The Online Multi-Agency Intervention and Support Barometer

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'stronger together'

The Project Team

Child and Adolescent Mental Health Unit (SEPT)

Professor Samuel Stein (Child and Family Psychiatrist),
Helen Butler (Research Assistant)

Institute of Education, Thomas Coram Research Unit

 Dr Sarah Crafter (Research Consultant),

University of Northampton

Dr Lesley-Ann Smith (Research Assistant)

The Project Team

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This report presents the findings of a small feasibility study which sought to investigate the use of an online risk management Barometer. The barometer was developed with a view to helping multiple agencies communicate about vulnerable and 'at risk' patients within mental health settings. The research was commissioned by the South Essex Partnership Trust (SEPT) and undertaken by a team of clinical staff and researchers either within the Child Adolescent Mental Health Service (CAMHS) or academic institutions (Institute of Education, University of Northampton).

The Barometer is an online tool which allows staff from multiple agencies to access and share information with other staff if a patient is at risk. A traffic light system is adopted whereby either red (serious risk), amber (medium risk) or green (small risk) can be chosen in relation to a risk question. This small feasibility project sought to assess staff views of the online risk management Barometer tool. Therefore, the Barometer offers a way of providing an accessible, multi-agency, on-line risk assessment tool as a viable alternative to the variety of paper-based risk assessment tools presently used.

The key aims and objectives of this small research project are summarised as follows:-

- To evaluating how professionals felt about their current risk assessment tools
- To assess the ease of use and the relevance of questions within the Barometer tool
- To discuss some potential modifications/problem areas of incorporating the Barometer tool within mental health services and across a multi-disciplinary perspective

The research was conducted in three mental services within SEPT (2 x CAMHS and 2 x Adult Services) using a mixed-methods approach incorporating the use of one-to-one interviews, 'think aloud' methodology and two online questionnaires at different time points in the research. In total, 18 participants were recruited to take part in this research project. Participant involvement was separated into the following areas:-

- Baseline Interviewees – all 18 participants
- Experimental Group (CAMHS only and using the barometer) – 6 participants
- Control Group (CAMHS only but not using the barometer) – 7 participants

Summary findings

- There are a wide variety of current risk assessment practices both across agency teams and in some cases, within the same teams.

- Staff are well-versed in using paper-based risk assessment tools. These assessments vary across different services and are often specific to the Trust or a particular team.

- Staff who used the barometer felt that it provided a holistic patient-centred approach to risk management. Overall there was a consensus of opinion that the Barometer

tool could offer a viable alternative risk assessment tool to replace the variety of risk assessment methods currently used (the different methods of assessing risk within different services were seen as problematic).

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- Regardless of whether staff were describing current risk assessment practices or the use of the barometer most of the staff interviewed felt there should be greater clarity and better training for filling out risk assessments.

- Staff would like some parity with colleagues about whether they fill in their risk assessments in the same way. In terms of the barometer, training would need to take place around the meaning of the red, amber and green thresholds. Risk assessing was seen as something quite subjective.

- Staff differed in how they described their use of risk assessments. Some only used assessments in extreme situations (i.e. suicide), others only as a checklist, others as an aide memoir for clinical judgment; for others as a central part of their day-to-day clinical practice. The barometer would help standardize practices across the Trust but staff felt strongly that they should not have to fill in all 50 risk questions after the initial client assessment.

- Staff were positive about the use of computer-based risk assessment as long as it did not take longer than paper. All bar one participant using the barometer preferred the online approach to paper-based approaches

- The level of multi-agency co-operation varied by team. The use of a computer-based program (FACE) in one team did help with multi-agency communication. This suggests there is a great deal of potential for using the barometer, which unlike FACE, is totally accessible online in any setting.

- It was generally agreed that current paper-based risk assessments do not aid multi-agency working

- For most the barometer was straightforward to use after the first six or seven inputs. It was felt that the speed of filling in the Barometer became quicker with use. The 'traffic light' system was approved of by all those who used the barometer.

- One participant found getting to grips with using the Barometer at a time when there were staff shortages and very little time, problematic. Filling out the questionnaire during the client consultation time was difficult.

- There needs to be more research conducted on the content of the barometer questions as not all the participants felt the questions were relevant. Also, it should be made easier to skip some questions rather than just putting them in a green category.

- The sample of staff using the Barometer needed to be larger to gain a more well-rounded set of results.

Recommendations

Taking all the information to date, the following areas might prove fruitful for more discussion and thought:-

- Allocating more time for staff to complete the Barometer and risk assessment training (either in relation to the barometer or current risk assessment)

- A comprehensive training programme to both use the Barometer and assess risk with all stakeholder agencies concerned

- More practitioner input into the questions asked (this could involve other agencies such as social workers)

- A review of the questions on the prototype Barometer

1 Introduction

This report presents the findings of a small feasibility study which sought to investigate the use of an online risk management barometer. The barometer was developed with a view to helping multiple agencies communicate about vulnerable and 'at risk' patients within mental health settings. The research was commissioned by the South Essex Partnership Trust (SEPT) and undertaken by a team of clinical staff and researchers either within the Child Adolescent Mental Health Service (CAMHS) or academic institutions (Institute of Education, University of Northampton).

The report begins with a brief review of the literature and a background to the study, drawing together both academic and policy research to establish the context in which the research developed. Section 3 puts forward the aims of the research study. Section 4 describes the barometer and the methodological approach adopted in the study. The methods used to undertake the study to draw out the views of staff about current risk assessment practices and the use of the online barometer tool for evaluating risk. The findings of the study are examined in Sections 7, 8 and 9. Section 10 draws the research together, provides a summary of the findings and recommendations based on these findings.

2 Context of the study

2.1 Why Focus on Risk Assessment?

The multi-agency online risk management barometer was developed with a view to helping agencies communicate about vulnerable and 'at risk' patients within mental health settings. Local mental health services in the UK have been criticised for not managing patients who are at risk more effectively. Unfortunately, traditional risk assessment tools have generally proved be of limited usefulness, especially as they struggle to address multiple risks within a single measure and fail to facilitate effective communication between different professionals and agencies. Moreover, paper-based approaches to risk assessment make sharing information difficult and electronic forms of risk assessment have not worked well within current service provision.

Such concerns around assessing risk and communicating pertinent issues between stakeholder agencies have become increasingly prevalent within the media and social policy (Davies & Ward, 2012; Ward et al, 2004; The Laming Report, 2003). More notably, high profile cases involving the death of children revealed that different agencies (i.e. social workers, medical professionals) were aware of harm and neglect being inflicted upon the children but there were problems with communicating concerns (recording invariably involving the use of a variety of manual, paper based systems). The use of divergent risk assessment tools resulted in a lack of shared communication and agencies were assuming and relying on other service provisions to take the necessary undertakings to ensure safety rather than drawing up a coherent, multi-agency plan of agreed action.

Issues involving a lack of 'joined-up' thinking and sharing of information were also pivotal in the case of Ben Silcock.   In 1993, Ben Silcock, a diagnosed 'schizophrenic' was found in the lion's enclosure at London Zoo after having been mauled by some of these creatures.   This particular case drew attention to the negation of multi-agency communication after the introduction of the 'Care in the Community' programme with headlines thus; 'Which community, what care? Both have failed Ben' (*The Sunday Times*, 10 January, 1993). Such headlines were written as a result of Ben's father who subsequently drew media attention to how his son had received patchy and inconsistent treatment within service provisions. Although this is an old case, these are important factors to consider further in terms of effectively assessing risk as young and older adults with mental health difficulties usually come into contact with a diverse range of support services.   In this way, 'Care in the Community' has had to evolve into a new way of thinking and treating people with mental health difficulties living in community settings as opposed to the historical confinement within psychiatric institutions.

2.2 Risk and Mental Health Distress over time

Of course, risk does not just involve forms of abuse carried out upon particularly vulnerable members of the community such as young children but it is an issue encompassed within mental health distress symptomologies.   For example, the risk behaviours of self-harming and attempted suicides can form a regular pattern of life for some service users. Issues such as these can be further compounded by a lessening of social network supports or financial difficulties for example. This complex area covers the life-long spectrum, from child

and adolescent mental health through to working and older adults. Nevertheless, it would be reasonable to suggest that with this complexity, risk within mental health distress does not operate on a level continuum. Uncontrollable outside triggers can create a critical situation of risk which can arise outside scheduled clinical appointments with mental health professionals. This can also be the case for some people who have not been admitted within mental health provisions such as teenagers experiencing acute problems with stress due to examinations or bullying for example.

## 2.3 Technology as a tool for managing risk over time

Adverse health and care incidents can be reduced in frequency by sensible contingency planning, and risk assessment is therefore a national clinical governance expectation (Subotsky, 2003). One way to streamline risk management and improve communication is to move away from paper-based recording towards the use of cloud technology. There have been other examples of the use of technology to improve managing risk.

To our knowledge only two systems are remotely similar to our tool. One is the Common Assessment Framework (CAF) and the other is Child and Adolescent Risk Assessment Suite (CARAS). The CAF is an assessment and referral tool used to identify the needs of children (White et al., 2009). The CAF is essentially a Word document that covers broad thematic headings, which the practitioner comments on in various text boxes with a written qualitative description. It can be completed on-line or printed out and completed via hand. While there has been some positive experiences reported by practitioners using the CAF (Gilligan & Manby, 2008) there have also been substantial criticisms. For example, CAF is only able to identify concerns regarding a child, rather than a need (Pithouse et al., 2009). Many professionals felt that the structure of the form imposed constraints on the information they were able to provide resulting in ambiguity. More importantly, it is highly inefficient because the paperwork takes so long to fill in.

CARAS, developed by FACE, a health and social care software company, is a battery of screening questions and subsequent question schedules which identify risk factors, thus allowing for risk management plans to be formulated. However, given the extreme novelty of this software, independent evaluations of its efficacy are yet to surface. Neither CAF or CARAS are online tools but rather computer-based software. Since the barometer is Internet based, clinicians can log in using various platforms such as an iPad, iPhone, Laptop and Desktop PC, and update information whilst in the community as well as in the office. All information is stored on highly secure remote servers. The mobility aspect of the barometer means that clinicians have the most up-to-date information at all times and promotes effective communication.

2.4 How the barometer works

The Barometer is an online tool which allows staff from multiple agencies to access and
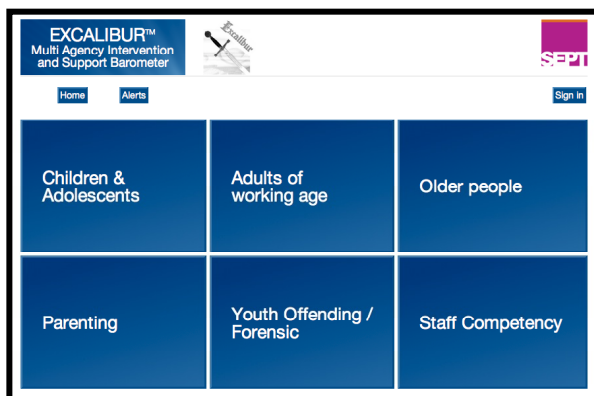
share information with other staff if a patient is at risk. The staff member (e.g. psychiatrist, GP, therapist, social worker) is given a secure log-in which takes them into the barometer where they can then find the client at risk within the database. The staff member is asked to fill out a series of fifty short questions based upon current risk assessment practices within CAMHS.

A traffic light system is adopted whereby either red (serious risk), amber (medium risk) or
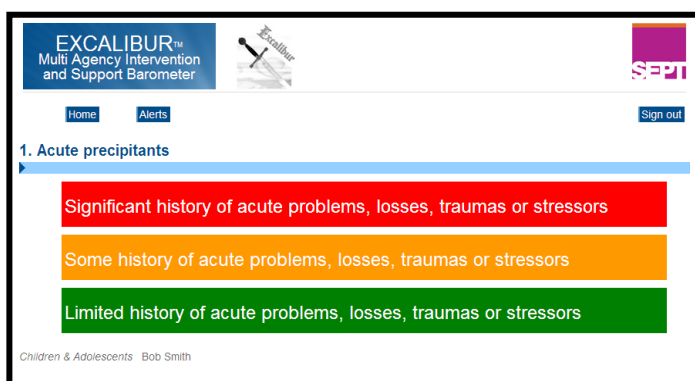
green (small risk) can be chosen in relation to each risk question. If risk on certain items is high (e.g. high suicide) then an alert can be sent to key staff so care can be provided in a proactive, rather than reactive, way. This tool is secure, can be accessed on the move, is user-friendly and recovery-focused.

The clinician can set up alerts in the form of a SMS or Email around specific criteria chosen by the clinician. The barometer produces a 'risk profile' which consists of various bar graphs depicting levels of risk, as well as highlighting risk questions answered red. These graphs provides a narrative of risk to be constructed, thus allowing clinicians to easily assess and compare fluctuations in risk levels over time.

The Barometer is an online tool which makes use of cloud technology. Being internet based, clinicians can log in using various platforms, iPad, iPhone, Laptop and Desktop PC, and update information whilst in the community as well as in the office. All information is stored on highly secure remote servers and the software is managed by specialist healthcare IT marketplaces. The mobility aspect of the barometer means that clinicians have the most up-to-date information at all times and promotes effective communication.

3 Rationale and Aims

This small feasibility project sought to assess staff views of the online risk management barometer tool. We were keen to explore the usability of the Barometer as well as staff members' views of the risk assessment questions. Whilst the pilot study mainly involved professionals working within mental health services (i.e. psychiatrists, CPN's and therapists), the concept of including other agencies was a dominant feature during the initial brainstorming sessions. Therefore we did speak to some other professionals (paediatricians, GPs) early on in the project about their current risk assessment practices with a view to looking at their involvement in a larger project in the future.

Therefore, the barometer offers a way of providing an accessible, multi-agency, on-line risk assessment tool as a viable alternative to the variety of paper-based risk assessment tools presently used.

The key aims and objectives of this small research project are summarised as follows:-

- To evaluating how professionals felt about their current risk assessment tools
- To assess the ease of use and the relevance of questions within the Barometer tool
- To discuss some potential modifications/problem areas of incorporating the Barometer tool within mental health services and across a multi-disciplinary perspective

4 Methods

The research was conducted in three mental services within SEPT (2 x CAMHS and 2 x Adult Services) using a mixed-methods approach incorporating the use of one-to-one interviews, 'think aloud' methodology and two online questionnaires at different time points in the research. This section provides an explanation of the methods and analytical approaches used during the study, alongside an account of the ethical issues identified and responded to. The research was conducted in several stages and these are outlined and discussed further.

4.1 Participants

In total, 18 participants were recruited to take part in this research project. The overall participant sample consisted of male and female professionals working within specialized psychiatric services (child, adolescent and adult), Pediatricians, and one General Practitioner. All participants were aged 21 years and over. Participant involvement was separated into the following areas:-

- Baseline Interviewees – all 18 participants
- Experimental Group (CAMHS only and using the barometer) – 6 participants
- Control Group (CAMHS only but not using the barometer) – 7 participants

In line with ethical considerations all participants were given pseudonyms to maintain anonymity and confidentiality. Pseudonyms were chosen taking into consideration a participant's ethnic origin.

Table 1 – Participant Table

Pseudonym	Occupation/Area of Service Provision	Project Involvement
Barry	Community Psychiatric Nurse/Clinical Lead - Adults	Experimental Group
Jacqueline	Systemic Family Psychotherapist – CAMHS	Experimental Group
Adi	Senior Trainee – Adults	Experimental Group
Jaydeep	Psychiatrist – Adults	Experimental Group
Arjun	Associated Specialist – Adults	Experimental Group
Dinesh	Consultant Psychiatrist – CAMHS	Experimental Group
Anne	Systemic Family Psychotherapist - CAMHS	Control Group
Babu	Psychiatrist – Adults	Control Group
Alice	Clinical Psychologist – CAMHS	Control Group
Aamir	Psychiatrist – Adults	Control Group
Peter	Consultant Psychiatrist – CAMHS	Control Group
Lutanga	Clinical Lead – Adults	Control Group
Tom	Community Psychiatric Nurse – Adults	Control Group
Anne	Consultant Pediatrician	Baseline Interviewee

Klaus	Consultant Pediatrician	Baseline Interviewee
Michael	General Practitioner	Baseline Interviewee
Dev	Psychiatrist – Adults	Baseline Interviewee
Claire	Clinical Psychologist – CAMHS	Baseline Interviewee

4.2 Data collection

Three forms of data collection have been used:

Baseline interviews

As the process of assessing and managing risk varies tremendously between different services it was decided that initial interview data collection would be focused around gaining baseline information about the risk tool in a variety of settings. The baseline interviews were conducted with all participants (experimental and control) as well as other professionals who work with at risk children, adolescents and adults including pediatricians and a General Practitioner (participants working outside of psychiatric services were involved in just the baseline interview and did not participate in any subsequent interviews).

All baseline interviews were conducted on a one-to-one basis between the researcher and the participant at a mutually agreed location within the working environment. The interview schedule focused on several themes including: "what current risk assessment tools are used?", "how happy they are with that tool?", and "how the tool facilitates multi-agency working".   The interview schedule was developed by the CAMHS Research Team. All participants were asked to read and sign an Informed Consent. In this way, permission was sought from all respondents to audio record the interviews for transcription and analysis purposes only.

The control group then continued with their usual risk assessment practices. Only the experimental group were asked to use the barometer in addition to their current risk assessment activities.

The Experimental Group

In addition to undertaking the baseline interview, participants allocated to the experimental group were asked to use the online Barometer tool for a period of five months. Participants in this group were sourced from selection of child and adult psychiatric services.

Training and 'think-aloud' methodology

The staff members who undertook to use the barometer were given a one-to-one training session and a small accompanying guide. Since one of the aims was to evaluate the use of the tool as it interfaces with the user it was proposed that this introduction would be captured using 'think-aloud' data (Young, 2005). The 'think-aloud' technique requires the research participant to speak aloud the thoughts in their head while they work, which is then captured using audio recording.

Online survey

An online survey was conducted at two time points. This survey focused on participant's evaluating the use of the Barometer. The first survey captured data from January 1st 2012 until mid-June 2012 with the second survey launched from 1st July 2012 to the 31st August 2012. The survey asked a series of questions around the use of the barometer tool and participants were asked to numerically rate features using a likert scale rating. Questions centered on the general use of the Barometer such as ease of use and questions around specific functions (the email alert system for example). The survey also focused on the risk management questions themselves and this included if there were any confusing questions, any irrelevant questions or if any important questions had been missed out. The online survey was developed by the CAMHS Research Team and utilised the Bristol Online Survey website. A paper survey was also made available and distributed to participants upon request.

Final Evaluation Interview

All experimental group participants were asked to undertake an 'exit' one-to-one audio-recorded interview. The interviews enabled the gathering of in-depth experiential views, which were not possible using the online survey-based method alone. For the participants using the Barometer this interview provided the opportunity for them to discuss in greater detail their experiences with the Barometer.

Topics covered included: 'positive and negative aspects of the barometer tool'; 'fluctuations of opinions over time'; 'technical difficulties and the facilitation of risk management'. Again, permission was sought from all respondents to audio record the interviews for transcription and analysis purposes only.

Ethical issues

The study was submitted for scrutiny and approval to the South Essex Partnership Trust Research Ethics Committee. Informed consent was required from all participants prior to taking part in any and all of the research phases. Project information sheets/leaflets were developed for each stage of the study. These explained the nature of the research and shared contact information for the project team.

All participants were asked to sign a consent form indicating their willingness to take part and for their data to be used in subsequent reports, publications and dissemination activities. All participants were made aware at each phase that they were able to withdraw from the research at any time with no penalty.

At all times during data collection confidentiality was assured; recorded interviews were anonymised using pseudonyms. All transcribed material and other data collected as part of the project was stored securely, according to the guidelines set by the Data Protection Act (1998) and the Freedom of Information Act (2000). All electronic information was filtered with anti-virus software. All members of the research team have experience in following strict ethical codes of practice and all have Criminal Records Bureau clearance.

5 Analysis - Baseline Interview - Current Risk Assessment Practices

The analysis is presented in the order in which data was collected. Therefore, the first section will present an analysis of the baseline interviews whereby all participants were asked to talk about their current risk assessment practices. There will be a brief presentation of data collected during the training for the barometer, followed by a presentation of the analysis from the two surveys. The final section will focus on what was discussed in the final interviews undertaken with staff members who had used the barometer.

Eighteen baseline interviews data were analysed looking for similar patterns or themes around what issues were raised by the participants. Four key themes emerged from the data collection and they are 'Subjective use of risk assessment tool', 'Purpose of Risk Assessment', 'Technological Interfacing' and 'Multi-Agency /Team Working'. Some of these themes have sub-themes because of the complexity of answers given to the interview questions. These themes and sub-themes are displayed below:-

Table 2 – A description of themes around current risk assessment practices.

Main Themes	Sub-themes	Description
Subjective use of risk assessment tools		This theme addresses how participants view risk assessment tools in a variety of ways. Overall, this theme addressed various aspects of staff experiences of risk assessment tool.
	Current risk assessment tool (not Barometer)	Participants descriptions of their current risk assessment tools
	Ways of using the tool	The variations in the use of risk assessment tools within and across discipline areas
	The (un)sharing of risk	Descriptions of how risk is tailored to individual professions/disciplines.
Purpose of risk assessment		Staff drew on a variety of explanations for why it was necessary to undertake risk assessments and what purpose they served
	Risk assessment for protection	Addresses participants discussions about 'who' risk assessment protects
	Checklist vs important tool	Refers to the depth of use of the barometer by staff
Technological interfacing	Computer vs paper	Participants were asked to comment directly on using technology to manage risk

Multi-agency/team working		Participants descriptions of working across and within services such as helpful discussions with colleagues

5.1 Theme One – Subjective Use of Risk Assessment Tools

This particular theme explores how participants' view risk assessment tools in a variety of ways. What is of interest here is how clinicians view the importance and efficacy of such tools and how these could be improved in the future. The views are highly subjective and varied. The sub-themes of 'Current risk assessment tool (not bggarometer)', Ways of using the tool' and 'The (un)sharing of risk' will be discussed further.

5.1.1 Current risk assessment tool (not Barometer)

The use of a risk assessment tool was discussed as a regular feature within clinical practice with all participants well-versed in completing assessments. Participants were asked which current risk assessment form they used.

In the following extract Alice, a Clinical Psychologist in CAMHS discusses using a recently introduced Risk Management Form.

> *"The only form I use is the one that has been introduced into the Trust a few months ago which is the Risk Management form that is now put in all files as standard now for all clients so I always complete that…I think it is quite straightforward. It is on once piece of paper, you can have it in your session with you so you can make sure you are thinking about the questions with the client which I think is really important. If we were to use a computerised one and the client was not there I am not quite sure how you would make sure you asked the relevant questions. I think it is quite important to have a tool that you can have with the client there so you can make sure you are covering all the areas. Although it is quite a limited technique on how many questions there are, it is all on one side of paper so I guess it is limited in that way. At least you can have it with you and you can make sure that you are thinking about all of that during the assessment which I think is quite helpful. I think the down side is that you are committing to something how risky someone is based on one meeting but actually that is probably in a way the reality of our job and that is what we do if we are doing emergency assessments."*

Here Alice talks about the ease of using an assessment on one piece of paper, which can be completed during a session with a client. Alice does have some concerns that using a computerised system might have potential problems in that clinicians may not always remember to ask all the pertinent questions required. However, Alice does acknowledge that the risk assessment tool she is using at this time is limited due to all the questions contained on a sheet of paper. Such issues could be overcome with the use of technology such as clinicians having continuous and sole use of an I-Pad for example.

One downside which Alice draws attention to is the focus on providing subjective evaluations after one meeting with a client. Arguably this is a viable concern if there is no other input

from other professionals in contact with clients on a regular basis. The use of the barometer tool could alleviate such concerns as a record of on-going transactions between clients and professionals would be recorded and therefore would readily be available, providing a history of risk measurements for each client.

In the following extract, Adi, a Senior Trainee with adults, discusses the use of an assessment within a closed psychiatric ward environment:-

> "Approximately a year and a half ago our Trust came up with a proforma in which, but I don't think it is nationally recognised tool. It is something that was locally conceived and it has been routinely used. The standard questions we ask are, this is usually done when we are planning to send them out on leave and this is valid up to 2 hours of them going out on leave. So if after those 2 hours they decide to go out, one has to be repeated. The standard questions we ask are: where are they going to? How long are they going for? Whether they have any thoughts of wanting to harm themselves, thoughts of wanting to harm others or whether they are thinking about suicide, whether there is a risk of them being perceived as an easy target by others, are they likely to be spending excess amount of money, how much money are they going out with. These are the kind of things we ask."

For Adi, the Trust she works in has produced a 'proforma' type of assessment before patients can be allowed out 'on leave', which suggests that the risk assessment tool used within this particular psychiatric institution is still at an early stage of use. Furthermore she discusses how it is not a nationally recognised tool and is only used within the immediate vicinity. Subsequently, professionals working within other psychiatric institutions and in other relevant areas would probably not have access to the historical records of mental health patients – possibly even if patients are eventually discharged into community care. This set of potential problems could be overcome by the sharing on client information on one system.

In the following data extract, Claire, a Clinical Psychologist within CAMHS, talks about the current risk assessment tool she uses:-

> Claire: "It is fine, fairly thorough, though it has never been explained to us, how we need to be using it and about what triggered its introduction so I have got no idea whether I am completing it the same as other people though I think I am. I don't have much clarity on that as it has only been going for a few months and so I fill it out at initial assessments and am told that I need to be repeating it every X number of weeks and months."
>
> Interviewer: "Do you feel comfortable in deciding when to repeat it?"
>
> Claire: "Not really, we haven't had any guidance, though obviously when I am concerned about a client I would be thinking about risk and making notes about it."

Claire discusses the positive aspect of the risk assessment in that the points within this tool are thorough but there is some ambiguity around the rationale of using this particular assessment and, furthermore, if it is a standardised assessment used across the service as a whole. Subsequently, within Claire's narrative there are elements which suggest that a lack of communication and training of this assessment "*it has never been explained to us, how we need to be using it and about what triggered its introduction so I have got no idea whether I am completing it the same as other people though I think I am.*" Here a formal

introduction to a risk assessment tool together with in-depth training would overcome any potential problems and anxieties felt by practitioners and provide a coherent and comprehensive risk assessment framework which everybody understands.

5.1.2 Ways of Using the Tool

This theme emerged as participants discussed the various ways in which their current risk assessments functioned. Explored within the following data extracts are the divergent methods used by practitioners such as verbatim records, asking pertinent questions only and the use of risk assessment tools under critical situations only.

Barry, a Community Psychiatric Nurses working with adults discusses how risk assessments are reviewed every 6 months unless there a critical situation emerges such as a client feeling suicidal:-

> *"Normally I guess we would look at it every 6 months, unless of course on a visit to a client they said that they were particularly unwell, suicidal and particularly if we were that concerned we would like to involve the Home Treatment Team then we would do a new risk document at that moment and then send that over to the Home Treatment Team so it is really triggering what the client says is the decision when we would use this tool. It is not every time we saw them, we only do it if there is a particular issue."*

In this way, this particular risk assessment is used mainly as a reactive measure which appears to be used at heightened levels of concern by practitioners which in turn generates the involvement of other services (e.g. the Home Treatment Team).

Ellisa, a Systemic Family Therapist working within CAMHS describes the type of risk assessment she was carrying out at the time of interview:-

> *"The form is very quick and that is good because it probably does the job of making you having to assess and record somehow and it is quick so you don't have to go through a lot of things. Just a tick and a sign and the date… As I say, I use it just to tick there is no problem so it has worked really well. I have never had to use it as yet when actually there has been a risk."*

In her narrative, Ellisa describes how the form is quick to complete and perhaps more importantly that having documentation to complete such as this requires a practitioner to carry out assessments which are subsequently kept on record. Nevertheless, Ellisa talks about how she uses this particular risk assessment as a means of recording (by using a tick box method) that there are no potential problems to highlight and at this time, she had not been presented with a client who could be deemed 'at risk'. For Ellisa, her current risk assessment does not take up too much of her time, a history is recorded by ticking boxes but as she has not experienced any heightened levels of risk this particular system she is describing may benefit from a more holistic approach with the input of other professionals who may identify areas of risk not included within this particular assessment.

In the following data excerpt, Claire discusses how she completes a standard CAMHS risk assessment form on initial contact time spent with clients. This suggests that risk assessment is something done at the initial meeting of a client rather than an ongoing

process. This does not mean however that assessments are not continuous within this particular service provision but that emphasis here is on the levels of risk associated within the initial contact time.

> *Interviewer: What current risk assessment tool/form do you use?*
>
> *Claire: A standard CAMHS risk assessment form for initial assessments and then more generally if I am worried about the case I will discuss with other colleagues.*

Other practitioners discussed drawing on the opinions of colleagues when a particular issue of risk came up. Claire does not elaborate if these discussions are formally recorded either on the risk assessment form or within the clinical notes. To offer a more comprehensive picture of higher levels of concern or indeed a lessening of risk, the barometer system allows practitioners to input a record of relevant information which in turn allows other practitioners to be aware of assessment outcomes in the order in which they happen.

5.1.3 The (un)sharing of risk

Within this sub-theme narratives emerged of the ways in which risk can be modified and subsequently adopted by the different roles and disciplines eminent within mental health service provisions. Here, a divergence of what constitutes risk could be variable between certain practitioners (i.e. a psychiatrist and a therapist) and the various levels of professional experience.

Aamir, a psychiatrist working with adults draws attention to the differences of perceiving risk between experience and inexperienced clinical staff.

> *Interviewer: What aspects of this assessment would you want to change if any?*
>
> *Aamir: At present I don't have any scales or anything that I use to measure and compare or that everyone would use the same rating*
>
> *Interviewer: Is there anything else you would like to add regarding your current risk assessment procedures?*
>
> *Aamir: Well obviously the risk tool does help but there might be differences between experienced or inexperienced nurse to doctors. So if there was something that would even out.*

Aamir suggest that perhaps using a system incorporating 'scales' or a system offering various levels of measuring risk would perhaps alleviate any differences when assessing risk.

Adi, a Senior Trainee working with adults emphasizes the subjective nature of completing risk assessment tools.

> *"It (risk assessment) is a very subjective kind of a thing so I think the more experienced you are the more good you would be at picking out risk. It is one question that is going to give the same answer, perceive the risk in everyone, so it is a lot to do with the experience of the person."*

For Adi, the ability to be able to pick up on potential risk issues depends on the experiences of practitioners, with less experienced practitioners being less able to assess risk effectively. Perhaps with a formalised training programme of assessing and managing risk for all professionals involved would go some way to ensuring that risk is perceived and controlled in a more unified and systematic manner.

Michael, a General Practitioner discusses how concerns around risk are managed on a weekly basis within the practice he works in.

> *"I guess we do have a practice meeting every week and we do discuss those families about which we have concerns and I guess we normally have two or three families that we would be discussing because we have concerns. Either about the clinical course, or generally it is about the social clinical mix that is going on and the mother having depression, or not coping very well. So we do do that, and that will be recorded in the minutes at the practice meeting. We have also have a health visitor there, so we are passing over that information but we don't formally record it, e.g. "we think the risk is" red, amber, green, or 1,2,3,4,5 or whatever it might be.".*

Rather than completing and sharing a formalised risk assessment tool, Michael talks about how individuals or families where a higher level of risk may exist are verbally discussed and then recorded within the weekly meeting minutes. This information is then shared with other professionals, such as a health visitor. What is important here is that this particular system is not formally recorded as a shared risk assessment tool and it does not allow practitioners to rate or code different levels of risk such as the use of the 'traffic light' system.

For Babu, a Psychiatrist working with adults, the sharing of risk with other professional agencies via the means of formal assessment is an important tool in managing risky issues with clients.

> *"I think if I go by my clinical practice, I can identify a lot of people who suffer from risk to themselves or other people and because we identified we refer them to specific agencies like the Home Treatment team, the Crisis Intervention team etc and by that the risk is managed. It is more or less day to day life, so if I take any clinic I can identify one patient with whom I assess the risk and dealt with it properly and in that case I think it is a good job in order to contain the risk."*

Here risk levels are shared and specific agencies are subsequently made aware of potential client risks in order that interventions can be put in place to control higher levels of risk. As Babu discusses this could involve other professionals such as the Home Treatment Team. It would be reasonable to suggest that having a shared access to such information affords a more holistic and responsibility is thereby shared between agencies in the on-going management of divergent risk levels.

5.2 Theme Two - Purpose Of Risk Assessment

The previous section has drawn our attention to the variant and subjective uses of different risk assessment tools across certain parts of health/mental health service provision. In a similar vein, this next section will show that staff see risk assessment tools as serving a

variety of purposes.

5.2.1 Risk assessment for protection

In an increasing age of litigation, institutions such as the NHS have a requirement to provide a documented record of client and practitioner interactions. In this way, should a complaint arise from a client as to their unsatisfactory treatment for example, Trusts and practitioners have a written record of events to either uphold a complaint or not. This is where an accessible 'paper' trail detailing all contact with clients and clinical outcomes become of paramount importance. With regards to risk, this theme of assessments as offering a means of legal protection for both the NHS Trust and clinicians was an interesting area to discuss further.

Claire a Clinical Psychologist in CAMHS spoke about how she perceived tools such as risk assessments as serving as a written record to defend any potential negative outcomes from a client's point of view.

> *"I suspect it is to do with the Trust wanting this so if something goes wrong with the client, everything is in place as they will have this form that we have filled out. I think it is a defensive thing for the Trust. Perhaps I have colleagues who would be less thorough in note taking around risk and so having this form prompts them."*

Here Claire expands on how some of her colleagues may provide less detail when writing about levels of perceived risk than other practitioners. These differing levels of input, and in this particular instance, around issues of potential risk can be alleviated by completing a risk assessment tool.

Alice, a Clinical Psychologist in CAMHS reiterates this perception of risk assessment forms functioning as a primary means to protect a Trust against potential client complaints.

> *"…I think that is why the Trust introduced this assessment form so that they were covering themselves, as it states it is the clinician's responsibility. I think it is good that we are thinking about that but I think it was brought in for the reason of the Trust protecting themselves and so I think equally as clinicians we have a duty to protect ourselves and also to help our clinical judgement, hence the need for making sure that we are completing the risk forms."*

In her narrative, Alice does not state that her perceptions of risk assessment as a negative but instead positions the completion of assessment tools as a way to protect practitioners as well as the Trust. It is interesting here that Claire does state that the need for completing these documented forms of assessing risk is very much rooted in the notion of protecting practitioners and the Trust rather than a tool to monitor fluctuating levels of a client's risk.

Conversely, Jacqueline does not view a risk assessment tool as a means of protecting the Trust or practitioners but, instead, Jacqueline uses risk assessment as a formalised way of ensuring that she has completed all areas of providing relevant information within client contact time.

> *I: Do you ever see it as a defensive tool, ie. if something happened after you saw the patient do you see the tool as backing you up and you could present*

your checklist to show what you have covered?

"No not at all. The checklist is not there to tell me what to do. I would refer to it to check I have covered everything but that is all. It is a piece of paper that we worked out is important to be covered in this situation but I wouldn't turn to it to justify or explain what I had or hadn't done"

Whilst Jacqueline discusses the importance of completing risk assessments, in her own case, she does not undertake this method as a means of defending and justifying what she has or what she hasn't done with clients. Risks assessments in this way are a method of ensuring that certain items are discussed and covered rather than a means of offering legal protection.

Babu, a Psychiatrist working with adults discusses how he views risk assessments as offering a more comprehensive picture of risk from both clients to themselves, a client's level of risk to others and of the levels of risk to clients from other people.

"It is very helpful, especially for patients who are a risk to themselves or a risk to other people or there is some sort of risk to children, of safeguarding adults, all these are important and if we don't do the risk assessment we are not going to be able to identify or manage it."

For Babu, risk assessment tools provide an important way of both flagging up the areas of potential risk which in turn enables practitioners to best manage these risks for the future safety of clients or indeed others.

5.2.2 Checklist versus important tool

This section focuses on the functionality and outcomes of using risk assessment tools. In other words, staff describe what can be achieved by their completion. There are also areas which practitioners feel could be modified to proffer a more effective method of containing risk in an on-going basis.

Adi, a Senior Trainee working with adults illuminates on how risk is a fluid phenomenon which does not operate on a level continuum. In this way, regular assessments can offer practitioners a more precise way of managing risk.

"You get a risk assessment done at that moment in time because risk is quite dynamic and can change from time to time. You get an accurate, if you look at the last few assessments that were done you get a snapshot of what has happened. How he/she has been over the last few weeks."

Risk assessment tools can therefore offer a method which provides a historical 'snapshot' of events which can in turn help inform a practitioner of a current situation. In other words, it is the amalgamation of previous inputs which could have a significant influence on how the current clinical assessments of risks are perceived. Thus, risk assessment forms can be important in providing a more dynamic system of containing risk.

For Claire, there appears to be a level of misunderstanding as to the functional benefits and

measurable outcomes of using risk assessment forms.

> *I: "What aspects of the assessment would you like to change?*
>
> *"I would just like to understand the significance of these forms and how they are going to be used, and if they are ever going to be used or just sit in the files. I don't see many of my colleagues using them."*

Previously, Adi described how looking at several risk assessments can provide a useful picture of risk over time. In the quote above Claire describes a negative feature of paper-based risk assessment if it is not used on an ongoing way. It would be reasonable to suggest that practitioners need to be made fully aware of the beneficial aspects of undertaking a formalised risk assessment in order that the positive outcomes can become embedded within clinical situations. Claire is also unsure as to whether her colleagues are undertaking the same kind of assessments she is using with an intonation that she does not see many practitioners completing them. This of course does not mean that her colleagues are not using risk assessment tools but could mean that there is a lack of 'joined up thinking and working practices' within her particular service provision.

Dinesh, a Consultant Psychiatrist working in child mental health services:

> *": Is there anything else you would like to add regarding using the present tool that you use?*
>
> *No, just if it is going to work it has to be meaningful and valid to my patient at that particular time. For me to see a result, for six months later, not just me ticking a box again saying the risk is high or low or whatever it is. There has got to be something more stimulating and more tangible."*

For Dinesh, if risk assessments are to have any meaning, a system needs to be in place where progression (whether that is positive or negative) can be readily monitored. In other words, assessments should not just be concerned with ticking boxes when client contact occurs.

For Jacqueline, risk assessments are more than a process of just 'ticking boxes'.

> *"There is a lot of feeling to be honest and a lot of clinical judgement rather than the checklist. It is more than ticking boxes."*

It would be reasonable to argue that a fairly straightforward method of ticking boxes as a means of assessment does negate the personal contact between the practitioner and client. For Jacqueline, there may be other cues suggesting risk or indeed stability such as non-verbal cues and a dialogue not covered by her current risk assessment. Nevertheless, whilst clinical judgement can as far as possible be incorporated into a risk assessment comprising of tick boxes, the perceptions and feelings the practitioner are not included within this particular method of gaining data. Perhaps a comment box would be useful to note down subjective clinical judgements as opposed to just offering practitioners a list of questions to complete as a more objective methodology.

Michael, a General Practitioner reiterates the point that outcomes of risk assessments should be measurable and have some impact upon client care :-

"There is a risk that it could be perceived as just another box that you have got to tick. Now that is always the risk and once you tick them that's fine, you don't have to do anything else. I think we need to show the outcome of the process. If I just filled out a risk assessment and nothing happened about it then I would well what's the point."

These are valid arguments to discuss if practitioners are to feel that completing risks assessments (whether paper based or via a computer) have any worth. These kinds of doubts as to what value current assessment based methods hold might be overcome by the shared updating of client's records between agencies. This would also mean that a client's current record of risk would be more valuable in terms of continuity as other professionals would have had some input as well.

5.3 Theme Three – Technological Interfacing

One of the defining features of the barometer is its use of technology for managing the recording of risk. We asked the staff to comment on their views about using technology versus paper.

5.3.1 Computer versus paper

Aamir, a Psychiatrist working with adults discusses how having sufficient time would be important if changes from a paper-based to an on-line system were to be implemented:

"I: Would you consider having something computer based as a benefit or a drawback?

Provided there is time there is no harm in trying it. There would have to be enough time to do it. Going from paper based to computer based. That would take longer. With the push towards leaner services, it is hard anyway to have enough time with a patient and then the tool that came in would have to consider that wouldn't you say?"

This is an important point to consider as Aamir draws attention to how services have already been cut back due to constrained financial constraints. Here Aamir discusses how time with clients is an issue for him at the moment which may be further compounded by completing an online questionnaire. A counter argument could be that with sufficient practice, undertaking an online risk assessment may be quicker than the current paper based assessment he is using but his perception is that his time is too limited to adopt a new way of assessing risk.

Adi, a Senior Trainee working with adults has a different perspective in that he thinks that a move towards being able to access client information via the internet would be a beneficial way forward:

"I think in our Trust most of the information is not available on the Internet. Everything is more or less paper based hence from one site to another to another, there is a delay in getting the information so it varies from place to place. Whereas in a neighbouring Trust or for that matter in our forensic unit everything is on the Internet so even if the on-call doctor came out of hours, clicked on the relevant areas, the whole snapshot of events would open. I

think that is good."

In his narrative, Adi highlights the importance of sharing a snapshot of events between multi-disciplinary agencies which he currently experienced. Again, there is an inference here of variation within services of receiving client information which can then impact upon care plans for example. For Adi, a move towards a more integrated and holistic system would be beneficial for both practitioners and clients alike.

5.4 Theme Four – Multi-Agency/Team Working

This theme was concerned with exploring how participants perceived working across other agencies and within services. Here the divergent levels of how risk might be both assessed and recorded were a primary factor within the data extracts. In terms of a multi-disciplinary assessment tools these are important issues to consider further.

Dev, a Psychiatrist working with adults discusses the risk assessment tool he used at the time of the interview:

> *"I think that the biggest flaw in it is the fact that it is not objective so it does it not give you any outcomes scores, it does not give you any indication of the level of risk. It is a very subjective measure really and that probably needs to change somewhat because if two people see the same person then they may come up with a different impression of the person and the impression that you want to say communicate will also be different while with a score, then everybody knows whether it is a high score or a low score so I think that is the biggest flaw in it.*

For Dev the subjectivity of the current system he used was flawed as two practitioners could have divergent perspectives of what was deemed a risk situation or not. Using a scoring system, or with the case of the barometer, a traffic light method of indicating varying risk levels would go some way to alleviate the subjective nature of writing down practitioner perceptions. Of course it would be reasonable to argue that all client observations are at some level subjective but having a system which uses a method of scoring would go some way to alleviating this concern.

Babu, a Psychiatrist working with adults talks about the multi-disciplinary approach to risk assessment used within his workplace:

> *"I: Is the FACE tool and your clinical judgement, do they work together to formulate a Risk?*
>
> *Yes that right. Because we work as a multi-disciplinary team and whenever we assess a patient we usually assess them according to our disciplines, like I am a psychiatrist, we have got CPNS, Social Workers, OTs and everybody uses the FACE and also we use our clinical skills in order to identify the risk and not only to identify it but also how to liaise with other people in order to manage this clinical risk."*

Here Babu refers to how risk is assessed and managed drawing from the particular strengths of divergent practitioners. This more holistic approach is seen as beneficial to Babu as all concerned have some input into the assessment tool. Risk assessment is

therefore a shared method of controlling and monitoring risk which can be of crucial importance when one considers the various agencies who will be in contact with a client at any given time.

6. Survey 1. Using the Barometer

Four respondents agreed to do the first survey within the first 8 weeks of using the barometer. Since this was a small pilot study it is worth bearing in mind that the sample was very small (*N=4*) therefore it is worth being cautious about the quantitative outcomes reported. A larger study sample would be needed to make bolder claims. However, analysis of the four participants who committed to using the Barometer still provide some useful information. All participants were asked to rate on a scale of 1-7 (1 is Extremely Difficult and 7 is Extremely Easy) their answers to the following questions:

Question	Rating - 1 is Extremely Difficult and 7 is Extremely Easy
How did you find logging into the Barometer?	4: 25.0% 1 5: 0.0% 0 6: 75.0% 3
What were your initial impressions of the dashboard?	4: 25.0% 1 5: 0.0% 0 6: 50.0% 2 7: 25.0% 1
How was it finding an existing client?	6: 100.0% 4
How useful was the 'Essential Information' function?	4: 50.0% 2 5: 0.0% 0 6: 25.0% 1 7: 25.0% 1
In general, were the questions asked by the Barometer useful?	4: 25.0% 1 5: 50.0% 2 6: 25.0% 1
How easy was it to select a risk category	

(e.g. red, amber, green)			
5:		75.0%	3
6:		0.0%	0
7:		25.0%	1

Overall the results above demonstrate that for this sample the basic use of the Barometer was well received. Only one participant set up an alert to notify if a case was severe. However, they highly rated this function. The participants liked that the barometer focused on risk and core issues and highlighted issues of patient safety.

Two of the participants did feel some of the Barometer risk questions were confusing and offered suggestions for improving them. For example, there were issues around the term rootlessness and there were some suggestions for additional questions. Some of the terminology did not fit with a clinician's particular practice-based approach. It was felt by two of the participants that after the initial assessment it would be repetitive to ask all of the questions at each appointment. In addition, the human rights aspect of the barometer was not adaptable to the specific needs of different types of patients.

7. Survey 2. Using the Barometer

At the end of the study participants were asked to comment on the use of the barometer after an extended period of using. Three participants took part in the exit survey. Only one of the participants had used the barometer regularly over an extended period of time so the results, while a useful indicator, should be cautiously interpreted.

Question	Rating - 1 is Extremely Difficult and 7 is Extremely Easy		
How did you find logging into the Barometer?	5:	33.3%	1
	6:	33.3%	1
	7:	33.3%	1
If you added a new patient, how did you find this?	5:	33.3%	1
	6:	33.3%	1
	7:	0.0%	0
	Not Applicable:	33.3%	1
How was it finding an existing client?	6:	33.3%	1
	7:	66.7%	2
How useful was			

the 'Essential Information' function?	4:	▬	33.3%	1
	5:	▬	33.3%	1
	6:		0.0%	0
	7:	▬	33.3%	1
How useful did you find the 'Patient Overview' function?	5:	▬	33.3%	1
	6:	▬▬▬	66.7%	2
In general, were the questions asked by the Barometer useful?	4:	▬	33.3%	1
	5:	▬	33.3%	1
	6:		0.0%	0
	7:	▬	33.3%	1
How easy was it to select a risk category (e.g. red, amber, green)	4:	▬▬▬	66.7%	2
	5:		0.0%	0
	6:		0.0%	0
	7:	▬	33.3%	1
How useful did you find the 'Reports' function	5:	▬▬	50.0%	1
	6:	▬▬	50.0%	1

Participant responses to the barometer changed little over time. They appreciated the complexity of risk issues and the thoroughness of the questions within the barometer. The flip-side of this was that one participant did feel there were too many questions. Again, they would have liked the option to miss some questions which were not pertinent to an individual case. Only one of the three participants set up an email alert relating to 'severity of risk' and highly rated this function. Two of the participants also found the 'reports' function a useful feature. Two participants had a very neutral response to using the 'traffic light' system of reporting which would need to explored further.

8. Exit interviews

Five of the staff members who used the barometer took part in an 'exit' interview at the end of the project. The aim of this last interview was to gain an understanding of what staff found both positive and challenging about using the barometer.

8.1 The beneficial aspects of the multi-agency barometer

All of the staff interviewed as at the end of the project agreed that the most positive aspect of the barometer was the whole patient approach to risk management. The major contributory factor in creating a holistic overview of patient care was the use of the traffic light system.

> "the positive aspects is that you get a visual picture um and there's no waiting around to get that information um no, no searching around for notes and um it's pretty easy to use as well um no flicking of pages so yes those are the positive aspects"

Dinesh mentions in the above quote the instantaneous access to information provided by the barometer which is largely a product of using cloud technology. Participants were specifically asked to comment on the use of online methods of recording patient information versus paper-based approaches. All bar one participant preferred the use of online technology to paper. As Arjun commented:

> "I think it is much easier to use it on line than on the paper and the problem with using paper is that is outdated basically and yeah we don't like to struggle with the paper and we already have a few risk assessments form um which nurses fill out and then we work with the mental health reviews that we have to update some of those and then um the paper as usual can be something that can be lost or hidden somewhere and so um comparatively I think the on line one is much, much better and in tune with the modern developments"

It was agreed by all who took part in the exit interview that the barometer did offer value for multi-agency working. Arjun described how he felt that at initial assessment comments by other practitioners would ensure relevant information was available which might not be in current practice.

> "if we see a 17 year old guy known to CAMHS buy they can't take him because he's an adult over 16 so we are also helping him and they have also been helping him and the linking will help.... if you see a forensic patient and if we have seen the patient and if we have raised the alert then the other services can also pick up the alert and linking services between the community health team and we would know we would have a link between the mental health team and the crisis team and if we used it and they also used it then if they know that patient is with the crisis team they can immediately go on line and check what the level of risk is yeah and we can make them aware that this is the time that he has improved and you can look at the rest of the barometer and um you can see feedback"

While there was a feeling that the barometer would be very useful for other mental health practitioners there would need to be some adaptations of the barometer to accommodate other professionals who deal with child protection (e.g. social workers, GPs etc…). As Barry said:

> "I can see the positives in that and if you produced an assessment and somebody had no idea of the patient and didn't have any idea of mental health issues if they saw an item highlighted in red um and obviously it goes down and mentions what the areas are and of course it can be invaluable to other people said"

For the most part this related to the way in which other clusters of professionals (e.g. teachers, police etc…) may have different risk thresholds for risk. For example, practitioners who are used to dealing with mental health patients tend to have a higher threshold for risk than other professionals. Also, the barometer would need to be tailored to different professional needs.

Overall, the traffic light system was something all participants approved of. It provided an accessible and easy snapshopt of clients. The reports function was particularly useful for providing a quick evaluation of assessment over time. There was some doubt cast about the subjectivity of rating questions. The issue of subjectivity in current risk assessment practices was mentioned a lot in the baseline interviews so arguably this is something that needs looking at. This would be particularly pertinent in relation to multi-agency working as risk measured within one sector would not be the same for others. Either way, it was felt that regular multi-agency training would be necessary.

> *"I think those who will be using it will need a lot of training to understand each and every question and then only can they be allowed to use it because um because if you use it in a team then in a multi-disciplinary team then every individual needs to understand what the question is asking and um what is the level of threshold for each question yeah otherwise it won't work so training is very, very important because if I hadn't have gone through the book I was given it would have been more difficult so I would have been ticking in the darkness basically yeah so training would be a very important part of the implementation of this um tool" (Arjun)*

It is useful to note that whether practitioners are talking about their current risk system, or the use of the new barometer tool, training on understanding risk thresholds is crucial. This kind of training and collaboration about risk levels is something that a number of participants said they would like to undertake.

8.2 Challenging features of the multi-agency barometer

The most negative feature mentioned about the barometer was the number of questions it was necessary to answer each time the barometer is used. Generally, participants were happy to use all fifty questions when first seeing a client but thereafter would have liked the option to skip questions that weren't pertinent to a case.

Part of the issue was the number of redundant statements and a lack of clarity of meaning over some other statements. Everyone questioned, for example, the notion of rootlessness throughout whole study. This had little meaning for any of the practitioners in a variety of settings. Arjun describes how he dealt the problem of understanding what statements might mean.

> *"a few questions which um I found were either insufficient or they were not giving the correct information so um I had difficulty in using those but I used my own experience to use them and they can be modified to highlight um certain points which are more common"*

While this person used their professional experience to fill in gaps in understanding, there does need to be clarification for staff about the statements and how they can be applied to

individual's practice. This would require ongoing reflexive training that other staff members argued was also needed for current risk practices.

Some of the questions on the barometer did not reflect the complexity of the clients problems – however, this was unusual and was the case in only a minority within this sample. Another clinician felt that questions were not necessarily adapted to particular approaches and in some cases, were repetitive. Jacqueline said:

> *I did find it and I can give details later on but um I do find it sometimes not very well adapted to the type of clients or to the type of work I do and um a little bit long and repetitive*

Staff felt that if questions were not applicable to their case/approach that there should be the option to skip sections or at least, have a 'not-applicable' option. Although it was recognized that you could never say there is no risk, some questions did not fit particular circumstances therefore 'not-applicable' is a good alternative.

The length of time taken to fill in the barometer questions was an issue though this did improve:

> *"...initially it used to take a long time because I had to read each and every question and understand it but as I got used to it, it was really helpful and I could do it much, much quicker"*

> *"Well initially I found it very difficult um and I'm very honest about it and I found it very difficult and it was taking a lot of time and I was struggling so I couldn't really use it and in fact once I had used it in 6 or 7 cases and I went to the leaflet, um the book that was given to me and that made the task a lot easier and having the opportunity to use it and getting yourself familiarised with the thing and that was helpful"* (Arjun)

This brings the discussions back to the issue of training, which, in the case of the barometer would also help to improve the speed with which it could be completed. The barometer was not often used within appointment times and difficulties remembering the questions meant that clinicians did not want to use while the client was with them. However, there weren't problems filling it in afterwards. Time is a luxury for all clinical staff and so adjustments would need to be made to speed up the filling-in process.

While the traffic light system was considered one of the most positive features of whole barometer if a clinician wanted to change their mind about which risk category they chose they were unable to amend their choice. This would be a recommendation for an upgraded barometer tool:

> *"If you get to use it regularly I think if it became one of your daily tools I think you could, you could consider it as very useful for risk planning and you know like I said when you see a certain amount of amber and what's going on and you know if that's to do with you know housing or social isolation or domestic violence that's come back to haunt them or you know so yes I think, I think if it's a daily tool if it's a useable daily tool then it would then be useful for professionals"* (Arjun)

For those members of staff who had been given an ipad there were some technical difficulties which would need to be overcome if the program was rolled out more widely. Current service provision relies on 3G working and it was not uncommon for 3G service to break down. The trust IT services were the only ones who could sort out problems and often took a long time. Staff did not like the lack of control over their technical issues

> *"I: So the problems were around the IPad as such?*
>
> *Jacqueline: It wasn't the IPad and its essential that it is managed in such a way that whoever uses it can solve the problems and troubleshoot and we cannot troubleshoot anyway so as soon as there's a problem we are completely stuck and can't use it so it's um if, if the Trust somehow organises the relationship between IT, the provider and the worker in such a way that there is a dialogue then it's, it's a nice idea to have this anywhere at any time and if you can't, it's really bad" (Jacqueline)*

Most participants that completed the barometer on the desktop PC were happy with the technological elements of the barometer.

9. Conclusions and recommendations

> *Do you think the barometer would make a difference to patients' care?*
>
> Well, if it is made fully operational and people were using it I think it would make a substantial difference because it immediately sends you an alert and there is an alarm and something needs to be done, you know. But that will only happen if it's used by a team, the entire team would use it and link in with other teams also - and a social worker using it, a support worker using it and the nurses using it and the care co-ordinator; then we know what the care co-ordinator has seen and what he has put on the web-site

The multi-agency risk management barometer was developed with a view to facilitating communication about a person at risk across several agencies. In this way it would be possible, for example, for a mental health worker to see if an individual had visited A&E for attempted suicide in the time since their last appointment. A social worker could monitor changes in mental health needs and so on…In developing an online system using cloud technology the barometer sought to bypass previous technological interfacing and software difficulties. Furthermore, a practitioner could check the client database while on the move.

This project reports on a small feasibility study looking at the first incarnation of this online barometer. This project sought to evaluate how staff in a select number of mental health clinical settings (adult and child) felt about their current risk assessment practices and the use of the new barometer tool. The methodology employed combined survey and interview data collated over a 6 month period of time. Furthermore, a wide range of practitioners from a variety of settings (e.g. GPs, mental health, Pediatrics) were interviewed about their current risk assessment practices.

It was clear from discussions about current risk assessment practices in the baseline interviews that there is quite a lot of variation both within and across services about what purpose risk assessments perform and how they are used. The majority did feel that an online system would work better than paper-based systems. However, the number of people using the barometer would need to be much greater to be able to make firmer judgments about its use.

Overall, most participants who used the barometer, particularly over a period of time did feel it provided a whole-patient approach to risk management. Given an appropriate level of improvement to technological interfacing and development, the barometer has the potential to improve communication within and across agencies about patients at risk. Improvement to technological interfacing between the practitioner and the online tool center require the

program to be more flexible. For example, fifty risk questions is a good idea on the initial assessment with a client but is not helpful in ongoing to subsequent meetings. Practitioners need to be able to go back to a question and change their mind about risk levels. Training about risk thresholds is vital, as would be ongoing training to use the barometer. Similarly, the barometer would need to have enough flexibility to be adapted to the requirements of different professions whilst sharing enough information about a patient to be useful.

However, this it is still important to remember that this is a very small study and a larger, more comprehensive study, would be necessary to take this tool forward. Taking all the information to date, the following areas might prove fruitful for more discussion and thought:-

- Allocating more time for staff to complete the Barometer and risk assessment training (either in relation to the barometer or current risk assessment)

- A comprehensive training programme to both use the Barometer and assess risk with all stakeholder agencies concerned

- More practitioner input into the questions asked (this could involve other agencies such as social workers)

- A review of the questions on the prototype Barometer

10. References

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