Assessing Suicide Risk and Intervening with High Risk Patients

2019 Family Medicine Refresher Course

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Acknowledgments

Portions of this talk include information from:

- *Suicide Prevention Toolkit for Rural Primary Care*

Appreciation to:

- Brave patients—honest, resilient & tough
- Nike Fleming, JD
- Alison Lynch, MD
Suicide Prevention Toolkit for Primary Care Practices

SUICIDE PREVENTION TOOLKIT for PRIMARY CARE PRACTICES
A GUIDE FOR PRIMARY CARE PROVIDERS AND MEDICAL PRACTICE MANAGERS

Primary care providers have an important role to play in suicide prevention.

Focus points

- Demographics and/or risk
- Screening best practices
- Safety planning
- Office management
- Self and team care
• Men die by suicide 3.5X more than women
• Over 75% 2017 suicide deaths were white males
• Firearms account for over 50% suicide deaths
2018 National Rates
per 100,000 people

Nation: 13.9

Iowa: 14.7
SD: 19.5
MO: 18.7
WI: 14.9
MN: 13.6
NE: 13.2
IL: 11.0

Range: 7.5 (NJ)
26 (MT)
Suicide rising across the US

More than a mental health concern

Suicide rates rose across the US from 1999 to 2016.


ND: 57.6%
IA: 36.2%
NV: 1.0%
Nation: 25.4%
Iowa Scope

CDC data

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24</td>
<td>14.1</td>
</tr>
<tr>
<td>25-34</td>
<td>16.5</td>
</tr>
<tr>
<td>45-54</td>
<td>17.3</td>
</tr>
<tr>
<td>55-64</td>
<td>16.1</td>
</tr>
<tr>
<td>65-74</td>
<td>15.3</td>
</tr>
<tr>
<td>75-84</td>
<td>13.6</td>
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</tbody>
</table>

- Light blue bars represent Iowa data.
- Dark blue bars represent U.S. data.
Why?

• Primary care is source of mental health care, particularly in rural and underserved areas.

• 70% to 80% of antidepressants are prescribed in primary care.

• Approximately 45% of people who died by suicide were seen by their primary care provider within a month before their death.
Why?
• Discussion of suicidal ideation does not consistently occur with depressed patient.
  – 11% of patients with ideation discussed this with their physician.
  – 36% of providers discussed suicide with SPs presenting with depression or adjustment disorder
Screening Evidence: General Population

- USPSTF recommends screening for depression when systems are available for treatment & follow up
- USPSTF Grade “I” evidence—
  - No recommendation to screen for suicide in general population
Those at risk

• Psychiatric conditions:
  – Depression, PTSD, anxiety, psychotic disorders, substance abuse.

• Over 80% of suicide victims suffered from one or more psychiatric problems.

• Recently released from inpatient treatment

• Recovering from an attempt.
Warning Signs vs. Risk Factors

- Anxiety
- Agitation
- Sleep problems
- Concentration issues
- Hopelessness
- Social isolation
- Impulse control
- Alcohol & drug use

- White
- Male
- Hx of attempt
- Family hx of suicide
- Age
- Divorce
Adolescents & Suicide Risk

- Suicide is the second leading cause of death of US youth.
- Over 75% of youths visit primary care provider annually.

Number of Iowa teens who considered suicide climbs 50 percent in 6 years

2018 Iowa Youth Survey shows increased suicide risk; alcohol, drug use declining
Methods & Implications

<table>
<thead>
<tr>
<th>Method</th>
<th>Number of Deaths</th>
<th>Lethality</th>
<th>Irreversibility</th>
<th>Accessibility</th>
<th>Acceptability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cutting</td>
<td></td>
<td></td>
<td></td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Jumping/Falling</td>
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<td></td>
<td></td>
<td>High</td>
<td>Low</td>
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<tr>
<td>Gas Inhalation</td>
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<td></td>
<td></td>
<td>High</td>
<td>Low</td>
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<tr>
<td>Poisoning/Overdose</td>
<td></td>
<td></td>
<td></td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Suffocation/Hanging</td>
<td></td>
<td></td>
<td></td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Firearms</td>
<td></td>
<td></td>
<td></td>
<td>High</td>
<td>Low</td>
</tr>
</tbody>
</table>

Legend: Black = High, Grey = Moderate, White = Low
Key Points

• Attempters typically struggle with psychiatric and/or substance abuse issues.
• Many attempts are not planned—impulse control
• Suicidal crises are brief
• Thoughts can quickly escalate to action (teenagers, EtOH, drug use)
• Lethality of the method is critical.
• Important to reduce access to highly lethal means before an acute suicidal crisis.
<table>
<thead>
<tr>
<th>Question</th>
<th>Past Month</th>
<th>Lifetime</th>
<th>Past 3 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Have you wished you were dead or wished you could go to sleep and not wake up?</td>
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<tr>
<td>2) Have you actually had any thoughts about killing yourself?</td>
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<tr>
<td>If YES to 2. answer questions 3, 4, 5 and 6</td>
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<td>If NO to 2. go directly to question 6</td>
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<tr>
<td>3) Have you thought about how you might do this?</td>
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<tr>
<td>4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?</td>
<td>High Risk</td>
<td></td>
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</tr>
<tr>
<td>5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</td>
<td>High Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always Ask Question 6</td>
<td></td>
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<td></td>
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<tr>
<td>6) Have you done anything, started to do anything, or prepared to do anything to end your life?</td>
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<tr>
<td><em>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.</em></td>
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</tbody>
</table>

Any YES requires a behavioral health referral. If the answer to 4, 5 or 6 is YES, immediately ESCORT to Emergency Personnel for further evaluation.

DON'T LEAVE THE PERSON ALONE. STAY WITH THEM UNTIL THEY ARE IN THE CARE OF PROFESSIONAL HELP.
The Columbia Protocol for Communities and Healthcare

THE COLUMBIA PROTOCOL FOR YOUR SETTING

The Columbia Lighthouse Project provides versions of the Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS), for use in community and healthcare settings. These are places where individuals and teams have the access and opportunity to systematically assess risk and save lives. Examples include:

- First response agencies, such as police and fire departments
- Healthcare facilities
- Military installations
- Colleges and schools
- Correctional facilities

Assessing Planning

• Do you have a plan? If so, how would you do it? Where would you do it?
• Do you have the _____ (means) that you would use? Where is it right now?
• What have you done to begin carrying out your plan? Have you made other preparations?
• What stops you from carrying out your plan?
Protective Factors

- Responsibilities to family and others
- Satisfaction and enjoyment
- Social support, sense of belonging
- Problem solving, coping with stressors
- Therapeutic relationships (Provider, clergy)
- Religious faith, spiritual beliefs
Intervening

Assessment and Interventions with Potentially Suicidal Patients

Patient has suicidal ideation or any past attempt(s) within the past two months. See right for risk factors and back for assessment questions.

**High Risk**
- Patient has a suicide plan with preparatory or rehearsal behavior
- Patient has severe psychiatric symptoms and/or acute precipitating event, access to lethal means, poor social support, impaired judgment

**Moderate Risk**
- Patient has suicidal ideation, but limited suicidal intent and no clear plan; may have had previous attempt
- Patient does not have access to lethal means, has good social support, intact judgment; psychiatric symptoms, if present, have been addressed

**Low Risk**
- Patient has thoughts of death only; no plan or behavior

Evaluate for psychiatric disorders, stressors, and additional risk factors

- Hospitalize, or call 911 or local police if no hospital is available. If patient refuses hospitalization, consider involuntary commitment if state permits
- Take action to prevent the plan
- Consider (locally or via telemedicine):
  1. psychopharmacological treatment with psychiatric consultation
  2. alcohol/drug assessment and referral, and/or
  3. individual or family therapy referral

Encourage social support, involving family members, close friends and community resources. If patient has therapist, call him/her in presence of patient.

Record risk assessment, rationale, and treatment plan in patient record. Complete tracking log entry, and continue to monitor patient status via repeat interviews, follow-up contacts, and collaboration with other providers. Make continued entries in tracking log.
Safety Planning

1. Warning Signs
2. Coping strategies
3. People that can distract
4. Family members
5. Professionals
6. Safe environment
Implementing the Safety Plan:
6 Step Process

Step 1: Warning Signs
► Ask: “How will you know when the safety plan should be used?”
► Ask: “What do you experience when you start to think about suicide or feel extremely depressed?”
► List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patient’s own words.

Step 2: Internal Coping Strategies
► Ask: “What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?”
► Assess likelihood of use: Ask: “How likely do you think you would be able to do this step during a time of crisis?”
► If doubt about use is expressed, ask: “What might stand in the way of you thinking of these activities or doing them if you think of them?”
► Use a collaborative, problem solving approach to address potential roadblocks and ID alternative coping strategies.

Step 3: Social Contacts Who May Distract from the Crisis
► Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
► Ask: “Who or what social settings help you take your mind off your problems at least for a little while?” “Who helps you feel better when you socialize with them?”
► Ask for safe places they can go to be around people (i.e. coffee shop).
► Ask patient to list several people and social settings in case the first option is unavailable.
► Remember, in this step, the goal is distraction from suicidal thoughts and feelings.
► Assess likelihood that patient will engage in this step; ID potential obstacles, and problem solve, as appropriate.

Step 4: Family Members or Friends Who May Offer Help
► Instruct patients to use Step 4 if Step 3 does not resolve crisis or lower risk.
► Ask: “Among your family or friends, who do you think you could contact for help during a crisis?” or “Who is supportive of you and who do you feel that you can talk with when you’re under stress?”
► Ask patients to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
► Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
► Role play and rehearsal can be very useful in this step.

Step 5: Professionals and Agencies to Contact for Help
► Instruct the patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
► Ask: “Who are the mental health professionals that we should identify to be on your safety plan?” and “Are there other health care providers?”
► List names, numbers and/or locations of clinicians, local urgent care services.
► Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
► Role play and rehearsal can be very useful in this step.

Step 6: Making the Environment Safe
► Ask patients which means they would consider using during a suicidal crisis.
► Ask: “Do you own a firearm, such as a gun or rifle?” and “What other means do you have access to and may use to attempt to kill yourself?”
► Collaboratively identify ways to secure or limit access to lethal means:
   Ask: ”How can we go about developing a plan to limit your access to these means?”
Things to Consider

- Family, support
- Ability to see patient again soon
- Patient’s level of anxiety & distress.
- Substance use
- Your own comfort level
- Likelihood of following referral suggestions
- Prior attempts, psych history
- Availability of methods/means
Emergency Holds

• Iowa Statute allows for holding until patient can be transported to an ER or acute treatment setting.
  – I am very concerned about your safety if you leave here and we need to get you help.
  – I understand that you are upset and I am worried about your safety. My job is to keep you safe.
  – We are going to keep you here to transport you to: __________________
Office Plan of Action

Things to consider:

– How will you screen? Who will screen?
– Where can you send patients?
– How will you hold patients?
– Who will stay with patient until police or transport arrive?
– Who will notify family or emergency contact?
– Who will notify the hospital if immediate hospitalization is required?
– Consult risk management and administration.
Office Protocol for Suicidal Patients – Office Template

Post in a visible or accessible place for key office staff.

- If a patient presents with suicidal ideation or suicidal ideation is suspected and detected with screening questions...
  - ____________________________ should be called/paged to assist with suicide risk assessment (e.g. physician, mental health professional, telemedicine consult, etc.).
  - ____________________________ should be called/paged to assist with collaborative safety planning.
  - Identify and call patient’s support person in the community (e.g. family member, pastor, mental health provider, other support person).

If patient requires hospitalization...

- Our nearest Emergency Department or psychiatric emergency center is ____________________________.
- Phone # ____________________________.
- ____________________________ will call ____________________________ to arrange transport.
  (Means of transport (ambulance, police, etc.) and phone #)
- Backup transportation plan: Call ____________________________.
  ____________________________ will wait with patient for transport.

Documentation and follow-up...

- ____________________________ will call ED to provide patient information.
  (Name of individual or job title)
- ____________________________ will document incident in ____________________________ (e.g. medical chart, suicide tracking chart, etc.).
- ____________________________ will follow-up with ED to determine disposition of patient.
  (Name of individual or job title)
- ____________________________ will follow-up with patient within ____________________________ (Time frame)
Non-Suicidal Self-Injury (NSSI)

• 15% adolescents
• Up to 22% in primary care.
• Differs in intent—reduce negative emotions.

• What impact is this having on your life?
• It sounds like it's difficult to handle the stress in your life without self-injuring.
• What do you think you would need to help you stop self-injuring?
Your Life Iowa

Alcohol
Whether you are an individual concerned with your own use of alcohol, or a concerned family member or friend. We can get you in touch with experts that can help.

Drugs
Whether it is Marijuana, Methamphetamine, prescription medications or use of another drug, we can get you in touch with experts that can help.

Gambling
Whether you are an individual concerned with your own gambling, or a concerned family member or friend. We can get you in touch with experts that can help.

Suicide
If you or someone you know has thoughts of suicide we can help through resources and connections to support. Connecting with help is the first step to changing your life.

https://yourlifeiowa.org/
www.MY3app.org

Target audience: Those at risk for suicide

Purpose:
Getting those at risk for suicide connected to their primary support network when they are in crisis; also provides safety planning and other helpful resources
References

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