Suicide Risk Assessment

March 2015

DIAMOND University
Objectives

1. Identify the risk factors for suicide.
2. Identify protective factors for suicide.
3. Identify the signs that may indicate when a person might be considering suicide.
4. Define elements of and how to complete a suicide risk assessment.
5. Understand how to use risk assessment to determine treatment options and develop plan for treatment.
Suicide Statistics

• 10th Leading cause of death in the U.S. in 2010 per the CDC. Suicide accounted for approximately 38,364 deaths an average of 105 deaths per day.
• The number one reason for admission to inpatient psychiatric care.
• Suicide rates for males are 4 times higher than for females.
• Suicide rates for males are highest among those age 75 and older. (36 per 100,000)
Statistics Continued

• Third leading cause of death for 15-24 year olds; second leading cause for persons 25-34; fourth leading cause for persons 35-54; and eighth for those 55-64.
• Among those 15-24, suicide accounts for 20% of all deaths annually.
• The rate of suicide for all adults over 75 is 16.3 per 100,000.
• In 2011, 487,000 people were treated in emergency departments for self-inflicted injuries.
• Rates are generally higher in Western and Rural areas.
More Statistics

• Generally, guns are the most common method of completed suicide.
• On inpatient units:
  – hanging is the number one method
  – followed by jumping from a height
• The rate of inpatient suicide is 1-4 per 1,000 psychiatric patient admissions.
Statistics, Methods & Gender

- Women ATTEMPT suicide more often than men.
- Men COMPLETE suicide more often than women, except in inpatients over age 60.
- 78% of patients deny suicidal ideation prior to the act.
- 23% of patients show improvement in their symptoms prior to committing suicide.
- Most inpatient suicides are among voluntary patients.

Reference: CDCinfo@cdc.gov
Assessment considerations

When assessing for suicide on an inpatient unit, the following needs to be taken into account:

- Risk factors
- Protective factors
- Personal history
- Family history
Risk Factors

• Prior history of *any* attempt, but especially if:
  – Attempt was at an inpatient unit.
  – If attempt follows a suicide assessment where the patient was assessed as a low risk.
• Seriousness of any prior suicide attempts
  – High lethality of a prior attempt predicts high lethality of a future attempt
• History of self abusive behaviors
• Acute suicidal ideation
• Social support system lacking
Risk Factors Continued

• Hopelessness
• Depression, Anxiety, and/or Psychosis
• Discontinuance of a benzodiazepine
• Highest risk is:
  – Within 24 hours of admission
  – Within 24 hours of discharge (either before or after)
  – The first week following discharge
• History of suicide in family
  – May be “normalized” as way to cope; OR
  – May be a protective factor in not wanting to repeat an act that was traumatic
Risk Factors Continued

• Substance abuse
• Recent loss, death, separation, or divorce
• History of sexual, physical, or emotional abuse
• Co-morbid medical illness, or terminal illness
• Male Gender
• Impulsivity/rapid shifts in mood
• Chronic pain
• Confusion/disorganization
Protective Factors

Protective factors are those things which serve to mitigate suicide risk. They are aspects of the patient’s experience that:

- Provide meaning, purpose, and value
- Support social connectedness
- Provide pleasure and contentment and make life worth living
- Support the client’s perception of self as effective, respected, loved, needed, and fulfilled
- Support the personality characteristics to assist a person in coping with crisis
Protective Factors Include...

- Effective clinical care for mental, physical, and substance use disorder
- Supportive family and friends, “others” who depend on the patient
- Communication and conflict resolution skills
- Access to examples of or previous experiences of successful coping, personal coping skills, and problem-solving abilities
- Sense of optimism, self-efficacy, perception of self as strong – a “survivor” or “fighter”
Protective Factors Continued

- Cultural and religious beliefs, practices, and activities that discourage suicide and support self-preservation
- Being employed or engaged in daily “work” where others depend on them
- Effective pain management
- A self image that is consistent with reality
- Discharge plans that are realistic and supportive of the patient’s self image and goals
Lethality & Intent

Two concepts to keep in mind:

1. **Lethality** — whether or not a person chooses a method most likely to ensure death; does so alone and in a place where the likelihood of being discovered is minimal to none

2. **Intent** — whether or not the person intends death as the ultimate outcome of the suicide attempt (vs. manipulating for another outcome)
Suicide Attempt vs. Gesture

- **Suicide attempt** — the means are lethal and the intent is to die
- **Suicide gesture** — the means are often not lethal and the intent is to create another outcome, such as:
  - To influence, coerce, or punish others who are emotionally significant to the person
  - To relieve subjective distress and relieve tension
- While a suicidal gesture is not generally lethal, **ANY** suicidal gesture **can be** lethal and **ALL** threats of suicide must be taken seriously!
Warning Signs – Verbal Clues

“I wish I were dead.”
“I wish I could end it all now.”
“I am such a burden to my family.”
“I don’t know if I can hang in there.”
“I have nothing left to live for.”
“I want to die.”
“I am going to kill myself.”
“I just want to go to sleep and not wake up.”
“I’m no use to anyone.”
Warning Signs – Behavioral Clues

• Giving away prized possessions
• Anxiety or agitation
• Loss of appetite
• Weight loss/excessive weight gain
• Making a will, getting financial affairs in order
• Making funeral arrangements
• Withdrawal from family/friends
• Withdrawal from social activities
• Excessive sleeping/insomnia
• Expressing concern about their absence & wondering how family/friends will take it
Warning Signs – Feelings

- Hopelessness – cannot expect anything better; no one else can help either
- Helplessness – unable to change one’s life circumstances
- Worthlessness – unlovable, inadequate, no reason to stay alive
- Powerlessness – does not have control over own life
Assessing for Suicide

There is no reliable and effective way to predict with absolute certainty who will attempt or complete suicide. Risk factors, protective factors, and family/personal history provide some insight.

The following series of slides will focus on how to talk to a person about suicide in order to assess the potential risk and develop an appropriate plan of intervention.
Assessment Do’s & Don’ts

**DO**
- Be non-judgmental
- Let the client know that other people have shared similar feelings, thoughts, etc.
- Be direct
- Appear unhurried and comfortable with hearing what the person is saying
- Notice hesitancy & body language
- LISTEN!

**DON’T**
- Promise to keep secrets or not tell anyone
- Rush the assessment
- Accept the first “no”
- Shut down communication by showing discomfort or judgment of the person’s feelings
- Be afraid to say the word “suicide”
Assessment Process

The assessment of suicidal ideation proceeds along a gradient beginning with specifically questioning the client regarding consideration of self-harm. The answer to each question leads to the next question. You will address the following areas:

1. The presenting suicidal behavior
2. The current suicidal ideation
3. Recent suicidal ideation/suicide attempts
4. Past suicide ideation/Attempts

The next several slides will walk through the process of assessing a person for suicide risk.
Client Assessment

Assess the presence of/consideration of self-harm.

“Do you or have you had thoughts of hurting yourself?”

If the answer is YES, continue.
Client Assessment Continued

Ask whether thoughts of suicide have occurred.

“Have you ever thought about killing yourself or wished that you were dead?”

If the answer is YES, continue.
Client Assessment Continued

Is the client currently thinking of suicide?

- How often are the thoughts?
- Are the thoughts fleeting, periodic, or constant?
- Are the thoughts increasing, decreasing, or remaining the same?
Client Assessment Continued

Do the suicidal thoughts occur under specific circumstances?

• Same time each year
• When spouse leaves town on business
• Following alcohol use
• Etc.
Are the suicidal thoughts passive or active?

- Passive
  - “I’d be better off dead.”
  - “I just wish I could go to sleep tonight and not wake up.”

- Active
  - “When I am driving my car, I get the impulse to drive into other cars.”
  - “When I leave here, I plan to kill myself.”
Client Assessment Continued

Does the patient have a current intent to die?

Does the patient have the current desire to die?
Is there a specific plan?

“If you were to get to the point that you actually decided to kill yourself, how would you do it?”

• **Observe while asking** – Do they have an answer readily at hand showing that they have been thinking it over, or do they roll their eyes around the room showing they are having to consider?

• Method high or low lethality? Access to means? (gun, hanging, overdose on medications, etc.)

• A planned time or place?

• A mental or physical rehearsal?

• If the patient has a plan, the means to carry it out, has planned the time or place, and is mentally rehearsing it, **HE OR SHE IS AT VERY HIGH RISK!**
Client Assessment Continued

Does the person experience command hallucinations?

If so, do they give commands of self-harm or suicide?

Don’t be afraid to ask the question.
Client Assessment Continued

Is there a history of suicide attempts?
• When?
• Where? (At home? In the hospital? At school?, etc.)
• What methods were used?
• What were the circumstances surrounding the attempt(s)?
• What had been the expected outcome of the attempt(s)?
• Was there treatment? If so, what type?
• How does the person feel about the failure of past attempt(s)?

The goal is to identify a pattern (i.e., same time each year, same method, impulsive vs. planned, response to a stressor, etc.).
Client Assessment Continued

What is the person’s attitude toward suicide?

• Is it inevitable?
• Is it desirable?

OR

• Is there ambivalence or rejection of actually carrying out the plan?
Client Assessment Continued

Does the patient have barriers, or protective factors, to suicide?

• Can the patient identify reasons for living?
• How has he or she managed to evade the act of suicide thus far?
Intervention

You have now completed a thorough suicide assessment. You have assessed the patient’s thoughts, feelings, behaviors, risk factors, and protective factors.

What’s next?
How to proceed?

Always consider the *least restrictive environment* that still provides safe and effective treatment. The choice will depend upon your assessment of the client’s current level of suicide risk.

*Not every mention of suicide represents an urgent suicidal crisis.*
Clinical Intervention

Clinical intervention is based on:

• Reducing risk factors;
• Enhancing protective factors; and
• Working collaboratively with the client, family members, and significant others, including other treatment and service providers.
Immediate Interventions

When high and imminent risk of suicide is detected...

- Stay with the patient and reassure the patient that we will keep them safe until the crisis passes.
- Ensure that the patient has no objects on their person or in the immediate environment that could be used to harm self.
- Notify the attending physician and charge nurse and place on 15 minute checks or 1-1 arms length observation.
Emergency Room Options

If the evaluation is on a patient in the ED, release from the ED may be possible after a suicide attempt or in the presence of suicidal ideation if:

• Suicidality is a reaction to precipitating events (e.g., an exam failure, relationship difficulties), particularly if the person’s view of the situation has changed since coming to the ED
• The client’s intent and plan/method have low lethality
• The individual has a stable and supportive living situation
• The client is able to cooperate with follow-up recommendations
Release from ED

• Medical staff ultimately make the decision.
• If the decision is made to discharge from the ED:
  – Ensure that patient agrees to have supportive people stay with them.
  – Decisions must be made regarding removal or restriction of firearms, medications, and other potentially lethal objects and dangerous substances, including drugs and alcohol.
  – Obtain client’s consent to assure their home environment is made safe by securing dangerous objects and substances.
  – It is recommended to enlist the assistance of the family/support system in removing lethal objects and dangerous substances.
  – Getting the client’s consent is helpful and necessary unless he or she is unable to make a reasoned judgment or form a working therapeutic alliance. (In which case, strongly recommend inpatient admission for this patient.)
Considerations for Hospitalization

- A high level of irresolvable stress
- Inability to make reasoned decisions
- High levels of rage or panic, inability to regulate emotion,
- Ego decompensation
- Impulsivity, unstable, and unpredictable behaviors
- Loss of control, violence
- Current intoxication

- The presence of a thought disorder
- Multiple previous serious suicide attempts
- Absence of adequate psychosocial support or people to monitor the person’s behavior
- Inability to establish or maintain a therapeutic alliance with the clinician
Hospitalization vs. Outpatient

Outpatient treatment may be more beneficial than hospitalization if:

- The client has chronic suicidal ideation and/or self-injury without prior medically serious attempts
- A safe and supportive living situation is available
- Outpatient psychiatric care is ongoing and a therapeutic alliance appears strong
Involuntary Hospitalization

Involuntary hospitalization should be instituted as an emergency intervention when a client...

• Meets the criteria for “danger to self or others” and refuses hospitalization.
• Lacks a working alliance with a healthy provider.
• Lacks the capacity to make a rational treatment decision.

*Know your state statutes regarding criteria and process.*
Considerations for involuntary Hospitalization is generally indicated after a suicide attempt or aborted suicide attempt if:

• The client is psychotic
• The attempt was violent, near lethal, or premeditated
• Precautions were taken to avoid rescue or discovery
• A persistent plan and/or intent is present
• Distress is increased or the person regrets surviving
• The individual is male, older than 45, especially with new onset of psychiatric illness or suicidal thinking
• Client has limited family and/or social supports, including lack of stable living situation
• There is current impulsive behavior, severe agitation, poor judgment, or refusal of help is evident
• There is a change in mental status with a metabolic, toxic, infectious, or other etiology requiring further workup in a structured setting
Considerations for involuntary admission

Admission is generally indicated in the presence of suicidal ideation with:

- A specific plan with high lethality
- High suicidal intent
Considerations for Involuntary Admission

Admission may be necessary *in the presence of suicidal ideation* with:

- Psychosis or major psychiatric disorder
- History of past attempts, particularly if medically serious
- Possible contributing medical condition (e.g., acute neurological disorder, cancer, infection, etc.)
- Lack of response to or inability to cooperate with partial hospital or outpatient treatment
- Need for a supervised setting for a medication trial or ECT
- Need for skilled observation, clinical tests, or diagnostic assessments that require a structured setting
- Limited family/social support, including lack of stable living situation
- Missing/limited ongoing clinician-patient relationship.
- Limited access to timely outpatient follow-up
Inpatient Treatment

Effective clinical care can reduce symptoms and risk for suicidal behaviors. Inpatient hospitalization can provide a higher degree of observation and supervision within a structured and safe environment than any other level of care.

- The patient is searched and all dangerous objects are removed per unit policy on contraband and patient searches.
- The structured milieu and regular programming provide a safer environment with boundaries and 24/7 staff to assist the patient through the crisis period of suicidality.
- Ego supportive and cognitive-behavioral therapy provides alternative problem-solving strategies and has shown to be effective in reducing suicidal ideation, depression, and hopelessness.
- Pharmacological therapies can be more aggressively implemented and monitored.
Inpatient Treatment

- The best way to protect a patient on an inpatient unit is to *establish and maintain supportive and positive sustaining therapeutic relationships*.
- The impulsive nature of suicidal acts makes it important to *maintain a high level of observation on a frequent basis*. A large number of serious suicide attempters have reported making the decision to act within 15 minutes of the actual act. So even a valid suicide assessment may fail to reveal that the intent will arise in the near future.
- Self-injurious behaviors and suicidality is on-going and repetitive for some. Help the person develop problem-solving strategies, distress tolerance, and emotional regulation skills that are less dangerous and more effective.
- Help the patient set short term goals that are meaningful and measurable in order to improve their sense of self efficacy.
- Risk for suicide should be assessed and documented each shift.
- The charge RN can implement 15 minute checks or 1-1 observation but *only the physician is authorized to terminate them*. 
Inpatient Treatment

- **Communicate with your team.** Tragedies have occurred when a staff member was unaware of specific statements or other patient suicide risks.
- The vision of a realistic and positive future is one of the most protective of factors because it means there is hope, which is incompatible with despair. You can help a patient attain such a vision by using future oriented questions such as “If I ask you 5 years from now what this period in your life was like what will you tell me?” “What will you tell me was the most helpful thing that happened?”
- Once suicidality is resolved, the treatment focus shifts to reducing factors that contributed to suicidality (i.e., problem-solving deficits, impulsivity, emotional regulation, lack of social supports, etc.) and increasing protective factors (social relations, meaningful work, pleasurable activities, etc.)
- Assure the discharge plan meets the patient’s social, physical, safety, and emotional needs and they have a follow-up appointment within a week of discharge.
A Note About Safety Contracts

Safety contracts can be problematic.

- They are not a guarantee of safety.
- Clinicians often feel falsely reassured of patient safety and decrease vigilance.
- Patients may manipulate around contracts.
- They are most useful in conjunction with an established and strong therapeutic relationship with patient.
- They have not been shown to be predictive or preventative of suicidal behavior.
Safety Plan/Crisis Plan

Prior to discharge, develop a safety or crisis plan which details how to maintain safety and access emergency services.

- Include all pertinent supports – family, friends, mental health physicians, etc.
- Include contact numbers for above. (In a crisis, the client may be unable to remember this information.)
- Creation of this plan is a therapeutic intervention, while also giving the client a concrete tool to use when in a crisis.
Documentation

“If it wasn’t documented, it wasn’t done!”

There are documentation needs throughout every step of the inpatient treatment process.

• Assessment
• Planning
• Intervention
• Reassessment
• Discharge and Prevention/Safety Planning
Documentation Needs

• Suicide assessment and reassessment should be documented daily in:
  – Progress Notes
  – Nursing Notes
  – Nursing Flow sheets
  – 15 minute Check sheets

• Document such things as:
  – What occurred to prompt a suicide assessment (behavior, statements, etc.)?
  – What questions were asked, what was patient response?
  – Who was consulted in determining action to take (physician, program director, Nurse Manager etc.)
Documentation Needs

• Interventions – Document in:
  – Progress notes, nursing notes, flow sheets
  – Master Treatment Plan
  – 15-minute checks
  – 1:1

• Outcomes (reassessment) – Document in:
  – Progress Notes
  – Nursing Notes
  – Master Treatment Plan Updates
Documentation Needs

• Safety Contract
  – Should be written and legible
  – Clear and concise
  – Names and phone numbers of emergency contacts and who to call for help
  – Clear instructions of what to do in an emergency
  – Copy for patient
  – Copy in chart
Documentation Needs

• Discharge Plan/Instructions – In addition to usual Discharge Plan Form used at your hospital:
  – Attach copy of Safety Contract
  – Document follow-up appointment within one week of discharge – name, phone number, time, and date of appointment. **DO NOT LEAVE IT UP TO THE PATIENT TO MAKE THE APPOINTMENT!**
  – Note regarding State of Suicidality at Discharge
Example of Discharge Note

Document assessment of state of suicidality of patient in discharge progress note:

“Patient states they are no longer having suicidal thoughts and that they feel hopeful about the future. They plan to return to work tomorrow, and have appointment with Dr. Smith on Friday at 1pm for follow-up. They have mutually set-up a Safety Plan with therapist, and have a copy to which they can refer in event of crisis. Copy of Safety Plan is also in patient record. Discharged at this time to home accompanied by family.”
No Guarantees

• Suicide may not always be preventable.
• The unit is designed with patient safety in mind but even the most well designed environments can still be used by the determined patient to harm themselves.
• It is the job of every staff member to;
  – be diligent in observations and safety checks;
  – be conscious of safety at all times;
  – Be alert to patient needs (spoken and unspoken);
  – Trust your “gut”; and
  – Communicate with the collaborative team regularly.
Bibliography

• Center for Disease Control and Prevention 2011-2013 www.cdc.gov/leading causes-causes-of-death( Fast Stats)
• www.medical news today.com (“What are top 10 leading causes of death in the US?).
• Resources:
The Suicide Prevention Resource Center www.sprc.org
SAMHSA – SAFE-T Assessment. Available app through Google and Apple Apps Store or http://www.samhsa.gov