Risk Matrix

GUIDANCE: AS PER NICE GUIDELINES ON RISK MANAGEMENT DATED 2022 (SEE BELOW), THIS MATRIX IS TO HELP CLINICIANS ASSESS AND REPORT RISK. THE MATRIX IS NOT AN INDICATOR OF FUTURE ACTION AND SHOULD NTO BE USED AS A TOOL TO DECIDE WHO CAN ACCESS TREATMENT. IT IS TO BE USED AS THE BASIS FOR A CONVERSATION WITH THE CLIENT ABOUT HOW BEST THEY CAN BE TREATED.

1.6 Risk assessment tools and scales

1.6.1 Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.

1.6.2 Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.

1.6.3 Do not use global risk stratification into low, medium or high risk to predict future suicide or repetition of self-harm.

1.6.4 Do not use global risk stratification into low, medium or high risk to determine who should be offered treatment or who should be discharged.

1.6.5 Focus the assessment (see the section on principles for assessment and care by healthcare professionals and social care practitioners) on the person's needs and how to support their immediate and long-term psychological and physical safety.

1.6.6 Mental health professionals should undertake a risk formulation as part of every psychosocial assessment.

PTSD Resolution
Counselling Forces' Veterans & Reservists
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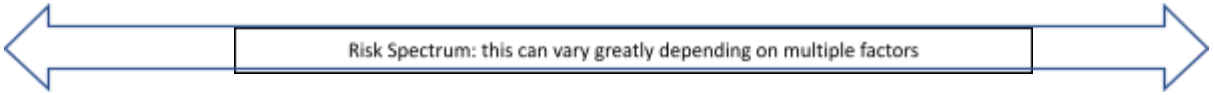

Presentation	Action in session	Low	Medium	High
These are some basic factors to consider. This list is non-exhaustive: ● Outcome Measures (OM) responses ● History ● Nature of thoughts ● Sense of future ● Sense of being burden ● Isolation ● Ability to cope ● Planning ● Access to means ● Capacity to act	HAVE THE CONVERSATION DO NOT RELY ON OM RESULTS ALONE Having the conversation can radically alter the initial perception of risk Response on OM may not correspond with client's intent. High risk clients may conceal suicidal intent. Low risk clients may score high on OM to express ideation only Note: assessment of risk may have altered by end of session as a direct result of your conversation about it.			

		General overview of profile: **OM responses** Low scores and conversation with client reveals scores are mainly or exclusively a result of ideation. Client is able to clearly articulate their reasons for indicating any risk and appears willing and able to engage in treatment. **History** Unlikely to have a history of suicide attempts. May have a history of low level suicidal ideation. If there is some sort of history then client has learned about their own 'warning signs'. Client may be self-harming to manage stress – be careful not to conflate this self-harming behaviour as a coping strategy with suicidal intent. **Nature of thoughts** Fleeting and not constant. They do not dominate client's thinking. **Sense of future** Sees a future and may even have plans for what they will do after the problem is gone. **Sense of being burden** Remains linked to support structures and follows ideas discussed in therapy to help them remain engaged in support. **Isolation**	General overview of profile: **OM responses** Can be variable. Main point is to establish what may be client's 'baseline' that they are able self-manage. **History** May have a mixed history of difficulty coping. May have accessed mental health support in the past. May have self-harmed in the past and continued to do so. May have recently re-started old behaviours indicative of declining mental health. **Nature of thoughts** Can vary depending on circumstances. Client is able to use strategies and techniques given during therapy. **Sense of future** Has some sense of a future in some circumstances depending on levels of stress. Is able to think about how to deal with stressors in the present. Plans to continue to engage with treatment. **Sense of being burden** May have closed themselves off from some, but not all, support structures. **Isolation** Not completely isolated, even if less socially engaged than before.	General overview of profile: **OM responses** Scores highly on suicide related questions on OMs and this is backed up during conversation with client. **History** A history of previous attempts can be indicative of current risk. (N.B. Be careful of the distinction between suicide attempts and self-harming behaviour). **Nature of thoughts** Persistent and difficult to resist. **Sense of future** Does not see a future at all, even if options are presented to them. **Sense of being burden** Is disengaging from support structures because they feel they are bothering others. Self-criticism for not getting better fast enough. **Isolation** Not engaging in with any support structures. Unable to access meaningful

		Support structures are in place and client is willing to connect with them if not already doing so. **Ability to cope with suicidal thoughts** Can clearly differentiate ideation from intent even if this comes only during psycho-education in the session. Client is confident about managing their suicidal thinking. **Planning** Either no plan or at all, or the plan is a generalised idea. **Access to means** No direct means in place or no plan to use improvised means in the immediate future. **Capacity to act** The plan is so generalised and the client's ability to withstand the ideation is so strong that both client and therapist are confident that commission of a suicidal act is highly unlikely between sessions.	**Ability to cope with suicidal thoughts** May be able to clearly distinguish between ideation and intent, or at least engage with therapy that helps them understand this. Their ability to make this distinction influences many of the areas below. **Planning** May or may not have a plan. Is willing to discuss with therapist ways of putting plan beyond use (throwing away rope, distributing medication with trusted others). **Access to means** Can vary greatly depending on personal circumstances and plan (means may be via using their car). Key point is how their ability to differentiate between ideation and intent help them manage this. **Capacity to act** Can vary greatly between sessions, often depending on other factors (personal, professional, financial). Can also vary depending on their ability to benefit from what is provided in therapy. Physically: they are able to do things to work against suicidal ideation (i.e. avoiding travel to a known suicide location). Emotionally: they are able to use ideas and techniques (psycho-education, self-calming) from therapy to handle ideation. Cognitively: they remain able to think beyond the problem when under stress.	dialogue with other people consistently enough to alter their self-perception. **Ability to cope with suicidal thoughts** Unable to resist suicidal thoughts on their own and unable to use strategies and techniques provided in therapy. **Planning** Has a plan and is actively thinking of it. **Access to means** Has the materials necessary already or is actively thinking of acquiring them. **Capacity to act** Physically: they can assemble the means for their plan, purchase materials, drive to the location, walk / climb / get access to the area for their plan. Emotionally: they are not afraid to die. Cognitively**:** have rationalised suicide to themselves, counteracting any reasons to stay alive discussed in therapy. They have made preparations for what happens after their death.

Recording		Update risk assessment on profile page if necessary. Risk plan likely to be unnecessary. Record your risk assessment and areas covered to manage risk in session notes.	Update risk assessment on profile page if necessary. Indicate risk plan on session page. Record your risk assessment and areas covered to manage risk in session notes	Update risk assessment on profile page if necessary. Indicate risk plan on session page. Record your risk assessment and areas covered to manage risk in session notes
Action: externals Third Parties Medication		It is unlikely that you would need to directly contact third parties or prescribers. If you think this may be needed, contact your supervisor and PTSDR..	Involvement of third parties and any conversation around medication will vary from case to case. Always stay within the limits of your remit. Discuss with client about any contact that may need to be started or renewed with other agencies or prescribers within the limits of client confidentiality when balanced against risk. If necessary, contact supervisor and PTSDR.	**Third Parties:** Confirm if client has current contact with secondary care services. Ask client permission to speak with trusted person and / or other clinicians. Ask client for permission to contact other agencies on behalf of client. If client does not give permission, consider the threshold at which you may breach confidentiality. Contact your supervisor in first instance. **Medication (caveat - only discuss this within the limits of your professional remit):** Check with client to see if medication may be a factor (side-effects, sudden stoppage etc). If necessary ensure that this issue can be addressed with medically trained clinicians.
Action: internals		You may wish to bring client to supervision but there is unlikely to be urgency in this.	Clients in this zone can vary greatly and they may be about to move to the Low Risk or High Risk category. You may wish to seek guidance from your supervisor and PTSDR.	You may wish to draw client to the attention of PTSDR, depending on the results of all the factors above.

		It is unlikely that you would need to contact PTSDR. It is unlikely that you will need to update crisis plan on Pragmatic Tracker.	The therapeutic relationship may be a critical factor in helping you decide how much internal support you need. You may need to discuss a crisis plan with client and ensure it is updated on Pragmatic Tracker.	If you have any doubts, contact your supervisor and PTSDR. You will need to discuss and put in place a crisis plan with client and ensure that this is recorded on Pragmatic Tracker.
CLIENT POTENTIAL RISK TO OTHERS				
		Low	Medium	High
Factors to consider: History Criminal record Current involvement with criminal justice system Probation officer? Current involvement with other clinical agencies Attitude to others Attitude to treatment Exacerbating factors (drugs, alcohol, relationship) Current involvement with agencies trying to assist with factors above (drugs, alcohol, relationship)		Client is more likely to be feeling anxious around others than outwardly aggressive but there is the potential for a reaction if they are in specific circumstances. Risk assessment in this area will relate to how well the client responds to treatment that keeps them away from provocation.	Client may have a history of aggression which may or may not have resulted in violent acts. These acts may have been limited, historic and subject to certain conditions such as alcohol or substance misuse. The key aspect is that the current conditions are different enough for past behaviour to be unlikely in the present.	Client has a history of aggression and is frequently aggressive in the present. If this is linked to substance misuse, then client can still be under the influence of those substances during their daily life.
Action		Liaison over risk with criminal justice system / probation is unlikely but may be considered. It is more likely that the emphasis will be on liaison with clinical agencies over treatment for risk factors such as alcohol or drug misuse.	Consider liaison with agencies that may be listed under the 'factors to consider' column in this section. Consider use of 'buddy system' if lone working, including home visits.	Definitely liaise with agencies listed under the 'factors to consider' column in this section. Inform supervisor and PTSDR of concerns. Lone working, including home visits, should not be conducted.