SAFE-T Protocol with C-SSRS, Safety Planning and Telephone Follow-up

Step 1: Identify Risk Factors

C-SSCS Suicidal Ideation Severity	Month	Lifetime (Worst)
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 kill yourself?*		
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.	3 Months	Lifetime

Current and Past Psychiatric Dx:
- □ Mood Disorder
- □ Psychotic disorder
- □ Alcohol/substance abuse disorders
- □ PTSD
- □ ADHD
- □ TBI / History of concussions
- □ 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
- □ Psychiatric diagnoses

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 workplace or ease of accessing

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)

Internal:	External:
□ Ability to cope with stress	□ Cultural, spiritual and/or moral attitudes against suicide
□ Frustration tolerance	□ Responsibility to children
□ Religious beliefs	□ Beloved pets
□ Fear of death or the actual act of killing self	□ Supportive social network of family or friends
□ Identifies reasons for living	□ 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 and Since Last Visit versions for comprehensive behavior/lethality assessment.

C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 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 committing 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	
Moderate (6-10) 11x, Mod. Severe (11-15) 13x, Severe (16-20) 19x, Very Severe (21-25) 34x the risk of suicide **Total Score**	

Notes:

Behaviors:

- □ Preparatory Acts (e.g., buying pills, purchasing a gun, giving things away, writing a suicide note)
- □ Aborted/self-interrupted attempts,
- □ Interrupted attempts and
- □ Actual attempts

□ **Assess for the presence of non-suicidal self-injurious behavior** (e.g. cutting, hair pulling, cuticle biting, skin picking) particularly among adolescents and young adults, and especially among those with a history of mood or externalizing disorders

□ **For Youths:** ask parents/guardian about evidence of suicidal thoughts, plans or behaviors and changes in mood, behaviors or disposition

□ **Assess for homicidal ideation, plan behavior and intent** particularly in:

- □ character disordered males dealing with separation, especially if paranoid, or impulsivity disorders

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	POSSIBLE INTERVENTIONS
High 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**	☐ Assessment of patient's medical stability ☐ Observation Status ☐ Elopement precautions ☐ Body/belongings search ☐ Pharmacological treatment ☐ Family/significant-other engagement ☐ Psychotherapy (CBT, DBT) ☐ Psychoeducation (coping skills, stress management, symptom management, etc.) ☐ Safety Plan ☐ Telephone Follow-up upon discharge **Safety needs to consider in the physical environment:** ☐ Assess the physical environment, focusing on limiting access to methods. The most common methods of suicide in hospitals are hanging, suffocation and jumping. **If risk assessment is conducted in outpatient setting:** ☐ Place individual in a room that is away from exits but close to staff where patient is observed at all times ☐ Beware of elopement risk if patient is against admission AND/OR wanting to be alone to follow through with plans of suicide
Moderate Risk ☐ Suicidal ideation **WITHOUT plan, intent or behavior in past month** (C-SSRS screen #2 or #3) **Or** ☐ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior) **Or** ☐ Multiple risk factors and few protective factors	☐ **Directly address suicide risk, implementing suicide prevention strategies** ☐ **Develop Safety Plan**	☐ Pharmacological treatment ☐ Psychotherapy (CBT, DBT) ☐ Psychoeducation (coping skills, stress management, symptom management, etc.) ☐ Engagement with family-member or significant-other ☐ Safety Plan ☐ Provide National Suicide Prevention Lifeline card and local emergency contacts
Low Risk ☐ Wish to die (C-SSRS Suicidal Ideation #1) **no plan, intent or behavior** **Or** ☐ Suicidal ideation more than 1 month ago **WITHOUT plan, intent or behavior** (C-SSRS screen #2 or #3) **Or** ☐ Modifiable risk factors and strong protective factors **Or** ☐ No reported history of Suicidal Ideation or Behavior	**Discretionary Outpatient Referral**	☐ Provide information about warning signs. ☐ Provide National Suicide Prevention Lifeline card and local emergency contacts ☐ Wellness Recovery Action Planning (WRAP) ☐ Re-assess at treatment plan review

Step 5: Document Level of Risk, Rationale for Risk Assignment, Intervention and Structured Follow Up Plan (to be developed)

Risk Level :

[ ] High Risk [ ] Moderate Risk [ ] Low Risk Suicidal

Clinical Formulation:

1- Specify findings from Steps 1-3 (including risk and protective factors).
2- State clinical rationale for selected risk level and treatment setting.

Treatment Plan for Reducing Risk Level:

□ **If Suicidal:**

1- Discuss risk-linked interventions (see Step 4 for possible interventions)
2- Identify risk and protective factors that can be modified through treatment and intervention
3- If Access to Means is present, document instructions to patient and significant others
4- Develop *Risk Reduction Plan* with specific interventions to reduce risk factors and enhance protective factors.
5- Develop *Safety needs* for individual's physical environment and *Special Observations*, if warranted.
6- Create a Safety Plan
7- Create a Follow-up plan

□ **If not suicidal:**

1- Discuss warning signs
2- Provide National Lifeline information
3- Re-assess at treatment plan review

Suicide-Risk Following Discharge from INPATIENT Setting:

The highest risk of suicide is within the **first three days of discharge** from inpatient setting.
The next highest risk of suicide is during the **first 30 days** post discharge.

Community Prevention Practices

□ ***3 & 30 Follow-up:*** Outpatient appointment **MUST** be scheduled within the **first 3 days of discharge** with **close follow up** and support **during the first 30 days** of inpatient discharge.

□ ***Warm-hand off*** and ***Peer Bridger***: Outpatient staff and/or Peer Bridger meet with individual as an inpatient. Same Bridger and outpatient staff continues shared collaboration and connection with individual until outpatient connection and follow-up services are in place.

□ **Safety Plan** must be developed during the inpatient stay and shared with the individual's outpatient provider.

Guidelines for When to Document Suicide Risk Assessments:

□ At the time of inpatient and/or outpatient admission
□ With occurrence of any suicidal behavior or ideation
□ Whenever there is clinical change
□ Before increasing privileges or giving passes (if individual is in an inpatient setting for moderate /high risk individuals)
□ At regular intervals (i.e., treatment plan review) or as clinically indicated
□ At the time of inpatient or outpatient discharge

Collaborative Accountability:

A team-based, collaborative, shared responsibility approach to enhance individual's safety and foster on-going communication among team-members.