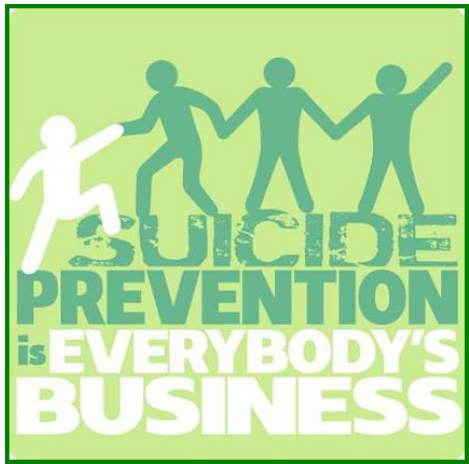
Caring for Patients with Suicide Risk: Building a Foundation for Assessment, Screening, and Treatment



Warning Signs of Suicide

A person at risk for suicidal behavior most often will exhibit warning signs:

Here's an Easy-to-Remember Mnemonic for the Warning Signs of Suicide: **IS PATH WARM?**

Ideation:	Expressed or communicated ideation threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself; and/or looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or talking or writing about death, dying or suicide, when these actions are out of the ordinary.
Substance Abuse:	Increased alcohol or drug use

Is Path Warm

Purposelessness:	No reason for living; no sense of purpose in life, start giving things away because there's no purpose in keeping anything, no reason to maintain their hygiene
Anxiety:	Anxiety, agitation, unable to sleep or sleeping all the time, difficulty concentrating
Trapped:	Feeling trapped (like there's no way out and things will never get better)
Hopelessness:	No future orientation

Is Path Warm

Withdrawal:	Withdrawal from friends, isolating from family and society
Anger ：	Rage, uncontrolled anger, seeking revenge, irritable
Recklessness:	Acting reckless or engaging in high risk activities, seemingly without thinking, impulsive behavior (especially in younger people)
Mood Change:	Dramatic mood changes, flat affect, depressed mood, acting out of character

Keys things to remember in assessing the degree of risk

Don’t hesitate to bring up the word “suicide”

- Many fear that asking them if they are suicidal will plant the idea in their mind. This is a myth! There is no research to support this. Being direct validates their pain and gives them the opportunity to talk.

The Role of Ambivalence

Talking with the suicidal person

Do's

- Ask the question, "are you suicidal?" or "are you having thoughts of killings yourself?"
- Ask if they have a plan
- Voice concern
- Tell someone else (NO CONFIDENTIALITY)

Don'ts

- Leave the person alone
- Be sworn to secrecy
- Don't assume the person is venting or it will pass, IT WON'T
- Challenge or dare
- Argue or debate

Tips for Asking the Suicide Question

- If in doubt, don't wait, ask the question
- If the person is reluctant, be **persistent**
- Talk to the person alone in a private setting
- Allow the person to talk freely
- Give yourself plenty of time
- Have your resources handy; phone numbers, counselor's name and any other information that might help

ASKING THE QUESTION

Direct Approach:

- "You know, when people are as upset as you seem to be, they sometimes wish they were dead. I'm wondering if you're feeling that way, too?"
- "You look pretty miserable, I wonder if you're thinking about suicide?"
- "Are you thinking about killing yourself?"

NOTE: If you cannot ask the question, find someone who can.

How NOT to ask the suicide question

- "You're not thinking of killing yourself, are you?"
- "You wouldn't do anything stupid would you?"
- "Suicide is a dumb idea. Surely you're not thinking about suicide?"

HOW TO OFFER HOPE

- Listen to the problem and give them your full attention
- If they talk about their reasons for dying, don't challenge them or tell them they "shouldn't feel that way." Validate their experience. Tell them you want to help.
- Remember, suicide is not the problem, only the solution to a perceived insoluble problem
- Do not rush to judgment
- Offer hope in any form

Then say:

- "I don't want you to kill yourself, I want to help"
- "I don't want this to happen, let's go talk to somebody?"
- "I'm not an expert in this, but there are people that are. Let's go talk to somebody"
- "I can't keep this a secret. We need to talk to somebody. I'll go with you?

YOUR WILLINGNESS TO LISTEN AND TO HELP CAN REKINDLE HOPE, AND MAKE ALL THE DIFFERENCE.

GETTING HELP

- Suicidal people often believe they cannot be helped, so you may have to do more.
- **The best referral involves taking the person directly to someone who can help (take them to the nearest ER, call 911, take them to a health care clinic, or call the Lifeline.)**
- The next best referral is getting a commitment from them to accept help, making the arrangements to get that help, and checking in with them daily and letting them know that you are there if they need you.

More specific to Primary Care

More than just the words they use

- People at risk of suicide may try to reach out to their PCP, sometimes directly, but most of the time *indirectly*.
- Rarely will patients immediately volunteer the information that they are thinking of suicide.
- Be alert for warning signs that a patient may be at risk of imminent suicide
- **For this reason, we advocate that <u>all</u> patients be asked, "any depression or suicidal thoughts in the last 3 months?"**

Assess Risk Factors

- The strongest predictor of suicide is a previous attempt.
- The Big Four:
  - Past Suicide Attempt
  - Diagnosis of mood disorder
  - Increasing use/abuse of alcohol or drugs
  - History of self-harm (e.g. cutting)

Signs specific to Adolescents

- Volatile mood swings or sudden change in personality
- Indications that they are in unhealthy, destructive, or abusive relationships
- Sudden deterioration in hygiene
- Self-mutilation

Signs specific to Adolescents

- Fixation with death (poems, letters, chat rooms)
- Eating disorders, especially combined with dramatic shifts in weight
- Gender identity issues
- Depression

Signs specific to the Elderly

- Stockpiling medications
- Buying a gun
- Giving away money or possessions or sense of urgency to settle estate or finalize will.
- Taken sudden interest or loss of interest in religion.
- Failure to care for themselves in terms of the routine activities of daily living.

Signs specific to the Elderly

- Withdrawing from relationships
- Experiencing failure to thrive, even after appropriate medical treatment
- Scheduling a medical appointment for vague symptoms.
- Chronic issues of pain management
- Undiagnosed depression

Depression in the Elderly

Before a diagnosis of depression is made, screen for some common health issues that can affect mood, including:

- Alzheimer's
- Thyroid disorders
- Multiple Sclerosis
- Heart attack
- Stroke

Depression in the Elderly

- Parkinson's disease
- Cancer
- Diabetes
- Hormonal imbalances
- Vitamin B12 deficiency
- Electrolyte imbalances or dehydration
- Some Viral Infections

Depression in the Elderly

The following medications may cause symptoms of depression:

- blood pressure medication
- arthritis medication
- hormones
- steroids

Medications and Suicide

Specific medications that are currently being investigated for their role in possibly causing suicidal ideations:

- Anticonvulsives such as Depakote, Lyrica, and Neurontin.
- Smoking cessation medication Chantix.
- Allergy medication Singulair.
- Acne medication Accutane
- Antidepressants (SSRI's) when used with young people.

Suicide Inquiry

- When multiple risk factors are present, a suicide inquiry is warranted.
- Patients may not spontaneously report suicidal ideations, but at least 70% communicate their intentions or wish to die to significant others.
- Ask patients directly and seek collateral information from family, friends, EMS personnel, police, and others

Suicide Inquiry
Thoughts of Suicide

- In a non-judgmental, non-condescending, matter-of-fact approach, ask the question;
  - "Have you ever had thoughts of killing yourself?"
  - "How often do you have thoughts of suicide?"
  - "Are you suicidal?"

  Ask specifically about duration, frequency,

  and intensity of thoughts and feelings

Suicide Inquiry
Plan

- When suicidal ideation is present, providers should immediately move to asking whether the patient has a plan for suicide. *Get specifics*.
- A higher risk level should be assigned to patients that have a lethal, detailed, and specific plan.

Suicide Inquiry
Plan

- Sample questions include:
  - "Do you have a plan to end your life? If so, how would you do it?"
  - "Do you have a timeline in mind for ending your life?"
  - "What have you done to begin to carry out the plan? Have you rehearsed what you would do?"

Suicide Inquiry

Intent

- Determine the extent to which the patient expects to carry out the plan and believes the plan to be lethal vs. self-injurious
- Explore the patient's reasons to die vs. reasons to live.
- Administer mental status exam if in doubt about mental status.

Suicide Inquiry

Intent

- Sample questions:
  - "How confident are you that this plan would actually end your life?"
  - "Have you made other preparations?" (e.g. updated life insurance, updated wills, made arrangements for pets)
  - "How likely do you think you are to carry out your plan?"

Assess Protective Factors

- Protective factors can mitigate risk in a person with moderate to low suicide risk.
- Building protective factors should be a part of safety planning with your patients.

Protective Factors

- Effective and appropriate **clinical care** for mental, physical, and substance abuse disorders (depression is the one of the most treatable of all psychiatric disorders)
- Easy access to a variety of **clinical interventions** and support for help seeking
- **Restricted access** to highly lethal methods of suicide

More Protective Factors

- Family and community **support**
- Support from ongoing medical, mental health and substance abuse **care relationships**
- Learned **skills** in problem solving, conflict resolution, and nonviolent handling of disputes
- **Cultural** and **religious** beliefs that discourage suicide and support self-preservation instincts

PCP Intervention

- ✓ Utilizing friends and family members that can be contacted in order to distract from suicidal thoughts.
- ✓ Contacting health professionals or agencies, including 911 and the 1-800-273-TALK or going to the emergency room.
- ✓ Reducing the potential for use of lethal means.

The patient should share their plan with a family member or friend.

SAMPLE SAFETY PLAN

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008).

The one thing that is most important to me and worth living for is:

_____

WICHE Mental Health Program
Across the West · Across the Nation · Across the Boundaries

SPRC Suicide Prevention Resource Center

PCP Intervention

Encourage a support network

- Help patient develop a pre-determined list of supportive individuals and their contact information. The network may include friends, family, clergy/minister, co-workers, therapist, suicide lifeline number.
- Encourage patient to utilize network even when they are not a critical level.

PCP Intervention

Practice Coping Strategies

- Patients who are familiar with their own triggers and cues can utilize coping strategies and may be able to prevent themselves from reaching a point where they feel out of control.

PCP Intervention

Practice Coping Strategies

- Questions to help patient identify triggers
  - ✓"How do you feel in the hours or days before you first notice that you are suicidal?"
  - ✓"What do you notice in your thoughts and feelings, or in your body?"
  - ✓"What are your triggers? What happens just before you start feeling or thinking this way?"

PCP Intervention

Practice Coping Strategies

- If the patient is unable to answer these questions, family members and friends have likely noticed changes that occur before the patient enters crisis.

- PCPs can help patients develop effective coping strategies. Each patient will have their own strategies. Help the patient think through what works for them.

PCP Intervention

Practice Coping Strategies

- Sample questions to get patients thinking about effective coping techniques are:
  - ✓ “What relaxes you?”
  - ✓ “When was the last time you felt relaxed or peaceful? What were you doing?”
  - ✓ “Are there any things that you do that help you take your mind off of suicide?”
  - ✓ “Who do you spend time with that makes you feel good?”

Encourage the patient to practice their coping strategies

PCP Intervention

- A Safety Plan is developed collaboratively with the patient and is designed to decrease the probability that the patient will attempt suicide in the near future.
- The plan is intended to be stepwise and to assist the patient with the following:
  - ✓Recognizing warning signs that a crisis may be approaching.
  - ✓Identifying coping strategies that can be used by the patient to soothe their emotions.

Safety Plan app

Safety Plan

Two Penguins Studios LLC

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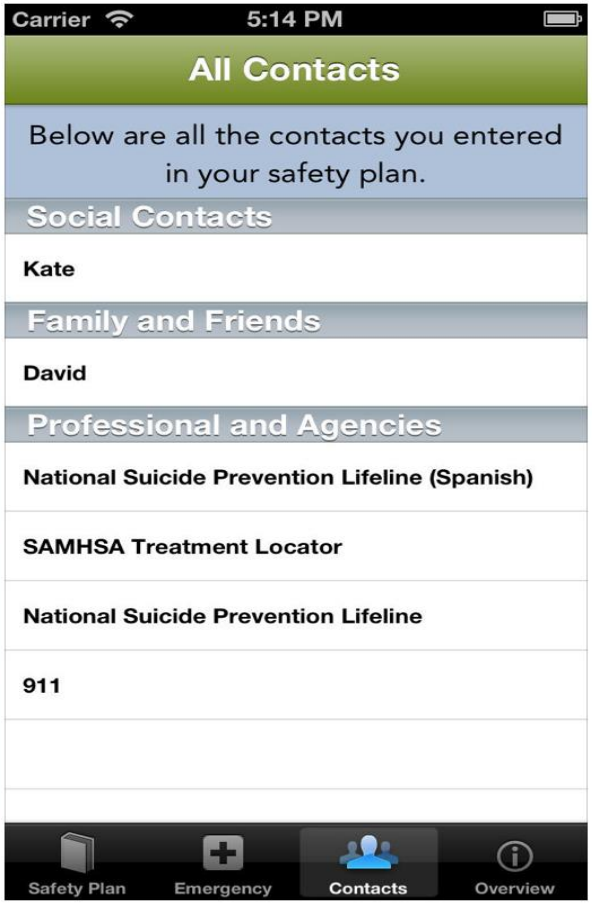

Documentation and Follow-up care

- Document suicide risk assessment, management plan, actions that occurred, and any consultation.
- In case of hospitalization, the admitting facility will need this information.
- In case of a lawsuit, charts would be examined to determine whether the physician recognized the risk factors and considered the benefits of exerting control over the patient.

Documentation and Follow-up care

- Follow up with patient – studies show that even simple follow-up contact with suicidal patients reduces their risk of repeat attempts.
- Follow-up must include assessing for recurrent or increased suicidality
- Follow-up should focus on medication adherence
- Document all follow-up care

Suicidality Treatment Tracking Log (for Patient Chart)

Patient Name _____ Medical Record #_____ Primary Care Provider_____

Session Date								
V = Visit P = Phone C = Cancellation NS = No Show	V P C NS	V P C NS	V P C NS	V P C NS	V P C NS	V P C NS	V P C NS	V P C NS
Suicidal thoughts?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Suicidal Behaviors?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Risk: H = High M = Moderate L = Low	H M L	H M L	H M L	H M L	H M L	H M L	H M L	H M L
Medication Prescribed?	Yes No Meds	Yes No Meds	Yes No Meds	Yes No Meds	Yes No Meds	Yes No Meds	Yes No Meds	Yes No Meds
Medication Dosage/Start Date								
Medication Adherence	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Medication Side Effects								
Other Interventions								
Mental Health Provider	Yes No _____	Yes No _____	Yes No _____	Yes No _____	Yes No _____	Yes No _____	Yes No _____	Yes No _____

Suicide Status Tracking discontinued (date ____/____/____) because: Suicidality Resolved_____Dropped out _____Other _____

Office Protocol

Developing an office protocol for hospitalization

- It is helpful to have an office protocol to follow once you have determined that a patient is high risk for suicide.

- A protocol can make the process of hospitalizing a patient easier or both provider and patient.

Office Protocol

Questions to answer in developing your office protocol are:

1) What are the laws in your state regarding involuntary admission?
2) Where will all necessary forms for hospitalizing suicidal patients be kept?
3) What psychiatric units are closest?
4) Is there a mental health provider in your area?

Protocol for Suicidal Patients - Office Template
Post in a visible or accessible place for key office staff.

If a patient presents with suicidal ideation or suicidal ideation is suspected and detected with screening questions…

✓ _____ should be called/paged to assist with suicide risk assessment (e.g., physician, mental health professional, telemedicine consult etc.).

✓ Identify and call emergency support person in the community (e.g., family member, pastor, mental health provider, other support person).

If a patient requires hospitalization…

✓ Our nearest Emergency Department or psychiatric emergency center is _____. Phone #_____.

✓ _____ will call _____to arrange transport.
(Name of individual or job title) (Means of transport [ambulance, police, etc] and phone #)

Backup transportation plan: Call_____.

✓ _____will wait with patient for transport.

Documentation and Follow-Up…

_____will call ED to provide patient information.

✓ _____will document incident in_____.
(Name of individual or job title) (e.g. medical chart, suicide tracking chart, etc.)

✓ Necessary forms/ chart-flagging materials are located _____.

✓ _____will follow-up with ED to determine disposition of patient.
(Name of individual or job title)

✓ _____ will follow up with patient within_____.
(Name of individual or job title) (Time frame)

Screens for Depression and Suicide Risk

“The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential clinical judgment, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior.”

From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

For a tentative diagnosis of depression;

- Questions 1 or 2 are endorsed in the shaded area.
- If there are at least 4 checks in the shaded section (including Questions #1 and #2), consider a depressive disorder.
- if there are at least 5 checks in the shaded section (one of which corresponds to Question #1 or #2), consider Major Depressive Disorder (a dx of MDD indicates 25x the risk of suicide.)
- Shaded response to question #9 indicates 10x the risk of suicide

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	
TOTAL:				

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- **Not difficult at all** _____
- **Somewhat difficult** _____
- **Very difficult** _____
- **Extremely difficult** _____

Interpretation of Total Score

Total Score Depression Severity

- 1-4 Minimal depression
- 5-9 Mild depression
- 10-14 Moderate depression
- 15-19 Moderately severe depression
- 20-27 Severe depression

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

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2. Feeling down, depressed, or hopeless	0	1	2	3
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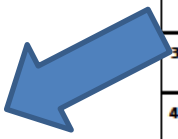
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	
TOTAL:				

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	**Not difficult at all** _____
	Somewhat difficult _____
	Very difficult _____
	Extremely difficult _____

SAFE-T Protocol with C-SSRS, Safety Planning and Telephone Follow-up

Ideation Severity Subscale

- Questions 1-5: Five types of ideation of increasing severity
- Score presence/absence of any suicidal ideation yes/no
- Questions 1 &2 are screening questions; if the answers to both are “no”, you do not need to ask questions 3-5 and may skip to the “suicidal behavior” section.
- The most severe ideation endorsed (1-5) becomes the score for this section.
- Bottom section provides history, presenting symptoms, and stressors.



SAFE-T Protocol with C-SSRS, Safety Planning and Telephone Follow-up

Step 1: Identify Risk Factors

C-SSCS Suicidal Ideation Severity	48 hr	Month	Lifetime (Worst)
1) Wish to be dead *Have you wished you were dead or wished you could go to sleep and not wake up?*			
2) Current suicidal thoughts *Have you actually had any thoughts of killing yourself?*			
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) *Have you been thinking about how you might kill yourself?*			
4) Suicidal Intent without Specific Plan *Have you had these thoughts and had some intention of acting on them?*			
5) Intent with Plan *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*			

C-SSRS Suicidal Behavior: *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	48 hr	3 Months	Lifetime

Current and Past Psychiatric Dx:
- ☐ Mood Disorder
- ☐ Psychotic disorder
- ☐ Alcohol/substance abuse disorders
- ☐ PTSD
- ☐ ADHD
- ☐ TBI
- ☐ Cluster B Personality disorders or traits (i.e., Borderline, Antisocial, Histrionic & Narcissistic)
- ☐ Conduct problems (antisocial behavior, aggression, impulsivity)
- ☐ Recent onset

Presenting Symptoms:
- ☐ Anhedonia
- ☐ Impulsivity
- ☐ Hopelessness or despair
- ☐ Anxiety and/or panic
- ☐ Insomnia
- ☐ Command hallucinations
- ☐ Psychosis

Family History:
- ☐ Suicide
- ☐ Suicidal behavior
- ☐ Axis I psychiatric diagnoses requiring hospitalization

Precipitants/Stressors:
- ☐ Triggering events leading to humiliation, shame, and/or despair (e.g. Loss of relationship, financial or health status) (real or anticipated)
- ☐ Chronic physical pain or other acute medical problem (e.g. CNS disorders)
- ☐ Sexual/physical abuse
- ☐ Substance intoxication or withdrawal
- ☐ Pending incarceration or homelessness
- ☐ Legal problems
- ☐ Inadequate social supports
- ☐ Social isolation
- ☐ Perceived burden on others

Change in treatment:
- ☐ Recent inpatient discharge
- ☐ Change in provider or treatment (i.e., medications, psychotherapy, milieu)
- ☐ Hopeless or dissatisfied with provider or treatment
- ☐ Non-compliant or not receiving treatment

☐ **Access to lethal methods:** Ask specifically about presence or absence of a firearm in the home or workplace or ease of accessing

SAFE-T Protocol with C-SSRS, Safety Planning and Telephone Follow-up

Intensity of Ideation Subscale ***(Referring only to the most severe ideation endorsed above for the timeframe of interest)*:**

- Add the highest numbers endorsed on the 5 intensity items (Frequency, Duration, Controllability, Deterrents, and Reasons for Ideation).
- The sum ranges from 2 to 25, with the higher number indicating more intense ideation.
- If no ideation was endorsed on the Severity Subscale, assign a score of 0 or N/A for the Intensity Subscale.

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)

Internal:	External:
□ Ability to cope with stress	□ Cultural, spiritual and/or moral attitudes against suicide
□ Frustration tolerance	□ Responsibility to children
□ Religious beliefs	□ Beloved pets
□ Fear of death or the actual act of killing self	□ Supportive social network of family or friends
□ Identifies reasons for living	□ Positive therapeutic relationships
	□ Engaged in work or school

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior)

If semi-structured interview is preferred to complete this section, clinicians may opt to complete C-SSRS Lifetime/Recent and Since Last Visit versions for comprehensive behavior/lethality assessment.

C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation identified above)	48 hr	Month	Lifetime (Worst)
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day			
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous			
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts			
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply			
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply			
Total Score			

Notes:

Behaviors:

- □ Preparatory Acts (e.g., buying pills, purchasing a gun, giving things away, writing a suicide note)
- □ Aborted/self-interrupted attempts,
- □ Interrupted attempts and
- □ Actual attempts

□ **Assess for the presence of non-suicidal self-injurious behavior** (e.g. cutting, hair pulling, cuticle biting, skin picking) particularly among adolescents and young adults, and especially among those with a history of mood or externalizing disorders

□ **For Youths:** ask parents/guardian about evidence of suicidal thoughts, plans or behaviors and changes in mood, behaviors or disposition

□ **Assess for homicidal ideation, plan behavior and intent** particularly in:

- □ character disordered males dealing with separation, especially if paranoid, or impulsivity disorders

INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e.,1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.

Most Severe

Most Severe Ideation: _____ _____

Type # (1-5) ***Description of Ideation***

Frequency ____

How many times have you had these thoughts?

(1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day

Duration ____

When you have the thoughts, how long do they last?

(1) Fleeting - few seconds or minutes
(2) Less than 1 hour/some of the time
(3) 1-4 hours/a lot of time
(4) 4-8 hours/most of day
(5) More than 8 hours/persistent or continuous

Controllability ____

Could /can you stop thinking about killing yourself or wanting to die if you want to?

(1) Easily able to control thoughts
(2) Can control thoughts with little difficulty
(3) Can control thoughts with some difficulty
(4) Can control thoughts with a lot of difficulty
(5) Unable to control thoughts
(0) Does not attempt to control thoughts

Deterrents ____

Are there things - anyone or anything (e.g. family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?

(1) Deterrents definitely stopped you from attempting suicide
(2) Deterrents probably stopped you
(3) Uncertain that deterrents stopped you
(4) Deterrents most likely did not stop you
(5) Deterrents definitely did not stop you
(0) Does not apply

Reasons for Ideation ____

What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?

(1) Completely to get attention, revenge or a reaction from others.
(2) Mostly to get attention, revenge or a reaction from others.
(3) Equally to get attention, revenge or a reaction from others and to end/stop the pain.
(4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling).
(5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling).
(0) Does not apply

INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e.,1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.

Most Severe

Most Severe Ideation: _____ _____

Type # (1-5) ***Description of Ideation***

Frequency ____

How many times have you had these thoughts?

(1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day

Duration ____

When you have the thoughts, how long do they last?

(1) Fleeting - few seconds or minutes
(2) Less than 1 hour/some of the time
(3) 1-4 hours/a lot of time
(4) 4-8 hours/most of day
(5) More than 8 hours/persistent or continuous

Controllability ____

Could /can you stop thinking about killing yourself or wanting to die if you want to?

(1) Easily able to control thoughts
(2) Can control thoughts with little difficulty
(3) Can control thoughts with some difficulty
(4) Can control thoughts with a lot of difficulty
(5) Unable to control thoughts
(0) Does not attempt to control thoughts

Deterrents ____

Are there things - anyone or anything (e.g. family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?

(1) Deterrents definitely stopped you from attempting suicide
(2) Deterrents probably stopped you
(3) Uncertain that deterrents stopped you
(4) Deterrents most likely did not stop you
(5) Deterrents definitely did not stop you
(0) Does not apply

Reasons for Ideation ____

What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?

(1) Completely to get attention, revenge or a reaction from others.
(2) Mostly to get attention, revenge or a reaction from others.
(3) Equally to get attention, revenge or a reaction from others and to end/stop the pain.
(4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling).
(5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling).
(0) Does not apply

INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e.,1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.

Most Severe Ideation: _____ _____

Type # (1-5) ***Description of Ideation***

Most Severe

Frequency ____

How many times have you had these thoughts?

(1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day

Duration ____

When you have the thoughts, how long do they last?

(1) Fleeting - few seconds or minutes
(2) Less than 1 hour/some of the time
(3) 1-4 hours/a lot of time
(4) 4-8 hours/most of day
(5) More than 8 hours/persistent or continuous

Controllability ____

Could /can you stop thinking about killing yourself or wanting to die if you want to?

(1) Easily able to control thoughts
(2) Can control thoughts with little difficulty
(3) Can control thoughts with some difficulty
(4) Can control thoughts with a lot of difficulty
(5) Unable to control thoughts
(0) Does not attempt to control thoughts

Deterrents ____

Are there things - anyone or anything (e.g. family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?

(1) Deterrents definitely stopped you from attempting suicide
(2) Deterrents probably stopped you
(3) Uncertain that deterrents stopped you
(4) Deterrents most likely did not stop you
(5) Deterrents definitely did not stop you
(0) Does not apply

Reasons for Ideation ____

What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?

(1) Completely to get attention, revenge or a reaction from others.
(2) Mostly to get attention, revenge or a reaction from others.
(3) Equally to get attention, revenge or a reaction from others and to end/stop the pain.
(4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling).
(5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling).
(0) Does not apply

INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e.,1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.

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When you have the thoughts, how long do they last?

(1) Fleeting - few seconds or minutes
(2) Less than 1 hour/some of the time
(3) 1-4 hours/a lot of time
(4) 4-8 hours/most of day
(5) More than 8 hours/persistent or continuous

Controllability ____

Could /can you stop thinking about killing yourself or wanting to die if you want to?

(1) Easily able to control thoughts
(2) Can control thoughts with little difficulty
(3) Can control thoughts with some difficulty
(4) Can control thoughts with a lot of difficulty
(5) Unable to control thoughts
(0) Does not attempt to control thoughts

Deterrents ____

Are there things - anyone or anything (e.g. family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?

(1) Deterrents definitely stopped you from attempting suicide
(2) Deterrents probably stopped you
(3) Uncertain that deterrents stopped you
(4) Deterrents most likely did not stop you
(5) Deterrents definitely did not stop you
(0) Does not apply

Reasons for Ideation ____

What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?

(1) Completely to get attention, revenge or a reaction from others.
(2) Mostly to get attention, revenge or a reaction from others.
(3) Equally to get attention, revenge or a reaction from others and to end/stop the pain.
(4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling).
(5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling).
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INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e.,1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.

Most Severe

Most Severe Ideation: _____ _____

Type # (1-5) ***Description of Ideation***

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Duration ____

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(2) Less than 1 hour/some of the time
(3) 1-4 hours/a lot of time
(4) 4-8 hours/most of day
(5) More than 8 hours/persistent or continuous

Controllability ____

Could /can you stop thinking about killing yourself or wanting to die if you want to?

(1) Easily able to control thoughts
(2) Can control thoughts with little difficulty
(3) Can control thoughts with some difficulty
(4) Can control thoughts with a lot of difficulty
(5) Unable to control thoughts
(0) Does not attempt to control thoughts

Deterrents ____

Are there things - anyone or anything (e.g. family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?

(1) Deterrents definitely stopped you from attempting suicide
(2) Deterrents probably stopped you
(3) Uncertain that deterrents stopped you
(4) Deterrents most likely did not stop you
(5) Deterrents definitely did not stop you
(0) Does not apply

Reasons for Ideation ____

What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?

(1) Completely to get attention, revenge or a reaction from others.
(2) Mostly to get attention, revenge or a reaction from others.
(3) Equally to get attention, revenge or a reaction from others and to end/stop the pain.
(4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling).
(5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling).
(0) Does not apply

SAFE-T Protocol with C-SSRS, Safety Planning and Telephone Follow-up

There are no "cut off" score for intensity. That said, we do have the following data that looked at ranges of scores and risk ratios for suicide behavior and found a **34X** increase for the 21-25 range with lower odds ratios as the score range drops. **These scores are best used to help inform clinical judgment when there is uncertainty about disposition and to assess change over time.**

Moderate (6-10)	11x
Mod. Severe (11-15)	13x
Severe (16-20)	19x
Very Severe (21-25)	34x

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)

Internal:	External:
□ Ability to cope with stress	□ Cultural, spiritual and/or moral attitudes against suicide
□ Frustration tolerance	□ Responsibility to children
□ Religious beliefs	□ Beloved pets
□ Fear of death or the actual act of killing self	□ Supportive social network of family or friends
□ Identifies reasons for living	□ Positive therapeutic relationships
	□ Engaged in work or school

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior)

If semi-structured interview is preferred to complete this section, clinicians may opt to complete C-SSRS Lifetime/Recent and Since Last Visit versions for comprehensive behavior/lethality assessment.

C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation identified above)	48 hr	Month	Lifetime (Worst)
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day			
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous			
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts			
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply			
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply			
Total Score			

Notes:

Behaviors:

- □ Preparatory Acts (e.g., buying pills, purchasing a gun, giving things away, writing a suicide note)
- □ Aborted/self-interrupted attempts,
- □ Interrupted attempts and
- □ Actual attempts

□ **Assess for the presence of non-suicidal self-injurious behavior** (e.g. cutting, hair pulling, cuticle biting, skin picking) particularly among adolescents and young adults, and especially among those with a history of mood or externalizing disorders

□ **For Youths:** ask parents/guardian about evidence of suicidal thoughts, plans or behaviors and changes in mood, behaviors or disposition

□ **Assess for homicidal ideation, plan behavior and intent** particularly in:

- □ character disordered males dealing with separation, especially if paranoid, or impulsivity disorders

SAFE-T Protocol with C-SSRS, Safety Planning and Telephone Follow-up

Suicidal Behavior Subscale:

- **4 types of suicidal behaviors are scored yes/no** and identify categorical occurrence and density of actual, interrupted, aborted attempts and preparatory behaviors and distinguish suicidal and non-suicidal self injurious behavior.
- **Presence of an attempt is a number one risk factor for dying by suicide**
- **Number of suicidal behaviors** – the total number of each type of suicidal behavior that occurred during the given time period shows the *density* of suicidal behavior (more behaviors represents higher degree of risk – for example, multiple attempters are more at risk than single attempters).

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)

Internal:	External:
□ Ability to cope with stress	□ Cultural, spiritual and/or moral attitudes against suicide
□ Frustration tolerance	□ Responsibility to children
□ Religious beliefs	□ Beloved pets
□ Fear of death or the actual act of killing self	□ Supportive social network of family or friends
□ Identifies reasons for living	□ Positive therapeutic relationships
	□ Engaged in work or school

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior)

If semi-structured interview is preferred to complete this section, clinicians may opt to complete C-SSRS Lifetime/Recent and Since Last Visit versions for comprehensive behavior/lethality assessment.

C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation identified above)	48 hr	Month	Lifetime (Worst)
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day			
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous			
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts			
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply			
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply			
Total Score			

Notes:

Behaviors:

- □ Preparatory Acts (e.g., buying pills, purchasing a gun, giving things away, writing a suicide note)
- □ Aborted/self-interrupted attempts,
- □ Interrupted attempts and
- □ Actual attempts

□ **Assess for the presence of non-suicidal self-injurious behavior** (e.g. cutting, hair pulling, cuticle biting, skin picking) particularly among adolescents and young adults, and especially among those with a history of mood or externalizing disorders

□ **For Youths:** ask parents/guardian about evidence of suicidal thoughts, plans or behaviors and changes in mood, behaviors or disposition

□ **Assess for homicidal ideation, plan behavior and intent** particularly in:

- □ character disordered males dealing with separation, especially if paranoid, or impulsivity disorders

SAFE-T Protocol with C-SSRS, Safety Planning and Telephone Follow-up

High Risk

- ***Suicidal ideation with intent*** or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5)

Or

- ***Suicidal behavior within past 3 months*** (C-SSRS Suicidal Behavior)

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential **clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."
From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

RISK STRATIFICATION	TRIAGE	POSSIBLE INTERVENTIONS
High Risk □ Suicidal ideation with intent or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5) Or □ Suicidal behavior **within past 3 months** (C-SSRS Suicidal Behavior)	Refer to Psychologist or Psychiatrist to evaluate for hospitalization Place on Facility High Risk List	□ Assessment of patient's medical stability □ Observation Status □ Elopement precautions □ Body/belongings search □ Pharmacological treatment □ Family/significant-other engagement □ Psychotherapy (CBT, DBT) □ Psychoeducation (coping skills, stress management, symptom management, etc.) □ Safety Plan □ Telephone Follow-up upon discharge **Safety needs to consider in the physical environment:** □ Assess the physical environment, focusing on limiting access to methods. The most common methods of suicide in hospitals are hanging, suffocation and jumping. **If risk assessment is conducted in outpatient setting:** □ Place individual in a room that is away from exits but close to staff where patient is observed at all times □ Beware of elopement risk if patient is against admission AND/OR wanting to be alone to follow through with plans of suicide
Moderate Risk □ Suicidal ideation **WITHOUT plan, intent or behavior in past month** (C-SSRS screen #2 or #3) Or □ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior) Or □ Multiple risk factors and few protective factors	Refer to mental health professional to evaluate risk factors and determine appropriate treatment setting	□ Pharmacological treatment □ Psychotherapy (CBT, DBT) □ Psychoeducation (coping skills, stress management, symptom management, etc.) □ Engagement with family-member or significant-other □ Safety Plan □ Provide National Suicide Prevention Lifeline card and local emergency contacts
Low Risk □ Wish to die (C-SSRS Suicidal Ideation #1) **no plan, intent or behavior** Or □ Suicidal ideation more than 1 month ago **WITHOUT plan, intent or behavior** (C-SSRS screen #2 or #3) Or □ Modifiable risk factors and strong protective factors Or □ No reported history of Suicidal Ideation or Behavior	Outpatient	□ Provide information about warning signs. □ Provide National Suicide Prevention Lifeline card and local emergency contacts □ Wellness Recovery Action Planning (WRAP) □ Re-assess at treatment plan review

SAFE-T Protocol with C-SSRS, Safety Planning and Telephone Follow-up

High Risk Triage

- Refer to Psychologist or Psychiatrist to evaluate for hospitalization
- Place on Facility High Risk List

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential **clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."
From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

RISK STRATIFICATION	TRIAGE	POSSIBLE INTERVENTIONS
High Risk □ Suicidal ideation with intent or intent with plan in past Behavior)	Refer to Psychologist or Psychiatrist to evaluate for hospitalization Place on Facility High Risk List	□ Assessment of patient's medical stability □ Observation Status □ Elopement precautions □ Body/belongings search □ Pharmacological treatment □ Family/significant-other engagement □ Psychotherapy (CBT, DBT) □ Psychoeducation (coping skills, stress management, symptom management, etc.) □ Safety Plan □ Telephone Follow-up upon discharge **Safety needs to consider in the physical environment:** □ Assess the physical environment, focusing on limiting access to methods. The most common methods of suicide in hospitals are hanging, suffocation and jumping. **If risk assessment is conducted in outpatient setting:** □ Place individual in a room that is away from exits but close to staff where patient is observed at all times □ Beware of elopement risk if patient is against admission AND/OR wanting to be alone to follow through with plans of suicide
Moderate Risk □ Suicidal ideation **WITHOUT plan, intent or behavior in past month** (C-SSRS screen #2 or #3) Or □ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior) Or □ Multiple risk factors and few protective factors	Refer to mental health professional to evaluate risk factors and determine appropriate treatment setting	□ Pharmacological treatment □ Psychotherapy (CBT, DBT) □ Psychoeducation (coping skills, stress management, symptom management, etc.) □ Engagement with family-member or significant-other □ Safety Plan □ Provide National Suicide Prevention Lifeline card and local emergency contacts
Low Risk □ Wish to die (C-SSRS Suicidal Ideation #1) **no plan, intent or behavior** Or □ Suicidal ideation more than 1 month ago **WITHOUT plan, intent or behavior** (C-SSRS screen #2 or #3) Or □ Modifiable risk factors and strong protective factors Or □ No reported history of Suicidal Ideation or Behavior	Outpatient	□ Provide information about warning signs. □ Provide National Suicide Prevention Lifeline card and local emergency contacts □ Wellness Recovery Action Planning (WRAP) □ Re-assess at treatment plan review

SAFE-T Protocol with C-SSRS, Safety Planning and Telephone Follow-up

High Risk Possible Interventions

- Assessment of patient's medical stability
- Observation Status
- Elopement precautions
- Body/belongings search
- Pharmacological treatment
- Family/significant-other engagement
- Psychotherapy (CBT, DBT)
- Psychoeducation (coping skills, stress management,
- symptom management, etc.)
- Safety Plan
- Telephone Follow-up upon discharge

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential **clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."
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RISK STRATIFICATION	TRIAGE	POSSIBLE INTERVENTIONS
High Risk Behavior)	Refer to Psychologist or High Risk List	☐ Assessment of patient's medical stability ☐ Observation Status ☐ Elopement precautions ☐ Body/belongings search ☐ Pharmacological treatment ☐ Family/significant-other engagement ☐ Psychotherapy (CBT, DBT) ☐ Psychoeducation (coping skills, stress management, symptom management, etc.) ☐ Safety Plan ☐ Telephone Follow-up upon discharge **Safety needs to consider in the physical environment:** ☐ Assess the physical environment, focusing on limiting access to methods. The most common methods of suicide in hospitals are hanging, suffocation and jumping. **If risk assessment is conducted in outpatient setting:** ☐ Place individual in a room that is away from exits but close to staff where patient is observed at all times ☐ Beware of elopement risk if patient is against admission AND/OR wanting to be alone to follow through with plans of suicide
Moderate Risk ☐ Suicidal ideation **WITHOUT plan, intent or behavior in past month** (C-SSRS screen #2 or #3) Or ☐ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior) Or ☐ Multiple risk factors and few protective factors	Refer to mental health professional to evaluate risk factors and determine appropriate treatment setting	☐ Pharmacological treatment ☐ Psychotherapy (CBT, DBT) ☐ Psychoeducation (coping skills, stress management, symptom management, etc.) ☐ Engagement with family-member or significant-other ☐ Safety Plan ☐ Provide National Suicide Prevention Lifeline card and local emergency contacts
Low Risk ☐ Wish to die (C-SSRS Suicidal Ideation #1) no plan, intent or behavior Or ☐ Suicidal ideation more than 1 month ago **WITHOUT plan, intent or behavior** (C-SSRS screen #2 or #3) Or ☐ Modifiable risk factors and strong protective factors Or ☐ No reported history of Suicidal Ideation or Behavior	Outpatient	☐ Provide information about warning signs. ☐ Provide National Suicide Prevention Lifeline card and local emergency contacts ☐ Wellness Recovery Action Planning (WRAP) ☐ Re-assess at treatment plan review

SAFE-T Protocol with C-SSRS, Safety Planning and Telephone Follow-up

High Risk Possible Interventions

Safety needs to consider in the physical environment:

- Assess the physical environment, focusing on limiting access to methods. The most common methods of suicide in hospitals are hanging, suffocation and jumping.

If risk assessment is conducted in outpatient setting:

- Place individual in a room that is away from exits but close to staff where patient is observed at all times
- Beware of elopement risk if patient is against admission AND/OR wanting to be alone to follow through with plans of suicide

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential clinical judgment, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."
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RISK STRATIFICATION	TRIAGE	POSSIBLE INTERVENTIONS
High Risk Behavior)	Refer to Psychologist or High Risk List	☐ Assessment of patient's medical stability ☐ Observation Status ☐ Elopement precautions ☐ Body/belongings search ☐ Pharmacological treatment ☐ Family/significant-other engagement ☐ Psychotherapy (CBT, DBT) ☐ Psychoeducation (coping skills, stress management, symptom management, etc.) ☐ Safety Plan ☐ Telephone Follow-up upon discharge **Safety needs to consider in the physical environment:** ☐ Assess the physical environment, focusing on limiting access to methods. The most common methods of suicide in hospitals are hanging, suffocation and jumping. **If risk assessment is conducted in outpatient setting:** ☐ Place individual in a room that is away from exits but close to staff where patient is observed at all times ☐ Beware of elopement risk if patient is against admission AND/OR wanting to be alone to follow through with plans of suicide
Moderate Risk ☐ Suicidal ideation WITHOUT plan, intent or behavior in past month (C-SSRS screen #2 or #3) Or ☐ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior) Or ☐ Multiple risk factors and few protective factors	Refer to mental health professional to evaluate risk factors and determine appropriate treatment setting	☐ Pharmacological treatment ☐ Psychotherapy (CBT, DBT) ☐ Psychoeducation (coping skills, stress management, symptom management, etc.) ☐ Engagement with family-member or significant-other ☐ Safety Plan ☐ Provide National Suicide Prevention Lifeline card and local emergency contacts
Low Risk ☐ Wish to die (C-SSRS Suicidal Ideation #1) no plan, intent or behavior Or ☐ Suicidal ideation more than 1 month ago WITHOUT plan, intent or behavior (C-SSRS screen #2 or #3) Or ☐ Modifiable risk factors and strong protective factors Or ☐ No reported history of Suicidal Ideation or Behavior	Outpatient	☐ Provide information about warning signs. ☐ Provide National Suicide Prevention Lifeline card and local emergency contacts ☐ Wellness Recovery Action Planning (WRAP) ☐ Re-assess at treatment plan review

SAFE-T Protocol with C-SSRS, Safety Planning and Telephone Follow-up

General Guidelines for;

- Treatment plan for reducing risk level
- Suicide risk following discharge from inpatient setting
- Community Prevention Practices
- Guidelines for when to document suicide risk assessment

Step 5: Document Level of Risk, Rationale for Risk Assignment, Intervention and Structured Follow Up Plan (to be developed)

Risk Level :

[ ] High Risk [ ] Moderate Risk [ ] Low Risk Suicidal

Clinical Formulation:

1- Specify findings from Steps 1-3 (including risk and protective factors).
2- State clinical rationale for selected risk level and treatment setting.

Treatment Plan for Reducing Risk Level:

☐ **If Suicidal:**
1- Discuss risk-linked interventions (see Step 4 for possible interventions)
2- Identify risk and protective factors that can be modified through treatment and intervention
3- If Access to Means is present, document instructions to patient and significant others
4- Develop *Risk Reduction Plan* with specific interventions to reduce risk factors and enhance protective factors.
5- Develop *Safety needs* for individual's physical environment and *Special Observations*, if warranted.
6- Create a Safety Plan
7- Create a Follow-up plan

☐ **If not suicidal:**
1- Discuss warning signs
2- Provide National Lifeline information
3- Re-assess at treatment plan review

Suicide-Risk Following Discharge from INPATIENT Setting:

The highest risk of suicide is within the **first three days of discharge** from inpatient setting.
The next highest risk of suicide is during the **first 30 days** post discharge.

Community Prevention Practices

☐ ***3 & 30 Follow-up:*** Outpatient appointment **MUST** be scheduled within the **first 3 days of discharge** with **close follow up** and support **during the first 30 days** of inpatient discharge.

☐ ***Warm-hand off*** and ***Peer Bridger:*** Outpatient staff and/or Peer Bridger meet with individual as an inpatient. Same Bridger and outpatient staff continues shared collaboration and connection with individual until outpatient connection and follow-up services are in place.

☐ **Safety Plan** must be developed during the inpatient stay and shared with the individual's outpatient provider.

Guidelines for When to Document Suicide Risk Assessments:

☐ At the time of inpatient and/or outpatient admission
☐ With occurrence of any suicidal behavior or ideation
☐ Whenever there is clinical change
☐ Before increasing privileges or giving passes (if individual is in an inpatient setting for moderate /high risk individuals)
☐ At regular intervals (i.e., treatment plan review) or as clinically indicated
☐ At the time of inpatient or outpatient discharge

Collaborative Accountability:

A team-based, collaborative, shared responsibility approach to enhance individual's safety and foster on-going communication among team-members.

Lethal Means Counseling

As taken from “Means Matter” from the Harvard School of Public Health, www.meansmatter.org

If you're concerned that a patient or client is suicidal, in addition to using your standard clinical strategies to assess and manage suicidal risk, talk with them and their family members about whether there are firearms and other lethal means at home.

Speak with the Client's Family and Loved Ones

(If the client is an adult, follow your agency's protocols regarding gaining the client's permission to contact family/loved ones)

- Explain that you're concerned their loved one is at risk for suicide.
- Ask if there are firearms at home and explain why you're asking (the presence of a gun increases the chance that a suicide attempt will be fatal).
- Ask the men too. When clinicians speak with a parent, it is often the mother. Women don't always know when their male partner has a firearm at home. If possible, speak with all adults in the home.
- Ask about all firearms. If there's one gun, there's usually more than one.

Lethal Means Counseling

- Assess each relevant household (e.g., for a teenager in a joint custody situation, ask about both parent's homes).
- Advise that the safest option is not having firearms at home until the situation improves.
- Local law enforcement may be able to store the guns (or dispose of them). (Don't state that this is a definite option unless you're acquainted with the agency's policy; not all agencies provide this service.)
- Sympathize with gun owners who find the option of living without a firearm at home, even temporarily, very difficult. Don't minimize that this is a tough sacrifice. You're all on the same team trying to keep the patient safe. But be firm that the safest option is keeping guns out of a suicidal person's home.
- Storing the firearms at a trusted friend's or relative's until the situation improves may be an acceptable option to the owner. Not everyone can hold on to firearms.*

Lethal Means Counseling

- Locking the firearms up is also an option if the family won't remove the guns, but it's not the safest option. Lock all firearms unloaded in a safe designed for firearms or in a tamper-proof, locked storage place. Lock the ammunition separately. Better yet, advise the family not to keep ammunition at home until the situation improves. Be sure the keys or combinations aren't accessible to the person at risk.
- Hiding unlocked guns is not advised. Remember, kids know their parent's hiding places!
- Document in your notes that you've reviewed this information with the family.
- Don't limit your conversation to lethal means. Lethal means counseling is only one part of a comprehensive approach to activating the client's support system.

Lethal Means Counseling

- **Note**: Most people who kill themselves (except with pills) do so on their first attempt. Many never sought treatment for suicidal feelings. As a clinician, you may come into contact with them over some other issue--marriage counseling, court-remanded anger management, substance abuse treatment, etc. This underlines the importance of including suicide assessment with all clients.

Medications

- Limit prescriptions of lethal medications to suicidal patients to a non-lethal quantity.
- Call the Poison Control Hotline if you need help determining a non-lethal quantity: 1-800-222-1222.
- Advise clients and families to remove lethal doses from the home.
- Document in your notes that you've reviewed this information with the client.