Suicide Prevention and Management in Healthcare Practice Settings; A Comprehensive Evidence-based Approach

CME offering from MMA

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Maine Suicide Prevention Program

In partnership with: NAMI Maine

Education, Resources and Support—It's Up to All of Us.

Maine Suicide Prevention Program

A program of the Maine Center for Disease Control and Prevention since 1998

Statewide Activities Include:

- **Data** collection, analysis & dissemination of **print materials**
  - *SAMHS's* The Maine Prevention Store: https://www.mainepreventionstore.com/
- **Training** and consultation on suicide prevention and assessment to a wide range of partners statewide.
- **Technical Assistance** for schools and healthcare organizations addressing suicide risk or coping with a suicide loss.
- Partnering with Maine Medical Association for specific programing for healthcare systems.
- *Beyond the Basics in Suicide Prevention Conference*

Objectives and Financial Disclosure

“Speakers and planners have no significant or relevant financial relationships with Commercial Interest to disclose.”

Learning Objectives:

- Articulate the rationale for a structured approach to suicide assessment and management in healthcare
- Describe to elements of suicide assessment and Collaborative Safety Planning
- Appreciate the recent trends in suicide across the lifespan in Maine

Introduction

- When you experience the suicide, it is a devastating loss of life deeply impacting family, friends, staff and the community.
- A suicidal crisis is almost always transient and treatable
- Suicide is “the most preventable form of death in the US today.” (David Sacher, former US Surgeon General)
- Having the tools and processes in place prepares you to be a prevention and intervention resource.

Suicide in the United States, 2019

- **47,511** Americans died by suicide in 2018; about 1 person every 11 minutes[1]
- Suicide deaths are **2.6 times** the number of homicides (homicides=18,830) [1]
- **10th** leading cause of death across the lifespan[1]
  - **2nd** leading cause of death for **10-34** year olds
- 3.6 Male deaths by suicide for every female death[1]
- Approximately 6000 Veterans die by suicide each year; accounting for **14%** of all suicides annually[2]
- Since 2009, suicides have **exceeded** motor vehicle crash related deaths[1]

1. U.S. CDC WISQARS Fatal Injury Data, 2018 update. Accessed July 2020; https://www.cdc.gov/injury/wisqars/index.html
2. 'VA National Suicide Data Report, 2005-2016' report, September 2018, U.S. Department of Veteran Affairs.

Suicide in Maine, 2017-2019

- **273 suicide deaths per year on average[1]**
  - **9th** leading cause of death among all ages (previously 10th, 2012-2014)
  - **2nd** leading cause of death ages 15-34
  - **4th** leading cause of death ages 35-54

- More suicide deaths in Maine than homicides and motor vehicle traffic deaths[1]:
  - **13.5x** homicide deaths (770 suicide deaths vs 57 homicides)
  - **1.6x** motor vehicle deaths (770 suicide deaths vs 495 motor vehicle traffic dea

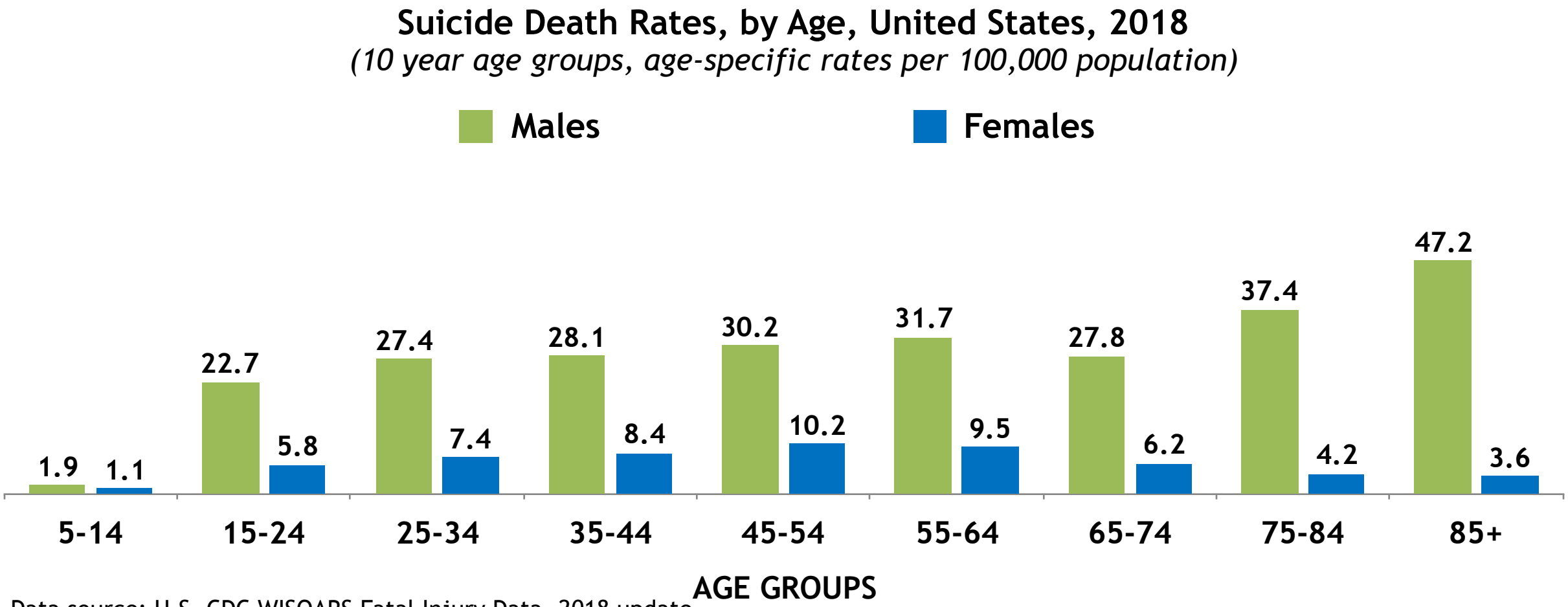
1. U.S. CDC WISQARS Fatal Injury Data, 2018 update. Accessed July 2020 ; https://www.cdc.gov/injury/wisqars/index.html

Suicide in Maine, 2016-2018

- Every **1.3 days** someone dies by suicide in Maine[1]
  - **Every 1.7 weeks** a young person (10-24 years) dies by suicide
- Approximately **4** female attempts per every **3** male attempts[2]
- **Firearms** most prevalent method of all suicide deaths (**53%**) [1]
  - Among youth ages 10-24 years, 60% of suicide deaths by firearms

1. U.S. CDC WISQARS Fatal Injury Data, 2017 update. Accessed July 2020; https://www.cdc.gov/injury/wisqars/index.html
2. Maine Hospital Inpatient Database, Maine Health Data Organization, 2016-2018.

In the U.S., suicide death rates among men are higher than women in all age groups.



Data source: U.S. CDC WISQARS Fatal Injury Data, 2018 update.

Trends in Suicidal Behavior in School-Age Youth

- In general, suicide risk increases with age through adolescence and young adulthood.
- Nationally and in Maine we have seen an increase in suicide in youth under age 15. Significantly, girls have shown more marked increase than boys.
- This is also reflected in increases in depression, anxiety an increase in depression, anxiety and NSSI among girls.
- School staff generally report increased signs that their students are under greater levels of stress and show reduced ability to cope with the stresses.
- These were pre-pandemic concerns.

Suicide Attempts

- A suicide attempt may be the first overt sign that someone is struggling!
- A call for Help
  - Often trigger being seen by a provider!
- Estimates 25 attempts for every suicide death
  - 200:1 for adolescents
- ***A past suicide attempt is most predictive of future suicide behavior. A more recent and severe the attempt, increases risk.***
- The response made to a suicide attempt strongly impacts future risk!

Mental Illness as a Risk Factor for Suicide

"Depression predicts suicide ideation, but not suicide plans or attempts among those with ideation. Instead, disorders characterized by severe anxiety/agitation (e.g., PTSD) and poor impulse-control (e.g., conduct disorder, substance use disorders) predict which suicide ideators go on to make a plan or attempt." Nock 2009

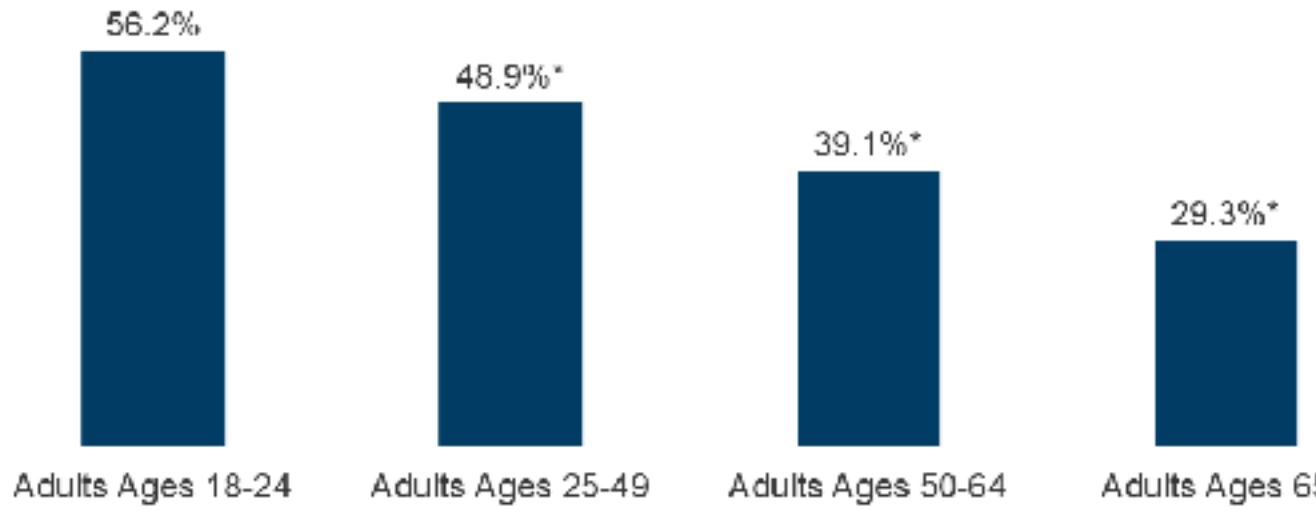
Comorbidity Issues in Suicidality

- 96% of suicide attempters and 89% of ideators met criteria for 1 or more DSM-IV disorder(Nock et al, 2103)
- Most common Dx. MDD, phobias, ODD, substance use Dx, and CD.
- DX with greatest predictor for suicide attempts include MDD, PTSD, eating disorders and Bipolar Dx.
- Highest risk for attempts among ideators with Dx characterized by high anxiety, agitation and poor behavior control.

COVID Impact: Anxiety and Depression

Figure 3

Share of Adults Reporting Symptoms of Anxiety and/or Depressive Disorder During the COVID-19 Pandemic, by Age



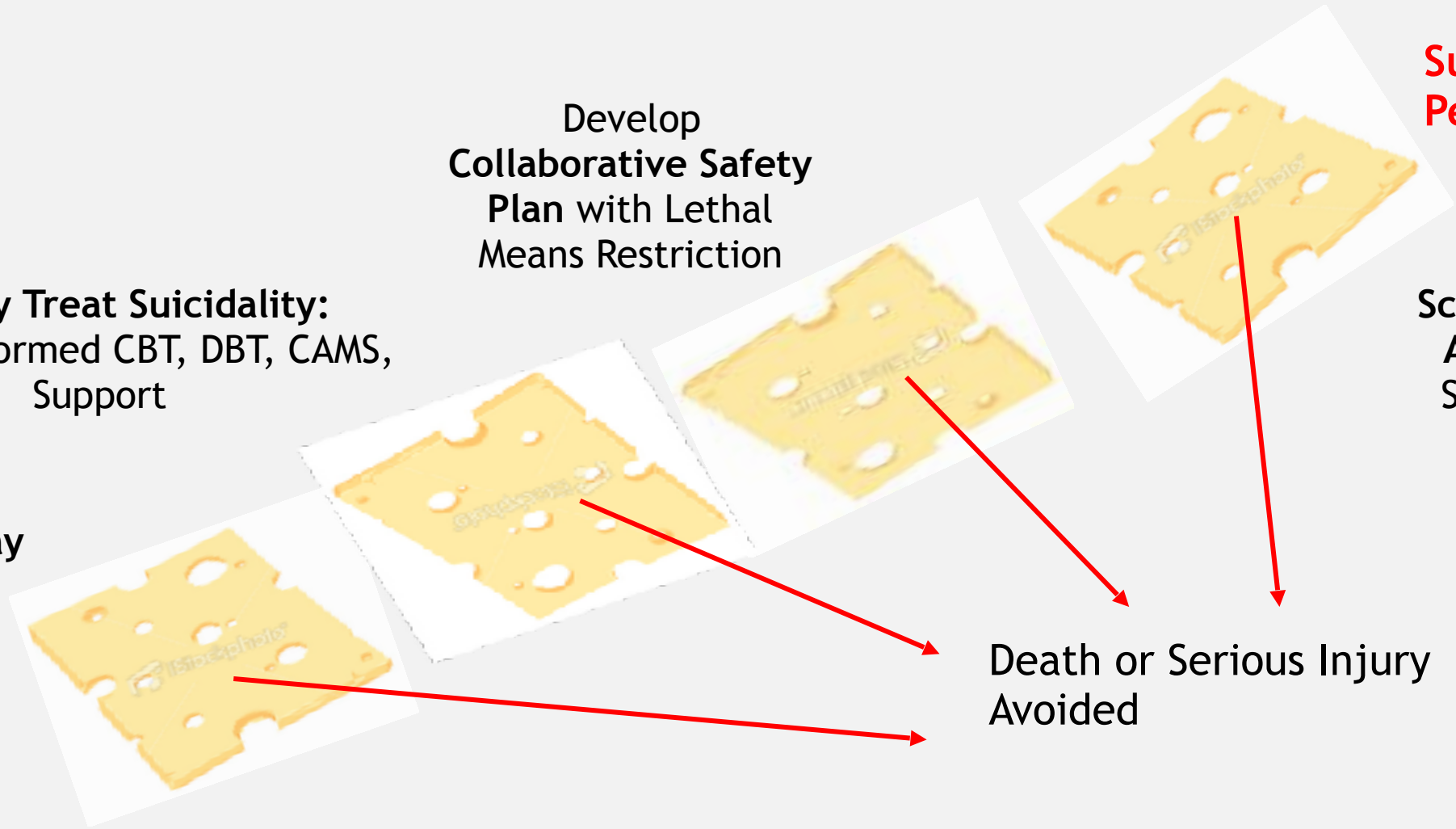
NOTES: *Indicates a statistically significant difference between adults ages 18-24. Data shown includes adults, ages 18+, with symptoms of anxiety and/or depressive disorder that generally occur more than half the days or nearly every day. Data shown is for December 9 – 21, 2020.
SOURCE: U.S. Census Bureau, Household Pulse Survey, 2020

KFF

Because suicide is often preventable…

Working toward Suicide Safer Care

Systematic Suicide Care
Plugs the Holes in Health Care



Developing a Suicide-Informed Practice

- All staff see suicide prevention as part of their work and within their role.
- Training and support is available for their roles.
- **Protocols** are in place guiding screening, identification, assessment, management of risk
  - A standardized **assessment** tool is used
  - **Referrals** are made for treatment as indicated
  - **Collaborative Safety Planning** is used as a management tool
  - Continuity of care is assured through **proactive follow-up** for those identified as at risk.

Asking About Suicide

"The answers you get depend upon the questions you ask."

Thomas Kuhn

What is Your Reaction When Your Patient Talks About Suicide?

- Personal, at the gut level
- Professional
  - What are your concerns?
    - How will I manage this visit
    - Who else do I need to involve
    - What resources are available (in-house and community)
    - How do I know when I've done enough?
- How do you take care of yourself?

Asking About Suicide
Overcoming Societal Reluctance

- *Talk about suicide directly and without hesitation.*
  - Asking will not increase risk; it is what is needed
- *Ask using concrete and direct language.*
  - Are you thinking about dying today?
  - **How often** do you consider killing yourself?
  - Are you suicidal? Do you have a plan?
- *Vague or indirect questions elicit vague responses:*
  - Are you thinking of hurting yourself?
  - Do you feel safe?
- When in doubt about the answer, repeat the question differently. Not badgering, but gently persistent…

Assessment and Management Tools

Putting the information together to determine level of risk.

Decisions on Clinical Tools & Documentation

- What tools will be used as a depression screen and available for indicating suicide **screening** need? **PHQ-2 or PHQ-9…**
- What will you use as a **suicide screening/assessment tool**?
  - C-SSRS screen and assessment version across all programs?
  - Additional inpatient assessment questions?
  - Other…
- Will a standardized **safety-planning tool** be used?
- Who manages referrals for services?
- How will you track patients in need of **follow-up** or having a history of suicide attempts?
  - Clinical care outreach?
- How will elements be d**ocumented** and how will access to information be managed to ensure staff readiness?

Assessing Risk using Columbia Suicide Severity Rating Scale (C-SSRS)

- An evidence-based screening tool with applications as an assessment instrument
- Valid and reliable with many populations
- Level of information based upon clinical conversation guiding response
- Enables more nuanced estimation of risk
- Versions available for use with children/ adolescents.
- Used in primary care, inpatient settings, EDs, schools, by crisis teams…

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screening Version – Since Last Contact – for Medical/Surgical

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Since Last Contact**	
Ask questions that are bold and <u>underlined</u>	**YES**	**NO**
Ask Questions 1 and 2		
1) **<u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>**		
2) **<u>Have you actually had any thoughts of killing yourself?</u>**		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) <u>Have you been thinking about how you might do this?</u> E.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it."		

4) Have you had these thoughts and had some intention of acting on them? As opposed to "I have the thoughts but I definitely will not do anything about them."		
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?		
6) Have you ever done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: Was this within the past 3 months?**	**Lifetime** **Past 3 Months**	

Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral at Discharge
Item 2 Behavioral Health Referral at Discharge
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and Consider Patient Safety Precautions
Item 4 Psychiatric Consultation and Patient Safety Precautions
Item 5 Psychiatric Consultation and Patient Safety Precautions
Item 6 Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and Consider Patient Safety Precautions
Item 6 3 months ago or less: Psychiatric Consultation and Patient Safety Precautions

Using the C-SSRS Screen

- If the answer to the first 2 questions is ***NO***:
  - Ask the final question about Suicide Behavior to rule out history.
  - A NO answer on Q-6 finishes the screen.

- If ***YES***, ask questions 3,4,5 and 6.

- AN increase in yes answers indicates an increased risk. Presence of current or recent intent and plan indicates a full assessment is needed.
  - Complete full assessment or refer for crisis assessment of suicidality
  - Consider who is available to consult…

C-SSRS Full Assessment

- If C-SSRS screen indicates suicide risk, complete assessment version to determine level of risk and level of care needs,
- Suicidal Behavior
  - Suicide attempt history and para suicidal behavior history and details including **self-injurious behavior** done without suicidal intent
  - **Actual Attempt:** Most recent, most severe and trend toward increasing severity of damage…
  - Details about attempts **aborted** by self or **interrupted** by others,
  - A detailed assessment of recent **preparatory actions** including acquisition or availability of lethal means, rehearsal, writing a note. . .
  - An assessment of lethality, **level of damage** of attempt made,
  - **Potential lethality** of means and methods identified even if no damage

Short-term (Acute) Risk Factors and Symptoms- Psychological States

- Current **depression,** self-rated level of depressive Sx.
- **Acute psychic distress** (including anxiety, panic and especially agitation)
- **Extreme humiliation/disgrace**, shame, despair, loss of face
- **Acute Hopelessness / Demoralization**
- **Desperation**/sense of 'no way out'
- Inability to conceive of alternate solutions/**problem-solve**
- **Breakdown in communication**/loss of contact with significant others(including therapist)
- **Impulsivity/Aggression/Agitation**

Resources for Help

To address the Crisis

- **Statewide Crisis Line (888-568-1112)**
- **National Suicide prevention Lifeline 800-273-8255**
- Hospital emergency room
- 911

For follow-up, support & information

- NAMI Maine's Teen Support Text Line
- Evaluation for medication management
- Referral to community counselors/therapist
- Other…. ?

With whom can you consult for questions and concerns?

When to Call or Text Crisis

- “Call early, call often”
- Crisis clinicians are:
  - Available 24 / 7 by phone call or text through a statewide center.
  - Clinicians available regionally to come to your location or meet in a safe place for an assessment
  - Gatekeepers for admission into a hospital
- Call or Text for a phone consult when you are:
  - Concerned about someone’s mental health
  - Need advice about how to help someone in distress
  - Worried about someone and need another opinion
- The initial contact is free

1-888-568-1112

MAINE CRISIS LINE

CALL. TEXT. CHAT.

Safety Planning and Follow-up

Collaborative Safety Planning

A Safety plan is a written list of coping activities, personal, social and professional resources **developed with a person**, for use after the initial crisis:

- More than "*Assess and refer*" for those not hospitalized.

- Safety planning is work with a person willing, ready & able to engage in planning for their safety
  - Allows exploration of personal and social resources and the ability to mobilize them.
  - An opportunity for collateral contact
  - A time for securing lethal means!

7 Steps of Safety Planning
Handout

- Step 1: Recognize warning signs
- Step 2: Engage internal coping strategies
- Step 3: Connect with people and places that can serve as a distraction from suicidal thoughts and who offer support
- Step 4: Identify and engage family members or friends who may offer help and support
- Step 5: Identify professional resources
- Step 6: Reduce the potential for use of lethal means
- Step 7: Acknowledge what is worth living for!

Lethal Means Restriction

Securing Access to Lethal Means

- ***Always ask about the presence of firearms***, alcohol, drugs and medication (or other means as identified)
- Work with collateral contacts as needed to secure lethal means.
  - Family &/or parents/ friends (adult)
  - Police
- Document the query, the response and the plan.
- Access should be made as difficult as possible

Assured Follow-up is Vital

As many as 70 percent of suicide attempters of all ages will never make it to their first outpatient appointment. Across all studies, the rate for non-attendance is about 50 percent.

Efforts to improve suicide assessments, follow-up and continuity of care and to forestall readmission should target higher-risk patients prone to disengagement and non-adherence.

David Knesper, MD

Follow-up Care after the Crisis

- **For a person at increased suicide risk, close follow-up is a vital and integral part of care.**
-
- Studies support the benefit of follow-up contact in reducing the incidence of future suicide attempts.
  - Presents the opportunity to assess for improvement or lack of improvement
  - Allows for altering treatment and supports.

- A practice tracking system can be an effective tool to ensure needed follow-up is scheduled and documented. A flagging system…

Acknowledgements

This training was developed with resources and materials adapted from many sources in the US, including:

Action Alliance for Suicide Prevention: Zero Suicide Initiative

American Foundation for Suicide Prevention

American Association of Suicidology

Columbia University C-SSRS

American Psychiatric Assoc.- APA guidelines

Maine Suicide Prevention Program

National Alliance On Mental Illness of Maine

MSPP Training and *Technical Assistance*

- *Suicide Prevention Gatekeeper Training (Virtual Option)*
- *Practice-level Lunch and Learn (Virtual Option)*
- *Suicide Prevention Protocol Development Training & TA*
- *Suicide Assessment for Clinicians (Virtual Option)*
- *Collaborative Safety Planning*
-
- *Non-Suicidal Self Injury*

Contact NAMI Maine Training Coordinator for more details: mspp@namimaine.org

Suicide Safer Care Training Portal

The Maine Center for Disease Control and Prevention and Sweetser are pleased to bring you the Suicide Safer Care Training Portal found at: https://sweetser.academy.reliaslearning.com/

Maine Suicide Prevention Program

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Questions?