Mind Matters ECHO

Module: Depression
Session 5: Managing Suicidal Patients in Primary Care

September 14, 2022

Project ECHO®

Mount Sinai Health Partners

Welcome!

- Pre-survey: bit.ly/depressionmeeting5
- Hub team introductions
- Disclosures
- Questions during presentations

Case Presentation

Jill Sisselman, DO

Sisselman Medical Group

Patient Information

Demographic Information	• 22 year old cis female • Lives alone
Medical History	• None
Current Psychiatric Diagnoses	• Depression • Anxiety
Current Treatment Plan	• Start medications and therapy as soon as possible; daily PCP check-ins in the interim
Current Medications	• Prozac
Past Psychiatric Medications	• Lexapro
Family Psychiatric and Social History	• None reported
History of Trauma	• None reported

Patient Information

Symptoms of Depression	• Lack of motivation • Feelings of hopelessness, helplessness, and/or guilt • Thoughts of suicide
Symptoms of Anxiety/Panic	• Intrusive worrisome thoughts
Suicidality	• Current passive ideation (thoughts without plan and/or intent)
Areas of Support and Consultation Being Sought	• Psychotherapeutic consultation
Main Question	• When to send a patient to the ER via ambulance versus working on an outpatient plan

Case Presentation

Robert Fields, MD

Chief Population Health Officer

Mount Sinai Health System

Project ECHO
Suicide and Suicide Prevention

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Terminology

- “Active” Suicidal Thinking: Thoughts/desires to commit suicide
- “Passive” Suicidal Thinking: wish to be dead/being better off dead
- Estimated that ~13% of people will have lifetime passive SI, ~10 in past year[1]
- **Rates of passive SI are 3 times higher in people with psychiatric conditions, like depression, PTSD, bipolar disorder, or schizophrenia[1]**

Terminology

- Suicidal ideation varies in severity
  - Thoughts of suicide
  - Thinking about how to commit suicide (considering a method)
  - Making a specific plan - preparations
- In 2020, an estimated 12.2 million American adults seriously thought about suicide, 3.2 million planned a suicide attempt, and 1.2 million attempted suicide[2]
- Passive and active ideation are **equally** predictive of suicide attempt and completed suicide[1]

Physician reactions to completed suicide

- Report stigma about asking about it – increase patient risk? **(it doesn't)**
- Level of distress depended on professional support network
- Barriers to seeking professional support
- **Pulled in two directions: suicide is inevitable and even unpreventable vs. guilt, blame, responsibility**[3]
- Time constraints in assessment[4]

Common reactions: moral distress/moral injury

- Moral Distress: Arises from a conflict in aims – you want to "do the right thing" but it's not possible; and are torn between values
- Moral injury: Actively participating in or failing to prevent, harm

- Evokes anger, exhaustion, sadness, self-blame
- Situations that could evoke moral distress
  - Participating in care with which you do not agree
  - Torn between family, team and patient wishes
  - Failing to prevent adverse outcome
  - **Resource limitations/discharge planning**

Cognitive Distortions (mental filters) to keep in mind

Unfair Comparisons	Judgment Focus	Personalizing
Interpreting events in terms of standards that are unrealistic and finding yourself inferior in comparison	Viewing yourself, others, and events in terms of evaluations of good/bad or superior/inferior	Attributing a disproportionate amount of the blame to yourself for negative events

How people can develop a negative outlook after stressful/traumatic events

Assimilation

- Pre-trauma core beliefs about the world stay the same → thoughts about your role in the event change instead
- If I do everything right, my patient will live (core belief)→ patient completes suicide → I failed (thought about self)

Over-accommodation

- Overall core beliefs change **too much** after event
- I can affect change in my job (core belief) → patient dies → my work is pointless (core belief)

Healing from moral distress

Assimilation and Over-Accommodation	→	Self-compassion, watch out for huge shifts in thinking
Guilt and self-blame	→	Ask: Do your feelings fit the facts?
Rigid and critical thinking	→	Cognitive flexibility; acknowledging our circumstances
Isolation	→	Peer support; building trust and connection

Additional strategies[5]

- Find space to talk about and share your experiences **(avoid avoiding)**
- Find ways to advocate for change in future situations, if needed
- Seek professional support if distress persists

Key findings about screening in primary care

- Data from 45 U.S. primary care practices showed **only 24%** of patients with depression were screened for SI; **30%** of patients with current or documented SI or prior attempt were referred for specialty care[6]

- Only 38% of simulated depressed patients requesting anti-depressant medications were screened for SI by PCPs[7]

- 38% of U.S. adults who completed suicide visited their PCP in prior 1 month; 50-70% in older adults[8]

PHQ-9

- 9-item measure of self-reported depression severity
- Originally published in 2001
- Ranges:

PHQ-9 Score	Depression Severity
0 – 4	None-minimal
5 – 9	Mild
10 – 14	Moderate
15 – 19	Moderately Severe
20 – 27	Severe

Question 9: the “suicide item”[9]

In the past 2 weeks, how much have you been *bothered* by….thoughts that you would be better off dead, *or* thoughts of hurting yourself in some way?

- The PHQ-9 Item 9 is not a “gold standard” assessment of suicidal ideation/severity – the C-SSRS is
- The PHQ-9 item is vague, “lumps” a lot together
- A score of 1 (“several days”) does not mean “passive SI”
- The **PHQ-2** does not ask about suicide

How helpful is it?[10]

- Endorsement of Item 9 > 0/'not at all' does statistically elevate risk of completed suicide
- **Patients can answer "not at all" and still complete suicide:** 39% of attempts and 36% of suicide deaths within 30 days of completing a PHQ occurred among those responding “not at all”

Experiences of patients who deny SI on PHQ but then make attempts[11,12]

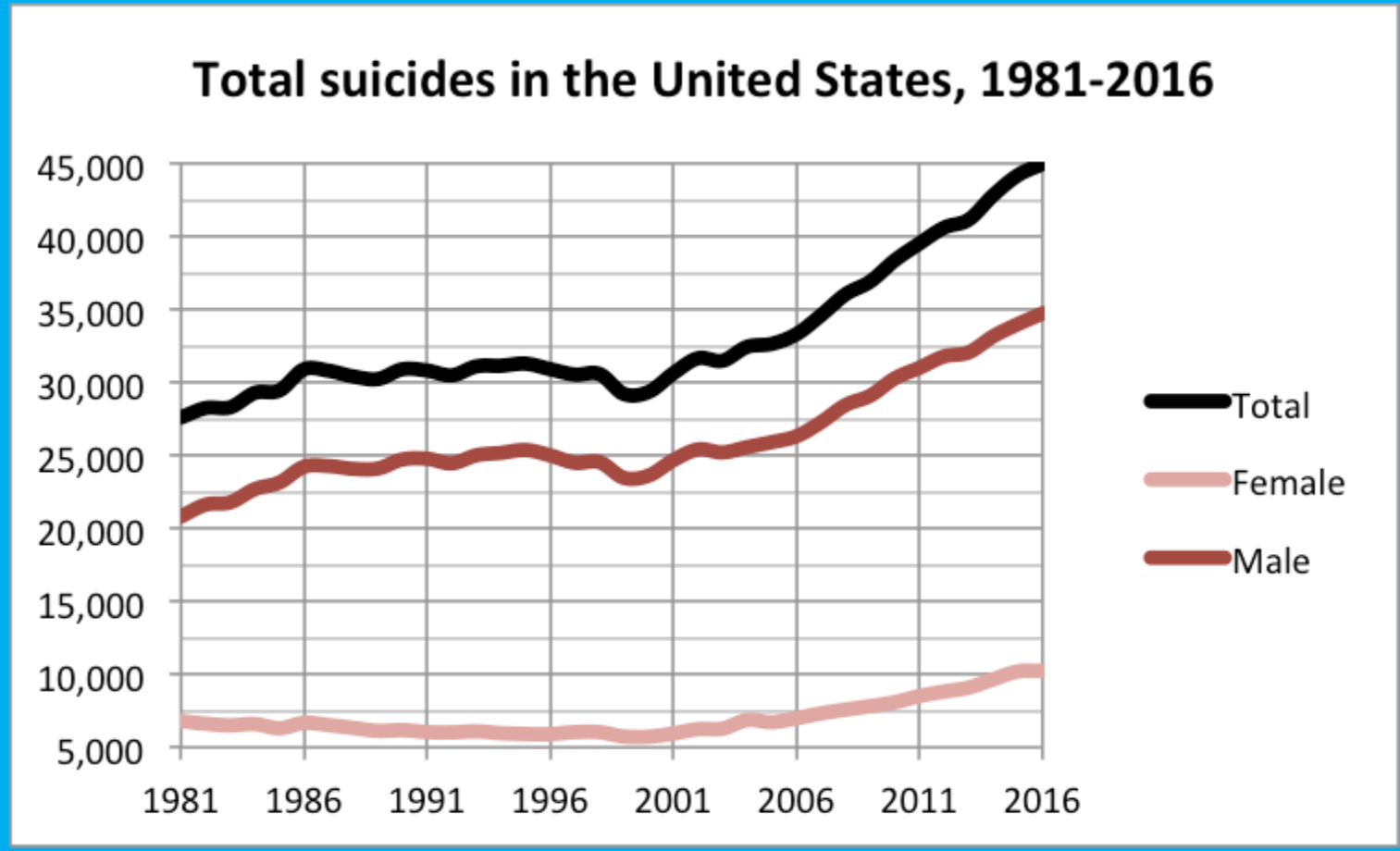
- **I just didn't want anybody to freak out.** If they read that, who knows they won't handcuff me and send off a whole bunch of sirens, you know what I mean? I would think the therapist would have to start telling other people, 'Hey, this guy might hurt himself.

- Just that I think when somebody is feeling suicidal, it's really important to not make them feel like they are trapped. That's kind of the worst. Like, they take you to the hospital and make you feel like you're in jail. I think it should be a little more—it's like, you already feel like crap. **So, you shouldn't feel like you're being punished. So, that's kind of what it feels like.**

- If I feel suicidal, I'm going to act immediately. It's not like I'm feeling suicidal, days prior. I don't let it go that long. I'm just going to say if I'm feeling this way, I'm going to act on it. **But if someone would say, 'Do you feel that you're maybe somehow emotionally dysregulated or emotionally out of control or emotionally overwhelmed or something like that?' I would have said, 'Oh, yes, absolutely.'"**

What can we do? Know who's at risk

Source: CDC, 2022



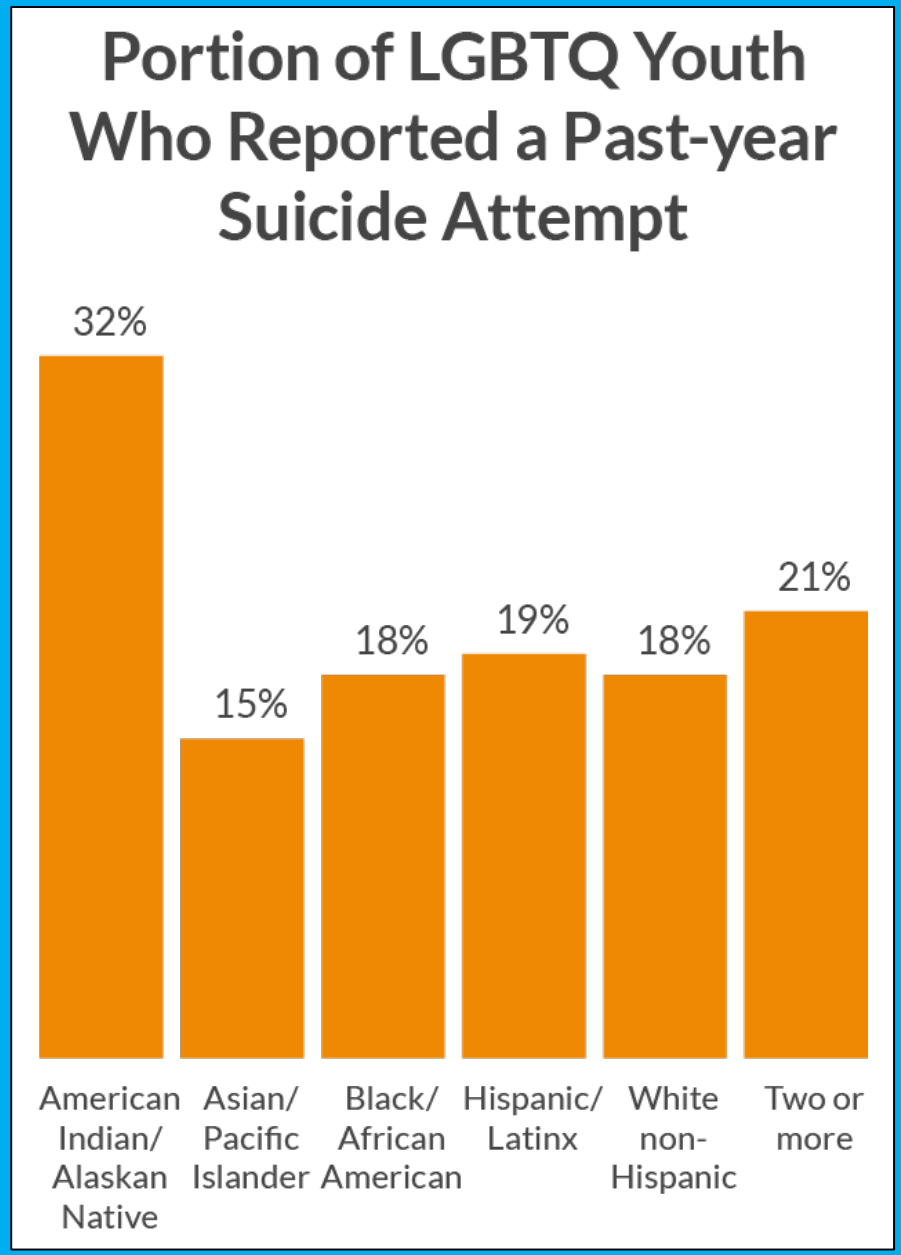
Source: CDC/WISQARS fatal injury report

Specific demographic risk factors

10 Leading Causes of Death, United States
2020, Both Sexes, All Ages, All Races

	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 4,043	Unintentional Injury 1,153	Unintentional Injury 685	Unintentional Injury 881	Unintentional Injury 15,117	Unintentional Injury 31,315	Unintentional Injury 31,057	Malignant Neoplasms 34,589	Malignant Neoplasms 110,243	Heart Disease 556,665	Heart Disease 696,962
2	Short Gestation 3,141	Congenital Anomalies 382	Malignant Neoplasms 382	Suicide 581	Homicide 6,466	Suicide 8,454	Heart Disease 12,177	Heart Disease 34,169	Heart Disease 88,551	Malignant Neoplasms 440,753	Malignant Neoplasms 602,350
3	Sids 1,389	Homicide 311	Congenital Anomalies 171	Malignant Neoplasms 410	Suicide 6,062	Homicide 7,125	Malignant Neoplasms 10,730	Unintentional Injury 27,819	Covid-19 42,090	Covid-19 282,836	Covid-19 350,831
4	Unintentional Injury 1,194	Malignant Neoplasms 307	Homicide 169	Homicide 285	Malignant Neoplasms 1,306	Heart Disease 3,984	Suicide 7,314	Covid-19 16,964	Unintentional Injury 28,915	Cerebrovascular 137,392	Unintentional Injury 200,955
5	Maternal Pregnancy Comp. 1,116	Heart Disease 112	Heart Disease 56	Congenital Anomalies 150	Heart Disease 870	Malignant Neoplasms 3,573	Covid-19 6,079	Liver Disease 9,503	Chronic Low. Respiratory Disease 18,816	Alzheimer's Disease 132,741	Cerebrovascular 160,264
6	Placenta Cord Membranes 700	Influenza & Pneumonia 84	Influenza & Pneumonia 55	Heart Disease 111	Covid-19 501	Covid-19 2,254	Liver Disease 4,938	Diabetes Mellitus 7,546	Diabetes Mellitus 18,002	Chronic Low. Respiratory Disease 128,712	Chronic Low. Respiratory Disease 152,657
7	Bacterial Sepsis 542	Cerebrovascular 55	Chronic Low. Respiratory Disease 54	Chronic Low. Respiratory Disease 93	Congenital Anomalies 384	Liver Disease 1,631	Homicide 4,482	Suicide 7,249	Liver Disease 16,151	Diabetes Mellitus 72,194	Alzheimer's Disease 134,242
8	Respiratory Distress 388	Perinatal Period 54	Cerebrovascular 32	Diabetes Mellitus Influenza & Pneumonia 50	Diabetes Mellitus 312	Diabetes Mellitus 1,168	Diabetes Mellitus 2,904	Cerebrovascular 5,686	Cerebrovascular 14,153	Unintentional Injury 62,796	Diabetes Mellitus 102,188
9	Circulatory System Disease 386	Septicemia 43	Benign Neoplasms 28		Chronic Low. Respiratory Disease 220	Cerebrovascular 600	Cerebrovascular 2,008	Chronic Low. Respiratory Disease 3,538	Suicide 7,160	Nephritis 42,675	Influenza & Pneumonia 53,544
10	Neonatal Hemorrhage 317	Benign Neoplasms 35	Suicide 20**	Cerebrovascular 44	Complicated Pregnancy 191	Complicated Pregnancy 594	Influenza & Pneumonia 1,148	Homicide 2,542	Influenza & Pneumonia 6,295	Influenza & Pneumonia 42,511	Nephritis 52,547

Source: WSQARS



Source: The Trevor Project

Impact of the pandemic

- Rising rates of mental health distress and service needs in U.S. and NYC

- From August 2020–February 2021, rates of anxiety or depression in U.S. adults went from to 36.4% to 41.5%; unmet mental health care needs went from 9.2% to 11.7%.[13]

- August 2021: 25% and 18% of New York City adults reported probable anxiety and depression in the past two weeks, respectively (*Epi Data Brief*, December 2021)

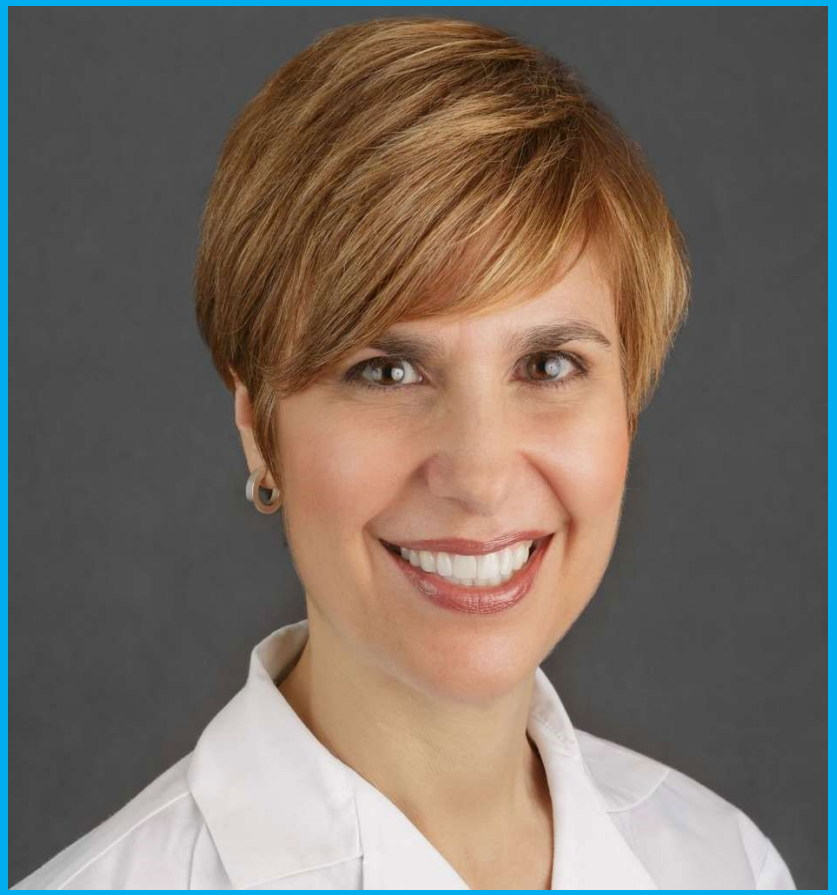
New York City statistics

- Data from 2020 suggest that suicide deaths in New York (542 people) remained stable relative to a 10-year look-back period and is about **half** the national rate (Source: NYC Health)

- **But that still means every 16 hours, someone in New York City dies by suicide**

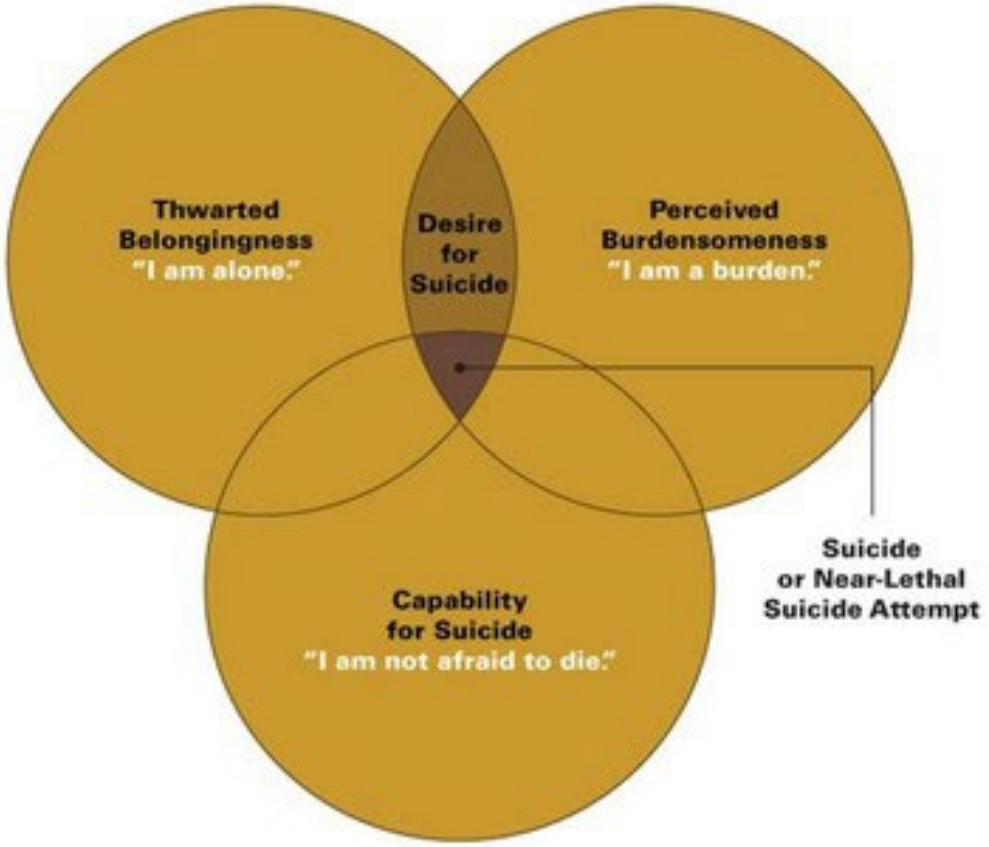
- 2.4% of NYC adults thought about suicide over the prior year; among those who thought about it, 14.1% attempted suicide (Source: NYC Health)

Health care workers

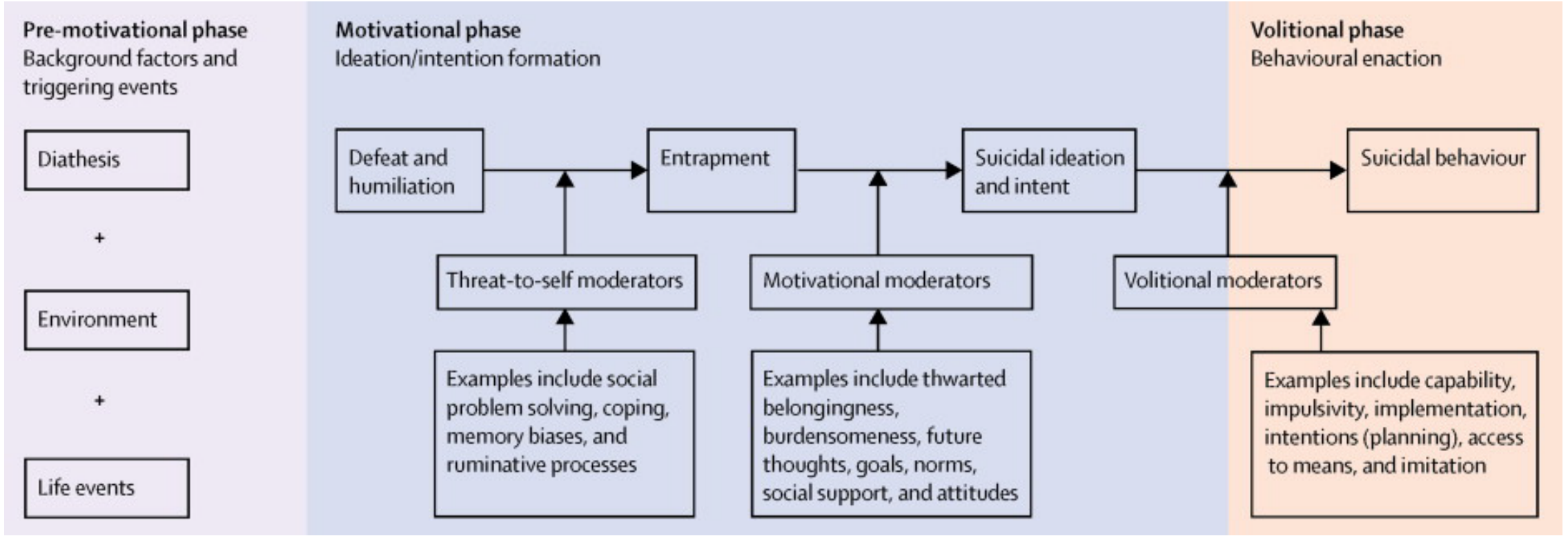


- Health care workers have increased rates of suicidal ideation and attempt vs. general public[14]
- 15% of health care workers seeking care endorsed some degree of SI[15]

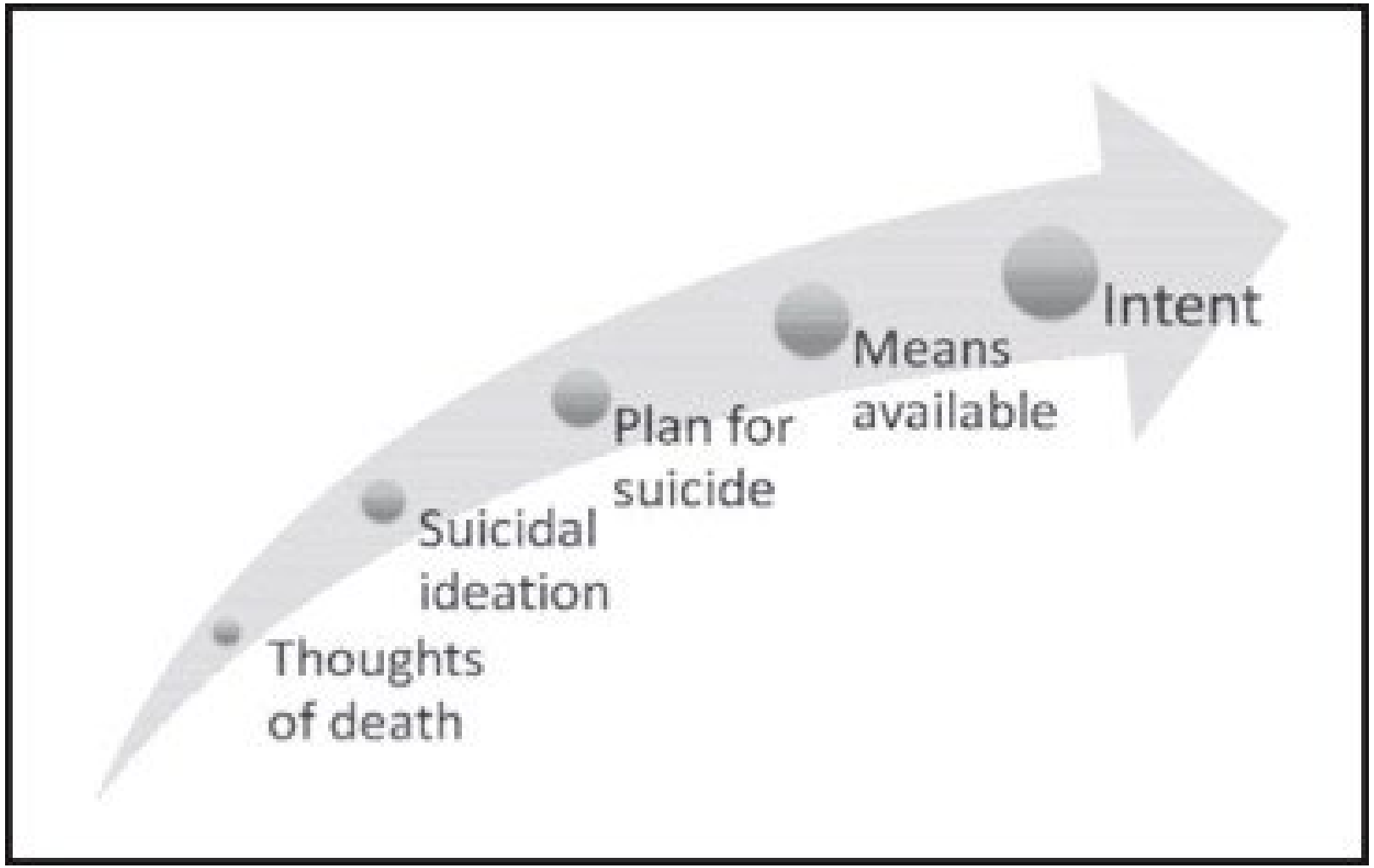
Why do people attempt suicide? Joiner's Interpersonal Theory[16]



Motivational-volitional model of suicide behavior[17]



Best practices in suicide assessment



COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** E.g. "*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.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

	YES	NO
6) ***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 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: *Was this within the past three months?***		

- Low Risk
- Moderate Risk
- High Risk

- The C-SSRS is the "gold standard" measure of suicide severity
- Standardized administration and brief training
- Many versions including "past month" and "since last visit"

C-SSRS Primary Care

C-SSRS Screener Training - English (USA) - YouTube

Additional recommendations

- Non-judgmental and curious approach is crucial! **PRACTICE**
- Use standard questions. **ASK DIRECTLY!**
  - Avoid leading questions: "you're not thinking of suicide, are you?"
- Review practice-wide response procedures
- Coping/safety plans can be completed with the patient, including who to contact in an emergency, coping tools, and physiological-emotional signs of distress
  NYC Well Safety Plan
- “No-harm contracts” have no value whatsoever and should not be used

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior, and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

SAMHSA SAFE-T Protocol

1. RISK FACTORS

- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- ✓ **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
  Co-morbidity and *recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Family history:** of suicide, attempts, or Axis 1 psychiatric disorders requiring hospitalization
- ✓ **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g, loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- ✓ **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- ✓ **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- ✓ **External**: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious.
  Explore ambivalence: reasons to die vs. reasons to live

* *For Youths:* ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition

* *Homicide Inquiry:* when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

SAMHSA SAFE-T Protocol *continued*

4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- ✓ **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

988
SUICIDE & CRISIS LIFELINE

There is hope

Talk with us.

If you or someone you know needs support now,
call or text 988
or
chat 988lifeline.org

PEP22-08-03-004

THANK YOU!

ANY QUESTIONS?

References

1. Liu, R. T., Bettis, A. H., & Burke, T. A. (2020). Characterizing the phenomenology of passive suicidal ideation: a systematic review and meta-analysis of its prevalence, psychiatric comorbidity, correlates, and comparisons with active suicidal ideation. Psychological medicine, 50(3), 367-383.

2. Facts About Suicide (cdc.gov)

3. Malik, S., Gunn, S., & Robertson, N. (2021). The impact of patient suicide on doctors and nurses: a critical interpretive meta-synthesis. Archives of suicide research, 1-20.

4. Leavey, G., Mallon, S., Rondon-Sulbaran, J., Galway, K., Rosato, M., & Hughes, L. (2017). The failure of suicide prevention in primary care: family and GP perspectives–a qualitative study. BMC psychiatry, 17(1), 1-10.

5. Murray, H., & Ehlers, A. (2021). Cognitive therapy for moral injury in post-traumatic stress disorder. The Cognitive Behaviour Therapist, 14.

6. Hepner, K. A., Rowe, M., Rost, K., Hickey, S. C., Sherbourne, C. D., Ford, D. E., ... & Rubenstein, L. V. (2007). The effect of adherence to practice guidelines on depression outcomes. Annals of internal medicine, 147(5), 320-329.

7. Feldman, M. D., Franks, P., Duberstein, P. R., Vannoy, S., Epstein, R., & Kravitz, R. L. (2007). Let's not talk about it: suicide inquiry in primary care. The Annals of Family Medicine, 5(5), 412-418.

8. Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry. 2002;159:909-16. [PMID: 12042175]

9. Na et al, 2018, JAD

References (continued)

10. Simon, G. E., Coleman, K. J., Rossom, R. C., Beck, A., Oliver, M., Johnson, E., ... & Rutter, C. (2016). Risk of suicide attempt and suicide death following completion of the Patient Health Questionnaire depression module in community practice. The Journal of clinical psychiatry, 77(2), 20461.

11. Richards, J. E., Whiteside, U., Ludman, E. J., Pabiniak, C., Kirlin, B., Hidalgo, R., & Simon, G. (2019). Understanding why patients may not report suicidal ideation at a health care visit prior to a suicide attempt: a qualitative study. Psychiatric Services, 70(1), 40-45.

12. Richards, J. E., Hohl, S. D., Whiteside, U., Ludman, E. J., Grossman, D. C., Simon, G. E., ... & Williams, E. C. (2019). If you listen, I will talk: the experience of being asked about suicidality during routine primary care. Journal of general internal medicine, 34(10), 2075-2082.

13. Vahratian, A., Blumberg, S. J., Terlizzi, E. P., & Schiller, J. S. (2021). Symptoms of anxiety or depressive disorder and use of mental health care among adults during the COVID-19 pandemic—United States, August 2020–February 2021. Morbidity and Mortality Weekly Report, 70(13), 490.

14. Chan, L. F., Sahimi, H. M. S., & binti Mokhzani, A. R. (2022). A global call for action to prioritize healthcare worker suicide prevention during the CoViD-19 pandemic and beyond. Crisis.

15. DePierro, J., Marin, D. B., Sharma, V., Costello, Z., Starkweather, S., Katz, C. L., ... & Charney, D. S. (2021). Developments in the first year of a resilience-focused program for health care workers. Psychiatry research, 306, 114280.

16. Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner Jr, T. E. (2010). The interpersonal theory of suicide. Psychological review, 117(2), 575.

17. O'Connor, R. C. (2011). Towards an integrated motivational–volitional model of suicidal behaviour. International handbook of suicide prevention: Research, policy and practice, 1, 181-98.