Suicide & Homicide Assessment

(adapted from the *Crisis Assessment Form developed by Cashing & Boyd)*

Risk Assessment

Part A: Danger to Self

Suicidal Ideation: Yes____ No____

- Are you currently having any thoughts of hurting yourself (self-harm) or of killing yourself?
- If yes, tell me more about what the thoughts are (ask about specifics)
- Are the thoughts increasing in frequency and intensity?
- Are you spending a lot of time contemplating suicide or hurting yourself? Or are they fleeting thoughts? (during the last 48 hours)
- How are you responding to the thoughts? (dwelling vs. distracting self)

Active suicidal thoughts with intensity, increasing frequency, and occupying a lot of time all increase risk.

Suicidal Plan: Yes____ No____

- Are you spending a lot of time planning how you would hurt or kill yourself?
- Do you have a specific plan?
- If yes, what are the specific details of the plan (when, what, where, how)
- Do you have a specific date when you would hurt or kill yourself?
- Is there anything that would hold you back? (family, friends, religious convictions, pets, etc.)

A well-thought out plan increases risk.

Access to Plan: Yes____ No____

- Do you have access to your plan? (e.g., Do you have a gun or access to a gun?)
- If plan involves an overdose, ask what pills they plan to take, where the pills are now, and have they been stockpiling pills?
- Access location of means (e.g., where is the gun/rope/pills, etc.?)

The more accessible the plan, the higher the risk.

Preparations Made: Yes____ No____

- Have there been previous suicide attempts? (what did they do?)
- How many past attempts? What happened? Who found you? Did you require medical attention?
- Did you tell anyone about the suicide attempt?
- Did you try to hide if from others?
- Was your aim to kill yourself, or was it accidental?
- Have you ever come close to taking any action or risky behavior that has result in a threat to your life? (unintentional and/or past risky actions/behaviors)
- Assess lethality of previous attempts and/or past risky actions/behaviors
- How is the current suicide/self-harm plan similar or different from past attempts?

Serious lethal attempts and/or attempts made in isolation increase risk.

Command Hallucinations: Yes____ No____

- Are you hearing any voices or seeing any visions telling you to harm or kill yourself?
- Are you receiving any messages (e.g., from internal or external sources)?
- If yes, what is the voice saying? What is the vision? Whose voice is it?
- How often is the voice or vision occurring?
- Are others involved?
- How is the voice or vision making you feel? (scared? Is it a derogatory voice?)

If the person is experiencing command hallucinations, immediate hospital or medical attention should be sought to ensure safety of client. The person may be admittable to the hospital on an involuntary basis if s/he is unable to go on his/her own.

Family/Network History: Yes____No____

- Have any of your family members of close friends or acquaintances completed suicide or made any serious attempts?
- If so, when?
- How did they complete suicide?

Risk increases if family/network history of completed suicide exists and risk further increases the more recent the family/network completed suicide.

Part B: Danger to Others

Homicidal Thoughts: Yes____ No____

- Are you currently having any thoughts of hurting or killing anyone?
- What thoughts are you having? Tell me more (get specific details).
- Who are the thoughts about?
- How far are you away from that (those) person(s)? How long would it take for you to find them?
- Is there anyone there with you right now? (Assess safety of other person)
- How much time are you spending thinking about hurting or killing that (those) person(s), or someone? Are the thoughts fleeting?
- Have you pictured yourself following through with your plan?
- Is the intensity of the thoughts increasing?

Current Violent Thought: Yes____ No____

Plan

- Find out as many details as possible
- Who does it involve?
- How soon do they plan to carry it out?
- What means (weapons, etc.) does it entail? Are the means to carry out the plan in place?
- When do they intend to act on their thought/plan?

Also assess general thoughts of violence or anger. (Do such thoughts relate to past abuse/trauma? How do they express anger and violence?)

Access to Plan: Yes____ No____

- Is (are) the person(s) you are wishing to harm/kill within access? (versus feeling vengeful toward someone you have lost track of and are unable to locate)
- Do you have weapon/means in place to carry out the plan? (How easily can client access the means needed?)
- Have you started to follow that person (e.g., stalking)? (Does the client know the person's routine?)
- If you are following the person, are you carrying weapons with you?

History of Violence: Yes____ No____

- Have you had any history of violence towards others? If yes, find out the details of violent acts - what, when, who, consequences, remorse.
- Have you ever been a victim of violence/abuse?
- Have you ever been charged and/or convicted of violence (assault) in the past? (when, what was the nature of the offense, etc).

Fears & Consequences: Yes____ No____

- Are you concerned about the potential consequences if you act on your plan to harm/kill someone else? (e.g., legal, incarceration, impact on other person and family, remorse)

Command Hallucinations: Yes____ No____

- Are you hearing any voices (internal or external) or seeing any visions telling you to hurt or kill someone else?
- If yes, where are the voices/visions coming from?
- What are the voices/visions telling you?
- Do you recognize the voice or the person(s) in the vision?
- How are you coping with hearing the voices or seeing the visions?
- How long have the voices/visions been occurring? Are the intensifying (occurring more frequently, for longer periods of time?)

If command hallucinations are occurring, risk of harm to others is very high. Immediate medical attention/psychiatric assessment should be sought. If person is unwilling to do so, an involuntary hospital admission may be needed.

Overall Evaluation of Risk for Danger to Others:

None Low Moderate High

- Risk is high if the individual has a clear plan, means, and access to the person(s) s/he wishes to harm/kill
- Command hallucinations also present high risk. Hallucinations could lead the individual to act impulsively, even if a clear plan and access are not in place.
- A violent history, lack of remorse, no fear of consequences all further increase risk.

None to Low risk when thoughts are more based in anger with no plan of action and no access/means available to act on thoughts.

Clinical Presentation:

Angry	Weight Change	Indifferent
Anxious	Substance Abuse	Incoherent
Hallucinating	Self-Harm	Alert
Coherent	Agitated	Sleep change
Sadness	Paranoid/Delusional	Hopeless/helpless
Labile (rapid change in mood/presentation)	Disoriented	Appetite disturbance

Specifics:

Risk Assessment:

Danger to Self	Yes____ No____
Suicidal Ideation	Yes____ No____
Suicide Plan	Yes____ No____
Access to plan	Yes____ No____
Preparations made	Yes____ No____
Previous attempts	Yes____ No____
Command hallucinations	Yes____ No____
Fmaily/Network History	Yes____ No____
Withdraw/Isolated	Yes____ No____
Future Orientation	Yes____ No____
Danger to others	Yes____ No____
Homicidal thoughts	Yes____ No____
Current Violent Thoughts	Yes____ No____
Access to plan	Yes____ No____

Violent history	Yes____ No____
Fears consequences	Yes____ No____

Risk Assessment Summary:

Self	None	Low	Moderate	High
Others	None	Low	Moderate	High

Wants help: Yes____ No____

Specifics & Action Plan: