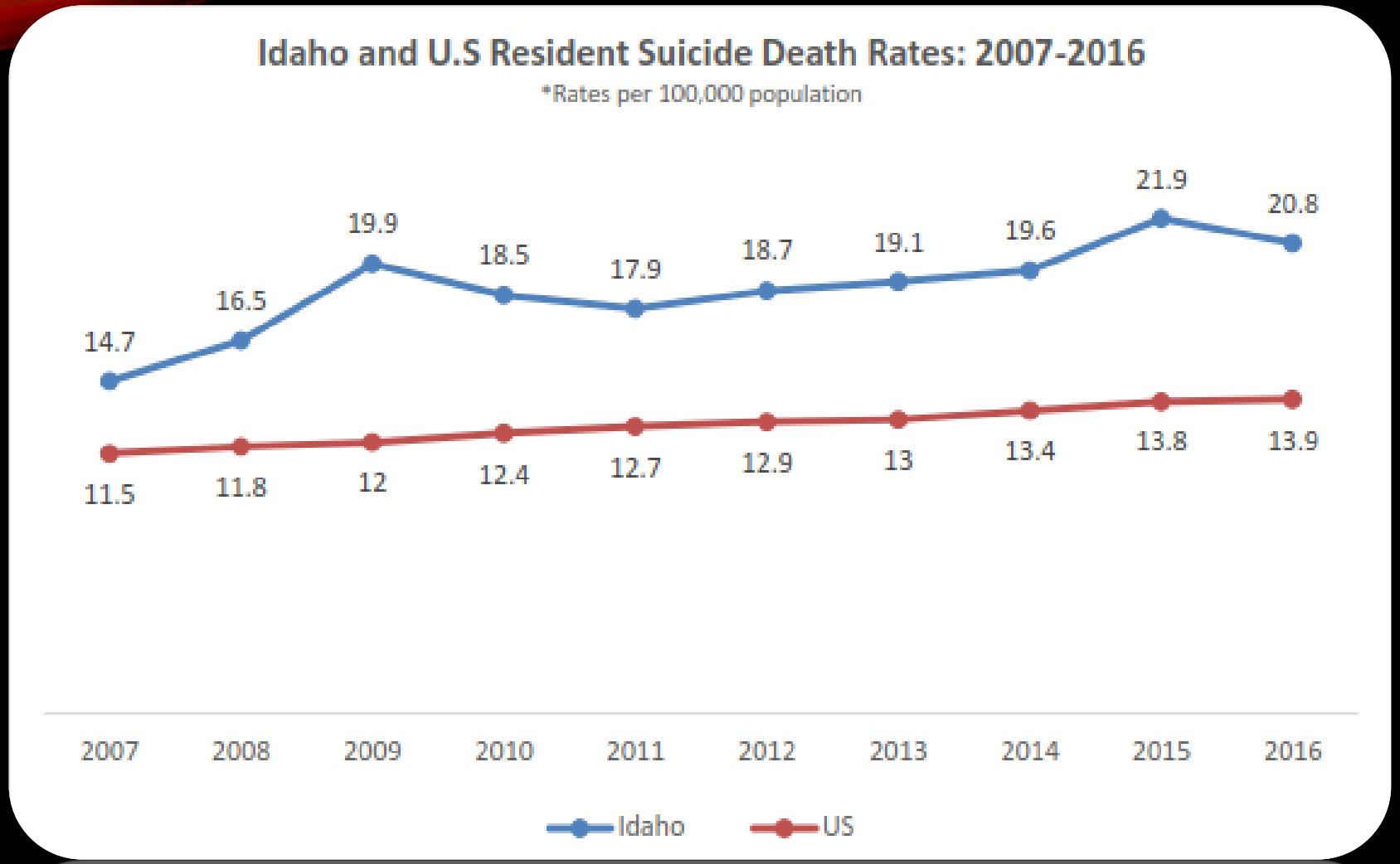
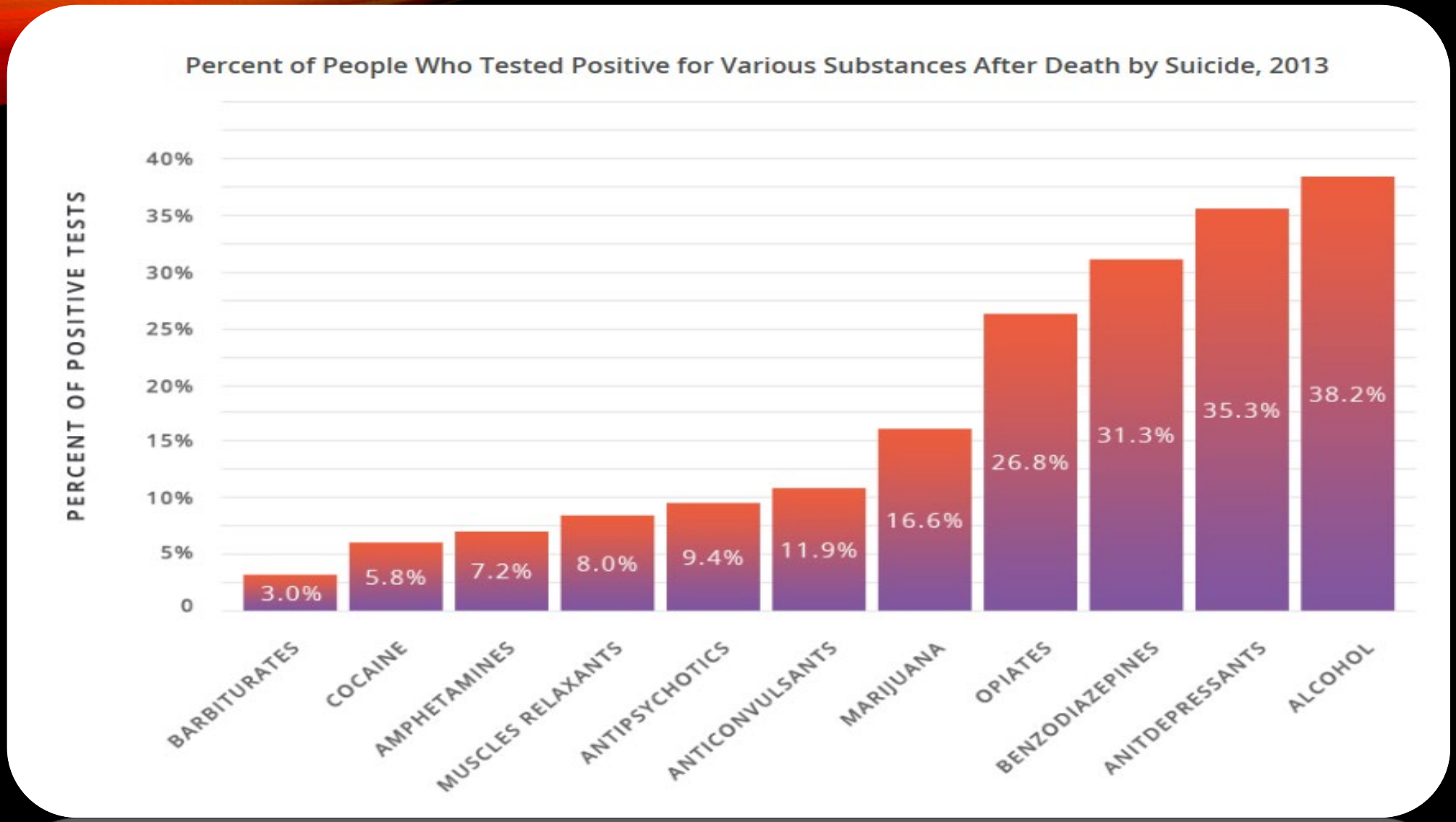
ASSESSING AND MANAGING SUICIDE RISK

Ernest, DON 2019

There will be a discussion on core elements for assessing and managing suicide risk in conjunction with the Columbia-Suicide Severity Rating Scale and Basic Suicide Screen


Idaho and U.S Resident Suicide Death Rates: 2007-2016
*Rates per 100,000 population
14.7
16.5
19.9
18.5
17.9
18.7
19.1
19.6
21.9
20.8
11.5
11.8
12
12.4
12.7
12.9
13
13.4
13.8
13.9
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
Idaho
US


Percent of People Who Tested Positive for Various Substances After Death by Suicide, 2013
PERCENT OF POSITIVE TESTS
40%
35%
30%
25%
20%
15%
10%
5%
0
3.0%
5.8%
7.2%
8.0%
9.4%
11.9%
16.6%
26.8%
31.3%
35.3%
38.2%
BARBITURATES
COCAINE
AMPHETAMINES
MUSCLES RELAXANTS
ANTIPSYCHOTICS
ANTICONVULSANTS
MARIJUANA
OPIATES
BENZODIAZEPINES
ANITDEPRESSANTS
ALCOHOL

MANAGE YOUR OWN REACTION(S)

Fears

- You may encourage the patient to think about suicide
- Suicidal behavior will occur
- You may be sued

Anger

- Irritation, resentment, disgust, hate, malice, and aversion

Helplessness

- A therapist may experience self-doubt or a sense of inadequacy about his or her capacity to assess and formulate risk or be helpful

Hopelessness

- A therapist may feel that the patient is a hopeless case, leading to difficulty establishing or maintaining a feeling of empathic understanding or basic respect

UNDESIRABLE ATTITUDES & BELIEFS

- Withdrawing, minimizing, and being under-responsive
- Becoming controlling, adversarial and hyper-responsive

KEYS TO REMAIN THERAPEUTIC

Personal awareness, consultation from colleagues, and, when the emotional demand becomes too great, professional consultation

COLLABORATE (WORK AS A TEAM)

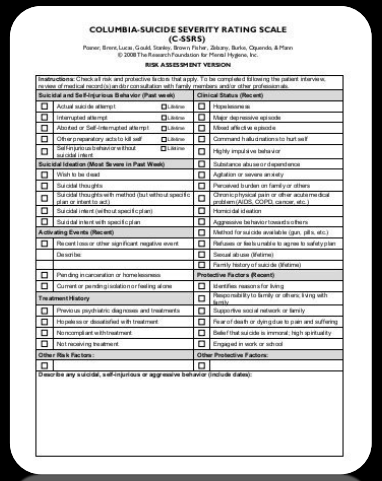
Obtain professional consultation, education, and personal supportive relationships. Give your colleagues permission to "call you" on statements or behaviors that indicate burnout, withdrawal, or over-control. Also, preach self-care.

KNOW RISK FACTORS FOR SELF AS THE CLINICIAN

- Loss of patient/client
- Job/position changes
- Relating to the patient/client
- Health problems
- History of substance abuse

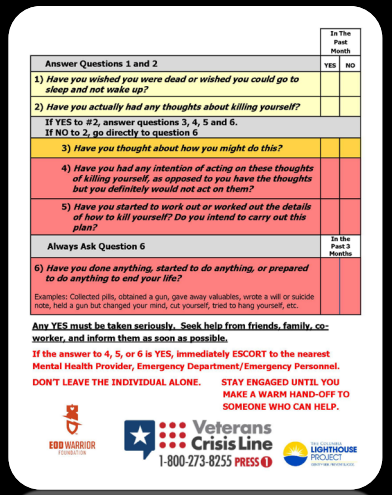
ASSESSMENT (COLUMBIA-SUICIDE SEVERITY RATING SCALE/BASIC SUICIDE SCREEN)

The **Columbia Protocol**, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS), 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.



COLUMBIA-SUICIDE SEVERITY RATING SCALE
(C-SSRS)

RISK ASSESSMENT VERSION



	In The Past Month	
Answer 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 actually had any thoughts about killing yourself?*		
If YES to #2, answer questions 3, 4, 5 and 6. If NO to 2, go directly to question 6		
3) *Have you thought about how you might do this?*		
4) *Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on 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?*		
Always Ask Question 6	**In the Past 3 Months**	
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, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		

Any YES must be taken seriously. Seek help from friends, family, co-worker, and inform them as soon as possible.

If the answer to 4, 5, or 6 is YES, immediately ESCORT to the nearest Mental Health Provider, Emergency Department/Emergency Personnel.

DON'T LEAVE THE INDIVIDUAL ALONE. **STAY ENGAGED UNTIL YOU MAKE A WARM HAND-OFF TO SOMEONE WHO CAN HELP.**

EOD WARRIOR FOUNDATION

Veterans Crisis Line 1-800-273-8255 PRESS 1

LIGHTHOUSE PROJECT

COLUMBIA-SUICIDE SEVERITY RATING SCALE

The Columbia Protocol was the first scale to address the full range of suicidal thoughts and behaviors that point to heightened risk. That means it identifies risk not only if someone has previously attempted suicide, but also if he or she has considered suicide or prepared for an attempt. For example, buying a gun, collecting pills, or writing a suicide note, was the suicide attempt aborted because of an interruption, change of heart, or family/friend intervention?

USERS OF THE TOOL ASK PEOPLE:

- If they have thought about suicide and when?
- What actions they have taken to prepare for suicide
- If they have ever had a suicide attempt that was interrupted by another person or self-aborted? When did this occur?

THE COLUMBIA PROTOCOL SCREENS FOR THIS WIDE RANGE OF RISK FACTORS WITHOUT BECOMING UNWIELDY OR OVERWHELMING. INCLUDED ARE EVIDENCE-SUPPORTED QUESTIONS REQUIRED FOR A THOROUGH ASSESSMENT. THE COLUMBIA PROTOCOL IS:

- **Simple**: Ask all the questions in a few moments or minutes — with no mental health training required to ask them.
- **Efficient**: Use of the protocol redirects resources to when they are needed the most. Reducing unnecessary referrals and interventions and identifying who needs help and support.
- **Effective:** Real-world experience and data show the protocol has helped prevent suicide.
- **Evidence-supported:** An unprecedented amount of research has validated the relevance and effectiveness of the questions used in the Columbia Protocol to assess suicide risk, making it the most evidence-based tool of its kind.
- **Universal**: The Columbia Protocol is suitable for all ages and special populations in different settings and is available in more than 100 country-specific languages.

BASIC SUICIDE SCREEN

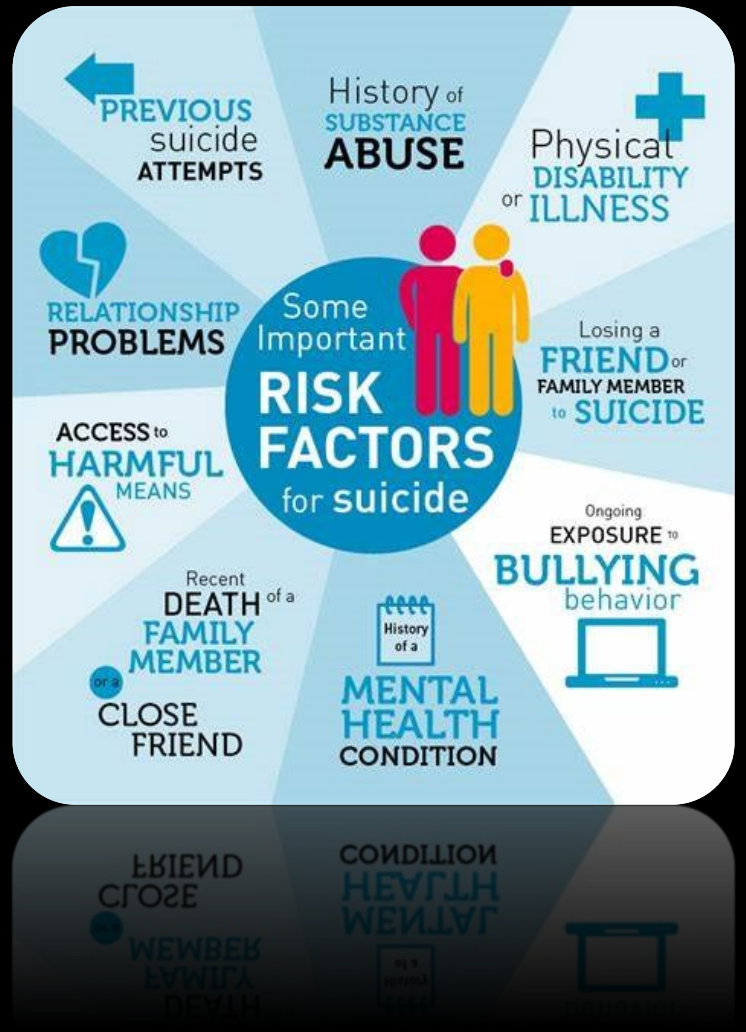
- There are three aspects of creating a full assessment of suicide risk and providing a foundation for treatment planning:

  - Gather complete information about past, recent, and present suicidal ideation and behavior.
  - Gather information about the patient's context and history.
  - Synthesize this information into a prevention-oriented suicide risk formulation anchored in the patient's life.

- The purpose of assessment is not to predict which patient might take his or her own life but, rather, to do the best job we can to increase safety, reduce risk, and promote wellness and recovery.

KNOW RISK FACTORS

- History of suicide
- History of mental illness
- Drug/alcohol abuse
- Legal issues/Custody battles
- Recent death of family/friend
- Financial issues/loss of job
- Relationship issues
- Health problems



COPING RESOURCES/STRATEGIES

- What the patient does to distract themselves from their stressors/suicidal thoughts:
  - **Internal:** Journaling, meditating, and REBT-rational, emotive, behavioral therapy
  - **External:** Family, friends, support groups, hotlines, therapists

Actions Taken (Respond to Crisis)

What are we going to do about it?
Must be specific actions that matches patient triggers, method of suicide, and individual's circumstance.
For every trigger-have an intervention.

Outpatient

Have someone stay with patient/client, call support team/people, lock medications up, call authorities-get people involved

Hospital

Increase level of observation, adding precautions, notify MD, consulting with case manager, offering reassurance, medication changes

PLANNING & RESPONSE

- Discharge planning
- People they can use for support
- Counseling set-up
- Plan A & Plan B (back-up plan)
- List triggers and coping skills
- Offer numbers in the community they can reach out to during times of crisis
- Always share plan with family/support member
- Address barriers for adhering to the plan and change as necessary

FOLLOW-UP

- After care appointments-did they attend ?
- Medical appointments
- Reaching out through postcard/letter/phone call

QUESTIONS?