

The Assessment of Suicidality

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Financial Disclosures

- Royalties—Oxford Press

Overview

- Importance to primary care
- Understanding the nature of suicide
- Risk factors versus warning signs
- Risk assessment, not prediction
- How to ask about suicide
- Safety planning and treatment

Scope of the Problem

- Suicide is the 10th leading cause of death in the US
 - In the 10- to 34-year old group 2nd leading cause of death
 - 4th leading cause of death ages 35 to 54
 - 8th leading cause of death ages 55-64
- ~1 suicide per 11 minutes in the US
- In 2017, >47,000 suicides
- In 2017 the age-adjusted suicide rate was 14.0/100,000 (10.5 in 2000)
- In 2017, firearms accounted for almost 60% suicides

Suicide and Primary Care

- **45% of individuals who die by suicide saw their primary care physician in the month prior to their death; only 20% saw a mental health professional**
- **60% suicides were suffering from a major depressive episode at the time of death**
- **Primary care doctors write >60% of prescriptions for antidepressants**
- **Primary care providers are on the front lines of suicide prevention**

Medicolegal Aspects

- **Bad outcome is not an indication of clinician or hospital negligence**
- **Suicide is a low base rate event and not predictable**
- **NO standard of care exists for the PREDICTION of suicide**
- **Prevention ≠ prediction**
- **A standard of care does exist for clinicians to adequately assess suicide RISK when it is clinically indicated**
- **Suicide risk assessment is an informed clinical judgment NOT a prediction**

The Etiology of Suicidal Ideation (Shea, 2011)

Three main etiologies:

- 1.Situational**
- 2.Psychological**
- 3.Biological**

A blend of these factors are at work in most suicidal individuals.

Suicide has multiple causes. There is no one reason for a person's suicide.

Precipitants for Suicidal Ideation

- 1. External factors (situational)**
 - **Public humiliation, job loss, death of a loved one, rejection by a loved one, serious illness especially one involving pain or anticipated cognitive deficits**
- 2. Psychological factors**
 - **Cognitive distortions and binds**
 - **Often exacerbated by stressors and biological factors**
- 3. Neurobiological dysfunction**
 - **Brain changes related to major psychiatric disorders such as major depression, bipolar disorder, psychosis, and severe anxiety**
 - **Toxins such as alcohol and other substances**

Risk Factors vs Warning Signs

- Risk factors are characteristics of a large sample of people who have died by suicide that appear to be more common than in the general population
- A warning sign (sometimes called risk predictor) is a characteristic of an individual that indicates that the person is at more imminent risk for suicide
- Risk factors and warning signs can overlap in an individual

Risk Factors

- History of a suicide attempt
- Family history of suicidal behavior, especially suicide
- Caucasian
- Male
- Increasing age
- Access to lethal means
- Alcohol/substance abuse
- Divorce
- TBI
- Physician
- Prisoner, especially male
- History of sexual abuse
- Mental illness, especially mood disorders
- Recent discharge from a psychiatric hospitalization
- ADHD especially comorbid
- LGBT
- Self-injurious behavior

Warning Signs

- Suicidal thoughts or plans
- Talking or writing about death or suicide
- Increasing alcohol or drug use
- Withdrawing from others
- Anxiety
- Agitation
- Hopelessness
- Clinical depression
- Significant mood changes
- Talking about feeling like a burden to others
- No purpose for living
- Increased or decreased sleep
- Feeling trapped or desperate
- Impulsive or reckless behavior
- Rage or anger
- Psychotic thinking

The Three Tasks of Suicide Risk Assessment

1. Obtaining information related to risk factors and warning signs for suicide in a particular patient
 2. Obtaining information related suicidal ideation and planning
 3. Clinical decision making applied to #1 and #2
- Shea (2002)

Dear Joanie,

I want to explain why you're reading this note. My death has absolutely nothing and everything to do with you and Anna. You two have meant everything to me, but I can no longer live with my own pain and the pain I am causing you. You have been a rock through it all—the hospitalizations, the rehabs, all of it. There is no way to express my love and gratitude except through my last act—to free you from being my caretaker. I'm taking away from all that Anna deserves, and she deserves the best from both of us, but I cannot give that to her. I've planned this down to the last detail, and thank God neither you nor Anna will not be the ones to find my body. Finding my father marked me for life. Just know that I believe in a merciful God who will forgive me, as I hope you and Anna can. All my love for all eternity.
Bill

SAD PERSONS Scale (Patterson, Doan, Byrd et al., 1983)

S	Sex	M
A	Age	<19 or >45
D	Depression	or other mood disorders; hopelessness
P	Previous suicide attempt	
E	Ethanol	or other substance use
R	Rational thinking loss	psychotic thinking
S	Social supports lacking	
O	Organized plan	
N	No spouse	
S	Sickness	chronic debilitating disease

Guidelines for Action with SAD PERSONS
(Patterson et al., 1983)

TOTAL POINTS	PROPOSED CLINICAL ACTION
0-2	Send home with follow-up
3-4	Close follow-up; consider hospitalization
5-6	Strongly consider hospitalization depending on strength of the follow-up arrangement
≥7	Hospitalize or commit

The NO HOPE Scale
(Shea, 1987)

N	No framework for meaning
O	Overt change in clinical condition
H	Hostile interpersonal environment
O	Out of hospital recently
P	Predisposing personality factors
E	Excuses for dying to help others

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Bill

Screening versus Risk Assessment

- **Suicide screening is not the same as suicide risk assessment.**
- **Screening is typically done in non-mental health settings (primary care and ED)**
- **The problem with data and statistics**
 - **No evidence that routine screening for SI in primary care settings actually decreases suicide attempts or mortality, but**
 - **54% of people who died by suicide did not have a known mental health condition (CDC, NAMI websites)**

Suicide Screening

- **Typically takes the form of validated instruments, but do little more than identify those for whom a more thorough assessment is needed.**
- **PHQ-9**
 - **Useful for screening but not for diagnosis of MDD**
 - **Some indication that item 9 is an inadequate tool for screening for suicidal ideation and risk (Na et al., 2018)**
- **Columbia Suicide Screen Risk Scale (C-SSRS)**
- **ED-SAFE**
- **ASQ-4**

Patient Health Questionnaire (PHQ-9) (Kroenke, Spitzer, Williams 2001)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Source: Agency Medical Directors' Group

Columbia-Suicide Severity Rating Scale (C-SSRS) With Triage Points for Primary Care

SUICIDE IDEATION DEFINITIONS AND PROMPTS		Final score
Ask questions that are bolded and underlined.		YES NO
Ask Questions 1 and 2		
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. <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i>		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/current suicide, "I've thought about killing myself" without specific thoughts of means to kill oneself/associated methods, intent, or plan. <i>Have you actually had any thoughts of killing yourself?</i>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "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." <i>Have you been thinking about how you might kill yourself?</i>		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I definitely will not do anything about them." <i>Have you had these thoughts and had some intention of acting on them?</i>		
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. <i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i>		
6) Suicide Behavior Questions: <i>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</i> 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. If YES, ask <i>How long ago did you do any of these?</i> • Over a year ago? • Between three months and a year ago? • Within the last three months?		

Mild suicide risk

Moderate suicide risk

Severe suicide risk

Source: SAMHSA
Authors: Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann © 2008
The Research Foundation for Mental Hygiene, Inc.

ED-SAFE Study (Miller et al, 2017)

THE PATIENT SAFETY SCREENER (PSS-3)

This tool can be used to detect suicide risk in EDs and inpatient medical settings with patients ages 12 years and older.

Ask the following three questions exactly as worded. If the answer to Question 3 is Yes, ask Question 3a

Opening script: *Now I'm going to ask you some questions that we ask everyone treated here, no matter what problem they are here for. It is part of the hospital's policy and it helps us to make sure we are not missing anything important*

1. In the past two weeks, have you felt down, depressed, or hopeless?
 Yes No Patient unable to complete Patient refused

2. In the past two weeks, have you had thoughts of killing yourself?*

 Yes No Patient unable to complete Patient refused

3. In your lifetime, have you ever attempted to kill yourself?*

 Yes No Patient unable to complete Patient refused

3a. If yes, when did this happen?
 Within past 24 hours (including today) Within last month (but not today) Between 1 and 6 months ago
 More than 6 months ago Patient unable to complete Patient refused

*Patient presenting with a current suicide attempt is an automatic Yes on Items 2 and 3.

Source: Suicide Prevention Resource Center

ED-SAFE Study (Miller et al, 2017)

THE ED-SAFE SECONDARY SCREENER (ESS-6)

This tool should be administered by the provider after a patient endorses active suicidal ideation in the past two weeks (PSS Item 2= Yes) OR suicide attempt within the past 6 months (PSS Item 3 = within past 6 months).

A. Assess the following six indicators using all data available to you, including patient self-report, collateral information, medical record review, and current observations.

	Yes	No	Unable to complete
1. Positive on both safety screener (PSS-3) items: active ideation with a past attempt	1	0	
2. Recent or current suicide plan *	1	0	
3. Recent or current intent to act on ideation*	1	0	
4. Lifetime psychiatric hospitalization	1	0	
5. Pattern of excessive substance use	1	0	
6. Current irritability, agitation, or aggression	1	0	
Sum score (1 for each "Yes")	Total		

Anyone presenting with a current suicide attempt is an automatic Yes on items 1, 2 and 3.

*Items 2, Plan and 3.Intent are critical items for interpretation.

Source: Suicide Prevention Resource Center

Suicide Screening—Pediatric

Ask Suicide-Screening Questions (ASQ)—ages 10-24

- In the past few weeks have you wished you were dead?
- In the past few weeks, have you felt that you or your family would be better off if you were dead?
- In the past week, have you been having thoughts about killing yourself?
- Have you ever tried to kill yourself?

If "Yes" to any of the above:

- Are you having thoughts of killing yourself right now? (and describe)
- <https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml>

Suicide Risk Assessment

- More comprehensive than screening and done by a clinician (including a primary care physician) trained to assess risk
- No screening or assessment tool is a substitute for clinical judgment, but:
 - Must know major risk factors for completed suicide
 - Best defense in the event of a poor outcome is the ability to:
 - Convey a knowledge of the subject area
 - Documentation of having performed a psychiatric evaluation
 - Documentation of having performed a risk assessment
 - Documentation of rationale with respect to treatment and disposition

Suicide Risk Assessment

The following guideline for a suicide risk assessment is not a recipe—the elimination of one or more of these items does NOT necessarily indicate an inadequate risk assessment

Suicide Risk Assessment

Major Risk Factors for Completed Suicide

- Prior suicide attempts
- Family history of suicidal behavior
- Mental illness, especially mood disorders
- Substance or alcohol abuse
- Access to lethal means

Other Risk Factors

- Caucasian
- Male
- Access to lethal means
- Divorce; significant loss
- TBI
- Physician
- Prisoner, especially male
- Trauma history, especially sexual abuse
- Recent discharge from a psychiatric hospitalization
- ADHD especially comorbid
- LGBT
- Self-injurious behavior

Suicide Risk Assessment

Mental Disorders

- Mood disorders—major depression and bipolar disorder
- Psychosis
- Anxiety—severe anxiety in combination with depression
- Substance use disorders
 - Recent increase?
 - Involved in recent attempt?
- Is there a family history of mental illness?
 - Suicide attempts
 - Death by suicide

Asking about Suicide

Goal is to elicit valid information

- Interview patient separately and in private
- Appear unhurried
- Try not to type or take notes when asking about suicide
- Use segues and ask in a way that does not tap into fears that others perceive the patient as weak, “crazy,” selfish, etc.

Asking about Suicide

Validity techniques (Shea, 2011)

- Behavioral incident - asking for specifics (How many pills did you take? Did you empty the bottle?)
- Shame attenuation - Sometimes when people are under a lot of stress, they have thoughts of suicide. Have you ever had thoughts of being better off dead or killing yourself?)
- Gentle assumption - How often have you thought of killing yourself?
- Symptom amplification - How many times a day do you think about killing yourself—20? More?
- Denial of the specific - Have you thought of hanging yourself? Shooting yourself?
- Normalization - Sometimes when people are depressed, their thoughts are so intense that they almost seem like voices. Has that ever happened to you? Some of my patients of my patients with depression have thought that their families would be better off without them. Have you ever thought that?

Asking about Suicide

Suicidal Ideation

- Nature of the thoughts—suicide thinking as a continuum
 - Desire to be dead but no thought of killing self
 - Desire to kill self but no plan
 - Desire to kill self with thoughts of how to do so
- How often do the thoughts occur?
- Have they increased in frequency or intensity?
- How do the thoughts make you feel?

Asking about Suicide

Lethal Means

- Does the patient want to die?
- Does the patient want to be dead now?
- What methods have been considered and for what reason?
 - Level of potential lethality
 - Preparatory behaviors
 - Farthest they've come
- Access to lethal means

Asking about Suicide

Anticipated Method or Plan

- Obtain explicit details of plan
 - What?
 - When?
 - Where?
 - How?
- Have you thought of doing it in a way that no one could save you?
- Do you think this would kill you?

Suicide Risk Assessment

Social Supports and Community Resources

- Work and/or school performance
- Bullying—not just a “kid” thing

Exposure

- Friends or family
- School/community exposure-contagion?
- Media Exposure

Trauma History

- Especially sexual abuse

Suicide Risk Assessment

Previous Attempts

- Have their been previous attempts to harm self?
 - Self harm versus intent to die
 - Details regarding previous attempts:
 - Plans to avoid detection
 - Potential for lethality
 - Decision making regarding method
 - Medical attention
 - Suicide note
 - Anyone told of plans?
 - Was attempt aborted and how?

Suicide Risk Assessment

Impulsivity

Recent Losses or Legal Consequences

Future Orientation

- Hopeless?
- Reasons for Living

Protective Factors

- **Protective factors**
 - Reasons for living (family, moral, pets, etc.)
 - Religious faith that can be harnessed in positive ways (requires discussion)
- **Research around protective factors is equivocal**
 - Hopelessness is a risk/warning sign, but hopefulness not protective
 - Religion

Clinical Vignette

Maura is a 38 yo divorced academic researcher with two children, ages 1 and 3, who presents with symptoms of a URI. She admits to getting only 2-3 hours of sleep a night and lays in bed worrying about whether her most recent grant submission will be funded. She endorses depression and anxiety, and during adolescence made a suicide attempt by overdose for which she was hospitalized for 2 weeks. She mentions that she is under considerable strain because one or more of her colleagues are attempting to sabotage her research.

She describes her ex-husband as having been physically abusive to both her and their children. The court ordered her to pay spousal support, and he has visitation, which he exercises sporadically.

Suicide Risk Assessment

Obtain information from collateral sources

- Confusion regarding HIPAA
- In an emergency, in life and death issues (which suicide is), do not require consent, but good to obtain anyway.
- Can ALWAYS listen to information family wants to provide

Safety Planning

- **Family members and/or close friends should be involved in safety planning—increases buy-in and compliance**
- **Warning signs/precipitants and plan to avoid and/or cope**
- **Secure/remove lethal agents**
- **Individual coping**
 - **Review reasons for living**
 - **Distracting activities**
 - **Relaxation, exercise, etc.**
- **Professionals who can help with contact information**
- **Crisis names and phone numbers**
- **Interpersonal coping**
 - **Identify friends to help distract or lift mood**
 - **Identify trusted adults to approach when having suicidal thoughts (parent, relative)**

Follow-up

- **Strongest evidence-base is follow-up**
- **Phone, text, postcard if unable to get into mental health treatment rapidly and doesn't want or require hospitalization**
- **Treat depression with therapeutic dosages**
- **Follow-up can be life saving especially if mental health treatment is difficult to access or poor—see weekly or more frequently if necessary**
- **The enemy of the good is the perfect—15 minutes with a doctor who cares is better than waiting 1 month for a 1-hour appointment with a therapist**