Suicide Risk Assessment

Presented to Suicide Prevention Coordinators 8/21/07

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Director of Education
VISN 3 MIRECC
Acknowledgements

Many of these slides were adapted or borrowed whole from other sources. I would like to thank Dr. Gretchen Haas, Dr. Morton Silverman, The American Foundation for Suicide Prevention, Dr. Charlene Thomesen of Northport VAMC in VISN 3, the Suicide Prevention Resource Center, Dr. Mellman of VISN 18, Dr. Larry Adler and Jan Kemp of VISN 19, and the National Center for Patient Safety for information and materials I have borrowed from them.

All interpretations and the presentation of this information is my responsibility, as are any inaccuracies.

Thank you.
Undesirable Suicide Assessment
Annual Incidence Estimates: Suicide

• General Population:
  – 1,000,000 worldwide, 30,000 US each year
  – worldwide rates - 10 to 35 per 100,000
  – U.S. rates - 10.8 per 100,000
  – New York – 6.6 per 100,000
  – New Jersey – 6.9 per 100,000
  – Idaho—21.1 per 100,000

• Clinical Population:
  – VAMC (Philadelphia)
    • <age 65: 83 per 100,000
    • >age 65: 45 per 100,000
  – VA psychiatric inpatients: est 279 per 100,000
  – Previous attempters: est 1,000 per 100,000
Facing the facts...

- Suicide is the 11th leading cause of death in the US, all people, all ages.
- Suicide is considered to be the 2nd leading cause of death among college students.
- Suicide: 3rd leading cause of death 10-24.
- Suicide: 2nd leading cause of death 24-34.
- Suicide: 4th leading cause of death 35-44.
- Suicide: 5th leading cause of death 45-54.
- Suicide: 8th leading cause of death 55-64.
- Suicide is the fourth leading cause of death for adults between the ages of 18 and 65.
- Suicide is highest in white males over 85. (48.42/100,000, 2004)
Suicide Rates by Age, Race, and Gender (US, 2002)

Source: National Center for Health Statistics

Note: non-Hispanic ethnicity
Why all Staff (Primary Care) should Care

• 25% of Primary Care pts have Diagnosable MH Disorder
  – 1/2 are undetected, untreated *because*
    • 75% c/o somatic symptoms.
  • TIME
• If Primary Care Provider sees 2000 pts, one could expect:
  – 1 suicide every 2 yrs;
  – 10 serious attempts/yr.,
  – 50 with suicidal ideation.
• IN the VHA patients who suicide have as last contact
  – Outpatient Mental Health: 42%
  – Inpatient Mental Health: 25%
  – Outpatient Primary Care: 25%
• Outpatient Suicides within 1 month of contact: 78%
A Suicide Attempt is any behavior that is dangerous to oneself and is accompanied by the intent to die.
VHA Handbook: Parasuicide

Any suicidal behavior with or without physical injury (i.e. short of death) including the full range of known or reported attempts, gestures and threats.
Predictors of suicide attempts differ from predictors of suicide, however, suicide attempters are at the highest risk for future death by suicide.
We are much better at assessing suicide risk then we are at predicting suicide: and Numeric Scales don’t work

Table 1. **Logistic regression analysis: Suicides and Controls**

<table>
<thead>
<tr>
<th>Risk Factor (%)</th>
<th>Suicides (N = 202)</th>
<th>Control subjects (N = 984)</th>
<th>Unadjusted OR (95% CI)</th>
<th>Adjusted OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSM-III-R diagnosis in prior month</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood disorders</td>
<td>56.4</td>
<td>6.7</td>
<td>18.1*** (12.4, 26.2)</td>
<td>10.9*** (6.5, 18.5)</td>
</tr>
<tr>
<td>Substance use disorders</td>
<td>31.2</td>
<td>10.0</td>
<td>4.1*** (2.9, 5.9)</td>
<td>NS</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>6.9</td>
<td>5.1</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>2.5</td>
<td>0.3</td>
<td>8.3** (2.0, 35.0)</td>
<td>NS</td>
</tr>
<tr>
<td>Non-affective psychosis</td>
<td>5.9</td>
<td>0.2</td>
<td>31.0*** (6.9, 139.7)</td>
<td>7.3** (1.1, 47.4)</td>
</tr>
<tr>
<td>Lifetime history of antisocial behavior</td>
<td>14.9</td>
<td>4.3</td>
<td>3.9*** (2.4, 6.4)</td>
<td>NS</td>
</tr>
<tr>
<td>Previous suicide attempts</td>
<td>17.3</td>
<td>1.0</td>
<td>20.4*** (9.9, 42.0)</td>
<td>9.5*** (3.0, 29.7)</td>
</tr>
<tr>
<td>Psychiatric hospital admission in prior year</td>
<td>17.3</td>
<td>0.3</td>
<td>68.5*** (20.8, 225.4)</td>
<td>21.9*** (4.8, 99.7)</td>
</tr>
<tr>
<td>History of out-patient psychiatric treatment</td>
<td>58.4</td>
<td>16.0</td>
<td>7.4*** (5.3, 10.3)</td>
<td>NS</td>
</tr>
<tr>
<td>Sociodemographic and psychological factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>77.7</td>
<td>48.4</td>
<td>3.7*** (2.6, 5.3)</td>
<td>7.8*** (4.4, 13.6)</td>
</tr>
<tr>
<td>No formal educational qualifications</td>
<td>41.6</td>
<td>26.6</td>
<td>2.0*** (1.4, 2.7)</td>
<td>2.1** (1.3, 3.4)</td>
</tr>
<tr>
<td>Low income</td>
<td>63.9</td>
<td>35.7</td>
<td>3.2*** (2.3, 4.4)</td>
<td>2.9*** (1.8, 4.6)</td>
</tr>
<tr>
<td>Poor parental relationship during childhood</td>
<td>30.7</td>
<td>11.5</td>
<td>3.4*** (2.4, 4.9)</td>
<td>2.3** (1.3, 4.0)</td>
</tr>
<tr>
<td>Recent stressful interpersonal life events</td>
<td>69.3</td>
<td>27.5</td>
<td>5.9*** (4.3, 8.3)</td>
<td>2.7*** (1.7, 4.4)</td>
</tr>
<tr>
<td>Recent stressful legal life events</td>
<td>16.3</td>
<td>1.2</td>
<td>15.8*** (8.0, 31.2)</td>
<td>5.4*** (2.3, 12.8)</td>
</tr>
</tbody>
</table>

** P < 0.0025; *** P > 0.0025.
Table 2. **Logistic regression analysis: Serious Suicide attempts and Controls**

<table>
<thead>
<tr>
<th>Risk Factor (%)</th>
<th>Suicide Attempts (N=275)</th>
<th>Control subjects (N = 984)</th>
<th>Unadjusted OR (95% CI)</th>
<th>Adjusted OR (95% CI)</th>
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<tr>
<td>Mood disorders</td>
<td>78.2</td>
<td>6.7</td>
<td>49.8*** (34.1, 72.9)</td>
<td>17.6*** (10.4, 29.6)</td>
</tr>
<tr>
<td>Substance use disorders</td>
<td>38.9</td>
<td>10.0</td>
<td>5.8*** (4.2, 7.2)</td>
<td>NS</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>23.3</td>
<td>5.1</td>
<td>5.7*** (3.8, 8.4)</td>
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<td>Eating disorders</td>
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<td>Lifetime history of antisocial behavior</td>
<td>30.9</td>
<td>4.3</td>
<td>10.0*** (6.7, 15.0)</td>
<td>NS</td>
</tr>
<tr>
<td>Previous suicide attempts</td>
<td>23.6</td>
<td>1.0</td>
<td>30.1*** (15.2, 59.6)</td>
<td>14.2*** (4.7, 43.1)</td>
</tr>
<tr>
<td>Psychiatric hospital admission in prior year</td>
<td>22.9</td>
<td>0.3</td>
<td>97.2*** (30.2, 312.4)</td>
<td>15.0** (3.2, 71.4)</td>
</tr>
<tr>
<td>History of out-patient psychiatric treatment</td>
<td>70.9</td>
<td>16.0</td>
<td>7.4*** (5.3, 10.3)</td>
<td>NS</td>
</tr>
<tr>
<td><strong>Sociodemographic and psychological factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (Mean age, 30.0 years)</td>
<td>(Mean age, 43.5 years)</td>
<td>n/a</td>
<td>1.04*** (1.02, 1.05)</td>
<td></td>
</tr>
<tr>
<td>No formal educational qualifications</td>
<td>53.8</td>
<td>26.6</td>
<td>2.0*** (1.4, 2.7)</td>
<td>3.0*** (1.8, 5.0)</td>
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<tr>
<td>Low income</td>
<td>72.0</td>
<td>35.7</td>
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<td>2.2** (1.3, 3.6)</td>
</tr>
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<td>Recent stressful legal life events</td>
<td>18.9</td>
<td>1.2</td>
<td>15.8*** (8.0, 31.2)</td>
<td>3.6* (1.4, 9.5)</td>
</tr>
<tr>
<td>Recent stressful work related life events</td>
<td>38.2</td>
<td>15.5</td>
<td>3.1*** (2.2, 4.3)</td>
<td>2.8** (1.6, 4.8)</td>
</tr>
<tr>
<td>Low Social contact</td>
<td>36.4</td>
<td>5.8</td>
<td>9.3*** (6.5, 13.4)</td>
<td>2.8** (1.5, 5.2)</td>
</tr>
</tbody>
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* P < 0.05; ** P < 0.005; *** P < 0.0001; NS P > 0.05.
Table 3. **Logistic regression analysis: Suicides and Serious Suicide Attempts**

<table>
<thead>
<tr>
<th>Risk Factor (%)</th>
<th>Suicides (N = 202)</th>
<th>Suicide Attempts (N = 275)</th>
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</tr>
<tr>
<td>Non-affective psychosis</td>
<td>5.9</td>
<td>1.1</td>
<td>5.7** (1.6, 20.6)</td>
<td>8.5** (2.0, 35.9)</td>
</tr>
<tr>
<td><strong>Demographic and psychological factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age (years)</td>
<td>36.8</td>
<td>30.0</td>
<td>n/a</td>
<td>1.03*** (1.02, 1.04)</td>
</tr>
<tr>
<td>Male</td>
<td>77.7</td>
<td>45.1</td>
<td>4.2*** (2.8, 6.4)</td>
<td>1.9* (1.1, 3.2)</td>
</tr>
<tr>
<td>Poor social contact</td>
<td>22.8</td>
<td>36.4</td>
<td>1.9** (1.3, 2.9)</td>
<td>2.0* (1.1, 3.5)</td>
</tr>
</tbody>
</table>

* P < 0.05; ** P < 0.005; *** P < 0.0001.
Mnemonic/Acronym

- History of Suicide Attempt (family history as well)
- Ideation (Intent and Plan)
- Symptoms
  - Hopeless, Anxiety, Pain (psychic, physical), Insomnia, Intoxication
- Impulsivity
- Disease
- Environmental and Social
- Access to Means
- Live (Reasons to...)
  - Loving, Working, Playing, Meaning (Skills)
If You Don’t Ask—
They Won’t Tell

• In one psychological autopsy study only 18% spontaneously told professionals of intentions.

• In a study of suicidal deaths in hospitals:
  ▪ 77% denied intent on last communication
  ▪ 28% had “no suicide contracts” with their caregivers
National Comorbidity Study

Cumulative Probabilities for Transition

- Ideation → Plan 34%
- Plan → Attempt 72%
- Ideation → Unplanned Attempt 26%

Within 1 year of onset of IDEATION:
- 60% of all planned 1st attempts
- 90% of all unplanned 1st attempts
Major Depressive Disorder

- Depressed Mood
- Appetite (increased or decreased)
- Motor (agitation or retardation)
- Energy
- Sleep (insomnia or hypersomnia)
- Thought (concentration, indecisiveness)
- Anhedonia (interest)
- Guilt (worthlessness)
- Suicide
Risk Factors: Psychiatric Illness

- Major Depressive Disorder 20.4
- Bipolar Disorder 15.0
- Dysthymic Disorder 12.1
- Schizophrenia 8.5
- Obsessive Compulsive Disorder 7.8
- Cluster B Personality 5.9
- PTSD 5.1
### Risk Factors: Medical Illness and Substances

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedative Abuse</td>
<td>20.3</td>
</tr>
<tr>
<td>Opioid Abuse</td>
<td>14.0</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>5.9</td>
</tr>
<tr>
<td>AIDS</td>
<td>6.6</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>5.1</td>
</tr>
<tr>
<td>Cannabis Abuse</td>
<td>3.9</td>
</tr>
<tr>
<td>Dementia</td>
<td>3.6</td>
</tr>
<tr>
<td>Spinal Cord Injury</td>
<td>3.5</td>
</tr>
<tr>
<td>TBI</td>
<td>3.1</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>3.1</td>
</tr>
<tr>
<td>Cigarette Smoking</td>
<td>2-2.5</td>
</tr>
<tr>
<td>Other Things That Increase the Risk</td>
<td></td>
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<tr>
<td>------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>White Male                                                            doubles the risk</td>
<td></td>
</tr>
<tr>
<td>Live in Nevada                                                        doubles the risk</td>
<td></td>
</tr>
<tr>
<td>Live in Finland or Hungary                                            4x the risk</td>
<td></td>
</tr>
<tr>
<td>Have a gun at home                                                    6x the risk</td>
<td></td>
</tr>
<tr>
<td>Have a parent who killed Self                                         6x the risk</td>
<td></td>
</tr>
<tr>
<td>White Male &amp; older than 75                                            7x the risk</td>
<td></td>
</tr>
<tr>
<td>Commit a violent crime                                                7-10x the risk</td>
<td></td>
</tr>
<tr>
<td>Addicted to heroin                                                    20x the risk</td>
<td></td>
</tr>
<tr>
<td>Untreated Depression                                                  50x the risk</td>
<td></td>
</tr>
<tr>
<td>Previous Suicide Attempt                                              100x the risk</td>
<td></td>
</tr>
</tbody>
</table>
Warning Signs

- People frequently see their doctor
  - Only 50% have seen a psychiatrist
  - 75% saw Primary Care MD within 3 months of completing Suicide
    - 50% within one month
    - 25% within one week

- 75% give clues to the people around them
Warning Signs

Ideation
Substance Abuse
Purposelessness
Anxiety
Trapped
Hopelessness
Withdrawal
Anger
Recklessness
Mood Change
Warning Signs: Talk

- 66% said something to a family member or friend
- Overt (active suicidal ideation)
  - “I want to kill myself”
  - “I am going to kill myself”
- Covert (passive suicidal ideation)
  - “I would be better off dead”
  - “Life has lost its meaning for me”
  - “It’s just too much to put up with anymore”
  - “I can’t go on any longer”
  - “Nobody needs me anymore”
  - “Maybe a car will hit me”
Warning Signs: Action

• 80% give a clue
  – Buy a gun
  – Stockpile medications
  – Take a sudden interest, or lose interest in religion
  – Take risks
  – Have previous suicide attempt/s
  – Make amends: Thank You’s & Good-byes
  – Get affairs in order
  – Make a Will
  – Give away prized possessions
  – Have sudden unexplained recovery from severe depression
  – Spend Money or give gifts or charity that is out of character
Long-term (Diathesis) Risk Factors

- history of suicide attempt
- family history of suicide
- history of Psychiatric Disorder
  - major depression or bipolar disorder
  - schizophrenia/schizoaffective disorder
  - personality disorder (Cluster B)
  - PTSD and TBI
  - history of alcohol or drug abuse
- history of aggressive behavior
- pattern of impulsivity and impulsive behavior
- Demographics: gender, age, ethnicity
Acute Factors

- acute psychic pain
- current depression
- current substance abuse or impulsive overuse
- anxiety, panic, insomnia
- extreme humiliation/disgrace; narcissistic mortification
- hopelessness
- demoralization
- desperation/sense of ‘no way out’
- inability to conceive of alternate solutions
- break-down in communication/loss of contact with significant other (including therapist)
Psychosocial Factors

- Living alone
- Limited social contacts
- Lack of dependents
- Financial hardship
- Legal Troubles
- Loss of contact with significant other (including therapist)
- Developmental Impasses across lifespan
- Interpersonal conflict
  - break-down in communication
- Novel situations that are stressful
- Disgrace
Suicide risk varies over time within the life of the individual.
Protective (Mitigating) Factors

- Nurturing caretaking Role (children, elders, pets)
- Religious Faith
- Interpersonal and connections
- Social Role
- Purpose and meaning in life
- Problem Solving ability
- Resilience
- Persistance
- Coping Skills
- Attitudes towards Suicide
- “Psychic Toughness”
Suicide Fantasies

- Reunion
- Rebirth
- Retaliatory abandonment
- Revenge
- Self-punishment
  - Death Penalty self inflicted
- Atonement
- Escape (pain or rage)
- Identification with dead person
- To be rescued from attempt
- Control
- Expendable Child
- The Wish to Kill, be killed, to die
Mental Illness

Life Events
- Psychic Pain
- Hopelessness
- No Respite

Affective Instability
Impulsive Aggression

Suicide Ideation
Suicidal Behavior
- Coping Skills
- Resilience
- Values
- Reasons to live

Low Serotonin Activity

Hx of Attempt

- Smoking
- Head Injury
- Substance Abuse

Created by Bruce Levine, MD
DDx for Psychological Intervention

Unbearable Perturbation

Operant Behavior  Escape Behavior

Cry for Help
LOCAL TITLE: 21 DAY CERTIFICATION
DATE OF NOTE: AUG 02, 200708:26
ENTRY DATE: AUG 02, 200708:26:19
AUTHOR: INDRAPRAJ, MINTE
EXG CUSING: URGENCY:
STATUS: COMPLETED

SKIN ASSESSMENT
SHARED SKIN RISK ASSESSMENT

- Sensory Perception: 3 = Slightly Limited
- Moisture: 4 = Rarely moist
- Activity: 2 = Challenged
- Mobility: 2 = Very Limited
- Nutrition: 3 = Adequate
- Friction: 1 = Problem
  15-18 Mild Risk
  Score: 10

MEDICATION PATCHES
The patient has the following patches on the skin:
- Micro Glycerine patch

MAJOR RISK FACTORS / SPECIAL POPULATIONS
The patient has the following spinal cord injury or neurologic deficit:
- Paraplegic

CURRENT SKIN ASSESSMENT
Skin Color:
- Color: Normal for ethnic group
Skin Temperature
- Temp: Warm
Skin Moisture
- Moisture: Moist
Skin Turgor
- Turgor: Within normal limits

SKIN PROBLEMS
Other:
- Tape burns on abdomen
Visit 08/02/07 21 DAY CERTIFICATION, 00 TEST, MINTIE INDIR-MAWAIJ (Aug 02,07@08:26)

LOCAL TITLE: 21 DAY CERTIFICATION

DATE OF NOTE: AUG 02, 20070826
ENTRY DATE: AUG 02, 20070826:18
AUTHOR: INDIR-MAWAIJ, MINTIE
RXD COSTUMER:
URGENCY:
STATUS: COMPLETED

SKIN ASSESSMENT

BRADEN SKIN RISK ASSESSMENT

Sensory Perception: 3 = Slightly Limited
Moisture: 4 = Rarely Moist
Activity: 2 = Chairfast
Mobility: 2 = Very Limited
Nutrition: 3 = Adequate
Friction: 1 = Problem

15-18 Mild Risk
Score: 18

MEDICATION PATCHES
The patient has the following patches on the skin.
nitro glycerine patch

MAJOR RISK FACTORS / SPECIAL POPULATIONS
The patient has the following spinal cord injury or neurologic deficit.
Paraplegic

CURRENT SKIN ASSESSMENT
Skin Color:
Color: Normal for ethnic group
Skin Temperature
Temp: Warm
Skin Moisture
Moisture: Moist
Skin Turgor

SKIN PROBLEMS
Other:
tape burns on abdomen

Health Factors: VASOD SKIN INITIAL, SKIN PROBLEM - OTHER, PERSURE ULCER PROTOCOL INITIATED, SKIN MANAGE NUTRITION, SKIN REDUCE FRICTION AND SHEAR, SKIN PATCHES
LOCAL TITLE: 21 DAY CERTIFICATION

DATE OF NOTE: AUG 02, 2007 08:26
ENTRY DATE: AUG 02, 2007 08:26:18

AUTHOR: INDAR-MARAJ, MINTIE EXP COSIGNER:
URGENCY:
STATUS: COMPLETED

SKIN ASSESSMENT

BRADEH SKIN RISK ASSESSMENT

Sensory Perception: 3 = Slightly Limited
Moisture: 4 = Rarely Moist
Activity: 2 = Chairfast
Mobility: 2 = Very Limited
Nutrition: 3 = Adequate
Friction: 1 = Problem

16-18 Mild Risk
Score: 18

MEDICATION PATCHES
The patient has the following patches on the skin:
nitro glycerine patch

MAJOR RISK FACTORS / SPECIAL POPULATIONS
The patient has the following spinal cord injury or neurologic deficit.
Paraplegic

CURRENT SKIN ASSESSMENT

Skin Color:
Color: Normal for ethnic group

Skin Temperature
Temp. Core

Skin Moisture
Moisture: Moist

Skin Turgor
Turgor: Within normal limits

SKIN PROBLEMS

Other:
- Tape burns on abdomen

Health Factors: VANDO SKIN INITIAL, SKIN PROBLEM: OTHER, PRESSURE ULCER PROTOCOL INITIATED, SKIN MANAGE NUTRITION, SKIN REDUCE FRICTION AND SHEAR, SKIN PATCHES
LOCAL TITLE: 21 DAY CERTIFICATION

DATE OF NOTE: AUG 02, 2007 08:26
ENTRY DATE: AUG 02, 2007 08:26:18

AUTHOR: MINTIE, INDAR-MARAJ
RXD COSTUMER:

URGENCY:
STATUS: COMPLETED

SKIN ASSESSMENT

BRAEMAN SKIN RISK ASSESSMENT

Sensory Perception: 3 = Slightly Limited
Moisture: 4 = Rarely Moist
Activity: 2 = Chairfast
Mobility: 2 = Very Limited
Nutrition: 3 = Adequate
Friction: 1 = Problem

15-18 Mild Risk
Score: 18

MEDICATION PATCHES

The patient has the following patches on the skin:
- Nitro glycerine patch

MAJOR RISK FACTORS / SPECIAL POPULATIONS

The patient has the following spinal cord injury or neurologic deficit.
Paraplegic

CURRENT SKIN ASSESSMENT

Skin Color:
- Color: Normal for ethnic group

Skin Temperature
Temp: Warm
Skin Moisture
- Moisture: Moist

Skin Turgor
- Turgor: Within normal limits

SKIN PROBLEMS

Other
- Tape burns on abdomen

Health Factors: VANOD SKIN INITIAL, SKIN PROBLEM - OTHER, PFESSURE ULCER PROTOCOL INITIATED, SKIN MANAGE NUTRITION, SKIN REDUCE FRICTION AND SHEAR, SKIN PATCHES
Reminder Dialog Template: V3 SUICIDE ASSESSMENT

IDEATION  Click for info about IDEATION

- Patient presently has no suicidal ideation.
- Pt has
  - PASSIVE IDEATION
  - ACTIVE IDEATION
  - PASSIVE AND ACTIVE IDEATION.
  - WITH INTENT  WITH PLAN.

Previous attempts: Click for info about PREVIOUS ATTEMPTS

- Patient has never made a suicide attempt.
- Previous attempts: Describe:

Click for more about CHRONIC RISK  Click for info about ACUTE RISK

IMPULSIVITY PREDICTORS  Click for info about IMPULSIVITY

Indications:
- Minimal indication of impulsivity
- History of violence
- History of verbal aggression
- History of impulsive behaviors such as
  - spending
  - driving fast
  - excessive travel
  - sexual acting out
  - substance consumption
  - binge eating
  - Other:

- History of head injury with loss of consciousness or repeated head injuries without loss of consciousness.
- History of inability to abstain from smoking

ADDITIONAL COMMENTS:
ILLNESS  

- None
- Depression
- PTSD
- Bipolar Disorder
- Substance Abuse
- Alcohol Abuse
- Psychosis
- Eating disorder
- Severe medical illness
- Cluster B Personality
- Pain

(Optional to describe any entries on the list above except for Serious Medical Illnesses. For Serious Medical Illnesses, please describe.)

Describe:

CURRENT SYMPTOMS  

Click of info about ACUTE SYMPTOMS

SEVERE EMOTIONAL DISTRESS

- Patient DOES complain of severe emotional distress.
- Patient DOES NOT complain of severe emotional distress.

PSYCHIC ANXIETY

- Patient DOES endorse severe anxiety.
- Patient DOES NOT endorse severe anxiety.

PANIC SYMPTOMS

- Patient DOES describe panic symptoms
- Patient DOES NOT describe panic symptoms.

HOPELESSNESS AND/OR DEMORALIZATION

- Patient DOES express hopelessness and/or demoralization.
- Patient DOES NOT express hopelessness and/or demoralization.
### INSOMNIA
- Patient DOES complain of insomnia.
- Patient DOES NOT complain of insomnia.

### OBSESSIONALITY
- Patient DOES evidence obsessionality.
- Patient DOES NOT evidence obsessionality.

### RECENT INTOX
- Patient DOES have recent intoxications.
- Patient DOES NOT have recent intoxications.

### HALLUCINATIONS
- Patient DOES endorse hallucinations.
- Patient DOES NOT endorse hallucinations.

### PHYSICAL PAIN
- Patient DOES complain of physical pain.
- Patient DOES NOT complain of physical pain.

### ADDITIONAL COMMENTS:

### SOCIAL RISKS
- Poor Social Support
- Isolation
- Environmental Change
- Recent Discharge
- Recent Loss
- Acute Life Stressors
- Family History of Suicide
- Other
- None

Describe all that apply:
MEDICATION HISTORY

- Poor Adherence
- Reliable adherence
- Recent Lithium Withdrawal
- Recent Medication Change
- Insufficient pain management.
- NONE

ADDITIONAL COMMENTS: [Input Field]

FIREARMS

AVAILABILITY
- Firearms ARE NOT available.
- Firearms ARE available.

RESTRICTED
- Access IS restricted
- Access IS NOT restricted.

ADDITIONAL COMMENTS: [Input Field]

CONSIDERATION OF OTHER MEANS TO COMMIT SUICIDE

- Patient has not considered other means.
- Patient has considered other means to commit suicide.
  - Other means ARE NOT available.
  - Other means ARE available.

ADDITIONAL COMMENTS: [Input Field]
### MITIGATING CIRCUMSTANCES

- Ethical, religious beliefs
- Hopes and plans for future
- Beliefs for continued living
- Explicit reasons for living
- Dependent others
- Attitudes (e.g., Psychic Toughness)
- Living with others
- Regular contacts with supports

**ADDITIONAL COMMENTS:**

### CATEGORY OF RISK

**Click for info about OVERALL RISK**

### CURRENT ACUTE RISK FACTORS

- No current acute risk factors
- There are current acute risk factors.

**ADDITIONAL COMMENTS:**

The next two categories refer predominantly to the long-term or life-long type risk, rather than aspects of more acute suicide risk.

### BASELINE RISKS

- Baseline increased risk
- Baseline limited risk

**ADDITIONAL COMMENTS:**
INTERVENTIONS AND PLAN:

- Click for info about INTERVENTION AND PLAN
- Click for info about RISK FACTORS ADDRESSED

CONTAINMENT: PLANS FOR MODIFICATION OF ENVIRONMENT
- Continuation of current treatment plan. No modifications necessary.
- Change in treatment plan
- Family/others will increase contact with patient.
- Family agrees to observe patient
- Mobilization of other social support (e.g. residence, staff agrees to observe)
- Removal of means
- Initiate emergency hold
- Admit to inpatient care
- Place patient on 1 to 1.

ADDITIONAL COMMENTS:

ARRANGE CONTINUING CARE:
- Make sure patient has outpatient follow up scheduled.
- Referral/consult sent to
- Patient to be seen within 24 hours
- Patient given emergency numbers
- Patient given emergency numbers card

ADDITIONAL COMMENTS:

TREATMENT OF RISK FACTORS:

ACUTE FACTORS ADDRESSED:
- No change indicated. Current plan is appropriate.
- N/A
- Symptoms
- Environmental Factors
- Medication Factors
TREATMENT OF UNDERLYING PSYCHIATRIC DISORDERS:

☐ Medication Change or Adjustment
☐ Psychotherapeutic Changes or Adjustment
☐ No change at this time.

☐ CONTACT MADE WITH FAMILY/SOCIAL SUPPORT: Describe:

☐ Suicide Prevention Coordinator contacted.

PATIENT RESPONSE TO CHANGES:

☐ N/A. No change indicated.
☐ Positive
☐ Negative
☐ Neutral

ADDITIONAL COMMENTS:
"Discouraging data on the antidepressant."
What can one do?

• Be alert for the risks factors identified
• Talk to the person empathically in a quiet location showing your concern
• Trust your instincts
• “We are in this together”
• Validate feelings without supporting Suicidal behavior
• Make it very hard for them to reject you and make you unavailable
• Be open to possibilities and problem solving opportunities but expect that some efforts will be rejected
Suicide Prevention Coordinators—
Develop a relationship with your Local Recovery Coordinator.
Recovery by enhancing meaning, purpose, functioning and connectedness is a suicide prevention program (but a person has to stay alive to recover from mental illness).
Therapeutic Alliance

• What Hurts?
• How much does it Hurt?
• The Suicide Sequence:
  – I hurt too much
  – I won’t put up with this pain
  – I can kill myself
  – I can’t put up with this pain
• Mollify the PsychAche
• Avoid the countertransference error:
  – If this was me, I would feel suicidal too
It is precisely the “can’ts”, “won’ts”, “have to’s”, “nevers”, “always”, and “onlys” that are to be negotiated in treatment (psychotherapy).
Life is often a choice amongst lousy alternatives; the key to functioning, to wisdom and to life itself is often to choose the least lousy alternative that is practically possible.