Detailed risk assessment

Risk assessment is a fluid process that should be formulated individually using a biopsychosocial approach. Risk assessment is not a 'tick box exercise' and should be made in the spirit of genuine compassion and collaboration with the patient. Wherever risk is identified, this should be discussed within clinical supervision and, where appropriate, shared with other professionals involved in the patient's care (e.g. GP). Risk stratification of 'low', 'medium' and 'high' is no longer recommended.

See the NHS England full guidance '[Staying Safe from Suicide]'

Risk to self

If you identify a patient as being at risk, please gather answers to the following questions, where relevant:

Are you currently experiencing any thoughts of ending your life or harming yourself?

- What are the kind of thoughts you are experiencing?
- How often are you experiencing these thoughts?
- How long do these thoughts last for?
- How intense do the thoughts feel? Are they fleeting and passive, or dwelling and compelling?
- Are you able to dismiss the thoughts or distract yourself?

Have you made any plans to end your life/harm yourself?

- Have you chosen a method of ending your life? What have you thought about?
- Have you made a specific plan around when, where and what you would do?
- Have you researched any methods?

Have you taken any actions or made any preparations towards harming yourself or ending your life?

- Do you have access to, or have started collecting, the means to act on your thoughts? (Medication, rope, etc.)
- Have you started making any preparations for ending your life or putting your affairs in order? (Writing letters, sorting financial affairs, giving belongings away, etc.)

How likely is it that you will act on these thoughts?

- On a scale of 0-10 how likely is it that you will act on your thoughts? (0 = no likelihood, 10 = certainty)
- If they indicate intent to act, ask if they intend to act soon.
- Does this rating change? If so, how often? What makes it go up or down?

Have you attempted to end your life or harm yourself before?

- How many times?
- When was the last attempt? The time before that?
- What was going on at the time, what triggered the actions?
- Do things feel similar now?
- What did you do?
- Was it planned or impulsive?
- Did you seek help? Did you stop yourself? Or were you found or interrupted by someone?
- Did you receive any mental health input following this/these attempts?

Vulnerability factors

Is there anything going on for you right now or in the near future that could increase your risk of acting on your thoughts? (e.g. relationship end, unstable relationship, loss, homelessness, substance use, impulsive behaviour, stress/pressures at work, long-term health conditions esp. pain)

Think **Thomas Joiner** Interpersonal theory of suicide

1. Thwarted belongingness - “I am alone”
2. Perceived burdensomeness - “I am a burden”
3. Acquired capability - reduced fear of suicide and elevated physical pain tolerance

If you suspect all three ‘Thomas Joiner’ factors are present, regardless of whether the patient expresses current suicidal ideation or not, seek supervision immediately

Protective factors

- What stops you from acting on your thoughts?
- What do you feel the impact would be on those around you?
- Do you have a support network?
- Do you feel a part of a community/sense of belonging? (e.g. church, allotment, women’s group)
- Do you have a responsibility to look after others? (e.g. children, pets, neighbours)
- Do you have events you are looking forward to? (e.g., wedding, new job, baby, holiday)
- Do you feel it is okay to ask for help when you need it?

Hopefulness

- Do you feel things can get better or improve?
- How often do you feel like this? (often, sometimes, never)
- Have things been bad before and got better?

Deliberate self-harm

For full guidance see NICE recommendations

- Have you ever taken any action to deliberately harm yourself?
- How did you harm yourself? (e.g. cutting, burning, pinching, hitting)
- How severe were the injuries and where are they located?
- Did they need medical attention?
- How frequently do you self-harm?

- What are the triggers and warning signs?
- Is there anything that is still easily accessible you can remove to reduce the risk of future self-harm?
- What alternative coping strategies can you use to manage your distress?

Neglect

- Are you taking care of your personal hygiene?
- Are you eating regular meals?
- Is your weight within a healthy range?
- Are you getting enough sleep?
- Is your living environment safe?

Safeguarding

- Are there any children or vulnerable adults involved?
- What are their names, D.O.B and current living address?
- Are you or do you think you might be pregnant?

Do you currently feel able to keep yourself safe?

- Are they agreeable to a safety plan?
- If they are not able to agree to a long-term safety plan, can they agree to a short-term plan, while we try to get appropriate services involved?
- Is there anyone they can include in their safety plan?

Consent and reporting

Within a safeguarding context, consent is not required to share information if an individual is at risk of harm. While transparency is ideal, the duty to protect overrides confidentiality.

- **Seek supervision**: Always discuss risk concerns within supervision by raising a non-urgent risk task.

- **If risk is imminent do not delay taking action**. Take all relevant action then raise an urgent risk debrief task.
- **When to seek consent:** Always try to get consent from the individual before sharing information, provided it is safe and doing so does not increase the risk of harm.
- **Sharing without consent:** You can and should share information without permission if there is an immediate emergency, a risk of significant harm, a threat to life, or if seeking consent would put the individual or someone else at further risk.
- **Proportionality:** Only share what is strictly necessary, and only share it with the professionals or authorities who genuinely need to know.
- **Record your decisions:** Always document what information was shared, with whom, and the exact reasons for your decision. This applies regardless of whether you decided to share the information or withhold it.

Priority demographics from DHCSC Suicide Prevention Strategy (2023-28)

1. **MIddle aged men** - men in this demographic frequently present to primary care services with somatic physical complaints, social isolation or substance abuse rather than explicitly stating suicidal intent
2. **Neurodivergent individuals** - be wary of diagnostic overshadowing - attributing self-harm crisis behaviours simply to neurodivergence
3. **Children and young people** - consider impulsivity and heavy influence of digital environments
4. **People with a history of self-harm** - carry a higher statistical risk of suicide. Every new self-harm episode must be assessed rather than dismissed as repetitive
5. **Criminal justice system contact** - navigating criminal justice system or moving between secondary and primary care represent critical windows of vulnerability where there is a sudden drop in support
6. **Perinatal mental health** - suicide remains the leading cause of maternal death in UK during first postnatal year - direct referral to specialist perinatal mental health teams to be considered if pregnant or a new mother who presents with suicidal ideation. If referral to social care is required, explicitly reassure mothers that seeking help is a protective factor to keep families together. Sleep deprivation to also be considered as an escalating factor in this group.