The Mental Status Exam (MSE)

Purpose The Mental Status Exam (MSE) is a series of questions and observations that provide a snapshot of a client's current mental, cognitive, and behavioural condition.

Goals The Mental Status Exam has the following three goals:

(1) To get a baseline measure of psychological functioning

(2) To get a measure of biological, psychological and social factors that predisposed, precipitated, and perpetuate the client's current functioning

(3) To establish a client's capacity to function.

When to Use

The Mental Status Exam is done during first interviews, when there is reason to believe a client is cognitively altered, and during a crisis or emergency situation.

*****Safety for the client and/or the worker takes priority over completing the Mental Status Examination.*****

Procedure The Mental Status Examination is best done through the normal progress of a first interview, by observing a client's verbal and non-verbal behaviour. Areas of inquiry include:

(1) Observations of appearance, activity level, behaviour, speech, and attitude toward the interviewer

(2) Level of consciousness

(3) Thought content

(4) Affect and Mood

(5) Cognition, reality contact, memory

(6) Confidence in information given.

See The Form MSE for step by step instructions and a list of questions.

Department of Health & Social Services
Mental Status Examination

Circle all that apply	*Column A (Normal)*	*Column B (Problem)*	*Column C (Problem)*
1. General Appearance	well groomed	unkept	very poor
2. Attitude	cooperative	uncooperative	very angry
3. Health	good	poor	very poor
4. Activity Level	alert	slowed	agitated
5. Speech	fluent	slowed	broken
6. Level of consciousness	coherent	periods of loss of consciousness	
7. Affect and Mood	normal	sad	manic
8. Thought content	spontaneous	illogical	flight of ideas
9. Preoccupations	none	antisocial	obsessions
10.Hallucinations/ Delusions	none	voices/visions	persecutions
11.Suicidality	no pattern	threats	plan/attempt
12.Cognition/Thinking	orientation x3	incomplete	disorganized
13.Memory	normal	slowed	difficult
14.Intoxication	none	drinking	intoxicated
15.Confidence in MSE information	good	poor	very poor

****** Items circled in column B and C, indicate action is needed******

Signature of Counsellor: Date:

COMMUNITY COUNSELLING PROGRAM

MENTAL STATUS EXAMINATION

Notation Symbols To Use

√ = Determination Made
ND = No Data And Cannot Be Inferred
HX = History: Described But Not Demonstrated

Abbreviation Explanations

NP = Not Present
S or **O** = Slight or Occasional
M or **R** = Marked or Repeated

			NP	S	O	M	R
		1. Physically unkempt, unclean					
Appearance		2. Clothing disheveled, dirty					
		3. Clothing atypical, unusual, bizarre					
		4. Unusual physical characteristics					
Comments Re: Appearance							
		5. Slumped					
	Posture	6. Rigid, tense					
		7. Atypical, inappropriate					
		8. Anxiety, fear, apprehension					
	Facial	9. Depression, sadness					
	Expression	10. Anger, hostility					
	Suggests	11. Decreased variability of expression					
		12. Bizarreness, inappropriateness					
Behavior							
		13. Accelerated, increased speed					
	General	14. Decreased, slowed					
	Movements	15. Atypical, peculiar, inappropriate					
		16. Restlessness, fidgety					
	Quality	17. Increased, loud					
	Of	18. Decreased, slowed					
	Speech	19. Atypical quality, slurring, stammer					
		20. Domineering					
	Interviewer-	21. Submissive, overly compliant					
	Patient	22. Provocative					
	Relationship	23. Suspicious					
		24. Uncooperative					

Comments Re: Behavior							
			NP	S	O	M	R
		25. Inappropriate to thought content					
		26. Increased lability of affect					
		27. Blunted, absent, unvarying					
Feeling (Affect/Mood)		PREDOMINANT MOOD IS					
		28. Euphoria, elation					
		29. Anger, hostility					
		30. Fear, anxiety, apprehension					
		31. Depression, sadness					
Comments Re: Feeling							
		32. Illusions					
Perception		33. Auditory hallucinations					
		34. Visual hallucinations					
		35. Other type of hallucination					
Comments Re: Perception							
		36. Impaired level of consciousness					
	Intellectual	37. Impaired attention span/concentration					
	Functioning	38. Impaired abstract thinking					
		39. Impaired calculation ability					
		40. Impaired intelligence					
		41. Disoriented to person					
	Orientation	42. Disoriented to place					
Thinking		43. Disoriented to time					
	Insight	44. Difficulty in acknowledging the presence of psychological problems					
		45. Mostly blames others or circumstances for problems					
	Judgment	46. Impaired ability to manage daily living activities					
		47. Impaired ability to make reasonable like decisions					
		48. Impaired immediate recall					
	Memory	49. Impaired recent memory					
		50. Impaired remote memory					
		51. Obsessions					
	Thought	52. Compulsions					
	Content	53. Phobias					
		54. Derealization/depersonalization					

			NP	S	O	M	R
	Thought	55. Suicidal ideation					
	Content	56. Homicidal ideation					
	(Con't)	57. Delusions					
Thinking		58. Ideas of reference					
(Con't)		59. Ideas of influence					
	Stream of	60. Associational disturbance					
	Thought	61. Thought flow decreased, slowed					
		62. Thought flow increased					

Comments Re: Thinking

MENTAL STATUS EXAM COMPLETED IN 24 HOURS OF ASSESSMENT

SIGNATURE	
DATE	
TIME	

ADULT SCREENING ASSESSMENT INTERVIEW FORM

(This form has been adapted from AADAC)

Client Name _____ Interviewer Name _____

Client Phone Number _____ Date of Interview _____

What made you decide to come to services at this time? *(If you were referred by someone else, what is your understanding about why they referred you?)*

_____

_____

_____

_____

_____

_____

_____

NOTES:

Initial Treatment Plan:

_____

_____

_____

A. Addiction Severity

1. Information on Addiction Severity

IDENTIFY BEHAVIOUR *i.e.; Alcohol, Drug (Specify), Gambling*				
Pattern - (daily, weekends, bender)				
Quantity - per: day, weekend, bender				
When/Age use started				
When problematic use began				
Changes in pattern or periods of abstinence				
Method of Administration				
Context of Use *(where, with whom)*				
Last Use				
Withdrawal - *symptoms & frequency*				

2. What are the good things about your alcohol/drug use and/or gambling behaviour?

_____
_____
_____
_____
_____

3. What are the less good things about your alcohol/drug use and/or gambling behaviour?

_____
_____
_____
_____
_____

4. What effects have you experienced in your life as a result of your alcohol/drug use and/or gambling behaviour?

❒ Family	❒ Relationships/Social Life
❒ Employment	❒ Financial
❒ Educational	❒ Physical Health
❒ Legal	❒ Emotional/Psychological
❒ Spiritual	❒ Leisure

5. When did you first begin to question your alcohol/drug use/gambling behaviour?

_____
_____
_____

6. Have you made attempts on your own to change your alcohol, drug and/or gambling behaviour? Have you had other (previous/current) treatment for your alcohol, drug and/or gambling behaviour?

_____

_____

_____

_____

7. ADDICTION SEVERITY RATING

	no real problem treatment not indicated		**slight problem** treatment probably not necessary		**moderate problem** some treatment indicated		**considerable problem** treatment necessary		**extreme problem** treatment absolutely necessary	
Alcohol	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Drug	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Gambling	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**

ADS Score_____ DAST Score_____ SOGS Score_____

B. Medical

1. At the present time are you taking any medication prescribed by a doctor?

❒ Yes ❒ No

If yes, what medication(s)? _____

_____

_____

Current Doctor's Name: _____

Reason prescribed:_____

_____

2. Are you taking any over the counter medications?

❒ Yes ❒ No

If yes, what medications? _____

_____

Reason: _____

_____

3. (For Women) Are you Pregnant?

❒ Yes ❒ No

4. Do you have any chronic medical problems? (that is any medical problem that interferes in your daily life in some way, e.g., asthma, diabetes, back problems, disabilities)?

❒ Yes (Specify) _____

_____

❒ No

5. Have you experienced any medical problems in the last month?

❒ Yes (Specify) _____

_____

❒ No

6. MEDICAL RATING

no real problem treatment not indicated		**slight problem** treatment probably not necessary		**moderate problem** some treatment indicated		**considerable problem** treatment necessary		**extreme problem** treatment absolutely necessary	
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**

C. Psychological/Emotional Functioning

1. Have you ever seen a doctor or counsellor for psychological, emotional or mental health concerns? (depression, stress, etc.)

❒ Yes (Specify) _____ ❒ No

2. Have you ever:

			Related to use		
	Yes	**No**	**Yes**	**No**	**Notes**
a) Experienced serious depression					
b) Experienced serious anxiety or tension					
c) Experienced thoughts of suicide					
d) Attempted suicide					
e) Have you thought about suicide in the last few days✡					
f) Experienced trouble controlling violent behaviour					
g) Been abused (physical, emotional, sexual)					

✡ If the client is currently having suicidal thoughts, then conduct a suicide risk assessment.

3. At the time of the interview, is the client: (To be completed by the interviewer only. Mark all that apply)

- ❒ Obviously depressed/withdrawn
- ❒ Obviously hostile
- ❒ Obviously anxious/nervous
- ❒ Having trouble with reality testing, thought disorders, paranoid thinking
- ❒ Having trouble comprehending, concentrating, remembering
- ❒ Having suicidal thoughts
- ❒ Other (specify _____)
- ❒ Showing no signs of the above problems

4. Psychological/Emotional Functioning Rating

no real problem	**slight problem**	**moderate problem**	**considerable problem**	**extreme problem**
treatment not indicated	treatment probably not necessary	some treatment indicated	treatment necessary	treatment absolutely necessary
0 1	**2 3**	**4 5**	**6 7**	**8 9**

D. Social Stability

1. At present are you living in:

- ❒ a house or apartment **(2)**
- ❒ a room **(1)**
- ❒ have no residence **(0)**

2. Are you currently living with others who are emotionally supportive of you?

❒ Yes **(2)** ❒ No **(0)**

3. Do you have contact with a support system: *(Family, 12 Step involvement, Close Friends)*

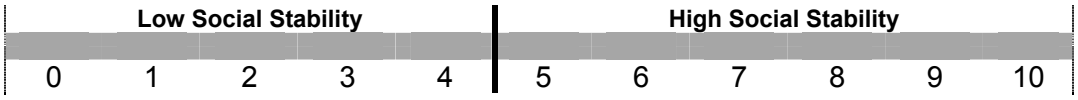
❒ Daily **(2)** ❒ Monthly **(0)**
❒ Weekly **(1)** ❒ No Contact **(0)**

4. Do you have a stable source of income?

- ❒ Yes **(2)** What source?_____
- ❒ Sometimes **(1)**
- ❒ No **(0)**

5. In the past 12 months have you:

- ❒ Been a student or employed full time for 12 months **(2)**
- ❒ Been a student or employed full time for 6 – 11 months or part time for 12 months **(1)**
- ❒ Otherwise **(0)**



E. Readiness for Change

1.

Client Rating	Interviewer Rating	Current Motivational Stage
❒	❒	1. Pre-contemplation
❒	❒	2. Contemplation
❒	❒	3. Preparing for Action
❒	❒	4. Action
❒	❒	5. Maintenance

2. How can we be helpful to you at this time? *(Pre-contemplators & Contemplators) or* **How can we be helpful to you in making change now?** *(Preparing for Action, Action and Maintenance stages)*

_____

_____

_____

F. Final Question

1. Is there anything else that you think is important for me to know?

_____

_____

_____

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Circle the number that best describes your situation today.

1. I am not worried about my use of alcohol or drugs or my gambling, and I am here only because someone else requested I come.

2. I am not sure if I have a problem with alcohol, drugs or gambling.

3. I know I have a problem with alcohol, drugs or gambling, but I am not sure how to change it.

4. I am ready to make changes, and I am here to get help to make those changes.

5. I have already made the changes I need to make and I want help to maintain those changes.

Treatment Goals Checklist

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Date: _____

Client Name:_____

The following is a list of goals that people coming to treatment sometimes have. Please indicate which are your present goals by circling Yes and which are not your present goals by circling No.

1.	To deal with my problem of alcohol and/or drug use and/or gambling.	Yes	No
2.	To learn to manage stress appropriately.	Yes	No
3.	To learn to stand up for myself better.	Yes	No
4.	To be able to deal with my feelings and express them directly.	Yes	No
5.	To improve my relationship with members of my family (spouse, children, parents, etc.).	Yes	No
6.	To be able to get along better socially.	Yes	No
7.	To improve my ability to find and keep a job.	Yes	No
8.	To learn to use my leisure time better.	Yes	No
9.	To improve my living arrangements.	Yes	No
10.	To deal effectively with my financial problems.	Yes	No
11.	To deal effectively with my legal problems.	Yes	No
12.	To deal effectively with my medical problems.	Yes	No
13.	To manage my emotional/mental health issues appropriately.	Yes	No
14.	Other – Please Specify _____	Yes	No

SUMMARY

How many goals have you indicated? _____

Of the goals you indicated, which are the most important for you to solve at the moment?

My first most important goal is # _____
My second most important goal is # _____
My third most important goal is # _____

Suicide Risk Assessment Check List

	Low	Moderate	High
Current Plan			
Lethality of means	❑ method unlikely to be fatal or immediate (time for rescue)	❑ method potentially fatal	❑ firearms, hanging, jumping – (highly lethal and immediate methods)
Availability of means	❑ has not thought about it	❑ may not be immediately available but has access to means	❑ has means in hand
Specificity: ❖ Method (what) ❖ Time (when) ❖ Location (where) ❖ Details (how)	❑ vague ❑ unplanned	❑ has some ideas but nothing definite ❑ may have settled on a time and place	❑ well thought out ❑ immediately or near future ❑ has decided on location
Prior Behaviour			
Prior suicidal behaviour	❑ no prior attempts or previously attempted with low lethality.	❑ may have seriously attempted in past	❑ Past attempts of high lethality, may know someone close who has attempted or completed
Resources			
Significant People /Isolation	❑ large support system, concerned and available	❑ few or only one who is available	❑ none or one
Stressors			
Recent Losses (job, divorce, death)	❑ does not appear to have major losses	❑ fairly important & recent losses ❑ may have experienced multiple losses over time	❑ just had important loss (often the last straw) ❑ fearful of impending loss (e.g. divorce, losing job etc)
Symptoms			
Cognitive/Behavioural	❑ cognitive (thinking) and behavioural functioning is fairly stable	❑ may be losing perspective (sees death as only way out) ❑ may have difficulty eating, sleeping etc.	❑ may have difficulty controlling thoughts and managing emotions.
Hopelessness/ Helplessness	❑ vague feelings of depression/isolation, but demonstrates ability to consider other life-sustaining solutions.	❑ Some feelings of helplessness-hopelessness, depression	❑ Overwhelming feelings of hopelessness, helplessness, depression

Source: Suicide Information Education Centre/Suicide Prevention Training Programs Calgary AB 1999

COMMUNITY COUNSELLING PROGRAM

CLIENT CARE PLAN

CLIENT NAME: _____

DATE OF BIRTH: _____

DIAGNOSIS: _____

MEDICATIONS:	**DOSAGE:**	**COMPLIANCY:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHYSICIAN: _____

PSYCHIATRIST: _____

CARE PLAN:

RECOMENDATIONS:

Signature of Case-Worker	**Signature of Client**
Date	**Time**

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GUIDELINES FOR THE

CLIENT CARE PLAN

The Client Care Plan is an essential case management tool when working with and monitoring the progress of clients, especially those with a psychiatric diagnosis who have a reasonable degree of independent living and functioning at the community level. This tool has been utilized effectively and efficiently in Mental Health throughout the Southern provinces of Canada.

The implementation of this tool is innovative and empowering, especially for the Client but it also lends itself to cost effective client management. At a time when Government is no longer at liberty to financially support inefficient use of expensive services such as medivac and after hour care, the Client Care Plan lends itself to minimizing such unnecessary costs by preventing the misuse and duplication of services of Health and Social Services, NGO's and other partners.

The Client Care Plan (CCP) can be utilized effectively in a Case Management Team approach, which should always include the Client. In terms of its function, the CCP consists of the following components:

1. Identifying the client's needs and support systems
2. Reviewing the client's coping mechanisms, strategies and resources
3. Identifying the Case Manager
4. Identifying the after hour services
5. Reviewing the appropriate use/access of services (including after hour/emergency services)
6. Reviewing the consequences/expectations that will result if the client and/or professionals deviate from this plan.

It is essential that both the client and the professionals agree to the terms of the CCP as well as agree to follow the plan, otherwise, it will neither facilitate consistency in care nor client ownership and responsibility for his/her behaviors.

The Client Care Plan assists in the management of clients with a Psychiatric Diagnosis and works particularly well with those individuals diagnosed with a major mental illness such as Schizophrenia, Bipolar Affective Disorder, Depression, Anxiety Disorders, and Personality Disorders e.g. Borderline Personality Disorder (BPD).

Here is an example of the advantages of utilizing the CCP with a client diagnosed with BPD. The Diagnostic and Statistical Manual of Mental Disorders: Forth Edition defines the disorder in the following terms;

> "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts."

That is to say, the client possesses poor impulse control, highly manipulative behavior, and frequent suicidal ideations/gestures/attempts. They are clients who are attention-seeking individuals that will adopt and engage in negative behaviors such as, self harming/self mutilating behaviors, in exchange for attention. They are not, however, discretionary in the type of attention they provoke, i.e., they do not necessarily look for positive attention, as long as it is attention focused on the self. In the realm of professional energies, the client is very "high maintenance".

Thus, it is very important for care providers in the community to have the insight and ability to adhere to consistent client care management and acknowledge the importance of providing optimum and effective client care. In turn, it is a tool that if followed closely and consistently, will assist in the decrease of professional "burn-out" with respect to providing services to that particular client. In addition, it will clearly define limits and boundaries for the client and staff, thus decreasing the potential for the occurrence and/or fostering of manipulative behaviors. However, if the professionals or the clients do not respect the CCP, then you will have a situation that is manipulated by the behaviors of the consumer, who, in this case in point, suffers from BPD. As already noted above, its diagnostic features make for the potential of increased manipulative behaviors, inappropriate use of emergency/after hours services, duplication of services, etc. This ultimately leaves both the service providers and the client at a high level of frustration.

The Client Care Plan lists client's medications in the following format:

1. Name of the Medication
2. Doseage of the Medication
3. Compliancy of the Medication

These are key components to a client's medication regimen. It is not sufficient to record one or two of these components; all three must be assessed in relation to each other.

It is important to know the client's Psychiatrist as it is this professional who should be consulted when there are problems with the medication(s). It is also this

individual who will be familiar with the client's psychiatric history and current diagnostic features of their mental illness in terms of the expressed symtomologies. In addition, it is very important to know the client's baseline, if you do not know then one must obtain this information from a professional who knows the client well, either the psychiatrist, the nurse, or the social worker. Without the client's baseline, the professionals involved in assessing and working with the client on a continuous basis, will not have a reference point from which to work. Any future care plans or treatment recommendations will be skewed if one is basing decisions on inaccurate information.

You will also note that there is a section for "Recommendations". This is included in the plan for outlining goals or objectives that may be premature for the present but possible in the future. It is also a section that can be utilized for notations in reference to interventions that were successful and those that were unsuccessful. Like any plan, goals always need to be identified, implemented, evaluated, and reviewed. In the case of Client Care Plans, the client must be involved in the planning stage of the care plan and also be in agreement with the plan itself, otherwise, it will be ineffective and fail. This not only would be disappointing for the staff involved but also setting up the client for failure and therefore possible regression.

The CCP should be reviewed on a monthly basis with the Case Manager and the client. If the family has also been identified as a good support to the client, or if the client is under the age of 18 years of age, then the CCP should be reviewed with the family members, as they will be an integral part of the CCP. If there are changes or omissions to the plan, they should be communicated, in writing, to the rest of the Primary Community Care Team, i.e. Mental Health/Addiction Counselor, Social Worker, Community Health Nurse, Community Wellness Workers and others as required, in a timely fashion.

Department of Health & Social Services
Suicide Risk Assessment

Purpose The Suicide Risk Assessment[1] is a process of asking specific questions with a client, to determine the relative risk of suicidal behaviour. Although, research determines there is no way of predicting suicidal behaviour in all people, there are several basic factors for judging a person at risk for completing suicide.

Goals The Suicide Risk Assessment, as adapted for use in the NWT has the following three goals:

(1) To determine the immediate risk of suicide (Current Suicide Plan, Prior suicidal behaviour, and Resources or C.P.R).

(2) To assess risk factors for suicidal behaviour such as addiction, stresses and limited coping abilities.

(3) To assist in care planning in the immediate and short term, given suicidal tendencies are present.

When to Use

(1) The Suicide Risk Assessment, as adapted for the NWT is done during any and all times where there is reason to suspect suicidal actions or tendencies.

(2) When a client is referred for a suicidal risk assessment from other agencies and individuals in the community.

(3) As part of an intake or screening interview for new clients

*****Safety for the client and/or the worker takes priority over completing the Suicidal Risk Assessment.*****

Procedure The Suicide Risk Assessment is best done through the normal progress of an interview with a client, but can also be used as a step by step list of questions to ask. Areas of inquiry include:

See The SRA Form for step by step instructions and a list of questions.

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[1] Adapted from Los Angeles Suicide Prevention Centre (1990), Department of Health and Social Services, Nunavut (2003) and Valfre (2001) Essentials of Mental Health Care.

RISK ASSSESSMENT MATRIX

	MILD	MODERATE	HIGH/IMMINENT
IDEATION	Has periodic intense thoughts of death or not wanting to live that last a short while	Regularly occurring, intense thoughts of death &/or wanting to die, that are often difficult to dispel	Thoughts of death or wanting to die are very intense & seem impossible to get rid of
IMMEDIACY OF PLANS	No immediate. suicide plan No threats Does not want to die	Not sure when but soon Indirect threat Ambivalent about dying	Has imminent date, time in mind Clear threats Doesn't want to live Wants to die
METHOD	Means unavailable Unrealistic or not thought through	Lethality of method is variable with some likelihood of rescue or intervention	Lethal, available method with no chance for intervention
EMOTIONAL STATE OR MOOD	Sad, cries easily Irritable	Pattern of "up and down" mood swings. Rarely expresses any feelings.	No vitality (emotionally numb) Emotional turmoil (anxious, agitated and angry)
LEVEL OF EMOTIONAL DISTRESS	Mild, emotional hurt	Moderately intense	Unbearable emotional distress or despair Feels rejected, unconnected, and with no support
SUPPORT/ PROTECT-IVE FACTORS	Feels cared for by - family, peers and/or other adults	Minimal or fragile support Moderate conflict with parents and peers	Intense conflict with parents and/or peers Socially isolated
PREVIOUS ATTEMPTS	None	1 previous attempt Some suicidal behaviour	Previous attempts Severe self-mutilation
REASON TO LIVE/HOPE	Wants things to change and has some hope Has some future plans	Pessimistic hope Vague, negative future plans	Feels hopeless, helpless, powerless Sees future as meaningless, empty
SYMPTOMS OF DE-PRESSION	Down and out; Irritable mood; Loss of interests and joy; Loss of energy; No motivation; hyper or slowed down; Eats: to much or too little; Sleeps to much or not enough; Can't concentrate; Feels extreme guilt; Feels worthless		
OTHER RISK FACTORS	Family history of suicidal behaviour; Suicidal friends; Current loss; Previous losses; Substance misuse; Current school problems; Recent criminal charges; Has a diagnosed mental health disorder; Is very impulsive; Has negative attitudes re: seeking help; Parent(s) or helps do not take the child/youth's suicidality seriously.		
OVERALL RISK			

Adapted from Regional MCF Risk Assessment Form

Department of Health and Social Services
SUICIDE DATA FORM-2003

Full Name _____
Surname All Given Names

Gender: Male ☐ Female ☐

Marital Status

S-ingle **M**-arried **W**-idowed **D**-ivorced **A**-part (separated) **C**-ommon-law _____

Community where death occurred_____Region _____

Home Community _____ Region _____

Date of Birth _____ Date of Death _____ Age _____
Year Month Day Year Month Day

Employed at Time of Death: Yes ☐ No ☐

If yes, was employment (circle all that apply):

Seasonal Full Time Part Time Self-Employment

Location of Death: At Home ☐ Other ☐ Specify _____

If at home, in what part of the home? _____

Was deceased by themselves at time of suicide? Yes ☐ No ☐

Method of Suicide:_____

Time between death and discovery _____ hours

Attempt to Resuscitate: Yes☐ No☐

Autopsy: Yes☐ No☐ Toxicology: Yes☐ No☐

Alcohol use suspected at time of death Yes☐ No☐

Drug use suspected at time of death Yes ☐ No ☐

Recent Events

EVENT	LAST 24 HOURS	PRIOR HISTORY	COMMENTS
Family breakup/separation			
Relationship breakup			
Pending criminal proceedings			
Physical or sexual abuse			
Job/Income/Status loss			
Social Exclusion by Peers			
Death of friend/relative			
Change in living situation			
School or work failure			
Change in child welfare status			
Birthday/Anniversary			
Other			

Reasons given for suicide:

_____

_____

Past suicide committed by family or person known to the deceased: Yes ☐ No ☐

WHO	RELATIONSHIP	WHEN
_____	_____	_____
_____	_____	_____
_____	_____	_____

Chronic Health Problems

1. _____

2. _____

Comments: _____
_____

MENTAL HEALTH HISTORY	√	COMMENTS
Was person seen by formal care giver during the week prior to suicide?		Specify:
Past involvement with Child Welfare Family Services?		
History of criminal conviction involving harm to another?		Type:
History of other criminal conviction?		
History of drug abuse?		
History of alcohol abuse?		
History of family violence or abuse?		Specify:
History of homosexuality?		
History of extended separation from family due to school, medical, other?		Specify:
History of abusing others?		Specify:
Psychiatric history on chart?		

Comments concerning utilization of mental health/social services: (type of agency(s), last seen, duration of treatment, hospitalizations, other help seeking behaviours)

_____
_____
_____
_____
_____
_____
_____

Other Social/Health History

Ethnicity: ____ I-nuit D-ene C-aucasian M-etis O-ther (specify) _____

Level of Education: Highest Grade Level Attained _____
Post-secondary education _____

Did deceased live alone? Yes☐ No☐

If no, type of household:

____ Spousal, no children
____ Spousal, with children
____ Single parent
____ Extended/generational
____ Foster home
____ Shared with roommates
____ Other - please specify _____

Position in Family

Parent ☐ Child ☐ (___ of ____children)

Other ☐ Please specify _____

Source of main household income

____ Employment of deceased
____ Employment (other)
____ Income Support/social assistance
____ Other (please specify) _____

Any other additional information:
_____
_____
_____
_____
_____
_____
_____

_____ _____
Signature of Person Completing Form Date and Time

_____
Position

Department of Health & Social Services

Suicide Risk Assessment

Age/Date of Birth

Gender ____ Male ____ Female Ethnicity_____

Ask the following questions and circle Yes or No. Use space to write details.

Current Suicide Plan

1. Have you thought of harming or killing yourself? Yes No
   If no, proceed to question 4.

_____
_____

2. Do you have a plan in place to harm yourself? Yes No
   If you were to harm yourself, how would you go about it?

   __Pills __Firearm/gun __Truck/boat/car __Other

_____
_____

3. Do you have the items you need for your plan? Yes No
   What other things have you done to prepare?

   __ Suicide Note __Giving Items away

_____
_____

Prior Suicidal Behaviour

4. Have you thought or attempted to harm yourself before? Yes No
   When? What Method? How was it resolved?

_____
_____

Resources & Buffers

5. Do you have reasons that keep you from harming yourself? Yes No
   What? Who?

_____
_____

Stress and Symptoms

6. Do you have any health or addiction problems? Yes No

_____
_____

7. Have you noticed a change in your drinking/drug use? Yes No

_____
_____

8. Have you noticed changes in your feelings/ability to cope? Yes No

_____
_____

9. Are you under significant stress at this time? Yes No

__Grief/loss __Housing __Job __Family __Legal

_____
_____

10. Do you think you can control your behaviour and refrain from acting on your suicidal thoughts or impulses?

Yes No

_____
_____

Risk Assessment Summary		Action
____ Low Risk	→	Safety plan, weekly monitoring & counselling as necessary.
____ Increased Risk	→	Safety plan, daily monitoring, counselling and involvement of community resources
____ Extremely High Risk	→	Follow Suicide Intervention Protocol

_____ _____
Signature Date and Time

_____
Position

COMMUNITY COUNSELLING PROGRAM

SUICIDE RISK ASSESSMENT

Age Ranges: 0-15 ___ 16-20 ___ 21-30 ___ 31-40 ____ 41-60 ___ <61 ___

Gender: Male ☐ Female ☐ Ethnicity:

Suicide Risk Estimation - Indicators

Suicidal Ideation	**Yes ☐**	**No ☐**	**Stresses**	**Yes ☐**	**No ☐**
__ Isolated Thoughts			__ Significant Loss		
__ Frequent Thoughts			__ Intolerable Loss		
__ Threatening Suicide			__ Alone/Isolated		
__ Attempt In Progress			__ Mental Disorder		
__ Threats (Indirect)			__ Abuse or Assault		
			__ Alcohol Involved		
			__ Drugs Involved		
			__ Law Involvement		

Symptoms	**Yes ☐**	**No ☐**
__ Change In Behavior		
__ Change In Physical Condition		
__ Change In Thoughts		
__ Change In Feelings		
__ Give Away Possessions		

C.P.R. – Predictors

Current Suicide Plan **Yes ☐** **No ☐** **Preparations** **Yes ☐ No ☐**

__ Unspecified
__ Overdose
__ Firearms
__ Vehicle Collision
__ Slashing/Stabbing
__ Carbon Monoxide
__ Jumping
__ Hanging
__ Other (Specify)

__ Means Acquired
__ Means Easily Available
__ Suicide Note Written
__ Unknown

Timing **Yes ☐ No ☐** **Prior Suicidal Behavior** **Yes ☐ No ☐**

__ Immediate
__ Within 24 Hours
__ After 24 Hours
__ Unknown

__ Isolated Thoughts
__ Frequent Thoughts
__ History of Previous Attempts
__ Suicide of Significant Figure

Resources **Yes ☐ No ☐** **Risk Estimation**

__ Internal Resources
__ External Resources

__ High
__ Medium
__ Low
__ Unknown

_____
Signature (position designation)

Date: **Time (hrs):**

COMMUNITY COUNSELLING PROGRAM
SUICIDE STATISTICS FORM

SUICIDE COMPLETIONS & ATTEMPTS

Gender: Male ___ Female ___ Place of Residence: _____

Age Ranges: 0-15 ____ 16-20 ____ 21-30 ____ 31-40 ____ 41-60 ____ <61 ____

Inuit ____ Dene ____ Non-Inuit ____

Married ____ Single ____ Common Law ____ Divorced ____ Separated ____

Employed ____ Unemployed ____ Student ____ Retired ____

Children: Yes ___ Number of Children _____
No ___

Known Psychiatric Diagnosis _____ Psychiatrist _____

SUICIDE COMPLETION ____ **SUICIDE ATTEMPT ____**

Date of Completion/Attempt (Y/M/D) ____/____/____ Approx. Time (Hrs) _____

Method _____ Current Status _____

Community Where Incident Occurred _____

Prior Suicide Attempts Yes ____ No ____ U/K ____

Year _____ Method _____
Year _____ Method _____
Year _____ Method _____
Year _____ Method _____

Familial History of Attempts/Completions Yes ____ No ____
Significant Other History of Attempts/Completions Yes ____ No ____
Relationship to Client _____ Year _____ Method _____
Relationship to Client _____ Year _____ Method _____

Risk Factors Involved At Time of Incident:

Alcohol ____ Gambling ____
Drugs ____ Assault ____
Depression ____ Law ____
Relationship Problems ____
Recent Intolerable Loss ____

Was Client Medivaced? Yes ____ No ____ Hospital_____

Date of Medivac (Y/M/D) ____/____/____ Receiving Physician _____

Status at Hospital _____

Was Follow-Up Referral Made? Yes ____ Name _____
Agency _____

No ____ Reason _____
_____

_____

Name (Indicate Designation) _____ Telephone _____

Date (Y/M/D) _____ Time (Hrs) _____

Please complete this form within 24hours of incident and fax to Clinical Supervisor for Community Counselling Program.