**RESOURCES**

- Download this card and additional resources at [www.sprc.org](http://www.sprc.org) or at [www.stopasuicide.org](http://www.stopasuicide.org)

**ACKNOWLEDGEMENTS**

- 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**

for Mental Health Professionals

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)**

COPYRIGHT 2009 BY EDUCATION DEVELOPMENT CENTER, INC. AND SCREENING FOR MENTAL HEALTH, INC. ALL RIGHTS RESERVED. PRINTED IN THE UNITED STATES OF AMERICA. FOR NON-COMMERCIAL USE.
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, 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

- **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

- **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 disorders 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., setting, medication, psychotherapy, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.