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Tony L. Sheppard, Psy.D., CGP

NSSI Case Example One

Marcus is a 9 year old male. He is diagnosed with ADHD and Disruptive Mood Dysregulation Disorder. He bangs his head on the bleachers at school when he doesn't play well on the basketball team.

He has recently started burning himself with erasers in his room at night. He is clear that he doesn't want to die.

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Marcus

Alexian Brothers Urge to Self-Injure Scale (ABUSI)

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The questions below apply to **the last week**. Place an "X" in the box next to the most appropriate statement

1. **How often have you thought about injuring yourself or about how you want to injure yourself?**
   - ☐ **Never**, 0 times in the last week
   - ☐ **Rarely**, 1 -2 times in the last week
   - ☐ **Occasionally**, 3 – 4 times in the last week
   - ☑ **Sometimes**, 5 – 10 times in the last week, or 1 -2 times a day
   - ☐ **Often**, 11 – 20 times in the last week, or 2 – 3 times a day
   - ☐ **Most of the time**, 20 – 40 times in the last week, or 3 – 6 times a day
   - ☐ **Nearly all of the time**, more that 40 times in the last week, or more than 6 times a day
2. **At the most severe point, how strong was your urge to self-injure in the last week?**
   - ☐ **None** at all.
   - ☐ **Slight**, that is, a very mild urge.
   - ☐ **Mild** Urge.
   - ☐ **Moderate** Urge.
   - ☐ **Strong** Urge, but **easily** controlled.
   - ☑ **Strong** Urge, but **difficult** to control.
   - ☐ **Strong** Urge **and would have self-injured if able to**.
3. **How much time have you spent thinking about injuring yourself or about how you want to injure yourself?**

☐	☐	☐	☑	☐	☐	☐
None.	Less than 20 min.	21-45 min.	46-90 min.	90 min to 3 hrs.	3-6 hrs.	More than 6 hrs.

4. **How difficult was it to resist injuring yourself in the last week?**

☐	☐	☐	☑	☐	☐	☐
Not difficult at all	Very mildly difficult	Mildly difficult	Moderately difficult	Very difficult	Extremely difficult	Was not able to resist

5. **Keeping in mind your responses to the previous questions, please rate your *overall average* urge or desire to injure yourself in the last week.**
   - ☐ **Never** thought about it and **never** had the urge to self-injure.
   - ☐ **Rarely** thought about it and **rarely** had the urge to self-injure.
   - ☐ **Occasionally** thought about it and **occasionally** had the urge to self-injure.
   - ☑ **Sometimes** thought about it and **sometimes** had the urge to self-injure.
   - ☐ **Often** thought about it and **often** had the urge to self-injure.
   - ☐ Thought about self-injury **most** of the time and had the urge to do it **most** of the time.
   - ☐ Thought about self-injury **nearly all** the time and had the urge to do it **nearly all** the time.

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Tony L. Sheppard, Psy.D., CGP

Suicide Case Example One

DiAngelo is 11 years old and placed in his 3rd foster home. His father died from a drug overdose and his mother abandoned him at the age of 4. He was diagnosed with diabetes 3 months ago. Father was physically abusive and there was domestic violence in the home. He is currently suicidal; stating that he plans to run in front of a car while playing

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D. Angelo

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

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SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month YES	Past month NO
Ask questions that are bolded and underlined.		
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***	✓	
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***	✓	
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*" ***Have you been thinking about how you might do this?***	✓	
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***	✓	
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***	✓	
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Were any of these in the past 3 months?***	**Lifetime** ✓ **Past 3 Months** ✓	

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

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Suicide Case Example Two

Monica is a 14 year old female. She is diagnosed with Major Depressive Disorder and is treated with medication. She has frequent thoughts of wanting to die. She had thoughts of drowning herself over the summer. She has no plan to do anything, stating that she loves her parents too much.

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Monica

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

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SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month YES	NO
Ask questions that are bolded and underlined.		
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***	✓	
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***	✓	
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*" ***Have you been thinking about how you might do this?***		✓
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		✓
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		✓
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Were any of these in the past 3 months?***	**Lifetime** ✓	**Past 3 Months** ✓

- Low Risk
- Moderate Risk
- High Risk

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OSI

OTTAWA SELF-INJURY INVENTORY

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Name: _____ **Sex**: ☐ Male ☐ Female

Today's Date: ____ DD ____ MM ____ YY **Date of Birth**:____ DD ____ MM ____YY **Age**: ____

1.

How often in the past month have you: *circle "0" if not at all and circle "3" if daily*	**not at all**	**at least once**	**weekly**	**daily**
Thought about injuring yourself without the intention to kill yourself?	0	1	2	3
Actually injured yourself, without the intention to kill yourself?	0	1	2	3

2.

How often in the past 6 months have you: *circle "0" if not at all and circle "4" if daily*	**not at all**	**1 to 5 times**	**monthly**	**weekly**	**daily**
Thought about injuring yourself without the intention to kill yourself?	0	1	2	3	4
Actually injured yourself, without the intention to kill yourself?	0	1	2	3	4

3.

How often in the past year have you: *circle "0" if not at all and circle "4" if daily*	**not at all**	**1 to 5 times**	**monthly**	**weekly**	**daily**
Thought about taking your life (killing yourself)?	0	1	2	3	4

4. **Have you ever made an actual attempt to take your life?** ☐ no ☐ yes

If yes, then please indicate the number of times:

in the past month: ____ in the past 6 months: ____ in the past year: ____ prior to one year ago: ____

5. **Have you ever been treated by a doctor after injuring yourself on purpose? (e.g., stitches, wound dressings, etc.)**

☐ no ☐ yes

If yes, how often did a doctor treat you in the *past year* for hurting yourself on purpose?_____ time(s)

6. **Have you been kept in hospital because of hurting yourself on purpose?**

☐ no ☐ yes

If yes, how many times in the *past year* did you stay overnight in emergency? _____

If yes, how many times in the *past year* did you get admitted to a hospital unit?_____

Mary Kay Nixon, M.D. & Paula Cloutier, M.A.
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7. **If you indicated that you had thought about or actually injured yourself in questions 1-4:**
How old were you when you started to self-injure? _____ (years old)

8. **The first time you hurt yourself, where did you get the idea?** (please ☑ only one)

- ☐ I read about it on an internet website
- ☐ I read about it on a Web Blog
- ☐ I read about it in a book or magazine
- ☐ I saw it happen in a movie or on television
- ☐ I saw other people do it in a non-hospital setting
- ☐ I heard about it from other people in a non-hospital setting
- ☐ I heard about it from other people in a hospital setting
- ☐ I saw other people do it in a hospital setting
- ☐ It was my own idea
- ☐ Other (please list)_____

9.

When you get the urge to hurt yourself: *circle "0" if not at all and circle "4" if extremely*	**Not at all**		**somewhat**		**extremely**
The urge is distressing / upsetting	0	1	2	3	4
The urge is comforting	0	1	2	3	4
The urge is intrusive / invasive	0	1	2	3	4

10. **Do you <u>only</u> harm yourself after taking drugs or alcohol?** ☐ no ☐ yes

11. **Do you let other people know that you harm yourself?**

- ☐ no one
- ☐ some people
- ☐ most people

who do you tell? →

- ☐ friend(s)
- ☐ psychologist/psychiatrist
- ☐ other Mental Health Professional
- ☐ telephone helpline
- ☐ family member(s)
- ☐ family doctor
- ☐ school counsellor
- ☐ other (specify)

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Nixon & Cloutier, 2005

12. a) **What areas of your body did/do you injure?**

Please (√) all that apply

	WHEN YOU FIRST STARTED	CURRENTLY (past month if still self-injuring)
Scalp		
Eye(s)		
Ear(s)		
Face		
Nose		
Lips		
Inside of mouth		
Neck/throat		
Chest		
Breast(s)		
Back		
Shoulder(s)		
Abdomen		
Hips/buttock(s)		
Genitals		
Rectum		
Upper arm/elbow		
Lower arm/wrist		
Hand/fingers		
Thigh/knee		
Lower leg/ankle		
Foot/toes		
Other (specify):		

b) *Above, please circle the part that you currently injure the most*

13. a) **How did/do you injure yourself (without meaning to kill yourself)?**

Please (√) all that apply

	WHEN YOU FIRST STARTED	CURRENTLY (past month if still self-injuring)
Cutting		
Scratching		
Interfering with wound healing		
Burning		
Biting		
Hitting		
Hair pulling		
Severe nail biting and/or nail injuries		
Piercing skin with sharp pointy objects		
Piercing of body parts		
Excessive use of street drugs		
Excessive use of alcohol		
Trying to break bones		
Headbanging		
Taking too much medication		
Taking too little medication		
Eating or drinking things that are not food		
Other (specify):		

b) *Above, please circle the method that you currently use the most*

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14.

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Why do you think you started and if you continue, why do you still self-injure (without meaning to kill yourself)? *Please circle the number that best represents how much your self-injury is due to that reason. Circle "0" if it has never been a reason that you self-injure and "4" if it has always been a reason that you self-injure.*	**Why did you start?** Never a reason			Sometimes a reason	Always a reason	**If you continue, why do you continue?** Never a reason			Sometimes a reason	Always a reason
1. to release unbearable tension	0	1	2	3	4	0	1	2	3	4
2. to experience a "high" that feels like a drug high	0	1	2	3	4	0	1	2	3	4
3. to stop my parents from being angry with me	0	1	2	3	4	0	1	2	3	4
4. to stop feeling alone and empty	0	1	2	3	4	0	1	2	3	4
5. to get care or attention from other people	0	1	2	3	4	0	1	2	3	4
6. to punish myself	0	1	2	3	4	0	1	2	3	4
7. to provide a sense of excitement that feels exhilarating	0	1	2	3	4	0	1	2	3	4
8. to avoid getting into trouble for something I did	0	1	2	3	4	0	1	2	3	4
9. to distract me from unpleasant memories	0	1	2	3	4	0	1	2	3	4
10. to change my body image and/or appearance	0	1	2	3	4	0	1	2	3	4
11. to belong to a group	0	1	2	3	4	0	1	2	3	4
12. to release anger	0	1	2	3	4	0	1	2	3	4
13. to show others how hurt or damaged I am	0	1	2	3	4	0	1	2	3	4
14. to experience physical pain in one area, when the other pain I feel is unbearable	0	1	2	3	4	0	1	2	3	4
15. to stop people from expecting so much from me	0	1	2	3	4	0	1	2	3	4
16. to relieve feelings of sadness or feeling "down"	0	1	2	3	4	0	1	2	3	4
17. to stop me from thinking about ideas of killing myself	0	1	2	3	4	0	1	2	3	4
18. to stop me from acting out ideas of killing myself	0	1	2	3	4	0	1	2	3	4
19. to produce a sense of being real when I feel numb and "unreal"	0	1	2	3	4	0	1	2	3	4
20. to release frustration	0	1	2	3	4	0	1	2	3	4
21. to get out of doing something that I don't want to do	0	1	2	3	4	0	1	2	3	4
22. to prove to myself how much I can take	0	1	2	3	4	0	1	2	3	4
23. for sexual excitement	0	1	2	3	4	0	1	2	3	4
24. to diminish feeling of sexual arousal	0	1	2	3	4	0	1	2	3	4
25. other (please specify):	0	1	2	3	4	0	1	2	3	4

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15.

If you indicated that you had thought about or actually injured yourself in questions 1-4, do you feel relief (better) after harming yourself?	Never		Sometimes		Always
circle "0" if never and circle "4" if always	0	1	2	3	4

If you feel relief, how long does the relief last? *(please (√) only one)*

- ☐ less than 1minute
- ☐ 1 to 5 minutes
- ☐ 6 to 30 minutes
- ☐ 31 to 60 minutes
- ☐ hours
- ☐ days

16. Once you think about harming yourself, do you always do it? ☐ yes ☐ no

17. When you hurt yourself on purpose, on average, how much time goes by between thinking about it and doing it? (Please (√) 1 item only)

- ☐ less than 1 minute
- ☐ 1 minute to 5 minutes
- ☐ 6 minutes to 30 minutes
- ☐ over 30 minutes but less than 1 hour
- ☐ hours
- ☐ days

18.

Do you feel physical pain when you harm yourself?	Never		Sometimes		Always
circle "0" if never and circle "4" if always	0	1	2	3	4

19.

Do you hurt or think about hurting yourself after stressful things happen?	Never		Sometimes		Always
circle "0" if never and circle "4" if always	0	1	2	3	4

↓

If you indicated that you thought about or actually injured yourself in questions 1-4, what kinds of stressful situation(s) typically led to self-injury?

- ☐ abandonment (please specify)_____
- ☐ failure (please specify)_____
- ☐ loss (please specify)_____
- ☐ rejection (please specify)_____
- ☐ other (please specify)_____

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Nixon & Cloutier, 2005

20.

Since you started to self-injure, have you found that: *circle "0" if never and circle "4" if always*	**Never**		**Sometimes**		**Always**
1.The self-injurious behaviour occurs more often than intended?	0	1	2	3	4
2. The severity in which the self-injurious behaviour occurs has increased (e.g., deeper cuts, more extensive parts of your body)?	0	1	2	3	4
3. If the self-injurious behaviour produced an effect when started, you now need to self-injure more frequently or with greater intensity to produce the same effect?	0	1	2	3	4
4. This behaviour or thinking about it consumes a significant amount of your time (e.g., planning and thinking about it, collecting and hiding sharp objects, doing it and recovering from it)?	0	1	2	3	4
5. Despite a desire to cut down or control this behaviour, you are unable to do so?	0	1	2	3	4
6. You continue this behaviour despite recognizing that it is harmful to you physically and/or emotionally?	0	1	2	3	4
7. Important social, family, academic or recreational activities are given up or reduced because of this behaviour?	0	1	2	3	4

21.

If you are trying to resist hurting yourself, what do you do instead? *Please (√) all that apply*	
Never try to resist	
Talk with someone	
Exercise / sports	
Reading writing, music, dance	
Watch television, play video or computer games	
Do things to relax (e.g., hot bath, yoga, deep breathing)	
Use alcohol and or street drugs	
Do anything to keep hands busy	
Other (specify):	

b) For question 21, *please circle the most helpful thing you do to resist hurting yourself.*

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22.

How motivated are you at this time to stop self-injuring?	Not at all Motivated		Somewhat Motivated		Extremely Motivated
	0	1	2	3	4

23. **What treatment(s) if any, have you received with the goal of reducing and/or eliminating your self-harm?**

(Please (√) all items that apply)

- ☐ I have not had treatment
- ☐ individual therapy
- ☐ family therapy
- ☐ I declined treatment
- ☐ school counselling
- ☐ medication (please specify) _____
- ☐ Self help (e.g., self-help books, internet)
- ☐ group therapy

other (please specify)_____

24. **What treatment(s) if any, have you found the most helpful in reducing and/or eliminating your self-harm?**

(Please (√) all items that apply)

- ☐ I have not had treatment
- ☐ individual therapy
- ☐ family therapy
- ☐ I declined treatment
- ☐ school counselling
- ☐ medication (please specify) _____
- ☐ Self help (e.g., self-help books, internet)
- ☐ group therapy

other (please specify) _____

25.

I feel that this questionnaire has fully described my experience of Self-Injury	Strongly Disagree		Somewhat Agree		Strongly Agree
	0	1	2	3	4

26. **Is there anything else you would like to share with us regarding your self-injury behaviour?**

_____

_____

_____

_____

_____

_____

_____

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Nixon & Cloutier, 2005

Alexian Brothers Urge to Self-Injure Scale (ABUSI)

The questions below apply to **the last week**. Place an "X" in the box next to the most appropriate statement

1. **How often have you thought about injuring yourself or about how you want to injure yourself?**
   - ☐ **Never**, 0 times in the last week
   - ☐ **Rarely**, 1 -2 times in the last week
   - ☐ **Occasionally**, 3 – 4 times in the last week
   - ☐ **Sometimes**, 5 – 10 times in the last week, or 1 -2 times a day
   - ☐ **Often**, 11 – 20 times in the last week, or 2 – 3 times a day
   - ☐ **Most of the time**, 20 – 40 times in the last week, or 3 – 6 times a day
   - ☐ **Nearly all of the time**, more that 40 times in the last week, or more than 6 times a day
2. **At the most severe point, how strong was your urge to self-injure in the last week?**
   - ☐ **None** at all.
   - ☐ **Slight**, that is, a very mild urge.
   - ☐ **Mild** Urge.
   - ☐ **Moderate** Urge.
   - ☐ **Strong** Urge, but **easily** controlled.
   - ☐ **Strong** Urge, but **difficult** to control.
   - ☐ **Strong** Urge **and would have self-injured if able to**.
3. **How much time have you spent thinking about injuring yourself or about how you want to injure yourself?**

☐	☐	☐	☐	☐	☐	☐
None.	Less than 20 min.	21-45 min.	46-90 min.	90 min to 3 hrs.	3-6 hrs.	More than 6 hrs.

4. **How difficult was it to <u>resist</u> injuring yourself in the last week?**

☐	☐	☐	☐	☐	☐	☐
Not difficult at all	Very mildly difficult	Mildly difficult	Moderately difficult	Very difficult	Extremely difficult	Was not able to resist

5. **Keeping in mind your responses to the previous questions, please rate your *overall average* urge or desire to injure yourself in the last week.**
   - ☐ **Never** thought about it and **never** had the urge to self-injure.
   - ☐ **Rarely** thought about it and **rarely** had the urge to self-injure.
   - ☐ **Occasionally** thought about it and **occasionally** had the urge to self-injure.
   - ☐ **Sometimes** thought about it and **sometimes** had the urge to self-injure.
   - ☐ **Often** thought about it and **often** had the urge to self-injure.
   - ☐ Thought about self-injury **most** of the time and had the urge to do it **most** of the time.
   - ☐ Thought about self-injury **nearly all** the time and had the urge to do it **nearly all** the time.

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Alexian Brothers Level of Care Criteria for Patients with Non-Suicidal Self-Injury

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	Contributing Factors	Level 1 Outpatient	Level 2 Intensive Outpatient	Level 3 Partial Hospitalization	Level 4 Residential Treatment Center	Level 5 Inpatient Hospitalization
Suicidality	Ideation	Wish to be dead or suicidal thoughts				
	Plan	Without plan; OR…		Without plan; OR With plan AND…		With plan; OR…
	Intent to Act	Able and willing to keep self alive			Willing, but not able to keep self alive	Not willing or not able to keep self alive
	Behavior	No attempt or history of attempt (> 1 month)		Aborted or self-interrupted attempt (past week); OR actual or interrupted attempt (past month)		Actual or interrupted attempt (past week)
	Lethality	None or minor			Moderate or higher	
NSSI	Frequency & Severity	Episodic, superficial injuries	Multiple times per week of superficial injuries AND/OR Intermittent injuries requiring some medical attention		Multiple times per week of superficial injuries OR Intermittent injuries requiring substantial medical attention	Multiple times per day of superficial injuries; OR Intermittent injuries requiring substantial medical attention; OR Any ingestion or insertion of objects that may result in internal injury
	Urge to Self-Injure	No urges, OR Able and willing to resist acting on urges	Urges, but able and willing to resist acting on urges	Moderate urges and not always able or willing to resist acting on urges	Strong urges and not able or willing to resist acting on urges	Strong urges and not able or willing to resist acting on urges; OR Any urge to ingest or insert objects that may result in internal injury
Motivation		Fair to good	Fair	Partial motivation	Poor to fair	Very poor to poor
Treatment Adherence		Adheres to Treatment Plan			Only adherent in a highly structured environment	Not adherent; OR only adherent in a highly structured envrionment
Functional Impairment		Self sufficient in community	Needs intermittent monitoring and structure to function	Needs daily monitoring and structure to function	Needs 24 hour supervision for functioning	
Environmental Support		Family or significant others able to provide minimally adequate emotional support and structure			Family or significant others unable to provide minimally adequate emotional support and structure	
Treatment availability		Within driving distance or able to stay at hotel near treatment center			Too far to drive or not safe to stay in hotel near treatment center	

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Alexian Brothers Level of Care Criteria for Patients with Non-Suicidal Self-Injury

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Definitions

Level 1: Does not require monitoring, significant structure, or intervention to interrupt NSSI or to maintain safety outside of program.

Level 2: Requires minimal monitoring, structure, and intrevention to interrupt NSSI. Is generally able to maintain safety outside of program.

Level 3: Requires monitoring (generally daily), increased structure, and intervention to interrupt NSSI and to maintain safety outside of program.

Level 4: Requires significant monitoring, externally imposed structure, and interventions to interrupt NSSI and to maintain safety outside of program.

Level 5: Requires 24-hour intensive monitoring, structured support, or constant intervention to interrupt NSSI or to maintain safety outside of program.

Able = Patient has the necessary skills and resources necessary to keep self safe/resist urges

Willing = Patient chooses or intends to choose to use skills or resources to keep self safe/resist urges

Suicidality = best measured by the Columbia Suicide Severity Scale (C-SSRS)

NSSI frequency & severity = multiple measures available (e.g., Alexian Brothers Assessment of Self-Injury, Inventory of Statements about Self-Injury, Ottawa Self-Injury Inventory, Self-Injurious Thoughts and Behaviors)

Urge to Self Injure = can be measured by the Alexian Brothers Urge to Self-Injure scale

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Helpful questions to assess sharing about self-injury practices online

- How often do you visit the Internet to get or share health information?
- Have you ever made friends over the Internet?
- Have you ever visited a Web site to find out about or to talk about self-injury?
- Are there places you regularly go to find out about or to talk about self-injury?
- How often do you visit this/these site(s)?
- What do you like to do most while there?
- Do you like to post messages (or videos) or do you like to just see what is happening?
- What type of site(s) do you visit?
- Can you tell me the name of the sites you like the best?
- How close do you consider your Internet friends to be?
- Have you ever met with friends you made online?
- How comfortable do you feel hearing stories from others who self-injure?
- Have you shared your own story? How did this feel?
- What do you like most about having friends that you only really know through the Internet?
- How honest are you when you share information on the Web? (Do you minimize or tend to embellish?)
- Do you tend to remain anonymous, or do you share your name and contact information?
- Do you have Internet friends with whom you talk about self-injury?
- Do you ever take their advice?
- Can you provide examples of advice you got from an Internet friend that you used?

Adapted from: Whitlock, J., Lader, W., & Conterio, K. (2007). The internet and self-injury: What psychotherapists should know. *Journal of Clinical Psychology*, *63*(11), 1135-1143.

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Tony L. Sheppard, Psy.D., CGP

NSSI Case Example Two

Celine S.*

14 year old Female

Celine is being seen in an outpatient clinic setting. She is coming in following an NSSI relapse that was triggered by arguments with her girlfriend of 3 months. This is Celine's longest relationship. She was successful in stopping NSSI in her previous course of therapy.

*This is a fictional profile. No Private Health Information is revealed in this case example or any of the supporting materials.

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OSI

OTTAWA SELF-INJURY INVENTORY

Name: Celine S. **Sex:** ☐ Male ☑ Female

Today's Date: 11 DD 30 MM 2017 YY **Date of Birth:** 11 DD 04 MM 03 YY **Age:** 14

1.

How often in the past month have you: *circle "0" if not at all and circle "3" if daily*	not at all	at least once	weekly	daily
Thought about injuring yourself without the intention to kill yourself?	0	1	2	(3)
Actually injured yourself, without the intention to kill yourself?	0	1	(2)	3

2.

How often in the past 6 months have you: *circle "0" if not at all and circle "4" if daily*	not at all	1 to 5 times	monthly	weekly	daily
Thought about injuring yourself without the intention to kill yourself?	0	(1)	2	3	4
Actually injured yourself, without the intention to kill yourself?	(0)	1	2	3	4

3.

How often in the past year have you: *circle "0" if not at all and circle "4" if daily*	not at all	1 to 5 times	monthly	weekly	daily
Thought about taking your life (killing yourself)?	0	(1)	2	3	4

4. **Have you ever made an actual attempt to take your life?** ☐ no ☑ yes

If yes, then please indicate the number of times:

in the past month: ____ in the past 6 months: ____ in the past year: ____ prior to one year ago: 1

5. **Have you ever been treated by a doctor after injuring yourself on purpose? (e.g., stitches, wound dressings, etc.)**

☑ no ☐ yes

If yes, how often did a doctor treat you in the *past year* for hurting yourself on purpose?_____ time(s)

6. **Have you been kept in hospital because of hurting yourself on purpose?**

☐ no ☑ yes

If yes, how many times in the *past year* did you stay overnight in emergency? no

If yes, how many times in the *past year* did you get admitted to a hospital unit? no

Mary Kay Nixon, M.D. & Paula Cloutier, M.A.
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7. **If you indicated that you had thought about or actually injured yourself in questions 1-4:**
How old were you when you started to self-injure? 8 (years old)

8. **The first time you hurt yourself, where did you get the idea?** (please ☑ only one)

- [✓] I read about it on an internet website
- [ ] I read about it on a Web Blog
- [ ] I read about it in a book or magazine
- [ ] I saw it happen in a movie or on television
- [ ] I saw other people do it in a non-hospital setting
- [ ] I heard about it from other people in a non-hospital setting
- [ ] I heard about it from other people in a hospital setting
- [ ] I saw other people do it in a hospital setting
- [ ] It was my own idea
- [ ] Other (please list)_____

9. **When you get the urge to hurt yourself:**

circle "0" if not at all and circle "4" if extremely	**Not at all**		**somewhat**		**extremely**
The urge is distressing / upsetting	0	1	2	(3)	4
The urge is comforting	0	(1)	2	3	4
The urge is intrusive / invasive	0	1	(2)	3	4

10. **Do you only harm yourself after taking drugs or alcohol?** [✓] no [ ] yes

11. **Do you let other people know that you harm yourself?**

- [ ] no one
- [✓] some people
- [ ] most people

who do you tell? →

- [✓] friend(s)
- [ ] psychologist/psychiatrist
- [ ] other Mental Health Professional
- [✓] telephone helpline
- [ ] family member(s)
- [ ] family doctor
- [ ] school counsellor
- [✓] other (specify) grandmother

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12. a) **What areas of your body did/do you injure?**

Please (√) all that apply

	WHEN YOU FIRST STARTED	CURRENTLY (past month if still self-injuring)
Scalp		
Eye(s)	✓	
Ear(s)		
Face		
Nose		
Lips		
Inside of mouth	✓	
Neck/throat		
Chest		
Breast(s)		
Back		
Shoulder(s)		
Abdomen	✓	
Hips/buttock(s)		
Genitals		
Rectum		
Upper arm/elbow		
Lower arm/wrist	✓	✓
Hand/fingers		
Thigh/knee		✓
Lower leg/ankle		
Foot/toes		
Other (specify):		

b) *Above, please circle the part that you currently injure the most*

13. a) **How did/do you injure yourself (without meaning to kill yourself)?**

Please (√) all that apply

	WHEN YOU FIRST STARTED	CURRENTLY (past month if still self-injuring)
Cutting	✓	✓
Scratching	✓	✓
Interfering with wound healing	✓	
Burning		
Biting	✓	
Hitting		
Hair pulling		
Severe nail biting and/or nail injuries		
Piercing skin with sharp pointy objects	✓	
Piercing of body parts		
Excessive use of street drugs		
Excessive use of alcohol		
Trying to break bones		
Headbanging		
Taking too much medication		
Taking too little medication		
Eating or drinking things that are not food		
Other (specify): punching	✓	

b) *Above, please circle the method that you currently use the most*

14.

Why do you think you started and if you continue, why do you still self-injure (without meaning to kill yourself)? *Please circle the number that best represents how much your self-injury is due to that reason. Circle "0" if it has never been a reason that you self-injure and "4" if it has always been a reason that you self-injure.*	**Why did you start?** Never a reason	Sometimes a reason	Always a reason	**If you continue, why do you continue?** Never a reason	Sometimes a reason	Always a reason
1. to release unbearable tension	0 1 2 3 **4**			0 1 **2** 3 4		
2. to experience a "high" that feels like a drug high	0 **1** 2 3 4			0 1 2 **3** 4		
3. to stop my parents from being angry with me	**0** 1 2 3 4			**0** 1 2 3 4		
4. to stop feeling alone and empty	0 1 2 **3** 4			0 1 **2** 3 4		
5. to get care or attention from other people	**0** 1 2 3 4			**0** 1 2 3 4		
6. to punish myself	0 1 2 3 **4**			0 1 **2** 3 4		
7. to provide a sense of excitement that feels exhilarating	**0** 1 2 3 4			0 1 2 **3** 4		
8. to avoid getting into trouble for something I did	**0** 1 2 3 4			**0** 1 2 3 4		
9. to distract me from unpleasant memories	**0** 1 2 3 4			0 1 **2** 3 4		
10. to change my body image and/or appearance	**0** 1 2 3 4			**0** 1 2 3 4		
11. to belong to a group	**0** 1 2 3 4			**0** 1 2 3 4		
12. to release anger	0 1 2 **3** 4			0 1 2 **3** 4		
13. to show others how hurt or damaged I am	**0** 1 2 3 4			**0** 1 2 3 4		
14. to experience physical pain in one area, when the other pain I feel is unbearable	**0** 1 2 3 4			**0** 1 2 3 4		
15. to stop people from expecting so much from me	**0** 1 2 3 4			0 **1** 2 3 4		
16. to relieve feelings of sadness or feeling "down"	0 1 2 3 **4**			0 1 2 **3** 4		
17. to stop me from thinking about ideas of killing myself	0 1 2 3 **4**			0 **1** 2 3 4		
18. to stop me from acting out ideas of killing myself	0 1 2 3 **4**			**0** 1 2 3 4		
19. to produce a sense of being real when I feel numb and "unreal"	0 1 2 **3** 4			0 **1** 2 3 4		
20. to release frustration	0 1 2 3 **4**			0 **1** 2 3 4		
21. to get out of doing something that I don't want to do	**0** 1 2 3 4			**0** 1 2 3 4		
22. to prove to myself how much I can take	**0** 1 2 3 4			0 **1** 2 3 4		
23. for sexual excitement	**0** 1 2 3 4			**0** 1 2 3 4		
24. to diminish feeling of sexual arousal	**0** 1 2 3 4			**0** 1 2 3 4		
25. other (please specify):	0 1 2 3 4			0 1 2 3 4		

15.

If you indicated that you had thought about or actually injured yourself in questions 1-4, do you feel relief (better) after harming yourself?	**Never**		**Sometimes**		**Always**
circle "0" if never and circle "4" if always	0	1	2	(3)	4

If you feel relief, how long does the relief last? *(please (√) only one)*

- ☐ less than 1minute
- ☐ 1 to 5 minutes
- ☐ 6 to 30 minutes
- ☐ 31 to 60 minutes
- ☑ hours
- ☐ days

16. Once you think about harming yourself, do you always do it? ☐ yes ☑ no

17. When you hurt yourself on purpose, on average, how much time goes by between thinking about it and doing it? (Please (√) 1 item only)

- ☐ less than 1 minute
- ☐ 1 minute to 5 minutes
- ☐ 6 minutes to 30 minutes
- ☐ over 30 minutes but less than 1 hour
- ☑ hours
- ☐ days

18.

Do you feel physical pain when you harm yourself?	**Never**		**Sometimes**		**Always**
circle "0" if never and circle "4" if always	0	1	(2)	3	4

19.

Do you hurt or think about hurting yourself after stressful things happen?	**Never**		**Sometimes**		**Always**
circle "0" if never and circle "4" if always	0	1	(2)	3	4

↓

If you indicated that you thought about or actually injured yourself in questions 1-4, what kinds of stressful situation(s) typically led to self-injury?

- ☐ abandonment (please specify)_____
- ☑ failure (please specify) not feeling good enough
- ☐ loss (please specify)_____
- ☑ rejection (please specify) fight with friend or girlfriend
- ☐ other (please specify)_____

20.

Since you started to self-injure, have you found that: *circle "0" if never and circle "4" if always*	**Never**		**Sometimes**		**Always**
1.The self-injurious behaviour occurs more often than intended?	0	1	2	3	4
2. The severity in which the self-injurious behaviour occurs has increased (e.g., deeper cuts, more extensive parts of your body)?	0	1	2	3	4
3. If the self-injurious behaviour produced an effect when started, you now need to self-injure more frequently or with greater intensity to produce the same effect?	0	1	2	3	4
4. This behaviour or thinking about it consumes a significant amount of your time (e.g., planning and thinking about it, collecting and hiding sharp objects, doing it and recovering from it)?	0	1	2	3	4
5. Despite a desire to cut down or control this behaviour, you are unable to do so?	0	1	2	3	4
6. You continue this behaviour despite recognizing that it is harmful to you physically and/or emotionally?	0	1	2	3	4
7. Important social, family, academic or recreational activities are given up or reduced because of this behaviour?	0	1	2	3	4

21.

If you are trying to resist hurting yourself, what do you do instead? *Please (√) all that apply*	
Never try to resist	
Talk with someone	✓
Exercise / sports	✓
Reading writing, music, dance	✓
Watch television, play video or computer games	
Do things to relax (e.g., hot bath, yoga, deep breathing)	✓
Use alcohol and or street drugs	
Do anything to keep hands busy	
Other (specify):	

b) For question 21, *please circle the most helpful thing you do to resist hurting yourself.*

22. **How motivated are you at this time to stop self-injuring?**

Not at all Motivated		Somewhat Motivated		Extremely Motivated
0	1	2	3	(4)

23. **What treatment(s) if any, have you received with the goal of reducing and/or eliminating your self-harm?**

(Please (√) all items that apply)

- [ ] I have not had treatment
- [√] individual therapy
- [ ] family therapy
- [ ] I declined treatment
- [ ] school counselling
- [√] medication (please specify) Zoloft
- [√] Self help (e.g., self-help books, (internet))
- [√] group therapy

other (please specify) _____

24. **What treatment(s) if any, have you found the most helpful in reducing and/or eliminating your self-harm?**

(Please (√) all items that apply)

- [ ] I have not had treatment
- [√] individual therapy
- [ ] family therapy
- [ ] I declined treatment
- [ ] school counselling
- [ ] medication (please specify) _____
- [ ] Self help (e.g., self-help books, internet)
- [√] group therapy

other (please specify) _____

25. **I feel that this questionnaire has fully described my experience of Self-Injury**

Strongly Disagree		Somewhat Agree		Strongly Agree
0	1	2	3	(4)

26. **Is there anything else you would like to share with us regarding your self-injury behaviour?**

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***Have you been thinking about how you might do this?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question:	**Lifetime**	
Have you ever done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
If YES, ask: *Were any of these in the past 3 months?*	**Past 3 Months**	

- Low Risk
- Moderate Risk
- High Risk

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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

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SAFE-T

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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-based, 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.

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SAFE-T Protocol with C-SSRS - Recent

Step 1: Identify Risk Factors

C-SSRS Suicidal Ideation Severity	Month
1) Wish to be dead *Have you wished you were dead or wished you could go to sleep and not wake up?*	
2) Current suicidal thoughts *Have you actually had any thoughts of killing yourself?*	
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) *Have you been thinking about how you might do this?*	
4) Suicidal Intent without Specific Plan *Have you had these thoughts and had some intention of acting on them?*	
5) Intent with Plan *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*	

C-SSRS Suicidal Behavior: *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. If "YES" Was it within the past 3 months?	Lifetime Past 3 Months

Current and Past Psychiatric Dx:
□ Mood Disorder
□ Psychotic disorder
□ Alcohol/substance abuse disorders
□ PTSD
□ ADHD
□ TBI
□ Cluster B Personality disorders or traits (i.e., Borderline, Antisocial, Histrionic & Narcissistic)
□ Conduct problems (antisocial behavior, aggression, impulsivity)
□ Recent onset

Presenting Symptoms:
□ Anhedonia
□ Impulsivity
□ Hopelessness or despair
□ Anxiety and/or panic
□ Insomnia
□ Command hallucinations
□ Psychosis

Family History:
□ Suicide
□ Suicidal behavior
□ Axis I psychiatric diagnoses requiring hospitalization

Precipitants/Stressors:
□ Triggering events leading to humiliation, shame, and/or despair (e.g. Loss of relationship, financial or health status) (real or anticipated)
□ Chronic physical pain or other acute medical problem (e.g. CNS disorders)
□ Sexual/physical abuse
□ Substance intoxication or withdrawal
□ Pending incarceration or homelessness
□ Legal problems
□ Inadequate social supports
□ Social isolation
□ Perceived burden on others

Change in treatment:
□ Recent inpatient discharge
□ Change in provider or treatment (i.e., medications, psychotherapy, milieu)
□ Hopeless or dissatisfied with provider or treatment
□ Non-compliant or not receiving treatment

□ **Access to lethal methods:** Ask <u>specifically</u> about presence or absence of a firearm in the home or ease of accessing

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Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)	
Internal: □ Ability to cope with stress □ Frustration tolerance □ Religious beliefs □ Fear of death or the actual act of killing self □ Identifies reasons for living	**External:** □ Cultural, spiritual and/or moral attitudes against suicide □ Responsibility to children □ Beloved pets □ Supportive social network of family or friends □ Positive therapeutic relationships □ Engaged in work or school

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior)

If semi-structured interview is preferred to complete this section, clinicians may opt to complete C-SSRS Lifetime/Recent for comprehensive behavior/lethality assessment.

C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 1-5 identified above)	Month
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	
Total Score	

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential **clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."
From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

RISK STRATIFICATION	TRIAGE
High Suicide Risk □ Suicidal ideation with intent or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5) **Or** □ Suicidal behavior **within past 3 months** (C-SSRS Suicidal Behavior)	□ **Initiate local psychiatric admission process** □ **Stay with patient until transfer to higher level of care is complete** □ **Follow-up and document outcome of emergency psychiatric evaluation**
Moderate Suicide Risk □ Suicidal ideation with method, **WITHOUT plan, intent or behavior in past month** (C-SSRS Suicidal Ideation #3) **Or** □ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) **Or** □ Multiple risk factors and few protective factors	□ **Directly address suicide risk, implementing suicide prevention strategies** □ **Develop Safety Plan**
Low Suicide Risk □ Wish to die or Suicidal Ideation **WITHOUT method, intent, plan or behavior** (C-SSRS Suicidal Ideation #1 or #2) **Or** □ Modifiable risk factors and strong protective factors **Or** □ No reported history of Suicidal Ideation or Behavior	□ **Discretionary Outpatient Referral**

Step 5: Documentation

Risk Level :

[ ] High Suicide Risk
[ ] Moderate Suicide Risk
[ ] Low Suicide Risk

Clinical Note:

- □ Your Clinical Observation
- □ Relevant Mental Status Information
- □ Methods of Suicide Risk Evaluation

- □ Brief Evaluation Summary
  - □ Warning Signs
  - □ Risk Indicators
  - □ Protective Factors
  - □ Access to Lethal Means
  - □ Collateral Sources Used and Relevant Information Obtained
  - □ Specific Assessment Data to Support Risk Determination
  - □ Rationale for Actions Taken and Not Taken

- □ Provision of Crisis Line 1-800-273-TALK(8255)
- □ Implementation of Safety Plan (If Applicable)

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COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Pediatric/Cognitively Impaired – Lifetime Recent

Version 6/23/10 m6/29/17

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in ***The Columbia Suicide History Form****, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.]* Standardized Evaluation in Clinical Practice*, pp. 103 -130, 2003.)*

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact *posnerk@nyspi.columbia.edu*

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SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Lifetime: Time He/She Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you thought about being dead or what it would be like to be dead?*** ***Have you wished you were dead or wished you could go to sleep and never wake up?*** ***Do you ever wish you weren't alive anymore?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
2. Non-Specific Active Suicidal Thoughts General, non-specific thoughts of wanting to end one's life/die by suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you thought about doing something to make yourself not alive anymore?*** ***Have you had any thoughts about killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."* ***Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u>, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?*** ***This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you ever decided how or when you would make yourself not alive anymore/kill yourself? Have you ever planned out (worked out the details of) how you would do it?*** ***What was your plan?*** ***When you made this plan (or worked out these details), was any part of you thinking about actually doing it?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐

INTENSITY OF IDEATION

The following feature should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe).	Most Severe	Most Severe
Lifetime - Most Severe Ideation: _____ _____ ***Type # (1-5)*** ***Description of Ideation*** ***Recent - Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation***		
Frequency ***How many times have you had these thoughts?*** ***Write response***_____ (1) Only one time (2) A few times (3) A lot (4) All the time (0) Don't know/Not applicable	____	____

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SUICIDAL BEHAVIOR **www.groupworksky.com** *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 Months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Did you ever do anything to try to kill yourself or make yourself not alive anymore? What did you do?*** ***Did you ever hurt yourself on purpose? Why did you do that?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to make yourself not alive anymore when you _____?*** ***Or did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe:	**Yes** ☐ **No** ☐ Total # of Attempts _____	**Yes** ☐ **No** ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Has subject engaged in Self-Injurious Behavior, intent unknown?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of interrupted _____	**Yes** ☐ **No** ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of preparatory acts _____	**Yes** ☐ **No** ☐ Total # of preparatory acts _____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

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- 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.

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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?"**

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Suicide Case Example Three

Ali is a 17 year old male diagnosed with iBolar Disorder and Cannabis Abuse Disorder. He is a Senior in High School. He was Recently Discharged from an inpatient facility following a three week stay. isHdoctor is currently hanging Mood Stabilizer medications. Ali's Father has cancer and is undergoing treatment out of state/Ali is staying with grandparents.

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Ali

SAFE-T Protocol with C-SSRS - Recent

Step 1: Identify Risk Factors

C-SSRS Suicidal Ideation Severity	Month
1) Wish to be dead *Have you wished you were dead or wished you could go to sleep and not wake up?*	✓
2) Current suicidal thoughts *Have you actually had any thoughts of killing yourself?*	✓
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) *Have you been thinking about how you might do this?*	✓
4) Suicidal Intent without Specific Plan *Have you had these thoughts and had some intention of acting on them?*	✓
5) Intent with Plan *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*	

C-SSRS Suicidal Behavior: *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. If "YES" Was it within the past 3 months?	Lifetime ✓ Past 3 Months ✓

Current and Past Psychiatric Dx:
- ☑ Mood Disorder
- ☐ Psychotic disorder
- ☑ Alcohol/substance abuse disorders
- ☐ PTSD
- ☐ ADHD
- ☐ TBI
- ☐ Cluster B Personality disorders or traits (i.e., Borderline, Antisocial, Histrionic & Narcissistic)
- ☐ Conduct problems (antisocial behavior, aggression, impulsivity)
- ☐ Recent onset

Presenting Symptoms:
- ☑ Anhedonia
- ☑ Impulsivity
- ☑ Hopelessness or despair
- ☑ Anxiety and/or panic
- ☑ Insomnia
- ☐ Command hallucinations
- ☐ Psychosis

Family History:
- ☐ Suicide
- ☑ Suicidal behavior
- ☑ Axis I psychiatric diagnoses requiring hospitalization

Precipitants/Stressors:
- ☐ Triggering events leading to humiliation, shame, and/or despair (e.g. Loss of relationship, financial or health status) (real or anticipated)
- ☐ Chronic physical pain or other acute medical problem (e.g. CNS disorders)
- ☐ Sexual/physical abuse
- ☐ Substance intoxication or withdrawal
- ☐ Pending incarceration or homelessness
- ☐ Legal problems
- ☐ Inadequate social supports
- ☐ Social isolation
- ☑ Perceived burden on others

Change in treatment:
- ☑ Recent inpatient discharge
- ☑ Change in provider or treatment (i.e., medications, psychotherapy, milieu)
- ☑ Hopeless or dissatisfied with provider or treatment
- ☐ Non-compliant or not receiving treatment

☑ **Access to lethal methods:** Ask specifically about presence or absence of a firearm in the home or ease of accessing

Father's pain meds

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Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)	
Internal: ☑ Ability to cope with stress ☐ Frustration tolerance ☑ Religious beliefs ☐ Fear of death or the actual act of killing self ☐ Identifies reasons for living	**External:** ☑ Cultural, spiritual and/or moral attitudes against suicide ☐ Responsibility to children ☑ Beloved pets ☑ Supportive social network of family or friends ☑ Positive therapeutic relationships ☑ Engaged in work or school

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior)

If semi-structured interview is preferred to complete this section, clinicians may opt to complete C-SSRS Lifetime/Recent for comprehensive behavior/lethality assessment.

C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 1-5 identified above)	Month
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	4
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	4
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	4
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	2
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	5
Total Score	19

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential **clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."
From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

RISK STRATIFICATION	TRIAGE
High Suicide Risk ☐ Suicidal ideation with intent or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5) **Or** ☐ Suicidal behavior **within past 3 months** (C-SSRS Suicidal Behavior)	☐ **Initiate local psychiatric admission process** ☐ **Stay with patient until transfer to higher level of care is complete** ☐ **Follow-up and document outcome of emergency psychiatric evaluation**
Moderate Suicide Risk ☐ Suicidal ideation with method, **WITHOUT plan, intent or behavior in past month** (C-SSRS Suicidal Ideation #3) **Or** ☐ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) **Or** ☐ Multiple risk factors and few protective factors	☐ **Directly address suicide risk, implementing suicide prevention strategies** ☐ **Develop Safety Plan**
Low Suicide Risk ☐ Wish to die or Suicidal Ideation **WITHOUT method, intent, plan or behavior** (C-SSRS Suicidal Ideation #1 or #2) **Or** ☐ Modifiable risk factors and strong protective factors **Or** ☐ No reported history of Suicidal Ideation or Behavior	☐ **Discretionary Outpatient Referral**

Step 5: Documentation

Risk Level :

[ ] High Suicide Risk
[ ] Moderate Suicide Risk
[ ] Low Suicide Risk

Clinical Note:

- ☐ Your Clinical Observation
- ☐ Relevant Mental Status Information
- ☐ Methods of Suicide Risk Evaluation
- ☐ Brief Evaluation Summary
  - ☐ Warning Signs
  - ☐ Risk Indicators
  - ☐ Protective Factors
  - ☐ Access to Lethal Means
  - ☐ Collateral Sources Used and Relevant Information Obtained
  - ☐ Specific Assessment Data to Support Risk Determination
  - ☐ Rationale for Actions Taken and Not Taken
- ☐ Provision of Crisis Line 1-800-273-TALK(8255)
- ☐ Implementation of Safety Plan (If Applicable)

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Safety Planning Case Example

Jimmy is a 19 year-old college student diagnosed with Major Depression & Autism Spectrum Disorder (Level 1). He Recently came out to group as bisexual and fears coming out to parents. Parents recently divorced and he's in his first year of college. Jimmy experienced Lots of suicidal ideation last semester and informs his therapist of this in a post-semester session. He Agreed to complete the Plan with his college counseling center therapist and for it to be shared with the co-leaders of the group he's a patient in.

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Jimmy

Patient Safety Plan Template

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

1. Isolation
2. Sleeping between classes
3. Dreams about death

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. Music
2. Group Therapy
3. Video Game Club

Step 3: People and social settings that provide distraction:

1. Name Joey B. Phone 599-8822
2. Name Bailey H. Phone 443-9049
3. Place Rec Center 4. Place Arcade

Step 4: People whom I can ask for help:

1. Name Mom Phone 448-1420
2. Name Dad Phone 448-1362
3. Name GSA Ally (Alys) Phone 992-7701

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

1. Clinician Name Dr. Naray Phone 909-4411
   Clinician Pager or Emergency Contact # Counseling Center
2. Clinician Name Ms. Colleen at Group Phone 909-4411
   Clinician Pager or Emergency Contact # Counseling Center
3. Local Urgent Care Services Univ. Hosp
   Urgent Care Services Address 101 Muhammad Ali Blvd.
   Urgent Care Services Phone 292-8772
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. Mom keeps meds
2. Stay away from the Bridge

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

Grandma