RAPID ASSESSMENT OF PATIENTS IN DISTRESS

These questions are to assist in the assessment of people with potential mental health problems in the emergency department, and to consider urgency of need for mental health referral and security measures.

Name:	Address:	DOB:
Next of Kin:	Telephone:	NHI:

Commentary

Use Mental State Examination if disoriented.

Consider safety issues for person and staff.

Use prompts over page to assess for suicide.

*** May need to institute measures to prevent inappropriate self discharge prior to full assessment NOW.**

Is the person too sedated, sleepy or disoriented to give an adequate history?

Does the person need an interpreter?

Enquire about old notes/any existing mental health files.

Start a problem list.

Seek consent to contact whānau/family/ friends.

Check if they are from this area.

Do you need to contact anyone immediately or can it wait until the following morning?

Fax contact information.

WHAT IS THE PROBLEM?

Disorientation in:

- ☐ Time?
- ☐ Place?
- ☐ Person?
- ☐ Suicidal ideation*
- ☐ Anxiety/panic attacks
- ☐ Thoughts disordered
- ☐ Bizarre behaviour*
- ☐ Depressed
- ☐ Intoxication*
- ☐ Hallucinating
- ☐ Aggression*
- ☐ 'Stress'
- ☐ Drug and alcohol withdrawal*
- ☐ Delusional
- ☐ Agitation*

WHY NOW?

- ☐ Self-referral
- ☐ Concern from others
- ☐ Personal crisis
- ☐ GP referral
- ☐ Person won't talk
- ☐ Mental Health Act 1992
- ☐ Police presentation
- ☐ Deliberate self-harm

CAN I GET AN ADEQUATE HISTORY NOW? ☐ Yes ☐ No

IS THERE A PSYCHIATRIC HISTORY? ☐ Yes ☐ No

If yes, working diagnosis? _____

Current medications? _____

Legal status? ☐ Mental Health Act 1992 ☐ Informal

Is there an existing management plan? ☐ Yes ☐ No

WHAT DOES THE PERSON WANT?

- ☐ Someone to talk to
- ☐ Accommodation
- ☐ They don't know
- ☐ Psychiatric input
- ☐ Medication
- ☐ Inpatient treatment
- ☐ Detox
- ☐ Outpatient treatment

WHERE CAN I GET INFORMATION FROM? (note contact details)

- ☐ Whānau/family members or friends?
- ☐ GP?
- ☐ Community health centre?
- ☐ Voluntary agencies?
- ☐ Case management?
- ☐ Therapist/counsellor?
- ☐ NGOs?
- ☐ Psychiatrist?
- ☐ Psychologist?

IS ANYONE ELSE WITH THEM OR IN THE WAITING ROOM?

Does the person have children? ☐ Yes ☐ No

Where are they now? _____

CAN YOU TELL ME HOW YOU ARE FEELING AT THE MOMENT?

MINISTRY OF HEALTH MANATŪ HAUORA
The Royal Australian and New Zealand College of Psychiatrists - New Zealand Branch.
Mental Health COMMISSION
Council for Mental Well-Being Trust
NZNO Mental Health Nurses Section
NEW ZEALAND GUIDELINES GROUP

These questions will help determine the level of observation needed in the emergency department.

Commentary

Consider whether the person is safe to be alone.

Risk factors include:

- definite plan
- hopelessness
- severe depression
- psychotic symptoms
- recent discharge from a psychiatric unit
- use of alcohol, street drugs, particularly recent escalation
- recent suicide attempt
- single men: young, elderly
- homelessness
- medical illness
- history of childhood abuse
- recent suicide attempt by a whānau/family member or a friend.

IF YOU SUSPECT A PERSON IS CARRYING A WEAPON NOTIFY SECURITY NOW

Predictors of violence include history of impulsivity and previous violence, alcohol and substance use, antisocial traits/behaviours.

Complete a physical examination.

Make triage decisions and decide whether to refer for a psychiatric assessment.

Does the Mental Health (Compulsory Assessment and Treatment) Act 1992 need to be applied? Is a Duly Authorised Officer required?

Does Child, Youth and Family Services need to be called (to offer 'care and protection' to under 17 year old)? (0508 FAMILY)

Involve social supports in discharge planning.

SUICIDE ASSESSMENT

Have you had thoughts that life isn't worth living? ☐ Yes ☐ No

Have you thought of harming yourself? ☐ Yes ☐ No

Are you thinking of suicide? ☐ Yes ☐ No

Have you tried to harm yourself in the past? ☐ Yes ☐ No

If yes, how many times? _____

When was the most recent time? _____

How often are you having these thoughts? _____

Have you thought about how you would act on these (is there a plan)? *(Does this plan seem feasible? Are the methods available? Is it likely to be lethal?)*

_____

Have you thought about when you might act on this plan?

Are there any things/reasons that stop you from acting on these thoughts? _____

Do you know anyone who has recently tried to harm themselves?

IF A SUICIDE ATTEMPT HAS BEEN MADE

What did you hope would happen as a result of your attempt? *(Did they want to die, or end their pain?)* _____

Do you still have access to the method used? ☐ Yes ☐ No

Did you use alcohol or drugs before the attempt? What did you use?

Do you have easy access to a weapon? ☐ Yes ☐ No

HAVE YOU THOUGHT OF HURTING ANYONE ELSE? ☐ Yes ☐ No

If yes, have you acted on these thoughts? ☐ Yes ☐ No

Have you been involved in any fights recently? ☐ Yes ☐ No

If yes, were you using drugs or alcohol at the time? ☐ Yes ☐ No

DO YOU FEEL SAFE AT THE MOMENT? ☐ Yes ☐ No

WHO DO YOU LIVE WITH?

Is there anyone at home right now? ☐ Yes ☐ No

Is there anyone we need to call? _____

HOW IS YOUR GENERAL HEALTH?

WHAT TRIGGERED THESE THOUGHTS/ACTIONS?

(What are key stressors, for the person, eg, financial, relationships, employment, bereavement?)

What lead you to try and take your life? _____

What lead you to having these thoughts? _____

What has been going on in your life lately? Are there any things that have been worrying or upsetting you? _____

WHAT WOULD MAKE A DIFFERENCE AT THE MOMENT?

(Can the person see anything changing in their situation?)

Can we make a list of the main problems? _____

What can we do now? _____

What needs to be done later? _____

Adapted from Wilhelm, Kotze, Ballard and Hudson, Consultation Liaison Psychiatry and Emergency Departments, St Vincent's Hospital, Sydney. 2001.

Copies of this tool can be downloaded from NZGG's website www.nzgg.org.nz