



Suicide Awareness & Assessment

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Suicide Awareness

- Suicide rates
- Why suicide?

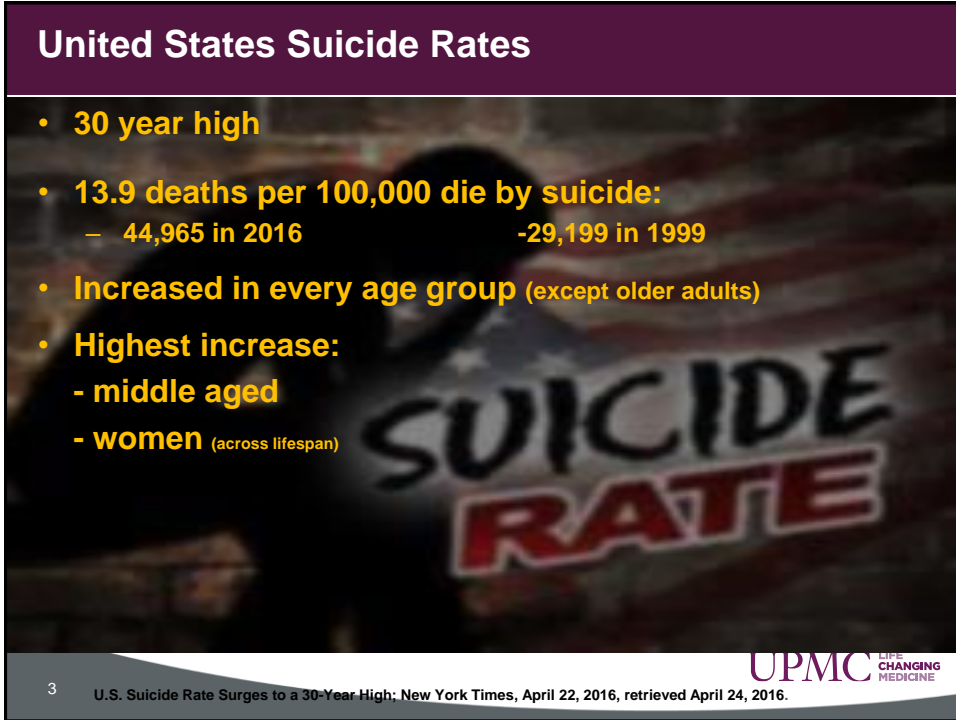
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United States Suicide Rates

- **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)

3 U.S. Suicide Rate Surges to a 30-Year High; New York Times, April 22, 2016, retrieved April 24, 2016.

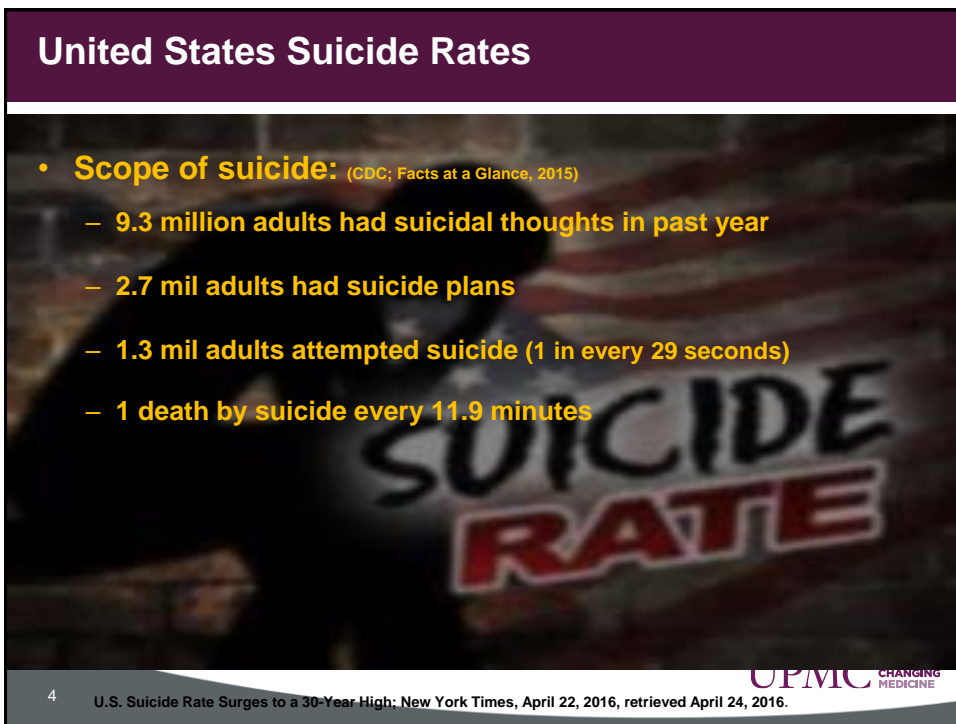


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United States Suicide Rates

- **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

4 U.S. Suicide Rate Surges to a 30-Year High; New York Times, April 22, 2016, retrieved April 24, 2016.



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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

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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).

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Suicide Assessment

- 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

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Conduct a suicide assessment

RESOURCES

- Download this card and additional resources at <https://www.spr.org>
- Resources for implementing The Joint Commission 2007 Patient Safety Goals on Suicide Risk: <https://www.spr.org/SharedDocs/Reports.aspx?cid=20070801>
- SAFE-T** aligns with the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors: http://www.psychiatryonline.com/practguide/practguidePage_144.asp
- Practice Parameters for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40:17 (supplement): 24-31.

ACKNOWLEDGMENTS

- Originally conceived by Douglas Jacobs, MD, and developed as a collaboration between Screening for Mental Health, Inc. and the Suicide Prevention Resource Center.
- This material is based upon work supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) under Grant No. 1U79SE07300. Any opinions, findings, conclusions, or recommendations expressed in this material are those of the author and do not necessarily reflect the views of SAMHSA.

**National Suicide Prevention Lifeline
1-800-273-TALK (8255)**



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

- 1 IDENTIFY RISK FACTORS
How many risk factors can be identified in this case?
- 2 IDENTIFY PROTECTIVE FACTORS
How many protective factors can be identified in this case?
- 3 CONDUCT SUICIDE INQUIRY
Suicide thoughts, plans, behaviors, and intent
- 4 DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Develop intervention plan.
- 5 DOCUMENT
Assessment of risk, protective factors, and intervention plan

Suicide assessments should be conducted at first contact, with any subsequent suicidal behaviors, increased suicidal ideation, or persistent clinical change for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- Identified risk factors:** history of prior suicide attempts, altered suicide thoughts, or self-harm behavior
- Current/last psychiatric diagnosis:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TD, PTSD, Cluster B personality disorders, recent diagnosis, comorbid depression, aggression, impulsivity
- Comorbidities:** are more than 1 of these clinical conditions
- Any symptoms:** anhedonia, insomnia, headaches, anxiety/panic, global insomnia, comorbid health issues
- Family history:** of suicide, attempts, or Axis I psychiatric diagnosis requiring hospitalization
- Personality/Personality/Behavioral:** Impulsive control, history of hoarding, shame, or anger or a loss of inhibition, financial or health issues—will at all times; history of multiple stressors (e.g., loss, divorce, death, illness); family involvement; history of physical or sexual abuse; history of trauma
- Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- Access to means:**

2. PROTECTIVE FACTORS Protective factors, even if present, may not counteract significant acute risk

- Internal:** ability to cope with stress, religious beliefs, psychiatric resilience
- External:** responsibility to others or beloved pets, academic/religious responsibility, social supports

3. SUICIDE INQUIRY Specific questioning about thoughts, plans, behaviors, intent

- Plan:** specific, location, lethality, availability, emergency contacts
- Behaviors:** past attempts, altered thoughts, references to self-harm, suicidal ideation, suicidal ideation with intent or plan, suicidal ideation with suicidal ideation
- Intent:** current or future suicidal ideation, suicidal ideation with intent or plan, suicidal ideation with suicidal ideation
- Thoughts:** suicidal ideation with suicidal ideation, suicidal ideation with suicidal ideation
- Thoughts:** suicidal ideation with suicidal ideation, suicidal ideation with suicidal ideation

4. RISK LEVEL/INTERVENTION

- Assessment of risk level:** is based on clinical judgment, after completing steps 1-3
- Assessment of patient or environmental circumstances:** change

RISK LEVEL	RISK/PROTECTIVE FACTOR	SIGNIFICANCE	POSSIBLE INTERVENTIONS
High	Previously diagnosed with severe depression or acute psychiatric crisis; suicidal ideation with suicidal ideation; suicidal ideation with suicidal ideation	Personality level suicide attempt or persistent suicidal ideation with suicidal ideation; suicidal ideation with suicidal ideation	Admission generally indicated unless a significant change in status; suicidal ideation with suicidal ideation; suicidal ideation with suicidal ideation
Moderate	Multiple risk factors, but protective factors	suicidal ideation with suicidal ideation, suicidal ideation with suicidal ideation	Admission may be necessary depending on risk factors; suicidal ideation with suicidal ideation; suicidal ideation with suicidal ideation
Low	Minimal risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptoms reduction; suicidal ideation with suicidal ideation

5. DOCUMENT risk level and elaborate treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, ECT, contact with significant others, constraints). Review interventions. If admission, follow up plan. For youths, treatment plan should include rules for parents/guardians.

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Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)

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)

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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

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Step 1: Identify risk factors

Risk factors for both suicide and homicide:

Stressor/loss leading to humiliation, shame, or despair	Increased irritability and/or becoming easily frustrated
Current/symptomatic psychiatric illness	Increased alcohol or drug use
Inadequate or overwhelmed coping skills for acute distress	Social isolation; withdrawal from friends, family, supports
Non-suicidal self-injury/self-inflicted injury	Hopelessness/helplessness/lack of reason for living
Anxiety/insomnia	Access to lethal means/recently obtained a weapon



Risk Factors for Suicide:

Suicide attempt (within last 30 days)	Suicide attempt (over lifetime)
Acts of furtherance/suicidal behaviors	Inadequate or overwhelmed coping skills for acute distress
Intent to commit suicide	Physical pain
Suicidal planning	Family history of suicide
Suicidal ideation	Medical illness/morbidity
Impulsivity	Physical or chronic impairment
Recent discharge from inpatient psychiatric care (Note: clients are at elevated risk for suicide during the first year after hospital discharge; this risk is most pronounced in the first weeks to months post discharge)	history of trauma or loss such as abuse as a child, bereavement or economic loss.

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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.

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Step 2. Protective Factors

Protective factors may not counteract significant acute suicide risk


NOTE: Some protective factors are time sensitive

Coping Skills

Internal: Stress management, hope, coping skills

Protective factors:
Internal Protective Factors

Cultural and spiritual beliefs that discourage aggression and harming others or self
History of successfully solving problems, resolving conflict and handling disputes
Hopeful
Future planning/identifies reasons for living
Sense of responsibility to family, children, and/or pets
Frustration tolerance
Religious beliefs/spirituality
Ability to cope with stress
Optimistic outlook
Positive coping skills
Fear of death or the actual act of killing oneself



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Step 2. Protective Factors


Protective factors may not counteract significant acute suicide risk


NOTE: Some protective factors are time sensitive

External: pets, family, relations, connections

External Protective Factors:

Engaged in treatment for psychiatric, physical, and substance use disorders; willing to access treatment and support; maintains therapeutic relationships
Supportive community, social network, family and friend supports
Presence of pets for whom the individual has a strong affinity
Can identify supports (family, personal connections, other relationships) – specify in comments
Able to develop a crisis/safety plan to protect against suicide/homicide
Engaged in work or school





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Step 2. Protective Factors

Protective factors may not counteract significant acute suicide risk

NOTE: Some protective factors are time sensitive

- 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?

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Step 3. Ask Specifically About Suicide

When asking about suicide we should...

To Do:

- Be engaging; build trust & rapport
- Put the individuals and their needs first
- Demonstrate empathy, show you care
- Create a conversational approach
- Normalize and validate the concerns raised
- Focus the conversation on the person at risk for suicide
- Take the time to find out about "why suicide"




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Suicide is Complex


Our attitudes/beliefs regarding suicide can become a barrier



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Barriers for talking about one's risk for suicide



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

<http://www.psychiatrictimes.com/couch-crisis/importance-talking-about-suicide>

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Suicidal Cues

Feelings

Statements

Thoughts

Situations

Physical

Warning Signs

Behaviors

Changes

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

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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

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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



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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



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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



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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.**

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Means Restriction Strategies

THINGS

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to do

- Guns removed, safely stored/locked
- Medications monitored/limited
- Routinely assess suicide risk
- Consider hospitalization for high risk
- Check in with individual/follow-up
- Compare Treatment Team notes
- Assess all lethal means access
- Use Safety/Crisis Plan
- Consult with Supervisor/Designee
- Avoid use of "No-Suicide contracts"
- Increase observation/contacts/supports




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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

(Simon, T.R., Swann, A.C., Powell, K.E., Potter, L.B., Kresnow, M., and O'Carroll, P.W.
 Characteristics of Impulsive Suicide Attempts and Attempters. SLTB. 2001; 32(supp):49-59)



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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

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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

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Step 4. Determine Level of Risk

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.)

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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

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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

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Never use "Contract for Safety"

Download more graphics at www.psdgraphics.com

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.

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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