NHS
Avon and Wiltshire
Mental Health Partnership
NHS Trust

Emergency Department Adult Mental Health Assessment Matrix

Date: D D / M M / Y Y Y Y Time of assessment: H H : M M

This Mental Health Assessment Matrix assists the ED practitioner in determining the risk the patient presents of self-harm or suicide as well as the risk of potential harm to staff.
Risk assessment requires clinical judgement. This form is an adjunct to clinical judgement and should be completed by a registered practitioner.

For staff use only
Hospital number:
Surname:
First name:
Date of birth
NHSno: _ _ _ / _ _ _ / _ _ _ _:

Use hospital identification label

Does patient have an existing mental health management plan? ☐Yes ☐ No

Issues to be explored through questioning

Why is the person presenting now?

What are the precipitating (trigger) events to this presentation?

Does the person have medicines, alcohol or weapons on them that could cause harm? ☐**Yes** ☐**No**

Does the person have any close/meaningful family/friends/social support?

Note physical description – include height, build, distinguishing features, clothing, skin colour, hair colour and style

Are there any child protection issues? ☐Yes ☐No If yes or suspected, follow Safeguarding protocol

Are there any adult safeguarding issues? ☐Yes ☐No If yes or suspected, follow Safeguarding protocol

Background, observations and behaviours

Please tick appropriate response	**Yes**	**No**
1. Does the person have any immediate plans to, or do they seem likely to, harm self or others?	☐	☐
2. Is the person obviously disturbed, threatening, agitated or unpredictable in their behaviour?	☐	☐
3. Is this presentation a result of self-harm?	☐	☐
3. Does the person have history of violence?	☐	☐
4. Does the person have a history of mental health problems or self-harm?	☐	☐
5. Is there any suggestion that the person may abscond?	☐	☐

Suicide risk screen

The greater the number of positive responses, the higher the risk

	Yes	No	Unsure		Yes	No	Unsure
Previous self-harm	☐	☐	☐	Family history of suicide	☐	☐	☐
Previous significant suicide attempt	☐	☐	☐	Marked difficulty in coping with recent life event – eg: loss, bereavement, unemployment, relationship breakdown, etc.	☐	☐	☐
Self-reported suicide attempt by individual (and/or family/others)	☐	☐	☐	Family or others concerned about risk	☐	☐	☐
Retains suicidal thoughts (ideation)	☐	☐	☐	Lack of support or breakdown in social circumstances	☐	☐	☐
Has current suicide plan (intent)	☐	☐	☐	Separated/widowed/divorced/domestic violence	☐	☐	☐
Thoughts of hopelessness and/or helplessness	☐	☐	☐	Male gender	☐	☐	☐
Low in mood	☐	☐	☐	Aged over 65 years	☐	☐	☐
Displaying bizarre or unpredictable behaviour	☐	☐	☐	On-going or previous contact with mental health services	☐	☐	☐
Alcohol/drug misuse	☐	☐	☐	Indifferent to or ambivalent about engaging with suggested follow-up or seeking further help	☐	☐	☐
Poor physical health/Pain	☐	☐	☐	Relatively easy access to lethal means of harm	☐	☐	☐

Clinical assessment and plan

After assessment, what level of risk do you think this patient has?	☐ High	☐ Medium	☐ Low
Are enhanced observations required?	☐ Yes	☐ No	
***Add Acute Trust hyperlink to relevant policy**	☐ Red	☐ Amber	☐ None
Do you think this patient has capacity to decide to leave?			
***Add Acute Trust hyperlink to relevant policy**	☐ Yes	☐ No	
Referral for mental health assessment *If **'No'** a clear rationale must be documented in the clinical notes*	☐ Yes	☐ No	

Print name: Date: D D / M M / Y Y Y Y

Signature: Time: H H : M M

Designation: Contact/Bleep number:

Levels of risk and suggested actions

Low	Standard observation levels. Routine
Medium	Consider implementing enhanced levels of observation and supervision. If person absconds, follow missing person's procedures.
High	Consider temporary 1:1 nursing observation and supervision, pending full psychosocial assessment

Risk level	Risk factors	Actions
Low	• There may be mental health issues, but no plans to harm self or others. • No evidence of immediate vulnerability.	• Treatment and follow up to be arranged by ED team. • Consider level of mental health support required and offer individual relevant self-help – eg: via GP or IAPT, etc.
Medium	• Retains thoughts of self-harm or indicators of underlying mental illness – eg: depression. • Mental state likely to deteriorate without treatment. • Patient is potentially vulnerable.	• Refer for mental health assessment. • Consider use of enhanced observation and supervision. • Do not allow patient to leave unaccompanied prior to mental health assessment. • Check, 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 ED electronic patient record. • Missing person's policy and procedure to be implemented if person absconds.
High	• 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. • Reluctant to engage or behaviour indicates lack of cooperation. • May lack capacity to consent to, or refuse, proposed treatment. • Mental state will rapidly deteriorate.	• Refer for mental health assessment. • Consider 1:1 nursing observation and supervision. • Refer to any existing background or historical information contained on the ED electronic patient record. • Assess 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, as appropriate. • Missing person's policy and procedure to be implemented if person absconds.

NHS number

Hospital number:

Patient name: