Mental Health Risk Retention Group, Inc.
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Risk Assessment for Violence Protocol

A collision of diverse realities: corporate leadership initiatives, adverse action incident, conflicting public policy mandates and legislation, incorporating evolving clinical research into clinical practice patterns and legal entanglements challenges the Center to continuously rethink how it views the universe of risk management. Yesterday's impossibilities and assumptions become today's opportunity and discipline. Risk management has become embedded in all aspects of the Center's operation.

Corporate Leadership:

In 1993, the Center's Executive Director challenged the Center's clinical managers and professional staff to systematically develop and implement clinical protocols stipulating preferred practice guidelines. Shortly thereafter, the Center established a protocol development process (See Appendix 1). The procedure for initiating a protocol task group resides with any employee or group of employees regardless of status or credential. Once initiated the proposal is screened utilizing the following criteria: need and impact on effectiveness and efficiency. The next step in the development process is establishing a task group consisting of management and those professionals who are impacted. This process is consistent with the Center's mission, management philosophy and goals (See Appendix 2). The protocol implementation process involves the task group submitting their proposed protocol in compliance with the established format (See Appendix 1) for management and executive staff review and their recommendation for approval. The Executive Director approves all protocols. The signature of the task group facilitator(s) and Executive Director are affixed on each protocol. This process ensures staff participation, ownership and utilization.

Public Policy The State transferred to Community Mental Health Centers the responsibility for monitoring persons conditionally released who were found to be not guilty by reason of insanity and incompetent to stand trail due to mental illness. This increased responsibility exacerbated our risk potential exponentially.

Incident Just prior to this change a severely mentally disabled client the Center had been serving for more than ten years, stabbed two persons, killing one and wounding the other.

Risk Assessment for Violence Protocol:

Because of these realities the ensuing systematic process brought to light current research data and outcomes, conflicting mandates (public policy vs. legislation), the need for professional guidelines, training and continuous/vigilant monitoring of our diverse environment. The notice of a pending claim action coupled with the Ohio Supreme Court ruling in the case, Morgan v. Fairfield Family Counseling Center, stimulated the Center's Risk Assessment for Violence Protocol initiative. (See Appendix 3).

The utilization of the protocol's Risk for Violence Inventory (See Appendix 4) enables professional staff regardless of licensure status or discipline to identify high-risk patients who may potentially act out in violent or aggressive acts, facilitates appropriate supervisory involvement and monitoring, identifies appropriate and necessary level of care options and assures an efficient and effective manner for documenting assessment and actions in compliance with practice and legal guidelines and rules.

Prior to the Risk Assessment for Violence Protocol implementation the Center assumed managers and professional staff were cognizant of and effectively managing at risk clients. Once this assumption was subjected to the Center's established protocol development process, we became aware of the significant variance between the assumption and reality. Our Risk Assessment for Violence Protocol has enabled the Center to move from assumption to fact, from no data to a comprehensive array of data and from assumed risk management to disciplined risk management.

The implementation of the Center's Risk Assessment for Violence Protocol clearly demonstrates quality of care improvement. Enhancing our professional competence and confidence related to identifying and engaging high-risk clients is viewed as a client and community benefit since the ultimate quality care criteria is strengthening client functioning. The client's perception of quality related to the Center's comprehensive system of care options as well as specific programs and services indicates exceptional outcomes (See Appendix 5). A cluster of the Center's client satisfaction survey outcomes indicate that we consistently exceed internationally benched marked outcomes. These results coupled with professional participation in targeted inservice training (See Appendix 6) and increased utilization of the Risk Assessment for Violence Protocol instrument evidences increased quality of care.

The Center's professional staff have been and are intimately involved in all aspects of protocol development and most especially in the development of the Risk Assessment for Violence Protocol. The task group reviewed the literature and research, particularly the MacArthur Violence Risk Assessment Study (Monahan, 1998), the Ohio Supreme Court ruling, included professionals deposed in the Center's adverse action incident, and anticipated recent legislation: House Bill 71, 1999.

All professional staff participated in the inservice training and their suggestions lead to further refinements of the protocol. The task group produced an introductory video specific to the topic. The Risk Assessment for Violence Protocol was utilized 78 times in the first year of implementation and has been utilized 146 times so far this year. The protocol inventory has recently been amended in light of Ohio House Bill 71 to include Duty To Warn provisions. The

protocols inventory is in compliance with all preferred practice and legal documentation standards. Risk tolerance expectations have been included in all staff job descriptions (See Appendix 4). Currently, professional staff have identified a need to amend and create a like protocol inventory to be focused towards children/adolescents. This is in the final stage of approval. Because of the consistent and frequent referral to the Center's protocol manual, the Center is in the process of migrating from a paper protocol manual to copying the manual to a compact disk format.

Replication and Relevance:

The Center has copyrighted their protocols and is willing to assist other behavioral health providers is whatever way possible. The Risk Assessment for Violence Protocol can be easily modified to fit any behavioral health organizations structure. Our Risk Assessment for Violence Protocol is both relevant and ideally suited for replication, since, the integrity of the Inventory incorporates both past and contemporaneous valid research, captures data in compliances with required practice and legal documentation guidelines and enhances efficient and effective professional utilization and clinical management oversight (See Appendix 7).

Existing Resources:

The Center's Protocol development process was already operant, the Risk Assessment for Violence task group was established within these parameters. The Center's standing Inservice Training Committee facilitated the trainings utilizing members of the protocol task group as facilitators and accessing the Center's video production capabilities.

History and Scope of Organization:

Scioto Paint Valley Mental Health Corporation was incorporated in 1965 as a 501 C (3)

Date # of Staff # of Clients Crisis Contacts Service Area Budget

FY '66 2 101 0 1 County $60,000

FY '99 224 8,576 29,768 5 Counties $10 Million

The Center serves a five county rural area in South Central Ohio, a geographic area greater than the size of the State of Delaware. We provide a comprehensive array of services to a diverse population. The Center's decentralized management model has enabled us to maintain a tradition of innovation. We operate five outpatient clinics, a children's residential center, an adult residential center and a blend of staffed, supervised and unsupervised housing options. Service options at each outpatient site include:

adult and children outpatients. community support: continuum of care for the severely mentally impaired. substance abuse. partial hospitalization, 24 hour crisis, employee assistance, critical incident stress debriefing, community education and consultation and forensic monitoring. Our specialized program options include: DUI Intensive 48 hour group educational and assessment services, Poly Recovery Program intensive outpatient substance abuse treatment. QA continuous improvement process, Forensic services: court referred assessments, conditional release assessment and monitoring. sexual offender groups and shop lifting groups. and Transitional Services: facilitating and coordinating inpatient discharge planning related to internal and external continuum of care placements, assuring availability of community services.

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