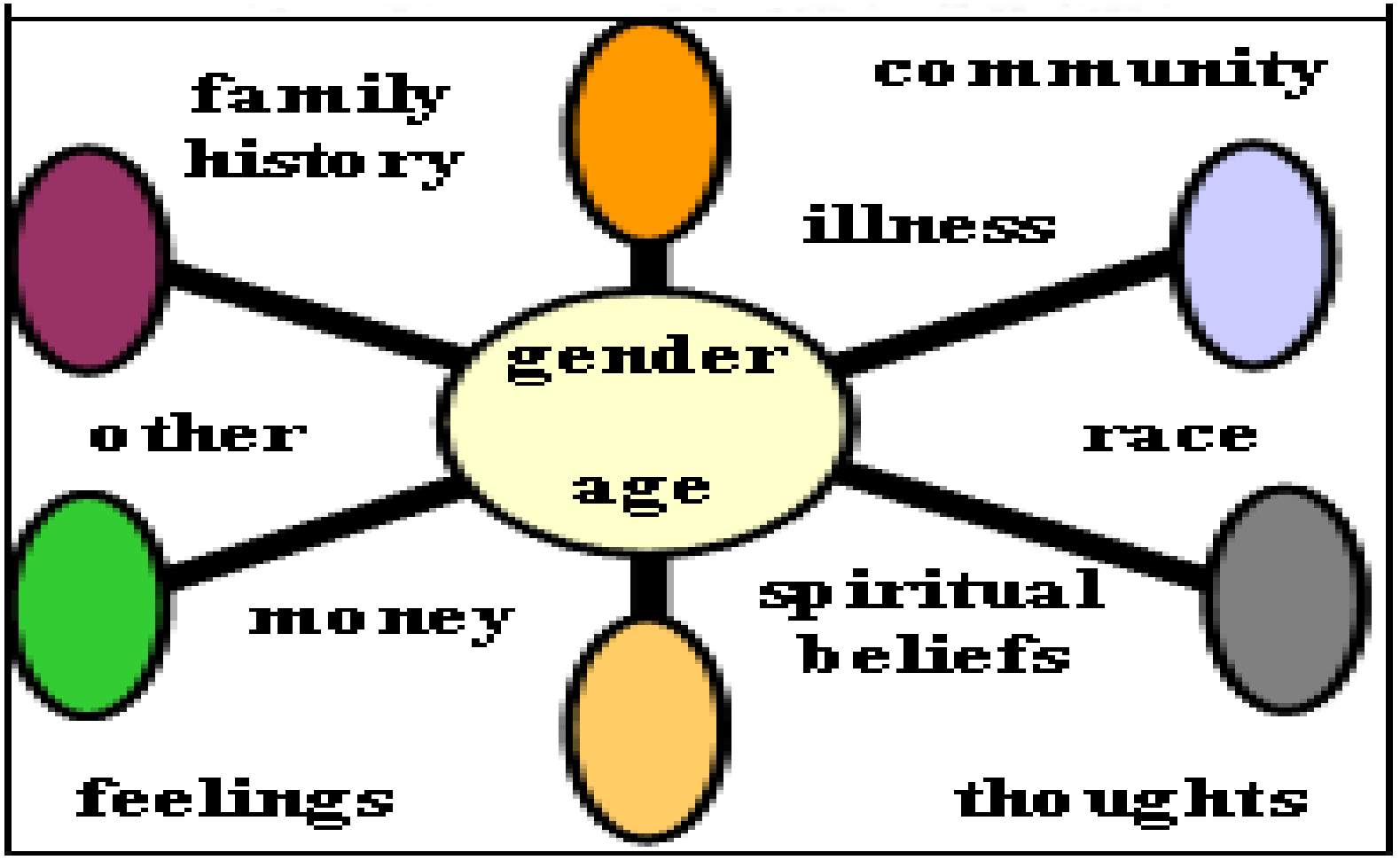
Comprehensive Mental Health Assessment



What is not Mental Illness

- The fundamental question of what is and what is not mental illness is “complicated and contentious”

  (Bloch,S. and Singh.,B).
- It is normal to experience emotions such as anxiety and sadness. Many of us would have experienced these emotions prior to an exam or following a relationship break up or for some, the loss of their sporting team in a Grand Final.

“Normal” vs. “Illness”

- There is no exact division between **normal** and **pathological**.
- Perhaps one way to conceptualise it is that when the symptoms become severe and persistent.
- Symptoms begin to interfere with a person’s ability to cope with personal relationships, work, environment, sleep, diet;
- It leads to personal distress for the client and for those close to them.

What is Mental Illness?

- Mental illness is a general term that refers to a group of illnesses
- An illness in which a persons thinking, feelings and behaviour become distorted and mixed up.
- It impacts across the biopsychosocial whole

Mental illness is…

a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom

DSM IV, 1994

Broad Categories of Mental Illness

- Psychotic disorders e.g. Schizophrenia
- Mood disorders e.g. Depression, Bi Polar Affective Disorder
- Internal disorders e.g. Generalised Anxiety Disorders
- Personality disorders

Some useful facts

- One in five Australians will experience a mental illness
- Episodes can come and go. Some people experience illness once, for others it recurs throughout their lives
- Most mental illnesses can be effectively treated or managed
- People who have an illness suffer considerably. They can experience rejection and risk being marginalised within the community

What causes mental illness?

- We don’t know, there are several factors
- Biological
- Psychological
- Social
- Biopsychosocial assessment
- Kaleidoscope of causes

The interweaving of typical bio-psycho-social factors with time – (Bloch,S. and Singh, B. p.36)

	Biological	Psychological	Social
Predisposing	Genes Mother's alcoholism Maternal health in pregnancy	Upbringing Parental strife Personality traits	Cultural demands Poverty migration
Precipitating	Trauma Infections Illicit drugs	Bereavement Exam failure Being jilted	Retirement Being robbed Stock market loss
Perpetuating	Malnutrition Poor sanitation Dependency on drugs	Bad marriage Conflict with neighbours Delinquent offspring	Demands at work Refugee status Financial obligations

The bio-psycho-social model of mental illness

- **Biological**
  - genes
  - brain structure
  - neuro-biology
  - drugs
- **Psychological**
  - personality development
  - emotional & interpersonal
  - meaning & purpose
- **Social**
  - life events & stressors
  - age & gender
  - culture & networks

Diagnosis of mental illness

- **DSM V – the current methodology used for diagnostic criteria for all metal health disorders.**

What is it?

The comprehensive mental health assessment is an important tool in assessing and evaluating a clients condition. The core features are:

- Conversation and observation
- Signs and symptoms
- Establish therapeutic alliance

AIM

- The assessment should culminate in a summary of the facts and a formulation of clear treatment goals and plans.
- If possible, they are discussed with and are acceptable to the client and family/carers.

Engagement

- The process of assessment strengthens engagement and engagement is essential for effective assessment.
- Through the process of engagement the clinician and the client develop a therapeutic alliance.
- Therapeutic orientation is not as important as the therapeutic relationship.
- The therapeutic relationship is central to all stages of the continuum of care from assessment through to referral and follow up.

Introduction to client

- Establish rapport with the client.
- Collect basic demographics and state purpose of interview
- Provide a safe environment

A Comprehensive Assessment

The key components of a Comprehensive Assessment include:

- History
- Psychosocial/developmental and personal history
- Mental State
- Cognitive Assessment
- Substance Use
- Medical/Biological – physical assessment
- Risk

History

- History of present illness
- Psychiatric history and medical history
- AOD
- Psychosocial/Developmental History (Personal History)
- Social History
- Family History

Psychosocial / developmental history

Gather their story –

- What is their current living situation?
- Who are their supports?
- Where did they grow up?
- How would they describe their childhood?
- Is their a history of trauma – what type?
- Educational achievement
- ETC.

Social History

- Current situation
- Family
- Work
- Finance
- Friendship groups
- Hobbies - interests

Family History

- Genogram
- Attitude to family – how do they see themselves within the family group
- Quality of relationships and contact with family
- History of mental illness
- History of suicide in other family members

THE MENTAL STATE EXAMINATION

Why do a MSE?

- Provides baseline information regarding a person's mental state at the time of interview
- Helps identify who may need a more comprehensive psychiatric assessment
- To assist with diagnosis
- To guide interventions
- To evaluate patient's progress
- To inform the risk assessment
- To support discharge planning
- Structured approach to understanding the psychological state of patients

When do Nurses Conduct am MSE?

- On admission – scheduled and structured and systematic data gathering
- Ongoing assessment and evaluation – structures and informal
- During crisis – structured and focussed.

Mental Status Examination

The mental state examination is recorded under the following headings:

- Appearance and behaviour
- Rapport
- Speech
- Mood
- Affect
- Thought
- Perception
- Cognition
- Insight

Appearance and behaviour

Ideally, this should provide a detailed description of the patient, which evokes a clear image in the mind of someone who subsequently reads the notes.

Appearance and behaviour

- Physical characteristics- hair and eye colour, ethnic origin, stature and posture.
- Facial characteristics- e.g. furrowing of brow, tear-rimmed eyes facial expression and eye contact.
- Overall quality of appearance- kempt or unkempt, personal hygiene standards (including body odour)
- What is the general behaviour of the patient- is there disinhibition, psychomotor retardation, any sign of response to hallucinatory experiences.
- What is the patient's response to the strange situation of the interview?

Appearance and Behaviour

- Physical appearance
    - e.g.. grooming, hygiene, clothing
- Motor behaviour
    - e.g. agitation, repetitive behaviour tremors, restless
- Reaction to situation
    - hostile, friendly, withdrawn, uncommunicative

Rapport

This is a measure of the quality of the interaction between the patient and examiner.

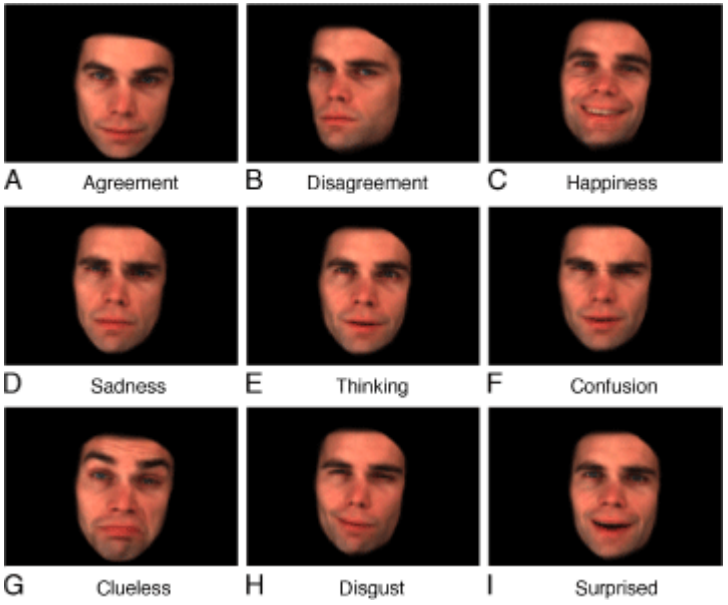
- Instead of simply commenting on whether or not rapport is present, it is helpful to describe the actual characteristics of the interaction and how it changes throughout the interview.
- Comment on any suspiciousness, hostility or inappropriate ‘chumminess’.
- It is normal for there to be a degree of anxiety in any initial interview.
- Rapport may be improved when the parents leave the room.

Speech

- Relates to the physical aspects :
  - rate
  - volume
  - quantity of information supplied
- For example
  - mutism
  - poverty of speech
  - pressured speech

Mood

Mood is the internal feeling or emotion as expressed by the person.



Assessing Mood

Margot Case Story.mpg

Affect

Affect is the external emotional response

- Observed by clinicians.
- Normal
- Restricted - decrease in intensity and range of emotional expression
- Blunted - severe decrease in intensity and range

Form of Thought

- **Assessed by what the person says and how they say it**
- Amount of thought produced
    - poverty of thought, flight of ideas
- Continuity of ideas
    - logical flow of ideas, ability to stick with the topic
    - circumstantial, tangential, thought blocking
- Disturbances in language
    - use of words that do not exist or incoherent conversations
    - neologisms, word approximations

Thought Content

Delusions - fixed false beliefs

- e.g.. persecutory, referential, religious, nihilistic, grandiose

- Suicidal thoughts
- Preoccupations
- Hypochondriacal symptoms
- Phobias

Illustration for Phillip Adams in Weekend Magazine on hypochondria

Perception

Under this category any abnormalities in the way in which the patient perceives the world is recorded.

A hallucination is defined simply as a ‘percept in the absence of a stimulus’

Cognition

- A basic cognitive test involves establishing whether the patient is orientated in time, person and place.
- More complicated testing methods are available to try and establish the nature or the degree of any cognitive impairment.
- These include the ‘mini mental state examination’

Sensorium and Cognition

- Level of Consciousness
- Memory
- Orientation
- Concentration
- Abstract thoughts
- Judgement

and

Insight - the individuals awareness /understanding of their situation

Insight

- **It is usually insufficient to say 'insight is absent or present**
- **It is more helpful to describe the following:**
  - **Does the client think they are ill?**
  - **Do they think they have a mental illness?**
  - **Do they think they need treatment?**
  - **If so do they accept treatment?**
  - **If they don't think they are ill but accept treatment why do they do this?**
- **Just because someone refuses treatment does not mean they have no insight.**

Substance use assessment

Why do we need to know ?

- To determine a baseline for each individual person
- To ensure that each person receives appropriate interventions to achieve their best

AOD Assessment

Substance Groups

1.Stimulants

- Amphetamines
- Caffeine
- Cocaine
- Nicotine

2.Sedatives

- Alcohol
- Opioids
- Benzodiazepines
- Inhalants
- Cannabis

3.Hallucinogens

- **LSD**
- **Cannabis (large doses or strong preparations)**

4. Poly-substance

Substance Related Disorders: Intoxication

- A reversible substance-related syndrome which occurs due to recent intake of a high dose of a substance

Substance Related Disorders: Abuse

Substance use at a level which leads to:

- Failure to fulfil obligations
- Risk to safety of self or others eg.drink driving
- Legal problems
- Social and interpersonal problems

Substance Related Disorders: Dependence

Maladaptive pattern of use leading to significant impairment or distress including tolerance & withdrawal symptoms (physical)

- Use increases over time
- Unsuccessful attempts to cut down
- Time spent on substance related activities increases, other activities decrease
- Use continues despite persistent health risks
- **Critical issue is loss of control over use**

Substance Related Disorders: Withdrawal

- Manifestation of dependence
- Substance-related syndrome occurring after cessation or reduction of that substance after prolonged or heavy use
- Clinical picture is commonly the reverse of the drug effect
  e.g. Sedative withdrawal features agitation, anxiety, tremor, sweating

What do we need to know?

- Type of drug
- Frequency of use
- Average daily intake – no. injections/day
- Duration of this episode, time and date of last use.
- What happens when you stop?

Why do we need to do?

- Withdrawal management
- Adequate pain management
- Continuation of Substitution Maintenance Therapies (nicotine, methadone and buprenorphine)
- It can be an opportunity for change
- Assessment is part of assessment of overall health status

How do we ask?

- Start with legal drugs – alcohol, cigarettes
- Ask in context of lifestyle questions
- Maintain your sense of humour/adopt a non-judgmental attitude
- Explain these issues may impact on treatment and that you want to ensure the patients safety and appropriate treatment

Physical Health Assessment

Margot Franklin – Albury Wodonga Health

with thanks to kah-Seong Lok in preparing this presentation

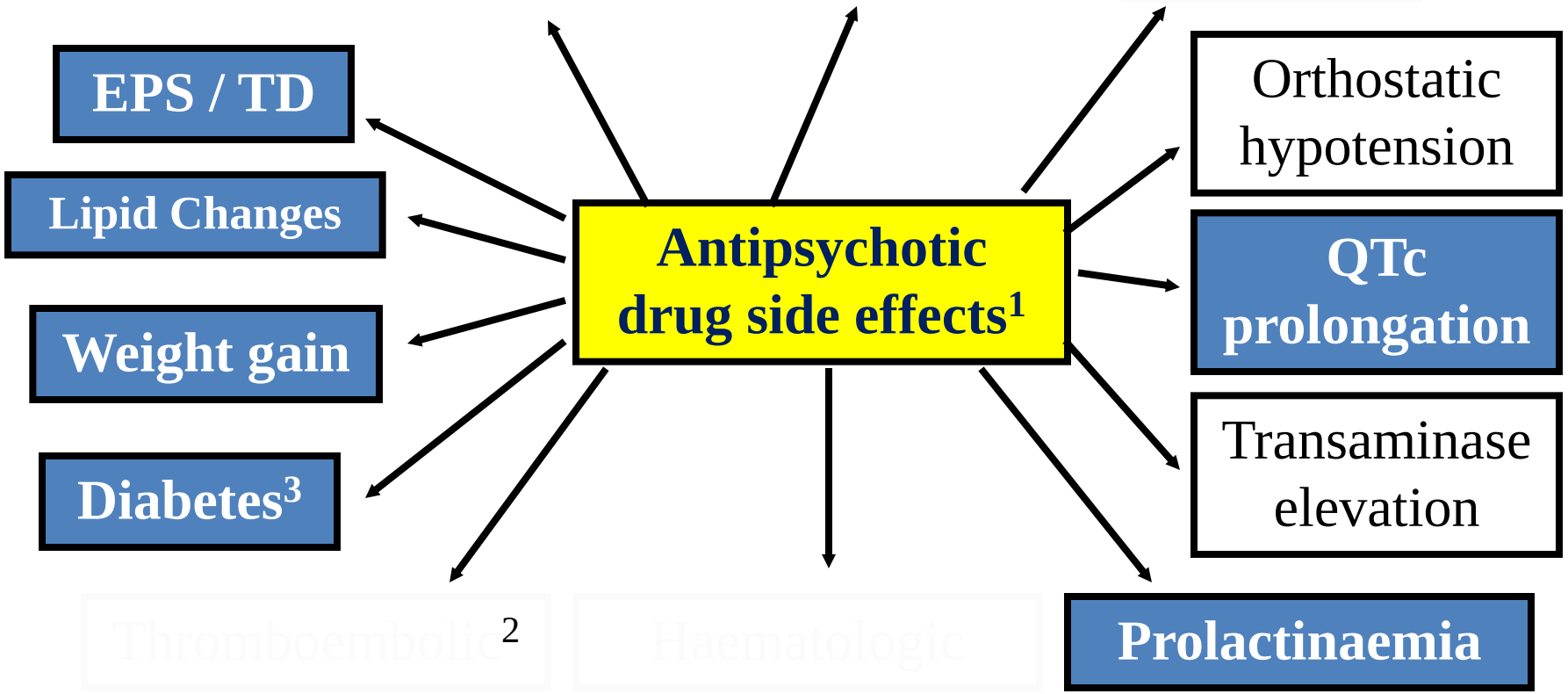
Outline

- Why do we need to do a physical assessment?
- What are we looking for in each component of the physical assessment?
- What investigations do we perform and why do we do them?

Issues for the Mentally Ill

- Disorganised lifestyle
- Poverty
- Stigma
- Lack of motivation
- Lack of social support
- Substance abuse
- Complex medication regimens
- Separation from medical services

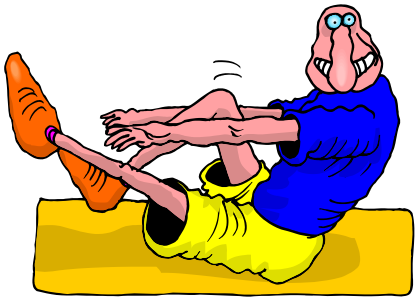
Main Side Effects Associated With Antipsychotic Drugs

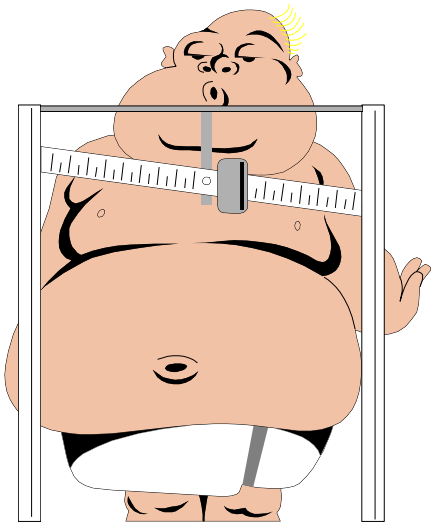


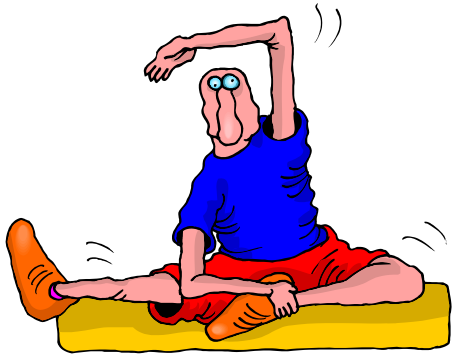
Atypical Antipsychotics and Increased Cardiovascular Risk

- Weight Gain
- Changes in Lipid Profiles
- Impaired Glucose Tolerance
- Insulin Resistance
- Type 2 Diabetes

Weight Gain

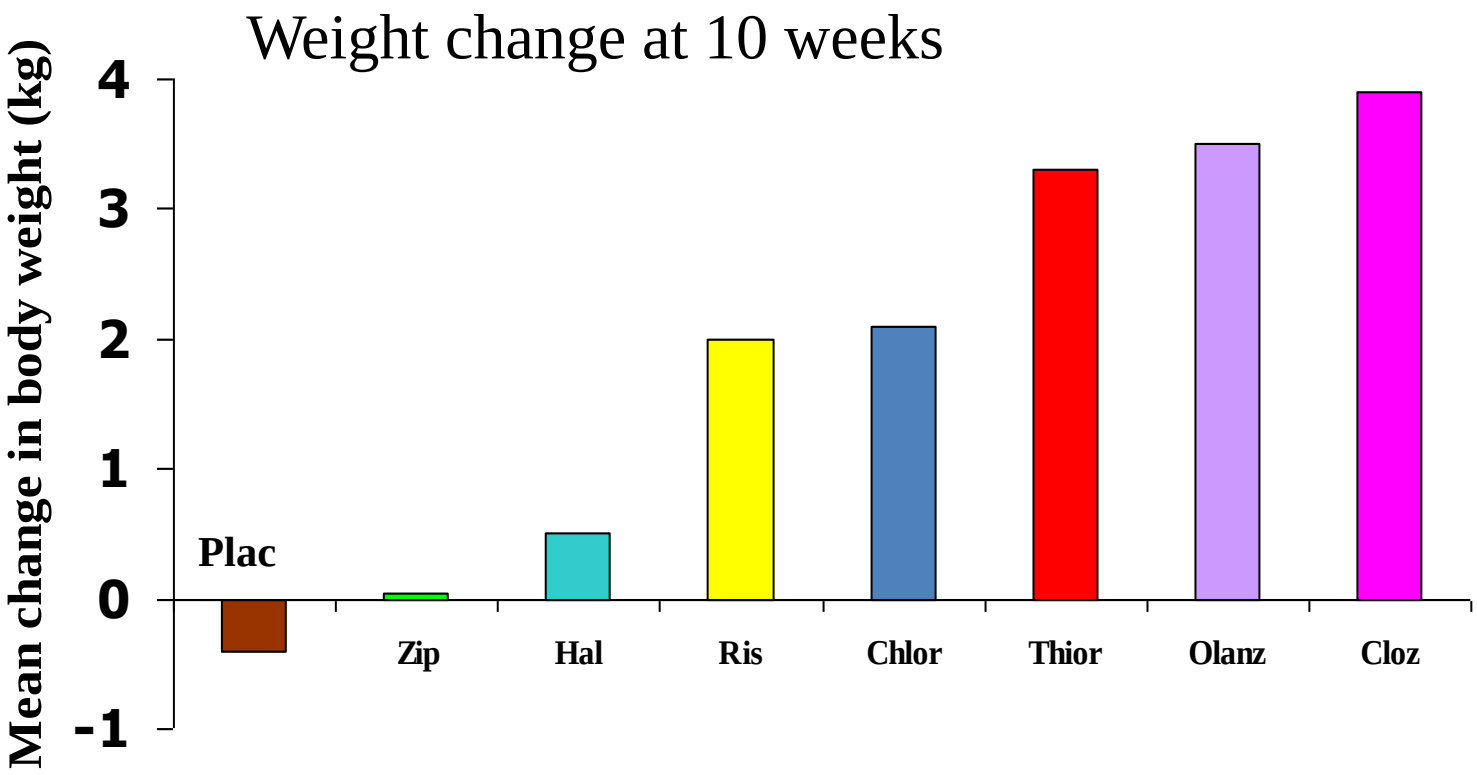






- There is an increasing obesity epidemic in the general population
- Patients with schizophrenia pre-treatment had increased weight.. Why

Antipsychotics and Weight Gain



Risp plateau 3/12

cloz plateau 48/12

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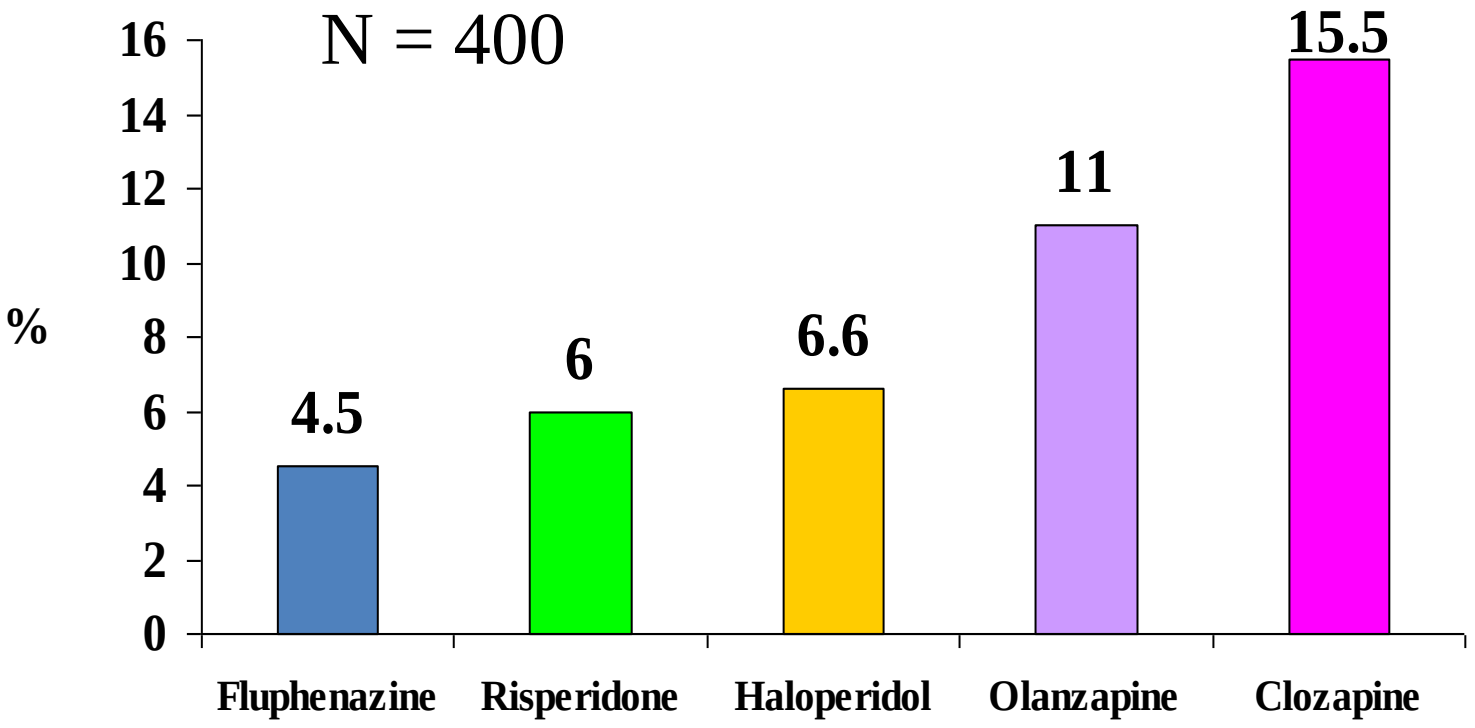
Antipsychotics and Lipid Changes

- Increases in total cholesterol and plasma triglycerides
- Significant differences between atypical antipsychotics
- Fasting measurements of up to 12 months' duration

Lipid profile

	Reference Range	
Cholesterol	< 5.50	mmol/L
Triglyceride	0.5 - 2.0	mmol/L
HDL-Cholesterol	1.0 - 1.6	mmol/L
LDL-Cholesterol	0.5 - 3.0	mmol/L
LDL/HDL	0.5 - 3.0	ratio

Prevalence of Type 2 Diabetes in Patients Receiving Antipsychotics



Conventional Antipsychotics and Diabetes

- Patient group is already at risk prior to antipsychotic treatment
- Higher rates with low potency antipsychotics
  - especially phenothiazines, e.g. chlorpromazine
- Lower rates with high potency antipsychotics
  - e.g. haloperidol

Atypicals and Diabetes

- **Type 2 Incidence**
  - Clozapine: 12% - 36%
  - Olanzapine: 6% - 35% (Lilly data base 3.1%)
  - Reported with and without weight gain

- **Risperidone and quetiapine**
  - Limited observations linking these drugs with diabetes

Managing At-Risk Mentally Ill Patients

- Prevent
- Screen and monitor risk factors
- Motivate patient and carers
- Advise on diet and lifestyle
- Treat DM and all other risk factors
- Establish links with other services

Clinical Assessment

- Assess for risk factors
- Baseline measures
    - fasting glucose, lipid profile, weight, BMI
- Are they on a high risk antipsychotic?
- Monitor those at high risk
- Ensure an adequate antipsychotic trial before switching, ie 12 weeks

Psycho-education

- Patients and families
  - Metabolic risks starting/continuing antipsychotics
  - Weight gain, diabetes, diabetic ketoacidosis
  - Need for exercise, dietary control

Vital signs

- Blood Pressure
  - 120/80 mmHg
  - >140/90 mmHg
  - Postural drop: >15 mmHg systolic, > 10 mmHg diastolic
- Pulse
  - 60-100 bpm, regular
- Respiratory rate
  - 12-20 bpm
- Temperature
  - 36.6 – 37.2^{o}C (hot weather - 0.5^{o}C higher)
  - Axillary (0.5^{o}C) < Oral (0.2^{o}C) < Rectal
  - Diurnal variation (A.M. -> 6-10 P.M.)
  - Elderly – “colder”

Body Mass Index

- BMI = $\frac{\text{weight (kg)}}{\text{height (m)}^2}$
  - e.g. Pt weighs 98.5 kg, Height 1.76 m
  - BMI = 98.5 ÷1.76 ÷1.76 = 31.8 (3 significant figures)

Underweight	below 20
Acceptable weight	20 – 25
Overweight	25 – 30
Obese	30 – 35
Morbidly obese	above 35

- A 'healthy weight range' can be defined as the body weight, adjusted for height, which is associated with *longest high quality life expectancy.*
- BMI does not give a direct measure of adiposity. *Abdominal adiposity* is of concern as it has been associated with dyslipidaemia, hypertension and Type 2 diabetes mellitus.

Medication Monitoring:

Clozapine Protocol

- FBE – WCC and neutrophils(NB), Group
- Cardiac Workup..troponins/ECG/? Echocardograph/CK levels
- weekly, bloods for 18/52 then monthly ECG
- Echocardiogram at 6/52 and 12/12 thereafter

Medication Monitoring:

Lithium Monitoring:

Prior to commencement:

FBE

Ongoing:

Weekly FBE and lithium levels. (Therapeutic levels are very close to toxic levels). Serum Lithium is monitored 12 hours after last dose

Therapeutic Range is 0.5-1.0 ummol/l

If they become ill/ dehydrated/disorientated levels need to be assessed asap

Medication Monitoring:

Sodium Valproate Monitoring

Prior to commencement:

FBE, with

Ongoing:

Weekly FBE and valproate levels for 4-6 weeks , then monthly.

Serum Valproate is monitored 12 hours after last dose

Therapeutic Range is 350-700ummol/l

If they become ill/ dehydrated/disorientated levels need to be assessed asap

Nursing Assessment

- Health history
- Physical exam
- **Remember to: Look, Listen and Feel**

Nursing History

- Patient profile – height, weight, vital signs
- Current medical issues
- Past history
- Family history
- Medications
- Allergies
- Review of systems

Pain

- Location
- Length of time
- Severity
- Quality

General Survey

- Age, sex, race
- Body build, height, weight
- Posture and gait
- Hygiene and grooming
- Signs of Illness
- Affect
- Cognitive Processes

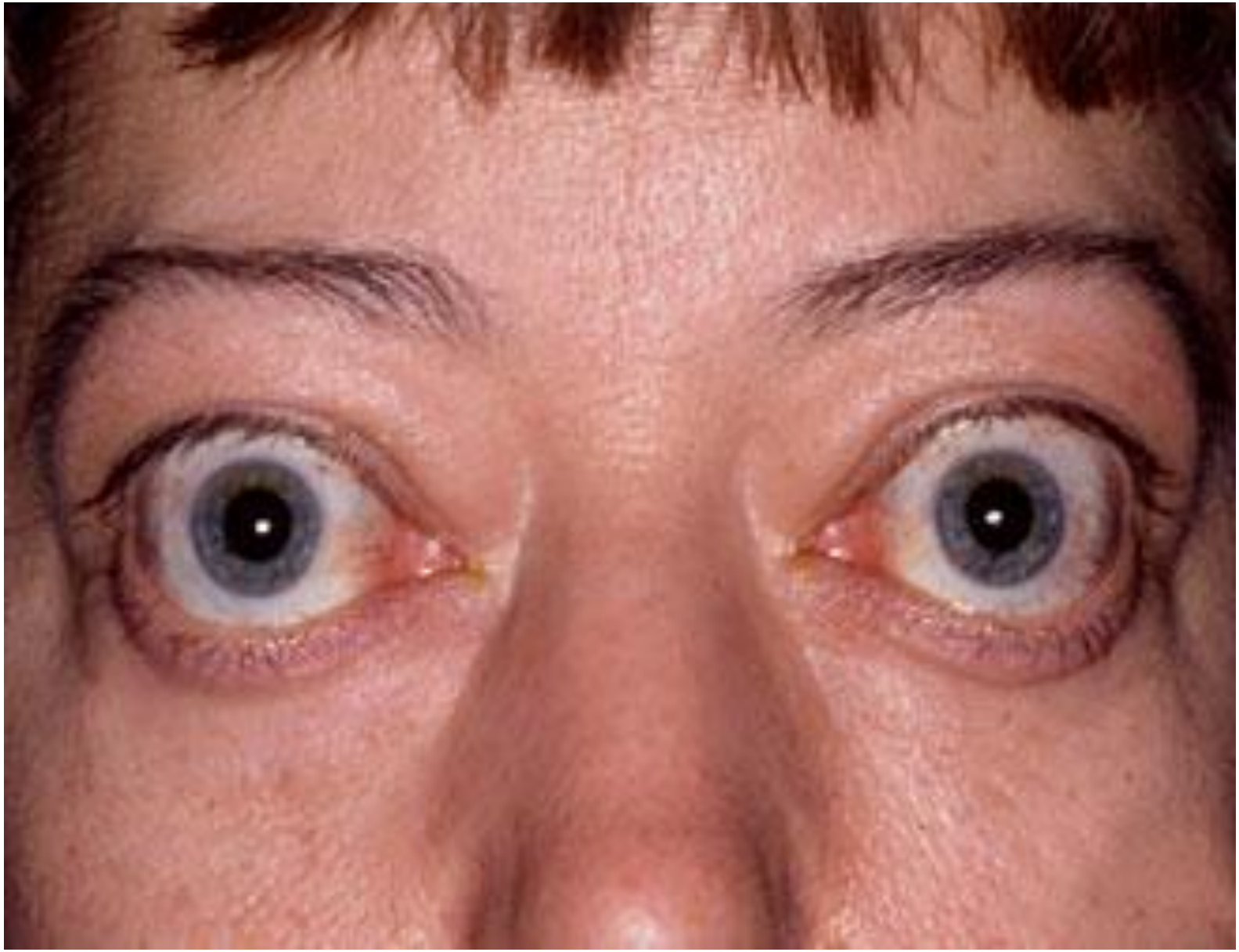
Skin

- Color
- Vascularity
- Lesions
- Temperature
- Turgor
- Texture
- Wounds

Head and Neck

- Inspect scalp and hair
- Facial Symmetry
- Eyes – color, pupil size
- Ears
- Inspect Nose
- Inspect Mouth/teeth

- Neck
  - ROM
  - stiffness



Poor Oral Hygiene

Chest: Lungs

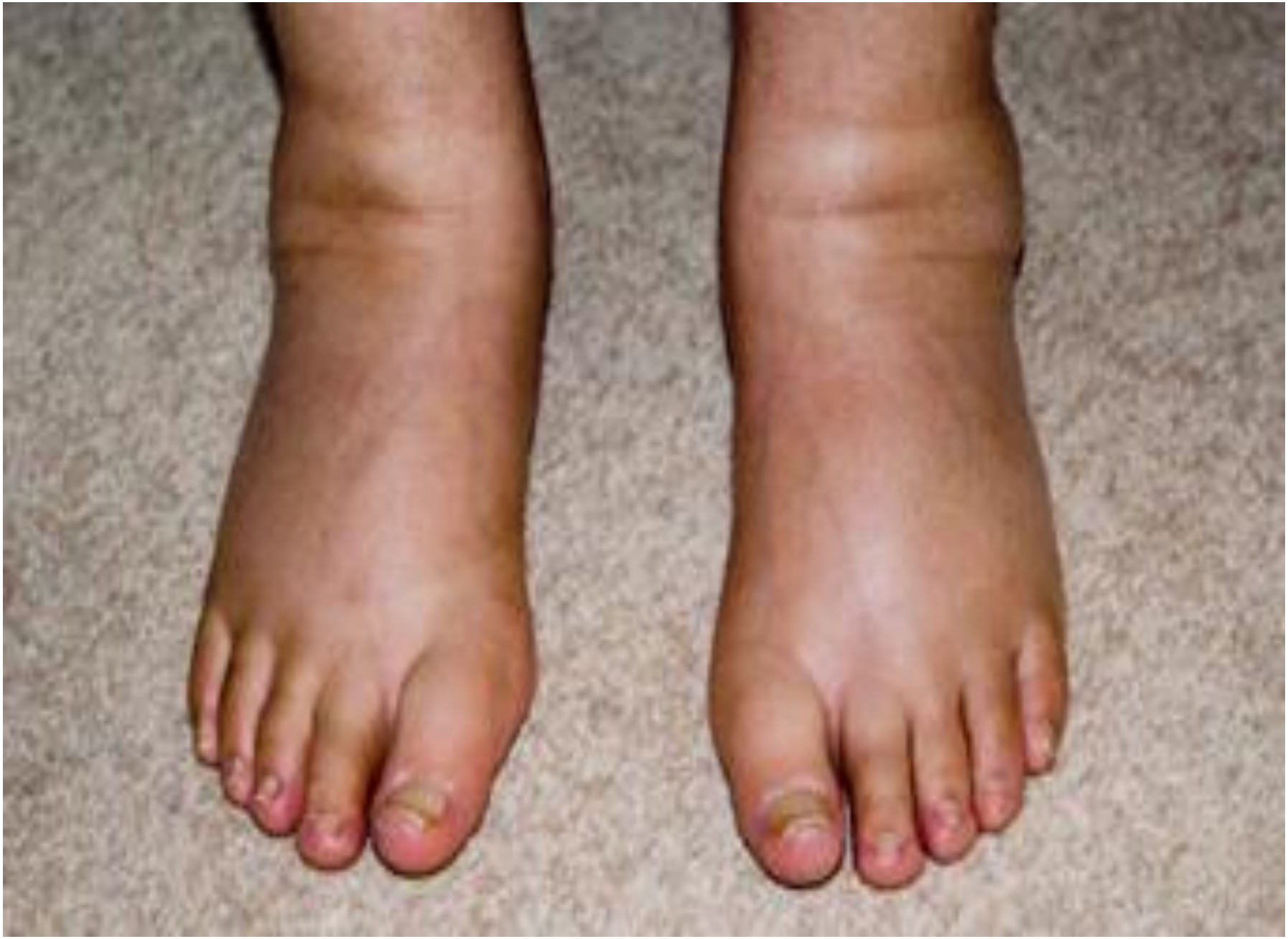
- Respirations
  - labored
  - unlabored
- Chest shape
- Chest symmetry
- Breath sounds

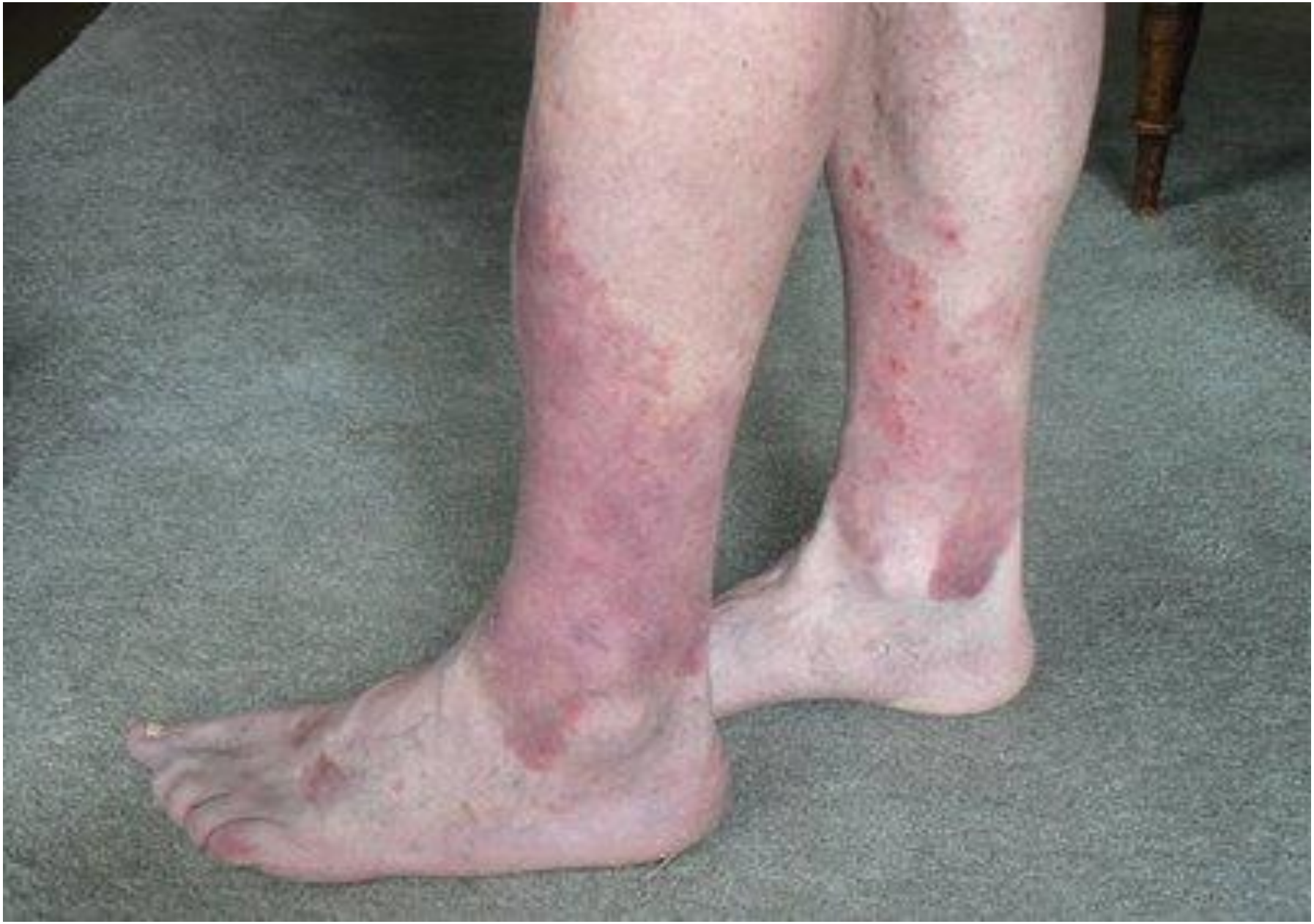
Abdomen

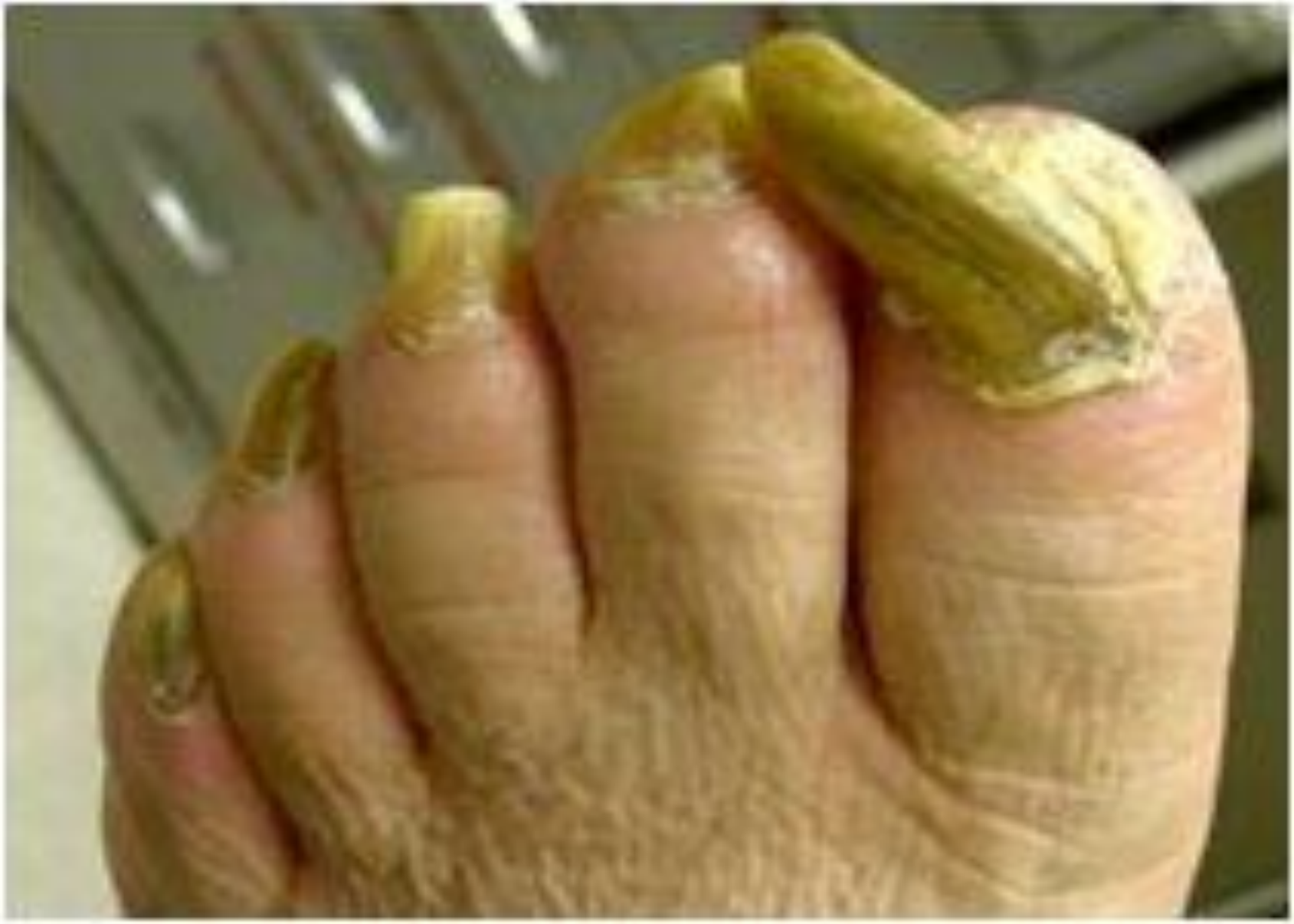
- Contour
- Size
- Bowel sounds
- Tenderness
- Palpate bladder

Extremities

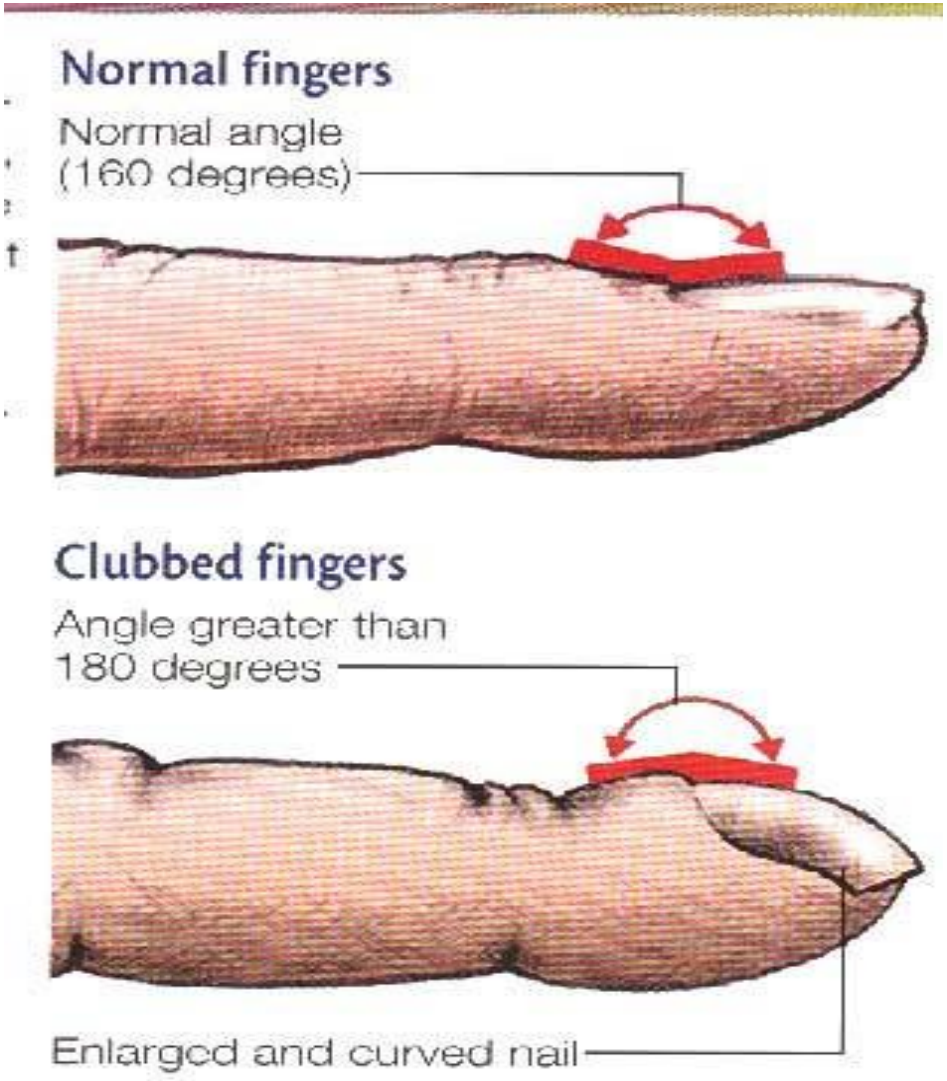
- ROM present
- Temperature – clammy skin, cold, hot
- Strength
- Capillary refill
- Peripheral pulses
- Edema
- Nails







Clubbing of Fingernails



Risk Assessment

Risk Assessment

Whenever you interview a client, you may forget some of the psychiatric interview, but always perform a risk assessment.

Principles of Risk Assessment

- The clinician's focus is about first understanding the clinical risk and then managing i.e. preventing, minimising and addressing this risk as part of good clinical care.
- Assessing and managing clinical risk is an integral part of service delivery.
- It is ideally located within the overall provision of care to individuals.

Timing of risk assessment

- While risk assessment is an aspect of every clinical encounter, it is of particular importance at times of:
  - Entry and exit from the service.
  - Transition between parts of the service.
  - Changes affecting the individual emanating from within or without

Types of risk

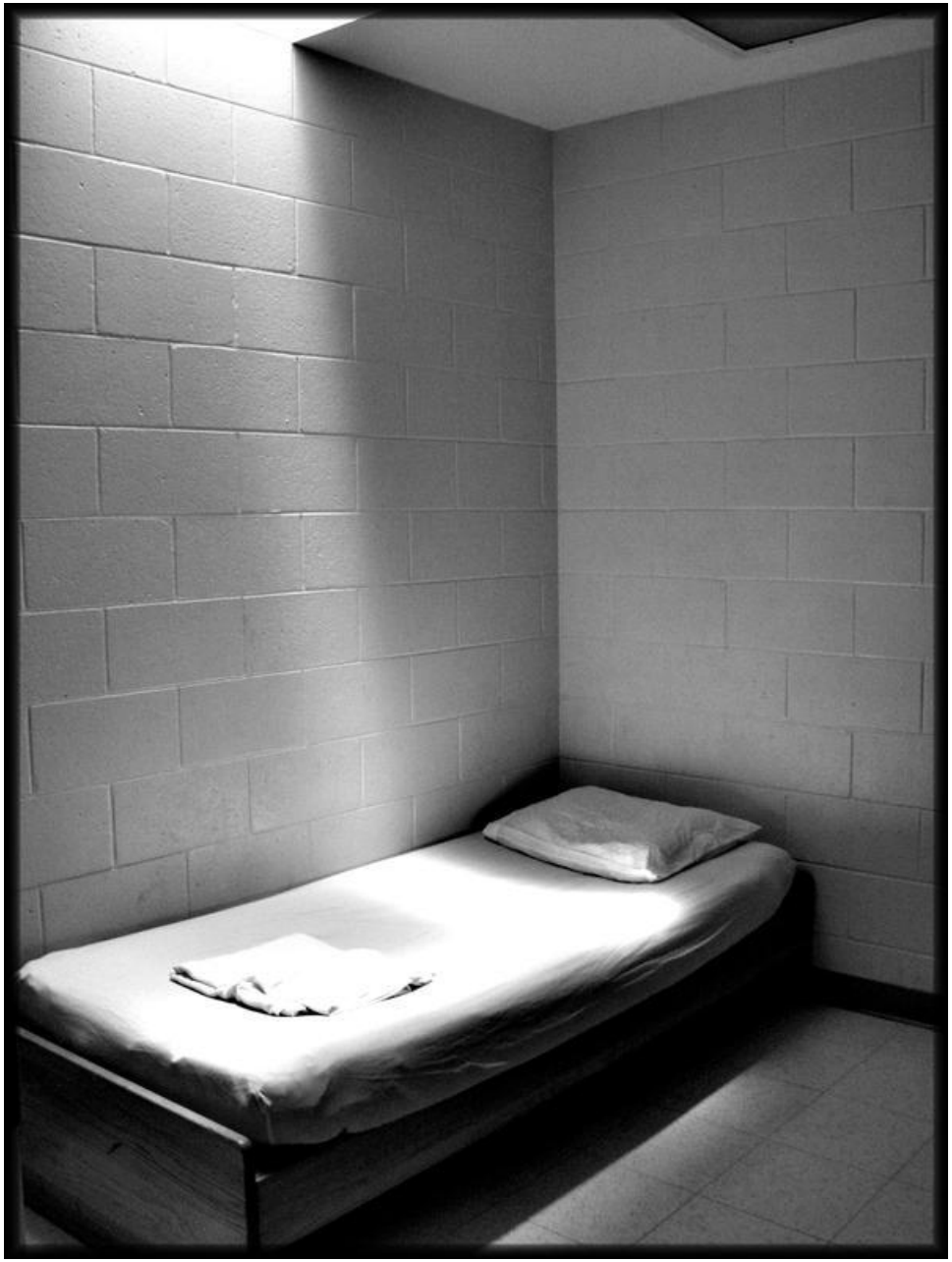
Using a broad definition of risk as the likelihood of an adverse event or outcome, clinical risk includes the following domains:

- Suicide/self harm
- Harmful/hazardous drug use
- Compromised physical health and self-care
- Neglect of mental health needs (absconding, non-adherence to treatment, relapse)
- Financial/sexual/social/occupational vulnerability (e.g. compromised driving, reckless spending and decision-making, neglect of relationships/responsibilities, exploitation)
- Risk of violence (verbal, emotional, sexual, physical) to people or property
- Risk from the treatment itself

Homelessness


I'D LIKE TO PUT THIS POOR JUDGEMENT BEHIND ME - AND MOVE ON TO THE NEXT ONE...

	Lower	RISK OF AGGRESSIVE BEHAVIOUR	Higher
Presentation & ability to collaborate with care	Voluntary Thorough understanding & acceptance of treatment Open to help & believes we can help Able to enter into/sustain an agreement with the team		Involuntary / police escort Poor/minimal understanding & not accepting treatment Resistant / opposed to help Unable to enter into/sustain an agreement with the team
Mental state Thought & cognition	Ability to think rationally & process information Reality-based / no disturbance of thinking No intent to harm Able to retain information Orientated Not under the influence of mind altering drugs/alcohol		Irrational Not reality-based, disturbed thinking, preoccupied with suspicious / paranoid thoughts; sense of entitlement, themes of violence / control of others Clear intent to cause harm (e.g. threats / actual) Inability to retain information Disorientated Under the influence of mind altering drugs/alcohol
Emotional arousal	Minimal or no anxiety / fear / anger		Extremely anxious / angry / frightened & 'out of control', highly aroused, sweaty, dilated pupils
Perceptual disorder	Minimal / no perceptual disorder		Actively responding to hallucinations & difficult to distract from inner world, command hallucinations with violent themes
Behaviour	Quiet / calm / cooperative		Extremely agitated / loud / abusive language / physically, verbally threatening / impulsive / resistive
History	No history of aggression		Young, male Previous aggressive behaviour (particularly toward health workers), forensic history of violent crime, association with subculture prone to violence
Demographics	Occasional or no drug use		History of drug/alcohol abuse especially recent use



Approaches to Risk Assessment

1. Clinicians' familiarity with the various domains of risk, and the clinical factors that are associated with that risk,

2. A comprehensive structured clinical assessment

3. Clinical use of an anamnestic analysis of previous risk

Assessment Approach

- The approach aims, through an active engagement with the person and an understanding of their background, their life situation and the pressures upon them, to recognise increases in risk.

The Generic /Structured Clinical Approach

1 Current state of mind/mental state

2 Current situational factors

3 Historical/predisposing factors

Mental State

- **Behaviour**
  - dangerous or threatening actions
  - aggression
  - deliberate self harm
- **Individual's attitude/rapport**
  - cooperation/engagement
  - refusal to co-operate
- **Affect**
  - arousal, anger, hostility, irritability, suspiciousness, fear
  - low mood or elevated mood

Mental State

Thought Content

- Thoughts of fantasiesof deliberate self harm or harm to others
- Persecutory thoughts, delusions
- external control
- preoccupation,obsession, jealousy
- cultural beliefs
- meaning of current stresses
- current attitude to past risk behaviours

"It feels like people are always trying to avoid me."

Mental State

- **Perceptions**
  - command hallucinations (especially linked with delusional beliefs)
  - misidentification

Risk Factors

- **Cognition**
  - Temporary or permanent cognitive impairment(s)
- **Biological**
  - presence/absence of treatment, non-compliance with treatment
  - presence or absence of physical illness
  - substance use, intoxication or withdrawal
- **Psychological**
  - losses
  - shame
  - developmental stages
  - other changes
- **Social/cultural**
  - cultural transgression
  - financial stress
  - arrest or criminal charges

Historical and Predisposing Factors

- Demographics, age, sex
- History of mental disorder/risk behaviours
- Patterns of illness and treatment response including level of insight, adherence an engagement with treatment
- Features of past crises
- Family history including history of risk behaviours by other members
- Personality

Anamnestic Assessment

- This can be regarded as a detailed examination of past history/incidences of risk.
- The model is based on the assumption that past risk and the context in which it occurred is the best indicator of risk in the future.
- It is developed in collaboration with the person as much as is possible in order to provide a detailed retrospective analysis of the conditions in which risk occurred.
- The past is a good predictor of the future

Anamnestic Assessment

- Anamnestic assessment includes any cues or early warning signs that would assist the service and the client on the prevention of future episodes.
- This is termed a "risk profile" which informs any current risk assessment. It includes the following sections:
  - Mental state at the time
  - Treatment compliance at the time
  - Substance use at the time
  - Social context at the time
  - (Retrospective) subjective early warning signs
  - (Retrospective) objective early warning signs

Sources of information needed for risk assessment and management

- Informants including referral sources and those who know the individual well such as family and friends. This may extend to paid carers and other relevant agencies.
- This should include an outline of concerns, the basis for the concerns, and if any specific interventions are felt to be required and why.
- Interview with the individual.This should include reviewing those concerns raised by third parties.
- Previous clinical records including recent clinical contacts.

Risk Formulation

- Risk formulation is a summary of the risk data. Broadly speaking, with reference to risk assessment, it involves a summary statement of:
- Nature of current presentation/context (e.g. crisis assessment after threatening….)
- Predisposing risk factors
- Current/situational factors and mental state

Documentation

- Documentation of risk formulation and management is incorporated into the generic clinical notes
- Documentation has a service specific format/structure – risk assessment form.
- The documentation is accessible particularly to those who need to see the patient in crisis

- **Risk Formulation as Part of Clinical Assessment**
  - Identification and documentation of risk factors for the individual
  - Clarifying risk profile i.e. risk type present and imminence

▼

- **Risk Management Plan**
  - Informed by formulation
  - Prioritising interventions to target the individual's risk profile

▼

- **Communication about the plan**
  - With consumer, family/caregivers
  - Within team, service
  - With other relevant agencies

▼

- **Act in accordance with the plan**

▼

- **Evaluate Outcomes**

▼

- **Review Plan**
  - In consultation with the client, family/caregivers
  - Regular, ongoing, at crisis points
  - Identify gaps

Suicide Risk Assessment

Suicide Risk Assessment

- This forms part of comprehensive assessment
- This presentation will provide some guidelines for exploring a clients expression of suicidal feelings
- It will provide you with a summary of the essential elements in suicide risk assessment
- The framework will help you discuss your formulation with each other and other services

Be Aware

- There are no absolute predictors of suicide.
- Even with the most diligent assessment and treatment, clients may continue to exhibit suicidal behaviour

The Detection of Suicidality

The assessment of suicidality is an active process during which clinicians evaluate:

- The person's epidemiological risk factors
- Mental state - particularly depression
- Suicidal ideation
- Suicidal plans
- Client self -control
- Intent

Common Predictors of Suicide

- Psychiatric illness
- Problematic substance use
- Suicidal ideas, plans and intent, lethality of method
- History of previous attempts
- Isolated
- Themes of hopelessness, cognitive rigidity
- Older white male

Common Predictors of Suicide

- Modelling, suicide in family, genetics
- Work problems, financial difficulties
- Relationship problems
- Stress, life events
- Physical illness
- Repetition of above, chronic suicidality

Protective factors

- Hopefulness
- Social supports
- Cognitive flexibility
- No significant losses
- Lack of precipitating stressful events

Communication

- Clear communication between the worker and client is critical to the process.
- Any indicators of suicidal intent need to be overted and discussed
- Allow the person to express suicidal ideas.
- It is important to explore the content.
- Work toward understanding the problems the client perceives can only be resolved by suicide.

Engage the client

- Let them talk and use your skills to encourage this.
- Ask questions sensitively but succinctly.
- Discussing a persons suicidal feelings is unlikely to encourage them to act upon their feelings.
- People are hurting, don’t be scared to talk to them

Exploring Suicidal Ideation

- "You certainly seem to be doing it tough right now, have things become so bad that you have had thoughts of suicide?"
- "It is not unusual for people in your position to experience suicidal thoughts, has this happened for you?"

Assessing Suicide Plan

S specificity

L lethality

A availability

P proximity

Assessing Self Control

- The ability of the client to exert self control should be assessed.
- Here and now
- Past incidents, behavioural history

Assessing Intent

- Evaluating intent requires a determination of whether a client is talking and acting in a manner that suggests that they will suicide.
- Self report
- Family/carer report
- Personal observation

Decision Making related to Risk Assessment

- This a complex issue
- Role of the individual practitioner
- Role of the organisation

Lets see how a risk assessment can be done

Suicide risk assessment in an inpatient setting.mp4

What Next?

- After conducting your comprehensive assessment what happens with the information collected?

- Informs collaborative care
- Needs to be Documented
- Needs to be handed over to the clinical team
- Communicated to others where relevant – e.g.: addiction medicine, GP, others