Directions: Use your mouse or the arrows on your keyboard to click through this tutorial.
Diamond Healthcare Corporation

Suicide Risk Assessment

For Outpatient Programs

2009
Objectives

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

• **8th** Leading cause of death in the U.S.
• Highest among adults over age 65
  – White men over the age of 85 have the greatest risk of all age/gender/race groups.
• Guns are the most common method of completed suicide, hanging is second
• Women ATTEMPT suicide more often than men (2 to 1 ratio)
• Men COMPLETE suicide more often than women (4 to 1 ratio)
• Women are more likely to overdose or cut themselves
• Men are more likely to use guns
Assessment considerations

When assessing for suicide, the following need to be taken into account:

• Risk factors
• Protective factors
• Personal and family history
Risk Factors

• Prior history of any attempt

• Seriousness of a prior suicide attempt
  - High lethality of a prior attempt predicts high lethality of a future attempt

• Diagnosed with a mental illness
  - Especially depression, though risk is high with any psychiatric disorder (including substance abuse, schizophrenia, borderline personality disorder, bipolar disorder)
  - Psychiatric hospitalization in past year, esp. if due to suicidality
Risk Factors, cont.

- Acute suicidal ideation
- Lack of social support system
- Hopelessness
- Glamorization of death, esp. if coupled with history of impulsive, self-destructive behavior
- 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, cont.

- Substance abuse
- Recent loss, separation or divorce
- History of sexual, physical or emotional abuse
- Debilitating medical illness
- Gender (see previous slides)
- Impulsivity/rapid shifts in mood
- Access to a gun
Protective factors are those things which serve to mitigate suicide risk. They are the areas of life which provide meaning and support, as well as the personality characteristics that assist a person to cope with life challenges.

The following slides illustrate a few of the protective factors for each risk category.
<table>
<thead>
<tr>
<th><strong>Risk Factors:</strong></th>
<th><strong>Protective Factors:</strong></th>
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</thead>
<tbody>
<tr>
<td>Mental Disorders, esp. mood disorders (major depression, bipolar disorder)</td>
<td>Effective clinical care for mental, physical and substance use disorders</td>
</tr>
<tr>
<td>Substance Use (often co-exists with mental disorders)</td>
<td>Motivation for treatment</td>
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<tr>
<td>Medical—loss of health, loss of functioning, chronic pain</td>
<td>Support through ongoing medical and mental health care relationships</td>
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# Risk vs. Protective: Psychological

## Risk Factors:
- Certain personality types (borderline & antisocial DO's, ineffective coping styles, impulsive/aggressive or depressive/withdrawn)
- States of Mind (self-hate, despair, low self-esteem, psychic pain, hopelessness or helplessness, suicidal ideation)
- Developmental history (abuse, previous suicide attempts, psychiatric treatment)
- Family history of violence, suicide, substance abuse, parental psychopathology

## Protective Factors:
- Coping skills, problem-solving abilities
- Sense of optimism, self-efficacy beliefs
- Individual strengths
- Social contacts
Risk vs. Protective: Social

**Risk Factors:**
- Stressful Life Events—Loss, unemployment, family conflict, lack of social support, legal issues
- Exposure to Suicide—Family, society (local clusters that have a contagious influence), influence of media

**Protective Factors:**
- Support networks
- Conflict resolution and nonviolent handling of disputes
- Strong family connections
Risk vs. Protective: Cultural

**Risk Factors:**

- Cultural, religious & spiritual beliefs—positive or negative perception of suicide, belief that suicide is a noble resolution of personal dilemmas (vs. that it is immoral)
- Stigma vs. cultural acceptance of violence
- Experience of humiliation or shame

**Protective Factors:**

- Cultural and religious beliefs, practices and activities that discourage suicide and support self-preservation
Risk vs. Protective: Environment

**Risk Factors:**

Environmental Barriers—
Unwilling to seek help due to stigma, unable to access health care treatment

Easy access to lethal means

Economic conditions (impoverishment, poor living conditions, diet, health care, etc., can lead to feelings of hopelessness)

Natural disasters/other traumatic events

**Protective Factors:**

Access to health and mental health care

Support for efforts to seek help

Restricted access to lethal means of suicide
## Risk vs. Protective: Demographic

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
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<tbody>
<tr>
<td>Male gender (completed suicides)</td>
<td>Social and community support</td>
</tr>
<tr>
<td>Female gender (attempts)</td>
<td></td>
</tr>
<tr>
<td>Single, divorced, widowed, separated, living alone, socially isolated</td>
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<tr>
<td>Lesbian, gay, bisexual youth</td>
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<tr>
<td>Whites, Native Americans</td>
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<td>Teens and the elderly</td>
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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 is lethal and the intent is to die
- Suicide gesture—the means is 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 to relieve tension

While a suicide gesture is not generally lethal, **ANY** suicide 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—Behavior 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 his 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 person know that other people have shared similar feelings, thoughts
- 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”
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 have thoughts of hurting yourself?")

If the answer is YES, continue.
Ask whether thoughts of suicide have occurred. (“Do you ever think about killing yourself or wish that you were dead?”)

If the answer is YES, continue.
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?
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, cont.

Does the client have a current **intent** to die?

Does the client have the current **desire** to die?
Is there a specific plan? Elicit details:

- Method to be used (gun, hanging, overdose on meds, etc.)
- Accessibility of method (Does the client have access to means to carry out the identified method—i.e., guns, stockpiled meds, etc. Just because they do not currently have access, do not assume that they are unable to obtain the means!)
- A planned time or place
- A mental or physical rehearsal

The goal is to determine lethality of plan. If the client has a plan, has 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!
Does the person experience command hallucinations? If so, do they give commands of self-harm or suicide?
Is there a history of suicide attempts?

- When?
- 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 attempts?

The goal is to establish a pattern (i.e., same time each year, same method, impulsive vs. planned, response to a stressor).
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?
Does the client have barriers, or protective factors, to suicide?

- Can the client identify reasons for living?
- How has he or she managed to evade the act of suicide thus far?
You have now completed a thorough suicide assessment. You have assessed the client’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 is based on reducing risk factors and enhancing protective factors. Work collaboratively with the client, family members and significant others, including other treatment and service providers.
Immediate Interventions

When high acute risk factors are present (serious planning or intent, lethal method with access to means), an immediate response is required. Immediate interventions include:

- Triage at the Emergency Department
- Safeguarding the environment
- Hospitalization
ED Triage

Release from the ED may be possible after a suicide attempt or 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 or method have low lethality
- The individual has a stable and supportive living situation
- The client is able to cooperate with follow-up recommendations
When the client remains at home, decisions must be made about removal or restriction of firearms, medications, and other potentially lethal objects and dangerous substances, including drugs and alcohol. Even if a person’s desire for death is transient or passive, the risk for accidental suicide increases with the presence of a lethal method. 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. It may also be helpful to enlist the assistance of the family in removing lethal objects and dangerous substances.
The decision to hospitalize a client takes into consideration the risks and benefits of both outpatient versus inpatient care in the context of the client’s risk.

Where risk is deemed to be high and acute, considerations for hospitalization include:

- 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, or multiple previous serious suicide attempts
- Absence of an adequate psychosocial support system or people to monitor the person’s behavior
- Inability to establish or maintain a therapeutic alliance with the clinician
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

When a client in need of hospitalization meets the criteria and refuses hospitalization, lacks either a working alliance or the capacity to make a rational treatment decision, involuntary hospitalization should be instituted as an emergency intervention.

Know your state statutes regarding criteria and process.
Considerations for involuntary

Hospitalization is generally indicated \textit{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 is generally indicated in the presence of suicidal ideation with:

- Specific plan with high lethality
- High suicidal intent
Admission may be necessary in the presence of suicidal ideation with:

- Psychosis or major psychiatric disorder
- Past attempts, particularly if medically serious
- There is a possible contributing medical condition (e.g., acute neurological disorder, cancer, infection)
- Client shows lack of response to or inability to cooperate with partial hospital or outpatient treatment
- The client needs a supervised setting for a medication trial or ECT
- The client needs skilled observation, clinical tests, or diagnostic assessments that require a structured setting
- There is limited family and/or social support, including lack of stable living situation
- An ongoing clinician-patient relationship is missing
- There is limited access to timely outpatient follow-up
Outpatient Treatment

Effective clinical care can reduce symptoms and risk for suicidal behaviors. Monitor at-risk behavior and include appropriate levels of observation and supervision.

- Intensive follow-up, more frequent appointments, case management, telephone contacts or home visits may improve the situation over the short term.
- Short-term cognitive-behavioral therapy provides alternative problem-solving strategies and has shown to be effective in reducing suicidal ideation, depression and hopelessness.
- Motivate and support the client in getting to a referral source or to their next therapy session.
Outpatient Treatment

Continuing suicidality is best treated on an outpatient basis as long as the client has a supportive living situation and a positive and sustaining therapeutic relationship.

- Self-injurious behaviors and suicidality may be on-going and repetitive for some people. Help the person understand how suicidal thinking and behavior is a way to cope, and collaboratively develop alternate problem-solving strategies, distress tolerance, and emotional regulation skills that are less dangerous and more effective.
- Document any changes in risk and protective factors; set goals for each session so changes may be appropriately addressed.
- Engage in collaborative problem-solving with the client to determine what can be accomplished between sessions.
- Review the client’s response to treatment interventions, address barriers in adhering to the plan and revise the plan as necessary...session by session.
Outpatient Treatment

Once suicidality is resolved, treatment focus shifts to addressing the factors that contributed to the client’s prior suicidality (i.e., problem-solving deficits, impulsivity, emotional regulation, lack of social supports, etc.).

• A strong therapeutic relationship will assist in maintaining stability in a vulnerable client.
• Ongoing risk for suicide should be routinely monitored, assessed and documented.
• Assure that client, family and significant others are following through with agreed-upon actions.
• Assure continuity of care and follow-up contact with all clients deemed at risk for suicide.
A Note about Safety Contracts

Safety contracts can be problematic.

• They are not a guarantee of safety
• Clinicians often feel falsely reassured of client safety and decrease vigilance
• Clients with borderline personality disorder and passive-aggressive personality disorder may manipulate around contracts
• The only hope of effectiveness is in conjunction with an established and strong therapeutic relationship with client
Rather than developing a “contract,” consider a safety plan or crisis plan which details how to 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.
Throughout every step of the process from assessment to intervention, everything which occurs must be documented.

- What occurred to prompt a suicide assessment (behavior, statements, etc.)?
- What questions were asked, what was client response?
- Who was consulted in determining action to take (physician, hospital administrator, program director, etc.)
- What action was taken on behalf of client?
- What was the outcome?
Post Test

Click the “x” in the upper right corner to close this screen.

Open the post test called Suicide Risk Assessment For Outpatient Programs and proceed to take the test.