Suicide Prevention in Healthcare Settings

Southeast Nebraska Suicide Prevention Project

2003
What Healthcare Settings?

- Emergency Departments
- General Hospital Units after admission
- Community mental health agencies
- Private mental health practices
- Mental Health Inpatient Units
- Doctor’s Office
- Services such as youth health services, postnatal services, etc
Why Focus on Suicide Prevention
In Healthcare Settings?

Luoma, Martin, and Pearson (2002) Examined rates of contact with primary care and mental health care professionals by individuals before they died by suicide.

*Results of this study showed:
- Contact with primary care providers in time leading up to suicide is common
- 3 out of 4 suicide victims had contact with their primary care providers within the year of suicide.
Why Focus on Healthcare Settings? (cont.)

- 1/3 of the suicide victims had contact with mental health services
- 1 in 5 suicide victims had contact with mental health services within a month before their suicide
- Older adults had higher rates of contact with primary care providers within 1 month of suicide than younger adults

Additional Stats

- Physicians detect only 1 of 6 patients who later go on to commit suicide (Blumenthal, 1990)
- More than 80% of patients experiencing a first psychiatric crisis seek medical rather than psychiatric treatment (Blumenthal, 1990)
Healthcare Staff

- Have a long and close contact with the community and are well accepted by local people
- Provide the vital link between the community and healthcare system
- Knowledge of the community enables them to gather support from family, friends, and organizations
- In position to provide continuity of care
- Entry point to health services for those in distress
- Available, accessible, knowledgeable, and committed to providing care

Surgeon General’s Call To Action 1999

- Intervention: Enhance services and programs, both population-based and clinical care

- Improve the ability of primary care providers to recognize and treat depression, substance abuse, and other major mental illnesses associated with suicide risk. Increase the referral to specialty care when appropriate
Understanding Components of Suicidal Act

The common cause:
- unendurable psychological stressors

The stressors leading to the suicide act:
- related to the frustrated psychological needs of the person

The purpose:
- to find a solution to problems

(Ed Schniedman)
Understanding Components of Suicidal Act (cont.)

The goal:
- to end ‘consciousness’ and escape psychological distress

The emotion:
- hopelessness-helplessness

The action:
- aimed at finding a ‘way out’ or escape

(Ed Schniedman cont)
Epidemiologist Eve K. Moscicki remarked, “A psychiatric disorder is a necessary condition for suicide to occur”.

However, the presence of a psychiatric disorder is not sufficient cause.
The majority of people who commit suicide have a diagnosable mental disorder.

Suicide and suicidal behaviors are more frequent in psychiatric patients.

World Health Organization 2000
Mental Disorders That Increase Suicide Risk

- All forms of depression
- Personality disorder (antisocial and borderline personality with traits of impulsivity, aggression and frequent mood changes)
- Schizophrenia
- Alcohol Abuse
- Organic mental disorder
- Other mental disorders
The most common psychiatric disorders associated with completed suicide are major depression and alcohol abuse.
Depression

Symptoms include:

- Feeling sad during most of the day, every day
- Losing interest in usual activities
- Losing weight (when not dieting) or gaining weight
- Sleeping too much or too little or waking too early
- Feeling tired and weak all the time
Depression (cont.)

- Feeling worthless, guilty or hopeless
- Feeling irritable and restless all the time
- Having difficulty in concentrating, making decisions or remembering things
- Having repeated thoughts of death and suicide

Adapted from World Health Organization 2000
Why is Depression Missed

Variety of treatments are available for depression, there are several reasons why this illness is often not diagnosed:

- People are embarrassed, consider it a sign of weakness
- People are not familiar with symptoms and do not recognize it
- People have another physical illness which makes it difficult to detect the depression
- Patients with depression may present with a wide variety of aches and pains

Adapted from World Health Organization 2000
Depression in Primary Care

- 5 to 9 percent of adult patients in primary care settings have depression
- 50 percent of those go undiagnosed & untreated
- Women, family history of depression, unemployed, chronic diseased, are among those at increased risk for depression

Screening for Depression

- Formal screening makes it easier to detect depression

- If screening, have systems in place to assure accurate diagnosis, effective treatment, and follow-up

Screening for Depression

- Many tools available to screen for depression
- Little evidence to recommend one over the other
- “Our panel found that asking two simple questions – over the past 2 weeks, have you ever felt down, depressed, or hopeless, and have you felt little interest or pleasure in doing things—may be as effective as using longer screening instruments”.

- Affirmative response to the two questions may indicate need for more in-depth diagnostic tools

U.S. Preventive Services Task Force Chairman Dr. Alfred Berg, Chair of the Department of Family Medicine, University of Washington, Seattle.
Children’s Depression

- 2% of children and 4.5% of adolescents in primary care settings have depression
- Insufficient evidence to recommend for or against screening for children or adolescents
- Screen children and adolescents for suicidality
- Parents were relieved that a clinician was delving into a topic that they feared discussing with their children

More details are in "Detecting suicide risk in a pediatric emergency department: Development of a brief screening tool," by Dr. Horowitz, Phillip S. Wang, M.D., Dr. P.H. Gerald P. Koocher, Ph.D, and others, in the May 2001 Pediatrics 107 (5), pp. 1133-1137
Schizophrenia

Adults with Schizophrenia have increased risk of suicide:
- Young, Single, Unemployed Males
- In the early stage of illness
- Depressed
- Prone to frequent relapses
- Highly educated
- Paranoid

10% of people with schizophrenia commit suicide
Schizophrenia

*People with Schizophrenia are most at risk…*

- in the early stages of illness, when confused and/or perplexed
- early in recovery, when outwardly their symptoms are better but internally they feel vulnerable
- early in relapse, when they feel they have overcome the problem, but the symptoms recur
- soon after discharge from hospital

Adapted from World Health Organization 2000
Implications for Health Services

Mental health clients are 10X more at risk of suicide than the general population.

Mental health clients are 100X more at risk of suicide at the time of discharge from inpatient care:
- Mixed level of precaution and supervision
- Perceived loss in level of support
- Possible relapse due to exposure of home circumstances
- May not be fully recovered
- Non adherence to treatment regimes
- Stigma?

Centre for Mental Health, NSW Health Department 1999
Alcoholism/Substance Abuse and Depression

- Alcoholism in adults
- Substance abuse in adolescents
- Alcoholism/substance abuse coupled with a mood disorder dramatically increases the risk

Adapted from N. Gregory Hamilton, MD
Vol 108/No 6/November 2000/PostGraduate Medicine
Alcoholism

- One third of persons completing suicide were dependent on alcohol
- 5-10% of people who are dependent on alcohol end their life by suicide
- At time of suicidal act many are under the influence of alcohol
Characteristics of the Person with Alcohol Problems who Suicides

- Started drinking at young age
- Consumed alcohol over long period of time
- Drank heavily
- Poor physical health
- Depressed
- Disturbed and chaotic lives
- Recent interpersonal loss
- Performed poorly at work
- Family history of alcoholism

Adapted from World Health Organization 2000
Physical Illnesses Associated with Suicide

**Central Nervous System**
- Multiple sclerosis
- Epilepsy
- Temporal lobe epilepsy
- Spinal cord injury
- Delirium Tremens
- Huntington's Disease

**Gastrointestinal System**
- Peptic ulcer

**Genitourinary System**
- Renal failure on dialysis

**Autoimmune Disorders**
- Rheumatoid arthritis
- Systematic lupus erythematosus (SLE)
- Diabetes mellitus
- Cushing's disease

**Cancer**
- Maxillofacial (head and neck)
- Gastrointestinal
- Pulmonary

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Adapted from Comprehensive Textbook of Suicidology 2002
Medical Conditions

- Be cognizant of patients’ perception of their chronic or debilitating physical illness, increased suicide risk, and suicidal behaviors.
- Carefully explore other risk factors and protective factors.
- Create treatment plan that includes risk management protocol.
1. Ask about history of substance abuse and psychiatric illness
2. Assess mood, affect, and judgment
3. Look at risk factors and symptoms of suicide
4. Interview family member
5. Develop treatment plan

Gliatto and Rai in the March 15th, 1999 issue of American Family Physician
General Screening Guidelines
When Patient Presents With Suicide Risk

- Screen new patients using CAGE questions (for substance abuse)
- Record brief mental status exam
- Look for
  - Evidence of depressed mood, anxiety or substance abuse
  - Recent stressors
  - Suicidal risk / warning signs
CAGE Questionnaire

Alcohol Dependence is likely if the patient gives two or more positive answers to the following questions:

- Have you ever felt you should **CUT** down on your drinking?
- Have people **ANNOYED** you by criticizing your drinking?
- Have you ever felt bad or **GUILTY** about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**EYE-OPENER**)?
Determining Level of Suicidality

1. Clinical Assessment
   a. Inquire about feelings of depression (feeling down/blue)
   b. Ask about length, frequency, intensity, sleep interruption, concentration problems and appetite
   c. Ask about hopelessness, pessimism, discouragement. Is intensity of these feelings so much that life does not seem worthwhile?
Determining Level of Suicidality

d. Thoughts of suicide
   • persistence & intensity of thoughts
   • effort to resist thoughts
   • impulses to carry out thoughts
   • Plan
     • taken any initial action (e.g. buying gun, hoarding pills)
     • how detailed are the plans, are lethal means available?

e. Can person manage feelings if they occur, is there a support system to help manage?
## Determining Level of Suicidality

### 2. SAD PERSONS SCALE (Quick and Easy Assessment)

- **Sex**: 1 if patient is mail, 0 if female
- **Age**: 1 if patient is (25-34; 35-44; 65+)
- **Depression**
  - **Previous attempt**: 1 if present
  - **Ethanol abuse**: 1 if present
  - **Rational thinking loss**: 1 if patient is psychotic for any reason (schizophrenia, affective illness, organic brain syndrome)
  - **Social support lacking**: 1 if these are lacking, especially with recent loss of a significant other
  - **Organized Plan**: 1 if plan made and method lethal
  - **No spouse**: 1 if divorced, widowed, separated, or single (for males)
  - **Sickness**: 1 especially if chronic, debilitating, severe (e.g.; non-localized cancer, epilepsy, MS, gastrointestinal disorders)

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SAD PERSON Guidelines for Action

- 0-2 Send home with follow-up
- 3-4 Close follow-up
- 5-6 Strongly consider hospitalization, depending on confidence in the follow-up arrangement
- 7-10 Hospitalize or commit

Hospitalization

When do you hospitalize?

- Patients with a plan, access to lethal means, recent social stressors and symptoms suggestive of a psychiatric disorder should be hospitalized immediately
Hospitalization

Inform family of decision to admit and do not leave patient alone while he or she is transferred to a more secure environment.
Patient Expresses Suicidal Ideation

- Patient has a suicide plan
  - Patient has access to lethal means, has poor social support and poor judgment
    - Hospitalize
  - Patient does not have access to lethal means, has good social support and good judgment
    - Evaluate for psychiatric disorders or stressors
      - Appropriate therapeutic intervention
        - Patient does not respond optimally
          - Refer to psychiatric consultant

Adapted from American Family Physician March 15, 1999 Michael F. Gliatto, M.D., Anil K. Rai, M.D. Page 6
BryanLGH Medical Center and Lincoln/Lancaster County Crisis Center

- Two separate facilities
- BryanLGH Medical Center Mental Health is not related to the Crisis Center
- When EPC happens individual transported to Crisis Center unless Medical Condition requires Hospital Treatment
- BryanLGH has 24 hour mental health assessment nurse available in ED for those patients voluntarily seeking treatment
State of Nebraska public policy declares that mentally ill dangerous persons be encouraged to obtain voluntary treatment.

It is when voluntary treatment is refused that the individual can be subjected to emergency protective custody.

The majority of mentally ill dangerous persons do obtain voluntary treatment.
Emergency Protective Custody
Criteria
Criteria 83-1009

- Mentally Ill and/or chemically dependent
- Danger to self or others
- Inability to care for self
Nebraska’s Emergency Protective Custody Process

- Person is believed to be Mentally Ill & Dangerous
  - Obtain Preadmission Screening
    - Emergency Protective Custody indicated
      - Mental Illness & Dangerousness evident
        - Information goes to County Attorney
          - Evaluation within 36 hours
            - Petition filed in District Court
              - Hearing Scheduled
            - Petition not filed
              - Person Released
        - Dangerousness or Mental Illness not evident
          - No custody indicated
            - Make referrals
    - Dangerousness or Mental Illness not evident
      - No custody indicated
        - Make referrals
EPC Process

- Law enforcement initiates
- M.D. or LMHP have option to complete form that provides more information for law enforcement about the individual and will most likely need to testify at the BMH hearing
EPC Process Continued

- Patient needs to be evaluated within 36 hours by a psychiatrist or psychologist
- Evaluation and recommendations are submitted to County Attorney to determine whether or not to file the papers for a Board of Mental Health Hearing
- County Attorney Timelines:
  - If deemed committable – intent to file must be given and hearing scheduled with 7 days of the date of the EPC
  - If deemed NOT committable – County Attorney must decide within 24 hours of receiving the information whether to file petition
- Mental Health Board hearing will be held to determine treatment needs and/or placement needs of the patient
Physicians who would like to drop EPC will need to submit a recommendation to the County Attorney.
County Attorney will make a decision whether or not to drop EPC or file papers for Board of Mental Health.
EPC Process for Youth (LAST RESORT)

- Same criteria (mentally ill/dangerous)
- Physical assessment needed prior to placement
- EPC youth are placed at BryanLGH Medical Center West or the Lincoln Regional Center (LRC)
- BryanLGH Medical Center and LRC communicate daily regarding bed availability and will decide the most appropriate placement for the youth
Alternative to Youth EPC

- A responsible adult may authorize admission for treatment without initiating EPC process

- Temporary Immediate Custody may be initiated by Law Enforcement if needed
Survivor Issues

- Normalize expression of feelings such as shock, fear, sadness, guilt, anger at others or at the victim – Assure feelings will become less intense after talking, counseling.
- Assure no right way to feel after a suicide - Each person will need to go through individual grief.
- Clarify the facts.
- Acknowledge “why” questions - Victims choice - Only victim knows “why”
Optional Slides
Lancaster County Crisis Center

Once EPC’d adult individuals may be taken to the Crisis Center operated by Lancaster County.

While at Crisis Center individual will be preparing for Board of Mental Health hearing.

Please call the Crisis Center prior to leaving.
Lancaster County Crisis Center Continued

- Once making call to Crisis Center they will:
  - Be able to inform you of bed availability
  - If bed is available:
    - Individual needs to be medically stable (No IV’s, and O2)
  - Individual needs to be mobile
  - Only staffed with 1 RN for 15 beds
If beds are full at Crisis Center the next alternative would be BryanLGH Medical Center West

If this happens, please call the Administrative Supervisor 475-1011 at BryanLGH Medical Center West and indicate you have an EPC and the Crisis Center is full and inquire about bed availability.
Contact the administrative supervisor:

- They will make determination on capability and capacity to receive patient.
- If able to receive patient, they will coordinate receiving patient through the Emergency Department or as a direct admit to unit/physician.
EPC Process Continued

- If medically unstable (OD, intoxication BAC > 200):
  Individual will need to be admitted to BryanLGH Medical Center West and not Crisis Center
EPC Process Continued

If BAC is < 200:
Patient will need to be stable for transfer prior to leaving hospital
EPC Documentation (83-1021)

EPC CERTIFICATES

- Observed Behavior of subject
- Witness description of subject’s behavior
- Environmental Description
  Historical Information

What do you see?
What do you hear?
Trust your intuition....
EPC Documentation

What the County Attorney and Mental Health Professionals Need to know . . .

– Current Information
  - risk factors and behaviors
  - Current mental health diagnosis / treatment
  - Current medical factors

– Historical Information
  - Including information about past behavior is appropriate
    – Mental Health history; contacts with law enforcement; incidents of violence or crisis
Psychologically Unstable Patient Presents to ED (Believed to be mentally ill and/or chemically dependent and dangerous)

Patient is unstable medically and refuses help for mental health concerns

Stabilize patient medically and call law enforcement for EPC and then transfer to Regions EPC facility
Psychologically Unstable Patient Presents to ED (Believed to be mentally ill and/or chemically dependent and dangerous)

Patient is medically stable and refuses treatment for mental health concerns

Contact law enforcement for EPC and make transfer to Regions EPC facility
Emergency Room Decision Tree

- Psychologically Unstable Patient Presents to ED (Believed to be mentally ill and/or chemically dependent and dangerous)
- Patient is medically unstable and wants treatment
- Contact BryanLGH Medical Center or other area treatment facility for transfer. If calling BryanLGH as for Administrative Supervisor
- Contact ambulance and law enforcement if indicated
Emergency Room Decision Tree

- Psychologically Unstable Patient Presents to ED (Believed to be mentally ill and/or chemically dependent and dangerous)
- Patient is medically stable and wants treatment
- Contact BryanLGH Medical Center Administrative Supervisor or area treatment facility and ambulance for transfer
Admission Criteria for EPC Facilities

Identify the EPC facility in your area
Know their admission criteria

1. Medical Stability
   1. Intoxication
   2. Invasive procedures needed (IV’s? Feeding tubes?)
   3. Ambulatory

2. Criminal Charges
   1. Degree of violence / Seriousness of charges
   2. Transfers from jail

3. Age
   1. Juvenile vs. Adult