

Mental Health Clinical Assessment Service (MH CAS)
Standard Operating Procedure (SOP)



Mental Health

Integrated Access Partnership

Intelligent Mental Health System Response

Mental Health Clinical Assessment Service (MH CAS)

Standard Operating Procedure

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Introduction

The Integrated Access Partnership (IAP) is a collaborative, award winning, innovative endeavour which is transforming urgent and emergency care services (999 and 111) for people in mental health crisis.

In collaboration, BrisDoc Healthcare Services (BrisDoc), Avon and Wiltshire Mental Health Partnership Foundation Trust (AWP) and South Western Ambulance Service NHS Foundation Trust (SWASFT) – as well as Avon and Somerset Police, Avon Fire and Rescue, and voluntary sector organisations – have implemented an integrated urgent and emergency care front door service across both 999 and 111 for people in mental health crisis. The service provides three layers of intervention and trusted onward referrals to support any person presenting with mental health needs to 999 or 111; providing remote advice through a multidisciplinary mental health team, or a rapid face-to-face response through a network of ‘mobile pods’ across the area.

The IAP services are outlined in the table below. Each part of the service is covered by a separate standard operating procedure.

Service Line	Service Provision	
Mental Health Specialist Desk (MH SD) SWASFT Emergency Operations Centre (EOC) St James A, St James Court, Bradley Stoke BS32 4QJ 0300 369 0151	BNSSG	24/7
	BSW	08:00 – 00:00 (7/7)
	Cornwall	08:00 – 00:00 (7/7)
	Devon	08:00 – 00:00 (7/7)
	Dorset	08:00 – 00:00 (7/7)
	Gloucestershire	08:00 – 00:00 (7/7)
	Somerset	08:00 – 00:00 (7/7)
Mental Health Response Vehicle (MH RV) Bristol Ambulance Station, Croydon Street, Easton, Bristol BS5 0DA (contact via MH SD)	BNSSG	24/7
	Cornwall & Isles of Scilly	14:00 – 02:00 Fri – Sun only
	Gloucestershire	14:00 – 00:00 Mon – Thurs only
	Somerset	10:00 – 22:00 (7/7)
Mental Health Link Officer (MHLO) (situated at MH SD)	Avon & Somerset Police footprint	24/7
Mental Health Clinical Assessment Service (MH CAS) BrisDoc Healthcare Services, Unit 21 Osprey Court, Hawkfield Business Park, Bristol BS14 0BB 0117 233 1402	BNSSG	24/7
Emergency Services Mental Health Professional Line (MH PL) incorporated within MH CAS 0117 233 1402	BNSSG	24/7
Urgent Assessment Centre Gloucester House, Southmead Hospital, Dorian Way, Bristol BS10 5NB	BNSSG	17:30 – 00:00 (7/7)

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Objective

This standard operating procedure (SOP) is to provide guidance to IAP staff on the day-to-day operation of the Mental Health Clinical Assessment Service (MH CAS).

Overarching SOP

Please refer to the Overarching SOP for matters relating to:

- Key Roles & Responsibilities
- Clinical Intervention
- Clinical Records
- People with Unmet Needs – High Intensity Users (HIU)
- Safeguarding
- Data Protection and Confidentiality
- Business Continuity
- Quality and Governance
 - Learning Events/Incidents
 - Clinical Audit

Mental Health Clinical Assessment Service (MH CAS) Overview

MH CAS Review, Triage and Assessment is available within Bristol, North Somerset and South Gloucestershire (BNSSG) only. MH CAS has expanded to provide a 24/7 service. This part of the IAP is the entry point for Mental Health support via NHS 111.

MH CAS staff receive training on the use of SevernSide systems. Adastral has a series of 'queues' which can be assigned to different specialisms. The MH CAS will have a dedicated 'Mental Health' advice queue. Staff in the MH CAS will only contact patients once they are held on the Mental Health Adastral call queue. Calls can arrive in this queue via several routes:

- Direct referral from 111 Health Advisor or 111 Online via the Directory of Services (DoS)
- Direct call from patient speaking with MH CAS Call Handler by phoning 111 and choosing option 2
- Direct call from professional speaking with MH CAS Call Handler by phoning the MH PL
- From the IUC Advice Queue – pushed or pulled into the Mental Health Queue
- From the System CAS Advice Queue – pushed or pulled into the Mental Health Queue
- From the ACE Advice Queue – pushed or pulled into the Mental Health Queue

The MH CAS will call back patients allocated to the Mental Health queue in order of prioritisation. 111 mental health calls within the MH call queue will be prioritised for call back using the priorities pre-defined by Adastral and will be informed by MH CAS call handler assessment, using the IAP's Priority Support Tool or the NHS Pathways assessment. Calls meeting category A+B of the UK MHTS would be best managed by registered staff.

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Resourcing

As a minimum, the MH CAS must be staffed by:

- 1x MH CAS Shift Manager
- 1x MH CAS Call Handler
- 1x Band 7 or 1x Band 6 registered mental health professional.

Process & Functionality

While operating in the MH CAS, IAP staff must comply with BrisDoc Policies and SOPs which are available here: [Policies & SOPs – Radar \(radar-bridoc.co.uk\)](https://radar-bridoc.co.uk). The MH CAS shift manager will be available at all times should any advice or support on process or functionality be needed to IAP staff operating in the MH CAS.

The digital functionality available to IAP staff operating in the MH CAS includes:

- Aداstra and associated functionality
 - Templates (Clinical Record)
 - GP Connect (Own GP Appointment Booking)
 - Practice Liaison Service (Own GP Emergency Follow Up, the following day)
 - Electronic Prescribing (via Physical Health Team)
 - Agency Referral (to MIU/UTC/ED)
- Access to EMIS (patient's own GP record)
- Access to Connecting Care (via EMIS)
- Access to RiO ([Citrix Gateway \(awp.nhs.uk\)](https://awp.nhs.uk))
- AccuRx (Photo and Video Consulting and Patient texting) ([Accurx](#))
- Access to BrisDoc Weblinks Functionality ([Weblinks – BrisDoc Healthcare Services](#))
 - BrisDoc Clinical Toolkit ([BrisDoc Clinical Toolkit](#))
 - MiDoS ([MiDoS – BrisDoc Healthcare Services](#))
 - ToxBaSe ([Tox Base – BrisDoc Clinical Toolkit](#))

Training and User guides are available here: [Training / User Guides – BrisDoc Clinical Toolkit](#)

Receiving Cases

The majority of cases for MH CAS will be received by MH CAS Call Handlers, answering telephone calls received via NHS 111 (option 2) or from emergency services phoning the MH PL.

All calls will be answered and handled in line with the [MH CAS Call Handler Handbook](#). This will include escalating cases for a warm practitioner transfer, or urgent MH CN review, dependent on the answers callers provide to specific questions.

The call journey for patients phoning NHS 111 and choosing option 2 for mental health is outlined in Appendix 5.

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Case Finding

There are multiple queues within Adastral, such as 'IUC Advice' and 'System CAS'. The MH CN will have access to all queues and, when able, will 'fish' in these queues to find patients that may benefit from mental health specialist input.

To support a case, it must be transferred to the mental health queue. A case tag must be added to make others aware the case is being managed by the MH CAS team. When the MH CAS intervention is complete, the case should be closed. If the case subsequently requires a physical health intervention, the case tag should be removed and the case forwarded to the relevant Adastral queue.

SevernSide's physical health clinicians and Clinical Navigators can also add the mental health case tag to draw the case to the MH CAS team's attention for advice, support or intervention. If the MH CN reviews a case and determines the case does not require input from the MH CAS team, the case tag must be removed.

Clinical Navigation

The most senior registered MH clinician working in MH CAS will take the role of Mental Health Clinical Navigator (MH CN) in triage and prioritisation of calls in the queue, in accordance with the [IAP Practitioner Handbook](#).

GP Follow Up & Prescribing

BNSSG Registered Patients ONLY

Only the MH CAS has the functionality to contribute to the patient's own GP's clinical record system (EMIS), with the Adastral case report being shared automatically on completion of each case via a post event message (PEM).

Any member of staff operating within the IAP can make professional referrals to the patient's own GP, using the MH PL. When calling, please identify as calling from the IAP and that you want to share information with the patient's own GP. The detail relating to the patient contact, requested action for the GP and subsequent referral **MUST** be recorded within the RiO clinical record.

	Telephone	Process
In Hours	0117 233 1402	You will be connected to the patient's own GP Practice
Out of Hours*		Patient information will be added to Adastral to be managed by the MH CAS team the next working day (this may not then be actioned until the following working day)

*The out of hours pathway is only appropriate for requesting follow up from the patient's GP practice on the next working day (longer delays for bank holidays). Mental health clinicians who need more urgent clinical advice or a prescription out of hours, must contact the professionals' line and request a call back from one of the BrisDoc clinicians.

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The MH CN will review the calls relating to an 'out of hours' contact, search the RiO notes and copy and paste the clinical information into Adastral. All out of hours referrals must be processed by the MH CAS mental health team as soon as practicable. Practices may only reconcile referrals once a day; therefore, they may not get looked at after this has occurred in the morning of the following working day.

Information copied to Adastral must reflect the assessment conducted out of hours and include a clear request for the GP to action. The assessment plan recorded in RiO may, for example, read: '...Assessment completed, no role for mental health services. Request for GP to offer routine consultation and review anti-depressant medication'.

Booking GP Appointments Using GP Connect

'GP Connect' can be used to request telephone appointments with a patient's own GP surgery where you have concerns that a patient may not or cannot make contact with their GP surgery themselves. GP Connect appointments can only be booked for the same day, except during the out-of-hours period, where appointments can be booked for the next working day (or later that same day between 00:00 – 08:00). Please note that it is not possible to book GP Connect appointments between 18:00 on a Friday and 08:00 on a Sunday, as the next day remains in the out-of-hours period.

Deploying the Mental Health Response Vehicle

To deploy the Mental Health Response Vehicle (MH RV) for a patient who has been assessed in the MH CAS, the IAP staff member must contact the MH CN in the MH SD requesting its availability. This can be done via the phone or MS Teams. If the MH RV is available and the MH CN agrees for its deployment, case notes must be added to reflect the onward pathway for the patient and the accepted referral to 999. The Adastral case must then be closed, marked as referred to 999.

A new case must be opened by the MH SD on CAD (SWASFT system) and the management of the patient continues in line with the operation of the MH RV (see separate SOP). If further intervention is required, a new case must be opened via the MH PL (0117 233 1402) to allow record keeping and intervention as required.

Where the MH RV is not available, an alternative suitable plan must be made.

Liaising with Physical Health

Should a patient require support from a physical health clinician, the MH CAS team member can take one of the following approaches:

Primary need is mental health with secondary physical health need

Provide the intervention required and make suitable notes within the clinical record, take brief details of the physical health needs and discuss them with the SevernSide Clinical Co-Ordinator (SevernSide CC).

Primary need is physical health with secondary mental health need

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Provide notes to the record to assist the assessment from the physical health clinician and support their decision making in regards to mental health intervention – this should include noting the advice given and any referrals made on behalf of the patient by the MH CAS.

Where the primary need is unclear

Seek further information from the patient, conduct a suitable assessment and liaise with the SevernSide CC to determine and agree the best course of action.

Prescribing

If a patient requires a prescription, wherever possible, the assessment and recommendations should be recorded by the MH CAS team member within the Adastra case record. This should then be discussed with the SevernSide CC and transferred to the relevant queue for the electronic prescription to be sent by the relevant clinician.

A list of open pharmacies is available here: [Find a pharmacy - NHS \(www.nhs.uk\)](http://www.nhs.uk)

(N.B Please ask the Shift Manager about Bank Holidays)

Arranging a physical health (999) ambulance

Where a patient requires a physical health ambulance, this should be arranged by phoning 999. The mental health practitioner phoning 999 must identify themselves as calling from the MH CAS; it is imperative that practitioners do not identify as phoning from NHS 111.

Accessing Interpreting Services for Patients who Speak Limited English

BrisDoc have access to an interpreter service provided by Language Line. Contact details are as follows:

Phone number: 0845 310 9900

Organisation name: BrisDoc Healthcare Services Limited

Code: L52612

Making a call to a limited English speaker

- Dial the Language Line phone number (above)
- Request the language the patient speaks through the interactive voice response (IVR) system
- When the interpreter is connected, the interpreter can call the patient for you to create a conference call.

Accessing Interpreting Services for Patients Using British Sign Language

BrisDoc has an account with Sign Solutions to access interpreters for British Sign Language (BSL), which can be used to contact patients using BSL.

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To book an interpreter, telephone Sign Solutions on 0121 447 9620. You will then need to choose either option 1 for face-to-face support, or option 2 for video support (which is likely to be most appropriate for any remote triage). You will need to quote 'BrisDoc Healthcare Services' so that the account can be located and relevant assistance provided. For patients who have entered the MH CAS from NHS 111, the interpreter will ideally have been booked in advance; however, it is best to check this and make our own arrangements if necessary.

For patients using BSL requiring contact from the 999 MH Desk, the MH CN at EOC will transfer the care of the patient to the MH CAS, as there is not currently an option to make outbound BSL contact from SWAST EOC. The MH CAS clinician will need to contact Sign Solutions to book the interpreting services. An interpreter may not be immediately available. When an interpreter is booked, the patient should be notified of the expected contact time via SMS (through AccuRx) so that they are aware when they should expect to be contacted and to try to minimise failed contacts.

Conducting a video consultation

Advise the interpreter that you will be using the AccuRx platform. Once they have located someone, they will provide you with their email address for you to invite them.

To start your consultation, you should send the SMS text with the video invitation, as usual, to the patient. You then have two options:

- On your confirmation email, you can copy the invitation link and send this on to your interpreter
- If the confirmation email is not received, you can open the video consultation and then copy the URL from the top of the webpage and send this to the interpreter.

When Sign Solutions has been used for a consultation, please ensure the Mental Health Shift Manager is made aware so that it can be documented that the service has been used.

Case Closure

When the case has been completed, it should be closed and the relevant information added including coding, onward referral, and case questions answered. Where an unregistered team member has completed the case, it **MUST** be flagged using the MH CN Review Tag. The senior registered MH clinician must then review the case before closing it, ensuring the intervention and outcomes were appropriate based on the assessment of the patient. **Unregistered team members must not close cases.**

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Monitoring & Change Register

The IAP SOP will be reviewed at least annually and more regularly to account for service changes and expansion.

Date	Version	Author	Change
18/02/2022	1.0	Matthew Truscott	Version 1.0 published
27/09/2022	1.1	Matthew Truscott and Rhys Hancock	Updated subject to review
17/08/2023	2.0	Matthew Truscott, Rhys Hancock and Kerry Geoghegan	Updated as part of Integrated Access Partnership and relationship with other IAP services. Added details of accessing BSL interpreters. Added Appendix 5.
12/09/2023	2.1	Ollie Crandon	Added details of arranging a physical health ambulance.
28/03/2024	2.2	Ollie Crandon	Amended MH CAS operating times. Added 'GP Connect' to 'GP Follow Up and Prescribing' Formatting amendments
03/04/2024	2.3	Ollie Crandon	Amended Appendix 5 (changes to MH CAS resourcing)
09/04/2024	2.4	Ollie Crandon	Added 'Accessing Interpreting Services for Patients who Speak Limited English'
28/10/2024	2.5	Ollie Crandon	Removed Appendix 5 (changes to MH CAS resourcing) Added Appendix 5 (call journey for patients phoning NHS 111 and choosing option 2) Updated throughout with reference to MH CN Updated 'Arranging a physical health ambulance' Updated 'Clinical Navigation' Updated 'Case finding' Updated 'Resourcing' Added Links to Call Handler and IAP Practitioner Handbooks

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Appendices

Appendix 1: SBAR Format for Assessment

IAP staff will use the SBAR format for recording their assessment. This assessment will capture key factors of assessment in line with AWP guidance found in the clinical toolkit. The SBAR will be supplemented with the Risk Assessment and Formulation Guidance available in the AWP Clinical Toolkit. Below is an example of the SBAR format being used clinically.

Situation
<ul style="list-style-type: none"> • The referral screened as per current policy. • For routine 4wk referrals which include any of the 4 identified points noted below
Background
<ul style="list-style-type: none"> • Assessed by the recovery or crisis team within the last year? • Have they been assessed by street triage and/or Psych liaison within the last 3 months? • If someone has a significant history and contact with the mental health team • If the referrer is asking for a specific request i.e., medication review, medication advice, signpost to psychology
Assessment
<ul style="list-style-type: none"> • What has changed since their last assessment? Explore have they followed recommendations made in the last assessment? • Focus on current risks, any safeguarding and current concerns. Ensure the UK Triage Mental Health rating scale is referenced. • If there is no need for secondary services or the referred person does not meet the criteria, then the Triage clinician will sign post to the relevant services that can help. • If the clinician feels a further assessment is indicated, then refer to the relevant sector for assessment. • SBAR to be documented in the service user's progress notes and in Triage and Assessment Form. Ensuring a Full Triage was not completed is documented, outlining which 4 points above signified a SBAR was appropriate
Recommendation
<ul style="list-style-type: none"> • Once the assessment has been completed, using the SBAR, a care pathway will be identified - either signposting or secondary assessment.

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Appendix 2: UK Mental Health Triage Scale

UK Mental Health Triage Scale				
Triage Code /description	Response type/ time to face-to-face contact	Typical presentations	Mental health service action/response	Additional actions to be considered
A Emergency	IMMEDIATE REFERRAL Emergency service response	Current actions endangering self or others Overdose / suicide attempt / violent aggression Possession of a weapon	Triage clinician to notify ambulance, police and/or fire service	Keeping caller on line until emergency services arrive / inform others Telephone Support.
B Very high risk of imminent harm to self or to others	WITHIN 4 HOURS Very urgent mental health response	Acute suicidal ideation or risk of harm to others with clear plan or means Ongoing history of self harm or aggression with intent Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Urgent assessment under Mental Health Act Initial service response to A & E and 'front of hospital' ward areas	Crisis Team/Liaison/ face-to-face assessment AND/OR Triage clinician advice to attend a hospital A&E department (where the person requires medical assessment/ treatment)	Recruit additional support and collate relevant information Telephone Support. Point of contact if situation changes
C High risk of harm to self or others and/or high distress, especially in absence of capable supports	WITHIN 24 HOURS Urgent mental health response	Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent Rapidly increasing symptoms of psychosis and / or severe mood disorder High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Overt / unprovoked aggression in care home or hospital ward setting Wandering at night (community) Vulnerable isolation or abuse	Crisis Team/Liaison/ Community Mental Health Team (CMHT) face-to-face assessment	Contact same day with a view to following day review in some cases Obtain and collate additional relevant information Point of contact if situation changes Telephone support and advice to manage wait period
D Moderate risk of harm and/or significant distress	WITHIN 72 HOURS Semi-urgent mental health response	Significant patient / carer distress associated with severe mental illness (but not suicidal) Absent insight /early symptoms of psychosis Resistive aggression / obstructed care delivery Wandering (hospital) or during the day (community) Isolation / failing carer or known situation requiring priority intervention or assessment	Liaison/CMHT face-to-face assessment	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
E Low risk of harm in short term or moderate risk with good support/ stabilising factors	WITHIN 4 WEEKS Non-urgent mental health response	Requires specialist mental health assessment but is stable and at low risk of harm during waiting period Other services able to manage the person until mental health service assessment (+/- telephone advice) Known service user requiring non-urgent review adjustment of treatment or follow-up Referral for diagnosis (see below) Requests for capacity assessment, service access for dementia or service review / carer support	Out-patient clinic or CMHT face-to-face assessment	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
F Referral not requiring face-to-face response from mental health	Referral or advice to contact alternative provider	Other services (outside mental health) more appropriate to current situation or need	Triage clinician to provide advice, support Advice to contact other provider and/or phone referral to alternative service provider (with or without formal written referral)	Assist and/or facilitate transfer to alternative service provider Telephone support and advice
G Advice, consultation, information	Advice or information only OR More information needed	Patient or carer requiring advice or information Service provider providing information (collateral) Initial notification pending further information or detail	Triage clinician to provide advice, support, and/or collect further information	Consider courtesy follow up telephone contact Telephone support and advice

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Appendix 3: Clinical Audit Tools

Key Principles of Audit:	Remote Contact (Telephone/Video)	Clinical Records
Key Principles of Audit:	<ul style="list-style-type: none"> Makes effort to speak directly to patient / Confirms ABC's Confirms Demographics. Introduces Self, purpose of call. Professional, Caring & Compassionate approach. Accurately determines the presenting complaint, including use of Video Consultation (as appropriate) Seeking collateral input from carers , friends and relatives wherever practicable Determines relevant Past Medical History including Medications and Allergies where appropriate. Reaches a safe and appropriate outcome and communicates this effectively. Safeguarding where relevant Relevant, Accurate Clinical Advice Provided Targeted & General Worsening Advice Provided Uses appropriate questioning techniques and avoids Jargon Manages risk accurately to arrive at a timely outcome 	<ul style="list-style-type: none"> The level of clinical recording is proportionate in relation to review, triage and assessment (as defined in SOP above). Evidence of format for assessment that aligns with SBAR framework. Risks are clearly formulated using Structured Professional Judgement with reference to UKMHTS The key components of Mental State Examination is recorded in all 'triage' and 'assessment' calls Any reference to capacity is decision specific Non-registered staff referencing clinical supervisor in relation to all clinical decision making Records show a final impression and formulation that captures risk and clinical impression Plans are clear and proportionate to the presenting situation

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Appendix 4: Clinical Tool Kit – Structured Professional Judgement (Risk)

Please note – IAP staff should not consider this exhaustive guidance on risk and should access the AWP clinical tool kit.

The four categories of risk factors

As you consider risk factors, it is useful to have a shared understanding of what you mean by the classification of different types of risk. The framework below is a modified version of Structured Professional Judgement.

<p>1. Static risk factors:</p> <p>These are factors that do not change or alter in any way; they are statements of fact – events or factors that the person or professional cannot alter – that have been shown to have a marked correlation with future untoward outcomes as a result of studying groups of people with the same characteristics. For example, static factors known to be indicative of increased risk of suicide are:</p> <ul style="list-style-type: none"> • History of self-harm • History of violence towards others • Seriousness of previous suicide attempts • Previous admission to psychiatric hospital • History of mental illness • Family history of self-harm and suicide • Aged over 65 years • Male gender • History of psychologically traumatic event/s <p>It is important that our risk summary includes the recording of our sustained attempts to gather historical as well as current risk factors from the service user directly, any involved carer/s, previous health</p>	<p>2. Dynamic - stable risk factors</p> <p>These are long-term in nature. It is possible to intervene with these factors in order to reduce their influence on the level of risk. Stable factors known to be indicative of increased risk of suicide are:</p> <ul style="list-style-type: none"> • The absence of a stable relationship – e.g.: divorce, separation, bereavement • Psychiatric diagnosis – all mental illness is associated with an increased risk of suicide, in particular depression; some mental illnesses are associated with symptoms such as command hallucinations which focus on harm to others • Suicidal or self-harming thoughts or ideas – usually referred to as ‘suicidal ideation’ and this needs to be present in order for a person to develop suicidal intent • On-going impact of childhood trauma and adversity • Substance misuse • Negative attitude of the person from their carers • Social deprivation • Middle-aged years
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<p>records – e.g.: from CAMHS, and other agencies such as the person's GP, probation service, police, housing, etc.</p>	
<p>3. Dynamic – acute risk factors or risk triggers</p> <p>These are present for a short length of time and may fluctuate markedly in both duration and intensity. Attending to these factors is arguably one of the most important components of the whole risk assessment process.</p> <ul style="list-style-type: none"> • Acute suicidal ideation, communication and intent • Acute feelings of hopelessness or helplessness • Active psychological symptoms, such as low self-esteem/self-worth, negative thoughts, belief that others will be “better off without me” • Negative impact from use of drugs or alcohol • Psychiatric hospital admission and discharge – while psychiatric admission can be useful as a way of maintaining/contributing to the person's safety, the process of admission and discharge are in themselves associated with a high degree of risk • Transitions in care – this includes major changes and alterations to the person's care or care pathway, such as the handover from one care team/service to another, change of care coordinator, any other major alteration in the way the person's care is delivered, or by whom it is delivered • Transitions in the phase and nature of a person's mental health difficulties – e.g.: • At risk of prodrome to psychosis and the early phase of recovery are known to be times of greater risk for some individuals who experience psychotic episodes. 	<p>4. Future risk factors:</p> <p>Some future risk factors can be anticipated and will result from the changing circumstances of the individual:</p> <ul style="list-style-type: none"> • Access to preferred method of suicide; this needs careful consideration and will vary from setting to setting. For example, in an inpatient unit, environmental factors such as easy access to fixed ligature points, need to be considered. In a community setting, this may include access to medication with a high lethality, access to firearms, etc. • Nature and extent of service and professional contact. This is linked to transitions in care but is of prime importance in its own right; examples may include situations whereby a person does not have easy or direct access to services (e.g.: out-of-hours), poor inter-team/service communication, and arrangements for staff/service contact when the person's care coordinator is not available. • Future response to physical treatments (including, for example, impact of side effects of medication) • Future response to psychosocial interventions • Future intra and inter-personal stress

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- The period when the person's mood starts to improve after an episode of depression – i.e.: when the level of activity and motivation returns, enabling them to act on their earlier suicidal thoughts.
- Nature and degree of interpersonal stress/conflict – this will include any significant life event, as defined and understood by the service user. It could be something very obvious such as a relationship breakdown, loss of employment, or may include on-going communication difficulties and issues within existing relationships, such as those with the person's significant other, children, parents, etc.
- Reduced ability to problem-solve – this is a key deficit and is linked to the other psychological symptoms identified above. If the person is unable to consider alternative ways of dealing with their stress that are future-orientated, then risk will be increased exponentially.

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Appendix 5: Call Journey for Patients Phoning NHS 111

When a caller phones NHS 111, they are presented with the following options:

- If your call is about physical health, press 1
- If you are in mental health crisis, press 2
- If you are a healthcare professional or lab technician, press 3.

Callers choosing option 2 enter the IAP's interactive voice response (IVR) which helps to direct callers to the most appropriate service, depending on how they respond to the questions posed. The following is a simplification of the call 'journey' faced by callers selecting option 2, with the questions asked and the possible outcomes depending on the caller's responses:

If you are under 18 years of age, or calling about someone who is under 18 years of age, please press 1

1 selected:

If you are known to a CAMHS team and need support from that team, please press 1

1 selected again:

Depending on the time of day, the caller will be diverted to the CAMHS Crisis & Intensive Outreach Team Hunt Group or will be given the option to select their CAMHS team and be transferred directly to that team.

1 not selected again:

All callers under 18 years of age, not known to a CAMHS team, are transferred immediately to a MH CAS call handler.

1 not selected:

Please select from one of the following options:

If you would like to speak to your Recovery Care Co-ordinator, please press 5

5 selected:

Callers are presented with the options to choose their Recovery Team and be transferred directly to that team.

5 not selected:

If you are known to and would like to speak to someone in your local Crisis Team, please press 6

6 selected:

Callers are presented with the options to choose their Crisis Team and be transferred directly to that team.

6 not selected:

For urgent mental health support, please press 7 or hold

7 selected (or no option selected):

Callers are transferred to a MH CAS call handler.