Suicide Risk Assessment and Management

Capital Health Network
Mental Health Expo
Presented by

Bruno Aloisi
ACT Health

Adapted from work of ACT Health staff members: Rachael McMahon, Dr Kristie Thorneywork & Matthew Ferriman (2014).
Overview

1. Suicide, data and theoretical models
2. Vulnerable Population groups
3. Suicide Assessments and Intervention
What is Suicide?

• Attempted suicide – self injurious behaviour with a non fatal outcome accompanied by evidence that the person intended to die.

• Death by suicide – death resulting from an intentional self inflicted act with evidence (either explicit or implicit) that the person intended to die by his or her own hand. Sometimes evidence is not clear or is disputed because suicidal intent appeared absent or was ambiguous.
Suicide – A Global Problem

• Every year, more than 800 000 people die from suicide; this roughly corresponds to one death every 40 seconds

• According to WHO (2014), suicide is among the third leading causes of death among those aged 15-44 years in some countries, and the second leading cause of death in the 10-24 years age group
Suicide in Australia

• Most recent data indicates that suicide is currently ranked as the 13th leading cause of all deaths

• This equates to almost eight (7.85) deaths by suicide each day

• Highest rates of suicide are in NT (20.8 per 100,000) followed by Western Australia (14.4 per 100,000).

• ACT has the lowest rates of suicide (9.2 per 100,000) compared to 11.2 per 100,000 (nationally).
Suicide in Australia

• Suicide attempts
  – 20-30 times more attempts than suicides (De Leo, Cerin, Spathonis, & Burgis, 2005)
  – Gender paradox – females more likely to attempt, males more likely to die (ratio of 3:1)
  – Likely to be under reported

• Method of Suicide:
  – Hanging: 56.3%
  – Poisoning by drugs: 15.4%
  – Poisoning by other methods (including alcohol and motor vehicle exhaust): 6.6%
  – Firearms: 6.2%
  – Other methods (includes drowning and jumping/falling from height)

(ABS, 2016)
Suicide by Age in Australia

Australian Bureau of Statistics
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Theories of Suicide

• Social – Durkheim
  • Egotistic Suicide (most common)
  • Altruistic Suicide (Others before self)
  • Anomic Suicide (too little moral regulation, unable to meet expectations)
  • Fatalistic – too much integration, can’t influence anything
Crisis Theories

• States of crisis
  – Insurmountable obstacles
  – Exceeds current coping/resources

• Consequences
  – Impaired or maladaptive problem solving
  – “Severe affective, behavioural and cognitive malfunctioning” (James & Gilliland, 2013, p. 8)
  – Increased feelings of hopelessness, worthlessness, inadequacy and burdensomeness

• Assisting individuals to overcome crisis points and develop solutions to their problems
Theories of Suicide

Biological
  e.g. Serotonergic and noradrenergic systems

Biopsychosocial
  Stress-diathesis model

Mann, 2003
Theories of Suicide

Psychological

Freud (1917) - Internalised aggression
Shneidman (1993) - Psychache
Joiner (2005) - Interpersonal

Video - Case Study
At Risk Populations

• Mental illness
• LGBTI
• Indigenous groups
• Forensic groups
• Children and adolescents
• Older populations
Mental Illness

- Psychological autopsy studies have demonstrated that in up to 90% of deaths by suicide, a retrospective psychiatric diagnosis can be made (Windfuhr & Kapur, 2011).

- Assessment of suicide in this population goes hand in hand with assessment of mental illness.

- Psychotic illness
- Affective disorders
- Substance abuse
- Personality disorder
LGBTI

- 3.5-14 times higher rates than heterosexual peers.
- 6 x more same-sex attracted young people attempt suicide.
- Average age of first attempt is quite low, about 16 years.
- Transitional ‘coming out’ phase is high risk period.
- Higher prevalence of vulnerability factors such as social isolation, familial rejection and D&A use.
Aboriginal and Torres Strait Islander peoples:

• There were 996 suicide deaths registered across Australia between 2001 and 2010 where the deceased person was identified as being of Aboriginal or Torres Strait Islander origin. This represented approximately 5% of all suicide deaths registered in this period.

• Young Aboriginal and Torres Strait Islander males (15-19 years) are 4.4 times more likely to die by suicide than are other young Australian males. Similarly, young Aboriginal Torres Strait Islander females (15-19 years) are 5.9 times more likely to die by suicide than are other young females.
Forensic Populations

• Suicide is the leading cause of death in prisoner populations in the majority of developed countries (Konrad et al., 2007)
• Suicide rates for individuals in prisons higher than corresponding population in community (males, females, children, adolescents)
• Link between overcrowding and suicide – 75% in UK between 2000-2004
• Usually at night
• High risk following entering prison, major moves within or between prisons, and following release
Children and Adolescents

• Suicide is rare, although suicidal ideation and behaviour is common in adolescence
• Similar clinical risk factors
• Some idiosyncratic features
  – Contagion
  – Impaired relationship with parents
  – Perceived excessive control and low care from parents
• Attempts may be more impulsive and less lethal than adults
• Safety plan is key
• Where possible, consider involving parents/guardians in care planning

Gordon & Melvin (2014)
Older Populations

• High rates of suicide
• Significant risk factors
  – High rates of loss
    • Purpose
    • Family
    • Mobility
    • Independence
  – High rates of physical health co-morbidities
  – Access to means (e.g., medications)
Prediction vs Assessment

• Suicide Prediction:

Refers to being able to foretell whether suicide will or will not occur at some future point based on the presence or absence of a specific set of vulnerability factors. Low accuracy, low clinical utility.

• Suicide Vulnerability Assessment:

Refers to the development of a clinical judgment about an individual’s suicide risk in the very near future. Risk assessment is based on the weighing up of a large volume of available clinical information. Risk assessment is carried out in a systematic, disciplined way. It is not guessing or clinical intuition.

Adapted from Jacobs (1998)
What is Suicide Vulnerability Assessment?

“The goal of a suicide assessment is not to predict suicide, but rather to ... appreciate the basis for suicidality, and to allow for a more informed intervention”

“Suicide risk assessment is a process not an event”
What is Suicide Vulnerability Assessment?

“Suicide risk assessment is a multifaceted process for learning about a person, recognizing and addressing his or her needs and stressors, and working with him or her to mobilize strengths and supports. While suicide risk assessment tools are a part of this process, these should be used to support the assessment process, rather than to guide it.”

(Perlman, Neufeld, Martin, Goy, & Hirdes, 2001)
When is Assessment Indicated?

Ask EARLY and ask OFTEN – but in particular:

– When a consumer presents in crisis
– At initial appointment when someone presents to a practice particularly when they have a history of mental illness or self-harm/suicide
– Before or after a change in treatment setting (e.g. after recent discharge from a hospital setting)
– Abrupt changes in clinical presentation (i.e., sudden worsening or improvement in symptoms)
– Worsening of symptoms despite treatment
– Anticipation of or experience of significant interpersonal loss of significant stressor (i.e., financial loss, legal programs, personal shame, humiliating events)
– Onset of physical illness (i.e., life threatening/severe pain/loss of role or function)

Adapted from APA Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors (2003)
Approaching Suicide Assessment

Sound suicide assessment involves three components:

• Obtaining information about risk factors, warning signs and protective factors
• Obtaining information about the person’s suicidal thoughts, plans, behaviours, desire and intent
• Making a clinical formulation based on these components

(Shea, 2009)
Engaging Suicidal Individuals

• Crisis intervention strategies
  – Engagement is part of intervention
• Establish therapeutic alliance *collaboration is critical*
  – Process, not a thing
  – Genuine, caring, non-judgemental approach
  – Tolerance, acceptance
  – Active listening, understanding
  – Be aware of own emotions
• Explore and define the problem
  – Acknowledge the suicidal individual’s situation in clear specific detail
  – Ask direct questions – promote a climate of open disclosure
Static, Dynamic, & Future Risk Factors

• Static
  – Non-changeable life factors (e.g. history of suicide attempts, family history of suicide, chronic mental illness, ethnicity or cultural background, age, gender etc)
Static, Dynamic, & Future Risk Factors

Dynamic

- Proximal vulnerability factors of short or unstable temporal duration (e.g. intoxication, domestic incident)
- Vulnerability factors readily open to change/treatment (e.g., substance misuse, treatment of underlying mental illness, coping skills)
- Factors that may be open to change through longer term intervention (e.g. personality characteristics, attitudes)

Adapted from Wilson  https://marisluste.files.wordpress.com/2010/11/1_2_robin_wilson.ppt
Static, Dynamic, & Future Risk Factors

Future

– Factors that may elevate risk
– These may change rapidly, generally as a result of environmental or intra-personal conditions
– Providing the client the resources to try and cope in these situation or avoid these situations all together

Adapted from Wilson  https://marisluste.files.wordpress.com/2010/11/1_2_robin_wilson.ppt
Suicide Risk Factors

- Psychiatric Illness Co-morbidity
  - Personality Disorder/Traits
  - Previous Attempts
  - Impulsiveness
  - Access to Weapons
  - Family History
  - Psychodynamics/Psychological Vulnerability

- Substance Use/Abuse
- Severe Medical Illness
- Hopelessness & Perceived Burdensomeness
- Life Stressors
- Suicidal Behaviour

Warning Signs

• Observable signs that may indicate more immediate risk of suicide
• Do not indicate the probability of longer-term risk
• They are acute and transient in nature
• They may set the process of suicide into motion and therefore require immediate intervention and response

(Rudd, 2008; Rudd et al., 2006)
Warning Signs

- Communication of intent to suicide
- Researching suicide methods
- Seeking access to means
- Talking about death, dying or suicide
- Hopelessness
- Being unable to find reasons for living
- Lack of purpose in life
- Feeling trapped

(Rudd et al., 2006)
Warning Signs

- Withdrawal
- Sleep difficulties
- Dramatic mood changes
- Intense emotions including anxiety, anger and rage
- Agitation
- Reckless behaviour or engaging in risky activities
- Deterioration in functioning
- Increased substance use

(Rudd et al., 2006)
Ambivalence

• Even right up until the final moments suicide survivors report having ambivalence about following through on their plan, some actually report changing their mind after they have acted
Protective Factors

- Resilience and adaptability to change
- Friends and family support
- Service accessibility
- Religious/cultural beliefs
- Positive outlook
- Future oriented plans
- Resources (financial and physical)
- Problem-solving ability
- History of dealing with problems effectively
Asking About Suicide

Ask about:
- Suicidal ideation
- Suicide plans (method, time, access to means, intent, lethality)
- Reasons for wanting to die/live
- Immediate safety (“have you already harmed yourself in any way?”)

Give added consideration to:
- Setting
- Context
- Length of Assessment
- Rapport
- Training
- Client Estimation of Risk

Jacobs (1998)
Asking about Suicide

“For some people when they feel like that, they have experienced thoughts of taking their own life. Are you feeling like that? Have you ever felt like that?“

“It sounds like you are really struggling at the moment, you said you are feeling hopeless, I need to ask ... are you thinking about ending your life”

“Things sounds really difficult at the moment, you have told me that you feel depressed and that life isn’t what it used to be. For some people this might bring up thoughts of suicide, have you had any thoughts like that?”
Risk of Harm to Others

- Worldwide, 1-4% of individuals who die by suicide engage in homicide immediately prior to their deaths (Large, Smith, & Nielssen, 2009)

- Possible warning signs include:
  - Having a history of violent behaviour
  - Threatening an identifiable victim
  - Having a credible motive for engaging in violence (France, 2014)
Assessment Tools

- Many suicide risk assessment tools have been developed, however in general they have low clinical utility for predicting who will die by suicide, especially in the short term.
- Structured professional judgment is critical
  - Clinical interview with supporting tool/guiding document

Chiles & Strosahl (2004)
Assessment Tools continued

- Multiple available tools
  - Beck Scale for Suicide Ideation
  - Beck Hopelessness Scale
  - Reasons For Living Inventory
  - Suicide Attempt Self Injury Interview
  - Suicide Vulnerability Assessment Tool (SVAT) - locally developed ACT Health tool

Chiles & Strosahl (2004)
Intervention

• Multiple avenues for intervention
  – Immediate
  – Medium term
  – Longer term

• Clinical decision based upon consideration of relevant vulnerability factors, present episode of illness, symptoms, and the specific suicide inquiry

• Specifically identify protective factors and attempt to utilise these in the development of management plan
Immediate risk

If the threat is immediate and time critical call 000 and ask for Ambulance or Police

• Identify patient’s name, location and nature of concern
Immediate risk cont..

Is home-based care possible?

– Ensure the person is medically stable
– Involve the persons support systems
– Treatment and monitoring at home
– Minimise risk and develop a hierarchical crisis plan – remove access to means, consider medication prescription judiciously
– Reinforce that plans can be revisited/changed as required
– Discuss options for longer-term supports (i.e., referrals to mental health services, psychologist etc)
– Important to engage the person in active treatment, goal directed, collaborative
Immediate risk cont..

Is hospital-based assessment required?

– Voluntary/Involuntary

– Explaining the process/goals and discussing options with patient even if involuntary action is being taken

– Emergency Apprehension
Emergency Services and acute mental health responses

- Police and Ambulance ‘000’
- Mental Health Triage 1800 629 354
- Crisis Assessment and Treatment Team (CATT) – via MH Triage number above.
- Hospital Emergency Departments- Mental Health clinicians in ED/Psychiatry Registrar
Medium and Longer Term Intervention

- Interventions should relate to dynamic and future risk factors identified during assessment
- May include:
  - Psychoeducation
  - Safety and coping strategies
  - Targeted treatment of suicidal thoughts/behaviours and underlying mental health issues—Cognitive Behaviour Therapy, Dialectical Behaviour Therapy
  - Collaborative development of crisis management plan with clinical services
  - Skills development (social skills, stress management, assertiveness)
  - Medication
  - On-line resources
Medium and Longer Term

• Should relate to dynamic and future risk factors identified during assessment
• May include:
  – Referrals to other services including
    – Mental Health Triage 1800 629 354
    – ACT Health- GP Psychiatry Consultation Line
      PH: 6174 5679  Tues, Thurs 1-2pm
    – Lifeline – 13 11 14
    – Kids Helpline – 1800 55 1800
    – Suicide Call Back Service – 1300 659 467
Mobilising Strengths and Supports

- An individual’s existing support network is also critical to wellbeing and includes:
  - Family
  - Friends
  - Partners
  - Others?

- Can you help the person to identify strategies that they have used to get through difficult times in the past?
- Can you help them to access these again?
Things to Keep in Mind

- Level of Distress – Psychache
- Meaning & motivation for the individual – Hopeful or Hopeless?
- History of suicidal behaviour
- Current suicidal thoughts
- Intent and lethality
- Suicide Plan – Rehearsal (physical and psychological)
- Access to means
- Coping potential
- Social supports
- Level of confidence in assessment
- Collaborative information

Jacobs (1998)
Case Study

Identify the static, dynamic and future risks
- Think about how would you manage or treat the risks
Case Study- Jenny

Jenny is a 50 year old woman who attends your Practice for the first time as has recently moved to ACT from interstate after a relationship breakdown. She sounds very flat when she speaks. She says she is depressed and is having thoughts of killing herself by taking an overdose. She noted that she has a full box of panadol in her cupboard. She has been drinking white wine throughout the morning. She says she feels that she is never going to find happiness. She indicates that she has cut her upper thigh a few times last night but the injury is superficial.
Case Study cont..

You talk at length with Jenny and discover she lives alone in government housing. She has no children. She has been diagnosed with depression “on and off” over her life time. Jenny described her family as “bad eggs”. She states that her father was an alcoholic who was often in trouble with the police, and that her mother attempted suicide multiple times over the years. Both parents live interstate and have little contact with Jenny. Jenny had an older brother who died in a car accident several years ago. Jenny explains that she was driving and feels to blame for his death. She is not sleeping or eating well. She states that she has gained 23 kg in the last 2 years, adding to her sense of worthlessness.
Case Study cont..

Jenny states she has a lot of anxiety during the day and feels “dizzy” if she goes out in public. She feels as though she has no value in the world. She wants to do volunteer work with St Vincent de Paul but doesn’t feel she has the confidence to organise that. She has also thought about volunteering at that RSPCA as she worked as a veterinary nurse when she was younger and really enjoyed it. She used to be quite involved in community activities in her but stopped attending these a few years ago due to chronic back pain that she developed following the car accident.
Case Study cont..

Jenny states that she has had lots of contact with mental health services interstate. She stated that she had 6 psychiatric admissions for suicidal ideation, three of which were on an involuntary basis. She has had 4 previous suicide attempts. She is unwilling to go back into hospital again and states that she was “only ever kept for 24 hours anyway”. She describes having no belief in services and perceives that “they don’t really care”. She attends psychiatric outpatient appointments “only when she feels up to it”. Jenny reports she does have some good friends and her new next door neighbour is particularly supportive. Her neighbour plans to take her out for dinner for her birthday next week.
Jenny reports that she is currently prescribed diazepam, Endep (amitriptyline), and something else that she can’t remember, but unable to provide the name of her previous GP interstate/practice name and can’t provide previous medication/scripts. She is not currently seeing a psychologist as she feels “they all look down on her”. She stated that she has “tried everything but nothing works”.