Managing Suicide in Primary Care

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Consider Your Own Bias and Beliefs about Suicide

1. Why do people kill themselves?
2. What do I believe morally, spiritually and/or religiously about suicide?
3. What type of person makes a suicide attempt?
4. Can suicide be prevented?
5. Who do I know who has been suicidal, made an attempt or died by suicide?
6. What do I think about my own personal thoughts of death, dying and/or suicide?
7. How have the suicide deaths of my clients influenced my practice habits?
8. What is my responsibility to my clients as a clinician?

Adequate Training?

Studies have found that less than half of behavioral health professionals receive formal training in suicide risk management in graduate school and the average total duration of formal suicide management training is under 2 hours in duration (Bongar & Harmatz, 1991; Feldman & Freedenthal, 2006; Guy, Brown & Poelstra, 1990).

A recent study found that psychologists found:

> "Psychologists were less willing to work with a client experiencing suicidality than an individual without elevated suicide risk. Those indicating a reluctance to provide services reported greater concerns over the adequacy of their suicide-related skills and training and fewer resources in the community."

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Suicide-Related Terms

Suicide attempt

Intentional, self-enacted, potentially injurious behavior with any (nonzero) amount of intent to die, with or without injury

Suicidal ideation

Thoughts of ending one's life or enacting one's death

Nonsuicidal self-injury

Intentional, self-enacted, potentially injurious behavior with no (zero) intent to die, with or without injury

Nonsuicidal morbid ideation

Thoughts about one's death without suicidal or self-enacted injurious content

A Few Words about Nonsuicidal Self-Injury

In the year following treatment for nonsuicidal self-injury, 1 out of 5 people repeat the act and over 20% die by suicide (Owens et al. 2002)

Almost half of those who seek medical care following an incident of nonsuicidal self-injury, had consumed alcohol in the period prior to the incident (Hawton et al. 1989; Touquet et al. 2008)

Standardizing Suicide Language

Consider eliminating the following terms:

Suicide gesture

Parasuicide

Suicide threat

Self-mutilation

“Commit” suicide

“Cry for help”

Should We Screen for Suicide Screening in Primary Care?

- Only 17% of pts endorsing SI on paper-and-pencil screeners disclosed SI to PCPs during medical appt (Bryan et al, 2008)

- 6.6% of depressed pts endorsed SI/DI on PHQ-9 (Corson et al., 2004)
  - 35% of positive screens had SI
  - 20% of positive screens had plan

- USPSTF found inadequate evidence about the costs and the benefits of routine screening in primary care (O'Connor, Gaynes, Burda, Williams C, Whitlock, 2013)

Prevalence Rates

- Prevalence rate for suicidal ideation and suicidal behaviors in general medical settings = 2 to 5% (Cooper-Patrick, Crum, & Ford, 1994; Olfson et al, 1996; Pfaff & Almeida, 2005; Zimmerman, et al., 1995)

- It remains one of the top ten causes of death in America among adults. (31K per year; Hoyert, Heron, Murphy, & Kung, 2006)

- Among children and adolescents ages 10-18, it remains the #2 cause of death (Centers for Disease Control, 2016)
  https://www.cdc.gov/injury/wisqars/pdf/leading_causes_of_death_by_age_group_2016-508.pdf

- For PC patients referred to integrated BH provider, prevalence = 12.4% (Bryan et al, 2008)

Suicide in Primary Care

- Suicidal patients report poorer health and visit medical providers more often (Goldney et al, 2001)
  - Greater levels of bodily pain
  - Lower energy
  - More physical limitations

- Medical visits increase in frequency in weeks preceding death by suicide (Juurlink et al, 2004)
  - Up to 3 visits per month for suicidal patients

Suicide in Primary Care

- Estimated 1-10% of PC patients experience suicidal symptoms at any given time

- Of individuals who die by suicide:
  - 45% visit PCP within one month (Luoma, Martin, & Pearson, 2002)
  - 20% visit PCP within 24 hrs (Pirkis & Burgess, 1998)
  - 73% of the elderly visit w/in 1 month (Juurlink et al., 2004)

Primary Care is a Critical Window of Opportunity

Top 5 chief complaints by patients during the visits immediately preceding their suicides:

Anxiety

Unspecified gastrointestinal symptoms

Unexplained cardiac symptoms

Depression

Hypertension

Other Problems

- GPs noted suicide risk in only 3% of patients who died by suicide (Appleby et al, 1996)

- Nonpsychiatric providers less likely to ask about suicide, and pts are less likely to endorse SI (Coombs et al, 1992)

- Suicidal pts much less likely to communicate suicide risk to nonpsychiatric providers than MH providers (Isometsa et al, 1994)

The Importance of Fluid Vulnerability Theory

Suicide risk is actually comprised of two dimensions:

1. Baseline: Individual's "set point" for suicide risk, comprised of static risk factors and predispositions

2. Acute: Individual's short-term or current risk, based on presence of aggravating variables and protective factors

Implications for Care

Suicide risk fluctuates over time from moment to moment, & can re-emerge after resolution

In PC, there is no such thing as a “closed case”

Multiple attempters especially will require ongoing monitoring, preventive interventions

When suicidal patients are sick, they will still see a PCP.

Limitations of Psychiatric Hospitalization

Psychiatric Hospitalization is not the “Gold Standard” for treatment

→Many clinicians assume that hospitalizing suicidal clients actually treats the suicidal symptoms. In most cases it doesn’t, it simply removes the clients’ opportunities and means to attempt suicide.

→This may be why the post-discharge suicide rate is approximately 100 times the global suicide rate during the first 3 months after discharge and patients admitted with suicidal thoughts or behaviors have rates near 200 times the global rate upon discharge (Chung et al., 2017)

→Therefore, it is incumbent on us - the outpatient medical community to more fully and accurately address the suicide

A Common Miscalculation Systems Make

“We just need to pay for more inpatient beds to handle the volume of at-risk patients.”

Treatment MUST occur primarily in outpatient settings.

Roles

Staff Member	Role
PCP	Identify, refer, warm handoff, manage medication
Nurse	Identify, refer, coordinate care, communicate
Medical Assistant	Identify, refer, coordinate care, communicate
BHP	Identify, assess and reduce risk, determine disposition, make recommendations to staff, *provide treatment
MH Provider	Provide treatment and continuously assess risk; provide consultation & liaison services

*The type of treatment delivered depends on the setting and integration model.

Role of Nurses and Medical Assistants

- Screening for suicidal symptoms
- Care coordination and facilitation of disposition

(Bryan & Corso, 2014)

Role of PCP

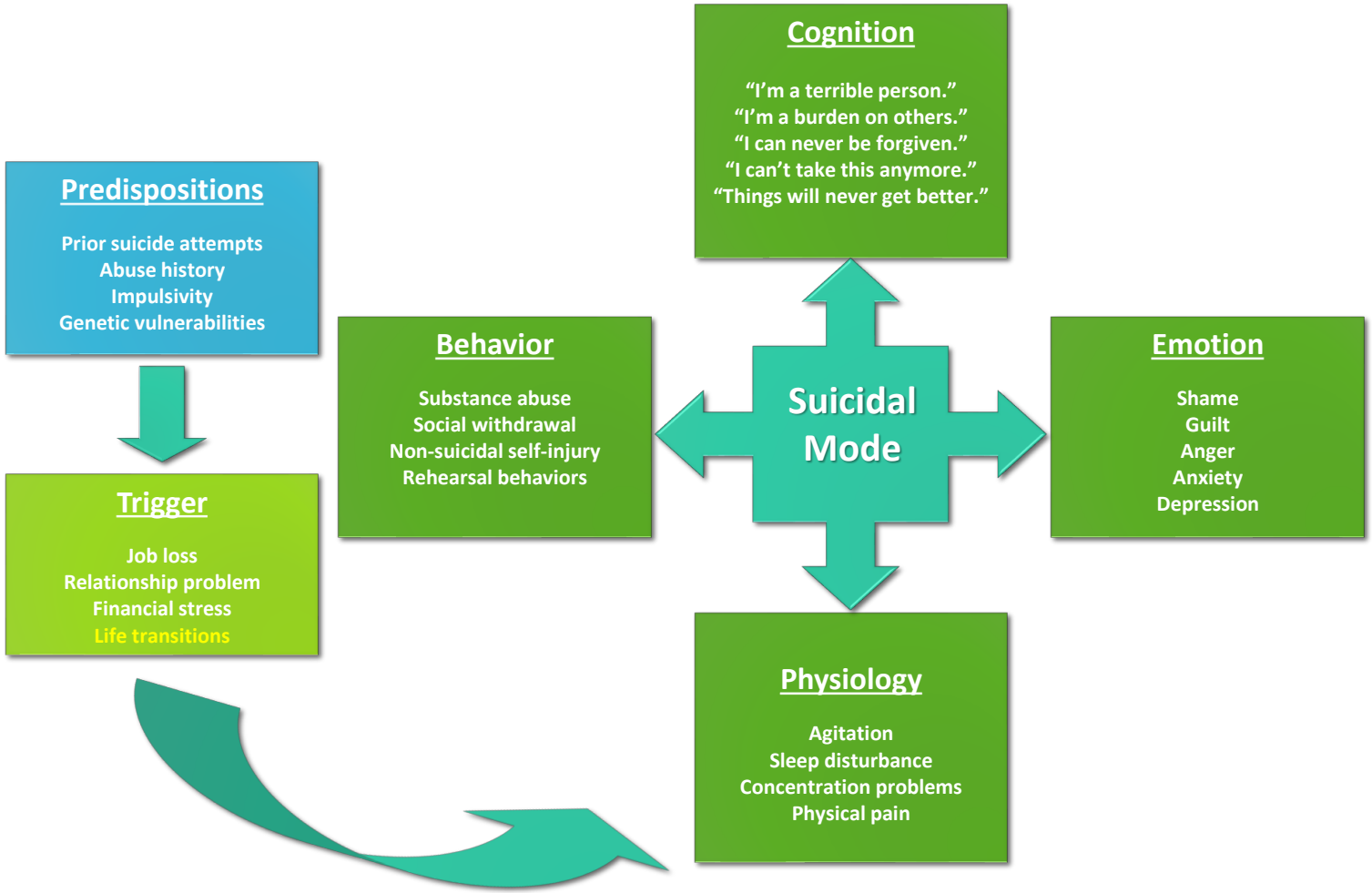
- Follow-up assessment and risk determination
- Warm hand-off
- Medication management

(Bryan & Corso, 2014)

Role of BHC

- Integration of MH into primary care is practical and effective approach
- Risk assessment primarily
- Additional management interventions if needed
- Transition/bridge to specialty MH services

(Bryan & Corso, 2014)


Predispositions
Prior suicide attempts
Abuse history
Impulsivity
Genetic vulnerabilities
Trigger
Job loss
Relationship problem
Financial stress
Life transitions
Cognition
"I'm a terrible person."
"I'm a burden on others."
"I can never be forgiven."
"I can't take this anymore."
"Things will never get better."
Behavior
Substance abuse
Social withdrawal
Non-suicidal self-injury
Rehearsal behaviors
Suicidal Mode
Emotion
Shame
Guilt
Anger
Anxiety
Depression
Physiology
Agitation
Sleep disturbance
Concentration problems
Physical pain

Suicide is a State of…

- Hopelessness
- Burdensomeness
- Powerlessness
- Thwarted Belongingness

Don’t try to talk the person out of killing himself/herself

Instead, Help Patients Learn to Cope

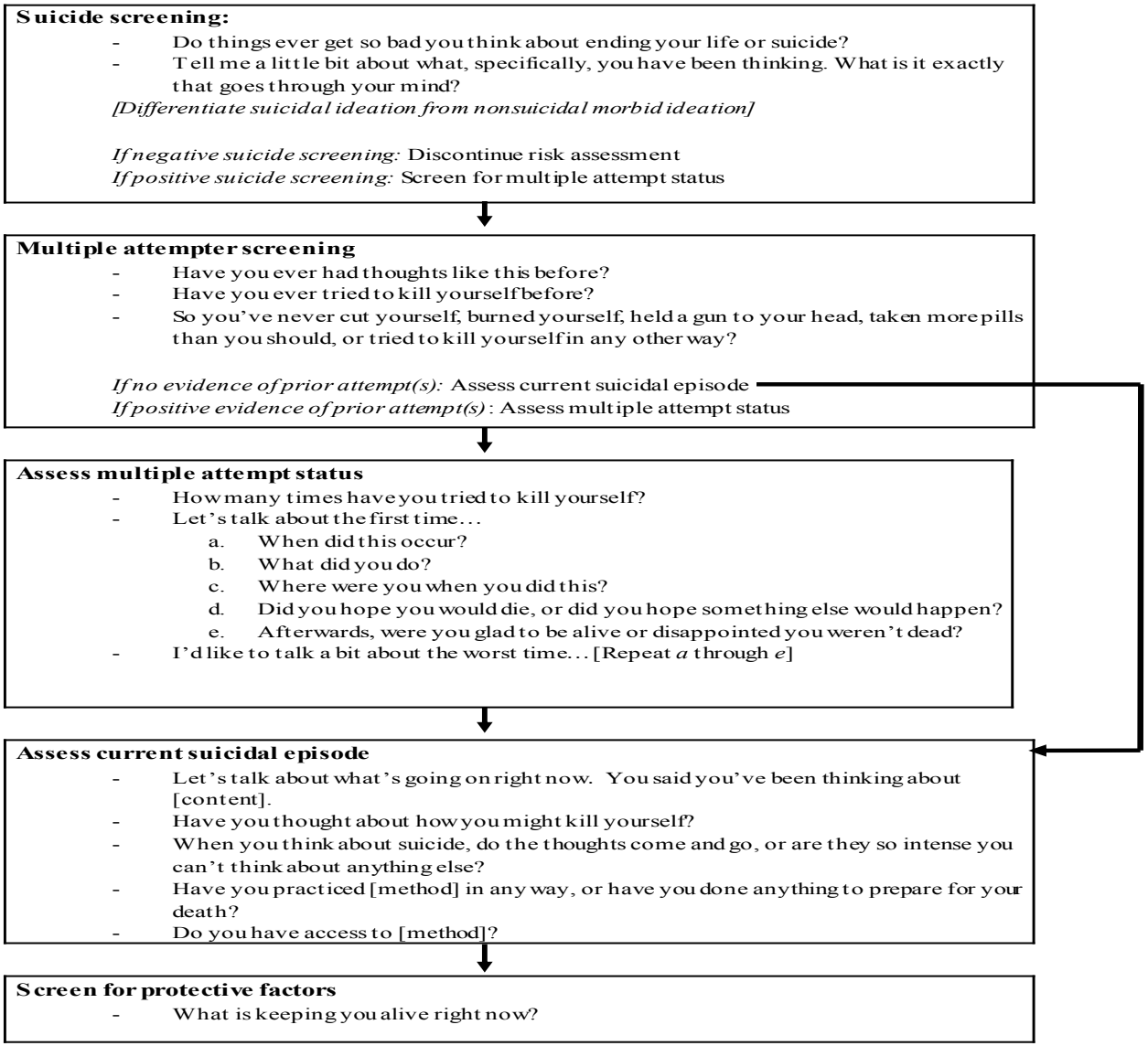
- A stronger sense of meaning in life is significantly associated with lower emotional distress, less severe suicidal ideation, and better functioning across multiple domains of life (Bryan et al., 2013).

- "Effective" Crisis Response Planning reduces suicide attempts up to 76% (Bryan et al., 2017 a, b)

- BCBT reduces suicidal behavior by 60% compared to treatment as usual (Bryan et al., 2015)

The Bad News About Risk Prediction

According to two recent studies, considering the last 50 years of research, our ability to predict future suicides and suicidal behaviors is generally poor (Belsher et al., 2019; Franklin et al,. 2017).



(Bryan, Corso, Neal-Walden, & Rudd, 2009)

SKILL ONE

Differentiate suicidal ideation from nonsuicidal ideation*

*also called non lethal morbid ideation or death ideation

Sample Questions

Have you thought about ending your life or killing yourself?

Have you had thoughts of death or dying? If so, have you thought you might play a role in making your death happen?

Some people think about not being here or falling asleep and not waking up, while others think about actually doing something to enact their death. Are your thoughts more like the first ones or the second ones?

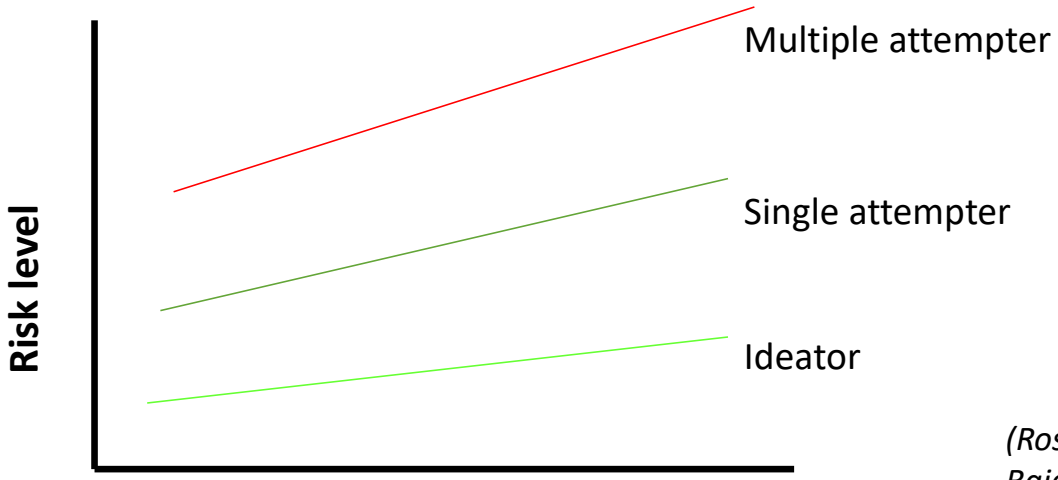
SKILL TWO

Assess for past suicidal behaviors and multiple attempt history

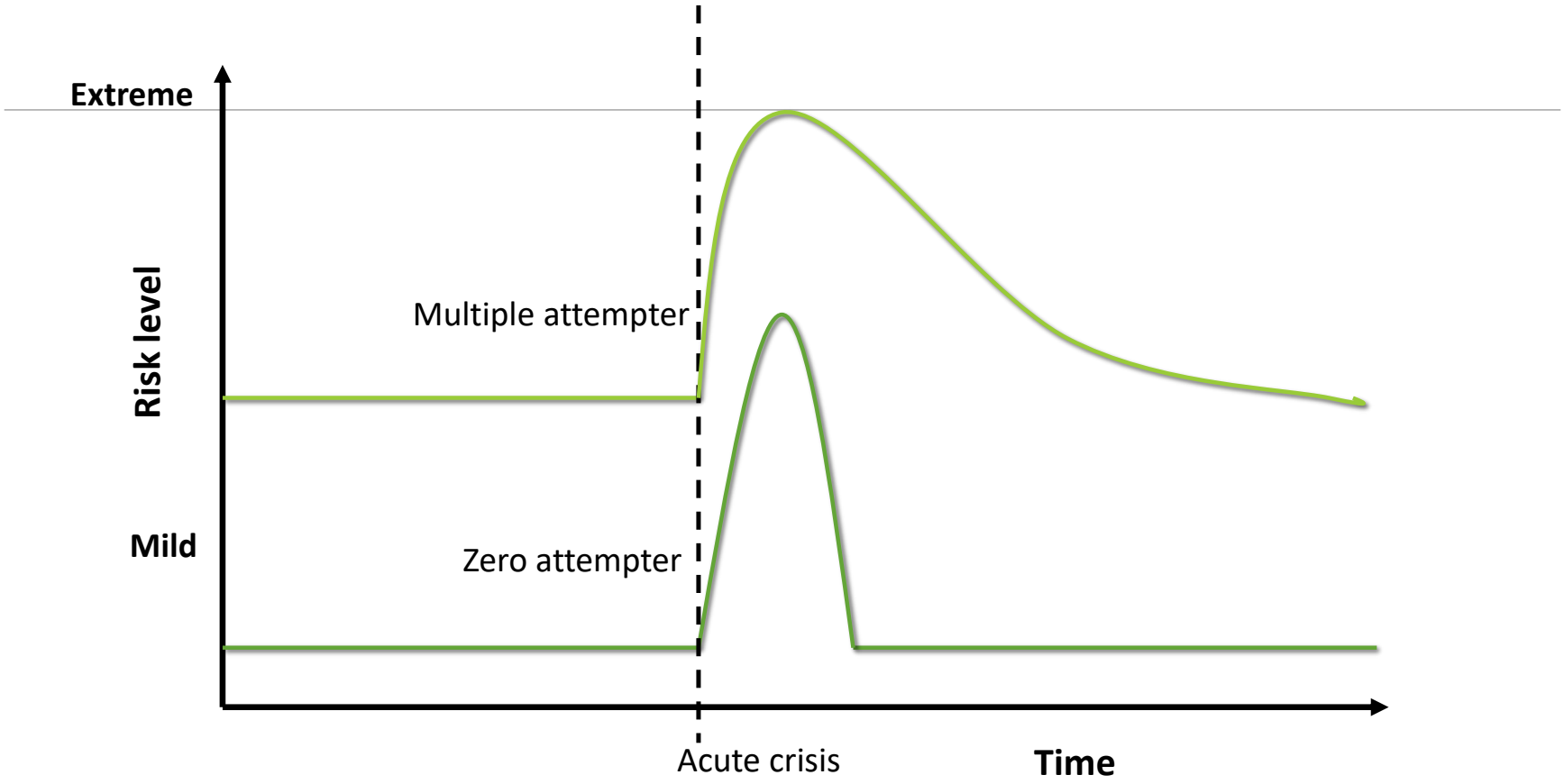
Why Bother?

Three distinct groups:

- Suicide ideator: Zero previous attempts
- Single attempter: One previous attempt
- Multiple attempter: 2 or more previous attempts



(Rosenberg et al, 2005; Rudd, Joiner, & Rajab, 1996; Wingate et al, 2004)


Extreme
Risk level
Mild
Multiple attempter
Zero attempter
Acute crisis
Time

Multiple Attempters

Objective indicators are better predictors than subjective indicators (Beck et al., 1974; Beck & Steer, 1989; Harriss et al., 2005; Hawton & Harriss, 2006)

Survival reaction can serve as indirect indicator of intent (Henriques et al., 2005)

“Worst point” suicidal episode better predictor than other episodes (Joiner et al., 2003)

Sample Questions

Have you ever tried to do anything, prepared to do anything or started to do anything to end your life?

Have you ever mentally or physically rehearsed how you might end your life?

Have you ever had a prior suicide attempt?

(if yes) Have you had two or more?

SKILL THREE

Assess the current suicidal episode

Current Suicidal Episode

Resolved Plans & Preparation

- Sense of courage
- Availability of means
- Opportunity
- Specificity of plan
- Duration of suicidal ideation
- Intensity of suicidal ideation

Suicidal Desire & Ideation

- Reasons for living
- Wish for death
- Frequency of ideation
- Desire and expectancy
- Lack of deterrents
- Suicidal communication

≥2 factors of suicidal desire and ideation = mild

≥1 factor of resolved plans and preparation = moderate

Anything above these = Severe or Extreme

Current Suicidal Episode

Intent

Objective

- Isolation
- Likelihood of intervention
- Preparation for attempt
- Planning
- Writing a suicide note

Subjective

- Self-report of desired outcome
- Expectation of outcome
- Wish for death
- Low desire for life

Sample Questions

Have you thought about how you might kill yourself?

Do you know where or when you might do this?

When you think about suicide, do the thoughts come and go, or are they so intense you can't think about anything else?

Have you practiced [method] in any way, or have you done anything to prepare for your death?

Do you have access to [method]?

What do you hope will happen?

Assess Access to Lethal Means

Suicidal intent has weak relationship with lethality of suicide attempt

(Brown et al., 2004; Plutchik et al., 1988; Swahn & Potter, 2001)

Patients tend to have inaccurate expectations about lethality of methods

(Beck, Beck, & Kovacs, 1975; Brown, Henriques, Sosdjan, & Beck, 2004)

Availability of means demonstrates strong association with lethality

(Eddleston et al, 2006; Peterson et al, 1985)

Assess Access to Lethal Means

Among survivors of highly lethal suicide attempts:

24% made the decision to act within 5 mins

70% made the decision to act within 60 mins

(Simon et al., 2001)

Strong link between suicide and length of time from firearm purchase

(Wintemute et al., 1999)

Means Restriction Effectiveness

Reducing access to lethal methods for suicide reduces suicide rates by that method:

- Firearms (Beautrais, 2000; Beautrais et al., 2006; Leenaars et al., 2003; Loftin et al., 1991)
- Carbon monoxide (Nordentoft et al., 2006)
- Barbiturates (Nordentoft et al., 2006)
- Pesticides (Gunnell et al., 2007)

Means Restriction Counseling Effectiveness

Of those clients or parents who receive means restriction counseling following a suicide attempt (vs. no counseling):

- 86% vs. 32% lock up/dispose of medications (McManus et al., 1997)
- 75% vs. 48% removed prescription meds
- 48% vs. 22% removed OTC meds
- 47% vs. 11% restricted alcohol access
- 63% vs. 0% removed firearm

(Kruesi et al., 1999)

Assess Intent and Address Ambivalence Explicitly

Most people, when they think about killing themselves, don't truly want to die, they just don't want to live if they have to keep feeling all the bad things they feel. **Is that how you feel?**

"Most people who are thinking about suicide have reasons for living and reasons for dying – they are ambivalent. And, the things that are upsetting them are so overwhelming that they can't see any way to overcome it all, so killing themselves comes to mind, as a way to stop the pain. **Does that describe you?"**

"Is it that you want to die because you can't keep living with how you feel and you can't find any other way to make it go away? **In other words, if you could get past the things that are causing you pain, and you were feeling better, would you still want to die? Or would you want to live? "**

What do Patients Believe about their Suicidal Symptoms?

- I'm going crazy
- Since I've never felt this way before, I can't relate to myself – I don't feel like me
- I am losing control of myself
- I might not be able to stop myself from acting on my suicidal thoughts
- I'm not who I thought I was

Explain that Suicide is a State of Ambivalence

Most people, when they think about killing themselves, don't truly want to die, they just don't want to live if they have to keep feeling all the bad things they feel.

SKILL FOUR

Ask about Reasons for Living

- Addresses ambivalence…hopefully it tips the scale in the right direction
- It keeps the person future oriented

"Before, we discussed how you have ambivalence about living and dying – that you don't really want to die, but you just can't stand living this way. If we could help you relieve your pain, what would that allow you to enjoy in life?"

"What is keeping you alive right now?"

"Take all the pain and put it aside in your mind for a moment; what is the most important thing to you in your life?"

SKILL FIVE

Crisis Response Plan (CRP)

Helping patients create AND USE a CRP is one of the most effective tools you can provide.

Warning Signs

Pacing
Feeling angry
"I can't take this anymore"

Self-Management

Go for a walk
Listen to some music
Play games on my phone

Reasons For Living

My kids (Tim and Lisa)
My wife (Susan)

Social Support

Call Susan (wife): 555.555.5555
Call John (friend): 555.555.5555

Crisis & Professional Services

Call my doctor & leave a message: 555.555.5555
Call hotline: 1.800.273.TALK
Crisis text line: 838255
Go to hospital
Call 911

Suicide Risk Assessment Plan

- ❑ Ask about suicidal thoughts differentiate these from nonsuicidal thoughts
- ❑ Ask about any history of suicide attempts
- ❑ Ask about current suicidal thoughts, plans and intent
- ❑ Ask about any plans and access to means
- ❑ Explain ambivalence – ask if the person feels ambivalent
- ❑ Transition discussion to reasons for living (in light of ambivalence)
- ❑ Develop a crisis response plan -> not simply a safety plan → NEVER a safety contract!

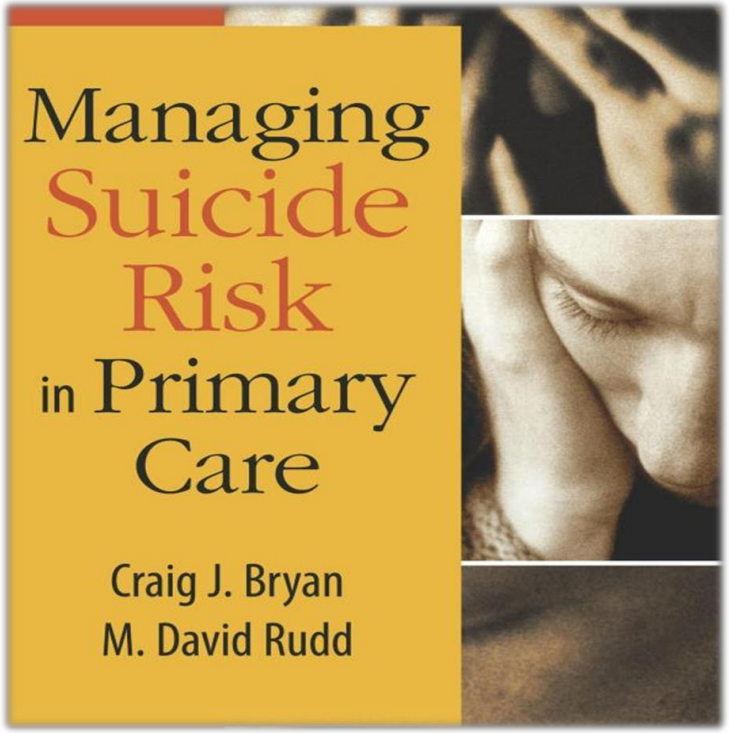
Suicide Documentation Plan

- ❑ Document presence/absence of suicidal thoughts vs. death ideation
- ❑ Document number of prior suicide attempts
- ❑ Document presence/absence any plans and access to means
- ❑ Document static and dynamic risk factors; frequency duration and intensity of current suicidal thoughts, plans and intent
- ❑ Document your explicit discussion of ambivalence and the patient's response
- ❑ Document your discussion of reasons for living
- ❑ Document that patient agreed to outpatient treatment (insert type) with use of a crisis response plan

Table 4. Factors Associated With an Increased Risk for Suicide

Suicidal thoughts/behaviors
Suicidal ideas (current or previous)
Suicidal plans (current or previous)
Suicide attempts (including aborted or interrupted attempts)
Lethality of suicidal plans or attempts
Suicidal intent
Psychiatric diagnoses
Major depressive disorder
Bipolar disorder (primarily in depressive or mixed episodes)
Schizophrenia
Anorexia nervosa
Alcohol use disorder
Other substance use disorders
Cluster B personality disorders (particularly borderline personality disorder)
Comorbidity of axis I and/or axis II disorders
Physical illnesses
Diseases of the nervous system
Multiple sclerosis
Huntington's disease
Brain and spinal cord injury
Seizure disorders
Malignant neoplasms
HIV/AIDS
Peptic ulcer disease
Chronic obstructive pulmonary disease, especially in men
Chronic hemodialysis-treated renal failure
Systemic lupus erythematosus
Pain syndromes
Functional impairment
Psychosocial features
Recent lack of social support (including living alone)
Unemployment
Drop in socioeconomic status
Poor relationship with family[a]
Domestic partner violence[b]
Recent stressful life event
Childhood traumas
Sexual abuse
Physical abuse
Genetic and familial effects
Family history of suicide (particularly in first-degree relatives)
Family history of mental illness, including substance use disorders
Psychological features
Hopelessness
Psychic pain[a]
Severe or unremitting anxiety
Panic attacks
Shame or humiliation[a]
Psychological turmoil[a]
Decreased self-esteem[a]
Extreme narcissistic vulnerability[a]
Behavioral features
Impulsiveness
Aggression, including violence against others
Agitation
Cognitive features
Loss of executive function[b]
Thought constriction (tunnel vision)
Polarized thinking
Closed-mindedness
Demographic features
Male gender[c]
Widowed, divorced, or single marital status, particularly for men
Elderly age group (age group with greatest proportionate risk for suicide)
Adolescent and young adult age groups (age groups with highest numbers of suicides)
White race
Gay, lesbian, or bisexual orientation[b]
Additional features
Access to firearms
Substance intoxication (in the absence of a formal substance use disorder diagnosis)
Unstable or poor therapeutic relationship[a]

Book Recommendation



Questions

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