There is no standardized interview for completing the Suicide Assessment Template. In order to assist the clinician doing the assessment, a series of questions applicable to each aspect of the suicide risk assessment is offered below. The intent is for these questions offer suggestions for how to inquire about any areas of the risk assessment and an aid for the clinician in establishing a dialogue with the patient about his/her suffering and suicidality.

These illustrations are not to be understood as prescriptive. They are by no means the only way of asking the patient about suicidality. This is not a recommendation to ask these questions from the start of the first box through the end of the template in the exact sequence described, or to even ask all of the questions that are listed here. These questions are not part of a validated, structured instrument for the assessment of suicide risk. They are questions culled from clinical experience, VHA/DoD Clinical Practice Guidelines for Depression and Psychosis, from various scales such as the SCID, Beck and Hamilton Depression Inventories, Barrett's Impulsivity Scale, as well as other suicide assessments.

A good suicide assessment is based upon a good psychiatric/clinical interview. It begins with determining the chief complaint of the patient. The interview than covers the current symptoms, life circumstances and stressors, past history—psychiatric, medical, social, vocational and educational, family, developmental, financial, spiritual, etc., with the evaluation of suicide woven into the concomitant elicitation of the patient's circumstances. Concerns about suicide can arise from the chief complaint, e.g. the patient states "I feel like committing suicide," to past history e.g. "I took an overdose when I was 14, went to sleep, and no one found out", to spiritual e.g. "I feel like God has left me, and now nothing feels like it means anything", or any other area.

The basic strategy for elucidating an individual's suicide risk involves eliciting his or her statements about suicidality, evoke the patient's ideas about what would attenuate suicidal ideation/intent, as well as what exacerbates it, and wherever possible gather collateral data to confirm patient's story.

A possible sequence of questions following this strategy is:

- *What brings you here?* (to begin inquiry into chief complaint). After establishing what is troubling the patient be it psychiatric symptomatology, a medical condition, substance abuse, a social or environmental situation—
- *Are you discouraged about your …*(fill in problem elicited above)
- *Are there times when you feel like crying (feel hopeless, feel worthless) because of this situation?*
- *At those times, what thoughts go through your head?*
- *Have you ever felt that if things don't change life is not worth living?*
- *Have you ever wished you were dead?*
- *Have you reached a point where you want to kill yourself?*
- *Have you reached a point where you have devised a plan to end your life?*
- *How would you do it?*
- *Do you have the necessary items for completion of the plan available?*

Patient Information:

Current Suicidal Ideation/Intent/Plan: (patient may be at risk for suicide without voicing ideation, intent or plan)

Ideation yes [ ] no [ ]

{if yes to ideation then the options of passive or active will appear, and the positives will be checked off and described. For a yes at least one would need to be checked but both could be applicable}

Passive yes [ ] no [ ]
Active yes [ ] no [ ]
Intent yes [ ] no [ ]
Plan yes [ ] no [ ]

Describe: *free text required*
[NO's will be included in the note generated from template]

- Have you ever felt that if things don't change life is not worth living?
  - …that life has no meaning?
  - …that life has no purpose?
- Have you ever wished you were dead?
  - Have you imagined dying by accident?
  - Have you imagined getting a terminal illness?
  - Have you ever thought you wouldn't be missed?
  - …that those around you would be better off if you were gone?
- Have you reached a point where you want to kill yourself?
- Have you reached a point where you have devised a plan to end your life?
  - Have you been giving things away?
  - Have you arranged to see someone, almost as a farewell?
  - Have you prepared a suicide note?
  - A will?
- How would you do it?
- Do you have the necessary items for completion of the plan available?
  - Have you gone about assembling the items in your plan?

Longstanding, Chronic Risk Factors: *these factors place the person at an increased risk for suicidal behavior. They are relatively immutable trait type characteristics (the exception being an illness that enters remission)*

Previous Suicide Attempts: (describe circumstances, stressors and means of previous suicide attempts, in particular the details of the most recent attempt prior to the current one, including response to treatment interventions) *free text required*

- Have you ever tried to kill yourself before?
  - Have you ever had an accident that was life threatening? (e.g. car accident, fall, accidental overdose, life threatening allergic reaction to a known allergen, etc.)
- How did you do it?
- What is your understanding of what led to the attempt?
- What was going on in your life at the time of your attempt?
- What enabled you to remain alive?
- How did you feel when you found out you survived?
- Who knew/knows about that attempt?
- Did you receive any treatment after that attempt?
- How did the treatment help?
- Did you make any changes in your life after your suicide attempt?

- Did the suicide attempt lead to any changes in your life?
- Were there any other suicide attempts?

Impulsivity:	**Violence**	**yes [ ]**	**no [ ]**
	Verbal Aggression	yes [ ]	no [ ]
	Head Injury	yes [ ]	no [ ]
	Smoking	yes [ ]	no [ ]
	Impulsive behaviors	yes [ ]	no [ ]

Describe: *free text required for positives*
[NO's will be included in the note generated from template]

- Have you ever been angry with other people?
- Do you get angry more frequently than other people you know?
- When you get angry to express it verbally?
- Do you shout at other people? Curse?
- Do other people get afraid of you?
- Do you hit things, like punching a wall? Throw things? Break things?
- Have you ever thrown things at other people?
- Hit other people?
- Hurt someone when you hit them?
- Severely injured someone?
- Killed them?
- Been arrested for any of these acts?

In regards to evaluating for impulsivity

- Do you tend to be restless?
- Do you tend to be impatient?
- Do you tend to blurt out things that you're thinking?
- Do you tend to act before thinking things through?
- When you want something, do you need to get it right now?
- Do you think about the consequences of your actions before you do them?
  - …whether they get you what you want?
  - …their impact on others people?
- Are you good at making plans to achieve your goals?
- Can you do something difficult, if you know it will feel better later?
  - How much later?

And Specific impulsive behaviors?

- Do you smoke cigarettes?
- Do you drink alcohol?
- Do you use drugs?
- Do you binge on alcohol and drugs? (etc.)
- Do you overeat?
  - Binge eat?
  - Purge? (vomiting, laxatives, diuretics)
- Do you gamble?
  - Ever lose more than you want to?
  - …more than you can afford?
- Do you think you have a greater need for sex than other people?
  - Does this ever interfere with other areas of your life?
  - Create problems with other people?
  - Create problems for you?

Illness:		
	[ ]Depression	[ ] Substance Abuse
	[ ] Psychosis	[ ] Alcohol Abuse
	[ ]Bipolar Disorder	[ ] Serious medical Illness
	[ ]Cluster B personality	[ ] Pain

Describe: *specify, free text optional except for serious medical illness which should be described.*
[only positives will be incorporated in note]

If there are questions about diagnosis please see DSM-IVTR or the appropriate VHA/DoD clinical practice guideline.

Acute Factors: *these are factors that place a person in a more acute risk of suicide. They are not as longstanding, tend to be more mutable, and are targets for treatment. When identified in a person at risk, the treatment plan should describe how these factors will be addressed.*

Symptoms:	psychic anxiety	yes [ ]	no [ ]
	panic	yes [ ]	no [ ]
	hopelessness/demoralization	yes [ ]	no [ ]
	insomnia	yes [ ]	no [ ]
	obsessionality	yes [ ]	no [ ]
	alcohol use	yes [ ]	no [ ]
	hallucinations	yes [ ]	no [ ]
	pain	yes [ ]	no [ ]

Describe: *free text for all yes responses*
[NO's will be included in the note generated from template]

Psychic Anxiety

- Have you felt particularly anxious or nervous?
- Do you frequently worry that bad things will happen?
  - Do you have a hard time stopping this worry?
- Do you feel keyed up or on edge?
  - Do you often feel restless?
  - Physically tired?

Panic

- Have you had a panic attack, when you suddenly felt frightened or anxious or suddenly developed a lot of physical symptoms?
- Have these attacks come out of the blue—in situations where you didn't expect to be nervous or uncomfortable
  - Did you worry that there might be something terribly wrong with you like you might be having a heart attack or going crazy?
  - Did you worry a lot about having another one?
  - Did you do anything differently because of the attacks

Hopelessness/Demoralization

- Do you feel discouraged about the future?
- Do you feel that you have nothing to look forward to?
- Do you feel like you've tried everything?
  - And nothing has worked?
  - And there is nothing left to try?
- Do you feel that the future is hopeless and can't improve?
- Do you feel like you just want to give up?

Insomnia

- Do you sleep as well as you usually do?

- Do you have trouble falling asleep?
- Do you wake during the night?
  - Get out of bed?
  - How often
- Are you able to go back to sleep?
- Do you wake up several hours earlier than usual and can't fall back to sleep?

Obsessionality

- Have you been bothered by thoughts that didn't make sense to you, but kept coming back to you even when you tied not to have them?
  - E.g. thoughts like hurting someone even though you didn't want to, or contamination by germs or dirt?
  - Constantly replaying conversations or events over and over, even when you don't want to think about it?
- Did you try hard to get these thoughts out of your head?
  - What would you try to do?
  - Where did you think these thoughts were coming from?
- Do you have to do things in a very particular way, or in a very defined sequence in order to feel comfortable with how it will turn out?
- Have you been paying more attention to details recently?
  - Has this gotten in the way of accomplishing the tasks you set out to do?

Alcohol Use

- Do you drink alcohol?
  - How much and How often?
- Have you been drinking more than usual?
  - How much and How often?
- Have you had more than five drinks on one occasion?

Hallucinations

- Do you hear things that other people don't hear?
  - E.g. noises, voices of people whispering or talking?
- What did you hear?
  - How often did you hear it?
  - What did they say?
  - Did you recognize the voices?
  - How many were there?
- Were they talking to you?
  - …to each other?
- Did they ever tell you to do things?
  - Did you ever act on what they told you?
  - What did they tell you to do?

Pain

- Are you in pain?
- Do you receive treatment for the pain?
  - What is the treatment?
  - Is it effective
- Has your pain changed recently?

- Has your ability to tolerate the pain changed recently?

Social: check all that apply

[ ] Poor Social Support [ ] Isolation
[ ]Environmental change [ ] Recent discharge
[ ] Recent loss [ ] Acute life stressors
[ ] Family history of suicide

Describe: *free text required if positive responses.*

- Have you recently been discharged from the hospital?
- What is your current living situation?
  - How long have you been there?
  - Has anything in this situation changed recently?
  - How has that been for you?
- Who do you count on when you need help?
  - Have there been any changes in those relationships recently?
- How is your relationship with your family, spouse, significant other, parents children, friends?
  - Have there been any changes in your relationship with your family?
    - …Spouse, significant other?
    - …parents or children?
    - …friends
- How is work (or school, finances)
  - Has anything changed here recently?
  - How has that been for you?
- Has anyone or anything close to you (important to you) died?
  - …left you?
- Have you received any troubling news recently?
- Did anyone in your family ever kill themselves?

Medication Factors: [ ] adherence to medication
yes [ ] no [ ]
[ ] recent Lithium withdrawal
[ ] recent medication change
[ ] pain management (where applicable)

Describe: *free text required*

Patients nonadherent with medication are at increased risk, since nonadherence prevents treating the symptoms or illnesses placing the individual at risk, and indicates problems in the therapeutic alliance. In addition, nonadherence can reveal patients stockpiling of medications as a means for a suicide attempt. Recent Lithium withdrawal in Bipolar individuals increases risk of suicide at least fivefold (5) over 4-6 months (with some estimates in the literature going out to 1 year). There is evidence that lithium responsiveness and clozapine responsiveness are mitigating factors in suicide risk. Patients requiring pain management may be at increased risk because of chronic pain or abuse of pain medications.

Personal Risk Factors: (particular factors that have triggered previous suicidal behavior or are leading to current suicide risk; may include idiosyncratic circumstances predictive only in this patient. This involves an individualized constellation of factors, usually both chronic factors and a combination of acute factors that have led to current or previous suicidal impulses and/or the attempts described above, if applicable)

Describe: *free text required*

In examining suicidal individuals, researching suicide, and performing psychological autopsies, many patients demonstrate particular circumstances that enhance suicidal propensities and behavior. These are peculiar to each individual and may entail particular embarrassments or humiliations, specific types of interactions with particular individuals, some reminder of traumatic experience, whether overt or covert, and many other possibilities. It is these constellations that illuminate the nature of the psychic pain the patient experiences, the circumstances that make it unmanageable and cause suicidal impulses to outweigh the mitigating factors in a person's life. These factors are important to elucidate in assessing the risk of the current situation, and for treatment planning, especially if they are amenable to intervention.

Firearms: Currently Available yes [ ] no [ ]
Removed yes [ ] no [ ]

Describe: *free text required*
[NO's will be included in the note generated from template]

- **Do you own a gun?**
- **Where is it?**
- **Can you have a family member/friend turn it into a police station?**
- **Can you give it to a family member/friend/ for safekeeping?**
- **Can you remove it from the house?**
- **Will you remove the ammunition from the house?**
- **Can we call that person now to do this?**
- **How will we go about doing this?**

Access to other Means: Currently Available yes [ ] no [ ]
Removed yes [ ] no [ ]

Describe: *free text required*
[NO's will be included in the note generated from template]

Mitigating Factors: (alternatives to suicide, plans and hopes for future, beliefs supportive of continued living, religious beliefs, reasons to continue living, dependant children, psychic toughness, other)
Describe: *free text required*

These are all the factors that diminish the risk of patients acting on suicidal feelings or impulses, or of reaching the level of suicidal behavior in the face of high risk symptoms, diagnoses, and circumstances. None are absolute and must be judged against the circumstances contributing to risk. Included in mitigating factors are good relationship with caregiver, a good therapeutic alliance, intact social supports, problem solving and coping skills, and awareness that suicide is a product of an illness (2,4,5)
Psychic Toughness is best defined as the demonstrated lifelong resiliency to pain, stress, discomfort and the problems of life. It refers to those who can take the difficulties, usually manage them and continue functioning. It also refers to the capacity to endure distressing experiences and circumstances, as well as the quantity of intense affect a person can bear.
Many of these factors are inferential, but certain ones can be asked directly of a patient. The difficulty with some of these questions is that they need to be asked in a particularly empathic manner, and not necessarily in the generic phrasing described below. Suicidal individuals can be extremely sensitive to empathic breaks, or hearing things as shoulds, which can enhance feelings of guilt and inadequacy.

- Is there anything you are looking forward to?
- Do you have anything important coming up?
- What has helped you resist your suicidal feelings up until now?
- When you are not feeling this badly, what has been the things you most valued, or were most important in your life?
- Does spirituality or religion play a role in your life?

- Who would miss you when you're gone? (relates to questions listed above)
- Have you discussed these feelings with anyone in your life?
- Have you thought of any ways do handle (whatever the circumstances are) without having to kill yourself?
- If there was a way of handling (whatever the circumstances are) that did not involve killing yourself would you be willing to try?
    - Is there someone we could call for help with this?

Category of Risk: (the first check off is if there are acute factors, identified above, currently active that need to be addressed)

[ ] Acute Factors Current

(the next two categories refer predominantly to the long-term or diathesis type risk, rather than aspects of more acute suicide risk)

[ ] Baseline Increased Risk

[ ] Limited risk

There is no fixed formula for determining the level of suicide risk and this evaluation requires good clinical judgment. Generally it is related to the level of pain the individual is in, that individual's ability to bear the pain, while finding ways to solve or endure the problems (symptoms and circumstances) leading to the current state, without attempting to end the pain by ending one's life. Like physical pain, psychic pain does not follow a pure lesion model; symptoms and stressors that are unendurable for one patient may be quite endurable for another.

Roughly the level of suicide risk is proportional to the amount of distress from the patients psychiatric symptoms and distress from environmental, psychological and social stressors, and inversely proportional to the ability to endure those stressors, and the mitigating factors.

This is the stress aspect. The diathesis is the factors that make it less likely that the person will be able to endure the stressors of life. These are the risk factors of the psychiatric illnesses listed above, the trait of aggressive impulsivity and behaviors associated with this, a history of previous suicide attempts, and a family history of suicide.

The diathesis factors are relatively immutable and are facts of the patients' life. A psychiatric diagnosis plus any of the other factors places a patient in a chronic high risk category. The psychiatric diagnosis itself, particularly if the patient remains symptomatic, or if any acute factors are present, may be enough for a clinician to make the judgment that a patient is a chronic high risk. It is important to note that the psychiatric diagnosis, despite being a longstanding issue is mutable; adequate treatment may place the illness in complete remission. For a patient in complete remission of their psychiatric syndrome, it can be appropriate to lower their chronic risk level. Such a remission frequently strengthens the patient's therapeutic alliance, hopefulness, and of course, diminishes their psychic pain.

The assessment has two tasks. The first is to help in identifying those patients who are chronic high risk individuals. The second is to help identify those individuals developing a clinical picture that places them more acutely at risk. This is where the presence of acute factors occur within the setting of the presence of diathesis or chronic factors. The greater the number and severity of the acute factors and the lesser the number and strength of the mitigating factors the higher the risk. This is a complex and subtle clinical judgment, and management is geared towards enhancing the mitigating factors and ameliorating the acute factors, as well as treating the diathesis factors as assertively as possible.

Some patients that are acutely high risk, communicate directly or indirectly that they are suicidal right now. The goal of treatment is immediate containment and relief of the most acute factors. Containment may require hospitalization, but with cooperation from patient, family, significant others, and or staff, frequently hospitalization can be avoided.

In general, managing suicidality in the community wherever possible is a more efficacious way of addressing the acute and chronic factors that drive the suicidal behavior.

Acute Factors Current: This concretely identifies those patients where there are active and current Acute Risk Factors affecting the clinical picture. As a clinician does the suicide risk assessment, it will become clear which patients endorse enough acute risk factors (and frequently longstanding factors as well) that they create significant near term concern in regards to their potential suicidality. At that instant the clinician will initiate treatment, and interventions designed to ameliorate and contain the patient's suicide risk, by addressing those factors, biological, psychological or social that enhance the risk. The suicide assessment helps collect and document the targets for such intervention.

Baseline Increased Risk is related to the diathesis factors described above. Management involves the assertive treatment of the psychiatric disorder, and sensitivity to any new emergence of acute risk factors or disruption in mitigating factors. There is no algorithm or formula for deciding when a patient is in this category. Having previous suicide attempts generally will place a person in this category. Having a serious mental illness or a substance disorder does not automatically place one in this category. Having a high level of impulsivity does not automatically place on in this category. Having both a serious illness and a high level of impulsivity, along with any other factors is likely to place an individual in this category. It is important to be vigilant about follow-up with veterans in this category: missed appointments should be addressed with immediate phone calls and timely rescheduling. For patients where phone contact fails, alternate means of communication should be utilized wherever possible.

Limited Risk are veterans with some diathesis factors but have not reached the level of concern with suicidality that the chronic high risk veteran has. They may be impulsive or have an illness that puts them at higher than expected risk, but very limited current problems and no previous history of suicide. Another possibility is the history of suicide had low intent, low lethality many years ago, and the patient's current symptoms and illness are fairly stable.

It may also include patients with above diagnoses in remission or recovery. They may be patients where the mitigating factors so outweigh the risk factors that the clinician does not judge them to rise to the level of concern of a chronic high risk individual. This category would also include veterans who have no history of suicide, low impulsivity, well stabilized psychiatric illnesses, and strong mitigating factors.

Interventions and Plan: see progress note of (*date of note)* The progress note should document the steps taken towards ensuring the patients safety, their level of cooperation with these procedures, steps taken towards relieving the factors creating the acute distress. A complete treatment plan involves addressing the acute factors, treating the underlying psychiatric illness, decreasing access to means, enhancing the mitigating factors. For patients who are acutely at risk, these aspects should be addressed immediately with plans for follow-up described. It is impossible to treat everything all at once, so it is reasonable to treat the most important, highest risk and distressing aspects first, and then move on to other issues as patient improves.