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Risk Assessments for mental health service users: ethical, valid and reliable?

Abstract

This article considers the nature and basis of risk assessments in mental health services, based on empirical research on the tools used within NHS Mental Health Trusts in England which found a wide variety of such tools in use within them. The article examines the problems and potential benefits in the use of such tools, and argues for an inclusive and holistic approach to risk assessments which incorporate our knowledge of the risks of risk assessments. The article pays particular attention to risk assessment procedures as relevant to social workers who have to uphold the requirements of the General Social Care Council Code of Practice, which provides particular emphasis on issues of risk, and service user and carer involvement in assessments. Potential biases and limitations of risk assessment approaches, it is proposed, need to be taken into account in order to have a balanced view of the value of such approaches. The article provides a critique of the validity and effectiveness of current risk assessment tools, focusing in upon one key area in mental health work, the assessment and management of potential violence.

Article (7955 words)

Introduction

It can be argued that the core business of public agencies such as local authorities, NHS Mental Health Trusts and probation is framed in terms of their risk strategies (Beck, 1992, Giddens, 1990, 1991; Rose 2002). For mental health services, risk strategies which have become 'operationalised' through practice guidance and form a central theme in the National Health service's National Service Framework (Department of Health, 1999), and provide a particular emphasis within the new Care Programme Approach (Morgan, 2007). Concepts of risk are constructed by the media, government and the public, and these are increasingly impacting upon professional practices (Denney, 2005; Morgan, 2007). For Beck (1992), this situation is indicative of an emerging 'Risk Society', where notions of risk and risk strategies have been adopted from the corporate world and internalised by the legal, scientific academic and other professions.

Giddens (1990, 1991) argues that one reason for this is a breakdown of trust in society. Public agencies, and professionals who work within them, are increasingly treated as untrustworthy, and in need of regulation and inspection from central government agencies such as the Commission for Care Standards Inspection (see

www.csci.org.uk/). In social work services, for example, Parton and O'Byrne contend that

'...social work, particularly in the UK, has lost its way. In particular, we (the authors) have become concerned that social work both in the way we think about it, and practice it, has become very defensive, overly proceduralised and narrowly concerned with assessing, managing, insuring against risk', and since the 1990s, the introduction of sophisticated attempts to make 'social workers accountable for, and subject their practice to, ever more detailed reviews, inspections, audits and managerial oversight and prescription.' (Parton and O'Byrne, 2000:1).

This article examines the reliability and justifiability of such an emphasis on risk assessments in mental health work, and provides a critique of current risk assessment tools, strategies, and practice, and in particular in relation to one particular issue in mental health work- the assessment and management of potential violence. Within this analysis, the framework for professional social work practice as set out in the General Social Care Council (GSCC) Codes of Practice (2002), which social workers employed in mental health services are required to enact, and the effects of the Codes concerning the involvement of service users and carers in risk assessments, will be discussed. Following a critical discussion of the bases upon which models of risk are constructed, the article moves on to examine issues arising from the variability between professionals in their decision making.

The knowledge base for mental health risk assessment

The bases on which professionals assess risk and act upon such assessments have changed significantly in recent times. Kronenfeld and Glik (1991) saw the current perceptions of risk in the medical sociology field as reflecting a shift in people's thought processes away from emphasis on fate or luck, to concepts of prediction and control. This scientific rationalism has itself being challenged as the dominant scientific paradigm for explaining and predicting events; certain elements of scientific theory have challenged the concept that events are explicable and predictable, and that such ideas of predictability demonstrates a misunderstanding of science which, in fact, has increasingly emphasised chance and randomness as features in many complex systems, for example, within theoretical constructs such as quantum physics and chaos theory (see e.g. Lorenz, 1972). These approaches draw from technical /rational based scientific methods as utilised in the natural sciences. Drawing upon such theoretical constructs, current risk assessment procedures are based on the premise that we can fully know and understand the world around us, and that we can determine cause and effect from observation of events within a positivist paradigm. It is these notions of predictability and control which are important in contemporary risk assessment and decision-making in mental health work.

Whilst scientific methods demand replicability and experimental evidence as the basis of knowledge and action, usually examining only very few factors (and often only one), in the area of social work services, this is much more problematic. It can be argued that there is a multitude of possible influences which can vary over time,

within different contexts, at any one particular point in time which can affect the service user's actions and decisions. This means it is very difficult to attempt to have a high level of certainty and predictability in the personal social services (Morgan, 2007; Titterton, 2005; Webb, 2007). In the area of risk, there seems to be a leap from theory to claims of operational expertise, and little work has been carried out to produce an effective social model of risk (Blumenthal and Lavender, 2000; Stalker, 2003; Titterton, 2005).

Dominant risk paradigms

Within the field of social work, as opposed to the natural sciences, however, two areas consistently arise as being key features of such risk assessments; these are actuarial and individual professional based approaches. If we look at the prediction of violence for individuals, Fitzgibbon argues that clinical and actuarial risk assessments on their own are 'remarkably inefficient ways of predicting who will proceed to commit offences' (2007:137). Indeed, there is evidence that the mix of actuarial methodology and individual characteristics of violent offenders which are used in such social systems, is ineffective in predicting risk (Morgan, 2007). In addition, the fact that very rare events, which constitute most of the high risk areas in human service work, such as people with mental health problems who may carry out violent acts against others, including murders, are less likely to be accurately reflected in general risk factors by such actuarial data. For example, the next sexual offence which will occur is more likely to be committed by somebody who has no prior record of such offending than someone who has (Aldhous, 2007). Much sexual offending, and probably the great majority of it, goes undetected, so therefore it is not possible to use quasi-actuarial data arising in predicting risk, as the factors involved in situations where many- probably the majority- of those who commit such offences are neither prosecuted or convicted. Therefore, factors in these unknown (to agencies) situations cannot be included in any such actuarial assessment or systematic review of risk factors. Actuarial bases for such prediction of individual human behaviour are difficult to import from the worlds of, for example, insurance, where it can work effectively. This is because, unlike the world of the personal social services, insurance companies group together risks. So for example in car insurance, insurance companies group together categories by age bands, postcode, type of car, previous record of accidents/thefts etc; what they do not try to do is to predict which one of the insured individuals over the ensuing year will have an accident in their car, or have their car stolen. Yet this is precisely what risk assessments are expected to achieve in the personal social services- i.e. predict what an assessed individual's behaviour will be in the future.

Even if actuarial statistics are seen to be valid in such circumstances, this does not necessarily aid agencies or practitioners to decide what to do about such assessed risks, and what level of risk should lead to certain decisions and actions. Let us assume that there were to be a normative way of estimating the probability of a specified outcome, for example, in relation to the probability that a service user under

a compulsory order in the mental health system might be violent towards somebody in the forthcoming year. If there were to be an assessment of probability of 100% of this event (which could always be contested in any event), what would the responsible professional do? It may be this is a clear indicator, for example, for continuation of a compulsory order and detention in a mental health unit. However, what if the probability of the event were to be assessed as 90%; would this justify the same decisions/actions as for a probability of 100%? And on what basis? The same question then can be posed for an 80% probability, 70%, 20% or 1%. At what point on the sliding scale of probabilities does a professional *not* do what they *would* do for the 100% probability?

In addition to these questions about risk assessment processes in the social field, in the mental health area, in contrast to the highly developed and centralised risk assessment in probation work for example (Canton, 2005), there is at present no generally accepted set of factors in assessments to guide professionals in areas known to be risk factors for and from mental health service users, based on a systematic review of the evidence base. Hawley et al.'s (2006) research demonstrated significant variability in the elements, and processes for, risk assessments across different Mental Health Trusts in England, and demonstrates that there can be significantly different assessments made for individuals in different parts of the country. These factors are then compounded by our knowledge of the great variation in the use of risk assessment tools by different individual professionals.

How professionals assess risk

Relatively little is known about how social workers actually assess risk. What is known is that there is long-standing and clear evidence that judgments made by individual professionals can vary significantly even when using the same risk assessment tools (Morgan, 2007).

If we look to research in comparable professions in the mental health field, Brunton (2005) examined how psychiatric nurses assess risk, with particular reference to the risk of violence in crisis situations, and found a paucity of literature on the ways nurses assess risk- which is also true for social workers. The largest body of research was opinion- based, rather than based on empirical research. Brunton notes that decision-making is an essential and integral aspect of clinical practice, and that risk assessment has become a major feature which impacts upon such decision-making. He notes that nurses need to develop skills of critical thinking to progress their clinical competence further, particularly in relation to risk assessment and dangerousness, as the evidence is that nurses are often unaware of how they go about such decision-making processes. He considered that nurses rely to a great extent on unexamined intuition and 'experience'. He argues that whilst intuition may have a part to play in identifying initial issues, structured risk assessments are needed in order to improve the validity and reliability of nurses' risk decision-making- a

conclusion also reached by Canton in relation to risk assessment in probation and mental health services (2005).

Normative models of decision-making

Normative models of decision-making try to overcome such problems for professionals to help them make more rational, objective assessments that are likely to bring about the desired outcome (Middleton et al., 1999). The aim of such normative, rule-based models is to exclude biases in decision-making processes. The problem with such models is twofold; firstly, that they are based on the idea that the world is explicable and predictable as long as we have the correct data, and use it in the “right way”. Secondly, even if we accept that within the largely unpredictable social world and motivations of individuals that it is possible to accurately use such methods, one of the limitations of such technical/rational models is that they are very time-consuming and require high levels of skill which few staff have, and will be expensive and time-consuming to train staff to fulfil (Brunton, 2005). This then touches on the issue of unbounded rationality, which takes as its premise that if a professional is given all the data and unlimited time, it is possible to reach a truly normative judgment. However, one of the difficulties in this argument concerning unbounded rationality is that such normative judgments require infinity of data and infinity of time- but also that it is beyond the computational ability of the human mind. Therefore all risk decisions using analytic methods are by definition suboptimal against a truly normative standard. Other factors then come in to play when professionals attempt to analyse these multitude of possible factors, probabilities and variability in assessments. These include the issue of the heuristics, particularly the availability heuristic.

The availability heuristic

One area of bias in professional decision-making and risk assessments is the result of the availability heuristic (Middleton et al. 1999; Gale, Hawley and Sivakumaran, 2003). Heuristics are basically ‘rules of thumb’ professionals follow in order to make judgements quickly and efficiently. People use judgement heuristics to process the large amounts of information with which they are faced (see e.g. Girgenzer, 2000). The availability of information to professionals will affect their judgements about the likelihood of certain events, and hence their prediction of risk. Tversky and Kahneman (1974) considered the availability heuristic to be the process whereby decision-makers assess the frequency or probability of an event by the ease with which instances or occurrences can be brought to mind - hence the greater focus from the media, politicians, and potentially agencies and professionals, on the likelihood of people with mental health problems carrying out murders after one or more highly publicised events. The more dramatic and easy to visualise the reported event the more likely it will be contained within such a heuristic.

One element affecting the availability heuristic for agencies and individual workers is examined by Butler and Drakeford (2003, 2005), in relation to the extent to which policy and practice can be affected by the findings and recommendations of formal Inquiries on single and isolated media and politically constructed “scandals” within mental health and social care work. Butler and Drakeford examine the forces involved in setting the Inquiries’ terms of reference, and the effects on policy, guidance and practice arising from each scandal they study. They then demonstrate how subsequent public and agency policy can be heavily influenced by the findings of tragic, but rare and unrepresentative types of situations in social work, influencing perceptions of risk for public, professionals, and social work agencies. This thesis would appear to be supported by the *Avoidable Deaths* report from the National Confidential inquiry in 2006, which, having examined 249 cases of homicide by current or recent patients, found no evidence of an increase in such homicides over previous periods (University of Manchester, 2006).

Butler and Drakeford consider the concern from politicians, the media, and professionals concerning perceived high risk of mental health patients murdering members of the public, following several highly publicised such events in England in the last few years of the 20th century, such as the murder of a complete stranger by Christopher Clunis (2003, 2005). Such inquiry findings have led to proposals in England and Wales which would allow people with “Dangerous and Severe Personality Disorders” to be detained even where there is no anticipated therapeutic benefit (Canton, 2005). Szmuckler (2000) raises questions as to how far we should take findings from individual Inquiries in reformulating policies in this way.

These queries concerning the objectivity and effectiveness of professional decision-making again add to other concerns in this area, such as the variation in content and construction of risk assessment tools in NHS Mental Health Trusts in England found in the research of Hawley et al. (2006).

Risk Assessment Tools in NHS Mental Health Trusts in England

The findings of research study into risk assessment tools used within NHS Mental Health Trusts in England provides evidence of the wide variability in the content of such tools (Hawley et al., 2006). These Trusts now employ social workers, medical staff, nurses, occupational therapists, and other professionals, all who may use such risk assessment tools. 83 Trusts were contacted, and 53 (64%) provided returns. This research provided evidence of a number of factors in policies and practices which require to be taken into account in risk assessment and risk management processes and procedures.

A content analysis of the areas covered in the Risk Assessment Tools was undertaken. Within such a content analysis there is a process of identifying certain main themes within the documents examined (Burns, 2000). This then leads to the systematic

identification of the major categories and subcategories within these themes. This can then be used as the basis for the construction of a taxonomy of categories and issues formulated from the analysis, giving indications of where there are important elements within the document, and in this case, between documents.

As part of the research, categories were constructed and analysed in relation to whether there was historical/current evidence of possible risk for the person being assessed, or whether the judgement in the category appeared to be founded upon more widely based evidence of risk to certain groups from an actuarial based approach.

Category 1: Suicide

The most commonly mentioned category within the risk assessment tools was that of suicide. 47 of the 53 forms addressed this (89%). Perhaps what is surprising in this finding, given the great emphasis on this area in the National Service Framework (Department of Health, 1999), and the literature and research on mental health, is that this factor was not present in all risk assessment forms.

The following items were mentioned at least once in each of the forms examined. The percentages given below are the forms which included the subcategory at least once.

- Suicide attempts – 70%
- Suicide intent – 45%
- Suicide ideation—40%
- Violent methods of self harm – 19%
- Suicide threats or gestures – 13%
- Life-threatening attempt – 2%

Generalised risk factors in relation to suicide were also mentioned in the forms, seemingly but not explicitly based on research evidence:

- Lack of control/little control over life- 21%
- Separated/widowed/divorced – 17%
- Expressing high levels of distress – 17%
- Client suffers from a major mental illness – 17%

One identified area within the contents of the forms which was difficult to categorise, concerning the basis on which it is judged, was ‘risk of suicide attempt’, which was contained within 26% of the forms.

Category 2: Self harm

Self harm was mentioned in 42 of the 53 forms (79%).

Again, the surprising feature here is that it is not mentioned in 21% of the forms examined.

The subcategories within these 21% of forms are as follows:

- Deliberate self harm – 33%
- Past history of harm – 29%
- Ideas of self harm – 21%
- Current self harming behaviour – 7%
- Historical self harm through e.g. bulimia, anorexia, starvation – 10%
- Attempted to conceal an act of self harm – 2%
- Non life-threatening self harm—2%

Generalised risk factors which appeared on the forms are as follows:

- Risk of deliberate self harm 29% - (it was not clear if the judgment was to be based on historical evidence, or how the information was to be sought)
- Minor self harm – 2%
- Accidental self harm- 14% - (again, it was not clear if the judgment was to be based on historical evidence, or how the information was to be sought).

Category 3: Risk to others

This category was mentioned in 39 of the 53 forms (74%). Again, the query has to be raised as to why this was not present in the other 26% of the forms, given the concerns which there have been, rightly or wrongly, in relation to mental health service users and the risk of violence, as set out previously in this article.

In addition to having the largest omission rate amongst the forms, this was the category that was broken down into the most subcategories:

- Previous violence/history of violence- 79%
- Violent fantasies/delusional ideation—46%
- Conducted arson or expressed intent – 46%
- Current thoughts, behaviour or symptoms indicating a risk of violence/abuse – 41%
- History of harm to others – 33%
- History of using weapons – 33%
- Expressing or intent of preparation to harm others – 33%
- Hallucinations, e.g. auditory /can be violent – 33%
- Abuse and exploitation of others – 31%
- Previous secure settings placement, for example prisons/ special hospitals – 31%
- Conviction for violent or sexual offences – 18%
- Previous dangerous impulsive acts- 26%
- Denial of previous violent acts – 10%
- Previous serious violence – 8%
- Other activities suggesting risk, for example stalking, injunctions – 8%
- Hostility shown to others – 5%

- Immediate risk to physical safety of others as a result of dangerous behaviour – 3%
- Hostage taking – 3%

One grouping of subcategories related to sexual offending and behaviour:

- Inappropriate sexual behaviour – 28%
- Risk of past sexual abuse or assault – 28%
- Risky sexual behaviour- 8% (it was not always clear in the forms how this was defined)
- Fantasies of sexual behaviour – 3%
- On the sex offenders register- 3%

The fact that not all forms expressly address issues of violence and self harm do not appear to be in accordance with government policy which states that service users' risk of harm to others should be routinely assessed by mental health professionals (Department of Health, 2000). Also, given the emphasis on domestic violence in public policy in recent years, it is of note that this issue is not expressly considered for people with mental health problems either as victims or perpetrators (Morgan, 2007).

Basis of assessments

It was not clear in the great majority of forms on what basis the assessment of each category is made. There was a clear need to make explicit on what basis the judgement was to be made, for example, on the basis of previous history of the individual's behaviour? If so, where will this information come from, and can it be relied upon? Is it based on actuarial methods, relevant to the person's situation being assessed, and related to their clinical diagnosis and social circumstances assessment? There was no indication in the forms of how, or if, service users and/or carers contributed the risk assessment.

Issues of timescales and currency of information/assessments were found to be a significant area of concern when examining the initial risk assessment. Whilst most of the categories were based on historical features for the assessed individual, rarely was there consideration given to timescales which would be relevant; did the incident(s) occur 12 years ago, or two days ago? Was it an isolated or repeated behaviour, with a pattern of behaviour over a period of time, and if so how well is this documented and analysed? These were all areas of concerns in relation to the majority of forms studied. Nor was attention paid to the possible risks within a future time span, so such risk factors might have been relevant within the next two days, or in the next few years.

Acceptable biases?

The findings of this research give further weight to the criticisms of Higgins *et al.* (2005) concerning how a professional is to make sense of how they evaluate their

assessment of risk given the weaknesses of current models, processes and tools. When we consider these research findings, and set them against the issues arising from current knowledge about the risks of risk assessments as set out so far in this article, this research into risk assessment tools used by NHS Mental Health Trusts in England provides evidence concerning how there may be a ‘multiplier’ effect in relation to assessment of risk for individual mental health service users. The acknowledged problems in the tools themselves, when we add to this our knowledge of the variation in how risk assessments may be carried out by different individual practitioners, the possibility of bias free assessments- and therefore the decision making processes based upon them- become exponentially reduced, raising questions about how such risk assessment tools, and the use of professional knowledge and understanding of service users situations, should be considered in risk assessment processes. The effects on service users of such processes, and how they might be included in them more effectively, are now considered.

Service User and Carer involvement in risk assessments

Mental health social workers who are assessing risk have significant powers in terms of the effects of decisions they can make concerning service users’ lives. This is particularly true when acting in the Approved Social Worker role under the Mental Health Act 1983 in relation to compulsory admission procedures, and when in the future they will be acting as Approved Mental Health Practitioners under the new Mental Health Act 2007. Given these powers, and the areas of concern in relation to the reliability and effectiveness of risk assessment processes as currently formulated in mental health services, we now turn to the question of how ethically sound the use of such risk assessments are when considered against the GSCC Codes of Practice for social workers.

The General Social Care Council (GSCC) is the professional regulatory body for social workers in the UK. Its Codes of Practice (General Social Care Council 2002) place great emphasis on social workers taking the nature, basis and effects of risk assessments and any resulting risk management strategies seriously. The relevant sections are as follows:

“As a social care worker, you must respect the rights of service users while seeking to ensure that their behaviour does not harm themselves or other people.

This includes:

- Recognising that service users have the right to take risks and helping them to identify and manage potential and actual risks to themselves and others;

- Following risk assessment policies and procedures to assess whether the behaviour of service users presents a risk of harm to themselves or others”.

The Codes also require social workers to take into account the service user’s perspective in assessments and interventions, for example as set out in the following sections:

- “Respecting and, where appropriate, promoting the individual views and wishes of both service users and carers;
- Supporting service users’ rights to control their lives and make informed choices about the services they receive;
- Promoting the independence of service users and assisting them to understand and exercise their rights;
- Recognising and using responsibly the power that comes from your work with service users and carers.”

These elements of the Codes provide significant areas for consideration when applying risk assessment tools in social work.

Given some of the uncertainties about risk assessments raised so far in this article, and the effects on service users of assessments that can stay with people potentially for life, a further important consideration concerns the extent to which such assessments are commensurate with service users’ and carers’ interests, and also to what extent service users and carers should be involved in such risk assessments, as recommended in a recent Department of Health (2007) document.

Research exploring risk assessment and risk-management from the perspective of how much service users perceived themselves to pose a risk to others provides some valuable insights into issues concerning risk assessments for mental health service users (Langan, 2000; Langan and Lindow, 2004). The study involved 17 service users, and relatives, friends, mental-health and other community staff. Among the service user participants, 12 had assaulted someone, 5 had made a serious threat or indirect threat of risk of harm, for example to children or others. 9 had attempted suicide, and 5 had considered suicide.

The study found great inconsistencies in approach concerning how staff assessed risk. One of the most effective ways of approaching risk assessment was to get to know the service user over time and to engage with them; according to Langan this was likely to give a far more balanced assessment over systems involving a series of tick boxes.

Langan also encountered contradictions in the way that staff viewed risk assessment. While some thought that a more formal risk assessment was just a way of ‘covering their backs’, many said they would like to see a more systematic means of assessment. Among service users, the study found varying levels of agreement - some saw their assessments as reasonably accurate, whilst others disagreed with them. The study found that professionals are often fearful of being honest with service users, believing that honesty about risk assessments might actually generate risky behaviour. In Hawley et al.’s study (2006), it was not clear from the forms which were examined how service users were involved in their risk assessments, if at all; in light of the present agenda within health and social work to include service users/patients in their care and treatment, it seems that in this important area of mental health assessment work, there is much work still to be done to include people within their own risk assessments, and risk management plans.

Taking these considerations raised in this article so far into account, this article now applies these considerations to a highly charged area of mental health work in recent years, which demonstrates the effects of politically charged discourses, particularly following the Christopher Clunis inquiry (Butler and Drakeford, 2003, 2005): the assessment of risk of violence from mental health service users.

Mental health assessment and Risk of violence

The problems associated with current models and practice in relation to risk assessment is highlighted further when we examine a particularly important issue in the mental health field, relating to the risks of violence in relation to people with mental health problems, and one of the key areas for Approved Social Workers (the role to be reformulated as Approved Mental Health Practitioners in 2008) to consider in deciding whether to approve compulsory detention of a person with mental health problems under the Mental Health Act 1983. The public, the media and professionals often associate an increased risk of violence from people who have a mental health problem (Blumenthal and Lavender, 2000; Petch, 2001; Butler and Drakeford, 2003, 2005). As evidenced in Hawley et al.’s study of risk assessment tools in NHS Mental Health Trusts, there was great variation in how risks of violence were addressed within the different tools, providing the possibility for risk assessment by geography and possibly individual professional bias, not by natural justice and scientific endeavour.

Montandon and Harding (1994) carried out a study that shows that there are serious reasons to doubt assessments of risk of violence and social behaviour between different professionals in this field. They state that there are differences amongst staff in assessing levels of risk between males and females, and differences depending on professional background, confirming concerns about inter-rater reliability in assessment of risk. They contend that adequate controls for confounders should be used by including a comprehensive set of background variables. They consider that the concept of dangerousness should be disaggregated into its component parts; the

variables used to predict violence; the amount and type of violence being predicted; the likelihood that harm will occur; and that risks must be treated as a probability estimate that change over time and context.

These findings correspond with those from the work of Higgins *et al.* (2005). Their study involved a semi-structured questionnaire, analysed by way of a content analysis, which inquired into the use of risk assessment documentation in relation to the risk of violence from patients in adult psychiatry services. The questionnaire was sent to consultant psychiatrists in England. They found that most NHS Trusts had standard risk forms incorporating the assessment of violence, but only around half provided training for their use. They also found striking variations in their content and complexity, which was also found by Hawley *et al.*'s research. Unstructured narrative sections in such forms relied on the knowledge of the person completing the form as to what information was relevant; whereas where tick boxes were present, this structured the professionals' decision-making in relation to potential risk factors. The negative side of such tick boxes were that this communicated little useful information for a risk assessment process, and does not contextualise issues of risk; an essential part of a full risk assessment, the authors argue. They concluded that structured narrative sections appeared to combine the best elements of both methods by guiding the professionals to the areas they might need to consider, and allowing them to contextualise this. They also found that the rationale for using scoring systems for risk assessments was unclear, again according with the findings of Hawley *et al.*'s research, and that their validity for use with the general population was questionable. They found little guidance for those completing the forms on how to make a meaningful interpretation of the scores, leading to the distinct possibility of false positives or negatives, leading to a poor basis for risk management. Around half the forms which they examined did not include a plan for managing any identified risks. Again these findings were consistent with those from Hawley *et al.*'s research.

The National Confidential inquiry report, *Safer services: National Confidential inquiry into suicide and homicide by people with mental health problems* (Appleby *et al.*, 1999), found that from a review of inquiries into suicides and homicides, a number of major themes emerge:

- The need to obtain a detailed and accurate recording of the individual's development and history, without which it is impossible to produce an effective understanding of risk. Particularly important is the accurate recording of incidents of violence and the situations that generated these incidents, especially given the importance of past behaviour in predicting future behaviour. The use of a number of sources, e.g. relatives and staff, and methods, e.g. interviews and notes, to identify these incidents of violence are also important in establishing the facts and parallels the procedures recommended in triangulation in qualitative research. The involvement of and assessment of the views of the people closest to the person has frequently been

overlooked. Without such information it is not possible to accurately assess risk.

- High quality team working and interagency co-operation and liaison is crucial, as is a flow of information between team members and across agencies both to assess risk accurately and to co-ordinate the management of that risk. They stress the importance of preventing the patient losing contact with services.

The importance of staff being adequately trained to undertake risk assessment is reiterated in most reports, including the National Confidential Inquiry. This emphasises the importance of staff training and retraining concerning knowledge of predictors of risk, to help them make holistic, professional decisions, not just as technicians completing tick boxes- which do not aid the assessment, nor any decisions concerning interventions based upon them. It is important not to over state the accuracy of the potential to predict violence. Conclusions from inquiries state that rarely was the homicide in question predictable.

These areas, when compared with those raised as areas for further consideration and development in this article, would suggest that agencies and professionals need to consider certain areas in their risk assessment tools and personal decision-making. The concerns and areas for development for the use of risk assessment tools could be summarised as:

- How effective and reliable are current risk assessment models and tools? Have they been systematically researched and monitored for effectiveness? Are they ethically sound?
- Given the great variability in such tools across England in NHS Mental Health Trusts, there is a case for a systematic review based on reliable evidence for the areas to be included in risk assessment guidance which can guide professionals to the areas they need to consider, but which allows them to take into account their knowledge of the individual, based on their own professional expertise and learning which they are able to justify in their assessment.
- If checklists are used, how are the weightings between the different areas in any such checklist determined, in order to provide guidance in relation to potential risk management plans?
- Are the issues of timescales taken into account to ensure a fair and effective assessment of risks in this way? For example, are risks graded/set out clearly in relation to the time span in which they occurred, and/or are likely to occur?
- How can the problem of inter-rater reliability be minimised- otherwise, the risk assessment can be seen as a lottery based on the worker the service user happens to have (in addition to the particular tool they might be using in the local area), which could determine the assessed needs of the service user, and affect her/his individual rights? Such inter-rater reliability could be dealt with by devising risk assessment processes which use the structured guidance, as

opposed to tick boxes, suggested by Higgins et al. (1995) and Canton (2005), and by agencies monitoring completed risk assessment forms as part of an audit undertaken at regular intervals.

- Is the process for the benefits of service users, or the agency's own purposes? How transparent are risk assessment procedures and completed assessments to professionals, service users and carers? Are service users and carers fully involved in assessments of risk, and regular reviews of their assessments?
- What part of the process considers whether service users should be allowed to take risks as part of their self-determination?
- How much individual professional discretion is left to staff, in order to ensure that professional judgement as well as actuarial methods are included in such assessments, allowing professionals to justify their own assessment of risk, whilst guided by the tools' items, but at the same time ensuring that such judgment is only used by skilled and knowledgeable staff carrying out the assessment/intervention and not based on prejudice/biases?

Conclusions

Given the frequent use of Risk Assessment Tools by social workers, the prominent emphasis given to social workers' assessment and management of risks as set out in the General Social Care Council Code of Practice (2002), and the evidence of problematic areas within current risk assessment practices and tools in mental health settings as set out in this article, it would appear to be necessary to re-examine risk assessment and risk management in mental health work from a recognition of the concerns in this area.

One way of approaching the issue of risk is to try to bring such methods nearer to the ideal of a normative model without fully implementing all the elements of it; such prescriptive models are designed to bring "the results of actual thinking into closer conformity to the normative model" (Baron, 1994:8). Intuition and experience as the basis of judgment and decision-making building upon practice knowledge can be developed in a way which helps front-line workers to assess risk, whilst it can be argued, needing to use guidelines developed from an evidence based knowledge grounded within a systematic analysis of the research literature which provides actuarial, but also, it is argued, process data which aids in the consideration of what risks there might be in certain situations. Baron presented the concept of ethical satisficing, recognising that professionals cannot know or consider all the relevant evidence in relation to research that has been produced in the area in which an answer is needed. This is a key issue for social workers in attempting to meet their ethical standards under their Codes of Practice. Baron argues that there must be a mix between actuarial risk assessment and clinical professional judgment in our area of the human sciences, as do Parsloe (1999) and Canton (2005). This leads to an approach in which professionals are aided in their assessment and decision making by guidance on

the types of risks they may assess in a situation, but not in a prescriptive or didactic manner. Within such a process, there is the opportunity to overcome the checklist, 'tick box' approach which can distort and bring into disrepute risk assessments. However sophisticated the risk assessment tools that professionals use, it is important that there is acknowledgement that where professionals are using the human sciences in assessing possibilities concerning human behaviour, these are essentially still judgements at least partly based on knowledge and experience, and involve interpretation of how risk assessment tools can be used (see for example, the discussion of this in relation to child protection work by Bostock et al., 2005 and Cooper et al., 2003).

Whilst it may be seen to be important to use some forms of actuarial guides in alerting professionals to the areas they should take into account when completing assessments, this should not expect to subsume the critical faculties of professionals to allow them to contextualise their assessment of individual items, and move beyond constricting items in any assessment tool. Such an approach might be based on the best elements of actuarial and professional decision-making approaches as set out by Higgins et al. (1995) and Canton (2005). Such processes could ensure that professionals think through and justify their decisions within their agency's aims and procedures, and should challenge them to be able to say how they have made individual decisions concerning service users' risks to self and others. However, whilst this professional responsibility for risk assessments and ethical use of them is key, there have to be changes within other parts of the system as well. There has to be a move beyond the culture of blame of individual professionals which prevents their using their professional judgment, raised as an area of concern by the National Confidential Inquiry (University of Manchester, 2006).

Risk assessment procedures cannot give professionals, agencies, or policymakers a precise readout of predictive features within overall risk work. That still has to be left to professional judgment, for example weightings of different risk factors, whether they are present or not, and how they all fit together; which they must be able to justify in their assessment decisions, based on what approaches, and why. It would appear to be important agencies and individual professionals recognise the limits of risk assessment tools. On the other hand, for too long agencies and professionals have often ignored or rejected more systematic ways of assessing risk, and more effective ways in dealing with it, and some of the methods employed by risk assessment and risk management as suggested in this article may well be incorporated within policies and practices to the benefit of themselves and their service users.

The different problematic areas considered so far in this article- individual biases in risk assessments and decision-making, the validity and reliability of risk assessment tools utilised within the agencies, and inclusion of service users and carers in the assessments, and reviews of them- are key areas to be considered in the active development of risk assessment methods and tools, and how valid they are in relation to how they are used, and particularly, whether confidence can be invested in such

methods when considering the rights of service users, and the effects on them as required by ethically sound practice, and the GSCC Codes.

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