

# The Development of Mental Status Examination Training for Professionals at the Sussex Centre for Children and Young People



# Contents

Forward	1
Executive Summary	2
Introduction	3
The Project	4
Appendices	
I) Illustrative pathway for the development of mental status examination training for non-medical professionals at the Sussex centre for children & young people (CAMHS)	10
II) In-Patient Risk Assessment of Potentially Life Threatening Mental States	12
III) Home Visit Risk Screening Assessment	16
IV) Outreach Team Training Package	23
V) New Ways of Working Training Quiz	39
VI) New Ways of Working Questionnaire	41
Contact Details	42

---

# Forward

---

New Ways of Working represents a cultural shift in the way that mental health services are delivered. It emphasizes person centred value based approaches where services are responsive and flexible to the needs of those that use them.

New Ways of Working is about developing new and enhanced roles for staff. It is about designing systems and processes that support staff in the delivery of care in a way that is personally, organizationally and financially sustainable. New Ways of Working supports the development of a flexible workforce, which is adaptable to changing needs.

This project, which sought to extend the roles of a multidisciplinary staff group through an education programme, demonstrated that patients can benefit from staff working in extended roles. The direct benefits were important and enhanced the experience of young people using the services. Equally important at a project level were unexpected positive benefits to being involved in the change programme with greater distribution of responsibilities beyond the project parameters across a whole staff team. This projects success stems from an effective well coordinated and led staff group working together to bring about change. This is not always easy, and achievements include the overcoming of obstacles.

New Ways of Working is about having the right people with the right skills in the right place in the right job at the right time and as demonstrated in this project working together to achieve a common goal with the needs of young people at their centre.



Dr Tim Morris, *NWW CAMHS Project Lead*

e: [timmorri@liverpool.ac.uk](mailto:timmorri@liverpool.ac.uk)



Barry Nixon, *National Workforce Lead CAMHS*

e: [Barry.Nixon@wwl.nhs.uk](mailto:Barry.Nixon@wwl.nhs.uk)

---

# Executive Summary

---

## The Assessment of Life Threatening Mental States by Non-Medical Staff

The aim of this project was to enable non-medical staff to receive training and gain confidence in performing risk assessments which have traditionally been undertaken by medical staff. Two multi-disciplinary staff groups participated in the project; the inpatient adolescent unit and the outreach adolescent team.

The project involved the development of an 'at risk' proforma which was manualised, baseline measures of knowledge and confidence and a staff training package. There were two training sessions for each of the staff groups and a follow up 'trouble shooting' session three months after. The project was implemented immediately after the two training sessions.

The project was audited in a number of ways.

- 1) An audit was carried out to measure pre and post knowledge and pre and post confidence levels.
- 2) The proportion of cases that were considered to involve life threatening mental states.
- 3) The number of case that required immediate medical staff involvement.

Both staff groups increased in confidence and knowledge. The implementation of the risk proforma allowed for the accurate identification of those at high risk and appropriate management.

---

# Introduction

---

The Sussex Centre for Children and Young people (SCCYP) is the Tier 4 CAMH Service for the Tier 3 CAMHS of East Sussex, West Sussex and Brighton & Hove. The Adolescent In-Patient Unit at the Sussex Centre until recently was an open generic service, commissioned solely to provide in-patient care. However, modernisation funding allowed for the development of an Adolescent Outreach Service and a Day Service, as well as In-patient provision as a stepped model of care.

In order to improve response times, particularly for cases seen as high risk and, therefore, urgent, a home visit would be arranged, and following discussion with the consultant psychiatrist (and if time allowed the rest of the multidisciplinary team) a care plan would be implemented, which either aimed to avoid admission by providing some intensive further assessment and support in the community, or prepared the young person and their family for an admission.

## Aims and objectives

To develop a protocol based system of undertaking at risk mental states whereby children and young people receive an accessible and timely service at times of crisis or urgency that will determine a stepped pathway of care with various options commensurate with need in both a community outreach and in-patient setting. This will then enable a wide range of

professionals to achieve and develop values and evidence based practices through the acquisition of new competencies to enable them to carry out assessment and activities that would normally be associated with members of the psychiatric team.

The two main aims are therefore to provide training to non-psychiatric staff in risk assessments and to increase their confidence.

## Target groups

The project included all qualified non-medical professionals, including 13 nurses, 1 clinical psychologist and 1 occupational therapist. It is anticipated that the current project will become integrated into ongoing service development and training. Service users will then have access to a more comprehensive package of care and needs can be met within the multi-disciplinary team.

# The Project

The project proposed two pathways of training to account for the different needs of inpatient and outreach work [Appendix I]. A protocol based system was developed to allow risk assessments and a modified mental state examination to be carried out by inpatient team [Appendix II] and the outreach team [Appendix III].

A training package was developed by the consultant psychiatrist and nurse consultant (project lead), which aimed to equip staff with further knowledge regarding the components of mental state examinations, terminology used and also to help increase their confidence. A training manual was provided for inpatient and outreach staff [Appendix IV]. Training was delivered separately for the inpatient and outreach teams due to the varying needs and differences between inpatient and community settings.

The in-patient team had two half day training days and an hour follow up session. The outreach team had one half day training session and an hour follow up session.

An audit was carried out alongside the project to obtain measures of knowledge and confidence of staff before and after training. Knowledge was measured using a set of multiple choice questions regarding mental state examinations [Appendix V]. The average pre and post training scores were compared. Confidence was measured in relation to carrying out risk assessments and making risk decisions. Staff were asked to rate their confidence on a scale of 1-10 (not very confident to very confident) [Appendix VI] and the average pre and post training scores were compared.

## Inpatient

The inpatient team focussed on the audit of risk management process and management of potentially life threatening mental states (Appendix II). A detailed risk assessment was completed and a decision made to determine if a potentially life threatening mental state is present as well as a decision regarding the urgency of psychiatric involvement.

Once the category of a high risk situation is identified, protective factors e.g. positive resources and potentials are identified and considered in the risk management plan. Measures to reduce the level of risk can then be put in place e.g. increasing observation levels.

The staff carrying out the risk assessment must then decide on the extent to which the protective factors and interventions have reduced the risk.

Colour coding was used to identify the severity of risk identified:

- Red indicated a need to discuss with psychiatrist because of potentially life threatening danger.
- Amber indicated concern but not an immediately life threatening situation. Discussion with other team member was required.
- Green indicates risk management strategies seen as addressing the risk and a date for review is set.

At this stage if the red option has been chosen staff should go immediately to the section titled presence of potentially life threatening mental state and make a decision regarding the urgency of psychiatric involvement.

If the amber option has been selected, the outcome of discussion with team member should be recorded and any new measures put in place e.g. develop a detailed risk management plan in the nursing care plan. Staff must then decide on the extent to which this further discussion with team member has reduced the risk.

Life threatening mental states have been categorised into the following headings:

- 1) Active suicidality/hopelessness
- 2) Persecutory delusions
- 3) Command Auditory Hallucinations
- 4) Passivity: Limited capacity to resist acting on delusions/hallucinations
- 5) Severe anorexic thinking resulting in not drinking fluid for more than 12 hours
- 6) Other

There are four options provided for the decision regarding urgency of psychiatric involvement although a fifth option was added where no psychiatric involvement was needed.

- 1) Need to seek immediate psychiatric assessment
- 2) Need to seek psychiatric opinion next working day
- 3) Need to seek psychiatric opinion within the week
- 4) Seek psychiatric advice as part of next weekly multidisciplinary review
- 5) No psychiatric advice needed

If at any stage the green option was selected the risk management strategies was determined as addressing the risk and a review date is set. There was no need to proceed to the next section.

## Outreach

The outreach team audit of risk assessment included the frequency of potentially life threatening mental state and the need to involve the psychiatrist in the risk management plan (appendix 3).

A detailed risk assessment was completed and a decision made about if there is presence of a life threatening mental state. A further decision is made regarding the timing of further multidisciplinary discussion.

The initial reason for outreach involvement or a description of the crisis necessitating re-assessment is identified. If there was a life threatening state identified it is categorised accordingly using the same format as the inpatient team. The details of the potentially life threatening mental state and protective factors are identified. A decision regarding the timing of further multidisciplinary discussion was made from the following four options:

- 1) Need to contact psychiatrist immediately for planning emergency intervention
- 2) Will await next working day discussion with other team member
- 3) Will await discussion with other team member within the next week
- 4) Will await discussion at next outreach team meeting

## Inpatient results

The majority of staff members improved their mental state examination test score following training. The average pre-training quiz score was 89% and the average score post training was 93%.

Confidence for risk assessments and decision making was rated pre and post training. On average confidence scores have increased. The average pre training score for risk assessments was 62.7% and the average post training score was 79%. For decisions the average pre training score was 67.6% and the average post training score was 81.3%.

In the first three months of the project 12 risk assessment forms were completed by the inpatient staff. Life threatening mental state was present in five risk situations. Within these life threatening mental state situations, three required immediate psychiatric assessment; one required a psychiatric opinion within the week and one as part of the next multidisciplinary review (see table 1). All life threatening mental states were categorised as 'active suicidality/hopelessness'.

**Table 1: Decision making on the identification of life threatening mental state (in-patient)**

Decision	Value	Percentage
Immediate	3	60
Next Working day	0	0
Within the week	1	20
Next multidisciplinary review	1	20

There were seven cases identified as non life threatening. None required immediate psychiatric opinion, one required it the next working day, three the next multidisciplinary review and three did not need it at all (table 2). All non life threatening cases were categorised as active/suicidality/hopelessness.

**Table 2: Decision making on the identification of a non-life threatening mental state (in-patient)**

Decision	Value	Percentage
Immediate	0	0
Next Working day	1	14
Within the week	0	0
Next multidisciplinary review	3	43
Not needed	3	43

## Outreach results

The majority of staff members improved their mental state examination test score following training. The average pre-training quiz score was 89% and the average score post training was 93%.

Confidence for risk assessment and risk decision-making was self-rated pre and post training. The average test score for confidence in risk assessment pre-training was 70% and in post training it increased to 80%. The average test score for confidence in decision making pre-training was 71% which post training increased to 77%.

22 risk assessment forms were completed by the outreach staff. None required immediate psychiatric opinion. Two (9%) required next working day discussion with another team member, three (14%) required discussion with a team member within the week and 17 (77%) could await discussion at the next outreach meeting.

Life threatening mental states were present in six (27%) risk assessments. One case (17%) required further discussion the next working day, two (33%) within the week and three (50%) at the outreach team meeting (see table 3). The majority of life threatening mental states (83%) were 'active suicidality/hopelessness'. One was categorised as 'other' which was further explained as 'perceived concealment of overdose – aetiology unknown'.

**Table 3: Decision making on the identification of life threatening mental state (outreach)**

Decision	Value	Percentage
Immediate	0	0
Next Working day	1	17
Within the week	2	33
Outreach team meeting	3	50

For non life threatening mental states one case (6%) required further discussion the next working day, one (6%) within the week and 14 (88%) at the next outreach team meeting (see table 4).

**Table 4: Decision making on the identification of life threatening mental state (outreach)**

Decision	Value	Percentage
Immediate	0	0
Next Working day	1	6
Within the week	1	6
Outreach team meeting	14	88

## Summary of results

The initial findings indicate that both inpatient and outreach multi-disciplinary staff have the knowledge and confidence to enable them to carry out the assessment of a life threatening mental state and determine action required.

Whilst, the process of carrying out risk assessments and decision making within the multidisciplinary team began even before the principles of NWW project were fully introduced. Developing a protocol based system has enabled and enhanced ability to undertake such assessments.

## Output of NWW on practices and procedures

### Ward round

The weekly multi disciplinary team meeting, known as ward round, has traditionally involved the consultant psychiatrist taking a lead upon the discussion of cases and ultimately looked upon for the final decision. It was felt that the name should be changed in order to reflect current practices. Names that have been suggested include multidisciplinary team meeting and clinical team meeting. The meetings are currently chaired by a different member of the nursing team each week and decisions are made by the whole team.

## Incident Forms

It was anticipated that the introduction of the new risk assessments in modified mental state examination, may reduce the need to fill out the trust incident report forms (IR1). It was felt that as feedback is never received from the trust regarding IR1s we could use our risk assessment forms as part of our in house checks on the number of incidents. However, the audit forms have not served a purpose for monitoring incidents and it was suggested that separate documentation is still necessary.

## Junior doctors

Concern was expressed as to how junior doctors will be able to develop skills in mental state examinations if the multi-disciplinary team are carrying out more regular modified mental state examinations. A solution to this was to involve junior doctors in the process of NWW and work in partnership with the nursing team to ensure a thorough risk assessment is being carried out. This was explored in two ways.

- 1) To allow the multi-disciplinary team to complete the risk assessment and then to carry out the modified mental state examination alongside the junior doctor.
- 2) Regular mental state examinations are still required as part of a patients individual care plan which may be scheduled in by a doctor or psychiatrist. Doctors can still request a mental state examination.

## Cooperation of multidisciplinary team involvement

A crucial part of the project was the collaborative effort from the multi disciplinary team, including full participation in all stages of the training and implementation. This was enhanced by the high visibility leadership from the consultant psychiatrist shared with the professional leadership of the nurse consultant. It was also essential to have dedicated project management time for the project worker to ensure paper work completion, data collection and general monitoring of staff progress.

The inpatient team have expressed concerns about the increased paperwork and some have found it difficult to get into the habit of completing a form before asking a doctor to carry out a mental state examination. This was noted on many occasions by the doctors, who then found themselves reminding staff to carry out the risk assessment first. It is therefore a matter of combing the audit risk assessment forms with the current risk assessment tools to enable a full and thorough assessment to take place, whereby it shouldn't seem like extra paperwork as only one form would be required.

## Project Management

The project was overseen by Mark Hardcastle Nurse Consultant (Project Lead) and Tim Gillett Consultant Psychiatrist. Bev White Project Worker assisted in the day to day data collection and analysis. Kristina Antonvoa (SHO) joined the project mid way and assisted in the auditing process.

Staff who were absent during training were given an individual catch up session with Mark Hardcastle. The outreach training was re-scheduled to a later date as staff were not available for the original training day. This was due to the part time working hours of several staff making availability limited. As a result the outreach training was delivered later than planned.

## Programme support

The project was supported mainly by internal staff. External staff were invited to the NWW meetings which were regularly held at the SCCYP. Greater links with other projects may have been helpful.

## Budget

The finance provided by the National CAMHS NWW Workforce Project funded the secondment of Project Worker Bev White and allowed for other expenses to implement the project.

## Dissemination Plan

The project is due for dissemination in early 2008. Results will be shared with staff at the SCCYP and taken to wider audiences at relevant conferences.

## Impact and Sustainability

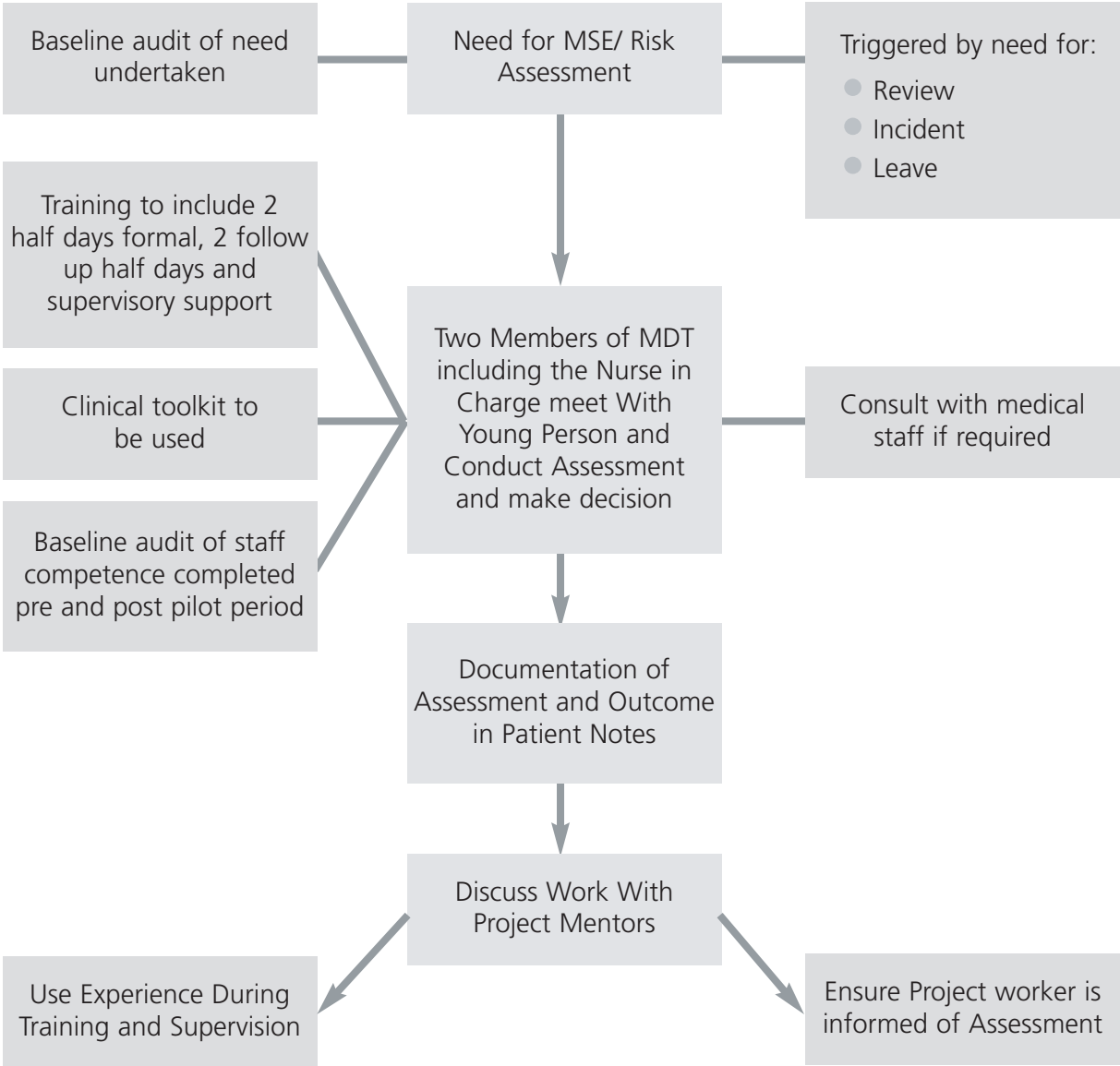
An extension of the project over one year would allow for a more detailed analysis. As the current data set is too small for statistical analysis results are only an indicator of what can potentially be achieved. It is hoped that the project will eventually become embedded into current practices in line with the New Ways of Working frameworks. Staff will need to receive ongoing training in order to keep knowledge and skills up to date to carry on undertaking risk assessments usually associated with psychiatric staff. New staff will also require the same training. At the end of the years extension a full audit will be completed and results ready for publication.

# Appendices

## Appendix I

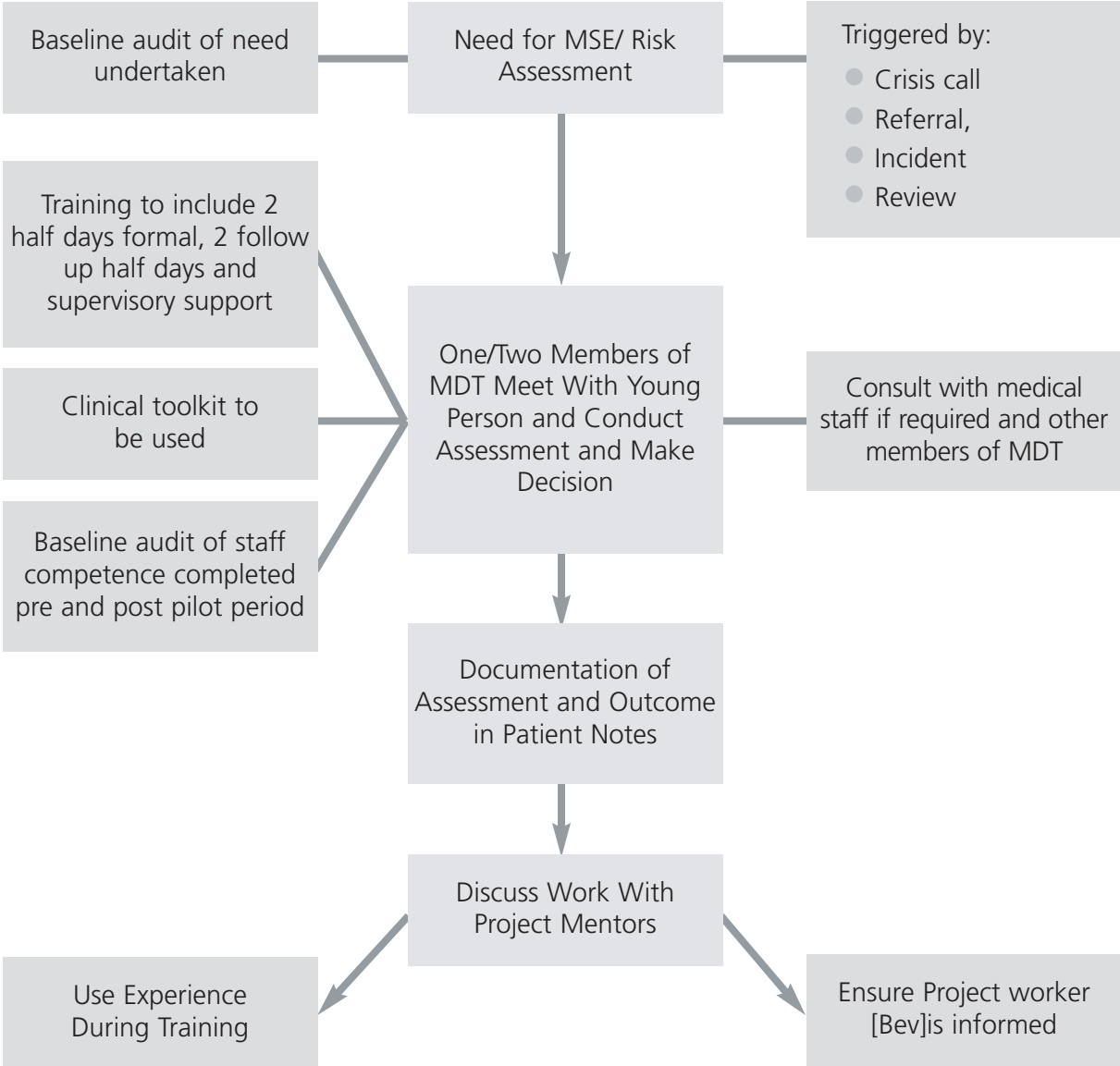
### Illustrative pathway for the development of mental status examination training for non-medical professionals at the Sussex centre for children & young people (CAMHS)

#### In-patient/day-patient



**Illustrative pathway for the development of mental status examination training for non-medical professionals at the Sussex centre for children & young people (CAMHS)**

**Outreach**



# Appendix II

Complete this form for all risk situations identified.

## In Patient Team

### Audit of Risk Management Process and Management of Potentially Life Threatening Mental State

Date of Assessment

Assessment carried out by

Name \_\_\_\_\_

Name \_\_\_\_\_

#### Category of New High Risk Situation Identified

### Category of Risk

#### Risk to Self

Suicide Attempts or Threats/Expressing Suicidal Ideas/Considered, Planned Intent/Self Harm, Cutting, Overdose/Putting self at risk in Other Ways e.g. Absconding/ Drug, Solvent or Alcohol Abuse/Other Self Harm e.g. Eating Disorder/Expressing High levels of Distress

#### Risk to Others

Physical Harm/Threatening Behaviour/Bullying Others/Signs of Anger or Frustration/Excessive interest in Fire Setting/Sexualised Behaviour/False Allegations

#### Risk from others

Sexual abuse/Physical Abuse/Emotional abuse/Neglect/Exposure to Violence/Exploitation/Bullying/Family Psychiatric Illness

#### Other Risks

Significant Life Events/Adverse Social Circumstances/High risk Medical Condition e.g. epilepsy, diabetes/Destruction of Property/Racist Behaviour

### **Protective Factors (eg Positive Resources and Potentials) Identified**

### **Measures put in place to reduce the level of risk**

E.g. Review current safeguards/ Increase observation level/ Increase Support for Young Person/ Increase Support for Carers/ Develop Appropriate Treatment Programme/ Educate Young Person, Family about the Risks/ Develop ideas with Young Person, Family to reduce risks/ Refer to Social Services

### **Extent to which protective factors and interventions have reduced risk**

- RED** Need to discuss with psychiatrist because of potentially life threatening danger
- AMBER** Ongoing concern: Need to discuss with another team member
- GREEN** Risk Management strategies seen as addressing the risk and review set

**Outcome of discussion with team member**

E.g. Develop detailed Risk Management Plan in Nursing Care Plan

**Extent to which discussion with team member have reduced risk**

- RED** Need to discuss with psychiatrist because of potentially life threatening danger
- AMBER** Ongoing concern: Need to discuss with another team member
- GREEN** Risk Management strategies seen as addressing the risk and review set

**Presence of Potentially Life Threatening Mental State?**      **Y/N**

If **Yes**

Active Suicidality/Hopelessness?

Persecutory Delusions?

Command Auditory Hallucinations?

Passivity: Limited Capacity to resist Acting on Delusions/Hallucinations?

Severe Anorexic Thinking resulting in Not drinking fluid for more than 12 hours?

Other?

**Details of Potentially Life Threatening Mental State Identified**

**Decision Regarding Urgency of Psychiatric Involvement**

Need to seek immediate psychiatric assessment

Need to seek psychiatric opinion next working day

Need to seek psychiatric opinion within the week

Seek psychiatric advice as part of the next Weekly Multidisciplinary Review

# Appendix III

## Home Visit Risk Screening Assessment

Service User Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Network of Support**

Network of Support	Names (where relevant)	Copies sent to:
Service User	<input type="checkbox"/> _____	<input type="checkbox"/>
Carer(s)	<input type="checkbox"/> _____	<input type="checkbox"/>
General Practitioner	<input type="checkbox"/> _____	<input type="checkbox"/>
Psychiatrist	<input type="checkbox"/> _____	<input type="checkbox"/>
Community Psychiatric Nurse	<input type="checkbox"/> _____	<input type="checkbox"/>
Ward Link Nurse/Key Nurse	<input type="checkbox"/> _____	<input type="checkbox"/>
Social Worker	<input type="checkbox"/> _____	<input type="checkbox"/>
Occupational Therapist	<input type="checkbox"/> _____	<input type="checkbox"/>
Psychologist	<input type="checkbox"/> _____	<input type="checkbox"/>
Support Worker(s)	<input type="checkbox"/> _____	<input type="checkbox"/>
Voluntary Agency Worker(s)	<input type="checkbox"/> _____	<input type="checkbox"/>
School/college contact	<input type="checkbox"/> _____	<input type="checkbox"/>
Connexions	<input type="checkbox"/> _____	<input type="checkbox"/>
CPA/Care-co-ordinator	<input type="checkbox"/> _____	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/> _____	<input type="checkbox"/>

**Risk Indicators: Suicide**

	Yes	No	Unknown		Yes	No	Unknown
Previous attempts on their life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Expressing high levels of distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous use of violent methods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Helplessness or hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mis-use of drugs and/or alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family history of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Major psychiatric diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Relationship difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expressing suicidal ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School non-attendance/ Unemployed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Considered/planned intent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent significant life events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Believe no control over their life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Major physical illness/disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Estranged from family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Other: (please specify) _____							
Comments: _____							
_____							

**Neglect**

	Yes	No	Unknown		Yes	No	Unknown
Previous history of neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of positive social contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failing to drink properly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unable to shop for self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failing to eat properly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insufficient/inappropriate clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty managing physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty maintaining hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Living in inadequate accommodation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Experiencing financial difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lacking basic amenities (water/heat/light)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty communicating needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pressure of eviction/repossession	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Denies problems perceived by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: (please specify) _____							
Comments: _____							
_____							

### Aggression/Violence

	Yes	No	Unknown		Yes	No	Unknown
Previous incidents of violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paranoid delusions about others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous use of weapons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Violent command hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mis-use of drugs and/or alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Signs of anger and frustration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Male gender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually inappropriate behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Known personal trigger factors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Preoccupation with violent fantasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expressing intent to harm others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Admissions to secure settings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous dangerous impulsive acts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Denial of previous dangerous acts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Known convictions for aggression/violence/contact with Criminal Justice System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Risk to other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: (please specify)	_____						
Comments:	_____						
	_____						

**Other**

	Yes	No	Unknown		Yes	No	Unknown
Self-injury (e.g. cutting, burning)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exploitation by others (e.g. financial)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other self-harm (e.g. eating disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exploitation of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stated abuse by others (e.g. physical, sexual, emotional neglect, domestic violence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Culturally isolated situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abuse of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Non-violent sexual offence (e.g. exposure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Harassment by others (e.g. racial, physical, bullying)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arson (deliberate fire-setting only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Harassment of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Accidental fire risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risks to child(ren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other damage to property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous contact with CAMHS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Previous contact with other specialist services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parental mental health issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other: (please specify) \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

**Summary of Assessment**

### **Initial Management Plan**

Is a more detailed assessment needed?      Yes       No

### **Outreach Team**

#### **Audit of Risk Assessment, Frequency of Potentially Life Threatening Mental State and Need to Involve a Psychiatrist in the Risk Management Plan**

Reason for requested SCCYP Involvement or description of crisis necessitating re-assessment

**Presence of Life Threatening Mental State?      Y/N**

**If Yes**

Active Suicidality/Hopelessness?

Persecutory Delusions?

Command Auditory Hallucinations?

Passivity: Limited Capacity to resist Acting on Delusions/Hallucinations?

Severe Anorexic Thinking resulting in Not drinking fluid for more than 12 hours?

Other?

**Details of Potentially Life Threatening Mental State Identified**

**Protective Factors (e.g. Positive Resources and Potentials) Identified and measures put in place to reduce level of risk**

**Decision regarding timing of further Multidisciplinary discussion**

Need to contact psychiatrist immediately for planning emergency intervention

Will await next working day discussion with other team member

Will await discussion with other team member within the next week

Will await discussion at next outreach team meeting

Name of Assessor \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Name of Assessor \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

# Appendix IV

## Sussex Centre for Children and Young People

### OUTREACH Team Training Package

#### 'New Ways of Working in CAMHS'

#### Risk Assessment of Potentially Life Threatening Mental States

#### Training Manual

#### Day 1

1st March 2007

#### Team Training

#### Risk Assessment of Potentially Life Threatening Mental States

The training today is part of 'New Ways of Working' Project aimed at developing the skill base of CAMHS professionals to enable them to legitimately carry out assessments traditionally associated with the role of the Child Psychiatrist

In-patient staff members have already attended a similar training course over the course of the last few months

The overall Aims and Objectives of the project are outlined below

#### ***Aim***

To develop the skills and knowledge of Multidisciplinary Team Members to enable them to respond to the immediate need for mental health assessment of a child or young person at times of crisis and risk when a child or young person is either in the community or an in-patient

#### ***Objective***

The development of values and evidence based practices through the acquisition of new competencies, which will enable multidisciplinary staff to carry out assessment, and decision-making activities that would normally be associated with members of the psychiatric medical team

#### Teaching Plan for New Ways of Working in CAMHS

#### Using Modified Mental State Assessment to Assess Risk

#### ***Learning Aims***

- 1) To improve outreach risk assessment information eliciting/documentation and make explicit decisions around timing of information sharing.
- 2) To recognise existing team member skills present in performing mental state assessments and in seeking appropriate involvement of team psychiatrists.

### ***Learning Outcomes***

Following training team members will have confidence in ensuring that when a high-risk situation is encountered during an assessment:

- (a) Information is gathered regarding the risk and regarding potentially protective factors.
- (b) A decision is made and documented regarding how the risk is managed and how information is shared with the team.
- (c) Team member will be able to recognise a potentially life threatening mental state, perform a modified mental state assessment and make a judgement as to when to involve a psychiatrist in the further assessment.

### **Day 1**

- 1-30** Quiz!
- 2-00** Introduction to the Training and its Objectives
- 2-10** Looking at scenarios
- 3-15** Tea
- 3-30** The Baseline Audit Proforma and its Application
- 4-30** Close

### **Day 2**

- 1-30** Assessing High Risk Mental States
- 2-30** Assessing Young People/ Children you have known in practice
- 3-15** Tea
- 3-30** Protective Factors : Positive Resources and Potentials  
Factors that help keep people safe
- 4-15** Trouble Shooting and final post-training quiz
- 4-30** Close

## **Risky Situation Assessment**

What is the situation

What do you do?

Information required about risk.

Anything which makes it safer.

Who do I need to discuss this with and when (why not sooner/why not later)?

## **Potentially Life Threatening Mental State Assessment**

What was the situation?

What did you do?

Information required about risk.

What made it safer?

Who did I need to discuss this with and when?

## Case Scenario Number 1

### Young Person's Script

You are 13.

You have been bullied for two years. Feel like everything has been tried to stop it. Nothing works. Your family moved house to get away from them two months ago but last week you found out they have also moved to the house next door! You have reached "rock bottom" and cannot see any point to living.

You are thinking about taking a pack of Paracetamol you bought this morning.

You took 20 Paracetamol last week when you found out that the bullies were living next door, but did not tell anyone. You do not want to upset your parents by killing yourself and you want to keep alive for the sake of your older sister's new baby daughter.

### Case Scenario Number 1

#### *Assessors Script and Task*

Think about how to ask about:

- Hopelessness.
- Suicidal thinking.
- Suicidal planning.
- Previous suicidal acts.
- Protective factors.

Ask Questions:

Score 1 if there is suicidal thinking.

Add 2 if there is hopelessness

Add 3 if there is a plan

Add 4 if there has been a previous attempt.

Subtract 1 for any protective factors

Score out of 10 is \_\_\_\_\_

## Case Scenario Number 2

### Young Person's Script

You are a 16-year-old boy. You have been out of school for the past 2 years and you have got into the habit of smoking cannabis and inhaling solvents.

Your family give you lots of grief because of this so you spend most of your time in your room on your computer or watching TV

2 days ago you had been watching The Matrix on DVD and during the course of the film you had the realisation that you could be living in a virtual world like a computer game controlled by aliens!

After the film ended although you switched off the TV the picture remained with strange alien like creatures on the screen, which floated away from the TV and tried to take over your mind

Since then you have begun to see your family, your school and your family doctor as agents of the Matrix so it feels safest to stay in your room and not let anyone in

You have a bread knife under your pillow in case anyone tries to attack you

Your stepfather resembles the leader of the Matrix and at times you have considered that the best way to free yourself from the matrix is to engage in combat with him

You still feel as though you can trust your mother and she has got some tablets from the doctor which she says will help you sleep

Some people have come to visit to find out why you have been upset recently

You are uncertain about them but your mother says you can trust them to tell them what is happening

### Case Scenario Number 2

#### ***Assessors Script and Task***

You have been asked to assess a 16-year-old boy at home

His GP referred him to CAMHS because of his family's concern that he seems depressed and withdrawn

The local Child Psychiatrist has referred for Outreach Assessment because he has refused to attend for appointments and now has barricaded himself in his room for the past 2 days

See if you can engage with him through the bedroom door!

Why has he barricaded himself in?

What are the assessed risks?

Are there any protective factors?

What kind of plan needs to be put in place and when should it be reviewed?

Who do you need to share this plan with and when?

## Training Assessment Form

### Outreach Training Session 1

List the Aims of this Session

Describe the key learning areas for you

What do you think you have achieved in terms of increased Knowledge or skills in light of the identified outcomes for this session?

**Knowledge**

**Skills**

What was the most important area covered in your view?

## Sussex Centre for Children and Young People

### OUTREACH Team Training

#### 'New Ways of Working in CAMHS'

#### Risk Assessment of Potentially Life Threatening Mental States

### Training Manual

#### Day 2

15th March 2007

#### Team Training

#### Risk Assessment of Potentially Life Threatening Mental States

The training today is part of 'New Ways of Working' Project aimed at developing the skill base of CAMHS professionals to enable them to legitimately carry out assessments traditionally associated with the role of the Child Psychiatrist

In-patient staff members have already attended a similar training course over the course of the last few months

The overall Aims and Objectives of the project are outlined below

#### ***Aim***

To develop the skills and knowledge of Multidisciplinary Team Members to enable them to respond to the immediate need for mental health assessment of a child or young person at times of crisis and risk when a child or young person is either in the community or an in-patient

#### ***Objective***

The development of values and evidence based practices through the acquisition of new competencies, which will enable multidisciplinary staff to carry out assessment, and decision-making activities that would normally be associated with members of the psychiatric medical team

#### **Teaching Plan for New Ways of Working in CAMHS**

#### **Using Modified Mental State Assessment to Assess Risk**

#### ***Learning Aims***

3. To improve outreach risk assessment information eliciting/documentation and make explicit decisions around timing of information sharing.
4. To recognise existing team member skills present in performing mental state assessments and in seeking appropriate involvement of team psychiatrists.

### **Learning Outcomes**

Following training team members will have confidence in ensuring that when a high-risk situation is encountered during an assessment:

- (d) Information is gathered regarding the risk and regarding potentially protective factors.
- (e) A decision is made and documented regarding how the risk is managed and how information is shared with the team.
- (f) Team member will be able to recognise a potentially life threatening mental state, perform a modified mental state assessment and make a judgement as to when to involve a psychiatrist in the further assessment.

### **Day 1**

- 1-30** Quiz!
- 2-00** Introduction to the Training and its Objectives
- 2-10** Looking at scenarios
- 3-15** Tea
- 3-30** The Baseline Audit Proforma and its Application
- 4-30** Close

### **Day 2**

- 1-30** Assessing High Risk Mental States
- 2-30** Assessing Young People/ Children you have known in practice
- 3-15** Tea
- 3-30** Protective Factors : Positive Resources and Potentials  
Factors that help keep people safe
- 4-15** Trouble Shooting and final post-training quiz
- 4-30** Close

## 'Potentially Life Threatening' Mental States

### **What is a potentially life threatening mental state?**

Active Suicidality/Hopelessness

Persecutory Delusions

Command Auditory Hallucinations

Passivity:Limited Capacity to resist Acting on Delusions/ Hallucinations

Severe Anorexic Thinking resulting in Not drinking fluid for more than 12 hours

Other?

### **Notes**

### **Active Suicidality**

Depression/ Withdrawal/ Tearfulness part of the presentation and may be reason for community assessment

Most worrying when part of a psychotic illness with insight into the prognosis presented as a 'rational suicide'

Part of Suicide Risk Assessment looking at previous attempts at self harm

- Suicidal thinking – I'd be better off dead, I could kill myself by hanging myself
- Hopelessness-nothing can change for the better

Active Suicidality – the intention to imminently carry out a plan with evidence of a genuine desire to avoid being prevented

### **Notes**

### **Persecutory Delusions**

'Paranoia' – Beside the mind = Delusional

A Delusion is a fixed belief without basis in reality and not explicable within the persons social, cultural or religious context

People are out to get me

- Justified: associated with depressive psychosis may also be voices saying bad things in the second person eg 'you are worthless' 'piece of sh\*\*t' 'pooh face' greater danger to self
- Unjustified-don't deserve it: associated with schizophrenic psychosis may also be voices commenting in the 3rd person eg 'she is standing up now' – like running commentary greater danger to others

### **Notes**

### **Command Auditory Hallucinations**

Hallucinations: hearing and seeing things which aren't there!

Visual Hallucinations are associated with toxic confusional states eg drug induced delirium: disorientation/ confusion/ anxiety-small creatures or shadows

Command Hallucinations: voices saying 'do something' eg 'jump' 'cut' 'kill' etc. More likely to be complained of by YP with personality and relationship difficulties but may be feature of psychosis

### **Notes**

**Passivity**

Passivity: Limited Capacity to resist Acting on Delusions/ Hallucinations

With any delusions or hallucinations always ask:

- What do you make of the unusual experience-how does it come about what's the explanation for it?
- How real does it seem?
- To what extent are you able to resist following your impulses?
- To what extent are you drawn to carry out what is being suggested?

**Notes****Severe Anorexic Thinking**

Severe Anorexic Thinking resulting in not drinking fluid for more than 12 hours

Very rare to sustain a 'Fluid Strike' but life threatening if genuine and for more than 2 days

Therefore important to take action at an early stage- notify GP to arrange paediatric hospital admission

**Notes**

**Other?**

Grandeosity- very unusual PLTMS

I can fly!

Threats to poison, stab, set fire to, shoot- more likely to be associated with early personality and relationship difficulties rather than evidence of PLTMS

**Group Exercise: Assessing Young People/Children you have known in practice****Get into groups of 3**

Think of a case you have been involved with where a child/ young person presented with a high risk mental state during the home visit

What details about the high risk mental state did you manage to elicit?

Were there any factors which made you think the risk was more manageable than it had appeared at first?

What kind of risk management plan did you put in place?

What arrangements were made for you to share and review the plan?

Tell the group about your case and get them to fill out the Audit Form as if they had been on the home visit

## Protective Factors : Positive Resources and Potentials

Factors that help keep people safe

Slide 1

### Risk and Protective Factors

- If risk is associated with the increased potential for an adverse event occurring then protective factors are associated with reducing the likelihood of the event.
- Protective factors enhance resilience and serve to counterbalance risk factors.
- Like risk, protective factors may be individual biopsychosocial issues, environmental or socio-cultural in nature.

---

---

---

---

---

---

---

---

Slide 2

### Risk and Protective Factors

- Understanding the interactive relationship between risk factors and protective factors and how this can be modified is the essence of risk management.
- Risk factors that can't be altered such as an historical suicide attempt can serve as an alert to others at times during times of stress, mental illness or substance misuse.

---

---

---

---

---

---

---

---

Slide 3

### Protective Factors

- Healthy and strong family, friends and community support.
- Effective care planning and early sign monitoring
- Personal characteristics such as good self esteem
- Ease of access to support and help
- Restricted access to highly lethal means of suicide
- Skills in problem solving and conflict resolution
- Cultural and religious beliefs that discourage suicide

---

---

---

---

---

---

---

---

Slide 4

### Solution focussed approach

- Examine what has helped in the past. What has the person done in the past that appears to reduce risk ?
- What is the person doing now to reduce risk ?
- What strengths, resources, beliefs and attributes can be built upon?

---

---

---

---

---

---

---

---

Slide 5

**Using protective factors in a management plan**

- Ensure appropriate supervision at home or in hospital
- Consider how the person can access further support including contingency and personal safety plans that include alternatives and choices
- Build supportive therapeutic relationship that includes problem sharing and solving, help to reduce conflict, advice on distraction and activity scheduling
- Remove means of suicide
- Continue to monitor and revise plan

---

---

---

---

---

---


---

---

Slide 6

**Framework to Guide Intervention**

I  
M  
M  
I  
N  
E  
N  
C  
E



- Impending (hours) – survival
- Very near (days) – crisis resolution
- Near (weeks) – support and problem solving
- Distal (months) – therapeutic achievement

---

---

---

---

---

---

---

---

Slide 7

**Do's and Don'ts Advice to Relatives and Friends**

- Do listen
- Show appreciation that they have confided
- Do contact a professional if you are concerned and take advice.
- Do distract
- Let them know you care
- Can you remove stressors and potential means of suicide?

---

---

---

---

---

---

---

---

Slide 8

**Do's and Don'ts Advice to Relatives and Friends**

- Don't panic but do take things seriously
- Don't be dismissive or say things like 'pull yourself together'
- Don't blame yourself
- Don't shoulder it all, get support from others

---

---

---

---

---

---

---

---

## Training Assessment Form

### Outreach Training Session 2

List the Aims of this Session

Describe the key learning areas for you

What do you think you have achieved in terms of increased Knowledge or skills in light of the identified outcomes for this session?

**Knowledge**

**Skills**

What was the most important area covered in your view?

# Appendix V

## NWW Training QUIZ

Name \_\_\_\_\_

**Mark all questions with T=True or F=False**

1. The following statements about risk are true:

- A. All risks identified at a home assessment should be shared with a team psychiatrist immediately.
- B. Information about safety factors is irrelevant in assessing an extremely high risk situation.
- C. It is important to make an explicit decision about the nature of the risk, how it is to be managed, who to share the decision with and the timing of the discussion.
- D. A potentially life threatening mental state will always be more dangerous than any other risks identified.
- E. A potentially life threatening mental state should require the early involvement of one of the team psychiatrists as part of the risk management plan.

2. The following statements are true about mental state assessments:

- A. A full mental state assessment involves a detailed family history and early development.
- B. A young person's appearance, attitude, behaviour and speech may give important clues to the presence of a potentially life threatening mental state.
- C. A young person who looks depressed and withdrawn and who may be contemplating suicide should not be asked about suicidal thoughts in case it precipitates an attempt.
- D. A judgement about a young person's thought content and thought process are important elements of a mental state examination.
- E. Drug intoxication makes it impossible to perform a mental state examination.

3. A suicide risk assessment.....

- A. need not take account of the young person's history of past self harm.
- B. takes account of current suicidal thoughts.
- C. needs to evaluate the immediacy of any suicidal plans made.
- D. revealing evidence of psychosis (hallucinations and delusions) is likely to raise the level of concern.
- E. Takes account of what might have stopped a young person from attempting during a period of suicidal contemplation.

4. The following statements refer to potentially life threatening mental states:
- A. A young person with command auditory hallucinations may be at risk of acting on suggestions given by voices.
  - B. Many young people nowadays carry knives for defence so asking about a young person's possession of, and intent to use weapons is irrelevant.
  - C. Persecutory ideas may result in suicidal or homicidal responses.
  - D. Severe psychotic depression with self deprecatory delusions and second person auditory hallucinations lowers the suicide risk.
  - E. 'Passivity' refers to the phenomenon of resisting the suggestions made by hallucinations and delusions.
5.  A. An anorexic with as BMI of 17 is safe to be allowed not to drink fluids for up to a week.
- B. A young man who is withdrawn and uncommunicative should be asked specifically about strange or unusual experiences as he may believe he is under the control of aliens.
  - C. Persecutory delusions may result in either violence towards a person who is seen as part of the persecution or in self harm depending on whether the persecution is seen as justified.
  - D. Grandiosity may be associated with pressured speech and flight of ideas and may represent a dangerous mental state.
  - E. Failure to document assessments and decisions can be excused when dealing with especially high-risk situations.

# Appendix VI

## New Ways of Working Questionnaire

Please answer the following questions as accurately as possible:

1) Most of my work is with the outreach service? Yes / No

2) How long have you been qualified? \_\_\_\_\_

3) What Band are you on? \_\_\_\_\_

Please rate your level of confidence by marking a cross on the line, as shown in the example below:

*I am able to sing in public:*

Not at all confident |-----X-----| Very confident

4) I am able to make risk assessments on young people:

Not at all confident |-----| Very confident

5) I am able to make risk decisions based on the assessments of young people:

Not at all confident |-----| Very confident

Please return your completed questionnaire immediately to Bev White's tray.

Thank you.

# Contact Details

<b>Lead Contact:</b>	Dr Tim Gillett
<b>Name or organisation:</b>	Sussex Partnership NHS Trust
<b>Contact details:</b>	Sussex Centre for Children and Young People (Colwood) Princess Royal Hospital Lewes Road Haywards Heath West Sussex, RH16 4EX tel: 01444 448713
<b>CAMHS Regional Development Worker:</b>	Linda Wollam
<b>Geographical area covered by project:</b>	Sussex







---

If you require further copies of this report please contact:

**Barry Nixon**, *National Workforce Lead for CAMHS*

**e:** *Barry.Nixon@wwl.nhs.uk*

This can also be downloaded from *[www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)*

