1. *Risk Assessment covers:*

- Current Risk (in any of the below listed areas)
- Past risk behaviours
- Context or factors that might increase / decrease risk
- What would indicate increased risk has occurred
- Protective Factors
- Risk Management Plan

2. *Areas of Potential Risk:*

- Risk To Self
- Risk To Others
- Safeguarding Children
- Safeguarding Vulnerable Adults
- Risk from Others
- Risk Of Exploitation
- Risk Of Neglect

3. *Risk Management*

- Risk assessment is a standard component of every in-take assessment and reviewed as part of routine clinical care at every appointment, in collaboration with the service user. NTT operates a monthly review calls system where the allocated clinician will contact service users who have been identified as having medium or high risk
- Risk is routinely screened for by the use of standardised questionnaires (e.g. PHQ9; item 9) as well as additional screening questions. Where risk is identified, the clinician will also record a risk narrative on IAPTus, the electronic patient record system, to provide a context.

- NTT operates a daily duty system, whereby a senior clinician is available to discuss and coordinate any arising risk issues should the line manager not be available

  • Any high risk must be discussed with the Line manager or senior clinician of the day, but appropriate action must be taken without delay (e.g. police welfare check; ambulance and A&E).

  • Any medium risk issues must be discussed with the line manager by the next working day. If this cannot be managed within primary care, service user is stepped-up to secondary care services.

  • Any other risk and safety concerns, where the patient presents with a known risk profile without any acute changes, must be discussed at the weekly case management supervision meeting and/or with another senior clinician within one working week.

  • GPs and other clinicians with previous knowledge of the patient, and other relevant services must be informed and involved when necessary in risk management and prevention.

  • If a patient disengages from the service, every effort will be made to contact the patient on three separate occasions by telephone as well as by letter and the GP and other agencies involved in this patient's care will be informed within five working days.

4. The risk rating - following a risk assessment, the clinician should indicate the risk rating which is categorised as following:

- "No risk" refers to no additional risk above population baseline.
- "Low" refers to a low level of risk, this would include individuals with either previous acts of self-harm and no current suicidal thought, plans, intent or action. Or, individuals with no previous acts of self-harm but presenting with suicidal thoughts to any degree without any plans intent or action.

- “Medium" refers to a medium level of risk where there is both previous history of any type of self-harm and current suicidal thoughts. There would not be any plans for suicide (there may be plans for self-harm however the clinician must distinguish this from suicidal plans), intent (again there may be intent to self-harm in reaction to distress but no intent to risk life) or action (again the person may have taken action to self-harm that this must be distinguished from action to end life.) Where this is ambivalent or ambiguous information the default is to allocate this against suicidality.
- "High" refers to a high level of risk and either imminent or actual onward referral. This would be present if a person reports plans for suicide, intent or action. Or where there are strong suicidal thoughts with significant impulsivity, recent self-harm or consensus that the person presents in the high risk group.