

## Article

# Investigating mental health risk assessment in primary care and the potential role of a structured decision support tool, GRiST

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## ABSTRACT

**Aim** To explore current risk assessment processes in general practice and Improving Access to Psychological Therapies (IAPT) services, and to consider whether the Galatean Risk and Safety Tool (GRiST) can help support improved patient care.

**Background** Much has been written about risk assessment practice in secondary mental health care, but little is known about how it is undertaken at the beginning of patients' care pathways, within general practice and IAPT services.

**Methods** Interviews with eight general practice and eight IAPT clinicians from two primary care trusts in the West Midlands, UK, and eight service users from the same region. Interviews explored current practice and participants' views and experiences of mental health risk assessment. Two focus groups were also carried out, one with general practice and one with IAPT clinicians, to review interview findings and to elicit views about GRiST from a demonstration of its functionality. Data were analysed using thematic analysis.

**Findings** Variable approaches to mental health risk assessment were observed. Clinicians were anxious that important risk information was being missed, and risk communication was undermined. Patients felt uninvolved in the process, and both clinicians and patients expressed anxiety about risk assessment skills. Clinicians were positive about the potential for GRiST to provide solutions to these problems.

**Conclusions** A more structured and systematic approach to risk assessment in general practice and IAPT services is needed, to ensure important risk information is captured and communicated across the care pathway. GRiST has the functionality to support this aspect of practice.

**Keywords:** GRiST, Improving Access to Psychological Therapies (IAPT), mental health, primary care, risk assessment

## Introduction

Patients suffering from mental health problems are doubly disadvantaged in that they experience both the unpleasant symptoms of their condition and increased risk of harming themselves or others. Depression, for example, is positively related to increased risk of suicide,<sup>1</sup> and also contributes to self-harm<sup>2</sup> and self-neglect.<sup>3</sup>

The importance of improving mental health and well-being is emphasised in current policy objectives in the UK.<sup>4</sup> Assessment of risks associated with mental health problems is increasingly documented as a key component of mental health care, with recent policy highlighting best practice.<sup>5,6</sup> Primary care has a key role to play in the detection of risk: on average, a person with severe mental health problems has 13–14 consultations with their general practitioner (GP) per year,<sup>7</sup> and suicide victims commonly consult their GP in the time leading up to their death.<sup>8,9</sup>

Although many researchers have explored the delivery of mental health care in the general practice context<sup>10–14</sup> relatively little is known about how risk assessments are conducted. Most available evidence in the UK is from secondary care, which shows that risk assessment processes can vary considerably between mental health trusts,<sup>15–17</sup> a pattern which is replicated in other countries such as the USA.<sup>18</sup> Nurses, who do the bulk of risk assessments, often rely upon their experience and intuition rather than recognised tools.<sup>19</sup> The net result is that risk information is rarely collected or recorded in any systematic way,<sup>16</sup> and there is resistance to practice standardisation.<sup>15</sup> Furthermore, agreement about risk between primary and secondary care clinicians has been identified as poor, highlighting the need for improved collaborative working between the two sectors.<sup>8</sup>

There is also a lack of evidence about risk assessment within community based primary care mental health services. The landscape for primary care mental health in the UK has changed considerably recently, with the implementation of Improving Access to Psychological Therapies (IAPT) services. Following recommendations by the National Institute for Health and Clinical Excellence (NICE), this large-scale initiative aims to improve mental health by providing psychological therapies, such as cognitive-behavioural therapy and counselling, to individuals suffering with mental health problems.<sup>20</sup> The services were initially piloted and full roll out across England is planned after 2011.<sup>21</sup> IAPT services provide clinicians with direct access to mentally ill patients who may be at risk, so that understanding the risk assessment process within these services and

trying to strengthen practice is essential if adverse risk outcomes are to be avoided for large numbers of patients.

Most primary care risk assessment research focuses on suicide and consistently highlights the need for improved detection of suicide risk.<sup>8,22</sup> Work by Bajaj *et al*<sup>23</sup> explored GPs' and patients' perspectives on suicide screening. They found that GPs lack confidence in assessing suicide risk and that limited time within a consultation, cultural and language differences, and concerns about the impact of assessment on mental health status, are perceived barriers to effective screening. In the same study, patients showed support for suicide screening, yet some were concerned that doing so could provoke thoughts of self-harm. There is clearly a delicate balance to be achieved during assessment between skilful elicitation of important risk information and, at the same time, allowing patients to feel safe.

This paper aims to explore the risk assessment practice and experiences of both general practice and IAPT clinicians, as well as service users' experiences. It also tries to redress the imbalance between suicide and other risk research by covering all risks and considering whether a new multiple risk assessment tool, the Galatean Risk and Safety Tool (GRiST), could help to support practice.

Recognising that many adverse outcomes are preventable, the Department of Health guidance *Best Practice in Managing Risk*<sup>5</sup> aims to 'support services in adopting a more systematic approach to risk assessment and management'. GRiST is one of only three tools covering all risks that are recommended for use within this guidance. It is a web-based decision support system designed to support systematic collection of risk information to inform structured clinical judgement. GRiST is modelled on how mental health experts think about risk, but also accumulates a database of anonymous patient information, that generates invaluable insights into the relationship between patients' risk profiles and the risk judgements clinicians make about them. There are multiple interfaces to the risk model underpinning GRiST, making it useful for a variety of users in different clinical contexts, with versions already in use within secondary care for adults, older people, and children and adolescents' services. Versions of GRiST for primary care and IAPT services are currently under development, as is one to be used by service users for self-assessment. The vision is for GRiST to aid risk communication and to provide continuity of risk information from a patient's home throughout the entirety of their care pathway. This paper examines the potential usefulness of GRiST in primary care, based on an analysis of current problems.

In summary, the research has four aims, to:

- explore current risk assessment practice within general practice and IAPT services
- investigate the experiences and views of primary care clinicians in relation to mental health risk assessment
- investigate the experiences and views of service users concerning mental health risk assessment within the primary care context
- assess the potential usefulness of GRiST within general practice and IAPT services.

## Methods

### Recruitment

For the interviews, we used purposive sampling to identify potential research participants within both general practice and IAPT services. This was small-scale exploratory research within two primary care trusts (PCTs) in the West Midlands. It involved 16 primary care clinicians, eight from general practice and eight from IAPT services, plus eight service users. The general practice participants came from a total of seven practices and IAPT clinicians from two different services. All potential clinicians were identified through recommendations from research facilitators based at the University of Warwick, and general practice managers and clinicians working as part of the local primary care research network. Service users (SUs) who were receiving psychological therapies from their local IAPT services were invited to take part by an IAPT therapist (AN), who is a

member of the research team. The nature of the research was explained to the service users at the end of group therapy sessions and invitations to take part were also sent to the managers of two local service user groups, who provided contact details of interested individuals. The eight service users who agreed to participate all had received a diagnosis of depression, and three also had anxiety or stress-related disorders. Data collection took place during 2009 (when the IAPT services were still being called by their original name: Primary Care Mental Health Services).

Two focus groups were set up, one with seven primary care clinicians from one general practice and the other with six IAPT clinicians from the same service. Six of the 13 participants were also part of the interview sample and so the total clinician sample is therefore 23 (see Box 1 for participants' characteristics).

### Data collection

We adopted a qualitative approach, involving semi-structured face-to-face interviews and focus groups with primary care clinicians and service users. Semi-structured interview guides were created which were based upon findings of previous literature and the research team's experience from both clinical practice and years of researching mental health risk assessment in secondary care. Box 2 presents the topics which participants were asked about in the interviews. Interviews lasted approximately 30 minutes. Clinicians were asked a series of questions focusing on their experiences of carrying out risk assessments in primary care. Interviews with service

#### Box 1 Characteristics of interview participants

Primary care practitioners	Mental health services users
General practice staff ( <i>n</i> = 8)	Recruited from local primary care mental health services <i>n</i> = 5
(Coming from a total of seven practices)	Recruited via local service user groups <i>n</i> = 3
GPs ( <i>n</i> = 4)	
Practice nurses ( <i>n</i> = 4)	
Improving Access to Psychological Therapy staff ( <i>n</i> = 8) (from two different primary care mental health service organisations)	Female <i>n</i> = 3; male <i>n</i> = 5
Counsellors ( <i>n</i> = 3)	
Primary care graduate mental health workers ( <i>n</i> = 4)	
Clinical psychologist ( <i>n</i> = 1)	

**Box 2** Topics covered in the interviews*Topics covered in interviews with general practice and IAPT clinicians*

Current role in relation to assessing mental health risk  
 Risk assessment methods and procedures used in primary care  
 Challenges associated with assessing mental health risk in primary care  
 Referral procedures to secondary mental healthcare services  
 Experiences of referring patients to secondary mental healthcare services  
 Challenges associated with referring patients to secondary care mental health services  
 Recommendations for improving risk assessment and referral procedures

*Topic guide for service users*

Experiences of mental health risk assessment in general practice/primary care  
 Experiences of mental illness  
 Experiences of mental illness consultations in primary care  
 Perspectives on doctors' behaviour during primary care mental health consultations  
 Consequences of consulting with primary care clinicians for a mental health problem  
 Views on how mental health risk assessments are done in primary care  
 Recommendations for improving risk assessment procedures

users explored their experiences of consulting with GPs and IAPT service clinicians for a mental health problem, and of being risk assessed within the general practice context. Participants were asked open-ended questions about their experiences and were probed for more detailed information when required. Interviews were carried out at either participants' place of work (clinicians only), the University of Warwick, or at service user group venues. All interviews were audio-taped and transcribed verbatim. Audio-files and transcripts were anonymised through the use of participant ID numbers prior to checking and data analysis. Two focus groups were carried out after the interviews had been analysed to discuss the findings. Participants were also given a presentation about GRiST, an opportunity for 'hands on' practice in using it, and a chance to discuss its potential usefulness in primary care. One focus group was carried out within a general practice, and one was carried out at a local IAPT service. Detailed notes were taken during the focus groups.

**Data analysis**

Interview transcripts were analysed using thematic analysis that resulted in the development of a coding framework, which was used to identify the major themes within the data. The thematic analysis which was undertaken involved six distinct phases identified by Braun and Clarke.<sup>24</sup> The first phase involved rereading transcripts so that the researchers became familiar with the data. A set of initial codes was created, and the data were coded, which allowed for the emergent themes to be identified. Themes

were reviewed and final definitions and names of themes were selected. Lastly, a written report of the findings was produced, during which relevant extracts were selected to support the themes which were identified. The reliability with which two independent coders (LV and EG) applied the coding framework to a 10% sample of the data was assessed, resulting in 90% agreement. Any discrepancies in coding were discussed between coders.

**Results****Findings from interviews**

Six main themes in relation to risk assessment within primary care were derived from the interview data, and are presented within the results. These themes are variable approaches to risk assessments, fear in relation to missing mental health risk, the quality of the doctor-patient relationship, lack of time to carry out thorough risk assessments, lack of service user involvement in risk assessments, and difficulties in communicating risk information.

*Variable approaches to risk assessments*

Despite the small and defined geographical location of the study, no standard approach to mental health risk assessment was apparent. General practice clinicians used various methods, which included observing and assessing patient presentation (e.g. body language during the consultation, verbal cues, as-

pects of patients' social circumstances), asking direct questions, and using decision support software (a package called MENTOR) and risk assessment scales for detecting the risks of suicide, anxiety and depression (see Box 3). The main tool used was the Patient Health Questionnaire 9,<sup>25</sup> but other risk-specific tools, such as the Hospital Anxiety and Depression Scale<sup>26</sup> and the Generalised Anxiety Disorder (GAD-7)<sup>27</sup> were also used when required. Reflecting existing research findings, participants mainly spoke about depression screening and assessment of suicide risk, with only limited reference to other risks such as self-harm, harm to others and self-neglect. As might be expected, attention was mostly given to assessing the prior conditions (e.g. depression) from which risk arises, rather than focussing on potential risks per se.

Within IAPT services, the main method for detecting risk was using the Clinical Outcomes in Routine Evaluation–Outcome Measure (CORE-OM), a client self-report measure designed to assess health outcomes, but which also incorporates questions addressing the risks of suicide, self-harm and harm to others.<sup>28</sup> Clinicians asked service users to complete a CORE-OM before each treatment session. Clinicians had also received a specialised skills-based training package (STORM) in risk assessment and management of suicide and self-injury,<sup>29</sup> and were using the techniques that they had learned during their consultations with patients.

Despite the range of tools used, our findings show that IAPT clinicians did not have set procedures or questions for assessing mental health risk, and were flexible in the approaches they adopted. They often relied upon their own clinical judgement and experience about how to approach the topic of mental health risk, as illustrated by the two quotes below.

'There's no standardised assessment that we go through. We have quite short appointments, so forty or fifty minutes sometimes and really we might see someone who has got very mild depression and no risk issues at all ... so that's why we're quite flexible in the way that we assess for it really.' (IAPT Worker 6)

'There aren't any set questions that we ask about risk. I think whether I decide to go down the route of asking about risk is probably based on my knowledge of their histories ... So if there's definitely a history I think, probably, I would definitely ask about it. If there isn't a history I wouldn't necessarily ask about it.' (IAPT Worker 4)

Although this approach gives clinicians flexibility, not screening for risk information in any systematic way means that there is potential for important pieces of risk information to be missed. In the absence of a structured and systematic approach to risk assessment, four clinicians spoke about the importance of using their 'gut instinct' whilst assessing mental health risk, as described below:

'I think it really boils down to gut instinct in that sense. You know, you can just ... there's nothing else but gut instinct to tell you whether someone really does want to kill themselves, or just has a fleeting thought so it's completely unscientific but I think that's the way it is.' (IAPT Worker 1)

'I think with a lot of people that there's also an element of gut instinct, of what you feel about people.' (IAPT Worker 4)

'There's probably clinical gut instinct in there somewhere.' (IAPT Worker 6)

Gut instinct is clearly an important clinical resource, based on observing patterns of risk cues in patient

### Box 3 Reported methods used for assessing mental health risk

#### General practice

Asking direct questions about risk

Decision support software (MENTOR)

Assessing patient presentation (i.e. gender, age, people living alone)

*Risk assessment and screening tools:* PHQ-9, Hospital Anxiety and Depression Scale, Geriatric Depression Score, Generalised Anxiety and Depression Score

#### Primary care mental health services

Asking direct questions about risk

Team discussions about 'risky' patients

Use of combined sources of risk information (history, presentation, body language)

Use of techniques learned at STORM training events (for risk of suicide and self-harm)

Training events (for risk of suicide and self-harm)

*Risk assessment and screening tools:* PHQ-9, CORE-OM, Generalised Anxiety and Depression Score, Health and Wellbeing Scale, The Warwick–Edinburgh Mental Well-Being Scale

presentations over years of clinical experience. However, if 'gut' unease could be located within the precise details of a patient's risk profile, risk information could be communicated and shared more effectively both within and between services.

### *Fear about missing mental health risk*

As the above findings suggest, assessing mental health risk was not seen as 'an exact science' where there was always the possibility to 'get it wrong'. Instead, clinicians were more worried that they might not collect all of the relevant information to assess risk, and that this would result in something being 'missed'. Three expressed their fears:

'First it's picking it up and realising you've missed something afterwards, which is terrifying regarding risk, so thinking "Shit, I should have followed through on that".' (IAPT Worker 6)

'I think the other challenge that we've come across recently is that a couple of clients have actually committed suicide and that brings it to a question, quite often, of why wasn't it picked up on or is there anything that we missed?' (IAPT Worker 4)

'Part of the problem is actually participating when you're in one of those situations and you might just not realise that there are questions that need asking, but you weren't aware of it because you haven't picked it up and then sadly, sometimes you find out later when something's happened that you might have been able to prevent it.' (GP 2)

In these situations, the benefit of having a more systematic approach to risk assessment is clear. It would ensure coverage of all the risk areas which need to be considered, and provide suitable questions for tapping into the required information. It is also likely to contribute to improved outcomes for both service users and clinicians: helping to keep people safe and bringing greater peace of mind and confidence respectively. However, asking questions about risk was seen as particularly difficult for inexperienced clinicians, as the following three quotes demonstrate:

'I suppose the big challenge would be being a relatively new GP in the practice and perhaps having rather ... being nervous or anxious about the consultation and faltering a little on your communication skills when you're trying to assess what's going on really.' (GP 1)

'It was difficult at first to be asking people questions about risk. That is particularly difficult, but you just have to get used to doing it.' (IAPT Worker 3)

'In the early days it was incredibly difficult to ask people if they were suicidal because you didn't know what the answer would be.' (Practice Nurse 1)

Having access to some tried and tested questions for eliciting risk information may be useful for clinicians in the early days of their careers, until they are confident to develop their own. It may be particularly useful for practice nurses who reported having very limited involvement in detailed mental health risk assessment. Most claimed that this was something undertaken by their GP colleagues. Consequently, they often felt ill-equipped to assess mental health risk, despite the fact that they often have more time and opportunity to do so than their GP colleagues. Two explained:

'I find it fairly difficult to assess maybe because of a lack of training or maybe because of the responsibility.' (Practice Nurse 3)

'I think there are training needs, to be honest. I don't have a great deal of experience apart from my general training with mental patients.' (Practice Nurse 4).

### *The quality of the clinician-patient relationship*

Questioning techniques aside, our findings identified that mental health risk assessment is also dependent on the quality of the clinician-patient relationship. In particular, clinicians were aware that they were reliant on patient honesty for effective mental health risk assessment. Two commented:

'I think the challenge there in some ways was if someone's determined to do it [complete suicide] they're not going to tell people about it because they'll stop them from doing it.' (IAPT Worker 4)

'What people put down [on the CORE-OM form] might not be what they think or even want to do.' (IAPT Worker 1)

Service users shared this concern. One commented:

'I think it would be very easy, you know, if somebody was feeling suicidal, and didn't want anybody to know they wouldn't have to tick the box. You know they could cover if they wanted to ... somebody could just tick the box that they think you want ... and so you could then run away and just do it.' (SU 6)

However, a good, well-established relationship with a GP was seen as an essential prerequisite for accurate assessment of risk. Service users' experiences of primary care mental health consultations varied greatly depending on the nature of their relationship with the assessing GP, as one explained:

'You know, I suppose building up a relationship so that you've got honesty is really important because if you are wary of your GP and you think that they're going to say, overreact and get you assessed then you might end up in hospital and you're not going to be honest are you?' (SU 2)

### *Lack of time to carry out thorough risk assessments*

The quality of risk assessments achieved is also affected by time constraints. Three clinicians explained the problem in general practice:

'In a busy consultation, which is always time-pressured a patient may have come in for some other reason and so we may fail to take advantage of opportunities to assess risk simply because the focus of the consultation is elsewhere.' (GP 2)

'Time, you don't have time to do it [risk assess].' (GP 3)

'You can't do it [risk assess] in five minutes, not with mental health issues – you just can't.' (Practice Nurse 1)

If the constraints of the general practice consultation do not allow for in-depth assessment of risk, a mechanism needs to be found by which all relevant risks can be screened rapidly, whilst at the same time ensuring the safety of the patient and others around them. This information can then be communicated to other clinicians further along the patient's care pathway, who have more time and opportunity to undertake a fuller risk assessment. Indeed, the limited time available to GPs was the service users' main concern about risk assessment within primary care (mentioned by four service users). They felt that in order for a clinician to detect risk accurately it was necessary to have an open conversation in which their thoughts, feelings and social situation were probed. Two service users described how current practice makes them feel:

'There is that need for a little more time and talking to people. You know, I mean I understand it's not easy. I don't have the answers. But just filling in a form and ticking a few boxes isn't really assessing how somebody really feels.' (SU 6)

'It was almost like seven minutes on the clock [the consultation]. That's how I felt. The second one [GP] gave me a first consultation of at least nearly half an hour and subsequently it's been like a good 15/20 minutes. So I've had the time and I think you need that because it's so difficult to make a diagnosis or to try and put things into perspective in such a short period of time.' (SU 7)

These comments express a common experience, where patients often feel they are being 'processed'

but not properly understood. The introduction of IAPT services, where clinicians have more time is a welcome and timely development from the patients' perspective.

### *Lack of service user involvement in risk assessments*

The service users concurred that GPs tend to elicit risk information by asking very general questions (e.g. how's it going?). They were also aware that their GPs were intuitive and were often picking up on body language and the way that they presented during the consultation. However, some doubted GPs' skills in the area of risk assessment, as the following two comments illustrate:

'Most GPs don't have really much knowledge of mental health problems, despite the fact that 40% of people they see are because of mental health problems, you know? I do wonder whether they do have the skills to properly risk assess.' (SU 2)

'I don't think she [the GP] did that sort of risk assessment really because of her lack of mental health training.' (SU 1)

In IAPT services, five (of eight) of the service users recalled being asked to complete a form to detect risk or the severity of their depression. However, four of these participants were unaware of which forms they had completed and why. Two reported:

'I got no feedback actually. No feedback at all. Which really made me feel they wanted to get to the bottom of is this guy suicidal or is this guy going to cause a problem to harm himself or others? If so, then we need to do something else. We need to section him or something, I suppose, I don't know. I think having marked my sheet, or whatever, it's come back as this guy's no menace to society so let's carry on. But I didn't get any feedback, no.' (SU 4)

'I didn't get the form until the end of the consultation and I was asked to fill it in and drop it in at reception. Maybe filling it in at the beginning of the consultation would have been better ... I never had any comeback. There wasn't ever any follow up to that [the risk assessment form] and I didn't have to do it again ... perhaps the Inventory should have been done first and then "come back and see me in a few days time when I've had a look at it".' (SU 8)

Both scenarios suggest that service users were not as involved in the risk assessment process as they could be, and that clinicians tend to extract information from them, but without discussing its significance with them. There is also not enough time to digest and utilise the information collected from patients

within consultations, to guide risk assessment. These are both missed opportunities.

### *Difficulties in communicating risk information*

The above findings describe differences in how risk information *is collected*. This section explores how risk information *is used* once it has been collected. Methods used to communicate risk within and between services varied between primary healthcare settings. For participants working within IAPT services, risk information was communicated via team discussion or informal conversation with colleagues, whereas GPs communicated risk information primarily to secondary care services using a referral form documenting referral reasons.

The GP was reported to be the 'hub' for risk information and the clinician responsible for making decisions about risk management. All of the practice nurses, counsellors and IAPT workers within our study reported that they would communicate with their GP colleague if they suspected that a patient was 'high risk'. Communication with GPs was achieved via telephone, and for those working within a practice, in person.

While for the majority of participants, communicating risk to clinicians within their organisations was facilitated by the close proximity of colleagues and generally not seen as a problem, it was not always easy. Four participants reported that they had experienced difficulties communicating risk to other clinicians. In particular, they felt that their concerns were not always taken seriously. Communicating risk information to secondary care services was seen as even more of a challenge, due to differing perspectives on risk, as illustrated by clinicians' comments below:

'You've known a patient for say 10 years, you refer them that day as high suicide risk, the doctor involved actually decides they're not high suicide risk and discharges them even though you've really explained why you think they're at high risk ... sometimes you don't feel you're listened to and sometimes ... you know ... although the psychiatrists are meant to be more experienced in mental health than we are – and I suppose they are in many areas, I think the family doctor is perhaps in a better position to say that somebody is going to end their own life or harm themselves on occasion and if we urge them to admit a patient I think they should listen to that quite carefully ...' (GP 1)

'I think the problems come when you've got professionals who may be feeling quite callous about risk as well, so for instance, the crisis team are a fantastic team but because they deal with

crisis and risk every day all day, then when you're working in primary care and you're a bit worried about a client it can seem kind of small-fry to them in comparison to what they're having to deal with and so it's hard to ... Sometimes it's hard to communicate when it is about gut instinct or feelings.' (IAPT Worker 6)

If a common approach to collecting risk information and a common risk language could be achieved, which traverses service and healthcare sector boundaries, this would be of considerable benefit to patients and those around them, and improve clinicians' job satisfaction.

## Findings from focus groups

### *Reactions to GRiST*

Findings from the focus groups showed positive reactions to GRiST, with clinicians believing it could aid the risk assessment and referral process within primary care. Suggested benefits included the facilitation of risk communication between primary and secondary care and increased collection and recording of risk information, which could lead to increased risk detection. They particularly liked the comprehensive but concise summary output reports (produced at the end of a completed assessment), which support referrals to the crisis team and secondary care services by helping to demonstrate the reasons why a clinician thought that a person was 'at risk'. Participants also liked GRiST collecting holistic information about patients relevant to risk. They thought this may help highlight 'at risk' individuals who would not be detected by using other tools, such as the PHQ-9.

One potential concern in the focus groups was the time that would be needed to complete a full assessment using the existing version of GRiST. It was explained that GRiST has flexible interfaces that can be customised using its layered structure so that clinicians collect only the information essential for them at any specific point on the care pathway. The clinicians appreciated this, and thought that the rapid screening questions would be suitable for use in general practice. Information collected could then be 'passed over' to secondary care services, where clinicians have time to complete the full assessment. There was a general consensus in both focus groups that the tool should be completed after consultations have finished so that communication between clinician and patient is not hindered. Participants found navigation of the online tool simple, and were able to use it with relative ease.

There was considerable discussion within the focus groups about the potential usefulness of a self-

assessment version of GRiST, which patients could complete and bring to their consultations. This was deemed useful, because it would quickly highlight areas of concern, so that consultations with clinicians could begin at a more meaningful point with a more focused agenda. A prototype of the service user version of GRiST, myGRiST, is currently being developed and tested by local service users for this purpose.

## Discussion

This paper has highlighted a number of problems surrounding the assessment of risk associated with mental health problems in the primary care context. These affect both general practice and IAPT services, and, as a consequence, also have an impact on secondary care mental health services and the ongoing care provided for patients. There is a lack of consistency in the risk assessment approaches and tools used across the three service areas, so that there is inevitable variation in the risk information collected, and in the way it is recorded and communicated both within and between services. This could disrupt the continuity of risk information travelling with patients along their care pathway. It means that important information is more likely to be missed, or not captured in a way that makes it immediately accessible and useful to receiving clinicians further along the care pathway. Not surprisingly, fears of missing important risk information within the given time constraints were common, and may explain how opportunities to intervene to prevent suicide are sometimes missed.<sup>8,9</sup> Tools that ensure the relevant risk issues have been appropriately considered are thus essential.

Our study also showed that primary care clinicians have received variable training in risk assessment techniques, which left many, particularly less experienced clinicians, feeling ill-equipped to be alert to and to elicit risk information from patients, and to discuss it. However, as reported by others,<sup>23</sup> questions about suicidal intention, for example, were perceived as very difficult to ask, both at the level of choosing the right language, but also choosing the right moment in the consultation to broach the subject. Further, the collection of risk information was shown to be very much dependent on the quality of the clinician-patient relationship and interaction, and particularly on the level of trust that had been established. Achieving the right conditions and acquiring and using the right assessment and communication skills within the context of brief primary care consultations is enormously difficult,

and there is a need for further research into effective ways of doing this.

Our findings also elucidated how patients perceive risk assessment in primary care. Most of their comments related to lack of feedback and involvement in the process, particularly where they had been asked to provide information about themselves ahead of consultations. This set up an expectation of involvement in discussions about their risk status and factors in their lives affecting risk, so that they could play a more active part in making decisions about their care and in self-management. By and large, however, patients experienced frustration because the information they had provided was seldom referred to, so that their experiences were often contrary to policy objectives of achieving patient empowerment.<sup>30,31</sup> Patients were also often conscious of and critical of clinicians' lack of confidence in assessing risks associated with mental health problems, and were weary of endlessly repeating their history each time they encountered a new clinician or service.

## Role of GRiST in primary care

One of the aims for this research project was to explore how well GRiST could address many of the issues raised and what modifications might be needed for it to fit the circumstances of general practice and IAPT services. Its immediately obvious qualities were a structured and systematic approach to mental health risk assessment which helps integrate information across the patient care pathway. It has a layered structure, which means that key risk information can be captured through a set of rapid screening questions that address multiple risks as well as covering generic patient information pertinent to all risks. If clinicians complete the rapid screening questions they will have considered all areas which mental health experts consider relevant for assessing risk<sup>32</sup> without necessarily having to collect all the detailed data. Instead, GRiST is designed so that clinicians flag up areas requiring further investigation by clinicians further along the care pathway, who have more time available for assessment. The web-based technologies underpinning GRiST facilitate flexible interfaces to ensure the right level of detail is appropriate to the particular point in the care pathway.<sup>33</sup>

GRiST can address insecurities about assessing risk and the inexperience of colleagues because it is based on a detailed model of risk expertise elicited from multidisciplinary mental health practitioners.<sup>32</sup> This provides a useful educational resource and a structured approach to which questions to ask. The primary care and IAPT questions are couched in

language which can be directly asked of patients, which should lessen the anxiety of inexperienced clinicians and help them to collect the right information.

Our research has highlighted that patients feel uninvolved in the risk assessment process. If the primary care and IAPT version of GRiST is used in conjunction with myGRiST for patients, the amount of risk information available as a basis for discussion and on which to make risk assessment decisions will be increased, significant time will be saved in history taking (including clinicians having to ask difficult and sensitive questions), and consultations can be more focused on key, shared concerns. For patients, this will have the benefit of increased involvement in their care and because their online information will be stored, they will not have to repeat their history endlessly to new clinicians or services. Patients will also have improved understanding of factors affecting risk in their lives, and of how to self-manage risk.

While study findings are derived from a small sample of clinicians, services and service users in one locality, so that their generalisability is questionable, the issues raised resonate with published findings from other research and with the GRiST team's experiences of working with general practice and IAPT services in other parts of the country (see later). Research is needed, however, to evaluate the use of GRiST and myGRiST in general practice and IAPT services.

### Subsequent work

Since undertaking this study, four further focus groups have been conducted with clinicians from two different IAPT services in another part of England, with service user involvement. As a result, a layer of six primary care and IAPT questions have been added to sit on top of the GRiST rapid screening questions. These lead into the screening questions if appropriate, to provide the quick and 'light touch' yet comprehensive approach needed for risk assessment in primary care. The resulting tool, which can be viewed at [www.egrist.org](http://www.egrist.org), means that general practice, IAPT and secondary care clinicians can collect risk information using the same approach, which preserves continuity of information and ensures it is communicated in the appropriate manner in each context. This should help to minimise the loss of important risk information and may improve relations between primary and secondary care clinicians.

## Conclusion

Findings from this study point to the need for a more structured and systematic approach to risk assessment in general practice and IAPT services, which is compatible with risk assessment practice in secondary mental health care. GRiST provides a vehicle with the potential to improve risk assessment practice across the care pathway, by helping clinicians and patients collect and share appropriate information more easily and at a level commensurate with the particular point in the care pathway. Simultaneously, GRiST provides a transparent audit trail about what information risk decisions were based upon, and how risk has been managed.

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#### CONFLICTS OF INTEREST

Christopher Buckingham and Ann Adams are the co-developers of the Galatean Risk Screening and Safety Tool (GRiST). This study was undertaken as part of a wider programme of research to assess the need for and the feasibility of developing specialist versions of GRiST for primary care and for service users.

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