

Suicide Risk Assessment and Safety Planning

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Presenter Notes

SLIDE 3

- Outline/Suggested Timing of curriculum for a 1-hour lecture:
 - Definitions and Epidemiology, Risk and Protective Factors Slides 4-13: Approximately 15 mins
 - Risk assessment and level of care determination Slides 14-21: Approximately 15 mins
 - Role Play exercise including discussion and questions afterwards: Approximately 15 mins
 - Safety Planning and Resource Slides 25-32: Approximately 15 mins

SLIDE 4

- Definitions and language – important
- Reasons behind the change in terms and our culture – stigma reducing, less blame on the individual
- **Non-suicidal Self-Injury or Deliberate Self-Harm:**
 - intentional self-harm with NO intent to die (e.g., skin-cutting, burning, banging head)
- **Suicidal Ideation:**
 - thoughts about killing yourself
- **Suicide Attempt:**
 - intentional self-harm WITH intent to die (e.g., taking pills, hanging, shooting self)
- **Death as a result of Suicide: (vs completed or successful suicide)**
 - *fatal* intentional self-harm WITH intent to die

SLIDE 5

- Experiencing suicidal thoughts is somewhat common – about 4.3% of the US population reports having serious thoughts of suicide in the past year (about 12 million adults)
- A smaller percentage of these make suicide plans, about a third of those who make plans then make an attempt, and a much smaller percentage die by suicide – about 3% of those who attempt then die by suicide

SLIDE 6

- Ask audience: When looking at differences in suicide by sex, who do you think has the highest rate?
- 80% of deaths by suicide are among men (4x higher likelihood of dying by suicide)
- What about by age? the highest suicide rate was among males aged 85 and older with 22.4 deaths per 100,000, followed by males aged 75-84 and those in the 25-34 group similar

SLIDE 7

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- Important to look at some differences in these averages by racial, sex and ethnic group. So when we say men over the age of 85 are highest risk this is really referring to white men
- White men have fairly high rates across age groups, but still highest rates seen in the older age groups
- Those identifying as Hispanic (per definitions used in this data) men have higher rates than women but fairly similar across age groups (though slightly higher in the 25-34 age bracket)
- Looking at American Indian/Alaska natives its really the younger age groups that are at higher risk for suicide, for both women and men, but particularly in men
- Same when looking at black or African American men

SLIDE 8

- Rural rates are 2x higher than urban rates
- Occupation:
 - **Veterans:** Suicide rates among veterans were 1.5 times greater than non-veterans, after adjusting for age and gender in 2016.
 - Workers in certain industries like mining and construction (rate of about 45 – 54 suicides per 100,000)
 - Also medical student and physicians
- Sexual and gender identity
 - Though data is somewhat limited on suicide deaths among these groups, we know that suicide attempts are much higher in the groups listed here-
 - In general, we see those from under-represented or resourced groups like those with disabilities and sexual and gender minorities – for whom rates are highest in younger age groups like high school, - rates are about 23% among the high school aged LGBTQ community compared to those who identified as heterosexual
 - Across several studies it has been found that 40% or more trans people have attempted suicide at least once in their lifetime.
- Dickey, Lore M., & Budge, S. L. (2020). Suicide and the transgender experience: A public health crisis. *American Psychologist*, 75(3), 380–390. <https://doi-org.proxy.library.emory.edu/10.1037/amp0000619>
- Previous suicide attempts and family history of suicide are also [risk factors](#).

SLIDE 9

- > attempts associated with higher risk (Park et al., 2018); 40 X more likely to die by suicide (Harris & Barraclough, 1997);
- Suicide attempts tend to recur with each attempt showing increased capability of lethality
- Almost half of those with a serious suicide attempt make another attempt in the next 5 years

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- As you can see here – history of attempts is by far the greatest risk factor for suicide death, above and beyond any other psychiatric diagnosis including borderline PD and bipolar disorder
- Additional distal risk factors:
 - History of childhood abuse
 - Childhood abuse → future attempts (Fuller-Thompson et al., 2016)
 - Sexual abuse: 3.5 X more likely to make an attempt
- Psychiatric disorder: even though past attempt is greater risk factor, hx of psychiatric diagnosis is also a risk factor - 90% of individuals who die by suicide have at least 1 current Dx
- Medical conditions:
 - HIV/AIDS
 - Cancer
 - Chronic pain
 - Autoimmune disease (e.g., MS)
 - Severe neurological disorders
 - Traumatic Brain Injury (~4 X higher)
 - Returning Service Members TBI: 15- 23%
- Park, S., Lee, Y., Youn, T. *et al.* Association between level of suicide risk, characteristics of suicide attempts, and mental disorders among suicide attempters. *BMC Public Health* **18**, 477 (2018). <https://doi.org/10.1186/s12889-018-5387-8>

SLIDE 10

- More than 50% of all suicide deaths are by firearm
- Women are more likely to attempt via overdose, but it is less likely to result in death

SLIDE 15

- What settings do you screen for suicide/have you seen it? Or where do you anticipate seeing it/need to screen for it?
- What are barriers you see in asking about suicide

SLIDE 16

- How are you going to ask about suicidal thoughts – what questions would you ask
- In your lifetime, have you ever had thoughts
 - that you would be better off dead?
 - of killing yourself?
 - about how you would kill yourself?
- In your lifetime, have you ever
 - attempted to kill yourself ...
 - (where you had at least some intent to die)?
 - hurt yourself on purpose even if it wasn't with the intention to die?
- Important to be specific with questions

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SLIDE 17

- **Use all of this information to Determine → level of risk** (low, moderate, high), complete safety plan as indicated

SLIDE 18

- Walk through how to determine level of risk and associated recommended level of care:
- **Low risk for suicide** (outpatient referral):
 - Wish to die or Suicidal Ideation WITHOUT method, intent, plan or behavior OR
 - Modifiable risk factors and strong protective factors OR
 - No reported history of Suicidal Ideation or Behavior
- **Moderate risk for suicide:**
 - Suicidal ideation with method, WITHOUT plan, intent or behavior in past month (C-SSRS Suicidal Ideation #3) OR
 - Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) OR
 - Multiple risk factors and few protective factors
- **High risk for suicide:**
 - Suicidal ideation with intent or intent with plan in past month (C-SSRS Suicidal Ideation #4 or #5) OR
 - Suicidal behavior within past 3 months (C-SSRS Suicidal Behavior)

SLIDE 19

- If you judge them to be at imminent/high risk for suicide, your number one role is to address immediate safety needs

SLIDE 21

- If you have judged someone not to be at immediate risk (i.e., needing inpatient level of hospitalization), what is our role in crisis intervention
- As the clinician, your role is crisis intervention/problem-solving:
 - Validate emotions/wish to die Why would we validate someone's emotions/wish to die?
 - Teach/practice coping skills
 - Generate hope and reasons for living
 - Remove means (e.g. problem solve getting rid of firearm)
- We will come back to safety planning after practicing with the risk assessment.

SLIDE 22

- [have participants go into breakout rooms or divide into pairs if in person]
- [share SAFE-T protocol document in chat or have printed copies and have trainees pair up to practice for ~10 mins to run through the document. Goal is for them to get practice/familiarity with asking the questions and determining level of care based on the

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information they obtain. They can also bring any questions back to larger group.
Facilitate discussion based on grey areas and need for clinical judgment]

SLIDE 23

- [adapt case as needed]

SLIDE 26

- What happened right before you started feeling suicidal?
- What were you thinking right then?
- What was your level of sadness, anger, (other emotions)?
 - 1 (none) to 10 (worst)
- What were you feeling in your body?
- What did you do next?
- What helped/or made you feel worse?
- For the patient in the case, what were their warning signs? Think back to IS PATH WARM
 - Insomnia, substance use, purposelessness, agitation, (feeling) trapped, hopelessness, withdrawal, anger, reckless behavior, mood change
- **Patient's Warning Signs:**
 - Thoughts: "I can never catch a break"
 - Mood: Anxious, angry
 - Body: Tense
 - Thought Processes: racing thoughts; catastrophizing
 - Behavior: Taking steps towards suicide
- **Helpful Question:**
 - *How do you know when the safety plan should be used?*
- What might be internal coping strategies? **Helpful Question:**
 - *What can you do on your own if you start to become distressed?*
- People or social settings that provide distraction
 - **Helpful Question:**
 - *Who or what social settings help you take your mind off your problems for a little while?*
- People who you might ask for help
 - **Helpful Questions:**
 - *Among your family or friends, who do you think you could contact for help during a crisis? Could also include clergy or sponsor*
 - *Who is supportive of you and who do you feel that you can talk with when you're under stress?*
- Professionals/agencies – Crisis text line, suicide prevention lifeline already on there, GA crisis access line
 - *Who are the mental health professionals that we should identify to be on your safety plan?*

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- What might you need to do to make environment safe? A crucial step – routinely ask about access to a lethal method and brainstorm ways to restrict access
- Assess the likelihood that plan will be used:
 - What are the Barriers/Obstacles?
 - Help patient problem solve to increase success
- **Helpful Questions:**
 - *How likely is it that you will use the safety plan?*
 - *What might get in the way of using the plan?*

SLIDE 28

- What additional details might you want to know based on the case we discussed earlier?
- Where might you want to go next?
- How many would decide hospitalization vs. making safety plan?