Suicide Assessment and Prevention
St Claire Regional Medical Center
October 21, 2015

Objectives
1. Review the national suicide rates
2. Identify groups at highest risk of suicide
3. Explore common methods of suicide
4. Identify the 4 phases of Suicide Assessment
5. Review discharge planning tasks to decrease risk
6. Understand use of an evidenced-based tool to decrease risk post discharge CALM (Counseling Access to Lethal Means)
9.4 MILLION AMERICAN ADULTS HAD SERIOUS THOUGHTS OF SUICIDE IN 2014
In 2014, 3.9% of American adults aged 18 and older thought seriously about killing themselves during the past 12 months, according to a report from the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA found that during this same period 3.1% of adults made suicide plans, and 0.5% of adults made non-fatal attempts at suicide.

Adults with substance use disorders or major depressive episodes had higher rates of serious suicide thought and behaviors. The percentage of adults who had serious thoughts of attempting suicide over the past 12 months has remained relatively stable since SAMHSA started tracking this issue in 2008.

The report also shows that only about half (51.4%) of adults who had serious thoughts of suicide in the past 12 month had received mental health services. To help people who have attempted suicide take their first steps toward healing and recovery, SAMHSA is providing free copies of A Journey Toward Health and Hope: Your Handbook for Recovery after a Suicide Attempt. The booklet features firsthand experiences of individuals who have survived a suicide attempt and their supporters.

Suicide Rates – CDC 2015
- 10th leading cause of death in the U.S. and #1 cause of injury-related death
- CDC (2015): 41,000 suicides per year - Average of 105 each day
- CDC: 494,169 self-harm injury (ED visits)
- 1 of every 5 people who committed suicide made a health care visit in the week before death
- 25% of those seeking medical treatment were diagnosed with a psychiatric diagnosis
- 33% + ETOH, 23% antidepressants, 20.8% opiates (including heroin and Rx pain medications)
Suicide Rate by Age

GROUPS AT INCREASED RISK

Groups with Increased Risk

- American Indians/Alaska Natives
- Individuals bereaved by suicide
- Individuals in justice and child welfare settings
- Individuals who engage in NSSI
- Individuals with medical conditions
- Individuals with mental and/or substance abuse disorders
- Lesbian, gay, bisexual, and transgender (LGBT) populations
- Members of the Armed Forces and veterans
- Men in midlife
- Older men
American Indians/Alaska Natives

- Suicide is the second leading cause of death among AI/AN youth aged 10-34
- Young Native men aged 20-24 have the highest rate of the population: 40.79 deaths per 100,000 [www.cdc.gov/injury/wisqars/fatal.html]
- Special risk factors particular to this group include alcohol and substance abuse, limited mental health access, and historical trauma

Individuals Bereaved by Suicide

- Each year more than 13 million people report they have known someone who died by suicide in the last year [Crosby & Earls, 1994]
- Exposure to suicide carries risk for elevated rates of guilt, depression, and other psychiatric symptoms
- Individuals bereaved by suicide may have an increased risk of suicide

Individuals in Justice and Child Welfare Settings

- Suicide is the single most common cause of death in secure justice settings [World Health Organization and International Association for Suicide Prevention, 2007]
- Risk factors for both juvenile and adult inmates include:
  - Mental disorders and substance abuse
  - History - physical, sexual, and emotional abuse
  - Current and prior history of self injury or suicide
  - Legal disciplinary problems
  - Family history of suicide
  - Poor family support and single-parent home
Individuals Who Engage in Nonsuicidal Self-Injury (NSSI)

• NSSI is defined as the direct and intentional destruction of one’s own body tissue in the absence of the intent to die (Nock & Fauazza, 2012)
• NSSI includes behaviors such as cutting, hitting, scratching, or burning that can lead to serious injury
• Research indicates that there is an increased risk for repetition as well as death within 10 years (Hawton & Harris, 2006)

Individuals with Medical Conditions

• Several medical conditions are related to increased risk of suicide:
  - Cancer is the most common. The National Cancer Institute has identified cancers of mouth, throat, and lung as highest risk factors
    - 63-85% of individuals with cancer who die by suicide meet criteria for severe depression, anxiety, and thought disorder (Klonsky, Leonge, & Gallego, 2009)
  - Degenerative Diseases of the CNS (Fiedorowicz & Paulsen, 2011)
    - Huntington Disease prevalence 2-4 times greater
    - Multiple sclerosis prevalence rate 3 times general population
    - Parkinson’s Disease - Suicide ideation is elevated but depression seems to be the predictor of suicide ideation

Individuals with Medical Conditions

• Several medical conditions are related to increased risk of suicide:
  - Traumatic Brain Injury – Often have significant cognitive impairment as well as perceptual and motor deficits
    - Executive brain dysfunction is a contributing factor to suicide behaviors: Risk has been identified as 3-4 times greater
  - HIV/AIDS – Lifetime prevalence of suicide attempts range from 22-50 percent. Individuals with AIDS were 44 times more likely to attempt suicide (Goldman, Mannix, & Hoven, 2000)
  - Chronic Kidney Disease – Severe end-stage kidney disease often develop psychiatric disorders such as affective disorders, delirium, schizophrenia, and psychoses that results in requests to withdraw from dialysis.
  - Arthritis – Persistent pain and dysfunction
Individuals with Psychiatric Illness

- Mood disorders are among the most common and may be the most life-threatening psychiatric illness
  
  (2012 National Strategy for Suicide Prevention: Goals and Objectives for Action)

<table>
<thead>
<tr>
<th>Mental Disorder</th>
<th>Symptom</th>
<th>Prevalence</th>
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</thead>
<tbody>
<tr>
<td>Mood Disorders:</td>
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<tr>
<td>Major Depression</td>
<td>Sadness, loss of interest</td>
<td>12-17% lifetime prevalence</td>
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<tr>
<td>Bipolar Disorder</td>
<td>Mood swings-sadness to hopelessness</td>
<td>1.3 to 5% die by suicide</td>
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<tr>
<td>Anxiety Disorders</td>
<td>Panic, GAD, panic disorders, OCD</td>
<td>18% lifetime prevalence</td>
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<td></td>
<td>Commonly co-occurring - mental, physical, &amp; SA</td>
<td>10% die by suicide</td>
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<tr>
<td>Borderline Personality Disorder</td>
<td>Patterns of instability in relationships, self-image, emotions</td>
<td>6-10% lifetime prevalence</td>
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<tr>
<td>Schizophrenia</td>
<td>Disturbances in perception, thought, language, social function</td>
<td>0.3-0.7% lifetime prevalence 5% die by suicide</td>
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</tbody>
</table>

Individuals with Psychiatric Illness

- SAMHSA reports nearly one in five adult Americans experienced a diagnosable mental illness in 2013 (43.8 million)
- 9.3 million American adults (3.9%) had serious thoughts of suicide
- 2.7 million (1.1%) made suicide plans
- 1.3 million (0.6%) attempted suicide

Lesbian, Gay, Bisexual, and Transgender Populations

- Gay and bisexual male and adolescents estimated 4x’s those of heterosexual males
- Lesbian and bisexual females estimated twice those of heterosexual
- LGB adolescents and adults twice as likely to report a suicide attempt in the last year (CDC, 2008)
- Across studies 12-19% LGB adults reported making an attempt vs. 5% all U.S. adults and 30% LGB adolescents vs. 8-10% U.S. adolescents
Men in Midlife

• Men 20’s – 50’s account for majority of suicide
• Contributing factors:
  ▪ Reluctance to seek help
  ▪ Engagement in interpersonal violence
  ▪ Distress/economics
  ▪ Dissolution of intimate relationship

Older Men

• Older white males have disproportionately high rates of death by suicide
• 2009 rate of death by suicide among older white males 30.15 per 100,000 (3x’s the general population 11.77 per 100,000) (www.cdc.gov/injury/wisqars/fatal.html)
• Most older adults who die by suicide were seen by their primary physician in the last three months of life (Luoma; Martin & Persons, 2002)
• Factors that increase risk:
  ▪ Mental disorder
  ▪ Physical illness or functional decline
  ▪ Social disconnection
  ▪ Older men less likely to report suicide ideation
Older Men

Members of the Armed Forces and Veterans
• 2001 DoD recorded 160 total suicides (10.3 per 100,000)
  (Armed Forces Medical Examiner System, 2011)
• Rates began to increase in 2006
• 2009 DoD rate reported as 309 (18.3 per 100,000)
• Army National Guard has had largest increase since 2009
• In 2012 Army reported an average of six soldiers a week committing suicide
• Service members white, under 25, junior enlisted (E1-E4), or high school educated were identified at increased risk
  (U.S. Department of Defense, 2010)

Members of the Armed Forces and Veterans
• Firearms most frequently used method for suicide
• Drug overdose most frequent method for attempts (Rx drugs higher than illegal drugs)
• JAMA Nov. 2014 reported U.S. Army suicide rate now higher than civilian rate
• Most suicides:
  • No known history of mental illness
  • Not known to have communicated risk of self-harm
  • Most suicides occurred in non-deployed setting; 2013 National Guard rate reported at 151, 8% higher than 2012
  • More than 50%, no hx. of deployment
  • Occur within 1 year of hospitalization
Children and Young Adults

- Each year 5-8% of U.S. children and young adults attempt suicide
- Second leading cause of death, ages 15-34
- In 2010, 6,867 youths between 10 and 24 died by suicide, making it the second leading cause of death for this age group
- Most individuals have visited a health provider 3 months to 1 year before their death (usually in an ED) (CDC 2010)
- Approximately 1 out of every 15 high school students attempts suicide each year (CDC 2010a)
- 1.2 million HS students attempted in 2011 (CDC)
- Suicide is the 2nd leading cause of death among college students (SPRC)
- Rates of completed suicide range between 6.5 and 7.5 per 100,000 \(\Rightarrow\) 1,500 per year (Schwartz, 2011, 2013)

Farmers

- Exact numbers higher than general population, hard to quantify due to under-reporting and mislabeling
- 1980's farm crisis, drought, and ban on grain exports and then 2008 recession lowered fixed prices on milk
- Most common means – guns

METHODS
Methods of Suicide

The largest number of suicides occurred among men 79% violent means

• 51.5% firearms
• 24.5% suffocation
• 16.1% poisoning


Drug Related Suicide Visits to ED

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4 Phases of Suicide Assessment

1. Interviewing
2. Information Gathering
3. Evaluation of Risk
4. Recommendation for Action
2. Information Gathering

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Information to Guide</th>
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<tr>
<td><strong>Current Presentation</strong></td>
<td>Suicidal thoughts, plans or intent; specific methods considered; patient's expected lethality; any firearms accessible; evidence of hopelessness, impulsivity, panic attacks, or anxiety; reason for living or plans for future; ETOH or substance abuse; thoughts plans or intentions of violence towards others</td>
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<tr>
<td><strong>Psychiatric Illness</strong></td>
<td>Current signs and symptoms of psychiatric disorders with particular attention to mood disorders, schizophrenia, substance abuse disorders, anxiety disorders and personality disorders; previous psychiatric treatment, including hospitalizations</td>
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<tr>
<td><strong>History</strong></td>
<td>Previous suicide attempts, aborted attempts, or other self-injurious behavior, previous or current medical diagnoses and treatments, including hospitalizations and surgeries; family history of suicide or suicide attempts; family history of mental illness of substance abuse</td>
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<tr>
<td><strong>Psychosocial Situation</strong></td>
<td>Acute psychosocial crises and chronic stressors which may include perceived losses, financial difficulties, or changes in socioeconomic status; family discord or domestic violence, and past or current sexual or physical abuse, neglect or trauma; employment status; cultural or religious beliefs about death and suicide</td>
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<tr>
<td><strong>Strengths and Vulnerabilities</strong></td>
<td>Coping skills; personality traits; past responses to stress; capacity for reality testing; ability to tolerate psychological pain and self-soothe</td>
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3. Evaluation of Risk
Risk and Protective Factors

Risk
• Prior attempt(s)
• Mood disorders
• Substance abuse
• Access to lethal means
• Anxiety, panic attacks
• Command hallucinations
• Lack of social support
• Loss of concentration, interest, and pleasure

Protective Factors
• Effective care mental/physical
• Connectedness
• Problem solving skills
• Cultural religious beliefs
• Family community support
• Employed
• Restricted access to lethal means

Warning Signs
• Overt threats to harm self
• Seeking means
• Talking or writing about death, dying
• Hopelessness
• Rage, anger, revenge seeking
• Feeling trapped
• Withdrawal, isolation
• Agitation, unable to sleep
• Dramatic mood changes
• Lack of sense of meaning or purpose

Impulsive, Agitated Behaviors May Be a Predictor of Suicide
• Recent study results released 8/29/2015
Behaviors include:
  o Risky behaviors such as reckless driving or sudden promiscuity or,
  o Nervous behaviors such as agitation, hand-wringing or pacing
  o Doing things on impulse with little thought about the consequences
SAFE-T (SAMHSA)
Suicide Assessment Five-step Evaluation and Triage

1. IDENTIFY RISK FACTORS
   Note those that can be modified to reduce risk

2. IDENTIFY PROTECTIVE FACTORS
   Note those that can be enhanced

3. CONDUCT SUICIDE INQUIRY
   Suicide thoughts, plans, behavior, and intent

4. DETERMINE RISK LEVEL INTERVENTION
   Determine risk. Choose appropriate intervention to address risk

5. DOCUMENT
   Assessment of risk, rationale, intervention, and follow-up

Ask Suicide Screening Questions (ASQ)

(ASQ) Ask Suicide Screening Questions
- A set of 4 questions that takes emergency department nurses or physicians less than 2 minutes to administer can successfully identify youth at risk for attempting suicide

1. Current thoughts of being better off dead
2. Current wish to die
3. Current suicidal ideation
4. History of suicide attempt

- Positive responses to 1 or more of the 4 questions identified 97% of the youth at risk for suicide regardless of whether the patient came to the ED for psychiatric or general medical concerns

Columbia Suicide Severity Rating Scale
C-SSRS
4. Recommendation for Action

1. Admission IP
   - Despite insufficient evidence to demonstrate the effectiveness of acute hospitalization in the prevention of suicide, hospitalization is indicated in suicidal patients who cannot be maintained in a less restrictive care setting (VA/DoD clinical guideline for assessment and management of patients at risk for suicide, 2013).

2. Alternate level of care
   - Documentation and planning of disposition if not admitted
   - IF ADMITTED – observation level/precautions

PREVENTION STRATEGIES

Environment

- Culture of Safety
- Psych Safe Rooms – ED
- Pro active Risk Assessment
- Staff Orientation and Training
- Communication
- Meaningful Rounds
- Observation Levels
- Suicide Reassessment
- Treatment Plan (inpatient and post hospital plans)
- Safety Plan on discharge
Treatment Care Planning

Discharge ‘Musts’

3 Interventions
Limitation of access to lethal means
1. Preservation of contact
2. Emergency call numbers

C A L M

Counseling on Access to Lethal Means
- Limiting access to lethal means and methods of self-harm is an effective strategy to lower overall suicide rates
  - First ask about suicidal thoughts and past suicide attempts
  - Second ask about access to lethal methods of self harm
  - Third engage family and patient in reducing access to means
The AUDIT-C

AUDIT-C is a questionnaire made by the World Health Organization for the use of non-medical professionals to screen for alcohol dependence. It includes questions about the frequency of alcohol use, the number of drinks consumed, and the effects of drinking. The AUDIT-C consists of 8 questions, with a score ranging from 0 to 20. A score of 3 or more is considered indicative of harmful alcohol use.

1. Have you felt that you should cut down on your drinking?
2. Have people annoyed you by criticizing your drinking?
3. Have you ever felt bad or guilty after drinking?
4. Have you had a drink first thing in the morning to steady your nerves or to help get rid of a hangover (eye opener)?
5. Have drinks increased in size or amount?
6. Have you had more drinks than you intended to?
7. Have you needed a drink first thing in the morning to get straight or steady your nerves or to help get rid of a hangover (eye opener)?
8. Have you felt withdrawal symptoms when you haven’t been drinking for a few days?

A score of 3 or more is considered indicative of harmful alcohol use.
Pre-Discharge Reassessment

- AHRQ approved VADoD Practice Guidelines
- Assessment of presence and access to lethal means should include:
  a. Fire Arms: Always inquire about access to fire arms and ammunition (including privately-owned firearm) and how they are stored
  b. Medications: Perform medication reconciliation for all patients. For any current and/or proposed medications consider the risk/benefit of any medications which could be used as a lethal agent to facilitate suicide. Consider prescribing limited supplies for those at an elevated risk for suicide or with histories of overdose or the availability of a caregiver to oversee the administration of the medications.
  c. Household poisons: Assess availability of chemical poisons, especially agricultural and household chemicals. Many of these are highly toxic.
- Document reassessment on all discharges
Suicide Communications Are Made To Others

Adolescents - 50% communicated their intent to family members

Elderly - 58% communicated their intent to their primary care doctor

2015 NAMI National Convention
Questions

References

- 2005 to 2011 SAMHSA Drug Abuse Warning Network (DAWN)
- Donald Mullen, M.D., department chairman, psychiatry and psychology, Conwell Clinic; Patton Rieves-Bright, M.D., division chief, child and adolescent services, South Carolina Hospital, Amityville, N.Y.; European College of Neuropsychopharmacology, news release, Aug. 20, 2015.
References

- MAHRA. DHHS Report August 7, 2014. Emergency Department Visits for Drug-Related Suicide Attempts have increased.

Resources

- American Association of Suicidology
- American Evaluation Association
- CDC Evaluation Group
- CDC Facebook Page on Violence Prevention www.facebook.com/vetoviolence
- Centers for Disease Control and Prevention www.cdc.gov/violenceprevention
- Centers for Disease Control and Prevention www.cdc.gov/violence prevention
- http://www.cdc.gov/eval
- http://www.rochesterpreventsuicide.org
Resources

- http://www.suicidology.org
- National Institute of Mental Health, Suicide Research Consortium
- National Mental Health Association-Effective Prevention Programs
- National Mental Health Association-Effective Prevention Programs
- National Institute for Mental Health www.nimh.nih.gov
- Research-Based prevention: a Pyramid for Effectiveness
  http://www.cprl.unc.edu/levels.html
- Substance Abuse and Mental Health Services Administration www.samhsa.gov
- Suicide Prevention Resource Center (SPRC)
- Suicide Prevention Resource Center www.sprc.org
- Surgeon General’s Call to Action to Prevent Suicide
  www.surgeongeneral.gov/library/calltoaction
- University of Rochester Center for the Study and Prevention of Suicide
  www.sprc.org

3 educational products (Massachusetts Dept. of Public Health)

- Preventing Transgender Suicide: An Introduction for Providers
- Saving Our Lives: Preventing Suicide in Transgender Communities (video & discussion guide)
- Saving Our Lives: Transgender Suicide Myths, Realities & Help