| **MENTAL HEALTH RISK ASSESSMENT MATRIX** | | |
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| **Risk Level** | **Key Assessment Information** | **Actions and Timescales** |
| **Medium to High Risk** | * May demonstrate one of more of the following:   + Highly aroused   + Reluctant to wait   + Cognitive impairment   + Thought disorder   + Perceptual disturbance * Self-harm: requires either assessment prior to discharge, or follow existing care plan. * Unwilling or unable to take responsibility for maintaining own safety in the short to medium term, and unlikely to attend for next-day mental health follow up. * Uncertainty regarding patient’s ability to engage with a management plan that involves direct discharge without specialist assessment. | * Referral for mental health assessment prior to discharge or transfer. * Mental health assessment undertaken and completed within 3 hours of referral, patient’s physical condition permitting. * May require close observation by nursing staff, and patient should not be allowed to leave unaccompanied prior to mental health assessment. * If person is currently known to mental health services, inform the relevant team of their attendance. * Missing person’s policy and procedure to be implemented if person absconds. * Refer to any existing background or historical information contained on the electronic patient record. |
| **High Risk** | * Clear plans to engage in further self-harming behaviour, or to harm others. Suicidal ideation *and* intent present. * Marked agitation, hyper-arousal and behavioural disturbance. * Difficult to engage and behaviour demonstrates non-cooperation with assessment and treatment. * May lack capacity to consent to, or refuse, proposed care and treatment. * Likely to act on thoughts of self-harm or suicide at the earliest opportunity. * Mental state will deteriorate rapidly and dangerously without immediate intervention and will be physically vulnerable. | * Referral for urgent mental health assessment. * Mental health assessment undertaken and completed within 2 hours of referral, patient’s physical condition permitting. * Will require close or one-to-one nursing observation and contact. * Undertake test of capacity if any doubt regarding ability to consent to treatment, or should they refuse to remain in hospital pending mental health assessment. * If lack of capacity, consider use of Mental Capacity Act or Mental Health Act, pending mental health assessment and specialist advice. * Missing person’s policy and procedure to be implemented if person absconds. |

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| Revised: Jan 2016. Review date: 2018.  Developed with acute hospital partners across Avon & Wiltshire and collaboration with the University of Bristol by:  Avon & Wiltshire Mental Health Partnership NHS Trust.;.  © 2004 – 2013 Avon & Wiltshire Mental Health Partnership NHS Trust www.awp.nhs.uk |

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| Great Western Hospitals FT Col A**EMERGENCY DEPARTMENT**  **MENTAL HEALTH ASSESSMENT MATRIX** |

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| Patient’s Name:  Date of Birth: Hosp. No:  Name of Triage Clinician(s):  Date: Time: |

**Factors to be considered before and during the mental health triage process:**

These are not intended to exclude a specialist mental health assessment, but should be considered before making a referral.

* Complete assessment within 1 hour of arrival – if this is not possible (eg. Due to unconsciousness, intoxication, etc.) – complete as much as possible and return to it as soon as the patient’s condition allows.
* Rule out and treat, if necessary, any underlying problems, eg. Alcohol / drug intoxication, pain, vomiting, etc.
* Distinguish between ‘medically fit’ and ‘assessment fit’. Medically fit means there are no indications for further medical or physical management in relation to this episode; assessment fit means that the person can actively participate in a psychiatric interview.
* Refer to existing Trust or department policies and guidance for managing violence, aggression and intoxication.
* If the person has an identified alert on Patient First, refer to their mental health plan.

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| **Assessment Categories** | | |
| **1. Background history and general observations** | **Yes** | **No** |
| * Immediate risk to self, you or others? |  |  |
| * Immediate (within the next few minutes or hours) plans to harm self or others? |  |  |
| * Aggressive and / or threatening? |  |  |
| * Suggestion or likelihood that the person may try to abscond? |  |  |
| * This presentation is self-harm? |  |  |
| * Currently under the influence of alcohol/illicit drugs? |  |  |
| * Reported / known history of self-harm? |  |  |
| * Reported / known history of violence? |  |  |
| * Significant housing or accommodation problems |  |  |
| * Reported / known history of psychiatric illness / mental health service contact? |  |  |
| **Details of all Yes responses:** | | |
| **2. Mental State Examination** | **Yes** | **No** |
| * Markedly disturbed behaviour that suggests psychosis and/or immediate risk |  |  |
| * Does the patient feel controlled by external forces? |  |  |
| * Is the patient’s appearance and behaviour inappropriate to the situation? |  |  |
| * Inappropriately or excessively quiet, withdrawn and / or uncooperative? |  |  |
| * Is the person pre-occupied or easily distracted? |  |  |
| * Obviously distressed, markedly anxious or highly aroused? |  |  |
| * Does the patient appear to be experiencing delusions or hallucinations? |  |  |
| * Requires mental health assessment in order to effect safe discharge |  |  |
| * Is there any disturbance of speech? | **Yes** | **No** |
| * Is there any disturbance in mood? | **Yes** | **No** |
| * Is there ongoing suicidal ideation? | **Yes** | **No** |
| * Does the patient have impaired cognition (MMSE)? | **Yes** | **No** |
| * Does the patient lack insight into their condition? | **Yes** | **No** |

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| **Details of all Yes responses:** | | | | | | | |
| **3. Issues to be explored through brief questioning** | | | | | | | |
| * Why is the person presenting now? What recent event(s) triggered this presentation? | | | | | | | |
| * Person’s level of social support – partner / significant other, family members (including children), friends: | | | | | | | |
| * Details of any safeguarding concerns. Record all actions and outcomes: | | | | | | | |
| **Suicide risk screen**  The following factors are associated with an increased risk of suicide. Pay particular attention to the “Dynamic” and “Future” categories, and consider these carefully when planning and implementing your referral and discharge plans. Seek advice from more senior staff if in doubt. | | | | | | | |
| **Static**  *Personal demographic factors, not amenable to change or intervention* | **Yes** | **No** | **N/K** | **Stable**  *Personal factors, usually addressed over the long-term* | **Yes** | **No** | **N/K** |
| History of self-harm |  |  |  | Widowed, separated, divorced |  |  |  |
| Family history of suicide |  |  |  | Substance misuse |  |  |  |
| Age > 55 years |  |  |  | Childhood trauma |  |  |  |
| Male |  |  |  | Personality disorder |  |  |  |
| Previous self-harm using a high lethality method |  |  |  | Current psychiatric illness |  |  |  |
| **Dynamic**  *Present for an uncertain length of time; may vary markedly in duration and intensity* | **Yes** | **No** | **N/K** | **Future**  *Can be anticipated and will be dependent upon the individual’s changing circumstances* | **Yes** | **No** | **N/K** |
| Suicidal thoughts and ideas |  |  |  | Ready access to preferred method of suicide |  |  |  |
| Hopelessness and helplessness |  |  |  | Lack of clarity about level of support from services |  |  |  |
| Unstable / unpredictable substance misuse |  |  |  | Reluctant engagement with treatment and support services |  |  |  |
| Recent discharge from psychiatric ward |  |  |  | Impulsiveness as a response to stress |  |  |  |
| Unwilling / unable to take responsibility for their own safety |  |  |  | Consistent wish to die |  |  |  |
| Unresolved / poorly managed physical illness, e.g. chronic pain |  |  |  |  |  |  |  |
| **Category of overall risk identified:**  1 or more red, amber, yellow or green items denotes the overall risk category and suggested interventions | | | | | | | |
| **Provisional Mental Health Diagnosis:** | | | | | | | |
| **Plan and outcomes following mental health triage:**  Describe all actions and interventions. Include details of referral to other teams(s), telephone calls / advice and discharge / transfer or follow-up plans. | | | | | | | |

**Signed: Designation:**

**Print Name: Date:**

**To be completed by a registered practitioner only**

| **MENTAL HEALTH RISK ASSESSMENT MATRIX** | | |
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| **Risk Level** | **Key Assessment Information** | **Actions and Timescales** |
| **Low Risk** | * Mental health problem may be present, but no evidence of *immediate* risk to self or others. * Person is prepared and capable of taking responsibility for maintaining their own safety. If appropriate: relatives, family or friends are prepared and available to provide informal support. * Existing or background mental health information does not indicate the need for automatic reassessment at every presentation. | * Routine referral to mental health liaison not required. * Treatment and follow-up arranged by ED Team. * May benefit from referral back to primary care services, e.g. GP, Practice Nurse. * Consider health promotion advice, e.g. to address alcohol use, and self-referral to appropriate services. * Refer to any existing background or historical information contained on the electronic patient record. |
| **Medium-Low Risk** | * Mental health problem(s) present. * Behaviour is co-operative and person demonstrates engagement with health staff during assessment and treatment. * Mental state likely to be at risk of deterioration if current difficulties are not addressed. * May be physically vulnerable in certain circumstances. * Existing or background mental health information indicates the possible need for reassessment following emergency presentation. | * Non-urgent mental health referral – next day mental health follow-up appointment can be offered (Monday – Friday). * Person’s agreement to refer to mental health staff should be sought, but no urgent / immediate action required if they do not wish to engage. * If person is currently known to mental health services, inform the relevant team of their attendance. * Refer to any existing background or historical information contained on the electronic patient record. |