



*A Resource Guide
for Implementing the*

The Joint Commission

2007 Patient Safety Goals on Suicide

*Featuring the
Suicide Assessment Five-step Evaluation and Triage
(SAFE-T)*

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*Dr. Jacobs would like to acknowledge the American Psychiatric Association (APA) for permission to use content from the
APA Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors,
and Laura Fochtman, MD for her thoughtful editorial assistance.*

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STATEMENT OF INTENT

The Joint Commission has recently published its 2007 National Patient Safety Goals¹, including a requirement related to patient suicide.

Screening for Mental Health, Inc. in collaboration with The Suicide Prevention Resource Center (SPRC), developed a suicide assessment protocol, *the Suicide Assessment Five-step Evaluation and Triage (SAFE-T)*².

This document serves as a resource guide, using the SAFE-T protocol as a centerpiece to facilitate implementation of the Joint Commission patient safety goal on suicide. This material is not intended to function as a standard of care, nor does it include every acceptable approach to meeting this goal.

The following resources were used:

- American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors^{3/4}
- The SAFE-T, a suicide assessment protocol for mental health care providers developed by Douglas Jacobs, MD and The Suicide Prevention Resource Center⁵
- The suicide risk assessment teleconference training sponsored by the National Association of Psychiatric Health Systems (NAPHS)⁶

For specific questions about the Joint Commission's requirement and/or applicability contact The Joint Commission at 630-792-5000 or visit the website www.JointCommission.org

THE JOINT COMMISSION GOAL 15A: THE ORGANIZATION IDENTIFIES CLIENTS AT RISK FOR SUICIDE

According to The Joint Commission, the requirements apply only to behavioral healthcare and psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

Rationale for Requirement 15A

Suicide ranks as the eleventh most frequent cause of death (third most frequent in young people) in the United States, with one person dying from suicide every 16.6 minutes. Suicide of a care recipient while in a staffed, round-the-clock care setting has been the #1 most frequently reported type of sentinel event since the inception of the Joint Commission's Sentinel Event Policy in 1996. Identification of individuals at risk for suicide, while under the care of, or following discharge from a health care organization, is an important first step in protecting and planning the care of these at-risk individuals⁷.

Implementation Expectations for Requirement 15A

- (M) C 1. The risk assessment includes identification of specific factors and features that may increase or decrease risk for suicide.
- (M) C 2. The client's immediate safety needs and most appropriate setting for treatment are addressed.
- (M) C 3. The organization provides information such as a crisis hotline to individuals and their family members for crisis situations.

THE SUICIDE ASSESSMENT FIVE-STEP EVALUATION AND TRIAGE (SAFE-T)

At the core of Screening for Mental Health's (SMH) mission is the dissemination of educational materials and resources to healthcare professionals. In collaboration with the Suicide Prevention Resource Center, SMH designed the SAFE-T, a suicide assessment protocol consistent with the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors. This protocol outlines a series of steps in conducting a comprehensive suicide assessment, estimating suicide risk and developing treatment plans and interventions responsive to the risk level; however, the ultimate determination of suicide risk is a clinical judgment.

SAFE-T (Suicide Assessment Five-step Evaluation and Triage)

1. Identify risk factors, noting those that can be modified to reduce risk
2. Identify protective factors, noting those that can be enhanced
3. Conduct suicide inquiry: suicidal thoughts, plans, behavior and intent
4. Determine level of risk and choose appropriate intervention to address and reduce risk
5. Document the assessment of risk, rationale, intervention and follow-up instructions

The question regarding the utility of suicide scales in clinical practice is often raised and was thoroughly addressed in the APA Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors. Below, please find an excerpt from page 23 on this point.

Understand the Relevance and Limitations of Suicide Assessment Scales⁸

“Although a number of suicide assessment scales have been developed for use in research ..., their clinical utility is limited. Self-report rating scales may sometimes assist in opening communication with the patient about particular feelings or experiences. In addition, the content of suicide rating scales, such as the Scale for Suicide Ideation and the Suicide Intent Scale, may be helpful to psychiatrists in developing a thorough line of questioning about suicide and suicidal behaviors. However, existing suicide assessment scales suffer from high false positive and false negative rates and have very low positive predictive values. As a result, such rating scales cannot substitute for thoughtful and clinically appropriate evaluation and are not recommended for clinical estimations of suicide risk.”

APPLYING THE SAFE-T MODEL TO THE JOINT COMMISSION GOAL

In preparing this resource guide, the SAFE-T protocol has been amplified to demonstrate a method for implementing the new Joint Commission requirements on patient safety. For each Implementation Expectation of the Joint Commission requirements, the corresponding SAFE-T steps are identified and described in detail.

M(C) 1: THE RISK ASSESSMENT INCLUDES IDENTIFICATION OF SPECIFIC FACTORS AND FEATURES THAT MAY INCREASE OR DECREASE RISK FOR SUICIDE.

The first Implementation Expectation corresponds to steps one, two and three of the SAFE-T.

Step 1: Identify risk factors, noting those that can be modified to reduce risk.

Relevant risk factors⁹ are determined while completing a psychiatric evaluation. Information sources may include the patient, medical records, referring treatment providers, family and friends.

- **Current and Past Psychiatric Diagnoses:** Especially mood disorders (depressed or mixed phase), psychotic disorder, alcohol/substance abuse disorders, Cluster B personality disorders or traits, eating disorders and anxiety disorders. Co-morbidity and recent onset of illness increase risk
- **Key Symptoms:** Anhedonia, impulsivity, hopelessness or despair, anxiety/panic, global insomnia and command hallucinations
- **Suicidality:** Current suicide ideation, intent, plan, or attempt and prior attempts aborted attempts, suicide rehearsal or non-suicidal self-injury. History of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- **Family History:** Suicide, attempts (first-degree relatives) or Axis I psychiatric diagnoses requiring hospitalization
- **Precipitants/Stressors:** Triggering events leading to humiliation, shame or despair, (i.e., loss of relationship, financial, or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). History of abuse or neglect. Intoxication
- **Access to firearms**
- **Physical Illnesses:** Certain medical diagnoses and conditions are associated with higher risk of suicide. There should be a low threshold for seeking psychiatric consultation in these situations, particularly in the presence of even mild depressive symptoms.
 - * Malignant neoplasms
 - * HIV/ AIDS
 - * Peptic ulcer disease
 - * Kidney failure requiring hemodialysis
 - * Pain syndromes
 - * Functional impairment including organic brain injuries

- * Diseases of nervous system, especially Multiple Sclerosis and Temporal Lobe Epilepsy
- **Cognitive Dimensions:** Thought constriction, polarized thinking
- **Childhood Trauma:** Sexual/physical abuse, neglect, parental loss
- **Demographic:** Male, elderly group, widowed, divorced or single marital status, particularly for men

The following risk factors can be modified through treatment and intervention in ways that may reduce suicide risk

- **Specific Psychiatric Symptoms:** Hopelessness, psychic pain/anxiety, decreased self-esteem, impulsivity, aggression, panic attacks, agitation and psychosis can be treated with medications and psychotherapy
- **Environmental:** Access to firearms and other lethal means of suicide can be restricted.¹⁰ Individuals can be observed until intoxication resolves.
- **Inadequate Social Supports:** Family members and close friends can be educated about illness and resources to provide more social support.

Step 2: Identify protective factors¹¹ - noting those that can be enhanced. (The presence of protective factors may not counteract significant acute suicide risk)

- **Internal:** Ability to cope with stress, religious beliefs, frustration tolerance, absence of psychosis
- **External:** Responsibility to children or beloved pets, positive therapeutic relationships, social supports

Step 3: Specific questioning about thoughts, plans, behaviors, intent¹².

- Ask about suicidal ideation (frequency, intensity, duration), plans and behaviors
- Ask about suicidal ideation in the last 48 hours, past month and worst ever
- * *“Whether or not a plan is present, if a patient has acknowledged suicidal ideation, there should be a **specific inquiry about the presence or absence of a firearm** in the home or workplace. It is also helpful to ask whether there have been recent changes in access to firearms or other weapons, including recent purchases or altered arrangements for storage. If the patient has access to a firearm, the psychiatrist is advised to discuss with and recommend to the patient or a significant other the importance of restricting access to, securing, or removing this and other weapons. Such discussions should be documented in the medical record, including any instructions that have been given to the patient and significant others about firearms or other weapons.”*
 -- Excerpted from page 23 of the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors

- If a plan is identified, evaluate steps taken to enact the plan, preparations for dying and the patient's expectations of lethality. Timing, location of plan, lethality of method and availability are key to evaluating level of risk
- Ask about behaviors: rehearsals (e.g., tying noose, loading gun), aborted attempts, and past attempts, versus non-suicidal self injurious actions
- Ask about intent: extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; explore ambivalence: reasons to die versus reasons to live
- Assess for homicidal ideation, particularly in postpartum women and character disordered males dealing with separation, especially those who are paranoid or have Cluster B personality disorders or traits
- Assess access to lethal methods, including firearms¹³ (see above excerpt)
- Assess for the presence of non-suicidal self-injury, particularly among adolescents and young adults, and especially among those who have a mood disorder or externalizing disorders. The assessment should mirror that of assessment of suicide risk and should include questions about the presence of intent to die, the function of or reasons for engaging in the behavior, methods used, frequency and severity of past self-injurious behavior, and the presence of plan and intent to engage in future self-injury¹⁴

M(C)2: THE CLIENT'S IMMEDIATE SAFETY NEEDS AND MOST APPROPRIATE SETTING FOR TREATMENT ARE ADDRESSED.

The second Implementation Expectation corresponds to the fourth step of the SAFE-T.

Step 4: Determine level of risk and develop an intervention plan to address the risk¹⁵

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential clinical judgment, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."¹⁶

--Excerpted from page 24 of The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors

Addressing immediate safety needs begins with the patient's arrival in the emergency department (ED)^{17/ 18}

High Risk Patients include those who:

- Have made a serious or nearly lethal suicide attempt **or**
- Have persistent suicide ideation and/or planning **and:**
 - ★ Have command hallucinations
 - ★ Are psychotic
 - ★ Have recent onset of major psychiatric syndromes, especially depression
 - ★ Have been recently discharged from psychiatric inpatient unit
 - ★ Have a history of acts/threats of aggression

Interventions for high risk patients include:

- Assessment of patient's medical stability
- One-to-one constant staff observation and/or security
- Elopement precautions
- Body/belongings search
- Administration of psychotropic medications to reduce agitation and/or application of physical restraints¹⁹ as clinically indicated

Moderate Risk Patients include those who:

- Have multiple risk factors and few protective factors
- Display suicidal ideation with a plan, but do not have intent or behavior

Interventions for moderate risk patients include:

- Admission may be necessary (depending on risk factors)
- Development of a crisis plan
- Providing emergency information, including both local and national phone numbers (i.e., National Suicide Prevention Lifeline at 1-800-273-TALK)

Low Risk Patients include those who:

- Have modifiable risk factors and strong protective factors
- Have thoughts of death, but do not have a plan, intent or behavior

Interventions for low risk patients include:

- Outpatient referral
- Symptom reduction
- Providing emergency information, including both local and national phone numbers
(i.e., National Suicide Prevention Lifeline at 1-800-273-TALK)

Guidelines for selecting a treatment setting after the evaluation is completed in the ED²⁰

Hospital Admission is generally indicated:

After a suicide attempt or aborted suicide attempt if:

- Patient is psychotic
- Attempt was violent, near-lethal, or premeditated
- Precautions were taken to avoid rescue or discovery
- Persistent plan and/or intent is present
- Distress is increased or patient regrets surviving
- Patient is male, older than 45 years of age, especially with new onset of psychiatric illness or suicidal thinking
- Patient has limited family and/or social support, including lack of stable living situation
- Current impulsive behavior, severe agitation, poor judgment, or refusal of help is evident
- Patient has change in mental status with a metabolic, toxic, infectious, or other etiology requiring further workup in a structured setting

In the presence of suicidal ideation with:

- Specific plan with high lethality (e.g. plans to shoot self and has a gun)
- High suicidal intent (e.g. "I can't take this any longer; I must find a way to make it stop. My family would be better off without me.")
- Severe anxiety, agitation or perturbation

Admission may be necessary:

After a suicide attempt or aborted suicide attempt, except in circumstances for which admission is generally indicated, in the presence of suicide ideation with:

- Psychosis
- Major psychiatric disorder
- Past attempts, particularly if medically serious
- Possibly contributing medical condition
- Lack of response to or inability to cooperate with partial hospital or outpatient treatment

- Need for supervised setting for medication trial or electroconvulsive therapy
- Need for skilled observation, clinical tests, or diagnostic assessments that require a structured setting
- Limited family and/or social support, including lack of stable living situation
- Lack of an ongoing clinician-patient relationship or lack of access to timely outpatient follow-up
- In the absence of suicide attempts or reported suicidal ideation/plan/intent but evidence from the psychiatric evaluation and/or history from others suggests a high level of suicide risk and a recent acute increase in risk

Release from emergency department with follow-up recommendations may be possible.

After a suicide attempt or in the presence of suicidal ideation/plan when:

- Suicidality is a reaction to precipitating events (e.g., exam failure, relationship difficulties), particularly if the patient's view of the situation has changed since coming to the emergency department
- Plan/method and intent have low lethality
- Patient has stable and supportive living situation
- Patient is able to cooperate with recommendations for follow-up, with treatment provider contacted, if possible, if applicable

Outpatient treatment may be more beneficial than hospitalization.

- Patient has chronic suicidal ideation and/or self-injury without prior medically serious attempts, if a safe and supportive living situation is available and outpatient psychiatric care is ongoing
- If patient is determined to have no intent to die from their self-injury and their behavior is determined to be of low lethality (e.g., superficial cutting or burning) and does not require medical attention

Guidelines for Inpatient Suicide Assessments

- Assessments are conducted at critical stages of treatment (admission, change in privilege level, change in mental status, before discharge)
- Documentation of assessments and related changes in treatment plan, precaution levels, or privilege, transitions between treatment units and discharge plans are critical
- Because there are multiple members of a treatment team, both verbal and written communication regarding patient suicide risk are important

Immediate Safety Needs of Hospitalized Patients

- In a patient being admitted for suicidality, close observation needs to be considered until the patient has received a complete psychiatric evaluation and suicide assessment.
- Familiarity with indications for appropriate pharmacologic intervention, seclusion, restraints, body and belongings searches, and 1:1 monitoring is essential

- **Familiarity with utility and limitations of Suicide Prevention Contracts (known as “no-harm contracts” or “contracts for safety”)**

Potential utility needs to be weighed against potential limitations

- * Have been used clinically in either verbal or written form to assess or manage suicide risk
- * Sometimes viewed as helpful in judging the strength of the therapeutic alliance or the extent of the patient’s ambivalence about seeking help if suicidal impulses occur
- * May provide an opportunity to educate patients about staff availability or about coping with suicidal impulses
- * However, use of suicide prevention contracts is often overvalued
- * No evidence supports their effectiveness
- * Do not act as legally binding contracts
- * May inappropriately reduce clinical vigilance particularly if substituted for more detailed assessments of suicide risk

Characteristics of the individual patient, nature of the therapeutic alliance and the treatment setting must also be considered

“Suicide prevention contracts are only as reliable as the state of the therapeutic alliance...As a result, the use of suicide prevention contracts in emergency settings or with newly admitted and unknown inpatients is not recommended. Furthermore, patients in crisis may not be able to adhere to a contract because of the severity of their illness. Suicide prevention contracts are also ill-advised with agitated, psychotic, or impulsive patients or when the patient is under the influence of an intoxicating substance.”

--Excerpted from page 68 of the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors

Suicide Risk and Observation Levels

The monitoring of the suicidal patient includes a range of frequency of observations from 1:1 (constant observation), to 15 minute checks, to 30 minute checks, as well as different categories of restrictions.

Examples of restrictions include:

- Supervised Bathroom
- Unit restriction
- Restriction to public areas
- Supervised sharps
- Placement in hospital clothing

The determination of the level of observations and restrictions depends upon the level of risk assessed that occurs, for example, at the time of checks.

Safety Needs to Consider in the Physical Environment

- Assess the physical environment, focusing on controlling patient access to methods of self-injury
- The most common methods of suicide in hospitals are hanging, suffocation and jumping

- Suicidal patients on medical units are in less controlled, therefore, higher-risk physical environments; Safety is increased by providing closer observations, often 1:1 with a sitter
- The following questions should help address areas of potential vulnerability in the physical facility:

Access to means of hanging, suffocation, and strangulation

- * Are there fixtures (shower heads, light fixtures, curtain rods, closet doors, door knobs) from which something heavy could be suspended?
- * Do closets and showers have break-away rods?
- * Are there any hospital beds on the unit? Is observation of patients who require medical equipment (e.g., beds, intravenous lines, oxygen) adequate?
- * Under what circumstances are shoelaces and belts taken from the patient? What assessment allows their return? How are these events documented?
- * Are linen closets locked?
- * Are guitars and other string instruments allowed on the unit?
- * Are plastic trash can liners on the unit?

Access to jumping as a method of suicide

- * Is the unit located higher than ground level?
- * Do patients have access to windows, balconies, fire escapes, any place from which they could jump?
- * Are the windows able to be opened or broken?

Access to other potentially harmful items

- * Is a body/belongings search done on admission?
- * Is the unit locked?
- * Are items brought in by visitors searched?
- * Are items such as belts/glass bottles/cigarette lighters taken from patients?
- * Are cleaning supplies closely monitored by staff?
- * Are there electrical outlets in the bathrooms?
- * Are there blow-dryers or other electrical appliances?
- * How are razors for shaving monitored?

Challenges to transporting patients

- * Is the reason for taking the patient off the unit urgently needed or required? The increased risk associated with the transport should be balanced by the benefit of the testing.
- * Consider where the patient is going. Is that facility safe? Does the patient have access to places from which to jump or hang?
- * Consider a higher level of observation for the duration of the time the patient is off the more secure unit, e.g., if the patient is on 15 minute checks consider a 1:1 for the transport. If the patient is on 1:1 and in restraints consider 2:1 for the transport and having the patient restrained in transit.
- * Staff responsible for the observations must be informed of the status of the patient and aware of their options and level of responsibility for intervening in a crisis.

M(C)3: THE ORGANIZATION PROVIDES INFORMATION SUCH AS A CRISIS HOTLINE TO INDIVIDUALS AND THEIR FAMILY MEMBERS FOR CRISIS SITUATIONS.

The third Implementation Expectation corresponds to the fifth step of the SAFE-T.

Step 5: Document the assessment of risk, rationale, intervention and follow up instructions

Patient Discharge Guidelines and Information

From the ED

- Identify and, if appropriate, contact outpatient support system; family/friends
- Develop appropriate plan; referral to current treatment providers/outpatient clinic
- Inform patient and/or family/friends (if indicated) about the signs of increased suicide risk; especially sleep disturbance, anxiety, agitation, and suicidal expressions and behaviors
- If the patient does not wish to permit contact with family, this should be documented
- Provide emergency contact numbers (local and national numbers, such as 800-273-TALK) and instructions about when to call

From an Inpatient Unit

- Provide the patient and the family/friends with discharge instructions
- Explain the uneven recovery path from their illness, especially depression. e.g., “There are likely to be times when you feel worse—that doesn’t mean that the medications have stopped working. Contact your healthcare clinician if this happens”
- Inform the family/friends (if indicated) about the signs of increased suicide risk; especially sleep disturbance, anxiety, agitation and suicidal expressions and behaviors
- If the patient does not wish to permit contact with family, this should be documented
- Provide information for follow-up appointment, which may include contacting current provider and/or scheduling an appointment
- If presence of firearms has been identified, document instructions given to patient and/or significant other²¹
- Provide prescriptions that allows for a reasonable supply of medication to last until the first follow-up appointment (when indicated)
- Provide information about local resources available, such as emergency contact numbers (local and national numbers, such as 1-800-273-TALK) and instructions

Suicide Risk Following Discharge

- Suicide risk increases following discharge across diagnostic categories
- Suicide attempts are also more frequent in the time period following discharge

Other Documentation Guidelines

When to Document Suicide Risk Assessments

- At the time of hospital admission
- With occurrence of any suicidal behavior or ideation
- Whenever there is any noteworthy clinical change
- Before increasing privileges/giving passes
- Before discharge

What to Document in a Suicide Assessment

- Risk level
- Basis for the risk level (including presence and characteristics of any suicidal or non-suicidal self-injury thoughts or behaviors)
- Treatment plan for reducing the risk, including observations and other restrictions
- Documenting team meetings and communications can facilitate communication as well as risk management
- The issue of firearms (assessed before discharge). If present, document instructions; if absent, document as pertinent negative

Example of a Physician's Note

This 62 y.o., recently separated man is experiencing his first episode of major depressive disorder. In spite of his denial of current suicidal ideation, he is at moderate to high risk for suicide, because of his serious suicide attempt and his continued anxiety and hopelessness. The plan is to hospitalize with suicide precautions and medications, consider ECT w/u. Reassess tomorrow.

Example of a Nursing Note

Mr. X consistently denied suicidal ideation this evening when asked. However, he continued to pace and ruminate about how he had ruined his life and shamed his family by making a suicide attempt and being hospitalized. PRN Ativan was given. Patient was restricted to public areas and monitored on 15 minute checks. The Ativan was somewhat effective, after one hour he was sitting still in the TV room and not pacing.

SCREENING FOR MENTAL HEALTH AND DOUGLAS JACOBS, MD

Screening for Mental Health, Inc (SMH), a non-profit organization, first introduced the concept of large-scale mental health screening in 1991 with its flagship program, National Depression Screening Day® (NDS). Its success spurred the creation of National Alcohol Screening Day®, the National Eating Disorders Screening Program® and the expansion of NDS to include screening for bipolar and anxiety disorders, including post traumatic stress disorder. SMH also developed a unique workplace and healthcare screening program utilizing online and telephone interactive technology. Recently, the Department of Defense contracted with SMH to create the nation's first voluntary mental health self-assessment program for service members and their families. Additionally, SMH has developed the SOS Signs of Suicide® Program, the only evidence-based youth suicide prevention shown to reduce suicide attempts in a randomized controlled study. Through the website www.StopASuicide.org, SMH provides educational information for both professionals and the general public.

The founder and CEO of Screening for Mental Health, Douglas G. Jacobs, M.D., is an Associate Clinical Professor of Psychiatry at Harvard Medical School and a nationally recognized expert on suicide and depression. While maintaining an active clinical practice in Massachusetts, he has edited three books; including the textbook "Harvard Medical School Guide to Suicide Assessment and Intervention." Additionally, he has published numerous papers on suicide and led academic seminars on the subject. He served as the Chairperson for the Work Group of the American Psychiatric Association's Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors (2003). In 2004, he received the Massachusetts Psychiatric Society's Outstanding Psychiatrist Award for Advancement of the Profession.

GLOSSARY OF TERMS²²

Suicide: Self-inflicted death with evidence (either explicit or implicit) that the person intended to die

Suicide Attempt: Self-injurious behavior with a nonfatal outcome accompanied by evidence (either explicit or implicit) that the person intended to die

Aborted Suicide Attempt: Potentially self-injurious behavior with evidence (either explicit or implicit) that the person intended to die but stopped the attempt before physical damage occurred

Suicidal Ideation: Thoughts or serving as the agent of one's own death. Suicidal ideation may vary in seriousness depending on the specificity of suicide plans and the degree of suicidal intent

Suicidal Intent: Subjective expectation and desire for a self-destructive act to end in death

Lethality of suicidal behavior: Objective danger to life associated with a suicide method or action. Note that lethality is distinct from and may not always coincide with an individual's expectation of what is medically dangerous

Non-suicidal self-injury: Direct, deliberate destruction of one's own body tissue without any intent to die, such as cutting or burning one's own skin²³

REFERENCES

- ¹ To learn more about the Joint Commission National Patient Safety Goals, go to:
<http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals>
- ² *Suicide Assessment Five-step Evaluation and Triage* (2007), developed by Douglas Jacobs, MD, Screening for Mental Health, Inc in collaboration with the Suicide Prevention Resource Center (SPRC)
- ³ American Psychiatric Association Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors can be downloaded at:
http://www.psych.org/psych_pract/treatg/pg/suicidalbehavior_05-15-06.pdf
- ⁴ Jacobs D, Brewer M. APA Practice Guideline Provides Recommendations for Assessing and Treating Patients with Suicidal Behaviors. *Psychiatric Annals* 2004; 34(5):373-380.
Available at: <http://www.stopasuicide.org/downloads/Sites/Docs/APASuicideGuidelinesReviewArticle.pdf>
- ⁵ *Suicide Assessment Five-step Evaluation and Triage* (2007), developed by Douglas Jacobs, MD, Screening for Mental Health, Inc in collaboration with the Suicide Prevention Resource Center (SPRC)
- ⁶ CD available for purchase at <http://www.naphs.org/teleconference/suicide.html>
- ⁷ From the The Joint Commision's standards:
<http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals>
- ⁸ Page 23 from Reference 3
- ⁹ Table 4, page 25-26 from Reference 3
- ¹⁰ Page 23 from Reference 3
- ¹¹ Table 5, page 27 from reference 3
- ¹² Table 3, page 22 from Reference 3
- ¹³ Page 23 from Reference 3
- ¹⁴ Nock MK, et al. Non-Suicidal Self-Injury Among Adolescents: Diagnostic Correlates and Relation to Suicide Attempts. *Psychiatry Research* 2006; 144:65-72.
- ¹⁵ The assessments are based on clinical judgment. The categories listed are examples, but are not to imply that other situations do not exist.
- ¹⁶ Page 24 from Reference 3
- ¹⁷ Fochtmann LJ. Emergency Services. In: Simon RI, Hales RE. *Textbook of Suicide Assessment and Management*. Arlington, VA: American Psychiatric Publishing, Inc; 2006. p. 381-400.
- ¹⁸ Risk: A Guide for ED Evaluation and Triage Poster, 2006, created by the American Association of Suicidology and the Suicide Prevention Resource Center
- ¹⁹ Jacobs, D. Evaluation and Management of the Violent Patient in Emergency Settings. *Psychiatric Clinics of North America* 1983; 6: 263.
- ²⁰ Table 8, page 53 from Reference 3
- ²¹ Page 23 from Reference 3
- ²² Page 9 from Reference 3
- ²³ Reference 12.