Safety Plans for Risk of Suicide:

Putting the Person in the Driver's Seat to a Safe Destination

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DISCLOSURE STATEMENT

The presenter has no conflicts of interest to disclose.

Objectives

As a result of this training the participant will be able to:

- Describe at least 4 risk factors and 4 protective factors that should be taken into account when formulating risk for suicide.
- Identify the use of the acronym IS PATH WARM in the development of warning signs for the patient's safety plan.
- Describe the CASE model for assessing suicide risk.
- Describe and demonstrate the use of the safety plan for suicide risk.

The Joint Commission NATIONAL PATIENT SAFETY GOAL # 15 (2018)

- **The organization identifies clients at risk for suicide.**

Definition of Suicide

- **Suicide is** "an act or omission is a suicide if a person intentionally brings about his or her own death, unless the death (a) is coerced or (b) is caused by conditions that are not specifically arranged by the agent for the purpose of bringing about death" (Beauchamp, 1996).
- **Suicide is** the act of killing yourself, most often as a result of depression or other mental illness. (American Psychological Association 2017)
- **Suicide is** defined as death caused by self-directed injurious behavior with intent to die as a result of the behavior. (NIMH 2017)

SUICIDE STATISTICS 2017

Suicide is the 10th leading cause of death in the U.S. in 20167. (NIMH)

2nd leading cause of death in the U. S. for children and adolescents.

There are between 25 attempted suicides for every suicide death. (NIMH 2016)

Borderline personality disorder patients may exhibit non suicidal injury behaviors e.g. hesitation marks of cutting most common physical findings.

464,995 people visited a hospital for injuries due to self-harm behavior in 2016 (one in 12 for every patient who died by suicide.)

50% to 75% of all people who try to die by suicide tell someone about their intention.

Source: **American Foundation for Suicide Prevention website 2017**

Suicide Statistics 2017

Mortality

All suicides Rates have increased in the last decade

Number of deaths: 44,965 (2016)

Deaths per 100,000 population:

- 1990-2000=10.4
- 2017 13.42 US
- 2017 13.92 FL

Age:

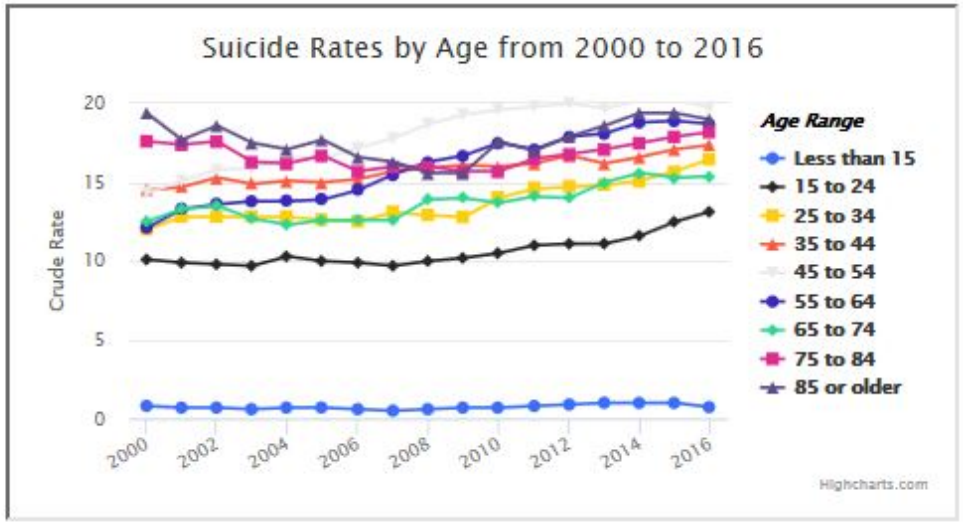
Rate of death by suicide is highest for middle age men (white in particular)

Source: **American Foundation for Suicide Prevention website 2017**

SUICIDE RATES BY AGE

Suicide Rates by Age

In 2016, the highest suicide rate (19.72) was among adults between 45 and 54 years of age. The second highest rate (18.98) occurred in those 85 years or older. Younger groups have had consistently lower suicide rates than middle-aged and older adults. In 2016, adolescents and young adults aged 15 to 24 had a suicide rate of 13.15.



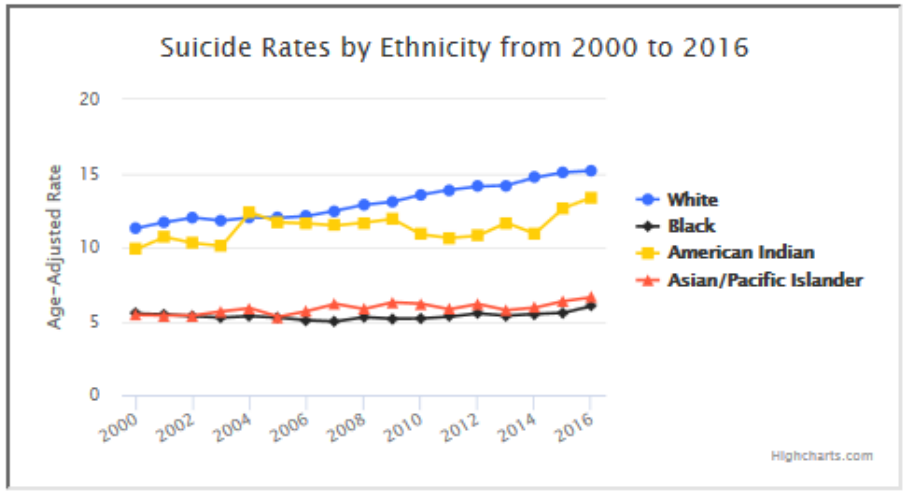
Source: **American Foundation for Suicide Prevention website 2017**

SUICIDE RATES BY RACE/ETHNICITY

Suicide Rates by Race/Ethnicity

In 2016, the highest U.S. suicide rate (15.17) was among Whites and the second highest rate (13.37) was among American Indians and Alaska Natives (Figure 5). Much lower and roughly similar rates were found among Asians and Pacific Islanders (6.62), and Black or African Americans (6.03).

Note that the CDC records Hispanic origin separately from the primary racial or ethnic groups of White, Black, American Indian or Alaskan Native, and Asian or Pacific Islander, since individuals in all of these groups may also be Hispanic.

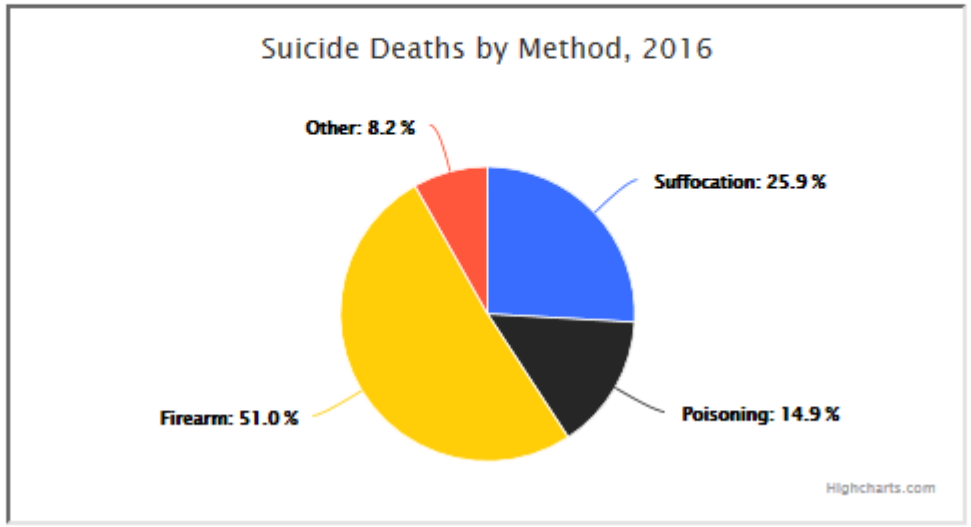


Source: **American Foundation for Suicide Prevention website 2017**

SUICIDE METHODS

Suicide Methods

In 2016, firearms were the most common method of death by suicide, accounting for a little more than half (51.01%) of all suicide deaths. The next most common methods were suffocation (including hangings) at 25.89% and poisoning at 14.90%.



Source: **American Foundation for Suicide Prevention website 2017**

The Secret Language of Suicide

- Patients who are thinking about or feeling that they want to die by suicide have a very difficult time telling others.
- 78% of patient who are asked if they plan to hurt themselves deny. (APNA 2016)
- Identifying a patient who is suicidal is described by Dr. Shawn Christopher Shea as similar to putting the putting pieces of a jig saw puzzle together. You have to have all the pieces and they need to be upright on the table. (Shea 2002)
- They feel a lack of belonging and hopelessness. (Joiner 2005)
- 25% of suicides occur in a non-behavioral health setting and the root cause reveals a lack of proper assessment.(NIMH 2017)

Things to Remember is a Patient is At Risk for Suicide

- Remember that a patient who is having suicidal ideation or who has attempted to die by suicide is in a lot of psychological pain. They are not thinking clearly.
- Listen to them empathically non-judgmentally.
- BE KIND.
- Report any suicidal statements or behaviors immediately to thewhomever you need to report to. Take them to someone who can do a more thorough assessment.
- Remember when a patient is under the influence of alcohol or drugs they may at a higher risk to attempt to die by suicide because of impaired judgement.
- The goal of a suicide assessment is not to predict suicide, but rather to...appreciate the basis for suicidality, and to allow for a more informed intervention" – (Jacobs, Brewer, & Klein-Benheim, 1999, p. 6).

INAPPROPRIATE WORDS TO USE WHEN DESCRIBING SUICIDE

- Completed suicide
- Successful suicide
- Unsuccessful suicide
- Suicidal gesture/manipulative act/suicide threat
- Failed suicide
- Para suicide
- Suicidality

Appropriate: died by suicide or tried to die by suicide

(APNA Advocates for Hope Suicide Risk Assessment Training 2016)

SUICIDE: PHENOMENOLOGY

(Phenomenology studies conscious experience as experienced from the subjective or first person point of view i.e. what is it like to be suicidal or what is it like to have a relationship with someone who is wanting to die by suicide)

What Are Some Common Themes with Patients Who Tried to Die by Suicide

- "**I do not belong.**"
- **"I am a burden."**
- "My life will never change. It is just **hopeless**"
- "What's the point of living. I've made so many mistakes."
- "It's too late for me."
- "You don't get blamed for having a physical pain but if you try to kill yourself because of your mental pain everybody blames you and is angry.
- "They wouldn't let me see my children like I was some kind of a dangerous person."
- "I was told by my pastor to find another church."

What Do Patients Say is Helpful

- **Validation**: "Good for you for coming forward. It must have been difficult to ask for help.
- **Non-judgement:** " She invited me to tell my story. She didn't say I was crazy."
- **Letting me talk about it**. "They were so great. They actually told me they were interested in hearing what happened. Openly and without fear. This is huge."
- **Ask questions:** "I think the best reaction would be if someone asked me what I needed and how they could help me."

WHAT'S GOING ON?

Mental health assessment: Listen to their story, big picture, holistic, may use screening tools and evidence based questioning

Principle of assessment, observation, data collection:

- Tell them your purpose, credentials, build trust; find out who is in their life personally and psychiatrically

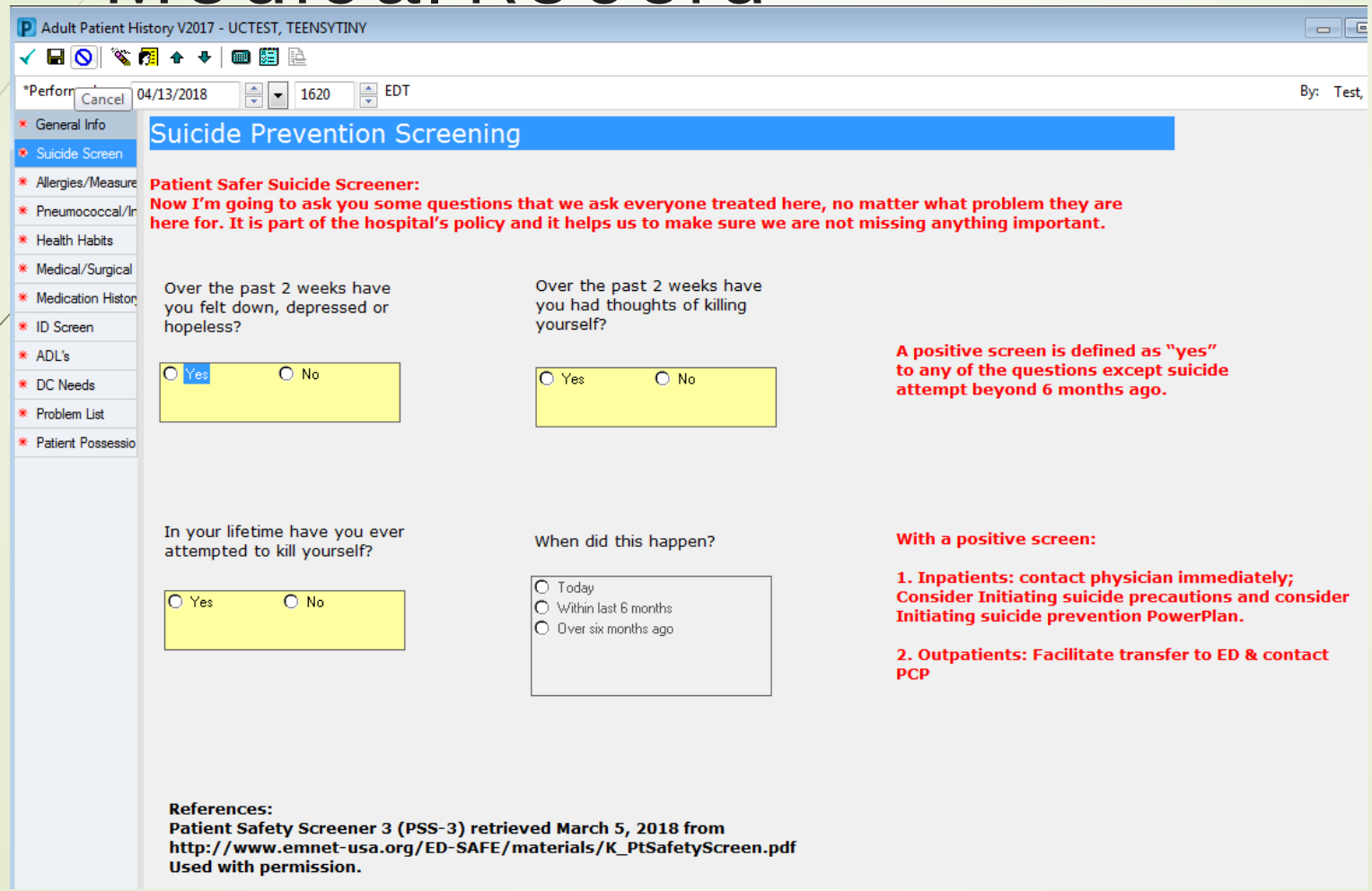
Process of assessment:

- Build rapport, use language engagement strategy, pace and follow, observe and describe, "**what the patient says."**
- Mental Status exam: Follow APA practice guidelines (2013)

Evidence Based Screening Tools for Suicide Risk Assessment in the Literature

- According to the Suicide Prevention Resource Center review of expert panel summaries tools: mixed research findings on the ability of both screening and assessment to accurately predict who may be at risk of suicide but found that screening can be helpful in preventing suicide. (SPRC 2012)
- Suicide risk assessment needs to be thorough, person-centered, and simple. It needs to incorporate multiple approaches to ascertain a person's level of distress and risk of suicide. (Pearlman 2011 p.65)
- PhQ-9 tool for depression. (Spitzer 2015)
- Columbia Suicide Severity Rating Scale: CSSRS Asks specific questions regarding suicide risk (Posner 2009)
- Ask Suicide Questions (ASQ) Screening Tool: Suicide Risk Assessment Screening Tool Kit (2015)
- The Suicide Risk Assessment Inventory: A Resource Guide for Canadian Health care Organizations. Toronto, ON: Ontario Hospital Association and Canadian Patient Safety Institute has a list of all the risk assessment tools, authors, contact information, cost etc.

Suicide Screening Tool in an Electronic Medical Record

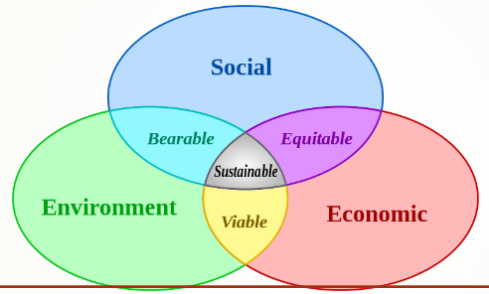


RISK FACTORS FOR SUICIDE

Risk factors definition: These are features or situations that may increase the possibility of a patient wanting to or trying to die by suicide.

HEALTH

ENVIRONMENTAL



HISTORICAL

Mental Health Conditions/Addictions
Depression, schizophrenia, BPD
Bipolar, conduct disorder,
Drugs and/or alcohol
Serious chronic health conditions
Especially with pain
Aggression, recklessness
Traumatic brain injury

Poor relationships
Prolonged stress, bullying, unemployment
Access to lethal means including firearms, drugs
Life events which may include death, divorce
humiliation, shame or job loss.
Exposure to another person's suicide or graphic
or sensationalized accounts of suicide.
Absence of a support system

Previous suicide attempts *
Family history of suicide
Child abuse, neglect or trauma
Non-suicidal harmful behavior
involving a hospitalization.*
*** weak correlation with higher risk**
Unwilling to seek help: Stigma
Cultural/Religious/Brainwashing

MALES: MORE LETHAL MEANS

WOMEN: MORE ATTEMPTS

RACE: CAUCASIAN

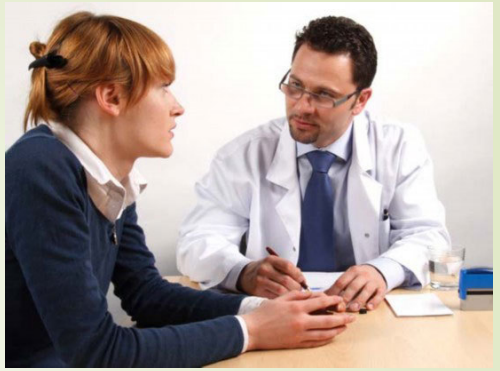
AGE:>45

Protective Factors A number of protective factors have been identified (DHHS 2016):

- Effective clinical care for mental, physical, and substance abuse disorders
- Access to care, a supportive environment and permission to access help.
- Family and community support
- Support from ongoing medical and mental health caregivers
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts

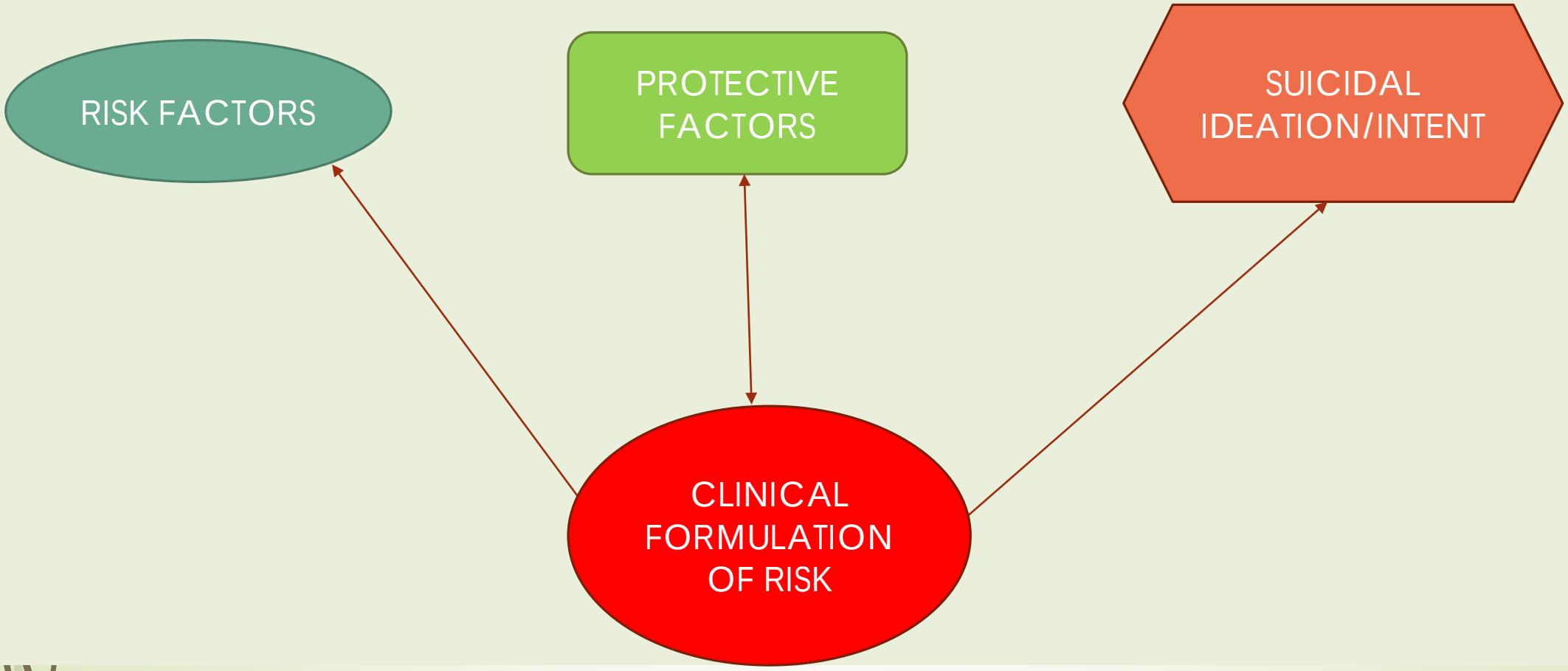
Is Path Warm: WARNING SIGNS

An acronym that can help identify warning signs when you are listening to their story. American Association of Suicidology 2011)



ITEM	PATIENT'S STORY
1. **I-**Ideation	Says she thinks about suicide all the time. She is not planning to die by suicide now.
2. S- Substance Abuse	History of alcohol and cocaine use
3. P- Purposelessness	Many statements made related to purposelessness
4- A- Anxiety	Foot tapping, says she sometimes feels anxious
5. T- Trapped	Sees suicide as the only way out of her stress and loneliness
6. H- Hopeless	Wished she hadn't lived after trying to die by suicide
7. W- Withdrawal	Doesn't have any friends and doesn't go out
8. A-Anger	Expressing anger with her husband
9. R- Recklessness	Using alcohol and cocaine when she's

SUICIDAL ASSESSMENT PROTOCOL (Shea 2012)



CASE MODEL QUESTIONS

You want to make the patient understand by meta communication that it's ok to talk about this subject. (Shea 2012)

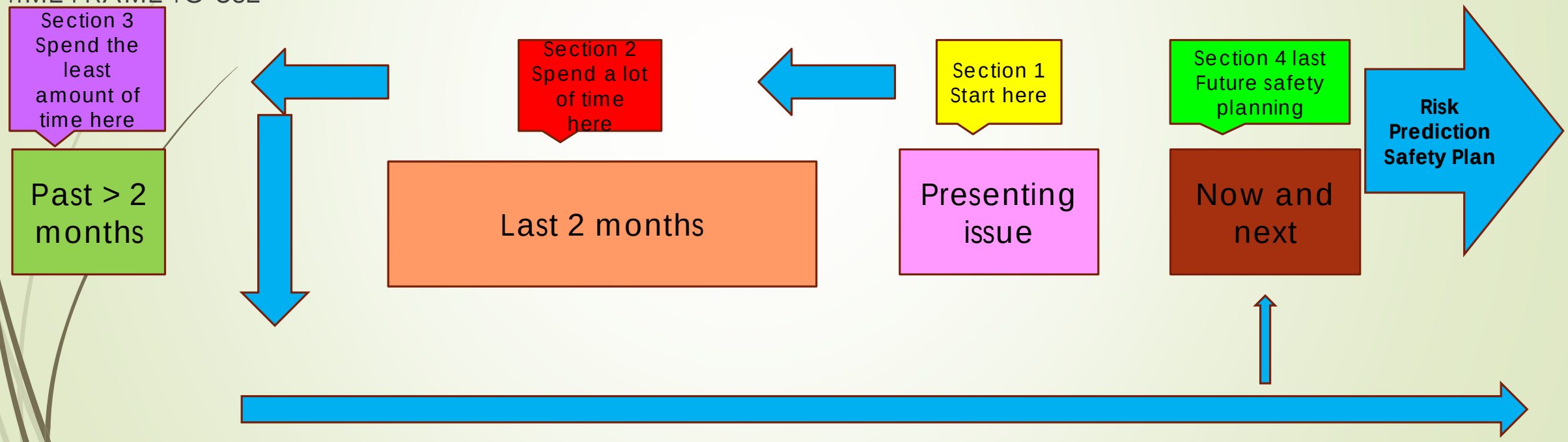
QUESTIONING TECHNIQUE	DESCRIPTION
1. NORMALIZATION	" Sometimes when people are depressed they find themselves thinking about killing themselves. Have you been having those thoughts?"
2. SHAME ATTENUATION	"With everything you've been going through or all the pain you are having have you been having any thoughts of killing yourself?"
3. BEHAVIORAL INCIDENT: fact finding or sequencing	" Talk to me about what happened. Just the facts" or Tell me the first thing you remember and then what happened?
4. SYMPTOM AMPLIFICATION	" On your worst days how much time do you think about killing yourself 50%, 70% 90%?
5. DENIAL OF THE SPECIFIC HELPS TO UNCOVER SUICIDAL PLANS Do you cannon the questions.	" Have you have thoughts of overdosing?" " Have you had thoughts of shooting yourself?
6. GENTLE ASSUMPTION	"How many times have you ever thought of killing yourself? How many recently?

HOW TO ELICIT SUICIDEAL INTENTION

Like putting pieces of a jigsaw puzzle together, (adapted from Shea 2012)

Strategies to Use: normalization, shame attenuation, behavioral incident, gentle assumption, denial of the specific(adults), symptom amplification.

TIME FRAME TO USE



SAFETY PLAN OF CARE

- Focus on skill building, treatment adherence, emotional regulation, personal responsibility, give control back to the patient
- Written safety plan(show video) They write it and in their own words
- Environmental safety plan (part of the safety plan)
- Documentation

EXAMPLE OF A SAFETY PLAN
Must be developed by the person (you can coach)

1	WARNING SIGNS: Think IS PATH WARM			
2	PERSONAL COPING TO CALM OR COMFORT SELF			
3	ACTIVITIES FOR DISTRACTION (SOCIAL SETTINGS)			
4	PEOPLE I CAN TALK TO	Name Phone #	Name Phone #	Name Phone #
5	PROFESSIONALS	Name Phone #	Name Phone #	Name Phone #
6	STEPS TO MAKE MY ENVIRONMENT SAFE			
7	HOSPITAL EMERGENCY ROOM			

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