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WELCOME BACK!

Today's Topic:

Suicide Risk Assessment

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SUICIDE ASSESSMENT AND DOCUMENTATION

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SPEAKER DISCLOSURES

✓ No conflicts of interest

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The following series planners have no relevant conflicts of interest to disclose:

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- ✓ Any conflicts of interest? No

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OBJECTIVES

1. Identify risk factors for suicide
2. Discuss cases
3. Columbia Suicide Severity Rating Scale (C-SSRS)

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FACTS ABOUT SUICIDE

- Nearly 50% of people who die by suicide see their primary care doctor in the month before their death
- 25% of young adults have suicidal thoughts
- 9% of young adults carry out a suicide attempt if they have experienced at least one of the following: asthma, arthritis, cancer, chronic bronchitis, diabetes, hypertension, gout, lupus, stroke or thyroid disease
- 25% of people who die by suicide are seen in the emergency room for nonpsychiatric reasons in the 12 months prior to their death

- Reference: http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/healthcare/

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RISK FACTORS-DEMOGRAPHICS

- White men 85 yo or older: highest rate of suicide
- Risk of lethal suicide increases with age
- Young adults have more non-lethal attempts
- Marital status:
  - highest risk: never married
  - lowest risk: married with children
- Living alone
- Veterans
- Rural vs. urban setting

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RISK FACTORS—HISTORICAL

- History of prior attempt—strongest single risk factor—about 5 times more likely to die by suicide. Magnified if more than 1 prior attempt
- History of self harming behavior
- Family history of suicide: heritability 30-50%
- Childhood abuse, especially sexual abuse
- Adverse childhood experiences

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RISK FACTORS—PSYCHIATRIC DISORDERS

- Depression, bipolar, substance use, schizophrenia, personality disorders, panic disorder, PTSD
- Presence of depression and anxiety together increases the risk
- Psychosis increases the risk regardless of diagnosis
- 20-25% of people who commit suicide are intoxicated with alcohol

RISK FACTORS—PHYSICAL HEALTH

- Increased risk as physical health declines
- Chronic pain, cancer, CAD, COPD, diabetes, terminal illness

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RISK FACTORS CONTINUED—SYMPTOMS

- Hopelessness, guilt, loneliness—symptoms that can persist
- Impulsivity—especially in adolescents and young adults
- Combine the above with substance use--particularly lethal.
- Panic
- Severe insomnia

RISK FACTORS: SITUATIONAL

- Family or marital conflict
- Unemployment
- Social withdrawal
- Loss (financial, interpersonal, professional)
- Recent discharge from an inpatient unit

RISK FACTORS—SUICIDE-SPECIFIC

- Passive vs. active
- Frequency and intensity of thoughts—and how this compares to past history
- Current plan
- Access to lethal means (firearms, med stockpiles)
- Preparation—researching, assembling means
- Rehearsing
- Putting affairs in order
- Writing a note

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PROTECTIVE FACTORS

- Positive and available social support
- Positive therapeutic alliance
- Feeling of responsibility: children, family, pets
- Fear of suicide, dislike of suicide
- Religious beliefs
- Hope for the future, life satisfaction
- Intact reality testing
- Presence of positive coping skills, good judgment

COMPLICATING FACTORS

- Who else is in the home?
- Are children involved?
- Children can be a major protective factor for many patients, but actively suicidal patients are not good caretakers. CPS referral needs to be considered if children are involved.
- Minor children should not be in a roll of caretaker, calling 911, etc.
- Similarly, if a patient is the caretaker of an older adult, their wellbeing needs to be considered.

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C-SSRS FOR PRIMARY CARE

HTTP://CSSRS.COLUMBIA.EDU/DOCUMENTS/C-SSRS-SCREENER-TRIAGE-PRIMARY-CARE/

Ask questions that are in bold and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** 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.	**Lifetime**	
If YES, ask: ***Was this within the past 3 months?***	**Past 3 Months**	

Response Protocol to C-SSRS Screening

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

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CASE 1

Susan is a 23 year old woman who comes in to see you for worsening depression. She has a long history of depression and mood fluctuations in dating back to childhood. She has been seen in the local community mental health center, but when her therapist left she did not like her newly assigned therapist and does not want to go back there. She has previously been diagnosed at different times with major depressive disorder and bipolar II disorder, and has been prescribed both antidepressants and mood stabilizers. Her current combination of lamotrigine 200 mg daily and bupropion XL 150 mg daily has been the best combination for her, and you have continued prescribing it after she left the community mental health center. Her last therapist thought that borderline personality disorder made sense as a diagnosis, and had been doing some DBT skills in their work together. Susan struggles with near daily thoughts of death. She has had these thoughts since as far back as she can remember. She was sexually abused by a male relative from the ages to 5 to about 10. Her early life was generally difficult; her mom had bipolar disorder, used drugs and was in and out of jail. When she was 12 she went to live with an aunt and her living environment was much more stable. She self-harmed to escape painful feelings from the age of 13 up until a couple of years ago when her therapist helped her to develop other coping strategies. She has a history of one suicide attempt at age 17 after breaking up with a boyfriend. She took some acetaminophen and other pills she found in her aunt's medicine cabinet right after the argument that led to the break-up. She was found unresponsive, was revived by EMS and spent about a week voluntarily in the hospital. She has a history of drinking heavily in her teens, but stopped after this hospitalization.

When you see her today, her PHQ is 21, with a 2 on question 9. She has felt more depressed in the last two weeks in the context of finding out her mother died of an overdose sometime last year. She had a beer for the first time in 4 years when she heard the news. She has had difficulty sleeping, and has had a few trauma-related nightmares, the first time she has had nightmares since her early teens. She is feeling more hopeless, and is using distress tolerance skills to distract herself. The thought of overdosing has crossed her mind, but she was able to distract herself and it passed. She still lives with her aunt, and she spends time caring for her 2 year old daughter. She says she wants to be there for her daughter, and doesn't want to go back to drinking and self-harming.

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CASE 2

- Brad is a 43-year-old man with no prior behavioral health diagnosis who has been seeing you yearly for routine primary care. He is an engineer at a local company, and leads a large team. He is married with two teenage children. Brad experienced a major stressor at work when his team did not deliver a project on time, and some team members began to complain to senior management about his leadership style. Since then for the past 6 weeks, Brad has been feeling really down and ruminating about his competence. He has been working late and going to bed late, but then waking up at 4 am with a sense of dread. He has not been eating consistently and has lost about 10 pounds. His PHQ is 18, with a 1 on question 9. When you ask directly about suicide, he says he feels like a failure, and thinks at times his family would be better off without him. He says he knows this isn't true, that he needs to be there for his wife and kids. He denies having any plan to harm himself.
- His wife came with him today because she is very worried about him. You ask her to join you and Brad in the exam room and she tells you that Brad was drinking heavily over the weekend and she found him on Sunday evening rummaging around in the garage. He was looking in a drawer where he keeps bullets for his hunting rifle. Brad is embarrassed that she brought this up, and does not completely remember the incident. He says he has not used is rifle for several years, and doesn't own bullets for it. He says he would never shoot himself with it, when asked what might prevent him from harming himself with the rifle, he says he's not sure it is even working properly, and is thinks it would not be effective. He says "If I am going to kill myself, I would do it right."

CASE 3

- Judy is a 63-year old woman with a history of depression in her 40's after a divorce. She is currently living with her adult daughter and working as a home health aide. She has remained single since her divorce, but has a large social network though her church. After the divorce she took sertraline and improved. She felt hopeless back then about ever having another relationship, but she had three young kids at home and focused on them and connecting with her sisters in the area and got through it. She is coming in to see you today to discuss ongoing chronic pain stemming from a car accident she had in her 50's. She was hit head on, lost consciousness and suffered severe whiplash. Since then she has been taking as needed opioids, but you note that she has been taking them daily for the past few months, and for the first time is today asking you for an early refill. When you reviewed the PMP prior to going in to see her, you see she received another prescription last month from provider in a different clinic. When you ask her about this, she becomes very tearful and won't immediately engage in a discussion about it. She then tells you she has not been able to go to work for the past month due to very low mood and pain, and has been spending much of her time in bed. Her older daughter who is 25 and lives with her is struggling with addiction, and Judy thinks she took the last bottle of opioids you had prescribed for her. Judy tried to do without for a few days, but then felt really sick. She was so embarrassed to ask you for more, that she went to another clinic a town away and pretended she was establishing care there. You want to get a sense of the severity of her depression, so you ask her to complete a PHQ while you see another patient. When you return, she has completed it with a total score of 15 with a 3 on question 9. You ask the social worker to join you, and after you both ask directly about suicide, she tells you that she thinks she is addicted to pain medication and does not want to live like this. She found some drugs in her daughter's room that she thinks is heroin, so she is planning to steal a syringe from her patient and try to inject these drugs with the intent to overdose. She is convinced she is to blame for her daughter's drug addiction because she was not able to stick out her marriage, and that her family will be better off without her.

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