SECTION - MEDICAL/NURSING SERVICES
ADMINISTRATIVE DIRECTIVE NO. 526
(Replaces AD 526 dated 11/9/06)

Effective Date: December 7, 2006

SUBJECT: SUICIDE PREVENTION

I. PURPOSE

To ensure that all Individuals at Coalinga State Hospital are monitored for and prevented from harming themselves.

II. AUTHORITY

California Code of Regulations, Department of Mental Health Special Order No. 115.

III. POLICY

It is the policy of this hospital to:

A. Prevent suicide.

B. Prevent injuries from occurring due to threats of suicide, suicide attempts or episodes of self harm.

C. Make an accurate and effective response to the psychological needs of any Individual who makes an attempt or threat of suicide or self-harm.

D. Provide prompt and appropriate treatment of any self-inflicted physical injuries.

E. Respond appropriately to the needs of both staff and other Individuals when a suicide, serious injury, or other disturbing event has occurred.

F. Provide accurate information within limits of confidentiality to responsible and concerned persons, agencies, or news media.

All staff and employees of this hospital share responsibility for implementation of this policy. It is primarily the responsibility of each individual Wellness and Recovery Team (WRT) member, including program management, psychiatric technicians, nurses, psychologists, social workers, rehabilitation specialists and psychiatrists to maintain awareness of risk, to communicate specific information about such risk or potential, and to provide necessary care and treatment.

The guidelines provided in this directive consist of basic minimum standards of prevention and care, and shall be adhered to by all treatment programs. Treatment programs may develop program-specific procedures in accordance with their particular environments, treatment team recommendations, and Individual populations.

IV. METHOD

A. General Precepts

1. It should be recognized that suicide or self-injury may occur in a variety of clinical conditions or situations such as:

   a. A depressive illness;

   b. A crisis, especially if it involves a serious loss of some kind, or the receipt of any information that may be construed by a particular Individual as having serious negative consequences (bad news);

   c. A psychosis;

   d. A pattern of personality disturbance.

2. Our primary duty is to assure Individual safety, which includes safety from self-harm. No suicide threat or gesture should be ignored. Persons who talk about suicide do often attempt it; persons who make suicide attempts or gestures in manipulative or self-dramatizing ways do often kill themselves, harm themselves seriously, or harm others.

   a. When a person is thought to be at risk of suicide or self-harm, he will be informed clearly about evaluations being made and about actions to be taken.

   b. Once initiated, suicide precautions should never be relaxed abruptly. Risks sometimes actually increase as the Individual seems to improve. Nor should any type of suicide precautions be ordered for a preset time limit. Lowering the level of observation must be done after a face to face evaluation by the psychiatrist.

3. It is crucial that attention be paid to the context in which a suicidal or self harming action has occurred, so that appropriate responses can be made to pertinent precipitating stimuli and treatment plans may be developed. Attention to the Individual's relationship to staff and their actions, as well as to other Individuals, is always important.

B. Signals of suicide risk

The assessment of suicide risk can sometimes be difficult. However, there are a number of signals that should alert staff to the need for a more thorough assessment (to be discussed below).

1. Changes in behavior, such as:

   a. Refusing food or medication;

   b. Saving medication;

   c. Asking about suicide;

   d. Talking of death, futility;

   e. Giving away possessions;

   f. Checking layout of unit;

   g. Loosening bolts, tearing sheets;

   h. Suicide notes or writing;

   i. Pacing;

   j. Increase in auditory hallucinations.

2. Changes in mood, such as:

   a. Hopelessness, helplessness, worthlessness;

   b. Depression with agitation, restlessness;

   c. Unrelieved anxiety;

   d. Guilt and self-blame;

   e. Bitter anger;

   f. Mood swings;

   g. Sudden drastic mood shift, euphoria;

   h. Crying;

   i. Difficulty concentrating;

j. Appearing exhausted.

3. Situational factors, such as:

a. Admission to facility within past week, unit changes within 48 hours.

b. Recent communication from outside of the hospital, especially relatives.

c. Pending change of legal status, recent court hearing.

d. Any significant news, good or bad, should be told to the Individual with consideration of how he may react.

e. Anniversary of important event.

f. Debilitating illness.

4. Demographic factors:

a. Male

b. Middle-aged

c. Single/divorced

d. History of substance abuse

C. Assessment of suicide risk:

1. On admission:

a. All newly admitted Individuals must be evaluated for the risk of potential danger to themselves.

b. All new admissions shall have a Suicide Risk Assessment (SRA) by the Team Psychologist within 5 days of admission (See SRA instruction).

c. Each Individual is seen on admission, by a nurse and a psychiatrist. The psychiatrist will do a suicide risk assessment, which should include:

i. Current suicidal ideas or plan – details.

ii. Prior suicidal ideas – plans – attempts – details.

iii. Lethality of prior attempts and current plan.

iv. Means of plan and accessibility of materials.

v. Level of depression.

vi. Level of agitation.

vii. History of weight loss/decreased sleep/decreased concentration.

viii. Presence of command auditory hallucinations.

d. If the results warrant, (significant suicide risk), the Individual should be:

i. Placed on appropriate level of observation.

ii. Notify team psychologist no later than the next working day.

iii. Notify the Psychiatric Medical on Call (PMOC) for that evening.

iv. Team psychologist should administer the full SRA the next day.

v. The unit WRT team must meet the next working day to devise an interim WRT plan.

2. During hospital stay:

a. Concern can arise at anytime during an Individual's stay that there is a suicide risk. This can be noted by any staff member. They are to:

b. Immediately notify shift lead or unit supervisor.

c. During regular working hours:

i. Put Individual on 1:1 and immediately call psychiatrist to evaluate face to face. Psychologist and RN must be notified within one hour.

ii. Psychologist shall do an SRA that day.

iii. Psychiatrist, RN or psychologist and team decide on level of observation within the hour.

iv. WRT meets by the next day to devise revision of Wellness and Recovery Plan (WRP).

d. Outside of working hours:

i. Put Individual on 1:1 and call psychiatrist immediately to evaluate.

ii. Individual must be seen within 24 hours, face to face, by the psychiatrist. Psychiatrist will evaluate face to face at least daily until the next regular work day, when complete SRA will be administered by Psychologist and WRT will meet to revise WRP.

D. Assigning level of risk:

1. While there is no approach that is always correct in management of these situations, it is helpful to assign a "Level of Risk" after the evaluations described above, in order to help decision-making, as well as to make the response to risk as homogeneous as possible within the organization. During business hours this is best done by the WRT, including psychiatrist. If not possible, then by the psychiatrist, psychologist and RN. After hours, this is done by the PMOC with input from nursing staff.

a. The level of risk can be conceptualized as a continuum from one to three, then back to one and then virtually zero;

One: New patient, no history of any suicidal ideas or attempts, otherwise unknown to staff – Level of observation: q. 15 minute check-review in 24 hours.

Two: Contemplating self harm – Line Of Sight (LOS).

Three: Actively suicidal/acute – Level of Observation 1:1.

Two: Resolving situation, less acute – LOS.

One: Much better but not out of the woods entirely – LOS Q. 15 minute checks.

Zero: Situation resolved – no special observation needed.

E. Monitoring:

1. Level 3–Acute risk:

a. 1:1 arms length. No staff member shall be assigned 1:1 observation for more than 2 continuous hours, without an hour on other duties before the next period of 1:1.

b. Remove sharps, belt etc.

c. Monitor in bathroom stall.

d. May be in single room (on 1:1).

e. All staff to be alerted at shift change report.

f. Monitor medication ingestion.

g. Check room and person daily for harmful objects.

2. Level 2–Contemplating or recovering:

a. LOS–No staff shall be assigned LOS for 4 continuous hours before a one hour break.

b. Room near nurse's station.

c. Monitor medication ingestion.

d. Check room and person daily for harmful objects.

3. Level 1–New patient or almost fully recovered:

a. Q. 15 minute checks.

b. Know whereabouts at shift change.

c. Not in single room.

d. Keep ahead of staff when in a group.

e. Monitor medication ingestion.

F. Re-assessment:

1. When the Individual is improving, he shall be evaluated for a less restrictive amount of observation by the psychiatrist, psychologist and RN (business hours) or PMOC (after hours). The task of lowering the Level of Observation is much riskier than increasing the level. Many factors must be considered, including:

a. Sleep;

b. Appetite;

c. Concentration;

d. Agitation;

e. Mood;

f. Participation in ward activities;

g. A statement by the Individual that they will not harm themselves is not enough–there must be objective signs of improvement, as listed above.

V. DOCUMENTATION

A. The assessment and re-assessment of each Individual as to risk of suicide or self-harm shall be specifically documented fully in notes by the psychiatrist, psychologist, nursing staff and psych techs and on the Kardex by the assigned nursing staff. Documentation must reflect that the risk is recognized and evaluated and that reasonable measures are ordered and orders are followed. All staff must record pertinent observations. The Individual's chart shall be flagged with appropriate stickers. Any significant risk shall be noted in the Individual's Wellness and Recovery plan. Appropriate orders and plan shall be entered in the Individual's chart.

B. Orders must be written clearly, to show what restriction/observations are in place and how they will be accomplished.

C. As soon as the Individual's condition changes so that the risk is higher or lower, that change shall be noted in the Interdisciplinary Notes. The entire WRT will evaluate the Individual before there is any lowering of the Level of Observation.

D. Any information received by staff from the Individual's family or others regarding potential suicide risk will be brought to the attention of the WRP team psychologist, RN and psychiatrist within one hour. This information will be documented in the Individual's chart.

E. Whenever an Individual is deemed to be at risk of self-harm or has a history of self-harm, all relevant information should be in the WRP. Circumstances that are known to increase or decrease risk should be noted.

F. When an Individual is on 1:1 or LOS observation, staff should write a note at least every two hours regarding the current status and mood of the Individual. These notes shall be reviewed at each change of shift. To the extent possible, non-nursing staff of the Interdisciplinary Team shall participate in this review (see Section V-A).

G. The assigned persons shall interact with the Individual on observation to provide reassurance and emotional support, and to assess the Individual's mood continuously.

H. Each Individual on Level 2 or 3 suicide precaution shall be reassessed daily by a psychologist with a face-to-face interview in collaboration with the Interdisciplinary.

I. Team (business hours), and shall document that assessment in the Progress Notes and Inter-Disciplinary Notes (as appropriate).

VI. REPORTABLE INJURIES

A. If an Individual has made a suicide attempt or has injured himself in any way, this constitutes a medical emergency and shall be treated as such.

B. All suicide attempts and injuries shall be documented in Special Incident Reports (SIRs) as well as the documentation in the medical record.

C. Any serious injury sustained from a suicide attempt or gesture shall be photographed as soon as is practical by Hospital Police Services.

D. Serious injuries and serious suicide attempts will be Headquarters reportable incidents, thus Program Management (or Program Officer of the Day) are responsible to notify the Executive Officer of the Day (EOD), Standards Compliance and the Clinical Administrator.

VII. TRAINING

A. An overview of suicide assessment and intervention will be provided during orientation for nursing and other clinical staff.

B. All clinical staff and affected support staff will receive work site orientation to the policies and procedures for suicide prevention.

C. Annual updates will be provided at Clinical Case Conferences and Colloquia.

W. T. VOSS
Executive Director

Cross Reference(s):
A.D. No. 830 - Special Incident Reports
A.D. No. 552 - Restraint and/or Seclusion
Appendix A-Beck Depression Scale
Appendix B-Linehan "Reasons to Live Scale"

SUICIDE RISK ASSESSMENT

Date: _____

MH-C 9002 (NEW 11/06)

SUICIDE RISK SCREEN

To be completed by nursing staff.

Current / past thoughts of suicide:	☐ No ☐ Yes	Discrete panic attack or severe anxiety:	☐ No ☐ Yes
Current / past plan to take own life:	☐ No ☐ Yes	Severe inability to experience pleasure:	☐ No ☐ Yes
Suicide attempts:	☐ No ☐ Yes	Pattern of aggression / anger:	☐ No ☐ Yes
History of self-harm:	☐ No ☐ Yes	Extreme sense of being alone:	☐ No ☐ Yes
Family history of suicide:	☐ No ☐ Yes	Onset / worsening of serious medical condition:	☐ No ☐ Yes
Recent loss:	☐ No ☐ Yes	Significant change in behavior or mental status:	☐ No ☐ Yes

If any item endorsed (marked yes) complete notifications:

Psychiatrist (date/time): **Psychologist (date/time):**

Nursing actions taken:

RN Signature (date/time):

SUICIDE RISK ASSESSMENT

To be completed by a psychiatrist or a psychologist within 24 hours.

SUICIDE RISK	☐ Low	☐ Medium	☐ High

Summary of Suicide Risk Assessment: Include conditions that might increase risk, recommended interventions and protective factors:

ADDRESSOGRAPH

Summary of Suicide Risk Assessment: Include conditions that might increase risk, recommended interventions and protective factors.

Psychologist signature(date/time):

ADDRESSOGRAPH

Includes information from the Beck Scale for Suicide Ideation (BSSI), the Reasons for Living Scale (RFL), chart review clinical interview and other instruments as clinically indicated.

Suicide Risk Clinical Interview Guidelines :

1. Suicidal ideation/prior attempts/ plan: For Example: You seem to feel very bad; have you found yourself thinking of hurting yourself? Have you ever felt life was not worth living? Have you thought of how you might hurt yourself (plan)? How recently? How often? Do you think that what you plan to do will kill you? If you were to kill yourself, when would you do it? What is stopping you from killing yourself? Sometimes have you been afraid that, in spite of yourself, in one of your really down periods you might kill yourself? How likely is it you will act on suicidal thoughts? Are you "taking care of business" in case you kill yourself? What has been keeping you alive? If prior attempts, list date / method/ context below. What happened? What were your thoughts/feelings prior/during your last attempt?

Date	Method	Context

ADDRESSOGRAPH

2. Behavioral cues: For Example What are you usually able to do that you are not able to do now? You are not as active as you usually are; what has changed? Do you have any fears of losing control? Any changes in your sleep patterns? Describe any changes in your relationships with others. How are you feeling physically? Any concerns regarding your health?

3. Affective state: For Example What feeling do you experience most often during the day? Rate the intensity of how you feel on a scale of 1 – 10 with 1 being the worst and 10 the best. How does this compare to _____? If your current feeling state didn't change, could you tolerate the way you feel? What do you think will happen in the future? Do you believe a time will come when you feel better? Is there anything you think you should be punished for? What gives meaning to your life? Do you hurt so bad you cannot go on living?

ADDRESSOGRAPH

4. Cognitive/perceptual factors: For Example How have you handled difficult times in the past? What do you believe would be of help to you right now? What have the voices been telling you today? Is it OK for you to keep on living? What are some alternatives to suicide to help you? Are you having trouble thinking?

5. Protective Factors: For Example: Who helps you when you are having a hard time? What do you see as being helpful? What do you believe you need to survive? Who do you feel safe talking to here? Identify which staff you can talk to on each shift.

ADDRESSOGRAPH

6. Other Factors:

ADDRESSOGRAPH

SUICIDE RISK ASSESSMENT - INSTRUCTIONS

Measure: **Reasons for Living Inventory – 48 Items (RFL; 1983)**
Author: Linehan, M., Goodstein, J., Nielsen, S., & Chiles, J.

Introduction

- RFL is a 48-item self-report measure that assesses the beliefs and expectations for not committing suicide.
- RFL may be used to explore differences in the reasons for living for individuals who engage in suicidal behavior and those who do not.
- RFL represents a positive approach to assessing suicidal intent. It is the reduction of pleasure that indicates the readiness or intention to commit suicide.
- RFL measures a range of beliefs that support continuation of on-going life.
- RFL yields a profile of scores on six scales:
    1. Survival and Coping Beliefs
    2. Responsibility to Family
    3. Child Related Concerns
    4. Fear of Suicide
    5. Fear of Social Disapproval, and
    6. Moral Objections

Administration

- Self-administration takes 5-10 minutes to complete. Instructions are printed on the form.
- Each item is rated on a 6-point Likert scale ranging from 1 ("not at all important") to 6 ("extremely important").

Scoring

- RFL yields six scale scores and total score
- Each scale score is calculated by summing the items and dividing by the number of items.
- Total score is calculated by summing the items and dividing by the number of items.
- A computer scoring template (Microsoft Excel spreadsheet) is available upon request.
- It is possible to score the instrument with missing items. Contact the Psychology Resource Center for further instruction.

SUICIDE RISK ASSESSMENT - INSTRUCTIONS

Interpretation

- Normative data (Means and SD) are provided by the authors
- Data are drawn from inpatient psychiatric setting
- Compare the profile of scores with the following clinical groups:
    1. Parasuicide
    2. Suicide Ideation
    3. Nonsuicidal
- The profile can be construed as reflecting increased wishes to die (the lower the score, the higher the suicide risk)
- Normative data (Means and SD) for general population are also available

INSTRUCTIONS: Many people have thought of suicide at least once. Others have never considered it. Whether you have considered it or not, we are interested in the reasons you would have for **not** committing suicide if the thought were to occur to you or if someone were to suggest it to you.

On the following pages are reasons people sometimes give for **not** committing suicide. We would like to know how important each of these possible reasons would be to you at this time in your life as a reason to **not** kill yourself. Please rate this in the space at the left on each question.

Each reason can be rated from 1 (Not At All Important) to 6 (Extremely Important). If a reason does not apply to you or if you do not believe the statement is true, then it is not likely important and you should put a 1. Please use the whole range of choices so as not to rate only at the middle (2, 3, 4, and 5) or only at the extremes (1, 6).

In each space put a number to indicate the importance to you of each reason for **not** killing yourself.

1. Not At All Important (as a reason for **not** killing myself, or, does not apply to me, I don't believe this at all).
2. Quite Unimportant
3. Somewhat Unimportant
4. Somewhat Important
5. Quite Important
6. Extremely Important (as a reason for **not** killing myself, I believe this very much and it is very important).

Even if you never have or firmly believe you never would seriously consider killing yourself, it is still important that you rate each reason. In this case, rate on the basis of **why killing yourself is not or would never be an alternative for you.**

SUICIDE RISK ASSESSMENT - INSTRUCTIONS

In each space put a number to indicate the importance to you of each for **not** killing yourself.

1. Not At All Important
2. Quite Unimportant
3. Somewhat **Unimportant**
4. Somewhat **Important**
5. Quite Important
6. Extremely Important

_____ 1. I have a responsibility and commitment to my family.

_____ 2. I believe I can learn to adjust or cope with my problems.

_____ 3. I believe I have control over my life and destiny

_____ 4. I have a desire to live.

_____ 5. I believe only God has the right to end a life.

_____ 6. I am afraid of death

_____ 7. My family might believe I did not love them

_____ 8. I do not believe that things get miserable or hopeless enough that I would rather be dead

_____ 9. My family depends upon me and needs me

_____ 10. I do not want to die

_____ 11. I want to watch my children as they grow

_____ 12. Life is all we have and is better than nothing

_____ 13. I have future plans I am looking forward to carrying out

_____ 14. No matter how badly I feel, I know that it will not last

_____ 15. I am afraid of the unknown

_____ 16. I love and enjoy my family too much and could not leave them

_____ 17. I want to experience all that life has to offer and there are many experiences I haven't had yet which I want to have

_____ 18. I am afraid that my method of killing myself would fail

_____ 19. I care enough about myself to live

_____ 20. Life is too beautiful and precious to end it

SUICIDE RISK ASSESSMENT - INSTRUCTIONS

In each space put a number to indicate the importance to you of each for **not** killing yourself.

1. Not At All Important
2. Quite Unimportant
3. Somewhat **Unimportant**
4. Somewhat **Important**
5. Quite Important
6. Extremely Important

_____ 21. It would not be fair to leave the children for others to take care of

_____ 22. I believe I can find other solutions to my problems

_____ 23. I am afraid of going to hell

_____ 24. I have a love of life

_____ 25. I am too stable to kill myself

_____ 26. I am a coward and do not have the guts to do it

_____ 27. My religious beliefs forbid it

_____ 28. The effect on my children could be harmful

_____ 29. I am curious about what will happen in the future

_____ 30. It would hurt my family too much and I would not want them to suffer

_____ 31. I am concerned about what others would think of me

_____ 32. I believe everything has a way of working out for the best

_____ 33. I could not decide where, when, and how to do it

_____ 34. I consider it morally wrong

_____ 35. I still have many things left to do

_____ 36. I have the courage to face life

_____ 37. I am happy and content with my life

_____ 38. I am afraid of the actual "act" of killing myself (the pain, blood, violence

_____ 39. I believe killing myself would not really accomplish or solve anything

_____ 40. I have hope that things will improve and the future will be happier

_____ 41. Other people would think I am weak and selfish.

SUICIDE RISK ASSESSMENT - INSTRUCTIONS

In each space put a number to indicate the importance to you of each for **not** killing yourself.

1. Not At All Important
2. Quite Unimportant
3. Somewhat **Unimportant**
4. Somewhat **Important**
5. Quite Important
6. Extremely Important

_____ 42. I have an inner drive to survive

_____ 43. I would not want people to think I did not have control over my life

_____ 44. I believe I can find a purpose in life, a reason to live

_____ 45. I see no reason to hurry death along

_____ 46. I am so inept that my method would not work

_____ 47. I would not want my family to feel guilty afterwards

_____ 48. I would not want my family to think I was selfish or a coward

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BSS®

Date: _____

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Directions: Please carefully read each group of statements below. Circle the one statement in each group that **best** describes how you have been feeling for the **past week, including today.** Be sure to read all of the statements in each group before making a choice.

Part 1

1 0 I have a moderate to strong wish to live.
1 I have a weak wish to live.
2 I have no wish to live.

2 0 I have no wish to die.
1 I have a weak wish to die.
2 I have a moderate to strong wish to die.

3 0 My reasons for living outweigh my reasons for dying.
1 My reasons for living or dying are about equal.
2 My reasons for dying outweigh my reasons for living.

4 0 I have no desire to kill myself.
1 I have a weak desire to kill myself.
2 I have a moderate to strong desire to kill myself.

5 0 I would try to save my life if I found myself in a life-threatening situation.
1 I would take a chance on life or death if I found myself in a life-threatening situation.
2 I would not take the steps necessary to avoid death if I found myself in a life-threatening situation.

If you have circled the zero statements in both Groups 4 and 5 above, then skip down to Group 20. If you have marked a 1 or 2 in either Group 4 or 5, then open here and go to Group 6.

Subtotal Part 1

Part 2

6 0 I have brief periods of thinking about killing myself which pass quickly.
1 I have periods of thinking about killing myself which last for moderate amounts of time.
2 I have long periods of thinking about killing myself.

7 0 I rarely or only occasionally think about killing myself.
1 I have frequent thoughts about killing myself.
2 I continuously think about killing myself.

8 0 I do not accept the idea of killing myself.
1 I neither accept nor reject the idea of killing myself.
2 I accept the idea of killing myself.

9 0 I can keep myself from committing suicide.
1 I am unsure that I can keep myself from committing suicide.
2 I cannot keep myself from committing suicide.

10 0 I would not kill myself because of my family, friends, religion, possible injury from an unsuccessful attempt, etc.
1 I am somewhat concerned about killing myself because of my family, friends, religion, possible injury from an unsuccessful attempt, etc.
2 I am not or only a little concerned about killing myself because of my family, friends, religion, possible injury from an unsuccessful attempt, etc.

11 0 My reasons for wanting to commit suicide are primarily aimed at influencing other people, such as getting even with people, making people happier, making people pay attention to me, etc.
1 My reasons for wanting to commit suicide are not only aimed at influencing other people, but also represent a way of solving my problems.
2 My reasons for wanting to commit suicide are primarily based upon escaping from my problems.

12 0 I have no specific plan about how to kill myself.
1 I have considered ways of killing myself, but have not worked out the details.
2 I have a specific plan for killing myself.

13 0 I do not have access to a method or an opportunity to kill myself.
1 The method that I would use for committing suicide takes time, and I really do not have a good opportunity to use this method.
2 I have access or anticipate having access to the method that I would choose for killing myself and also have or shall have the opportunity to use it.

14 0 I do not have the courage or the ability to commit suicide.
1 I am unsure that I have the courage or the ability to commit suicide.
2 I have the courage and the ability to commit suicide.

15 0 I do not expect to make a suicide attempt.
1 I am unsure that I shall make a suicide attempt.
2 I am sure that I shall make a suicide attempt.

16 0 I have made no preparations for committing suicide.
1 I have made some preparations for committing suicide.
2 I have almost finished or completed my preparations for committing suicide.

17 0 I have not written a suicide note.
1 I have thought about writing a suicide note or have started to write one, but have not completed it.
2 I have completed a suicide note.

18 0 I have made no arrangements for what will happen after I have committed suicide.
1 I have thought about making some arrangements for what will happen after I have committed suicide.
2 I have made definite arrangements for what will happen after I have committed suicide.

19 0 I have not hidden my desire to kill myself from people.
1 I have held back telling people about wanting to kill myself.
2 I have attempted to hide, conceal, or lie about wanting to commit suicide.

Go to Group 20.

20 0 I have never attempted suicide.
1 I have attempted suicide once.
2 I have attempted suicide two or more times.

If you have previously attempted suicide, please continue with the next statement group.

21 0 My wish to die during the last suicide attempt was low.
1 My wish to die during the last suicide attempt was moderate.
2 My wish to die during the last suicide attempt was high.

_____ **Subtotal Part 2**

_____ **Total Score**

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