

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: _____

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___ **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

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**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 symptomatology.

____ 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: _____

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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:

- | | |
|---|--|
| <input type="checkbox"/> Reduced/eliminated suicidal ideation | <input type="checkbox"/> Decreased fearfulness |
| <input type="checkbox"/> No current suicidal intent/plans | <input type="checkbox"/> Absence of acute psychotic symptoms |
| <input type="checkbox"/> No current SIB | <input type="checkbox"/> Improved sleep |
| <input type="checkbox"/> Decreased depression | <input type="checkbox"/> Future orientation |
| <input type="checkbox"/> Decreased anxiety | <input type="checkbox"/> Cooperation with treatment |
| <input type="checkbox"/> Decreased agitation | <input type="checkbox"/> Resolution of situational stressors |
| <input type="checkbox"/> Other: _____ | |

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.