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 Acts or preparation towards engaging in Self-Directed Behavior: 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 thoughts?
   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 injury 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

<table>
<thead>
<tr>
<th>Type</th>
<th>Sub-Type</th>
<th>Definition</th>
<th>Modifiers</th>
<th>Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoughts</td>
<td>Non-Suicidal</td>
<td>Self-reported thoughts regarding a person’s desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent.</td>
<td>N/A</td>
<td>• Non-Suicidal Self-Directed Violence Ideation</td>
</tr>
<tr>
<td></td>
<td>Self-Directed Violence Ideation</td>
<td>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).</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Suicidal Ideation</td>
<td>Thoughts of engaging in suicide-related behavior.</td>
<td>• Suicidal Intent:</td>
<td>• Suicidal Ideation, Without Suicidal Intent</td>
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<tr>
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<td></td>
<td>For example, intrusive thoughts of suicide without the wish to die would be classified as Suicidal Ideation, Without Intent.</td>
<td>- Without</td>
<td>• Suicidal Ideation, With Undetermined Suicidal Intent</td>
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<td></td>
<td>- Undetermined</td>
<td>• Suicidal Ideation, With Suicidal Intent</td>
</tr>
<tr>
<td></td>
<td>Preparatory</td>
<td>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).</td>
<td>• Suicidal Intent:</td>
<td>• Non-Suicidal Self-Directed Violence, Preparatory</td>
</tr>
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<td></td>
<td></td>
<td>For example, hoarding medication for the purpose of overdosing would be classified as Suicidal Self-Directed Violence, Preparatory.</td>
<td>- Without</td>
<td>• Undetermined Self-Directed Violence, Preparatory</td>
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<td></td>
<td>- Undetermined</td>
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<td>Non-Suicidal</td>
<td>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.</td>
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<td>• Non-Suicidal Self-Directed Violence, Without Injury</td>
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<td>Self-Directed Violence</td>
<td>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).</td>
<td>- Without</td>
<td>• Non-Suicidal Self-Directed Violence, Without Injury, Interrupted by Self or Other</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- With</td>
<td>• Non-Suicidal Self-Directed Violence, With Injury</td>
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<td></td>
<td>- Fatal</td>
<td>• Non-Suicidal Self-Directed Violence, With Injury, Interrupted by Self or Other</td>
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<td></td>
<td>• Interrupted by Self or Other</td>
<td>• Non-Suicidal Self-Directed Violence, Fatal</td>
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<tr>
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<td>Undetermined</td>
<td>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.</td>
<td>• Injury</td>
<td>• Undetermined Self-Directed Violence, Without Injury</td>
</tr>
<tr>
<td></td>
<td>Self-Directed Violence</td>
<td>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.</td>
<td>- Without</td>
<td>• Undetermined Self-Directed Violence, Without Injury, Interrupted by Self or Other</td>
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<td>Suicidal</td>
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<td>• Suicide Attempt, Without Injury</td>
</tr>
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<td></td>
<td>Self-Directed Violence</td>
<td>For example, a person with the wish to die cutting her wrists with a knife would be classified as Suicide Attempt, With Injury.</td>
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<td>• Suicide Attempt, Without Injury, Interrupted by Self or Other</td>
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<td></td>
<td></td>
<td></td>
<td>- With</td>
<td>• Suicide Attempt, With Injury</td>
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<td></td>
<td></td>
<td></td>
<td>- Fatal</td>
<td>• Suicide Attempt, With Injury, Interrupted by Self or Other</td>
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<td>• Interrupted by Self or Other</td>
<td>• Suicide Attempt, With Injury, Interrupted by Self or Other</td>
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* Developed in collaboration with the Centers for Disease Control and Prevention
**Self-Directed Violence Classification System**

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<th>Definition</th>
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<td>Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.</td>
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<td><strong>Suicidal Intent:</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Physical Injury:</strong></td>
<td>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.</td>
</tr>
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<td><strong>Interrupted By Self or Other:</strong></td>
<td>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.</td>
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## SUICIDE IDEATION DEFINITIONS AND PROMPTS:

### Ask questions that are in bolded and underlined

<table>
<thead>
<tr>
<th>Past month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

### 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?
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
**CAMS Suicide Status Form-SSF IV (Initial Session)**

**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).

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

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.

<table>
<thead>
<tr>
<th>Rank</th>
<th>REASONS FOR LIVING</th>
<th>Rank</th>
<th>REASONS FOR DYING</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

*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: ____________________________________________ 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: ____________________________________________

**TREATMENT PLAN (Refer to Sections A & B)**

<table>
<thead>
<tr>
<th>Problem #</th>
<th>Problem Description</th>
<th>Goals and Objectives</th>
<th>Interventions</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Self-Directed Violence</td>
<td>Safety and Stability</td>
<td>SSF Stabilization</td>
<td>Plan Completed</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td>3</td>
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</tbody>
</table>

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. ____________________________________________________________

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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
Other: __________________________

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  Explanation: __________________________
- Mild  __________________________
- Moderate  __________________________
- Severe  __________________________
- Extreme  __________________________

CASE NOTES:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Next Appointment Scheduled: _______________ Treatment Modality: __________________________

Clinician Signature __________________________ Date __________________________
CAMS On-Going Care

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 pressed 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: 1 2 3 4 5 : Extremely high risk
   (will not kill self) (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

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

TREATMENT PLAN UPDATE

Patient Status:
□ Discontinued treatment □ No show □ Cancelled □ Hospitalization □ Referred/Other: ____________________________

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<td></td>
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<td></td>
<td>Plan Updated</td>
<td></td>
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<tr>
<td>2</td>
<td></td>
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<td>3</td>
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</table>

Patient Signature Date Clinician Signature Date
**Section C (Clinician Post-Session Evaluation):**

**MENTAL STATUS EXAM** (circle appropriate items):

<table>
<thead>
<tr>
<th>ALERTNESS:</th>
<th>ALERT</th>
<th>DROWSY</th>
<th>LETHARGIC</th>
<th>STUPOROUS</th>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>ORIENTED TO:</th>
<th>PERSON</th>
<th>PLACE</th>
<th>TIME</th>
<th>REASON FOR EVALUATION</th>
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<th>ELEVATED</th>
<th>DYSPHORIC</th>
<th>AGITATED</th>
<th>ANGRY</th>
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<td>AFFECT:</td>
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<td>BLUNTED</td>
<td>CONstricted</td>
<td>APPROPRIATE</td>
<td>LABILE</td>
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<tr>
<td>OTHER:</td>
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<tr>
<th>THOUGHT CONTINUITY:</th>
<th>CLEAR &amp; COHERENT</th>
<th>GOAL-DIRECTED</th>
<th>TANGENTIAL</th>
<th>CIRCUMSTANTIAL</th>
</tr>
</thead>
<tbody>
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<tr>
<th>THOUGHT CONTENT:</th>
<th>WNL</th>
<th>OBSESSIONS</th>
<th>DELUSIONS</th>
<th>IDEAS OF REFERENCE</th>
<th>BIZARRENESS</th>
<th>MORBIDITY</th>
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<tbody>
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<table>
<thead>
<tr>
<th>SPEECH:</th>
<th>WNL</th>
<th>RAPID</th>
<th>SLOW</th>
<th>SLURRED</th>
<th>IMPOVERISHED</th>
<th>INCOHERENT</th>
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<table>
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<th>GROSSLY INTACT</th>
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<td>OTHER:</td>
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<table>
<thead>
<tr>
<th>REALITY TESTING:</th>
<th>WNL</th>
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</thead>
<tbody>
<tr>
<td>OTHER:</td>
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</tbody>
</table>

**NOTABLE BEHAVIORAL OBSERVATIONS:**

**DSM-IV-R MULTI-AXIAL DIAGNOSES:**

<table>
<thead>
<tr>
<th>Axis I</th>
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<tbody>
<tr>
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<tr>
<td>Axis II</td>
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<td>Axis IV</td>
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<tr>
<td>Axis V</td>
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</tbody>
</table>

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

- [ ] No Significant Risk  
  Explanation: ____________________________________________________________
- [ ] Mild
  Explanation: ____________________________________________________________
- [ ] Moderate
  Explanation: ____________________________________________________________
- [ ] Severe
  Explanation: ____________________________________________________________
- [ ] Extreme
  Explanation: ____________________________________________________________

**CASE NOTES:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Next Appointment Scheduled: ____________  Treatment Modality: ______________________

______________________________  __________________________
Clinician Signature          Date
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: 1 2 3 4 5 : Extremely high risk
   (will not kill self) (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): ________________________________

____________________________________  ___________________________________
**Section C (Clinician Outcome Evaluation):**

**MENTAL STATUS EXAM (circle appropriate items):**

<table>
<thead>
<tr>
<th>ALERTNESS:</th>
<th>ALERT</th>
<th>DROWSY</th>
<th>LETHARGIC</th>
<th>STUPOROUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORIENTED TO:</td>
<td>PERSON</td>
<td>PLACE</td>
<td>TIME</td>
<td>REASON FOR EVALUATION</td>
</tr>
<tr>
<td>MOOD:</td>
<td>EUTHYMIC</td>
<td>ELEVATED</td>
<td>DYSPHORIC</td>
<td>AGITATED</td>
</tr>
<tr>
<td>AFFECT:</td>
<td>FLAT</td>
<td>BLUNTED</td>
<td>CONstricted</td>
<td>APPROPRIATE</td>
</tr>
<tr>
<td>THOUGHT CONTINUITY:</td>
<td>CLEAR</td>
<td>&amp; COHERENT</td>
<td>GOAL-DIRECTED</td>
<td>TANGENTIAL</td>
</tr>
<tr>
<td>THOUGHT CONTENT:</td>
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<tr>
<td>Axis IV</td>
<td></td>
</tr>
<tr>
<td>Axis V</td>
<td></td>
</tr>
</tbody>
</table>

**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

ACKNOWLEDGEMENTS

- Originally conceived by Douglas Jacobs, MD, and developed as a collaboration between Screening for Mental Health, Inc. and the Suicide Prevention Resource Center.
- This material is based upon work supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) under Grant No. 1U79SM57392. Any opinions/findings/conclusions/recommendations expressed in this material are those of the author and do not necessarily reflect the views of SAMHSA.

National Suicide Prevention Lifeline
1.800.273.TALK (8255)

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

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

(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

**FRANCISCAN HEALTH SYSTEM**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Points</th>
<th>0</th>
<th>1</th>
<th>2</th>
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</thead>
<tbody>
<tr>
<td><strong>Suicidal Ideation</strong></td>
<td>No current suicidal thoughts</td>
<td>Intermittent or fleeting suicidal thoughts</td>
<td>Constant suicidal thoughts</td>
<td>□ Night □ Day □ Evening</td>
</tr>
<tr>
<td></td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td></td>
</tr>
<tr>
<td><strong>Suicide Plan</strong></td>
<td>No plan</td>
<td>Has plan without access to planned method</td>
<td>Has plan with actual or potential access</td>
<td>□ Night □ Day □ Evening</td>
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<tr>
<td></td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td></td>
</tr>
<tr>
<td><strong>Plan lethality (while in hospital)</strong></td>
<td>No plan</td>
<td>Low lethality of plan (e.g., superficial scratching, head banging, pillow over face, biting, holding breath)</td>
<td>Highly lethal plan (e.g., cutting, overdose, hanging, jumping)</td>
<td>□ Night □ Day □ Evening</td>
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<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td></td>
</tr>
<tr>
<td><strong>Elopement</strong></td>
<td>No elopement risk</td>
<td>Low elopement risk</td>
<td>High elopement risk</td>
<td>□ Night □ Day □ Evening</td>
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<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td></td>
</tr>
<tr>
<td><strong>Symptoms (check all that apply)</strong></td>
<td>0 - 2 symptoms present</td>
<td>3 - 4 symptoms present</td>
<td>More than 4 symptoms present</td>
<td>□ Night □ Day □ Evening</td>
</tr>
<tr>
<td>Night Day Evening</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
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<tr>
<td>□ □ □ Impulsivity</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
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<td>□ □ □ Shame</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
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<tr>
<td>□ □ □ Helplessness</td>
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<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
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<tr>
<td>□ □ □ Anhedonia</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td></td>
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<tr>
<td>□ □ □ Hopelessness</td>
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<td>□ Night □ Day □ Evening</td>
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<td>□ □ □ Guilt</td>
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<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
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<tr>
<td>□ □ □ Anger/rage</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td></td>
</tr>
<tr>
<td><strong>Current mood/motivation (e.g., reunion fantasies, preoccupation with death)</strong></td>
<td>None / Rarely</td>
<td>Frequently</td>
<td>Constantly</td>
<td>□ Night □ Day □ Evening</td>
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<tr>
<td></td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td></td>
</tr>
<tr>
<td><strong>Agrees to a plan for safety while in the hospital</strong></td>
<td>Reliably agrees to a safety plan</td>
<td>Agrees to a safety plan but is ambivalent or guarded</td>
<td>Unwilling or unable to agree to a safety plan</td>
<td>□ Night □ Day □ Evening</td>
</tr>
<tr>
<td></td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td></td>
</tr>
<tr>
<td><strong>Refer to H&amp;P or psychosocial assessment</strong></td>
<td>Current admission precipitated by suicide attempt</td>
<td>Attempt history</td>
<td>No previous attempts</td>
<td>□ 0 □ 1</td>
</tr>
<tr>
<td></td>
<td>□ 0 □ 2</td>
<td>□ 0 □ 1</td>
<td>□ 0 □ 1</td>
<td></td>
</tr>
<tr>
<td><strong>Clinician's subjective appraisal of risk:</strong></td>
<td>Patient's replies not trustworthy, several nonverbal cues</td>
<td>Patient's replies questionably trustworthy, at least 1 nonverbal cue</td>
<td>Patient's replies trustworthy</td>
<td>□ Night □ Day □ Evening</td>
</tr>
<tr>
<td></td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td></td>
</tr>
<tr>
<td><strong>Scoring key:</strong></td>
<td>High potential = 10 or more</td>
<td>Moderate potential = 7 - 9</td>
<td>Low potential = 4 - 6</td>
<td></td>
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<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td>□ Night □ Day □ Evening</td>
<td></td>
</tr>
</tbody>
</table>

**Total Score:**

Night___ Day___ Evening_____

**Unable to reassess and review plan with patient due to:**

(Not necessary to complete Part II) 🗒️ Signature: ___________________________ Time: ___________ AMPM

**Unable to reassess and review plan with patient due to:**

(Not necessary to complete Part II) 🗒️ Signature: ___________________________ Time: ___________ AMPM

Night: Signature/Title: ___________________________ Time: ___________ AMPM

Day: Signature/Title: ___________________________ Time: ___________ AMPM

Evening: Signature/Title: ___________________________ Time: ___________ AMPM
Algorithm A: Assessment and Management of Risk for Suicide in Primary Care

1. Person presenting with warning signs, may have suicidal ideation, or recent suicide attempt(s) or self-directed violence behaviors
   \[ (A) \]

2. Assess risk for suicide: \[ (B) \]
   1. Evaluate intensity and duration of suicidal thoughts, intent, plan, preparatory behavior, or previous attempt \[ (C) \]
   2. Gather data on warning signs, risk factors, and protective factors for suicide \[ (D) \]

3. Determine the level of risk for suicide \[ (E) \]
   Determine appropriate setting of care \[ (E) \]

4. Is the person at high acute risk for suicide? (see Table 1) \[ (E) \]
   - Yes
     - Continue on Algorithm B
   - No

5. Is the person at intermediate acute risk for suicide? (see Table 1) \[ (E) \]
   OR
   - Other concerns about person's safety or the level of risk cannot be determined?
   - Yes
     - Continue on Algorithm B
   - No

6. Is the person at low acute risk for suicide? (see Table 1) \[ (E) \]
   - Yes
     - Consider consultation with Behavioral Health Specialty
     - Discuss safety and restriction of access to lethal means
     - Treat mental health and medical conditions
     - Address psychosocial needs
     - Encourage social support (family/unit members, friends, command and community resources)
     - \[ (F) \]
   - No

7. \[ (E) \]
   1. Refer to Behavioral Health provider for complete psychosocial evaluation
   2. Contact Behavioral Health provider to determine acuity of referral
   3. Limit access to lethal means
   4. Document risk assessment

8. The person is currently not at elevated acute risk for suicide (Risk is below the scope of risk considered in this CPG)

9. \[ (E) \]
   1. Maintain direct observational control of patient
   2. Transfer with escort to Urgent/Emergent care setting for evaluation of need for hospitalization
   3. Document risk assessment

10. Continue monitoring patient status and reassess risk in follow-up contacts \[ (E) \]
    Document risk assessment \[ (E) \]

11. Continue routine management and treatment of underlying condition and evaluate periodically for thoughts and ideation \[ (E) \]
    Document risk assessment \[ (E) \]
Table 1. Determine Level of Risk For Suicide and Appropriate Action in Primary Care

<table>
<thead>
<tr>
<th>Risk of Suicide Attempt</th>
<th>Indicators of Suicide Risk</th>
<th>Contributing Factors †</th>
<th>Initial Action Based on Level of Risk</th>
</tr>
</thead>
</table>
| High Acute Risk         | • Persistent suicidal ideation or thoughts  
                          • Strong intention to act or plan  
                          • Not able to control impulse  
                          • 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 † †  
                          • 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  
                          • 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

14 Person has current suicidal thoughts, ideation presumed to be at HIGH to INTERMEDIATE level of ACUTE RISK for suicide

15 Complete psychosocial evaluation by a Behavior Health provider
   Document risk assessment

16 Are there indications for admission?
   [E:3]

17 Yes
   Hospitalize - consider involuntary commitment if patient refuses
   • Stabilize psychiatric conditions
   • Monitor Safety
   • Consider initiating suicide-focused therapies

18 No
   Can the patient be managed in less restrictive environment?
   All the following are met:
   - No current suicide intent, AND
   - Psychiatric symptoms are stable, AND
   - Able and willing to follow Safety Plan
   [E:2]

19 Yes
   Refer to appropriate setting of care for treatment and follow-up
   [F-1; E:5]

19 No
   Maintain person in the least restrictive setting of care that manages safety risks appropriately
   [F]

20 Yes
   Patient at HIGH ACUTE RISK for Suicide?

21 No
   Patient at INTERMEDIATE ACUTE RISK for Suicide
   Current suicidal ideation, no intent or plan, no suicidal preparatory behavior or suicide attempt

22 Discuss safety and restriction of access to lethal means
   Treat mental health and medical conditions
   Address psychosocial needs
   Encourage social support (family/unit members, friends, command and community resources)
   [G]

23 Continue monitoring patient status and reassess risk in follow-up contacts
   Document risk assessment

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

25. Person at HIGH ACUTE RISK for suicide managed in outpatient behavioral health specialty care

26. Secure patient safety: [G]
   - Provide patient and family education [G1]
   - Limit access to lethal means [G2]
   - Establish Safety Plan [G2]
   - Address psychosocial needs [G5]
   - Document rationale and treatment plan [H]

27. Re-Evaluate the current treatment plan [H]
   - Optimize the treatment of the underlying condition, to include adding evidence-based psychotherapy or modifying ongoing psychotherapy to address suicide risk: [K]
   - Initiate suicide-focused psychotherapy (cognitive therapy for suicide prevention or problem-solving therapy) addressing the risk for suicide in non-psychotic patients with previous suicide attempt (if not addressed above): [J]
   - Consider problem-solving for patients without previous attempt
   - Modify/Optimize pharmacotherapy of the underlying disorder to reduce suicide risk: [M]
   - Review any prescribed or OTC medication to reduce the risk of suicide: [L]

28. Continue treatment and monitoring in follow-up visits: [Q]
   - Re-assess risk for suicide: [P]
   - Address adherence to treatment and engagement in care: [Q]

29. Patient discontinues or refuses care? [Q]
   - No
   - Yes

   Y

30. Manage according to facility requirements for re-locating and re-engaging

   + Continue routine care: [B]
   + Periodically re-assess risk for suicide and monitor for relapse: [S]

31. Patient's risk for suicide decreased to low or below?
   - Yes
   - No

   Y

32. Return to Algorithm B

   Assessing appropriate setting of care

   N

Interventions to Improve Adherence

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

<table>
<thead>
<tr>
<th>NAME &amp; PHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ________________________________________________________________________________________</td>
</tr>
<tr>
<td>2. ________________________________________________________________________________________</td>
</tr>
<tr>
<td>3. ________________________________________________________________________________________</td>
</tr>
<tr>
<td>4. ________________________________________________________________________________________</td>
</tr>
</tbody>
</table>

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