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Psychiatry and Addictions Case Conference

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

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Christopher R. DeCou, PhD



HARBORVIEW

INJURY PREVENTION
& RESEARCH CENTER

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Integrated Care
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GENERAL DISCLOSURES

The University of Washington School of Medicine also gratefully acknowledges receipt of educational grant support for this activity from the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout Washington State.

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.”

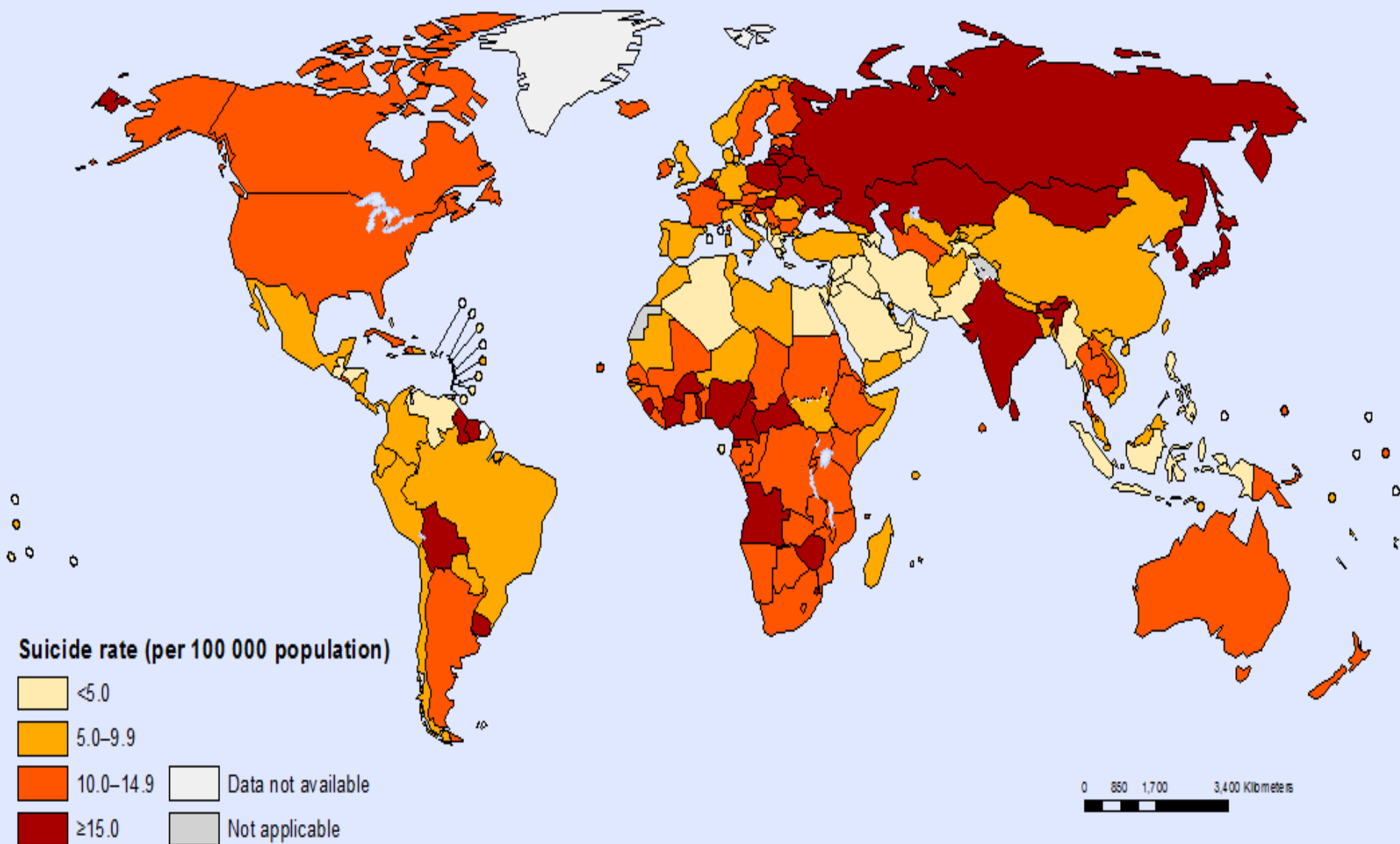
(De Leo, et al. 2004)

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)

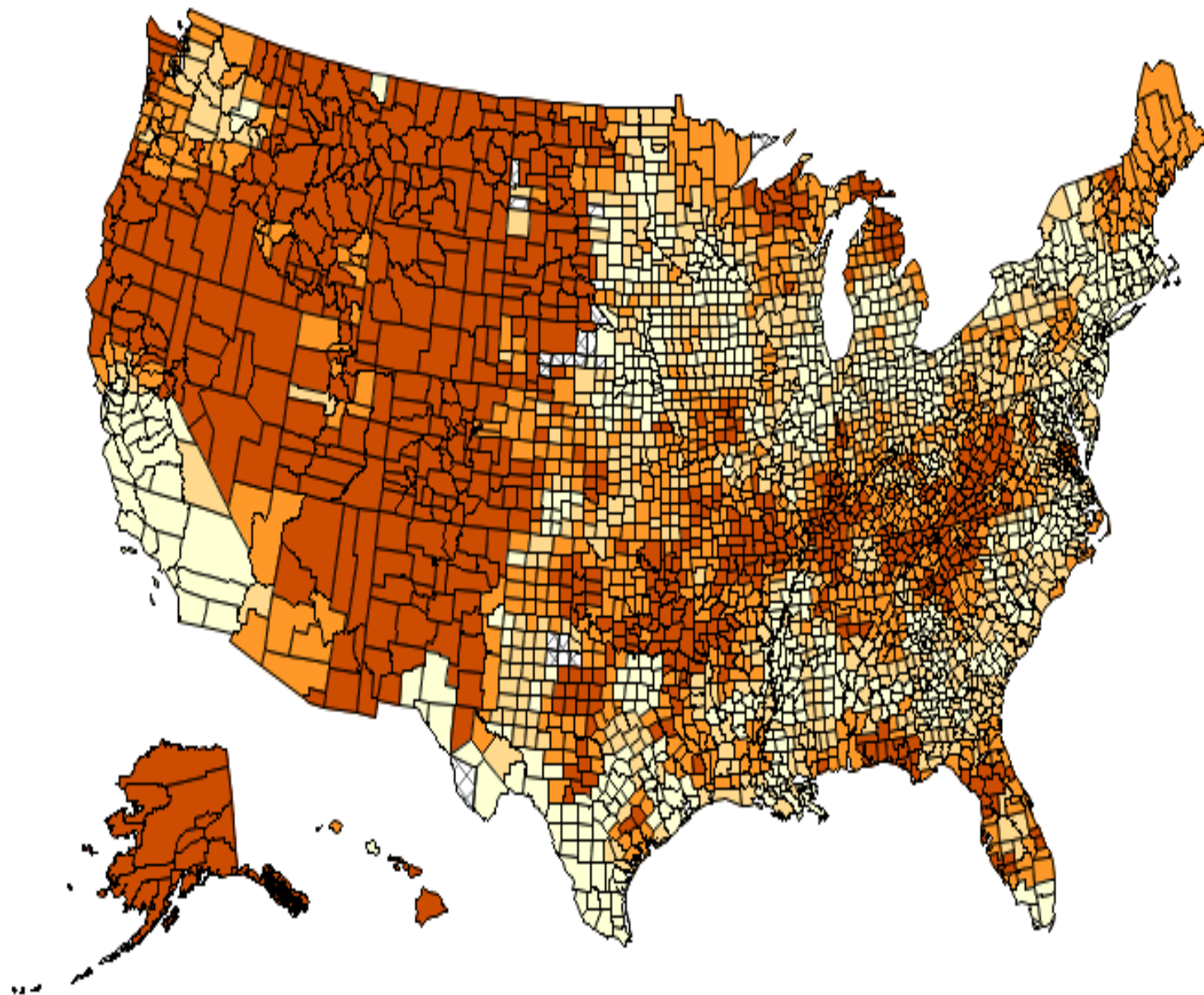
Worldwide, one suicide death every 40 seconds.

Age-standardized suicide rates (per 100 000 population), both sexes, 2015



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



Suppressed/Unstable/Undefined

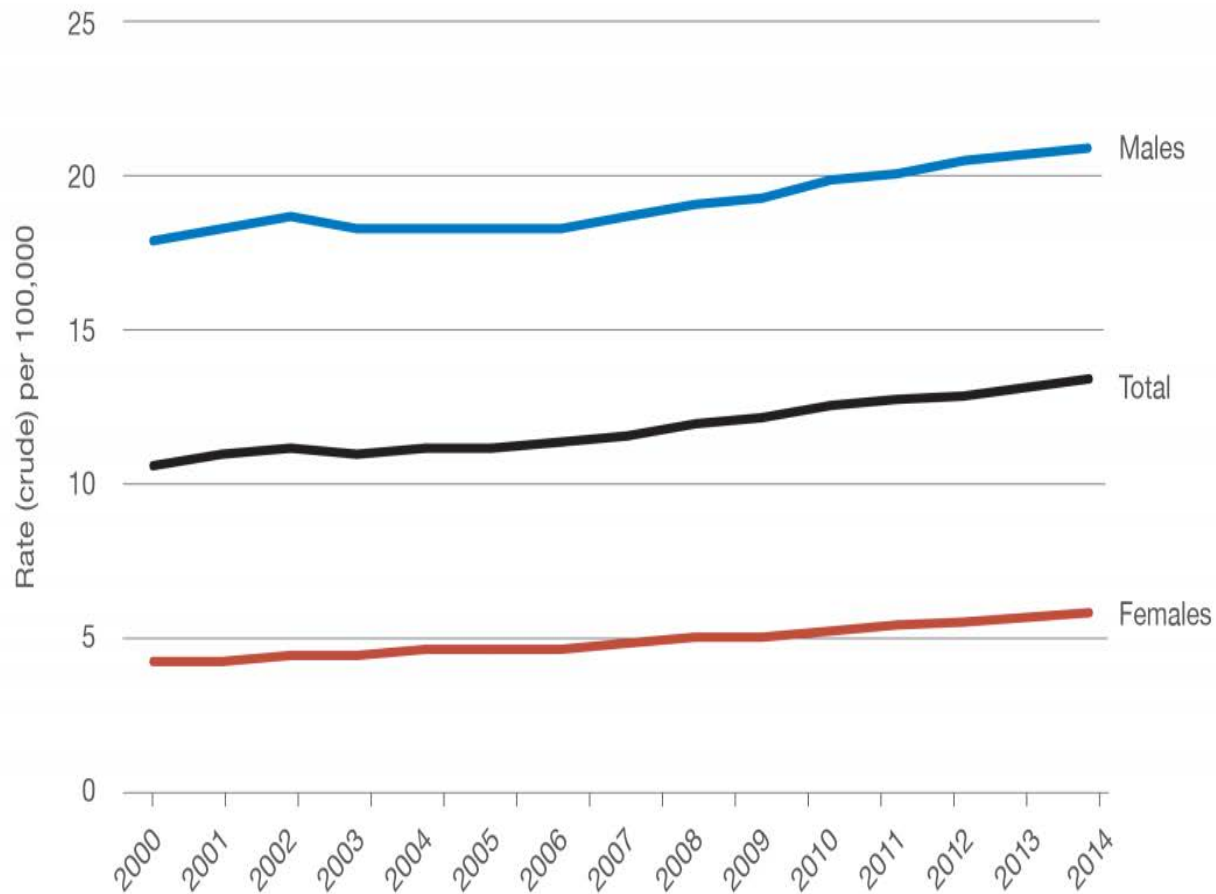
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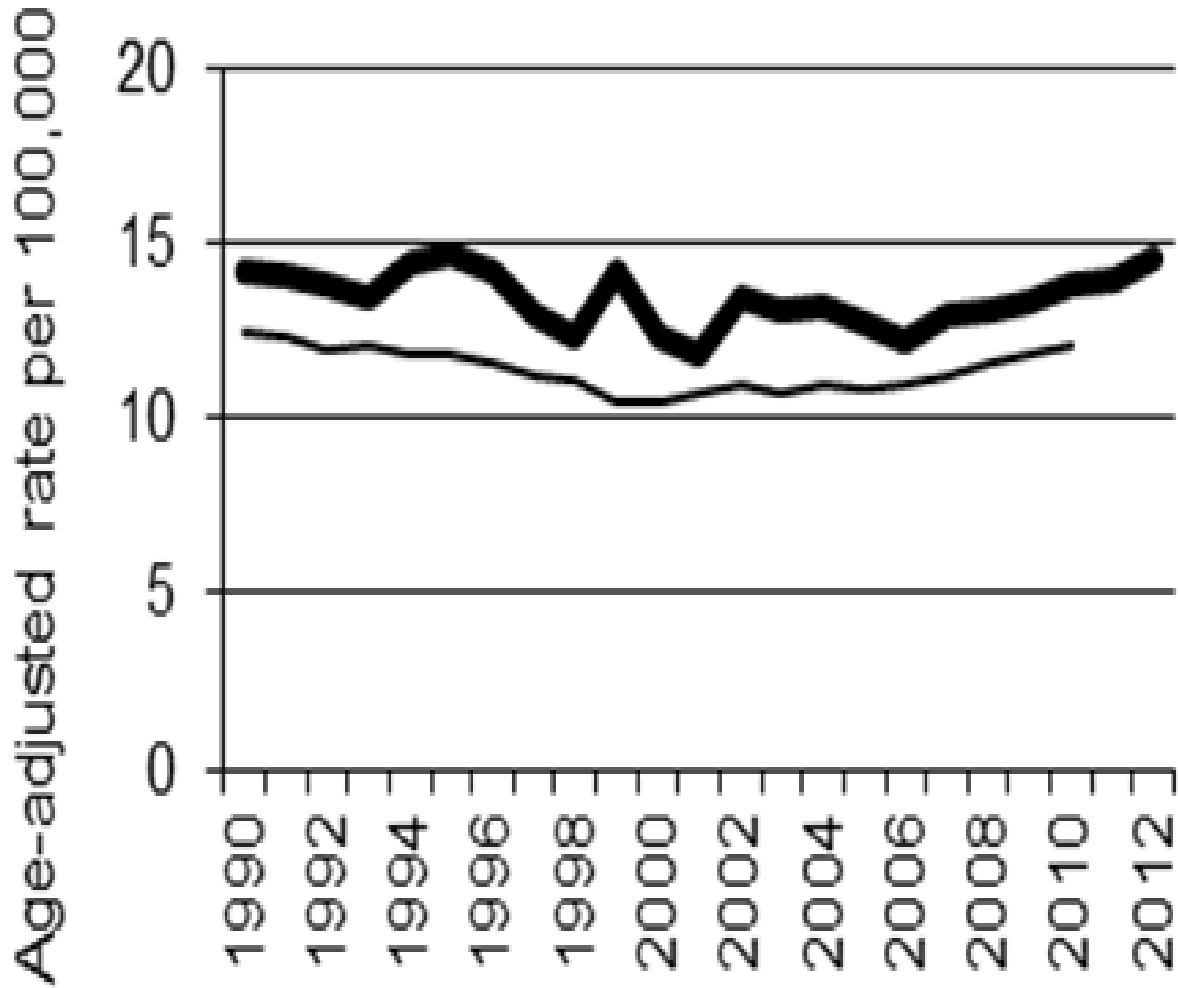
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Suicide Deaths in the United States by Sex, 2000–2014



Source: WISQARS Fatal Injury Reports, 1999–2014

Suicide WA State and US Death Certificates



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)

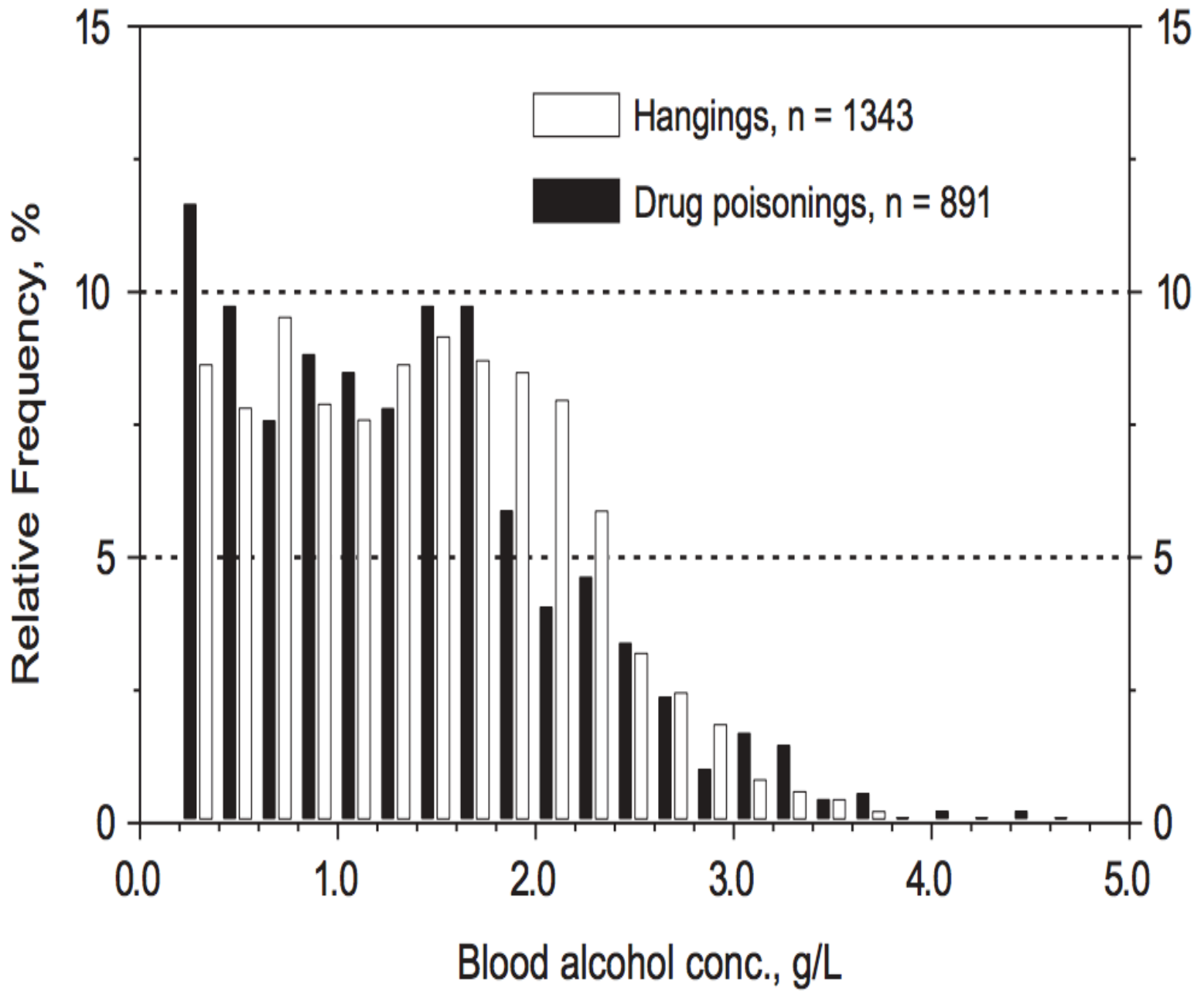
Significant Loss
Relationship Problems
Burden to Others

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

Legal/Financial Issues
Housing Concerns

Shame

Psychological Pain
Stress
Agitation
Hopelessness
Self-Hate



WARNING SIGNS

Ideation

Substance Use

Purposelessness

Anxiety

Trapped

Hopelessness

Withdrawal

Anger

Recklessness

Mood Changes

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

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?”

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?”

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

SUICIDE ASSESSMENT DECISION TREE (RISK STRATIFICATION)

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

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*

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.

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)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann
© 2008 The Research Foundation for Mental Hygiene, Inc.

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.

Past 3 Months	Suicidal and Self-Injurious Behavior	Lifetime	Clinical Status (Recent)
<input type="checkbox"/>	Actual suicide attempt	<input type="checkbox"/>	<input type="checkbox"/> Hopelessness
<input type="checkbox"/>	Interrupted attempt	<input type="checkbox"/>	<input type="checkbox"/> Major depressive episode
<input type="checkbox"/>	Aborted or Self-Interrupted attempt	<input type="checkbox"/>	<input type="checkbox"/> Mixed affective episode (e.g. Bipolar)
<input type="checkbox"/>	Other preparatory acts to kill self	<input type="checkbox"/>	<input type="checkbox"/> Command hallucinations to hurt self
<input type="checkbox"/>	Self-injurious behavior <i>without</i> suicidal intent	<input type="checkbox"/>	<input type="checkbox"/> Highly impulsive behavior
Suicidal Ideation Check Most Severe in Past Month			<input type="checkbox"/> Substance abuse or dependence
<input type="checkbox"/>	Wish to be dead		<input type="checkbox"/> Agitation or severe anxiety
<input type="checkbox"/>	Suicidal thoughts		<input type="checkbox"/> Perceived burden on family or others
<input type="checkbox"/>	Suicidal thoughts with method (but without specific plan or intent to act)		<input type="checkbox"/> Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.)
<input type="checkbox"/>	Suicidal intent (without specific plan)		<input type="checkbox"/> Homicidal ideation
<input type="checkbox"/>	Suicidal intent with specific plan		<input type="checkbox"/> Aggressive behavior towards others
Activating Events (Recent)			<input type="checkbox"/> Method for suicide available (gun, pills, etc.)
<input type="checkbox"/>	Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)		<input type="checkbox"/> Refuses or feels unable to agree to safety plan
Describe:			<input type="checkbox"/> Sexual abuse (lifetime)
			<input type="checkbox"/> Family history of suicide (lifetime)
<input type="checkbox"/>	Pending incarceration or homelessness	Protective Factors (Recent)	
<input type="checkbox"/>	Current or pending isolation or feeling alone	<input type="checkbox"/>	Identifies reasons for living
Treatment History			<input type="checkbox"/> Responsibility to family or others; living with family
<input type="checkbox"/>	Previous psychiatric diagnoses and treatments	<input type="checkbox"/>	Supportive social network or family
<input type="checkbox"/>	Hopeless or dissatisfied with treatment	<input type="checkbox"/>	Fear of death or dying due to pain and suffering
<input type="checkbox"/>	Non-compliant with treatment	<input type="checkbox"/>	Belief that suicide is immoral; high spirituality
<input type="checkbox"/>	Not receiving treatment	<input type="checkbox"/>	Engaged in work or school
Other Risk Factors			Other Protective Factors
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	

Describe any suicidal, self-injurious or aggressive behavior (include dates)

<http://cssrs.columbia.edu/>

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



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)

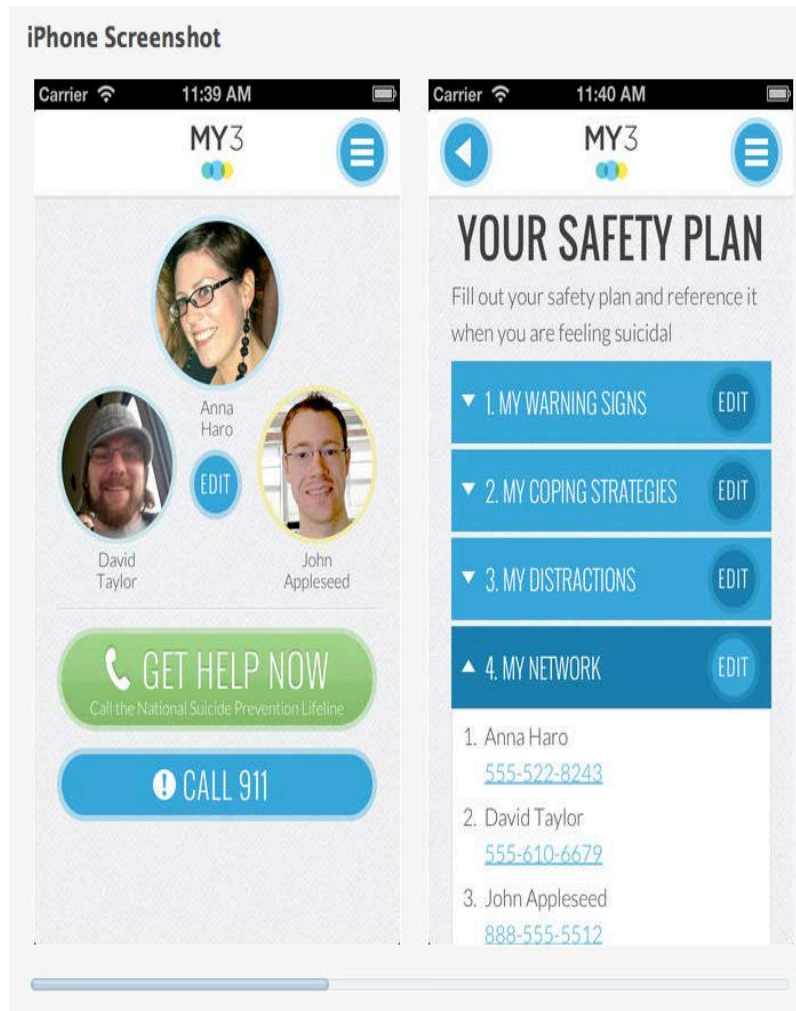
HOW TO ADDRESS CONTINGENT SUICIDALITY...

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

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



CHRIS DECOU
DECOU@UW.EDU