Suicide and State Mental Health Authorities: Our Time to Lead

December 6, 2011

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- Please mute your line during the presentation by pressing *6
- Press *6 again to un-mute your line

Webinar sponsored with support from the Substance Abuse and Mental Health Services Administration (SAMHSA)
• Taking the lead in your state: addressing suicide for people with serious mental illness
• National efforts
  • Lifeline—answered more than 3 million calls since its launch in January 2005
Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
New Opportunities for SMHA Leadership in Suicide Prevention

Mike Hogan NYS OMH

Originally Developed and Presented to Action Alliance EXCOM by David Litts, O.D., SPRC
Pyramid of Suicidal Behaviors--U.S.

- 8,300,000 Seriously Considered Suicide
- 1,100,000 Suicide Attempts
- 678,000 Attempts Requiring Medical Attention
- 500,000 Hospitalizations
- 33,700 Suicides

Source:
State (Lowest & Highest) | Age-adjusted Rate (per 100k)
--- | ---
New Jersey | 6.7
Alaska | 22.1

Source: Centers for Disease Control and Prevention (CDC) vital statistics
Moving Beyond the Demographics

Suicides:

• Male : female = 4:1
• Elderly white males -- highest rate
• Working aged males – 60% of all suicides
• Concern for SMHA’s : People with serious mental illness: rate 6-12x; People with health concerns: 50%+ of suicides w/in 30 days of PCP visit

Attempts:

• Female>>male
• Rates peak in adolescence and decline with age
• Concern: Latina youth and LGBT

Source:
Suicide prevention efforts tend to focus on “at-risk” groups (rates greater than general population)

- **White Males 65+**: 3-4x
- **Veterans/Military**: 2-4x
- **Alaskan Natives/American Indians (AN/AI)**: 2-4x
- **Lesbian, Gay, Bisexual, Transgender (LGBT) Youth**: 2-3x

We should focus intervention on those at highest risk

- **Individuals with Serious Mental Illness (SMI)**: 6-12x

**White Males 65+**
The American Association of Suicidology reports the 2006 suicide rate for elderly white males was 31 per 100,000, but 48 per 100,000 for those over 85. [http://bit.ly/men-s](http://bit.ly/men-s)

**Veterans/Military**
In 2010, *USA Today* reported the current U.S. Army suicide rate at 22 per 100,000 ([http://usat.ly/army-s](http://usat.ly/army-s)), but the Fort Hood rate was 47 per 100,000. [http://bit.ly/ft-s](http://bit.ly/ft-s)

**AN/AI**
In the Suicide Prevention Resource Center (SPRC) library, Alaskan Native/American Indian males ages 15 to 24 had the highest rate at 28 per 100,000. *USA Today* reported in 2010 a suicide rate for those AN living in Alaska of 42 per 100,000. [http://usat.ly/an-ak](http://usat.ly/an-ak)

**LGBT Youth**
The SPRC library says little can be said with certainty about death rates. However, other research suggests two to three times the national rate. [http://bit.ly/wik-lgbt](http://bit.ly/wik-lgbt)

**Individuals with SMI**
In 2008, a UK study by Osborn et al. found the hazard ratio for individuals with SMI, including schizophrenia, to be nearly 13 times the general population. In Dec. 2010, King’s Health Partners found the risk to be 12 times greater during the first year following diagnosis of a serious mental illness. [http://bit.ly/SMI-suicide-12x](http://bit.ly/SMI-suicide-12x)

Note: The suicide rate in the general population was 11.5 per 100,000 in 2007.
Evolving Awareness, Emerging Knowledge

- Leadership by Surgeon General David Satcher, MD
  - National Strategy for Suicide Prevention (2001)
    - 11 Goals, Many Objectives
    - Public Health Orientation

- Garrett Lee Smith grant program
  - Focus on Youth Suicide Prevention

- Our Awareness is Evolving...
Redefining What Can Be Done I: U.S. Air Force Program

- A SYSTEMATIC APPROACH FOCUSED ON ALL MEMBERS, FAMILIES
- STRONG LEADERSHIP FROM THE TOP
- CONTINUAL ASSESSMENT AND MEASUREMENT

Source:
National Action Alliance for Suicide Prevention

- Launched Sept 10 2010 (World Suicide Prevention Day)
  - Secretaries Sibelius and Gates, Pam Hyde
  - Co-chairs: Army Secretary John McHugh, Sen. Gordon Smith
- Vision: A nation free of the tragic experience of suicide
- Mission: To advance the National Strategy for Suicide Prevention (NSSP) by:
  - championing suicide prevention as a national priority
  - Revising, and catalyzing efforts to implement high priority objectives of the NSSP
  - cultivating the resources needed to sustain progress
Action Alliance Organization

**EXECUTIVE COMMITTEE**
- **Private Sector Members** (senior executives of leading for-profit and non-profit organizations, philanthropic organizations, research and practitioners, and survivors of suicide loss and attempts)
- **Public Sector Members and Ex Officio Members**

**Advisory Groups**
- National Council for Suicide Prevention
- Federal Working Group on Suicide Prevention
- Ad Hoc Advisory Groups

**SPRC**
- Executive Secretary
- Project Coordinator(s)
Action Alliance
Clinical Care & Intervention Task Force

Michael Hogan, PhD – NYS Office of Mental Health
David Covington, LPC, MBA – Magellan Health Services
--Report of the **Task Force** focuses on health and behavioral health

--Available at Action Alliance web site:

http://actionallianceforsuicideprevention.org/
LESSONS LEARNED

- We started seeking training and tools, but found more powerful solutions (e.g., culture and core values in systems)
  - USAF
  - Henry Ford Health Systems
  - Magellan Maricopa
- Deaths by suicide are preventable. They result from deficits in health/mental health care
  - Lack of mental health awareness in primary care
  - Failure to focus on suicide risk and prevention in behavioral health
- We have focused on particulars, e.g. training. We learned systems can save lives. We focus on **populations under care** where leverage and accountability exist
Suicide Prevention: What SMHA’s Can Do

- Ensure you have a champion
- “Install” Evidence Based suicide prevention capabilities in behavioral health systems and services:
  - Columbia-Suicide Severity Rating Scale
  - CBT, DBT
- Help mainstream health care raise its game
  - Health Homes and Health Plans
  - Primary Care: FQHC’s, Patient Centered Medical Homes
- Stay connected to Lifelines (1-800-273-TALK)
- Lead from the front, with heart and strategy

Thank you!
Central Arizona Programmatic Suicide Deterrent System

Dr. Laura Nelson, ADHS Medical Director & DBHS Deputy Director

David Covington, LPC, MBA Magellan Chief of Adult Services
BH Workforce Surveys

# participants in 2009 (Arizona) - 1,641
2010 (Arizona) – 1,801
2010 (Georgia) – 1,552
Behavioral Health Workforce Survey

Attitudes

Knowledge

Skills

Supports
I have worked with a consumer who ended his/her life by suicide.

- Yes, more than one: 19%
- Yes, one person: 19%
- Don’t know: 9%
- No: 53%
ASIST suicide intervention training is changing the culture of community behavioral healthcare

Learn advanced suicide intervention and first aid skills

ASIST
Applied Suicide Intervention Skills Training
A 2-day workshop at either Southwest Network or Choices

2010 WORKSHOP SCHEDULE
You may attend classes at either location. Class sizes are limited—register now to get the dates and locations of your choice.
Jan. 12-13 SWN
Jan. 27-28 SWN
Feb. 9-10 SWN
Feb. 26-27 SWN
Mar. 9-10 SWN
Mar. 24-25 SWN
Apr. 13-14 SWN
Apr. 28-29 SWN
May 11-12 SWN
May 26-27 SWN
June 8-9 SWN
June 22-23 SWN
July 13-14 SWN
July 28-29 SWN
Aug. 10-11 SWN
Aug. 25-26 SWN
Sep. 15-16 SWN
Sep. 23-24 SWN
Oct. 9-10 SWN
Oct. 26-27 SWN
Nov. 9-10 SWN
Nov. 17-18 SWN
Dec. 14-15 SWN

Staff who have completed the ASIST training “completely agree” that they have the training, skills and supports to engage and support those at risk of suicide at significantly higher rates.

<table>
<thead>
<tr>
<th>Workforce Survey</th>
<th>2009 AZ</th>
<th>2010 GA</th>
<th>2010 AZ</th>
<th>‘10 vs. ’09 ∆</th>
<th>‘10 vs. GA ∆</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample</td>
<td>1,630</td>
<td>1,550</td>
<td>665</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>14%</td>
<td>10%</td>
<td>41%</td>
<td>↑ 187%</td>
<td>↑ 289%</td>
</tr>
<tr>
<td>Skills</td>
<td>15%</td>
<td>10%</td>
<td>34%</td>
<td>↑ 131%</td>
<td>↑ 247%</td>
</tr>
<tr>
<td>Supports</td>
<td>18%</td>
<td>14%</td>
<td>35%</td>
<td>↑ 97%</td>
<td>↑ 151%</td>
</tr>
</tbody>
</table>

Above: Comparison of the 2009 Maricopa County and 2010 Georgia statewide with the 2010 Maricopa County ASIST trained respondents shows significant increases in “completely agree” responses.

Outcomes: Recipients, Workforce & Public Stewards

38% of the Maricopa behavioral health workforce reports someone in their care has died by suicide (19% more than once)
Steering Committee & Formal Charter

Initial collaborative included top legislator, senior BH provider leadership, police, probation, national SME
Adaptive Change Structure (2009-present)

Steering Committee with Formal Guiding Charter

Task Force

Family

Peer

Race/Equity

Community

Workgroups
Suicide Prevention & Intervention Clinical Initiative:
Changing the Course of Suicide in Maricopa County’s Community Mental Health System
Steering Committee Charter (Version 1.2)

Section 1: Mission Statement

The Suicide Prevention & Intervention Steering Committee will operate formally from November 2009 until August 2011 with the ultimate goal of reducing the prevalence of suicide deaths among the 80,000 individuals enrolled in Regional Behavioral Health Authority (RBHA) services in Maricopa County, Arizona. Our goal is to equip our provider network of agencies with better skills, knowledge, attitudes and supports for engaging those at risk of suicide.

We believe three principles are paramount towards the fulfillment of this overall mission. The members of this steering committee resolve to:

1. **Persistent focus** - this is an adaptive change process that will take time, but we must also move quickly enough to shift culture and provide an adequate threshold of staff/support for the changes to take root as a new status quo

2. **Leadership lenses** - we need to be mindful of recipient voice and participation, engaging family, race & equity issues, outcomes focus, community integration and provider collaboration

3. **Data-Driven & Research-Based** – this work must be firmly founded on emerging evidence-based practices and programs and outcomes aggressively reviewed through quantitative analysis

It is important to note at the outset that this steering committee does not intend to duplicate the extremely positive work of other groups/programs that already exist, such as the Arizona Suicide Prevention Coalition. This clinical initiative is designed to meet an unmet need that exists here and in many other states -- fully equipping all Community Mental Health System client staff to ensure the overall drive towards zero that suicide.
Model Framework

Six Essential Elements

Metaphor of a comprehensive safety net (GGB)

Core principles: niche to core; peer led & designed
The Maricopa County Programmatic Suicide Deterrent System (Six Essential Elements)

A community collaborative steering committee meets quarterly, a task force meets monthly and six targeted workgroups meet as needed to design and implement the project.

All-staff Suicide Intervention Training (ASIST)
Attempt Survivor Peer Support Groups
Clinical Care & Interventions
Family Engagement
Community Integration
Race/Ethnicity Best Practices
Public sector behavioral healthcare has viewed suicide prevention as peripheral, not core business

SPRC (August 2010) – “Charting the Future: A Progress Review”
SPRC examined 11 professional groups including psychology, social work, psychiatric nursing, and counseling and found only one had increased attention on suicide since the 2001 National Strategy called for improved training. Accreditation standards give scant attention.

Forbes (September 2010) – “The Forgotten Patients”
The mental health industry ignores the 35,000 a year who die by suicide. The DSM-IV offers no advice on how to assess suicide risk. The NIH is spending a paltry $40 million in 2010 for studying suicide versus $3.1 billion for AIDS research.
Monitor & Report Outcomes

Include mortality and process metrics
Suicide Rate Per 100,000
Magellan Active Episodes - All BH

FY2007: 77.2
FY2008: 52.8
FY2009: 35.8
FY2010: 47.5
FY2011: 32.1

↓58%
Suicide Rate Per 100,000
Magellan Active Episodes - SMI Only

↓42%
FY2011
Magellan RBHA

SMI – 21
GMH/SA - 13
Child - 1

Males – 22
Females – 13
Total - 35
Effective suicide intervention results in fewer inpatient admissions, less intrusion and lower costs.

In the December 2010 “Policy for Helping Callers at Imminent Risk,” SAMHSA emphasizes the need to reduce unnecessary hospitalizations and “active rescues” through stronger engagement, collaboration and follow-up.

Maricopa County Assertive Community Treatment Team (ACT) Inpatient Utilization Per 100

Since the beginning of 2010, the ACT system Level I inpatient utilization rate has declined 51%.
Two Final Thoughts

Zerocancer.org
ZERO: The Project to End Prostate Cancer

The Lee Award for Good Practices of Suicide Prevention
Central Arizona Programmatic Suicide Deterrent System Project, USA
International Association of Suicide Prevention
Beijing 2011
Types of Resources
www.sprc.org

- Best Practices Registry
- State suicide prevention information
- Clinical tools and toolkits
- Searchable resource library

- Archived webinars
  - Continuity of care
  - ED interventions
  - ED and crisis centers

- Provider web pages
  - Primary care
  - Emergency department
  - Mental health
Best Practices Registry (BPR) For Suicide Prevention

The BPR consists of three sections, each with different types of best practice listings. In essence, the BPR is three registries in one. Read More...

BPR Overview
Advice on Using the BPR
Search All Listings

Section I: Evidence-Based Programs
Section II: Expert/Consensus Statements
Section III: Adherence to Standards

FAQ
How to Apply
Help
Marketing Materials
Minnesota State Suicide Prevention Information

BROWSE the contents of this page:

- Contact Information
- Recent Developments
- State Events
- History of State Suicide Prevention Efforts
- State and Local Prevention Resources
- Legislation/Resolutions
- Funding Sources

Click on full description to understand the categories.

Minnesota Contact Information:

The SPRC state contacts are available for suicide prevention program questions, but not crisis calls. If you are thinking of hurting yourself, or if you are concerned that someone else may be suicidal, call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255).

Phyllis Brashler  
Suicide Prevention Coordinator  
Minnesota Department of Health  
PO Box 64882  
St. Paul, MN 55164  
Tel: 651.201.3586  
Email: phyllis.brashler@state.mn.us

Dr. Dan Reidenberg  
Executive Director  
Suicide Awareness Voices of Education  
8120 Penn Avenue South  
Suite 470  
Bloomington, MN 55431  
Tel: 952-946-7998
All Providers
(Patient Handouts)

Suicide Warning Signs

These signs may mean someone is at risk for suicide. Risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change.

- Talking about wanting to die or to kill oneself.
- Looking for a way to kill oneself, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or in unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated; behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

Suicide is Preventable.
Call the Lifeline at 1-800-273-TALK (8255).

Sources:
http://depts.washington.edu/lokitup/
Safety Planning Guide

A Quick Guide for Clinicians
may be used in conjunction with the “Safety Plan Template”

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?
A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is brief, is in the patient’s own words, and is easy to read.

WHO SHOULD HAVE A SAFETY PLAN?
Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?
Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN
There are 6 steps involved in the development of a Safety Plan.

Sample Safety Plan

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. 
2. 
3. 

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. 
2. 
3. 

Step 3: People and social settings that provide distraction:

1. Name ___________________________ Phone ___________________________
2. Name ___________________________ Phone ___________________________
3. Name ___________________________ Phone ___________________________

Step 4: People whom I can ask for help:

1. Name ___________________________ Phone ___________________________
2. Name ___________________________ Phone ___________________________
3. Name ___________________________ Phone ___________________________

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name ___________________________ Phone ___________________________
2. Clinician Name ___________________________ Phone ___________________________
3. Local Urgent Care Services: Phone ___________________________
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. 
2. 

The one thing that is most important to me and worth living for is:


Safety Planning Guide and Safety Plan Template ©2008 Barbara Stanley and Gregory K. Brown, are reprinted with the express permission of the authors. No portion of the Safety Plan Template may be reproduced without their express, written permission. You can contact the authors at bhs2@columbia.edu or gregbrow@mail.med.upenn.edu.
Crisis Support Planning

CRISIS SUPPORT PLAN

FOR: ______________________________ DATE: ______________

I understand that suicidal risk is to be taken very seriously. I want to help ______________ find new ways of managing stress in times of crisis. I realize there are no guarantees about how crises resolve, and that we are all making reasonable efforts to maintain safety for everyone. In some cases inpatient hospitalization may be necessary.

Things I can do:

- Provide encouragement and support
  - ______________________________
  - ______________________________
- Help ______________ follow his/her Crisis Action Plan
- Ensure a safe environment:
  1. Remove all firearms & ammunition
  2. Remove or lock up:
     - knives, razors, & other sharp objects
     - prescriptions & over-the-counter drugs (including vitamins & aspirin)
     - alcohol, illegal drugs & related paraphernalia
  3. Make sure someone is available to provide personal support and monitor him/her at all times during a crisis and afterwards as needed.
  4. Pay attention to his/her stated method of suicide/self-injury and restrict
Inpatient Psychiatry & Emergency Departments

- White paper: *Continuity of Care for Suicide Prevention and Research*
- SPRC Research to Practice webinar: *Linking Together a Chain of Care: How Clinicians Can Prevent Suicide*
Is Your Patient Suicidal?

1 in 10 suicides are by people seen in an ED within 2 months of dying. Many were never assessed for suicide risk. Look for evidence of risk in all patients.

**Signs of Acute Suicide Risk**
- Talking about suicide
- Seeking lethal means
- Purposeless
- Anxiety or agitation
- Insomnia
- Substance abuse
- Hopelessness
- Social withdrawal
- Anger
- Recklessness
- Mood changes

**Other factors:**
- Past suicide attempt increases risk for a subsequent attempt or suicide; multiple prior attempts dramatically increase risk.
- Triggering events leading to humiliation, shame, or despair elevate risk. These may include loss of relationship, financial or health status—real or anticipated.
- Firearms accessible to a person in acute risk magnifies that risk. Inquire and act to reduce access.

Patients may not spontaneously report suicidal ideation, but 70% communicate their intentions to significant others. Ask patients directly and seek collateral information from family members, friends, EMS personnel, police, and others.

**Ask if You See Signs or Suspect Acute Risk—Regardless of Chief Complaint**

1. Have you ever thought about death or dying?
2. Have you ever thought that life was not worth living?
3. Have you ever thought about ending your life?
4. Have you ever attempted suicide?
5. Are you currently thinking about ending your life?
6. What are your reasons for wanting to die and your reasons for wanting to live?

These questions represent an effective approach to discussing suicidal ideation and attempt history; they are not a formalized screening protocol.

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

This 24-hour, toll-free hotline is available to those in suicidal crisis. The Lifeline is not a resource for practitioners in providing care.

10% of all ED patients are thinking of suicide, but most don’t tell you. Ask questions—save a life.
Emergency Department Guide

- **Screen:**
  - Universally or selectively
  - Paper/pencil, computer, or by clinician

**Suicide Risk: A Guide for ED Evaluation and Triage**

1 in 10 suicides are by people seen in an ED within 2 months of dying. Many were never assessed for suicide risk. Look for evidence of risk in all patients.

### Signs of acute suicide risk

- Talking about suicide or thoughts of suicide
- Seeking lethal means to kill oneself
- Purposelessness—no reason for living
- Anxiety or agitation
- Insomnia
- Substance abuse—excessive or increased

- Hopelessness
- Social withdrawal—远离 friends/family members
- Anger—uncontrolled rage/bordering on aggressive violence
- Recklessness—dramatically increased

### Other factors:

- Post suicide attempt increases risk for a subsequent attempt or suicide; multiple prior attempts dramatically increase risk.
- Triggers: events leading to humiliation, shame, or disrupt chronic stress. These may include loss of relationship, financial or health status—real or anticipated.
- Firearms accessible to a person in acute risk magnify that risk. Insure and act to reduce access.

### Before discharging

Before discharging, patients may not spontaneously report suicidal ideation, but 70% communicate their intentions to significant others. Ask patients directly and seek collateral information from family members, friends, EMS personnel, police, and others.

Ask if you see signs or suspect acute suicide regardless of chief complaint.

1. Have you ever thought about death or dying?
2. Have you ever thought that life was not worth living?
3. Have you ever thought about ending your life?
4. Have you ever attempted suicide?
5. Are you currently thinking about ending your life?
6. Are you your reasons for wanting to die and your reasons for wanting to live?

These questions ease the patient into talking about a very difficult subject.

- Patients who respond “yes” to the first may be “talking good” to avoid talking about death or suicide. Always continue with subsequent questions.

- When suicidal ideation is present, clinicians should ask about:
  - frequency, intensity, and duration of thoughts;
  - the existence of a plan and whether preparatory steps have been taken; and
  - intent (e.g., “How much do you really want to die?” and “How likely are you to carry out your thoughts/plans?”)

These questions represent an effective approach to discussing suicidal ideation and attempt history; they are not a formalized screening protocol.

10% of all ED patients are thinking of suicide, but most don’t tell you. Ask questions—save a life.
Emergency Departments – Cont’d

- Lifeline’s Crisis Center–Emergency Department Partnership Toolkit
- SPRC Research to Practice webinars:
  - Advancing Suicide Prevention Practice in the Emergency Department Setting
  - Suicidal Patients in the Emergency Department: Improving Care through Partnerships with Crisis Centers
Primary Care

Suicide Prevention Toolkit for (Rural) Primary Care

Includes:
- Quick Start Guide
- Office Protocol Development Guide
- Primer
- Pocket Card
Assessment and Interventions with Potentially Suicidal Patients

A Pocket Guide for Primary Care Professionals

Suicide Risk and Protective Factors

**RISK FACTORS**

- Current/past psychiatric disorders: especially mood disorders, psychotic disorders, alcohol/substance abuse, TBI, PTSD, personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive PD).
- Co-morbidity with other psychiatric and/or substance abuse disorders and recent onset of illness increase risk.
- Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations, intoxication. For children and adolescents: also oppositionality and conduct problems.
- Suicidal behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior.
- Family history: of suicide, attempts, or psychiatric diagnoses, especially those requiring hospitalization.
- Precipitants/stressors: triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial, or health status – real or anticipated).
- Chronic medical illness (esp. CNS disorders, pain).
- History of or current abuse or neglect.

**PROTECTIVE FACTORS**

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

- Internal: ability to cope with stress, religious beliefs, frustration tolerance.
- External: responsibility to children or beloved pets, positive therapeutic relationships, social supports.
Screening: uncovering suicidality
- Other people with similar problems sometimes lose hope; have you?
- With this much stress, have you thought of hurting yourself?
- Have you ever thought about killing yourself?
- Have you ever tried to kill yourself or attempted suicide?

Assess suicide ideation and plans
- Assess suicidal ideation – frequency, duration, and intensity
  - When did you begin having suicidal thoughts?
  - Did any event (stressor) precipitate the suicidal thoughts?
  - How often do you have thoughts of suicide?
  - How long do they last?
  - How strong are the thoughts of suicide?
  - What is the worst they have ever been?
  - What do you do when you have suicidal thoughts?
  - What did you do when they were the strongest ever?
- Assess suicide plans
  - Do you have a plan or have you been planning to end your life? If so, how would you do it? Where would you do it?
  - Do you have the (drugs, gun, rope) that you would use? Where is it right now?
  - Do you have a timeline in mind for ending your life? Is there something (an event) that would trigger the plan?

Assess suicide intent
- What would it accomplish if you were to end your life?
- Do you feel as if you’re a burden to others?
- How confident are you that your plan would actually end your life?
- What have you done to begin to carry out the plan?
  - For instance, have you rehearsed what you would do (e.g., held pills or gun, tied the rope)?
- Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?
- What makes you feel better (e.g., contact with family, use of substances)?
- What makes you feel worse (e.g., being alone, thinking about a situation)?
- How likely do you think you are to carry out your plan?
- What stops you from killing yourself?

Endnotes:
1 SAFE-T pocket card. Suicide Prevention Resource Center & Mental Health Screening. (n/d).
Assessment and Interventions with Potentially Suicidal Patients

**High Risk**
- Patient has a suicide plan with preparatory or rehearsal behavior
- Patient has severe psychiatric symptoms and/or acute precipitating event, access to lethal means, poor social support, impaired judgment
- Hospitalize, or call 911 or local police if no hospital is available. If patient refuses hospitalization, consider involuntary commitment if state permits
- Take action to thwart the plan

**Moderate Risk**
- Patient has suicidal ideation, but limited suicidal intent and no clear plan; may have had previous attempt
- Patient does not have access to lethal means, has good social support, intact judgment; psychiatric symptoms, if present, have been addressed
- Consider (locally or via telemedicine):
  1. Psychopharmacological treatment with psychiatric consultation
  2. Alcohol/drug assessment and referral, and/or
  3. Individual or family therapy referral
- Evaluate for psychiatric disorders, stressors, and additional risk factors
- Encourage social support, involving family members, close friends and other community resources. If patient has therapist, call him/her in presence of patient.
- Record risk assessment, rationale, and treatment plan in patient record. Complete tracking log entry, and continue to monitor patient status via repeat interviews, follow-up contacts, and community resources. Make continued entries in tracking log.

**Low Risk**
- Patient has thoughts of death only; no plan or behavior
Recognizing and Responding to Suicide Risk in Primary Care
(Am. Assoc. of Suicidology)

SPRC Research to Practice webinar:
A Suicide Prevention Toolkit for Rural Primary Care
Behavioral Health

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical changes, 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/post psychiatric disorders; especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity).
- Co-morbidity and recent onset of illness increase risk
- Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- Family histories of suicide, attempts or Axis I psychiatric disorders requiring hospitalization
- Precipitants/Stressors/Interpersonals triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (e.g., CHS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation.
- Change in treatment; discharge from psychiatric hospital, provider or treatment change
- Access to firearms

2. PROTECTIVE FACTORS
- Protective factors, even if present, may not counteract significant acute risk
  - Internal: ability to cope with stress, religious beliefs, frustration tolerance
  - External: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY
- Specific questioning about thoughts, plans, behaviors, intent
- Ideation: frequency, intensity, duration—In last 48 hours, past month and worst ever
- Plan: timing, location, lethality, availability, preparatory acts
- Behaviors: past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self-injurious actions
- Intent: extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act is lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live
  * For youths: ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors or disposition
  * Homicide inquiry: when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.

4. RISK LEVEL/INTERVENTION
- Assessment of risk level is based on clinical judgment, after completing steps 1-3
- Reassess as patient or environmental circumstances change

<table>
<thead>
<tr>
<th>RISK LEVEL</th>
<th>RISK / PROTECTIVE FACTOR</th>
<th>SUICIDALITY</th>
<th>POSSIBLE INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Psychiatric disorders with severe symptoms, or acute precipitating event, protective factors not relevant</td>
<td>Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal</td>
<td>Admission generally indicated unless a significant change reduces risk. Suicide precautions</td>
</tr>
<tr>
<td>Moderate</td>
<td>Multiple risk factors, few protective factors</td>
<td>Suicidal ideation with plan, but no intent or behavior</td>
<td>Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers</td>
</tr>
<tr>
<td>Low</td>
<td>Modifiable risk factors, strong protective factors</td>
<td>Thoughts of death, no plan, intent or behavior</td>
<td>Outpatient referral, symptom reduction. Give emergency/crisis numbers</td>
</tr>
</tbody>
</table>

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT
- Risk level and rationale; treatment plan to address/reduce current risk (i.e., medication, setting, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.)
Behavioral Health

Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals

One-day workshop

Sponsored Locally
Behavioral Health

- Recognizing and Responding to Suicide Risk (RRSR) - AAS
- **TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment**
- SPRC Research to Practice webinar on *TIP 50*
Nursing Homes

— Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities -
http://store.samhsa.gov/product/SMA10-4515

• Produced in collaboration with NASMHPD
• Available through SAMHSA
Suicide and State Mental Health Authorities: Our Time to Lead

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- Dr. Michael Hogan, Ph.D., Commissioner, New York State Office of Mental Health and Public Sector Co-lead of the Clinical Care and Intervention Task Force for the National Action Alliance for Suicide Prevention - Michael.Hogan@omh.ny.gov

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