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Risky Business: Identification, Assessment and Management of Risk Factors in Clinical Practice

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ABSTRACT: Mental health professionals manage risk in a myriad of ways. A key element of effective mental health treatment is the ability to assess and manage the risks that impair client safety and impact the effective treatment. However, many clinicians, whether new and seasoned, lack the skills and/or confidence to effectively identify, assess and manage risk. In this article, we identify several factors that contribute to this gap, including the lack of a consistent and clear definition for risk in the literature, academic training that highlights liability with minimal to no discussion on the interpersonal dynamics inherent in risk assessment, poor or ineffective supervision and the lack of a widely accepted risk assessment and management process or tool. Utilizing a semi-structured, 5-item survey questionnaire, practitioners (n = 75) were asked to define risk and their level of comfort identifying, assessing, and stabilizing commonly presented risk factors. An analysis of participant responses reinforced that most clinicians feel they do not have adequate risk assessment and management skills or are insecure about the skills they do have. Absent from the majority of the responses were references to the relational dynamics that permeate the risk assessment process and impact how the client and clinician work together to manage the risk. The findings suggest a need for both a systemic process and a comprehensive framework for clinical risk management. Strategies and recommendations are included to guide supervisors and practitioners in navigating effective, clinically competent risk identification, assessment and stabilization.

Keywords: risk assessment, risk management, risk stabilization, clinical practice, culturally relevant practice

Risk factors are an inherent component of clinical practice. Clinical skills critical to client safety and improved well-being include the capacity for assessment and management of risk factors. While seemingly straightforward, risk is a term with multiple prospective meanings. Within mental health, social work and psychology literature, risk refers to a range of concepts that include organizational liability, danger to clients, environmental hazards and clinician vulnerability. However, there is limited research on risk defined specifically within the context of clinical practice.

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Thus, we define risk as: *Situations, contexts, symptoms, behaviours, intentions or dynamics that create barriers to client safety, therapeutic rapport or effective treatment*. Espoused by this definition, we identify the most common risk factors in clinical practice as suicide, homicide, child abuse, elder/dependent adult abuse, domestic violence, substance abuse and grave disability. While not an exhaustive list, these seven factors address the most significant barriers to therapeutic safety and clinical efficacy.

The ambiguity of the definition of risk is exacerbated by the challenges in the implementation of risk management strategies in practice settings. Effective clinical risk management necessitates composure and stability, the opposite of the fear and panic that can come with facing outcomes with potential violence, tragedy, pain and death. For many practitioners, the uncertainty regarding risk prediction versus navigation of a risk continuum in the contemporary managed care setting fosters the fear of medical/legal reprisal, resulting in defensive positioning or polarized reactions that ultimately impede clinical efficacy (Wand, 2012). Thus, practitioners must develop the knowledge and skills to confidently identify, assess and stabilize a multitude of risk factors in a variety of practice settings within a climate where professional protection may overshadow client connection.

Clinicians are most likely to confront several distinct risk factors in clinical practice which present challenges and correlated barriers to client safety, well-being and ability to participate in treatment effectively. As mentioned previously, the risk factors most frequently encountered that present barriers to effective clinical practice include suicide, homicide, child abuse, elder/dependent adult abuse, domestic violence, substance abuse and grave disability. In addition to practice related exposure, these concepts maintain consistent representation in both the Licensed Clinical Social Worker (LCSW) and Licensed Marriage and Family Therapist (LMFT) examinations, reflecting the critical role risk management retains in the training of licensed practitioners. However, the educational tools sanctioned by master's degree programs may have some culpability in the practitioner's challenges to develop risk assessment and management skills. Many practice or counselling course textbooks contain minimal references to risk; at most, there are references to child abuse, elder abuse, suicide and homicide primarily as they relate to reporting responsibilities or hospitalization. The unintended result may be to encourage new clinicians to prioritize avoiding personal liability over interpersonal problem solving with difficult topics.

Further, it is a commonplace for organizations to focus on practitioner training and oversight rather than supervisor support and ongoing training. Assessment for supervisor competencies and goodness of fit for the supervision role are frequently minimized (U.S. Merit Systems Protection Board, 2010) and reduced to a question of whether (or not) individuals have obtained licensure, required coursework and are capable of supervising. Focusing on credentials versus competence creates a clinical quandary where practitioners continue to grow while supervisors stagnate. This dynamic may be a function of fiscal survival; because practitioner productivity is directly responsible for reimbursement, organizational administration may neglect to invest time and/or money in supervisor development, which yields minimal funding.

Without a consensus in the literature of what constitutes a clinical risk or a comprehensive overview of clinical risk management in master's level academic textbooks, field practicum (for students) and practice experience (for postgraduate clinicians) are the primary vehicles for practitioners to learn to navigate risk. However, the absence of a pedagogical framework for risk often places the responsibility for clinical direction on individual supervisors whose experience and skills vary considerably depending on their discipline, setting, context, and population. Thus, practitioners' knowledge base regarding risk is shaped by the competence, clarity and communication capacity of their supervisors. Because many supervisors do not receive ongoing training and support (U.S. Merit Systems Protection Board, 2010), supervisors may be ill-prepared to manage the complexities inherent in risk assessment and management. Reliance upon supervisors' skills, discretion and/or the cohesion of the supervisory relationship potentially places clients, clinicians and therapeutic efficacy at risk for confusion (at best) or catastrophe (at worst).

Clearly, mental health practitioners (the terms clinician, provider and practitioner will be used interchangeably in this article) need access to both a process and a structure to navigate the intricacies of risk identification, assessment, stabilization and ongoing management. This article will convey a comprehensive risk management framework for new and seasoned clinicians. The authors address the gaps in risk literature, propose a risk assessment tool and provide practitioners with a process to utilize for thorough, consistent risk management. Of course, supervision remains an essential part of the process; however, this article aims to support both the supervisor and the clinician by offering a framework that clarifies clinical competencies. Risk management is declarative knowledge that falls within the category of competencies, while best practices refer to the procedural knowledge that supervisors utilize to implement competencies in

supervision (Borders, 2014). Thus, the risk management framework allows supervisors to integrate competencies with best practices for optimal training, development and clinical efficacy.

Literature Review

Practitioners are faced with a plethora of potential clinical risks while managing concurrent legal and ethical standards regarding risk identification, assessment and stabilization. However, contemporary risk and crisis literature consistently separates risk by type of behaviour and context in which the risk is being assessed, and overwhelmingly focuses on client suicidality, self-harm or homicide (Barry, 2007). Such a narrow perspective undermines two factors essential to understanding and implementing effective risk management: 1) the complex nature of clinical assessment and risk assessment/management as a whole system; and 2) risk assessment/management is a process experienced by both the client and the clinician. Inherent in this perspective is the absence of the awareness that risk assessment is an interpersonal process, which has the simultaneous objectives of keeping clients safe, managing ethical, legal challenges while maintaining the integrity of the therapeutic relationship.

Risk assessment is frequently described as a mechanism for predicting risk behaviour (Littlechild & Hawley, 2009) and ameliorating those behaviours before they reach a point of crisis. Despite the abundance of risk literature, identification of a comprehensive definition of risk assessment consistent across settings is challenging. The most essential elements of the definition, which vary depending on the source, are a) the inclusion of risk as a systematic process of evaluation that b) is conducted through interpersonal contact. Defining risk assessment in this manner establishes a foundation which values the process as relational while underscoring the systemic framework that is critical in practice. This definition, although exiguous within the context of mental health, denotes the foundation from which risk assessment is carried out, "the systemic process". Within Marriage and Family Therapy, Clinical Social Work and Psychology, the term *process* denotes a relational interaction with a primary goal of helping the client**.** However, the value and execution of any process will vary, based on environmental and professional context**.**

There is some, albeit minimal, literature focusing on how clinicians should initiate risk assessment with clients. Glancey and Chaimowitz (2005) argued that risk assessment should be considered part of daily clinical practice and examined the advantages and disadvantages of assessment tools versus using clinical judgement alone to assess risk and create risk management plans. Although this line of exploration is suggestive of risk assessment/management being a

process, it falls short by neglecting to consider the clinician and the clients responses to that risk assessment process, a consideration that is integral to understanding the therapeutic consequences inherent in risk assessment. Risk assessment/management is not just about client risk of harm to self or others – but developing a therapeutic relationship with clients through engagement (Deuter et al., 2013). The lack of literature on the process of risk assessment/management reflects the overall disconnection evident in clinical risk assessment in mental health settings. Although practitioners frequently associate risk assessment and management with delivering safe and effective mental health care (Wand, Isobel & Derrick, 2015), there is a dearth of research that indicates *how* this is executed. Risk best practices for new clinicians reinforce risk assessment as something that's done TO clients, as opposed to a relational process between clients and clinicians.

A common theme in the literature is the limitations of risk assessment tools (Littlechild & Hawley, 2009). Formalized risk assessment and management procedures were viewed as prioritizing "safety" over individual growth and development (Wand, Isobel & Derrick, 2015). Frequently, risk assessment tools are propagated as a clinical framework for comprehensive assessment and management of crisis circumstances. Clinicians are often faced with the dilemma of choosing between patient welfare and the practitioner protection (Wand, Isobel & Derrick, 2015). Wand, Isobel and Derrick (2015) further indicated that clinicians considered risk assessment tools to be "too mechanical, behaviorally reductive and dehumanizing (p. 148)." Thus, although mental health agencies understandably place an enormous weight on risk assessment for the purpose of avoiding liability, clinicians working in these settings recognize that client well-being and therapeutic efficacy may be inadvertently compromised as a result. There is a growing recognition that despite the heavy influence of risk assessment and management in mental health care, there is presently an absence of research evidence to support the effectiveness of this clinical framework in reducing risk (Wand, Isobel & Derrick, 2015). The inability to effectively reduce risk based on assessment tools further serves to create a clinical atmosphere of fear, resulting in the over-reaction of clinicians who are either unaware of the interpersonal process essential to effective risk assessment and/or are working in environments where avoiding the legal repercussions of clients risk behaviour are highlighted above all else. Deuter and colleagues (2013) refer to mental health's focus on risk rather than "holistic care and engagement, collaboration, therapy, and addressing social and other stressors. Our current focus is one of 'surveillance', of involuntary treatment, observation and medication (p. 159)."

While there is a wealth of research and theory which explores teaching clinical assessment skills to students, there is a scarcity of literature addressing how risk assessment and management is taught at the graduate level. There is no evidence that the process of risk assessment/management, which includes managing clinician anxiety, balancing liability concerns with effective therapeutic work and encouraging client collaboration, is included when clinical assessment skills are taught. Burgeoning practitioners need knowledge and skills in risk identification, assessment and stabilization to be effective agents of change in micro, mezzo and macro practice settings.

Methodology

This research utilized a qualitative phenomenological research approach design (Creswell, 2012; Reason & Bradberry, 2008) to explore the experiences of the 75 participants. Specifically, the researchers sought to explore mental health professionals' understanding of the risk identification, assessment and stabilization training needs among MSW students and postgraduate school mental health professionals (both unlicensed and licensed practitioners) working with vulnerable communities. Utilizing a semi-structured 5-item survey questionnaire, participants were asked to share their understanding of what risk factors are and their comfort level with the following clinical activities: *(1) Identifying risk factors; (2) Assessing risk factors; and (3) Stabilizing risk factors*.

Participants

Participants in this study were selected via snowball sampling from first and second-year MSW students, faculty and related field placement employees in a public University located in Southern California. Participants were informed of the survey through student-initiated email blasts and social media posts. This purposive sampling promoted 'typical case sampling' of an effected population (Crossman, 2019). The participants consisted of (n=75) first and second-year MSW students, MSW associates, Marriage and Family Therapist interns, Psychologists, and Licensed LCSW's and MFT's.

Participant Demographics

Among the 75 participants who participated in the study, the majority were female-identified, with 81% identifying as female (n=61), 17% identifying as male, and 1% identifying as gender non-conforming/genderqueer. 77% of the participants (n=58) fell within the age range of 18-30, with 8% between the ages of 31-40, 10% between the ages of 41-50, and 4% between the ages of 51-65. The diversity of the participants was as follows: 49% identified as Latinx/Hispanic,

32% identified as Caucasian/White, 5% identified as African American/Black, 2% identified as Pacific Islander, 9% identified as Native American, and 1% identified as *Other*. Participants were also asked to identify their discipline; 75% identified as Social Workers, 13% as Marriage and Family Therapists, 2% as Counselors, 1% as Psychologists, and 6% responded as *Other*. The majority of respondents were students, with 89% identifying as graduate students. 5% of participants indicated being licensed for over 20 years, 2% were licensed between 10-20 years, 1% were licensed up to 5 years, and 1% identified as working towards licensure.

Procedures

The survey consisted of both open and closed-ended questions that explored participants' understanding of risk in mental health settings, their confidence around risk, their process around risk, and comfort levels in identifying, assessing, and managing/stabilizing risk. In addition, participants were asked to share how they navigate the challenges of encountering risk. Examples of questions asked that elicited answers were *"How do you define risk in mental health setting?", "How do you identify risk?", "How do you assess for risk?", "How do you manage/stabilize risk?", "What makes identifying risk challenging?", "What makes assessing risk challenging?",* and *"What makes managing or stabilizing risk challenging?"* Closed-ended questions (i.e. Yes/No) were as follows: *"Do you know how to identify risk?" "Do you know how to assess for risk"* and *"Do you know how to manage or stabilize risk?"* The second set of questions asked participants about their comfort levels, on a 7 point Likert scale ranging from extremely uncomfortable to extremely comfortable, in identifying, assessing, and managing/stabilizing the seven risks mentioned above (i.e. suicide, homicide, child abuse, elder or dependent adult abuse, domestic violence, substance use or abuse, and grave disability).

Results

Participants were able to define risk in multiple ways. The primary themes participants utilized in determining risk were *the potential for harm, danger* or *unsafe circumstances*. Participants described risk in the following ways:

- *"Risk is the probability of unsafe behaviours."*
- *"I define risk in mental health as any signal that harm can occur for a person. Risk can be harm of hurting oneself or others, or simply of specific symptoms that may manifest into larger diagnoses. Risk is a signal that something more detrimental may occur."*
- *"In mental health settings, I define risk as anything that can impede the safety and well-being as a client."*

- *"Something that may cause harm (whether that be an emotional, physical, etc.) to a person (yourself, client or others); even the chance or exposure to such a thing."*

While many of the participants linked risk to self-harm and harm to others, the responses are generally broad, referring to emotional or physical circumstances rather than direct references to suicide, homicide, domestic violence and other risk factors. Vague references to harmful experiences or dynamics suggest that participants may not be aware of specific risk factors and may impact their ability to identify and address them in therapeutic interactions. Further, the vague nature of these responses suggests that while participants are fearful of the dangers of risk, translating the nebulous nature of the term into tangible practice, behaviours or symptoms is challenging.

The participants also identified identity markers, lived experiences, mental illness and trauma as factors that may increase vulnerability to risk. Participants recognized that exposure to oppression, prior experiences of trauma and ongoing discrimination were reflective of increased risk. Participants' responses indicated that risk encompassed more than just a measurement of potential harm and reflected their beliefs that *marginalization resulted in increased vulnerability for risk*. They stated:

- *"People who are more underprivileged in society are at more of a risk for mental illness, oppression, etc."*
- *"Risk in mental health settings is broadly defined, as various factors could impact ones mental health or play a role in the efficacy of mental health treatment. Risk factors include poverty, low socioeconomic status, physical impairments (diagnoses or developmental impairments), substance use and addictions, abuse of any kind, trauma history, immigration status, or belonging to a stigmatized or marginalized intersectional identity."*
- *"Risk within the mental health settings deals with looking at factors that an individual has that make them more susceptible to mental health disorders."*
- *"I define risk in a mental health setting as an environmental, social, and identity markers that heighten safety concerns."*

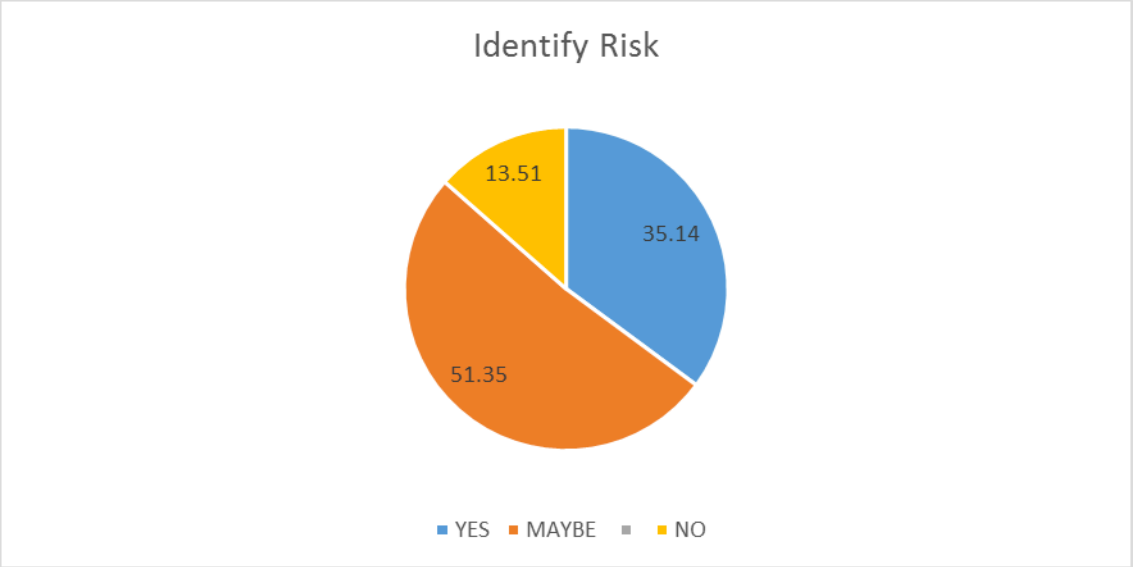
These responses, while accurately capturing the nuances of risk and the increased vulnerability of marginalized populations, add clarity to the difficulty in navigating risk. Danger, oppression, risk and marginalization are often overwhelming concepts for clinicians to unpack. Thus, the capacity to be curious about intersectional identity and historical trauma while concurrently engaging clients

to inquire about risk necessitates a level of cultural humility not reflected in risk literature.

Identification of Risk

Participants indicated that for the most part, they were unclear about how to identify risk (Figure 1.1). Over half (51%) of participants stated that *Maybe* they could identify risk while 35% indicated that *Yes*, they felt confident they could identify risk. The remaining 13% stated that *No*, they did not feel comfortable identifying risk. These findings are disturbing at best; without an awareness of how to identify risk, clinicians are likely to miss the curiosity, inquiry, observation and assessment necessary to address and manage potentially life-threatening factors.

Figure 1.1



Risk Assessment

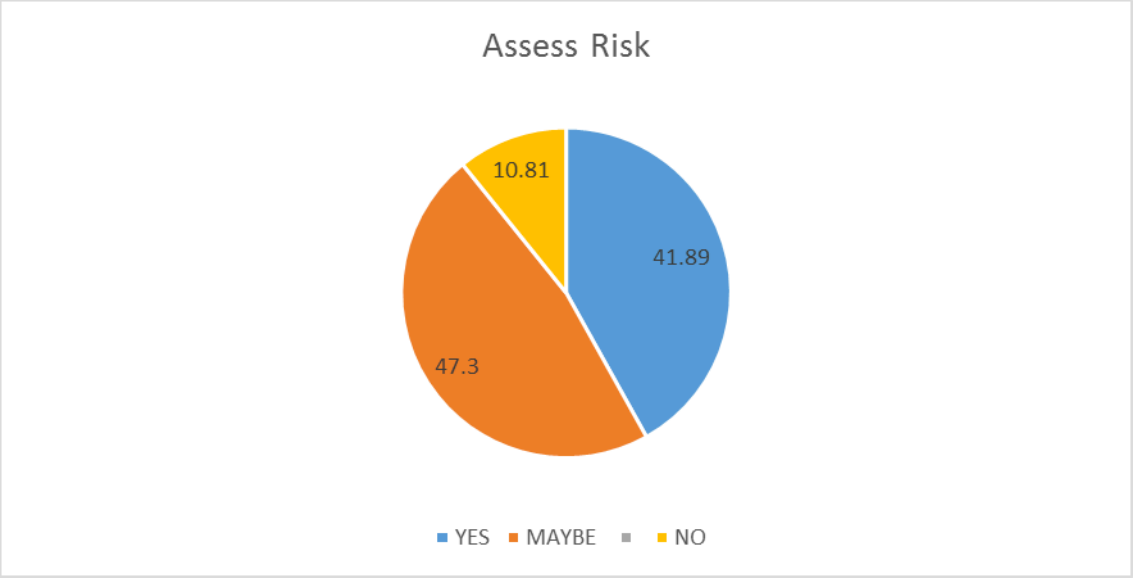
While there was a range of responses to the risk assessment question, the majority of the participants referred to the importance of utilizing an approach such as a Bio-Psycho-Social assessment, and supplementing with tools provided to them by their agency or supervisor. They also indicated that without clarity from their supervisor or in the absence of a supervisor, they were unclear how to proceed. Participants were clear that they understood they needed to ask clients direct questions, however, only a few referenced the need to observe clients, speak to collateral contacts or consider data (i.e. police reports, previous therapist records, prior hospitalizations, etc.). A few of the participants referred to specific standardized questionnaires (for suicide or homicide), but the majority referenced diagnostic and assessment tools vaguely. Participants indicated they assessed for risk assessment in the following ways:

- *"Ask direct and/or open questions and listen to clients for keywords or non-verbal cues."*
- *"During the assessment, if a risk is presented, you use a diagnostic tool to assess."*

- *"There are various questionnaire tools that clinicians can use to assess risk. It will often depend on the type of risk that is present. For example, if a client expresses suicidality, the clinician should conduct a thorough suicide risk assessment."*
- *"Ask direct questions, look at data such as previous hospitalizations, use collateral information."*
- *"Bio-psycho-social"*

The majority of the participants indicated (47%) that *Maybe* they understood how to assess for risk (Figure 1.2). Just under half of the participants (42%) indicated *Yes*, they had an understanding of how to assess for risk (42%), while a smaller percentage (11%) felt *No*, they did not know how to assess risk. These responses appear directly related to the prior question- if the majority of participants were unclear on how to identify risk, it follows that they may be equally unclear about what and how to assess for them.

Figure 1.2



Risk Management and Stabilization

Many of the participants recognized that risk management often involves identification of what type of risk it is, and if reporting or involving additional resources is necessary. Many of them indicated that their responses would vary depending on the level of risk, threat or how imminent it was. It is clear that for these participants, there was a clear line of demarcation between when clients were in serious danger, requiring additional support, versus clients that could be supported without the need for additional resources. For many of the participants, this was reflected in responses that immediately involved law enforcement or a medical facility.

However, a significant number of participants responded "*I don't know*" to this question. Participants stated:

- *"You see if it is an immediate threat. If so you call the necessary people in such as PMRT and stay with the client. If the client is threatening to immediately harm you or someone else and has a plan call the police."*
- *"By developing a safety plan for the client. Helping the client de-escalate so that they are able to manage their symptoms."*
- *"Depending on the type of level of risk, for immediate risk of harm request psychiatric evaluation for a hold."*
- *"A clinician's duty is to protect the client and anyone who may be harmed by the client (through abuse or homicide) from immediate danger. This can mean contacting child & family services or the police. In cases of suicidality, the clinician needs to decide whether the client needs to be hospitalized immediately, or if they are able to wait to receive additional mental health help."*
- *"I have no idea."*

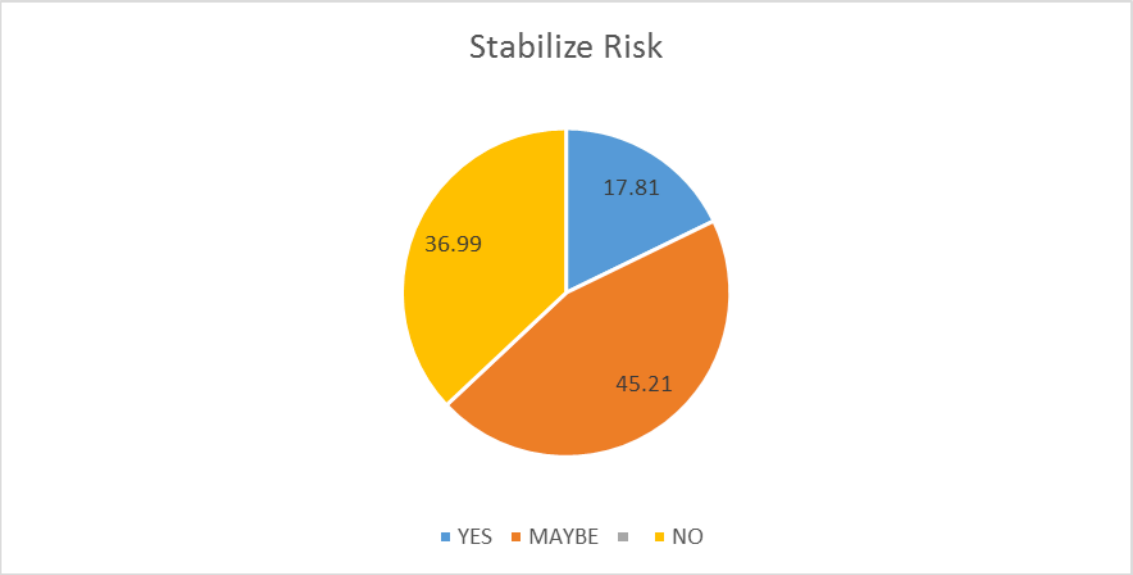
Many participants indicated that their primary contact was their supervisor, who, would guide them to address the client's risk. However, they also indicated that their supervisor's availability and general support within the agency would determine how they managed the risk. Others indicated that they understood that risk management involved some degree of negotiation, communication, safety planning and ongoing integration of risk management in their treatment plans. While these responses are positive and reflect an academic understanding of appropriate treatment planning and risk management, they don't address how to navigate with vulnerable, acute risks often present in community mental health or child welfare settings. The responses from the participants reflect a general ambiguity, with references to *safety plan, monitor and eliminate risk, be there for them, protective factors* and *be preventative* illustrate more of a state rather than specific direction when it comes to risk management. Additionally, none of the participant responses reflects consideration of the interpersonal process between clinician and client that is inherent in culturally relevant risk management. Examples of participant statements include:

- *Honestly, I would do whatever the agency I work with tells me, but since there is no clear guidance on this, I try to be preventative and present with the family in order to understand when things might be going in a certain direction.*
- *Provide client with the right resources.*

- *By developing a plan to eliminate risk factors and maximize protective factors.*
- *Consulting with a supervisor. Continuously monitoring the risk, working with the client to mutually set goals and treatment plans.*
- *By identifying the person's safety plan, and see who they trust to call and be there for them when they have ideation of harming themselves or others.*

The majority of the participants (45%) stated that *Maybe* they knew how to stabilize or manage risk factors, while a sizable number (37%) indicated *No*, they did not know how to navigate this in clinical spaces (Figure 1.3). The minority of participants, (18%) stated the felt like *Yes*, they did know how to stabilize risk. This is particularly concerning because of the corresponding safety risk for clients and liability for practitioners if the understanding of what do to or how to manage risk is unclear. Because the majority of tools are assessment oriented, practitioners are left without a systematic way to assess and manage risk. This has the potential to promote a sense of having to reinvent the wheel with each risk assessment and further reinforce feelings of insecurity in the clinician.

Figure 1.3



Discussion

Ensuring client safety is central and crucial to the provision of effective mental health services, and in particular with vulnerable populations. Findings suggested that the majority of the mental health professionals who participated in this study were unsure of how to identify and assess for risk. Protecting clients and practitioners from harm is a key priority in the profession, in addition to knowing how to effectively assess, manage and stabilize risk. A Vision for Change

(2006) asserted "the development of clinical risk-management and risk-assessment approaches within mental health settings is essential. Reducing exposure to litigation and financial risk addresses just one narrow aspect of the risk-management agenda. The recording and analysis of adverse events in clinical risk management must be seen in a wider context of service user safety, staff safety, quality service delivery and clinical governance" (pg. 104). These are essential skills, and providing such protection is a foundational component in the mental health profession.

Participants' comments reflected their beliefs that oppression results in increased vulnerability, engendering increased levels of risk. Culturally relevant clinical practice includes risk assessment and management which takes into account vulnerability experienced by the client and is often exacerbated by their intersectional identities (e.g. a Black client experiencing homelessness, transgender youth of colour recently emancipated, or an undocumented single mother of five). Thus, practitioners must be curious about the intersectional nuances of clients, their interpersonal and environmental contexts and their protective factors, in addition to the presenting problems. Understanding clients holistically while not generalizing their lived and living experiences aids in the development of therapeutic rapport, positions the clinician for cultural humility and fosters mutual respect. A climate of mutual respect allows clients to be seen and heard and ensures that providers can effectively see, assess and address risk in clinical settings. Mental health professionals, depending on their social location, privilege, or bias may miss these intersectional identity factors, rendering the therapeutic environment unsafe. It is impossible to provide effective clinical care services without safety; thus, it is the responsibility of the mental health profession to provide comprehensive instruction and ongoing training for culturally relevant engagement to effectively identify, assess and manage risk among vulnerable communities.

This study has emphasized that knowledge and practice skills in assessment and management of risk is vital to providing quality care and services in the mental health profession. Effective risk management skills entail the implementation of clear and concise procedures that support honouring the humanity and dignity of the clients served. This approach allows practitioners to support clients in the here and now and encourages a dynamic of sensitivity to the client's needs, vulnerabilities and behaviours while simultaneously seeing them without risk related fears. The authors believe that the following are pivotal steps to take when risk identifying, assessing and managing/stabilizing clients:

1. Identify client intersectional identities and needs to provide culturally relevant care while stabilizing clients.

2. Practitioners are curious about the presence and impact of stigma at all levels of risk management (identifying, assessing and stabilization).

3. Risk assessment skills should support and honour the client's current reality (including experiences of power, privilege or lack thereof), with acknowledgement of differences in identity and social location.

4. Interpersonal dynamics that occur between the clinician and client should be acknowledged, unpacked and processed as they occur during the identification, assessment and management of risk.

The certainty of clinical practice is that risk assessment tools can aid clinical judgement but not replace it, conversely it is the individual and not a scale or a test who makes the final decision with service provision. Participants in this study clearly indicated that they depend largely on the direction of a supervisor for clinical guidance; when the supervisor is unclear, overwhelmed or unavailable, it leaves less seasoned practitioners and their clients vulnerable to poor risk decision making. Effective communication (between practitioners and clients and practitioners and supervisors) is key in managing risk in clinical practice. Lipscomb and Ashley (2017) refer to this as the *triple process*. All forms of communication are essential to achieve effective risk management care while delivering services. Findings from this study suggest specific communication strategies that are vital to achieve competency in risk management:

1) Listen with genuine concern to comprehensively understand the client's perception of the problem, current context, intersectional lens and concerns. Navigation to ensure client and practitioner safety is a collaborative process that involves deconstructing the perspectives of clients, practitioners and supervisors.
2) Maintain a position of curiosity rather than expertise. Clinicians must simultaneously engage clients while obtaining information regarding the nature, duration, frequency, intensity and history of the risks. This is not the time to psycho-educate clients or guilt them into signing a safety plan.
3) Thorough documentation records are important to maintain to promote caution regarding liability, accountability and consistent client care as a mental health practitioner.
4) Establishment of risk specific treatment plan objectives. Once risks are stabilized, ongoing monitoring, reviewing and tracking client's changes and progress as they relate to safety plan objectives.

5) Consistent guidance for unlicensed practitioners in a) maintaining awareness of the responsibilities in identification, assessment and stabilization of risk, b) teaching clinicians the content and process of risk management; and c) ongoing documentation of their efforts.

In essence, risk management requires that mental health professionals consider clients not as mere passive participants of service but rather as actively involved, contributors and informants of the risk and safety planning process.

Conclusion

This article sought to explore mental health professionals' understanding of the risk identification, assessment and stabilization training needs of master's level graduate students, while in graduate programs and after graduation working with vulnerable communities. What emerged from this exploration is the need for a risk management process that addresses the gap between academic knowledge obtained from graduate education and postgraduate clinical supervisors that can be

References

Barry, M. (2007). Effective Approaches to Risk Assessment in Social Work: An International Literature Review. *Scottish Executive Social Research.*

Borders, D. (2014). Best practices in clinical supervision: Another step in delineating effective supervision practice. *American Journal of Psychotherapy, 68*, 2, 151-162.

Creswell, J. W. (2012). *Educational research: Planning, conducting, and evaluating quantitative and qualitative.* Boston: Person Educational, Inc.

Crossman, A. (2019, October 17). Understanding purposive sampling. Retrieved from: https://www.thoughtco.com/purposive-sampling-3026727.

Department of Health and Children (2006). A Vision for Change Stationary Office, Dublin.

Deuter, K., Galley, P., Champion, A., Gordon, A., Halczuk, T., Jackson, A., Jones, A., Legg, L., Murison, J., Newman, C. & Procter, N. (2013). Risk assessment and risk management: Developing a model of shared learning in clinical practice. *Advances in Mental Health*, *11*(2), 157-162.

Glancey, G. & Chaimowitz, G. (2005). The Clinical Use of Risk Assessment. *The Canadian Journal of Psychiatry,* 50, 1.

Littlechild, B. & Hawley, C. (2009). Risk Assessments for mental health users: ethical, valid,

reliable? *Journal of Social Work,* DOI: 10.1177/1468017309342191.

Lipscomb, A. E., & Ashley, W. (2017). Colorful disclosures: Identifying identity-based differences and enhancing critical consciousness in supervision. *Smith College Studies in Social Work, 87*(2-3), 220-237.

Reason, P. & Bradberry, H. (2008). (eds) *The Sage Handbook of Action Research: Participative Inquiry and Practice.* Sage, CA.

U.S. Merit Systems Protection Board. (2010). A Call to Action: Improving First-Level Supervision of Federal Employees. A Report to the President and the Congress of the United States. May 2010. Retrieved at: http://www.mspb.gov/netsearch/viewdocs.aspx?docnumber=516534&version=517986&application=ACROBAT.

Wand, T., Isobel, S., & Derrick, K. (2015). Surveying clinician perceptions of risk assessment and management practices in mental health provision. *Australasian Psychiatry,* 23, 2, 147-153.

Wand, T. (2012). Investigating the evidence for the effectiveness of risk assessment in mental health care. *Issues in Mental Health Nursing, 33*, 2–7. DOI: 10.3109/01612840.2011.616984.