The Tavistock and Portman NHS
NHS Foundation Trust

Clinical Risk Assessment Procedure

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Contents

Clinical Risk Assessment Procedure

1 Introduction

The Tavistock and Portman NHS Foundation Trust (the Trust) has very particular needs in terms of a clinical risk assessment system for patients. The Trust provides psychological therapies to a wide range of patients covering the lifespan, from infancy to older adults. Unlike most other mental health trusts, it has no in-patient beds or psychiatric wards. However, risk remains an important consideration in all the care provided for all our patients. Also, a number of our services are engaged in assessment rather than direct treatment which means that they consider risk from a specific perspective and their assessment of risk determines how they start work and under what conditions.

A system which accommodates those at high risk runs the risk of having poor face validity to clinicians who routinely treat patients who present a low risk, and consequently the systems may fall out of use. Consequently, an effective and efficient system needs to be able to address the risks posed by those patients who raise concern and anxiety, whilst simultaneously not wasting the time of clinicians by applying disproportionate risk assessment to the vast majority of cases where the likelihood of harmful actions by patients is low. The model of risk assessment which involves "one size fits all" is clearly cumbersome and wasteful.

With this as a background the Trust recognises the importance of assessing patients for risk factors and responding to those risk factors both during the assessment phase of contact and throughout their on-going treatment if accepted.

This document sets out the framework in which risk assessment is carried out at the Trust, and the documentation that is to be used to record the results of the assessment. It provides a guideline to the approach rather than a rigid prescription due to the range of clinical presentations, approaches to therapy and age range of patients that are treated at the Trust.

2 Purpose

The purpose of this procedure is to provide a framework for a consistent approach to clinical risk assessment across the Trust, and to detail the way in which risk assessments should be recorded and communicated to relevant professionals and others with a legitimate interest.

3 Scope

The principles in this document should be followed by all clinical staff with direct responsibility for the assessment and on-going treatment of patients referred to the Trust. Risk assessment and management should be a collaborative process with the client/patient as they ultimately need to learn to take responsibility for managing their own risk and the clinician should construct a collaborative safety plan with the /patient which they regularly review as part of their ongoing work. This is also a dynamic process and therefore points to the importance on continual review.

Administrative staff who work directly with clinicians will support the process of documenting risk assessment by supporting the timely completion of the Trust's designated forms, and ensuring that correspondence with GPs referrers, and others with a legitimate interest, is dispatched promptly.

4 Definitions

Clinical approach to risk assessment	Evaluation of risk on the basis of the clinical expertise and judgement of the clinician. This is carried out using a clinical approach by gathering information from the patient[1].
Actuarial approach to risk assessment	Assessing risk which is founded on empirical population based research studies that have identified various static and historical variables which have been found to predict the risk of a particular outcome: in our population violence and self-harm, and in very extreme cases, suicide and homicide.
Structured clinical risk assessment	This approach is Based on national guidance; it involves the use of clinical judgment that is guided by a standardised format, and taking into account actuarial risk factors. Structured clinical risk assessment is the approach taken by the Trust and detailed in this document.

5 Duties and responsibilities

5.1 Medical Director

The Medical Director has overall responsibility for this procedure in his role as lead for clinical risk.

5.2 Associate Medical Director (Patient Safety and Clinical Risk Lead)

The Associate Medical Director (Patient Safety and Clinical Risk Lead) will ensure that directors of clinical services and Heads of Discipline are fully aware of the requirements for risk assessment and documentation. The director will advise the Trust on all aspects of

clinical risk assessment that affect the Trust, in particular changes in national approaches to risk assessment, provision of care or other aspects of psychological therapies that could have an effect on the assessment or management of risk presented by Trust patients.

[1] The clinical approach has been criticised for being too subjective, with poor inter-rate reliability.

5.3 Directors of clinical services and associate clinical directors

Clinical Directors and Associate Clinical Directors will promote high standards of risk assessment and risk documentation in practice, and will ensure that adequate supervision arrangements are in place to support trainees in risk assessment.

5.4 Qualified Clinical Staff

Clinical staff will follow the principles within this procedure and undertake risk assessment of their patients at appropriate intervals during assessment and treatment at the Trust. Clinical staff will ensure that risk assessment findings are documented fully and accurately and that where risk factors are identified, these are considered in care planning and in communication with relevant others (e.g. GP, referrer, and other members of the patient's care team)

5.5 Clinical Trainees

Clinical trainees will follow the principles within this procedure and undertake risk assessment of their patients at appropriate intervals during care at the Trust. Clinical trainees will ensure that risk assessment findings are documented fully and accurately and that where risk factors are identified these are considered in care planning and in communication with relevant others (e.g. GP, referrer, other members of the patient's care team). In addition, trainees will refer to their supervisor in all circumstances when a risk assessment identifies risks that require action outside the scope or capability of the trainee, and ensure that their supervisor signs off complete assessment, termly review and closure forms.

5.6 Associate Medical Director (clinical audit lead)

The Associate Medical Director will lead the Trust's programme of audits of record keeping standards. These audits will include assessment of compliance with the completion of risk sections on the Trust's assessment, termly and closure forms in line with the Health Record Keeping Standards.

5.7 Clinical Governance and Quality Manager

The Clinical Governance and Quality Manager will provide support to the associate medical directors in discharging their roles.

6 Procedures

For background and context discussions to the Trust's approach to Clinical Risk Assessment please see Appendix B.

6.1 Conducting an Effective Risk Assessment

6.1.1 Initial considerations

Risk assessment and management should be a collaborative process with the client/patient, as they ultimately need to learn to take responsibility for managing their own risk and the clinician should construct a collaborative safety plan with the patient, which they regularly review as part of their ongoing work. This is also a dynamic process and therefore points to the importance of continual review.

A number of criteria should be considered when assessing a patient's risk of harm to themselves or to others. Along with clinical judgements derived from one's interaction with a patient, establishing historical and material facts relating to an individual's risk is

of critical importance to providing the foundation for a safe psychotherapeutic treatment.

Best practice involves drawing together information elicited during assessment interviews, together with background information supplied by the referrer. An aspect of this will inevitably involve asking direct questions, if clinical judgement requires it. Information may also be sought from third parties where deemed appropriate (these may be relatives or carers and people from any agency involved in the person's care).

For patients at risk of self-harm and/or suicide, the clinician should take guidance from the respective procedures.

Risk assessment of children and vulnerable adults is likely to focus on the possibility of that child/vulnerable adult being harmed. Various settings within the trust, including Gloucester House need to keep updated risk plans with risk assessments reviewed following incidents. Awareness, sound clinical knowledge and expertise should also guide the clinician assessing possible harm to children and/or vulnerable adults. Further advice on this can be found in the Trust's Safeguarding Children and the Safeguarding Adults procedures.

6.1.2 Guide to assist clinical judgement when assessing a patient's risk

The decision tree (see appendix C) guides the clinician though a 4 stage structured risk assessment as follows:

- Stage 1: History of Risk and Current Risk
- Stage 2: Long-term Risk
- Stage 3: Situational Assessment
- Stage 4: Assessment of Acute Risk

A summary of the consideration to be given to each of these stages is set out below. This is a guide; each clinician will need to assess risk for each individual patient in the light of the individual patient's needs, understandings and presentation. It is important that each of these stages is considered when drawing together a risk profile for a patient.

Stage 1: History of Risk and Current Risk

The initial consideration is whether the patient has a recent/current history of harm to self and/or other and to explore this in more detail. There should always be enquiry about a patient's current suicidal thinking and past history of self-harm or suicide attempts. If there is no history of harm to self and/or other, the clinician should then consider whether they are satisfied with a rating of "low risk" from a clinical point of view. If the clinician has no other reasons to be concerned about risk, then the boxes indicating low risk should be ticked on the core documentation (see below).

Stage 2: Long-term Risk

If there has been a history of harm to self and/or other, the clinician should proceed to the next stages of risk assessment. This is a review of factors associated with long-term risk of harm to self and others. Clinicians should review the presence or absence of known material factors associated with suicidal and para-suicidal behaviour and/or harm

to others, and use this information to determine whether there is a low, medium or high level of background risk in the patient. These material factors are summarised in Appendix E. Any protective factors that mitigate or reduce the risk should also be identified.

Stage 3: Situational Assessment

Once again, if there is a history of harm to self and/or other, or if the clinician is concerned about the risk presented by the patient in the absence of previous risky behaviour, the clinician should make further enquiries into the circumstances of the risky behaviour. In other words, the clinician should enquire about the situations in which the behaviour has arisen in the past, and therefore about the situations in which it is likely to occur in the future. The situational assessment would also include existing areas of assessment as follows:-

- **Frequency**: how frequently has the risk behaviour been enacted, and is this frequency changing (the more frequent the behaviour, the more risk presented).
- **Severity**: how severe was the risk behaviour.
- **Immediacy**: how recently was the risk behaviour carried out?
- **Pattern**: are there specific situations that provoke a risk behaviour (eg: break-up of relationship or loss –this could indicate potential high risk periods during a patient's course of treatment).

Stage 4: Assessment of Acute Risk

The assessment of current and/or imminent risk of harm to self and/or other is a largely clinical endeavour. Here the patient's current state of mind is assessed, including:

- **Ideation**: how frequent, intrusive or worrying are the thoughts to the patient with regard to the risk behaviour and is this frequency increasing (the greater the prominence, persistence and intrusiveness of thoughts, the higher the risk). The clinician should also determine the level of despair expressed by the patient.

- **Intent**: a statement from the patient that they intend to harm themselves/others is the strongest indicator of risk and should never be dismissed.

- **Planning:** how far has any plan regarding risk behaviour been developed (thoughts without any plan or access to the means to carry out a risk behaviour carry less risk than a formulated plan)

Stage 5: Formulation

The formulation of the risk should aim to answer the questions:

- How serious is the risk?
- Is the risk specific or general?
- How immediate is the risk?
- Is the risk liable to diminish fairly quickly? (if yes on what basis is that prediction made?, eg removal of stressors))
- Are circumstances likely to arise that will increase the risk?
- What specific treatment, and which management plan, including the involvement

of other agencies if necessary, can best reduce the risk?

The formulation may include thoughts about the meaning of enactment/s, how and when these might be repeated in relationships with others, possible transference manifestations and countertransference responses, as well as other factors likely to have a bearing on risk, such as substance misuse, relationship issues and the effect of treatment and breaks.

6.2 Managing Patient Risk

6.2.1 Action to be taken if patient is assessed as being at immediate risk

The following process should be followed when dealing with immediate significant risk posed by a patient

Action to be taken by Clinical Trainees:

When there is concern regarding a patient's deterioration involving increased risk to themselves or others or increased possibility of harm advice should be sought without delay in the following order:

1. From the case consultant or senior clinician responsible, or in their absence
2. From the departmental rota duty consultant or other senior clinical managers, or if they are not able to be contacted
3. From a member of the Medical Discipline in the department.

Action to be taken by Senior Clinicians:

Senior clinicians may need to act to deal with a crisis with a patient themselves. However, they are advised to seek the involvement of a member of the Medical Discipline in the department, if possible.

It is always best practice to confer with colleagues and very important that any discussions with other colleagues are documented in the case notes.

In all above cases, if the patient requires urgent transfer to an acute psychiatric unit this should be arranged via a 999 ambulance call and in accordance with the Rapid Transfer Procedure.

6.2.1 On-going risk management

Assessment and management of risk are an interlinking process. The first involves a gate keeping role, whilst the second concerns the management of the risks identified. Whilst the process of assessment is intended to be a generic one across the Trust as a whole, management will be tailored to each group.

Risk management aims at containing the risk a patient may present to themselves or others, or often in the case of children and vulnerable adults containing the risk of harm that may be perpetrated against them.

The level of risk a patient presents may allow for containment within the therapeutic

environment of the Trust. However a patient may present with a high enough risk to warrant the involvement of other professionals. At the point of assessment, it is important to remember that at times treatment may exacerbate the level of risk.

If it is determined that the risk of harm to self or other is high, it may be necessary to have the agreement of other professionals involved in the patient's care external to the Trust, such as the local mental health team, to provide backup before accepting a patient into treatment, particularly if the patient is subject to CPA (see below).

6.2.2 Risk Assessment and Management and Care Coordination

Effective care co-ordination is required by all those receiving services from the Trust. The purpose of care coordination is to ensure all patients in the Trust receive appropriate therapeutic interventions efficiently with good communication between patients, carers and services. Issues of risk should be dealt with systemically beyond reporting, including consideration of who should be kept updated, including family members, who is responsible for helping the client to follow through on their own safety plan, how do people in the client's network know what to do if the risk increases etc.

The Care Programme Approach (CPA) is the approach to care coordination that is applicable to those people under the care of Mental Health Trusts with mental health problems and the most complex needs Consideration of risk issues plays an important role in deciding eligibility for CPA.

The majority of patients receiving treatment in the Trust do not meet the threshold for CPA and are not subject to the formal system of care co-ordination under CPA. However, all patients in the Trust accepted for treatment should have an identified case manager or case coordinator who is responsible for overseeing their treatment and may be contacted by the patient if necessary.

The minority of patients treated in the Trust who are subject to CPA would also be under the care of another (acute) mental health trust, which will hold responsibility for the CPA co-ordination of the patient.

6.3 Specific consideration categories:

6.3.1 Risk assessment for under 18 yrs

The principles for risk assessment are as set out as above. Assessment may include the assessment of the carer/parent's risk, as well as the child's risk.

High risk patients under 18: Any practitioner identifying a child as high risk must ensure that the case is raised with the case supervisor or senior member of the team for advice and planning decisions.

In the event of 'immediate' high risk accessing additional clinical support may be indicated and/or consideration of the need to transfer the patient to a more appropriate setting, (refer to the Rapid Transfer Procedure).

6.3.2 Identification of at risk children living with an adult with mental health issues

As part of the risk assessment of every 18+ patient the clinician should enquire as to whether or not children or young people below 18 live with the patient. If the answer is 'yes', consideration should be given to whether the clinical presentation of the patient poses any risks to the child. There is a space on the printed assessment form for this data to be recorded.

If immediate risk is identified then additional clinical support may be indicated including as appropriate referral for advice to the Safeguarding Lead -refer to the Safeguarding Children Procedure.

Any concerns and advice sought from the Safeguarding Advisors or a senior clinician must be recorded in the patient record.

6.3.3 Impact of 'Digital Life' on the mental health of patients

With the increasing use of internet and social media via e.g. mobile phone, clinicians should be aware of the potential for a patient's 'digital life' to impact on their mental health and behaviour, and should consider it in their information gathering as part of a risk assessment. For example, clinicians assessing young people after episodes of self-harm should ask routinely about their use of social networking sites and the possibility of on line bullying.
Similarly, patients who feel suicidal may access on-line sites that encourage suicidal behaviour.

6.3.4 Domestic violence

Clinicians should be aware of the risks of domestic violence. The patient may be directly involved in a relationship that includes domestic violence, or in the case of a child, the patient may have witnessed domestic violence between his parents or care-givers.

6.3.5 Sexual safety

Clinicians should be alert to any risks associated with sexual behavior. They should also consider the possibility of increased risks from others to specific groups, such as due to sexual orientation or gender. These may be sexual risks that the patient poses towards others (see Appendix E for the actuarial risks associated with sexual offending) or sexual risks that the patient may be exposed to from others (please see respective procedures).

6.3.6 MAPPA eligible patients

MAPPA was established by the Criminal Justice and Court Services Act (2000) and came into being in 2001. MAPPA provides a statutory framework for inter- agency co-operation in assessing and managing violent and sex offenders in the community in England and Wales. Under the arrangements, 'Responsible Authorities' – namely Police, Probation and Prisons are supported by 'duty to co- operate' agencies including health, housing, and social services to manage the risk to the public posed by dangerous offenders.

Patients at the Portman Clinic may be subject to MAPPA, and in each case, the involved clinicians will ensure that these patients' clinical records **and** clinical risk assessment

communicate clearly the identified risk areas and agreed management, including liaising with MAPPA, with all involved staff. Further advice may be sought from the Trust MAPPA Lead (Associate Medical Director, Patient Safety and Clinical Risk).

6.4 Recording and Reviewing the Risk assessment

6.4.1 Patients undergoing Assessment:

During assessment a note of each session is to be made in the clinical record, as either a written note or a typed summary of the session.

At the conclusion of assessment a Trust Assessment form is completed (there are two forms: 'under 18', and, 'over 18').

The most up to date form is on Care Notes) for all patients whose clinical care is being recorded electronically.
If a paper file is being maintained (e.g. Portman patients) the most up to date assessment form will be found on the intranet

Note: for patients who are undergoing assessment only this form acts as the closure form and no separate closure form is required.

Any significant risks identified in the risk assessment need to be reported to the referrer at the end of the assessment with recommendations on how these can be managed.

6.3.2 Patients in Treatment

A written note is to be made in the clinical record on each occasion the patient has an appointment. At each appointment the clinician should be mindful of the patient's risks and record any changes to identified risks. There needs to be appropriate recording, including by ticking relevant box on care notes to indicate no identified change to risk.

Formal review of risk assessment for patients in treatment

For patients accepted into treatment, as a minimum, risk assessment should be reviewed and where appropriate updated at the conclusion of each term/ 6 months (the frequency will depend on the clinical service) and recorded on the Trust's review Form.

For under 18 patients the Safeguarding and Risk under 18 form should be completed in order to record or update risks.

For over 18 patients the Assessment Summary over 18 should be completed in order to record or update risks.

Closure Review (patients in treatment only)

At the conclusion of treatment and closure the risk assessment again should be revisited and an updated risk assessment should be recorded on the Closing Summary Form.

The most up to date form can be located on CareNotes.

7 Training Requirements

The Trust has conducted a training needs analysis in respect of clinical risk assessment training and concluded that all clinical staff who assess and treat patients must be familiar with both the approaches to risk assessment used at the Tavistock and the documentation that is used to record assessments.

Training will be delivered in the following way:

- Trust induction (all staff) includes an introduction to the core risk assessment documentation and the importance of competing all the risk sections, as well as signposting to all policies and procedures pertaining to clinical risk assessment and management (see Section 10 below).

- Trust Clinical Induction (all clinical staff) includes a session on how to conduct a clinical risk assessment, including both clinical and actuarial factors.

- Trust Inset (all staff) includes brief update on clinical risk assessment and signposting to all policies and procedures pertaining to clinical risk assessment and management (see Section 10 below).

- On-going training and support will be delivered to clinicians at Directorate level supervision and team meetings.

The aim of training of clinicians is two-fold. The primary aim is to impart the system of assessing and managing risk as outlined in this document. All clinicians should attend clinical risk assessment training every three years as a minimum.

Departments with 'high risk patients' will offer additional local specific training to support the work of those units. This will take a variety of forms including one to one training, seminars and multi-professional team meetings when individual patients are discussed. This training will include training in the use of recognised validated risk assessment tools such as the HCR-20, the PCL-R or the Static 99 which are widely used in other mental health settings, particularly in the forensic field.

8 Process for monitoring compliance with this Procedure

The Patient Safety and Clinical Risk Work stream, reporting to the Clinical Quality Risk and Governance Committee (CQSGC) is responsible for monitoring compliance with this procedure.

It will do this in a variety of ways including:

- receiving information on incidents relating to risk assessment
- receiving results of an annual audit of risk assessment documentation as part of the on-going rolling audit of record keeping standards
- advising the Trust on the need for further action on receipt of external advice or guidance in relation to risk assessment of mental health patients
- monitoring action plans arising from any of the above.

9 References

Department of Health (2007) Best Practice in Managing Risks: principles and guidance for best practice in the assessment and management of risk to self and others in mental health services.

HM Government (2011) No health without mental health: a cross-government mental health outcomes strategy for people of all ages New Horizons. A shared vision for mental health.

University of Manchester website lists all the National Confidential Inquiries into Suicide and Homicide by People with Mental Illness (NCI/NCISH): www.medicine.manchester.ac.uk.

10 Associated documents[2]

Prevention of Suicide Policy and Procedure

Assessment and Management of Self-harm Procedure

Policy and Procedures for Safeguarding Children and the Management of Suspected Child Abuse

Safeguarding of Adults at Risk Policy and Procedure

Procedure for Audit of Health Records (contains health record keeping standards)

Procedure for the Rapid Transfer of an Acutely Unwell Patient Clinical

Supervision Procedure

Discharge and Closure Procedure

Incident reporting procedure

Procedure for the investigation of serious incidents

Consent to treatment procedure

Promoting sexual safety procedure

[2] For the current version of Trust procedures, please refer to the intranet.

Appendix A: Equality Impact Assessment

Completed by	Irene Henderson
Position	Clinical Governance & Quality Manager
Date	April 2019

The following questions determine whether analysis is needed	**Yes**	**No**
Is it likely to affect people with particular protected characteristics differently?		X
Is it a major policy, significantly affecting how Trust services are delivered?		X
Will the policy have a significant effect on how partner organisations operate in terms of equality?		X
Does the policy relate to functions that have been identified through engagement as being important to people with particular protected characteristics?		X
Does the policy relate to an area with known inequalities?		X
Does the policy relate to any equality objectives that have been set by the Trust?		X
Other?		

If the answer to *all* of these questions was no, then the assessment is complete.

If the answer to *any* of the questions was yes, then undertake the following analysis:

	Yes	**No**	**Comment**
Do policy outcomes and service take-up differ between people with different protected characteristics?			

What are the key findings of any engagement you have undertaken?			
If there is a greater effect on one group, is that consistent with the policy aims?			

If the policy has negative effects on people sharing particular characteristics, what steps can be taken to mitigate these effects?			
Will the policy deliver practical benefits for certain groups?			
Does the policy miss opportunities to advance equality of opportunity and foster good relations?			
Do other policies need to change to enable this policy to be effective?			
Additional comments			

If one or more answers are yes, then the policy may unlawful under the Equality Act 2010 –seek advice from Human Resources.

Appendix B: Principles for Effective Clinical Risk Assessment

These principles should be adapted to the local clinical setting.

Current thinking on risk assessment

There are two broad approaches to assessing risk of behavior reoccurring: the clinical and the actuarial approach. On the one hand, the clinical approach refers to the evaluation of risk based on the clinical expertise and experience of the clinician. On the other hand, the actuarial method describes an approach to assessing risk which is founded on empirical population based research studies that have identified various historical variables which have been found to predict the risk of a particular outcome: in our population violence and self-harm, and in extreme cases, suicide and homicide.

There are advantages and pitfalls to both approaches. In general, the actuarial approach is highly standardised, and on the whole has been found by research to be more accurate. However, the factors associated with high risk tend to be static, unchanging and unalterable historical variables, such as previous history of action.
Whilst actuarial assessment has some benefit in forecasting long-term risk, often the clinical need is in assessing acute risk. Furthermore, the information concerns populations rather than individuals, and therefore assumptions may be made about an individual patient because of that person's membership of a group, determined by the presence or absence of particular characteristics. Consequently, the prediction of any individual person's behaviour is highly inaccurate.

Clinical risk assessment tends to be focused upon changeable processes, such as the mental state of the patient. However, this approach tends to be subjective and difficult to measure, with high variability between clinicians in what factors guide the consideration of risk.

A sensible system of risk assessment and management should aim to combine the information from both clinical and actuarial sources. Current thinking on risk assessment is that it should be less concerned with prediction and more concerned with making a formulation about risk. This would have the aim of assisting clinical thinking about whether and under what conditions a psychological intervention can take place safely. Predicting whether or not a particular behaviour will reoccur is notoriously difficult and inaccurate for any individual patient. We therefore recommend that careful judgements be made by clinicians based on actuarial factors as well as clinical ones in making a risk formulation in the case of high risk patients, where a full risk assessment will be required (see below).

Making risk assessment a more meaningful task

On-going risk assessment is an integral part of providing a safe and good service. However, various inquiries following high profile serious incidents have contributed to a culture of blame and defensive practice, and consequently risk assessment and risk management is at risk of becoming a bureaucratic exercise devoid of any real meaning.

This guide is intended to contribute to a culture in which risk evaluation becomes a more meaningful exercise, and is viewed as integral to the clinical task. The trust's strengths in psychoanalytic and systemic can contribute to a unique model of risk, as follows.

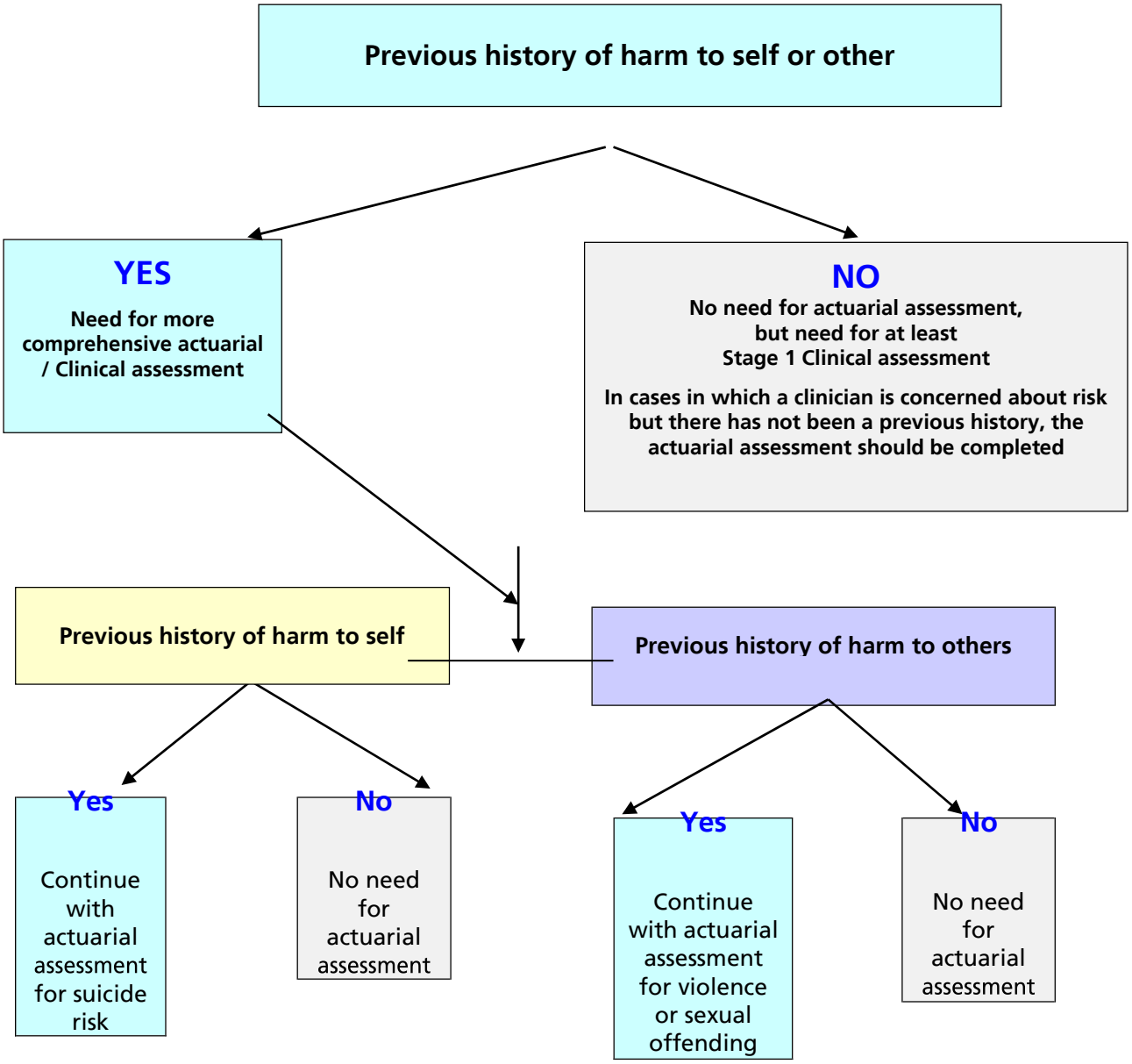
Amongst other issues, there are two aspects of the psychoanalytic model which make a unique contribution to thinking about risk. The first is that action in the context of the therapeutic frame in the form of enactment is considered to be meaningful, or symptomatic. Therefore both small and large violations of the treatment frame contribute to an understanding of the patient, as well as of the therapist and the treatment context, i.e. the organisation (the department and Trust). Second, there is a dynamic relationship between the patient and the therapist. Amongst other questions, we would always critically enquire into whether enactments by the therapist may be understood as relating to the patient. Furthermore, we would also consider whether enactments by the patient may be understood in the context of interventions by the therapist.

The notion of risk, therefore, may be extended to thinking about risk as any action on the part of the patient or the therapist which deviates from the therapeutic frame. Even small enactments on the part of the therapist and/or the patient may be considered within this model. Major violations in the form of high risk behaviours on the part of the patient may be viewed as being on a continuum with minor transgressions of the treatment frame, although they will of course be treated in practice as being qualitatively different.

The purpose of the above conceptualisation is to return risk assessment to the clinical task. Such a framework will allow for the provision of valuable information which will further the development of understanding of the organisation, the employees and the organisational task. Clearly, such a conceptualisation requires a move away from the notion of inquisition and blame for the transgression of boundaries and a move towards

a culture of professionally informed enquiry.

Appendix C: RISK ASSESSMENT DECISION TREE



Appendix D: Risk Assessment (all patients)[3]

RISK HISTORY – (put details in summary) - Please tick a box in each category if positive history	
Any history of suicide attempts?	☐
Any history of deliberate self harm?	☐
Any history of poor self-care?	☐
Any history of being a victim of violence when the perpetrator was under the influence of alcohol?	
Any history of violence to adults?	☐
Any history of violence to children?	☐
Any history of sexual violence to adults?	☐
Any history of sexual harm to a child?	☐
Any history of drug abuse?	☐
Any history of alcohol abuse?	☐
Any history of alcohol abuse leading to harm to others?	
Any history of eating disorder?	☐
Any history of inpatient treatment?	☐
Any history of any other high risk behaviours? (specify details in summary)	☐
Any other criminal history? (specify details in summary)	☐
Any other antisocial behaviour? (specify details in summary)	☐

CURRENT LEVEL OF RISK – Please tick one box for each category				
		Mild	**Moderate**	**Severe**
Suicide				
Self-Harm				
Harm to Others				
Legal/Forensic/Risk of imprisonment				
Psychiatric Breakdown				

[3] This is reproduced from the Trust's Assessment Form (over 18), for the most up to date form for over and under 18's please access the 'Assessment Form' on Care Notes or from the internet

Sexual exploitation				
Domestic Violence				
Alcohol misuse				
Self-neglect				
Drug misuse				

Summary

Note *this section is to be completed for all patients:*

- *If risky behaviours identified, and/or CORE risk sub score is above cut off point then specify nature of behaviour, quality, quantity and when this occurred.*
- *Highlight areas where information is not known and recommended follow-up action*
- *If no risks are identified record this finding here (eg "no current risks identified")*

Risks to Children

Does the patient have children under 16 living with them? **Yes / No**
If yes do you identify any risk to the child(ren) Y**es / No** (if yes you must seek advice from Child Lead)

Appendix E: Guidelines for Completing Risk Rating

- The Risk Rating is an estimation which is made based on your clinical impression of the patient as well as the actuarial factors identified in the patient which relate to the particular risk behaviour.

- Please use the accompanying list of actuarial risk factors identified by research to be associated with the risk of the particular behaviour being repeated to complete this section and incorporate these risk factors with your clinical judgement of the patient.

- The completion of the form will depend on the particular risk behaviours identified with the patient. There is space for three risk ratings (mild, moderate, and severe). There is no need to complete all three of these. Please only complete these where there are concerns about particular risks to self and/or other.

- Please remember that the value of the actuarial approach is in the longer term forecasting of risk rather than in deciding whether a behaviour is imminent or not. This information is useful in making a risk formulation and in deciding whether or not other professionals need to be involved as part of the management of the identified risks during the period of treatment.

- As a general guide, risk ratings are as follows:-

Risk rating	Risk findings
Mild	Evidence suggests that it is unlikely that the particular risky behaviour will be repeated. There are few actuarial risk factors present and clinical impression indicates few causes for concern.
Moderate	Evidence suggests that there is a risk of the behaviour being repeated. There may be some actuarial factors present which raise concerns. The impression of the clinician is that there is some likelihood of the behaviour being repeated.
Severe	There are a number of actuarial factors present associated with the risk of the behaviour being repeated. Clinical impression suggests that there is concern that the behaviour could be repeated. Treatment needs to take place within the context of a risk management plan.

ASSESSING THE RISK OF REPETITON

Below is a risk of various factors which have been found by research to be associated with the risk of the behaviour being repeated. They are listed separately for harm to self, suicidal behaviour, violence to others and recidivist sexual offending. These lists are intended as a broad guide to actuarial assessment only.

VIOLENCE TO OTHERS	
Previous violence	Specify number of incidents and nature of violence. The number of violent incidents increases the risk level, but the severity of the violence does not
Criminal history	History of convictions for non-violent offences increases the likelihood of future violence.
Attachment issues	Living with both biological parents to age 16 protects against future violence. Separations from parents, and other attachment issues, including abuse and neglect, especially in infancy, increases risk
Educational problems	Slight or moderate discipline problems marginally increase risk. Significant disciplinary problems, particularly expulsion increases risk
Alcohol abuse problems	Alcohol abuse in biological parent, teenage alcohol problems, adult alcohol problems, alcohol involved in previous offence/s increases risk
Relationship instability	Living in the same home as spouse for 6 months or more is protective. Relationship instability increases risk
Young age at first violent incident	Age under 26 increases the risk of violence
Major mental illness	The presence of mental illness in someone who has been violent decreases their likelihood of violence when compared to a population of violent individuals
Personality disorder	Presence of PD diagnosis increases the risk of violence.
Prior supervision failure	Failure on prior conditional release, such as breaches of probation, bail violations increases risk

SEXUAL OFFENDING	
Previous sexual offending	Previous sexual offences significantly increases risk
Prior sentencing dates (excl index)	Previous non-sexual offending increases risk
Any convictions for non-contact sex offences	Convictions for non-contact sexual offences, such as voyeurism or exhibitionism increases risk
Index non-sexual violence	Violence used in offence increases risk
Prior non-sexual violence	Violence of any kind in history increases risk
Any unrelated victims	Unrelated victims increases risk
Any stranger victims	Stranger victims increases risk
Any male victims	Male victims increases risk

SEXUAL OFFENDING	
Age	Young age increases risk
Marital status	Cohabiting with spouse is protective

SELF HARMING BEHAVIOUR	
Previous attempts	Increases risk
Gender	Female gender increases risk
Age	Risk decreases with age
Childhood sexual abuse, physical abuse and neglect	Increases risk
Mental disorder	Personality disorder: Borderline and antisocial
Substance abuse	Increases risk
Mood instability	Increases risk
Childhood separation	Increases risk

SUICIDAL BEHAVIOUR	
Previous suicide attempts	Increases risk
Gender	Male gender increases risk
Age	Risk increases with age
Mental disorder	Personality disorder, major depression, schizophrenia
Substance abuse	Increases risk
Social Isolation	Increases risk
Physical illness	Increases risk
Serious intent to die	Increases risk
Previous self-harm	Increases risk