Suicide Risk Reduction: Assessment and Safety Planning

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MAGELLAN BEHAVIORAL HEALTH OF PA

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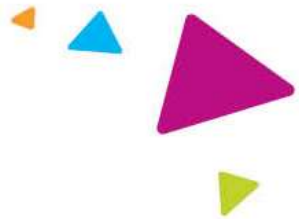
Course Outline

1. Preparation in assessment of suicide risk
2. Ethical considerations
3. Psychological factors associated with suicide risk
4. Evidence-based suicide risk assessments
5. Risk assessments that support clinical decision making
6. Safety planning

Learning Objectives



01	02	03	04	05	06
Describe The Benefit Of Being Prepared To Assess Suicide Risk	Outline Ethical Considerations: Duty of Care & Standard of Care	Apply Psychological Factors Associated With Suicide Risk	Identify Elements Of Evidence-based Suicide Risk Assessments	Explain Risk Assessments That Support Clinical Decision Making	Relate Elements Of Safety Planning

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Presenter Bio

- Dr. Siegler is the Psychologist Advisor for Magellan Behavioral Health of PA. He provides consultation to the care management team reviews of community-based service requests and supports children's service providers striving to provide effective and accountable treatment services to the individuals and families they serve. Dr. Siegler has extensive experience providing consultation services in educational, psychiatric, and forensic settings. He has provided staff training to behavioral health providers on a variety of topics related to clinical excellence and clinical accountability. Prior to joining Magellan, Dr. Siegler has held clinical leadership positions in psychiatric inpatient, psychiatric residential treatment, extended acute care, intensive behavioral health services, and outpatient settings.

Is it possible to avoid treating persons at risk of suicide?

Encountering suicidal patients is unavoidable

ED visits for suicidal ideation have increased with the Pandemic

Working with suicidal patients is stressful, demanding, and threatening to one's image of oneself as knowledgeable, competent, and efficacious.

Tiptoeing around the word "suicide" delays appropriate interventions.

36% of women and 18% of men had contact with a mental health professional within one month of their suicide.

Luoma, J. B., Martin, E., Pearson, J. L. (2002).Contact with mental health and primary care providers before suicide: A review of the evidence. American Journal of Psychiatry, 159(6), 909 – 916.

Brewer,A. G., Doss, W., Sheehan, K. M., Davis, M. M., Feinglass, J.M. (2022). Trends in suicidal ideation-related emergency department visits for youth in illinois: 2016–2021. *Pediatrics,* 150 (6), 39-48.

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Barriers to clinician competence and confidence?

- Suicide focused treatment modalities not taught during formal training or internship
- Mandatory annual agency training often focus on increasing adherence with policy and procedure.
- Clinicians may not be reimbursed Continuing Education.
- Clinicians may not know about high quality, no cost training

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Overcoming Barriers

Genuine desire to help patients do better.

Empirical support for the treatment.

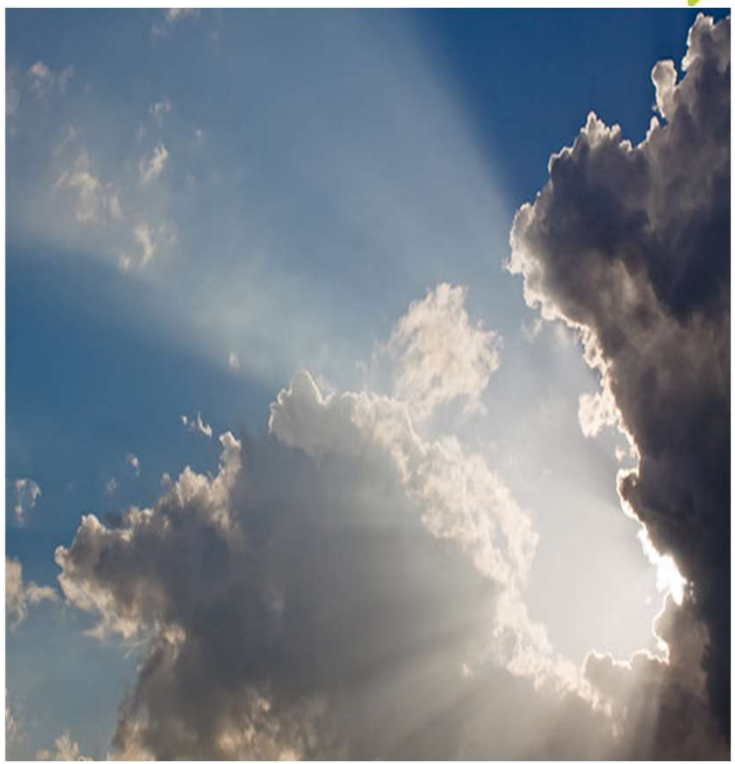
Directives or mandates by leadership (i.e., being forced to do it).

Fear of losing a patient to suicide and then being blamed.

Fear of litigation for malpractice wrongful death.

Everyone else is doing it and feeling left out.

Seeing is believing. (being convinced that a treatment may actually. work.



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“Why do people attempt suicide?”

Suicide is a highly complex and multifaceted phenomenon

Intrapersonal Perception (maladaptive cognitions, hopelessness, low self-esteem, meaninglessness, negative self attributions

External Environment (social status, lack of income, abuse, discrimination, poverty, unemployment)

Orsolini, L., Latini, R., Pompili, M., Serafini, G., Volpe, U., Vellante, F., Fornaro, M., Valchera, A., Tomasetti, C., Fraticelli, S., Alessandrini, M., La Rovere, R., Trotta, S., Martinotti, G., Di Giannantonio, M., & De Berardis, D. (2020). Understanding the Complex of Suicide in Depression: from Research to Clinics. *Psychiatry investigation*, *17*(3), 207–221. https://doi.org/10.30773/pi.2019.0171

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“Why do people attempt suicide?” Cultural Differences

Latino/African Americans

- Most endorsed: EXTERNAL ENVIRONMENT (social status, lack of income, abuse, discrimination,)
- Least endorsed: INTRAPERSONAL (cognitions of hopelessness, self-esteem, meaninglessness, negative self attributions)

Asian American & Caucasians

- Most endorsed: INTRAPERSONAL PERCEPTION (maladaptive cognitions)
- Least endorsed: EXTERNAL ENVIRONMENT (escaping stress, poverty, unemployment)

Chu, C., Buchman-Schmitt, J. M., Stanley, I. H., Hom, M. A., Tucker, R. P., Hagan, C. R., Rogers, M. L., Podlogar, M. C., Chiurliza, B., Ringer, F. B., Michaels, M. S., Patros, C. H. G., & Joiner, T. E., Jr. (2017). The interpersonal theory of suicide: A systematic review and meta-analysis of a decade of cross-national research. *Psychological Bulletin, 143*(12), 1313–1345.

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3 Theories of Suicidality

Cube Model	Hopelessness	Self-Regard
• External Psychological Stressors • Agitation – impulsive desire to "do something" • Psychological pain	• Negative view of the self in relation to the future	• Awareness of one's inadequacies • Negative Attribution of Failures • Self-awareness is painful. • Escape from aversive self-awareness • Self Loathing

Shneidman, E. S. (1999). The psychological pain assessment scale. Suicide and Life-Threatening Behavior, 29, (4), 287-294.
Beck, A. T., Brown, G., Berchick, R. J., Stewart, B. L., Steer, R. A. (2006). Relationship between hopelessness and ultimate suicide: A replication with psychiatric outpatients. Focus, 4 (2), 291-296.
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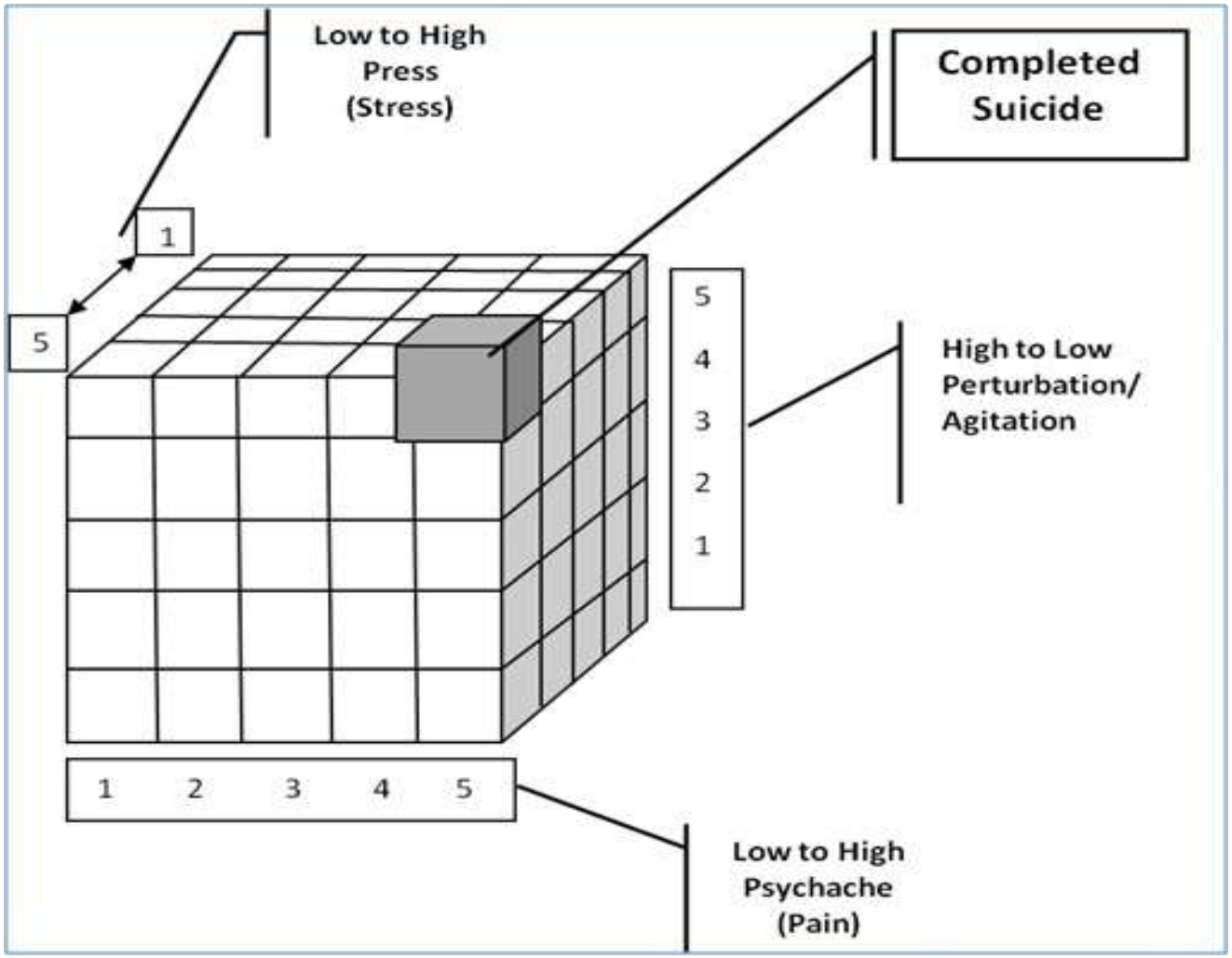
Cube Model



Shneidman, E. S. (1999). The psychological pain assessment scale. Suicide and Life-Threatening Behavior, 29, (4), 287-294.

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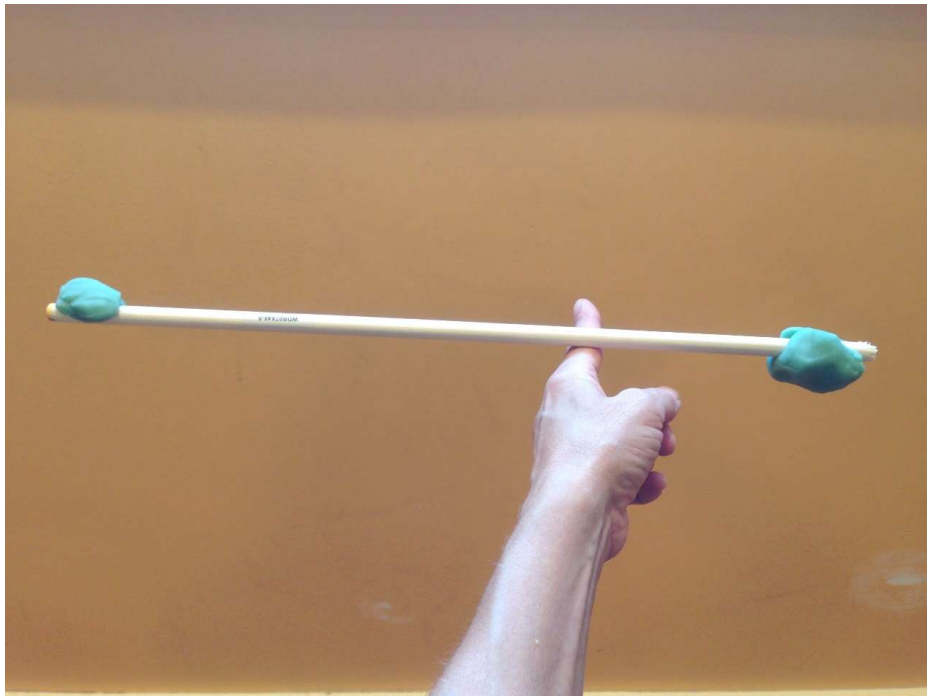
Ambivalence



Individuals who present for therapy are, to some degree, ambivalent about completing the suicide.

Essential to remember the ‘wish to die’ is opposed in a Decisional Balance with the ‘wish to live’

AND – Effective assessment requires overcoming fear and having empathy for the person’s suffering and desire to end their suffering.

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Standards of Care

Duty of Care

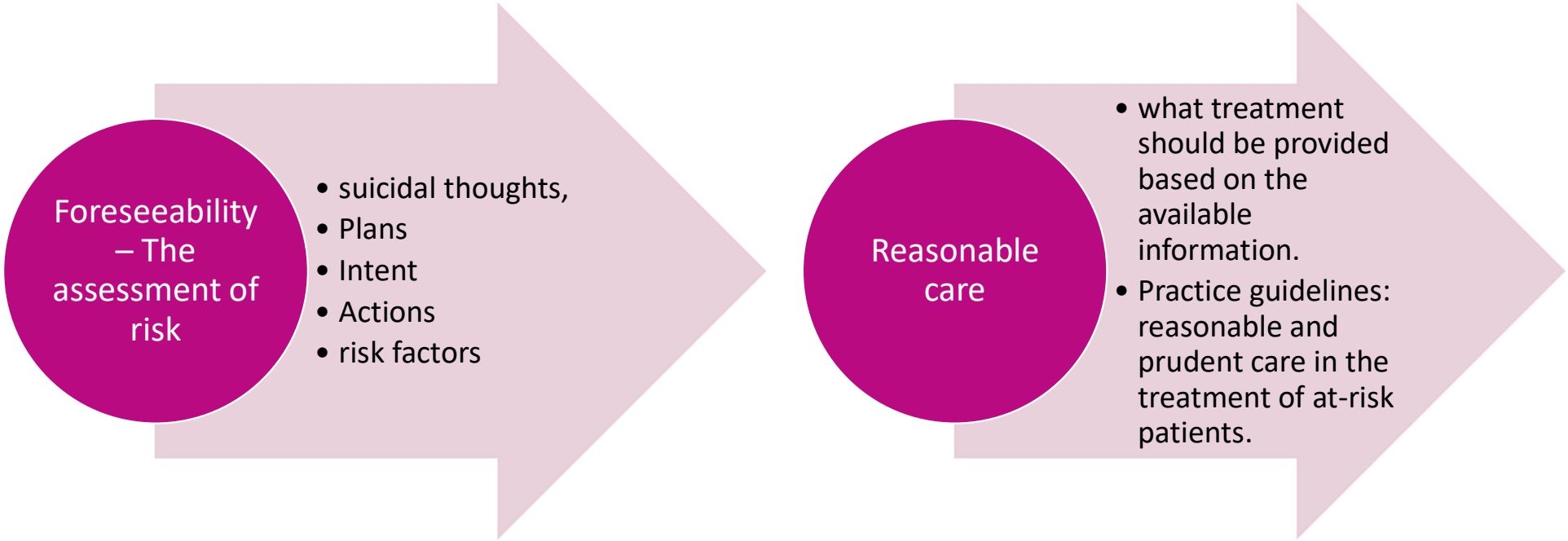
The duty to attempt reasonably to prevent the suicide of the patient.

Standard of Care

The degree of skill and care customarily used in similar circumstances by similar clinicians.

Berman, A.L., Jobes, D.A., & Silverman, M.M. (2007). Adolescent suicide: Assessment and intervention. American Psychological Association

Liability – 2 factors



Pinals D. A. (2019). Liability and Patient Suicide. *Focus (American Psychiatric Publishing)*, *17*(4), 349–354.

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Commonly Alleged Failures In Meeting Standards Of Care : Foreseeability.

Alleged failures.	Remedies.
Appropriately diagnose patient.	Obtain history of current and past problems.
	Perform mental status exam
	Conduct assessment of suicidality to determine suicidal risk.
	Reach tentative diagnosis.
	Provide risk-benefit analysis of treatment options to support critical clinical management decisions.
	Consider least restrictive environment options.
	Develop initial treatment plan and discuss treatment plan with patient
	Obtain informed consent and discuss limits of confidentiality.
	Obtain collateral information from support network with patients consent.
Appropriately foresee future behavioral problems	Reassess regularly with diagnosis, level of suicidality. , and appropriateness of all aspects of the treatment plan.
	Obtain consultation when indicated.

Commonly Alleged Failures In Meeting Standards Of Care: Causation.

Alleged failures.	Remedies.
Provide protection against harm.	Implement treatment plan.
	Monitor treatment plan results.
	Provide. informed consent about changes in treatment plan.
	Discuss confidentiality with patient.
Treat conditions associated with suicidal behaviors.	Consider consultation when indicated.
	Provide plan specific interventions.
Carry out treatment plan as written.	Monitor adherence to treatment plan.

Competent Risk Assessment

Foreseeability-How much screening/assessment is enough?

Use Empirically Supported Structured Tools

Screening Tools

In-Depth Individualized Assessment

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Static vs Dynamic Risk Factors

Static risk factors

- History of behavior likely to result in death (gesture)
- Seriousness of suicidal gesture
- Previous AIP admission
- History of MH Diagnosis
- History of SUD
- Personality disorder/traits
- Childhood adversity
- Family history of suicide
- Age, gender and marital status

Dynamic risk factors

- **Suicidal ideation, verbalization, and intent**
- **Hopelessness**
- **Active psychological symptoms**
- **Treatment adherence**
- **Substance use**
- **Psychiatric admission and discharge**
- **Psychosocial stress**
- **Problem-solving deficits**

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4 Steps to Risk Assessment and Risk Management

1) Policies and Procedures

- Do you have a suicide risk management specific P&P?
- Are your P&Ps aligned with your usual and customary practices of assessing and treating individual experiencing suicidal crisis?

2) Reliable Assessment Procedures

- Do you assess all clients for suicide risk?
- What do you use for:
  - Screening
  - In Depth Assessment of Risk

4 Steps to Risk Assessment and Risk Management

3) Clinical Consultation

- Ethically Indicated
- Clinically Indicated
  - Suicide specific countertransference
  - Suicide “Blackmail”
- Can Reduce Liability

4) Suicide Specific Documentation

- Contemporaneous
- Thorough

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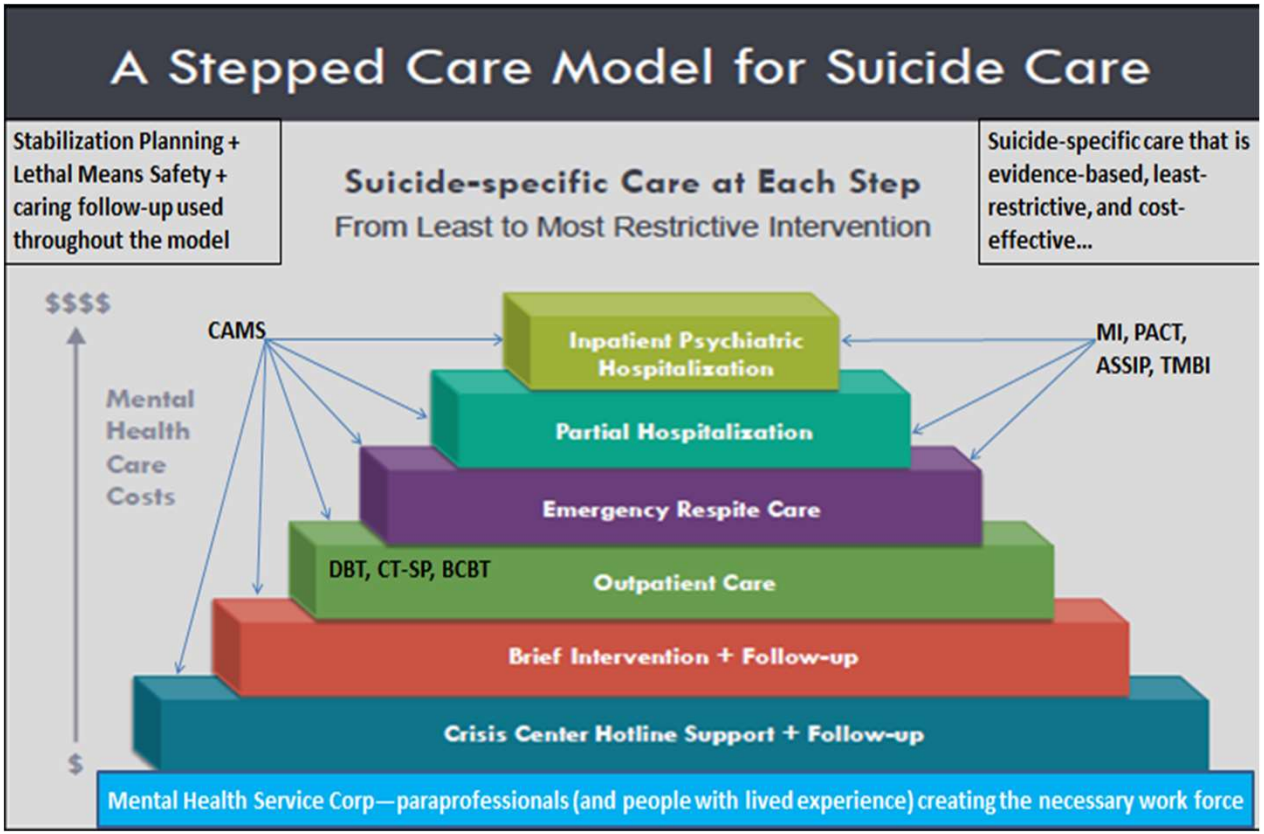
Suicide Specific Treatment



- Increase Member access to high quality suicide risk assessment and risk reduction interventions at ALL levels of care.
- Increase clinician access to high quality tools and training resources
- Increase utilization of high-quality suicide risk assessment and suicide risk reduction intervention at all levels of care

Jobes, D. A., Gregorian, M. J., & Colborn, V. A. (2018). A stepped care approach to clinical suicide prevention. *Psychological services*, *15*(3), 243.

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Evidence Based Treatments for Suicidal Risk

- Dialectical Behavior Therapy (DBT)
- Cognitive Therapy for Suicide Prevention (CT-SP)
- Collaborative Assessment and Management Of Suicidality (CAMS)
- Post-Admission Cognitive Therapy (PACT)

Assessment of Suicidal Risk

High quality assessment tools …

- Evidence based
- Assesses ideation & behavior
- Low burden
- Have utility in many settings
- Guides decision making on Level of Care

Essential Tools

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Pediatric - Since Last Contact – Communities and Healthcare

Version 6/23/10

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in ***The Columbia Suicide History Form****, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.]* Standardized Evaluation in Clinical Practice*, pp. 103 -130, 2003.)*

CAMS SUICIDE STATUS FORM–4 (SSF-4) INITIAL SESSION

Patient: Kevin Clinician: David Jobes Date: 6/23 Time: Noon

Section A (*Patient*):

Rate and fill out each item according to how you feel right now. Then rank in order of importance 1 to 5 (1 = most important to 5 = least important)

Rank	
3	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, not stress, not physical pain*): **Low pain:** 1 2 3 (4) 5 **:High pain** What I find most painful is: being stuck in my own skin
5	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): **Low stress:** 1 2 3 4 (5) **:High stress** What I find most stressful is: being here
4	3) RATE AGITATION (*emotional urgency; feeling that you need to take action; not irritation; not annoyance*): **Low agitation:** 1 2 3 (4/5) **:High agitation** I most need to take action when: Someone does something untrustworthy
1/1.5	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): **Low hopelessness:** 1 2 3 4 5 (10) **:High hopelessness** I am most hopeless about: anything changing
1	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): **Low self-hate:** 1 2 3 4 5 (10) **:High self-hate** What I hate most about myself is: everything
N/A	6) RATE OVERALL RISK OF SUICIDE: **Extremely low risk: (will *not* kill self)** 1 2 3 4 (5) **:Extremely high risk (will kill self)**

1) How much is being suicidal related to thoughts and feelings about yourself? **Not at all:** 1 2 3 (4) 5 **: completely**

2) How much is being suicidal related to thoughts and feeling about others? **Not at all:** 1 2 3 (4) 5 **: completely**

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING
3	my mom	1	people don't get it / they don't care
2	maybe something will get better	3	nothing is going to change
1	See how Breaking Bad ends	4	I don't contribute to society
		1	People would be better off if I was dead

I wish to live to the following extent: **Not at all:** 0 (1) 2 3 4 5 6 7 8 **: Very much**

I wish to die to the following extent: **Not at all:** 0 1 2 3 (4) 5 6 7 8 **: Very much**

The one thing that would help me no longer feel suicidal would be: MIB flash thing on everyone and then myself

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Safety Planning

Old terminology: Contract for Safety

- Episodic
- Limited scope
- Rote/routine

Current Terminology: Safety Planning

- More comprehensive; think globally, home supports, creative thinking
- Concept of “Safety Net”
- Action oriented
- What should a safety plan include?
  - Revisiting safety plans throughout treatment

WHAT IS A SAFETY PLAN?

A prioritized written list of coping strategies and sources of support

Patients can use these strategies before or during a suicidal crisis.

Safety Planning is associated with reduced subsequent suicide attempts

Doupnik SK, Rudd B, Schmutte T, et al. Association of Suicide Prevention Interventions With Subsequent Suicide Attempts, Linkage to Follow-up Care, and Depression Symptoms for Acute Care Settings: A Systematic Review and Meta-analysis. *JAMA Psychiatry.* 2020;77(10):1021–1030.

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WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive safety plan.

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

There are 6 Steps involved in the development of a Safety Plan

https://www.sprc.org/sites/default/files/SafetyPlanningGuide%20Quick%20Guide%20for%20Clinicians.pdf

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The Stanley Brown Safety Planning Intervention

A brief standalone intervention that may reduce further suicidal behavior

A systematic and comprehensive approach to maintaining safety in suicidal patients.

Patients are given tools that enable them to resist or decrease suicidal urges for brief periods of time, reducing the risk for suicide.

Includes means restriction and emergency contacts, and utilizes internal coping skills and distracting strategies

Stanley, B. & Brown, G. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk, Cognitive and Behavioral Practice, 19(2), 256-264.

The Safety Plan Intervention

Takes approximately 20 to 45 minutes to complete

Completed after a comprehensive suicide risk assessment

A collaborative stance is most effective for developing the safety plan.

Step 1: Warning Signs

- Ask: “How will you know when the safety plan should be used?”
- Ask: “What do you experience when you start to think about suicide or feel extremely depressed?”
- List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the person’s own words

Step 2: Internal Coping Strategies

- Ask: “What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?”
- Assess likelihood of use: Ask: “How likely do you think you would be able to do this step during a time of crisis?”
- If doubt about use is expressed, ask: “What might stand in the way of you thinking of these activities or doing them if you think of them?”
- Use a collaborative, problem solving approach to address potential roadblocks and ID alternative coping strategies.

Step 3: Social Contacts Who May Distract from the Crisis

- Instruct the person to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Ask: “Who or what social settings help you take your mind off your problems at least for a little while?” “Who helps you feel better when you socialize with them?
- Ask for safe places they can go to be around people (i.e. coffee shop).
- Ask patient to list several people and social settings in case the first option is unavailable.
- Remember, the goal is <u>distraction</u> from suicidal thoughts and feelings.
- Assess likelihood that patient will engage in this step; ID potential obstacles, and problem solve, as appropriate.

Step 4: Family Members or Friends Who May Offer Help

- Instruct patients to use Step 4 if Step 3 does not resolve crisis or lower risk.
- Ask: “Among your family or friends, who do you think you could contact for help during a crisis?” or “Who is supportive of you and who do you feel that you can talk with when you’re under stress?”
- Ask patients to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
- Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- Role play and rehearsal can be very useful in this step.

Step 5: Professionals and Agencies to Contact for Help

- Ask: “Who are the mental health professionals that we should identify to be on your safety plan?” and “Are there other health care providers?”
- Instruct the patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- List names, numbers and/or locations of clinicians, local urgent care services.
- Include the 988 Suicide & Crisis LifeLine
- Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- Role play and rehearsal can be very useful in this step.

988: A Direct Link for Suicide Prevention and Crisis Support

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Step 6: Making the Environment Safe

- Ask patients which means they would consider using during a suicidal crisis.
- Ask: “Do you own a firearm, such as a gun or rifle??” and “What other means do you have access to and may use to attempt to kill yourself?”
- Collaboratively identify ways to secure or limit access to lethal means: Ask: “How can we go about developing a plan to limit your access to these means?”

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