Suicidality Assessment and Documentation for Healthcare Providers:

A Brief, Practical Guide

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Jennifer M. Giddens

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Dedication

From David

To Kathy, without whose unending love and support, accommodation and guidance, this book would not have been written

and

To my pride and joy - my children Sascha and Tara, and my grandsons, Dashiell, Thapelo and Hamish, in the hope that they will inherit a world less victim to suicide.

From Jennifer

To my parents - Ben and Linda; my brother - Matt; my aunt – Joan; the rest of my family, and Darryl for all of their continued encouragement and support

and

To all who have struggled, are struggling, and will struggle with suicidality, hopefully new treatments will be available soon.

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From David

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PhD, Ahmad Hameed MD, Emily Bruer MEd, David Williamson PhD, John Greist MD, Jim Mundt PhD, and JP Lindenmayer MD for the many discussions and insights I enjoyed with them over years of collaboration on research and publications on suicidality issues; and most important to all our patients who communicated their long struggles, their fears and invaluable insights into the experience of suicidality. Patient insights have been very central in the development of the material for this book. None of these friends and colleagues should be held responsible for any of the errors, oversights, or excesses in this book. Some will disagree with some of the content. However I valued the debates with them on many of the points we raised and I look forward to future discussions and collaboration on the many unresolved issues as we all collaborate together in improving the lives of our patients.

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From Jennifer

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From David and Jennifer

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Preface

Some parts of this book were previously published in an earlier book titled Suicidality: A Roadmap for Assessment and Treatment. This brief, practical guide presents the sections from the earlier publication that clinicians can use to improve their assessment and documentation of suicidality. It is our hope that the ideas, recommendations, and assessments in this book will facilitate improved communication between health care providers and their suicidal patients.

1

Introduction

"While on an inpatient psychiatric unit after a suicide attempt, they took my blood pressure 4 times a day, but never asked me about my suicidality." - Anon

The purpose of this book is to provide the healthcare professional with a brief practical guide to suicidality assessment and documentation. The biggest challenge for the healthcare provider in addressing this issue is "time". Most clinicians know how to do a thorough suicidality assessment in an ideal world, if they had unlimited time available. They seek guidance on how to most efficiently assess and document suicidality within their time constraints.

The following chapters provide an overview of how to efficiently and accurately, conduct and document a suicidality assessment. We include the suicidality assessment scales to use and offer guidance on how to use them operationally to make a disposition decision. We provide tips for interviewing suicidal patients and try to dispel some myths about the nature of suicidality. We hope this will offer insight to the assessment and understanding of suicidality. Chapter 5 has structured templates for a psychiatric history, a visit progress note, and a visit face sheet. We offer an overview of a phenotypic classification for suicidality disorders, current medications used to treat suicidality, and some resources for clinicians, patients, friends, and family.

2

Myths and Questions on Suicidality

Introduction

The purpose of this chapter is to address commonly accepted assumptions, myths, and questions relating to suicidality. The responses address a series of themes that recur throughout the book. They describe a perspective and the approach we have taken to outline a way forward in the future investigation of suicidality.

Topics addressed in this chapter:

- Countertransference in Assessing Suicidality
- Willfulness of Suicidality
- Causes of Suicidality
- Suicidality Phenomena
- Classification of Suicidality Disorders
- Psychological Treatments for Suicidality
- Medication Treatments for Suicidality
- Prediction of Suicidality

Suicidality Questions

Countertransference in Assessing Suicidality

Are suicidal patients aware that clinicians fear listening to patients talk about suicidality and fear discussing suicidality with patients? Are clinicians freaked out by suicidality?

A patient stated, "You think you are interviewing us, but we are interviewing you. As the discussion of suicide deepens we can see the fear and anxiety in your eyes and face. You have tuned us out, you are no longer listening, and you do not want to hear any more."

Willfulness of Suicidality

Is suicidal ideation always willful?

No. While it is commonly assumed that all suicidality is willful, sometimes it is not.

Do any suicidal patients try to resist their suicidal experiences?

Yes. While it is assumed that suicidal patients are not trying to help themselves get better, many of them are desperately struggling to keep themselves safe and alive. Contrary to popular belief, some patients with chronic suicidality have strong self-preservation instincts concurrent with their suicidality. It is a myth that patients will not meet internal resistance within themselves when they attempt suicide, even if they have already planned the attempt.

Are all chronically suicidal people being willfully suicidal (possibly to seek attention)?

No. Just because a patient's suicidality does not respond to a treatment, you cannot assume the patient is willfully suicidal. Many chronically suicidal people do not have access to effective anti-suicidality treatments. Until effective and specific anti-suicidality treatments are available to patients, it is premature to assume the patient is being willfully suicidal.

Most suicidal patients are deemed to be depressed and are treated with an antidepressant or a mood stabilizer. These treatments are not approved for the treatment of suicidality and, indeed, have boxed warnings about their increased risk of inducing suicidality, especially in those under 25 years old. When many suicidal patients do not respond to these treatments and, especially when these treatments make their suicidality worse, they may give up hope. This hopelessness contributes to the worsening of their suicidality. They fear that their clinicians blame them for failing to respond to these ineffective treatments and that clinicians attribute their chronic suicidality to ongoing willfulness. This is a particular problem when their depression improves, but their suicidality does not.

Patients who experience suicidality should be seeking attention. If a patient is experiencing suicidality they are likely to be very distressed. These patients should be afforded the same opportunity to seek attention and care for their distress as a patient suffering from any other disabling condition or illness.

Do all suicidal people attempt suicide in order to hurt or to punish those around them?

No. Many people who attempt suicide are drowning in their own pain and are unable to focus on the pain of those around them. They experience such despair that their mindset shifts and

they feel they are a burden to those around them. They may feel that loved ones would be better off without them. Many of these people believe they will limit the suffering of their loved ones, by halting the ongoing frustration, worry, and distress that their loved ones would experience for many years, if they continue to live. They believe that killing themselves will free their loved ones from having to "put up with" them. They believe this is like quickly ripping off the Band-Aid so their loved ones can move on with their lives.

While it is common for the relatives and friends of suicidal people to feel hurt and suffer greatly in the aftermath of a suicide attempt, it does not mean that the person who made a suicide attempt (including those who died) intended this pain.

Causes of Suicidality

Is there always an external social event that precipitates suicide?

No. Contrary to popular belief, some people are suicidal for reasons other than external social events. Not everyone who attempted suicide did so in response to a psychosocial event or because they were depressed. There are multiple other precipitants for suicide. Some patients experience suicidal impulse attacks (in some way similar to panic attacks in Panic Disorder or tics in Tourette's Disorder), which cause them to feel a sudden need to make a suicide attempt, often for no obvious reason to them. Others experience suicidality due to medical illnesses or neurological conditions.

Is there always an obvious motive for suicide?

No. Although we would like to believe there is always a motive for suicide, this is not always true. Some people experience overwhelming or engulfing impulses to make a suicide attempt which last for hours. Many of these people may be unable to manage these suicidal impulses on their own and lose the struggle against these impulses. Others may attempt suicide in response to a suicidal command hallucination or to stop the command hallucination even though they themselves do not want to die.

Does suicidality progress in a predictable ordered sequence?

No. While this is a common belief, suicidality does not progress in a predictable ordered sequence. The belief that suicidality starts as passive suicidal ideation, moves into active suicidal ideation, which then leads to suicidal intent and on to suicidal planning, that turns into suicidal preparatory behaviors, and is followed by suicide attempts is a flawed linear model of suicidality. It seems like a very neat, orderly, logical sequence. Unfortunately, it does not reflect reality most of the time. Clinicians often gauged the severity of suicidality by how far the patient had progressed on this linear spectrum. This sequence also dictated the design of some suicidality scales and classification systems for events of suicidality. This model of suicidality provides clinicians with a false understanding of the patient's experience and can misguide the clinician in their judgment of suicide risk.

For example, a patient with Schizophrenia experiences command hallucinations ordering them to kill themself. When these command hallucinations relentlessly persist the patient may make a suicide attempt in response, but only because they want the auditory commands to stop and not

because they want to kill themself. This patient may not engage in any other suicidal ideation, intent, planning, or preparatory behaviors.

Are there genetic vulnerabilities to suicidality independent of the suicidality vulnerability to mood disorders?

Yes. Some alleles, genetic mutations, and epigenetic changes are associated with a significantly increased rate of suicidal ideation and behaviors[1] [2] [3] [4] [5] [6]. Many of these genetic biomarkers are not known to be associated with a predisposition to mood disorders[7] [8].

Are people with impulsive personality disorders more likely to make impulsive suicide attempts? Do those who make impulsive suicide attempts have impulsive personalities?

Not necessarily. Nearly all clinicians have seen patients who have made impulsive suicide attempts. They assume that the person making the impulsive suicide attempt has an impulsive personality disorder. Studies using several different scales that measure impulsive personality traits have consistently found low correlations between scores on these scales and suicide attempts. This has always been a puzzle for clinicians. It appears that some patients who make impulsive suicide attempts have a unique Impulse Attack Suicidality Disorder (IASD). These subjects are not necessarily impulsive personalities in any way in the rest of their lives. Indeed they are often very cautious, even compulsively careful in their decision making, withdrawn, isolated, not sociable or outgoing, nor given to rash decisions in other areas of their life. The impulsive behavior in their case is strictly confined to the attacks of impulsive suicidality. (See chapter 6 for a brief description of Impulse Attack Suicidality Disorder.)

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[1] Labonte B, Turecki G. Epigenetics. Chapter 32 (pages 288-306) in in A Concise Guide to Understanding Suicide:Epidemiology, Pathophysiology and Prevention. Edited by Stephen H. Koslow, Pedro Ruiz, and Charles B. Nemeroff. Cambridge University Press 2014.

[2] Bailey CR, Greene AM, Neumeister A. The use of neuroimaging to investigate the pathophysiology of suicide. Chapter 33 (pages 307-316) in A Concise Guide to Understanding Suicide:Epidemiology, Pathophysiology and Prevention. Edited by Stephen H. Koslow, Pedro Ruiz, and Charles B. Nemeroff. Cambridge University Press 2014.

[3] Anango V, Bach H. Brain serotonin in suicides with psychological autopsy. Chapter 34 (pages 317-324) in A Concise Guide to Understanding Suicide:Epidemiology, Pathophysiology and Prevention. Edited by Stephen H. Koslow, Pedro Ruiz, and Charles B. Nemeroff. Cambridge University Press 2014.

[4] Chandley MJ, Ordway GA. The noradrenergic system in depression and suicide. Chapter 35 (pages 325-335) in A Concise Guide to Understanding Suicide:Epidemiology, Pathophysiology and Prevention. Edited by Stephen H. Koslow, Pedro Ruiz, and Charles B. Nemeroff. Cambridge University Press 2014.

[5] Pandey GN. Brain corticotropin releasing factor and the hypothalamic-pituitary-adrenal axis in suicide. Chapter 36 (pages 336-342) in A Concise Guide to Understanding Suicide:Epidemiology, Pathophysiology and Prevention. Edited by Stephen H. Koslow, Pedro Ruiz, and Charles B. Nemeroff. Cambridge University Press 2014.

[6] Dwivedi Y. Receptor signaling in suicide. Chapter 37 (pages 343-356) in A Concise Guide to Understanding Suicide:Epidemiology, Pathophysiology and Prevention. Edited by Stephen H. Koslow, Pedro Ruiz, and Charles B. Nemeroff. Cambridge University Press 2014.

[7] Niculescu, A. B., Levey, D. F., Phalen, P. L., Le-Niculescu, H., Dainton, H. D., Jain, N., ... & Salomon, D. R. (2015). Understanding and predicting suicidality using a combined genomic and clinical risk assessment approach. *Molecular psychiatry*, *20*(11), 1266-1285.

[8] Kaminsky, Z., Wilcox, H. C., Eaton, W. W., Van Eck, K., Kilaru, V., Jovanovic, T., ... & Smith, A. K. (2015). Epigenetic and genetic variation at SKA2 predict suicidal behavior and post-traumatic stress disorder. *Translational psychiatry*, *5*(8), e627.

Bipolar Disorder may make some patients behave impulsively especially during manic / hypomanic episodes. Bipolar Disorder is itself associated with increased rates of suicidality. This does not mean every patient with Bipolar Disorder who acts impulsively during a manic episode has a primary impulsive personality disorder. Nor does it mean that everyone who makes an impulsive suicide attempt has Bipolar Disorder or an impulsive personality disorder. Missing the existence of a unique IASD in the past, led to this confusion and misunderstanding.

Suicidality Phenomena

Should we use the term 'suicidal ideation and behavior' or 'suicidality'?

We advise against using term 'suicidal ideation and behavior'. There is more to suicidality than "ideation" and "behavior". We prefer the term 'suicidality'. The reason is that the Unexpected Suicidal Impulse Attacks (USIA) start in a physical precognitive manner that antecedes suicidal ideation and behavior. Auditory command hallucinations start in an auditory form that antecedes suicidal ideation and behavior. Dreams are, strictly speaking, not generally considered as a form of suicidal ideation, but rather are memories of an antecedent event that contained images of suicidality phenomena. For these reasons and to cast the net widely enough to accommodate all these and other core phenomena experienced by those who are suicidal, while delimiting these from the phenomena of other neighboring classes, we prefer the broader term 'suicidality'. It provides brevity and an economy of language in communications, by using one word to summarize a cluster of core suicidal phenomena. The following definition of suicidality accommodates those phenomena not currently captured within the bounds of usual 'suicidal ideation and behavior'.

suicidality [sui (of oneself) + cide (a killing) + ality (the state of being real or actual)] – all suicidal phenomena including ideation, behaviors, impulses, command hallucinations, dreams, delusions, and / or precognitive experiences related to suicide and / or any suicidal phenomenon related to suicide that arches across a time frame but did not appear as an ideation of behavior during that time frame. For example, a patient that previously made plans or intends to kill themself at a future date, but may not have thought about it during a particular time frame. This definition deliberately excludes theories or speculations about, predictions from or likelihood of a suicidal ideation or behavior. It also excludes experiences that may be comorbid with or correlated with core suicidal phenomena, but in and of themselves are not directly suicidal experiences (e.g. hopelessness, depression, anxiety, grief). The range of core suicidality phenomena are identified in the list below.

Suicidality phenomena

- passive suicidal ideation
- active suicidal ideation
- impulsive suicidality
- suicidal hallucinations
- suicidal delusions
- suicidal dreams
- suicide plan - method (how)
- suicide plan - means (with what)

- suicide plan - date (when)
- suicide plan - place (where)
- suicide plan - thinking about any task you want to complete before killing yourself – "unfinished tasks"
- intent to act in any suicidal way,
- intent to die by suicide
- preparatory suicidal behaviors (aborted = halted by self)
- preparatory suicidal behaviors (interrupted = halted by another person or event)
- preparatory suicidal behaviors (neither aborted nor interrupted)
- suicide attempts (halted by self)
- suicide attempts (halted by another person or event)
- suicide attempts (completed as intended)
- accidents involving any suicidal accident
- died by suicide

Other phenomena needing assessment to enhance accuracy of suicidality data collection

- non-suicidal self-harm behaviors
- death from other causes

Should we stop thinking about suicidality exclusively as a complication of depression?

Yes. Of the top 38 disorders in psychiatry, 34 have elevated standard mortality ratios (SMR) from suicide[9]. Suicidality is associated with most of the disorders that psychiatrists treat in clinical practice even in subjects who are not obviously depressed. The assumption that everyone who is suicidal must be depressed has led to many unfortunate consequences. For example, it is commonly assumed that the way to screen people for suicidality is to ask them about depression. In reality, the best way to screen for suicidality is to ask about suicidality[10]. It has also led to clinicians routinely trying to treat suicidality with antidepressants. While the use of antidepressants may be helpful for some patients with Major Depressive Disorder, it may also make other types of suicidality much worse. It has led to research focusing its efforts on treating suicidality by using depression models in the search for such treatments and in the design and conduct of the clinical trials with anti-suicidality medications. It is likely to be more accurate to think about suicidality disorders as a series of Axis 1 psychiatric disorders that can be comorbid with other psychiatric disorders, but could also exist independently of other psychiatric disorders. As long as we fail to disaggregate the suicidality disorder from other disorders it will be an impediment in searching for effective anti-suicidality medication treatments and in understanding the diverse pathophysiology associated with the different suicidality disorders.

[9] Harris, E. C., & Barraclough, B. (1997). Suicide as an outcome for mental disorders. A meta-analysis. The British Journal of Psychiatry, 170(3), 205-228.

[10] Preti, A., Sheehan, D. V., Coric, V., Distinto, M., Pitanti, M., Vacca, I., ... & Petretto, D. R. (2013). Sheehan suicidality tracking scale (S-STS): reliability, convergent and discriminative validity in young Italian adults. *Comprehensive psychiatry*, *54*(7), 842-849.

While it may be true that many suicidal patients experience depression, there has been little if any research showing that the suicidality is *the result* of the depression. Some suicidal patients experience suicidality they cannot control and for which they have been unable to find effective treatments. These patients may become depressed due to the negative impact their suicidality has had upon their lives. Some of these patients may find that their suicidality leads to functional impairment in their work, in their social life and relationships, and in their family life[11]. Researchers have assumed the depression is the cause of the suicidality, when the suicidality can actually be the cause of the depression. As one subject said, "all my psychiatrists assume that I am suicidal because I am depressed. Did it ever cross their minds that I might be depressed because I have a suicide disorder?"

Can someone have suicidal behavior and no suicidal ideation within a timeframe?
Yes. Although this is not common, it does occur. It seems to surprise clinicians when they see it for the first time. For example, when administering the suicidality module of the Mini International Neuropsychiatric Interview (MINI)[12], a patient denied having any suicidal ideation in the past month. Towards the end of the suicidality module, when asked if he had made any suicide attempts in the past month, he admitted to having made a serious suicide attempt 5 days earlier. When asked to explain this apparent inconsistency, he described the events as follows:

> "I had been feeling very well for the last 3 months, without any suicidal ideation or behaviors. Then, in the past week, I noticed that I was getting increasingly manic and my wife started to irritate me more and more with her criticisms of my behavior. Five days ago, we got into a violent argument. I suddenly erupted into a volcanic rage and wanted to kill her, but I knew I shouldn't do that so I quickly tried to find some other way of punishing her. During this violent argument I saw a large bottle of her medications on a shelf, out of the corner of my eye. Without thinking, I suddenly ran over, opened the bottle, emptied the pills into my hand, and swallowed them, and when I had swallowed the whole bottle I said to her 'You see, what you are doing is going to kill me. You will have on your conscience for the rest of your life that you killed me and you will know that it was all your fault. I am going to leave in my car now and you will not be able to find me until I am dead.' I raced out of my house and went to a place in the woods where I knew they wouldn't be able to find me and shortly thereafter went into a coma and was found unconscious the next day. They brought me to the hospital where I recovered. All of this was done suddenly in a violent rage, without any thought that I was killing myself, but rather as a thought that I was punishing and harming her. So, no, I had no suicidal ideation in the past month, but I did make a suicide attempt."

[11] Giddens, J. M., & Sheehan, D. V. (2014). Is There Value in Asking the Question "Do you think you would be better off dead?" in Assessing Suicidality? A Case Study. *Innovations in clinical neuroscience*, *11*(9-10), 182. Available from: http://innovationscns.epubxp.com/i/425963/182

[12] Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., ... & Dunbar, G. C. (1998). The Mini-International Neuropsychiatric Interview (MINI): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of clinical psychiatry*.

This is a reason why you cannot assume that if someone has no ideation that they had no suicidal intent, suicidal plans, or suicidal behaviors within a given timeframe.

Can someone make a suicide plan and not have suicide intent?
Yes. When experiencing a suicidal impulse attack, some patients report they are able to more easily resist the suicidal impulse if they give into making a suicide plan. These patients report that making a suicide plan frequently causes the impulse attack symptoms to significantly reduce in severity. Patients may give into this urge to plan in order to more quickly reduce the severity of symptoms in an impulse attack, even if they have no intent to actually carry out this plan. Paradoxically, the generation of a suicide plan serves the role of warding off the need to immediately act on the suicidal impulse attack. We refer to this paradoxical strategy as the suicide plan *gambit* strategy. As in chess, a gambit is a strategy that makes a short-term sacrifice for a longer-term gain.

Can someone have suicidal intent but no suicidal ideation within a timeframe?
Yes. Consider the patient who denied having any suicidal ideation in the past week. When asked if he had any suicidal intent he answered in the affirmative. When asked to explain this apparent discrepancy he clarified as follows.

> "Two years ago I was very depressed and suicidal and decided that I would kill myself. Then I realized that this would break my parents' hearts. They have been very good to me. I am their only son and I couldn't do this to them. However, I did decide that, because of my chronic suffering, that [sic] as soon as they died I would kill myself right away. I do not have any specific plan of how I would do this and postponed acting on it until after they died, but they are only in their 50s and they could live another 20 years (or more). However, if they were killed in a car accident next week, I would kill myself the following day. So, in the past week I have had no suicidal thoughts or plans, because this intent may be far off in the future and there is no need for me to reflect on it. I made the decision 2 years ago, hence, in the past week, I have had no suicidal ideation, plans, or behavior, but the intent remains there from that past decision as a cloud, not in my overt consciousness, but ready to be implemented if the opportunity presents."

Do we need a classification of suicidality phenomena?
Yes. To our knowledge there is no strict classification of suicidality *phenomena*. However, there are classifications systems of suicidality events that include descriptions of many of the core suicidality phenomena within these suicidality event categories. Nonetheless, identifying the core suicidality phenomena in need of capture is a separate task from the capture of data on suicidality events. In general, all suicidality scales are designed to capture aggregate scores for a range of suicidality phenomena and their severity or seriousness within a given timeframe. For example, if a patient had multiple events of suicidal ideation or suicidal preparatory behaviors in the past month, the scales combine the severity / seriousness rating for the aggregate of these events over the past month. Some of these events may have been mild while others may have been severe. The aggregate rating might then be moderate. Hence, the system used to capture severity / seriousness ratings needs to be different from the data capture method used for

individual suicidality events if it is to be done efficiently for each agenda. In the final analysis, to properly capture data about suicidality, one system is needed to directly capture information about the severity of the *phenomena*, a separate system is needed to capture suicidality *event* data, and a third classification system is needed to capture information about suicidality *disorders*. In this way the characteristics, attributes, and qualities associated with the phenomena, the events, and the disorders are captured in a way that is highly specific to the core features while delimiting them from their immediate neighbors.

Do we need a new classification of suicidality events?

Yes. There are several current classifications of suicidal *events*. The most notable include the Columbia-Classification Algorithm of Suicide Assessment (C-CASA)[13], the expanded USFDA classification categories in the 2012 draft guidance document (FDA-CASA 2012)[14], and another proposed by O'Carroll et al 1996[15]. In general, these systems intermingle classifications of suicidal phenomena with suicidal events. Attempts to develop scales and classification categories / algorithms to capture information separating out individual suicidality events from each other have led to much confusion[16] [17]. The C-CASA and FDA-CASA 2012 are used in a manner that collapses all phenomena of suicidality experienced within a timeframe into one category. Both systems ask that you code the highest coded category. For example, if a patient experiences suicidal ideation and then immediately engages in a preparatory suicidal behavior, these classification systems only require the preparatory suicidal behavior to be coded. When you only have the coding to review, there is no way for a clinician to know whether or not the preparatory suicidal behavior occurred with the suicidal ideation. Instead of only capturing the highest coded event, we should capture all of the phenomena experienced in each event of suicidality within a timeframe. It is not efficient and is too time consuming to complete a *severity scale* for suicidality phenomena on each event in a given timeframe, especially when there are many suicidality events. For example, consider a patient who has 10 suicidal events within a 24-hour period. If it takes 8 minutes for the average suicidal subject to complete the standard S-STS or C-SSRS, it would take 80 minutes to properly rate the phenomena across the day's events. The Tampa - Classification Algorithm for Suicidality Assessment (T-CASA) captures all necessary information on events in a fraction of this time for the 10 events. (The T-CASA

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[13] Posner, K., Oquendo, M. A., Gould, M., Stanley, B., & Davies, M. (2007). Columbia Classification Algorithm of Suicide Assessment (C-CASA): classification of suicidal events in the FDA's pediatric suicidal risk analysis of antidepressants. *The American journal of psychiatry*, *164*(7), 1035-1043.

[14] US Food and Drug Administration. (2012). Guidance for industry: suicidal ideation and behavior: prospective assessment of occurrence in clinical trials. *Silver Springs, MD: US Food and Drug Administration Available at: http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/ucm315156.htm. Accessed November 6*, 2015.

[15] O'Carroll, P. W., Berman, A. L., Maris, R. W., Moscicki, E. K., Tanney, B. L., & Silverman, M. M. (1996). Beyond the Tower of Babel: a nomenclature for suicidology. *Suicide and Life-Threatening Behavior*, *26*(3), 237-252.

[16] Giddens, J. M., Sheehan, K. H., & Sheehan, D. V. (2014). The Columbia-Suicide Severity Rating Scale (C–SSRS): Has the "Gold Standard" Become a Liability?. *Innovations in clinical neuroscience*, *11*(9-10), 66. Available from: http://innovationscns.epubxp.com/i/425963/66

[17] Sheehan, D. V., Giddens, J. M., & Sheehan, K. H. (2014). Current assessment and classification of suicidal phenomena using the FDA 2012 Draft Guidance document on suicide assessment: a critical review. *Innovations in clinical neuroscience*, *11*(9-10), 54. Available from: http://innovationscns.epubxp.com/i/425963/54

classification system and the system used to collect this data in an efficient manner is discussed in detail in our book Suicidality: A Roadmap for Assessment and Treatment.[18])

Using a suicidality scale to obtain the details of an event of suicidality requires rating the full spectrum of suicidal phenomena (including all of the suicidal phenomena not experienced and those experienced and to what extent). In contrast, the T-CASA only requires the patients to indicate which phenomena they experienced in each event from a list.

There is no way for anyone using either the C-CASA or the FDA-CASA 2012 to know if an antidepressant is specifically increasing the severity, or seriousness, or frequency, or time spent in, nor the combinations of other suicidality phenomena associated with the USIAs within the event. Similarly, these two classification algorithms do not have a way to capture command hallucination events about suicidality if that occurs in response to a medication. These are major safety concerns and are not confined to only these examples.

To complicate matters further, when the FDA-CASA 2012 asks the rater to capture information on suicidality events, it focuses on capturing the event it deems the most serious using its Guttman Scaling procedure of ranking seriousness of events. However, as we have documented elsewhere[19] [20] [21] their Guttman Scale ranking of seriousness does not necessarily line up with the gravity of the events from the patient's perspective.

Classification of Suicidality Disorders

Is there more than one suicide disorder?

Yes. There are at least several different suicidality disorders. For example, the experience and phenomena associated with an Impulse Attack Suicidality Disorder are quite different from the experience and phenomena associated with a Life Event Induced Suicidality Disorder. The response to treatment and the natural history of these disorders appear to be different.

Is there a classification of suicidality disorders?

Yes. See chapter 6 for a phenotypic classification of Suicidality Disorders.

Are suicidality disorders independent "Axis I disorders"?

Yes. This appears likely. Currently suicidality is seen as a cluster of symptoms secondary to other 'Axis I' psychiatric disorders. It is assumed that when an Axis I psychiatric disorder is treated the

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[18] Sheehan, D. V. and Giddens, J. M. 2015. *Suicidality: A Roadmap for Assessment and Treatment*. Chapter 4.1. Available from: http://www.harmresearch.org

[19] Giddens, J. M., Sheehan, K. H., & Sheehan, D. V. (2014). The Columbia-Suicide Severity Rating Scale (C–SSRS): Has the "Gold Standard" Become a Liability?. *Innovations in clinical neuroscience*, *11*(9-10), 66. Available from: http://innovationscns.epubxp.com/i/425963/66

[20] Sheehan, D. V., Giddens, J. M., & Sheehan, K. H. (2014). Current assessment and classification of suicidal phenomena using the FDA 2012 Draft Guidance document on suicide assessment: a critical review. *Innovations in clinical neuroscience*, *11*(9-10), 54. Available from: http://innovationscns.epubxp.com/i/425963/54

[21] Sheehan, D. V., Giddens, J. M., & Sheehan, I. S. (2014). Status Update on the Sheehan-Suicidality Tracking Scale (S-STS) 2014. Appendix F. *Innovations in clinical neuroscience*, *11*(9-10), 93. Available from: http://innovationscns.epubxp.com/i/425963/92

related suicidality will respond automatically in its wake. One only has to study the response of suicidality to antidepressants to see that this is often not the case. With all antidepressants approved by the USFDA for the treatment of Major Depressive Disorder in those under 25 years, suicidality increases with decreasing age, even when the medication improves the depression. Between the ages of 25 and 65 the response to the suicidality is not significantly different from placebo, even when the drug is better than placebo in treating the MDD. Only in those over the age of 65 is the antidepressant reliably superior to placebo in treating the suicidality, while it is also effective in treating the MDD[22].

Sometimes, in treating a patient with Bipolar Depression, the suicidality resolves with lithium alone, while the patient continues to be just as depressed as ever. Conversely, in some other patients with Impulse Attack Suicidality Disorder, treating the suicidality with magnesium can resolve the suicidality. In IASD, the depression secondary to the suicidality resolves after the suicidality clears, even though the magnesium has no direct antidepressant effect. This suggests that suicidality disorders and mood disorders may have a different pathophysiology and response to treatment.

Do we need a new classification of suicidality disorders?
Yes. If we find an effective and specific anti-suicidality treatment and use it in a clinical trial that includes an enriched sample of suicidal patients, the trial is very likely to fail. If we used an SSRI or an SNRI in a clinical trial that included an enriched sample of all patients who walked into the clinic declaring that they were depressed, the SSRI and SNRI would fail to separate out from placebo in a double blind study. The reason is that such a depression study would have some patients with Major Depressive Disorder, some patients with Bipolar Disorder, some patients with Schizoaffective Disorder, some patients with cocaine or amphetamine withdrawal, etc. The benefit of the SSRI in the Major Depressive Disorder group would be offset by the failure of the other disorders to respond. Because of the heterogeneous nature of the different suicidality disorders, the anti-suicidality effect of the medication in one of the suicidality disorders may be offset by the failure to provide benefit in the other suicidality disorders. Hence, in conducting trials with anti-suicidality medications, we need to investigate these disorder phenotypes one at a time, in order to detect when an anti-suicidality treatment is effective and when it is not. (See chapter 6 for an overview of these phenotypic suicidality disorders.)

Psychological Treatments for Suicidality
Do we need a new different type of suicide psychotherapy specifically for suicidality?
Yes. Listening to patients speaking about their suicidality makes many clinicians apprehensive. This anxiety interferes with their ability to learn, understand, and help patients cope with their suicidality. A new psychotherapy is needed to help clinicians better interact with suicidal patients, so that the clinician can be more comfortable and the patient can feel better

[22] Stone, M., Laughren, T., Jones, M. L., Levenson, M., Holland, P. C., Hughes, A., ... & Rochester, G. (2009). Risk of suicidality in clinical trials of antidepressants in adults: analysis of proprietary data submitted to US Food and Drug Administration. *Bmj*, *339*.

understood, and so that the patient is not offended or alarmed by the clinicians' reactions. (See chapter 3 tips for interviewing suicidal patients.)

Does talking to patients about suicidality make suicide attempts more likely?
Sometimes yes, sometimes no. The evidence on this point remains unclear. Some data suggest that it is possible that talking to patients about suicidality may not increase their distress[23] [24]. However it probably depends how this is done, the relationship with the clinician, and the clinician's ability to tolerate such discussions without overreacting.

Medication Treatments for Suicidality

Can some meds make suicidality worse?
Yes. ADs[25], SSRIs[26], SNRIs[27], TCAs[28], antipsychotics[29], anticonvulsants[30] [31], varenicline[32], oseltamivir[33] [34], corticosteroids[35] [36] have all been associated with a worsening of suicidality in some patients.

Can ADs worsen suicidality?
Yes. Antidepressants can increase suicidality in those under 25 years compared to placebo. The younger the age, the greater the increased risk of suicidality[37].

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[23] Gould, M. S., Marrocco, F. A., Kleinman, M., Thomas, J. G., Mostkoff, K., Cote, J., & Davies, M. (2005). Evaluating iatrogenic risk of youth suicide screening programs: a randomized controlled trial. *Jama*, *293*(13), 1635-1643.
[24] Linehan, M. M., Korslund, K. E., Harned, M. S., Gallop, R. J., Lungu, A., Neacsiu, A. D., ... & Murray-Gregory, A. M. (2015). Dialectical Behavior Therapy for High Suicide Risk in Individuals With Borderline Personality Disorder: A Randomized Clinical Trial and Component Analysis. *JAMA psychiatry*, *72*(5), 475-482.
[25] Stone, M., Laughren, T., Jones, M. L., Levenson, M., Holland, P. C., Hughes, A., ... & Rochester, G. (2009). Risk of suicidality in clinical trials of antidepressants in adults: analysis of proprietary data submitted to US Food and Drug Administration. *Bmj*, *339*.
[26] Ibid.
[27] Ibid.
[28] Perroud, N., Uher, R., Marusic, A., Rietschel, M., Mors, O., Henigsberg, N., ... & Aitchison, K. J. (2009). Suicidal ideation during treatment of depression with escitalopram and nortriptyline in genome-based therapeutic drugs for depression (GENDEP): a clinical trial. *BMC medicine*, *7*(1), 60.
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[30] Arana, A., Wentworth, C. E., Ayuso-Mateos, J. L., & Arellano, F. M. (2010). Suicide-related events in patients treated with antiepileptic drugs. *New England Journal of Medicine*, *363*(6), 542-551.
[31] Patorno, E., Bohn, R. L., Wahl, P. M., Avorn, J., Patrick, A. R., Liu, J., & Schneeweiss, S. (2010). Anticonvulsant medications and the risk of suicide, attempted suicide, or violent death. *Jama*, *303*(14), 1401-1409.
[32] Kuehn, B. M. (2008). FDA warns of adverse events linked to smoking cessation drug and antiepileptics. *Jama*, *299*(10), 1121-1122.
[33] Jeon, S. W., & Han, C. (2015). Psychiatric Symptoms in a Patient with Influenza A (H1N1) Treated with Oseltamivir (Tamiflu): A Case Report. *Clinical Psychopharmacology and Neuroscience*, *13*(2), 209.
[34] Kim, H. G., Kim, H. J., & Cho, Y. S. (2010). A Case of Auditory Hallucination after Intake of Oseltamivir for H1N1 Treatment. *Journal of the Korean Society of Emergency Medicine*, *21*(3), 402-404.
[35] Lewis, DA and Smith, RE. Steroid-induced psychiatric syndromes: a report of 14 cases and a review of the literature. J Affect Disord. 1983; 5: 319–332.
[36] Bräunig, P, Bleistein, J, and Rao, ML. Suicidality and corticosteroid-induced psychosis [letter]. Biol Psychiatry. 1989; 26: 209–210.

Can ADs improve suicidality?
Yes. Antidepressants can decrease suicidality in those over 65 years compared to placebo. The older the age the more the antidepressant is superior to placebo in reducing suicidality[38].

Are there OTC medications that worsen suicidality?
Yes. For example, calcium supplements may worsen suicidality in those with magnesium sensitive Impulse Attack Suicidality Disorder (IASD) (perhaps by interfering with the absorption and effect of magnesium). Withdrawal from opiates and NMDA receptor antagonists like magnesium or ketamine can worsen suicidality in some IASD subjects.

Can some meds improve suicidality?
Yes. For example, magnesium may improve suicidality in some with IASD. Lithium decreases suicidality ideations and behaviors in a significant number of patients with both Bipolar Disorder and Major Depressive Disorder[39]. Clozapine has been approved by the USFDA for reducing suicidal behavior in patients with schizophrenia or schizoaffective disorder[40] [41].

Is it appropriate to exclude persons from clinical trials specifically designed for the treatment of suicidality because they are 'too suicidal'?
No. Excluding patients from clinical trials for suicidality due to the severity of suicidality is not appropriate. If a patient is able to provide informed consent to be in a study, they should be allowed to be in a study, regardless of their severity of suicidality. Not doing so borders on discrimination and is a violation of the Americans with Disabilities Act. If an individual patient is excluded from a clinical trial for a suicidality treatment because they are too suicidal, their exclusion from the study may actually cause them to feel more hopeless and more depressed, which may actually end up further contributing to their suicidality.

Should we avoid conducting double-blind placebo controlled clinical trials to investigate medications for the treatment of suicidality?
No. We should conduct placebo-controlled trials with suicidal patients in investigating anti-suicidality treatments.

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[37] Stone, M., Laughren, T., Jones, M. L., Levenson, M., Holland, P. C., Hughes, A., ... & Rochester, G. (2009). Risk of suicidality in clinical trials of antidepressants in adults: analysis of proprietary data submitted to US Food and Drug Administration. *Bmj*, *339*.
[38] Ibid.
[39] Tondo, L., & Baldessarini, R. (2011, February 10). Can Suicide Be Prevented? Retrieved November 9, 2015, from http://www.psychiatrictimes.com/bipolar-disorder/can-suicide-be-prevented
[40] Novartis Pharmaceuticals Corporation. (2014). HIGHLIGHTS OF PRESCRIBING INFORMATION: CLOZARIL® (clozapine) tablets, for oral use. East Hanover, NJ. Retrieved from https://www.pharma.us.novartis.com/product/pi/pdf/Clozaril.pdf Accessed May 1, 2015.
[41] Meltzer, H. Y., Alphs, L., Green, A. I., Altamura, A. C., Anand, R., Bertoldi, A., ... & Potkin, S. (2003). Clozapine treatment for suicidality in schizophrenia: international suicide prevention trial (InterSePT). *Archives of general psychiatry*, *60*(1), 82-91.

Failure to have a placebo arm in such studies can provide very misleading results and failure to control for the natural history of chronic suicidality. Such investigations would require exposing many more patients to risk to get an accurate answer to the questions compared to doing a non-inferiority trial design. On ethical grounds it is safer to aim for the greatest accuracy in getting an answer while exposing the fewest number of patients to potential risk compared to any of the alternative methodologies. For example, if a potential anti-suicidality treatment was investigated in a non-inferiority design while using an antidepressant as the active control comparator, the result could show a statistically significant difference in favor of the anti-suicidality treatment compared to the antidepressant. However, the antidepressant in such a trial might itself be increasing the risk of suicidality while the anti-suicidality medication was in fact behaving in a way that was no better than a placebo. Without the presence of a placebo arm in such a trial it would not be possible to make this assessment. Furthermore, it could lead to an anti-suicidality treatment being deemed effective, when in fact it was not. That itself could be a dangerous and inaccurate conclusion. In the meantime, patients would have been exposed to danger in the generation of an inaccurate conclusion. This is hardly an ethical approach. The same standard as applied to all other serious and potentially lethal illnesses needs to be applied to suicidality research as well. Patients with suicidality are capable of giving informed consent and should have the option of giving that informed consent to participate.

Obviously, data safety monitoring boards should be an inherent part of the conduct of such trials and wisdom ought to prevail including all of the necessary safety precautions to ensure that patients are protected in an optimal way. The world needs to find specific anti-suicidality medication treatments. To do this in the most efficient and safe manner while providing scientific confidence in the results will require using double-blind placebo controlled designs.

Do no-harm contracts work?

No. No-harm contracts do not prevent patients from attempting to kill themselves nor do they provide medico-legal protection for the clinician. Some research has even shown the use of no-harm contracts results in patients being less communicative about their suicidality[42].

Prediction of Suicidality

Can suicide attempts and deaths be predicted at an individual level?

No. The evidence suggests that suicide attempts and deaths can be correlated with some predictive factors at a *group* level. However, the ability to do this at the *individual* level is so fraught with false-positives and false-negatives that we have little confidence in such individual risk predictions[43] [44] [45].

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[42] Miller, MC. Contracting for safety. Chapter 40 (pages 372-377) in A Concise Guide to Understanding Suicide: Epidemiology, Pathophysiology and Prevention. Edited by Stephen H. Koslow, Pedro Ruiz, and Charles B. Nemeroff. Cambridge University Press 2014.

[43] Jenkins GR, Hale R, Papanastassiou M, Crawford MJ, Tyrer P. Suicide rate 22 years after parasuicide: cohort study. BMJ. 2002;325:1155.

[44] Pokorny, Alex D. "Prediction of suicide in psychiatric patients: report of a prospective study." Archives of general psychiatry 40.3 (1983): 249-257.

[45] Pokorny, Alex D. "Suicide prediction revisited." Suicide and life-threatening behavior 23.1 (1993): 1-10.

Should efforts be focused on predicting suicidal behaviors?
It would be more productive to allocate resources to understand the phenomenology, genetic and other biomarkers of suicidality, and to find effective and specific anti-suicidality treatments. This could reduce the symptoms, the suffering, and impairment associated with suicidality disorders. Studies investigating predictive factors for suicidal behaviors at the individual level have found that it is not possible to reliably do so with our current methods[46] [47] [48].

Has prediction of suicide risk helped lower suicide rates? This has been a holy grail of suicide research and has not been particularly fruitful.
Current research about suicide risk has been based upon lumping all suicidal subjects into the same suicidality class and attempting to find patterns. This is similar to lumping everyone with a heart problem into the same class and attempting to find mortality risk factors for their 'heart problem'. By subdividing 'heart problems' into separate disorders, researchers were better able to investigate individual cardiac disorders and to find appropriate treatments for each specific cardiac disorder. Using this approach, cardiologists were successful in lowering mortality rates from these 'heart problems'. Studying suicidality one phenotype (and someday, one genotype) at a time, is likely to be a more productive approach to lowering suicide rates. (See chapter 6 for a classification system of Suicidality Disorders.)

Conclusion

The abbreviated answers to the above questions may expose clinicians to a new perspective on suicidality. We hope it offers new insights, into an improved understanding of, and ability to assess suicidality.

[46] Jenkins GR, Hale R, Papanastassiou M, Crawford MJ, Tyrer P. Suicide rate 22 years after parasuicide: cohort study. BMJ. 2002;325:1155.
[47] Pokorny, Alex D. "Prediction of suicide in psychiatric patients: report of a prospective study." Archives of general psychiatry 40.3 (1983): 249-257.
[48] Pokorny, Alex D. "Suicide prediction revisited." Suicide and life-threatening behavior 23.1 (1993): 1-10.

3

Tips for Interviewing Suicidal Patients

> "Psychiatrists are interesting people. You can go and talk to a psychiatrist about violence, rape, murder, plunder, pillage, and chaos. They sit calmly listening like Buddhas, completely unfazed. Then you start talking about your suicidality. All of a sudden you can see their expression change. There is alarm on their face and fear in their eyes. Their brains are spinning. They are no longer listening to you. You are freaking them out. If they are alarmed about this, with all their experience, why shouldn't you, watching their reaction, become even more alarmed than you already are? You don't want to frighten your psychiatrist. So you start back peddling in your discussion about your suicidality. They don't want to hear this stuff anymore. If they are that alarmed and frightened by your suicidality, how can they possibly help you? If they are unable to listen to the details about your suicidality, how can you unburden your concerns and communicate your struggles in dealing with your suicidality? You can't speak to your minister, priest, rabbi, imam, family, or friends about your suicidality, because they get too alarmed and aren't equipped to handle this. For problems of a psychological nature, society appointed and trained mental health professionals to listen to, sort through, and assist you with these concerns. However, many mental health clinicians struggle in dealing with your suicidality, and their response to such discussions often has the opposite to the intended effect."
>
> *Anon*

We often unnecessarily adopt different strategies in dealing with suicidal patients, than we use when dealing with non-suicidal patients. We should not abandon good psychotherapeutic

principles used for other conditions, when working with suicidal patients. We need psychotherapeutic strategies to specifically address the needs of our patients with suicidality. We need to listen without judgment or alarm to the suicidal struggles of our patients.

Topics addressed in this chapter:

- Before Interacting with Patients
- While Interacting with Patients
- After Interacting with Patients
- Summary

Before Interacting with Patients

Deal with your own countertransference on suicidality.

Ultimately you have no control over a patient's decision to make a suicide attempt or to not make a suicide attempt. You need to accept your relative lack of control over this situation. You cannot control your patients as you might hope. Accepting this is very difficult, but it will allow you to get closer to your patient. It may result in the patient being more honest with you and being more willing to contact you and rely on your judgment in times of crisis.

You must constantly deal with your own helplessness. Ultimately there are no reliable treatments for many cases of suicidality. Many patients with suicidality know this from experience, but clinicians often fail to understand this and adopt an unnecessarily optimistic outlook in the face of the limited available and approved anti-suicidality treatments. It is okay for you not to have all the answers. Understanding your own helplessness in the situation may enable you to be more available to the patient in times of crisis.

Stop viewing suicidality exclusively as either a symptom of depression or a response to stress. Although these are two reasons people may experience suicidality, they are *not the only* reasons people experience suicidality. Basing your interactions with a suicidal patient upon these assumptions can cause a suicidal patient who is experiencing a different form of suicidality to feel as though they are not understood. If the patient is in crisis, this type of message can make the patient feel worse. It is better to approach patients without these assumptions. Allow the patient to share their unique suicidality experiences.

Similarly, please do not assume that putting a suicidal patient on an antidepressant will necessarily help their suicidality. Some patients have found that antidepressants increase the

frequency of their impulsive suicidality[1] and researchers have found that some patients with Bipolar Depression respond differently to antidepressants and / or because some of them may have a different genetic polymorphism variant[2] [3].

Lithium can provide an anti-suicidality effect even when it is not having any antidepressant effect at the same time. It is as if lithium has the ability to pharmacologically dissect out anti-suicidality effects from antidepressant effects in some individuals. Furthermore, some, but not all suicidal patients, get anti-suicidality benefit from lithium[4].

Some clinicians assume incorrectly that patients with chronic suicidality must be "attention seeking", or must have Borderline Personality Disorder (or both). This assumption has led some clinicians to not even discuss suicidality with their patients, out of fear of reinforcing the 'attention-seeking'. One patient told the second author (JG) his psychiatrist told him "we don't talk about *that* here" after he brought up his recent increase in severity of suicidality. This devastated him. He already felt like killing himself and was trying to get help, but his psychiatrist told him they could not talk about it! He felt even worse after that interaction with his psychiatrist. When dealing with chronically suicidal patients, it is not productive to assume they all have Borderline Personality Disorder. We should avoid such assumptions and be willing to listen attentively and non-judgmentally to patients discussing their unique suicidality.

Paradoxically, Impulse Attack Suicidality Disorder (IASD) can lead to a decrease in risk taking and can restrain impulsive traits and behaviors (see chapter 6 for more information about suicidality disorders). In contrast, when subjects with IASD respond to treatment they may feel less inhibited or less restrained and their trait impulsivity scores may increase. We believe this paradox prompts clinicians to assume that patients who make impulsive suicide attempts, have higher impulsive trait scores. However, data from several studies using different scale measures of impulsive traits did not find consistent strong correlations between impulsive personality traits and suicidality[5] [6]. . One study with inconclusive results compared a group of adolescents with non-suicidal self-injury (NSSI) only (n = 31) and another group with NSSI plus suicide attempt (n = 25) on two measures of laboratory behavioral impulsivity. They reported a statistically significant difference between these small samples in only one of these two

[1] Sheehan, D. V. and Giddens, J. M. 2015. *Suicidality: A Roadmap for Assessment and Treatment*. Available from: http://www.harmresearch.org

[2] Sachs, G. S., Nierenberg, A. A., Calabrese, J. R., Marangell, L. B., Wisniewski, S. R., Gyulai, L., ... & Thase, M. E. (2007). Effectiveness of adjunctive antidepressant treatment for bipolar depression. *New England Journal of Medicine*, *356*(17), 1711-1722.

[3] Kim, B., Kim, C. Y., Hong, J. P., Kim, S. Y., Lee, C., & Joo, Y. H. (2008). Brain-derived neurotrophic factor Val/Met polymorphism and bipolar disorder. *Neuropsychobiology*, *58*(2), 97-103.

[4] Tondo, L., & Baldessarini, R. (2011, February 10). Can Suicide Be Prevented? Retrieved November 9, 2015, from http://www.psychiatrictimes.com/bipolar-disorder/can-suicide-be-prevented

[5] Corruble E, Benyamina A, Bayle F, Falissard B, Hardy P. Understanding impulsivity in severe depression? A psychometrical contribution, Progress in Neuro-Psychopharmacology & Biological Psychiatry 27 (2003) 829– 833.

[6] Horesh N, Self-Report vs. Computerized Measures of Impulsivity as a Correlate of Suicidal Behavior. Crisis 2001; Volume 22 (1): 27–31.

measures[7]. The usual assumption is that people with impulsive personalities are more likely to engage in suicide attempts. This is not always true. Many patients who do not have impulsive personalities attempt suicide impulsively because they have Impulse Attack Suicidality Disorder (IASD) and cannot cope with the very specific unexpected, unprovoked suicidal impulse attacks. It is possible that a patient making an impulsive suicide attempt is suffering from IASD, which is not the same thing as having an impulsive personality disorder. Until the relationship between *overall trait* impulsivity and *suicidality specific* impulsivity is fully understood, please do not assume patients with a history of multiple suicide attempts or those with IASD necessarily have an impulsive personality.

While Interacting with Patients

Be calm and non-judgmental. Accept the patient's experiences as they are and do not judge their suicidality. Allow the patient the freedom to express the reality of their experiences. Your office may be the only place they are able to be honest about what they experience. Patients deserve such a safe place.

Do not over-react to suicidal statements. Clinicians are quick to hospitalize patients when suicidality is mentioned, because they fear the patient will make a suicide attempt. Yes, a suicide attempt is possible, but putting a patient with chronic suicidality in the hospital every time they experience a flare in their suicidality can interfere with their life, their job, and their relationships and may cause their suicidality to become more disabling. Use your best clinical judgment and avoid overreacting in discussions of suicidality.

Ask for details or examples from the patient's experience to better understand, but do not insist the patient provide these to you. Talking about suicidality is very difficult for some patients. Pressuring the patient too much may harm the therapeutic relationship.

Focus on the resistance instead of the content. Some patients may be hesitant to discuss the content of their suicidality. Clinicians often want to know such details. One approach in handling this is to not directly pursue the content that is sought, but instead to focus on discussing the patient's resistance to divulging this information. For example, "Ok. I know you are hesitant to tell me the content of your suicidal thoughts or plan, but can you tell me about your fears of what would happen if you shared this information with me?" Keeping the discussion going by focusing on the resistance itself, rather than the content, allows the patient to eventually feel more comfortable in divulging the content directly without feeling pressured. This is a technique often used in discussing difficult material with patients in psychotherapeutic settings.

[7] Dougherty D.M., Mathias C.W., Marsh-Richard D.M., et al. (2009) Impulsivity and clinical symptoms among adolescents with non-suicidal self-injury with or without attempted suicide. Psychiatry Res. 169(1),22–27.

Your therapeutic relationship with patient is central. Do your best not to do anything to jeopardize this relationship. The patient needs someone they can reach out to in times of crisis. Harm to the relationship can hinder the patient's willingness to reach out.

Ensure patients have the appropriate contact information if they are in crisis. Give them the national hotline phone numbers, the online chat web addresses, your phone number, and the local crisis center phone number. (The International Suicide Prevention Wiki has a number of resources around the world.) Make sure they know that calling 911 (or emergency services telephone number in other countries) is an option if the crisis warrants it.

Do not ask patients to promise you they will not harm themself. This type of request may lead to a breakdown in the therapeutic relationship. Similarly, do not encourage the patient to promise anyone (other than themself) that they will not self-injure or make a suicide attempt. The patient's loved ones may expect such a promise. If the patient is unable to keep their promise, there may be far-reaching effects in their relationship with the loved one to whom they made the promise. It is best to avoid such expectations. For a more detailed discussion on this point see the discussions on No Harm Contracts in Sheehan & Giddens[8] and Contracting for Safety by Michael Miller[9].

Ask for feedback from the patient. Find out how they would like you to handle a suicidal crisis. Write this down and develop a plan. Ensure that you and the patient are in agreement on how best to proceed in handling future suicidal crises. If you have helped a patient with a suicidal crisis, seek feedback on what worked and what did not work for that patient. Write this down, so that your response can be customized to that patient's future needs.

There are a host of concerns (potential hospitalization, social stigma) that weigh on patients when attempting to reach out for help in a crisis. These concerns make it difficult for some patients to communicate during a suicidal crisis. In order to circumvent this issue, it may be helpful for you and your patient to decide on an alternative phrase, which the patient can use to communicate that they are in a suicidal crisis. If you create such an alternative phrase, make sure it is something both of you will remember. Add it to your written plans to help that patient through a suicidal crisis.

Your psychotherapeutic role is not to solve the patient's problem for them. Your role is to listen, to help *them* clarify the problem, and to help them identify *their own* solutions to solve the problem. Then you support them (lend them your ego strength) in implementing their own solutions.

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[8] Sheehan, D. V. and Giddens, J. M. 2015. *Suicidality: A Roadmap for Assessment and Treatment*. Chapter 15.1. Available from: http://www.harmresearch.org

[9] Miller, M. (2014). Contracting for Safety. In S. Koslow, P. Ruiz, & C. Nemeroff (Eds.), *A concise guide to understanding suicide: Epidemiology, pathophysiology, and prevention*. Cambridge University Press.

After Interacting with Patients

Document the details of the interaction. This is medico-legally important. See chapters 4 and 5 and see appendix A in Shawn Shea's book for a good discussion on this documentation[10].

Ensure that anyone who covers your emergency calls is aware of the patient's suicidality in the event it is difficult for the patient to verbalize this while in crisis. Make sure the covering clinician is also aware of any "alternative phrases" you have set up with your patients, to communicate when they are in a suicidal crisis. Keep an organized list of the specific plans and "alternative phrases" for your suicidal patients. Update this file regularly to ensure it is available to anyone covering your emergencies.

Be available to the suicidal patient as necessary. Suicidal crises do not always present at the most opportune times. Some patients may delay reaching out for help in an attempt to cope with their suicidality on their own. Suicidal patients may find themselves worn out from the struggle during the day against their suicidality, and only reach out late at night, when they feel too exhausted to continue struggling on their own.

Consult peers to help you feel more comfortable treating your suicidal patient(s). Your peers may have suggestions or tips that may help you or your patient. Your peers may also serve as a safe place *for you to discuss* your concerns, fears, or worries about treating a patient with suicidality. It is not easy to consistently listen to a person's experience of suicidality, and not be able to quickly resolve their distress. It is important for you to take care of yourself emotionally, so you are available to help your patient(s). Local or regional associations of health care workers should consider setting up such a support system for clinicians working with suicidal patients.

Consider using one of the suicidality tracking scales, like the S-STS or S-STS CMCM, to track the severity of the patient's suicidality over time. Also consider using a suicide plan tracking scale like the SPTS, to track the patient's suicidal planning over time. These scales may help ensure that you are taking a systematic and thorough approach to suicidality assessment and tracking.

Summary

Stay calm. Listen. Ask for more information. Don't overreact.

[10] Shea, S. (2011). Appendix A: How to Document a Suicide Assessment. In *The practical art of suicide assessment: A guide for mental health professionals and substance abuse counselors* (2nd ed.). Mental Health Presses.

4

Suicidality Assessment and Tracking

4.1

Putting Suicidality Assessment and Tracking into Practice

Topics addressed in this chapter:

- Guideline for Family Physician Setting
- Guideline for Mental Health Setting
- Additional Recommendations

Introduction

We should stop playing ostrich with suicidality in clinical practice. Ignoring it will not make it go away. The idea that we should ask about depression in detail, but avoid asking about suicidality details is potentially harmful to patient care and exposes clinicians to medico-legal liability. The fear is that it may open up a Pandora's box for the clinician. Clinicians fear they will find that suicidality is more prevalent than previously acknowledged. They worry that talking about suicidality will make it worse. This could overwhelm the system with a need to refer everyone with even mild levels of suicidality for further assessment with a psychiatrist.

We need practical guidelines for non-psychiatrists to triage suicidal patients to 4 levels of further management. The non-psychiatrist:

1. manages the suicidality, without referral. *Monitor over time* (Level 1)
2. manages the suicidality, but *needs more information* on the suicidality or Non-Suicidal Self-Injury (NSSI) before deciding what to do next (Level 2)
3. *refers* the patient to a psychiatrist (Level 3)
4. *admits* the patient to an inpatient psychiatry facility (Level 4)

Color Code Interpretation

- Green: Allow the patient to go home and monitor for worsening.
- Blue: Give S-STS CMCM and review. Based on findings, with prudent clinical judgment, either continue to monitor, refer, or admit. Use your best clinical judgment.
- Purple: Refer to a psychiatrist or mental health specialist.
- Red: Seriously consider admission to an inpatient psychiatric facility.
- Orange: Give them the Sheehan-Suinocerality Tracking Scale (S-SNTS) and review.

Time Spent Experiencing Suicidality

In general, the more time spent in suicidality the greater the need for either a referral or an admission. However, five minutes in an unexpected suicidal impulse attack may be far more dangerous than five hours spent with only passive suicidal ideation. Time spent experiencing suicidality tends to be highly correlated with the severity of suicidality[1]. It is very useful collateral information. You should always ask about the time spent in suicidality (as outlined at the bottom of page 2 of the S-STS).

Scores on the S-STS Standard Version

- Anyone with a total score of ≥ 1 should be asked by a clinician, not necessarily a psychiatrist or psychologist, about the nature and basic details of the scores they endorsed on the S-STS.
- Anyone with a score of ≥ 2 on questions 1a, 5 - 12, or 14 should be referred to a psychiatrist or a psychologist for further investigation of their suicidality.
- Anyone with a score of ≥ 2 on questions 1a, 5 - 12, or 14 should trigger an alert for immediate suicidality consultation before allowing the patient to go home. If they are not in a medical or mental health facility, they should be contacted directly and immediately.
- Apart from these approximate guidelines, clinicians reviewing the S-STS scores should use their best clinical judgment to override these approximate guidelines based upon the circumstances of each case and the relationship of the clinician with the patient.

[1] Giddens, J. M., & Sheehan, D. V. (2014). Is a count of suicidal ideation and behavior events useful in assessing global severity of suicidality? a case study. *Innovations in clinical neuroscience*, *11*(9-10), 179. Available from: http://innovationscns.epubxp.com/i/425963/178

SHEEHAN-SUICIDALITY TRACKING SCALE (S-STS)

INSTRUCTIONS: PLEASE USE DATA FROM ALL SOURCES AND CONSIDER SEVERITY, FREQUENCY, TIME SPENT AND TIME FRAME IN YOUR RESPONSES.
THE RESPONSE "NOT AT ALL" TO ANY QUESTION MEANS "NONE" AND MEANS THAT THE THOUGHT, EXPERIENCE OR BEHAVIOR "DID NOT OCCUR AT ALL".
THROUGHOUT THE SCALE THE WORD ***INTEND OR INTENT*** MEANS ANY INTENTION GREATER THAN ZERO. SCORE THE MOST SERIOUS EPISODE THAT OCCURRED.

In the past (timeframe):

1. did you have any accident?
(this includes taking too much of your medication accidentally)
IF NO, SKIP TO QUESTION 2. IF YES, GO TO QUESTION 1a:

NO ☐ YES ☐

	Not at all	A little	Moderately	Very	Extremely
1a. how seriously did you plan or intend to hurt yourself in any accident, either by not avoiding a risk or by causing the accident on purpose?	0	1	2	3	4

IF THE ANSWER TO QUESTION 1a IS 0 (= Not at all), SKIP TO QUESTION 2.
IF THE SCORE IS 1 OR HIGHER, GO TO QUESTION 1b:

1b. did you intend to die as a result of any accident? NO ☐ YES ☐

In the past (timeframe), **how seriously did you:**

	Not at all	A little	Moderately	Very	Extremely
2. think (even momentarily) that you would be better off dead, need to be dead or wish you were dead? How many times? ____	0	1	2	3	4
3. think (even momentarily) about harming or hurting or injuring yourself – with at least some intent or awareness that you might die as a result – or think about suicide (killing yourself)? How many times? ____	0	1	2	3	4
4. have a voice or voices telling you to kill yourself or have dreams with any suicidal content? mark either or both: ☐ a voice or voices ☐ a dream	0	1	2	3	4
5. have any suicide method in mind (i.e. how)? #	0	1	2	3	4
6. have any suicide means in mind (i.e. with what)? #	0	1	2	3	4
7. have any place in mind to attempt suicide (i.e. where)? * #	0	1	2	3	4
8. have any date / timeframe in mind to attempt suicide (i.e. when)?*#	0	1	2	3	4
9. intend to act on thoughts of killing yourself? mark either or both: did you intend to act: ☐ at the time ☐ at some time in the future	0	1	2	3	4
10. intend to die as a result of a suicidal act? mark either or both: did you intend to die: ☐ at the time ☐ at some time in the future	0	1	2	3	4
11. feel the need or impulse to kill yourself or to plan to kill yourself sooner rather than later? mark either or both: was this: ☐ to kill yourself ☐ to plan to kill yourself mark either or both: was this: ☐ largely unprovoked ☐ provoked	0	1	2	3	4
12. take active steps to prepare for a suicide attempt in which you expected or intended to die (include anything done or purposely not done that put you closer to making a suicide attempt)?	0	1	2	3	4
13. injure yourself on purpose without intending to kill yourself? How many times? ____	0	1	2	3	4
14. attempt suicide (try to kill yourself)?	0	1	2	3	4

"A suicide attempt is a potentially self-injurious behavior, associated with at least some intent (> 0) to die as a result of the act. Evidence that the individual intended to kill him- or herself, at least to some degree, can be explicit or inferred from the behavior or circumstance.
A suicide attempt may or may not result in actual injury." (FDA 2012 definition[1,2]). * Note: Items 7 & 8 on S-STS ("a plan for suicide") means not going beyond ideas or talking about a plan for suicide. If actual behaviors occurred, the event should not be coded on item 7 or 8, but as "preparatory behavior" (item 12). Both events can occur separately over the same timeframe. # Note: clinician should ask for details.

Guideline for Family Physician Setting

A patient presents to a family physician's office for evaluation of recurrent headaches that are not responding well to analgesics. After taking a good medical history, conducting a physical exam, and ordering lab tests to rule out medical causes of the headaches, the family physician cannot find any medical cause for the persistence of the headaches. On reviewing the Mini International Neuropsychiatric Interview (MINI) Screen[2] paperwork completed by the patient in the waiting room prior to the visit, the family physician notes that the patient has depressive symptoms. The MINI Screen contains 2 specific questions on suicidality, 1 on suicidal ideations and another on suicidal behaviors. She is now concerned that these depressive symptoms may be part of a mood disorder. To follow up on this initial diagnostic impression, she asks one of her staff to do the full MINI (which takes, on average, 15 minutes). She reviews the findings on the MINI with her staff colleague and the patient. The findings suggest that the patient appears to have Major Depressive Disorder and has both active suicidal ideation and a suicide plan with some intent. The patient states that he has been depressed for approximately 1 year and that the depression has recently worsened, significantly. This worsening coincided with the flare up of his headaches. The family physician wonders what she should do next. She is concerned about the potential risk involved and the need to provide proper treatment for this patient.

What should she do next?

The family physician tells the patient that she is concerned about his level of depression and associated suicidality. She wants to ensure that she has a deeper grasp about what is going on before deciding what would be the best care to provide him. She asks the patient if he would mind filling out two detailed scales on his suicidality. The patient indicated that he would be happy to do so since he has been struggling with his suicidality in an ever-escalating way over the past several months. The family physician explains that some of these questions may appear to repeat questions asked on the MINI, but will capture the information in a more detailed manner. The patient is given the S-STS CMCM version and the SPTS. The patient completes this information in the waiting room and lets the office staff know when this task is completed. On reviewing the data captured the family physician realizes that the patient was planning to kill himself in the next 1 to 3 weeks if he could not get relief from his suffering. In discussions with the patient, he said he was pleased that the family physician had taken the time to investigate his problems so thoroughly. He was comforted by the detail covered by the scales and felt that the physician and her staff were trying to provide good care for him. Given this interest and concern, he said he felt more hopeful and did not feel any urgent need to act on these suicidal thoughts and he would be willing to wait until she could arrange an appointment with one of her psychiatry specialist colleagues. The family physician offered the patient a printed list of the names and contact information of all the psychiatrists with whom she consulted in her city. They discussed which of these psychiatrists might be covered by his insurance and selected and prioritized the names available. She then had her office staff call the psychiatrists in order to set

[2] Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., ... & Dunbar, G. C. (1998). The Mini-International Neuropsychiatric Interview (MINI): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of clinical psychiatry*.

up an appointment as soon as possible. A firm appointment was made for the patient for the following week and the family physician recommended that he came back in the interim if he felt any significant worsening of the suicidality or the depression. The patient was also given a list of crisis hotline numbers to use if his suicidality significantly worsened and was unable to reach the family physician. Given the proximity of the appointment with the psychiatrist they both decided to defer the decision on which medication to start until after he sees the psychiatrist. The family physician provided a printed copy of the completed MINI, the S-STS CMCM, and the SPTS to the patient so he could review these with the psychiatrist. Her office staff asked the patient to sign a release of her medical records regarding her recent care of him, which he did. Her office staff then sent copies of the records, the structured diagnostic interview (MINI), the S-STS CMCM, the SPTS, and her recent medical workup to the consulting psychiatrist with a brief summary letter asking that he call her or consult with her in the event he had any questions about the patient's medical care.

What the Family Physician's Office Needs to Have Ready, Organized, and Available in the Office Every Day:

1. The MINI Screen*[3], which is given to every new patient or to any patient that has not completed the MINI Screen* or the full MINI* in the past year.
2. The full MINI*.
3. The S-STS* and the S-STS CMCM*.
4. The SPTS.
5. A list of all psychiatrists in the area with their contact information.
6. A standardized covering letter template for psychiatric referrals to accompany the medical records that the family physician might choose to send in advance of the patient's appointment with the psychiatrist.

* The above structured interviews and scales are also computerized. The computerization does all the navigation through the structured interviews and scales in background and also scores these instruments and provides a scored .pdf file of these instruments that can be appended to an electronic medical record and sent to the consulting psychiatrist specialist.

This family physician has provided exemplary care in the management and disposition of this patient.

Guideline for Mental Health / Psychiatrist / Psychologist / Psychiatric Social Worker / Psychiatric ARNP / Inpatient Psychiatry Setting

Outpatient Setting

At the initial screening visit all patients are given a structured diagnostic interview (a full MINI). The psychiatrist or any mental health practitioner trained in the use of the MINI can do this. This

[3] The Mini International Neuropsychiatric Interview Screen is available at http://www.HarmResearch.org

can be done on paper or in the computerized form. The computerization does all the navigation through the structured interviews in background and also scores this instrument and provides a scored .pdf file of the completed document that can be appended to an electronic medical record. Using this information with a medical and psychiatric history and information gathered at an interview, the clinician then makes a psychiatric diagnosis and documents any other comorbid disorders. At the follow up visits the patient is scheduled to arrive at the office 15 minutes before the time scheduled with the clinician and completes the following scales in the waiting room either on paper or in the computer to track their response to treatment and monitor any treatment emergent problems.

1. Symptom scale to assess the primary axis I symptom cluster.
2. A brief measure of functional impairment.
3. A suicidality tracking scale and, where indicated, a suicidality plan tracking scale.
4. A patient-rated global improvement scale.
5. A face sheet asking the patient to prioritize the topics / issues they wish to discuss with the clinician at the visit.

When the patient completes these they are attached to the chart (physically or electronically). The clinician reviews these at the start of the visit and compares these scores with the baseline and prior visit scores. Copies of the suicidality scales and other documentation templates are available in chapters 4.2 – 4.4, chapters 5.2 – 5.4, and appendices 2.1 – 2.5. The clinician can use this information to guide them about further lines of questions to ask to better understand any suicidality that is present. If the clinician is concerned that the suicidality score on the S-STS standard version is escalating to a point where hospitalization or much closer monitoring of suicidality is indicated, it may be prudent at that juncture to complete the S-STS CMCM version and the SPTS. The Clinically Meaningful Change Measure (CMCM) portion on pages 10 and 12 (patient-rated and clinician-rated, respectively) may serve as a useful guide to the clinician on the level of care they need to provide at that juncture. Since nearly all of this information is completed by the patient immediately prior to the visit, it not only does not eat into the clinician's time with the patient, but can save a great deal of time and provide a useful basis for problems that need to be addressed during the visit. This information reflects a high level of care and attention to a broad spectrum of clinical concerns. It provides documentation and medico-legal protection for the clinician in the event of adverse outcomes in the case.

The challenge in "suicide risk assessment" is as follows:

1. If a patient has little or no suicidality, the usual decision is to allow the patient to go home from the visit while arranging appropriate follow-up care.
2. If a patient is very suicidal, the usual decision is to hospitalize the patient.
3. If the patient is moderately suicidal, this decision is more difficult to make. Consider the patient-rating of the last question on page 10 of the S-STS CMCM which asks "Over the next (timeframe) How likely are you to try to kill yourself?". Discuss with the patient the reason they choose the score on page 10 of the S-STS CMCM that reflects the treatment level they think they currently need for suicidal impulses, ideation, and behavior. These two variables are central in the final clinician judgment of suicidal risk. Clinicians weigh

these 2 critical variables with the severity of suicidality symptoms (pages 1 & 2 – particularly the seriousness of intent [questions 9 & 10]), the risk and protective factors (pages 4 & 5), the suicidality compounding features (pages 6, 7, & 9), the level of functional impairment (page 8) caused by the suicidality and their clinical "intuition" based on experience, in making a final "judgment of suicide risk" decision. Although seriousness of intent often weighs heavily in making this judgment, placing too much weight on intent can sometimes be misleading. For example, a patient may not have any intent at the time of the visit or within the past 24-hours, but this could change very suddenly and in an alarming direction with the sudden onset of an Unexpected Suicidal Impulse Attack (USIA). Conversely, a patient may have very serious intent because they are in the middle of a severe USIA, but after the USIA subsides the suicidal intent may dissipate quickly and may not pose a near term risk.

Table 4.1: General recommendations for mental health providers in using information from the S-STS CMCM to make a "clinician judgment of suicide risk" and a "clinician judgment of treatment needed".

		Score from "How likely are you to try to kill yourself?" on page 10 of S-STS CMCM.		
		0 – 3	4 – 6	7 – 10
Score from Patient-rated Level of Treatment Needed on page 10 of S-STS CMCM.	0 – 3	Allow the patient to go home	Weigh variables; consider sending to ER for evaluation, daily check-ins, and weekly visits	Hospitalize
	4 – 6	Weigh variables; consider sending to ER for evaluation, daily check-ins, and weekly visits	Weigh variables; consider sending to ER for evaluation, daily check-ins, and weekly visits	Hospitalize
	7 – 10	Hospitalize	Hospitalize	Hospitalize

Document your reasoning behind your decision, especially if it deviates from the approximate guidance in the above table or if communication between the clinician and patient results in you not hospitalizing a patient who has a score of 7 or higher on either of the two questions in the table above. The table above is only a general guideline. Apart from these approximate guidelines, clinicians reviewing the S-STS CMCM scores should use their best clinical judgment to override these approximate guidelines based upon the circumstances of each case and the relationship of the clinician with the patient. You will need to deviate from the above recommendations in caring for the individual needs of each patient. If your clinical intuition deviates from the above general recommendations, trust your experience and judgment and document the reason that leads to your "judgment of suicidal risk" decision and disposition.

Inpatient Care

All inpatients should be given a full structured diagnostic interview within the first 24 hours of admission by a clinician trained in the use of the structured interview. Baseline admission day scores should be captured on all of the above-mentioned scales. These can be used as a basis for tracking response to treatment and documenting outcomes. The admitting psychiatrist can then review the findings in the structured diagnostic interview and make any adjustments in their responses and diagnostic scoring based on new or additional information. This information may be collected from the patient, loved ones, or caregivers. The experienced psychiatrist specialist will be able to help the patient better understand some of the questions that may have been confusing or not accurately understood at the time of the initial data capture. This initial structured diagnostic interview will ensure that the primary Axis 1 disorder is more accurately anchored to DSM criteria. It also increases the likelihood of detection of other comorbid Axis 1 disorders. The S-STS, the S-STS CMCM, and the SPTS can be completed daily by the patient to monitor any possible treatment emergent suicidality on antidepressants / mood stabilizers / antipsychotic medications. The use of the above scales on a daily basis in inpatient services can help facilitate communication between suicidal patients and staff. These instruments may also provide the needed documentation to justify an extension of stay for suicidal patients in the event that insurance companies question the need for such additional treatment.

Additional Recommendations

Homicidality in Subjects with Suicidality

Homicidality can be comorbid with suicidality. Some subjects with suicidality are suicidal because they are experiencing homicidality. Consequently, all subjects with suicidality should be assessed for comorbid homicidality. If a clinician has any concerns about the presence of homicidality, the Sheehan – Suicidality / Homicidality Screen Questions (S-SHSQ) can be used to screen for homicidality. The MINI has an optional homicidality module. In addition, we have a

Sheehan-Homicidality Tracking Scale (S-HTS)[4] and we have a Homicide Plan Tracking Scale (HPTS)[5] for those who have comorbid homicidality and suicidality.

Patients with comorbid homicidality need to be monitored more closely. Some of these individuals could get treatment emergent homicidality in the course of treatment.

Rater Training

If a healthcare system implements use of these scales system-wide, it is prudent to organize rater training for the clinicians on the use, interpretation, and application of the scales. Annual refresher training on the use of these scales for healthcare providers ensures a high standard of care and patient safety.

Suicidality Assessment Checklist

To assist clinicians and healthcare providers in keeping track of the suicidality assessments completed for a particular patient's care, we created the following checklist.

[4] Sheehan, IS, Sheehan DV. Homicidality Scale (S-HTS). http://professorsheehan.com/scales/
[5] For the HPTS contact jennifermgiddens@gmail.com

Suicidality Assessment Checklist

- ☐ Sheehan – Suicidality / Homicidality Screening Questions (S-SHSQ)
- ☐ Sheehan – Suicidality Tracking Scale (S-STS)
- ☐ Sheehan – Suicidality Tracking Scale Clinically Meaningful Change Measure (S-STS CMCM) Version

- ☐ Pediatric Versions of the Sheehan – Suicidality Tracking Scale (S-STS)
- ☐ Adolescent Sheehan – Suicidality Tracking Scale Clinically Meaningful Change Measure (S-STS CMCM) Version
- ☐ Suicide Plan Tracking Scale (SPTS)
- ☐ Suicidality Modifiers Scale (SMS)
- ☐ Suicidal Impulse Attack Scale (SIAS)

- ☐ Mini International Neuropsychiatric Interview (MINI) for Suicidality Disorders Studies

- ☐ Sheehan – Homicidality Tracking Scale (S-HTS)
- ☐ Homicide Plan Tracking Scale (HPTS)

- ☐ Visit Face Sheet Template
- ☐ Psychiatric Visit Progress Note
- ☐ Psychiatric History Template

4.2

Sheehan - Suicidality / Homicidality Screening Questions (S-SHSQ)

Introduction

The Sheehan - Suicidality / Homicidality Screening Questions (S-SHSQ) is designed to quickly screen for suicidality and homicidality in clinical and in research and correctional facilities settings. It is not a substitute for the S-STS[1] or the S-HTS[2]. These screening questions do not constitute a basic suicidality or homicidality assessment. These questions were adapted from the Mini International Neuropsychiatric Interview (MINI) Screen[3] [4].

The (S-SHSQ) has 6 core questions, 3 for suicidality and 3 for homicidality. It is available in both a lifetime look-back and a generic timeframe look-back to accommodate a variety of timeframe contingencies to meet the need of the individual clinician or setting. The S-SHSQ can be either clinician-rated or patient-rated.

If the patient answers "yes" to any of these screening questions, you should follow-up by administering the S-STS / S-HTS[5].

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[1] Sheehan DV, Giddens JM, Sheehan IS. Status Update on the Sheehan-Suicidality Tracking Scale (S-STS) 2014. *Innov Clin Neurosci*. 2014;11(9–10):93–140. Available from: http://innovationscns.epubxp.com/i/425963/92

[2] Sheehan, IS, Sheehan DV. Homicidality Scale (S-HTS). http://professorsheehan.com/scales/

[3] Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., ... & Dunbar, G. C. (1998). The Mini-International Neuropsychiatric Interview (MINI): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of clinical psychiatry*.

[4] The Mini International Neuropsychiatric Interview Screen is available at http://www.HarmResearch.org

[5] Sheehan, IS, Sheehan DV. Homicidality Scale (S-HTS). http://professorsheehan.com/scales/

Sheehan – Suicidality / Homicidality Screening Questions (S-SHSQ) (Lifetime)

Suicidality

In your lifetime, did you:

1. think that you would be better off dead or wish you were dead?	NO	YES
2. think about killing yourself, or wanted to be dead, or planned to kill yourself, or done anything that you hoped would cause your death?	NO	YES
3. have a voice or voices telling you to kill yourself or dream about killing yourself?	NO	YES

Homicidality

In your lifetime, did you:

1. think that someone else would be better off dead or wish that someone were dead?	NO	YES
2. think about killing someone else, or wanted someone to be dead, or planned to kill someone else, or done anything that you hoped would cause someone else's death?	NO	YES
3. have a voice or voices telling you to kill someone or dream about killing someone?	NO	YES

Questions adapted directly from:

1. Sheehan DV, Lecrubier Y, Harnett-Sheehan K, Amorim P, Janavs J, Weiller E, Hergueta T, Baker R, Dunbar G: The Mini International Neuropsychiatric Interview (M.I.N.I.): The Development and Validation of a Structured Diagnostic Psychiatric Interview. J. Clin Psychiatry, 1998;59(suppl 20): 22-33.

2. Appendix A in Sheehan DV, Giddens JM, Sheehan IS. Status Update on the Sheehan-Suicidality Tracking Scale (S-STS) 2014. Innov Clin Neurosci. 2014;11(9–10):93–140.

3. Sheehan, IS, Sheehan DV. Sheehan - Homicidality Tracking Scale (S-HTS). http://professorsheehan.com/category/homicidality-scale/.

Sheehan – Suicidality / Homicidality Screening Questions (S-SHSQ) (Any timeframe)

Suicidality

In the past (timeframe), **did you:**

1. think that you would be better off dead or wish you were dead? NO YES
2. think about killing yourself, or wanted to be dead, or planned to kill yourself, or done anything that you hoped would cause your death? NO YES
3. have a voice or voices telling you to kill yourself or dream about killing yourself? NO YES

Homicidality

In the past (timeframe), **did you:**

1. think that someone else would be better off dead or wish that someone were dead? NO YES
2. think about killing someone else, or wanted someone to be dead, or planned to kill someone else, or done anything that you hoped would cause someone else's death? NO YES
3. have a voice or voices telling you to kill someone or dream about killing someone? NO YES

Questions adapted directly from:

1. Sheehan DV, Lecrubier Y, Harnett-Sheehan K, Amorim P, Janavs J, Weiller E, Hergueta T, Baker R, Dunbar G: The Mini International Neuropsychiatric Interview (M.I.N.I.): The Development and Validation of a Structured Diagnostic Psychiatric Interview. J. Clin Psychiatry, 1998;59(suppl 20): 22-33.
2. Appendix A in Sheehan DV, Giddens JM, Sheehan IS. Status Update on the Sheehan-Suicidality Tracking Scale (S-STS) 2014. Innov Clin Neurosci. 2014;11(9–10):93–140.
3. Sheehan, IS, Sheehan DV. Sheehan - Homicidality Tracking Scale (S-HTS). http://professorsheehan.com/category/homicidality-scale/.

Conclusion

The S-SHSQ allows clinicians to quickly screen for suicidality and homicidality in clinical, research, and other settings.

4.3

Sheehan - Suicidality Tracking Scale (S-STS)

Adapted from: Sheehan DV, Giddens JM, Sheehan IS. Status Update on the Sheehan-Suicidality Tracking Scale (S-STS) 2014. Innov Clin Neurosci. 2014;11(9–10):93–140. http://innovationscns.epubxp.com/i/425963/92

Introduction

A suicidality scale should assess the full range of suicidality phenomena. The Sheehan - Suicidality Tracking Scale (S-STS) is designed for use as both a safety and an efficacy outcome tracking measure in clinical and in research settings. It is designed to be sensitive in detecting change in suicidality over time. The S-STS was developed to provide a balance of being comprehensive, brief, and efficient, yet sensitive to change in assessing suicidality.

The standard version of the S-STS has 14 core questions and 9 additional questions contingent on the responses to the core 14. The S-STS is laid out for ease of navigation on 3 pages. Page 1 contains all of 14 core suicidality phenomena and could be used as a stand-alone page in clinical settings. It is designed for use in both clinical and research settings.

The primary goals in the design of the S-STS were for it to be:

- short and inexpensive
- simple, clear, and easy to administer or to self-rate
- highly sensitive - i.e. able to detect a high proportion of patients who are suicidal
- sensitive to change in suicidality
- specific - i.e. able to screen out those who are not suicidal
- capable of use in pediatric settings (the 3 linguistically validated pediatric versions of the S-STS are specifically designed for this purpose)
- capable of use in geriatric settings
- compatible with categories in the FDA draft guidance for prospective assessment of suicidal ideation and behavior
- useful in clinical as well as research settings
- useful in detecting an efficacy signal for anti-suicidality medications (the adult and adolescent versions of the S-STS Clinically Meaningful Change Measure [CMCM] are specifically designed for this purpose)

Because of the risks associated with suicidality, and in the interest of safety, the expectations and hurdles for such a suicidality scale are higher than for other scales in psychiatry. To meet these expectations and in response to much valuable feedback, the S-STS has evolved over time. This chapter provides a 2016 version of the *standard* S-STS (in contrast to the adult and adolescent versions of the S-STS CMCM and the 3 pediatric versions of the standard S-STS).

Operational Use S-STS

In practice the easiest way to use it is as follows: pages 1 and 2 are patient-rated or clinician-rated, and questions 17 through 22 on page 3 are completed by the clinician, only if the patient misses a follow up appointment and is not available to complete the scale.

SHEEHAN-SUICIDALITY TRACKING SCALE (S-STS)

INSTRUCTIONS: PLEASE USE DATA FROM ALL SOURCES AND CONSIDER SEVERITY, FREQUENCY, TIME SPENT AND TIME FRAME IN YOUR RESPONSES.
THE RESPONSE "NOT AT ALL" TO ANY QUESTION MEANS "NONE" AND MEANS THAT THE THOUGHT, EXPERIENCE OR BEHAVIOR "DID NOT OCCUR AT ALL".
THROUGHOUT THE SCALE THE WORD ***INTEND OR INTENT*** MEANS ANY INTENTION GREATER THAN ZERO. SCORE THE MOST SERIOUS EPISODE THAT OCCURRED.

In the past (timeframe):

1. did you have any accident?
(this includes taking too much of your medication accidentally)
IF NO, SKIP TO QUESTION 2. IF YES, GO TO QUESTION 1a:

NO ☐ YES ☐

	Not at all	A little	Moderately	Very	Extremely
1a. how seriously did you plan or intend to hurt yourself in any accident, either by not avoiding a risk or by causing the accident on purpose? IF THE ANSWER TO QUESTION 1a IS 0 (= Not at all), SKIP TO QUESTION 2. IF THE SCORE IS 1 OR HIGHER, GO TO QUESTION 1b:	0	1	2	3	4

1b. did you intend to die as a result of any accident?

NO ☐ YES ☐

In the past (timeframe), **how seriously did you:**

	Not at all	A little	Moderately	Very	Extremely
2. think (even momentarily) that you would be better off dead, need to be dead or wish you were dead? How many times? ____	0	1	2	3	4
3. think (even momentarily) about harming or hurting or injuring yourself – with at least some intent or awareness that you might die as a result – or think about suicide (killing yourself)? How many times? ____	0	1	2	3	4
4. have a voice or voices telling you to kill yourself or have dreams with any suicidal content? mark either or both: ☐ a voice or voices ☐ a dream	0	1	2	3	4
5. have any suicide method in mind (i.e. how)? #	0	1	2	3	4
6. have any suicide means in mind (i.e. with what)? #	0	1	2	3	4
7. have any place in mind to attempt suicide (i.e. where)? * #	0	1	2	3	4
8. have any date / timeframe in mind to attempt suicide (i.e. when)?*#	0	1	2	3	4
9. intend to act on thoughts of killing yourself? mark either or both: did you intend to act: ☐ at the time ☐ at some time in the future	0	1	2	3	4
10. intend to die as a result of a suicidal act? mark either or both: did you intend to die: ☐ at the time ☐ at some time in the future	0	1	2	3	4
11. feel the need or impulse to kill yourself or to plan to kill yourself sooner rather than later? mark either or both: was this: ☐ to kill yourself ☐ to plan to kill yourself mark either or both: was this: ☐ largely unprovoked ☐ provoked	0	1	2	3	4
12. take active steps to prepare for a suicide attempt in which you expected or intended to die (include anything done or purposely not done that put you closer to making a suicide attempt)?	0	1	2	3	4
13. injure yourself on purpose without intending to kill yourself? How many times? ____	0	1	2	3	4
14. attempt suicide (try to kill yourself)?	0	1	2	3	4

"A suicide attempt is a potentially self-injurious behavior, associated with at least some intent (> 0) to die as a result of the act. Evidence that the individual intended to kill him- or herself, at least to some degree, can be explicit or inferred from the behavior or circumstance.
A suicide attempt may or may not result in actual injury." (FDA 2012 definition[1,2]). * Note: Items 7 & 8 on S-STS ("a plan for suicide") means not going beyond ideas or talking about a plan for suicide. If actual behaviors occurred, the event should not be coded on item 7 or 8, but as "preparatory behavior" (item 12). Both events can occur separately over the same timeframe. # Note: clinician should ask for details.

SHEEHAN-SUICIDALITY TRACKING SCALE (S-STS) - EVENTS REPORT

15. IF ANSWER 14 IS POSITIVE ASK:

In the past (timeframe), how many times did you attempt suicide? ____

	When? dd/MMM/yyyy	How?	How serious was each attempt? Not at all	A little	Moderately	Very	Extremely	Level
1.			0	1	2	3	4	
2.			0	1	2	3	4	
3.			0	1	2	3	4	
4.			0	1	2	3	4	
5.			0	1	2	3	4	

Add rows as needed.

Levels of Attempt (halted by self, by another person or event, or not at all)
Level **1**: You started the suicide attempt, but then **you decided to stop** and did not finish the attempt.
Level **2**: You started the suicide attempt, but then **you were interrupted** and did not finish the attempt.
Level **3**: You went through the suicide attempt **completely** as you meant to.

16. IF ANSWER 12 IS POSITIVE ASK:

In the past (timeframe), how many times did you take active steps to prepare for a suicide attempt in which you expected or intended to die (include anything done or purposely not done that put you closer to making a suicide attempt)? ____
(Include only the times when you stopped short of making an actual suicide attempt.)

	When? dd/MMM/yyyy	How?	How serious was each preparation? Not at all	A little	Moderately	Very	Extremely	Level
1.			0	1	2	3	4	
2.			0	1	2	3	4	
3.			0	1	2	3	4	
4.			0	1	2	3	4	
5.			0	1	2	3	4	

Add rows as needed.

Levels of Preparation
Level **1**: You took active steps to prepare to kill yourself, but you did not start the suicide attempt.
Level **2**: You were about to try to kill yourself, but then **you stopped yourself** just before harming yourself.
Level **3**: You were about to try to kill yourself, but then **someone or something stopped you** just before harming yourself.

TIME SPENT PER DAY WITH ANY SUICIDAL IMPULSES, THOUGHTS OR ACTIONS OVER THE PAST (TIMEFRAME**):**
Usual time spent per day: ____ hours ____ minutes.
Least amount of time spent per day: ____ hours ____ minutes.
Most amount of time spent per day: ____ hours ____ minutes.

SHEEHAN-SUICIDALITY TRACKING SCALE (S-STS) - CLINICIAN USE ONLY

Complete this section *if the patient does not return for the scheduled follow up visit* and is not available to permit completion of pages 1 and 2.

FOR CLINICIAN USE ONLY

	NO	YES
17. Missed appointment - reason: subject died from a completed suicide?	0	100
18. Missed appointment - reason: subject died, but not enough information to code as a suicide?	0	0
19. Missed appointment - reason: subject died from cause(s) other than suicide?	0	0
20. Missed appointment - reason: subject alive, but not available because of a suicide attempt?	0	4
21. Missed appointment - reason: subject alive, but not available for known reasons other than suicide?	0	0
22. Missed appointment - reason: subject alive, but not available, for uncertain reasons, or "lost to follow up"?	0	0

Total Scale Score Add scores from Questions 1a (only if 1b is coded YES), + 2 through 11 + [the highest of 12 or any row of 16] + [the highest of 14 or any row of 15] + 17 + 20 [on page 3]. **TOTAL** ☐

☐ I have reviewed the answers on Pages 1 and 2 with the patient.

_____ _____
Clinician Signature dd/MMM/yyyy

☐ I have reviewed the answers on Pages 1 and 2 with my doctor or clinician.

_____ _____
Patient Signature dd/MMM/yyyy

References

1. Guidance for Industry Suicidal Ideation and Behavior: Prospective Assessment of Occurrence in Clinical Trials. August 2012. Revision 1. U.S Department of Health and Human Services, Food and Drug Administration, Center for Drug Evaluation and Research (CDER), Silver Spring, MD 20992-0002. http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm/ Direct download from www.fda.gov/downloads/Drugs/Guidances/UCM225130.pdf
2. Posner K, Oquendo MA et al. Columbia Classification Algorithm of Suicide Assessment (C-CASA): Classification of Suicidal Events in the FDA's Pediatric Suicidal Risk Analysis of Antidepressants. C-CASA Definitions in Table 2, page 1037. Am J Psychiatry 2007; 164:1035-1043

The author is grateful to JM Giddens for very valuable advice in the development of the S-STS and of the S-STS CMCM versions.

Validation of the S-STS

The standard version of the S-STS has been validated in 2 studies against other standardized suicide rating scales. The validation and reliability statistics have been presented at scientific meetings, and have been published in peer-reviewed scientific journals[1] [2].

Conclusion

The S-STS allows clinicians to assess and monitor suicidality in clinical, research, and other settings. The following chapters also contain the adult and adolescent versions of the S-STS CMCM and the 3 pediatric versions of the standard S-STS. Additional documents related to the S-STS (e.g. scoring instructions and tracking logs) are available free of charge at http://www.HarmResearch.org

[1] Sheehan DV, Alphs L, Mao L, et al. Comparative validation of the S-STS, the ISST-Plus, and the C–SSRS for assessing the suicidal thinking and behavior FDA 2012 Draft Guidance suicidality categories. Innov Clin Neurosci. 2014;11(9–10):32–46. http://innovationscns.epubxp.com/i/425963/32

[2] Youngstrom, E. A. and Hameed, A. and Mitchell, M. and Van Meter, A. and Freeman, A. J. and Perez Algorta, Guillermo and White, A. and Clayton, P. and Gelenberg, A. and Meyer, R. E. (2015) Direct comparison of the psychometric properties of multiple interview and patient-rated asessments of suicidal ideation and behavior in an adult psychiatric inpatient sample. Journal of Clinical Psychiatry. ISSN 0160-6689. http://www.psychiatrist.com/jcp/article/pages/2015/v76n12/v76n1219.aspx

4.4

Sheehan - Suicidality Tracking Scale
Clinically Meaningful Change Measure (S-STS CMCM) Version

Adapted from: Sheehan DV, Giddens JM, Sheehan IS. Status Update on the Sheehan-Suicidality Tracking Scale (S-STS) 2014. Innov Clin Neurosci. 2014;11(9–10):93–140. http://innovationscns.epubxp.com/i/425963/92

Introduction

The Clinically Meaningful Change Measure (CMCM) version of the S-STS is an expanded version of the standard S-STS. It was developed to specifically test the anti-suicidality effects of medications. The S-STS CMCM was designed to address an expectation that treatments for suicidality should demonstrate a clinically meaningful change in the management or disposition of a patient's care, in addition to improving their core suicidality symptoms. It operationalizes the system of thorough suicidality assessment long in place in psychiatric settings.

Organizational Structure of S-STS CMCM

The CMCM version of the S-STS is organized into 5 conceptual sections (see figures 4.1 and 4.2 below). Section one covers the core suicidality phenomena. This section is identical to the standard S-STS. The second section provides an opportunity to rate a series of risk or protective factors that might be important aggravating or relieving factors in the subject's suicidality. The third section is a series of 11-point (0–10) discretized visual analog (DISCAN) scales on which a

patient can rate various compounding features (e.g. their ability and willingness to cope with their suicidality, their ability and willingness to "stay safe," the extent to which their suicidality is deliberate, the extent to which it is impulsive, the extent to which it is unpredictable, and the extent to which it has impacted the quality of the patient's life). The fourth section measures the extent to which the suicidality has impaired the patient's work, social, or family life. The fifth section of the S-STS CMCM rates the judgment of risk and level of treatment needed.

Figure 4.1: Organizational Structure of S-STS CMCM vs. S-STS Standard Version

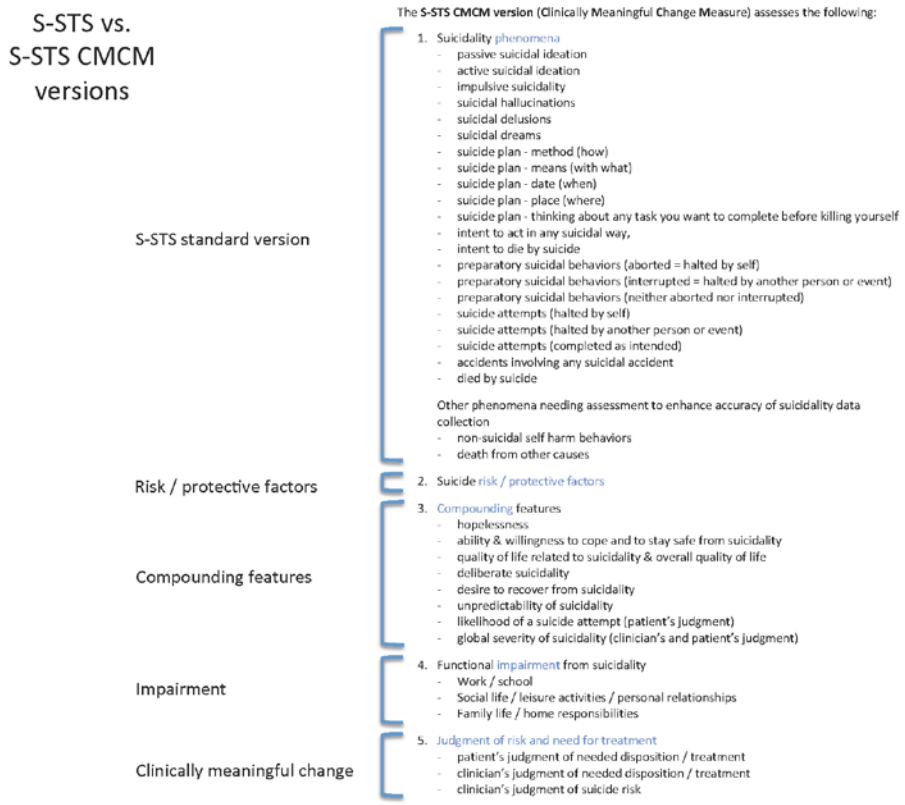
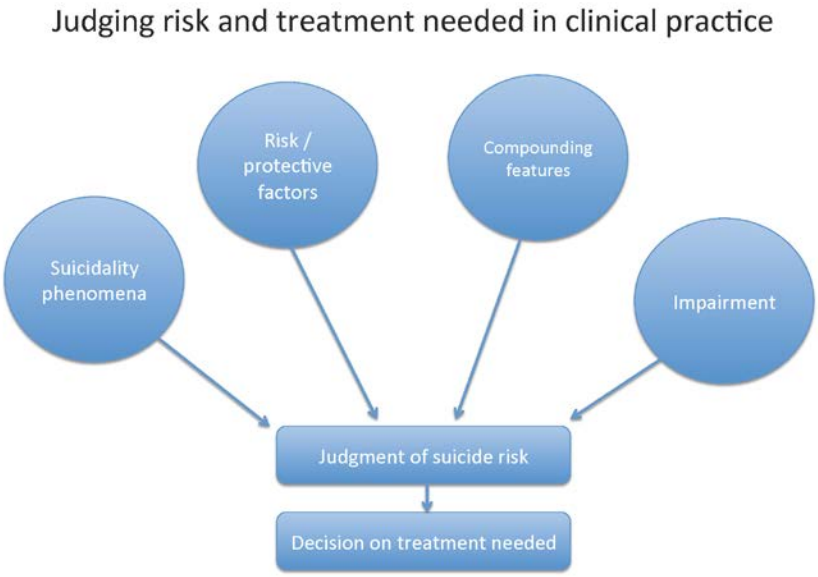


Figure 4.2: S-STS CMCM Clusters Contributing to Judgment of Risk and Treatment Needed



Operational Use S-STS CMCM

In practice the easiest way to use it is as follows: pages 1 and 2 can be patient-rated or clinician-rated; pages 4 through 10 are patient-rated; the clinician then reviews pages 1 through 10, asks any additional probe questions the clinician deems necessary to complete the assessment, and then completes pages 12 and 13. The lower portion of page 13 (questions 17 through 22) is completed by the clinician only if the patient misses a follow up appointment, and is not available to complete the scale.

SHEEHAN-SUICIDALITY TRACKING SCALE (S-STS CMCM Version)

INSTRUCTIONS: PLEASE USE DATA FROM ALL SOURCES AND CONSIDER SEVERITY, FREQUENCY, TIME SPENT AND TIME FRAME IN YOUR RESPONSES.
THE RESPONSE "NOT AT ALL" TO ANY QUESTION MEANS "NONE" AND MEANS THAT THE THOUGHT, EXPERIENCE OR BEHAVIOR "DID NOT OCCUR AT ALL".
THROUGHOUT THE SCALE THE WORD ***INTEND OR INTENT*** MEANS ANY INTENTION GREATER THAN ZERO. SCORE THE MOST SERIOUS EPISODE THAT OCCURRED.

In the past (timeframe):

1. did you have any accident? NO ☐ YES ☐
(this includes taking too much of your medication accidentally)
IF NO, SKIP TO QUESTION 2. IF YES, GO TO QUESTION 1a:

	Not at all	A little	Moderately	Very	Extremely
1a. how seriously did you plan or intend to hurt yourself in any accident, either by not avoiding a risk or by causing the accident on purpose?	0	1	2	3	4

IF THE ANSWER TO QUESTION 1a IS 0 (= Not at all), SKIP TO QUESTION 2.
IF THE SCORE IS 1 OR HIGHER, GO TO QUESTION 1b:

1b. did you intend to die as a result of any accident? NO ☐ YES ☐

In the past (timeframe), **how seriously did you:**

	Not at all	A little	Moderately	Very	Extremely
2. think (even momentarily) that you would be better off dead, need to be dead or wish you were dead? How many times? ____	0	1	2	3	4
3. think (even momentarily) about harming or hurting or injuring yourself – with at least some intent or awareness that you might die as a result – or think about suicide (killing yourself)? How many times? ____	0	1	2	3	4
4. have a voice or voices telling you to kill yourself or have dreams with any suicidal content? mark either or both: ☐ a voice or voices ☐ a dream	0	1	2	3	4
5. have any suicide method in mind (i.e. how)? #	0	1	2	3	4
6. have any suicide means in mind (i.e. with what)? #	0	1	2	3	4
7. have any place in mind to attempt suicide (i.e. where)? * #	0	1	2	3	4
8. have any date / timeframe in mind to attempt suicide (i.e. when)?*#	0	1	2	3	4
9. intend to act on thoughts of killing yourself? mark either or both: did you intend to act: ☐ at the time ☐ at some time in the future	0	1	2	3	4
10. intend to die as a result of a suicidal act? mark either or both: did you intend to die: ☐ at the time ☐ at some time in the future	0	1	2	3	4
11. feel the need or impulse to kill yourself or to plan to kill yourself sooner rather than later? mark either or both: was this: ☐ to kill yourself ☐ to plan to kill yourself mark either or both: was this: ☐ largely unprovoked ☐ provoked	0	1	2	3	4
12. take active steps to prepare for a suicide attempt in which you expected or intended to die (include anything done or purposely not done that put you closer to making a suicide attempt)?	0	1	2	3	4
13. injure yourself on purpose without intending to kill yourself? How many times? ____	0	1	2	3	4
14. attempt suicide (try to kill yourself)?	0	1	2	3	4

"A suicide attempt is a potentially self-injurious behavior, associated with at least some intent (> 0) to die as a result of the act. Evidence that the individual intended to kill him- or herself, at least to some degree, can be explicit or inferred from the behavior or circumstance.
A suicide attempt may or may not result in actual injury." (FDA 2012 definition[1,2]). * Note: Items 7 & 8 on S-STS ("plan for suicide") means not going beyond ideas or talking about a plan for suicide. If actual behaviors occurred, the event should not be coded on item 7 or 8, but as "preparatory behavior" (item 12). Both events can occur separately over the same timeframe. # Note: clinician should ask for details.

SHEEHAN-SUICIDALITY TRACKING SCALE (S-STS CMCM Version) - EVENTS REPORT

15. IF ANSWER 14 IS POSITIVE ASK:

In the past (timeframe), how many times did you attempt suicide? ____

	When? dd/MMM/yyyy	How?	How serious was each attempt? Not at all	A little	Moderately	Very	Extremely	Level
1.			0	1	2	3	4	
2.			0	1	2	3	4	
3.			0	1	2	3	4	
4.			0	1	2	3	4	
5.			0	1	2	3	4	

Add rows as needed.

Levels of Attempt (halted by self, by another person or event, or not at all)
Level **1**: You started the suicide attempt, but then **you decided to stop** and did not finish the attempt.
Level **2**: You started the suicide attempt, but then **you were interrupted** and did not finish the attempt.
Level **3**: You went through the suicide attempt **completely** as you meant to.

16. IF ANSWER 12 IS POSITIVE ASK:

In the past (timeframe), how many times did you take active steps to prepare for a suicide attempt in which you expected or intended to die (include anything done or purposely not done that put you closer to making a suicide attempt)? ____
(Include only the times when you stopped short of making an actual suicide attempt.)

	When? dd/MMM/yyyy	How?	How serious was each preparation? Not at all	A little	Moderately	Very	Extremely	Level
1.			0	1	2	3	4	
2.			0	1	2	3	4	
3.			0	1	2	3	4	
4.			0	1	2	3	4	
5.			0	1	2	3	4	

Add rows as needed.

Levels of Preparation
Level **1**: You took active steps to prepare to kill yourself, but you did not start the suicide attempt.
Level **2**: You were about to try to kill yourself, but then **you stopped yourself** just before harming yourself.
Level **3**: You were about to try to kill yourself, but then **someone or something stopped you** just before harming yourself.

TIME SPENT PER DAY WITH ANY SUICIDAL IMPULSES, THOUGHTS OR ACTIONS OVER THE PAST (TIMEFRAME**):**
Usual time spent per day: ____ hours ____ minutes.
Least amount of time spent per day: ____ hours ____ minutes.
Most amount of time spent per day: ____ hours ____ minutes.

PATIENT RATED PAGES

Clinically Meaningful Change Measures for Suicide Outcomes Assessment

(S-STS CMCM VERSION, PATIENT RATED DOMAINS ARE ON **PAGES 4 THROUGH 10**)

Current Factors to Consider in Making the Clinically Meaningful Change Assessment

Some consider the factors below as risk factors for suicidality. However they are all not necessarily so and sometimes they can be protective factors. The impact of each factor can change over time within an individual.

The factors are intended to serve as useful prompts during the evaluation and in tracking both initial and newly emerging factors during follow up. If any of the factors disturb you, please discuss it with your clinician.

Indicate the impact of the factors below on your suicidality over the past (timeframe).

	Factor	**Does Not Apply**	Lessens Suicidality *A lot*	Lessens Suicidality *Moderately*	Lessens Suicidality *A little*	**No impact on Suicidality**	Increases Suicidality *A little*	Increases Suicidality *Moderately*	Increases Suicidality *A lot*
	Suicidality								
1	Any suicidal impulses, ideation and behavior from pages 1 & 2 of the S-STS CMCM	☐	☐	☐	☐	☐	☐	☐	☐
2	Amount of time spent daily with suicidal ideation and behaviors	☐	☐	☐	☐	☐	☐	☐	☐
3	Feeling a need to make an attempt sooner rather than later	☐	☐	☐	☐	☐	☐	☐	☐
4	Hearing voices telling or commanding you to kill yourself or someone else	☐	☐	☐	☐	☐	☐	☐	☐
5	Overwhelmed feeling	☐	☐	☐	☐	☐	☐	☐	☐
6	Exhaustion from struggling against suicide	☐	☐	☐	☐	☐	☐	☐	☐
7	Hopeless feeling or nothing to live for	☐	☐	☐	☐	☐	☐	☐	☐
8	Easy access to guns or means for suicide	☐	☐	☐	☐	☐	☐	☐	☐
9	Seriousness of past suicide attempt(s)	☐	☐	☐	☐	☐	☐	☐	☐
10	Religious or spiritual reasons that influence your decision to kill yourself	☐	☐	☐	☐	☐	☐	☐	☐
	Family / Social								
11	Recent loss or death of a loved one	☐	☐	☐	☐	☐	☐	☐	☐
12	Recent anniversary of the death of a loved one	☐	☐	☐	☐	☐	☐	☐	☐
13	Recent conflict or break up with family, spouse, partner or close friends	☐	☐	☐	☐	☐	☐	☐	☐
14	Lonely or socially isolated or homeless	☐	☐	☐	☐	☐	☐	☐	☐
15	Lack of close family or social support	☐	☐	☐	☐	☐	☐	☐	☐
16	Withdrawal from family, work or social responsibilities	☐	☐	☐	☐	☐	☐	☐	☐
17	Bisexual, homosexual or transgender or uncertain sexual or gender orientation with resulting unsupportive family or support system	☐	☐	☐	☐	☐	☐	☐	☐
18	First or second degree relative with a history of suicidal impulses, ideation or behavior (including attempts or completed suicide)	☐	☐	☐	☐	☐	☐	☐	☐

	Factor	**Does Not Apply**	Lessens Suicidality *A lot*	Lessens Suicidality *Moderately*	Lessens Suicidality *A little*	**No impact on Suicidality**	Increases Suicidality *A little*	Increases Suicidality *Moderately*	Increases Suicidality *A lot*
	Personal History								
19	Had a recent major life change or loss (e.g. loss of job, school failure, financial loss, gambling loss, mounting financial debt)	☐	☐	☐	☐	☐	☐	☐	☐
20	Recent trouble with the law or serious legal problems or recent incarceration	☐	☐	☐	☐	☐	☐	☐	☐
21	Recent deep sense of shame or loss of reputation	☐	☐	☐	☐	☐	☐	☐	☐
22	Survivor of sexual abuse, sexual violence or rape	☐	☐	☐	☐	☐	☐	☐	☐
23	Survivor of violence, torture bullying or emotional abuse	☐	☐	☐	☐	☐	☐	☐	☐
24	Witnessed or caused serious violence or death to another person	☐	☐	☐	☐	☐	☐	☐	☐
25	Recent military service or service in a war zone or a war survivor	☐	☐	☐	☐	☐	☐	☐	☐
26	History of or current aggressive or violent behavior or high irritability	☐	☐	☐	☐	☐	☐	☐	☐
27	Spending time on suicide or death related internet sites	☐	☐	☐	☐	☐	☐	☐	☐
28	History of impulsive suicidality	☐	☐	☐	☐	☐	☐	☐	☐
29	History of risk taking	☐	☐	☐	☐	☐	☐	☐	☐
30	Male over 55	☐	☐	☐	☐	☐	☐	☐	☐
	Health								
31	Depression or bipolar disorder	☐	☐	☐	☐	☐	☐	☐	☐
32	Panic attacks or high anxiety or agitation	☐	☐	☐	☐	☐	☐	☐	☐
33	Schizophrenia or schizoaffective disorder	☐	☐	☐	☐	☐	☐	☐	☐
34	Alcohol abuse	☐	☐	☐	☐	☐	☐	☐	☐
35	Substance (drug) abuse	☐	☐	☐	☐	☐	☐	☐	☐
36	Posttraumatic Stress Disorder	☐	☐	☐	☐	☐	☐	☐	☐
37	Recent sleep disturbance	☐	☐	☐	☐	☐	☐	☐	☐
38	Have an “incurable disease” or severe chronic or terminal illness	☐	☐	☐	☐	☐	☐	☐	☐
39	In severe physical pain (acute or chronic or fluctuating)	☐	☐	☐	☐	☐	☐	☐	☐
40	Recent unplanned pregnancy or sexually transmitted disease	☐	☐	☐	☐	☐	☐	☐	☐
41	Recent infection, inflammatory states (allergies or asthma) or an autoimmune disease flare up (e.g. Crohn’s Disease, Lupus or Multiple Sclerosis)	☐	☐	☐	☐	☐	☐	☐	☐
42	Head injury	☐	☐	☐	☐	☐	☐	☐	☐
43	Unable to get needed psychiatric treatment or medication	☐	☐	☐	☐	☐	☐	☐	☐
44	Switched from a medication or a formulation or a dose that was effective or you were not taking your medication as directed	☐	☐	☐	☐	☐	☐	☐	☐
45	Recently started on a psychiatric or an antiepileptic medication	☐	☐	☐	☐	☐	☐	☐	☐
46	Other:	☐	☐	☐	☐	☐	☐	☐	☐
47	Other:	☐	☐	☐	☐	☐	☐	☐	☐

Add and score additional “other” factors as necessary.

SHEEHAN - SUICIDALITY TRACKING SCALE (CMCM Version)

CLINICALLY MEANINGFUL CHANGE MEASURES (PATIENT RATED)

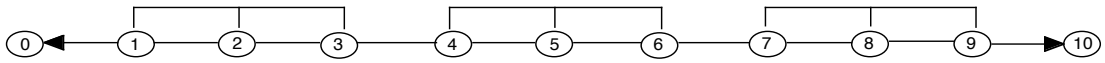
(Please mark ONE circle for each category.)

In the past (timeframe):

HOPELESSNESS

Rate your level of hopelessness:

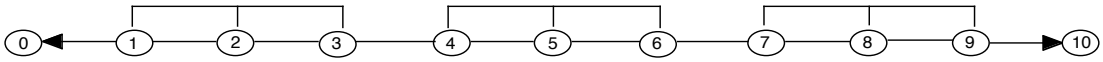
None **Mild** **Moderate** **Severe** **Extreme**



ABILITY TO COPE

Rate your ability to cope with your suicide impulses, thoughts, and behaviors:

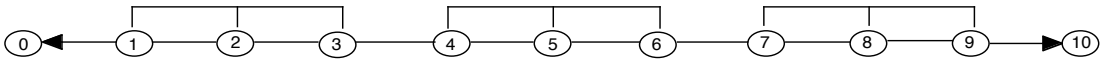
Completely Able **Very Able** **Moderately** **A Little** **Not Able**



WILLINGNESS TO COPE

Rate your willingness to cope with your suicide impulses, thoughts, and behaviors:

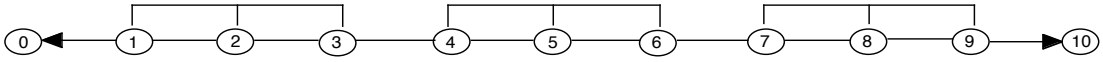
Completely Willing **Very** **Moderately** **A Little** **Not Willing**



ABILITY TO STAY SAFE

Rate your ability to keep yourself safe:

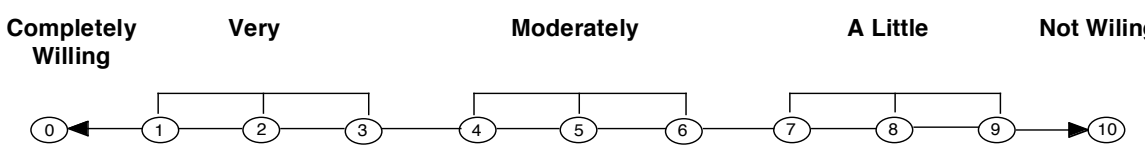
Completely Able **Very Able** **Moderately** **A Little** **Not Able**



In the past (timeframe):

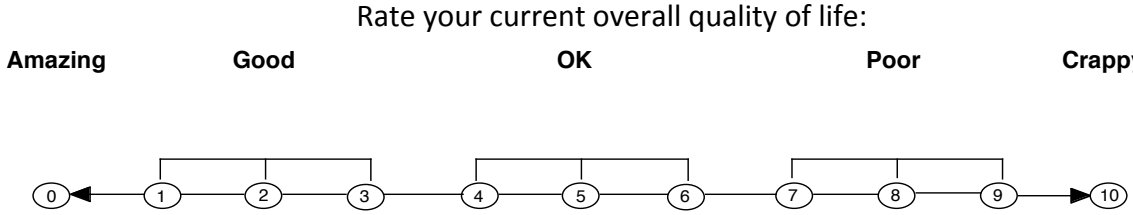
WILLINGNESS TO STAY SAFE

Rate your willingness to keep yourself safe:



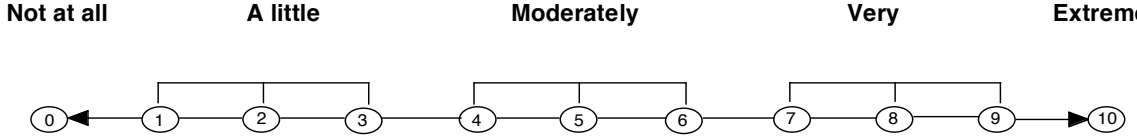
OVERALL QUALITY OF LIFE

Rate your current overall quality of life:



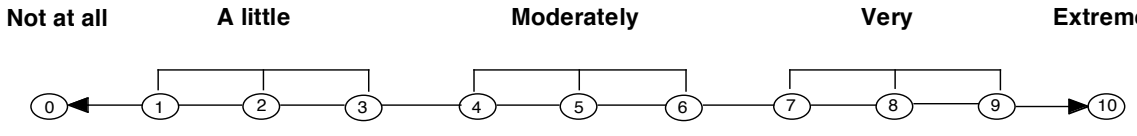
DELIBERATE SUICIDALITY

How deliberately were you thinking about or planning to kill yourself:



IMPULSIVELY SUICIDAL

How strong was the impulse to act in any suicidal way:



SHEEHAN - SUICIDALITY TRACKING SCALE (CMCM Version)

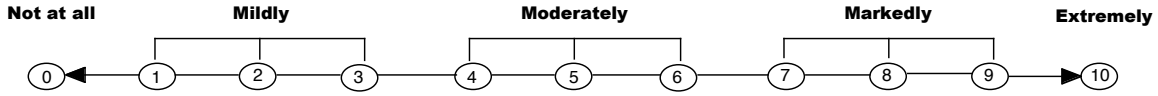
LIFE IMPAIRMENT FROM SUICIDALITY (PATIENT RATED)

Please mark ONE circle for each category.

In the past (timeframe):

WORK* / SCHOOL

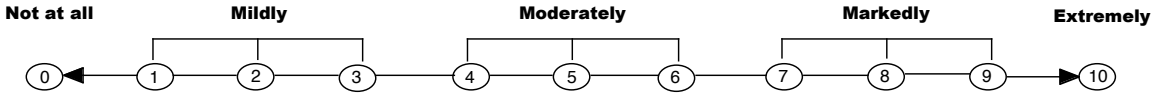
The suicide symptoms have disrupted your work / school work:



☐ I have not worked /studied at all during the past timeframe **for reasons unrelated to the suicide symptoms**.
* Work includes paid, unpaid volunteer work or training. If your symptoms interfered with your ability to find or hold a job or contributed in any way to your currently not working, you must give a score on this scale.

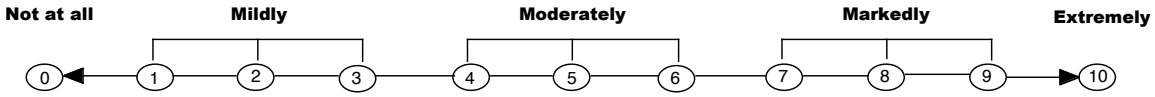
SOCIAL LIFE

The suicide symptoms have disrupted your social life / personal relationships / leisure activities:



FAMILY LIFE / HOME RESPONSIBILITIES

The suicide symptoms have disrupted your family life / home responsibilities:



DAYS LOST

How many days in the last (timeframe) did you miss from work or school or were unable to carry out your normal responsibilities because of your suicide thoughts, impulses, and behaviors? _____

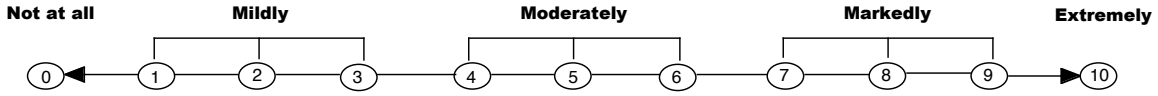
DAYS UNDERPRODUCTIVE

How many days in the last (timeframe) were you less productive while at work or at school or during your daily responsibilities because of your suicide thoughts, impulses, and behaviors? _____

In the past (timeframe):

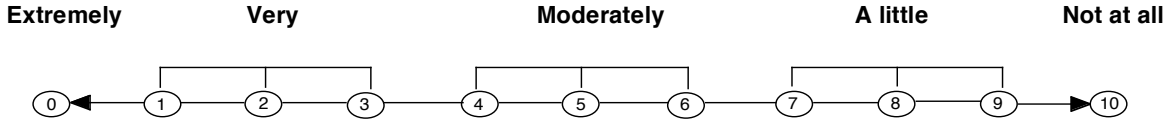
QUALITY OF LIFE DISRUPTION BY SUICIDALITY

The suicide symptoms have disrupted the quality of your life:



DESIRE TO RECOVER FROM SUICIDALITY

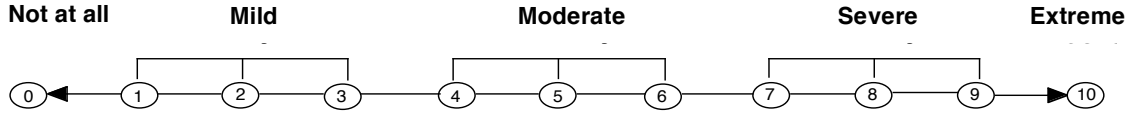
Rate your desire to recover from your suicide impulses, thoughts and behaviors:



If you can't imagine the possibility of recovery, choose "10"

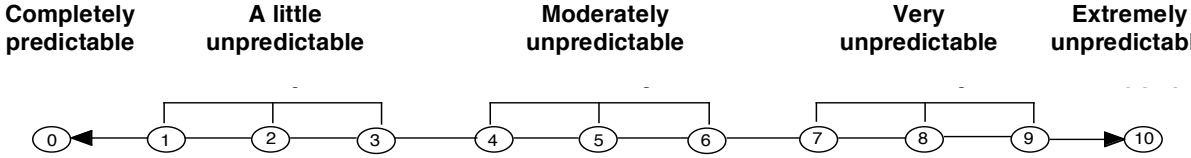
GLOBAL SEVERITY OF SUICIDAL IMPULSES, THOUGHTS, AND BEHAVIORS

Rate the overall severity of all your suicide impulses, thoughts, and behaviors:



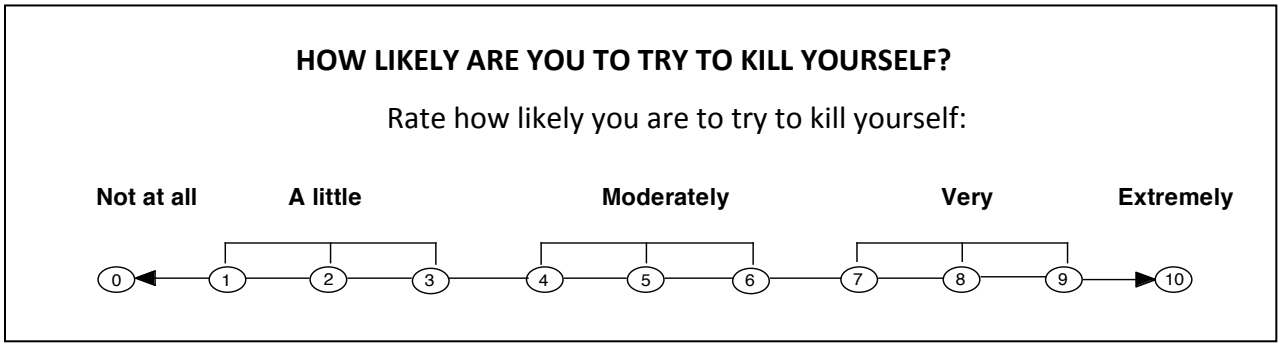
HOW UNPREDICTABLE WAS YOUR SUICIDALITY

Considering the time when your suicidality was most unpredictable,
how unpredictable was it at that time?



☐ Since starting my current medication / treatment, my suicidality became even more unpredictable than ever before.

Over the next (timeframe):



Patient Rated: Circle the score that best describes your current treatment needs:

At this time:

Score	Treatment level you think you currently need for suicidal impulses, thoughts or behaviors
10	I need to be in the hospital for more than 24 hours, with someone watching or protecting me at all times and I need or I request physical or medication restraints to protect me from trying to kill myself. (24/7 inpatient with constant one-on-one observation, possible need or request for physical or chemical restraints)
9	I need to be in the hospital for more than 24 hours, with someone watching or protecting me at all times. (24/7 inpatient one-on-one)
8	I need to be in the hospital for more than 24 hours, with someone watching or checking on me every 15 minutes. (24/7 inpatient on suicide precautions (e.g. 15 minute checks))
7	I need to be in the hospital for more than 24 hours. (24/7 inpatient)
6	I need to be in the hospital for more than 24 hours and be allowed to leave the ward or to go on visits outside the hospital from time to time. (24/7 inpatient with privileges to leave ward on visits outside hospital)
5	I need to stay up to 24 hours in the Emergency Room and then talk to the doctor again to decide if it is safe to discharge me home or if I need to be admitted to the hospital ward or if I need to attend therapy for several hours multiple times a week. (Stay up to 24 hours in Emergency Room then re-evaluate whether to admit or discharge or partial hospitalization or intensive outpatient program)
4	I only need outpatient weekly visits with daily calls to tell my doctor or therapist if I am OK (what are called daily check-ins).
3	I only need outpatient weekly visits.
2	I only need outpatient visits at least monthly.
1	I only need outpatient visits as needed and I would like to be monitored in case my suicidal thoughts or behaviors get worse.
0	I need no treatment at all.

CLINICIAN RATED PAGES

Clinically Meaningful Change Measures for Suicide Outcomes Assessment

(S-STS CMCM VERSION, CLINICIAN RATED DOMAINS ARE ON **PAGES 12 AND 13**)

Clinically Meaningful Change Measures for Suicide Outcomes Assessment

(CLINICIAN RATED)

This Sheehan - Suicidality Tracking Scale, Clinically Meaningful Change Measures version (S-STS, CMCM version) is for use in evaluating whether a treatment for suicidality has a clinically meaningful impact beyond the suicidal phenomena alone.

Suicide risk cannot be accurately predicted at an individual level. However, based on all the information available on pages 1 and 2, pages 3 through 10 in the S-STS, CMCM version, and using your clinical experience, provide on the horizontal analog scale below and using the anchors in the table below, your best judgment of this patient's current level of clinically meaningful suicide risk and need for treatment of suicidality. This clinician "judgment of suicide risk" may drive your "judgment of level of management needed". Ask any additional probe questions or for any clarifications as needed.

In making this judgment, factor in and make balanced trade-offs between the following elements in each case:

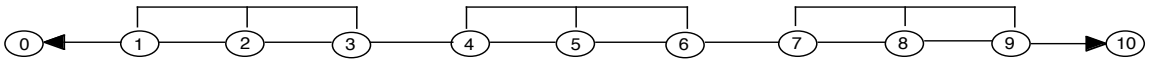
- Suicidal ideation (including suicidal impulses, and dreams, hallucinations and delusions involving suicide)
- Suicidal planning
- Suicidal intent and patient's perception of how likely they are to attempt suicide again in the future
- Suicidal behaviors (including impulsive suicidality)
- Suicide risk / protective factors
- Ability and willingness to cope with and to stay safe from suicidality
- Desire to recover from suicidality
- History of suicidality
- Quality of life
- % of suicidal ideation that is willful or deliberate
- Time spent in suicidality
- Global severity of suicidal impulses, ideation and behaviors
- Type of suicide disorder

These factors and trade-offs vary from one case to the next and over time in the same case.

At this time:

Clinically Meaningful Change Measure for Suicide Outcomes Assessment

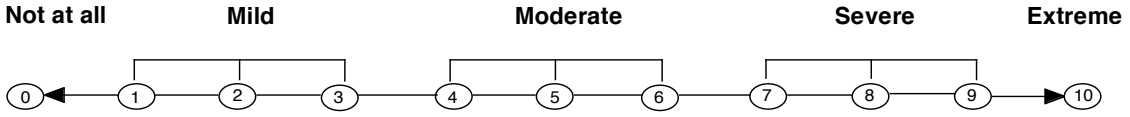
Anchor your judgment of the suicide risk and level of clinically meaningful management needed, with a single score, based on the table below:



Score	Judgment of Suicide Risk	Judgment on Level of Management Needed for Suicidality
10	Imminent	24/7 inpatient with constant one-on-one observation and with possible need or patient request for physical or chemical restraints
9	Severe	24/7 inpatient one-on one hospitalization with constant one-on-one observation
8	High	24/7 inpatient hospitalization with suicide precautions (e.g. 15 minute observation checks)
7	Major	24/7 inpatient hospitalization
6	Elevated	24/7 inpatient hospitalization with privileges to leave ward on visits outside hospital
5	Moderate	Up to 24 hours in ER, then re-evaluate whether to admit or discharge or partial hospitalization or intensive outpatient program
4	Modest	Outpatient weekly visits with daily check-ins
3	Mild	Outpatient weekly visits
2	Slight	Outpatient visits at least monthly
1	Remote	Outpatient visits as needed and if in treatment monitor for treatment emergent suicidality
0	No apparent risk	None

GLOBAL SEVERITY OF SUICIDAL IMPULSES, THOUGHTS, AND BEHAVIORS

Rate the overall severity of the patient's suicide impulses, thoughts, and behaviors:



SHEEHAN-SUICIDALITY TRACKING SCALE (S-STS) - CLINICIAN USE ONLY

Complete this section *if the patient does not return for the scheduled follow up visit* and is not available to permit completion of pages 1 and 2.

FOR CLINICIAN USE ONLY

	NO	YES
17. Missed appointment - reason: subject died from a completed suicide?	0	100
18. Missed appointment - reason: subject died, but not enough information to code as a suicide?	0	0
19. Missed appointment - reason: subject died from cause(s) other than suicide?	0	0
20. Missed appointment - reason: subject alive, but not available because of a suicide attempt?	0	4
21. Missed appointment - reason: subject alive, but not available for known reasons other than suicide?	0	0
22. Missed appointment - reason: subject alive, but not available, for uncertain reasons, or "lost to follow up"?	0	0

Total Scale Score Add scores from Questions 1a (only if 1b is coded YES), + 2 through 11 + [the highest of 12 or any row of 16] + [the highest of 14 or any row of 15] + 17 + 20 [on page 13].

TOTAL ☐

☐ I have discussed the answers above with the patient.

_____ _____
Clinician Signature dd/MMM/yyyy

☐ I have discussed the answers above with my doctor or clinician.

_____ _____
Patient Signature dd/MMM/yyyy

References

1. Guidance for Industry Suicidal Ideation and Behavior: Prospective Assessment of Occurrence in Clinical Trials. August 2012. Revision 1. U.S Department of Health and Human Services, Food and Drug Administration, Center for Drug Evaluation and Research (CDER), Silver Spring, MD 20992-0002. http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm/ Direct download from www.fda.gov/downloads/Drugs/Guidances/UCM225130.pdf
2. Posner K, Oquendo MA et al. Columbia Classification Algorithm of Suicide Assessment (C-CASA): Classification of Suicidal Events in the FDA's Pediatric Suicidal Risk Analysis of Antidepressants. C-CASA Definitions in Table 2, page 1037. Am J Psychiatry 2007; 164:1035-1043

The author is grateful to JM Giddens for very valuable advice in the development of the S-STS and of the S-STS CMCM versions.

Conclusion

The S-STS CMCM was developed to sensitively test the anti-suicidality effects of treatments. It has additional domains needing assessment before and during treatment. Clinicians can use the scale to measure and judge the extent of a treatment's clinically meaningful effect. This scale provides a roadmap to "open doors" to a thorough "big picture" exploration and tracking of key features of suicidality for individual patients. The S-STS CMCM provides good documentation of a thorough and systematic assessment of suicidality.

4.5

When to Use the Other Suicidality Scales in Appendix 2

For patients under the age of 18, there are 3 pediatric versions of the S-STS. In addition, there is an adolescent S-STS CMCM that is suitable for more in depth assessment and tracking of suicidality in those between the age of 13 and 17.

Use the Suicide Plan Tracking Scale (SPTS) when you need to explore suicidal planning in more detail.

Use the Suicidality Modifiers Scale (SMS) when you need to investigate suicidal impulsivity, hopelessness, loss of enjoyment, and overwhelmed feeling in more detail. We noticed that the third question in each of these 4 domains, were particularly useful as first early warning signals of an impending worsening of suicidality.

Use the Suicidal Impulse Attack Scale (SIAS) when you need a very brief measure of suicidality symptoms. For example, the SIAS is suitable for tracking response to a rapid onset of action treatment, like ketamine in the emergency room.

Appendix 2 contains the scales mentioned in this chapter. All versions of these scales are available at http://www.HarmResearch.org.

5

Documentation of Suicidality

5.1

Brief Introduction to Documentation

"If it's not documented, it didn't happen." - Anon

Death by suicide is a leading cause of filings for claims of malpractice in the field of mental health[1] [2]. Regrettably suicide is not reliably predictable at an individual level. Mental health practitioners cannot always prevent it, even when they are well trained and exercise due caution, consistent with best practice guidelines. There is a long-held belief that suicidality progresses to death by suicide in a linear manner. However, both clinical experience and our data do not support this "linear model". The progression of suicidality is non-linear, dynamic, chaotic, turbulent, sensitively dependent on initial conditions, and often unpredictable at the individual level[3]. This causes clinicians much worry and concern. Interviewing thoroughly, asking all the right questions, and assessing all the risk factors is not adequate, if it is not associated with good documentation of these best practices in the medical record. The purpose of this book is to provide clinicians with a structured and systematic approach, not only to the assessment of suicidality, but also to its documentation in the medical record.

If a patient dies by suicide, the clinician's records may be subpoenaed. Examiners scrutinize these records, and judge them on the assessment, monitoring, and treatment provided. The documentation in these records should reflect the clinician's judgment, thoughtfulness, and attention in providing an appropriate standard of care. This documentation is the best protection in the event of a malpractice suit.

---

[1] Paris, J. (2002). Chronic suicidality among patients with borderline personality disorder. Psychiatric Services.

[2] Kelley JT: Psychiatric Malpractice. New Brunswick, NJ, Rutgers University Press, 1996.

[3] Sheehan, D. V. and Giddens, J. M. 2015. *Suicidality: A Roadmap for Assessment and Treatment*. Chapters 2 and 12.5. Available from: http://www.harmresearch.org

5.2

Visit Face Sheet Template

Introduction

Prior to a visit or consultation with a health care provider, the patient and the clinician have different agendas. To focus the clinician's attention on the core patient's problems and questions, it is prudent to provide a face sheet such as the example below to have the patient identify their main problems and questions. For example, the clinician may assume that the patient has come for a follow up visit to monitor their response to an antidepressant treatment. However, the patient may be coming to the visit because they want the clinician to complete a form to help them get food stamps and to get them to write a report for their divorce lawyer, so that they will not loose custody of their children on mental health grounds. The patient may wait bring up these two additional requests at the very end of the allotted time for the visit. If the clinician had known about these issues from the start, they would have allocated the visit time to accommodate these requests.

MAIN PROBLEMS / QUESTIONS YOU WANT ADDRESSED AT TODAY'S VISIT

To help us meet your needs today, please outline briefly the main problems or questions that you would like your physician to help you with at today's visit.

For problems you would prefer not to mention in writing just write the words "ask me" opposite any of the 4 problems below.

1.	

2.	

3.	

4.	

Conclusion

The visit face sheet can assist the patient in communicating their needs for the visit to their clinician. This assists the clinician in better managing their time with the patient.

5.3

Psychiatric Visit Progress Note Template

Introduction

In order to maintain consistency, quality control, and to systematize the collection of critical information for mental health care, use the visit progress note template below. It reduces the likelihood of the clinician overlooking items of importance. This affords better healthcare protection for the patient and better medico-legal protection for the clinician. It helps you not to forget to check or to document something important.

Operational Use of the Visit Progress Note

Below is a blank visit progress note template followed by a completed example.

In the medication dosage section, record both the total daily dose and the distribution of the total daily dose at 4 different time points during the day (e.g. breakfast, lunch, evening meal, bedtime). Record all medications whether prescribed or over the counter, whether for medical or psychiatric reasons.

In the adverse events section is a free text field to record side effects from any of the current medications.

In the psychometric scales section record the scale scores from the scales completed by the patient in the waiting room immediately prior to the visit. Add additional scales as necessary.

In the compliance with treatment plan there is a free text field to record any relevant information related to adherence. Clinicians should always verify the extent of adherence to the treatment regimen prescribed and try to understand any barriers to compliance.

In the clinical symptoms section describe the response of the initial presenting symptoms to treatment. Describe any residual symptoms and their severity. In this section record the absence of key symptoms or behaviors that could be relevant to the treatment of the patient. For example, "Patient denies any alcohol or substance abuse.", "Patient denies any hallucinations or delusions.", and "Patient denies any suicidal ideation, impulses, behaviors, or suicide attempts." In the free text field record any additional information that provides closure to prior symptoms or concerns or to highlight symptoms of concerns you wish to monitor in the future. It is particularly important to record information about suicidality, homicidality, and substance use here. Use additional space including the back of the form if necessary.

In the psychosocial stressors section, record the role of current psychosocial stressors in aggravating the patient's condition. Note the resolution of any prior stressors that may contribute to the patient's current or future status.

In the section on concurrent illnesses record the presence and severity of any significant current medical illnesses and any role these may play in aggravating the patient's mental health problems.

In the psychotherapeutic process section record critical information that relates to any psychotherapy you provide to the patient. Documentation of psychotherapy is often important in mental health settings for reimbursement purposes.

In the medication prescription section record any prescriptions that you renew for the patient with the dose, the number dispensed, and the number of refills.

In the treatment instructions section record any directions given to the patient on implementing the treatment plan.

In the objectives / anticipated benefits / time to meet treatment goals sections identify the treatment objectives and the expectation of the time to meet these objectives.

In the next visit section record the decision to follow up or discharge the patient.

In the free text field in the comments section record any additional information as prompts for the future and to summarize and provide an overview of the visit and progress to date. Use additional space including the back of the form if necessary.

Patient Name: Date of Birth:
Date of Visit: Diagnosis Code:

PROGRESS NOTES FOR FOLLOW-UP VISIT #

Patient was seen for _____ minutes in follow-up: ☐ Medication Mgmt. ☐ Psychotherapy. ☐ Evaluation. ☐ Consultation. ☐ Family Therapy. ☐ E/P Office Visit. ☐ Telephone Call. Other:_____

Medication Dosage:☐ no medication

_____ mgs. daily p.o. of _____[+ + +]

_____ mgs. daily p.o. of_____[+ + +]

_____ mgs. daily p.o. of _____[+ + +]

_____ mgs. daily p.o. of _____[+ + +]

_____ mgs. daily p.o. of _____[+ + +]

_____ mgs. daily p.o. of _____[+ + +]

Adverse Reactions:

Psychometric Scales: [measuring target behavioral symptoms & response to treatment ↑, ↓, → (scales in file): Patient has completed this visit's psychometric rating scales: SPS_____.S-STS_____.SDS_____.STRESS_____. SUPPORT___. PATIENT GLOBAL____.BECK____.MONTGOMERY-ASBERG_____.YOUNG MANIA ____. MINI IMPAIRMENT ____.

Compliance with Treatment Plan: ☐ Compliant ☐ Needs improvement ☐ Other:_____

Clinical & Behavioral Symptoms and Progress of Treatment:
Patient's anxiety/phobic symptoms have ☐improved ☐not changed ☐worsened since the last visit ☐not applicable
Patient's depressive symptoms have ☐improved ☐not changed ☐worsened since the last visit ☐not applicable
Patient's manic symptoms have ☐improved ☐not changed ☐worsened since the last visit ☐not applicable
Since starting treatment the patient has ☐improved ☐worsened approx. _____ % since starting treatment here.
☐ Patient denies any alcohol or substance abuse. ☐ Patient denies any hallucinations or delusions.
☐ Patient denies any suicidal ideation, impulses, behaviors, or suicide attempts.

Patient name: Date of visit:

Psychosocial Stressors:
Patient had _____ psychosocial stressors since the last visit.

Concurrent Illnesses:

Evidence of Psychotherapeutic Process: ☐not applicable

Medication: ☐ none

Given a prescription for _____ # _____x_____mg. tabs x ____ refills.

Given a prescription for _____ # _____x_____mg. tabs x ____ refills.

Given a prescription for _____ # _____x_____mg. tabs x ____ refills.

Given a prescription for _____ # _____x_____mg. tabs x ____ refills.

Treatment Intervention & Instructions to Patient:
☐ Reviewed potential medication side effects, benefits and risks with patient. ☐ Reviewed Therapeutic Intervention with patient. ☐ With patient consent, I communicated with their family / caregiver on the increased risk of suicidality from medication(s) prescribed. ☐ Patient refused consent for this communication. ☐ Patient was instructed to:

Treatment Plan: ☐ Continue current treatment plan ☐ Change treatment plan as indicated

Objectives: ☐ Maximize improvement ☐ Maintain Improvement Other_____
Anticipated Benefits: ☐ Reduce Symptoms ☐ Restore coping skills ☐ Restore lost function
☐ Improve coping skills ☐ Improve social function ☐ Improve work function
☐ Protect from future relapses ☐ Other _____

Est. time required to meet treatment goals? ☐ ____ weeks(s) / month(s) / years(s) ☐unable to determine
☐ not applicable ☐ estimate of number of sessions required _____

Next Visit: Patient will return for follow up and further monitoring of medication and treatment:
☐ _____ days / weeks / months ☐ PRN ☐ will call ☐ Discharge ☐ Other _____
Comments:

_____ _____
Physician's Printed Name Physician's Signature

Patient Name: Jane Doe Date of Birth: 01/01/1990
Date of Visit: 01/06/16 Diagnosis Code: F33.41

PROGRESS NOTES FOR FOLLOW-UP VISIT #

Patient was seen for 60 minutes in follow-up: ☑ Medication Mgmt. ☑ Psychotherapy. ☐ Evaluation. ☐ Consultation. ☐ Family Therapy. ☐ E/P Office Visit. ☐ Telephone Call. Other:_____

Medication Dosage:☐ no medication

150	mgs. daily p.o. of	Sertraline	[	0	+	0	+	0	+	150	]
1	tab. daily p.o. of	Multivitamin tab	[	1	+	0	+	0	+	0	]
_____	mgs. daily p.o. of	_____	[		+		+		+		]
_____	mgs. daily p.o. of	_____	[		+		+		+		]
_____	mgs. daily p.o. of	_____	[		+		+		+		]
_____	mgs. daily p.o. of	_____	[		+		+		+		]

Adverse Reactions:

No nausea, headaches or loose bowel movements, all of which she had transiently in the early weeks of treatment on sertraline. She is now tolerating it much better. No significant anxiety from sertraline. She has some orgasmic delay since on the higher dose of sertraline.

Psychometric Scales: [measuring target behavioral symptoms & response to treatment ↑, ↓, → (scales in file):
Patient has completed this visit's psychometric rating scales: SPS 0. S-STS 5. SDS 5. STRESS_____.
SUPPORT +8. PATIENT GLOBAL +8. BECK 6. MONTGOMERY-ASBERG 7. YOUNG MANIA 0. MINI IMPAIRMENT 10.

Compliance with Treatment Plan: ☑ Compliant ☐ Needs improvement ☐ Other:_____

Clinical & Behavioral Symptoms and Progress of Treatment:
Patient's anxiety/phobic symptoms have ☑improved ☐not changed ☐worsened since the last visit ☐not applicable
Patient's depressive symptoms have ☑improved ☐not changed ☐worsened since the last visit ☐not applicable
Patient's manic symptoms have ☐improved ☐not changed ☐worsened since the last visit ☑not applicable
Since starting treatment the patient has ☑improved ☐worsened approx. 55 % since starting treatment here.
☑ Patient denies any alcohol or substance abuse. ☑Patient denies any hallucinations or delusions.
☐ Patient denies any suicidal ideation, impulses, behaviors, or suicide attempts.

She has some residual suicidal ideation. It is much improved compared to when she started on the antidepressant 2 months ago. She had mild passive and active ideation transiently, and thought transiently about the method, the means and the location, if she ever gets seriously depressed again and does not respond to the antidepressant or if it "stops working". However she denies any suicidal intent, impulses, dreams or behaviors. She does not consider that puts her at significant risk in the near future, especially as she has improved. She agreed to call me immediately if it worsens. Her depressed mood, anhedonia, and interest in things has improved significantly ("I am enjoying my music again"). Insomnia is gone. She is concentrating better at work, while reading and interacting with others. Appetite has improved. There are a few very mild residual depressive symptoms. But with each visit her depressive scale scores lessen. No evidence of mania or hypomania, hallucinations or delusions. No alcohol or drug abuse. Sensorium and intellectual abilities are intact. She is more optimistic about her future. She has overcome most of the functional impairment that was present at the initial visit. Overall she is 80% improved.

Patient name: John Doe Date of visit: 01/06/16

Psychosocial Stressors:
Patient had ____no_____ psychosocial stressors since the last visit.

She has returned to work full time and is coping well.

Concurrent Illnesses:

No medical problems.

Evidence of Psychotherapeutic Process: ☐not applicable

She discussed her adjustment in getting back to work and her ability to take care of her children and her improved relationship with her husband she her MDD improved

Medication: ☐ none

Given a prescription for Sertraline # 30 x 100 mg. tabs x 2 refills.

Given a prescription for _____ # _____ x _____ mg. tabs x _____ refills.

Given a prescription for _____ # _____ x _____ mg. tabs x _____ refills.

Given a prescription for _____ # _____ x _____ mg. tabs x _____ refills.

Treatment Intervention & Instructions to Patient:
☑ Reviewed potential medication side effects, benefits and risks with patient. ☑ Reviewed Therapeutic Intervention with patient. ☐ With patient consent, I communicated with their family / caregiver on the increased risk of suicidality from medication(s) prescribed. ☑ Patient refused consent for this communication. ☑ Patient was instructed to: stay on this current dose for the present and to take it all at hs po.

Treatment Plan: ☑ Continue current treatment plan ☐ Change treatment plan as indicated

Objectives: ☑ Maximize improvement ☐ Maintain Improvement Other_____
Anticipated Benefits: ☑ Reduce Symptoms ☑ Restore coping skills ☑ Restore lost function
☑ Improve coping skills ☑ Improve social function ☑ Improve work function
☑ Protect from future relapses ☐ Other _____

Est. time required to meet treatment goals? ☑ 12 weeks(s) / month(s) / years(s) ☐unable to determine
☐ not applicable ☑ estimate of number of sessions required monthly
She appears to be progressively improving with time and I expect the remaining symptoms will improve as a function of time as long as she remains adherent toe the sertraline.
Next Visit: Patient will return for follow up and further monitoring of medication and treatment:
☑ 3 days / (weeks) / months ☐ PRN ☐ will call ☐ Discharge ☐ Other _____
Comments:

Much improved since starting sertraline treatment. Functioning better and home, with her family and at work. She is pleased with her progress so far. She still has some mild residual symptoms, which are likely to improve further with time. If they persisit or worsen the sertraline dose can be increased by 25 mgs/day to 175 mgs.

David V Sheehan MD — *David Sheehan MD*
Physician's Printed Name — Physician's Signature

Conclusion

The psychiatric visit progress note template is designed to provide the clinician with a systematic approach to documenting important information at each follow up visit. It reduces the likelihood of the clinician overlooking items of importance. This affords better healthcare protection for the patient and better medico-legal protection for the clinician.

5.4

Psychiatric History Template

Introduction

In order to maintain consistency, quality control, and to systematize the collection of critical information for mental health care at the initial intake visit, use the psychiatric history template below. It reduces the likelihood of the clinician overlooking items of importance. This affords better healthcare protection for the patient and better medico-legal protection for the clinician. It helps you not to forget to check or to document something important.

Operational Use of the Psychiatric History

Below is a blank psychiatric history template. The clinician will find that the structure used for this psychiatric history and the directions on completing it will be self-evident based on their prior training in mental health. However, we wish to highlight a few points.

Complete the psychiatric summary section of page 1 at the end of the visit after everything else is complete. First complete the identifying data free text field. It is useful to discipline yourself to interview the patient and to collect and document the information as you progress through the interview, in the order in which it is laid out in the template. In this way, when the visit is complete, all of the documentation is complete. If the patient offers information out of order from the template sequence, take mental note of the information, tell the patient that you will come back to investigate that information later, and stick to the order of data gathering as presented in the template. For example, patients often prepare a description in their mind prior to the visit of the problem they want to discuss. Use open-ended questions to invite them to present this description.

The first task is to get a precise and complete description of the current presenting problem. At this juncture, avoid going back to the onset and progression of the current problem until the presenting problem is fully described and documented. In the course of providing information on their presenting problem patients will start to describe specific symptoms or symptom clusters. At that point tell the patient that you have a system for precisely asking about all the common symptoms in mental health and the descriptions they are giving you provide the opportunity to now ask about and assess their symptoms using a structured diagnostic interview like the Mini International Neuropsychiatric Interview (the MINI)[1]. This takes approximately 15 minutes. The information collected and organized in the MINI helps frame the subsequent data gathering in the psychiatric history. Proceed to collect information on the onset and course of the presenting problem and document this in the free text field in this section. Complete the remaining sections of the history in the sequence outlined in the template. Although the multi-axial diagnostic system has been abandoned by the DSM-5, we think it has heuristic value in illustrating an overview of your understanding of the relationships between the component elements of the patient's presenting problem. Formulate your treatment plan, discuss it with the patient, and seek the patient's feedback and involvement in implementing the plan. Then complete the psychiatric summary on page 1.

[1] Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., ... & Dunbar, G. C. (1998). The Mini-International Neuropsychiatric Interview (MINI): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of clinical psychiatry*.

PSYCHIATRIC EVALUATION

Interview Date	Patient Name	Patient ID #	Gender	Age	Birth Date	Marital Status

Address

Email Address:

Social Security No.	Emergency Contact Name & Telephone No.	Referred by (name & phone number):

PSYCHIATRIC SUMMARY

1.	Presenting Problem:	
2.	DSM-5 Criteria met for:	
3.	Duration of Illness:	
4.	Recent Life Stresses:	
5.	Suicidal Ideation / Behavior / Attempts:	
6.	Alcohol/Drug Abuse:	
7.	Medical Illnesses:	
	(Current or in remission)	
8.	Current Medications:	.
9.	Allergies & Medication Reactions:	
10.	Response to Past Treatments:	
11.	Compliance to Past Treatment:	
12.	Treatment Plan:	

HISTORY

IDENTIFYING DATA

(Interview Date, Interviewer's Initials, Race, Age, Marital, Referral, D.O.B., Address, Phone #.)

PRESENTING PROBLEM (S)

•Patient's Description of Symptoms or Problem (primary and complications)
•Frequency, Duration, Intensity (scale 0-10 where 10 is maximum & 0 is none)
•New Symptoms or Recurrence of Old Condition?
•Time Frame
•Impact of problem on patient's life
•Patient's Treatment Expectations
•Clinician's Comments

STRUCTURED INTERVIEW SUMMARY

On the MINI structured diagnostic interview the patient's symptoms meet criteria for the following disorder(s):

		Current major depressive episode			Current obsessive-compulsive disorder
		Recurrent major depressive episode			Current posttraumatic stress disorder
		Current MDE with melancholic features			Current alcohol abuse/dependence
		Current dysthymia			Current substance abuse/dependence
		Current suicidality			Current psychotic disorder
		Current mania/hypomania			Lifetime psychotic disorder
		Lifetime mania/hypomania			Current anorexia nervosa
		Current panic disorder/limited symptom attacks			Current bulimia nervosa
		Lifetime panic disorder/limited symptoms attacks			Current generalized anxiety disorder
		Current agoraphobia			Lifetime antisocial personality disorder
		Current Social Phobia/ Social Anxiety Disorder			

ONSET AND COURSE OF PRESENTING PROBLEM

(Use patient's own words whenever possible)
- When? (Date chronology of events accurately including exacerbations and remissions)
- How? (Under what circumstances? Precipitants? Relationship to life events?)
- Why? (Aggravating/relieving factors)
- Previous treatment (and treatment response) for presenting problem
- Patient's treatment expectations

The symptoms first began:

PAST PSYCHIATRIC HISTORY

	No	Yes
Have you been treated for your present problem or any nervous or psychiatric condition?		
Have you ever been hospitalized for a psychiatric problem?		

From	To	# Of Visits	Provider*	TX**	Problem/Diagnosis	Rate Success ±100% Worse/Better

*1=Psychiatrist, 2=Other Physician, 3=Psychologist (Ph.D.), 4=other therapist, 5=Emergency room, 6=Health clinic/hospital, 7=Diagnostic tests
**1=Medications, 2=Psychotherapy, 3=Counseling, 4=Behavior Therapy, 5=Group Therapy, 6=Psychoanalysis, 7=ECT (Shock Therapy), 8=Other Treatments.

Estimate of patient's compliance to past treatment/ medication?	Very Good	Good	Fair	Poor

PSYCHIATRIC MEDICATIONS (PAST & CURRENT)

	No	Yes

Anxiolytics: Valium/diazepam, Librium/chlordiazepoxide, Serax/oxazepam, Tranxene/chlorazepate, Ativan/lorazepam, Xanax/ Alprazolam, Klonopin/clonazepam, BuSpar/buspirone, Equanil/Miltown/meprobamate, Antipsychotics**:** Thorazine, Stelazine, Haldol, Triavil, Prolixin, Mellaril, Trilafon, Clozapine, and Risperidone. **Cyclic/Atypical Antidepressants:** Tofranil/Imipramine, Elavil/ Amitriptyline, Sinequan/doxepin, Clomipramine/anafranil, Pamelor/nortriptyline, Norpramin/desipramine, Vivactyl/protrip-tyline, Ludiomil/ maprotiline, Deseryl/Trazodone, Nefazodone, Serzone, Wellbutrin/bupropion. **Selective Serotonin Up-take Inhibitors:** (e.g., Prozac, Zoloft, Paxil, Luvox, Effexor, Remeron); **MAO inhibitors:** (e.g., Nardil, Marplan, Parnate, Selegiline); **Lithium:** (e.g., Eskalith, Lithobid, Lithane, Lithonate); **Amphetamines:** (e.g., Ritalin/Methylphenedate); **Narcotics:** (e.g., Methadone, Percodan); **Barbiturates** (e.g., Phenobarbital, Seconal, Nembutal); **Anticonvulsants:** (e.g., Dilantin, Valproic Acid, Tegretol, Carbamazepine); **Beta Blockers:** (e.g., Inderal, Propranolol, Corgard, Tenormin); **Calcium Channel Blockers:** (e.g., Verapamil, Nifedipine, Diltiazem); **Sleeping Pills:** (e.g., Dalmane, Sominex, Halcion, Chloral Hydrate, Restoril, Noctec, Ambien); **List others not mentioned.**_____

Name of Drug	Max. Daily Dose	Dose of Tablet	Distribution of Tablets Per Day B+L+D+B*	# Days, Weeks or Months Taken	Date of Last Dose	Success: ±100% Worse/Better

*B+L+D+B = at breakfast, at lunch, at dinner, at bedtime

PAST PSYCHIATRIC HISTORY (Cont.)

SUICIDE / SELF HARM HISTORY

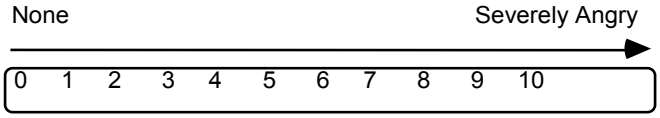
	No	Yes
Have you ever made a suicide attempt or tried to harm yourself?		
Do you ever feel the urgent need or impulse to injure or to kill yourself?		
Total Number of Past Suicide Attempts:		

How seriously did you intend to kill yourself? (Place an **X** under mildly/moderately/very column)

#	Year	Mildly	Moderately	Very	Method Used	Where Treated/Hospitalized
1						
2						
3						
4						
5						

COMMENTS:

HISTORY OF VIOLENCE OR HOMICIDE



How angry & hostile have you been in the past month? ☐

	No	Yes
Do you ever feel the urgent need or impulse to injure someone else?		
Have you ever seen anyone killed or seriously injured?		
Have you ever *tried* to kill or injure someone else?		
Have you ever killed or injured someone else?		

COMMENTS:

PAST MEDICAL HISTORY

1. **MAJOR ILLNESSES** No Yes

Year	Illness	Treatment	Result

2. **SURGERY** No Yes

Year	Type of Surgery	Reason for Surgery	Result

3. **HOSPITALIZATIONS** No Yes

Year	Illness	Treatment	Result

4. **INJURIES/ACCIDENTS** No Yes

Year	Injury

PAST MEDICAL HISTORY

5. **PHYSICAL/SEXUAL ABUSE** No Yes

Year	Include unreported injuries/untreated injuries (beatings/concussion/rape/abuse)	By spouse/partner/family member/other

6. **ALLERGIES** No Yes

Drugs/Food/Environment	Type of Reaction: Allergy or Side Effect	MD Clarification / Allergy or Side Effect

CURRENT HEALTH PRACTICES

1. Are you currently taking any **NON-PSYCHIATRIC** medicines on a regular or intermittent basis? No Yes

a. **Prescription Drugs (Current):** Drugs you can get only with a doctor's order (includes birth control pills). No Yes

Name of drug	Mgs Per tablet	Daily dose distribution [B+L+D+B]	How long have you been taking it?	Reason for taking Medication

CURRENT HEALTH PRACTICES

b. **Non-Prescription Drugs (Current):** Examples include aspirin, cold tablets, cough medicines, laxatives, vitamins, minerals, some sleeping pills and nerve pills. Also include here any herbal treatments, "natural treatments", or "alternative medicines".

	No	Yes

Name of drug	Mgs per tablet	Daily dose distribution, [B+L+D+B]	How long have you been taking it?	Reason for taking medication

2. **Street Drugs:** Do you currently use, or have you used in the past, any street or illegal drugs, or prescription drugs that were not prescribed for you?

	No	Yes

Name of substance	Now use X	Past	How often? [Use dates when appropriate.]

3. **Tobacco Use:** Never

	Ever	Now	# of Years Used	Amount/Day
Pipe				
Cigarettes				
Cigars				
Chewing				

If you **stopped**: When did you stop? _____

CURRENT HEALTH PRACTICES

4. **Alcohol Use (Past Year)**

	Never	1-2 drinks /day or less	3 or more drinks/day
Hard liquor/spirits			
Wine/sherry/coolers			
Beer and ale			

if you **stopped**: When? _____
How much did you drink?_____

COMMENTS:

5. **Sexuality**
Female only

First date of last menstrual period:			Regular	Irregular
Length of Cycle:		days		
	No	Yes	Year	
Surgically Sterile?				
Post Menopausal?				
Child bearing potential?				
Contraceptives?				
Specify type:				

Have you had any of the following diseases?	No	Yes
Recurrent/Resistant Yeast Infection		
Trichomonas		
Chlamydia		
Herpes		
Gonorrhea		
Syphilis		
Papilloma virus (genital warts)		
HIV Positive		

FAMILY PSYCHIATRIC / MEDICAL HISTORY

										Mother's		Father's	
Directions: X = yes; ? = unsure	No Hx	Mother	Father	Sisters	Brothers	Aunts	Uncles	Cousins	Children	M	F	M	F
Anxiety													
Depression													
Manic-depressive disturbance													
Schizophrenia													
Suicide (failed attempts)													
Suicide (successful attempts)													
Early/Late Dementia													
Alcohol abuse													
Drug abuse													
Child Behavior Problems													
Imprisonment/detention													
Mental retardation													
Domestic violence/child abuser													
Learning disabilities													
Eating disorders													
Any psychiatric hospitalization													
	No Hx	Mother	Father	Sisters	Brothers	Aunts	Uncles	Cousins	Children	MM	MF	FM	FF
Diabetes Mellitus													
Heart Disease													
Mitral Valve Prolapse													
High Blood Pressure													
Stroke													
Cancer: lung, colorectal, breast													
prostate, cervical/uterine,													
pancreas, endocrine, other													
Thyroid Disorder													
Seizures (Epilepsy)													
Migraine Headaches													
Irritable Bowel Syndrome/Colitis													
Asthma													
Ulcers													
Other:													
Unexpected Death													

PATIENT HAS NO INFORMATION ON BIOLOGICAL: ☐ Mother ☐ Father ☐ Either Parent

SOCIAL HISTORY

A. Relevant history, current status of, and recent changes or stresses

Home/Family
•place of birth•cultural background•childhood happiness•parental violence•family trauma•current living arrangement

Occupational
•occupation•currently working/not working

Financial
•financial problems•any bankruptcy

Educational
•educational level completed•learning problems or school problems

Interests/Leisure Activities
•hobbies/interests/leisure activities•church/social organization involvement•military service

Legal
•arrests/convictions/probation/imprisonment/parole•civil actions•bankruptcy •juvenile •?Malpractice suits filed •Other law suits •Comments
.

B. Support systems (availability and quality)

Family

Agencies, etc. involved with patient or family
•Names and phone numbers of contact persons•Medicare/Medicaid•HRS/Welfare/Food Stamps
•AA/NA•Family Service/Church Support

MENTAL STATUS EXAMINATION

GENERAL APPEARANCE

Dress and Grooming ☐ Neat and appropriate
____ Unkempt
____ Inappropriate
____ Seductive

Posture ☐ Unremarkable
____ Stooped
____ Stiff
Bizarre

Facial Expression ☐ Unremarkable
____ Tense
____ Stressed
____ Worried
____ Perplexed
____ Hypervigilant
____ Sad
____ Psychomotor retardation
____ Tearful
____ Bored
____ Labile
____ Elated
____ Angry or Sullen
____ Suspicious/Distrustful
____ Silly
____ Grimacing

Eyes/Gaze ☐ Unremarkable
____
____ Avoids direct gaze
____ Stares into space
____ Glances furtively

Level of Consciousness
____ Alert, conscious
____ Very sedated/not alert
____ Unconscious/semi comatose
Fluctuates

Attitude Towards Examiner
____ Cooperative
____ Uncooperative
____ Hostile
____ Suspicious

Motor Behavior ☐ Unremarkable ____ Impaired

MENTAL STATUS EXAMINATION

SENSORIUM / INTELLECTUAL ABILITIES (Clinician's Impression)

COGNITIVE	Average or Above Average (>80)	Below Average (<80)
Intelligence		
Fund of Knowledge		

	Impaired	Not impaired	Describe/Clarify Where Appropriate
Judgment			
Insight			
Ability to Abstract			

MEMORY IMPAIRMENT	Not impaired	Mildly Impaired	Moderately Impaired	Severely Impaired	Describe/Clarify Where Appropriate
Immediate					
Recent					
Remote					
ORIENTATION IMPAIRMENT					
Time					
Place					
Person (self & others)					

ATTENTION	Normal	Somewhat Impaired	Severely Impaired	Describe/Clarify Where Appropriate
Concentration				
SPEECH & LANGUAGE				
Speech & Fluency				
Naming				
Comprehension & Repetition				
Abnormal Patterns				
ABILITY TO CALCULATE:				
(Serial 7s; serial 3s)				

RELIABILITY OF INFORMATION	Very Good	Good	Fair	Poor

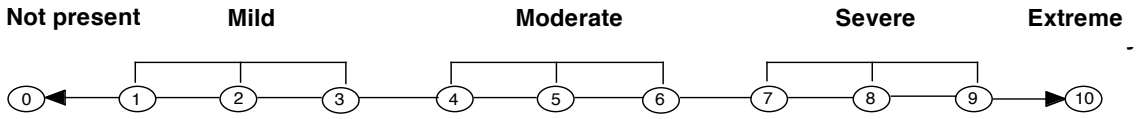
Additional information on questions often recorded in the Mental Status Exam Section (e.g., thought process, thought content, mood, emotion) is captured in the M.I.N.I. (structured interview) section of this evaluation.

ADDITIONAL DESCRIPTIVE COMMENTS:

DISABILITY / FUNCTIONAL IMPAIRMENT

SEVERITY OF DISABILITY / IMPAIRMENT

Use this scale to rate in the score column of the table below, how much your symptoms have disrupted your ability to function in the following areas of your life:



Assessment of Impairment of Functioning

	Domain Name	Score
1	Work or school work	
2	Social life or leisure activities (like hobbies or things you do for enjoyment)	
3	Family life and / or home responsibilities	
4	Ability to get along with people	
5	Personal and social relationships	
6	Ability to understand and to communicate with others	
7	Ability to take care of yourself (washing, showering, bathing, dressing properly, brushing teeth, laundry, combing / brushing hair, eating regularly)	
8	Made you disruptive or aggressive towards others	
9	Financially (ability to manage your money)	
10	Ability to get around physically	
11	Spiritual or religious life	
12	How much did your condition have an impact on other people in your family?	
	Total Score	

DIAGNOSIS

Code

Axis I: _____
_____
_____

Axis II: _____

Axis III: _____
_____
_____

Axis IV: Psychosocial stressors: _____ / 6

Axis V: Assessment of Functioning Scale Total Score: Current: _____

TREATMENT PLAN:

1. I reviewed the diagnosis and treatment options with the patient in detail.
2. I discussed the patient's participation in the study and answered questions from the Informed Consent Form.
3. The patient appears clinically eligible to enter the study.
4. Pending the results of the physical examination and laboratory tests, the patient will enter the study.

.

Physician's Signature: _____ Date: _____

Conclusion

The psychiatric history template is designed to provide the clinician with a systematic approach to documenting important information at the initial screening or consultation visit. It reduces the likelihood of the clinician overlooking items of importance. This affords better healthcare protection for the patient and better medico-legal protection for the clinician.

6

Classification of Suicidality Disorders

Introduction

It is likely that the anti-suicidality medication that works for one suicidality disorder may fail in another and may even worsen the other. A classic example is that known, approved, effective antidepressants, even when they are effective for Major Depressive Disorder, can make those under 25 years more suicidal, those over 65 less suicidal, and those between the ages of 25 and 65 no better off than placebo in controlling their suicidality[1]. In this scenario the antidepressants appear to be making one group of suicidal patients better, the other worse, while the third group remain unchanged. It is likely that the same scenario will pertain to other suicidality disorders. Some, but not all cases of suicidality may respond to lithium[2], others to clozapine[3], others to ketamine[4], and yet others to magnesium[5]. Hence, we need a phenotypic classification of

[1] Stone, M., Laughren, T., Jones, M. L., Levenson, M., Holland, P. C., Hughes, A., ... & Rochester, G. (2009). Risk of suicidality in clinical trials of antidepressants in adults: analysis of proprietary data submitted to US Food and Drug Administration. *Bmj*, *339*.

[2] Tondo, L., & Baldessarini, R. (2011, February 10). Can Suicide Be Prevented? Retrieved November 9, 2015, from http://www.psychiatrictimes.com/bipolar-disorder/can-suicide-be-prevented

[3] Meltzer, H. Y., Alphs, L., Green, A. I., Altamura, A. C., Anand, R., Bertoldi, A., ... & Potkin, S. (2003). Clozapine treatment for suicidality in schizophrenia: international suicide prevention trial (InterSePT). *Archives of general psychiatry*, *60*(1), 82-91.

[4] Berman RM, Cappiello A, Anand A, et al. Antidepressant effects of ketamine in depressed patients. *Biol Psychiatry*. 2000; 47(4):351–354.

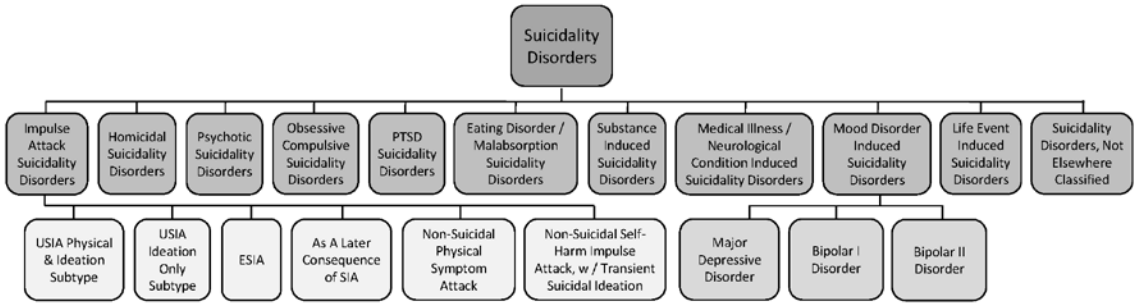
[5] Sheehan, D. V. and Giddens, J. M. 2015. *Suicidality: A Roadmap for Assessment and Treatment*. Chapters 6.1, 9.2, and 12.3. Available from: http://www.harmresearch.org

suicidality disorders, to help us to identify classes of medications that may be uniquely effective for each suicidality disorder.

Our classification of suicidality disorders is a phenotypic classification[6], in contrast to a genotypic classification. It is a classification based on currently available composites of the clinically observable symptoms, signs, behaviors, development, family history, course of illness, and response to treatment. Each suicidality disorder class / phenotype should be a predictive cluster, like the disorders in DSM-5[7], with specific diagnostic criteria for each, with a structured diagnostic interview that can guide the clinician in assigning subjects to each diagnostic class. The classification presented below is based on phenomenological observations of suicidal patients and the mining of datasets of suicidal patients over time. It will inevitability be improved with better evidence and by trial and error.

There are 11 different suicidality disorder phenotypes in our classification in Figure 6.1 below.

Figure 6.1: Suicidality Disorder Phenotypes

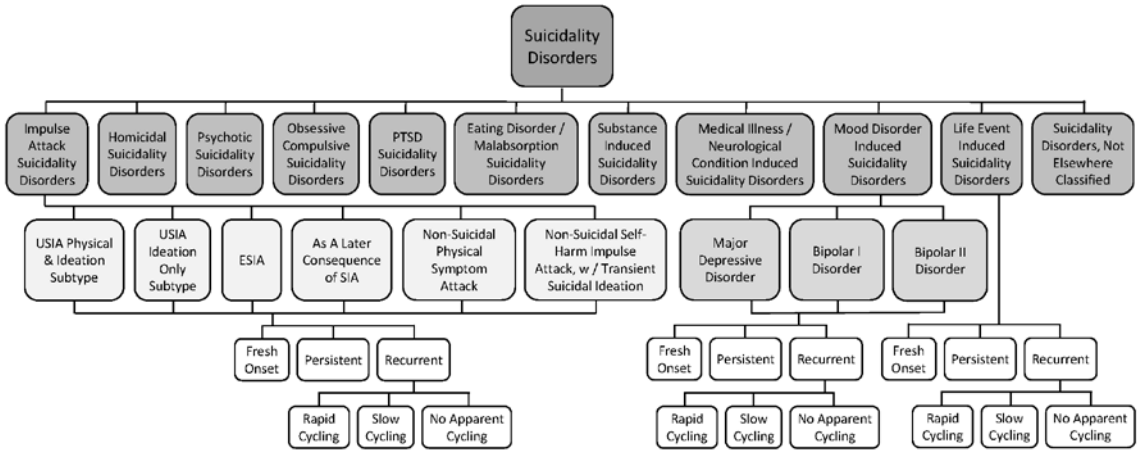


Three of these disorders have 5 symptom pattern specifiers as shown in Figure 6.2 below.

[6] Sheehan, D. V. and Giddens, J. M. 2015. *Suicidality: A Roadmap for Assessment and Treatment*. Chapter 6.1. Available from: http://www.harmresearch.org

[7] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.

Figure 6.2: Suicidality Disorder Phenotypes and Symptom Pattern Specifiers



The suicidality disorder class, shown in Figure 6.3 below, is Impulse Attack Suicidality Disorders (IASD) and its associated cardinal features. IASD is associated with unexpected, unprovoked attacks of an urgent need to kill oneself. They may occur without warning and for no apparent reason to the patient. There are 4 distinct episodes, which may be experienced by those with IASD and a total of 5 symptom patterns in IASD.

Figure 6.3: Cardinal Features of Impulse Attack Suicidality Disorders (IASD)

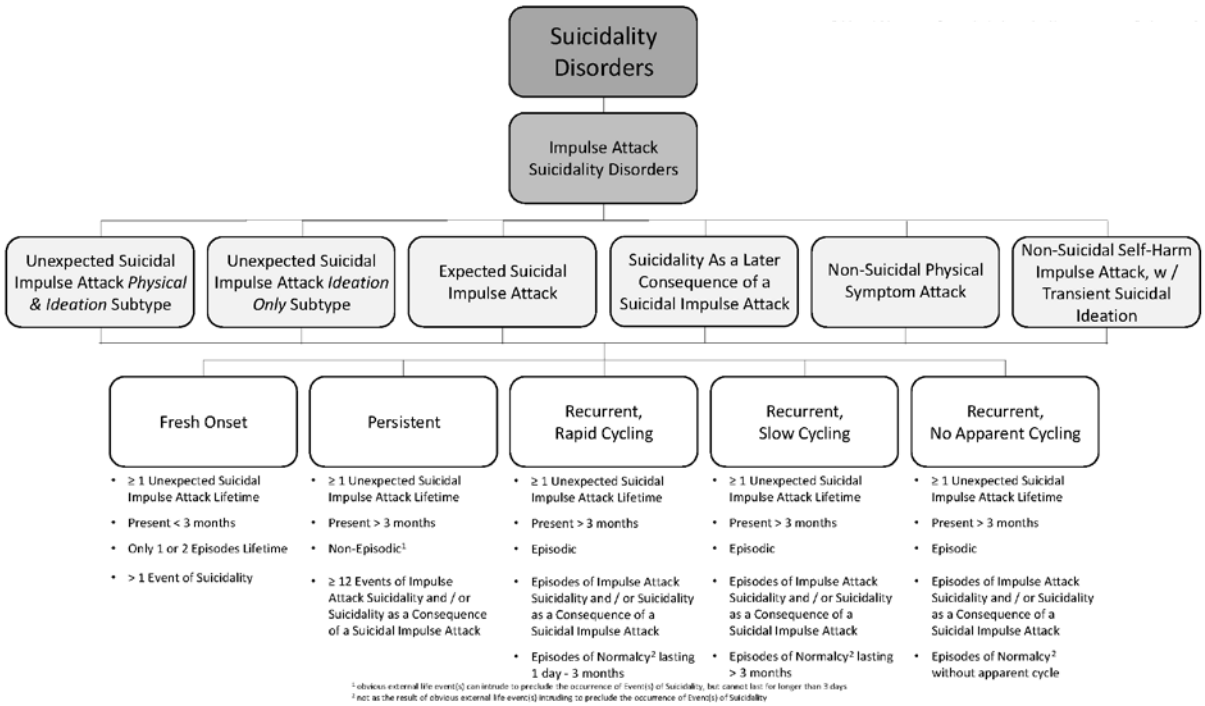


Figure 6.4 below shows 4 additional suicidality disorders and their cardinal features:

1. Homicidal Suicidality Disorders
2. Psychotic Suicidality Disorders
3. Obsessive Compulsive Suicidality Disorders
4. PTSD Suicidality Disorders

Figure 6.4: Cardinal Features of 4 Suicidality Disorders Phenotypes

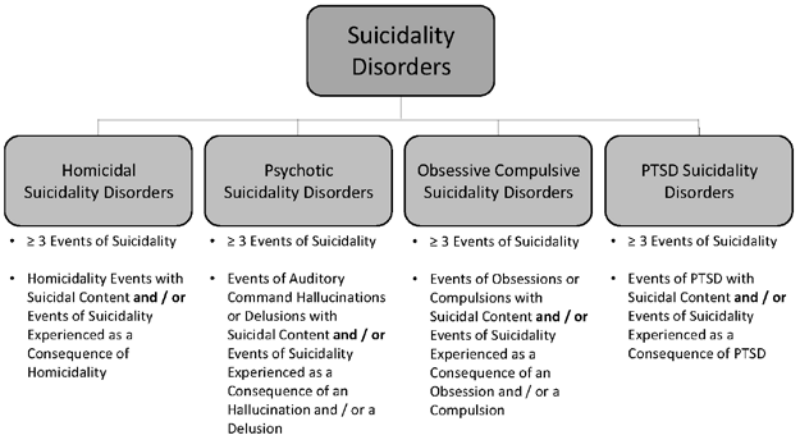
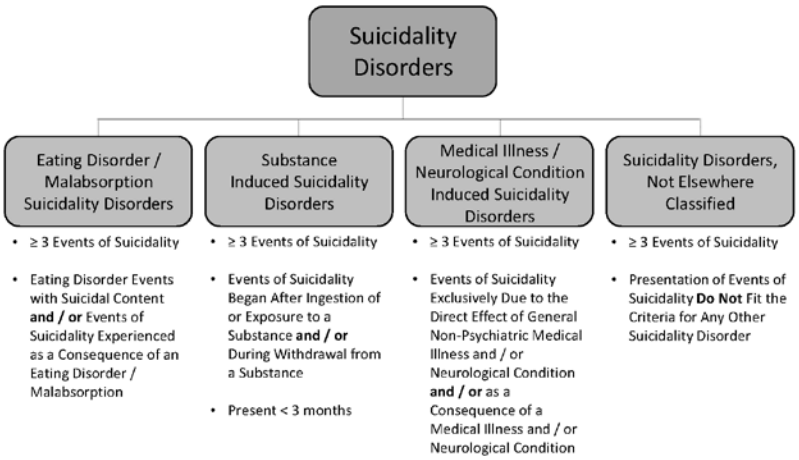


Figure 6.5 below shows another 4 additional suicidality disorders and their cardinal features:

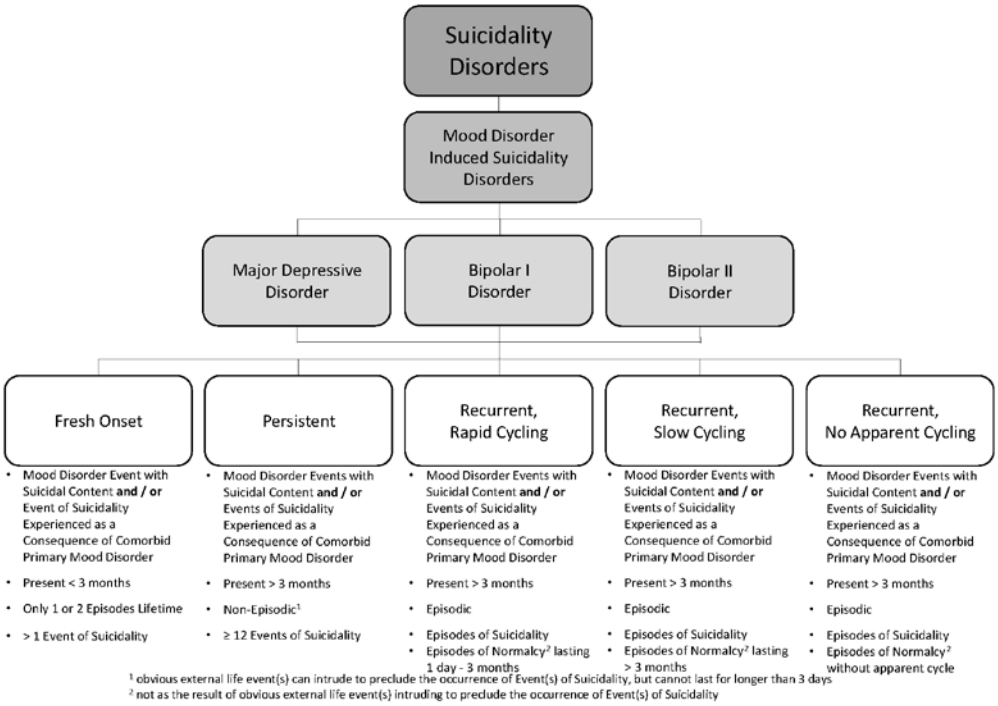
1. Eating Disorder / Malabsorption Suicidality Disorders
2. Substance Induced Suicidality Disorders
3. Medical Illness / Neurological Condition Induced Suicidality Disorders
4. Suicidality Disorders, Not Elsewhere Classified

Figure 6.5: Cardinal Features of 4 Additional Suicidality Disorders Phenotypes



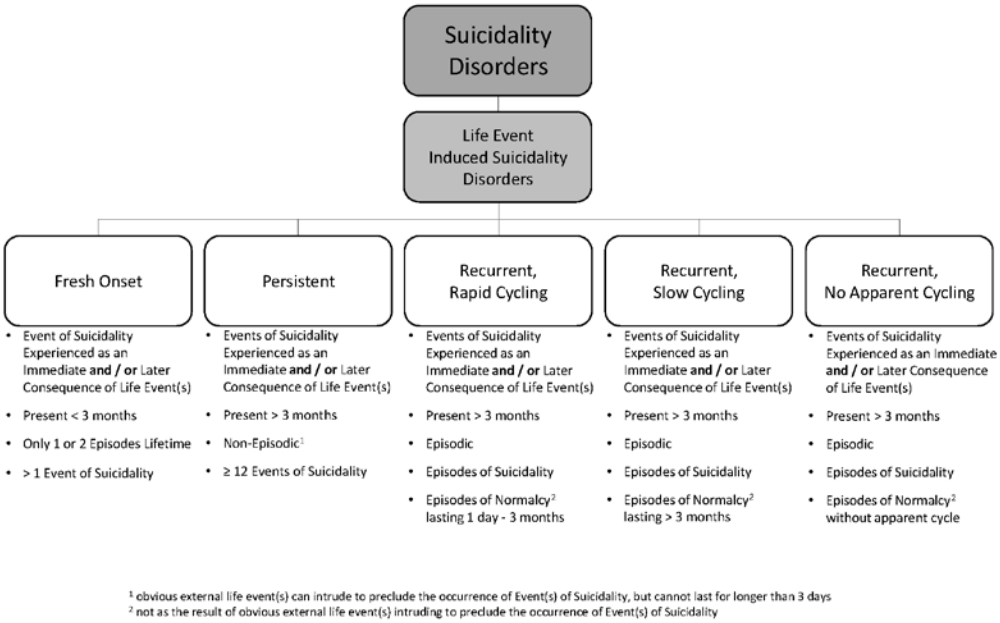
The suicidality disorder class, shown in Figure 6.6 below, is Mood Disorder Induced Suicidality Disorders and its associated cardinal features. There are a total of 5 symptom patterns in this suicidality disorder class.

Figure 6.6: Cardinal Features of Mood Disorder Induced Suicidality Disorders



The suicidality disorder class, shown in Figure 6.7 below, is Life Event Induced Suicidality Disorders and its associated cardinal features. There are a total of 5 symptom patterns in this suicidality disorder class.

Figure 6.7: Cardinal Features of Life Event Induced Suicidality Disorders



One suicidality disorder class, shown in Figure 6.5 above, is Suicidality Disorders, Not Elsewhere Classified and its associated cardinal features. This is a residual category class. We include this disorder class to accommodate suicidal patients who do not meet criteria for any of the aforementioned phenotypes, in the interest of safety, and to preclude omitting such patients. This class provides a place to collect other possible phenotypes, which we have not yet identified. Future research on larger datasets of this class may provide insights, currently not available.

Diagnostic Evaluation of Suicidality Disorder Phenotype

We have developed a structured diagnostic interview called the Suicidality Disorders Module (Module Z)[8] of the Mini International Neuropsychiatric Interview (MINI)[9]. The standard version of the MINI is used to screen patients. It collects information on the symptom clusters for the most common psychiatric disorders in clinical practice. This permits a reproducible documentation of the principle comorbidities associated with the suicidality. This assists clinicians with psychiatric diagnosis and in making inclusion / exclusion decisions in their clinical trials. The MINI for Suicidality Disorders Studies Module Z[10] operationalizes the diagnostic

[8] Sheehan, D. V. and Giddens, J. M. 2015. *Suicidality: A Roadmap for Assessment and Treatment*. Chapter 14.11. Available from: http://www.harmresearch.org

[9] Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., ... & Dunbar, G. C. (1998). The Mini-International Neuropsychiatric Interview (MINI): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of clinical psychiatry*.

[10] Sheehan, D. V. and Giddens, J. M. 2015. *Suicidality: A Roadmap for Assessment and Treatment*. Chapter 14.11. Available from: http://www.harmresearch.org

criteria for each of the suicidality disorder phenotypes and for their specifiers. This provides a way to reproducibly assign patients to one or another phenotype in the interest of assigning them to the most appropriate treatment for their specific phenotype of suicidality disorder. For example, you would not choose to use clozapine to treat suicidality in an elderly patient with Major Depressive Disorder Induced Suicidality Disorder. Similarly, you would not choose to use Dialectical Behavioral Therapy to treat suicidality in a patient with Psychotic Suicidality Disorder who has active suicidal command hallucinations. The MINI for Suicidality Disorders Studies is a reproducible system to assure healthcare systems that the phenotypic diagnosis and the corresponding treatments are consistently implemented across clinics.

We provide a numeric coding system for each suicidality disorder phenotype and its associated specifiers along the lines used by DSM-5 and ICD-10 (although neither of these include any of the suicidality disorders identified in our classification). This numeric coding can be used in medical records to document the presence of the suicidality disorder phenotype.

The Mini International Neuropsychiatric Interview (MINI) for Suicidality Disorders Studies is available at http://www.HarmResearch.org

Conclusion

The above phenotypic classification of suicidality disorders is presented in the hope that it will lead us towards an earlier and more specific identification of anti-suicidality treatments and provide increased precision in genotyping and biomarker investigations of each of these suicidality phenotypes. In may also assist clinicians in identifying different clinical courses, different prognosis, and different responses to treatment for each phenotype.

7

Overview of Current Medication Treatments for Suicidality

Topics addressed in this chapter:

- Clozapine
- Lithium
- Antidepressants (SSRIs, SNRIs, TCAs, MAOIs)
- Ketamine / Esketamine
- High Magnesium Oxide / Low Calcium Dietary Intake Regimen (+Mg-Ca)
- Nitrous Oxide

Clozapine

Clozapine is approved by the U.S. Food and Drug Administration for reducing the risk of recurrent suicidal behavior in patients with Schizophrenia or Schizoaffective Disorder who are judged to be at risk of re-experiencing suicidal behavior. Clozapine has also been reported to reduce the rate of hospitalization for suicide attempts in the long-term treatment of

Schizophrenia or Schizoaffective Disorder in the InterSePT study[1]. The doses needed to provide this anti-suicidality behavior effect were 200mg - 900mg a day.

Lithium

Evidence available from a series of meta-analysis by Tondo and Baldessarini suggest that lithium has anti-suicidality properties in patients with both Bipolar Disorder and Unipolar Major Depressive Disorder[2]. Twenty-five studies have reported this property of lithium.

It may even have anti-suicidality properties in some patients with other psychiatric disorders. It appears to be effective for many patients in reducing suicidality in the short-term and in protecting against emergence of suicidality in the long-term. When lithium is stopped after a year or more of use there is a substantial increase (a possible rebound reactivation) in suicidality over the following few months.

Although the evidence is limited the anti-suicidality doses are similar to the doses and to the blood levels considered therapeutic in Bipolar Disorder (i.e. 0.8 – 1.2 MEq/L).

In the acute treatment of Bipolar Depression lithium may improve the suicidality in the near-term without, at the same time, showing any antidepressant effect. It appears at times to disaggregate the anti-suicidality from the antidepressant effects. In contrast, antidepressants may disaggregate its antidepressant properties from anti-suicidality properties in some patients. Antidepressants may have an antidepressant effect in some patients without having any or much anti-suicidality effects at the same time in other patients.

Lithium is not approved by the U.S. Food and Drug Administration for the specific treatment of suicidality.

Antidepressants (SSRIs, SNRIs, TCAs, MAOIs)

Antidepressants can make patients with Major Depressive Disorder under 25 years more suicidal, those over 65 less suicidal, and those between the ages of 25 and 65 not much better off than patients taking placebo in controlling their suicidality, even when they are effective in controlling the depressive symptoms[3]. This resulted in regulatory agencies requiring boxed warnings in the prescribing information, for all antidepressants. Antidepressants are not approved by the U.S. Food and Drug Administration for the specific treatment of suicidality.

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[1] Meltzer, H. Y., Alphs, L., Green, A. I., Altamura, A. C., Anand, R., Bertoldi, A., ... & Potkin, S. (2003). Clozapine treatment for suicidality in schizophrenia: international suicide prevention trial (InterSePT). *Archives of general psychiatry*, *60*(1), 82-91.

[2] Tondo, L., & Baldessarini, R. (2011, February 10). Can Suicide Be Prevented? Retrieved November 9, 2015, from http://www.psychiatrictimes.com/bipolar-disorder/can-suicide-be-prevented

[3] Stone, M., Laughren, T., Jones, M. L., Levenson, M., Holland, P. C., Hughes, A., ... & Rochester, G. (2009). Risk of suicidality in clinical trials of antidepressants in adults: analysis of proprietary data submitted to US Food and Drug Administration. *Bmj*, *339*.

Ketamine / Esketamine

Following the initial observation by Berman RM et al that ketamine appeared to have antidepressant properties, several investigators and pharmaceutical companies have attempted to replicate these findings with ketamine, esketamine, and some other NMDA-receptor antagonists[4].

The early data suggest that ketamine and esketamine given intravenously provide an anti-suicidality effect within 15 to 45 minutes. This effect is maintained over the first 3 to 4 days after which it decreases back to baseline levels by 7 days (on average). Currently, it is being investigated for the management of suicidality in outpatient settings over 4 to 6 weeks until other therapeutic agents can stabilize the patient's condition after that time (e.g. lithium, clozapine, antidepressants, mood stabilizers). Under the current protocol, patients are seen as outpatients 2 to 3 times a week (e.g. Monday, Wednesday, and Friday) and given these infusions to maximize the anti-suicidality properties while awaiting stabilization of their primary disorder with other, long-term medications.

Ketamine / esketamine have adverse events that preclude their safe use over the long-term (for example, abuse liability, possible nephrotoxicity, and dissociative states and cognitive impairment). It remains unclear at this time to what extent patients may experience rebound reactivation of the suicidality after the ketamine / esketamine treatment ends.

Other NMDA-receptor antagonists are currently under investigation for their anti-suicidality properties. Some of these are given intravenously, some are given intranasal, and some are given orally.

The U.S. Food and Drug Administration approve no formulation of ketamine, its enantiomers, or of other NMDA-receptor modulators for the specific treatment of suicidality.

High Magnesium Oxide / Low Calcium Dietary Intake Regimen (+Mg-Ca)

Preliminary results suggest that a high magnesium oxide / low calcium daily dietary intake regimen decreased the seriousness of the suicidal impulses, suicidal ideations, and suicidal behaviors in Impulse Attack Suicidality Disorder (IASD). The dose needed to achieve this effect was approximately 1000 mg per day taken in divided doses, 4 times daily. This appears to be effective only when coupled with a reduction to 30% of the recommended daily intake of calcium. More information is available on this topic in chapter 6.2, 9.1, and 12.3 in Sheehan and Giddens[5].

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[4] Berman RM, Cappiello A, Anand A, et al. Antidepressant effects of ketamine in depressed patients. Biol Psychiatry. 2000; 47(4):351–354.

[5] Sheehan, D. V. and Giddens, J. M. 2015. *Suicidality: A Roadmap for Assessment and Treatment*. Chapters 6.2, 9.1, and 12.3. Available from: http://www.harmresearch.org

The above-mentioned high magnesium oxide / low calcium daily dietary intake regimen is not approved by the U.S. Food and Drug Administration for the specific treatment of suicidality.

Nitrous Oxide

Preliminary evidence suggests that nitrous oxide may reduce suicidal ideation in patients with treatment resistant depression[6]. Nagele suggests that this effect may be mediated via the NMDA complex.

The U.S. Food and Drug Administration has not approved nitrous oxide for the specific treatment of suicidality.

Conclusion

Suicidality has been largely ignored as a specific treatment target for psychotropic medication. This is surprising given that it is the 10th leading cause of death from all causes in the United States[7], the 15th leading cause of death internationally[8], and a leading cause of morbidity, impairment, and human suffering[9]. This needs to change.

[6] Nagele, P., Duma, A., Kopec, M., Gebara, M. A., Parsoei, A., Walker, M., ... & Zorumski, C. F. (2015). Nitrous oxide for treatment-resistant major depression: a proof-of-concept trial. Biological psychiatry, 78(1), 10-18.
[7] Suicide: Facts at a Glance. (2015, September 3). Retrieved September 15, 2015, from http://www.cdc.gov/violenceprevention/pub/suicide_datasheet.html
[8] Suicide data. (n.d.). Retrieved May 15, 2015, from http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/
[9] Giddens, J. M., & Sheehan, D. V. (2014). Is There Value in Asking the Question "Do you think you would be better off dead?" in Assessing Suicidality? A Case Study. *Innovations in clinical neuroscience*, *11*(9-10), 182. Available from: http://innovationscns.epubxp.com/i/425963/182

Appendix 1

Basic Definitions of Suicidality Phenomena

Suicidality phenomena defined in this chapter:

- Suicidality
- Unexpected Suicidal Impulse Attack (USIA)
- Expected Suicidal Impulse Attack (ESIA)
- Suicidality Later Induced by Suicidal Impulse Attack(s) (SIA)
- Suicidal Homicidality (Homicidal Experience with Suicidal Content)
- Suicidality Later Induced by the Desire to Kill Someone Else (Homicidality)
- Suicidal Hallucination
- Suicidality Later Induced by Hallucination(s)
- Suicidal Delusion
- Suicidality Later Induced by Delusion(s)
- Suicidal PTSD Experience
- Suicidality Later Induced by PTSD
- Suicidal Obsession
- Suicidality Later Induced by Obsession(s)
- Suicidal Compulsion
- Suicidality Later Induced by Compulsion(s)
- Suicidal Eating Disorder Experience
- Suicidality Later Induced by Eating Disorder / Malabsorption
- Suicidal Dream
- Suicidality Later Induced by Dream(s)
- Suicidality Immediately Induced by Substance(s)
- Suicidality Immediately Induced by Medical Illness(es) / Neurological Condition(s)
- Suicidality Later Induced by Medical Illness(es) / Neurological Condition(s)
- Suicidality Immediately Induced by a Mood Disorder Experience
- Suicidality Later Induced by Mood Disorder
- Suicidality Immediately Induced by Life Event(s)
- Suicidality Later Induced by Life Event(s)
- Suicidality Later Induced by Desire to Harm, but Not Kill, *Yourself*
- Suicidality Later Induced by the Desire to Harm, But Not to Kill, *Someone Else*
- Phenomena with Suicidal Content, Not Elsewhere Classified
- Suicidality Later Induced by Other Phenomena
- Suicidal Ideation
- Passive (Suicidal) Ideation
- Active (Suicidal) Ideation
- Suicide Plan
- Suicide Method
- Suicide Means
- Suicide Location
- Suicide Date
- Work On or Completion of Unfinished Tasks
- Suicidal Intent
- Suicidal Behavior
- Aborted Action
- Interrupted Action
- Suicidal Preparatory Behavior
- Suicide Attempt
- Suicide Attempt Halted
- Suicide Attempt Not Halted
- Died by Suicide / Death by Suicide / Completed Suicide
- Non-Suicidal Self-Injurious Behavior / Non-Suicidal Self-Injury
- Non-Suicidal Self-Injury Ideation

Suicidality - [sui (of oneself) + cide (a killing) + ality (the state of being real or actual)] - all suicidal phenomena including ideation, behaviors, impulses, command hallucinations, dreams, delusions, and / or precognitive experiences related to suicide and / or any suicidal phenomenon related to suicide that arches across a time frame, but did not appear as an ideation or behavior during that time frame. For example, a patient who previously made plans or intends to kill herself at a future date, but may not have thought about it during a particular time frame. This definition deliberately excludes theories or speculations about, predictions from or likelihood of a suicidal ideation or behavior. It also excludes experiences that may be comorbid with or correlated with core suicidal phenomena, but in and of themselves are not directly suicidal experiences (e.g. hopelessness, depression, anxiety, grief).

Unexpected Suicidal Impulse Attack (USIA) - any event of suicidality experienced as a sudden need or impulse (with varying degrees of urgency) to plan or to act in any suicidal way. This may or may not be associated with physical symptoms. It is totally or largely *unexpected* or could not have been predicted to occur minutes before the attack.

Expected Suicidal Impulse Attack (ESIA) - any event of suicidality experienced as a sudden need or impulse (with varying degrees of urgency) to plan or to act in any suicidal way. It is totally or largely *expected* or could have been predicted to occur minutes before the attack. These events can occur either with or without the physical symptoms described in the USIA Physical and Ideation Subtype. This is conceptually similar to the expected / situational type of panic attacks in panic disorder.

Suicidality Later Induced by Suicidal Impulse Attack(s) (SIA) - any suicidality that occurs as a later consequence of any Suicidal Impulse Attack (SIA). For example, a patient experienced a SIA yesterday. Today, she feels fearful that another SIA will occur soon and begins to think that she should kill herself before the next SIA can occur.

Suicidal Homicidality (Homicidal Experience with Suicidal Content) - a homicidality experience that contains any suicidal phenomenon within its immediate content / expression. For example, a patient got into an argument with his wife. He is so angry with her that he thinks about killing her and then killing himself.

Suicidality Later Induced by the Desire to Kill Someone Else (Homicidality) - any suicidality that occurs as a later consequence of a desire to kill someone else (homicidality). For example, a patient is so furious with his ex because she got full custody of his kids that he thinks about killing her. Out of fear that he will act on these persistent homicidal thoughts and leave his children without a mother, he considers killing himself. He reasons it is better for him to die than to kill someone else.

Suicidal Hallucination - an hallucination that contains any suicidality phenomenon within its immediate content / expression. For example, a patient experiences an auditory command hallucination to kill themself.

Suicidality Later Induced by Hallucination(s) - any suicidality that occurs as a later consequence of an hallucination. For example, a patient with Schizophrenia has been experiencing an increase in hallucinations lately. Today, he is fearful that his Schizophrenia is out of control again. He begins to think that he should kill himself before he is again overwhelmed by more hallucinations.

Suicidal Delusion - a delusion that contains any suicidality phenomenon within its immediate content / expression. For example, a patient believes their family will be killed if they do not kill themself.

Suicidality Later Induced by Delusion(s) - any suicidality that occurs as a later consequence of a delusion. For example, a patient with Schizoaffective Disorder had a very convincing delusion in which he thought he needed to climb Mount Everest by the end of the month, otherwise the world would end. Last night his girlfriend convinced him to go to the ER for treatment. The medication they gave him controlled his delusion. Over the following days he realizes his Schizoaffective Disorder had seriously relapsed, that it may do so again, and that he will become a perpetual burden to others. He considers this unfair that his girlfriend may have to live with and manage his condition. He thinks about killing himself before his condition again relapses.

Suicidal PTSD Experience - a PTSD experience that contains any suicidality phenomenon within its immediate content / expression. For example, a patient with PTSD experiences a flashback to a time when they thought about killing themself.

Suicidality Later Induced by PTSD - any suicidality that occurs as a later consequence of PTSD. For example, a patient with PTSD experiences frequent flashbacks of trauma she endured during combat. She consistently relives watching her friends die in combat. These flashbacks have slowly worn her down to the point that she feels they will never stop. She thinks about killing herself to make these flashbacks stop.

Suicidal Obsession - an obsession that contains any suicidality phenomenon within its immediate content / expression. For example, a patient experiences recurrent, unwanted, intrusive thoughts of killing themself, that are unwanted and distasteful to them.

Suicidality Later Induced by Obsession(s) - any suicidality that occurs as a later consequence of an obsession. For example, a patient has a recurrent obsession to scream obscenities during a quiet time at church. Being a very religious woman, she fears that she will be punished by God for these obsessive thoughts. Rather than allow these obsessions to continue, she entertains thoughts about killing herself to put an end to these blasphemous thoughts.

Suicidal Compulsion - a compulsion that contains any suicidality phenomenon within its immediate content / expression. For example, a patient's mother and grandmother both died by suicide during a full moon. Every month during a full moon he has a repetitive urge to kill himself. During tonight's full moon, he feels a need to act on this urge to reduce the anxiety and distress he experiences at this time and prevent something bad from happening to others in his

family. He never has suicidality at other times. He is not otherwise delusional. He has insight into the superstitious nature of this compulsion, but cannot stop it from recurring each full moon.

Suicidality Later Induced by Compulsion(s) - any suicidality that occurs as a later consequence of a compulsion. For example, a patient spends 14-hours a day in the shower washing herself because she feels dirty and contaminated. In addition to dermatological problems and excoriation of her skin, this compulsive showering has caused major functional impairment in her life and has led to severe conflicts with her family. She feels unable to stop this behavior, which she finds totally exhausting. As a consequence, she has felt increasingly suicidal and is now making preparatory suicidal behaviors for her imminent suicide attempt.

Suicidal Eating Disorder Experience - an eating disorder experience that contains any suicidality phenomenon within its immediate content / expression. For example, a patient with an eating disorder thinks about starving themself to death.

Suicidality Later Induced by Eating Disorder / Malabsorption - any suicidality that occurs as a later consequence of an eating disorder or malabsorption condition. For example, a patient with no history of suicidality has bariatric surgery to reduce his obesity. Following the procedure, he becomes suicidal and remains suicidal for months. The removal of part of his stomach caused selective malnutrition and a failure to absorb an adequate amount of some essential nutrients, like magnesium.

Suicidal Dream - a dream that contains any suicidality phenomenon within its immediate content / expression. For example, a patient has a dream that they killed themself.

Suicidality Later Induced by Dream(s) - any suicidality that occurs as a later consequence of dream(s). For example, a patient with a history of chronic suicidality had a dream during which he died. Upon waking, he is overwhelmed and frustrated because he thought he had died and was finally free from his chronic suicidality. He thinks about killing himself to avoid the future disappointment of dying in another dream only to wake up and find he is still alive and having to face more suffering.

Suicidality Immediately Induced by Substance(s) - any suicidality that occurs as a direct and / or immediate consequence of ingestion of a substance. For example, a patient felt suicidal when she became intoxicated on LSD. It was her first experience of suicidal ideation.

Suicidality Immediately Induced by Medical Illness(es) / Neurological Condition(s) - any suicidality that occurs as a direct and / or immediate consequence of a general, non-psychiatric medical illness and / or neurological condition. For example, a patient with Trigeminal Neuralgia experiences constant pain. He thinks about killing himself in order to end this pain.

Suicidality Later Induced by Medical Illness(es) / Neurological Condition(s) - any suicidality that occurs as a later consequence of a general, non-psychiatric medical illness and / or neurological condition. For example, a patient experiences suicidal ideation during phase 2 of the Huntington's Disease.

Suicidality Immediately Induced by a Mood Disorder Experience - any suicidality that occurs as a direct and / or immediate consequence of a mood disorder experience. For example, a patient with Major Depressive Disorder experiences severe depressed mood and hopelessness, which immediately leads them to think about killing themself.

Suicidality Later Induced by Mood Disorder - any suicidality that occurs as a later consequence of a mood disorder. For example, a patient with Bipolar I Disorder returns home from a 10-day inpatient stay following a manic episode, because he stopped his medications. He has a long history of non-adherence to his medications. He is frustrated with himself for again putting his family through this. He thinks about killing himself to avoid causing his family further pain.

Suicidality Immediately Induced by Life Event(s) - any suicidality that occurs as a direct and / or immediate consequence of at least one life event including, but not limited to those identified by Durkheim as influences on suicidality. This attribution should be directly obvious to any third party outside the clinician and patient involved in the assessment. Suicidality reactions to life events that are clearly out of proportion to the reality and the gravity of the life event may indicate the need to consider some other suicidality phenomenon or phenomena, rather than suicidality immediately induced by life event(s). The reasonable person's judgment test should apply when determining if the life event is sufficiently grave to justify the observed suicidality. For example, a patient's parents were just killed in a car accident. On hearing of their deaths, sadness overwhelms the patient and she thinks about killing herself to join her parents.

Suicidality Later Induced by Life Event(s) - any suicidality that occurs as a later consequence of at least one life event including, but not limited to those identified by Durkheim as influences on suicidality. This attribution should be directly obvious to any third party outside the clinician and patient involved in the assessment. Suicidality reactions to life events that are clearly out of proportion to the reality and the gravity of the life event may indicate the need to consider some other suicidality phenomenon or phenomena, rather than suicidality later induced by life event(s). The reasonable person's judgment test should apply when determining if the life event is sufficiently grave to justify the observed suicidality. For example, a patient had to flee his home due to war. He is currently living in a refugee camp. His prospects of leaving the camp anytime soon are minimal. He is increasingly frustrated by his current life circumstances and thinks about killing himself.

Suicidality Later Induced by Desire to Harm, but Not Kill, *Yourself* - any suicidality that occurs as a later consequence of a desire to harm, but not kill, oneself. For example, last week a patient with a history of Non-Suicidal Self-Injury (NSSI) promised her husband she would stop cutting herself. Last night she was unable to resist the urge to cut herself. Today she is very upset at herself for not fulfilling her promise to her husband. She thinks about killing herself to avoid her husband finding out she broke her promise to him.

Suicidality Later Induced by the Desire to Harm, but Not Kill, *Someone Else* - any suicidality that occurs as a later consequence of a desire to harm, but not to kill, someone else. For example, a patient was raised in a very religious household. His girlfriend recently introduced him to BDSM

(bondage, dominance, and sadomasochism). He found that he really enjoys the role of dominant sadist. He feels conflicted between these new feelings and his religious upbringing. He thinks about killing himself in order to avoid again sinning by engaging in BDSM with his girlfriend.

Phenomena with Suicidal Content, Not Elsewhere Classified - any phenomenon other than a SIA, an hallucination, a delusion, a PTSD experience, an obsession, a compulsion, an eating disorder experience, or a dream, that contains any suicidality phenomenon within its immediate content / expression

Suicidality Later Induced by Other Phenomena - any suicidality that occurs as a later consequence of any phenomenon other than a SIA, homicidality, an hallucination, a delusion, a desire to harm (but not kill) someone else, an obsession, a compulsion, an eating disorder or malabsorption, medical illness(es) or neurological condition(s), a mood disorder, dream(s), life event(s), or a desire to harm, but not kill, oneself. This is a catch-all category for any suicidality that occurs as a later consequence of any phenomenon that does not fit into a class of phenomena defined above.

Suicidal Ideation - a desire or wish or need or preference to be dead or a thought about being dead in relation to another experience of suicidality or a thought to hurt, harm, or injure oneself with the intent or awareness that one could die as a result or any strategizing for or accounting of or thought(s) of future action(s) for a suicide attempt (including thoughts to make a plan). The ideation may concern, but is not limited to, the method, the means, the location, the date, and / or any unfinished tasks.

Passive (Suicidal) Ideation - any thought of wishing or wanting or needing to be dead or of wishing or wanting or needing to not be alive anymore or the thought of being better off dead or the desire to go to sleep *and never wake up* or the thought of not wanting to be alive anymore. The phrase "passive ideation" refers to ideas of dying that *do not require a change in usual behavior* on the part of the patient to die.

Active (Suicidal) Ideation - any thought of killing oneself. The phrase "active ideation" refers to ideas of dying that *requires a change in usual behavior* on the part of the patient to die.

Suicide Plan - any strategy for or account of or thought(s) for future action(s) of a suicide attempt (including thoughts to make a plan). This plan may concern, but is not limited to, the method, the means, the location, the date, and / or any unfinished tasks.

Suicide Method - any thought of a way any person could attempt to kill themself. This includes, but is not limited to a specific method (e.g. gunshot wound to the head), a general method (e.g. exsanguination), an active method (e.g. an overdose of insulin), or a passive method (e.g. an insulin dependent diabetic failing to take their insulin).

Suicide Means - any thought of tool(s) any person could use to attempt to kill themself. Examples include a rope to hang themself or a gun to shoot themself. This includes, but is not

limited to a specific means (e.g. their mother's sleeping medication) or a general means (e.g. some type of pills).

Suicide Location - any thought of a location any person could use to attempt to kill themself. Examples include their car in a closed garage to die via carbon monoxide poisoning or the Golden Gate Bridge where they could jump to their death. This includes, but is not limited to a specific location (e.g. the Sea of Trees in Japan) or a general location (e.g. the forest).

Suicide Date - any thought of a date any person could use to attempt to kill themself or any thought of a time frame within which they would like to die. This includes, but is not limited to a specific date (e.g. January 1st, 2016), a specific time frame (e.g. before next year), or a general date or time frame (e.g. soon).

Work On or Completion of Unfinished Tasks - any time spent actively engaged in a task that a patient would like to complete prior to a suicide attempt. This includes, but is not limited to tasks the patient works on or completes with the mind-set that they will be closer to making a suicide attempt when the task is completed. This includes, but is not limited to tasks the patient works on or completes that they previously thought were important for them to complete prior to making a suicide attempt.

Suicidal Intent* - any intent* > 0 to make a plan to kill oneself *or* to take action to kill oneself *or* to die as the result of a suicide attempt at any point in time. This includes, but is not limited to: the intent* to consider the method, means, location, date, time frame, unfinished tasks, or involvement of others to be used in the suicide plan; active and passive suicide attempts (see suicide method for examples of active and passive methods); persons that actually make an attempt and those that did not make an attempt, but did have some intent* > 0 to attempt to kill oneself; and persons that actually make an attempt, and those that did not make an attempt, but did have some intent* > 0 to attempt to kill oneself.

Suicidal Behavior - any (set of) behavior(s), either incomplete or completed, that are either 1) not viewed by the patient to be potentially lethal and stop short of taking action on a suicide attempt, but assist the patient in preparing to take action on a suicide attempt *or* 2) perceived by the patient to be potentially lethal, connected with any level of intent* (> 0) to die, that does not result in a fatality *or* 3) a fatality clearly and confidently (evidence beyond a reasonable doubt) caused by self-injurious or purposely reckless or negligent behavior that is connected with any level of intent* to die as a result of said self-injurious or purposely reckless behavior. (See the definitions for suicidal preparatory behavior, suicide attempt halted, suicide attempt not halted, and died by suicide for more details and information.)

Aborted Action - any action that is stopped by the subject on their own initiative, without interruption by an external intervention

Interrupted Action - any action perceived by the patient to intervene to the extent of stopping the action from proceeding

Suicidal Preparatory Behavior - any behavior(s) that are not viewed by the patient to be potentially lethal and stop short of taking action on a suicide attempt, but assist the patient in preparing to take action on a suicide attempt. These preparatory behavior(s) may concern, but are not limited to, the method, the means, the location, the date, and / or any unfinished tasks. We deliberately did not try to make subtypes of these behaviors or try to classify them in a hierarchal array as in FDA-CASA 2012 because there is no way to correctly generalize any such hierarchy to any individual case based on the gravity of the preparations. We judge the gravity of the preparatory behaviors based upon the patient's perception of the gravity rather than relying on the details. Here, as elsewhere, the focus of seriousness / gravity / danger is patient centric rather than circumstance or clinician centric. The patient's perspective on potential lethality can be inferred by a reasonable group of experts, if the patient is not available or refuses to provide it themselves, but should not always be assumed, unless the evidence is compelling.

Suicide Attempt - any (set of) behavior(s), either incomplete or completed, perceived by the patient to be potentially lethal, connected with any level of intent* (> 0) to die, that does not result in a fatality. The behavior may or may not result in any actual harm to the patient. The (set of) behavior(s) may or may not be incomplete due to an interruption by events outside the patient's body or existence, or may be incomplete due to the patient aborting** the already started, perceived lethal behavior(s) before it (they) are fully executed. The intent to die can be inferred by a reasonable group of experts, but should not always be assumed, unless the evidence is compelling. Not all self-injury is suicidal. This intent to die refers to the intent at the time of initiation of the suicide attempt. **The patient's desire to abort the already started, perceived lethal behaviors can be self-imposed, or imposed by another.

Suicide Attempt Halted - any incomplete (set of) behavior(s) perceived by the patient to be potentially lethal connected with any level of intent* (> 0) to die that does not result in a fatality. The behavior may or may not result in any actual harm to the patient. The (set of) behavior(s) may be incomplete due to an interruption by events outside the patient's body or existence, or may be incomplete due to the patient aborting the already started, perceived lethal behavior(s) before it (they) are fully executed. The intent to die can be inferred by a reasonable group of experts, but should not always be assumed, unless the evidence is compelling. Not all self-injury is suicidal. This intent to die refers to the intent at the time of initiation of the suicide attempt.

Suicide Attempt Not Halted - any completed (set of) behavior(s) perceived by the patient to be potentially lethal that is connected with any level of intent* (> 0) to die that does not result in a fatality. The behavior may or may not result in any actual harm to the patient. The behavior does not have to be potentially injurious. Only the patient's perception that it is self-injurious is necessary. (See Examples 1 and 2 below.) The intent to die can be inferred by a reasonable group of experts, but should not always be assumed, unless the evidence is compelling. Not all self-injury is suicidal. This intent to die refers to the intent at the time of initiation of the suicide attempt.

Example 1: consider a cinnamon challenge competition for young adults. The goal in this challenge was to attempt to swallow a heaping tablespoon full of cinnamon within 60 seconds without drinking any water. To dissuade her child from participating in the challenge one mother warned the child that it would kill them. The belief that the cinnamon challenge was potentially lethal spread among teens. With this understanding a teen decides to make a suicide attempt by trying to swallow a heaping tablespoon of cinnamon. This counts as a suicide attempt, because the teen thought this would kill them.

Example 2: a child just finished watching the movie Snow White. In an attempt to harass the young child an older sibling offers the child an apple, which they tell their younger sibling, comes from the same tree as the one in the movie. With the assumption it would make them sleep forever, the child eats the apple. Because the child thought eating the apple would kill them, just as it put Snow White into the 'Sleeping Death', this event counts as a suicide attempt.

Died by Suicide / Death by Suicide / Completed Suicide - a fatality clearly and confidently (evidence beyond a reasonable doubt) caused by self-injurious or purposely reckless behavior that is connected with any level of intent* (> 0) to die as a result of said self-injurious or purposely reckless or negligent behavior. The intent to die can be inferred by a reasonable group of experts, but should not always be assumed, unless the evidence is compelling. Not all self-injury resulting in death is suicidal. This intent to die refers to the intent at the time of initiation of the suicide attempt.

Additional Related Definitions

Non-Suicidal Self-Injurious Behavior / Non-Suicidal Self-Injury - any (set of) behavior(s), either incomplete or completed, that are either 1) not viewed by the patient to be potentially lethal and stop short of taking action on a self-injury attempt, but assist the patient in preparing to take action on a self-injury attempt *or* 2) perceived by the patient to not be potentially lethal, connected with no level of intent* (= 0) to die, that does not result in a fatality *or* 3) a fatality clearly and confidently (evidence beyond a reasonable doubt) caused by self-injurious or purposely reckless behavior that is connected with no level of intent* to die (= 0) as a result of this self-injurious or purposely reckless or negligent behavior. We do *not* consider non-suicidal self-injurious behavior to be suicidal behavior. However, as with the suicidal behaviors there may be interrupted, aborted, or neither interrupted nor aborted self-injurious behaviors.

Non-Suicidal Self-Injury Ideation - a desire or wish or need or preference to be injured or thought about being injured or a thought to hurt, harm, or injure oneself with NO intent (= 0) to die as a result or any strategizing for or accounting of or thought(s) of future action(s) for a self-injury attempt (including thoughts to make a plan). The ideation may concern, but is not limited to, the method, the means, the location, the date, and / or any unfinished tasks.

* Intent is defined as the state of a person's mind that directs them towards a specific action.

Appendix 2

Additional Suicidality Assessment Scales

Pediatric Versions of the Sheehan – Suicidality Tracking Scale (S-STS)

Adolescent Sheehan – Suicidality Tracking Scale Clinically Meaningful Change Measure (S-STS CMCM) Version

Suicide Plan Tracking Scale (SPTS)

Suicidality Modifiers Scale (SMS)

Suicidal Impulse Attack Scale (SIAS)

Appendix 2.1

Pediatric Versions of the Sheehan - Suicidality Tracking Scale (S-STS)

Adapted from: Amado DM, Beamon DA, Sheehan DV. The linguistic validation of the Pediatric versions of the Sheehan-Suicidality Tracking Scale (S-STS). Innov Clin Neurosci 2014;11(9–10):141–163. http://innovationscns.epubxp.com/i/425963/140

Introduction

A pediatric suicidality scale should assess the full range of suicidality phenomena in children and adolescents. The pediatric S-STS was designed to be cognitively appropriate and linguistically understood by children and adolescents across the spectrum of the ages from childhood into adulthood. Clinicians can use it to prospectively follow suicidality from the earliest ages into adulthood, in cohorts of children using the same instrument in its staged linguistic validation forms, across the spectrum of ages. The pediatric S-STS provides clinicians with an age appropriate method of communicating with children and adolescents about suicidality.

It is capable of use as both a safety and an efficacy outcome measure in clinical and research settings. In the context of efforts to find and develop anti-suicidality treatments, the pediatric S-STS was designed to be very sensitive in detecting anti-suicidality effects in modest sample sizes of children and adolescents.

The pediatric S-STS offers guidance on how to phrase the adult questions or target symptoms into each child's age appropriate language. Developing age and cognitive appropriate versions of a scale for children and adolescents should not be left entirely up to the subject judgments of individual "experts" in choosing the most appropriate choice of language. These choices should be based on empirical studies in language development over the spectrum of age groups. Otherwise there is an unacceptable level of inter-rater *unreliability* and increases the likelihood of both type I and type II errors.

The standard version of the pediatric S-STS has 14 core questions and 9 additional questions contingent on the responses to the core 14. The pediatric S-STS is laid out for ease of navigation on 3 pages. Page 1 contains all of 14 core suicidality phenomena and could be used as a stand-alone page in clinical settings.

Development of the Pediatric Versions of the S-STS

We used the empirically based system already in place and widely adopted by school systems throughout the United States, Canada, and the United Kingdom for linguistic validation of educational texts, to make three pediatric versions: one for 6- to 8-year-olds, a second for 9- to 12-year-olds, and a third for 13- to 17-year-olds. See Amado et al 2014 for more detailed information about this linguistic validation process[1].

Operational Use Pediatric Versions of the S-STS

An Education Advisory Committee; comprised of faculty in academic departments of education who specialized in elementary and high school education, child and adult psychiatrists, and elementary school teachers in both the public and private sector; made a number of recommendations about the implementation of the pediatric scales:

1. The 6- to 8-year-olds version should be clinician-rated, by reading the scale orally to the child. A parent or guardian should ideally be present during the interview, though this may not be appropriate in some situations, and should be asked at the start of the interview to avoid answering for the child unless the child provides information that appears to the parent to be erroneous. If there is discrepant information, the clinician should try to resolve the discrepancy in the interest of making an accurate assessment.
2. The 9- to 12-year-olds version should be either clinician-rated or self-rated. This is best done with the parent and clinician present, rather having the child self-rate alone. Some children may need less or more independence while self-rating the scale.
3. The 13- to 17-year-olds version should be self-rated. Adolescents are less likely to involve parents and others in their inner lives or in interviews.
4. The 6- to 8-year-olds and some of the 9- to 12-year-olds may have difficulty properly understanding the spectrum of graded response options to the questions. Comprehension of the graded response options can be tested at the beginning of the interview. If needed, clinicians can use a variety of adjunctive aids to visually illustrate the escalating and graded nature of the response options. An increasing number of physical objects, like blocks or other manipulables can be used for this purpose.

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[1] Amado DM, Beamon DA, Sheehan DV. The linguistic validation of the Pediatric versions of the Sheehan-Suicidality Tracking Scale (S-STS). *Innov Clin Neurosci* 2014;11(9–10):141–163. Available from: http://innovationscns.epubxp.com/i/425963/140

SHEEHAN-SUICIDALITY TRACKING SCALE (S-STS) – Child Version (6-8 years)

INSTRUCTIONS: PLEASE USE DATA FROM ALL SOURCES AND CONSIDER SEVERITY, FREQUENCY AND TIME FRAME IN YOUR RESPONSES.
THE RESPONSE "NOT AT ALL" TO ANY QUESTION MEANS "NONE" AND MEANS THAT THE THOUGHT OR BEHAVIOR "DID NOT OCCUR AT ALL".

1. **In the past** (timeframe), **did you have an accident?** NO ☐ YES ☐
   (this includes taking too much of your medication by accident).
   IF NO, GO TO QUESTION 2. IF YES, GO TO QUESTION 1a:

	Not at all	A little	In the middle	A Lot	Really a Lot
1a. How much did you try to **get hurt** in an accident, or how much did you try to **hurt yourself** in an accident?	0	1	2	3	4

IF THE ANSWER TO QUESTION 1a IS 0 (= Not at all), GO TO QUESTION 2.
IF IT IS SCORED 1 OR HIGHER, GO TO QUESTION 1b:

1b. Did you try to die or make yourself dead because of an accident? NO ☐ YES ☐

In the past (timeframe)**, how much did you:**

	Not at all	A little	In the middle	A Lot	Really a Lot
2. wish you were dead? How many times? ____	0	1	2	3	4
3. think about hurting yourself, **knowing** you could die, or how much did you think about making yourself dead **? How many times? ____	0	1	2	3	4
4. hear a voice telling you to make yourself dead or have a dream or a nightmare about making yourself dead **?	0	1	2	3	4
5. think about **how** to make yourself dead **?	0	1	2	3	4
6. think about **what you would use** to make yourself dead **?	0	1	2	3	4
7. think about **where you would go** to make yourself dead **?	0	1	2	3	4
8. think about **when you would** make yourself dead **?	0	1	2	3	4
9. mean to **go ahead and to do something** to make yourself dead **?	0	1	2	3	4
10. **mean to die** (or make yourself dead) from hurting yourself?	0	1	2	3	4
11. feel all of a sudden that you had to make yourself dead **?	0	1	2	3	4
12. do things to **get ready** to make yourself dead **?	0	1	2	3	4
13. hurt yourself **without** trying to make yourself dead **? How many times? ____	0	1	2	3	4
14. try to make yourself dead * (**)?	0	1	2	3	4

* "A suicide attempt is a potentially self-injurious behavior, associated with at least some intent (> 0) to die as a result of the act. Evidence that the individual intended to kill him or herself, at least to some degree, can be explicit or inferred from the behavior or circumstance.". *A suicide attempt may or may not result in actual injury." (FDA 2012 definition[1,2]).* * Note: Items 7 & 8 on S-STS ("plan for suicide") means not going beyond ideas or talking about a plan for suicide. If actual behaviors occurred, the event should not be coded on item 7 or 8, but as "preparatory behavior" (item 12). However, both events can occur separately over the same timeframe. ** Some children may relate better to the wording "to kill yourself" rather than "to make yourself dead".

15. IF THE ANSWER TO QUESTION 14 IS 1 OR HIGHER ASK:

In the past (timeframe), how many times did you try to make yourself dead? ____

	When? dd/MMM/yyyy	How?	How hard did you try each time? Not at all	A little	In the middle	A lot	Really a lot	Level
1.			0	1	2	3	4	
2.			0	1	2	3	4	
3.			0	1	2	3	4	
4.			0	1	2	3	4	
5.			0	1	2	3	4	

Add rows as needed.

Levels of Making Yourself Dead
Level **1**: You started to try to make yourself dead, and did something that could hurt you, but then **you stopped yourself**.
Level **2**: You started to try to make yourself dead, and did something that could hurt you, but then **someone or something stopped you**.
Level **3**: You did **everything you could** to try to make yourself completely dead.

16. IF THE ANSWER TO QUESTION 12 IS 1 OR HIGHER ASK:

In the past (timeframe), how many times did you do things **to get ready** to make yourself dead? ____
(CLINICIAN: Include only the times when the child stopped before starting to kill themselves). **

	When? dd/MMM/yyyy	How?	How hard did you try each time? Not at all	A little	In the middle	A lot	Really a lot	Level
1.			0	1	2	3	4	
2.			0	1	2	3	4	
3.			0	1	2	3	4	
4.			0	1	2	3	4	
5.			0	1	2	3	4	

Add rows as needed.

Levels of Getting Ready to Make Yourself Dead
Level **1**: You ONLY did things to **get ready** to make yourself dead, but you did not start to make yourself dead.
Level **2**: You ONLY did things to **get ready** to make yourself dead, but then **you stopped yourself** before you hurt yourself.
Level **3**: You ONLY did things to **get ready** to make yourself dead, but then **someone or something stopped you** before you hurt yourself.

HOW MUCH TIME DO YOU SPEND EVERY DAY THINKING ABOUT MAKING YOURSELF DEAD?

____ Not at all. ____ A little. ___ In the middle. ____ A lot. ____ Really a lot.

SHEEHAN-SUICIDALITY TRACKING SCALE (S-STS) - CLINICIAN USE ONLY

Complete this section *if the patient does not return for the scheduled follow up visit* and is not available to permit completion of pages 1 and 2.

FOR CLINICIAN USE ONLY

	NO	YES
17. Missed appointment - reason: subject died from a completed suicide?	0	100
18. Missed appointment - reason: subject died, but not enough information to code as a suicide?	0	0
19. Missed appointment - reason: subject died from cause(s) other than suicide?	0	0
20. Missed appointment - reason: subject alive, but not available because of a suicide attempt?	0	4
21. Missed appointment - reason: subject alive, but not available for known reasons other than suicide?	0	0
22. Missed appointment - reason: subject alive, but not available, for uncertain reasons, or "lost to follow up"?	0	0

Total Scale Score Add scores from Questions 1a (only if 1b is coded YES), + 2 through 11 + [the highest of 12 or any row of 16] + [the highest of 14 or any row of 15] + 17 + 20 [on page 3]

TOTAL ____

☐ I have reviewed the answers on Pages 1 and 2 with the patient.

_____ _____
Clinician Signature dd/MMM/yyyy

☐ I have reviewed the answers on Pages 1 and 2 with my doctor or clinician.

_____ _____
Patient Signature dd/MMM/yyyy

References

1. Guidance for Industry Suicidal Ideation and Behavior: Prospective Assessment of Occurrence in Clinical Trials. August 2012. Revision 1. U.S Department of Health and Human Services, Food and Drug Administration, Center for Drug Evaluation and Research (CDER), Silver Spring, MD 20992-0002. http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm/ Direct download from www.fda.gov/downloads/Drugs/Guidances/UCM225130.pdf
2. Posner K, Oquendo MA et al. Columbia Classification Algorithm of Suicide Assessment (C-CASA): Classification of Suicidal Events in the FDA's Pediatric Suicidal Risk Analysis of Antidepressants. C-CASA Definitions in Table 2, page 1037. Am J Psychiatry 2007; 164:1035-1043

The author is grateful to for very valuable advice in the development of the pediatric versions of the S-STS to Darlene Amado and Darlene Beamon and to JM Giddens in developing the adult S-STS and adult S-STS CMCM versions.

SHEEHAN-SUICIDALITY TRACKING SCALE (S-STS) – Child Version (9-12 years)

INSTRUCTIONS: PLEASE USE DATA FROM ALL SOURCES AND CONSIDER SEVERITY, FREQUENCY AND TIME FRAME IN YOUR RESPONSES.
THE RESPONSE "NOT AT ALL" TO ANY QUESTION MEANS "NONE" AND MEANS THAT THE THOUGHT OR BEHAVIOR "DID NOT OCCUR AT ALL".

1. **In the past** (timeframe), **did you have an accident?** NO ☐ YES ☐
(this includes taking too much of your medication by accident).
IF NO, GO TO QUESTION 2. IF YES, GO TO QUESTION 1a:

	Not at all	A little	Somewhat	Very	Extremely
1a. How seriously did you plan or expect to hurt yourself on purpose in an accident?	0	1	2	3	4

IF THE ANSWER TO QUESTION 1a IS 0 (= Not at all), GO TO QUESTION 2.
IF IT IS SCORED 1 OR HIGHER, GO TO QUESTION 1b:

1b. Did you try to die as a result of an accident? NO ☐ YES ☐

In the past (timeframe)**, how much did you:**

	Not at all	A little	Somewhat	Very	Extremely
2. think that you would be better off dead or wish you were dead? How many times? ____	0	1	2	3	4
3. think about hurting yourself, with the possibility that you might die? Or **how much** did you think about killing yourself **? How many times? ____	0	1	2	3	4
4. hear a voice telling you to kill yourself, or have a dream or a nightmare about killing yourself **?	0	1	2	3	4
5. think about **how** to kill yourself **?	0	1	2	3	4
6. think about **what you would use** to kill yourself **?	0	1	2	3	4
7. think about **where you would go** to kill yourself **?	0	1	2	3	4
8. think about **when** to kill yourself **?	0	1	2	3	4
9. want to **go through with a plan to** kill yourself **?	0	1	2	3	4
10. **want** to die by hurting yourself?	0	1	2	3	4
11. think about killing yourself ** sooner rather than later?	0	1	2	3	4
12. do things to **prepare** to kill yourself **?	0	1	2	3	4
13. hurt yourself on purpose **without** trying to kill yourself **? How many times? ____	0	1	2	3	4
14. try to kill yourself * (**)?	0	1	2	3	4

* "A suicide attempt is a potentially self-injurious behavior, associated with at least some intent (> 0) to die as a result of the act. Evidence that the individual intended to kill him or herself, at least to some degree, can be explicit or inferred from the behavior or circumstance.". *A suicide attempt may or may not result in actual injury." (FDA 2012 definition[1,2]).* * Note: Items 7 & 8 on S-STS ("plan for suicide") means not going beyond ideas or talking about a plan for suicide. If actual behaviors occurred, the event should not be coded on item 7 or 8, but as "preparatory behavior" (item 12). However, both events can occur separately over the same timeframe. ** Some children may relate better to the wording "to make yourself dead" rather than "to kill yourself".

15. IF THE ANSWER TO QUESTION 14 IS 1 OR HIGHER ASK:

In the past (timeframe), how many times did you try to kill yourself? ** ____

	When? dd/MMM/yyyy	How?	How hard did you try each time? Not at all	A little	Somewhat	Very	Extremely	Level
1.			0	1	2	3	4	
2.			0	1	2	3	4	
3.			0	1	2	3	4	
4.			0	1	2	3	4	
5.			0	1	2	3	4	

Add rows as needed.

Levels of Trying To Kill Yourself
Level **1**: You started to kill yourself, but then **you decided to stop** and did not finish trying.
Level **2**: You started to kill yourself, but then **someone or something stopped you**.
Level **3**: You did **everything you wanted** to do in trying to kill yourself.

16. IF THE ANSWER TO QUESTION 12 IS 1 OR HIGHER ASK:

In the past (timeframe), how many times did you do things to **prepare** to kill yourself? ** ____
(CLINICIAN: Include only the times when the child stopped before starting to kill themselves.) **

	When? dd/MMM/yyyy	How?	How much did you prepare each time? Not at all	A little	Somewhat	Very	Extremely	Level
1.			0	1	2	3	4	
2.			0	1	2	3	4	
3.			0	1	2	3	4	
4.			0	1	2	3	4	
5.			0	1	2	3	4	

Add rows as needed.

Levels of Preparing to Kill Yourself
Level **1**: You did things to **get ready** to kill yourself, but you did not start to kill yourself.
Level **2**: You did things to **get ready** to kill yourself, but then **you stopped yourself** just before you hurt yourself.
Level **3**: You did things to **get ready** to kill yourself, but then **someone or something stopped you** just before you hurt yourself.

HOW MUCH TIME DO YOU SPEND EVERY DAY THINKING ABOUT MAKING YOURSELF DEAD?

____ Not at all. ____ A little. ____ In the middle. ____ A lot. ____ Really A lot.

SHEEHAN-SUICIDALITY TRACKING SCALE (S-STS) - CLINICIAN USE ONLY

Complete this section *if the patient does not return for the scheduled follow up visit* and is not available to permit completion of pages 1 and 2.

FOR CLINICIAN USE ONLY

	NO	YES
17. Missed appointment - reason: subject died from a completed suicide?	0	100
18. Missed appointment - reason: subject died, but not enough information to code as a suicide?	0	0
19. Missed appointment - reason: subject died from cause(s) other than suicide?	0	0
20. Missed appointment - reason: subject alive, but not available because of a suicide attempt?	0	4
21. Missed appointment - reason: subject alive, but not available for known reasons other than suicide?	0	0
22. Missed appointment - reason: subject alive, but not available, for uncertain reasons, or "lost to follow up"?	0	0

Total Scale Score Add scores from Questions 1a (only if 1b is coded YES), + 2 through 11 + [the highest of 12 or any row of 16] + [the highest of 14 or any row of 15] + 17 + 20 [on page 3]

TOTAL ☐

☐ I have reviewed the answers on Pages 1 and 2 with the patient.

_____ _____
Clinician Signature dd/MMM/yyyy

☐ I have reviewed the answers on Pages 1 and 2 with my doctor or clinician.

_____ _____
Patient Signature dd/MMM/yyyy

References

1. Guidance for Industry Suicidal Ideation and Behavior: Prospective Assessment of Occurrence in Clinical Trials. August 2012. Revision 1. U.S Department of Health and Human Services, Food and Drug Administration, Center for Drug Evaluation and Research (CDER), Silver Spring, MD 20992-0002. http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm/ Direct download from www.fda.gov/downloads/Drugs/Guidances/UCM225130.pdf
2. Posner K, Oquendo MA et al. Columbia Classification Algorithm of Suicide Assessment (C-CASA): Classification of Suicidal Events in the FDA's Pediatric Suicidal Risk Analysis of Antidepressants. C-CASA Definitions in Table 2, page 1037. Am J Psychiatry 2007; 164:1035-1043

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SHEEHAN-SUICIDALITY TRACKING SCALE (S-STS) – Child Version (13-17 years)

INSTRUCTIONS: PLEASE USE DATA FROM ALL SOURCES AND CONSIDER SEVERITY, FREQUENCY AND TIME FRAME IN YOUR RESPONSES.
THE RESPONSE "NOT AT ALL" TO ANY QUESTION MEANS "NONE" AND MEANS THAT THE THOUGHT OR BEHAVIOR "DID NOT OCCUR AT ALL".

1. **In the past** (timeframe), **did you have any accident?** NO ☐ YES ☐
   (this includes taking too much of your medication by accident).
   IF NO, SKIP TO QUESTION 2. IF YES, GO TO QUESTION 1a:

	Not at all	A little	A fair amount	Very	Extremely
1a. How seriously did you plan or expect to hurt yourself on purpose in any accident or put yourself in a position where you could be hurt? IF THE ANSWER TO QUESTION 1a IS 0 (= Not at all), SKIP TO QUESTION 2. IF IT IS SCORED 1 OR HIGHER, GO TO QUESTION 1b:	0	1	2	3	4

1b. Did you want to die as a result of any accident? NO ☐ YES ☐

In the past (timeframe)**, how seriously did you:**

	Not at all	A little	A fair amount	Very	Extremely
2. think that you would be better off dead or wish you were dead or need to be dead? How many times? ____	0	1	2	3	4
3. think about hurting yourself, with the possibility that you might die? Or **how seriously** did you think about killing yourself? How many times? ____	0	1	2	3	4
4. hear a voice or voices telling you to kill yourself or have a dream or a nightmare about killing yourself?	0	1	2	3	4
5. have a way or a method (**how**) in mind to kill yourself?	0	1	2	3	4
6. think about **what you would use** to kill yourself?	0	1	2	3	4
7. think about **where you would go** to kill yourself?	0	1	2	3	4
8. think about **when** you could kill yourself?	0	1	2	3	4
9. expect to **go through with a plan to** kill yourself? did you intend to act: at the time ☐ at some time in the future ☐	0	1	2	3	4
10. **expect** to die from hurting yourself? did you intend to die: at the time ☐ at some time in the future ☐	0	1	2	3	4
11. feel the need to kill yourself sooner rather than later? was this: for no good reason ☐ for some good reason ☐	0	1	2	3	4
12. do things to **prepare** to kill yourself?	0	1	2	3	4
13. hurt yourself on purpose **without** trying to kill yourself? How many times? ____	0	1	2	3	4
14. try to kill yourself *?	0	1	2	3	4

* "A suicide attempt is a potentially self-injurious behavior, associated with at least some intent (> 0) to die as a result of the act. Evidence that the individual intended to kill him or herself, at least to some degree, can be explicit or inferred from the behavior or circumstance.". *A suicide attempt may or may not result in actual injury." (FDA 2012 definition[1,2]).* * Note: Items 7 & 8 on S-STS ("plan for suicide") means not going beyond ideas or talking about a plan for suicide. If actual behaviors occurred, the event should not be coded on item 7 or 8, but as "preparatory behavior" (item 12). However, both events can occur separately over the same timeframe.

15. IF THE ANSWER TO QUESTION 14 IS 1 OR HIGHER ASK:

In the past (timeframe), how many times did you try to kill yourself? ** ____

	When? dd/MMM/yyyy	How?	How seriously did you try each time? Not at all	A little	A fair amount	Very	Extremely	Level
1.			0	1	2	3	4	
2.			0	1	2	3	4	
3.			0	1	2	3	4	
4.			0	1	2	3	4	
5.			0	1	2	3	4	

Add rows as needed.

Levels of Trying To Kill Yourself
Level **1**: You started to kill yourself, but then **you decided to stop**.
Level **2**: You started to kill yourself, but then **someone or something stopped you**.
Level **3**: You did **everything you wanted** to do to try to kill yourself.

16. IF THE ANSWER TO QUESTION 12 IS 1 OR HIGHER ASK:

In the past (timeframe), how many times did you do things to **prepare** to kill yourself? ** ____
(Include only the times when you stopped before starting to kill yourself.) **

	When? dd/MMM/yyyy	How?	How seriously did you prepare each time? Not at all	A little	A fair amount	Very	Extremely	Level
1.			0	1	2	3	4	
2.			0	1	2	3	4	
3.			0	1	2	3	4	
4.			0	1	2	3	4	
5.			0	1	2	3	4	

Add rows as needed.

Levels of Preparing to Kill Yourself
Level **1**: You did things to **get ready** to kill yourself, but you did not start to kill yourself.
Level **2**: You did things to **get ready** to kill yourself, but then **you stopped yourself** just before you hurt yourself.
Level **3**: You did things to **get ready** to kill yourself, but then **someone or something stopped you** just before you hurt yourself.

HOW MUCH TIME DO YOU SPEND EVERY DAY THINKING ABOUT MAKING YOURSELF DEAD?

____ Not at all. ____ A little. ____ In the Middle. ____ A lot. ____ Really A lot.

SHEEHAN-SUICIDALITY TRACKING SCALE (S-STS) - CLINICIAN USE ONLY

Complete this section *if the patient does not return for the scheduled follow up visit* and is not available to permit completion of pages 1 and 2.

FOR CLINICIAN USE ONLY

	NO	YES
17. Missed appointment - reason: subject died from a completed suicide?	0	100
18. Missed appointment - reason: subject died, but not enough information to code as a suicide?	0	0
19. Missed appointment - reason: subject died from cause(s) other than suicide?	0	0
20. Missed appointment - reason: subject alive, but not available because of a suicide attempt?	0	4
21. Missed appointment - reason: subject alive, but not available for known reasons other than suicide?	0	0
22. Missed appointment - reason: subject alive, but not available, for uncertain reasons, or "lost to follow up"?	0	0

Total Scale Score Add scores from Questions 1a (only if 1b is coded YES), + 2 through 11 + [the highest of 12 or any row of 16] + [the highest of 14 or any row of 15] + 17 + 20 [on page 3]

TOTAL ☐

☐ I have reviewed the answers on Pages 1 and 2 with the patient.

_____ _____
Clinician Signature dd/MMM/yyyy

☐ I have reviewed the answers on Pages 1 and 2 with my doctor or clinician.

_____ _____
Patient Signature dd/MMM/yyyy

References

1. Guidance for Industry Suicidal Ideation and Behavior: Prospective Assessment of Occurrence in Clinical Trials. August 2012. Revision 1. U.S Department of Health and Human Services, Food and Drug Administration, Center for Drug Evaluation and Research (CDER), Silver Spring, MD 20992-0002. http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm/ Direct download from www.fda.gov/downloads/Drugs/Guidances/UCM225130.pdf
2. Posner K, Oquendo MA et al. Columbia Classification Algorithm of Suicide Assessment (C-CASA): Classification of Suicidal Events in the FDA's Pediatric Suicidal Risk Analysis of Antidepressants. C-CASA Definitions in Table 2, page 1037. Am J Psychiatry 2007; 164:1035-1043

The author is grateful to for very valuable advice in the development of the pediatric versions of the S-STS to Darlene Amado and Darlene Beamon and to JM Giddens in developing the adult S-STS and adult S-STS CMCM versions.

Conclusion

We developed the pediatric versions of the Sheehan-Suicidality Tracking Scale (S-STS) to be comprehensive, brief, efficient, and linguistically and cognitively age appropriate, yet sensitive to change, in assessing suicidality in children and adolescents. Clinicians can use these scales to better understand, assess, and monitor child and adolescent suicidality, in clinical, research, and other settings. The pediatric S-STS provides a structured format for children and adolescents to directly express any suicidal symptoms. We hope this will start a process that may protect children and adolescents and reduce the tragic loss of life internationally from this silent and often preventable epidemic.

Appendix 2.2

Adolescent Sheehan - Suicidality Tracking Scale
Clinically Meaningful Change Measure (S-STS CMCM) Version

Adapted from: Sheehan DV, Giddens JM, Sheehan IS. Status Update on the Sheehan-Suicidality Tracking Scale (S-STS) 2014. Innov Clin Neurosci. 2014;11(9–10):93–140. http://innovationscns.epubxp.com/i/425963/92

Introduction

The adolescent Clinically Meaningful Change Measure (CMCM) version of the S-STS is an expanded version of the standard pediatric S-STS. It was developed to specifically test the anti-suicidality effects of medications in a linguistically and cognitively age appropriate manner, for adolescents. The adolescent S-STS CMCM was designed to address an expectation that treatments for suicidality should demonstrate a clinically meaningful change in the management or disposition of a patient's care, in addition to improving their core suicidality symptoms. It operationalizes the system of thorough suicidality assessment long in place in psychiatric settings.

The adolescent S-STS CMCM follows the same organizational structure and operational use as the adult S-STS CMCM. See chapter 4.4 for more information.

SHEEHAN-SUICIDALITY TRACKING SCALE (Adolescent S-STS CMCM Version)

INSTRUCTIONS: PLEASE USE DATA FROM ALL SOURCES AND CONSIDER SEVERITY, FREQUENCY, TIME SPENT AND TIME FRAME IN YOUR RESPONSES.
THE RESPONSE "NOT AT ALL" TO ANY QUESTION MEANS "NONE" AND MEANS THAT THE THOUGHT, EXPERIENCE OR BEHAVIOR "DID NOT OCCUR AT ALL".
THROUGHOUT THE SCALE THE WORD ***INTEND OR INTENT*** MEANS ANY INTENTION GREATER THAN ZERO. SCORE THE MOST SERIOUS EPISODE THAT OCCURRED.

1. **In the past** (timeframe), **did you have any accident?** NO ☐ YES ☐
(this includes taking too much of your medication by accident).
IF NO, SKIP TO QUESTION 2. IF YES, GO TO QUESTION 1a:

	Not at all	A little	A fair amount	Very	Extremely
1a. How seriously did you plan or expect to hurt yourself on purpose in any accident or put yourself in a position where you could be hurt? IF THE ANSWER TO QUESTION 1a IS 0 (= Not at all), SKIP TO QUESTION 2. IF IT IS SCORED 1 OR HIGHER, GO TO QUESTION 1b:	0	1	2	3	4

1b. Did you want to die as a result of any accident? NO ☐ YES ☐

In the past (timeframe)**, how seriously did you:**

	Not at all	A little	A fair amount	Very	Extremely
2. think that you would be better off dead or wish you were dead or need to be dead? How many times? ____	0	1	2	3	4
3. think about hurting yourself, with the possibility that you might die? Or **how seriously** did you think about killing yourself? How many times? ____	0	1	2	3	4
4. hear a voice or voices telling you to kill yourself or have a dream or a nightmare about killing yourself?	0	1	2	3	4
5. have a way or a method (**how**) in mind to kill yourself?	0	1	2	3	4
6. think about **what you would use** to kill yourself?	0	1	2	3	4
7. think about **where you would go** to kill yourself?	0	1	2	3	4
8. think about **when** you could kill yourself?	0	1	2	3	4
9. expect to **go through with a plan to** kill yourself? did you intend to act: at the time ☐ at some time in the future ☐	0	1	2	3	4
10. **expect** to die from hurting yourself? did you intend to die: at the time ☐ at some time in the future ☐	0	1	2	3	4
11. feel the need to kill yourself sooner rather than later? was this: for no good reason ☐ for some good reason ☐	0	1	2	3	4
12. do things to **prepare** to kill yourself?	0	1	2	3	4
13. hurt yourself on purpose **without** trying to kill yourself? How many times? ____	0	1	2	3	4
14. try to kill yourself *?	0	1	2	3	4

* "A suicide attempt is a potentially self-injurious behavior, associated with at least some intent (> 0) to die as a result of the act. Evidence that the individual intended to kill him or herself, at least to some degree, can be explicit or inferred from the behavior or circumstance.". *A suicide attempt may or may not result in actual injury." (FDA 2012 definition[1,2]).* * Note: Items 7 & 8 on S-STS ("plan for suicide") means not going beyond ideas or talking about a plan for suicide. If actual behaviors occurred, the event should not be coded on item 7 or 8, but as "preparatory behavior" (item 12). However, both events can occur separately over the same timeframe.

15. IF THE ANSWER TO QUESTION 14 IS 1 OR HIGHER ASK:

In the past (timeframe), how many times did you try to kill yourself? ** ____

	When? dd/MMM/yyyy	How?	How seriously did you try each time? Not at all	A little	A fair amount	Very	Extremely	Level
1.			0	1	2	3	4	
2.			0	1	2	3	4	
3.			0	1	2	3	4	
4.			0	1	2	3	4	
5.			0	1	2	3	4	

Add rows as needed.

Levels of Trying To Kill Yourself
Level **1**: You started to kill yourself, but then **you decided to stop**.
Level **2**: You started to kill yourself, but then **someone or something stopped you**.
Level **3**: You did **everything you wanted** to do to try to kill yourself.

16. IF THE ANSWER TO QUESTION 12 IS 1 OR HIGHER ASK:

In the past (timeframe), how many times did you do things to **prepare** to kill yourself? ** ____
(Include only the times when you stopped before starting to kill yourself.) **

	When? dd/MMM/yyyy	How?	How seriously did you prepare each time? Not at all	A little	A fair amount	Very	Extremely	Level
1.			0	1	2	3	4	
2.			0	1	2	3	4	
3.			0	1	2	3	4	
4.			0	1	2	3	4	
5.			0	1	2	3	4	

Add rows as needed.

Levels of Preparing to Kill Yourself
Level **1**: You did things to **get ready** to kill yourself, but you did not start to kill yourself.
Level **2**: You did things to **get ready** to kill yourself, but then **you stopped yourself** just before you hurt yourself.
Level **3**: You did things to **get ready** to kill yourself, but then **someone or something stopped you** just before you hurt yourself.

HOW MUCH TIME DO YOU SPEND EVERY DAY THINKING ABOUT MAKING YOURSELF DEAD?

____ Not at all. ____ A little. ____ In the Middle. ____ A lot. ____ Really A lot.

PATIENT RATED PAGES

Clinically Meaningful Change Measures for Suicide Outcomes Assessment

(S-STS CMCM VERSION, PATIENT RATED DOMAINS ARE ON **PAGES 4 THROUGH 10**)

Current Factors to Consider in Making the Clinically Meaningful Change Assessment

Some consider the factors below as risk factors for suicidality. However they are all not necessarily so and sometimes they can be protective factors. The impact of each factor can change over time within an individual.

The factors are intended to serve as useful prompts during the evaluation and in tracking both initial and newly emerging factors during follow up. If any of the factors disturb you, please discuss it with your clinician.

Indicate the impact of the factors below on your suicidality over the past (timeframe).

	Factor	**Does Not Apply**	Makes your Suicidality *better*	**No impact on Suicidality**	Makes your Suicidality *worse*
	Suicidality				
1	Any suicidal impulses, ideation and behavior from pages 1 & 2 of this rating scale	☐	☐	☐	☐
2	Amount of time spent daily with suicidal ideation and behaviors	☐	☐	☐	☐
3	Feeling a need to make an attempt sooner rather than later	☐	☐	☐	☐
4	Hearing voices telling or commanding you to kill yourself or someone else	☐	☐	☐	☐
5	Overwhelmed feeling	☐	☐	☐	☐
6	Exhaustion from struggling against suicide	☐	☐	☐	☐
7	Hopeless feeling or nothing to live for	☐	☐	☐	☐
8	Easy access to guns or means for suicide	☐	☐	☐	☐
9	Seriousness of past suicide attempt(s)	☐	☐	☐	☐
10	Religious or spiritual reasons that influence your decision to kill yourself	☐	☐	☐	☐
	Family / Social				
11	Recent loss or death of someone you loved	☐	☐	☐	☐
12	Recent anniversary of the death of someone you loved	☐	☐	☐	☐
13	Recent conflict or break up with family, husband / wife, partner or close friends	☐	☐	☐	☐
14	Lonely or isolated or homeless or with few or no friends	☐	☐	☐	☐
15	Lack of close family or support from others	☐	☐	☐	☐
16	Withdrawal from or spending less time with family, work or friends	☐	☐	☐	☐
17	Bisexual, homosexual or transgender or uncertain sexual or gender orientation with resulting unsupportive family or friends	☐	☐	☐	☐
18	A family member with a history of suicidal impulses, ideation or behavior (including attempts or completed suicide)	☐	☐	☐	☐

	Factor	**Does Not Apply**	Makes your Suicidality *better*	**No impact on Suicidality**	Makes your Suicidality *worse*
	Personal History				
19	Had a recent major life change or loss (e.g. loss of job, school failure, financial loss, mounting financial debt)	☐	☐	☐	☐
20	Recent trouble with the law or serious legal problems or recent time in jail	☐	☐	☐	☐
21	Recent deep sense of shame or loss of reputation	☐	☐	☐	☐
22	Survivor of sexual abuse, sexual violence or rape	☐	☐	☐	☐
23	Survivor of violence, torture bullying or emotional abuse	☐	☐	☐	☐
24	Saw or witnessed or caused serious violence or death to another person	☐	☐	☐	☐
25	A war survivor or recent military service or service in a war zone	☐	☐	☐	☐
26	Hurting others or being aggressive or violent or very grouchy or irritable	☐	☐	☐	☐
27	Spending time on suicide or death related internet sites	☐	☐	☐	☐
28	Wanting to suddenly kill yourself	☐	☐	☐	☐
29	Doing things that are risky	☐	☐	☐	☐
	Health				
30	Depression or bipolar disorder	☐	☐	☐	☐
31	Panic attacks or high anxiety or agitation	☐	☐	☐	☐
32	Hearing voices others can't hear or seeing things no one else can see or believing things other people thought were strange or weird	☐	☐	☐	☐
33	Abusing alcohol	☐	☐	☐	☐
34	Abusing drugs	☐	☐	☐	☐
35	Posttraumatic Stress Disorder	☐	☐	☐	☐
36	Recent difficulties sleeping	☐	☐	☐	☐
37	Have an "incurable disease" or severe illness or an illness you think will kill you	☐	☐	☐	☐
38	In severe physical pain	☐	☐	☐	☐
39	Recent unplanned pregnancy or sexually transmitted disease	☐	☐	☐	☐
40	Recent infection, allergies or asthma or an autoimmune disease flare up (e.g. Crohn's Disease, Lupus or Multiple Sclerosis)	☐	☐	☐	☐
41	Head injury	☐	☐	☐	☐
42	Unable to get treatment or medicine for a mental health problem	☐	☐	☐	☐
43	Stopped a medicine that helped you or you changed the amount of medicine you were taking	☐	☐	☐	☐
44	Recently started on a medicine for a mental health problem or seizures	☐	☐	☐	☐
45	Other:	☐	☐	☐	☐

Add and score additional "other" factors as necessary.

SHEEHAN - SUICIDALITY TRACKING SCALE (CMCM Version)

CLINICALLY MEANINGFUL CHANGE MEASURES (PATIENT RATED)

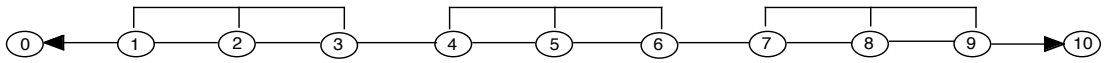
(Please mark ONE circle for each category.)

In the past (timeframe):

HOPELESSNESS

Rate your level of hopelessness:

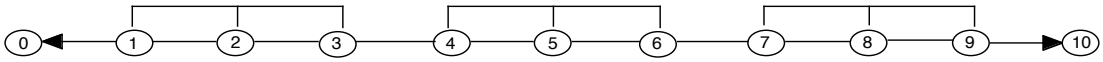
None **Mild** **Moderate** **Severe** **Extreme**



ABILITY TO COPE

Rate your ability to cope with your suicide impulses, thoughts, and behaviors:

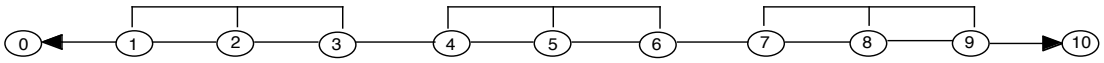
Completely Able **Very Able** **Moderately** **A Little** **Not Able**



WILLINGNESS TO COPE

Rate your willingness to cope with your suicide impulses, thoughts, and behaviors:

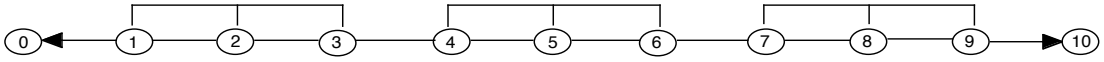
Completely Willing **Very** **Moderately** **A Little** **Not Willing**



ABILITY TO STAY SAFE

Rate your ability to keep yourself safe:

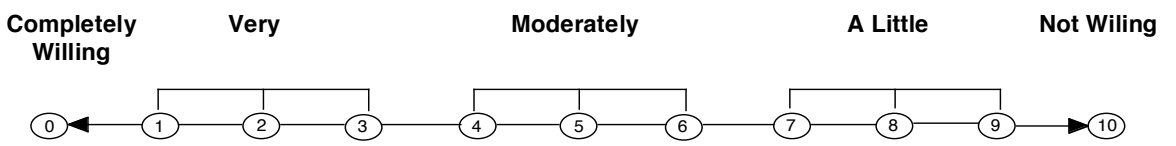
Completely Able **Very Able** **Moderately** **A Little** **Not Able**



In the past (timeframe):

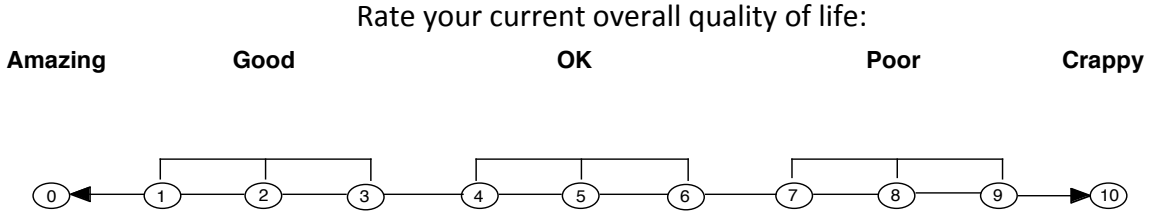
WILLINGNESS TO STAY SAFE

Rate your willingness to keep yourself safe:



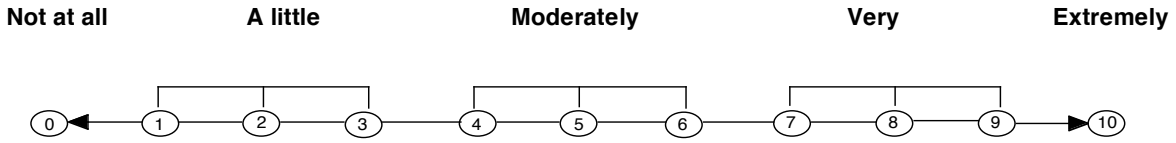
OVERALL QUALITY OF LIFE

Rate your current overall quality of life:



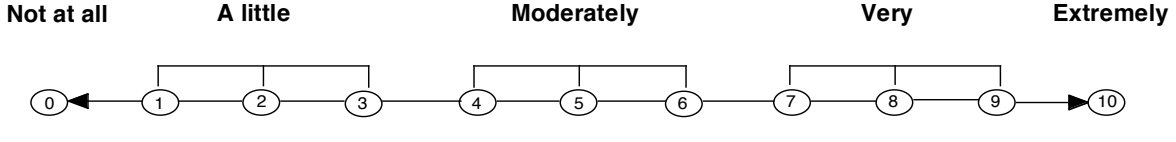
DELIBERATE SUICIDALITY

How deliberately were you thinking about or planning to kill yourself:



IMPULSIVELY SUICIDAL

How strong was the impulse to act in any suicidal way:



SHEEHAN - SUICIDALITY TRACKING SCALE (CMCM Version)

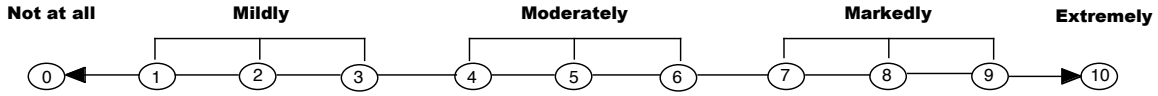
LIFE IMPAIRMENT FROM SUICIDALITY (PATIENT RATED)

Please mark ONE circle for each category.

In the past (timeframe):

WORK* / SCHOOL

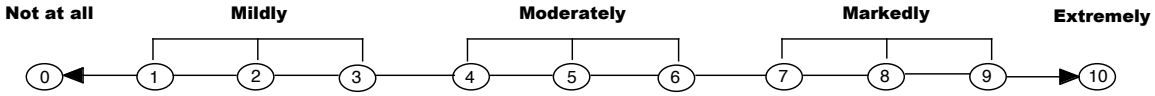
The suicide symptoms have caused problems at work or school:



☐ I have not worked /studied at all during the past timeframe **for reasons unrelated to the suicide symptoms**.
* Work includes paid, unpaid volunteer work or training. If your symptoms interfered with your ability to find or to hold a job or contributed in any way to your currently not working, you must give a score on this scale.

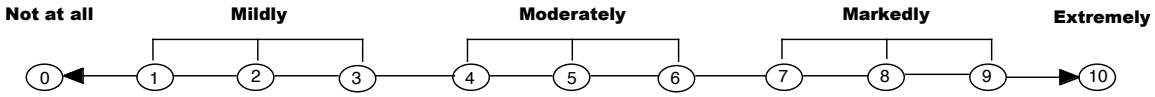
SOCIAL LIFE

The suicide symptoms have caused problems with friends or fun activities:



FAMILY LIFE / HOME RESPONSIBILITIES

The suicide symptoms have caused problems with your family or doing chores at home:



DAYS LOST

How many days in the last (timeframe) did you miss from work or school or were unable to do normal things because of your suicide thoughts, impulses, and behaviors? _____

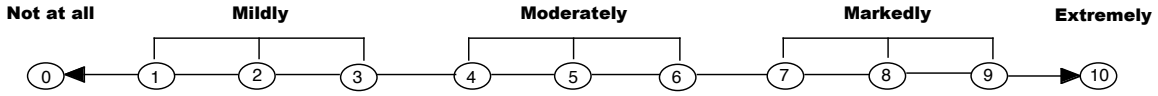
DAYS UNDERPRODUCTIVE

How many days in the last (timeframe) were you able to do less at work or at school or during your normal routine because of your suicide thoughts, impulses, and behaviors? _____

In the past (timeframe):

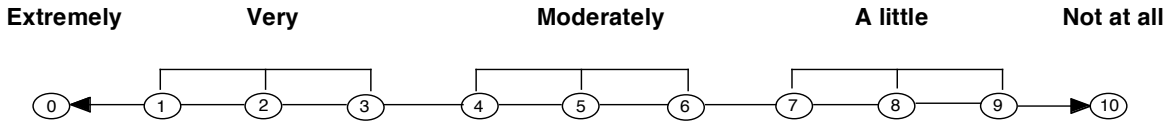
QUALITY OF LIFE DISRUPTION BY SUICIDALITY

The suicide symptoms have caused problems with the quality of your life:



DESIRE TO RECOVER FROM SUICIDALITY

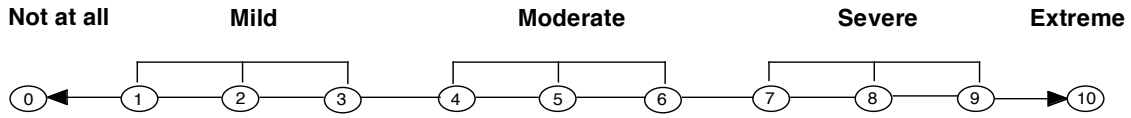
Rate your desire to recover from your suicide impulses, thoughts and behaviors:



If you can't imagine the possibility of recovery, choose "10"

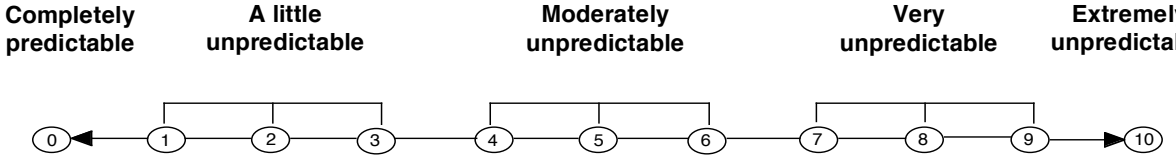
GLOBAL SEVERITY OF SUICIDAL IMPULSES, THOUGHTS, AND BEHAVIORS

Rate the overall severity of all your suicide impulses, thoughts, and behaviors:



HOW UNPREDICTABLE WAS YOUR SUICIDALITY

Considering the time when your suicidality was most unpredictable,
how unpredictable was it at that time?

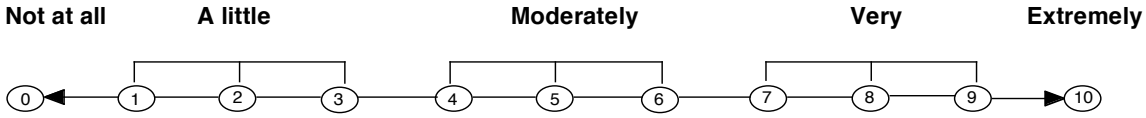


☐ Since starting my current medication / treatment, my suicidality became even more unpredictable than ever before.

Over the next (timeframe):

HOW LIKELY ARE YOU TO TRY TO KILL YOURSELF?

Rate how likely you are to try to kill yourself:



Patient Rated: Circle the score that best describes your current treatment needs:

At this time:

Score	Which treatment below do you think you need now for your suicidal impulses, thoughts or behaviors?
10	I need to be in the hospital for more than 24 hours, with someone watching or protecting me at all times and I need or I request that someone do everything they can to stop me from trying to kill myself. (24/7 inpatient with constant one-on-one observation, possible need or request for physical or chemical restraints)
9	I need to be in the hospital for more than 24 hours, with someone watching or protecting me at all times. (24/7 inpatient one-on-one)
8	I need to be in the hospital for more than 24 hours, with someone watching or checking on me every 15 minutes. (24/7 inpatient on suicide precautions (e.g. 15 minute checks))
7	I need to be in the hospital for more than 24 hours. (24/7 inpatient)
6	I need to be in the hospital for more than 24 hours and be allowed to leave the ward or to go on visits outside the hospital from time to time. (24/7 inpatient with privileges to leave ward on visits outside hospital)
5	I need to stay up to 24 hours in the Emergency Room and then talk to the doctor again to decide if it is safe to discharge me home or if I need to be admitted to the hospital ward or if I need to attend therapy for several hours multiple times a week. (Stay up to 24 hours in Emergency Room then re-evaluate whether to admit or discharge or partial hospitalization or intensive outpatient program)
4	I can live at home, but I need to visit with my doctor every week and call my doctor every day to let them know how I'm doing (what are called daily check-ins).
3	I only need to visit with my doctor every week while I live at home.
2	I only need to visit with my doctor once a month while I live at home.
1	I only need to visit my doctor if my suicidal thoughts or behaviors get worse.
0	I don't need to see a doctor at all.

CLINICIAN RATED PAGES

Clinically Meaningful Change Measures for Suicide Outcomes Assessment

(S-STS CMCM VERSION, CLINICIAN RATED DOMAINS ARE ON **PAGES 12 AND 13**)

Clinically Meaningful Change Measures for Suicide Outcomes Assessment

(CLINICIAN RATED)

This Sheehan - Suicidality Tracking Scale, Clinically Meaningful Change Measures version (S-STS, CMCM version) is for use in evaluating whether a treatment for suicidality has a clinically meaningful impact beyond the suicidal phenomena alone.

Suicide risk cannot be accurately predicted at an individual level. However, based on all the information available on pages 1 and 2, pages 3 through 10 in the S-STS, CMCM version, and using your clinical experience, provide on the horizontal analog scale below and using the anchors in the table below, your best judgment of this patient's current level of clinically meaningful suicide risk and need for treatment of suicidality. This clinician "judgment of suicide risk" may drive your "judgment of level of management needed". Ask any additional probe questions or for any clarifications as needed.

In making this judgment, factor in and make balanced trade-offs between the following elements in each case:

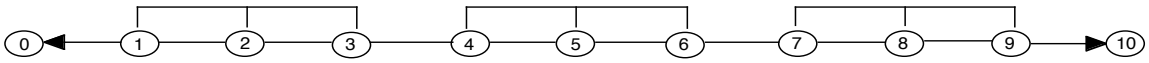
- Suicidal ideation (including suicidal impulses, and dreams, hallucinations and delusions involving suicide)
- Suicidal planning
- Suicidal intent and patient's perception of how likely they are to attempt suicide again in the future
- Suicidal behaviors (including impulsive suicidality)
- Suicide risk / protective factors
- Ability and willingness to cope with and to stay safe from suicidality
- Desire to recover from suicidality
- History of suicidality
- Quality of life
- % of suicidal ideation that is willful or deliberate
- Time spent in suicidality
- Global severity of suicidal impulses, ideation and behaviors
- Type of suicide disorder

These factors and trade-offs vary from one case to the next and over time in the same case.

At this time:

Clinically Meaningful Change Measure for Suicide Outcomes Assessment

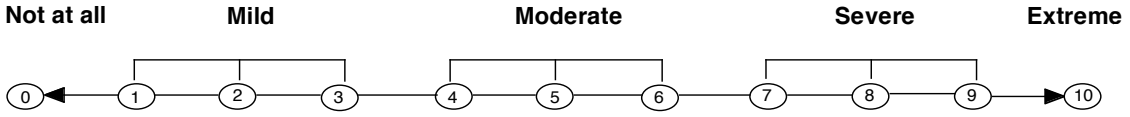
Anchor your judgment of the suicide risk and level of clinically meaningful management needed, with a single score, based on the table below:



Score	Judgment of Suicide Risk	Judgment on Level of Management Needed for Suicidality
10	Imminent	24/7 inpatient with constant one-on-one observation and with possible need or patient request for physical or chemical restraints
9	Severe	24/7 inpatient one-on one hospitalization with constant one-on-one observation
8	High	24/7 inpatient hospitalization with suicide precautions (e.g. 15 minute observation checks)
7	Major	24/7 inpatient hospitalization
6	Elevated	24/7 inpatient hospitalization with privileges to leave ward on visits outside hospital
5	Moderate	Up to 24 hours in ER, then re-evaluate whether to admit or discharge or partial hospitalization or intensive outpatient program
4	Modest	Outpatient weekly visits with daily check-ins
3	Mild	Outpatient weekly visits
2	Slight	Outpatient visits at least monthly
1	Remote	Outpatient visits as needed and if in treatment monitor for treatment emergent suicidality
0	No apparent risk	None

GLOBAL SEVERITY OF SUICIDAL IMPULSES, THOUGHTS, AND BEHAVIORS

Rate the overall severity of the patient's suicide impulses, thoughts, and behaviors:



SHEEHAN-SUICIDALITY TRACKING SCALE (S-STS) - CLINICIAN USE ONLY

Complete this section *if the patient does not return for the scheduled follow up visit* and is not available to permit completion of pages 1 and 2.

FOR CLINICIAN USE ONLY

	NO	YES
17. Missed appointment - reason: subject died from a completed suicide?	0	100
18. Missed appointment - reason: subject died, but not enough information to code as a suicide?	0	0
19. Missed appointment - reason: subject died from cause(s) other than suicide?	0	0
20. Missed appointment - reason: subject alive, but not available because of a suicide attempt?	0	4
21. Missed appointment - reason: subject alive, but not available for known reasons other than suicide?	0	0
22. Missed appointment - reason: subject alive, but not available, for uncertain reasons, or "lost to follow up"?	0	0

Total Scale Score Add scores from Questions 1a (only if 1b is coded YES), + 2 through 11 + [the highest of 12 or any row of 16] + [the highest of 14 or any row of 15] + 17 + 20 [on page 13].

TOTAL ☐

☐ I have discussed the answers above with the patient.

_____ _____
Clinician Signature dd/MMM/yyyy

☐ I have discussed the answers above with my doctor or clinician.

_____ _____
Patient Signature dd/MMM/yyyy

References

1. Guidance for Industry Suicidal Ideation and Behavior: Prospective Assessment of Occurrence in Clinical Trials. August 2012. Revision 1. U.S Department of Health and Human Services, Food and Drug Administration, Center for Drug Evaluation and Research (CDER), Silver Spring, MD 20992-0002. http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm/ Direct download from www.fda.gov/downloads/Drugs/Guidances/UCM225130.pdf
2. Posner K, Oquendo MA et al. Columbia Classification Algorithm of Suicide Assessment (C-CASA): Classification of Suicidal Events in the FDA's Pediatric Suicidal Risk Analysis of Antidepressants. C-CASA Definitions in Table 2, page 1037. Am J Psychiatry 2007; 164:1035-1043

The author is grateful to JM Giddens for very valuable advice in the development of the S-STS and of the S-STS CMCM versions.

Conclusion

The adolescent S-STS CMCM was developed to sensitively test the anti-suicidality effects of treatments in a linguistically and cognitively age appropriate manner. It has additional domains needing assessment before and during treatment. Clinicians can use the scale to measure and judge the extent of a treatment's clinically meaningful effect. The adolescent S-STS CMCM provides a structured format for adolescents to directly express any suicidal symptoms. This scale provides a roadmap to "open doors" to a thorough "big picture" exploration and tracking of key features of suicidality for individual patients. The adolescent S-STS CMCM provides good documentation of a thorough and systematic assessment of suicidality.

Appendix 2.3

Suicide Plan Tracking Scale (SPTS)

Introduction

The Suicide Plan Tracking Scale (SPTS) is designed to capture many details of suicide planning and to allow clinicians to track suicide planning over time. It provides the patient a way to share the details of suicide plans with their clinician. It offers the clinician a format to better understand the extent of patient's suicide planning. The use of the SPTS can help the patient get appropriate, individualized care, which may help them be safe.

Operational Use of the SPTS

The SPTS is a 7-page scale. Page 1 contains directions for patients. Pages 2 through 7 of the SPTS contains 35 questions which covers 7 domains of suicide planning: method, means, location, date / timeframe, intent, incomplete preparations, and people involved. We recommend the use of a systematic, structured approach to elicit information on suicide planning and to track these details over time. The SPTS can be used in both clinical and research settings. It can be rated in 3 ways: 1. patient-rated; 2. clinician-rated; or 3. patient-rated followed by a blind clinician-rating, followed by a reconciliation of these ratings in a joint interview. The 2 Optional Items pages of the SPTS provide the clinician with additional information about the factors that impact the patient's suicidal planning.

Below is the current 2016 version of the SPTS.

Suicide Plan Tracking Scale (SPTS)
Directions for patients

Talking about any thoughts or plans to kill yourself can be very difficult. Your clinician may ask you to answer the following questions again at future appointments in order to understand if you have made any further planning or if your thoughts have changed over time. There are a number of questions that you will be asked to answer and, although it may be difficult, please do your best to be honest. If you are *really* uncomfortable answering any of the questions, please leave them blank instead of giving a dishonest answer. One of the answers to many of the questions is "Not at all". Only use this answer if you had absolutely no thoughts about the topic of the question during the timeframe. If you have any questions about the meaning of words, phrases, and / or questions refer to Appendix 1 or ask your clinician.

□ I have read and I understand the above paragraph.

Patient Signature: _____ Date: _____

Suicide Plan Tracking Scale (SPTS)

Over the past (timeframe):

Method

		Not at all	A little	Partially	Mostly	Totally
1.	How seriously have you thought about any methods you might use to kill yourself?	0	1	2	3	4
	1.a. How many methods have you thought about using to kill yourself? ____					
2.	How completely have you decided on any methods you might use to kill yourself?	0	1	2	3	4

Means

3.	How seriously have you thought about any means you might use to kill yourself? Means are anything you would use in the process of killing yourself.	0	1	2	3	4
	3.a. How many means have you thought about using to kill yourself?					

		None	A little	Partial	A lot	Complete
4.	How much access do you have to any of these means?	0	1	2	3	4

		Not at all	A little	Partially	Mostly	Totally
5.	How completely have you decided on any means you might use to kill yourself?	0	1	2	3	4

Location

6.	How seriously have you thought about any locations you might use in your plan(s) to kill yourself?	0	1	2	3	4
	6.a. How many locations have you thought about? ____					

		None	A little	Partial	A lot	Complete
7.	How much access do you have to any of these locations?	0	1	2	3	4

		Not at all	A little	Partially	Mostly	Totally
8.	How completely have you decided on any locations you might use to kill yourself?	0	1	2	3	4

Date

9.	How seriously have you thought about any timeframes and / or any specific dates during which you might try to kill yourself?	0	1	2	3	4
	9.a. How many different timeframes and / or specific dates have you thought about? ____					

	Not at all	A little	Partially	Mostly	Totally
10. How completely have you decided on any timeframes and / or any specific dates during which you might try to kill yourself?	0	1	2	3	4

Intent

11. How seriously do you intend to make any plans to kill yourself?	0	1	2	3	4
11.a. How many different plans do you intend to make to kill yourself? ____					
12. How seriously do you intend to act on any plans to kill yourself?	0	1	2	3	4
12.a. How many different plans do you intend to use to kill yourself? ____					
13. How seriously do you intend to die from acting on any plans to kill yourself?	0	1	2	3	4

Incomplete Preparations

14. How seriously have you thought about any tasks you would like to complete before you try to kill yourself? Examples of tasks include, but are not limited to, writing a suicide note, giving away personal property, arranging for a pet to be taken care of, settling financial affairs, or following through on commitments.	0	1	2	3	4
14.a. How many tasks have you thought about? ____					
15. How emotionally prepared are you to act on any plans to kill yourself?	0	1	2	3	4
16. How complete are the final preparations to kill yourself?	0	1	2	3	4

Involvement of Others

17. How seriously have you thought about involving others in your plan(s) to kill yourself? This includes, but is not limited to harming or injuring others during a suicide attempt, suicide by cop, plans to make a suicide attempt in a public place, suicide pacts, or other social, cultural, or religious expectation that increases the likelihood of an attempt.	0	1	2	3	4
17.a. How many people have you thought about involving? ____					
18. How important is the involvement of others in your plan(s) to kill yourself?	0	1	2	3	4
19. How seriously do you intend to involve others in your plan(s) to kill yourself?	0	1	2	3	4

	No	Yes
20. Do you intend to seriously injure or kill someone else in the process of killing yourself?	☐	☐

IF YES TO QUESTION 20, CONSIDER USING S-HTS or HPTS [1]

[1] S-HTS = Sheehan - Homicidality Tracking Scale. HPTS = Homicide Plan Tracking Scale. See General Directions for more information.

21.a. What methods have you thought about using to kill yourself? (Please list consistent with response to 1.a.)	21.b. How much have you decided to use this method?					21.c. How easily can you access the means for this method?					21.d. How important is it for you to use this method to kill yourself?				
	Not at all	A little	Partially	Mostly	Totally	No access	Very difficult	Moderately difficult	A little difficult	Not difficult	Not at all	A little	Partially	Mostly	Totally
1.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
2.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
3.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
4.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
5.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
6.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
7.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
8.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
9.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
10.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4

22.a. What means have you thought about using to kill yourself? (Please list consistent with response to 3.a.)	22.b. How much have you decided to use this means?					22.c. How easily can you access this means?					22.d. How important is it for you to use this means to kill yourself?				
	Not at all	A little	Partially	Mostly	Totally	No access	Very difficult	Moderately difficult	A little difficult	Not difficult	Not at all	A little	Partially	Mostly	Totally
1.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
2.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
3.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
4.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
5.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
6.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
7.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
8.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
9.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
10.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4

23.a. What locations have you thought about using to kill yourself? (Please list consistent with response to 6.a.)	23.b. How much have you decided to use this location?					23.c. How easily can you access this location?					23.d. How important is it for you to use this location to kill yourself?				
	Not at all	A little	Partially	Mostly	Totally	No access	Very difficult	Moderately difficult	A little difficult	Not difficult	Not at all	A little	Partially	Mostly	Totally
1.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
2.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
3.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
4.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
5.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
6.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
7.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
8.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
9.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
10.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4

24.a. What timeframes or dates have you thought about using to kill yourself? (Please list consistent with response to 9.a.)	24.b. How much have you decided to use this timeframe or date?					24.c. How far away is this timeframe or date?						24.d. How important is it for you to use this timeframe or date to kill yourself?				
	Not at all	A little	Partially	Mostly	Totally	> 1 Month (1 or more)	Weeks (1 - 4)	Days (1 - 7)	Hours (0 - 24)	Minutes (0 - 60)	Already passed	Not at all	A little	Partially	Mostly	Totally
1.	0	1	2	3	4	0	1	2	3	4	1	0	1	2	3	4
2.	0	1	2	3	4	0	1	2	3	4	1	0	1	2	3	4
3.	0	1	2	3	4	0	1	2	3	4	1	0	1	2	3	4
4.	0	1	2	3	4	0	1	2	3	4	1	0	1	2	3	4
5.	0	1	2	3	4	0	1	2	3	4	1	0	1	2	3	4
6.	0	1	2	3	4	0	1	2	3	4	1	0	1	2	3	4
7.	0	1	2	3	4	0	1	2	3	4	1	0	1	2	3	4
8.	0	1	2	3	4	0	1	2	3	4	1	0	1	2	3	4
9.	0	1	2	3	4	0	1	2	3	4	1	0	1	2	3	4
10.	0	1	2	3	4	0	1	2	3	4	1	0	1	2	3	4

25.a. What tasks have you thought about completing before you kill yourself? (Please list consistent with response to 14.a.)	25.b. How much have you decided to complete this task?					25.c. How complete is this task?					25.d. How important is it for you to complete this task before you kill yourself?				
	Not at all	A little	Partially	Mostly	Totally	Not at all	A little	Partially	Mostly	Totally	Not at all	A little	Partially	Mostly	Totally
1.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
2.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
3.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
4.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
5.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
6.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
7.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
8.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
9.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
10.	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4

	Not at all	A little	Partially	Mostly	Totally
26. How important is it for you to use any specific method to kill yourself?	0	1	2	3	4
27. How important is it for you to use any specific means to kill yourself?	0	1	2	3	4
28. How important is it for you to use any specific location to kill yourself?	0	1	2	3	4
29. How important is it for you to use any specific timeframe or date to kill yourself?	0	1	2	3	4
30. How important is it for you to complete all tasks before you kill yourself?	0	1	2	3	4

Time Spent Each Day with Any Suicidal Planning

31. Usual time spent planning for suicide each day: _____ hours _____ minutes.

32. Least amount of time spent planning for suicide each day: _____ hours _____ minutes.

33. Most amount of time spent planning for suicide each day: _____ hours _____ minutes.

Please be truthful:

	No	Yes
34. Were you having any thoughts about suicide while answering any of the above questions?	☐	☐

	Not at all	A little	Partially	Mostly	Totally
35. How truthful are your responses to all of the above questions?	0	1	2	3	4

Please give the SPTS to your clinician.

SPTS Scoring Section

Total Scale Score

Add answers for the following questions to create the total score:

1. _____	2. _____	3. _____	4. _____	5. _____	6. _____	7. _____
8. _____	9. _____	10. _____	11. _____	12. _____	13. _____	14. _____
15. _____	16. _____	17. _____	18. _____	19. _____		

Total Score: _____ (Out of 76)

Specific Plan Scores

Ranking	Specific Plan	Component Category	Product (x Factor) Score[2]
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

For the patient:

☐ I have reviewed the above data with the clinician.

Patient Signature: _____

Date: _____

For the clinician:

☐ I have reviewed the above data with the patient.

Clinician Signature: _____

Date: _____

[2] See Example 1 under Highest Method in Scoring and Tracking Directions for an example of calculation.

Suicide Plan Tracking Scale (SPTS)
Optional Items

Over the past (timeframe):

Methods

36. How important has each of the following been as a factor in your thoughts about any methods?

	Not at all	A little	Partially	Mostly	Totally
36.a. comfort / method not painful	0	1	2	3	4
36.b. easy access to means or location / practicality	0	1	2	3	4
36.c. lethality	0	1	2	3	4
36.d. other: please specify _____	0	1	2	3	4

Means

37. How important has each of the following been as a factor in your thoughts about any means?

37.a. comfort / means not painful	0	1	2	3	4
37.b. easy access / practicality	0	1	2	3	4
37.c. lethality	0	1	2	3	4
37.d. special importance of means to yourself or to other(s)	0	1	2	3	4
37.e other: please specify _____	0	1	2	3	4

Location

38. How important has each of the following been as a factor in your thoughts about any locations?

38.a. comfort / familiarity	0	1	2	3	4
38.b. easy access / practicality	0	1	2	3	4
38.c. assistance in method / means	0	1	2	3	4
38.d. body being located	0	1	2	3	4
38.e. body not being located	0	1	2	3	4
38.f. other: please specify _____	0	1	2	3	4

Date

39. How important has each of the following been as a factor in your thoughts about any timeframes and / or any specific dates?

	Not at all	A little	Partially	Mostly	Totally
39.a. easy access to location	0	1	2	3	4
39.b. easy access to means	0	1	2	3	4
39.c. the need to kill yourself or to plan to kill yourself sooner rather than later	0	1	2	3	4
39.d. the anniversary of a particular event	0	1	2	3	4
39.e. enough time to prepare for an attempt	0	1	2	3	4
39.f. other: please specify _____	0	1	2	3	4

Intent

40. How important has each of the following been as a factor in your intent to make any plans to kill yourself or to take action to kill yourself or to die from acting on any plans to kill yourself?

40.a. an impulse or urgent need to plan or to act or to die	0	1	2	3	4
40.b. losing hope that your life would get better	0	1	2	3	4
40.c. major changes in your life	0	1	2	3	4
40.d. events outside of your control	0	1	2	3	4
40.e. your memories	0	1	2	3	4
40.f. other: please specify _____	0	1	2	3	4

Role of Plan

41. Does having a plan partially or fully worked out help you keep yourself safe, make it more difficult to keep yourself safe, both, or none of these?

Helps Keep Me Safe	Both	Makes it Harder to Keep Me Safe	None of These
☐	☐	☐	☐

Additional Notes

Conclusion

The SPTS allows clinicians to assess and monitor suicide planning in clinical, research, and other settings. Additional documents related to the SPTS (e.g. scoring instructions and tracking logs) are available free of charge at http://www.HarmResearch.org

Appendix 2.4

Suicidality Modifiers Scale (SMS)

Introduction

The Suicidality Modifiers Scale (SMS) assesses factors that can influence some domains of suicidality. For each domain covered, it assesses:

1. the severity of each domain
2. the ability to experience / resist the domain
3. the loss of desire to experience / resist the domain
4. how much memories impacted the domain
5. how much events outside the patient's control impacted the domain
6. how much events within the patient's control impacted the domain

What is unique about the SMS?

Suicide attempts in the young are frequently impulsive. Suicide attempts in the elderly are often associated with hopelessness. This scale uniquely investigates these and other domains association with suicidality in each patient. Not all of these domains are suicidal phenomena in and of themselves. However, all of them are acknowledged factors that can compound existing suicidal phenomena.

Use and Value

The SMS may be helpful in providing a deeper understanding of attacks of impulsive suicidality, the extent to which they are present, their effect on the patient, and the effect of memories and events on these impulse attacks (if any). This could provide more useful information about the nature of attacks of impulsive suicidality than the heretofore norm of using impulsive personality trait scales in suicidality. We have found that impulse attacks as identified in the SMS do not correlate with trait impulsivity in suicidal patients.

Use to Clinicians

The answers to items 4 through 6 above provide the clinician with information about critical target domains. This helps the clinician to understand and to assist the patient in coping with these memories and events. The SMS sometimes provided an early warning sign of impending worsening of suicidality before it became apparent in other ways. This was particularly true of question 3 – "the loss of desire to hold back the impulse to plan or to act in any suicidal way". The change in the score on this question tended to consistently precede other changes during deterioration in a subject with Impulse Attack Suicidality Disorder. Question 3 also lagged behind improvement in other areas and was one of the last questions in that domain to fully resolve.

Suicidality Modifiers Scale (SMS)

Impulsivity

Over the past (timeframe):

	Topic	Not at all	A little	Moderately	Very	Extremely
1.	How strong was the impulse (urgent need) to plan or to act in any suicidal way?	0	1	2	3	4
	Ability to Resist Suicidal Impulses					
2.	How difficult was it to resist this impulse?	0	1	2	3	4
	Desire to Resist Suicidal Impulses					
3.	How much did you **lose the desire** to resist this impulse?	0	1	2	3	4
	Memories Modifier					
4.	How much did your memories make you **lose the desire** to resist this impulse?	0	1	2	3	4
	Events Modifier 1					
5.	How much did events **outside** your control make you **lose the desire** to resist this impulse?	0	1	2	3	4
	Events Modifier 2					
6.	How much did events **within** your control make you **lose the desire** to resist this impulse?	0	1	2	3	4

Hopelessness

Over the past (timeframe):

	Topic					
1.	How much did you lose hope that your life would get better?	0	1	2	3	4
	Ability to Be Hopeful					
2.	How difficult was it for you to be hopeful that your life would get better?	0	1	2	3	4
	Desire to Be Hopeful					
3.	How much did you **lose the desire** to be hopeful that your life would get better?	0	1	2	3	4
	Memories Modifier					
4.	How much did your memories make you **lose the desire** to be hopeful that your life would get better?	0	1	2	3	4
	Events Modifier 1					
5.	How much did events **outside** your control make you **lose the desire** to be hopeful that your life would get better?	0	1	2	3	4
	Events Modifier 2					
6.	How much did events **within** your control make you **lose the desire** to be hopeful that your life would get better?	0	1	2	3	4

Suicidality Modifiers Scale (SMS)

Loss of Enjoyment

Over the past (timeframe):

	Topic	Not at all	A little	Moderately	Very	Extremely
1.	How much did you lose your ability to enjoy things or to feel happiness and joy in your life?	0	1	2	3	4
	Ability to Enjoy					
2.	How difficult was it for you to feel this happiness and joy?	0	1	2	3	4
	Desire to Enjoy					
3.	How much did you **lose the desire** to experience this happiness and joy?	0	1	2	3	4
	Memories Modifier					
4.	How much did your memories make you **lose the desire** to experience this happiness and joy?	0	1	2	3	4
	Events Modifier 1					
5.	How much did events **outside** your control make you **lose the desire** to experience this happiness and joy?	0	1	2	3	4
	Events Modifier 2					
6.	How much did events **within** your control make you **lose the desire** to experience this happiness and joy?	0	1	2	3	4

Overwhelmed Feeling

Over the past (timeframe):

	Topic					
1.	How overwhelmed have you felt?	0	1	2	3	4
	Ability to Resist Overwhelmed Feeling					
2.	How difficult was your struggle with this overwhelmed feeling?	0	1	2	3	4
	Desire to Resist Overwhelmed Feeling					
3.	How much did you **lose the desire** to struggle with this overwhelmed feeling?	0	1	2	3	4
	Memories Modifier					
4.	How much did your memories make you **lose the desire** to struggle with this overwhelmed feeling?	0	1	2	3	4
	Events Modifier 1					
5.	How much did events **outside** your control make you **lose the desire** to struggle with this overwhelmed feeling?	0	1	2	3	4
	Events Modifier 2					
6.	How much did events **within** your control make you **lose the desire** to struggle with this overwhelmed feeling?	0	1	2	3	4

Conclusion

The SMS assesses the presence of some domains that compound suicidality. It investigates factors that can influence these domains of suicidality. The SMS may be particularly helpful in assessing impulsive suicidality and hopelessness in a way that is very sensitive to change and may provide an early warning sign of impending worsening of suicidality before it becomes apparent in other ways.

Appendix 2.5

Suicidal Impulse Attack Scale (SIAS)

Introduction

What is unique about the SIAS?

The Suicidal Impulse Attack Scale (SIAS) assesses the components of a suicidal impulse attack. These components are the:

1. need or impulse for the patients to kill oneself sooner rather than later
2. need or impulse for the patients *to plan* to kill oneself sooner rather than later
3. patients' *thoughts* about killing oneself or of being better off dead
4. *associated physical* symptoms

Purpose

The SIAS is specifically designed for use as a very brief measure of components within a suicidal impulse attack. Because the suicidal impulse attack events are relatively brief compared to chronic suicidality, an instrument is needed to quickly measure these events over very short periods of time in anti-suicidality impulse attack treatments. For example, in acute ketamine infusion treatment studies, if the interval between assessments is very short, there is not enough time to administer any of the standard validated suicidality scales to assess those short intervals. The SIAS may serve as a brief assessment to capture the severity of the core phenomena of the suicidal impulse attack over very short periods of time.

Clinical and Research Use

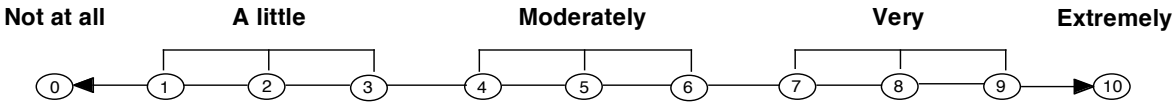
The primary application of the SIAS is most likely to be in Impulse Attack Suicidality Disorder (IASD). However it may have value in the acute tracking of other suicidality disorders. It allows a clinician to determine if a patient with IASD is responding to treatment. The scale allows clinicians and researchers to assess the severity of the essential components of suicidal impulse attacks and to monitor these components over time. The use of the SIAS in conjunction with the Suicidality Modifiers Scale (SMS) may help identify patterns in how the domains of the SMS do or do not influence subsequent suicidal impulse attacks. Emergency room or crisis center staff can use the SIAS frequently (every 15 minutes or hour) to monitor the suicidality severity.

Suicidal Impulse Attack Scale (SIAS)

In the past (timeframe: past 10 minutes / 20 minutes / 1 day / 1 week / 1 month):

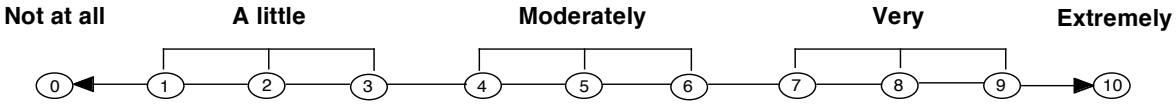
Suicidal Impulse Action

How strong was the need or impulse *to kill yourself* sooner rather than later:



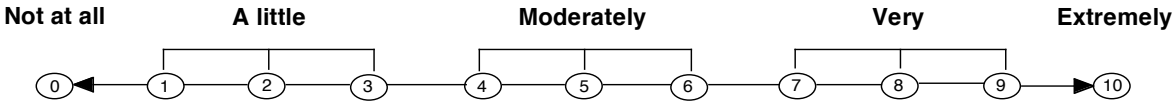
Suicidal Impulse Planning

How strong was the need or impulse *to plan to kill yourself* sooner rather than later:



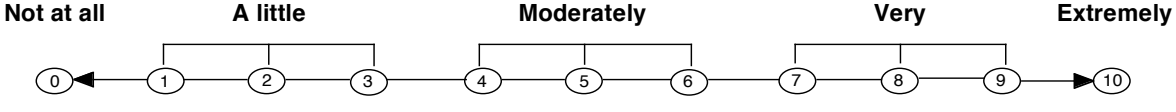
Suicidal Ideation

How seriously did you *think about killing yourself or that you would be better off dead:*



Physical Symptoms

How much were you bothered by *any physical symptoms*:



Conclusion

The SIAS is a very brief assessment of the components of a suicidal impulse attack. The SIAS may be helpful in measuring a suicidal patient's response to acute treatment. It can also be used to track response to rapid onset of action anti-suicidality treatments.

Appendix 3

Suicidality Resources for Clinicians, Patients, Friends, and Family

Introduction

Many organizations and advocacy groups try to reach out and provide information, assistance, and resources to clinicians, patients, families and friends of those who struggle with suicidality. Their offerings are many and varied. In aggregate these sites are a doorway into a rich array of thoughtful assistance and useful ideas.

Please note: many of these resources are or contain links to crisis hotlines or crisis chats. Although they are commonly advertised as being "confidential", many will break this 'confidentiality' and send law enforcement to a suicidal persons' door if they believe the person to whom they are interacting is at a high risk of attempting suicide. The end result sometimes is an involuntary stay at a mental health facility for 3 days. Using these resources means risking this potential disruption to a suicidal person's life, which can cause further ramifications to their work, family responsibilities, and social life.

These resources are divided into the following categories:

- Suicidality Facts
- Suicidality Prevention
- Resources for Clinicians
- Resources for Patients
- Resources for Friends and Family
- Other Resources

Suicidality Facts

World Health Organization Suicide Prevention
http://www.who.int/mental_health/suicide-prevention/en/
Contains information about international suicide statistics and the First World Health Organization Suicide Report.

Centers for Disease Control Suicide Prevention Page
http://www.cdc.gov/violenceprevention/suicide/
Contains various publications and resources about suicide, including the national suicide data and statistics.

Centre for Suicide Prevention (CSP)
http://www.suicideinfo.ca/
Began in 1981 as the Suicide Information and Education Centre (SIEC), the Centre for Suicide Prevention (CSP) contains multiple resources with information on suicide. The CSP contains the world's largest English Language collection of suicide-related materials. The website offers facts about suicide, suicide prevention information, details about training workshops, and links to crisis centers across Canada.

Suicidality Prevention

American Association of Suicidology (AAS)
http://www.suicidology.org
Has links to other suicide prevention websites, information on suicide, suicide facts, warning signs of suicide, crisis centers and support groups. It has a bookstore for books on suicide prevention, assessment, support and treatment. It is involved in suicide research, clinical services and providing support for families and friends of those who died by suicide.

American Foundation for Suicide Prevention (AFSP)
http://afsp.org/
Raises money for research on suicide prevention. Provides information on how to apply for a research grant on suicide prevention. It has useful information on suicide statistics and how to deal with the media on issues relating to suicide.

Yellow Ribbon Suicide Prevention Program
http://www.yellowribbon.org/
The Yellow Ribbon Suicide Prevention Program is focused on reducing stigma and enabling communication about suicidality. It has many chapters in the United States and 5 international chapters. The site has various resources for those experiencing suicidality and is well known for the Ask4Help Cards, which a suicidal person can give to another to communicate that they are experiencing a suicidal crisis.

Army G – 1: Army Suicide Prevention Program
http://asamra.hqda.pentagon.mil/hr/suicide/default.asp
This site provides various resources and information about suicide prevention. It is updated with information about military programs and initiatives. It also contains information about suicide prevention training and contact information for programs specifically designed to prevent suicide among members of the military and their families.

International Association for Suicide Prevention (IASP)
https://www.iasp.info/
Provides information from around the world on suicide prevention. Has an official relationship with the World Health Organization. It has an official journal (Crisis: The Journal of Crisis Intervention and Suicide Prevention). It is associated with an annual international Congress on Suicide (IASP) and provides information about upcoming and past meetings. It reports on awards for research in the field of suicidology.

Surgeon General's Call to Action on Suicide Prevention 1999
http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBBH
Surgeon General David Satcher's 1999 call to action improved awareness of suicide prevention in the USA. It called for a national strategy for suicide prevention. It improved media and public awareness of the problem.

Resources for Clinicians

Training Institute for Suicide Assessment (TIAS)
http://www.SuicideAssessment.com
The website of the Training Institute for Suicide Assessment is a very good resource for those seeking training in suicide assessment by Shawn Shea MD. Dr. Shea is the author of the most widely used books in the field of suicide assessment and clinical interviewing in mental health. It is an excellent book, full of humanity and clinical wisdom, by a very caring, compassionate clinician, who gives frequent workshops around the United States, on suicide assessment and clinical interviewing technique. He offers training workshops, which can be arranged by contacting him through this site.

Suicide Prevention Resource Center (SPRC)
http://www.sprc.org/
Contains information on suicide prevention, webinars, and a library primarily focused at clinicians and other health care professionals. It contains a best practices registry including evidence-based programs, consensus statements from experts, and adherence to standards.

Sudden Loss: Crisis Management in the Schools – An ERIC / CAPS Digest
http://files.eric.ed.gov/fulltext/ED315700.pdf
Contains information for educators on how to handle the aftermath of suicide in a school setting. It has helpful insights for those working with children. Much of this information can be adapted for use in other settings.

Resources for Patients

International Suicide Prevention WIKI
http://suicideprevention.wikia.com/wiki/International_Suicide_Prevention_Directory
The International Suicide Prevention Wiki (ISP Wiki) is a worldwide directory of suicide prevention hotlines, online chat, text-lines, and resources.

Suicide…Read This First
http://www.metanoia.org/suicide
There is much here of interest to those who are struggling with suicidal thoughts. It provides online support groups and links to other websites of interest. It encourages and makes it easy for suicidal people to seek help. It provides information about self-help books and where you can find these books.

Content About Suicide @ The Mighty
http://themighty.com/category/suicide/
The Mighty frequently has content about suicidality aimed at helping suicidal patients and their loved ones and at helping to provide information about suicidality. One post lists 23 messages from people who have been suicidal. In another, they teamed up with PostSecret to collect images and messages for those thinking about suicide. Most of their posts also offer information about crisis hotlines and crisis texts.

National Suicide Prevention Lifeline
http://www.suicidepreventionlifeline.org/
Provides a crisis chat and crisis hotline phone number that redirects to a national network of 163 crisis centers across the United States.

The Icarus Project
http://theicarusproject.net/
The Icarus Project is an online, mutual-aid community seeking to overcome the limitations of the labels of mental illness. It offers support forums and resources, including a crisis toolkit, for those with mental illness.

Resources for Friends and Family

SA\VE – Suicide Awareness\Voices of Education
http://www.save.org
The focus of this site is in providing support to families and friends of those who died by suicide. It does this through improving public awareness and education. It provides information on how to answer questions about suicide, how to tell children about a suicide, what to do if someone you know is suicidal, and how to start a support group.

American Psychiatric Association – Suicide Prevention
http://www.psychiatry.org/patients-families/suicide-prevention
Contains basic information about suicide and resources for patients and their families.

Other Resources

National Alliance on Mental Illness (NAMI)
https://www.nami.org/
Contains informational resources on mental illness and has support groups across the United States for those with mental illness and their families.

National Institutes of Mental Health (NIMH)
https://www.nimh.nih.gov/index.shtml
Researches mental health issues and provides information and outreach programs. Contains links for researchers to apply for grants and funding.

National Anxiety Foundation
http://www.lexington-on-line.com/naf.html
The National Anxiety Foundation offers informational resources on anxiety and panic disorder. It includes book recommendations and links to other sources.

International Society for Bipolar Disorders (ISBD)
http://www.isbd.org/
The International Society for Bipolar Disorders offers informational resources on bipolar disorders. It has chapters in 23 countries. The website contains resources and links for patients and advocates.

Harm Research Institute
http://www.HarmResearch.org
The Harm Research Institute is a volunteer organization that brings together those with clinical experience and personal experience in harm-related conditions to study harm phenomena. It contains multiple suicidality assessment scales and other information on suicidality disorders.

List of Acronyms

+Mg-Ca	High Magnesium / Low Calcium Dietary Intake
AAS	American Association of Suicidology
AD	Antidepressant
AFSP	American Foundation for Suicide Prevention
C-CASA	Columbia-Classification Algorithm of Suicide Assessment
CMCM	Clinically Meaningful Change Measure of the Sheehan-Suicidality Tracking Scale
CSP	Centre for Suicide Prevention
DISCAN	Discretized Visual Analog
DSM-5	Diagnostic and Statistical Manual of Mental Disorders 5th Edition
ESIA	Expected Suicidal Impulse Attack
FDA	United States Food and Drug Administration
FDA-CASA 2012	US FDA Classification Algorithm for Suicide Assessment from 2012 draft guidance
HPTS	Homicide Plan Tracking Scale
IASD	Impulse Attack Suicidality Disorder
IASP	International Association for Suicide Prevention
ICD-10	International Statistical Classification of Diseases & Related Health Problems (10th rev.)
ISBD	International Society for Bipolar Disorders
MAOI	Monoamine Oxidase Inhibitor
MDD	Major Depressive Disorder

MINI	Mini International Neuropsychiatric Interview
MINI Screen	Mini International Neuropsychiatric Interview Screen
NAMI	National Alliance on Mental Illness
NIMH	National Institutes of Mental Health
NMDA	N-Methyl-D-aspartic Acid or N-Methyl-D-Aspartate
NSPSA	Non-Suicidal Physical Symptom Attack
NSSI	Non-Suicidal Self-Injury
OTC	Over-the-Counter
PTSD	Posttraumatic Stress Disorder
S-HTS	Sheehan-Homicidality Tracking Scale
S-SHSQ	Sheehan-Suicidality / Homicidality Screening Questions
S-SNTS	Sheehan-Suinocerality Tracking Scale
S-STS	Sheehan-Suicidality Tracking Scale
S-STS CMCM	Sheehan-Suicidality Tracking Scale Clinically Meaningful Change Measure
SA\VE	Suicide Awareness\Voices of Education
SIEC	Suicide Information and Education Centre
SIA	Suicidal Impulse Attack
SIAS	Suicidality Impulse Attack Scale
SMR	Standard Mortality Ratio
SMS	Suicidality Modifiers Scale
SNRI	Serotonin–Norepinephrine Reuptake Inhibitor
SPRC	Suicide Prevention Resource Center
SPTS	Suicide Plan Tracking Scale
SSRI	Selective Serotonin Re-uptake Inhibitor or Serotonin-Specific Reuptake Inhibitor
T-CASA	Tampa-Classification Algorithm for Suicidality Assessment
TCA	Tricyclic Antidepressant
TIAS	Training Institute for Suicide Assessment
USFDA	United States Food and Drug Administration
USIA	Unexpected Suicidal Impulse Attack

About the Authors

David. V. Sheehan

David V. Sheehan, M.D., M.B.A. is Distinguished University Health Professor Emeritus at the University of South Florida College of Medicine. He was Professor of Psychiatry, Director of Psychiatric Research and Director of the Depression and Anxiety Disorders Research Institute at the University of South Florida College of Medicine and Professor of Psychology at the University of South Florida College of Arts and Sciences.

Dr. Sheehan was born and educated in Ireland. He completed his residency training in psychiatry at Massachusetts General Hospital and Harvard Medical School. At Harvard Medical School, where he was Assistant Professor of Psychiatry, he was on the full-time faculty for 12 1/2 years. He was the Director of Anxiety Research and Director of the Psychosomatic Medicine Clinic at Massachusetts General Hospital. He received his MBA (summa cum laude) from the University of South Florida. He served as Director of Psychiatric Research for the Department of Psychiatry and Behavioral Medicine at the University of South Florida College of Medicine from 1985-2007. He has written over 550 abstracts and 300 publications including a bestseller *The Anxiety Disease (which sold over ½ a million copies)*. He has edited / served on the editorial board of 9 books/monographs. Cumulatively, his publications have been cited over 20,800 times. One of his scientific publications has been identified in Essential Science Indicators as a "Current Classic" on 3 separate occasions and as the paper with the greatest absolute increase in citations in the fields of psychiatry and psychology in the last decade (1999-2009).

He has been awarded over $20 million for 130 research grants. He was awarded 2 patents by the United States Patent Office in 1996 and 2015. He has given expert testimony to the Unites States Congress.

He has been a consultant to the World Health Organization, the World Federation of Societies of Biological Psychiatry, the International Academy for Biomedical and Drug Research, the US Food and Drug Administration, and as a research grant reviewer for the National Institute for Mental Health (NIMH). He was a consultant to the American Psychiatric Association (APA) Working Group to Revise DSMIII Anxiety Disorders, the APA Task Force on Benzodiazepine Dependency and the APA Task Force on Treatments of Psychiatric Disorders. He has also served on the national and international advisory boards of numerous pharmaceutical companies and of non profit foundations including the National Anxiety Foundation, the National Depressive and Manic Depressive Association, the Council on Anxiety Disorders, the Anxiety Disorder Association of America, and the Council on Anxiety Disorders and The Foundation for Improving Data Quality.

He has been invited to give over 2000 lectures in 68 countries throughout the world on anxiety and mood disorders, suicidality, measurement based care, psychopharmacology and biological psychiatry. He was elected as a member of the American College of Psychiatrists and is a Distinguished Life Fellow of the American Psychiatric Association and is a Charter Member of the National Academy of Inventors. Among other honors, he has been included in "The Best Doctors in America" published by Woodward/White Inc. every year from 1992 until his retirement in 2010.

Jennifer M. Giddens

Jennifer M. Giddens is the co-founder and co-director of the Harm Research Institute and of Harm Research Press. In her five years since founding the Tampa Center for Research on Suicidality, her research focus has been to better understand suicidality phenomena and other harm-related conditions.

Jennifer has co-authored 3 abstracts, 10 publications, and 2 books, all on the topic of suicidality. A review of her first book, *Suicidality: A Roadmap for Assessment and Treatment*, predicted it would "revitalize the field of suicidology". She is co-author with D.V. Sheehan of the Suicidality Disorders Module of the Mini International Neuropsychiatric Interview. She consulted on the development of the Sheehan - Suicidality Tracking Scale and the Sheehan - Homicidality Tracking Scale. She is co-author and co-copyright holder with D.V. Sheehan of the Suicidality Modifiers Scale (SMS), the Homicidality Modifiers Scale (HMS), and the Suicidal Impulse Attack Scale (SIAS). Jennifer is also co-author and copyright holder with D.V. Sheehan of the Suicide Plan Tracking Scale (SPTS) and the Homicide Plan Tracking Scale (HPTS).

Jennifer presented at the November 2015 International Society for CNS Clinical Trials and Methodology (ISCTM) Conference on Suicidal Ideation and Behavior Assessment. She co-authored scripts used by ProPhase LLC, to develop rater training on all versions of the Sheehan - Suicidality Tracking Scale.

With over 25 years of experience, Jennifer is currently serving as a patient advocate for those with suicidality.