Managing risk: Clinical decision-making in mental health services

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Abstract

Risk assessment and management is a major component of contemporary mental health practice. Risk assessment in health care exists within contemporary perspectives of management and risk aversive practices in health care. This has led to much discussion about the best approach to assessing possible risks posed by people with mental health problems. In addition, researchers and commentators have expressed concern that clinical practice is being dominated by managerial models of risk management at the expense of meeting the patient's health and social care needs. The purpose of the present study is to investigate the risk assessment practices of a multidisciplinary mental health service. Findings indicate that mental health professionals draw on both managerial and therapeutic approaches to risk management, integrating these approaches into their clinical practice. Rather than being dominated by managerial concerns regarding risk, the participants demonstrate professional autonomy and concern for the needs of their clients.

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In this paper we report on the findings of a study exploring the risk assessment practices of a multidisciplinary mental health service in Australia. Risk assessment and management are major components of contemporary mental health practice. Risk, described as "the likelihood of an adverse event happening" (Muir-Cochrane & Wand, 2005, p. 5), can include patient aggression (Daffern & Howells, 2009), suicide and self-harm (Thompson, Powis, & Carradice, 2008), absconding (Muir-Cochrane, Mosel, Gerace, Esterman, & Bowers, 2011), substance abuse (Thomson, 1999), and diverse concerns, such as medical co-morbidity, exploitation, social exclusion, victimization, and poverty (Kelly & McKenna, 2004; Muir-Cochrane, 2006). The increasing importance placed on risk assessment and management is reflected in not just policy, but also the daily care of consumers by health care professionals worldwide (de Nesnera, & Folks, 2010; Department of Health, 2007; Langan, 2010; Oordt, Jobes, Fonseca, & Schmidt, 2009).

The focus on risk in the provision of mental health care arose as a consequence of a complex set of social, political, and economic changes. This includes the adoption of market-based principles in the provision of health care, more generally, and a consequent rise in managerialism with its focus on the use of managerial techniques to optimise organisational performance, in the 1970s and 1980s (Sawyer, Green, Moran, & Brett, 2009; Alaszewski, 2005; Gregory & Holloway, 2005). This was furthermore underpinned by the contemporary framework of a "risk aversive culture" (Cleary, Hunt, Walter, & Robertson, 2009, p. 644). Within this context there is a general perception that all risks can and should be identified and ameliorated. This has led to much discussion about the best approach for assessing the risks posed by individuals with mental health problems; this includes the risks to both themselves and others. Within the research literature, the nature of assessment and management is often framed in terms of prediction, particularly the strengths and weaknesses of actuarial and clinical judgment approaches (Dolan & Doyle, 2000; Petrila & Douglas, 2002; Swanson, 2008).

The centrality of a risk management approach to the provision of health care has raised a number of tensions for service providers. Researchers and commentators have expressed concern that clinical practice is being dominated by a managerial model of risk management at the expense of meeting the patient's health and social care needs (Godin, 2004). Furthermore, concerns have been raised about the diminishment of professional discretion and autonomy, and the deskilling of professionals as a result of the introduction of regulatory regimes, such as risk management, into the health sector (Alaszewski, 2005; McDonald, Postle & Dawson, 2008); others have found that health professionals are able to

interpret and negotiate risk management policies to maintain professional autonomy (Ruston, 2006; Sawyer, 2009). There are also issues associated with potential iatrogenic effects of risk management, such as the risks posed to patients by prescribed medications (Busfield, 2004; Heyman, 2004; Hoyle, 2008).

The focus in mental health care on working within a recovery framework (Anthony, 1993; Deegan, 1988) has important implications for risk assessment and management. Policy and service reform to implement the principles of recovery—which focus on the consumer's goals, potential for change and growth, and a transparent and collaborative relationship with health care professionals (Barker & Buchanan-Barker, 2005)—has been identified as important in maintaining a recovery focus (Ramon, Healy, & Renouf, 2007; Rickwood, 2005; Substance Abuse and Mental Health Services Administration, 2005), and inherent in such principles is, indeed, the notion of risk:

> [Recovery] is a complex and multifaceted concept, both a process and an outcome, the features of which include strength, self-agency and hope, interdependency and giving, and systemic effort, which entails risk-taking (Ramon, Healy, & Renouf, 2007, p. 119)

The challenge exists, therefore, in the practical implementation of a balance between a focus on the risk a consumer is seen to pose, particularly in areas where risk to others and self is involved, and the development of "a respectful and considered therapeutic relationship [which] assists the patient to achieve a sense of ownership and responsibility for their mental illness, treatment and risk management" (Kelly, Simmons, & Gregory, 2002, p. 208).

Given the issues described above, it is important to explore and understand how clinicians engage in and understand the risk assessment process and manage risk. Godin (2004), for example, found that community mental health nurses in the UK experienced tensions in utilising more explicit and standardised assessment practices alongside clinical judgment and intuition, as well as prioritising certain types of risk such as suicide and self-harm over other potential risks. In a study on mental health nursing assessment, MacNeela, Scott, Treacy, and Hyde (2010) suggested that "psychiatric nurses' assessment practices are influenced more by experiential, tacit knowledge than by formal decision aids and assessment models" (p. 1298), and proposed that this is at odds with concerns in health care for transparency, accountability, and quality assurance. These researchers also pointed to the

importance of examining cognitive decision-making processes as well as social and environmental factors.

The purpose of the present study is to investigate the risk assessment practices of a multidisciplinary mental health service. Specifically, the study aims to: (a) examine the clinical decision-making practices of the mental health service multidisciplinary team in relation to risk assessment of mental health consumers; (b) examine the perceptions, knowledge, and attitudes in relation to risk assessment in this service; and (c) explore the barriers and enablers experienced by the multidisciplinary team in relation to effective risk assessment practices.

METHOD

Participants

Purposeful sampling was used to recruit health professionals working in the acute care and community settings of one mental health service. Participants were required to have worked in the service for at least six months, in order to ensure knowledge and experience of risk assessment and management practices in the service. Recruitment was through a project information sheet distributed to all staff in the mental health division. Participant recruitment continued until data saturation had occurred (Pope, Ziebland, & Mays, 2000), with 15 multidisciplinary health professionals recruited to participate in the study. Table 1 presents participant work experience and demographic details.

[Insert Table 1 about here]

The Mental Health Service

The service consists of an acute admission ward (located within a general hospital) and community mental health services for consumers over 65 years of age with mental health problems. The acute admission ward, though primarily a mental health care ward, is also used for those consumers with minor physical issues because of its professional skill mix. Formal risk assessments in the acute ward are required daily or weekly, depending on determination of regularity needed for an individual consumer, and are reviewed weekly by the consultant with the multidisciplinary team on ward rounds. In the community services, case managers are responsible for ensuring risk assessment is undertaken, with formal assessment required every three months.

Procedure

Participants completed a demographic information sheet, read a hypothetical case scenario, and completed a risk assessment and management tool. Participants then took part in a semi-structured interview exploring their approach to risk management for the case scenario and in daily practice.

Materials

The Case Scenario

The case scenario written by the research team described a consumer, Jim, who was brought into the emergency department by police after threatening his wife with violence and detained under mental health legislation to the acute care ward. The purpose of the case scenario was to stimulate participants to think about how they assess and manage risk when using a risk assessment and management tool.

Risk Assessment and Management Tool

The Risk Assessment and Management Tool was based on a tool developed by the Department of Human Services (2002) as an aid for the mental health clinician. The tool is used in the acute care setting—although the community service uses a similar instrument—and consists of three sections: (a) risk history, (b) risk assessment (documenting individual risks and overall risk), and (c) risk management plan.

Interview Schedule

Semi-structured interview questions were developed for two interview phases. The first set of questions related to the participant's completion of the risk assessment and management plan (tool) for the case scenario. The second set of questions focused on risk assessment and management in the participant's daily work, exploring perceptions and knowledge of risk assessment and management.

Ethical Considerations

Ethical approval was obtained from the relevant University and Hospital ethics committees. Participants signed a consent form and were later provided with an opportunity to check transcripts for verification purposes (National Health and Medical Research Council, 2007). One participant declined the use of their interview data, citing that they did not feel that they had articulated satisfactorily their perspectives on risk assessment and management.

Due to the small number of staff in the service, participants are not identified by their discipline; although it should be noted that discussion of core themes was similar across professions.

Data Analysis

The method of analysis was a hybrid thematic approach utilising the data-driven inductive approach of Boyatzis (1998) in order to reach higher levels of interpretive understanding. The thematic analysis was based on emergent issues from the text, as well as the research questions of the present study in an iterative process. Thematic analysis was used as "a coherent way of organizing or reading some interview material in relation to specific research questions. These readings are organized under thematic headings in ways that attempt to do justice both to the elements of the research question and to the preoccupations of the interviewees" (Burman, 1996, p. 57).

Interview transcripts were divided between research team members, who were responsible for developing preliminary codes and emerging themes for their transcripts. Once the research team had formulated a list of all emergent themes, each researcher read all transcripts and was responsible for coding particular identified themes. The team regularly met to discuss findings, and one researcher read and coded all transcripts and compared this analysis with those of the individual researchers. Research team members also examined the transcript coding of other team members, using extracts of interviews. In the majority of cases there was agreement on coding, and any differences were discussed and resolved.

Rather than separate the two phases of the interview, the interview transcripts were coded as a whole in order to provide a coherent picture of the participants' decision-making regarding risk assessment and management. As such, we have not included a detailed analysis of the outcome of participants' application of the tool to the case scenario (the paper reporting these findings is available, upon request, from the authors). Examples are given in the results section of both where participants spoke specifically of the scenario, and where they focused on their clinical decision making more generally.

RESULTS

When discussing risk assessment and management, the participants drew on two main standpoints: a managerial view and a therapeutic view. The managerial standpoint is characterised by a focus on the risk the consumer poses to others, and incorporates systematised processes and procedures. The therapeutic standpoint is characterised by a focus

on risks to the consumer, including risks to dignity, autonomy, consumer rights, and individualised care oriented around the notion of recovery (incorporating the positive benefits of risk for the consumer).

The findings indicate that the mental health professionals integrated these two standpoints into their clinical practice. We argue that rather than being dominated by managerial concerns regarding risk, the participants demonstrated professional autonomy and concern for the needs of their clients. This can be seen in the following discussion of the study themes, namely: Purpose of Risk Assessment, Process of Risk Assessment, Responsibility for Risk Assessment, and Mastery.

Purpose of Risk Assessment

The purpose of risk assessment was identified as keeping the consumer, their family, the community, staff, and other consumers safe. As such the participants saw risk assessment and management primarily as "a preventative tool" (Participant 6), although the eradication of risk was seen as an unrealistic goal:

> . . . that's what you're aiming to work towards, that it's a low risk and that it's managed as best it can be, and that the risks are identified, you can't necessarily get rid of those. (Participant 4)

This is, in part, because the focus of assessment is on potential, rather than actual, risks, which makes it difficult to predict risks with definitive accuracy.

There was a tension in participants' discussion about risk in their day-to-day practice, and about the potential risks posed by the fictional consumer, Jim, described in the case scenario. In particular, tension was noted between the managerial focus on systems for prevention and ensuring safety versus delivering individualised care that was mindful of the rights of the consumer, as can be seen in the following comment:

> I can't tell you it's black and white, every case has to be judged individually and you treat each patient as an individual, but you obviously have to protect staff, other patients, too, so you set up systems that will protect people. (Participant 1)

Clinicians therefore had to balance these competing interests.

Balancing risk prevention and individualised care provides both a philosophical and a practical challenge. This is particularly the case with high risk or detained clients, and potential worst-case scenarios were cited as reasons for hyper vigilance, as can be seen in the following comment about Jim:

> . . . if we say he only needs hourly sightings, but in the mean time he goes and half kills another patient because we haven't checked on him for 45 minutes, it's a coroner's case. (Participant 5)

Other participants noted the risk aversive nature of risk assessment and management and highlighted how this could lead to interpreting more in a situation than is warranted by the available evidence, with subsequent negative implications for the consumer.

Process of Risk Assessment

The tensions between managerial and therapeutic standpoints can also be seen in participants' discussion about the process of risk assessment and management. Drawing on a managerial approach, this process is described as a staged, structured, linear, and "systematic process" (Participant 1), involving the identification of risk and planning for how it will be managed. Identifying risk and establishing goals and specific strategies determined consumer care and were seen as the "building blocks of care" (Participant 5).

By contrast, a therapeutically oriented process was described as non-linear and non-static. For example, a community team member discussed how it was important to be in the moment with the consumer and use all opportunities to assess risk, rather than focus specifically on the linearity implied by the paperwork:

> I think some new staff don't necessarily appreciate that; they have their paperwork, correct that bit, and go on to the next bit of paper and it's sort of knowing how to do a complete assessment of the situation. (Participant 4)

Another participant discussed the importance of adapting the management plan to reflect changes in the consumer's condition over time:

> I would hate to be thinking there's a risk assessment out there that's still the same, I'd be concerned, it should change. (Participant 10)

In order to manage the competing emphases of managerial and therapeutic standpoints, the participants generally highlighted the importance of clinical judgment based on experience in the assessment and management of risk. This was evident in the ways in which they drew on various sources of information in their risk assessment.

Information

The risk assessment process described by participants involved the use of diverse information, weighing multiple interdependent factors to obtain an overall picture of risk. In this way, assessment became a consideration of the interrelationship of multiple potential risks, which can be seen in participants' discussions about Jim. One participant believed that Jim's temper was not "a risk in itself," but that "when it's mixed with a couple of other things . . . it contributes to the risk" (Participant 1). Risk assessment therefore involved piecing together numerous sources of information (e.g., medical, psychological, observational) and making a judgment about what is or is not relevant in relation to risk.

There were important sources of information that were considered valid by the participants. One of the first avenues for information was through observation and interaction with the physically present consumer, which occurred over time. Other health professionals, such as the general practitioner, and engaged services would be contacted, as well as police and paramedics. Family and caregivers were identified as a rich source for collateral information and care planning, particularly when they have cared for the client and have knowledge of their history. One participant identified that information from Jim's family and caregivers provides insight into "knowing him with his illness, but [also] knowing him before that" (Participant 6).

The case history of the consumer was discussed at length, particularly the context of the admission, including events prior to hospital presentation. It was deemed important to understand whether issues (e.g., domestic violence) were long-standing or had occurred in relation to illness, as this would have implications for risk, diagnosis, and strategies of care. While several professionals believed that history was very important, it was stressed that aged-related changes through dementia could involve dealing "with something completely new" (Participant 6), even between the current and most recent previous admission. History of hospitalisation was important for another reason: mainly as "current armoury" (Participant 5) in determining triggers and potential interventions. In general, then, history was to be used carefully and in conjunction with a range of other information sources:

> It's just one factor, a person may have no history but then there's a whole series of circumstances which put the person at acute risk. (Participant 14)

Responsibility for Risk Assessment

There were two opposing views regarding who is responsible for risk assessment and management. Risk assessment and management was officially seen as the doctor's responsibility, with formal risk assessments during the week and at business hours being conducted by a doctor (outside of regular hours, mental health nurses, in collaboration with another nurse, could conduct the assessment). Participants cited psychiatric knowledge and legal responsibility as the reasons for this. However, participants also stated that risk assessment was the responsibility of all staff, and that the best way to come up with a risk management plan is to talk with the other members of the consumer's care team: "Like five fingers of a hand, work well together" (Participant 5). Professionals often referred to making use of not only the skills and expertise of other discipline perspectives, but also their own knowledge of the components of consumer care: "you've also got to be a little bit multi-d in yourself, I think" (Participant 9).

In practice, collaboration occurred through joint assessments, consulting with other professionals after assessment, and intake referrals and ward rounds involving members of the team. Participants, however, reflected on their own responsibility as case managers or nurses: "Ultimately [the doctors are] relying on you … you need to be sure that you're feeding back the appropriate information" (Participant 4). In this way the nature of shared accountability became apparent, which could lead to reluctance to be the one who is ultimately responsible for a risk-related decision:

> It's so much a blame culture I think as well that nobody wants to be the one to say, "Yes, I think that person is safe to be at home." (Participant 4)

Participants also drew on therapeutic concerns when considering consumer involvement in decision-making. Almost all participants acknowledged that the role that the consumer played depended on factors such as level of acuity and age-related issues, such as dementia. One participant discussed how they would often involve the consumer in risk assessment by communicating the nature of the process and what they had found, stating: "I don't think there's anything to hide" (Participant 9). This transparency was important

particularly in the early stages of hospitalisation where procedures and rights (e.g., Mental Health Act) are foreign to the consumer, and strategies to reduce risk are often more staff-led.

Most participants focused discussion of consumer involvement on risk management rather than assessment; in most cases, this reflected improvement in a consumer's mental health and a subsequent greater role and responsibility in their management. One participant reflected on a range of notions in addressing whether the consumer can play a role in their risk management:

> We encourage [consumer involvement]. I firmly believe that empowering someone to be their own barometer in life is the best … way for recovery, however a lot of our clients really aren't in that situation of being able to do that, especially on initial admission, but as time goes on the recovery model is to invite them to participate in their own recovery, their own progress. (Participant 2)

However, this participant acknowledged that the focus on recovery by individual clinicians might differ: "I really don't know how much each individual nurse does enable the client to be the participant" (Participant 2). Other discussions regarding involving consumers revolved around the practicalities of management rather than consumer goals, and so recovery, as a theoretical notion, was more often referred to implicitly, rather than explicitly. That being said, issues of risk assessment and management being "about the consumer" (Participant 7) and references to "ownership" (Participant 7), "participating in the whole management" (Participant 6), and "a right to be involved in their own care as much as possible" (Participant 5) were often present.

Although only discussed at length by two participants, a further tension was apparent in regard to the role of consumer choice in risk management and the ability to "take risks." One way to navigate this was to for the clinician to take on the role of overseer and be responsible in an overarching way while still allowing the consumer to take personal responsibility:

> Certainly as a clinician you feel that you need to oversee the process with your clinical judgment but, at the same time, you're really endeavouring to get the client . . . to be as responsible as possible. Let's say, in terms of the wording, that there's equal responsibility there. (Participant 14)

Mastery

In the discussions about the knowledge and skills required for conducting clinically sound risk assessment and management, we once again see participants drawing on both managerial and therapeutic considerations. Participants highlighted the importance of formal training and development, and in particular training in the use of risk assessment and management tools and orientation to current research. They also discussed informal training, the sharing of intuitive knowledge by more experienced staff to support the novice clinician, and incorporating life skills into the risk assessment:

> Instinct, you need to have a lot of instinct . . . you know, you can't learn a lot of things out of a book so, therefore, life skills and having an awareness of reading body language. (Participant 2)

This related to the competency of the clinician to complete an assessment and develop a management plan, and included additional skills and attributes such as being motivated, objective, aware, precise, and sensitive and empathic to the needs of the consumer and caregivers. In this way, the therapeutic relationship was particularly important:

> Other people may have, individually, found a way to have a more collaborative relationship with a client . . . may just be a personal little way that they do something that is natural to them so therefore they can pass that on to others. (Participant 2)

While managerial and therapeutic concerns can be seen as conflicting, mastery was generally described as the result of the blending of formal training with more tacit understandings of risk.

Participants also discussed support mechanisms within the multidisciplinary team, particularly documentation and communication. Verbal and written communication among team members was seen as vital in being able to master risk assessment and management effectively: "We need to be on the same page and talk to each other" (Participant 10). This was particularly important given the nature of 24-hour care and the rotation of staff (e.g., both regular and agency nurses), and staff had a responsibility to use and receive communication mechanisms effectively:

> Other times, staff don't look at them [risk management plans] at all and that causes a problem, especially when there's an incident, you're answerable . . . and you go back and look at the risk assessment and no one's updated it and no one's written anything on it. (Participant 10)

The risk assessment and management tool was seen as an important way to gather information in a more structured and systematic way, ensuring certain areas were covered. This then leads to risk management considerations:

> I think probably in terms of highlighting crucial areas, key areas and by giving them a score then they can be prioritized . . . and again it helps staff in that it's a tool that promotes reflection and analysis of the situation and discussion. (Participant 14)

In this way, the tool allowed a "clear short snap of 'this is the areas we need to look at or work from"' (Participant 14), although some risks might lend themselves more to a score (e.g., harm to self and others) than others (e.g., level of support available, treatment response). The tool could also be used to discuss risk in more concrete terms, showing other professionals what has been documented, and could ensure continuity of care to the extent it was updated and accurate, "like a map" (Participant 3). However, while the risk assessment and management tool was seen as useful in facilitating structure and communication, participants acknowledged the nature of the documentation:

> They're an important thing, but I think we just need to be very careful what we write on them . . . I mean these go with the client and go to other places and I think that staff, all staff are thinking before they write things on them. (Participant 10)

Another support mechanism related to policy and procedure. Professionals spoke of the structure policy provided "to get a team all on track together" (Participant 13).However, responsive clinical practice was underscored, and the interplay between policy and practice became apparent:

> So policies and procedures can again alert you to important things and important steps to follow, but policies and procedures are always secondary I think to clinical judgment and things such as your intuition and integrity. (Participant 14)

Participants highlighted the importance of integrating risk management processes into daily practice and workplace culture, which facilitated the use of risk assessment and management processes, as well as the development of mastery of risk assessment.

DISCUSSION

This study demonstrated that for mental health clinicians, risk assessment and management form a large part of multidisciplinary practice, but also involve a tension between managerial and therapeutic concerns that the clinician must negotiate in his or her daily care of a consumer. The sample was limited to a small number of health professionals working in a specialised setting and used a single case scenario, but the data collected allowed a rich analysis of the issues involved in risk assessment and management.

Participants described their approach to risk assessment and management as a staged, logical and continuous process. This reflects managerial concerns with systematised processes and procedures (Quirion, 2003), including the move away from assessing the physically present patient to looking at records and collateral sources discussed by Godin (2004). However, while the participants in our study discussed the use of collateral information, they also identified the importance of assessing the physically present consumer. Furthermore, the participants acknowledged the complexity and diversity of assessing potential risk factors. Such complexity in analysing information has been found in other nursing research, where, for example, professionals make decisions in both structured and more intuitive ways (Thompson et al., 2009), and not always as normative models—which describe how decisions ought to be made, but do not take account of factors such as how much information or time an individual has—would suggest (Littlechild & Hawley, 2009).

Participants conceptualised the underlying purpose of risk assessment as ensuring safety, a perspective which accords well with dominant conceptions of risk assessment (Muir-Cochrane &Wand, 2005).However, this focus on safety had to exist alongside therapeutic engagement and individualised care. A similar tension was reflected in the findings of Bowers et al. (2006), where staff grappled with a balance between control (for example, when management strategies such as increased observation are required) and the wishes of the consumer. In addition, it was found in that study that when an adverse incident did occur, there was increased focus on risk assessment, patient monitoring, and ward security. While increased attention to assessment and management would ideally be accompanied by a concomitant decrease in adverse incidents (although this is complex, see

Daffern & Howells, 2002; Whittington & Wykes, 1996), there remains the potential for practice to become overly focused on predicting and preventing risk, which is not always possible. Indeed, participants in the present study reflected on challenges regarding this, at times, dual focus, suggesting that risk aversion can produce a situation where assessment is opposed to contemporary and mindful health care.

The tension between managerial and therapeutic concerns also was reflected in participants' discussions of responsibility. Professionals believed that consumers should participate in assessment and management and, in this way, a good understanding of the recovery model and notions of self-determination and least restrictive care were evident (World Health Organization, 1996, 2003). However, consumer involvement could be influenced by the nature of the presentation and individual clinician beliefs and practice. In the present study, a number of ways of implementing recovery principles were discussed, including involving consumers directly and giving them responsibility in their management, family and caregiver involvement, as well as additional factors such as open communication, and an acknowledgement of the consumer's right to take risks. Practices such as discussing with consumers their admission, the ward structure, and treatment have been identified as important to reducing incidents of absconding and other risk behaviours in acute-care settings (Mosel, Gerace, & Muir-Cochrane, 2010), and as particularly important in facilitating an adjustment to care settings for older persons (e.g., Meehan, Robertson, & Vermeer, 2001). More explicit attention to recovery principles may, therefore, be needed. In addition, a particular challenge seemed to exist early in an admission where the clinician may feel particularly responsible for patient safety, and recovery and management were seen as more suitable once the patient moved beyond an initial acutely-unwell presentation and passive role (see Davidson, O'Connell, Tondora, Styron, & Kangas, 2006; Thompson, Powis, & Carradice, 2008).

In the present study, nurses' perceptions of their role in risk assessment was more clearly delineated than previous studies (Bishop & Ford-Bruins, 2003). This may relate to a stronger role and expectation of nurse involvement in the multidisciplinary team in this service. However, the primary role of the doctor in formal documentation and a hierarchy of responsibility also were discussed, and analysis revealed that clarification of responsibility (e.g., legal or professional) and shared accountability and establishment of practices consistent with this may be needed. Responsibility concerns did emerge and "the culture of blame of individual professionals, which prevents their using their professional judgment" (Littlechild & Hawley, 2010,

p. 226) was apparent. However, while very much aware of legal responsibility and adverse incidents, risk assessment was not discussed solely as a documentation exercise or legal requirement. Instead, it was an important part of clinical practice and a significant part of overall assessment. It may be that the integration of risk assessment and management into practice in the form of admission meetings, hand-over, ward round, and before initial home visits, contributed to such a perception.

The tool was seen as important in documentation and analysis of risk, although there was concern in focusing on the tool instead of conducting a fuller assessment. Therefore, a balance between using and not becoming encumbered by the tool was important (Godin, 2004). Both formal and informal training and development was seen to be important to effective risk assessment that balances managerial and therapeutic concerns, with more experienced staff seen as potential resources for young clinicians. Professional development of clinical judgment and analytic and therapeutic skills could be accomplished under supervision and, in this way, responsive and reflective clinical practice was seen to be important in developing risk competency (Alaszewski, 2006).

CONCLUSION

The present study demonstrated the integration of both managerial and therapeutic concerns into the risk assessment and management practices of acute care and community mental health professionals working in the service. Rather than being dominated by managerial concerns regarding risk, the participants demonstrated professional autonomy and concern for the needs of their clients. The ability of health professionals to maintain autonomous practice despite the increasing dominance of management in contemporary health care has been found in other studies (Ruston, 2006; Sawyer, 2009).

Future research should investigate consumer and caregiver perspectives on risk assessment and management, and make use of a number of real-life scenarios (or examination of real practices on the ward) to further explore and verify key processes and practices uncovered in this study.

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Table 1. Participant work and demographic information

Work and demographic factors	**Sample details**
Work setting (acute or community)	Acute (*n*=9); community (*n*=1); both acute care and community (*n*=5)
Participant ages	*n*=12 aged 40-64 years, *n*=3 aged 25-39 years
Profession	Nurses (*n*=9; 7 mental health trained registered nurses; 2 registered nurses without mental health training); psychiatrists (*n*=2), psychologists (*n*=1), social workers (*n*=2), occupational therapists (*n*=1).
Experience in mental health	*Median*=12 years (*Range*=0.5-35 years)
Years total service in profession	*Median*=12 years (*Range*=0.5-39 years)
Months worked in ward/service	>24 months=7; 18-24 months=3; 7-12 moths=3; 1-6 months=2