A full psychiatric assessment is recommended whenever there is serious concern about a person being suicidal. However, the nurse needs to decide whether referral is appropriate and in some cases the risk of suicide is not obvious. Thus, conducting a suicide risk assessment is a crucial first step in identifying the need for an initial or follow-up psychiatric assessment.

There is no known clinical assessment tool that predicts with total certainty whether or not a person will attempt suicide. The nurse therefore has to make a reasonable decision based on the evidence available. The assessment model presented below is designed to help the nurse collect the most relevant information. The model highlights six areas that should be explored with either the person or family members or friends.

When to assess a person for suicide risk

It is appropriate to assess a person’s suicide risk when he or she:

- is brought to hospital with injuries that may be self-inflicted
- shows any sign of suicidal or self-destructive thinking or behaviour
- is severely depressed

If a person is known to have previously attempted suicide, it is appropriate to assess his or her suicide risk:

- on initial contact
- on admission to hospital
- on the occasion of any noteworthy clinical change (e.g. new symptoms, mental status changes, new stressors)
- before discharge

For further information see also the following MIND Essentials resource – ‘Caring for the person who is suicidal’.
How to assess a person’s suicide risk

Step 1: Engage with the person’s feelings and emotions, ask about suicidal thoughts or plans and be non-judgemental and respectful

- An assessment of current thoughts about suicide needs to be undertaken. Almost all people considering suicide have given some indication of their intention, and a number of them have been seen by a GP or health worker in the days, weeks or months preceding the attempt.
- Don’t be afraid to ask – contrary to popular thought, asking about suicide does not prompt someone to take action; rather, it may be a way of acknowledging how serious the person’s situation is. This can be helpful in itself. Ask questions such as: ‘Just how bad have things become for you?’ or ‘You’ve said that sometimes it feels like there is no point any more. Does that mean you have been thinking about hurting yourself or even taking your own life?’
- Indications of suicide intent may be overt or covert. A person may make statements such as: ‘I wish I were dead’ or ‘Life isn’t worth living any more’. The intention may be more vague, with comments such as: ‘It’s OK now, soon everything will be fine’. Behavioural signs may include giving away treasured items, ensuring pets are looked after or contacting and saying goodbye to friends.
- Consider the increased risk presented by the person’s mental state. Those at greater risk may be depressed, psychotic or impulsive. There may also be elements of guilt, shame or hopelessness related to a recent event (e.g. loss of job, divorce, ill health). Ask about the frequency of suicidal thoughts, their intensity and how much control the person feels he or she has over them.

Step 2: Ask if the person has made any plans

- Ask if the person has a plan to end his or her life. Consider how detailed the plan is and the degree of determination expressed about dying.
- Ask about access to the means the person has described. Does the person have a gun or medication? Has he or she planned where to jump from? Has the person thought about when – when no one is home or the family have gone on holidays?
- Try to find out if the person has recently been finalising arrangements or giving away possessions. Is someone else concerned about the person’s health or safety?
- Assess if there are any thoughts of harm to someone else.
- A person is at high risk of suicide if he or she has a specific plan that involves using a highly lethal method to which he or she has access. People who are psychotic, however, are also at high risk regardless of detailed planning because of poor impulse control, impaired judgement and grossly impaired thinking.

Step 3: Ask about any previous attempts

- For people who have previously attempted suicide there is a five-fold increase in risk of subsequent attempts. Ask about the circumstances, method, intent and lethality. For example, you could ask: ‘What did you do when you attempted suicide before?’ ‘What did you want to achieve at that time?’ and ‘How long ago was the attempt?’
Step 4: Ask about drug and alcohol use

- Assess the person’s recent alcohol and drug use, particularly what alcohol and drugs the person uses and how intoxicated he or she becomes from this use. People who have a high level of alcohol and drug use and often or always become intoxicated should be considered at higher risk.

Step 5: Ask about social supports

- A person’s support network of both family and friends is also an important factor. Studies have shown that adolescents with less supportive networks or little social contact with these networks are at a higher risk of attempting suicide.
- Social support needs to be assessed in terms of the amount of support available as well as the quality of the support that is given. People who live alone may be at greater risk when they are suicidal because there may be less chance of rescue.
- Talking to family and friends may help with understanding how the person usually copes, what supports exist and any other risk factors not already identified. It is also important to determine the willingness and ability of the network to provide support.

Step 6: Ask about reasons for hope and other protective factors

- Ask questions about the person’s reasons for living, such as what he or she lives for or how he or she views the future. People showing little hope for the future are at a higher risk. You could ask: ‘What kind of future do you see for yourself?’ or ‘Can you see things getting any better?’
- It is also useful to ask about the person’s willingness to accept help or if he or she believes that help is possible.

Reviewing the assessment

Some questions you may want to ask yourself are:

- How confident am I in my assessment? (e.g. low, medium, high confidence)
- Which factors mainly informed my assessment? (e.g. mental health problems, what the person said)
- Are there any questions relating to these factors that I should have asked?
- Are there any dimensions that I missed altogether?
- Can I identify any assumptions based on my own values that may not be appropriate for this person?
- What actions will I take?
- What follow-up will I do?
- Is there anyone I have met recently who would have benefited from the opportunity to talk about suicidal thoughts?
- How possible has it been for me to engage effectively with people whose lives are very different from my own (e.g. people living in poverty or with different sexual identity or with chronic illness)?

(Adapted from Commonwealth Government Department of Health and Ageing and Government of South Australia, 2007)
Where to next?

Once you have conducted the assessment, carefully document the findings. The MHOAT documentation (see appendix 1 on next page) provides a NSW Health form that is appropriate for guiding and documenting suicide risk. It may also be appropriate to speak with someone about the assessment. Dealing with suicidal people is stressful, and it helps to review your assessment with a colleague or manager and agree together on an appropriate course of action. The suicide risk assessment should help inform care planning. See the MIND Essentials resource ‘Caring for the person who is suicidal’.

Further reading

For more information, see the Mental Health First Aid Manual at www.mhfa.com.au. Internet access required.

Also see the following direct links to relevant guidelines and recommendations for specific health care settings:


Sources


Appendix I: MH-OAT Form

The following is from the MH-OAT document for suicide risk assessment and may be a useful way of recording your assessment.

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
<th>MRN:</th>
</tr>
</thead>
</table>

Suicide risk assessment guide:

**Issue** | **High risk** | **Medium risk** | **Low risk** |
--- | --- | --- | --- |
At risk* Mental State | Severe depression; | Moderate depression; | Nil or mild depression; |
- depressed | Command hallucinations or delusions about dying; |Same sadness; | Sadness; |
- psychotic | Preoccupied with hopelessness, despair, feelings of worthlessness, severe anger, hostility. | Some symptoms of psychosis. | No psychotic symptoms; |
- hopelessness, despair | | | Feels hopeful about the future; |
- guilt, shame, anger, agitation | | | No suicidal ideation, hostility; |
- impulsivity | | | No suicidal ideation, hostility; |

Suicide attempt or suicidal thoughts | | | |
- intentionality | Evidence of clear intention; | Frequent thoughts; | Nil or vague thoughts; |
- lethality | Attempt with high lethality (level); | Multiple attempts of low lethality; | |
- access to means | | | No recent attempt or 1 recent attempt of low lethality and low intentionality; |
- previous suicide attempts | | | |

Substance disorder | | | |
- current misuse of alcohol and other drugs | Current substance intoxication, abuse or dependence. | Risk of substance intoxication, abuse or dependence. | Nil or infrequent use of substances. |

Circumstances of History | | | |
- family, co-oc, medical records | Unable to access information, unable to verify information, or there is conflicting account of events to that of those of the person at risk. | Access to some information but some doubts to plausibility of person’s account of events. | Able to access information and verify information and account events of person at risk (logic, plausibility). |
- other service providers / sources | | | |

Strengths and Supports | | | |
- coping and connectedness | Patient is refusing help; Lack of supportive relationships / hostile relationships; | Patient is ambivalent; Moderate connectedness, few relationships; Available but unwilling / unable to help; | Patient is accepting help; Therapeutic alliance forming; Highly connected / good relationship and support; Willing and able to help consistently; |
- | | | |

Reflective practice | | | |
- level & quality of engagement | Low assessment confidence or high changeability or no rapport, poor engagement. | - High assessment confidence / low changeability; | |
- changeability of risk level | | | Good rapport, engagement; |
- assessment confidence in risk level | | | |

Is this person’s risk level changeable? | Yes | No |
Are there factors that indicate a level of uncertainty in this risk assessment? | Low Assessment Confidence | Yes | No |
If “yes”, please specify: |

Document your risk assessment details and plan here: Include self harm and risk to others, vulnerability to sexual / physical / financial harm, consider religious and spiritual beliefs that may influence risk.

Overall suicide risk rating: | High risk | Medium risk | Low risk | No (foreseeable) risk |
Risk of harm to others: | High risk | Medium risk | Low risk | No (foreseeable) risk |
If any risk noted above, please tick ‘ALERTS’ box on front page.

Staff Name: | Signature: | Designation: | Date: |