Suicide Prevention, Assessment, and Intervention

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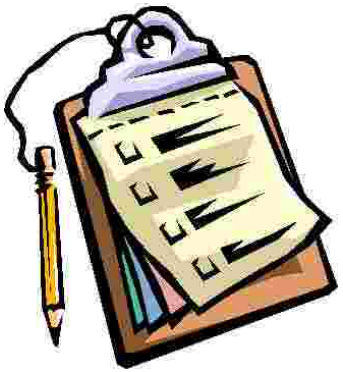
May, 7, 2020

Objectives



- Analyze issues related to suicide risk
- Describe the role of the nurse or clinician in assessment, management and referral of the suicidal client
- Discuss appropriate follow-up for long-term management of the suicidal client

Infectious Disease > COVID-19

COVID-19 and Suicide: 'A Perfect Storm'?

— Suicide prevention should be considered in public health plans, researchers argue

by Elizabeth Hlavinka, Staff Writer, MedPage Today April 10, 2020

What happens when a global pandemic coincides with a national suicide crisis?

Secondary outcomes of the COVID-19 coronavirus such as economic stress and decreased access to mental health treatment risk colliding with a rising suicide rate

MEDPAGE TODAY, 2019

Question

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

- A. True
- B. False

Case Study

- A community nurse in a large urban center is asked to see Julian. Julian, a 22-year-old man who identifies as Anishinabe, has entered the clinic and requested to see a physician or nurse. He shows minimal emotion (i.e. flat effect), and seems preoccupied and restless. He shares that he is experiencing suicidal thoughts

What is the first thing the nurse should do?

- A. Ask what brings him to the clinic and attempts to understand what she might do to make him comfortable.
- B. Completes a history that includes questions about his family and community
- C. Reflect on her own assumptions, beliefs and values that impact how she responds to Julian.
- D. Asks him about his beliefs about health, illness, and healing.

What is this patient's risk level?

- A. Low Acute Risk
- B. Intermediate (moderate) Acute Risk
- C. High Acute Risk
- D. Unable to determine

Definitions

- **Suicide** is defined as death caused by self-directed injurious behavior with intent to die as a result of the behavior.
- A **suicide attempt** is a non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in injury.
- **Suicidal ideation** refers to thinking about, considering, or planning suicide.

Suicide in the United States

- Suicide was the **tenth** leading cause of death overall in the United States, claiming the lives of over 47,000 people.
- Suicide was the **second** leading cause of death among individuals between the ages of 10 and 34
- There were more than twice as many suicides (47,173) in the U.S. as homicides (19,510).
- On average, 123 suicides/day

(CDC, 2017)

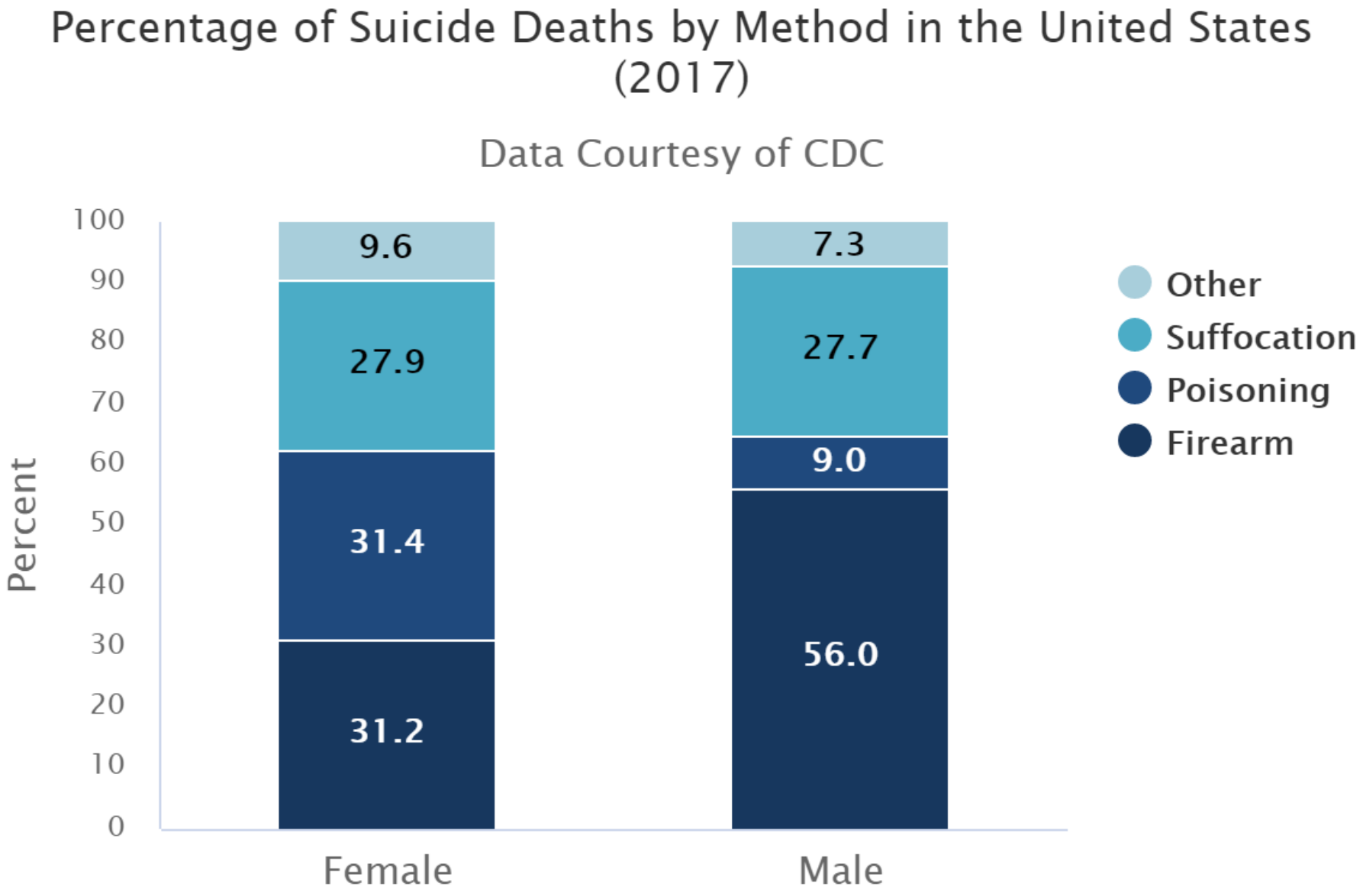
https://www.nimh.nih.gov/health/statistics/suicide.shtml

Leading Causes of Death in the United States (2016)

Data Courtesy of CDC

	Select Age Groups							
Rank	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Unintentional Injury 847	Unintentional Injury 13,895	Unintentional Injury 23,984	Unintentional Injury 20,975	Malignant Neoplasms 41,291	Malignant Neoplasms 116,364	Heart Disease 507,118	Heart Disease 635,260
2	**Suicide 436**	**Suicide 5,723**	**Suicide 7,366**	Malignant Neoplasms 10,903	Heart Disease 34,027	Heart Disease 78,610	Malignant Neoplasms 422,927	Malignant Neoplasms 598,038
3	Malignant Neoplasms 431	Homicide 5,172	Homicide 5,376	Heart Disease 10,477	Unintentional Injury 23,377	Unintentional Injury 21,860	CLRD 131,002	Unintentional Injury 161,374
4	Homicide 147	Malignant Neoplasms 1,431	Malignant Neoplasms 3,791	**Suicide 7,030**	**Suicide 8,437**	CLRD 17,810	Cerebro-vascular 121,630	CLRD 154,596
5	Congenital Anomalies 146	Heart Disease 949	Heart Disease 3,445	Homicide 3,369	Liver Disease 8,364	Diabetes Mellitus 14,251	Alzheimer's Disease 114,883	Cerebro-vascular 142,142
6	Heart Disease 111	Congenital Anomalies 388	Liver Disease 925	Liver Disease 2,851	Diabetes Mellitus 6,267	Liver Disease 13,448	Diabetes Mellitus 56,452	Alzheimer's Disease 116,103
7	CLRD 75	Diabetes Mellitus 211	Diabetes Mellitus 792	Diabetes Mellitus 2,049	Cerebro-vascular 5,353	Cerebro-vascular 12,310	Unintentional Injury 53,141	Diabetes Mellitus 80,058
8	Cerebro-vascular 50	CLRD 206	Cerebro-vascular 575	Cerebro-vascular 1,851	CLRD 4,307	**Suicide 7,759**	Influenza & Pneumonia 42,479	Influenza & Pneumonia 51,537
9	Influenza & Pneumonia 39	Influenza & Pneumonia 189	HIV 546	HIV 971	Septicemia 2,472	Septicemia 5,941	Nephritis 41,095	Nephritis 50,046
10	Septicemia 31	Complicated Pregnancy 184	Complicated Pregnancy 472	Septicemia 897	Homicide 2,152	Nephritis 5,650	Septicemia 30,405	**Suicide 44,965**

https://www.nimh.nih.gov/health/statistics/suicide.shtml



In Primary Care:

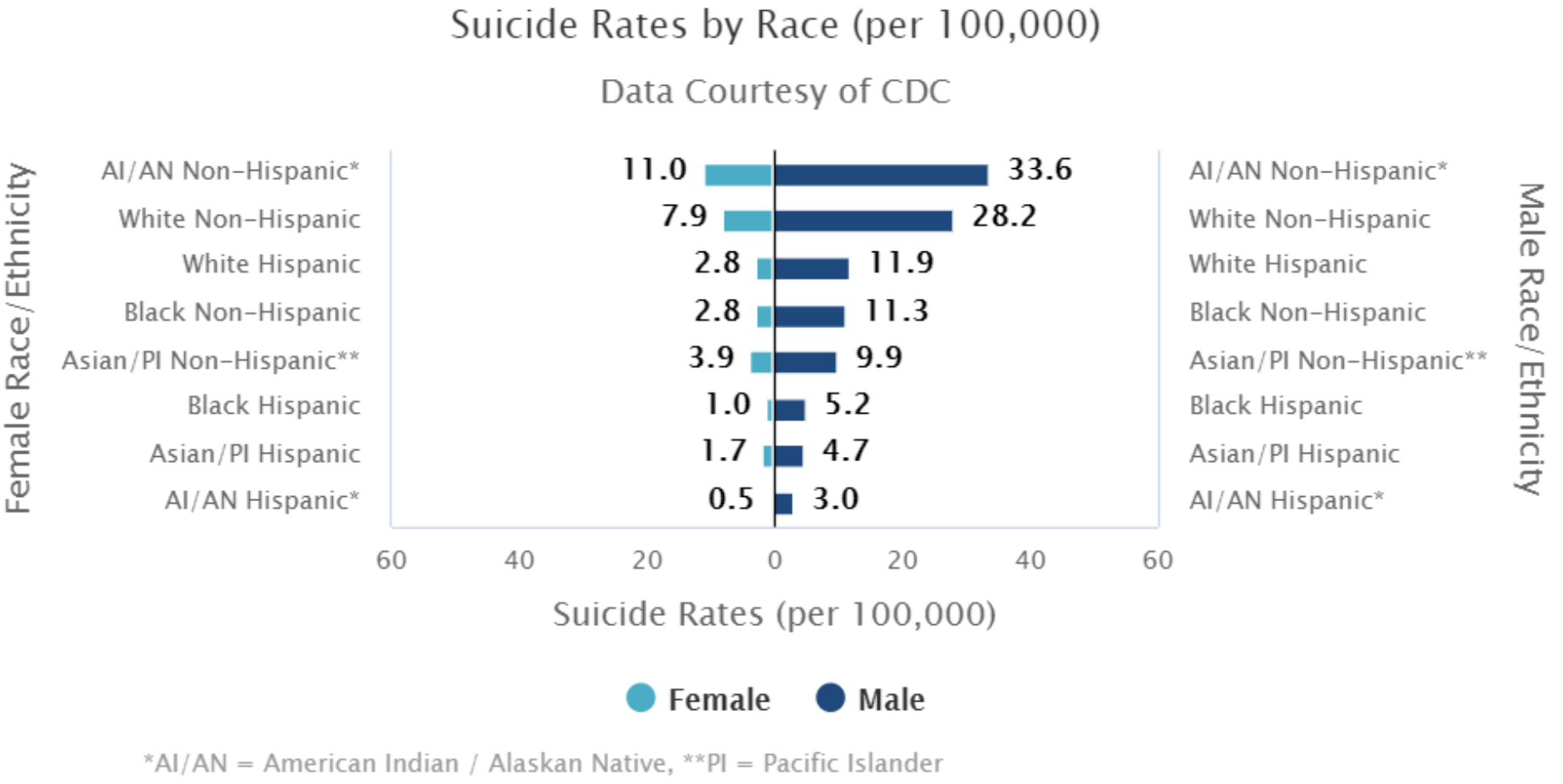
- At least 2/3's of suicide deaths occur within about 30 days of a medical contact, be that an emergency department (ED), a primary care practice, or a mental health professional.
- 83% of individuals who died by suicide had a health care visit in the year prior and contact with a PCP was the most common type of visit (64%)

Comorbidity

- Adults with a mental illness are at increased risk for attempting and completing suicide
- More than 70% of adults who have attempted suicide have an anxiety disorder
- Adults who has a Substance Use Disorder (SUD) or Major Depressive Disorder (MDD) episode within the past year have higher rates of suicidal thoughts, plans, and attempts

Epidemiology

- High Risk Populations
- Gender
- Age
- Race/Ethnicity
- LGBTQ
- Mental Illness
- Veterans


Suicide Rates by Race (per 100,000)
Data Courtesy of CDC
Female Race/Ethnicity
Male Race/Ethnicity
AI/AN Non-Hispanic*
White Non-Hispanic
White Hispanic
Black Non-Hispanic
Asian/PI Non-Hispanic**
Black Hispanic
Asian/PI Hispanic
AI/AN Hispanic*
11.0
33.6
7.9
28.2
2.8
11.9
2.8
11.3
3.9
9.9
1.0
5.2
1.7
4.7
0.5
3.0
60
40
20
0
20
40
60
Suicide Rates (per 100,000)
Female
Male
*AI/AN = American Indian / Alaskan Native, **PI = Pacific Islander

CDC, 2017

Other Vulnerable Populations: Child or Adolescent

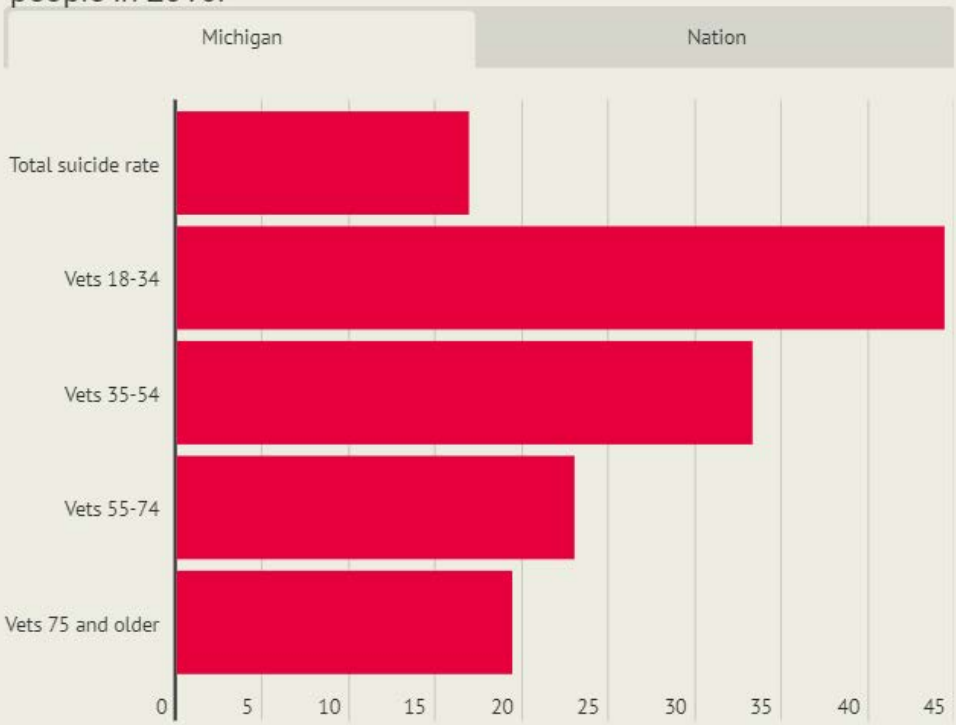
- Acute embarrassment or loss that seems major to the individual
- Strong desire to die with a definite, lethal method in mind
- Relatively older youth
- Prior attempts
- Male – 4x greater than females
- Concurrent major psychopathology
- Substance abuse
- Overall poor coping style
- High level of environmental stressors
- Poor or impaired communications with adults
- Inconsistent and chaotic family support

Veteran's and Suicide

- 6000 Veteran Suicides yearly
- Veterans are at a 1.5 x greater risk of suicide
- 69% involve firearms
- Veterans recently using VHA services have a higher rate than those who did not utilize VHA services

Veterans pay high price

Michigan veterans, especially the young, kill themselves at a higher rate than the state as a whole. Michigan suicide rates per 100,000 people in 2016:



Source: U.S. Department of Veterans Affairs

Michigan's Suicide Rate

- Spiked 33% from 1999 to 2016
- 2nd leading cause of death for ages 15-24
- Higher rates among:
  - Young people
  - Rural residents
  - Veterans
  - Famers
- Opioid use disorders link to suicide and unintentional suicide

Effective Prevention Strategies

- Train staff to recognize and respond to warning signs
- Screen for and manage depression
- Screen all patients for suicide risk
- Educate patients about warning signs for suicide
- Safety plan
- Promote connectedness
- Teach coping and problem-solving skills

Risk Factors

Health factors	Environmental factors	Historical factors
Mental health conditions:(e.g., depression, bipolar, schizophrenia, anxiety disorder)	Access to lethal means (e.g., firearms, drugs)	Previous suicide attempts
Substance use problems	Prolonged stress/harassment/bullying	Family history of suicide
Personality traits of aggression, mood changes	Stressful life events (e.g., rejection, divorce)	Childhood abuse, neglect, or trauma
Serious physical health conditions, including pain	Exposure to another person's suicide, or to graphic & sensationalized suicide accounts	
Traumatic brain injury		

There is never **one** risk factor that results in completed suicide…there are always **multiple** risk factors.

https://afsp.org

Assessing Suicide Risk

- Strongest Warning Signs – take immediate action
  - Threatening to hurt or kill one's self
  - Talking of wanting to hurt or kill one's self
  - Looking for the means to kill one's self – access to firearms, pills, etc.
  - Talking about feeling hopeless

Warning Signs

Talk	Behavior	Mood
If a person talks about:	Behaviors that may signal risk, especially if related to a painful event, loss or change:	People who are considering suicide often display one or more of the following moods:
Killing themselves	Increased use of alcohol or drugs	Depression
Feeling hopeless	Actively looking for a way to end their lives (e.g., online searching)	Anxiety
Having no reason to live	Withdrawing from activities	Loss of interest
Being a burden to others	Isolating from family and friends	Irritability
Feeling trapped	Sleeping too much or too little	Humiliation/Shame
Unbearable pain	Visiting or calling people to say goodbye	Agitation/Anger
	Giving away prized possessions	Relief/Sudden Improvement
	Aggression	
	Fatigue	

https://afsp.org

Protective Factors

- May mitigate risk in a person with moderate to low risk
  - Sense of responsibility to family
  - Life satisfaction
  - Social support; sense of belonging
  - Coping skills
  - Problem-solving skills
  - Strong therapeutic relationship with a trusted provider
  - Religious faith

Protective Factors

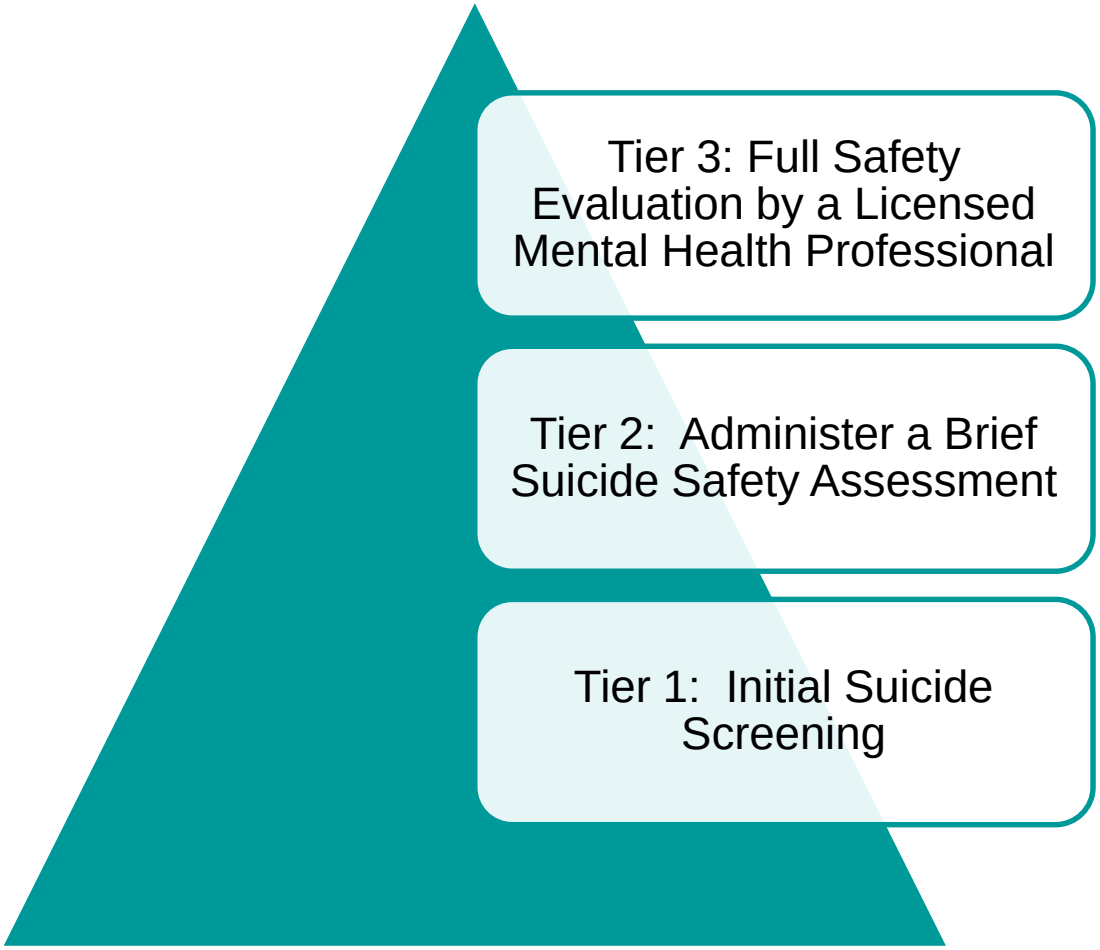
- Quality care for mental, physical and substance use disorders
- Quality family and community support
- Cultural and religious beliefs that discourage suicide
- Continuous and quality medical and mental health relationships
- Skills in problem solving, conflict resolution and nonviolent skills to handle disputes

New Research on Suicide Prevention

Recommendations for suicide prevention released by the National Action Alliance for Suicide Prevention in June 2018

Identified gap	Strategies to close the gap
Not proactively identifying intense suicide risk	Routine suicidality screening of individuals with mental illness, substance use disorder, or when injuries could be due to self-harm
Not acting effectively for safety	Safety planning (helping patients to recognize and manage suicidal thoughts) and lethal means reduction
Not providing supportive contacts for people at risk of suicide	Caring contact (via telephone, text, email, postcard, or letter) 48 hours and 1 week after health care visit for patients deemed at risk of suicide

Implementing Universal Suicide Risk In Medical Settings



Brahmbhatt K et al. 2018

Screening

- Universal screening: use of a validated screening tool to identify individuals at risk
  - Patient Health Questionnaire-2
    - Initial screening
  - Patient Health Questionnaire-9
    - Item #9 to identify suicide risk
      - "Over the past two weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?"
      - Possible Responses: "Not at all," "Several days," "More than half the days," or "Nearly every day"
  - Columbia Suicide Severity Rating Scale
    - Specialized tool (http://cssrs.columbia.edu/)

Question

- Once a person is seriously considering suicide, there is nothing you can do.

- A. True
- B. False

Question

- Suicide happens without warning.

- A. True
- B. False

Clinical Evaluation

- Evaluating a client for suicide risk does not predict its occurrence; rather it is a judgment of current likelihood of an attempt
- Discussing plans or ideas may relieve client of anxiety and guilt and establish a safe environment for full assessment of the concern

Suicide Inquiry

- Suicide is very personal:
  - Use nonjudgmental,
  - non-condescending, matter-of-fact approach
  - empathic listening

- Begin interview with general questions and move to specific.
- Look for a + response to question 9 on PHQ-9 – inquire further

Nonjudgmental Listening

- Pay close attention to:
  - Your attitudes and how they are conveyed
  - Acceptance, genuineness, and empathy
- Effective communication skills, both verbal and nonverbal
  - Ask questions to show you genuinely care.
  - Listen to what is being said and how they say it
  - Show that you are listening
  - Avoid giving unhelpful advice

Considerations

Suicidal people often experience tremendous ambivalence - appeal to the part that wants to live:

- Offer immediate emotional support
- Strengthen protective factors
- Value their experiences

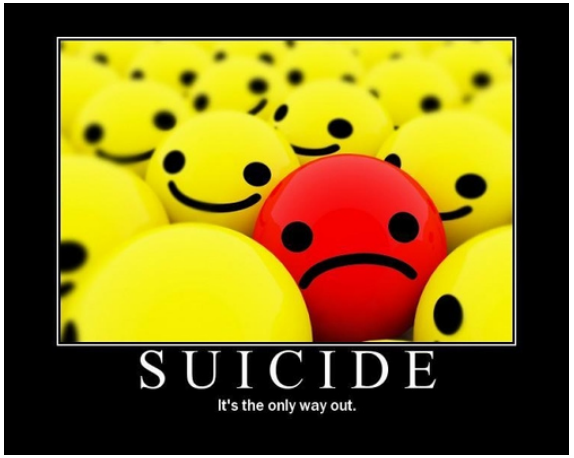
Thoughts of Suicide

- Uncover suicidal thinking
  - “Sometimes, people in your situation (describe) lose hope; I’m wondering if you may have lost hope too?”
  - “Have you ever thought about killing yourself?”
  - “Have you ever thought things would be better if you were dead?”
  - “This must be a hard time for you; what do you think about when you are feeling down?”
  - “Are you thinking of killing yourself?” If so……then ask about a plan

Prior Attempts

- A history of a prior attempt is the strongest predictor of future suicidal behavior

- “Have you ever tried to kill yourself or attempt suicide?”



Questions to Assess Suicidal Ideation

- “When did you begin having suicidal thoughts?”
- “How often do you have thoughts of suicide?” “How long do they last?” “How strong are these thoughts?”
- “What do you do when you have suicidal thoughts?”

Plan

- Ask whether the patient has a plan and if so, get specifics
  - “Do you have a plan or have you been planning to end your life? If so, how would you do it.? Where would you do it?”
  - “Do you have the means (pills, weapon, rope) that you would use? Where is it right now?”
  - “Do you have a timeline in mind for ending your life? Is there something (an event) that would trigger the plan?”

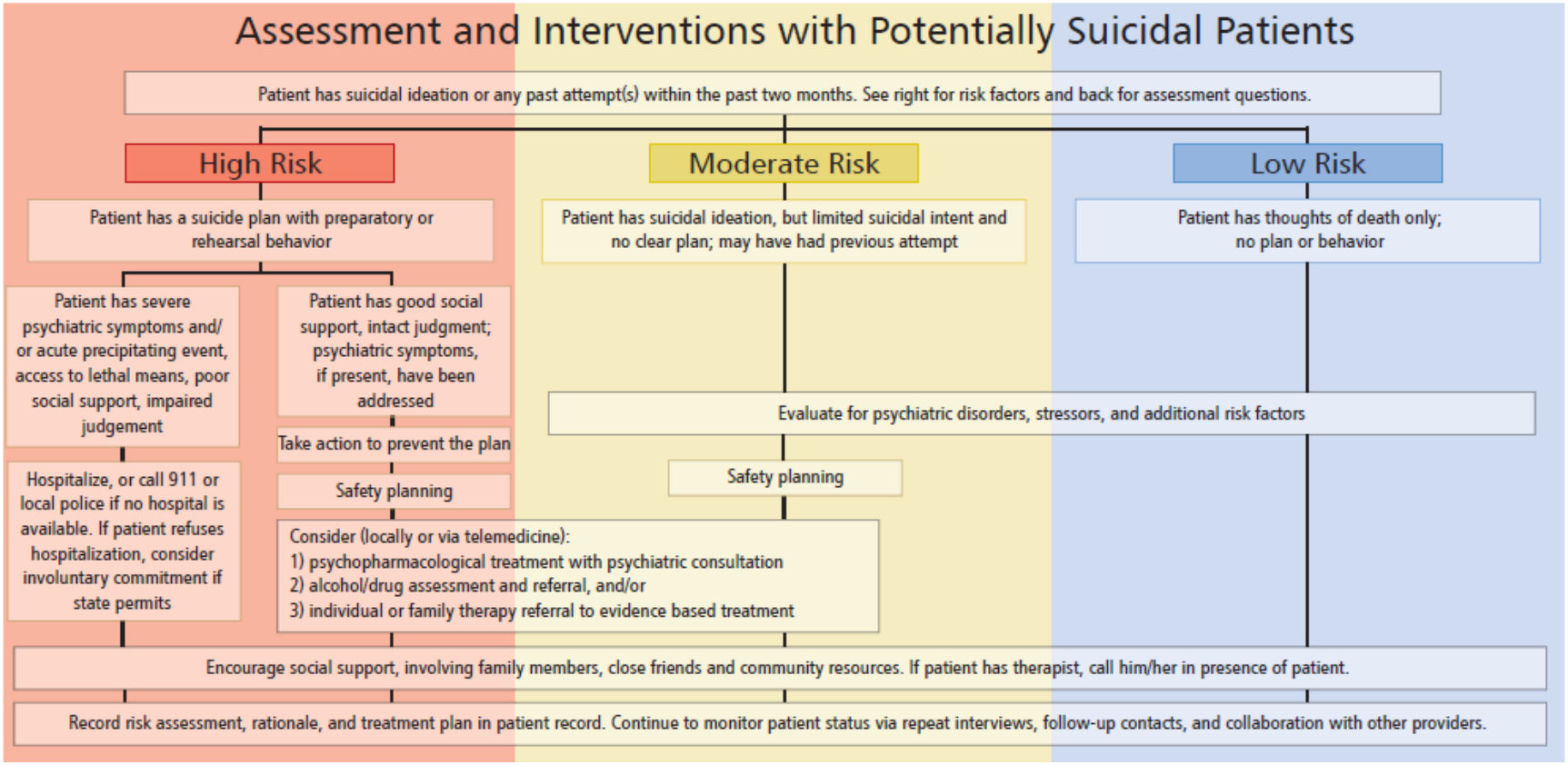
Intent

- Determine the extent to which the patient expects to carry out the plan
- Explore the patient's reasons to die vs. reasons to live
  - Many patients are ambivalent about suicide
  - Get them to focus on reasons for living
- Consider the patient's judgement and level of impulse control
- "How likely do you think you are to carry out your plan?"
- "What stops you from killing yourself."

Evaluation

- Assessment of risk factors of suicide risk, including but not limited to:
  - current suicidal ideation, lethality
  - prior suicide attempt(s)
  - current psychiatric conditions (e.g., mood disorders, substance use disorders) or symptoms (e.g., hopelessness, insomnia, and agitation),
  - prior psychiatric hospitalization
  - recent biopsychosocial stressors
  - availability of firearms –recent purchase, Internet search
  - making a will; getting the house in order

Clinical Judgement of Suicide Risk



WICHE Mental Health Program and Suicide Prevention Resource Center

https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskCPGProviderSummaryFinal5088212019.pdf

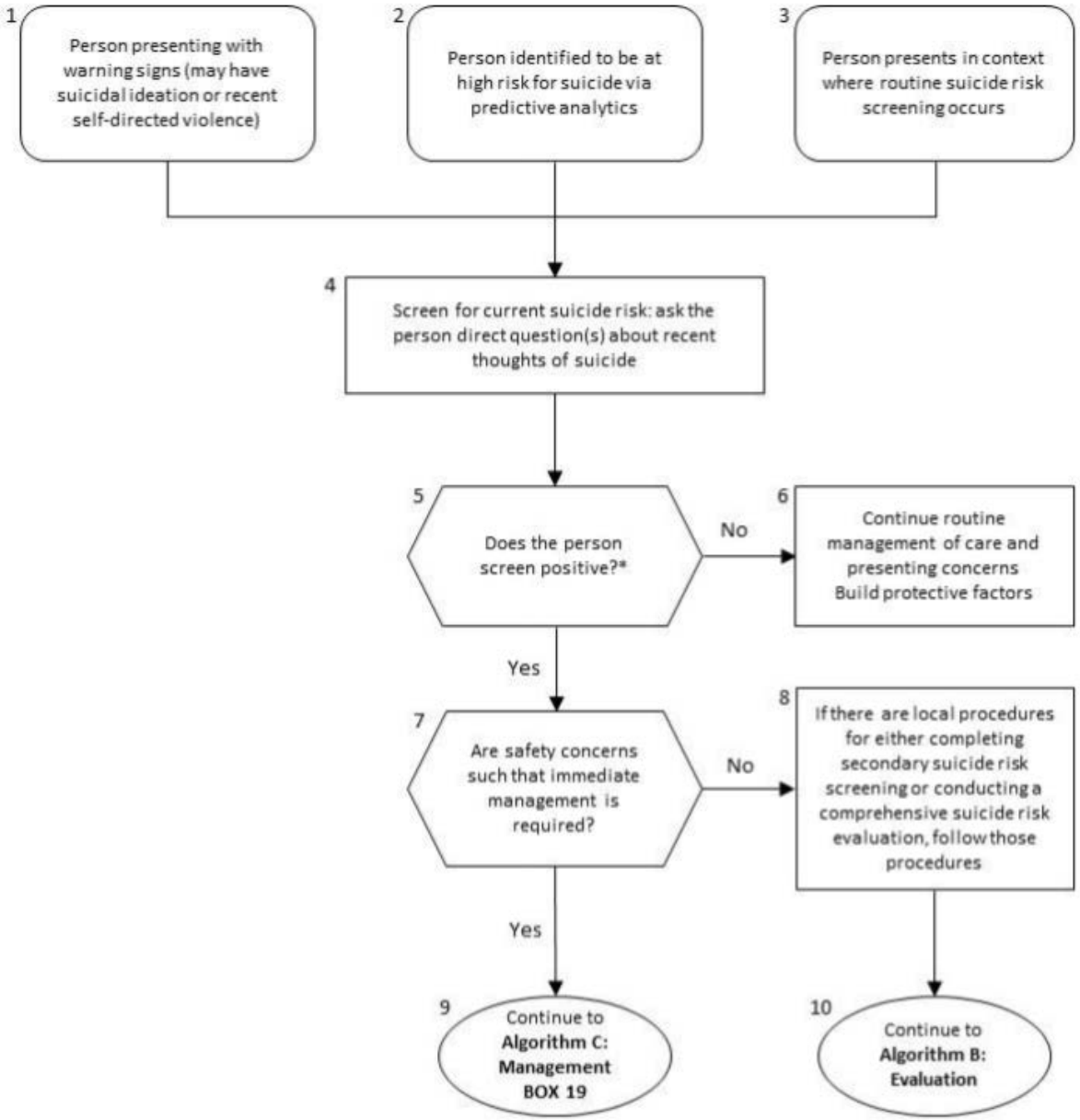
VA/DoD Clinical Practice Guidelines

THE ASSESSMENT AND MANAGEMENT OF PATIENTS AT RISK FOR SUICIDE

Provider Summary

Version 2.0 | 2019

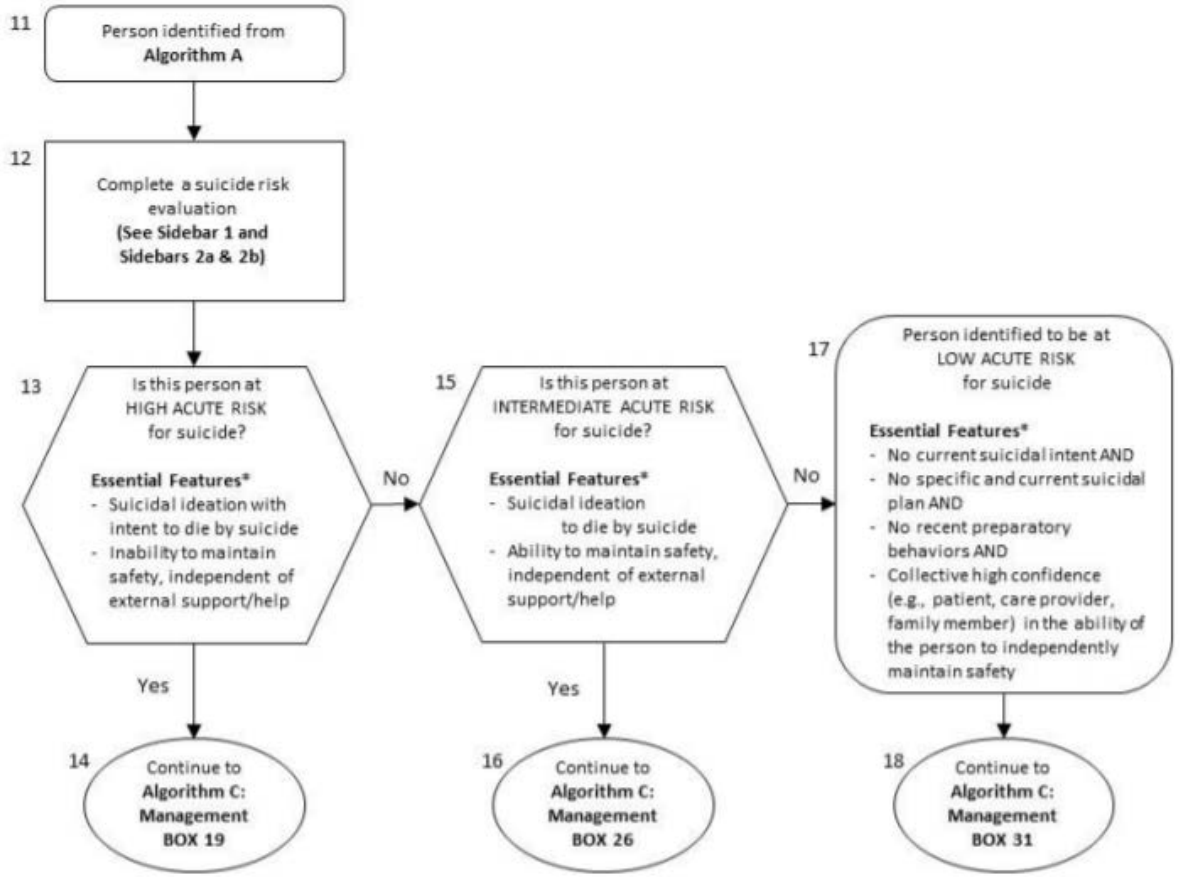
Algorithm A: Identification of Risk for Suicide



*Note: Follow to Box 7 if screen is negative but additional evidence (e.g., collateral) suggests the need for continued screening and/or evaluation

VA/DoD, 2019

Algorithm B: Evaluation by Provider



*Source: Rocky Mountain MIRECC Therapeutic Risk Management – Risk Stratification Table. Available at: https://www.mirecc.va.gov/visn19/trm/

Sidebar 1. Risk Factors for Suicide*

- Any prior suicide attempt
- Current suicidal ideation
- Recent psychosocial stressors
- Availability of firearms
- Prior psychiatric hospitalization
- Psychiatric conditions (e.g., mood disorders, substance use disorders) or symptoms (e.g., hopelessness, insomnia, agitation)

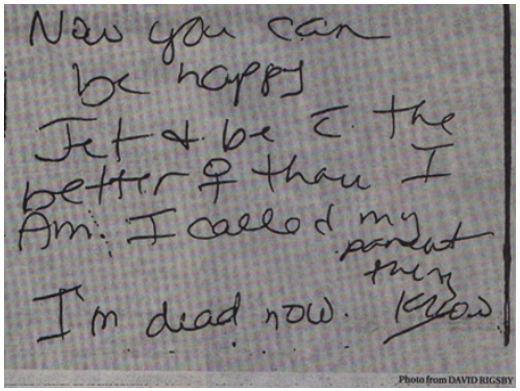
**Necessary as part of a comprehensive assessment of suicide risk, but not sufficient*
(See Recommendation 3)

VA/DoD, 2019

Sidebar 2a. Essential Features from Risk Stratification Table – Acute Risk[2]		
Level of Risk	**Essential Features**	**Action**
High Acute Risk	– Suicidal ideation with intent to die by suicide – Inability to maintain safety, independent of external support/help Common warning signs: – A plan for suicide – Recent attempt and/or ongoing preparatory behaviors – Acute major mental illness (e.g., major depressive episode, acute mania, acute psychosis, recent/current drug relapse) – Exacerbation of personality disorder (e.g., increased borderline symptomatology)	– Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors – These individuals may need to be directly observed until they are transferred to a secure unit and kept in an environment with limited access to lethal means (e.g., keep away from sharps, cords or tubing, toxic substances) – During hospitalization co-occurring conditions should also be addressed
Intermediate Acute Risk	– Suicidal ideation to die by suicide – Ability to maintain safety, independent of external support/help These individuals may present similarly to those at high acute risk, sharing many of the features. The only difference may be lack of intent, based upon an identified reason for living (e.g., children), and ability to abide by a safety plan and maintain their own safety. Preparatory behaviors are likely to be absent.	– Consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment (e.g., acute psychosis) – Outpatient management of suicidal thoughts and/or behaviors should be intensive and include: frequent contact, regular re-assessment of risk, and a well-articulated safety plan – Mental health treatment should also address co-occurring conditions
Low Acute Risk	– No current suicidal intent AND – No specific and current suicidal plan AND – No recent preparatory behaviors AND – Collective high confidence (e.g., patient, care provider, family member) in the ability of the patient to independently maintain safety Individuals may have suicidal ideation, but it will be with little or no intent or specific current plan. If a plan is present, the plan is general and/or vague, and without any associated preparatory behaviors (e.g., "I'd shoot myself if things got bad enough, but I don't have a gun"). These patients will be capable of engaging appropriate coping strategies, and willing and able to utilize a safety plan in a crisis situation.	– Can be managed in primary care – Outpatient mental health treatment may also be indicated, particularly if suicidal ideation and co-occurring conditions exist

VA/DoD, 2019

High and Immediate Acute Risk



- Focus on establishing safety
- **Imminent risk = hospitalization**
- Aggressive treatment of underlying psychiatric disorder if present
  - Typically requires hospitalization
- Know how to access emergency psychiatric services and rules for involuntary hospitalization

(VA/DoD, 2019)

High Acute Risk, cont….

- Contact family or support network to assist in elimination of access to potentially lethal means
- No empirical evidence to support the usage of “no harm” or “no suicide” contracts
- Implementing crisis response plans and safety plans are the preferred strategy

(VA/DoD, 2019)

Intervention: Low Risk

- PCP Treatment
- Collaborative Safety Planning/Crisis Plan
- Referral to Evidence Based Treatment
- Documentation and Follow up Care

Crisis Response Plan

- Semi-structured **interview of recent suicidal ideation** and chronic **history** of suicide attempts;
- **Unstructured conversation** about recent **stressors** and current **complaints** using supportive listening techniques
  - identification of clear signs of crisis (behavioral, cognitive, affective or physical);
- Self-management skill identification including things that can be done on the patient's own to distract or feel less stressed
- **Identification of social support** including friends, caregivers, and family members who have helped in the past and who they would feel comfortable contacting in a crisis
- **Review of crisis resources** including medical providers, other professionals, and the suicide lifeline
- **Referral** to treatment including follow-up appointments and other referrals as needed.

Practical Dispositions/Referrals

- Primary care provider for treatment
- Referral to a mental health provider
- Outpatient referral including day program, crisis center, mobile crisis center units and/or home with support/family
- Crisis intervention: 4-6 sessions
- Supportive therapy
- Community/Family services
- Monitor and follow-up

National Suicide Hotline

- **If you are in a crisis and need help right away:**
- Call this toll-free number, available 24 hours a day, every day: 1-800-273-TALK (8255). You will reach the National Suicide Prevention Lifeline, a service available to anyone. You may call for yourself or for someone you care about. All calls are confidential.

Advice for Family Members

- If you think someone is suicidal, do not leave him or her alone.
- Try to get the person to seek immediate help from his or her doctor or the nearest hospital emergency room, or call 911.
- Eliminate access to firearms or other potential tools for suicide, including unsupervised access to medications.

Key Points

- Know the facts about suicide; these are changing with this COVID-19 pandemic
- Risk factors and warning signs are key to understanding who is at risk
- Assessment and screening are essential
- A safety plan or crisis planning is a brief intervention
- Determining the patient's risk level will help determine the intervention

Suicide: one person dies every 40 seconds

WHO, 2019

Resources

- **In the U.S., call 1-800-273-8255:** National Suicide Prevention Lifeline

  http://www.suicidepreventionlifeline.org/

- Veterans Crisis Line
  https://www.veteranscrisisline.net/get-help/chat

- American Foundation for Suicide Prevention

  http://www.afsp.org/

Resources

- National Institute of Mental Health
  http://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml

- Training Institute for Suicide Assessment and Clinical Interviewing (TISA)
  http://www.suicideassessment.com/

- American Association of Suicidology
  http://www.suicidology.org/web/guest/home

- Suicide Prevention Resource Center (SPRC) Understanding Risk and Protective Factors for Suicide: A Primer for Preventing Suicide
- http://www.sprc.org/resources-programs/understanding-risk-protective-factors-suicide-primer-preventing-suicide