Suicide Prevention Resource Center

Linking Together a Chain of Care: How Clinicians Can Prevent Suicide

David A. Litts, O.D.
Director Science and Policy
Suicide Prevention Resource Center
June 29, 2010

Overview

- Epidemiology
- Detecting suicide risk
- Clinical interventions and tools
- Training Implications
**Epidemiology**

**Incidence**
- ~ 1 Million suicides/year worldwide*
- >33,000 suicides/year in the U.S.**
- Suicide attempts, U.S.(adults)***
  - 1.1 M attempts
  - 678,000 attempts requiring medical care
  - 500,000 attempts resulting in an overnight hospital stay
- Suicide ideation, U.S. (adults)***
  - 8.3 M (3.7%) seriously considered suicide during past year


---

**Demographics**

**Suicides:**
- Male:female = 4:1
- Elderly white males -- highest rate
- Working aged males – 60% of all suicides
- American Indian/Alaskan Natives, youth and middle age

**Attempts:**
- Female>>male
- Rates peak in adolescence and decline with age
- Young Latinas and LGBT

Epidemiology among Patients

Prevalence of suicidal behaviors

- Suicidal ideation at time of visit
  - Primary care: 2-4 percent (Olfson 1996, 2003)
  - Emergency departments: 8-12 percent*

- Suicide attempts
  - Pts with major depression: 10% attempted during a past major depressive episode**

- Suicide
  - Pts with serious mental illness: lifetime suicide risk 4-8%
    (1% lifetime suicide risk for general population)***


Understanding Risk Factors
Clinically Salient Suicide Risk Factors

- Previous suicide attempt
  - Majority die on first attempt
- Suicidal ideation, plan, intent
- Major mood or anxiety disorder
- Substance abuse disorder
- Other mental illnesses
- Co morbidity (psych/SA)
- Physical illness, chronic pain
- CNS disorders/traumatic brain injury
- Insomnia

Suicidality

Generally:
Risk ↑’d with
1) severity of symptoms,
2) # of conditions
3) recent onset

Additional Salient Risk Factors for MHPs

- Impulsivity
  

- Failed belongingness
- Perceived burdensomeness
- Loss of fear of death and pain
  
Protective Factors

- Family and community connections/support
- Clinical care (availability and accessibility)
- Resilience
- Coping/life skills
- Frustration tolerance and emotion regulation
- Cultural and religious beliefs; spirituality

Source:


Warning Signs (For the Public)

Tier 1: Call 911 or seek immediate help
- Someone threatening to hurt or kill themselves
- Someone looking for ways to kill themselves: seeking access to pills, weapons, or other means
- Someone talking or writing about death, dying, or suicide

Warning Signs (For the Public)

Tier 2: Seek help by contacting a mental health professional or calling 1-800-273-TALK

- 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 use
- Withdrawing from friends, family or society
- Anxiety, agitation, unable to sleep, or sleeping all the time
- Dramatic mood changes
- No reason for living; no sense of purpose in life


Triggering Events

- Acute events leading to:
  - Humiliation,
  - Shame, or
  - Despair
- Includes real or anticipated loss of:
  - Relationship
  - Status: financial or health

Clinical Chain in Suicide Prevention

- Detecting potential risk
- Assessing risk
- Managing suicidality
  - Safety planning
  - Crisis support planning
  - Patient tracking
- MH Treatment
- F/U Contact

Poll

- Look at the two clusters of conditions. Both represent conditions that in and of themselves increase risk for suicide. Which group is the more serious with regard to elevating suicide risk?
  - a. Chronic pain, traumatic brain injury, multiple sclerosis
  - b. Major depression, alcohol dependence
Suicide Prevention Resource Center

Primary care
A Suicide Prevention Toolkit for (Rural) Primary Care
http://www.sprc.org/pctoolkit/index.asp

Psychosocial Problems in Primary Care

- In the United States health care system, primary care is the #1 source for mental health treatment.
- Primary care is many times a patient’s only source for MH treatment of any kind.
- Approximately 70% of visits to a primary care clinic have at least some psychosocial or behavioral component contributing to the problem (Gatchel & Oordt, 2003)
- Depressive symptoms are more debilitating than diabetes, arthritis, GI disorders, back problems, and hypertension. (Wells et al, 1989)
Psychosocial Problems in Primary Care

- Comorbid psychiatric-physical disorders are more impairing than either “pure” psychiatric or “pure” physical disorders. (Kessler, Ormel, Demler & Stang, 2003)
- Less than 50% of PCPs feel competent in managing suicide (Annenberg Adolescent Mental Health Project, 2003)
- Mental health was 1 of 6 research areas primary care providers felt were important (AAP, 2002)

Why Suicide Prevention in Primary Care?

- Suicide decedents twice as likely to have seen a PC provider than a MH provider prior to suicide*
  - 70% of adolescents see their primary care provider (PCP) at least once per year (U.S. DHHS, 2001)
  - 77% of adolescents with mental health problems go see their PCP (Schurman et al., 1985)
  - 16% of adolescents in the last year were depressed and 5% were at risk for a serious suicide attempt (Survey of pediatricians--Annenberg Adolescent Mental Health Project, 2003)
- PC acceptable to patients
  - Over 70% of adolescents willing to talk with a primary care physician about emotional distress (Good et al., 1987)

Why Primary Care?

- More than 25 medical illnesses have been identified with significantly elevated risks for suicidality (Berman & Pompili, in preparation).
- Many at-risk subpopulations served (e.g., HIV, chronic illness, family planning)
  - Reach working-aged men
- Many key risk factors for suicide are easily observed in primary care settings
- Fits chronic disease mgmt model in pt centered medical home
- Patient education

Prescribing in PC

Figure 1
Percentage of U.S. retail psychotropic prescriptions written from August 2006 to July 2007, by type of provider*

Contact with Primary Care and Mental Health Prior to Suicide

<table>
<thead>
<tr>
<th>All Ages</th>
<th>Month Prior</th>
<th>Year Prior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>19%</td>
<td>32%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>45%</td>
<td>77%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact w/ PC by Age</th>
<th>Month Prior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &lt;36</td>
<td>23%</td>
</tr>
<tr>
<td>Age &gt;54</td>
<td>58%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact w/ MH by Gender</th>
<th>Month Prior</th>
<th>Year Prior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>18%</td>
<td>35%</td>
</tr>
<tr>
<td>Women</td>
<td>36%</td>
<td>58%</td>
</tr>
</tbody>
</table>


Safe Firearm/Ammunition Storage

Figure 3.

Source: (Grossman et al., 2005)
PC Opportunities Missed

- Actors portrayed standardized patients with symptoms of major depression and sought help in PCP offices. *PCPs inquired about suicide in less than half (42%) of these patient encounters* (Feldman et al, 2007).
- 20% of adults who die by suicide visit their PCP within 24 hours of their death. (Pirkis & Burgess, 1998)
- Youths are more likely to die by suicide than all medical illnesses combined (CDC)

---

**Toolkit: Primary Care Suicide Prevention Model**

**Prevention Practices**
1. Staff vigilance for warning signs & key risk factors
2. Universal depression screening for adults and adolescents
3. Patient education:
   - Safe firearm storage
   - Suicide warning signs & 1-800-273-TALK (8255)

**Intervention**

- Warning signs: major depression, anxiety, substance use disorder, insomnia, chronic pain, PTSD, TBI
- Screen for presence of suicidal thoughts
- Suicide Risk Assessment
- Risk Management: referral, treatment initiation, safety planning, crisis support planning, documentation, tracking and follow up

- No screening necessary
- Rescreen periodically
Suicide Prevention Resource Center

Emergency Department

ED Treatment of Mental Disorders

- 100 million ED visits in 2002.
- 20% increase in number of visits over prior decade.
- 15% decrease in number of EDs over prior decade.
- 6.3% of presentations were for mental health.
- 7% of these were for suicide attempts = 441,000 visits.

ED Treatment of Mental Disorders

- Suicidal ideation (SI) common in ED patients who present for medical disorders.
- Study of 1,590 ED patients showed 11.6% with SI, 2% (n=31) with definite plans.
- 4 of those 31 attempted suicide within 45 days of ED presentation.


- 1 in 10 suicides are by people seen in an ED within 2 months of dying


C. Bradberry, personal communication with D. Litts regarding South Carolina NVDRS-linked data. December 19, 2007.

---

ED Treatment of Mental Disorders


- 165 ED patients with suicidal ideation self-identified on a computer screening
- Physician and nurse were informed
- Six month f/u
  - 10% were transferred to psychiatric services
  - Only 25% had any notation in the chart re suicide risk
  - 4 were seen again in the ED with suicide attempts—none were there for mental health problems on the index visit

Look for signs of acute suicide risk

Screen:
- Universally or selectively
- Paper/pencil, computer, or by clinician
# Emergency Department Guide

## Evaluation and rapid triage

**High risk patients** include those who have:
- Made a serious or nearly lethal suicide attempt
- Persistent suicide ideation or intermittent ideation with intent and/or planning
- Psychosis, including command hallucinations
- Other signs of acute risk
- Recent onset of major psychiatric syndromes, especially depression
- Been recently discharged from a psychiatric inpatient unit
- History of acts/threats of aggression or impulsivity

**Recommended interventions:**
- Rapid evaluation by a qualified mental health professional
- One-to-one constant staff observation and/or security
- Locked door preventing elopement from assessment area
- Inpatient admission
- Administer psychotropic medications and/or apply physical restraints as clinically indicated
- Other measures to guard against elopement until evaluation is complete (see below)

**Moderate risk patients** include those who have:
- Suicide ideation with some level of suicide intent, but who have taken no action on the plan
- No other acute risk factors
- A confirmed, current and active therapeutic alliance with a mental health professional

**Interventions to consider:**
- Guard against elopement until evaluation is complete (see below)
- Psychiatric/psychological evaluation soon/when sober
- Use family/friend to monitor in ED if a locked door prevents elopement

**Low risk patients** include those who have:
- Some mild or passive suicide ideation, with no intent or plan
- No history of suicide attempt
- Available social support

**Interventions to consider:**
- Allow accompanying family/friend to monitor while waiting
- May wait in ED for non-urgent psychiatric/psychological evaluation

## Poll

> Have you ever directly asked someone if he/she was thinking about ending his/her life?

- Yes
- No
Normalizing Technique

- Makes it easier for a person to disclose a highly stigmatized condition: having suicidal thoughts
- Step 1: Normalizing: Tell the person that it is not uncommon for people in their circumstances to feel hopeless, want to die, or even consider killing themselves
- Step 2: Inquiry: Have you ever had any of those feelings or thoughts?

Skill Building: Risk Detection Using Normalizing Technique

- Scenario A: 74 y/o male being treated with marginal success for severe chronic back pain associated with degenerative changes in the lumbar spine. He was recently widowed. His affect is consistent with someone who has lost hope.
- Scenario B: 24 y/o veteran of two Iraq War deployments with traumatic brain injury. After two years of rehabilitation, he is coming to terms with the magnitude of his long-term disability.
- Scenario C: 38 y/o female with debilitating panic attacks that interfere with work performance and her ability to meet her responsibilities to her family. She mentioned drinking more and more to try to “get through”. 
Suicide Prevention Resource Center

Mental health

~19% of suicides had contact with MH within the past month; ~32% within the past year (Luoma, 2002)
41% of suicide decedents who had received inpatient psychiatric care died within one year of their discharge; 9% within one day. (Pirkis, 1998)
Of patients admitted for attempt (Owens et al., 2002)
  - 16% repeat attempts within one year
  - 7% die by suicide within 10 years
  - Risk of suicide “hundreds of times higher” than general population
Inpatient Suicide

- Second most common sentinel event reported to The Joint Commission (First is wrong-side surgery)
- Since 1996*: 416(14%)
- Method:
  - 71% Hanging
  - 14% Jumping

Factors in Suicide

- 87% Deficiencies in physical environment
- 83% Inadequate assessment
- 60% Insufficient staff orientation or training

* Sentinel event reporting began in 1996.
Source: Joint Commission on Accreditation of Healthcare Organizations. (2005). Reducing the Risk of Suicide. Oak Brook, IL: JCAHO.

---

National Comorbidity Survey and Replication*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide</td>
<td>2.8%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Ideation</td>
<td>14.8/100k</td>
<td>13.9/100k</td>
</tr>
<tr>
<td>Plan</td>
<td>.7%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Gesture</td>
<td>.3%</td>
<td>.2%</td>
</tr>
<tr>
<td>Attempt</td>
<td>.4%</td>
<td>.6%</td>
</tr>
</tbody>
</table>

9708 respondents, face-to-face survey, aged 18-54
Queried about past 12 months
No significant changes

National Comorbidity Survey and Replication*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideators with plans</td>
<td>19.6%</td>
<td>28.6%</td>
<td>p=.04</td>
</tr>
<tr>
<td>Planners with gestures</td>
<td>21.4%</td>
<td>6.4%</td>
<td>p=.003</td>
</tr>
<tr>
<td>Tx among ideators with gestures</td>
<td>40.3%</td>
<td>92.8%</td>
<td></td>
</tr>
<tr>
<td>Tx among ideators with attempts</td>
<td>49.6%</td>
<td>79.0%</td>
<td></td>
</tr>
</tbody>
</table>


Insufficient Treatment

“A recognition is needed that effective prevention of suicide attempts might require substantially more intensive treatment than is currently provided to the majority of people in outpatient treatment for mental disorders.”

Suicide Prevention Resource Center

Clinical interventions

Patient Management Tools

- Safety Plan/Crisis Response Plan
  - Collaboratively developed with patient
  - Template that is filled out and posted
  - Includes lists of warning signs, coping strategies, distracting people/places, support network with phone numbers

# Safety Planning

**Safety Planning Guide**

A Quick Guide for Clinicians may be used in conjunction with the "Safety Plan Template" (URL: http://www.sprc.org/library/SafetyPlanningGuide.pdf)

**Safety Planning Guide and Safety Plan Template ©2008 Barbara Stanley and Gregory K. Brown, are reprinted with the express permission of the authors. No portion of the Safety Plan Template may be reproduced without their express, written permission. You can contact the authors at bhs2@columbia.edu or gregbrow@mail.med.upenn.edu.**

**Sample Safety Plan**

- **Step 1:** Writing down the steps helps to order ideas and priorities for developing.
- **Step 2:** A list of people to contact when needed.
- **Step 3:** People who can help.
- **Step 4:** People who can be brought in when needed.
- **Step 5:** Recruitment and support.

- **Implementing the Safety Plan:** There are 6 steps involved in the development of a Safety Plan.

**Patient Management Tools**

- **Crisis Support Plan**
  - Provider collaborates with Pt and support person
  - Contract to help - includes reminders for ensuring a safe environment & contacting professionals when needed


- **Patient tracking**
  - Monitor key aspects of suicide risk at each visit

Crisis Support Plan

CRISIS SUPPORT PLAN

I understand that suicidal risk is to be taken very seriously. I want to help
find new ways of managing stress in times of crisis. I realize there are no guarantees about
how crises resolve, and that we are all making reasonable efforts to maintain safety for
everyone. In some cases, inpatient hospitalization may be necessary.

Things I can do:

- Provide encouragement and support
- Help follow his/her Crisis Action Plan
- Ensure a safe environment:
  - Remove all firearms & ammunition
  - Remove or lock up:
    - knives, razors, & other sharp objects
    - prescriptions & over-the-counter drugs (including vitamins & aspirin)
    - alcohol, illegal drugs & related paraphernalia
  - Make sure someone is available to provide personal support and monitor
    him/her at all times during a crisis and afterwards as needed.
  - Pay attention to his/her stated method of suicide/self-injury and restrict


ED Patient Engagement

Brief Interventions

EDC
Emergency Departments

- Brief Interventions
  - Motivational interviewing
  - Acute Cognitive Therapy*
  - Safety planning; support planning
  - Means restriction ed.


Emergency Department

Before discharging

Check that:

- Firearms and lethal medications have been secured or made inaccessible to patient
- A supportive person is available and instructed in follow-up observation and communication regarding signs of escalating problems or acute risk
- A follow-up appointment with a mental health professional has been recommended and, if possible, scheduled
- The patient has the name and number of a local agency that can be called in a crisis, knows that the National Suicide Prevention Lifeline 1-800-273-TALK (8255) is available at any time, and understands the conditions that would warrant a return to the ED
Effective MH Therapies

- Lithium (bipolar disorder)
- Clozapine (schizophrenia)
- Dialectic Behavioral Therapy (Linehan)
  - ↓ in hospitalization and attempts for chronic suicidal behavior
- Brief intervention, cognitive-behavioral therapy (Brown)
  - 50% decrease in repeat attempts
  - ↓ depression
  - ↓ hopelessness
- Brief intervention, psychodynamic interpersonal therapy (Guthrie)

** Quality of the therapeutic relationship a key factor **


Caring Follow-up Contact

- 605 Adults d/c from ED after attempt by o/d or poisoning (Vaiva et al., 2007)
  - Contact by phone one month after d/c ↓‘d attempt by 45% during next year
- Patients who by 30 days after hospital d/c for suicide risk had dropped out of tx (Motto, 2001)
  - Randomized to receive f/u non-demanding post-cards
  - ↓ suicides for two years
- 394 randomized after a suicide attempt (Carter et al., 2005)
  - Those who rec’d 8 postcards during year ↓‘d repeat attempt by 45%
Caring F/U Contact—ED

- Brief intervention and f/u contact
  - Randomized controlled trial; 1867 Suicide attempt survivors from five countries (all outside US)
  - Brief (1 hour) intervention as close to attempt as possible
  - 9 F/u contacts (phone calls or visits) over 18 months

Results at 18 Month F/U

<table>
<thead>
<tr>
<th>Percent of Patients</th>
<th>Died of Any Cause</th>
<th>Died by Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual Care</td>
<td>1.5</td>
<td>3.0</td>
</tr>
<tr>
<td>Brief Intervention</td>
<td>0.5</td>
<td>3.0</td>
</tr>
</tbody>
</table>


Crisis Lines

- Seriously suicidal callers reach out to crisis lines
- Effective outcomes—immediately following call and continuing weeks after
  - Decreased distress
  - Decreased hopelessness
  - Decreased psychological pain
  - Majority complete some or all of plans developed during calls
- Suicidal callers (11%) spontaneously reported the call prevented them from killing or hurting themselves
- Heightened outreach needed for suicidal callers
  - With a history of suicide attempt
  - With persistent intent to die at the end of the call


Crisis Lines—New Roles

- Crisis hotlines can provide continuity of care for at risk persons outside of traditional BH system services
- Provide access to f/u in rural areas
- Monitor/track at risk persons after hospital discharge
Poll

Which of the following has been shown to be ineffective in preventing suicidal behaviors?

- Collaborative safety planning
- Counseling parents on safe storage of guns/ammunition
- No suicide contract
- Brief cognitive therapy
- Caring follow-up contacts
Clinical Chain in Suicide Prevention

- Detecting potential risk
- Assessing risk
- Managing suicidality
  - Safety planning
  - Crisis support planning
  - Patient tracking
- Treatment
- F/U Contact

Suicide Prevention Resource Center

Training Implications
Competency Chasm

- Large portions of mental health providers have had no formal training in the assessment and management of suicidal patients


Competency Chasm

Chief Psychiatry Resident Survey

- Surveyed chief residents from all 181 U.S. residency programs (59% response rate)
- 19 of 25 topics were judged to require more attention by more than half of the respondents.

Clinical Training for Mental Health Professionals

- One day workshop
- Developed by 9-person expert task force
- 24 Core competencies
- Skill demonstration through video of David Jobes, Ph.D.
- 175 Page Participant Manual with exhaustive bibliography
- 6.5 Hrs CE Credits
- ~100 Authorized faculty across the U.S.

Contact Isaiah Branton, AMSR Training Coordinator, SPRC Training Institute, at 202-572-3789 or ibranton@edc.org

Nationally Disseminated Curricula for MHPs

- **Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals.**
  - A one-day workshop focusing on competencies

- **QPRT: Suicide Risk Assessment and Management Training.**
  - A 10 - hour course available either on-line or face-to-face
  - http://www.qprinstitute.com

- **Recognizing and Responding To Suicide Risk: Essential Skills for Clinicians.**
  - Two-day advanced interactive training with post-workshop mentoring.

- **Suicide Care: Aiding life alliances (Canada only)**
  - One-day seminar on advanced clinical practices
  - http://www.livingworks.net/SC.php
A Resource Guide for Implementing the
The Joint Commission
2007 Patient Safety Goals on Suicide


Keep informed of developments in suicide prevention. Receive the Weekly Spark – SPRC's weekly e-newsletter!
http://mailman.edc.org/mailman/listinfo/sprc
dlitts@edc.org
www.sprc.org