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Disclaimer

The guidelines presented in this document are intended to promote good practice in the person centred assessment and safeguarding of risks. They may be adopted in whole, or adapted in part to meet service provider needs. The authors would like to acknowledge that in enabling risk, even with the best quality clinical practice, procedures and safeguards in place, incidents will inevitably occur.

For this reason, neither the authors, nor the Centre for Disability Studies, can accept liability in respect of any claims for personal and/or property damage, or any financial losses, sustained following the occurrence of incidents in disability services.
Key Definitions

**Bio-psycho-social model**
Is an approach positing that biological, psychological (which entails thoughts, emotions, and behaviors), and social factors influence the development and maintenance of behaviors, including behaviors of concern.

**Complex Support Needs**
Individuals with complex support needs are those:
- who are experiencing (or are at risk of experiencing) multiple and interrelated conditions or factors which contribute to an intensity of support need. Examples of these conditions or factors include: multiple disabilities, dual diagnosis (i.e. mental health and disability), significant medical conditions or significant deteriorating health conditions, behaviours involving harm to self or harm to others, alcohol and/or drug issues, and issues relating to past experience of trauma or neglect – in addition to having an intellectual disability
  
  **AND/OR**
- who are experiencing (or are at risk of experiencing) one or more situational factors that impacts on the complexity of their support needs or the ability of their natural supports to meet their needs. Examples of situational factors include a lack of natural supports, family/carer stress, a breakdown in carer arrangements, young people who are leaving care, involvement in the criminal justice or forensic system, and multi-agency involvement in supporting an individual
  
  **AND**
- who challenge the service system’s capacity to respond to their support needs because of its structure, organisation or resourcing.

**Dignity of risk**
“Dignity of risk refers to a commitment to each person’s right to control his or her own life, including both good and bad experiences.” (Parsons, Cocks & Williamson, 2009, p. 37)

The ADHC *Behaviour Support Policy* (2012) provides additional detail:
“The principle that everyday risks are a part of life and the freedom to make choices, take risks and experience the consequences, good and bad, contributes to personal dignity.”
Duty of care

“Duty of care can be physical, emotional, financial or social; it is the obligation to take reasonable care to make sure you or another person are not harmed. ‘Reasonable’ means the degree of care that could be expected from a competent and skilled person in the particular job. Neglect is the failure to maintain duty of care” (ADHC *Code of Conduct*, 2012).

In relation to behaviour support, Duty of Care is the obligation incumbent on disability workers and supervisors in their regular professional dealings with Service Users [individuals] to ensure that all reasonable measures are taken to prevent harm which may be reasonably foreseen. The standard of care appropriate for any given situation may depend on the level of a person’s skill. For example, the standard of proficiency expected from a qualified nurse will be higher than that required from a worker without special skills. Negligence is a failure to exercise this Duty of Care (ADHC *Behaviour Support Policy*, 2012).

Multi disciplinary team approach

A multidisciplinary team approach in providing disability support can be described as a partnership among professionals of different disciplines inside and outside the disability sector and the community with the aim of providing quality continuous, comprehensive and efficient services.

Person centred planning

Person centred planning is “an approach to social justice and inclusion originally developed in supporting people with learning disabilities” (Stirk & Sanderson, 2012, p. 24).

Additionally, “A person-centred approach is one which seeks to gather information about a Service User’s [individuals] lifestyle, skills, relationships, preferences, aspirations, and other significant characteristics, in order to provide a holistic framework in which appropriate, respectful and meaningful behaviour supports may be developed” (ADHC *Behaviour Support Policy*, 2012).

Person centred thinking

Person centred thinking is founded in person centred planning. Person centred thinking employs a range of person centred thinking tools that help to determine the following:

- How does the person want to live and be supported?
- How can people have more choice and control in their lives?
- What is our role in delivering what is important to people and how they want to be supported? How
well are we supporting people in the way they want to live? How can we work together to keep what is working and change what is not working?

- How can we keep learning about the person and what we need to provide the best support? (Sanderson & Lewis, 2011)

<table>
<thead>
<tr>
<th><strong>Protective factors</strong></th>
<th>Protective factors enhance the likelihood of positive outcomes and lessen the likelihood of negative consequences from exposure to risk (Jessor, Turbin &amp; Costa, 1998). They can be defined as &quot;influences that modify, ameliorate or alter a person's response to some environmental hazard that predisposes [that person] to a maladaptive outcome&quot;. Research strongly suggests that protective factors may offset the effects of exposure to risk factors. Protective factors encompass and include social bonding to family, school, community and peers; healthy beliefs and clear standards for behaviour; as well as individual characteristics.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reasonable risk taking</strong></td>
<td>Reasonable risk taking means that staff are using sound judgement and are expected to show that they have carefully thought through what might happen and acted responsibly in line with this (Methven, 2012).</td>
</tr>
<tr>
<td><strong>Risk</strong></td>
<td>Risk means possibility of danger as well as actual danger (Health and Safety at Work Act 1974 S1 1974/143).</td>
</tr>
<tr>
<td><strong>Risk assessment</strong></td>
<td>A gathering of information and analysis of the potential outcomes of identified behaviours. Identifying specific risk factors of relevance to an individual, and the context in which they may occur. This process requires linking historical information to current circumstances, to anticipate possible future change (Morgan, 2000).</td>
</tr>
<tr>
<td><strong>Risk factors</strong></td>
<td>When considering risk factors, it is important to distinguish between static and dynamic risk factors. Static risk factors are defined as “unchanging characteristics of the individual or events in their past” (Lindsay &amp; Beail, 2004, p. 230). Static risk factors refer to factors that can only increase, i.e. the individual commits a further assault, which is an additional incident contributing to their historical risk. The only variable that decreases static risk is increasing age.</td>
</tr>
</tbody>
</table>
Dynamic risk factors refer to aspects of the individual that can change over time, e.g. interpersonal relationships, the degree and nature of social support networks, vocational involvement, participation in treatment programs, and substance abuse (Lindsay & Beail, 2004). Hanson & Harris (2000) subdivide dynamic factors into stable and acute dynamic risk factors. Stable dynamic factors can remain unchanged for longer periods of time but are treatable, e.g. alcoholism, attitudes supportive of violence. Acute dynamic factors may change extremely quickly, e.g. deterioration in mood, alcohol intoxication.

Safeguards refer to specific measures that aim to minimise the risk of harm to a person, protect their right to be safe and empower them to have choice and control over their lives (KPMG, 2012). The safeguarding framework fosters a risk enablement culture, where people are empowered to make everyday choices just like everybody else.

Sensible risk management is about enabling innovation and learning and focusing on reducing real risks, both risks with a high likelihood of occurring and those with a high impact. Sensible risk management is not about creating a totally risk-free society and "generating useless paperwork mountains", but it is also not about reducing protection of people from harmful risks (Health and Safety Executive, 2006).

A vulnerable adult is defined as a person aged 18 or over, who has either a dependency on others or a requirement for assistance in the performance of basic functions; a severe impairment in the ability to communicate with others; or has a reduced ability to protect themselves from assault, abuse or neglect. This can be a result of an intellectual or physical disability; a physical or mental illness, chronic or otherwise (including an addiction to alcohol or drugs); or a reduction in physical or mental capacity.
1. Introduction

This Practice Guide to Person Centred Clinical Risk Assessment has been developed in response to significant work undertaken by the Department of Family & Community Services, Ageing, Disability and Home Care (ADHC) regarding the support of vulnerable individuals with complex needs from both a systems perspective and in terms of clinical decision making. It is designed to assist practitioners in completing **in-depth person centred clinical risk assessment** when previous assessment, screening or risk identification procedures (such as *The Risk and Vulnerability Identification Checklist* (ADHC, 2013) have indicated the need for such an in-depth assessment. This guide should be read in conjunction with ADHC’s Safeguarding Framework: *A Person Centred Approach to Risk Management for Clients of Community Support Teams* (July 2013) which outlines the same principles and basic approaches in a more general sense although not focussed on the area of in-depth clinical risk assessment.

The **target group** for this type of clinical risk assessment are people with disability receiving services from ADHC or other disability service providers.

The practice guide is targeted at **behaviour support clinicians or other specialised staff supporting people with disability** and is designed to give guidance on how to conduct in-depth clinical risk assessments in a person centred manner. Step-by-step instructions take you through the process. A list of resources, including specialised and standardised assessment tools that can assist you in the process is attached in the Appendix. It is essential that you have the correct skills and expertise to administer these tools. It is your responsibility to check what these requirements are for specific tools and to seek appropriate expert advice and support where needed. It is also necessary to make a decision whether the circumstances of the person ask for a behaviour assessment or a clinical risk assessment (or both). The following considerations may assist you in the decision making:

<table>
<thead>
<tr>
<th><strong>Primary purpose of a clinical risk assessment is to:</strong></th>
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<tr>
<td>1. Identify risk and what is impacting on risk</td>
</tr>
<tr>
<td>2. Identify the level / type and urgency of safeguarding to a client and their support system</td>
</tr>
<tr>
<td>3. Inform a plan for support</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Primary purpose of a behaviour assessment is to:</strong></th>
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</thead>
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<tr>
<td>1. Understand why behaviours occur</td>
</tr>
<tr>
<td>2. Assist in developing a Behaviour Support Plan (BSP)</td>
</tr>
<tr>
<td>3. Inform effective implementation of a (BSP)</td>
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</tbody>
</table>

**Please note:** Information from both assessment types can be used to inform the development of both behaviour and clinical risk assessments.
The word “risk” is generally defined as the possibility of suffering harm or loss (Heinemann Dictionary). Traditional risk assessment focuses on the identification of risks and looks at the chance, high or low, of somebody or something being harmed, and how serious that harm can be. It is concerned with protecting workers and businesses and complying with the law. It is designed to focus on the work health and safety risks that occur in the workplace that have the potential to cause harm, as well as to identify the extent and severity of the harm that could occur. The law does not expect organisations to eliminate risk, but they are expected to protect people as far as is “reasonably practicable” (Workcover NSW, 2011). Risk can arise from activities or events across multiple domains in a person’s life, for example health, nutrition, swallowing, mobility and transitioning (ADHC, Behaviour Support Policy, 2012).

Australia complies with the International Risk Management Standard AS/NZ ISO 31000 (2009) which provides practical guidance for organisations that are either required by law, or are voluntarily seeking, to implement an effective risk management program. It provides guidance on selection and application of systematic techniques for risk assessment, as well as risk management vocabulary and terminology with the aim of encouraging a coherent approach in this area. It contains eleven risk management principles and uses a seven-step process to risk management. In this context, risk assessment is simply a careful examination of what could cause harm to people, and determining whether enough precautions and reasonable control measures have been taken to prevent harm and if more are needed.

In the human services context however, and particularly in relation to vulnerable people with complex support needs, traditional risk management can easily lead to risk avoidance or risk aversion practices, as the examination of the risk is at the centre of the process. This can encourage restriction and exclusion, and can place barriers to social inclusion and a good quality of life. The experience of many people who use support services is that “risk” is the reason given to them why they are not able to do the things that other people are doing every day (Neill et al., 2008).

Making decisions about risks and risk management can be problematic as the people making the decision are not always the people affected by the risk. This can be an issue especially if services fear real or imagined consequences to them as a result of the risk taken by the person supported (Sanderson, 2012; Neill et al., 2008). Solely focusing on risk “encourages practitioners to look for what is going wrong rather than what is going right” (Booth & Booth, 1998, p. 205). In the UK, the Department of Health (2009) states that risks need to be recognised, understood and minimised where possible. However this should not mean avoiding risks at all costs, as taking risks is an integral part of a person’s self-determination. Therefore,
another way of looking at risk is taking a balanced approach by weighing up good outcomes against bad outcomes and taking an approach that is “thorough, professional and personalised” in recognising that life and risk are inseparable (Sanderson & Lewis, 2012). A person centred approach to risk taking acknowledges that an organisation needs to foster a positive risk taking culture in contrast to a risk-averse culture which minimises life and learning opportunities for people receiving support services.

A risk enablement culture acknowledges that service providers must recognise that people supported by services have the right, and therefore must be supported, to take risks in their lives, in full recognition and expectation that they will suffer the same setbacks and heartaches that we all do (Methven, 2011).

What is risk assessment?

Traditionally, a risk assessment involves considering what could happen if someone is exposed to a hazard and the likelihood of it happening; or if any behaviours of an individual pose a risk to others. Therefore, risk assessment includes both looking at what could happen to a person, and what a person might do.

A risk assessment can help determine risk severity, whether existing control measures are effective, what action should be taken, as well as the urgency of the action (Workcover NSW, 2011).

A culture of assessing almost every aspect of a person’s life has developed over the years, which can have restrictive and patronising results for the people supported (Methven, 2012). Issues associated with traditional risk assessment are now increasingly recognised by people using services, their families and many service providers, who are on the search for alternative approaches to risk (Neill et al., 2008). Risk assessments should not be designed to limit choice and freedom; their purpose should be enabling people to live the lives they want as safely as possible.

A person centred approach to risk, in contrast to traditional risk assessment, takes a balanced approach with the inbuilt assumption that the purpose of any risk assessment is just as much about the happiness of the person, the family and the community, as it is about safety (Neill et al., 2008). The person-centred approach to risk uses questions around a framework of purpose, people, process and progress; this implies that we must think seriously about what we are trying to achieve before we start the assessment process (Sanderson, 2012).

When assessing risk, it is essential to consider both risk factors and protective factors. Defining risk factors helps to identify potential harm and is necessary in order to find appropriate responses (this is further described in Section 3). Protective factors have a reverse effect and can enhance the likelihood of positive
outcomes and lessen the likelihood of negative consequences from exposure to risk (Jessor, Turbin & Costa, 1998)

In the person centred context “risk assessment should focus on expanding the choice and control people have in their life, and [enable] people to try new things and develop their skills and competences” (Methven 2012, p. 244).

What is risk management and safeguarding?

Risk management is not about avoiding all risks, as “innovation and service improvement sometimes involve taking calculated and planned risks” (ADHC, n.d.). It is important that “an organisation must be able to demonstrate that it has adequate and appropriate systems that ensure the safety of the people supported in day-to-day tasks” (Methven, 2012, p. 241); this should include a balanced approach of determining what is important to the person, as well as what is important for the person.

Managing risks can be considered within a safeguarding framework. Safeguards refer to specific measures that aim to minimise the risk of harm to a person or from a person, protect their right to be safe and empower them to have choice and control over their lives (KPMG, 2012). In the current policy context it is recognised that under the National Disability Insurance Scheme (NDIS) “safeguards should occur with minimal restriction to a person’s choice and control, recognising their ability to take risks and make mistakes” (Commonwealth of Australia, 2012). This is in line with contemporary approaches to safeguarding that are about fostering a risk enablement culture, where people are empowered to make everyday choices just like everybody else.

Risk in a person centred organisation – from risk management to risk enablement

For persons with disability, a person centred approach to risk and achievement, risk assessment and risk management is now called for. Such an approach enables people and those who support them (families, carers and service providers) to focus on safety, yet also ensures there are opportunities to try new things and take risks that are a natural part of life. We all take risks every day, such as making a cup of tea in the morning (risk of injury through boiling water), or driving to work (risk of a car accident). Allowing people with disability to take those same every day risks is referred to in the literature as “dignity of risk”.

Practitioners of person centred approaches have now begun to combine risk management tools with person centred thinking tools. This involves a process for
people using services, and those who support them to “manage risk, make decisions, take actions and learn together” (Sanderson & Lewis, 2012). It is recognised that risk-averse or avoidant practices put people at risk of losing independence, choice and control. In this context, it is about putting people and not organisations first.

A person centred approach to risk improves the basic system of risk management contained in the International Risk Management Standard AS/NZ ISO 3100 (2009). It begins by identifying what matters to people, and considers their wishes, goals and dreams at the beginning of the process, so that everyone involved has a shared understanding of the purpose of a risk assessment.

Person centred approaches identify what is important to a person from his or her own perspective, and what is important for a person (UK Department of Health, 2007; Methven, 2012). In this context, things that are important for people can refer to things that make a person safe, free from abuse or abusing others, or healthy (e.g. medical procedures or specific equipment) as well as being valued. Things that are important to people, refer to a person’s hopes and dreams, and how a person wishes to lead her or his life. Everyone finds what is important to them and important for them may conflict from time to time (Sanderson, Smull & Harvey, 2008). In finding appropriate solutions, it is important to strive towards achieving a balance of where the person can be both safe and happy.

**What types of risks might be assessed in a person centred clinical risk assessment?**

The specific risks that are ‘assessed’ in clinical risk assessments vary markedly. Such risks include, but are not confined to:

- Risk of *psychological* harm to self or others. (e.g. risk of psychological distress due to an anxiety disorder, or risk of committing a sexual assault, or risk of social isolation due to behaviour of concern)
- Risk of *physical* harm to self or others (e.g. violence, risk of self injury or suicide, risk of side-effects of a medication)
- Risk of legal harm (e.g. risk of imprisonment; risk of self-incrimination due to disability)

A positive approach to clinical risk assessment is driven by a number of key principles including:

- **Person Centredness**: Any positive approach to risk for people with disability who require support must include the basic tenets of all person centred approaches; keeping the person at the centre, treating family and friends as partners, a focus on what is important to the person, an intent to build connections with the community, being prepared to go beyond conventional service options, and continuing to listen to and learn with the person (Neill et al., 2008).

- **Sensible Risk Management**: Sensible risk management encourages innovation and learning, and most importantly, focuses on reducing real risks, both those with a high likelihood of occurring and those with a high impact. Sensible risk management is not about creating a totally risk-free society and “generating useless paperwork mountains”, however it is also not about reducing protection of people from harmful risks (Health and Safety Executive, 2009).

- **Risk Enablement Culture**: At the forefront of a positive approach to risk management is a risk enablement culture. A risk enablement culture underpins person centred risk assessment as it supports staff in facilitating positive risk taking. Often, service providers are uncertain about their responsibility to keep a person safe from harm versus the developmental benefits from risk taking. In this context, duty of care may place limits on risk taking because of legal responsibilities (Parsons, Cocks & Williamson, 2009).

- **Use of A Multidisciplinary Approach**: A multidisciplinary team approach is essential when identifying risk and protective factors and formulating risk management plans that are necessary to safety for all, as well as support planning and risk reduction. Often appointing a team leader/case manager will assist in coordinating and managing the assessment and collating information to be shared with all relevant parties. The team leader will usually be a senior level clinician, or in some organisations it may be a case manager or key worker.

- **Limiting and Prioritising Information**: Methven (2012) argues that having an abundance of completed risk assessments for people with disability can lead to important information about genuine and important risks being lost and “buried among numerous risk assessments relating to risks that [are] unlikely and improbable” (p. 250). It is useful to make a conscious effort to reduce paperwork by reducing the amount of risk assessments for each person supported. This assists in underlining that the key role in supporting people with disabilities is to
support them safely to achieve their goals and dreams rather than spending all that time to write, review, read and sign risk assessments that are ineffective. Limiting and prioritising the information in risk an assessment also means that staff have access to manageable information they need.

- **Understand the Person’s Capacity to make Decisions:** In a person centred clinical risk assessment the involvement of the person with disability in any decision making is a priority, where possible and appropriate. It is generally accepted that decision-making capacity is decision specific. For example, a person with an intellectual disability may have the capacity to make decisions about some aspects of their lives, but not others. In the specific context of a decision having to be made, capacity includes the ability to understand the nature of the decision in question, appreciate the options and associated risks and benefits, and the ability to communicate a choice.

For children, parents will have responsibility for decision-making to ensure individual right. In NSW, some adults with disability will have a legally appointed guardian, while some may be under a financial management order for financial and legal matters only. For other adults with intellectual disability, there may be informal arrangements and no clear framework that provides a just means of substitute decision-making when an adult with intellectual disability lacks the ability (i.e. capacity) to make important decisions independently. General principles with respect to lifestyle and healthcare decisions are:

- It is generally accepted that adults have the right to determine for themselves whether or not to accept health recommendations and to consent to participation in research or treatment;
- Providing an adult has the capacity to consent, to contravene his or her wishes may be unlawful;
- If an adult lacks the capacity to consent (e.g. due to intellectual disability or because of severe dementia) it should be possible to provide a treatment, even though the person cannot consent, providing that the particular treatment is in the person’s best interest (e.g. to save a life, prevent disability, reduce pain); and
- Surrogate or substituted decision-making provisions under law can assist timely and appropriate provision of treatment services.

The key ethical principles are therefore:

- respect for adult autonomy;
- the central importance of decision-making capacity in determining whether personal autonomy may be overridden;
- the concept of ‘best interests’ in determining a course of action when a person lacks capacity.
If a person with an intellectual disability appears to lack capacity to make a specific decision regarding risk and/or treatment, and is advised to agree with strategies or undergo treatment in their best interest, family / care staff have a responsibility to help the person become informed through the use of different methods of communication (books, pictures and videos etc). Even if it is not possible to achieve fully informed consent, maximally informed agreement and an attempt to determine and heed the wishes of the person concerned should be the goal.

Professionals and other persons serving and supporting people with intellectual disabilities should be knowledgeable about the legislative framework within which they work and to be able to balance an individual's rights to respect and autonomy with an appreciation of their need for care, protection, and at times, support and treatment.

For further information on assessing an individuals capacity to make decisions refer to the NSW Trustee and Guardian website www.tag.nsw.gov.au
3. Process of Person Centred Clinical Risk Assessment

Sanderson & Lewis (2012) describe a step-by-step process for person centred clinical risk assessment. This process has been adapted for this guide to reflect current processes within ADHC, as well as the work of other leading authors in the area of person centred risk assessment (e.g. Neill et al., 2008; Allen et al., 2008; Parley, 2011; Bates & Silberman, 2007; Alaszewski & Alaszewski, 2002). The process is outlined below and the person centred tools that complement each step are described (also see Figure 1).

In-depth clinical risk assessment and management must be timely, use a bio-psycho-social approach and, according to clinical best practice, be based on structured clinical judgement, using a combination of assessment methods such as observations, interviews and relevant specific instruments.

It is understood that you may be required to use specific specialised or standardised risk assessment tools as specified by the organisation you work for. The following steps should be seen as principles underpinning any stage of the in-depth risk assessment. Advice is given in the step-by-step instructions as to when in the assessment specialised tools may be used.

It is essential that you have the correct skills and expertise to administer these or other tools selected. It is your responsibility to check what these requirements are for specific tools and to seek appropriate expert advice and support where needed.

General Instructions

- Select staff with expertise in the identified risk area/s who are to undertake the person centred clinical risk assessment, e.g. forensic risk assessment may require an assessor with specialised training in the forensic area. It is recommended that agencies maintain a register of staff skills in specific assessment areas to support this allocation process.

- Be aware of your organisation’s relevant policies and procedures when selecting who is to be involved, as well as selecting and using instruments and developing risk formulations.

- Be aware that although a number of risk assessment tools are available that can be used as an aid to clinical decision making these tools are not a substitute to person centred risk assessment. To date, for most areas of concern, e.g. in the forensic area, no single risk assessment instrument provides a comprehensive
picture. There is a lack of evidence to support the superiority of either an actuarial (i.e. quantitative) or structured (i.e. qualitative) clinical guideline approach alone. Various current instruments and tools that may be considered for use with specific populations and/or when assessing specific issues are referenced in this guide (see Appendix). Please note these are not the only tools available. Newer evidence-based instruments or procedures may emerge at various times that may prove more effective, especially if they provide good information on the validity and reliability of the instrument with regard to the specific population and/or application required.

- Where a risk assessment is required the following work process steps should be completed:
  - Complete a review of the service request with the referrer, preferably within a week of allocation (consent is confirmed when the request is first received);
  - Set up an initial stakeholder meeting with all those involved in the person’s life, including the person themselves where possible;
  - Develop a service agreement with the person and their support system;
  - Complete the person centred clinical risk assessment and the assessment report. All or some of the person centred tools used during the assessment process can be shared with the person and their family / support staff. Be aware completion of these tools does not replace the need to complete a clinical report. An analysis of the information sourced using different techniques and tools in essential. (see Appendix for a sample report template).
  - Where appropriate, assist the person and their supports to develop a plan to implement any recommendations made in the assessment report.
  - Ensure that all risk management strategies are included in the incident prevention and response plans (IPRP) / Behaviour Support Plan (BSP).

- Be aware of the communication needs, aids or supports of the person (and/or others) so that they can fully participate in the assessment process.

- A person centred clinical risk assessment should include information from multiple sources. Even if the report eventually generated is only brief, it is still important to be thorough in gathering information. The following sources of information should be considered during the assessment process:
  - Interviews. These should be conducted with the person, members of their family or carers, or other professionals involved. Conducting more than one interview will enable the clinician to obtain a range of perspectives about the person and their risk issues.
  - Observations. These may be appropriate if the person cannot be interviewed, or if little is known about the person in novel settings.
- **File Reviews.** This can enable the clinician to minimise the demand on interviewees to re-tell stories and information but rather focus on the critical areas of information to be gathered in person. It provides the input of a range of professionals and stakeholders who have been involved with the person and can help the clinician form a plan about further interviews and assessment required.

- **Standardised Norm-Referenced Tools.** These are tools that have been developed to permit comparison of the person assessed to a specific peer group, so that a comparative statement can be made about their risk. Even though the goal of risk assessment is to work out how to manage risk, it may be useful to identify the relative level of the risk. This would only be the case when risks are to be prioritised or compared, i.e. when deciding to service one person before another based on their relative risk, or when deciding to address one area of risk before another, for an individual person. Establishing an objective risk level may also be of use for people wanting to evaluate the effectiveness of an intervention program (i.e. pre and post levels of risk).

- **Research Literature.** There is a wealth of readily available literature on all types of risk assessment. In carrying out any thorough risk assessment, up-to-date information should be sought about the area being assessed. A significant amount of research has been done to highlight what factors are relevant to the occurrence of different events that may be the target of a risk assessment. The amount of well controlled investigation on most topics of interest provides significant support to clinicians in the identification and intervention of specific factors known to change the risk of a target event from occurring (e.g. Andrews, Bonta & Wormith, 2006 for a review of risk and criminality). However, be aware that individuals will also always have unique factors that contribute to their risk of a certain event occurring.

- **Expert advice.** Experts include people who know the person well. Expert advice can also be sought by the clinician as part of their professional supervision.

- **Written assessments, reports and support plans** should contain information essential for maintaining safety. They should contain sensible precautions to reduce the risk of harm to the person supported, staff, and anyone else affected. The precautions should balance what is important to the person supported with what is important for the person and others with whom they live, work and socialise. Wherever possible, the person centred risk assessment and support plan is not used to curtail or ban activity unless that activity poses a real danger to the person and/or others. Where certain activities need to be restricted, alternative ways to increase choice and control and skill and competence in safe
areas are to be investigated and developed. Plans need to be in place to monitor and wind back restrictions based on evidence whenever possible. A report template that takes the above criteria into account is provided in the Appendices.
Figure 1: Person Centred Approach to Clinical Risk Assessment

5 Steps

(1) The Person
Tools:
- Person centred plan and/or
- One page profile
- Relationship circle

(2) Status Quo
Tools:
- Working/not working from different perspectives

(3) Goals & Dreams
Tools:
- Success looks like from different perspectives

(4) History
Tools:
- 4+1 questions
- What are the consequences if we do nothing?
- Communication dictionary

(5) Action Plan
Tools:
- Blue Sky Thinking
- Happy/safe grid
- Decision making agreement
Specific Instructions

(1) The Person – What is important to and important for the person?

This step in the risk assessment serves the purpose of identifying protective factors, as well as getting to know the person and what is important to her or him. While risks may also be identified here it is not the primary purpose of this section.

Regardless of which tool is used to conduct a clinical risk assessment, involving the person concerned and the people who care about her or him is fundamental. This is especially so if the person facilitating the assessment and the person with disability have not previously met and therefore have no shared history. If person centred planning documents already exist they should be reviewed by the person facilitating the assessment and the person with disability and/or those in their support system.

A good starting point for identifying protective factors is the *important to/for tool*. This tool assists in sorting what is important to the person (what makes her or him happy, content and fulfilled) from what is important for the person (health and safety, being valued) while working toward a good balance (Helen Sanderson Associates, 2007).

Smull (2005) describes the human issue of striving for a balance between what is *important to* and what is *important for* us. This balance accounts “for issues of health and safety but recognises that perfect health and perfect safety are rarely achieved and all of us address what is ‘important for’ us in the context of what is ‘important to’ us” (p.21).

The process should assume a positive view of the person and aim to identify what a person’s gifts and skills are, what people like and admire about her or him, as well as investigating what is necessary to keep her or him and others safe. The process should be based on finding creative solutions rather than simply ruling things out because they are ‘too dangerous’.

One way to identify this is through a person’s *one page profile*. If a person already has a one page profile, it is advisable to obtain this before conducting a risk assessment. A one page profile is typically divided into three sections; and the information can be useful to make safeguarding decisions:
• **A person’s gifts and skills**
  This section provides a summary about the person’s strengths and capacity, as well as protective factors that can be built upon when considering taking and managing risks later in the process.

• **What is important for that person from her or his perspective**
  This includes information about what the person enjoys and what makes life worth living for her or him. This information is particularly important to be able to make risk enablement decisions, as it is essential to strive towards maintaining and nurturing these aspects in a person’s life. In the later stages of the assessment it might be necessary to identify how this can be done safely, with the least amount of restriction.

• **How to best support the person**
  This section explores a person’s support needs (e.g. Multi-element Support Plans and strategies, medication etc.) and may include information about current safeguarding strategies.

The purpose of a one page profile for risk assessment is to get to know the person quickly, but it can also be the starting point for a more detailed person centred description of the person, as each person centred tool leads to further information that can be added (HSA, n.d.).

In the **what is important to/for** section it is also useful to determine those in the person’s support system, otherwise known as a circle of support. To determine the person’s circle of support, consider using a **relationship circle** to identify key people. A relationship circle can be particularly useful to explore

- whom a person knows
- how they know them
- who knows whom
- how these networks can help the person find opportunities and support to live the life they want (HSA, n.d.).

The relationship circle is useful to identify the types of support networks of a person, including family, friends, supports from work and education and paid support. This tool helps to identify if there are any important issues around relationships and who to talk to when developing a risk assessment and management plan. It is also useful in identifying relationships that can be strengthened and identifies opportunities to create social inclusion (Lunt, Sanderson & Coyle, n.d.). It highlights whether the person’s social relationships act as protective (e.g. positive,
strong family support) or risk factors (e.g. absence of support, negative influence, maltreatment etc.).

People identified as positive supports are valuable in contributing to all aspects of a risk assessment including:

- initial collection of information
- framing of what a risk under discussion actually is,
- generating ideas and solutions,
- evaluating these solutions,
- decision making around the risk,
- implementing the actions
- the learning that takes place during these actions (Sanderson & Lewis, 2012).

At the end of the *what's important to/for* section you may be able to collate the following information about who the person for whom you are completing the risk assessment:

- Diagnoses;
- Health and medical wellbeing;
- Family and relationships history;
- Educational history;
- Accommodation history;
- What are the person’s skills and strengths;
- What is important to the person from their own perspective;
- Protective Factors;
- Overview of how to best support the person.

(2) Goals and Dreams – How do the risk management strategies enable the persons hope and dreams.

Identifying what the person’s goals and dreams are distinguishes person centred clinical risk assessment from traditional clinical risk assessment. A vision of what success could look like and what could be different or better for the person is put together from the perspective of the person, as well as those who support her or him.

One way to approach this is through using the *Success looks like...* tool, first from the perspective of the person, and then adding the perspectives of others (e.g. family, the community, staff, the organisation) (Neill et al., 2008). To identify this, list what success would look like from the perspective of each person involved in the process.
For each identified risk, think and talk about possible solutions that would lead to success as identified with this tool. This can assist in finding creative solutions for mitigation strategies or safeguarding.

(3) Status Quo – Where are we now?

The purpose of this part of the risk assessment is to further clarify risk and protective factors as they apply to the person. At this point, specialised and/or standardised tools, such as those for forensic risk assessment may also be completed.

In a person centred risk assessment it is important to first ask the question of where we are now and what the current risks applicable to the person are. This can be identified through recognising what is working/not working from the perspective of the person, as well as those who support her or him.

Finding out what is working well in the person’s life gives more detailed insight into protective factors in the person’s life and can help in developing and finding strategies to address any aspects that are not working well. It can also clarify where important outcomes for people are not being met because of a risk-averse approach. Here, you can also identify if recognised risks in a person’s life are sufficiently controlled (Methven, 2011).

In looking at what’s not working risk factors can be more clearly identified and it is important to consider the following:

- What is the problem you are trying to solve? At this point in the assessment it is important to outline the risk issue that the person has been referred for and identify if the risk is:
  - Posed to the person from other people; or
  - Posed to self and others, for example through self-harm (self-injurious behaviour, suicide) or behaviours of concern that further stigmatise and restrict an individual such as disruptive or socially offensive behaviours, verbal, physical and/or sexual aggression and violence, stalking and predatory behaviours often associated with attachment problems or criminal acts including arson etc.

- The static and dynamic risk factors related to the risk issue.
• How all people involved see the risk - ensure you consider the risk from all points of view (including the person, their family, their support system and the wider community).

• Analysis of barriers hindering the person from being a valued member of community, including, but not limited to:
  
  o **Social barriers (lack of natural supports through friends and/or family).** Social isolation proves to be an important issue confronting people with disability. The Australian Bureau of Statistics estimates that 15% of people with disabilities aged 15 to 59 (or 287,500 individuals) live alone compared to 6.8% of people without disabilities. For some people with disabilities, the years of isolation and exclusion have had a profound impact on self-worth and self-esteem (Commonwealth of Australia, 2009).

  o **Lack of self-motivation/confidence.** This can for example result from isolation and exclusion due to limited or no social networks, as described above.

  o **Active or “positive” symptoms of major mental illness.** There is a higher prevalence of psychopathology found in people with intellectual disabilities compared to the general population. The consequences go far beyond the immediate health and physical safety impacts on a person. Social responses from community, family members, work colleagues and carers may have a stronger and longer term impact on the quality of life of people with disability.

  o **Significant alcohol or other drug use.** People with disabilities experience a number of risks that increase their chances for substance abuse to adversely impact their lives. These risks include: medication and health problems, societal enabling, a lack of identification of potential problems, and a lack of accessible and appropriate prevention and treatment services.

  o **Communication barriers.** This includes receptive and expressive communication, alternative and augmentative communication (AAC) and social skills. Barriers to effective communication significantly impacts upon engagement in school, community and family life. American statistics indicate that people who rely on AAC have at best a 15% chance of
gaining employment (Harris Survey, 2000). Reliance on others to support communication attempts that are ineffective and unclear can also increase the risk of loneliness and decrease participation of people with barriers to effective communication (Cooper, 2009).

- **Lack of adaptive skills.** This includes social skills, daily living skills, coping and tolerance skills. The person may not have acquired these skills as the result of limited opportunities to learn, poor schooling, absenteeism and low expectations of them from others.

- **Lack of services / Inadequate support.** Disability services are intended to provide people with disabilities and their families, friends and carers with the assistance they need to fully participate in daily and community life (Commonwealth of Australia, 2009). When these services are not sufficiently available, or not appropriate to the person’s needs, a person may face increased barriers to social inclusion and full participation. Barriers may also be present because of over-support (restricts the person in their independence and autonomy), under-support (not enough support to achieve what is important to the person) and inappropriate types of support (for example not sufficiently trained staff or not appropriate to the person’s support needs).

- **Community hostility.** This refers to when people with disability are being segregated, excluded, marginalised and ignored. Many people with disability report that they face such experiences (Commonwealth of Australia, 2009).

- **The built environment and transport.** This refers to barriers posed by limited physical access to facilities and services in the community. Lack of access poses a common barrier to full participation.

The analysis of what is working and not working from different perspectives provides an agenda, as areas agreed upon by all parties are identified, but also conversation about differing perspectives is opened up (Livesley, 2013). Here it is important that the goals and dreams of the person concerned are put first, balanced against the possibility of harm. This can be achieved through using the happy/safe
grid, as set out in the (5) Action Plan section. It is also important that a decision making agreement is developed, especially if differing ideas about solutions exist (also see (5) Action Plan).

The outcome of this section should be a list of both protective factors, as well as risks. Towards the end of this section of the assessment it is advisable to collate all risks discussed and applicable to the person into a table, indicating the likelihood and severity. The next step is to look at these risks from a solution focused perspective. This means that for each risk, possible solutions and mitigation strategies should be developed (Livesley, 2013), as described in the next steps.

(4) History – What have we tried and learned?

The next step of the process involves gathering information on the history of the person’s experience of the risk issue from their own perspective. This is complemented by data from additional sources (see Section 1).

By compiling this information, new strategies can be trialled within the context of what has already been tried and what has been learned from previous experiences, including strategies that have been successful and unsuccessful.

Using the 4+1 questions tool can help identify what has been tried in the past, what was learned from that strategy or experience, what those involved were pleased with (i.e. what worked), but also concerned about (i.e. what didn’t work). This can then help determine where to place energy as a next step and identify a way ahead (Livesley, 2013).

It is important to contextualise the behaviours of a person by asking: “Why did the person behave in this way? At this time? In this situation?” (Allen et al., 2008, p.8) when looking at what worked and what didn’t work. Critical questions here will relate to the person’s behaviour assessment and support plan, if applicable. Ensure current information from behaviour assessment plans is available when conducting the risk assessment.

Unlike conventional clinical risk assessments, the person centred approach should also explore the consequences of not taking the risk, to the person, to their family, the community and the service provider. It needs to be acknowledged that by not taking a particular risk a person’s independence and self-determination may be jeopardised. Here, it is important to find a balance of the potential consequences of
not taking the risk against the potential consequences of taking the risk. Ask the following questions:

- What is the general impact?
- What are the opportunities lost? What will be missed if we don’t support the person to take the risk?
- What does the law say?

By looking at the legal context, the process can be informed by policies and procedures within the organisation and current law requirements.

By the end of this section you should be able to discuss the effectiveness of previous strategies and supports and contextualise the behaviour/s of the person. You should be able to highlight the consequences of taking the risk/not taking the risk for the person and their support system.

(5) Action Plan – What shall we do next?

This last step of the process has the aim of developing an action plan based on the information that has been gathered in the previous steps. Summarising the overall risk issue at this point is useful in developing safeguarding strategies.

An action plan essentially provides recommendations to safeguard the person and their support system. Before completing the action plan it is important to analyse all of the information collated during the risk assessment and provide a summary statement on the following:

- Formulation – bio-psycho-social factors impacting the risk issue;
- Identify the type, level and urgency of safeguarding that is required for the person related to the risk.

In developing an action plan it is useful to firstly list strategies and solutions that all people involved agree on. Evaluate the identified risks and decide upon precautions / enablers to support positive risk taking. These strategies should be founded in the conversations that occurred as part of the previous four steps in the process. Step-by-step control measures need to be put in place to ensure that the person can achieve what they want in the safest possible way (see support plan below).

Additional blue sky thinking techniques can assist in finding a wider range of solutions where “the management of the risk must match the gravity of potential harm” (Bates & Silberman, 2007, p. 7). Blue sky thinking is a planning tool which aims to facilitate the finding of creative
ideas and solutions. In order to generate new ideas, all people involved are encouraged to 'shout' ideas into the room for an agreed timeframe. These ideas are documented and in a second step carefully considered by questioning whether the ideas are a) positive and b) possible (Livesley, 2013).

Various proposed solutions can then be mapped onto a happy/safe grid, which enables clear action planning with a justification why some strategies have been adopted and why others have been rejected. When mapping solutions onto the happy/safe grid, the four dimensions happy, unhappy, safe and unsafe are balanced against each other to find solutions that reflect both what’s important to and important for the person. This assists in moving from situations which make the person happy but unsafe to where they and the community are safer, and from strategies where the person is safe but unhappy to where they can be happier. Risks are balanced against what the person wants and what would make them happy, thus giving people “dignity of risk” (Livesley, 2013).

Using a decision making agreement (Duffy, 2006) ensures that the person has choice and control within this process. All selected solutions are placed on an action plan that specifies “who will do what by when”. Using such an agreement assists in identifying where and to what extent the person supported has the capacity to make her or his own decisions and decreases the risk that the person is not involved in making decisions. It further ensures that those who support the person know what good support looks like for the person and identifies who the best person is to make a particular decision.

Table 1: Decision making agreement, adapted from Lunt & Bassett (n.d.)

<table>
<thead>
<tr>
<th>Important decisions about Tom’s life</th>
<th>How I must be supported</th>
<th>Who makes the final decision?</th>
</tr>
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<tbody>
<tr>
<td>Visit the shops</td>
<td>Staff who know me well will support me in visiting the shops at quiet times which will help me if I get anxious or upset. They will share their learning with other staff.</td>
<td>The staff, mum and I will decide on strategies as part of my support plan.</td>
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Utilise the above described tools for guidance to develop an agreed support strategies with the person, their circle of support and the team, which must include:
• positive approaches,
• augmentative and alternative communication (AAC) strategies where relevant (e.g. visual sequences, social stories etc., e.g. for people with autism spectrum disorders),
• step-by-step control and mitigation strategies,
• clearly outline who will do what by when,
• set realistic timeframes,
• include a monitoring and review plan.

It is essential that the structure and presentation of this support plan is provided in a format appropriate to the audience. This may mean the production of more than one version, e.g. an easy read version for the person supported, as well as a more complex written plan for professionals.

When selecting options for managing, minimising and enabling risks, success can depend to a large extent on ensuring that all key people involved (including the person and their circle of support) are content with the process for reaching decisions, and with the decisions themselves. They will have to be satisfied about:

• The way uncertainty has been addressed,
• The reasonableness of any assumptions made, and
• How other relevant factors such as person centred dreams and goals, personal, family and community needs, financial, technological and other considerations such as legal ramifications have been taken into account in the decision making process.

Where there are significant differences of opinion:
• Find out and focus on the uncertainties that matter,
• Clarify why a particular method was chosen in preference to others for estimating the risk,
• Encourage participants to be open regarding the evidence base, assumptions and other critical information that has contributed to the value or judgement obtained,
• Review and clarify how the decision reflects and upholds the person centred philosophy and values, enabling positive risk taking where appropriate and/or mitigating and managing risks that are unacceptable, or tolerable.
Develop a plan of action for communication, and for looking ahead and ensuring risks that pose greatest or most immediate harm, therefore requiring most attention, are addressed first.

It is important to note that using person centred thinking tools requires flexibility. The more serious an issue, the more people may be involved and the more time can be spent considering the risk and possible management strategies in greater detail.

Note here also that as part of person centred planning, positive practices should be focused upon as foundational principles of a positive approach. In some cases however, restrictive practices may be decided upon in consultation with the Behaviour Support Clinician, if these serve an overall positive goal. Practices that restrict the freedom of a person are defined by ADHC and explained in the ADHC Behaviour Support Policy (ADHC, 2012). It is essential that compliance with this policy is ensured. Restrictive practices must be documented and be part of a Behaviour Support Plan (BSP).

(6) Monitor, Review and Evaluate

It is important that the risks identified throughout the process and their matched strategies are reviewed regularly. This should occur as specified in the policies and procedures of your organisation, or linked with the recommended timeframes attached to particular risk assessment tools used during the assessment.

When developing an action and support plan, a monitoring, review and evaluation strategy should be set up. It should be tailored to the individual person and the type and severity of the risk. A system for monitoring and reviewing progress should include indicators for evaluating how far the measures introduced are successful in addressing the problem (e.g. eliminating risk, combating the risk at source, enabling greater choice and control, enabling people to try new things and develop skills and competencies, reducing restrictive practices etc.).
4. References


5. Appendices - Templates and resources
Sample Report Template

SAMPLE PERSON CENTRED CLINICAL RISK ASSESSMENT
REPORT TEMPLATE

METHODOLOGY AND SOURCES OF INFORMATION

This section of the report should outline the following:

- The rationale for the report (highlighting the referral request and person making referral);
- Sources of information. A Person Centred Clinical Risk Assessment should include information from multiple sources. Sources of information might include:
  - Interviews – These should be conducted with the person (where possible), members of their family or carers, or other professionals involved;
  - Observations – These may be appropriate if the person cannot be interviewed, or if little is known about the person in novel settings;
  - File Reviews;
  - Standardised Norm-Referenced Tools;
  - Research Literature.

SECTION 1 – THE PERSON: WHAT'S IMPORTANT TO & FOR THE PERSON

This section of the report should include the following information:

Summary profile of the person:

- Who the person is including but not limited to;
  - Diagnoses;
  - Health and medical well being;
  - Family and relationships history;
  - Educational history;
  - Accommodation history;
  - Their skills and strengths;
  - What is important to the person from their own perspective;
  - Protective factors (i.e. factors that reduce the risk of harm);
  - Overview of how to best support the person.
SECTION 2 – GOALS & DREAMS: WHERE DO WE WANT TO BE

This section of the report should include the following information:

Identify what the person’s “dreams and goals” are. Specifically, it is important to generate what could be better for the person from their perspective and their support system. Also it is important to discuss from the perspective of the person what support do they need to achieve their dreams and goals.

SECTION 3 – STATUS QUO: WHERE ARE WE NOW

This section of the report should include the following information:

- Identify the risk issue that the person has been referred for.
- Outline the static (i.e. non changeable) and dynamic (i.e. changeable) risk factors related to the risk issue;
- Outline maintaining factors (related to the risk issue, factors and current management);
- Provide an analysis of barriers hindering the person from being a valued member of the community including:
  - Social barriers;
  - Lack of self motivation / confidence;
  - Active or “positive” symptoms of major mental illness;
  - Significant alcohol or other drug use;
  - Communication barriers;
  - Availability of supports to the person;
  - Inadequate support to the person;
  - Community hostility;
  - The environment;
  - Lack of skills and opportunities;
- Outline what is (currently) working well for the person in relation to the risk issue, as with what is important to / for the person to highlight protective factors.

SECTION 4 – WHAT HAVE WE TRIED AND LEARNED

This section of the report should include the following information:

- Outline from the person's perspective what strategies they have themselves tried in the past and discuss the effectiveness of the strategies;
- Outline previous strategies and supports and discuss their effectiveness, importantly include the perspective of the person;
- Contextualise the behaviour/s of the person;
- Highlight the consequences for the person and their support system in eliminating the risk behaviour by answering the following questions:
- What is the general impact of the risk issue;
- What opportunities will be lost for the person if they are not supported to take the risk;
- What does the law say regarding the risk issue?

**SUMMARY STATEMENT - FORMULATION**

The summary statement should be made only after analysing all of the information collected in the previous steps. The summary statement should include the following information:

- Formulation of what biological / psychological / environmental factors are impacting the risk issue;
- Identify the type / level / urgency of safeguarding that is required for the person related to the risk issues;

**SECTION 5 – WHAT SHOULD WE DO NEXT?**

This is the recommendation section of the report and should be informed by the person centred action plan (see (5) Action Plan) referred to in this practice guide. It is important here to identify a timeframe for review, as well as to outline monitoring and evaluation processes.

**ENDORSEMENT**

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Forensic Risk Assessment

In the forensic context, actuarial risk assessment tools generally involve assessing the presence or absence of well-defined static or dynamic risk variables in past or current behaviour, and adding these variables to obtain a total score that may be referenced against a table of probabilities for similar offenders. The resulting probability is the likelihood to re-offend. The actuarial approach includes instruments researched and validated with mainstream offender populations such as the Static-99 and the Violence Risk Assessment Guide (VRAG; Quinsey et al., 1998).

Structured clinical (or professional) assessments or structured clinical judgements incorporate clinical factors that are usually dynamic, at least in the short to medium term, e.g. presence of symptoms, compliance with medication, level of insight, nature of acute symptoms that may change frequently in the short to medium term. This approach has proven as effective (or more effective) in estimating risk than certain actuarial tests designed to measure risk in the same populations (Boer, Tough & Haaven, 2004).

Current best practice uses a ‘convergent’ approach, where relevant actuarial and structured clinical instruments can be used to provide an overall risk picture of the person’s offending behaviour, with relevant actuarial tools providing a ‘risk baseline’ to determine treatment programs and supervision intensity, while relevant structured clinical guideline tools can help determine overall level of risk, treatment needs and changes in dynamic and overall risk over time.

Additional considerations when selecting tools for a particular person with offending behaviour (Boer et al., 2004; Boer, 2003) include:
- The purpose—why am I doing this specialised risk assessment?
- The degree to which the instruments are supported by data relevant to the person,
- The degree to which the instrument/s provide information relevant to the referral question or specific risk behaviour of concern, and
- The degree to which the instruments contribute to a comprehensive ‘risk picture’ for the behaviour/s of concern.

When considering selection from the following forensic instruments and approaches (Table 2) or their equivalents for specific persons and purposes, take account of ability to inform both risk and risk manageability features in line with current evidence based practice.
Mental Health Concerns

Mental health concerns can result in serious harm to the person; serious harm to another person; or serious impairment of the person. Risks may also be posed by systems and treatment, such as the side-effects of medication, ineffective care, institutionalisation and social stigma. There is a significant degree of overlap in the symptoms rated as mental illness and those rated as challenging behaviour by carers (Holden & Gitlesen, 2009) that cannot be ignored. Self-injurious behavior, for example, can be associated with affective disorders in people with mild and moderate intellectual disability (Hemmings, 2006), while some phenotype-related behaviours of genetic disorders suggest a higher prevalence of both behavioural and psychiatric problems in certain disorders (Thakker, Bamidele, Ali, & Hassiotis, 2012).

Table 3 outlines a selection of instruments that may assist in clinical risk and risk management considerations for mental health concerns.
Table 2: Forensic clinical risk assessment instruments

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<tr>
<th>Area of Concern</th>
<th>Instrument</th>
<th>Comments</th>
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<tr>
<td>Intellectual disability &amp; criminal offences</td>
<td>• Structured clinical assessment</td>
<td>Vulnerability to injustice, abuse or neglect in the criminal justice process. Assess risk factors: - understanding legal rights; false confessions; physical and sexual abuse when in custody; factors surrounding a person’s suspected or convicted offending including relationship between the offending and any mental ill-health, drug and alcohol abuse, and social factors, such as homelessness and unemployment.</td>
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<tr>
<td>Intellectual Disability and sex offences</td>
<td>• Rapid Risk Assessment for Sexual Offence Recidivism (RRASOR) (Hanson 1997)</td>
<td>Can provide good estimate of overall risk baseline for recidivism for this group (Tough, 2001).</td>
</tr>
<tr>
<td>Intellectual disability and violent or sexually violent behaviour</td>
<td>• Violence Risk Appraisal Guide (VRAG) Quinsey et al., 2006)</td>
<td>Can be used by front line managers. Consider especially: • What is the likelihood the individual will engage in sexual violence if no efforts are made to manage the risk? • What is the probable nature, frequency and severity of any future sexual violence? • Who are the likely victims of any future sexual violence? • What steps could be taken to manage the risk for sexual violence? • What circumstances might exacerbate the risk? • Are there any other unique factors that would increase or decrease the risk?</td>
</tr>
<tr>
<td>Mental health issues and offending</td>
<td>• HCR-20 (Webster, Douglas, Eaves &amp; Hart, 1997)</td>
<td>Can assist in predicting actual attempted or threatened physical violence, provides historical, clinical and risk management scales.</td>
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| ID and psychopathology in children                  | • Brief Psychiatric Rating Scale for Children (BPRS-C; Hughes, Rintelmann, Emslie, Lopez & MacCabe, 2001)  
  • Pediatric Symptom Checklist (PSC; Jellinek et al., 1999) | Active symptoms of schizophrenia and depression                                                                                           |
| ID and psychopathology related to risk of violence   | • Psychopathology Checklist-Revised (PCL-R) (Hare, 1991; Hare, 2003)  
  • The Psychopathology Instrument for Mentally Retarded Adults (PIMRA) (Matson, 1988)  
  • The Reiss Screen for Maladaptive Behaviour (Reiss, 1994)  
  • The Psychiatric Assessment Schedule for Adults with Developmental Disability (PAS-ADD 10) or The Mini PAS-ADD (Prosser, Moss & Costello, 1997) | Schizophrenia; depression, antisocial personality disorder can result in violence  
  Some personality characteristics may increase risk (such as grandiosity, lack of remorse, glibness and superficial charm, lack of empathy, shallow affect and pathological lying) and behavioural characteristics (such as proneness to boredom, poor behavioural controls, impulsivity, irresponsibility and early behavioural problems) (Mullen, 2001). |
| State of mind and situational variables (Mullen, 2001) | • Structured clinical assessment – observation, interviews, behavioural data | State of mind (e.g. presence of anger or fear, delusions that evoke fear or provoke indignation or produce jealousy, clouding of consciousness or confusion, ideas of influence, and command hallucinations). |
| Additional mental illness risk variables             | • Structured clinical assessment                                           | • Poor compliance with medication and treatment,  
  • Poor engagement with treatment services, treatment resistance and lack of insight into the illness  
  • Co-existence of substance abuse with mental illness                                                                                     |
| Suicide, self harm                                   | Structured clinical assessment: Known Indicators of suicide risk:  
  • Has a clear plan for suicide  
  • Intends to use a method that is actually lethal  
  • Has access to the intended means and it is feasible for them to carry out their plan  
  • Does not hope to be rescued during the planned suicide attempt | A clinical risk assessment of suicidality includes whether the person's behaviour may constitute a risk of harm to others, including dependent children.  
Further information; NSW Department of Health (2004).  
*Suicide Risk Assessment and Management Protocols.*  
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<td>Borderline personality disorder (BDP) and suicide/self harm</td>
<td>Risk assessment should be ongoing and in addition to the general indicators above assessment should aim to identify changes in The pattern of suicidal behaviours, Changes in the pattern of self-harm behaviours Co-occurring mental illness or substance use, Sources of psychosocial support and The person’s mental state, particularly identifying depression, hopelessness, and suicidal thoughts.</td>
<td>A person who has BPD may live with persistent thoughts of self-harm, but also experience acute self-harming impulses from time to time. Some use self-harms as a way of regulating their emotions and may not be suicidal (NHMRC, 2013). Risk of self-harm or suicide fluctuates over time, and should always be taken seriously. The NHMRC guidelines for crisis, post crisis and ongoing management of people with Borderline Personality Disorder (BPD) at risk of suicide, and importantly, advise that chronically suicidal people recover when their quality of life improves (NHMRC, 2013, p. 128).</td>
</tr>
</tbody>
</table>
**Person Centred Tools**

**(1) The Person – What is important to and important for the person?**

One page profile

**What people like and admire about...**

**What’s important to ...**

**What good support looks like to ...**

**Important to / important for**

<table>
<thead>
<tr>
<th>What’s important to..</th>
<th>What’s important for ..</th>
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</table>
(2) Status Quo – Where are we now?

<table>
<thead>
<tr>
<th>Working</th>
<th>Not working</th>
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<tbody>
<tr>
<td><em>Person’s perspective</em></td>
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<tr>
<td><em>Family’s perspective</em></td>
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<tr>
<td><em>[...] perspective</em></td>
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<tr>
<th>Risk</th>
<th>Comments</th>
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</table>
3) Goals and Dreams - Where do we want to be?

Success looks like...

<table>
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<tr>
<th>Success looks like...</th>
<th>From the perspective of the person</th>
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<tbody>
<tr>
<td></td>
<td>From the perspective of ...</td>
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<td>From the perspective of ...</td>
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</table>

(4) History – What have we tried and learned?

4+1 questions

<table>
<thead>
<tr>
<th>What have we tried?</th>
<th>What have we learned?</th>
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</thead>
<tbody>
<tr>
<td>What are we pleased about?</td>
<td>What are we concerned about?</td>
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</table>

What do we need to do next?
(5) Action Plan – What shall we do next?

**Happy/Safe Grid**

- **Happy**
- **Safe**
- **Unsafe**
- **Unhappy**

<table>
<thead>
<tr>
<th>Positive supports</th>
<th>Strategies</th>
<th>By when?</th>
<th>Who is responsible?</th>
<th>Monitor and Review*</th>
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</thead>
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<tr>
<th>Important decisions about [person’s life]</th>
<th>How I must be supported</th>
<th>Who makes the final decision?</th>
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