RISK ASSESSMENT
USING RISK TO INFORM TREATMENT OPTIONS

Dr Daniel Chetcuti
Consultant Psychiatrist & Clinical Lead for Acute Services

Christine Henham
Clinical Operational Manager

FOOD FOR THOUGHT.....

- What is a Risk Assessment?
- When should a risk assessment be done?
- Who is responsible for completing a risk assessment?
- What should a good risk assessment consist of?

TRADITIONALLY....

Risk assessment was the domain of medics.....but.....

- Resources?
- Increasing pressure on all staff and services?
- Empowering the MDT?
- Sharing out the risk management?

APPROACHES TO A RISK ASSESSMENT

Most Risk Assessments tend to be....

- Heavily influenced by medical jargon
- Often have a significant basis in the diagnosis
- Sometimes are a tick-box exercise
- Not necessarily meaningful to a patient

SHARING OUR RISK ASSESSMENTS...

- **Risk assessments are integral to our decision making.**
  - How comfortable are we sharing our risk assessments with patients and carers?
  - How does the risk assessment inform the management and care plan delivery?
  - How do we make a risk assessment meaningful to a carer and a patient?

FEW CONCEPTS....

Stages of Suicidal Planning:

Ideation → Vague Planning → Detailed Planning → Intent → Actioning

AMBIVALENCE.....

Do I really want to kill myself?

POSITIVE RISK TAKING

WHEELBARROW ANALOGY

LET'S CHANGE OUR APPROACH.....

A risk assessment based on diagnosis & medical jargon is probably only meaningful to a handful of people

A risk assessment which approaches the patient difficulties from a functional & humanistic perspective is much more comprehensive, has more meaning to a broader range of audiences/MDT members, and is easier to relate to from a patient & carer perspective.

OLD SCHOOL VS NARRATIVE

Undergraduate teaching guides us to take a structured history

- Clinician led
- Focussed on a set agenda
- May not address all the patient/carer concerns

A Narrative approach to history taking however is

- Led primarily by the patient, with the clinician guiding the interview
- Is more personal to the patient
- Once proficient in the skill, tends to be more time-efficient.

5P APPROACH TO HISTORY & RISK...

- Predisposing Factors
- Precipitating Factors
- Presenting Factors
- Perpetuating Factors
- Protective Factors
- ..... and a 6th 'P' ..... Pharmacology

5P APPROACH VS OLD-SCHOOL

- Presenting Factors + Precipitating Factors is largely equivalent to 'Presenting Complaint' and 'History of Presenting Complaint'
- Predisposing Factors and Perpetuating Factors often covers the majority of past psychiatric history, medical / social / forensic History
- Protective Factors often covers areas such as finances, employment, family support, etc
- Add another 6th P.....Pharmacology (i.e. medications).....should cover the basis for a solid overall clinical history!

PROS AND CONS OF 5P'S:

Pros:
- Comprehensive in capturing all domains
- Easy to remember once you become used to it
- Most patients tend to prefer this approach

Cons:
- Doesn't necessarily capture how risk changes on daily basis in Urgent Care Settings – possibly better suited to community settings
- Doesn't encourage staff to identify which parts of risk profile interventions are aimed at
- 1 generic template unlikely to serve both Acute as well as community settings

MOVING AWAY FROM GENERICS....

Use the 5P's in thinking/identifying about the risk

BUT reorganise how these are documented by categorising them into

- Background (Static) Risk Factors
- Dynamic Risk Factors
- Protective Factors

WHAT'S BEING PROPOSED

5P based history taking & risk assessment leading to care plan formulation, using the risk assessment as a direct reference to identify the rational for any interventions being offered.

In addition, clarify which risks are ongoing and why, including rational for this risk not reducing over the course of a mental health intervention

RISK ASSESSMENT

Static Risk Factors	→	Low/Moderate/High
+		+
Dynamic Risk Factors	→	Low/Moderate/High
-		-
Protective Factors	→	Low/Moderate/High
Overall Risk	→	Low/Moderate/High

STATIC / BACKGROUND RISK FACTORS

Who is the patient?

- Demographics
- Personal History
- Past Psych History (incl previous risk events)
- Family History

DYNAMIC FACTORS

What happened? (circumstances)
What was the expected outcome?
Current Mental State & situation.

_____

Has anything changed since?

_____

Recent Life events, esp 'loss events' most predictive of completed suicide

PROTECTIVE FACTORS

- What might stop you?
- Family?
- Children?
- Partner?
- Pets?
- Any signs of future planning?
- Any signs of hope for the future?
- Anything positive?

CASE SCENARIO – SAMPLE 1

17 year old student, living at home with supportive parents. No previous psychiatric history but has poor self-esteem.

She presents to A&E having taken an impulsive overdose of 50 x Paracetamol and 20 x Ibuprofen

Triggered by argument with her boyfriend "to teach him a lesson". She texted her boyfriend whilst in A&E, and they have made up. She is relieved to be alive.

RISK ASSESSMENT

Demographics	Low Risk (female, young, student, supportive parents)
Past History	Low Risk (No previous history)
Circumstances	High Risk (potentially lethal dose of Paracetamol, impulsive but self-disclosed)
Expected Outcome	Low-Moderate Risk (no clear suicidal intent, attention-seeking more likely)
Current Situation	Low Risk (happy to be alive, mental state stable, back with boyfriend)
Protective Factors	Moderate (supportive parents, boyfriend)
Overall Risk	**Low-Moderate risk of completed suicide**

CASE SCENARIO – SAMPLE 2

38 year old unemployed lady, well-known with EUPD. Multiple previous admissions. Multiple previous OD's. Last admission 2 weeks ago.

She presents to A&E having taken a mixed paracetamol + Diazepam OD, now demanding an admission or else she will jump off Beachy Head.

CCO has recently been changed. At recent medication review, all her medications were stopped.

RISK ASSESSMENT

Demographics	Moderate Risk (female, unemployed)
Past History	High Risk (previous admissions & risk to self)
Circumstances	High Risk (potentially lethal dose of Paracetamol, self-presented to A&E, no final acts)
Expected Outcome	Low-Moderate Risk (ambivalent intent, ongoing threats – wanting readmission)
Current Situation	High Risk (threatening suicide attempt if not admitted, risk of acting our/perceived rejection)
Protective Factors	**Low (no supportive network identified)**
Overall Risk	**Moderate-High risk of completed suicide**

MODIFIABLE VS UNMODIFIABLE

Modifiable Risk Factor

- A risk factor where it is possible to offer an intervention to alter the risk being presented

Unmodifiable Risk Factor

- A risk factor which is static, often historical, and current interventions will not alter that risk.

EFFECTIVE INTERVENTIONS....

Static Risk Factors	Often Unmodifiable
Dynamic Risk Factors	Often Modifiable
Protective Factors	Often Modifiable

CASE SCENARIO – SAMPLE 3

52 year old single male, homeless in B&B, past h/o drug use, abstinent x 6 months. 2 x previous suicide attempts over 2 years ago by OD.

Diagnosis of EUPD, open to Community Team.

Today presents to A&E having taken 10 x street Diazepam. Found unconscious on street. Denies suicidal intent, but stating wanted to get some sleep. No remorse. Wants routine CMHT f/u and declines all other help offered.

RISK ASSESSMENT

Demographics	High Risk (male, homeless, age)
Past History	High Risk (drug use, previous OD's, Dx of EUPD)
Circumstances	Low-Moderate Risk (OD on street diazepam in context of previous drug use. Average dose
Expected Outcome	Low Risk (no clear suicidal intent – wanting to get sleep)
Current Situation	Moderate Risk (No remorse, little change in circumstances)
Protective Factors	Low (poor supportive network but open to CMHT)
Overall Risk	**Moderate risk of completed suicide**

MODIFIABLE FACTORS WARRANTING INTERVENTION

Demographics	High Risk (male, **homeless**, age)
Past History	High Risk (drug use, previous OD's, Dx of EUPD)
Circumstances	Low-Moderate Risk (OD on street diazepam in context of previous drug use. Average dose
Expected Outcome	Low Risk (no clear suicidal intent – **wanting to get sleep**)
Current Situation	Moderate Risk (No remorse, little change in circumstances)
Protective Factors	Low **(poor supportive network but open to CMHT**
Overall Risk	Moderate risk of completed suicide

WHAT'S MODIFIABLE CAN CHANGE....

- At that point in time (and not indefinitely)
- Subjective as depends on resources available to you there and then

TALKING ABOUT RISK....

Short-term vs Long-term

Various types

- Self vs others
- Children
- Neglect
- Physical health
- Abuse – sexual, physical, emotional

Same concepts can be applied to other risk domains

USING RISK IN CARE PLANNING

The factors contributing to the risk assessment can be used as a basis for formulating a care plan

- Shared common goals
- Clear expectations
- Clear signposting and rational
- Easy to measure effectiveness of interventions
- In cases where chronic/ongoing risk is present, rational for decision making becomes more transparent

INCORPORATING RISK IN CARE PLANS

- Summary of Reasons for my admission:
- Factors contributing to my admission:
- The team are regularly assessing my risk, and are particularly concerned about:
- The team will help me with the following areas that I am currently struggling with:
- The team have identified that I need support in these other areas, but they are unable to directly help with this. However, they will still support me by:
- The team are concerned about these factors, although they acknowledge the limited potential for change in the short-term (eg. during an admission or acute crisis period):
- CRHT may consider me for supported discharge following admission, with ongoing support at home. For this to be able to happen, the following areas need to be addressed:

PROS AND CONS OF USING THIS METHOD

Pros:

- Rational for decision making & interventions is clearly documented
- Good framework for 'positive risk-taking'
- Identifies those areas where risk is non-modifiable, as well as those areas where risk can be modified but not through a mental health intervention (indirectly serving as a prompt to mental health staff)
- Overall risk summaries still need to be provided, but at least rational for risk levels is clear

PROS AND CONS OF USING THIS METHOD

Pros:

- Patient centred rather than 'agenda' based
- Any member of the MDT should be able to apply a 'functional' approach to risk assessment
- Other non-psych healthcare staff can have a clearer understanding of risk with very basic training – i.e. more transferable = easier to empower others
- Makes risk assessment more understandable to both patient and carers

PROS AND CONS OF USING THIS METHOD

Cons:

- New way of thinking about risk
- Not everyone will be familiar with it
- Can be seen as another way of 'resisting' referrals / admissions & ticking boxes
- Requires more time to think about and document, at least until it becomes accustomed to

SUMMARY OF OVERALL RISKS

A summary of overall risks is still required (eg low risk of suicide, moderate risk of harm to others)

Difference is that the rational for arriving at the risk levels is much clearer, and any interventions offered are goal-focussed.

QUESTIONS?

THANKS