Positive Risk-Taking

Practical ways of working with risk

“Whose risk is it anyway?”

Southern Health NHS Trust
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### Whose risk are we working with?

Primarily these guidelines are about working with the person (service user or patient), but we have to be particularly mindful of risks understood and experienced by relatives and other carers. The safety of staff within the Trust and those of other agencies is vitally important, as good practice is less likely to happen when staff feel at risk, for whatever reasons. Finally, we should not underestimate the importance of considering risks to the wider public when this is a specific issue, and to the organisation in the very rare event that negligent practice emerges... but good practice is not consistent with a ‘cover-your-back’ approach.

These guidelines are a resource to inform good practice. They are an update of previous Trust Guidance (November 2009), and have been informed by a wide consultation with staff and some service users through a *Practice Based Evidence* initiative across the Trust between November 2010 and July 2011.
Introduction: What do the best practitioners do?

Good or best practice is something all practitioners should reasonably aspire to achieve when working in health and social care services, including when working with risk. In order to identify what this is we can look to Department of Health documents and organisational policy and procedures, but the most useful source will often be asking and observing some of the local practitioners themselves. *Practice based evidence* is a recognition that messages from research are helpful but occasionally limited in the scope of their practical usefulness; but important evidence often emerges from the good work done by people, often in pressured situations, finding workable solutions to daily problems. Many of the exceptional workers share a range of qualities in the way they go about their work:

- The value of self-reflection, and using opportunities for individual, peer and team supervision, as well as informal support of colleagues; they are always open to new learning
- A focus on the relationship with service users and carers, and remain curious to develop the detail that enables a truly person-centred way of working that includes considerations of risk and safety
- Seeking detail and context, so they always see the person rather than just the risk
- Seeking to develop a picture of what people can do rather than simply seeing risk as a means to profile the deficits and problems that need preventing, restricting or minimising
- Making reasoned risk decisions usually in collaborative partnerships that involve service users, carers, colleagues and wider service providers as will be appropriate to the specific situation
- Understanding the need to take risks for specific positive outcomes; but also when not to
- Using a structured approach to working with the dynamic changing nature of risk; with a combination of facts and intuitive impressions in appropriate ways that doesn’t confuse the two in communication with others
- Analysis of risk information that tests out the initial hypotheses they may have established, and always being open to change their formulation of how they convert assessment information into individualised plans
- Recording complex risk information in succinct ways that convey the important messages to others who need to know
- Making use of tools and approaches that are available, but as a support to good practice rather than feeling unduly constrained by them
- They understand that risk cannot be eliminated; with the inherent unpredictability of human nature and fallibility of systems things will occasionally go wrong.

These guidelines draw on a combination of locally identified good practice and the work of the author (Steve Morgan, *Practice Based Evidence*) over a period of 15 years consultancy and publications in the field of working with risk. They should act as a reference point for all practitioners working within Trust services, to be read and regularly consulted on an individual basis and periodically used by teams in their own review of practice. They set a tone for what good practice should include, but should not be read as a rigid template to be adhered to in ways that restrict creativity or flexibility of thinking and working.
Definitions:
Are we all talking about the same thing?


**RISK**: is the likelihood of an event happening with potentially harmful or beneficial outcomes for self and others. (Possible behaviours include suicide, self-harm, neglect, aggression and violence; with an additional range of other positive or negative service user experiences).

**RISK ASSESSMENT**: is the **gathering of information** through processes of communication, investigation, observation and persistence; and **analysis** of the potential outcomes of identified behaviours. Identifying specific **risk factors** of relevance to an individual, and the circumstances in which they may occur. This process requires linking the **context** of historical information to current circumstances, to anticipate possible future change.

**RISK MANAGEMENT**: is the statement of **plans** and the allocation of **responsibilities** for translating **collective decisions** into real actions. It is the activity of exercising a duty of care where risks (positive and negative) are identified. It entails a broad range of responses linked closely to the wider process of care planning. The activities may involve preventative, responsive and supportive measures to diminish the potential negative consequences of risk and to promote potential benefits of taking appropriate risks. These will occasionally involve more restrictive measures and crisis responses where the identified risks have an increased potential for harmful outcomes. It should also clearly identify the dates for reviewing the assessment and the management plans.

**Note**: There are a number of definitions of risk, risk assessment and risk management in the wider risk literature. They all have similar meanings but may differ slightly in emphases they place on specific concepts, particularly the positive potentials of people, and the role of prediction in practice. If you adhere to different definitions it is important that you reflect on what the meaning is for you and debate it with other colleagues who may hold a different perspective on what risk is, or indeed the more user-friendly and engaging concept of safety.
The following principles provide a broad context for assessing and managing risk in practice:

**Introduction**
1. Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user’s own experience, and clinical judgement.

**Fundamentals**
2. [Positive risk-taking] as part of a carefully constructed plan is a required competence for all mental health practitioners.
3. Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.
4. Risk management must be built on a recognition of the service user’s strengths and should emphasise recovery.
5. Risk management requires an organisational strategy as well as efforts by the individual practitioner.

**Basic ideas in risk management**
6. Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.
7. Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.
8. Knowledge and understanding of mental health legislation is an important component of risk management.
9. The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.
10. Where suitable tools are available, risk management should be based on assessment using the *structured clinical judgement approach*.
11. Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user.

**Working with service users and carers**
12. All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.
13. Risk management must always be based on awareness of the capacity for the service user’s risk level to change over time, and a recognition that each service user requires a consistent and individualised approach.

**Individual practice and team working**
14. Risk management plans should be developed by multidisciplinary and multi-agency teams operating in an open, democratic and transparent culture that embraces reflective practice.
15. All staff involved in risk management should receive relevant training, which should be updated at least every three years.
16. A risk management plan is only as good as the time and effort put into communicating its findings to others.
Positive risk-taking ~ SPECIFIC & MEANINGFUL

The use of language is a vitally important component of good practice, it lies at the heart of good communication… ambivalent language perpetuates poor communication, as different people interpret the meaning of the same phrases in different ways.

*Positive Risk Management* is a general term created by the Department of Health. Its main function is to set an overall positive tone in the way people consider risk.

*Positive risk* is a phrase that lacks any depth or meaning, to be avoided if at all possible.

*Positive risk-taking* describes something specific that service users and practitioners do as part of challenging but progressive ways of working. It is something that everyone engages in to different levels and frequencies in their daily lives, so it should be appropriate for service users in carefully considered and reasoned risk decision-making. It does what it says on the tin: it is *taking risks for positive outcomes*. The activity is *taking risks*, and the ‘positive’ attachment is about the clearly defined *outcomes* that the service user &/or practitioners wish to achieve by taking the aforementioned risks. The *positive* is not attached to the term *risk*!

**Definition**

*Positive risk-taking is:* weighing up the potential benefits and harms of exercising one choice of action over another. Identifying the potential risks involved (i.e. good risk assessment), and developing plans and actions (i.e. good risk management) that reflect the positive potentials and stated priorities of the service user (i.e. a strengths approach). It involves using ‘available’ resources and support to achieve the desired outcomes, and to minimise the potential harmful outcomes.

It is characterised by:

- Real empowering of people through collaborative working from the outset of discussions about risk and risk-taking
- A clear understanding of *responsibilities*, that service users and services can reasonably hold in *specific situations*; and understanding the consequences of different courses of action
- Making *decisions* based on a range of choices available, and supported by adequate and accurate information
- Supporting people to access *opportunities* for personal change and growth
- Establishing *trusting* working relationships, whereby service users can *learn* from their experiences, based on taking chances just like anyone else
- Working positively and constructively with risk depends on a full appreciation of the service user’s *strengths* in order to identify the positive resources that underpin the confidence to take the risk
- Focusing on the ‘*here and now*’, but with clear knowledge of what has worked or not worked in the past, and why. The influence of *historical* information lies in the deeper *context* of what happened rather than the simple *stigma* of the events themselves
- It is an *on-going* risk decision-making process, not a one-off decision
- A clear focus on the specific *outcome* to be achieved, so it involves a process of attempting to script what the future could look like.
What supports positive risk-taking to happen in practice?

- A person-centred approach with an in-depth focus on developing an assessment of strengths alongside problems and risks... the strengths will be the resources
- Consensus across a team (and wider network of support) to think and work in this way, as healthy discussion opens up a more constructive dialogue... not everyone will agree with challenging ideas and plans, and occasionally damage limitation will be the final arbiter
- Encouraging some practitioners, especially Doctors, to give up some of their perceived level of personal responsibility for decisions where it closes down possibilities in favour of a more obvious risk averse decision
- Clear ideas about what constitutes personal and collective responsibilities and accountability
- Appropriate tools to support the process of individual and team risk decision-making... these may not only be risk tools, but do need to be recognized tools/forms/checklists for supporting the dynamic process of formulation
- Timing of risk-taking decisions will greatly influence some risk decisions (i.e. time of day as well as specific day in some instances)
- Clearly communicating positive achievements; successful outcomes breed further confidence
- High quality supervision and support
- Priorities and resources focused on the creative challenge of doing things differently... including protected time to undertake the important analysis of risk information (e.g. as in the process of formulation practiced by some staff, or detailed summarizing done by some less experienced in techniques of formulation)
- Clarity in how we describe to relatives (and other service providers) what we are doing to reduce the risks
- Good team-based systems for recording and monitoring decisions
- It becoming a part of the fabric of training and service monitoring, particularly within teams, and for all practitioners to take personal responsibility for keeping their own learning up-to-date
- An organisational culture that understands and supports the philosophy of positive risk-taking as a principle of good practice (see below)
- Challenging any negative perceptions that positive risk-taking is only driven by the need to save money through cutting services
ORGANISATIONAL CULTURE

Good quality risk decision-making will be influenced by many factors, and things can go wrong even when the best practice has been followed. The social care risk framework (Independence, choice and risk: a guide to best practice in supported decision-making. Department of Health, 2007) recognises that: “… The most effective organisations are those with good systems in place to support positive approaches rather than defensive ones. The corporate approach to risk that an organisation takes overwhelmingly influences the practice of its workforce.”

It is important to remember that any decision is likely to be acceptable if:

1. It conformed to relevant guidelines
2. It was based on the best information available
3. It was documented
4. The relevant people were informed.

However, there is still a long way to go before consistency of attitude and approach is achieved in how managers conduct Critical Incident Reviews (CIR’s), or even agreement on what needs a CIR. Nobody denies the need for investigations, the concern is more about the frequency in which many dedicated practitioners feel unsupported through the process of trying to learn the lessons, and even feeling blamed from the earliest stage even where there is no subsequent findings of malpractice. The experience of feeling ‘guilty until proved innocent’ through the processes of investigation seriously detracts from the potential to consider appropriate positive risk-taking and objective risk decision-making. Furthermore, there is an apparent lack of recognition of where good practice and good decisions are being achieved, with a sole bias towards focusing attention on the negative. It is very rare for practitioners to have deliberately and negligently contributed to an incident, and they are also traumatised by the rare tragic outcomes.

A consistent approach to investigations that challenges the predominant negativity of the blame culture would require the Critical Incident Review processes to better encompass positive practice as well as failings, as these are part of the ‘critical’ analysis, and recommendations should also reflect ‘notable practice’ not just failings. From the authors discussions held within Mersey Care Trust in 2002 it is recommended that the process should consider adopting the following approach if it is to support morale and motivation of practitioners:

☐ The first contact after an incident should be asking how practitioner(s) are feeling, as they are likely to be personally traumatized to differing degrees
☐ The first contact should also stress that Senior Management believe practitioners did everything they possibly could to manage the care and support effectively (i.e. rare events of negligent practice will be picked up later, and can be managed appropriately)... nobody benefits from assuming staff practiced poorly from the outset whenever an incident has happened
☐ Flexible offers of advice and support should be made available from the outset and delivered as required throughout the process of investigation... nobody benefits from staff left in the dark and at the mercy of anxieties about what might happen
☐ Genuine staff support at the most critical times doesn’t cost the organisation financially, but lack of support does through staff morale, sickness and retention.
A shift of focus
We aren't usually known for the things we cannot do, yet we more often see service users described almost exclusively by their limitations. Assessment in mental health and learning disability services is essentially about the things people want or need to change in their lives. This will usually be about problems and difficulties they are experiencing. However, it should recognise that often the best way to change things is through doing more of what you are good at. This is about using more of the identified abilities (one of the elements of strengths, alongside achievements, personal qualities, interests, wants and wishes) to promote positive and desired change. Assessment should also include the support that family, friends and carers are providing, thus extending the idea of the assessment going beyond what the service user can do, to what other resources they have to help them.

Strengths and risks
Risk is most usually about the negative events or possibilities in a person’s life, but positive risk-taking (as described on p6-7) is unlikely to happen if the only information you have is negative, about the things a person can’t do; it has to be supported by an appreciation of strengths, what a person can do. Yet risk assessment (and most other assessment) tools almost universally ignore the need to prompt a full development and appreciation of strengths and how we can work with them to help manage the risks. It also ignores the need for time to develop trusting working relationships, particularly when a practitioner is under pressure to ‘get the risk assessment done’ in a short timescale. The goal of the first session should be to get the person to come back to another session (not solely to get the paperwork completed!).

Putting identified strengths to good use
Identifying and working with strengths should be the ethos of working from outset with everyone, including working through crises and difficulties. It is part of teasing out the appropriate therapeutic interventions; helping the person to tell their story… it is a skilled intervention not to be done in a patronizing way (i.e. not for practitioners to just run through a checklist quickly as if strengths is then done!)… it is an intervention in itself. Consider the timing for asking of subtle delicate questions related to individual personal circumstances. As a process it can be a subtle communication of optimism, hope and validation, and is closely aligned to the ethos underpinning Wellness Recovery Action Plans (WRAP).

The following checklist is offered as a reminder to the considerations that may help in constructing a full and comprehensive picture of a person’s strengths, as well as prompts to make use of these resources in your consideration of how to manage the risks and promote safety.
Working with Strengths Checklist


1. What are the personal qualities you identify in the individual service user?

2. What are the personal qualities you identify in informal carers?

3. For each of the person’s main life domains (e.g. housing, money, relationships, health, daily functioning, meaningful activity, spirituality), identify what is positive at the moment (e.g. what resources the person has in place themselves, what is currently settled and stable, what support they have around them).

4. In each of the life domains discussed, what past achievements do we know of? (e.g. what has worked well, what they have enjoyed, what successes they have had.)

5. In each of the life domains discussed, what do we know the service user (and carers, where relevant) wants for the future?

6. What information can we provide about different choices that may be relevant to any expressed wishes for the future? (i.e. how fully aware are we of the availability of choices – are we thinking creatively around the individual, or about what resources and services are more readily available?)

7. How will we use the identified strengths in helping the person to achieve their wishes, desires and dreams? (e.g. focusing attention on applying their personal qualities; supporting the use of identified resources, such as carers, most effectively; recapturing the potential things that have worked in the past.)

8. How will we work with decisions made about choices we may not agree with? (e.g. how can we promote working with ‘early signs’ of stress/things going wrong? What crisis responses may be appropriate? What contingency plans can we put in place?)
Risk Decision-Making

Any risk-related decision is likely to be acceptable if:
- It conforms with relevant guidelines
- It is based on the best information available
- It is documented; and
- The relevant people are informed.

As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at the time. A positive organizational approach to managing risk means being aware that risk can never be completely eliminated, and aware that management plans inevitably have to include decisions that carry some risk. This should be explicit in the decision-making process and should be discussed openly with the service user/patient.

A checklist to inform clinical decision-making

The following checklist (on p12) has been developed and used by the Practice Based Evidence Independent Consultancy in discussions with groups of multidisciplinary practitioners over several years. It offers a structured approach to any level of risk decision-making, whether something that needs to be decided by an individual quickly in a risky situation or by a team through carefully considered clinical review of a complex case. It is not a rigid structure to be adhered to in all situations, but does help to develop reasoned positive risk-taking decisions in complex cases if followed rigidly by a person chairing the review.

It should become a familiar list of considerations if read and consulted on a regular basis. It doesn’t contain any considerations that all practitioners take into account at times during their practice, but it does put significant considerations together in a list that should flow logically if used as a structure. It also reflects the Department of Health best practice guidance (2007) which highlights the importance of using a ‘structured clinical judgement approach’ to risk decision-making.

Local practitioner suggestions for potential implementation of the checklist (not a prescriptive or exhaustive list):

- The existing MDT Review checklist is general, but could have a specific reference to this Risk Decision-Making checklist in certain instances
- Available for use in Ward review/CPA when deemed appropriate (e.g. helping to structure information being communicated to Doctors in the decision-making process, communicating the rationale for decisions)
- For structuring and recording discharge decisions (or transfer to acute ward from PICU)
- Use in professionals meetings to guide some complex risk decisions
- For raising the profile of some of the most challenging positive risk-taking decisions being made within services
- As a useful and comprehensive series of prompts for routine risk decision-making, including some discussions within supervision sessions
- The importance of prompts for us to be considering ‘how particular types of decisions were managed before’
A Structured Approach to Risk Decision Making

- Is the required decision reactive (to what the person is doing or plans to do) or proactive (to be initiated more by the service providers)?
- Is the service user’s understanding and experiences of risk clearly understood (it may be very different from the professional’s assessment of the risks)?
- Is the carer’s (as appropriate) understanding and experiences of risk clearly understood (it may at times contradict that of the service user)?
- What behaviours are identified as being risky in relation to the specific circumstances of the decision (i.e. what is your risk assessment)?
- What is the clear definition of the risk that is being taken (the emphasis is on the detail)? Have you considered the other options that are available?
- What are the positive desired outcomes to be achieved through taking the specific risk (short &/or long-term)?
- What strengths can be identified and used in pursuit of a positive risk-taking plan (including personal qualities, abilities, achievements, resources, motivations and wishes)?
- Are there any clearly defined stages to be accounted for in a risk-taking plan?
- What are the potential pitfalls, and estimated likelihood of them occurring? Have you thought of these in relation to the other appropriate options? [Important for demonstrating that alternatives have been evaluated in the risk decision-making process]
- What are the potential safety nets (inc. early warning signs, crisis and contingency plans)?
- Has this course of action been tried before, and if so what were the outcomes?
- If tried before, how was the plan managed and what can now be done differently (what needs to, and can change)?
- What is your formulation from all the above information (clearly weighing up the different alternatives considered and presenting the reasoned decision that has been taken, with appropriate reasons why you have not taken the alternative decision)?
- Who agrees (and importantly disagrees) with the plan?
- How will progress of the plan be monitored?
- When will the plan be reviewed?
Components of GOOD PRACTICE IN ASSESSING RISK

Assessing and managing risk are not separate and independent functions in reality. When a risk is identified there is an immediate responsibility to do something in response, even if that is only to communicate it to someone else; but it could mean a direct intervention to an immediate crisis, or a complex consultation leading to a risk management plan. Within the range of possible responses you may also have to take a risk as part of responding to a situation.

- Assessing risk starts at the first point of contact (referral, telephone call or face-to-face contact), and it continues as a dynamic on-going process, not a one-off event
- From the point of initial contact consider how to engage the service user (and carers where appropriate) in full collaborative discussion of what risk means to them, and what their experiences of risk are:
  - Consider use of language (e.g. talking about safety may be more engaging for many than talking about risk)
  - The importance of enabling people to tell their story
  - Create opportunities for both service users & carers to speak independently and freely
  - Develop a narrative account in order to capture detail (even though you may only be documenting succinct bullet points to summarise the detail)
- Assessment made in a one-off interview can only be risk screening, not a full assessment… assessing risks accurately and comprehensively requires trust and takes time, and it is only part of a wider assessment

- Accessing information from many sources:
  - You can only work with the information you have available to you, so record the sources of information on which you are basing your assessment and subsequent judgements
  - Adopt caution about accepting its accuracy until you can corroborate it (c.f. we read the newspapers but don’t necessarily believe what we read!)
- Risk history is about the chronology of events, the accurate detail and individual context in which the risks occurred (it is not a simple numerical representation of incidents):
  - The important information is what is going on for the person in their life now
  - Historical information is only relevant where the patterns and context of the past are re-emerging now
  - We must see the person not just the risk

[Continued on next page]
Components of good practice in assessing risk (continued)

- Balancing an appreciation of risk factors (research based) and protective factors (individual to the person):
  - Risk factors are indicators of what could go wrong, elevating the risk
  - Protective factors are those that can reduce or mitigate the likelihood of the risk happening (e.g. a person’s own learning about their condition, social supports, personal safety nets)

- When estimating likelihood give consideration to:
  - The recency with which risks have occurred
  - The severity of the risk (impact it could have if it occurred)
  - The immediacy/frequency of its occurrence (or re-occurrence)
  - The identification of patterns of risk behaviours
  - Timing can be about different times of the day or different days that may elevate or reduce risks

- Considering risk to whom?
  - The service user, relatives/carers, staff, wider public
  - Taking into account environmental/geographical risks within units or the local community
  - To include consideration of 1 or 2 person contacts, age/race/gender of practitioners (if possible)

- Use of personal/professional skills:
  - Engagement, respect, genuinely person-centred, communication
  - Asking difficult questions, and dealing with difficult answers… not asking the question doesn’t mean the issue goes away
  - Observational & listening skills (inc. hearing what people are saying, not what you think they said)

- Awareness of the influence of personal/professional values and principles, including where they may include prejudices
- Appropriate levels of curiosity and proactive in seeking clarity
- Awareness of issues of equality, and how it can be compromised by assumptions around risk
- Awareness of statutory responsibilities (e.g. safeguarding & child protection)
- When to ask for a specialist assessment (e.g. forensic assessment; cognitive assessments; falls risk assessment)

- Responsibility for documenting and sharing risk assessment information:
  - Succinct and clearly structured
  - Inclusion of clearly attributed statements of service user/carers views (i.e. easily distinct in notes from service providers accounts)... good example locally of ‘Admission Accounts’ where patients were encouraged to write their view of what lead them to be admitted
  - Sharing information needs to be within bounds of confidentiality, but understood from a basis that sharing leads to better judgements (as opposed to not sharing means we can’t be criticized)
  - Awareness that systems risks are also a part of what we should be assessing (e.g. how the complexities of systems, structures and procedures may occasionally impose a rigidity that can cause frustration and elevate risk)
A STRUCTURED CLINICAL JUDGEMENT APPROACH

Actuarial approaches:
Based on addressing risk at a group level, but they cannot move from group to individual risk evaluations easily. Their accuracy is lowest in detecting rare events. They are able to predict at all only when the person being assessed comes from the population for which the tool was developed.

Clinical approaches:
Provide individualised and contextualised assessments, but are vulnerable to individual bias and poor inter-rater reliability. They have been reported, however, to achieve better than chance levels of accuracy. These approaches can be either structured or unstructured, or a combination of the two.

Actuarial approaches are mainly structured and clinical approaches predominantly unstructured, although the latter may also have aspects of structured assessment. Unstructured assessment involves the selection and measurement of risk factors based on a mental health professional’s clinical experience and theoretical orientation. Risk factors are combined in a holistic manner to develop a professional opinion about a person’s level of risk in relation to violence.

Structured clinical (or professional) judgement approaches:
A concept supported by the Department of Health document on Best Practice in Managing Risk (2007) which recognizes that any assessment of risk will be determined by a combination of elements, the relative proportions of which will differ between people and across different time frames for the same person. These elements are:

- An appreciation of research evidence, primarily the identification of specific risk factors
- Knowledge of the individual service user and their social context
- The service user’s own experience
- Clinical judgement (which can include a careful appreciation of how we use intuition)

When we think about evidence for our assessment and subsequent judgements be aware that evidence-based research in risk is limited to categories of violence & aggression and suicide & self-harm... it is an accurate picture of what has gone wrong (through numbers of deaths), and an indication of what could go wrong (lists of risk factors). It offers no source of optimism or hopefulness for working with risk, this has to come from practice-based evidence (i.e. what you know about the specific individual, as opposed to general populations referred to in research).

- The research evidence (e.g. demographic information) should be used in a flexible way as prompts and guides to potential indicators of risk
- The impact of language should be considered (e.g. ‘suicidal ideation’ gets ticked and we move on to another topic; but this language can get in the way of helping us to think about asking the challenging questions)
- There is a danger of seeing everything as risk; individualise and contextualize by focusing more on what risk means in the specific situation... good practitioners are constantly enquiring, seeking, developing information and ideas
- Risk Category/Factors lists can act as prompts, an aide memoir, they do not need to be ticked lists... real people don’t fit into lists that easily
- Telling the story is always the most important function of any structured approach... develop the conversation as a higher priority than ticking boxes
How do we use Intuition/Gut Feelings?

As an adjunct to objective assessment most practitioners recognize they use this element of clinical judgement on a regular basis, but it is one that needs to be used with extreme caution and clarity of purpose if it is not to lead to confusion and controversy… on its own it is not a safe assessment of a situation!

- **What is it?**
  - It is experience… something from your personal or professional history… subtle cues when something is either ‘not quite right’ or ‘a chance worth trying’
  - An impression of what might be, but you are unaware immediately of the factual basis… you can’t immediately say why but there is something, an alarm bell to be followed up
  - Intuition has been identified as “… knowledge without conscious reasoning… influenced by professional experience and the understanding and use of one’s own and others’ emotions. [It] appears to be embedded, but actively hidden, within a larger clinical reasoning framework.” [Chaffey, L., Unsworth, C. and Fossey, E. (2010) A grounded theory of intuition among occupational therapists in mental health practice. *British Journal of Occupational Therapy* 73(10): 300-308.]

- **What are the difficulties associated with its use?**
  - *Easily dismissed* by those who take the view that only objective statements of fact can be communicated
  - *Easily confused* with other factual statements, and misinterpreted as being fact
  - It could be leading you in a wrong direction through your own personal biases (i.e. not everyone uses experience thoughtfully)
  - You may narrowly process subsequent information in your search to find only evidence that supports your theory
  - It could give some practitioners a form of validation for not pursuing more rigorous searches and analysis of information
  - When and how to share these feelings appropriately and constructively with service users?

- **How should it be used?**
  - It should never be left as a final statement without a clear indication of *what you intend to do with it*
  - It should be investigated as soon as possible through other sources of stronger evidence, and discussion with colleagues

- **How may it be documented?**
  - Document what it is, but more importantly *what you are going to do about it* (which is also important for others to know/be aware of)
  - Use of less emotive terms such as ‘my concerns are…’ or ‘my impressions…’ alongside clearly identified factual information; use of the SOAP (Subjective, Objective, Action, Plan) framework; use as a clearly identified reflective statement in a summary
  - It is vitally important to clearly distinguish it from the factual stuff!
How do we make sense of risk information?

Risk formulation
All too often there is little or no reference to the analysis that good practice in working with risk requires. The good practitioners focus attention specifically on the bridge between what we have assessed and how this informs the subsequent plan… it is what makes the process personal. A number of terms are used to reflect what happens at this bridge: summarizing, critical analysis, clinical reasoning or formulation, which range in their degrees of complexity.

What is it?
- Developing the ‘why’ questions that help us to disentangle the complex information about a person’s experiences
- Developing a hypothesis from assessment information and testing that hypothesis, being open to change your initial ways of thinking as new information and connections of information come to light
- It is about identifying thoughts and intent; the signs, factors and emotions that may contribute to elevating the risk in specific situations, and balancing these with the protective factors that may diminish or mitigate the risk
- It involves using a longitudinal process of how a person’s history may influence the here and now… with an emphasis on hope
- It is identifying and interpreting individual cycles or patterns of thoughts, feelings and behaviours (including maintenance cycles)

Considerations in developing the analysis:
- Letting go of preconceived fears or ideas about the person

- Developing an understanding of what elevates or diminishes risks in a person’s life, balancing the psychological, social and medical
- Shared communication with others, particularly the service user
- Flexibility of the concept; there is not one rigid way of arriving at a hypothesis; it requires practitioners to be open not opinionated, and genuinely collaborative rather than focused on me/my/mine
- It can be developed pictorially or diagrammatically if that best suits the person, the staff member, or the situation
- It is not about being right or wrong, it is about the dynamic changing nature of what we are working with, and it takes time
- It is not a tick-box exercise, it is about broader understanding (i.e. two people with the same diagnosis can be entirely different!)
- It can help to challenge those moments when staff ‘feel stuck’ with the historical presentation of the individual

One method often used by Psychologists for structuring the more complex process of risk and the wider experiences of someone’s life is formulation, which can be structured as the 5 P’s (i.e. one way of analyzing and managing complex information):

- Presenting problems > Predisposing factors > Precipitating factors > Perpetuating factors > Protective factors
Components of good practice in managing risk

Assessing the risks is the starting point of good risk management, as we need to be very clear about what risks we are dealing with, and to avoid as best as possible falling into the easy trap of assumptions based on historical headlines of what a person has done. Good risk management is most usually based within a relationship between services and the service user & carer, and is a collaborative activity wherever possible, rather than something done to people. How we manage risks can be thought of as a timeline around an event:

□ Before > much of what we do that is good practice contributes to preventative risk management, but this runs the risk of labeling everything as risk
□ During > the fight or flight responses, including de-escalating situations, dealing with the crisis, removing the source of risk (when appropriate), implementing an agreed plan, working collaboratively to minimize the risk and its potential impact/outcomes
□ After > reviewing and supporting people where a risk has had an impact, avoiding knee-jerk impulses or subtle messages to attribute blame

Risk management essentially involves individual & collective responsibilities and accountability; plans, actions and reasoned risk decisions; discussions and documentation of the key elements; communicating of risk information clearly. Within this broad remit there are a number of important considerations:

□ As the basis for making challenging risk decisions positive risk-taking forms a component of good risk management… it also reflects a significant way in which services can demonstrate their desire to give humanity back to people… including optimism towards recovery
□ A strengths approach, depending on the level of knowledge about the person, will offer key information about the positive resources that can be used when working with risk through a carefully constructed risk management plan/response, ideally developed with the person
□ A primary focus should always be on safety, as well as the goals of promoting independence and autonomy for the individual service user
□ Confidence to challenge specific behaviours through respectful and open discussion
□ Service users have rights, including the right to make unwise decisions (c.f. Mental Capacity Act, 2005), but with those rights service users also have clearly negotiated personal responsibilities, which also challenges some service providers to drop the need to rescue people
□ Being very clear what the aims are that the services and service user/car are working towards… a general aim of managing risks is meaningless and unhelpful to all involved
□ Knowing you can be wrong! You can only work with the information available to you (and your reflection/clinical judgement skills)
□ Being aware of own limitations… being able to say I am out of my depth (i.e. culture of the team is crucial to enabling this, and authority issues will have a significant influence on how supported and able individual’s feel to be honest)

[Continued on next page]
Components of good practice in managing risk (continued)

- Changing risk decisions, actions and plans in response to the dynamic changing nature of risks:
  - Clear crisis & contingency plans in response to anticipated relapses
  - Communicating changes openly with all who need to know
- A balanced view of risk prevention and risk reduction, and how we may need to urgently switch between these modes of response
- Being aware of when to intervene, and importantly when not to intervene
- A team culture of reflective practice, learning, peer support, recognition of different tolerances of risk through different experiences, sharing different opinions on how a risk should be managed (e.g. different opinions held in response to self-harming behaviour)
- Good use of the multidisciplinary/multi-agency systems within services for communicating information and arriving at collective reasoned risk decisions
- Guidelines that explain how staff will be backed-up and supported, particularly when something goes wrong… good risk management rarely emerges from practitioners who are more focused on the fear of things going wrong, and what the consequences of trying to do their best will be

Team Working

The practitioner may sometimes be working alone, but in most situations the best assessments and the most effective decisions are made by a team of experienced practitioners in consultation with the service user/patient and carer. Decisions and assessments should also be based on collaboration between health and social care agencies in hospitals and in the community. In some cases they should be based on collaboration between general and specialist services. The judgements made in a risk assessment should be made in collaboration with others in the multidisciplinary team and with the service user/patient and carer. In instances where the risk seems high, the involvement of senior colleagues to advise and support may be helpful.

Multidisciplinary teams should think about the way that they operate and communicate: effective decision-making is more likely in an atmosphere of openness and transparency, where all views are welcomed and responsibility is shared. Teams should consider the best way for them to resolve disagreements about a decision, to ensure that the best decisions are made and that team cohesion is preserved. Teams should also be alert to group processes such as the pressure to conform and the potential for groups to recommend more risky courses of action than an individual would. When working across agencies, a common understanding and language should be established for the issues that will be addressed.
TRAFFIC LIGHT SYSTEMS

Trust Redesign Statement

A Zoning System is used to support the team to prioritise work, taking risk into account and supporting workload allocation.

Broader Context

There is no empirical evidence base for the effectiveness of zoning systems... they have emerged idiosyncratically as a practical initiative that is easily understood through our recognition of traffic lights. The literature mainly cites: I. Ryrie et al (1997) Zoning: A system for managing casework and targeting resources in community mental health teams. *Journal of Mental Health* 6(5): 515-524.

Practice Based Evidence local ‘working with risk’ reflections:
- Observing very inconsistent use of zoning across and within Southern Health NHS Foundation Trust ACP sectors (2010/11)
- Primarily an ACP initiative, but should easily equate with the levels of intensity of community team service provision

Local Statement of Good Practice

The use of a zoning system across Trust services is primarily a means for communicating current levels of risk, needs and readiness for changing the intensity of the package of care for individuals in a quick and simple way. The characteristics of the system are that it should:

- Have multi-disciplinary ownership as a method of communication, but it can just as easily be used by single disciplines (e.g. in their own communication/handover of information)
- Have practical value in the day-to-day work of all staff... contributing to but not complicating communication of information
- Be guided by simple broad criteria, not overly complicated descriptions (see Zoning Criteria)
- Primarily function as a prompt to discuss the specific details for the individual at a current point in time
- Be adopted as a dynamically changing reference to what is being observed reflecting current / immediate risks & behaviours, and vulnerability / safeguarding issues when appropriate
- Contribute to a collaborative process of formulation and decision-making
- Be implemented flexibly (within the broadly agreed criteria) in response to local team / service needs (e.g. some services will use it in daily handovers, others will prioritise its discussion for professionals multidisciplinary team meetings)
- Relate to levels of risk and behaviours, NOT equate to team/service responsibility (i.e. not Red = in-patient; Amber = community team; green = discharge from services)

The three zones should equate to the degrees of intensity &/or responses within each team or part of the service. Any communication to other staff/teams that references the zoning system needs to give clinical details (i.e. not just saying ‘urgent because they are in the red zone’).
Multi-Agency Public Protection Arrangements

Multi Agency Public Protection Arrangements (MAPPA) began in the late 1990s with improved working relationships between Criminal Justice System agencies. The Police, Probation and Prison Services are the key bodies involved in managing risk within MAPPA. In addition a number of other agencies have a Duty to Cooperate with MAPPA. These include Health Service Organisations (i.e. NHS Trusts and PCTs). Offenders who commit sexual or violent offences and who receive a Hospital Order (or Guardianship) will be subject to MAPPA. MAPPA applies to patients who have been convicted of relevant violent or sexual offences. Offences are grouped into 3 categories:

Category 1  Registered sex offenders (1997 Sex Offenders Act).

Category 2  Violent offenders and other sex offenders. Convicted of relevant violent or sexual offences (see MAPPA guidance) receiving a prison sentence of 12 months or more after April 2001, or subject to Hospital or Guardianship Order (Section 37 Mental Health Act 1983).

Category 3  Offenders who have a conviction for relevant violent or sexual offence and who are deemed to pose a risk of serious harm to the public.

For each individual subject to MAPPA, one of 3 levels of risk management can apply:

Level 1  Ordinary risk management should apply when MAPPA management of risk falls primarily under one agency. This does not mean other agencies are not involved.

Level 2  Multi Agency Public Protection Meeting. Level 2 is needed when the offender requires active involvement and coordination of interventions from other agencies to manage the presenting risks of harm.

Level 3  Multi Agency Public Protection Meeting. Level 3 was intended to cover the “Critical Few” where there is risk to others of serious harm, which is high and imminent. Level 3 MAPPP are expected to include representations from agencies that are senior enough to make decisions involving allocation of resources.

The MAPPA legislation imposes a duty on public bodies, including NHS Trust and PCTs to cooperate with the responsible authority for MAPPA. This includes the following obligations:

- A duty to cooperate in the provision of information to other MAPPA agencies in order to allow risk assessment and risk management.
- Duty for health professionals to consider as part of ongoing care planning whether there is a need to share information about persons who meet the criteria for MAPPA registration
- A duty on professionals to consider as an ongoing part of care planning whether there is a need to refer to the responsible authority for consideration for registration for MAPPA.

Staff should refer to the the relevant Trust policy for guidance before sharing confidential information with other agencies including MAPPA. Practitioners should always discuss the disclosure of any clinical information to MAPPA with a Consultant Psychiatrist.
Recording Risk Information

Styles/Qualities of good documentation

- Headings & sub-headings e.g.:
  - Presenting problems… clarity of what risks we are working with
  - History… with specific context & detail… linking what is happening now to what has happened in the past, with awareness of how it was previously resolved
  - Avoid the traps of making assumptions based on historical information… see the person not the risk
  - Protective factors… specific and personal to the individual

- Use of bullet-points… easier to quickly grasp the information (but can they restrict the creativity enabled within a narrative approach?)

- Capturing immediacy, frequency, duration… specific statements that can provide a base for measures that balance qualitative & quantitative information

- Use of detailed analysis/summarizing/formulation in helping to tell the story… but long narrative styles are less often read; so we need to use narrative in real time but record the information more succinctly

- Potential use by some of diagrammatic representation with the person

- If using High/Medium/Low statements you need to include an explanation, not just the level alone

Guidelines for good documentation

- The first question is who are you recording information for (the Trust, you & colleagues, the service users)?

- Written in language everyone can understand… jargon only serves to exclude people, so if it has to be used add an explanation

- Less use of abbreviations, or clearly reference what they mean

- History is a collaborative process… avoiding making assumptions based on history that are not substantiated in the present… be clear about the relative weight being given to historical information as it links to the present

- Quality chronology of events (an event diary) is about the accuracy of dates and the detail of information (inc. creating a timeline electronically)

- Recency and frequency of events could trigger something like a traffic light type/level of responses to the specific events… reflect the urgency

- Include a specific focus on individual’s strengths and protective factors

- Reference decisions against something!

- Focus on safety rather than risk (i.e. we assess the risks in order to increase a person’s safety)

- Consistent use and cross-referencing numbered items in a care plan and subsequent

Recording risk incidents

Whenever staff become aware that harm has occurred to anyone, then the details must be recorded as precisely as possible in the patients clinical record. As a minimum this should include:

- What happened?
- What were the circumstances?
- What were the consequences?
- How does what happened relate to mental illness?
Guidelines for using RiO Risk Assessment

- Be clear that the Risk Assessment is a statement of the current risks, not necessarily an exercise in prediction unless you state it is being used to communicate that purpose.

- Include, in your use of the summary section of the form, a statement of the sources of information available in making the assessment/judgements/plans… including a reflection of how collaborative the individual process has been.

- Use the ‘Summary’ section first (but, not as a summary, it should be your structured account of assessment > analysis > management plans)… then tick boxes and linked narrative evidence for each section of tick-boxes where relevant.

- Use your own framework of good practice and cut & paste it into the ‘Summary’ box, if this captures your process of good practice.

- Be aware of any inconsistencies of where you may be cutting & pasting risk information (e.g. are you using the RiO Risk Assessment as well as the Core Assessments for recording risk information?)

- Using the ‘Risk Event’ button to transfer information into the risk section of RiO… the same function does not happen when using the ‘Significant Event’ button!

- Don’t tick what you do not know… you can’t untick boxes but you can change ticks, so don’t do it until you really know… it is a work in progress.

- Unticked boxes can be covered by a consistent statement (e.g. ‘unknown at this time’) to indicate that you have thought about it… this also reflects that developing an assessment of risk is a dynamic process… information can be built up and edited.

- The lack of any risk management prompts in RiO emphasizes the importance of using the ‘Summary’ box as the first point of reading & recording whenever the RiO Risk Assessment is opened.

- Do not underestimate the importance of verbal handovers and discussions… telling other practitioners ‘just look on RiO’ is lazy and poor practice, particularly when there are occasions when RiO has not even been updated (e.g. CRHT > ward at point of admission where the update will not appear for at least another couple of hours), or when you personally don’t even think RiO is that good!
Practitioners should be aware of the Policy for Managing Incidents (NCP 16) which advises on the 
review of all incidents in SHPT. It is recognised that things can go wrong even when best practice 
has been used. However if this does happen then it is important to learn why, including identifying 
any mistakes that were made. Learning from ‘near misses’ is vital to improving services, although 
not all lessons learned will require changes in practice – they may not necessarily lead to better 
outcomes. SHPT promotes a culture of openness and honesty so that staff feel able to be honest 
about the decisions that they have taken, the basis on which they made their decisions, and how 
things might have been done differently and better: lessons can be learned and, where necessary, 
practices can be changed for the better. Training could also be improved as a result. It is important 
to remember that any decision is likely to be acceptable if it conformed to relevant guidelines, it 
was based on the best information available, it was documented and the relevant people were 
informed
Risk Training Strategy

Department of Health statement from ‘Best Practice in Managing Risk’ (DH, 2007)

Best practice point 15 states: All staff involved in risk management should receive relevant training, which should be updated at least every three years. This training does not have to be classroom-based but should include attention to:

- the indicators of risk;
- the importance of identifying high-risk periods;
- options for flexible and robust risk management;
- ways of maximizing involvement;
- communication and therapeutic relationships; and
- relevant aspects of the Mental Health Act.

Service users and carers should be involved in delivering training to practitioners. The training should include an emphasis on an awareness of long-term clinical and social needs, as well as knowledge of the person’s current mental condition and an awareness of how risk changes as the service user’s level of care changes (e.g. following discharge or when on leave).

Risk training is an equal responsibility at individual, team and organization levels, but needs tools/guidelines to access as resources. Induction training and on-going risk training require very different approaches.

1. Individual practitioner responsibilities:
   - Continual reflective practice as an integral part of day-to-day working
   - Make use of the Practice Based Evidence reflective practice tools as personal prompts and occasionally in supervision where appropriate
   - Read and use the Positive Risk-Taking: Practical ways of working with risk document, in association with the Trust Risk Policy, as relevant source information

2. Team responsibilities:
   - To complete a team evaluation using the Practice Based Evidence Working with Risk reflective practice tool
   - To set a team meeting within the first 6 weeks of the new teams from the redesign and discuss the evaluation and what the team collectively identify as an area of practice to review amongst themselves
   - To establish a 6-monthly team meeting for reviewing agreed areas of risk practice (e.g. as prompted by items on the reflective practice tools)
   - To record attendances and reflective tool evaluation as a means of informing the Trust that continued risk training is happening
   - To use the Working with Risk Practice Guidelines and team case material, as appropriate, as resources for the focus of team training
   - To identify and nurture individual’s who have a specific interest in risk as ‘champions’ taking a lead in ensuring team responsibilities are organized and delivered (e.g. WRAP leads or AMHP’s, but not exclusively these people)

[continued on next page]
Trust Risk Training Strategy (continued)

3. Organisation responsibilities:
   - To recognize the value of individual reflection & team-based flexible training initiatives as meeting the needs of best practice
   - To update the Trust Policy and Practice Guidelines as a continuing source of basic risk information for all staff
   - To audit team attendances and reflective practice tool summaries as evidence of practice development (far in excess of DH requirements)
   - To develop the Risk Management Panels initiative as a further source of support for the most challenging casework [N.B. This is a separate initiative from risk training, but should be seen as one of many means of providing valuable learning opportunities within and across the Trust]
   - To clearly differentiate risk minimization from risk elimination in practice (not just as convenient words in policy documents)
   - Training Department staff to:
     - Provide a reduced number of risk training workshops, specifically for new staff induction purposes only
     - Induction training sessions to be co-facilitated with service users/carers where appropriate
     - Induction workshops to include reference to the Trust strategy, vision and expectations; use of reflective practice tools & guidelines; specific language of positive risk-taking; documenting risk to Trust standards using RiO
     - ‘Training team staff’ involved in risk training to attend an equivalent of 1 team-based session/month as observers; but also to collate the Trust audit information, offer reflections, and collate information on unmet risk training needs identified
     - Training staff to reflect on how the messages through risk training, personalization, WRAP and ImROC are consistent; and how risk links to other legal requirements identified through MCA, MHA updates, safeguarding

Intended outcomes from a revised strategy

   - Regular personal and team practice development and reflective practice on risk as a requirement of all practitioners (integrated into their current work responsibilities, not seen as an additional burden on time)
   - A more widely held view of how training is integrated with what staff do in practice, not to be seen as something separate from it that usually only happens in workshops
   - More focused team-based risk training using relevant case material
   - Meeting organization audit needs for feedback on Department of Health/NHS Litigation Authority required standards (providing evidence far in excess of the minimum standard required)
   - More focused use of training department staff time, in line with practitioner and team expressed needs
   - More financially efficient use of finite resources (training department staff as well as reduced travelling time of others to centralized workshops of less value or impact)
Appendix 1 ~ Diagrammatic representation of a model of good practice in working with risk
Appendix 2 ~ Risk Factors

Static risk factors are unchangeable (e.g. a history of child abuse or suicide attempts).

Dynamic risk factors are those that change over time (e.g. misuse of alcohol). Dynamic factors can be aspects of the individual or aspects of their environment and social context, such as the attitudes of their carers or social deprivation. Because they are changeable, these factors are more amenable to management. Dynamic risk factors that are quite stable and change only slowly are called stable or chronic risk factors.

Those factors that tend to change rapidly are known as acute risk factors or triggers and, as they do change rapidly, their influence on the level of risk may be short-lived. Particular sensitivity should be exercised when discussing historical factors from earlier in the life of the patient. The relevance and accuracy of these may need to be explained to the patient, and it is possible that carers may be unaware of these historical events or of their significance so many years on.

The following risk factors for violence and suicide have been derived from the available research (Department of Health 2007)

Risk Factors for Suicide

Demographic factors
• Male
• Increasing age
• Low socioeconomic status
• Unmarried, separated, widowed
• Living alone
• Unemployed

Background history
• Deliberate self-harm (especially with high suicide intent)
• Childhood adversity (e.g. sexual abuse)
• Family history of suicide
• Family history of mental illness

Clinical history
• Mental illness diagnosis (e.g. depression, bipolar disorder, schizophrenia)
• Personality disorder diagnosis (e.g. borderline personality disorder)
• Physical illness, especially chronic conditions and/or those associated with pain and functional impairment (e.g. multiple sclerosis, malignancy, pain syndromes)
• Recent contact with psychiatric services
• Recent discharge from psychiatric in-patient facility

Psychological and psychosocial factors
• Hopelessness
• Impulsiveness
• Low self-esteem
• Life event
• Relationship instability
• Lack of social support

Current ‘context’
• Suicidal ideation
• Suicide plans
• Availability of means
• Lethality of means
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
- First violent at a young age
- History of childhood conduct disorder
- History of non-violent criminality

Clinical history
- Psychopathy
- Substance misuse
- Personality disorder
- Schizophrenia
- Executive dysfunction
- Non-compliance with treatment

Psychological and psychosocial factors
- Anger
- Impulsivity
- Suspiciousness
- Morbid jealousy
- Criminal/violent attitudes
- Command hallucinations
- Lack of insight

Current context
- Threats of violence
- Interpersonal discord/instability
- Availability of weapons
Appendix 3 ~ Resources


Royal College of Psychiatrists (2008). Rethinking risk to others in mental health services.
http://www.rcpsych.ac.uk/publications/collegereports/cr/cr150.aspx
