5-POINT SUICIDE RISK ASSESSMENT TOOL

Items below in amber indicate the more worrying side of things

No test or tick box scoring questionnaire is good enough to identify people who will go on to kill themselves. There are quite a few around, but unfortunately, they are either not specific or sensitive enough. The majority of assessment tools have low validity in predicting suicidal behaviour accurately and often result in high false-positive findings. **Fortunately, approximately 80% of suicidal people appear to give some indication of their intention.** This means that if we ask open questions and listen carefully to their story - we are more likely to pick out the ones at high risk of doing it. If you are looking for a questionnaire with a scoring system to help you decide the level of suicidal risk, unfortunately, they are generally not fit for purpose. Instead, you are better with an assessment sheet like this, which encourages you to explore the patient's story from various windows to help you "get a feel" for their narrative and help decide whether the patient in front of you is at high risk or not. This assessment sheet might look like it has many areas, but the more you use it, the more familiar and easy it will become. If you allow the patient to tell their story and help facilitate them along the way, you will cover most areas effortlessly. There is an art to suicidal risk assessment, and I hope this assessment sheet will help you develop that. This Assessment sheet focuses on 5 areas

1. Presenting Problem
2. Five Triage Questions
3. Ideation-Plans-Lethality-Means-Intent (IPLMI)
4. Patient Factors (PAMPi)
5. Social Factors (SSS)

1. PRESENTING PROBLEM:

- *"I know things have been difficult for you. Would you mind telling me what's been going on?"*
- *"And you've had thoughts that you would be better off dead or hurting yourself in some way? Tell me about those."*
- *e.g. Depressed & now feeling suicidal? Any events/circumstances that have triggered suicidal thoughts?*
- *Allow the patient to speak. Let them tell their story fully. Try not to interrupt.*
- *Let the patient lament (it is therapeutic in itself).*

2. FIVE TRIAGE QUESTIONS

i.	*"Are you able to **keep yourself safe** until this assessment is completed?"*	☐ Yes - ☐ No
ii.	*"Are you in **possession of a gun/weapon**/have easy access to a gun or weapon?"*	☐ Yes - ☐ No
iii.	*"Have you **felt like hurting yourself**?"*	☐ Yes - ☐ No
iv.	*"Have you **felt like hurting anyone else**?"* If Yes – refer to psychiatry	☐ Yes - ☐ No
v.	*"Have you **already hurt yourself or anyone else**?"*	☐ Yes - ☐ No

Note:

- If yes to (iv) → refer to psychiatry
- If yes to (v) → then the level of risk is severe; it is unnecessary to complete the remainder of this form. Despatch mobile crisis response team and/or police. Remember your duty to protect yourself and your colleagues.
- Point (iii) - the possession of firearms - is a crucial fact to ascertain if suicidal but is generally quite rare (thank goodness!).

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3. IDEATIONS-PLANS-LETHALITY-MEANS-INTENT (IPLMI)

IDEAS

- *"What thoughts have you had about ending your life?"* Use patients own words.
- *"Has anything triggered these thoughts like a break-up, money or family problems, and such?"*
- Are these thoughts fleeting, periodic or constant? *"And how often and when are you having these thoughts?"*

☐Fleeting ☐Periodic ☐Constant

PLANS

- *"So, you have had thoughts about doing xxx to yourself. Can you tell me a bit more detail on what plans you have made or were thinking about?"*
- Encourage the patient to tell their story (or narrative). It's important to build a real picture of what is going on for them, their thoughts and their plans.

☐Not worrying ☐Not Sure ☐Worrying
(← unclear *vs* detailed & specific→)

LETHALITY

- From what the patient has told you so far, how dangerous does their plan sound?

☐Not worrying ☐Not Sure ☐Worrying
(← minimal risk *vs* certainty of death→)

MEANS

- Has the patient given away anything about having *access* to instruments/methods to carry out their plan? Explore.

☐Not worrying ☐Not Sure ☐Worrying
(← no access *vs* continuous access→)

INTENT - this bit is incredibly important (4 things, DOG-H)

i) DESIRE

- From what the patient has told you so far, how strong does their **DESIRE** to end it all seem?
- E.g. Have they written a suicide note? Made/changed their will? Secretive about their plans?
- From the areas above - have they gone out and bought items? Have they decided when and where?

☐Not worrying ☐Not Sure ☐Worrying
(← no desire *vs* desire to complete plan→)

ii) EFFECT ON OTHERS

- Have they considered the EFFECT OF SUICIDE ON OTHERS? E.g. partner, parents, siblings, kids. Do they care?
- *"So at the moment, it seems as if there something that has stopped you from doing it. What might that be?"* >>> *"Doc, it's my kids, I don't think I could put my kids through that ordeal".*
- *"So James, thank you for sharing that with me. It can't have been easy. You said you had children and a partner. Did I hear that correctly?"* >>> *"Yes doc, I do"* >>> *"I'm just wondering if you had gone ahead with your plan, what effect it might have on them?"* (Does the patient care or not care?)

☐Not worrying ☐Not Sure ☐Worrying
(← shows remorse *vs* does not care about effect on others→)
Says *"they will cope….."*

iii) GUILT

- Strong feelings of guilt are a red flag.
- *"Do you often feel bad about yourself, or that you are a failure or have let yourself or your family down?"*

☐Not worrying ☐Not Sure ☐Worrying
(← no feelings of guilt *vs* strong feelings of guilt →)

iv) HOPELESSNESS

- Is there a sense of future orientation? Strong feelings of hopelessness (not able to see a future) is another red flag.
- *"How do you see your future John?"*

☐Not worrying ☐Not Sure ☐Worrying
(← can see a future *vs* unable to see →)

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4. PATIENT FACTORS (PAMPi)

PSYCHIATRIC HISTORY

i. SUICIDE HISTORY

- Explore suicide and self-harming behaviours in self and in family. Begin with past 3 months.
- Attempts: number, when, method, lethality, rescues, etc.

☐Not worrying ☐Not Sure ☐Worrying
(← no history *vs* multiple life-threatening acts or a severe attempt→)

ii. DEPRESSION/ANXIETY

- Is there any of these co-existing in the patient? If so, how bad is it?

☐Not worrying ☐Not Sure ☐Worrying
(← normal affect *vs* severe depression→)

- Revisit feelings of HOPELESSNESS about the future? Red Flag: *"How do you see your future?"*

☐Not worrying ☐Not Sure ☐Worrying
(← can see future *vs* unable to see→)

iii. PSYCHOSIS

- Any symptoms or history of psychosis, delusions, auditory/visual hallucinations.
- Include dates, diagnoses, meds.

☐Not worrying ☐Not Sure ☐Worrying
(← no history *vs* severe delusions→)

ALCOHOL & DRUGS

- In self and in family members.
- Is patient currently using? If so, list substance(s), amount, and when taken.

☐Not worrying ☐Not Sure ☐Worrying
(← none *vs* heavy dependence→)

MEDICAL CONDITIONS

- Any medical conditions like a terminal illness - cancer, MND etc.
- Any new horrible medical diagnoses like Retinitis Pigmentosa, Pulmonary Fibrosis.
- Any medical conditions which cause chronic and severe pain? Disabling Rheumatoid Arthritis for instance.

☐Not worrying ☐Not Sure ☐Worrying
(← no history *vs* multiple co-morbidity→)

PERSONALITY & IDENTITY

i. BEHAVIOURAL:

- Do they tend to be impulsive, be emotionally labile, hostile, rage, etc.

☐Not worrying ☐Not Sure ☐Worrying
(← minimal *vs* extreme→)

ii. INTROVERTS vs EXTROVERTS

- Does the patient like to keep themselves to themselves; not many friends?
- (PS Both introverts & extroverts are at risk of depression and suicide. 1998 study says introverts at risk a bit more, though)

☐Not worrying ☐Not Sure ☐Worrying
(← extroverts *vs* introverts→)

iii. POOR COPING SKILLS

- For instance, talk of helplessness, negation of self and others.

☐Not worrying ☐Not Sure ☐Worrying
(← good coping skills *vs* poor coping→)

iv. IDENTITY ISSUES

- Any issues with sexual orientation or gender identity?

☐Not worrying ☐Not Sure ☐Worrying
(← no issues *vs* sexual orientation/gender issues→)

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5. SOCIAL FACTORS (SSS)

A good support network can be a strong protective factor against suicide. Therefore, it is essential to slow down and work out what a patients social support network is like.

STRESSORS

- Explore situation or recent changes with family, relationship, job, school, health, divorce, marriage, grief, losses, money, gambling & debt, involvement with the justice system, residential instability, bullying, etc.

☐Not worrying ☐Not Sure ☐Worrying
(← few stressors *vs* many stressors→)

SUPPORT SYSTEM

- A good support system, like living WITH a caring and loving family, is more protective than someone who is isolated and living alone. So, ask about family, friends, co-workers, roommates. Define relationships.

☐Not worrying ☐Not Sure ☐Worrying
(← supportive contacts *vs* no support→)

SPIRITUAL & CULTURAL

- Explore a person's attitude towards suicide - acceptance, ambivalence, rejection?
- Explore their cultural views on death and suicide - acceptance, ambivalence, rejection?
- Explore their spiritual views: Belonging to a faith can be protective.

☐Not worrying ☐Not Sure ☐Worrying
(← belonging to society *vs* no place in society→)

MAKING A CLINICAL JUDGEMENT ABOUT THE LEVEL OF SUICIDAL RISK

Remember: This suicidal risk assessment tool can be used as an aid to suicide risk assessment, but it should not be used as a substitute for a thorough clinical psychiatric evaluation. Therefore, this tool is intended to help behavioural health professionals conduct a comprehensive assessment by stimulating an enhanced line of questioning.

1. SLOW DOWN AND BUILD A TRUE PICTURE

- Slow down and think over the above 5 things. Build a story as you journey through the different areas.

2. HIGHLIGHT THE WORRYING vs PROTECTIVE THINGS

- Try and highlight things that worry you and compare to the things that don't worry you.
- The following table might help you by identifying risk factors and factors offsetting mitigating identified risks. Get a blank sheet of A4 and fold in half. Consider the RISKS on one side and OFFSETS on the other.

WORRYING THINGS (RISKS)	NOT WORRYING/PROTECTIVE THINGS (OFFSETS)
Especially note… *Strong feelings of guilt* *Strong feelings of hopelessness*	*Especially note…* *good support from family/friends*

3. MAKE A JUDGEMENT

- Having considered the above and using your clinical judgment, what do you think the risk of suicide is?
- Only 3 things to consider:

☐Low ☐Med ☐High

4. ACTION

- Now consider what action needs to be taken. One of 4 things:

☐ Nothing – as low risk
☐ Medication, Crisis Plan & Follow Up/Referral
☐ Admit to the hospital voluntarily
☐ Admit under section

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This page is left intentionally blank for you to make your notes…
Continue below to read further guidance notes

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GUIDANCE NOTES - please read

Most experts note that suicide is almost impossible to predict. There is no test both sensitive enough to identify most people who will go on to kill themselves and so accurate that it will not falsely predict suicide for many others. The difficulty predicting death from suicide is due in large part to the relatively low incidence of completed suicide in the general population, combined with the unacceptability of false negative predictions. Fortunately, approximately 80% of suicidal individuals appear to give some indication of their intention, and thus present opportunities for intervention, assessment, and treatment. Crisis intervention is essential in the prevention of both potentially fatal and non-life-threatening suicide attempts (also referred to as parasuicidal behavior). In large part this is due to the fact that the suicidal urges are frequently acute in duration, ranging from minutes to days. The assessment of acute suicide risk is a subjective clinical judgment based on a review of the known risk factors (both aggravating and mitigating), current intent and planning, prior history of suicidal thought/behavior, and current emotional state. Most individuals will reveal suicidal thoughts/urges in response to direct questions. In fact, there is some evidence that suicidal patients often hope to be asked about their suicidal intentions. There is no evidence that, when asked in a progressive, professional, and sensitive manner, asking direct questions about suicidal ideation implants thoughts of suicide in otherwise non-suicidal individuals. Although most suicidal individuals are depressed, most depressed individuals are not suicidal. For this reason, depression alone is a poor predictor of suicide risk. A sense of hopelessness, loss of control, and anger are some other important clinical predictors of risk and should be assessed with direct questions. In particular, the degree of hopelessness should be assessed. Effective questions may include "Have you had thoughts of hurting or killing yourself?" or "Are you having thoughts of hurting yourself now?" If suicide ideation is present, the existence of a specific plan should be assessed. The more specific and detailed the plan, the greater the danger. Effective questions may include "What have you thought of doing?" or "Have you tried to hurt or kill yourself in the past? When? How?" The clinician should never agree to keep suicidal threats or plans confidential. Rather, they should take whatever steps are necessary to prevent the individual from self-harm. High-risk individuals should never be left unsupervised for any period of time and should be monitored constantly.

Impaired judgment is another factor and can result from depressive, psychotic, or substance abuse related conditions. The availability and degree of psychosocial support is a further consideration.

Note Keeping

Due to the significant risk of claims against the professionals following a completed suicide, sound record keeping is essential, particularly in regard to treatment rationale and the assessment and management of risk. All contacts with the patient (e.g., phone calls, correspondence, etc) must be included. The response to any non-compliance (e.g., failed appointments, refusal to take medications as prescribed, refusal to accept treatment recommendations, etc.) must also be documented fully. Documentation of collaboration with others is an essential element of both effective treatment and risk management. Finally, the record should include evidence that the risks associated with suicidal urges, the underlying psychiatric disorders, and treatment interventions have been adequately explained to the patient.

During the evaluation of new or existing persons/behavioural health recipients, persons conducting assessments should follow the six steps outlined below in assessing suicide risk:

1. Conduct a thorough assessment,
2. Specifically inquire about suicide,
3. Determine the extent of suicidal ideation,
4. Assess lethality and determine level of risk,
5. Determine if a Crisis Plan exists, and
6. Complete a Next Steps Interim Service Plan or Crisis Plan to ensure the safety of the person/behavioural health recipient.

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1. Conduct a thorough assessment

- Previous or current medical diagnoses and treatments, including surgeries or hospitalizations, medications;
- Previous psychiatric diagnoses and treatments, including illness onset and course, psychiatric hospitalizations, medications, as well as substance use disorders;
- Current signs and symptoms of psychiatric disorders with particular attention to mood disorders (primarily major depressive disorder or mixed episodes), schizophrenia, substance use disorders, anxiety disorders (including post traumatic stress disorder (PTSD)), and personality disorders (especially borderline and antisocial personality disorder);
- Family history of mental illness, including substance abuse and suicide;
- Acute psychosocial crises and chronic psychosocial stressors, which may include actual or perceived interpersonal losses, financial difficulties, or changes in socioeconomic status, family discord, domestic violence, and past or current sexual or physical abuse or neglect;
- Employment status, living situation (including whether or not there are infants or children in the home), and presence or absence of external supports;
- Family constellation and quality of family relationships;
- Cultural or religious beliefs about behavioural health issues;
- Coping skills;
- Past responses to stress (including prior suicide attempts); and
- Ability to tolerate psychological pain and satisfy psychological needs.

All persons should be assessed for risk of harm towards self or others. Any person who shows evidence of depressed mood, anxiety, or substance abuse should be specifically assessed for suicidal risk. Because one interview may not be sufficient, screening should continue over a series of visits whenever possible, and risk should be re-evaluated regularly.

The goal is always to ensure the safety of the person.

2. Specifically inquire about suicide

Asking persons/behavioural health recipients about suicide will not give them the idea or incentive to commit suicide. Most who consider suicide are ambivalent about the fact and will feel relieved that the behavioural health professional is interested and willing to discuss their ideas and plans. Unfortunately, not all persons/behavioural health recipients are forthcoming about psychiatric symptoms and thoughts of suicide; therefore, it is recommended that assessors make an introductory statement followed by specific questions, and ask follow up questions to indirect statements of suicidal intent.

In assessing the current presentation of suicidality, behavioural health professionals/assessors should evaluate the following:

1. Suicidal or self-harming thoughts, plans, behaviours, and intent;
2. Specific methods considered for suicide, including their lethality and the patient's expectation about lethality, as well as whether the means are accessible;
3. Evidence of hopelessness, impulsiveness, panic attacks, or anxiety (including PTSD);
4. Reasons for living and plans for the future;
5. Alcohol or other substance use (type, recency, frequency); and
6. Thoughts, plans, or intentions of violence toward others.

It is also important to inquire about previous suicide attempts, aborted attempts, or other self harming behaviours, as well as to determine if there is a family history of suicide or suicide attempts, as those are two of the risk factors most strongly correlated with predicting suicide risk.

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3. Determine the extent of suicidal ideation

Suicidal ideation is having thoughts of suicide or of taking action to end one's own life. Suicidal ideation includes all thoughts of suicide, both when the thoughts include a plan to commit suicide and when they do not include a plan. If suicidal intent is expressed or discovered, persons conducting assessments should probe further to specifically investigate the onset and duration of suicidal ideation.

- When did thoughts of suicide begin?
- Did any event (stressor) precipitate the suicidal thoughts?
- How often do suicidal thoughts occur?
- What makes the person feel better (i.e., contact with family, use of substances)?
- What makes the person feel worse (i.e., being alone)?
- Does the person have a plan to end his/her life?
- How much control over his/her suicidal ideas does the person have?
- What stops the person from killing him/herself (i.e., family, religious beliefs)?

When determining the level of risk, the use of a Likert scale is recommended. A Likert scale uses survey questions where respondents are asked to rate the level at which they agree or disagree with a given statement in order to measure attitudes, preferences, and subjective reactions.

For example: *"I experience suicidal thoughts often."*

Strongly Disagree *Strongly Agree*

1 2 3 4 5 6 7 8 9 10

The person conducting the assessment should ask follow up questions to determine what that number signifies to the individual; for example, "On a good day, how would you rate yourself?"

4. Assess lethality and determine level of risk

Plan

If the person has identified a plan, what are the specific methods considered? Culture and gender play an important role. For example, in some cultures, the subject of death is taboo and not discussed. Additionally, some methods may be more prevalent among a particular culture or population. Males typically choose more lethal methods, such as the use of firearms; on the other hand, females most commonly overdose on medications. It is crucial that persons conducting the assessment approach this portion of the interview with care and sensitivity.

Avoid bringing your own belief system into the situation. Take caution to prevent instilling any feelings of guilt. Try to identify what the meaning of this act would be to this individual.

Lethality

Possible follow up questions include:

1) How far did you get with your plan? (For example, has the person "practiced" by holding the gun to his/her head or the medications in his/her hand?)
2) Have you considered the outcome of your suicide? or What would it be like if you were dead? (For example, has the person imagined their funeral? How people will react to his/her death?)
3) Have you made any specific arrangements? (For example, has he/she given away possessions, changed a will or life insurance policy, gone to confession or sought spiritual counsel, or spoken to friends about plans?)

Accessibility

Examples: Does he/she own a gun or have access to firearms or any other potentially lethal weapon? Is there access to potentially harmful medications or illicit drugs?

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5. Determine if a Crisis Plan exists

If an individual has established an At-Risk Crisis Plan (also referred to as a crisis plan or safety plan) in the past, care should be taken to identify the plan and ensure that guidelines are followed. For example, the assessor or dispatcher should ask: "Have you developed a safety plan?" Individuals that work closely with at-risk persons who have identified plans should be aware of the person's individualized safety plan. If the person is a behavioural health recipient, this should be referenced in the Interim Service Plan.

6. Complete a Next Steps Interim Service Plan or Crisis Plan to ensure the safety of the person/behavioural health recipient

The goal is to ensure the safety of the individual. In the context of a crisis call taken via telephone, if the person indicates that he/she does not feel safe, initiate the most appropriate action(s):

(1) engage the individual further to determine if you can de-escalate the situation,
(2) ask to speak with a family member or significant other in the home in order to enlist their assistance in keeping the individual safe until additional support arrives,
(3) ask the family member or significant other to transport the individual to the nearest crisis centre for additional evaluation, or
(4) discontinue the assessment and immediately dispatch a mobile crisis response team.

The immediate need is to get the person to a safe place.

At minimum, all staff should be knowledgeable about the following:

1. Signs and symptoms for suicide risk,
2. Indirect cues/requests for help,
3. Sensitivity to callers in crisis/cultural competence,
4. Identifying the existence of a safety plan,
5. Referral procedures specific to the agency, and
6. Local resources for assistance.

END OF DOCUMENT

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