Suicide Awareness & Assessment

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Suicide Awareness

- Suicide rates
- Why suicide?

United States Suicide Rates

- 30 year high
- 13.9 deaths per 100,000 die by suicide:
  - 44,965 in 2016
  - 29,199 in 1999
- Increased in every age group (except older adults)
- Highest increase:
  - middle aged
  - women (across lifespan)

U.S. Suicide Rate Surge to a 30-Year High; New York Times, April 22, 2016, retrieved April 24, 2016.
United States Suicide Rates

- Scope of suicide: (CDC, Facts at a Glance, 2015)
  - 9.3 million adults had suicidal thoughts in past year
  - 2.7 mil adults had suicide plans
  - 1.3 mil adults attempted suicide (1 in every 29 seconds)
  - 1 death by suicide every 11.9 minutes

Why Suicide?

Interpersonal-Psychological Theory of Suicidal Behavior

Individual: has desire to die by suicide & the ability to do so
1. feeling like a burden to others
2. feelings of loneliness/social disconnect
3. learned to overcome fears related to pain, injury or death

Dr. Thomas Joiner

Prevention of Suicide

- Increase rate of suicide across the United States
  - The Joint Commission (TJC) – issued a Sentinel Event Alert.
    - Issue 56 – February 24, 2016
- Effective suicide prevention includes clinical preventative services.
- Clinical preventative services includes:
  - Preventative screening.
  - Suicide assessment by primary care and health care providers
- It is important that we identify individuals who are at risk for suicide in all settings.
- The use of consistent screening and assessment tools combined with the examination of one’s entire clinical picture can help identify individuals at risk for suicide (use of SAFE-T model).
Suicide Assessment Five-step Evaluation and Triage (SAFE-T) model
- Asking specifically about suicide
- Complexity of suicide; attitudes, beliefs and barriers
- Suicidal Cues, invitations and warning signs
- Means education and impulsivity
- SAFE-T documentation

Conduct a suicide assessment

Steps of the SAFE-T Model
1. Identify risk factors – noting those that can be modified to reduce risk.
2. Identify protective factors – noting those that can be enhanced.
3. Ask specifically about suicide – suicide thoughts, plans, behaviors, intent.
4. Determine level of risk and choose appropriate intervention to address and reduce risk.
5. Document the assessment of risk, rationale, intervention and follow-up instructions.

Source: SAMHSA (www.samhsa.gov)
SAFE-T Model Recommendation

• Suicide Assessments should be conducted…
  - at first contact
  - with any subsequent suicidal behavior, increased ideation, or pertinent clinical change
  - treatment plan reviews and prior to a change in treatment plan (i.e., progress to next phase)
  - at discharge

Step 1: Identify risk factors

Modifying Risk Factors

• Risk factors can be modified through treatment & intervention to reduce suicide risk.
  – Specific psychiatric symptoms: can be treated with medications and psychotherapy.
  – Environmental: access to firearms and other lethal means of suicide can be restricted. Individuals can be observed. Medications secured/monitored; firearms removed, car keys removed, etc.
  – Inadequate/lack of social supports: family members and close friends can be educated about illness and resources to provide more social support.
Step 2. Protective Factors

Protective factors may not counteract significant acute suicide risk

NOTE: Some protective factors are time sensitive

Internal: Stress management, hope, coping skills

Protective factors:
Internal Protective Factors

- Sense of responsibility to family, children, and/or pets
- Religious beliefs/spirituality
- Ability to cope with stress
- Optimistic outlook
- Positive coping skills
- Fear of death or the actual act of killing oneself

External: pets, family, relations, connections

External Protective Factors:

- Engaged in exercise, hobbies, interests, and outside use disorders; seeking to access treatment and support, maintain therapeutic relationship
- Supportive community, social network, family and friends supports
- Presence of pets for whom the individual has a strong affinity
- Can identify supports (family, personal connections, other relationship) – specify in comments
- Able to develop a crisis/safety plan to protect against suicide/homicide
- Engaged in work or school

- Today’s reasons for living (protective factors) can be tomorrow’s reasons for dying (risk factors)

- Ask when only a few protective factors are identified

What do you think you would do if your current protective factor(s) were not available?
Step 3. Ask Specifically About Suicide

When asking about suicide we should...

**To Do:**
- Be engaging; build trust & rapport
- Put the individual and their needs first
- Demonstrate empathy, show you care
- Create a conversational approach
- Validate and validate the concerns raised
- Focus the conversation on the person and not the suicide
- Take the time to find out about "why suicide"

Suicide is Complex

Our attitudes/beliefs regarding suicide can become a barrier

Barriers for talking about one's risk for suicide

Key: reduce barriers by having a conversational approach and building rapport
Suicidal Cues

Feelings

Statements

Thoughts

Situations

Physical

Behaviors

Invitations, which are warning signs or cues someone may be at risk for suicide, are often associated with loss and/or pain.

Step 3. Ask Specifically About Suicide

What’s the best way to ask about suicide?

Ask:

In the past month, including today, has there been a time when you wished you were dead, had passive suicide thoughts or believed that suicide could be an option for you?

Be Direct:

Suicide vs. Hurt Oneself

Step 3. Ask Specifically About Suicide

Does “No” Mean “No”?

Motivations to not report accurately one’s risk for suicide:

- Stigma
- Fear of hospitalization
- Fear of being judged
- Afraid to disappoint you/others
- Ambivalent and unsure of answer
- Incredibly difficult to acknowledge
- Fear of next steps/consequences
- Lack of trust in you
Step 3. Ask Specifically About Suicide

What if they say “Yes”?
- Do not leave the individual alone
- Explore “Why”; explore reasons for living and dying
- Modify Risk Factors / Increase Protective Factors
- Determine appropriate level of care/setting/observation level/need to be on a precaution (inpatient)
- Consult with others (supervisor, crisis agency, treatment team, etc...)
- Develop Crisis/Safety Plan
- Assess individual’s confidence that their plan will help them stay safe
- Document communication and responses with human supports in regards to their role identified in the plan

When Asking...

Not Everyone answers questions regarding suicide honestly

Also consider:
1. Means Education (Safety): awareness regarding how a person attempts suicide
2. Impulsivity: actions based on sudden urges rather than careful thought

Means Restriction (means safety)

- Can be an effective strategy used to help prevent suicide
- When lethal means are less available, suicide rates by that method decline
- Regardless if an individual reports being suicidal or does or does not identify a method for suicide, we will always assess for lethal means access including firearms/weapons
- It is important to discuss with patient and collaterals (family, etc.) means restrictions, limiting access to lethal means, and steps they will take to reduce access to such means.
- Documentation should include instructions given to the individual & significant others about firearms and other means.
Means Restriction Strategies

**THINGS**
- Gates removed, safety stored/blocked
- Medications monitored/limited
- No history shows suicide risk
- Consider hospitalization for high risk
- Check in with individual/follow up
- Compare Treatment Team notes
- Aware all limited means accessible
- Use Safety/Unit Plan
- Consult with Supervisor/Bulldozer
- Build use of “No-suicide contract”
- Increase observation/monitoring

Impulsivity as a Risk Variable

Some suicides involve careful planning, others appear to have an impulsive component & occur during a short-term crisis

- Houston study: 153 suicide attempters (ages 13-34):
  - 25% deliberated for less than 5 minutes
  - 87% deliberated less than a day

- Attempters who deliberated less than 5 minutes
  - less likely to have considered another method of suicide
  - perceived a greater likelihood of discovery
  - had a lower expectation of death

Step 4. Determine Level of Risk

Very complex; consider entire clinical picture including...
- current level of functioning
- recent changes in treatment
- diagnosis
- history related to suicidal behavior
- changes in risk/protective factors

Consider:
- individual’s level of suicidal intent
- the degree to which the person intend to die
- level of commitment to staying safe/alive

Determine:
- level of risk
- appropriate treatment setting/level of care
- plan to address risk
Step 4. Determine Level of Risk

3 Categories of Risk

- High Risk
- Moderate Risk
- Low Risk

Use SAFE-T card as reference – *see SAMHSA website to order SAFE-T cards

Strategies to Address Risk

- Assess and monitor clients for suicidal thoughts, desires, plans or history of attempts.
- Ensure that the person is receiving treatment for psychiatric disorders and/or substance use disorders.
- Facilitate prompt entry into follow-up treatment.
- Engage the family or significant others.
  - help identify suicidal risk factors.
  - assist with environmental/means restrictions (remove / safely store guns, secure medications, remove car keys, etc.)

Step 5. Document Assessment

Document the assessment of risk, rationale, intervention, follow-up, crisis/safety plan and instructions

- Must spell out details of suicide screening/assessment as well as content of crisis/safety plan
- Each time a suicide screening/assessment occurs it should be documented
- Avoid the following documentation:
  - No HI/SI
  - Individual contracted for safety
SAFE-T Documentation

DOCUMENTATION NEEDS TO INCLUDE:

- presence or absence of suicidal ideation (SI)
- level of suicidal intent
- risk/protective factors
- risk level and rationale
- plan to address/reduce current risk
- contact with collaterals/consultation
- firearm/means access instructions
- follow-up & safety plans
- list of emergency contact numbers provided

If Not documented; it didn’t happen

Never use “Contract for Safety”

A contract should never be used:
- It is an ineffective clinical approach.
- Creates a false sense of safety

“Contract for safety” should never be written in documentation.

A best practice approach is safety planning.

Summary

- Suicide in the U.S. is a serious health problem and national crisis
- We need to focus efforts on preventing suicide by screening, assessing, and responding accordingly
- SAFE-T assessment model can be a valuable tool when assessing for suicide