Oldham

NHS
Oldham Care Organisation
Northern Care Alliance NHS Group

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Suicide Risk Assessment in Overdose/DSH

Name: ……

Hosp No: ……

D.O.B: ……

- **All patients who attend with OD / DSH should have a suicide risk assessment carried out.**
- **All patients <16 must be assessed by CAMHS**
- **All patients should be offered Mental Health team input**
- **All patients ≥65 years presenting with DSH/OD must be referred to the Mental Health team. (NICE 2004)**

Does the patient consent to Mental Health Assessment +/- treatment?	Yes / No

Medical treatment may comprise of: (brief description)	

Capacity assessment (circle appropriate response)	Understand risks?	Yes / No
	Believe the information?	Yes / No
	Retain the information?	Yes / No
Has capacity? Yes / No	Weigh up/and make and communicate a decision?	Yes / No

Suicidal intent

DSH / OD alone	Yes / No
Preparation not to be found	Yes / No
Suicide note / text / email	Yes / No
Planned attempt?	Yes / No
Violent method eg. Hanging	Yes / No
Previous OD / DSH?	Yes / No
Did they want to die?	Yes / No
Did they think they would die?	Yes / No
Do they still want to die?	Yes / No

Brief Mental State Examination

Appearance	
Behaviour	
Speech	
Mood (specifically ongoing suicidal intent)	
Thought	
Perception	
Cognition	
Insight	

SAD PERSONS score

<6 May be safe to discharge (depending on circumstances).
6-8 **Requires** Mental health team review
>8 Possibly requires hospital admission, **requires** Mental Health team review.

Do not use the SAD PERSONS score alone to decide upon discharge.

Refer to Mental Health team if psychotic, major depressive or manic symptoms found.

OVERALL IMPRESSION OF RISK: HIGH / LOW

S – male sex	1
A - age <19 or >45	1
D – depression / hopelessness	2
P - previous self harm / psychiatric care	1
E - ethanol use	1
R - rational thinking loss	2
S – single / widowed / divorced	1
O- organised attempt	2
N - no social support	1
S - stated future intent	2
TOTAL	