

# Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)

## *A Quick Guide for Clinicians*

### Step 5: Document

- Risk level and rationale; treatment plan to address/reduce current risk; firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include role for patient/guardian
- Documentation should occur at first assessment and/or triage, whenever there is a change in clinical state, with any major shifts in treatment plan, at any change in the level of care, and before terminating a relationship.

### Question-Asking Strategies

- Other people have similar problems sometimes lose hope; have you?
- Are you feeling hopeless about the present or future?
- This must be a hard time for you; what do you think about when you're feeling down?
- With this much stress, have you thought of hurting yourself?
- Have you had thoughts about taking your life?
- When did you have these thoughts and do you have a plan to take your life?
- What would happen to your family or significant others if you did that?
- What has kept you from acting on these thoughts?
- Have you ever had a suicide attempt?

### Step 1: Identify Risk Factors

Note those that can be modified to reduce risk

### Step 2: Identify Protective Factors

Note those that can be enhanced

### Step 3: Conduct Suicide Inquiry

Suicide thoughts, plans, behaviours, and intent

### Step 4: Determine Risk Level/Intervention

Determine risk. Choose appropriate intervention to address and reduce risk

### Step 5: Document

Assessment of risk, rationale, intervention, and follow-up

Suicide assessment and documentation should occur at first assessment and/or triage, whenever there is a change in clinical state, with any major shifts in treatment plan, at any change in the level of care, and before terminating a relationship.

### Step 1: Identify Risk Factors

- Suicidal behaviour: history of prior suicide attempts or self-directed violence
- Current/past psychiatric disorders: especially mood disorders, psychotic disorders, alcohol and substance abuse, ADHD, PTSD
- Key symptoms: anhedonia, impulsivity, aggression, hopelessness, anxiety, insomnia
- Family History: of suicide, attempts, child maltreatment, or Axis I psychiatric disorders requiring hospitalization
- Stressors: triggering events leading to humiliation, shame, or despair. Ongoing medical illness. Intoxication. Family distress. History of physical or sexual abuse. Social isolation. Loss of primary relationships, culture, or sense of community.
- Access to firearms, pesticides, or other lethal means

### Step 2: Identify protective factors

- Family and community support, feelings of connectedness
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes and coping with stress
- Cultural and religious beliefs that discourage suicide and support instincts for self-preservation
- Responsibility to children or beloved pets

### Step 3: Conduct Suicide Inquiry

- Ideation: frequency, intensity, duration (in the last 48 hours, past month, and worst ever)
  - “What kinds of thoughts have you been having?”
  - “How long have you been having these thoughts? When did they first start?”
- Suicide Plan: timing, location, lethality, access to means, preparatory acts
  - “Do you have a plan of how you would kill yourself?”
  - “Do you have any firearms or other weapons at home?”
- Intent: extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal or self-injurious
  - “In the next 24-48 hours, how likely is it that you will act on your suicide plan?” (Ask the patient to rate the likelihood on a scale of 1 to 10, with 1 being very unlikely and 10 being certain.”
  - Explore ambivalence: reasons to die vs. reasons to live.

### Step 4: Determine Risk Level/Intervention

- Assessment of risk level is based on clinical judgment, after completing steps 1-3

RISK LEVEL	RISK/PROTECTIVE FACTORS	SUICIDALITY	POSSIBLE INTERVENTIONS
<b>HIGH</b>	Psychiatric disorders with severe symptoms, or acute precipitating event	Potentially lethal suicide attempt or persistent ideation with strong intent or rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions.
<b>MODERATE</b>	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behaviour	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
<b>LOW</b>	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behaviour	Outpatient referral, symptom reduction. Give emergency/crisis numbers.