SUICIDE SAFE CARE FOR PATIENTS

BUILDING A FOUNDATION FOR ASSESSMENT, SCREENING, AND TREATMENT

WICHE
Western Interstate Commission for Higher Education

ZERO SUICIDE

MONTANA DPHHS

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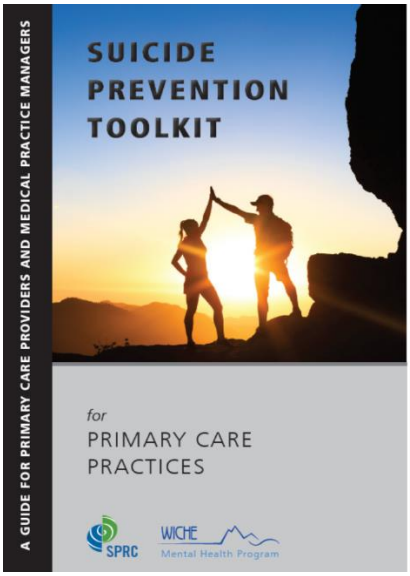
Information for this training is based on material obtained by the following sources:

Montana Department of Public Health and Human Services
www.dphhs.mt.gov/suicideprevention



The Suicide Prevention Resource Center (SPRC) and the Western Interstate Commission for Higher Education (WICHE)
http://www.sprc.org/settings/primary-care/toolkit

The US Department of Health and Human Services, the National Action Alliance for Suicide Prevention, the Suicide Prevention Resources Center, and the Substance Abuse and Mental Health Services Administration.
http://zerosuicide.sprc.org/

"Depression is such a cruel punishment. There are no fevers, no rashes, no blood tests to send people scurrying in concern, just the slow erosion of self, as insidious as cancer. And like cancer, it is essentially a solitary experience; a room in hell with only your name on the door."

Martha Manning, Undercurrents: A Life Beneath the Surface (1994)

Suicide Fact Sheet

Source: Center for Disease Control – WISQARS website, http://www.cdc.gov/injury/wisqars/index.html, (August, 2023),

- Suicide has surpassed car accidents as the No. 1 cause of injury-related death in the United States. There has been a 30% increase in the number of suicides in the United States since 1998. (CDC, 2019)
- In 2022 there were **49,449 suicides in the U.S.** (135 suicides per day; 1 suicide every 11 minutes). This translates to an annual **suicide rate of 14.9 per 100,000**.
- Suicide is the eleventh leading cause of death.
- Males complete suicide at a rate 3.5 times that of females. However, females attempt suicide 3 times more often than males.
- Firearms remain the most commonly used suicide method, accounting for **53%** of all completed suicides.
- Up to 45% of individuals who die by suicide visit their primary care provider within a month of their death, with 20% of those having visited their primary care provider within 24 hours of their death
- Those suffering from chronic pain are 3 times the risk of suicide.

Suicide among Children

- In 2020, **581 children ages 10 to 14 completed suicide in the U.S. (youngest – two 7 year olds)**
- Suicide rates for those between the **ages of 10-14 increased 60%** between 1981 and 2010.

Suicide among the Young

- Suicide is the 2nd leading cause of death among young (15-24) Americans; only accidents and homicides occur more frequently. In **2020, there were 6,062 suicides by people 15-24 years old**
- Youth (ages 15-24) suicide rates increased more than 200% from the 1950's to the mid 1990's. The rates dropped in the 1990's but went up again in the early 2000's.
- Research has shown that most adolescent suicides occur after school hours and in the teen's home.
- Within a typical high school classroom, it is likely that three students (one boy and two girls) have made a suicide attempt in the past year.
- *Most* adolescent suicide attempts are precipitated by interpersonal conflicts. The intent of the behavior appears to be to effect change in the behaviors or attitudes of others.
- The biggest factor associated with adolescent suicidal ideations is parental disconnect (not feeling validated or accepted by their parents)

Suicide in our LGBTQ youth

Source: The Trevor Project (www.thetrevorproject.org)

- LGBTQ youth are **4 times** more likely, and questioning youth are 3 times more likely, to attempt suicide as their straight peers.
- Nearly **half** of young transgender people have seriously thought about taking their lives, and one quarter report having made a suicide attempt.
- LGBTQ youth who come from **highly rejecting families are 8.4 times** as likely to have attempted suicide as LGBT peers who reported no or low levels of family rejection.
- Each episode of LGBTQ victimization, such as physical or verbal harassment or abuse, **increases the likelihood of self-harming behavior by 2.5 times** on average.

Suicide among our Veterans

Source: Veterans Administration. VA Suicide Prevention Program: Facts about Veteran Suicide, September, 2017.

- The VA estimates the suicide rate for veteran 38.4 per 100,000
- In the US, a veteran dies by suicide every 70 minutes, 22 a day, or over 7,000 suicides a year.
- For 2018-2019, the rate of suicide for Montana's veterans is 67 per 100,000 (Office of Epidemiology and Scientific Support, Montana DPHHS, 2019), triple the national rate (22).

Suicide among College Students

- It is estimated that there are more than **1,100 suicides on college campuses per year**.
- **1 in 12** college students has made a suicide plan (**2nd leading cause of death**)
- In 2000, the American College Health Association surveyed 16,000 college students from 28 college campuses.
  - **9.5% of students had seriously contemplated suicide.**
  - An estimated **24,000 suicide attempts** occur annually among US college students age 18-24 (JAMA).

***Source**: American Association of Suicidology webpage. http://www.suicidology.org/web/guest/stats-and-tools/statistics , May 24, 2010, Journal of the American Medical Association (2006), Vol. 296, No. 5*

Suicide among the Elderly

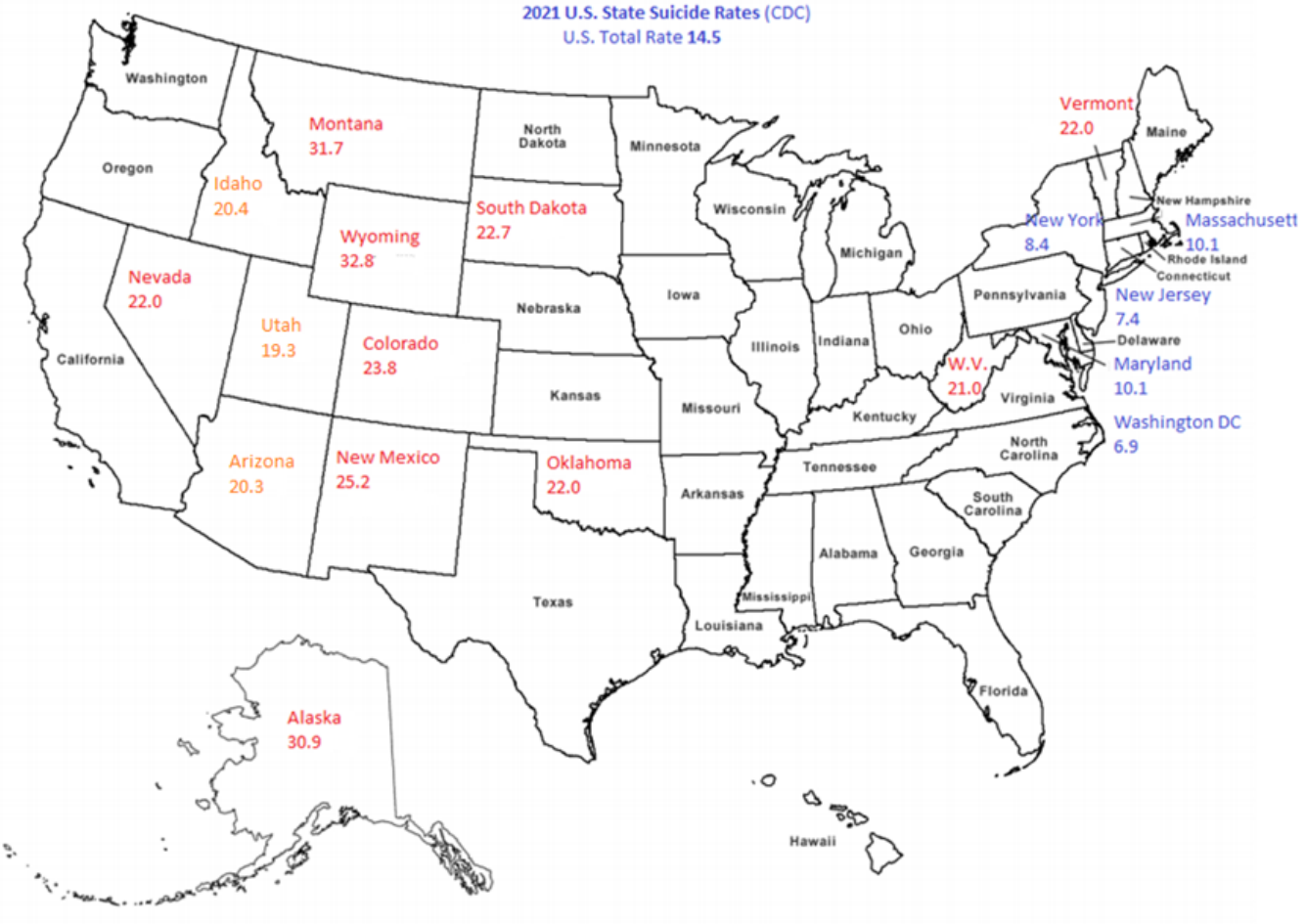
- In 2020, 9,137 Americans over the age of 65 died by suicide for a rate of 16.4 per 100,000
- The rate of suicide for women typically stabilizes after age 64 (after peaking in middle adulthood)
- 85% of elderly suicides were male; the rate of male suicides in late life was 7 times greater than for female suicides.
- Elders who complete suicide:
  - 73% have contact with primary care physician within a month of their suicide. Nearly half of those people visited with their primary care physician within **two weeks** of their suicide.

Suicide in Montana

Data Source: CDC (2/23), Montana Office of Epidemiology and Scientific Support (January, 2023, 2021 Montana Youth Risk Behavior Survey (September, 2022)

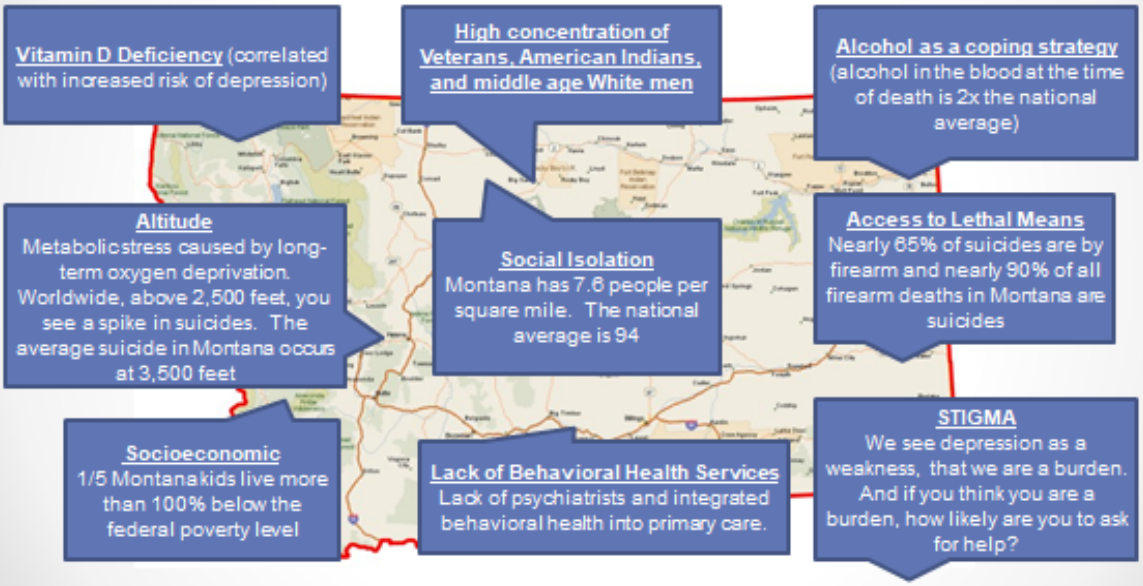
- For all age groups, Montana has ranked in the **top five** for suicide rates in the nation, for the past thirty years. **In a report for 2021 in the National Vital Statistics Report, Montana has the 2nd highest rate of suicide in the nation** (354 suicides for a crude rate of 31.7/100,000)
- *In Montana, between 2011-2020, the highest rate of suicide is among American Indians (32 per 100,000) although they only constitute 6% of the state's population. Caucasians are second at 25.3 per 100,000.*
- *Firearms (62%), suffocation (20%), and poisoning (9%) are the most common means of suicide in Montana. Other means include carbon monoxide, overdose, motor vehicles accidents, and jumping from heights.*
- *In Montana in 2011-2020 the youth suicide (ages 11-17) rate is 11.9/100,000. This is more than double the national rate for the same age group (4.98). In 2020, 62% of the youth suicides were completed by firearms.*

- According to the 2021 Youth Risk Behavior Survey, during the 12 months before the survey, 10.2%of all Montanan students in grades 9 through 12 had made a suicide attempt and 13.5% of 7th and 8th graders. For American Indian students, 17.6% had attempted suicide one or more times in the twelve months before the survey. There is a 380% increase in suicidal ideations for students getting "D"'s compared to "A"'s.
- Suicide is the number **one** cause of preventable death in Montana for children ages 10-14
- Over the past ten years suicide is the number **two** cause of death for children ages 10-14, adolescents ages 15-24 and adults ages 25-44.
- Studies show that for every completed suicide, there are 6 survivors. Given there are approximate 300 suicides in Montana every year, that means there are about 1,800 new survivors every year in Montana. *A survivor of suicide is 3x the risk of completing suicide themselves.*



Why does Montana have such a high rate of suicide?

It's not one factor, but rather multiple factors all occurring at the same time.
It is a cultural issue.



Toxicology Results	Count	Percent
Any toxicology performed	301	100%
Number of Substances Detected		
0	100	33%
1	43	43%
2 or more	158	52%
Substances Detected		
Alcohol	93	31%
Antidepressants	61	20%
Marijuana	49	16%
Opiates	33	11%
Amphetamines	31	10%
Benzodiazepines	27	9%
Anticonvulsants	20	7%
Muscle Relaxants	13	4%
Antipsychotics	10	3%
Cocaine	6	2%
Barbiturates	3	1%
Other	15	5%

MONTANA SUICIDE RATES BY COUNTY 2013-2022

Montana Total 26.4 2853

COUNTY	RATE	NUMBER	COUNTY	RATE	NUMBER
Beaverhead County	24.4	26	Madison County	19.3	21
Big Horn County	29.6	36	Meagher County	¥	6
Blaine County	46.2	29	Mineral County	¥	19
Broadwater County	¥	13	Missoula County	23.3	291
Carbon County	36.7	31	Musselshell County	51.6	22
Carter County	¥	†	Park County	38.1	68
Cascade County	25.5	215	Petroleum County	0	0
Chouteau County	¥	16	Phillips County	¥	17
Custer County	24.8	28	Pondera County	¥	8
Daniels County	¥	†	Powder River County	¥	5
Dawson County	¥	13	Powell County	38.7	31
Deer Lodge County	36.7	37	Prairie County	¥	†
Fallon County	¥	†	Ravalli County	28.8	147
Fergus County	21.7	27	Richland County	30.3	33
Flathead County	26.1	261	Roosevelt County	37.6	38
Gallatin County	19.8	223	Rosebud County	44.8	37
Garfield County	¥	†	Sanders County	32	39
Glacier County	30.5	40	Sheridan County	¥	9
Golden Valley County	¥	†	Silver Bow County	38	128
Granite County	¥	12	Stillwater County	35.4	29
Hill County	22.2	31	Sweet Grass County	¥	11
Jefferson County	38.1	42	Teton County	¥	16
Judith Basin County	¥	†	Toole County	¥	9
Lake County	36.5	108	Treasure County	¥	5
Lewis and Clark County	22.8	159	Valley County	¥	19
Liberty County	¥	†	Wheatland County	¥	5
Lincoln County	31.2	63	Wibaux County	¥	†
McCone County	¥	†	Yellowstone County	25.1	406

¥ = Suppressed rate due to count <20
† = Suppressed count <5
Top 10 counties

Social Factors Associated With Suicide

Suicidal behavior is associated with a wide variety of social factors, but correlates most highly with:

- Social Isolation (isolation from peers or social relationships that are troubled)
- Social Disorganization (society lacks the regulatory constraints necessary to control the behavior of its members.)
- Downward Social Mobility (socioeconomic)
- Rural Residency

Approximately 90% of those who complete suicide suffer from mental illness.

- The most frequent diagnosis is Major Depression
- The 2nd most frequent diagnosis is Alcoholism

REMEMBER: *Depression is Treatable!*

Depression is one of the most treatable of all psychiatric disorders in young people.

- ❖ 86% treatment success rate with a combination of antidepressants and therapy*
- ❖ Only 40-70% with either by themselves.

* Source: The TADS Team. The Treatment for Adolescents with Depression Study (TADS): Long-term Effectiveness and Safety Outcomes. Archives of General Psychiatry. Oct 2007; VOL 64(10).

Rebound Effect – This is a very important effect to watch for. People do not recover overnight unless there is a very important reason. People tend to come out of wanting to commit suicide slowly. Some times people who have decided to kill themselves may appear quite happy. This is because they have finally made up their minds and see an end to their pain and anguish. They aren't really happy. They are simply relieved of their burden or stress or pain. Also, sometimes people who are severely depressed and contemplating suicide don't have enough energy to carry it out. But, as the disease begins to "lift" they may regain some of their energy but will still have feelings of hopelessness.

You can't tell the difference by looking at them. Studies of people who have been institutionalized for depression who later killed themselves all indicate that the period of greatest suicidal risk is not when the people are in the depths of depression, but during the first 90 days after the depression begins to lift.

Warning Signs of Suicide

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

Ideation	Expressed or communicated ideation threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself; and/or looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or talking or writing about death, dying or suicide, when these actions are out of the ordinary.
Substance Abuse	Increased alcohol or drug use
Purposelessness	No reason for living; no sense of purpose in life, start giving things away because there's no purpose in keeping anything, no reason to maintain their hygiene
Anxiety	Anxiety, agitation, unable to sleep or sleeping all the time, difficulty concentrating
Trapped	Feeling trapped (like there's no way out and things will never get better)
Hopelessness	Hopelessness, no future orientation
Withdrawal	Withdrawal from friends, isolating from family and society
Anger	Rage, uncontrolled anger, seeking revenge, irritable
Recklessness	Acting reckless or engaging in high risk activities, seemingly without thinking, impulsive behavior (especially in younger people)
Mood Change	Dramatic mood changes, flat affect, depressed mood, acting out of character

VERY IMPORTANT - All suicidal ideations are serious and every precaution needs to be taken, even if you believe the action is purely to gain attention. NEVER PUT A PERSON IN THE POSITION OF NEEDING TO PROVE THAT THEY ARE SERIOUS. Suicidal ideations are a cry for help. **DON'T AVOID THE TOPIC, TALK ABOUT THE FEELINGS AND DON'T BE AFRAID TO MENTION THE WORD "SUICIDE."** Most people will respond honestly. Many people are hesitant to bring up the subject of suicide for fear that they will be planting the idea in the mind of the person. This is a serious mistake! If the person is suicidal, asking them might lead to a conversation that could prevent the suicide.

Assessing the Degree of Risk – Mental health professionals should be used whenever possible, but once you suspect potential suicide, the best procedure is to approach the person in a **warm, accepting, non-judgmental manner** and ask a question similar to:

"Have you had thoughts of killing yourself?" or "Are you suicidal?"

Be careful with how you word your questions. Avoid asking questions that start with "why…". This elicits a defensive response and may cause the youth to close down. For example, don't ask a youth, "Why would you want to do something like that?" Instead ask, ***"How would you harm yourself?"*** This will let you quickly know if the youth has a **suicide plan**.

If the youth does have a suicide plan, remember the four factors that help you determine the seriousness of the risk.

- **Specificity** – How specific are the details of the plan of attack. The greater the amount of detail, the higher the risk.
- **Lethality** – What is the level of lethality of the proposed method of self-attack? The higher the lethality, the higher the risk.
- **Availability** – What is the availability of the proposed method? The more readily available the proposed method is the higher the risk.
- **Proximity** – What is the proximity of helping resources? The greater the distance the youth is from those you could help him, the higher the risk.

Four factors to use to access the current level of risk (given an attempt)
The strongest behavioral warning is an attempted suicide.

- **Dangerousness** – The greater the dangerousness of the attempt, the higher the current level of risk. *e.g. Did the youth take five pills or twenty five*?
- **Intent** – Did the youth believe that taking five pills was going to actually kill him? DON'T JUST LOOK AT THE BEHAVIOR, LOOK AT THE INTENT BEHIND THE BEHAVIOR.
- **Rescue** – Did the youth tell anyone that they made the attempt? Did the youth leave any signs (notes, give away possessions), or just acted normally? **70-80% of the people who die by suicide give warning signs!**
- **Timing** – The more recent the attempt, the higher the current level of risk.

Talking with a Suicidal Person

(Source: The Mayo Clinic, http://www.mayoclinic.org/diseases-conditions/suicide/in-depth/suicide/art-20044707)

Start by asking questions

The first step is to find out whether the person is in danger of acting on suicidal feelings. Be sensitive, but ask direct questions, such as:

- How are you coping with what's been happening in your life?
- Do you ever feel like just giving up?
- Are you thinking about dying?
- Are you thinking about suicide?
- Have you thought about how you would do it?
- Do you know when you would do it?
- Do you have the means to do it?

Asking about suicidal thoughts or feelings won't push someone into doing something self-destructive. In fact, offering an opportunity to talk about feelings may reduce the risk of acting on suicidal feelings.

Look for warning signs

You can't always tell when a loved one or friend is considering suicide. But here are some common signs:

- Talking about suicide — for example, making statements such as "I'm going to kill myself," "I wish I were dead" or "I wish I hadn't been born"
- Getting the means to commit suicide, such as buying a gun or stockpiling pills
- Withdrawing from social contact and wanting to be left alone
- Having mood swings, such as being emotionally high one day and deeply discouraged the next
- Being preoccupied with death, dying or violence
- Feeling trapped or hopeless about a situation
- Increasing use of alcohol or drugs
- Changing normal routine, including eating or sleeping patterns
- Doing risky or self-destructive things, such as using drugs or driving recklessly
- Giving away belongings or getting affairs in order when there is no other logical explanation for why this is being done
- Saying goodbye to people as if they won't be seen again
- Developing personality changes or being severely anxious or agitated, particularly when experiencing some of the warning signs listed above

Get emergency help, if needed

If you believe someone is in danger of committing suicide or has made a suicide attempt:

- Don't leave the person alone.
- Call 911 or your local emergency number right away. Or, if you think you can do so safely, take the person to the nearest hospital emergency room yourself.
- Try to find out if he or she is under the influence of alcohol or drugs or may have taken an overdose.
- Tell a family member or friend right away what's going on.

If a friend or family member talks or behaves in a way that makes you believe he or she might commit suicide, don't try to handle the situation without help — get help from a trained professional as quickly as possible. The person may need to be hospitalized until the suicidal crisis has passed.

Offer support

If a friend or loved one is thinking about suicide, he or she needs professional help, even if suicide isn't an immediate danger. Here's what you can do.

- **Encourage the person to seek treatment.** Someone who is suicidal or has severe depression may not have the energy or motivation to find help. If your friend or loved one doesn't want to consult a doctor or mental health provider, suggest finding help from a support group, crisis center, faith community, teacher or other trusted person. You can help by offering support and advice — but remember that it's not your job to become a substitute for a mental health provider.
- **Offer to help the person take steps to get assistance and support.** For example, you can research treatment options, make phone calls and review insurance benefit information, or even offer to go with the person to an appointment.
- **Encourage the person to communicate with you.** Someone who's suicidal may be tempted to bottle up feelings because he or she feels ashamed, guilty or embarrassed. Be supportive and understanding, and express your opinions without placing blame. Listen attentively and avoid interrupting.
- **Be respectful and acknowledge the person's feelings.** Don't try to talk the person out of his or her feelings or express shock. Remember, even though someone who's suicidal isn't thinking logically, the emotions are real. Not respecting how the person feels can shut down communication.

- **Don't be patronizing or judgmental.** For example, don't tell someone, "things could be worse" or "you have everything to live for." Instead, ask questions such as, "What's causing you to feel so bad?" "What would make you feel better?" or "How can I help?"
- **Never promise to keep someone's suicidal feelings a secret.** Be understanding, but explain that you may not be able to keep such a promise if you think the person's life is in danger. At that point, you have to get help.
- **Offer reassurance that things will get better.** When someone is suicidal, it seems as if nothing will make things better. Reassure the person that these feelings are temporary, and that with appropriate treatment, he or she will feel better about life again.
- **Encourage the person to avoid alcohol and drug use.** Using drugs or alcohol may seem to ease the painful feelings, but ultimately it makes things worse — it can lead to reckless behavior or feeling more depressed. If the person can't quit on his or her own, offer to help find treatment.
- **Remove potentially dangerous items from the person's home, if possible.** If you can, make sure the person doesn't have items around that could be used to commit suicide — such as knives, razors, guns or drugs. If the person takes a medication that could be used for overdose, encourage him or her to have someone safeguard it and give it as prescribed.

Take all signs of suicidal behavior seriously

If someone you know says he or she is thinking of suicide or is behaving in a way that makes you think the person may be suicidal, don't play it down or ignore the situation. Many people who commit suicide have expressed the intention at some point. You may worry that you're overreacting, but the safety of your friend or loved one is most important. Don't worry about straining your relationship when someone's life is at stake.

You're not responsible for preventing someone from taking his or her own life — but your intervention may help the person see that other options are available to stay safe and get treatment.

Suicide Prevention Resources (trainings and programs)

- **QPR**- A two hour gatekeeper training that provides anybody the ability to recognize the warning signs, how to intervene, and who to refer the person to.
- **ASIST** - A two-day workshop designed to provide participants with gatekeeping knowledge and skills. Gatekeepers are taught to recognize the warning signs and to intervene with appropriate assistance.
- **SOS: Signs of Suicide** - School-based program which combines a curriculum that aims to raise awareness of suicide and reduce stigma of depression. There is also a brief screening for depression and other factors associated with suicidal behavior.
- **Parents as Partners** – A 9 page booklet that helps parents recognize the symptoms of depression and the warning signs of suicide in their children and how to intervene.
- **Crisis Intervention Training** - CIT came out of the Memphis Police Dept. and is a training for law enforcement officers to help them manage mental health issues when they respond to a call.
- **PAX Good Behavior Game** - The PAX Good Behavior Game is an environmental intervention used in the classroom with young children to create an environment that is conducive to learning. The intervention is designed to reduce off-task behavior; increase attentiveness; and decrease aggressive and disruptive behavior and shy and withdrawn behavior. The intervention also aims to improve academic success, as well as mental health and substance use outcomes later in life.
- **Mental Health First Aid**- Mental Health First Aid is an adult public education program designed to improve participants' knowledge and modify their attitudes and perceptions about mental health and related issues, including how to respond to individuals who are experiencing one or more acute mental health crises or are in the early stages of one or more chronic mental health problems.
- **Crisis Action School Toolkit on Suicide (CAST-S)** The goal in the creation of CAST-S was to support each school district and their communities to have access to much needed resources in developing their own protocols and crisis plan for preventing and addressing youth suicides. The CAST-S is a free resource for all Montana school leaders and staff (https://dphhs.mt.gov/assets/suicideprevention/cast-s2022.pdf)

For additional information about these programs or other evidenced-based practices, go to http://www.sprc.org/featured_resources/bpr//ebpp.asp or http://www.nrepp.samhsa.gov/

Other Available Suicide Prevention Resources

(go to www.dphhs.mt.gov/suicideprevention to download these programs)

- **Suicide Prevention Toolkit for Rural Primary Care Physicians** – Assessment and intervention material for physicians in rural communities.
- **Suicide Prevention Toolkit for Senior Living Communities** – Assessment and intervention material for assisted living programs and nursing home.

Additional Suicide Prevention Resources

- **Montana Suicide Prevention Website at www.dphhs.mt.gov/suicideprevention**
- In the event of an immediate crisis, **Call 911**, law enforcement, or take the person to the **nearest hospital emergency room or clinic**.
- **Montana Suicide Prevention Crisisline at 988 (call, text, or chat)**
  Provides immediate assistance to individuals and Veterans in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider www.suicidepreventionlifeline.org
- **American Association of Suicidology (202) 237-2280**
  Call for written material on suicide and suicide prevention or visit www.suicidology.org
- **American Foundation for Suicide Prevention (888) 333-AFSP (2377)**
  For more information on suicide prevention, call toll free or visit www.afsp.org
- **National Alliance for the Mentally Ill (800) 950-NAMI (6264)**
  Call Help Line for local support group and/or additional materials on depression, or visit www.nami.org
- **Suicide Prevention Resource Center (SPRC) 877-GET-SPRC (438-7772)**
  Provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies, and to advance the National Strategy for Suicide Prevention. Includes materials for students, parents, school staff, and others. Includes state suicide data on state pages www.sprc.org.
- **The Trevor Project (www.thetrevorproject.org).** Founded in 1998 by the creators of the Academy Award®-winning short film TREVOR, The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people ages 13-24.

Saint Louis University Mental Status Examination
Form Details

Who Can Complete the Form: Social Services, Reflections/Passages Program Coordinators, Licensed Nurses, MDs, NPs, OTs, PTs, Residence Supervisors and Other Qualified Healthcare Professionals.

Purpose of the Form: To screen individuals to look for the presence of cognitive deficits, and to identify changes in cognition over time.

Instructions for Use:

1. Complete resident demographics at the top of the page.

2. We recommend that you put the date and the name of the evaluator on the bottom of the page as well (see #19).

3. Administration should be conducted privately and in the examinee's primary language. Be prepared with the items you need to complete the exam. You will need a watch with a second hand on it.

4. Record the number of years the patient attended school. If the patient obtained an Associates, Bachelor's, Master's or Doctorate degree, note the degree achieved instead of actual years of school attended.

5. Determine if the patient is alert. Do not answer "yes" or "no", but indicate level of alertness. Alert indicates that the individual is fully awake and able to focus. Other descriptors include: drowsy, confused, distractible, inattentive, preoccupied.

6. Begin by asking the patient the following:
   "Do you have any trouble with your memory?" "May I ask you some questions about your memory?"
   Then proceed with the exam questions.

7. Read the questions aloud clearly and slowly to the examinee. It is not usually necessary to speak loudly but it is necessary to speak slowly.

8. Begin by asking the patient something similar to the following:
   "Do you have any trouble with your memory?" "May I ask you some questions about your memory?" "I'd like to see how good your memory is by asking you some questions." You may need to reassure patients by telling them that this is not a test that they can fail but merely a tool much like a thermometer that takes temperature is a tool. What this does is checks for the amount of memory they have.
   Then begin to administer the exam questions.

9. Score the questions as indicated on the examination.

10. On question #4, read the statement as listed on the exam. Ask the patient to repeat each of the five objects (Apple, Pen, Tie, House, Car) that you recite to make sure that the patient heard and understood what you said. Repeat them as many times as it takes for the patient to repeat them back to you correctly.

Saint Louis University Mental Status Examination
Form Details

11. On question #5, make sure the patient is focused on you prior to reciting the information. Obtain an answer for the first part of the question ("How much did you spend") before moving on to part two ("How much do you have left?"). Do not prompt or give hints, but do give ample time to the patient to answer the questions. If the patient asks you to repeat the question you may do so once.

12. Redirect the patient's attention if necessary back to you to answer question #6. Give them one minute to complete the question. Be sure to time them.

13. Continue with the exam questions in the order that they are listed.

14. On question #8, state each number by its individual name. 87 is pronounced eight, seven; 649 is pronounced six, four, nine; 8537 is pronounced eight, five, three, seven.

15. On question #9, either draw a large circle on the back of the examination form or provide the patient with a separate piece of paper with a larger circle printed on it and attach it to the original examination form. When scoring, give full credit for either all 12 numbers or all 12 ticks. If the patient puts only 4 ticks on the circle, prompt them once to put numbers next to those ticks (12, 3, 6, and 9) for full credit. When scoring the correct time, make sure the hour hand is shorter than the minute hand and that the minute hand points at the 10 and the hour hand points at the 11.

16. You may also provide a separate sheet with larger examples of the forms listed on question #10 for those with vision impairment. This sheet should be created by enlarging the figures on the examination form and can also be attached to the original form.

17. Read question #11 as written, and provide ample time to answer each question. Do not repeat the story but do make sure they are paying attention the first time you read it to them. Do not prompt or give hints. The answer of Chicago as the state she lives in gets no credit but you may prompt them once by repeating the question.

18. Score the examination as listed at the bottom of the page, circling the level based on the score.

19. Sign and date the form.

20. Upon Completion of the Form:

☒ Record the score in the patient's record and comment on any indicated changes

☒ Depending upon office protocols, either put the sheet in the patient's record, place it in a separate identified location, or destroy the worksheet once the score is recorded in the patient record (Specify based on Office Center Policy)

21. Form Status: (Varies by office)

Mandatory for (e.g., patients with diagnoses or indicators of cognitive loss)

Mandatory for _____

Saint Louis University Mental Status Examination

Name:_____ **Age**:_____

Is Patient alert? YES NO **Level of Education:** <HS >= HS

___/1 | 1 | **#1 What day of the week is it?**

___/1 | 1 | **#2 What is the year?**

___/1 | 1 | **#3 What state are we in?**

#4 Please remember these five objects. I will ask you what they are later.

Apple Pen Tie House Car

#5 You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.

1 | **How much did you spend?**

___/3 | 2 | **How much do you have left?**

#6 Please name as many animals as you can in one minute.

___/3

0	0-4 animals	1	5-9 animals
2	10-14 animals	3	15+ animals

___/5 **#7 What were the five objects I asked you to remember?**

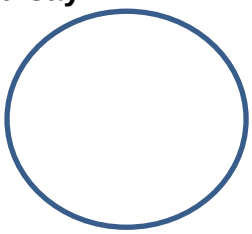
1 point for each correct answer

#8 I am going to give you a series of numbers and I would like you to give them back to me backwards. For example, if I say 42, you would say 24.

___/2

0	87	1	649	1	8537

#9 This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.



2 | Hour marker okay

___/4 | 2 | Time correct

1 **#10 Please place an X in the triangle.**

___/2 | 1 | **Which of the figures is largest?**

#11 I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

2 **What was the female's name?** 2 **What work did she do?**

___/8 | 2 **When did she go back to work?** 2 **What state did she live in?**

TOTAL

_____

Scoring

High School Education		Less Than High School Education
27-30	**Normal**	25-30
21-26	**MNCD***	20-24
1-20	**Dementia**	1-20

*Mild Neurocognitive Disorder

Suicidality Treatment Tracking Log (for Patient Chart)

Patient Name _____ Medical Record #_____ Primary Care Provider_____

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

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

Instructions for Completing the Treatment Tracking Log

The Treatment Tracking Log is designed to parsimoniously display critical information in a sequence of treatment sessions with primary care patients at-risk of suicide. More specific details about the patient and treatment (e.g. medication name and dosage) would be located in a patient's medical chart. This form is used to quickly update the primary care provider of the suicide status of an individual and to easily remind the provider of recent interventions or problems with regard to the patient's treatment.

1. **Session Date**. In this space write the date of the primary care "visit." Each visit contact should include the day, month and year of the visit. It is important to log scheduled appointments which are cancelled or are otherwise not kept. The other information about the patient would likely be unknown to the primary care provider for these sessions, but "missed" appointed sessions might be indicators of needed patient outreach.
2. Circle the letter that identifies the **type of session** interaction with the patient. A telephone conversation with a patient should be included as a treatment "session." It is also important to note if a patient was scheduled for a treatment session and either cancelled the visit or did not come to the appointment.
3. **Suicidal Thoughts?** At each session, the primary care provider should ask the patient if he or she currently has thoughts about dying as a result of one's own actions. The question can be asked in a variety of ways. Record the patient's response as a "Yes" or "No" by circling the appropriate response. Record "Yes" if there is ANY level or indication of suicidal thoughts. Thoughts can include thinking of a plan for suicide. For example, ask, "Are you currently thinking about ending your life?" If the response is positive, probes should be made to learn more. For example, "Have you thought about how you would kill yourself?"
4. **Suicidal Behaviors?** If the patient acknowledges suicidal thoughts, the primary care provider should probe if the patient has acted in any way that is suicidal. The primary care provider can gain this knowledge by asking questions such as "Have you spoken with anyone about your thoughts of killing yourself?" "Have you made an attempt to end our life since our last contact?" "Have you made any preparations toward ending your life?"
5. **Risk.** Circle the patient's level of risk as Low, Moderate or High according to the Assessment and Intervention Tool in this toolkit.
6. **Medication Prescribed.** Circle "Yes" if the primary care or a mental health provider has prescribed medication for a mental health diagnosis.
7. **Medication Dosage/Start Date.** Note the prescribed dosage on the date of the session. If medication is newly prescribed, note the date the medication is initially taken by the patient. If a different or additional medication is prescribed for the mental health condition, note the date the different or additional medication is initially taken by the patient.
8. **Medication Adherence.** To the best of the primary care provider's knowledge, note if the patient is taking the prescribed dosage by circling "Yes" or "No."
9. **Medication Side Effects.** Write in the space provided any complaints or noted problems related to the medication.
10. **Interventions.** In this space, note specific interventions that occurred during the session.
11. **Mental Health Provider?** Circle "Yes" if the primary care provider is aware that the patient is currently a client of a mental health provider. Space is provided to include the mental health provider's name or contact information, if having this information accessible is useful.

Once the primary care provider discontinues tracking the patient regarding suicide status, note the reason why the tracking is closed. This item should include the date of discontinuing the tracking process and should include both positive and negative reasons for discontinuing the process. If a patient drops out of care, any attempt(s) to try to contact or re-engage into care can be noted in one or more session columns. The date of the action should be entered on "Session date." Attempt(s) to contact or re-engage the patient, or inquire of others about the patient can be noted under "Other Interventions."

Office Protocol for Suicidal Patients – Development Guide

The purpose of an Office Protocol for Suicidal Patients is to anticipate and have an appropriate plan in place before a suicidal patient is identified. This office suicidal patient care management plan allows providers and office staff to be prepared when treating a patient who is assessed to be at high risk for suicide. Initial assessment of a potentially suicidal patient can be conducted by a member of the office staff or by an external consultant. An office protocol template, to simplify the process of further assessing and potentially hospitalizing a high-risk patient, can be found on the following page of this Toolkit. It will help a practice to proactively answer the logistical questions related to getting additional psychiatric care for patients before a crisis occurs, and guide providers quickly and efficiently when a patient is in need of such care.

The office protocol is an essential component of a comprehensive office strategy for suicide prevention, and may be developed during staff meetings. Once the protocol is developed, it may be useful for the office to implement a "dry run" with a mock patient to ensure that the protocol can be followed seamlessly. Suicide prevention trainings, including warning signs to look for, inquiring about suicidal ideation, and how to respond to suicidal individuals, can be provided to all office staff as an in-service. See Module 3: Effective Prevention Strategies, in the Primer section of this Toolkit, for detailed information about effective suicide prevention strategies for primary care offices. Though these strategies may require an investment of time and money, they constitute best practices for care and may save lives.

Consider involving all office staff in suicide prevention efforts. Staff members are frequently in positions to observe changes in behavior or hear patients express suicidal ideation that the patient may be reluctant to share with the provider. Office staff can play a crucial role by detecting concerning behaviors and alerting the patient's provider.

Locate specific information about your state's involuntary treatment laws and post this in the office along with contact information for mental health professionals who are responsible for making these determinations in your area.

Make sure you have information in the office about the National Suicide Prevention Lifeline, 1-800-273-TALK (8255), which also offers free materials, including posters and cards with the Lifeline number. Professionals at that number can also direct practices to community mental health service providers in their area.

Office Protocol for Suicidal Patients – Office Template

Post in a visible or accessible place for key office staff.

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

- _____ should be called/paged to assist with suicide risk assessment (e.g. physician, mental health professional, telemedicine consult, etc.).
- _____ should be called/paged to assist with collaborative safety planning.
- Identify and call patient's support person in the community (e.g. family member, pastor, mental health provider, other support person).

If patient requires hospitalization ...

- Our nearest Emergency Department or psychiatric emergency center is _____
- Phone # _____
- _____ will call _____ to arrange transport.
  (Name of individual or job title) (Means of transport [ambulance, police, etc.] and phone #)

Backup transportation plan: Call _____

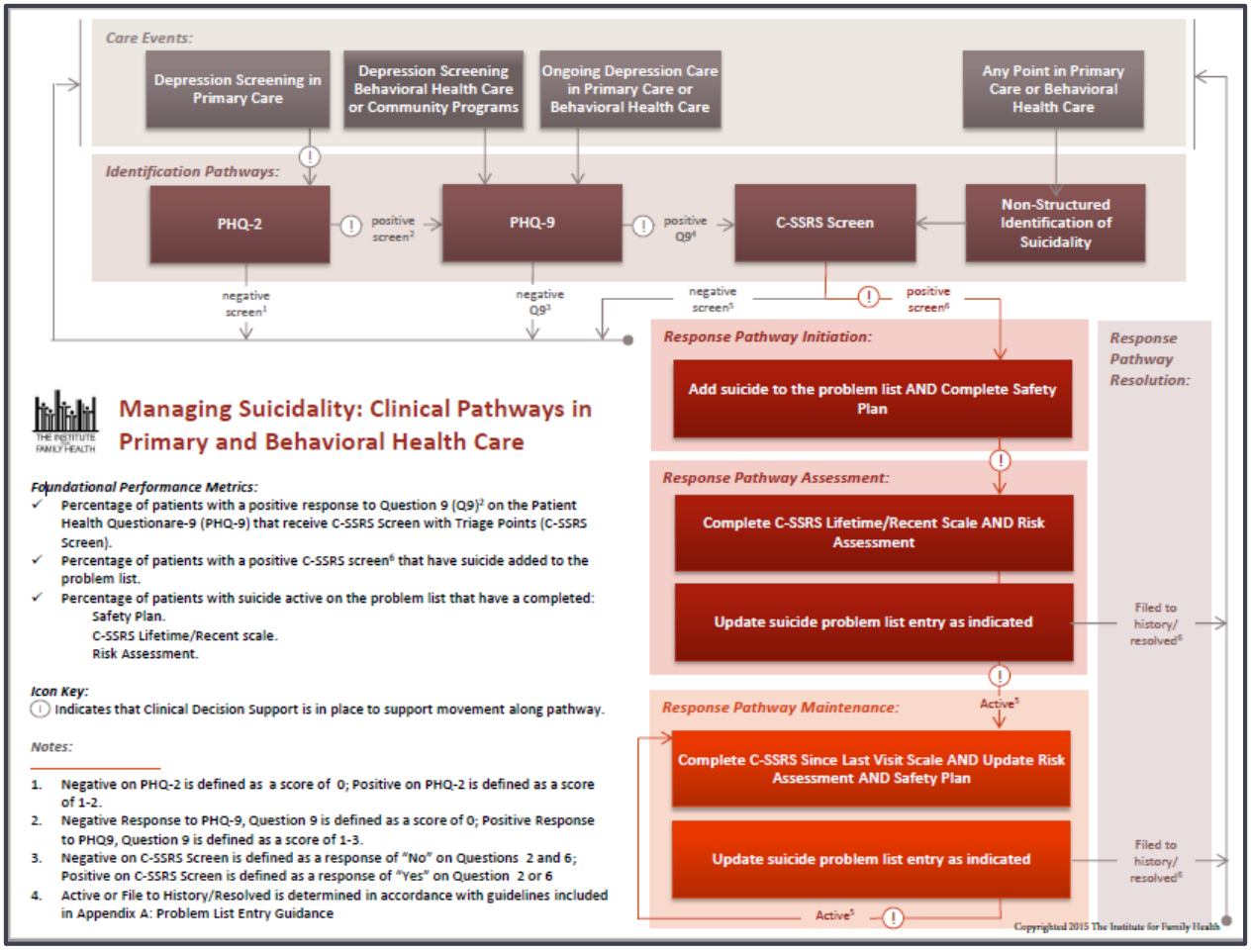
- _____ will wait with patient for transport.

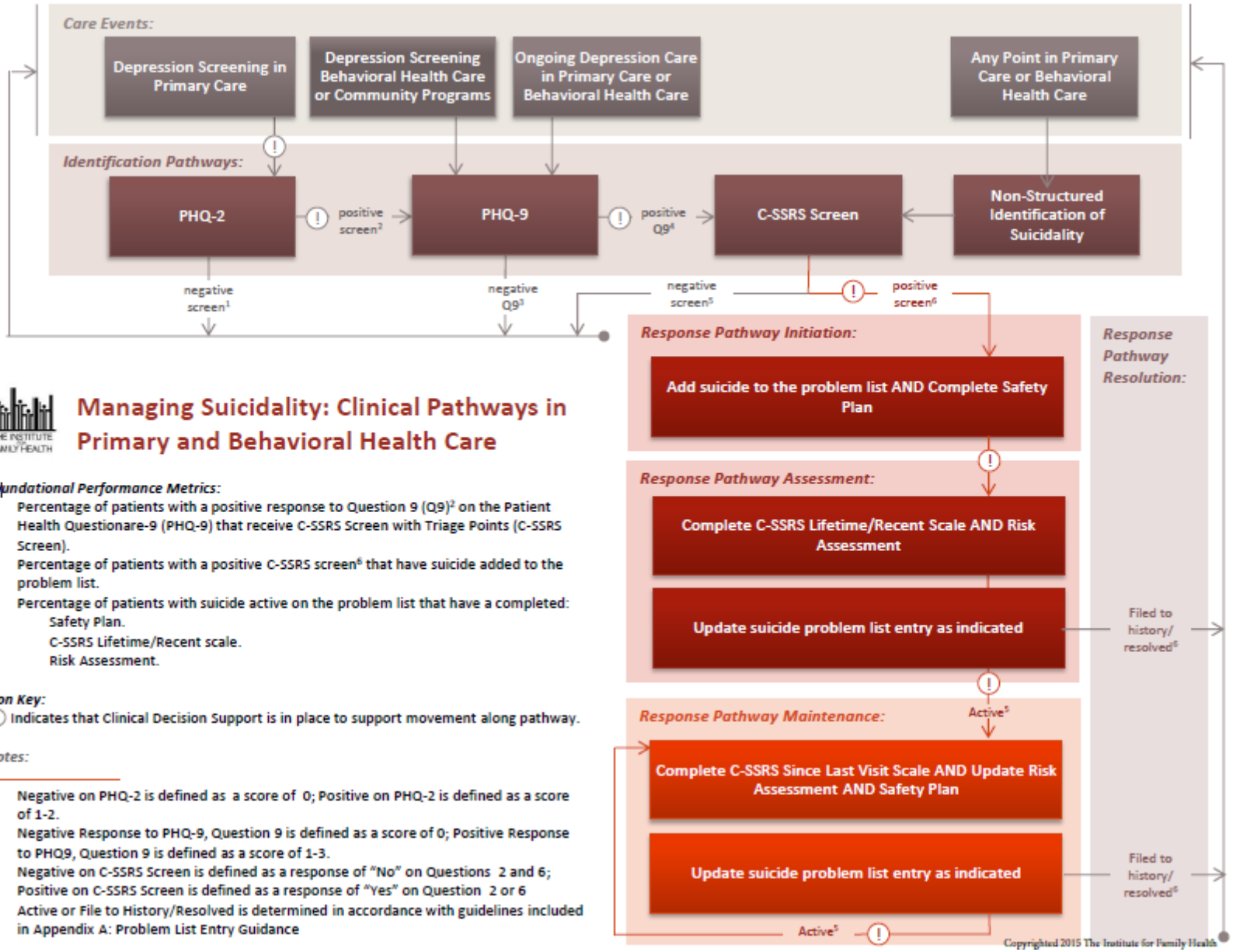
Documentation and follow-up ...

- _____ will call ED to provide patient information.
- _____ will document incident in _____
  (Name of individual or job title) (e.g. medical chart, suicide tracking chart, etc.)
- Necessary forms/instructions/chart-flagging materials are located _____
- _____ will follow-up with ED to determine disposition of patient.
  (Name of individual or job title)
- _____ will follow-up with patient within _____
  (Name of individual or job title) (Time frame)

Institute for Family Health
Clinical Pathways for Managing Suicidality

The Institute for Family Health created a Managing Suicidality: Clinical Pathways in Primary and Behavioral Health Care resource to guide staff through their organization's approach to identification and response.





Managing Suicidality: Clinical Pathways in Primary and Behavioral Health Care

Foundational Performance Metrics:

- ✓ Percentage of patients with a positive response to Question 9 (Q9)[2] on the Patient Health Questionare-9 (PHQ-9) that receive C-SSRS Screen with Triage Points (C-SSRS Screen).
- ✓ Percentage of patients with a positive C-SSRS screen[6] that have suicide added to the problem list.
- ✓ Percentage of patients with suicide active on the problem list that have a completed:
  - Safety Plan.
  - C-SSRS Lifetime/Recent scale.
  - Risk Assessment.

Icon Key:

ⓘ Indicates that Clinical Decision Support is in place to support movement along pathway.

Notes:

1. Negative on PHQ-2 is defined as a score of 0; Positive on PHQ-2 is defined as a score of 1-2.
2. Negative Response to PHQ-9, Question 9 is defined as a score of 0; Positive Response to PHQ9, Question 9 is defined as a score of 1-3.
3. Negative on C-SSRS Screen is defined as a response of "No" on Questions 2 and 6; Positive on C-SSRS Screen is defined as a response of "Yes" on Question 2 or 6
4. Active or File to History/Resolved is determined in accordance with guidelines included in Appendix A: Problem List Entry Guidance

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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

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

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

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

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

A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

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

A2662B 10-04-2005

Severity Measure for Depression—Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Name:_____ **Age:** _____ **Sex: Male** ❑ **Female** ❑ **Date:**_____

Instructions: How often have you been bothered by each of the following symptoms during the past **7 days**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(0) Not at all	**(1) Several days**	**(2) More than half the days**	**(3) Nearly every day**	
1.	Feeling down, depressed, irritable, or hopeless?					
2.	Little interest or pleasure in doing things?					
3.	Trouble falling asleep, staying asleep, or sleeping too much?					
4.	Poor appetite, weight loss, or overeating?					
5.	Feeling tired, or having little energy?					
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?					
7.	Trouble concentrating on things like school work, reading, or watching TV?					
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?					
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?					
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

G4: PHQ-A (continued)

Instructions to Clinicians

The Severity Measure for Depression—Child Age 11–17 (adapted from PHQ-9 modified for Adolescents [PHQ-A]) is a 9-item measure that assesses the severity of depressive disorders and episodes (or clinically significant symptoms of depressive disorders and episodes) in children ages 11–17. The measure is completed by the child prior to a visit with the clinician. Each item asks the child to rate the severity of his or her depression symptoms **during the past 7 days**.

Scoring and Interpretation

Each item on the measure is rated on a 4-point scale (0=Not at all; 1=Several days; 2=More than half the days; and 3=Nearly every day). The total score can range from 0 to 27, with higher scores indicating greater severity of depression. The clinician is asked to review the score of each item on the measure during the clinical interview and indicate the raw score in the section provided for "Clinician Use." The raw scores on the 9 items should be summed to obtain a total raw score and should be interpreted using the table below:

Interpretation Table of Total Raw Score

Total Raw Score	Severity of depressive disorder or episode
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

Note: If 3 or more items are left unanswered, the total raw score on the measure should not be used. Therefore, the child should be encouraged to complete all of the items on the measure. If 1 or 2 items are left unanswered, you are asked to calculate a prorated score. The prorated score is calculated by summing the scores of items that were answered to get a partial raw score. Multiply the partial raw score by the total number of items on the PHQ-9 modified for Adolescents (PHQ-A)—Modified (i.e., 9) and divide the value by the number of items that were actually answered (i.e., 7 or 8). The formula to prorate the partial raw score to Total Raw Score is:

$$\frac{(\text{Raw sum} \times 9)}{\text{Number of items that were actually answered}}$$

If the result is a fraction, round to the nearest whole number.

Frequency of Use

To track changes in the severity of the child's depression over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the child's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the child that might warrant further assessment, treatment, and follow-up. Your clinical judgment should guide your decision.

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

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

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Columbia Suicide Severity Rating Scales (C-SSRS)

Answer Questions 1 and 2 *In the past month...*	Past Month
1 Have you wished you were dead or wished you could go to sleep and not wake up?	
2 Have you had any thoughts about killing yourself?	
If YES to 2, answer questions 3, 4, 5 and 6 If NO to 2, go directly to question 6	
3 Have you thought about how you might do this?	
4 Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?	**High Risk**
5 Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	**High Risk**
Always Ask Question 6 *In the past 3 months...*	
6 Have you done anything, started to do anything, or prepared to do anything to end your life? *Ex: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide notes, held a gun but changed your mind, hang yourself, etc.*	**High Risk**

Any YES must be taken seriously. Seek help from friends, family, co-workers, and inform them as soon as possible.

If the answer to 4, 5, or 6 is YES, immediately call 988 or ESCORT to Emergency Personnel for care.

DON'T LEAVE THE PERSON ALONE. LOCK UP FIREARMS AND MEDICATIONS. CALL THE MONTANA SUICIDE PREVENTION LIFELINE AT 988 OR TEXT "MT" TO 741741

THE COLUMBIA LIGHTHOUSE PROJECT
IDENTIFY RISK. PREVENT SUICIDE.

MONTANA DPHHS

Scoring the Columbia Suicide Severity Rating Scale

Ask the first 2 questions by saying, "**in the past month**…

1. **Have you wished you were dead or wished you could go to sleep and not wake up**?
2. **Have you had any thoughts about killing yourself**?

If "NO" to #2, go directly to question 6 and say "in the past 3 months…"

6. **Have you done anything, started to do anything, or prepared to do anything to end your life**?

If YES to #2, answer questions 3, 4, 5, and 6

3. **Have you thought about how you might do this**?
4. **Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them**.
5. **Have you started to work out the details of how to kill yourself? Do you intend to carry out the plan**?

If the answer to 4, 5, or 6 is "YES", immediately CALL 988 OR ESCORT THE PERSON TO EMERGENCY PERSONNEL. IF IN A HEALTHCARE SETTING, INITIATE YOUR OFFICE PROTOCOL FOR TREATING A HIGH-RISK PATIENT.

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

Brief Suicide Safety Assessment

asQ Ask Suicide-Screening Questions

What to do when an adult patient screens positive for suicide risk:

- Use after a patient **(18+ years)** screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These can be hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the patient

Review patient's responses from the asQ
Interview the patient alone; ask any visitors to leave the room

Frequency of suicidal thoughts

Determine if and how often the patient is having suicidal thoughts.

Ask the patient: "In the past few weeks, have you been thinking about killing yourself?" **If yes, ask:** "How often?" (once or twice a day, several times a day, a couple times a week, etc.) "When was the last time you had these thoughts?"

"Are you having thoughts of killing yourself right now?" **(If "yes," patient is at imminent risk and requires an urgent/STAT mental health evaluation and cannot be left alone. Notify patient's medical team.)**

Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means).

Ask the patient: "Do you have a plan to kill yourself?" **If yes, ask:** "What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

Past behavior

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).

Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"

If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?" "Did you want to die?" (Intent is as important as lethality of method) **Ask:** "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future attempts.

Symptoms Ask the patient about:

Depression: "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"

Anxiety: "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"

Impulsivity/Recklessness: "Do you often act without thinking?"

Hopelessness: "In the past few weeks, have you felt hopeless, like things would never get better?"

Anhedonia: "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"

Isolation: "Have you been keeping to yourself more than usual?"

Irritability: "In the past few weeks, have you been feeling more irritable or grouchier than usual?"

Substance and alcohol use: "In the past few weeks, have you used drugs or alcohol excessively or more than usual?" **If yes, ask:** "What? How much? Has this caused any legal problems or problems with more people in your life?"

Sleep pattern: "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"

Appetite: "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"

Other concerns: "Recently, have there been any concerning changes in how you are thinking or feeling?"

Social Support & Stressors

(For all questions below, if patient answers yes, ask them to describe.)

Support network: "Is there a trusted person you can talk to? Who? Have you ever seen a therapist/counselor?" **If yes, ask:** "When and for what purpose?"

Family situation: "Are there any conflicts at home that are so difficult to manage that they are causing you a lot of distress?"

Employment: "Do you currently have a job?" If yes, ask: "Do you ever feel so much pressure at work that you can't take it anymore?"

Domestic violence: "Are you worried that anyone in your life is trying to hurt you?"

Suicide contagion: "Do you know anyone who has killed themselves or tried to kill themselves?"

Reasons for living: "What are some of the reasons you would NOT kill yourself?" (e.g. belief system/faith/family/other)

asQ Ask Suicide-Screening Questions

Brief Suicide Safety Assessment

3 Make a safety plan with the patient

Create a safety plan for managing potential future suicidal thoughts. A safety plan is different than making a "safety contract"; asking the patient to contract for safety is NOT effective and may be dangerous or give a false sense of security.

Say to patient: "Our first priority is keeping you safe. Let's work together to develop a safety plan for when you are having thoughts of suicide."

Examples: "I will tell my partner/friend/sibling." "I will call the hotline." "I will call _____."

Discuss coping strategies to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).

Discuss means restriction (securing or removing lethal means): "Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?"

Ask safety question: "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe; but a "yes" is a reason to act immediately to ensure safety.)

4 Determine disposition

After completing the assessment, choose the appropriate disposition plan. *If possible, nurse should follow-up with a check-in phone call (within 48 hours) with all patients who screened positive.*

- ❑ **Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts).** Send to emergency department for extensive mental health evaluation (unless contact with a patient's current mental health provider is possible and alternative safety plan for imminent risk is established).
- ❑ **Further evaluation of risk is necessary:** Review the safety plan and send home with a mental health referral as soon as patient can get an appointment (preferably within 72 hours).
- ❑ **Patient might benefit from non-urgent mental health follow-up:** Review the safety plan and send home with a mental health referral.
- ❑ **No further intervention is necessary at this time.**

For all positive screens, follow up with patient at next appointment.

5 Provide resources to all patients

- **24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454**
- **24/7 Crisis Text Line: Text "HOME" to 741-741**

asQ
Ask Suicide-Screening Questions

Script for nursing staff

Say to parent/guardian:
"National safety guidelines recommend that we screen all kids for suicide risk. We ask these questions in private, so I am going to ask you to step out of the room for a few minutes. If we have any concerns about your child's safety, we will let you know."

Once parent steps out, say to patient:
"Now I'm going to ask you a few more questions."
Administer the ASQ and any other questions you want to ask in private (e.g. domestic violence).

If patient screens positive, say to patient:
"These are hard things to talk about. Thank you for telling me. I'm going to share your answers with [insert name of MD, PA, NP, or mental health clinician] and he/she will come speak with you."

If patient screens positive, and parent/guardian is awaiting results, say:
"We have some concerns about your child's safety that we would like to further evaluate. It's really important that he/she spoke up about this. I'm going to talk to [insert name of MD, PA, NP, or mental health clinician], and he/she will further evaluate your child for safety."

asQ
Ask Suicide-Screening Questions

Parent/guardian flyer

Your child's health and safety is our #1 priority. New national safety guidelines recommend that we screen children and adolescents for suicide risk.

During today's visit, we will ask you to step out of the room for a few minutes so a nurse can ask your child some additional questions about suicide risk and other safety issues in private.

If we have any concerns about your child's safety, we will let you know.

Suicide is the 2nd leading cause of death for youth. Please note that **asking kids questions about suicide is safe**, and is very important for suicide prevention. Research has shown that asking kids about thoughts of suicide is not harmful and **does not put thoughts or ideas into their heads**.

Please feel free to ask your child's doctor if you have any questions about our patient safety efforts.

Thank you in advance for your cooperation.

Patient Safety Plan Template

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

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Place _____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

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

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

Step 6: Making the environment safe:

1. _____
2. _____

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

_____

- For methods with **low lethality,** clinicians may ask patients to remove or limit their access to these methods themselves.
- Restricting the patient's access to a **highly lethal method,** such as a firearm, should be done by a designated, responsible person – usually a family member or close friend, or the police.

WHAT ARE THE STEPS AFTER THE PLAN IS DEVELOPED?

ASSESS the likelihood that the overall safety plan will be used and problem solve with the patient to identify barriers or obstacles to using the plan.

DISCUSS where the patient will keep the safety plan and how it will be located during a crisis.

EVALUATE if the format is appropriate for patient's capacity and circumstances.

REVIEW the plan periodically when patient's circumstances or needs change.

REMEMBER: THE SAFETY PLAN IS A TOOL TO ENGAGE THE PATIENT AND IS ONLY ONE PART OF A COMPREHENSIVE SUICIDE CARE PLAN

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WICHE

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Safety Planning Guide

A Quick Guide for Clinicians

may be used in conjunction with the "Safety Plan Template"

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is **brief,** is in the **patient's own words,** and is **easy** to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.

WICHE
Western Interstate Commission for Higher Education

Implementing the Safety Plan: 6 Step Process

Step 1: Warning Signs

- Ask: **"How will you know when the safety plan should be used?"**
- Ask: **"What do you experience when you start to think about suicide or feel extremely depressed?"**
- List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patient's **own words**.

Step 2: Internal Coping Strategies

- Ask: **"What can you do, on your own, if you become suidical again, to help yourself not to act on your thoughts or urges?"**
- Assess likelihood of use: Ask: **"How likely do you think you would be able to do this step during a time of crisis?"**
- If doubt about use is expressed, ask: **"What might stand in the way of you thinking of these activities or doing them if you think of them?"**
- Use a collaborative, problem solving approach to address potential roadblocks and ID alternative coping strategies.

Step 3: Social Contacts Who May Distract from the Crisis

- Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Ask: **"Who or what social settings help you take your mind off your problems at least for a little while?" "Who helps you feel better when you socialize with them?"**
- Ask for safe places they can go to be around people (i.e. coffee shop).
- Ask patient to list several people and social settings in case the first option is unavailable.
- Remember, in this step, the goal is distraction from suicidal thoughts and feelings.
- Assess likelihood that patient will engage in this step; ID potential obstacles, and problem solve, as appropriate.

Step 4: Family Members or Friends Who May Offer Help

- Instruct patients to use Step 4 if Step 3 does not resolve crisis or lower risk.
- Ask: **"Among your family or friends, who do you think you could contact for help during a crisis?"** or **"Who is supportive of you and who do you feel that you can talk with when you're under stress?"**
- Ask patients to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
- Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- Role play and rehearsal can be very useful in this step.

Step 5: Professionals and Agencies to Contact for Help

- Instruct the patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- Ask: **"Who are the mental health professionals that we should identify to be on your safety plan?"** and **"Are there other health care providers?"**
- List names, numbers and/or locations of clinicians, local urgent care services.
- Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- Role play and rehearsal can be very useful in this step.

Step 6: Making the Environment Safe

- Ask patients which means they would consider using during a suicidal crisis.
- Ask: **"Do you own a firearm, such as a gun or rifle??"** and **"What other means do you have access to and may use to attempt to kill yourself?"**
- Collaboratively identify ways to secure or limit access to lethal means: Ask: **"How can we go about developing a plan to limit your access to these means?"**

What Clinicians Can Do

Following is a summary of the steps, goals, and things to consider when talking with clients about reducing access to lethal means.

1. Raise the issue.

Behavioral Goal: Motivate the family to reduce access to lethal means at home.

Considerations:

- Firearms – Guns are highly lethal and irreversible (there's no time to reconsider once the trigger is pulled). Reducing access to a gun can save a life. Ask **all** clients at risk if they have access to firearms and discuss ways to reduce access.

- Medications – Medications are the most common method for suicide attempts. While medications are far less likely to result in death, some are more deadly than others.

Sample Language:

- "When someone is struggling in the ways that you are, sometimes suicidal feelings can emerge and escalate rapidly. There are a few steps we routinely recommend for the home to make things safer."

- "Guns are the most frequent method of suicide *death*, and pills are the most frequent method of suicide *attempt*, so let's start by limiting access to those."

Behavioral Goal: Assess how guns and medications are currently stored at home.

Considerations:

- Firearms – Your goal is not to make people feel interrogated or worry that their guns may be taken from them. Your goal is to let them know about voluntary steps they can choose to take. Speak to the adult who knows the most about the household's firearms which is usually the husband. Often the wife doesn't know how all of the guns are stored. If a client splits their time between homes, such as in joint custody situations, assess both homes.

Sample Language:

- "What some gun owners in your situation do is temporarily store their guns away from home with someone they trust or at a self-storage unit, gun shop, or police department. If you have guns at home, I'd like to talk over storage options like that with you."

- "Let's also talk over what types of medications are in your home and how they're stored."

2. Develop a plan.

Behavioral Goal: Safely store firearms until the client recovers.

Considerations:

- Storing firearms away from the home temporarily is the safest choice. Here are some options:
  - **Relative or friend**: Be sure they are not prohibited from possessing firearms (e.g., due to conviction for felony or domestic violence). Also, some states have laws governing temporary transfers of guns between individuals.
  - **Self-storage rental unit**: Store guns unloaded.
  - **Gun shop or shooting range**: Some offer storage services for a fee or as a free service to regular customers/members. A background check may be required to retrieve guns.
  - **Pawn shop**: For a small loan, you can leave your guns with a pawn shop in most states. Retrieving guns involves a background check in addition to repaying the loan and interest.
  - **Law enforcement**: Some police departments will hold guns on a temporary basis in an emergency. Some will even pick them up. Check their policies before bringing any guns in.
- If off-site storage is not possible, here are the second-best options for firearms:
  - **Lock the firearms in a gun safe or tamper-proof storage box** (ideally with ammunition locked in a separate location), and keep the keys/combinations away from the person at risk. Locking guns in a glass-fronted case, in a wooden case with external hinges, or with only a cable lock that can be easily cut are not as safe as locking guns in a sturdy gun safe.
  - **Disassemble the guns**, and store a key component, like the slide or the firing pin separately or away from the home.
- Quick and easy access to a loaded firearm during a suicidal crisis adds a lot of risk. If none of the off-site or on-site storage options are possible, anything that delays access can help. Here are some additional safety considerations:
  - A locked gun is safer than an unlocked gun, no matter who holds the key.
  - An unloaded gun is a lower suicide risk than a loaded gun, especially if the ammunition is stored separately or away from the home.
  - Hiding guns is not recommended. Family members, especially children and teens, often know or can find the hiding places someone else uses.
  - If a loaded gun is needed for self-defense, discuss with the client and family the short-term comparative risk of suicide versus a home invasion, as well as alternative means for self-defense.

Sample Language:

If the gun owner is the person at risk:

- "Can someone else hold the key or change the combination for now?"

If the gun owner is a family member:

- "Until [client name] is better, would storing the guns away from home work for your family?"

If the family is unwilling/unable to store guns away from home:

- "Would you be willing to lock the guns very securely and separately from the ammunition, and ensure [client name] has no access to the keys or combination?"
- "Would you be willing to ask someone who doesn't live in the home to hold the keys or to change the combination for now?"
- "Would you be willing to remove a critical component of the gun so that it can't fire?"

If the family is not willing to secure the guns at home, give the key/combination to someone else, or temporarily disable the gun:

- "What other options would you be willing to consider to increase safety?"
- "Would you be willing to store and lock the ammunition separately from the locked gun or not keep ammunition at home for now?"

If the reason a family member provides for holding on to the gun is self-defense:

- "For right now, while [*client name*] is at risk of suicide, that gun may be more likely to cause harm than safety."
- "Can you think of any other way to protect your home?" (Examples: outdoor lighting, a dog, or pepper spray)
- "If you have to have a self-defense gun, keeping it on you or in a lock box that [client's name] can't get into will be safer than [client's name] having access to it.

Behavioral Goal: Reduce availability of medications (even those still accessible so that they would not cause serious harm if taken all at once).

Considerations:

- Families should safely dispose of medications they no longer use.
- Provide advice on storing the medications they do need to keep on hand:

- Keep only small quantities of over-the-counter medications on hand.
- Lock up abuse-prone pills (e.g., opioids, benzodiazepines, muscle relaxants, sedatives, barbiturates, amphetamines).
- Ask their doctor or pharmacist, or the poison control center (1-800-222-1222) for help in determining safe quantities for their prescriptions (e.g., for some people, one week's worth may be safe).
- Do not lock up rescue medications such as inhalers and EpiPens.

Sample Language:

- "Now let's make sure there's nothing in the medicine cabinet that could do serious harm to [client name] if she or he took them all at once."

Behavioral Goal: Reduce access to any other method that a client's ideation has focused on.

Considerations:

- If the client has thoughts about using another method (particularly one that is highly lethal), discuss a plan for reducing access to that method.
- It is impossible to entirely "suicide-proof" a home.

Sample Language:

- "Let's talk about some ways you can stay safe and avoid [the method]."

3. Document and Follow Up

Behavioral Goal: Agree on roles and timetable.

Considerations:

- Specific steps with names and timetables work better than a general plan like "family will secure the guns."

Sample Language:

- "Let's review who's doing what and when: Dad will take the guns to his brother's house this weekend and in the meantime, he will put them in the gun safe. Mom will put a week's worth of [client's name] antidepressants in the pill sorter and lock up the rest. She will dispose of old medications and talk to a pharmacist tomorrow about safe amounts of the other medications."

Behavioral Goal: Document the plan and next steps.

Considerations:

- Note the discussion and plan in the medical record so that it is accessible to other providers.

Sample Language:

- "I've written down the plan here for you to take with you. We'll give you a call in a few days to see how things are going."

Behavioral Goal: Confirm that the plan was implemented.

Considerations:

- Follow-up contacts have been shown to increase the likelihood that a family will actually implement the plan as well as reduce the likelihood of readmission to an inpatient facility.

Sample Language:

- "Hi! I wanted to check in and see how [client's name] is doing and also ask how the plan is going that we talked about for gun and medication storage."

“Caring Contacts” Intervention

Taken from a webinar by the American Association of Suicidology entitled, “Post Treatment Caring Contacts for Suicide Prevention” by David D. Luxton, PhD., M.S., on January 15, 2015

Caring letters is a suicide prevention intervention that entails the sending of brief messages that espouse caring concern to patients following discharge from treatment.

- Simple, non-demanding, expressions of care that...
  - With multiple contacts, may contribute to a sense of belongingness (via a caring connection)
  - Reminders of treatment availability may provide route to seek help
  - May help patients to feel better about treatment and therefore motivate them to adhere to treatment
- Original *caring letters* study (Motto,1976; Motto & Bostrom, 2001)
- Sent caring letters to patients who did not continue in care
- Letters were sent monthly, decreasing to quarterly, for five years.
- Example Motto letter:

“Dear ____: It has been some time since you were here at the hospital, and we hope things are going well for you. If you wish to drop us a note we would be glad to hear from you.”

Sample caring email

Dear **[patient's name]**,
We appreciated the opportunity to get to know you while you were at the hospital. We hope things are going well for you.
We remember how you said that you enjoy hiking around the South Puget Sound. With the return of the summer weather, we hope you're getting a chance to get out there and explore some new trails. Anyway, we just wanted to send a quick e-mail to let you know we are thinking about you and wishing you well.
If you wish to drop us a note, we would be glad to hear from you.

Sincerely, Cassidy and Laura

Please note that the following resources are always available to you:
[List of resources]

Please know that I make every attempt to respond to my emails each business day. If for some reason you need immediate assistance, please reach out to the resources listed above. Also, you should refrain from replying with any sensitive personally identifiable material or confidential information to include medical information over the internet. If you choose to send such information via email, you do so at your own risk.

If you will be changing your contact information (email address, phone number, postal address), feel free to let us know so that we can stay in contact with you.

Other Caring Contact Studies

Outcomes: Self-directed violence or suicide ideation reduction (Luxton, June, & Comtois, 2013)

- **Postcards**(Beautraiset al., 2010; Carter et al., 2005; Carter et al., 2007)
- **Postal letters**(Motto, 1976; Motto & Bostrom, 2001)
- **SMS Texting**(Chen, Mishara & Liu,2010; Comtois, et al)
- **Email**(Luxton et al., 2012)
- **Mixed modality** (in-person, phone, etc.) (Fleischmann et al., 2008)

Ideally, contacts would be made at the following intervals

- Within 3 days of visit
- Once at two weeks
- Once at 4 weeks
- Once at 2 months and 3 months

RESOURCES

- Download this card and additional resources at **http://wwww.sprc.org**
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide **http://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 **http://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

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National Suicide Prevention Lifeline

1-800-273-TALK (8255)

http://www.sprc.org

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

HHS Publication No. (SMA) 09-4432 • CMHS-NSP-0193

Printed 2009

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

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

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

www.samhsa.gov

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, global 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

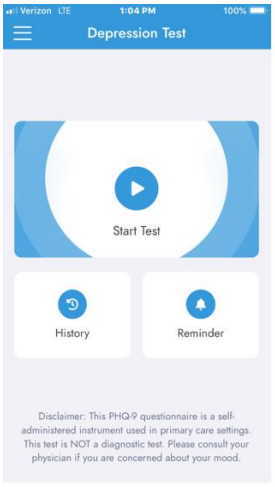
- ✓ **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- ✓ **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses 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

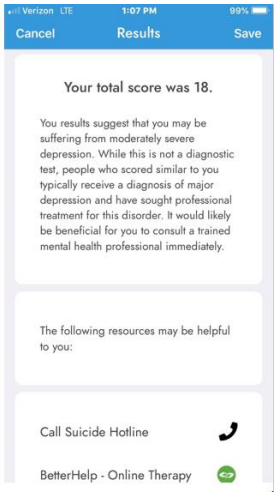
(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT

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



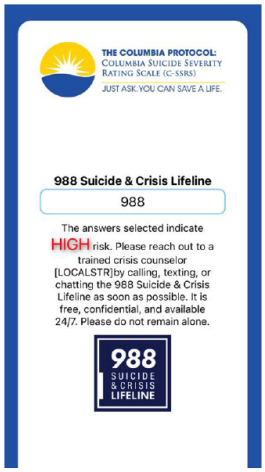
Depression Screen App

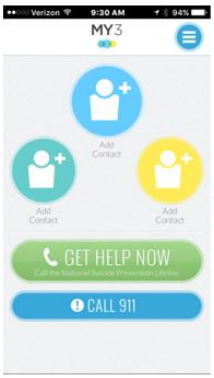


C-SSRS App search "Columbia Protocol"

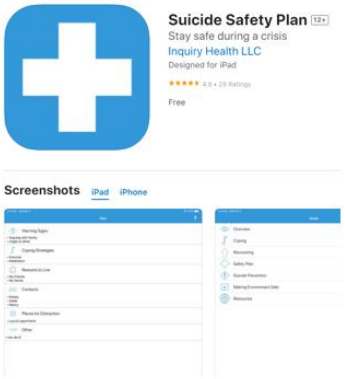
THE COLUMBIA PROTOCOL:
COLUMBIA SUICIDE SEVERITY RATING SCALE (C-SSRS)
JUST ASK. YOU CAN SAVE A LIFE.

Powered By PS Solutions

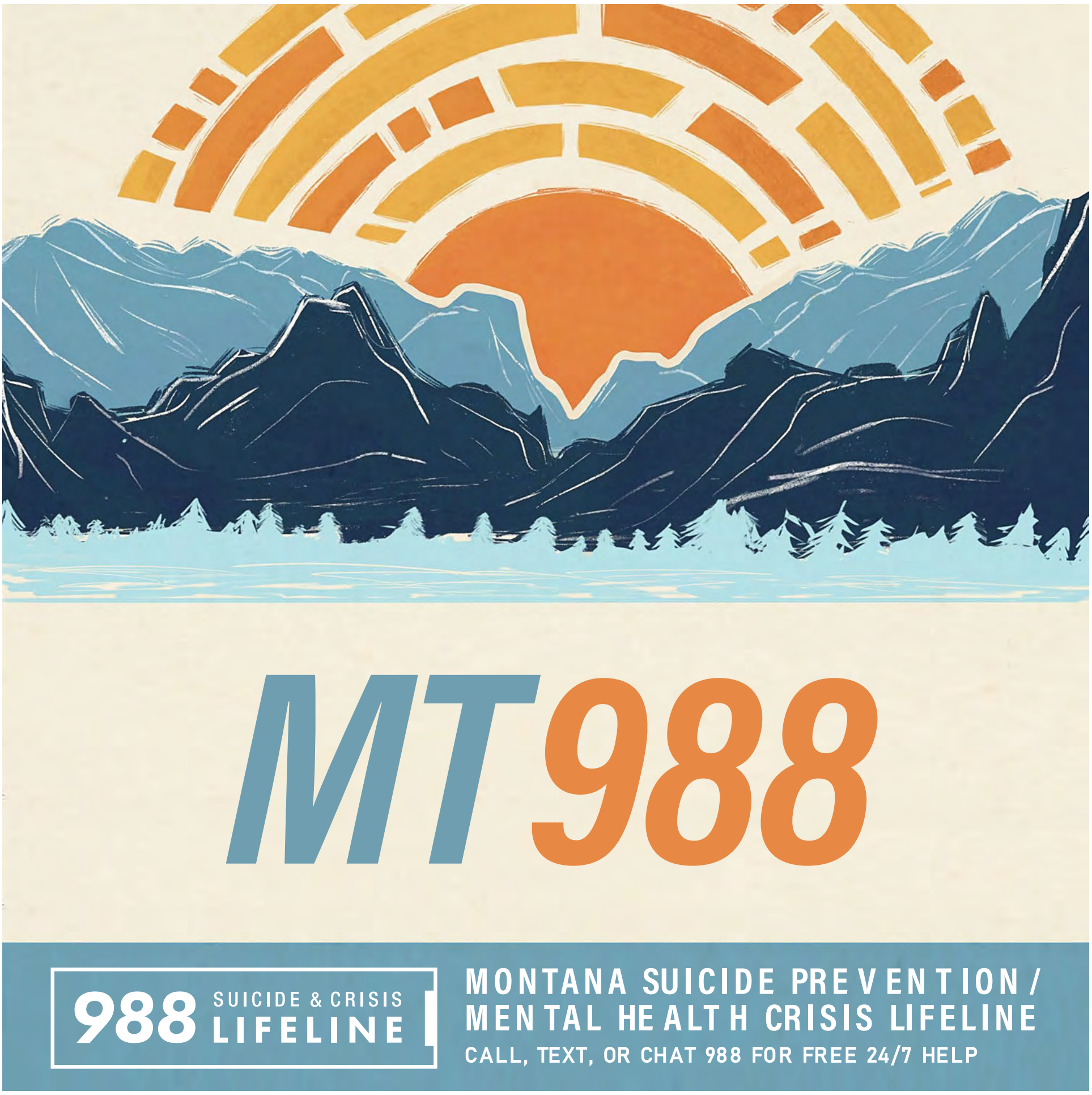




Safety Plan app



Safety Plan App



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Victoria Keto | MSU-Bozeman

Montana 988 Suicide Prevention and Mental Health Crisis Lifeline

Montana's 988 Suicide Prevention and Mental Health Crisis Lifeline provides free and confidential emotional support to people in suicidal crisis or emotional distress, 24 hours a day, 7 days a week, across Montana. The MT 988 Suicide & Crisis Lifeline is an effective, life-saving safety net for those experiencing a mental health crisis, especially those with nowhere else to turn.

Connect

All calls to the MT 988 Suicide & Crisis Lifeline are answered by trained crisis workers at three regional call centers around the state. All Montana crisis centers are accredited, provide training for counselors, and disseminate best practices. Local counselors at crisis centers are familiar with community mental health resources that are part of the Montana 211 referral network.

Resources

For more information on how the MT 988 Suicide & Crisis Lifeline can help you or someone you know who is in crisis, or to find out how to spread the word about MT 988 in your community, go to https://dphhs.mt.gov/suicideprevention/

MONTANA DPHHS

https://dphhs.mt.gov/suicideprevention/