HANDOUT #1

Self-Directed Violence (SDV) Classification System
Clinical Tool—Key Terms (CDC)

Self-Directed Violence: Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.

Suicidal Intent: There is past or present evidence (implicit or explicit) that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions. Suicidal intent can be determined retrospectively and in the absence of suicidal behavior.

Preparatory Behavior: Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away).

Physical Injury (paraphrased): A bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical, or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance (e.g., bodily harm due to suffocation, poisoning or overdoses, lacerations, gunshot wounds, etc.). Refer to the Classification System for the Centers for Disease Control and Prevention definition.

Interrupted By Self or Other: A person takes steps to injure self but is stopped by self/another person prior to fatal injury. The interruption may occur at any point.

Suicide Attempt: A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior.

Suicide: Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior.

BEGIN WITH THESE 3 QUESTIONS·

1. Is there any indication that the person engaged in self-directed violent behavior that was lethal, preparatory, or potentially harmful.
   If NO, proceed to Question 2 **If YES, proceed to Question 3**

2. Is there any indication that the person had self-directed violence related <u>thoughts?</u>
   If NO to Questions 1 and 2, there is insufficient evidence to suggest self-directed violence----NO SDV TERM
   IF YES, proceed to Decision Tree A

3. Did the behavior involve any <u>injury</u> or did it result in death?
   If NO, proceed to Decision Tree B
   If YES, proceed to Decision Tree C

Self-Directed Violence Classification System*

Type	Sub-Type	Definition	Modifiers	Terms
Thoughts	Non-Suicidal Self-Directed Violence Ideation	Self-reported thoughts regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent. For example, persons engage in Non-Suicidal Self-Directed Violence Ideation in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).	N/A	•Non-Suicidal Self-Directed Violence Ideation
	Suicidal Ideation	Thoughts of engaging in suicide-related behavior. For example, intrusive thoughts of suicide without the wish to die would be classified as Suicidal Ideation, Without Intent.	•Suicidal Intent: -Without -Undetermined -With	•Suicidal Ideation, Without Suicidal Intent •Suicidal Ideation, With Undetermined Suicidal Intent •Suicidal Ideation, With Suicidal Intent
Behaviors	Preparatory	Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away). For example, hoarding medication for the purpose of overdosing would be classified as Suicidal Self-Directed Violence, Preparatory.	•Suicidal Intent: -Without -Undetermined -With	•Non-Suicidal Self-Directed Violence, Preparatory •Undetermined Self-Directed Violence, Preparatory •Suicidal Self-Directed Violence, Preparatory
	Non-Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent. For example, persons engage in Non-Suicidal Self-Directed Violence in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).	•Injury -Without -With -Fatal •Interrupted by Self or Other	•Non-Suicidal Self-Directed Violence, Without Injury •Non-Suicidal Self-Directed Violence, Without Injury, Interrupted by Self or Other •Non-Suicidal Self-Directed Violence, With Injury •Non-Suicidal Self-Directed Violence, With Injury, Interrupted by Self or Other •Non-Suicidal Self-Directed Violence, Fatal
	Undetermined Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Suicidal intent is unclear based upon the available evidence. For example, the person is unable to admit positively to the intent to die (e.g., unconsciousness, incapacitation, intoxication, acute psychosis, disorientation, or death); **OR** the person is reluctant to admit positively to the intent to die for other or unknown reasons.	•Injury -Without -With -Fatal •Interrupted by Self or Other	•Undetermined Self-Directed Violence, Without Injury •Undetermined Self-Directed Violence, Without Injury, Interrupted by Self or Other •Undetermined Self-Directed Violence, With Injury •Undetermined Self-Directed Violence, With Injury, Interrupted by Self or Other •Undetermined Self-Directed Violence, Fatal
	Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent. For example, a person with the wish to die cutting her wrists with a knife would be classified as Suicide Attempt, With Injury.	•Injury -Without -With -Fatal •Interrupted by Self or Other	•Suicide Attempt, Without Injury •Suicide Attempt, Without Injury, Interrupted by Self or Other •Suicide Attempt, With Injury •Suicide Attempt, With Injury, Interrupted by Self or Other •Suicide

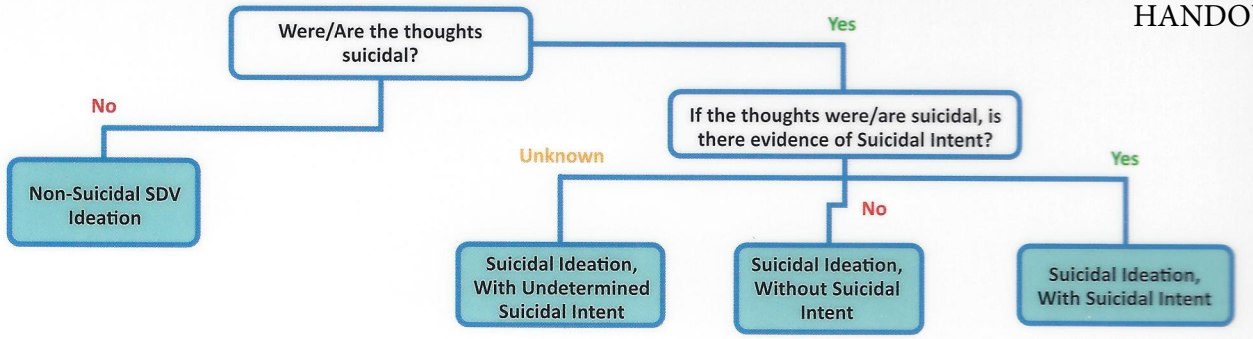
* Developed in collaboration with the Centers for Disease Control and Prevention

Self-Directed Violence Classification System*

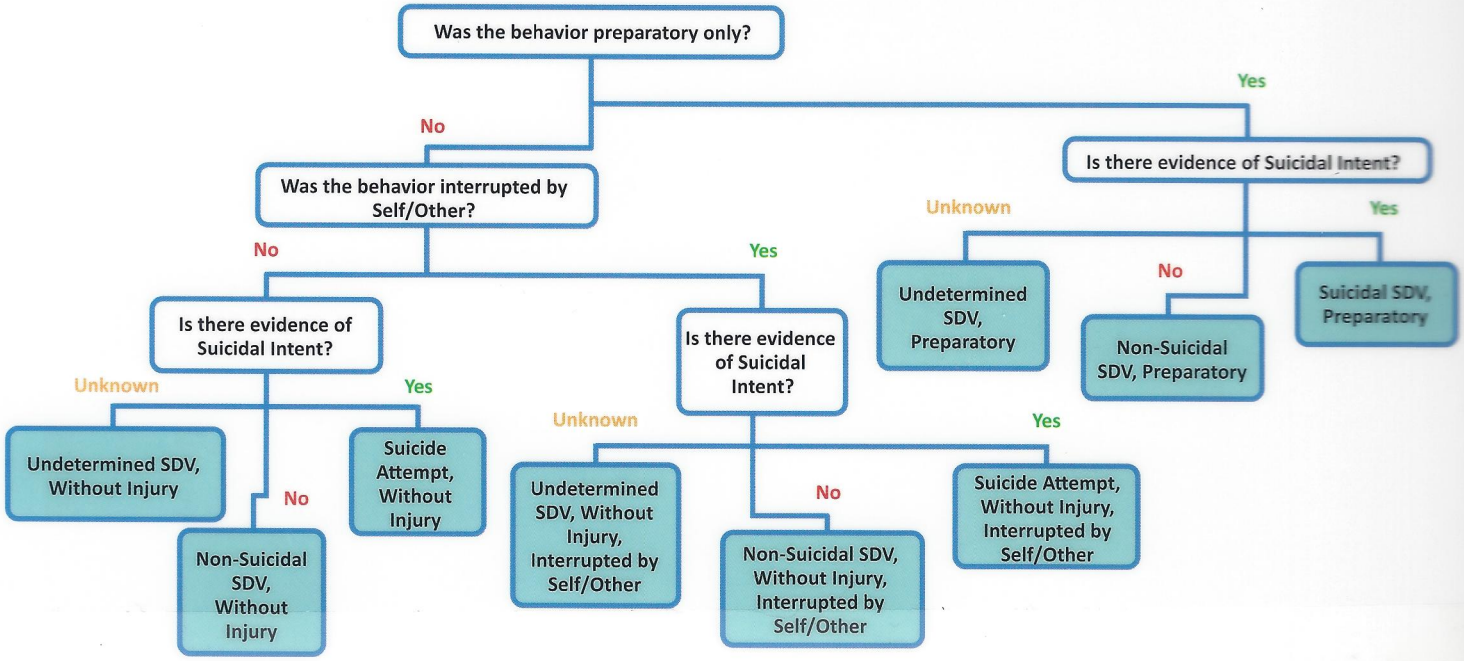
Key Terms	***Self-Directed Violence:*** Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. ***Suicidal Intent***: There is past or present evidence (explicit and/or implicit) that at the time of injury the individual intended to kill self and wished to die and that the individual understood the probable consequences of his or her actions. ***Physical Injury:*** A (suspected) bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical, or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance. In some cases an injury results from an insufficiency of vital elements, such as oxygen. Acute poisonings and toxic effects, including overdoses of substances and wrong substances given or taken in error are included, as are adverse effects and complications of therapeutic, surgical and medical care. Psychological injury is excluded in this context. ***Interrupted By Self or Other****:* A person takes steps to injure self but is stopped by self/another person prior to fatal injury. The interruption may occur at any point. ***Suicide Attempt***: A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior. ***Suicide***: Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior.

* Developed in collaboration with the Centers for Disease Control and Prevention

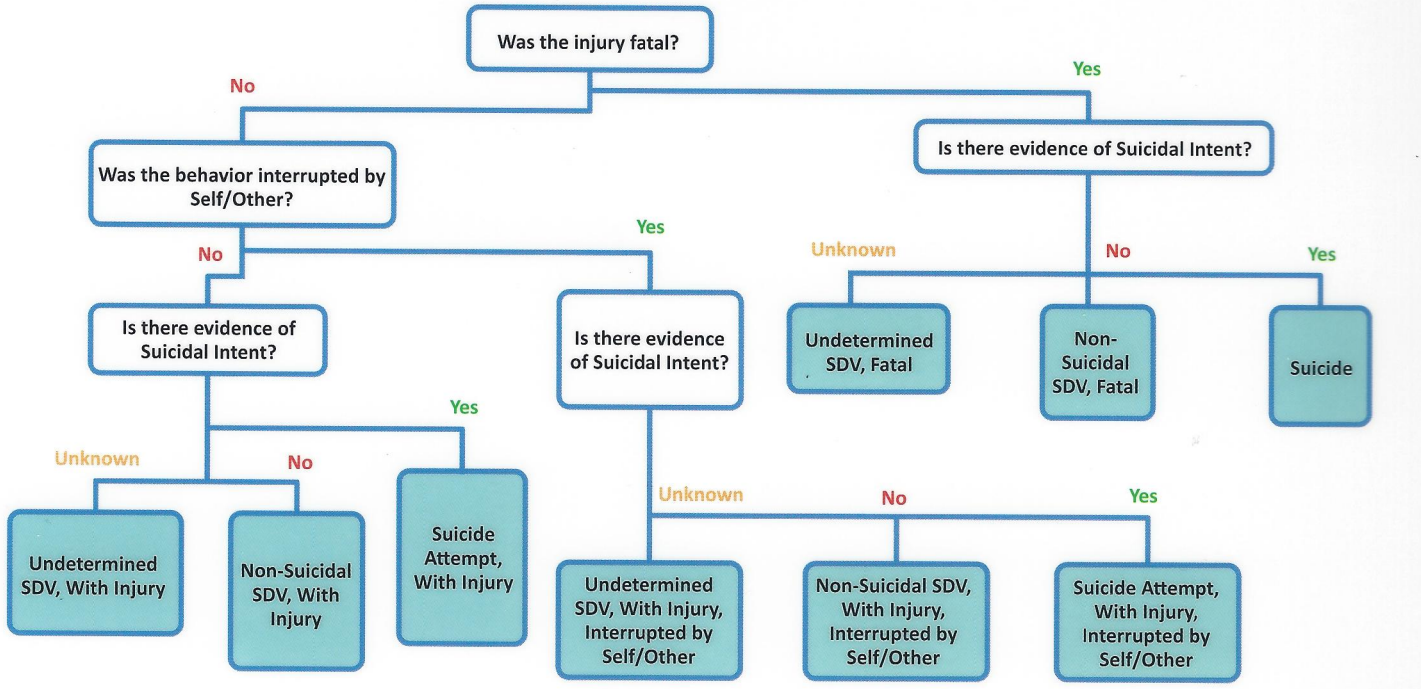
DECISION TREE A: THOUGHTS



DECISION TREE B: BEHAVIORS, WITHOUT INJURY



DECISION TREE C: BEHAVIORS, WITH INJURY



HANDOUT #4

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version with Triage Points

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	**Past month**	
Ask questions that are in bolded and underlined	**Yes**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan*." ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to "*I have the thoughts but I definitely will not do anything about them*." ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question ***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. **If YES, ask: *How long ago did you do any of these?*** · Over a year ago? · Between three months and a year ago? · Within the last three months?		

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version with Triage Points

II. Response Protocol to C-SSRS Screening

(Linked to last item answered YES)

Item 1 – Mental Health Referral at discharge
Item 2 – Mental Health Referral at discharge
Item 3 – Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor/ Procedures
Item 4 – Psychiatric Consultation and Patient Safety Monitor/ Procedures
Item 5 – Psychiatric Consultation and Patient Safety Monitor/ Procedures
Item 6 – If over a year ago, Mental Health Referral at discharge
If between 1 week and 1 year ago- Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor
If one week ago or less- Psychiatric Consultation and Patient Safety Monitor

Disposition:
- Mental Health Referral at discharge
- Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor/ Procedures
- Psychiatric Consultation and Patient Safety Monitor/ Procedures

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

CAMS Suicide Status Form-SSF IV (Initial Session)

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (*Patient*):

Rate and fill out each item according to how you feel right now.
Then rank in order of importance 1 to 5 (1=most important to 5=least important).

Rank	
____	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*): **Low pain: 1 2 3 4 5 :High pain** What I find most painful is: _____
____	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): **Low stress: 1 2 3 4 5 :High stress** What I find most stressful is: _____
____	3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*): **Low agitation: 1 2 3 4 5 :High agitation** I most need to take action when: _____
____	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): **Low hopelessness: 1 2 3 4 5 :High hopelessness** I am most hopeless about: _____
____	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): **Low self-hate: 1 2 3 4 5 :High self-hate** What I hate most about myself is: _____
N/A	6) RATE OVERALL RISK OF SUICIDE: **Extremely low risk: 1 2 3 4 5 :Extremely high risk (will not kill self) (will kill self)**

1) How much is being suicidal related to thoughts and feelings about yourself? **Not at all: 1 2 3 4 5 : completely**
2) How much is being suicidal related to thoughts and feelings about others? **Not at all: 1 2 3 4 5 : completely**

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	**Rank**	REASONS FOR DYING

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much
I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be: _____

_____

Suicide Status Form-IV (Initial Session—page 2)

Section B (*Clinician*):

Y N Suicide plan: When: _____
Where: _____
How: _____ Y N Access to means
How: _____ Y N Access to means

Y N Suicide Preparation Describe: _____

Y N Suicide Rehearsal Describe: _____

Y N History of Suicidality

- Ideation Describe: _____
  - Frequency _____ per day _____ per week ____ per month
  - Duration _____ seconds _____ minutes ____ hours
- Single Attempt Describe: _____
- Multiple Attempts Describe: _____

Y N Current Intent Describe: _____

Y N Impulsivity Describe: _____

Y N Substance abuse Describe: _____

Y N Significant loss Describe: _____

Y N Interpersonal isolation Describe: _____

Y N Relationship problems Describe: _____

Y N Burden to others Describe: _____

Y N Health problems Describe: _____

Y N Physical pain Describe: _____

Y N Legal problems Describe: _____

Y N Shame Describe: _____

Section C (*Clinician*):

TREATMENT PLAN (Refer to Sections A & B)

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	*Self-Directed Violence*	*Safety and Stability*	*SSF Stabilization Plan Completed* ☐	
2				
3				

YES ____ NO _____ Patient understands and concurs with treatment plan?
YES ____ NO _____ Patient at imminent danger of suicide (hospitalization indicated)?

_____ _____

Patient Signature Date Clinician Signature Date

SSF STABILIZATION PLAN

Ways to reduce access to lethal means:

1. _____

2. _____

3. _____

Things I can do to cope differently when I am in a suicide crisis (consider crisis card):

1. _____

2. _____

3. _____

4. _____

5. _____

6. **Life or death emergency contact number:** _____

People I can call for help or to decrease my isolation:

1. _____

2. _____

3. _____

Attending treatment as scheduled:

Potential Barrier: Solutions I will try:

1. _____

2. _____

Section D (*Clinician Post-Session Evaluation*):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS:	ALERT DROWSY LETHARGIC STUPOROUS
	OTHER: _____
ORIENTED TO:	PERSON PLACE TIME REASON FOR EVALUATION
MOOD:	EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY
AFFECT:	FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE
THOUGHT CONTINUITY:	CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
	OTHER: _____
THOUGHT CONTENT:	WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY
	OTHER: _____
ABSTRACTION:	WNL NOTABLY CONCRETE
	OTHER: _____
SPEECH:	WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
	OTHER: _____
MEMORY:	GROSSLY INTACT
	OTHER: _____
REALITY TESTING:	WNL
	OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

PRELIMINARY DSM-IV-R MULTI-AXIAL DIAGNOSES:

Axis I _____

_____

Axis II _____

_____

Axis III _____

Axis IV _____

Axis V _____

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

- ❑ **No Significant Risk**
- ❑ **Mild**
- ❑ **Moderate**
- ❑ **Severe**
- ❑ **Extreme**

Explanation:

_____

_____

_____

CASE NOTES:

_____

_____

_____

_____

Next Appointment Scheduled: _____ Treatment Modality: _____

_____

Clinician Signature Date

CAMS On-Going Care

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (*Patient*):

Rate each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*):	**Low pain: 1 2 3 4 5 :High pain**
2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):	**Low stress: 1 2 3 4 5 :High stress**
3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*):	**Low agitation: 1 2 3 4 5 :High agitation**
4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*):	**Low hopelessness: 1 2 3 4 5 :High hopelessness**
5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):	**Low self-hate: 1 2 3 4 5 :High self-hate**
6) RATE OVERALL RISK OF SUICIDE:	**Extremely low risk: (will not kill self) 1 2 3 4 5 :Extremely high risk (will kill self)**

In the past week: Suicidal Thoughts/Feelings Y__ N__ Managed Thoughts/Feelings Y__ N__ Suicidal Behavior Y__ N__

Section B (*Clinician*):

Resolution of suicidality, if: current overall risk of suicide <3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings ☐ 1st session ☐ 2nd session

Complete **SSF Outcome Form at 3rd consecutive resolution session**

TREATMENT PLAN UPDATE

Patient Status:

☐ Discontinued treatment ☐ No show ☐ Cancelled ☐ Hospitalization ☐ Referred/Other: _____

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	*Self-Directed Violence*	*Safety and Stability*	*SSF Stabilization Plan Updated* ☐	
2				
3				

_____ _____

Patient Signature Date Clinician Signature Date

Section C *(Clinician Post-Session Evaluation):*

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS:	ALERT DROWSY LETHARGIC STUPOROUS OTHER: _____
ORIENTED TO:	PERSON PLACE TIME REASON FOR EVALUATION
MOOD:	EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY
AFFECT:	FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE
THOUGHT CONTINUITY:	CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL OTHER: _____
THOUGHT CONTENT:	WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY OTHER: _____
ABSTRACTION:	WNL NOTABLY CONCRETE OTHER: _____
SPEECH:	WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT OTHER: _____
MEMORY:	GROSSLY INTACT OTHER: _____
REALITY TESTING:	WNL OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DSM-IV-R MULTI-AXIAL DIAGNOSES:

Axis I _____

_____

Axis II _____

_____

Axis III _____

Axis IV _____

Axis V _____

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

- ❑ **No Significant Risk**
- ❑ **Mild**
- ❑ **Moderate**
- ❑ **Severe**
- ❑ **Extreme**

Explanation:

_____

_____

_____

CASE NOTES:

_____

_____

_____

_____

Next Appointment Scheduled: _____ Treatment Modality: _____

_____

Clinician Signature Date

CAMS Outcome (Final Session)

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (*Patient*):

Rate each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*):	**Low pain:**	**1**	**2**	**3**	**4**	**5**	**:High pain**
2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):	**Low stress:**	**1**	**2**	**3**	**4**	**5**	**:High stress**
3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*):	**Low agitation:**	**1**	**2**	**3**	**4**	**5**	**:High agitation**
4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*):	**Low hopelessness:**	**1**	**2**	**3**	**4**	**5**	**:High hopelessness**
5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):	**Low self-hate:**	**1**	**2**	**3**	**4**	**5**	**:High self-hate**
6) RATE OVERALL RISK OF SUICIDE:	**Extremely low risk: (will not kill self)**	**1**	**2**	**3**	**4**	**5**	**:Extremely high risk (will kill self)**

In the past week: Suicidal Thoughts/Feelings Y__ N__ Managed Thoughts/Feelings Y__ N__ Suicidal Behavior Y__ N__

Were there any aspects of your treatment that were particularly helpful to you? If so, please describe these. Be as specific as possible.

What have you learned from your clinical care that could help you if you became suicidal in the future?

Section B (*Clinician*):

Third consecutive session of resolved suicidality: ____ Yes ____ No (if no, continue CAMS tracking)

**Resolution of suicidality, if for third consecutive week: current overall risk of suicide <3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings

OUTCOME/DISPOSITION (Check all that apply):

___ Continuing outpatient psychotherapy ___ Inpatient hospitalization

___ Mutual termination ___ Patient chooses to discontinued treatment (unilaterally)

___ Referral to: _____

___ Other. Describe: _____

Next Appointment Scheduled (if applicable): _____

_____ _____

Patient Signature Date Clinician Signature Date

Section C (*Clinician Outcome Evaluation*):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS:	ALERT DROWSY LETHARGIC STUPOROUS
	OTHER: _____
ORIENTED TO:	PERSON PLACE TIME REASON FOR EVALUATION
MOOD:	EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY
AFFECT:	FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE
THOUGHT CONTINUITY:	CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
	OTHER: _____
THOUGHT CONTENT:	WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY
	OTHER: _____
ABSTRACTION:	WNL NOTABLY CONCRETE
	OTHER: _____
SPEECH:	WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
	OTHER: _____
MEMORY:	GROSSLY INTACT
	OTHER: _____
REALITY TESTING:	WNL
	OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DSM-IV-R MULTI-AXIAL DIAGNOSES:

Axis I _____

_____

Axis II _____

_____

Axis III _____

Axis IV _____

Axis V _____

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

- ❑ **No Significant Risk**
- ❑ **Mild**
- ❑ **Moderate**
- ❑ **Severe**
- ❑ **Extreme**

Explanation:

_____

_____

_____

CASE NOTES:

_____

_____

_____

_____

_____

_____

Clinician Signature Date

How do you Remember the Warning Signs of Suicide?

Here's an Easy-to-Remember Mnemonic:

IS PATH WARM?

I	Ideation
S	Substance Abuse
P	Purposelessness
A	Anxiety
T	Trapped
H	Hopelessness
W	Withdrawal
A	Anger
R	Recklessness
M	Mood Change

A person in acute risk for suicidal behavior most often will show:

Warning Signs of Acute Risk:

- Threatening to hurt or kill him or 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.

These might be remembered as expressed or communicated **IDEATION**. If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral.

Additional Warning Signs:

Increased **SUBSTANCE** (alcohol or drug) use
No reason for living; no sense of **PURPOSE** in life
ANXIETY, agitation, unable to sleep or sleeping all the time
Feeling **TRAPPED** - like there's no way out
HOPELESSNESS
WITHDRAWING from friends, family and society
Rage, uncontrolled **ANGER**, seeking revenge
Acting **RECKLESS** or engaging in risky activities, seemingly without thinking
Dramatic **MOOD** changes

If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral.

These warning signs were compiled by a task force of expert clinical-researchers and 'translated' for the general public.

RESOURCES

- Download this card and additional resources at **www.sprc.org** or at **www.stopasuicide.org**
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide **www.sprc.org/library/jcsafetygoals.pdf**
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors **www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx**
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

ACKNOWLEDGEMENTS

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National Suicide Prevention Lifeline

1.800.273.TALK (8255)

www.sprc.org

www.mentalhealthscreening.org

HANDOUT #7

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

for Mental Health Professionals

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans behavior and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention and follow-up

NATIONAL SUICIDE PREVENTION LIFELINE

1.800.273.TALK (8255)

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity). *Co-morbidity* and *recent onset of illness increase risk*
- **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- **Family history:** of suicide, attempts or Axis 1 psychiatric disorders requiring hospitalization
- **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame or despair (e.g., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation.
- **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- **Ideation:** frequency, intensity, duration--in last 48 hours, past month and worst ever
- **Plan:** timing, location, lethality, availability, preparatory acts
- **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self injurious actions
- **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live

** For Youths: ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors or disposition*
** Homicide Inquiry: when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.*

4. RISK LEVEL/INTERVENTION

- **Assessment** of risk level is based on clinical judgment, after completing steps 1-3
- **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (e.g., setting, medication, psychotherapy, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.

SUICIDE/SELF HARM ASSESSMENT TOOL

HANDOUT #8

FRANCISCAN HEALTH SYSTEM

Date:	Points		
	0	1	2
Suicidal ideation	No current suicidal thoughts ❑ Night ❑ Day ❑ Evening	Intermittent or fleeting suicidal thoughts ❑ Night ❑ Day ❑ Evening	Constant suicidal thoughts ❑ Night ❑ Day ❑ Evening
Suicide plan	No plan ❑ Night ❑ Day ❑ Evening	Has plan without access to planned method ❑ Night ❑ Day ❑ Evening	Has plan with actual or potential access ❑ Night ❑ Day ❑ Evening
Plan lethality (while in hospital)	No plan ❑ Night ❑ Day ❑ Evening	Low lethality of plan (e.g., superficial scratching, head banging, pillow over face, biting, holding breath) ❑ Night ❑ Day ❑ Evening	Highly lethal plan (e.g., cutting, overdose, hanging, jumping) ❑ Night ❑ Day ❑ Evening
Elopement	No elopement risk ❑ Night ❑ Day ❑ Evening	Low elopement risk ❑ Night ❑ Day ❑ Evening	High elopement risk ❑ Night ❑ Day ❑ Evening
Symptoms (check all that apply) Night Day Evening ❑ ❑ ❑ Impulsivity ❑ ❑ ❑ Shame ❑ ❑ ❑ Helplessness ❑ ❑ ❑ Anhedonia ❑ ❑ ❑ Hopelessness ❑ ❑ ❑ Guilt ❑ ❑ ❑ Anger/ rage	0 - 2 symptoms present ❑ Night ❑ Day ❑ Evening	3 - 4 symptoms present ❑ Night ❑ Day ❑ Evening	More than 4 symptoms present ❑ Night ❑ Day ❑ Evening
Current morbid thoughts (e.g., reunion fantasies, preoccupation with death)	None / Rarely ❑ Night ❑ Day ❑ Evening	Frequently ❑ Night ❑ Day ❑ Evening	Constantly ❑ Night ❑ Day ❑ Evening
Agrees to a plan for safety while in the hospital	Reliably agrees to a safety plan ❑ Night ❑ Day ❑ Evening	Agrees to a safety plan but is ambivalent or guarded ❑ Night ❑ Day ❑ Evening	Unwilling or unable to agree to a safety plan ❑ Night ❑ Day ❑ Evening

Refer to H&P or psychosocial Assessment	Current admission precipitated by suicide attempt		Attempt history	
	❑ 0	❑ 2	❑ 0	❑ 1
	No	Yes	No previous attempts	Past attempts

Clinician's subjective appraisal of risk:		Night	Day	Evening
Patient's replies not trustworthy, several nonverbal cues	4	❑	❑	❑
Patient's replies questionably trustworthy, at least 1 nonverbal cue	3	❑	❑	❑
Patient's replies trustworthy	0	❑	❑	❑

Scoring key:			Total Score:
	High potential	= 10 or more	
	Moderate potential	= 7 - 9	Night _____ Day _____ Evening _____
	Low potential	= 4 - 6	

❑ Unable to reassess and review plan with patient due to: _____
(Not necessary to complete Part II) Signature: _____ Time: _____ AM/PM

❑ Unable to reassess and review plan with patient due to: _____
(Not necessary to complete Part II) Signature: _____ Time: _____ AM/PM

Night: Signature/Title: _____ Time: _____ AM/PM

Day: Signature/Title: _____ Time: _____ AM/PM

Evening: Signature/Title: _____ Time: _____ AM/PM

596755

(04/12/11)

CATHOLIC HEALTH INITIATIVES

Franciscan Health System

St. Joseph Medical Center, Tacoma, WA
St. Francis Hospital, Federal Way, WA
St. Clare Hospital, Lakewood, WA
St. Elizabeth Hospital, Enumclaw, WA
St. Anthony Hospital, Gig Harbor, WA

SUICIDE/SELF HARM ASSESSMENT TOOL

Patient Information

Algorithm A: Assessment and management of Risk for Suicide in Primary Care

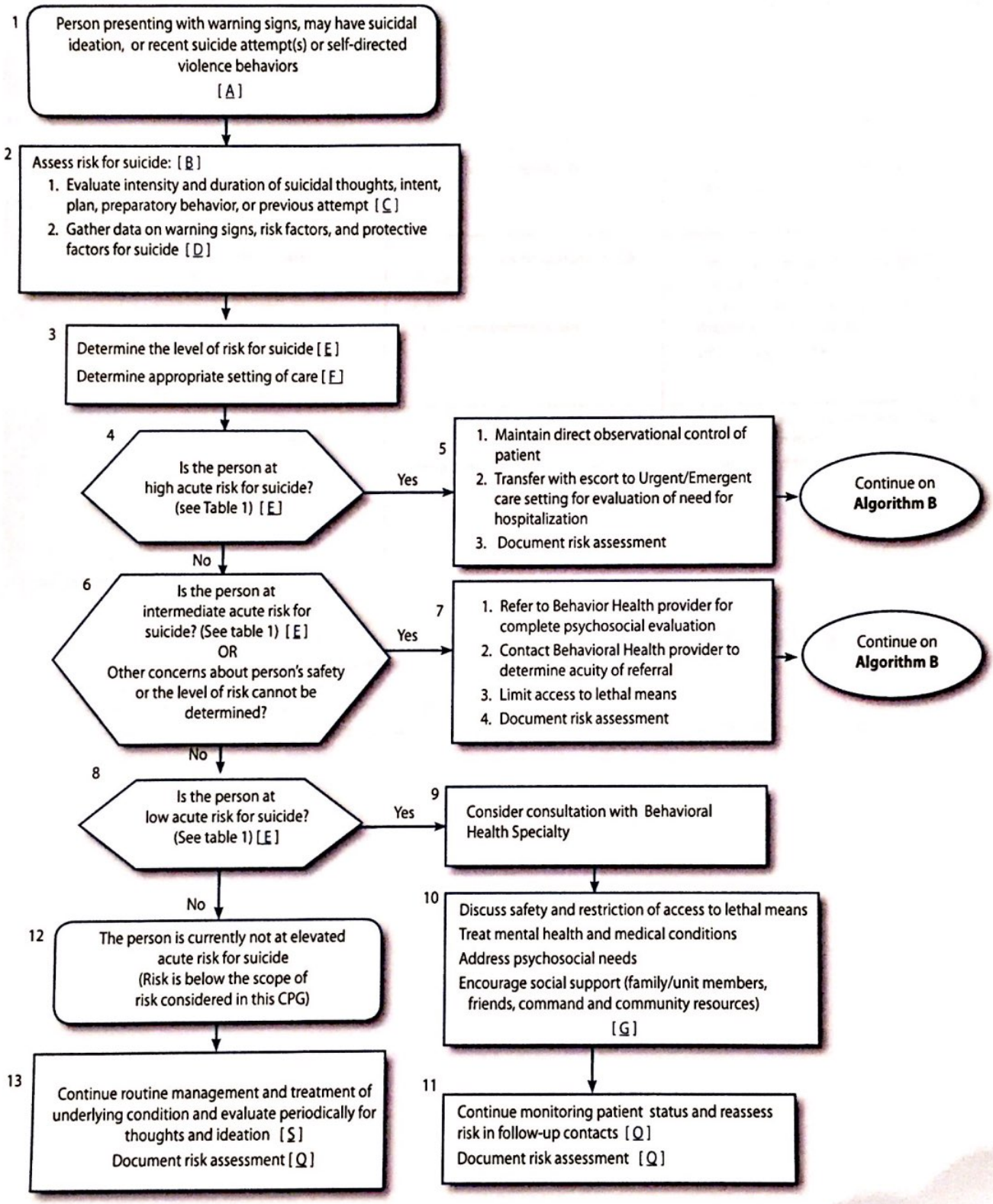


Table 1. Determine Level of Risk For Suicide and Appropriate Action in Primary Care

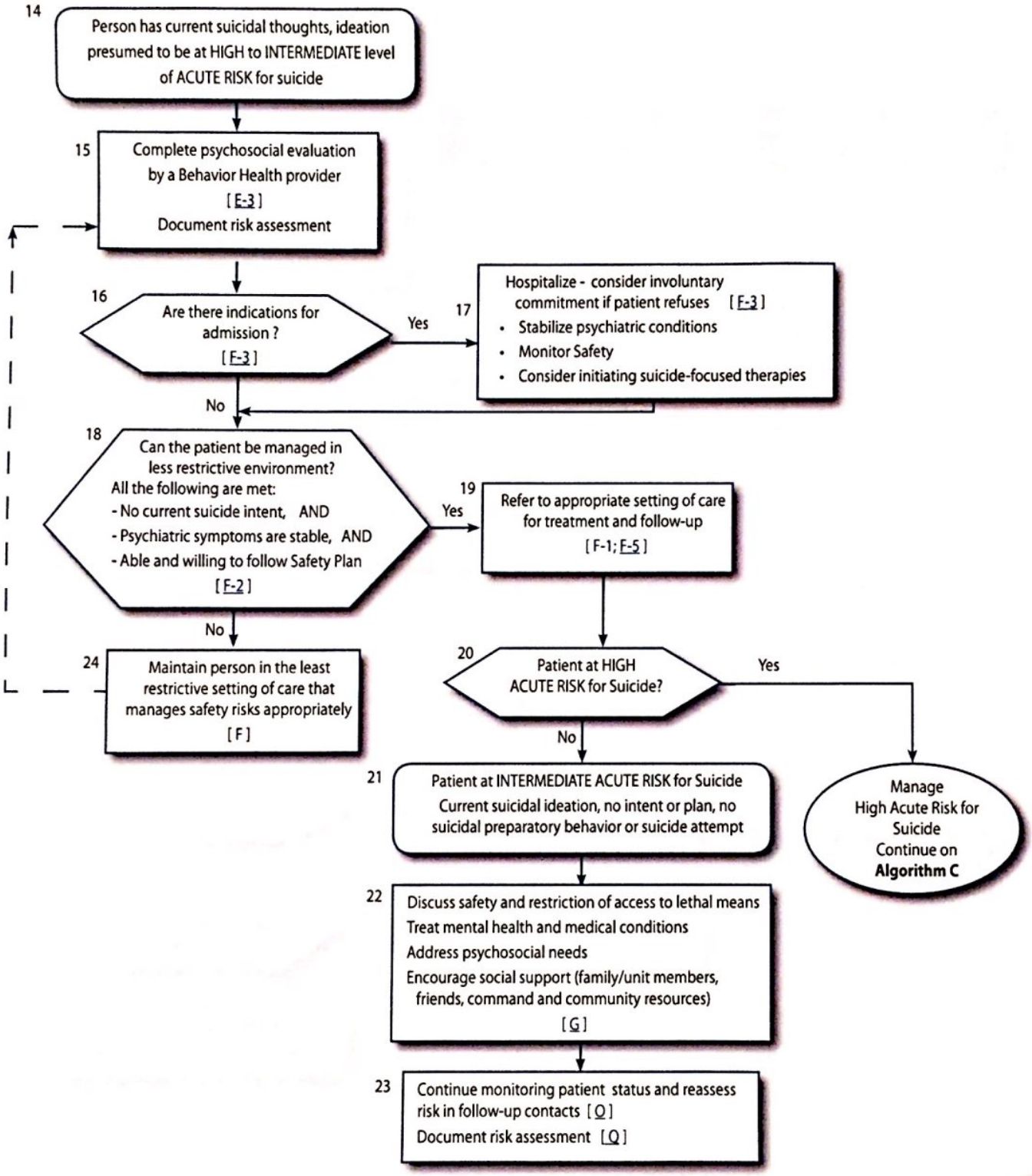
Risk of Suicide Attempt	Indicators of Suicide Risk	Contributing Factors †	Initial Action Based on Level of Risk
High Acute Risk	• Persistent suicidal **ideation** or thoughts • Strong **intention** to act or plan • Not able to control **impulse** OR • **Recent suicide attempt** or **preparatory behavior** ††	• Acute state of mental disorder or acute psychiatric symptoms • Acute **precipitating** event(s) • Inadequate **protective factors**	• Maintain direct observational control of the patient. • Limit access to lethal means • Immediate transfer with escort to Urgent/ Emergency Care setting for Hospitalization
Intermediate Acute Risk	• Current suicidal **ideation** or thoughts • **No intention** to act • Able to control the **impulse** • **No recent attempt** or **preparatory behavior** or rehearsal of act	• Existence of **warning signs** or **risk factors** †† AND • Limited **protective factor**	• Refer to Behavioral Health provider for complete evaluation and interventions • Contact Behavioral Health provider to determine acuity of referral • Limit access to lethal means
Low Acute Risk	• Recent suicidal **ideation** or thoughts • No **intention** to act or plan • Able to control the **impulse** • No planning or rehearsing a suicide act • No previous attempt	• Existence of **protective factors** AND • Limited **risk factors**	• Consider consultation with Behavioral Health to determine: - Need for referral - Treatment • Treat presenting problems • Address safety issues • Document care and rational for action

† Modifiers that increase the level of risk for suicide of any defined level :

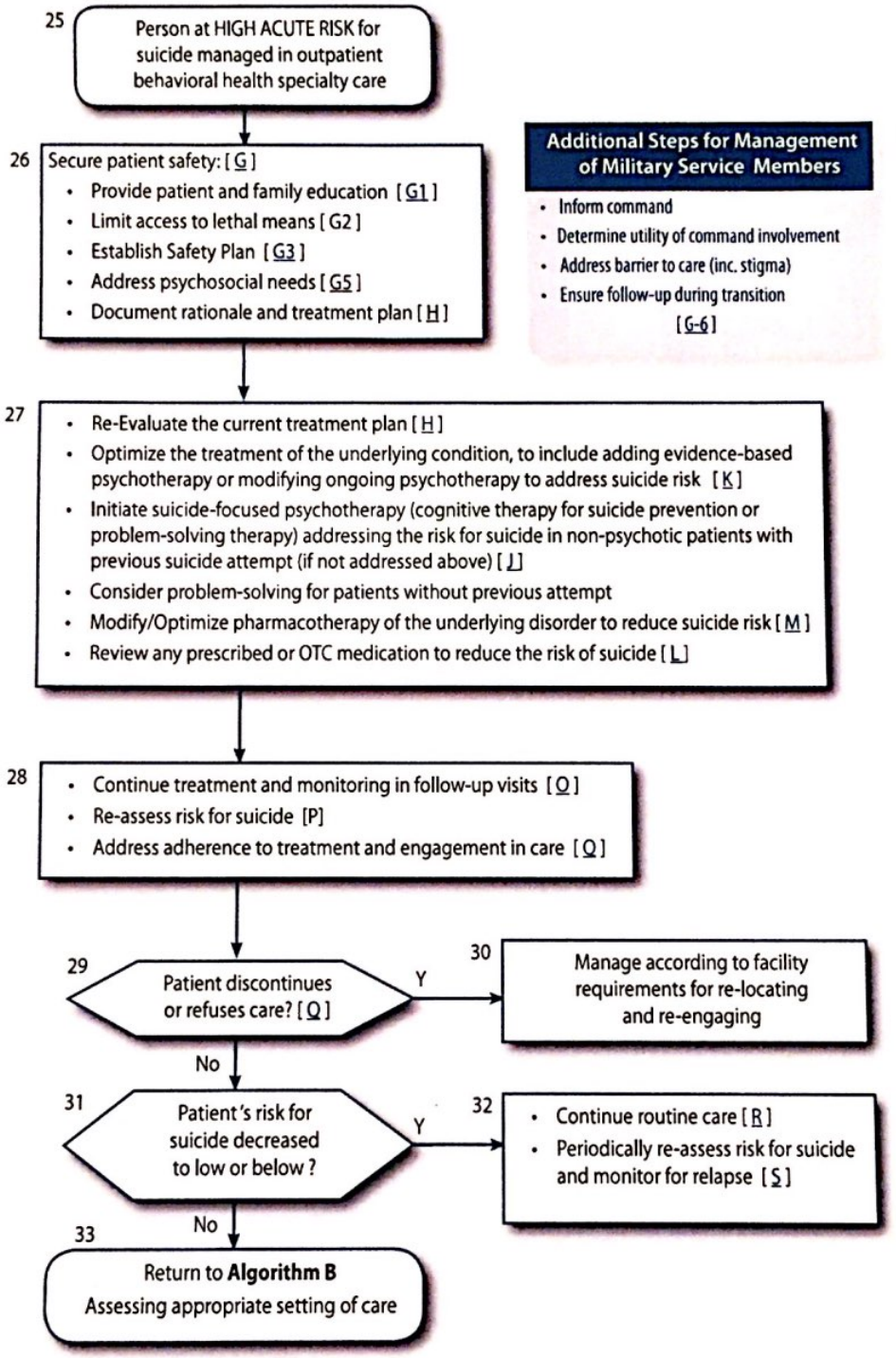
- **Acute state of Substance Use**: Alcohol or substance abuse history is associated with impaired judgment and may increase the severity of the suicidality and risk for suicide act
- **Access to means** :(firearms, medications) may increase the risk for suicide act
- **Existence of multiple risk factors or warning signs** or lack of protective factors

†† Evidence of suicidal behavior warning signs in the context of denial of ideation should call for concern (e.g., contemplation of plan with denial of thoughts or ideation)

Algorithm B: Assessment and Management by Behavioral Health Care Provider



Algorithm C: Management of Patient at High Acute Risk for Suicide



Additional Steps for Management of Military Service Members

- Inform command
- Determine utility of command involvement
- Address barrier to care (inc. stigma)
- Ensure follow-up during transition

[G-6]

Evidence-Based Treatment to Reduce Repetition of Suicide Behavior

Psychotherapy

Treating the Suicide Risk: [J]

- *CT for suicide prevention*
- *PST*

Treating Underlying Disorder:

Borderline Personality Disorder: [K-1]

- DBT
- CBT
- IPT

Substance Use Disorder [K-3]

Pharmacotherapy

- Reduce the risk for suicide [L]

Treating Underlying Disorder:

- Antidepressants [M-1]
- Antypsychotics [M-2]
- Lithium [M-3, 4]
- Clozapine [M-5]
- Antiepileptics [M-6]
- Opioid overdose [M-8]

Other

- ECT [N]

Interventions to Improve Adherence

- Case- Care Management [Q-1]
- Facilitating access to care [Q-2]
- Mailing caring letters/postcards [Q-3]
- Telephone contact [Q-4]
- Outreach (home visit) [Q-5]
- Assertive outreach [Q-6]
- Counseling and other psychosocial interventions [Q-7]

BD - Bipolar Disorder; BPD - Borderline Personality Disorder; CT-Cognitive Therapy; CBT - Cognitive Behavior Therapy; DBT- Dialectical Behavior Therapy; IPT- Brief psychodynamic Interpersonal Therapy; MDD - Major Depressive Disorder; OTC-Over the Counter; PST-Problem Solving Therapy; SUD - Substance Use Disorder

HANDOUT #13-Teresa Johnson, RN

Staff Name: _____ **My Mental Health Safety Plan** **Patient Name**: _____

Fill This out Using the Backside if Needed, Keep in a Visible Place, Educate Friends/Family to Involve Them in Your Care, and Know to Seek Help **Early**

GREEN: Go Ahead

What this may look like to me:

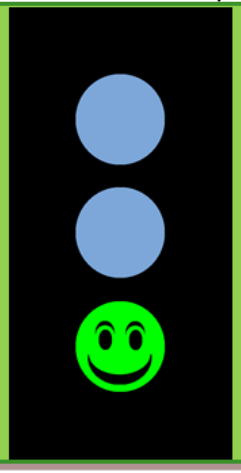
- I feel hopeful for my life and future
- I am doing things that I enjoy and taking care of myself
- I have no self-harm/suicidal thoughts or plans
- Here are other traits of a healthy me:

_____

_____

_____

_____



What I can do to stay healthy:

- Continue taking my medicines as prescribed
- Attend all my mental health appointments
- Communicate openly with my support people
- Take care of my health and hygiene
- Other things I know I can do to stay healthy:

_____

_____

_____

_____

YELLOW: Caution

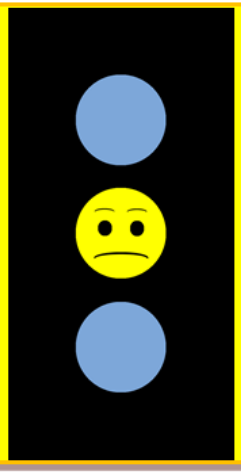
What this may look like to me:

- I am losing interest in my hobbies and loved ones
- My sleep and/or appetite is not normal
- I may have some suicidal thoughts but no plan or intent
- Here are my other symptoms or stressors:

_____

_____

_____



What I could do to regain my health:

- Call my support people (names and numbers):

_____

- Call my therapist/MD (names/numbers/appointments):

_____

- Take part in my daily activities and self-care
- My plans for avoiding this state/becoming healthy again:

_____

_____

_____

RED: Stop! Medical Alert

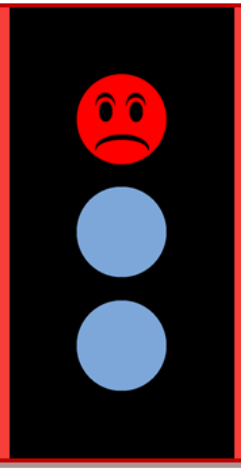
What this may look like to me:

- I have no ability/desire to care for myself
- I have an actual suicide plan with access to resources (weapons etc.) and/or have made a self-harm attempt
- I am not thinking clearly
- Other signs that I am in crisis:

_____

_____

Above all, I AM worth it. I can overcome these symptoms and return to my healthy state in the green zone again!



What actions I can take to stay safe and be healthy:

- Call 911 and get to the closest Emergency Room
- Other ways my support and I can save me:

_____

_____

Call the crisis safety line before tragedy strikes:

- Pierce: (253) 396-5180 or 1-800-576-7764
- King: (206) 461-3200 or 1-800- 621-4636
- Kitsap: (360) 479-3033
- 24-hour WA crisis line: 866-427-4747
- National Suicide Prevention Hotline: 1-800-273-8255

Case Study - Samantha

Case Goal

Persons at risk for suicide present with similar often identifiable warning signs, risk factors and protective factors. You are the nurse on the inpatient unit who is assigned to care for Samantha today. Consider what you can access in your mental status exam. After reading the case study, identify the warning signs, risk factors and what interventions you would perform this morning. Suicide is preventable when early assessment, interventions, communication and safety plans are in place.

Samantha went to the ER last night and was admitted to your unit after taking several tablets of Ibuprofen and Benadryl to help her sleep. She is very sleepy and hard to arouse this morning. When she is awake she is nauseated.

Samantha is a 22 year old Caucasian college junior. Her mother and stepfather live about three hours away. They stay in touch, but are not particularly "close". Samantha's only sibling is a sister, Joan, who is in graduate school at the same school where Samantha is a student. They see each other at least once or twice a week. Joan has always been more outgoing and energetic.

Samantha has a history of-non suicidal self-injury (NSSI). Her last NSSI was three days ago and did not require medical attention. This first occurred after her first "serious" boyfriend informed Samantha he thought he needed to take a break from their relationship because it was more serious than he was ready for. Samantha suspects his reactions were, at least in part due to her seeing the scars from the NSSI. He is the only person Samantha ever let find out about the NSSI.

Samantha does work at the library part time. She finds the work boring, but it gives her spending money. She and one co-worker participate in a new book club. Her grades are "okay" by her description. She maintains a 3.25 GPA> There have been no recent changes in her academic performance. She has started to question whether or not her major, elementary education, is really what she wants to pursue, but she cannot think of another choice. She loved teaching Sunday school and thought teaching might be her calling. Samantha often wonders about what it would be like to go to sleep and just not wake up. Lately, the idea of going to sleep and not waking up is becoming more appealing. She has written notes in her diary of how she feels and is considering her options. She has never sought any kind of counseling. She was encouraged to go to therapy when her best friend in high school took a lethal overdose the day before graduation. They had planned to be college roommates.

Key Learning Points of This Case

1. *Recognize potential warning signs of persons at risk for suicide using the mnemonic IS PATH WARM as research based identifiers.*

   a. Describe Samantha's warning signs using the mnemonic IS PATH WARM?

I	
S	
P	
A	
T	
H	
W	
A	
R	
M	

   b. What questions could you ask to help clarify the extent of the suicidal ideation?

2. *Identify risk factors and warning signs of suicide.*

   a. Determine level of risk

b. Identify clinical interventions

c. Who in your hospital setting needs to be notified of your interventions?

Case Study Part II

It has been 24 hours on you unit and Samantha is fully awake and explains that she was having difficulty sleeping and just had a severe headache that she was trying to get rid of. She explains she wasn't trying to kill herself, just get some sleep, but if died she probably deserved to die.

The plan is to discharge her home today and follow up with outpatient services. As her nurse you understand that persons are very vulnerable at discharge and up to 48 hours after discharge so you need to prepare for this and document your nursing interventions. Start by creating the safety plan using the resources you are aware of at your own hospital and community.

1. Identify 3 protective factors Samantha has described in her discussion.

2. Partner with Samantha and create a written safety plan.
   (Assume all persons she discussed in the case are willing to be a part of the safety plan).

   Use the Components of a Patient Safety Plan on the next page to complete this assignment.

Components of a Safety Plan

1. Warning Signs

2. Personal Coping Strategies to Calm or Comfort Myself

3. Reasons for Living

4. Activities for Distraction (Social Settings / or Persons to contact)

5. Professional Contacts and phone numbers

6. Step to make the my environment safe

7. Where to go if I still need help-hospital address, phone number, contact

Sources:
Schimelpfening, N. How to create a suicide safety plan. Retrieved June 3, 2015 from http://depression.about.com/od/suicideprevent/a/suicidesafetyplan.htm

==========

SUICIDE SAFETY PLAN

==========

STEP 1: RECOGNITION OF SIGNS THAT LEAD TO SUICIDAL THOUGHTS

1. _____
2. _____
3. _____
4. _____
5. _____

STEP 2: WAYS OF COPING WITHOUT ASSISTANCE FROM OTHERS

1. _____
2. _____
3. _____
4. _____
5. _____

How likely do you think it is that you would be able to do this step during a time of crisis? [Rate on a scale of 1 to 5]

1- Very Unlikely
2- Not Likely
3- Undecided
4- Likely
5- Very Likely

What are some potential obstacles?

_____

_____

STEP 3: SOCIAL SETTINGS THAT MAY DISTRACT FROM THE CRISIS

SETTING & LOCATION

1. _____
2. _____
3. _____
4. _____

How likely do you think it is that you would be able to do this step during a time of crisis? [Rate on a scale of 1 to 5]

1- Very Unlikely
2- Not Likely
3- Undecided
4- Likely
5- Very Likely

What are some potential obstacles?

_____

_____

STEP 4: REACHING OUT TO FRIENDS OR FAMILY MEMBERS

NAME & PHONE NUMBER

1. _____
2. _____
3. _____
4. _____

How likely do you think it is that you would be able to do this step during a time of crisis? [Rate on a scale of 1 to 5]

1- Very Unlikely
2- Not Likely
3- Undecided
4- Likely
5- Very Likely

What are some potential obstacles?

_____

_____

STEP 5: CONTACTING PROFESSIONALS

Therapist:

_____

Primary care physician or psychiatrist:

_____

What are some potential obstacles?

_____

24-hour emergency Suicide Hotline: 1-800-273-8255 (800-273-TALK) Veterans press 1

STEP 6: MAKING THE ENVIRONMENT SAFE

Patient has access to firearms: Yes or No GUN LOCK: Yes No NA

Patient has access to other means: Yes or No

Other Means include:

_____

Plan for restricting access:

_____

PRACTICE SESSION: CASE METHOD OF SUICIDE INTERVIEWING

Normalization

"Sometimes when people are feeling as depressed as you're describing, they may think of killing themself. I'm wondering if you're having any of those thoughts."

Shame Attenuation

"With all of your pain, I'm wondering if you're having thoughts of killing yourself?"

Behavioral Incident

"What happened next?"

Remember to include the anchor questions:

When?

Where?

Gentle Assumption

"What other ways have you thought of killing yourself?"

Denial of the Specific

"Have you thought of shooting yourself?" (pause)
"Have you thought of overdosing?" (pause)
"Have you thought of hanging yourself?" (pause)
……continue to list other methods

Symptom Amplification

"On your worst days, how much time do you spend thinking of killing yourself…….10 hours a day, 14 hours, 18 hours?"

(can use percentages instead of hours if preferred "70% of the day, 80%, 90%?)

Shawn Shea, MD

Dartmouth University

http://www.suicideassessment.com/pdfs/PsychiatricTimesArticleparts1-2PDF.pdf