THE GLASGOW RISK SCREEN

<table>
<thead>
<tr>
<th>Context of Assessment</th>
<th>Date of Assessment:</th>
<th>Date of Review:</th>
<th>Keyworker:</th>
</tr>
</thead>
<tbody>
<tr>
<td>On admission □</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>MDT review □</td>
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<tr>
<td>Emergency review □</td>
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<td>On discharge: □</td>
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<td>C.P.A. review: □</td>
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<td>Annual update: □</td>
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<tr>
<td>Other: □</td>
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</table>

A. This document should form an integral part of a comprehensive mental health assessment and care planning process.
B. This is not an exhaustive list of safety issues / risk factors. It is merely intended to provide an initial indicator of the potential sources of risk, and hence inform clinical management.
C. The expectation that all safety risks can be predicted is unrealistic, and initial assessment may be based on incomplete information.
D. If completed by one person (eg. out of hours), this assessment should be discussed as soon as is practicable with the Consultant and multi-disciplinary team (inc. users and carers where appropriate).

**Suicide/Self-Harm**

<table>
<thead>
<tr>
<th>HISTORICAL</th>
<th>Violence</th>
<th>Neglect / other risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous self-harm</td>
<td>Previous violent acts</td>
<td>History of self-neglect</td>
</tr>
<tr>
<td>Use of violent methods</td>
<td>Use of weapons</td>
<td>Lives alone</td>
</tr>
<tr>
<td>Major psychiatric diagnosis</td>
<td>Admission to secure units or IPCU</td>
<td>Lacks basic housing amenities</td>
</tr>
<tr>
<td>Past diagnosis of personality disorder</td>
<td>Convictions for violence / assault</td>
<td>Socially or culturally isolated</td>
</tr>
<tr>
<td>Socially isolated</td>
<td>Past diagnosis personality disorder / psychopathic traits</td>
<td>History of being exploited</td>
</tr>
<tr>
<td>Major physical illness</td>
<td>Alcohol or drug misuse</td>
<td>Other Risks</td>
</tr>
<tr>
<td>Alcohol/drug misuse</td>
<td>Male under 35</td>
<td>Has neglected dependent others</td>
</tr>
<tr>
<td>Family history of suicide</td>
<td>Prior supervision failure</td>
<td>Previous fire risk</td>
</tr>
</tbody>
</table>

**SHORT-TERM OR PRECIPITATING**

| Planning suicide                    | Intoxicated                       | Current self-neglect |
| Access to lethal method             | Active positive psychosis         | Difficulty communicating needs |
| Hopeless / helpless                 | Violent fantasies                | Confusion or disorientation |
| Recent major loss                   | Identified target                 | Sexually inappropriate / assaultative |
| Recent psych in-patient discharge   | Access to weapons                | Significant financial problems |

**PROTECTIVE**

<table>
<thead>
<tr>
<th>Willing to respond to advice/carers</th>
<th>Willing to respond to advice/carers</th>
<th>Willing to respond to advice/carers</th>
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</thead>
<tbody>
<tr>
<td>Has close relationship (or loved pet)</td>
<td>Availability of appropriate services</td>
<td>Availability of appropriate services</td>
</tr>
<tr>
<td>Religious beliefs</td>
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Summary Formulation, including safety concerns identified:

Confirm Risk Management Plan is recorded in case notes (see overleaf): ☐

Completed by (sign): Print name:
Introduction
This risk assessment form should be completed as fully as possible on admission to hospital. The initial risk screen should be reviewed at the next multi-disciplinary team meeting. It is envisaged that the safety issues / risk assessment will be reviewed and possibly altered at times of subsequent significant events. For example:
a. At the point of discharge from hospital
b. For those in continuing care beds, an annual update should be considered.
c. For those subject to the CPA, an annual update should be considered.
d. In those undergoing a significant adverse change in their mental health or circumstances.

Operational Definitions
Not all the variables listed overleaf require further explanation or definition. However, some notes:

- **Suicide**
  S1. Includes self harm coming to medical attention and actual suicide attempts.
  S2. Use of firearms; knives; rope / ligature; jumping off building or bridge; fire; suffocation or gas inhalation.
  S4. Record of senior clinician making evidence based diagnosis.
  S7. May require third party history to establish. What was purpose, and effect on behaviour of substance use?
  S9. How detailed are the plans? Serious intent? Are there precautions against detection, and final goodbyes?
  S10. See S2.
  S11. Could be a manifestation of underlying low mood. Feels trapped or describes external locus of control?
  S12. Significant recent (< 1 month) life event, maybe with accompanying behavioural change.
  S13. Recent = <1 month, from acute psychiatric inpatient unit, whether planned or not.
  S14. Some individuals may respond better to friend or family member, than professional carer.
  S15. Is there someone (or a pet) who needs them or loves them?
  S16. Catholic and Jewish faiths said to be particularly protective.

- **Violence**
  V1. Serious or planned acts, that maybe came to others’ (eg police, carers, medical) attention.
  V3. Includes locked residential schools, young offender units, and secure hospital settings
  V4. Includes homicide, attempted murder, bodily harm, common assault but not always breach of peace
  V5. See S4. Psychopathy is classically characterised by impulsivity, callousness, criminal versatility, and a lack of remorse or empathy
  V8. Major failures in parole, probation, or mental health legislative compliance. Also, escape risk from institutions
  V9. With drinks or drugs at the time of assessment
  V10. Includes destructive command hallucinations, referential paranoid delusions, and passivity phenomena
  V11. Preoccupation with violent thoughts, including recorded and printed material
  V13. This may indicate the degree of planning
  V15. May be correctional or medical / rehabilitative.

- **Neglect / other**
  N1. Neglect of environment, personal care and health. Defined by reference to that person’s background.
  N3. Water / heat / light. Is the absence of amenities beyond the individual’s control?
  N5. The individual may be inadvertently vulnerable, secondary to mental illness or cognitive impairment.
  N6. This might be deliberate, or as a result of disability.
  N7. Inadvertent or deliberate.
  N9. Speech or cognitive impairment, or cultural / language difficulties
  N10. Fluctuating level of consciousness, or delirium, as well as other cognitive impairment.
  N11. This must be directly witnessed, and be more than inappropriate comment.
  N12. It may not be the total debt value, but the impact of the debt that matters
  N14. Medical, rehabilitative, or social services.

- **Summary formulation**
This is the clinician’s / clinical team’s synthesis of the variables assessed along with the findings at clinical interview, with evidence for and against a determination of risk level (eg high or low risk) being considered.

- **Risk Management**
Risk management planning will flow on from risk formulation. This should be recorded in the clinical notes. Risk management strategies to consider might include:
  - safe and appropriate levels of nursing observation
  - use of the Mental Health Act, where appropriate
  - use of low stimulus or secure areas, if appropriate
  - use of suitable medication, when indicated
  - referral to other agencies eg. police, social work
  - liaison and cooperation with relatives or carers
  - referral to Care Programme Approach

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