



## **Atrium Clinic Risk Assessment-Community and Workplace originally 2020 (Review 2025)**

**To be read alongside** Atrium Consent to receive services, Online therapy guidance, Safeguarding Policy, Safety planning as standard, GP template letter for safeguarding

### **Rationale**

Clinical Risk Assessment Procedures are important to keep clients safe. Whilst more specific risk assessment procedures are required in secondary and specialist services and our forensic pathways, our Community and Workplace pathways still need clinical risk assessment systems that are clear and understood by our staff team and clients. Risk remains an important consideration in all the care provided for all our clients in partnership with the NHS too. Just because we might not see as much 'risk' in our clients as other services, procedures can be forgotten and so this document reminds us of expectations for managing risk and supporting clients better. Risk assessment is a precarious science, and **all Atrium** practitioners are advised to **safety plan routinely** for our clients at times of set back or difficulty and as part of discharge planning to prepare for difficulties. Risk management processes keep the practitioner safe, and you should always keep the guidance of your professional body and your indemnity requirements in mind too.

An effective and efficient process needs to be able to address the risks posed by our primary care level clients with whom we work, who also want to maintain their ownership of their own health and life choices, confidentiality of data and who have come out of the NHS and statutory services for our help. Our response needs to be proportionate to 'risk' and our action needs to be collaborative, consented and transparent when possible. Our thinking and decisions need to be shared between us as professionals as well as with the client to ensure we get to the best decisions in the interest of the client. Risk management in our context is also a dynamic process and therefore points to the importance of continual sessional review. Administrative /pathway staff who work directly with clinicians and clients will contribute and support the process of considering risk and documenting risk assessment in conjunction with involving other partners such as GPs, specialist services and workplace managers. Sometimes it might be the payment of a session that alerts one of the team to a changed circumstance and increased risk to the client, so it is everybody's responsibility to monitor risk whenever we are in contact with the client and take appropriate action to ask questions and report.

The Clinician has an important role in risk assessment based on clinical expertise and judgment. This is carried out using a clinical approach by gathering information from the client where we ask questions which may address past and current circumstances. An Actuarial approach to risk assessment 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 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.

**Who is this for?**

All Atrium employed, self-employed staff and trainees.

**Registration with Atrium and when we cannot safeguard**

Where clients are not registered with us, we can only signpost as we are not an emergency service. We do not register clients with Atrium without a GP, as we safeguard in collaboration with the GP who has a duty of care. 111 can offer advice on getting a GP in the client’s area for urgent assessments. If workplaces with whom, we have arrangements to supply services, have concerns for an employee, we can support the workplace to support the member of staff (advice and signposting) but we cannot approach a non-registered client at all, nor a client without their consent to contact them based on ‘hearsay’ from another party. If non- registered clients phone up and are in distress, we can offer advice eg. Samaritans/emergency services, 111 and also offer a clinician to phone them back by consent as a goodwill measure. Clearly this would not be appropriate in an emergency situation when an emergency service is appropriate.

**4 stage structured risk assessment**

This is a guide; each staff member will need to assess risk for each individual in the light of the individual’s needs, understandings and presentation. To be too intrusive with questioning individuals ‘not at risk’ can lead to the client withdrawing from the help they seek. If practitioners have concerns on risk at any stage, they should **always** consult the clinical supervisor /safeguarding lead for support and advice even after a session has been completed. In the event that the supervisor is not contactable for more urgent situations, they should reach out to peers for their further ‘thinking together’ to ensure they are supported and remain within this framework.

**Stage 1: History of Risk and Current Risk** –We check this on ‘intake’ and should return to it during the first full assessment as part of therapy/wellbeing intervention. We may return to it because of an impromptu discussion with the client that leads us to have concerns about their risk. The initial risk consideration responds to the client’s presentation and a CORE assessment and may then trigger more questions on whether the client has a recent/current history of harm to self and/or other and to explore this in more detail. Always read the CORE assessment and consider it considering the client’s other narrative. There should always be enquiry about an individual’s current suicidal thinking and past history of self-harm or suicide attempts if a history is indicated or if there is evidence from the CORE

assessment or wider assessment of risk of harm to self or others. Any risk detected should always be explored and actioned by further enquiry, safety planning, further professional advice or safeguarding supervision. If there is no history of harm to self and/or others and no current risk indicated, the pathway coordinator should then consider whether they are satisfied with an initial rating of low risk so the client can move forward to a commencement of therapy/coaching. At any point in this process the pathway coordinator can move into emergency advice-999 calls, other people in household to support accessing help etc and/or seek the advice of the clinical supervisor, organize a call back to the client from the clinician (within the hour) or discuss with the clinician and arrange to call the client back and/or move into a safety planning situation whilst further action is agreed. We should advise clients of our Consent to Share policy including circumstances when we could alert the GP and workplace specifically for certain risk situations in urgent circumstances.

**Stage 2: Long-term Risk** –We do not put much investment into this as our clients are typically brief but where we judge there is longer term risk we can consider additional GP support, secondary support and additional signposting notwithstanding routine safety planning on discharge. Clinicians should review the presence or absence of known material factors associated with suicidal and para-suicidal behaviour and/or harm in light of longer term concerns. Any protective factors that mitigate or reduce the risk should also be identified.

**Stage 3: Situational Assessment** If there is a history of harm to self and/or other, or if the clinician is concerned about the risk presented by the client in the absence of previous risky behaviour, the clinician should make further enquiries into the circumstances of the risky behavior in an exploratory risk assessment conversation. 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 in the course of therapy).
  - Where are the protective factors and strategies? What are they? How can you incorporate them into safety planning?
- **Stage 4: Assessment of Acute Risk** - Here the client’s current state of mind is assessed, including:
- Ideation: how frequent, intrusive or worrying are the thoughts to the client 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 client.

- Intent: a statement from the client 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)

5. Further stages **Formulation and** consolidated thinking with another clinician, typically clinical supervisor

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? In the next 24-48 hours for immediate risk
- Is the risk liable to diminish fairly quickly? (if yes on what basis is that prediction made?, eg removal of stressors such as exams)
- Are circumstances likely to arise that will increase the risk?
- What specific management plan with other agencies, 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. Clinicians are also periodically invited to complete CASE training for risk to strengthen risk-based assessment using risk focused questioning.

## 6. Atrium notes

Indicate what you have done if you are alerted to risk but keep notes brief and remember that if the 'worst thing happened' in an unpredictable science, how would you want your professionalism to be evaluated? Show you have evaluated risk in an expanded assessment integrating the strands of information from CORE/further questioning and addressed it. Place CORE risk score at the left corner of your notes e.g. '10 – low risk'

'I conducted Risk assessment stages/process –(My judgment) - Bob did say he was very low but that 'he would never kill himself as impact on children', no prevailing stressors and Bob indicated he was 'safe' and CORE not deteriorated; reviewed safety plan together that he wrote , agreed to session next week and Bob has said he has GP appointment this week ; reviewed plan of management with supervisor and who else (eg.GP) /if anyone should be included in this information by client agreement/preferably unless risk dictates otherwise.' Agree the notes you write with client as a preference. 'Bob , how can we

write about our conversation on the risk to yourself?' If you need advice first or consultations, delay writing your note to ensure that the client's needs are met first.

EG safety planned in case situation deteriorated including discussed with supervisor'.

## 7. Atrium care coordination and follow up

To ensure all clients receive our best care we aim to encourage good communication between client and their workplace, their GP as appropriate and enable and support direct communication **by client consent** preferably with other care partners, family members who can support the client and need to be aware of their safety plan.

Some clients may be followed up by our Atrium listening service and if there are new or deteriorating wellbeing issues associated with increased risk, trainees should notify the clinical supervisor and the pathway team as soon as possible and/or the clinician who was first involved in the client relationship to agree a plan moving forward to support the client to manage the risks and ensure further assessment.

Additional risks may become apparent through the auditing of the CORE system and the pathway coordinators and CORE specialists should always share concerns with the practitioner but the responsibility for further action always lies with the clinician and a consultation with the supervisor may be warranted to consider the risks and actions together.

## 8. Other factors for risk assessment and consideration within safety planning

i. Impact of 'Digital Life' on the wellbeing of our clients should be considered. With the increasing use of internet and social media via e.g. mobile phone, clinicians should be aware of the potential for a client'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 adults after episodes of self-harm should ask routinely about their use of social networking sites and the possibility of online bullying. Similarly, clients who feel suicidal may access on-line sites that encourage suicidal behaviour. Domestic violence risks should also be considered. Clinicians should be aware of the risks of domestic violence. The client may be directly involved in a relationship that includes domestic abuse, violence and situational risk and safety to 'speak openly' should always be considered in undertaking therapeutic work. iii. 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 client poses towards others or sexual risks that the client may be exposed to from others. Atrium falls outside MAPPA eligible patients guidelines. 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 cooperation 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. How we work in such situations, is more judgment based and discretionary in

Atrium because client confidentiality is very privileged but it is always ‘topped’ by concerns of risk and safety to self and others. All such concerns should be shared with your supervisor.

### **9. Working with teenagers**

The Atrium clinic does not actively seek to work with children unless we have specific links into local safeguarding authorities e.g. Essex and Cambridgeshire. Staff who work with children must be trained to work with them and also hold a lens to the higher threshold for safeguarding, greater expectations for family coordination and parent, school involvement when appropriate. They should ensure that risk assessments ideally involve parents at the beginning of the work and that young people agree to Consent to share and family discussions to keep them safe.

### **10. How we implement this framework in practice**

- i. Train in induction of new staff
- ii. Ensure new staff read our risk and safeguarding documentation (on induction checklist)
- iii. Reinforce induction training with clinical supervisor and peer practice sessions.
- iv. Clinical supervision on a specific case –request a consultation within 24 hours of concerns and immediately for significant concerns. Practitioners will be expected to show familiarity with the stages of risk assessment and management and be able to address those in the supervisory discussion.
- v. Group supervision and peer discussion –reference and review how this framework connects with individual cases.