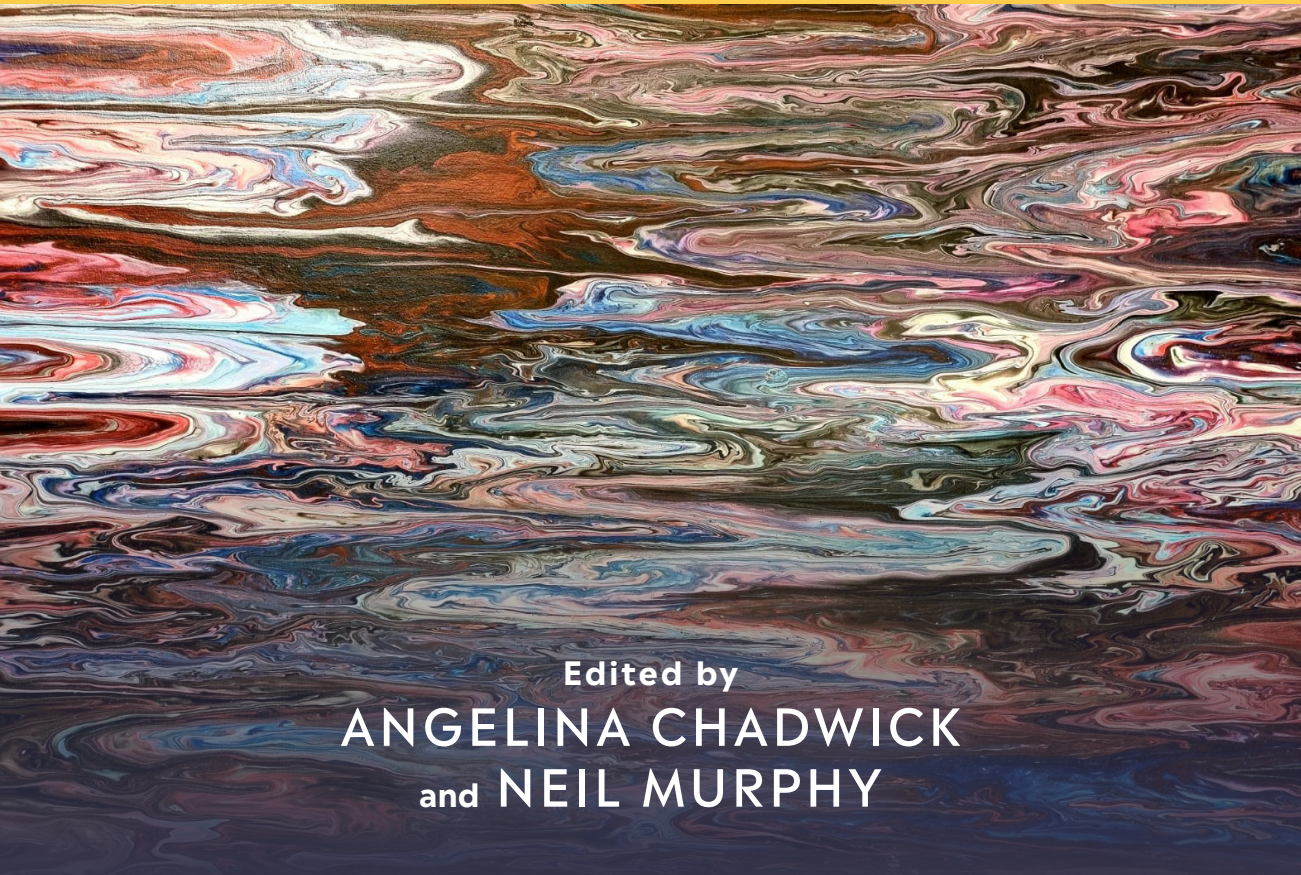
ESSENTIALS

MENTAL HEALTH

A Non-Specialist Introduction for Nursing and Health Care



Edited by
ANGELINA CHADWICK
and NEIL MURPHY

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Cover image by John Edgerton

"As I struggle with mental health issues (depression) I find that painting helps me clear my mind and gives me something to concentrate on helping ease my depression."

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Edited by

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Abbreviations

A&E	accident and emergency (department)
ADHD	attention deficit hyperactivity disorder
AMHP	approved mental health professional
ASD	autism spectrum disorder
BPC	British Psychoanalytic Council
CAMHS	child and adolescent mental health services
CBT	cognitive behavioural therapy
COPD	chronic obstructive pulmonary disease
CPA	Care Programme Approach
CRHTT	crisis resolution and home treatment team
CQC	Care Quality Commission
EIS	early intervention (in psychosis) service
EIT	early intervention (in psychosis) team
GMMH	Greater Manchester Mental Health NHS Foundation Trust
GP	general practitioner
IAPT	Improving Access to Psychological Therapies
MUS	medically unexplained symptoms
NCCMH	National Collaborating Centre for Mental Health
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
OCD	obsessive–compulsive disorder

ONS	Office for National Statistics
PHE	Public Health England
PICU	psychiatric intensive care unit
PPP	postpartum psychosis
PRN	when required (pro re nata)
PTSD	post-traumatic stress disorder
RCN	Royal College of Nursing
SMI	severe mental illness
UNCRC	United Nations Convention on the Rights of the Child
WHO	World Health Organization

Introduction

Mental health is something that we all possess alongside our physical health. However, in health care services, funding and the focus for debate are commonly attached to the more tangible physical ('seen and understandable') aspects of health. It is easier to recognise someone who has collapsed with a heart attack or someone who is bleeding due to an injury than it is to recognise someone who is depressed or someone who is paranoid. Therefore, those with a 'seen and understandable' illness are more likely to have access to services than those whose illness is not as apparent or understood. Over recent years you will have become aware of the increase in awareness of mental health issues and problems, through the media and those you come across in physical health care services.

You will have become aware that, as we live longer and make lifestyle choices that can have an impact on our physical and mental health, people are also more prone to more than one illness; this is known as comorbidity or multimorbidity. An example of this would be a young person diagnosed with type 1 insulin-dependent diabetes who becomes depressed at the thought of the restrictions this could pose on their life; or another person struggling with a long-term illness such as psoriasis becoming increasingly anxious about leaving their home and becoming agoraphobic. As a result, there has recently been a call for 'parity of esteem' in health care policy and literature. This means there is a drive to raise the importance, awareness, services and funding of mental health care to that of physical health care. So, you may ask, what has all of this got to do with this new mental health textbook? Well, the answer lies in those patients you will be nursing. Many will have both physical and mental health problems due to lifestyle choices, inequalities in access to health care services and living longer.

The Nursing and Midwifery Council (NMC), as a professional body, sets standards of proficiency and competencies to guide the pre-registration training and development of qualified nurses, to ensure that they are knowledgeable and skilled to nurse the patients in their care. The review of these pre-registration nursing standards (NMC, 2018a) has emphasised the need for all fields of practice to be aware of the practice and utility of skills in other fields of the health care service. So just as mental health nurses need to be knowledgeable and skilled in recognising physical health problems in patients with mental health problems, the same principle applies to non-mental health nurses, to adult, learning disability,

and children and young people's nurses, and even to midwives, all of whom need to know about mental health problems. In a bid to increase the knowledge and skills of non-mental health nurses through teaching within our higher education institute, we, as a team of mental health academics and practitioners, have developed this textbook. It is aimed at non-mental health nurses, to support development in your knowledge, understanding and skills to recognise, support and signpost someone with an emerging or known mental disorder.

The chapters of this textbook focus on the many different dimensions of mental health and illness across the age continuum. *Chapter 1* looks at what mental health and illness are and the differing terms used, as well as the interplay with physical health. In *Chapter 2* we explore the different approaches and theories around mental illness, to develop your knowledge about their origins and how these differ from the medical model. *Chapter 3* focuses on the important communication skills required to support someone in mental crisis. *Chapter 4* considers many of the common diagnosable mental disorders and aims to make them understandable. *Chapter 5* explores mental health in early life, i.e. children and young people, and discusses therapies and services available to this group. *Chapter 6* examines mental health in adulthood and the services available to those individuals. *Chapter 7* moves on to mental health in later life, discussing the mental health conditions of older adults and exploring the interventions, practice and services available. *Chapter 8* considers legal and ethical aspects when supporting those with mental health problems, as well as your role and responsibilities as a professional in this area. Finally, *Chapter 9* examines risk in mental health, as well as stigma and labelling, which contribute to the ignorance and fear people have towards those with a mental illness.

The chapters have been written by experienced mental health nurses working in education, with further contribution from experienced practitioners. These individuals have a wealth of knowledge, experience and expertise, and have published extensively in many different nursing journals and now in their chosen chapter(s). Given the bank of their clinical experiences we felt it prudent to permit the authors to use varying terms when referring to patients, clients and/or service users depending on their specialist areas. Similarly, in reference to those with mental health problems they use the terminology from their practice areas, for example mental health difficulties, mental conditions and others. We hope that from reading the text, undertaking the activities and reflecting on what you have learnt you will develop professionally and ultimately be a more holistic practitioner.

Angelina Chadwick
Neil Murphy

Chapter 9

Risk

Neil Murphy

LEARNING OUTCOMES

By the end of this chapter you should be able to:

9.1 Understand the concept of risk

9.2 Describe the process and elements of assessing risk

9.3 Articulate factors influencing the presence (static and dynamic) of risk in patients

9.4 List factors related to risk of violence and suicide

9.5 Reflect on how risk affects an individual and develop a simple formulation (explanation) for their risk.

9.1 Introduction

Risk is a concept that has many meanings that can relate to various situations, and in this chapter the focus is in relation to health. Generally, definitions of risk contain reference to potential danger, loss or injury. But the potential of risk (e.g. history of self-harm or violence that is not evident at the time) does not always need to relate to a physical event: risk can relate to values, rights and opportunities.

Risk is linked to a variety of things in our lives and often we are unaware of its presence. The hidden influence of risk can affect how much insurance you pay for your home or car. Risk is involved in your employment and in your recruitment to any future role. It is also identifiable in the lifestyle you adopt and in many of the decisions you take.

- Risk can be a planned event – for example, a young person may be offered car insurance on a high-powered car but it will come at some financial cost.
- It can be unplanned – for example, employing people to take on a role and finding that they are unable to fulfil the role, leading to plans not being achieved.
- It can be predictable – for example, if you have an ageing employment base and you do not plan for people leaving through retirement (and still need the same number of staff) then you will be short of staff.

- Finally, it can be unpredictable and uncontrollable – for example, arriving at work to find that the rest of the team have all independently left a message that they cannot come in today, so an order due to be completed cannot be fulfilled.

All the above factors will probably resonate with your experiences. The perception of risk involves each individual and their subjective view of something negative happening because of some factor they have encountered. It is intuitive in many cases, but the skill to assess and manage risk can be developed from this initial intuition. Often you will have a sense of unease and foreboding. Such senses are commonly related to you perceiving something that you are uncomfortable with or find confusing and potentially threatening to you. Each person will view an event in a unique and individual way. The way you view something is governed by many factors, but primarily by experience and knowledge. Therefore, if you think something is going to be risky, you will react in the way that you have learnt to react to risky events.

Risk can be interpreted in a negative and frightening way, but it can also be interpreted as excitement. The key theme here is that there is some interpretation that is related to you as an individual. The way you react to the risk may lead to learned actions for the future, in a way of coping. For example, if you are late for work, you might drive at an uncomfortable speed but arrive in work in sufficient time not to be noticed by your manager. The cognitive reaction to the risk of driving uncomfortably fast leads you to feel that you can take such a risk again, each time becoming accustomed to the feelings until they are not uncomfortable but potentially enjoyable.

A major problem that health care workers encounter is that they cannot avoid risk. In most forms of health care, risk needs to be assessed (e.g. triage carried out in an A&E department, a patient refusing to take their medication). The way you feel about and interpret risk and your level of experience will influence the way you assess and deal with the risk.

In mental health care, risk assessment is often related to having to remove decision-making from a risky individual. This may involve giving fewer options, so as to provide a clear direction to address any risk, or in some circumstances detaining people against their wishes. The removal of decision-making may indirectly give more ownership of a risk back to the person, by enabling them (if possible) to see that there was an alternative way to addressing the risk that may have been different from their initial choice but resulted in no harm. The next section will explore risk and risk assessment in mental health care as related to direct personal care.

9.2 Assessing risk

Risk is defined, in relation to health, as the likelihood, imminence and severity of a negative event occurring: for example, violence, self-harm or self-neglect (Department of Health, 2009). The art of assessing risk has been explored over

many years by many authors, but specifically by Monahan and Steadman, and the MacArthur Foundation, culminating in them suggesting that risk assessment is usually seen as attempts to predict risk (e.g. see Monahan *et al*., 2001). The many and varied areas related to risk are frequently researched, and UK national statistics are produced annually – for example, the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) project, based at the University of Manchester, has collected information about all suicides in the UK since 1996. Despite this, many clinicians remain a little unsure about the best way to assess risk. Much of the evidence for this is seen in the research debates related to the value of assessing risk (see Szmukler and Rose, 2013) and the many and varied tools created to assess risk (see University of Manchester, 2018).

Guidance from the Royal College of Psychiatrists (RCPsych, 2016) suggests that risk assessment must acknowledge its dynamic nature and that risk is subject to changes in presentation over short periods of time. Just as risk can change over time, so historically has the approach to assessing risk. Risk assessment and management in mental health care is commonly influenced by adverse events, such as the death of Rocky Bennett, who suffocated while being restrained in the prone position, a 'traditional' restraint at the time (Mind, 2013, p. 3).

Much current practice related to risk assessment and management is found in the Department of Health's *Best Practice in Managing Risk* (Department of Health, 2009). Its guidance in many areas is used throughout this chapter and many NHS Trust policies are linked to this best practice advice.

There are some key concepts in assessing risk:

- Risk is a normal thing to encounter in our everyday life.
- Risk can be 'static' or 'dynamic' (each will be developed later in the chapter).
- The Department of Health (2009) argues that risk assessment is a sensitive topic and one that can be challenging; I would further argue that this is the case for both the person being assessed and the people assessing.
- The NMC (2018b) argues that nurses should, where possible, aim to protect people who may be at risk or are considered vulnerable from harm, neglect or abuse.

ACTIVITY 9.1

What risks do you think you face in your everyday life? Think about the past few days and write them down.

9.2.1 Static risk

Static risks are usually unchanging and often referred to as historic risk – for example, a history of childhood neglect or a history of self-harm.

Mental health risk assessment has focused on historical factors that have been seen repeatedly in groups of people (e.g. in age groups, professions, in relation to past risk behaviours). Service response has been aimed at reducing risks as a

way of protecting people. One way of achieving this is to remove responsibility for their actions from the person at risk. However, by taking responsibility for maintaining safety instead of enabling the person at risk to develop the skills to do so for themselves, services can in some cases increase the risk rather than diminish it.

ACTIVITY 9.2

How do you think that mental health services may act with a person who said that they were at risk of suicide? Write down your thoughts.

9.2.2 Dynamic risk

Dynamic risk is fluid and can include a person's mental state and lifestyle choices. Dynamic risks are ever-changing.

It is normal for people to feel that life is not good at times, and some people who have limited cognitive ability or life experience articulate these thoughts as feeling suicidal. Someone feeling as though they may be suicidal does not always equate to someone who is actively suicidal and at a high level of risk. Just because someone states that they feel suicidal does not mean that they are actively wanting to end their life. However, a nurse needs to accept that the person may be suicidal, establish in what way they are at risk and report this information immediately to a senior colleague, ensuring that the person remains safe.

The NMC argues that, as a nurse, you need to accept that people who may be, or state that they may be, at risk have the right to refuse or not take part in treatment, but that you will need to act in their best interests (see *Section 8.2.1*). That may not be a simple linear action. Often the nurse needs to involve other professionals, but such a decision may require them to share confidential information with others who the person may not want the nurse to speak to (see *Section 9.4* on safeguarding). This decision does not fall to the student nurse, but information gathered by a student nurse may be important to more senior staff's decision to share confidential information with other professionals.

9.2.3 Factors influencing the risk of suicide and violence

Although there are many other factors related to risk in mental health presentations, violence and suicide are discussed next. The reason for this is that both are reported in national statistics each year. *Table 9.1* highlights some of the key areas of information gathered over many years that have been found to contribute to the risk of violence and suicide. The table shows only a modified short version of the information available and is used for indicative purposes (more comprehensive data is collected by the NCISH; see also Department of Health, 2009).

Table 9.1 *Factors influencing the risk of violence and suicide*

	Violence	Suicide
Demographics	Young age Male Employment problems	Increasing age Male Unemployment Living alone
History	History of violence Childhood maltreatment	History of self-harm (also family history of suicide) History of abuse History of mental illness
Clinical history	Psychopathy/personality disorder Non-adherence to treatment	Diagnosis of mental illness (e.g. depression, personality disorder, schizophrenia) Contact (may have been recently discharged) with psychiatric services Physical illness
Psychological	Impulsivity Anger and suspicion Violent attitude Lack of insight into problem	Impulsivity Hopelessness and lack of self-esteem Lack of support Life event
Current context	Threatening Access to weapons	Suicidal and has plans Access to means Lethality of means

9.2.4 Risk of vulnerability

Amendments to the Mental Health Act in 2007 suggest that people leaving a mental health hospital should continue to receive help because of their potential vulnerability. Vulnerability related to mental illness is seen in people who may be exploitable and are at risk of being victimised. This is associated with people being intimidated, bullied and, in some instances, abused. Care is needed to consider such vulnerability, to assess each person for the potential for such risk and to explore ways to manage any identified risks. Importantly, empowering the individual to

have a voice and articulate how things are for them is inherent in developing an accurate assessment. A person might be victimised by others simply because they have a mental health problem or even because they are on medication.

9.2.5 Risk of self-neglect

Many of the tools designed for assessing risk in the mentally unwell include sections that focus on neglect (by the self and others) (see Morgan, 2000).

Self-neglect can take many forms, but is often associated with some form of deficient behaviour, such as lack of self-care or unconscious omission of action that might impinge on the person's health. Care is needed not to confuse a risk behaviour that has some conscious action (e.g. deliberately not taking medication) and someone's unconscious omission or action due to confusion or preoccupation.

ACTIVITY 9.3

In what ways do you believe that having a mental illness may cause vulnerability or self-neglect? Write down your thoughts.

9.3 Considerations in assessing risk

To make further sense of the risks detailed in this chapter it was found simplest to use the headings from *Best Practice in Managing Risk* (Department of Health, 2009) to frame the discussion in this section.

9.3.1 History

As can be seen from many of the risk assessment tools, such as the 20-item Historical–Clinical–Risk Management scale, version 3 (HCR-20V3) (Douglas *et al.*, 2013), and from static risk factors, a history of a person presenting with risks is a major predictor in the person posing a risk again. Many of the risks people present with are related to their past behaviour, such as substance misuse, alcohol use, self-neglect, use of violence or self-harm. Knowledge of these historical behaviours can be beneficial for the nurse and the patient, but it may also cause a problem for both.

ACTIVITY 9.4

What potential problems could happen if a health care worker has knowledge of a person's past risk-related behaviour? Write down your thoughts.

A history of violence or self-harm are often seen as powerful predictors of a person's potential to be violent or to self-harm in the future. However, just because a person has a history of risky behaviour, this should not mean that they should be constantly viewed as posing a risk. Care is needed to establish the risks present and to see whether a pattern of risk from the past is happening again. Often on further investigation a trigger to such behaviours can be found and this can be seen as an early warning sign for the potential risk.

Key themes that should be considered are:

- a relationship between becoming mentally unwell and the use of violence or self-harm
- a lack of tolerance and a level of impulsivity
- an increase in stress for the person, which could be social, familial or environmental.

There are several things that should be looked for when assessing historical risks:

- What has stopped the risks from being actualised?
- What has changed between the period of being 'well' and now 'becoming unwell'?
- Are the risks following a pattern seen before?

9.3.2 Environment

If a person has been living in an environment where certain behaviours are acceptable (as a member of a gang, for example), then some of their displayed actions and coping strategies may not conform to the expectations of others outside of that environment. Similarly, if someone has been in a hospital environment, has a military background, has been in prison or has had some long-term exile from societal influences, then their behaviour and their understanding of society may be compromised. A person from such environments may present with risky behaviours, but may also be at risk because they do not understand currently acceptable societal behaviours.

It is important to remember as well that hospital environments do have specific levels of risk attached to them. People in such environments may be vulnerable and others can exploit and take advantage of them both in hospital and on returning to their usual place of living. For some, remaining in hospital may seem a safe solution to either the risks they pose or the risks they are vulnerable to. But the longer a person remains in a hospital environment, the longer their skills for life may become compromised and coping strategies altered and modified to fit with that environment.

9.3.3 Mental state

The symptoms of some mental disorders can increase the risks the person poses both to themselves and to others. Symptoms related to the belief that someone controls them or is intending to harm them or that they have unique abilities that they do not have (delusional beliefs) can cause some people to act or place themselves in precarious situations where harm may occur. Alongside this, the strength of their belief may cause an increase in anger or suspiciousness if others contradict their viewpoint. Commonly, behaviours become less predictable, and the person can lose any insight and capacity to control their responses. Here an increase in symptoms can be seen to increase risks, with the person becoming more unwell and often less engaged with care providers or carers.

Occasionally, a person's mental state can become so entrenched in misperceptions that they stop caring for themselves and actively avoid contact. Reinforcement by the actions of others can lead to further entrenchment and a spiralling downwards of mental health.

9.3.4 Information from others

Carers and friends can illuminate changes that have occurred recently in a person who is becoming unwell. Often, such people have essential knowledge of the person's usual practice and behaviour and their coping strategies and, more importantly, awareness of deterioration in health. Care is needed not to ignore any information related to risk. An important factor for the nurse is not to appear to be favouring service perspectives over those of clients or carers, as this may inadvertently antagonise the situation. Carers are important people in the recovery of someone who has a mental health difficulty. These people are in frequent contact with the individual and provide support by offering more time and encouragement than a health care professional can ever offer.

9.3.5 Clinical judgement

A relatively recent addition to risk assessment is the inclusion of clinical judgement. Clinical judgement has a range of factors that need to be considered. Nurses need to have knowledge of all fields of health presentation, and your undergraduate training is intended to equip you with the fundamentals. However, when you are qualified and working in adult physical care, knowledge about mental health may become a little faded. The judgement an adult nurse needs to demonstrate includes the ability to reflect on personal experience of working with people with a mental health problem, taking into account other patients they may have met in the past who presented in a similar way. The nurse also needs to establish what risks the nurse, the patient and the carer may feel are present and decide, once sufficient information has been gathered, who to discuss the risk with further.

An important factor regarding clinical judgement is that it is only one component of the way that the nurse will establish the level of risks. Acting only on clinical judgement without historic information and standard risk information will mean that any risk assessment is limited in its value. However, the combination has been seen to complement the accuracy of assessments and is seen in more recent risk assessment tools (Douglas *et al.*, 2013). The health care professional's knowledge and understanding can, when paired with a structured tool, have more accuracy and be more meaningful to all in its outcomes. The process also enables confirmation by the patient and their involvement in establishing a formulation (understanding or explanation) of how things link together in their unique life.

9.4 Safeguarding

Safeguarding is an essential area for discussion in any health or social care service. Much of the focus is on the protection of the person's wellbeing and their human rights. So far in this chapter, safeguarding issues have been identified without direct

reference to, but hopefully with an implication of, partnership in establishing the risks. The sections related to vulnerability (*Section 9.2.4*) and neglect (*Section 9.2.5*) have raised themes related to potential exploitation and quality of life. In this section the focus is realigned to themes involved in any safeguarding discussion: abuse and, in more detail, neglect.

A brief overview of exemplars of both abuse and neglect is offered in the rest of this section (see *Activity 9.6*) to aid identification of key areas and to supplement understanding with regard to risk. *Figure 9.1* shows the main themes.

Figure 9.1 *Key areas of abuse.*

ACTIVITY 9.5

List some potential safeguarding issues related to the themes in *Figure 9.1*. Write down your thoughts.

Although each area is identified separately, in some cases one area is implicit in another. For example, domestic abuse may have psychological/emotional factors involved, financial abuse can involve domestic and psychological/emotional abuse.

Neglect is a simple term that has many complicated connotations. Neglect can be under the control of an individual, a deliberate act, and can also relate to personal values and raise cultural and professional challenges.

ACTIVITY 9.6

Can you identify whether the following are examples of neglect?

- Ben is a 16-year-old person who has a heart condition and depression and who will not take his medication. His parents have been found to be grinding some medication and adding it to his food.
- Sally is a 60-year-old person who has been removed from a GP's list for over-attendance. She has a long-term health problem and cannot understand why her behaviour is a problem or why she cannot see the GP when she wants to.
- Sna is a 20-year-old person who has taken a large overdose and has deteriorating neurological signs of life, but breathes independently. Doctors identify a chest infection but decide not to treat it.
- Billy is a 40-year-old person who has stopped putting his garbage out for collection; instead, he hoards it in his house. He stores the refuse in sealed plastic bags in his home and his neighbours continually leave rude messages on his door.

Throughout this section (including *Activity 9.6*), there are many answers, and the nurse will start to consider how to make sense of each one. To manage such instances the Department of Health (2011b) advocates a stepped approach in which the first necessity is to identify safeguarding events. Once identified, there would need to be an assessment to establish the issues and people involved, then the development of some response. Ultimately the local authority in the area where the event takes place will have a specific protocol to enact such safeguarding (e.g. see Local Government Association, 2018). As a health care professional, you will need to be aware of such protocols and may need to raise concerns. Hart's (2014) pocket guide to risk assessment and management for practitioners is a simple reference guide that supplements this chapter.

9.5 Boundaries

Within the concept of risk, boundaries of individuals, services and others are important. After all, levels of confidentiality and professionalism are expected from professionals, but what boundaries exist in the eyes of the person receiving care? With respect to risk assessment, they have the right to know of any decisions made for them and to be involved in any risk assessment and development of a management plan.

Care is needed with risk, as some people's behaviour and risk factors can involve others. The nurse needs to explore such instances but also to be vigilant not to breach confidentiality inadvertently when sharing information on identified risks. It is a natural feeling to consider sharing risk details with people who may be involved in the care of the person (such as a relative) or have some vested interest (e.g. a police officer), but the first step would be to discuss and share with senior staff involved in the person's care in order to establish the best route forward.

Also, importantly, sharing risk information with others who are not involved in the care or management of care could breach the rights of the person concerned and

not adhere to the General Data Protection Regulation (GDPR) (for guidance see Information Commissioner's Office, 2018).

9.6 Mass media

Mass media have played a part in educating and informing people about the risks associated with mental illness. Although selective in nature, the media commonly offer some sound and clear messages related to public health issues and the impact of mental ill health on performance. Campaigns such as Time to Change, led by Mind and Rethink Mental Illness, have been in existence for many years, yet many people are only recently becoming aware of them and their focus on mental health. The reasons for this probably include increased media publicising of World Mental Health Day (10th October) and celebrity acknowledgement and public sharing of experiences of mental ill health.

It is important to highlight some of the issues perhaps missed by the lack of publicising of Time to Change, where it was argued that the mentally ill are more at risk from people without mental illness and from themselves than the general public is at risk from the mentally ill. Although the general public increasingly associates violence with mental ill health, in fact the rate of violence in the mentally unwell has remained constant since the 1990s. In all forms of violence, the most common denominators are drugs and alcohol, not mental ill health. The Time to Change campaign is no longer running, but it continues to maintain a government-funded website offering advice related to mental ill health – see www.time-to-change.org.uk.

Unfortunately, much of the media's representation of mental ill health is still negative. Negative representation is seen in particular in relation to people with schizophrenia and implied drug misuse (Murphy, Fatoye and Wibberley, 2013). Such negative representations have been found to influence practitioners' opinions and actions in a restrictive fashion (Murphy, 2015), causing them to look for risks even when none are indicated.

Public attitudes have been influenced by media reporting over many years. An example is seen in a study by Appleby and Wessely (1988). This happened to be in progress at the time of the Hungerford massacre, a series of random shootings by Michael Ryan (a man initially labelled mentally ill) in August 1987. Before the incident, they had been asking people their opinions about the mentally ill and found that most cared about and wanted a more inclusive approach to help people with a mental health problem to reintegrate into society. The research continued after the incident, with opinion changing to wanting the mentally ill to be separated for public safety. Around six months later the research found that opinion had reverted to the original findings for care and inclusion.

This theme of acceptance and then rejection may be stimulated by media reporting, but it may also be influenced by repressed thoughts and stigmatised views related to trust. This is seen in many examples where the public have resisted the placing of mental health units in their local area, citing fears of danger and risk from the

mentally ill. Yet public consultations and representations by service user forums have become the method of addressing fears and have enabled many new community mental health units to be built and become part of the fabric of future mental health care (e.g. see Sussex Partnership NHS Foundation Trust, 2019).

9.7 Practicalities of the assessment of risk

The Department of Health (2009) argues that risk assessment needs to be based in a sensitive way on individual presentation and to take into account individual need and ability. No assessment of risk can be accurately completed without the person who presents with the risk, or without having assessed a range of other factors: the person's social context, their clinical history (both past and current mental health problems) and their own understanding of factors influencing the way they feel at the moment.

9.7.1 Process of developing an understanding and management of risk

The Department of Health (2009) directs health care professionals to use a five-step cyclical model for assessing risk (*Figure 9.2*).

The cycle aims to involve the person who presents with the risk in all decisions at all stages. The process begins with an assessment of the individual emerging risk, how it is seen by the person and others and how it can escalate. Then an agreed plan to manage the risk is put in place, monitored and reviewed for effectiveness. The cycle is then repeated for existing or new risks.

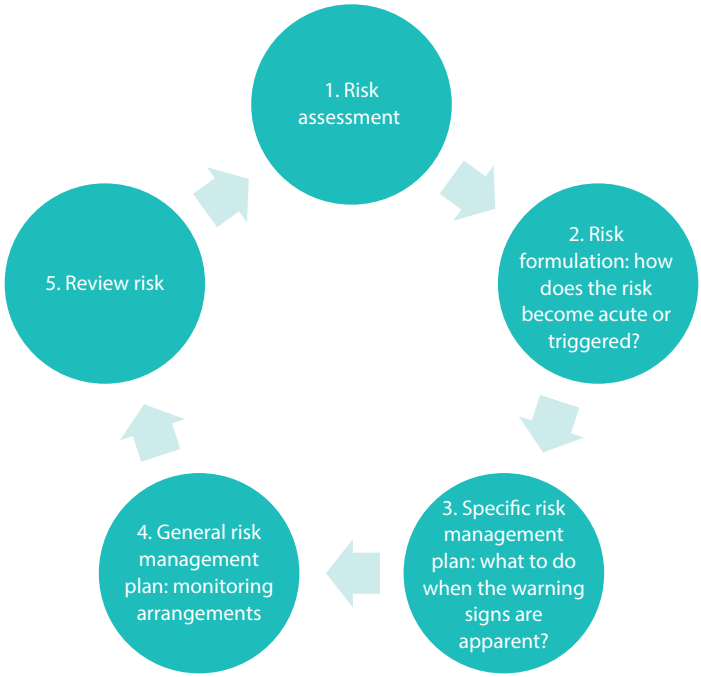

Figure 9.2 *A five-step model for assessing risk and planning risk management (Department of Health, 2009). Reproduced under an Open Government Licence 3.0.*

9.7.2 Application of risk assessment and management to a person

Over the chapters in this book, you will have looked at a range of aspects influencing how mental illness is both presented and viewed. The final section of this chapter provides you with an opportunity to link some of these themes, ranging from a specific type of presentation to an understanding of risk to an individual person.

Scenario: Stephen

Stephen is an 18-year-old person who has presented at A&E with chest pain. He has been to the department many times over the past month. He appears poorly nourished and in a dishevelled state.

ACTIVITY 9.7

What is the first thing you think the nurse engages in with Stephen? Write down your thoughts.

In assessing Stephen, the triage nurse establishes that he has been to the department before for similar difficulties, but also asks whether there was any medical history in his past and any family history of mental illness. Stephen says that he had been in hospital as a child and was supported by the CAMHS team. He says that his brother took his own life when Stephen was 14 years old, also that his mother has had CBT over the past two years after coming off antidepressant drugs.

ACTIVITY 9.8

What are CAMHS teams? What do they do? Write down your thoughts.

It transpires that Stephen had received inpatient care in a local mental health unit for adolescents. On further enquiry it was established that Stephen had used cannabis from the age of around 12 and had experienced delusions on such use. He says he had been excluded from school for supplying drugs to peers and had been arrested on many occasions in relation to drugs. He had spells of 'living rough' and had been abused by older rough sleepers.

ACTIVITY 9.9

What are delusions and how may they cause risks? Write down your thoughts.

Talking more about his chest pain, Stephen says that is being caused by not using cannabis (something he stopped about three weeks ago, after being thrown out of the family home for problems associated with it by his parents). Stephen admits that he is 'sofa surfing' (which he has done before when asked to leave places) and that he is feeling quite tense. This tension is often expressed in losing his temper. Stephen admits to having hit his mother when delusional and after this incident

he felt so bad that he took an overdose of paracetamol. The event made him think about his brother's death and he wondered whether he had had any influence on this. He says he doesn't care what happens to him.

ACTIVITY 9.10

What risks do you think Stephen poses to himself and others? Write down your thoughts and try to evaluate how Stephen judges the level of risk to himself and others.

CHAPTER SUMMARY

Key points to take away from *Chapter 9*:

- Risk is present in all aspects of our own and other people's lives.
- The general public is portrayed by the media as being in danger from people with mental ill health, yet reports show that the mentally ill are more at risk from the general public.
- Many of the ways that risk is conceptualised (to self, to others, neglect and vulnerability) are influenced by awareness of the person's history.
- Risk is not solely dependent on the person but is also influenced by others in society, including the media.
- Various guidelines highlight safeguarding needs and approaches, and nurses need to be aware of these in order not to exacerbate the risks already facing a person or introduce new risks.
- Using risk assessment tools is only part of understanding risk; appreciating the other contributory factors and their importance to a person with mental ill health is also essential in assessing the person.

Questions

Question 9.1	Describe how risk is viewed within health care. (*Learning outcome 9.1*)
Question 9.2	Describe the process and elements of assessing risk. (*Learning outcome 9.2*)
Question 9.3	What are the static and dynamic presentations of risk in patients? (*Learning outcome 9.3*)
Question 9.4	Reflect on and detail the factors that may increase the risk of violence and suicide in people with mental health difficulties. (*Learning objectives 9.4 and 9.5*)

FURTHER READING

Hart, C. (2014) *A Pocket Guide to Risk Assessment and Management in Mental Health*. Routledge.

Fitzgerald, N. and Fitzgerald, R. (2016) *Mental Status Examination: a comprehensive core skills guide for all health professionals*. CreateSpace Independent Publishing Platform.

Social Care Institute for Excellence (2015) *Safeguarding Adults Reviews (SARs) under the Care Act*. Available at: www.scie.org.uk/safeguarding/adults/reviews/care-act (accessed 23 June 2021).

Time to Change: www.time-to-change.org.uk