Suicide Risk Assessment

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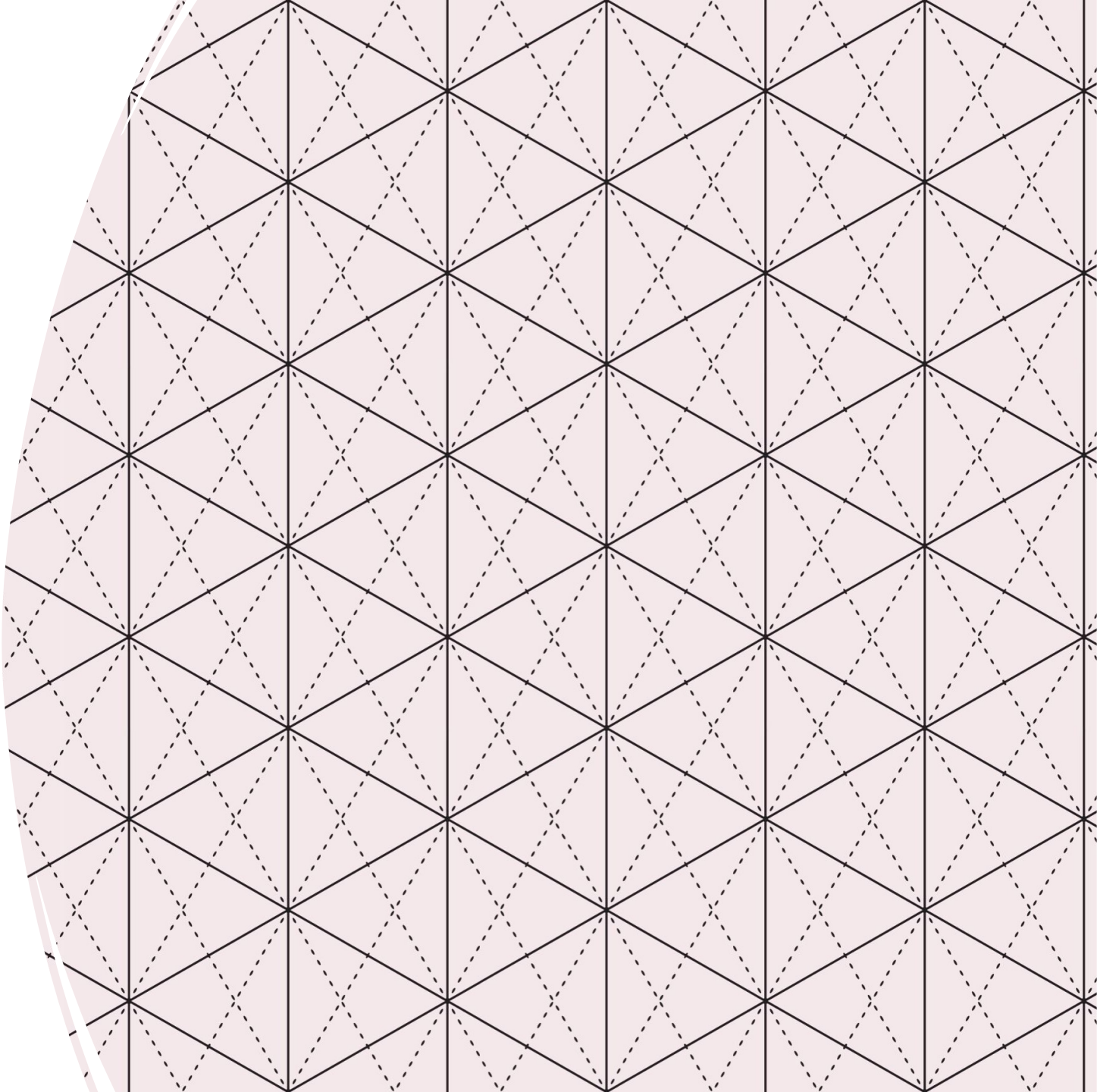
Tsehootsooi Medical Center



Current work

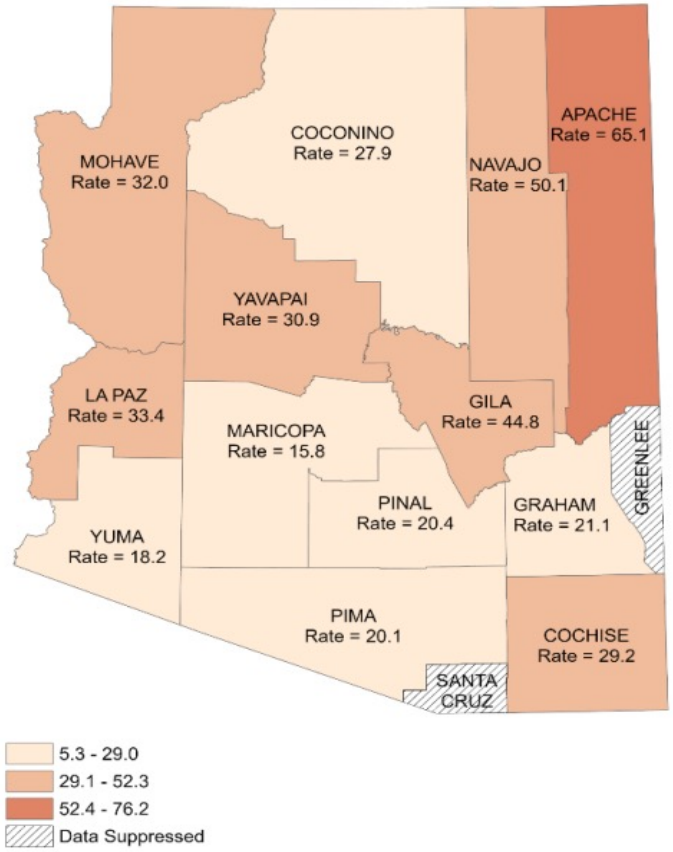
Tsehootsooi Medical Center

Serves the Fort Defiance Agency

- 43,940 population spread over 3 million acres
- 25 bed ER
- 100-200 patients daily (MGH 321, Tufts 110-164)

Suicide Rate in Apache County, Navajo Nation

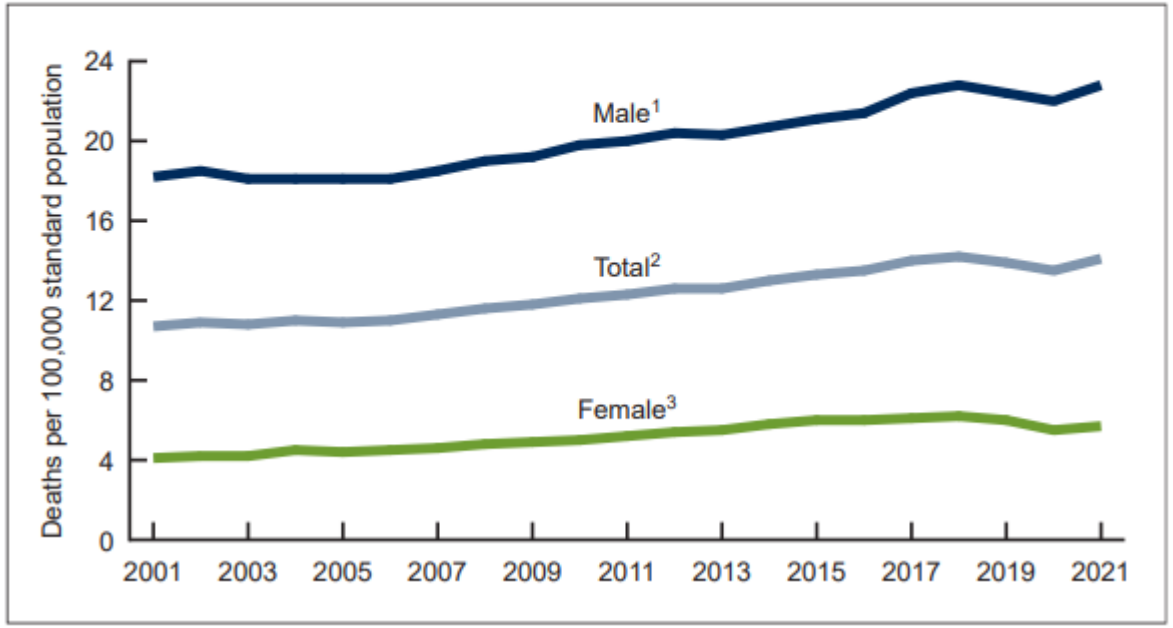
Mortality rates[a] of suicide by county of residence: Arizona, 2021



Note: [a]Number of deaths per 100,000 population age-adjusted to the 2000 U.S. standard.

From 2001 through 2021, suicide rates increased most years for males and females.

Figure 1. Age-adjusted suicide rates, by sex: United States, 2001–2021



Resources

Suicide Assessment and Treatment Course 2023 (McLean Hospital)

The Suicidal Crisis by Igor Galynker

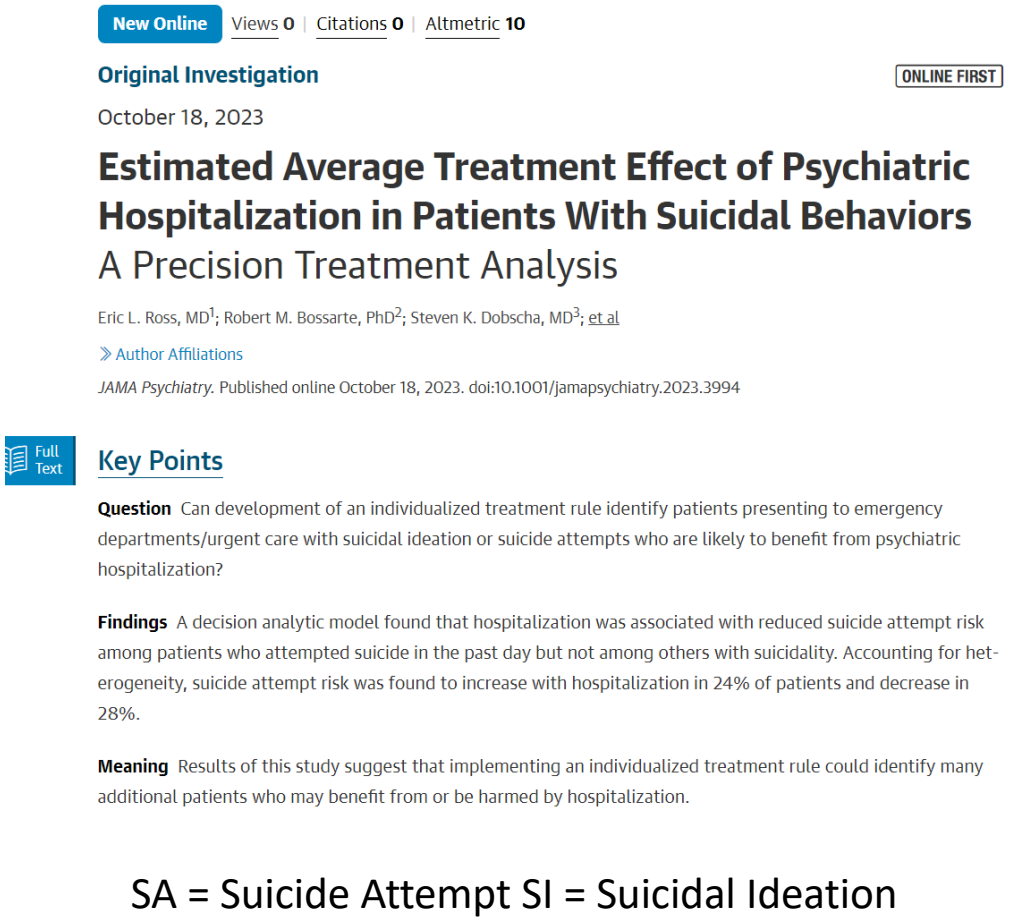
Why People Die by Suicide by Thomas Joiner

Brief CBT for Suicide Prevention by Craig J. Bryan and M. David Rudd

Suicide Prevention Stahl's Handbooks

Tyler Black, MD

JAMA Psychiatry 2023



New Online | Views 0 | Citations 0 | Altmetric 10

Original Investigation ONLINE FIRST

October 18, 2023

Estimated Average Treatment Effect of Psychiatric Hospitalization in Patients With Suicidal Behaviors

A Precision Treatment Analysis

Eric L. Ross, MD[1]; Robert M. Bossarte, PhD[2]; Steven K. Dobscha, MD[3]; et al

Author Affiliations

JAMA Psychiatry. Published online October 18, 2023. doi:10.1001/jamapsychiatry.2023.3994

Full Text

Key Points

Question Can development of an individualized treatment rule identify patients presenting to emergency departments/urgent care with suicidal ideation or suicide attempts who are likely to benefit from psychiatric hospitalization?

Findings A decision analytic model found that hospitalization was associated with reduced suicide attempt risk among patients who attempted suicide in the past day but not among others with suicidality. Accounting for heterogeneity, suicide attempt risk was found to increase with hospitalization in 24% of patients and decrease in 28%.

Meaning Results of this study suggest that implementing an individualized treatment rule could identify many additional patients who may benefit from or be harmed by hospitalization.

SA = Suicide Attempt SI = Suicidal Ideation

196,610 visits

Sample included SA in the last day, SA in the last 2-7 days and SI with no recent attempt

For patients presenting in the aftermath of an SA, clinicians could reasonably consider hospitalization the DEFAULT approach in that it might be expected to substantially reduce the overall risk of subsequent SAs without increasing the risk among any identifiable patient subset.

For patients with suicidality other than in the immediate aftermath of an SA, hospitalization is not a justifiable DEFAULT approach, as hospitalization is associated with an increased risk of subsequent SAs in 20.0% to 40.0% of patients and decreased risk in another 20.0%to 40.0%.

Suicide Assessment

WHY?

Clinical - guide treatment decisions to provide best care

Legal – meet standard of care specifically foreseeability and reasonable care

Words matter

Assessment vs Screening

Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	High Risk	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	High Risk	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself; or 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, etc. **If yes, was this within the past 3 months?**		High Risk

988 SUICIDE & CRISIS LIFELINE

If YES to 2 or 3, seek behavioral healthcare for further evaluation.
If the answer to 4, 5 or 6 is YES, get immediate help: Call or text 988, call 911 or go to the emergency room.
STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

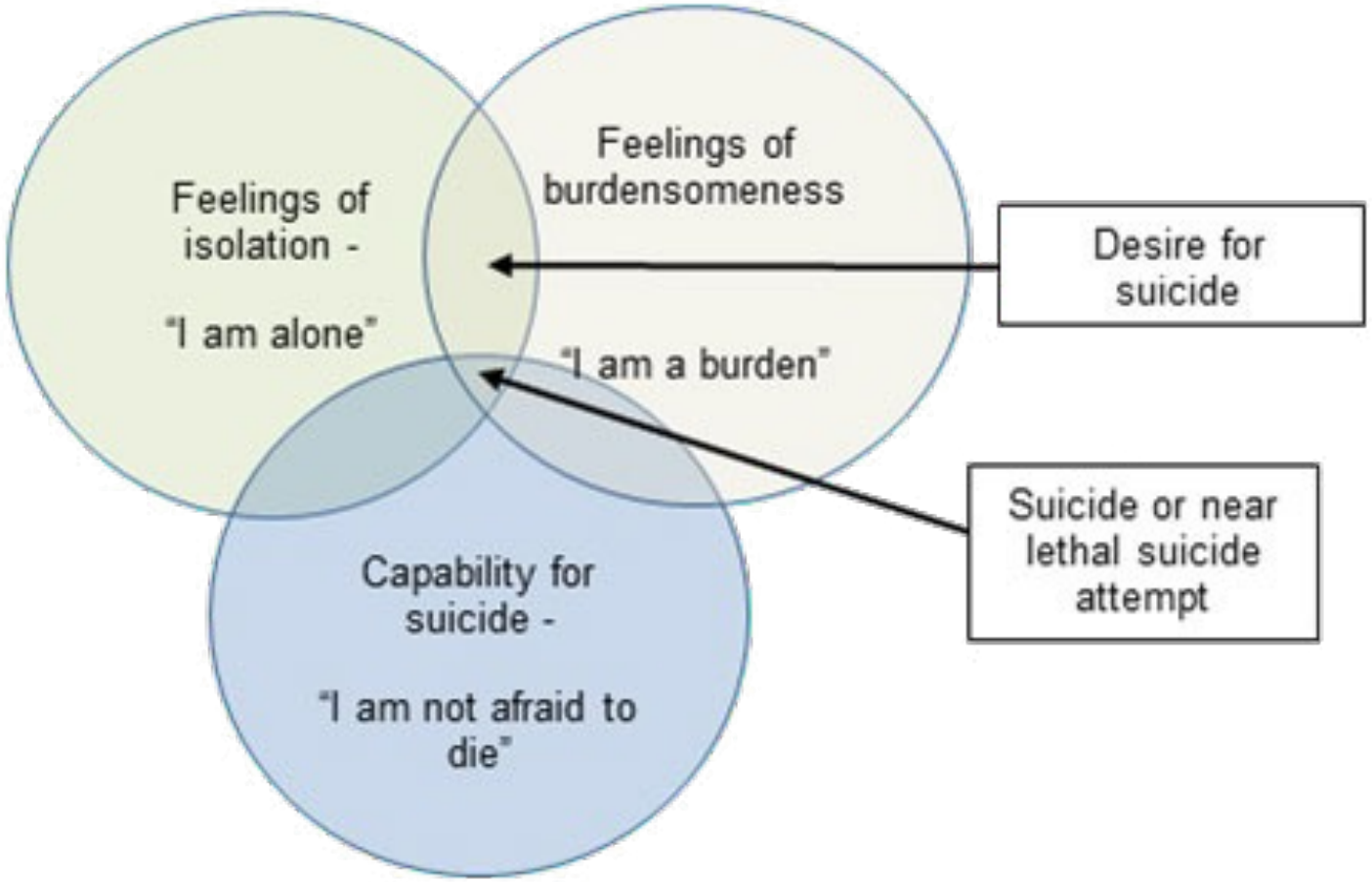
Rapport above all

Assessment vs Screening

"…risk assessment relies almost exclusively on clinicians' expertise and judgment. Traditional risk scales do not substantially improve on clinical judgment, and while some machine learning models have begun to surpass the accuracy of clinical risk prediction, these have not been widely implemented." (Ross et al., 2023)"

Interpersonal theory of suicide

- Joiner, 2005



Acute Suicidal Affective Disturbance/ Suicidal Crisis Syndrome

ASAD	SCS
A. A drastic increase in suicidal intent over the course of hours or days, as opposed to weeks or months B. One (or both) of the following: marked social alienation (e.g., social withdrawal, disgust with others, perceptions that one is a liability on others) and/or self-alienation (e.g., self-hatred, perceptions that one's psychological pain is a burden) C. Perceptions that one's suicidality, social alienation, and self-alienation are hopelessly unchangeable D. Two (or more) manifestations of overarousal (i.e., agitation, irritability, insomnia, nightmares)	A. Persistent or recurring feeling of entrapment and urgency to escape or avoid a perceived inescapable and unavoidable life situation. Although death may appear as the only escape, explicit suicidal ideation need not be (though may be) present B. Affective, behavioral, and cognitive changes associated with the experience of entrapment, including at least 1 item from a to d: a. Affective disturbance b. Loss of cognitive control c. Disturbance in arousal d. Social withdrawal

Assessment strategies

- Categories
  - Suicidal desire
  - Resolved planning

- Resolved planning has stronger association with suicide attempts so should be weighed heavier

Assessment post attempt

Describing subjective vs objective intent

- Subjective
  - entails what the patient explicitly reports to the clinician regarding his or her motivations at the time of the injury (e.g., “I wanted to die” or “I didn’t think it would actually hurt me”)
- Objective
  - situational, contextual, or behavioral factors present at the time of the injury that provide indirect or implicit evidence for the patient’s motivations. For example, careful planning of a suicide attempt, taking steps to prevent rescue or discovery, and/or practicing the suicide attempt in advance

Clinical example

A 55-year-old Native American male presents to the TMC emergency department while intoxicated stating that immediately prior to presentation he put a loaded firearm to his head with the intent to kill himself but when he pulled the trigger the safety was still on. He then came to the ER for help. Patient stays overnight in the ER and in the morning while clinically sober patient states that he was “just drunk and stupid and does not want to kill himself.”

LOW RISK

OR

HIGH RISK

Suicide Crisis Syndrome

- Part A: The core feature of the SCS is persistent and desperate feelings of **entrapment,** which is an urgency to escape or avoid an unbearable life situation when escape is perceived as impossible. Thus death appears as the only achievable solution to unbearable pain.

Suicide Crisis Syndrome

- Part B: *Part B*: In addition, SCS involves the following:

1. **Affective disturbance**, which amplifies the desperate need to escape

2. **Loss of cognitive control**, which amplifies the perception of the impossibility of escape

3. **Hyperarousal,** which fuels action to achieve the escape through suicide

- “Suicide cannot be predicted and in some cases cannot be prevented, but an individual’s suicide risk can be assessed and a treatment plan can be designed with the goal of reducing the risk.” (Jacobs & Brewer, 2004, p. 380)

Risk Factors

- Mental practice/vivid preoccupation (visions of their own death)
- Hopelessness
- Perceived burdensomeness
- Thwarted belongingness
- Loss of fear of death
- Acute anhedonia
- Global insomnia
- Severe psychic anxiety, panic attacks,
- Lack of remorse following a suicide attempt,
- entrapment/hyperarousal

Risk Factors

- Activating events
- Psychosis
- Etoh/substance use
- history of suicide attempts
- history of non-suicidal self injury
- history of psychiatric hospitalizations
- History of psychiatric diagnosis

Protective Factors

- Social connectedness
- sense of responsibility to family,
- moral objections such as spiritual or religious beliefs
- positive coping skills
- positive social support
- positive therapeutic relationship
- fear of death
- fear of social disapproval

Documentation

“You can be wrong but you can’t be negligent”

-somebody

Negligence

- Duty
- Breach of Duty
- Damages
- Causation

Importance of documentation

- Allows decision making to be understood by other providers, expert witnesses and you
- Record is defense

Professional judgement rule:

- Just because patient was harmed does not mean standard of care was breached
- As long as your approach was reasonable that’s okay
- Deference is with the provider but there needs to be something to base this on

Documentation tips

What action was taken and why?	• Evidence based interventions
What actions were considered but rejected and why?	• “considered inpatient tx but…”

Documentation tips

- Address modifiable risk factors
- Acknowledge non-modifiable risk factors

Documentation Tips

Note subtle future orientation and ask about future plans

Safety plan documented in note

Patient quotes can help “I would never do it” etc.

Document reasons for living

Recognize limitations of plan due to unseen events

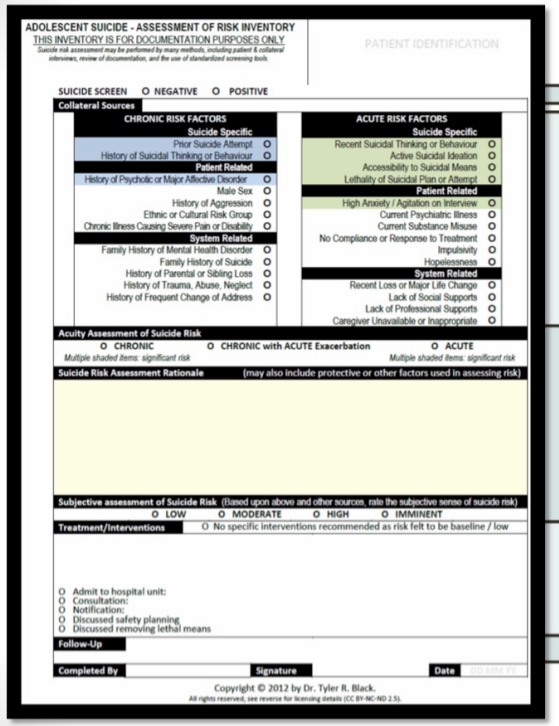
Be transparent and realistic about weighing risks versus benefits

Factors that influence safe dispo home

- Family and social support
- Future orientation
- Close follow up with safety check in
- Safety plan
- Medications*

Documentation tips

- Use standardized approach
- Clearly document and label assessment in note



ADOLESCENT SUICIDE - ASSESSMENT OF RISK INVENTORY

THIS INVENTORY IS FOR DOCUMENTATION PURPOSES ONLY

Suicide risk assessment may be performed by many methods, including patient & collateral interviews, review of documentation, and the use of standardized screening tools.

PATIENT IDENTIFICATION

SUICIDE SCREEN O NEGATIVE O POSITIVE

SCRE

Collateral Sources

CHRONIC RISK FACTORS

Suicide Specific
- Prior Suicide Attempt O
- History of Suicidal Thinking or Behaviour O

Patient Related
- History of Psychotic or Major Affective Disorder O
- Male Sex O
- History of Aggression O
- Ethnic or Cultural Risk Group O
- Chronic Illness Causing Severe Pain or Disability O

System Related
- Family History of Mental Health Disorder O
- Family History of Suicide O
- History of Parental or Sibling Loss O
- History of Trauma, Abuse, Neglect O
- History of Frequent Change of Address O

ACUTE RISK FACTORS

Suicide Specific
- Recent Suicidal Thinking or Behaviour O
- Active Suicidal Ideation O
- Accessibility to Suicidal Means O
- Lethality of Suicidal Plan or Attempt O

Patient Related
- High Anxiety / Agitation on Interview O
- Current Psychiatric Illness O
- Current Substance Misuse O
- No Compliance or Response to Treatment O
- Impulsivity O
- Hopelessness O

System Related
- Recent Loss or Major Life Change O
- Lack of Social Supports O
- Lack of Professional Supports O
- Caregiver Unavailable or Inappropriate O

ANALYSIS OF RISK FACT

Acuity Assessment of Suicide Risk

O CHRONIC O CHRONIC with ACUTE Exacerbation O ACUTE

Multiple shaded items: significant risk *Multiple shaded items: significant risk*

Suicide Risk Assessment Rationale (may also include protective or other factors used in assessing risk)

DELIBERATION OF RISK ASSESSMEN

Subjective assessment of Suicide Risk (Based upon above and other sources, rate the subjective sense of suicide risk)

O LOW O MODERATE O HIGH O IMMINENT

Treatment/Interventions O No specific interventions recommended as risk felt to be baseline / low

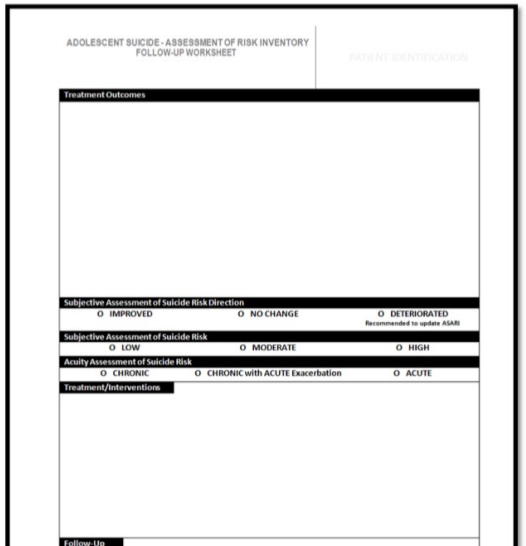
INTERVENTIONS FOR IDENTIFIED RISKS

O Admit to hospital unit:
O Consultation:
O Notification:
O Discussed safety planning
O Discussed removing lethal means

Follow-Up

ENSURING SPECIFIC FOLLOW-UP

Completed By Signature Date DD MM YY



ADOLESCENT SUICIDE - ASSESSMENT OF RISK INVENTORY
FOLLOW-UP WORKSHEET

PATIENT IDENTIFICATION

Treatment Outcomes

Subjective Assessment of Suicide Risk Direction

O IMPROVED O NO CHANGE O DETERIORATED
Recommended to update ASARI

Subjective Assessment of Suicide Risk

O LOW O MODERATE O HIGH

Acuity Assessment of Suicide Risk

O CHRONIC O CHRONIC with ACUTE Exacerbation O ACUTE

Treatment/Interventions

Follow-Up

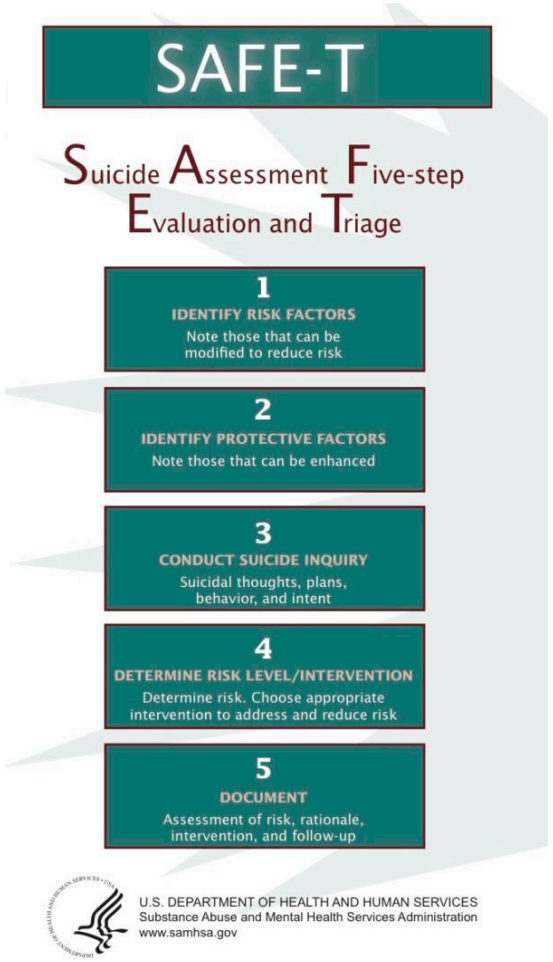
The ASARI

- The assessment of suicide and risk inventory

SAFE T

- SAFE-T (Suicide Assessment Five-Step Evaluation and Triage):

- Identify risk factors, noting those that can be modified to reduce risk
- Identify protective factors, noting those that can be enhanced
- Conduct a suicide inquiry. Ask specifically about suicidal thoughts, plans, behavior, and intent
- Determine level of risk. Choose appropriate intervention to address and reduce risk
- Document the assessment of risk, rationale, intervention, and follow-up instructions



Documentation and assessment by domain

Suicide-specific beliefs

• Hopelessness • Perceived burdensomeness • Shame • Self-hatred • Isolation or thwarted belongingness • Feeling trapped

Impulse control and behavioral dysregulation

• Nonsuicidal self-injury • Substance abuse • Aggression

Protective factors

• Reasons for living • Hope • Meaning in life • Optimism • Social support

Documentation and assessment by domain

Baseline risk factors

• Previous suicide attempts • Previous psychiatric diagnoses • Male gender • History of abuse or trauma • Family history of suicide (proxy for genetic risk)

Activating events

• Relationship problems • Financial problems • Legal or disciplinary problems • Acute health condition or exacerbation • Other significant loss (actual or perceived)

Symptoms (Emotional and physical)

• Depression • Guilt • Anger • Physiological agitation • Insomnia • Hallucinations • Pain

Modifiable Risk Factors

- Substance use
  - Alcohol: naltrexone, acamprosate, gabapentin, topiramate
  - Stimulants: mirtazapine, olanzapine, bupropion, topiramate
  - Opiates: buprenorphine
- Access
- Social supports
- Symptoms
- When in doubt ask the patient about what their motivations for suicide were/are?

Meds

Risks of tx	Benefits of tx
Risks of not using tx	Benefits of not using tx
Alternatives under consideration	

- Consider targeting symptoms of primary psychiatric dx as well as suicide risk as while some overlap some are separate.
- Discuss risks and benefits of both options – not only risks vs benefits of treating with medications but also not treating in relation to suicide ris:

Myths related to legality

"Risk assessment is to determine if someone is going to kill themselves"

- Suicide can't be predicted
- Expectation is to use clinical decision making to assess risk and reduce impact of risk factors

"If a patient denies suicidality documenting that is sufficient"

- One study of inpatient suicides showed 78% of patients denied SI on last assessment
- Not an assessment without clinical reasoning and judgment

Safety planning

- Not contracting for safety
- Includes:
  - Warning signs
  - Distractions
  - Supports
  - Resources
  - Reasons for living
  - Ideas to keep environment safe

- Stanley-Brown Safety Plan

Suicide risk as its own target

Certain medications have evidence for reducing suicide risk. These are not a silver bullet but can help modify risk.

- Lithium
- Clozapine
- Ketamine
- Antidepressants

Lithium

- 1. Lithium is an effective mood stabilizer for bipolar disorder, and has effectiveness as an augmentation agent for unipolar depression. Stabilizing mood symptoms especially over the long term can contribute to suicide risk reduction.
- 2. Lithium has a large evidence base for having a protective effect against suicide drawn from more than 50 studies.
- 3. Reduces suicide rates 60–80% in studies comparing lithium to placebo as well as lithium to other medications.
- 4. Suicide attempt rates are also significantly reduced.
- 5. These suicide preventive effects are likely present for both unipolar and bipolar mood disorders.
- 6. Lithium's suicide protective mechanism of action is not certain, but is possibly related to its effects in reducing aggression and impulsivity.

Moutier, Christine Yu; Pisani, Anthony R.; Stahl, Stephen M. (2021) Suicide Prevention: Stahl's Handbooks (Stahl's Essential Psychopharmacology Handbooks). Cambridge University Press. Kindle Edition.

Lithium

- Cons of using lithium
  - Unclear how rapid action is
  - Narrow therapeutic index
  - Risk of toxicity and renal problems
  - Need for regular monitoring
- Likely underutilized due to these factors as well as lack of industry profit potential and possibly stigma

How to dose/monitor (lithium)

- Consider normal initiation recommendations 300-600 mg at HS.
  - Usually I start at 300 mg HS especially if patient is sensitive to side effects
- Labs
  - Lithium levels, thyroid, kidney function
  - I usually aim for .6-.8 for lithium levels which is typically in the 900 mg range
    - Usually doubling dose will double level

Clozapine

- SGA
- First medication to receive a suicide preventive indication and from 2003 until 2020 it was the only medication in the USA with a suicide preventive indication for those with psychotic d/o
- Beats other SGAs in head to head trials for reducing suicide

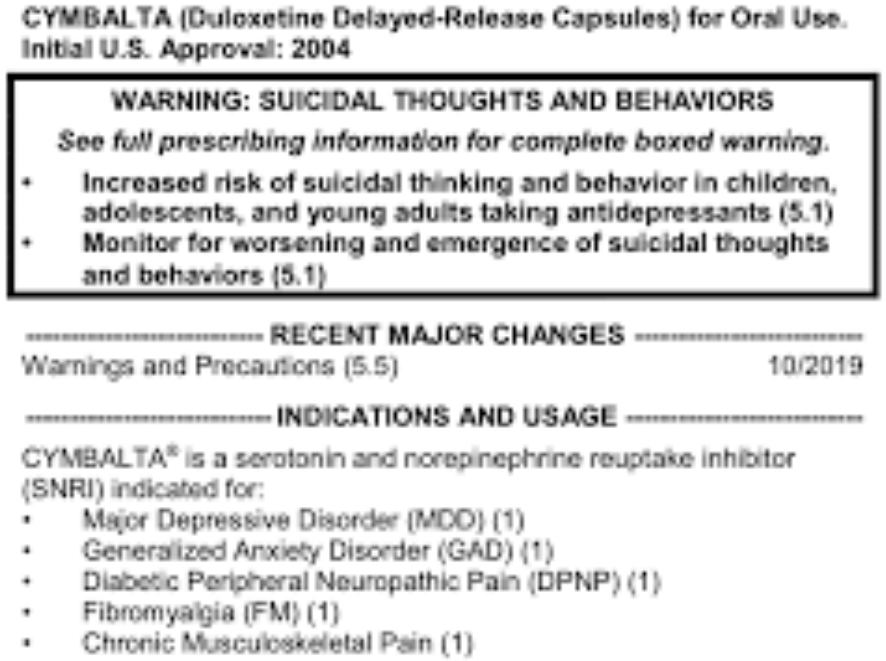
CONS

- Need for regular labs, Risk Evaluation and Mitigation Strategy (REMS), risk of neutropenia

Evidence for rapid reduction in suicidal ideation

Limitations:

- Cost (esketamine), need for IV infusion (ketamine), need more medical monitoring, data only looks at ideation not behaviors, possibility of rebound symptoms



CYMBALTA (Duloxetine Delayed-Release Capsules) for Oral Use.
Initial U.S. Approval: 2004

WARNING: SUICIDAL THOUGHTS AND BEHAVIORS

See full prescribing information for complete boxed warning.

- **Increased risk of suicidal thinking and behavior in children, adolescents, and young adults taking antidepressants (5.1)**
- **Monitor for worsening and emergence of suicidal thoughts and behaviors (5.1)**

RECENT MAJOR CHANGES

Warnings and Precautions (5.5) 10/2019

INDICATIONS AND USAGE

CYMBALTA® is a serotonin and norepinephrine reuptake inhibitor (SNRI) indicated for:

- Major Depressive Disorder (MDD) (1)
- Generalized Anxiety Disorder (GAD) (1)
- Diabetic Peripheral Neuropathic Pain (DPNP) (1)
- Fibromyalgia (FM) (1)
- Chronic Musculoskeletal Pain (1)

Black Box Warning for Antidepressants

- Newer antidepressants are associated with a slightly increased risk of suicidal events (but not suicide) compared with placebo in RCTs in youth.
- Four to eleven times more depressed youth benefit from antidepressants than experience a suicidal event.

- Pharmacoepidemiologic studies, which are much larger and more representative of patient populations than RCTs, show a protective effect of regional antidepressant use on suicide.

- Youth most likely to experience a suicidal event in the early phase of medical treatment have high baseline suicidal ideation, family conflict, alcohol and substance use, nonsuicidal self-injury, and non-response to treatment.

Brent, 2016

Chronic suicidality – (JOBEs, 2023)

No standard definition – consider hx of 2+ attempts, dx of personality disorder, hx of 5+ inpatient hospitalizations

Typically more egosyntonic than dystonic

Inpatient tx? – may increase risk, may be reinforcing. Limited data but something to consider.

DBT – dozens of RCTs

MBT – replicated data with chronic populations

CAMS – Multiple published trials and supported by metaanalysis. Performed well one head to head RCT with DBT.

Recent Case

70 yo Navajo male hx of PTSD, MDD, AUD in sustained remission brought to ER from PCC for SI, positive CSSRS, PHQ-9 20, 3 on 9.

He reports feeling “lonely and depressed” “what's the use of staying alive.”

PTSD from childhood and military with active symptoms of intrusive memories

Aborted suicide attempt at age 16

Feels hopeless and worthless and “sometimes” like a burden to his family

Severed ties with family except for one sister who has medical issues

Risk assessment

- Suicide risk assessment: Patient's suicide risk is moderate to high given past history of suicide attempt, PTSD, thwarted belongingness, current depressive symptoms, feelings of being hopeless and worthless, access to firearms, entrapment/hyperarousal
- There is an absence of the following risk factors Mental practice/vivid preoccupation (visions of their own death), loss of fear of death, acute anhedonia, global insomnia, severe psychic anxiety, panic attacks, history of nonsuicidal self injury and history of psychiatric hospitalizations
- Patient has protective factors of spiritual practice and connectedness and is help seeking. There is also future orientation and that patient mentioned multiple appointments including a hearing appointment and I appointment that he wanted to go to which probably would not be something that he would be looking forward to he was planning on killing himself.
- I discussed multiple treatment options and patient states that he would like to voluntarily go to an inpatient psychiatric facility which I do think would be beneficial to the patient given the fact that he has never started treatment for PTSD and I suspect that much of his depressive symptoms and suicidal ideation or being driven by a past trauma and how it affected his current relationships.

ChANGE OF PLANS

- Given patient's insight about what is going on for him as well as the fact that
- he is very help seeking stating that he wants to come back for outpatient care to
- see me so he can work on his past trauma and also proactively asked if there
- might be a medication that could be helpful for his depressive symptoms I do not
- believe that it would be beneficial to patient's safety to force him to go to the
- hospital as there is not any evidence that in the long-term psychiatric
- hospitalization will reduce suicide risk in fact there is evidence that could
- save the opposite and since patient is not in immediate danger he would be
- beneficial to keep report and therapeutic alliance that I have built with him so
- far intact.
-
- Given the chronicity of pt's suicidality, I have to do something that will
- actually help them long-term. I believe pt is not suicidal now, so my
- responsibility is to help decrease pt's suicide risk, as best I can, in the long
- term. The
- best way to help pt is to refer him for close outpatient behavioral health follow
- up and for long
- term follow-up, so that pt can have
- somewhere to go and someone to support pt as symptoms and stressors develop.
- This is the best way to keep pt alive. So, we discussed a crisis plan for
- future suicidality using the stanely-brown template which is evidenced based to
- reduce suicide
- behaviors.
-
- We discussed patient's firearm and patient states that with his suicidal ideation
- he is never had any plan or intent and that he would never use his firearm on
- himself and that he needs to keep it around for protection but he does keep
- ammunition and gun in separate places for safety.

WHAT CHANGED?

- Established strong rapport by listening to patients story
- Discovered motivation (memories of trauma and family relationships)
- Listened for ambivalence and what has kept patient alive so far
- Patient began to talk about hopes for the future
- Patient requested med to help with symptoms, and referral to therapy
- Safety check by phone in 24 hours, follow up with me and referral to therapy