

MENTAL HEALTH RISK ASSESSMENT MATRIX

(reproduced from Avon & Wiltshire Mental Health Partnership NHS Trust, 2004)

****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 (<i>please circle</i>): Single/Married/Widowed/Divorced		
Living Circumstances (<i>please circle</i>): Alone/With Family or Friends/Other (<i>If other, specify</i>)		
Employment (<i>please circle</i>): Employed/Unemployed/Retired/Student/Other (<i>If other, specify</i>)		
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• Is the person quiet and withdrawn?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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family history of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous use of violent methods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unemployed/retired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide plan/expressed intent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Male gender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current suicidal thoughts/ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Separated/widowed/divorced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopelessness/helplessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of social support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family concerned about risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disengaged from services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol and/or drug misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor adherence to psychiatric Tx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic physical illness/pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Access to lethal means of harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:

Print 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
LOW RISK	<ul style="list-style-type: none"> • 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

MENTAL HEALTH RISK ASSESSMENT MATRIX

Level of risk	Key assessment information
MEDIUM RISK	<ul style="list-style-type: none">• 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.
HIGH RISK	<ul style="list-style-type: none">• 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 <i>on-going suicidal intent remains</i>.• 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.