Risk Assessment and Management in Mental Health Nursing

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and

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Assessing and managing risk is a core part of the practice of all mental health nurses, regardless of whether they practice in a high-secure facility or in a primary care setting. It is certainly a truism that ‘psychiatry is a risky business’. This fact is continually emphasised in governmental publications and the colossal growth of research and professional papers on the subject of risk and mental health. Recent national reviews of mental health nursing in both England and Scotland have re-emphasised the importance of nurses’ contribution to this activity. Psychiatry is innately risky because of the complexity of human motivation in the context of mental health problems and the resulting complexity of predicting future behaviour. This book provides a rigour to thinking about risk assessment and management, placing existing research findings in the context of day-to-day practice and, most importantly, ethical practice.

Mental health nursing has always been a profession that has had to balance the need to help protect people with mental illness, with the need to protect their rights to independence and self-determination. From the earliest times, nurses have been expected to successfully contain risk and have been held accountable when this has been unsuccessful. For example, in the nineteenth century nurses were fined if any of their charges managed to escape their care.

This book raises important issues regarding current perspectives on risk. In terms of proportionality, there are more forms of risk that nurses need to address than just those of direct risk from individuals to themselves through self-harm or harm to others through violence. This is an important point to be made, as the reality is that both suicide and homicide by people with mental illness are relatively rare events compared to the frequency with which individuals suffer abuse or neglect. Mental health nurses are open to pressures from the media and politicians to be over-reactive to perceived risk and consequently act in ways that are ultimately neither therapeutic nor in the long-term in the interests of people who receive mental health services.
Another significant point relates to attitudes to the management of risk, which have recently been the subject of much discussion. Mental health services are understandably concerned that they can be unfairly blamed when serious incidents such as suicides or homicides take place. Such unfair criticism can have the unfortunate effect of making healthcare services overly negative about the possibility of managing risk effectively in the majority of cases. The reality is that mental health nurses and others do effectively manage to work together with people with mental health problems to prevent harm. Every practicing nurse will be able to think of dozens of occasions when he or she has made an important contribution in this regard.

A key message within this book is that while statistical methods support the prediction of risk to a degree, it is through individual engagement and the consequent understanding of the unique motivations and thoughts of individuals that meaningful assessments are made and are the means through which much of the successful management of risk takes place. This book therefore valuably reiterates that mental health nurses need to combine the skills of rational evidence-based analysis with those of empathy for and sensitivity to the individual.

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Chapter 1
Introduction

Phil Woods and Alyson M. Kettles

Whether or not we like it, risk assessment and management is part of daily life for us. Every day, whether as a health professional or as a father, mother, son, daughter, husband or wife, and so on, we will be undertaking assessments of risk and consequently putting interventions in place to somehow manage or reduce those risks. One only has to do a quick literature search on risk to receive thousands of results from this, confirming Hayes’ (1992) claim that for many years it has been an important concept in health, behavioural and social sciences, legal communities and the risk epidemic in medical journals (Skolbekken 1995). Indeed:

‘...one of the most lively areas of theoretical debate in social and cultural theory in recent times is that addressing the phenomenon of risk and the role it plays in contemporary social life and subjectivities’ (Lupton 1999, p.1).

It is a clear fact within current mental health practice that risk assessment is very central to practice (Woods 1996) and indeed it is a requirement by society that we protect those who would need it and those that society needs protecting from. Doyle and Duffy (2006), amongst others, state how assessing and managing risk is a key task for mental health clinicians. Bloom et al. (2005) stress that it is an inherent dimension of psychiatric practice and Lewis and Webster (2004) that it is one of the highest profile tasks of mental health professionals. Rose (1998) informs how ‘the language of risk now prevails mental health in the UK’. Professor Louis Appleby, in the foreword to a recent Department of Health (2007) document on Best Practice in Managing Risk, states that it is clear that ‘safety is at the centre of all good healthcare’ (p.3).

- So what is this thing called risk assessment?
- How do we do it?
- How do we do it well?
- What do we measure?
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- How do we know if we are measuring the right things?
- How do we know if we have done it well?
- When do we do it?
- For whom do we do it?

These are just some of the many questions that roll off the tongue in relation to risk assessment and management. Those reading this book could probably also think of many more questions that they need answered. Well, it is hoped that this book may answer some of these questions and perhaps some readers may have themselves. It cannot be expected to answer all questions for all mental health nurses, but it can help to pave the way for them to consider their own practices and hopefully look further for answers that they may need.

Kettles (2004) discusses how health professionals understand risk in a variety of ways, but generally in mental health care, risk means a range of potential adverse events. Indeed, McClelland (1995) highlighted that one of the main problems that nurses face in their approaches to risk assessment, and its management, is that it is affected to a large degree by who defines the risk and how it is defined. This in itself is problematic in so much as if we as mental health nurses do not agree what is or what is not risk then how can we provide continuity of care across a range of services, and of course good risk management?

In this book, risk assessment and management have been viewed in the widest sense, although Chapters 2 and 3 will consider this more. As a starting point, risk can be considered as the probability of harm to self or others or a serious unwanted event; risk assessment is the process of determining this probability; and risk management is the process or intervention through which identified risks are reduced or alleviated. So risk can be considered from all perspectives: from deterioration in mental health status to suicide or homicide.

As mental health nurses and members of society it has to be noted that day by day we assess and manage risks well. How do we know this? Well, in our daily lives we manage to drive to work, cross the road and eat healthy diets, to name but a few examples. All these have potential risks involved in them and need us to put in place management plans to reduce these risks. In our professional lives, for example, when caring for a number of suicidal patients, why is it that they do not all manage to end their lives? Clearly we have assessed and are managing the risks associated with this well. What we are really doing is positive risk taking, ‘weighing up the potential benefits and harms of exercising one choice or another’ (Morgan 2004, p.18). But how often do we really consider how we have done this?

Over the past 20 years or so mental health practice has changed considerably and this has developed specific challenges for the mental health nurse’s
role in risk assessment and management. Policy changes have seen a growing emphasis on community care rather than institutional care, where in the latter it was far easier to assess and manage risk through the added control and place of the sanctuary they provided for those cared for in them. Inpatient beds are becoming scarcer and periods of stay in hospital tend to be much reduced. These issues mean that those finding themselves in hospital are likely to be higher risk and demand enhanced skills from the mental health nurses who care for them. Conversely this also means that those who do not get admitted are perhaps more likely to be more risky than in the past, demanding different skills from the mental health nurses working in the community, perhaps with larger caseloads resulting from these changes. With this drive for community care and the related crisis intervention and assertive outreach services that have developed, risk assessment and management has been taken to a new level of difficulty.

According to the Department of Health (2001, pp.11–13), crisis resolution/home treatment teams provide a service for adults with severe mental illness with an acute psychiatric crisis of such severity that, without the involvement of a crisis resolution/home treatment team, hospitalisation would be necessary. Current policy in the UK (and throughout the world) has developed around the notion that people experiencing mental illness should receive treatment in the least restrictive environment, thereby minimising disruption in their lives. Crisis resolution/home treatment can be provided in a range of settings and offers an alternative to inpatient care. These services have developed to intervene with all four phases to crisis resolution:

- assessment
- planning
- intervention; and
- resolution.

As any and all of these phases are complex in many cases, effective risk assessment and management is a crucial yet challenging component.

In the same document, the Department of Health (2001) lays out clear implementation guidelines for assertive outreach services for those who have difficulty in maintaining lasting and consenting contact with services. Often they have severe mental health problems with complex needs and have difficulty engaging with services and often require repeat admission to hospital. Assertive outreach has been shown to be an effective approach to the management of these people and clearly good risk assessment and management is a crucial component of these services.

More recently, in the publication *From Values to Action: The Chief Nursing Officer’s Review of Mental Health Nursing* (Department of Health 2006), key
recommendation 10 (in relation to improving outcomes for service users) clearly states:

‘Mental Health Nurses need to be well trained in risk assessment and management. They should work closely with service users and others to develop realistic individual care plans’ (p.5).

Throughout this key document many of the other recommendations are underpinned by issues of good risk assessment and management. Similarly, the document Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland (Scottish Executive 2006) highlights one of the visions of mental health services as:

‘Enabling, person-centred recovery and strengths-based focus with a move towards positive management of individual risk’

with a mental health nursing response of

‘Adopting frameworks for practice that promote values-based practice, maximising therapeutic contact time and the therapeutic management of individual risk’ (p.11).

Again throughout this key document many of the other practice and care issues discussed are done so in relation to good risk assessment and management. A clear stark message is therefore being sent by two major reviews of mental health nursing that risk assessment and management is high on the professional agenda.

As well as these developments in policy we can also observe that the provision of forensic services has grown vastly and more and more mental health nurses are finding themselves working within these areas with no specific advanced skills to prepare them for the task. Within these services there is a heightened pressure on mental health nurses to provide formal assessments of risk and related management strategies in very stressful patient situations. Some have taken up this challenge, however, using a systemic approach, such as the ‘New to Forensic Programme’ in Scotland (http://www.forensicnetwork.scot.nhs.uk/newtoforensic.asp).

When things go wrong in mental health services, inquirers who are tasked to find answers to what occurred frequently report failings in risk assessment and management. Often these are the results of tragic consequences. The corollary of such incidents is often a shift in public and political opinion and greater expectations placed upon nurses and other healthcare professionals. A tendency towards a more litigious society also places similar pressures on nurses and other healthcare professionals to provide
accurate assessments of risk, which are often unrealistic. The result can be that clinicians will err on the side of caution and consider someone to be a higher risk than he or she actually is.

It is hoped that readers will find this book useful for their practice and take some thoughts or resources from it that can be used to enhance their current practice.

Topics covered in this book

In Chapter 2, John Cordall introduces some of the major discussion around risk assessment and management in mental health nursing. He sets forth some interesting discussion, critical debate and crucial challenges for mental health nursing. Such topics are expanded in later chapters as:

- Why assess risk?
- What constitutes effective assessment?
- The need for training.
- Mental health nursing roles.

Alyson Kettles and Phil Woods, in Chapter 3, introduce some of the theory of risk. The focus is on the wider theoretical aspects of risk assessment and management. The chapter outlines many common terminologies and defines terms clearly. This is important because much confusion surrounds the term ‘risk assessment’. Concepts of variables and how they contribute to predicting outcome are discussed, introducing some of the latest thinking in the field. The chapter introduces the concept of risk management and its relationship to the risk assessment process. It is important that these theoretical foundations are laid so they can be related in the rest of the book.

In Chapter 4, Phil Woods and Alyson Kettles highlight and discuss some of the many instruments and processes that are available to assess and manage risk. The chapter includes an analysis of the requirements for the instruments cited and appropriate situations for their use. There is discussion on the inappropriate use of instruments, both in terms of incorrect interpretation and infringement of copyright, or other publisher requirements, such as training. The chapter also focuses on the detailed research required to develop such instruments and how good risk management is based on sound risk assessment and can be informed by the use of such instruments and processes described.

Phil Woods, in Chapter 5, discusses the issue of risk to others. One particular theme that is examined in depth is evidence of links between violence and mental health. This chapter discusses some of the demographic and clinical variables that are associated with such risk and the importance
of the nurse–patient relationship in the risk assessment and management process. Forensic issues are also discussed, as many of the offending issues that those working in this area have to deal with are related to risk to others.

Through Chapter 6, Lee Murray and Eve Upshall examine risk to self and some of the strategies for assessment and management. The most obvious and catastrophic aspect of risk to self is suicide, followed by varying degrees of self-harm (some of which are life threatening). Murray’s approach to assessing and managing the risk of suicide and self-harm is a central component of the chapter. This approach, although developed in child and youth services, is equally applicable to adult services. Issues of self-neglect and vulnerability are also discussed. The chapter addresses such issues as diagnosis, developmental issues, gender, culture and the importance of the nurse–patient relationship in the risk assessment and management process.

In Chapter 7, Lois Dugmore discusses the risk of substance misuse. She unravels some of the complex issues surrounding the relationship between substance misuse and mental health. Policy issues are also identified. Early on in the chapter the effects of commonly abused drugs are discussed and the relative risk factors identified. The chapter contains a critical examination of the issues of assessment and management, care pathways, treatment options and harm reduction.

Chapter 8 is where Alyson Kettles and Phil Woods draw some conclusions, summarising the book and highlighting some key themes that it has contained. It is hoped this will help point readers towards other resources to develop their knowledge and understanding of risk assessment and management.

References


Introduction


Chapter 2
Risk Assessment and Management

John Cordall

Introduction

The concepts of risk assessment and management (which unless specifically noted will include risk taking) play a significant part in mental health nurses’ (MHNs) everyday practice (Department of Health (DH) 2006), together with that of multidisciplinary teams (MDTs) (Jones and Plowman 2005), and will continue to do so, regardless of whether it is thought they should. This is informed by suggestion that specific risks in psychiatry are broad and incorporate:

- treatment effect adversity;
- self-harm;
- dangerousness to others; and
- risks to children

(Holloway 1998).

Despite this, there needs to be a balance between the needs of individual service users (and offenders) and the protection of the public (Prins 1999). A further consideration is that having a paucity of information and/or ignorance of such is tantamount to ‘clinical gambling’, with such gambles having the capacity to precipitate catastrophes (Snowden 1997).

The suggestion is not aimed at undermining the expanding amount of evidence-based research and practice within the professional press, but there does seem to be a paucity of information, from a mental health nursing perspective particularly (Crowe 2003). Focus is aimed at the need for improved consistency in the application of risk assessment and management techniques, given their centrality in mental health practice (Mason 1998; Kemshall 1999) and the pivotal role of MHNs in the interface between the two (Doyle and Dolan 2002).
However, here lies a dilemma. Despite the importance attributed to risk assessment and management, particularly in their protection of the welfare of mental health service users, that of the public, nurses themselves and the mental health services generally (Crowe 2003), perhaps a significant ring of truth is heard in the title The 'Crystal Ball' of Risk Assessment, one of Prins' (2005a) many eloquent works. Again, without being at all provocative to individuals contributing to the expansion of risk literature per se, yet acknowledging risk assessment and management's inexact nature as a science (Doyle and Dolan 2002), or even as an art rather than a science (Prins 2002), there seems to remain much debate about the concepts involved.

Admittedly, there have been developments since some of the late 1990s' proposals associated with factors such as (to name a few):

- what needs to be understood about risk assessment (Hollin 1997);
- the clarity of this and what should be assessed (Mason 1998);
- developing nursing risk strategies (Robinson and Collins 1999);
- proposals for a way forward (O’Rourke et al. 1997); and
- the lessons learnt from Inquiry reports (Reith 1998).

However, further work is needed. Perhaps, Grounds’ (1995) suggestions that there are limits to professionals’ risk knowledge, limits to their assessment of it, and imposed limits from service structure and ethos remain valid. Though he did reflect that progress may be made in the first two, it was not necessarily so with the latter, owing to drives towards community care and the security and public protection levels afforded when individuals are detained.

No doubt, significant reminders of previous criticisms of the mental health services for their risk failures (North East Thames and South East Thames Regional Health Authorities 1994; Petch 2001; Robinson et al. 2006) may be expected (though never condoned) by some in the mental health and criminal justice professions (Prins 2005b). However, reminders appear to be something that the public may neither want to hear nor think they should hear, given their expectations that professionals should get it right every time (Petch 2001). This is despite professionals themselves knowing that they cannot (Prins 2005b), and that risk assessments are not a talismanic charm against disasters (Maden 2003). There the dilemma remains and seems likely to remain for some time.

Standardising and simplifying risk language

Accepting the notion that the concept of risk can mean different things to different people (Doyle 2000; Kettles 2004), and MHNs, together with their
MDTs, are no exception, then having a consistent knowledge and understanding of the terms is important. This appears to be the case particularly in the context of assessing the risk of violence, if there remains truth in Webster et al.’s (2004, p.25) comment:

‘At present there seems a regrettable tendency for researchers to talk one language and clinicians another. Researchers are often insensitive or unknowledgeable about clinical realities and clinicians too often are ill-informed about the results of dependable, informative research studies.’

On a similar wavelength, Prins (2005b) proposed that a gradual change in language occurred well over 20 years ago, with the terms ‘danger and dangerousness’ being substituted by the notion of ‘risk’. Regardless of the terminology used, individual professionals today are likely to recall where these terms have been used interchangeably, with a seeming innate understanding of what is (or in some instances is not) being referred to within the context of clinical discussions. However, does this simply add more misunderstanding to what seems, in this context, to be an already confused area of MHNs’ professional practice?

Snowden (1997) suggests that ‘risk’ is a more attractive term than ‘dangerousness’, thus enabling objectivity and greater analytical robustness to focused questions aimed at identifying what the risks are, their severity and frequency, along with who may be at risk.

The Royal Society’s (1992) use of risk terminology (cited in Prins 2005b, p.97) offers what could be interpreted as a useful framework for MHNs to work within, thereby achieving better consistency, and ultimately understanding, of respective risk issues.

- **Risk** – the probability of a particular adverse event occurring within a stated time period, or resulting from a particular hazard.
- **Risk assessment** – the study of decisions subject to uncertain circumstances, which was split into two components, risk estimation and risk evaluation.
- **Risk management** – decision making and implementation around risks, emerging from risk estimation and risk evaluation.

Without doubt, Prins (2005b, p.97) provides a most thought-provoking statement when he articulates the Royal Society’s (1992) acknowledgement of the Health and Safety Executive’s (1988) quote on ‘tolerable risk’:

‘Tolerability does not mean “acceptability”. It refers to the willingness to live with risk to secure certain benefits and in the confidence that it is being properly controlled. To tolerate a risk means that we do not regard it as negligible or
something that we might ignore, but rather as something we need to keep under review and reduce still further if and as we can.’

The author feels that this epitomises what MHNs should use to improve clarity in their vital roles in respect of risk assessment and management, but just as important is for them to all use a similar language. This must also include an overt recognition of and wider broadcasting of evidence that validates their risk roles, but more importantly also openly informs the wider profession, their services and trusts and the public that working with service users’ risks does have potential for things to go wrong. This may minimise some of the misperceptions about risks that were evident previously (Petch 2001), though it must be acknowledged that whether or not MHNs do this as well as they possibly can, it is likely that both risk assessment and management will continue to pose difficult questions, as highlighted by Mason (1998).

**Why assess risks?**

Based on the explicit statement by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (1998) to mental health and learning disability nurses, the risk management process is an integral part of their roles; it enables optimum care levels, values risk taking and attempts to reduce risks, though it is rarely possible to eliminate them. Clarity is contained in one UKCC paragraph!

Perhaps regarded by some (Grounds 1995; Cooke 2007) as a seminal work, Scott (1977) seems to have precipitated the continuing debate about what is now viewed as risk, with his proposals on the concept of dangerousness. Acknowledging that the discussion continues on the differences between dangerousness and risk per se (for example, Mason 1998; Prins 2005a), and that it should continue (though not in this chapter), one can draw a comparison with some of Scott’s 30-year-old views on dangerousness and substitute the word ‘risk’:

‘It (dangerousness) is difficult to define, yet important decisions are based on it; . . . it is a term that raises anxiety and which is therefore peculiarly open to abuse, especially to over-response of a punitive, restrictive or dissociative nature. . . . The label, which is easy to attach but difficult to remove, may contribute to its own continuance. . . .’ (Scott 1977, p.127)

This could quite easily be affiliated to the premise of risk in today’s professional world.
Duggan (1997) suggested that the assessment of dangerousness had been replaced by the assessment (and management) of risk, implying that the two are inextricably linked and inseparable, similar to the view of Kennedy (2001). The latter claimed that risk assessment is improvable on the basis that it informs appropriate risk management and ultimately mental health services overall, whilst Reed (1997) saw risk assessment not as a stand-alone initiative, but linked to a risk management plan, inclusive of review procedures.

Grounds (1995) had a much simpler perspective on clinical (risk) assessment, purporting it to be about making defensible decisions about dangerous behaviour, not primarily about prediction. West (2001), with regard to sex offender risk assessment, concluded that clinicians had little choice but to make decisions around dangerousness prediction and determining risk, given government, institute and public pressure.

However, risk assessment and management remains a central feature to meet service user needs and is thus a vital component in the Care Programme Approach (CPA) process (National Institute for Mental Health in England (NIMHE), 2004a) and, as such, falls into a healthcare trust’s clinical governance arrangements (DH 1999a) as part of its continuous improvements in the quality and standards of care and treatment delivery.

The idea of formal risk assessment of people who have mental disorders is discussed in Taylor’s (2001) Expert Paper: Mental Illness and Serious Harm to Others. In this (p.14), she highlights that an assessment process should include:

- risk of harm to others;
- risk to self;
- risk from others to patients (exploitation; for serious offenders – media exploitation and/or revenge attacks);
- risk of treatment non-compliance or abscondion;
- risk of substance misuse.

By contrast, Mason (1998) suggests that risk assessment in mental health practice has three main foci – violence risk, dangerousness and recidivism risk – though he perceived that there was a lack of concordance and strong confusion in the literature about what was being assessed and an interchanging of the terms’ uses.

Comparatively, Lipsedge (2001) highlights that the greatest current concern for mental health services’ risk management (and therefore risk assessment) is suicide and violence, but adds that most of the violence in communities is not committed by psychiatric patients, nor do those diagnosed with psychiatric conditions commit serious violent acts.
Kennedy (2001) proclaims that it is the mental health services’ effectiveness as a risk management process for overall patient populations that really matters. Importance is attributed to the many national drivers that have recommended the need to reduce and manage respective risks. These include:

- **The National Suicide Prevention Strategy** (DH 2002b).
- **Mainstreaming Gender and Women’s Mental Health** (DH 2003).
- **Mental Health Policy Implementation Guideline. Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings** (National Institute for Mental Health in England 2004a).

From a simple perspective, risk assessment may be aimed at achieving some balance in the responsibilities of service users, society, mental health services and healthcare professionals (Moore 1996), but at its heart must be the needs of service users, whether it be in terms of planning their future with them, maintaining their presence within their respective communities, projecting future treatment needs, or evaluating the necessity of continued detention for those who require it, amongst others. Regardless, Holloway (1998) acknowledges that the process requires attention to detail, which can be difficult within busy practice areas. However, he succinctly stresses this importance by proposing two clinically consistent themes emerging in Inquiry literature – failures in (1) understanding experiences and the social context of patients’ inner worlds, along with (2) communicating associated information, particularly about dangerous behaviours, to key people. This sends out a powerful message, but should also act as a key factor in prompting and encouraging MDTs to improve their risk assessment and management skills through incorporating lessons learnt from such Inquiries (Reith 1998). Furthermore, when risk is not perceived as being managed, the likelihood of subsequent Inquiry is increased, with loss of trust in the healthcare professional to fulfil his or her role, making protest futile until improved risk management occurs (Maden 2005).

Contrastingly, Cooke (2007) claimed the following to be important in validated risk assessment:

- protection of the public;
- protection of staff and other patients/prisoners;
- equitable treatment of patients/prisoners;
- cost of holding individuals at too high a security level;
- targeting treatment resources where most needed.
Although these may have clarity and affinity for many, Bingley (1997) suggests that risk assessment also has accompanying moral and ethical challenges, together with potential costs for service users, their families, supporters and society. Regardless, he proposes that it must be afforded the highest priority, particularly for the competence of the assessment, along with subsequent management derived from its findings.

Szmukler (2003) seems to offer some support for Bingley’s position in his discussion of the ‘values’ of risk assessment and management, together with their potential costs and benefits to society and particular social groups.

The idea of potential service user costs should not be underestimated. Robert (2006) offers personal experiences as a basis for highlighting the need for greater collaborative assessment and management of risk between MDTs and service users, which incorporates more empowerment, thus enabling potential negative conscious or unconscious influences, including stigma and fear of service users, to be minimised. Involving service users more, and thereby developing new systems of risk, will contribute to payoffs in public protection and service user care (Hollin 1997).

Crowe (2003) also alludes to some challenges in her thoughtful article on deconstructing mental health nursing risk assessment and management, concluding that the profession should examine its role in regard to those posing risks to others, thereby ensuring that practices correspond with responsibilities.

Although sad to say, and despite cognisance of the UKCC’s (1998) position on defensible clinical practice, a further reason for risk assessment is seemingly the more commonplace questions regarding the availability, completion of and efficacy associated with risk assessments ‘when things go wrong’. As if validating this, Prins (2005b) proposes that MDTs have to work within a blame culture, whereas Mullen (2002, p.296) makes an even starker statement:

‘When tragedies occur, be they death or injury to the patient or inflicted by the patient, the question is now almost certain to be raised about whether adequate risk assessment procedures were in place to prevent, or minimise, such an untoward outcome. The question may be raised by administrators eager to place any blame that is going on the clinicians, by coroners seeking to apportion contribution to the death, by enquiries deciding who to pillory, and most egregious of all, by colleagues prepared to self-righteously point the finger of blame.’

This is not to suggest that there should be a blame-free culture, as society itself is far from that (Alaszewski 1998), nor that the impact of a tragedy should be minimised (Reed 1997), but rather that we should strive for a just culture. This goes back to educating the public that professionals cannot get it right every time, as risk assessment remains a ‘risky business’
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(Prins 2002), prediction is not possible (Potts 1995) and risk assessments are fallible (Munro and Rumgay 2000). Yet, pro-rata, the thousands of risk decisions that are made in everyday mental health practice which go right are seemingly outweighed by those that go wrong. This is despite the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (DH 1999b) which highlights findings that within its sample of mental health service users who committed suicide, an individual’s immediate risk of suicide was estimated as low or absent in 85% of cases at their last service contact. This is not to detract from the recognised failures the Inquiry articulated, but serves simply to flag up some of the hardships that professionals face. This needs to be uppermost in MDT thinking, along with the many other associated variables linked to practice. Perhaps Kemshall (1999, p.33) offers a balanced view of professionals’ roles by claiming:

‘Practitioners have an obligation to act responsibly and defensibly on risk, but not guarantee its prevention’.

What constitutes effective risk assessment?

Is this an unanswerable question? If Petch (2001) is correct in proposing the stark reality that regardless of how good risk assessment tools are, either clinical or actuarial, professionals will not significantly impact on public safety unless mental health services generally improve, then yes, it is possibly an unanswerable question. Munro and Rumgay (2000) seem to offer a similar perspective, drawing on their examination of findings from public inquiries into homicides by people with mental illness. Their conclusion concludes that improved risk assessment has only a limited role in reducing homicides, with overall mental healthcare improvements suggestive as being the most effective preventative strategy therein.

Despite this initial discussion, the starting point for effective risk assessment and management has to be full service user and carer/family involvement. In keeping with DH (1999a) policy regarding qualitative healthcare, services are currently charged, as part of their overall clinical governance role (Secker-Walker and Donaldson 2001), with providing contemporary evidence-based risk assessments that direct care and treatment and reduce risks (Doyle 2000). Any such individual assessment must be facilitated by an awareness of the relevant research knowledge (Grounds 1995). At a basic level, clinicians who identify risks have a responsibility to act so that risks are reduced and effectively managed (Reed 1997). This is what service users want (Manthorpe and Alaszewski 2000; Robert 2006).
However, Higgins et al. (2005) found high variability in practice within general adult psychiatry amongst randomly selected trusts across England when reviewing risk assessments in use to manage harm to others. This included both a lack of consensus concerning suitable methods of risk assessment and variance in training availability. Kettles et al.’s (2003) review of risk assessment in UK forensic psychiatric units recommended a need for more consistent approaches using both reliable and valid up-to-date tools, on a multidisciplinary basis, which in turn could aid care continuity and individual care pathways. Shortfalls in consistency, reliability and validity in locally designed processes were also emergent findings in MacCall’s (2003) forensic risk assessment review of healthcare in Australia and New Zealand, from which he declared a necessity for more robust research to improve efficacy. Similar themes are integral to recent UK national guidelines (DH 2007) for best practice in risk management, which propose that up-to-date evidence bases be embedded in everyday risk management, so that assessment of users’ recovery, structured risk assessment, collaborative MDT working and positive risk management become commonplace in mental health services.

Potts (1995) revealed what are perceived as factors found in good risk assessments from a Home Office perspective. These include:

- quality and range of information;
- completeness and objectivity of analysis;
- concrete evidence of progress;
- realistic forward planning.

(See Potts’ chapter for a wider expansion of criteria.)

O’Rourke et al. (1997) went further with their proposed Risk Assessment Management and Audit System (RAMAS) as a model to help clinicians in their roles in individual care and public safety. RAMAS measures dangerousness, mental instability, self-harm and vulnerability on an MDT basis involving service users. It is aimed at informing risk management strategies and facilitating both structure and support to decision making.

The DH (1995) also articulates that the key principle of risk assessment is to use all available resources of information; otherwise a proper assessment cannot be made. Admittedly, this can be an arduous but nonetheless essential practice, yet as Grounds (1995) claims, thorough risk assessments are resource dependent, particularly taking into account the realities of service pressures. Does this mean that services are likely to be swamped by the ever-competing demands for precious time, which is more noticeable in its absence than its availability amongst MHNs and MDTs? The author suggests that this may be so.