Suicidal Ideation: Identification and Management in Primary Care

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Summary: Suicide is a major cause of preventable, premature death. Of those who complete suicide, 50% have had contact with a physician in the previous month before they died, and 70% had contact within the previous year. All physicians can play a key role by screening high risk patients for suicidal ideation, followed by close monitoring and referral when necessary.

Abbreviations

ED, emergency department; EMS, emergency medical services, such as calling 911

Terms

- Suicide attempt : Intentional, self enacted, potentially injurious behavior with any (nonzero) amount of intent to die, with or without injury
- Suicidal ideation : Thoughts of ending one's life or enacting one's death
- Nonsuicidal self-injury : Intentional, self-enacted, potentially injurious behavior without intent to die, with or without injury
- Passive suicidal ideation : Thoughts about one's death without suicidal or self- enacted injurious content

Case

- F. is a 35-yo male who comes to see you: "I just can't sleep – can you give me something for my sleep?" Further history reveals that his mood is down, he is crying regularly, and he has problems with poor energy, appetite, and concentration.
- In terms of stressors, he reports that his wife left him six months ago, along with his 8-yo son. "I see my son on weekends, but it feels like he is pulling away from me."
- In the past month, he reports onset of passive suicidal ideation: "There's no sense in going on…"
- In the past week, he was laid off due to restructuring in his department
- Now he says, "I don't know if I can take this anymore… It'd be easier to not be around anymore."

Epidemiology

- In Canada, 3,890 people are reported as having completed suicide in 2009, a rate of 11.5 per 100,000 people (Statistics Canada, 2009)
- Suicide is highest in youth and the elderly
    - For Canadian youth (aged 15-24), suicide is the second leading cause of death (following motor vehicle collisions)
- Gender
    - Females: 3-4 times more likely to attempt suicide, using passive means such as poisoning (Norris et al., 2012)
    - Men: 4 times more likely to complete suicide using violent means such as hanging or firearms (Norris et al., 2012)

Specific Issues in Youth

- Impulsivity is higher in youth
- Youth are more impulsive, which means they are at higher risk than adults
- Stresses in youth include bullying, troubles communicating feelings , conflictual relationships with parents/guardians, negative peers (e.g. peers who engage in suicidal/parasuicidal behaviours)

Specific Issues in the Elderly

- Older adults who see a physician prior to their suicide tend to report somatic symptoms or despair
- They generally do not volunteer or may downplay thoughts of suicide unless directly questioned

Screening

- Screening is important as 50% of those who completed suicide saw a physician in the previous month (Stovall et al., 2003), and 70% of those who completed suicide saw a physician in the previous year
- Top 5 chief complaints by patients during the visits immediately preceding their suicides (Corso, 2014)

    1. Anxiety
    2. Unspecified gastrointestinal symptoms
    3. Unexplained cardiac symptoms
    4. Depression
    5. Hypertension

- Who to screen?
    - Screen high risk patients such as those with the following warning signs:
        - Patient appears distressed or mentally unwell
        - Clear statements about suicide, e.g. “I’d be better off dead.”
        - Covert statements about suicide, e.g. “I’m not sure how long I can take this.”
        - Threatening to hurt or kill oneself
        - Family members or friends express concern about the patient based what the patient has said, or a change in behaviour

- Risk factors include:
    - Mental health issues
        - 90% of those with completed suicide had addictions and/or mental health issues such as:
            - Depression (especially psychotic depression)
            - Anxiety,

        - Addictions,
        - Schizophrenia
        - Psychosis symptoms such as command hallucinations to harm oneself
        - Personality disorders (e.g.. borderline personality disorder),
    - Relationship stresses as relationship breakup or losses
    - Single, divorced or widowed individuals have a higher suicide rate than those who are married
    - Recent discharge from hospital following psychiatric admission
    - Recent suicide in their community or network
    - Family history of suicide
    - Past history of attempted suicide
    - Hopelessness

Screening Tools

- Screening questions on clinical interview
    - "When people go through situations such as you've been going through, sometimes people feel that life isn't worth living…"
    - "Do things ever get so bad that you you feel that life isn't worth living?"
    - If YES, then proceed to more specific questions

- Patient Health Questionnaire (PHQ-9)
    - PHQ-9 has a suicidal ideation item
    - 7% of depressed patients screen positively (endorsing suicidal ideation) on PHQ-9 (Corson et al., 2004), and of those
        - 35% of positive screens had suicidal ideation
        - 20% of positive screens had a plan
    - Link to online PHQ-9

- Columbia Suicide Severity Rating Scale (C-SSRS)
    - http://www.cssrs.columbia.edu/documents/C-SSRS1-14-09-SinceLastVisit-Clinical.doc

- Tool for Assessment of Suicide Risk for Adolescents (TASR-A)
    - http://teenmentalhealth.org/care/health-professionals/clinical-tools/

General Principles

- Although a clinical interview is not therapy per se, it can nonetheless therapeutic
- Always provide unconditional, radical empathy, validation and acceptance (as opposed to judgment and criticism), for example:
    - Patient: "Ever since he left me, I've been feeling down."
    - Clinician (Empathy and validation): "He left you? That sounds horrible. That can't be easy, what you've been through."
- Avoid criticism or judgement: Avoid starting off with statements like, "You should ___" "I knew it wasn't going to work out…. Its too bad you didn't listen to my advice…" etc.

History / Interviewing Guide

Identifying data	Gender Age Marital status Work/School

HPI	
• Introducing the topic	"With everything that's been going on…" "When people feel sad, they can sometimes have thoughts that life isn't worth living…"
• General question	"Have you had any thoughts that life isn't worth living?" "Tell me more…"
• Self-harm	"Any thoughts about harming yourself?"
Suicidality	"Any thoughts about ending your life?"
• Plan and access to means	"Have you thought about how you would harm yourself?" For each method, ask about preparations E.g. if patient reports overdosing, then ask about stockpiling medications E.g. if patient reports shooting himself, then ask about access to gun or ammunition "Any other ways?" "Have you changed your will or life insurance policy or given away your possessions?"
• Severity of the Intent	How strong are the thoughts of following through with these plans? Since when have you had these thoughts? How often do they happen? Weekly? Daily? All the time? In the next 1-2 days, how likely is it that you would act on your plan? (On a scale between 0 and 10, where 0 is not at all, and 10 is definitely)
• Rehearsing	Have you "practiced" your suicide? (e.g., put a gun to your head or held medications in your hand) What thoughts were going through your mind when you did that?
Stressors	What is the stress that makes you want to end your life? What stresses have you been under these days, e.g. work, home, relationships?
Psychosis	Seeing any things that others can't see? Hearing any things such as voices that others can't hear? Do the voices tell you to do things? Any people that are out to harm you?
Medications	What medications are you on? Any over-the-counter medications such as decongestants?
Alcohol / Substance Use	How much alcohol do you drink, if at all? Do you use any recreational drugs, e.g. marijuana, ecstasy, cocaine, etc.?
Past history	Have you ever attempted suicide in the past? Have you ever been diagnoses with or treated for anxiety, depression, or other mental health problems?
Family history	Have any family members ever attempted suicide in the past? Have any family members ever been diagnoses with or treated for anxiety, depression, or other mental health problems?
Social Supports	Do you have friends or family with whom you are close? Have you told them about these thoughts?
Protective factors / coping	Despite these thoughts, you are here today, which suggests to me that the part of you that wants to live is stronger than the part that wants to die. What keeps you going? Who, or what has stopped you from ending your life? Usual protective factors · Religious belief that suicide is wrong · Being married · Children under 18 at home · Employment · Strong therapeutic relationship · Good problem-solving skills · Good self-esteem

Future goals	When you get over this stressful time in your life, what do you hope for the future?

Physical Exam

If the patient has attempted suicide, then perform a physical exam, and refer to emergency medical services (EMS) if necessary

General	Any signs of alcohol intoxication or drug use? Is the patient alert and oriented, or does the patient appear groggy from alcohol or drug use?
Head	Any signs of head trauma? Any bruising /scars around neck, which suggests hanging
Skin	Any signs of self harm such as self-induced cuts, scratches, burns?

Differential Diagnosis / Comorbidity

Suicidal ideation is not a diagnosis per se, but is a symptom that can occur along with other conditions and issues, such as:

- Psychiatric conditions such depression, anxiety, bipolar disorder, psychotic conditions such as schizophrenia, alcohol and substance use, trauma
- Medical conditions, especially terminal illnesses such as cancer

Management: General Principles

Do's

- Keep the patient safe
- Express concern, caring and support for the patient
- Validate that the patient must be in distress and emotional pain to be thinking about suicide, and that you are there to support them with this distress and emotinoal pain
- Decrease the risk of suicide such as by limiting means
- Increase the reasons for living
- Providing immediate symptomatic relief for symptoms such as
    - Insomnia
    - Agitation / anxiety
- Treat any comorbid psychiatric disorders, e.g. major depression, anxiety
- Provide hope, e.g. “I will work with you to help get these feelings better."

Don'ts

- Do not simply tell the patient to not kill themself, as this may be interpreted as being invalidating about how the patient feels

Management: Triage the Risk Level

High risk • Patient has a suicide plan, high intent, access to means • Patient has just attempted suicide	• Do not leave the patient alone and place him or her in as safe an environment as possible • Transfer immediately to the nearest emergency room • Call the recipient hospital and give ED physician or psychiatrist as much relevant information as you can. • Whenever possible, send a brief note with your contact information • If the patient is voluntary: ◦ If patient is cooperative and wants help he or she could be transferred to hospital as a voluntary patient with a responsible family member or friend ◦ Let the ED know when the patient leaves your office and to let you know if the patient does not arrive within a reasonable time. • If the patient is not voluntary, or there is a risk of patient becoming agitated and disrupted ◦ Complete necessary forms in your jurisdiction (link to next section) ◦ Contact police to request that they take the patient to the nearest ED ◦ Do not try to physically stop the patient if he or she tries to leave • If family or spouse is not aware, then have your staff notify family of the plan
Moderate risk • Patient has suicidal ideation with plan, but no current intent to carry out the plan; no access to means	• Refer to urgent mental health services that can see the patient (ideally within next few days) • Ask a family member to help with removing means of suicide such as weapons and medications from the home • Create a safety plan (aka crisis plan, suicide action plan) with the patient/family • Provide resources such as emergency and crisis numbers • Follow-up soon with the patient, and continue with frequent follow-up until the patient is seen by mental health services
Low risk • Suicidal ideation, but no plans • Good social supports	• Patients with suicidal thoughts but no plan and no serious risk factors (e.g. previous attempt) can often be managed in a primary care setting • Consider referral for counseling / support to help with relationship and other stresses • Create a crisis plan (aka suicide action plan) with the patient/family • Provide resources such as emergency and crisis numbers • Provide ongoing follow up and monitoring • Provide office-based education and counseling for depression and suicidal ideation • Provide self-help materials • Ensure that there is treatment for any co-existing mental health conditions such as depression, anxiety, attention deficit hyperactivity disorder (ADHD), addictions

Involuntary admission

In Ontario

- Physicians can fill out a Form 1, and then call the police to have the patient taken to a hospital for psychiatric assessment http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-6427-41~1/$File/6427-41_.pdf

- View hospitals providing psychiatric assessment, i.e. schedule 1 facilities http://www.health.gov.on.ca/en/common/system/services/psych/designated.aspx

More...

Develop a Safety Plan

- Develop a safety plan, aka crisis plan, with the patient
- Developed by working with the patient when the patient is in a better emotional space, this can then be used by the patient when they are in distress, to help them with positive coping strategies

- The plan must be created collaboratively with the patient, based on their wishes and preferences, as opposed to simply a set of instructions that the physician has arbitrarily decided upon
- The plan can be written down a sheet of paper, or a 3x5 card
- Key elements are :
    - What are the signs that I am in crisis? »
        - E.g. When I start having crying spells and can't stop crying
    - What can I do if I am in crisis?
        - E.g. Call a family member, go for a walk, listen to music, etc.
    - Who are the family and friends that I can turn in crisis?
        - E.g. spouse, mother, father, best friend, etc.
    - What crisis numbers, professionals or emergency services can I turn to in crisis?
        - E.g. local distress line, local hospital, counselor's telephone
- Online Safety Plan which can be printed out or downloaded

Management: Long-term

- Patients with acute suicidal ideation are typically admitted
- After hospitalization, patients are discharged typically back to the family physician, possibly with additional mental health follow-up
- Patients may continue to have chronic or low grade suicidal ideation
- Interventions
    - Involve the patient's support system in the management, such as spouse, supportive family members
    - Regular follow-up with the primary care physician
    - For chronic suicidal ideation, it is not possible to do an in-depth screening each time, but the primary care provider can look for red flags for increased suicidal ideation

Management of Chronic Suicidal Ideation: Counseling Interventions

- Patients may feel suicidal when they are 1) overwhelmed by stresses, and 2) disconnected from people or activities that give them hope and meaning
- For this reason, many strategies focus on helping to 1) support patients with their stresses, and 2) reconnect people to healthy, meaningful people and activities
- Interventions dawn various therapies including interpersonal psychotherapy, cognitive behaviour therapy, dialectical behaviour therapy, humanistic therapy (such as logotherapy) and positive psychology:

- Developing a list of reasons for living
- Dealing with stresses.
- Identify what stressors the person is facing, typically school, work or relationships.
- Help the patient cope with those stresses
- Re-connect the patient to meaningful people
    - Identify people that the patient can spend time with doing activities, e.g. going for a walk
    - Identify people that the patient can spend time with for emotional support, e.g. someone who can just listen (without nagging or lecturing) when the person is sad
- Altruism.
    - Being helpful to others in the person's personal network, e.g. making lunch for an ill friend; helping an elderly neighbour with doing groceries; taking a family member's dog for a walk
    - Connecting with the community in a meaningful way, e.g. volunteer work in a hospital
- Being spiritual.
    - Feeling connected to somewhat greater than oneself is helpful for mental health, e.g. religion, helping the environment, participating in a cause, etc.
- Identify pleasant activities that give enjoyment to the patient such as

    - Creative activities such as singing, playing music, painting, writing, etc.
    - Physical activities
    - Social activities
- Lifestyle interventions such as
    - Getting enough sleep.
    - Eating a healthy diet.
    - Getting enough exercise.
    - Spend time outside in nature.

Documentation

- Notes should contain
    - A determination of the person's level of risk and the rationale used to arrive at that determination (based on warning signs, potentiating factors and protective factors)
    - Plans for treatment and preventive care
    - Structured tools can help with documentation the completed tool can simply be placed or scanned into the chart

Information Resources for Patients

- "Coping with Suicidal Thoughts" is a handout for patients who are thinking about suicide, providing hope and practical advice www.comh.ca/publications/resources/pub_cwst/cwst.pdf
- "How to make a suicide safety plan" http://suicideline.org.au/at-risk/how-to-make-a-suicide-safety-plan
- In case of a crisis such as suicidal ideation www.eMentalHealth.ca has links to crisis services in various areas across Canada
- For children/youth in a crisis www.kidshelpphone.ca across Canada

Case, Part 2

- F. is a 35-yo male who comes to see you with sleep problems, and during the course of the visit, expresses "There's no sense in going on…"
- You ask: "Have you had any thoughts that life isn't worth living?" and he says, "Yes, I've sometimes been feeling like that lately."
- You ask him further, "Have you had any thoughts of ending your life?" and he says, "Sometimes when its late at night and I can't get to sleep, I do get thoughts that it'd be easier if I weren't around."
- You ask him, "Does it ever get to the point where you think about ways of ending your life?"
- He admits that sometimes he thinks about taking an overdose, or hanging himself, however, he quickly adds, "I'd never do it of course, because I couldn't do that to my son."
- You validate his relationship with his son: "It sounds like your relationship with your son is very important to you. Tell me more about your son…"
- After that, you ask, "What are the other reasons that keep you living?", and he tells you that he wouldn't want to disappoint his own parents
- Your assessment of his risk shows that although he has passive suicidal ideation, the good news is that he does not have any active plans nor intent
- He does not meet any criteria for an involuntary admission hospital, as you do not believe he is at risk currently of "serious bodily harm to himself, another person, nor serious physical impairment."
- Given that his presenting complaint was troubles with sleep, you discuss some sleep hygiene strategies and

suggest melatonin if necessary
- You talk about how you are going to see him in a few days, but in the meanwhile, you give him a crisis number to call, in the event things worsen
- You ask your admin support to book an appointment to see him within a few days. You walk out with him, and look into his eyes, while shaking his hand and saying, “I will see you next week…”

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About this Document

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