Mental Health Risk Assessment and Management in Community Organizations – Region of Peel

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About the Centre for Community Based Research

CCBR is a recognized leader in community-based research in Canada with over 300 research projects during its 26 years of operation, and a pioneer in community based research and evaluation. CCBR researchers use research to study and to create social innovation, balancing academic excellence with community relevance. CCBR is an independent, entrepreneurial, non-profit organization. Please visit www.communitybasedresearch.ca.

EXECUTIVE SUMMARY

The Centre for Community Based Research engaged in a research project to examine the issues surrounding risk assessment and management among mental health and justice organizations in Peel Region. This project was conducted on behalf of the Peel Human Services and Justice Coordinating Committee. A review of relevant literature was conducted, followed by focus groups, interviews, and email surveys of service providers in Peel Region.

Literature Review

- The definition of risk is typically general, and is usually in reference to the potential of "adverse consequences" to individuals (e.g., service providers, community members, self-harm, etc.). Risk is then further operationalized through assessment.
- There is a long standing debate regarding the relative efficacy of structured ("actuarial") versus unstructured (clinical) risk assessments (e.g., violence, self-harm). In general, structured approaches show greater predictive validity. However, structured approaches are most often predicting behaviour over a longer term and independent of context.
- Clinical approaches address dynamic risk (aspects of risk that change and can be changed) while actuarial approaches are more often concerned with status risk (unchangeable factors, such as criminal record, other personal history, etc.).
- Contemporary research and theory calls for a more integrated approach of clinical and actuarial approaches. Some tools and instruments reflect this integration.
- Clinical assessments serve multiple purposes in that they may be superior to actuarial methods in identifying short-term dynamic risk, and therefore contribute to individual needs and interventions.

Research Findings

- **Many organizations in Peel do not conduct formalized risk assessments** with standardized tools, although risk is implicated in a range of clinical assessments. Risk assessment is often reactive, and is closer in character to risk management.
- All respondents emphasized the **need to incorporate dynamic risk factors** into risk assessments. However, there was also an identified need to introduce more structured approaches.
- Perceived **efficacy of risk assessment varied** across organizations. Overall, improved risk assessment was desired for a number of reasons:
    - To achieve greater consistency in assessments.
    - To complement existing clinical assessments of risk and needs.
    - To improve the perceived "trustworthiness" of assessments.
    - To offset bias associated with single risk factors.
    - To enhance organizational accountability.
- **Organizations have varying levels of "tolerance" to risk**, which leads to the potential for "floating criteria" – inconsistent application of risk assessment procedures and related decisions regarding service access.
- **Some levels of risk are too high** for many organizations, such as history of arson, severe violent crime, sexual crimes, and violent offenses in service environments.

- **Housing and shelter services** are a high need service for many consumers with high risk, yet **have lower risk tolerance** due to the service context (far more exposure, congregate living, etc.).
- There were a number of **organizational and systemic barriers associated with information** sharing regarding risk:
    - Information received from other organizations is incomplete and difficult to acquire.
    - Information is not timely. Long wait times for needed information delays assessment and service planning.
    - Information may not be properly collected and assessed, due to a lack of staff training and experience using assessment tools.
    - Sometimes there is too much information, potentially leading to improper use of information that is typically low in relevance.
    - The validity of assessments may be challenged, especially when the assessments is primarily clinical in nature.
    - Requirements of disclosure and consent can limit information.
    - Disclosure can become a condition of service, which limits fair access of consumers.

Recommendations for Organizational and Systems Change

- Mental health and other service providing organizations should **pursue greater integration of clinical practice and structured risk assessment tools**. Several questions need to be answered in doing so:
    - *What tools should be used*? There are many options available depending on the type of risk. For example, the HRC-20 is a brief, validated instrument that assesses actuarial and clinical risk.
    - *When should tools be used*? Organizations need to decide the point at which risk assessments should be conducted and under what circumstances.
    - *Who should be conducting risk assessments*? Currently, not all staff or even organizations have the appropriate training and resources to use particular risk assessment tools.
- **Integration of risk assessment procedures** with the future Ontario Common Assessment of Need may introduce cross-organizational consistency.
- The **system should facilitate an ongoing working group of providers** to share risk practices, review risk definitions, criteria for service access, and system-wide barriers, in order to develop solutions for practice-based coordination and, possibly, develop some consistent risk assessment practices.
- The **system should pursue collaboration and coordination in service delivery**. As it applies to risk assessment/management, such collaboration may serve to establish consensus on risk and potentially centralize risk assessment procedures. A barrier to this approach is addressing differing levels of organizational tolerance to risk as it applies to liability and other safety issues.

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A. Introduction

Peel Human Services and Justice Coordinating Committee (PHSJCC)

A group of mental health and human and justice service organizations in the Peel Region, under the auspices of the Peel Human Services and Justice Coordinating Committee (PHSJCC), have formed a partnership to review, develop, and expand services and supports for people with mental health difficulties who come in contact with the law. This collaboration strategically focuses on system changes that promote diversion of consumers, where possible, from traditional justice services. This alternative approach is based on long-standing recognition that justice services, as conventionally arranged, are unresponsive to the diverse needs of mental health consumers. This problem is greatly exacerbated by a wide range of societal barriers that keep people in a cycle of disadvantage – poverty, barriers to service access, and homelessness, for example – that lead to ongoing exposure to police, the courts, and criminal institutions. Solving complex, systemic problems such as these is challenging and requires the participation and resolve of multiple organizational partners in collaboration with the individuals and families that are living the issue. The PHSJCC represents an ideal partnership of innovative service providers who are committed to developing and implementing recommendations and best practices for mental health and justice diversion services.

Canadian Mental Health Association – Peel Branch

One of the lead organizations on the PHSJCC committee is the Canadian Mental Health Association - Peel Branch (CMHA/Peel). In general, CMHA/Peel is dedicated to enhancing the well-being of all people in the community by promoting and supporting good mental health. They are recognized as a person-centred, community mental health organization that empowers diversity and culture, addresses personal and professional needs, and facilitates positive community development within the Peel region. The values that drive CMHA/Peel's reputation and mission include: everyone has the right to fully participate in community life; optimism and the emphasis of ability over disability; everyone has the right to basic necessities of life; everyone has the right to equal access of education, employment, healthcare, culture and recreation; diversity and individual differences enrich the community; mental health is an essential part of total well-being; and mental health should be achieved through the provision of services as well as self-help, families, and the expression of neighbourhood spirit.

On behalf of the PHSJCC, CMHA/Peel served as the main contact agency to oversee the regional recommendations and best practices for risk assessment and management as it concerns affiliated mental health service providers.

Background to the Project

PHSJCC members (e.g., CMHA/Peel's Mental Health and Justice Services, Supported Housing in Peel, and COAST Peel) recognized a need to evaluate their progress in modifying and improving the system. Accordingly, they formed the Mental Health and Justice Diversion Services (MHJDS) committee. In 2006, they began with the creation of a preliminary logic model and outline of their service model. In 2007, the committee revisited evaluation with an identified

need to expand on previous work, and completed an evaluability assessment of the service system with the Centre for Community Based Research (CCBR).

The evaluability assessment examined the system level relationships between the MHJDS partnership organizations. The focus of the analysis was on the referral pathways between these main organizations, with specific attention paid to the range of barriers that prevent, or make difficult, effective service coordination.

While the results of the evaluability assessment were important and useful to the partners, a limitation was the lack of information pertaining to the sectors and organizations beyond the partnership that operate within the mental health and justice systems. Generally, it was found that the referrals and communication between the partners functioned well and as planned, with some exceptions; however, gaps and barriers in the system more broadly were apparent and not well understood.

In 2007-2008, the evaluability assessment was extended in a new project that attempted to widen the scope of relevant organizations in the Peel Region. Through their examination of the referral pathways amongst affiliated MHJDS organizations they found that there was general ambiguity surrounding what is meant by an individual who is "high risk" (e.g., violent, abusive, suicidal, prone to substance abuse), which instigated some concern regarding how risk is being defined, how the respective definitions are being applied, and how service providers are making the determination of risk in the first place. For example, risk could be based on a label associated with a case file, clinical assessment, criminal record, or on trial periods in programming. This could lead to the troublesome possibility that mental health organizations exclude by over-applying "high risk" labels to people with criminal records, quite independent of real risk or reasonable knowledge of criminal background and behaviour. This may include denial of services on the grounds that people need special supports based solely on their supposed criminality – even when there is little evidence that the supports they need are any different from other people with mental health difficulties that are *not* involved in the justice system.

Current Project

In light of these concerns, in 2009, CMHA/Peel enlisted CCBR to conduct a research project regarding the assessment of risk and risk management in mental health and community services. Specifically, CMHA/Peel identified the need for an examination of how risk is being defined, assessed, and managed across the spectrum of inter-connected support services that make up mental health and justice diversion services (MHJDS), in order to inform recommendations for future policy and practice.

B. Methodology

In order to address the PHSJCC's concerns and identified needs, CCBR utilized four main research strategies: a review of the previous research literature, focus groups, interviews, and an email survey.

Literature Review

A literature review of risk, risk assessment, and risk management, in the area of mental health, was conducted. The primary goals of this review were two-fold: first, to identify how risk is being defined in the literature and, second, to identify best practices for risk assessment/ management. Accordingly, key words (e.g., risk, risk assessment) were entered and searched within the PsycInfo and Google Scholar databases. The results of these searches yielded various types of risk-related studies, which were further refined following a preliminary review of abstracts and through the use of the references from relevant articles. In general, the literature review is expected to help enhance stakeholder understanding concerning risk assessment and management and inform future 'risk' assessment and management practices.

Focus Groups

We conducted a total of three focus group sessions. All focus groups were conducted with mental health service providers from organizations that sit on the PHSJCC. Four participants attended the first session, five participated in the second session, and four participated in the third session. Participants represented various types of mental health and justice service organizations, including mental health case management, addictions support, dual diagnosis services, general community mental services and supports, legal aid, and corrections.

In all three groups, participants were given a brief overview of the background and purpose of the project. The general content of the questions examined: how risk is being defined, policies and procedures of risk assessment, recommendations concerning risk assessment, and risk management (see Appendix A for the respective questions). The sessions were audio-recorded, transcribed, and coded for common themes and patterns.

Interviews and Electronic Responses

A total of two interviews were conducted with individuals that were unable to attend the allotted focus group time-slots. The intent and content of these interviews was the same as that of the focus groups (i.e., gain an understanding of how risk is being defined, how risk is being managed, what kind of policies and procedures are in place, and what recommendations the interviewees had concerning risk assessment and management). The interview participants represented a local hospital service and an ACTT program. The content of these interviews similarly examined how risk is being defined and the policies and procedures of risk assessment, and risk management. Similarly, these interview sessions were audio-recorded, transcribed, and coded for common themes and patterns in relation to the focus group findings.

Some participants completed an electronic version of the focus group discussion questions (see Appendix A). A total of four emails with attached discussion question responses were returned.

Respondents represented police services, crisis housing, and other mental health programs. The data from the completed interviews and electronic discussions questions complemented the responses and insights drawn from the aforementioned focus groups.

C. Literature Review

Introduction

The demands for, and necessity of, risk assessment and management is changing within the mental health community (Douglas & Skeem, 2005). As mental health services have become increasingly focused on providing support in the community, there has been an increase in the number of high risk (e.g., potentially violent, prone to self harm) individuals being served/treated within the community, rather than institutional settings (Vinestock, 1996). However, community based mental health is not new and as far as mental health professionals are concerned, assessing and managing risk is a well-established, albeit challenging, part of everyday practice (Kapur, 2000). Risk and its assessment and management have a wide range of mental health implications for service users, as well as legal and public policy impact on organizations and communities. The concept of risk and the associated risk factors need to be understood as clearly as possible within mental health and justice service contexts (Douglas & Skeem, 2005; Vinestock, 1996).

Below, we present a review of the literature on risk assessment and risk management as it pertains to mental health service providers. Beginning with a discussion concerning the definition of risk, we will proceed by examining how risk is being assessed and managed, and finish with conclusions concerning best-practices as identified in the literature.

An Overview of Risk and Mental Illness

Risk assessment, or more specifically, the societal concern of *predicting* violence, criminality, self-harm, suicide, sexual assault, and other behaviours, has been a subject of interest among social scientists, criminologists, and others for many years. The literature regarding risk assessment is expansive, and a large subarea pertains specifically to the behaviours of people with mental illness. This subject has engendered much debate, generally beginning with Paul Meehl's paper dating back to 1954. Meehl demonstrated that actuarial predictions (i.e., predictions based on personal characteristics and demographics) were more effective at predicting risk than clinical assessment, which tended to hover around chance levels. Generally speaking, this finding has endured to the present, with acknowledgement that the integration of certain clinical assessments into newer actuarial tools has enhanced prediction. Clinicians routinely dismiss the superiority of actuarial methods, arguing that clinical assessment uncovers important personal variables that are otherwise missed.

This debate, however, belies an extremely important observation – it has been well understood for many years that the levels of risk associated with mental illness are no different (or in some studies, not appreciably higher) than that of the general population. On average, the presence of risk is quite low, and certainly inconsistent with negative stereotypes of consumers as "high risk" that are perpetuated in public discourse, government policy, and media characterizations.

This means that the relative success of actuarial versus clinical approaches is a moot point, since the actual scope of the societal problem is minor.

It is also known that many of the better actuarial predictors are independent of mental illness. For example, young males have a statistically higher probability of violence than the rest of the population (Choe, Teplin, & Abram, 2008). Alcohol use has been found to increase this risk in both the general population and people with mental illness (Steadman, 1998). If mental illness poses very low risks of violence, risks that are little or no different from people without mental illness, then risk assessment becomes discriminatory and a potential violation of human rights. As Allen (1997) says:

> ...contemporary society is highly concerned with the relatively low possibility of the mentally ill committing acts of serious violence. This inference suggests that there exists a perceived lack of control over events, induced by deeply ingrained public fears of unreason and violence by the mentally ill, and government policy on institutional closure. These social perceptions have led to exaggerated concerns and demands by the general public in relation to the care and control of the mentally ill. (p. 370)

He continues,

> If, in fact, mental illness has no significant relationship to violence, then the continual screening of psychiatric patients for actuarial predictive factors (which generate a high level of false positives), may lead to the unnecessary infringement of the rights of patients. Such infringement will be based on characteristics that patients share with many non-mentally ill people, who are left to live their lives without undue intervention. (p. 371)

Despite these observations, there are several legitimate reasons for contemporary mental health organizations to pursue risk assessment. First, legislative and legal edicts require that organizations take "reasonable course of action in determining the risks that exist and plan for their minimization or control" (Carver, 1996)[1]. This includes conducting "risk assessments", although it is unclear what specific assessment practices correspond to a "reasonable course of action". Without reasonable precaution, mental health and other community organizations may be held liable for violent or other adverse consequences. As a sidebar, it should also be mentioned that applicable laws require that *each organization* must complete their own assessments, since relying on others' assessments in the system does not reflect an acceptable level of caution. Pragmatically, this is a huge barrier to under-resourced organizations while also reflecting a troublesome and invasive repetitiveness for consumers.

A second reason to conduct risk assessments is that there is significant overlap between assessing for risk and assessing for need. In other words, part of the process of intake and assessment in many community mental health programs and services speaks to potential risk as it simultaneously speaks to need, although formal actuarial assessments are most often not involved. A third reason is that amongst those who experience mental health difficulties, there are a significant number of people living in the community who may pose a risk to themselves or others, and as such, health care practitioners must find ways to offset these risks.

[1] This reference reflects the American context. However, Canadian liability laws are not appreciably different.

Defining Risk

But what do we mean by risk? Although there are many different definitions of 'risk' used by researchers and practitioners alike, often depending on the nature of their field (e.g., law, physical sciences, social sciences), nearly all of them generally refer to 'risk' as the probability/possibility that something adverse will happen. Consequently, over the course of its evolution, the term risk has become synonymous with terms such as 'danger', 'threat', and 'peril' (Goddard et al., 1999). This speaks to the common problem of under-specifying risk and what the risk entails. For example, some rightly observe that risk is somewhat different from "dangerousness", since risk for violence (or other behaviours) exists on a continuum (Dixon & Oyebode, 2007). Someone might have a moderate risk for aggression or violence but not be particularly dangerous in the sense of inflicting any serious harm.

Risk often under-specifies the potential targets. Despite this understanding that something adverse could happen, it is necessary to understand and clarify the direction of the risk – to whom something adverse could happen (Snowden, 1997). For example, is it the concern of risk for the individual, family and friends, service provider staff, or general community members? Research has demonstrated that risk of violence among consumers, which is already quite low, is much more likely to be directed toward friends or family members and in their home (Allen,1997). This finding reflects an even lower likelihood of violence in the context of community mental health and other programs, which is the primary area of concern for organizations. This underscores the importance of context in defining and understanding risk.

Furthermore, it is important to understand what type, or outcome, of 'risk' is of concern. For instance, risk could be viewed as the risk of violence (including sexual abuse), self-harm or suicide, and/or substance abuse, among other things (e.g., Department of Health, 1994, in Ryan, 2002; Kapur, 2000). Accordingly, when defining risk, it is important to identify both the direction and the outcome of risk. Ironically, research has demonstrated that people with mental illness are much more likely to be the *victims* of violence and other harms, rather than the perpetrators. Much attention is paid to assessing the risk of violent or other behaviours among consumers, yet less formal assessment is made of their own vulnerabilities, which appear to be much more troublesome.

As mentioned, risk is multidimensional and context-dependent (Gunn, 1990; Kapur, 2000). It is not static but dynamic: "risk ebbs and flows over time within each individual" (Douglas & Skeem, 2005, p. 348). Risk can vary depending on the individual's different personal characteristics and environmental conditions (e.g., age, living conditions, socio-economic status, family history, life events, and use of medications; see Skeem & Mulvey, 2002). The nature and extent of risk can, accordingly, increase and/or decrease depending on the period of time in the individual's life (Kapur, 2000; Snowden, 1997). Consider, for example, that the risk factors associated with first onset major depressive disorder are not the same as those for a relapse and/or concurrent disorders. It is, consequently, important that the direction of risk, type (outcome) of risk, and the individual's personal factors (including their environmental/contextual factors) are considered when defining, assessing, and managing risk.

Risk Assessment

As previously noted, the concept of 'risk' is multi-dimensional, which is of particular concern to members of the mental health community (Ryan, 1996, 2000). In these environments, risk has

been primarily concerned with the risk of physical violence (including sexual assault) that the individuals could pose to other people (e.g., community members, service provider staff), as well as the risk that the individuals could cause harm to themselves (e.g., suicide, 'cutting'; Ryan, 2000). Risk assessment is not only concerned with the (presumed) risks associated with mental disorders, but with other purported predictors of risk that may, together, lead to problems. For example, alcohol and drug use and medication non-compliance may have higher associations with violent and other behaviour.

We now provide an overview of common risk assessment practices in the field and the implications for mental health and other organizations. Please note that most of the research on mental illness and risk pertains to violent behaviours, although there are a subset of studies on risk assessment for sexual assault (Hanson & Thornton, 2000) and self-harm.

As described at the outset, for over 50 years risk assessment methods have been polarized between "clinical" (unstructured) methods and "actuarial" (structured and statistical) methods (see Aegisdottir et al., 2006). This debate has been recognized as one of the longest-running, but also with the most consistent and numerous empirical findings that favour structured/actuarial over the unstructured/clinical (Grove et al., 2000). Meta-analytic research has consistently found that actuarial assessments are superior to clinical assessments (especially in the prediction of violence; Aegisdottir et al., 2006).

Clinical Risk Assessment

Clinical risk assessment is characterized by subjective, intuitive judgements made by professionals (e.g., psychiatrists, psychologists, social workers) to synthesize an individual's (i.e., client's) information (Aegisdottir, 2006; Monahan, 2008). It is often based on 'professional impressions', interpersonal sensitivity (e.g., developing questions in the moment), and the theoretical perspective of the assessor, which are used to guide the 'holistic' assessment of the individual's risk. Due to the direct interpersonal activities/discussions that are often part of such an assessment, clinicians are often privy to individual-specific "out of the ordinary" information that may not be captured in more structured assessments (Chwalisz, 2006). It is, however, important to note that although this "out of the ordinary" information will arise, risk assessment researchers have discovered that clinicians using an unstructured approach tend to identify what they think is "out of the ordinary" information more often and give it more weight in their final assessment of risk than they really should (see Bishop & Trout, 2002, for discussion). It should be noted that researchers agree that clinical judgment should be used to support structured methods, rather than be treated as a separate, stand-alone, method (Hilton, Harris, & Rice, 2006; Litwack, 2001; Westen & Weinberger, 2004).

Actuarial Risk Assessment

Contrary to clinical assessment procedures, the decision(s) for which variables to include in structured risk assessments have been made prior to its administration (Monahan, 2008). That is, the clinician does not exercise the option and/or discretion to assess for risk factors beyond those established in the structured risk assessment tool – all decisions concerning the selection and measurement of risk factors have been decided (structured) for them in advance, based on past empirical findings.

Structured risk assessments are derived from statistical prediction within various large-sample studies (e.g., using explicit scoring procedures). Subjective insights on the part of the individual administering the assessment (Grove et al., 2000) are excluded. Structured risk assessments are prescribed and standardized so that the risk assessment process can be replicated (which provides enhanced reliability). Actuarial assessments do not require clinical training but do require advanced training in the administration of tests and the collection of relevant research-based information (Aegisdottir et al., 2006).

Clinical versus Actuarial Approaches

Research finds that actuarial methods are at least equal to, but typically more accurate than clinical methods (Aegisdottir et al., 2006; Grove et al., 2000). More specifically, on average across target behaviours, there is approximately a 13% increase in assessment accuracy when using a structured assessment instrument versus a clinical approach. This rate is even higher for predicting violence. At first glance, a 13% increase in accuracy may not seem significant; statistically, it is meaningful. Aegisdottier et al. (2006) note that "out of 1000 predictions of violence, the statistical method should correctly identify 90 or more violent clients than will the clinical method. The victims of violence would not consider this effect small" (p. 368). One could counter that the mass testing of people with mental health disorders will also identify a sizeable number of "false positives" – individuals who will be labelled as violent, and treated as such, when there was no risk to begin with. Truly, a "small effect size" can have much larger consequences. If overall risk of violence is generally low, and if many individuals are miscategorized to begin with, these improvements may not be particularly meaningful.

Another major difference between clinical and actuarial methods is the timeframe of prediction. Clinical prediction is designed to assess behaviour, such as violence, in the near term, whereas actuarial prediction specifies much longer timelines – some studies examined violence over the course of 7 years. If success rates of prediction are on such extended timeframes, it is difficult to see how the method is applicable to mental health organizations operating in the "here and now". In fact, within shorter time frames, actuarial methods would likely produce higher rates of "false positives".

Why are clinical methods often no better than chance? Holt (1958, 1970), an early entrant to the debate, argued that the studies comparing clinical-actuarial methods failed to fully capture best practices in clinical assessment, rendering the comparisons invalid. Studies have also tended to use "average clinician judgements" as opposed to the "best clinician judgements". We know that clinicians still proceed as if clinical approaches are preferable and useful. Steadman et al. (2000) provide some insight on this dilemma:

> *...virtually all existing risk assessment tools are derived from main effects linear regression models that imply that a single solution fits all persons whose violence risk is being evaluated. Clinicians, however, appear not to believe this (Gigerenzer, 1996). Second, although the overall accuracy rates of existing risk assessment tools represent a clear statistical improvement on chance, the magnitude of that improvement is not seen as clinically significant.* (p. 84)

Nonetheless, the lower predictive ability of clinical approaches is a robust finding, suggesting that elements of actuarial approaches need to be integrated into practice on some level. Potts (1995) provides factors that may potentially weaken risk assessment in the clinical context:

1. Minimization of historical events
2. Over-reliance on recent progress
3. Sudden change of views of the care team
4. Extraneous factors, not openly recognized
5. Infrequency, discontinuity of assessment
6. Non-verification of statements by patient and/or others
7. Not taking account of evidence contrary to the patient's assertions
8. Not recognizing patient manipulation and consequent staff discord
9. Lack of thorough investigation and assessment of assertions of "insight" and "remorse"
10. Lack of openness between those involved in the client's care and treatment
11. Discounting information if not supportive of hoped-for outcomes
12. Self-expectations of being decisive and successful
13. Avoiding confrontation with the patient

Integrating Actuarial and Clinical Methods

Recently, Monahan (2008) argued that risk assessment can be best understood on a 'continuum of structure' and that the dichotomy of actuarial versus clinical methods has outlived its utility. New approaches have attempted a level of synthesis between the two and there are arguable benefits to both methods (see Aegisdottir, Spengler, & White, 2006). For example, it can be argued that actuarial methods improve with the incorporation and formalization of clinical techniques and assessments (Westen & Weinberger). Some of the best indicators of risk require clinical skill to measure, and there is a place for clinical prediction within, rather than separate from, structured measures (Hilton et al., 2006; Strohmer & Arm, 2006).

Considering the role of both approaches, what elements are recommended in risk assessment? In contemporary risk assessment, a comprehensive set of risk factors, indicators, and clinical judgments are considered. One of the original studies on risk assessment, the MacArthur Violence Risk Assessment (see Monahan, in press), categorized risk factors into four broad categories: *personal factors*, *historical factors*, *contextual factors*, and *clinical factors*. Conceptually, there is considerable overlap of these factors. Personal factors, for example, could be part of one's personal history and/or may link to clinical issues.

Personal factors: This category includes basic demographics (sex, age, marital status) and other personal factors, such as employment, income status, and a range of personality and psychological variables.

Historical factors: Typically the best predictor of behaviour is past behaviour. History-based risk factors refer to past violence and/or criminality (or other behaviours, such as sexual assault or self-harm), but also to family history (including family conflict, attitudes towards family,

criminality, alcohol and drug use, etc.), education, development (e.g., victim of bullying), work history, past mental disorder, sexual history and interests, medication history, etc.

Contextual factors: Refer to other contextual factors in the person's life, such as housing status, living arrangements, conflict with others, level of social and family support, current income stability, and so on. Context factors may also include current medication status/compliance and current alcohol and drug use.

Clinical factors: Refer to current diagnosis and presentation of symptoms. Thus, clinical factors more specifically reflect present mental state, such as subjective feelings of tension, feeling persecuted, hallucinations/delusions (and their nature), severe depression/hopelessness, command hallucinations, intense jealousy, resistance to treatment, level of insight about their illness, and so on.

In the literature there is a wide range of risk assessment tools and approaches, varying across different target risk behaviours, such as violence, sexual assault, self-harm, and suicide. Because violence prediction has garnered the most attention, we will review some of the common risk assessment methods in this area.

Risk Assessment of Violence

On average, according to Mossman (1994), clinicians using unstructured violence risk assessment procedures are able to distinguish violent from non-violent individuals with a very modest, slightly better than chance, degree of accuracy. Consequently, the lack of predictive validity and reliability of unstructured methods for violence risk assessment has driven researchers and practitioners to develop more structured risk assessment procedures in order to increase predictive validity (Monahan, 2008).

In structured violence risk assessment, as well as most other forms of risk assessment, the process can be conceptualized within three main phases: 1) the selection of risk factors, 2) the process of combining them, and 3) finalizing the estimate of risk (Monahan, 2006, in Monahan, 2008). In the first phase, decisions about which risk factors to include and how they are going to be measured are made prior to the administration of any assessment. The operational definitions of the risk factors are explicit. In the second phase (combining of risk factors), the assessor takes the individual's scores on each of the risk factors and combines them to create an overall estimate of risk. Sometimes different risk factors are weighted more heavily than others, depending on the tool used and/or the presence of additional clinical judgment; this process of combining risk factor scores could be as simple as adding up all the scores and/or a more complicated mathematical procedure (Banks et al., 2004). In the third phase (finalizing the estimate of risk), the assessor reviews the previous two phases and, depending on the assessment process, incorporates unstructured insights (e.g., from available records, interviews, significant others) and makes a final estimate of risk. In comparison, the final estimate of risk in clinical assessment is holistically and subjectively derived by the clinician.

Some structured assessment tools incorporate some unstructured freedom (e.g., HCR-20, see Monahan, 2008) whereas others do not (VRAG, see Harris et al., 2002). Notably, some researchers have suggested that it is important that health professionals use caution when overriding the final estimate of a structured assessment; past research has demonstrated that even when experts are given the results of structured assessments, they are not more accurate

in their assessment than the tool itself – they might even make a less accurate judgement than the tool (see Bishop & Trout, 2002).

There are a variety of violence risk assessment tools that have been developed and validated within the empirical literature. Below we will briefly review a few of the violence risk assessment tools that have come up in the empirical literature.

The HCR-20. The Historical/Clinical/Risk Management – 20 (HCR-20; Webster et al., 1997) is a structured professional judgement (SPJ) instrument that is particularly relevant to general aggression (Douglas and Skeem, 2005). It is structured in the sense that the authors have prespecified the 'risk factors'; however, it does not structure the process to obtain a final estimate of risk – the health professional is given the freedom to combine the results of the 20 risk factors to come to a final intuitive estimate of risk (Monahan, 2008). The 20 factors measured represent the authors' perceptions of which risk factors have come up in the empirical literature. These 20 factors reflect 10 'Historical' items (i.e., previous violence, age at first violent incident, relationship instability, employment problems, substance use problems, major mental illness, psychopathology, early maladjustment, personality disorder, and prior supervision failure), five 'Clinical' items (i.e., lack of insight, negative attitudes, active symptoms of major mental illness, impulsivity, and unresponsiveness to treatment), and five 'Risk Management' items (i.e., plans lack feasibility, exposure to destabilizers, lack of personal support, non-compliance with remediation attempts, and stress). These factors are measured on a three-point scale that identifies whether or not the factor is present. A score of 0 means that there is "no" presence of the risk factor; a score of 1 means that there "may be" the presence of the factor; and a score of 2 means that "yes" the risk factor is present. It may be of interest to note that the HCR-20 was developed using a sample of institutionalized people who were followed for approximately two years after their discharge into the community (Douglas et al., 1999).

The COVR. The Classification of Violence Risk (COVR; Monahan et al., 2005) is the first violence risk assessment software. According to Monahan (2008), it was developed to estimate the risk of violence among acute psychiatric patients. Using a computer, the COVR directs the health professional through a chart review and 10-minute interview with the client that can measure up to 40 risk factors. This yields a report that identifies the client's risk within five different categories (e.g., 1% likelihood of violence in the first category, 26% in the middle category, and 76% likelihood of violence in the fifth/highest category). The final estimate of risk, provided by the COVR, is generated using "classification tree" methodology. Classification tree approaches represent another example of how clinical processes have informed structured assessments. In 'tree" methods, different combinations of risk factors combine people into "low" versus "high" risk. These combinations are derived in a contingent manner – the questions asked will lead to different questions depending on the answer. This is more representative of clinical practice.

It is important to note that the authors contend that the final risk decision be informed by the information from the COVR but that the health professional should make the final assessment of risk – drawing on rare factors (i.e., direct threats) and/or available data/records that they are privy to.

The COVR was developed drawing on data from the MacArthur violence risk assessment study (Monahan et al., 2001). This research assessed 1000 patients in acute psychiatric facilities on 134 possible risk factors and followed for 20 weeks in the community after discharge from the hospital. 40 risk factors emerged from this research as the most predictive of violence, which are consequently the 40 risk factors that the COVR is capable of measuring using the COVR

software (although the authors note that the health professional is free to choose which of the 40 risk factors to assess based on the individual client). Some of the identified risk factors include: seriousness and frequency of prior arrests, young age, male gender, being unemployed, seriousness and/or frequency of abuse as a child, a diagnosis of antisocial personality disorder, lack of a diagnosis of schizophrenia, whether the individual's father used drugs or left home before the individual was 15 years of age, substance abuse, impaired anger control, and violent fantasies (see Monahan, 2008, for case examples of the use of the COVR).

The VRAG. The Violence Risk Appraisal Guide (VRAG; first published in 1993; see Quinsey et al, 2006) assesses 12 risk factors that have been designed to predict violence in mentally ill offenders. The VRAG demonstrated strong predictive validity (Harris et al., 2002). Originally, the VRAG was developed using a sample of 600 men from a high security hospital. From a sample of 50 potential risk factors, the authors identified 12 factors that were the best predictors for risk of violence. These factors are: score on the Hare Psychopathy Checklist-Revised, separation from parents at under age 16, lack of victim injury in index offense, lack of a diagnosis of schizophrenia, never married, elementary school maladjustment, male victim offense history, older age at index offense, alcohol abuse history, and diagnosis of a personality disorder. These risk factors are combined using statistical weighting and the weighted scores are summed to provide a final estimate of risk. It is important to note that the authors of the VRAG do not believe that any clinical review of the structured risk assessment should take place. In fact, they believe that the use of clinical judgement could contaminate the estimate of risk (Quinsey et al., 2006).

Needless to say, there are many other violence risk assessment tools available that have emerged in the literature. Some of these instruments include: the Level of Service Inventory – Revised (LSI-R; Andrews & Bonta, 1995), the Problem Identification Checklist Scales (PICS; to supplement the VRAG; see Quinsey et al., 2006), the Violence Risk Scale (VRS; Wong & Gordon, 1999), and the Structured Outcome Assessment and Community Risk Monitoring (SORM; see Grann, et al., 2005). Although some of these measures are designed specifically for use in community environments (e.g., SORM), they may be newly developed measures and/or have potentially been developed without the use of a specific emphasis on people with mental health difficulties. Accordingly, caution and appropriate research should always be used when selecting a violence risk assessment tool that will meet both the needs of the client and the health service provider.

Dynamic Risk Factors, Risk Management, and Interventions

A key distinction yet to be made in this discussion is the difference between static and dynamic risk factors. Static risk factors are those indicators of risk that are relatively unchangeable. Historical and personal risk factors are prime examples. In contrast, dynamic risk factors are in fact changeable and thus are often the targets of intervention. Clinical and contextual factors fit into this category, such as medication status, alcohol and drug use, social support, and many mental illness symptoms.

Douglas and Skeem (2005) point out that structured, actuarial methods have emphasized static risk and that the primary purpose of these types of risk assessments has been to make "single point decisions" about future behaviour. For example, decisions about discharge from institutions, parole issues, or acceptance into programs have been made based on an assessment of "risk status", i.e., the probability of behaviour occurring sometime in the future. On the other hand, clinicians are most often concerned with identifying appropriate

interventions and gathering information about "risk state". Risk state focuses on the dynamic change of contextual risk factors. The emphasis is on the here and now, and the potential, for example, of someone becoming violent in the near term because they have gone off their medication, lost their housing, and have begun drinking.

There are very few studies that have focused on dynamic risk assessment (Douglas & Skeem, 2005). While many actuarial tools include elements of dynamic risk (e.g., the HCR-20), they seldom receive direct empirical attention. Douglas and Skeem (2005) provide a list of dynamic risk factors that are deemed important in the prediction of violence:

- Impulsiveness
- Negative affectivity
    - Anger
    - Negative mood
- Psychosis
- Antisocial attitudes
- Substance use and related problems
- Interpersonal relationships
- Treatment alliance and adherence
    - Treatment and medication compliance
    - Treatment-provider alliance

The distinction between "static risk status" and "dynamic risk state" is very important for it provides a reasonable explanation for the consistent finding that actuarial methods out-predict clinical methods. Actuarial methods predict behaviour over longer time periods (as short a time as three months, but more commonly over years). When the behaviour occurs at any point in this time frame, the prediction is deemed successful. In contrast, a clinical focus on dynamic risk may not predict the behaviour in many cases, since the assessment is in reference to the short-term. In the short-term, this assessment may in fact be correct. In studies comparing the two approaches, the clinical method is deemed unsuccessful in predicting the behaviour (a false negative) when, over a longer time period, the behaviour is observed. In short, the actuarial method has time on its side.

One might argue that clinical approaches are inferior because of this focus on dynamic risk – that clinicians should also be using actuarial methods in order to predict behaviour over longer time frames. This point misunderstands the immediate and most pressing role of clinicians and of mental health organizations in general. Namely, the most immediate concern is with *risk management*, and the hope that clinical and social interventions will a) directly address and impact dynamic risk and b) will provide protection against the static risk factors that have put people at a disadvantage. In other words, a focus on dynamic risk is the only avenue to improve and enhance mental health. After all, one cannot change the risk factor "age of first violent offence".

The emphasis on dynamic (i.e., clinical, contextual, social, personal, etc.) risk assessment in mental health organizations leads us to the observation that assessments are not conducted merely to make single point decisions about the person (such as program eligibility), but to conduct an assessment of need. Ideally, the goal of risk assessment should be to identify those individuals who need the most help, who are most vulnerable and disadvantaged. Rather than seeing risk assessment as a method to exclude or control, it can be seen as tool to identify necessary supports and treatments, including proactive and preventative measures. Indeed, it might be misleading, and potentially damaging, to even use the global term "risk assessment", because it is not merely that and because the term perpetuates negative connotations and stereotypes about people with mental health difficulties.

What are the elements of risk management? Clearly, risk management is focused on dynamic factors and may be highly individualistic. Allen (1997) summarized a set of factors from previous studies that should be considered when managing risk (in this case, violence, but also applicable to self-harm and suicide):

- Immediate safety of situation for all concerned
- Appropriateness of environment and other ongoing circumstances such as monitoring and support in relation to the level of risk
- Whether those involved in working with the risk are adequately aware of it and trained to assess it and manage it. Do they create or exacerbate the risk?
- The degree of support and supervision that those working with risk receive
- The level of communication and coordination between individuals working with the risk
- The plans explicitly identified and in place for removing, reducing or controlling the risk
- The degree to which all involved are aware of and adhering to such plans
- The identification of legalistic/disciplinary responses to the occurrence of harm, for all concerned

With this background context of risk assessment and management in place, we will now turn to the findings of research study itself. Our concern here is to provide the context of practice in Peel Region as it relates to risk – how it is defined and assessed, the challenges inherent in this process, and the actions that are (or are not) taken as a result. Throughout, we will reflect on these findings within the context of the literature review and end with an overall conclusion and recommendations.

D. Research Findings

Defining Risk

Respondents did not articulate general or overarching definitions of risk; neither have formal definitions been established organizationally. This is not particularly problematic, since definitions in the literature are also overly general and certainly do little, on their own, to inform risk assessment and management. Respondents instead defined risk in relation to negative consequences experienced by certain affected groups. Three main categories were discussed:

- Risk of violence or harm to others, including service providers, family members, or general community members. This includes sexual assault.
- Risk of self-harm, including suicide. Self-harm includes physical actions (e.g., cutting, overdosing, etc.) as well as harm due to self-neglect (not eating, unsuitable clothes in winter, etc.).
- Risk of victimization, due to existing vulnerabilities. This was particularly emphasized by respondents working with people with developmental disabilities.

A fourth category was different in emphasis. Some individuals spoke of "organizational risk", which refers to the negative legal (and other) consequences of incidents related to negative behaviours. In other words, a backdrop of risk assessment and management is the concern that unmanaged (or unmanageable) risk may lead to some form of personal harm that the organization will subsequently be held liable for.

> *Organizational risk specifically is ...the risk to the agency in terms of this person causing harm in the community to someone else which would then implicate the organization either through property damages, physical harm to others, or even a coroner's inquest.*

Indeed, this concern is one motivation for organizations to effectively assess risk and, in some cases, a motivation to exclude individuals who are perceived to be high risk.

Risk Assessment

When respondents began talking about and defining risk, they quite naturally began identifying common indicators or risk factors associated with the behaviours in question. These factors were many and varied and were largely reflective of what is present in the literature. Before we discuss the *methods* used by organizations in conducting risk assessment, we first will discuss the main indicators of risk that are the focus of organizations.

Static factors

Respondents felt static factors were important indicators of risk. Basic history of behaviour was considered a crucial, but preliminary, category of information. For example, criminal history and recidivism is useful information as to the severity, type, and context of the offenses (e.g., "assault" records may be verbally based). Young age is also factor that is considered, as is history of mental illness.

Dynamic factors

All respondents emphasized the need to incorporate dynamic factors – those factors that are contextual and/or clinical – into any consideration of risk. Static factors alone were deemed insufficient to truly understand risk. For example, one respondent described the most pernicious conditions for high risk:

> *The riskiest person in community mental health in terms of harm to someone else is a young male between 16 and 24 who has schizophrenia, is off his medication and uses a fair amount of substances and alcohol, and has quite a bit of criminal history, possibly if he was in foster care when he was young.*

This description reflects historical static factors (age, criminal history, mental health diagnosis, and foster care) but also dynamic factors (medication compliance, substance use). Clinical and social context was deemed particularly important and it was observed that static risk factors are important insofar as they generalize from the setting to setting. Behaviour in jail, for example, may have very little to do with behaviour in the community, since the context, triggers, and causes of behaviour are entirely different. Furthermore, risk assessment is often conducted to ascertain the risk of negative behaviours occurring during service use and/or within the physical domain of the organization. Some risk factors, important in some contexts, may not be relevant in others, despite the intense stigma that may be associated. For example:

> *...clients come into our agency that have been labelled pedophiles...and when you assess the situation and they admit to having done some things that have contributed to them in getting the label, and then they will say that it was in this situation, all six years and younger and always under the influence. Well, we don't have any six-year olds in our agency so the risk is fairly low.*

In general, it was understood among the respondents that a "really high risk for reoffending behaviour" may be quite irrelevant to risk in services. For example:

> *In terms of providing service, there are really specific demarcations that need to be made. A person may be at a really high risk for reoffending behaviour – that doesn't really say anything at all about whether that person will present any risk to a service provider or housing society. If the*

service providing agency is forced into using forensic types of RA, they're being misled as to what they actually need to do with that individual.

Respondents also commented on complex chains of events that implicate multiple, dynamic risk factors and demonstrate how single risk factors (especially "criminal record") lack important context. For example:

...sometimes, often, income will determine criminal behaviour. We've had folks in various jobs who have been housed in affordable subsidized housing, but the fixed income that the individual receives on ODSP wasn't enough to maintain what they needed. So the person became engaged and involved in drugs, was both using and selling drugs out of the apartment, things went bad, there were weapons involved, there was a shooting, no one got hurt...the guy was arrested and because all of the weapons were left there he was charged with weapons possession and ended up back in the justice system. Here's a case you can look at and say, now he's criminal and he's free and he didn't have much to start with, he was a guy with depression and needed affordable housing, but he needed more money.

Another example was in reference to income insecurity as key driver for risk. This reflects a dynamism that cannot be reduced to a single, static risk factor:

For example, if I have a client whose criminal behaviour gets them sent to jail, and then they lose their housing because they missed their rent, now I have someone who has come out of jail, they are perhaps homeless, and they may have lost their income security as well. They may have a lot of trouble reconnecting with the service providers that need to get them back on their meds because they've lost all the other social supports that kept them compliant with their meds in the first place.

Dynamic factors were quite clearly deemed important to risk assessment in reference to self-harm, suicide, and vulnerability. In fact, in terms of enhancing personal safety, it is precisely those dynamic factors that need to be monitored for there to be effective support and treatment plans. Static factors, such as previous suicide attempts or a history of "wandering behaviour", become important flags to properly explore dynamic factors.

Risk Assessment in Peel Region

What do risk assessments actually look like in organizations in Peel Region? We found there were some variation and some common themes in the ways in which risk assessments are conducted. We summarize these findings below.

A focus on clinical assessments. Generally, organizations tend not to use formal, structured risk assessments, although some do. Organizations, especially those engaged specifically in justice

diversion programming, may receive structured risk information from the criminal justice system, including scores from the VRAG and the LSI-R (which is a generic predictor of criminal recidivism, see Austin, 2006). Additional, the Ontario Provincial Police have a Threat Assessment Unit that is highly trained in a range of risk assessment tools. Across mental health organizations, however, few structured formal risk assessment tools are used, in favour of unstructured clinical methods.

At intake, clinical risk assessment is part of needs assessment. In absence of formal tools, risk assessment is often interwoven into clinical practice and assessment of need. Many organizations, for example, will conduct clinical assessments when assessing suitability for programs or building support plans, and this is seen as part of risk assessment. During this process (which is often staged, beginning with a phone call, then a face-to-face meeting, followed by a longer and more formal assessment), certain flags will be raised prompting more thorough investigation into risk, which could lead to other specific tools (see next point).

Services for high risk individuals are constantly attuned to risk. For some mental health programs, "risk" is a day-to-day and constantly threatening reality. For example, ACTT teams service exceptionally vulnerable people with severe and complex mental health and addiction issues living in the community. Risk to self (through neglect or active self-harm) and to others is constantly reviewed ("status checks"), based on presenting circumstances and contributing factors, such as substance use, medication, housing and shelter, physical health needs, suicide ideation, and other issues.

In certain contexts, specific risk related tools are used. There are range of basic behavioural checklists and other tools that organizations use to examine specific areas of risk. For example, there a range of tools to assess substance use (e.g., Rosenberg, 1998) or an immediate risk of suicide.

Risk assessment is sometimes replaced by reactive risk management. Because formal risk assessment is often not conducted, there is an emphasis on risk management. Investigation into risk may be prompted by new behaviours or changes in a person's life, such as when someone stops taking medication, is showing suicide ideation, is using alcohol, or is beginning to show a new level of aggressiveness, to name a few examples. This reflects the dynamic, contextual nature of risk assessment.

Legal counsel does not assess risk. Organizations such as Legal Aid and legal counsel in general do not conduct risk assessments. First, the perceived level of risk is deemed low by lawyers and contact is time-limited. Risk management, via safety protocols, is general and enacted universally, rather than on a client-by-client basis. Second, it is often not in the client's best interest to have a risk assessment conducted (from the perspective of legal aid) since that information can be used against them in sentencing and other legal consequences. Consequently, lawyers tend to minimize the application of risk assessments to their clients. Third, conducting risk assessments is simply outside the purview of legal counsel, who do not tend to see themselves as gatekeepers of community safety in the manner that health providers are.

Corrections use actuarial assessments of risk. Correctional organizations are "in the business of risk", especially when it comes to discharge planning. Corrections facilities develop discharge plans in consultation with community mental health organizations (e.g., CMHA) but rely on structured static risk assessments at the outset, which can limit available community service and support options (we will return to this point). One representative had this to say:

...all clients who demonstrate significant mental health issues are referred to discharge planning through CMHA, but the challenge has been what will that look like? We do use the standard risk assessment tools in depression and the level of service inventory, to measure risk and need. Unfortunately (the LSI) is a very flawed instrument when it comes to clinical work because it was designed to measure risk of recidivism and then to determine level of security and the appropriate level of classification in custody...but it does impact decisions around referrals and discharge planning.

Perceived Effectiveness of Risk Assessment and Organizational Needs

We asked respondents about their abilities to assess risk and the related needs of organizations in this assessment domain. There were mixed responses to this area of questioning. Some organizations felt that they functioned well in this area. For example:

Where we do a good job is on the clinical risk, where our staff will ask about medication compliance, how many hospitalizations, how do you know when you're getting ill. We do an amazing job in terms of crisis plans and teaching our consumers and clients how to use those crisis plans. So that area I think we do a very good job.

In contrast, many others were not so confident in their risk assessment procedures.

[The risk assessment] *isn't very specific. That's part of the reason why organizationally we're looking at how can we better define risk? Clients come into our service fairly openly without too much risk assessment being done...when clients come in, we ask a few questions around risk. But essentially it's more done as an issue arises – so a client will start presenting as suicidal or threatening and then staff will sit down with them and address what the issues are, so it's a more informal process.*

Respondents expressed a need to have more formalized and standardized tools that could be used to effectively and more objectively assess risk. So while it was clear that clinical and dynamic factors need to be incorporated, respondents also felt having a degree of consistency of their methods would benefit the overall risk assessment process. There were a number of reasons provided for this need:

Greater consistency in assessments. There is an identified need to achieve a greater level of consistency between service providers and across organizations that is otherwise difficult to achieve via subjective assessments.

Complement and inform existing clinical assessments. Organizations suggested structured, standardized tools would help add useful information to existing unstructured approaches and would also function to flag areas of concern not otherwise investigated by providers.

Trustworthiness of assessments. Structured assessments would provide a level of objectivity and accuracy so that referral partners would feel more informed and view assessments as trustworthy. Over time, this would translate into more consistent referral partnerships and practices.

Offset bias of single risk factors. The presence of some risk factors are oftentimes weighted too heavily (e.g., by referral organizations), even in the presence of additional clinical judgement and context. The use of standardized tools may add additional objective (therefore more persuasive) evidence needed to offset single factors.

> ...[if you conduct] *a risk assessment using standardized tools and they score very low, then* [referral organizations] *cannot just turn them down just because they have a sexual assault in their history. You're able to combat that with these tools being administered with reliability.*

Provide organizational accountability. A current need for improved, more structured risk assessment tools is in part to provide a basis for organizational accountability to risk and a level of protection against liability, i.e., "a reasonable course of action was taken to assess risk".

While standardized, structured tool use is a preferred addition to the existing clinical and social assessments, respondents added a few cautions. First, the mandate of risk assessment is not to exclude but to include. In other words, risk assessments should "open doors" rather than close them, and are tightly connected to need and service planning. Thus, while it is important to address organizational liability, this is not the central reason for risk assessment:

> *We as service providers should not be driving the mandate of our organization based on our own fear of accountability.*

Second, respondents do not wish to adopt a risk assessment tool or package that leads to excessive testing of consumers across the multitude of services in Peel Region. It was pointed out that consumers are already required to "tell their story" and participate in a range of clinical assessments over and over again throughout the system. A recommended model would be to have standardized needs assessment that was reliable in detecting heightened levels of risk which could then be followed up with more extensive risk assessment tools. There was some hope among respondents that the proposed Ontario Common Assessment of Need (OCAN) might meet this need for risk screening. Ideally, this would mean that individuals would only need to get tested once and the assessment would be shared across service providers. Respondents felt that the OCAN could provide the "flags" to internal risk assessment procedures that are conducted, as required, by each organization.

> *We're hoping to get a more formal process out of a risk assessment tool that can be used with the OCAN.* [The OCAN] *has certain flags in it. We have to determine if those flags pop up, do we then go to a deeper risk assessment as it relates to criminal behaviour, substance used, etc.? So for example, let's take criminal behaviour, let's say the flags go up for*

substance use – then you obviously need to do a more comprehensive concurrent disorder screen.

This, of course, will mean that individual risk assessment tools and protocols would have to be adopted by each organization. This is a significant gap because it is unclear to organizations what risk assessment tools could or should be used. Even more importantly, the reason to do a risk assessment is also to determine needs and a service plan, which is difficult to do without additional clinical information.

> [re: an information file on a person]...*when you pull it, it has all of that criminal history, behaviours more on the criminal side, and already it is looking risky. You then do the interview, on the phone or in person, only to realize, yes you know what, this person has had significant involvement, the insight into the mental health is not there, the medication, using a lot of substances, whatever. Then, in that case, what risk assessment do we pull from our filing cabinet? Staff need to know which one to pull or complete, how to complete it. It may be an in-house service or someone you consult with. Then you need to figure out based on the results of your assessment, what service plan do we need to put in place? By not doing any risk assessment, you don't allow for that piece to happen, and also for the organization to say, given our staffing resources, given our physicality, all those factors, this person may not be suitable – with a risk assessment, you're making an informed decision, as opposed to just a very subjective decision.*

Organizational Tolerance, Information Flow, and their Impact on Risk Assessment

It was clear from the range of data that there is great variability in how organizations respond to risk assessment findings. The results of risk assessments are generated either internally by organizations or received from other associated organizations and agencies. Two interrelated issues appear to have a significant impact on the decisions following from risk assessment or, more generally, risk information: Organizational tolerance and information flow.

Organizational Tolerance

Respondents remarked that organizations have varying levels of tolerance for different types of risk. This leads to the presence of "floating criteria" used by organizations to determine eligibility for a program or service. Thus, it is all too common for organizations to deny services to an individual based on perceived risk, despite such decisions being based on incomplete and/or inappropriate information. A lack of policy and corresponding practices on how to make consistent decisions about risk tends to perpetuate this problem.

Organizational tolerance understandably varies. There are a number of organizations, or services within organizations, that have very high tolerances for risk. The Peel Addiction and

Assessment Centre (PAARC), for instance, has an open-door policy and accepts all individuals regardless of risk. However, since many more programs are restrictive (and may not admit current substance users regardless of risk), PAARC may have more individuals with high risk:

> *...what happens is that because other agencies won't take* [people with high risk]*, we end up with a case load of all high risk, high acuity clients and it becomes a dumping ground. So that's a challenge for us in terms of other people's definition of risk.*

Other programs and services are specifically designed to service people experiencing high levels of risk. ACTT, as mentioned, is a good example. Additionally, mental health and justice diversion programs are intentionally built to meet this need. The problem, however, lies in that fact that the success of most individualized programs dealing with high risk people depends quite heavily on the access to supporting programs and services. Many of these services and programs have a much lower tolerance of risk. For example, corrections will provide criminal history and other risk assessment information that is focused on recidivism, but emphasize that discharge planning requires more clinical information:

> *If someone gets a really high score* [on measures of recidivism]*, we don't look at that clinically. We don't give any value to it but some people do. One of my frustrations is when you are trying to connect clients with other wrap-around services, who have had no face-to-face contact with a client who is being referred. Just based on criminal history and an analyzed score,* [the service] *will say that they don't quite meet the criteria for the program. But there are all kinds of mitigating factors that have contributed to a path that is now being used against a person.*

Other comments are illustrative of presumed risk functioning as a barrier to services:

> *We have some hospitals in our own region will not take anyone who has outstanding charges, no matter what the charges are. It's completely ridiculous, it is completely unacceptable and a human rights violation. But there is no context given at all, outside of the fact that there are charges given.*

> *There is also a rigidity with some service providers, that once they hear certain pieces, doors do close and it might be that it is risk, and there have been times when we've heard "that person's too high risk, we can't support them appropriately". It comes down to one person's interpretation of what risk is versus one agency's or one person's interpretation of risk.*

There are also particular cases where risk is generally deemed too high based on the type and severity of offence. For example, an individual convicted of arson would typically be deemed too high risk for congregate living services. Finding services for people who have committed offenses within the service environment are particularly vulnerable because other organizations

are much less likely to serve them. Such individuals are particularly difficult to serve in the community because their perceived risk exceeds the tolerance of most organizations.

> *I had a situation where someone who was already being assisted in a community living situation offended within that environment and then had to find somewhere else to go. And they had so many physical and psychological mental health challenges that in fact had to be in a 24hr care facility. But because he had been charged – not even convicted – with an assault, a whole bunch of doors immediately closed to him. And you can understand that because they were looking at the context of the assault, and saying "if we let him in here, maybe the same thing will happen to the other residents in this facility". And then the question arises, what do you do with him?*

Some respondents expressed concern about certain criminal histories being labelled high risk, when the real motivation to deny service is a moral discomfort with the offense itself, rather than actual risk.

> *People will say that they have a "eww" factor about* [pedophilia]*, that "eww, I don't want to deal with that client". And that's not a risk assessment, that's transference.*

Housing services play a crucial role in this issue. Since housing organizations and the people within in them experience the most contact with each other, exposure to risk is much higher. Safety of staff and residents, as well as organizational liability, requires lower levels of tolerance for risk. While housing organizations are interested in more effectively assessing risk, evidence of harm to self or others makes it much less likely that an individual can be accommodated. In this context, we also know that a lack of housing puts individuals with mental health and addictions into situations of much greater vulnerability.

An unfortunate by-product of low organizational tolerance is the possibility that some referrals are underestimating risk in order to secure services for consumers (which is perhaps also due to a lack of critical training regarding risk). For example:

> *…frontline workers who really might not have the scope of skill we would really like to see may misrepresent their client in order to get them admitted into a program. Even if they don't realize, they assume that there are limiting criteria for admission, so they present their client in a very favourable light to get them admitted so they can get service for them.*

Another individual added that this creates concern and mistrust when receiving certain referrals:

> *The problem is that that creates a risk right there…so there are actually services that we now know if you get a referral from this service, you need to do a really thorough risk assessment because you can be guaranteed that the information is not* [accurate]*.*

Finally, respondents also suggested that the presence of wait lists at organizations may lead to "selective intake", whereby lower risk individuals are given precedence. If this truly reflects practice, it represents an additional systemic bias that leaves high risk individuals (real or perceived) underserviced.

Information Flow

Risk assessment in large part depends on the timely flow of comprehensive information. Respondents talked at length about how a lack of information makes it difficult to assess risk and how this leads to overly subjective and/or biased decisions about services. What follows are some of the major themes from the research.

Information is lacking. Respondents commented that risk information received is incomplete and difficult to acquire. Thus, organizations may end up making decisions based on single static risk factors, such as criminal history. Conversely, crucial risk information may be absent, creating a heightened risk environment without proper risk management in place if a high risk individual is accepted into services.

Information is not timely. Organizations often have to wait long periods to obtain needed information, which delays further assessment and negatively impacts service planning.

Information may not be properly assessed. In some cases, staff do not have the necessary training to interpret certain risk information, such as scores on an assessment instrument, its validity, and relevant use:

> *The only people* [the tool] *is valuable for is the people that understands what the tool can really measure. That's the risk, because when other people want your report, they're not trained on that tool, they don't understand the limitations of that tool and the purpose of it even. So, then they generalize it to other stuff that has no relevance.*

There is a downside to too much information. One respondent commented that they were concerned about E-health because it may produce extensive information that is additional to what is normally used and needed:

> *Suddenly you will have access to information that you would normally not have access to. Do you need it? How will it impact? Potential for biases to impact people's treatment of care is huge.*

Validity of information may be challenged. Risk assessments and information transferred between organizations may be challenged or dismissed on various grounds. For example, more dynamic information, gathered by self-report, may not be sufficient to offset other risk factors that take precedence in some organizations (such as criminal record), because they are deemed unreliable.

Disclosure and consent can limit information. Respondents acknowledged the extreme importance of informed consent when accessing and sharing personal information of consumers, and felt that strong ethical guidelines were observed in practice. However, a lack of

consent also can have the effect of restricting the information needed for proper risk assessment.

Disclosure can become a condition of service. Respondents expressed concern over the potential consequences for consumers when they elect to withhold personal information. When requested information is risk related, it can lead to denial of services because proper risk assessment is not possible. It may also lead to consumers falsifying information (to get services) or to serious disincentives for consumers to access services in the first place. This is a serious difficulty, because it essentially requires an individual to label themselves and to have that label follow them around the system without personal control as to how and when this label is used. From a certain perspective, this may be a violation of human rights under the Charter. No other area of the health system requires this level of personal disclosure in order to receive services.

> *There's nothing stopping an agency from saying unless you provide the consent for us to look at your criminal record, you can't even get in the front door. For the individual it's a bad situation to be in. If I don't sign the consent I don't get access.*

Risk Management

Respondents were asked about risk management practices. In some ways, the distinction between risk assessment and management are not easily separable. While formal assessment may happen at intake, most people spoke of risk assessment as including ongoing, day-to-day clinical assessment, support, and service planning. Indeed, risk management is often viewed as the ongoing application of dynamic risk assessment. Many respondents also suggested that the most beneficial approach to risk management was to reduce risk through effective service delivery and supports. While this may seem obvious, risk management could potentially be quite limited, serving as a mere clinical monitoring function (i.e., to ensure risk does not fluctuate upwards) but without active intervention. This narrower approach to risk management is not present in Peel, from the perspective of respondents. Rather, respondents viewed risk management as a secondary concern to the primary focus of supportive planning and recovery.

There were, however, other elements of risk management that were more focused on ongoing safety assurances. Thus, organizations had a range of safe practices such as ensuring two people being in the office at any one time, the use of "panic buttons" worn as necklaces, staff sitting with their back to an exit during interviews, and a variety of call-in procedures when conducting outreach services. Respondents felt their safety practices were well developed and communicated among staff. The only difficulties seemed to be limited resources, in some cases, to be optimally safe. For example, lack of resources prohibits outreach workers doing calls in pairs.

E. Recommendations for Organizational and Systems Change

The previous sections summarize respondents' perceptions of risk assessment and related issues and challenges in Peel Region. Respondents also provided significant commentary on how organizations and the system as a whole can improve risk assessment and management practices. In this final section we will draw on the findings so far and incorporate a series of recommendations for system capacity in the area of risk from the perspective of respondents and in relation to the existing literature.

Combining Clinical Practice with Structured Tools

Past research has consistently shown that actuarial, structured methods are superior to clinical subjective approaches to risk assessment. However, such studies tend to look at longer-term behavioural predictions, without consideration to the context of risk (e.g., the level of risk to the service environment may be minimal). In Peel, and elsewhere, clinical practitioners are much more concerned with dynamic risk that may present itself in the day-to-day. In fact, clinical and social-personal assessments may be superior in assessing and managing immediate risk. More and more actuarial tools are attempting to incorporate dynamic risk to improve prediction and it is much more common now for researchers to emphasize the importance of complementing actuarial tools with collateral clinical (and other) information.

Respondents acknowledged that the clinical, subjective approaches that are most common in risk assessment locally need to be improved through the greater use of standardized tools. As mentioned in a previous section, this will aid consistency and trustworthiness of assessments. There are some challenges in introducing standardized tools:

1. What tools should be used? There are many tools to select from, with a range of static and dynamic risk factors (see literature review). There are also a number of risk-specific tools to choose from.

2. When should tools be used? A reality of organizational liability is that each organization should be conducting their own risk assessments. It is unclear when (i.e., the circumstances under which) such assessments need to be conducted.

3. Who should be conducting risk assessments? Not all staff, or even all organizations, have the appropriate training and resources to appropriately use particular risk assessment tools.

Recommendation: The introduction of the OCAN may help direct solutions to some of these problems. The OCAN does not comprehensively assess risk, but will function to "flag" certain areas where risk may be high. If all organizations will be using the OCAN, this can help provide consistency to when and how risk assessment is pursued. Respondents suggested that risk assessments be conducted internally by each organization, but decisions on which instruments should be used need to be reviewed, along with implications for staff training (see next section on organizational collaboration for more information).

Organizational Collaboration on Understanding Risk

Many of the barriers individuals experience in gaining access to services have to do with shifting and inconsistent application of risk definitions or interpretation of risk information. Respondents commented how these inconsistencies lead to considerable frustration among individuals and families:

> *It's really confusing for the families we work with. One agency is saying this is risk, and another one is not – it gets confusing because this language to them means nothing and they feel like there's so many barriers everywhere they go, so then they give up. It's not very good for the families.*

> *And families have said to us, "I'm supporting* [the individual] *by myself in my family home, but yet they're too high risk for professionals to engage with them?" How do you have that conversation with a family member and then leave?*

Despite the inconsistent application of risk assessments, respondents reported that the mental health and addictions system in Peel has a spirit of collaboration and a willingness to partner in order to solve some of these inconsistencies. For example:

> *We have a hidden gift that isn't acknowledged. We have long time staff that have been working for a long time and are really skilled and they have this network. They talk together, they trust one another...and it circumvents all that other stuff. They have established relationships and they get together and present client issues, they negotiate how each other can help out this client and within the context of the agencies' policies.*

> *I think there is quite a bit of collaboration, in terms of how to best support the individual while recognizing some of the risks that exist and not necessarily denying services, but rather just modifying it.*

Respondents endorsed continual, cross-organizational collaboration to address inconsistencies in risk assessment and to share practices. Interestingly, the process of collaboration was seen as more important than any sort of final risk assessment product:

> *When one embarks on creating such a tool, the process itself in terms of creating the tool would be quite beneficial. It's not necessarily for what would result from that process but getting the parties together, getting them to understand each other's pressures and perspectives, and interpretations and definitions, let alone networking. I would make it a*

broad-based project over time as opposed to a couple of months, with a representative from each organization.

It's about finding improvements rather than perfection in risk management. Any movement toward improving it, even if the system is not perfect, is the way to go. But I think so often when we get together there is a risk of people always saying "no, I can't buy into that because I'm not happy with it". Because they are looking for perfection. We have to keep working on this until we get it absolutely right, and then we'll roll it out. That's why we can miss a meeting for 8 months and we're still talking about the same stuff. You're not going to get there. There's got to be some kind of commitment to make it a little bit better, to make it one step better.

Recommendation: The system should facilitate an ongoing working group of providers to share risk practices, review risk definitions, criteria for service access, and system wide barriers in order to develop solutions for practice-based coordination and, possibly, develop some consistent risk assessment practices.

Organizational Collaboration in Practice

A barrier to effective system wide risk assessment is related to a long-recognized and more general barrier – limited collaboration and coordination in direct-services delivery. Risk assessment and management can only be enhanced by greater service coordination of wrap-around services. This is not to say that coordination is not happening in Peel – it certainly is in relation to many organizational partnerships, formal and informal. The ACTT model, for example, already utilizes multidisciplinary teams in services and supports. As the system moves toward cross-organizational partnerships (or even teams), there can be greater opportunities to have more consistent understandings of risk, common use of tools, and more complete and efficient sharing of information. This point also underscores the observation that risk assessment and management are not easily separated – nor should be – from effective support planning. Risk assessment is a subarea of overall assessment and support in order to identify and meet needs:

Under normal circumstances, a person who is really challenging would generally be told, "we can't support you because of the way configure our services". A staff person who is conducting the assessment can come back to the team and say "well, maybe collectively we can support this individual". [Normally] you can only see the individual twice a week, but collectively we could see them four to five times a week.

A current challenge to collaborative practice is that many organizations are not specifically funded to do this:

There are certain natural partnerships that happen…we do that all the time, where we will call one another up and talk and do that type of thing. The difficulty for us is that our funding formula is not set up to support that. It is set up to support individual clients with a primary worker. So we have actually been advocating with our funders to allow us some flexibility in our funding target so we can do that type of collaboration. We need formal permission to be able to do this and ways to document it.

Recommendation: The system should pursue collaboration and coordination in service delivery. As it applies to risk assessment/management, such collaboration may serve to establish consensus on risk and potentially centralize risk assessment procedures. A barrier to this approach is addressing differing levels of organizational tolerance to risk as it applies to liability and other safety issues. However, collaboration in practice leading to common risk assessment tools and approaches would serve to at least provide greater clarity and objectivity to differing levels of tolerance.

In Closing

Risk assessment and management is a complex area of community mental health with a long history of debate about how best to predict undesired behaviours or outcomes, such as violence, self-harm, self-neglect, and vulnerability. Currently in Peel, risk assessment is conducted inconsistently by organizations in mental health and addictions, as well as other related community organizations. Risk information is also interpreted differently by different organizations, leading to inconsistencies in a range of service decisions. "Floating criteria" for eligibility for service access create gaps and barriers for the most vulnerable of citizens. However, there exists in Peel the incentive to capitalize on existing partnerships and collaborations (represented in part by the PHSJCC), to understand how to better assess and manage risk.

This report documented the findings of a research project that examined risk assessment and management practices in Peel Region. Many different issues came to the forefront, including variation in practice, problems in referral practices, differing levels of organizational risk tolerance, and problems in information flow. A number of recommendations were made by respondents to improve system capacity and practices in the region.

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G. Appendices

Appendix A – Focus Group Questions

Definitions of Risk

1. How is 'risk' being defined at your organization?
    - What do you mean by the term 'risk'? (e.g., violence, drugs, sexual assault, other behaviours)
    - What kind of behaviours would a high-risk individual exhibit?
        - e.g., how would they impact the program environment

Policies and Procedures in Risk Assessment

2. In general, what kind of policies and procedures does your organization have concerning risk assessment?

3. How is risk assessed at your organization?
    - Is it considered a formal or informal process? How so?
    - What tools and information are being used?
    - What information do you have or acquire about the individual in advance of the assessment?

4. What is being considered as 'too much risk'?
    - In relation to service provision and safety?

5. Who assesses for risk in your organization?
    - What kinds of skills or training are required or needed?

6. When and how often is 'risk' being assessed at your organization?
    - Upon program entry? Throughout the duration of the program? Exit?

7. What are some of the common barriers and challenges of assessing risk at your organization?
    - Practical/logistical?
    - Information barriers?
    - Response/reaction of individuals? Disclosure? Are there concerns or issues related to over-assessment?

8. What are some common problems the organization or program experiences if risk is not properly assessed?

Risk Management

9. What kind of policies and procedures does your organization have concerning risk management?
    - What happens in risk management?
    - Is it informal monitoring? Formal monitoring?
    - What actions are taken when there is a new heightened risk?

10. What kind of training do staff members receive concerning risk management?

Sharing information on risk

11. How is information about consumer risk being shared between your organization and others?

- How often does this happen? Is this a common practice?
  - e.g., are you sharing case files, client history, and other details – probation plans?
- How is this beneficial, or not?
  - For the client? For your organizations?

What are the barriers to information sharing?