Suicide Assessment Guidelines

Confidential

Name of Professional: _____

Initials of the Client/Patient: _____

Date of completion: _____

Scope and Use of these Guidelines

These assessment guidelines are intended as a guide for clinical decision making, and are based on known and significant risk factors (correlates) of suicide.

The scores obtained through the questions here and their resultant recommendations, should not be considered conclusive, because individuals may not necessarily answer questions straightforwardly, and are always free to act contrary to what they say.

Whenever possible, it is important to discuss any intended action with a colleague for a second opinion and added perspective, especially when there appears to be a high risk requiring immediate interventive action.

When using the questions in these guidelines, please read the important accompanying guidance notes in parentheses.

Disclaimer: The impression gained from using these assessment guidelines, is not a diagnosis of any mental health difficulty, it is a means of understanding a client's perception and memory of their experience and behaviour at that point in time. However, this may suffice as a basis for thoughtful collaborative action if there are indications suggesting a client/patient may be at risk.

Compiled by Dr John Ashfield.

A more expansive version of these assessment guidelines has been adapted for and is in use in Palliative Care in the UK.

RISK FACTORS	
Has the client/patient thought that they don't want to live anymore?	☐ N/A ☐ Yes +3 ☐ No
Have they thought about taking their own life?	☐ N/A ☐ Yes +3 ☐ No
• Have they thought about how they would do it?	☐ N/A ☐ Yes +3 ☐ No
• Have they made preparations?	☐ N/A ☐ Yes +4 ☐ No
• Do they have the means?	☐ N/A ☐ Yes +2 ☐ No
• Do they have a plan?	☐ N/A ☐ Yes +4 ☐ No
• Do they believe it would be fatal?	☐ N/A ☐ Yes +4 ☐ No
TOTAL SO FAR	
Have they made a previous suicide attempt? *(Often, presumed suicide attempts, on closer questioning, were intended to stop emotional pain not to extinguish life – hence the questions that follow).*	☐ N/A ☐ Yes +4 ☐ No
• **Did they intend to die?** *(This is an important distinction because self-harm has a different intent and suggests lower risk).*	☐ N/A ☐ Yes +4 ☐ No
Was this more about self-harm?	☐ N/A ☐ Yes –2 ☐ No
Do they have a history of repeated self-harm? *(Repeated self-harm elevates the risk of suicide, due to accidental death, and perhaps being accustomed to hurting oneself).*	☐ N/A ☐ Yes +2 ☐ No
Are they male *(males are at greatest risk - by far the majority of suicides are male. Most at risk are males aged 45-54 years, second highest at risk are aged 85 and over).*	☐ N/A ☐ Yes +3 ☐ No
Are they unemployed?	☐ N/A ☐ Yes +4 ☐ No
Have they recently divorced or separated *(in the last 24 months)? (For males this is one of the most common events associated with suicide ideation).*	☐ N/A ☐ Yes +4 ☐ No
TOTAL SO FAR	

RISK FACTORS

Please make any notes as appropriate below.

RISK FACTORS continued	
Are they socially isolated? *(Some people are socially isolated despite having family or being married. It is important to ask about their experience of social connectedness and support).*	☐ N/A ☐ Yes +2 ☐ No
Are they a heavy alcohol drinker or do they use non-prescription drugs? *(Heavy drinkers are up to 120 times more likely to die by suicide. Heavy drinking is defined as consuming 8 or more drinks each week for women and 15 or more drinks each week for men).*	☐ N/A ☐ Yes +3 ☐ No
Are they recently bereaved or have they experienced a number of bereavements in the past?	☐ N/A ☐ Yes +2 ☐ No
Do they have current mental health difficulties (such as major depression, bipolar affective difficulties or psychosis)? *(That a person has had a mental health difficulty in the past does not necessarily mean that such a difficulty has persisted or is current).*	☐ N/A ☐ Yes +3 ☐ No
Are they experiencing acute psychological distress or anxiety?	☐ N/A ☐ Yes +4 ☐ No
Are they experiencing sexual identity difficulties?	☐ N/A ☐ Yes +2 ☐ No
Do they have a terminal or life-limiting illness?	☐ N/A ☐ Yes +2 ☐ No
TOTAL SO FAR	

PROTECTIVE FACTORS	
Do they have positive social support (family, friends, colleagues, community)?	☐ N/A ☐ Yes –4 ☐ No
Have they demonstrated positive help-seeking behaviour?	☐ N/A ☐ Yes –4 ☐ No
TOTAL SO FAR	

PROTECTIVE FACTORS continued	
Have they expressed the wish not to harm loved ones?	☐ N/A ☐ Yes –4 ☐ No
Have they developed a rational view of ending their life, in relation to a terminal or life-limiting disease? *(Such a view might suggest ending their lives as notionally reasonable and desirable, but can be protective, since it can ameliorate a sense of powerlessness to have an exit plan. Few people actually follow through with such plans).*	☐ N/A ☐ Yes –3 ☐ No
Do they have positively supportive religious or spiritual beliefs? *(Most religious and spiritual belief systems are also opposed to suicide).*	☐ N/A ☐ Yes –2 ☐ No
Have they voluntarily relinquished means (such as firearm or poison)? *(Means that may have posed an extra risk if readily available during times of suicidal thinking).*	☐ N/A ☐ Yes –2 ☐ No
Have they initiated or are they prepared to use monitoring and safety behaviour (such as ringing a family member several times a day to 'check-in')?	☐ N/A ☐ Yes –2 ☐ No
Are they actively pursuing strategies (with a counsellor or other resource/support person) **to monitor and lessen their distress/anxiety?**	☐ N/A ☐ Yes –5 ☐ No
TOTAL SO FAR	
OVERALL TOTAL SCORE	

Determining the level of risk

Measures of risk here are based on known correlates of suicide, but are intended as a guide only in the support of clinical judgement. Protective factors e.g. engaging in psychological therapy, have been attributed a value which is deducted from the overall score.

Risk Levels

Low 3-15: Client/patient has had suicidal thoughts but no plan, intention, nor have they intentionally acquired means; other risk factors may be present but not pronounced. Both you and the client/patient consider them to be safe.

Medium 16-39: Client/patient has had suicidal thoughts but is ambivalent about or has talked in the past tense about intention and plan; may have means; other risk factors may be present and may be pronounced. Both you and the client/patient believe them to be safe for now.

High 40+: Client/patient has had suicidal thoughts. They have disclosed intention, means and plan. Other pronounced risk factors may or may not be present. Both you and the patient/client believe them to be unsafe and that further preventive action is needed.

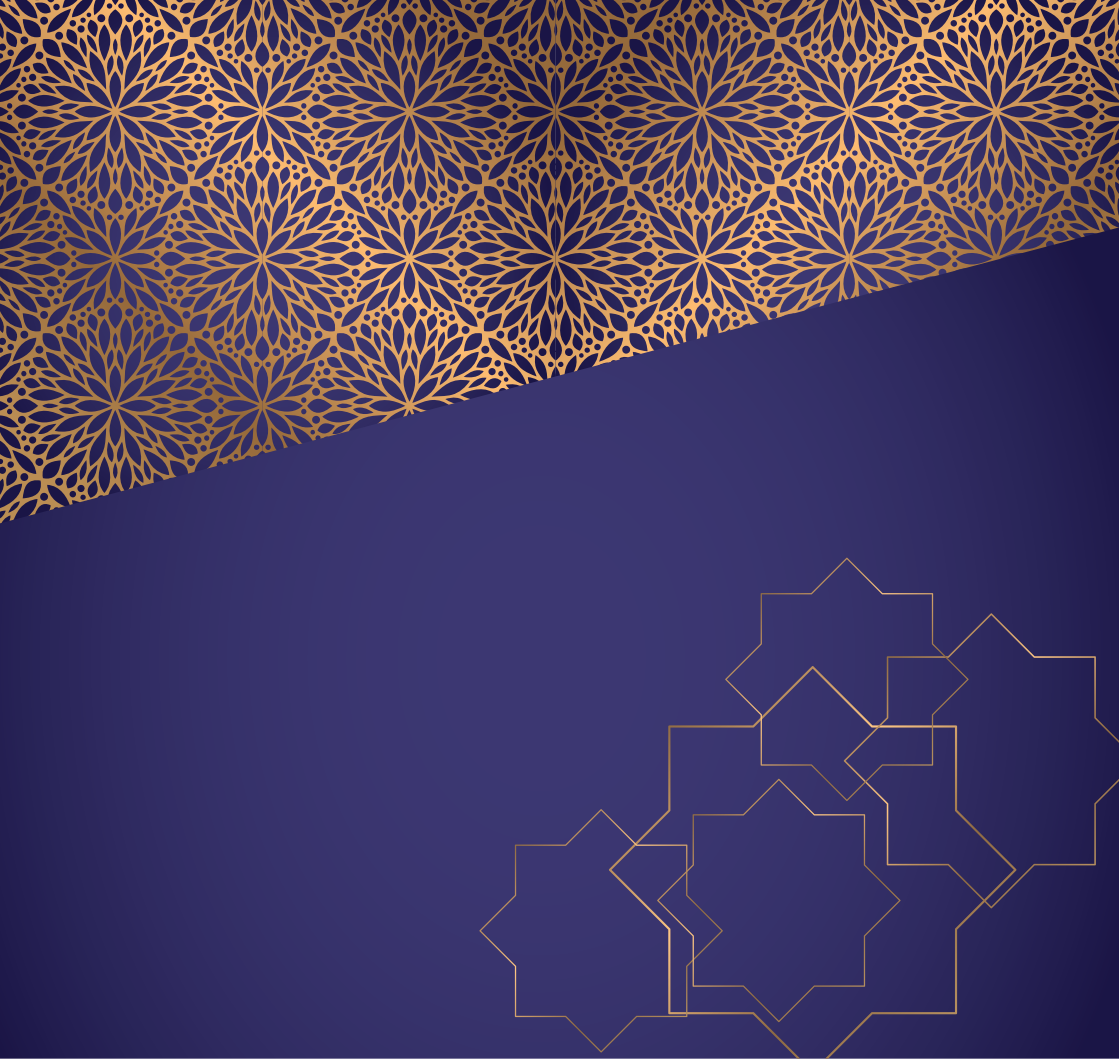
Action Recommendations:

Low 3-15: Monitor; speak to the client/patient 1-2 days after assessment, to check on sustained low risk and safety.

Medium 16-39: Monitor frequently or arrange for this to occur: speak to the client/patient 1-2 days after initial assessment. If their risk status doesn't return to Low within a few days of close monitoring, or appears to elevate, formulate a safety plan. With their consent, inform their GP. With their consent, inform trusted family members or friends that are available to monitor and support them.

High 40+: Refer to a Mental Health Crisis Service. Advise the client's/patient's GP that a referral has been made. In the event that these options are not viable, call an ambulance. In the event that the client/patient terminates your session with them or refuses to remain until help can be arranged, notify the police immediately.

***Where the involvement of a Mental Health Team, GP, ambulance, police, or hospital occurs, do not assume longevity of support.** Your ongoing involvement with a client/patient may be vital to their recovery and normalisation and can occur (with the client's/patient's consent) alongside these other sources of intervention. Psychological counselling, psychotherapy, or professional pastoral care, may be the most important overall contribution to their recovery and normalisation.



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