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# Clinical Risk Management in Mental Health Services: 10 principles for best practice

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## ABSTRACT

Risk assessment and management are a fundamental part of clinical practice within international mental health (MH) services. In the United Kingdom (UK), the evidence to support the effectiveness of structured risk assessment and management remains limited, although the perception remains that structured management frameworks are effective in reducing risk in MH care. Despite the importance of risk management within MH services, the most recent UK wide guidance was published in 2009. This perspective paper reports on a prioritisation project to provide up-to-date best practice principles in clinical risk management to enhance the consistency, quality and safety of MH practice for UK mental health services, with the principles also having some relevance to MH services in other anglophone countries. A three-stage approach was used including literature review, referral to mental health experts for review and final evaluation and sign off by users of MH services as experts by experience. Ten principles for best practice were confirmed as a benchmark for practice and are offered as a benchmark to improve the quality and safety of MH practice.


## INTRODUCTION

Risk assessment and management are a fundamental part of clinical practice within international mental health (MH) services. However, little consensus exists on which risk assessment instruments or framework should be used (Ayhan & Üstün, 2021). Research in the UK supports this view. An observational study in 32 English hospitals found that at least 20 risk tools for self-harm were in use (Quinlivan et al., 2014) suggesting a lack of consensus among clinicians as to which is best to use. A recent large-scale review of risk assessment instruments employed in the United Kingdom (UK) concluded that assessment processes require better consistency across services with adequate training on how to assess, formulate and manage risk with an emphasis on service user and carer involvement (Graney et al. 2020). Correlating with more international studies (e.g., Kessler et al., 2020), the authors found an over-reliance on risk instruments provided false assurance for staff, and service users and carers were left unsure about what to do in a crisis.

The evidence to support the effectiveness of structured risk assessments remains limited, although the perception from MH practitioners is that such management frameworks are effective in reducing risk in MH care (Wand et al., 2015). Despite the importance of risk

management within MH services, national guidance in the UK has not kept pace with academic and clinical practice development, given that the most recent guidance was published by the Department of Health (DOH) in 2009. This paper reports on a recent project to critique the 2009 guidance and critically review relevant literature since 2009, as well as draw on clinical and service user views, to provide up-to-date best practice principles in clinical risk management that may enhance the consistency, quality, and safety of MH practice.

## BACKGROUND

Across international MH settings, particularly acute MH care, much debate exists about the nature and processes of assessing and managing service user risks (Hawton et al., 2022). Risk tends to be contextualised in terms of the potential dangers linked with mental disorders for example, focusing on risk to self and others concerning self-harm, suicide, and aggression Following a risk assessment, interventions need to be implemented to mitigate prevent/manage any potential risk event occurring and/or limit their recurrence. Yet, aggregating risk based on diagnosis can result in the conflation of risk with serious mental illness e.g. the questioned correlation between people with schizophrenia and the increased risk of violence alongside under-appreciating risk concerns from an individual, for example regarding the risk of suicide (Large and Nielssen, 2011).

Assessments have been developed to consider dynamic and situational factors which contribute to a better understanding about how, when and why risk events may occur for individual service users. Lantta et al. (2016) observed this with the *Dynamic Appraisal of Situational Aggression* (DASA) assessment, which alongside the *Brøset Violence Checklist* (BVC) (Linaker and Busch-Iversen, 1995; Almvik et al. 2000), are supported by the UK National Institute for Health and Care Excellence (NICE) (2015) guidance for the short-terms management of violence and aggression. However, as Lantta et al. (2016) suggests, a thorough risk assessment, one which includes meaningful safety interventions for the person it concerns, requires the involvement of service users and their significant others, such as carers and/or family members. Such involvement does not always occur, and Langan (2008) found that service users were not aware that professionals were formally assessing risks, while the majority of clinicians in the study did not share the results of their risk assessments with service users. Reluctance to involve service users may occur due to the clinical assumption that mental illness increases disorientation to such a degree, service users are unable to fully grasp their own risk needs or

that generally, mental illness comes with the person having some risk illiteracies (Coffey et al., 2017). The latter can indicate a possible clinical mistrust of service user intentions, which may increase paternalistic practices with risk management, as well as overlooking their voices to inform meaningful risk management interventions (Ahmed et al.,2021; Conlon et al., 2024).

There has been a shift from considering risk in MH care, to exploring safety with service users being at the heart of any assessment and management of risk (Berzins et al., 2018). Aligning to recovery-based principles in that, despite MH problems, care ought to focus on personal wellbeing and improving the meaningfulness of the service users' lives (Onken et al., 2007). This requires service user involvement with the assessment and management of their own safety/risk needs to ensure any agreed interventions, whenever possible, have a personal significance to the service users themselves with developing their own lives (Comtois et al., 2023). It has long been recongised that such involvement may inspire individual desires to live, thus reducing suicide risks, while violence and aggression may result from frustrations owing to MH care lacking a personal relevance to the individual (Sreeram et al., 2023). Within a scope of enhancing safety, calculated risks are agreed to improve a quality of life (positive risk taking), lessening restrictive practices such as physical restraint in hospital settings which can aggravate a sense of trauma to people already experiencing mental distress, as well as their voices guiding clinicians on safety concerns and helpful ways forward (Higgins et al., 2016). This might also include psychological safety, in that the service users' views are respected however influenced by mental distress so they do not feel humiliated via MH clinical teams excluding and downplaying their views about their own care needs (Deering et al., 2019).

Growing evidence suggests that a safety focus involving service user views may aid their recovery journeys and help to address deficient approaches to risk assessment, particularly to lessen the lack of service user involvement in their own care (Hawton et al., 2022). However, concern remains, particularly in the UK about poor and potentially oppressive risk management practices. These practices continue to focus on prediction using actuarial factors e.g. demographic factors related to particular risks, while not always asking about service user and carer views in what might be helpful (Quinlivan et al., 2020). Moreover, internationally, a fear about the blame associated with incorrect risk assessment outcomes in which there has been an adverse risk event, may result in MH nurses avoiding service user interactions as to not be accused of any impropriety with providing care (Muir-Cochrane et al., 2018). In turn, such

fears may lessen service user involvement with their own risk assessment and management plans in case it may increase clinical risk concerns (Felton et al., 2018).

There appears to be disparity with principles guiding therapeutic risk management, in which recovery, trauma informed care and co-production approaches are relegated to secondary consideration in the assessing and management of risks. Principles can guide the manner clinicians should be providing care based on particular values and beliefs relevant to the care setting (Varkey, 2021). Hence, this paper aims to illustrate a prioritisation project that resulted in achieving 10 principles of good practice in risk assessment and management. These were informed by clinical and service user perspectives, with the aim of addressing the incoherence currently experienced with providing risk management, particularly in the UK. It was also vital that the principles were deemed accessible for all those who might be affected by the assessing and managing of risk in MH care settings, notably service users, their carers, and/or families and friends as well as MH clinicians such as nurses and doctors.

## DESIGN AND AIM

This is a perspective paper presenting the prioritising of 10 principles of good practice in assessing and managing risk within MH care settings. Whilst risk management generally may be more prominent in acute MH care (e.g. in hospitals and crisis intervention teams) given the acuity of mental illness, these principles were devised with all MH settings in mind. Evidence suggests the aforementioned issues with managing risk are not limited to when a person is under hospital care but also within community settings, which ideally are focused on assisting service users with enriching a personal sense of their recovery (Holley et al., 2016).

## METHOD

### *Methodology*

Drawing on a similar approach with prioritising research, the principles were devised via identifying gaps in the literature and gathering relevant evidence to inform good practice. This was to ensure that the principles had the greatest potential benefit for those providing and receiving risk management practices. Prioritising commonly commences with reviewing relevant literature as well as statuary guidelines (Viergever et al., 2010), which were found to be limited to the aforementioned report from the DOH in 2009. Findings are then refined drawing on views from people with expertise in the field, with the aim of prioritising the

findings. Whilst the principles in this paper are in numerical order, this does not assign an order of importance. All 10 principles are equally important but as a method of focussing on the principles, the prioritisation exercise employed an expert reference group phased approach, to systematically investigate and agree the content of the best practice principles (Viergever et al., 2010).

*Approach*

Firstly, a review of the 2009 guidance and published literature since was conducted with a cohort of 14 frontline staff including nurses and allied health professionals. The findings were then reviewed to produce version 1 of the 10 draft principles for good practice. Recruitment was via a post graduate masters module for frontline staff n MH services in Yorkshire UK, and responses were based on participant experiences of adopting risk management in their daily practices. Secondly, the data was reviewed by a national clinical risk management reference group in which all authors were already members. In total, 30 group members were asked about their views in an online consultation, which refined the principles and ensured their alignment with contemporary MH care in the UK. The group consisted of senior MH nurses working in clinical practice and leadership roles, education and/or research, and resulted in agreement of version 2 of the principles. Thirdly, version 2 of the principles was reviewed by a diverse range of 49 experts by experience of MH services. Consultation occurred online either individually or via facilitated engagement events to ease the accessibility for those living in different geographical locations, with the final draft of the principles agreed (version 3) as shown in Table 1. An expert by experience and co-author (AG) was instrumental in co-ordinating service user consultation and feedback. Drawing on the author's social networks and regional patient and public involvement groups, people with expert by experience were invited to participate via email. Whilst already drafted in some form, the consultation raised additional critiques about the wording of the principles. This meant the principles were further refined as to be meaningful to whomever may provide and/or be at the receiving end of risk assessment and its management within MH care settings.

## FINDINGS

The review of the DOH 2009 guidance highlighted key principles that remained relevant to support best practice. These were the use of a structured clinical judgement approach; positive risk management and therapeutic risk taking; collaboration with the service user and carer; a focus on strengths and assets of the person, and the use of risk formulation to help understand

and explain the risks. Risk formulation however appeared to move beyond mere assessment primarily conducted by clinician drawing on service user electronic notes and observations. It involved a partnership with the service user with harmonising clinical and personal understandings together about safety needs, and any changes to these, while also considering the person's history and MH. Personal and environmental factors were also included which may cause safety issues as well as could be reframed as potential protective factors (Logan et al., 2011). Service users and clinicians collaborating in such a way may by itself increase service user safety, specifically through gaining some recognition that their views matter, and are informing how to develop their own safety needs (Deering et al., 2019).

Risk assessment, nevertheless, undoubtedly remained a vital part of a comprehensive bio-psychosocial assessment involving the strengths and needs of the service user with a focus on the person's vulnerabilities and safety needs to self and others (NICE, 2022). The use of structured clinical judgments including evidence-based instruments were recommended in the DOH 2009 guidance to ensure consistency and objectivity. However, since then, concerns have been raised about the usefulness of such risk assessment approaches, especially when customised by services with little evidence, and adopted to predominately predict rather inform judgements about risk and/or safety issues affecting the self and others (Quinlivan et al., 2017).

It was found that in the UK, there is a growing consensus that risk stratification within risk assessments should not be used to predict future suicide or repetition of self-harm, as evidence to support risk prediction does not exist (Hawton et al., 2022). The triaging of service users in MH services based on needs and risks is still essential for ensuring interventions and support are matched to the needs and risks of the person being assessed (Sands et al., 2016). However, caution is advised as the use of risk stratification, which can be subverted to delay services and justify the denial of treatment (NICE, 2022).

Alternatively, formulation-based approaches to risk management are recommended and recently in Wales (UK), a formulation-based approach to clinical risk management: the WARRN (Wales Applied Risk Research Network) was found to enhance clinical skills with formulation, safety-planning and communication while increasing clinical confidence with conducting risk assessment and management (Snowden et al., 2019). A similar evidence-based *Formulation Informed Risk Management* (FIRM) framework for MH services was developed, emphasising the importance of a dynamic approach where service users are collaborators

within the assessment process. The FIRM framework demonstrated clear benefits in terms of confidence in use, formulation of risk, risk management and improved communication (Doyle et al., 2022). Structured approaches to risk management remain an important part of clinical practice in supporting decision making when employed to develop personalised risk formulations that inform safety plans aimed at preventing harm (Grant & Lusk, 2015).

A key aspect of effective risk management is the adoption of a compassionate and collaborative stance by the clinical assessor, which actively supports service user involvement (Nathan and Bhandari, 2024). Whilst the use of collaborative decision-making remains an emerging field of research, key enablers identified include good quality therapeutic relationships and agreement on the value of collaboration (Deering et al., 2024), while an openness to the challenges of collaboration and confidentiality are also helpful (Dunlop, 2019). Discussing the limits of confidentiality with service users is essential to gain a shared understanding of what will happen to any information disclosed and helps to make an informed decision about what is safe to disclose. During a risk assessment, it is important to have a mutual understanding of the applicable limitations of confidentiality from the outset (Langan, 2008), such as regarding risks to others and/or safeguarding concerns (Quinlivan et al., 2020). Moreover, with this project identifying the importance of carer involvement with providing risk/safety related information, encouraging their involvement may be valuable if safe to do so (Jackson et al., 2019).

Collaboration has contributed to using safety planning as an effective way to manage risk with service user and carers (Hawton et al., 2022), but it still requires the involvement of staff who are adequately trained and clinically supervised in terms of risk assessment and management (Higgins et al., 2016; NICE 2022). This should support assessors to be proficient and confident when engaging with positive risk taking and encouraging service user/carer involvement in the safety-planning process. Staff expected to assess, formulate and manage risk in MH services should have opportunities for regular, high-quality clinical supervision which is seen as essential to therapeutic risk taking as regular, inclusive and open discussion can promote shared responsibility, flexibility and creative decision-making (Fenton et al., 2017). Furthermore, supervision was highlighted as a potential aid in discussing suicidality with service users (Ahmed et al., 2021).

The evidence linking clinical supervision to the quality and safety of patient care reveals that supervision is most effective when its educational and supportive functions are separated from

its managerial and evaluative functions (Tomlinson, 2015). Therefore, supervision should be provided that is tailored to individual clinician needs and takes into account the emotional impact for the person, promotes compassionate care and develops confidence and competence. Following serious untoward incidents, learning lessons and not blaming, along with a duty of candour, have been fundamental doctrines of UK government policy for nearly a decade (Francis, 2015). Wand (2017) suggests that a culture of blame fertilises back-covering, responsibility-shifting and finger-pointing all of which impose a poisonous and paralysing power on MH care and service delivery. A blame culture in MH services can lead to fear and deter staff from seeking help or admitting they are struggling, especially when working with service users who may be a risk to themselves, to others or from others. As part of a safety culture, risk assessors need to be supported to make defensible decisions and avoid damaging defensive practice, while learning and implementing lessons learned arising from incidents.

The feedback on earlier draft of the principles from service users was invaluable. In response, the principles (see Table 1) were improved to enhance the need for a comprehensive assessment of personal needs, collaborative working, clearer communication and shared understanding of risks and safety planning. Experts by experience observed that the proposals clearly reflected their needs and priorities. They valued the emphasis on the service user throughout. They suggested that these principles would improve professional practice and would be a good step towards improving service user experience of assessment and management.

**Table 1: Ten best practice principles for clinical risk management in mental health services.**

[*please place table 1 here*]

## DISCUSSION

The purpose of this paper was to outline the process and outcome of creating 10 principles of good practice for the assessment and management of service user risks within MH care settings. Whilst the 10 principles were devised with UK MH care in mind, the relevance of the principles were also assessed against international research at the end of the project, showing that they do have application to international MH care settings, particularly within anglophone countries. The project originated because in the UK, there had not been recent updates on statuary guidance in what might involve good practice within the provision of assessing and managing

risks. In addition, having guiding principles can be useful as a benchmark to inform good practices, one in which has been reviewed in the literature and validated by service user and clinical voices.

It was found that the 2009 UK DOH guidance still provides sound principles for practice, and these can be further enhanced by more recent literature, the experiences of experts in MH practice and the lived experience of service users. Outcome based research on risk, shared-decision making and how to enhance service user safety is limited (Ahmed et al., 2021) but based on the review of the literature and utilising expert opinions of service users and clinicians, 10 principles for best practice in clinical risk management for MH services were proposed in Table 1. These principles are offered to support best practice by firstly invoking thought and discussion amongst stakeholders towards a consensus or *Concordia Principalis* that can inform future national guidance or *Concordia Regularis* in this area, which can be used as a benchmark for best practice. Ultimately, best practice principles and guidance should lead to enhanced consistency and clarity, improved quality and safer MH practice. Careful planning and implementation, and further research is required, including more outcome-based research in terms of efficacy of risk management practice, and further research into the perspectives and experiences of service users and carers.

In risk management for people with mental illness, a critical balance has to be struck between professional paternalism and service user autonomy. This is not always easy as reflected internationally with different mental health legislation. For example, Compulsory Community Treatment Orders (CTOs) are used in more than 70 jurisdictions worldwide, including the UK (Mikellides et al., 2019). However, the order is not used in the Republic of Ireland, the closest neighbour of the UK, where the idea of their introduction has faced strong critique (Brosnan, 2018). Yet, internationally, there are many commonalities regarding approaches to the assessment and management of risk. From available international guidelines commonalities include emphasis on service user involvement in the risk process, multi-agency collaboration and person centred care (Australian Commission on Safety and Quality in Health Care, 2018; Health Service Executive (Ire) 2009; Standards Australia & New Zealand, 2004). These are factors that are also alluded to in the 10 principles for clinical risk management (Table One).

## RELEVANCE TO MENTAL HEALTH NURSING

The assessment and management of risk is a mandatory and essential part of international MH care. However, there has been little statutory UK guidance that has kept abreast of the latest developments in the field. These 10 principles of good practice can act as a benchmark to inform a values-based approach when assessing and managing the safety of service users, which similarly to Australia and Northern America, tend to be led by MH nurses in the UK (Lakeman et al., 2023; Gerolamo et al., 2024). The principles imply that risk management requires a relational approach that promotes service users' dignity and voice when informing safety interventions whenever possible. Nevertheless, given the apprehension that can come with the assessment and management of risk, it is imperative that all MH care settings in the UK, and countries beyond, provide regular supervision for nurses and other MH practitioners, so that good practice can be maintained while they also feel supported and safe when encountering complex risk concerns (Ahmed et al., 2021).

## LIMITATIONS

It is recognised that the principles devised and presented in the paper are particularly relevant to UK MH care, although they do seem to have relevance to other countries with similar service provision, such as Australia and North America. Collating the principles in the way we did lacks some of the rigour expected with empirical research, increasing the risk of bias in their interpretation, although a range of experts were consulted and contributed and all involved have taken a keen interest with developing risk management in MH care, be it in its provision or at the receiving end when under MH services. Of note, research does suggest an issue with the assessment and management of risk in that it is not easily identifiable particularly to service users (Deering et al. 2024). Hence a limitation might be the interpretation in what can be classed as risk management over other care practices. This is important when considering the changing focus of enriching service user safety, which interweaves with many other care practices, notable with recovery practices and trauma informed care (Berzins et al. 2018).

## CONCLUSION

This paper presented the construction of 10 principles of good practice when assessing and managing risk. It was informed by a literature review commencing with research in 2009 onwards, which was critically evaluated with the principles further refined by service user and clinical perspectives. For too long these practices seem to not have been informed by scientific

rigour nor the perspectives of service users and their significant others on what is useful. It is therefore hoped that the 10 principles can be employed as a starting point to improve the assessment and management of service user safety within diverse mental health care settings.

**Table 1 Ten best practice principles for clinical risk management in mental health services**

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| 1. The focus of any risk assessment is on ***assessing the physical and psychosocial safety*** of the service user and those coming into contact with them, empathetically listening to their experiences, preferences and beliefs and working with their views, to reduce harms to self and others, and from others (including harms arising from clinical practice and treatment). |
| 2. Decisions about risk should be based on a ***structured approach*** that is informed by: service user experience and history; the views of family/carers (whenever possible); skills-based training; evidence-based practice, and compassionate approaches. |
| 3. ***Risks are dynamic*** and can change very quickly. A coherent approach to team-working and to communication with service users and carers, and flexible means of ***accurately documenting*** ongoing concerns, are required for safety planning. |
| 4. Safety planning must recognise and build on the ***strengths and preferences of service users and protective factors***. Safety plans should implement the least restrictive course of action, with a therapeutic focus on consistently supporting the service user to pursue a fulfilling life. |
| 5. ***Collaboration with service users and family/carers*** is vital in the ongoing assessment and formulation process to inform safety planning. |
| 6. Risk assessment, formulation and safety planning processes should be ***clearly explained*** to the service user. Service users should always be made aware of the limits of confidentiality, and what will happen to anything they share. |
| 7. Constructing a meaningful account of risk is essential to enabling *a* ***shared understanding and personal formulation*** of needs that respects cultural background. It must be written in non-stigmatising language, in terms the service user can understand, and should accurately represent their experience, and be shared with the service user whenever possible. |
| 8. Given the dynamic nature of risk, risk stratification ratings such as ***Red-Amber-Green or numerical scaling****,* may be useful for matching interventions to personal needs, but they must not be used as a means of predicting future harm or denying interventions. |
| 9. ***Regular clinical supervision*** for staff and reflective practice within teams should acknowledge and support the emotional labour of staff working with risks, while mitigating the risk of overly restrictive and coercive professional practice. |
| 10. ***Learning without blame from incidents*** and other people's experiences, including service users and family members, supported by the duty of candour is essential. |

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