How do I do a proper suicide assessment and document it in my note?

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GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

☑ Any conflicts of interest?
LEARNING OBJECTIVES

• Orient to suicide epidemiology and facts

• Identify risk factors and drivers for suicidal behavior

• Review standard-of-care for addressing suicidality:
  I. Suicide-specific assessment
  II. Detailed Safety Plan
  III. Appropriate Referral & Follow-up
“An act with a fatal outcome which the deceased, knowing or expecting a potentially fatal outcome, has initiated and carried out with the purpose of bringing about wanted changes.”

(De Leo, et al. 2004)
KEY TERMS

• Died by Suicide (completed, suicided; never ‘successful’ ‘committed’)
• Attempted Suicide (Aborted, Rescued, Interrupted, Non-fatal)
• Survivor (Loss, Attempt)
• Suicidal Plans, Preparation, Rehearsal
• Suicidal Threats
• Instrumental Suicidal Behavior
• Non-Suicidal Self-Injury (NSSI)
• Suicidal Ideation (Passive, Active, Intent, Morbid Ruminations)
Worldwide, one suicide death every 40 seconds.
IN THE UNITED STATES

• Approximately 46,000 deaths per year

• 10th ranking cause of death overall, 2nd among young people

• More than 1,000,000 attempts per year

• More than 6,000,000 people seriously considered suicide

• Approximately half of suicide deaths occur by firearms
Suicide Deaths in the United States by Sex, 2000–2014

Source: WISQARS Fatal Injury Reports, 1999–2014
CORE ASSUMPTIONS

- Suicide is a complex and fearsome behavior
- Risk for lethal self-harm (suicidal behavior) unfolds over time
- People who die by suicide have both a desire for death and the acquired capability for enacting suicidal behavior
- Individual suicides are not predictable, but risk can be reduced with timely access to appropriate care
RISK FACTORS
Suicidal Ideation
Suicide Plan
Suicide Preparation
Suicide Rehearsal
History of Suicidal Behavior

History of Psychiatric Illness
History of Psychiatric Treatment

Impulsivity

Substance Use (Dependence v. Abuse)

Significant Loss
Relationship Problems
Burden to Others

Health Problems
Chronic/Impairing Pain
Sleep Problems
Recent/New Disability

Legal/Financial Issues
Housing Concerns

Shame

Psychological Pain
Stress
Agitation
Hopelessness
Self-Hate

(Jobes, 2016; Linehan, 1993; Joiner 2009)
Relative Frequency, %

Blood alcohol conc., g/L

Hangings, n = 1343

Drug poisonings, n = 891

Jones et al., 2013
WARNING SIGNS

Ideation
Substance Use

Purposelessness
Anxiety
Trapped
Hopelessness

Withdrawal
Anger
Recklessness
Mood Changes

American Association of Suicidology
NOW WHAT?
RECOMMENDED STANDARD CARE ELEMENTS

• **Identify/Screen patients** at intake & periodically for suicidality

• **Stratify** according to level of risk (low, moderate, high)

• Develop collaborative **Safety Plan**
  • Update every visit until risk is reduced/resolved

• Engage patient in **Outpatient Treatment**

(National Action Alliance for Suicide Prevention, 2018)
GOALS OF ASSESSMENT/MANAGEMENT

1. Characterize & understand current suicidality
2. Identify risk factors & Psychiatric History
3. Develop detailed safety plan
4. Establish follow-up/referral care
5. Document standard of care
CURRENT SUICIDALITY: DESIRE FOR SUICIDE

• “Are you having any thoughts of hurting or killing yourself?”

• “Do you ever have thoughts of wanting to be dead or thoughts that you would be better off dead?”

• Thoughts/images of killing themselves or of their dead body

Joiner et al., 2009
CURRENT SUICIDALITY: THWARTED BELONGINGNESS

- “Do you feel connected to other people?”
- “Do you live alone?”
- “Who can you turn to when you feel bad or need help?”

Joiner et al., 2009
CURRENT SUICIDALITY: PERCEIVED BURDENSOMENESS

- “Sometimes people think, ‘the people in my life would be better off if I was gone.’ Do you think that?”
- “How would your family respond to your death by suicide?”
- “What contribution do you make to the lives of those around you?”

Joiner et al., 2009
ACQUIRED CAPABILITY

• Detailed History of Attempts, Plans, Threats, NSSI
  (date, method/means, medical care, rescued/aborted)
• Access to Lethal Means
• Painful & Provocative Events
• Patterns over time
• Chain Analysis for recent behaviors

Joiner et al., 2009
Multiple Attempter (Acquired Capability)?

Yes  No

Any other significant finding = AT LEAST Moderate Risk

Elevated on Resolved Plans & Preparation?

Yes  No

Any other significant finding = AT LEAST Moderate Risk

Elevated on Suicidal Desire & Ideation

Yes  No

Any other significant finding = AT LEAST Moderate Risk

Low Risk

Any other significant finding = AT LEAST Moderate Risk

Moderate Risk

(Adapted from Joiner et al., 1999; 2009)
STRUCTURE OF BRIEF ASSESSMENT

• “Tell me the story of...”

• Past Attempts/Fearlessness About Death
• Resolved Plans & Rehearsal/Preparation
• Current Suicidality (Ideation, Intent)

• Ability/Willingness/Capacity to stay safe
• Brief review of crisis intervention options

• Chart Review/Collateral Information

(Adapted from Joiner et al., 1999; 2009)
Assess suicidal desire and ideation:

1. Have you been having thoughts/images of suicide? (thoughts/images of killing yourself?) Tell me about that.
2. Do you think about wanting to be dead?
3. Thwarted belongingness: Do you feel connected to other people? Do you live alone? Do you have someone you can call when you’re feeling badly? [completely absent?]
4. Perceived burdensomeness: Sometimes people think: “the people in my life would be better off I was gone.” Do you think that?

Assess “other significant findings”:

13. Precipitant stressors: Has anything especially stressful happened to you recently? [death of loved one; divorce; major break-up; job loss]
14. Hopelessness: Do you feel hopeless?
15. Impulsivity: When you’re feeling badly, how do you cope? Sometimes when people feel badly, they do impulsive things to feel better. Has this ever happened to you? [e.g., cutting your skin, drinking alcohol, running away, binge eating, promiscuous sex, physical aggression, shoplifting].
16. [Presence of psychopathology: rated by interviewer]

Assess Resolved plans and preparations:

5. Duration [look for pre-occupation]: When you have these thoughts, how long do they last?
6. Intensity: How strong is your intent to kill yourself? 0 not intense at all, 10 very intense.
7. Past suicidal behavior: Have you attempted suicide in the past? How many times? Methods used? What happened (e.g., hospital?). Non-suicidal self-injury? Family history?
8. Specified plan [look for vividness, detail]: Do you have a plan for how you would kill yourself?
9. Means and opportunity: Do you have [the pills, a gun, etc.]? Do you think you’ll have an opportunity to do this?
10. Have you made preparations for a suicide attempt? [e.g., buying pills]
11. Do you know when do you expect to use your plan?
12. Fearlessness: Thinking about suicide, do you feel afraid? 0 very afraid, 10 not at all afraid.

(Joiner et al., 1999; 2009)
HELPFUL ASSESSMENT/MANAGEMENT TOOLS

- Columbia Suicide Severity Rating Scale (C-SSRS)
- Suicide Behavior Questionnaire – Revised (SBQ-R)
- Linehan Risk Assessment and Management Protocol (LRAMP)

- Collaborative Assessment & Management of Suicidality (CAMS)
- Dialectical Behavior Therapy (DBT)
# COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

**RISK ASSESSMENT**

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s), and/or consultation with family members and/or other professionals.

<table>
<thead>
<tr>
<th>Past 3 Months</th>
<th>Suicidal and Self-Injurious Behavior</th>
<th>Lifetime</th>
<th>Clinical Status (Recent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual suicide attempt</td>
<td></td>
<td>Hopelessness</td>
</tr>
<tr>
<td></td>
<td>Interrupted attempt</td>
<td></td>
<td>Major depressive episode</td>
</tr>
<tr>
<td></td>
<td>Aborted or Self-Interrupted attempt</td>
<td></td>
<td>Mixed affective episode (e.g. Bipolar)</td>
</tr>
<tr>
<td></td>
<td>Other preparatory acts to kill self</td>
<td></td>
<td>Command hallucinations to hurt self</td>
</tr>
<tr>
<td></td>
<td>Self-injurious behavior without suicidal intent</td>
<td></td>
<td>Highly impulsive behavior</td>
</tr>
</tbody>
</table>

**Suicidal Ideation**  
Check Most Severe in Past Month

- Wish to be dead
- Suicidal thoughts
- Suicidal thoughts with method (not without specific plan or intent to act)
- Suicidal intent (without specific plan)
- Suicidal intent with specific plan

**Activating Events (Recent)**

- Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)
- Refuses or feels unable to agree to safety plan

Describe:

- Sexual abuse (lifetime)
- Family history of suicide (lifetime)

**Pending Incarceration or Homelessness**

- Pending incarceration or homelessness

**Protective Factors (Recent)**

- Current or pending isolation or feeling alone

**Treatment History**

- Responsibility to family or others, living with family
- Supportive social network or family
- Fear of death or dying due to pain and suffering
- Fear that suicide is immoral, high spirituality
- Engaged in work or school

**Other Risk Factors**

- Gross motoric disorders
- History of non-compliance
- Impaired judgment
- Other

**Other Protective Factors**

- Engaged in work or school
- Supportive social network or family
- Gross motoric disorders

Describe any suicidal, self-injurious or aggressive behavior (include dates)
Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral
Item 2 Behavioral Health Referral
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Behavioral Health Consultation and Patient Safety Precautions
Item 5 Behavioral Health Consultation and Patient Safety Precautions
Item 6 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions
SAFETY PLANNING & CRISIS INTERVENTION
SAFETY PLAN

• Triggers/Antecedents/Vulnerabilities
• Internal/Individual Coping Strategies
• Social Support (non-suicide-specific)
• Specific contact info to prevent suicide
• Crisis Intervention/On-Call Resources

(Not a ‘No Suicide Contract’)
CRISIS INTERVENTION

• Family Friends

• Provider/Therapist/Case Manager

• Crisis Lifeline

• Emergency Department
MEANS RESTRICTION

• Assessment of highly lethal threats.

• Make it more difficult for patient to access dangerous objects.

• Creativity and collaboration.

• Managing the ubiquity of dangerous objects.
REFERRAL & FOLLOW-UP

- Voluntary psychiatric inpatient care
- Increase weekly visits with therapist
- Phone consultation/support

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org
CONTINGENT SUICIDALITY/SUICIDAL BEHAVIOR

• Limited empirical evidence.

• Contingently suicidal less likely to engage in suicidal behavior (Lambert et al., 1996; 2002)

• Reasons for refusing discharge typically center on access to resources (e.g., homelessness)
HOW TO ADDRESS CONTINGENT SUICIDALITY...

1. Define & Document
2. Suicide Risk Assessment
3. Document Interventions to Reduce Risk
4. Rationale for Discharge; Reason Care is Contraindicated
5. Document Discussion of Discharge & Problem-Solving
6. Consult & Document Consultation

Bundy et al., 2014
DOCUMENTATION

• Precision in describing suicidal thoughts and behavior.

• Distinguish between attempts, NSSI, and instrumental behavior.

• Use quotes to articulate patient’s perceptions of safety planning.

• Note consultation w/ other providers, collateral contacts.

• Note VIP conversation.
OTHER HELPFUL TOOLS

**iPhone Screenshot**

**MY3**

- Anna Haro
- David Taylor
- John Appleseed

**YOUR SAFETY PLAN**

Fill out your safety plan and reference it when you are feeling suicidal.

1. **1. MY WARNING SIGNS**
2. **2. MY COPING STRATEGIES**
3. **3. MY DISTRACTIONS**
4. **4. MY NETWORK**

**GET HELP NOW**

- Call the National Suicide Prevention Lifeline
- **CALL 911**

**Virtual Hope Box**

- Distract Me
- Inspire Me
- Relax Me
- Coping Tools

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