Gateshead Health
NHS Foundation Trust

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Version Control

Version	Release	Author/Reviewer	Ratified by/Authorised by	Date	Changes (Please identify page no.)
1.0	08/08/2012	Claire Downes/Sandra Dickson	Mental Health Act Committee	27/07/2012	
2.0	25/08/2015	Kath Cavagan	Mental Health Act Committee	24/07/2015	4,7,8,9,10,11,12, 13
3.0	01/09/2019	David Gilbert	**Mental Health** Performance and Quality Meeting	26/03/2019	All

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Clinical Risk Management and Suicide Prevention

1 Introduction

Suicide prevention is a key national priority for all Health and Social Services.

On average, a person dies every two hours in England as a result of suicide and people with mental health problems are a particularly high risk group for committing suicide.

The National Confidential Inquiry in to Suicide and Homicide by people with Mental Illness, Annual Report, July2014, show a rise in the number of patient suicides since 2006, with the highest number estimated in 2012 .

The number of patient suicides is influenced by death coding and the number of people under mental healthcare.

- Patient suicide numbers have been rising in all UK countries

In the UK, hanging is the most common method of suicide in the general population and among patient suicides

In 2017, a total of 5,821 suicides were registered in the UK.

- Patients are at their highest risk of suicide within two weeks of discharge; 526 died within the first week.
- The UK male suicide rate of 15.5 deaths per 100,000 was the lowest since our time-series began in 1981; for females, the UK rate was 4.9 deaths per 100,000, this remains consistent with the rates seen in the last 10 years.

- Males accounted for three-quarters of suicides registered in 2017 (4,382 deaths), which has been the case since the mid-1990s.
- The highest age-specific suicide rate was 24.8 deaths per 100,000 among males aged 45 to 49 years; for females, the age group with the highest rate was 50 to 54 years, at 6.8 deaths per 100,000.

KEY FINDINGS

1. **Suicide after discharge from hospital**
   - The first 90 days after discharge remain a time of particularly high suicide risk – this is especially true in the first 1-2 weeks.
   - In related research, suicide in the first 2 week post-discharge has been linked to admissions lasting less than 7 days and to adverse life events.

2. **Suicide by hanging**
   - Hanging remains the commonest method of suicide in both the general and patient populations.

- Figures show that deaths by hanging continue to rise. In 2017 there were over 3100 suicides by hanging in the UK, 813 in mental health patients.

3. Suicide by patients under crisis resolution and home treatment (CR/HT)

- Suicide by patients receiving care under crisis resolution/home treatment teams (CR/HT) is now substantially more common than in in-patient care. In 2002-12 there were more than 2300patient suicides in the UK under CR/HT.

  The % of total has reduced, there being a fall in in-patient numbers, and an increase in the number of patients supported in the community.

- Living alone is a common antecedent of suicide by patients under CR/HT
- Suicide continues to be more than three times as common in males than in females
  groups, with rates among males highest for those aged 45-49 years and among females highest for those aged 50-54 years.
- Hospital-presenting patients should receive assessment following self-harm in line with NICE guidelines, to enable early identification and treatment of alcohol problems.
- Suicide risk is raised 49-fold in the year after self-harm, and the risk is higher with increasing age at initial self-harm.

  Good management of self-harm is an essential part of the suicide prevention strategy.

The NICE Guidelines for Managing Self-Harm (2013) guides practice.

Effective treatment for depression is supported by implementing **the NICE guidance on depression- (2009/2018)**

Depression in Adults: The Treatment and Management of Depression in Adults (2009): (Updated 2018)
The importance of a trusting relationship
Hope and Optimism when exploring treatment options
Awareness of stigma

Depression in Adults, Quality Standards (2011) guides the provision of high quality, cost –effective care.

Physical Health
Around 25 per cent of mental health patients who die by suicide have a major physical illness (accounting for 3,410 deaths between 2005-2013). This highlights the importance of integrating mental and physical health for

people of all ages across primary, secondary and specialist NHS services, including for people with long-term physical health conditions and ensuring timely physical health assessments and follow-up treatment for people living with mental health problems.

Department of Health, Preventing suicide in England, 3rd annual report (2017)
Supports the implementation of the National Suicide Prevention Audit as a tool to assist in building up an understanding of local demographic factors, such as high –risk groups, development of Action Plans, and interagency working

Thus, with this background, it is important that professions in the mental health arena work together cohesively and are supported in clinical practice by their managers. The involvement of an adequate training programme aimed at addressing clinician's needs in terms of risk assessment and management needs to be made available.

It is with this in mind that the following scope has been identified.

Risk can be defined as:
The use of a process to aid the recognition and rating of the chance of loss, harm or injury to patients, the public or those providing care as a consequence of a shift in an individual's well-being. This may be physical, psychological or social in origin or a combination of these three factors.

Best Practice in Managing Risk (2007) suggests clinical risk as relating to a negative event which could be violence, self harm/suicide, self-neglect or the adverse effects of hospitalisation. Assessment of risk covers aspects such as: how likely the event is to, or how soon the event will, occur and how severe the outcome may be if it does occur.

2 Policy scope

Gateshead Health NHS Foundation Trust is committed to the development of comprehensive services for people with mental health problems. The responsibilities of promoting equality and opportunity and upholding human rights unless there is a real and serious danger to public safety are recognized. An integral part of this is to ensure that all people who have contact with the service receive a comprehensive clinical risk assessment. Best Practice in Managing Risk (2007) suggest service user's history of violence, self-harm or self neglect as well as looking at relationships, social contacts/support networks, housing issues or recent difficulties could all be relevant in clinical risk assessment.

3 Aim of policy

The policy aims to:

- Provide all clinical staff with a minimum standard of practice for assessing the clinical risk and associated management of all service users**.**
- Provide practice guidelines and information on factors which contribute to increased risk within an individual to either themselves or others.
- Promote good practice in Suicide Prevention Strategies and support the National Suicide Prevention Strategy.
- Provide a minimum standard of recording and communicating clinical risk for all assessing staff.
- Provide a standard for training in clinical risk assessment and risk management.
- Provide information for quality, monitoring and audit purposes.

Who does this policy apply to?

The policy is aimed at all staff within mental health services who throughout the course of their work have responsibility for conducting clinical psychiatric assessment of service users. This includes:

- Qualified nursing staff
- Medical staff
- Occupational therapy staff
- Psychology staff

It is recognised that some staff who do not have assessing responsibilities may, in their contact with service users, identify risk factors within individuals. This information should always be communicated to the personnel involved in that service users care.

4 Duties (roles and responsibilities)

The Trust Board

The Trust Board is responsible for implementing a robust system of corporate governance within the organisation. This includes having a systematic process for the development, management and authorisation of policies.

The Chief Executive

The Chief Executive is ultimately responsible for ensuring effective corporate governance within the organisation and therefore supports the Trust-wide implementation of this Policy.

Executive director, Associate directors , Service line managers, Heads of department and Matrons
Are responsible for ensuring staff are aware of and adhere to this policy and that actions comply with the Mental Health Act.

Ward and Unit Managers and Care Co-ordinators
Are responsible for

- Ensuring that all appropriate employees in healthcare posts attend the appropriate training as set out in the training needs analysis.
- Implementation of the systems and processes that are in place to monitor compliance with the policy.

All Clinical Staff
All identified staff, having contact with or involvement in the care of the service-user, are responsible for

- Ensuring that the principles outlined in this policy are adhered to and applied.
- Maintaining their individual competence in suicide prevention strategies, including Risk Assessment and Risk Management and attending training as required by their roles.

5 Definitions

Care Programme Approach – The approach used in Secondary Mental Health services to assess, plan and co-ordinate the range of treatment and care required.

Clinical Risk Assessment – The process by which assessing clinical staff determine how likely it is that a negative event will occur, how soon it is expected and how severe the outcome will be. (e.g. violence, self-harm/suicide, self-neglect).

Clinical Risk Management – The development of one or more flexible strategies aimed at preventing a negative event from occurring or, if this is not possible, minimising the harm caused.

Dual Diagnosis – An individual who has a mental health illness and who is using illicit drugs and/or alcohol.

Protective Factors – Any factor which can help to protect the individual from suicidal acts.

Self Harm – The various methods by which people deliberately harm themselves including cutting and self-poisoning.

Suicidal Ideation or Behaviour – Thoughts or actions of engaging in suicide related behaviour.

Suicide – A deliberate act that intentionally end one's life.

Formulation – a theoretically-based explanation or conceptualisation of the information obtained from a clinical assessment. It offers a hypothesis about the cause and nature of the presenting problems

6 Clinical Risk Assessment and Clinical Risk Management

Risk Assessment and Risk Management are not once only activities. They are ongoing processes which will be under constant review.

Risk Assessment and Care Planning will be completed and reviewed at critical points in the service user's journey through the Mental Health Services.

- Any initial interview must seek to develop rapport and sufficiently engage an individual to carry out the process of assessment.

- Staff safety is to be considered in the risk assessment process, following departmental Protocols, Trust Policies, eg Lone Worker Policy, guiding where the assessment is to take place, and the involvement of significant others.

- Clinical skills such as active listening should be used and non-judgemental, reflective responses should be used to assist an individual to explore current issues.

- The clinician should attempt to gain information from all readily available resources in order to put together an individual's clinical risk. This may include talking with other professionals, relatives, friends, carers, police and GP's. Past records may need to be obtained as well as access to the IT system.

- Consideration of discrepancies between what is reported and what is observed should be noted.

- Clinicians may wish to consider the use of rating scales in measuring particular areas of functioning pertinent to the assessment (e.g. suicide ideation scale). Risk Assessments carried out by Nursing staff are recorded on the FACE Assessment Tool (Appendix 1).

- A comprehensive assessment of risk will be carried out for all service users. Where risk is identified the level of risk should be determined and recorded.

- The Service user and carer, when appropriate, should be involved in the creation of the Risk Management Plan, they should be provided with a copy of this agreed plan, together with a written confirmed follow-up appointment. They should also have out-of-hours contact details, knowing who to contact in crisis.

- Those staff conducting clinical risk assessments without access to the computerised system should continue to use the paper copy of risk assessment documentation.

6.1 Clinical Risk Assessment

Assessment should include consideration of the following areas:

- Situational – access to means, settling of affairs, impending life crisis, previous suicide attempt, physical illness/loss, family history of suicide.
- Clinical – e.g. diagnosis of depression, use of illicit drugs/alcohol, signs of hopelessness, anger, compulsions.
- Social – e.g. single, widowed, separated, homeless, living alone, male.

6.2 Risk Factors for suicide:

- Male, age(39- 64 highest current risk)
- Low socioeconomic status, but also some occupations, e.g. farmers, vets, pharmacists, dentists, medical practitioners.
- Unmarried, separated, divorced, widowed (especially if recent)
- Living alone/homeless
- Unemployed or retired
- Physical Illness
- Lesbian, Gay, Bisexual, Transgender
- Black Minority Ethnic Groups
- Older Persons especially with recent loss, bereavement, deterioration in physical health
- Deliberate self-harm (especially with high suicide intent)
- Childhood sexual abuse, bereavement
- Family history of suicide, alcoholism
- Family history of mental illness
- Previous suicide attempts
- Substance misuse
- Recent discharge from inpatient psychiatric care, highest risk in first 7 days, reducing in 2 nd week, reduced further after 3 month.
- Recent release from Prison

Psychological and Psychosocial Factors

- Hopelessness
- Impulsiveness
- Low self-esteem
- Life event
- Relationship problems
- Lack of Social Support

Current Factors

- Suicidal Ideation
- Suicide plans
- Availability of means
- Lethality of means

For non-fatal repetition:

- Current unemployment
- Criminal record
- Anti-social personality
- Hopelessness
- History of high expressed emotion
- History of abuse
- Poor engagement

For violence:

- History of violent behaviour
- Youth
- Male
- Low socio-economic status
- Low educational level
- Clinical diagnosis (anti social or psychopathic personality disorder, schizophrenia, manic depression and psychotic depression)
- Medication non compliance and/or failure to attend appointments
- Concurrent substance misuse
- Homelessness
- Situational factors (particularly those that have been associated with past violence and in particular the first offence).

6.3 Warning signs/behaviour that may indicate increased risk of suicide

- Withdrawal from the company of others and/or refusal to see visitors
- Self neglect, not eating or paying attention to washing hair and clothes
- Decrease in participation in work, education hobbies and activities
- Marked change in mood or behaviour, acting 'out of character'
- Lack of motivation
- Tidying up affairs/giving away possessions
- Apparent up-lift in mood, with no situational changes—Decision made.

6.4 Dual Diagnosis

Substance misuse has been identified as a significant factor in some incidents of self-harm and suicide, particularly in relation to use of alcohol. Alcohol is associated with a range of mental health problems and consequences

including depression, anxiety, risk-taking behaviour, personality disorders and schizophrenia.

6.5 Risk Management

When drawing up a risk management care plan the following should be included:-
A needs led or "5P" formulation should be considered

Clear description of the risk: What exactly is the risk related to.

Predisposing factors: Factors within the service user's characteristics and presentation which elevate the risk e.g. previous history, diagnosis

Precipitating / Trigger Factors: Situational or personal factors which have led to increased risks.

Perpetuating Factors: Longer term factors which keep risk an ongoing problem e.g. alcohol dependence

Protective Factors: Any factors which protect against suicidal acts e.g. engagement with care services, close relationships

Presentation (or Presenting) Factors – The problem which is faced by the individual or any obvious signs or symptoms upon assessment

Clinical Interventions: Detailed explanation of what clinical interventions have been explored with the service user/carer and their views of the management plan. Clearly state who is responsible for specific actions and how the plan is to be monitored and reviewed.
Reduce access to available means, eg, Remove excess medication, -check for any medication that is no longer prescribed, but quantities may have been retained,.

Care Programme Approach (CPA): The framework of assessment, management, treatment and interventions within secondary mental health services. Complex needs may increase risk factors or may prevent the service user's recovery. Those service users assessed with highest levels of risk or complexity (usually involving a wide range of Multi-disciplinary members and other agencies/professionals) will be identified under the trust CPA policy, this must be clearly documented in the all mental health records. See MH27 Policy Care Programme Approach

Crisis Plans: Clearly identify crisis planning. Actions to be taken in the event there is a deterioration in mental health. Include contact numbers of agencies/services that can be accessed. Regularly review the crisis plan with the patient, giving reminder of resources/contacts available.

6.6 Suicide and Older People

People over the age of 65 are more successful than any other age group at taking their own lives. Complex social, psychological, biological and spiritual processes; depression, underlying physical ill health and frailty and social isolation are important risk factors.

Recognising those at Risk
Factors that an older person is considering suicide can be verbal, behavioural and situational. The presence of depression or other mood disorder is highly significant.

Verbal
- Directly expressing the wish to die or take own life
- Indirect, such as talking about things as if they will not be around to see them or take part in them

Behavioural
- Hoarding medication
- Making or changing a will
- Sudden interest in giving things away and putting affairs in order
- Self-neglect – losing interest in life

Situational
- Sudden changes in circumstances such as death of a partner or close friend, retirement, moving home, diagnosis of a serious illness.
- On-discharge planning Following hospital discharge

Symptomatic
- Depression accompanied by anxiety
- Sudden recovery from deep depression
- Changes in sleep and eating habits
- Presence of tension, agitation or guilt
- Isolating self, impulsiveness

A previous suicide attempt is highly indicative of a future attempt.

7 Training

Suicide Prevention
- Risk Assessment & Management
- Care Planning
- Connecting with People
- Mental Health First Aid

Suicide prevention training should be completed by clinical staff and repeated every 3 years.

Staying safe if you're not sure life's worth living
A new online resource developed by the Royal College of Psychiatrists, Connecting with People, Samaritans, Grassroots Suicide Prevention, State of Mind, leading academics, people with lived experience and their carers.
www.connectingwithpeople.org/StayingSafe

8 Diversity and inclusion

The Trust is committed to ensuring that ,as far a reasonably practicable, the way we provide services to the public, staff and visitors reflects their individual needs and dos not discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010). The aim of this policy is to ensure there is a process to aid the recognition and rating of the chance of loss, harm or injury to patients, the public or those providing care as a consequence of a shift in an individual's well being.

The policy recognises different risk factors for diverse groups, and it aims to promote a human rights based approach. An equality analysis has been conducted on this policy.

9 Monitoring compliance with the policy

Standard / Process / Issue	Monitoring and Audit			
	Method	By	Committee	Frequency
Suicide Prevention Audit	National Toolkit. Ward-Managers Checklist Community checklist	Suicide Prevention Leads -	Mental Health Act Compliance Meeting Mental Health Performance & Quality.	Annual

10 Consultation and review

This policy has been reviewed against The National Suicide Prevention Strategy for England which was written following consultation with service users, carer's and advocates for service users. Comments from Divisional and Assistant Divisional Manager, Mental Health Clinical Lead and Mental Health Lead Professionals have been invited.

11 Implementation of policy (including raising awareness)

This policy will be implemented in accordance with policy "Policy for the development, management and authorisation of policies OP27" and policy training will be included in the programme of training as detailed in section 7 of this policy.

12 References

Department of Health- Preventing Suicide in England-2 Years On- 3rd Annual Report on the Cross Government Outcome Strategy to Save Lives Feb 2017

Department of Health Statistical up-date on Suicide Feb 2017

Royal College of Psychiatry 2010- Self-Harm, Suicide and Risk- A Summary

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness July 2017

The NICE Guidelines for Managing Self-Harm (2011; updated 2017).

NICE guidance on depression- (2009; updated 2017)

Depression in Adults: The Treatment and Management of Depression in Adults (2009)
Depression in Adults, Quality Standards (2011)

13 Associated documentation

This policy should be read in conjunction with:
Supportive Engagement & Observation, 2018
MH11: Clients who use Drugs or Alcohol
Care Standard 28b- Deliberate Self-Harm
Care Programme Approach, 2018

Appendix 1

FACE Risk Profile OP **Confidential**

This form to be completed following the assessment and/or review of risk, in accordance with local Risk Management Standards. Written details of current and past risk/behaviour should be provided on p.2/3.

Family name:	Given name:	
Preferred name:	Title:	Date of birth:
NHS No:	Social Services ID:	
Care co-ordinator name:	Contact details (tel/e-mail/fax):	

Other agencies involved (check as appropriate and detail below)						None	
Primary care		Physical medicine		Social services		Mental Health services	
Private sector		Probation Service		Police		Voluntary Sector	
Other							

Assessment details

Location of assessment:						Date of assessment:							
Assessment type						Initial		Review		Discharge			
Legal status	None		Informal in-pt		Detained		On leave		S117		Guardianship		

ASSESSMENT SUMMARY

Is there any evidence of a history of significant risk behaviour?					Yes		No	
Involved in serious incident in past 3 months?	No		Near miss		Yes		Not known	

Current risk status		
Risk of severe self-neglect		*Rate all items using the scale shown (n/k = not known):* **0 = No apparent risk**. No history or warning signs indicative of risk. **1 = Low apparent risk.** No current behaviour indicative of risk but person's history and/or warning signs indicate the possible presence of risk. Necessary level of screening/vigilance covered by standard care plan, i.e. no special risk prevention measures or plan are required. **2 = Significant risk.** Person's history and condition indicate the presence of risk and this is considered to be a significant issue at present i.e. Care plan requires a contingency risk management plan. **3 = Serious apparent risk.** Circumstances are such that a risk Management plan should be/has been drawn up and implemented. **4 = Serious and imminent risk.** Person's history and condition Indicate the presence of risk and this is considered imminent (e.g. Evidence of preparatory acts). Highest priority to be given to risk prevention
Domestic risk (e.g. dangerous use of appliances)		
Risk of suicide		
Risk of falling		
Risk of abuse/exploitation by others		
Risk related to wandering		
Risk related to physical condition (e.g. stroke)		
Risk of violence/harm to others		
Risk of deliberate self-harm		
Risk of accidental self-harm		
Risk re. medication management		
Risk to daily activities/routines		
Risk of loss of autonomy		
Risk of social isolation		

Persons potentially at risk										None	
Self		Partner/spouse		Parent			Staff Member		General Public		
Child		Is there a dependent child?		Y		N			Other (specify)…		

Further actions recommended/required (check as appropriate and detail below)					None	
Further risk assessment		Discussion with team members		Date of next review		

Completed by:	Profession:

Signature:	Date:

Name:	Main ID:	Completed by:

RISK FACTORS AND WARNING SIGNS

Enter √ or 'yes' in all boxes which apply. Enter 'n/k' if not known. 'No' if not present. Time frame for all Current warning signs = past month. Under Notes give brief description of risk factor/warning sign.

Personal circumstances indicative of risk	History	Current	**Notes**
Recent bereavement (esp. of main carer)			
Breakdown or loss of carer support			
Concern expressed by others (relatives, carers)			
Social isolation			
Physical abuse/victimisation by others			
Emotional abuse/victimisation by others			
Financial abuse/victimisation by others			
Ill-suited home environment			
Rootlessness			
Recurrence of circumstances previously associated with risk behaviours			
Physical problems indicative of risk	History	Current	
Fall(s)			
Life-threatening illness/procedure (e.g.			

cardiac problems)			
Mobility problems (e.g. cannot manage stairs)			
Transferring/manual handling			
Sensory impairment			
Hypothermia			
Pressure sores			
Susceptibility to infection (e.g. in poor home environment)			
Swallowing difficulties			
Incontinence			
Dehydration			
Other physical problem indicative of risk (specify)			
Mental health problems indicative of risk	History	Current	
Severe forgetfulness/memory problems			
Severely depressed mood			
Ideas of self-harm/suicidal ideation			
Symptoms of severe mental illness (e.g. delusions)			
Ideas of harming self/others			

Behaviour indicative of risk	History	Current	
Severe self-neglect			
Domestic risk (e.g. unsafe use of appliances)			
Failure to respond to emergencies			
Wandering			
Drug/alcohol abuse			
Suicide attempts			
Threats/intimidation of others			
Physical harm to others			
Unsafe driving			
Other behaviour indicative of risk (specify)			
Treatment and care-related indicators	History	Current	
Difficulties in management of medication/treatment			
Discontinuation of/low concordance with treatment			
Failure to attend appointments			
Difficulties with/failure to engage with services			
Unplanned disengagement from services			
Any other risk factor(s) (specify)			

Name:	Main ID:	Completed by:

Descriptive Summary of Main Risks Identified *(Give brief details of recency, severity, frequency, pattern, ideation and intent; include details of serious untoward incidents, near misses etc.)*

Have actions been taken in the past to reduce risk? *(Detail + effectiveness)*	YES		NO		UNCLEAR	

Person's view of risk *(Give details, including person's view of what is needed to reduce risk)*

Is service user aware of possible risks?	YES		NO		UNCLEAR	

Carer's view of risk *(Give details, including carer's view of what is needed to reduce risk)*

Are the person's carer(s)/family aware of possible risks?	YES		NO		UNCLEAR	
Protective factors *(e.g. self-monitoring, social support)*						

Name:	Main ID:	Completed by:
Risk Management/Crisis Contingency Plan		
Date completed:	Review date:	
Areas of concern to be addressed by plan		

Actions to be taken *e.g. in the event of risk behaviour/relapse/failure to attend (in order of priority, detail below)*	NONE	

Send further appointment		Discuss with RMO		Contact GP	
Contact care co-ordinator		Contact care manager		Contact nominated carer	
Telephone		Visit home		Other *(specify)..*	

Information sources available / accessed in completing risk profile *(Tick all sources used)*							
Person assessed		Case notes		Carer/relative		Other *(specify)*	
Completed by *(print name):*						Profession:	
Signature:						Date:	

Copies to	**Yes / No**	**Date, if yes**	**Copies to**	**Yes / No**	**Date, if yes**
File			Mental health services		
Person assessed			Health services		
Carer			G.P.		
Social services			Other		

Name:	Main ID:	Completed by:

Descriptive Summary of Main Risks Identified *(Give brief details of recency, severity, frequency, pattern, ideation and intent; include details of serious untoward incidents, near misses etc.)*

Have actions been taken in the past to reduce risk? *(Detail + effectiveness)*	YES		NO		UNCLEAR	

Person's view of risk *(Give details, including person's view of what is needed to reduce risk)*

Is service user aware of possible risks?	YES		NO		UNCLEAR	

Carer's view of risk *(Give details, including carer's view of what is needed to reduce risk)*

Are the person's carer(s)/family aware of possible risks?	YES		NO		UNCLEAR	
Protective factors *(e.g. self-monitoring, social support)*						

Name:	Main ID:	Completed by:
Risk Management/Crisis Contingency Plan		
Date completed:	Review date:	
Areas of concern to be addressed by plan		

Actions to be taken *e.g. in the event of risk behaviour/relapse/failure to attend (in order of priority, detail below)*	NONE	

Send further appointment		Discuss with RMO		Contact GP	
Contact care co-ordinator		Contact care manager		Contact nominated carer	
Telephone		Visit home		Other *(specify)..*	

Information sources available / accessed in completing risk profile *(Tick all sources used)*							
Person assessed		Case notes		Carer/relative		Other *(specify)*	
Completed by *(print name):*						Profession:	
Signature:						Date:	

Copies to	**Yes / No**	**Date, if yes**	**Copies to**	**Yes / No**	**Date, if yes**
File			Mental health services		
Person assessed			Health services		
Carer			G.P.		
Social services			Other		