Suicide Risk Assessment

ID# 230

Columbia Suicide Risk Assessment

☑ Columbia Suicide Risk Assessment

Date assessed:

Ask Questions 1 and 2

1. Within the past month, have you wished you were dead or wished you could go to sleep and not wake up? Y | N

2. Within the past month, have you actually had any thoughts of killing yourself? Y | N

If YES to 2, ask questions 3, 4, 5, and 6. If NO, go directly to question 6.

3. Have you been thinking about how you might kill yourself? Y | N

4. Have you had these thoughts and had some intention of acting on them? Y | N

5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? Y | N

6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? Y | N

If YES, How long ago did you do any of these?

- ☐ Over a year ago
- ☐ Between three months and a year ago
- ☐ Within the last three months

Additional information / Follow Up:

Complete

Crisis Planning

Safety Plan

The Guidance Center

Triggers:

When these things happen, I am more likely to feel unsafe or upset

- ☐ **Not being listened to / not having control**
- ☐ **Loud noises**
- ☐ **Problems at work or school**
- ☐ **Feeling unwell**
- ☐ **Difficulties with partner, family, friends , or co-workers**
- ☐ **Loss of a loved one**
- ☐ **Financial stressors**
- ☐ **Being isolated / feeling lonely**
- ☐ **Relapse**
- ☐ **Being stared at or touched**
- ☐ **Darkness**
- ☐ **People yelling / arguments**
- ☐ **Cravings for illicit substance**
- ☐ **Feelings of shame, guilt, and / or regret**
- ☐ **Particular Person:** _____
- ☐ **Time of Day and / or Year / Anniversary Loss:** _____
- ☐ **Other:** _____

Inside Warning Signs:

These are things **I may notice** just before I feel unsafe or upset

- ☐ **Thoughts of hurting myself/others**
- ☐ **Hallucinating**
- ☐ **Negative thoughts**
- ☐ **Feeling confused**
- ☐ **Feeling anxious, nervous, or paranoid**
- ☐ **Wanting to destroy things**
- ☐ **Feeling unwell**
- ☐ **Cravings to use drugs and / or alcohol**
- ☐ **Change in appetite**
- ☐ **Poor self-esteem / self defeating thoughts**
- ☐ **Nightmares / flashbacks**
- ☐ **Other:** _____

Outside Warning Signs:

These are things **other people may notice** just before I feel unsafe or upset

- ☐ **Change in appearance**
- ☐ **Eating more / less**
- ☐ **Refusing to take my medication**
- ☐ **Sleeping more / less**
- ☐ **Feeling someone is out to get me**
- ☐ **Using drugs and / or alcohol**
- ☐ **Change in physical behavior**
- ☐ **Change in emotional behavior**
- ☐ **Displaying in aggressive behaviors**
- ☐ **Feeling overwhelmed or apathetic**
- ☐ **Disengaging from family and friends**
- ☐ **Other:** _____

Risk Assessment:

The following checked items increase my risk for crisis

- ☐ **Access to firearms or sharp objects**
- ☐ **I feel I am in an unhealthy relationship**
- ☐ **Access to drugs or illegal substances or history of illicit substance abuse**
- ☐ **Medication changes or not taking prescribed medication**
- ☐ **No identified natural supports / family not getting along**
- ☐ **Being isolated for a long period of time**
- ☐ **Recent loss of person, home, job, or belonging**
- ☐ **Legal involvement**

Crisis Planning

Safety Plan

The Guidance Center

Risk Assessment (continued):

- ☐ **Prior or current suicidal ideation**
- ☐ **Family history of suicide or prior / current suicide attempts**
- ☐ **Major Depressive Disorder Diagnosis**
- ☐ **Financial difficulties**
- ☐ **Sleep difficulties**
- ☐ **History of military training**
- ☐ **Other:** _____

Things that help me feel better and stay more in control:

These are things that help me calm down, stay safe, or things I might like to try in the future

- ☐ **Talking with friends, family, & peers**
- ☐ **Relaxing**
- ☐ **Taking my medication**
- ☐ **Deep breathing**
- ☐ **Exercising**
- ☐ **Talking to my therapist or support staff**
- ☐ **Partaking in my favorite hobby**
- ☐ **Other:** _____

Helpful things in life and keeps you safe:

- ☐ **Sense of meaning and purpose in life**
- ☐ **Religious or spiritual practice**
- ☐ **Identified natural supports/supportive family**
- ☐ **Positive help-seeking behaviors**
- ☐ **Stable housing**
- ☐ **Stable income**
- ☐ **Sense of hope**
- ☐ **Doing well at school or work**
- ☐ **Good health care practices**
- ☐ **Engagement in activities**
- ☐ **Other:** _____

Crisis Contacts:

These are the names and numbers of individuals I can contact during a crisis

1. Call **911** for immediate physical danger
2. Present to the Emergency Room at the nearest hospital for assistance and evaluation

Hospital Name: _____ Hospital Address: _____

3. Call the **24-hour Crisis Hotline at 1-814-362-4623** or 1-800-459-6568 for assistance
4. Contact my **Program Staff at 814-362-6535** for support
5. Emergency Contact Info: _____

NAME NUMBER

Signature:_____

Questions?
Call today at 814-362-6535

AUDIT-C Questionnaire

Patient Name _____ Date of Visit _____

1. How often do you have a drink containing alcohol?
   - ☐ a. Never
   - ☐ b. Monthly or less
   - ☐ c. 2-4 times a month
   - ☐ d. 2-3 times a week
   - ☐ e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?
   - ☐ a. 1 or 2
   - ☐ b. 3 or 4
   - ☐ c. 5 or 6
   - ☐ d. 7 to 9
   - ☐ e. 10 or more

3. How often do you have six or more drinks on one occasion?
   - ☐ a. Never
   - ☐ b. Less than monthly
   - ☐ c. Monthly
   - ☐ d. Weekly
   - ☐ e. Daily or almost daily

Fagerstrom Test for Nicotine Dependence

	PLEASE TICK (✓) ONE BOX FOR EACH QUESTION	
How soon after waking do you smoke your first cigarette?	Within 5 minutes 5-30 minutes 31-60 minutes	☐ 3 ☐ 2 ☐ 1
Do you find it difficult to refrain from smoking in places where it is forbidden? e.g. Church, Library, etc.	Yes No	☐ 1 ☐ 0
Which cigarette would you hate to give up?	The first in the morning Any other	☐ 1 ☐ 0
How many cigarettes a day do you smoke?	10 or less 11 – 20 21 – 30 31 or more	☐ 0 ☐ 1 ☐ 2 ☐ 3
Do you smoke more frequently in the morning?	Yes No	☐ 1 ☐ 0
Do you smoke even if you are sick in bed most of the day?	Yes No	☐ 1 ☐ 0
	Total Score	

SCORE	1- 2 = low dependence 3-4 = low to mod dependence	5 - 7= moderate dependence 8 + = high dependence

Add up the scores from the questionnaire.

Information about scoring the Test is on the next page.

Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? _____

LEC-5 Standard

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war-zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden violent death (for example, homicide, suicide)						
15. Sudden accidental death						
16. Serious injury, harm, or death you caused to someone else						
17. Any other very stressful event or experience						

Adults ONLY

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Children ONLY

Patient Health Questionnaire:

modified

Name: _____ Clinician: _____ Date: _____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the past year have you felt depressed or sad most days, even if you felt okay sometimes?

[ ] Yes [ ] No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life?

[ ] Yes [ ] No

Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

[ ] Yes [ ] No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: Severity score: _____

Appendix

WellRx Questionnaire

DOB_____ Male___ Female _____

WellRx Questions

1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?

_____ Yes _____ No

2. Are you homeless or worried that you might be in the future?

_____ Yes _____ No

3. Do you have trouble paying for your utilities (gas, electricity, phone)?

_____ Yes _____ No

4. Do you have trouble finding or paying for a ride?

_____ Yes _____ No

5. Do you need daycare, or better daycare, for your kids?

_____ Yes _____ No

6. Are you unemployed or without regular income?

_____ Yes _____ No

7. Do you need help finding a better job?

_____ Yes _____ No

8. Do you need help getting more education?

_____ Yes _____ No

9. Are you concerned about someone in your home using drugs or alcohol?

_____ Yes _____ No

10. Do you feel unsafe in your daily life?

_____ Yes _____ No

11. Is anyone in your home threatening or abusing you?

_____ Yes _____ No

BASELINE

CLIENT ID: _____ CLIENT INITIALS: _____

DATE OF REASSESSMENT: _____

☐ADULT ☐CHILD*

The Guidance Center

The National Outcome Measurements (NOMs survey) is a quality standards measurement tool required by our federal funding source. Data collected using the NOMs is used to guide programs and services offered by The Guidance Center so we can assure we are meeting the needs of our clients and our community. Clients are selected at random and all identifying personal information is removed before responses are submitted to our funding source. If you would prefer to complete this survey in a face-to-face interview, please let the receptionist know and they will connect you with an interviewer. ***Participation in the NOMs interview is voluntary and is in no way connected to your ability to receive services through The Guidance Center.***

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* For children under the age of 11, this survey must be completed by a caregiver. For children ages 11-17, the survey may be completed by the child or the caregiver.

Who completed this survey? ☐ Child ☐ Caregiver

DEMOGRAPHIC DATA

1. What do you consider yourself to be?

○ Male ○ Transgender (male to female) ○ Gender non-conforming ○ Decline to answer
○ Female ○ Transgender (female to male) ○ Other (please specify):

2. Do you think of yourself as:

○ Straight or Heterosexual ○ Queer ○ Asexual
○ Homosexual (Gay Or Lesbian) ○ Pansexual ○ Something else (please specify):_____
○ Bisexual ○ Questioning ○ Decline to answer

3. Are you [is your child] Hispanic, Latino/a, or of Spanish origin?

○ Yes ○ No ○ Decline to answer

3a. If you are [your child is] of Hispanic, Lationo/a, or Spanish origin, what ethnic group do you [your child] consider yourself [themselves]? You may indicate more than one.

○ Central American ○ Dominican ○ Cuban ○ Mexican
○ Puerto Rican ○ South American ○ Other (Please specify): ○ Decline to answer
_____

4. What is your [your child's] race? You may indicate more than one.

○ Black or African American ○ South Asian ○ Korean ○ Guamanian or Chamorro
○ White ○ Chinese ○ Vietnamese ○ Samoan
○ American Indian ○ Filipino ○ Other Asian ○ Other Pacific Islander
○ Alaska Native ○ Japanese ○ Native Hawaiian ○ Decline to answer
○ OTHER (Please specify): _____

5. [CLIENTS 5 YEARS OLD OR OLDER] Do you [does your child] speak a language other than English at home?

○ Yes ○ No ○ Not Applicable

5a. IF QUESTION 5 IS YES, What is this language?

○ Spanish ○ Other (please specify):

6. [ADULT CLIENTS ONLY] Have you ever served in the Armed Forces, the Reserves, or the National Guard?

○ Yes ○ No ○ Don't know ○ Not Applicable

7. [ADULT CLIENTS ONLY] Are you currently serving on active duty in the Armed Forces, the Reserves, or the National Guard?

○ Yes ○ No ○ Decline to answer ○ Don't know

SECTION A: FUNCTIONING

1. How would you rate your [your child's] overall mental health right now?

○	○	○	○	○	○
Excellent	Very Good	Good	Fair	Poor	Decline to answer

2. Please indicate your [your child's] response to each of the following statements regarding how you [they] have been functioning over the past 30 days:

During the past 30 [thirty] days	Yes	No	Decline to answer
I am [my child is] handling daily life.	○	○	○
I am [my child is] able to deal with unexpected events in my [their] life.	○	○	○
I [my child does] get along with friends and other people.	○	○	○
I [my child does] get along with family members.	○	○	○
I do [my child does] well in social situations.	○	○	○
I do [my child does] well in school and/or work.	○	○	○
I have [my child has] had a safe place to live.	○	○	○

3. Please indicate how you have [your child has] been feeling over the <u>past 30 days</u>:

During the past 30 [thirty] days, did you [your child] feel ...	Yes	No	Decline to answer
Nervous?	○	○	○
Hopeless?	○	○	○
Restless or fidgety?	○	○	○
So depressed that nothing could cheer you [your child] up?	○	○	○
That everything was an effort?	○	○	○
Worthless?	○	○	○
Bothered by psychological or emotional problems?	○	○	○

SECTION B: STABILITY IN HOUSING

1. In the past 30 [thirty] days, have you [has your child] ...

	Yes	No	Decline to answer
Been homeless?	○	○	○
Spent time in a hospital for mental health care?	○	○	○
Spent time in a facility for detox/inpatient treatment for a substance abuse disorder?	○	○	○
Spent time in a correctional facility (e.g., jail, prison, [juvenile] facility)?	○	○	○
Gone to an emergency room for a mental health or emotional problem?	○	○	○
Been satisfied with the conditions of your living space?	○	○	○

2. In the past 30 [thirty] days, where have you [has your child] been living most of the time?

- ○ Private Residence
- ○ Foster Home
- ○ Residential Care
- ○ Crisis Residence
- ○ Residential Treatment Center
- ○ Institutional Setting
- ○ Jail/Correctional Facility
- ○ Homeless/Shelter
- ○ Other: _____
- ○ Don't know
- ○ Decline to answer

SECTION C: EDUCATION AND EMPLOYMENT

1. Are you [is your child] currently enrolled in school or a job training program?

○	○	○
Yes	**No**	**Decline to answer**

<u>2.</u> <u>[ADULT CLIENTS ONLY]</u> What is the highest level of education you have finished, whether or not you received a degree? Select One.

- ○ Less than 12th grade
- ○ Vocational/Technical (VO/TECH) Diploma
- ○ 12th Grade/High School Diploma/GED
- ○ Some College or University
- ○ Bachelor's Degree (BA, BS)
- ○ Graduate Work/Degree
- ○ Don't know
- ○ Decline to answer

3. [ADULT CLIENTS ONLY] Are you currently employed? Select One.

- ○ Employed full-time (35+ hours per week)
- ○ Employed, part-time
- ○ Unemployed, but looking for work
- ○ Not employed, not looking for work
- ○ Not working due to a disability
- ○ Retired, not working
- ○ Don't know
- ○ Decline to answer
- ○ Other: _____

4. In the past 30 [thirty] days, did you have enough money to meet your [your child's] needs?

○	○	○
Yes	**No**	**Decline to answer**

SECTION D: CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 [thirty] days, have you [has your child]...

	Yes	No	Decline to answer
1a. Been arrested?	○	○	○
1b. Spent time in jail/correctional facility or been on probation?	○	○	○

[SECTION E: NOT INCLUDED ON THIS ASSESSMENT]

SECTION F: SOCIAL CONNECTEDNESS

Please answer for relationships with persons other than your [your child's] mental health provider(s) over the past 30 days.	Yes	No	Decline to answer
I am [my child is] happy with my [their] friendships.	○	○	○
I have [my child has] people with whom I [they] can do enjoyable things.	○	○	○
I feel [my child feels] that I [they] belong in the community.	○	○	○
In a crisis, I [my child] would have the support needed from family or friends.	○	○	○
I have [my child has] family or friends that are supportive of my [their] recovery.	○	○	○
I [my child] generally accomplish[es] what I [they] set out to do.	○	○	○

Thank you for your valuable input. Please return the completed survey to the staff member who gave it to you or to the receptionist.

For agency use only
Return all surveys to Colleen Chahal
Rec'd by CMC: _____
Credible entry date: _____
SPARS Entry date:_____