Medicine In the Margins Schedule:
1:00-1:30 Social Determinants of Health- Dr. Ed Ehlinger
1:30-2:00 Race and Racism in Medicine- Dr. Stephen Nelson
2:00-2:30 Mass incarceration and Corrections- Latasha Jennings, MPH
2:30-3:45 Tabletop skills/resources session- Drs. Tseganesh Selameab and Mike Aylward
3:45-4:15 Immigrant and Migrant Health- Dr. Pat Walker
4:15-4:30 Rural Disparities- Dr. Laura Rathe
4:30-5:00 Tabletop resources/commitment session- Drs. Tseganesh Selameab and Mike Aylward

Points to Remember About Suicide Assessment and Management
From Bev Long, PsyD, LP, with considerable input from Suzanne Witterholt, MD

- Suicide is not *caused* by a diagnosis
- Suicide, from the patient’s point of view is NOT the problem – it is their solution to the problem
- Suicide is a solution for unbearable pain accompanied by the thought that it would be better to be dead than to be in this pain
- When a person is in unbearable pain (stress, physical pain, etc fit here) they lose the capacity to problem solve – they lose the flexibility in their thinking
- Treating a person who is suicidal requires treatment to prevent acting on the urge:
  - Acknowledging the problem the patient is trying to solve and validating the pain (NOT validating the use of suicide, but “getting” that the pain is extreme)
  - Decreasing imminent risk factors in the person and environment
  - Increasing problem solving in the person and environment

Some Statistics about Suicide

- There were 44,965 deaths by suicide in the US in 2016, averaging 123 per day
- For every suicide, there are 25 attempts
- The majority of gunshot deaths are suicide, according to the CDC: in 2016, there were 23,109 by suicide vs 15,549 by homicide
- 40% of suicide deaths had positive blood alcohol
- 10th leading cause of death across all ages
  - 2nd among 10 to 34 year olds
- Suicide is the 8th leading cause of death in Minnesota
- Death by suicide vs homicide:
  - Homicide 2016: 101 and Suicide 2016: 726
- The majority of people who suicided presented to their primary clinic and/or an ED 30 days prior
Most common complaints: stomach ache, head ache, other pain
Violent behavior in the past year increases the risk of completed suicide in all people
Acute use of alcohol is associated with an increased likelihood of a suicide attempt and is dose dependent

The Joint Commission: 2016 Sentinel Event Alert

- “All medical patients in all medical settings (inpatient hospital units, outpatient practices, emergency departments) be screened for suicide risk”
- Use valid suicide risk screening tools


- Protocols and training
- Versions:
Copy of the Columbia Suicide Screen and Severity Rating Scale:

<table>
<thead>
<tr>
<th>Question</th>
<th>Lifetime</th>
<th>Past Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask Questions 1 and 2</strong></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>1) Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Have you actually had any thoughts of killing yourself?</td>
<td></td>
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<td>If YES to 2, ask questions 3, 4, 5, and 6.</td>
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<tr>
<td>If NO to 2, go directly to question 6.</td>
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<tr>
<td>3) Have you been thinking about how you might do this?</td>
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<tr>
<td>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.”</td>
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<tr>
<td>4) Have you had these thoughts and had some intention of acting on them?</td>
<td></td>
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<tr>
<td>As opposed to “I have the thoughts but I definitely will not do anything about them.”</td>
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<tr>
<td>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?</td>
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<td></td>
</tr>
<tr>
<td>6) Have you done anything, started to do anything, or prepared to do anything to end your life?</td>
<td>Lifetime</td>
<td>Past 3 Months</td>
</tr>
<tr>
<td>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.</td>
<td>Lifetime</td>
<td>Past 3 Months</td>
</tr>
</tbody>
</table>

**General Guidelines for Gathering Information about Suicide Risk**

- 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

**Brief Interventions: basics**

- Validate emotional pain (do NOT state that it makes sense they want to commit suicide! DO say “I know you are in terrible distress, and it makes sense you would want relief, but suicide is not the answer” or something along those lines
- Generate hope
- Identify and reinforce reasons for living
- Maintain position that suicide is an ineffective or maladaptive solution to current problems
- Challenge or counteract suicidal models

**Suicidal Behaviors: Crisis Management**

- Assess imminent risk of suicide
- Focus on the present
- Problem solve the current problem
- Reduce high risk environmental factors
- Reduce high risk behavioral factors
- Commit to a plan of action
- Troubleshoot the plan
- Anticipate a recurrence of the crisis response
- Re-assess suicide potential

**“Caring Contacts” Intervention: Luxton, et al**

“Caring letters is a suicide prevention intervention that entails the sending of brief messages that espouse caring concern to patients following discharge from treatment.” Simple, non-demanding expressions of care that with multiple contacts may contribute to a sense of belonging; reminders of treatment availability may provide route to seek help; may help patients to feel better about treatment and therefore motivate them to adhere to treatment.

Connection to others is a powerful suicide prevention tool!