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# **SUICIDE RISK ASSESSMENT IN PRIMARY CARE**

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I HAVE NO CONFLICTS OF INTEREST TO DECLARE

# OBJECTIVES

- Understand the scope of the public health issue
- Understand the difference between static and dynamic risk factors
- Appreciate the principles of risk assessment
- Know the utility and limitations of risk assessment scales

# SCOPE OF THE PROBLEM

- Incidence of Suicide
  - US as a whole: 14 suicides per 100,000 in 2017 (up from 12 in 20012)
  - Western mountain states: about 20+/100,000

Source: CDC via Am Foundation Suicide Prev

# SCOPE OF THE PROBLEM

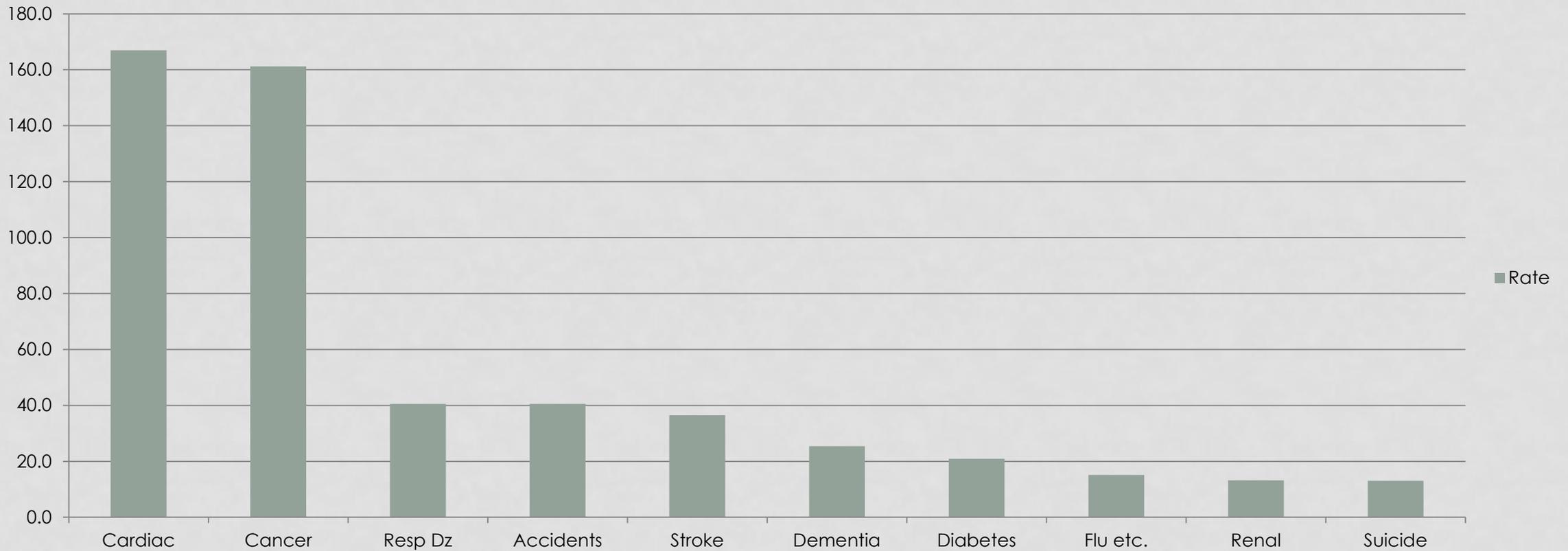
Suicide ranks 10th most common cause of death in the US (homicide ranks 15th)

Each day, 94 people die each day by suicide (on average, 69 men and 25 women).

Herron et al. 2015

# 10 TOP CAUSES OF DEATH IN AMERICA

Age-adjusted Rate

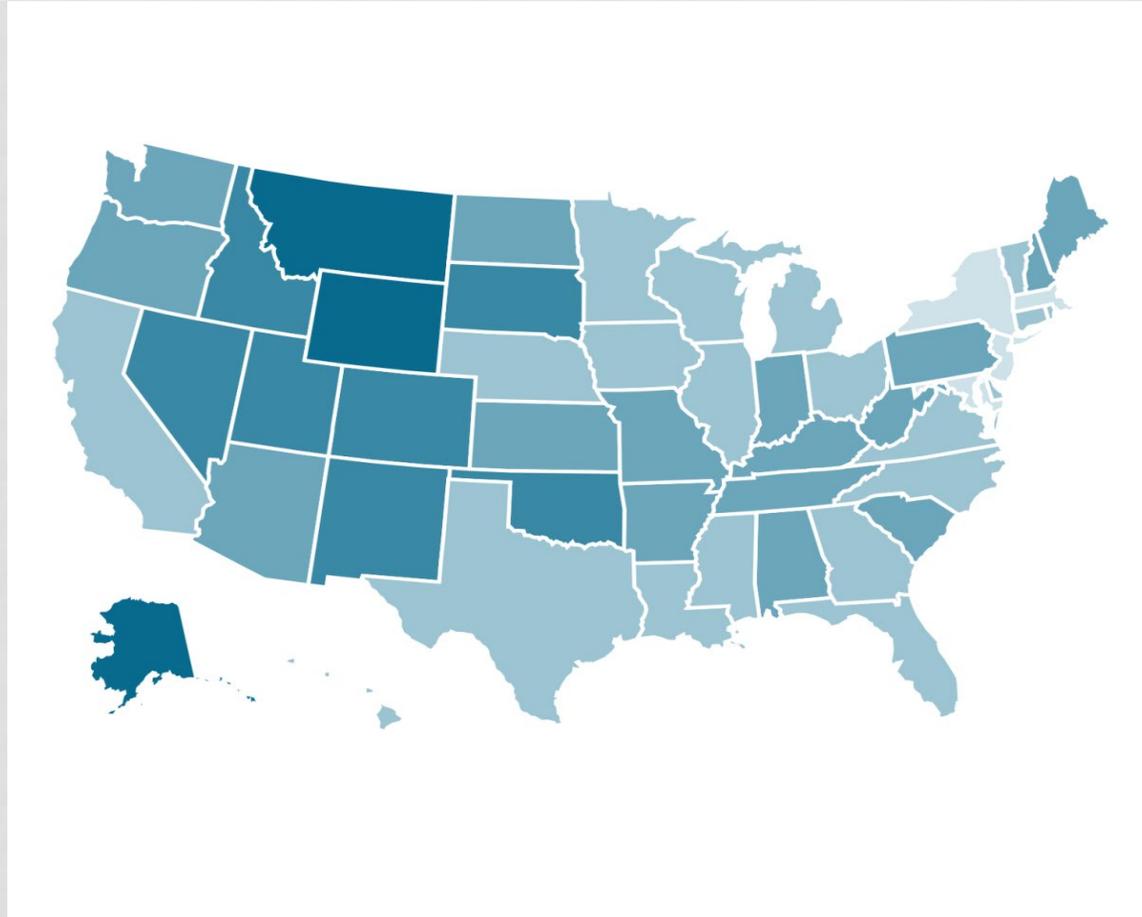


# SCOPE OF THE PROBLEM

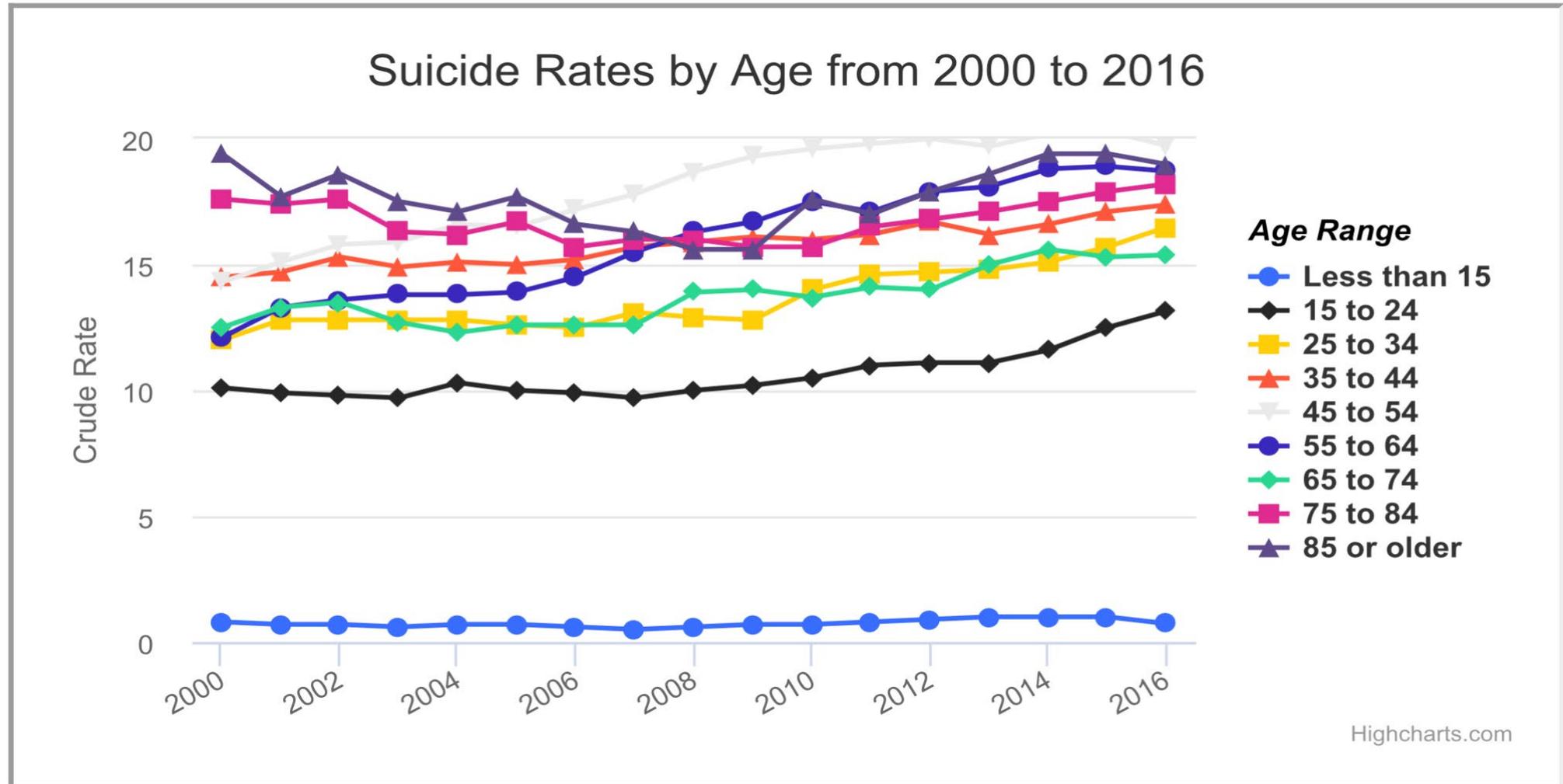
- On average, there are **117** suicides per day.
- The rate of suicide is **highest in middle age** — white men in particular.

<https://afsp.org/about-suicide/suicide-statistics/>

# SCOPE OF THE PROBLEM

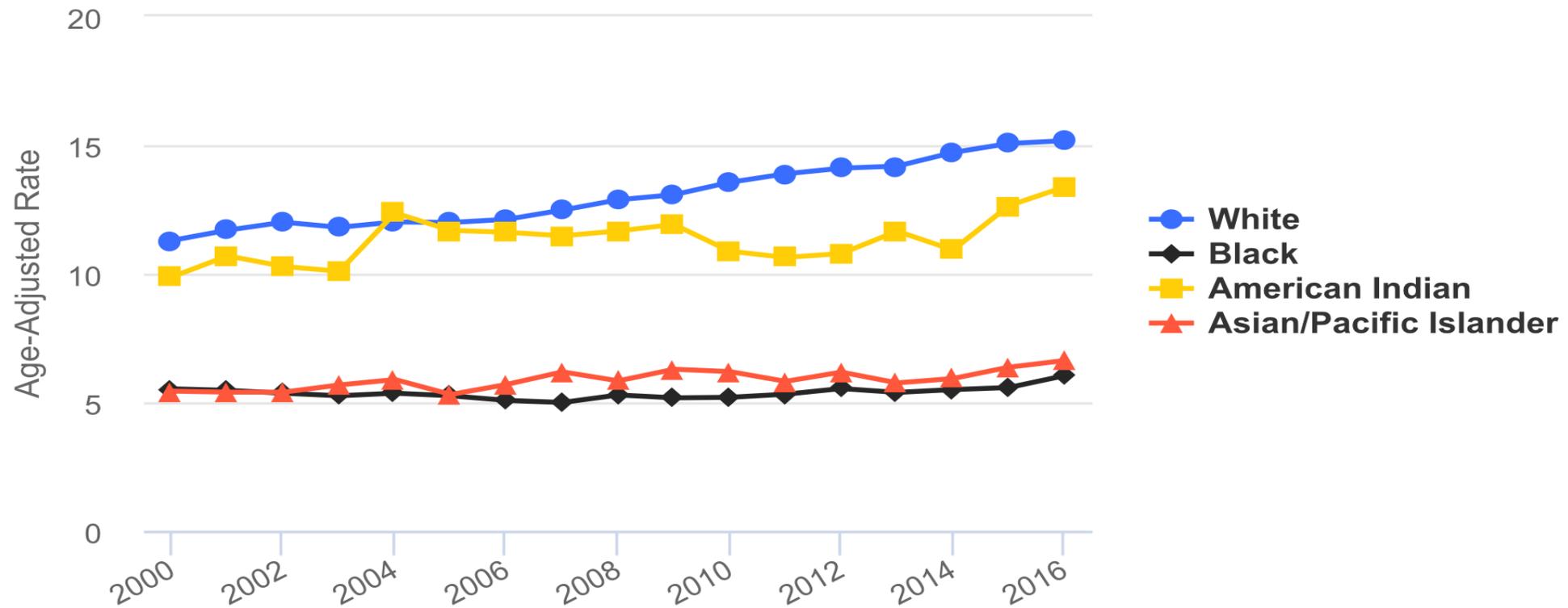


# SCOPE OF THE PROBLEM



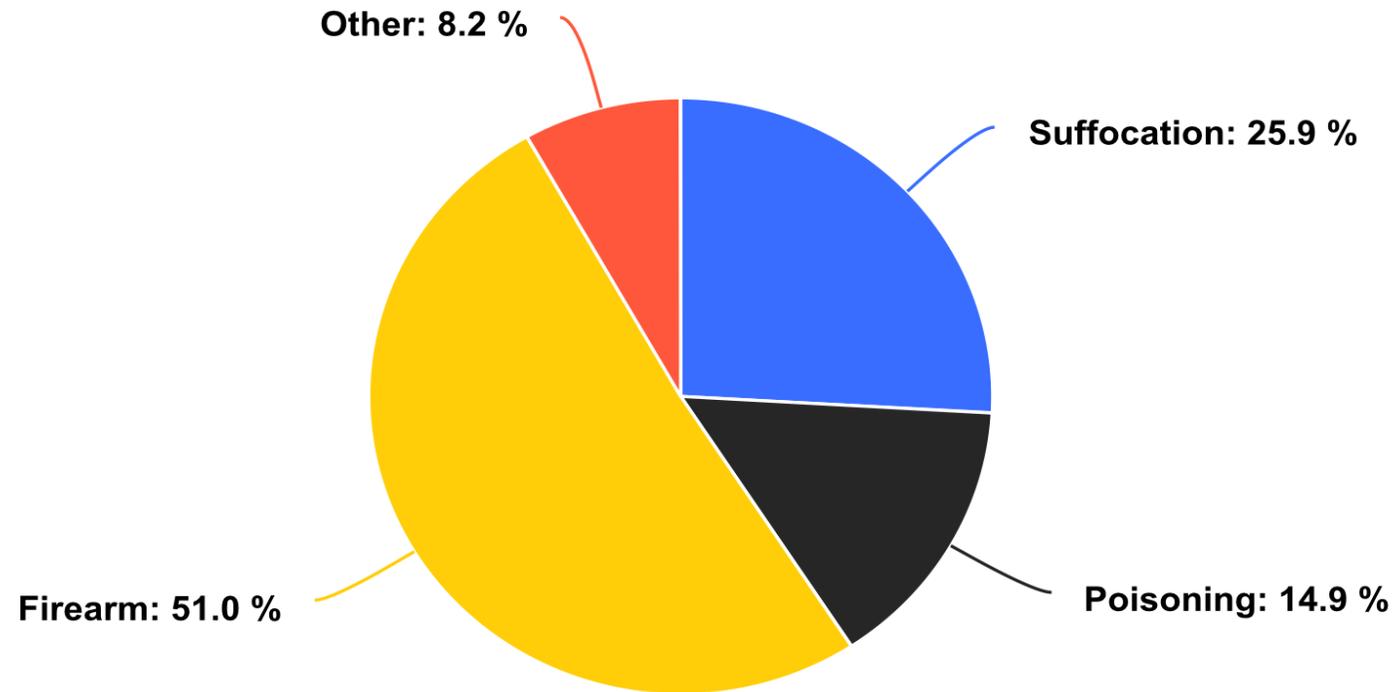
# SCOPE OF THE PROBLEM

## Suicide Rates by Ethnicity from 2000 to 2016



# SCOPE OF THE PROBLEM

Suicide Deaths by Method, 2016



# SCOPE OF THE PROBLEM

- Numbers are unreliable:
  - Reported numbers of suicide suffer from misreporting of ambiguous cases of accidental death.
  - For attempted suicide (parasuicide), numbers are even more unreliable. Some estimates claim the number is 10 times that of completed suicides.

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- We cannot predict suicide, but we can assess and quantify risk.

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- **How likely is this patient to commit suicide in the next 24 hours?**
- Your answer to this question should be determined by evaluating “dynamic risk factors.”

# DYNAMIC RISK FACTORS

- Dynamic Risk Factors are risk factors that determine acute suicide risk and that can be manipulated.
- In contrast: Static risk factors are associated with lifetime risk. They are not subject to change. They include gender, age, ethnicity, marital status, family history and many others.

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- **How dangerous is the idea?**
- Some means of suicide are easily accessible and likely lethal – gunshot wounds and hanging, for example.
- On the other hand, "running into traffic" seems ubiquitously accessible, but most likely will result in an accident or an arrest by police as opposed to a near certainty of death.

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- **Does the person have a plan?**
  - The actual execution of suicidal actions faces an inherent deterrent in our survival instincts.
  - The presence of concrete plans suggests an incipient overcoming of such barriers.

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- **Does the person have a plan?**
  - Lowered barriers are of particular concern
    - If the plan includes ingestion of disinhibiting substances, such as alcohol, or
    - If there is a history of attempted suicide in the past.

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- **Is there intent to carry out the plan?**
  - Suicidal fantasies, including imaging of the means and the aftermath, can serve a purpose in themselves, even though the patient declares that, "I'd never do this. I'm way too chicken."
  - Intent can be signaled by certain actions (farewell letter, writing a last will)

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- **Is there intent to carry out the plan?**
  - “Passive suicidal ideation“:
    - This usually takes the form of declaration that there is nothing left to live for and, "I'd rather not wake up tomorrow."
    - Such a state of mind is indicative of profound unhappiness, but it does not constitute an immediate threat of suicide.

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- **Access to Means**

- Primarily firearms, the preferred method of suicide in the US
- Plans to kill oneself by overdose would also presuppose access to medications or other substances

Herron et al. 2015

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- **Preparatory steps**
  - Suicide note
  - Giving away personal property
  - Giving away or euthanasia of pets
  - (Re-)writing one's will

# WHAT IS THE IDEATION LIKE?

- Suicidal ideation is not a monolithic concept.
  - The precise nature should be explored. Some people have had recurrent suicidal fantasies for many years without ever acting upon them. That doesn't mean you should dismiss such thoughts as unimportant. Rather, you should consider that suicidal ideation might be a means of defending against an even greater misery, and that it could suggest therapeutic interventions rather than immediate confinement.

# WHAT IS THE IDEATION LIKE?

- Frequency of suicidal thoughts
  - A first onset can, in itself, be frightening: The person may feel like an original barrier has been crossed.
  - The associated mood needs to be explored in depth. That need by itself may require hospitalization

# WHAT IS THE IDEATION LIKE?

- Intensity
  - How compelling is it?
  - Is there ambivalence?
  - Is it a constant, pervasive thought?

# WHAT UNDERLIES THE IDEATION?

- Evaluation of the underlying meaning of the ideation can improve the risk assessment.
- It may be a cry for help, especially in a situational fix where the patient feels they have exhausted all possible avenues of resolution.
- A more extended discussion, including the involvement of ancillary professionals liaising with certain social service agencies, may sometimes show a way to resolution.

# WHAT UNDERLIES THE IDEATION?

## **Suicidal ideation due to psychosis:**

- Command hallucinations, such as "a voice" that tells the person that he or she must perform an act of self-destruction.
- Delusional episode: The person "must" commit suicide in order to atone for causing untold grief and disasters, for example.

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

## **Current intoxication:**

- The disinhibiting properties of many intoxicating substances are dangerous.
- The ability to solve problems also hits a nadir during intoxication and early withdrawal, so that a “situational fix” may be perceived as a reason to consider suicide when in fact, in a sober state, that option would be dismissed.

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- Concurrent **anxiety** has been found to be a major factor to elevate the acute risk of suicide
  - Anxiety can be a side-effect of certain psychotropic medications
  - Akathisia (inability to sit still) is a dangerous side-effect of antipsychotics

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- **Suicide risk assessment must include thought towards the immediate future**
- Hopelessness is an aggravating factor
- What are the plans for the future.
  - What about tomorrow?
  - Next weekend?
  - Going back to work or school?

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- **What Deterrents Are Operative?**

- Fear is a deterrent. The step of taking one's own life presupposes overcoming a very basic fear that is rooted in our survival instincts.
- Concern about family. The preservation of empathic capacity in a suicidal patient in itself is probably a hopeful sign.

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- **What Deterrents Are Operative: Religion**
  - Christianity, Islam and Judaism do not condone suicide.
  - Life is a divine gift and not for man to trifle with.

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- **What Deterrents Are Operative: Religion**
  - However:
    - Most religious practice today recognizes that in almost all cases of suicide mental illness played a decisive role.
    - Condemnation and judgment are seen as misplaced.
    - Support and help for the survivors is a high priority.

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- **The assessment of suicide risk should be thought of as a grid in which factors are considered and weighted.**
  - On one side there are aggravating factors such as the presence of psychosis, the presence of a realistic plan and access to means.
  - On the other side, there are mitigating factors or deterrents.
  - **The weighing requires judgment.**

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- **When talking with a suicidal person, you should ask yourself two questions:**
  - How do I feel about the safety of this person if I leave him/her alone now?
  - Has the interview with the person changed anything?

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- **How do I feel about the safety of this person if I leave him/her alone now?**
  - This relates to your gut feeling, also referred to as countertransference. We all have empathy, and our sense of whether a person has the wherewithal or resilience to survive for another day should be taken into account as a decision-parameter.

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

- **Has the interview with the person changed anything?**
  - It is useful to reflect on the conversation with the person. The interaction may have helped the person see the original problem or stressor in a different context, and incipient solutions may have emerged.
  - The experience of being listened to and understood may also reduce the despair underlying suicidal ideation.

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

## What about "Contracting for Safety"?

- After your conversation you are still concerned, but suggest that the other person "sign a contract" which stipulates that he or she will take other steps if suicidal urges recur, such as calling a hotline, or the ED, or an identified responder.
- The professional consensus is that empirical evidence does not support such contracts.

Edwards and Sachmann 2010

# PRINCIPLES OF SUICIDE RISK ASSESSMENT

## **Empirical evidence does not support such contracts?**

- A contract has no meaning for a person who truly means to commit suicide (after all, what is the sanction for breach of contract?)
- A contract can possibly lull you into a false sense of certainty that the person has committed to a predetermined safe course of action.

# CASE

## **Should you ask directly if he has thought of killing himself?**

- The assessment of suicidal ideation requires straightforward inquiry. There need not be any concern that the question would disturb the patient or trigger suicidal thoughts.
- If indeed the patient had been thinking of suicide, the inquiry will be perceived as empathic and induce some relief.

# FINAL THOUGHTS ON SUICIDE

## “Suicidal gesture”

- Not a recommended choice of words
- The term minimizes the seriousness of the act
- The expression is judgmental
- The term say more about the evaluator than about the patient

# FINAL THOUGHTS ON SUICIDE

## Rating scales

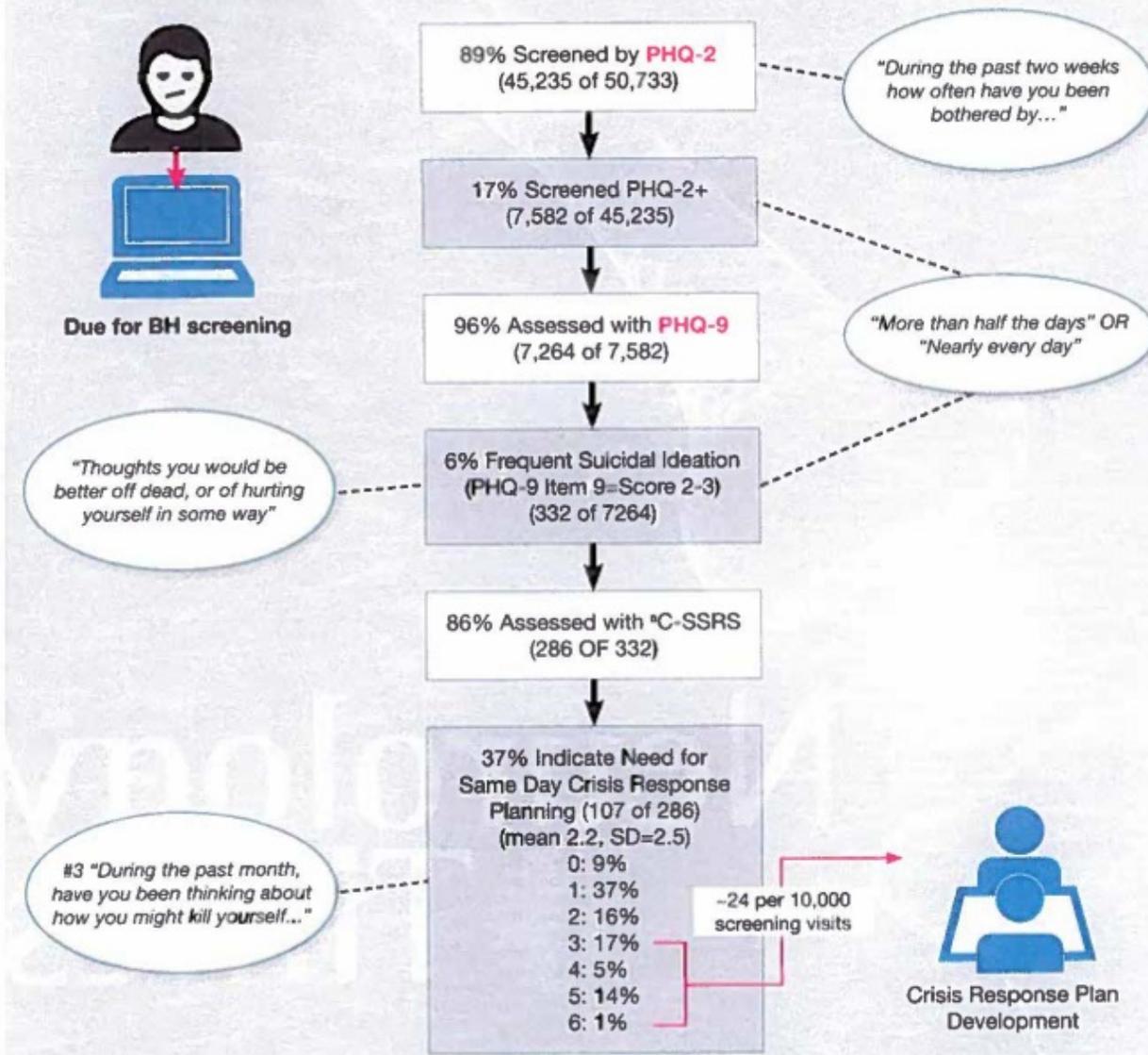
Limited utility

Do not replace clinical judgment

Do not make up for lack of rapport

Do remind clinicians to inquire about certain things

**FIGURE. Results of standard primary care workflow designed for suicidal patients during July 2018, Kaiser Permanente Washington Primary Care System**



BH, behavioral health.

Note: Prevalence outcomes distinguished from process outcomes in shaded boxes.

# FINAL THOUGHTS ON SUICIDE

- National Hotline
  - 1-800-SUICIDE or 1-800-784-2433
  - 1-800-273-TALK or 1-800-273-8255

# REFERENCES

Edwards SJ, Sachmann MD. No-suicide contracts, no-suicide agreements, and no-suicide assurances: a study of their nature, utilization, perceived effectiveness, and potential to cause harm. *Crisis*. 2010;31:290-302

Gaynes BN, West SL, Ford C, et al. Screening for suicide risk: a systematic evidence review for the U.S. Preventive Services Task Force. *Annals of Internal Medicine*. 2004;140:822-835

Hall RC, Platt DE, Hall RC. Suicide risk assessment: a review of risk factors for suicide in 100 patients who made severe suicide attempts. Evaluation of suicide risk in a time of managed care. *Psychosomatics* 1999;40:18-27.

Heilbron N, Compton JS, Daniel SS, et al. The problematic label of suicide gesture: alternatives for clinical research and practice. *Professional Psychology, Research and Practice* 2010;41: 221–227

Heron M. Deaths: leading causes for 2010. *National Vital Statistics Reports*. Hyattsville, MD: National Center for Health Statistics. 2013, vol 62 no 6

# REFERENCES

Mann JJ. [A current perspective of suicide and attempted suicide](#). *Annals of Internal Medicine* 2002;136:302-311

O'Connor E, Gaynes B, Burda BU, et al. [Screening for and treatment of suicide risk relevant to primary care: a systematic review for the U.S. Preventive Services Task Force](#). *Annals of Internal Medicine*. 2013;158:741-754

Wong FK, Wolanin A, Smallwood P. The suicidal patient. In Riba MB, Ravindranath B (eds.): *Clinical Manual of Emergency Psychiatry*. Washington, DC, American Psychiatric Publishing, 2010, pp.47-49.