individual, bearing in mind the practical constraints, resources available and the rights of the individual to be treated in the least restrictive manner compatible with minimal risk;
- Ensure that a regular review system is established so that levels of risk can be revised in the light of more recent information. This should include service users on extended s17 leave.
- Exchange of information so that all relevant parties have knowledge of risk factors to be able to manage risk effectively in line with AMHC Policy.

STANDARD 6 – Development of effective risk management plans

Care Plans (regardless of whether they are ward based care plans or community CPA care plans) will contain agreed interventions that aim to manage and/or reduce the risk behaviours identified in the assessment.

2.1 Management of the Risk of Harm to Other People

2.1.1 General principles

Three principles underlie the management of service users who present a risk of dangerous behaviour:

- When a clinician has identified the risk of dangerous behaviour, they are responsible for acting to ensure that risk is reduced and managed effectively;
- The management plan should change the balance between risk and safety; and
- With service users who present a risk of dangerous behaviour, clinicians should, following assessment of the risk, aim to make the service user feel safer and less distressed as a result of the interview.

2.1.2 The management plan

The management plan must be based on an accurate and thorough assessment, and adoption of the principles above. ***Clinicians should consider the appropriate level of support and containment.***

The following list is not exhaustive but covers options that clinicians may need to consider in formulating a management plan

- Referral to the relevant crisis team
- Has the person been included in the Care Programme Approach?
- Has the use of legal powers been considered (e.g. Supervised Discharge or Guardianship)?
- What community supports are available (family, carers, community mental health workers, accommodation needs, day care needs, probation service etc.)?
- Do the carers and family have access to appropriate support and help, including self-help groups?
- Have the carers (professional as well as lay) and family been adequately informed about the services needed and how they can be accessed? Are they realistic in their expectations?
- Have all agencies involved with the service user been consulted and involved in formulating the management plan?
- Has information been exchanged by statutory agencies to enable all parties to contribute to the management plan?
- Is the service user known to the Borough Risk Management Panel? (local contacts for Risk Management can be found in Appendix 4)
- Is it safe to discharge that in-patient if appropriate community support is not immediately available on discharge?
- Is admission as an in-patient necessary?
- Should the service user be detained in hospital?
- What level of physical security is needed?
- Should the service user be placed in locked or secure accommodation?
- What level of observation and monitoring is required?
- How should medication be used?
- How should further episodes of violence be managed?
- Should the police or security be called? and
- What has helped to reduce risk in the past?

2.2 Management of the Risk of Suicide

Management of the imminently suicidal requires careful judgement of the risks involved balanced against the support and care that can be provided in the community and the rights of the service user. Although admission to hospital may appear to be the safest course of action, it is not necessarily always the best.

2.2.1 The management plan

The management plan should consider the same options as those listed for the management of harm to others, following the principal of negotiating safety.

Hospital care, possibly under the *Mental Health Act*, should be considered when the suicide risk is high. Risk is highest when the person has a history of serious suicide attempts, is isolated and without support, has clear suicidal ideas and plans, is non-compliant with treatment and is under stress in the home environment.

If care other than as an in-patient is being considered, once again the same questions should be asked as for risk of harm to others. In addition there are several strategies that can make community care safer.

- Referral to the relevant crisis team;
- Ensure as a matter of urgency that the community mental health team is involved under the CPA guidelines;
- Increase the frequency of home visits and out-patient appointments;
- Work with the service user to make them feel safer, both by providing emotional support and by putting in place practical interventions;
- Agree a timetable for care and support with relatives and/or friends;
- Arrange day hospital or day care attendance on a regular basis, with rapid follow up for failure to attend;
- Liaise with the service user's GP to make sure that if antidepressants are prescribed, relatively non-toxic drugs are chosen, or they are prescribed frequently in small quantities;
- Make sure that the service user and their relatives know how to access help quickly from services, at any time of the day or night;
- Agree a contract with the service user that they will not deliberately harm themselves between appointments; and
- Ensure that other agencies working with the service user have appropriate information to be fully aware of the danger of suicide.

If the service user is to be managed in hospital, their safety must be paramount and consideration should be given to the need for the following interventions:

- What level of physical security is needed?
- What level of observation and monitoring is required?

- Should the service user be placed in locked or secure accommodation?
- Has the service user had their belongings checked for dangerous/sharp objects?
- Is there a system for ensuring that the multi-disciplinary team reviews the management plan?
- How should medication be used?
- Should the service user be formally detained in hospital if necessary?

2.2.2 Longer-term management of suicide risk

The need for longer term management of the potentially suicidal person can arise where a service user has made more than one serious suicide attempt over a lengthy period of time, possibly linked to a relapsing depressive condition, an affective psychosis or schizophrenia. It is particularly important in these situations to identify any precipitating factors, like sudden life changes and losses, changes in mood, increases in symptomatology or relapses. It may be necessary to keep in fairly close contact so that if any of these circumstances repeat themselves a further risk assessment can take place and appropriate action taken. Carers and relatives can be asked to help with this monitoring process and will need to know where to gain help quickly if a crisis arises.

Note that even where someone has made a series of attempts at self harm that do not seem intended to end in death, the risk of completed suicide still exists, and increases over time.

2.3 Management of the Risk of Severe Self-Neglect

As for risk of harm to others and risk of suicide, the principal of negotiating safety should be followed. Although self-neglect can be quite serious, it is rare that it should require compulsory admission under the *Mental Health Act*. Through the Care Programme Approach and careful liaison between community care agencies, the risk of harm from severe self-neglect can be minimised, but rarely eliminated. For service users with severe and enduring mental illness, the risk of severe self-neglect is often associated with non-compliance with medication. Therefore, having effective monitoring mechanisms in place as part of the CPA will decrease the risk of self-neglect.

For service users being managed in the community under the Care Programme Approach, the following questions should again be considered:

- Has the use of legal powers been considered (Community Treatment Order, Supervised Discharge, Guardianship or the use of section 47 of the National Assistance Act)?
- What community supports are available (e.g. family, carers, community mental health workers, care management, housing support workers etc.)?
- Do the carers and family have access to appropriate support and help?
- Have other agencies working with the service user had appropriate information so they are fully aware of the danger of self-neglect?

Have the carers (professional as well as lay) and family been adequately informed about the services needed and how they can be accessed? Are they realistic in their expectations?

