Clinical Risk Assessment and Management: Guidance for Practitioners

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Clinical Risk Assessment and Management: Guidance for Practitioners

Purpose of document:
To provide mental health practitioners (health and social care staff) with up-to-date, evidence-based, guidance on the assessment and management of clinical risk in mental health settings.

This document IS NOT a definitive or exhaustive guide or text on the assessment and management of risk. It therefore does not provide detailed or prescriptive examples relating to every possible scenario that might be encountered by staff in clinical settings. This guidance should be read and understood in the context of an individual practitioner's professional knowledge, training and experience, clinical and managerial supervision, and access to specialist advice and support. If in doubt, always seek appropriate advice via your line management or professional supervision routes.

This document goes through the various clinical risk assessment fields, in the order that they appear on the screen within RiO; this format may not appear to be the most logical way of approaching risk assessment, but this convention is adhered to because it is the way that our electronic record system requires such information is recorded. Some sections contain detailed examples to help illustrate key concepts and actions; this is not the case for every field, as there is significant overlap between the categories.

Introduction to clinical risk assessment and management

Best practice involves making decisions based on knowledge of…the individual service user and their social context, knowledge of the service user's own experience, and clinical judgement.[1]

Risk assessment is the prelude to effective risk management; it involves identifying, recording and communicating the factors or characteristics that are likely to increase or decrease the level of risk for the individual. The other fundamental aspect of risk assessment is the use of professional knowledge and skills to collate these factors and make a judgement regarding the level of risk posed by or for the service user at a given point in time. Risk assessment consists of more than simply identifying risk factors and ticking a list of those that apply; instead, it is predicated on the following fundamental principles:

[1] *Best Practice in Managing Risk* (2007) Department of Health

- The recording of a risk assessment only provides a snap-shot of identified risks *at that moment in time*. Assessing risk is a dynamic process that is affected by a wide range of different personal, interpersonal, relational, and environmental factors.
- Risk assessment, no matter how good, will not prevent or eliminate *all* untoward outcomes, but it *will* make untoward outcomes less likely.
- Effective engagement and communication with and between the service user, their carer(s), other professionals and agencies, underpins all risk assessment and management.
- Risk assessment is meaningless unless it is communicated effectively within and between teams, services, professionals, service users and carers.

1. Static or fixed risk factors:

These are factors that do not change or alter in any way; they are statements of fact – events or factors that the person or professional cannot alter – that have been shown to have a marked correlation with future untoward outcomes as a result of studying groups of people with the same characteristics. For example, static factors known to be indicative of increased risk of suicide are:

- History of self-harm
- History of violence towards others
- Seriousness of previous suicide attempts
- Previous admission to psychiatric hospital
- History of mental illness
- Family history of self-harm and suicide
- Aged over 65 years
- Male gender

It is important that our risk assessments include the recording of our sustained attempts to gather historical as well as current risk factors from the service user directly, any involved carer/s, previous health records e.g. from CAMHS, and other agencies e.g. GP, probation, police, housing.

2. Stable risk factors

These are long-term in nature and are likely to endure for many years. It is possible to intervene with these factors in order to reduce their influence on the level of risk, but such intervention/treatment is likely to be of a long-term nature. Stable factors known to be indicative of increased risk of suicide are:

- The absence of a stable relationship – eg: divorce, separation, bereavement
- Psychiatric diagnosis – all mental illness is associated with an increased risk of suicide, in particular depression; some mental illnesses are associated with symptoms such as command hallucinations which focus on harm to others
- Suicidal or self-harming thoughts or ideas – usually referred to as 'suicidal ideation' and this needs to be present in order for a person to develop suicidal intent
- Personality traits/disorder
- Perceptions of childhood adversity
- Substance use/misuse
- Aged between 16 and 35 years

3. Dynamic risk factors

These are present for an uncertain length of time and may fluctuate markedly in both duration and intensity. It is attention to these factors in the short to medium term that is required in order to respond to and manage risk effectively. Dynamic factors known to be associated with an increased risk of suicide include:

- Suicidal ideation, communication and intent
- Feelings of hopelessness
- Degree of perceived helplessness
- Active psychological symptoms, such as low self-esteem/self-worth, negative thoughts, belief that others will be "better off without me"
- Degree and extent of substance use/misuse
- Psychiatric admission and discharge – while psychiatric admission can be useful as a way of maintaining/contributing to the person's safety, the process of admission and discharge are in themselves associated with a high degree of risk
- Transitions in care – this includes major changes and alterations to the person's care or care pathway, such as the handover from one care team/service to another, change of care coordinator, any other major alteration in the way the person's care is delivered, or by whom it is delivered

- Transitions in phase of mental health difficulties – e.g. at risk/prodrome to psychosis and the early phase of recovery are known to be times of greater risk for some who experiences psychotic episodes
- Nature and degree of interpersonal stress/conflict – this will include any significant life event, as defined and understood by the service user. It could be something very obvious such as a relationship breakdown, loss of employment, or may include ongoing communication difficulties and issues within existing relationships, such as those with the person's significant other, children, parents, etc.
- Reduced ability to problem-solve – this is a key deficit and is linked to the other psychological symptoms identified above. If the person is unable to consider alternative ways of dealing with their stress that are future-orientated, then risk will be increased exponentially.

4. Future risk factors:

These can be anticipated and will result from the changing circumstances of the individual:

- Access to preferred method of suicide; this needs careful consideration, and will vary from setting to setting. For example, in an inpatient unit, environmental factors such as easy access to fixed ligature points, need to be considered. In a community setting, this may include access to medication with a high lethality, access to firearms, etc.
- Nature and extent of service and professional contact. This is linked to transitions in care, but is of prime importance in its own right; examples may include situations whereby a person does not have easy or direct access to services (eg: out-of-hours), poor inter-team/service communication, and arrangements for staff/service contact when the person's care coordinator is not available
- Future response to physical treatments (including, for example, impact of side effects of medication)
- Future response to psychosocial interventions
- Future intra and inter-personal stress

Risk Recognition

Effective risk recognition involves the use of structured professional judgement. It means that after you have identified the risk factors that apply to the individual and their situation, you weigh them up and reach a conclusion as to the likelihood of a serious or untoward outcome occurring. It is recommended that for each identified risk factor you will categorise the overall risk as either 'high', 'medium' or 'low', as described below.

In recognising risk it is necessary to identify, based on the information obtained as part of the assessment, the level of concern we have regarding risk. This categorisation of level of concern in relation to risk should be formulated and presented as:

- High risk
- Medium risk
- Low risk

Formulating our levels of concern in this way, allows us to identify the people who we are most concerned about and consequently prioritise our resources on them.

Definitions of these risk categories, and of how to identify the degree of risk posed, are provided below; these are taken from the national guidance on good practice related to risk assessment (DH, 2007).

High risk: A term used for a person who presents a risk of engaging in an act that is either planned or spontaneous, which is very likely to cause serious harm. There are few, if any, protective factors to mitigate or reduce risk. The person requires intensive, and possibly long-term, risk management, including planned and negotiated supervision and close monitoring. They will also require intensive and well organised treatment.

Medium risk: A term used for a person who has the potential to engage in serious harm but, in the most probable future scenarios, there are sufficient protective factors to moderate that risk. The individual demonstrates that they want to engage with, and at time contribute to, planned risk management strategies and may respond to treatment. This person may become 'high risk' in the absence of the protective factors identified in the risk assessment.

Low risk: A term used for a service user who may have engaged in, attempted or threatened serious harm in the past, but a repeat of such behaviour is not thought likely between now and the next scheduled risk assessment. They are likely to cooperate well and contribute helpfully to risk management planning, and they are likely to respond to treatment. In all probable future scenarios in which risk might become an issue, a sufficient number of protective factors (eg: rule-adherence, good response to

treatment, trusting relationships with staff, etc.) to support ongoing desistance from harmful behaviour can be identified.

You cannot develop a meaningful and person-centred risk management plan unless you have recognised risk, and then make a professional judgement regarding how to manage the risks. Sticking with suicide risk as an example, there are three broad categories of self-harming behaviour, and your risk management plan will be based on identifying which of the following motivations apply to the service user in question:

1. Motivated by the aim of managing/controlling overwhelming feelings and emotions.
2. Motivated by a transient or short-lived desire to end their life – for this group of people there is often a significant degree of ambivalence at the time of their actions regarding the desire to live or die, and such ambivalent thought may present before, during and after an episode of self-harm.
3. Motivated to end their life.

Remember, these are not definitive categories, and some people may not fit neatly into one or the other, but you will need to identify interventions in your management plan that take account of the most likely motivations for the person concerned.
Assessing and recognising risk in people with learning disability can be difficult. Verbal communication of thoughts and feelings may be limited. Other means of communication can be used to support assessments and gather information, such as using simple sentences supported with pictures to aid understanding.

Risk management

Your risk management plan will be based on the information obtained during the risk assessment stage, and further informed by your recognition of the risks. **The plan to manage the identified risks must be documented in the CARE PLANNING section of RiO**. For each identified clinical risk you must ensure that they are addressed by a corresponding risk management interventions/actions. Below is an example of three different types of risk for one service user, which have been identified as part of the risk assessment, and have now been assigned a series of risk management interventions. You should record your risk management interventions in this format within the Care Planning section of RiO..

Problem/Need Text	Intervention/Actions and Frequency	Anticipated Outcome and Client's View	Authorised by	Main person(s) responsible	Planned/Actual Start Date,	Actual End Date
Mr X has frequently expressed specific plans to end his own life by deliberately causing a collision when driving his car.	1. Communicate our concern to Mr X regarding his risk to himself. 2. Seek his consent and agreement not to drive whilst he retains specific suicidal plans. 3. Seek his cooperation to give his car keys to his son, so that he is unable to act on any impulse to drive. 4. Reassess his mood and suicidality at each contact, and amend this aspect of his care plan accordingly. 5. Mr X's son is aware of the risk issues, and has agreed to contact his care coordinator regarding any significant changes to his mental state.	Mr X is currently appreciative of staff input from the Recovery service and is considered to have been very open and honest regarding his risk factors. Mr X's engagement with the Recovery service and his son is expected to contribute significantly to him keeping himself safe and to not actually act on his plan to cause a collision.	Authorisation not required	SPECIFY OTHER IN INTERVENTION /ACTION		

Problem/Need Text	Intervention/Actions and Frequency	Anticipated Outcome and Client's View	Authorised by	Main person(s) responsible	Planned/Actual Start Date,	Actual End Date
	6. Staff from Local Authority Home Care are aware of these risks and are monitoring Mr X's mental state when they visit and will liaise with his care coordinator and his son as required.*					
Mr X has fallen on two occasions and remains unsteady on his feet.	[follow principles as in the above example]					
Mr X is at risk of financial exploitation, as his daughter has been convicted of fraudulently obtaining money from his state pension.	[follow principles as in the above example]					

*Other parts of the care plan will address Mr X's mental health treatment needs, which are also aimed at reducing risk, they would not have to be repeated here.

The "Crisis, Relapse and Contingency Plan" within RiO can be used to include risk management, but this should always be developed subsequent to the main risk management plan/s within the care planning section. The "Crisis, Relapse and Contingency Plan" contains the following headings and these should be populated accordingly:

- Crisis plan
- Who will be caring for any dependent children
- Relapse Indicators/warning signs
- Contingency plan

The 'Crisis plan' should focus on self management and social network support to prevent relapse, at the point when the first early warning signs are noticed.

The 'Contingency plan' is for if the crisis plan does not manage to avoid a full relapse. It should focus more on what AWP services input will be.

Where a "Crisis, Relapse and Contingency Plan" exists, you must make a note in the risk management plan that it exists.

Effective and appropriate risk management is underpinned by the following key principles:

- Assess risk – see above
- Recognise risk – see above
- Risk management is not concerned with eliminating all risks – there is no such thing as a completely risk free culture, environment or setting
- Risk management is a collaborative process between the service (professionals) and the service user and their carer(s)
- Good risk management is dependent upon good communication
- Good risk management is dependent upon meaningful engagement between the service and the service user and their carer(s)

- Positive risk-taking will be a legitimate part of some risk management plans, and will involve weighing-up the relative likelihood of an untoward event occurring in a particular situation or setting, in order to avoid care becoming unnecessarily restrictive
- Risk management plans and actions are reviewed and evaluated in light of feedback, additional information and changes in circumstances, as part of a dynamic risk assessment and risk recognition process
- Identify those factors that are amenable to intervention/action – remember, some factors are 'static', and cannot be changed or managed
- Develop a plan or plans to address each area of risk identified – do this with the service user and carer(s). The degree of active participation in the process by any of the above will be influenced by a number of factors, including the person's mental state, the impact of psychiatric symptoms on their ability to communicate or be actively involved, the environment and setting. For example, the role of both the service user and carer will be different in an inpatient setting, as opposed to their own home
- Address areas of risk/risk factors explicitly with service users and carers, using jargon-free language. For example, work with them to consider situations, settings or events that may make them consider self-harm/suicide, and then identify and agree ways in which they can respond to, or cope with, the risk of this happening
- Remember high risk situations and specifically tailor management plans to address these – for example, in the phase immediately following discharge from hospital – how will the person access help, who will respond, how will the professional/service be contacted and by whom?
- For each identified risk, in the relevant free-text box, note the factors that are likely to increase or decrease the risk
- Identify the service user's strengths and encourage them to identify situations and circumstances where they can actively participate in helping to manage their risks. This demonstrates understanding on the part of the professional/service and encourages a sense of personal control and responsibility
- Record and document your plan
- Share your plan (within the limits of confidentiality) with all those who need to know, and all those who play a part in the ongoing management of risk for this person.

Recording risk assessment information on RiO

Clinical risk assessment is accessed on RiO by clicking "Risk Information" on the "Case Record" screen. Clicking "Risk Information" offers "Risk Assessment", which is dealt with in this guidance. This section of RiO may be more accurately called a "Risk Summary"

rather than a “Risk Assessment” because it records a summary of all the risk information and cannot encompass all of the risk assessment. However, “Risk Assessment” is the wording currently used within RiO.

There is also “HCR-20”, which is used by our Secure services, three different “Safeguarding Children” sections which are not covered by this guidance. The “Risk Incidents” field in RiO is the place where you should record risk incidents that have not already been recorded and access historical risk incidents.

Attention is drawn specifically to the following domains:

- Risk incidents – in order to ensure that risk incidents are recorded appropriately, you should record this as a progress note, and before saving this entry, check the tick box that says “Add to Risk History” at the bottom left hand of the screen. This will then automatically populate the “Risk History Incidents” section
- Any risk history entries should specify when the incident took place, how the incident came to light (if not directly observed by you), who reported it, any antecedents, the behaviour observed during the incident (if known), and the outcome or consequences of this event.

“Risk Assessment” is separated into different headings which are dealt with here in the order that they appear on the RiO screens. The “Risk Screen” in RiO must have all of the risk screening questions answered.

- The term “In last 6 months” refers to the 6 months immediately preceding the current assessment.
- The term, “Ever” refers to you needing to consider whether the particular risk or event has ever applied to, or affected the individual. This specifically excludes the last 6 months.

You should use your professional discretion whether to edit the current Risk Assessment, or begin a new one; there may be occasions when it is entirely appropriate to start a new risk assessment record, for example, when a service user has a large number of historical risk assessments, making them difficult to navigate. In such a situation, it may be more appropriate to consolidate the risk assessment and add any new risk information to a new risk assessment record.

The risk assessment record should be updated at every significant event, and at every CPA review. Any Risk Assessment or risk management care plan addition or update that is recorded on RiO by someone who is not the Care Co-ordinator, must be followed up with notification of this action, to the Care Co-ordinator.

1 Harm to self

RiO heading	Guidance	Links to
Act with suicidal intent	It is important to differentiate between *suicidal ideation* and *suicidal intent*. The following is a definition of the terms associated with suicidal behaviour: *Suicidal ideation:* This refers to suicidal thoughts, which may or may not be accompanied by suicidal intent. Suicidal thoughts are very common in people with a range of mental health problems, in particular depression – eg: the person who believes that they will be better off dead, but have no plans to act on this thought. *Suicidal intent*: May follow on from suicidal ideation, in that the person has plans or intentions to act on their suicidal thoughts. These may be *passive* or *active* intentions; *passive* = e.g.: visualising or fantasising about walking in front of a vehicle, but with no concrete plan associated with it; *active* = e.g.: specific plans to leave the building at the next opportunity and walk into oncoming traffic. *Suicide attempt:* This may follow on from active suicidal intent, when the person physically attempts to end their life – eg: jumping off the roof of a building with the intention to die, but surviving. When assessing risk in relation to the potential to act with suicidal intent you are assessing the risks associated with both future self-harm and attempted suicide. There is a complex relationship between self-harm and suicide; not all self-harming actions/behaviour are motivated by the person wanting to end their life. However, self-harm is a predictive risk factor for future suicide; this can simply be because the person is engaging in risky behaviours, such as injuring themselves physically, which in turn means that they are more likely to die as a result. However, for some people, self-harming behaviour can be an attempt to deliberately end their life. If a person has previously acted with suicidal intent, then there is	AWP Missing Persons & Absent Without Leave Procedure CLI_EMT_08 AWP Nurse in Charge Procedure CLI_EMT_10 AWP Seclusion Procedure CLI_EMT_09 Best Practice in Managing Risk (2007) DH Providing guidance to families to help them to support a person who may be suicidal RCN Mental Health Nursing of Adults with Learning Disabilities.pdf

RiO heading	Guidance	Links to
	a much greater risk of eventual suicide. When recording this, note the following: • Frequency and dates of previous suicidal behaviour • Intent at the time – eg: did they plan to harm themselves (ie: the intention was not to end their life), but misjudged or miscalculated, resulting in near fatality? • What changed in their life as a result of their previous actions • Attitude to surviving the previous attempt(s) When assessing risk of acting with suicidal intent in a person with a learning disability it is important to remember that although suicide attempts are less frequent in this group of people when compared with the general population, this risk should not be disregarded. A suicide attempt (ie: deliberate action to end life), may be misinterpreted as self-harming behaviour, because the person with a learning disability may not possess the knowledge or ability to complete suicide successfully. . A person with a learning disability may have different levels of expressive and receptive communication, and therefore may understand more or less than they appear to from their verbal skills. It is essential to fully check their understanding of the questions asked during assessment. **How will you assess and quantify any identified risks?** Please refer to the four risk headings, above – ie: fixed factors, stable factors, etc. You will need to make a judgement regarding the relative weight or importance you attach to each factor when making your risk management plan. Remember, the importance of these factors can change over time, and may vary from episode to episode. **How will you construct a risk management plan?**	

RiO heading	Guidance	Links to
	The aim of a risk management plan is to reduce or minimise the potential impact of the identified risk factors, thereby reducing the overall risk of suicide. In drawing up your risk management plan, focus on practical interventions or steps linked to each identified risk factor. For example: ***Risk factor:*** Access to potentially lethal means of suicide by driving ***Intervention:*** • Advised not to drive – seek the person's cooperation and appreciation of the need not to drive. • Agreed with his partner that she will take responsibility for looking after the car keys.	
Self-injury or harm	There is a complex relationship between self-harm and suicide; not all self-harming actions/behaviour are motivated by the person wanting to end their life. However, you will need to differentiate between an episode of self-harm motivated by the desire to end life, as opposed to the person who may use cutting themselves as a means of coping with inter-personal difficulties. For the remainder of this section, we are therefore referring to situations when the person injures themselves without intending to end their life. There are numerous possible reasons why a person may engage in self-harm/injury, when not motivated by suicide. Some of the most common reasons include the following: • Coping with the internal distress caused by difficult personal relationships • A dysfunctional means of communicating and dealing with emotions and feelings - sometimes referred to as "a cry for help" • A way of relieving tensions – paradoxically this can, in some cases, be an alternative to committing suicide, and some individuals describe how being able to exercise a choice	

RiO heading	Guidance	Links to
	over whether to self-harm, is a way of 'staying safe' and of managing suicidal thoughts. However, it must be remembered, that whatever the underlying motivations, engaging in self-harming behaviours increases overall risk of disability and death. • A form of help-seeking behaviour • A form of challenging behaviour in someone with learning disabilities. **How will you assess and quantify any identified risks?** You will need to re-assess the person's motivations for self-injury regularly. Remember, people who regularly self-harm, may also be at risk of developing other risk characteristics such as becoming severely clinically depressed, so they may become a suicide risk at some point in the future. Therefore, If you identify any additional risks, you should refer to the guidance above. **How will you construct a risk management plan?** The aim of a risk management plan is to reduce or minimise the potential consequences of the identified risk factors, thereby reducing the negative impacts of the self-harming behaviour (which may be physical and psychological). For example: ***Risk factor:*** Repeatedly cutting left forearm with a razor blade. ***Intervention:*** • Provide health promotion information on the risks associated with self-injury • Assist the person to identify the triggers and precipitants to self-harm • Identify with them alternatives to self-harm as a way of communicating	
Suicidal ideation	Suicidal ideation is the term used when thoughts of suicide are present. Many people with mental health problems are likely to consider suicide during the course of their illness, but	

RiO heading	Guidance	Links to
	only a few of them will act on these thoughts. Suicidal ideas may not always be accompanied by suicidal intent – *passive* thoughts of death, where the person visualises or fantasises about being dead, are very common, particularly in individuals who are depressed. As identified in the section 'Act with suicidal intent', if *active* thoughts of death and dying are present, these will be accompanied by suicidal intentions, whereby there is a degree of consideration, or planning, to end life. **How will you assess and quantify any identified risks?** It is important to assess the following: • Nature of the suicidal ideation – ie: is it passive, or active. • Length of time such thoughts have been present – eg: suicidal ideas can have been present for years, months, weeks, days, or hours. • Likelihood that the person will act on their suicidal ideas – ie: is there a risk that such thoughts will progress into suicidal intentions. • The specificity of any active suicidal ideas – eg: how specific is the person about their intention to end their life; weigh-up and evaluate variables such as their access to their identified means, the presence of other people to observe them, the degree of engagement or cooperation with treatment and care that the person is displaying. • Frequency of suicidal thoughts, and how able the person has been at resisting these, so that they do not act on them. **How will you construct a management plan?**	

RiO heading	Guidance	Links to
	The aim of a risk management plan is to reduce or minimise the potential impact of the identified risk factors, thereby reducing the overall risk of suicide. In drawing up your risk management plan, focus on practical interventions or steps linked to each identified risk factor. For example: ***Risk factor:*** 1. Intrusive thoughts of wanting to be dead and imagining not waking up the next day (passive suicidal ideation). 2. Repetitive thoughts of driving into oncoming traffic, and finding it hard to resist this each time he drives his car (active suicidal ideation, leading to suicidal intent). ***Interventions:*** 1a) Encourage the person to verbalise and express their thoughts in a safe and non-judgemental atmosphere, as this will help to reduce the likelihood of developing active suicidal thoughts. 1b) Assist the person to re-frame and re-consider negative thoughts in the context of evidence that challenges their assertion that they would be better off dead. 2a) Encourage the person to verbalise and express their thoughts in a safe and non-judgemental atmosphere, as this will reduce the likelihood of engaging in these actions. 2b) Advise the person not to drive and seek their cooperation and consent to share with others their current pre-occupations and level of risk.	
Self-	Many of our service users will have a significant level of vulnerability, directly influenced by	AWP Clinical Procedures

RiO heading	Guidance	Links to
neglect	their mental state and psychological symptoms. Particular groups of people who may be at increased risk of self-neglect include those affected by the following: • Dementia • Severe depression • Delirium – including that caused by alcohol and illicit substance withdrawal • Psychosis Things that may indicate self-neglect include: • Excessive smoking, alcohol use, and illicit drug use. • Lack of attention to usual activities of daily living – eg: lack of mobility, not eating and drinking, reduced attention to usual standards of personal hygiene. • Not ensuring adequate heating and lighting. • Significant reduction in usual self-care, eg: being unable to avoid exploitation by others. **How will you assess and quantify any identified risks?** In assessing and quantifying this type of risk, it is important to remember that in most situations the information will need to be gathered over an extended period of time, and from a number of different sources. For example, assessment in the context of the person's usual	Package Marsden Manual of Nursing Procedures

RiO heading	Guidance	Links to
	home environment and behaviour – eg: physical setting, person's state of dress, physical health, etc.; collateral information from other sources - eg: carer, family member, partner, GP, etc.; historical context – eg: length of time problems have been present, and whether the apparent self-neglect has followed closely the trajectory of the person's mental health problems. It is also important to assess the extent to which the person has awareness of their self neglect, and insight into any motivation for it. In some cases, self-neglect will be a direct consequence of the person's underlying mental illness, eg: the person with an eating disorder who will not eat because they believe that they are grossly overweight, or the person who has a psychotic illness and believes that their tap water has been poisoned, and will not drink. **How will you construct a management plan?** The aim of a risk management plan is to reduce or minimise the potential impact of the identified risk factors, thereby reducing the overall risk of harm from self-neglect. In drawing up your risk management plan, focus on practical interventions or steps linked to each identified risk factor. For example: ***Risk factor:*** Poor diet and fluid intake due to low mood. ***Interventions:*** • Assess the person's weight, including BMI, height, usual eating and drinking patterns, extent to which current deterioration in mental state has impacted on usual behaviour, likes and dislikes, ability to manage self-care, such as shopping, cooking, preparing food, etc. Subsequent interventions may include: arranging home care/support, liaise with	

RiO heading	Guidance	Links to
	carer/family members and enlist their support if appropriate. • Identify underlying motivational factors linked to poor diet and fluid intake – for example, lack of knowledge, poor access to food/drink, disordered thoughts about food and/or self (such as believing that they do not deserve to eat), physical retardation due to low mood, etc. Subsequent interventions may include: provide information and resources about food, encourage the person to eat and drink within limits.	

2 Harm from others

RiO Heading	Guidance	Links to
Risk of neglect	Many of our service users will have a significant level of vulnerability. Neglect includes acts of omission and commission. Things to consider are medical or physical care needs being ignored, failure to provide access to appropriate health, social care or educational services, withholding of the necessities of life, such as medication, adequate nutrition and heating. During assessments, speaking with the service user alone and speaking with any identified carer/s separately for part of the assessment will provide the greatest opportunity for discovering neglect. It is also important to ensure that communication takes place with other agencies involved in the person's care, for example, social services, probation, etc. Current risk and past neglect should be recorded separately. People with learning disabilities may be particularly vulnerable to harm from others. **How will you assess and quantify any identified risks?** Wherever possible, open, enquiring questions should be used instead of closed questions which elicit 'yes' or 'no' answers, such as when asking about medication use or physical health you could ask: • "How do you manage your medication?" • "What help do you get from anyone in managing your medication?"	Safeguarding vulnerable adults AWP Policy to safeguard adults at risk Safeguarding children AWP Policy to Safeguard Children Safeguarding on Ourspace Email Public Protection & Safeguarding Team – ppsg@awp.nhs.uk Multi-Agency Public Protection Arrangements (MAPPA)

	Observation of the environment when the assessment is at the person's home and interactions with the carer/s may give as much information as the answers to your questions and conversation. Remember, neglect most often occurs with people who are known to the individual. If risk is identified, the member of staff should try to remain calm and not convey shock or disbelief, but instead demonstrate concern that what is being reported has happened. Observation when assessing risk of harm from others including neglect is key in assessing risk in people with a learning disability, as verbal communication may be difficult. **How will you construct a management plan?** The person's care plan should be used to record how the risk/s will be managed. Additionally, where a member of staff discovers alleged abuse and/or neglect, they must contact/refer under the local multi-agency safeguarding adult procedures, and seek advice on any actions needed, such as reporting to the police where a crime may have taken place, and not contacting the alleged abuser until there is an agreed safeguarding strategy in place. ***Risk factor:*** Evidence of suspected significant physical and emotional neglect. ***Interventions:*** • Ensure the person's immediate safety – this may, in some cases, necessitate immediate contact with other agencies, such as police and social services. Remember, consider the safety of the individual as well as yourself.	

	• Seek advice from designated AWP public protection and safeguarding professionals, as soon as practically possible. • Record observations and concerns identified. • Reassure the person by explaining that the processes to be followed will aim to ensure their safety and welfare, encourage them to ask questions, identify any additional emotional support needs, etc. • Consider referral to advocacy support service • Liaise with other formal and informal carers. .	
Risk of sexual exploitation	Refer to detailed guidance in "Risk of neglect" section, above. Sexual exploitation may include rape, sexual assault, sexual acts carried out without the consent of the individual, or where the individual was pressured into consenting to something that they did not want to do. Practitioners should remain aware that sexual exploitation may be perpetrated by a younger person against an older person.	See links above
Risk of emotional /psychological abuse, including bullying	Refer to detailed guidance in "Risk of neglect" section, above. This may include emotional abuse, threats of harm or abandonment, deprivation of contact with significant others. The following behaviours can also be forms of emotional and psychological abuse: humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation, or withdrawal from services or supportive networks. Abuse can be a single act or repeated acts. Abuse is a violation of an individual's human and civil rights by any other person or persons (DH/Home Office, 2000).	See links above
Risk of unlawful restrictions (e.g. locks	Refer to detailed guidance in "Risk of neglect" section, above. An assessment in the home environment is likely, though not always, to provide more specific information regarding this type of risk, when compared to an assessment away from the home. Any risk of harm from others, that has	See links above

on doors, physical restraints, etc.)	already been identified, will inform you whether or not you will need to obtain more specific information about this type of risk. As well as an intention to actually cause harm to the individual, service users may also be at risk in this respect if carer/s are concerned about them wandering and/or coming to harm.	
Risk of physical harm	Refer to detailed guidance in “Risk of neglect” section, above. This may include behaviours from others such as hitting, slapping, pushing, kicking, spitting, misuse of medication, and inappropriate or excessive restraint. Any visible marks should be asked about in a sensitive and supportive manner, in order to elicit their cause. For example, some people may have an underlying medical condition which causes them to bruise or mark easily.	See links above
Risk of financial abuse	Refer to detailed guidance in “Risk of neglect” section, above. Financial or material abuse includes theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.	See links above
Risk caused by medication /services /treatment	Refer to detailed guidance in “Risk of neglect” section, above. This would most often be identified by the service user and/or carer/s themselves, but may need staff to identify possible risk especially where they have specific concerns or knowledge about this. Staff caring for individuals are in a position of authority in relation to users of the services they provide, therefore practitioners should always aim to provided care in a way that recognises this, and is delivered in a way that encourages the independence and well-being of service users. Always record any specific risks identified.	See links above

3 Harm to others (Secure services within the Specialised & Secure SBU will use HCR-20)		
RiO Heading	Guidance Below is a list of risk characteristics that are associated with an increased risk of harm to others by people with mental health problems; these are taken from the national guidance contained in *Best Practice in Managing Risk* (DH, 2007). **(General) Risk factors for violence** **Demographic factors** • Male • Young age • Socially disadvantaged neighbourhoods • Lack of social support • Employment problems • Criminal peer group **Background history** • Childhood maltreatment • History of violence – either victim or perpetrator • First violent at a young age • History of childhood conduct disorder • History of non-violent criminality **Clinical history** • Psychopathy • Substance abuse • Personality disorder • Schizophrenia • Difficulty dealing with new or novel situations and events – eg: responding aggressively to situations with which the person is unfamiliar (also referred to	AWP Health and Safety Policy for Lone Working Safeguarding vulnerable adults AWP Policy to safeguard adults at risk Safeguarding children AWP Policy to Safeguard Children Safeguarding on Ourspace Email Public Protection & Safeguarding Team – ppsg@awp.nhs.uk Multi-Agency Public Protection Arrangements (MAPPA)

	as 'Executive Dysfunction') • Non-compliance with treatment **Psychological and psychosocial factors** • Excessive or inappropriate anger • Inappropriate impulsivity • Excessive or inappropriate suspiciousness • Morbid jealousy • Criminal/violent attitudes • Command hallucinations • Lack of insight **Current 'context'** • Threats of violence • Interpersonal discord/instability • Availability of weapons Risk of harm to others in people with a learning disability can be associated with mental health problems; however it can also be associated with 'challenging behaviour'. Whilst the relationship between the two is complex, it is important to consider mental health problems in their own right, and not simply attribute the behaviour to the person's learning disability.	The Mansell Report
Sexual assault (including touching/exposure)	Sexual violence is defined as: Actual, attempted or threatened harm to another person that is deliberate and non-consenting and is sexually motivated.	Email Public Protection & Safeguarding Team – ppsg@awp.nhs.uk Multi-Agency Public Protection Arrangements (MAPPA)
Violence/aggre	Some mental health problems are associated with a potential increased risk of	AWP Health and Safety Policy

ssion/abuse to family	violent and aggressive behaviour towards others. In some instances, a person may be referred to, or come to the attention of mental health services because of a specific incidence of violent behaviour; such occurrences may be as a direct result of the symptoms of a mental illness, such as the person responding to violent command hallucinations, or linked to a complex delusional belief system. One of the most important aspects of risk assessment is linking the person's history of violence/aggression, with their current presentation. **How will you assess and quantify any identified risks?** Questioning and observation of the person should be based on the individual's history and the circumstances leading up to referral or contact with mental health services – eg: identify any triggers or precipitants to a specific violent incident, ask questions that are likely to elicit information about the person's reasoning and motivations for behaving aggressively. It is important to obtain as much information as possible about any particular risks to specific individuals (either known or not personally known to the service user). Wherever possible, obtain as much collateral information from other sources – eg: family, friends, other agencies (in particular police and/or probation service) – as a way of ensuring that suspected risks to others are as detailed and accurate as possible. Any previous violent incidents need to have the specific context and details recorded. **How will you construct a management plan?** The aim of a risk management plan is to reduce or minimise the potential impact of the identified risk factors, thereby reducing the overall risk of violence and aggression. In drawing up your risk management plan, focus on practical	for Lone Working Safeguarding vulnerable adults AWP Policy to safeguard adults at risk Safeguarding children AWP Policy to Safeguard Children Safeguarding on Ourspace Email Public Protection & Safeguarding Team – ppsg@awp.nhs.uk Multi-Agency Public Protection Arrangements (MAPPA) AWP Confidentiality and Information-Sharing with Families and Carers AWP Using, Sharing and Recording Information Protocol for Joint Working

	interventions or steps linked to each identified risk factor. Normally the Care Co-ordinator, but any nominated practitioner who becomes aware of the risk factor, should ensure that a multi professional discussion and review occurs as soon as practically possible. This ensures that a considered decision can be made regarding the responses to the identified risk/s. However, in an emergency situation, take all reasonable precautions to ensure the safety of yourself, your colleagues and others. ***Example risk factor:*** The service user makes repeated statements of wanting to harm a named individual who is known to them. ***Interventions:*** • Discuss with the service user the specifics of the risk – ie: any planned intent, their access to the person including where they live, access to any stated means of how they would harm the other person, their motivation for the threat. • Treat any frank psychiatric symptom that may be directly contributing to the person's statements, e.g. delusional beliefs, command hallucinations. • Seek advice from designated AWP public protection and safeguarding professionals, as soon as practically possible. This will include taking action to ensure the safety of the identified victim/s - ie: inform them of current risk and speaking to the service user about the limits of confidentiality and the need to share information with other agencies regarding this risk. • Record observations and concerns identified and inform relevant managers/senior practitioners as appropriate. • Consider the appropriate degree of involvement of carer/s in the delivery of care – eg: positive reporting to professionals if the service user's mental	Across Adult Mental Health and Children's Services

	state deteriorates.	
Violence/aggression/abuse to other clients	Refer to detailed guidance in “Violence/aggression/abuse to family” section, above.	
Arson	Refer to detailed guidance in “Violence/aggression/abuse to family” section, above.	
Hostage taking	Refer to detailed guidance in “Violence/aggression/abuse to family” section, above.	AWP Guidance for Hostage Situations
Weapons	Refer to detailed guidance in “Violence/aggression/abuse to family” section, above.	
Risk to children	Refer to detailed guidance in “Violence/aggression/abuse to family” section, above. If risk noted then separate RiO screen to be completed.	Safeguarding children
Violence/aggression/abuse to staff	Refer to detailed guidance in “Violence/aggression/abuse to family” section, above.	
Violence/aggression/abuse to general public	Refer to detailed guidance in “Violence/aggression/abuse to family” section, above.	
Exploitation of others (e.g. financial, emotional)	Refer to detailed guidance in “Violence/aggression/abuse to family” section, above.	Safeguarding vulnerable adults

Stalking	Refer to detailed guidance in “Violence/aggression/abuse to family” section, above. Assess the risk history of both the specific act of stalking and also any other aspect of predatory abuse behaviour.	
Risk to vulnerable adults	Refer to detailed guidance in “Violence/aggression/abuse to family” section, above.	Safeguarding vulnerable adults
4 Accidents		
Falls	Refer to relevant guidance and specific risk screening and assessment checklists via Our Space.	AWP Policy for the Prevention and Management of Falls and Falls from a Height AWP Risk Control Checklist for Slips, Trips, Falls and Falls from a Height
Accidental harm outside the home (e.g. wandering)	Refer to relevant guidance and specific risk screening and assessment checklists via Our Space.	AWP Wandering Risk Assessment Chart
Unsafe use of medication	This may include a range of behaviours, including accidental overdose of medication caused by some form of physical and/or sensory impairment.	AWP Hints and tips about the practical aspects of using medication
Other accidental harm at home	This will be person and context-specific, and could relate to a range of different types of incident – examples may include: accidental fire caused by smoking, hypothermia, etc.	
Driving/Road	Some mental health problems can render an individual unfit to drive, and the	DVLA At a glance Guide to the

safety	DLVA provide detailed advice on this issue through the document 'At a glance Guide to the current Medical Standards of Fitness to Drive'.	Current Medical Standards of Fitness to Drive
5 Other Risk Behaviours		
Incidents involving the police	This should include any incidents that have involved the police and may be relevant to any clinical risk.	
Correspondence	Anything related to clinical risk in relation to letter writing such as a threatening letter to an individual or a disinhibited letter to a publication etc.	
Phone calls	Any clinical risk related behaviour (similar to correspondence above).	
Restricted client	Has the person ever been subject to S37 or S41 of the MHA?	Mental Health Act guidance
MAPPA	Has the person been under MAPPA or has this been considered?	Multi-Agency Public Protection Arrangements (MAPPA) Email Public Protection & Safeguarding Team – ppsg@awp.nhs.uk
Schedule 1	Has the person been a Schedule 1 offender under the Children and Young Peoples Act 1933. The offences range from murder and child abuse to any offence causing bodily injury to a child. (offence against a child or person under the age of 18 years). The term Schedule 1 under this act is no longer used . Full details of the current position are outlined in Home Office Circular 16/2005 "Guidance on offences against Children" . This also contains the	AWP Policy to Safeguard Children Safeguarding on Ourspace Email Public Protection &

	revised list of offences against children currently on statute. Term currently in use is " Risk to Children".	Safeguarding Team – ppsg@awp.nhs.uk
Visitors	Consider whether visitors pose any risks to service users or staff. In community settings, consider whether any potential risks are posed by or to visitors in a person's home.	AWP Security Policy and any service/team visitor's procedures. Refer to Mental Health Act Code of Practice Chapter 19 - AWP Procedure for Children Visiting Adult Mental Health Inpatient Facilities AWP Policy to Safeguard Children Safeguarding on Ourspace Email Public Protection & Safeguarding Team – ppsg@awp.nhs.uk
Sex Offenders Act 2003	The Sexual Offences Act 2003 came into force on 1 May 2004. It repealed almost all of the existing statute law in relation to sexual offences. The purpose of the Act was to strengthen and modernise the law on sexual offences, whilst improving preventative measures and the protection of individuals from sexual offenders.	Multi-Agency Public Protection Arrangements (MAPPA) Email Public Protection & Safeguarding Team – ppsg@awp.nhs.uk

TILT high risk	This refers to the TILT Report (Tilt et al 2000) which reviewed security in High Secure Hospitals – this element is an assessment of an individual's dangerousness to others. This will generally not be applicable in AWP except in some Specialised and Secure services.	
Probation Service involvement	If service users are currently subject to any form of probation order or license conditions, record what type of order they are on, the expiry date, and any specific conditions that are attached. Also record the name and contact details of the probation officer in charge of the case, as you may need to invite them to CPA meetings, etc. This is particularly relevant if the service user is subject to an order with a mental health treatment requirement. Check the nature of the offending if violent, sexual or other offences with high risk issues attached then consider asking if service user is currently under MAPPA or if this is required .	Caldicott Guardian Information Governance Multi-Agency Public Protection Arrangements (MAPPA) Email Public Protection & Safeguarding Team – ppsg@awp.nhs.uk
Damage to property	Record details of any known damage to property.	
Theft	Record details of any known theft, if this is relevant and appropriate.	
6 Factors Affecting Risk		
RiO Heading	**Guidance**	**Links to**
Substance	Risk will nearly always be increased in individuals when under the influence	AWP Dual Diagnosis Strategy -

misuse (e.g. alcohol/drug abuse)	of alcohol and/or other drugs. There is a requirement to assess and record all substance misuse. Ask about use and then specifically focus on how use affects specific risks as identified in the sections above. The risk management plan needs to consider specific interventions for managing risk when the person is intoxicated. This may necessitate liaison with other services such as the Emergency Department, primary care services, etc.	Co-existing Mental Health and Alcohol and Drug Use Problems
Risk of losing essential services	Such as electricity or gas due to non payment of bills or water due to a burst pipe.	
Major life event	These are significant factors and frequently precipitate urgent presentations or requests for help. There may be any number of different life events, but common ones will include the following; loss or separation of a loved one (bereavement), loss of job or major role, moving home, major changes to the person's treatment or care plan, transition between services etc. There will be a wide range of response from individuals concerning different life events, and the impact of these events should be considered on an individual basis.	
Current mental state	Consider this specifically in relation to how it affects the risks already identified. It may be helpful to write the risk management plan specifying different actions depending on different specific mental states that the service user is known to present with. For example, lowered mood, marked thought disorder, command hallucinations, and altered mental state secondary to acute intoxication or delirium.	
Client would be able to summon help	Would they summon help or not? What might reasonably happen to prevent their attempts? How might summoning or not summoning affect the risks identified above? For example, whether or not the service user has called staff before when their suicidal intent has been high - this should be included	

	in the risk assessment and management plan. Practical issues may include whether they have credit on their mobile 'phone.	
Refusal of services	How might refusal of services affect the risks identified above? This could be a refusal to see anyone from mental health services or reluctant cooperation and perhaps refusal of a specific aspect of the care plan that staff recommend. This can often cause conflict and anxiety amongst professionals and the service user and their relatives.	
Discontinuation of medication	How might discontinuation of medication affect the risks identified above? Not taking medication can have a direct impact on someone's mental state and consequent clinical risk. Unplanned cessation of medication should prompt a care planning review, especially when medication is being used to maintain a stable mental state e.g. individuals with psychosis.	AWP Medicines Policy
Housing status	What is their current and near future housing status? How might this affect the risks identified above?	
Client is unaware of risk	Is the Client unaware of risk? If so, then to what extent? How might this affect the risks identified above? Consider also the extent to which the service user recognises and agrees with any risks identified as part of the assessment process. In some instances, some individuals may be aware that their behaviour or situation is risky, but are unwilling to engage with strategies to mitigate or reduce this.	
Client's care network is unaware of risk	Are individuals in the Client's care network unaware of risk? If so, then to what extent? How might this affect the risks identified above? The person's carer/s needs to be actively involved in both the risk assessment and risk management processes, although the degree to which they are willing or able	AWP Confidentiality and Information-Sharing with Families and Carers

	to be involved will vary from person to person. Expressions of concern from carers regarding the level of risk posed by the individual should always be listened to, and taken seriously by staff. Consider also the role of the person's identified carer in delivering the risk management plan – e.g.: positive reporting of any deterioration in the person's mental state, feedback to staff regarding their behaviour and responses to situations when staff are not present. In some situations the service user may request that they do not want their carer to be informed of specific details regarding their treatment and care; this can cause difficulties for staff when trying to balance the need to respect the service user's wishes, whilst also recognising the carer's needs and their role in the risk assessment and management process. Respecting client confidentiality should never prevent staff from listening to the carer's concerns and acting on specific information to reduce or manage risk.	AWP Using, Sharing and Recording Information Protocol for Joint Working Across Adult Mental Health and Children's Services Providing guidance to families to help them to support a person who may be suicidal
	7 Summary	
	This involves summarising the risk factors you have identified in your assessment, and these will form the basis of your risk management plan, as documented in the care plan section. This summary will include a list of all the risk characteristics that have been identified for this person, alongside a numerical list of the care plans where each of these risks are addressed (i.e. interventions). Example; Risk of further overdose of medication – addressed in care plan number 1. Identified risks generally increased when Care Co-ordinator is on leave –	RiO Care planning help guides

	addressed in care plan number 2 The risk management plan should then specifically address each identified risk factor with clear, unambiguous interventions aimed at reducing the identified risks.	