CLINICAL RISK MANAGEMENT

A Clinical Tool and Practitioner Manual

Steve Morgan

The Sainsbury Centre for Mental Health
Clinical Risk Management

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Dedication

For Thomas and Bethan.
Also for all the service users who experience risk much more frequently as victims rather than as perpetrators. May the process of assessing and managing these issues become more collaborative.
Disclaimer

The guidelines and documentation offered in this publication are intended to promote good practice in the assessment and management of risks. They may be *adopted in whole*, or *adapted in part* to local needs. However, the prospect of eliminating all future risks is unrealistic, and we strongly support the aim of practitioners, teams and organisations in pursuit of risk minimisation. Even with the best quality clinical practice and procedures in place, some incidents will inevitably occur.

For this reason, neither the author, nor the Sainsbury Centre for Mental Health, can accept liability in respect of any claims for personal and/or property damage, or any financial losses, sustained following the occurrence of incidents in local mental health services.
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Introduction

The aims of the Clinical Tool and Practitioner Manual are to provide:

1. A practical tool for guiding and documenting the integrated assessment and management of clinical risks in mental health services.

2. A template to individual practitioners and area services for the development of their own locally relevant clinical tool. This template may be adopted in whole, or adapted in part, to the needs of local services.

3. Practical explanations for the structure and format of the clinical tool.

4. A response that realistically addresses some of the themes outlined in the section on ‘Practice-based Evidence’.

5. Examples of some of the issues confronted by mental health services engaged in the management of clinical risks.

6. A format that may meet shared needs across an area mental health service within the context of the Care Programme Approach. For use in acute services, crisis intervention and longer-term community mental health teams.

DEFINITIONS

Risk (in mental health):

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

Risk assessment:
A gathering of information and analysis of the potential outcomes of identified behaviours. Identifying specific risk factors of relevance to an individual, and the context in which they may occur. This process requires linking historical information to current circumstances, to anticipate possible future change.

Risk management:
A statement of plans, and an allocation of individual responsibilities, for translating collective decisions into actions. This process should name all the relevant people involved in the treatment and support, including the individual service user and appropriate informal carers. It should also clearly identify the dates for reviewing the assessment and management plans.
Mental health services in recent years have become dominated by the call for ‘evidence-based practice’. We quite rightly demand that users of services should expect and receive treatment and supportive interventions that are clearly demonstrated to be effective. The National Institute of Clinical Excellence (NICE) has been established with a remit to search for the national and worldwide research evidence for the effectiveness of the treatments and approaches being used across the health service in the UK. Most professional journals that previously focused on descriptive accounts of service delivery have undertaken dramatic shifts of emphasis in favour of publishing research-based articles. Organisations can be expected to be aware of the evidence base to support their service development structures. Similarly, practitioners and multi-disciplinary teams can be expected to be aware of the evidence base, which supports their routine clinical practice.

However, when we apply this approach to the complex issues of risk, a number of fundamental considerations arise:

1. What are the sources of evidence?
2. Who uses which sources?
3. How is the evidence used?

SOURCES OF THE EVIDENCE

The available evidence on risk generally focuses on the incidence of tragedies (Taylor and Gunn, 1999; Appleby, 1999), service failures (NHS Executive, 1994a; Sheppard, 1996), and research factors supporting the identification of broad categories of risk e.g. harm to others and harm to self (Lipsedge, 1995; Borum, 1996; Buchanan, 1997). Most commonly, the evidence focuses on the incidence of violence and homicide, with a secondary concern for suicide. Appleby (1999) clearly demonstrates these priorities to be in opposition to their real incidence. Severe
self-neglect whilst being identified in Government guidance (NHS Executive, 1994b) receives comparatively little attention in the research literature (Morgan, 1998a; 1998b). Similarly, the experience of service users as victims of risk, rather than perpetrators, receives little attention.

REPRESENTATION OF THE EVIDENCE

The reporting of the evidence demonstrates an equally disproportionate bias towards the incidence of violence and homicide. The media play a leading role in generating a misrepresentation of mental health services in general, and the policy of community care more specifically. Nonetheless, public perceptions and fears are strongly influenced by this bias in the absence of any other information forthcoming from the service providers. Successive governments are prone to the influence of the ballot box and consequently will be persuaded by the evidence that influences public opinion.

Feedback from participation in risk workshops suggests that many busy practitioners appear to be in a similar position to the general public. Whether by workload, inclination, or lack of access they receive more knowledge of the evidence from media reports than from the professional research (even though it appears contradictory to their experience of the incidence of different risks). Yet, in order to find more objective accounts, particularly of the incidence of homicide and suicide within mental health services, we need to look to the professional press (Taylor and Gunn, 1999; Appleby, 1999).

USES OF THE EVIDENCE

How the evidence translates into practical guidance is a further source of concern. It is frequently used to justify the needs for successive forms of government guidelines (Department of Health, 1990; 1995). Whilst these may occasionally be based on reasonable principles, the impact on clinical practice is more often felt to be bureaucratic and administrative impositions, more concerned with the completion of paperwork, than with the reality of clinical practice.

Major research initiatives establish complex methods of assessing the risk (Monahan and Steadman, 1994), which do not easily translate from research-based practice to routine clinical practice. This is primarily because of resource issues – time being a major concern. There may also be issues of ownership: where practitioners perceive an imposition of complex solutions that fail to reflect their experiences, they may feel less motivated to implement new ideas.
A narrow media representation of the risks in mental health engenders wide-ranging fears – with real or perceived expectations appearing unrealistic, and somewhat misguided. These are generated at a number of levels:

- **Fears are engendered in the general public**, that a national policy of community care is to blame for the homicides of innocent people. The expectation is one of ‘risk elimination’, if this policy is to be pursued further.

- **Fears are engendered in mental health practitioners**, that their performance will be measured by their ability to predict risk and ensure public safety. The expectation is one of ‘individual scapegoating’ for any service failings.

- **Fears are engendered in service commissioners and managers**, that the mental health agenda is driven, and ultimately measured, by the risk agenda. The expectation is that finite resources will continue to be stretched across infinite demands, whilst still ‘effectively managing’ the complex sources of risk.

These unrealistic expectations fail to acknowledge the unpredictable role that risk plays in the whole context of human behaviour, not just in mental health. The common outcome in clinical practice is one of trained and experienced staff having their confidence undermined. This in turn perpetuates a need for a more coercive approach to service delivery, based more on a fear of failure than on a genuine appreciation of service user needs.

**INQUIRY FINDINGS**

The prominence of the public inquiry into homicides committed by people with a mental health problem is owed primarily to the directives contained in government guidance (NHS Executive, 1994a). Doyle (1998) suggests that individual inquiries provide important messages at both local and national levels. They highlight constructive messages that are specific to the deficits of the care and treatment in an individual case. They also remind us of recurring themes in relation to the failures of service delivery:

- failure to obtain sufficient knowledge about service user’s history
- poor communication between disciplines
- lack of collaboration between agencies
- lack of resources
- failure to adequately assess and manage risk.
The issues of intra-agency and inter-agency communication and co-ordination of services are frequently highlighted. Without attempting to undermine the validity of the message, we need to also look at the problem from a ‘practice-based evidence’ perspective, in order to achieve a fuller appreciation of what might need to change to make services more effective. The system is made up of many parts, each with their different philosophies and remits of work, but each of which needs to be integrated to achieve effective systems of risk identification and management:

- statutory and non-statutory sectors
- health and social services
- short-term acute and long-term support services
- inpatient and community services.

The implication from a service’s perspective is that improved communication and co-ordination does not happen just because a report highlights the need. Significant changes of attitude are needed towards local joint working arrangements, and agreed policies and protocols for assessing and managing risk need to be put into place.

Another very significant message that needs to be carried into service development and delivery is that of accurate recording and accounting of historical information. All too often the key historical information pointing to risk potential has been omitted, withheld or down-played (Ritchie et al., 1994). The vital significance of accessing, and appropriately using, historical information needs realistic boundaries. The time is not available to access all documented information on the history of all service users.

The repetitive nature of many of the findings is beginning to undermine their significance as meaningful messages for change in clinical practice (Muijen, 1997). However, this repetition also suggests that the evidence is failing to drive more effective clinical practice.

**RISK DOCUMENTATION**

The focus on ‘evidence-based practice’ may be expected to influence the format of clinical tools towards risk assessment based on ‘rating scales’ and ‘weightings’ (e.g. Worthing Priority Care, 1995). A numerical approach to clinical tools may fit more easily than a narrative approach to the needs of research and audit. However, Stein (1998) in his survey of Trusts across the UK has found that practitioner and organisational preference has been more in favour of ‘checklists’ than rating scales.
“The prediction of self-harm or harm to others is a complex and unreliable synthesis of observed past behaviour (both inside and outside of hospital) and of future context in the community. The key predictors are well understood but there is much less agreement about how they should be weighted…” (Stein, 1998). Risk workshop participants have also broadly stated a preference for a combination of checklists and narrative formats for developing an aide-memoir and more detailed assessment.

The promotion of the concept of ‘risk assessment’ in the literature has also resulted in a general lack of guidance on what to do when the risks have been identified i.e. ‘risk management’. Good quality risk assessment is not separate and distinct from good quality risk management. They should be seen as entirely integrated functions of the same process. The resulting training and agreed local documentation should give a strong emphasis to all aspects of risk management (Morgan and Hemming, 1999).

One element of managing risks in mental health settings will be the need for reactive crisis management. Whilst this will always have a place in mental health it should not be seen as the basis for all clinical activity. The messages from clinical practice suggest that pro-active and positive risk-taking also need to be given a strong priority if service users are to be encouraged to participate in the assessment and management of their own risks (Morgan, 2000).

To avoid the inevitable fears of blaming and scapegoating, the clinical tools at our disposal should not be designed in a way that sets practitioners on the road of working with risks in isolation from their multi-disciplinary and multi-agency team colleagues. They need to directly encourage a shared approach to information sharing and decision making. A focus on quality risk management requires recognition of the goal of risk minimisation through an integration of the responsibilities performed by the individual, the team, and the organisation.

Finally, risk should be placed into its true context as one of many components in comprehensive mental health service delivery. It is about integrated, multi-disciplinary, multi-agency discussion and co-ordination; promoting service user and carer involvement, and valuing colleagues across all sectors. Risk is an integral part of the wider spectrum of good mental health care, and of health promotion…not separate from it! The evidence for improvements to clinical practice will be gained from closer scrutiny of clinical practice, not solely from the academic research programmes.
REFERENCES


METHODS OF ASSESSMENT

The means by which individuals gather information and conduct their assessment are many and varied. The most significant factors are:

- access to relevant information
- time for gathering, discussing and analysing the information.

The methods used are:

- access to past records from all relevant sources;
- self reports at interview;
- observing discrepancies between verbal and non-verbal cues;
- reports from significant others, formal and informal discussions, with:
  - carers, friends, relatives
  - other team members/other teams
  - other statutory or voluntary sector mental health agencies
  - police, probation, courts;
- rating scales and/or descriptive reports;
- intuitive gut reactions (vital clues, not easily documented);
- recognising repeating patterns of behaviour.

It is not always a solitary exercise, although initial data collection, interviews and observations may be the responsibility of one or two people. It requires perseverance and persistence to gain the relevant information, and detailed multi-disciplinary discussion to organise and evaluate it. Assessment is as much about telephone conversations and written requests as it is about translating the information into a coherent plan of action.
The methods of assessment are undoubtedly time-consuming with an inevitable impact on practitioner workloads. If effective risk minimisation requires comprehensive assessment and service co-ordination, difficult organisational decisions may need to be made, particularly about service priorities and the impact of practitioner caseloads of 25 upwards on effective management of identified high-risk service users. Audit systems also need to recognise the total workload involved in a 'case' i.e. face-to-face contact is only one element of the work involved.

MENTAL STATE ASSESSMENT

A central theme to all assessment of risk will be an assessment of the person’s mental state. This specialist area of assessment is not the subject of this particular publication, therefore will not be dealt with in any detail here.

What is important to note, at this stage, is that everyone is involved in mental state assessments but to differing degrees of expertise and knowledge:

● specialist detailed mental state assessments are the expertise of the Psychiatrist (general and forensic);

● non-specialist detailed mental state assessments are regularly performed and documented by the other mental health professions (nursing, social work, occupational therapy, psychology); based on initial training, post-graduate experience, and exposure to specialised mental state assessment tools (e.g. mental state examination, brief psychiatric rating scale, diagnostic interview);

● all workers in the independent (voluntary) sector services, by virtue of their focus and experience, will be making judgements of mental state against what is broadly considered to be the norm for behaviour; some of these workers will have higher degrees of expertise in this area, depending on both post qualification and personal experience;

● significant carers and service users themselves, generally know when something is not quite usual, i.e. changes in a person's mental state. They often communicate concerns based on such an assessment, but their ordinary use of language is not always accorded the significance it deserves. Consideration of these early warning signs probably offers the best hope for effective risk prevention or minimisation!
CONFIDENTIALITY ISSUES

It is essential to have close liaison with and between all agencies involved in delivering mental health services for service users. Full and accurate information is crucial if the level and type of risk is to be accurately assessed and effectively managed. Health, social services, independent sector, criminal justice and specialist service providers (e.g. substance misuse, housing) should be routinely involved in collaborative management plans, where their expertise is relevant.

The importance of information sharing cannot be over-emphasised when assessing future risk of an individual. The messages from report of inquiries, and from government departments, have all too frequently proved that information indicating an increased risk existed but had not been communicated and acted upon. Key pieces of historical information were often frequently overlooked or played down. Confidentiality is frequently called upon as a defence. Yet, in completing assessments of risk, information should be shared with other agencies according to need in particular instances, whilst respecting the confidentiality of third party information.

The above statement need not be seen as a contradiction of terms. The identified risks, and management plans, should ideally be developed in collaboration with the service user. This information can then be passed on to the relevant people and agencies with the specific agreement of the service user. Where this agreement is not possible, or is refused, an objective decision will need to be collectively taken on whether there are grounds to breach confidentiality in the interests of the protection of others. Legal precedents have been set supporting practitioners who breached confidentiality where there was a clear statement of intent to endanger a named person. These important decisions should not be left as the responsibility of an individual alone, they should at least be discussed with a supervisor and/or the team of people within the specific agency, who are already involved in the care of the individual. These decisions should also be made in accordance with locally agreed confidentiality agreements.

Being prepared to learn the ‘language’ of other agencies is an important part of effective multi-agency communication. It is envisaged that by undertaking joint training sessions, and the introduction of common risk assessment procedures and documentation, that a common language will evolve between all statutory and non-statutory sector agencies within a local area service. Respecting information from all other sources is vital.
There is a strong argument for developing local information leaflets to inform service users about the importance of sharing information whilst also respecting confidentiality. Being more open about the difficulties, and the current lack of clear guidance, may be a significant step towards reducing some of the barriers.
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CLINICAL RISK MANAGEMENT SUMMARY SHEET

Steve Morgan  The Sainsbury Centre for Mental Health

Client’s name: Date of birth / /

To be used as a summary of the comprehensive assessment and management plan, or as a brief up-date when a detailed version is not required.

SUMMARY OF RISK ASSESSMENT

Involvement of service user and/or carers in assessment

Primary risks identified

Other risks identified

INITIAL RISK MANAGEMENT PLAN

Precautions

To be discussed with

Information needed

Actions

Completed by Date Time

Review date

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This format should form an integral part of a comprehensive mental health assessment and care planning process. This is not an exhaustive list of risk factors; it gives an initial indicator of the potential sources of risk, and possible management responses. Accurate prediction of risk is difficult, as the initial assessment will necessarily be based on incomplete, and possibly inaccurate information. This assessment should offer a guide to areas requiring further discussion and investigation, and an initial plan of management within available resources. If completed by one person, this assessment should be quickly discussed with the Responsible Medical Officer and/or multi-disciplinary team (inc. users and carers, where appropriate)...

### NETWORK OF SUPPORT AND COPIES SENT TO

<table>
<thead>
<tr>
<th>Network of Support</th>
<th>Names (where relevant):</th>
<th>Copies sent to:</th>
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<tbody>
<tr>
<td>Service User</td>
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<tr>
<td>Carer(s)</td>
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<td>General Practitioner</td>
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<td>Psychiatrist</td>
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<td>Social Worker</td>
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<td>Occupational Therapist</td>
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<td>Psychologist</td>
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<td>Support Worker(s)</td>
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<td>Voluntary Agency Worker(s)</td>
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<tr>
<td>Other (please specify)</td>
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### RISK INDICATORS

#### SUICIDE

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<tr>
<th>Risk Indicator</th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
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<tbody>
<tr>
<td>Previous attempts on their life</td>
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<td></td>
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<tr>
<td>Previous use of violent methods</td>
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<tr>
<td>Misuse of drugs and/or alcohol</td>
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<tr>
<td>Major psychiatric diagnoses</td>
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<td></td>
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<tr>
<td>Expressing suicidal ideas</td>
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<tr>
<td>Considered/planned intent</td>
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<tr>
<td>Believe no control over their life</td>
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<tr>
<td>Other (please specify)</td>
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<td></td>
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<tr>
<td>Expressing high levels of distress</td>
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<tr>
<td>Helplessness or hopelessness</td>
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<td></td>
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<tr>
<td>Family history of suicide</td>
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<tr>
<td>Separated/widowed/divorced</td>
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<tr>
<td>Unemployed/retired</td>
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<tr>
<td>Recent significant life events</td>
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<tr>
<td>Major physical illness/disability</td>
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### Comments

........................................................................................................
........................................................................................................
**NEGLECT**

- Previous history of neglect
- Failing to drink properly
- Failing to eat properly
- Difficulty managing physical health
- Living in inadequate accommodation
- Lacking basic amenities (water/heat/light)
- Pressure of eviction/repossession
- Other (please specify)

- Lack of positive social contacts
- Unable to shop for self
- Insufficient/inappropriate clothing
- Difficulty maintaining hygiene
- Experiencing financial difficulties
- Difficulty communicating needs
- Denies problems perceived by others

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**AGGRESSION/VIOLENCE**

- Previous incidents of violence
- Previous use of weapons
- Misuse of drugs and/or alcohol
- Male gender, under 35 years of age
- Known personal trigger factors
- Expressing intent to harm others
- Previous dangerous impulsive acts
- Other (please specify)

- Paranoid delusions about others
- Violent command hallucinations
- Signs of anger and frustration
- Sexually inappropriate behaviour
- Preoccupation with violent fantasy
- Admissions to secure settings
- Denial of previous dangerous acts

---

**OTHER**

- Self-injury (e.g. cutting, burning)
- Other self-harm (e.g. eating disorders)
- Stated abuse by others (e.g. physical, sexual)
- Abuse of others
- Harassment by others (e.g. racial, physical)
- Harassment of others
- Risks to child(ren)
- Other (please specify)

- Exploitation by others (e.g. financial)
- Exploitation of others
- Culturally isolated situation
- Non-violent sexual offence (e.g. exposure)
- Arson (deliberate fire-setting only)
- Accidental fire risk
- Other damage to property

---

**Comments**

-

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SITUATIONAL CONTEXT OF RISK FACTORS
(including, for example – arousal in official settings, risks in community locations, friends/neighbours/carers, need for two workers, race or gender considerations, etc.)

HISTORICAL AND/OR CURRENT CONTEXT OF FACTORS

SUMMARY OF ‘POSITIVE’ RESOURCES AND POTENTIALS
SUMMARY OF ‘RISK ASSESSMENT’
(including, for example – factors, context, gut reactions/intuition, potential for positive risk taking, etc)

OPPORTUNITIES FOR RISK PREVENTION
(including risk mitigating/protective factors)

‘RISK MANAGEMENT’ CONSIDERATIONS
(including, for example – who, what, how, when, expected outcome, positive potentials, etc.)

Care Programme Approach registration (tick all relevant areas)

- CPA
- Section 117
- Other Section
- Supervised discharge

- Level
  - Standard
  - Enhanced

Role of client and/or carer in plan

- Client involved
- Client agreed to plan
- Carer involved
- Carer agreed to plan

Comments

[Blank lines]
SHORT-TERM CRISIS MANAGEMENT OPTIONS

LONG-TERM RISK MANAGEMENT OPTIONS

POSITIVE RISK OPTIONS (and support needed)

RESPONSIBILITIES FOR ACTIONS (including timescale and/or dates)

Date of next review: ________________________________ Place: ________________________________
Completed by (for collective responsibility): ________________________________ Date: ________________________________
By the nature of its structure and design, a clinical tool for assessing and managing risk should function as a guide to practitioners for the ‘collection’, ‘discussion’ and the ‘documentation’ of information. The format is broadly structured into:

- summary sheet
- assessment (checklists)
- assessment (narrative)
- management plan.

### SUMMARY SHEET

#### SUMMARY OF RISK ASSESSMENT

1. **Involvement of service user and/or carers in assessment**
   
   A central principle of good practice in mental health, but not always achievable in practice, hence the need to document the status of involvement clearly on the front sheet. In some instances, the issues of risk may not have been clearly discussed; or, one or other party may have fundamental disagreements with the plan.

2. **Identified risks**
   
   A summary of current and/or historical concerns, separated into primary and other significant risks, will be readily deduced from the previous assessment formulation.
The summary of a plan needs to identify any specific precautions that may influence its implementation (e.g. need for more than one worker, location of meetings, race or gender considerations, etc.). An initial plan should not be considered the responsibility of one individual in isolation. It may have been compiled by one person in a short period of time, but the emphasis should still encourage broader discussion for collective decision making.

Gaps in information will be inevitable. Recognition of these, and how they may be followed up, will be an important element of planned action. This will also act as a statement of ‘current’ knowledge, in the event of something going wrong.

A summary of the likely actions should primarily reflect the immediate needs. Where possible, the statement of actions should logically reflect the assessment information as it is translated through the decision-making process.

**DETAILED ASSESSMENT & MANAGEMENT PLAN**

*Introductory statements*

The following statements are intended to reflect the organisation’s policy on risk within comprehensive mental health service delivery. They should act as a reminder to the individual practitioner and multidisciplinary team, that risk is an inevitable part of the work. It should be incorporated into clinical practice confidently, not through restrictive practice based primarily on fear of failure. Individual practitioner and collective team confidence will only be built on the knowledge that the organisation recognises what are ‘reasonable’ expectations.

The organisation should also demonstrate support for its staff at times when incidents occur, recognising that reasonable expectations linked to good practice can achieve ‘minimisation’ rather than elimination of risks.

1. This format should form an integral part of a comprehensive mental health assessment and care planning process.

   This statement acts as a reminder that the primary function is the delivery of a mental health service of which risk constitutes one element of daily clinical practice. Fear of failure should not perpetuate an illusion, that it is the risk business overshadowing all other functions of mental health services.
To this end, risk assessment will form one part of comprehensive
mental health assessment. Furthermore, on-going assessment and
management of risk should be placed in a collective decision-making
forum – the broader care planning process within an integrated
Care Programme Approach/Care Management system.

2 This is not an exhaustive list of factors; it gives an initial
indicator of the potential sources of risk, and possible
management responses.

No checklist can aim to be an all-inclusive representation of
human behaviour. Where they have been validated in research,
they can serve to highlight some of the more frequently occurring
risk markers observed in the context of mental health. Clinical
practitioners are concerned with the responsibility for assessing and
managing the risks experienced by individual people in their care.
Consequently, the relevant risk factors in a given clinical situation
will be determined by the context of the circumstances experienced
by the individual service user. Research can only offer a useful supple-
mentary guide.

Completion of an assessment checklist will usually serve as an
indicator of potential risks at a particular point in time; or at least
across a short timescale. Previous behaviour is a strong indicator of
future potential behaviour, and the importance of historical accuracy
must not be underestimated. However, the context of historical risks
also needs to be understood and weighed up in relation to current
circumstances. People do have a capacity to change.

3 Accurate prediction of risk is difficult, as the initial
assessment will necessarily be based on incomplete,
and possibly inaccurate information.

Research on practitioner predictive ability of risks is not encouraging.
Establishing prediction as a priority expectation, may only serve to
strongly undermine practitioner confidence. The reality of clinical
circumstances means that practitioners are frequently being asked to
make judgements based on information that is both scattered across
several agencies, and frequently protected by claims of confidentiality.

It is simply unreasonable to expect accurate predictive abilities, when
the very nature of human behaviour can be highly unpredictable. The
information on which predictions are inevitably based is either not
available, or inaccurately communicated.

Practitioners should not be primarily judged on their ability to predict
the unpredictable. Not at least until information systems perform
more efficiently, rapidly and accurately; and issues of confidentiality
are resolved to the satisfaction of all, including the service user.
4 This assessment should offer to guide areas requiring further discussion and investigation, and an initial plan of management within available resources.

The assessment and management of risk is a fluid process. To be meaningful to clinical practice it needs to be a practical tool that supports and guides collective discussion between all the relevant personnel, including the service user and significant carers. Gaps in information should be seen as sources for further discussion and investigation, rather than assumptions that may occasionally prove to be false.

Signing and dating a piece of documentation serves to place the current level of knowledge and reasoned decision making in the context of time. Practitioners should not be fearful of being held accountable for information they did not have at a particular point in time, nor for the resources that were not available or accessible at that point in time.

5 If completed by one person, the assessment should be quickly discussed with the Responsible Medical Officer and/or multi-disciplinary team (inc. service users and carers, where appropriate).

The design of clinical tools all too often reinforces the work of the practitioner in isolation. Organisations should openly encourage the importance of collective decision making and information sharing, through its practical policy guidance.

Crisis situations will occasionally happen, and the individual will be required to make rapid decisions and take actions in isolation. The more usual approach should be driven by a culture that expects risk to be assessed and managed by multi-disciplinary and multi-agency teams or networks of people, who share information and expertise necessary to support joint decisions.

**NETWORK OF SUPPORT AND COPIES SENT TO**

Naming all of the people directly or indirectly involved in the care and support of an individual service user, helps to identify the sources of information and decision making. Some will have a greater input and a more clearly defined role than others. The ‘Copies sent to…’ offers the basis for establishing the primary current network of communication – who is more fully involved in the plan and/or decision-making process.

These two sections offer a basis for developing a sense of collective responsibility for the whole process of risk identification and the management responses.
Effective decision making, as the basis of good quality risk management, requires that we investigate into the circumstances in which a risk has, or is most likely to happen, i.e. the context. What is the most likely pattern of events that may lead to a risk occurring? Who have been the victims previously, and why? Does the person feel the need to react to their own fears or experiences, and if so, why? This information will be strongly based on an accurate and reliable historical account.

The examples given in the brackets of this section are not an exhaustive list. They act as guides to the type of assessment information you may consider.

This section of the clinical tool has a dual purpose: it can be used to further develop the ‘Comments’ sections of the previous risk indicators; and/or it can be used to develop other sources of risk beyond that posed to, or by, the individual service user.

Apart from the failings of intra-agency and inter-agency communication, the other most significant lesson to be learned from repeated ‘report of inquiries’ is the loss, or oversight, of key historical factors indicating the potential for risk. However, the emphasis must be equally placed on accurate detailing of the context within which the historical incidents occurred. The timescale and frequency with which previous incidents or events have taken place can have a significant influence on the decision-making process that will underpin effective risk management plans.

Depending on the details of the specific incidents - knowing that there is one serious risk occurring 20 years ago, or a series of similar incidents every 2 years up to and including the present time, may significantly alter the way we approach the assessment and management of the current situation.
Risk is more usually seen in the context of behaviour patterns that have the potential for harmful outcomes. However, an essential aspect of our daily lives involves the weighing up of potential benefits from exercising one choice of action over another. This is positive risk-taking, and involves each of us in exercising degrees of autonomy over how we make use of the resources and options that are open to us, and accessing the desired and necessary support that is available to help us achieve our desired aims.

Considering the potential for positive risk-taking should be an essential element of risk assessment. Ultimately, risk management will be dependent on the availability of resources. In addition to the availability of resources within the mental health services, it is vitally important to investigate what resources are available to, or through, the service user, their significant carers and other social supports, as well as the wider community.

A focus on a person’s own coping mechanisms, and previous achievements, will greatly help the task of engaging a working relationship. It is one of the most likely elements on which to develop trust; and will thus offer a strong foundation for good quality and effective risk management.

It is the positive potentials, and stated priorities of the service user themselves, that will guide towards more likely directions for successful collaborative interventions. Positive risk-taking should always be considered as an effective counter-balance to the more usual negative and coercive approaches adopted towards risk in mental health.

This is a drawing together and summarising of the assessment information gathered up to this point. Approached correctly this part of the format will act as a tool to process your thoughts through accurate summary, and not simply a repetition of what has already been documented. It will include quantitative and qualitative information: specific and accurate historical risk factors, and the contextual detail that will offer a more individualised assessment of the person and their environmental, situational and social characteristics.

The more controversial, but no less influential, aspect of comprehensive risk assessment and management lies in the area of ‘gut reaction’ or ‘intuition’. This is difficult to pin down precisely, and may possibly include
an intangible representation of feelings for the particular set of circumstances presenting at the time of the assessment. It represents a reflection of the sum total of an individual’s personal and professional experience which they bring to bear on the qualitative assessment of the situation. It is often hard to objectify those feelings at the back of the mind, those thoughts that tell you things may not be quite what they appear to be. Yet, they are extremely valuable warning bells that may register a need for caution. Conversely, they are the messages that can quite often suggest a potential for taking a positive risk where other objective factors indicate or suggest otherwise.

The formal documentation of gut reactions may pose significant dilemmas:

- negative feelings expressed about a service user’s potential for risk may prove unfounded and inaccurate, and could also potentially be misconstrued to further label and stigmatise a person unnecessarily by others involved in the management and support;
- service users accessing their written mental health service notes may have strong and valid reasons for objecting to negative instincts being expressed in documentation without substantiating evidence;
- what legal standing would they be attributed, if case notes are called before the courts or inquiry panel?

However, these should not deny the significance of gut reaction within decision-making processes, and practitioners should be encouraged to develop their confidence for sharing such feelings with service users, as well as colleagues, where it is appropriate.

Where documented, they should be clearly referenced as gut reaction/intuition, to avoid being confused with objective fact-based evidence.

**‘RISK MANAGEMENT’ CONSIDERATIONS**

The process of assessment, and thinking through the formulation of the assessment information, will necessarily trigger thoughts about the potential actions and reactions in the context of known local resources. Practitioners who identify risks carry responsibilities to take actions with a view to ensuring the risk is reduced and/or managed effectively. In this way the processes of risk assessment and risk management, whilst being distinct functions in themselves, become part of the same integrated and continuous process. Assessment is seen as the identification and description of the risks; and management is a clear statement of plans, actions and responsibilities, linked to the intended outcome of minimising and/or managing the risks.
The intended outcome is as important as the who, the what, the when and the how. It offers a baseline for measuring success or failure, on which to review and change the plans. This should not be seen as a basis for perpetuating a blame culture. Just as risk is a fluid entity, constantly changing, so the plans to manage the risks need to be responsive to change. A statement of risk management plans will rarely be cast in tablets of stone. However, clear documentation of the decisions, and the reasoning for them, will greatly improve the defensibility of the plans should something go wrong.

The service context in which multi-agency and multi-disciplinary working should exist is the Care Programme Approach. This is the forum for sharing information, and collectively deciding and changing management plans. All those involved in the discussions and decisions should be indicated by the previous ‘Network of Support’. The involvement and agreement of service user and/or carer will be particularly significant information at this stage (as included in the previous Summary Sheet).

The details of the risk management plan should be considered under the following five headings:

- **Risk prevention** – the incorporation of risk management within the broader system of care planning implies that all aspects of good care plans will necessarily contribute to the prevention of risk (e.g. relationship-building, suitable accommodation, meaningful daytime activity, etc.).

  Negative risk factors may be counter balanced by ‘risk-mitigating’ factors i.e. the positive resources and potentials that may help to act against the negative risk occurring. These may also be thought of as ‘protective’ factors, which will be supports for a person depending on their individual circumstances and coping methods e.g. living with supportive carers, previous history of ability to adjust to life events, clear lessons learned from a previous suicide attempt, being able to verbalise their distress to others.

- **Crisis management** – includes awareness of individual and service responses available to potentially manage and minimise risks as they are happening (e.g. diffusion strategies at the individual face-to-face level, 24 hour crisis response services to avoid hospital admission or arrange it appropriately, etc.).

- **Long-term risk management** – use of medical and psychosocial interventions with an expressed intention of managing a person’s risk behaviours (e.g. medication management, anger management, supportive counselling, etc.).
● **Positive risk** – being able to define and articulate the type of positive risk that may be appropriate to pursue, in the given situation. This will also need a clear statement of the support that practitioners will require to enable them to translate ideas about positive risk-taking into real actions e.g. backing of multi-disciplinary team, line management, organisational risk policy (particularly in the event of not achieving the desired outcome).

● **Responsibility for actions** – the decisions made within the Care Programme Approach should be collective decisions. However, they should outline the individual responsibilities for putting the plans into actions i.e. who will do what, and when. This should also document the responsibilities of the service user and/or carers, where appropriate.

### FLEXIBILITY OF THE CLINICAL TOOL

A reasonable expectation would be the completion of the whole format early in the care and support of an individual who is referred to a part of the area mental health services. This would be within days for the specialist acute services, and weeks for the longer-term support services (e.g. assertive outreach, community mental health team). More specific standards should be determined by the local area service, to correspond to other locally agreed service standards.

Where risk status changes, the whole assessment and management plan will need to be repeated/up-dated i.e. when there is a significant increase or decrease in the potential for the primary risks.

Where risk status remains relatively static over a period of time, only the summary sheet may be re-considered and up-dated. However, it is recommended that even in the circumstances of apparent static risk status, the whole assessment should be re-appraised at least annually (and more frequently where previous high risks suggest the additional caution).

The frequency of use of the clinical tool is flexible to local service needs. It should be seen as a document for recording the gathering of risk assessment information from the point of referral to a service. This baseline of information will be gradually built up as new information comes to light from subsequent discussions and interviews with colleagues, service users and relevant carers; as well as further information obtained from other documented sources e.g. clinical notes held across different agencies.
The potential for reviewing positive risk-taking should also be considered within the determination of increased frequency of reviews.

Familiarity with an agreed format usually speeds up its process of completion; it is the information gathering that frequently takes up the time. However, you should never under-estimate the time required for discussion and risk management decision making; particularly in the effort to promote a climate of collective responsibility for risk decisions.

To avoid repetition of the process, this information should be able to follow a person who moves through parts of the system. The inpatient unit should be able to expect quick access to the previous assessments, as well as adding their own perspective through assessment of the person in need of acute care.

There is no one single way in which this format can be used, other than the way that is agreed for consistency within an area based mental health service. In some services it may replace existing documentation, in others it may become supplementary to other documentation. It is a part of comprehensive mental health assessment, not a replacement for it.
The broad categories are:

1. **Suicide** – the inflicting of damage or injury to self, with the intention of relieving extreme tension or distress with an intended outcome of death.

2. **Neglect** – the act of disregarding care for self, with the consequence of serious risk to personal health and well being.

3. **Aggression/violence** – an expression of anger, fear or despair, through an extreme and forceful delivery of actions and emotions, inflicting harmful or damaging effects. Violence would include actual physical assault on another individual, extreme outpouring of verbal or written threats and damage to property.

4. **Other risks** – a category designed to reflect a range of risk factors, frequently observed but distinct from the behaviours in the above three categories.

**SUICIDE INDICATOR**

When assessing a person’s risk of suicide the practitioner should consider both previous and most recent suicide attempts. This includes serious (e.g. suffocation, overdose, hanging, etc.) and less serious attempts (e.g. wrist scratching, or anything intended as a ‘cry for help’). Do not consider accidental self-injury or any other unrelated injury. Detail the method used, and the considered seriousness of the attempt.

When considering the severity of an attempt, look at the context in which it was made (e.g. if the person attempted to hang themselves and were only discovered by chance, this is considered more severe than someone who takes a small overdose and then presents themselves to an A&E department). The more severe, the greater the perceived risk.
• **Previous attempts on their life**

  When was the attempt made? The more recent the greater the perceived risk. Have there been several attempts? The more frequent attempts have been made the greater the perceived risk. Consider length of time between attempts - the shorter the period the greater the perceived risk. Consider previous methods - are they similar in nature, is there a pattern? Do previous methods show seriousness of attempt (e.g. only found by accident on previous occasions or did they plan to be found)? Is there a gradual escalation in seriousness of method, or is it the same?

  Are there triggers to the behaviour in the previous attempts (e.g. does the person attempt to harm themselves in given situations, at certain times of the year, such as anniversaries)? If there is a pattern the perceived risk is increased.

  If there is a potential to learn from previous experience the possibility arises of yielding information about risk-mitigating or protective factors.

• **Previous use of violent methods**

  All forms of self-harm or attempted suicide can be considered as violent, but the intensity of the violent action can vary, and the method used may indicate the level of intent. The more violent the action, the more serious the perceived risk. The violent nature of the attempted self-harm or suicide should consider both the previous and current attempts made.

  Violent forms of self-harm or suicide include the use of firearms, knives, rope/other ligatures, drowning, jumping off buildings or in front of moving vehicles/trains, suffocation and inhalation of gases, fire, chemicals, drugs, alcohol and other hazards.

• **Misuse of drugs and/or alcohol**

  When considering whether drugs, alcohol or other substances had a major part to play in the attempted suicide consider both the previous and current attempts made. The taking of drugs or other substances, particularly non-prescription and illegal drugs should be considered. What was the intended purpose of taking them? Is there a resulting change in behaviour (e.g. aggressive, withdrawn, lowering of mood, elation) which may indicate an increased perception of the risk of suicide?

• **Major psychiatric diagnoses**

  Diagnoses of depression, schizophrenia and manic depression are indicated as more prevalent in the incidences of suicide. Depressive symptoms, psychotic experiences, and evidence of thought disorders,
whilst not indicating suicidal intent in isolation, are found to be contributory factors.

- **Expressing suicidal ideas**
  Expression of suicidal ideas should include any fleeting or substantial thoughts made by the person about ending their life, although there may have been no attempts at self-harm. Previous and current thoughts should be explored. Does the person have thoughts or fantasies about taking their own life? How often do these thoughts occur? How does the person respond to these ideas?

- **Considered/planned intent**
  Has the person given any indication of developing plans to harm themselves? Has the person thought about the means they may use? Has the person expressed a resolve to carry out the intended actions – there is no truth in the idea that people who talk about suicide will not carry it out. Seriously expressed intent is the best indicator of intended behaviour.

- **Belief in having no control over their life**
  Does the person express feelings that they have lost all control over what happens to them? Do they consider themselves to be a passive prisoner of their own negative thoughts? If the person feels they no longer have any ability to change their way of thinking away from the negative, or that they can no longer exert any positive influence over their destiny, the perceived risk will be increased.

- **Expressing high levels of distress**
  Expressions of extreme distress with current and/or previous personal circumstances may contribute to a reduced belief in other means to resolve the situation. Reduced faith in alternatives to relieve distress may focus attention on suicide as the only option for success.

- **Helplessness or hopelessness**
  Feeling completely unable to resolve a situation, or to find other solutions, is an indication of the increased perceived risk. Other scales have been developed to specifically measure feelings of helplessness and hopelessness in relation to the potential for suicide risk.

- **Family history of suicide**
  Consider any family history of suicide. This has been found to be an indicator of increased perceived risk for the individual.
● **Separated/widowed/divorced**

Both past and present marital status should be considered. What impact has changing marital status had on the individual’s behaviour? Not all changes of status will necessarily bring negative suicidal outcomes. The opportunity for risk-mitigating factors should equally be considered e.g. leaving a stressful relationship.

● **Unemployed/retired**

Both past and present work history needs to be considered. What impact has changing status had on the individual’s behaviour? Not all unemployed and retired people become suicide risks. Protective factors may be relevant in individual cases e.g. more time to indulge in chosen leisure activities or voluntary work.

● **Recent significant life events**

Losses, bereavements and significant changes in personal circumstances need to be considered. Has the person gone through a number of significant changes or life events in recent months or years? What impact have these changes made to the individual’s behaviour? More significant life events are likely to indicate increased stresses, and an increased perceived risk.

Alternatively, we need to consider the individual’s own coping mechanisms for dealing with difficult changes. These may mitigate against or protect the person against the potential for suicidal feelings.

● **Major physical illness/disability**

Is the person suffering physical ill health? Both past and present health status needs to be considered (acute and chronic illness). How has the illness impacted on the individual’s behaviour? How much control or influence do they perceive the illness to have over their life, and ability to function satisfactorily? The greater the perceived impact the greater the perceived risk. What supports are in place to help protect the individual against potential suicidal ideas e.g. membership of a specific disability group.

● **Other**

Potential factors identified in research include age (below 35 and over 60); gender (more females attempt, more males succeed); access to means; isolation, and lack of positive social contracts/relationships/networks/cultural links.
Effective assessment based on this Indicator will require access to the relevant information currently documented in many different sources, and the confidence to ask direct questions about potentially distressing material in a skilled manner. Not enquiring about suicidal ideas, intent and past attempts, for fear of triggering their renewed potential is largely a myth. For many people, talking with someone who demonstrates active listening skills, empathy and understanding can offer some sense of relief from intense distress. It also enables clearer and more focused management plans to be agreed.

Areas of enquiry may include (not an exhaustive list):
- detailed accounts of past feelings and attempts
- levels of despair
- thoughts about ending life
- development of suicide plans
- reasons or motives for plans
- new or increasing stresses in life
- hopes for the future
- current/past sources of enjoyment.

Whilst this assessment is significantly weighted towards the successful conclusion of a negative outcome i.e. completed suicide, we need to pay equal attention to assessing potential risk mitigating factors i.e. the thoughts, ideas, resources and relationships that support a person’s potential to draw back from suicidal intent. These are the factors that offer hope and support for the person in the future. They may also include the lessons learnt from previous negative experiences e.g. is there any positive thinking that has evolved from a previous failed suicide attempt? What has been, and remains important to you? What impact would you consider your death would have on other people?

**NEGLECT INDICATOR**

This is probably the category of risk with the highest incidence in mental health services. It is also an area with a strong potential for imposing personal standards and subjective views. These may not be shared by the individual service user, and therefore may not be so helpful in the development of an agreed management plan.
Previous history of neglect
A previous history of serious neglect, by self and others, will be the strongest indicator of repeat or continuing behaviour patterns. This will relate to neglect of environment as well as personal care and health. Where possible, some consideration needs to be given to the standards being operated by the person reporting the occurrence of self-neglect – are these personally and culturally appropriate, or are they based solely on individual judgement?

Failing to drink properly
Fluid intake is vital for life and well being. Consider whether the person has adequate intake, and to what extent their intake may relate to a condition of self-neglect rather than other causes (e.g. economic). The more severe the deficiency the greater the perceived risk.

Failing to eat properly
Whilst not as urgent as fluid intake, nutritional intake can still become life threatening if sufficiently neglected. To what extent is the reduced nutritional intake a factor of neglect, or a factor of other causes (e.g. economic)? The more severe the deficiency the greater the perceived risk.

Difficulty managing physical health
Consider whether the person is managing any of their physical health problems adequately. How this impacts on the person’s behaviour in meeting their physical needs will depend on the degree of the physical problem (e.g. has the person recently developed a physical illness that has caused major life changes, such as diabetes). The physical health needs of people with primary psychiatric diagnoses may frequently be overlooked, or attributed more to symptoms of a psychiatric condition. This potential needs to be guarded against.

Living in inadequate accommodation
Consider whether the person’s accommodation is adequate and able to provide a living environment, which is reasonably comfortable and supportive. Assess the current level of care and support, and the degree to which it impacts on the person’s ability to remain within their current accommodation.

Lacking basic amenities (water/heat/light)
These are considered the basic elements of need to support an adequate quality of living environment. If any or all are absent,
consider the reasons for the absence. Have amenities been cut-off due to a basic failing on behalf of the person themselves? Consider what support may be required to re-instate the amenities, and what changes of behaviour may be needed to achieve this aim. What is the person’s own view of the situation where amenities are lacking?

- **Pressure of eviction/repossession**
  Eviction relates to rented sector tenants, and repossession relates to private sector homeowners. Consider whether the person is experiencing impending loss of accommodation. Both past and present evidence of such loss should be considered. What are the underlying reasons for real or impending loss of accommodation? What is the person’s own reaction to these reasons?

- **Lack of positive social contacts**
  Consider whether the person has social contacts that will enable their behaviour and lifestyle to be challenged or compared with that of other people they feel close to and/or respect. Consider whether other people who know the individual hold perceptions of neglect, or whether they are able to shed light on personal or cultural influences on behaviour patterns.

- **Unable to shop for self**
  Consider whether the person is able to shop for themselves and purchase basic necessities for every day living. Are they able to access services correctly, or ask for appropriate help? What are the most likely reasons for any particular failing in this area?

- **Insufficient/inappropriate clothing**
  Consider whether the person’s clothing afford them sufficient warmth and comfort. Is it a potential source of drawing attention to themselves, with the potential for exploitation by others? Does inappropriate clothing reflect reasonable differences of thinking and culture, or is it a sign of impeded mental state?

- **Difficulty maintaining hygiene**
  Consider if the person can meet their personal hygiene needs, both simple and complex (e.g. personal grooming, basic health care, washing, laundering). What may be required in order to bring about changes to these abilities?
● **Experiencing financial difficulties**

Both past and present evidence of financial difficulty should be considered. What support and care is currently necessary in order to impact on the person’s ability to manage their finances? Is the situation brought about by inappropriate forms of spending and/or failure to access all the entitlements they have? Consider whether the person has any significant debts. What are the sources of these debts, and how may the person respond to new knowledge of such debts?

● **Difficulty communicating needs**

Consider whether the person has any difficulties in communicating with others, whether through language, attitudes or conflicting ideas. Is the person orientated in person, place and time; confusion often leads to deterioration in self care and ability to communicate difficulties on the person’s ability or desire to care for themselves.

● **Denies problems perceived by others**

Consider whether the person is preoccupied with thoughts, which are not in keeping with the person’s circumstances, and how these ideas affect their ability to cope. Is repeated denial based on substantial evidence, or is it completely unsubstantiated and indicative of an impaired mental state.

● **Other**

Potential factors that may indicate real or perceived self-neglect may include: care for their domestic environment; adequate management of a physical disability; impact of symptoms of mental impairment; impact of drug, alcohol or other substance abuse.

An overall assessment of serious neglect will largely depend on an accumulation of factors, rather than one factor in isolation. Furthermore, sharing information and discussing viewpoints collectively will help practitioners consider their own standards and boundaries within the assessment and management of self-neglect.

Areas of enquiry may include (not an exhaustive list):

- problems coping with daily needs
- understanding of the concerns of others
- reasons for sustaining the status quo
- understanding of the meaning of environmental health
- recognition of a personally deteriorating condition
- consideration given to the advice of others
- understanding consequences of courses of action.

AGGRESSION/VIOLENCE INDICATOR

This category may represent the lowest incidence of all the broad indicators, but it holds the potential to attract most attention through its ability to tap into personal and collective fears of assault.

- **Previous incidents of violence**
  This is stated in the research as being the most prominent indicator of future violent behaviour. Has the person’s behaviour, past and present, resulted in their intent to harm other individuals, whether named or otherwise? Have they made physical threats to others, which may or may not have resulted in physical injury or destruction of property? Have they made psychological threats to others, which may or may not result in injury, by inciting others to act in a violent manner? The assessment needs to list past incidences, and elaborate the circumstances leading up to these events. Consider the frequency, the more persistent and repetitive the behaviour the higher the risk. Conversely, we also need to be aware of and investigate the individual’s potential to learn from previous behaviour, as a possible protective or risk-mitigating factor.

- **Previous use of weapons**
  Was a weapon used by the person to harm others? Consider what type of weapon. Consider both past and most recent use of weapons in the context of current circumstances. Has the person made weapons, hidden weapons, or carried weapons on a regular basis? Have they a history of using objects impulsively as a weapon (e.g. picked up a chair to use as a weapon, thrown a cup with the intention to harm others)?

- **Misuse of drugs and/or alcohol**
  Consider past and present evidence of alcohol, drug or other substance misuse, and the degree to which it impacts on a person’s behaviour. The use of alcohol and/or drugs correlates with a high incidence of aggressive and violent behaviour. How have drugs and/or alcohol figured in the circumstances leading to any previous incidents of aggression and/or violence?
● **Male gender, under 35 years of age**
  Research evidence points to aggression and violence being committed more frequently by males than females, and by people under 35 more than over 35. Do not consider these factors in isolation, but in relation to many others within this Indicator.

● **Known personal trigger factors**
  Consider known information elicited from knowledge of the person's history of aggressive and violent behaviours. Can they identify any triggers themselves? Is there a known pattern (e.g. stressful events, methods, frequency)? Conversely, have protective factors been identified through the individual's understanding of personal trigger factors?

● **Expressing intent to harm others**
  Is there any evidence of planning assaults, such as targeting particular people? What is the access to means, i.e. weapons? If they admit to thoughts of harming others, the risk is increased. If they have access to means, the risk is increased. If they have stated their intent to harm someone else, the risk is increased.

● **Previous dangerous impulsive acts**
  Is there a history of responding to circumstances with impulsive acts of a dangerous nature (e.g. lashing out with a weapon)? Has the person denied any planned intent, but just acted on the spur of the moment? Has the person engaged in dangerous risk-taking with no claimed forethought? The assessment should aim to elicit the person's thinking in relation to such risk-taking (e.g. any remorse, or understanding of the high risks). If the person has learned about their own impulsivity, this may constitute a protective factor against repeated patterns.

● **Paranoid delusions about others**
  Evidence of paranoid delusions towards specific individuals, and a consideration of the impact these have had on the person's behaviour. Who are they currently paranoid about? How do they wish to resolve these concerns? Are they considering a need for violence towards others?

● **Violent command hallucinations**
  What is the context of the hallucinations (do they relate to specific others or a need to attack others in general)? How strongly are the commands shaping the behaviour of the individual?
● **Signs of anger and frustration**
These signs may be verbal or non-verbal, and represent an increased level of physical and emotional tension. Consider the issues promoting these feelings. What does the person feel now (e.g., powerless to change circumstances with anything less than aggression and/or violence)? Do they have thoughts of harming others? Do they resort to anger to resolve conflict in everyday interactions? What have been the previous outcomes of expressions of anger and personal frustration? What has been the potential for identifying risk-mitigating factors in this instance?

● **Sexually inappropriate behaviour**
Consider any evidence of sexual behaviour towards children, and any sexual behaviour that does not involve consent of others. Sexual behaviours being practised amongst consenting adults are not to be considered. Incidents or plans to rape, or to subject others to sexual humiliations under threat of harm are to be considered as an indicator of future increased perceived risk.

● **Preoccupation with violent fantasy**
Evidence should be considered of a previous and current focus of thoughts on violent acts towards others. This may result from preoccupation with violent and/or sexual printed/recorded material, particularly with a plan to re-enact the fantasies on others.

● **Admissions to secure settings**
Consider previous admissions to high/medium/low secure units, including any history of seclusion. Although not always an indicator of a violent history, being in a secure setting may indicate a complex need, and some people may have a serious history of poor conduct disorder with a potential for aggression and/or violence.

● **Denial of previous dangerous acts**
Assessment needs to balance different views of what constitutes violence. What is the person’s own explanation and interpretation of their previous behaviour determined as violent by others? How is the denial conveyed (e.g., in an aggressive or passive manner)?

● **Other**
Examples may include:
Known victims, and the reasons why they become victims; assessed severity of previous acts; stalking behaviours; hostage taking.
Many of the factors covered within this Indicator may engender difficulty in formulating questions without the fear of eliciting aggressive or violent responses.

Areas for enquiry may include (not an exhaustive list):

- history of aggression and violence;
- family history of aggression and violence;
- personal justifications for using aggression and violence;
- considered options for resolving anger and frustration;
- personal responses to fear or threat;
- carrying, or use, of weapons;
- current plans to harm others, general or specific;
- contacts with the criminal justice system.

INDICATOR OF OTHER RISKS

This is a less focused Indicator, attempting to recognise a range of potential sources of risk, which lie outside of the previous three most frequently quoted in the literature and policy statements. Factors within this category reflect a combination of risks experienced by the service user and those potentially perpetrated by the service user.

The service user’s own experiences of risk, real and perceived, are a vitally important element of a comprehensive assessment. They recognise the all-too-frequent experience of service users as victims, not always perpetrators, and help to counter balance the biased picture more frequently portrayed by media, public and government statements.

- **Self-injury** (e.g. cutting, burning)
- **Other self-harm** (e.g. eating disorders)

Self-injury and self-harm are frequently associated with, and categorised with, suicide. Whilst these actions do undoubtedly feature as significant factors in the history of many completed and unsuccessful suicide attempts, they are considered separately in this assessment format. For many people the act of self-harming is not a suicidal precursor; it is indeed quite opposite. For many people forms of self-harming are adopted as the only way to relieve the extreme emotional tension and distress they are experiencing. In this scenario they become life-saving devices rather than life threatening.
Two categories are preferred here, instead of one broad category of ‘self-harm’. This reflects an attempt to distinguish actions with an immediate consequence of injury, from those with a longer-term harming effect. Whilst the broad aim may be self-harm, the needs for each, the proposed outcomes of each, and the consideration of management of each may be quite different.

The assessment of both should investigate the history, frequency, and degrees of harm caused, but most importantly the person’s own reasons for engaging in such actions. The causes may be more a target of appropriate management than the effects.

- **Stated abuse by others** (e.g. physical, sexual)
- **Stated abuse of others**

Assessment of abuse requires consideration of whether one person misuses power over another; for example, by subjecting them to sexual or physical discomfort without any consideration for the victim’s feelings or consent. Abuse involves gratification of one’s own needs irrespective of the welfare of the other person.

This is not an area of personal experience that people readily admit to experiencing or perpetrating on others. Reliance may have to be placed on the accuracy of previously documented discussions with others, in the first instance. In interview, this sort of information may be gleaned from skilful probing of other currently presented facts (e.g. specific allegations made), or it may be forthcoming in the longer-term as a consequence of a developing trusting relationship.

- **Stated harassment by others** (e.g. racial, physical)
- **Stated harassment of others**

Assessment of harassment requires consideration of whether a person verbally intimidates another on perceived grounds of inequality; for example, tormenting another person for being of different colour, gender, sexuality, or physical appearance. Some personally held prejudices may be expressed more by the attitudes and descriptions of others.

An assessment of harassment also needs to take account of the assessor’s potential degrees of prejudice.
● **Risks to child(ren)**  
  This factor may range from the extreme examples of paedophilia, or the sexual and physical assault of children by their own family relations, to emotional abuses of neglect or inappropriate exploitation. At a less intentional level, children may be at emotional risks by their very presence in a home situation characterised by violence, self-harm or bizarre behaviour patterns.  
  The assessment of children at risk may be aided by known contact with relevant Social Services and other agencies. The assessment is made more complex by the potential harm that can be placed on a child by the act of removing them from a home situation, or by subjecting them to inappropriate or intrusive interviewing about circumstances beyond their comprehension or control.

● **Stated exploitation by others** *(e.g. financial)*

● **Stated exploitation of others**  
  Assessment of exploitation requires consideration of whether a person has deliberately set out to make use of some knowledge of another person’s situation with the sole aim of personal gain; for example, over-charging for goods or services, or over-extending the use of someone else’s goodwill. Potential exploitation can be ambiguous, so the assessment requires clear evidence.

● **Culturally isolated situation**  
  This factor is most overtly assessed on ethnic or racial grounds, where a person is assessed to be lacking any social contact with people of similar origin. However, it may be equally prevalent for some individuals experiencing social isolation from others of similar spiritual or socio-political backgrounds, sexual orientation, or like-minded beliefs and social norms. This factor will only be properly assessed as a risk where the individual expresses concerns and feelings of deep sadness and loss about such isolation.

● **Non-violent sexual offence** *(e.g. exposure)*  
  Not all sexual risks involve sexual contact. The assessment needs to consider the real and potential impact of fear and threat. Great distress can be caused to a person fearful of physical or psychological threats to their well being; for example, flashing or stalking may generate fears of more serious and harmful threats to the victim.
● **Arson** *(deliberate fire setting only)*

Where there is a history of fire setting, the assessment should consider the target property, severity of outcome, frequency and pattern of behaviour. It is important to investigate what the potential or real triggers were for the individual's behaviour, such as stressful events, frustration, anger, or fantasising. What was the function of setting the fire, i.e. the intended outcome?

● **Accidental fire risk**

Careful consideration must be made in the assessment for the potential for accidental fires. This is not the same as arson, and will be managed in an entirely different way. It is frequently, but not solely, linked to factors of self-neglect e.g. hoarding of items and rubbish, failure to extinguish used cigarettes, use of candles when major utilities (gas and electricity) have been disconnected.

● **Other damage to property**

This is a factor frequently considered within the definition of violence. If the local policy statement explicitly includes this factor within violence, it will be assessed in the appropriate Indicator, not here. However, where insufficient definition is available, it may be considered here under any other damage not caused by fire (e.g. smashing windows, breaking furniture, damaging cars, etc.).

● **Other**

No assessment format can hope to be totally inclusive. This option is offered in order to document specific risks identified for an individual, which may be difficult to fit into any other factor or Indicator above.

As this Indicator is very broad ranging, so too will be the potential areas of enquiry. Some examples to consider are (not an exhaustive list):

- benefits gained from self-injury or self-harming;
- experiences as a victim of risks from others;
- exploitation or abuse by others;
- loss of contact with people of similar background, ideas or beliefs;
- how children may experience risks;
- experiencing sexual attraction towards others;
- damage to property resulting from anger or frustration.
This section offers examples of four issues encountered in clinical practice, where the clinical tool may offer some useful guidance. A further three completed case studies offer examples of how the clinical tool may be used in the assessment and management of specific situations.

ACCEPTING A ‘REFERRAL’

Assessing risk is a vitally important element of the clinical process from the very first point of contact with the care system. Yet, this is frequently the point at which information is most scarce, or issues of risk can be conveniently left out or played down, for whatever reasons.

The Clinical Risk Management Tool (or local adaptation) may be of benefit to this stage for a number of purposes, acting as:

- a template for organising information gathering;
- a reminder to practitioners of the broad areas of risk that they need to be aware of;
- a message to referrers of the value placed on good quality risk information from the outset, as an inclusion criterion more often than an exclusion criterion;
- a guide to developing good quality care planning (including risk management plans) from the outset;
- a tool to reinforce or underpin the stated inclusion and/or exclusion criteria for a specialist service.

In the case of this latter point, a label of ‘Borderline Personality Disorder’ commonly provokes conflicting discussions within services as to whether or not they should accept a referral for care and support. Whilst not being able to solve this conundrum with a blanket
statement here, this tool may be of some use to specific local services. By following the details of the format, it may be possible to reach an objective decision on the basis of considering the detailed behaviours and potential management plans, rather than on the more usual emotive professional ideologies that people tend to line up behind.

TO ADMIT OR NOT TO ADMIT?

One of the most frequent decisions being grappled with on a daily basis across all mental health services is whether or not a person needs a hospital admission. The decision becomes more acute, in its own right, when faced with 100%+ bed occupancy rates. Difficult decisions are having to be made on a basis of greatest need, because the resources are not available to admit all the people who meet a looser set of criteria.

Whilst the ultimate decision most frequently lies with the doctors (or in some cases the crisis team as gatekeeper to admission and discharge), the issue of potential hospital admission is being considered on a daily basis by all workers involved in delivering mental health services (statutory and voluntary sectors); and indeed, by service users and their carers, when involved in the decision-making process.

The factors that ultimately determine whether someone is admitted or not, are many and varied, and too complex to be fully covered in this publication. As well as need, there is also the consideration of what local alternatives are available e.g. do we have the right kind of resources to sustain someone outside of hospital who would otherwise occupy a hospital bed?

The final decision will, more often than not, turn on issues of risk (to self and/or others). What the Clinical Risk Management Tool may be able to offer to local area services, is the basis for a common language and assessment of the risks, whilst simultaneously being asked to consider the positive potentials and resources available to manage the situation. There can be no substitute for developing adequate alternative resources, but in the meantime, the many people who have to make the difficult decisions should be offered the tools to aid and support the decisions they make.
‘POSITIVE RISK-TAKING’

‘Positive risk-taking’ is perhaps one of the most difficult concepts to put into practice within a context of a ‘blame culture’. Risk-taking is not negligent abdication of clinical responsibility. It is about making good quality clinical decisions to support and sustain a course of actions that will lead to positive benefits and gains for the individual service user. Seen in this way, positive risk-taking should be seen as the first choice focus of clinical interventions. Its basis within the expressed personal wishes of the service user, certainly offers the best starting point for a collaborative working relationship.

‘Positive risk-taking’ is not just about ideas; it also has to be about targeting resources and agreed decisions between all people involved in the network of care and support. The Clinical Risk Management Tool offers an opportunity to enquire into, and identify, the resources and the positive risks that may be possible. It also requires a collaborative plan to be agreed and reviewed in order to proceed with the desired course of action.

Taking an example of a young male (early 20s) who is experiencing intense suicidal ideas, with a history of a previous failed attempt, the logical idea is to think of the place of greatest safety, i.e. hospital admission. If this same person turns out to have made the previous attempt immediately on admission to a hospital ward (because of the stigma of psychiatric hospitals within his peer group), this no longer appears to be the clear place of greatest safety. In this instance, it would be advisable to begin considering what alternatives may be available outside of hospital, even potentially outside of the system. What voluntary agencies locally engage with young men? What intensity of support may be able to be offered into this home? What sources of appropriate talking treatments are available for a young man locally? How can the statutory services take on a supporting and co-ordinating role, with potentially reduced direct contact with the young service user? What options are available for developing self-help?

The Clinical Risk Management Tool does not give clear answers to these questions, but may offer a structure with which to discuss and consider them.
COLLECTIVE RESPONSIBILITY

Risk decision making carries one of the most significant fears for many mental health practitioners – being held personally responsible for failure resulting in tragedy. This fear is greatly fuelled by the perception that formal documentation requiring your signature will then be easily used to locate the person to whom blame can be attached.

In this scenario, ‘paperwork paralyses practice’, as people become more defensive in their practice, fearful of what they document, and looking to shift responsibility to someone else, where possible. Not a very positive snapshot of clinical practice, not realistically supportive of the service user perspective, but a widely held perception nonetheless.

Good practice is based on confidence, and confidence is based on reducing the levels of fear experienced by practitioners. Nobody wishes to deny the existence of individual responsibility, to ensure that our own personal practice is up to a recognised standard. However, the very difficult decisions around issues of serious risk, should be made on the basis of collaborative information sharing, discussion, and consensus agreement on the immediate plan of actions to be pursued. Only one person needs to do the writing, in most cases, and this would more usually be an identified care co-ordinator. However, all people involved in the network of care should be clearly identified on the documentation, as having collaborative involvement in the discussions and decisions. There will be instances where dissent from the decisions will have to be accepted and recorded.

The documentation should serve to demonstrate the current state of knowledge, decision-making processes, plans, and available resources. In this way, it is the main source of defence in the face of scrutiny of practice when something goes wrong.

The following completed examples of the Clinical Risk Management Tool should be scrutinised for their examples of sharing responsibilities for risk.
CASE EXAMPLE 1

The following example has identifying information changed, but is largely based on a true case. It is appreciated that many referrals do not contain so much detail, whilst others sometimes offer more.

REFERRAL INFORMATION

Dear Assertive Outreach Team

Re: Milos M. – dob: 1.9.37.

Address: South London

I would be grateful if you would consider accepting the referral of this 62-year-old gentleman to your service, with a view to offering intensive support to sustain him in the community. He was born in Yugoslavia, but arrived with his wife in the UK in early 1959. He has two children both born in the UK.

Milos was diagnosed with paranoid schizophrenia in the mid 1960s, following a serious assault on a policeman called to the family house in response to neighbours’ concerns about a domestic dispute. He has spent several years in secure psychiatric settings, before returning to live with his family in a South London council maisonette. He has four subsequent admissions to a psychiatric unit outside of London, and has only received minimal community support from the hospital staff and voluntary car service, transporting him back and forth to hospital for his fortnightly depot injection and collection of oral medication. His occasional refusal to do the 30-40 mile round trip has contributed to his relapses through non-compliance with medication.

Milos’s wife has recently died of pneumonia, following hospital admission for heart and lung complaints. One child rarely visits him; the other was closer to the mother and no longer has contact.

The hospital rightly feels that responsibility should be transferred to local services. They are unable to offer sufficient support simply though the ward, at the distance away from his home. The concerns they have communicated to me are the strong possibility that Milos will not be able to cope at home, and will soon require long-term hospitalisation. He will totally disagree with this option.

Milos has failed to attend outpatient appointments sent to him, and is believed to be suffering a poor physical condition. His speech is impeded by a cleft palate, as well as a relatively poor command of English. He remains on a Home Office Restriction Order, and may present serious risks to others, as well as himself. I attach a copy of the detailed summary from the hospital ward.

Yours sincerely,

Dr X
Medical Director

NB The following completed Clinical Risk Management Tool is an example of what would have resulted from a number of weeks’ work following referral. It is based on the hospital summary (not included here), medical notes, visits to the hospital ward, and a few initial visits to Milos at home. It is also a reflection of early attempts to connect with a potential network of support.
Clinical Example 1/p1

**CLINICAL RISK MANAGEMENT SUMMARY SHEET**

Steve Morgan  The Sainsbury Centre for Mental Health

<table>
<thead>
<tr>
<th>Client's name:</th>
<th>MILOS M.</th>
<th>Date of birth</th>
<th>11/9/1937</th>
</tr>
</thead>
</table>

To be used as a summary of the comprehensive assessment and management plan, or as a brief up-date when a detailed version is not required.

### SUMMARY OF RISK ASSESSMENT

- **Involvement of service user and/or carers in assessment**
  - MILOS RESPONDS TO CASE MANAGER INITIATED DISCUSSIONS (AGREEING OR DISAGREEING WITH POINTS RAISED). HIS SON LIVES OUTSIDE LONDON, BUT VERBALLY AGREES TO INITIAL PLANS OVER THE PHONE.

- **Primary risks identified**
  - SEVERE SELF NEGLECT & DETERIORATING PHYSICAL CONDITION. SERIOUS VIOLENCE TO OTHERS OVER 30 YEARS AGO (SINGLE INCIDENT OF STABBING), WITH OCCASIONAL VERBAL AGGRESSION SINCE (REMAINS ON HOME OFFICE RESTRICTION ORDER FOR ORIGINAL INCIDENT).

- **Other risks identified**
  - HARASSMENT BY LOCAL YOUTHS. VERBAL AGGRESSION WHEN DISAGREEING WITH SOME ASSESSMENT OF HIS PROBLEMS, OR WHEN OCCASIONALLY FRIUSTRATED BY HIS COMMUNICATION DIFFICULTIES.

### INITIAL RISK MANAGEMENT PLAN

- **Precautions**
  - KEEP HOME VISITS, BRIEF BUT FREQUENT. ENGLISH LANGUAGE IS POOR, AND SPEECH IS MORE DIFFICULT TO UNDERSTAND BY HIS CLEFT PALATE. MILOS USUALLY ACCEPTS RESPECTFUL REQUESTS TO REPEAT WHAT HE HAS SAID, BUT WILL OCCASIONALLY FEEL FRIUSTRATED, AND APPEAR ANGRY.

- **To be discussed with**
  - RMO; HOSPITAL WARD; ASSERTIVE OUTREACH TEAM; HOUSING; SON.

- **Information needed**
  - CONTINUOUS ASSESSMENT OF HIS REACTION (OR CURRENT LACK OF REACTION) TO HIS WIFE'S RECENT DEATH. HOUSING DEPARTMENT RESPONSE TO CURRENT RENT ARREARS.

- **Actions**
  - CONTINUE TO ENGAGE RELATIONSHIP. GRADUALLY DISSOLVE HOSPITAL INPUT. ASSESS FOR DEPRESSIVE SYMPTOMS AND/OR SUICIDAL IDEAS. DISCUSS AND DEVELOP PLANS WITH TEAM COLLEAGUES & RMO. REVIEW IN ONE MONTH IN TEAM MEETING.

<table>
<thead>
<tr>
<th>Completed by</th>
<th>S. Morgan</th>
<th>Date</th>
<th>1-11-99</th>
<th>Time</th>
<th>4-15pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review date</td>
<td>6-12-99</td>
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</tbody>
</table>

© The Sainsbury Centre for Mental Health 2000 • CLINICAL RISK MANAGEMENT
DETAILED ASSESSMENT & MANAGEMENT PLAN

Client's name: MILOS M. Date of birth 1/9/1937

This format should form an integral part of a comprehensive mental health assessment and care planning process.

This is not an exhaustive list of risk factors; it gives an initial indicator of the potential sources of risk, and possible management responses.

Accurate prediction of risk is difficult, as the initial assessment will necessarily be based on incomplete, and possibly inaccurate information.

This assessment should offer a guide to areas requiring further discussion and investigation, and an initial plan of management within available resources.

If completed by one person, this assessment should be quickly discussed with the Responsible Medical Officer and/or multi-disciplinary team (inc. users and carers, where appropriate)...

### NETWORK OF SUPPORT AND COPIES SENT TO

<table>
<thead>
<tr>
<th>Network of Support</th>
<th>Names (where relevant:)</th>
<th>Copies sent to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service User</td>
<td>MILOS</td>
<td></td>
</tr>
<tr>
<td>Carer(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Psychiatric Nurse</td>
<td></td>
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<tr>
<td>Ward Link Nurse/Key Nurse</td>
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<tr>
<td>Social Worker</td>
<td></td>
<td></td>
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<tr>
<td>Occupational Therapist</td>
<td></td>
<td></td>
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<tr>
<td>Psychologist</td>
<td></td>
<td></td>
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<tr>
<td>Support Worker(s)</td>
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<td></td>
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<tr>
<td>Voluntary Agency Worker(s)</td>
<td></td>
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<tr>
<td>Other (please specify)</td>
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</table>

### RISK INDICATORS

#### SUICIDE

- Previous attempts on their life
- Previous use of violent methods
- Misuse of drugs and/or alcohol
- Major psychiatric diagnoses
- Expressing suicidal ideas
- Considered/planned intent
- Believe no control over their life
- Other (please specify)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
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<tbody>
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</table>

- Expressing high levels of distress
- Helplessness or hopelessness
- Family history of suicide
- Separated/widowed/divorced
- Unemployed/retired
- Recent significant life events
- Major physical illness/disability

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<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
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Comments: RECENT DEATH OF HIS WIFE. MILOS STRONGLY DENIES SUICIDAL THOUGHTS OR PLANS. EXPLAINS HIS OWN DISTRESS AS PEOPLE CONTROLLING HIM, DENIES ANY SPECIFIC FEELINGS TOWARDS RECENT LIFE EVENTS E.G. LOSS OF HIS WIFE.
### NEGLECT

- Previous history of neglect
- Failing to drink properly
- Failing to eat properly
- Difficulty managing physical health
- Living in inadequate accommodation
- Lacking basic amenities (water/heat/light)
- Pressure of eviction/repossession
- Other (please specify)

<table>
<thead>
<tr>
<th>Risk</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of positive social contacts</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
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<tr>
<td>Unable to shop for self</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Insufficient/inappropriate clothing</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Difficulty maintaining hygiene</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Experiencing financial difficulties</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Difficulty communicating needs</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Denies problems perceived by others</td>
<td>☑</td>
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</tbody>
</table>

**Comments:** Remains seated in living room almost 24 hours/day, limited diet, using dirty utensils & kitchen. Threadbare clothing. Neglect has been observed for several years, not just since wife’s death.

### AGGRESSION/VIOLENCE

- Previous incidents of violence
- Previous use of weapons
- Misuse of drugs and/or alcohol
- Male gender; under 35 years of age
- Known personal trigger factors
- Expressing intent to harm others
- Previous dangerous impulsive acts
- Other (please specify)

<table>
<thead>
<tr>
<th>Risk</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid delusions about others</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
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<tr>
<td>Violent command hallucinations</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Signs of anger and frustration</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Sexually inappropriate behaviour</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Preoccupation with violent fantasy</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Admissions to secure settings</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Denial of previous dangerous acts</td>
<td>☑</td>
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</tbody>
</table>

**Comments:** One very serious incident over 30 years ago. Relapses of condition not characterised by violence. Reluctant to discuss potential symptoms of illness or risk factors.

### OTHER

- Self-injury (e.g. cutting, burning)
- Other self-harm (e.g. eating disorders)
- Stated abuse by others (e.g. physical, sexual)
- Abuse of others
- Harassment by others (e.g. racial, physical)
- Harassment of others
- Risks to child(ren)
- Other (please specify)

<table>
<thead>
<tr>
<th>Risk</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploitation by others (e.g. financial)</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Exploitation of others</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Culturally isolated situation</td>
<td>☑</td>
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<tr>
<td>Non-violent sexual offence (e.g. exposure)</td>
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<tr>
<td>Arson (deliberate fire-setting only)</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Accidental fire risk</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Other damage to property</td>
<td>☑</td>
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</tbody>
</table>

**Comments:** Frequently taunted by local youths because of his dishevelled appearance, with verbal abuse and objects thrown at him. Neglect of lit cigarettes & matches poses potential accidental fire risk.
SITUATIONAL CONTEXT OF RISK FACTORS

(including, for example – arousal in official settings, risks in community locations, friends/neighbours/carers, need for two workers, race or gender considerations, etc.)

MILOS RESPONDS ANGERLY TO ANY SUBJECT OF DISCUSSION HE PERCEIVES TO BE OFFICIAL E.G. HOUSING, MONEY, PREVIOUS HOSPITAL/SECURE ADMISSIONS. HE DENIES ANY NEED FOR HELP, BUT ACCEPTS VISITS AS A FORM OF SOCIAL CONTACT.

PERSONAL HYGIENE & CONDITION OF HIS FLAT IS CAUSING CONCERN TO SOME OF HIS NEIGHBOURS. THEY REQUIRE REASSURANCES FROM WORKERS GOING TO HIS FLAT THAT HE IS SAFE & OK AT HOME, AND NOT GOING TO PRESENT A RISK TO THEM, OBJECTIVELY HE IS IN A VERY NEGLECTFUL CONDITION.

MILOS USES A FEW LOCAL SHOPS, BUT HE IS OPEN TO ABUSE AND HARASSMENT BY LOCAL YOUTHS ON OCCASIONS WHEN HE IS OUTSIDE THE FLAT.

MILOS IS RELATIVELY ISOLATED FROM PEOPLE OF SIMILAR ETHNIC BACKGROUND, BUT HE DOES NOT FEEL THIS IS A PROBLEM. HE IS FROM THE FORMER YUGOSLAVIA, BUT APPEARS RELATIVELY UNAWARE OF THE POLITICAL & SOCIAL TROUBLES OF THE LAST DECADE.

HISTORICAL AND/OR CURRENT CONTEXT OF FACTORS

HE HAS ONE INCIDENT OF VERY SERIOUS VIOLENCE OVER 30 YEARS AGO, STABBING A POLICEMAN WHO WAS CALLED TO INVESTIGATE A REPORTED DOMESTIC DISPUTE. MILOS REMAINS ON A HOME OFFICE RESTRICTION ORDER BECAUSE OF THIS INCIDENT. AGGRESSION OF A VERBAL NATURE IS A MORE COMMON FEATURE OF HIS PERSONAL EXPERIENCES OF FRUSTRATION. THESE MAY ALSO BE POTENTIALLY LINKED TO PSYCHOTIC EXPERIENCES (HE FREQUENTLY APPEARS TO BE RESPONDING TO OTHER STIMULI). SELF NEGLECT IS A SEVERE AND CONTINUOUS FEATURE OF HIS HISTORY OVER MANY YEARS, IT IS THE MOST INSTANTLY OBSERVED CHARACTERISTIC OF HIS CURRENT PRESENTATION.

SUMMARY OF ‘POSITIVE’ RESOURCES AND POTENTIALS

INITIAL CONTACT WITH HIS SON INDICATES HE WILL BE IN MORE CONTACT WITH MILOS NOW THAT THE ASSERTIVE OUTREACH TEAM IS BECOMING INVOLVED. MILOS HAS NOT REFUSED TO ANSWER THE DOOR, OR REFUSED ACCESS FOR OUR VISITS, HE ENGAGES IN DISCUSSION, AND ACCEPTS THE NEED TO REPEAT HIMSELF TO HELP OUR UNDERSTANDING OF WHAT HE IS SAYING.

MILOS HAS A SENSE OF HUMOUR, INITIATED BY THE WORKERS MAKING JOKES ABOUT THEMSELVES, AND THEIR INABILITY TO SPEAK SERBO–CROAT.

DIET IS LIMITED, BUT HE DOES FOLLOW A RIGID DAILY PATTERN, HE ALLOWED US TO ACCOMPANY HIM TO THE LOCAL SHOPS, AND TWO SHOPKEEPERS APPEARED FRIENDLY, CONCERNED AND SUPPORTIVE TOWARDS HIM.

THE NEIGHBOURS EXPRESS SOME CONCERNS, BUT A DESIRE TO HELP AND UNDERSTAND IF THEY CAN, THEY DO NOT APPEAR TO SOLELY WANT HIM MOVED AWAY, THE POTENTIAL IS THERE TO SUPPORT MILOS AT HOME, AT LEAST IN THE SHORT-TERM.
SUMMARY OF ‘RISK ASSESSMENT’
(including, for example – factors, context, gut reactions/intuition, potential for positive risk taking, etc)

PSYCHOTIC SYMPTOMS – PERSISTENT, BUT NOT ELIMINATED BY CHANGES OF MEDICATION, CONTEXT OF LONELINESS, RESPONDING TO HALLUCINATIONS – NOT EASILY ADDRESSED.

WITH CULTURAL & PHYSICAL COMMUNICATION DIFFICULTIES, VERBALLY AGGRESSIVE RESPONSES TO MULTIPLE SOURCES OF FRUSTRATION NOT FOUNDED ON RECENT OR CURRENT INTENT TO HARM OTHERS.

STRONG WISH TO HAVE HIS OWN SPACE, BUT ACCEPTS CONTACT THAT DOES NOT IMPOSE VIEWS OR ACTIONS ON HIM – NEED TO BE AWARE WHEN HIS FRUSTRATION IS INCREASING AND ADJUST DISCUSSIONS APPROPRIATELY.

DENIES ANY STRONG FEELINGS ABOUT THE RECENT LOSS OF HIS WIFE – INDEPENDENT REPORTS SUGGEST HIS BEHAVIOUR PATTERNS HAVE NOT CHANGED FROM BEFORE TO AFTER HER DEATH (NEEDS CONTINUED ASSESSMENT).

NEEDS FLEXIBLE AND CREATIVE APPROACH TO HIS NEEDS AND WISHES– MILOS WILL ENGAGE WITH THE APPROACH THAT DOES NOT APPEAR TO RESTRICT HIM, BUT WILL NOT COPE WITH MANY DIFFERENT PEOPLE OR INCONSISTENT MESSAGES FROM SERVICES.

‘RISK MANAGEMENT’ CONSIDERATIONS
(including, for example – who, what, how, when, expected outcome, positive potentials, etc.)

Care Programme Approach registration (tick all relevant areas)

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<tr>
<th>CPA</th>
<th>Yes</th>
<th>No</th>
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<td>Section 117</td>
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<td>Other Section</td>
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<td>Supervised discharge</td>
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Level

- Standard
- Enhanced

Section

Role of client and/or carer in plan

Client involved

- Yes
- No

Carer involved

- Yes
- No

Client agreed to plan

- Yes
- No

Carer agreed to plan

- Yes
- No

Comments

LIMITED INVOLVEMENT OF MILOS THROUGH DISCUSSIONS, BUT HE WILL NOT AGREE OR ACCEPT PARTS OF PLAN, DUE TO DENIAL OF PROBLEMS OBSERVED BY OTHERS, HIS SON AGREES WITH PLAN, AND SUGGESTS HE WILL TRY AND BECOME MORE INVOLVED.

OPPORTUNITIES FOR RISK PREVENTION
(including risk mitigating/protective factors)

DEVELOP TRUST THROUGH ONE CASE MANAGER & SUPPORT WORKER IN THE ASSERTIVE OUTREACH TEAM – FREQUENT BUT SHORT VISITS (X5 / WEEK INITIALLY).

LOOK TO MAINTAIN CURRENT SITUATION i.e. PREVENT FURTHER DETERIORATION, AND WORK WITH MILOS’S OWN DEGREE OF ACCEPTANCE OF CONTACT.

ENGAGE POSITIVE POTENTIALS OF NEIGHBOURS AND SHOPKEEPERS, TO ALERT CASE MANAGER TO ANY CONCERNS AT AN EARLY STAGE. ESTABLISH STRONG AND SUPPORTIVE LINK WITH MILOS’S SON.
SHORT-TERM CRISIS MANAGEMENT OPTIONS

NEGOTIATE THE POTENTIAL HOLDING OF A KEY TO HIS FLAT, WITH CLEAR GUIDELINES OF HOW IT WOULD ONLY BE USED IN AN EMERGENCY i.e. WHEN HE MAY BE ABLE TO SHOUT OUT BUT NOT GET TO THE DOOR (OR WHEN NO ANSWER AT DOOR, AND NOT SEEN BY NEIGHBOURS OR SHOP-KEEPERS FOLLOWING HIS REGULAR ROUTINE).

NEGOTIATE FUTURE AVAILABILITY OF SHORT-TERM BED AT OUT-OF-TOWN HOSPITAL UNIT, IN A FUTURE CRISIS, EVEN AFTER HIS DEPOT MEDICATION VISITS HAVE CEASED (AS HE IS WELL KNOWN & LIKED BY THE STAFF).

LONG-TERM RISK MANAGEMENT OPTIONS

CASE MANAGER TO ACCOMPANY MILOS ON VISITS TO OUT-OF-TOWN HOSPITAL UNIT FOR HIS DEPOT INJECTIONS, UNTIL HE CAN BE PERSUASED TO ACCEPT MEDICATION AT HOME, MONITOR HIS USE OF ORAL MEDICATION.

CONTACT THE HOUSING DEPARTMENT TO EXPLAIN THE PLAN OF GRADUAL ENGAGEMENT, AND NEGOTIATE THEIR HOLDING BACK ON TAKING ACTION AGAINST HIM FOR SUBSTANTIAL RENT ARREARS.

OFFER TO EXPLAIN ALL INFORMATION THAT ARRIVES IN THE POST (BEWARE OF HIS LIKELY ANGRY RESPONSE TO LETTERS REGARDING HIS RENT ARREARS).

POSITIVE RISK OPTIONS (and support needed)

WORK WITH MILOS'S PRIORITY, TO STAY WHERE HE IS, BECAUSE HIS HOME IS ALL HE IS CONCERNED ABOUT.

ACCEPT THAT HIS APPARENT SYMPTOMATOLOGY HAS BEEN CONSISTENT FOR MANY YEARS, AND RELATIVELY UNCHANGED BY MEDICATION INCREASES AND CHANGES – NEGOTIATE A REDUCTION, TO BE PLANNED AND CLOSELY MONITORED AT HOME, SUPPORT NEEDED FOR MAIN WORKERS – CONSISTENT SUPPORT AND UNDERSTANDING FROM MULTIDISCIPLINARY TEAM, TO ACCEPT RISKS AND PURSUE THIS PLAN.

RESPONSIBILITIES FOR ACTIONS (including timescale and/or dates)

CASE MANAGER & SUPPORT WORKER TO PURSUE PLAN, WITH REGULAR TEAM DISCUSSIONS AND REVIEW.

PLAN TO REVIEW ALL MEDICATION OVER NEXT MONTH, AND AIM FOR FUTURE DEPOT MEDICATION TO BE ADMINISTERED AT HOME WITHIN 3 MONTHS.

G.P. TO DO JOINT VISIT WITH CASE MANAGER, TO MONITOR PHYSICAL CONDITION, CASE MANAGER TO PLAN THIS VISIT AFTER INITIAL DISCUSSIONS WITH MILOS.

Date of next review: 6/12/99
Place: AT TEAM BASE
Completed by (for collective responsibility): S.Morgan
Date: 11/11/99
Clinical Examples

CASE EXAMPLE 2

The following example has identifying information changed, but is largely based on a true case.

Re : Margaret J. – dob : 15/6/1970

Margaret and her partner Brian have both been well known to the local area mental health services for several years. They were accepted two years ago by the newly established Assertive Outreach Team, largely because of Brian’s diagnosis of schizophrenia. He had just experienced his third hospital admission in less than two years. Margaret was considered to be the more stable of the two of them, but prone to stress from Brian’s fluctuating mental state. She feels particularly attached to her two daughters from a previous relationship.

The relationship has been through a relatively settled period for almost a year, but the team are concerned that both Margaret and Brian are currently relapsing. Margaret faces a particularly significant anniversary that may significantly increase her suicide risk.

The following completed Clinical Risk Management Tool is an example of the crisis function developed through an assertive outreach team. This function will be limited to the team’s known clients who are regularly supported but are recognised to be heading into a particular period of crisis in their lives, which will heighten the potential for risks.
Clinical Example 2/p1

CLINICAL RISK MANAGEMENT SUMMARY SHEET

Steve Morgan  The Sainsbury Centre for Mental Health

Client's name:  MARGARET J.  Date of birth  15 / 6 / 1970

To be used as a summary of the comprehensive assessment and management plan, or as a brief up-date when a detailed version is not required.

SUMMARY OF RISK ASSESSMENT

Involvement of service user and/or carers in assessment  MARGARET AND HER SISTER ARE CLOSELY INVOLVED IN DISCUSSIONS OF THE ASSESSMENT & PLAN, HER PARTNER (BRIAN) IS CURRENTLY EXPERIENCING A RELAPSING PSYCHOTIC CONDITION, AND REJECTS MOST DISCUSSIONS

Primary risks identified  STRONG SUICIDAL IDEAS, WITH A SIGNIFICANT HISTORICAL ANNIVERSARY EMERGING (HER MOTHER'S DEATH BY SUICIDE). VOLATILE RELATIONSHIP BETWEEN MARGARET AND BRIAN.

Other risks identified  POOR DIET & INCREASED ALCOHOL INTAKE. PSYCHOLOGICAL & EMOTIONAL IMPACT OF EVENTS ON THE TWO CHILDREN.

INITIAL RISK MANAGEMENT PLAN

Precautions  INCREASING SUICIDAL IDEAS, WITH POSSIBILITY OF PLANNED INTENT AND/OR ATTEMPT ON HER LIFE. VOLATILE RELATIONSHIP WITH PARTNER, BRIAN IS AGGRESSIVE DUE TO CURRENT PSYCHOTIC RELAPSE, BOTH PARTNERS HAVE INCREASED THEIR ALCOHOL CONSUMPTION.

To be discussed with  RMO; ASSERTIVE OUTREACH TEAM; IN-PATIENT UNIT; CLIENT'S SISTER.

Information needed  AVAILABILITY OF CLIENT'S SISTER FOR CRISIS RESPITE PLACEMENT, EITHER FOR MARGARET OR POSSIBLY HER TWO Daughters. SOCIAL WORK REPORTS ON CHILDREN PERFORMANCE & BEHAVIOUR AT SCHOOLS, RMO AGREEMENT FOR PRN MEDICATION PRESCRIPTION, FOR USE IN CRISIS RESPONSE.

Actions  CASE MANAGERS TO DISCUSS PLAN WITH MARGARET AND HER SISTER. DAILY SUICIDE ASSESSMENT (INC. MARGARET IN PROCESS). EMERGENCY CONTACT NOTES FOR MARGARET & HER SISTER. DAILY MONITORING OF BRIAN'S CONDITION, AND IMPACT ON MARGARET'S CONDITION. LIAISE WITH CHILD, SOCIAL SERVICES.

Completed by  S. Morgan  Date  1-3-2000  Time  11-30am

Review date  15-3-2000
DETAILED ASSESSMENT & MANAGEMENT PLAN

Client's name:  MARGARET J.  Date of birth  15 / 6 / 1970

1. This format should form an integral part of a comprehensive mental health assessment and care planning process.
2. This is not an exhaustive list of risk factors; it gives an initial indicator of the potential sources of risk, and possible management responses.
3. Accurate prediction of risk is difficult, as the initial assessment will necessarily be based on incomplete, and possibly inaccurate information.
4. This assessment should offer a guide to areas requiring further discussion and investigation, and an initial plan of management within available resources.
5. If completed by one person, this assessment should be quickly discussed with the Responsible Medical Officer and/or multi-disciplinary team (inc. users and carers, where appropriate)...

NETWORK OF SUPPORT AND COPIES SENT TO

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<td>MARGARET J.</td>
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<tr>
<td>Carer(s)</td>
<td>BRIAN S.</td>
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<tr>
<td>General Practitioner</td>
<td>DR. A.</td>
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<td>DR. B.</td>
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RISK INDICATORS

SUICIDE

- Previous attempts on their life
- Previous use of violent methods
- Misuse of drugs and/or alcohol
- Major psychiatric diagnoses
- Expressing suicidal ideas
- Considered/planned intent
- Believe no control over their life
- Other (please specify)

Expressing high levels of distress
Helplessness or hopelessness
Family history of suicide
Separated/widowed/divorced
Unemployed/retired
Recent significant life events
Major physical illness/disability

REPORTED IMPULSIVE ACTS IN PAST HISTORY.

Comment: HISTORY OF 2 SUICIDE ATTEMPTS, ONE OVERDOSE, ONE OF HANGING. MARGARET FEELS UNDER PRESSURE COPING WITH BRIAN'S PSYCHOTIC ILLNESS, AND WITH TWO YOUNG CHILDREN.
MOTHER'S SUICIDE IS VERY SIGNIFICANT EVENT FOR MARGARET, WITH ANNIVERSARY COMING IN 3 WEEKS.
Clinical Example 2/p3

**NEGLECT**

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**AGGRESSION/VIOLENCE**

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<td>Paranoid delusions about others</td>
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<td>Violent command hallucinations</td>
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<td>Denial of previous dangerous acts</td>
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**OTHER**

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<td>Other damage to property</td>
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**Comments**

- **FINANCIAL DIFFICULTIES CAUSED BY BOTH PARTNERS. PAST & CURRENT ALCOHOL ABUSE. HOUSING DEPARTMENT ARE NEGOTIATING PLANS TO MANAGE A REDUCTION OF RENT ARREARS. MARGARET WILL GO WITHOUT FOOD IN ORDER THAT THE CHILDREN CAN EAT.**

- **HER PARTNER IS MORE PRONE TO AGGRESSION & VIOLENCE, TOWARDS MARGARET, AND OTHERS OUTSIDE THE HOME.**

- **MARGARET HAS NO HISTORY OF VIOLENCE TOWARDS OTHERS. SHE OCCASIONALLY GETS VERY FRUSTRATED ABOUT HER PERSONAL CIRCUMSTANCES AND WILL SHOUT. SHE HAS NO FURTHER INTENTIONS OF HARM TO ANYONE OTHER THAN HERSELF.**

- **SHE HAS NO DESIRE TO HARM HER OWN CHILDREN. SOCIAL SERVICES ARE MONITORING CHILDREN FROM PERSPECTIVE OF PROGRESS WITHIN AN EMOTIONALLY VOLATILE FAMILY UNIT. MARGARET DENIES AN EATING DISORDER, BUT IS PERIODICALLY OBSERVED TO BE AT RISK.**
SITUATIONAL CONTEXT OF RISK FACTORS
(including, for example – arousal in official settings, risks in community locations, friends/neighbours/carers, need for two workers, race or gender considerations, etc.)

MARGARET LIVES WITH HER PARTNER (BRIAN) AND THE TWO CHILDREN AGED 9 & 6 FROM A PREVIOUS RELATIONSHIP. BOTH ADULTS HAVE REGULAR CONTACT WITH MENTAL HEALTH SERVICES OVER THE LAST 10 YEARS, WITH FLUCTUATING SPELLS OF SETTLED AND STABLE MENTAL HEALTH. BOTH EXPERIENCE INTERMITTENT RELAPSES, BUT WHEN THESE RELATIVELY CO-INCIIDE (AS CURRENTLY), THEIR RELATIONSHIP BECOMES LESS STABLE AND MORE VOLATILE. AT THESE TIMES ALCOHOL CONSUMPTION INCREASES FOR BOTH OF THEM, WITH INCREASED FINANCIAL DIFFICULTIES. MARGARET Responds BY STOPPING EATING AS SHE BECOMES MORE DEPRESSED, LEADING TO SUICIDAL FEELINGS AND INCREASING INTENT.

TWO WORKERS ARE NEEDED TO SEPARATE OUT THE NEEDS OF MARGARET AND BRIAN, BUT HE BECOMES MORE ANGRY AND THREATENING WHEN CONFRONTED BY TWO WORKERS ON OCCASIONS.

SINCE HER MOTHER’S SUICIDE (OVERRIDE) 16 YEARS AGO, MARGARET BELIEVES SHE WILL DO THE SAME; AND EACH ANNIVERSARY HAS BEEN VERY SIGNIFICANT FOR MARGARET.

HISTORICAL AND/OR CURRENT CONTEXT OF FACTORS

MARGARET HAS HAD 2 SERIOUS SUICIDE ATTEMPTS. SHE ATTEMPTED TO HANG HERSELF CLOSE TO THE FIRST ANNIVERSARY OF HER MOTHER’S SUICIDE (FOUND BY HER OLDER SISTER). SHE ODOURED A FEW WEEKS AFTER THE BIRTH OF HER SECOND CHILD – ALSO CLOSE TO AN ANNIVERSARY OF HER OWN MOTHER’S DEATH (FOUND BY HER FIRST PARTNER).

SUICIDAL THOUGHTS ARE A REGULAR EXPERIENCE FOR HER, BUT THEY INTENSIFY USUALLY NEAR EACH ANNIVERSARY OF HER MOTHER’S SUICIDE, AND WHEN BOTH HER & BRIAN APPEAR TO EXPERIENCE SIMULTANEOUS RELAPSES OF THEIR CONDITIONS.

SUMMARY OF ‘POSITIVE’ RESOURCES AND POTENTIALS

MARGARET IS VERY CONCERNED ABOUT THE WELFARE OF HER 2 DAUGHTERS, AND DESPERATELY WISHES THAT THEY SHOULD COME TO NO HARM, OR HAVE TO INHERIT HER MENTAL HEALTH CONDITION.

MARGARET’S ELDER SISTER IS MARRIED WITH ONE CHILD. THIS IS A STABLE RELATIONSHIP, WITH NO HISTORY OF PSYCHIATRIC PROBLEMS. SHE LIVES CLOSE BY AND IS VERY SUPPORTIVE TOWARDS MARGARET AND HER DAUGHTERS.

MARGARET HELD AN AMBITION TO WRITE FICTION (WHICH SHE NO LONGER FEELS CAPABLE OF DOING). SHE HAS PREVIOUSLY ATTENDED A LOCAL COMMUNITY CENTRE FOR CREATIVE WRITING CLASSES, BUT INTERMITTENTLY.
**SUMMARY OF ‘RISK ASSESSMENT’**

(including, for example – factors, context, gut reactions/intuition, potential for positive risk taking, etc)

MARGARET HAS RECENTLY REDUCED HER EATING AND INCREASED HER ALCOHOL INTAKE. SHE EXPRESSES SUICIDAL IDEAS BECAUSE SHE CAN’T COPE WITH BRIAN’S PARANOID IDEAS AND VERBAL AGGRESSION. SHE IS CONCERNED THAT HER OWN DEPRESSIVE SYMPTOMS MEAN SHE IS UNABLE TO COPE WITH THE CHILDREN. SHE HAS CEASED MEDICATION FOR THE LAST 3 WEEKS.

SHE HAS RECENTLY DIVULGED HEARING HER MOTHER’S VOICE CALLING HER TO JOIN HER. SHE FEELS THAT KILLING HERSELF WOULD BE A GOOD OPTION, BUT FOR THE EFFECT IT WOULD HAVE ON HER 2 DAUGHTERS. SHE WOULD LIKE TO END HER RELATIONSHIP WITH BRIAN, BUT FEARS HOW HE MAY REACT.

SHE FEELS MORE VULNERABLE WHEN THE CHILDREN ARE BOTH AT SCHOOL, AND COULD BE AT AN INCREASED RISK OF A SUICIDE ATTEMPT WHILE THEY ARE OUT. THE ANNIVERSARY OF HER MOTHER’S SUICIDE IS IN 3 WEEKS, AND THIS IS A VERY SIGNIFICANT EVENT IN HER HISTORY OF DEPRESSION AND SUICIDE ATTEMPTS.

---

**‘RISK MANAGEMENT’ CONSIDERATIONS**

(including, for example – who, what, how, when, expected outcome, positive potentials, etc.)

**Care Programme Approach registration** (tick all relevant areas)

- **CPA**
  - Yes
  - No
  - Level: □ Standard □ Enhanced
- **Section 117**
  - Yes
  - No
- **Other Section**
  - Yes
  - No
- **Supervised discharge**
  - Yes
  - No

**Role of client and/or carer in plan**

- **Client involved**
  - Yes
  - No
- **Client agreed to plan**
  - Yes
  - No
- **Carer involved**
  - Yes
  - No
- **Carer agreed to plan**
  - Yes
  - No

---

**OPPORTUNITIES FOR RISK PREVENTION** (including risk mitigating/protective factors)

MARGARET HAS AN UNDERSTANDING OF HER CHANGING CONDITION, AND ENGAGES IN DISCUSSION ABOUT THE SERIOUSNESS OF HER DISTRESSING EXPERIENCES.

MARGARET’S ELDER SISTER IS A STRONG SOURCE OF SUPPORT, AND IS AN ALTERNATIVE SOURCE OF INFORMATION TO CHALLENGE AND/OR CORROBORATE THE HISTORICAL ACCOUNTS ACCESSED FROM VARIOUS SOURCES.

THE CHILDREN ARE AN IMPORTANT SOURCE OF CONCERN AND INTEREST FOR MARGARET.

MARGARET HAS PREVIOUS INTERESTS IN CREATIVE WRITING.
**LONG-TERM RISK MANAGEMENT OPTIONS**

Identify early warning signs of relapse with Margaret, and how they can progress to suicidal ideas & plans.

Supportive counselling to explore the impact and personal meaning of her mother's suicide.

Discuss the eating and alcohol adjustments used by Margaret to cope with difficult situations.

Possibly explore the relationship between Margaret & Brian (when both are more settled).

Monitor the progress of the 2 children, in liaison with social services.

Focus on the creative writing as a positive ability; explore its potential.

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**SHORT-TERM CRISIS MANAGEMENT OPTIONS**

Inform all relevant people (professional & non-professional) of the significant historical risk of Margaret's mother's suicide anniversary (with Margaret's agreement).

Inform the in-patient unit & accident & emergency department of the potential need for a short-term emergency admission (agreeing to keep them regularly up-dated of the situation).

Discuss with Margaret's sister the potential need for respite for Margaret and/or the children.

Careful co-ordination with Brian's care plan & risk management plan.

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**POSITIVE RISK OPTIONS** (and support needed)

Initially establish intensive support without re-establishing medication (but having PRN prescription in place for use in deteriorating crisis – informing Margaret of the conditions that may trigger this need).

Support and monitor the 2 children at home for as long as possible (using Margaret's sister as the respite option, instead of a social services placement).

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**RESPONSIBILITIES FOR ACTIONS** (including timescale and/or dates)

Case management (assertive outreach team) to implement & monitor risk management plan - with regular clinical supervision, team manager support, and multidisciplinary team discussion.

RMO to prescribe emergency medication; and monitor hospital bed availability for Margaret or Brian, if needed.

Social services maintaining regular contact with schools.

Case managers to co-ordinate a care programme approach review for Margaret, and one for Brian, as soon as possible (both reviews to be carefully co-ordinated).

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Date of next review: 15-3-2000

Completed by (for collective responsibility): S. Morgan

Place: AT TEAM OFFICE

Date: 1-3-2000
CASE EXAMPLE 3

The following is an example of situations frequently encountered by acute inpatient staff, as re-counted by people attending risk workshops. Identifying information has been changed.

Re: David S. – dob – 10/12/76

David was admitted to the inpatient unit two weeks ago, following a Mental Health Act assessment in the community requested by a local GP. He lives alone in a bedsit near the centre of town. He has no previous contact with local area mental health services. David states that he moved into the area from another part of the UK approximately 18 months ago, but is reluctant to give any further details of his background or family.

On admission he was dishevelled and aggressive in presentation, and appeared to be experiencing psychotic symptoms. He was admitted for further assessment on Section 2 of the Mental Health Act 1983. Very little information was passed to the inpatient unit staff at the point of admission.

The following Clinical Risk Management Tool has been completed by the allocated staff nurse on the ward. It is based on observations, brief interviews/discussions with David, and consultation with other members of the ward team. David is to be discussed in the ward round tomorrow, to report progress and to initiate a plan for current management towards discharge.
Clinical Example 3/p1

### CLINICAL RISK MANAGEMENT SUMMARY SHEET

**Steve Morgan**  The Sainsbury Centre for Mental Health

<table>
<thead>
<tr>
<th>Client's name:</th>
<th>DAVID S.</th>
<th>Date of birth</th>
<th>10 / 12 / 76</th>
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</table>

*To be used as a summary of the comprehensive assessment and management plan, or as a brief up-date when a detailed version is not required.*

#### SUMMARY OF RISK ASSESSMENT

- **Involvement of service user and/or carers in assessment:** DAVID INVOLVED IN DISCUSSION ON A RELUCTANT BASIS - NOT CURRENTLY ACKNOWLEDGING RISKS EXIST, NO CONTACT WITH CARERS.

- **Primary risks identified:**
  - RECENT PHYSICAL AGGRESSION LEADING TO IN-PATIENT ADMISSION, HOSTILE AND VERBALLY AGGRESSIVE INTERACTIONS ON UNIT (GRADUALLY SUBSIDING).

- **Other risks identified:**
  - POSSIBLE SUICIDE RISK - NEEDING FURTHER OBSERVATION AND ASSESSMENT.
  - LACK OF ANY HISTORICAL INFORMATION.

#### INITIAL RISK MANAGEMENT PLAN

- **Precautions:** KEEP DISCUSSION AND INTERACTIONS TO VERY SHORT PERIODS OF TIME - ALWAYS INITIATED BY A STATEMENT OF HOW THE INFORMATION IS NEEDED TO SUPPORT DAVID TOWARDS AN EARLIER DISCHARGE FROM THE IN-PATIENT UNIT.

- **To be discussed with:** ALL MEMBERS OF IN-PATIENT TEAM.

- **Information needed:** HISTORICAL INFORMATION ON PREVIOUS INCIDENTS, RISKS OR CONTACTS WITH MENTAL HEALTH SERVICE IN OTHER AREAS, WHAT SUPPORTS DOES HE HAVE? CONTINUED DRUG SCREENING; STATUS OF CURRENT TENANCY OF BEDSIT.

- **Actions:** WARD STAFF TO SUSTAIN INFORMAL OBSERVATIONS ON REGULAR BASIS, AND BRIEF DISCUSSIONS. NURSING AND OCCUPATIONAL THERAPY STUDENTS TO ATTEMPT A PEER, RATHER THAN A PROFESSIONAL RELATIONSHIP.

**Completed by:** Ward Staff Nurse  **Date:** 28/3/2000  **Time:** 6:15pm

**Review date:** 29/3/2000

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DETAILED ASSESSMENT & MANAGEMENT PLAN

Client's name: DAVID S.  Date of birth  10 / 12 / 1976

1. This format should form an integral part of a comprehensive mental health assessment and care planning process.
2. This is not an exhaustive list of risk factors; it gives an initial indicator of the potential sources of risk, and possible management responses.
3. Accurate prediction of risk is difficult, as the initial assessment will necessarily be based on incomplete, and possibly inaccurate information.
4. This assessment should offer a guide to areas requiring further discussion and investigation, and an initial plan of management within available resources.
5. If completed by one person, this assessment should be quickly discussed with the Responsible Medical Officer and/or multi-disciplinary team (inc. users and carers, where appropriate)...

NETWORK OF SUPPORT AND COPIES SENT TO

<table>
<thead>
<tr>
<th>Service User</th>
<th>Carer(s)</th>
<th>General Practitioner</th>
<th>Psychiatrist</th>
<th>Community Psychiatric Nurse</th>
<th>Ward Link Nurse/Key Nurse</th>
<th>Social Worker</th>
<th>Occupational Therapist</th>
<th>Psychologist</th>
<th>Support Worker(s)</th>
<th>Voluntary Agency Worker(s)</th>
<th>Other (please specify)</th>
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RISK INDICATORS

**SUICIDE**
- Previous attempts on their life
- Previous use of violent methods
- Misuse of drugs and/or alcohol
- Major psychiatric diagnoses
- Expressing suicidal ideas
- Considered/planned intent
- Believe no control over their life

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<tr>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
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Expressing high levels of distress
Helplessness or hopelessness
Family history of suicide
Separated/widowed/divorced
Unemployed/retired
Recent significant life events
Major physical illness/disability

Comments: DAVID STATES HE HAS NO CURRENT SUICIDE PLANS, BUT REMAINS VERY GUARDED ABOUT PREVIOUS EXPERIENCES, ALTERNATES BETWEEN AGGRESSIVE OUTBURSTS AND QUIET PERIODS WHEN HE ISOLATES HIMSELF FROM OTHER PATIENTS AND STAFF.
Clinical Example 3

### NEGLECT

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<th>Yes</th>
<th>No</th>
<th>Don't know</th>
<th>Comments</th>
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<td>Previous history of neglect</td>
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<td></td>
<td>Failing to drink properly</td>
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<td>Failing to eat properly</td>
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<td>Difficulty managing physical health</td>
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<td>Living in inadequate accommodation</td>
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<td>Lacking basic amenities (water/heat/light)</td>
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<td>Pressure of eviction/repossession</td>
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<td>Other (please specify)</td>
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**Comments**: David gives few details about himself, and denies he is ill. His only expressed wish is to be discharged and left alone, occasionally aggressive responses to further discussion.

### AGGRESSION/VIOLENCE

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<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
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<td>Previous incidents of violence</td>
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<td>Previous use of weapons</td>
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<td></td>
<td>Misuse of drugs and/or alcohol</td>
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<td></td>
<td></td>
<td>Male gender, under 35 years of age</td>
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<td>Known personal trigger factors</td>
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<td>Expressing intent to harm others</td>
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<td>Previous dangerous impulsive acts</td>
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**Comments**: Aggressive on admission to unit. Continues to respond to social contact and questions in a verbally aggressive manner on occasions, refuses to accept potential experience of illness, or drug taking as a trigger.

### OTHER

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<tr>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
<th>Comments</th>
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<td></td>
<td>Self-injury (e.g. cutting, burning)</td>
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<td>Other self-harm (e.g. eating disorders)</td>
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<td>Stated abuse by others (e.g. physical, sexual)</td>
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<td>Abuse of others</td>
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<td>Harassment by others (e.g. racial, physical)</td>
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<td>Harassment of others</td>
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<td></td>
<td>Risks to child(ren)</td>
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<td>Other (please specify)</td>
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**Comments**: No information currently available. David is reluctant to engage in discussions about real or potential risks.
SITUATIONAL CONTEXT OF RISK FACTORS
(including, for example – arousal in official settings, risks in community locations, friends/neighbours/carers, need for two workers, race or gender considerations, etc.)

DAVID GENERALLY BECOMES AGgressive WHEN IN CONTACT WITH OTHER PEOPLE, PARTICULARLY STAFF ENQUIRING INTO HIS CURRENT AND PAST LIFE EXPERIENCES. HE ALSO RESPONDS WITH HOSTILE GLANCES TO OTHER PATIENTS WHO ATTEMPT TO SPEAK TO HIM.

ANALYSIS OF URINE SAMPLES HAS PROVED POSITIVE FOR CANNABIS AND CRACK COCAINE. THE ONLY SOCIAL INTERACTION ON THE WARD THAT HE HAS NOT HAD A HOSTILE OR NEGATIVE REACTION HAS BEEN BRIEF ENCOUNTERS WITH 2 OTHER IN-PATIENTS KNOWN TO BE REGULAR DRUG USERS.

HISTORICAL AND/OR CURRENT CONTEXT OF FACTORS

NO ACCESS TO HISTORICAL INFORMATION, AND DAVID REFUSES TO ENGAGE IN DISCUSSIONS ABOUT HIS HISTORY.
CURRENT INCIDENCE OF AGGRESSIVE ACTIONS. Q.P. REPORTS THAT DAVID HAS ASSAULTED A NEIGHBOUR LIVING IN ONE OF THE OTHER BEDSITS IN THE HOUSE IN WHICH HE LIVES. THE INCIDENT IS REPORTED TO BE A FIGHT IN THE STREET (NO USE OF WEAPONS), STARTED BY DAVID ACCUSING HIS NEIGHBOUR OF SPYING ON HIM AND STEALING THINGS FROM THE FLAT WHEN DAVID IS OUT.

VERBALLY AGGRESSIVE & SUSPICIOUS OF OTHERS ON THE WARD (STAFF & OTHER PATIENTS).

SUMMARY OF ‘POSITIVE’ RESOURCES AND POTENTIALS

CHANGE FROM DISHEVELLED APPEARANCE ON ADMISSION TO APPROPRIATE LEVELS OF SELF CARE.
LACK OF OTHER INFORMATION ON POSITIVE RESOURCES DUE TO:
- LACK OF INFORMATION WITHIN MENTAL HEALTH SYSTEM;
- LACK OF INFORMATION FROM DAVID HIMSELF;
- REFUSAL TO ENGAGE IN INITIAL DISCUSSIONS WITH THE OCCUPATIONAL THERAPIST.
SUMMARY OF ‘RISK ASSESSMENT’
(including, for example – factors, context, gut reactions/intuition, potential for positive risk taking, etc)

DAVID PRESENTS ON ADMISSION WITH AN INCIDENT OF VIOLENCE LINKED TO SYMPTOMS OF SUSPICION OF HIS NEIGHBOURS. THERE IS EVIDENCE OF RECENT DRUG-TAKING FROM ANALYSIS OF URINE SAMPLE. HE PRESENTS WITH FURTHER HOSTILE AND AGGRESSIVE RESPONSES TO STAFF OR PATIENT CONTACTS ON THE WARD. LEVELS OF AGGRESSION HAVE DECREASED OVER THE 2 WEEKS OF IN-PATIENT ADMISSION.

INITIAL DIAGNOSIS IS SCHIZOPHRENIA, WITH CONSIDERATION OF A POSSIBLE DRUG-INDUCED PSYCHOSIS.

DAVID IS QUARDED ABOUT ANY DISCUSSIONS OF CURRENT OR PREVIOUS SUICIDE IDEAS. HIS DENIAL OF CURRENT SUICIDE THOUGHTS OR PLANS DOES NOT APPEAR TO CARRY CONVICTION, SO GUT REACTION IS ONE OF MAINTAINING A HIGH LEVEL OF INFORMAL OBSERVATION BY THE WARD TEAM.

‘RISK MANAGEMENT’ CONSIDERATIONS
(including, for example – who, what, how, when, expected outcome, positive potentials, etc.)

Care Programme Approach registration (tick all relevant areas)

<table>
<thead>
<tr>
<th>CPA</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>Section 117</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Other Section</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Supervised discharge</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Level</td>
<td>Standard</td>
<td>Enhanced</td>
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</tbody>
</table>

Role of client and/or carer in plan

| Client involved | Yes | No |
| Carer involved | Yes | No |
| Client agreed to plan | Yes | No |
| Carer agreed to plan | Yes | No |

Comments. DAVID HAS HAD THE CONCERNS OF OTHERS EXPLAINED TO HIM, AND THE REASONS FOR DISCUSSING RISKS WITH HIM, HE DENIES ANY BIAS FOR RISK, OR THE NEED FOR ANY PLANS.

OPPORTUNITIES FOR RISK PREVENTION (including risk mitigating/protective factors)

INSUFFICIENT INFORMATION CURRENTLY.

AWAIT FURTHER SETTLING OF BEHAVIOUR PATTERN COMENCE DISCUSSIONS AND EDUCATION ABOUT LINK BETWEEN DRUGS AND POTENTIAL PSYCHIATRIC RELAPSE.

INTRODUCE IDEAS OF ‘EARLY WARNING SIGNS’ AND ‘RELAPSE PREVENTION’ WITH DAVID WHEN HE IS MORE AMENABLE TO DISCUSSION.
SHORT-TERM CRISIS MANAGEMENT OPTIONS

Regular informal observations, to continue assessment of potential suicide risk.

Keep staff discussions with David to short periods, initiated by clear explanations of the need for information to support his progress to an earlier discharge.

Increase levels of contact as his levels of hostility and verbal aggression subside.

LONG-TERM RISK MANAGEMENT OPTIONS

Review diagnosis and needs for commencing medical treatment.

Referral to community drug + alcohol team.

Investigate status and suitability of David’s current tenancy.

POSITIVE RISK OPTIONS (and support needed)

Encourage student nurse to attempt to engage discussions with David on a peer level, rather than emphasising the medical nature of the unit’s primary functions.

Discuss same potential involvement of occupational therapy student currently on placement with the ward occupational therapist.

Close supervision of students involved, including initial discussion of possible range of approaches that may have beneficial outcomes.

RESPONSIBILITIES FOR ACTIONS (including timescale and/or dates)

Ward staff nurse to co-ordinate the risk management plan.

Ward team to review needs for medical treatment and section 3, based on continuous assessment of risks.

Ward social worker to investigate David’s current tenancy (council or private).

Ward staff nurse and occupational therapist to discuss potential role for students on current placement.

Date of next review: 29/3/2000

Place: IN WARD ROUND

Completed by (for collective responsibility): WARD STAFF NURSE

Date: 28/3/2000

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