THANK YOU

BEHAVIORAL HEALTH CLINICAL PROGRAM TEAM:

Carolyn Tometich, PMHNP-BC – Operations Director
Mark Foote, MD – Medical Director
Mark Latkowski, BA – Compliance Consultant
Troy Whittaker, MHA, RRT – CQI Manager
Jonathan Wrathall, PhD – Outcomes Analyst
Linda Webb – Administrative Assistant

CME TEAM:

SarahAnn Whitbeck
Daniel Sowards
Julie Davis

LDS HOSPITAL
INTRODUCTION

WHY: Reduce Suffering

WHAT: Scope of the problem
Modify risk factors

HOW: Columbia Suicide Severity Rating Scale
Risk Assessment Tool
Safety Plan
Everyone Plays a Role: Utah Suicide Prevention

Doug Thomas, LCSW
Director- Division of Substance Abuse and Mental Health
Kim Myers, MSW
Suicide Prevention Coordinator

utah department of human services
Division of Substance Abuse and Mental Health
STRETCH BREAK

Napolean Exercise Stretch 1.wmv

http://mediahost.intermountain.net/communications/srleadership/fall2014/Napoleon%20Exercise%20Stretch%201.wmv
THE SUICIDE PREVENTION CARE PROCESS MODEL

Carolyn Tometich, PMHNP-BC
Operations Director, Behavioral Health Clinical Program
WHAT DOES THIS MEAN TO YOU

“I AM SUICIDAL”
THE CARE PROCESS MODEL

• Overview
• Screening
• Tools – C-SSRS (Columbia Suicide Severity Rating Scale)
• Which Tool to Use Where
• Identifying Risk Factors
• Modifying Risk Factors
• Safety Plan
• All tools are located at: BHCP Website, topics, suicide assessment
Kim and Doug reviewed:

- Prevalence of patients at risk for suicide (high)
- Perceived skill in caring for suicidal patients (low)
- State action plan regarding:
  - Using common tools (C-SSRS)
  - Wide spread education
  - Patient resources
Suicide Assessment and Prevention Development Team

• Evaluated many tools - No perfect tool
• Since there wasn’t a perfect tool – basic quality improvement processes
  • Standardize
  • Educate
  • Measure
Who is the CPM Team?

Mark Foote, MD
Richard Martini, MD
Ben Holt, MD
Wayne Cannon, MD
Liz Joy, MD
Todd Allen, MD
Scott Whittle, MD
Carolyn Tometich
Mark Latkowski
Brenda Reiss-Brennan
Roger Keddington
Hallie Rector
Jan Orton
Shelly Read
Jef Huntington
Jonathan Wrathall
Troy Whittaker
Delia Rochon
Nancy Nelson
Sid Young
Amanda Flanders
Linda Webb
What is in the CPM

- Description of the problem (Kim and Doug reviewed)
- Description of appropriate language
- Which tool to use based on location
- Description the process and tools
  - Screen standard tools (Adult and Pediatric Screeners)
  - Behavioral Health Providers use more in-depth forms (Lifetime/Recent or Since Last Visit)
- Complete a **Risk Assessment**
  - Protective factors
  - Risk factors
- Identification of appropriate level of care
- For patients going home, develop **Safety Plan**
What is **not** in the CPM but critical for patient care?

Communication Skills and Clinical Judgment
## Language

<table>
<thead>
<tr>
<th>Words to Use</th>
<th>Don’t Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attempted suicide</td>
<td>Completed suicide</td>
</tr>
<tr>
<td>Died by suicide</td>
<td>Failed attempt</td>
</tr>
<tr>
<td>Protective factors</td>
<td>Parasuicide</td>
</tr>
<tr>
<td>Risk factors</td>
<td>Successful suicide</td>
</tr>
<tr>
<td>Safety Plan</td>
<td>Suicidality</td>
</tr>
<tr>
<td></td>
<td>Nonfatal suicide</td>
</tr>
<tr>
<td></td>
<td>Suicide gesture</td>
</tr>
<tr>
<td></td>
<td>Manipulative Act</td>
</tr>
<tr>
<td></td>
<td>Suicide threat</td>
</tr>
</tbody>
</table>
Recommended actions based on patient responses to screening tool

Each location has a recommended set of actions depending on the patients response category:

**Low** – Continue with usual care and communication

**Moderate** – Likely needs additional assessment or plan

**High** – Likely to need a higher level of care, more observation and intervention
<table>
<thead>
<tr>
<th><strong>C-SSRS Quick Screen questions (in the last month)</strong></th>
<th><strong>Action if patient response “Yes”</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question</strong></td>
<td><strong>“Yes” indicates</strong></td>
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<tr>
<td>1. Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td>Wish to be dead</td>
</tr>
<tr>
<td>2. Have you actually had any thoughts of killing yourself?</td>
<td>Nonspecific thoughts</td>
</tr>
<tr>
<td>3. Have you been thinking about how you might kill yourself?</td>
<td>Thoughts with method (without specific plan or intent to act)</td>
</tr>
<tr>
<td>4. Have you had these thoughts and had some intention of acting on them?</td>
<td>Intent (without plan)</td>
</tr>
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<td>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?</td>
<td>Intent with plan</td>
</tr>
<tr>
<td>6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?</td>
<td>Behavior</td>
</tr>
</tbody>
</table>

- >1 year ago: LOW
- 1-12 months ago: MODERATE
- Past 4 weeks, during current inpatient stay, since last assessment: HIGH
TOOLS **DO NOT REPLACE**
CLINICAL JUDGEMENT
Standard Questions in the C-SSRS
(ALL ABOUT THOUGHTS AND BEHAVIOR)

WISH TO BE DEAD

THOUGHTS OF KILLING YOURSELF

THINKING ABOUT HOW

THOUGHTS WITH SOME INTENT

STARTED TO/OR WORKED OUT PLAN

DONE ANYTHING, STARTED TO DO SOMETHING, OR PREPARED TO DO ANYTHING
ED Triage

If your patient has a BH Concern

New Questions – Not new process

- Tandem
- ECIS
- iCentra
### Columbia Suicide Severity Rating Scale (C-SSRS) — Adult/Adolescent (≥ 12 years) Quick Screen

Ask each question, then ask whether the patient has had these thoughts or behaviors in the past month if he or she does not provide that information.

#### Suicidal Ideation

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<th>Questions</th>
<th>Past month</th>
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<td>Yes □ No □</td>
<td>Wish to be dead. Subject endorses thoughts about a wish to be dead or not alive anymore, or a wish to fall asleep and not wake up. Example: &quot;I've wished I wasn't alive anymore.&quot;</td>
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<td>2. Have you actually had any thoughts of killing yourself?</td>
<td>Yes □ No □</td>
<td>Non-specific, active suicidal thoughts. General non-specific thoughts of wanting to end one's life or commit suicide. Example: &quot;I've thought about killing myself.&quot;</td>
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</table>

If YES to 2. ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.

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<td>3. Have you been thinking about how you might kill yourself?</td>
<td>Yes □ No □</td>
<td>Active suicidal ideation with any methods (not plan) without intent to act. Person endorses thoughts of suicide and has thought of at least one method. Example: &quot;I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it...and I would never go through with it.&quot;</td>
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<td>4. Have you had these thoughts and had some intention of acting on them?</td>
<td>Yes □ No □</td>
<td>Active suicidal ideation with some intent to act. Active suicidal thoughts of killing oneself, and patient reports having some intent to act on such thoughts. Example: &quot;I have had the thought, and I have considered acting on them.&quot; Note: &quot;I have the thoughts but I definitely will not do anything about them.&quot;</td>
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<td>5. Have you started to work out or worked out the details of how to kill yourself?</td>
<td>Yes □ No □</td>
<td>Active suicidal ideation with specific plan. Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. Example: &quot;Next Thursday when I know my husband will be at the office late, I am going to take the sleeping pills I keep in the upstairs medicine cabinet.&quot;</td>
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#### Suicidal Behavior

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<td>Yes □ No □</td>
<td>Actual attempt. A potentially harmful act committed with at least some wish to die, as a result of an act. Behavior was in part thought of as a method to kill oneself. Intent does not have to be 100%. If there is any intent to die associated with the act, it can be considered an actual suicide attempt. There does not have to be injury or harm, just the potential for injury or harm. For example, if a person pulls the trigger with a gun in mouth but gun is broken so no injury results, this is considered an attempt. Aborted or self-interrupted attempt. When person takes steps toward making a suicide attempt, but stops himself/herself before he/she actually has engaged in any self-destructive behavior. Interuppted attempt. When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act. If not for that, an actual attempt would have occurred. Preparatory acts or behavior. Acts or preparation toward imminent making a suicide attempt.</td>
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**In the past 3 months?**

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**In the past 2 weeks?**

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<td>6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?</td>
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<td>Actual attempt. A potentially harmful act committed with at least some wish to die, as a result of an act. Behavior was in part thought of as a method to kill oneself. Intent does not have to be 100%. If there is any intent to die associated with the act, it can be considered an actual suicide attempt. There does not have to be injury or harm, just the potential for injury or harm. For example, if a person pulls the trigger with a gun in mouth but gun is broken so no injury results, this is considered an attempt. Aborted or self-interrupted attempt. When person takes steps toward making a suicide attempt, but stops himself/herself before he/she actually has engaged in any self-destructive behavior. Interuppted attempt. When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act. If not for that, an actual attempt would have occurred. Preparatory acts or behavior. Acts or preparation toward imminent making a suicide attempt.</td>
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**Clinician Signature:** ___________________________ **Date:** ___________ **Time:** ___________
Suicide Prevention – ED

SCREENING and ACTIONS

Patient presents with mental health concern or clinical suspicion of suicidal ideation present

SCREEN for suicide risk using the C-SSRS Quick Screen

Q1: Have you wished you were dead or wished you could go to sleep and not wake up?
Q2: Have you actually had any thoughts of killing yourself?
No to 1 vs. yes to 2 or yes to both

Q3: Have you been thinking about how you might kill yourself?
Q4: Have you had these thoughts and had some intention of acting on them?
Q5: Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
Q6: Have you ever done anything, started to do anything, or prepared to do anything to end your life?

LOW RISK
- Consider referral to MHI or BH provider at discharge from ED
- Consider patient education

MOROCCO: Nursing Interventions
- Crisis worker (CW) evaluation
- Psychiatric consult recommended

MODERATE RISK
- Nursing interventions
- PSA until CW evaluation
- ED physician consult
- CW evaluation
- Psychiatric consult highly recommended

HIGH RISK
- Nursing interventions
- PSA until CW evaluation
- ED physician consult
- CW evaluation
- Psychiatric consult highly recommended

If in the past 4 weeks: CW evaluation, nursing interventions, PSA, psychiatric consult highly rec.
If 1-12 months ago: CW evaluation, psychiatric consult rec.
If >1 year ago: Consider referral at discharge from ED, consider providing patient education

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Not intended to replace physician judgment with respect to individual variations and needs.
Inpatient Behavioral Health Units
AND
Inpatient Medical Units

Standardize process of suicide assessment:

• ALL inpatient behavioral health patients (on IP units)
• Patients on inpatient Medical floors who:
  • Are on physician ordered suicide precautions
  • Any patient that the nurse believes is at risk (refer to suicide risk CPG)
• Ask the questions – since the last nurse assessed you.....
Columbia Suicide Severity Rating Scale (C-SSRS) — Adult/Adolescent (≥12 years) Quick Screen

Ask each question, then ask whether the patient has had these thoughts or behaviors in the past month if he or she does not provide that information.

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<td>2. Have you actually had any thoughts of killing yourself?</td>
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<td>3. Have you been thinking about how you might kill yourself?</td>
<td>Yes/No</td>
<td>Active suicidal ideation with any method (not plan) without intent to act. Person endorses thoughts of suicide and has thought of at least one method. Example: “I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it … and I would never go through with it.”</td>
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<td>4. Have you had these thoughts and have some intention of acting on them?</td>
<td>Yes/No</td>
<td>Active suicidal ideation with some intent to act. Active suicidal thoughts of killing oneself, and patient reports having some intent on such thoughts. Example: “I have the thoughts, and I have considered acting on them.” Note: “I have the thoughts, but I definitely will not do anything about them.”</td>
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<td>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?</td>
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<td>Active suicidal ideation with specific plan. Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. Example: “Next Thursday when I know my husband will be at the office late, I am going to take the sleeping pills I keep in the upstairs medicine cabinet.”</td>
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Suicidal Behavior

| 6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? | Yes/No | Actual attempt. A potentially lethal or injurious act committed with at least some wish to die, as a result of an act. Behavior was in part thought of as a method to kill oneself. Intent does not have to be 100%. If there is any intention to die associated with the act, then it can be considered an actual suicide attempt. Person does not have to be in immediate danger or harm, just the potential for injury or harm. Example: If a person pulls the trigger with gun in mouth but gun is broken so no injury results, this is considered an attempt. |
| In the past 3 months?                                                                 | Yes/No |                                                                                                                                 |
| In the past 2 weeks?                                                                 | Yes/No | Aborted or self-interrupted attempt. When person takes steps toward making a suicide attempt, but stops him/herself before he/she actually has engaged in any self-destructive behavior. Example: When the person is interrupted by an outside circumstance from starting the potentially lethal act (if not for that, an actual attempt would have occurred). |
|                                                                                     | Yes/No | Interrupted attempt. When the person is interrupted by an outside circumstance from starting the potentially lethal act (if not for that, an actual attempt would have occurred). |
|                                                                                     | Yes/No | Preparatory acts or behavior. Acts or preparation toward intentionally making a suicide attempt. |

Clinician Signature: ___________________________ Date: ___________ Time: ___________
Suicide Prevention – INPATIENT

SCREENING and ACTIONS

Patient presents with mental health concern or clinical suspicion of suicidal ideation present

SCREEN for suicide risk using the C-SSRS quick screen

Q1: Have you wished you were dead or wished you could go to sleep and not wake up?
Q2: Have you actually had any thoughts of killing yourself?

no to 1, yes to 2 OR yes to both

Q3: Have you been thinking about how you might kill yourself?
Q4: Have you had these thoughts and had some intention of acting on them?
Q5: Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
Q6: Have you ever done anything, started to do anything, or prepared to do anything to end your life?

 ACTIONS based on positive responses (respond based on highest level of risk)

LOW risk
- Continue with plan of care
  Note: Patient response to question 6 may increase risk and result in additional steps.

MODERATE risk
- Continue with plan of care
- Initiate nursing interventions

HIGH risk
- Notify charge nurse/shift coordinator & attending physician
- Assess need for 1:1
- Initiate nursing interventions
- Administer C-SSRS Lifetime/Recent Assessment

If in the past 4 weeks:
- Notify charge nurse/shift coordinator & attending physician
- Assess need for 1:1
- Initiate nursing interventions

If 1–12 months ago:
- Assess risk factors & consider referral to MH or BH provider; nursing interventions

If ≥1 year ago:
- Consider referral to MH or BH provider & patient education

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Not intended to replace physician judgment with respect to individual variations and needs.
PROVIDER IN A PRIMARY CARE OFFICE OR SPECIALTY CLINIC
Columbia Suicide Severity Rating Scale (C-SSRS) — Adult/Adolescent (≥12 years) Quick Screen

Ask each question, then ask whether the patient has had these thoughts or behaviors in the past month if he or she doesn’t provide that information.

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### Suicidal Behavior

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**Clinician Signature: ________________________ Date: ____________ Time: ____________**
SCREENING and ACTIONS

(+ on PHQ-9 (q. 9) or clinical suspicion of suicidal ideation or behaviors)

SCREEN for suicide risk using the C-SSRS Quick Screen

Q1: Have you wished you were dead or wished you could go to sleep and not wake up?

Q2: Have you actually had any thoughts of killing yourself?

No to 1, yes to 2 OR yes to both

Q3: Have you been thinking about how you might kill yourself?

Q4: Have you had these thoughts and had some intention of acting on them?

Q5: Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

Q6: Have you ever done anything, started to do anything, or prepared to do anything to end your life?

 ACTIONS based on positive responses (respond based on highest level of risk)

- Consider referral to MHI or BH provider
- Consider patient education

Note: Patient response to question 6 may increase risk and result in additional steps.

- Assess risk factors and facilitate evaluation for inpatient admission or complete Safety Plan with follow-up within 24-48 hours
- Educate patient

- Facilitate immediate evaluation
- Educate patient

- If in the past 4 weeks: Facilitate immediate evaluation for inpatient care and educate patient
  - If 1-12 months ago: Assess risk factors and refer to MHI or BH provider and educate patient
  - If ≥1 year ago: Consider referral to MHI or BH provider and consider patient education

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BH PROVIDERS

Complete a more comprehensive assessment:
• Lifetime/Recent or Since Last Visit Form
• Risk Assessment
• Safety Plan
Ask the first 5 questions on the screen but:

- **Expand on assessment of suicidal thoughts by asking about:**
  - Frequency
  - Duration
  - Controllability
  - Deterrents
  - Reasons
- **Expand on assessment of behaviors**
Risk Assessment
Identification of Risk Factors

Modifiable Risk Factors
- Anxiety
- Insomnia
- Intoxication

Non Modifiable Factors
- Gender
- Age
- Adverse events (i.e. family suicide, childhood abuse)
## Suicide Prevention — Risk Assessment Tool

**Instructions:** Complete this tool after interviewing the patient (including administration of the C-SRS Lifetime/Recent Assessment), reviewing medical records, and/or consulting with family members and/or other professionals. Check all risk and protective factors that apply. After you complete the tool, review the number and type of positive responses to guide your treatment plan.

**Purpose:** This tool enables you to estimate the patient's suicide risk through a comprehensible assessment of risk and protective factors.

**Additional resources:** Refer to the Suicide Prevention CPM for a discussion of risk factors, definitions of terms, and strategies for talking about suicide with patients.

### Suicidal and self-injurious behavior

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Past 3 months</th>
<th>Lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual suicide attempt</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Intentional self-harm</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Other than suicidal</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Self-injurious behavior without suicidal intent</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

### Suicidal ideation

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Past 1 month</th>
<th>Lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wish to be dead</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Suicidal thoughts with method but without specific plan or intent</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Suicidal ideation without specific plan</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

### Activating events

<table>
<thead>
<tr>
<th>Event</th>
<th>Recent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment</td>
<td>□</td>
</tr>
<tr>
<td>Loss of significant event</td>
<td>□</td>
</tr>
<tr>
<td>Abuse</td>
<td>□</td>
</tr>
<tr>
<td>Pending consequence</td>
<td>□</td>
</tr>
<tr>
<td>Change in living situation</td>
<td>□</td>
</tr>
</tbody>
</table>

### Treatment history

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Any history</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy</td>
<td>□</td>
</tr>
<tr>
<td>Psychiatric medications and treatments</td>
<td>□</td>
</tr>
<tr>
<td>Mental illness</td>
<td>□</td>
</tr>
<tr>
<td>History of treatment</td>
<td>□</td>
</tr>
<tr>
<td>Not responding to treatment</td>
<td>□</td>
</tr>
<tr>
<td>Recent poor admission</td>
<td>□</td>
</tr>
</tbody>
</table>

### Other risk factors

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Any</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol or drug abuse</td>
<td>□</td>
</tr>
<tr>
<td>Family history</td>
<td>□</td>
</tr>
<tr>
<td>Personalized risk factors</td>
<td>□</td>
</tr>
</tbody>
</table>

### Clinical status

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Current/total</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>□</td>
</tr>
<tr>
<td>Medications</td>
<td>□</td>
</tr>
<tr>
<td>Medical condition</td>
<td>□</td>
</tr>
<tr>
<td>History of depression</td>
<td>□</td>
</tr>
<tr>
<td>History of suicide</td>
<td>□</td>
</tr>
<tr>
<td>History of anxiety</td>
<td>□</td>
</tr>
<tr>
<td>Reliability to family</td>
<td>□</td>
</tr>
<tr>
<td>Supportive social network</td>
<td>□</td>
</tr>
<tr>
<td>Fear of death or dying due to pain and suffering</td>
<td>□</td>
</tr>
<tr>
<td>Fear of being left in hospital or hospital</td>
<td>□</td>
</tr>
<tr>
<td>History of suicide or attempted suicide</td>
<td>□</td>
</tr>
<tr>
<td>History of substance use disorder</td>
<td>□</td>
</tr>
</tbody>
</table>

### Protective factors

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Current/total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support</td>
<td>□</td>
</tr>
<tr>
<td>Family</td>
<td>□</td>
</tr>
<tr>
<td>Friends</td>
<td>□</td>
</tr>
<tr>
<td>Other</td>
<td>□</td>
</tr>
</tbody>
</table>

### Other protective factors

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Current/total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
</tr>
</tbody>
</table>

### Behaviors

Describe any suicidal, self-injurious, or aggressive behavior.

---

Clinician Signature: ____________________________  Date: ____________  Time: ____________  

---

**Intermountain Healthcare**

Suicide Prevention Risk Assessment Tool SP004

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Modify Risk Factors

Identify a risk factor and modify in some way:

- Insomnia – Treat
- Anxiety – Treat
- Intoxication – Wait
- Guns in the home – Remove
Safety Plan or Safety Contract

**Safety Plan**
- Helps patient clearly identify steps/actions to be taken if suicidal thoughts return
  - Who to call
  - What actions to take
  - Action to make home safer, such as removing guns, stockpiled medications

**Safety Contract**
- Doesn’t legally protect clinician
- Doesn't assist the patient in managing suicidal ideation/plans
## Suicide Prevention Safety Plan

As you fill in this form, focus on your own needs and what would be helpful to you in times of crisis. Your healthcare provider may also review with you to discuss ideas.

<table>
<thead>
<tr>
<th>The one thing that is most important to me and worth living for is:</th>
</tr>
</thead>
</table>

### Warning signs
Signs that a crisis might be developing. What are some thoughts, daydreams, wishes, and so on that signal danger for me?
- 
- 

### Internal coping strategies
What takes my mind off my problems? Relaxation techniques, physical activity, hobbies, something else?
- 
- 

### People and social settings that can distract me
Who can I call on to distract me? Where can I go?
- **Name:** 
  - **Phone:**
- **Name:** 
  - **Phone:**
- **Name:** 
  - **Phone:**

### People who can help
Who can I call when I need help? Friends, family, someone else?
- **Name:**
  - **Phone:**
- **Name:**
  - **Phone:**
- **Name:**
  - **Phone:**

### Professionals or agencies I can contact during a crisis
Who can I call for help? My doctor, a mental health provider, a suicide hotline?
- **Clinician name:**
  - **Phone:**
  - **Pager or emergency #:**
- **Clinician name:**
  - **Phone:**
  - **Pager or emergency #:**
- **Clinician name:**
  - **Phone:**
  - **Pager or emergency #:**
- **Local urgent care services:**
  - **Phone:**
  - **Address:**
  - **Suicide prevention hotline phones:** 1-800-273-TALK (8255)

### Making the environment safe
How can I make my environment safer? For example, can I remove guns, medications, and other items?
- 

Questions?
BREAK—10 MINUTES