



Suicide Risk Management

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1



American Foundation
for Suicide Prevention

Suicide Prevention

Saving Lives

One Community at a Time

American Foundation for Suicide Prevention
Dr. Paula J. Clayton, AFSP Medical Director
120 Wall Street, 22nd Floor
New York, NY 10005
1-888-333-AFSP
www.afsp.org



Some statistics

- Approximately 30,000 deaths/yr in U.S.
- Every 17 minutes someone dies.
- Suicide rates stable in past 5 yrs.
- 2nd leading cause of death for college students.
- Rate in white males over 85 is 48/100k.
- Suicide rate is almost double homicide rate.

3



Washington State Facts (courtesy www.SPRC.org)

- **9th ranking cause of death**
- **Average of 789 residents die by suicide each year**
- **Suicide rate: 13.9 per 100,000**
- **Average of 2.2 suicides every day**

4



Washington State Facts (courtesy www.SPRC.org)

- **Males**
 - 79% of suicides
 - rate 22.2 per 100k
 - 8th ranking cause of death
- **Females:**
 - 21% of suicides;
 - rate 5.7 per 100k
 - 16th ranking cause of death
- **Male suicide rate 3.9 times the female rate**

5



Washington State Facts (courtesy www.SPRC.org)

- **White Non-Hispanic (NH): 89% of suicides; rate 15.4**
- **Hispanic: 3% of suicides; rate 5.7**
- **Black NH: 2% of suicides; rate 7.8**
- **White NH suicide rate 2.0 times the Black NH rate**

6



Washington State Facts (courtesy www.SPRC.org)

- Highest Rate = 70+ years
 - 14% of suicides
 - rate 2.2 times the rate for 15 to 19 year olds
- Washington is in the middle of the national ranking by state

7



Suicide Is Not Predictable

- Risk factors are sensitive
- Risk factors are NOT specific

8



Suicide Communications Are Often Not Made to Professionals

- In one psychological autopsy study only 18% told professionals of intentions.
- In a study of suicidal deaths in hospitals:
 - 77% denied intent on last communication
 - 28% had “no suicide contracts” with their caregivers

9



Preventing Suicide

- Education
- Treatment
- Means Restriction

10



Preventing Suicide...

Education Tools

- AFSP Website www.afsp.org
- AFSP College Film, *The Truth about Suicide*
- AFSP Teen PSA
- AFSP Newsletter
- AFSP PowerPoint Presentations
- National Institute of Mental Health www.nimh.nih.gov
- Center for Disease Control www.cdc.gov
- Suicide Prevention Resource Center www.sprc.org
- American Association of Suicidology www.suicidology.org
- Planned informal talks for caregivers with AFSP researchers

11



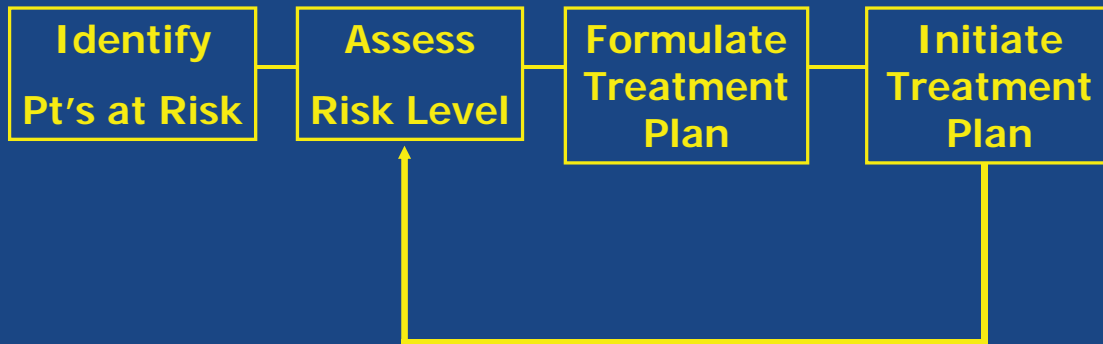
Hotlines/DMHP's

- **National Suicide Prevention Lifeline**
 - 1-800-273-TALK
 - www.suicidepreventionlifeline.org
- **Crisis Clinic**
 - 866 4CRISIS [866.427.4747]
 - Local 206.421.3222
 - www.crisisclinic.org
- **911**

12



Suicide Risk Management



13



Assessment

- Current mental status
- Suicidal Behavior History
- Current environmental risk factors
- Static Risk Factors
- Establishing a Risk Level

14



Current Mental Status

Suicide Ideation

- **Passive Ideation**
 - Better off dead
 - Life is not worth living
 - Wish I could just disappear
 - Imagining funeral, or post-funeral world

15



Suicide Ideation cont...

- **Active Ideation**
 - Wish to harm self
 - Imagining killing self
 - Planning methods
 - How detailed
 - How lethal
 - How available

16



Current Mental Status *Preparatory Behavior*

- Accumulating means
- Putting affairs in order
 - Saying goodbyes/visiting
 - Updating wills
 - Checking on insurance status
- Rehearsing

17



Current Mental Status *Describing Ideation*

- Evaluating Ideation
 - How “strong”
 - Intensity, Impulsiveness, distressing
 - How frequent
 - How long do ideas last

18



Asking the Questions

- Be very attentive
- Remain calm and non-threatened
- Give the patient time to talk
- Stress a team approach to supporting the patient
- Be willing to say *suicide* without flinching

19



Current Mental Status...

- Comorbid psychiatric illness
- Hopelessness
- Reasons for Living
 - What are they
 - How important
 - Do they out weight the wish to die
- Distress due to acute stressors
- Motivation to engage in treatment
- Substance abuse

20



Current Mental Status...

- **Reasons for Living**
 - Feels strongly connected to loved/ones
 - Has interest in future (job, children, etc)
 - Feels a purpose in life and wants to fulfill it
 - Strong religious reasons
 - Suicide is inconsistent with self-view
 - *Document reasons (absence or presence thereof)*

21



Suicidal Behavior History

- **Any past attempts**
 - When, how, why
 - Lethality
 - Why are you still alive
- **Past ideation**
 - How did this resolve

22



Current Environmental Factors

- **Why Now?** (terminal illness, loss, etc)
- **Forms of social support**
 - Spouse, Family, mental health specialists, clergy...
- **Employment status**
- **Availability of means**
- **Isolation levels**
 - Thwarted Belongingness
 - Perceived Burdensomeness

23



Static Risk Factors

- **Past attempts**
- **Family history of suicide**
 - Who, When, Impact
- **Age**
 - As age increases attempt decrease but risk of death increases
- **Gender**
 - Women more attempts
 - Men more deaths
- **History of Psychiatric Illness**
- **History of substance abuse**

24



Protective Factors

- Ideation is distressing
- Crisis is associated with acute events that are amenable to intervention
- Patient is enthusiastic about treatment
- Strong social support network

25



Establishing a Risk Level

- **Putting It All Together**
 - Ideation (behavior, active, passive)
 - History of attempts and/or ideation
 - Co-morbid psychiatric conditions
 - Psychosocial Stressors
 - Psychosocial Protective Factors

26



Establishing a Risk Level...

- Passive ideation is generally going to be a low to medium risk level
- Active ideation is generally going to be medium to high
- Other factors are used to discriminate (e.g. history, mood disorder, substance abuse)

27



Generating a Treatment Plan

- Based on established risk level
- AND - clinical judgment
 - Follow-up (soon, 1 week)
 - Prescribe & follow-up (soon, 1 week)
 - Refer to MHS
 - Hospitalization (voluntary or involuntary)

28



Elements of a Treatment Plan

- Treat mood disorder if/when present
- Patient education on community resources
- Patient education on practice resources
- Frequent follow-up and re-assessment
- Clear treatment implementation plan
 - Who is going to follow-up when?
 - Who is coordinating inter-provider communication?
 - Who is updating/modifying treatment plan based on course of risk?
- Means Restriction

29



Means Restrictions

- Removing firearms
- Removing poisons
- Removing drug stockpiles
- Control access to lethal drugs
- Patient initiated removal of means
- Involvement of social support network

30



Documentation

- **The assessment process**
 - By Who
 - When
 - Where
- **Risk factors**
 - Ideation
 - Other Mental Status
 - Static Risk Factors
 - Protective Factors
- **The assigned risk level based on Risk Factors**
 - Low, Medium, High (acute and/or long-term)
- **The treatment plan**

31



Clinical Resources

- **Managing Suicidal Risk: A Collaborative Approach: David A. Jobes. Guilford Press**
- **The Assessment and Management of Suicidality: By M. David Rudd, PhD, ABPP. Professional Resource Press**
- **Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors: American Psychiatric Association**
- **Cognitive Therapy for Suicidal Patient: Wenzel, Brown, Beck, American Psychological Association**

32



Acknowledgements

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<http://www.rochesterpreventsuicide.org/>

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Suicide Prevention Action Network
Washington Youth Suicide Prevention Program**

33



Asking the Questions

- Do you ever get so sad or down that you think that life is not worth living?
- Do you ever have the wish that you could just disappear?
- Do you think of acting on the feelings by hurting yourself, or taking your life?
- What kinds of ideas do you have about suicide?
- When do you feel most like hurting yourself?
- Do you have a plan?
- When would you be tempted to implement such a plan?
- Do you have the means to implement the plan?
- How do you react to situations that trigger thoughts of suicide?
- What might you do to stop yourself? Are you interested in stopping yourself?
- Are you frightened by the temptation to take your own life?
- What do you think about suicide as a solution to your troubles?

34