Gloucestershire Hospitals NHS
NHS Foundation Trust

Name:	
Date of Birth:	DD / MM / YYYY
MRN Number:	
NHS Number:	
(OR AFFIX HOSPITAL LABEL HERE)	

Emergency Mental Health Risk Assessment

Triage

Site: GRH / CGH /	Date	Time

Triaged by: Signature	Print Name

ECG	GCS	BP	Pulse	Temperature	Respiration Rate	Capillary Blood Glucose	Alcohol Reading

Physical Description

Capacity Assessment
Assume capacity unless proved otherwise

Does the individual have capacity? Yes ❑ No ❑

Capacity assessed by either a) Legal Test (Consent Form 4)
b) Mini Mental Test

Does the individual have any care responsibilities for children under 16?
Yes ❑ No ❑

If yes, please complete the following:

Child's name

Child's DOB

Child's address

Nature of care role (e.g. main carer):

Factors to be considered when undertaking an initial assessment of a person with a suspected mental health problem:

- Has a physical cause for the problem(s) been ruled out?
- Has drug and/or alcohol intoxication been ruled out as a cause?
- Is the person physically well enough (e.g. not sedated, intoxicated, vomiting or in pain) to undertake a detailed interview with mental health staff? Reassess when not intoxicated.
- If the person has a known mental health history, always check for background assessment and care planning information with the Mental Health Liaison Team 0300 422 5490 Bleep 2517.
- Between 22:00 and 07:00 hours telephone the Mental Health Night Crisis Team on 0800 1690398 or pager 0765 9113275.

Assessment Categories

Assessor Signature	Print Name	Time

1. Background history and general observations	Yes	No
• Does the person pose an immediate risk to self, you or others?		
• Does the person have any immediate (i.e. within the next few minutes or hours) plans to harm self or others?		
• Is the person aggressive and/or threatening?		
• Is there any suggestion, or does it appear likely that the person may try and abscond?		
• Does he/she have a history of violence?		
• Has the person got a history of self-harm?		
• Does the person have a history of mental health problems or psychiatric illness?		
If yes to any of the above, record details below:		

2. Appearance and behaviour	Yes	No
• Is the person obviously distressed, markedly anxious or highly aroused?		
• Is the person behaving inappropriately to the situation?		
• Is the person quiet and withdrawn?		
• Is the person inattentive and uncooperative?		
If yes to any of the above, record details below:		

3. Issues explored through brief questioning

- Why is the person presenting now? What recent event(s) precipitated or triggered this presentation? Give details below:

- What is the person's level of social support (i.e. partner/significant other, family members, friends)? Give details below:

	Yes	No
• Does the person appear to be experiencing any delusions or hallucinations?		
• Does the person feel controlled or influenced by external forces?		
• Are there major housing or accommodation problems?		

If yes to any of the above, record details below:

4. Suicide risk screen - greater number of positive responses suggests greater level of risk

	Yes	No	D/K		Yes	No	D/K
Previous self-harm	❑	❑	❑	Family history of suicide	❑	❑	❑
Previous use of violent methods	❑	❑	❑	Unemployed/retired	❑	❑	❑
Suicide plan/expressed intent	❑	❑	❑	Male gender	❑	❑	❑
Current suicidal thoughts/ideation	❑	❑	❑	Separated/widowed/divorced	❑	❑	❑
Hopelessness/helplessness	❑	❑	❑	Lack of social support	❑	❑	❑
Depression	❑	❑	❑	Family concerned about risk	❑	❑	❑
Evidence of psychosis	❑	❑	❑	Disengaged from services	❑	❑	❑
Alcohol and/or drug misuse	❑	❑	❑	Poor adherence to psychiatric Tx	❑	❑	❑
Chronic physical illness/pain	❑	❑	❑	Access to lethal means of harm	❑	❑	❑
Past psychiatric history	❑	❑	❑	Currently pregnant/ pregnancy in last 12 months	❑	❑	

5. Additional suicide risk screen - complete for under 18 year olds

	Yes	No	D/K		Yes	No	D/K
Family / relationship crisis (including recent traumatic event, current parent / child conflict, family breakdown, violence within home, long term family dysfunction / disruption)	❑	❑	❑	History of antisocial behaviour (recklessness, damage to property, fire-setting arrest and involvement with Criminal Justice)	❑	❑	❑
Problems at school / work (including truancy and non-attendance exclusion, low educational attainment, long term persistent bullying, unemployment)	❑	❑	❑	History of abuse, severe victimisation / exploitation, including childhood abuse / neglect	❑	❑	❑
Poor coping style / personal resources (impulsivity, poor interpersonal and life skills, lack of support network, history of absconding)	❑	❑	❑	Recent actual or threatened loss (divorce, separation, death of significant attachment figure)	❑	❑	❑
Parental mental health / substance misuse problems	❑	❑	❑				

Action plan and outcomes following initial risk screen

Describe all actions and interventions following assessment. Include details of referral to other team(s), telephone calls/ advice and discharge/transfer or follow-up plans.

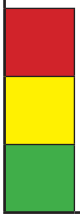
Mental Health Assessment	
General Description Appearance (i.e. self care/neglect, clothing, posture) Behaviour and psychomotor activity (i.e. pacing, wringing or pill rolling of hands, agitation, mute or other aimless activity) Attitude towards staff (i.e. uncooperative, friendly, defensive, evasive, has a rapport been established?)	
Mood and Affect Mood (i.e. depressed, despairing, irritable, anxious, angry, euphoric, expansive, frightened, may fluctuate rapidly between) Affect (i.e. affect may not be congruent with mood, may be flat, within normal range) Appropriateness	
Speech Rate, volume, rhythm, rapid, slow, pressured, monotonous, loud, slurred or mumbled	
Perceptual Disturbances Hallucinations; auditory, visual, olfactory, tactile, illusions or misperception	
Thought Process or form of thought (i.e. disturbance in the continuity of thought i.e. Knights moves -incomprehensible connections or new words created by patient) Content of thought (i.e. delusions, paranoia, preoccupations, obsessions, compulsions, phobias)	
Cognition Alertness and level of consciousness Orientation Memory Concentration	
Impulse Control Is the patient able to control impulses e.g. sexual, aggressive or other impulses?	
Judgement and Insight: Judgement (i.e. does patient understand the likely outcome of their actions and are they influenced by their understanding? Is patient aware of socially inappropriate behaviour?) Insight (i.e. does patient have any awareness that behaviour is a cause for concern, deny or blame others?)	
Drug and Alcohol: Number of units per week, binge drink or drink constant, which illicit drugs, help sought to reduce or quit?	
Reliability: Is what patient says reliable? Can it be corroborated?	

Capacity Assessment

- Does the patient have an impairment of brain or mind?
- Can they: understand
  retain
  weigh up
  communicate

What category of overall risk have you identified?

Give reasons and rationale for your decision



Action Plan and Outcomes:

If the patient's condition has changed since triage another risk assessment needs to be completed.

If patient is incapacitated with no known person interested in their welfare and serious elective treatment is proposed, an IMCA must be obtained

Formulation of assessment - refer to the risk assessment matrix below and summarize:		
• What is the key problem?		
• What is the level of risk – e.g. low, medium, high? Refer to matrix		
• Is referral to the Mental Health Liaison Team or on-call mental health staff indicated?		
Assessor Signature	**Print Name**	**Time**

Mental Health Assessment Risk Assessment Matrix			
Level of Risk	**Key assessment information**	**Clinical actions**	**Timescales**
Low Risk	• Mental health problem may be present, but person has no thoughts or plans regarding harm to self or others. • May have already engaged in impulsive self-harming behaviour, but now regrets actions and **has no plans or thoughts relating to further self-harming behaviour**. Patient is confident about maintaining his/her own safety and relative(s)/significant other(s) are prepared to provide informal support on discharge. • No evidence of immediate or short-term physical vulnerability or risk.	• Treatment and follow-up arrangements managed by admitting team. * Assess capacity and see * box • May benefit from referral to primary care services – e.g. GP, practice nurse. • Consider whether may benefit from mental health promotion/ mental health advice – e.g. safe alcohol consumption, information regarding non-statutory agencies. • Provide relevant patient and carer information.	• Referral to mental health liaison service not required. • Advice from liaison staff regarding onward referral and/ or follow-up arrangements may be required. • In the case of self-harm, arrange for patient details to be passed to liaison staff in order to arrange further contact if necessary. • Non-urgent follow-up or contact from liaison staff within 72 hours of request.
Medium Risk	• Mental health problem(s) present and/or has non-specific thoughts or ideas regarding harm to self or others - e.g. regrets that self-harm failed to lead to death, but no intention to undertake further self-harm. • There is no plan to act on self-harming or suicidal thoughts. • However, the person's mental state is at risk of deterioration and they may be physically vulnerable in certain circumstances.	• Person's agreement to refer to mental health should be sought, but no urgent action required if patient does not wish to engage. * Assess capacity and see * box • Option to discuss with GP who has the ability to refer to their locality Primary Care Assessment Team (single point of entry for GPT) • If person known to mental health services, inform relevant team of their attendance. • Provide relevant patient and carer information	• Non-urgent referral to Mental Health Liaison Team. • Out-of-hours, seek advice from on-call mental health staff. • Placement in liaison follow up slot and seen within 72 hours (liaison service not available 7 days a week)

High Risk	• Serious mental health problem(s) present, including possible features and symptoms of psychosis. • May well have frank plans to engage in further self-harming behaviour, or to harm others. • Has clearly identifiable risk characteristics, such as imminent thoughts or plans relating to self-harm (or harm to others) or suicide. • May have already engaged in self-harming behaviour, and on-going suicidal intent remains. • May lack capacity and competence to consent to or refuse on-going care and treatment. • Person likely to act upon thoughts of self-harm at the earliest opportunity. • Mental state will certainly deteriorate without intervention and will almost certainly be physically vulnerable.	• Urgent mental health assessment required and a risk management plan developed to address immediate or short-term risk indicators. ∗ Assess capacity and see * box • Mental health assessment required before person can be discharged. • The person's mental state will deteriorate and increase level of risk if not treated. Immediate action required, including urgent mental health assessment and an action plan developed to address immediate risk factors. • Is likely to require close or one-to-one observation by a member of nursing staff.	• Urgent referral to Mental Health Liaison Team or duty mental health staff. • Ring relevant Locality Crisis Resolution Home Treatment Team between 0800hours and 2200hours or Wotton Lawn Night Triage Service between 2200hours and 0720hours. Response time for assessment is within 4 hours. • Police to be informed if person absconds. • All reasonable attempts should be made to stop the person leaving the department before mental health assessment. The presence of hospital security staff may be required.

- **All young people under the age of 18 to be admitted for psychiatric assessment.**
- **Young people 16+ will be assessed by the Mental Health Liaison Team.**

∗ Patient must have formal capacity assessment. If patient has no capacity, consult with others about treatment in his / her best interest. If incapacitated and unaccompanied and serious elective treatment is required an IMCA must be obtained.

Additional Information