



Historical and Current Risk Indicators			
Please add any dates for historical risk			
Section 1 Suicide/self-harm			
Static		Dynamic	
a) Previous attempts on their life	<input type="checkbox"/>	j) Previous use of violence	<input type="checkbox"/>
b) Major psychiatric diagnosis	<input type="checkbox"/>	k) Highly distressed	<input type="checkbox"/>
c) Believe no control over their life	<input type="checkbox"/>	l) Helplessness or hopelessness	<input type="checkbox"/>
d) Family history of suicide	<input type="checkbox"/>	m) Separated/widowed/divorced	<input type="checkbox"/>
e) History of abuse	<input type="checkbox"/>	n) Unemployed/retired	<input type="checkbox"/>
f) Male	<input type="checkbox"/>	o) Recent significant life events	<input type="checkbox"/>
g) Age 15-24 or above 60 yrs	<input type="checkbox"/>	p) Expressing suicidal ideas	<input type="checkbox"/>
h) Misuse of drugs and/or alcohol	<input type="checkbox"/>	q) Considered planned/intent	<input type="checkbox"/>
i) Past significant loss	<input type="checkbox"/>	r) Clinically significant depressive symptoms	<input type="checkbox"/>
Section 2 Aggression and violence			
Static		Dynamic	
a) Previous incidence of violence	<input type="checkbox"/>	i) Paranoid delusions about others	<input type="checkbox"/>
b) Previous use of weapons	<input type="checkbox"/>	j) Signs of anger/frustration	<input type="checkbox"/>
c) Male under 35 yrs	<input type="checkbox"/>	k) Sexually inappropriate behaviors	<input type="checkbox"/>
d) Known personal trigger factors	<input type="checkbox"/>	l) Denial of previous dangerous acts	<input type="checkbox"/>
e) Previous dangerous impulsive acts	<input type="checkbox"/>	m) Expressing intent to harm others	<input type="checkbox"/>
f) Previous admissions to forensic services	<input type="checkbox"/>	n) Relationship instability	<input type="checkbox"/>
g) Verbal aggression	<input type="checkbox"/>	o) Employment problems	<input type="checkbox"/>
h) Forensic history	<input type="checkbox"/>	p) Violent command hallucinations	<input type="checkbox"/>
Section 3 Neglect and vulnerability			
Static		Dynamic	
a) Previous history of neglect	<input type="checkbox"/>	f) Unable to shop for self	<input type="checkbox"/>
b) Difficulty managing physical health	<input type="checkbox"/>	g) Insufficient appropriate clothing	<input type="checkbox"/>
c) Living in inadequate accommodation	<input type="checkbox"/>	h) Difficulty maintaining hygiene	<input type="checkbox"/>
d) Pressure of eviction	<input type="checkbox"/>	i) Difficulty communicating needs	<input type="checkbox"/>
e) Social isolation from peers	<input type="checkbox"/>	j) Denies problems perceived by others	<input type="checkbox"/>
		k) Failing to eat or drink properly	<input type="checkbox"/>
Section 4 Others			
a) Self-injury	<input type="checkbox"/>	k) Intellectual Disability	<input type="checkbox"/>
b) Other self-harm	<input type="checkbox"/>	l) Exploitation by others	<input type="checkbox"/>
c) Previous emotional trauma/abuse	<input type="checkbox"/>	m) Exploitation of others	<input type="checkbox"/>
d) Risk to children	<input type="checkbox"/>	n) Culturally isolated	<input type="checkbox"/>
e) Children at home? Yes/No Ages_____		o) Accidental fire risk	<input type="checkbox"/>
f) Non-compliance with medication	<input type="checkbox"/>	p) Other damage to property	<input type="checkbox"/>
g) Sexual offences	<input type="checkbox"/>	q) Harassment by others	<input type="checkbox"/>
h) Arson	<input type="checkbox"/>	r) Eating disorder	<input type="checkbox"/>
i) Absconding from unit	<input type="checkbox"/>	s) Poor sleep	<input type="checkbox"/>
j) Cognitive defects	<input type="checkbox"/>	t) Financial	<input type="checkbox"/>

Substance use:

Alcohol use amount regularity and type _____

Illicit drug use amount regularity and type _____

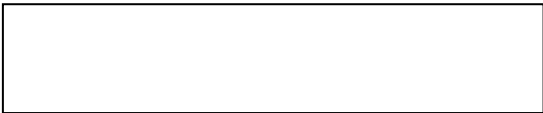
Other substances (solvents, synthetic cannabis): yes / no

Please state: _____

If _____ is likely to suffer withdrawal symptoms on admission please commence a CIWA monitoring and discuss with psychiatrist.

Please add any comments you wish to make (include dates) around risks and potential risks to expand on any boxes that have been indicated (use **abbreviated number e.g. 1d = family history of suicide**).

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TOOL 2: FORMULATION

Pathway/triggers to harming behaviours - pattern description

Consider - mental state, situational problems, substance abuse, weapons both internal and external factors

Name: _____ is at risk of acting in the following way:

Describe the nature of the risk:

-
-
-
-
-
-
-
-
-

Name: _____ is more likely to act this way:

Describe the behaviours / situations associated with the risk: *e.g. relationship issues, whanau, financial issues*

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Early Warning Signs:

-
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Disclosed or suspected psychological trauma, please describe:

Screened for Domestic Violence, Yes / No: (see prompts on page 6 & please follow VIP protocols)

Does patient consent to accessing services to help with the trauma of domestic violence?

If yes, whom have you involved in the care: sign & date when completed

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The following act as protective factors / strengths:

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-
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Please add any further comments you wish to make:

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Completed By: _____

Date: ___ / ___ / _____

Position: _____

Next Review Date: ___ / ___ / _____

TOOL 3: TREATMENT & RELAPSE PREVENTION PLAN

SHARED INFORMATION / CONTACT LIST	
Individual / Group/ involved in care (Contact Details)	Information to be shared / purpose/ referrals made
Cell #	
Whanau Cell #	Keep informed of appt's, and progress
CMH + AS (06) 8692 097 0800 999 014	
Mental Health Crisis Team 0800 243 500	Crisis Management
Clinical Specialist	Monitor Mental Health
Community Support Worker Cell #	Keep informed of appt's, and progress
Pharmacy	Dispense Medication
NASC	Needs Assessment of Supports required



SPECIFIC STRATEGIES

Care Plan relating to Risk Assessment

Include beneficial therapies e.g. sensory modalities, CAT input, CBI: refer to above table.

Please sign & date each entry.

- Suicide / self-harm:

- Aggression / violence

- Neglect / vulnerability

- Substance misuse

- Other risks

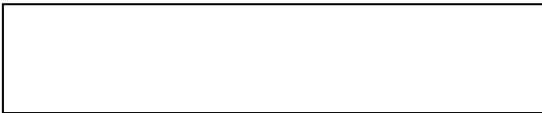
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SPECIFIC STRATEGIES FOR CARE PLANNING, TREATMENT RISK REDUCTION

(Include supports that may be necessary to meet recovery goals , e.g. NGO supports, accommodation assistance, medication oversight, CSW, clinical specialist)

	WHO?	WHEN?
<ul style="list-style-type: none"> Stable accommodation/supportive home environment 		Current/ongoing
<ul style="list-style-type: none"> Monitoring of Mental State 	Clinical Specialist (C/S)& Registered Clinician (RC)	C/S /PRN RC 3 Monthly/PRN
<ul style="list-style-type: none"> Crisis Management 	Mental Health Crisis Team (MHCT)	PRN
<ul style="list-style-type: none"> Urgent Psychiatrist assessment 	On-call Psychiatrist	PRN
<ul style="list-style-type: none"> Community Supports Includes: 	Community Support Worker (CSW)	Ongoing
<ul style="list-style-type: none"> Pharmacy 	Pharmacy	
<ul style="list-style-type: none"> NASC – Needs Assessment 	NASC	6 Monthly R/V



Risk Review Sheet to be completed weekly or when risk alters N.B. More than one risk can be added to each box, use further sheets if required	
Please tick and add comments to whichever area applies: 1. Suicide/self-harm <input type="checkbox"/> 2. Aggression/violence <input type="checkbox"/> 3. Neglect/vulnerability <input type="checkbox"/> 4. Substance misuse <input type="checkbox"/> 5. Other	Risk Statement:
Signature: Designation: Date:	Next Review Date:
Please tick and add comments to whichever area applies: 1. Suicide/self-harm <input type="checkbox"/> 2. Aggression/violence <input type="checkbox"/> 3. Neglect/vulnerability <input type="checkbox"/> 4. Substance misuse <input type="checkbox"/> 5. Other	Risk Statement:
Signature: Designation: Date:	Next Review Date:

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<p>Please tick and add comments to whichever area applies:</p> <ul style="list-style-type: none"> 1. Suicide/self-harm <input type="checkbox"/> 2. Aggression/violence <input type="checkbox"/> 3. Neglect/vulnerability <input type="checkbox"/> 4. Substance misuse <input type="checkbox"/> 5. Other 	<p>Risk Statement:</p>
<p>Signature: _____ Designation: _____ Date: _____</p>	<p>Next Review Date:</p>
<p>Please tick and add comments to whichever area applies:</p> <ul style="list-style-type: none"> 6. Suicide/self-harm <input type="checkbox"/> 7. Aggression/violence <input type="checkbox"/> 8. Neglect/vulnerability <input type="checkbox"/> 9. Substance misuse <input type="checkbox"/> Other 	<p>Risk Statement:</p>
<p>Signature: _____ Designation: _____ Date: _____</p>	<p>Next Review Date:</p>

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MENTAL STATE EXAMINATION

Appearance: (Dress, posture, facial expression, psychomotor activity, mannerisms, volition)

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Self-care issues (sleep pattern, eating appetite, weight loss/ gain, anhedonia, libido)

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Behavior: (Ccooperativeness, eye contact)

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Speech: (Volume, rate, amount and flow, special features or accent or impediments)

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Mood and Affect: (Anxious, congruent, elated, depressed)

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Thought Process: (Accelerated, slowed, spontaneous, loose associations, logical or illogical, circumstantial, thought blocking)

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Thought Content: (Delusional, preoccupied, grandiose, overvalued ideas, self-condemnatory or ideas of reference)

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Suicidal/Homicidal/Violent Ideation: (plan, intent, means)

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Perception: (Misperceptions, hallucinations, abnormal experiences)

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Orientation and Cognition: (Memory, intelligence and concentration)

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Insight/Judgement: (Does the patient accept that they are ill and/or require treatment? Is their judgement impaired?)

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