Mersey Care NHS
NHS Foundation Trust

TRUST-WIDE CLINICAL POLICY DOCUMENT

USE OF CLINICAL RISK ASSESSMENT TOOLS

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Lead Executive Director:	**Executive Director of Nursing**
Lead Author(s):	**Specialist Clinical Psychologist & Lead for Secure Psychological Services on Risk**

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2017– Version 4

Quality, recovery and wellbeing at the heart of everything we do

Mersey Care NHS
NHS Foundation Trust

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USE OF CLINICAL RISK ASSESSMENT TOOLS

Further information about this document:

Document name	**POLICY AND PROCEDURE FOR THE USE OF CLINICAL RISK ASSESSMENT TOOLS SA10**
Document summary	**To ensure that a thorough and consistently high standard is applied to the assessment of clinical risk in order that the risks identified can be managed effectively and safely.**
Author(s) Contact(s) for further information about this document	**Specialist Clinical Psychologist & Lead for Secure Psychological Services on Risk**
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To be read in conjunction with	
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Version Control:

		Version History:
2015 – Version 3		April 2015
2016 – Version 3	Review – approved by Executive Lead	February 2016
2017- Version 4		February 2017

SUPPORTING STATEMENTS

this document should be read in conjunction
with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

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1 PURPOSE AND RATIONALE

1.1 This policy is based on the following three core assumptions:

a) Service users should expect that the clinical risks presented by them will be assessed and reviewed as often as deemed necessary in order that the risks identified can be managed effectively, safely and progressively over time;

b) Service users should expect staff in Mersey Care NHS Foundation Trust to demonstrate a good if not high level of competence in the assessment and management of clinical risk and that competence in this area will be promoted by (i) Trust-sponsored training courses that are freely available and appropriate for the needs of clinical staff in the different directorates, and (ii) an easily accessible network of qualified support and advice with which care plans incorporating risk management guidance can be checked and improved

c) Positive risk management of service users will be promoted but only when (i) there is a shared and good understanding of the risks posed by the service user, (ii) when risk can be effectively and repeatedly assessed and there are the resources to manage the risk and protective factors identified as relevant to the case at hand, and (iii) where the outcome of assessment and management activity will be an improvement in the service user's quality of life and mental health over time.

1.1.1 Risk is an unavoidable component of the life of any individual and it is neither possible – nor desirable – to remove all risk from the experience of service users. However, members of the public have a right to be protected from any significant harm that may be posed by a service user of Mersey Care NHS Trust, where those rights are legitimately subject to (a) the limitations of available information and (b) the capacity of Trust staff to anticipate often complex clinical risk.

1.1.2 Decisions involving clinical risk always involve balancing the health and safety of service user and others with service users' quality of life, their personal growth and their right to exercise choice and autonomy in the care they receive. It is acknowledged that achieving this balance is often a complex task where absolute safety can never be guaranteed.

1.1.3 Structured professional (or clinical) judgment is the approach recommended as the core technique for assessing and managing the risks posed by service users to themselves or to others. Structured professional judgment is a method designed to promote best practice in risk assessment by the linking of judgment to an evidence-base, both of the risks to be managed (e.g., risk of violence) and good clinical practice. Structured professional judgment is to be contrasted with risk prediction – or actuarial risk assessment – in which judgments (e.g., low, moderate, high) of likelihood of re-offending are made. While the latter approach can be useful, it does not encapsulate all of what practitioners are interested in when they are trying to prevent a harmful outcome from occurring in an individual service user. The structured professional judgment approach lends itself to multi-disciplinary team work, leading to the formulation of risk potential, and transparent risk management planning linked to the risk factors – and protective factors – identified in a single individual. Actuarial risk assessment cannot be used in a satisfactory or transparent way to achieve this same outcome (Hart et al, 2007).

1.1.4 Service users and carers should receive all the support they wish and require in order to contribute to risk assessments and risk management planning, as well as to make careful and acceptable judgments about the potential benefits as well as the potential hazards of any situation they encounter or with which they are attempting to manage.

1.1.5 Information and encouragement should be given to service users and carers in order to maximise their freedom of choice, and to encourage independence (having regard to their capability in law, their age and level of understanding). Adults who lack capacity in law should be protected from significant harm.

1.1.6 Service users and carers should be able to access clinical information regarding risk, held in their name, and they should be informed in advance on what basis this information may be shared with others. Decisions that follow from assessments of clinical risk should be shared with those affected or their representatives.

1.1.7 All clinical risk assessments should be sensitive to the race, religion, culture, gender, sexual orientation, disability, and communication needs of service users.

1.1.8 Interventions following from assessments of clinical risk should be the least restrictive possible in the circumstances.

Rationale

1.2 The purpose of this policy is to ensure a thorough and consistently high standard of practice in respect of clinical risk assessment in order that the range of relevant clinical risks can be identified and then managed effectively and safely. This policy proposes the following framework:

- The policy sets out the principles underlying clinical risk assessment in Mersey Care NHS Trust.
- The policy proposes a system for managing clinical risk assessment tools within the Trust; and
- The policy outlines the systems for ensuring that appropriate and high quality training and post-training support is provided to staff to support the practice of clinical risk assessment across all directorates.

1.3 This policy is substantially underpinned by Best Practice in Managing Risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services, available from www.nimhe.csip.org.uk/risktools. This is a set of guidance published by the Department of Health in June 2007 and updated in December 2008, which is intended to provide direction in a key area of clinical practice. The Policy Author is a co-author of the Best Practice guidance. The Best Practice website, which is linked to the website of Mersey Care NHS Trust, contains more information about translating these guidelines into practice in mental health services, including information about the use of clinical risk assessment tools – see Appendix 5.

1.4 This policy has also been informed by Rethinking Risk to Others in Mental Health Services: Final Report of a Scoping Group, which was published by the Royal College of Psychiatrists in June 2008 and is available from www.rcpsych.ac.uk/files/pdfversion/CR150.pdf. While this report focuses only on risk of harm to others, it reiterates the principles of best practice and the use of tools.

1.5 In addition, anyone referring to this policy and procedure must be familiar with, and comply with, the following:

- The Mental Health Act (1983) and Code of Practice 2015
- The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Amended Mental Health Act 2007)
- The respective Codes of Practice of the above Acts of Parliament
- The Human Rights Act 1998 and the European Convention on Human Rights]
- The Violence, Crime and Victims Act 2004
- The Care Programme Approach
- All Mersey Care NHS Foundation Trust policies on the Mental Health Act 1983 as appropriate

2 OUTCOME FOCUSED AIMS AND OBJECTIVES

2.1 The Trust's aim is to effectively manage clinical risk by using valid assessment tools enabling staff to identify the risks posed by service users to themselves / and or others and implement appropriate and effective care to mitigate the risks.

3 SCOPE

3.1 This policy and procedure applies to all practitioners in Mersey Care NHS Trust, regardless of qualifications and experience, who are required to assess and manage clinical risks as a part of their duties, whether on Trust premises or not.

4 DEFINITONS

4.1 A full glossary of terms can be found at Appendix 4.

5 DUTIES

5.1 The **Executive Director of Nursing** is responsible for ensuring that practice in clinical risk assessment and management in Mersey Care NHS Foundation Trust is at an acceptable standard and is informed by current research and thinking on the subject . This requirement will ensure that revisions to this policy will be appropriate and well-informed.

5.2 **Managers** will ensure that all practitioners utilising clinical risk assessment tools use (a) only tools described in the Trust's Portfolio and (b) the structured professional judgment approach. Further, service managers will ensure that all practitioners are trained and familiar with the tools they use.

5.3 All **practitioners** in Mersey Care NHS Foundation Trust must ensure that their practice in respect of clinical risk assessment and management adheres to the principles described in this policy. Further, they must ensure that their training in the use of the tools recommended is no more than three years old.

5.4 **Chief Operating Officers** (COO's) are responsible for ensuring that their staff are aware of this policy and are able to access the appropriate training in order to comply with this policy. The COO's will also need to ensure that processes are in place to monitor compliance with this policy.

6 PROCESS

6.1 This section of the policy document covers four key areas:

- General format of clinical risk assessments and risk management planning in Mersey Care NHS Trust.
- Frequency of risk assessments and reviews.
- Support and training for best practice in clinical risk assessment and management.
- The purpose and use of Mersey Care Trust's Organisational Portfolio of Clinical Risk Assessment Tools.
- Duties and responsibilities.
- Audit.

6.2 General format of clinical risk assessments and risk management plans

6.3 Clinical risk assessment and management are integral to the Care Programming Approach. The general format described below is intended to support and enhance current practice when assessing and managing clinical risks within the CPA process.

6.4 A clinical risk assessment should make reference to the following five elements:

- A clear statement about the nature of the harmful outcome to be prevented (e.g., harm to others, harm to self, suicide).
- A brief summary of the risk and related protective factors that are relevant to the harmful outcome to be prevented (e.g., mental illness, personality disorder, substance abuse, social support). Tools, such as the CPA risk assessment, or a more technically demanding tool like the START, can be used to help practitioners identify what the most important risk and protective factors are in each case.
- A risk formulation, which is an account usually presented in a paragraph or so of text, in which the practitioner working with the client and/or colleagues in a multidisciplinary team provides an account or explanation for the risks presented by the service user. This account will explain how and why the most relevant risk and protective factors interact with one another to create elevated risk.
- A risk management plan will be linked directly to the risk and protective factors used in the risk formulation. The plan will provide suggestions of treatment strategies designed to repair or restore psychological (and/or physical) functioning. It will provide suggestions for supervision strategies, designed to contain or organise or structure the service user's day-to-day life thus reducing the potential for harmful outcomes to be triggered. The plan will also make some suggestions for how risk can be monitored during the period between reviews, by identifying early warning signs of a relapse to violence or self-harm or suicide and suggestion what might be done to prevent them from resulting in a harmful outcome.

- It is expected that the risk management plan will help change the most important risk or protective factors, reducing the potential for harmful outcomes to happen. Reviews examine the effectiveness of risk management strategies and recommend either their continuation because risk is being effectively managed or their improvement in order to manage risk more effectively or confidently. A risk management plan should recommend what those conducting future reviews need to look out for as evidence of improved – or insufficient – risk management.

6.5 Clinical risk assessments may be extensive (several pages long, as in Level Three risk assessments contained in specialist reports, described below) or they may be brief (1-3 paragraphs, describing Level Two risk assessments contained in clinical case notes such as EPEX, described below). They may be regarded as clinical risk assessments when they contain all of the above five elements.

Level 1 Assessments

6.6 Level One risk assessments are those assessments that are brief to do and report (5-30 minutes), involve a review of mainly recent clinical information (the last week or so), and are likely to inform risk management in the following few days or weeks. Level One risk assessments largely involve practitioners identifying risk factors and possibly protective factors and making brief recommendations for risk management plans. Level One risk assessments require regular review and their relative brevity makes this possible. Examples of Level One risk assessment tools used in Mersey Care NHS Foundation Trust are as follows: CPA Risk Assessment, pre-discharge risk reviews, pre-leave risk reviews.

Level 2 Assessments

6.7 Level Two risk assessments involve a little more work than Level One assessments and risk formulation and risk management planning are detailed and explicit. The same tools may be used as in Level One assessments but the practitioner spends more time thinking about the information to hand, preparing a formulation and designing a risk management plan. Alternatively, more specialised tools, such as the Short-Term Assessment of Risk and Treatability (START), may be used to make more detailed observations about risk and protective factors and more comprehensive risk management plans. Because of the detail and the attention given to the way in which harmful outcomes might occur in the future, Level Two assessments are likely to be informative of risk over quite short time periods (hours, days) as well as up to weeks and even several months from the time of assessment. Level Two risk assessments may take up to 45 minutes or an hour to do and brief training is recommended to ensure that tools can be used to the maximum benefit.

Level 3 Assessments

6.8 The most detailed level of clinical risk assessment require comprehensive tool-based evaluations of historical and clinical risk factors. Level Three assessments are the most demanding in terms of time (they require upwards of a day to complete due to the need to research clinical notes, interview the service user and others, and write a detailed report running to several pages in length) and skill base (i.e., training in the use of specific clinical risk assessment tools plus supervised practice). Examples of Level Three risk assessments are as follows: HCR-20 violence risk assessment guide, the Risk for Sexual Violence Protocol (RSVP), and the Spousal Assault Risk Assessment Guide (SARA). Findings at this level of risk assessment will be informative for periods of time from several months up to a year although reviews can take place more regularly depending on the service user's

clinical presentation and their place on the care pathway. In general, however, such assessments are regarded as longer-range forecasts of risk as compared to Level One and Two assessments.

6.9 Appendix 1 contains a quick reference guide to the appropriate and Trust-approved tools and the level of assessment they offer.

6.10 Each of these three levels of risk assessment should be regarded as ideally a multidisciplinary undertaking – the views of many (e.g., a care team) are more desirable than the views of one. However, one member of the clinical team may take responsibility for collating and communicating the findings of the assessments made.

6.11 The cooperation of a service user in a clinical risk assessment should be sought. Their collaboration in the identification of most relevant risk and protective factors, the risk formulation and the risk management plan is highly desirable. The reason for any non-cooperation should be sought and recorded. Risk assessments may proceed without the cooperation of the service user where risks to self or others require urgent management. The service user should be informed of this.

6.12 Provision should be made for service users who have limited cognitive ability or limited language or communication skills. For example, the risk assessor may work more closely with fellow practitioners and family members or carers to gather information and develop the formulation. If the service user's first language is not English or if the service user has hearing problems, an interpreter should be used to ensure communication is possible.

6.13 Attempts should also be made to engage service users who are acutely mentally ill. However, if risk of harm to the self or others is regarded as imminent and unacceptably high or potentially unmanageable, the risk assessment should proceed urgently. The absence – and indeed, the presence – of cooperation should be recorded in all communications made following the assessment (e.g., a report). Efforts should be made to engage the reluctant service user in a collaborative risk assessment on the next occasion one is required and it is safe for all parties to do so.

6.14 This policy applies to clinical risk assessments carried out on all service users regardless of ethnic or cultural background, gender orientation or sexual preference. Audit processes (see section 2.5) will be used to ensure the fair application of this policy.

Frequency of risk assessments and reviews

6.15 Service users should be assessed – or reviewed – at key turning points in their care pathway. Key turning points include but are not limited to the following:

- first referral to secondary mental health services
- re-referral due to a deterioration in mental state
- on admission into acute inpatient services
- pre-leave of absence trip from inpatient services
- pre-discharge from inpatient services
- when mental state or risk management appears to be deteriorating and the concerns of staff about the safety of the service user increase.

6.16 Level One risk assessments will form the majority of the risk assessments undertaken with Level Two assessments being replied upon for more complex or

challenging cases, that is, those where there are competing problems or single problems that are severe in presentation or consequences. Level Three assessments will be utilised less frequently because of the time they require to complete. A level three risk assessment should be considered when the service user's clinical presentation is complex (e.g., extensive psychiatric comorbidity), risks exist in a number of areas or have the potential to result in incidents that are severe in their consequences for the service user (e.g., the client is a serious suicide risk) or others (e.g., the client is at risk of violence, sexual violence, intimate partner violence, stalking or harassment).

Purpose and use of Mersey Care Trust's Organisational Portfolio of Clinical Risk Assessment Tools

6.17 All clinical risk assessment tools used in Mersey Care NHS Foundation Trust must have a basis in evidence. The Best Practice in Managing Risk guidance referred to earlier contains a section on risk tools and a summary of the evidence base upon which they have been generated.

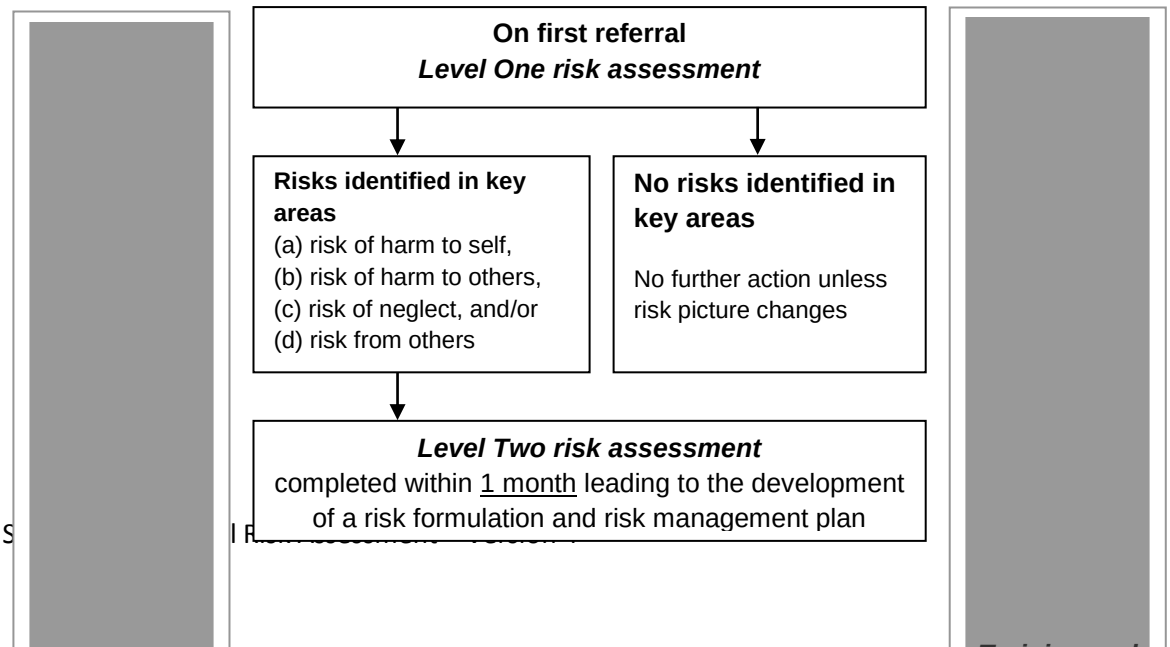
6.18 All clinical risk assessment tools appropriate for use by Mersey Care NHS Foundation Trust staff are listed and described in the Portfolio of Clinical Risk Assessment Tools, which can be found on the Trust's website linked to this policy.

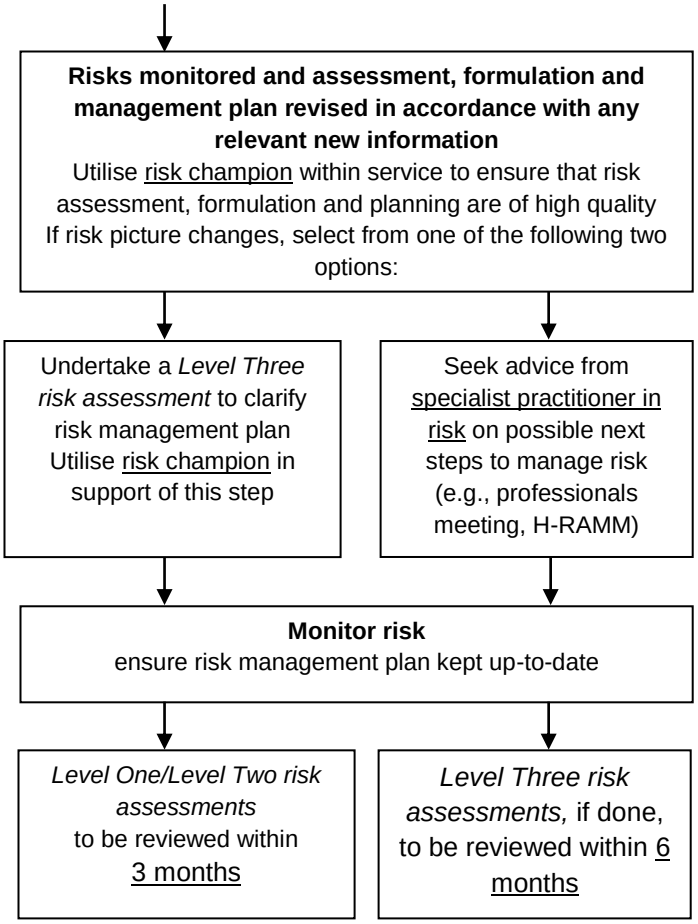
6.19 The Portfolio of Clinical Risk Assessment Tools includes information about the following: (a) the training requirements of each tool; (b) contact information about the lead person in each directorate who is knowledgeable about the application of the tool in their sector; and (c) information about when the particulars and conditions of use of each tool in each Directorate will be reviewed and updated. (See Appendix 2 for a list of the categories of information provided about each entry in the Trust's Portfolio of Clinical Risk Assessment Tools).

6.20 A database has been established of all staff participating in training on clinical risk assessment practice. This database is a contribution towards demonstrating compliance with the training requirements set down in the Trust's Portfolio.

6.21 Figure 2 below illustrates the corporate procedure for clinical risk assessment and management in Mersey Care NHS Trust, which tools should be used to support in order to provide structure and an evidence-base to important decisions about the care and management of service users.

Figure 2: Flow chart illustrating corporate procedure for undertaking clinical risk assessments in Mersey Care NHS Trust




Risks monitored and assessment, formulation and management plan revised in accordance with any relevant new information
Utilise risk champion within service to ensure that risk assessment, formulation and planning are of high quality
If risk picture changes, select from one of the following two options:
Undertake a *Level Three risk assessment* to clarify risk management plan
Utilise risk champion in support of this step
Seek advice from specialist practitioner in risk on possible next steps to manage risk (e.g., professionals meeting, H-RAMM)
Monitor risk
ensure risk management plan kept up-to-date
Level One/Level Two risk assessments
to be reviewed within 3 months
Level Three risk assessments, if done, to be reviewed within 6 months

7 CONSULTATION

7.1 A Trust Working Group was established in 2004 to develop a process for collating and managing the use of clinical risk assessment tools. This group was initially responsible for the development of this policy and procedure, which has been in place since that time and reviewed annually. Further consultation to review this policy has been undertaken by the policy author with the Trust's Risk Manager.

7.2 As indicated in section 1.1.2, this policy is substantially underpinned by the Department of Health Best Practice in Managing Risk national guidance on clinical risk assessment and management. This document was subject to a national and international review process, including close scrutiny by a panel of service user and carer representatives. The present policy on clinical risk assessment in Mersey Care NHS Foundation Trust has benefited greatly from the comments made on the original Best Practice guidance.

7.3 Most aspects of this policy are already in place (e.g., admission assessments, training). The annual audit process, in combination with training and other professional meetings, will be used as the basis for ensuring the most widespread knowledge about this policy and also its fair and equitable application to all service users. Annual reviews of this policy will be used as the basis for marking progress in its implementation.

8 TRAINING AND SUPPORT

8.1 Training courses are available or in development for all of the Level One, Two and Level Three risk assessment tools available to support clinical judgment in this area of practice. All courses are free of charge to members of MCT staff. The training requirements of this policy are available in the Trusts Learning & Development Policy (HR05).

8.2 Level Two and Level Three training courses are available at two levels – skills acquisition (two day courses covering essential skills in the use of techniques in various kinds of clinical risk assessment) and skills maintenance (an update on research and practice for already trained assessors). Training in Level Two and Level Three risk assessment tools is recommended in order to ensure consistency of practice across practitioners and over time, and to ensure that the core principles of the structured professional judgment approach are understood.

8.3 Training will be available on pre-arranged dates each month to practitioners across the service available to attend. In addition, and by special arrangement, bespoke training will be provided to whole services (e.g., Sefton CMHT) on site. The latter is preferable to ensure (a) the training provided is tailored to meet the needs of the individual service, and (b) that a post-training network of support can be established within that service to ensure that the recommended practice in clinical risk assessment and management may be maintained over time.

9 MONITORING

9.1 The use of clinical risk assessment tools to inform practice in Mersey Care NHS Foundation Trust will be audited against the standards outlined in Appendix 3.

9.2 Audits will take place annually. Audits will be carried out by a responsible person appointed the Accountable Director.

9.3 A report describing the findings of the annual audit and compliance with all aspects of this policy will be presented to the Trust QAC by the policy author annually.

10 EQUALITY AND HUMAN RIGHTS ANALYSIS

Mersey Care NHS
NHS Foundation Trust

Equality and Human Rights Analysis

Title:
Area covered:

What are the intended outcomes of this work? *Include outline of objectives and function aims*
Who will be affected? *e.g. staff, patients, service users etc*

Evidence
What evidence have you considered?
Disability (including learning disability)

Sex
Race *Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.*
Age *Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*
Gender reassignment (including transgender) *Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.*
Sexual orientation *Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.*
Religion or belief *Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.*
Pregnancy and maternity *Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.*
Carers *Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.*
Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.*
Cross Cutting *implications to more than 1 protected characteristic*

Human Rights	Is there an impact?

	How this right could be protected?
Right to life (Article 2)	*Use not engaged if Not applicable*
Right of freedom from inhuman and degrading treatment (Article 3)	*Use supportive of a HRBA if applicable*
Right to liberty (Article 5)	
Right to a fair trial (Article 6)	
Right to private and family life (Article 8)	
Right of freedom of religion or belief (Article 9)	
Right to freedom of expression Note: this does not include insulting language such as racism (Article 10)	
Right freedom from discrimination (Article 14)	

Engagement and Involvement *detail any engagement and involvement that was completed inputting this together.*

Summary of Analysis *This highlights specific areas which indicate whether the whole of the document supports the trust to meet general duties of the Equality Act 2010*

Eliminate discrimination, harassment and victimisation

Advance equality of opportunity

Promote good relations between groups

What is the overall impact?

Addressing the impact on equalities

There needs to be greater consideration re health inequalities and the impact of each individual development /change in relation to the protected characteristics and vulnerable groups

Action planning for improvement

Detail in the action plan below the challenges and opportunities you have identified. *Include here any or all of the following, based on your assessment*

- *Plans already under way or in development to address the **challenges** and **priorities** identified.*
- *Arrangements for continued engagement of stakeholders.*
- *Arrangements for continued monitoring and evaluating the policy for its impact on different groups as the policy is implemented (or pilot activity progresses)*
- *Arrangements for embedding findings of the assessment within the wider system, OGDs, other agencies, local service providers and regulatory bodies*
- *Arrangements for publishing the assessment and ensuring relevant colleagues are informed of the results*
- *Arrangements for making information accessible to staff, patients, service users and the public*
- *Arrangements to make sure the assessment contributes to reviews of DH strategic equality objectives.*

For the record
Name of persons who carried out this assessment:
Date assessment completed:
Name of responsible Director:
Date assessment was signed:

11 SUPPORTING DOCUMENTS

11.1 This Policy should be read in conjunction with Working Together to Safeguard Children, which can be found at the following website:

http://www.everychildmatters.gov.uk/_files/AE53C8F9D7AEB1B23E403514A6C1B17D.pdf

11.2 In addition, the Trust's Safeguarding Procedures for the Protection of Children (Trust policy SD13) and the Trust policy on the use of clinical risk assessment tools (SA10) should also be consulted. Both policies are available at www.merseycare.nhs.uk.

Reference documents

11.3 SA10 – MCT Policy and Procedure for the use of clinical risk assessment tools. Available at: www.merseycare.nhs.uk/about_mersey_care/policies_procedures.asp#Service%20Administration%20Policies

11.4 Mersey Care NHS Foundation Trust organisational portfolio: clinical risk assessment tools. Available at: www.merseycare.nhs.uk/about_mersey_care/policies_procedures.asp#Service%20Administration%20Policies

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11.5 Hart, S.D., Michie, C. & Cooke, S.D. (2007). Precision of actuarial risk assessment instruments: Evaluating the 'margins of error' of group v. individual predictions of violence. British Journal of Psychiatry, 190 (suppl. 49), s60-s65.

11.6 Department of Health, National Risk Management Programme (2007). Best Practice in Managing Risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services.

12 GLOSSARY OF TERMS

12.1 A Glossary of Terms can be found in Appendix 4.

Appendix 1

Quick reference guide to clinical risk assessment tools acceptable for use in Mersey Care NHS Trust, sorted by level of assessment

	Risk of harm to others	Risk of harm to self	Risk of self-neglect	Risk of victimisation
Level one	• CPA Screen (Safety Profile) • Core Outcomes in Routine Evaluation (CORE)	• CPA Screen (Safety Profile) • CORE • Beck Hopelessness Scale	• CPA Screen (Safety Profile) • CORE	• CPA Screen (Safety Profile) • CORE
Level two	• Short-Term Assessment of Risk and Treatability (START) • Intermediate-Risk Assessment and Management Plan (I-RAMP)	• STORM • START • Suicide Risk Assessment: Short Form • I-RAMP	• START • I-RAMP	• START • I-RAMP
Level three	• HCR-20 • Risk for Sexual Violence Protocol (RSVP)/Sexual Violence Risk-20 (SVR-20) • Spousal Assault Risk Assessment Guide (SARA) • Structured Assessment of Violence Risk in Youth (SAVRY) • Joint-Risk Assessment and Management Plan (J-RAMP)	• Suicide Risk Assessment: Long Form • Joint-Risk Assessment and Management Plan (J-RAMP)	• Joint-Risk Assessment and Management Plan (J-RAMP)	• Joint-Risk Assessment and Management Plan (J-RAMP)

Appendix 2

Template: Guidelines for the use of clinical risk assessment tools

Title:	Title of the risk assessment tool
Author:	Individual and organisation
Trust/Directorate Lead:	Please provide contact details of a Lead in the Directorate or organisation who will champion the use of this tool in this setting
Target population:	List service user/patient groups that the tool is appropriate to use with
Risks assessed:	List specific areas of risk targeted by the tool
For use by:	List services and staff groups approved to use tool
Training needed:	List any training needed prior to using the tool
Training provided:	List training provided to meet requirements above
Copyright information:	List any Trust licences, and restrictions on copying and distributing the assessment tool (if externally produced). List any intellectual property protections (if internally produced).
Evidence base:	List references to research validating the assessment tool
Further information:	Provide further guidance on how the tool should be used, what should be done with the information collected, etc.

Appendix 3

Standards for the use of clinical risk assessment tools in Mersey Care NHS Foundation Trust

1. Essential Assessments

1.1 All service users referred to Mersey Care NHS Foundation Trust will, as part of their admission assessments, have a clinical risk assessment completed and reported, which is a Level One risk assessment (e.g., CPA Risk Screen).

1.2 All service users in whom concerns about risk are active and on going should have a Level Two risk assessment that is no more than six months old for the duration of the active period of care.

2. Clinical Risk Assessment Tools

2.1 Clinical risk assessment tools of all three levels will be used to develop a risk formulation and a risk management plan.

3. Staff Training and Competencies

3.1 All staff undertaking Level Two and Level Three risk assessments, especially risk champions and specialist practitioners in clinical risk, will have undergone training in the use of the clinical risk assessment tools used at each level. This training will be updated every 36 months at most.

3.2 A sufficient quantity of training will be available in Mersey Care NHS Foundation Trusting all of the clinical risk assessment tools approved for use.

4. Service User and Carer Involvement

4.1 Where possible and practical, risk formulations and risk management plans will be discussed with the service user prior to their implementation and this discussion will be recorded (e.g., on EPEX).

Appendix 4

Glossary of Terms

Assessment	The process of gathering information via personal interviews, psychological/medical testing, review of case records and contact with collateral informants for use in making decisions
Assessment levels	*Level one* and *level two risk assessments* are quick to administer but generate only limited amounts of information applicable over a relatively brief timeframe. *Level one and two risk assessments* may be completed and updated often and will serve to monitor risks assessed at length on admission and at major reviews. *Level Three risk assessments* are time consuming but generate a substantial amount of information. *Level Three risk assessments* are suitable for use at key points in the service user's care pathway, such as prior to a professionals meeting or an H-RAMM where complex risk management arrangements will be discussed.
HCR-20	Historical-Clinical-Risk Management-20; a *level three risk assessment* tool that is for use by practitioners with experience in working with service users who have a history of violent conduct.
High risk	This service user presents a risk of committing an act that is either planned or spontaneous, but which is very likely to cause serious harm. There are few if any protective factors to mitigate or reduce that risk. The service user requires long-term risk management, including planned supervision and close monitoring, and when the service user has the capacity to respond, intensive and organised treatment.

Medium risk	This service user is capable of causing serious harm, but in the most probable future scenarios, there are sufficient protective factors to moderate that risk. The service user evidences the capacity to engage and occasionally, to contribute helpfully, to planned risk management strategies and may respond to treatment. This service user may become a high risk in the absence of the protective factors identified in this assessment.
Low risk	This service user may have caused, attempted or threatened serious harm in the past but a repeat of such behaviour is not thought likely between now and the next scheduled risk assessment. He or she is likely to cooperate well and contribute helpfully to risk management planning and he or she may respond to treatment. In all probable future scenarios in which risk might become an issue, a sufficient number of protective factors (e.g., rule adherence, good response to treatment, trusting relationships with staff) to support on-going desistance from harmful behaviour can be identified.
Protective factors	Any circumstance, event, factor or consideration with the capacity to prevent or reduce the severity or likelihood of harm to others or to self
Risk	The nature, severity, imminence, frequency/duration and likelihood of harm to others or self
Risk assessment tools	Clinical risk assessment tools make explicit an empirically-based assessment of risk in one key area (e.g., harm to others)
Risk factors	These are the conditions or characteristics that we assume have a relationship to the potential to harm another person or the self
Risk formulation	A risk formulation is the outcome of a process whereby a single practitioner or care team working together examine all the risk and protective factors relevant to the service user being assessed *in order to* produce a coherent explanation in a narrative form of how and why the most relevant risk factors interact with one another over time to bring about changes in risk.

Risk management	A risk management plan will be linked directly to the risk and protective factors making up the key elements of the risk formulation and will include recommendations about *treatment*, *supervision*, *monitoring* and possibly also *victim safety planning*. It is expected that a risk management plan will bring about changes in critical risk and protective factors in order to make risk manageable and ensure the safety of all.
CPA	Care Programme Approach is the basic level assessment used to highlight the needs of patients and to develop a plan of care from.
RSVP	Risk for Sexual Violence Protocol; a *level three risk assessment tool*. The RSVP is a more advanced form of sexual violence risk assessment than its predecessor, the SVR-20. The RSVP is a management- or treatment-oriented tool that explicitly incorporates scenario planning methods for risk formulation and is more appropriate for use by practitioners with a high level of expertise in working with sexual offenders.
Skills acquisition	Training sessions of one- to two-days in duration provided for practitioners who wish to acquire skills in the clinical assessment of risk of harm to others and self using *level three risk assessment* tools
Skills maintenance	Training sessions of one-half to one-day in duration provided to practitioners who attended skills acquisition training courses more than one year previously and who wish to have an update on practice issues and research
START	Short-Term Assessment of Risk and Treatability; a *level two risk assessment tool*
STORM	Skills-based Training on Risk Management; guidance for suicide risk assessment and management
Structured professional judgment	The framework proposed in this document is a model of clinical risk assessment linked to risk management. Clinical risk assessment tools exemplify the model.
SVR-20	Sexual Violence Risk-20; a *level three risk assessment* tool. The SVR-20 is a simple assessment tool appropriate for use by practitioners with limited experience of working with sexual offenders.

Appendix 5

Clinical Risk Assessment Tools

Mersey Care NHS Trust Organisational Portfolio:

Clinical Risk Assessment Tools

LAST UPDATED

April 2015

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2. Principles of clinical risk assessment

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3. Guidance on clinical risk assessment tools

Clinical Risk Assessment Tools
Overview
TOOL DESCRIPTIONS

Appendix

Appendix 1
Summary of level of assessment provided and training and experience required for each tool

1. Introduction

This Portfolio is a resource for Trust staff to use when seeking guidance on the selection of a suitable risk assessment tool(s), where the objective of assessment is the effective and safe management of clinical risk.

This Portfolio covers the following topics:

- The principles of clinical risk assessment and management in Mersey Care NHS Foundation Trust(Section 2); and
- Guidance on the use of clinical risk assessment tools that are acceptable for use across services in this Trust (Section 3).

This Portfolio should be read in conjunction with Mersey Care NHS Foundation Trust **Policy and Procedure for the Use of Clinical Risk Assessment Tools** (SA10, available on www.merseycare.nhs.uk).

In addition, this Portfolio is substantially underpinned by *Best Practice in Managing Risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services*, available from www.nimhe.csip.org.uk/risktools. This is a set of guidance published by the Department of Health in June 2007 and updated in December 2008, which is intended to provide direction in a key area of clinical practice. Mersey Care NHS Foundation Trust along with the University of Liverpool developed this *Best Practice* guidance. The *Best Practice* website, which is linked to the website of Mersey Care NHS Trust, contains more information about translating these guidelines into practice in mental health services, including information about the use of clinical risk assessment tools: www.managingclinicalrisk.nhs.uk.

2. Principles of clinical risk assessment

This Portfolio describes in more detail the approach to clinical risk assessment and management in Mersey Care NHS Trust. The Portfolio begins with an introduction, and information is then divided into the following sections:

- Understanding risk
- Choosing the right tool
- Formulating individual risk
- Developing a risk management plan
- Updating the plan
- Risk communication

2.1 Introduction

Many forms of clinical risk are encountered in Mersey Care NHS Trust:

- that service users will harm their family members or peers, members of the public, or staff members,
- that service users will try to harm themselves or even attempt to take their own lives,
- that service users will neglect themselves to the detriment of their physical and mental health,
- that service users will be victimised by others.

Risk assessments are carried out by members of staff in Mersey Care NHS Foundation Trust on service users in their care on a regular basis. All of these risk assessments are evaluations by trained staff based on their knowledge of individual service users and the context in which risks require to be assessed and managed.

Research indicates that the reliability and validity of such assessments of risk are improved if practitioners use a structured form of risk assessment, where the structure is derived from research relevant to the nature of the risk being assessed (e.g., violence, sexual violence, suicide, self-injury, risk to children). Risk assessment tools have been created as aids to support the work of practitioners trying to keep service users safe and in receipt of appropriate care, treatment and management. However, the judgement of practitioners to interpret the outcome of risk assessments and to implement and monitor appropriate risk management plans is essential and not always supported by the range of clinical risk assessment tools available.

There follows a description of a framework for clinical risk assessment called **structured professional judgement**. Guidance is given on (a) understanding the risks posed, (b) identifying relevant risk factors and choosing the right tool to help you do so – if there is one available, (c) formulating individual risk, (d) developing a risk management plan linked directly to the risk assessed, and (e) updating that plan on the basis of the success – or otherwise – of efforts at risk management. Finally, the framework below offers guidance on (f) the communication of risk-relevant information to colleagues and service users.

2.2 Understanding risk

Risk assessment is an estimation of risk potential based on our understanding of the presence and relevance of certain conditions that we assume to be risk factors and the absence of certain other conditions that we assume to be protective factors. The objective of any assessment of risk is to *prevent* the hazardous outcome from occurring, or at the very least, *minimise* its impact on the individual or others. This definition applies to assessments of risk of all negative outcomes.

The first task of a risk assessment is to be specific about the hazard or hazards to be prevented. For example, a service user with a history of harming others may undergo a risk assessment with a view to preventing further acts of violence. In a setting like Mersey Care NHS Trust, a service user with a history of violence in the community may undergo an assessment of the risk of violence towards family and peers but also violence towards staff. If such a service user also has a history of self-injury, risk of further acts of self-injury and suicide may be additional targets for assessment. Therefore, it is essential that practitioners are absolutely clear about the risk – or risks – they wish to assess, about the hazardous outcomes they wish to prevent. The service users should be the primary source of information on this matter.

Practitioners should be realistic about the risks they identify for management and they should use a *time frame* as their guide. It is pointless to assess the risk of violent re-offending at some unspecified time in the future in a service user newly admitted to a Mersey Care NHS Foundation Trust inpatient facility whose treatment and rehabilitation is likely to last several months if not years and in whom other considerations – such as weekend leave, family contact – are likely to precede those about re-offending. More usefully in such a case, risk of harm towards others in scenarios that are likely to be encountered in a ward setting and in the next few days, weeks or even months is a more realistic objective.

The *objective* of the assessment should be to produce a risk formulation relevant to the time frame under consideration. Risk assessments relevant to Leave of Absence (LOA) trips or family visits at the weekend, for example, should produce a risk formulation relevant to the hours or days following the assessment. Risk assessments relevant to a move of ward or for an annual review or MHRT, for example, should produce a risk formulation relevant to the weeks or months following the assessment.

Risk assessments reflect priorities *at the time the assessment was undertaken*. An assessment of the violence risk posed by a service user, which was carried out more than a year ago should not be regarded as relevant to the present. Risk factors change and lessons are learned about risk management in response to the comprehensive care offered to service users in Mersey Care NHS Trust. Therefore, assessments

should be updated in order to ensure their conclusions and recommendations are current and relevant.

Key Tasks in <u>Understanding Risks</u>:

- All risk assessments should commence with the identification of the key risks or hazardous outcomes to be prevented. The assistance of the service user in this task is very important.
- It is likely that more than one risk will be identified across the four domains of risk of harm to others (including sexually inappropriate or abusive behaviour, fire-setting, hostage-taking, bullying), harm to self, self-neglect, and victimisation.
- Risks should be identified and evaluated within a time frame that is realistic given the service user's circumstances and the purpose of the assessment.
- Risk assessments should be updated – it should not be assumed that old assessments are relevant now because dynamic risk factors can change, altering our understanding of the risks posed and the risks to be managed.

2.3 Choosing the right tool

Risk assessment tools are not available for every situation in which practitioners wish to manage risk and prevent harmful outcomes. Only a limited number of useful tools are available for use in mental health settings with service users about whom concerns exist regarding risk. Further, most of the tools available are suitable for assessing risk in the **medium- to long-term** (defined as the six or twelve months following assessment – the HCR-20, for example, which is a *Level Three risk assessment*). However, more tools are becoming available to support risk decision-making in the **short-term** (i.e., hours to days/weeks – the START assessment, for example, which is a *Level Two risk assessment*). A clear understanding of the risks being assessed and for what purpose will help practitioners to choose the best tool to do the job.

Risk assessment tools are optimally useful at different stages in the dynamic assessment process. Also, practitioners have many demands on their time and different levels of detail will be required for risk assessments of different types. For example a pre-LOA risk assessment may require up to 30 minutes of work by the multidisciplinary team caring for the service user being assessed, and the findings will be useful in preparing for the LOA trip planned. However, a risk assessment following admission to a Mersey Care NHS Foundation Trust inpatient facility or for an annual review or mental health tribunal may require work over several days by the care team and the service user. The outcome of such an assessment will be a valuable decision-making tool, influential in the service user's care pathway, and likely to underpin other more short-term risk assessments too. Practitioners should use the tool that suits the job, and the most labour-intensive tools should be reserved for difficult cases only.

In the event that a tool or instrument is not available to support the decision-making of practitioners trying to assess and manage specific risks, the following guidelines should be considered:

1. **Examine** in detail – ideally with the service user – the antecedents and consequences of past instances of the behaviour to be prevented in the future (e.g., self-injury);
2. Ideally, consult or already be familiar with the relevant **literature** to inform judgement about what factors could be important in the genesis of the behaviour to be prevented;
3. **Identify** those factors that appeared to be directly related – or relevant – to the past occurrence of the behaviour that is to be prevented in the future (e.g., personality disorder, experience of abuse and neglect in childhood, substance use);
4. Differentiate between ***predisposing factors*** (e.g., personality disorder, childhood abuse) and ***triggers*** that are likely to generate a spike in risk in the short-term in a person who has the predisposing factors you have identified (e.g., intoxication, unstable mood, paranoid beliefs, conflict with another person);
5. **Formulate** future risk on the basis of how predisposing factors and triggers come together (see next section); and
6. **Prioritise** the short-term management of triggers prior to the treatment or management of predisposing factors.

Key Tasks in <u>Choosing a Risk Assessment Tool</u>:

- Determine whether there is a risk assessment tool available that could support decision-making about risk in individual service users.
- If risk assessment tools are available, choose specific tools to support decision-making about the risks presented by individual clients based on their suitability to the task at hand. That is, use a tool designed to support decision-making about risk for violence with a client whose risk of violence towards others has been highlighted for prevention.
- Use the Trust's Portfolio of Clinical Risk Assessment Tools to guide choice of tool in this area. The Scottish Risk Management Authority (RMA) document RATED (2nd Edition)[1] provides more detailed information about the instruments available and suitable for use with service users in Britain.
- If no tool is available, follow the guidance 1-6 above.

[1] www.RMAscotland.gov.uk/ViewFile.aspx?id=280

2.4 Formulating individual risk

A risk formulation should be **differentiated** from a diagnostic formulation and treatment formulation. Some of the same information will be relevant to formulations in more than one area (e.g., personality problems are likely to be relevant to formulations in all areas). However, the purpose of these different formulations varies – a risk formulation is for future harm prevention or minimisation, a diagnostic formulation is for information about clinical presentation, a treatment formulation is for care pathway planning. Practitioners need to be clear about which kind of formulation they are preparing and avoid confusing one with the other.

A **risk formulation** is an **explanation** of how risks in specified areas arise in a particular individual given the presence and relevance of conditions that we assume to be risk factors – and the absence of other factors that we regard otherwise as protective factors – for a hazardous outcome that is to be prevented. Traditionally, this explanation is a narrative account of the ways in which the risk factors most relevant to the hazardous outcome – identified using risk assessment tools or the guidance points – interact with one another or 'knit' together to generate levels of risk regarded as unacceptable in the context in which the individual is being managed.

A risk formulation guides risk management planning by making evident the risk factors to be targeted in order to manage and thereby minimise risk. A risk formulation should be used as the **benchmark** against which the effectiveness of risk management may be measured over time.

Key Tasks in <u>Formulating Individual Risk</u>:

- Identify – using appropriate clinical risk assessment tools or carefully structured clinical judgement – those risk and protective factors regarded as most relevant to the occurrence of the hazardous outcome to be prevented;
- Determine how they interact with one another or 'knit' together to create an unacceptable level of risk, and which risk and protective factors are therefore most critical and/or unique to the individual;

- Describe this formulation in words, where risks in one area (e.g., harm to others) are formulated separately from risks in any other area (e.g., risk of harm to self).

2.5 Developing a risk management plan

A **risk management plan** should be based on the outcome of the risk assessment that preceded it. The risk management plan should target those risk and protective factors deemed in the assessment to be essential to the elevation of risk.

Risk management planning involves evaluating the contribution to risk management of **treatment** (psychological therapy, medication, milieu therapy, other psychosocial interventions), **supervision** (restrictions on activities or structures and supports that should improve the functioning of protective factors), **monitoring** (the identification and detection of early warning signs of a relapse to violence or self-harm and an agreement about action to be taken in response to their observation), and if required, **victim safety planning** (attention to the ways in which targets of harm can make themselves harder or more resilient to harm or in a better position to avoid victimisation). Once again, the service user's thoughts and opinions should be taken into consideration because without their information and guidance, risk management planning may not be appropriately targeted or effective.

Key Tasks in <u>Risk Management Planning</u>:

- A risk management plan must be based on the risk assessment that preceded it and, in particular, from the risk formulation.
- The risk management plan will target trigger factors first (e.g., unstable mood, paranoid beliefs) before predisposing factors (e.g., personality disorder).
- Risk will be managed through attention to activities in four areas: treatment (e.g., medication, psychological therapy), supervision (e.g., restricted activities, structure, supports), monitoring (i.e., identification of early warning signs and agreed action on their observation), and if required, victim safety planning.

2.6 Updating the plan

A risk management plan should be updated by reviewing critical and other relevant risk and protective factors on a regular basis. **Change** in risk and/or protective factors in any area should prompt a **revision of the relevant risk formulation**.

The **timing** of revisions or reviews of risk management plans should be realistic and agreed in advance. Therefore, LOA risk assessments should be renewed/revised on each occasion that an LOA is due to occur. An individual whose risks are being managed, such that there have been no recent incidents of violence or self-harm, may be reviewed monthly, or six-monthly or following a course of treatment designed to alter a predisposing risk factor (such as personality disorder). An individual whose behaviour is volatile and unpredictable should be reviewed on a daily or weekly basis.

Revisions should involve a review of (a) **relevant risk and protective factors**, especially those regarded as triggers, (b) the **risk formulation** for the hazardous outcome of concern, and (c) **treatment**, **supervision**, and **monitoring** provision as well as and **victim-safety planning** activities.

Key Tasks of <u>Updating Risk Management Plans</u>:

- Update risk management plans following a review of relevant risk and protective factors and risk formulation.
- Update treatment, planning, supervision and victim-safety aspects of the risk management plan on each review.
- Agree timetable for updating plans at the time of initial or last assessment.

2.7 Risk communication

A risk assessment and risk management plan is only useful to others if its contents are communicated clearly and contain all the information fellow practitioners need to assist in the prevention of harm. Reports of risk assessments and plans should refer to the following:

(a) a clear statement about **why** the assessment was undertaken and **what** will be done with the findings,
(b) a clear statement **identifying the harmful outcomes to be prevented**,
(c) the extent to which the service user was able to **collaborate** in the assessment process and why and how the assessment was carried out in the event that the service user **refused to cooperate**,
(d) the extent of the **involvement of others** in the assessment process,
(e) **how** the assessment was carried out, including a description of the tools used, if any,
(f) a statement about the **risk and protective factors most relevant** to the harmful outcomes to be prevented (critical),
(g) a **risk formulation**, or more than one in the event of a service user presenting risks in several areas (critical),
(h) a **risk management plan** linked directly to the formulation and covering the areas of **treatment**, **supervision**, **monitoring** and **victim safety planning activities** (critical).
(i) The report should conclude with a clear statement about **when** the assessment should be reviewed, and **what** aspects of the current assessment should be targeted on review at that time.

(j) If one or more clinical risk assessment tools were used to inform the assessment and management process, the details of the findings of this aspect of the assessment should be put in an **appendix** in order that this level of detail does not detract from the risk formulation.

Attention should be paid to the **style of writing** – findings and recommendations should be clear.

Reports containing the findings of a risk assessment and a risk management plan could include all of the above features and run to **one or two pages**. Alternatively, a risk assessment and management plan on admission to the hospital may be **in excess of ten pages in length**. Risk communications will vary widely in length but the essential features of an evaluation of this nature should not be compromised because of the need for a quick or brief assessment.

If possible and feasible, show a **draft of the risk communication** to the service user and seek their opinions about (a) inaccurate reporting, and (b) differences of opinion. Consider making changes or additions to the report on the basis of what the service user has said as feedback. Securing the collaboration of the service user at this stage and in this way may reduce any negative responses to the final report. Such a process also **models collaborative risk assessment and management**.

Key Tasks of Risk Communication

- The communication of the findings of a risk assessment is an essential part of the whole evaluation process.
- Regardless of the nature or the expected length of the final communication, the report must contain certain information – information about relevant risk factors, a risk formulation, a risk management plan, and a date for review.
- As much as possible, the service user should have a role to plan in both the assessment and management planning and in the completion of the report.

3. Guidance on clinical risk assessment tools

The main part of this Portfolio provides summary descriptions of the important risk assessment tools acceptable for use by practitioners in the various Directorates and services in Mersey Care NHS Trust. Tools have been identified as acceptable on the basis of their capacity to provide evidence-based support for professional judgements about the risks posed by and to service users. Each of the tools was designed to help practitioners gather the information most relevant to the risks being assessed using the framework described above.

The choice of clinical risk assessment tool largely depends on the risk being assessed; one would not use an instrument designed for assessing violence risk to assess the risk of suicide or self-harm. However, some information is common to all risk assessments, and section 3 describes tools that assess multiple risks, differentiating them from those assessing specific risks.

Everyone has a role to play in the collection and evaluation of information relevant to risk and in the process of managing the risks identified. Training in clinical risk assessment is an important part in the process of ensuring all practitioners in the Trust are aware of their role and responsibilities in respect of risk assessment and management. Training is also essential to ensure the appropriate and consistent use of sometimes highly specialised risk assessment tools. Training courses in clinical risk assessment practice are available for suitably experiences and qualified practitioners in Mersey Care NHS Trust. Information about training is provided in the policy to which this Portfolio is linked and a summary of the training requirements for each tool described in the pages to follow.

This Portfolio does not offer the reader access to actual copies of the tools described. Most of the tools are copyrighted, they cost money to buy, and they are suitable for use only by those who are experienced and trained to use them and describe their use in reports and statements that may be submitted to Court. However, what follows is basic information about what you and your colleagues could be using and why, and where you should go to find out more.

This section begins with a summary of the tools acceptable for use in Mersey Care NHS Foundation Trust to structure assessments of clinical risk. Appendix 1 summarises the training requirements for each tool and the level of assessment provided.

Coordination and management of Risk Assessments in the Trust

The Suicide Prevention and Clinical Risk strategy Group will:

- Review the efficacy of using each of the recommended risk assessments tools on an annual basis.
- Liaise with Division leads to gain information on the number of staff who have received training on the use of specific assessment tools.
- Monitor the valid and appropriate use of risk assessment tools within the trust, including the access to copyright.
- Coordinate trust wide training where this is appropriate.
- Identify gaps in use and availability of specific risk assessments.
- Provide a report annually for the Health and Safety Committee regarding the use and availability of specialist risk assessments.

The role and Responsibilities of Division, Clinical Leads

Each Division will nominate a senior clinician to oversee the use of frequently used risk assessment tools. One individual may become the lead for several risk assessment tools, or have responsibility for the use one specific tool . They will:

- Become proficient in the use of the assessment tool and provide guidance in its use to colleagues.
- Apply for copyright.
- Identify how many staff need to be trained to use the tool and organise access to suitable sessions, either Division specific or trust wide.
- Report any gaps in availability regarding risk assessment tools to their Division director and the Suicide Prevention and Clinical Risk Strategy Group.
- Monitor the currency of the assessment tools used by reviewing the literature, attending clinical risk management training etc.

Clinical Risk Assessment Tools

Overview

The following table provides an overview of the clinical risk assessment tools suitable for use in Mersey Care NHS Foundation Trust and an indication of their optimal area of use.

TOOLS	Risk of harm to others	Risk of sexual harm	Risk of self-harm/suicide	Risk of self-neglect/ vulnerability
Multiple risks				
Care Programme Approach (CPA) Risk Screen	●	●	●	●
Clinical Outcomes in Routine Evaluation (CORE)	●	●	●	●
Intermediate and Joint-Risk Assessment and Management Plan (I-RAMP, J-RAMP – Learning Disability Services only)	●	●	●	●
Short-Term Assessment of Risk and Treatability (START)	●	●	●	●
TILT High Risk Patient Assessment (High Secure Services only)	●	●	●	●
Risk of harm to others including sexual violence				
HCR-20	●			
Risk for Sexual Violence Protocol (RSVP)		●		
Sexual Violence Risk-20 (SVR-20)		●		
Spousal Assault Risk Assessment Guide (SARA)	●			
Structured Assessment of Violence Risk in Youth (SAVRY)	●			
Risk of harm to self or suicide				
Beck Hopelessness Scale (BHS)			●	

Assessment of Multiple Risks

Title:	**CPA Risk Screen**
Author:	Department of Health
Trust/Division Lead:	Steve Bradbury, Head of Quality and Improvement
Target population:	Any individual where potential risks have not previously been assessed or they require review, or where details of a risk assessment are not available
Risks assessed:	Examines a comprehensive set of indicators to identify areas for further assessment using more formal tools, covering the key areas of (a) harm to others, (b) harm to self and suicide, (c) self-neglect, and (d) risk of victimisation or vulnerability
For use by:	All practitioners in Mersey Care NHS Foundation Trust
Training needed:	The Risk Screen should be used under supervision until user is sufficiently experienced
Training provided:	Cascaded through supervisory arrangements
Copyright information:	The CPA Risk Screen is the property of the NHS and Mersey Care NHS Trust, as with all other trusts, has use of it in this local area
Evidence base:	There is no formal evidence base, but it is a good practice risk screen based on work from the Sainsbury Centre for Mental Health
Further information:	This tool should be used to screen for indicators of risk in key areas, which should inform subsequent, more detailed assessments

Title:	**Clinical Outcomes in Routine Evaluation (CORE)**
Author:	Mental Health Foundation and CORE System Group
Trust/Division Lead:	Contact Steve Morgan in the first instance at steve.morgan@merseycare.nhs.uk
Target population:	Clients entering adult mental health care services for the first time, or returning to mental health services after a period out of care, and/or where information is not readily available and potential risks are unknown
Risks assessed:	Screens four dimensions – well-being, problems or symptoms, functioning and risk – using a self-report questionnaire; the risk section is brief
For use by:	All practitioners in Mersey Care NHS Foundation Trust where they with more detailed information than is available from the CPA Risk Screen
Training needed:	See organisational Training Needs Analysis
Training provided:	Via Trust e-learning package
Copyright information:	Mental Health Foundation and CORE System Group c/o the Psychological Therapies Research Centre, 17 Blenheim Terrace, University of Leeds, Leeds LS2 9JT; 0113 233 1957 or ptrc@psychology.leeds.ac.uk
Evidence base:	Please contact publishers at address above
Further information:	As with the CPA Risk Screen, the CORE should be used to screen for indicators of problems and risk in key areas, which should inform subsequent, more detailed assessments

Title:	**Intermediate Risk Assessment and Management Plan (I-RAMP)**
Author:	Local Division , Mersey Care NHS Trust
Trust/Division Lead:	Richard Whitehead, Local Division
Target population:	Clients of the Learning Disabilities Directorate already assessed using the CPA Risk Screen, the outcome of which suggests the existence of problem areas requiring further assessment *NB. Complex problem areas should be responded to with a J-RAMP assessment – the I-RAMP assessment can be bypassed in this instance*
Risks assessed:	As required, administer sections on (a) risk to self (e.g., deliberate self-harm, risks associated with mobility, physical or sexual abuse by others, alcohol/substance abuse), (b) risks to others (e.g., verbal or physical aggression, risks to children, fire-setting, theft), or (c) risks to property (client's own property or the property of others)
For use by:	Learning Disabilities Directorate, in particular Named Health Worker and lead clinician
Training needed:	Training is required
Training provided:	A formal training package is available - contact Richard Whitehead and also see the Trust's *Directory of Learning and Development Opportunities* for dates of next courses
Copyright information:	The I-RAMP is the property of the Learning Disabilities Directorate, Mersey Care NHS Trust
Evidence base:	Contact Richard Whitehead and also Jim Williams at the University of Liverpool for more information
Further information:	For further guidance on how the tool should be used and what should be done with the information collected, please contact Richard Whitehead richard.whitehead@merseycare.nhs.uk

Title:	**Joint Risk Assessment and Management Plan (J-RAMP)**
Author:	Local Division
Trust/Division Lead:	Richard Whitehead, Local Division
Target population:	Clients of the Learning Disabilities Directorate already assessed using the CPA Risk Screen and possibly the I-RAMP, the outcome of which suggests the existence of complex or significant problem areas requiring further assessment
Risks assessed:	Risk is comprehensively assessed, including risk in the following areas: (a) suicide, (b) self-harm, (c) abuse, (d) violence to others, (e) criminal offending, and (f) neglect
For use by:	Learning Disability Directorate staff, led by the Named Health Worker (grade G or above) and specialist clinician working with the team
Training needed:	Training is required
Training provided:	A formal training package is available - contact Richard Whitehead and also see the Trust's *Directory of Learning and Development Opportunities* for dates of next courses
Copyright information:	This risk assessment is the property of Learning Disabilities Directorate
Evidence Base:	Contact Richard Whitehead and Jim Williams at the University of Liverpool for more information
Further Information:	For further guidance on how the tool should be used and what should be done with the information collected, please contact Dr Richard Whitehead richard.whitehead@merseycare.nhs.uk

Title:	**Short Term Assessment of Risk and Treatability (START)**
Author:	Webster et al (2004)
Trust/Division Leads:	**For general queries** Steve Morgan, Director of Patient Safety steve.morgan@merseycare.nhs,uk **For specific Divisional issues** Neil Jackson ,Secure Psychological Services neil.jackson@merseycare.nhs.uk Steve Rose, High Secure Services Practice Development Team steve.rose@merseycare.nhs.uk Zoe Prince, Nurse Consultant , Local Division zoe.prince@merseycare.nhs.uk Andy Brown , Nurse Consultant, Secure Division andy.brown@merseycare.nhs.uk Jon Tynan, Specialist Learning Disabilities Division Jonathan.tynan2@merseycare.nhs.uk
Target population:	Service users where there are concerns about risk in the short-term, (hours, days, weeks)
Risks assessed:	Risk of (a) harm to others, (b) harm to self, (c) suicide, (d) substance use, (e) absconding, (f) self-neglect, and (g) victimisation, in the short-term (0-3 months)
For use by:	Clinical teams, especially by qualified nursing members of those teams
Training needed:	Training is essential – START assessments should not be undertaken by individuals who have not been trained in the use of the tool. See organisational Training Needs Analysis.
Training provided:	Training courses are provided by local specialists in each Division *It is expected that suitably qualified and experienced practitioners will attend two training sessions, one to introduce the structured professional judgement approach, and the other to discuss a case formulation based on the START*

Copyright information:	START materials should not be copied – materials available from start@forensic.bc.ca and more information in general from www.bcmhas.ca/Research/Research_START.htm
Evidence base:	Please contact Division leads for copies of the most up to date research papers on the START
Further information:	This assessment is suitable for use when the CPA Risk Screen indicates the presence of risks in key areas, in order to formulate risk and prepare a focused risk management plan, for managing risk in the short-term

Title:	**Tilt High Risk Patient Assessment**
Author:	David McKenna, Director of Security, High Secure Services
Trust/Division Lead:	David McKenna, High Secure Services
Target population:	All service users in Ashworth Hospital
Risks assessed:	Risk of (a) harming others, (b) suicide and self-harm, (c) being the victim of an assault by others, (d) escape, and (e) organising action in collaboration with others to subvert security and safety
For use by:	All clinical teams in Ashworth Hospital
Training needed:	Awareness of assessment tool usage
Training provided:	Cascade training via security liaison nurses, also clinical teams, ward nurse managers, and Responsible Clinicians
Copyright information:	Exact copyright and usage details to be agreed with the Director of Security
Evidence base:	This Protocol has to be used in High Secure services as part of the recommendations made by Sir Richard Tilt
Further information:	If this assessment indicates areas of risk, information is reviewed each time there is a change to the client's presentation, ideally every care team meeting, and at least at the annual CPA review

Title:	**HCR-20 Violence Risk Assessment Guide**
Authors:	Webster et al (1997); revision to manual expected 2011
Trust/Division Leads:	**For general queries** Steve Morgan, Director of Patient Safety steve.morgan@merseycare.nhs,uk **For specific Division issues** Neil Jackson ,Secure Psychological Services neil.jackson@merseycare.nhs.uk Steve Rose, HSS Practice Development Team steve.rose@merseycare.nhs.uk Zoe Prince, Nurse Consultant , Local Division zoe.prince@merseycare.nhs.uk Andy Brown , Nurse Consultant, Secure Division andy.brown@merseycare.nhs.uk Jon Tynan, Specialist Learning Disabilities Division Jonathan.tynan2@merseycare.nhs.uk
Target population:	Individuals with a known or suspected history of violence; mentally disordered offenders, prisoners and individuals in the community; men and women; adults (including individuals whose violent conduct occurred in childhood or adolescence)
Risks assessed:	Violence, in the medium – to long-term (6-12 months)
For use by:	Qualified psychiatrists, psychologists, social workers and nurses with experience of (a) working professionally with individuals with a history of violence, and (b) making structured assessments of clinical constructs
Training needed:	Training is essential – HCR-20 assessments should not be undertaken by individuals who have not been trained in its use. See organisational Training Needs Analysis.
Training provided:	See the Trust's *Directory of Learning and Development Opportunities* for information about training courses, or contact Steve Morgan / Division leads - suitably qualified and experienced practitioners should attend a two-day introductory training course provided by an authorised trainer and

	subsequently, annual updates
Copyright information:	HCR-20 materials should not be copied and only officially printed materials should be used. HCR-20 materials are available from www.proactive-resolutions.com
Evidence base:	Contact HSS Psychological Services for a copy of the up-to-date annotated bibliography for the HCR-20 (dated 2008), listing all the research projects on-going internationally using this instrument; there is an international evidence-base for the use of this tool
Further information:	For further guidance on how the tool should be used, what should be done with the information collected, please contact Neil Jackson.

Title:	**Risk for Sexual Violence Protocol (RSVP)**
Authors:	Hart et al (2003)
Trust/Division Lead:	Neil Jackson, Secure Psychological Services neil.jackson@merseycare.nhs.uk
Target population:	Individuals with a known or suspected history of sexual violence; mentally disordered offenders, prisoners and individuals in the community; men and women; adults (including individuals whose violent conduct occurred in childhood or adolescence) and, with caution, adolescents between the ages of 16 and 17 years
Risks assessed:	Sexual violence, in the medium- to long-term (6-12 months)
For use by:	Qualified psychiatrists, psychologists, social workers and nurses with experience of (a) working professionally with individuals with a history of violence, and (b) making structured assessments of clinical constructs
Training needed:	Training is essential – RSVP assessments should not be undertaken by individuals who have not been trained in their use
Training provided:	Only external training available. Contact HSS Psychological Services for details.
Copyright information:	RSVP materials should not be copied and only officially printed materials should be used. RSVP training materials are presently available from www.proactive-resolutions.com
Evidence base:	For a review, please see comprehensive review in first two chapters of RSVP manual, available from Caroline Logan; the evidence base for the use of this tool as a support for clinical judgement about sexual violence risk is growing
Further information:	For further guidance on how the tool should be used, what should be done with the information collected, please contact Caroline Logan

Title:	**Sexual Violence Risk-20 (SVR-20)**
Authors:	Boer et al (1997)
Trust/Division Lead:	Neil Jackson, Secure Psychological Services neil.jackson@merseycare.nhs.uk
Target population:	Individuals with a known or suspected history of sexual violence; mentally disordered offenders, prisoners and individuals in the community; men and women; adults (including individuals whose violent conduct occurred in childhood or adolescence) and, with caution, adolescents between the ages of 16 and 17 years
Risks assessed:	Sexual violence, in the medium- to long-term (6-12 months)
For use by:	Qualified psychiatrists, psychologists, social workers and nurses with some experience of (a) working professionally with individuals with a history of violence, and (b) making structured assessments of clinical constructs
Training needed:	Training is required – SVR-20 should not be undertaken by individuals who have not been trained in its use.
Training provided:	Only external training is available. Contact Neil Jackson for details.
Copyright information:	SVR-20 materials should not be copied and only officially printed materials should be used. SVR-20 materials are available from www.proactive-resolutions.com
Evidence base:	Contact Neil Jackson.
Further information:	For further guidance on how the tool should be used, what should be done with the information collected, please contact Neil Jackson.

Title:	**Spousal Assault Risk Assessment Guide (SARA)**
Author:	Kropp et al (1999)
Trust/Division Lead:	Neil Jackson, Secure Psychological Services neil.jackson@merseycare.nhs.uk
Target population:	Provides a more detailed assessment of risk of spousal assault among violent offenders initially assessed using HCR-20
Risks assessed:	Risk factors for spousal or family-related assault
For use by:	Qualified psychiatrists, psychologists, social workers and nurses with experience of (a) working professionally with individuals with a history of violence, and (b) making structured assessments of clinical constructs
Training needed:	Training is essential – SARA assessments should not be undertaken by individuals who have not been trained in the use of the structured professional judgement approach at the very least
Training provided:	Only external training is available. Contact Neil Jackson for details.
Copyright information:	SARA materials should not be copied and only officially printed materials should be used. SARA materials can be obtained from www.proactive-resolutions.com
Evidence base:	A summary of information about the evidence base for the SARA can be found in the Scottish Risk Management Authority's RATED-2 document, available to download at www.RMAscotland.gov.uk
Further information:	Contact Neil Jackson.

Title:	**Structured Assessment of Violence Risk in Youth (SAVRY)**
Author:	Borum et al (2006)
Trust/Division Lead:	Neil Jackson, Secure Psychological Services neil.jackson@merseycare.nhs.uk
Target population:	Male and female adolescents between the age of 12 and 18 years
Risks assessed:	Physical violence (in the medium to long term – 6-12 months)
For use by:	Qualified psychiatrists, psychologists, social workers and nurses with experience of (a) working professionally with individuals with a history of violence, and (b) making structured assessments of clinical constructs
Training needed:	Training is essential – SAVRY assessments should not be undertaken by individuals who have not been trained in the use of the structured professional judgement approach at the very least
Training provided:	Only external training available. Contact Neil Jackson for details.
Copyright information:	SAVRY materials should not be copied and only officially printed materials should be used. SAVRY materials can be obtained from www.fmhi.usf.edu/mhlp/savry/statement.htm
Evidence base:	A summary of information about the evidence base for the SAVRY can be found in the Scottish Risk Management Authority's RATED-2 document, available to download at www.RMAscotland.gov.uk and also at the SAVRY website www.fmhi.usf.edu/mhlp/savry/statement.htm
Further information:	For more information, visit the SAVRY website on www.fmhi.usf.edu/mhlp/savry/statement.htm

Risk of Suicide and Self-Harm

Title:	**Beck Hopelessness Scale (BHS)**
Author:	Beck et al (1985)
Trust/Division Leads:	Please contact Steve Morgan for general inquiries steve.morgan@merseycare.nhs.uk Division Leads: Zoe Prince, Nurse Consultant, Local Division zoe.prince@merseycare.nhs.uk Andy Brown, Nurse Consultant, Secure Division andy.brown@merseycare.nhs.uk Neil Jackson, Secure Psychological Services neil.jackson@merseycare.nhs.uk Jon Tynan, Specialist Learning Disabilities Division Jonathan.tynan2@merseycare.nhs.uk
Target population:	All adult service users reporting hopelessness and at risk of serious self-harm or suicide
Risks assessed:	Risk of harm to self
For use by:	Clinical teams across Mersey Care NHS Trust, in particular by or under the supervision of qualified practitioners experienced in the use of the BHS and in the assessment and management of suicide risk more generally
Training needed:	See organisational Training Needs Analysis
Training provided:	None required, although supervision by experienced Practitioners is advised.
Copyright information:	The BHS is copyrighted by Harcourt Assessment. Only officially printed and copyrighted materials can be used.

Evidence base:	There is an extensive international evidence base including testing of the tool's structure and support for hopelessness as a risk factor for completed suicide. The BHS has been found to correlate well with change in clinical symptoms in randomised controlled trials of interventions for high risk or suicidal patients
Further information:	For further information, contact Neil Jackson in the first instance. Also go to www.harcourt-uk.com

From Mersey Care NHS Foundation Trust Policy and Procedure on the Use of Clinical Risk Assessment Tools (SA10):

2.1.3 Clinical risk assessments may be extensive (several pages long, as in *Level Three risk assessments* contained in specialist reports, described below) or they may be brief (1-3 paragraphs, describing *Level Two risk assessments* contained in clinical case notes such as EPEX, described below). They may be regarded as clinical risk assessments when they contain *all* of the above five elements.

Level 1 Assessments

2.1.4 *Level One risk assessments* are those assessments that are brief to do and report (5-30 minutes), involve a review of mainly recent clinical information (the last week or so), and are likely to inform risk management in the following few days or weeks. *Level One risk assessments* largely involve practitioners identifying risk factors and possibly protective factors and making brief recommendations for risk management plans. *Level One risk assessments* require regular review and their relative brevity makes this possible. Examples of Level One risk assessment tools used in Mersey Care NHS Foundation Trust are as follows: *CPA Risk Assessment, pre-discharge risk reviews, pre-leave risk reviews*.

Level 2 Assessments

2.1.5 *Level Two risk assessments* involve a little more work than Level One assessments and risk formulation and risk management planning are detailed and explicit. The same tools may be used as in Level One assessments but the practitioner spends more time thinking about the information to hand, preparing a formulation and designing a risk management plan. Alternatively, more specialised tools, such as the *Short-Term Assessment of Risk and Treatability* (START), may be used to make more detailed observations about risk and protective factors and more comprehensive risk management plans. Because of the detail and the attention given to the way in which harmful outcomes might occur in the future, Level Two assessments are likely to be informative of risk over quite short time periods (hours, days) as well as up to weeks and even several months from the time of assessment. *Level Two risk assessments* may take up to 45 minutes or an hour to do and brief training is recommended to ensure that tools can be used to the maximum benefit.

Level 3 Assessments

2.1.6 The most detailed level of clinical risk assessment require comprehensive tool-based evaluations of historical and clinical risk factors. Level Three assessments are the most demanding in terms of time (they require upwards of a day to complete due to the need to research clinical notes, interview the service user and others, and write a detailed report running to several pages in length) and skill base (i.e., training in the use of specific clinical risk assessment tools plus supervised practice). Examples of *Level Three risk assessments* are as follows: *HCR-20 violence risk assessment guide*, the *Risk for Sexual Violence Protocol* (RSVP), and the *Spousal Assault Risk Assessment Guide* (SARA). Findings at this level of risk assessment will be informative for periods of time from several months up to a year although reviews can take place more regularly depending on the service user's clinical presentation and their place on the care pathway. In general, however, such assessments are regarded as longer-range forecasts of risk as compared to Level One and Two assessments.