Offender's Name: _____ GDC ID#_____

SUICIDE RISK ASSESSMENT INSTRUMENT

(complete twice, 1) at initial assessment and 2) at discharge from Suicide Precautions)

Reason for Referral:

___1) Assess need for Suicide Precautions/baseline assessment
___2) Assessment for discharge from Suicide Precautions status (required)

History of Suicidal Behavior

[ ] Previous suicide attempt(s) in free world
Note when and method: _____
_____

[ ] Previous suicide attempt(s) in confinement
Note when and method: _____
_____

[ ] Serious suicide attempt(s) or SIB within past year
Note when and method: _____
_____

RISK FACTORS (Check all that apply)

___Resolved Plans and Preparation

[ ] Fearlessness of physical pain/injury/death
[ ] Availability of means and opportunity
[ ] Specificity of plan
[ ] Preparations for attempt
[ ] Significant intensity and duration of suicidal ideation

___ Suicidal Desire and Ideation

[ ] Can identify no reason for living
[ ] Wish to die
[ ] Talk of death and/or suicide
[ ] Perceives self as burden to others
[ ] Passive attempt, e.g. stops eating/taking fluids

___Current and Recent (within past 6 months) Stressors

[ ] Anniversary of important loss: (specify)_____
[ ] Recent/anticipated rejection/loss/bad news: (specify)_____
[ ] Isolation/segregation placement
[ ] Stressful dorm environment with concerns for safety
[ ] Recent physical/sexual abuse in prison
[ ] Recent negative court hearing outcome
[ ] Anticipated long-term lock-down
[ ] First incarceration
[ ] Known future court proceeding with potential for lengthened sentence
[ ] Chronic, serious or terminal illness
[ ] Limited/lack of support system
[ ] Other: _____

Offender's Name: _____ GDC ID# _____

___ General Symptomatic Presentation

[ ] Initial, recurrent, or exacerbation of clinical disorder
[ ] Feels lonely and alienated
[ ] Feels hopeless/helpless
[ ] No plans for the future
[ ] Depressed mood
[ ] Insomnia
[ ] Nightmares
[ ] Anxious/agitated
[ ] Poor problem-solving/poor judgment
[ ] Fearful for safety
[ ] Unbearable distress
[ ] Diagnosed personality disorder
[ ] Command hallucinations/delusions associated with SIB
[ ] Poor compliance with treatment or medication
[ ] Other: _____

___Other Predispositions to Suicidal Behavior

[ ] Chaotic family history
[ ] Family history of suicide
[ ] History of physical and/or sexual abuse
[ ] Other: _____

___Impulsivity

[ ] Significant current impulsive/violent behavior (physical/verbal aggression)

___Additional Factors/Considerations: _____
_____
_____

PROTECTIVE FACTORS

[ ] Support from family and/or significant others (ongoing, frequent contact)
[ ] Role in caring for children
[ ] Strong religious support and beliefs
[ ] Sense of belonging
[ ] Decreased state of anxiety or distress
[ ] Future life plans
[ ] Has a legal trade
[ ] Healthy stress management (e.g. exercise, reading, drawing, meditation)
[ ] Improved cell/dorm placement
[ ] Other: _____

_____Date: _____
Signature of MH provider completing pages 1 & 2 if other than Psychologist/Psychiatrist/APRN

Retention Schedule: Completed forms shall be placed in the offender's mental health file (section 4). At the end of the offender's need for mental health services and/or sentence, the mental health file shall be placed within the offender's health record and retained for 10 years.

Offender's Name: _____ GDC ID# _____

The following sections including recommendation should be completed only by Psychologist/Psychiatrist/APRN

RISK LEVEL AND INTERVENTION GUIDELINES

Always use in conjunction with clinical judgment.

Mild:

____Non-multiple attempter with ideation of limited intensity/duration, no or mild symptoms of resolved plans and preparation factor, and no/few risk factors.

Recommended Interventions: Coach offender on coping strategies, seeking social support, and best way to access MH staff if symptoms worsen. Establish appropriate interval for follow-up.

Suicide Precautions:

____Multiple attempter with any significant finding and/or general symptomotology.
____Non-multiple attempter with any notable findings or moderate-to-severe symptoms of the Resolved Plans and Preparations factor (see pg 1).
____Non-multiple attempter requiring significant medical intervention
____Other Justification: _____

Recommended Interventions: Placement on Suicide Precautions is mandatory. Increase frequency and/or duration of counseling contacts to address identified stressors and facilitate symptom resolution. Consider referral to Suicide Prevention group. Enhance protective factors. Frequently re-evaluate suicidal risk factors. Consider consultation. Consider medication if not already on it. Carefully document clinical decisions and activities and inform appropriate on-call staff as needed. Determine precautionary measures/restrictions. Provide frequent assessment by a mental health counselor and/or an upper-level provider to determine need for ACU/CSU placement. **IF PLACED IN ACU/CSU, COMPLETE THE SUICIDE PRECAUTIONS ROUNDS FORM (Attachment 3 - M69-01-03)**

Indicate additional interventions below:

[ ] Medication referral/evaluation
[ ] Increase therapeutic contacts to recommended frequency of ___ time(s) per_____
[ ] Initiate/Continue Suicide Precautions placement (recommend to security)
- [ ] 15-minute checks [ ] Constant watch [ ] One-on-one [ ] Other
- [ ] Jump-suit [ ] Paper gown [ ] Suicide proof gown [ ] Booties
- [ ] Normal meals with utensils [ ] Finger foods
- [ ] No personal property [ ] Allowed property:__

Psychologist/Psychiatrist/APRN signature: _____

Printed name: _____Date: _____

Offender's Name: _____ GDC ID# _____

FOR DISCHARGE FROM SUICIDE PRECAUTIONS - complete the Suicide Risk Assessment Instrument a second time in its entirety (Completed only by Psychologist/Psychiatrist/APRN):

Offender was placed on Suicide Precautions on _____ (date) for the following reasons:

_____

Improvement noted in the following clinical areas:

[ ] Reduced/eliminated suicidal ideation
[ ] No current suicidal intent/plans
[ ] No current SIB
[ ] Decreased depression
[ ] Decreased anxiety
[ ] Decreased agitation
[ ] Other:_____
[ ] Decreased fearfulness
[ ] Absence of acute psychotic symptoms
[ ] Improved sleep
[ ] Future orientation
[ ] Cooperation with treatment
[ ] Resolution of situational stressors

Additions/improvements in other protective factors: _____

_____

Remaining issues to be addressed: _____

_____ _____

RECOMMENDATIONS

[for current Suicidal Precautions status, change, or discharge from Suicide Precautions]

[ ] No special interventions or placement needed at this time.
[ ] Medication referral/evaluation
[ ] Increase therapeutic contacts to recommended frequency of ___ time(s) per_____
[ ] Other: _____

[ ] Discharge from Suicide Precaution Status
Follow-up recommendations: _____
_____

Psychologist/Psychiatrist/APRN signature: _____
Printed name: _____Date: _____

This instrument adapted from the work of Joiner Jr. T., Walker, R., Rudd, M., Jobes, D. (1999). Scientizing and routinizing the assessment of suicidality in outpatient practice. Professional Psychology: Research and Practice, 30, 447-452.

Retention Schedule: Completed forms shall be placed in the offender's mental health file (section 4). At the end of the offender's need for mental health services and/or sentence, the mental health file shall be placed within the offender's health record and retained for 10 years.