Suicide Assessment

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Why should we care?
Let’s start with the numbers...
Suicide in the US

- 2\textsuperscript{nd} leading cause of death in individuals 10-34
- 4\textsuperscript{th} leading cause of death in individuals 35-54
- 10\textsuperscript{th} leading cause of death overall

Source: CDC
Not good.
And it’s getting worse.

One of the few causes of death in the US that’s increasing.
From 1999-2016 the total suicide rate in the US increased 28% from 10.5 to 13.4 per 100,000.

Source: CDC
In NY, 29% increase in suicide from 1999-2016.

Source: CDC
But why is this EMS’s problem?
Many of them are our patients.

We are missing their suicidality because they don’t fit the stereotypical profile.
8% of ED patients presenting with non-psychiatric complaints had active suicidal ideation.

Undetected by treating ED clinicians

(Boudreaux et al., 2016)
≈20% of individuals who completed suicide were seen in the ER in the month before their death. Most not for psychiatric or substance use.

(Ahmedani et al., 2014)
Over half of individuals who complete suicide have no known mental health issues.

Source: CDC
Our model doesn’t fit reality.
Most EDS do not routinely screen for suicidality, even in patients with psychiatric complaints or known risk factors.

(Ting et al., 2012)
So why **NOT** us?

We’re the point of contact.
What I’m going to Cover Today

I. The suicidality progression
II. How to conduct a brief, effective suicide assessment
III. How to communicate the results of your assessment to hospital providers

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I. The suicidality progression
Suicidality tends to follow a standard progression.
If you know the progression you will know how to ask the right questions and gauge risk.
Ideation -> Intent -> Plan -> Attempt

Slowly or quickly
1. Suicidal Ideation

Thoughts of suicide or death
Relatively common
Suicidal Thoughts, Plans, and Attempts in the Past Year among Adults Aged 18 or Older: 2015

- 9.8 Million Adults Had Serious Thoughts of Committing Suicide
- 2.7 Million Made Suicide Plans
- 1.1 Million Made Plans and Attempted Suicide
- 1.4 Million Attempted Suicide
- 0.3 Million Made No Plans and Attempted Suicide

Source: SAMHSA
Why suicide?
Helplessness

“It’s bad and there’s nothing I can do about it.”
Hopelessness

“It’s bad and it’s never going to get better.”
Acute Distress

“I can’t bear this.”
Emotional AND/OR Physical Pain
Anxiety, depression, bipolar, schizophrenia, etc.

but also...
Chronic pain and chronic illness.

and also...
Anything that triggers shame, despair, humiliation.
Much suicidality stays at the level of ideation.

Protective factors.
Protective factors

• Moral/religious
• Obligations
• Effect on others
2. Intent
Moving from thoughts to plans.
3. Plan
How?
Means and lethality
History of attempts
Alcohol use

Impulsivity
But isn’t this difficult?
No.
II. Suicide Assessment
You have to ask the questions!
How to broach the topic?
1. **Empathize** and ask about ideation and history

Use clear language.
2 key questions

• Have you had thoughts of killing yourself?
• Have you ever made a suicide attempt?
  • Within last 6 months
If no, you’re done.
If yes...
1. Intent and plan

How?
2. Protective factors

Why not?
3. Alcohol use
Is this a thorough and complete suicide assessment?

No. But it’s surprisingly good.
5 simple questions

1. Thoughts of suicide?
2. History of attempt?
   If yes,
3. How?
4. Why not?
5. Alcohol use?
III. Communicating Your Assessment
What does the ED treatment team need to know?

What does a mental health professional need to know?
Use 5 questions as a guide
Assessment Results

1. Thoughts of suicide?
2. History of attempt?
If yes,
3. How?
   - Access?
   - Lethality?
4. Why not?
5. Alcohol use?
Bob, 52 YOM, chronic back injury

- Wants to be dead
- No history
- No plan
- Strong religious beliefs about suicide
- Some ETOH

- Wants to be dead
- No history
- “I would take pills.”
  - Has pills
- “They’d be better off without me”
- ETOH use
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- ETOH use
Use red flag words and phrases.
Remember, we’re bad at this in the ED.

You need to bring it to their attention.
What if they don’t listen?
You do what you can.
As I finish up…
What I Covered Today

I. The suicidality progression
II. How to conduct a brief, effective suicide assessment
III. How to communicate the results of your assessment to hospital providers
It’s simple.

5 questions
It’s (kind of) easy.
It’s up to you.
Thank you.

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