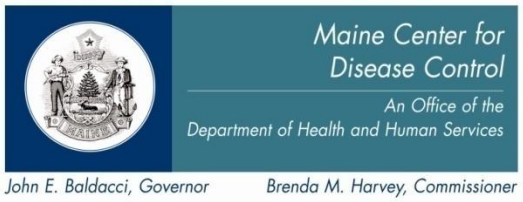
Suicide Assessment Training

Maine Youth Suicide Prevention

Education, Resources and Support–It's Up to All of Us.



MYSPP Gatekeeper Training Program

A collaborative program funded by Maine DHHS, CDC and operated by Medical Care Development since 1998

Statewide Collaborative Activities Include:

- Crisis Hotline 1-888-568-1112
- Information and Resource Center 1-800-499-0027
- Data collection, analysis & dissemination
- Dissemination of print materials and PSAs
- Training
  - Gatekeeper Training, Training of Trainers, Protocol Development
  - Student Lifelines Teacher Training
  - Suicide Assessment for Clinicians
- Lethal means education
- Technical assistance and support

MYSPP Resources

- MYSPP Website
  - Maine Youth Suicide Prevention:
  - www.suicideprevention.org
    - Gatekeeper Training Resource Book
    - Youth Suicide Prevention, Intervention & Postvention Guidelines
    - Fact sheets, resources,
    - Training and events calendar
    - Separate site for youth

MYSPP Contact Information

- Cheryl DiCara, MYSPP Program Coordinator:
  Cheryl.M.DiCara@maine.gov
  Phone: 207-287-5362
- Linda Williams, Director of Training & Education
  lwilliams@mcd.org
  Phone: 207-622-7566, ext. 243
- Greg A Marley, Director of Special Projects
  gmarley@mcd.org
  Phone: 207-701-7801

Agenda

- Suicide: Definitions and Language
- Statistics: Examination of the breadth of the problem
- Mental health disorders and suicide
- Special populations at risk
- Risk factors, warning signs and protective factors
- Conducting a suicide assessment interview
- Assessment of risk/Level of care determinations
- Working with suicidal clients
- Documentation and liability protection
- Suicide survivor needs (incl. clinicians as survivors)

Introduction

- For clinicians suicide is a specter that haunts practice. When a clinician experiences the suicide of a client, it:
  - Is a devastating loss of life
  - Leaves a crater of distress in its wake washing over
    - Family,
    - Friends, community
    - Treatment providers
  - Is easily perceived as a failure

Good assessment skills won't prevent all suicides, but…

Suicide: Definitions

- **Suicide**: Death that is self-inflicted with evidence (explicit or implicit) that the person intended to die
- **Suicide attempt**: Self injurious behavior with a non-fatal outcome accompanied by evidence of the person's desire or intent to die. (Differentiate from self harm)
- **Suicidal Ideation**: Thoughts of ending ones own life.

APA Practice Guidelines for Assessment and Tx of Pts with Suicidal Behaviors

Suicide Terms Defined

- **Suicidal threat**- "If _____, then I will kill myself.
- **Suicide Euphoria**- The calm that comes with a resolve to die; a time of planning and saying goodbye.
- **Suicidal "gesture"**- Often used to refer to a suicide attempt of low lethality. Gesture is pejorative.
- Suicide Survivor- Anyone deeply affected by the death of a loved one by suicide.

Suicide Assessment Defined

- **Suicide (risk) Assessment** refers to the establishment of a clinical judgment of risk in the very near future, based on the weighing of a very large mass of available clinical detail. Risk assessment carried out in a systematic, disciplined way is more than a guess or intuition – it is a reasoned, inductive process, and a necessary exercise in estimating probability over short periods.

Douglas Jacobs, MD

What the Statistics Tell Us

More Americans Die by Suicide Each Year Than by Homicide

Suicide: 34,598

11th ranking cause
11.5 per 100,000

Homicide: 18,361

15th ranking cause
6.1 per 100,000

Almost 2X more people killed themselves than were murdered by others in 2007

Maine 5 year average 2003 – 2007

All ages: 166 per year

10 – 24: 20 per year

Maine 2007

Suicides 191

Homicides 21

Research shows that:

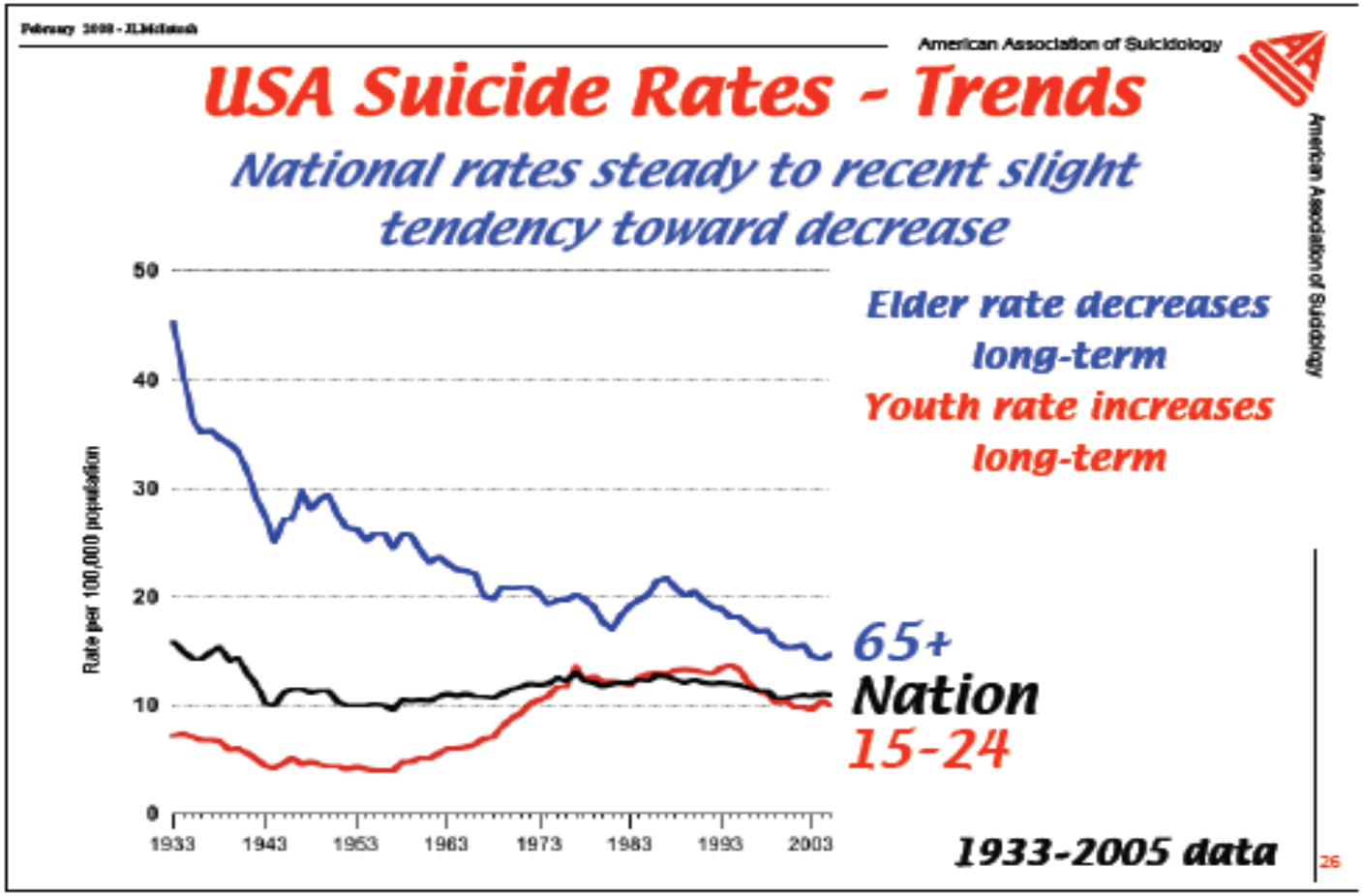
- During our lifetime:
  - 20% of us will have a suicide within our immediate family
  - 60% of us will personally know someone who dies by suicide
- Over the past year:
  - 7% knew someone who died by suicide
  - 1.1% had a family member or relative die by suicide

Youth Suicide Stats ME

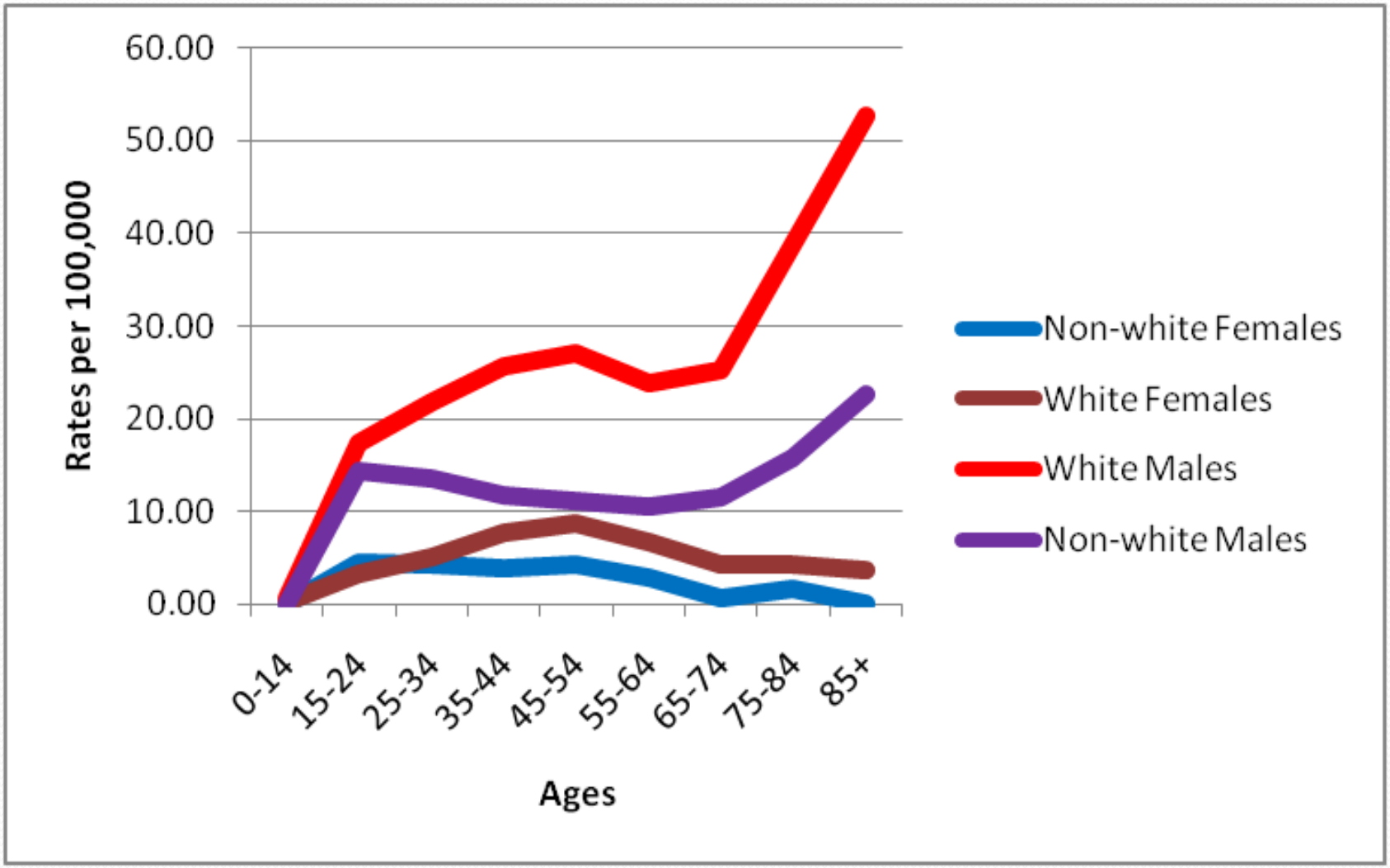
- Second leading cause of death among 15 to 24 year olds.*
- 13.8of high school students report having seriously considered suicide in the prior 12 months.**
- 19.5% of Maine 7 & 8 grade seriously considered…
- 11.8% in Maine report having made a suicide plan in the prior 12 months.**
- 9.0 of high school students report having attempted suicide.**

Youth and Elder Suicide Rates - Trends

American Association of Suicidology
2005 Official USA Statistics Overhead Set



Suicide Rates: Gender, Race, & Age



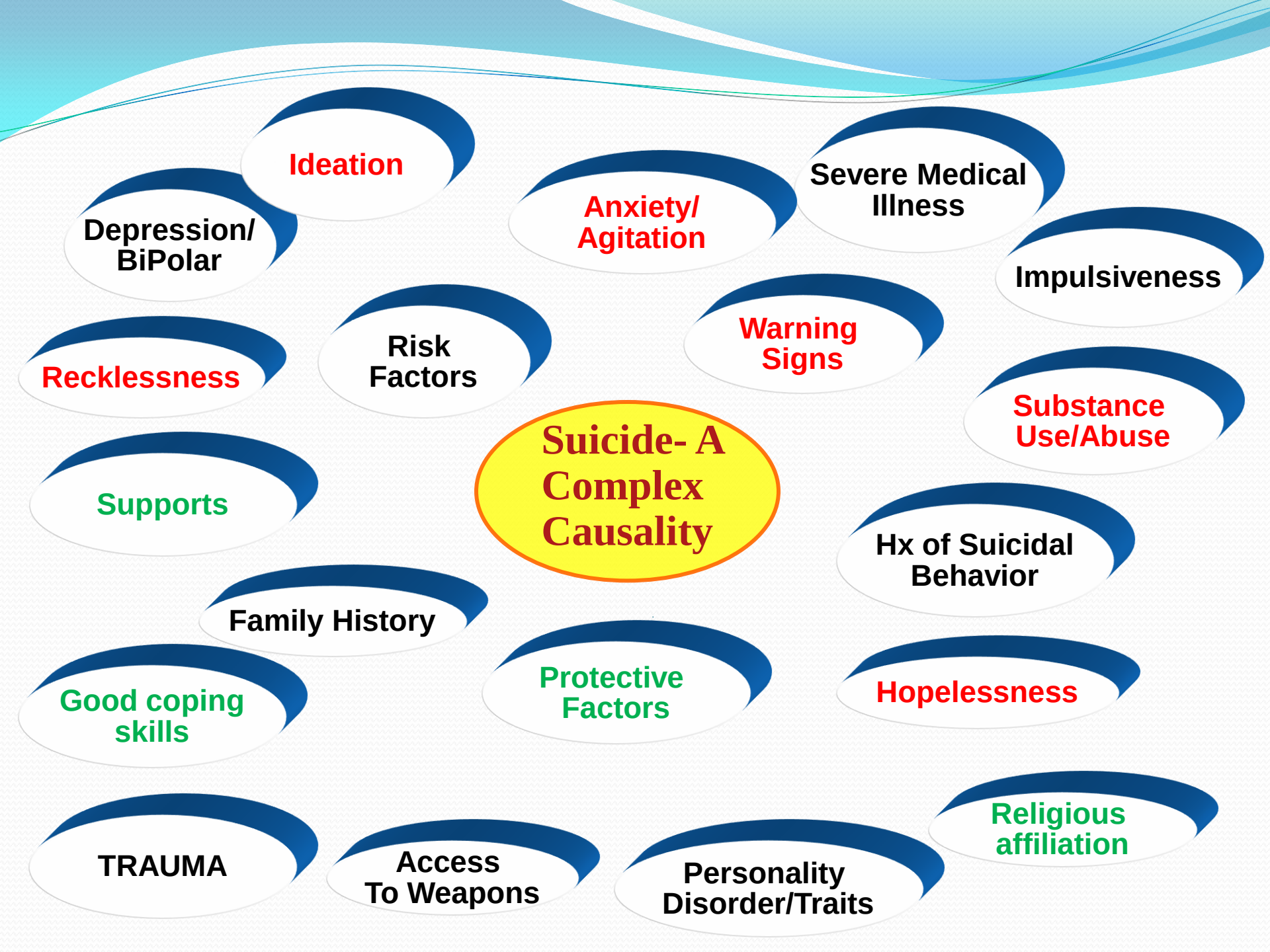
Suicide Methods (US)

population Means	% total 2007	Men	Women	Youth	Elders
Firearms	50.2%	56.0%	30.7%	47.2%	72.2%
Suffocation/ Hanging	23.6%	23.5%	18.9%	36.0%	10.4%
Poisons, gas, solid, liquid	18.4%	12.5%	40.3%	8.2%	10.8%
All other	7.8%	8.0%	10.2%	8.6%	6.6%

SUICIDE ATTEMPTS

- Estimated 25 attempts for every death by suicide
  - For youth, at least 100:1 ratio
  - For elders, 4:1 ratio with more lethal means and planning
- Females attempt 3 times as often
- Males die at a higher rate; 4:1 over females
  - More lethal means
- Though most youth attempters never again attempt suicide, it remains the strongest predictive factor for future suicidal behavior.

Warning Signs
Risk Factors
Protective Factors


Suicide- A Complex Causality
Ideation
Depression/ BiPolar
Anxiety/ Agitation
Severe Medical Illness
Impulsiveness
Recklessness
Risk Factors
Warning Signs
Substance Use/Abuse
Supports
Hx of Suicidal Behavior
Family History
Protective Factors
Hopelessness
Good coping skills
TRAUMA
Access To Weapons
Personality Disorder/Traits
Religious affiliation

Definitions:

- **Warning Signs**-the earliest observable signs that indicate the risk of suicide for an individual in the near-term (within minutes, hours or days.)
- **Risk Factors**-long standing conditions, stressful events or situations that may increase the likelihood of a suicide attempt or death. (Statistically significant)
- **Protective Factors**-the positive conditions, personal & social resources that promote resiliency and reduce the potential of suicide and other high-risk behaviors.

Two Tiered List of Warning Signs
(What to Look For & What to Do)
(AAS/Consensus Workgroup/'06)

First Tier: Overt & acute signs of a suicidal crisis:

1. Someone threatening to hurt or kill themselves
2. Someone looking for the means (gun, pills, rope etc.) to kill themselves
3. Someone talking or writing about their own death or suicide

- Are you or someone you love contemplating suicide?
- Get the Facts & Take Action.
- Call 911 or seek other immediate help when you hear, say or see any of these behaviors

Warning Signs Mnemonic

(from AAS, 2006)

- ❑ **I** **Ideation** / threatened or communicated
- ❑ **S** **Substance Abuse** / excessive or increased?

- ❑ **P** **Purposelessness** / no reasons for living
- ❑ **A** **Anxiety** /agitation / insomnia
- ❑ **T** **Trapped** / feeling no way out
- ❑ **H** **Hopelessness** / nothing will ever change

- ❑ **W** **Withdrawal** from friends, family, society
- ❑ **A** **Anger** (uncontrolled)/ rage / seeking revenge
- ❑ **R** **Recklessness**/ risky acts / unthinking
- ❑ **M** **Mood Changes** (dramatic)

Warning Signs - Verbal

- No one can help me. What's the use?
- I wish I were dead
- If I wasn't around, no one would miss me
- I won't be needing these things any more
- I'm a loser. I can't do anything right
- Life is not worth living
- I might as well shoot myself
- If I killed myself, then people will be sorry
- My family will be better off without me

Warning Signs - Behavioral

- Writing about death and suicide
- Increasing use of alcohol or drugs
- Withdrawing from family and friends, work or school
- Acting recklessly or impulsively
- Not addressing physical needs or appearance
- Sleeping or eating too much/too little
- Dropping out of usual behaviors
- Getting into trouble in school or with the law
- Aggression/fighting
- Giving away valuable possessions

Mental Illness and Suicide

Mental Health Disorders and Suicide

- Psychological autopsy studies done in various countries over almost 50 years report the same outcomes:
  - 90% of adults who die by suicide are suffering from one or more diagnosable psychiatric disorders:
    - Major Depressive Disorder
    - Bipolar Disorder, Depressive phase
    - Alcohol or Substance Abuse*
    - Schizophrenia
    - Personality Disorders such as Borderline PD

*Primary diagnoses in youth suicides.

Suicide Rates in High Risk Dx

Diagnosis	# studies	Standardized mortality rate	Lifetime rate (%)
Previous Suicide Attempt	9	38.4	27.5
Eating Disorders	15	23.1	
Major Depression	23	20.4	14.6
Sedative or mixed Drug abuse	7	20	14.6
Bipolar Disorder	15	15	15.5
OCD & Panic Disorder	12	10-11	7.2-8.2
Schizophrenia	38	8.45	6.0
Personality Disorders (all)	5	7.08	5.1
Alcohol Abuse	35	5.85	4.2

Mood Disorders and Suicide

Factors increasing risk profile:

- Active Alcohol Abuse
- Early in illness course
- Addition of anxiety or panic attacks with Depression
- Male risk is 4x female in depression,
- Women are equally at risk in Bipolar Disorder
- Initial or first suicide attempt is the most lethal

Major Depressive Disorder

- Dx most consistently identified in suicide deaths
  - However most depressed people never attempt suicide
  - Predictive of ideation, but not attempts
- Lifetime suicide risk 14.6%
- 20 fold increased mortality

Risk Factors- MDD

Highest Risk is During Depressive Episode and associated with:

- Degree of subjective desperation
- Depth of hopelessness
- Anxiety/psychic anxiety/panic attacks
- Aggressive or impulsive personality
- Preparations for a potentially serious suicide attempt *or rehearsal of a plan during a previous episode
- Recent hospitalization w/o improvement
- Psychotic symptoms

Bipolar Disorder

- Suicide risk highest:
  - in **depressed** phase
  - Co-morbid **anxiety** or insomnia
  - **Rapid cycling** of moods
  - Early recovery phase/**transitions** between mood states
  - Presence of **psychosis**
  - **Treatment resistance**
  - **Impulsivity** highly correlated with future suicide risk
  - Co-morbid **substance abuse**
- Several studies support Lithium as reducing risk

Schizophrenia

- Suicide risk 8.5 times general population
- Though some reports place lifetime risk as high as 15%, currently felt to be 5%
- Risk increased by:
  - Youth. First decade of illness.
  - Post hospital discharge; improvement after relapse,
  - Higher pre-morbid functioning,
  - Greater insight and hopelessness
  - Co-morbid substance abuse
  - Depressed mood

Substance Abuse Disorders

- Very high correlation between substance abuse and suicidal behavior, especially in youth.
- Male suicide risk associated with alcohol; female suicide risk associated with drug abuse.
- Poly-substance abuse is especially risky.
- Co-morbid Dx generally present ; Mood disorders, personality Dx and anxiety especially.
- Females with Co-morbid borderline personality
- Males with co-morbid depression.

Alcohol Abuse and Dependence

- Suicide usually occurs later in the course of the illness and with increasing age, with communications of suicidal intent lasting several years
- High Risk Profile:
  - Recent or impending interpersonal loss (relationship, job)
  - Co-morbid depression
  - High impulsivity
  - Access to firearms

Eating Disorders

- Compilation of 35 studies reported ED as highest risk
  - Suicide risk is 23 times that of general population
  - Most often with co-morbid depression, SA Dx….
  - 28% had co-morbid Personality Dx, Avoidant PD
  - Risk increased by:
    - Treatment avoidance
    - Substance abuse
    - History of prior attempts

Anxiety Disorders

- 6-10 fold suicide increase over general population
- Studies are limited and results inconsistent
  - One study bases upon 20,000 People with Anxiety disorder found much higher rate 193/100,000
- Co-morbid anxiety with mood, S A or Axis II heightens risk.
- Presence of acute anxiety drives impulsive action

Personality Disorders

- Cluster B are highest risk group
  - Borderline Personality Disorder
    - Lifetime suicide rate- 8.5%
    - With comorbid alcohol abuse, 19%
    - With alcohol abuse and MDD, 38%
    - At least 75% of BPD have made at least 1 suicide attempt(Jacobs)
  - Antisocial Personality
    - Impulsivity is a major factor
    - Facing adverse consequences to behavior

COMORBIDITY ISSUES

- In general, the interplay of multiple diagnoses increases suicidal Risk.
- Psychological retrospective Dx on 229 suicides and found:
  - 93% with one or more Axis I Dx.
  - 44% with multiple Axis I Dx
  - 31% with Axis I and II Dx
  - 46% had Axis I and medical concerns (Axis III)
  - 12% showed single Axis I Dx without co-morbidity

Special Populations

Special Populations

Men as a Specific High Risk Group

- Overall, 80% of suicide deaths are male (US)
  - General trend is true worldwide with a few exceptions
- Gender disparity highest in elders (especially white)
- Gender issues affecting risk in men include:
  - Poor help-seeking behavior/skills
    - Men less likely to react to crisis by talking to someone .
    - Less verbal; less emotional literacy
  - Increased rates of substance abuse
  - Choice of higher lethality means
  - Perceived burdensomeness
  - Struggle between belongingness/attachment and independence

Special Populations

Men as a Specific High Risk Group

- Increased Risk for men associated with:
  - Increasing age
  - Hx of physical/sexual abuse and other traumas
  - Social isolation, lack of support system
  - Relationship loss/ divorce / death
  - Substance abuse / binge drinking
  - Unemployment/ Job Loss
  - Access to lethal means, esp. firearms

Special Populations

Women

- Though overall risk is 25% of male, differing risk factors are present.
  - Alcohol abuse, but drug abuse more strongly correlated
  - Violence
  - Post-partum psychosis
  - Panic attacks
  - Eating disorders
  - Abuse history /Domestic violence history
- Highest risk is age 45-55.

Special Populations

Women

- Protective Factors
  - Pregnancy
  - Motherhood, especially with young children
  - Increased help-seeking behavior
  - Increased social skills, verbal skills
  - Emotional literacy
  - Choice of lower lethality methods

Special Populations

Traumatic Brain Injury

- Each year in the US
  - 1.7 million TBI with 50,000 deaths & 235K hospitalized.
  - 1.1 million treated and released;
  - 80-90,000 experience long term disability
    - Falls 28%
    - Car accidents… 20%
    - Struck by against.. 19%
    - Assaults 11%
- Military, especially combat experience increases risk

Special Populations

Traumatic Brain Injury-Enduring Symptoms

Cognition deficits	Mood	Behavior
Language/ communication	Depression/ Apathy	Lack of initiation
Attention, Memory concentration	Anxiety	Disinhibition
New learning	Irritability	Impulsivity
Information processing speed	Emotional lability or insensitivity	Restlessness
Judgment, insight, problem-solving	Egocentricity	Agitation and aggression

Special Populations

Veterans

- 20% of US suicides are former military personnel.
- Increased Veteran risk associated with:
  - Age; the younger and older vets are most at risk.
  - Severity of wounds/ hospitalization
  - Frequency of deployments, extended deployments
  - Physical/ sexual assault while in military
  - Active Substance abuse
- Risk heightened by presence of:
  - PTSD
  - Traumatic Brain Injury
  - Depression

Special Populations

Active Military

- US Army reported highest rate on record; 20.2 per 100K of ”confirmed suicides”
- More soldiers lost to suicide than to combat in either Iraq or Afghanistan in 2009.
- Military suicide rate has increased over the past 6 years
  - From below the national average to almost double
- Particularly high in Army and marines.

Special Populations

Elders and Suicide

- 12.6% of Population and 15.7% of suicides (2007)
- 84% of elder suicides are male
  - 30 per year in Maine on average
- 60-90% wi a mental Health diagnosis (us. Depression)
- Only 2-4% with Dx of terminal illness at time of death
- Firearms most common method, 72%;
  - Males-85% use firearms
  - Females-35% firearms

Special Populations

Chronic/Terminal Illness

- The high-risk patient is male, with head and neck cancer or myeloma, advanced disease, little social or cultural support, and limited treatment options. *
- The presence of multiple chronic illnesses increases incidence of suicide risk in elder patients. **
- Another Study of a small number of psychological autopsies of elder males showed threat if they "believed" they had cancer. All had Cancer Hx, many losses, rigid personality of self-sufficiency.***

Special Populations

Gay, Lesbian, Bisexual, Transgendered & Questioning

- Consensus has not been reached regarding the degree to which same-sex sexual orientation is a risk factor for suicide. In suicide deaths we often do not know orientation.
- Multiple studies show ATTEMPT rates 2-4 times higher for GLBTQ youth and some studies show higher death rates as well ~ more research needed.
- Critical risk factors include substance abuse, depression, abuse, victimization, bullying, etc.

Special Populations

Native Americans and Suicide

- Overall rate misleading: 12.1 for NA versus 11.5 for all US
- Adults age 25-29 overall rate is 20.67
- 1999-2005 males, age 15-24 rate was 27.99
- 2nd leading cause of death age 10-34
- Canadian coroner study showed wide variation in rates between tribal groups in BC.

Special Populations

Native Americans and Suicide

- Issues of acculturation undermine tribal unity;
  - Boarding school experience
  - Dislocation from family
  - Dislocation from the land
- NA youth face increased Anxiety, Depression & S.A.
- Lack of accessible, consistent, culturally appropriate treatment and support resources.
  - This has fueled a history of under-utilization of MH and medical services.

Special Populations

Native Americans- Protective Factors

- Connection to their community
  - Ties with elders
  - Family ties
  - Tribal spiritual orientation
  - Connection with the land/ earth
- Ability to talk about problems with family/ friends

Borowsky et al, 1999

What We See in Hindsight

Clinical features of Suicide in Teenagers

Psychiatric diagnosis present in majority

- Depression with or w/o other symptoms in well over half of suicides
- A significant number made a previous (known) attempt
  - Males 27-37%
  - Females 50-67%
- Alcohol abuse in 2/3rds of males 15-24 but uncommon in younger males (<14) and uncommon in females

What We See in Hindsight cont.

- Statements of hopelessness present in half of all suicides (but common feature of depression with or without suicidality)

- Problem solving deficits –esp. common to teens

- Aggressive/impulsive behavior common in both sexes

(Shaffer et al. 2007)

Acute Psychiatric Symptoms Associated with Suicide

- Hopelessness
- Impulsivity / Aggression
- Anxiety
- Command hallucinations

Psychiatric Presentation:

Hopelessness

- Research indicates relationship between hopelessness and suicidal intent in both hospitalized and non-hospitalized patients (Beck 1985, Beck 1990)
- Subjective hopelessness was associated with fewer reasons for living and increased risk for suicide (Malone 2000)
- Modifiable through various interventions

Psychiatric Presentation:

Impulsivity and Suicide

- Impulsive personality or other factors increasing impulsivity.
- Many studies have shown increased impulsive behaviors before suicide attempts or deaths.
- A study noted that 24% of attempt survivors had spent less than 5 mins. between the decision to attempt suicide and the actual attempt •
- Another study found that in 50% of adolescent suicide attempts: a "stressor" occurred only 24 hours before the attempt
- Important consideration with co-morbidities such as ADHD, anxiety, rage, substance abuse and Mood Disorders

Waldvogel et al 2008

Impulsivity Questions

- Do you feel in control right now?
- When have you felt out of control in the past?
- Does your anger and temper cause problems for you?
  - What does that look like?
- Have you engaged in forms of violence?
- What did you do that you thought was out of control?
- What do you do to help yourself feel more in control?
  - Does it work?
- When you're feeling out of control, how long does it usually take for you to recover?

Adapted from: M.D. Rudd, The Assessment and Management of Suicidality, 2006

Psychiatric Presentation:

Anxiety

Anxiety symptoms (independent of an anxiety disorder) associated with suicide risk:

- Panic Attacks
- Severe Psychic Anxiety (subjective anxiety)
- Agitation

In a review of inpatient suicides 79% met criteria for severe or extreme anxiety or agitation

Several studies show independent connection between Anxiety and suicidal behavior.

Psychiatric Presentation:

Command Hallucinations

- Existing studies are too small to draw conclusions, patients with command hallucinations may not be at greater risk, per se, than other severely psychotic patients.
- However, the majority of patients with suicidal command hallucinations should be considered seriously suicidal
- Management of patients with chronic command hallucinations requires consultation and documentation
- Command Hallucinations also increase risk for violence.

Adapted from A.P.A. Guidelines, Part A, p. 20-21

Previous Attempts

- One or more previous suicide attempts is the single most important predictor for suicidal behavior
- The more recent the attempt, the more potent a predictor, but the risk is heightened decades out.
- Youth risk for repeat attempt is highest the first 3-6 months after the initial attempt; the risk remains higher than the peer group for several years.
- Of those evaluated in the ER following a suicide attempt, about 1% per year take their own life, up to approximately 10% within 10 years.

Short-term (Acute) Risk Factors

- Current depression
- Current substance abuse or impulsive overuse
- Acute psychic distress (including anxiety, panic and especially agitation)
- Extreme humiliation/disgrace, shame, despair, loss of face
- Acute Hopelessness / Demoralization
- Desperation/sense of 'no way out'
- Inability to conceive of alternate solutions
- Break-down in communication/loss of contact with significant others(including therapist)
- Recent discontinuation of treatment

Protective Factors

- **Skills** to think, communicate, solve problems, manage anger
- **Purpose & value in life**-hope for future
- **Personal characteristics** -good health, positive outlook, healthy choices
- **Safe Environment –** restricted access to lethal means
- **Supports**-Supportive parents, friends, teachers & other caring adults –"Postcards from the Edge"

Protective Factors - Questions

- Even though you've been having a difficult time lately, something has kept you going. What are your reasons for living?
- Tell me about your hopes for the future?
- What would need to happen to help you be more hopeful about the future?
- What keeps you going in difficult times like this?
- Whom do you rely on during difficult times?
- Has treatment been effective for you in the past?

M.D. Rudd, The Assessment and Management of Suicidality, 2006

Kevin Hines: Survived a Jump from the Golden Gate Bridge

- I took another bus to the Golden Gate Bridge. I was crying. I was just so tired, so emotionally drained. I was just looking at people, wanting someone, anyone, to say, "Are you okay?" As much as I wanted that, I was hearing these voices saying, "You have to die."
- I got off the bus at the bridge, and stood there crying. I went onto the span very slowly. Almost reluctantly. The whole time begging myself not to jump, but the voices were too strong, I just couldn't fight them.
- **There were tons of people, it was 10 in the morning, bikers, joggers, tourists, workers, cops biking around. I found my spot. And I said to myself, if just one person, just one, comes up to me and asks me if I need help, I'll tell [them] everything. And this beautiful woman walked up to me, and she goes, "Will you take my picture?" And I thought, "What? Lady, I'm going to kill myself, are you crazy?" But she had sunglasses on, her hair blowing in the wind, she was a tourist, all she could see was this guy standing right where she wanted her picture taken. I must have taken five pictures of this lady. She had no clue.**
- **I thought at that moment, nobody cares. Nobody cares. So I handed her her camera. She walked away. I walked as far back to the railing closest to the traffic as I could, I ran, and I catapulted myself over the bridge. I didn't get on the ledge to have people talk me down. I just jumped.**

Assessment of Suicidal Behavior

Components of a Suicide Assessment

When to Assess

- At Intake
- At mention, observance, or report of suicidal ideation or prior suicidal behavior
- With observed change in mental status
- With increases environmental stress/ symptoms
- Immediately after self harm is reported
- At times of transition in Tx
- With a client predisposed to suicide; regularly

Berman, Jobes & Silverman, 2006

Asking About Suicide

"The answers you get
depend upon the questions
you ask."

Thomas Kuhn

Asking About Suicide

Overcoming Societal Reluctance

- Talk about suicide directly and without hesitation.
- Vague or indirect questions elicit vague responses:
  - Are you thinking of hurting yourself?
  - Do you feel safe?
  - You're **not** going to kill yourself **are you**?
- Ask using concrete and direct language.
  - Are you having thoughts of your suicide?
  - Are you thinking about dying today?
  - Are you considering killing yourself?
- When in doubt about the answer, repeat the question differently.

Asking About Suicide

- Components of Suicide Ideation to consider:
  - **Intent**- Subjective assessment of desire to die.
  - **Lethality**- Objective assessment of the likelihood of death resulting from the chosen means and plan.
    - May not coincide with the individuals expectation
  - Degree of **Ambivalence** /Desire to live & desire to die
  - **Intensity** and **frequency** and **duration** of impulses
  - Evidence of **suicide note** or other efforts to tie up ends.
  - **Deterrents and Protective Factors**- Family, positive support system, religion, work, other…

Beck et al, 1979

Suicidal Ideation

Detailed Questions

- How often do you think about killing yourself?
  - Hourly? Daily? Weekly?
- Describe how long they last and the intensity or severity of these thoughts
  - What triggers these thoughts?
  - What helps to make them go away?
- Can you rate these thoughts/feelings on a scale of 1 to 10?
- Exactly what do you think about when considering suicide?

Adapted from M.D. Rudd, The Assessment and Management of Suicidality, 2006

Components of Suicide Assessment

Evaluating a Suicide Plan

Risk/Rescue Issues:

- Method
- Lethality (perception and assessed)
- Timing
- Place or setting
- Availability of means, acquisition of means.
- Arranging sequence of events
- History of **past attempts** and details.

Jacobs (1998)

Suicidal Intent

Detailed Questions

- What are your reasons for wanting to die?
- What intentions do you have of acting on your thoughts?
  - Can you rate your intent on a scale of 1 to 10?
- Have you taken any steps in preparation for your death?
  - Acquiring the means that you would use?
  - Will? Finances? Note?
- Have you rehearsed your suicide in any way?
- Have you gone through the steps – mentally and/or physically?

M.D. Rudd, The Assessment and Management of Suicidality, 2006

Objective vs. Subjective Intent

- **Objective (observed) Intent** – what the patient actually does; level of intent is inferred from what is observed both present and past.
- **Subjective (expressed) Intent** – what the patient says

Clinician must always be on the lookout for observed **discrepancies** between what patients do and what they say – and discrepancies need to be challenged

BEHAVIOR TRUMPS DENIAL!

M.D. Rudd, The Assessment and Management of Suicidality, 2006

Some Questions to Ask YOURSELF

- What is the intent of the behavior?
- What is the lethality of the method?
- Is the plan “doable”?
- Was past attempt context similar to/different from current situation/context? If so, how?
- Likelihood of current/future events “pushing” patient into “suicide zone”? What has changed?
- Does the existing Tx & Rx need to be changed?
- What is the safest way to manage level of risk?

Assessment Tools

Putting the information together to form a level of risk decision

Clinical Assessment Forms

- The form used should match your setting and your population.
- There is no perfect form.
- Examples:
  - Value Options Form
  - Rudd Suicide Assessment Form
  - NY State Youth Correctional Form

Screening Tools

- Screening is not Assessment, but informs the process.
- Depression screening tools
  - BDI Becks Depression Inventory, I & II
  - Hamilton Depression Rating Scale
  - PQH-9 Patient Health Questionaire-9
  - PQH-A Patient Health Questionnaire-Adolescent

Screening, Child & Adolescent

- US Preventative Services Task Force report of 2009 recommends screening for 12-18 y/o but that in younger children, assessment is less accurate.
  - Becks Depression Inventory both Primary care and general BDI-PC
  - Patient Health Questionnaire-Adolescent PHQ-A
  - Center for Epidemiologic Study-Depression Scale-CES-D
  - Revised Clinical Interview Scale CIS-R

Suicide Risk Assessment

SAD PERSONAS SCALE

- **Sex** of patient
- **A**ge of patient
- **D**epression or affective disorder diagnosis
- **P**revious attempts at suicide
- **E**thanol and drug abuse (recent)
- **R**ational thinking loss
- **S**ocial supports lacking
- **O**rganized plan for suicide
- **N**o spouse
- **A**vailability of lethal means
- **S**ickness

Patterson et al., 1983; Campbell, 2004

Case Example

Warning Signs Mnemonic

- **I** **Ideation** / threatened or communicated
- **S** **Substance Abuse** / excessive or increased?

- **P** **Purposelessness** / no reasons for living
- **A** **Anxiety** /agitation / insomnia
- **T** **Trapped** / feeling no way out
- **H** **Hopelessness** / nothing will ever change

- **W** **Withdrawal** from friends, family, society
- **A** **Anger** (uncontrolled)/ rage / seeking revenge
- **R** **Recklessness**/ risky acts / unthinking
- **M** **Mood Changes** (dramatic)

Case Example

What is a Crisis?

- A crisis occurs when unusual stress, brought on by unexpected and disruptive events, render an individual physically and emotionally disabled – because their usual coping mechanisms prove ineffective
- A crisis overrides an individual's normal psychological and biological coping mechanisms – moving the individual towards maladaptive behaviors; flight or fight.
- Every crisis situation is a high risk situation

Crisis Management - I

Goals:

- Ensure immediate safety & stability
- Protect the patient from self-harm
- Effect immediate change
- Shift focus from crisis to resolution
- Identify underlying disorder, dysfunction, or event that precipitated the crisis
- Involve family/partner/social support network

Crisis Management - II

- Techniques:

- remove the means (agent)
- assure safety
- planning for the future (immediate)
- decrease isolation (social support)
- decrease anxiety and agitation
- (psychological perturbation)
- medication management
- hospitalization/ LOC (safety; security; stability)

Hoff (1984); Silverman (1999)

Level of Care Decision-Making

- Guidelines for selection of tx setting for clients at risk for suicide.
- Range of Care options
  - Hospital admission
  - Crisis Bed admission
  - Intensive follow-up
  - Regular follow-up

These are decisions that are best made in consultation!

Level of Care Guidelines

- **Hospital admission** indicated when:
  - Client is psychotic
  - Attempt was violent, premeditated &/or near lethal
  - Rescue seemed unlikely or avoided
  - Persistent intent/plan present before attempt
  - Survival of attempt increases distress.
  - Male, >45, esp. with onset of new MH illness/ SUI
  - Pt isolated from supports or in unstable living situation
  - Currently agitated, rageful, impulsive or refusing help.
  - Continuing S/I with plan and intent (APA Guidelines)

Level of Care Guidelines

- Following suicide attempt. ***Crisis Bed*** may be indicated when:
  - Compliant, known client with indications of remorse following attempt.
  - Attempt was impulsive and/or of low lethality and precipitant is resolved in clients mind.
  - Low /no risk of substance withdrawal
  - Isolated in community but in the presence of good supports in treatment.
  - For personality disordered with repeated, low lethality attempts.

(APA Guidelines)

Level of Care Guidelines

- Client may be released to **community/home** when:
  - Suicidal ideation exists or attempt made where:
    - Precipitants are resolved in client's perception
    - Plan, method and intent have low lethality
    - Client has stable and supportive environment (and engaged)
  - Client able to cooperate with tx recommendations and agrees to follow-up contact.
    - Client has good relationship with treatment provider

(APA Guidelines)

Treatment for the Suicidal Depressed Client

Preventing Suicide. . .

Psychotherapy

- Research shows that when it comes to treating depression, all therapy is NOT created equal.
  - Applying correct techniques reduces suicide attempts by 50% over an 18 month period*
- To be effective, psychotherapy must be:
  - Specifically designed to treat depression
  - Relatively short-term (10-16 weeks)
  - Structured (therapist should be able to give step-by-step treatment instructions for the client)
- Implement teaching of self-management techniques

Psychotherapies

- Cognitive Behavioral Therapy
- Dialectical Behavioral Therapy
- Interpersonal Psychotherapy (ITP)
- Collaborative Assessment and Management of Suicidality (CAMS)

Treatment for Suicidal Clients

CAMS Approach

- Philosophy and systemic approach for assessing, and managing suicidal risk with clients in community-based practice.
  - Engagement of the client in a collaborative manner to acknowledge and assess suicidal risk as a dynamic reality
    - Client self-rates elements of suicide status
    - Reasons for living vs. reasons for dying….
  - Clinician rates assessment elements and mental status
  - Collaborative treatment planning
  - Structure for ongoing work and discharge
    - Includes ongoing, regular assessment of risk.

Preventing Suicide. . .

Antidepressants

- Adequate prescription treatment and monitoring
  - Only 20% of medicated depressed patients are adequately treated with antidepressants.

    Reasons proposed:
    - Side effects
    - Lack of improvement
    - High anxiety not treated
    - Fear of drug dependency
    - Concomitant substance use
    - Didn't combine with psychotherapy
    - Dose not high enough
    - Didn't add adjunct therapy such as lithium or other medication(s)
    - Didn't explore all options including: ECT or other somatic treatment

Documentation and Risk Management

Litigation Risk

- Wrongful death is the most common malpractice claim (2nd is boundary violations).
- Decisions regarding lawsuits generally hinge on failure to properly evaluate risk of suicide over failure to predict as prediction is rarely possible.
  - Evaluate and document evaluation and results and associated plan.

Documentation and Risk Management

For a client remaining in the community

- Safety Plans, suicide contracts, no harm contracts, Coping Plans or Crisis Resolution Planning.
- Securing firearms and access to other lethal means
- Alerting and collaborating with significant others
- Consultation and back-up
- Documentation

(APA Practice Guidelines, 2003)

Safety Planning

- A Safety plan is a written list of coping activities personal, social and professional resources developed with a person, for use during a crisis :
- Avoid a “no suicide contract”
- Safety planning is a time to assess if a person is willing, ready & able to engage in planning for their safety
- Allows exploration of personal and social resources and the ability to mobilize them.

See also VA Safety Plan Quick Guide for Clinicians

Safety Planning

- A safety contract is recommended to include:
  - A clear recognition of triggers to crisis
  - Personal resources, skills and interests
  - Family and social resources
  - Professional contacts already engaged
  - Emergency contact/ Crisis Line
  - Plan for lethal means restriction
- Make it concrete, written and make sure a copy goes with the client. This is their resource!

Barbara Stanley & Gregory Brown

*Safety Plan Treatment Manual to Reduce Suicide Risk-VA version

Risk Management

Securing Access to Lethal Means

- Always ask about the presence of firearms, alcohol, drugs and medication
- Work with collateral contacts as needed to secure lethal means.
  - Family &/or friends
  - Police
- Document the query, the response and the plan.

Documentation and Risk Management

Communication with Family/ Significant Others

- Recognize the inherent tension between Client confidentiality and imminent risk.
- More clear with children and adolescents.
- Imminent risk permits disclosure of confidential information to prevent harm including:
  - Gather collateral/ historical info to assess risk.
  - Develop a safety plan/container.

Documentation and Risk Management

Documentation

Careful and consistent documentation is a cornerstone of good clinical practice and risk management

Document the process and results of each suicide assessment and the resultant Tx planning decisions.

- At Intake
- At disclosure of suicidal risk
- At any significant mental status change or significant client change for a previously suicidal client.

Documentation and Risk Management

Documentation cont.

- Level of communication, collaboration and alliance with client.
- Risk assessment results / copies of screens used
- Change in tx and supporting decision-making process.
- Record of consultation with other tx providers
- Record of contact with family/ support providers
- Any recommendations made to client/family…
  - Plan for Securing lethal means

Suicide Survivors

All deaths are not the same.

Survivors of Suicide

- Struggle to make meaning of the loss
  - Questions and need to know details..
  - Self recrimination and self doubt
  - Torment of “if only’s”
- Suffer from overwhelmingly complicated feelings including anger, sadness, relief, guilt
- May take up to 5 x as long to grieve
- Need understanding and support
- Come to terms with the loss more than heal.

How YOU can be Supportive After a Suicide

- Acknowledge the loss
- Share a special memory/story
- Use the name of the deceased
- Share your presence
- Acknowledge the good things
- Stay in touch
- Recommend Grief Support Center (Hospice)

Clinicians as Suicide Survivors

- Estimated that 20% of therapists and 50% of psychiatrists will lose a client to suicide over the course of their career.
- What the clinician feels…
- Healing is complicated by:
  - Litigation or fear of same,
  - Confidentiality that extends beyond the grave,
  - Stigma
  - Concern re professional standing and colleague reaction

Acknowledgements

- American Foundation for Suicide Prevention
- American Association of Suicidology
- Centers for Disease Control and Prevention
- American Psychiatric Assoc.- APA guidelines
- Maine Youth Suicide Prevention Program

Before You Leave…

Any Questions?

We need your Evaluation.

You need your Certificate of Attendance!

Thank You . . .

For learning about suicide prevention

Remember the need for Self-Care;

Addressing your own needs prepares you

to address the needs of others!