
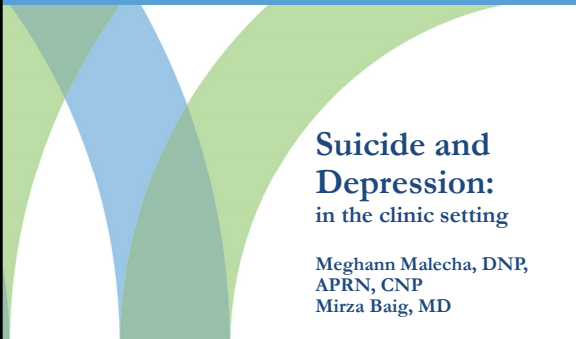


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Suicide and Depression: in the clinic setting


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DISCLOSURES


- None




Welcome




<https://www.youtube.com/watch?v=AZ-pU7ozt3g>






Suicide victims are not trying to end their life – they are trying to end the pain!⁴




Suicide *is* PREVENTABLE



Understanding Suicide: Statistics

- Nearly half of all patients saw their Primary Care Provider within the month prior to their completed suicide
- Over 40,000 Americans die by suicide every year
 - Veterans comprise 22.2% of suicides
- 10th leading cause of death in the US
 - 2nd leading cause of death ages 15-34
 - 8th leading cause of death in MN



Predisposing factors

1. Age: suicide risk increases with age, though there are rising rates in adolescents. Suicides peak after age 45 in men.
2. Race: White, American Indian
3. Sex: Males are at higher risk (men commit suicide 4 times more often than women in the United States).
4. Genetics

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Risk Factors/ Precipitating Factors

- Previous Suicide Attempt
- Problems with school or the law
- Breakup of a romance
- Unexpected pregnancy
- A stressful family life.
- Loss of security
- Mental illness/ mood disorders
- Stress due to new situations
- Failing in school or failing to pass an important test
- A serious illness or injury to oneself
- Seriously injuring another person or causing another person's death
- Major loss...of a loved one, a home, divorce in the family, a trauma, a relationship

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Protective Factors for Suicide

- Effective clinical care and access to healthcare
- Hope for the future
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution and nonviolent handling of disputes
- Cultural and religious beliefs
- Belief that suicide is immoral or that it will be punished
- Responsibility to children, family, or others (including pets) who person would not abandon

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Warning about protective factors:

- Be careful not to get a false sense of security due to the presence of protective factors.
- Protective factors:
 - Do not guarantee that at-risk individuals will not engage in suicidal behavior
 - May have less of a deterring effect in acute crises
- If multiple acute warning signs exist:
 - Protective factors do not change the fact that preventive actions may be necessary.

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Warning Signs

- Acting differently than they normally do
- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, such as searching online or buying a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings
- Giving away possessions

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Suicidality: the continuum

1. Suicidal ideation
2. Suicidal plan
3. Suicidal attempt
4. Completed suicide
5. Non suicidal self directed violence

****THOUGHTS VS BEHAVIOR-** How do you determine/assess the difference?

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Severity of intent to die

1. Passive: thoughts of death/ or being better off dead
2. Active: Concrete plans for killing oneself
3. Chronic: Persistent thoughts of suicide

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What is suicidal intention?

Often the most difficult part of the assessment.

1. Intention to harm himself or herself with the action
2. Intention to die as a result of the action
3. Capacity to understand consequences at the time of acting on intention

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General Guidelines

- Talk about suicide openly and matter-of-factly
- Be direct – ask “Are you planning to kill yourself?”
- Be specific, use clear and consistent terminology
- Be flexible
- Be active
- Be honest about reasons for responses

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Interventions

- Safety Planning Intervention
- Lethal Means Restriction
- Caring Contacts
- Collaborative Assessment and Management of Suicidality (CAMS)- specific therapy to manage suicide assessment and intervention.

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Principles

- Validate emotional pain
- Generate hope
- Identify and reinforce reasons for living
- Challenge or counteract suicidal beliefs and models
- Explore the Problem NOW!
- Identify events which have set off current crises response
- Formulate and summarize the problem situation with the suicidal person

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The foundation: EMPATHY



Video:

<https://www.youtube.com/watch?v=1Ewngu369Jw>

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No-Suicide Contracts vs. Safety Planning

No-Suicide Contracts

- Written or verbal agreement to not kill themselves
- Do not include strategies for what to do to reduce risk
- No empirical support
- Not recommended

2018 Behavioral Tech, LLC

Safety Planning

- Written list of strategies to use to reduce suicide risk
- Large randomized trials supporting effectiveness
- Recommended as best practice

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Safety Planning

- Concrete strategies to decrease the risk of suicide.
- Can be used as a stand-alone intervention
- Can be used during ongoing mental health treatment for patients with:
 - A history of suicidal behavior
 - Current suicidal ideation
 - Other factors indicating potential suicide risk

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Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, moods, situations, behaviors) that a crisis may be developing.

1. _____

2. _____

3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (distraction, relaxation, physical activity).

1. _____

2. _____

3. _____

Step 3: People and social settings that provide distraction.

1. Name _____ Phone _____

2. Name _____ Phone _____

3. Place _____ Phone _____

Step 4: People whom I can ask for help.

1. Name _____ Phone _____

2. Name _____ Phone _____

3. Name _____ Phone _____

Step 5: Professionals or agencies I can contact during a crisis.

1. Clinician Name _____ Phone _____

2. Clinician Pager or Emergency Contact # _____

3. Clinician Name _____ Phone _____

4. Clinician Pager or Emergency Contact # _____

5. Local Urgent Care Services _____

Urgent Care Services Address _____

Urgent Care Services Phone _____

6. Suicide Prevention Lifeline Phone: 1-800-273-8255 (24/7)

Step 6: Making the environment safe.

1. _____

2. _____

3. _____

How do I ensure my safety and the safety of others? I will _____

The one thing that is most important to me and worth living for is _____

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Safety Planning Steps

1. Recognizing warning signs
2. Using coping strategies
3. Socializing with family members or others who may offer support or distraction from the crisis
4. Contacting family members or friends who may offer help to resolve a crisis
5. Contacting professionals or agencies
6. Making the environment safe

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Distress tolerance: TIPP skills

- Temperature: Dive Reflex
- Intense Exercise: 10 minutes
- Paced Breathing: 4 in/6 out
- Paired Progressive Muscle Relaxation
- Additional- The 5-4-3-2-1 "Grounding" technique
- Check out these:

<https://www.youtube.com/watch?v=00RK6NRMq>
https://www.youtube.com/watch?v=h6thKw_mNxx
<https://www.youtube.com/watch?v=9XzebHZYMi8>
<https://www.youtube.com/watch?v=uN4FLtzmBDI>
<https://www.youtube.com/watch?v=MKxsRVAKrHg>

DBT Skills Manual Second Edition, Linehan

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Caring Contacts

- Evidenced Based Intervention – phone call or letter of concern sent to patient to reach out following a suicide attempt or to patients at risk for suicide



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Lethal Means Reduction

- Reducing access to lethal means saves lives.
- Many suicide attempts occur with little planning
 - Among survivors of near-lethal suicide attempts, 24% thought about it for < 5 minutes, 70% for < 1 hour
- Access to firearms is a strong risk factor for suicide.
 - 85% of suicide attempts with firearms are fatal
- Ask:
 - “What means do you have access to and are likely to use if you decide to try to kill yourself?”
 - “How can we develop a plan to limit your access to these means?”
- CALM training: Counseling on Access to Lethal Means

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Means Restriction Options for Firearms

- Safest option is storage away from the home
 - Give to a relative or friend
 - Gun shops and shooting ranges
 - Pawn shops
 - Self-storage rental units
 - Local law enforcement
- Storage at home
 - Can obtain trigger locks
 - Lock firearms unloaded and separate from ammo and ensure the person has no access
 - Disassemble the guns and store a critical part like the slide or firing pin away from home

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Emergency Intervention Options

- Police wellness check
- Mobile crisis response team
- Paramedics
- Emergency department
- Psychiatric hospitalization

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Psychiatric Hospitalization

- ❖ Evidence of severe impairment
- ❖ Suicidal or Homicidal ideation with imminent planning and/or intention
- ❖ Symptoms have not responded to a lesser restrictive treatment setting and require the structure, supervision, and safety of an acute care, secured treatment setting.
- ❖ May require medication adjustment and the monitoring of effects which are unable to be managed in an outpatient setting.
- ❖ May be exhibiting a significant decrease in functioning or severely vegetative behaviors (i.e. refusal to eat, extreme sleep disturbance, unable to complete ADLs).

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Resources

- Health and Peace Officer Hold Forms: <http://akn.allinahealth.org/policies/Patient%20Care%20Documents/Application%20for%20a%20Health%20Officer%20or%20Peace%20Officer%20For%20Emergency%20Admission%20SR-10510.pdf>
- Lighthouse Project: <https://cssrs.columbia.edu/>
- CALM training: <https://www.sprc.org/resources-programs/calm-counseling-access-lethal-means>
- Safety planning: https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf

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Depression

Depression

- In as many as 70% of individuals with depression, their depression goes undetected in primary care.
- WHO: Major Depressive Disorder the 2nd leading cause of years living with disability worldwide
- Disabling
- Misunderstood and Stigmatized
- Considerable impact from the individual to the broader economy (\$210.5 billion/year)

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Symptoms of Major Depressive Disorder

- Depressed mood
- Anhedonia
- Low energy
- Sleep change
- Weight change
- Psychomotor activity change
- Worthlessness
- Reduced concentration/decisiveness
- Thoughts of death or suicidal ideations

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Persistent Depressive Disorder

- Relatively fewer symptoms, but occurring chronically for at least 1 year in the pediatric population and 2 years for adults

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Bipolar Disorder

- 1 in 10 patients diagnosed with Major Depression have manic episodes
- Bipolar II Disorder
 - Hypomanic episode(s) with at least one episode of major depressive disorder
- Bipolar I Disorder
 - At least one manic episode; no requirement for depressive episode but typical patient history includes depression
- Treatment with antidepressant can increase the chance of mania, subsequent depression, and overall worsening long term

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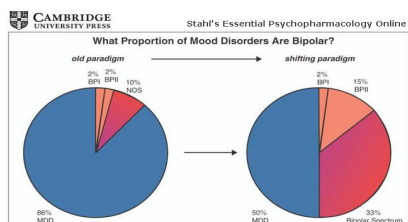


FIGURE 11-22 Prevalence of mood disorders. In recent years there has been a paradigm shift in terms of the recognition and diagnosis of patients with mood disorders. That is, many patients once considered to have major depressive disorder (old paradigm, left) are now recognized as having bipolar II disorder or another form of bipolar illness within the bipolar spectrum (shifting paradigm, right).

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Be the Change check

∞ What words do you associate with a person with **cancer**?

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Be the Change check

- ∞ What words do you associate with a person with a **mental health condition** and/or **addiction**?

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Primary Medication Treatment Options

- SSRI's
- SNRI's
- Other
- Tricyclics
- MAOI's

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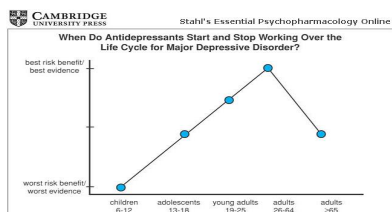


FIGURE 12-11 Antidepressants over the life cycle. The efficacy, tolerability, and safety of antidepressants have been studied mostly in individuals between the ages of 25 to 64. Existing data across all age groups suggest that the risk/benefit ratio is most favorable for adults between the ages of 26 to 64 and somewhat less so for adults between the ages of 19 to 25 due to a possibly increased risk of suicidality. This is not true for children and adolescents, who also suggest a somewhat risk of suicidality. This is not true for children and adolescents, who also suggest a somewhat risk of suicidality. This is not true for children and adolescents, who also suggest a somewhat risk of suicidality. This is not true for children and adolescents, who also suggest a somewhat risk of suicidality.

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SSRI's

- Citalopram
- Escitalopram
- Sertraline
- Fluoxetine
- Paroxetine
- Fluvoxamine

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SNRI's

- Typically do not cause qTC prolongation
- Contraindication shortly after a myocardial infarction
- Slight change of significant blood pressure increase
- May help with chronic pain or fibromyalgia

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SNRI's

- Venlafaxine
- Duloxetine
- Milnacipran
- Levomilnacipran
- Mirtazapine*

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Tricyclics

- Subjectively some psychiatric providers argue these may be more effective
- May be helpful with chronic pain, sleep, headaches, irritable bowel syndrome, etc.
- Higher risk of side effects
 - Anticholinergic activity
 - Blind as a bat, hot as a desert, dry as a bone, red as a beet, mad as a hatter
 - Cardiac impact, drowsiness
 - Highly lethal in overdose

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Tricyclics (most commonly prescribed)

- Amitriptyline, nortriptyline, doxepin, and many more

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Procedures

- Trans-magnetic Stimulation Program (TMS)
 - TMS therapy uses highly focused magnetic impulses to stimulate areas of the brain that may be underactive in patients with depression.
 - Abbott
- Electroconvulsive Therapy (known as ECT)
 - A controlled seizure inducing treatment to help the brain regulate mood. The patient is given a general anesthesia to sleep during the treatment. The psychiatrist gives a brief electrical stimulation to the brain.
 - This is done at Abbott, United, Mercy, and New Ulm Hospitals

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Discussion/Questions
Thank you!

Resources

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3. Yellow Ribbon Program. Retrieved from www.yellowribbon.org
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Resources (Continued)

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