SUICIDE PREVENTION: Assessment and Intervention

Michelle Giddings, DNP, APRN, FNP-BC, PMHNP-BC
American Psychiatric Nurses Association
Nevada Chapter - President

“I am passionate about helping my patients obtain their best quality of life”

Learning Objectives

The Objective for this session is to:

- Increase awareness about Suicide.
- Identify risk factors for Suicide.
- Improve understanding about Suicide Assessment.
- Promote the patient-centered approach in Suicide Prevention.
- Discuss 3 methods of screening for Suicide risk

SUICIDE STATISTICS

- Suicide tenth leading cause of death in US
- Highest suicide rate in US; Over 65 years old, especially white males >85 years.
- Women attempt twice as often as men, but use less lethal means
- Majority of suicides are committed by males
- Guns account for half of all suicides Worldwide

Suicide Statistics: Nevada

SUICIDE: NEVADA 2017 FACTS & FIGURES

Suicide Death Rates

	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
Nevada	558	18.38	11
Nationally	44,193	13.26	

Suicide is the **8th leading** cause of death overall in Nevada.

On average, one person dies by suicide **every 16 hours** in the state.

Based on most recent 2015 data from CDC. Learn more at afsp.org/statistics.

Suicide cost Nevada a total of **$593,140,000** of combined lifetime medical and work loss cost in 2010, or an average of **$1,084,351** per suicide death.

IN NEVADA, SUICIDE IS THE...

- **2nd leading** cause of death for ages 10-34
- **4th leading** cause of death for ages 35-44
- **5th leading** cause of death for ages 45-54
- **7th leading** cause of death for ages 55-64
- **14th leading** cause of death for ages 65 & older

Nearly three times as many people die by suicide in Nevada annually than by homicide; the total deaths to suicide reflect a total of **10,249** years of potential life lost (YPLL) before age 65.

30 YEARS STRONG

AMERICAN FOUNDATION FOR Suicide Prevention | afsp.org

Suicide Risk: Why Screen?

- Identifying persons at risk for suicide is the first step in Suicide prevention.
- Provides a standardized, evidence-based means to identify persons at risk.
- Offers a systematic approach to developing a treatment plan for persons at risk for suicide.

Risk Factors for Suicide

Risk factors increase the likelihood for suicide:

- Mental health problems:
  - Research has found that about 90% of individuals who die by suicide experience mental illness.
- Substance abuse or increased alcohol use
- Feeling Hopeless, Worthless, Despair
- Previous suicide attempts
- Hints or talk about suicide

ARE ALL SUICIDES PREVENTABLE?

SUICIDE PREVENTION

- Many suicides are preventable.
- Most suicidal people are Depressed.
- Prevention is often a matter of a caring person with the right knowledge being available in the right place at the right time.

CATEGORIES OF SUICIDAL BEHAVIOR

- Suicide ideation:
  - thought of self-inflicted death
- Passive:
  - only thoughts of suicide
- Active:
  - plans of causing one's own death
- Suicide attempt:
  - any self-directed action that will lead to death if not stopped. A suicide attempt may or may not result in injury).

All suicide behavior is serious, whatever the intent, and deserves nurse's highest priority care

SUICIDE ASSESSMENT

- Does person have plan, means to carry out plan?
- Most suicidal person is one who has:
  - Highly lethal method (e.g., gunshot to head)
  - Specific plan (as soon as wife goes shopping)
  - Means available (loaded gun in desk drawer)
- Person exhibits little ambivalence, as compared with someone "asking for help"

When assessing suicidal behavior, place emphasis on lethality of method threatened or used

SUICIDE ASSESSMENT STRATEGIES

- Self assessment: Examine one's own attitude toward suicide.
- Use a patient- centered approach for screening patients.
- Asked "what happened to you?" not "what's wrong with you?"
- Recognize that most suicidal patients are suffering mental pain.
- Reminding someone that he or she has multiple dimensions of wellness that include strengths could help restore a sense of self-respect or dignity.

SCREENING TOOLS

- PHQ 2 & PHQ 9 :
  - Developed with an educational grant from Pfizer.
- SAFE-T :
  - American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors
- ASQ :
  - asQ Suicide Risk Screening (NIMH)
- C-SSRS :
  - Columbia-Suicide Severity Rating Scale

SCREENING FOR SUICIDE RISK

Most widely use in primary care setting

- PHQ 2
- PHQ 9

Commonly used tool in Mental Health

- SAFE-T

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly Every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Suicide Assessment Five-step Evaluation and Triage — SAFE-T

1	2	3	4	5
IDENTIFY RISK FACTORS Note those that can be modified to reduce risk	**IDENTIFY PROTECTIVE FACTORS** Note those that can be enhanced	**CONDUCT SUICIDE INQUIRY** Suicidal thoughts, plans, behavior and intent	**DETERMINE RISK LEVEL/INTERVENTION** Determine risk. Choose appropriate intervention to address and reduce risk	**DOCUMENT** Assessment of risk, rationale, intervention, and follow-up

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

1. RISK FACTORS

- ✓ **Current/past psychiatric diagnoses:** especially mood disorders, psychotic disorders, alcohol/substance abuse, Cluster B personality disorders. *Co-morbidity and recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- ✓ **Family history:** of suicide, attempts or Axis 1 psychiatric diagnoses requiring hospitalization
- ✓ **Precipitants/stressors:** triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). History of abuse or neglect. Intoxication
- ✓ **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, absence of psychosis
- ✓ **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), versus non-suicidal, self-injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; explore *ambivalence*: reasons to die vs. reasons to live

* ***Homicide Inquiry:*** *when indicated, esp. postpartum, and 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
- ✓ ***Reassessment*** as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTORS	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan Give local/national emergency info*
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction Give local/national emergency info*

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

National Suicide Prevention Lifeline
***1.800.273.TALK**

5. DOCUMENT

- ✓ **Document:** Rationale for risk level, the treatment plan to address/reduce the current risk (i.e., medication, setting, E.C.T., contact with significant others, consultation) and firearm instructions, if relevant

RESOURCES

- Download this card and additional resources at www.sprc.org or at www.stopasuicide.org
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide http://www.stopasuicide.org/professional.aspx
- SAFE-T drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors http://www.psychiatryonline.com/pracGuideRoot.aspx?topic_14.aspx

ACKNOWLEDGEMENTS

- Originally conceived by Douglas Jacobs, MD, and developed as a collaboration between Screening for Mental Health, Inc. and the Suicide Prevention Resource Center.
- This material is based upon work supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) under Grant No. 1U79SM57360. Any opinions/findings/conclusions/recommendations expressed in this material are those of the author and do not necessarily reflect the views of SAMHSA.

DEVELOPED BY DOUGLAS JACOBS, MD

WWW.SPRC.ORG

WWW.MENTALHEALTHSCREENING.ORG

PROTECTIVE FACTORS AGAINST SUICIDE

- Effective clinical care for mental, physical, substance abuse disorders
- Easy access to clinical interventions
- Restricted access to lethal methods
- Family and community support and supportive relationships in ongoing medical/mental health care
- Learned skills in problem solving, conflict resolution, nonviolent handling of disputes
- Cultural and religious beliefs give sense of hope that discourages suicide

INTERVENTIONS

- Patient Education
- Assessing Suicide Risk
- Mobilizing Social Support
- Family Education
- Community resources
- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454

Unacceptable Terms

- Completed suicide
- Failed attempt
- Parasuicide
- Successful suicide
- Nonfatal suicide
- Suicide gesture
- Manipulative act
- Suicide threat

REFERENCES

Crosby AE, Ortega L, Melanson C. Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2011.

FACTS ABOUT ADULT SUICIDE: Office of Suicide Prevention http://suicideprevention.nv.gov/Adult/Facts_About_Suicide/

Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry 10th Edition; by Benjamin J. Sadock & Virginia A. Sadock.

Psychiatric Nursing: Contemporary PracticeMary Ann Boyd. Lippincott Williams & Wilkins, 2008

Screening Instruments for Depression Mark H. Ebell, MD, MS, Athens, Georgia Am Fam Physician. 2008 Jul 15;78(2):244-246

Screening and Assessment for Suicide in Health Care Settings: A Patient-Centered Approach http://zerosuicide.sprc.org

World Health Organization: Depression; A Global Health Crisis http://www.who.int/mental_health/management/depression/wfmh_paper_depression_wmhd_2012.pdf