Silberman School of Social Work

# Session 7:

# Solution Focused Approaches Addressing Suicidality

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## Definitions:

**Suicidal Ideation:** Passive thoughts about wanting to be dead or active thoughts about killing oneself, not accompanied by preparatory behavior.

There are two kinds of suicidal ideation: passive and active.

**Passive suicidal ideation** occurs when you wish you were dead or that you could die, but you don't actually have any plans to commit suicide.

**Active suicidal ideation,** on the other hand, is not only thinking about it but having the intent to commit suicide, including planning how to do it.

## Definitions:

**Self Harm:** An act with nonfatal outcome, in which an individual deliberately initiates a nonhabitual behavior that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which the subject desired via the actual or expected physical consequences.

**Suicidal Behavior or Preparatory Acts:** Acts or preparation toward making a suicide attempt, but before potential for harm has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away)

**Definitions:**

**Suicide plans:** Suicide plans are significant because they signal a more serious risk of carrying out suicidal behavior than does suicidal ideation without planning. Suicide planning exists on a continuum from vague and unrealistic plans to highly specific and feasible plans. Serious suicide planning may also involve rehearsal or preparation for a suicide attempt.

**Suicidal intention:** Suicidal intention (also called "intent") signals high, acute risk for suicidal behavior. Having suicidal intent is always serious because it signals that the client intends to make a suicide attempt. Some indicators of high intent include drafting a suicide note or taking precautions against discovery at the time of an attempt.

## Definitions:

**Suicide Attempt:** A nonfatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

**Suicidal Self-Directed Violence:** Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent. This encompasses suicide deaths and suicide attempts.

**Suicidal Behaviors:** Includes suicide, suicide attempts, other suicidal behavior, and preparatory acts.

# A Few Statistics

According to the American Foundation for Suicide Prevention (AFSP), 42,773 Americans die by suicide each year; about 117 suicides occur each day. In addition, for each suicide, there are 25 more people in the United States who survive a suicide attempt.

# A Few Statistics

Suicide is the 10th leading cause of death in the United States and almost one-half of our population's deaths by suicides are from firearms.

# A Few Statistics

Non-Hispanic white males have the highest rate of death by suicide, followed by American Indians and Alaska Natives.

# A Few Statistics

More than 30% of LGBTQ+ youth report attempting to end their life by suicide within the last year; more than 50% of youth who identify as transgender will have had at least one suicide attempt by the time they are 20 years old.

# A Few Statistics

The AFSP also notes the following statistics:

Individuals 85 years or older have the highest rate of death by suicide.

Death by suicide is the second leading cause of death for individuals aged 15 to 24.

# A Few Statistics

Hispanic females have the highest rate of suicide among adolescents.

Female adolescents have a higher rate of suicide attempts; however, male adolescents are four times more likely to die by suicide.

The field requires social workers to be aware of the warning signs and risk factors of suicide in order to have the ability to intervene, offer treatment, and prevent it. We need to work extensively on increasing our clients' protective factors in order to decrease the risk factors.

## Protective factors include the following:

effective mental health care;
connectedness to individuals, family, community, and social institutions;
problem-solving skills;
contacts with caregivers;
religious faith;
coping skills;
life satisfaction;
sense of responsibility to family or to a pet;
reality testing ability; and
strong therapeutic relationship.

## Risk Factors

a family history of violence or suicide

a family history of child abuse, neglect, or trauma

a history of mental health issues

a feeling of hopelessness

knowing, identifying, or being associated with someone who has completed suicide

## Risk Factors con't

engaging in reckless or impulsive behavior

a feeling of seclusion or loneliness

identifying as LGBTQIA+ with no family or home support

not being able to access care for mental health issues

a loss of work, friends, finances, or a loved one

## Risk Factors con't

having a physical illness or health condition

possessing a gun or other lethal methods

not seeking help due to fear or stigma

stress due to discrimination and prejudice

historical trauma, such as the destruction of communities and cultures

## Risk Factors con't

having attempted suicide before

experiencing bullying or trauma

exposure to graphic or sensationalized accounts of suicide

exposure to suicidal behavior in others

experiencing legal problems or debt

being under the influence of drugs or alcohol

Other behaviors that may be associated with increased short-term risk for suicide are:

when the patient makes arrangements to divest responsibility for dependent others (children, pets, elders),
or making other preparations such as updating wills, making financial arrangements for paying bills, saying goodbye to loved ones, etc.

## Risk Factors/Warning Signs

When working with clients who are struggling with severe mental health issues, it is crucial for social workers to have the skills to complete extensive risk assessments and comprehensive safety plans in order for individuals to receive proper care and prevent further harm. It is also important to understand the difference between warning signs and risk factors. Warning signs are directly related to imminent risk; however, risk factors are not. Although risk factors can increase an individual's risk of suicide, it does not necessarily mean that an individual is at imminent risk of suicide.

## Warning Signs

The following signs are considered the strongest indications of suicide risk:

threatening to hurt or kill oneself, or talking of wanting to hurt or kill oneself;

looking for ways to kill oneself by seeking access to firearms, available pills, or other means; and

talking or writing about death, dying, or suicide, when these actions are out of the ordinary for the person.

**Warning Signs** should alert the clinician that a mental health evaluation needs to be conducted in the VERY near future and that precautions need to be put into place IMMEDIATELY to ensure the safety, stability and security of the individual.

- Hopelessness
- Rage, anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped – like there's no way out
- Increasing alcohol or drug abuse
- Withdrawing from friends, family or society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic changes in mood
- No reason for living, no sense of purpose in life

## Ask Questions

Asking questions about suicidal ideation, intent, plan, and attempts is not easy. Sometimes the client will provide the opening to ask about suicide, but usually the topic does not readily flow from the presenting complaint and gathering of history related to the present illness. This can be particularly true in medical as opposed to behavioral health type settings.

## Ask Questions

Nevertheless it is important to ask a screening set of questions whenever the clinical situation or presentation warrants it. The key is to set the stage for the questions and to signal to the patient that they are naturally part of the overall assessment of the current problem. A great deal depends upon the clinician's familiarity with the key screening questions and the ease and comfortableness he/she/they has with the topic and the asking of the questions.

## Ask Questions

A good place in the clinical interaction for beginning this discussion is immediately following the report and/or the elicitation of the client's pain (physical or psychic) and distress. Introductory statements that lead into the questions pave the way to ensuring an informative and smooth dialogue and reassure the patient that you are prepared for and interested in the answers.

## Ask Questions

For example:

I appreciate how difficult this problem must be for you at this time. Some of my clients with similar problems/symptoms have told me that they have thought about ending their life. I wonder if you have had similar thoughts?

## Ask Questions

All suicidal ideations and suicidal threats need to be taken seriously.

A supervisor should ALWAYS be informed of this issue BEFORE the client leaves your office.

## Ask Questions -- For example:

"In the past few weeks, have you been thinking about killing yourself?" **If yes, ask:** "How often?" (once or twice a day, several times a day, a couple times a week, etc.) "When was the last time you had these thoughts?"

"Are you having thoughts of killing yourself right now?" **(If "yes," patient requires an urgent mental health evaluation and cannot be left alone. A positive response indicates imminent risk.)**

## Ask Questions -- For example:

"Do you have a plan to kill yourself? Please describe." **If no plan, ask:** "If you were going to kill yourself, how would you do it?" **Note: If the patient has a very detailed plan, this is more concerning** than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

## Ask Questions -- For example:

Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?" **If yes, ask:** "How? When? Why?" and assess intent: "Did you think [method] would kill you?" "Did you want to die?" **Ask:** "Did you receive medical/psychiatric treatment?"

## Ask Questions -- For example:

**Depression:** "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"

**Anxiety:** "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"

**Impulsivity/Recklessness:** "Do you often act without thinking?"

**Hopelessness:** "In the past few weeks, have you felt hopeless, like things would never get better?"

## Ask Questions -- For example:

**Isolation:** “Have you been keeping yourself more than usual?”

**Irritability:** “In the past few weeks, have you been feeling more irritable or grouchier than usual?”

**Substance and alcohol use:** “In the past few weeks, have you used drugs or alcohol?” **If yes, ask:** “What? How much?”

**Other concerns:** “Recently, have there been any concerning changes in how you are thinking or feeling?”

## Ask Questions -- For example:

**Support network:** "Is there a trusted person you can talk to? Who? Have you ever seen a therapist/counselor?" If yes, ask: "When and for what purpose?"

**Safety question:** "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe, but a "yes" is a reason to act immediately to ensure safety.)

**Reasons for living:** "What are some of the reasons you would NOT kill yourself?"

**Determine disposition**

After completing the assessment, choose the appropriate disposition.

**Emergency psychiatric evaluation:** Patient is at imminent risk for suicide (current suicidal thoughts). Urgent/STAT page psychiatry; keep patient safe

**Further evaluation of risk is necessary:** Request full mental health/safety evaluation

**No further evaluation in the ED:** Create safety plan for managing potential future suicidal thoughts and discuss securing or removing potentially dangerous items (medications, guns, ropes, etc.)

Send home with mental health referrals, or

No further intervention is necessary at this time

## Ways to be helpful to someone who is threatening suicide or engaging in suicidal behaviors:

- Be aware – learn the risk factors and warning signs for suicide and where to get help
- Be direct – talk openly and matter-of-factly about suicide, what you have observed, and what your concerns are regarding his/her well-being
- Be willing to listen – allow expression of feelings, accept the feelings, and be patient
- Be non-judgmental – don't debate whether suicide is right or wrong or whether the person's feelings are good or bad; don't give a lecture on the value of life
- Be available – show interest, understanding, and support
- Don't dare him/her to engage in suicidal behaviors.
- Don't act shocked and Don't ask "why"

## Ways to be helpful to someone who is threatening suicide or engaging in suicidal behaviors con't

- Don't be sworn to secrecy

- Offer hope that alternatives are available – but don't offer reassurances that any one
alternative will turn things around in the near future.

- Take action – remove lethal means of self-harm such as pills, ropes, firearms, and alcohol or other drugs

- Get help from others with more experience and expertise

- Be actively involved in encouraging the person to see a mental health professional as soon as possible and ensure that an appointment is made.

## Tools to Assist You

**Adult Emergency Department Brief Suicide Safety Assessment Guide - NIMH**
https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/adult-ed/adult-emergency-department-brief-suicide-safety-assessment-guide

**COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)**
**Risk Assessment**
https://suicidepreventionlifeline.org/wp-content/uploads/2016/09/Suicide-Risk-Assessment-C-SSRS-Lifeline-Version-2014.pdf

The Substance Abuse and Mental Health Services Administration/Health Resources and Services Administration Center for Integrated Health Solutions has screening tools available at https://www.samhsa.gov/resource/dbhis/screening-assessment-tools-chart

**Addressing Suicidal Behavior**
https://www.samhsa.gov/mental-health/suicidal-behavior

**Suicide Lifelines:**

National Suicide Prevention Lifeline 1-800-273-TALK or 1-800-273-8255

Suicide Prevention Center Hotline: 1-877-7-CRISIS or 1-877-727-4747

Crisis Text Line: Text HOME to 741741

Trevor Lifeline – LGBTQ 1-866-488-7386

Teen Line 1-800-TLC-TEEN or 1-800-852-8336

Veterans & Military Families 1-800-273-8255 Press 1