EMERGENCY DEPARTMENT
MENTAL HEALTH ASSSESSMENT MATRIX

****DO NOT COMPLETE IF PATIENT IS INTOXICATED WITH ALCOHOL/DRUGS****
Patient should be kept safe until they are no longer under the influence of alcohol/drugs

Patient's Name: …… Date of Birth: …… Number: ……

Marital Status (*please circle)*: Single/Married/Widowed/Divorced

Living Circumstances (*please circle)*: Alone/With Family or Friends/Other (*If other, specify*) …….

Employment *(please circle)*: Employed/Unemployed/Retired/Student/Other *(If other, specify)* ……

Name of Assessor(s): ……..

Date: …… Time: ……

Factors to be considered when undertaking an initial assessment of a person with a suspected mental health problem:

- Has a physical cause for the problem(s) been ruled out?
- Has drug and/or alcohol intoxication been ruled out as a cause?
- Is the person physically well enough (e.g. not sedated, intoxicated, vomiting or in pain) to undertake an interview with mental health staff?
- Manage violent and aggressive incidents as per department policy.
- If the person has a known mental health history, always check the mental health folder (located in Majors staff base) for background assessment and care planning information.

Assessment Categories		
1. Background history and general observations	**Yes**	**No**
• Does the person pose an immediate risk to self, you or others?		
• Does the person have any **immediate** (i.e. within the next few minutes or hours) plans to harm self or others?		
• Is the person aggressive and/or threatening?		
• Is there any suggestion, or does it appear likely that the person may try and abscond?		
• Does he/she have a history of violence?		
• Has the person got a history of self-harm?		
• Does the person have a history of mental health problems or psychiatric illness?		
If yes to any of the above, record details below: If previous self-harm: How long ago was the last attempt? ……		
2. Appearance and behaviour	**Yes**	**No**
• Is the person obviously distressed, markedly anxious or highly aroused?		
• Is the person behaving inappropriately to the situation?		
• Is the person quiet and withdrawn?		
• Is the person inattentive and uncooperative?		
If yes to any of the above, record details below:		

3. Issues to be explored through brief questioning

- Why is the person presenting now? What recent event(s) precipitated or triggered this Presentation?
  Give details below:

- What is the person's level of social support (i.e. partner/significant other, family members, friends)?
  Give details below:

	Yes	No
• Does the person appear to be experiencing any delusions or hallucinations?		
• Does the person feel controlled or influenced by external forces?		
• Are there major housing or accommodation problems?		

If yes to any of the above, record details below:

4. Suicide risk screen – greater number of positive responses suggests greater level of risk

	yes	no	d/k		yes	no	d/k
Previous self-harm	☐	☐	☐	Family history of suicide	☐	☐	☐
Previous use of violent methods	☐	☐	☐	Unemployed/retired	☐	☐	☐
Suicide plan/expressed intent	☐	☐	☐	Male gender	☐	☐	☐
Current suicidal thoughts/ideation	☐	☐	☐	Separated/widowed/divorced	☐	☐	☐
Hopelessness/helplessness	☐	☐	☐	Lack of social support	☐	☐	☐
Depression	☐	☐	☐	Family concerned about risk	☐	☐	☐
Evidence of psychosis	☐	☐	☐	Disengaged from services	☐	☐	☐
Alcohol and/or drug misuse	☐	☐	☐	Poor adherence to psychiatric Tx	☐	☐	☐
Chronic physical illness/pain	☐	☐	☐	Access to lethal means of harm	☐	☐	☐

Alcohol Consumption

Was alcohol consumed as part of the act or within 6 hours of the act? (*Please circle*) Yes/No/Don't Know
If yes, what and how much ……

Illicit Drug Consumption

Were illicit drugs consumed as part of the act or within 6 hours of the act? (*Please circle*) Yes/No/Don't Know
If yes, what and how much ……

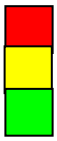
Current Contact with Psychiatric Services

At the time of attendance was the patient receiving psychiatric treatment? (*Please circle*) Yes/No/Don't Know
If yes, please √ box and name service (e.g. Callington Road / CMHT)

Inpatient ..... ❑ Community team..... ❑
(i.e. has been seen by a member of the psychiatric team and has further appointments)

Diagnosis: (*Please circle*) Yes/No/Don't Know If yes, diagnosis: ……

What category of overall risk have you identified?
Give reasons and rationale for your decision



Action plan and outcomes following initial risk screen:
Describe all actions and interventions following assessment. Include details of referral to other team(s), telephone calls/advice and discharge/transfer or follow-up plans

If level of risk is re-assessed and changed later, what category of overall risk have you identified?
Give reasons and rationale for your decision

Signed: …… Designation: ……

Name: …… Date: ……..

Formulation of assessment
Refer to the risk assessment matrix below and summarize:

- What is the key problem?
- What is the level of risk – e.g. low, medium, high? Refer to Matrix
- Is referral to the liaison psychiatry team or on-call mental health staff indicated?

MENTAL HEALTH RISK ASSESSMENT MATRIX			
Level of risk	**Key assessment information**	**Nursing actions**	**Timescales**
LOW RISK	• Mental health problem may be present, but person has no thoughts of plans regarding harm to self or others. • May have already engaged in impulsive self-harming behaviour, but now regrets actions and **has no plan or thoughts relating to further self-harming behaviour**. Patient is confident about maintaining his/her own safety and relative(s)/significant other(s) are prepared to provide informal support on discharge. • No evidence of immediate or short-term physical vulnerability or risk	• Treatment and follow-up arrangements managed by ED team • May benefit from referral to primary care services – e.g. GP, practice nurse. • Consider whether may benefit from mental health promotion/mental health advice – e.g. safe alcohol consumption, information regarding non-statutory agencies. • Provide 'Services to Help You' patient information booklet. • Patients in the ED due to self-harm who are medically fit for discharge can be offered immediate discharge and a Liaison Psychiatry Self-Harm Clinic appointment.	• Referral to liaison psychiatry service not required. • Advice from liaison staff regarding onward referral and/or follow-up arrangements may be required. • May request non-urgent follow-up or contact from liaison staff within 72 hours of request

MENTAL HEALTH RISK ASSESSMENT MATRIX			
Level of risk	**Key assessment information**	**Nursing actions**	**Timescales**
MEDIUM RISK	• Mental health problem(s) present and/or has non-specific thoughts or ideas regarding harm to self or others – e.g. regrets that self-harm failed to lead to death, but no intention to undertake further self-harm. • There is no plan to act on self-harming or suicidal thoughts. • However, the person's mental state is at risk of deterioration and they may be physically vulnerable in certain circumstances.	• Person's agreement to refer to mental health should be sought, but no immediate action required if patient does not wish to engage. • Advise to seek further assessment and help via primary care. • If person known to mental health services, inform relevant team of their attendance. • Provide relevant patient and carer information.	• Non-urgent referral to liaison psychiatry team. • Out-of-hours, seek advice from on-call psychiatric SHO up until 10pm. • Can be referred to Liaison Psychiatry team for assessment within 24 hours of referral.
HIGH RISK	• Serious mental health problem(s) present, including possible features and symptoms of psychosis. • May well have frank plans to engage in further self-harming behaviour, or to harm others. • Has clearly identifiable risk characteristics, such as imminent thoughts or plans relating to self-harm (or harm to others) or suicide. • May have already engaged in self-injurious or self-harming behaviour, and *on-going suicidal intent remains.* • May lack capacity and competence to consent to or refuse on-going care and treatment. • Person likely to act upon thoughts of self-harm or injury at the earliest opportunity. • Mental state will certainly deteriorate without intervention and will almost certainly be physically vulnerable. • The person has made attempts to leave the department/ward or you have reason to believe they intend to do so.	• Urgent mental health assessment required and a risk plan developed to address immediate or short-term risk indicators. • Mental health assessment required before person can be discharged. • The person's mental state will deteriorate and increase level of risk if not treated. • Immediate action required, including urgent mental health assessment and an action plan developed to address risk factors. • Is likely to require close or one-to-one observation by a member of nursing staff. • If person is non-compliant, Common Law powers should be used to temporarily detain the person pending a full mental health assessment. • Consider Section 5(2) of the Mental Health Act, discuss with CSM and medical staff.	• Urgent referral to liaison psychiatry service or duty mental health staff. • Seen by mental health staff within 1 hour of referral. • Police to be informed if absconds. • Out-of-hours, should be seen by on-call psychiatric SHO and Crisis Team. • All reasonable attempts should be made to stop the person leaving the department before a mental health assessment. The presence of hospital security staff may be required.