Wagstaff et al., Int J Ment Health Psychiatry 2018, 4:2
DOI: 10.4172/2471-4372.1000163

International Journal of Mental Health and Psychiatry

Case Report

A SCITECHNOL JOURNAL

Developing Risk Assessments from the Perspective of the Patient: A Case Study Report

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Received date: May 25, 2018; **Accepted date:** June 21, 2018; **Published date:** June 25, 2018

Abstract

This paper describes clinical team practice developed simultaneously but separately, in the Netherlands and the UK. Both teams work with patients with a significant risk history who are often unwilling to discuss risk; however it is imperative that clinicians do so. This paper discusses strategies the teams introduced to address this issue and case studies are used to illustrate the approaches.

In addition to building a collaborative relationship the starting point of the risk assessment and management process was a 'Stay well' plan in which the patient describes the strategies which enable them to stay well.

The case studies demonstrate how the changes to the risk assessment processes benefitted both the patients and the clinicians whilst also highlighting the need for on-going collaborative work. Making the perspective of the patient central to the risk assessment process; created an atmosphere of optimism and opportunities for dialogue and understanding.

This case study paper highlights good clinical practice developed simultaneously, by mental health teams in the north Netherlands and the West Midlands United Kingdom in writing risk assessment strategies that fore front the perspective of the patient. These risk assessment strategies are explained in detail, complimented by case studies from each team.

Keywords

Risk assessments; Mental health; Nursing practice

Introduction

Background

An important component of mental health nursing is to assess the needs of people accessing mental health services. Integral to such an assessment is the consideration of risks posed by patients, either to themselves or others. Risk assessment and management is a fundamental part of care mental health nursing practice.

Most of the risk assessment literature focuses on how professionals understand and manage risk; less has been written about how patients are involved in the process [1]. Kroner and Langan both highlighted that there is limited research into mental health patients being involved in their own risk assessment and management [2,3]. Langan interviewed mental health professionals for their perspective on involving patients in their own risk assessments and discerned four themes: 1) professionals lacked confidence and experience when discussing risk with patients; 2) most did not involve patients in risk assessment; 3) most patients were unaware that professionals were undertaking risk assessments of them and 4) there were differences in opinion between professionals and patients as to the seriousness of risk. He concluded that there was a gap between literature and practice about how to engage patients in risk assessment [3].

A recent UK review of 20 years of suicide and homicide data concludes that despite common risk factors, what puts a patient at risk is often down to the individual level; suggesting that since the highest priority of health services should be the safety of patients then risk management should be a personalized process [4]. Appleby also note that often risks are challenging to assess, as is the effectiveness of different interventions, and that safer practice becomes possible once a rigorous learning culture has been adopted [4].

If there is greater patient involvement in risk assessment, formulation and planning; then patients may be more likely to enter into a more detailed consideration of what they perceive to be their own protective factors [5]. If patients are encouraged to discuss what protects them as opposed to reducing their risk then they may well be more motivated to participate in discussions regarding future risks [6].

Whilst it is unrealistic to expect that all adverse incidents can be prevented, the risks for each individual can still be identified and managed, and adverse outcomes are potentially avoided. In the vast majority of cases, the safe and effective care by mental health services minimizes identified risks. Mental health nurses need to ensure that the basis of their risk assessments is made clear to patients [1]. The Department of Health states that risk assessments should be put together collaboratively with patients and should be based on "warmth, empathy and a sense of trust" [7]. Involvement in individual care and treatment, including risk assessment and management, can increase patient's self-esteem, improve individual outcomes and increase patient's satisfaction with services as mentioned in Offender Health Collaborative [8]. In cases where patients had been involved in identifying and monitoring risks they had a much stronger sense of engagement in and understanding of the process. In addition, they felt more empowered to highlight future risks, and were clearer about what they should do if they occurred. This is not to suggest that patients necessarily agree with how staff interprets events, but differences of opinion became more transparent in such cases.

Patients frequently find it hard to discuss risk and quickly disengage from the discussion when they feel their perspective is not acknowledged [9]. An assumption made when involving patients in their risk assessment process is that they have the self-knowledge to discuss their role in previous events and are able to understand current attitudes and future actions [2]. As individuals we each have unique and privileged access into our own internal states; in theory therefore

each individual patient is in an advantageous position with regard to discussing, understanding and predicting their own risk [10]. Poor engagement increases the scope for risk behaviour and significant incidents, for both patients and/or others. Issues of openness, denial, perspective and understanding impact on a person's ability to reflect on risk behaviours, making personal safety planning more difficult.

To address these concerns the teams in the Netherlands and the UK adopted risk assessment models which were built upon patients, collaboratively writing their risk assessment and management plans.

Context

The UK team was an Assertive Outreach team; Assertive Outreach teams are a community mental health service designed to engage with people with serious mental health problems who have difficulties engaging with services. Poor engagement is based on a number of influences: severity of illness, lack of insight into their presentation, views on treatment and diagnosis, substance misuse, lifestyle choices, and perspectives on culture and stigma [11-13]. The interventions and treatment plans aim to reduce the impact of poor engagement for the patient and those around them. Service design is based on intensive and consistent multidisciplinary input using a person centered holistic approach, with robust and sound risk assessment and management. A combination of medical, practical and psycho-social interventions are offered to enable patients to take more control over their health and personal life, increasing opportunities and resilience [14].

The forensic ACT treats about hundred patients in the north Netherlands with complex psychiatric and social problems, involving high levels of risk. Most patients use substances problematically and are subject to supervision probation by services. The forensic backgrounds of the patients include sexual offenses, burglary and drug-related offences. The care provided is intensive and multidisciplinary, in conjunction with judicial authorities. Whilst the risk assessments are carried out according to the national guidelines, the team's focus was to use the assessment to create a dialogue about risk management and recovery with the patients. The team takes an outreach approach, attempting to customize care for each patient. The team relies on creativity, daring, patience and flexibility by the team, patient and system. The team works with relatives, and stakeholders like the judiciary, living guidance and social pensions. Most interventions are delivered in the patient's home. Interventions include individual rehabilitation, treatment for trauma, addiction work and pharmacotherapy. As the patients are visited at home (or the place where they stay) the people surrounding them become involved.

Current Work

West Midlands

The risk assessment strategy for the West Midlands based team was three fold; an on-going log of historic risk events and factors that all staff who came into contact with the patient were able to contribute to. Typically, this log was a list of risk events and frequently lacked context for the events. Secondly, each team who had treatment responsibility for the individual patient contributed to a risk assessment and management plan through team knowledge and skilled observation of the patient. Furthermore, the team also used the 5Ps models as proposed by Kuyken to create a robust formulation of the risk for each patient, involving a team approach for case knowledge of the patient and their history [15]. This considers each risk behaviour as a presenting problem and identifies the predisposing, precipitating and perpetuating factors associated with the behaviour. Considerations of the protective factors (strengths) are included in the discussion. From this formulation a plan is made to support observation of the early warning signs of potential risk and, after discussion with the patient, these factors are added to the care plan to support safe management. Consequently finalized risk assessments and management plans were rarely shared with the patient and a review of processes highlighted a need to change the design of the risk assessment process. That there was minimal input from the patient, that was something the team were keen to address. However, there was a need for further staff training in order to support staff in having more open and engaging dialogue with patients around risk, which, as highlighted, is particularly challenging with this group.

Therefore, the risk assessment and management process were developed so that the starting point of the process was a 'Stay well' plan in which the patient describes the strategies which enable them to stay well. From the vantage point of having the patient, highlight what enables them to stay well, this can then lead into an informed discussion of what the patient perceives as their risks and also their perceptions on previous risk incidents. After the patient has highlighted strategies which they believe can help them stay well in the future, then it is hoped that this will create the opportunity for the patient to lead a discussion of how risk incidents can be prevented from happening in the future (or how future risk events can be better managed from their perspective). This process enables the patient to feel that the discussion of their risk is tailored to them and for their benefit, as opposed to being service driven.

North Netherlands

Risk assessment and management are important components of treatment for the Netherlands team; all patients have a risk assessment done twice a year, including completion of the START (Short Term Assessment of Risk and Treatability) by the multidisciplinary team [16]. START comprises dynamic variables that are responsive to treatment and management and summarise the potential (low, moderate, or high) for violence to others, suicide, self-harm, self-neglect, unauthorized absence, substance use, and risk of being victimized. Patients who have committed sexual offences are evaluated more frequently, and their short term risk is assessed using the ACUTE-2007 [17].

Whenever possible the team involves patients in the assessment and management of the risks; meaning the team are able to formulate individual risk management plans comprising of both treatment and relapse plans. In the relapse prevention plan the early warning signs and the actions that the patients and others should take in order to prevent a full relapse are described (thus lowering the risk). In order to begin the recovery process the team start treatment from the patient's perspective and develop a treatment plan, provides an overview of interventions, personal goals, risk assessment and early warning signs. The heart of the treatment plan is the question, 'What do you need to stay well and keep the risks low?'

One of the challenges of talking to patients about risk factors and early warning signs is overcoming their resistance to do so. Frequently patients do not recognize risk factors or early warning signs and often become confrontational. Building a collaborative relationship is essential to reduce risks and to be able to constructively discuss early warning signs. Taking the patient's view into account can be helpful in understanding and finding words for the problems and risks. The team

has learned the importance of patience when a patient relapses, and to be optimistic about their recovery when they restart the process. Ideally there is a joint treatment plan (incorporating the risk management and relapse prevention plan) written within 3 months; however practice shows that sometimes more time (1 to 2 years) is needed to come to a joint treatment plan.

Case Studies

What follows are case studies from each team highlighting how they implemented their new risk assessment strategies. Pseudonyms are used throughout. The three people in the cases gave verbal and written consent for their case studies to be included in this paper. The people in the case studies read through drafts of the paper, with 'Albert' & 'Prabjhot' editing the sections about them. These three people all found reading through the draft to be challenging, but felt reassured that the nurses were familiar with their working to help them stay well. They all commented on the mutual similarity between the three cases and felt being involved with this paper and improved the trust that they had with the team.

The case study from the UK team demonstrates the issues involved in fore-fronting the perspective of the patient in risk management.

Prabhjot

Prabhjot, a 49 year old South Asian woman, lives in her own home with her husband and 3 adult children. She has had 25 years involvement with mental health services and has a diagnosis of Paranoid Schizophrenia. Prabhjot enjoys the responsibility of managing the family home usually, but worries when she feels her husband and sons are not communicating with her and are not including her in discussions. This leads her to worry at night, her sleep becomes interrupted and she avoids discussing her concerns with them as she becomes scared that this will lead to her being admitted to hospital. This escalating anxiety typically results in a significant relapse of her illness, marked by feelings of paranoia toward her family. At these times she believes they are plotting against her, perceiving herself to be a bad wife/parent. These beliefs have led to both self-harm and suicide attempts, bouts of impulsive aggression and violence towards her family. Her husband and sons state that this comes with little warning for them, resulting in the need for emergency admissions to hospital due to the escalating aggression and violence.

Following one such episode, Prabhjot agreed to develop a 'Stay Well' plan structured around her strengths, acknowledging the person she is when she is well. She is often positive and happy, able to think clearly and talk with people, to perform a role within the home and likes shopping for food and clothes with her husband. This plan also helped to identify the things and people that are helpful to her and that keep her well, particularly when she is included in family discussions, being in touch with her sisters and helped highlight when she feels people are acting openly with her. Conversely, Prabhjot was able to describe the impact on her when this does not occur.

The 'Stay Well' dialogue helped highlight these dynamics, which consume her thoughts and quickly escalate. Both Prabhjot and family agreed to also discuss this, helping to share perspectives and highlighted anxieties as a group and individually for her welfare; when everyone was involved, it had a positive impact on her health and the dynamics within the home.

These discussions also helped Prabhjot describe in significant detail the early warning signs she experienced more than both family and the team were previously aware, and both her 'Stay Well' plan and crisis management plan were able to be adapted to include actions for her, her family and the team in a staged and structured way. The collaborative nature of this process helped everyone feel more empowered and in control of their experience and interactions, hope increased and the sense of helplessness in preventing future relapse diminished. For the team, an understanding of the greater detail and nuance of Prabhjot's experience has allowed them to offer a richer choice of interventions to her, encouraging responsibility within the family and supporting self-management, rather than having to intervene and disempower. These improvements have been sustained for more than a year.

The two case studies from the Netherlands demonstrate how the development of joint risk assessment, interventions and signalling of early warnings signs work in daily practice.

Albert

Albert lives a withdrawn existence in a house in a village. In the past he has been convicted of extortion, violence and harassment. Albert has anxiety problems, based on traumatic experiences. He uses cannabis, alcohol and benzodiazepines in problematic ways; though his alcohol dependence is treated with medication. Abusing substances raises the risk of Albert relapsing; there is the risk of criminal activity during a relapse and previous traumas fuel his psychosis. The team has cared for Albert in the community for a number of years. The team dispenses medication to Albert and offer practical support. Albert requires trauma treatment, but he struggles to control his anxiety and despite weekly contact with a psychologist does not really engage in the process.

The START risk assessment illustrated that when Albert's substance abuse was reduced he lived an apparently stable life, though with very little activity. When under the influence of drugs Albert is brisk, impulsive and, at times, irresponsible. In the past, Albert has harmed himself and others when under the influence, resulting in both intensified home visits and hospitalization. However, when the team have tried to discuss a risk assessment with Albert he has not recognized the pattern of risky behaviour described or his early warning signs. In an attempt to better manage the risks posed the team have used judicial authorization to engage Albert with trauma treatment. Under the 'Crisis-Prevention-card' scheme Albert can be voluntarily hospitalized for five days; the scheme is a voluntarily one; designed to deliver more personalized control for people experiencing a mental health crisis, though if the risks become too great then the team can decide to compulsorily admit Albert.

Writing the relapse prevention plan provided the opportunity to start discussing risk and early warning signs from Albert's perspective. The information from the risk assessment is used to inform the relapse prevention plan and the early warning signs are central to this plan. The team invested a lot of time in developing this plan with Albert. The first steps taken towards this joint plan was that Albert was encouraged to describe what made him tense and how the tension was relieved by him. Albert described his early warning signs; he described withdrawing from life, staying in bed and becoming more anxious. The people around Albert described how at this stage of relapse Albert lets his beard grow, does not take care of himself or his immediate environment. Albert then described how the team could ensure that things went better in the future; to prevent future relapses Albert was

to try to maintain structure to his day and hold a daily routine. Albert described how people around him could help by engaging him in daily conversation. Albert acknowledged how important it was for him to receive treatment for his anxiety issues. Albert wanted help from the team but wanted the treatment to be delivered in a caring manner and for the team to help him to think about how he was going to stay well. Albert was adamant that he should remain living by himself.

The anxiety and the tendency to use drugs are major concerns and he relapses quickly. Albert still has relapses. The anxiety and the tendency to use drugs are major concerns and he relapses quickly. The last time he started using drugs again was so severe that he had been taken to a general hospital and he was unconscious for several days. This relapse scared Albert and his family. Whereas previously he denied the severity of the risk, he now tells the team that he has got a better understanding of the risks that the team was talking about. He appreciates how the focus of the team's interventions is helping him staying well and the treatment and relapse prevention plan is the agenda for on-going conversation. The conversation about this paper allowed for the opportunity for Albert and the nurses to reflect that his case and situation are continually evolving and that his situation may improve in the years to come.

Ben

Ben has been under the care of the team for over five years. He has a history of contact with both mental health workers and the judiciary; which he has not found useful. He has experienced many setbacks over the years and he says he is used to this. Ben has a room in a supervised home facility and he spends his days wandering the streets. Ben is diagnosed with schizoaffective disorder and alcohol dependence and experiences regular psychotic relapses; all of which are complicated relationships. During relapses Ben uses increased amounts of illicit substances causing problems in his local community and the possibility of detention in jail. It is very difficult to talk to Ben about medication, early warning signs or risk factors, as he does not want medication and denies early warning signs. Since the start of treatment it has not been possible to make a joint treatment plan and giving rise to conflicts. Early on in his care the team has applied for the legal power to give Ben depot medication against his will; initially Ben was resistive to this however through regular contact with the team he is now more accepting towards them.

Recent risk assessments demonstrate how Ben has made significant progress; now he is on regular medication with fewer psychotic relapses and renewed contact with his family. Guidance from the supervised home facility and more structured daytime activities has contributed to lowering his risk. Ben continues to be reluctant to talk about risk factors, drug and alcohol use and his early warning signs but he will now talk about protective factors and how these are important to him. The team visits Ben weekly, the focus of the conversations are on his daily life, his early warning signs and in particular about what he needs in order to make sure that he stays well. Over the past five years Ben has moved to a position where he can now ask to be hospitalized in order to avoid a crisis. He uses a 'crisis prevention card', that means he can be hospitalized for a short period of time to prevent a deteriorating relapse. Despite saying that he does not want to know what is written in his treatment plan Ben does now listen to staff explaining their decisions. Whilst he refuses to make a relapse prevention plan he is able to explain which factors increase his tension and how he deals with these. For example, if a hospitalization is necessary, the team can make sure that he takes his radio with him into hospital, knowing that relieves his stress. This change in focus of the interactions with Ben maintains his faith that the teams are focused on his well-being.

Discussion

The case studies highlight that this is a developing area of work. As noted there have been some areas of success, with patients who have a history of disengaging with services, starting to engage in discussions with clinicians about what keeps them well. A consequence of which is the creation of new understanding and perspectives on risk and future risk management. This paper presents three case studies, all of which reflect mixed results. It is unrealistic to say that such models will supersede more traditional models of clinicians writing risk assessments; indeed there will likely be professional cynicism at the idea of high risk patients assuming responsibility for generating their own risk assessment and management plans. Furthermore, Forensic or Assertive Outreach community teams' case work can present significant challenges in providing treatment and support to those with limited insight, poor engagement, grandiose delusions, significant misuse of substances and alcohol and persistent treatment [14]. Those who deny having any form of mental illness or view service's attempts at engagement as intrusive or socially controlling may also find it difficult to engage with such personal risk and safety management plans. Health professionals need to be aware of the risk that whilst encouraging such interventions may be seen by services as positive, they may be viewed as coercive by patients and therefore counter-productive.

Having positive dialogue around treatment, interventions, concordance with treatment and self-management may be impossible at times [18]. Episodes of acute ill health may lead to hospital admissions and community management often requiring legal and statutory methods to impose engagement and treatment compliance. Whilst services need to work in this fashion it does reinforce the view that contact with services is driven by oppression and coercion and as such causes further difficulties in finding common ground as a basis to work on. Regardless, the models proposed by the teams in the Netherlands and the UK start to address the on-going issue of high risk mental health patients who refuse to discuss risk issues.

Conclusion

The teams in both the Netherlands and the UK were attempting to work with challenging patients; facing common problems of being required to manage high levels of risk in the community with patients who were reluctant to discuss the risks that they posed. The case studies presented here demonstrate both the successes achieved and also acknowledge where there is a need for on-going collaborative work. By fore-fronting the perspective of the patient in how they believe they can stay well in the future created an atmosphere of optimism and opportunities for dialogue and understanding.

Acknowledgement

All authors listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors, and that all authors are in agreement with the manuscript.

Conflict of Interest

There were no conflicts of interest and there was no external funding.

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