Suicide Assessment Five-step Evaluation and Triage — SAFE-T

1	2	3	4	5
IDENTIFY RISK FACTORS Note those that can be modified to reduce risk	**IDENTIFY PROTECTIVE FACTORS** Note those that can be enhanced	**CONDUCT SUICIDE INQUIRY** Suicidal thoughts, plans, behavior and intent	**DETERMINE RISK LEVEL/INTERVENTION** Determine risk. Choose appropriate intervention to address and reduce risk	**DOCUMENT** Assessment of risk, rationale, intervention, and follow-up

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

- ✓ **Current/past psychiatric diagnoses:** especially mood disorders, psychotic disorders, alcohol/substance abuse, Cluster B personality disorders. *Co-morbidity and recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- ✓ **Family history:** of suicide, attempts or Axis 1 psychiatric diagnoses requiring hospitalization
- ✓ **Precipitants/stressors:** triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). History of abuse or neglect. Intoxication
- ✓ **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, absence of psychosis
- ✓ **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), versus 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

* ***Homicide Inquiry:*** *when indicated, esp. postpartum, and 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
- ✓ ***Reassessment*** as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTORS	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 local/national emergency info*
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction Give local/national emergency info*

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

National Suicide Prevention Lifeline
***1.800.273.TALK**

5. DOCUMENT

- ✓ **Document:** Rationale for risk level, the treatment plan to address/reduce the current risk (i.e., medication, setting, E.C.T., contact with significant others, consultation) and firearm instructions, if relevant

RESOURCES

- Resource Guide for Implementing (JCAHO) 2007 Patient Safety Goals on Suicide www.mentalhealthscreening.org/events/ndsd/JCAHO.aspx
- SAFE-T was drawn from material from the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors www.psych.org/psych_pract/treatg/pg/SuicidalBehavior_05-15-06.pdf
- Download the card and additional resources at www.stopasuicide.org

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