ALL PATIENTS SAFE

Suicide Prevention for Medical Professionals

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> 44,193 SUICIDES

*Estimated

Source: CDC, SAMHSA, NIH
MEANS USED IN U.S. SUICIDES, 2015, PERCENTAGE

(\(n= 44,193\))

- **Firearms**: 50%
- **Suffocation**: 27%
- **Poison/Overdose**: 15%
- **Other**: 4%
- **Jump**: 2%
- **Cut**: 2%

70% of male Veteran suicide deaths are by firearm.

Source: CDC, VA, SAMHSA
MEANS USED IN U.S. SUICIDE ATTEMPTS WITH HOSPITALIZATION, 2015

(n=505,507)

- Poison: 52%
- Other: 24%
- Cut: 22%
- Firearms: 1%
- Suffocation: 1%

Source: CDC, SAMHSA
SUICIDE PREVENTION

LEARN™

Look
Empathize & listen
Ask & assess
Remove danger & plan for safety
Next steps to continuous care
# SUICIDE PREVENTION

<table>
<thead>
<tr>
<th>STEPS</th>
<th>BASIC</th>
<th>ADVANCED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Look</td>
<td>Warning signs; screening basics</td>
<td>Screening</td>
</tr>
<tr>
<td>Empathize &amp; Listen</td>
<td>Suicidal mind; empathy</td>
<td>Practice</td>
</tr>
<tr>
<td>Ask &amp; Assess</td>
<td>Ask directly</td>
<td>Assessment</td>
</tr>
<tr>
<td>Remove Danger &amp; Plan for Safety</td>
<td>Remove the danger</td>
<td>Safety planning</td>
</tr>
<tr>
<td>Next Steps to Continuous Care</td>
<td>Crisis resources; continuity of care</td>
<td>Management, treatment and your protocol</td>
</tr>
</tbody>
</table>
Concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in adolescents, adults, and older adults in primary care.

Recommendations:
- Screen for depression
- Collaborative care, mental health parity and home-based depression care for older adults
SCREENING FOR SUICIDE RISK
(cont’d)

Joint Commission,
Sentinel Event Alert Issue 56 – May 2014

1. Review each patient’s personal and family medical history for suicide risk factors.

2. Screen all patients for suicide ideation, using a brief, standardized, evidence-based screening tool.” More reliable than clinical judgement
   – Direct Question, PHQ-2 + Direct Question, PHQ-9, Other screeners

3. Review screening questionnaires before the patient leaves the appointment or is discharged

Source: The Joint Commission
DEPRESSION SCREENING IN PRIMARY CARE SETTINGS

PHQ-2

> Brief - 2 questions
> If score 3 or over, evaluate further

PHQ-9

> Brief – 9 questions
> Question 9: “Thoughts that you would be better off dead or that you want to hurt yourself in some way”

If patient screens positive for depression or suicidal thoughts, then evaluate further.

Source: PHQ-2, PHQ-9
# RISK FACTORS FOR SUICIDE

## HEALTH FACTORS
- Mental health conditions
- Alcohol and substance use disorder
- Serious or chronic health condition and/or pain
- Impulsive or aggressive behaviors

## ENVIRONMENTAL FACTORS
- Stressful life events especially loss (relational, financial, social)
- Prolonged stress
- Access to lethal means
- Local suicide cluster
- Barriers to accessing mental health treatment

## PERSONAL FACTORS
- Past suicide attempt
- Family history of suicide
- Family history of child maltreatment
- Intergenerational trauma
- Cultural and religious beliefs
- LGBT status
- Veteran status

Source: AFSP
YOU CAN OBSERVE THINGS IN YOUR PATIENTS THAT ARE NOT VERBALIZED

- Distress not always vocalized
- Tearful, anxious, or overly tired
- Not refilling or seems desperate to get medications
- Appears intoxicated
- Disoriented, accompanied by caregiver
- Change from usual behavior
Suicide is not about wanting to die. It’s about wanting to end pain.
THE SUICIDAL MIND

PULLED INSIDE A BLACK HOLE

> Despair
> Hopelessness
> Loneliness, isolation
> Cognitive impairment
> Seeking escape from pain
SUICIDE PREVENTION

Ask & assess:
WHEN DO I ASK

> Notice multiple warning signs together
> Notice concerning changes of behavior
> Your gut tells you something is wrong
> There is never harm in asking about suicide
SUICIDE PREVENTION

Ask & assess:

HOW TO ASK

> Be DIRECT:
  - “Are you thinking about suicide?”
  - “Are you planning to kill yourself?”

> Add context
  - “Sometimes when people are overwhelmed by life, when they can’t find solutions to their problems, they think about suicide. Are YOU thinking about suicide?”
Thank them for honesty, courage

Ask follow-up questions:

- Have you thought about how you might end your life?
- Do you have access to those means?
- Are you thinking of when you might end your life?
SUICIDE PREVENTION

Ask & assess:
IF YOUR PATIENT SAYS NO

Sometimes patients will not tell you they are thinking about suicide

- If your gut tells you to be concerned, return to the E step
- Be alert to discrepancies between self-report and screening tool
- Consider managing the patient as described in the R and N steps
## SAFE-T STEP 1: RISK FACTORS

### Health Factors
- Mental health conditions
- Alcohol and substance use disorder
- Serious or chronic health condition and/or pain
- Impulsive or aggressive behaviors

### Environmental Factors
- Stressful life events especially loss (relational, financial, homelessness, social)
- Prolonged stress
- Access to lethal means
- Local suicide cluster
- Barriers to accessing mental health treatment

### Personal Factors
- Past suicide attempt
- Family history of suicide
- Family history of child maltreatment
- Intergenerational trauma
- Cultural and religious beliefs
- LGBT status
- Veteran status

Source: CDC, AFSP
SAFE-T STEP 2: PROTECTIVE FACTORS

INTERNAL

> Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes
> Cultural and religious beliefs that discourage suicide and support instincts for self-preservation

EXTERNAL

> Effective clinical care for mental, physical, and substance abuse disorders
> Easy access to a variety of clinical interventions and support for help seeking
> Family, community support and pets (connectedness)
> Support from ongoing medical and mental health care relationships
SAFE-T STEP 3: WHAT IS C-SSRS

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS) - PRIMARY CARE VERSION

What is it?

> Validated instrument to assess suicide
> Six key questions about core elements of a suicide assessment

<table>
<thead>
<tr>
<th>SUICIDE IDEATION DEFINITIONS AND PROMPTS:</th>
<th>Past month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask questions that are in bold and underlined.</td>
<td>YES NO</td>
</tr>
<tr>
<td>Ask Questions 1 and 2</td>
<td></td>
</tr>
<tr>
<td>1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up?</td>
<td></td>
</tr>
<tr>
<td>Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td></td>
</tr>
<tr>
<td>2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, &quot;I've thought about killing myself&quot; without general thoughts of ways to kill oneself/associated methods, intent, or plan.</td>
<td></td>
</tr>
<tr>
<td>Have you had any actual thoughts of killing yourself?</td>
<td></td>
</tr>
<tr>
<td>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</td>
<td></td>
</tr>
<tr>
<td>3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. &quot;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.&quot;</td>
<td></td>
</tr>
<tr>
<td>Have you been thinking about how you might do this?</td>
<td></td>
</tr>
<tr>
<td>4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to &quot;I have the thoughts but I definitely will not do anything about them.&quot;</td>
<td></td>
</tr>
<tr>
<td>Have you had those thoughts and had some intention of acting on them?</td>
<td></td>
</tr>
<tr>
<td>5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.</td>
<td></td>
</tr>
<tr>
<td>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</td>
<td></td>
</tr>
<tr>
<td>6) Suicide Behavior Question: 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 valuable, 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.</td>
<td></td>
</tr>
<tr>
<td>If YES, ask: Was this within the past 3 months?</td>
<td></td>
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</table>

Response Protocol to C-SSRS Screening (Linked to last item marked "YES")

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 Consultation and Patient Safety Precautions
Item 6 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions

Source: C-SSRS
SAFE-T STEP 4: DETERMINING LEVEL OF RISK

<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 diagnoses 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 is 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>Modifiable risk factors, strong protective factors</td>
<td>Thoughts of death, no plan, intent, or behavior</td>
<td>Outpatient referral, symptom reduction. Give emergency/crisis numbers.</td>
</tr>
</tbody>
</table>

This SAFE-T Risk/Intervention Chart was created by SAMHSA and is intended to represent a range of risk levels and interventions, not actual determinations.
SAFE T STEP 5: DOCUMENT

> Document level of risk and information used to make that assessment
  – Document data from assessment tools
  – Document safety plan and means removal

> Plan to share documentation with other care providers

Source: SAMHSA
BREAKING CONFIDENTIALITY AND HIPAA

No release of information is needed to share patient information to provide continuity of care between medical providers

> One exception to this general rule is for psychotherapy notes.
BREAKING CONFIDENTIALITY AND HIPAA

Does HIPAA permit a doctor to contact a patient’s family or law enforcement if the doctor believes that the patient might hurt herself or someone else?

> YES.

The Privacy Rule permits a health care provider to disclose necessary information about a patient to law enforcement, family members of the patient, or other persons, when the provider believes the patient presents a serious and imminent threat to self or others.
It’s what we do with a friend too intoxicated to drive
MEDICATION SAFETY

1. Lock
2. Limit Access
3. Take-Back
4. Dispose

Order materials at SaferHomesCoalition.org
SAFER HOMES POSTCARD: MEDICATIONS

You do so much to keep your loved ones safe...

- Car seats
- Smoke alarms
- First Aid kits
- Bike helmets
- LOCK UP AND LIMIT ACCESS RX MEDICATIONS AND FIREARMS

SUICIDE IS PREVENTABLE
Medication overdoses too.

Go to SaferHomesCoalition.org

These steps protect against suicide/overdose/poisoning

1. LOCK UP your RX medications
2. LIMIT in-home supply of over-the-counter medications
3. TAKE-BACK go to takebackyourmeds.org
4. DISPOSE of meds with kitty litter or coffee grounds; place in your trash

You Can Save A Life
ACT BEFORE A CRISIS OCCURS

ACT TODAY TO STOP SUICIDE
Long Before a Crisis Occurs

He had done all his safety training...

...he was an excellent marksman

SUICIDE WAS THE LAST POSSIBLE THING ON OUR MINDS

LOCK AND LIMIT ACCESS TO YOUR FIREARMS

There were 6,578 firearm deaths* in Washington State between 2005-2015

78% SUICIDES

*Statistic from the WA Tracking Network, Dept. of Health

Source: WA DOH
YOU CAN SAVE A LIFE

Do Young People Live In or Visit Your Home?

LOCK UP
For their protection, do not allow children & teens unsupervised, unauthorized firearm access

LIMIT
Only firearm owner should access keys and combinations

CHOOSE
Carefully select a safe storage device for home-defense firearm with fast access for only you

82% OF TEENS WHO DIE BY SUICIDE WITH A GUN USE A FAMILY MEMBER’S FIREARM

Concerned About Yourself, Friend Or Family Member?

HOLD
Give a trusted individual keys and combinations

TRANSFER
Ask a friend or relative to hold firearms in an emergency temporary transfer

CALL
The National Suicide Prevention Lifeline
1-800-273-8255
Veterans Press 1
Crisis Text: 741-741

SAFER HOMES SUICIDE AWARE
YOU CAN SAVE A LIFE
SaferHomesCoalition.org
LOCK BOXES

- Life Jacket
  - $22 - $44
  - Depending on model

- Lock Box
  - $23 - $150 and up

- Gun Safe
  - $169 - $2,291

- Quick Access Pistol Safe Biometric Lock
  - $104 - $199

- Safe with quick Access
  - $275 - $500 and up
SAFETY PLANNING: 6 STEPS

1. Step 1
   What to watch for

2. Step 2
   Coping strategies
   (What I can do myself)

3. Step 3
   Places & community
   that provide distraction

4. Step 4
   Who I can ask for help

5. Step 5
   Providers & resources I can
   contact during a crisis

6. Step 6
   How can I make my
   environment safe

What is the one thing that is most important to me and worth living for?
ASSESS AND PLAN FOR SAFETY WITH SUPPORT

1. By phone
   – Press 1 for Veterans support
   – Non-emergency calls are welcome
   – Assessment and recommendations of local resources

2. By text
   – “Hello” 741-741

3. By Chat
   – CrisisChat.org

Call the National Suicide Prevention Lifeline
anytime, 24/7
1-800-273-8255
MAKING A REFERRAL FOR HOSPITALIZATION

State protocols will vary for involuntary detention

> Washington Specific: Involuntary determination is made by a Designated Mental Health Professional

**High risk patients will need intensive intervention to keep them safe**

**Voluntary**
- Some patients are voluntarily willing to take this step

**Involuntary**
- Some patients are unwilling to take this step but still need care

**Call to request an ambulance and transport to the emergency room**
- Both scenarios require this level of support

Source: SPRC, WA DSHS, King County
CARE TRANSITION AFTER HOSPITALIZATION

- Immediately after inpatient hospitalization and emergency patients are at high-risk
- Contact after emergency intervention for suicide is critical
- Additional resources to structure your first follow-up visit

Source: Zero Suicide, Brown & Green
CONTINUITY OF CARE FOR ALL PATIENTS AT RISK FOR SUICIDE

> Plan for close follow up in your practice
  – Continue to check in with the patient about safety plan and assess for suicidality

> Plan for referral
  – Know resources in your community and practice setting
  – Support patient to complete referral
  – Coordination of care with referral providers

> Long-term monitoring for suicide risk
  – Patient will always need a check in; may be brief
CARING LETTERS INTERVENTION

> What it is:
  - Routinely sending brief, caring messages to patients at elevated risk of suicide

> Why it’s helpful:
  - Tells patients you care
  - Reminds them that treatment is available

> Evidence:
  - Reduced suicide rates in a randomized clinical trial
MINIMAL ELEMENTS OF PROTOCOL

At a minimum a clinic protocol will address the following:

> **Look:**
  - How will you screen and identify those at risk for suicide?

> **Empathy:**
  - How will providers be trained and empowered to support patients at risk?

> **Ask & assess:**
  - What will your practice use to gather further information once a patient has screened positive for thoughts of suicide?
  - Do you have a triage plan for determining who needs to be sent to an emergency room immediately versus being followed in outpatient care.

> **Remove danger and plan for safety:**
  - What are the strategies in your community to remove means?
  - How will safety plans be generated and documented?
  - How will you make voluntary and involuntary treatment referrals?

> **Next steps to continuous care:**
  - How will you make sure to track any commitments?
  - How will you provide continuity of care and referrals?
Suicide prevention is a quality and safety issue for your practice

What can you do?
– Use the All Patients Safe practice protocol to develop an action plan for practice transformation
– Learn about and begin to implement Zero Suicide resources
Medical professionals can make an enormous impact on preventing suicides. They play an important role in educating all patients to proactively make homes safer to prevent suicide, accidents, and overdose/addiction.

To address suicide as a public health crisis, leading experts and healthcare organizations have collaborated to develop All Patients Safe: Suicide Prevention for Medical Professionals.

> Register today

https://www.apsafe.uw.edu/