

Best Practice in Managing Risk

*Principles and Evidence for Best Practice in the
Assessment and Management of Risk to Self and
Others in Mental Health Services*

Document prepared for the
National Mental Health Risk Management Programme

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Contact details	Dawn Fleming National Risk Management Programme London Development Centre 11-13 Cavendish Square, London W1G 0AN 0207 307 2431 www.nimhe.csip.org.uk/risktools
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Preface

The guidance contained in this document was first issued in June 2007. The 16 Principles of Best Practice in managing risk in mental health services were welcomed and have underpinned significant and positive developments in many trusts across England. Since June 2007, the team who developed the guidance have been involved in various projects supporting its national implementation. The guidance has now been updated and republished with information about its implementation.

Appendix 6 is a major addition to the document issued in June 2007. In this appendix, there is information about the implementation project. There is also information and support for trusts who want to assess how well practice in their locality meets the standards set – and to make improvements to clinical risk assessment and management practice in their area.

In addition, for further information about Best Practice in Managing Risk, its implementation in mental health trusts, and for teaching aids to promote best practice in clinical risk assessment and management, go to www.managingclinicalrisk.nhs.uk.

Foreword by the National Director for Mental Health, Professor Louis Appleby

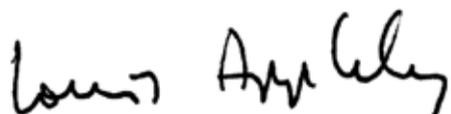
Safety is at the centre of all good healthcare. This is particularly important in mental health but it is also more sensitive and challenging. Patient autonomy has to be considered alongside public safety. A good therapeutic relationship must include both sympathetic support and objective assessment of risk.

In producing this practical best practice and implementation advice, we want to support services in adopting a more systematic approach to risk assessment and management – at individual practitioner, team and organisational level. The aim is to embed risk management in day-to-day practice, in particular as part of the Care Programme Approach (CPA).

We know that an unacceptable number of patients who die by suicide or commit homicide have not been subject to enhanced CPA, despite indications of risk. We also know that staff sometimes feel unable to intervene to reduce risk, feeling that tragedies are inevitable.

This document offers guidance on what can be done. It is unrealistic to expect services to prevent all deaths, but the clinical management of risk can be strengthened.

We have updated the Mental Health Act to bring it into line with community-based practice. A new power – supervised community treatment – was introduced from November 2008 to help to ensure that high risk and vulnerable patients receive the treatment that they need after hospital discharge. It is as important to have the right legal powers as it is to have the best clinical practice: both are part of the vital task of improving safety.

A handwritten signature in black ink, reading "Louis Appleby". The signature is written in a cursive, slightly slanted style.

Executive summary

This framework document is intended to guide mental health practitioners who work with service users to manage the risk of harm. It sets out a framework of principles that should underpin best practice across all mental health settings, and provides a list of tools that can be used to structure the often complex risk management process. The philosophy underpinning this framework is one that balances care needs against risk needs, and that emphasises:

- positive risk management;
- collaboration with the service user and others involved in care;
- the importance of recognising and building on the service user's strengths; and
- the organisation's role in risk management alongside the individual practitioner's.

Organisations, care teams and individual practitioners should benchmark their current practice against the principles set out here, and consider ways of moving towards embedding these principles in daily practice. They should also examine the list of tools given here and consider how their practice could be improved by incorporating one or more of the tools into their risk assessment and risk management practice.

16 Best Practice Points for Effective Risk Management

Summary

Introduction

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

Fundamentals

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

Basic ideas in risk management

6. Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.
7. Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.
8. Knowledge and understanding of mental health legislation is an important component of risk management.
9. The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.

10. Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach.
11. Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user.

Working with service users and carers

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

Individual practice and team working

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

Introduction

Risk management is a core component of mental health care and the Care Programme Approach. Effective care includes an awareness of a person's overall needs as well as an awareness of the degree of risk they may present to themselves or others. Many practitioners make decisions every day about how to help a service user to manage their potential for violence, self-harm, suicide or self-neglect. This framework document is intended to guide mental health practitioners in making these decisions and also to guide the organisations that employ them. The framework is based on the principle that modern risk assessment should be structured, evidence-based and as consistent as possible across settings and across service providers.^{1,2,3} This consistency is essential for good communication between agencies and practitioners. Also, a consistent approach to risk and its management will enable better communication and contribute to improved care. All service providers should have in place a set of policies and procedures relating to the management of risk,^{4,5} and this framework document should be used to inform these policies.

This framework relates to three main areas of risk: violence (including antisocial and offending behaviour), self-harm/suicide, and self-neglect. It aims to answer this question: *what is best practice in risk management in these areas?* Best practice involves combining the highest quality evidence with professional judgement about the person who is being assessed. The main principles of best practice are set out here and Appendix 1 contains detailed information about some tools that can guide risk decision-making. These tools are described in the Appendix in order to help practitioners to decide which of them are best suited to the situation faced by the service users with whom they work.

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

The principles set out here are applicable in all mental healthcare settings – from community-based care, including crisis intervention, assertive outreach and early intervention services, through to high secure care. Guidance about tools, though, is more complex. Some of the tools listed here are designed for specialist (e.g. forensic) services and others for general services. Some are deliberately designed to predict risk – usually in specific groups – while others are designed to aid the clinical judgement of practitioners who are trying to gain an overall view of the issues in order to prevent harmful outcomes from happening.

It is vital to note that both types of tool can only contribute one element in a broader overall view of the risks presented by a particular individual. The tools should only be used as part of a general clinical assessment conducted with the service user; the findings of these tool-based assessments must always be combined with relevant information on many other aspects of the service user's life and current situation. The tools are listed here because they will support effective and consistent risk management decision-making. *They are an aid to clinical decision making, not a substitute for it.*

Care teams should consider how their risk management procedures could be improved by integrating the principles here and one or more of the tools into their overall approach. By effectively combining research evidence with clinical expertise in a collaborative approach, care teams will be implementing the highest standards of evidence-based practice.⁶

Fundamentals

Positive risk management

Decisions about risk management involve improving the service user's quality of life and plans for recovery, while remaining aware of the safety needs of the service user, their carer and the public.⁷ Positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective.^{8,9} Positive risk management can be developed by using a collaborative approach.¹⁰ Over-defensive practice is bad practice. Avoiding all possible risks is not good for the service user or society in the long term, and can be counterproductive, creating more problems than it solves. Any risk-related decision is likely to be acceptable if:

- it conforms with relevant guidelines;
- it is based on the best information available;
- it is documented; and
- the relevant people are informed.¹¹

As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at the time.

Safety first

Given the nature of severe mental illness, there will always be circumstances in which decisions about the care plan are going to be dominated by immediate concerns about the safety of the service user and others. Lack of insight and

non-adherence to treatment plans that have been put in place to reduce psychopathological symptoms are particularly challenging aspects of the relationship between the service user and the practitioner. Psychopathological symptoms can seriously impact on a service user's ability to critically assess the implications of some of their actions, and this can result in unpredictable and potentially dangerous behaviour. In these situations, practitioners have to take decisions on behalf of a service user with their best interests in mind. The use of the Mental Health Act may well be part of the most appropriate risk management strategy here. A collaborative approach based on the principles of positive risk management is still the aim but clearly this will require special efforts in these situations.

Best practice point 2: Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners.

Box 1: What is positive risk management?

Positive risk-management means being aware that risk can never be completely eliminated. Therefore, management plans inevitably have to include decisions that carry some risk. This should be explicit in the decision-making process and should be discussed openly with the service user.

Positive risk management includes:

- working with the service user to identify what is likely to work – and what is not;
- paying attention to the views of carers and others around the service user when finally deciding a plan of action;
- weighing up the potential costs and benefits of choosing one action over another;
- being willing to take a decision that involves an element of risk because the potential positive benefits outweigh the risk;
- developing plans and actions that support the positive potentials and priorities stated by the service user, and minimising the risks to the service user or others;
- being clear to all involved about the potential benefits and the potential risks; and
- ensuring that the service user, carer and others who might be affected are fully informed of the decision, the reasons for it and the associated plans.

Another way of thinking about good decision-making is to see it as supported decision-making. Independence, *Choice and Risk*¹² has this to say:

“The governing principle behind good approaches to choice and risk is that people have the right to live their lives to the full as long as that does not stop others from doing the same. Fear of supporting people to take reasonable risks in their daily lives can prevent them from doing the things that most people take for granted. What needs to be considered is the consequence of an action and the likelihood of any harm from it. By taking account of the benefits in terms of independence, well-being and choice, it should be possible for a person to have a support plan which enables them to manage identified risks and to live their lives in ways which best suit them.”

A collaborative approach to risk management

As with all aspects of mental health care, the key to effective risk management is a good relationship between the service user and all those involved in providing their care. A three-way collaboration between the service user, carers and the care team can often be established, and this relationship should be based on warmth, empathy, respect and a sense of trust – with the aim of involving the service user in a collaborative approach to planning care. Full engagement is sometimes not possible but the potential for it should always be considered. This means that the process of risk management should be explained to everybody involved at the earliest opportunity. The development of the risk management plan itself should be carried out in an atmosphere of openness and transparency. If, for whatever reason, the service user is not involved in some element of risk management, this should be documented.

Best practice point 3: Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.

Recognising strengths and protective features

Risk management works best when a service user's strengths are recognised alongside the possible problems they might encounter and with which they might present.¹³ Every time a problem is identified, a strategy should be suggested and explored, building on the strengths of the service user. The emphasis should always be on a recovery approach and on the next stage in developing the service user's ability to cope when they are feeling vulnerable or as if difficult demands are being placed on them.

Best practice point 4: Risk management must be built on a recognition of the service user's strengths and should emphasise recovery.

Risk management at the organisational level

Risk management is not just the responsibility of individual practitioners. Organisations must adopt an integrated risk management approach in which risks are systematically identified, managed and reduced. The framework given in *Seven Steps to Patient Safety* should guide the development of a safety culture that learns from negative events and builds good practice.⁵ The seven steps are to

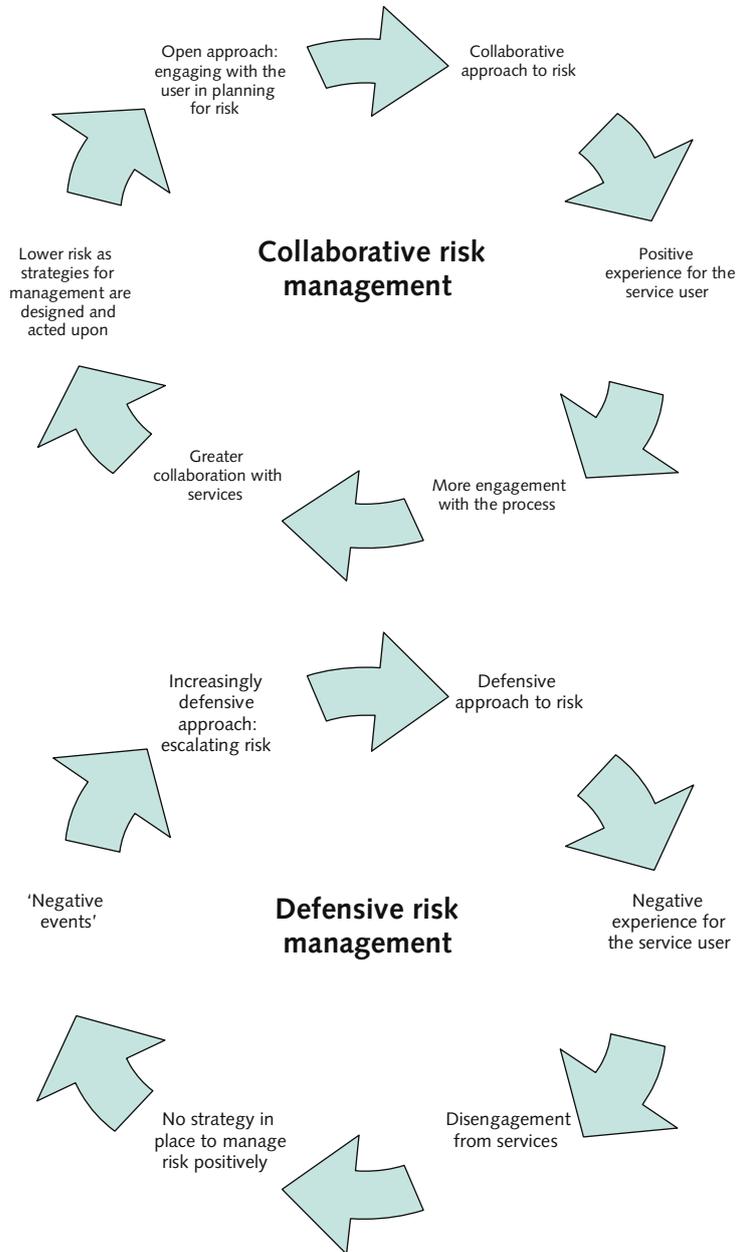
- build a safety culture;
- lead and support your staff;
- integrate your risk management activity;

- promote reporting;
- involve and communicate with service users and the public;
- learn from and share safety lessons; and
- implement solutions to prevent harm.

Services for people at risk of suicide and self-harm should also be designed with the *Twelve Points to a Safer Service* recommendations in mind.^{14,15} These points are listed in Appendix 3.

Best practice point 5: Risk management requires an organisational strategy as well as efforts by the individual practitioner

Figure 1: Positive and negative risk management cycles¹⁶



Basic ideas in risk management

Defining risk and risk management

It is important to be clear about the basic ideas underpinning the notion of risk. Risk relates to a negative event (i.e. violence, self-harm/suicide or self-neglect) and covers a number of aspects:

- What exactly is the outcome – or outcomes – to be prevented?
- How severe will the outcome be if it does occur?
- How soon is it expected to occur?
- How likely is it that the event will occur?

Risk assessment involves working with the service user to help characterise and estimate each of these aspects. Information about the service user's history of violence, or self-harm or self-neglect, their relationships and any recent losses or problems, employment and any recent difficulties, housing issues, their family and the support that's available, and their more general social contacts could all be relevant. It is also relevant to assess how a service user is feeling, thinking and perceiving others not just how they are behaving. Risk management then involves developing one or more flexible strategies aimed at preventing the negative event from occurring or, if this is not possible, minimising the harm caused. Risk management must include a set of action plans, the allocation of each aspect of the plan to an identified profession and a date for review.

Best practice point 6: Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.

Defining risk factors

A risk factor is a personal or contextual characteristic or circumstance which is linked to a negative event and that either causes or facilitates the event to occur. Risk factors can be categorised in a number of ways.¹⁷

- *Static factors* are unchangeable historic factors, e.g. a history of child abuse or suicide attempts.
- *Dynamic factors* are those that have changed and can continue to change over time, e.g. misuse of alcohol, mental state. Dynamic factors may be aspects of the individual or aspects of their environment and social context, such as the attitudes of their carers or social deprivation. Because they are changeable, these factors are more amenable to risk management.

- Dynamic risk factors that are quite stable and usually change only slowly, e.g. self-awareness, are called *stable* or *chronic* risk factors.
- Those that tend to change rapidly are known as *acute factors* and can act as *triggers* because they increase the level of risk when they are present, e.g., interpersonal conflict, intoxication. As acute dynamic risk factors can change rapidly, their influence on the level of risk may be short lived.

The key risk factors for violence and suicide identified through research are given in Appendix 2.

Particular sensitivity should be exercised when discussing historical factors from earlier in the life of the service user. The relevance of these factors and the accuracy of information obtained about them may need to be explored with the service user and it is possible that they and their carers may be unaware of these historical events or of their significance so many years on.

The purpose of risk management

Risk management starts with an evaluation of the potential for harmful outcomes to occur and the identification of the conditions that need to be present – singly or more likely together – in order to make risk increase in an unacceptable way. This information can then be used to focus efforts and expertise to deal in the short-term with the most relevant triggers and in the medium- to long-term with the remaining factors. The involvement of the service user in this assessment stage is highly desirable, as it is in the next phase when strategies are prepared to change or manage those conditions thus reducing risk. All risk management plans should include an awareness of the potential for changes in the level of risk over time. This means that dynamic factors will be emphasised and that risk is reviewed and plans updated on a regular basis. It is essential that, throughout this process, care teams and the service user maintain a clear focus on what risk they are assessing and why they are doing a risk assessment: “*Who is the risk assessment for and why is it being carried out?*”¹⁸

Best practice point 7: Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.

Risk management and the Care Programme Approach

Risk management is part of the Care Programme Approach (CPA) and should be aligned closely with it.¹⁹ The CPA involves identifying specific interventions based on an individual's support needs whilst taking into account safety and risk issues.

Care plans should be drawn up to meet all of the service user's needs, including those needs relating to risk. This creates a recorded management plan for the elements of risk both to self and others.²⁰ The outcome of the risk assessment should also feed back into overall clinical management, since CPA should be applied in cases where there is an increased risk related to mental health problems of harming oneself or others. These steps help to support the continuity of care, which is essential to effective risk management.

Risk management and the Mental Health Act

Given the nature of mental health problems, there are occasions where services have to intervene without the user's consent: the Mental Health Act is used regularly to manage risk of harm to self and others. It should always be seen as a last resort and it is important that service users who need to be treated under conditions of compulsion get the help they need. Using the Act does not remove the need for discussion with the service user – it is still necessary to maximise the service user's autonomy as much as possible within the restrictions. A good knowledge of the Act – and its associated Code of Practice and Memorandum – is essential to good risk management in mental health. The 2007 Mental Health Act changes include provision for supervised community treatment with the aim of improving safety for patients living in the community, and abolishes the treatability test with the aim that patients with personality disorder receive appropriate risk management. Local risk policies should specifically address issues in relation to the assessment and management of restricted patients.

Best practice point 8: Knowledge and understanding of mental health legislation is an important component of risk management

Screening and prioritising cases

Service users will vary in the degree to which they need a formal risk management plan. Screening for risk and needs should be part of a routine mental health assessment, but is not an end in itself and should, when necessary, lead to further action. Some service users will be identified as a priority for more in-depth assessment and intervention as a result of this routine screening, or will identify themselves as in need. General and forensic services have different degrees of experience of working with violence, and so they should work together to ensure that the right level of assessment is conducted in all cases. A second opinion should be sought from specialist services when appropriate, for instance, if a service user has a history of serious violence.

Duty of care to those who present a risk and others

As a basic principle, all mental health professionals recognise that reducing the risk of self-harm, suicide and self-neglect is part of the practitioner's fundamental duty to try and improve a service user's quality of life and recovery. There is also a clear professional duty of care to a service user who presents a high risk of harm to others when this risk is due to a mental health problem – this duty may include tackling stigma and discrimination. There is also a duty of care to other service users, other professionals and wider society. In many cases, improving a service users' quality of life may have wider benefits for others, such as reducing the risk to vulnerable groups of potential victims, including children. These goals are most likely to be achieved in the context of a good relationship between the service user and those providing their care.

Box 2: Supplementary NICE guidance on the short-term management of self-harm²¹***Respect, understanding and choice***

People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, health care professionals should take full account of the likely distress associated with self-harm.

Triage

All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm. Assessment should determine a person's mental capacity, their willingness to remain for further psychosocial assessment, their level of distress, and the possible presence of mental illness.

Assessment of risk

All people who have self-harmed should be assessed for risk. This assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness, and continuing suicidal intent.

Psychological, psychosocial, and pharmacological interventions

Following psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological, and social assessment, including an assessment of risk, and should not be determined solely on the basis of having self-harmed.

This guidance is available from: <http://www.nice.org.uk/guidance/CG16/quickrefguide/pdf/English>

Planning risk management

Risk assessment only has a purpose if it enables the care team and the service user to develop a plan of action in specific areas to manage the risks identified. This plan should be developed with the service user and their carer, and should be regularly reviewed.

Risk formulation

Risk formulation is a process in which the practitioner decides how the risk might become acute or be triggered.²² It identifies and describes predisposing, precipitating, perpetuating and protective factors, and also how these interact to produce an elevation in risk. This formulation should be agreed with the service user and others involved in their care in advance, and should lead to an individualised risk management plan. Every risk formulation should have attached to it a plan for what to do when the warning signs become apparent. The plan should also include more general aspects of management, such as monitoring arrangements, therapeutic interventions, appropriate placements and employment needs.

Best practice point 9: The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.

Figure 2: The risk management planning cycle



Types of risk assessment

There are three main approaches to risk assessment.

- In the past, risk assessment was anecdotal and inconsistent. It was based only on a largely *unstructured clinical* approach where information obtained in the course of an ongoing clinical assessment was considered. This information was not gathered systematically and any information considered relevant was not entered into the formulation of risk in a consistent and standardised way.
- The *actuarial approach* to risk assessment focuses on static risk factors that have been shown to be statistically associated with increased risk in large samples of people. A formulaic approach is usually used: an overall score is calculated as an indicator of presumed risk over a specific time period, generally measured in years. This approach should be used with caution with individual patients in clinical practice. Errors are likely to occur if tools based on this approach are used to predict individual risk rather than to manage it. They should only be used as one part of an overall risk assessment.
- *Structured clinical (or professional) judgement* is the approach that offers the most potential where *violence* risk management is the objective. This approach involves the practitioner making a judgement about risk on the basis of combining:
 - an assessment of clearly defined factors derived from research;
 - clinical experience and knowledge of the service user, including the carer's experience; and
 - the service user's own view of their experience.

All tool-based assessments should be conducted as one part of a thorough and systematic overall clinical assessment. This is particularly important when assessing the risk of suicide and self-harm, as there is currently no instrument with a sufficiently strong evidence base.

Best practice point 10: Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach.

Structured risk assessment

Risk management in mental health care should be structured and consistent.¹ It should be explicit to the service user and involve the service user's own priorities. It should be substantially informed by the structured clinical judgement approach outlined above. Decisions about care and security should not be based simply on the largely unstructured clinical approach, which could be subject to personal biases about the service user and may miss important factors such as the service user's strengths and resources or the views of the carer. These biases could lead to poor judgements where the risk is either overestimated or underestimated if key factors are missed. This is especially true if the judgements are made by an individual practitioner alone rather than by a clinical team working together. If it is not clear to the service user that their risk is being assessed, the principle of engagement is broken.

Providing care proportionate to risk

A fundamental principle of mental health care is that the level of security to which a service user is subjected should be as non-restrictive as possible and should be proportionate to the degree of risk that they actually present at the time.²⁰ Risk assessment can be integral to deciding the right level of intervention and support for a service user. When it is done properly – using the principles of involvement, working together and individualised support – risk management is empowering rather than disempowering for the service user²³ and can be a vital part of recovery.

Best practice point 11: Risk assessment is integral to deciding the most appropriate level of risk management and the right kind of intervention for a service user.

Box 3: A brief critique of three approaches to risk assessment***Unstructured clinical approach***

Since this is not a structured approach, important factors may be missed. While this unstructured approach sometimes provides vital information, it is not a feature of best practice in planned and formal risk management.

Actuarial approach

This approach also has a number of limitations.. First, it tends to ignore risk factors that do not occur commonly. Second, the capacity of the actuarial tool to make 'predictions' only applies when the service user being assessed comes from the population on which the tool was developed. In addition, actuarial tools cannot make predictions about individual behaviour limiting their application to individual risk assessment and management. Third, an emphasis on risk prediction rather than risk management is less useful for practitioners tasked with planning care. Finally, the emphasis on unchangeable static risk factors in this approach severely limits the usefulness in developing risk management strategies that are robust yet flexible. Some of the tools listed in Appendix 1 are actuarial, and these limitations must be borne in mind when considering whether to use them in practice. They should never be used as the only way of evaluating the risks posed by an individual service user. Actuarial tools used on their own also contradict the principles of diversity and individualised working.

Structured clinical judgement

Based on practice-based evidence, this is the most effective approach to violence risk assessment and management. Although, like the actuarial tools, these instruments are derived from research evidence, the clinician's discretion is seen as a vital element – especially in relation to formulating the assessment of risk and preparing risk management plans based on the risk factors identified. The effectiveness of these tools can be hard to test, given their range of applications and the difficulty of measuring prevented harm. Given their research focus, they may also exclude issues that the individual service user considers important – although most structured clinical judgement tools offer practitioners the opportunity to add extra risk factors and considerations as required.

Structured assessment is important in assessing suicide risk but there are as yet no instruments with a satisfactory evidence base. In this case, structured assessment means a systematic assessment of key risk factors and mental state leading to an informed clinical judgement.

Embedding risk management in everyday practice

The information that informs a risk management plan can be based on special interviews or reports, but risk management is also based on routine practices in mental health care. These routine practices include enhanced observation and preventing absconding where this is appropriate.¹⁹ Thinking about and recording risk management decisions is not an 'add-on' to practice, but should produce a structured and documented version of the clinical judgements that practitioners make everyday. This formal version of everyday practice should increase the confidence of practitioners when making decisions, especially if they are working collaboratively.

Working with service users and carers

Sharing decision-making

Each step in the process of developing a risk management plan should be based on discussions between the service user and those involved in their care. The service user should be offered the opportunity to take a lead role in identifying the risks from their point of view, drawing up plans for dealing with difficult situations, and indicating the sort of support they would prefer: service users and carers are often in the best position to comment on the robustness and practicality of the plan. The plan should include negotiated and individualised advance decisions on early warning signs of a relapse to violence or self-harm or suicidality, as well as preferred early interventions at times of crisis.^{3,4}

"Risk management can increase a user's awareness of their own behaviour and how others view them. This can enable them to manage their lives and relationships more effectively"

A user's view

Collaborative work with carers

Where there is a carer involved, they are a vital source of support for the service user and may also be a key person in helping to manage the risks identified.²⁴ Practitioners should be sensitive to the relationship between the service user and the carer, as there may be risks within this relationship and different points of view about the best actions to be taken. If the carer is at risk, they should be seen individually so the risks can be explored and actions can be agreed. The carer should receive enough information in a comprehensible format to enable them to provide the necessary care.²⁴ The carer's worries about the service user must always be taken seriously, even if the care team is less concerned.² The

carer should be offered an assessment and should be helped to develop a plan for meeting their own specific needs.

Confidentiality and disclosure

Agencies should have in place clear agreed policies on information-sharing, which advise on the 'need to know'. If someone other than the service user is at risk, advice must be sought from the police public protection team or multi-agency public protection arrangements (MAPPA) so that an appropriate public protection plan can be activated. The rationale for any disclosure without consent, e.g. to prevent harm, should be clearly documented.

Avoiding exclusion on the basis of negative risk

Social inclusion should be one of the goals of any risk management plan, and strategies to support the service user in achieving this should be identified. Service users are likely to be aware of their own risk and to want help, but may find it difficult to talk about this in case it increases stigma.⁹ Any risks identified should not be over-stated or needlessly used to exclude the service user from services or contact with people; this contributes to myths about mental health problems, stigma and discrimination. Unnecessary exclusion can be avoided by carefully linking risk assessment to risk management. Regular reassessment can provide opportunities for information sharing with the service user and their carer, and can establish a forum in which risk-related issues can be openly discussed.

“A trusting relationship between the user and their care-coordinator is the best foundation for successful risk management”

A user's view

Diversity

Clinical judgement is based on perceptions that can be biased without the practitioner being aware. Therefore, all staff involved in risk assessment must be capable of demonstrating an appropriate level of cultural sensitivity and competence.^{3,4,25} This competence applies to diversity in terms of race, faith, age, gender, disability and sexual orientation. Assumptions about any of these aspects may influence perceptions of risk. The practitioner should reflect on their assumptions about people from diverse groups within society and think about any judgements of risk that they are making about people from these groups. Some authorities have argued that assumptions about race can have an influence on judgements of risk.²⁵ Similarly, increasing age should not be assumed to decrease risk.

Assumptions about gender can also frame the way that risk is assessed in women and men. It is essential to stay open-minded about the potential for violence and self-harm or suicide – regardless of race and gender – and not to expect service users to conform to basic stereotypes.^{4,26} Other social groups are sometimes stigmatised as ‘always’ difficult in some way (e.g. service users with a personality disorder diagnosis or substance use problem). Structured assessment approaches and an awareness of relevant research on the use of different instruments with different groups will help with this aim. Practitioners should draw upon their own knowledge of equality issues and on the equality and diversity resources within their organisation for guidance; this will help set the context for fair and respectful judgements of risk. Reflective practice, clinical supervision and a team approach are also crucial.

Best practice point 12: All staff involved in risk assessment must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation

Recognising the fluidity of risk

Risk can change – sometimes over very short timescales. By definition, dynamic factors fluctuate in their contribution to the overall risk. Given the fluidity of risk, only the tools based on structured professional judgement are useful in monitoring change and engagement with the service user and carer. So there should be an established procedure to formally review the assessment of risk at regular intervals.

However, these reviews should not be rigidly limited to these time points. It is important that the procedure has some flexibility so that, in particular circumstances, an earlier or more timely formal review can be undertaken. This also guards against a ‘tick box’ mentality in completing risk assessment forms. All practitioners working with the service user need to be familiar with previous risk assessments so that they can be alert to changes in the nature and the level of risk. Particular attention should be paid to the relationship between substance misuse and changes in the risk of harm to self or others.²⁷ It is crucial that service users and carers have access to someone who they can contact in a crisis if the need arises, and that they are taken seriously if this occurs.

Box 4: Supplementary NICE guidance on the short-term management of violence³***Prediction***

Measures to reduce disturbed or violent behaviour need to be based on comprehensive risk assessment and risk management. Therefore mental health service providers should ensure that there is a full risk management strategy for all their services.

Working with service users

Service users identified to be at risk of disturbed/violent behaviour should be given the opportunity to have their needs and wishes recorded in the form of an advanced decision. This should fit within the context of their overall care and should clearly state what intervention(s) they would and would not wish to receive. This document should be subject to periodic review.

Risk assessment

Risk assessment should include a structured and sensitive interview with the service user and, where appropriate, carers. Efforts should be made to ascertain the service user's own views about their trigger factors, early warning signs of disturbed/violent behaviour and other vulnerabilities, and the management of these. Sensitive and timely feedback should complete this process.

Care plans

Risk assessment should be used to establish whether a care plan should include specific interventions for the short-term management of disturbed or violent behaviour.

Tools

Structured clinical judgement approaches and to a lesser degree, actuarial tools, should be used in a consistent way to assist risk assessment, although no 'gold standard' tool can be recommended.

This guidance is available from: <http://www.nice.org.uk/guidance/CG16/quickrefguide/pdf/English>

Regular review

Whilst remaining flexible, risk management plans should include scheduled dates for reassessment, so that they are not simply amended as a reaction to crisis or other events. These review requirements should be part of the risk management plan and not separate from it, and the service user and all those involved in their care should be involved in this review. Risk management plans should also include a clear statement of responsibility for carrying out specified tasks in the plan and for reviewing these tasks. From discussion with the service user, it is essential to

anticipate what circumstances would trigger a review outside the normal timetable and what times in the year are particularly difficult. There should be scope for the service user or carer to request a review. Also the risk management plan should be revisited before and during time periods that are recognised to be associated with increased risk, for instance, prior to leave, on return from leave and around the time of discharge and around the time of discharge or transfer between services, particularly if the level of security provided is changing.¹⁹

Recognising the individuality of risk

Each service user behaves differently when they begin to need support or intervention. It is important for care teams to prioritise their relationship with the service user so that personal signs and triggers ('signatures') can be identified by those involved in their care as well as by the service user her or himself. These signs and triggers will often be very individual to each service user. When they have been noted and their relevance to risk understood, they should lead to intervention as early as possible and should never be ignored.² Advanced decisions are an important component in developing individualised and collaborative care.

Best practice point 13: Risk management must always be based on awareness of the capacity for the service user's risk level to change over time and a recognition that each service user requires a consistent and individualised approach.

First contact with services

When the service user has a first crisis episode and has not had contact with mental health services before, the family's – and in particular the main carer's – contribution to information-gathering is critical. In this situation, the carer has the most knowledge about the service user and is a vital source of both information and support. But this will be a particularly difficult time for the carer as well as for the service user, and practitioners must acknowledge this when working with carers at this time.

"There is often a defensiveness from staff towards carers."

A carer's view

Individual practice and team working

What should trusts be doing to manage risk?

There are many practical steps that trusts should be considering in the area of risk management. These steps include:

- keeping the physical environment under regular review with respect to potential risk to self and others, including staff;
- conducting investigations as recommended by Department of Health guidance;
- learning from inquiries and reports by the National Patient Safety Agency and Healthcare Commission; and
- appointing senior staff to oversee clinical risk management.

Who should be doing risk management?

Risk management is everyone's business – including the service user's. The carer and the practitioner with whom the service user works most are in the best position to make the most important and relevant contribution to risk assessment and risk management planning, but all of those involved in providing care have a role to play. Anybody involved in tool-based risk assessment must know their own strengths in terms of their personal competencies and skills. Newly qualified staff should be allocated less complex cases and should be closely supervised. The more formal the risk assessment, the higher the degree of personal competency required, for example management of restricted patients needs to have appropriately skilled and experienced staff. All staff should receive supervision – regardless of their skills, competency or experience. Some of the instruments listed in Appendix 1 require special training or specific qualifications as a condition of their use, however, risk management is much more than just the use of tools.

"If a positive and open relationship exists between the user and their key worker risk management can be a positive process and a vital step towards recovery."

A user's view

Sources of information

A variety of sources should be used for accessing information on which to base the assessment and management plan. These sources must include interviews with the service user and carer, but can also draw upon reports, case notes and the relevant tools listed in Appendix 1.²³

Effective team work and partnerships

The practitioner may sometimes be working alone, but in most situations the best risk assessments and the most effective decisions are made by a team of experienced practitioners in consultation with the service user and carer. Decisions and assessments should also be based on collaboration between health and social care agencies in hospitals and in the community.^{1,20} In some cases, they should be based on collaboration between general and specialist services, such as forensic teams. The judgements made in an assessment of risk should be made in collaboration with others in the multidisciplinary team and with the service user and carer. In instances where the risk seems high, the involvement of senior colleagues to advise and support is likely to be helpful.

Care teams should think about the way that they operate and communicate: effective decision-making is more likely in an atmosphere of openness and transparency, where all views are welcomed and responsibility is shared. Teams should consider the best way for them to resolve disagreements, to ensure the best decisions are made and to preserve team cohesion. Teams should also be alert to group processes such as the pressure to conform and the potential for groups to recommend more risky courses of action than would an individual. When working across agencies, a common understanding and language should be established for the issues that will be addressed.²³

Best practice point 14: Risk management plans should be developed by multidisciplinary and multi-agency teams operating in an open, democratic and transparent culture that embraces reflective practice.

Meetings

There should be a clear discussion about the risk management plan at a formal multidisciplinary meeting, which the service user and their carer should be enabled to attend. The issue of risk needs to be discussed with sensitivity at this meeting and, since the service user or carer may feel inhibited in a large group, they should be given an opportunity to meet with key clinicians before and after the main meeting. They should also be able to have meetings separately from each other.

“There is nothing worse than tokenism, and we can smell it a mile off.”

A carer's view

Training

All practitioners involved in risk management should receive relevant training, and this should be updated at least every three years. This training does not have to be classroom-based but should include attention to the following:

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

Service users and carers should be involved in delivering training to practitioners. The training should include an emphasis on an awareness of long term clinical and social needs, alongside knowledge of the person's current mental condition and an awareness of how risk changes as the service user's level of care changes (e.g. following discharge or when on leave).¹⁴

Best practice point 15: All staff involved in risk management should receive relevant training which is updated at least every three years.

Recording information

All significant risk-related decisions should be recorded, signed and dated in suitable documentation. Also, whenever it is not possible to follow an important principle of best practice, the reason for this should be documented, signed and dated. The service user and all those involved in their care should have the opportunity to contribute to this documentation and be provided with copies. This information can be used collaboratively to plan future care.

Negative and judgemental labels must be avoided as they are a barrier to collaboration. A written record of the risk management plan allows practitioners to track changes in the level of risk and to note factors that have previously been considered important. This is particularly important when people have complex needs and are in contact with several agencies. Documentation also helps to protect practitioners in the event of a review.

Standardised documentation

The tools listed in Appendix 1 may assist in the development of a standardised approach to documentation within a trust or service. Local risk assessment procedures and proformas should be designed with evidence-based principles in mind such as stating clear and verifiable risk indicators and providing free text space for individual opinions.²⁸ When harm has occurred, the details should be recorded as precisely as possible:

- What happened?
- What were the circumstances?
- What were the consequences?
- How does what happened relate to mental illness?

Service user's views on these issues, risk and its future management should be included in the documentation.⁹ All relevant information should be recorded in the appropriate local format (e.g. CPA or other care planning documentation) and stored confidentially. The process of documentation should not become a bureaucratic end in itself or merely aimed at self-protection. Written documentation must be managed in accordance with the relevant legal statutes (e.g. the Data Protection Act, the Freedom of Information Act). Ultimately, local risk information will be stored electronically in the national Connecting for Health system that is currently under construction.

Communication

Once a risk management plan has been developed or reviewed, it must become a live document and be communicated to the service user and all of those involved in providing their care; the risk management plan has no purpose if it is not shared between the relevant parties and used as a basis for joint action. The service user's consent for sharing of information in this way should be sought, although the duty of confidentiality can be overridden if there is a clear risk of harm. The local policy on information-sharing should govern this process.

Best practice point 16: A risk management plan is only as good as the time and effort put into communicating its finding to others.

Decision-making in the real world

Decision-making by professionals involved in risk assessment and risk management is complex and is affected by many factors that are specific to the practitioner making the decision, such as their personal values, their own attitude toward risk, their workload, and the time they have available to address the matters in hand. It is important for professionals to be aware of and reflect upon the factors that influence

their decision-making to ensure that their values are enhancing the process rather than distorting it. Again, effective team working, individual supervision and good communication with others will support these processes. Feedback from the service user on this aspect of practice is useful as part of reflective practice.

Learning from adverse incidents

Things can go wrong even when best practice has been used. If things do go wrong or do not go according to plan, it is essential to learn why, including identifying any mistakes that were made.²⁹ Learning from 'near misses' is vital to improving services,⁵ although not all lessons learned will require changes in practice – they may not necessarily lead to better outcomes. The culture of an organisation can make all the difference in ensuring that staff feel able to be honest about the decisions they have taken, the basis on which they made their decisions, and how it might have been done differently and better: lessons can be learned and, where necessary, practices can be changed for the better. Training could also be improved as a result. It is important to remember that any decision is likely to be acceptable if it conformed with relevant guidelines, it was based on the best information available, it was documented and the relevant people were informed.¹¹

Learning from good practice

Most of our learning in risk management is based on looking back at adverse incidents. It is vitally important, though, to acknowledge that dealing with risk and making decisions is part of everyday practice, and that practitioners make the right decisions most of the time. Every right decision helps to prevent an adverse incident, so mental health organisations should set up systems for systematically learning from good practice as well. This should include sharing experiences amongst practitioners and encouraging multidisciplinary as well as peer review of clinical practice.

Appendix 1: Tools for Supporting Best Practice

Preamble

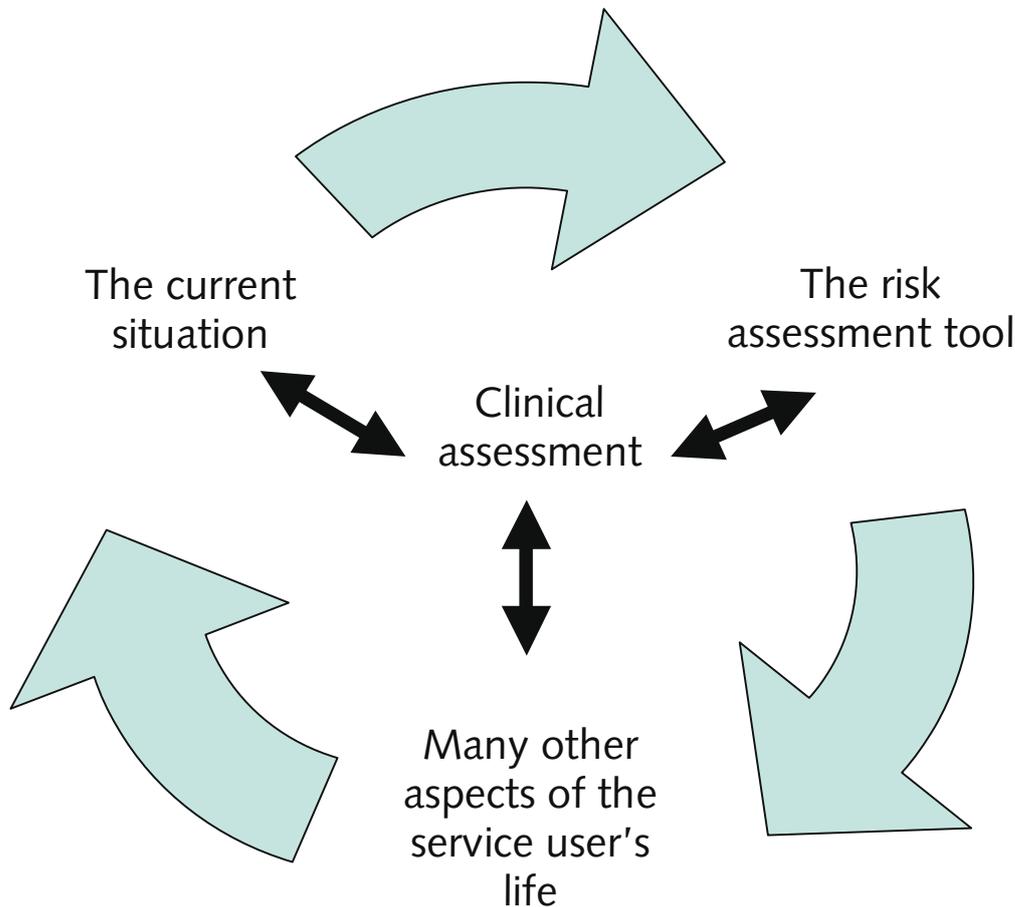
Best practice in clinical risk assessment and management relies, in part, on a consistent approach to the assessment of risk when working with an individual service user. This consistent approach can be improved by using tools and other packages that have been developed for this purpose and which have been tested in some way in real mental healthcare settings. In this appendix, information is provided about a selection of structured approaches that can be used as part of an overall risk management plan and which have been tested, at least to some extent, in this way. Most of these structured approaches are risk assessment tools or guides to clinical judgement, but some broader approaches, such as training programmes, have also been included. They have been selected and evaluated through a process of combining systematic review of the research literature and extensive consultation with experts in this area.

When thinking about risk assessment tools, two key warnings must be borne in mind.

Risk assessment tools must be used with caution.

A clinical risk assessment tool is a contribution to an overall view of the risks presented by a particular service user at a particular time. Completing a risk assessment tool in the company of the service user is not all that is required. The results of a tool-based assessment must always be combined with information on relevant aspects of the service user's life and current situation, including his or her sources of strength – or protective factors. The assessment is complete only when the practitioner develops a formulation based on the assessment findings and then develops a risk management plan covering treatment, supervision and monitoring options. Most risk assessment tools don't help practitioners to evaluate the role of protective factors or to derive formulations or risk management plans. Practitioners have to understand, through learning, training and experience, what these are and that they are an essential requirement if harmful outcomes are to be prevented.

Figure 3: Risk assessment tools as one part of the overall clinical assessment process



Choosing the right tool for the job is a complex task.

The tools listed here have been designed with a variety of purposes and with a variety of service users in mind. Some are actuarial (i.e., they offer estimations of the *likelihood* of harmful outcomes) and others provide structure for clinical judgements (i.e., they help with risk formulation using an empirical and clinical evidence base). Some have been through a rigorous process of scientific development whilst others have been tested with regard to their utility and acceptability to practitioners. Both approaches have advantages and disadvantages when underpinning good practice. Some tools have built-in prompts for thinking about the management of any risks that are identified whilst others do not. The choice of a particular tool by a care team must be based on a consideration of all the relevant factors and how they relate to the range of risks encountered by the team in practice.

Some of the structure for this section is adapted from the second edition of the Scottish Risk Management Authority *Risk Assessment Tools Evaluation Directory*. This directory³⁰ provides information on a wider range of violence instruments relating to court proceedings and should be consulted if further information is needed in this area.

Overview

	Page	Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/suicide	Self-neglect/vulnerability
Multiple risks						
CRMT	35	•			•	•
FACE	36	•			•	•
GRiST	39	•	•	•	•	•
RAMAS	37	•	•	•	•	•
GIRAFFE	38	•	•	•	•	•
START	40	•			•	•
Risk of violence, sexual violence, antisocial or offending behaviour						
HCR-20	42	•				
PCL-R	43			•		
PCL:SV	44			•		
STATIC-99	45		•			
SVR-20	46		•			
VRAG	47	•				
Risk of self-harm or suicide						
ASIST	49				•	
BHS	50				•	
SADPERSONS	51				•	
SIS	52				•	
SSI	53				•	
STORM	54				•	

Multiple risks

CRMT: Clinical Risk Management Tool/Working with Risk

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
•			•	•
Description	<p>The CRMT is a structured template checklist of relevant risk and contextual factors. The tool includes a structured assessment of suicide, neglect, violence, and other risks (rated as 'present' or 'absent') and free text boxes (three pages) for descriptions of the context of risk factors, positive resources, risk management considerations, opportunities for risk prevention, and risk management options (short- and long-term). A modified version (MST) is available with two levels (screening and comprehensive), and this version is embedded within a 'Working with Risk' training package, which emphasises positive risk management.</p>			
Depth	Screening and in-depth.			
Setting	All mental health service settings.			
Practitioners	All levels.			
Risk management	There is an emphasis on considering effective management once risks are identified. Guidance on positive risk management is provided in the manual and dedicated training workshops on 'Working with Risk'.			
Training	A Trainer's Manual and a Practitioner's Manual, with optional consultant training and development from Practice Based Evidence .			
Cost	Trainer's Manual for £179 and additional copies of the Practitioner Manual for £29			
Manual	Available from Pavilion Publishing (01273 623222 or www.pavpub.com)			
Evidence	There is no published evidence on tool development in terms of reliability or validity because the emphasis has been on the clinical utility of the tool. It has been constructed and developed in response to feedback from large numbers of practitioners attending training workshops and practice development projects. In one published study, the modified version of this tool was the preferred risk assessment tool when compared against three others.			
Origin	UK			
Formats	Paper only			
Contact	Steve Morgan, Practice Based Evidence			
Phone	07733 105264			
Email	stevemorgan57@hotmail.com			
Website	www.practicebasedevidence.com			

FACE: Functional Analysis of Care Environments

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
•			•	•
Description	<p>FACE is a portfolio of assessment tools designed for adult and older people's mental health settings. It includes both screening and in-depth levels of assessment and includes specialist forms applicable to areas such as substance use, mental capacity, perinatal services and forensic services. The tools meet both CPA and Health of the Nation Outcome Scales requirements. Risk is assessed using the FACE Risk Profile. This may be used either as a standalone tool or in conjunction with other FACE or local tools. Five sets of risk indicators are coded as present or absent and then a judgement of risk status (0-4) in seven areas (including violence, self-harm and self-neglect) is made. Scope for service user and carer collaboration is built into the system through tailored forms, including feedback on services (e.g. relationship with psychiatrist).</p>			
Depth	Screening and in-depth.			
Setting	Applicable to all general and forensic mental health settings			
Practitioners	Any mental health practitioner who has attended FACE training			
Risk management	The FACE Risk Profile specifically prompts recording of actions recommended or required as a result of the assessment.			
Training	One day training is required			
Cost	Outright purchase of the full system currently costs approximately £4000 per annum. For a medium-sized trust, the cost of the Risk Profile only is 40% of this.			
Manual	A detailed training guide is available, including standardised vignettes, prompts and guidance.			
Evidence	The tool has been developed with a UK mental health sample. There is evidence that the risk indicator sets are internally consistent and that raters agree when completing them independently. There is also evidence of good validity.			
Origin	UK			
Formats	Electronic and paper formats are available, including an enterprise database implementation with alerts, plans, incident records, aggregation systems/ benchmarking facilities and interfacing capabilities with other systems.			
Contact	Intermation Ltd, Nottingham			
Phone	0115 983 8788			
Email	info@facecode.com			
Website	www.facecode.com			

GRiST: Galatean Risk Screening Tool

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
•	•	•	•	•
Description	GRiST is a decision support system based on the expertise of multidisciplinary mental health practitioners, which identifies detailed information about all risks. When fully developed, it will be a web-based program for collecting information and generating risk quantifications, with full explanations of how these assessments were derived. The current version (May 2007) organises questions with rapid screening ones first that direct the assessor to more in-depth ones if required. However, the underlying representation of risk knowledge makes it easy for the information to be customised to particular clinical requirements. Free-text entry is allowed for each overall risk domain and the electronic version enables it to be recorded for any piece of risk data.			
Depth	Screening and in-depth.			
Setting	All mental health service settings.			
Practitioners	All levels – versions tailored for various levels of practitioner expertise are under development.			
Risk management	There is a free text prompt to consider action to be taken, but otherwise there is no guidance on risk management.			
Training	Not required, but reference to information on the website is advised.			
Cost	Free to service providers, subject to acknowledgement and internal use only.			
Manual	Not available, but information is available on the website.			
Evidence	The mental health expertise underlying GRiST has been derived from extensive interviews, focus groups and individual validation over a period of four years. The rigorous method of data collection and analysis has been described and there is evidence of good face validity. The tool is designed to make risk predictions but there is no published evidence as yet on its reliability or validity.			
Origin	UK			
Formats	Web-based and paper			
Contact	Dr Christopher Buckingham, Aston University			
Phone	0121 204 3450			
Email	c.d.buckingham@aston.ac.uk			
Website	www.galassify.org/grist			

RAMAS: Risk Assessment Management and Audit Systems

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
•	•	•	•	•
Description	RAMAS consists of a framework and a set of structured professional judgement tools designed to improve quality and safety in mental health care. The tools relate to risk to self, risk to others, vulnerability and mental health risk. Broader needs are considered alongside those related to risk. There is also an emphasis on developing a common risk language across care settings, and the system maps onto CPA. Service users, carers and voluntary agencies were involved in its development and the framework includes a service user's charter.			
Depth	Triage and in-depth/review			
Setting	All mental health and social care settings.			
Practitioners	Practitioners and teams wishing to adopt RAMAS must attend training (see below)			
Risk management	There is an emphasis on a partnership approach to risk need and responsivity.			
Training	Three levels are available: Level 1 (Triage) – Start Safe, Stay Safe (includes risk recognition and communication and is suitable for all staff); Level 2 – Risk and Care Management (suitable for qualified practitioners and maps onto the CPA); Level 3 – Training the Trainers (for experienced Level 2 users and risk managers)			
Cost	Contact the website below			
Manual	Level 1: Handbook available. Level 2: Professional manual comes as part of the training package.			
Evidence	The risk assessment tools within the RAMAS system have been developed and tested in UK mental health settings. There is evidence of good internal reliability, considerable construct validity and some concurrent validity. In terms of clinical utility, implementing RAMAS has been associated with increased practitioner satisfaction and there is evidence of good interagency agreement on risk ratings between community mental health, high secure and probation staff.			
Origin	UK			
Affiliation	NHS; University of Surrey; University College Cork.			
Formats	An electronic version is under development. It will be suitable for automation through national patient records and compatible with the CPA.			
Contact	See website			
Phone	See website			
Email	training@ramas.co.uk; margaret.murphy@ucc.ie			
Website	www.ramas.co.uk			

GIRAFFE: Generic Integrated Risk Assessment for Forensic Environments

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
•	•	•	•	•
Description	GIRAFFE is a risk assessment software suite arranged in functional modules. These include risk history, risk formulation, risk monitoring, risk management, risk handover and an adverse events recorder. The system enables the compilation, analysis, reporting and charting of risk-related information derived from a wide range of sources, such as case notes, interviews, observation and quantitative measures including data from other risk tools listed here. While there is no direct service user input to the system, it encourages a collaborative/consultative approach.			
Depth	In-depth.			
Setting	GIRAFFE was developed in a forensic mental health setting but is adaptable to other forensic or social care settings.			
Practitioners	It is intended for collaborative use by all members of the multidisciplinary team.			
Risk management	There is a strong emphasis on an individualised approach to risk formulation, risk management and review.			
Training	Recommended on-site cascade training.			
Cost	The system can be purchased outright but the project must be contacted directly for a quote.			
Manual	The system incorporates an electronic help manual together with website information. User support is offered.			
Evidence	There is no evidence available on the clinical utility of the tool.			
Origin	UK			
Formats	Electronic with textual/graphical printouts/dumps			
Contact	Julian Fuller, Project Director, 'GiraffeOnline', PO Box 35, Dawlish, Devon EX7 9DQ			
Phone	01626 864985			
Email	jrf@GiraffeOnline.co.uk			
Website	www.giraffeonline.co.uk			

START: Short-Term Assessment of Risk and Treatability

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
•			•	•
Description	START is a risk assessment and management decision support system developed in Canada. It adopts a global approach to risk by covering unauthorised leave, substance abuse, victimisation by others as well as risk to others, self-harm, suicide and self-neglect. The service user's strengths and risks on each of 20 dynamic factors are assessed on a scale of 0–2.			
Depth	In-depth.			
Setting	It was developed in a forensic psychiatric setting but may be applicable in general mental health settings as well.			
Practitioners	Practitioners from any mental health background can use the tool, but attendance at a training workshop is required.			
Risk management	The tool is designed to provide guidance on clinical interventions and to assess changes over time.			
Training	Contact below for further information.			
Cost	Not known.			
Manual	A manual is available.			
Evidence	There is preliminary evidence of good inter-rater reliability when completed by practitioners from different professions, and evidence of validity with a confirmed relationship between START scores and observed aggression. In terms of clinical utility, completion takes less than ten minutes on average and there is evidence of high acceptability among staff (e.g. ease of use).			
Origin	Canada			
Formats	Paper only			
Contact	British Columbia Mental Health and Addiction Services, 70 Colony Farm Road, Post Coquitlam, BC V3C 5X9 Canada			
Phone	604 524 7730			
Email	start@forensic.bc.ca			
Website	www.bcmhas.ca/Research/Research_START.htm			

Risk of violence or sexual violence, and antisocial or offending behaviour

HCR-20: Historical Clinical Risk-20

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
•				
Description	<p>The HCR-20 is a structured clinical judgement tool. It consists of 20 items, dividing risk assessment into three components: historical factors, clinical factors and risk management factors. These are seen as informing the clinician of relevant issues in a service user's past history, evaluating the presence of current dynamic issues in risk, and informing the practitioner of future risk management requirements. Each item is coded on two three-point scales evaluating, firstly, presence ('absent', 'possibly present', 'definitely present') then relevance to individual risk of violence ('not relevant', 'possibly relevant', 'definitely relevant'). Timescales for conducting the assessment are flexible and allow considerable leeway for individual judgment. The involvement of the service user in the assessment is encouraged.</p>			
Depth	In-depth.			
Setting	General and forensic mental health settings, males and females.			
Practitioners	Psychology or related degree plus relevant test administration training.			
Risk management	Risk management planning is built into the 'R' component of the tool and the publishers can supply a risk management companion guide in addition to the basic tool.			
Training	Training is strongly recommended. The test developer and trained others provide training sessions internationally.			
Cost	Currently approximately £80 start-up then approximately £2 per coding sheet. See publishers website for details. A new version is planned for publication in 2011. A new violence risk worksheet is now available supporting risk formulation and risk management planning.			
Manual	Available from the publisher for approximately £20.			
Evidence	This is not an actuarial risk prediction tool yet there is an international evidence base (including the UK) that supports an association between the findings of the HCR-20 and subsequent violence over long time periods in samples of both forensic and general mental health service users.			
Origin	Canada			
Formats	Paper only			
Contact	Psychological Assessment Resource Inc. 16204 North Florida Avenue, Lutz, FL 33549, USA or Proactive Resolutions			
Phone	+1 800 331 8378			
Email	See website			
Website	www.parinc.com			

PCL-R: Psychopathy Checklist-Revised

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
•		•		
Description	The PCL-R was designed as a tool to aid the assessment of psychopathic personality disorder in forensic patients. It has come to be used widely as a violence prediction tool despite discouragement from doing so, not least from the test author. The tool is a 20-item scale with items scored on the basis of a semi-structured interview and a collateral review of file-based information. Each item is scored on a 3 point scale based on how well the rater believes a client's character matches the description of each individual item.			
Depth	In-depth.			
Setting	Primarily forensic settings but may be applicable to antisocial and offending behaviour in general mental health settings. Most research on the PCL-R is on men; evidence for its clinical utility with women is more limited.			
Practitioners	Postgraduate qualification in a mental health profession is required			
Risk management	There is no explicit link to risk management strategies incorporated into the tool.			
Training	Specific training is required			
Cost	Current start-up costs are approximately £225 (paper format) and £290 (electronic format), then approximately £2 per coding sheet (£10 each if electronic). See publisher's website for details.			
Manual	Available from publisher.			
Evidence	The evidence base for this tool is extensive. There is evidence (including UK studies) of at least a moderate association between PCL-R score and violence post-discharge. The evidence for a link between PCL-R score and sexual violence recidivism is less strong. One of the factors which make up the tool ('antisocial behaviour') is more reliable in this respect than the other ('emotional detachment').			
Origin	Canada			
Formats	Paper and electronic			
Contact	Multi-Health Systems Incorporated, MHS (UK), 9a Kingfisher Court, Hambridge Road, Newbury, Berkshire RG14 5SJ, U.K.			
Phone	0845 601 7603			
Email				
Website	www.mhs.com			

PCL:SV: Psychopathy Checklist: Screening Version

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
•		•		
Description	The PCL:SV was developed to provide a shorter form of the PCL-R for use either as a brief assessment to determine whether a full PCL-R assessment is required or for the assessment of psychopathy in general psychiatric populations in whom criminal histories are less evident. It is a 12-item scale with items scored on the basis of a semi-structured interview and review of collateral file-based information. Each item is scored on a 3 point scale based on how well the rater believes a client's character matches the description of each individual item.			
Depth	Screening.			
Setting	General and forensic mental health settings.			
Practitioners	Postgraduate qualification in a mental health profession is required.			
Risk management	There is no explicit link to risk management strategies incorporated into the tool.			
Training	Specific training is recommended			
Cost	Currently approximately £110 start-up then approximately £1.60 per coding sheet. See publisher's website for details.			
Manual	Available from publisher.			
Evidence	The PCL:SV has not been as extensively evaluated as the PCL-R and the bulk of available evidence derives from outside of the UK. Available data suggest moderate to good associations between PCL:SV scores and aggression in both forensic and general psychiatric populations although, like the PCL-R, the PCL:SV was not designed as a risk prediction tool.			
Origin	Canada			
Formats	Paper only			
Contact	Multi-Health Systems Incorporated, MHS (UK), 9a Kingfisher Court, Hambridge Road, Newbury, Berkshire RG14 5SJ			
Phone	0845 601 7603			
Email				
Website	www.mhs.com			

STATIC-99

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
	•			
Description	The STATIC-99 is an actuarial scale developed specifically to assess the long-term potential for sexual recidivism in adult male sex offenders. The tool is made up of a ten-item list, with each item inviting a 'yes/no' response. One point is given for a 'yes' response to each of nine items, with three points given to the remaining item (prior sexual offences). A revised version, the STATIC-2002, remains in the process of development.			
Depth	Screening.			
Setting	Forensic mental health, males.			
Practitioners	Required qualifications are not specified.			
Risk management	As an actuarial tool, the scope for actively guiding individualised risk management plans is limited.			
Training	Training qualifications not specified.			
Cost	Free.			
Manual	None available . Coding guidelines are available from www2.ps-sp.gc.ca/publications/corrections/pdf/Static-99-coding-Rules_e.pdf			
Evidence	The evidence base for this tool is relatively small and will soon become outdated when the STATIC-2002 becomes available. However, evidence from a number of studies in various countries (including the UK) indicates low to moderate estimates of the predictive validity of the STATIC-99 in predicting sexual and non-sexual violent recidivism in rapists and child molesters.			
Origin	Canada/UK			
Formats	Paper only			
Contact	The main source is the following paper: Hanson & Thornton, 2002. The corresponding author's address is: Dr Andrew Harris, Senior Research Officer, Corrections Directorate, Solicitor General Canada, 11th. Floor, 340 Laurier Ave. West, Ottawa, Ontario, Canada K1A 0P8			
Phone	Not known			
Email	Not known			
Website	www.sgc.gc.ca			

SVR-20: Sexual Violence Risk-20

RSVP/Risk for Sexual Violence Protocol

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
	•			
Description	The SVR-20 is a very basic structured clinical judgement tool. It was designed to evaluate the risk of sexual recidivism in convicted sex offenders and there is good evidence for its psychometric properties and its efficacy. The 20-item scale is divided into three risk factor domains: psycho-social adjustment, sexual offences and future planning. Each item is rated on a three point scale ('not present', 'somewhat or possibly present' 'clearly present') and the general pattern observed is taken into account in evaluating risk as 'low' 'medium' or 'high'. The SVR-20 has been updated to the Risk for Sexual Violence Protocol (2003, www.proactive-resolutions.com), which is a more complex instrument designed to support clinical judgement from risk assessment through to risk management.			
Depth	In-depth.			
Setting	General and forensic mental health, males only although the RSVP may be used with women			
Practitioners	Psychology or related degree plus relevant test administration training.			
Risk management	The aim of the SVR-20 – and the RSVP – is to help in the development of risk management plans.			
Training	Training required.			
Cost	Currently approximately £60 start-up, then approximately 50p per coding sheet. See publisher's website for details.			
Manual	Available from the publishers for approximately £20.			
Evidence	As with the HCR-20, the SVR-20 and the RSVP were not designed as actuarial tools although there is good evidence of the relationship between SVR-20 risk factors and risk of sexually violent reoffending.			
Origin	Canada			
Formats	Paper only			
Contact	Psychological Assessment Resource Inc., 16204 North Florida Avenue, Lutz, FL 33549, USA			
Phone	+1 800 331 8378			
Email	See website			
Website	www.proactive-resolutions.com			

VRAG: Violence Risk Appraisal Guide

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
•				
Description	The VRAG is an actuarial tool made up of 12 items. One of these items is the total score of the PCL-R tool (see page 40) and the rest are based on information held in clinical files (e.g. psychosocial history). There is no reliance on interviews or questionnaires. All 12 items are scored from -5 to +12 and the total scores are divided into nine equal risk groupings.			
Depth	Screening.			
Setting	Forensic mental health services for males. There is a heavy reliance on items relating to previous offending behaviour			
Practitioners	Qualified mental health professionals.			
Risk management	There are no specific prompts on risk management strategies.			
Training	No specific qualifications have been set.			
Cost	Free.			
Manual	Not available but much of the work is described in the following book: Quinsey, V.L., Harris, G.T., Rice, M.E., & Cormier, C.A. (2006). <i>Violent offenders: Appraising and managing risk</i> (Second Edition). Washington, DC: American Psychological Association.			
Evidence	There is quite extensive evidence from various countries supporting the ability of the VRAG to predict future violence by offenders. Much of this is provided by the scale's authors. A small number of studies in the UK support moderate levels of predictive accuracy.			
Origin	Canada			
Formats	Paper			
Contact	Research Department, MHC, 500 Church St., Penetanguishene ON L9M 1G3, Canada			
Phone	Not known			
Email	mhcpres@mhcp.on.ca			
Website	www.mhcp-research.com/index.htm			

Risk of self-harm or suicide

ASIST: Applied Suicide Intervention Skills Training

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
			•	
Description	ASIST is a training programme developed in Canada and designed to prepare caregivers from a wide range of settings in suicide 'first aid'. It consists of a two-day package on suicide risk management for caregivers, which is interactive, intensive and closely related to practice. The aim is to prepare caregivers to recognise risk and develop skills to intervene to reduce the immediate risk. Awareness is raised on the importance of attitudes in this area and the resources available within local communities. The programme has been run in a number of countries worldwide and has been adopted as a national suicide intervention training programme by the Scottish Government.			
Depth	In-depth.			
Setting	All mental health settings in which suicide 'first aid' would be appropriate.			
Practitioners	All practitioners in these settings.			
Risk management	The course includes learning about intervening to prevent the immediate risk of suicide.			
Training	See 'Description' above.			
Cost	See website below. A range of paper and electronic supporting materials are available.			
Manual	Approximately £15.			
Evidence	ASIST has been adopted as a national suicide intervention training programme in Scotland. For further information, see the website below.			
Origin	Canada			
Formats	Not applicable			
Contact	Living Works, 4303D 11 Street SE, Calgary AB T2G 4X1 Canada			
Phone	+1 (403) 209-0242			
Email	info@livingworks.net			
Website	www.livingworks.net			

BHS: Beck Hopelessness Scale

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
			•	
Description	This is a self-report scale measuring an important suicide/self-harm risk factor, which takes less than ten minutes to complete. There are 20-items assessing feelings about the future. Each item is a true/false statement and scored 0 or 1. Negative responses on each item are summed to give a total score out of 20.			
Depth	Screening.			
Setting	General and forensic mental health settings.			
Practitioners	Psychology or related degree plus relevant test administration training.			
Risk management	There is no explicit link to risk management strategies incorporated into the tool.			
Training	General test administration training is required for purchase.			
Cost	Approximately £70 for a starter pack (manual and 25 forms), then approximately £1.50 per form.			
Manual	Available from the publisher for £36.50.			
Evidence	There is an extensive international evidence base including testing of the tool's structure and support for hopelessness as a risk factor for completed suicide. Some of the available evidence is derived from the UK. The BHS has been found to correlate well with change in clinical symptoms in randomised controlled trials of interventions for high risk or suicidal patients.			
Origin	USA			
Formats	Paper only for administration, but electronic analysis software is available			
Contact	Harcourt Assessment, Halley Court, Jordan Hill, Oxford OX2 8EJ			
Phone	01865 888188			
Email	info@harcourt-uk.com			
Website	www.harcourt-uk.com/			

SADPERSONS

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
			•	
Description	This brief tool assesses the presence or absence of ten risk factors for suicide e.g. male gender, social isolation. Each factor is rated 1 or 2 if present. Risk management is indicated if certain cut-off scores are exceeded. It is a very brief instrument so is easy to administer but makes a limited contribution to overall assessment.			
Depth	Screening.			
Setting	It was developed for American community settings but has been used in secondary mental health settings.			
Practitioners	Originally developed for senior medical students as novice risk assessors.			
Risk management	From a community perspective, interventions such as further evaluation/ treatment or immediate hospitalisation are linked to specific cut-off scores but these are not relevant to the UK setting.			
Training	No information available.			
Cost	Not known.			
Manual	Not available but information can be gained from the original source (Patterson W et. al., <i>Psychosomatics</i> , 24, 343-349, 1983) and a more recent paper (Roudebush et al., <i>Psychological Services</i> , 3, 137-141, 2006)			
Evidence	The available evidence is based on American samples and indicates that the tool is adequate as one part of an overall assessment. One review has criticised the lack of evidence indicating acceptable reliability and validity. There is a lack of evidence based on UK samples.			
Origin	USA			
Formats	Paper only			
Contact	W. M. Patterson, Smolian Clinic, Room 210, Department of Psychiatry, University Station, Birmingham, AL 15294, USA			
Phone	Not available			
Email	Not available			
Website	Not available			

SIS: Suicidal Intent Scale

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
			•	
Description	This interview-based or self-administered scale was designed to assess the intention to die amongst people who have attempted suicide. It has 15 items separated into circumstances related to the suicide attempt (e.g. presence of a suicide note) and self-report items (e.g. expectations of fatality). The first group of items can be completed retrospectively from case notes. Each item is scored on a 3-point scale and cut-offs for severity are provided. Five additional items do not contribute to the overall score. There are no specific cut-offs and a positive response to any item should be a cause for concern.			
Depth	Screening.			
Setting	General and forensic mental health settings.			
Practitioners	No limitations specified in the original source (see 'Manual' below).			
Risk management	There is no explicit link to risk management strategies incorporated into the tool.			
Training	None specified in the original source.			
Cost	None specified in the original source			
Manual	Not known but the source for the tool is: Beck, A., Schuyler, D., and Herman, I., <i>Development of suicide intent scales</i> , in <i>The Prediction Of Suicide</i> , A. Beck, H. Resnik, and D. Lettieri, Editors. 1974, Charles Press: Bowie, Maryland, USA.			
Evidence	An American review ³¹ concluded that the SIS score was not a risk factor for completed suicide over several years amongst inpatients hospitalised for attempted suicide. A recent UK study ³² concluded that the scale remains valuable as a clinical aid. Other studies have reported some associations between total or subscale scores and suicide-related outcomes.			
Origin	USA			
Formats	Paper only			
Contact	Beck Institute for Cognitive Therapy and Research, One Belmont Avenue, Suite 700, Bala Cynwyd, PA 19004-1610, USA			
Phone	USA +1 610 664 3020			
Email	beckinst@gim.net			
Website	beckinstitute.org/			

SSI: Scale for Suicide Ideation

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
			•	
Description	This is a 21-item scale that can be self-administered or completed via an interview in about ten minutes. It is designed to assess the intensity of a person's attitudes with regard to suicide and their behaviours and plans to complete suicide during the past week. Some 19 test items are each rated between 0 and 2 and summed to yield a total score ranging from 0-38. Two additional items ask about previous suicide attempts and the seriousness of intent in the most recent attempt. The first 5 of the 19 items act as a screening filter. Whilst a higher score is associated with a higher risk, there are no specific cut-offs and a positive response to any item should be a cause for concern.			
Depth	Screening.			
Setting	General and forensic mental health settings.			
Practitioners	It may be administered and scored by all practitioners but requires specialist training for purchase and interpretation.			
Risk management	There is no explicit link to risk management strategies incorporated into the tool.			
Training	General test administration training is required for purchase.			
Cost	Approximately £70 for a starter pack (manual and 25 forms), then approximately £1.50 per form.			
Manual	Available from the publisher for £36.50.			
Evidence	A major American review ³¹ found evidence of an association between scores on the interview version of this scale and completed suicide in outpatients. No such evidence for the self-report version listed here was reported. There is UK evidence of sensitivity to change in a self-harm intervention trial. A self-report version has been used to detect change in a UK trial.			
Origin	USA			
Formats	Paper only for administration, but electronic analysis software is available			
Contact	Harcourt Assessment, Halley Court, Jordan Hill, Oxford OX2 8EJ			
Phone	01865-888188			
Email	info@harcourt-uk.com			
Website	www.harcourt-uk.com/			

STORM: Skills-based Training on Risk Management

Violence	Sexual violence	Antisocial and offending behaviour	Self-harm/ suicide	Self-neglect/ vulnerability
			•	
Description	STORM is a suicide prevention training package bought as part of an overall suicide prevention strategy by organisations or partnerships of organisations in statutory and voluntary sectors. It can be delivered on-site in a short modular format or over 1-2 days. The package covers assessment, crisis management, crisis prevention and problem-solving when working with potentially suicidal service users. A Children's & Young Person's version is available as well as the adult version. Facilitators are professionals, non-professionals or service users with relevant experience trained to deliver the package in a cascade model.			
Depth	In-depth.			
Setting	STORM is designed for application in any mental care setting as well as for social care and criminal justice staff.			
Practitioners	Suitable for all mental health practitioners.			
Risk management	As part of an overall strategy, the main emphasis is on risk management.			
Training	See 'Description' above.			
Cost	Currently £1,500 per facilitator but contact below for a quotation.			
Manual	Not applicable			
Evidence	STORM has been given as an example of good practice in a recent review of progress in delivering on the National Service Framework standard relating to suicide.			
Origin	UK			
Formats	Not applicable			
Contact	Gill Lever-Green, STORM Co-ordinator, University of Manchester, Rusholme Academic Unit, Rusholme Health Centre, Walmer Street, Manchester M14 5NP			
Phone	0161 275 1869			
Email	g.d.lever-green@manchester.ac.uk			
Website	www.medicine.manchester.ac.uk/storm/			

Appendix 2: Risk factors for violence and suicide

This section provides a brief summary of the main factors that have been found to be associated with violence and suicide in the research literature.

Risk factors for violence

Demographic factors

- Male
- Young age
- Socially disadvantaged neighbourhoods
- Lack of social support
- Employment problems
- Criminal peer group

Background history

- Childhood maltreatment
- History of violence
- First violent at young age
- History of childhood conduct disorder
- History of non-violent criminality

Clinical history

- Psychopathy
- Substance abuse
- Personality disorder
- Schizophrenia
- Executive dysfunction
- Non-compliance with treatment

Psychological and psychosocial factors

- Anger
- Impulsivity
- Suspiciousness
- Morbid jealousy
- Criminal/violent attitudes
- Command hallucinations
- Lack of insight

Current 'context'

- Threats of violence
- Interpersonal discord/instability
- Availability of weapons

Ref: 33,34,

Risk factors for suicide

Demographic factors

- Male
- Increasing age
- Low socioeconomic status
- Unmarried, separated, widowed
- Living alone
- Unemployed

Background history

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

Clinical history

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

Psychological and psychosocial factors

- Hopelessness
- Impulsiveness
- Low self-esteem
- Life event
- Relationship instability
- Lack of social support

Current 'context'

- Suicidal ideation
- Suicide plans
- Availability of means
- Lethality of means

Ref: 35,36

Appendix 3: Twelve Points to a Safer Service

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness¹⁹ has developed a set of recommendations to improve policy and practice in mental health care settings. These 12 points are intended to be used as a checklist for local services and are the basis of a risk management toolkit that the National Institute for Mental Health in England (NIMHE) is currently making available to services.

The 12 points recommend:

- staff training in the management of risk - both suicide and violence - every three years;
- all patients with severe mental illness and a history of self-harm or violence to receive the most intensive level of care;
- individual care plans to specify action to be taken if patient is non-compliant or fails to attend;
- prompt access to services for people in crisis and for their families;
- assertive outreach teams to prevent loss of contact with vulnerable and high-risk patients;
- atypical anti-psychotic medication to be available for all patients with severe mental illness who are non-compliant with 'typical' drugs because of side-effects;
- strategy for dual diagnosis covering training on the management of substance misuse, joint working with substance misuse services, and staff with specific responsibility to develop the local service;
- inpatient wards to remove or cover all likely ligature points, including all non-collapsible curtain rails;
- follow-up within seven days of discharge from hospital for everyone with severe mental illness or a history of self-harm in the previous three months;
- patients with a history of self-harm in the last three months to receive supplies of medication covering no more than two weeks;

- local arrangements for information-sharing with criminal justice agencies; and
- policy ensuring post-incident, multidisciplinary case review and information to be given to families of involved patients.

A fuller account of the conclusions that support these recommendations are available in the *Safety First* report¹⁴: www.dh.gov.uk/assetRoot/04/05/82/43/04058243.pdf

Appendix 4: Glossary

Actuarial approach: An approach to risk assessment involving the use of statistical models³ to estimate the likelihood of a risk event such as suicide or harm to others. Actuarial assessments, though, depend on the person being assessed coming from the same population that which generated the statistical data used to make the risk evaluation. Therefore, the accuracy of assessments depends on the similarity of the individual with this population. Risk factors measured by actuarial tools are generally static (unchangeable) – some of the newer actuarial guides include dynamic (changeable) factors also. The findings of an actuarial risk assessment provide little guidance on risk management.

Aggression: A disposition, a willingness to inflict harm, regardless of whether this is behaviourally or verbally expressed and regardless of whether physical harm is sustained.³

Assessment: The process of gathering information via personal interviews, psychological/medical testing, review of case records and contact with collateral informants for use in making decisions.³⁰

High risk: A term used of a service user who presents a risk of committing an act – either planned or spontaneous - which is very likely to cause serious harm. There are few if any protective factors to mitigate or reduce that risk. The service user requires long-term risk management, including planned supervision and close monitoring and, when the service user has the capacity to respond, intensive and organised treatment.^{30,37}

Low risk: A term used of a service user who may have caused, attempted or threatened serious harm in the past but a repeat of such behaviour is not thought likely between now and the next scheduled risk assessment. They are likely to cooperate well and contribute helpfully to risk management planning, and they may respond to treatment. In all probable future scenarios in which risk might become an issue, a sufficient number of protective factors (e.g. rule adherence, good response to treatment, trusting relationships with staff) to support ongoing desistance from harmful behaviour can be identified.^{30,37}

Medium risk: A term used of a service user who is capable of causing serious harm but in the most probable future scenarios, there are sufficient protective factors to moderate that risk. The service user evidences the capacity to engage with, and occasionally contribute helpfully to, planned risk management strategies and may respond to treatment. This service user may become high risk in the absence of the protective factors identified in this assessment.^{30,37}

Protective factor: Any circumstance, event, factor or consideration with the capacity to prevent or reduce the severity or likelihood of harm to self or others.^{30,37}

Risk: The nature, severity, imminence, frequency/duration and likelihood of harm to self or others. A hazard that is to be identified, measured and ultimately, prevented².

Risk factor: A condition or characteristic assumed to have a relationship to the potential to harm another person or self.³⁷

Risk formulation: An explanation of how risks in specified areas arise in a particular individual given the presence and relevance of conditions that are assumed to be risk factors for a hazardous outcome that is to be prevented. A risk formulation should account for the role of protective factors as well as risk factors.³⁷

Risk management: The actions taken, on the basis of a risk assessment, that are designed to prevent or limit undesirable outcomes. Key risk management activities are treatment (e.g., psychological care, medication), supervision (e.g., help with planning daily activities, setting restrictions on alcohol use or contact with unhelpful others, and so on), monitoring (i.e., identifying and looking out for early warning signs of an increase in risk, which would trigger treatment or supervision actions), and if relevant, victim safety planning (e.g., helping a victim of domestic violence to make herself safe in the future and know better what to do in the event of perceived threat).³⁷

Self-harm: Self-poisoning or self-injury, irrespective of the apparent purpose of the act.²¹

Sexual violence: Actual, attempted or threatened harm to another person that is deliberate and non-consenting and is sexually motivated.³

Structured professional judgement: An approach toward risk assessment developed over the past decade. It involves the practitioner making a judgement about risk on the basis of combining an assessment of clearly defined factors derived from research with the use of their clinical experience and knowledge of the service user.

Violence: Actual, attempted, or threatened harm to another person that is deliberate and non-consenting.³

Vulnerability: Specific factors that relate to the likelihood of an individual being victimised, taken advantage of, or exploited by others. Vulnerable individuals may be subject to verbal abuse or harassment, physical or sexual abuse or intimidation, coercion into unwanted acts and bullying. Assessment of vulnerability may include consideration of mental state, physical/physiological conditions, psychological or social problems, cultural or gender issues.³

Appendix 5: Methods used to develop this framework

The principles section of this framework is made up of consensus statements based on consultation with the following groups through group meetings, group interviews, individual interviews and email contact:

- the National Mental Health Risk Management Programme 'Risk Assessment and Management Tools and Methods Expert Advisory Group' (July 2006 – June 2007)
- hospital and community based staff working for Mersey Care NHS Trust and North East Wales NHS Trust in adult mental health, medium secure care and high secure care (August – October 2006)
- service users from across England affiliated to the Mental Health Foundation Survivor Research Network (March 2007)
- carers affiliated to the Bath Carers Group (March 2007)
- researchers and practitioners from Ireland, the Netherlands, Norway and Turkey affiliated to the European Violence in Psychiatry Research Group (September 2006)

Appendix 1 of the framework was developed in the following way. The *multiple risk tools* were selected (1) following consultation with the Advisory Group on the basis (2) that they had evidence of clinical utility, reliability or validity from at least one published study and (3) that they had been implemented in at least one UK mental health trust.

The tools assessing *risk to others (violence, antisocial and offending behaviour)* were selected by the Department of Health to reflect policy priorities and evaluated with reference to a systematic review on this topic. Full details of the search strategy are available in the project report together with a detailed analysis of the evidence base³⁸. In summary, the electronic search term in Figure 3 was applied to all main health and criminal justice databases (including grey literature) for publications up to 2006. In addition, 41 journals were hand-searched from 1990 to 2003. The resulting database of more than 41,000 citations was searched for empirical studies of risk assessment and 662 relevant studies were identified evaluating over 200 structured risk assessment tools.

Figure 3: 'Risk to others' tools search term

```
(((Homicid* OR murder* OR manslaughter* OR infanticid* OR parricid*
OR assault* OR (bodily AND (harm OR assault)) OR assail* OR bugger*
OR sodom* OR molest* OR pedophil* OR paedophil* OR sadis* OR
somasochis* OR sado-masochis* OR anger* OR cruel* OR rapist* OR
(rape* AND offend*) OR physical abus* OR spouse abus* OR partner abus*
OR sexual abus*) OR ((dangerous* AND (behavior* OR behaviour* OR
histor* OR conduct*)) or violen*) AND (risk* OR predict* OR anteced* OR
assess* OR cause* OR reason* OR interven* OR prevention* OR preventing*
OR controlling* OR manage* OR treatment* OR treating* OR reduction* OR
reducing* OR stop* OR mental* OR forensic* OR psychiatric* OR offend*
OR Axis 1 OR Axis 2 OR criminal* OR detain* OR insan* OR NGRI OR retard*
OR (learning disab* OR learning-disab*) OR acquit*)) OR ((child abus* OR
elder abus* OR hostil* OR killing* OR attack* OR aggress*) AND (mental*
OR forensic* OR psychiatric* OR offend* OR axis 1 OR axis 2 OR criminal*
OR detain* OR insan* OR NGRI OR retard* OR (learning disab* OR learning-
disab*) OR acquit* OR disorder*)) NOT (cancer* OR cancer [mh] OR tumo*
OR tumour [mh] OR heart* OR heart [mh]))
```

The *self harm and suicide tools* were selected by one of two methods. The first method was to draw on a systematic review³¹ funded by the American National Institute of Mental Health. Three of the tools selected were those in the review which had evidence of predictive validity from mental health samples. Evidence relating to these tools and any new tools published since completion of the NIMH search (1998) was then sought by searching a database of suicide-related literature constructed for another project. To construct this database, the electronic search term in Figure 4a had been applied to a wide range of sources (i.e. C2Spectr; CINAHL; Cochrane; CRIB; Dissertation abstracts; Econlit; Medline; National Research Register; Psychinfo; Social Sciences Abstracts; and Social Sciences Index) and the resulting database contained more than 23,000 citations. Evidence relating to tools identified in the source review³¹ was sought by using the name of the tool and the main authors. This evidence was added to the appraisal in the source review. Evidence relating to new tools was sought using the term in Figure 4b and three new tools relating to working age adults in secondary care were identified but none of these had sufficient information available.

Figure 4a: Suicide citations search term

suicid* OR selfharm* OR self-harm* OR (self AND harm*) OR selfinjur* OR self-injur* OR (self AND injur*) OR selfpoison* OR self-poison* OR (self AND poison*) OR selfmutilat* OR self-mutilat* OR (self AND mutilat*) OR selflacerat* OR self-lacerat* OR (self AND lacerat*) OR selfcut* OR self-cut* OR (self AND cut*) OR parasuicid* OR para-suicid* OR ((deliberat* Or intent*) AND overdos*)

Figure 4b: Suicide tools search term

risk AND assessment AND (instrument* OR scale* OR measure* Or tool*)

The second method was the same as that for the multiple risk tools above i.e. three additional tools were selected (1) following consultation with the Advisory Group on the basis (2) that they had evidence of clinical utility, reliability or validity from at least one published study and (3) that they had been implemented in at least one UK mental health trust.

Three *tools specific to self-neglect* were initially identified through systematic review but were subsequently not included due to coverage of this dimension by the multiple risk tools.

Appendix 6: Implementing *Best Practice in Managing Risk*

In July 2007, the Department of Health initiated a six-month project to support the implementation across England of the *Best Practice* guidance. This project was led by the same group which had led on the development of the guidance itself published in June 2007. The objectives of the implementation project were to publicise the guidance as widely as possible and to provide practical support to mental health trusts across England in the development of their local clinical risk assessment and management practice.

The implementation project consisted of three stages. In the first stage, we developed a national communication framework for the *Best Practice* guidance in the form of a website. In the second stage, we ran two conferences, one in London and the other in Liverpool, to publicise the guidance and to provide examples of its local implementation. In the third stage, we provided support to seven mental health trusts across England in their implementation of the *Best Practice* guidance. On the basis of all this work, we developed the implementation plan that follows.

The 'Best Practice in Managing Risk' website

The website was set up at the following web address:
www.managingclinicalrisk.nhs.uk

To make sure that the website endures beyond the lifetime of the *Best Practice* implementation project, it is hosted on the Mersey Care NHS Trust website. All of the team involved in developing the *Best Practice* guidance have links with this Trust. The *Best Practice* website can be accessed either directly via the address above or through the Mersey Care website – www.merseycare.nhs.uk – then scrolling to the bottom of the homepage and clicking on the tan bar '*Managing Clinical Risk*'.

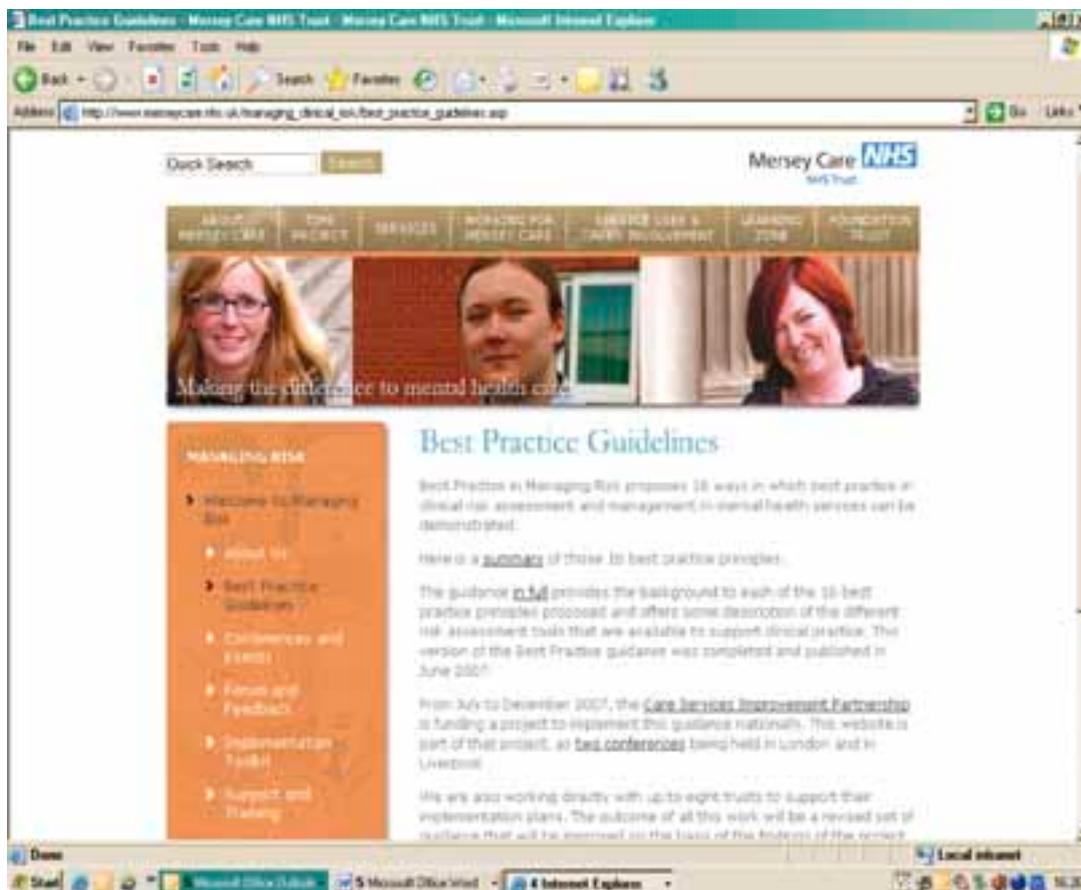
The website has a number of resources contained within its six 'silos' and all of these are listed on the left-hand side of the welcome page. In the first silo, entitled 'About Us', the *Best Practice* guidance is introduced, its purpose and contents are described, and its principle authors are introduced.

In the second silo, a link to a pdf copy of the full *Best Practice in Managing Risk* guidance is provided. A link to a shorter pdf copy of the 16 Best Practice principles

is also available, as well as links to other documents that may be helpful, such as publications on the recently revised Care Programme Approach and the new Mental Health Act.

In the third silo, there is more information about the 2007 London and Liverpool conferences – the programmes, the speakers and a selection of some of the presentations. Some of the first presentations here describe the process of how the guidelines were developed so these presentations should be consulted if more information on this aspect is required.

Figure 4: 'Best Practice in Managing Risk' website screenshot



In the fourth silo of the website, a forum for discussion is provided. This forum is supported by Google Groups so those interested in taking part have to sign up to take part. Being a part of the discussion group means having access to an increasing number of practitioners across the country who read the postings and contribute with thoughts, ideas and suggestions for developing and ultimately improving clinical risk assessment and management practice.

In the fifth silo of the website, information is provided about the implementation of the *Best Practice* guidance. An Implementation Toolkit (see below) was developed for trusts to use to diagnose just how good their practice is against the 16 Best Practice principles. This Toolkit is available to download for any interested trust or organisation to use as a basis for rating their practice against the recommended principles.

In the final silo of the website, a number of additional resources are made available to download. For example, teaching plans are available for trusts to examine when they are preparing induction or mandatory training packages that relate to clinical risk assessment and management. Teaching plans for more detailed presentations, such as an introduction to clinical risk assessment and management and the structured professional judgement approach, are also provided. Links are also available to the Seven Steps to Patient Safety document prepared by the National Patient Safety Agency and referred to in Best Practice Point number 5.

All of these silos on the website are updated regularly, with new information, new teaching materials, and new links to interesting and useful resources.

London and Liverpool *Best Practice* Conferences

On 23rd November 2007, the first of two national conferences took place to publicise the *Best Practice* guidance and to demonstrate to practitioners how the guidance could be implemented in their local area. This first conference took place in London, at the CSIP/NIMHE headquarters in the London Development Centre in Cavendish Square and was chaired by **Mr Tom Dodd** of the Care Services Improvement Partnership. As well as presentations by members of the document development team, speakers included **Dr Helen Gilbert**, who discussed service user and carer involvement. Presentations were also heard from **Mr Phil Garnham** of Oxleas NHS Foundation Trust, **Dr Kay Macdonald** of Sussex Partnership NHS Trust, and **Mr Patrick McKee**, **Dr Louise Fountain** and **Dr Julie Hankin** of Avon and Wiltshire Mental Health Partnership NHS Trust. All talked about the process of implementing the *Best Practice* guidance in their own trust and gave examples of what best practice looks like in their area. The website was launched at this meeting.

At the London conference, **Dr Helen Gilbert** made the following points about service user and carer involvement in clinical risk assessment and management:

1. Collaborative risk assessment is not an option – it is essential!
2. The key to effective risk management is a good relationship between the service user and all those involved in providing her or his care
3. Three-way collaboration between the service user, her or his carer and the care team should be based on trust in an atmosphere of openness and transparency
4. If, for whatever reason, the service user is not involved in some element of risk management, this should be documented

On 14th December 2007, a second conference was hosted at the Foresight Centre at the University of Liverpool and chaired by **Ms Janet Davies** of the Department of Health. **Professor Louis Appleby** set the scene for the meeting by discussing the national picture in which clinical risk assessment and management practice has developed and continues to progress. **Ms Kay Sheldon** and **Ms Sally Luxton** provided service user and carer perspectives, emphasising the collaboration and prevention messages that are a core element the *Best Practice* guidance. Implementation of *Best Practice* in two trusts was described by **Ms Karen Wilson** of Mersey Care NHS Trust and by **Ms Claire Taylor**, **Mr Roy Butterworth** and **Mr Mark Love** of Lancashire Care NHS Trust.

Both conferences were very well received. Service user and carer perspectives were rated highly in the feedback because they emphasised that best practice in risk management is achieved through a collaboration between service providers and service users and carers. Delegates also welcomed the Implementation Toolkit and the opportunity to talk to practitioners in other areas across the country, to share experiences and so feel less isolated in their attempts to assess and manage clinical risks.

London Conference Feedback:

- The presentation on service user and carer involvement was thought-provoking
- *I found most useful ...* the overall framework of the guidance and how this could be used in my practice assessing risk
- *I found most useful ...* the chance to think about how to implement these guidelines rather than just being presented with a document
- *I found most useful ...* ideas about developing best practice from various trusts around the UK
- *I found most useful ...* achieving an understanding about developing guidelines and how research informs best practice
- *I found most useful ...* networking and hearing the experience of those who have started to implement the guidance AND seeing the website in action
- *I found most helpful ...* hearing about the work of fellow trusts in terms of what to take back to our own localities

Liverpool Conference Feedback:

- *I found most useful ...* discussions about involving service users and carers in risk assessment
- *I found most useful ...* information about the website as well as a reduction in feelings of isolation
- *I found most useful ...* information about national developments, trends and expectations
- An excellent day, which provided a lot of food for thought

Implementing Best Practice

An important part of the implementation project was to support a selection of trusts across England to incorporate the *Best Practice* guidance into their local policy. Seven trusts were selected on the basis of their size, range of services, and geographical location: Avon and Wiltshire Mental Health Partnership NHS Trust, Oxleas NHS Foundation Trust, Sussex Partnership NHS Trust, Lancashire Care NHS Trust, East London NHS Foundation Trust, South Essex Partnership NHS Foundation Trust, and Mersey Care NHS Trust. A workshop was arranged in each trust to which directors of service and heads of specialty were invited.

All the workshops began with an introduction to the *Best Practice* guidance. Then, those attending were invited to gather into small groups and to rate their own Trust using the **Implementation Toolkit**. In this Toolkit, each one of the principles is listed and suggestions are provided for some of the ways in which Trusts may be demonstrating evidence of the best practice described. Those attending the workshop were invited to make ratings on the basis of the *extent* to which they thought their Trust could evidence each kind of best practice. A rating of '2' for each of the 16 principles suggests that a Trust can evidence the highest level of practice in the area described. A rating of '1' suggests that practice is good or that there is some evidence of best practice but that there is room for improvement. A rating of '0' suggests that work is in progress and that best quality practice is in development. The Implementation Toolkit is available on the *Best Practice* website [www.managingclinicalrisk.nhs.uk] along with the rating form that accompanies it.

After this rating exercise, there was a feedback session in which those attending were asked to describe and justify the ratings given by their group for their Trust. Any differences between groups were also discussed and in this way consensus ratings for each Trust on each of the 16 *Best Practice* principles were agreed. These consensus ratings, together with all the information gathered about the Trust at the workshop, were then compiled into a report, which contained an action plan moving from good practice to best practice. A template of the action plan, with some examples of best practice and developing practice, and some examples of the actions suggested in one or more of the trusts taking part in this exercise, is available on the *Best Practice* website.

The Implementation Toolkit thus underpinned a self-assessment exercise in which Trusts were helped to think of developments and improvements in local practice. Trusts were not compared with one another using the Toolkit – it was intended simply as an instrument to aid self-scrutiny and subsequent action. This Toolkit proved very popular and the action plans received by each trust as a result of the event were welcomed and acted upon. In response to feedback, a second version of the Toolkit – for individual practitioners to make ratings of their own best practice – has been developed and is also available on the *Best Practice* website.

Recommendations for Implementing Best Practice in your Trust

1. Determine who in your Trust is in the best position to lead an exercise in assessing best practice in clinical risk assessment and management. This person should be senior in the service and with the power to access key people and to make suggestions at a senior management level regarding changes in practice that will be heard and acted upon.

2. The identified person should arrange either a single workshop (likely to last around 3 hours in length) or interview the key people in the Trust (e.g., Medical Director, Director of Nursing, Risk Manager, and so on) individually. The discussion should focus on finalising ratings and gathering evidence for each of the principles based on evidence supporting claims of best practice or ideas about how best practice can be developed.
3. The identified person should then examine the action plan template and start to prepare an action plan for their Trust starting with any of the suggestions contained in this template.
4. Once the action plan has been drafted, those who attended the workshop or were interviewed should examine this report in order to make improvements and additional comments.
5. The identified person should then consult with the most senior managers in their Trust (for example, present the action plan or a summary of contents to the Trust Governance Committee) to get their approval for a root-and-branch review of clinical risk assessment and management. (*If approved, ask the Committee to consider appointing or seconding a project manager or member of staff for whom making developments in this area are a key responsibility*).
6. Identify the Trust clinical risk management groups that can take the lead in making the developments agreed. Offer the following items for discussion at their next meetings or, preferably, suggest they convene a special meeting at which these items will be discussed:
 - a. *The ideal process for risk assessment in this Trust* – when in a service user's care pathway do we need information about risk and what kinds of information do we need?
 - b. *Policy review and development* – which risk-relevant policies need review and what new policies need to be developed?
 - c. *Training* – what is needed and how will a training strategy be developed?
 - d. *Learning and development* – how can the library, intranet and other resources be developed to make risk-relevant information noticeable and available for interested staff?
 - e. *Risk champions* – if viable, how will they be identified and how will they be made to work in this Trust?
 - f. Decide on *examples of good practice* and effectively managed risk with service users and how these can be made more widely known, e.g., in

ward rounds, case conferences. This should also include ensuring that all practitioners ask service users what works for them as well as what doesn't

- g. Working towards better *collaboration* with service users and carers – how would they like to be more involved?
 - h. *Risk-relevant documentation* – review this to see if it is fit for purpose; consider convening a focus group of practitioners to discuss the documentation and get their opinions about what works and what doesn't work so well
 - i. How will this Trust know if the changes they are making are indeed improvements? *Define three to six standards* that should be met across most services most of the time – e.g., if relevant, “all care plans will include a risk formulation”; “all directorates and key services (e.g., EIT, AO, older adults, LD, CMHT, CAMHS, CRHT) will identify a willing risk champions within 12 months of this meeting and their training will be completed”, and so on
 - j. These clinical risk management groups should identify two or more members to lead in each area and be given 3-6 months to develop their plans for development in each area
7. At the next meeting of the Trust Governance Committee or equivalent, present a proposal for the development of practice in clinical risk assessment and management in this Trust. Seek the approval of this committee for the actions proposed. Ask to return each 6 months to provide an update.
 8. Recruit the assistance of the Trust's clinical audit department to help with the ongoing measurement of improvement.

Extract from a possible Action Plan developed following the exercise described above

No.	Best Practice Principle	Progress	Lead & Timescale	Average Rating
1.	<i>Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience and clinical judgement</i>	Good integration of clinical and non-clinical risk information and good communication with other departments relating to this.	Complete	
		The Intranet has been updated, and links are available for risk including NPSA, HSE and Dave Sheppard MH Law site.	Complete	
		Risk policies and procedures are being audited for compliance and effective implementation.	August 2008	
2.	<i>Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners.</i>	Risk Management Training programme is underway and will include a stronger emphasis on positive risk taking.	December 2008	
		Good practice opportunities are showcased as part of the learning lessons programme, and as part of the publication process.	Complete	

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This framework document was prepared by the following team:

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Dr. Caroline Logan	Mersey Care NHS Trust & University of Liverpool
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