Components of good practice in assessing & managing risk

The Complex Process of Assessing Risk

- Assessing risk starts at the first point of contact (referral, telephone call or face-to-face contact), and it continues as a dynamic on-going process, not a one-off event
- From the point of initial contact consider how to engage the service user (and carers where appropriate) in full collaborative discussion of what risk means to them, and what their experiences of risk are:
  - Consider use of language (e.g. talking about safety may be more engaging for many than talking about risk)
  - The importance of enabling people to tell their story
  - Create opportunities for both service users & carers to speak independently and freely
  - Develop a narrative or pictorial account in order to capture detail (even though you may only be documenting succinct bullet points to summarise the detail)
- Assessment made in a one-off interview can only be risk screening, not a full assessment… assessing risks accurately and comprehensively requires trust and takes time, and it is only part of a wider assessment
- Accessing information from many sources:
  - You can only work with the information you have available to you, so record the sources of information on which you are basing your assessment and subsequent judgements
  - Adopt caution about accepting its accuracy until you can corroborate it
- Risk history is about the chronology of events, the accurate detail and individual context in which the risks occurred (it is not a simple numerical representation of incidents):
  - Significant *behaviours*, *cognitions* and *personality* factors from taking a detailed history of mental state
  - The important information is what is going on for the person in their life now
  - Historical information is only relevant where the patterns and context of the past are re-emerging now
  - We must see the person not just the risk
- Balancing an appreciation of risk factors (research based) and protective factors (individual to the person):
  - Risk factors are indicators of what could go wrong, elevating the Risk [see Appendix 4: Risk Categories & Factors]
  - Protective factors are those that can reduce or mitigate the likelihood of the risk happening (e.g. a person's own learning about their condition, social supports, personal safety nets, etc.)
- When estimating likelihood give consideration to:

- The degree of *intent* (a statement from an individual that they *intend to harm* another person is the clearest indication of risk and should never be ignored **(**N.B. intent, whether implied or not, is the strongest and most powerful predictor of future behaviour)
- The level of *planning* (is the person thinking about *how* they intend harm; the existence of a plan elevates the likelihood)
- The *access to means* stated in the plan
- The recency with which risks have occurred
- The severity of the risk (impact it could have if it occurred)
- The immediacy/ frequency of its occurrence (or re-occurrence)
- The identification of patterns of risk behaviours
- Timing can be about different times of the day or different days that may elevate or reduce risks

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

• Use of personal/professional skills:
- Abilities and experience of working with risk (N.B. this is not just a quality associated with specific professional grades)
- Expertise developed through training, confidence and high quality support and supervision
- An appreciation of individual staff member's strengths and talents
- Engagement, respect, genuinely person-centred communication
- Asking difficult questions, and dealing with difficult answers… not asking the question doesn't mean the issue goes away

• Observational & listening skills (inc. hearing what people are saying, not what you think they said):
- Awareness of the influence of personal/professional values and principles, including where they may include prejudices
- Appropriate levels of curiosity and proactive in seeking clarity
- Awareness of issues of equality, and how it can be compromised by assumptions around risk
- Awareness of statutory responsibilities (e.g. safeguarding & child protection)
- When to ask for a specialist assessment (e.g. forensic assessment; cognitive assessments; falls risk assessment)

• Environmental risks:
- Physical layout of the home, office, ward (e.g. positioning of furniture, clear exit routes, presence of likely weapons)
- Effects of emotional arousal (e.g. long waiting times, lack of

information, temperature extremes, overcrowding, service needs taking a priority over service user needs)
    - The wider community (e.g. threats from others, visiting out of normal hours, remote locations, locations with known reputations, signs of carrying medication)
- Responsibility for documenting and sharing risk assessment information:
    - Succinct and clearly structured
    - Inclusion of clearly attributed statements of service user/carers views (i.e. easily distinct in notes from service Provider's accounts)
    - Sharing information needs to be within bounds of confidentiality, but understood from a basis that sharing leads to better judgements (as opposed to the idea that not sharing means we can't be criticized)
- Awareness that systems risks are also a part of what we should be assessing (e.g. how the complexities of systems, structures and procedures may occasionally impose a rigidity that can cause frustration and elevate risk):
    - Inter-agency communication and coordination
    - Inter-agency arrangements on confidentiality
    - Caseload sizes and priorities
    - Professionally relevant operational policies and procedures
    - Links with primary care, housing and voluntary sectors, etc.

Components of good practice in managing risk

How we manage risks can be broadly thought of as a timeline around an event:

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

Influences on Risk Management

- A strengths approach, depending on the level of knowledge about the person, will offer key information about the positive resources that can be used when working with risk through a carefully constructed risk management plan/response, ideally developed with the person

- A primary focus should always be on safety, as well as the goals of promoting independence and autonomy for the individual service user
- Confidence to challenge specific behaviours through respectful and open discussion
- Service users have rights, including the right to make unwise decisions (c.f. Mental Capacity Act, 2005), but with those rights service users also have clearly negotiated personal responsibilities, which also challenges some service providers to drop the need to rescue people
- Being very clear what the aims are that the services and service user/carer are working towards… a general aim of *managing risks* is meaningless and unhelpful to all involved
- Knowing you can be wrong! You can only work with the information available to you (and your reflection/clinical judgement skills)
- Being aware of own limitations… being able to say I am out of my depth (i.e. the culture of the team is crucial to enabling this, and authority issues will have a significant influence on how supported and able individual's feel to be honest)
- Changing risk decisions, actions and plans in response to the dynamic changing nature of risks:
    - Clear crisis & contingency plans in response to anticipated relapses
    - Communicating changes openly with all who need to know
- A balanced view of risk prevention and risk reduction, and how we may need to urgently switch between these modes of response
- Being aware of when to intervene, and importantly when not to intervene
- A team culture of reflective practice, learning, peer support, recognition of different tolerances of risk through different experiences, sharing different opinions on how a risk should be managed (e.g. different opinions held in response to a person with a learning disability using self-harming behaviour)
- Good use of the multidisciplinary/multi-agency systems within services for communicating information and arriving at collective reasoned risk decisions
- Guidelines that explain how staff will be backed-up and supported, particularly when something goes wrong (i.e. good risk management rarely emerges from practitioners who are more focused on the fear of things going wrong, and what the consequences will be even though they are trying to do their best).