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PDS-BEMR SUICIDE RISK ASSESSMENT GUIDE – Version 3

Key Principles to Consider When Conducting Suicide Risk Assessment (adapted from Granello, 2011):

Suicide Risk Assessment....

1. Is Treatment and Occurs in the Context of a Therapeutic Relationship	2. Is Unique for Each Person
3. Is Complex and Challenging	4. Is an Ongoing Process
5. Errs on the Side of Caution	6. Is Collaborative and Relies on Effective Communication
7. Relies on Clinical Judgement	8. Takes all Threats, Warning Signs, and Risk Factors Seriously
9. Asks the Tough Questions	10. Tries to Uncover the Underlying Message
11. Is Done in a Cultural Context	12. Is Documented

+ Risk or Protective Factor Present - Risk or Protective Factor Absent 0 Risk or Protective Factor Not Assessed

Mental Status Exam: In PDS you will be required to select a value for each of the areas below. You can make additional comments.

◯ Level of Consciousness ◯ Psychomotor Activity ◯ General Appearance ◯ Behavior
◯ Mood ◯ Thought Process ◯ Thought Content

In PDS you will be required to select a value for each of the risk/dynamic/protective factors below:

+ - 0 STATIC FACTORS	+ - 0 DYNAMIC FACTORS	+ - 0 PROTECTIVE FACTORS
◯◯◯ Chronic Medical Condition	◯◯◯ Agitation	◯◯◯ Able to Identify Reasons to Live
◯◯◯ Family Hx of Suicide	◯◯◯ Current Intoxication	◯◯◯ Adequate Problem Solving Skills
◯◯◯ High Profile Crime	◯◯◯ Current Physical Pain	◯◯◯ Denial of Suicidal Ideation
◯◯◯ Hx of Childhood Abuse	◯◯◯ Current Suicidal Ideation	◯◯◯ Future Orientation
◯◯◯ Hx of Psychiatric Hospitalization	◯◯◯ Current Suicidal Intent	◯◯◯ Religious Beliefs Against Suicide
◯◯◯ History of Mental Illness	◯◯◯ Current Suicidal Plan	◯◯◯ Social Support in the Institution
◯◯◯ Past Suicide Attempt	◯◯◯ Fear for Own Safety	◯◯◯ Supportive Family Relationships
◯◯◯ History of Violent Behavior	◯◯◯ Feeling Hopeless/Helpless	◯◯◯ View of Death as Negative
◯◯◯ Lack of Family Connections	◯◯◯ Feels Like a Burden	◯◯◯ Willingness to Engage in Tx
◯◯◯ Sex Offender Status	◯◯◯ Non-Adherence to Medical Tx	
	◯◯◯ Problem Solving Deficits	
	◯◯◯ Recent Significant Loss	
	◯◯◯ Sleeps Problems	
	◯◯◯ Social Isolation	
	◯◯◯ Uncontrolled Mental Health Issues	

Additional validated risk factors that may be relevant: Sentence >20 years; Self-harm in past month; Dual Diagnosis; Male Gender; History of Self-Injurious Behavior; Chronic/Uncontrolled Pain; No Spouse (Single, Divorced, Widowed)

Suicide Risk Assessment in PDS-BEMR

Classification of Suicide Related Behaviors

Did the inmate communicate regarding self-injury?

Suicide Related Communication:

Any verbal or non-verbal interpersonal communication of thoughts, wishes, or intent for suicide that does NOT produce self-injury.

Actions do not produce self-injury, although they have that intent. Examples may include

- placing a noose around one's neck in the presence of staff;
- writing a letter that states, "the world would be better without me";
- stating, "I'm going to kill myself."

Suicide Related Behavior:

A self-inflicted, potentially injurious behavior for which there is evidence that the person either (a) wished to use the appearance of a suicide attempt to attain some other end, or (b) intended, to some degree, to kill him/herself.

Was the act motivated by any intent to die?

Yes No Undetermined

Suicide Attempt:

A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Non-Suicidal Self Directed Violence:

If there is no evidence, whether implicit or explicit, of suicidal intent it is not an attempt, it is Non-Suicidal Self-Directed Violence – Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. This is your judgment and includes inmate self-report. Look at the big picture and account for other data that corroborates or contradicts self-report. This is a distinction that the executive staff and/or the IDO need to have made for them.

Did the act result in any injuries?

Yes or No

Medical interventions are not an injury, but are undertaken to avoid or address an injury.

Lethality Assessment

Indicate the method of self-harm or suicide attempt:

Asphyxiation – Hanging
Asphyxiation – Other
Cutting
Fire
Ingestion – Prescription Medication
Ingestion – Non-Prescription Medication
Ingestion – Other
Jumping
Other

Most of these are self-explanatory. Ingestion – Other is appropriate for swallowing razors and other foreign objects.

Lethality Risk:

Low Lethality:
- Death is impossible or highly improbable.
- The individual may receive medical attention, but it is not required for survival.
- Frequently, the act is done in a public setting, or is reported by the individual to ensure detection and assistance.
- Examples placed noose loosely around neck and did not attach the other end to another object; swallowed 10 Tylenol pills in front of staff; scratches or superficial cuts on neck or wrist.

Moderate Lethality:
- Death is a possible, but not highly probably, outcome of the act, in the opinion of the average person.
- Opportunity for detection and intervention was not certain.
- Medical or crisis intervention may be required to reduce the risk of death (e.g., pumping stomach, suturing cuts).
- Examples: swallowed 30 Tylenol cut neck and lost significant blood; placed ligature around neck and applied pressure.

High Lethality:
- Death is the probable outcome, although immediate and vigorous medical attention may reduce the risk.
- The individual took measures to avoid detection and intervention, or the method was so lethal that intervention was not likely to prevent death.
- Examples: placed ligature around neck and lost consciousness; attempted to hang self, but stopped when cellmate awoke; took a potentially lethal overdose and did not alert staff.

Examples of Protective Factors (Sanchez, 2001; United States Public Health Service, 1999)

- Strong connections to family and community support
- Sense of belonging, sense of identity, and good self-esteem
- Identification of future goals
- Support through ongoing medical and mental health care relationships
- Easy access to a variety of clinical interventions and support for help seeking
- Skills in problem solving, coping and conflict resolution
- Cultural, spiritual, and religious connections and beliefs
- Constructive use of leisure time (enjoyable activities)
- Effective clinical care for mental, physical and substance use disorders
- Restricted access to highly lethal means of suicide

Narrative should describe and reconcile your assessment of Risk & Protective Factors. This is the opportunity to explain your decision making and make it transparent. Risk and protective factors are not equally weighted and therefore cannot be simply compared on a one to one basis. One protective factor may outweigh several risk factors. Please do a case conceptualization here and use the narrative to make the inmate come to life for a reader.

Low Acute Risk

Suicidal ideation is absent or is of limited frequency, intensity, duration and specificity. There are NO identifiable plans and NO associated intent. There is good self-control based on both self-report and objective assessment. There may be mild symptomatology and morbid rumination may be present. Few risk factors are present and protective factors are identified, including available and accessible social support.

Moderate Acute Risk

Suicidal ideation is frequent with limited intensity and duration. Suicidal plans have some specificity, but NO associated intent. There is good self-control, limited to moderate symptomatology, some risk factors are present, and protective factors are identified, including available and accessible social support. Denial of ideation and intent may be present, if objective markers, such as suicide threats to others and agitation, contradict the self-report.

High Acute Risk

Frequent, intense, and enduring suicidal ideation, specific plans. Many risk factors are identified. Objective markers of risk are present (e.g., lethal method, rehearsal behaviors, saying "goodbye"); self-report of subjective intent may or may not be present. There is evidence of impaired self-control, severe symptomatology, multiple risk factors are present, and few, if any protective factors.

Present - Chronic Rick is present when there is a history of two or more suicide attempts
Absent - Chronic Risk is absent when there is a history of one or zero suicide attempts.

Note: Self-harm behaviors are not counted as suicide attempts.

ALWAYS consult with another psychologist if NOT putting an inmate on suicide watch (and upon release). In order to ensure the availability of a psychologist for consultation, proactively establish a network of psychologist peers both inside and outside of the local institution.

Recommendations:

If suicide risk is present, consider recommending the following interventions:

- Suicide Watch
- Brief Cognitive Behavioral Therapy for Suicide
- Positive Reinforcement
- Safety Plan
- Psychiatric Referral
- Reasons for Living Card
- CBT/DBT Skills Training Groups
- Coping Cards
- Recommendation for Double Cell
- Psychology Alert Code
- Change Care Level (UPDATE Diagnostic and Care Level Formulation)
- Property Restriction (If Returning to Restricted Housing)
- Suicide Risk Management Plan
- Consult with Unit Team
- Assign a Mental Health Cadre

Suicide Watch:

- A suicide watch is not warranted at this time

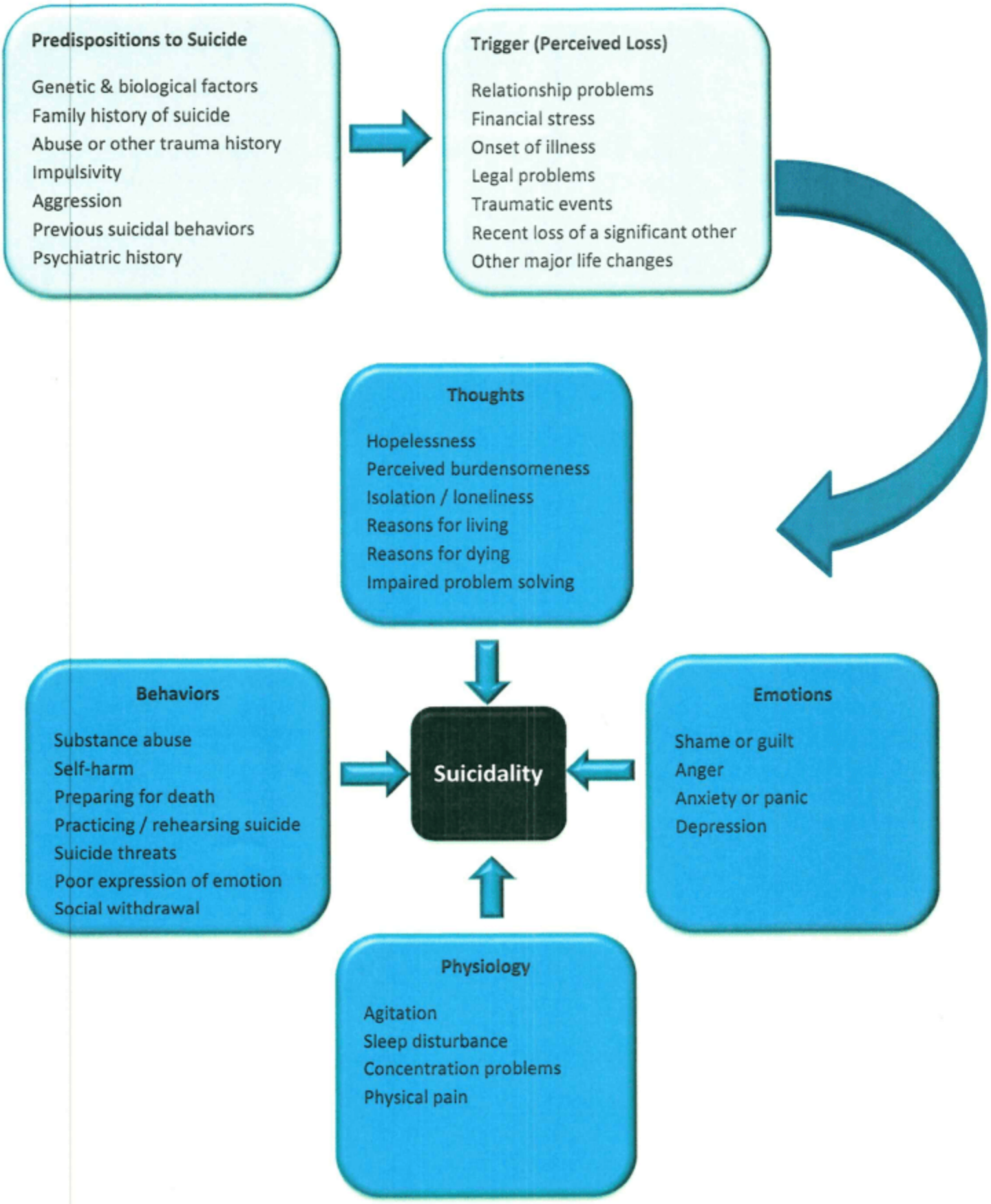
- A suicide watch is to be initiated immediately

- A suicide watch was initiated by non-clinical staff and continues to be warranted

- A suicide watch was initiated by non-clinical staff and is no longer warranted

Date	Notes

The Suicidal Mode



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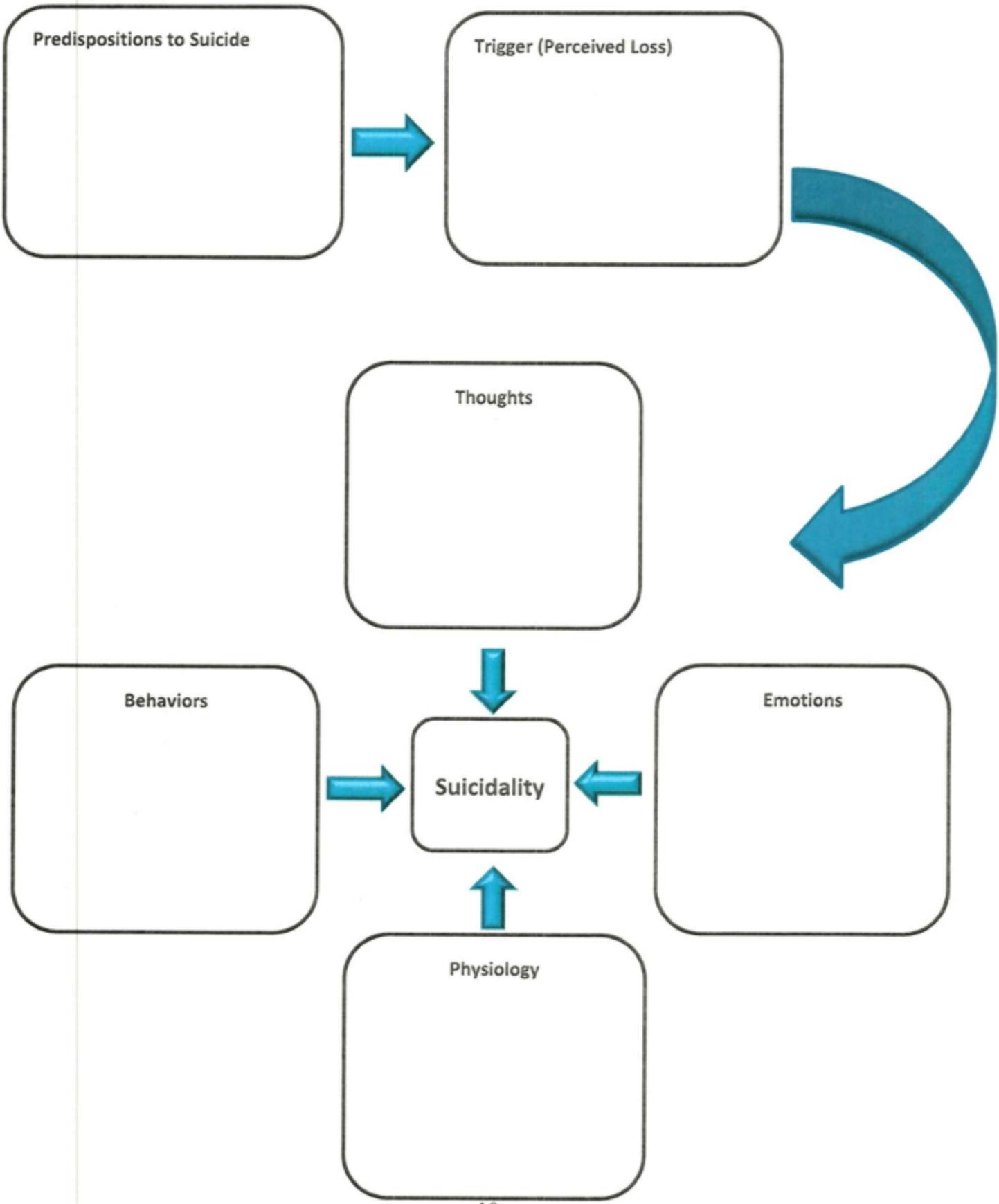

PDS-BEMR POST SUICIDE WATCH REPORT GUIDE

Watch End Date:	Watch End Time: AM/PM

Watch Conducted By:
- Both Inmates & Staff
- Inmate
- Staff

Transferred to a Medical Center: No/Yes

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Narrative for Risk Factors Assessed:

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Present

Chronic Risk is present when there is a history of two or more suicide attempts

Absent

Chronic Risk is absent when there is a history of one or zero suicide attempts.

Reason for referral:

Change in risk factors:

Reason for removal from watch:

Diagnosis:

Recommendations:

Date	Progress Notes

Thanks to Christopher Bush & Scott Forbes in the development of this guide