Managing Suicide Risk & Developing a Suicide Protocol

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Disclosures

The presenter and all planners of this education activity do not have a financial/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of the presentation.

Learning Objectives

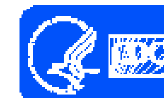
- Learn about suicide frequency, demographics, methods
- Review risk factors and protective factors for suicide
- Learn suicide prevention strategies
- Learn how to assess for suicide risk
- Learn how to create a treatment plan for a suicidal patient

SUICIDE FREQUENCY, DEMOGRAPHICS, & METHODS

10 Leading Causes of Death by Age Group, United States – 2014

Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
	Age Groups										
1	Congenital Anomalies 4,746	Unintentional Injury 1,216	Unintentional Injury 730	Unintentional Injury 750	Unintentional Injury 11,836	Unintentional Injury 17,357	Unintentional Injury 16,048	Malignant Neoplasms 44,834	Malignant Neoplasms 115,282	Heart Disease 489,722	Heart Disease 614,348
2	Short Gestation 4,173	Congenital Anomalies 399	Malignant Neoplasms 436	#2	#2	#2	Malignant Neoplasms 11,267	Heart Disease 34,791	Heart Disease 74,473	Malignant Neoplasms 413,885	Malignant Neoplasms 591,699
3	Maternal Pregnancy Comp. 1,574	Homicide 364	Congenital Anomalies 192	Malignant Neoplasms 416	Homicide 4,144	Homicide 4,159	Heart Disease 10,368	Unintentional Injury 20,610	Unintentional Injury 18,030	Chronic Low. Respiratory Disease 124,693	Chronic Low. Respiratory Disease 147,101
4	SIDS 1,545	Malignant Neoplasms 321	Homicide 123	Congenital Anomalies 156	Malignant Neoplasms 1,569	Malignant Neoplasms 3,624	#4	#4	Chronic Low. Respiratory Disease 16,492	Cerebro-vascular 113,308	Unintentional Injury 136,053
5	Unintentional Injury 1,161	Heart Disease 149	Heart Disease 69	Homicide 156	Heart Disease 953	Heart Disease 3,341	Homicide 2,588	Liver Disease 8,627	Diabetes Mellitus 13,342	Alzheimer's Disease 92,604	Cerebro-vascular 133,103
6	Placenta Cord. Membranes 965	Influenza & Pneumonia 109	Chronic Low. Respiratory Disease 68	Heart Disease 122	Congenital Anomalies 377	Liver Disease 725	Liver Disease 2,582	Diabetes Mellitus 6,062	Liver Disease 12,792	Diabetes Mellitus 54,161	Alzheimer's Disease 93,541
7	Bacterial Sepsis 544	Chronic Low Respiratory Disease 53	Influenza & Pneumonia 57	Chronic Low Respiratory Disease 71	Influenza & Pneumonia 199	Diabetes Mellitus 709	Diabetes Mellitus 1,999	Cerebro-vascular 5,349	Cerebro-vascular 11,727	Unintentional Injury 48,295	Diabetes Mellitus 76,488
8	Respiratory Distress 460	Septicemia 53	Cerebro-vascular 45	Cerebro-vascular 43	Diabetes Mellitus 181	HIV 583	Cerebro-vascular 1,745	Chronic Low. Respiratory Disease 4,402	#8	Influenza & Pneumonia 44,836	Influenza & Pneumonia 55,227
9	Circulatory System Disease 444	Benign Neoplasms 38	Benign Neoplasms 36	Influenza & Pneumonia 41	Chronic Low Respiratory Disease 178	Cerebro-vascular 579	HIV 1,174	Influenza & Pneumonia 2,731	Septicemia 5,709	Nephritis 39,957	Nephritis 48,146
10	Neonatal Hemorrhage 441	Perinatal Period 38	Septicemia 33	Benign Neoplasms 38	Cerebro-vascular 177	Influenza & Pneumonia 549	Influenza & Pneumonia 1,125	Septicemia 2,514	Influenza & Pneumonia 5,390	Septicemia 29,124	#10

Data Source: National Vital Statistics System, National Center for Health Statistics, CDC.
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.



Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Age-adjusted suicide rates, by s United States, 1999–2014

gender

16% ↑

24% ↑

45% ↑

0.01%

Deaths per 100,000 in specified group

23
20
15
10
5
0

17.8
Male
20.7

10.5
Total
13.0

4.0
Female
5.8

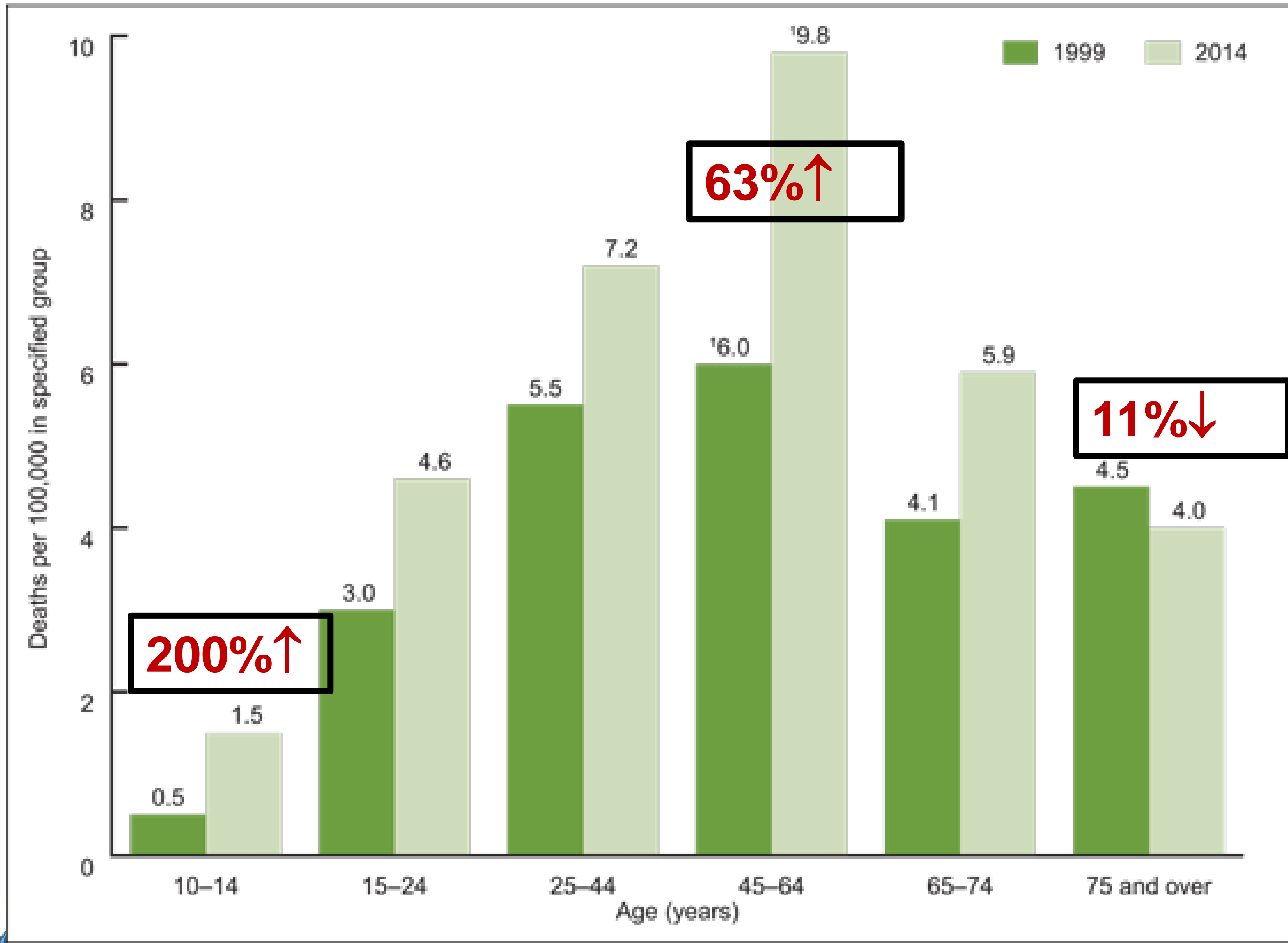
1999 2000 2002 2004 2006 2008 2010 2012 2014

Center for Clinical Systems Improvement

SOURCE: NCHS, National Vital Statistics System, Mortality.

Suicide rates for females, by age: United States, 1999 and 2014

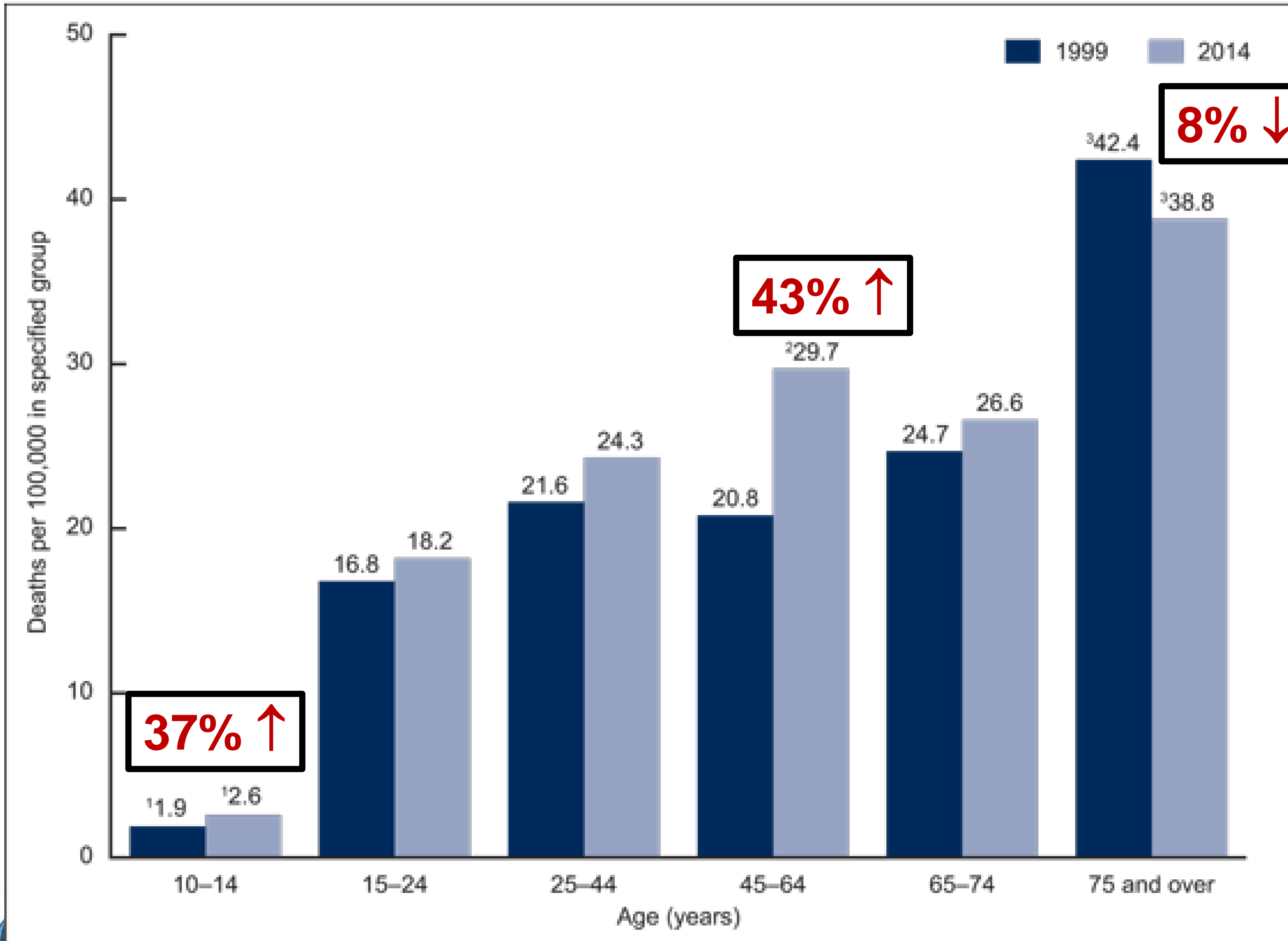
females



[1]Significantly higher than rates for all other age groups ($p < 0.05$).
SOURCE: NCHS, National Vital Statistics System, Mortality.

Suicide rates for males, by age: United States, 1999 and 2014

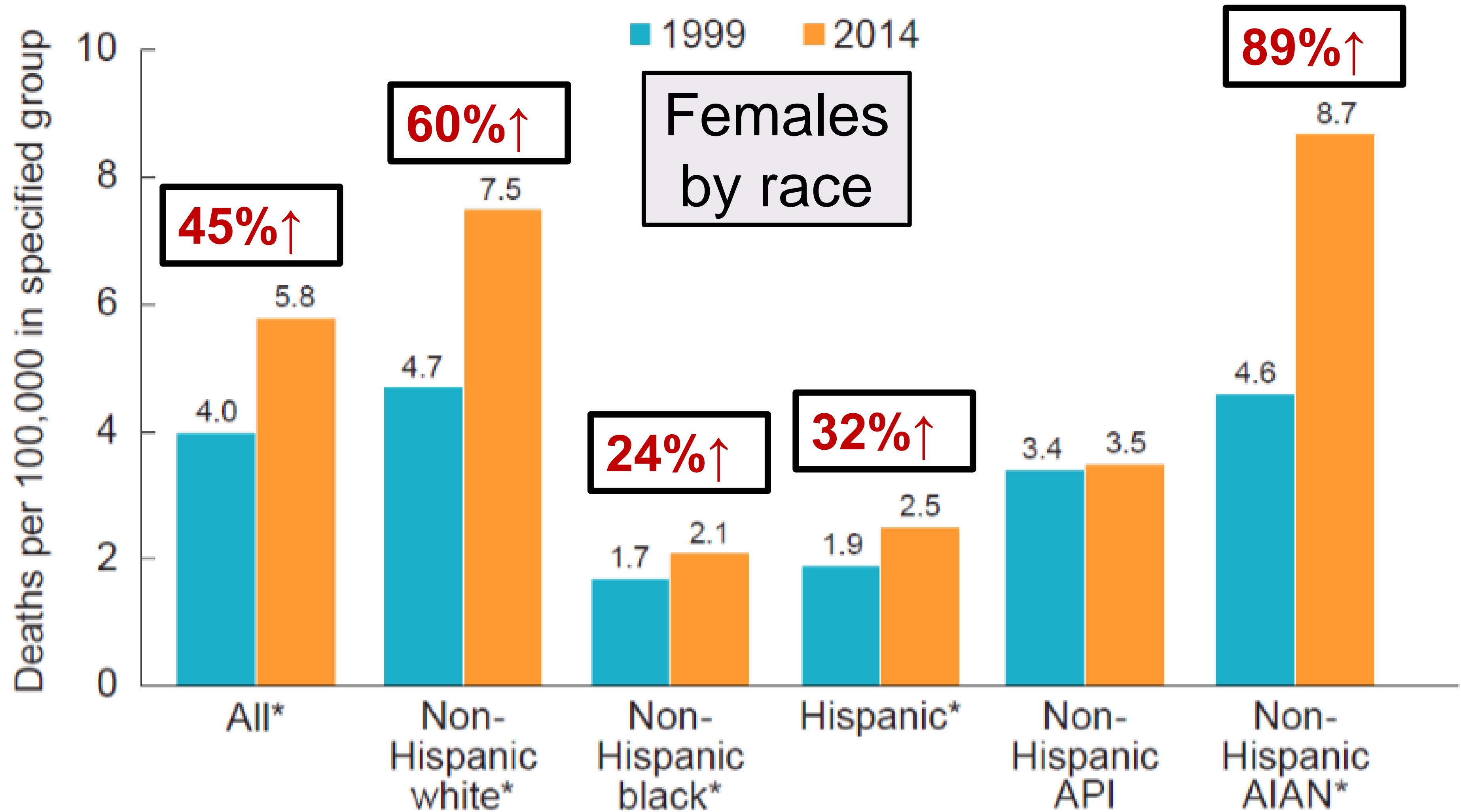
males



Center for Clinical Systems Improvement

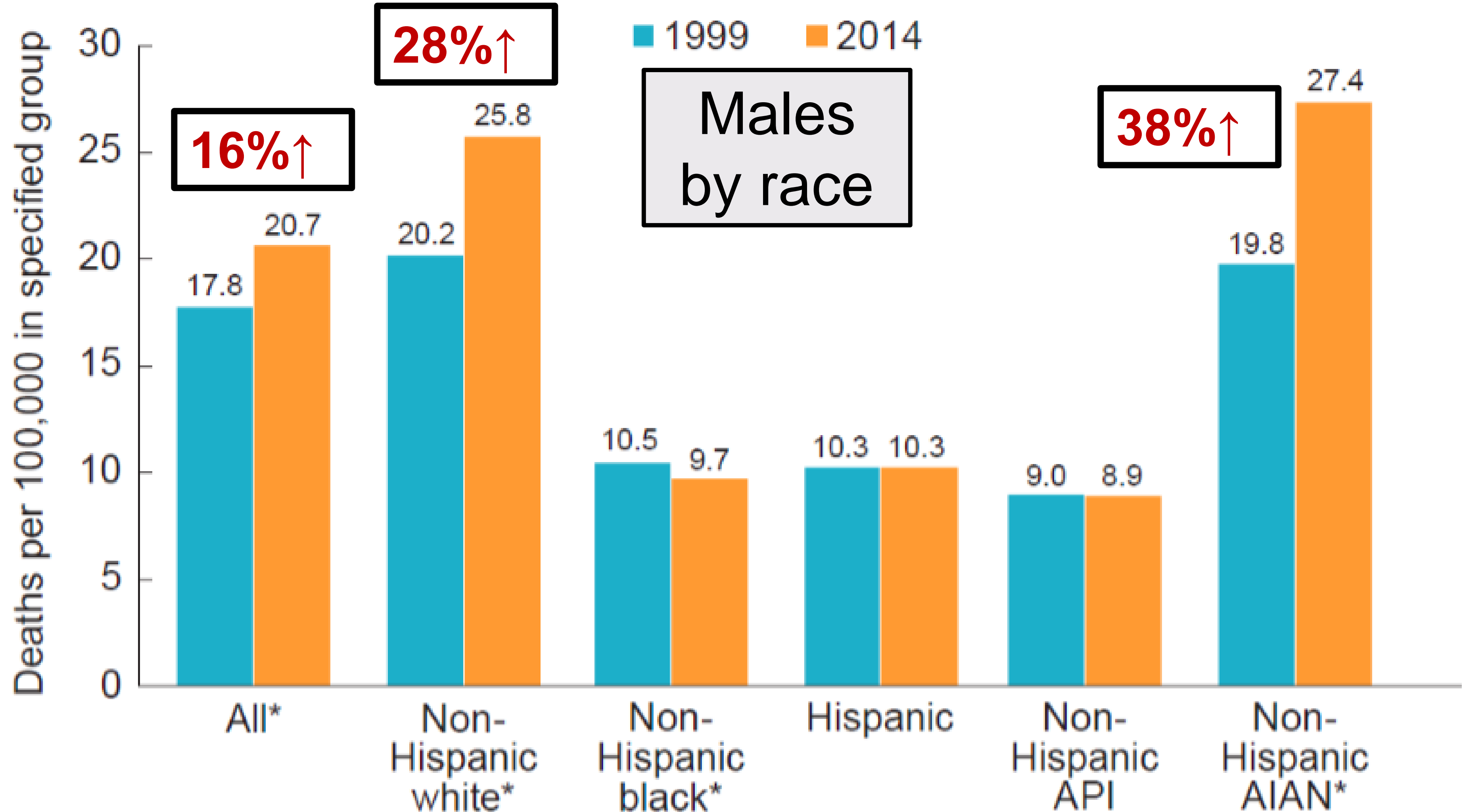
SOURCE: NCHS, National Vital Statistics System, Mortality.

Figure 1. Age-adjusted suicide rates for females, by race and Hispanic origin: United States, 1999 and 2014



* Difference in rates between 1999 and 2014 was significant ($p < 0.05$).
NOTES: Suicide is identified with ICD-10 codes U03, X60–X84, and Y87.0. Death rates for non-Hispanic American Indian or Alaska Native (AIAN), non-Hispanic Asian or Pacific Islander (API), and Hispanic persons may be underestimated and should be interpreted with caution; see Data source and methods.
SOURCE: CDC/NCHS, National Vital Statistics System mortality data, 1999 and 2014, available from: CDC WONDER online database.

Figure 2. Age-adjusted suicide rates for males, by race and Hispanic origin: United States, 1999 and 2014



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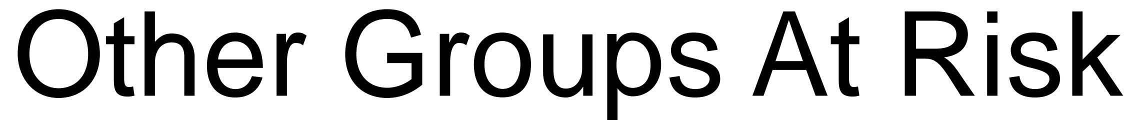


- Veterans:
  - 2x more likely to suicide
  - 18% of all U.S. suicides
- LGBT youth:
  - Attempt suicide 2-7x more than heterosexuals
  - 40+% transgender youth have attempted suicide
- Worldwide suicide rate highest amongst Eastern Europeans.

VA Suicide Prevention Program *Facts about Veteran Suicide July 2016*
Marshall A. Suicide Prevention: An Unmet Need. *Yale J Biol Med*. 2016;89(2):205–213
www.CDC.gov Suicide Facts at a Glance

Suicide Deaths by Method, 2015

Other: 7.9 %

Falls
Drowning
Cutting

Suffocation: 26.8 %

Firearm: 49.8 %

Poisoning: 15.4 %

Most common method for males

Most common method for females

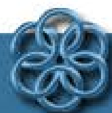
Highcharts.com

www.CDC.gov

Suicide and Primary Care

- Prescribe **most** (62%) antidepressants
- See suicidal patients **twice** as often MHPs
- Most likely to see suicidal patients in **month before death**
- Only 20% see a MHP in the **preceding month**

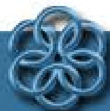
McDowell et al **Practical Suicide-Risk Management** *Mayo Clin Proc.* **2011;86(8):792-800**



Suicide and Primary Care

- Patients not asked about suicide
- Suicidal thoughts, behavior inadequately assessed & managed
- Insufficient length of treatment
- Medications not adjusted often enough
- Comorbid alcohol problems unidentified and untreated

McDowell et al **Practical Suicide-Risk Management** ***Mayo Clin Proc.*** **2011;86(8):792-800**



RISK FACTORS FOR SUICIDE

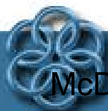
Risk Factors for Suicide

- Prior suicide attempt(s)
  - 5-6x more likely to make another attempt
- Current psychiatric illness lifetime suicide risk
  - 90-95% of suicides diagnosed with psychiatric illness – strongest single predictive factor of suicide
  - Major Depression – 15%
  - Bipolar – 15-25%
  - Schizophrenia – 10-12%
- Following inpatient care – especially w/in 7 days of D/C
  - 1/3 occur within 1 month of D/C
- Increased risk with substance use

McDowell et al **Practical Suicide-Risk Management** *Mayo Clin Proc.* **2011;86(8):792-800**

Demographic Risk Factors for Suicide

- Caucasian
- Male – more likely to die by suicide 3:1
- Women – more likely to attempt suicide 4:1
- Increasing age (men>75)
- Physicians
- Family history of suicide (1st degree relative who committed suicide increases risk 6x)
- Heritability of suicide is 30-50%



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Social Risk Factors for Suicide

- Easy access to lethal means
- Barriers to mental health
- Smoker
- PTSD
- Chronic pain
- TBI
- Lack of social supports
- Living alone
- Divorced/chaotic home life
- Occupational issues or unemployment
- Legal trouble/incarceration
- Cultural/religious beliefs
- Terminally ill

- Homosexuality
- Parental separation
- Abuse
- Bullying
- Local cluster of suicides/contagion
- Media glamorization
- Direct and indirect exposure to suicidal behavior - especially in adolescents and young adults.

- Anxiety or agitation
- Impulsive or reckless actions
- Insomnia
- Increased alcohol or drug use
- Increased or decreased sleep/insomnia
- Dramatic mood changes
- Threats to harm self
- Planning for suicide
- Talking/writing about suicide
- Hopelessness
- No purpose or reason for living
- Rage, anger, seeking revenge
- Feeling trapped
- Social withdrawal
- Interpersonal loss or rejection/shame

McDowell et al **Practical Suicide-Risk Management** ***Mayo Clin Proc.*** **2011;86(8):792-800**

Anti-depressants and Suicide Risk

- Higher risk of suicidal thoughts or attempts after:
  - Initiation of treatment
  - Discontinuation of treatment
  - Dose changes
- Indications for patient care:
  - Monitor closely at the start of treatment
  - Contact prescriber before stopping/changing med

www.fda.gov

Anti-depressants and Suicide Risk

The benefits far outweigh the risks.

TABLE 3. **Revised Insert Guidance for Black Box Warning**

Age range (y)	Drug-placebo difference in number of cases of suicidality per 1000 patients treated
Drug-related increases	
<18	14 additional cases
18-24	5 additional cases
Drug-related decreases	
25-64	1 fewer case
≥65	6 fewer cases

Protective factors

- No protective factors for those at high risk

- For low to moderate risk:
  - Coping skills
  - Distress tolerance
  - Religious/spiritual beliefs
  - Responsibility (kids, pets)
  - Social support/family
  - Parenthood, especially for mothers
  - Positive relationships (including with treatment team)

McDowell et al **Practical Suicide-Risk Management** ***Mayo Clin Proc.*** **2011;86(8):792-800**

PREVENTION

Suicide is impossible to predict…

…but CAN be prevented, and risk can and must be assessed

Screen

- Screen for depression:
  - PHQ-9
    - Score > 9
    - Explore more if question #9 is 1+
    - Risk of suicide attempt or death linearly related to response to question #9

- Screen for substance use disorder:
  - AUDIT (10 questions)

Other Screening Tools

- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)
- Collaborative Assessment and Management of Suicidality (CAMS)

https://www.integration.samhsa.gov/clinical-practice/screening-tools#suicide

Assess Risk

- Have a copy of:
  - Your agency's suicide protocol
  - Safety plan template
- Don't worry (or stay late) alone
  - Ask PCP or other colleague to assist you
  - Curbside consultation if available
  - Review your checklist with a colleague
- Assess for risk:
  - Low
  - Moderate
  - High

Assess Risk

- Suicide/SI is not a normal response to stress

- Consider that it is delusional to believe:
- Your loved ones are better off without you
- There is no chance for improvement
- Your life has no worth or meaning

Assess Risk

- NO psychiatric patient is zero risk!
- That means, every psychiatric patient you see has SOME suicide risk – it is your job to assess what that risk is
- Assess motivation, don't rely on just asking them about it
- Do not rely on SI/question #9 to determine risk:
  - Previous attempts?
  - Gestures?
  - Recent or prior hospitalization, PHP, IOP, rehab?
  - Recent stressors, loss, grief?
  - Lack of supports?
  - Family history of suicide?
  - "I just want to sleep and never wake up, but I would never kill myself" is NOT a zero risk statement!

Assess Risk

- Ask **every** patient, every time
- Do you feel hopeless? Like your life is meaningless? Like there is no reason to wake up in the morning? You would rather be dead or sleep and never wake up?
- Do you have any thoughts of death or dying?
- Do you have thoughts to harm or kill yourself?
- Do you have a plan to harm or kill yourself? If so, what is it?
- Have you acted on this plan in any way?
- Do you have access to a gun, knife, rope, medications, etc?
- Have you ever intentionally harmed yourself?
- Have you ever attempted to kill yourself?
- Has anyone in your family attempted or completed suicide?

Assess Risk

- If they can’t assure you of their safety, they are not safe
- Ask for clarification
- “What will killing yourself solve?”
- “What’s stopped you from killing yourself so far?”
- “Have you taken any action or made any plans for suicide?”
- “How does your religion feel about suicide?”
- “How would this affect your loved ones? Your kids/pets?”
- “What are your plans for the rest of the day/weekend?”
- “Do you have friends or family you can stay with?”
- “Who can we call to give you some support right now?”

Assess Risk

- Is the patient intoxicated?
- Is there a brain injury or illness?
- Is the patient agitated?
- Psychotic/delusional? Manic?
- Sleep deprived?
- Impulsive?

High Risk

- Moderate to severe depression
- Current mania
- Current psychosis
- Substance abuse in last month
- Suicidal intent
- Suicidal plan
- Severe anxiety/panic
- Severe anhedonia
- Hopelessness
- Insomnia
- Acute stressor/loss
- Veteran
- Impulsive (especially teens)

Moderate Risk

- Mild depression
- Current hypomania
- Dual diagnosis
- Moderate anxiety/panic
- Suicidal ideation
- History of suicide attempts/self-harm
- Family history of suicide
- Chronic severe pain
- Issues related to gender identity

Low Risk

- Anxiety
- Depression in remission
- Bipolar in remission
- Psychotic disorder in remission
- Any other Axis I or II disorder

Treatment Plan

- Level of care
  - High risk - same day psychiatric evaluation – inpatient, PHP, inpatient rehab
  - Moderate risk – psychiatric evaluation/follow-up w/in 48 hours, urgent psych intake, IOP
  - Low risk - psychiatric evaluation/follow-up w/in 7 days
  - Call patient immediately after missed appointments

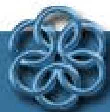
- Referrals
  - Therapy
  - Psychiatry
  - Substance use treatment

- Create a safety plan with the patient

- Contact family
  - Gather collateral information
  - Give family resources for local CMH/crisis numbers
  - Involve them in safety planning

- Restrict means

- Utilize collaborative care model for depression:
  - Decreased suicidal behavior
  - Faster time to treatment & remission of depression



Suicide Contract vs. Safety Plan

- No-suicide contracts do NOT prevent suicide
- Safety plans can:
  - Warning signs
  - Internal distraction
  - External distraction
  - Social support
  - Access to care
  - Restricting means

Kelly and Knudson, 2000

Brown Stanley safety plan template

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. ____________________
2. ____________________
3. ____________________

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. ____________________
2. ____________________
3. ____________________

Step 3: People and social settings that provide distraction:

1. Name____________________ Phone____________
2. Name____________________ Phone____________
3. Place____________________ 4. Place____________________

Step 4: People whom I can ask for help:

1. Name____________________ Phone____________
2. Name____________________ Phone____________
3. Name____________________ Phone____________

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name____________________ Phone____________
   Clinician Pager or Emergency Contact # ____________________
2. Clinician Name____________________ Phone____________
   Clinician Pager or Emergency Contact # ____________________
3. Local Urgent Care Services____________________
   Urgent Care Services Address____________________
   Urgent Care Services Phone____________________
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. ____________________
2. ____________________

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The one thing that is most important to me and worth living for is:

____

Restrict Means

- Education about locking up firearms
- Medications (prescription and OTC)
- Knives, razors
- Ropes, belts
- Roof, bridges

Documentation

- Risk level and rationale
- Treatment plan and rationale
- Safety/crisis plan
- Restriction of means
- Collateral information collected
- Follow-up plan
- Consultation

Case

45 y/o divorced, single, female, answers 2 on question 9 of PHQ-9 in your office today.

- 4 weeks of depression after she was fired from her job
- SI past week: "**Life would be easier if I were dead.**"
- Endorses SI, denies intent, or plan "I just need to sleep."
- No prior suicide attempts
- No firearms, or other lethal means
- Looking forward to job interview on Monday
- Panic attacks and insomnia for past 2 weeks
- On Lexapro 5mg daily, ran out 1 week ago
- No kids, no pets
- Lives alone
- No plans for the weekend
- No substance use

Sample Treatment Plan & Documentation

- Risk:
  - **MODERATE**
- Risk level based on your clinical judgment (how worried are you?)
- Acute thoughts of suicide in the past week
- Currently denies any suicidal intent or plan
- Hopeful, future oriented (job interview Monday, 9am)
- No access to firearms, other weapons, or stockpile of meds
- No history of suicide attempts
- Judgement intact – no psychosis, TBI, intoxication, impulsiveness
- Anxiety, insomnia
- Lives alone, no dependents, financial strain, no structure

Sample Treatment Plan & Documentation

- Declined voluntary hospitalization, no indication for involuntary as patient denies current suicide intent or plan
- Spoke with patient’s sister, who remove razors from patient’s home; will stay with her over weekend. Discussed with sister to call 911 if concerned about patient’s safety. Also given local CMH contact information if needs more resources, wants to initiate hospitalization.
- Safety/crisis planning done with patient, copy on her phone:
  - Warning signs – getting weepy, urge to cut forearms
  - Internal distraction – take a hot shower, play with cat, watch favorite movie
  - External distraction – call sister or Mom
  - Social support – sister, Mom
  - Access to care – call CMH, call crisis line, call clinic during business hours
  - Restrict means – sister will remove razors from the home

Sample Treatment Plan & Documentation

- Plan discussed with PCP - Restart Lexapro 5mg/day to treat depression/anxiety; start hydroxyzine 10mg (max 50mg) as needed for anxiety/insomnia, give only enough pills to cover her to psychiatry appointment to reduce risk for overdose
- F/up appointment with CM tomorrow, 12pm
- Urgent psychiatry intake scheduled for Friday at 1pm
- Pt's chart flagged for PHQ9 and risk assessment
- ER, 24/7 national suicide hotline info entered into patient's cell: 1-800-273-TALK
- Referred patient to www.nowmattersnow.org
  - Free DBT skills videos
  - Videos of patients' experiences
  - Support

The End

Thank you for attending today. We welcome you to watch the other webinars in this series. They can be found at www.miccsi.org/training/upcoming-events