

# Suicide Risk Assessment and Management Protocols

General Community Health Service



**NSW DEPARTMENT OF HEALTH**

73 Miller Street  
NORTH SYDNEY NSW 2060  
Tel. (02) 9391 9000  
Fax. (02) 9391 9101  
TTY. (02) 9391 9900  
**[www.health.nsw.gov.au](http://www.health.nsw.gov.au)**

This work is copyright. It may be reproduced in whole or in part for study or training purposes subject to the inclusion of an acknowledgement of the source. It may not be reproduced for commercial usage or sale. Reproduction for purposes other than those indicated above requires written permission from the NSW Department of Health.

© NSW Department of Health 2004

SHPN (MH) 040187  
ISBN 0 7347 3724 6

For further copies of this document please contact:  
Better Health Centre – Publications Warehouse  
Locked Mail Bag 5003  
Gladesville NSW 2111  
Tel. (02) 9816 0452  
Fax. (02) 9816 0492

Further copies of *Framework for suicide risk assessment and management* documents can be downloaded from:  
NSW Health website: [www.health.nsw.gov.au](http://www.health.nsw.gov.au)  
Intranet: [internal.health.nsw.gov.au/publications](http://internal.health.nsw.gov.au/publications)

September 2004

# Contents

*Framework for Suicide Risk Assessment and Management for NSW Health Staff* .....ii

**Introduction**.....1

**Assessment of suicide risk** .....2

Detection.....2

Preliminary suicide risk assessment.....3

– Brief psychiatric assessment.....3

Determination of suicide risk level.....4

– Changeability .....4

– Assessment confidence .....4

Consultation with colleagues .....5

Suicide Risk Assessment Guide .....6

**Management** .....7

Maximising a safe environment.....7

– Consultation or referral to specialist mental health service .....7

Management plan.....8

Managing a suicide attempt .....9

Managing a suicide death.....9

**Follow-up** .....10

**References** .....11

## Related documents

Framework for Suicide Risk Assessment and Management for NSW Health Staff – SHPN (MH) 040184

Suicide Risk Assessment and Management: Emergency Department – SHPN (MH) 040186

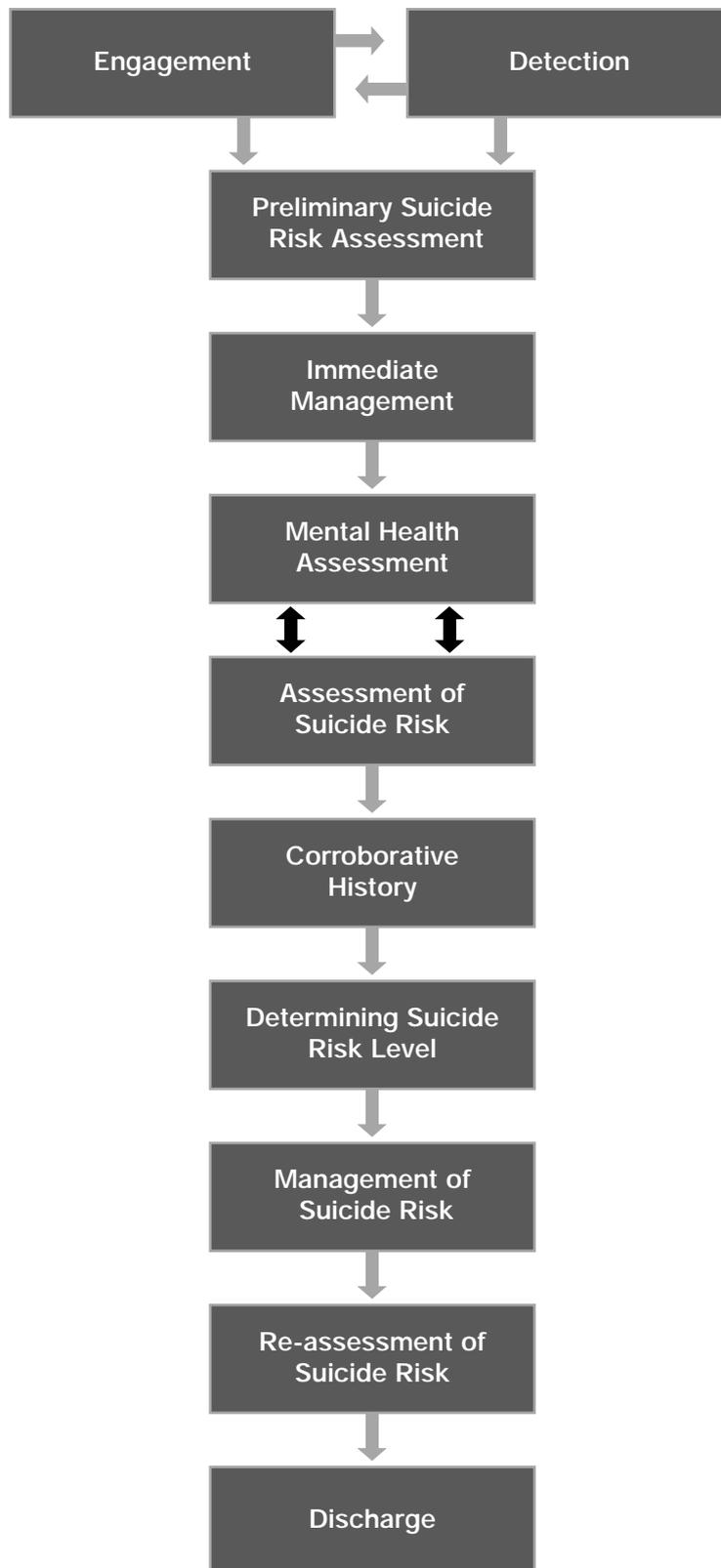
Suicide Risk Assessment and Management Protocols: General Hospital Ward – SHPN (MH) 040185

Suicide Risk Assessment and Management Protocols: Community Mental Health Service – SHPN (MH) 040182

Suicide Risk Assessment and Management Protocols: Mental Health In-Patient Unit – SHPN (MH) 040183

Suicide Risk Assessment and Management Protocols: Justice Health Long Bay Hospital – SHPN (MH) 040188

# Framework for Suicide Risk Assessment and Management for NSW Health Staff



# Introduction

Suicide is a major cause of death in NSW.

Attempted suicide is a significant cause of morbidity. Health care professionals are in a vital position for identifying people at risk of suicide and preventing suicide. Management of a person at risk of suicide requires assessment of risk, an estimation of the level of risk and appropriate interventions to minimise the risk.

All people with possible suicidal behaviour in contact with general health services must receive a preliminary screening for suicide risk and be referred to specialist mental health services or, at a minimum, consultation with a mental health service should occur on the assessment and management of suicide risk.

Competent management when a person is suicidal will have a significant influence on both morbidity and mortality outcomes.

**These suicide risk assessment and management protocols are to be read in conjunction with the NSW Health circular, *Policy Guidelines for the Management of Patients with Possible Suicidal Behaviour for NSW Health Staff and Staff in Private Hospital Facilities*<sup>1</sup> and the *Framework for Suicide Risk Assessment and Management for NSW Health Staff*.<sup>2</sup>**

# Assessment of suicide risk

## Detection

It has been estimated that up to ninety percent (90%) of people who die by suicide suffer from a diagnosable mental disorder.<sup>3</sup> A number of demographic factors are associated with increased risk of suicide, such as unemployment, alcohol and drug use, history of physical and/or sexual abuse, family discord, homelessness, incarceration and mental health problems, particularly depression.

The most important factors in assessing a person's **imminent suicide risk** are the **current personal risk factors**. Examples include:

- 'at risk' mental status, eg hopelessness, despair, agitation, shame, guilt, anger, psychosis, psychotic thought processes
- recent interpersonal crisis, especially rejection, humiliation
- recent suicide attempt
- recent major loss, trauma or anniversary
- alcohol intoxication
- drug withdrawal state
- chronic pain or illness
- financial difficulties, unemployment
- impending legal prosecution, child custody issues
- cultural or religious conflicts
- lack of social support network
- unwillingness to accept help
- difficulty accessing help due to language barriers, lack of information, lack of support or negative experiences with mental health services prior to immigration.

**Protective factors** have also been identified that may protect a person from suicide.

These include:

- strong perceived social supports
- family cohesion
- peer group affiliation
- good coping and problem solving-skills
- positive values and beliefs
- ability to seek and access help.

Early warning **signs of depression** should alert the health professional to the need for further assessment of suicide risk. Early warning signs include:

- depressed mood and/or anhedonia (loss of pleasure in usual activities)
- feelings of hopelessness
- isolated / withdrawn / reduced verbal communication
- difficulty sleeping
- refusing treatment
- reduced appetite
- complaints of pain/physical discomfort not consistent with physical health.

When suicide risk is suspected it is important for the health professional to inquire if the person is feeling suicidal. Suicide risk is not increased by a professional asking about the possibility of suicide risk.

**Intoxication** precludes a valid immediate assessment. However, if suicide risk has been identified in an intoxicated person they should be detained in an appropriate and safe setting until a full assessment is conducted. Enduring risk cannot be judged until the person is sober.

## Preliminary suicide risk assessment

When a person in contact with community services has been detected to be at risk of suicide, a preliminary assessment is to be conducted by the appropriate health professional prior to referral to specialised mental health services or other professionals (for example, general practitioner), where appropriate.

The purpose of this assessment is to determine:

- the severity and nature of the individual's problems
- the risk of danger to self or others
- whether a more detailed risk assessment is indicated.

There are a number of factors that need to be considered prior to the suicide risk assessment.

- What are the details of the presentation or referral or the circumstance (for example, an incident) that has brought the issue of suicide risk to the attention of staff?
- A brief chronological account of the presenting problem (why the person has come to the health service) should be elicited.
- Is the person medically well enough to participate in the interview? Do they require medical assessment?
- Access any collateral information available, for example, medical records, nursing reports, family, other health providers.
- Given individual circumstances and if appropriate, it is highly desirable to contact a family member or carer of the person and involve them in the assessment.
- **If the person is under 16 years**, the carer must be actively involved in the management plan whenever possible and should be contacted prior to discharge from a service. If no carer is available, a suitable advocate for the young person should be contacted.
- Discuss with family and friends whether the person's behaviour is out of character, how long it has been evident, how they deal with the crisis.
- Is the person known to a mental health service?

Essential aspects for preliminary screening of suicidal risk include:

- current predicament, stressors, social situation

- current thoughts of suicide
- previous suicide attempts or threats
- drug or alcohol use
- impulsiveness.

A hierarchy of screening questions that gently leads to asking about suicidal ideas is a generally accepted procedure for all health professionals (see Figure 1).

**Figure 1: Assessment of suicide risk (screening questions)**

- Have things been so bad lately that you have thought you would rather not be here?
- Have you had any thoughts of harming yourself?
- Are you thinking of suicide?
- Have you ever tried to harm yourself?
- Have you made any current plans?
- Do you have access to a firearm? Access to other lethal means?

## Brief psychiatric assessment

- Is the person experiencing any current psychiatric symptoms (presence of depressed mood and symptoms of depression such as reduced energy, concentration, weight loss, loss of interest, or psychosis, especially command hallucinations)?
- Is there a past history of psychiatric problems? (A history of a mental illness should raise the clinician's concern that the current presentation may be a recurrence or relapse.)
- Mental state assessment (GFCMA: Got Four Clients Monday Afternoon):
  - **G**eneral appearance (agitation, distress, psychomotor retardation)
  - **F**orm of thought (is the person's speech logical and making sense?)
  - **C**ontent of thought (hopelessness, despair, anger, shame or guilt)
  - **M**ood and affect (depressed, low, flat or inappropriate)
  - **A**ttitude (insight, cooperation).

## Assessment of suicide risk

- Coping skills, capacity and supports.
  - Has the person been able to manage serious problems or stressful situations in the past?
  - Does the person employ maladaptive coping strategies such as substance or alcohol abuse?
  - Are there social or community supports? Can the person use them?
- What collateral information is available, eg medical records, nursing reports, family, police, other health providers?
- Elicit information from family and friends to establish whether the behaviour is out of character, how long it has been evident, how they deal with crises.

### Additional aspects for assessment following an episode of self-harm or attempted suicide

- What exactly did the person do? For example, how many tablets used, length of time in the car, what sort of knife was used, what was the rope attached to?
- What precipitated the self-harm? Have they resolved or are they still present?
- What is the person's intention now? For example, how does he/she feel about things now? What are their plans?
- Is the person at risk of another suicide attempt?<sup>4</sup>

The person's family, if in attendance, should be informed of the assessment, further assessments required and the management plan.

## Determination of suicide risk level

There is no current rating scale or clinical algorithm that has proven predictive value in the clinical assessment of suicide.<sup>5, 6, 7</sup> A thorough assessment of the individual remains the only valid method of determining risk.

Assessments are based on a combination of the background conditions and the current factors in a person's life, and the way in which they are interacting.

Suicide risk assessment generates a clinician rating of the risk of the person attempting suicide in the immediate period. The person's suicide risk in the immediate to short-term period can be assigned to one of the four broad risk categories: high risk, medium risk, low risk, no (foreseeable) risk.

Refer to the **Suicide Risk Assessment Guide** (p 6) to assist in estimating the current level of suicide. It is a guide only, however, and is not intended to replace clinical decision-making and practice.

## Changeability

Changeability of risk status, especially in the immediate period, should be assessed and high changeability should be identified.

While risk status is by nature dynamic and requires re-assessment, highly changeable risk status is worth identifying, as it will guide clinicians as to the safe interval between risk assessments.

**High Changeability:** The clinician recognises the need for careful re-assessment and gives consideration as to when the re-assessment should occur, eg within 24 hours. More vigilant management is adopted with respect to the safety of the person in the light of the identified risk of high changeability.

## Assessment confidence

The clinician should consider the confidence he/she has in this risk assessment. A number of factors may indicate low assessment confidence. These include:

- factors in the person at risk, such as impulsivity, likelihood of drug or alcohol abuse, present intoxication, inability to engage
- factors in the social environment, such as impending court case, divorce with child custody dispute
- factors in the clinician's assessment, such as incomplete assessment, inability to obtain collateral information.

**Low Assessment Confidence:** The clinician recognises the need for careful re-assessment to occur, eg within 24 hours. More vigilant management is adopted with respect to the safety of the person in the light of the gaps in information or rapport.

- High Changeability Flag**
- Low Assessment Confidence Flag**

## Consultation with colleagues

- Assessment of people at risk of suicide is a complex and demanding task. It requires involvement of a mature, experienced clinician at some level.
- Wherever possible, all assessments of suicide should be discussed with a colleague or senior clinician at some stage of the assessment process.
- Consideration of the time of consultation should be based on the degree of concern for the person at risk. The greater the degree, the sooner the consultation should be sought.
- All teams involved in the assessment of people at risk should have access to regular (daily, or at least weekly) clinical forums such as a clinical case review where all cases are presented and discussed.
- For clients from culturally and linguistically diverse backgrounds, consideration needs to be given to obtaining information from a cultural consultant.

## Suicide Risk Assessment Guide<sup>2</sup>

To be used as a guide only and not to replace clinical decision-making and practice.

Issue	High risk	Medium risk	Low risk
<b>'At risk' Mental State</b> <ul style="list-style-type: none"> <li>– depressed</li> <li>– psychotic</li> <li>– <u>hopelessness</u>, despair</li> <li>– guilt, shame, anger, agitation</li> <li>– impulsivity</li> </ul>	Eg. Severe depression; Command hallucinations or delusions about dying; Preoccupied with hopelessness, despair, feelings of worthlessness; Severe anger, hostility.	Eg. Moderate depression; Some sadness; Some symptoms of psychosis; Some feelings of hopelessness; Moderate anger, hostility.	Eg. Nil or mild depression, sadness; No psychotic symptoms; Feels hopeful about the future; None/mild anger, hostility.
<b>Suicide attempt or suicidal thoughts</b> <ul style="list-style-type: none"> <li>– intentionality</li> <li>– lethality</li> <li>– access to means</li> <li>– previous suicide attempt/s</li> </ul>	Eg. Continual / specific thoughts; Evidence of clear intention; An attempt with high lethality (ever).	Eg. Frequent thoughts; Multiple attempts of low lethality; Repeated threats.	Eg. Nil or vague thoughts; No recent attempt or 1 recent attempt of low lethality and low intentionality.
<b>Substance disorder</b> <ul style="list-style-type: none"> <li>– current misuse of alcohol and other drugs</li> </ul>	Current substance intoxication, abuse or dependence.	Risk of substance intoxication, abuse or dependence.	Nil or infrequent use of substances.
<b>Corroborative History</b> <ul style="list-style-type: none"> <li>– family, carers</li> <li>– medical records</li> <li>– other service providers/sources</li> </ul>	Eg. Unable to access information, unable to verify information, or there is a conflicting account of events to that of those of the person at risk.	Eg. Access to some information; Some doubts to plausibility of person's account of events.	Eg. Able to access information / verify information and account of events of person at risk (logic, plausibility).
<b>Strengths and Supports (coping &amp; connectedness)</b> <ul style="list-style-type: none"> <li>– expressed communication</li> <li>– availability of supports</li> <li>– willingness / capacity of support person/s</li> <li>– safety of person &amp; others</li> </ul>	Eg. Patient is refusing help; Lack of supportive relationships / hostile relationships; Not available or unwilling / unable to help.	Eg. Patient is ambivalent; Moderate connectedness; few relationships; Available but unwilling / unable to help consistently.	Eg. Patient is accepting help; Therapeutic alliance forming; Highly connected / good relationships and supports; Willing and able to help consistently.
<b>Reflective practice</b> <ul style="list-style-type: none"> <li>– level &amp; quality of engagement</li> <li>– changeability of risk level</li> <li>– assessment confidence in risk level.</li> </ul>	Low assessment confidence or high changeability or no rapport, poor engagement.		<ul style="list-style-type: none"> <li>– High assessment confidence / low changeability;</li> <li>– Good rapport, engagement.</li> </ul>
<b>No (foreseeable) risk:</b> Following comprehensive suicide risk assessment, there is no evidence of current risk to the person. No thoughts of suicide or history of attempts, has a good social support network.			

Is this person's risk level changeable?

**Highly Changeable** Yes  No

Are there factors that indicate a level of uncertainty in this risk assessment? Eg: poor engagement, gaps in/or conflicting information.

**Low Assessment Confidence** Yes  No

# Management

## Maximising a safe environment

- The safety of both the person being assessed and the clinician is the primary concern at all times throughout the assessment process.
- The level of observation/supervision needs to be considered during the time that the person is waiting to be assessed and after the assessment while consultation or referral arrangements are being made. The level of observation required by a person will depend on the risk and the physical environment. Wherever possible, a person at risk of suicide should never be left alone.
- If possible, provide a calming support person to stay with the person at risk.
- All items that could be used for self-harm (including belts, ties, shoelaces, dangerous objects) should be removed from the person and their immediate environment.
- If at any stage of contact a staff member is made aware that the person is in possession of or can gain easy access to a firearm and there is concern about the person's mental state, the risk of suicide or threat to public safety, the police should be contacted to discuss the possibility of removing the firearm.<sup>8</sup>
- The use of the *Mental Health Act 1990* (NSW) may be necessary in the following instances to enable the continued observation and safety of the person:
  - if suicidal thoughts or verbal intentions are persistent and intense, or
  - the self-harming is serious in nature, or
  - there is evidence of a mental disorder or mental illness.
- If the suicide risk is detected during a home visit by the community health professional, and the person is willing, they may be escorted to the community health centre or hospital emergency department for a comprehensive suicide risk assessment to be conducted. If possible, the person should be escorted by two staff members.
- If a person who is considered to be at risk leaves the facility or other community setting, including the

person's home, prior to management arrangements being finalised, every effort should be made to locate the person. If there is serious concern, the police should be immediately contacted and provided with a description of the person and the likely areas where they may be located. The mental health service should also be contacted if it is known that the person is a client of the mental health service.

The person's family, if in attendance, should be informed of the assessment, further assessments required and the management plan.

## Consultation or referral to specialist mental health service

- General community health centres should have guaranteed access to specialist mental health services or other specialised and appropriate professions. The service must be accessible and provide a response commensurate with the estimated risk. A protocol must be in place that outlines how and when the mental health service will be contacted once the person is medically stable and a preliminary assessment has been conducted.
- A referral to the mental health service for a comprehensive suicide risk assessment should be made for the following presentations:
  - people who present following a suicide attempt or an episode of self-harm:
    - those who report or are reported to be preparing for suicide or have definite plans
  - people with probable mental illness or disorder:
    - those who are depressed, or have schizophrenia or other psychotic illness
  - people whose presentations suggest a probable mental health problem:
    - those who report accidental overdoses, unexplained somatic complaints or who present following repeated accidents, increased risk-taking behaviour, increased impulsivity, self-harming behaviours

## Management

(for example, superficial wrist-cutting), co-morbidity (eg alcohol and other drugs, intellectual disability, organic brain damage)

- people recently discharged from an acute psychiatric in-patient unit, especially within the previous month
- people recently discharged from an emergency department following presentation of psychiatric symptoms or repeat presentations for somatic symptoms.
- In some circumstances, referral to a mental health service is not always possible or practical, for example, in rural and remote areas. At a minimum, a phone consultation with the mental health service should occur.
- Relevant members of the community health centre treating team should be notified of the preliminary suicide risk assessment and management plan.
- In people with an identified suicide risk, there should be a clear referral and follow-up process. This process needs to be coordinated and integrated across all aspects of service delivery.

## Management plan

- People at risk of suicide who are to be managed by the general community health centre must have a management plan developed, wherever possible, in consultation with the person and the mental health service.
- Where a person is assessed as high to medium risk, there must be a referral to the specialist mental health service. A management plan is then developed collaboratively with the mental health service or professional taking the key responsibility for management of the suicide risk.
- The plan should be documented in the medical record and include the following:
  - the level of assessed suicide risk to the person
  - the steps to be taken to ensure their safety, for example:
    - the frequency of contact
    - the frequency of re-assessment and documentation of each suicide risk assessment, including a reviewed rating as high, medium or low.

- If a good therapeutic relationship has been established, a 'no self-harm contract' may be considered as one component of management. Clinical judgement needs to be used, that is, the person's agreement to the contract should not be given credence if the person is psychotic, intoxicated, made a recent and serious suicide attempt or is depressed to the extent that he/she cannot comprehend the terms of the contract. The contract should state that the person will agree to contact a specific person or service before performing any self-harm behaviour. The contract states clearly the services that will be provided to assist the person and his/her supports through the current crisis. The contract must be accompanied by frequent follow-up visits or contact by telephone. Such a contract is not legally binding and can never substitute for a thorough assessment. **It serves mainly to strengthen the therapeutic alliance.**<sup>9</sup>
- There must be specific strategies for the person and their support person/s to deal with symptoms and distress.
- There should be consideration of sleep, hygiene and, where appropriate, night sedation to assist the person's rest and sleep.
- It should include information regarding triggers, stressors, precursors, methods/plans and the individual importance of various factors to the patient, including anticipation of likely circumstances that may escalate the patient's risk.
- Include information regarding family and friends and details of significant relationships.
- There should be an agreed level of mental health service involvement during the period of risk.

## Managing a suicide attempt

- If the person is in any physical distress or requires medical care ring 000 for an ambulance. Do not leave the person.
- Remove the person from danger without placing any other person present at risk.
- Assess the person's current suicide risk. An attempted suicide usually indicates the person is at high risk in the immediate and short-term period.
- Provide support to other people present who may be acutely distressed including staff.
- Follow all related procedures in regard to incident reporting, management and review.<sup>10</sup>

## Managing a suicide death

Refer to the NSW Health *Postvention guidelines surrounding a suicide death for NSW Health staff and staff in private hospital facilities*.<sup>11</sup>

# Follow-up

- Where the person has been referred to a specialist mental health service for further management of suicide risk, the referring staff member must ensure firm follow-up arrangements are made and the person has attended the first appointment.
- The person, and where appropriate their family, must be provided with information about how to access urgent help, including a 24-hour contact telephone number.
- A follow-up appointment for reassessment must be provided.

People assessed to be at **high risk** of suicide must have a **follow-up appointment** with the relevant health provider (eg acute care team, community care coordinator/ case manager, general practitioner, private psychiatrist) **within 24 hours**. **Contingency plans** must be in place.

People assessed to be at **medium risk** of suicide must have a **follow-up appointment** with the relevant health provider **within one week**. **Contingency plans** must be in place.

People assessed to be at **low risk** of suicide must have a **follow-up appointment** with the relevant health provider **within one month** and accessibility to appropriate health services if required prior to appointment.

- If the person is under 16 years of age, contact must be made with the parents or guardian.
- There must be a plan to contact significant support people, including the general practitioner, private psychiatrist, care coordinator, case manager, family and friends about the potential suicide risk and about follow-up arrangements that have been made.

## Missed appointment

- Where a suicide attempt has been made or there is ongoing risk and the person does not attend an initial follow-up appointment, the relevant health care provider with whom the appointment has been made must immediately contact the person and assess his/her suicidal behaviour. All reasonable attempts to contact the person are to be undertaken.
- 'Reasonable' attempts include:
  - telephone calls
  - contacting family, other identified carer, general practitioner (all subject to privacy provisions)
  - visits to the person's residence, if practicable
  - follow-up letter.
- All attempts at contact must be documented in the medical file.

# References

- <sup>1</sup> NSW Department of Health. Circular 98/31 Policy guidelines for the management of patients with possible suicidal behaviour for NSW Health staff and staff in private hospital facilities, May 1998. Note: The policy was being revised at the time of preparation of these protocols.
- <sup>2</sup> NSW Department of Health. Framework for Suicide Risk Assessment and Management for NSW Health Staff. Sydney: NSW Department of Health, 2004 (in press).
- <sup>3</sup> Conwell Y, Duberstein PR, Cox C, Herrmann JH, Forbes NT, Caine ED. Relationships of age and axis I diagnosis in victims of completed suicide: a psychological autopsy study. *American Journal of Psychiatry*, 1996;153: 1001-1008.
- <sup>4</sup> NSW Health Department. Mental Health for Emergency Departments—A Reference Guide (Amended May 2002). Sydney: NSW Health Department, 2001-2002.
- <sup>5</sup> Pokorny AD. Prediction of suicide in psychiatric patients: report of a prospective study. *Archives of General Psychiatry*, 1983; 45:249-257.
- <sup>6</sup> Goldstein RB, Black DW, Nasrallah MA, Winokur MD. The prediction of suicide. *Archives of General Psychiatry*, 1991; 48:418-422.
- <sup>7</sup> Rissmiller DJ, Steer R, Ranieri WF, et al. Factors complicating cost containment in the treatment of suicidal patients. *Hospital and Community Psychiatry*, 1994;45(8):782-788.
- <sup>8</sup> NSW Department of Health, Centre for Mental Health. Memorandum of Understanding between NSW Police and NSW Health. Sydney: NSW Department of Health, 1998. (Updated Memorandum of Understanding between Police and NSW Health Flow Charts 2002 available at: [www.health.nsw.gov.au/policy/cmh/publications/mou\\_police-health.pdf](http://www.health.nsw.gov.au/policy/cmh/publications/mou_police-health.pdf))
- <sup>9</sup> Stanford EJ, Goetz RR, Bloom JD. The no harm contract in the emergency assessment of suicidal risk. *Journal of Clinical Psychiatry*, 1994; 55:344-8.
- <sup>10</sup> Adapted from South East Sydney Health Service. Managing a patient at risk of suicide on the in-patient unit. Final Draft Policy, 2001.
- <sup>11</sup> NSW Department of Health. Postvention guidelines surrounding a suicide death for NSW health staff and staff in private hospital facilities. Sydney: NSW Department of Health, 2004 (in development).









