

Practice Protocol
Assessing Suicidal Risk



**Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services**

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Purpose

To provide guidelines to improve the practice of assessing suicidal risk, thereby ensuring appropriate clinical practice and affecting positive clinical outcomes through appropriate and timely identification of symptoms and delivery of services for persons at risk for suicide and their families.

Targeted Population(s)

All at-risk populations (i.e., youth, adults, and families) statewide.

Introduction

As part of the 2005-2009 Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) Strategic Plan strategy to promote the understanding of the importance of behavioral health in overall wellness, DBHS convened a workgroup to improve suicide prevention and treatment services in collaboration with other organizations. Key objectives included the identification of best practices for assessing suicide risk and developing standardized risk assessments and treatment guidelines for persons at risk for suicide and their families.

Background

Behavioral health disorders are closely linked with suicidal behaviors. Studies show that 90 percent of individuals who die by suicide were suffering from a diagnosable and treatable behavioral health disorder at the time of their deaths. A significant number had contact with a physician in the last 12 months of their lives, and many physicians were unaware of the patients' suicidal intent. Thirty-four percent of suicidal persons were undergoing active treatment at the time of their deaths. These findings suggest that early efforts for improved risk identification and assessment might ultimately be successful in getting more at-risk individuals into treatment; therefore, it is essential that professionals are competent to assess, treat, and provide services that may help avoid or prevent suicidal behaviors.

Procedures

The following guidelines are established for use by behavioral health professionals or others involved in assessing those individuals at risk for suicide. The attached Special Suicide Risk Assessment tool will be incorporated as an addendum to the ADHS/DBHS Core Assessment and available for use at the initial intake (to supplement the Risk Assessment portion) or during follow up appointments, as indicated. In addition to the use of the ADHS/DBHS Special Suicide Risk Assessment addendum, T/RBHAs/providers may utilize other written documents and assessment tools for providing information and for additional documentation purposes. However, the T/RBHAs should periodically review all forms used to ensure the forms are consistent with nationally recognized practice guidelines such as those referred to in this document. Although not specifically required, it is highly recommended that the Special Suicide Risk Assessment tool be used as the primary clinical guidance document for assessing suicidal risk.

The Special Suicide Risk Assessment was also designed for use in crisis situations when the Core Assessment cannot be completed. It can be utilized in a variety of settings including, but not limited to: clinics, residential treatment facilities, crisis and first responder teams, etc. It can also be used for incoming crisis telephone calls, although that was not the primary intent. It is best used in face-to-face interactions. In some cases, phone staff may initiate the assessment,

but completion of the form would occur by a mobile team, urgent care center, or outpatient clinic provider.

During the evaluation of new or existing persons/behavioral health recipients, persons conducting assessments should follow the six steps outlined below in assessing suicide risk:

1. Conduct a thorough assessment,
2. Specifically inquire about suicide,
3. Determine the extent of suicidal ideation,
4. Assess lethality and determine level of risk,
5. Determine if a Crisis Plan exists, and
6. Complete a Next Steps Interim Service Plan or Crisis Plan to ensure the safety of the person/behavioral health recipient.

1. Conduct a thorough assessment

Behavioral health professionals/assessors should conduct a thorough assessment at the initial interview/intake or annual update appointment, adhering to ADHS/DBHS protocol. In the course of the interview, information on the person's history, psychosocial situation, and individual strengths and vulnerabilities should be obtained as follows:

- Previous or current medical diagnoses and treatments, including surgeries or hospitalizations, medications;
- Previous psychiatric diagnoses and treatments, including illness onset and course, psychiatric hospitalizations, medications, as well as substance use disorders;
- Current signs and symptoms of psychiatric disorders with particular attention to mood disorders (primarily major depressive disorder or mixed episodes), schizophrenia, substance use disorders, anxiety disorders (including post traumatic stress disorder (PTSD)), and personality disorders (especially borderline and antisocial personality disorder);
- Family history of mental illness, including substance abuse and suicide;
- Acute psychosocial crises and chronic psychosocial stressors, which may include actual or perceived interpersonal losses, financial difficulties, or changes in socioeconomic status, family discord, domestic violence, and past or current sexual or physical abuse or neglect;
- Employment status, living situation (including whether or not there are infants or children in the home), and presence or absence of external supports;
- Family constellation and quality of family relationships;
- Cultural or religious beliefs about behavioral health issues;
- Coping skills;
- Past responses to stress (including prior suicide attempts); and
- Ability to tolerate psychological pain and satisfy psychological needs.

All persons should be assessed for risk of harm towards self or others. Any person who shows evidence of depressed mood, anxiety, or substance abuse should be specifically assessed for suicidal risk. Because one interview may not be sufficient, screening should continue over a series of visits whenever possible, and risk should be reevaluated regularly. The goal is always to ensure the safety of the person.

2. Specifically inquire about suicide

Asking persons/behavioral health recipients about suicide will not give them the idea or incentive to commit suicide. Most who consider suicide are ambivalent about the fact and will feel relieved that the behavioral health professional is interested and willing to discuss their ideas and plans. Unfortunately, not all persons/behavioral health recipients are forthcoming about psychiatric symptoms and thoughts of suicide; therefore, it is recommended that assessors make an introductory statement followed by specific questions, and ask follow up questions to indirect statements of suicidal intent.

In assessing the current presentation of suicidality, behavioral health professionals/assessors should evaluate the following:

1. Suicidal or self-harming thoughts, plans, behaviors, and intent;
2. Specific methods considered for suicide, including their lethality and the patient's expectation about lethality, as well as whether the means are accessible;
3. Evidence of hopelessness, impulsiveness, panic attacks, or anxiety (including PTSD);
4. Reasons for living and plans for the future;
5. Alcohol or other substance use (type, recency, frequency); and
6. Thoughts, plans, or intentions of violence toward others.

It is also important to inquire about previous suicide attempts, aborted attempts, or other self-harming behaviors, as well as to determine if there is a family history of suicide or suicide attempts, as those are two of the risk factors most strongly correlated with predicting suicide risk.

3. Determine the extent of suicidal ideation

Suicidal ideation is having thoughts of suicide or of taking action to end one's own life. Suicidal ideation includes all thoughts of suicide, both when the thoughts include a plan to commit suicide and when they do not include a plan. If suicidal intent is expressed or discovered, persons conducting assessments should probe further to specifically investigate the onset and duration of suicidal ideation.

- When did thoughts of suicide begin?
- Did any event (stressor) precipitate the suicidal thoughts?
- How often do suicidal thoughts occur?
- What makes the person feel better (i.e., contact with family, use of substances)?
- What makes the person feel worse (i.e., being alone)?
- Does the person have a plan to end his/her life?
- How much control over his/her suicidal ideas does the person have?
- What stops the person from killing him/herself (i.e., family, religious beliefs)?

When determining the level of risk, the use of a Likert scale is recommended. A Likert scale uses survey questions where respondents are asked to rate the level at which they agree or disagree with a given statement in order to measure attitudes, preferences, and subjective reactions. For example:

assistance in keeping the individual safe until additional support arrives, (3) ask the family member or significant other to transport the individual to the nearest crisis center for additional evaluation, or (4) discontinue the assessment and immediately dispatch a mobile crisis response team.

For behavioral health recipients, individualized safety plans will be addressed in the Interim Service Plan (ISP) at intake. In the initial assessment, the person's current living situation, family relationships, and support system will be identified. It is the responsibility of the behavioral health professional to assess the immediate safety of the individual, and to determine what additional referrals may be necessary. It is important to respect individual and cultural preferences in the ISP and involve families as appropriate.

In other settings, other means can be used. Safety or "no-suicide" contracts are not essential. The person might not be competent to accept or understand the contract, and the person conducting the assessment should know not to relax his/her vigilance because a contract has been signed (AACAP, 2000).

Crisis and First Responder Teams

Crisis and first responder teams are expected to follow the steps outlined above whenever possible. Recognizing the nature of the crisis situation, it may not always be possible to conduct a complete assessment; however, it is crucial that teams follow guidelines for steps 2-4 outlined above (Specifically inquire about suicide; Determine extent of suicidal ideation; Assess lethality, and Determine level of risk) to evaluate suicide risk. The immediate need is to get the person to a safe place. After the immediate crisis is handled, a thorough assessment should be completed.

Phones/Front Line Staff

T/RBHAs and providers should periodically review their existing protocol and operational procedures for responding to crisis calls, as well as training staff in this area. At minimum, all staff should be knowledgeable about the following:

1. Signs and symptoms for suicide risk,
2. Indirect cues/requests for help,
3. Sensitivity to callers in crisis/cultural competence,
4. Identifying the existence of a safety plan,
5. Referral procedures specific to the agency, and
6. Local resources for assistance.

Understanding the Relevance and Limitations of Assessment Tools

These recommendations are based on the latest evidence base and practice guidelines from nationally recognized sources. However, it is important to keep in mind that the majority of assessment tools have low validity in their ability to accurately predict suicidal behavior, and often result in high rates of false positive findings. For that reason, suicide assessment scales may be used as aids to suicide assessment but should not be used as predictive instruments or as substitutes for a thorough clinical evaluation (APA, 2003). This tool is therefore intended to help behavioral health professionals conduct a thorough assessment by stimulating an enhanced line of questioning.

References:

American Academy of Child and Adolescent Psychiatry. (2000). Practice Parameter for the Assessment and Treatment of Children and Adolescents With Suicidal Behavior. Washington (DC): American Academy of Child and Adolescent Psychiatry.

American Psychiatric Association. (2003). Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors. American Journal of Psychiatry, Vol. 160, No. 11.

Berman, L. (2004). E&T Rationale. Unpublished manuscript.

Gliatto, M. & Rai, A. (1999). Evaluation and Treatment of Patients with Suicidal Ideation. Philadelphia, PA: American Academy of Family Physicians.

SPECIAL SUICIDE RISK ASSESSMENT ADDENDUM

Person's Name: _____ **ID#:** _____ **DOB:** _____
Address: _____ **Date:** _____
Phone: _____ **Contact Type:** Telephone Walk-in **Time:** _____
Location of Person (if other than above): _____
Gender: M F **Primary/Preferred Language:** _____ **Crisis Plan?** N Y **Date:** _____

1. PRESENTING PROBLEM OR REQUEST FOR ASSISTANCE:	
2. TRIAGE:	
a. Are you able to keep yourself safe until this assessment is completed? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Are you in possession of a gun or weapon or do you have easy access to a gun or weapon? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Have you felt like hurting yourself or anyone else? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes - Refer to Core Risk Assessment for Harm to Others <input type="checkbox"/> No d. Have you already hurt yourself or anyone else? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Note: If person answers "Yes" to 2d above and the level of risk is determined to be severe at this point, and a mobile crisis response team has been dispatched to continue the assessment, it is unnecessary to complete the remainder of this form.</i>	
3. IDEATIONS: (Describe any thoughts of dying or killing oneself in detail, using person's own words. Include circumstances that trigger suicidal thoughts.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None Low Med High Severe (No thoughts ↔ Obsessive thoughts)
Ideation is: Fleeting <input type="checkbox"/> Periodic <input type="checkbox"/> Constant <input type="checkbox"/> Increasing in: Severity <input type="checkbox"/> Urgency <input type="checkbox"/> Frequency <input type="checkbox"/>	
4. PLAN: (How would person carry out ideations? Use details, person's own words.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None Low Med High Severe (Unclear ↔ Detailed & specific)
5. MEANS: (Instruments/methods to be used; access to instruments. Use details, person's own words.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None Low Med High Severe (No access ↔ Continuous access)
6. LETHALITY: (Dangerousness of plan. Use details, person's own words.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None Low Med High Severe (Minimal risk ↔ Certainty of death)
7. INTENT: (Reports desire and intent to act on suicidal thoughts. Use details, person's own words.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None Low Med High Severe (No desire/denial ↔ Desire to complete plan)
8. HISTORY: (Suicide and self-harming behaviors, self and family; Attempts: number, when, method, lethality, rescues, etc. Begin with past three months.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None Low Med High Severe (No history ↔ Multiple life threatening acts or severe attempts)
What has prevented person from acting on suicidal thoughts in the past?	
9. SUBSTANCE ABUSE/USE: (History of use/abuse, access to substances, including family member substance abuse)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None Low Med High Severe (None ↔ Heavy use/dependence)
Is person currently using? If so, list substance(s), amount, and when taken.	
10. ACUTE LIFE STRESSORS: (Situation/recent changes with family, relationship, job, school, health, divorce, marriage, grief, losses, financial, residential instability, bullying, etc.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None Low Med High Severe (Few stressors ↔ Many stressors)

SPECIAL SUICIDE RISK ASSESSMENT ADDENDUM

11. DEPRESSION/AGITATION: (Affect, anxiety, restlessness, symptoms of depression)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None Low Med High Severe (Normal affect ← → Severe depression)
12. HOPELESSNESS: (Future orientation)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None Low Med High Severe (Can see future ← → Unable to see)
13. PSYCHOTIC PROCESSES: (History/symptoms of psychosis, delusions, auditory/visual hallucinations. Include dates, diagnoses, meds.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None Low Med High Severe (No history ← → Severe delusions)
14. MEDICAL FACTORS: (History/current medical conditions including chronic and severe pain, terminal illness, etc.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None Low Med High Severe (No history ← → Multiple symptoms)
15. BEHAVIORAL CUES: (Isolation, impulsivity, hostility, rage, etc.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None Low Med High Severe (Minimal ← → Extreme)
16. COPING SKILLS: (Helplessness, negation of self and others)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None Low Med High Severe (Good coping skills ← → Poor coping)
17. SUPPORT SYSTEM: (Family, friends, co-workers, roommates, spiritual affiliation, civic, school, etc. Define relationship(s) and details using person's own words.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None Low Med High Severe (Supportive contacts ← → No support)
18. OTHER FACTORS: (<u>OPTIONAL</u> . If previously mentioned, describe any recent lifestyle changes, sexual identity/orientation issues, involvement w/justice system, communication skills, other diagnoses.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None Low Med High Severe (Small significance ← → Severe impact)
19. CULTURAL CONSIDERATIONS: (<u>OPTIONAL</u> . If mentioned, describe person's attitude towards suicide—acceptance, ambivalence, rejection, etc; cultural views on death and suicide; specific concerns)	
20. OVERALL RISK LEVEL (based on clinical judgment): Low <input type="checkbox"/> Med <input type="checkbox"/> High <input type="checkbox"/>	
21. REASONING: (Identify risk factors and factors offsetting/mitigating identified risks)	
RISKS:	OFFSETS:
22. ACTION TAKEN: (Client signed Crisis Plan? Y <input type="checkbox"/> N <input type="checkbox"/> Interim Service Plan Completed? Y <input type="checkbox"/> N <input type="checkbox"/> Include details of appointments/referrals made)	

Clinician/BHP/Assessor: _____
Print Name and Credentials
Signature
Date

Clinical Liaison: _____
Print Name and Credentials
Signature
Date

Supervisor: _____
Print Name and Credentials
Signature
Date