Suicide Prevention for Clients Living with HIV/AIDS

HIV and Mental Health Update
Albany Medical Center
February 25, 2014

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• Chronic diseases put people at risk for suicidal ideation, attempts and completed suicide.

• Suicidal ideation among HIV-positive individuals is relatively common and associated with multiple factors.
If your client or patient was suicidal, what would you do first?

- American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors
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
• Work collaboratively with the client to engage and thoroughly assess needs.

• Interdisciplinary collaboration for psychiatric emergency admission.

• Developed a concrete safety plan and mobilized support system prior to discharge.

• Provide referrals for future ongoing concrete and mental health services.
Step 1: Identify Risk Factors

Which risk factors can be modified to reduce risk?

90% of adults who commit suicide have an associated psychiatric disorder.

- Major Depression
- Bipolar Disorder
- Substance Abuse *
- Conduct Disorder
- Anxiety Disorders
- Borderline Personality Disorder
- Schizophrenia
- Eating Disorders

What are the warning signs?

- Loss of significant relationship or family problems
- Changes in sleep patterns
- Decline in work performance
- Social withdrawal
- Writing goodbye letters to friends
- Disciplinary troubles at school or the law
Impulsivity

- currently intoxicated from drug or alcohol use
- acute psychosis with command auditory hallucinations or persecutory delusions
- decline in cognitive functioning
- agitated or manic
Intoxication
Hopelessness and dichotomous thinking
Prior Attempts
Post-hospitalization Transition
Suicide Rates

- Women are three times more likely than men to attempt suicide, while men are more likely to complete.
- European Americans have the highest rate of suicide in the US.
- Rates of suicide increases substantially in early adolescence.
- LGBT populations are an increased risk for suicide attempts.
Among PLWHA, who is most likely to report suicidal thoughts?

- Patients who do not identify as heterosexual
- HIV-related symptoms and medication side effects as more severe
- Regular marijuana use
- Elevated affective symptoms of depression
Suicide Risk Among African Americans

• African Americans have substantially lower rates of suicide when compared to other groups.

• The rate of suicide among African American males have increased greatly in recent decades.

• There is a high rate of suicidal attempts among Black men who have sex with men.
Black MSM at high risk for suicide?

- High rates of depression
- High rates of runaway behavior and homelessness
- Less likely to identify as LGBTQ
- Stigma and isolation
Black MSM report high rates of methamphetamine use and other substances.
Other Suicidal Risk Factors

• Stigma, quality of life concerns, disclosure fears
• Multiple losses
• Lack of social support
• Concerns about transmitting HIV
• Conflicts around sexual orientation
• Poorly controlled pain
• Cognitive dysfunction / delirium
Why should we all be concerned?

- 50% who completed suicide saw a primary care provider during the month before their deaths.
- 30% saw a mental health provider in the preceding year.
When should we be concerned?

- 26% reported attempting suicide since their HIV diagnosis
  - 27% acted within the first week of diagnosis
  - 47% acted within the first month after diagnosis

Cooperman & Simoni (2005)
Suicidal Thoughts & HIV Stage

In some studies, fully developed AIDS patients have less suicidal ideation than asymptomatic patients.
Step 2: Identify Protective Factors

*Note those that can be enhanced.*

Protective Factors

- Primary romantic relationship
- Higher self-efficacy for coping
- Spirituality
- Supportive relationships

Carrico et al 2007
Step 3: Inquire

Step 4: Determine Risk and Intervention

• Although we cannot predict suicide with 100% accuracy, providers are responsible for assessing risk and providing resources to reduce that risk.

Clinicians should assess HIV-infected patients for depression or other forms of mental illness to ensure early detection and treatment of patients who may be at increased risk of suicide.
For patients at risk, primary care providers should be informed and encouraged to screen for safety during medical visits.
Assessment should occur more frequently after the first three months of HIV diagnosis.
Monitor patients taking antidepressant medication closely for suicidal thoughts.

Ensure adherence to the follow-up plan after discharge from psychiatric hospitalization.
Do you sometimes feel so bad you think about suicide, dying or ending it all? If yes:

- How often?
- Do you have a plan (assess lethality)?
- Do you have the means?
- Have you decided when you would do it?
- Have you tried suicide before – what happened?
- Do you have any reason to want to keep living?
Screening and Managing Suicidal or Violent Patients

Have you had current or recent thoughts of hurting yourself? Have you had current or recent thoughts of hurting someone else?

Yes

Imminent Danger?
- Specific plan
- Means to carry out plan
- Actively using alcohol and/or substances
- Acute change in mental status
- Impulsivity
- Psychosis
- History of near-fatal suicide attempt or violence

No

Other Risk Factors?
- Psychiatric symptoms*
- Poorly controlled HIV-related physical symptoms
- Lack of social support
- Other previous suicide attempts or previous violence
- Family history of suicide/violence

Yes

- Initiate open, nonjudgmental dialogue about patient’s suicidal/violent thoughts. Discuss factors that would restrain the patient from acting.

No

- Initiate open, nonjudgmental dialogue about patient’s previous suicidal/violent thoughts.
- If treatment by the primary care clinician is unsuccessful, consult with/refer to mental health professional.
- If patient has a support network, consider involving patient’s family and friends, with patient’s permission.

STOP

In the past, have you ever had thoughts of hurting yourself/someone else?

No

Yes

- Initiate open, nonjudgmental dialogue about patient’s suicidal/violent thoughts. Discuss factors that would restrain the patient from acting.

* Psychiatric symptoms such as depression, hopelessness, or agitation.
• New York State mental health laws provide legal procedures for the management of patients who are imminently suicidal and/or violent.

• Patients may be held involuntarily, for up to 72 hours, while a mental health assessment is performed to determine a patient’s risk of harming self or others.
Safe Act Mandated Reporting

- The mandate applies to all practice environments: inpatient, outpatient, ER, private practice, hospital, community based organizations.
- Mandated reporters are physicians, psychologists, licensed clinical social workers and registered nurses.
- A report is mandated for an individual who is “likely to engage in conduct that will cause serious harm to self or others.”

Axis I: PTSD
Bipolar Disorder
Alcohol Abuse
Cocaine Abuse

Axis II: None

Axis III: HIV, Diabetes

Axis IV: Loss of Loved One

Axis V: GAF = 35
I really don’t know what I am going to do. In fact, I am afraid for myself right now.

Are you thinking about hurting yourself right now?

Risk
• hx self-harm
• Hx dissociation after traumatic loss
• Recent drug/alcohol use
• Recent loss of social support
• Recent loss of deterrent to self-harm
• Unable to assess for changes in mental status
Imminent Danger

• Providers should obtain an emergency evaluation if they determine that a patient is at imminent risk of harm to self or others.

• Call 911 if patient is actively suicidal with a plan or recent attempt.

• Prepare the patient for referral – stay connected, do not hand patient off without speaking to evaluating clinician.

• Involve people whom the patient perceives as supportive, such as friends and family, in treatment planning and management.
I should have never told you about this, now you are ruining everything".

When initiating treatment with high-risk patients, it is best to negotiate a collaborative treatment approach to suicidal thoughts and behaviors that includes:

1. a clear plan for de-escalating a suicidal crisis
2. negotiation of the mutual and individual responsibilities of clinician and patient in establishing and maintaining the patient’s safety
3. agreement to explore the precipitants and meaning of the crisis once it has passed
No Imminent Danger, with Risk Factors

- Patients who are not at immediate risk should be referred to outpatient mental health services.
- Discuss with patients the reasons why they think about suicide and should develop a plan to modify risk factors.
- A safety plan should be developed and communicated with all supportive providers.
No Imminent Danger, with Risk Factors

- Do not rely on ‘no-suicide’ contract alone
- Don’t rely on anti-depressants alone – with increase energy but lingering feelings of hopelessness patient may be more likely to attempt suicide
Modify Risk Factors

• Treatment of underlying mental health disorder, particularly depression
• Reduction of social isolation
• Alleviation of physical pain, physical impairments, sleep disturbance
• Removal of access to means of suicide or violence, such as medications and guns
Step 5: Documentation

Developing a Safety Plan

- Safety plan is developed by the clinician who obtains information of events occurring before, during, and after most recent suicidal crisis
- Safety plans should be:
  - Brief and use the patient’s own words
  - Easy to read
Safety Plan Components

1. Recognize warning signs of a suicidal crisis about to happen
2. Identify and employ internal coping strategies without needing to contact another person
3. Utilize contacts with people as a means of distraction from suicidal thoughts and urges
4. Contact family members or friends who may help to resolve a crisis and with whom suicidality can be discussed
5. Contact mental health professionals or agencies
6. Reduce potential use of lethal means
Step 1: Recognizing Warning Signs

- Recognize signs that immediately precede suicidal crisis

- May include personal situations, thoughts, images, thinking styles, mood, or behavior.
Step 2: Using Internal Coping Strategies

- Ask patient to list coping strategies they could employ without needing to contact others, as these strategies may distract patient from suicidal ideation.
Step 3: Utilizing Social Contacts as a Distraction and Support

- Identify key settings (exclude those with alcohol/substances) and people who are good “distractors” from own thoughts

- Socialize with others rather than reaching out for specific help
Step 4: Contacting Family/Friends Who May Help Resolve a Crisis

- Patient may choose to inform family/friends that they are experiencing a suicidal crisis

- Unlike Step 3, patient explicitly identifies that they are in crisis and need support and help
Step 5: Contacting Professionals and Agencies

• Professionals/clinicians who could assist patients in a time of crisis and corresponding telephone numbers and/or locations

• Patients should use this step if previous strategies were ineffective
Step 6: Reducing the Potential Use of Lethal Means

• Eliminate or limit access to any potential lethal means, even if no specific plan has been identified
Implementation of Safety Plan

• Assess likelihood that plan will be used and identify obstacles

• Evaluate if format is appropriate to patient’s capacity and circumstances

• Review plan periodically

• Safety plan is one component of comprehensive care of suicidal individual
Treatment and Prevention

• Community-based prevention
  – Crisis intervention programs, suicide hotlines

• Drug treatments
  – Lithium, selective serotonin reuptake inhibitors

• Psychological treatments
  – Dialectical behavior therapy, psychotherapy
• The Substance Abuse and Mental Health Services Administration sponsored Suicide Assessment Five-step Evaluation and Triage (SAFE-T; go to: http://store.samhsa.gov/product/SMA09-4432 to download or order a free pocket guide).

• Under 21 1-800-999-9999

• National Suicide Prevention Hotline 800-273-8255 or 1-800-LIFENET
The Columbia University HIV Mental Health Training Project, with funding from the New York State Department of Health AIDS Institute, now offers the Warmline. Mental health care providers with HIV clients can access assistance from a psychiatrist who specializes in the relationship between HIV and mental health. All calls will be returned within 48 business hours.

CONTACT US AT

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