

VISN 3
Suicide Awareness
Day

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Acknowledgements

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All interpretations and the presentation of this information is my responsibility, as are any inaccuracies.

Thank you.



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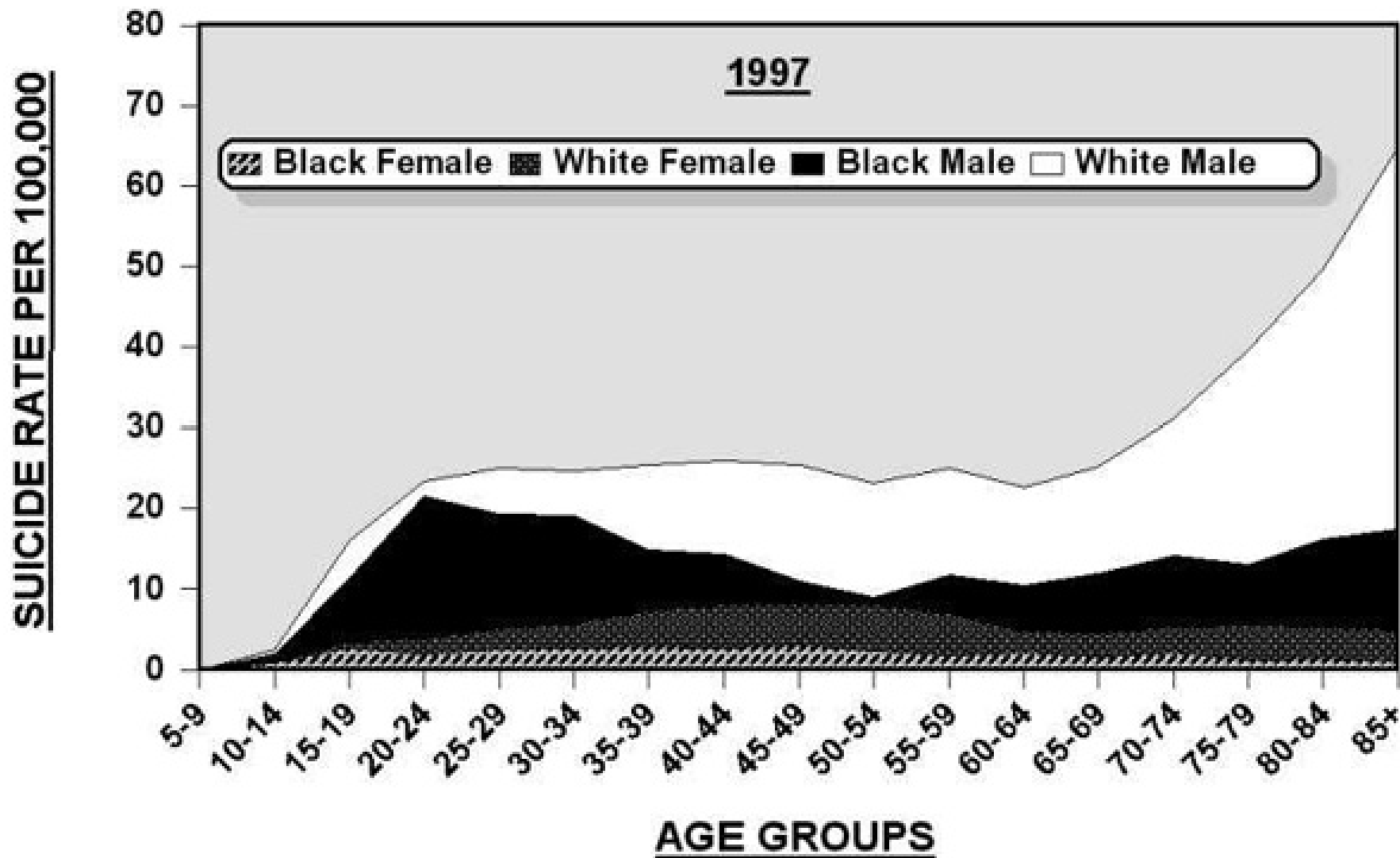


Annual Incidence Estimates: Suicide

- General Population:
 - 1,000,000 worldwide, 30,000 US each year
 - worldwide rates - **10** to **35** per 100,000
 - U.S. rates - **10.8** per 100,000
 - New York – **6.6** per 100,000
 - New Jersey – **6.9** per 100,000
- Clinical Population:
 - VAMC (Philadelphia)
 - <age 65: 83 per 100,000
 - >age 65: 45 per 100,000
 - VA psychiatric inpatients: est 279 per 100,000
 - Previous attempters: est 1,000 per 100,000



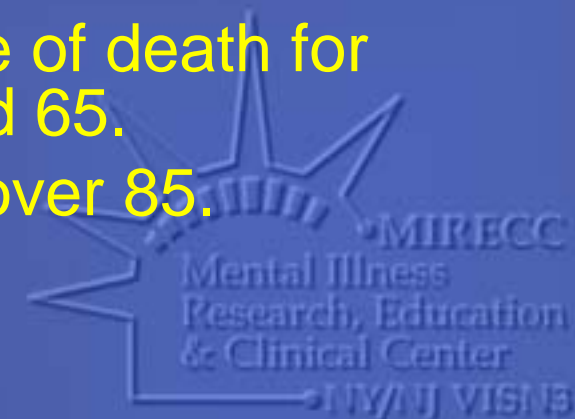
U.S. SUICIDE RATES BY AGE, GENDER, AND RACIAL GROUP



Source: National Institute of Mental Health
Data: Centers for Disease Control And Prevention, National Center For Health Statistics

Facing the facts...

- Suicide is the 11th leading cause of death in the US, all people, all ages
- Suicide is considered to be the 2nd leading cause of *death* among college students.
- Suicide: 3rd leading cause of death 10-24.
- Suicide: 2nd leading cause of death 24-34.
- Suicide: 4th leading cause of death 35-44.
- Suicide: 5th leading cause of death 45-54
- Suicide: 8th leading cause of death 55-64..
- Suicide is the fourth leading cause of death for adults between the ages of 18 and 65.
- Suicide is highest in white males over 85.
(48.42/100,000, 2004)



Why all Staff (Primary Care) should Care

- 25% of Primary Care pts have Diagnosable MH Disorder
 - 1/2 are undetected, untreated *because*
 - 75% c/o somatic symptoms.
 - TIME
- If Primary Care Provider sees 2000 pts, one could expect:
 - 1 suicide every 2 yrs;
 - 10 serious attempts/yr.,
 - 50 with suicidal ideation.
- IN the VHA patients who suicide have as last contact
 - Outpatient Mental Health: 42%
 - Inpatient Mental Health: 25%
 - Outpatient Primary Care: 25%
- Outpatient Suicides within 1 month of contact: 78%



Suicide risk
varies over time
within the life of the
individual.



A Suicide Attempt is any
behavior that is
dangerous to oneself
and
is accompanied by the
intent to die



VHA Handbook: Parasuicide

Any suicidal behavior with or without physical injury (i.e. short of death) including the full range of known or reported attempts, gestures and threats



Suicide Communications Are Often Not Made to Professionals

- In one psychological autopsy study only 18% spontaneously told professionals of intentions.
- In a study of suicidal deaths in hospitals:
 - 77% denied intent on last communication
 - 28% had “no suicide contracts” with their caregivers



National Comorbidity Study

Cumulative Probabilities for Transition

Ideation → Plan 34%

Plan → Attempt 72%

Ideation → Unplanned Attempt 26%

Within 1 year of onset of IDEATION:

60% of all planned 1st attempts

90% of all unplanned 1st attempts



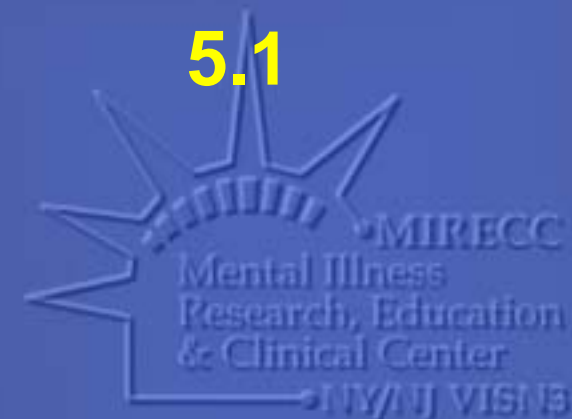
Major Depressive Disorder

- Depressed Mood
- Appetite (increased or decreased)
- Motor (agitation or retardation)
- Energy
- Sleep (insomnia or hypersomnia)
- Thought (concentration, indecisiveness)
- Anhedonia (interest)
- Guilt (worthlessness)
- Suicide



Risk Factors: Psychiatric Illness

- Major Depressive Disorder 20.4
- Bipolar Disorder 15.0
- Dysthymic Disorder 12.1
- Schizophrenia 8.5
- Obsessive Compulsive Disorder 7.8
- Cluster B Personality 5.9
- PTSD 5.1



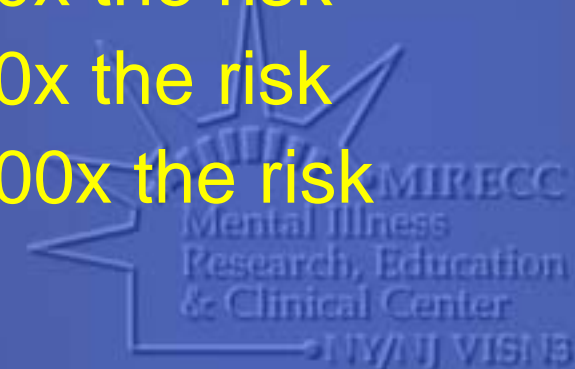
Risk Factors: Medical Illness and Substances

- Sedative Abuse 20.3
- Opioid Abuse 14.0
- Alcohol Abuse 5.9
- AIDS 6.6
- Epilepsy 5.1
- Cannabis Abuse 3.9
- Dementia 3.6
- Spinal Cord Injury 3.5
- TBI 3.1
- Chronic Pain 3.1
- Cigarette Smoking 2-2.5



Other Things That Increase the Risk

White Male	doubles the risk
Live in Nevada	doubles the risk
Live in Finland or Hungary	4x the risk
Have a gun at home	6x the risk
Have a parent who killed Self	6x the risk
White Male & older than 75	7x the risk
Commit a violent crime	7-10x the risk
Addicted to heroin	20x the risk
Untreated Depression	50x the risk
Previous Suicide Attempt	100x the risk



Warning Signs

- People frequently see their doctor
 - Only 50% have seen a psychiatrist
 - 75% saw Primary Care MD within 3 months of completing Suicide
 - 50% within one month
 - 25% within one week
- 75% give clues to the people around them



Suicide Attempts

- VA Eastern Colorado Healthcare System
- October 1st, 2004 - March 30th, 2006 (18 month period)
- 134 known attempts - under reporting issues
- Out of the 134 known attempts there were 14 completions.



Appointments

- 71 of the 134 patients were seen by a care provider in the system within 30 days of their attempt
- 44 of these 71 patients were seen within one week of their attempt
- 8 of the 14 patients who died were seen within 30 days of their successful attempt.



Warning Signs

Ideation

Substance Abuse

Purposelessness

Anxiety

Trapped

Hopelessness

Withdrawal

Anger

Recklessness

Mood Change



Warning Signs: Talk

- 66% said something to a family member or friend
- Overt (active suicidal ideation)
 - “I want to kill myself”
 - “I am going to kill myself”
- Covert (passive suicidal ideation)
 - “I would be better off dead”
 - “Life has lost its meaning for me”
 - “Its just too much to put up with anymore”
 - “I can’t go on any longer”
 - “Nobody needs me anymore”
 - “Maybe a car will hit me”



Warning Signs: Action

- 80% give a clue
 - Buy a gun
 - Stockpile medications
 - Take a sudden interest, or lose interest in religion
 - Take risks
 - Have previous suicide attempt/s
 - Make amends: Thank You's & Good-byes
 - Get affairs in order
 - Make a Will
 - Give away prized possessions
 - Have sudden unexplained recovery from severe depression
 - Spend Money or give gifts or charity that is out of character



Long-term (Diathesis) Risk Factors

- history of suicide attempt
- history of major depression or bipolar disorder
- history of alcohol or drug abuse
- schizophrenia/schizoaffective disorder
- personality disorder (Cluster B)
- family history of suicide
- history of aggressive (externalizing) behavior
- pattern of impulsive behavior



Acute Symptoms

- acute psychic pain
- current depression
- current substance abuse or impulsive overuse
- anxiety, panic, insomnia
- extreme humiliation/disgrace
- hopelessness
- demoralization
- desperation/sense of 'no way out'
- inability to conceive of alternate solutions
- break-down in communication/loss of contact with significant other (including therapist)



Protective (Mitigating) Factors

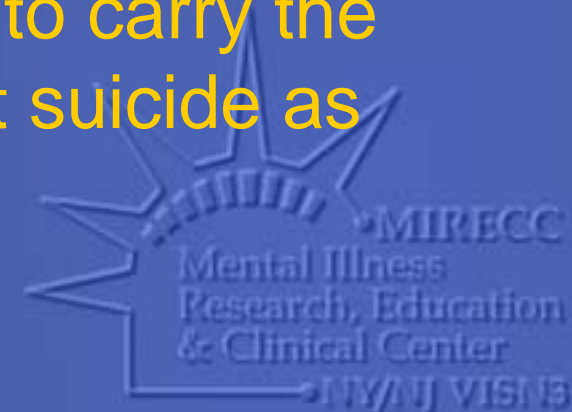
- Nurturing caretaking Role
 - children, elders, pets
- Religious Faith
- Interpersonal and connections
- Social Role
- Purpose and meaning in life
- Problem Solving ability
- Resilience
- Persistence
- Attitudes towards Suicide
- “Psychic Toughness”



- Myth: Asking about suicide would plant the idea in my patient's head.
- Reality: Asking how your patient feels doesn't create suicidal thoughts any more than asking how you patient's chest feels creates angina.



- Myth: The **M** words -- **M**ultiple, **M**anipulative attempts mean that the patient is just trying to get attention.
- Reality: Suicide “gestures” require thoughtful assessment and treatment. Multiple previous suicide attempts increase the likelihood of completed suicide. An operant, nonlethal suicide attempt has been shown to carry the same level of risk for subsequent suicide as any other attempt.



- Myth: There are talkers and there are doers.
- Reality: Most people who die by suicide have communicated some intent. Someone who talks about suicide gives the physician an opportunity to intervene before it's too late.



- Myth: If somebody really wants to die by suicide, there 's nothing you can do about it.
- Reality: Most suicidal ideas are products of underlying treatable causes. Providing a safe environment for treatment of the underlying cause can save lives.



- **MYTH:** People who have command auditory hallucinations to kill themselves are at particularly high risk for suicide.
- **REALITY:** 36-39% of people with schizophrenia and command auditory hallucinations engage in suicidal behavior, while 30-35% of people with auditory hallucinations engage in same. The risk factor is the hallucination in the face of other risk factors, not the command

(Harkavy-Friedman, et al 2003, Hellerstein, et al 1987)



- **MYTH:** Males are more likely to be suicidal.
- **REALITY:** Men COMPLETE suicide more often than women. *However, women attempt suicide three times more often than men.*



- **MYTH:** Improvement following a suicide attempt or crisis means that the risk is over.
- **REALITY:** Most suicides occur within days or weeks of “improvement” when the individual has the energy and motivation to actually follow through with his/her suicidal thoughts.



- **MYTH:** Once a person attempts suicide the pain and shame will keep them from trying again.
- **REALITY:** The most common psychiatric illness that ends in suicide is Major Depression, a recurring illness. Every time a patient gets depressed, the risk of suicide returns. The single most significant risk factor for suicide is a previous attempt



- **MYTH:** Suicide occurs in great numbers around holidays in November and December.
- **REALITY:** Highest rates of suicide are in April while the lowest rates are in December.



- **MYTH:** He/she really wouldn't do it, since ____.
 - he just made plans for a golf vacation
 - she has young kids
 - he signed a No Harm contract
 - he knows how dearly his family loves him
- **REALITY:** The intent to die can override any rational counter-thoughts. If the physician is dissuading himself/herself that the patient would really enact suicidal feelings, then closer assessment of the patient's safety and treatment needs are indicated



Guidelines for Clinical Management of Patient at Acute Risk for Suicide

- ensure immediate safety
 - Containment: Inpatient or Outpatient
- treat **acute risk factors** (current depression, psychosis or anxiety)
- remove/minimize **availability of means** (e.g. remove pills, guns, etc.)
- treat **chronic (long-term) risk factors** (e.g. prophylactic/continuation treatment of depression)
- enhance **protective factors** (e.g. engage family)



TBI

- 172 Outpatients with TBI screened for
 - Suicidal ideation (Beck Scale for Suicidal Ideation)
 - Hopelessness (Beck Hopelessness Scale)
- 35% of the subjects displayed a significant level of hopelessness
- 23% displayed suicidal ideation
- 18% had made a suicide attempt post-injury

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TURF WAR ON WEST 49th STREET



Guidelines for Management of Long Term Risk

- Pharmacologic/Somatic Treatments for Clinical Disorder Associated with high risk
- Prophylactic psychosocial treatments to enhance coping behaviors
- Ongoing monitoring
 - Good communication between treatment teams
 - Engagement of significant others



Liability*

- “PC providers may be held accountable for patients who attempt or commit suicide. In suicide-related claims for a large insurance underwriter for general hospitals and providers in the Boston area,
 - 42% of the providers named as defendants were nonpsychiatric, and
 - 30% of those cases involved patients being cared for in nonpsychiatric settings.”
- On inpatient Units 50% chance of Lawsuit

•Adapted from: Miller, MC & Paulsen, RH, *Suicide Assessment in the Primary Care Setting*,
• in *The Harvard Medical School Guide to Suicide Assessment and Intervention*,
•Jacobs, DG (Ed.), San Francisco: Jossey-Bass, 1999.

What can you do?

- Be alert for the risks factors identified
- Talk to the person gently in a quiet location showing your concern
- Trust your instincts
- Validate feelings without supporting Suicidal behavior
- Make referrals to a mental health professional
- Encourage participation in the Bereavement Counseling if they have lost a loved one recently.

