

# **SUICIDE RISK ASSESSMENT**

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## **BACKGROUND**

Attempted suicide by overdose or injury is a frequent presentation to the ED and a common cause of admission. The incident may result from a mood disorder such as major depression or it may be secondary to other medical or psychiatric illnesses, or the effects of drugs or alcohol. Alternatively the act may have been precipitated by a domestic or relationship crisis ('cry for help'), or there may be some other secondary gain. The patient's intentions should not be inferred solely by the apparent seriousness of the attempt.

## **CLINICAL ASSESSMENT**

Patients should be nursed in an environment safe from medications, needles, razors and other potential weapons, and they should be relieved of any such items about their person. They should be observed closely pending formal assessment and should be accompanied whenever they leave the clinical area (bathroom, smoking area etc). If the patient is deemed to present a significant risk to themselves or the public they should be persuaded/prevented from leaving the clinical area by appropriate means (Cross -reference: *Agitated Patient*).

Initial assessment and resuscitation (if necessary) is followed by a thorough history and physical examination. A family history of psychiatric disorder is important. Note the prescribed drug history and question in respect of recreational drug and alcohol use. Social circumstances, including personal debt and criminal charges are additional risk factors.

Observe for symptoms and signs of any chronic disease, which may significantly increase suicide risk. Routine investigations and special tests may be indicated to confirm or quantify any suspected organ failures. Routine determination of Paracetamol and Salicylate levels is advisable. Family members, ambulance personnel and the patient's GP may provide other important background information.

Perform a mini mental state examination (Cross- reference: mental state examination)

## **MONITORING, REFERRAL, DISPOSAL**

Options include discharge home (rarely appropriate during the first 12 hours). Refer all children and adolescents to the paediatric service. Adults may be disposed in accordance with the Modified SADPERSONS scale score, below. Patients who are uncommunicative should be admitted to the Critical Care Unit or Observation Ward as appropriate, where further monitoring and treatment, including antidotes, will be determined by the patients condition. Routine psychiatric review is advisable, once the patient is able to communicate and before discharge.

## MODIFIED SADPERSONS SCALE

<u>Pnemonic</u>	<u>Score</u>	<u>Characteristic</u>
S	Sex 1	Male
A	Age 1	<19 or >45
D	Depression, hopelessness 2	Admits to
P	Previous attempts/ Psychiatric care 1	Inpatient or out patient
E	Ethanol or drugs 1	History or clinical signs
R	Rational thought (loss of) 2	Organic brain syndrome, psychosis
S	Separated, widowed, divorced 1	
O	Organised, serious attempt 2	Or life-threatening presentation
N	No social support 1	
S	Stated future attempt 2	Or ambivalent

A score of < 5 indicates that the patient may probably be discharged  
 A score of 6 or more requires psychiatric consult  
 A score of > 9 means that the patient will require admission