Suicide Awareness & Assessment

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Suicide Awareness

- Suicide rates
- Why suicide?
United States Suicide Rates

- 30 year high
- Suicide rate increased 24% between 1999 – 2014
- 13.8 deaths per 100,000 die by suicide:
- Increased in every age group (except older adults)
- Highest increase: middle-aged; women (across lifespan)

**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
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
Prevention of Suicide

- Increase rate of suicide across the United States
  - The Joint Commission (TJC) – issued a Sentinel Event Alert.
    - Issue 56 – February 24, 2016

- Effective suicide prevention includes clinical preventative services.

- Clinical preventative services includes:
  - Preventative screening.
  - Suicide assessment by primary care and health care providers

- It is important that we identify individuals who are at risk for suicide in all settings.

- The use of consistent screening and assessment tools combined with the examination of one’s entire clinical picture can help identify individuals at risk for suicide (use of SAFE-T model).
Suicide Assessment

- 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
**Suicide Assessment Five**

**SAFE-T**

**Suicide Assessment Five-step Evaluation and Triage (SAFE-T)**

1. **IDENTIFY RISK FACTORS**
   - Note those that can be identified to reduce risk

2. **IDENTIFY PROTECTIVE FACTORS**
   - Note those that can be enhanced

3. **CONDUCT SUICIDE INQUIRY**
   - Specific questions about thoughts, plans, behaviors, intent

4. **DETERMINE RISK LEVEL/INTERVENTION**
   - Determine risk, appropriate intervention to address and reduce risk

5. **DOCUMENT**
   - Assessment of factors, rationale, intervention, follow-up

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**RESOURCES**

- Download this card and additional resources at [http://www.qspre.org](http://www.qspre.org)

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**National Suicide Prevention Lifeline**

1-800-273-TALK (8255)

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

**1. RISK FACTORS**

- **Suicidal behavior:** History of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- **Current/past psychiatric disorders:** Especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TB, FTSO. Cluster B personality disorders, conduct disorders (antisocial behavior), schizophrenia
- **Current/past medical problems:** Medical/surgical conditions, organ failure
- **Current/past history of suicide attempts:** Those who attempt suicide are at increased risk
- **Family history of suicide attempts or Axis I psychiatric disorders requiring hospitalization:** Suicide attempts are more common in families with a history of suicide
- **Precipitants/Stressors/Interpersonal:** Triggers leading to a change in mood, shame, or despair (e.g., loss of relationship, financial or health status, and/or physical health or emotional or sexual abuse. Social isolation
- **Change in treatment:** Discharge from psychiatric hospital, provider or treatment change
- **Access to resources:**

**2. PROTECTIVE FACTORS**

- **Internal:** Ability to cope with stress, religious beliefs, satisfaction with self
- **External:** Responsibility to children or loved ones, positive therapeutic relationships, social support

**3. SUICIDE INQUIRY**

- **Situational:** Frequency, intensity, duration, recent (the past 48 hours, past month, and worst ever)
- **Plan:** Timing, location, intent, availability, preparatory acts
- **Behavioral:** Past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self-injurious actions
- **Intent:** To what extent does the patient believe planning is necessary? To what extent does the patient believe they are lethal vs. self-injurious

**4. RISK LEVEL/INTERVENTION**

- **Assessment of risk:** Based on clinical judgment after completing steps 1-3
- **Severity:** Subjective clinical circumstances

<table>
<thead>
<tr>
<th>RISK LEVEL</th>
<th>RISK/PROTECTIVE FACTORS</th>
<th>SUICIDALITY</th>
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</thead>
</table>
| High       | Multiple risk factors, strong protective factors |Suicidal ideation or plans, but no intent or behavior | Treatment plan in place to address suicide risk. Admission is generally indicated unless a significant change reduces risk. Initiate treatment plan.
| Moderate   | Multiple risk factors, strong protective factors |Suicidal ideation or plans, but no intent or behavior | Admission may be necessary depending on risk factors. Develop crisis plan. Contact emergency/crisis numbers.
| Low        | Multiple risk factors, strong protective factors |Suicidal ideation or plans, but no intent or behavior | Develop referral; symptom reduction. Contact emergency/crisis numbers.

**5. DOCUMENT** Risk level and rationale: treatment plan to address suicide risk (e.g., medication, setting, psychotherapy, I.C.T., contact with significant others, consultation). Follow-up instructions, if relevant: follow-up plan. For inpatients, treatment plan should include roles for parent/ guardian.
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)
SAFE-T Model Recommendation

• Suicide Assessments should be conducted…

- at first contact

- with any subsequent suicidal behavior, increased ideation, or pertinent clinical change

- treatment plan reviews and prior to a change in treatment plan (i.e., progress to next phase)

- at discharge
## Step 1: Identify risk factors

### Risk factors for both suicide and homicide:

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

### Risk Factors for Suicide:

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Suicide attempt (within last 30 days)</td>
<td>Suicide attempt (over lifetime)</td>
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<tr>
<td>Acts of furtherance/suicidal behaviors</td>
<td>Inadequate or overwhelmed coping skills for acute distress</td>
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<tr>
<td>Intent to commit suicide</td>
<td>Physical pain</td>
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<tr>
<td>Suicidal planning</td>
<td>Family history of suicide</td>
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<tr>
<td>Suicidal ideation</td>
<td>Medical illness/morbidity</td>
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<tr>
<td>Impulsivity</td>
<td>Physical or chronic impairment</td>
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<tr>
<td>Recent discharge from inpatient psychiatric care</td>
<td>History of trauma or loss such as abuse as a child, bereavement or economic loss.</td>
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<tr>
<td>(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)</td>
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</tbody>
</table>
Modifying Risk Factors

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

Protective factors may not counteract significant acute suicide risk

**NOTE:** Some protective factors are time sensitive

**Internal:** Stress management, hope, coping skills

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

<table>
<thead>
<tr>
<th>External Protective Factors:</th>
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</thead>
<tbody>
<tr>
<td>Engaged in treatment for psychiatric, physical, and substance use disorders; willing to access treatment and support; maintains therapeutic relationships</td>
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<tr>
<td>Supportive community, social network, family and friend supports</td>
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<tr>
<td>Presence of pets for whom the individual has a strong affinity</td>
</tr>
<tr>
<td>Can identify supports (family, personal connections, other relationships) – specify in comments</td>
</tr>
<tr>
<td>Able to develop a crisis/safety plan to protect against suicide/homicide</td>
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<tr>
<td>Engaged in work or school</td>
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[Natural Supports Image]
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?
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”
Suicide is Complex

Our attitudes/beliefs regarding suicide can become a barrier

- It’s a sin
- Attention Seeking
- Mental Illness
- Cultural Beliefs
- Manipulation
- Suicide is for the weak
- Suicide is wrong
Key: reduce barriers by having a conversational approach and building rapport

Suicidal Cues

Feelings

Thoughts

Warning Signs

Statements

Situations

Physical

Behaviors

Changes

Invitations, which are warning signs or cues someone may be at risk for suicide, are often associated with loss and/or pain.
What’s the best way to ask about suicide?

Be Direct:

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?

Suicide vs. Hurt Oneself
Does “No” Mean “No”?

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

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

What if they say “Yes”?

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

Not Everyone answers questions regarding suicide honestly

Also consider:

1. **Means Education (Safety):** awareness regarding how a person attempts suicide

2. **Impulsivity:** actions based on sudden urges rather than careful thought
Means Restriction (means safety)

- Can be an effective strategy used to help prevent suicide
- When lethal means are less available, suicide rates by that method decline

- Regardless if an individual reports being suicidal or does or does not identify a method for suicide, we will always assess for lethal means access including firearms/weapons

- It is important to discuss with patient and collaterals (family, etc.) means restrictions, limiting access to lethal means, and steps they will take to reduce access to such means.

- Documentation should include instructions given to the individual & significant others about firearms and other means.
Means Restriction Strategies

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

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

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

Step 4. Determine Level of Risk

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

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

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

3 Categories of Risk

- High Risk
- Moderate Risk
- Low Risk

Use SAFE-T card as reference –

*see SAMHSA website to order SAFE-T cards
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.)*
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
DOCUMENTATION NEEDS TO INCLUDE:

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

If Not documented; it didn’t happen
Never use “Contract for Safety”

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

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

A best practice approach is safety planning.
Summary

• Suicide in the U.S. is a serious health problem and national crisis

• We need to focus efforts on preventing suicide by screening, assessing, and responding accordingly

• SAFE-T assessment model can be a valuable tool when assessing for suicide