RESOURCES

- Download this card and additional resources at http://www.sprc.org

ACKNOWLEDGMENTS

- Originally conceived by Douglas Jacobs, MD, and developed as a collaboration between Screening for Mental Health, Inc. and the Suicide Prevention Resource Center.
- This material is based upon work supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) under Grant No. 1U79SM57392. Any opinions/findings/conclusions/recommendations expressed in this material are those of the author and do not necessarily reflect the views of SAMHSA.

SAFE-T
Suicide Assessment Five-step Evaluation and Triage

1. IDENTIFY RISK FACTORS
   Note those that can be modified to reduce risk

2. IDENTIFY PROTECTIVE FACTORS
   Note those that can be enhanced

3. CONDUCT SUICIDE INQUIRY
   Suicidal thoughts, plans, behavior, and intent

4. DETERMINE RISK LEVEL/INTERVENTION
   Determine risk. Choose appropriate intervention to address and reduce risk

5. DOCUMENT
   Assessment of risk, rationale, intervention, and follow-up

National Suicide Prevention Lifeline
1-800-273-TALK (8255)

http://www.sprc.org

A Life in the Community for Everyone

SAMHSA
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

HHS Publication No. (SMA) 09-4432 • CMHS-NSP-0193
Printed 2009
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)
- **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

<table>
<thead>
<tr>
<th>RISK LEVEL</th>
<th>RISK/PROTECTIVE FACTOR</th>
<th>SUICIDALITY</th>
<th>POSSIBLE INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant</td>
<td>Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal</td>
<td>Admission generally indicated unless a significant change reduces risk. Suicide precautions</td>
</tr>
<tr>
<td>Moderate</td>
<td>Multiple risk factors, few protective factors</td>
<td>Suicidal ideation with plan, but no intent or behavior</td>
<td>Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers</td>
</tr>
<tr>
<td>Low</td>
<td>Modifiable risk factors, strong protective factors</td>
<td>Thoughts of death, no plan, intent, or behavior</td>
<td>Outpatient referral, symptom reduction. Give emergency/crisis numbers</td>
</tr>
</tbody>
</table>

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

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