

The assessment of clinical risk in mental health services

Please cite this report as:

The assessment of clinical risk in mental health services. National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Manchester: University of Manchester, 2018.

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The Healthcare Quality Improvement Partnership (HQIP) is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. HQIP's aim is to promote quality improvement, and it hosts the contract to manage and develop the Clinical Outcome Review Programmes, one of which is the Mental Health Clinical Outcome Review Programme, funded by NHS England, NHS Wales, the Health and Social Care Division of the Scottish Government, the Northern Ireland Department of Health, and the States of Jersey and Guernsey. The programmes, which encompass confidential enquiries, are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data. More details can be found at: www.hqip.org.uk/clinical-outcome-review-programmes/

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The interpretation and conclusions contained in this report are those of the authors alone.

Background

Suicide accounts for an estimated 1.4% of all deaths worldwide¹. In the UK, approximately 6,000 people die by suicide per year, although suicide rates are falling².

Many people who die by suicide are patients with mental illness and over a quarter are in touch with specialist services. In 2015, there were 1,538 deaths by suicide in individuals who had been in contact with mental health services in the previous 12 months³. Many had factors associated with high risk of suicide (e.g. self-harm, substance misuse, economic problems) but the majority (88%) were judged to be at low or no immediate risk of suicide by clinicians at their final service contact³.

What is risk assessment?

The assessment of clinical risk in mental healthcare is challenging but provides an opportunity to engage with patients, and their carers and families in order to promote the patients' safety, recovery and wellbeing⁴. A good risk assessment will combine consideration of psychological (e.g. current mental health) and social factors (e.g. relationship problems, employment status) as part of a comprehensive review of the patient⁵ to capture their care needs and assess their risk of harm to themselves or other people.

The Department of Health's Best Practice in Managing Risk⁶ defines risk as relating to the likelihood, imminence and severity of a negative event occurring (i.e. violence, self-harm, self-neglect). In mental health services risk assessment has traditionally focused on prediction⁷⁻⁸. Patients may be categorised into low, medium or high risk of a particular outcome. Checklists of characteristics or risk scales are sometimes used to estimate the likelihood of harm occurring. However, research suggests that categorising risk in such a way is unhelpful in guiding the treatment and management of a patient⁹, and has poor predictive value¹⁰⁻¹³. Our previous research has shown that despite common risk factors, risk is often individual and suggests risk management should be personalised¹⁴⁻¹⁵.

What do guidelines recommend?

National Institute for Health and Care Excellence (NICE) guidelines on the long-term management of self-harm state that risk assessment tools and scales should not be used to predict future suicide or repetition of self-harm, or to determine who should or should not be offered treatment. Rather, they might be used as prompts or measures of change¹⁶. A study by Quinlivan and colleagues¹² has shown that the predictive ability of risk scales varied widely. A later review, which aimed to combine the results of different studies, suggested the

pooled positive predictive value for suicide was 5%: for every 100 people rated at high risk, five would go on to die by suicide¹⁷. More importantly, risk scales would miss suicide deaths in the large 'low risk' group¹⁷.

NICE guidance also recommends risk assessment should take place as part of a comprehensive assessment of the patient's needs, taking into account previous suicidal behaviour, psychological and social factors, coexisting adversity (e.g. substance misuse), and access to medications¹⁶.

Examining the quality of risk assessment

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) has previously examined the quality of clinical risk assessment and management prior to suicide and has found evidence of a 'low risk paradox'. Specifically we found the immediate risk of suicide at the final service contact was judged by clinicians to be low or not present for the majority of patients who died by suicide³. Furthermore, the overall quality of risk assessment and management was considered by clinical raters to be unsatisfactory in 36% of cases¹⁵.

Despite risk assessment being a central component of current practice in mental health, there has been no recent national study

of the use of risk assessment tools across mental health services. There is also very little information on the views of clinicians, patients and carers about how helpful these tools are.

AIMS OF THE STUDY

The overall aim of the study was to examine different perspectives on the use of clinical risk assessment tools and to identify any areas for improvement. Specifically we wanted to:

- Determine which risk assessment tools are currently being used in mental health services.
- Explore the views of clinicians, patients and carers on their experience of risk assessment tools and how their use might be improved.
- Identify how these tools are being used prior to suicide, especially in people rated as at low or no risk of suicide at their final contact with a mental health professional.

METHOD

Study design and data sources

The study used a mixed-methods design combining quantitative and qualitative data collection methods and analysis. There were three components to data collection, as described below.

1. Survey of tools used in mental health services

We identified all mental health trusts and health boards (referred to as services in the remainder of the report) in the United Kingdom: England (59), Scotland (14), Wales (7) and Northern Ireland (5), and contacted each medical director (or other nominated individual) requesting details of the main risk assessment tools currently used in their service. We also requested any supporting guidance, policies and training provided to staff within each organisation.

All 85 organisations providing specialist mental health services in the UK responded and provided details of the main risk assessment tools in use. In total, we received 156 tools – 85 were used service-wide, 71 were adapted for use with specific patient groups (i.e. old age, child and adolescent). In addition 49 guidance/policies and 10 training packs were obtained. For clarity and to avoid double-counting, we restricted our analysis to the main

service-wide tools (n=85). Two-step screening processes were considered as one tool for the purposes of the analysis.

Information on the tools was recorded via a data extraction pro forma onto a standardised database for aggregate analysis. Data were collected on the tool's structure (layout, number of pages), content (the categorisation of risk, options to record text, tick boxes), and symptom profile (demographic, social and psychological factors).

2. Online survey

An online survey was launched on 7th September 2017 and closed on 6th March 2018. We wanted to understand the assessment of clinical risk in mental health services from different perspectives. The survey was used to record clinicians', patients' and carers' experiences of risk and safety assessment. Their views on the use of risk assessment tools and how they might be improved to benefit overall patient safety were also recorded.

Clinicians, patients and carers were directed to different sections of the online survey (see below).

Responses to the survey were provided anonymously to encourage candid answers.

The survey was advertised via the NCISH website, Facebook and Twitter.

Clinicians

Clinicians were asked:

- About the details of risk assessment tools they used within their service.
- If the tools had been validated.
- Whether they had received any training in their use.
- What they viewed as essential elements of a risk assessment.
- How the tools were used in a clinical setting (i.e. checklist, narrative/text, to inform management).

Patients and carers

Patients and carers were asked about whether safety and treatment needs had been discussed at meetings and how involved they felt in the planning and management of identified risks.

For patients, we wanted to know whether they:

- Felt listened to and understood when they were assessed.
- Were aware of any tools or checklists being used to plan or discuss their safety.
- Felt supported in keeping safe when feeling vulnerable.
- Understood and were involved in the risk assessment process.

3. Interviews with clinicians

Clinicians were randomly selected from the NCISH database to be interviewed about their

experience of assessing risk and safety. The NCISH database is a national consecutive case series of all patients who die by suicide within a year of contact with specialist mental health services. Clinical data are collected via a questionnaire sent to the clinician responsible for the care of the patient prior to their death. A full description of the NCISH method of data collection is provided on our website and in previous national reports³. From the NCISH database, a sample of patient suicides meeting the following inclusion criteria was selected:

- died by suicide in 2015 (the most recent complete year of NCISH data);
- viewed as being at low or no immediate risk of suicide at their last service contact;
- the last contact was within the three months prior to their death (to minimise recall bias).

We selected this 'low risk' sample to better understand the low risk paradox, that immediate suicide risk was judged by clinicians as low or not present in the majority of patients who died by suicide. These were the cases in which opportunities for improvement might be most readily identified.

There were 636 patient suicide deaths that met the inclusion criteria. A total of 136 clinicians who were responsible for the care of these patients prior to their death were randomly selected across three rounds of sampling for

potential interview. Oversampling was employed to take into account clinicians who no longer worked for the service or who felt unable to participate for other reasons, e.g. time limitations. The goal was to identify and interview a minimum of 20 clinicians. In total, 22 clinicians were interviewed. After 22 interviews, no new information was being obtained (data saturation had been reached). The clinicians were invited to participate in a semi structured telephone interview. The interviews aimed to establish whether a clinical risk assessment tool had been used and, if so, how, and to collect general views and experiences on risk assessment tools and scales. The participants included consultant psychiatrists, and a variety of other professions including mental health nurses, social workers, clinical risk managers, and psychologists. All four UK nations were represented.

Statistical analysis

Information obtained on risk assessment tools, guidance and training packs are presented as numbers and percentages. The denominator in all estimates is the number of valid cases. All proportions are provided as valid percentages. If an item of information was not known for a case (i.e. data were missing) the case was removed from the analysis of that item. Information was extracted from the main tool

used across services in an organisation (n=85). We did not receive supporting guidance, policies and training provided to staff from all services and it was unclear for tools provided without guidance, whether guidance was available but had been omitted. Data on items included in guidance were therefore incomplete and not considered robust enough for inclusion in the analysis. Data were analysed using Stata 15¹⁸.

Qualitative analysis

Thematic analysis was used to examine the responses from the online survey and the interviews. Key themes were identified from clinicians', patients' and carers' responses to the survey and we explored whether these differed between the 3 groups.

Themes were identified by one researcher (JG) and validated by another member of the research team (IH). Where there were uncertainties or disagreements about common themes, agreement was reached following discussion. NVivo software was used to manage, organise and analyse the data¹⁹.

Office for National Statistics (ONS) guidance on disclosure control was followed to protect confidentiality within death statistics, and cell counts under 3, including zero, have therefore been suppressed. This rule applies to all data in this report.

Definitions

Suicides were defined as deaths that received a conclusion of suicide or undetermined (open) at coroner's inquest, as is conventional in suicide research²⁰. See the appendix for a full list of the International Classification of Diseases, Tenth Revision (ICD-10)²¹ cause of death codes included in the study (pages 23-24).

Further definitions are also provided in the appendix.

Ethical approval

Approvals were received from the University of Manchester Research Governance and Ethics; National Research Ethics Service (NRES) Committee North West (26/06/2017); Health Research Authority Confidential Advisory Group (HRA-CAG) (06/09/2017); Public Benefit and Privacy Panel for Health and Social Care (PBPP) (06/09/2017); and Research Management and Governance approvals from individual NHS Trusts and Health Boards in Wales, Scotland and Northern Ireland. Local capability and capacity review was not required for participating NHS organisations in England.

RESULTS

1. Risk tools used in mental health services

All 85 NHS mental health organisations in the UK gave details of the main clinical risk assessment tools used in their service. In five services staff had the option to use risk scales (i.e. SADpersons, PATHOS, Beck hopelessness scale and the Columbia suicide severity rating scale (C-SSRS)) in conjunction with the main tool.

The assessments were all either formulation based tools with minimal prompts (promoting clinical judgement, see the appendix (pages 23-24) for a definition) (13, 15%) or multiple tick boxes in a checklist style (72, 85%). Although the use of tick boxes was comparatively common, all of the 85 tools examined also included the option for clinicians to record identified risks with a narrative. The majority (60, 70%) of tools were locally developed to a greater or lesser extent, with some devised

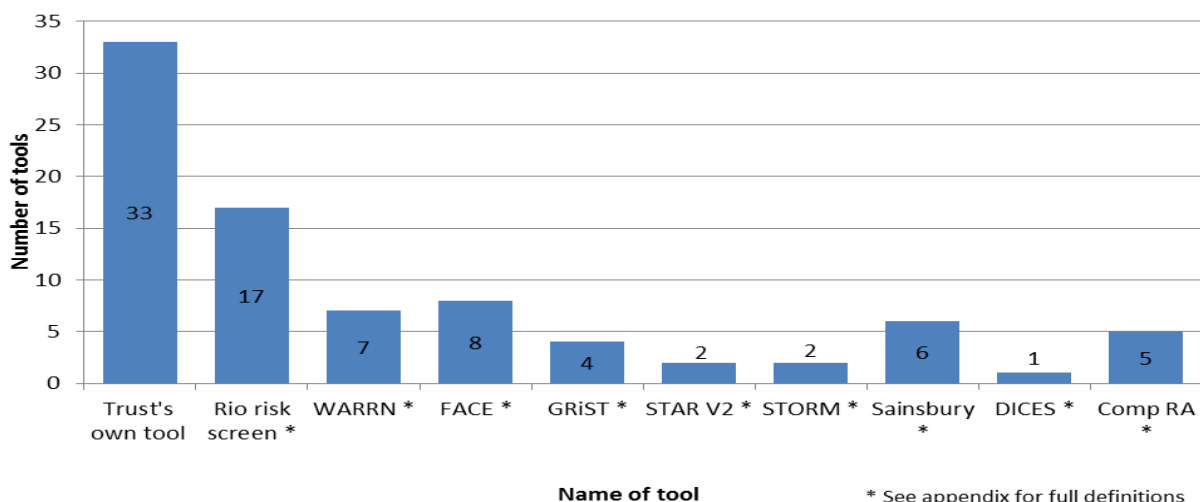
within an individual organisation (33, 39%; Figure 1), and others which were local adaptations of a recognised tool (27, 31%).

As shown in Figure 1, 17 (20%) services used a built-in risk summary embedded within the electronic patient record system Rio. All seven Local Health Boards in Wales used the Wales Applied Risk Research Network (WARRN), a tool developed by the National Leadership and Innovation Agency for Healthcare in Wales (now the NHS Wales Shared Services Partnership). All five Trusts in Northern Ireland used a two-step process, initially completing a 'standardised risk screening tool' for all patients, prior to applying a 'comprehensive clinical risk assessment and management tool' where required²². Screening tools were also used in seven (8%) other UK services.

How do mental health services use tools?

The key features of risk assessment tools used in mental health services are shown in Table 1. Forty-nine (58%) tools were accompanied by

Figure1: Types of tools used by mental health services in the UK



supporting guidance, ranging from a single page 'aide memoir', used by 23 (27%) services, to a 102 page policy. In 29 (34%) services the 'five Ps model' (facilitating the understanding of a case, its context and the way in which factors interact)²³ was used to underpin risk assessment formulation (see the appendix (pages 23-24) for a definition).

Table 1: Key features of risk assessment tools used in mental health services

	Number (%)
Tool feature	
Median number of pages in the tool (range)	5 (1-20)
Median number of pages in the guidance (range)	11 (1-102)
Treatment thresholds for different levels of risk	75 (89%)
Developed locally	60 (71%)
Score/outcome determines management	80 (94%)
Predictive instrument	81 (95%)
Categorisation system used:	
High/medium/low	48 (56%)
Red/amber/green	6 (7%)
Numeric (1-10)	13 (15%)

Most tools encouraged staff to make predictions of future behaviours, and over half asked clinicians to stratify risk, for example, into high, medium, and low risk categories. Overall, 80 (94%) tools used this risk

categorisation to inform care.

Content of tools

Table 2: Demographic, social and clinical items included in risk assessment tools

	Number (%)
Feature	
Family history of suicide	54 (64%)
Recent and lifetime contact with mental health services	52 (61%)
History of abuse	53 (62%)
Current victim of abuse	26 (31%)
Physical illness	57 (67%)
Living alone	34 (40%)
Homelessness	36 (42%)
Employment status	40 (47%)
Recent life events	39 (46%)
Domestic problems	31 (36%)
Stress tolerance*	24 (28%)
Psychosocial stressor	26 (31%)
Family social network	47 (55%)
Substance misuse	
lifetime use	76 (90%)
recent use	60 (71%)
Protective factors	52 (61%)

*Note: see the appendix (pages 23-24) for a definition

Tables 2 and 3 show items related to demographic and psychosocial characteristics, and suicide-related thoughts and behaviours included in risk assessment tools, respectively.

Collection of these data in the tools varied from a sequence of tick boxes, general prompts in a text box, to an unstructured narrative.

Table 3: Items related to suicidal thoughts and behaviour included in tools

	Number (%)
Self-harm	75 (88%)
Suicidal ideation	56 (66%)
Suicidal intent	40 (47%)
Suicide plan	49 (58%)
Concealed suicidality	14 (16%)
Past suicide attempt	56 (66%)
Precipitating event	35 (41%)
Access to means	27 (32%)
Intolerable distress	22 (26%)

Areas of risk

All of the 85 main service-wide tools examined were designed to document key areas of risk, as shown in Box 1.

Fifty-three (62%) tools included sections encouraging the clinician to incorporate input

from the patient and/or their carer(s) or family, but only 16 (19%) mentioned consultation with the GP.

Safety planning and changing risk

Ten (12%) organisations had introduced safety planning (see the appendix (pages 23-24) for a definition) into the risk assessment process.

One organisation had developed a safety plan app for smart phones and other devices.

Seventy-six (89%) of the tools reviewed encouraged clinicians to reflect on the fluidity of risk by prompting them to consider the types of risk factors shown in Box 2.

Box 2: Types of suicide risk factors considered in risk assessment tools

Dynamic

Factors are present at some point but may fluctuate in duration and intensity, e.g. hopelessness, substance misuse.

Stable

Factors do not change, e.g. personal factors, current diagnosis.

Static

Long-term factors likely to endure for many years, or that do not change, e.g. demographic factors, history of self-harm.

Future

Factors that can be anticipated and may result from changing circumstances, e.g. future stress, access to means.

Box 1: Key assessments of risk within tools

- Risk to self
- Risk to others
- Risks from others/exploitation/vulnerability
- Self-neglect
- Social circumstances/personal factors
- Substance misuse (including alcohol and drugs)
- Safeguarding child and adult

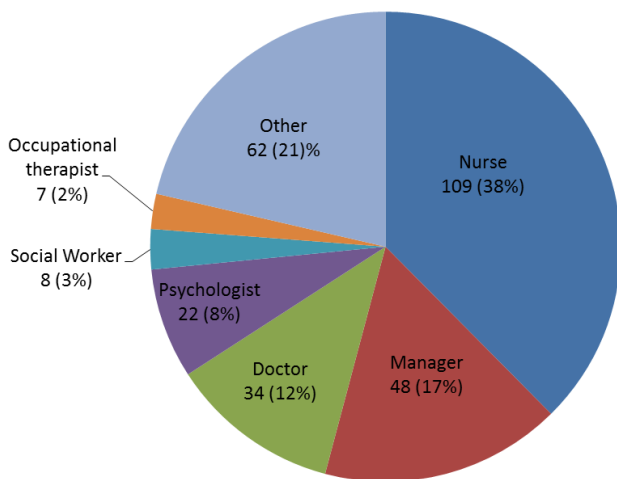
2. Online survey

a. Clinicians views

290 clinicians participated in the survey; mostly nurses (109, 38%; Figure 2). 262 (90%) clinicians reported using a risk assessment tool in their service, 47 (37%) used more than one.

82 (71%) clinicians said they had received training in the use of the risk assessment tool(s), and 51 (42%) reported that the tool they were using had been validated.

Figure 2: Number of clinicians who responded to the survey



Analysis of the survey text responses revealed a number of themes about the current use of tools, and suggestions for improvement.

Use of the tools:

Documenting risk

From the text responses, clinicians reported using risk assessment tools as a means of documenting clinical information and communicating it within and between services.

Tools were often also used as a platform to detail past and present patient needs to inform management plans. Many clinicians felt the tools were an adjunct to their clinical judgment, i.e. useful as an 'aide memoir' to prompt consideration of a patient's wider social factors. They stated that the tool was not used as a script to replace candid conversation; instead the tool should be used in conjunction with other sources of information.

Predictive ability

Around a third of nurses (15, 32%) and managers (11, 38%), and none of the doctors, thought tools had predictive value, compared to around two thirds of psychologists (20, 70%).

"I believe risk assessments assist information gathering but are not 'predictive'". [Nurse]

Essential functions of risk assessment

We asked clinicians what they thought were the essential functions of a risk assessment. Box 3 shows the common responses.

"Risk assessment tools are only as effective as the individual carrying them out. They can create a false sense of safety." [Doctor]

Box 3: Clinicians' views on the essential elements of a risk assessment tool

- To enable candid conversations allowing the development of a trusting relationship.
- To explore identified risks to help inform a management plan to reduce distress.
- To explore current distress and personal triggers of risk through knowledge of historical factors.
- To review and consider diagnosis, psychological incidents and social factors.
- To support the patient's recovery.
- To allow collaboration with patients and their family/carers for ongoing safety management.
- To help keep assessments relevant with up-to-date information.

Challenges with tools and suggestions for improvement

Several recurring themes were identified that were relatively critical of risk assessment tools. These are summarised in Box 4.

The main suggestions for improvements to risk assessment tools were to make them easier to complete and for better training for staff in what (and how) information should be recorded. Box 5 shows the suggested key areas for improvements.

Box 4: Clinicians' views on challenges with risk assessment tools

- Compared to full clinical case records, it is not easy to find relevant information.
- Tools can be lengthy and time consuming to complete.
- Tables and tick boxes are not always read by staff.
- Information may not always be accessible if updated incorrectly.
- Difficult to input information and track back, leading to details being lost.
- The use of tools may prevent staff from using experience and clinical judgement and provide false reassurance.

Box 5: Clinicians' views on improving risk assessment tools

- Improve consistency, make tools shorter, clearer and easier to complete.
- Make tools accessible to patients and carers, with explanations of specialist vocabulary.
- Remove scoring/rating systems.
- Provide sufficient training on the risk assessment process using case vignettes which are relevant to all staff.
- Promote staff confidence through ongoing training and supervision on how to record information and manage identified risks.
- Provide staff training on understanding risk and not just tool completion.

b. Patients' views

Forty-two patients completed the survey. A number of themes were identified from their responses.

Perceptions of risk assessment

Nine (35%) patients reported being aware of having a checklist or risk assessment tool being administered during meetings with their care team(s). Fourteen (53%) felt they were listened to during the meeting and 19 (73%) told us they were given the opportunity to discuss their own safety (Figure 3).

Twenty (77%) patients reported they were not offered the option of having a carer or family member/friend present during their assessment. Nine (35%) patients told us there was a lack of information given during the meeting on what to do or who to contact in a crisis.

Challenges with assessment and suggestions for improvement

A number of themes emerged. Some patients

were critical of the assessment process and felt there was inconsistency between teams. Some reported that their views had been disregarded by clinicians and that the assessments felt impersonal. Patients also highlighted a lack of consideration for how feelings of safety fluctuated. Their suggestions for how the risk assessment process could be improved are shown in Box 6.

Box 6: Patients' suggestions to improve risk assessment tools

- A personalised approach, not based on the completion of a checklist.
- Assessment by staff who are well-trained, have an understanding of managing distress, and who value the answers given.
- A focus on suicidal thoughts, i.e. encourage staff to confidently tackle difficult questions.
- Involve carers/families, including sharing crisis/safety plans with them.
- Provide information on local support options/helplines and 24-hour services, not just national numbers.

Figure 3: Patients' experience of risk assessment tools



c. Carers' views

Twenty-six carers completed the online survey. The themes identified from their responses are detailed below.

Perceptions of risk assessment

As shown in Figure 4, nine (45%) carers reported being present at an assessment where a patient's safety was discussed. However, carers expressed frustration and disappointment at their lack of involvement in safety planning, despite having raised concerns. Only nine (45%) felt their views were acknowledged. Over half (11, 55%) felt they were not given the chance to express their views on potential risk factors.

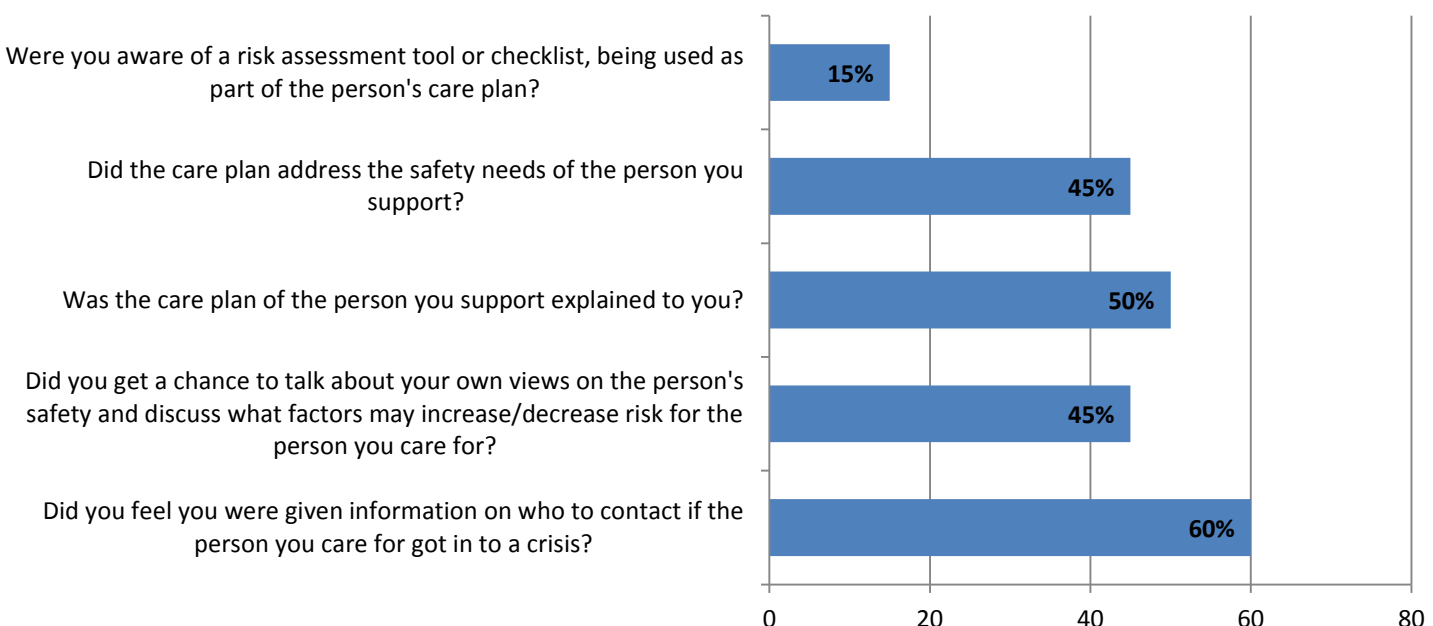
Challenges with assessments and suggestions for improvement

Carers did not feel they were given adequate information of where to go and what to do in a crisis. Carers reported a lack of communication and consultation, a lack of involvement in safety planning processes, and limited reassessment of plans.

Carers' suggestions on how risk assessments could be improved were often based on improved consultation and support from clinicians during periods of crisis (Box 7).

Carers emphasised that safety plans be discussed with carers and family members, and they welcomed plans that were devised collaboratively and which were achievable in the family context.

Figure 4: Carers experience of risk assessment tools



Box 7: Carers' suggestions for improving risk assessment and safety planning

- To have an understanding and knowledge of the care plan.
- To be given information and advice on what to expect, and how to manage situations at home, before and during a crisis.
- To be offered training to develop the skills and knowledge to support the patient, including in a crisis.
- To not be left feeling alone and unsupported.
- Better and more consistent consultant and information sharing with the family (where consent has been given by the patient).
- To discuss high risk behaviours with family and carers.

3. Clinicians' interviews

In total, 22 clinicians were interviewed about their experience of the assessment of clinical risk in mental health services. The interviewees included consultant psychiatrists (13), mental health nurses (3), managers (3), social workers (2) and a psychologist. All four UK nations were represented.

All the clinicians we spoke to were aware of the tools used within their organisation, how they were used and where they were located within the notes (whether paper or electronic).

What makes a good risk assessment?

Clinicians told us the tools were a useful resource, providing they were kept up to date and completed well. The risk summary section of the tool was viewed as a useful way of communicating identified areas of concern to other professionals and measures to prevent negative outcomes.

Clinicians told us an important element of risk assessment was the quality of the information gathered, building a rapport and how the assessment flowed. In particular, they mentioned good quality information should be gathered on: (i) the patient's current situation, (ii) their history of risk, and (iii) social factors.

Risk formulation

Clinicians carried out risk formulation - the process of summarising the assessment and identifying the risks and triggers and how these interacted – and felt it was essential to risk management.

“Practitioners need to learn how to assess, pull information together and summarise (formulate) where are we now? What do we do today?”

Updating tools

There was a consensus that risk assessments should be updated when there were any changes in care or the patient's circumstances,

i.e. following an incident of self-harm or hospitalisation, and as the organisation agreed as standard.

Clinicians reported that expected time frames for updating risk assessment documentation within mental health services varied from team to team, ranging from 4-12 months.

General principles

The clinicians told us risk assessment was not viewed as a one-off process, but an ongoing review after each interaction. It was mentioned that the risk assessment process needed to be personalised to take into account the dynamic nature of life situations and how individuals managed them.

“The dynamic nature of risk cannot always be predicted and managed”

The clinicians we interviewed noted the importance of gathering a thorough history of previous incidents, and having an awareness of triggers for distress, e.g. significant anniversaries. They told us a good risk history should include details of the incident and its consequences as well as the likelihood of the incident being repeated.

“Your job is not to predict who will die; your job is to engage with the problem the patient is presenting to you in a way that is helpful”

“We can’t predict human behaviour. Likelihood is an opinion, a professional judgement”

“An assessment flows the way you direct it but also the way the patient takes you. If they say something alarming, check that out, it may not fit into a box”

Issues with risk assessment

The interviewees echoed similar problems with risk assessments to those identified in the online survey, typically:

- administrative burden
- impersonal set of tick boxes
- poor quality information
- not updated regularly.

“The best tools are useless if they are blank”

Training

Clinicians’ felt that better training on risk formulation would give staff the confidence and understanding about how to document the most meaningful information.

“Training keeps risk at the forefront, it keeps it fresh”

They reported risk assessment training was received as part of professional training, but was often not refreshed or updated.

WHAT THIS STUDY CAN'T TELL US

- Although all services provided copies of risk assessment tools, the findings, from the web survey and interviews, are based on selected groups and small numbers, and should be interpreted with caution. They may not represent the views of all staff, patients and carers.
- The design of the study cannot allow us to draw direct causal links between the general gaps we identified in the risk assessment process and individual patient suicide.
- We did not look in detail at the modification of tools used in specific services, for example those caring for young people. The findings may not reflect ongoing improvements being made by services to their risk assessment tools and processes.
- The study cannot tell us about the quality of clinical risk assessment across services as a whole.
- We did not investigate how patient capacity to make treatment decisions might impact on the assessment of risk (see Appendix for definition). We did not explore how new approaches to clinical risk assessment could better support autonomy, patient choice and

engagement. These are potentially valuable areas for future research

Summary of findings

Characteristics of clinical risk tools

We collected data from all NHS mental health services in the UK. There was little consistency in the use of risk tools, although greater consistency within Wales and Northern Ireland. Tools varied widely in format, content, and the extent to which they had been adapted for local use.

For around 40% of tools there was no accompanying local guidance and fewer than one in five suggested liaising with primary care when assessing the patient. Most tools sought to predict future behaviour, and scores on the tool also determined management decisions. This is contrary to national guidance for self-harm assessment.

Views on clinical risk assessment

Clinicians reported that tools were sometimes useful (for example to act as a prompt or measure of change) and could be helpful as part of a wider process of formulation where different risks were considered together to determine the patient's management plan. Others suggested that the tools could provide false reassurance. Clinicians reported issues around lack of training in risk assessment processes, risk management, and practical

issues around user friendliness and accessibility of information.

Patients and their carers highlighted that tools must take account of fluctuating risk. They also emphasised the need for carer involvement, and clarity about what to do in a crisis.

Potential drawbacks of tools included inconsistency in their use or making the assessment process impersonal.

Clinical messages:

1. Risk assessment tools should not be seen as a way of predicting future suicidal behaviour. This is consistent with the NICE self-harm guidelines.
2. Risk is not a number, and risk assessment is not a checklist. Tools if they are used (for example as a prompt or a measure of change) need to be simple, accessible, and should be considered part of a wider assessment process. Treatment decisions should not be determined by a score.
3. There is a growing consensus that risk tools and scales have little place on their own in the prevention of suicide. This study suggests ways in which clinical risk assessment processes might be improved; by placing the emphasis on clinical judgement and building relationships, and

by gathering good information on (i) the current situation, (ii) history of risk, and (iii) social factors to inform a collaboratively-developed management plan.

4. Risk assessment processes need to be consistent across mental health services, and staff should be trained in how to assess, formulate, and manage risk. On-going supervision should be available to support consistency of approach.
5. Families and carers should have as much involvement as possible in the assessment process, including the opportunity to express their views on potential risk. The management plan should be collaboratively developed where possible. Communication with primary care may also be helpful.
6. The management of risk should be personal and individualised, but it is one part of a whole system approach that should aim to strengthen the standards of care for everyone, ensuring that supervision, delegation and referral pathways are all managed safely.

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Appendix

Definitions

Tool/variable	Definition
Functional Analysis of Care Environments (FACE)	Supports the assessment risk domains and encourages patient and carer collaboration.
Galatean Risk Screening Tool (GRiST)	Provides a structured and systematic approach to risk assessment.
DICES system	Describe the Risk; Identify the Options; Choose your preferred option(s); Explain your choice; Share your thinking.
Rio risk summary	This is a risk summary embedded within electronic patient records.
Welsh Assembly Risk Research Network (WARRN)	A formulation-based assessment, allowing patients and clinicians to work together. Used by all 7 Local Health Boards in Wales.
Sainsbury Clinical Risk Assessment Tool	A clinical tool and practitioner manual developed by the Sainsbury Centre for Mental Health ²⁴ .
Standard Tool for the Assessment of Risk; Version 2 (STAR V2)	A standard tool of risk assessment using tick boxes and text boxes.
Skills-based training on risk management (STORM)	A series of worksheets that aim to identify the problem and develop solutions.
Risk screening tool and the Comprehensive risk assessment and management tool	Northern Ireland's two-step risk assessment and management process.
Formulation-based tools	These use a systematic process of gathering and linking information. A summary describing the links between the problems.
Safety plan	A document designed for clinicians and patients to work together to devise coping strategies, problem solve and provide details of where to go when in distress. The patient is encouraged to keep a copy to refer to. There is little evidence of the validity of safety plans, although results from a recent cohort study have found them to be a useful component in suicide prevention ²⁵
Aide memoire	A list of areas to consider when completing a risk assessment.
5Ps model²³	<p>Problem: nature of the risk.</p> <p>Predisposing factors: historical factors, i.e. trauma, early attachment, life adversity, past relationships, social developments.</p> <p>Precipitating factors: recent triggers, issues, i.e. acute life events, events that have meaning, sudden changes, past reminders.</p> <p>Perpetuating factors: factors that keep the problem going, i.e.</p>

beliefs and interpretations, relationships, psychosocial stressors, self-care.

Protective factors: Evidence of resilience, engagement, interpersonal qualities, and social support.

Stress tolerance

The ability to manage life events that may impact negatively on a person's mental wellbeing.

Risk formulation

The process of summarising the assessment, identifying the risks and triggers, and how these interact together. Risk formulation (i) identifies 'why' someone engages in problematic behaviour not just 'if' they will engage in it, and (ii) encourages a shift away from simply identifying risk factors to thinking about how key variables interact and connect in the expression of risk.

ICD-10 codes

Deaths coded with the following ICD-10²¹ cause of death codes were included in the study: X60-X84; Y10-Y34 (excluding Y33.9); Y87. This is in line with ONS procedures for identifying deaths by suicide. Deaths receiving a narrative conclusion at coroner inquest were also included if ONS procedures for identifying suicide deaths applied one of the above ICD-10 codes.

Capacity

People are considered to lack capacity if they have an impairment which causes them to be unable to make a specific decision. The person should be able to understand, retain and weigh the information provided and communicate their decision. The possible causes of incapacity are wide-ranging and include dementia, acute confusion, depression, psychotic illness, distress or emotional disturbance.

Appendix

Independent Advisory Group

Name	Affiliation
Ben Thomas (Chair)	Department of Health, England
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Sarah Markham	Lay member
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