Welcome to SPRC’s Research to Practice Webinar on

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

David A. Litts, O.D.
Director Science and Policy

Suicide Prevention Resource Center

March 30, 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

- Society
- Community
- Relationship
- Individual
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 skills
- Frustration tolerance and emotion regulation
- Cultural and religious beliefs; spirituality

Source:
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
PRIMARY CARE

A Suicide Prevention Toolkit for (Rural) Primary Care

http://www.sprc.org/pctoolkit/index.asp
Why Primary Care?

- Suicide decedents twice as likely to have seen a PC provider than a MH provider prior to suicide*
- 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

## Contact with Primary Care and Mental Health Prior to Suicide

<table>
<thead>
<tr>
<th></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>

### Contact w/ PC by Age

<table>
<thead>
<tr>
<th>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>

### Contact w/ MH by Gender

<table>
<thead>
<tr>
<th>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>

Figure 3.

Gun Storage Practices and Youth Suicide Risk

Source: (Grossman et al., 2005)
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
Six sections

- Getting started
- Educating clinicians and office staff
- Developing mental health partnerships
- Patient management tools
- Patient education tools
- Resources

The Toolkit is available in 2 forms

- Hard copy, spiral bound ordered through WICHE
- Electronic copy (www.sprc.org)
1. Getting Started

**QUICK START GUIDE**

*How to use the Suicide Prevention Toolkit*

**STEP 1**
Communicate with staff about the new Suicide Prevention Initiative in your office. Determine who will be the lead coordinator in your office. That individual should familiarize himself/herself with the entire contents of the Toolkit.

**STEP 2**

**STEP 3**
Schedule necessary trainings for staff members according to the individual suicide prevention responsibilities determined in Step 2.

**STEP 4**
Develop a referral network to facilitate the collaborative care of suicidal patients. Use the “Developing Mental Health Partnerships” material in...
Protocol for Suicidal Patients - Office Template
Post in a visible or accessible place for key office staff.

If a patient presents with suicidal ideation or suicidal ideation is suspected...

- __________________________ should be called/paged to assist with evaluation of risk (e.g., physician, mental health professional, telemedicine consult etc.).
- Identify and call emergency support person in the community (e.g., family member, pastor, mental health provider, other support person).

If a patient requires hospitalization...

- Our nearest Emergency Department or psychiatric emergency center is __________________________. Phone # __________________________.
- __________________________ will call __________________________ to arrange transport.
  (Name of individual or job title) (Means of transport [ambulance, police, etc] and phone #)
  Backup transportation plan: Call __________________________.
- __________________________ will wait with patient for transport.

Documentation and Follow-Up...

- __________________________ will call ED to provide patient information.
  (Name of individual or job title)
- __________________________ will document incident in __________________________.
  (Name of individual or job title) (e.g. medical chart, suicide tracking chart, etc.)
- Necessary forms are located __________________________.
- __________________________ will follow-up with ED to determine disposition of patient.
  (Name of individual or job title)
- __________________________ will follow up with patient within __________________________.
  (Name of individual or job title) (Time frame)
2. Educating Clinicians and Office Staff

- Primer with 5 brief learning modules
  - Module 1- Prevalence & Comorbidity
  - Module 2- Epidemiology
  - Module 3- Effective Prevention Strategies
  - Module 4- Suicide Risk Assessment
    - Warning Signs, Risk Factors, Suicide Inquiry, Protective Factors
  - Module 5- Intervention
    - Referral, PCP Intervention, Documentation & Follow-up
3. Developing Mental Health Partners

- Letter of introduction to potential referral resources--template
  - Increasing vigilance for patients at risk for suicide
  - Referring more patients
  - SAFE-T card for Mental Health Providers
  - Invitation to meet to discuss collaborative management of patients
  - NSSP recommends training for health care professionals
  - Nationally disseminated trainings for MHPs
3. MH Partners

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical changes for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- Suicidal behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- Current/past psychiatric disorders: especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity).
- Co-morbidity and recent onset of illness increase risk
- Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- Family history: of suicide, attempts, or Axis I psychiatric disorders requiring hospitalization
- Precipitants/Stressors/Interpersonal: triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CHS disorders, pain), Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation.
- Change in treatment: discharge from psychiatric hospital, provider or treatment change
- Access to firearms

2. PROTECTIVE FACTORS

- Internal: ability to cope with stress, religious beliefs, frustration tolerance
- External: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY

Specific questioning about thoughts, plans, behaviors, intent
- Ideation: frequency, intensity, duration—in last 48 hours, past month and worst ever
- Plan: timing, location, lethality, availability, preparatory acts
- Behaviors: past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self-injurious actions
- Intent: extent to which the patient (1) expects to carry out the plan and (2) believes the plan will be lethal vs. non-lethal: Explore ambivalence: reasons to die vs. reasons to live

4. RISK LEVEL/INTERVENTION

- Assessment of risk level is based on clinical judgment, after completing steps 1-3
- Reassess as patient or environmental circumstances change

<table>
<thead>
<tr>
<th>RISK LEVEL</th>
<th>RISK / PROTECTIVE FACTOR</th>
<th>SUICIDALITY</th>
<th>POSSIBLE INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Psychiatric disorders, with severe symptoms, or acute precipitating event; protective factors not relevant</td>
<td>Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal</td>
<td>Admission generally indicated unless a significant change reduces risk, suicide precautions</td>
</tr>
<tr>
<td>Moderate</td>
<td>Multiple risk factors, few protective factors</td>
<td>Suicidal ideation with plan, but no intent or behavior</td>
<td>Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers</td>
</tr>
<tr>
<td>Low</td>
<td>Multiple risk factors, strong protective factors</td>
<td>Thought of death, no plan, intent or behavior</td>
<td>Outpatient referral, symptom reduction. Give emergency/crisis numbers</td>
</tr>
</tbody>
</table>

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (i.e., medication, setting, E.C.T., contact with significant others, consultation); firearm instructions. If relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.)
3. MH Partners – Telemental Health

- Web-based guide for developing a telemental health capacity (created by the U CO Denver as part of SAMHSA’s Eliminating Health Disparities Initiative) [www.tmhguide.org](http://www.tmhguide.org)

- Resources for
  - Clinicians/Administrators
  - Consumers
  - Policymakers
  - Community Members
  - Media
3. MH Partners

- SAMHSA mental health and substance abuse treatment locator guides ([www.samhsa.gov](http://www.samhsa.gov))
Suicide Risk and Protective Factors

**RISK FACTORS**

- Current/past psychiatric disorders: especially mood disorders, psychotic disorders, alcohol/substance abuse, TBI, PTSD, personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive PD).
- Co-morbidity with other psychiatric and/or substance abuse disorders and recent onset of illness increase risk.
- Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations, intoxication. For children and adolescents: also oppositionality and conduct problems.
- Suicidal behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior.
- Family history: of suicide, attempts, or psychiatric diagnoses, especially those requiring hospitalization.
- Precipitants/stressors: triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial, or health status – real or anticipated).
- Chronic medical illness (esp. CNS disorders, pain).
- History of or current abuse or neglect.

**PROTECTIVE FACTORS**

Protective factors, even if present, may not counteract significant acute risk.

- Internal: ability to cope with stress, religious beliefs, frustration tolerance.
- External: responsibility to children or beloved pets, positive therapeutic relationships, social supports.
4. PC Patient Management—Pocket Card

Assessment and Interventions with Potentially Suicidal Patients

A Pocket Guide for Primary Care Professionals

Screening: uncovering suicidality
- Other people with similar problems sometimes lose hope; have you?
- With this much stress, have you thought of hurting yourself?
- Have you ever thought about killing yourself?
- Have you ever tried to kill yourself or attempted suicide?

Assess suicide ideation and plans
- Assess suicidal ideation – frequency, duration, and intensity
  - When did you begin having suicidal thoughts?
  - Did any event (stressor) precipitate the suicidal thoughts?
  - How often do you have thoughts of suicide?
  - How long do they last?
  - How strong are the thoughts of suicide?
  - What is the worst they have ever been?
  - What do you do when you have suicidal thoughts?
  - What did you do when they were the strongest ever?
- Assess suicide plans
  - 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 (drugs, gun, 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?

Assess suicide intent
- What would it accomplish if you were to end your life?
- Do you feel as if you’re a burden to others?
- How confident are you that your plan would actually end your life?
- What have you done to begin to carry out the plan? For instance, have you rehearsed what you would do (e.g., held pills or gun, tied the rope)?
- Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?
- What makes you feel better (e.g., contact with family, use of substances)?
- What makes you feel worse (e.g., being alone, thinking about a situation)?
- How likely do you think you are to carry out your plan?
- What stops you from killing yourself?

Endnotes:
1 SAFE-T pocket card. Suicide Prevention Resource Center & Mental Health Screening, (n/d).
4. PC Patient Management—Pocket Card

Assessment and Interventions with Potentially Suicidal Patients

- **High Risk**
  - Patient has a suicide plan with preparatory or rehearsal behavior
  - Patient has severe psychiatric symptoms and/or acute precipitating event, access to lethal means, poor social support, impaired judgement
  - Hospitalize, or call 911 or local police if no hospital is available. If patient refuses hospitalization, consider involuntary commitment if state permits
  - Take action to thwart the plan
  - Consider (locally or via telemedicine):
    1. Psychopharmacological treatment with psychiatric consultation
    2. Alcohol/drug assessment and referral, and/or
    3. Individual or family therapy referral
  - Encourage social support, involving family members, close friends and other community resources. If patient has therapist, call him/her in presence of patient

- **Moderate Risk**
  - Patient has suicidal ideation, but limited suicidal intent and no clear plan; may have had previous attempt
  - Evaluate for psychiatric disorders, stressors, and additional risk factors

- **Low Risk**
  - Patient has thoughts of death only; no plan or behavior

Patient has suicidal ideation or any past attempt(s) within the past two months. See right for risk factors and back for assessment questions.
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.

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.
Kemball et al. (2008)

- 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

Is Your Patient Suicidal?

1 in 10 suicides are by people seen in an ED within 2 months of dying. Many were never assessed for suicide risk. Look for evidence of risk in all patients.

Signs of Acute Suicide Risk

- Talking about suicide
- Seeking lethal means
- Purposeless
- Anxiety or agitation
- Insomnia
- Substance abuse
- Hopelessness
- Social withdrawal
- Anger
- Recklessness
- Mood changes

Other factors:

- Past suicide attempt increases risk for a subsequent attempt or suicide, multiple prior attempts dramatically increase risk.
- Triggering events leading to humiliation, shame, or despair elevate risk. These may include loss of relationship, financial or health status—real or anticipated.
- Firearms accessible to a person in acute risk magnifies that risk. Insure and act to reduce access.

Patients may not spontaneously report suicidal ideation, but 70% communicate their intentions to significant others. Ask patients directly and seek collateral information from family members, friends, EMS personnel, police, and others.

Ask if You See Signs or Suspect Acute Risk—Regardless of Chief Complaint

1. Have you ever thought about death or dying?
2. Have you ever thought that life was not worth living?
3. Have you ever thought about ending your life?
4. Have you ever attempted suicide?
5. Are you currently thinking about ending your life?
6. What are your reasons for wanting to die and your reasons for wanting to live?

These questions represent an effective approach to discussing suicidal ideation and attempt history; they are not a formalized screening protocol.

National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

This is a free and confidential service available to those in suicidal crisis. The counselor is not a doctor or mental health professional.

10% of all ED patients are thinking of suicide, but most don’t tell you. Ask questions—save a life.
Screen:
- Universally or selectively
- Paper/pencil, computer, or by clinician

Evaluation and rapid triage

High risk patients include those who have:
- Made a suicide or death threat with intent
- Previous suicidal ideation or intentions
- History of suicide attempts
- Perceived life or serious medical illness
- Other signs of acute risk

Recommended interventions:
- Rapid evaluation by a qualified mental health professional
- Ongoing contact with support and observation
- Medication to prevent suicide
- Referral for mental health evaluation

Moderate risk patients include those who have:
- Suicidal ideation with some level of suicide intent, but who have shown no signs of the plan
- No access to means or intent
- A non-suicidal, current, and active therapeutic alliance with a mental health clinician

Interventions to consider:
- Suicide assessment and monitoring
- Psychiatric evaluation

Low risk patients include those who have:
- Suicidal ideation with low level of suicide intent, but with a plan or access to means
- No history of suicide attempt

Interventions to consider:
- No change
- Monitor

Before discharging

Check that:
- Risk assessment and suicidal ideation have been assessed and made accessible to patient
- A recognized person is available and instructed to follow up on the risk assessment

After discharging

- Interventions should be continued
- A suicide risk assessment should be performed

Suicide Risk: A Guide for ED Evaluation and Triage

1 in 10 suicides are by people seen in an ED within 2 months of dying.
Many are never assessed for suicide risk. Look for evidence of risk in all patients.

Signs of acute suicide risk
- Talking about suicide or thoughts of suicide
- Making a will or preparing to leave
- Perpetual—any reason for being
- Anxiety or agitation
- Insomnia
- Substance abuse
- Mood changes—often dramatic

Other factors:
- Past suicide attempts increase risk for a subsequent attempt or suicide; multiple prior attempts dramatically increase risk.
- Triggers (events leading to limitation, shame, or depression) These may include loss of relationship, financial or health status—real or anticipated.
- Firearms accessible to a person in acute risk magnify that risk. Ban guns and act to reduce access.

Patients may not spontaneously report suicidal ideation, but 70% communicate their intentions to significant others. Ask patients directly and seek collateral information from family members, friends, EMS personnel, police, and others.

Ask if you see signs or suspect acute risk—regardless of chief complaint
1. Have you ever thought about dying or suicide?
2. Have you ever thought about killing yourself?
3. Have you ever thought about ending your life?
4. Have you ever contemplated suicide?
5. Are you currently thinking about ending your life?
6. What are your reasons for wanting to die?

These questions are open-ended and should be asked of all patients who come to the ED. National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

For additional resources and materials, visit: Suicide Prevention Resource Center at www.sprc.org

National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
## 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
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”.
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.
# Trends in Suicidal Behavior

**1990-1992 vs 2001-2003**

## National Comorbidity Survey and Replication*

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

---

### Trends in Suicidal Behavior

**1990-1992 vs 2001-2003**

**National Comorbidity Survey and Replication**

<table>
<thead>
<tr>
<th></th>
<th>1990-1992</th>
<th>2001-2002</th>
<th>( P )</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>

“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.”

CLINICAL INTERVENTIONS
✓ 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 Guide**

A Quick Guide for Clinicians

may be used in conjunction with the “Safety Plan Template”

**Safety Plan FAQs?**

**WHAT IS A SAFETY PLAN?**
A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is brief, is in the patient’s own words, and is easy to read.

**WHO SHOULD HAVE A SAFETY PLAN?**
Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

**HOW SHOULD A SAFETY PLAN BE DONE?**
Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

**IMPLEMENTING THE SAFETY PLAN**
There are 6 Steps involved in the development of a Safety Plan.

---

**AMPLE SAFETY PLAN**

<table>
<thead>
<tr>
<th>Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 3: People and social settings that provide distraction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name __________________ Phone ___________________</td>
</tr>
<tr>
<td>2. Name __________________ Phone ___________________</td>
</tr>
<tr>
<td>3. Place __________________ Phone ___________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 4: People whom I can ask for help</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name __________________ Phone ___________________</td>
</tr>
<tr>
<td>2. Name __________________ Phone ___________________</td>
</tr>
<tr>
<td>3. Name __________________ Phone ___________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 5: Professionals or agencies I can contact during a crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clinician Name __________________ Phone ___________________</td>
</tr>
<tr>
<td>2. Clinician Name __________________ Phone ___________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local Urgent Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Services Address</td>
</tr>
<tr>
<td>Urgent Care Services Phone</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)</th>
</tr>
</thead>
</table>

Step 6: Making the environment safe

1. _____________________________________________________________
2. _____________________________________________________________

The one thing that is most important to me and worth living for is: __________________________

---

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

FOR: ___________________________ DATE: ___________________________

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:
  1. Remove all firearms & ammunition
  2. Remove or lock up:
     - knives, razors, & other sharp objects
     - prescriptions & over-the-counter drugs (including vitamins & aspirin)
     - alcohol, illegal drugs & related paraphernalia
  3. Make sure someone is available to provide personal support and monitor him/her at all times during a crisis and afterwards as needed.
  4. Pay attention to his/her stated method of suicide/self-injury and restrict...
ED Patient Engagement

Brief Interventions

Emergency Room Intervention for Adolescent Females
Date of Review: October 2007

Emergency Room Intervention for Adolescent Females is a program for teenage girls 12 to 18 years old who are admitted to the emergency room after attempting suicide. The intervention, which involves the girl and one or more family members who accompany her to the emergency room, aims to increase attendance in outpatient treatment following discharge from the emergency room and to reduce future suicide attempts. A review of the literature suggests that factors related to treatment noncompliance following a suicide attempt include family discord, maternal psychopathology, attempter depression, and negative experiences with emergency room staff. The intervention consists of three components designed to improve the emergency room experience for the adolescent and family, thereby changing the family’s conceptualization of the suicidal behavior and expectations about therapy. First, a 2-hour training is conducted separately with each of the six groups of staff working with adolescents who have attempted suicide. Second, the adolescents and their families watch a 20-minute videotape, filmed in Spanish and dubbed in English, that portrays the emergency room experience of two adolescents who have attempted suicide. Last, a bilingual crisis therapist delivers a brief family treatment in the emergency room.

Descriptive Information

<table>
<thead>
<tr>
<th>Topics</th>
<th>Mental health treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Areas of Interest</td>
<td>Suicide prevention</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Outcome 1: Treatment adherence</td>
</tr>
<tr>
<td></td>
<td>Outcome 2: Adolescent symptoms of depression</td>
</tr>
<tr>
<td></td>
<td>Outcome 3: Adolescent suicidal ideation</td>
</tr>
<tr>
<td></td>
<td>Outcome 4: Maternal symptoms of depression</td>
</tr>
<tr>
<td></td>
<td>Outcome 5: Maternal attitudes toward treatment</td>
</tr>
</tbody>
</table>

**Emergency Departments**

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


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

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


Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority

Editors
David A. Litte, OD
Suicide Prevention Resource Center
Alan Q. Radke, MD, MPH
Minnesota Department of Human Services
Morton M. Silverman, MD
Suicide Prevention Resource Center

Writers
Thomas J. Ruter, MAPA
Minnesota Department of Human Services
Miriam Davis, PhD
Medical Writer and Consultant in Medicine to Massachusetts General Hospital

National Association of State Mental Health Program Directors
Medical Directors Council
66 Canal Center Plaza, Suite 302, Alexandria, VA 22314
703-738-0333 Fax: 703-546-0517
www.nasmhpd.org

March 2008
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
Suicide Warning Signs

Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1-800-273-TALK if you or someone you know exhibits any of the following signs:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or 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, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

Sources:
http://depts.washington.edu/lokitup/
Poll
Clinical Chain in Suicide Prevention

- Detecting potential risk
- Assessing risk
- Managing suicidality
  - Safety planning
  - Crisis support planning
  - Patient tracking
- Treatment
- F/U Contact
TRAINING IMPLICATIONS
Large portions of mental health providers have had no formal training in the assessment and management of suicidal patients

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](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](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
For questions and feedback regarding the webinar, please contact:

Xan Young
Project Director, Training Institute
Suicide Prevention Resource Center, EDC
xyoung@edc.org

Tiffany Kim
Training Coordinator, Training Institute
Suicide Prevention Resource Center, EDC
tkim@edc.org