SUICIDE SAFETY MANAGEMENT

Unity Center for Behavioral Health

MARCH 2019 CoP meeting

COMPONENTS OF SUICIDE SCREENING AND ASSESSMENT

Suicide prevention interventions seek to:

- Optimize the safety of a patient with suicidal ideation and/or intent.
- Promote and enhance the therapeutic alliance with the patient.
- Ensure staff will remain alert to indications of increased risk of suicidal behavior for all patients throughout hospitalization.
- Provide interventions that will be initiated to maintain the safety and promote the recovery of patients deemed at risk for suicidal behavior while hospitalized.

ROLES AND RESPONSIBILITIES

❖ Suicide safety management <u>during hospitalization</u> involves the multi-disciplinary team to assure safety for the patient.

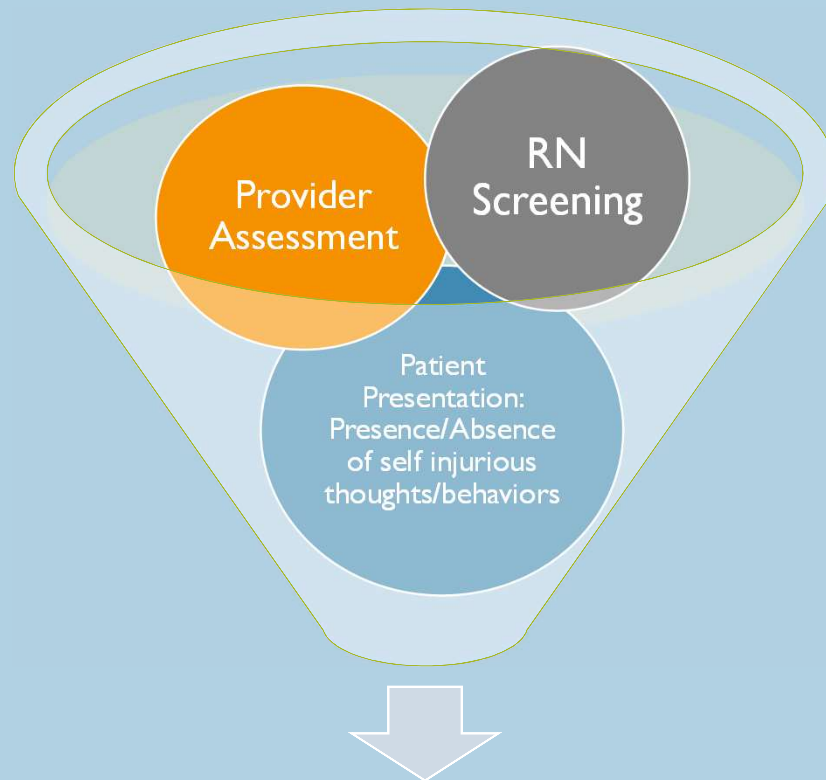
Evaluation of patient safety begins with:

1) A **SCREENING** completed by the RN and
2) An **ASSESSMENT** completed by the Provider

2) Suicide **assessment** done by Provider

3) Suicide safety management plan established

COMPONENTS OF SUICIDE SCREENING AND ASSESSMENT



Suicide Safety Management Plan

TOOLS FOR SUICIDE SCREENING AND ASSESSMENT

Though different disciplines utilize different structured tools to support their clinical judgements, it is vital that all members of the interdisciplinary team understand the entire process.

SCREENING TOOLS FOR THE RN

The RN is responsible for conducting the screening portion in the evaluation process for suicide risk. The screening is done using the Columbia Suicide Severity Rating Scale (C-SSRS).

The Columbia-Suicide Severity Rating Scale (C-SSRS) is an evidence based tool that supports suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs.

The Columbia Lighthouse Project

SCREENING TOOLS FOR THE RN (CONT.)

The structured C-SSRS screening tool is intended to screen the patient for:

- Whether and when they have thought about suicide (ideation)
- What actions they have taken — and when — to prepare for suicide
- Whether and when they attempted suicide or began a suicide attempt that was either interrupted by another person or stopped of their own volition (*The Columbia Lighthouse Project*)
- The C-SSRS is a screen. It is not perfectly predictive. It will suggest an overall risk level for suicidal behavior NOT SPECIFIC to risk in the hospital that will assist in the subsequent provider assessments.

All patients are screened as part of the PES triage/intake process and upon all admissions to the inpatient units use the C-SSRS (Screen Version)

STRUCTURED SUICIDE SCREENING TOOLS FOR RNS:

C-SSRS

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	YES	NO
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) 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. ***Have you actually had any 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) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*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.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***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) Suicide Behavior Question: ***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. **If YES, ask: *How long ago did you do any of these?*** • Over a year ago? • Between three months and a year ago? • Within the last three months?		

For inquiries and training information contact: Kelly Posner, Ph.D.
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Patients will also be screened twice a day on the inpatient units and the PES using the C-SSRS (Frequent Screener). This version is used for patients who are assessed frequently (ex. every shift)

STRUCTURED SUICIDE SCREENING TOOLS FOR RNS:

C-SSRS

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Frequent Screener

Ask questions that are bold and underlined	Since Last Contact	
Ask Question 2*	**YES**	**NO**
2) ***Have you actually had thoughts about 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?***		
4) ***Have you had these thoughts and had some intention of acting on them?*** 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.*"		
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?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
6) ***Have you 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.		

*** Note – for frequent assessment purposes, Question 1 has been omitted**

- Low Risk
- Moderate Risk
- High Risk

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Please see the following slides for how to complete documentation of the C-SSRS (Frequent Screener) in EPIC and in ROVER

RISK ASSESSMENT FOR SUICIDAL BEHAVIOR

Once the RN has completed the screening, the patient will be considered at a low, medium or high risk for suicide while in the hospital. The provider will then begin their risk assessment for suicidal behavior and formulate a suicide safety management plan.

RN Screening Assigns…

Low Risk

or…

Medium Risk

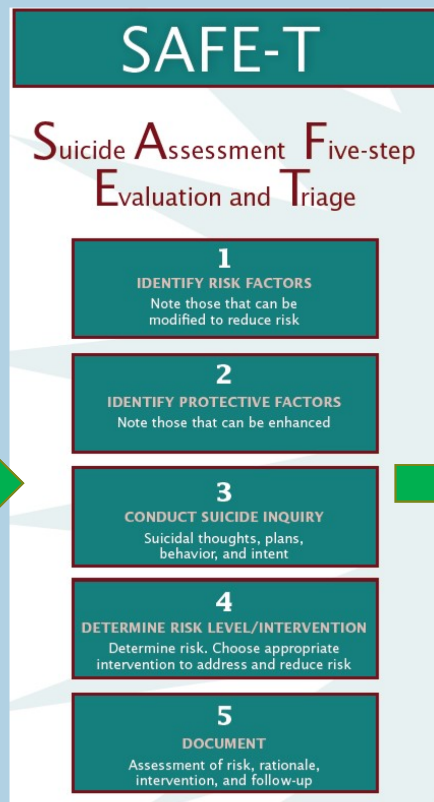
or…

High Risk

PROVIDER RISK ASSESSMENT FOR SUICIDAL BEHAVIOR

Providers will assess patient risk for suicide *(while hospitalized) incorporating the:

SAFE-T Protocol, the C-SSRS, and upon clinical judgment



Provider Assessment Assigns…

Low Risk
or…
Elevated Risk
or…
Extreme Risk

Based on risk level assigned, the provider will order the corresponding observation level as part of the suicide safety management plan:

Low risk for suicidal behavior while in hospital=Hourly Rounding

Elevated Risk for suicidal behavior while in hospital = Q.15-minute observations

Extreme risk for suicidal behavior while in hospital =1:1Observation

- **1:1 within 10 feet**
- **1:1 arm's distance**

RESOURCES

- Download this card and additional resources at **http://wwww.sprc.org**
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide **http://www.sprc.org/library/jcsafetygoals.pdf**
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors **http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx**
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

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National Suicide Prevention Lifeline

1-800-273-TALK (8255)

HHS Publication No. (SMA) 09-4432 • CMHS-NSP-0193
Printed 2009

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior, and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

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

- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- ✓ **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
  Co-morbidity and *recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Family history:** of suicide, attempts, or Axis 1 psychiatric disorders requiring hospitalization
- ✓ **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g. loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- ✓ **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- ✓ **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
- ✓ **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) vs. 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
- * *For Youths:* ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition
- * *Homicide Inquiry:* when indicated, esp. 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
- ✓ **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTOR	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 emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

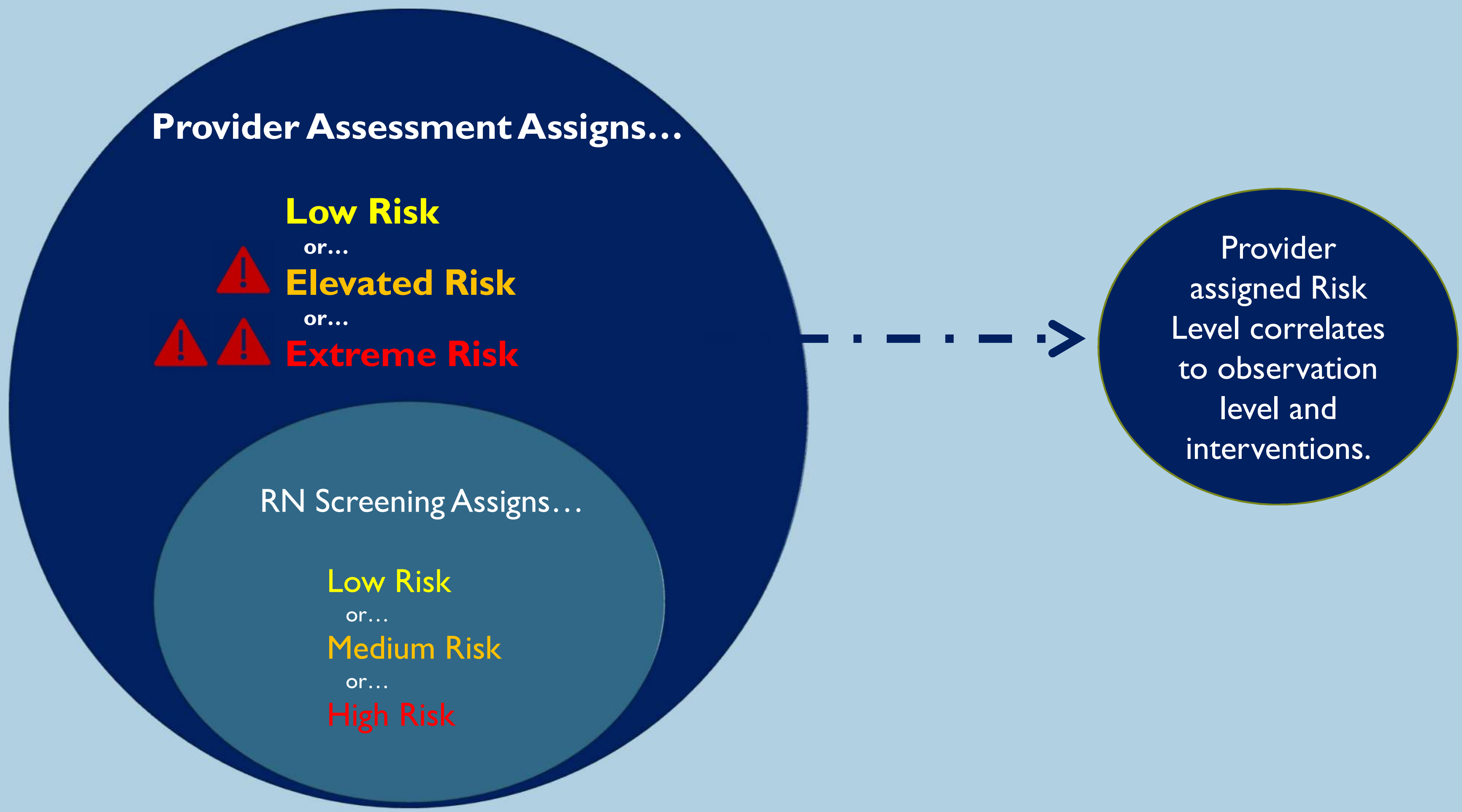
(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

STRUCTURED SUICIDE ASSESSMENT AND MANAGEMENT TOOLS <u>**FOR PROVIDERS**</u>: SAFE-T

LEVELS OF RISK:
RN SCREENING VS PROVIDER ASSESSMENT



SUICIDE SAFETY MANAGEMENT PLAN