CRISIS SERVICES:

Assessing for Lethality and Risk Factors Using the Zero Suicide Framework

WHO ARE WE?

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DISCLAIMER

This presentation will discuss topics related to suicide and other types of mental health crises.

If you are feeling overwhelmed or uncomfortable at ANY time during today's presentation, please feel free to turn your camera off and take a few moments.

In the event you need to speak to someone to debrief, please directly message Amber or Melanie, and they will set up a private break out room for you to process.

WHAT IS ZERO SUICIDE?

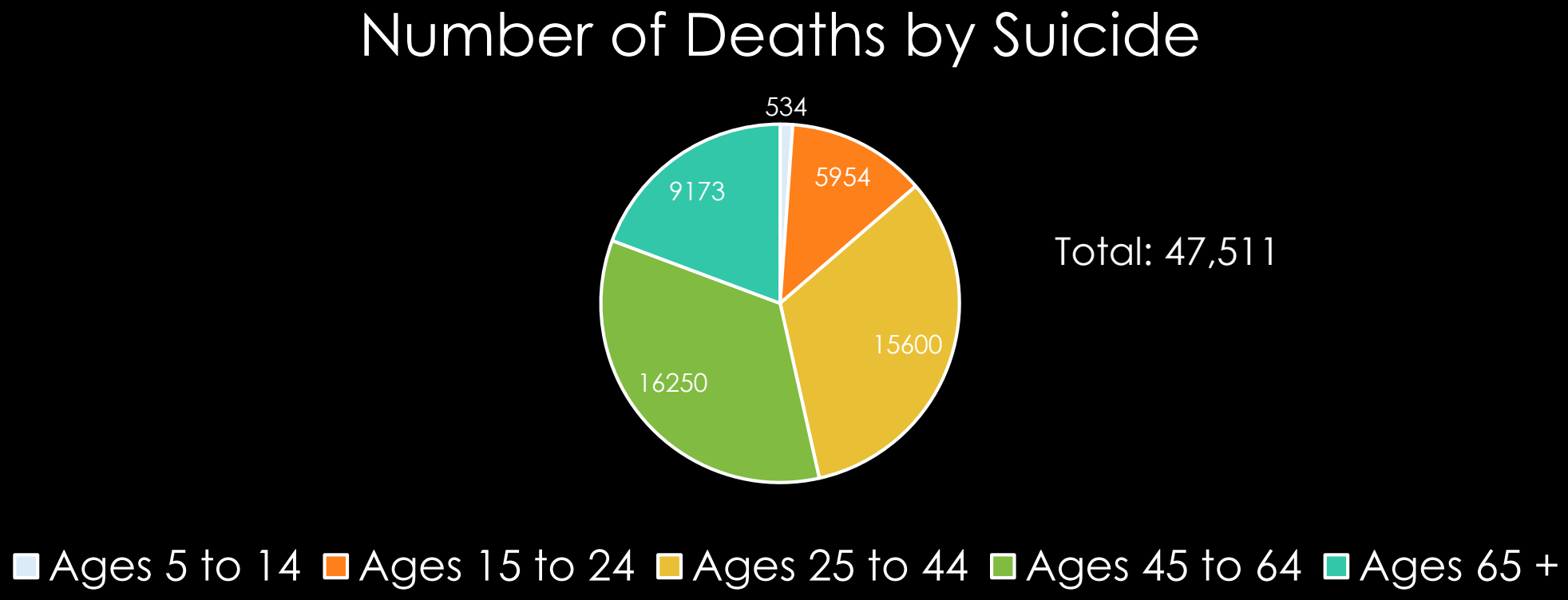
- A system-wide, organizational commitment to safer suicide care in health and behavioral healthcare systems
- A culture shift away from fragmented suicide care toward a holistic and comprehensive commitment to consumer safety
- A systems approach to care which focuses on error reduction and safety for consumers and staff

WHY ZERO SUICIDE?

Adopting the expectation that no one has to die by suicide allows us to rethink the paradigm and to find gaps in the system that may contribute to suicide deaths.

- The rate of death by suicide is increasing
- Zero Suicide's aim is to keep people alive so that they can experience recovery
- Using evidence-based practices specifically addressing suicide and continuous quality improvement system-wide, can result in a 75% reduction in suicide deaths

DEATHS BY SUICIDE IN UNITED STATES (2019)



American Association of Suicidology 2019 Fact Sheet

GENDER FACTS ON SUICIDE (2019)

Females:

- Total for year: 10,255
- Total per day: 28.1

Males:

- Total for year: 37,256
- Total per day: 102.1

American Association of Suicidology 2019 Fact Sheet

ETHNIC FACTS ON SUICIDE (2019)

- **Hispanic/Latino:** 4,331
- **Black/African Americans:** 3,309
- **Asian/Pacific Islanders:** 1,609
- **Native Americans/Alaska Natives:** 658

American Association of Suicidology 2019 Fact Sheet

LGBTQ RELATED SUICIDE STATISTICS

- LGBTQ youth are four times more likely to make a plan for suicide or attempt suicide.
- At least one LGBTQ youth between ages 13-24 attempts suicide every 45 seconds in the U.S.
- According to CDC, gay, bisexual, and other non-heterosexual males below the age of 25 are at a greater risk for suicide.

Trevor Project 2022

SUICIDE RATES BY DIAGNOSIS

- 2% to 15% of people diagnosed with Major Depressive Disorder die by suicide*
- 3% to 20% of people diagnosed with Bipolar Disorder die by suicide*
- 6% to 15% of people diagnosed with Schizophrenia die by suicide*
- People with alcohol dependence and persons who use drugs have a 10 to 14 times greater risk of death by suicide^

*Williams (2016)
^Essang, et. al. (2018)

FOLLOW UP IS CRUCIAL

- The risk of suicide or death is highest within **30** days of discharge from an emergency department or inpatient psychiatric unit
- Up to **70%** of people who leave the emergency department following a suicide attempt never attend their first outpatient appointment
- **19%** of people who died by suicide had contact with mental health services in the month prior to their death

Suicide Prevention Resource Center (2013)

7 ELEMENTS OF ZERO SUICIDE

ZEROSuicide
INSTITUTE

1) LEAD

- Zero Suicide involves a system-wide culture change committed to reducing suicide
- Involves all employees, not just those in clinical roles
- Includes review and change of center policies when indicated
- Includes a focus on consumer safety

ZEROSuicide INSTITUTE

2) TRAIN

- Train a competent, confident, and caring workforce
- Help employees feel confident that they can assess for suicidality and assist in intervention when needed
- Provide evidence-based trainings about suicide prevention to all staff on an ongoing basis

ZEROSuicide INSTITUTE

3) IDENTIFY

- Identify individuals with suicide risk via comprehensive screening and assessment
- Plan is to have more consistent screening and assessment of suicidality in all service departments.
- All people receiving Center services are to be screened for suicidality, even those for whom suicide is not a presenting concern.

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4) ENGAGE

- Engage all individuals at risk of suicide using a suicide care management plan
- Establish an outreach protocol for missed appointments
- Actively, collaboratively, and routinely engage each consumer in his or her own role in recovery from suicide risk
- Actively engage family members or other identified support persons in the role of consumer recovery, including lethal means reduction

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5) TREAT

- Treat suicidal thoughts and behaviors using evidence-based treatments
- Treating suicidality as a separate condition instead of a symptom of another disorder has been shown to be effective in reducing suicidal thinking and in increasing consumer involvement in treatment
- Develop policies for how to observe consumers with suicidal concerns and train staff on these policies

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6) TRANSITION

- Transition individuals through care with warm hand-offs and supportive contacts
- Includes transitions through levels of care and Center-based programs
- Includes transitions to and from hospitals and institutional settings
- Includes transitions to and from other LMHAs and LIDDAs

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7) IMPROVE

- Improve policies and procedures through continuous quality improvement processes
- Assess the effectiveness of staff training programs and adjust as indicated
- Work toward closing the “gaps” in the system where consumer contact is lost and potential suicidality is missed

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WHAT IS A MENTAL ILLNESS?

A condition that affects a person's thinking, emotional state, and behavior

Disrupts the person's ability to carry out daily tasks such as:

- Going to work or school
- Carrying out household tasks like chores, hygiene, etc.
- Engaging in satisfying or meaningful relationships

1 in 5 people live with a mental health disorder

1 in 20 U.S. adults experience serious mental illness each year

1 in 6 U.S. youth aged 6-17 experience a mental health disorder each year

50% of all lifetime mental illness begins by age 14, and 75% by age 24

NAMI 2022

DEPRESSION: SIGNS AND SYMPTOMS

Physical

- Fatigue
- Sleeping too much or too little
- Overeating or loss of appetite
- Lack of energy
- Weight loss or gain

Behavioral

- Withdrawal from others
- Loss of interest in personal appearance
- Crying spells
- Neglect of responsibilities
- Loss of motivation

Psychological

- Feelings of Hopelessness
- Sad or depressed mood
- Increased Anger or agitation
- Excessive feelings of Guilt
- Difficulty Concentrating
- Decreased interest in activities
- Thoughts of death and/or suicide

ANXIETY: SIGNS AND SYMPTOMS

Physical

- Rapid Heartbeat
- Blushing
- Dizziness
- Sweating
- Tremors and Shaking
- Nausea
- Shortness of Breath

Behavioral

- Avoidance of Situations
- Obsessive or Compulsive Behavior
- Distress in Social Situations

Psychological

- Decreased Concentration
- Racing thoughts
- Feeling “on edge”
- Excessive worrying
- Impatience
- Restlessness

RISK FACTORS FOR DEPRESSION AND ANXIETY

- Stressful or Traumatic Events
- Ongoing Stress and Anxiety
- Family History
- Medical Conditions
- Recent Childbirth
- Substance Use
- Difficult Childhood
- Medication Side Effect
- Previous Episode of Depression or Anxiety
- Another Mental Illness
- Chemical Imbalance
- Lack of Exposure to Bright Light in Winter

WHAT IS A MENTAL HEALTH CRISIS?

As defined in the Texas Administrative Code (TAC) title 26, Part 1, Chapter 301, Subchapter G, Division 1, rule 301.303:

Crisis – A situation in which:

a) The individual presents an immediate danger to self or others; or

b) The individual's mental or physical health is at risk of serious deterioration; or

c) An individual believes that he or she presents an immediate danger to self or others; or

d) That his or her mental or physical health is at risk of serious deterioration.

WHAT IS A MENTAL HEALTH CRISIS?

Suicidal ideations

- Thoughts of wanting to kill ones self

Homicidal Ideations

- Thoughts of wanting to kill someone else

Decompensation

- Reduction in cognitive abilities or reduction in ability to cope with stressors that could lead to imminent harm to self or others.

RISK FACTORS FOR SUICIDE

- **Gender:** Males complete suicide more often than females, although women attempt suicide three times more often than men.
- **Age:** Certain age groups are more at risk (e.g., adolescents and older adults).
- **Mental illness**
- **Chronic physical illness**
- **Use of alcohol or other substances**
- **Lack of social support:** For example, evidence shows that not having a spouse is a risk factor for males.
- **Previous attempt**
- **Organized plan**

MYTHS AND FACTS ABOUT SUICIDE

Suicide happens without warning.

- Myth?
- Fact?

If you ask a person about his or her suicidal intentions, you will encourage the person to kill themselves?

- Myth?
- Fact?

Improvement following a suicidal crisis means that the risk of suicide is over.

- Myth?
- Fact?

WARNING SIGNS OF SUICIDE

- Threatening to hurt or kill oneself
- Talking, writing, or posting on social media about death, dying, or suicide
- Acting recklessly or engaging in risky behaviors
- Increasing alcohol or drug use
- Feeling hopeless
- Withdrawing from family, friends, society
- Demonstrating rage and anger or seeking revenge
- Having a dramatic change in mood
- Feeling worthless or a lack of purpose

HOW TO SIT WITH SOMEONE IN CRISIS

- Prior to meeting with your client, conduct your own brief self-assessment of your ability to work with someone in crisis.
  - Are you feeling nervous?
  - Are you concerned for your safety?
  - Are you unsure how to approach the topic of suicide?
  - Are you feeling responsible for the outcome of the assessment and the client's wellbeing?
- These are all normal thoughts and feelings to have when first beginning to work with clients in crisis. As your experience and confidence grows, you may find these thoughts and feelings occur less frequently.

HOW TO SIT WITH SOMEONE IN CRISIS

What can you do?

- Take deep breaths to calm nerves
- Assess for potential safety concerns and make any adjustments needed to help you feel safe
  - Position yourself near the exit
  - Ensure your supervisor is aware of your location
  - Consider taking another staff member with you (if approved by Supervisor)
  - Ensure the client does not have access to weapons. You can ask if they have a knife in their pocket or in their backpack, etc. If so, your Supervisor will direct you on the protocol for ensuring the safety of any weapons present.
- Know who to call and what resources are available to you in the event your client needs to be referred for a higher level of care (i.e. psychiatric hospitalization)
  - Crisis Hotline
  - CCPD
  - MCOT/CIT
- Become familiar with your site's protocol for handling crisis situations
- If not directly handling the crisis, know what information to gather
  - First and Last name
  - DOB
  - Address of **current location**
  - Phone number for client
  - Physical description on client (in the event police may need to be notified)

HOW TO SIT WITH SOMEONE IN CRISIS

How do we demonstrate empathy when working with someone in crisis?

- Utilize active listening skills:
  - Validate their feelings
  - Use minimal encouragers (i.e. head nod, "go on," "I understand")
  - Provide a summary/reflection to help client feel understood and to check for accuracy of information.
  - Utilize "open" body language (i.e. eye contact, facing client, arms uncrossed)
- "Hold" their story
  - Often times a person in crisis just wants someone to listen to them

HOW TO SIT WITH SOMEONE IN CRISIS

How do you initiate the topic of suicide or homicide?

- Explain the purpose of your assessment and how it may benefit them
- Advise them you will be writing information on your crisis assessment to ensure accuracy of information
- Keep the assessment conversational where you can. Even though direct questions are asked, it should not feel like an interrogation
- Be direct when asking about thoughts of suicide/homicide
  - A common myth is that asking someone about suicide will give them the idea or encourage them to do it. This is FALSE. Talking about suicidal thoughts can often provide a relief to suicidal clients because it shows them it is okay to talk about those thoughts and that someone is willing to listen.

QUESTIONS TO ASK

Ask directly if the person is suicidal:

- "Are you having thoughts of suicide?"
- "Are you thinking about killing yourself?"

Ask directly if the person is homicidal:

- " Are you having thoughts of hurting someone?"
- " Are you having thoughts of killing someone?"

ASSESSING FOR LETHALITY

- Does the person have **current or recent** suicidal ideations?
- Has the person considered a **method** of how they will attempt suicide?
  - i.e. Overdose, firearm, hanging, etc.
- Does the person have a **plan** of how they are going to do this?
  - i.e. When are they going to attempt? Where?
- Does the person have the **means** available to carry out the plan?
  - i.e. The client has access to firearms, pills, etc.
- Does the person have **intent** to carry out this plan for suicide?
  - i.e. Have they expressed any protective factors? Do they believe they will act on these thoughts without intervention?

ASSESSING FOR LETHALITY CONT.

Precipitating events:

- what events, thoughts, or beliefs occurred leading up to the development of the suicidal thoughts?

Past History of attempts:

- Has the client attempted suicide in their past? If so, how long ago? How did they attempt? How did the crisis resolve?

Protective factors:

- People, beliefs, or events that help mitigate risk for suicide or homicide.

Mental Status Exam:

- An individual's observable presentation which may include their mood, affect, appearance, cognition and behaviors.

What **safety options** is the person willing to consider?

- Safety plan, family collaboration, outpatient mental health treatment, therapy, psychiatry, inpatient hospitalization, respite.

Columbia Suicide Severity Rating Scale (C-SSRS)[36]

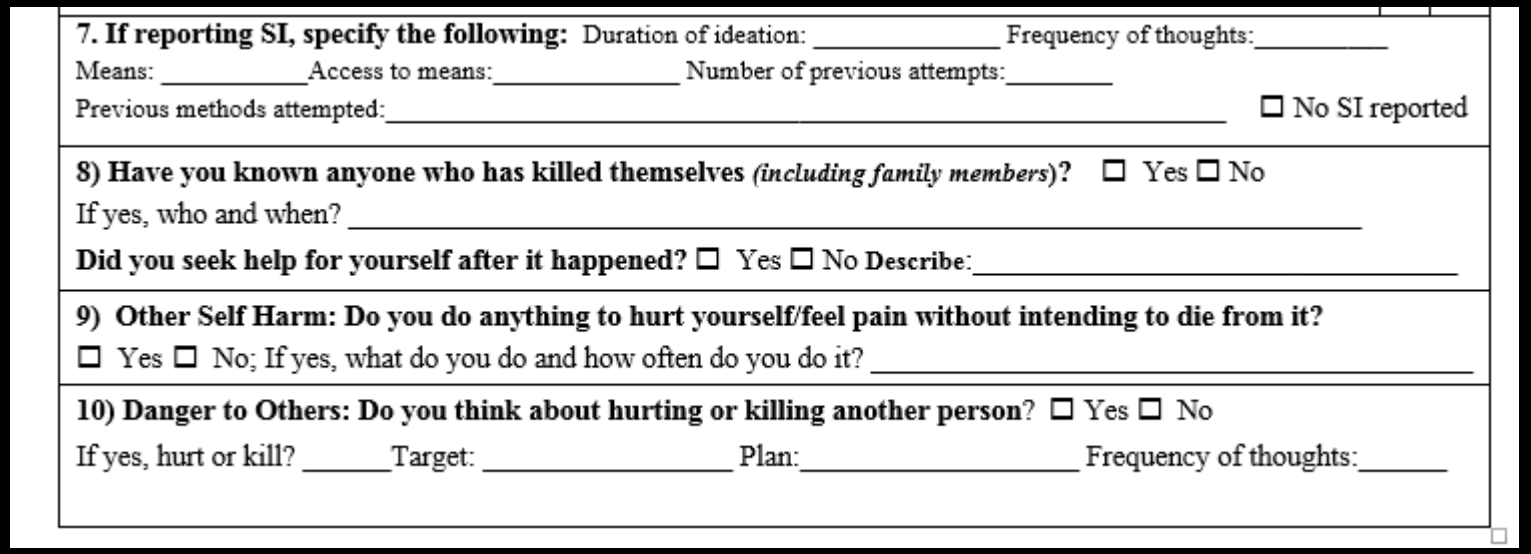
Risk History:

CSSRS- Columbia Suicide Severity Rating Scale **Ask questions that are bold and underlined.**

Ask Questions 1 and 2:	**Past Month**	
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?***	**Y**	N
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?***	**Y**	N
If YES to 2, ask questions 3, 4, 5 and 6. If NO to 2, go directly to question 6.	**Past Month**	
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 do this?***	**Y**	N
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?***	Y	**N**
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?***	Y	**N**
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? ©2008 Research Foundation for Mental Hygiene, Inc.	**Y**	N

- The C-SSRS is an evidenced based suicide risk assessment that assesses symptoms within the **past month**
- Questions in bold type are to be asked the way they are written, though assessor can clarify further if needed
- According to CSSRS.Columbia.edu, the screening tool is to be used in "a multitude of community and healthcare settings."

CRISIS ASSESSMENT DOCUMENT CONT.



7. If reporting SI, specify the following: Duration of ideation: _____ Frequency of thoughts:_____
Means: _____Access to means:_____ Number of previous attempts:_____
Previous methods attempted:_____ ☐ No SI reported

8) Have you known anyone who has killed themselves *(including family members)*? ☐ Yes ☐ No
If yes, who and when? _____
Did you seek help for yourself after it happened? ☐ Yes ☐ No **Describe**:_____

9) Other Self Harm: Do you do anything to hurt yourself/feel pain without intending to die from it?
☐ Yes ☐ No; If yes, what do you do and how often do you do it? _____

10) Danger to Others: Do you think about hurting or killing another person? ☐ Yes ☐ No
If yes, hurt or kill? _____Target: _____ Plan:_____ Frequency of thoughts:_____

- Describe the current suicidal ideation (if any) and include details such as:
  - Duration
  - Precipitating events
  - Plan
  - Means and Access
- Inquire if individual has known anyone who has died by suicide, if yes provide relevant details.
- Ask about non-suicidal self injury and obtain details regarding duration and frequency
- When assessing for danger to others make sure to distinguish HI from thoughts of hurting people. Obtain relevant details.

CRISIS ASSESSMENT DOCUMENT CONT.

Review of Reported Symptoms:

Depression: ☐ Depression ☐ Decreased concentration ☐ Worthlessness ☐ Guilt ☐ Hopelessness ☐ Helplessness ☐ Isolation ☐ Loss of energy ☐ Tearfulness ☐ Loss of interest in activities ☐ other: _____
Anxiety: ☐ Anxiety ☐ Worrying ☐ Restlessness ☐ Irritability ☐ Muscle tension ☐ Panic attacks ☐ Other: _____
Psychosis: ☐ Bizarre behavior, *Specify:* _____ ☐ Mania ☐ Paranoia ☐ Hallucinations, describe_____
Reported problems functioning at: ☐ Community ☐ Home ☐ School ☐ Work ☐ Other: _____
Behaviors noticed by client: ☐ Physically aggressive ☐ Verbally aggressive ☐ Guarded ☐ Social withdrawal ☐ Impulsivity
Sleep: ☐ No change ☐ Increased ☐ Decreased ☐ Nightmares ☐ Difficulty falling to sleep ☐ Frequently waking ☐ Sleep disturbance ☐ Other: _____ Hours of sleep per night: _____
Appetite: ☐ Increased ☐ Decreased Weight loss or gain? How much? _____ in last _____ ☐ days ☐ weeks ☐ months History of eating disorder (*type*): _____

- Review of symptoms:
  - Includes a combination of client report and clinical observation.
  - For example, a client typically does not report being psychotic or knows that they are experiencing delusions (fixed beliefs).

CRISIS ASSESSMENT DOCUMENT CONT.

Mental Status Exam:

Appearance: ☐ Appropriate ☐ Disheveled ☐ Inappropriate ☐ Poor Hygiene ☐ Well-groomed ☐ Other:_____	**Orientation:** ☐ Person ☐ Place ☐ Time ☐ Situation ☐ Day/Date
Motor Behavior : ☐ Normal ☐ Psychomotor retardation ☐ Psychomotor agitation ☐ Other:_____	**Mood** (reported emotion) **:** ☐ Apathetic ☐ Depressed ☐ Anxious ☐ Irritable ☐ Normal ☐ Elevated ☐ Other: _____
Affect (observed expression of emotion)**:** ☐ Congruent to mood ☐ Flat ☐ Blunted ☐ Hostile ☐ Labile ☐ Inappropriate ☐ Other: _____	**Speech:** ☐ Clear ☐ Slurred ☐ Rapid ☐ Mumbled ☐ Pressured ☐ Other: _____
Thought Process: ☐ No issues noted ☐ Blocking ☐ Flight of Ideas ☐ Tangential ☐ Delayed response ☐ Loose Associations	**Thought Content:** ☐ Goal Directed ☐ Denial ☐ Minimizes Problems ☐ Delusions -*describe*:_____
Short term memory: ☐ Intact ☐ Impaired **Long term memory:** ☐ Intact ☐ Impaired	**Abstract thinking:** ☐ Normal ☐ Impaired **Insight:** ☐ Good ☐ Fair ☐ Poor
Judgment: ☐ Good ☐ Fair ☐ Poor **Impulse control:** ☐ Good ☐ Fair ☐ Poor	**Estimated Intelligence:** ☐ Above Average ☐ Average ☐ Below Average

- Mental Status Exam:
  - Includes observed items such:
    - Appearance
    - Motor behavior
    - Affect
    - Orientation
  - Also includes Mood which is typically reported by the client
  - If client has an established baseline of abnormal functioning, you may put "within normal limits for client"

DOCUMENTING THE REPORTED CRISIS INFORMATION

Client reports current SI with a plan to overdose on pills, however he denies current intent. Client reported
having suicidal thoughts "off and on for the past two weeks. According to client, he quit taking his
medication three weeks ago because he did not think he needed them anymore and did not like the
side effect of feeling like a "zombie." Client explained he has ongoing conflict in his relationship and
his girlfriend broke up with him two days ago. Client states he cuts to "release stress" describing
himself as a "cutter" for the past two years. Client last engaged in self-harm one month ago. Client
denies AVH, including command. Client does describe wanting to "punch" people who provoke him
though consistently denies HI. Client reported he has a supportive brother who wants him to get help.

INFORMATION TO CONSIDER WHEN STAFFING OR DOCUMENTING A CRISIS

- What to staff:
  - Lethality
    - SI/HI (method, plan, intent, means, access, target, frequency, duration)
    - Psychosis (hallucinations, delusions)
    - Substance use/self-care/cognition that would put them in crisis
  - Current Risk factors
    - Hx of suicide attempts
    - Substance use
    - Impulsivity
    - Easy access to lethal means
  - Current Protective factors
    - Family and community supports
    - Positive relationships with children
    - Religious/spiritual beliefs
    - Coping skills

POSSIBLE CRISIS OUTCOMES

- Remember the definition of a crisis:
  a) The individual presents an immediate danger to self or others; or
  b) The individual's mental or physical health is at risk of serious deterioration; or
  c) An individual believes that he or she presents an immediate danger to self or others; or
  d) That his or her mental or physical health is at risk of serious deterioration.
- **Safety Plan:** A collaborative person centered document that lists clients' coping mechanisms, natural supports, and local resources by taking into consideration both current risk and protective factors. Ways the client may remain safe in their environment may also be included (i.e. pillbox, gun safe, etc).
- **Inpatient Psychiatric Hospitalization:** Utilized as a means of safety for individuals with the highest risk of danger to self and/or others. Patients will have access to doctor's services, medication, and therapy while working towards stabilization of symptoms.
- **Welfare Check:** Completed by local law enforcement agencies to check on an individual's wellbeing when it is believed they may be of danger to self and/or others.
  - **CCPD Non-Emergent:** 361-886-2600

POSSIBLE CRISIS OUTCOMES

- Not all crises end in hospitalization or safety plan
- We also need to consider what "crisis" means to our clients. It may not always involve immediate danger to self or others.
- A referral to a respite center, providing community resources, teaching coping skills, or even just providing quality supportive listening are other possible outcomes.

CRISIS HOTLINE
1-888-767-4493

- A hotline services that is available 24 hours, seven days a week that provides information, screening and intervention, support, and referrals to callers. Staff are trained and competent in crisis.
- Accredited by American Association of Sociology (AAS)
- Crisis Response times
  - Emergent: 1 hour
  - Urgent: 8 hours
  - Follow-up: 24 hours
- Collaborate with MCOT team for assessment

MHID SERVICES

- Mental Health Services for Adults and Youth
  - Crisis Services (MCOT, CIT)
  - Walk-in Crisis Clinic
  - Crisis Respite
  - Continuity of Care (COC)
- Intellectual and Developmental Disability Services
  - IDD Crisis Intervention

MOBILE CRISIS OUTREACH TEAM

- Crisis Screening, Assessment and Referral
- Psychiatric Evaluation
- Medication Training and Support Services
- Safety Monitoring
- Crisis Follow-up and Relapse Prevention
- Routine Case Management
- Psychosocial Rehabilitative Services

50 YEARS
MHID
Since 1969
Nueces Center for
Mental Health and Intellectual Disabilities

CRISIS INTERVENTION TEAM (CIT)

- Crisis intervention staff embedded with CCPD and Dispatch along with crisis intervention trained officers in response to 911 calls involving individuals with behavioral issues , including substance abuse/dependence.

50 YEARS
MHID
Since 1969
Nueces Center for
Mental Health and Intellectual Disabilities

COMMUNITY RESOURCES

- Nueces Center for Mental Health and Intellectual Disabilities (MHID)
  - Mental Health First Aid (MHFA)
  - LOSS Team
- Crisis Hotline: 1-888-767-4493
- NAMI
- Cenikor
- Bayview Behavioral Health
- Ocean's Health Care (Formerly Christus Spohn Memorial Hospital)
- Coastal Bend Wellness Foundation
- Amistad Community Health Center
- 211: United Way

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QUESTIONS?