RISK ASSESSMENT

The assessment of risk and the associated 'danger' (i.e. the degree of harm caused if the risk is realised) should be objective and take into account information from the client, carers and other professionals where appropriate.

Risk behaviours to be assessed should include the following:

- **Self-harm.**
- **Violence to others.**
- **Arson.**
- **Sexual assault/inappropriate behaviour.**
- **Verbal abuse.**
- **Absconding from hospital.**
- **Non-compliance with medication.**
- **Substance abuse.**
- **Self-neglect.**
- **Vulnerability.**
- **Risk to child.**
- **Disengagement from mental health after-care.**
- **Lack of insight.**

Risk behaviours that have occurred in the past should be examined looking at the details of the incidents, the antecedents, circumstances and planning for the acts. A history of past acts is the strongest predictor of future acts. A statement of intent by the client is also one of the clearest indicators of risk. A picture of increasing or decreasing risk over time should be established by the examination of previous incidents. Forensic history should be clearly established. A family/personal history of suicide, violence, substance misuse and childhood adversity are all factors that may increase current risk in the individual. The history of substance misuse should be elicited with particular attention paid to the relationship between risk behaviours and the presence of intoxication, withdrawal or other recent substance misuse. A judgement regarding the impulsivity of the acts and how the client deals with difficult feelings should be made. The relationship of symptoms of physical and mental illness to risk behaviour should be ascertained. In the case of violence or sexual assault, an assessment of victim empathy is necessary.

The risk assessment should be concluded by summarising the risks and dangers, identifying coping strategies of the client, and planning to minimize the occurrence of risk behaviours and the dangers associated with them in the future.

Risk assessment should be performed at the following times:

- **At screening assessment.**
- **At triage assessment.**
- **At full needs assessment.**
- **At review.**
- **At any other time that the worker feels that the degree of risk has changed.**

At screening assessment a brief history of previous acts of self-harm and violence should be ascertained, together with the client's current statements of planning and intent for future acts. At triage assessment a weighted risk assessment that delivers a score of low, medium or high risk should be completed. The advantages of such a tool are in highlighting a degree of risk that may otherwise be missed by the clinician during a necessarily brief assessment. Interpretation of the score should then be modified by the clinical judgement of the worker. The Beck Hopelessness Scale (Beck et al, 1974) delivers such a score and has moderate predictive validity for suicide completion over the next 10 years (Beck et al, 1990). Prioritisation of access to on-going work with the team should be directed by the findings of this risk assessment (as well as other factors). At full needs assessment and review, a more thorough approach will be necessary, making a detailed investigation of the risk factors, as described above.