Title: Suicide Assessment

Presenters: Mayumi Okuda, MD and Rosa Regincos, LMSW

Course Description:

This webinar provides an overview of how to conduct a suicide assessment with a client during intake at a Family Justice Center or similar co-located model. Speakers share the prevalence of suicide, discuss risk factors, define the spectrum of suicide and suicidal behaviors, and finally provide recommendations for emergency management of clients in crisis. Throughout the webinar speakers use case scenarios to provide practical approaches for engaging with survivors on various levels of the suicide ideation spectrum. The webinar provides frontline staff with tools necessary to ask survivors about suicide and equips them with the skills to help survivors who may be struggling with suicidal ideation.

Materials:

Columbia – Suicide Severity Rating Scale

Safety Planning Guide

Suicidality Protocol

Suicide Assessment

Polyvictimization Initiative:
Creating Pathways to Justice, Hope and Healing
Presenter – Dr. Mayumi Okuda

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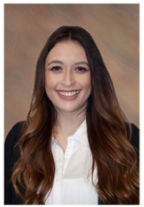
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COLUMBIA UNIVERSITY Department of Psychiatry

Suicide Assessment

Mayumi Okuda, M.D.
Women's Program- Department of Psychiatry
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Summary

- Epidemiology
- Clinical Scenario
- Risk Factors
- Suicide Definitions
- Protective Factors
- Emergency Management
- Resources

Epidemiology

- Suicide was the #2 leading cause of death among persons aged 15-34 years, the #4 among person aged 35-54 years
- Among people who die of suicide 19% are women, 81% are men
- Women report more attempted suicides
- Firearms, suffocation, and poison are by far the most common methods of suicide overall

Clinical Scenario

- *22 year old Dominican woman, in process of separating, who had experienced intimate partner violence during the past year. She reported feeling depressed, crying constantly, eating poorly, sleeping 2-3 of hours per night, drinking until intoxication. During the past month, she had been walking to a bridge thinking that she might jump (she didn't know how to swim), and she did not see a point in living. Her mother had been visiting and she felt safe around her, but mother was leaving in a week. She believed that if she died it would be easier for her parents to mourn her than having to support her financially.*

Risk Factors

- Chronic mental illness, particularly depression
- History of substance abuse
- Prior attempts
- Family history of suicide
- History of physical or sexual abuse
- Violence in the past year
- Homosexual youth, bisexual youth
- Physical illness: particularly those with poor prognosis/physical functioning and/or persistent pain
- Incarceration
- Unstable living conditions

Acute Risk Factors

- **Access to firearms**
- High levels of hopelessness
- Insomnia
- Anxiety, panic attacks
- Agitation
- Command auditory hallucinations (hearing voices telling them to hurt themselves/others)
- Substance use

Protective Factors

- Fear of social disapproval
- Positive survival beliefs, e.g., beliefs about one's purpose in life and ability to persevere
- Having a reason for living
- Religious beliefs
- Feeling needed by others
- Hope for the future

Myths and Challenges Regarding Suicide Assessment

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Columbia University Department of Psychiatry

DEFINITIONS

Posner K, Brown GK, Stanley B, et al. The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. Am J Psychiatry. 2011 Dec;168(12):1266-77.

SUICIDAL IDEATION

Wish to be Dead

- The individual endorses thoughts about their own death
- Examples: wish to be dead/better off dead, wish he/she were never born, thoughts that life is not worth living or the world would be better off without him/her, wish to fall asleep and not wake up

Non-specific Active Suicidal Thoughts

- General non-specific thoughts of wanting to end one's life/commit suicide "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan

Active Suicidal Ideation with Any Methods (not plan) without intent to act

- Thoughts of suicide and at least one method (a way they would do it)
- Different than a specific plan with time, place or method details worked out (e.g. thought of method to kill self but not a specific plan)
- If there's no plan or intent to act, the individual has thought of a way they would kill themselves but they are not intending to carry it on

Active Suicidal Ideation with some intent to act, without specific plan

- Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts

Active Suicidal Ideation with specific plan and intent

- Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out
- Ex: taking pills on Friday (hoping to die) after spouse leaves for work

SUICIDAL BEHAVIORS

Suicide Attempt

- A potentially self-injurious act committed with at least some wish to die, as a result of act
- Behavior was in part thought of as method to kill oneself. Intent DOES NOT have to be 100% (e.g. in part to sleep though thinking he/she might end up dying)
- If there is any intent/desire to die associated with the act, then it can be considered an actual suicide attempt
- There does not have to be any injury or harm (e.g. firing a gun with mechanism not working)

Interrupted Attempt

- The person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if not for that, actual attempt would have occurred)

Aborted Attempt

- When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior
- Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something/somebody else

Preparatory Acts or Behavior/ Other Suicidal Behaviors

- Acts or preparation towards imminently making a suicide attempt
- Includes anything beyond a verbalization or thought, such as assembling a specific method (e.g. buying pills, purchasing a gun) or preparing for one's death by suicide (e.g. giving things away, writing a suicide note)

Non-suicidal Self-injurious behavior/ Non-suicidal Self-directed violence

- Engaging in behavior that is purely, 100%, for reasons other than to end one's life
- Self-mutilation or behaviors to feel better, relieve internal pain, feel something, or affect external circumstances

Unacceptable Terms

- Suicide gesture, manipulative act, and suicide threat
- Value judgment with a pejorative or negative impression of the person's intent. They are usually used to describe an episode of nonfatal, self-directed violence
- A more objective description of the event is preferable such as non-suicidal self-injurious behavior or preparatory acts or behaviors depending on the case

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

Other Characteristics

- Lethality of Attempts: actual and potential
- Characteristics of Ideation
  - Frequency
  - Duration
  - Controllability
  - Reasons for Ideation
  - Deterrents

Clinical Scenario

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Management Low-Risk scenarios

- Mitigate or eliminate identified risk factors
- Treat associated disorders (referral to mental health services)
- Help from mental health professionals, family or significant others
- Address the abuse of substances
- Assist with the strengthening of social resources through active involvement of family/significant others
- Additional resources to mitigate stressors (housing, legal services, etc.)

Safety Plan

- For patients with risk factors and not in immediate need for care/transfer to ER
- Safety plans are preferred over contracts for safety
- They increase collaboration with the patient and provide a sense of control/agency

Emergency Management

- Suicide plan and/or intent is present
- Break with reality (disorganized thinking, hallucinations)
- There was a recent suicide attempt/interrupted/aborted that was violent, near-lethal, or premeditated
- Recent attempt where precautions were taken to avoid rescue or discovery
- Distress is increased or patient regrets surviving a recent attempt

Emergency Management

- New psychiatric illness or suicidal thinking
- Limited family and/or social support, including lack of stable living situation
- Current impulsive behavior, severe agitation, poor judgment, or refusal of help
- Change in mental status (confused, disoriented)
- Clinical decision (when in doubt remember that you are simply sending a client to the ER for an immediate evaluation by a psychiatrist, you are not deciding whether the client will be hospitalized)

Conducting Suicide Assessment at the FJC

- Objectives
  - Safe
  - Respectful
  - Effective
  - Transparent
  - Collaborative

Resources

- Training Columbia-Suicide Severity Rating Scale

http://www.cssrs.columbia.edu/training_cssrs.html

Thank You!

Alliance for HOPE International

www.allianceforhope.com

www.familyjusticecenter.com

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Mayumi Okuda Benavides, MD
Psychiatrist and Researcher
Columbia University

Mayumi Okuda served as a Chapman Perelman Fellow in Psychiatry at the Bronx Family Justice Center from 2014-2017. A psychiatrist trained in Bogotá, Colombia and at Columbia University Medical Center, Mayumi has worked with a wide range of patient populations, focusing her clinical work on minorities. Her earliest work with survivors of the ongoing conflict in Colombia inspired her to pursue the treatment of trauma and recovery in both research and clinical practice. Mayumi's clinical expertise includes pharmacological treatments for PTSD as well as psychotherapeutic approaches including EMDR, Cognitive Behavioral Therapy, Problem Solving Psychotherapy, Seeking Safety and Motivational Interviewing. Dr. Okuda has conducted research on the epidemiology of mood, anxiety and substance use disorders with a focus on violence, gender, and minorities publishing work on the epidemiology childhood abuse and intimate partner violence. Currently her work is focused on the integration of mental health services for survivors of intimate partner violence in non-specialty settings.

Rosa Regincos, **LMSW**
Trauma Therapist
Assistant Professor
Psychiatric Social Work
Columbia University

Rosa Regincos obtained her Clinical Psychology Degree at the Universitat de Barcelona, Spain in 1995. She also holds a degree 'In Treatment of Psychological Trauma' by Boston University and is a Licensed Master Social Worker by New York State. Ms. Regincos has extensive clinical experience in the area of psychological trauma with adults and children and perinatal mental health. She has worked at the New York State Psychiatric Institute's Anxiety Disorder Clinic and in the Boston Justice Trauma Center with Dr. Bessel Van ser Kolk. Ms Regincos is currently working as part of the Columbia University Medical Center's women's program team as an assistant professor in psychiatric social work and was been part of the pilot program implementing psychiatric and psychological services at the Bronx Family Justice Center as a therapist. Ms. Regincos also worked as a trauma therapist for the Safe Horizon counseling center in New York City treating children and adults survivors of interpersonal trauma. She has been trained in many different trauma evidence based treatments including EMDR, Seeking Safety, Trauma focused Cognitive Behavioral Therapy, SPARKS, Child Parent Psychotherapy and Risking Connection.

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen with Triage Points for Law Enforcement

Ask questions that are in bold and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you had any actual thoughts of killing yourself?		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Have you been thinking about how you might do this? e.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it."		
4) Have you had these thoughts and had some intention of acting on them? as opposed to "I have the thoughts but I definitely will not do anything about them."		
5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?		
6) Have you ever done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Lifetime**	
	Past 3 Months	
If YES, ask: Was this within the past 3 months?		

Response Protocol to C-SSRS Screening
Item 1 Behavioral Health Referral and Crisis Numbers
Item 2 Behavioral Health Referral and Crisis Numbers
Item 3 Consider Further Mental Health Evaluation
Item 4 Urgent Mental Health Evaluation with Escort
Item 5 Urgent Mental Health Evaluation with Escort
Item 6 Over 3 months ago: Consider Further Mental Health Evaluation
Item 6 3 months ago or less: Urgent Mental Health Evaluation with Escort

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.

- For methods with low lethality, clinicians may ask patients to remove or limit their access to these methods themselves.
- Restricting the patient's access to a highly lethal method, such as a firearm, should be done by a designated, responsible person – usually a family member or close friend, or the police.

WHAT ARE THE STEPS AFTER THE PLAN IS DEVELOPED?

ASSESS the likelihood that the overall safety plan will be used and problem solve with the patient to identify barriers or obstacles to using the plan.

DISCUSS where the patient will keep the safety plan and how it will be located during a crisis.

EVALUATE if the format is appropriate for patient's capacity and circumstances.

REVIEW the plan periodically when patient's circumstances or needs change.

remember: the safet y plan is a tool to engage the patient and is only one part of a comprehensive suicide care plan

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Implementing the Safety Plan: 6 Step Process

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 patient’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 patients 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, in this step, the goal is distraction 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

- Instruct the patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- Ask: “Who are the mental health professionals that we should identify to be on your safety plan?” and “Are there other health care providers?”
- List names, numbers and/or locations of clinicians, local urgent care services.
- 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 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?”

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. Place_____
4. Place_____

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_____

Clinician Pager or Emergency Contact #
_____

2. Clinician Name_____

   Phone_____

   Clinician Pager or Emergency Contact #
   _____

3. Local Urgent Care Services _____

   Urgent Care Services Address _____

   Urgent Care Services Phone _____

4. Local Urgent Care Services _____

   Urgent Care Services Address _____

   Urgent Care Services Phone _____

5. 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:

_____

Suicidality Protocol

Objectives

1. Safe
2. Respectful
3. Effective
4. Transparent
5. Collaborative

Current BXFJC Protocol

1. Assessment of Suicidal Risk: Activate protocol if risk is determined to be **HIGH RISK** or **UNCERTAIN**
2. If available, seek mental health professional (counselor, psychologist, psychiatrist) input/second look
3. Inform client of your concerns and your thought process
4. Emphasize your duty to protect their safety
5. Regardless of whether client agrees or not to go to ER, client should **ALWAYS** be taken via ambulance
6. Make sure you are informing client step by step of what's going on and what's going to happen
7. **Do not leave client unattended** (inform client of your concern about this), find help to ensure this
8. **Contact Administrative Staff** yourself or with the help of others [IM is an option if appropriate]
9. Administrative Staff alerts security about EMS being activated
10. Confirm Administrative Staff will **call 911** (provide DOB, Full name, description of the situation, status [e.g. calm, agitated], medical issues/medication).
11. If possible, write brief note with information on your suicide risk assessment and your contact information while waiting for EMS

12. EMS arrives, Administrative Staff communicates this to person activating protocol
13. Inform client that EMS arrived, describe scenario before they interact with EMS
14. Stay with client while EMS interviews them if they prefer this (clients typically do)
15. If possible, request that patient be taken to hospital where they receive care (with input/advocacy assistance from on-site clinician, but paramedics have ultimate decision on this)
16. If note was written, give EMS note to be delivered to physicians in ER
17. Client and EMS will leave through the back door
18. FJC Administrative staff will contact the hospital to inform physicians about your client. FJC Administrative staff will give your (service provider) contact information for hospital staff to follow-up once a determination is made (e.g. client is being discharged vs hospitalized).
19. Document all of the above in your notes
20. De-brief with staff involved in protocol

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Webinar Training

Suicide Assessment
1 Hour 15 min.

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