Promoting Quality Care

Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services

As revised May 2010

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Glossary of Terms

Care Coordinator	The individual responsible for overseeing the work of several Key Workers.
Disengagement	Loss of contact with mental health and learning disability services by the service user.
Dual diagnosis	Used to describe people with a combination of drug and alcohol misuse and mental illness.
Key Worker	The individual with responsibility for co-ordinating the care of mental health or learning disability service users with complex needs and for communicating with others involved in the service user's care.
Mental illness	A range of diagnosable mental disorders that excludes learning disability and personality disorder.
Risk	See Annex C
Risk Assessment	See Annex C
Risk Factor	See Annex C
Service User	An individual who is treated and cared for in secondary mental health and learning disability services for his/her mental health, behavioural or psychological problems. Such individuals may live in their own homes, are staying in care, or are being cared for in hospital.
Vulnerable Adult	A person, aged 18 or over, who is, or may be, in need of community care services, or resident in a continuing care facility by reason of mental or other disability, age or illness, or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation.

1.0 Introduction and Purpose

1.1 Introduction

A core function of mental health and learning disability services is to assess the treatment and care needs of people presenting to them. An integral part of such an assessment is the consideration of risks posed by some people with a mental disorder to either themselves or others. Understanding the level of risk that an individual may present forms part of his/her overall assessment, nevertheless it is an integral part of formulating an appropriate care package.

Risk assessment and management is a fundamental part of care within mental health and learning disability services, the responsibility for which is part of the practice of all service providers. Currently, the understanding and practice of good risk assessment and management is becoming increasingly important as local mental health and learning disability services continue to develop a more community-based model of provision. There is, however, great variation in process and procedure between service providers, yet the repetitive nature of serious adverse incidents and the findings of Independent Inquiries suggest a certain consistency to the failures in the system and highlight the need for a more standardised approach, as proposed by this regional guidance.

Whilst it is unrealistic to expect that all adverse incidents can be prevented, the risks for each individual can still be identified, managed and adverse outcomes possibly avoided. In the vast majority of cases, the safe and effective care and good professional practice provided by mental health and learning disability services minimise any risks identified.

However, a significant number of Serious Adverse Incidents (SAIs) do occur, particularly in mental health services and, therefore, a mechanism must be put in place to ensure learning is shared and acted upon. Local mental health and learning disability services report SAIs as part of routine practice, in keeping with the ethos of openness and “learning the lessons”.

1.2 Purpose

This guidance describes the principles of best practice to assist individual mental health and learning disability care professionals, multidisciplinary teams and the organisations within which they work, to make decisions about managing the potential risk that service users may cause harm to themselves or others (including the staff who care for them, their families, carers or the general public).

Not all risks posed by people with mental health problems are linked to their mental health condition: it is predominantly the latter which fall within the ambit of mental health professionals to influence.

This guidance aims to embed risk assessment and management into daily practice and ensure that all individuals who require treatment, care and support from secondary mental health and learning disability services receive this, based on an individual assessment of their care needs. It highlights good practice in the assessment and management of risk for all service users.

The experiences of those working in the field of mental health and learning disability, key lessons from Independent Inquiry reports and SAIs have been drawn together into this document. It details elements and processes that mental health and learning disability service providers should include in their operational protocols and procedures to ensure that effective assessment, care planning and discharge planning take place within the context of risk assessment and management.

Whilst this document replaces *'Discharge From Hospital And The Continuing Care In The Community Of People With A Mental Disorder Who Could Represent A Risk Of Serious Physical Harm To Themselves Or Others'* (DHSSPS 2004a), considerable work has already been undertaken within Health and Social Care (HSC) Trusts since the publication of the 2004 guidance to put in place relevant protocols and procedures. It is important that such work is built upon by the implementation of this new guidance.

1.3 Which Services Does This Guidance Apply To?

Adult Mental Health Services

This guidance and its principles of risk assessment and management are applicable to all secondary mental health services operating within all treatment environments (including hospital inpatient and community-based settings). It is also to be applied across services for co-morbid substance misuse and services for functionally mentally ill older people.

This guidance applies equally to people in contact with mental health services but without a defined functional mental illness, such as people with a personality disorder. Similarly, the guidance is applicable to those in contact with mental health services and who are in settings outside the health and social care sector, such as police stations or prisons.

Specialist Mental Health Services and Learning Disability Services

The broad principles of this guidance should be applied to any individual receiving care and treatment from learning disability and specialist mental health services, i.e. child and adolescent mental health services (CAMHS), forensic mental health and learning disability services and specialist substance misuse services. Supplementary guidance in relation to these services is contained in the addenda in this document.

Services Provided by Non-statutory Organisations

It is the responsibility of HSC organisations to ensure that this guidance is implemented within those non-statutory organisations contracted to provide care and treatment to service users. HSC organisations must also ensure that staff in these organisations receive appropriate training. All agents making a referral to secondary mental health and learning disability services must adhere to this guidance in communicating the appropriate risk information.

1.4 Objectives

The overarching aim of this document is to act as supportive guidance for health and social care staff within mental health and learning disability services to proactively manage the risk of harm and to deliver safe, effective care provision for service users, their families, their carers and for staff.

The objectives which this guidance sets out to achieve are to:

(1) Improve the safety and quality of services available to service users and their families/carers;

(2) Promote consistency and standardisation of best practice which is evidence-based across all care settings in Northern Ireland;

(3) Support fully integrated mental health and learning disability services and interfaces between these services and other service areas, such as family and child care;

(4) Facilitate regional reporting of adverse incidents and dissemination of associated learning; and

(5) Promote good practice which recognises the strengths of service users.

In achieving these objectives, it is necessary to take account of other developments including the modernisation and reform of mental health and learning disability services following the *"Bamford Review of Mental Health and Learning Disability (Northern Ireland)"* (The Bamford Review) and support for the safety and quality of services through the development of Mental Health and Learning Disability Service Frameworks for Northern Ireland.

This guidance will inform the future work of the Regulation and Quality Improvement Authority (RQIA) within mental health and learning disability services, both in terms of governance reviews and in relation to the future discharge of its functions under the Mental Health (Northern Ireland) Order 1986, through assessment of the application of the risk assessment and management principles it contains.

In preparing this document, account was taken of the statutory duties imposed on public bodies by Section 75 of the Northern Ireland Act 1998 and the Human Rights Act 1998. An Equality and Human Rights screening exercise was carried out which showed that a full Equality Impact Assessment was not required.

2.0 Good Practice Principles

There are several principles for good practice upon which the development of this guidance has been based.

Each of the principles below should be integrated into the everyday practice of individual mental health and learning disability care professionals and the multidisciplinary teams within which they work. Mental health and learning disability provider organisations should ensure that staff work in an environment conducive to applying these principles.

Working With Service Users and Carers

(1) Risk management should be person-centred and facilitated in collaboration with the service user and his/her family/carers;

(2) Service users must be assisted to harness their strengths and protective factors to contribute to their own risk reduction;

(3) Assessment of risk needs to include highlighting both the negative and positive aspects of any situation.

Team Working

(4) Risk assessment and management is the shared responsibility of all health and social care professionals. It requires balancing the opinions of different individuals and organisations;

(5) Risk management should be part of a coordinated approach with the relevant services and agencies which combine their efforts to care for service users;

(6) Individual practitioners must be confident to make positive risk management decisions within a supportive organisational culture;

(7) Both clinical and managerial supervision are fundamental to developing safe and effective risk management practice;

(8) A clear system of organisational learning is necessary to ensure key risks in mental health and learning disability services are identified, shared and acted upon. In so doing, services must strive to achieve positive risk management.

Risk Management Process

(9) Risk can only be minimised and not completely eliminated or avoided. It must be recognised, assessed and managed, as far as is possible;

(10) Risk strategies must adhere to evidence-based practice, where available, and should use a formulation approach with structured professional judgement to translate risk assessment information into appropriate risk management plans;

(11) Risk is dynamic and occurs in a context resulting from the interaction between individuals, situation and environments. Assessment is an ongoing process, recognising that risk factors will vary in significance for each individual service user as his/her circumstances change;

(12) Risk assessments and management plans should be regularly updated and reviewed as part of the overall care plan;

(13) As risk assessment is part of routine practice, training must be ongoing to ensure staff competency is maintained.

Communication

(14) Effective verbal and written communication is fundamental to risk minimisation. Systems should be in place to ensure that communication processes are sufficient to minimise potential breakdown;

(15) Good record-keeping and appropriate sharing of risk information are vital components in the management of risk. Confidentiality within accepted parameters should not be a barrier to effective communication (see Code of Practice on Protecting the Confidentiality of Service User Information, http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf*);*

(16) Communications should be in a format that optimises the likelihood of service user comprehension and participation. For clients who do not have the capacity to fully understand the risk management process, it is good practice to consider the appointment of an independent advocate.

3.0 Fundamentals of Risk Management

3.1 Recovery and Positive Risk-Taking

The concept of *"recovery"* recognises that people with a long-term mental illness should not be defined by it alone: they have the right to lead a meaningful life beyond their illness. Mental health services must support personal recovery, move beyond risk avoidance and towards positive risk taking, by providing effective care that is personally meaningful to the individual service user and his/her family/carers.

Such recovery-based practice aims to empower the service user through supporting choice, responsibility and self-management and emphasises that treatments, interventions and support must be delivered in consideration of how the service user wishes to live his/her life[1,2]. This involves a shift from the traditional 'assessment-treatment-cure' model of mental health care to engaging, negotiating and collaborating with the service user in the self-management of his/her mental illness[3]. It is important to encourage the service user to take personal responsibility for his/her care.

From a learning disability perspective, this approach reflects the social model of disability recognised within learning disability services.

Positive risk management acknowledges that it is not possible to eliminate all risk of harm, and that risk management plans will inevitably include decisions regarding care and treatment options that carry with them some risks[4]. Reasonable risks must be taken to develop an appropriate positive risk management plan, which is in keeping with the service user's plans for recovery.

It is important that there is an awareness of the risks that must be minimised (i.e. harm to self, harm to others, harm to children/vulnerable adults, and harm from others) and the risks that people have a right to experience in order to progress towards their goals of recovery[5].

Positive risk management is characterised as including[6]:

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[1] *Robert et al (2008)*
[2] *Shepherd et al (2008)*
[3] *RPsych / SCIE / CSIP (2008)*
4 DH (2007a)
[5] *See 6*
[6] *Morgan, S. (2007)*

- *Collaborative working between mental health professionals, the service user and his/her family/carer;*
- *A clear understanding of the responsibilities and consequences for actions that a service user can be reasonably expected to follow;*
- *Taking decisions based on a range of choices available;*
- *Full appreciation of the service user's strengths and weaknesses – based on previous experience;*
- *The availability of support should the positive risk management plan breakdown.*

3.2 Recognising the Strengths of Service Users

Whilst recovery-orientated services may increase risks, it is sometimes necessary in order for the service user to learn and grow. Avoiding all risk is not possible or desirable for either the service user or the general public. Choosing the safest possible option for care and treatment can be dis-empowering for the service user and counter-productive for his/her recovery.

Overstating risks and being overly risk averse carries with it human rights implications for the service user and resource implications for mental health and learning disability services. It can lead to unnecessary exclusion from services, stigmatisation and breakdown in the relationship between the service user and the mental health team.

A balance has to be struck between risk and the individual service user's ability to recover and participate in a normal life. Service users should receive treatment in the least restrictive environment to allow them to take personal responsibility for managing their own condition and avoid creating complete dependency on mental health and learning disability services.

Defensive practice is inappropriate, as it creates a focus on staff rather than the service user. Treatment should always be based on the values of holistic service user-centred care. Mental health and learning disability professionals must ensure that their practice is defensible rather than defensive[7].

[7] *See 4*

"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" (DH 2007, 8).

3.3 Safety

The central focus of mental health and learning disability services should be individual and personal autonomy. Risk assessment and management is the proportionate modification of and interference with that autonomy to promote the safety of the service user, his/her family/carers, the general public and mental health staff.

There is always the need to achieve a realistic balance between risk and restrictive practice. An excessively lenient or paternalistic approach serves to dis-empower clients and professionals.

3.4 Partnership Working With Service Users and Carers

Partnership working with service users and their family/carer(s) is one of the most important elements in effective risk assessment and risk management planning. A three-way collaboration of the service user, his/her family/carer and the mental health/learning disability team is essential to planning care[8]. Positive working relationships are based on knowing the service user and his/her individual circumstances. Family members and carers know the service user best and have first-hand information about his/her history, behaviours and situation.

Positive risk-taking may not be suitable for all service users, and it is likely that there will be occasions where the professional's views and those of the service user will differ. These need to be discussed and worked through to reach agreement as to what are acceptable risks, recognising that it may not always be possible to achieve full agreement.

In such circumstances, advocacy services can play an important intermediary role, giving service users the opportunity to express their views and concerns, assisting them to make informed decisions, and encouraging their personal responsibility for their ongoing care and treatment. In order to determine if the arrangements are working, specific measures of success and intended positive outcomes must be documented.

On certain occasions, individual service users may choose not to cooperate, or even obstruct the implementation of a care plan. On these occasions it must be recognised that such uncooperative behaviour will have significant implications for services attempting to manage and ameliorate risk.

[8] *DH (2007a)*

3.5 Effective Risk Communication

Good communication processes in mental health and learning disability services (both statutory and non-statutory) are particularly important when working with risk. Findings from the various Independent Inquiries in recent years have highlighted serious failings in the communication of service user information which have contributed to the tragic outcomes. Often information indicating an increased risk existed but had either not been communicated and acted upon, or had been overlooked or played down[9].

Therefore, it is essential that information available is recorded and communicated to all those who need to have access to it in order to care for the service user and protect him/her from harming him/herself or others. In completing assessments of risk, information should be shared with other agencies/individuals, where necessary, due to specific risks and in keeping with policies and professional guidance in respect of confidentiality. In recording and sharing such information, clarity is crucial.

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[9] *Morgan S. (2000)*

4.0 Working with Risk as Part of Everyday Practice

Working with risk in mental health and learning disability services as part of the overall care planning process should have two main components: risk assessment, which seeks to identify the specific risks in an individual; and risk management, which is a statement of the plans of treatment and support for the service user as well as individual responsibilities within the multidisciplinary team.

Risk can be minimised but not eliminated. It is dynamic, continually changing according to the individual service user's circumstances. Assessment, therefore, can only have a short-term time perspective and must be subject to review as frequently as the situation demands.

Risk relates to the likelihood of an event happening with potentially harmful or beneficial outcomes for self and others[10].

This guidance focuses on four categories of risk:

- *Risk of harm to* *<u>self</u>* *(e.g. deliberate self harm/suicide/self neglect);*
- *Risk of harm to* *<u>others</u>* *(e.g. homicide/violence/aggression);*
- *Risk of harm to* *<u>children/vulnerable adults</u>* *(either through acts of omission or commission);*
- *Risk of harm* *<u>from others</u>* *(e.g. domestic abuse/sexual, physical, emotional abuse/exploitation).*

4.1 The Risk Assessment Process

Risk assessment contains the following tasks:

- *collecting and communicating information on risk behaviour(s);*
- *identifying causes and consequences of risk behaviour(s);*
- *considering individual static and dynamic factors;*
- *identifying external risk factors (e.g. service issues);*
- *formulating a risk statement based upon risk factors and protective factors;*

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[10] *Morgan S (2000)*

- *developing risk reduction and management plans; and*

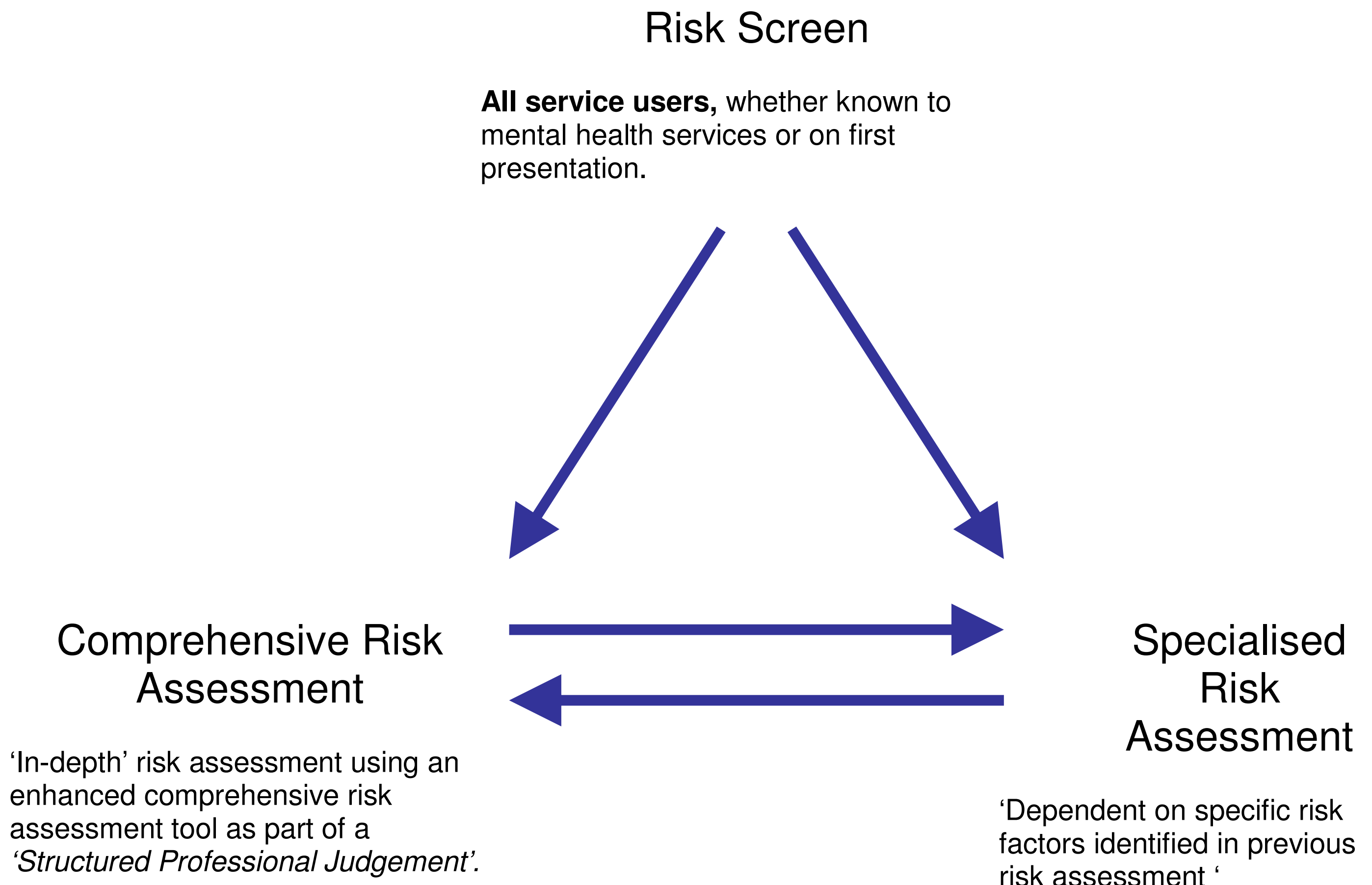
- *monitoring, feeding back, evaluating and modifying plans.*

Risk assessments should build on information collated at each step rather than being separate exercises, otherwise there is duplication for users and carers and important information may be lost at each assessment point.

It is good practice that EVERY individual referred to secondary mental health services should receive an initial screening for risk. This is considered to be part of routine mental health assessment[11].

Service users will vary in the degree to which they will require a formal risk assessment and management plan, and there is neither the capacity nor the necessity to carry out an in-depth risk assessment for every service user. Where necessary, service users will be identified as a priority for more in-depth assessment and intervention and scarce resources can be targeted appropriately towards these individuals, proportionate to the level of risk that they pose to themselves or others.

The process for completing risk assessments should be as follows (supporting information for this can be found in **Annex C**):



[11] *(DH 2007a)*

Risk Screen

Everyone referred to mental health services should receive a Risk Screen, including:

- *People entering services for the first time in all settings; and*
- *All service users currently known to mental health services, i.e. both inpatient and community mental health services.*

All professionals making a referral to secondary mental health services, including General Practitioners, secondary care and community care staff, must provide risk information in an appropriate form, as required by their local mental health services.

A Risk Screen provides a quick overview of the broad areas of potential risk for the service user, and prompts professionals to specify their understanding of risks present on initial contact. The aim is to:

- *Ask pertinent questions about his/her history and current situation;*
- *Identify the risk factors specific to the individual service user;*
- *Enable the multidisciplinary team to make initial decisions regarding the service user's care plan;*
- *Identify those service users presenting with high risk factors which would indicate further examination and a 'Generic Risk Assessment'.*

Screening need not be time-consuming and formalised, but should be conducted as part of the overall assessment of need and not a separate exercise. This approach will encourage a therapeutic relationship and should be seen as part of good clinical practice.

Whilst it is recognised that a risk screen may be completed by an individual practitioner, particularly in community-based services, a joint multidisciplinary risk screen, carried out by at least two or more disciplines, should be undertaken for all mental health inpatients, taking note of relevant information available from the family/ carers, the Approved Social Worker and any other professionals involved in the decision to admit.

In the case of non-statutory organisations contracted by the Board and Trusts to provide care and treatment to service users, it is expected that, where any risk has been identified prior to an individual engaging with these services, the risk assessment would be carried out by secondary mental health and learning disability services "referring" the service user. From this, a risk management plan should be drawn up to support the placement. This would be regularly monitored and reviewed within the placement.

Comprehensive Risk Assessment

According to the risk factors identified in the risk screen, a clinical decision may be taken, as appropriate, to progress to a comprehensive risk assessment where it is needed for reasons of complexity, history or high risk potential[12]. The value which can be gained from this more thorough level of investigation and reflection should be determined on an individual basis.

Assessment should commence as soon as a professional judgement about its need is made. Individual multidisciplinary teams will work to consider relevant risk factors as they carry out the comprehensive risk assessment.

It is important that the widest possible range of sources (i.e. corroborative evidence from all professionals, agencies and sectors) contribute to comprehensive risk assessments.

Specialised Risk Assessment

Dependent upon their history, some service users will require specific risk assessments. Some specialised risk assessment tools are already used within specialist services to assess, for example, violence and aggression, sexual violence, anti-social or offending behaviour and suicide/self-harm. A clear and approachable overview of the main tools available can be referred to in the document *'Best Practice in Managing Risk'* (DH 2007a).

As general mental health and learning disability services and specialist services will have different levels of experience in conducting specialised risk assessments, these services should work closely together to ensure the appropriate level of assessment is carried out.

4.2 Care Planning and Risk Management

The care planning process is underpinned by information gathering and sharing. The Care Plan should provide details of the full range of support services required, focus on the service user's strengths and seek to promote his/her recovery and independence.

Key information about a service user's medical, psychological and social care needs are necessary to inform development of an appropriate care package. The Care Plan specific to each individual service user must be drawn up, as appropriate, following comprehensive assessment of his/her:

- *mental state;*
- *past behaviour;*

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[12] *Morgan S. (2007)*

- *social functioning; and*
- *social circumstances.*

Identifying risk and formulating a management plan to mitigate that risk is an integral part of the care planning process and should not be seen a separate entity.

Indeed, a risk assessment is only useful if it enables the multidisciplinary team to develop an appropriate management plan to address identified risks for the individual service user[13]. Without this, a practitioner can feel stranded with nowhere to move on to.

Good clinical practice dictates that risk assessments should:

- *Be person-centred and prepared in collaboration with the service user and his/her family/carer;*
- *Involve live documents which follow the patient through their treatment journey and are updated regularly;*
- *Be reviewed routinely at regular intervals AND any time there are new concerns;*
- *Be contributed to by the entire multidisciplinary team;*
- *Be an ongoing and dynamic process, recognising that service users' risk status may vary;*
- *Inclusive of factors which reduce risk;*
- *Note any limitations of the risk assessment;*
- *Note the potential effects of not intervening and the possible unintended consequences of intervention;*
- *Inform discharge planning and the Care Plan; and*
- *Be disseminated to the service user and those involved in his/her care.*

Risk Management is the organised attempt to assess, reduce and manage identified risk to service users, their families/carers, healthcare staff and members of the public. A Risk Management Plan is an explicit statement of the planned interventions, treatment and support for the individual service user, based on the recorded risk assessment. The goal is to prevent or, where this is not possible, to minimise the likelihood of adverse incidents occurring which may result in harm to the service user and/or others.

[13] *DH (2007a)*

This is achieved by formulating a flexible Care Plan, informed by a structured risk assessment and associated risk management plan, contributed to by the widest possible number of health and social care professionals to enhance the accuracy of clinical judgement, and including the input of the service users and their carers. It is recognised that risk assessment and management processes rely on clinical judgement and cannot predict with complete certainty whether harmful outcomes will occur. It is suggested that formalised tools are used as part of risk assessment as they support effective and consistent risk management decision-making.

The outcome of risk assessments and the resulting options for managing any identified risks should be discussed with the service user and, where appropriate, his/her family/carers and advocate. Efforts must be made to include carers, and to actively encourage a partnership with the service user in contributing to formulation of a Care Plan.

The Care Plan will:

- *Identify specific interventions and anticipated outcomes;*
- *Be drawn up in collaboration with the service user and, where appropriate, his/her family/carer and advocate;*
- *Detail the contributions of all named individuals, services and agencies involved in care delivery;*
- *Record all the actions necessary to achieve agreed recovery goals;*
- *Specify a timescale by which the outcomes will be achieved or reviewed; and*
- *Include contingency and crisis plans, where appropriate.*

Efforts must be made to ensure that the service user and his/her family/ carers understand each element of the Care Plan, including the possible outcomes. The Care Plan should be countersigned by the service user and his/her family/carers to show that they have read, understood and agreed it and the associated risk management plan. Where they have not signed, a reason for this should be recorded.

A written copy of the Care Plan must be provided to all staff on the team directly responsible for delivering care and, with the consent of the service user, to any other relevant parties (including external agencies). Any individual named in a Care Plan should be involved in its development and agree his/her role in providing the services recorded in it. The Care Plan should clearly show the name of the Care Coordinator and Key Worker.

Care plans for patients in the community should be available to the patient's General Practitioner so that he/she can see the plan of interventions and

anticipated outcomes, can monitor the patient and be aware of any contingency and/or crisis plan.

The Care Plan must recognise the diverse needs of the service user reflecting his/her age, gender, ethnicity, sexuality, disability and culture. Where the service user's first language is not English, or where he/she has shown visual or hearing impairment, all reasonable steps must be taken to ensure that appropriate support is provided and that he/she fully understands the content of his/her Care Plan.

Contingency and Crisis Plans

Contingency arrangements, used to plan for known situations and prevent circumstances escalating into a crisis, should be incorporated into the Care Plan. It should detail the steps to be taken where, for example, the Key Worker/Care Coordinator is unavailable, part of the agreed Care Plan cannot be provided, or the service user is beginning to disengage from care and treatment.

A crisis plan should also be included in the Care Plan and should specify an explicit plan of action when a crisis situation is developing, i.e. the service user's mental state is rapidly deteriorating. As such crises frequently occur out-of-hours, it is beneficial to plan ahead for such an eventuality to ensure that appropriate action is taken. The Plan should detail specific triggers which are likely to exacerbate a service user's individual risk factors. Speaking to the service user and his/her family/carers about managing a crisis situation is essential, as they know their situation best, and what is most likely to alleviate any problems.

The involvement of any individual in crisis and contingency plans should be agreed with the named person, including family/carers and external agencies.

4.3 Review

Regular review dates for risk assessments and management plans must be incorporated into the Care Plan: the level of risk should dictate the frequency of review. Details as to who should take responsibility for communicating changes to the risk management plan must also be clearly recorded. Here there is a clearly defined co-ordination role for the Key Worker (community setting) and the Named Nurse (hospital setting).

Reviews are particularly necessary in the following circumstances:

- *Prior to discharge from inpatient care;*
- *At a change or transfer of care from one treatment environment to another;*

- *At a change in legal status (e.g. detention under the Mental Health (Northern Ireland) Order 1986);*
- *Following a crisis/relapse of illness/significant change in mental health condition; and*
- *Following a serious adverse incident or near miss.*

4.4 Multidisciplinary Team Meetings

Regular multidisciplinary team meetings, often also known as Team Assessment Meetings, must be held with the purpose of reviewing the service user's progress with care and treatment, including discussion of risk assessments and risk management plans. It is important that these team reviews have two or more disciplines present and that the service user and his/her family/carers are encouraged to contribute, where possible. Discussion amongst the various team members is essential for sharing information and forming a holistic view of the service user and his/her current circumstances.

Good practice suggests that ideally service users in general mental health inpatient facilities should have a formal weekly team review. All team reviews must be recorded in the patient's notes and should document the progress of the patient and agreed actions for named individuals with corresponding timescales for their completion. It is important that every professional has an equal opportunity within the team to participate in formulating the Care Plan for managing the service user's care and identified risks.

4.5 Roles and Responsibilities

It is important that individual mental health and learning disability services and their staff have clearly defined roles and responsibilities that address the key elements required for ongoing assessment and management of risk. Every member of the multidisciplinary team caring for a service user must be aware of his/her individual responsibilities in assessing and managing identified risks and the delivery of the agreed care package.

Key roles must be explicitly defined in operational policy documents, and in accordance with local arrangements, e.g. for Key Worker and care coordination roles. It is acknowledged that local arrangements have to be made for designation of such roles, nevertheless their functions and purpose must be consistent in all HSC Trusts.

The following, whilst not exhaustive, outlines the main responsibilities of each.

Named/Primary Nurse

For patients in hospital, the role of the Named/Primary Nurse is pivotal at the point of admission and onwards in identifying key issues and ensuring that care planning with acute inpatient links with all relevant community practitioners. They are also best placed in making and developing links with relatives and significant carers at an early stage of the admission process.

Key Worker

For patients in the community, the role of the Key Worker is pivotal in organising and monitoring the mental health and learning disability services needed by service users under his/her care. The Key Worker may be from any professional background within the multidisciplinary team, e.g. community psychiatric or learning disability nurse, social worker, psychiatrist, psychologist, occupational therapist. The appointment of the Key Worker, where required according to level of assessed risk, should be a formal item on the agenda of the initial care planning meeting.

The decision to appoint a Key Worker will be taken after a Generic or Specialised Risk Assessment and be allocated proportionate to the identified need, complexity and risk. The Key Worker must be named in the Care Plan.

The Key Worker should draw up a written Care Plan which addresses the holistic needs of the service user with his/her involvement and, where appropriate, his/her family, carers and/or advocate. It is vital that the Key Worker represents a single point of contact in mental health and learning disability services for the service user and his/her family/carers.

It is the duty of the Key Worker to ensure that all the necessary elements of the Care Plan are in place prior to discharge including medication, therapy, supervision and accommodation. The Key Worker is responsible for sending a copy of the patient's (written) Care Plan to all the professionals involved in providing care, including the GP and, where appropriate, to the service user and his/her family/carers.

The Key Worker must remain in regular contact with the service user and his/her family/carers, reviewing the Care Plan at frequent intervals to ensure that it is being carried out and to update it, as necessary. The Key Worker must advise other members of the multidisciplinary team when the service user's circumstances change, particularly when this might require a review or modification of the Care Plan.

Particular efforts must be made by the Key Worker to maintain contact with service users who might pose a risk to themselves or others if they became unwell. At times, an assertive approach to care will be required when the service user is unable or unwilling to maintain contact because of the nature of his/her mental illness: the Key Worker should not rely on service users

contacting them. Arrangements for such an eventuality should be discussed with the service user and his/her family/carers at the earliest opportunity.

Where the service user is non-compliant with his/her Care Plan, e.g. not taking medication or attending clinic appointments, all practical and reasonable efforts should be made by the Key Worker and other members of the multidisciplinary team to contact the service user and resolve the situation. It is the responsibility of the Key Worker to lead and coordinate action, as well as to alert and share information with members of the multidisciplinary team and others, e.g. GP, family/carers, voluntary sector agencies who could resolve the situation or anyone who may be at risk of harm (as appropriate). Where there are serious concerns regarding the safety of the service user or the public, then immediate consideration should be given to admission to hospital and informing the police.

The caseload of Key Workers must be carefully managed to ensure the necessary level of support can be provided to all service users. Further, it is the responsibility of the person coordinating care, in liaison with the Key Worker and, if appropriate, the team leader, to have in place arrangements for a deputy who will cover both planned and unplanned absences.

Care Coordination Role

The person fulfilling the care coordination role should be a senior manager responsible for providing health and social care services in the community where the service user resides. His/her role is to support and facilitate the Key Worker and multidisciplinary team in the delivery of agreed Care Plans, to ensure that appropriate services are available, where possible, and to communicate unmet need to commissioning organisations.

The person coordinating care must maintain a close working relationship with community mental health team leaders in their capacity to organise 'deputies' and support Key Workers.

The person coordinating care must have knowledge of community services, relevant legislation, the roles of other statutory and voluntary agencies and have access to resources. He/she will oversee several Key Workers and should undertake case supervision for each. He/she should chair multi-agency reviews at intervals of six months or more frequently, as necessary, for each service user who is subject to a comprehensive risk assessment and management plan.

4.6 Recording Information

Working with risk is all about the effective communication of information. The most accurate method of ensuring that information gathered is communicated to all members of the multidisciplinary team is by documentation in a service user's notes. It is, therefore, an essential part of standard good record-keeping practice for all professionals to document information available to them.

Documentation should describe what has happened and the reasoning for taking chosen responsive actions. It should not be seen as 'defensive' practice, but as an important safeguard to explain why actions were taken in response to particular circumstances. Individual clinical risk assessments naturally suffer from limited reliability and predictive validity, but it is not a test of accuracy: rather, of how reasonable the decisions made are in terms of the clinical situation, current knowledge and standards of good practice. Therefore, a system for recording the rationale for decisions relating to the risk, both supporting action and/or inaction, must be recorded.

Risk assessment and management plans must be documented clearly and legibly, kept up-to-date and be accessible to all professionals directly involved in the care and treatment of the service user concerned. Every agreed action should have a named individual responsible for seeing it through. This should be recorded in the service user's risk management plan along with a timescale for completion.

The information available, including the efforts made to seek all sources of additional information regarding the service user, should be documented. If information is sought but not received, or there is no response from the professional contacted, this should be documented including the time, date and the person with whom contact was attempted. Information acquired from the service user, his/her family/carers and other professionals for the purpose of assessing risk is usually reliable, but not always[14]. The professional must make every effort to substantiate information received, particularly if it is received from an unknown or unreliable source.

Basic principles for recording information include:

- *Seeking any information not available and recording delays in receiving such information;*
- *Recording and accounting for decision-making;*
- *Recording information in line with record-keeping guidelines issued by professional bodies; and*
- *Adhering to organisational policies and procedures relating to report writing and record-keeping.*

4.7 Confidentiality and Disclosure of Information

The use and sharing of service user information is an essential part of providing optimal care and treatment within health and social care[15]. However, when it comes to communicating information about 'risk' many mental health and learning disability professionals are unclear about what they can share and with whom, whilst fulfilling their duty of confidentiality.

[14] *Morgan S. (2007)*
[15] *DHSSPS (2008)*

Concern stems from having to balance the need to safeguard the service user's right to confidentiality as part of a trusting relationship and the requirement for disclosure of relevant personal, identifiable information to manage the risk of harm that may arise for the individual service user or others.

The Code of Practice on Protecting the Confidentiality of Service User Information, http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf should be referred to for more detailed information on any aspect of confidentiality.

General principles of good practice in relation to information sharing which should be adhered to include:

- *At the earliest opportunity explain to the service user why you may need to share certain information with other professionals to care for him/her appropriately - Duty To Warn;*
- *Gain the service user's written consent to share information;*
- *Explain to the service user that in some cases, the need to protect the public might take precedence over the duty of confidence, e.g. child protection; protection of vulnerable adults; prevention of serious harm to third parties;*
- *Only share information on a "need to know" basis i.e. the recipient will be involved with the patient's care or treatment, or he/she may be at risk of harm from the service user; and*
- *Record the reasons for any information sharing.*

4.8 Involving Service Users and Carers

"Few of us would relish being labelled as a risk" (Morgan S. 2007), therefore it is particularly important that staff are open and honest about the purpose of risk assessment and management, and encourage service users' participation in the process. Family members/carers and service users generally know themselves when something is not quite right, i.e. changes in a mental state[16]. Their concerns should be listened to and recorded, as they can help prevent or minimise behaviours likely to increase risk.

Service users may refuse permission for information to be shared with particular family members and relatives for a variety of personal reasons: such wishes should always be taken into account. Family/carers should be given sufficient knowledge to enable them to provide effective care, i.e. the provision of general information about mental illness, emotional and practical support for carers which does not breach confidentiality[17]. Carers

[16] *Langan and Lindow (2004)*
[17] *Royal College of Psychiatrists and The Princess Royal Trust for Carers (2004)*

should always be provided with the essential contacts and information necessary to allow them to provide care and access support from mental health professionals, both day-to-day and in times of crisis.

Clarification of those who should and should not be communicated with should be clearly noted in the service user's Care Plan. Clearly mental health professionals will need to fulfil their legal obligations to contact the service user's next of kin, where appropriate, under the Mental Health (Northern Ireland) Order 1986. If a service user requires the support of an advocate and/or nominated person, this service should be provided.

The needs of the service user will almost certainly affect the lives of his/her family and those who provide regular care and support to him/her. Therefore, carers should be offered an assessment of their caring, physical and mental health needs, which should be reviewed on a regular basis. This is particularly important where the service user has young children who may provide care to their parent: their welfare must be addressed.

4.9 Transfer and Transition

There are certain points in a service user's care pathway at which there is an increased potential for communication failures and a risk of information being lost or mis-communicated.

The most common is during **transition**, e.g. admission to hospital, discharge from hospital care to community services, and from child and adolescent services to adult mental health and learning disability services[18]. The need to effectively manage such transitions of care is essential.

It is particularly important that, where possible, all service users, their families and carers are introduced to and linked properly with continuing care and support services prior to moving from one form of care to another. This is particularly important in maintaining continuity of risk management and care planning. Protocols governing the movement of service users between services should be developed by mental health and learning disability service providers to create clear guidance for practitioners in reviewing risk management and care plans.

Transfers between mental health and learning disability services and other general healthcare services are a common occurrence. In addition, transfers between mental health and learning disability services in different provider organisations are becoming increasingly frequent: hence there is a need for explicit policies regarding the process for transfer of clinical responsibility. Services also need to consider the management of interfaces external to the healthcare system, e.g. with housing.

Guidance from the Royal College of Psychiatrists (1996) states that "<u>if the responsibility for care of a service user is passed on to another clinician or</u>

[18] *DHSSPS (2007b)*

service it must be handed over effectively and accepted explicitly" [19]. All known information which might be relevant to the risk assessment and management plan must be transferred, as should patient records and other relevant documentation to ensure the effective exchange of information. Key Workers can play a pivotal role in the safe management of transfers.

All HSC Trusts have developed their own local protocols based on the principles within the *'Protocol for the Inter Hospital Transfer of Patients and Their Records'* (CREST 2006). In addition, the Department has recently issued to Trusts recommended good practice principles on the transfer of patients of all ages and their records between psychiatric hospitals and has asked the Trusts to review their local arrangements to ensure that they comply with these principles. Provisions should be made for the transfer of service users to agencies external to the HSC system.

4.10 Interface Issues

Service users within mental health and learning disability services often have a range of care needs which no one treatment, service, or agency can meet. When care needs stretch across service boundaries, a holistic approach is required to view the many complex interfaces between mental health and learning disability services and other service areas in the healthcare system. It is necessary, therefore, for a coordinated approach among the relevant services and agencies which combine their efforts to care for the individual service user.

For instance, where mental health and learning disability services staff are working with a parent, in whatever capacity, they will need to take account of the welfare of the child(ren) in the household. This could mean interacting with family and child care services, as appropriate, to ensure that any perceived risks to children from a parent who has a mental disorder are recognised and assessed. This must meet with the new, strengthened child protection procedures and single assessment process established as part of the Understanding the Needs of Children In Northern Ireland (UNOCINI). Mental health and learning disability services staff have a crucial role in highlighting any child protection concerns and intervening to protect children.

HSC Trusts should make use of the training resource *Crossing Bridges: Learning Materials To Support Mentally Ill Parents and Their Children* (DH, 1998) produced by the Department of Health in England to inform the development of local protocols to manage the interface between mental health and family and childcare services.

4.11 Discharge Planning

Discharge planning should be initiated as soon as possible after the service user is admitted to a psychiatric or learning disability inpatient facility.

[19] *Royal College of Psychiatrists (1996)*

Where possible, an assessment of his/her risk of harm to him/herself or others needs to take place prior to discharge involving members of the multidisciplinary team (including the clinician, nurse, social worker, and key worker) and the service user, his/her family/carer, and advocate, where necessary. This is dependent on the assumption that risk assessment is regularly carried out throughout the inpatient stay and is used to inform suitability for discharge.

If the appropriate level of risk assessment is not achievable by discharge, one must be completed at the first follow-up appointment with the service user. Prior to discharge from hospital, service users and those who care for them need to be introduced to and linked with those providing ongoing care in the community.

The National Confidential Inquiry report, *Avoidable Deaths*[20], recommends the following action to ensure the safe transition from the inpatient environment to the community:

- *Regular assessment of risk during the period of discharge planning and trial leave;*

- *Agreed plans to address stressors that will be encountered on leave and on discharge;*

- *The patient to have ways of contacting services if a crisis occurs during leave or after discharge;*

- *Early follow-up on discharge, including telephone calls immediately after discharge […] and face-to-face contact within a week of discharge [for high risk patients];*

- *Support arrangements for people who discharge themselves from wards.*

4.12 Promoting Service User Engagement

There is the need for agreed action to be taken when a service user begins to disengage from services. A plan to engage effectively with service users and action to be taken for 'loss of contact' situations is essential. A history of disengagement is clearly an increased risk factor for recurrence: when service users with such a history are identified, mental health staff should proactively try to build engagement by talking with the service user and asking him/her[21]:

- *What are your usual early warning signs for relapse?*

- *What are your usual trigger factors for relapse?*

[20] *Appleby L, Shaw J, Kapur N, Windfuhr K et al. (2006)*
[21] *Morgan S. (2007)*

- *How would you normally cope when you feel that your mental state is declining?*

- *Who would you like to be involved in your care when you are in crisis? i.e. which family members/carers should be informed?*

The answers to such questions allow the service user to identify his/her own risks, influence the plan for dealing with difficult situations and create the opportunity for him/her to indicate the type of support that they would prefer and feel would suit him/her best. As noted previously, the service user's Care Plan should include crisis and contingency plans, as necessary, to guide professionals, family/carers and others involved in caring for him/her as to what to do when he/she disengages from services.

There will be some service users who do not wish to engage with mental health and learning disability services, despite encouragement. Their right to decline this input and pursue their recovery through other means should be acknowledged, with relevant parties notified, when necessary, of their circumstances.

4.13 Dual Diagnosis

Dual diagnosis is the combination of mental illness and a substance misuse problem. Risk assessment and management plans need to address specific factors relevant for individuals with a dual diagnosis. The severity of substance misuse, including the combination of substances used, is related to the risk of overdose, suicide, violence and/or homicide.

According to the National Confidential Inquiry report[22], service users with a dual diagnosis have high rates of previous violence and self-harm, and are more likely to be inpatients at the time of death than those without the condition. For those in the community, one third had missed their last appointment.

The Department of Health *'Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide'* (DH, 2002) advises that exploration of the possible association between substance misuse and increased risk of aggressive or anti-social behaviour is an integral part of risk assessment, and should be explicitly documented, if present.

The Bamford Review recommends developing expertise within mental health services for the management of dual diagnosis. The Department recognises dual diagnosis services as an area of need for future service development.

[22] *Appleby L, Shaw J, Kapur N, Windfuhr K et al. (2006)*

4.14 Awareness of the Mental Health (Northern Ireland) Order 1986

It is important that the level of restriction to which the service user is subject is proportionate to the risk that he/she presents. The emphasis should always be on recovery and working with the service user to determine how best to manage any problems that he/she might encounter.

Healthcare staff need to be aware of the powers available to them under the Mental Health (Northern Ireland) Order 1986 that can, if necessary, be used to minimise risk. Detention should always be used as a last measure where a service user is considered a significant risk to him/herself or others. Mental health and learning disability staff should not unduly restrict a service user by detention under this Order.

Where a voluntary inpatient, deemed to be at serious risk of causing harm to him/herself or others, indicates an intention to discharge himself or herself against medical advice, and a package of care has not been arranged, every effort should be made to persuade him/her to remain in the hospital until a package is agreed. In some cases the use of holding powers and detention may be appropriate.

Where holding powers and detention cannot be invoked, e.g. where a service user has been diagnosed as having a personality disorder only and he/she leaves the hospital before a suitable package of care can be put in place, it is essential that the hospital alerts those in the community who need to be aware of the situation. The responsible multidisciplinary team should agree a Care Plan in retrospect and identify a Key Worker and a person to carry out a care coordination role. Service users who discharge themselves against advice may still require and accept aftercare.

5.0 Learning from Adverse Incidents

In 2003, a statutory duty of quality was imposed on the services commissioned and provided by Health and Social Services Boards and Health and Social Care Trusts. Accordingly, these organisations are required to organise their structure to achieve integrated governance[23] in order to give equal priority to corporate, financial, clinical and social care matters.

Since 2003, HSC organisations have been required to comply with the core risk management controls assurance standard. The standard requires that there is "an agreed process for reporting, managing, analysing and learning from adverse incidents"[24].

Safety First: a framework for sustainable improvement in the HPSS (DHSSPS, 2006) sets out the Department's policy on safety. This includes the need to raise awareness of risk and to promote timely reporting of adverse incidents and sharing the learning across HSC environments.

In addition, the *Quality Standards for Health and Social Care* (DHSSPS, 2006) set out standards that the Department considers people should expect from HSC services. The standards are represented in five quality themes applicable to all HSC services and are "essential", i.e. the absolute minimum action necessary to ensure safe and effective practice. They are used by the RQIA to assess service quality and promote quality improvement across organisations.

In the context of this guidance, Theme 2, *Safe and Effective Care* – Criteria 5.3.1, *Ensuring safe practice and the appropriate management of risk and 5.3.2, Preventing, Detecting, Communicating and Learning from Adverse Incidents and Near Misses* have particular relevance to and impact upon risk assessment and management. The rationale for the theme states:

> *"Services must be delivered in a way that appropriately manages risk for service users, carers, staff, the public and visitors. Where an adverse incident has occurred or has been prevented from happening (a near miss), then systems need to be in place to assist individuals and organisations to learn from mistakes in order to prevent a reoccurrence" (DHSSPS 2006, 12).*

Accordingly, all adverse incidents involving service users known to mental health and learning disability services must be reviewed in such a way that enables lessons to be learnt and steps taken to reduce the likelihood of future similar events recurring.

Internal multidisciplinary reviews must be held as soon as practicable following an incident, to examine what happened and to make

23 *Establishing an Assurance Framework: A practical guide for management boards of HPSS organisations (DHSSPS, 2006)*
24 *Criterion 4 of the Risk Management Controls Assurance Standard*

recommendations as to how the service can be improved. These reviews should be in keeping with existing Departmental guidance *Health and Social Care Regional Template and Guidance for Incident Investigation/Review Reports* (DHSSPS 2007b) and regional good practice[25].

Dissemination of the key lessons learned along with the suggested evidence-based practice improvements should be communicated to frontline practitioners and disseminated through governance fora. As part of this, learning from adverse incidents should be targeted by sharing specific themes which occur regularly. It is also advisable that regular reviews of "near miss" untoward incidents take place as a "non-threatening" learning tool. A forum should be provided for all disciplines to record incidents and near misses to promote best practice.

There have been several local Independent Inquiries in recent years following homicides by people with a mental illness. The benefits for relatives in a thorough and transparent process have been apparent. Regional learning and the promotion of public confidence in the service are paramount.

5.1 Organisation and System-wide Learning

As previously stated, risk management is not just the responsibility of individual mental health and learning disability practitioners: it is the collective accountability of the multidisciplinary team and the wider organisation. Many adverse incidents occur as the result of a series of systems failures. However, it is not simply a matter of shifting responsibility from an individual to a blurred collective[26]. Rather, a reasonable balance must be reached between supporting an individual practitioner to make effective risk management decisions and the overall responsibility of the organisation to create a culture where there is a clear understanding of the complex issues surrounding risk. "It is recognised that in any organisation the principles should be 'what has happened' and 'how can we improve' rather than 'who made the error'"[27].

Clear arrangements, both regional and local, are required to ensure risk information is centralised and assimilated, as appropriate. Mental health and learning disability service providers should have robust clinical and social care governance systems in place that link in to the wider corporate risk management structure. This will ensure an integrated, organisation-wide response to tackling recurring risk issues.

HSC Trusts must tie in with established regional governance arrangements, and ensure that adverse incidents are consistently reported in accordance with DHSSPS and Regulation and Quality Improvement Authority Guidelines, and to comply with the Quality Standards for Health and Social Care.

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25 The review should be conducted in accordance with Mental Health Commission guidance (April 2006)
[26] Morgan S. (2007)
[27] DHSSPS (2007a)

6.0 Improving the Quality of Risk Management

6.1 Collaborative Working

Mental health and learning disability service users often require access to a wide range of interventions offered by various professionals. It is vital that all members of the multidisciplinary team providing care for the service user work closely together. Each discipline will have different professional skills, expertise and experience which, combined, will result in more informed risk assessments and management plans, and the formulation of comprehensive and appropriate Care Plans.

It is only when there is a firm commitment to this kind of team-working that staff will feel comfortable to examine their own practice with colleagues and learn from one another to create better outcomes for service users.

"Change can start now if there is sufficient commitment and vision in individual mental health services to make it happen" (Mental Health Commission Ireland, 2006).

6.2 Standardised Documentation

The RQIA's review of local practice found that there was a lack of consistency in the documentation used to assess and record the management of risk in HSC Trusts. In order to improve the quality of risk assessment and management processes, standardised assessment tools have been developed for use throughout mental health and learning disability services regionally. This should create procedures which are transferable across Trust boundaries and result in a standard approach to care planning. These tools are at section 8.0. The addenda (at section 9.0) also give guidance on appropriate tools for these specialist services.

6.3 Standards and Benchmarking

"What gets measured gets done". Risk assessment and management processes must be subject to audit, both internal and external, to ensure that they are effective in creating better outcomes for the service user. Ongoing monitoring of service delivery is vital to ensure that there are continuous checks and balances in the system, which will hopefully flag up any areas for improvement before an adverse incident occurs.

As noted above, HSC Trusts are to act collaboratively to develop an audit tool to assess compliance with this guidance. Governance reviews will be carried out by the RQIA, during which application of the risk assessment and management principles of this guidance may be assessed.

6.4 Training

Staff training in the assessment and management of risk is essential for improving the quality of risk management, and should be carried out as part of regular mandatory training for all mental health and learning disability staff, appropriate to their level. Staff need to be able to apply risk assessment tools competently and to use them, as appropriate, to inform risk management and care planning. To inform this, a "Training Needs Analysis" should be carried out as part of the implementation of this guidance.

The induction process for mental health and learning disability staff must include an overview of the local risk assessment and management process. Awareness and training sessions should be provided to the full range of mental health and learning disability staff, and other relevant staff who will be referring service users in to mental health and learning disability services. Refresher training should also be carried out, as necessary, where identified as a need through supervision.

HSC Trusts should develop information systems to record details of attendance at training events and be able to demonstrate that all staff have received relevant training on a regular basis.

6.5 Staff Support and Supervision

Clinical supervision is fundamental to developing safe and effective practice. It provides the opportunity to positively challenge professional practice to improve the quality of care.

Mental health and learning disability professionals benefit by continually developing their knowledge, skills, competence and confidence to provide the best care for service users in a protected, supportive environment. Regular supervision can also provide emotional support for this group of staff who regularly deal with difficult and complicated circumstances as part of their daily work. For managers, supervision is an opportunity to ensure that policy is being followed and professional standards are being maintained.

All mental health and learning disability staff should have the opportunity to share learning and receive support through clinical supervision, either on an individual or group basis. By making sure that risk, its assessment and management, is a regular aspect of clinical supervision, a contribution will be made to ensuring higher standards of care in mental health and learning disability services.

The guidelines developed by the DHSSPS Nursing and Midwifery Advisory Group, *Clinical Supervision For Mental Health Nurses In Northern Ireland: Best Practice Guidelines* (DHSSPS, 2004b) should be followed and the recommendations implemented throughout mental health nursing.

In order to further support staff, HSC Trusts should, as good practice, endeavour to put in place some of the following initiatives:

- *Multidisciplinary professional fora;*
- *Mentoring programmes;*
- *Champions at ward/team levels to support staff; and*
- *Group work sessions.*

7.0 The Way Forward

7.1 Implementation

The Department recognises that risk assessment and management cannot be solved by a policy and procedural response alone. These are fundamental systematic issues, which must take into account the anxieties of professionals, service users and their families/carers in order to facilitate improvement. This will require action and commitment by professionals, management teams and organisations, building on current good practice and experience.

Trusts must now:

- *Develop the protocols and procedures required to support implementation of this guidance;*
- *Use the standardised documentation (including the recommended risk assessment tools);*
- *Ensure staff are appropriately trained with regard to the use of risk assessment tools/documentation;*
- *Work collaboratively to develop an audit tool to assess compliance with this guidance; and*
- *Report regularly to the HSC Board on compliance with the elements contained in this guidance.*

7.2 Audit

The Department will commission from the RQIA an audit of compliance with this guidance, through the RQIA's programme of reviews, in 2011.

RISK SCREENING TOOL

NAME			DOB		DATE		TIME	
Outpatient / community		**Inpatient (insert Hosp No.)**			***Voluntary***		**Detained**	

INFORMATION SOURCES AVAILABLE / ACCESSED ON COMPLETING RISK HISTORY

Source		
Key Worker / Team Leader	Specify:	
Service user	Specify:	
Clinical notes	Specify:	
General Practitioner (GP) via referral	Specify:	
General Practitioner (GP) direct/ by telephone	Specify:	
Carer / relative	Specify:	
Police / probation services	Specify:	
Other (Please Specify)	Specify:	

PLEASE PROVIDE DETAILS UNDER EACH HEADING (HISTORICAL AND CURRENT)

SELF HARM / SUICIDAL BEHAVIOUR

	Yes		No		Unknown	

ALCOHOL/SUBSTANCE MISUSE

	Yes		No		Unknown	
If there is history of drug use, ever injected not under instruction of doctor	Yes		No		Unknown	

NEGLECT AND VULNERABILITY

	Yes		No		Unknown	

CHILS CARE AND VULNERABLE ADULT ISSUES (Specify arrangements for Children)

	Yes		No		Unknown	

PHSYICAL IMPAIRMENT (e.g. medical/ sensory)						
	Yes		No		Unknown	

DISSOCIAL OFENDING BEHAVIOUR						
	Yes		No		Unknown	

VIOLENCE &AGGRESSION						
	Yes		No		Unknown	

POTENTIAL DISENGAGEMENT/LOSS OF CONTACT/NON-COMPLIANCE/ABSCONDING						
	Yes		No		Unknown	

AREAS IDENTIFIED FROM MENTALSTATE ASSESSMENT						
	Yes		No		Unknown	

OTHER INDICATORS OF RISK						
	Yes		No		Unknown	

COLLATERAL HISTORY / RELATIONSHIP TO SERVICE USER
SUMMARY OF ACTIVE RISK
SUMMARY OF PROTECTIVE FACTORS

IMMEDIATE MANAGEMENT PLAN OF IDENTIFIED RISK ACTION	Name of Person(s) responsible	Signed:

CONTINGENCY ARRANGEMENTS
FURTHER ACTION NECESSARY **Discuss with Multidisciplinary Team** ☐   **Comprehensive Risk Assessment** ☐ **Specialised Risk Assessment** ☐   **Keep under review** ☐ **No further action required** ☐
DISTRIBUTION   **Service user** ☐ **Key Worker** ☐ **Other** ☐ **(specify)** ____________________________

Service User's signature: _______________________________________ **Date:** ____________________ **Refused to sign** ☐

Where signature refused, indicate reason ____

Signature: ____ **Date:** _____________________________

Designation _______________________________ **Contact Tel No:** ____________

Signature: ____ **Date:** _____________________________

Designation _______________________________ **Contact Tel No:** ____________

On inpatient admission - to be completed jointly by the admitting Doctor and nurse in consultation with the Family/Carers and others (if in attendance at time of admission).

RISK SCREENING TOOL – RECORD OF REVIEWS

NAME		DOB	

DATE/ TIME	UPDATE/ CHANGE IN RISK	ALTERATION TO RISK MANAGEMENT PLAN	LEAD RESPONSIBILITY	Signed:

AIDE MEMOIRE

SELF HARM / SUICIDAL BEHAVIOUR • Current suicidal thoughts, plans • Previous history of suicide attempts / self harm • Suicidal ideation / preoccupation • Family history of suicide / or recent loss • Access to means	**ALCOHOL / SUBSTANCE MISUSE** • Known history of alcohol / substance abuse • Currently misusing alcohol / substances • Known history of abusing stimulants • Previous non accidental overdose? • Consumption of alcohol, non-prescribed drugs, misuse of prescribed drugs / non concordance • Injecting drug use – see addictions addendum re hepatitis/HIV risk
NEGLECT & VULNERABILITY • Previous history of self neglect, inadequate housing, poor nutrition, poor hygiene • Current risk of self neglect • Risk of being exploited by others / history of exploitation • At risk of accidental wandering / falls / harm inside or outside the home	**CHILD CARE AND VULNERABLE ADULT ISSUES** • How many children? Ages? Carer? Custody arrangements • Vulnerable adult in household • Children currently on child protection register • Involvement of other services, eg, family and child care team, CAMHS, health visiting • UNOCINI done or needed • Threats violence to any child / children • Emotional abuse or neglect of any child / children • History of domestic violence
PHYSICAL IMPAIRMENT • Medical • Sensory	**DISSOCIAL & OFFENDING BEHAVIOUR** • Criminal history, including exclusion orders, bail • Conviction for violent offences • Conviction for sexual offences • Previously been a diagnosis made of psychopathy / antisocial personality disorder • History of containment - Special hospital, Medium Secure Unit, Locked Intensive Care Unit • Dissocial behaviours
VIOLENCE AND AGGRESSION • Previous violence, aggression or assault towards others including – other patients / staff / family / carers / general public • Talking of or planning to harm others • Display high anger, hostility, threatening behaviour • Threats against a particular individual • History of owning, carrying, using weapons • History of property damage • Arson (deliberate fire setting) • Sexual assault (includes touching / exposure)	**POTENTIAL DISENGAGEMENT** • Previous history of poor concordance with treatment / medication • Does the person understand his/her illness? • Does the person actively attempt to mislead others with respect to concordance with treatment? • Severe side-effects of medication • Unplanned disengagement from services • History of compulsory admission
MENTAL STATE • Appearance and behaviour • Speech • Mood • Perception, command hallucinations • Cognition • Mini Mental State • Insight • Previous history of serious mental illness • Thought content (over-valued ideas / delusions) • Relapse signatures	**RELATIONSHIP WITH RELATIVE / CARER** • Known history of threat / violence towards the relative / carer • Current risk of threat / violence towards the relative / carer • Known history of abuse towards the client
OTHER INDICATORS OF RISK • Recent severe stress • Concern expressed by others • Recurrence of circumstances associated with risk • Impending stressors e.g. court appearance • Abuse / victimisation by others • Social isolation • Lack of social or carer support system • High levels of stress of carer / high carer burden • Volatile personal relationships	**PROTECTIVE FACTORS** ▪ Willingness to engage with mental health services ▪ Compliance with medication ▪ Abstinence from alcohol/ drugs ▪ Family/ social support networks ▪ Faith/ religion ▪ Financial security ▪ Support from employer ▪ Weapons removed ▪ Fear of physical injury/ disability after failed attempt

- Nomadic lifestyle - Housing problems - Severe financial difficulties - Chronic medical illness - Terminal, painful or debilitating illness - Driving	**IMMEDIATE MANAGEMENT PLAN** - Action to be taken - Who is responsible for action - Date responsibility acknowledged - Need for some action to be recorded, even if discharge to GP. If so, record date GP informed.

COMPREHENSIVE RISK ASSESSMENT AND MANAGEMENT TOOL

NAME		DOB		DATE COMPLETED		TIME	
Outpatient/ community		Inpatient (insert Hosp No.)		*Voluntary*		Detained	

THOSE CONTRIBUTING TO RISK ASSESSMENT AND MANAGEMENT PLAN

NAME	ORGANISATION/ RELATIONSHIP	COPY SUPPLIED

FOR EACH HEADING WHERE RISK IDENTIFIED THROUGH SCREENING, PLEASE PROVIDE DETAILS (HISTORICAL AND CURRENT) (expand/delete sections below as necessary)
SELF HARM / SUICIDAL BEHAVIOUR
ALCOHOL/SUBSTANCE MISUSE (including injecting drug use)
NEGLECT & VULNERABILITY
CHILD CARE AND VULNERABLE ADULT ISSUES (Specify arrangements for care of any dependent children)
PHYSICAL IMPAIRMENT (e.g. medical/ sensory)
DISSOCIAL & OFFENDING BEHAVIOUR
VIOLENCE & AGGRESSION
POTENTIAL DISENGAGEMENT / LOSS OF CONTACT / NON COMPLIANCE / ABSCONDING
AREAS IDENTIFIED FROM MENTAL STATE ASSESSMENT
OTHER INDICATORS OF RISK

SUMMARY OF PROTECTIVE FACTORS

Overall Risk Summary		
Management Plan of Identified Risk Needs	**Intervention**	**Name of Person(s) responsible**
Contingency Plan Scenario (including Relapse Signatures)	**Intervention**	**Name of Person(s) responsible**

Service User's signature: ____ **Date:** _____________________ **Refused to sign** ☐

Where signature refused, indicate reason ____

Signature: ____ **Date:** ______________________ _______

Designation ________________________________ **Contact Tel No:** ____________

Signature: ____ **Date:** ______________________ _______

Designation _______________________________ **Contact Tel No:** ____________

COMPREHENSIVE RISK ASSESSMENT TOOL – RECORD OF REVIEWS

NAME		DOB	

DATE/ TIME	UPDATE/ CHANGE IN RISK	ALTERATION TO RISK MANAGEMENT PLAN	LEAD RESPONSIBILITY	Signed:

AIDE MEMOIRE

SELF HARM / SUICIDAL BEHAVIOUR • Current suicidal thoughts, plans • Previous history of suicide attempts / self harm • Suicidal ideation / preoccupation • Family history of suicide / or recent loss • Access to means	**ALCOHOL / SUBSTANCE MISUSE** • Known history of alcohol / substance abuse • Currently misusing alcohol / substances • Known history of abusing stimulants • Previous non accidental overdose? • Consumption of alcohol, non-prescribed drugs, misuse of prescribed drugs / non concordance • Injecting drug use – see addictions addendum re hepatitis/HIV risk
NEGLECT & VULNERABILITY • Previous history of self neglect, inadequate housing, poor nutrition, poor hygiene • Current risk of self neglect • Risk of being exploited by others / history of exploitation • At risk of accidental wandering / falls / harm inside or outside the home	**CHILD CARE AND VULNERABLE ADULT ISSUES** • How many children? Ages? Carer? Custody arrangements • Vulnerable adult in household • Children currently on child protection register • Involvement of other services, eg, family and child care team, CAMHS, health visiting • UNOCINI done or needed • Threats violence to any child / children • Emotional abuse or neglect of any child / children • History of domestic violence
PHYSICAL IMPAIRMENT • Medical • Sensory	**DISSOCIAL & OFFENDING BEHAVIOUR** • Criminal history, including exclusion orders, bail • Conviction for violent offences • Conviction for sexual offences • Previously been a diagnosis made of psychopathy / antisocial personality disorder • History of containment - Special hospital, Medium Secure Unit, Locked Intensive Care Unit • Dissocial behaviours
VIOLENCE AND AGGRESSION • Previous violence, aggression or assault towards others including – other patients / staff / family / carers / general public • Talking of or planning to harm others • Display high anger, hostility, threatening behaviour • Threats against a particular individual • History of owning, carrying, using weapons • History of property damage • Arson (deliberate fire setting) • Sexual assault (includes touching / exposure)	**POTENTIAL DISENGAGEMENT** • Previous history of poor concordance with treatment / medication • Does the person understand his/her illness? • Does the person actively attempt to mislead others with respect to concordance with treatment? • Severe side-effects of medication • Unplanned disengagement from services • History of compulsory admission
MENTAL STATE • Appearance and behaviour • Speech • Mood • Perception, command hallucinations • Cognition • Mini Mental State • Insight • Previous history of serious mental illness • Thought content (over-valued ideas / delusions) • Relapse signatures	**RELATIONSHIP WITH RELATIVE / CARER** • Known history of threat / violence towards the relative / carer • Current risk of threat / violence towards the relative / carer • Known history of abuse towards the client
OTHER INDICATORS OF RISK • Recent severe stress • Concern expressed by others • Recurrence of circumstances associated with risk • Impending stressors e.g. court appearance • Abuse / victimisation by others • Social isolation • Lack of social or carer support system • High levels of stress of carer / high carer burden • Volatile personal relationships	**PROTECTIVE FACTORS** ▪ Willingness to engage with mental health services ▪ Compliance with medication ▪ Abstinence from alcohol/ drugs ▪ Family/ social support networks ▪ Faith/ religion ▪ Financial security ▪ Support from employer ▪ Weapons removed ▪ Fear of physical injury/ disability after failed attempt

• Nomadic lifestyle • Housing problems • Severe financial difficulties • Chronic medical illness • Terminal, painful or debilitating illness • Driving	**IMMEDIATE MANAGEMENT PLAN** • Action to be taken • Who is responsible for action • Date responsibility acknowledged • Need for some action to be recorded, even if discharge to GP. If so, record date GP informed.

Addendum on Child and Adolescent Mental Health Services (CAMHS)

Background

To complement the production of the main guidance, it was recognised that there was a need for guidance in relation to the legislation, policies and procedures which staff need to take account of in their day-to-day work with children and young people who have emotional, psychological or psychiatric disorder.

Generally, the main guidance applies equally to children. This addendum, however, identifies circumstances where there are noteworthy differences between practice in the adult and child and adolescent arenas.

This addendum should, therefore, be read in conjunction with the core good practice guidance.

Context

Good assessment and the management of risk is integral to the treatment and care of children and young people.

The State, in accordance with the principle of Parens Patriae, has additional duties to children and young people, which it and its agents, such as Health and Social Care Trusts, Education Services and other statutory providers, must discharge in a responsible manner.

The Children Order requires that children are *children first* regardless of disability or illness. For CAMHS, this means that children and young people with emotional, psychological and psychiatric disorders who are patients should be treated and cared for as *children first*. The value base of CAMHS is family-oriented: this enable families and carers to be partners in the treatment and care of their children and young people. In addition to providing treatment and care directly to children, a key objective of the service is to help parents/carers better understand, manage and care for their children when they have a mental health or psychological problem.

Practitioners working with children and young people are part of a wider network of support. This includes family and other professionals, tasked with providing care, treatment, or support to the child or young person and his or her carers. To achieve effective risk assessment and management requires staff to work within a multi-agency, multidisciplinary and family context.

To assist them to contribute effectively to the multidisciplinary and family support networks, it is important that CAMHS professionals are aware of the additional responsibilities for children placed on statutory agencies, such as the Trusts' Family and Childcare Services which have the lead responsibility for discharging the Trusts' child protection responsibilities.

Generally, children and young people referred to CAMHS are not suffering from a mental disorder requiring their detention and treatment under the Mental Health (Northern Ireland) Order 1986 (the Mental Health Order). The mental health care

of children is, therefore, usually provided under the general duty in Article 4 of the Health and Personal Social Services (Northern Ireland) Order 1972, to provide integrated Health Services which promotes the physical and mental health of the people of Northern Ireland.

Legislative Base

Of particular relevance to CAMHS professionals, is the legislative base set out in the Children (Northern Ireland) Order 1995 (the Children Order) to safeguard and promote the welfare of:

- children in need;
- children in need of protection; and
- looked after children.

Health and Social Care Trusts are responsible for discharging statutory functions, delegated to them by the Health and Social Care Board under Schemes for the Delegation of Statutory Functions. These functions are discharged on behalf of each Trust by its Family and Childcare Programme. The HSC Board monitors performance against the Schemes on an annual basis.

Children in Need

Article 18 of the Children Order places a general duty on each Trust to safeguard and promote the welfare of children who are in need: this includes children with emotional, psychological and psychiatric disorders.

Article 17 of the Children Order states that a child is in need if:

a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of personal social services;
b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or
c) he is disabled.

Where children are assessed and identified as children in need under Article 17, Trusts are required under Article 18 to provide a range and level of personal social services appropriate to their needs. In so doing, the Trust discharges its general duty to safeguard and promote the welfare of children in need. A number of children in need will require the support of CAMHS professionals in addition to the Trusts' social care services.

Under the Children Order, there is no authority to admit or detain a competent child or young person in hospital against his or her wishes, or to prevent a child from leaving hospital because of mental health concerns. Such detentions can only be achieved through the provisions of the Mental Health legislation.

Children in Need of Protection

The Department's guidance *Co-Operating to Safeguard Children* (DHSSPS, 2003) and the Health and Social Services Boards' Area Child Protection Committees' Regional Child Protection Policy and Procedures, 2005 (ACPCs'

Policy and Procedures) set out the responsibilities of all agencies, professionals and services working with children to assist with the recognition of potential indicators of abuse and to be aware of their roles and responsibilities to assist with the protection of such children, including the requirement to share information with the Trusts' Family and Childcare Services. The sharing of information ensures that a comprehensive and holistic assessment can be made of the child's needs and circumstances to underpin the development of a Child Protection Plan to ensure the child's safeguarding needs are met.

Compulsory intervention in family life by a Trust is underpinned by its specific duties in Article 66 of the Children Order to safeguard and promote the welfare of children suffering or at risk of suffering harm. Article 50(3) of the Children Order sets out the criteria by which a judgement can be made whether the harm a child has suffered amounts to significant harm. In practice, however, mental health and other professionals' responsibilities are to consider whether there is reason to believe or suspect that a child has been abused, or is at risk of abuse.

Child abuse occurs when a child is neglected, harmed or not provided with proper care and may take the form of physical, emotional and/or sexual abuse, or neglect. CAMHS professionals should familiarise themselves with the ACPCs' Child Protection Policy and Procedures in relation to the definition of abuse (Paras 2.3 – 2.5). Guidance on significant harm is also available at Paras 2.6 – 2.14.

Each CAMHS staff member must be aware of his/her obligation to safeguard children in circumstances where harm or the likelihood of harm to the child is identified. In such cases, Departmental guidance and ACPCs' Policy and Procedures are clear that a referral must always be made to the Trust's Family and Childcare Services, through the relevant Gateway Team or Out-of-Hours Social Work Service. Each CAMHS professional must be aware of his/her obligation to safeguard children and to co-operate with the Trust's Family and Childcare Services, in circumstances where they identify abuse or the likelihood of abuse.

In some circumstances, the harm posed to a child may not come from a member of his or her family. This does not alter the duty to refer such children to the Trust's Family and Childcare Services for assessment.

Children who are in Need of Protection as a Result of Engaging in Risk-Taking Behaviours

In some situations, risks to children result not from the harm that may be caused to them by others, but rather from their own risk-taking behaviours. In these circumstances, the approach often taken is to offer support to the parents or care givers to ensure that they are better able to care for their children. Where risk-taking behaviours include self-harm and/or a risk of suicide, a thorough assessment of treatment and care needs and safety planning must be prioritised by CAMHS. This should be completed on a multidisciplinary and multi-agency basis. Where CAMHS professionals assess that the family situation is contributing to the risk-taking behaviours they should ensure that a referral is made to Trusts' Family and Childcare services to enable an assessment and support to be provided to the children and his/her family, as appropriate.

As a family-orientated service, CAMHS professionals recognise the importance of working with parents and carers. Young people in distress sometimes may, however, have mixed feelings about their parents/carers. This can place CAMHS professionals in a difficult position where risks are identified due to the young person's behaviours. Whilst seeking to preserve the rights of young people to confidentiality, CAMHS professionals should in the first instance work with children to gain their support for sharing information with their families in an effort to keep children safe. Ultimately, however, where the risks are significant, CAMHS professionals may have to breach confidentiality. In such instances, the young person should be advised that disclosures will be made either to parents/carers and/or social services.

No simple definition of a family exists. Sometimes children will be living in one parent families or families which have been reconstituted. When assessing children who are deemed to be in need or at risk, it is important to remember the role that is being played, or could be played, by the absent parent who may still retain parental responsibility for the child and be in a position to offer additional help and support.

Looked after Children

A child or young person is described as *looked after* when provided with accommodation for more than 24 hours by a Trust, either with his or her parents' consent, or through a Court Order placing the child in the care of a Trust. Each Trust has Corporate Parenting responsibilities to children whom it looks after. Like any other parent, the Trust has the duty to ensure the physical, social, emotional, educational and spiritual development of children or young person whom it looks after. The Trust's Family and Childcare social workers are responsible for fulfilling statutory functions on behalf of the Trust as a whole.

A significant number of the children and young people who are looked after have suffered loss, trauma or abuse. They are, therefore, a population with a disproportionate need for CAMHS support. CAMHS staff provide an important element of a wider range of support services which the Trust as a Corporate Parent will need to provide to children whom it looks after.

Article 174 (6) of the Children Order states that where a child or young person has been an inpatient in any hospital setting for more than 3 months, or the intention is that this will happen, then they are regarded as being accommodated. This means that where a child remains in hospital beyond the 3 months (or indeed for any period less than 3 months) for clinical reasons, i.e. is receiving medical care and treatment which cannot be provided in the child's home or in another community setting, the child is not accommodated within the meaning of Article 21 of the Children Order and Looked After Children (LAC) provisions do not apply.

However, where the child is in hospital for 3 months or is likely to be in for 3 months or more for clinical care and treatment, the Trust's community family support team, or the hospital based social worker, should be involved to assess the child and family needs as many families require support even in terms of the needs of other children in the family if they have to visit sick children for long periods. The Trust should, therefore, be asked to undertake an assessment of family needs at or before the conclusion of the 3 month period.

However, if a child's clinical care and treatment has been completed and he/she is fit to be discharged, but a lack of community resources are preventing that discharge, then the child becomes a looked after child and subject to all LAC provisions. The social worker is required to develop, with hospital colleagues, a plan which seeks to meet the child's basic developmental needs and at regular intervals to review and monitor that these needs continue to be met. This arrangement is regulatory in nature and parental responsibilities remain with the child's parents.

Risk Assessment Process

The process identified in the main document can be adopted by CAMHS staff for use with children and young people.

All incoming referrals should be screened in terms of clinical need and risk, to determine which element of CAMHS, or indeed any other service, is most appropriate to deal appropriately with the referral. It is important, therefore, that referrals contain all relevant details about any likely risks and their source.

CAMHS professionals should ensure that their generic assessment of risk is consistent with UNOCINI, the regional multidisciplinary assessment tool utilised within Family and Childcare Services. This will help to ensure a consistent approach for all professionals working within children's services. Further work is necessary for this to be realised.

Many children or young people who need emotional, psychological or psychiatric support can receive assistance from their General Practitioner, education or youth justice services, particularly if these services themselves are supported by an experienced CAMHS professional. Referrals to tier 2 services such as these should be the subject of risk screening.

All tiers 3 and 4 referrals to specialist CAMHS provision should be risk assessed. This includes a mental state assessment, which should address specifically the risk of self-harm or suicide.

CAMHS professionals should adopt the CAMHS FACE Risk Assessment Tool, which has equivalence to the comprehensive assessment as part of the main document. This is an evidence-based, multi-professional tool which has been developed over a 10-year period through collaboration of senior practitioners from around the United Kingdom.

The CAMHS FACE Risk Assessment Tool:

- is a systematic tool structured to enable safe clinical judgement, risk analysis and care formulation. The tool is supported by a validated scoring system designed to quantify both dynamic and static risk factors.
- assesses risk to self, risk to others and from others and places risk formulations in the context of the young persons history, taking full account of both family and social dynamics.
- promotes a "Strengths/Protective" factor based approach to risk management by proactively involving young people and their families in the identification and management of risks and needs.

- supports clinical supervision/governance arrangements through internal validation/clinical audit/outcome measures. The tool also supports the measurement of practitioner, team, and organisational 'risk-load.
- integrates with case management approaches.
- interfaces with the recording of serious incidents and near misses.
- includes specialist supplement in relation to forensic/substance misuse/dual diagnosis risk assessment
- is supported by in-depth training based on "training the trainer cascade methodology".
- A FACE risk profile should be completed by all tier 3 and 4 CAMHS services at point of contact with the child, young person and family system. This should be reviewed as part of overall care plan.

The model of initial, comprehensive and specific risk assessments is in keeping with the overall model advocated in the main part of this guidance for adult mental health.

Care Planning and Risk Management

The principles set out in the main guidance are applicable to Child and Adolescent Mental Health Services.

Risk assessments and management plans should always be incorporated into treatment and care plans and not be perceived as separate documents. There is a need to design such a document that could be used across the region.

Roles and Responsibilities of CAMHS Staff

CAMHS staff will fulfil the role of Key Worker or Care Co-ordinator.

Key Worker Role

For children and young people with complex or challenging needs, there are likely to be a number of agencies involved, some of which also will have identified staff as Key Worker. This is particularly the case for the Trusts' Family and Childcare staff, who in many instances will be discharging statutory duties. It is, therefore, important that there is clarity about the roles, responsibilities and powers ascribed to each Key Worker, where there is more than one.

The main guidance, setting out the roles and duties of a Key Worker, where the role is to organise and maintain the mental health services needed by the patient, is applicable also to CAMHS staff.

The Care Coordinator Role

The Care Co-ordinator role is new to CAMHS. The main guidance describes the role as supporting and facilitating the Key Worker and multi-disciplinary team in the delivery of agreed Care Plans, ensuring that appropriate services are available and coordinating deputies when Key Workers are not available. The Co-ordinator is also responsible for chairing multiagency reviews at intervals of 6 months, or more frequently if required, for each service user who is subject to

comprehensive risk assessment and risk management planning. Generally, these are individuals who are deemed to be at greatest risk to themselves or to others.

For CAMHS to introduce Care Co-ordination would require a review of all cases, to determine those which meet the *greatest risk* criterion. It will, however, take some time before such an approach is bedded in.

Where Care Co-ordination is deemed necessary and the Trust has, through its Family and Childcare Programme, other statutory duties to the child, then there should always be discussion to ensure that the these roles are clearly understood to avoid confusion or duplication and to ensure all statutory duties take precedence. Even with clarity regarding the distinct roles of Family and Childcare social workers, the use of Care Co-ordination will have resource implications for CAMHS.

Given that Care Co-ordination is used only in cases where the individual is deemed to be at *greatest risk to him/herself, or to others*, it is clear that the service needs to develop systems and processes to monitor and manage the care of individuals within this category. The concept of a Risk Register is not unanimously supported, albeit that it is recognised that some form of recording arrangements are necessary.
This is an issue which requires further discussion.

Confidentiality

The principles underpinning confidentiality set out in the main document are applicable to children and young people. The duty of care owed to children and young people is, however, in sharper focus given their increased vulnerability and dependence on adults. The ethos of a family-orientated service such as CAMHS should mean that every effort is taken by CAMHS professionals to ensure that parents are aware of the risks that their children's behaviour may pose.

Under the European Convention on Human Rights, children and young people have a right to confidentiality. A case by Gillick established the concept of increased competence to make decisions as children matured (*Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (HL)). **Gillick competence** is a term originating in England and is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Further information for staff is available in the Consent Guidance issued by DHSSPS in 2003 (*Good Practice in Consent).*

A key determinant of any child or young person's right to confidentiality is his or her competency to make such a decision. The determination of competency is a decision taken by the clinical team. Where it is deemed that the child is not competent, there is no duty on the professional to adhere to the child's request for confidentiality. Best practice requires that sharing information without consent is fully discussed with the young person; provided it will not compromise the safety of others or a possible police investigation.

The main guidance sets out the circumstances in which practitioners may disregard the patient's right to confidentiality, even where the patient is deemed to be competent: that is, where it is believed that there is a significant risk of harm to that adult or a belief that the adult poses a significant risk to the wider public. This

guidance applies also to children and young people. Indeed, professionals are under an obligation to take all necessary steps to protect the child or young person or the wider society, and are not bound by the duty of confidentiality.

Transfer and Transitions

The main guidance is deemed to be appropriate to the transfer of children and young people's cases.

Disengagement from the Service

The main guidance covering the circumstances where patients are not keeping appointments or maintaining treatment plans is appropriate for children and adolescents.

Additionally, it is good practice to proactively obtain the individual's and family's consent to share relevant information with other agencies. Given the often multiagency nature of work with children and young people, this would allow the concerns of CAMHS staff about disengagement from the service to be shared with other services/professionals who are still in contact with the child or family, thus enabling them to be better informed and potentially more vigilant.

In every instance, decisions to discharge children and young people from CAMHS should be taken only after assessment, which should include an assessment of any risk factors. The concept of an automatic discharge based upon failure to keep appointments, as a procedural response, should cease.

Discharge Planning

In general terms, the main guidance is applicable to children and young people.

An assessment of risk is necessary in each instance where a young person is discharged.

Where a discharge of a child or young person is taking place contrary to medical advice, consideration should always be given as to whether it is appropriate to detain the patient under the Mental Health Order. Where the threshold for detention does not exist, but CAMHS professionals have concerns about the capacity of the parents to adequately protect and safeguard their child, then these cases should be referred to Social Services. Where a young person is reluctant to return home, this should always be treated as an issue of concern which requires closer investigation and discussions with Family and Childcare social work staff to ensure the child's concerns are appropriately addressed.

Addendum on Forensic Mental Health and Learning Disability Services

Introduction

Forensic Mental Health and Learning Disability Services (forensic services) deal with some of the most disturbed and difficult to manage patients in psychiatric practice. Such services focus on the assessment and treatment of individuals with mental disorder, whose behaviours may bring them into contact with the Criminal Justice System (CJS), either because of the seriousness of their offending behaviour or their potential dangerousness. Their work is carried out predominantly, but not exclusively, at the interface between the Criminal Justice System and Mental Health/Learning Disability Services at both community and inpatient level.

Risk assessment and management is a core activity of HSC organisations and this is particularly evident in the delivery of forensic services. The term 'risk assessment and management' can cover a wide range of activities, ranging across corporate risk, financial risk and clinical risk. This framework, however, deals specifically with the process of assessing 'clinical risk' i.e. the risk posed by an individual to themselves or others because of their behaviours, in those who have been referred to forensic services and to support the development of a robust management strategy that minimises such risks.

As the assessment and management of people who may present a risk is not exclusively the domain of forensic services, the principles outlined in this framework should be assimilated into other areas of service delivery. Applying the principles of this framework alongside the main guidance and the NIO (2009) Guidance on Public Protection Arrangements, Northern Ireland, will support consistency of approach across HSC services.

Risk Assessment and Forensic Services

'Risk assessment informs risk management planning, which in turn informs subsequent assessment and planning in a live and dynamic process that continues throughout the lifetime of the offender,' (Risk Management Authority, 2007).

A significant bulk of the risk assessment work undertaken by forensic services tends to focus around the topic of violence, whether that is purely physical acts of aggression or sexual violence. Various tools have been developed to facilitate this process of risk assessment and management and include, for example, the HCR20, SARA, RSVP, Risk Matrix 2000 and the Stable and Acute Dynamic Assessment (Hanson and Harris 2007). The first three are used predominantly within the Health sector and the last two used predominantly within the Criminal Justice sector. However, although agencies are using a range of risk assessment tools, it is important to note that the tools used have been validated for their specific purpose and can be used together to influence the detail of risk management plans.

Regardless of the tools used in forensic services, as in other services there is a need for sound risk assessment involving appropriate methods used by trained and experienced staff, with risk assessment clearly linked to a risk management plan, and effective inter-agency communication arrangements in place.

Key Principles of the Risk Assessment and Management Process

Risk assessment by forensic services will:

- Be a live, dynamic, proactive process;
- Be based on collaborative multi-agency/multidisciplinary working, with timely communication and responsible information sharing;
- Be undertaken by appropriately trained staff;
- Show evidence of a thorough review of the relevant available information;
- Show evidence of the application of structured professional judgement involving utilisation of evidence-based, validated assessment tools that are fit for purpose;
- Produce a formulation of the risk, to include the robust risk management strategies with contingency planning and regular timely review;
- Address victim issues as part of the process; and
- Show best endeavours to elicit the cooperation of the individual under assessment.

Key Processes

1. Collaborative Working Arrangements

In order to effectively plan and implement risk management strategies, forensic services must put in place robust multi-agency and multidisciplinary working arrangements. This facilitates the collation of the diverse range of views and expert opinion that contribute to improved shared risk management. A central tenet of these arrangements will be effective, timely communication and responsible information sharing. This may involve the Public Protection Arrangements Northern Ireland (PPANI) and will ensure compliance with child protection responsibilities.

2. Client Engagement

Forensic services will use their best endeavours to positively engage, where possible, with the individual being assessed throughout the risk assessment and management process. This has the potential to promote compliance and co-operation with the risk management strategies being developed and implemented.

3. Risk Assessment

Forensic services will carry out risk assessment, not as a static process, but as a dynamic and continuous process that responds to changes in the individual's circumstances, as they occur. Forensic services will also ensure that the frequency of risk assessment reviews is dependent on the situation in which the individual finds him/herself: for example, an individual detained within a secure setting is likely to require less frequent risk assessment reviews than someone in a community setting.

In order for forensic risk assessments to be effective, they will incorporate the following dynamics:

- Clear evidence that there has been a thorough review of the relevant and available information collected from case files, records and interview sessions;
- The information collected must be applied to an evidence-based, validated risk assessment tool that is fit for purpose;
- There should be evidence that structured professional judgement has been utilised to support the identification of relevant and critical risk and protective factors;
- There should be a formulation of the risk that includes the nature, severity, imminence, frequency and likelihood of re-offending.
- Clear working examples of possible future risk scenarios that risk management plans will seek to avert;
- The risk formulation will also include information on the likely impact of the offending behaviours and to whom the offender poses a risk of serious violent or sexual harm:
    - **i.** Relevant risk factors (static, stable dynamic, acute dynamic);
    - **ii.** Active protective factors; and
    - **iii.** Early warning signs that risks are escalating.

For risk management to be effective, the information must be analysed and contextualised as to its soundness and relevance. Agencies/organisations that request a risk assessment from forensic services do not want a catalogue of events drawn from records and presented in a report. They require the information to be set in the context of the individual's experiences and circumstances. Therefore, any risk assessment that does not go beyond the information collection and collation process has no validity and would not support the principle of defensible decision-making.

4. Risk Management Planning

Risk management is the natural progression from risk formulation. It is the process whereby the validated and analysed information is developed into a risk management plan. Forensic services must develop plans which evidence the link between the identified risk factors/active protective factors and the risk management strategies employed to manage the risk.

Robust risk management involves strategies that exert external controls (monitoring, supervision, interventions) whilst attempting to enhance or maintain the individual's internal controls (motivation, self-agency, personal control, self-determination).

The risk management strategies being employed in forensic services must be:

Sufficient to manage as effectively as possible the risk posed;
Appropriate to the individual and the individual's situation;
Relevant to the risk factors;
Evidence-based; and
The *least restrictive* necessary.

Although all risk management plans will undergo regular review, particularly in the earlier stages of implementation, it is important to identify a review date, ideally in the near future, but certainly no longer than three months from last review or the initial implementation to ensure that the principles of risk management, i.e. that the level of intervention is guided by the individual's level of risk, still applies. Adopting this approach promotes the principles of defensible decision-making, thus ensuring necessity, proportionality, non-arbitrary, evidence-based, transparent processes in the decision-making process.

Risk management is enhanced considerably if the individual is motivated to participate in establishing and attaining the goals of the risk management plan.

5. Roles, Responsibilities, Communication, Co-ordination

All risk management plans developed by forensic services will clearly identify the roles and responsibilities of the various agencies/personnel involved in the implementation of the plan. Lines of communication, including contact numbers and names, will be included. Contingency plans should describe the course of action to be taken should the risk scenario change. The risk management plan should also clearly identify the case coordinator who will carry overall responsibility for the implementation of the risk management plan, and be the single point of contact for others involved in the delivery of the plan.

Addendum on Addictions Services

Introduction

Most addiction treatments are delivered within a menu-led service. In this way, most people negotiate their own management plan within the first few appointments and most people referred to Addiction Services play an active part in their own risk reduction plan.

Intravenous Drug Use

Use of the intravenous route to administer drugs carries particular risks to well-being. These include direct injecting risks with a danger of ischemia or embolus, both of which may lead to limb loss or death. In the early stages of injecting drug use there is a particularly high risk of accidental overdose because of the rapid onset of the drug effect. Over time, veins become sclerosed and the intravenous drug user may start to use significantly more dangerous injection sites such as groin or neck injecting, either of which may lead to significant illness or death. Infection may be introduced to the body without the normal means of defences. In particular, sharing of injecting equipment may lead to transmission of viruses including HIV and the various forms of hepatitis.

Harm Reduction

Because of the significant risks associated with intravenous drug use, management of those who do inject drugs normally follows a "harm minimisation" route. Individuals are encouraged to move away from more risky injecting behaviour into slightly safer oral drug use. This is encouraged through the Substitute Prescribing Services, which deliver high quality, focused education and direct intervention to reduce these risks. At Public Health level, needle exchange schemes, operated through community pharmacies, provide geographic access to injecting equipment with education to reduce the likelihood of sharing equipment.

The harm minimisation interventions have been shown to have effectiveness in reducing the spread of viruses at population level and should be acknowledged as risk reduction within the population.

Substitute Prescribing

Substitute Prescribing Services, in addition to the provision of substitute medication, give counselling and significant levels of psychosocial support to those attending for this service. In addition, they provide counselling and testing for the blood borne viruses: HIV; hepatitis B; and hepatitis C. They also provide vaccination against hepatitis B in people who have not developed antibodies, as well as onward referral and continued support to engage in treatment services for hepatitis C and HIV. This requires good liaison with Hepatology Services and the HIV Services for affected individuals. Such intensive, consistent client working as been shown to reduce the likelihood of continued illicit drug use and to reduce the medical and psychiatric morbidity associated with it. It has also been shown to significantly reduce associated criminal behaviours and to reduce the chaotic nature of the person's lifestyle.

Outreach

Those who inject drugs (usually Opiates) are frequently reluctant to engage in mainstream service treatment because of the very intensive nature of this treatment, as described in the previous paragraph. Outreach Services may provide a means of encouraging such people to access the mainstream services. They can also encourage use of other forms of harm minimisation, such as education about the dangers of injecting, safer injection techniques and safe sex. They can also encourage attendance at the needle exchange facilities available through the community pharmacies.

Reinstatement Overdose

Services must be alert to the risks of reinstatement overdose and death in injecting drug users, following voluntary or enforced abstinence. (Education of patients in this area forms part of recognised good practice in harm minimisation work. It is particularly important in custodial settings such as Prisons and Custody Suites as well as in services which encourage abstinence from Opiate drugs).

Children Affected by Drug Use of Others

Children may be affected by the drug and alcohol use of parents, siblings, or others within their family. The presence of addiction in a family member can lead to faulty family communications, disruption of the family system and inappropriate role modelling. In extreme cases, there may be parental neglect or physical, mental or sexual abuse of children either as a direct result of parental or other family substance use or the chaotic lifestyle potentially associated with it.

Risk assessment in Addiction Services must take account of this issue and as part of every assessment procedure there should be an attempt to establish whether there are any children within the family or with significant exposure to influence from the person with an identified substance misuse problem. Trusts must have clear policies and procedures regarding referral to Child and Family Childcare Services of any identified risk.

There is increasing recognition that services should be provided for families of those with the more serious elements of addiction or existing inappropriate family functioning. Clear protocols and policies must be in place to ensure appropriate referral between agencies and acknowledgement of the different roles of the respective agencies. Liaison must also be encouraged at all levels of these processes.

Those with Co-existing Mental Illness

The co-occurrence of substance use problems and psychiatric illness is often referred to as “dual diagnosis”. Within this document, the more narrow definition of “dual diagnosis” has been adopted: that is, those with severe and enduring mental illness and a co-occurring substance use problem. The overlap between serious mental health problems and alcohol and drug use is significant. Half of all patients with Schizophrenia have substance missue disorder and 50 to 60% of people with Bipolar Disorder have substance use disorder. Such co-morbidity is

associated with heavy use of psychiatric inpatient care, poor treatment compliance, poor prognosis and high offending rates.

Patients' needs may be multiple rather than "dual" and may include medical and social care needs in addition to straightforward psychiatric and substance use services.

Good risk management includes identification of the relevant risks presenting to either service and good liaison between the relevant services involved to develop the most appropriate care plan for the individual. Such patients frequently present to Psychiatric or Substance Misuse Services in an "emergency", with acute psychiatric disturbance made significantly worse by the presence of substance intoxication. Joint service involvement is appropriate to develop "longitudinal" treatment plans in order to best enable substance misuse interventions to be delivered at a time when the mental health problem is stable.

Some substances, particularly alcohol, Cannabinoids, hallucinogens and stimulants can produce psychotic symptoms directly without the presence of mental illness and without apparent vulnerability to these. The psychotic state may be sufficiently severe to warrant input from the Psychiatric Services if it persists beyond the spell of simple substance intoxication. The management of florid symptoms may, at times, require management through the Mental Health (Northern Ireland) Order 1986, if they are not simply the result of intoxication.

Primary Care Management of Psychiatric Conditions Within Addiction

Chronic heavy use of any addictive substance, including alcohol, may lead to neurotic conditions, including minor levels of depression, anxiety and other neurotic illneses. These are conditions, which are normally managed properly within Primary Care and for which the individual would not be expected to come into contact with the Secondary Care Psychiatric Services.

Workers within Substance Misuse Services should be capable of assessing, correctly identifying and managing these disorders, in partnership with the General Practitioner, at community level. They should also be able to adequately screen and identify more serious levels of depressive illness or other psychiatric illness, which may need referral to the Secondary Care Psychiatric Services for management.

The converse of this is that those working within the generic mental health services should be able to screen, identify and deliver brief interventions on addiction issues to those presenting with substance use problems as a manifestation of a psychiatric disorder requiring treatment. There should be policies and guidelines regarding referral in each case and regarding the liaison and communication between service personnel, when appropriate.

Those Who Self-harm

This group of people is "vulnerable" in terms of the relative risk of further self-harm or completed suicide in the 10 years after an episode of self-harm. The behaviour is frequently associated with substance use, which in itself, may be viewed by the patient as a form of self-harm. All Addiction Services staff should be able to carry out a screening risk assessment and should be able to carry out an assessment of risk of self-harm in individuals who have such a history.

The act of carrying out the risk assessment will, in many cases, be a useful piece of addiction work as it may help the individual to identify potential harms resulting from continued substance use. This may serve a "motivational" purpose and will enable the individual to become meaningfully involved in the development of plans to reduce his risk in the future. There are 2 significant management issues in this subgroup of patients.

a. Identification of Major Psychiatric Illness

Any person presenting to Addiction Services with a history of self-harm should have a full diagnostic screen to exclude the presence of depressive illness or other significant psychiatric illness. Any identified illness should be managed within Primary Care, but with the ability to refer for psychiatric opinion and management, if considered necessary. The identification and treatment of mental illness will reduce the risk of completed suicide.

b. Attention and Management of the Substance Misuse Issue

The act of addressing and managing a substance misuse issue will, in itself, reduce the likelihood of further self-harm regardless of the existence of other mental illness. There are various reasons for this, including the reduction in the depressed mood associated with chronic substance use, the positive attitude engendered by "dealing with" or undertaking to deal with a lifestyle issue and the associated social enhancement inherent in many addiction treatments. It should also be acknowledged that much self-harm behaviour is carried out while under the influence of alcohol or drugs so that the natural inhibitions are reduced.

Containment or amelioration of the addiction problem may lessen the likelihood of this. It should be borne in mind, however, that addiction is a chronic, relapsing condition. While some individuals can gain significant improvements (including cessation of substance use per se) of their illness during a spell of treatment, the risk of future relapse to substance use is very high and the risk appears to remain on a lifetime basis. Even with intensive, supportive management, only about 50% of the people attending services can expect significant amelioration of their substance use problem.

Pregnant Drug and Alcohol Users

In the case of pregnant women, risks to the mother and risks to the foetus must both be considered.

Risks to the mother include the normal sequelae of excessive drug or alcohol use, the unavailability of some of the normal pharmacological treatments because of the danger of teratogenicity, the potential for a difficult pregnancy and a difficult labour, risks of poor pregnancy outcome and the possibility of having to raise a child with significant disability.

Risks to the foetus include teratogenic affects from the drugs of misuse, potential teratogenic affects of treatments and substitute offered or prescribed (effects generally seen in the first 10 to 12 weeks of pregnancy), potential developmental delay and difficulty in assessing foetal dates (effects seen from substance use throughout pregnancy), potential for premature delivery and for complicated

labour (during this last 12 weeks of pregnancy), the potential for withdrawal syndrome manifesting in the foetus in the neonatal period, risk of death at any time during pregnancy or the neonatal period and risks of severe developmental delay or organ malfunction during childhood.

Pregnant women who use substances should have easy access to services for drug and alcohol misuse. Access should be signposted from Primary Care, and from Maternity Services and Addiction Services should prioritise these cases so that they are assessed as soon as possible after referral.

A variety of agencies must be involved in every instance. These include the normal Maternity Services as well as the normal child health services available to all women. There should be protocols and policies in place across services to enable easy access across services and to enable consultation liaison interactions without barriers and without waiting lists. There should be protocols for full and open sharing of information between the Addictions Services, Obstetricians, Community Midwives and the Childcare Social Services, where appropriate.

As the majority of care during pregnancy takes place within Primary Care, it is essential that the General Practitioner and the Primary Care structures are similarly fully informed. This enables good planning during pregnancy by the individual services and enables early decisions about optimum timing of delivery and management of delivery. Good aftercare services are also essential for both mother and infant to ensure optimum outcome.

For most women, advice and information about substance use should be available within Primary Care and should be delivered at the point where pregnancy is considered or as soon as a pregnancy is identified. Primary Care Services will normally refer more complicated cases to Addiction Services if it is considered that dependence on a substance is present, if the mother shows significant resistance to drug reduction or if a complicated withdrawal is envisaged.

Multiple substance use would often also be referred to Addiction Services. A full assessment should be made of substance use of the mother and her goals and aims for the pregnancy. Her motivation should be assessed to manage her substance use and advice and motivational interviewing are appropriate at this point.

It is imperative that women with undisclosed pregnancies should be encouraged to access the Maternity Services in order to establish the maturity of the foetus as early as possible. All complicated cases should involve the multidisciplinary team and should have a full assessment of risk carried out on the various domains, which appear relevant. There will often be additional involvement of the criminal justice services and there may additionally be issues of domestic or partner violence.

Children's Addiction Services

Most children who take drugs do so in a limited way and most learn over time to control their drug use. There are 2 significant sub-groups who may be at risk of additional harm.

a. Those Who Have Significant Pre-existing Psychological Problems

These children will often use drugs or alcohol in larger quantities then their peers and may use in isolation to their peers. They may demonstrate other high-risk behaviour such as truancy, conduct disorder, self-harm or other psychiatric disorder.

These children should be identified and should properly be referred to the Child and Adolescent Mental Health Services for assessment and management. Such children should be identified through screening processes by specialist services dealing with substance misuse in children and young people. These must have clear internal protocols and policies and must have strong links with the Child and Adolescent Mental Health Services at local level. There should be clear protocols and clear referral pathways.

b. Children Who Develop Significant Substance Misuse Problems

Those under the age of 18 may develop physical or psychological addiction to a drug of misuse, including alcohol. The management of children with addiction or other serious substance use problems should take place within the context of "child-centred" treatment.

There should be a holistic model of management, which takes into account the child's developmental level, other physical or psychiatric problems and should operate within the family environment and setting. Treatment models will normally include systemic family therapy and attention to education and all of the child's needs. They should also include specialist addiction work input by competent, trained staff.

Trusts should have policies and procedures in place for referral of all such children and should ensure that there is access to service provision for this age group. Good liaison is essential across the family and childcare network to ensure good and appropriate communication between the various agencies, which may be involved. Such children should not be exposed to adult substance misuse populations because of the risk of initiation of more dangerous drug taking behaviours or sexual behaviours.

Screening and Assessment Tools

The risk screening tool is appropriate for addiction services.

Similarly, the comprehensive assessment tool is appropriate to use to identify the nature of risk in cases where the screening process identifies specific risk, and where this is applied in specific cases, with the decision to apply made on the key worker's considered decision. It would not, for example, be appropriate to use automatically in all cases as most addiction cases are dealt with by a single case worker. Involvement of the multidisciplinary team in every case would require a staff resource which would be impossible to meet.

These more detailed instruments would be used as appropriate to describe and manage risk in cases that have been opened by the addiction services and which will require intensive support. All identified risk should be shared with the referrer, but it cannot all be managed from these low intensity, high volume services. The

priority has to be to identify reversible risk, such as psychiatric disorder, and risks posed to children. Addiction services should identify (screening) and refer to appropriate services, where they exist, issues like personality disorder and self-harm.

Annex

Risks Associated with Substance Abuse

Accidents

Most morbidity and mortality associated with substance use is due directly to accidents associated with intoxication. Alcohol and drug use account for a high proportion of road traffic accidents and fatalities, domestic accidents and work-related accidents. Mortality is highest in young adults and naive substance users from direct intoxication. Accidental overdose is a further significant cause of morbidity and mortality in this group. Serious accidents of this sort frequently arise in those who are not addicted to substances and who do not present to Addiction Services. Public Health advice and opportunistic advice from Primary and Secondary Care staff is an important part of prevention of such untoward events.

High-risk Behaviours

Substance use is associated with high-risk behaviour such as joy-riding, sexual promiscuity and high-risk ingestion of substances such as cigarette smoking and intravenous injection of drugs. Those who use alcohol or drugs have higher rates of deliberate self-harm than the general population. Continued excessive substance use in itself may be regarded as a form of “self-harm” with significant mortality rates, particularly in the case of alcohol, and significant levels of physical, psychiatric, and social disability resulting directly from substance misuse. Social disability includes major domestic effects including domestic violence, employment loss and interaction with the criminal justice system.

Lifestyle Choice

Those who develop significant dependence on a substance may develop a chaotic lifestyle. This results directly from the addictive process as the person’s life becomes increasing focused around obtaining and taking the drug of choice. Commitments and responsibilities become increasingly neglected and there will be increased self-neglect. This includes neglect of nutrition, of sleep, of grooming and self-care and neglect of normal social interaction. The dependent person often becomes isolated as he or she seeks to avoid influences which might moderate use of the drug of choice. Interventions to decrease the risk include treatment of the addiction process or, in more severe cases, harm reduction as a means of reducing risk.

Intravenous Drug Use

Use of the intravenous route to administer drugs carries particular risks to well-being. These include direct injecting risks with a danger of ischemia or embolus, both of which may lead to limb loss or death. In the early stages of injecting drug use there is a particularly high risk of accidental overdose because of the rapid onset of the drug effect. Over time, veins become sclerosed and the intravenous drug user may start to use significantly more dangerous injection sites such as groin or neck injecting, either of which may lead to significant illness or death. Infection may be introduced to the body without the normal means of defences. In particular, sharing of injecting equipment may lead to transmission of viruses including HIV and the various forms of hepatitis.

Harm Reduction

Because of the significant risks associated with intravenous drug use, management of those who do inject drugs normally follows a "harm minimisation" route. Individuals are encouraged to move away from more risky injecting behaviour into slightly safer oral drug use. This is encouraged through the Substitute Prescribing Services, which deliver high quality, focused education and direct intervention to reduce these risks. At Public Health level, needle exchange schemes, operated through community pharmacies, provide geographic access to injecting equipment with education to reduce the likelihood of sharing equipment.

The harm minimisation interventions have been shown to have effectiveness in reducing the spread of viruses at population level and should be acknowledged as risk reduction within the population. Outreach Services may help reduce risk in those unwilling to engage with mainstream services.

Addendum on Adult Learning Disability Services

Introduction and Context

Within learning disability services, an integral component of sound, robust and safe care delivery is the consideration of risk, and how that risk is effectively assessed and managed, in whatever context it arises. Learning disability services (statutory and non-statutory) work with a heterogeneous, diverse and often vulnerable service user group, and consequently, the concept of risk often presents in a range of different contexts

This addendum, specific to the adult learning disability population, is focused on identifying a small but significant number of individuals who, alongside their learning disability, may also have substantial additional psychiatric, personality, forensic and/or behavioural needs, and who consequently may present with significant risks to self and/or others. Such circumstances require processes of risk screening to be in place, to identify those presenting with the most significant risks and then, for robust, collaborative, and comprehensive risk assessment and management processes to be established, where appropriate, in order to minimise the risk and reduce the potential of harm to self and/or to others.

This addendum only applies to adults. Children with a learning disability should be considered in the context of the CAMHS addendum.

It should be noted that the future direction of service delivery will result in more people with a learning disability (mostly mild to borderline learning disability) receiving services from mainstream mental health, CAMHS and other specialist services such as forensics. In these circumstances, the service in question should use the risk assessment processes that are used routinely with other service users who use that particular service.

The Main Guidance

The principles, fundamentals and processes of risk assessment and management outlined in the main guidance are equally applicable within the field of learning disability. However, a number of key principles and issues that have particular relevance to the field of learning disability include the need to:

- ensure that professionals completing risk assessment and management plans utilise a human rights-based approach (see section below);

- consider proactive/preventative risk reduction measures in the formulation of risk management strategies, including protective factors and individual wishes and strengths;

- involve people with a learning disability and/or their carers in the process of risk assessment and management. Outcomes are likely to be more positive for all concerned if staff optimise the participation of service users and carers in the processes and the decisions made (see section below);

- ensure implementation of the processes and systems across and within other services and agencies (considering the impact on service commissioning and contracts) involved in care delivery to the learning disabled population to whom this addendum applies;

- ensure that risk assessment and management processes utilise positive risk-taking strategies, where appropriate. Overstating risks and being overly risk-averse carry human rights implications for the service user and resource implications for services, and can also lead to unnecessary exclusion from services and stigmatisation;

- ensure shared, multi-professional, and multi-agency collaboration and accountability, with individual practitioners feeling confident and competent to make risk management decisions within a supportive organisational structure;

- promote consistency and standardisation of process and documentation across all care settings in Northern Ireland; and

- consider the impact of these developments from a resource, training and supervision perspective across all involved agencies.

A Human Rights Based Approach

All of the human rights protected by the European Convention belong to and may be relevant for learning disabled people. There are a range of issues that need to be carefully considered in the risk assessment and management process for people with learning disabilities. For example, the individual's right to human rights such as freedom and choice may need to be balanced against the need to protect the individual and/or society's right to protection. Therefore, professionals completing risk assessment and management plans must consider the impact on an individual's human rights, particularly when they are considering interventions such as enhanced supervision, use of medication, or other restrictive practices such as physical restraint. In such circumstances, the least restrictive option needs to be carefully considered. In other circumstances, principles of choice and freedom (e.g. the right to have a sexual relationship) may override the need for protection, recognising that within the right circumstances, taking positive risks can be beneficial, yet still require to be carefully managed.

Consequently, the risk assessment and management process in this addendum places strong emphasis on a human rights-based approach, which means:

a) enabling meaningful involvement and participation of **all** key people, and, in particular, service users;
b) encouraging a positive and proactive approach to risk taking and risk management;
c) considering the least restrictive option(s); and
d) applying the principle of proportionality in all risk management strategies, whereby the management of the risk must match the gravity of potential harm.
   (Mersey Care NHS Trust 2008)

Accessible information relating to Human Rights can be found on the Equality and Human Rights Commission website.

http://www.equalityhumanrights.com/pages/eocdrccre.aspx

Involving Service Users and Carers

One of the most fundamental components of any human rights-based approach is involvement of the person concerned and the people who care for him/her. Consequently, the principles stated within the main guidance (Sections 3.4 and 4.8) are fully applicable to the learning disability population.

It is particularly important that staff are open and honest about the purpose and process of risk assessment and management and facilitate service users' and family/carer participation in the process. Consequently, it is important that efforts are made to make the process and documentation amenable and accessible. For example, summary and easy-read versions of the decisions made may have to be developed for some service users.

Family members and carers know the service user best and will have first-hand information about his/her history, behaviours and situation. Involving all relevant stakeholders from the outset in gathering information, in generating ideas and solutions will ensure a positive risk-taking approach and will help in the understanding of risk from various perspectives. Most importantly, such an approach will clarify the responsibilities of each person involved in managing risks effectively.

Positive risk-taking may not be suitable for all service users, and it is likely that there will be occasions where the professional's views and those of the service user and or the family/carer will differ. These need to be discussed and worked through to reach agreement as to what are acceptable risks, recognising that it may not always be possible to achieve full agreement. In such circumstances, the key worker needs to ensure that consideration of consent guidance, mental health legislation and human rights law have been made to ensure that any agreements are within the appropriate and acceptable frameworks. It is essential to recognise the potential within services and family carers for risk aversion that leads to the significant limitation of the person's life experiences and personal development.

In such circumstances, advocacy services can play an important intermediary role, giving service users the opportunity to express their views and concerns, assisting them to make informed decisions, and encouraging their personal responsibility for their ongoing care and treatment.

Service users may also refuse permission for information to be shared with particular family members and relatives for a variety of reasons: such wishes should always be taken into account. Clarification of those who should and should not be communicated with should be clearly noted in the service user's Care Plan. Professionals will, of course, need to fulfil their legal obligations to contact the service user's next of kin, where appropriate, under the Mental Health (Northern Ireland) Order 1986.

The issue of consent needs to be very carefully considered within the learning disability arena. The DHSSPS provides informative guidance regarding consent in the document "Seeking consent: Working with people with learning disabilities" (DHSSPS, 2004). However, recognising and understanding the issues involved in informed consent is often challenging, specifically where the individual's judgement is at odds

with that of the professionals/carers involved. Care needs to be taken that incapacity is not assumed relating to decision-making for people with learning disabilities, and shared discussion and decision-making should guard against such incidents in each case.

Further clarification around confidentiality, disclosure and consent can be found in the Code of Practice on Protecting the Confidentiality of Service User Information, http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf.

Risk Assessment and Management in Everyday Practice Within Learning Disability Services

The main guidance focuses on 4 distinct categories of risk:

- Risk of harm to self;
- Risk of harm to others;
- Risk of harm to children/vulnerable adults; and
- Risk of harm from others and individual vulnerability.

Considering the preference to have a common and shared framework/protocol across both mental health and learning disability services, these 4 categories will remain the predominant focus within the screening and comprehensive risk management processes.

Although the categories of risk will be universal across learning disability and mental health services, the specific sub-set of risks within each category will be different. An aide memoire (Appendix 1 to this addendum) has been developed to assist staff, users and carers to consider the nature of risk that may be relevant within each category. This aide memoire is however simply a guide to the processes of risk screening, and when completing the more comprehensive risk assessment and management plan. It does not provide a definitive or exhaustive list.

It is also known that people with learning disabilities are vulnerable to exploitation, coercion, harassment, abuse, intimidation and bullying. In this context, the risk assessment and management process will complement and support vulnerable adults' processes.

The Process of Risk Assessment and Management in Learning Disability Services

Considering that the majority of individuals with a learning disability who present to services will not require a risk assessment and management plan in this context, the process of risk assessment and management within learning disability services will follow a slightly different pathway from that outlined in Section 4 of the main guidance. Arrangements within learning disability services, will involve the following 4 stage process:

1. Routine initial assessment;
2. Risk Screen;
3. Comprehensive and/or Specialised Risk Assessment and Management Plan; and
4. Review.

Stage 1. Routine Initial Assessment

Routine initial assessment will take place as is currently the case for every individual who presents for community-based learning disability services. It is good practice for all types and levels of risk (where apparent) to be thoroughly explored at the initial assessment phase. Trusts should, therefore, satisfy themselves that the routine assessment processes utilised at various points of access to learning disability services will identify needs, in the context of additional behavioural, forensic, personality or psychiatric co-morbidity that may benefit from a risk screen.

It is anticipated that for the high majority of service users with a learning disability, there will be no need to move to the next stage of risk screening in the context of additional behavioural, forensic, personality or psychiatric needs.

Indicators of need to carry out a risk screen may include:

- A history of violence or harm to others;
- Involvement with the Criminal Justice System;
- Inappropriate sexualised behaviour;
- A history of being easily led/exploited by others;
- Any issues regarding access to children; and
- Behaviour change as a consequence of mental health deterioration.

NB. IN CIRCUMSTANCES OF ADMISSION TO HOSPITAL, THE RISK SCREEN SHOULD BE COMPLETED FOR ALL NEW ADMISSIONS.

Stage 2. Risk Screen

When it is decided to complete the risk screen (Appendix 2), this will be completed by the relevant named nurse and admitting doctor (hospital) or named/key worker (community). Clearly, other relevant members of the multi-disciplinary team will be involved in this process. As is stated within the main guidance, screening need not be time-consuming and formalised, but should be conducted as part of the overall assessment of need. This approach will encourage a therapeutic relationship and should be seen as part of good clinical practice.

Depending on the risk factors identified in the risk screen, a decision will need to be taken whether or not to progress to completion of the comprehensive risk assessment and management plan (Appendix 3) or, indeed, a specialised risk assessment process (see below).

There is no definitive threshold for such decisions. Clinical judgement, rather than specific scoring/rating systems, should inform decision-making through the stages of risk assessment and management. These decisions will be made by the relevant multidisciplinary team members involved in the service user's care, the line manager, and will include the service user and relevant carer(s).

This process should identify those individuals who have additional forensic, personality, psychiatric, and/or behavioural needs, **and** who present with

significant risks to self and others, **and** who require a more comprehensive assessment and management plan to address the risks that present.

Although not a definitive or exhaustive list, possible triggers for completion of the comprehensive risk assessment and management plan will include a previous history of involvement by the service user in activity such as:

- Sexual assault (as victim or perpetrator)
- Arson
- Exploitation
- Violence
- Self-harm
- Concerns regarding access to children

At the routine assessment stage it may be immediately apparent that a comprehensive or specialised risk assessment will be required. However, in many circumstances, the comprehensive/specialised risk assessment process and management plan may not be able to be initiated immediately. Therefore the risk screen will still need to be completed in order to provide an immediate and interim risk management plan.

The risk screen should be used as an interim measure for no longer than **28 days**.

NB. The risk screen also prompts the assessor to identify risks relating to physical health, such as epilepsy, complex health needs, risk of aspiration etc. However, this tool is specifically designed to assess and manage risks related to additional forensic, personality, psychiatric and behavioural needs. Therefore, any physical health risks identified at screening should be addressed via alternative risk assessment and management pathways (e.g. manual handling risk assessment).

Stage 3. The Comprehensive Risk Assessment and Management Plan

If a decision is taken to complete the comprehensive (or specialised) risk assessment and management plan, a key worker and care coordinator (Section 4.5 of main guidance) should be identified.

The key worker should ensure that the process of risk assessment and the development of the risk management plan is completed within 28 days of the risk screen being completed.

From a community perspective, completion of the comprehensive risk assessment and management plan (Appendix 3) should be facilitated by the key/named worker, although it is essential that it is contributed to by relevant members of the multidisciplinary team. Within the hospital setting, a member of the hospital staff will be responsible for facilitating completion of the comprehensive assessment and management plan. The multi-disciplinary team will agree who is best placed to take on this role. The service user and family members/carer(s) should (where possible and appropriate) be fully involved in the risk assessment and management process.

Accurate history-taking plays an important role in the process of risk assessment. Relevant information should be obtained from health records and referral letters, as well as by asking service users themselves, carers, and other family members. It is important to obtain past records from other hospitals, districts, or social services departments and a history of criminal offences (where applicable).

Sometimes it may not be possible to obtain sufficient information to conduct a thorough and accurate assessment: immediately, in which case, this should be recorded and arrangements made to seek relevant information at a later stage. Self-reliance on information provided by service users should always be considered in the context of other available information.

The subsequent risk management plan must be based on the outcome of the above assessment, whereby the multidisciplinary team share responsibility for ensuring that risk is minimised, as far as possible, and managed effectively. The management plan should ensure that there is an appropriate balance between protection and ensuring that the service users psychological, physical and social needs are addressed, and that human rights are not compromised.

Within the risk management plan the following areas should be considered:

a) Triggers and warning signs;
b) Proactive and preventative strategies;
c) Reactive and emergency strategies; and
d) Human rights considerations.

Within risk assessment and management, proactive and preventative strategies, rather than simply reactive approaches are more likely to have long term impact and are more consistent with a human rights based approach. Such proactive strategies may include:

- Putting in place a suitable social activities programme to reduce boredom and social isolation
- Provision of sex education
- Referral for psychological therapy
- Skills teaching such as anger/stress management
- Managing the environment e.g. reduction in noise or activity
- Education and training of staff in relation to behaviour management, communication, mental health needs etc.
- Referral to the relevant behaviour support team
- Increasing the availability of appropriate support (e.g. family, carers, professionals, community workers, advocates, accommodation needs, day care needs, Probation Service etc);

Reactive strategies are an immediate or emergency response to the specific risks identified, and may include:

- Increasing the frequency of home visits
- Increasing the level of observation
- The use of prescribed medication
- The use of prescribed physical intervention

- The use of legal processes such as the Mental Health (Northern Ireland) Order 1986 or calling the police

Where the risk management plan identifies needs that cannot be met, these must be recorded in the “unmet needs” section and immediately brought to the attention of the relevant line manager. Any dispute or disagreement should also be recorded in the relevant section and immediately brought to the attention of the relevant line manager.

When completed, the risk assessment and management plan should be signed by the service user and/or his/her principal carer. Should either be unable or unwilling to sign the reason(s) should be clearly recorded. The risk assessment and management plan should also be signed by the key worker/caseload holder, and all who contributed to its completion and should be signed by the care co-ordinator/line manager.

In finalising and agreeing the risk management plan it is good practice to consult with and involve those people who will be expected to deliver and monitor it. Consultation, therefore, should also take place with relevant service providers and other carers. Care delivery can take place in a range of different environments, including inpatient settings, day care, residential care, and in the person’s home. The risk assessment and management plan should therefore be integrated with other support plans such as the person’s Essential Lifestyle Plan or Service Plan as a process of best practice. This information should be recorded in the section “Communication and information sharing process”

Specialised Risk Assessment

Although it is anticipated that in most circumstances the generic risk assessment process will suffice, there will be some occasions when an adult with a learning disability presents risks in areas such as extreme violence and aggression, sexual violence, offending behaviour and suicide. In these circumstances, the following considerations should be helpful in ensuring a robust approach to specialised risk assessment and management tools/processes.

Most of the research and evidence base around specialised risk assessment tools has taken place within mental health settings. However, the literature on the use of specialised risk assessment tools in the learning disability population reflects increased recent interest in exploring the validity of tools developed within forensic or general mental health practice for this population.

Evidence is now growing that the following tools are useful and valid for the assessment of people with a mild/moderate learning disability who present with significant risks in areas such as violence, arson, sexual violence or other inappropriate sexual behaviour:

- HCR-20 - (Historical, Clinical, Risk management–20, Webster et al., 1997)
- PCL-SV - (Hare Psychopathy Checklist: Screening Version (PCL:SV), Hart et al., 2004);
- VRAG - (Violence Risk Appraisal Guide, Quinsey, 2003);
- RRASOR - (Rapid Risk Assessment of sexual offence recidivism, Hanson, 1997);

- Static-99 - (Hanson and Thornton, 1999);
- RAMAS - (Risk assessment, audit and management systems, O'Rourke and Hammond, 2004);
- RSVP - (The Risk for Sexual Violence Protocol, Hart et al., 2003);
- SARN – (Structured Assessment of Risk and Need, Thornton, 2002).

The development of new tools for specialised risk assessment with people with a learning disability has also progressed in recent years. Validation work continues on DRAMS (Dynamic Risk Assessment and Management Systems, Lindsay et al., 2004) a tool for the assessment of dynamic risk factors that is designed to be used collaboratively and specifically with service users with a learning disability. It shows evidence of effectiveness for both risk assessment and therapeutic purposes.

The ARMIDILLO (Assessment, Risk Management of Intellectual, Developmental or Learning Disabled Offenders, Boer et al., 2007) is also currently undergoing validation and shows a high level of face validity in its consideration of both internal and environmental risk factors.

These specialised risk assessments are likely to be undertaken by a relatively small number of clinicians and efforts should be made to ensure a degree of consistency across the region. Further clarification on the range of tools appropriate and available for use with those service users with a learning disability who present risks in these specific areas should be sought from the responsible medical officer, and/or local/regional forensic leads within the Learning Disability Service.

It should be noted that the need to utilise a specialised risk assessment process may become apparent having gone through all the stages of risk assessment. Equally, the need for specialised risk assessment may become apparent at the screening stage.

Stage 4. The Review Process

The level of risk and success of the management plan will determine the frequency of review, but in general it is expected that reviews should take place at least 6-monthly for those who have had a comprehensive or specialised risk assessment completed. Section 4.3 of the main guidance provides clarity in respect of the review process, and similar approaches to review should take place within learning disability services.

At review, it is important that relevant information is brought to the table, including any incidents/near misses since previous review, any changes in unmet needs, any changes in personnel, and what worked and what didn't in managing the risk. A format to assist in the review process is provided in Appendix 4 of this addendum.

It is recognised that there may be regional variation in the use of routine assessment (stage 1) formats for individuals who present to learning disability services. However, the same processes and documentation formats for stages 2 and 3 should be used consistently across the region. The review process (Stage 4) and forms should also be used consistently across the region.

Hospital Admission and Discharge Planning

As outlined in the main guidance, the key to good risk assessment and management for service users admitted to any inpatient assessment and treatment facility is effective communication and liaison between community and hospital personnel. Most admissions of learning disability service users to hospital are as a consequence of risk to self/others, or significant vulnerability. Consequently, it is recommended that **all** new admissions to hospital have a risk screen carried out on admission (which may be a review of a previous risk screen that has already been completed). This is necessary to inform the decision regarding the need for further in depth comprehensive or specialised risk assessment.

As outlined earlier, there may be circumstances where it is immediately apparent that a comprehensive or specialised risk assessment will be required. Once again, in acknowledging that the comprehensive/specialised risk assessment process and management plan may not be able to be initiated immediately, the risk screen will need to be completed in order to provide an immediate and interim risk management plan.

The risk screen should be used as an interim measure for no longer than **28 days**.

As part of safe and effective care delivery and robust discharge planning, the multidisciplinary team (including hospital and community personnel), the service user and carer, should be involved in determining and agreeing whether the comprehensive or specialised risk assessment and management plan needs to be applied on discharge. This decision should be routinely documented as part of the discharge planning process. For further guidance on the process of discharge planning, please refer to Section 4.11 of the main guidance.
As already highlighted, a member of the hospital staff will be responsible for coordinating the comprehensive risk assessment and management plan. The multi-disciplinary team will agree who is best placed to take on this coordinating role.

Interface arrangements

Service users who have a learning disability will encounter a range of other transitions and interface arrangements: e.g. between children and adult services; within generic health and mental health settings; and with other agencies (housing and employment). To effectively manage such circumstances and maintain continuity of risk management, the same principles as outlined in the main guidance (Sections 4.9 and 4.10) should be applied.

Protocols governing the interests of service users between and within services/agencies need to be developed by learning disability service providers to ensure clear guidance for staff in maintaining and reviewing risk management plans at such times.

Co-ordination Responsibilities

Considering the wide range of services and agencies that may be involved in the delivery of care and support to adults with a learning disability, critical to the success of effective risk assessment and management is a coordinated approach.

As outlined in the main guidance, statutory agencies will have lead and coordinating responsibility. Therefore, this responsibility will either be held by community learning disability teams for community-based service users, or by the learning disability hospital if an individual is admitted to that setting (see above). Without a designated lead/coordinating agency, there is the potential for confusion, duplication and disjointed application.

As stated above, many non-statutory and other agencies may be involved in the delivery of care and support to individuals, and to assure effective risk communication, the lead individual/service must ensure that information available is documented and communicated to all those who need to have access to it, in order to effectively care for the service user and protect him/her/others from the risks identified within the risk assessment (see Section 3.5 of the main guidance).

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Appendix1

AIDE MEMOIRE FOR LEARNING DISABILITY SERVICES

NB, THIS IS AN AIDE TO BOTH THE SCREENING AND THE COMPREHENSIVE RISK ASSESMENT PROCESSES AND IS NOT AN EXHAUSTIVE LIST

RISK OF HARM TO SELF

- Previous history of suicide attempts / self harm
- Suicidal ideation / preoccupation
- Family history of suicide / or recent loss
- Alcohol/ substance misuse.
- History of self harm or self injurious behaviour.
- Reckless behaviour.
- Impulsive behaviour
- Sexualised behaviour causing concern such as, promiscuity/exploitation

RISK OF HARM TO OTHERS

- Previous violence, aggression or assault towards others including – other patients vulnerable people / staff / family / carers / general public
- Actual or suspected criminal history.
- History of violent/sexual offences or assaults
- Previously been a diagnosis made of psychopathy / antisocial personality disorder
- Talking of or threats to harm others
- Display high anger, hostility, threatening behaviour
- History of owning, carrying, using weapons
- History of property damage or arson

RISK FROM OTHERS AND VULNERABILITY

- Known history of abuse towards the individual (physical, financial, sexual).
- History of being targeted/bullied
- History of being easily led and exploited by others.
- Previous history of poor engagement with services/ treatment / medication
- Problems coping with severe stress (e.g. bereavement)
- Current/previous history of severe self neglect, inadequate housing, poor nutrition, poor hygiene

CHILDREN AND/OR VULNERABLE ADULTS AT RISK

- Previous concerns regarding access to children.
- Service user has been linked to formal vulnerable adult processes.
- Involvement of other services, eg, family and child care team, CAMHS, health visiting.
- Threats of previous harm to, or preying on any child / children or other person.
- Emotional abuse or neglect of children
- History of family or domestic violence
- History of volatile personal relationships

THE FOLLOWING AREAS SHOULD ALSO BE CONSIDERED TO INFORM THE SCREENING, RISK ASSESSMENT AND MANAGEMENT PLAN PROCESSES

MENTAL STATE (IF APPLICABLE)

- Previous history of mental illness and associated risk behaviour
- Delusions and/or hallucinations (command) associated with risk behaviour.
- History of emotional distress associated with risk behaviour
- Relapse indicators.
- Medication effects, side effects and concordance.
- Previous involvement in therapy for anger management..

ENVIRONMENTAL FACTORS

- Suitability of the living environment (e.g. in design, or proximity to potential victims, access to intoxicants)
- Staffing levels
- Staff skills , attitudes and competencies
- Communication systems
- Lack of purpose and structure to day to day life

OTHER POSSIBLE INDICATORS OF RISK

- Recent severe stress/loss.
- Concern expressed by others
- Impending stressors e.g. court appearance
- Lack of social or carer support system
- Difficulties managing or coping with social and personal relationships
- Nomadic lifestyle
- Housing problems
- Severe financial difficulties
- History of compulsory admission
- Social isolation.

HUMAN RIGHTS CONSIDERATIONS

- Involving service users and carers (where appropriate) throughout the process. Consent process followed
- Consider wishes of service user
- Consider skills and strengths of the individual
- Utilise the least restrictive option
- Consider what is important "to" the service user
- Consider communication needs
- Facilitate understanding of the process
- Provision of appropriate and accessible information
- Consider advocacy arrangements
- Proportionality should be considered
- Emphasis on proactive and preventative strategies

POTENTIAL PROTECTIVE FACTORS

- Willingness to engage with learning disability services
- Compliance with medication
- Abstinence from alcohol/ drugs
- Effective family/ social support networks
- Faith/ religion
- Financial security
- Having a job / constructive activity
- Ability to communicate
- Belief that change is possible
- Previous approaches used successfully to manage risk
- Positive risk taking

ADDITIONAL RISKS (REQUIRING ALTERNATIVE PATHWAYS OF REFERRAL OR INTERVENTION)

- Complex physical health needs
- Specific co-morbid conditions such as Epilepsy, Diabetes etc. and associated risks
- At risk of accidental wandering / falls / harm inside or outside the home.
- Risks associated with nutrition/swallowing/aspiration
- Risks associated with daily living (e.g. road safety, fire safety etc)

Appendix 2

RISK SCREENING TOOL FOR LEARNING DISABILITY SERVICES

NAME		**DOB**		**DATE**		**TIME**	
Outpatient/ community		**Inpatient (insert Hosp No.)**		***Voluntary***		**Detained**	

INFORMATION SOURCES AVAILABLE / ACCESSED FOR COMPLETING RISK SCREEN		
Key Worker / Team Leader	Specify:	
Service user	Specify:	
Clinical notes	Specify:	
General Practitioner (GP) via referral	Specify:	
General Practitioner (GP) direct/ by telephone	Specify:	
Carer / relative	Specify:	
Police / Probation Services	Specify:	
Other (Please Specify)	Specify:	

PLEASE PROVIDE BRIEF DETAILS UNDER EACH HEADING ***(in particular, you should consider the likelihood and consequences of the risk behaviour taking place)***

RISK OF HARM TO SELF	**Yes □ No □ Unknown □**
RISK OF HARM TO OTHERS	**Yes □ No □ Unknown □**
RISK FROM OTHERS AND VULNERABILITY	**Yes □ No □ Unknown □**

CHILDREN AND/OR VULNERABLE ADULTS AT RISK	**Yes** □ **No** □ **Unknown** □
ASSESSMENT OF MENTAL STATE (IF APPLICABLE)	
ENVIRONMENTAL FACTORS THAT MAY BE ENHANCING THE RISK	
OTHER INDICATORS OF RISK	
CURRENT PROTECTIVE FACTORS	
OTHER RISKS HIGHLIGHTED DURING SCREENING *(NB: This section may highlight other risks such as risks associated with epilepsy, or risk of falls which will indicate the need for alternative pathways of risk assessment such as epilepsy risk assessment or manual handling risk assessment).*	
COLLATERAL HISTORY (INCL. RELATIONSHIP TO SERVICE USER)	

SUMMARY OF CURRENT RISKS:

(NB. *Should any risk issues have been identified in the above section, and the decision is* ***not to*** *proceed with the full risk assessment and management documentation, please specify reasons here).*

IMMEDIATE MANAGEMENT PLAN OF IDENTIFIED RISK

ACTION	LEAD RESPONSIBILTY	Signed/Date

Risk screen completed by:______________________ Designation: _______________

Date: __________________

Contact Tel. No. ___________________

Signature of Medical Officer *(for inpatient admissions only)* _____________________

Designation: ______________________ Date: _______________________________

Contact Tel. No. __________________________________

Service user signature: ____________________________ **Date:** ____________________

Unable/Refusal to sign ☐ Please explain:

Carer signature: __________________________________ **Date:** ____________________

Unable/Refusal to sign ☐ Please explain:

Is a comprehensive risk assessment and management plan indicated? Yes ☐ No ☐

Is a specialised risk assessment and management plan indicated? Yes ☐ No ☐

IF NO, PLEASE OUTLINE ACTION TAKEN____

Line Manager Signature: __________________________ **Designation:** ___________________

Date: ___________________

Contact Tel. No. ___________________

DISTRIBUTION
Service user ☐ Carer/Family member ☐ Key Worker ☐ Other ☐ (specify)

IF COMPLETING COMPREHENSIVE RISK ASSESSMENT AND MANAGEMENT PLAN:

KEY WORKER WIL BE: ____

CARE CO-ORDINATOR WILL BE: _____________________________________.

Appendix 3

COMPREHENSIVE RISK ASSESSMENT AND MANAGEMENT TOOL LEARNING DISABILITY SERVICES

NAME		DOB		DATE COMPLETED		TIME	
Outpatient/ community		Inpatient (insert Hosp No.)		*Voluntary*		Detained	

THOSE CONTRIBUTING TO COMPREHENSIVE RISK ASSESSMENT AND MANAGEMENT PLAN

NAME	ORGANISATION/ RELATIONSHIP	COPY SUPPLIED
OTHER INFORMATION SOURCES		

STATEMENT OF CURRENT CAUSE FOR CONCERN (including brief pen picture, background information, and why there is a need for comprehensive risk assessment)

CHRONOLOGY OF SIGNIFICANT EVENTS

EVENT (include date of event, if known)	Source of Information	Time/Date/Signature

HISTORICAL FACTORS: *(Consider an analysis of the significant events above. Assessors should look for patterns or trends in the service users behaviour. Analyse their frequency and severity and the context in which they took place (e.g. for aggressive or violent behaviour: has this been targeted at other service users, staff, children). Consider how these were managed previously. Other contextual issues such as exposure to institutional care, involvement with the criminal justice system, any history of drug/alcohol abuse)*

CLINICAL FACTORS: *(Consider the degree of learning disability, associated conditions (e.g. autism, epilepsy), physical and mental health factors that may affect the risks posed by or to the service user, previous clinical psychological or behavioural interventions associated with potential risks. Also consider the service users interpersonal style (traits such as impulsivity, hostility, anger, ability to self control will all affect how risk is managed):*

SOCIAL FACTORS: *(Consider previous and current social factors that may affect the risk behaviour, such as early childhood experiences, relationship stability, ethnicity, bullying, social isolation, finance, environmental factors(such as layout of environment, access to weapons) that may enhance or contribute to risk behaviour)*

HUMAN RIGHTS CONSIDERATIONS: *(What are the key human rights issues to consider in the formulation of this risk management plan. Consider the strengths and wishes of the service user, the need for advocacy, proactive/preventative strategies, positive risk taking, proportionality and least restrictive option).*

RISK MANAGEMENT PLAN FOR ....

1. RISK OF HARM TO SELF

A): Description of risk behaviour(s): *(Particular emphasis to likelihood of occurrence and potential consequences)*

B): Identify Triggers and Warning signs:

C): Proactive/Preventative strategies: *(consider protective factors and positive risk taking. Consider also environmental factors in preventing the risk/behaviour)*

D): Reactive/Emergency strategies: *(consider potential for human rights issues such as proportionality and least restrictive approach)*

2. RISK OF HARM TO OTHERS

A): Description of risk behaviour(s): *(Particular emphasis to likelihood of occurrence and potential severity of consequences)*

B): Identify Triggers and Warning signs:

C): Proactive/Preventative strategies: *(consider protective factors and positive risk taking. Consider also environmental factors in preventing the risk/behaviour))*

D): Reactive/Emergency strategies: *(consider potential for human rights issues such as proportionality and least restrictive approach)*

3. RISK FROM OTHERS AND VULNERABILITY

A): Description of risk behaviour(s): *(Particular emphasis to likelihood of occurrence and potential consequences)*

B): Identify Triggers and Warning signs:

C): Proactive/Preventative strategies: *(consider protective factors and positive risk taking. Consider also environmental factors in preventing the risk/behaviour))*

D): Reactive/Emergency strategies: *(consider potential for human rights issues such as proportionality and least restrictive approach)*

4. CHILDREN AND/OR VULNERABLE ADULTS AT RISK *(Specify arrangements for care of any dependent children)*

A): Description of risk behaviour(s): *(Particular emphasis to likelihood of occurrence and potential consequences)*

B): Identify Triggers and Warning signs:

C): Proactive/Preventative strategies: *(consider protective factors and positive risk taking. Consider also environmental factors in preventing the risk/behaviour))*

D): Reactive/Emergency strategies: *(consider potential for human rights issues such as proportionality and least restrictive approach)*

COMMUNICATION AND INFORMATION SHARING PROCESS: *(Specify who needs to receive a copy of this risk management plan, are there any confidentiality or consent issues in sharing information that need to be considered?)*

UNMET NEEDS IDENTIFIED: *(Please include any difficulties encountered in applying any of the preventative or control mechanisms to address the stated risks in any of the settings (including home) in which the individual receives care).*

Has this risk assessment and management plan been shared with the service user, and/or carers?

Service user: Yes ☐ No ☐ **Service user signature ……………………………**

Refusal to sign ☐

Unable to sign ☐

Carer: Yes ☐ No ☐ **Carer signature ……………………………**

Refusal to sign ☐

If not shared, please specify reasons.

Are there any disagreements with this risk assessment and management plan from the individual service user, main carers or relevant others? Yes ☐ No ☐

If yes, please specify nature of disagreement and outline action taken.

Signature of Key/Named Worker ______________________Date:________

Signature of Line Manager/Care Coordinator: ___________Date: ________

Signatures of all other professional/advocacy staff involved in the development of this comprehensive risk assessment and management plan

Name: ______________________ Designation: _________________ Date: _________

Name: ______________________ Designation: _________________ Date: _________

Name: ______________________ Designation: _________________ Date: _________

Name: ______________________ Designation: _________________ Date: _________

Name: ______________________ Designation: _________________ Date: _________

Name: ______________________ Designation: _________________ Date: _________

Name: ______________________ Designation: _________________ Date: _________

Date of Review: _____________________________

Appendix 4

Comprehensive Multidisciplinary Risk Assessment and Management Plan

Review Record

Service user name:____

Attended By **(Identify each person's role in the review)**	**Person's consulted** **Persons not in attendance**

Date of initial risk assessment:_________________ Date of last review: ___________________

Overview since previous risk assessment/management plan:(include any incidents/near misses, changes in unmet need or involved personnel, what worked and did not work, changes in service user's situation/understanding/co-operation levels/self management skills).

Action(s) required following this review		
Key actions	**Responsible person**	**Target date**

Signature of service user ___________________________Date _________________

Signature of Key/Named Worker __________________ Date: ________________

Signature of Carer ___________________________ Date __________________

Signature of Line Manager ____________________ Date __________________

Copies to: (please list all individuals/services who are provided with a copy of this form)

____
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____

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http://www.merseycare.nhs.uk/managing_clinical_risk/default.asp

Annex A

Assessment and Management of Risk Regional Steering Group Members

Ms Linda Brown (Chair)	DHSSPS
Mr Martin Bradley	DHSSPS
Ms Maura Briscoe	DHSSPS
Mr Hugh Connor	Eastern Health and Social Services Board
Ms Marie Crossin	CAUSE
Dr Oscar Daly	South Eastern Health and Social Care Trust
Mr Martin Daly	LAMP
Mr Oscar Donnelly	Northern Health and Social Care Trust
Ms Norma Evans	Northern Health and Social Care Trust
Mr Roy Keenan	DHSSPS
Dr Paula Kilbane	Eastern Health and Social Services Board
Mr Paul Martin	DHSSPS
Mr Brendan Mullen	Belfast Health and Social Care Trust
Professor Roy McClelland	Board for Mental Health and Learning Disability
Mr Paul McFall	LAMP
Mr Noel McKenna	Mental Health Commission (Northern Ireland)
Dr Ian McMaster	DHSSPS
Mr Colin McMinn	DHSSPS
Miss Gillian McMullan	DHSSPS
Ms Heather O'Neill	DHSSPS
Mr Jude O'Neill	Regulation and Quality Improvement Authority
Dr John Simpson	Southern Health and Social Care Trust
Mr Phelim Quinn	Regulation and Quality Improvement Authority

Annex B

Background

Context

In May 2006, both in response to serious adverse incidents reported to the Department and to the publication of the McCleery Independent Inquiry Report, DHSSPS established a multi-agency Regional Steering Group to address the issues raised in relation to the assessment and management of risk within adult mental health and learning disability services.

To do this, a key objective of the Group was to develop regional guidance to ensure that mental health provider organisations have robust risk assessment and management processes embedded in their practice to minimise, as far as possible, the occurrence of adverse incidents.

The Steering Group was informed in the development of this guidance by:

- *A review of current practice in HSC Trusts;*
- *A review of currently available information on adverse incidents in general mental health and learning disability services; and*
- *Regional stakeholder workshops to identify good practice and challenges in risk assessment and management by mental health services.*

The publication of the O'Neill Independent Inquiry Report in March 2008 significantly reinforced the need to urgently address these issues and highlighted recurring systematic failures, e.g. poor communication between professionals, lack of collaboration and ineffective interfaces between services, and a failure to adequately address the holistic needs of the service user and his/her families/carers.

Review of Current Practice

During the Autumn of 2007 the RQIA carried out the first dedicated Clinical and Social Care Governance Review of general adult mental health within each of the five HSC Trusts in Northern Ireland. The review was commissioned by the Steering Group to provide independent assurance that the Trusts have appropriate policies and standard operating procedures in place for the assessment and management of risk, which are in keeping with the McCleery Report recommendations and the 2004 Departmental Discharge Guidance.

Each Trust completed a 'Self Assessment Proforma' supported by evidentiary documents. Visits to validate the information were then completed by multidisciplinary review teams, comprising Health and Social Care professionals (Peer reviewers) and members of the public (Lay reviewers).

Key findings from these review visits have been incorporated into this guidance and an overview report was published by the RQIA in March 2008.

Review of Local Adverse Incidents

This work was informed by *'Supporting Safer Services'*, the second annual DHSSPS report promoting safety and learning arising from serious adverse incidents[28]. It found that between 1st January 2006 and 31st March 2007, 43% of all incidents notified to the Department came from mental health services. Whilst the report acknowledges that mental health service users are vulnerable to a number of potential risks such as self-harm, violence and aggression, which may be linked to their mental illness, much can still be done to reduce their risk of harm.

The report highlighted learning for mental health services categorised by three themes: assessment and management of risk; Trust internal reviews; and suicide and self-harm. Several areas for improvement in relation to the assessment and management of risk were suggested, including:

- *Prompt and proactive follow-up following discharge from inpatient care;*
- *Management of disengagement from services;*
- *Management of alcohol misuse, especially with dual diagnosis;*
- *Improving compliance with medication;*
- *Preventing absconding, especially detained patients;*
- *Increased staff awareness/training to encourage identification and management of specific well known risk factors;*
- *Improving assessment and management of risk, both to self and others, with particular focus on risk factors sometimes being identified but not managed prior to "inevitable" incident; and*
- *The need to establish consistency across HSC units on risk assessment and subsequent management.*

Regional Stakeholder Workshops

The Department held a series of workshops in each of the five HSC Trust areas across Northern Ireland between January and March 2008. These were extremely well attended, with representation from user and carer organisations, each of the different mental health professional groups in HSC Trusts, HSS Boards and from the voluntary sector. During the workshops, the outcomes of the RQIA review visits were reported and views taken on key issues and good practice examples regarding risk assessment and management. Feedback from the workshops has been incorporated into this guidance.

The views of service users, their families and carers must be central to any decisions affecting the future planning and delivery of mental health and learning disability services[29]. Voluntary sector organisations representing both service users and their families and carers through real-life experiences, have made a valuable contribution to the development of risk assessment and management processes.

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[28] *An adverse incident is "any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation" (DHSSPS 2007a, 7)*
[29] *DHSSPS (2007a)*

Similarly, as regards identifying examples of good practice and understanding the challenges of risk assessment and management, mental health staff are key. Collaboration with professionals working throughout the service in Northern Ireland is essential to explore the potential opportunities for improvement.

At the workshops, there was some apprehension about using the word ‘risk’ in mental health services, as it was thought it might stigmatise service users and act as a barrier to involving them in a collaborative process. Whilst this concern is recognised, for the purposes of this guidance “risk” is being used as it represents a commonly understood term within mental health and learning disability services.

It is important to reinforce that risk assessment is only one component of the overall comprehensive assessment of a service user’s health and social care needs, which contribute to the development of an effective Care Plan. A balance must be maintained between the need of the service user to progress towards recovery and the responsibility of mental health professionals to ensure the safety of the service user and that of those around him/her.

Development of Guidance

On the basis of these strands of work, the Department prepared draft guidance and issued it for consultation over July and August 2008. This included hosting one further stakeholder consultation conference. The responses to this exercise informed the finalisation of this document for the Steering Group’s approval.

Supporting Tools

In addition, to support the implementation of this guidance, the Steering Group oversaw the development of new regionally-agreed risk screening and risk assessment and management tools. These were piloted over a 12 week period in adult mental health services in each HSC Trust at the beginning of 2009, in order to test their viability in day-to-day practice and to enable them to be finalised.

Tools for use in learning disability services are being similarly piloted in those services within each Trust and will be issued when finalised. Tools for use in CAMHS are also being developed.

Specialist Addenda

Another element of the work has been to develop specialist addenda to the main guidance, on specialist mental health services (CAMHS, forensic mental health services and addiction services) and on learning disability services, to provide advice on any specific issues and procedures within these areas of provision. A stakeholder consultation exercise on draft versions of these addenda was conducted in the Spring of 2009, as a result of which, they have been finalised and incorporated into the guidance document.

What Is Meant by 'Risk'?

Risk relates to the possibility that service users will cause harm to themselves or others, i.e. physical violence to self (self-harm/suicide/self neglect) or to others, and psychological harm.

When actively assessing risk, historical information should be considered according to[30,31,32]:

- ***Recency*** *– When was the last incident of harm to self or others?*

- ***Severity*** *– How serious have previous incidents been?*

- ***Frequency*** *– How frequently do incidents of harm to self or others occur?*

- ***Pattern*** *– Is there a common pattern to the type of incident or the context in which it occurs?*

- ***Likelihood*** *– How likely is it that the event will recur?*

Risk assessment involves working with a service user to determine each of these aspects of risk. The assessment requires consideration of a wide variety of risk factors that will be of different significance for each individual and will vary in importance as his/her circumstances change.

Risk factors are not static and can be increased or decreased.

Risk factors relate to issues both internal and external to the client. There can be significant impact from external factors, for example: staff factors (attitudes; knowledge; training etc.); and organisational factors (such as openness of communication systems; models of staff support deployed etc.).

Risk Factors – A Risk Factor is "a personal characteristic or circumstance that is linked to a negative event that either causes or facilitates the event to occur" (DH, 2007a, 13).

The assessment of risk requires consideration of a wide variety of risk factors that will be of different significance for each individual and will vary in importance as his/her circumstances change. It also requires professionals to make a judgement on the basis of the information available at the time. This is always difficult but it is a professionally-informed decision. Consider:

- *What are the factors which contribute to the risk for the individual service user?*
- *Is the risk factor <u>stable</u> (e.g. history of child abuse) or <u>dynamic</u> (e.g. drug and alcohol use, current mental state)?*

- *Is the risk specific (i.e. directed at an individual person) or general?*

- *How can risk factors be modified or managed?*

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[30] *University Of Manchester (1996)*
[31] *DH (2007a)*
[32] *Royal College of Psychiatrists (1996)*

The National Confidential Inquiry into Suicides and Homicides by People with Mental Illness (Appleby L, Shaw J, Kapur N, Windfuhr K *et al.,* 2006) found risk factors for suicide to include: acute episodes of illness; recent hospital discharge; social factors such as living alone; and clinical features such as substance misuse and non-fatal self-harm.

Types of Risk Assessment

Risk assessment seeks to identify the specific risks in an individual service user. There are three main methods to predict risk outcomes.

The **unstructured clinical approach** is based on interviews with the service user and his/her family/carers. As it does not follow a structured format there is the potential that important risk factors will be missed (DH, 2007a). Also, the element of subjectivity in the approach makes it susceptible to bias on the part of the clinician (Ryan, 2006).

The **actuarial approach** measures levels of risk according to factors that have been shown as statistically associated with increased risk amongst a large population of people. An overall score is calculated as a predictor of future risk over a specified time period.

Actuarial tools have several weaknesses. They are only applicable and suitable for use with service users who come from the population for whom the tool was developed and they emphasise risk prediction rather than management (DH, 2007a). Also, they tend not to be sufficiently sensitive to the idiosyncrasies of every individual service user they are used to assess (Ryan, 2006).

- *Actuarial tools should only inform clinical judgement*
- *They are not a substitute for clinical judgement but an aid to it*

The structured clinical judgement approach combines the use of actuarial tools or evidence-based risk factors, clinical judgement and information from service users and their families/carers to assess risk. This is thought to be the best approach for risk assessment (Morgan J.F., 2007; Higgins *et al.,* 2005).