Silberman School of Social Work

Session 8:

Addressing Suicidality in Practice Background and Role Plays

HUNTER
The City University of New York

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.

What are the client's protective 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;
reality testing ability; and
strong therapeutic relationship.

What are the client's Risk factors?

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

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

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

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.

What are the warning signs for this client?

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 -- 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:

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?

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:

"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?”

What Questions Do You Ask the Client?

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?"

What is your disposition for the client?

Determine disposition

After completing the assessment, choose the appropriate disposition.

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

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

3. **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.)

4. Send home with mental health referrals, or

5. No further intervention is necessary at this time

In the Vignette Determine the Following:

1. What are the client's protective factors?
2. What are the client's risk factors?
3. What are the warning signs?
4. What is your disposition for the client?

Client # 1

Domingo is a 15 year old Latino, male identified youth. He has been upset because he is having academic struggles in school. His mother noticed cuts on his forearm over the weekend and when she confronted him about them – he started to cry uncontrollably and couldn't explain them. His mother is concerned that he might be suicidal – you are asked to assess him

Client # 2

Shante is a 35 year old African-American, female identified, lesbian woman and single parent of two school aged children. She has been depressed, has not been able to adequately care for her 6 and 8 year old children. She has been drinking heavily, over-using prescription medication and has been saying that maybe her children would be better off if she was not in their lives. Her friend is concerned that she might be suicidal – you are asked to assess her. She has tried to hurst herself before.

Client # 3

Joe is a 55 year old White, male identified, never married man. He has no contact with his family and few, if any friends. He lives alone in a studio apartment with his cat, Paula, whom he adores. He is currently unemployed and has given up trying to find work. He drinks heavily, smokes weed several times a day and seldom eats. He recently was found by his neighbor on the roof of their building, saying that he was going to jump and end it all. The neighbor is concerned that he is suicidal – you are asked to assess him.

Client # 4

Hanna is an 85 year old, Latina, female identified, widowed woman. She lives alone in a furnished room. Her 2 grown children have pre-deceased her and her 4 grandchildren seldom visit. She has been deeply depressed, has been double dosing on her anxiety/depression medication and was recently was found by her friend to be unconscious when she dropped by to visit. She is brought into the emergency room to be evaluated you are asked to assess her.