Managing Suicidal Patients in Family Practice

ARKANSAS BEHAVIORAL HEALTH INTEGRATION NETWORK (ABHIN)

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PRINCIPAL, NATIONAL CAPITAL REGION BEHAVIORAL HEALTH

DISCLOSURES

Managing Suicidal Patients in Family Practice

Dr. Kent Corso

October 23, 2020

Disclosures:

The following planning committee members for the **Arkansas Behavioral Health Network** seminar held on **October 23, 2020,** have no financial relationships with commercial interests:

Kimberly Shuler, CEO - ABHI	Marybeth Curtis, RN, BSN, WOCN – Nurse Planner, UAMS

The speaker, **Dr. Kent Corso**, wishes to disclose that he receives fees for Dept. of Defense funded suicide prevention research and suicide prevention training, consulting and program development. Dr. Corso has taken every precaution to ensure that the presentation identified above will be evidence-based or based on the best available evidence and free from bias and promotion.

Accreditation Statements:

Physicians, Nurses, and Pharmacists

Application for 2 hours of CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.

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Learning Objectives

1) Adopt language for suicidal patients that is respectful and non-judgmental.

2) Assist patients with suicidal symptoms in a collaborative, empowering way, anchored in their values and priorities.

3) Assess suicide risk in 10-15 minutes.

4) Discuss with patients ambivalence and reasons for living.

5) Collaboratively devise a crisis response plan that may reduce suicide attempts by 76%.

What are Gatekeeper Programs?

- They leverage the community …why is this beneficial?

- Often, these are the most common and fundamental type of suicide prevention program.


IF YOU SEE SOMETHING,
SAY SOMETHING.
BE SUSPICIOUS OF ANYTHING UNATTENDED.
Tell a cop, an MTA employee or call 1-888-NYC-SAFE.
Metropolitan Transportation Authority
TRANSIT WATCH
SubTalk
www.mta.info
New York City Transit Going your way
George E. Pataki
Governor, State of New York
Peter S. Kalikow
Chairman, MTA


if you
SEE | SAY
something | something™
Together, we can help
keep our community safe.


if you
SEE
something
SAY
something
If You See Something Say Something used with permission of the NY Metropolitan Transportation Authority.
Report suspicious activity to
1-855-FLA-SAFE
1-855-352-7233

How does one “Say Something?”

Myth:

Asking a person if he/she is thinking about suicide may result in a non-suicidal person becoming suicidal.

Reality:

There is no evidence that asking a person if he/she is having suicidal thoughts results in more suicidal symptoms.

…you're not going to give someone any ideas the individual hasn't already considered.

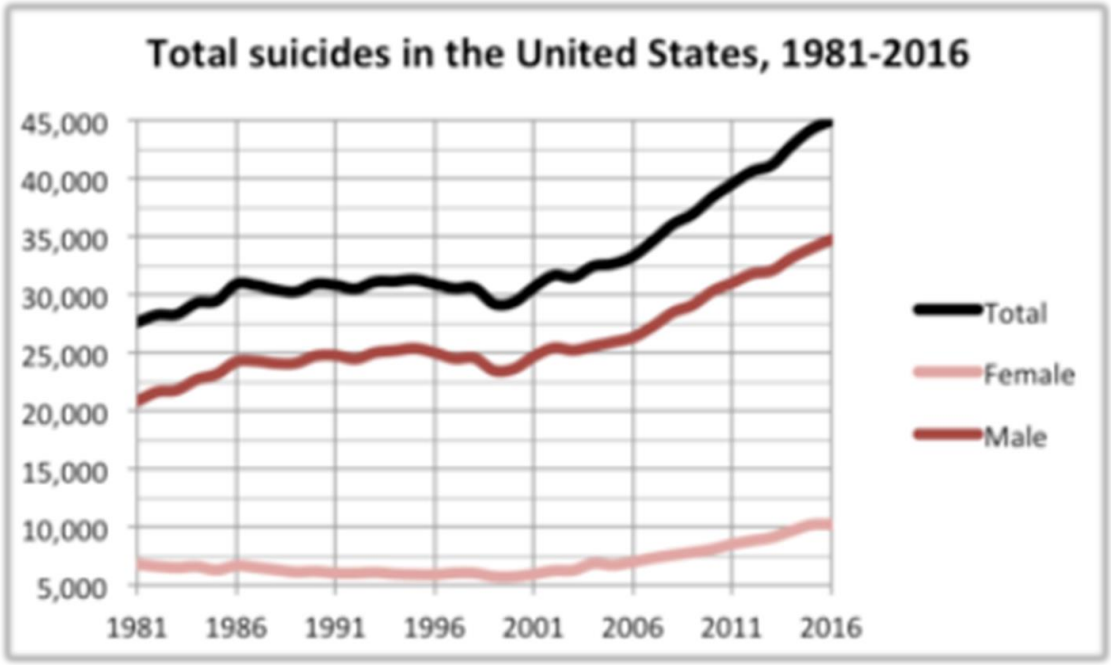
Asking THE QUESTION

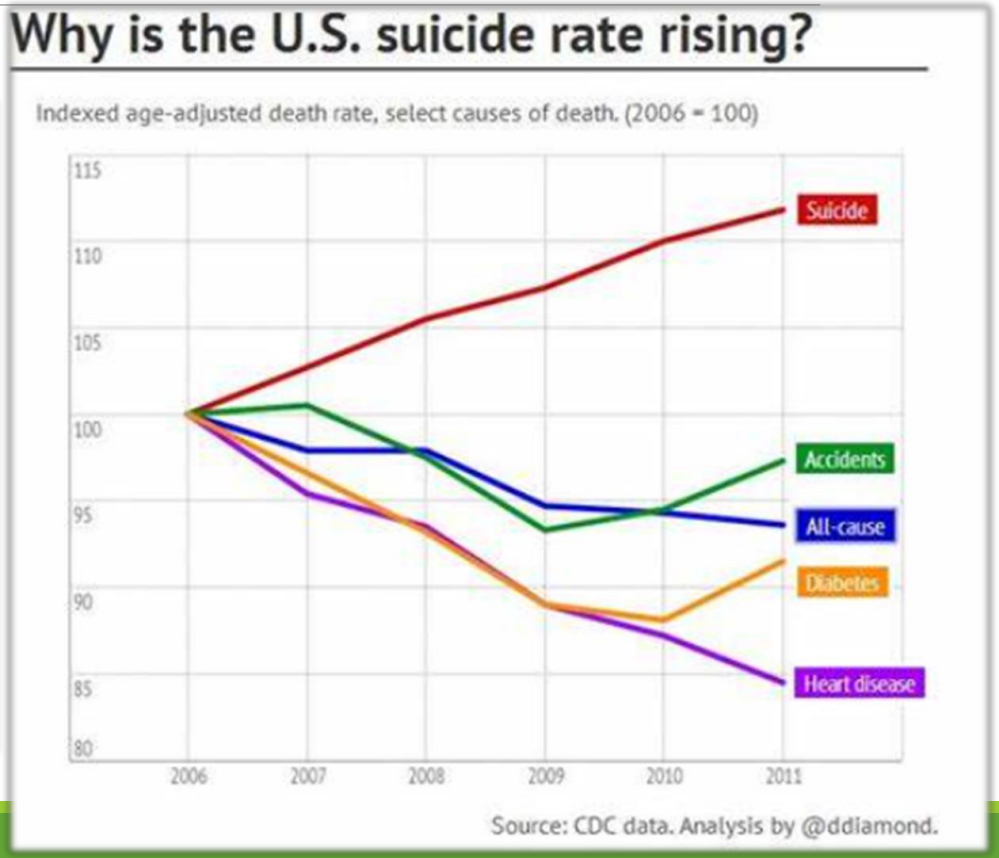
Listening to Suicide Attempt Survivors

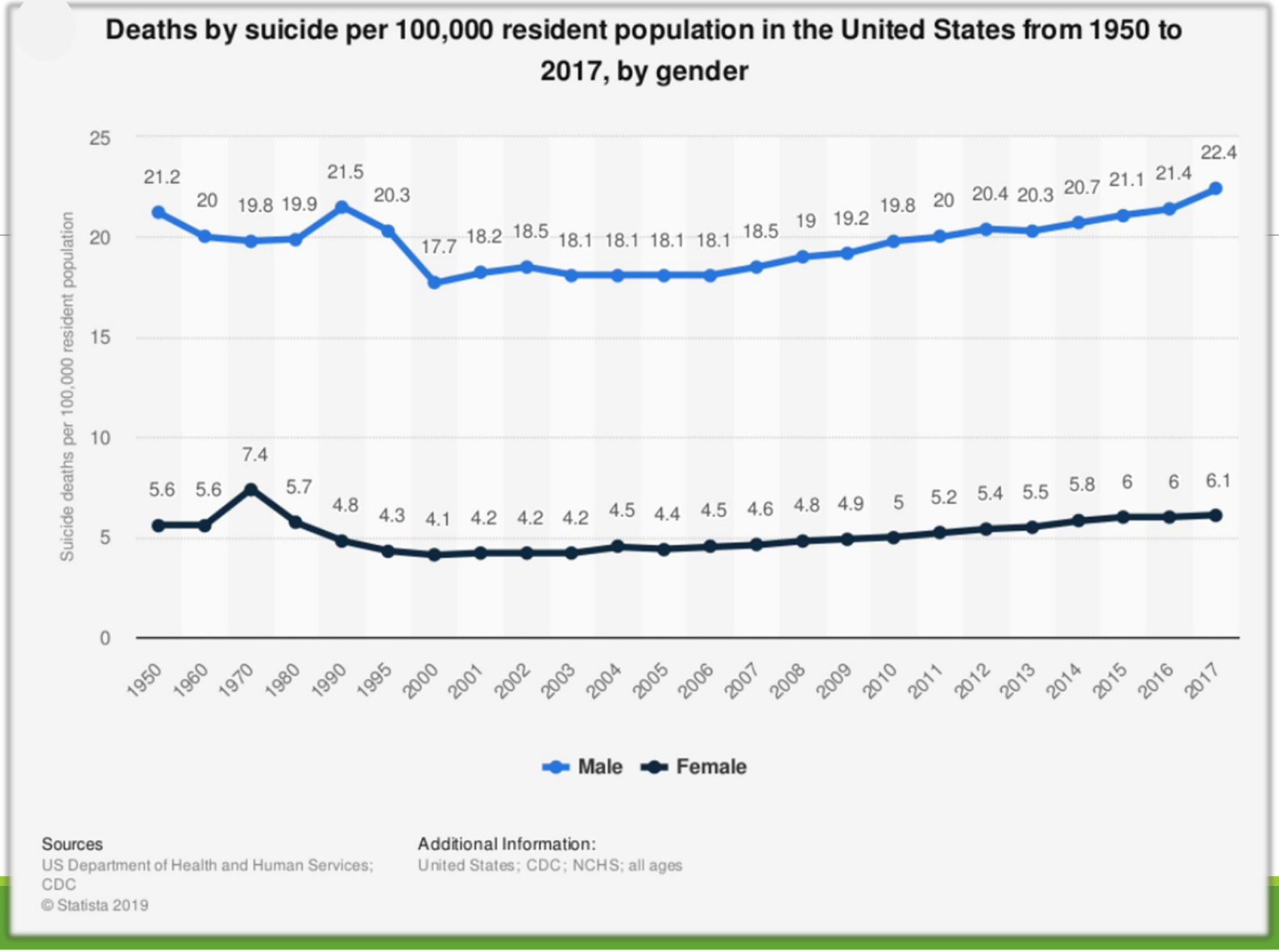
https://www.youtube.com/watch?v=kQ4XCNZdKfI&t=332s

(Stop at 5:32)

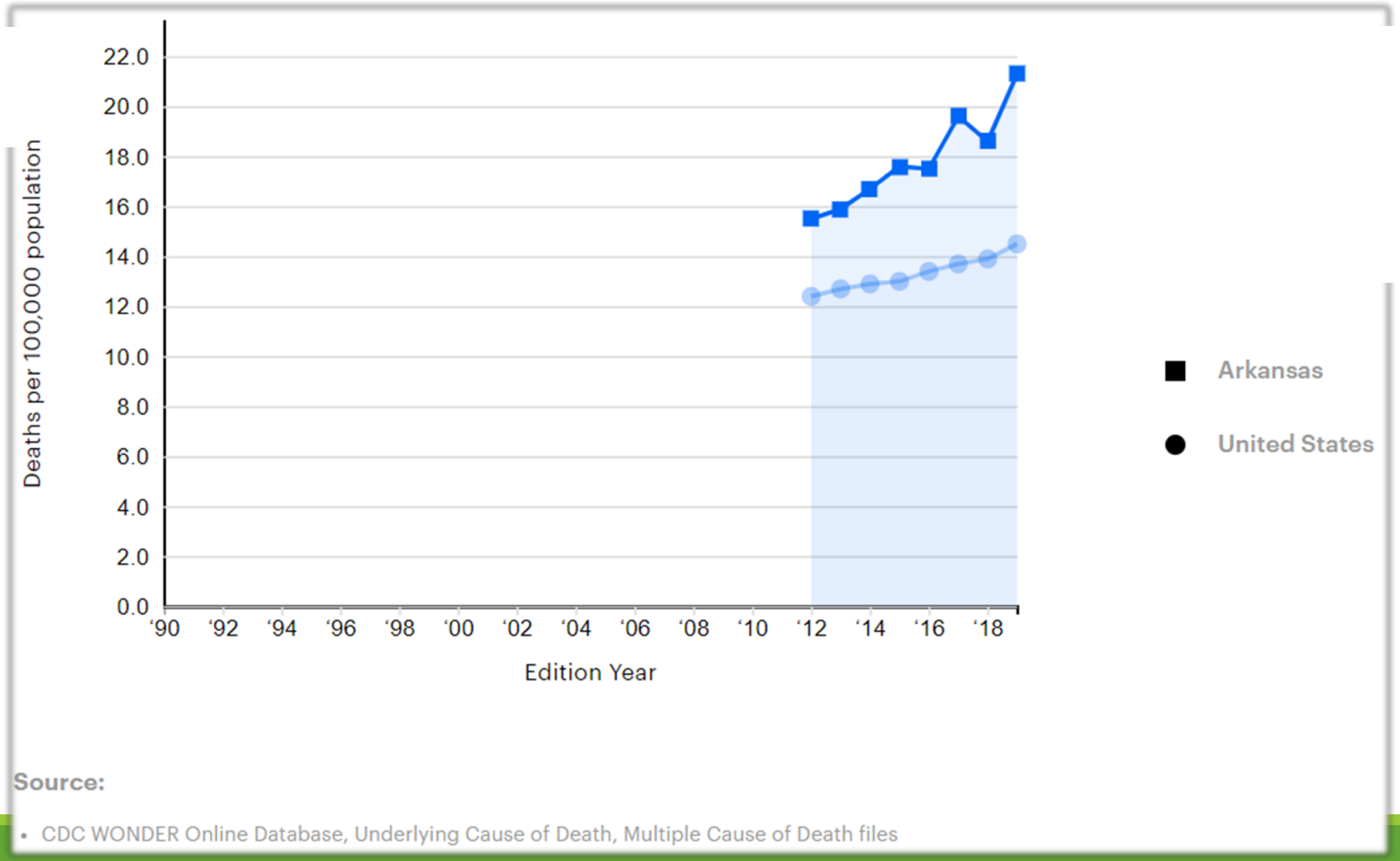
A Persistent Upward Trend






Deaths by suicide per 100,000 resident population in the United States from 1950 to 2017, by gender
Suicide deaths per 100,000 resident population
25
20
15
10
5
0
21.2 20 19.8 19.9 21.5 20.3 17.7 18.2 18.5 18.1 18.1 18.1 18.1 18.5 19 19.2 19.8 20 20.4 20.3 20.7 21.1 21.4 22.4
5.6 5.6 7.4 5.7 4.8 4.3 4.1 4.2 4.2 4.2 4.5 4.4 4.5 4.6 4.8 4.9 5 5.2 5.4 5.5 5.8 6 6 6.1
1950 1960 1970 1980 1990 1995 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017
Male
Female
Sources
US Department of Health and Human Services; CDC
© Statista 2019
Additional Information:
United States; CDC; NCHS; all ages

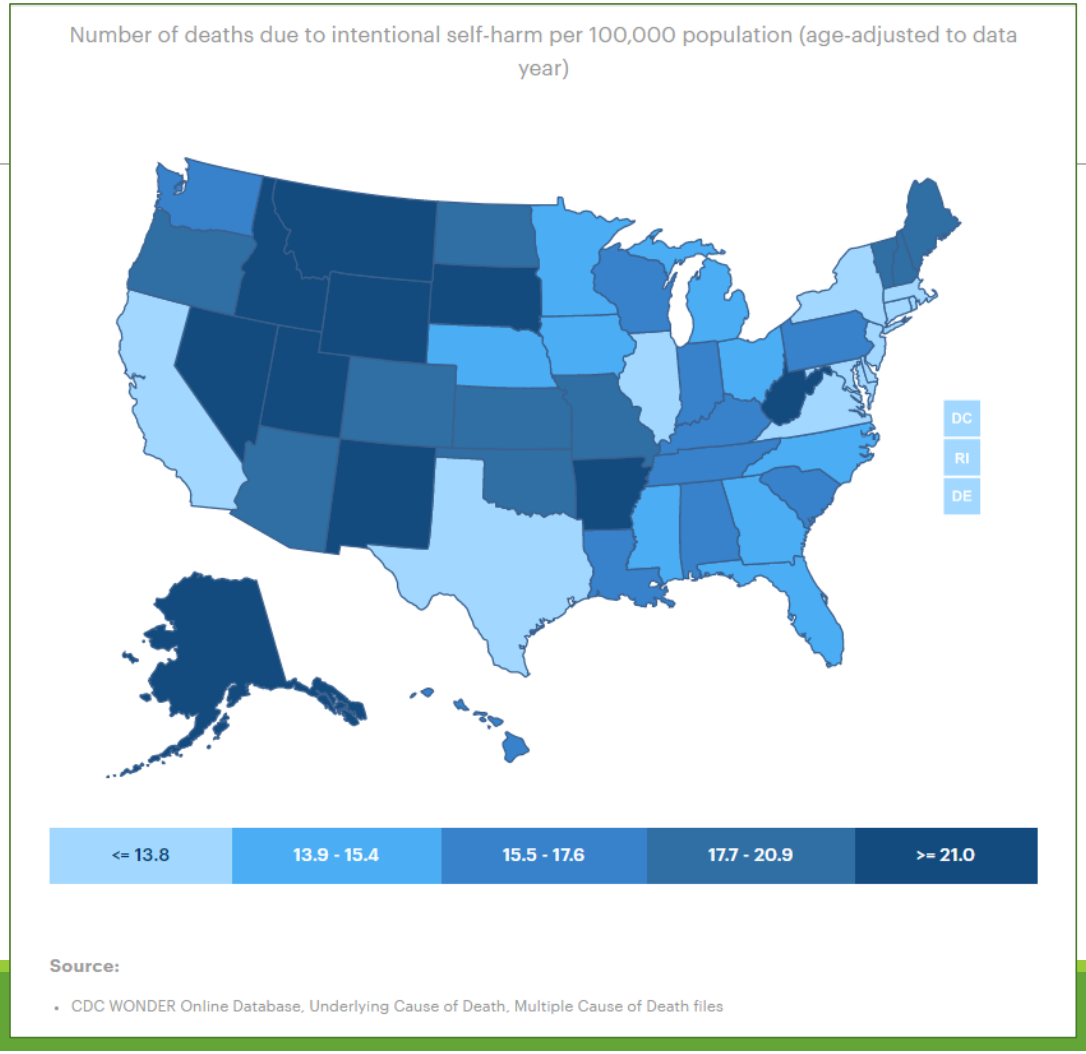
Arkansas Suicide Trends



Source:

- CDC WONDER Online Database, Underlying Cause of Death, Multiple Cause of Death files

Arkansas Suicide Trends



Traditional Suicide Risk Assessment Methods

White

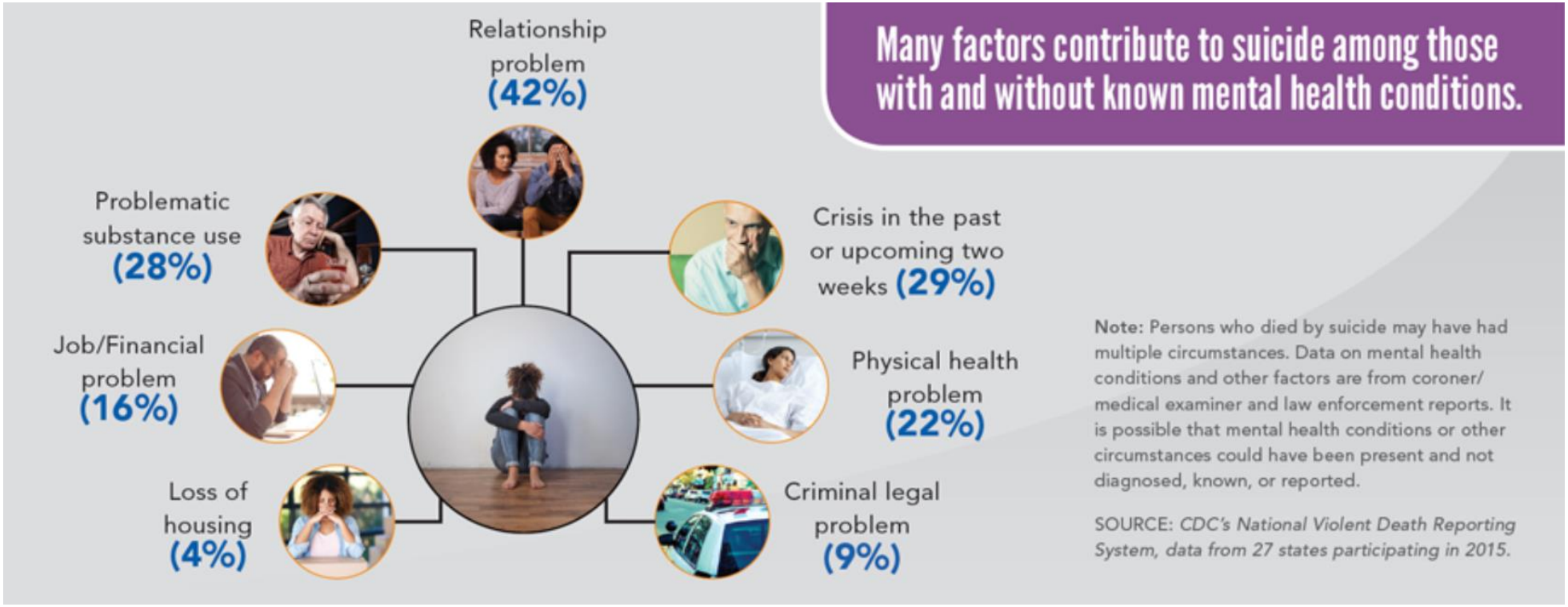
Male

Between ages of 18 and 25

Firearm owner

- Do people females, people of color, and those who aren't age 18-25 -- kill themselves?
- Do people kill themselves in ways that don't involve firearms?
- Has knowing these facts helped us prevent suicides overtime?

Contributing Factors



Research Explores these Factors Between-Subjects

Table 4. Factors Associated With an Increased Risk for Suicide

Suicidal thoughts/behaviors
Suicidal ideas (current or previous)
Suicidal plans (current or previous)
Suicide attempts (including aborted or interrupted attempts)
Lethality of suicidal plans or attempts
Suicidal intent
Psychiatric diagnoses
Major depressive disorder
Bipolar disorder (primarily in depressive or mixed episodes)
Schizophrenia
Anorexia nervosa
Alcohol use disorder
Other substance use disorders
Cluster B personality disorders (particularly borderline personality disorder)
Comorbidity of axis I and/or axis II disorders
Physical illnesses
Diseases of the nervous system
Multiple sclerosis
Huntington's disease
Brain and spinal cord injury
Seizure disorders
Malignant neoplasms
HIV/AIDS
Peptic ulcer disease
Chronic obstructive pulmonary disease, especially in men
Chronic hemodialysis-treated renal failure
Systemic lupus erythematosus
Pain syndromes
Functional impairment
Psychosocial features
Recent lack of social support (including living alone)
Unemployment
Drop in socioeconomic status
Poor relationship with family[a]
Domestic partner violence[b]
Recent stressful life event
Childhood traumas
Sexual abuse
Physical abuse
Genetic and familial effects
Family history of suicide (particularly in first-degree relatives)
Family history of mental illness, including substance use disorders
Psychological features
Hopelessness
Psychic pain[a]
Severe or unremitting anxiety
Panic attacks
Shame or humiliation[a]
Psychological turmoil[a]
Decreased self-esteem[a]
Extreme narcissistic vulnerability[a]
Behavioral features
Impulsiveness
Aggression, including violence against others
Agitation
Cognitive features
Loss of executive function[b]
Thought constriction (tunnel vision)
Polarized thinking
Closed-mindedness
Demographic features
Male gender[c]
Widowed, divorced, or single marital status, particularly for men
Elderly age group (age group with greatest proportionate risk for suicide)
Adolescent and young adult age groups (age groups with highest numbers of suicides)
White race
Gay, lesbian, or bisexual orientation[b]
Additional features
Access to firearms
Substance intoxication (in the absence of a formal substance use disorder diagnosis)
Unstable or poor therapeutic relationship[a]

But, Clinicians Examine Variables Within Subjects

We CANNOT Predict Future Suicides

According to two recent studies, considering the last 50 years of research, our ability to predict future suicides and suicidal behaviors is generally poor (Belsher et al., 2019; Franklin et al,. 2017).

Typical Risk Assessment

1. Risk Factors
2. Protective Factors

Do we ask these with other clinical problems AFTER the problem is present?

1. Ideation
2. Plans
3. Intent

This is insufficient and antiquated.

A Problematic Cycle among Providers

Better Safe than Sorry

- CRP
- Hospitalization

Negative patient experience

Future non-disclosure

Accurate

- Mutual trust
- Client empowerment
- Std of care

Positive patient experience

Future disclosure

Cavalier

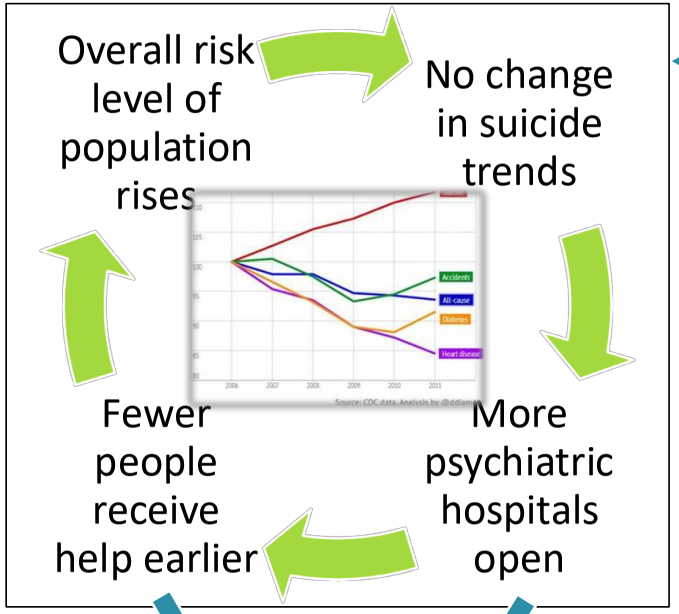
- Risk and liability
- Potential ethical violations

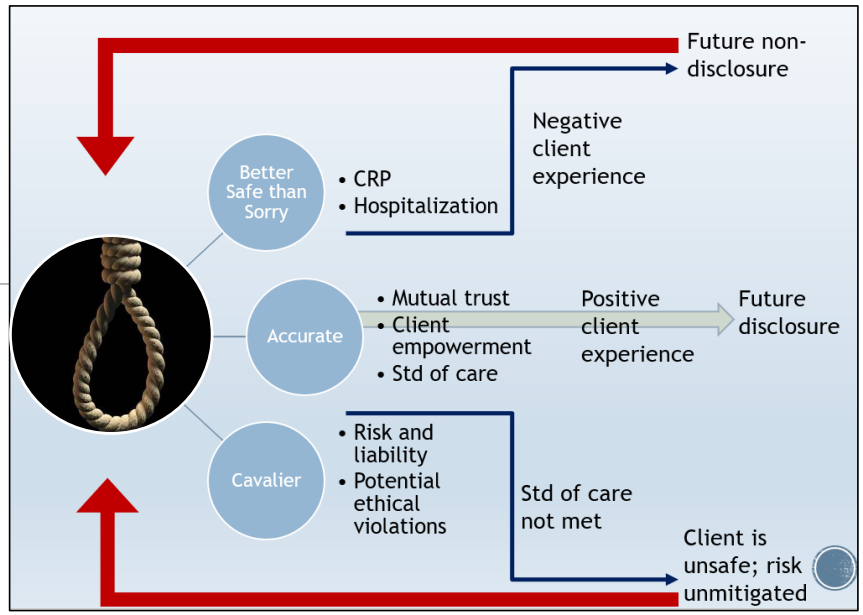
Std of care not met

Client is unsafe; risk unmitigated

At the System Level…

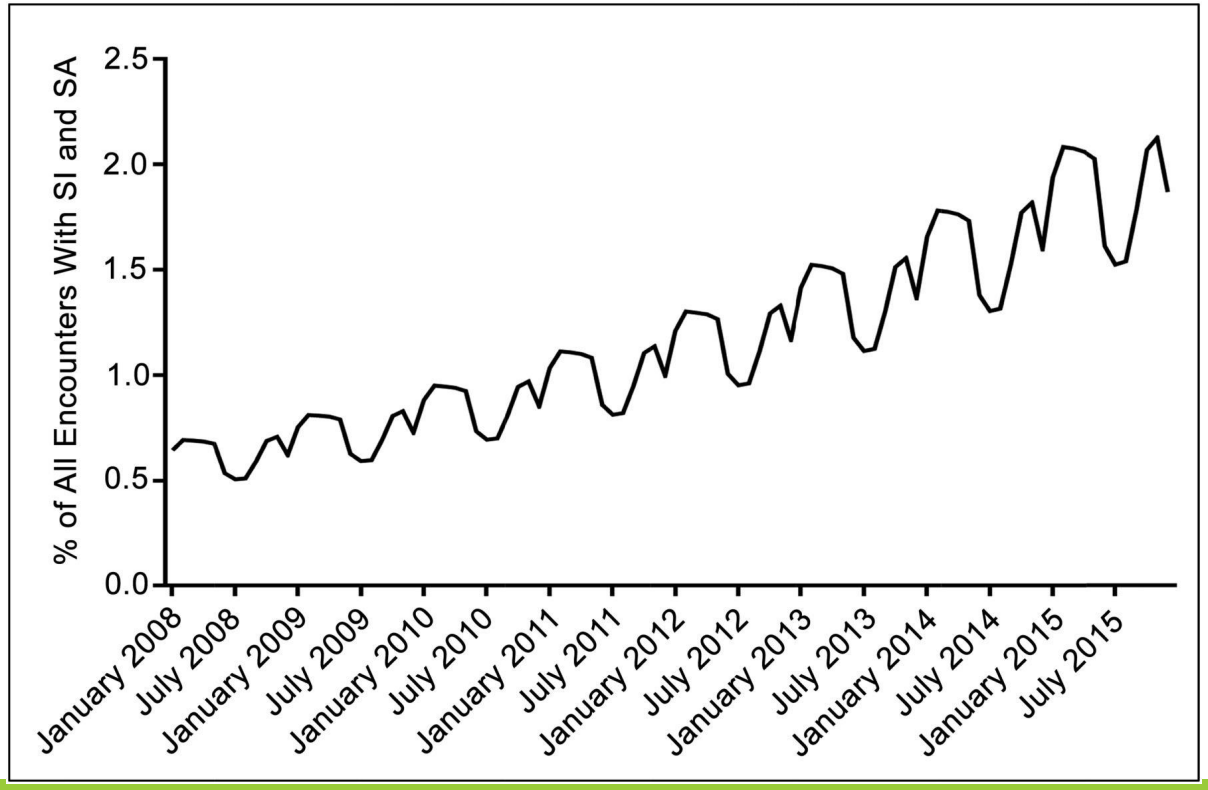
A Problematic Cycle





Outpatient MH providers' suicide management skills decline

Pediatric Hospitalizations



A Common Miscalculation Systems Make

“We just need to pay for more inpatient beds to handle the volume of at-risk patients.”

Treatment MUST occur primarily in outpatient settings.

Limitations of Psychiatric Hospitalization

Psychiatric Hospitalization is not the "Gold Standard" for treatment

→Many clinicians assume that hospitalizing suicidal patients actually treats the suicidal symptoms. In most cases it doesn't, it simply removes the patients' opportunities and means to attempt suicide.

→This may be why the post-discharge suicide rate is approximately 100 times the global suicide rate during the first 3 months after discharge and patients admitted with suicidal thoughts or behaviors have rates near 200 times the global rate upon discharge (Chung et al., 2017)

→Therefore, it is incumbent on us - the outpatient medical community to more fully and accurately address the suicide

Adequate Training?

Studies have found that less than half of behavioral health professionals receive formal training in suicide risk management in graduate school and the average total duration of formal suicide management training is under 2 hours in duration (Bongar & Harmatz, 1991; Feldman & Freedenthal, 2006; Guy, Brown & Poelstra, 1990).

Bongar, B., & Harmatz, M. (1991). Clinical psychology graduate education in the study of suicide: Availability, resources, and importance. *Suicide and Life-Threatening Behavior*, *21*(3), 231-244.

Feldman, B. N., & Freedenthal, S. (2006). Social work education in suicide intervention and prevention: An unmet need?. *Suicide and Life-Threatening Behavior*, *36*(4), 467-480.

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Adequate Training?

A recent study of psychologists found that:

> "Psychologists were less willing to work with a patient experiencing suicidality than an individual without elevated suicide risk. Those indicating a reluctance to provide services reported greater concerns over the adequacy of their suicide-related skills and training and fewer resources in the community."

Groth T., Baccio D.E. (2019). Psychologists' willingness to provide services to individuals at risk of suicide. *Suicide Life Threat Behav*. *49*(5):1241-1254.

Another recent study of all types of therapists found that:

Approximately one third of mental health professionals did not ask every patient about current or previous suicidal thoughts or behaviors.

Comfort, but not fear, was positively associated with greater odds of conducting evidence-based suicide risk assessments at initial appointments and adequacy of suicide risk management practices with patients reporting suicide ideation and a recent suicide attempt.

Roush, J. F., Brown, S. L., Jahn, D. R., Mitchell, S. M., Taylor, N. J., Quinnett, P., & Ries, R. (2017). Mental health professionals' suicide risk assessment and management practices. *Crisis*.

What Does One Suicide Cost Society?

→ The average cost of one suicide was $1,329,553.

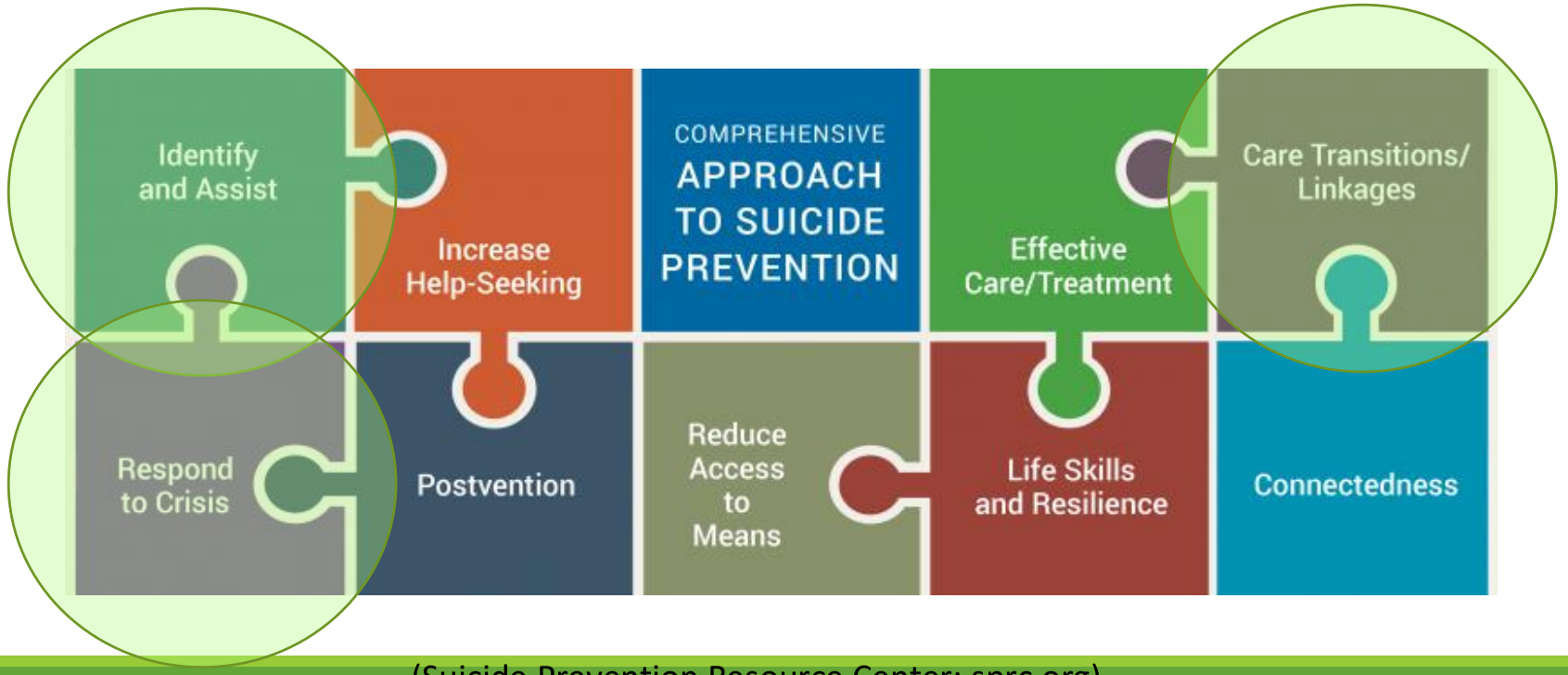
→ More than 97 percent of this cost was due to lost productivity. The remaining 3 percent were costs associated with medical treatment.

→ The total cost of suicides and suicide attempts was $93.5 billion.

→ Every $1.00 spent on psychotherapeutic interventions and interventions that strengthened linkages among different care providers saved $2.50 in the cost of suicides.

(Shepherd et al., 2015)

A Spectrum of Suicide Prevention Actions



(Suicide Prevention Resource Center; sprc.org)

Prevalence Rates

- Prevalence rate for suicidal ideation and suicidal behaviors in general medical settings = 2 to 5% (Cooper-Patrick, Crum, & Ford, 1994; Olfson et al, 1996; Pfaff & Almeida, 2005; Zimmerman, et al., 1995)

- It remains one of the top ten causes of death in America among adults. (31K per year; Hoyert, Heron, Murphy, & Kung, 2006)

- Among children and adolescents ages 10-18, it remains the #2 cause of death (Centers for Disease Control, 2016)
  https://www.cdc.gov/injury/wisqars/pdf/leading_causes_of_death_by_age_group_2016-508.pdf

- For PC patients referred to integrated BH provider, prevalence = 12.4% (Bryan et al, 2008)

Suicide in Primary Care

- Estimated 1-10% of PC patients experience suicidal symptoms at any given time

- Of individuals who die by suicide:
  - 45% visit PCP within one month (Luoma, Martin, & Pearson, 2002)
  - 20% visit PCP within 24 hrs (Pirkis & Burgess, 1998)
  - 73% of the elderly visit w/in 1 month (Juurlink et al., 2004)

Primary Care is a Critical Window of Opportunity

Top 5 chief complaints by patients during the visits immediately preceding their suicides:

Anxiety

Unspecified gastrointestinal symptoms

Unexplained cardiac symptoms

Depression

Hypertension

The Importance of Fluid Vulnerability Theory

Suicide risk is actually comprised of two dimensions:

1. Baseline: Individual's "set point" for suicide risk, comprised of static risk factors and predispositions

2. Acute: Individual's short-term or current risk, based on presence of aggravating variables and protective factors

Roles

Staff Member	Role
PCP	Identify, refer, warm handoff, manage medication
Nurse	Identify, refer, coordinate care, communicate
Medical Assistant	Identify, refer, coordinate care, communicate
BHP	Identify, assess and reduce risk, determine disposition, make recommendations to staff, *provide treatment
MH Provider	Provide treatment and continuously assess risk; provide consultation & liaison services

*The type of treatment delivered depends on the setting and integration model.

(Bryan & Corso, 2014)

Consider Your Own Bias and Beliefs about Suicide

1. Why do people kill themselves?
2. What do I believe morally, spiritually and/or religiously about suicide?
3. What type of person makes a suicide attempt?
4. Can suicide be prevented?
5. Who do I know who has been suicidal, made an attempt or died by suicide?
6. What do I think about my own personal thoughts of death, dying and/or suicide?
7. How have the suicide deaths of my patients influenced my practice habits?
8. What is my responsibility to my patients as a clinician?

What our Role is NOT

- Friend
- Guardian
- Savior
- Protector
- Instead, our job is to follow the standard of care

Standard of Care

A legal concept defined by statutes that vary by jurisdiction, established by experts who retrospectively judge whether

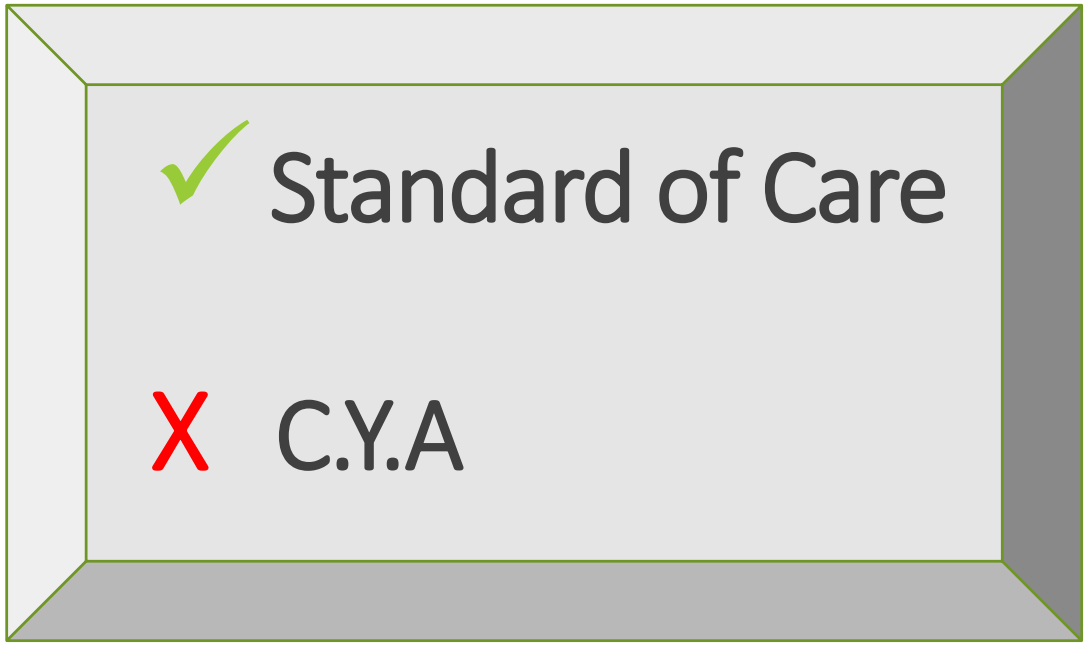
- a given event of interest (e.g., suicide) was *foreseeable*
- the clinician provided *reasonable care* (Berman, 2006)

→ What yardstick will our "reasonable peer" use?

Standard of Care

Essentially, the standard of care has been shaped more by *failures* in standard clinical practice with suicidal patients than empirical findings demonstrating what actually works (or does not work) with this population.

It is not directly defined by efficient, clear, and scientific investigation, but rather by decisions rendered by the legal system in malpractice cases, based largely upon the testimony of hired professionals who express opinions regarding clinical practice.


✓ Standard of Care
X C.Y.A

What Suicide is NOT

- A Cry for Help
- Attention Seeking Behavior
- Instrumental Behavior (manipulation)
- A Threat
- Self-injurious behavior
- Behavior that can be Boiled Down to Calculating Risk Factors
- Even if it was about attention and manipulation…aren't those problematic?

Suicide is a State of…

- Hopelessness
- Burdensomeness
- Powerlessness
- Thwarted Belongingness
- Ambivalence

Suicide is a State of **Ambivalence**

If a suicidal patient is talking with you, there is a part of him/her that wants to live, even if only a little bit

The patient is suicidal because the individual doesn't know how else to alleviate his/her suffering, not because he/she actually wants to die

It is one solution in the patient's problem-solving repertoire.

Identifying those who Are Suffering

What does someone's "baseline" look like?

Baseline Mode		Distress Mode
Happy	---------	Unhappy, down, sad, agitated, anxious
Social	---------	Withdrawn, shut down
Calm/stable	---------	Emotional, moody, impulsive, pressured speech, jumpy or shaky
Logical	---------	Racing thoughts, irrational thinking, tangential
Deliberate	---------	Erratic, random, scattered

Helping those who Are Suffering

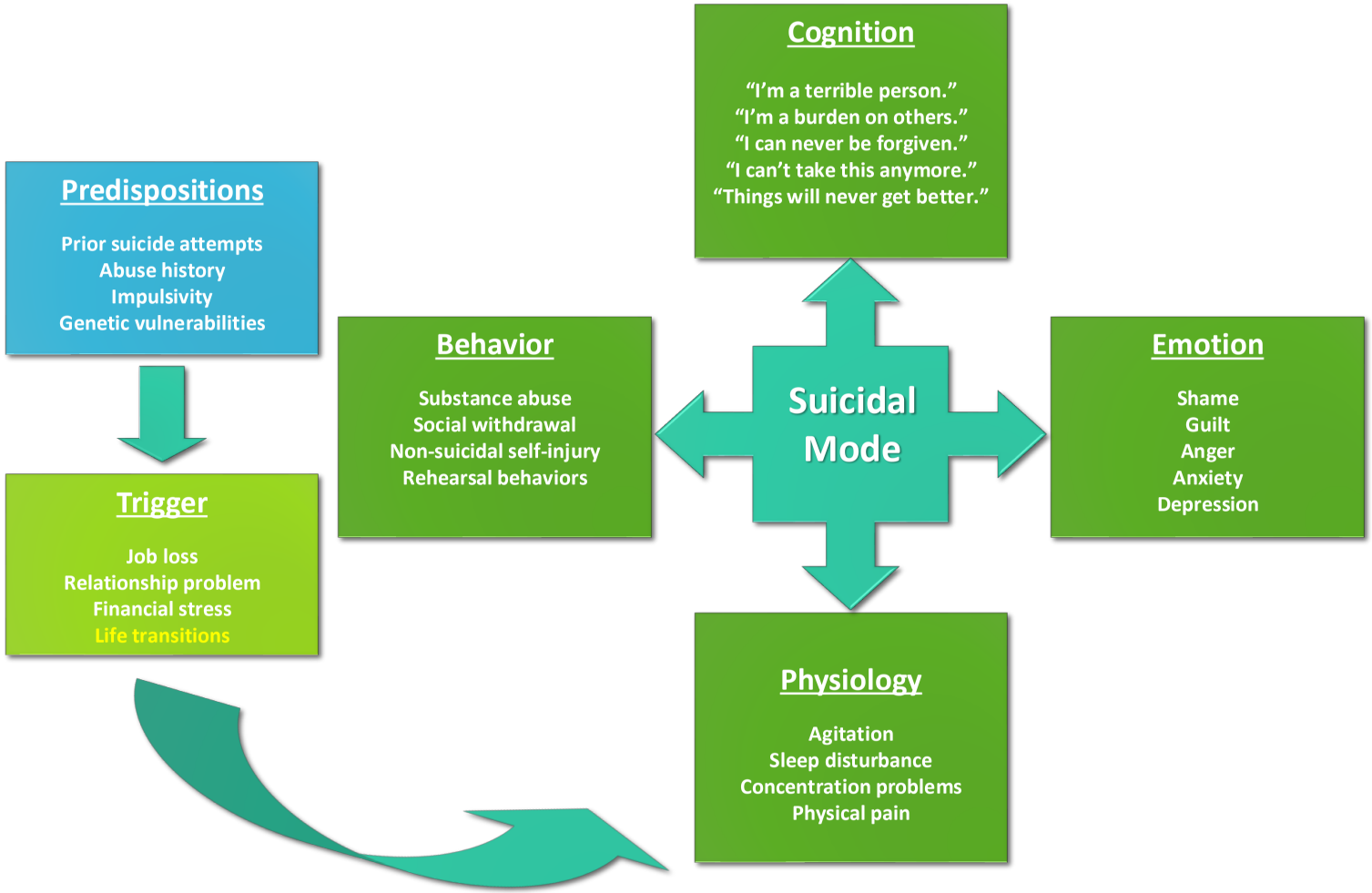
When someone seems different than his/her/their baseline, what do you say?

Start general and open with a question: “How are things going?”

…or a statement: “You seem different today…not like yourself.”

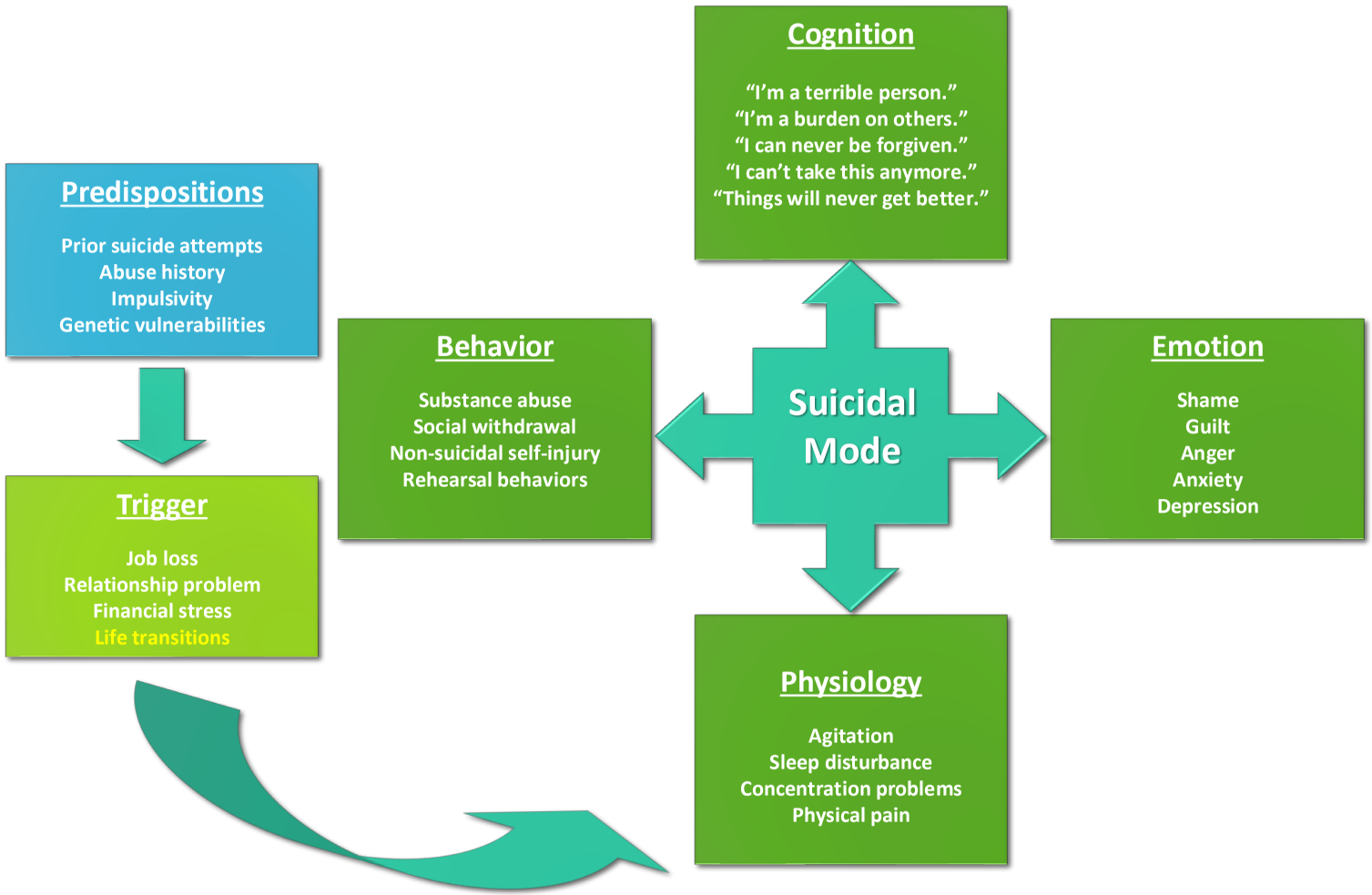
Then become more specific: “Have you been thinking about ending your life?”

…“Can I help you get to a doctor?


Predispositions
Prior suicide attempts
Abuse history
Impulsivity
Genetic vulnerabilities
Trigger
Job loss
Relationship problem
Financial stress
Life transitions
Cognition
"I'm a terrible person."
"I'm a burden on others."
"I can never be forgiven."
"I can't take this anymore."
"Things will never get better."
Behavior
Substance abuse
Social withdrawal
Non-suicidal self-injury
Rehearsal behaviors
Suicidal Mode
Emotion
Shame
Guilt
Anger
Anxiety
Depression
Physiology
Agitation
Sleep disturbance
Concentration problems
Physical pain

Video: Lifelong Struggle & Suicidal Mode

https://www.youtube.com/watch?v=yg5Z-8FWEYE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Agitation
Sleep disturbance
Concentration problems
Physical pain

What do Patients Believe about their Suicidal Symptoms?

- I'm going crazy
- Since I've never felt this way before, I can't relate to myself – I don't feel like me
- I am losing control of myself
- I might not be able to stop myself from acting on my suicidal thoughts
- I'm not who I thought I was

Help them avoid believing all of these!

Teach Them about Ambivalence

“Most people, when they think about killing themselves, don’t truly want to die, they just don’t want to live with all their pain. Is that how you feel?”

Help Patients Learn to Cope

- A stronger sense of meaning in life is significantly associated with lower emotional distress, less severe suicidal ideation, and better functioning across multiple domains of life (Bryan et al., 2013).

- "Effective" Crisis Response Planning reduces suicide attempts up to 76% (Bryan et al., 2017 a, b)

- BCBT reduces suicidal behavior by 60% compared to treatment as usual (Bryan et al., 2015)

Effective Coping Skills

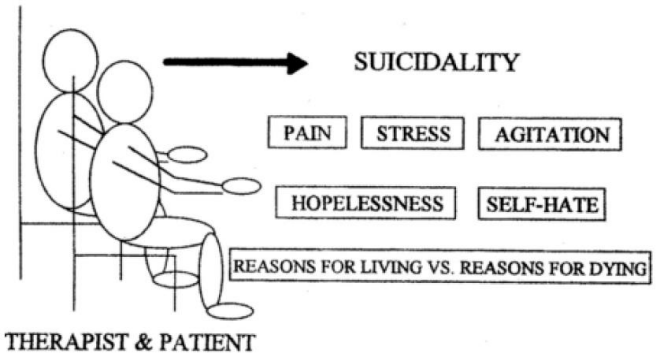
- Emotional regulation skills
  - Distress tolerance skills
  - Relaxation/mindfulness
    - ➢ These prevent the person from impulsively acting to stop the overwhelming emotions, thoughts and physical arousal
    - ➢ They must learn to prevent or interrupt the "suicidal mode"
- Adopting more helpful ways of thinking

"I got very angry when they kept asking me if I would do it again. They were not interested in my feelings. Life is not such a matter-of-fact thing and, if I was honest, I could not say if I would do it again or not. What was clear to me was that I could not trust any of these doctors enough to really talk openly about myself."

A Collaborative Approach

Collaborative approach to mental illness & suicide

- Suicide is a problem distinct from mental illness
- Patient is the expert of their own suicidal experience
- Clinician works alongside the patient to view suicide through the eyes of the patient



(Jobes, 2006)

Empowering Patients

Respect the patient's autonomy and ability to kill himself/herself

Don’t moralize

Avoid power struggles about options that limit the patient's autonomy

Recognize that suicidality is marked by ambivalence…address this head-on

A Collaborative Approach

Critical communications:

- “You are the expert about what you are thinking and feeling”
- “This is a problem like any other medical or psychosocial problem”
- “I am not afraid to address it”
- Reinforce help-seeking behaviors
- Decreasing patient's distress is most important goal (de-activate the suicidal mode)
- Protecting safety is essential
- “Help is available, and it works””

Standardizing Suicide Language

Consider eliminating the following terms:

Suicide gesture

Parasuicide

Suicide threat

Self-mutilation

“Commit” suicide

“Cry for Help”

Suicide-Related Terms

Suicide attempt

Intentional, self-enacted, potentially injurious behavior with any (nonzero) amount of intent to die, with or without injury

Suicidal ideation

Thoughts of ending one's life or enacting one's death

Nonsuicidal self-injury

Intentional, self-enacted, potentially injurious behavior with no (zero) intent to die, with or without injury

Nonsuicidal morbid ideation

Thoughts about one's death without suicidal or self-enacted injurious content

A Few Words about Nonsuicidal Self-Injury

Nonsuicidal self-injury

Intentional, self-enacted, potentially injurious behavior with no (zero) intent to die, with or without injury

--Cutting

--Branding

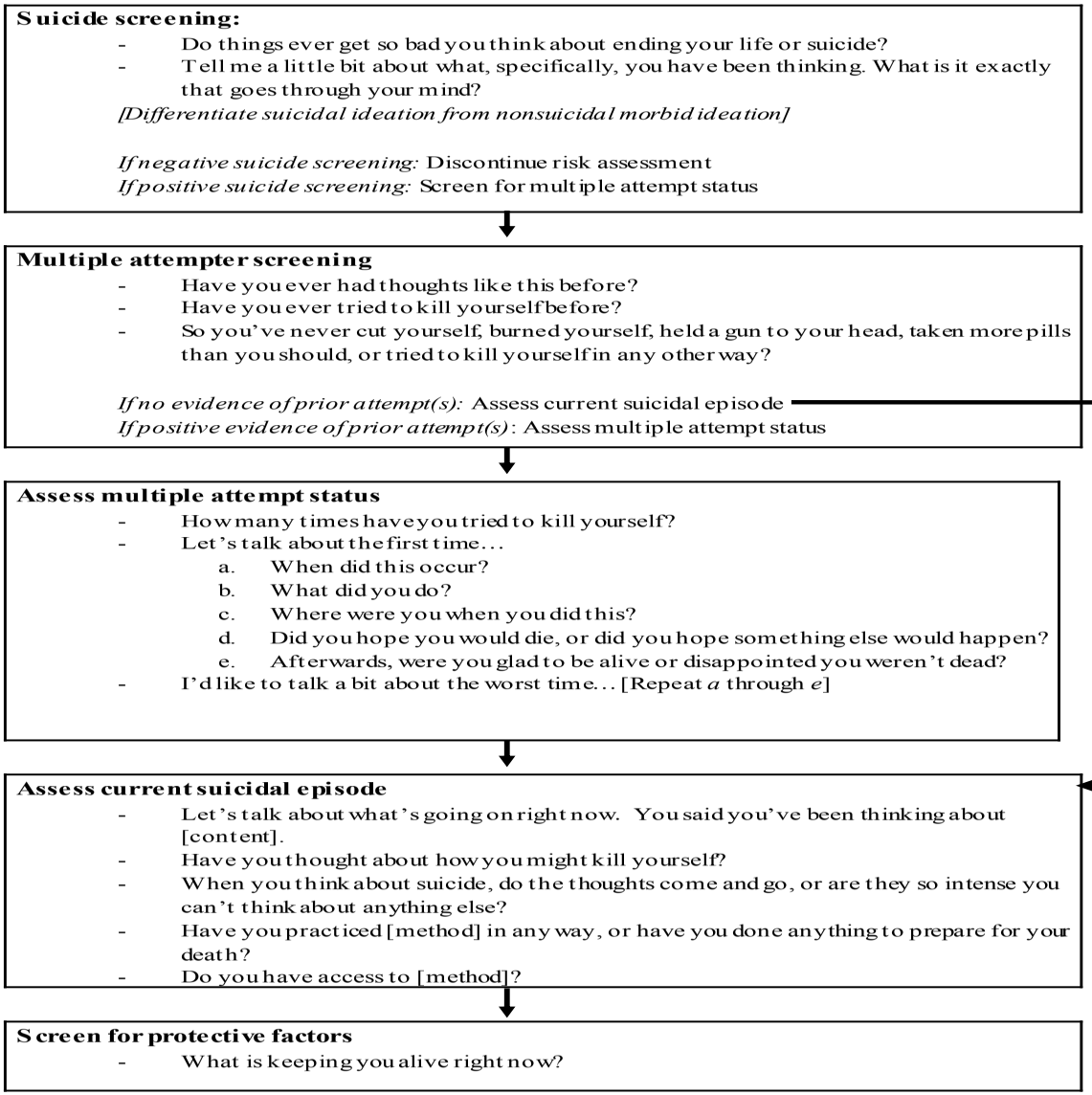
--Burning

Avoid dismissing these patients as unlikely to need further suicide-related care. …why?

A Few Words about Nonsuicidal Self-Injury

In the year following treatment for nonsuicidal self-injury, 1 out of 5 people repeat the act and over 20% die by suicide (Owens et al. 2002)

Almost half of those who seek medical care following an incident of nonsuicidal self-injury, had consumed alcohol in the period prior to the incident (Hawton et al. 1989; Touquet et al. 2008)



(Bryan, Corso, Neal-Walden, & Rudd, 2009)

RISK ASSESSMENT

SKILL 1

Differentiate suicidal ideation from nonsuicidal ideation*

*also called non lethal morbid ideation or death ideation

Suicidal ideation has stronger relationship with suicidal behaviors than nonsuicidal morbid ideation

(Joiner, Rudd, & Rajab, 1997)

Suicidal ideation associated with significantly higher levels of psychological distress than nonsuicidal morbid ideation

(Edwards et al., 2006; Fountaoulakis et al., 2004; Liu et al., 2006; Scocco & DeLeo, 2002)

Potential Survey Screening/Assessment Methods

Patient Health Questionnaire-9 (PHQ-9)

Behavioral Health Measure-20 (BHM-20)

Outcomes Questionnaire-30 (OQ-30)

Beck Depression Inventory-Primary Care (BDI-PC)

Columbia Suicide Severity Rating Scale

Sample Questions

Have you thought about ending your life or killing yourself?

Have you had thoughts of death or dying? If so, have you thought you might play a role in making your death happen?

Some people think about not being here or falling asleep and not waking up, while others think about actually doing something to enact their death. Are your thoughts more like the first ones or the second ones?

What are “Those Thoughts”?

○ Planning my death	SI - Thinking of suicide
○ Thoughts of death/dying	DI - Thinking of death
○ Wishing to be dead	DI - Thinking of death
○ Thinking about how I might kill myself	SI - Thinking of suicide
○ Thinking of killing myself	SI - Thinking of suicide
○ Wishing I could fall asleep and not wake up	DI -Thinking of death
○ Imagining I will play a part in causing my death	SI - Thinking of suicide

What are "Those Thoughts"?

- "I want to sleep and not wake up." DI - Thinking of death
- "I just want to end it all." SI - Thinking of suicide
- "I hate myself." DI - Thinking of death
- "What if I stop taking my meds for my chronic condition?" SI - Thinking of suicide
- "Killing myself would unburden my family." SI - Thinking of suicide
- "What would people say if I died?" DI - Thinking of death

Distinguishing between Death Thoughts and Suicidal Thoughts

- **Thoughts of death** are quite common and indicate that someone is feeling overwhelmed
- **Thoughts of death** do not reliably result in a suicide attempt or suicidal behaviors…unless they progress into suicidal thoughts first

- **Thoughts of suicide** are less common and indicate that someone is feeling so overwhelmed that he/she/they view ending life as a solution
- **Thoughts of suicide** are associated with higher psychological distress and are more closely tied to suicidal behaviors compared to thoughts of death
- **Thoughts of suicide** reliably result in a suicide attempt or suicidal behaviors

RISK ASSESSMENT

SKILL 2

Assess for past suicidal behaviors and multiple attempt history

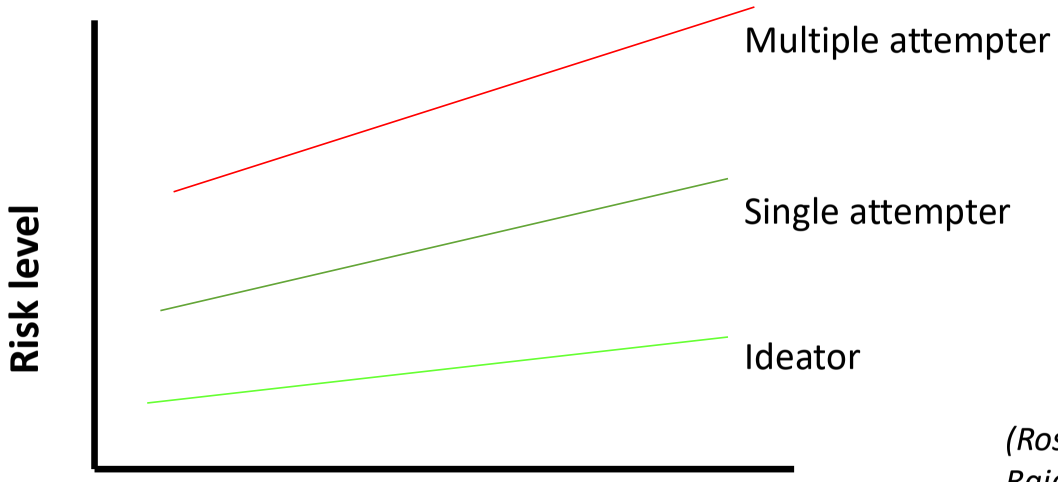
Past suicide attempts are the most robust predictor of future suicidal behaviors, even in the presence of other risk factors

(Clark et al., 1989; Forman et al., 2004; Joiner et al., 2005; Ostamo & Lonnqvist, 2001)

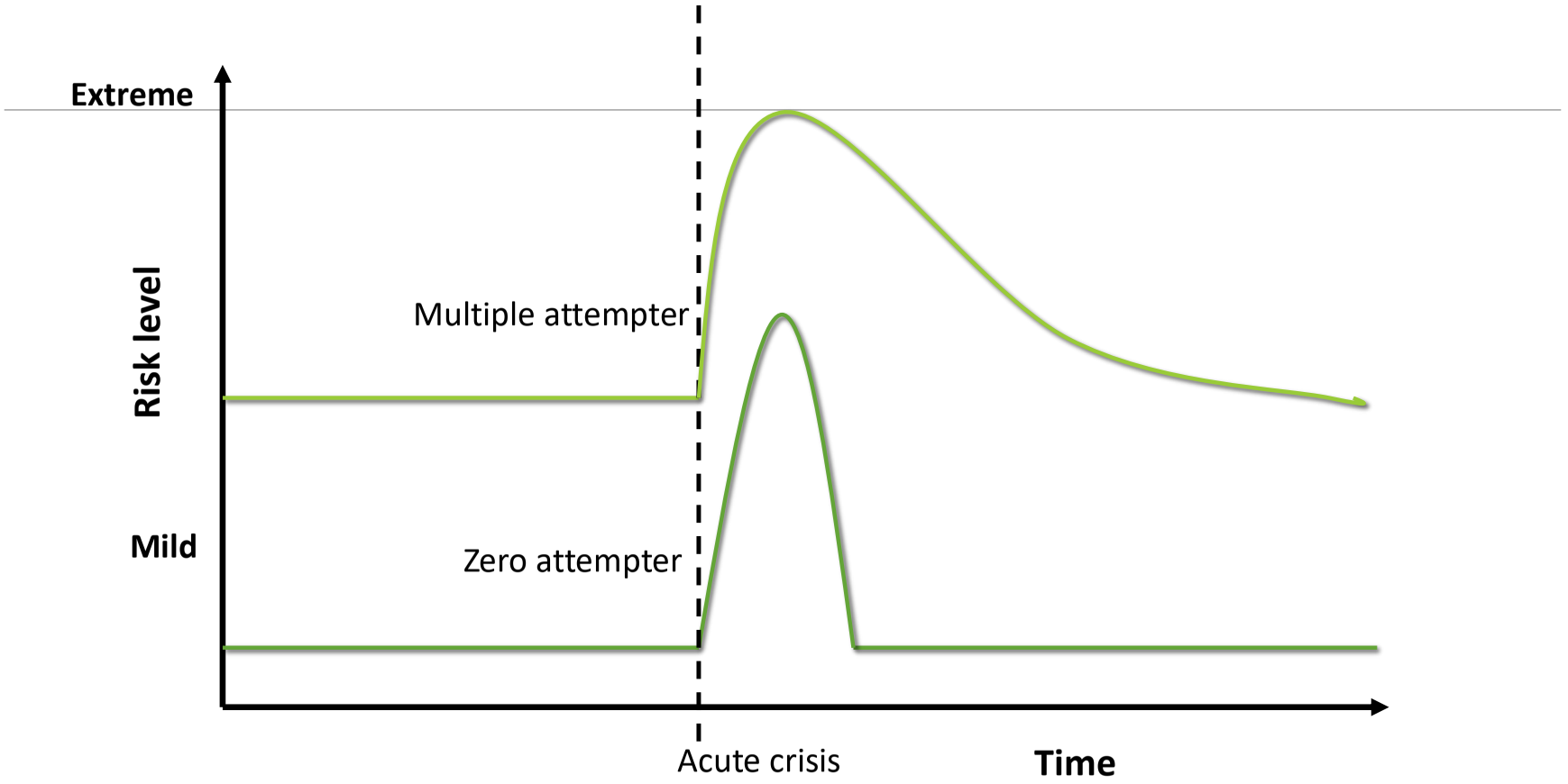
Why Bother?

Three distinct groups:

- Suicide ideator: Zero previous attempts
- Single attempter: One previous attempt
- Multiple attempter: 2 or more previous attempts



(Rosenberg et al, 2005; Rudd, Joiner, & Rajab, 1996; Wingate et al, 2004)


Extreme
Risk level
Mild
Multiple attempter
Zero attempter
Acute crisis
Time

Multiple Attempters

Objective indicators are better predictors than subjective indicators (Beck et al., 1974; Beck & Steer, 1989; Harriss et al., 2005; Hawton & Harriss, 2006)

Survival reaction can serve as indirect indicator of intent (Henriques et al., 2005)

“Worst point” suicidal episode better predictor than other episodes (Joiner et al., 2003)

Sample Questions

Have you ever tried to do anything, prepared to do anything or started to do anything to end your life?

Have you ever mentally or physically rehearsed how you might end your life?

Have you ever had a prior suicide attempt?

(if yes) Have you had two or more?

RISK ASSESSMENT

SKILL 3

Assess the Current Suicidal Episode

1. Thoughts and desires
2. Plans, preparation and rehearsal
3. Ambivalence and Intent
4. Access to **lethal** means

Current Suicidal Episode

Resolved Plans & Preparation

- Sense of courage
- Availability of means
- Opportunity
- Specificity of plan
- Duration of suicidal ideation
- Intensity of suicidal ideation

Suicidal Desire & Ideation

- Reasons for living
- Wish for death
- Frequency of ideation
- Desire and expectancy
- Lack of deterrents
- Suicidal communication

≥2 factors of suicidal desire and ideation = mild

≥1 factor of resolved plans and preparation = moderate

Anything above these = Severe or Extreme

Current Suicidal Episode

Intent

Objective

- Isolation
- Likelihood of intervention
- Preparation for attempt
- Planning
- Writing a suicide note

Subjective

- Self-report of desired outcome
- Expectation of outcome
- Wish for death
- Low desire for life

Sample Questions

Have you thought about how you might kill yourself?

Do you know where or when you might do this?

When you think about suicide, do the thoughts come and go, or are they so intense you can't think about anything else?

Have you practiced [method] in any way, or have you done anything to prepare for your death?

Do you have access to [method]?

What do you hope will happen?

Assess Intent in the Context of Ambivalence

"Most people, when they think about killing themselves, don't truly want to die, they just don't want to live if they have to keep feeling all the bad things they feel. **Is that how you feel?"**

"Most people who are thinking about suicide have reasons for living and reasons for dying – they are ambivalent. And, the things that are upsetting them are so overwhelming that they can't see any way to overcome it all, so killing themselves comes to mind, as a way to stop the pain. **Does that describe you?"**

"Is it that you want to die because you can't keep living with how you feel and you can't find any other way to make it go away? **In other words, if you could get past the things that are causing you pain, and you were feeling better, would you still want to die? Or would you want to live? "**

Examine the Patient in the Context of the Patient's Values

- **What's the most important thing to you in life right now?**
- **What are these things a barrier to you doing/being?**
- **If these were not plaguing you, what would you be focusing on in life?**

Why should the patient continue talking to you if he/she only wants to die?

Why should the patient engage in treatment with you?

Don’t try to talk the person out of killing himself/herself

…this means don’t “talk him/her off the ledge” either

…it’s like putting a band-aid on a gushing wound

Assess Access to Lethal Means

Suicidal intent has weak relationship with lethality of suicide attempt

(Brown et al., 2004; Plutchik et al., 1988; Swahn & Potter, 2001)

Patients tend to have inaccurate expectations about lethality of methods

(Beck, Beck, & Kovacs, 1975; Brown, Henriques, Sosdjan, & Beck, 2004)

Availability of means demonstrates strong association with lethality

(Eddleston et al, 2006; Peterson et al, 1985)

Assess Access to Lethal Means

Among survivors of highly lethal suicide attempts:

24% made the decision to act within 5 mins

70% made the decision to act within 60 mins

(Simon et al., 2001)

Strong link between suicide and length of time from firearm purchase

(Wintemute et al., 1999)

Means Restriction Effectiveness

Reducing access to lethal methods for suicide reduces suicide rates by that method:

- Firearms (Beautrais, 2000; Beautrais et al., 2006; Leenaars et al., 2003; Loftin et al., 1991)
- Carbon monoxide (Nordentoft et al., 2006)
- Barbiturates (Nordentoft et al., 2006)
- Pesticides (Gunnell et al., 2007)

Means Restriction Counseling Effectiveness

Of those patients or parents who receive means restriction counseling <u>following a suicide attempt</u> (vs. no counseling):

- 86% vs. 32% lock up/dispose of medications (McManus et al., 1997)
- 75% vs. 48% removed prescription meds
- 48% vs. 22% removed OTC meds
- 47% vs. 11% restricted alcohol access
- 63% vs. 0% removed firearm

(Kruesi et al., 1999)

RISK ASSESSMENT

SKILL 4

Addressing Ambivalence Head On

Some people, when they think about killing themselves, don't truly want to die, they just don't want to live if they have to keep feeling all the bad things they feel. Would you say that is what you're experiencing?

Most people who are thinking about suicide have reasons for living and reasons for dying – they are ambivalent. And, the things that are upsetting them are so overwhelming that they can't see any way to overcome it all, so killing themselves comes to mind, as a way to stop the pain. Does that describe you?

Is it that you want to die because you can't keep living with how you feel and you can't find any other way to make it go away? In other words, if you could get past the things that are causing you pain, and you were feeling better, would you still want to die? Or would you want to live?

Discuss Reasons for Living and Ambivalence

- Addresses ambivalence…hopefully it tips the scale in the right direction and it keeps the person focused on living (i.e., de-activates the suicidal mode)

"Before, we discussed how you have ambivalence about living and dying – that you don't really want to die, but you just can't stand living this way. If we could help you relieve your pain, what would that allow you to enjoy in life?"

"What is keeping you alive right now?"

"Take all the pain and put it aside in your mind for a moment; what is the most important thing to you in your life?"

Discuss Reasons for Living & Ambivalence

"Take all the pain and put it aside in your mind for a moment; what is the most important thing to you in your life?"

"These feelings and thoughts seem so overwhelming for you. What would you be doing if these weren't in the way?"

"All of these difficulties are obstacles or barriers to you living your life the way you want. What would your life look like if you weren't grappling with these barriers or obstacles?

Discuss Reasons for Living & Ambivalence

"You came in today to discuss this, which is actually evidence of your ambivalence. It suggests you're not yet ready to end your life. Did you know that? What do you think about that?"

"You've shared how difficult this has been and how overwhelmed you feel. What is keeping you from ending your life?"

Ask about Reasons for Living & Ambivalence

- Addresses ambivalence…hopefully it tips the scale in the right direction
- It keeps the person future oriented

"Before, we discussed how you have ambivalence about living and dying – that you don't really want to die, but you just can't stand living this way. If we could help you relieve your pain, what would that allow you to enjoy in life?"

"What is keeping you alive right now?"

"Take all the pain and put it aside in your mind for a moment; what is the most important thing to you in your life?"

Risk level	Clinical features		Indicated Clinical Response
	Ideator or Single Attempter	**Multiple Attempter**	
Very Low	No identifiable suicidal ideation (baseline risk level)	N/A	1. No particular changes in ongoing treatment.
Mild	Suicidal ideation of limited intensity and duration, no identifiable plans, no intent, identifiable protective factors	No identifiable suicidal ideation (baseline risk level)	1. Evaluate and re-evaluate any expressed suicidal ideation to monitor change in risk 2. Consider medication treatment 3. Increase interventions that support successful self-management strategies

Risk level	Clinical features		Indicated Clinical Response
	Ideator or Single Attempter	**Multiple Attempter**	
Moderate	Frequent suicidal ideation with moderate intensity and duration, some specific plans, minimal objective markers of intent, limited rehearsal or preparatory behaviors, identifiable protective factors	Suicidal ideation of limited intensity and duration, no identifiable plans, no intent, identifiable protective factors	1. Crisis response plan 2. Routinely reevaluate suicide risk, noting specific changes that reduce or elevate risk 3. Consider medication change if symptoms worsen or persist 4. Obtain professional consultation with a colleague following each appointment 5. Specifically target suicidal symptoms in the treatment plan 6. Means restriction counseling

Risk level	Clinical features		Indicated Clinical Response
	Ideator or Single Attempter	**Multiple Attempter**	
High	Frequent, intense, and enduring suicidal ideation, specific plans, clear objective markers of intent, rehearsal or preparatory behaviors, few if any protective factors	Frequent suicidal ideation with moderate intensity and duration, some specific plans, minimal objective markers of intent, limited rehearsal or preparatory behaviors, few if any protective factors	1. Consider referral for inpatient hospitalization evaluation (voluntary or involuntary, depending on situation) 2. Obtain professional consultation with a colleague following each appointment 3. Specifically target suicidal symptoms in the treatment plan 4. Crisis response plan 5. Means restriction counseling

Assessing protective factors?

Protective Factors

Less empirical support than risk factors

Buffer against suicide risk, but do not necessarily reduce or remove risk

Provide clues for intervention

Often prime positive emotional states

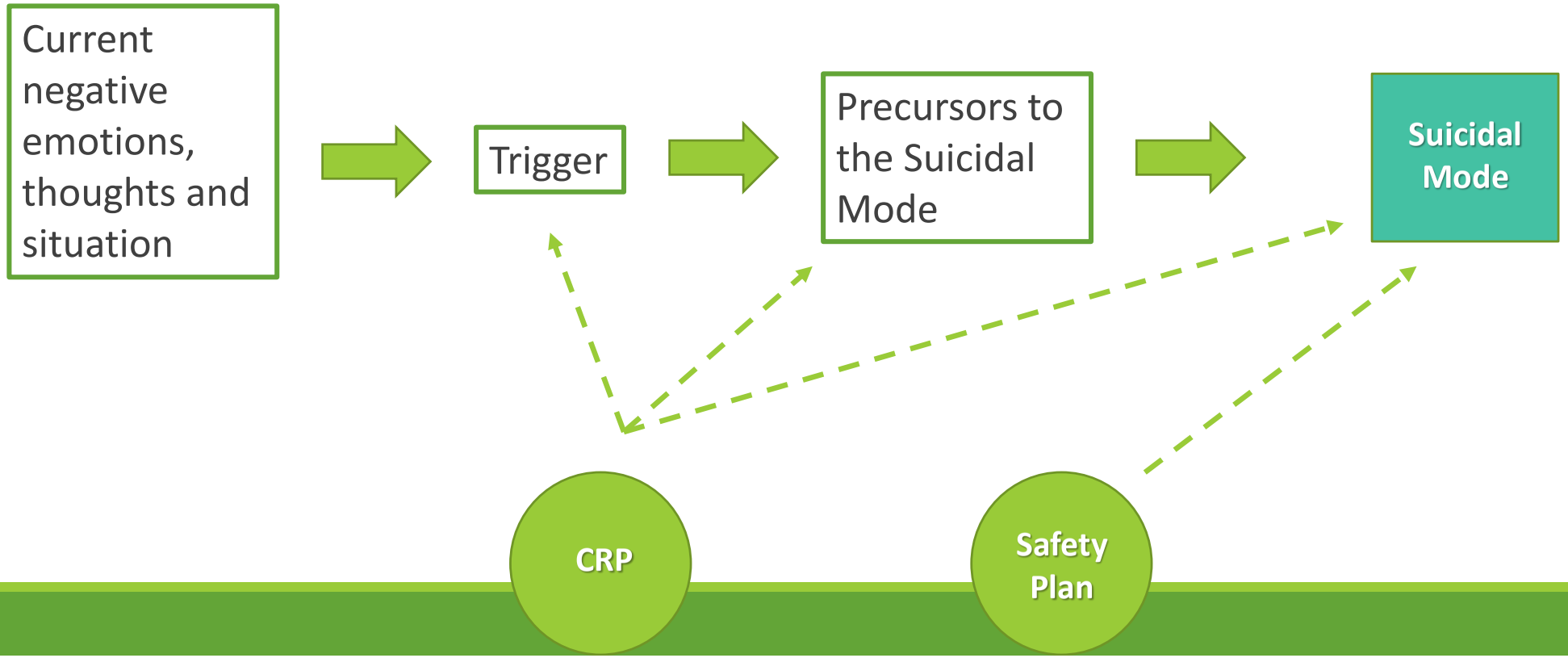
RISK ASSESSMENT

SKILL 5

Crisis Response Plan (CRP) vs Safety Plan

- Do we want to passively keep people safe?
- Do we want people to proactively work on coping differently?
- Do we want to change the sequence of events that reliably precede the patient's suicidal thoughts?
- Prompting them to think about and focus on their reasons for living is a critical differentiator.

Crisis Response Plan (CRP)



Crisis Response Plan (CRP)

Decision-making aid

Specific instructions to follow during crisis

Developed collaboratively

Purposes:

1. **Facilitate honest communication**
2. Establish **collaborative** relationship
3. Facilitate **active involvement of patient**
4. Enhance patient's commitment to **treatment**
5. **Develop healthier coping skills**

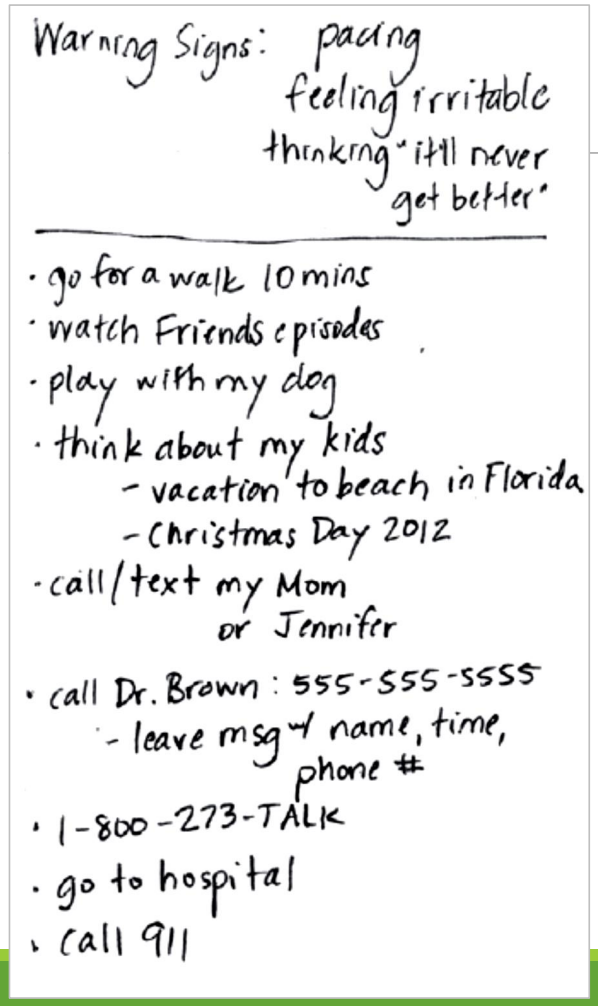
(Rudd, Mandrusiak, & Joiner, 2006)

Crisis Response Plan (CRP)

The CRP immediately reduces negative emotional distress and suicidal intent among suicidal individual (Bryan et al., 2017a).

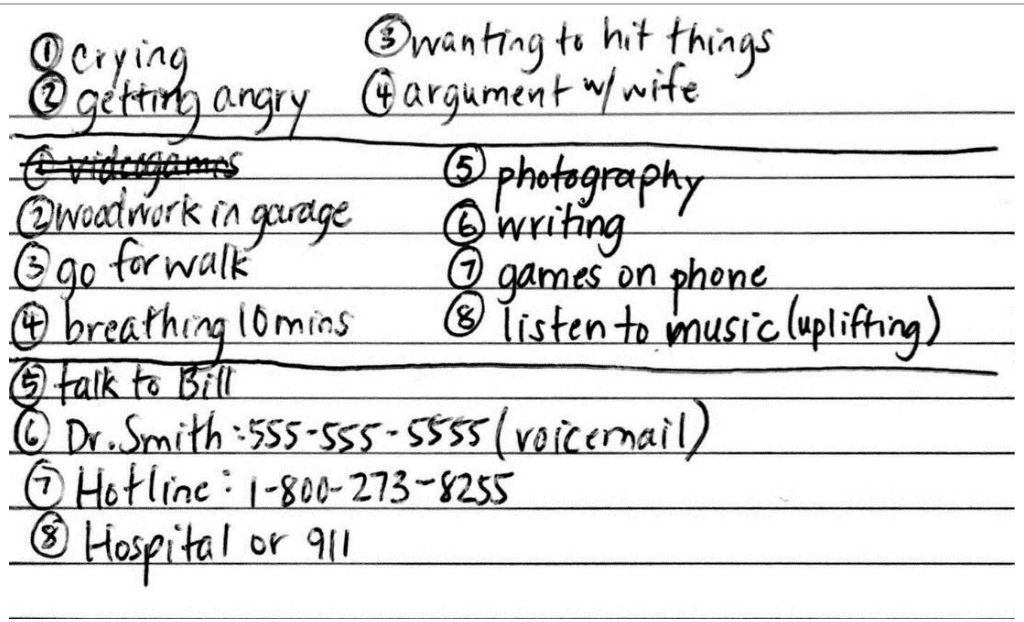
Discussing an individual's **reasons for living** during the CRP increases hope, leads to larger reductions in suicidal intent, and decreases the likelihood of psychiatric hospitalization (Bryan et al., 2017b).

Sample Crisis Response Plans



Warning Signs: pacing
feeling irritable
thinking "it'll never get better"

- go for a walk 10 mins
- watch Friends episodes
- play with my dog
- think about my kids
  - vacation to beach in Florida
  - Christmas Day 2012
- call/text my Mom or Jennifer
- call Dr. Brown: 555-555-5555
  - leave msg w/ name, time, phone #
- 1-800-273-TALK
- go to hospital
- call 911



① crying
② getting angry
③ wanting to hit things
④ argument w/ wife

~~① videogames~~
② woodwork in garage
③ go for walk
④ breathing 10 mins
⑤ talk to Bill
⑥ Dr. Smith: 555-555-5555 (voicemail)
⑦ Hotline: 1-800-273-8255
⑧ Hospital or 911

⑤ photography
⑥ writing
⑦ games on phone
⑧ listen to music (uplifting)

Crisis Response Plan (CRP)

Helping patients create AND USE a CRP is one of the most effective tools you can provide.

Warning Signs

Pacing
Feeling angry
"I can't take this anymore"

Self-Management

Go for a walk
Listen to some music
Play games on my phone

Reasons For Living

My kids (Tim and Lisa)
My wife (Susan)

Social Support

Call Susan (wife): 555.555.5555
Call John (friend): 555.555.5555

Crisis & Professional Services

Call my doctor & leave a message: 555.555.5555
Call hotline: 1.800.273.TALK
Crisis text line: 838255
Go to hospital
Call 911

Suicide Risk Assessment Plan

- ❑ Ask about suicidal thoughts differentiate these from nonsuicidal thoughts
- ❑ Ask about any history of suicide attempts
- ❑ Ask about current suicidal thoughts (frequency, duration, intensity)
- ❑ Ask about any plans (preparation, rehearsal) and access to means
- ❑ Explain ambivalence – ask if the person feels ambivalent and assess intent in the context of ambivalence
- ❑ Transition discussion to reasons for living (in light of ambivalence)
- ❑ Develop a crisis response plan -> not simply a safety plan → NEVER a safety contract!

Suicide Documentation Plan

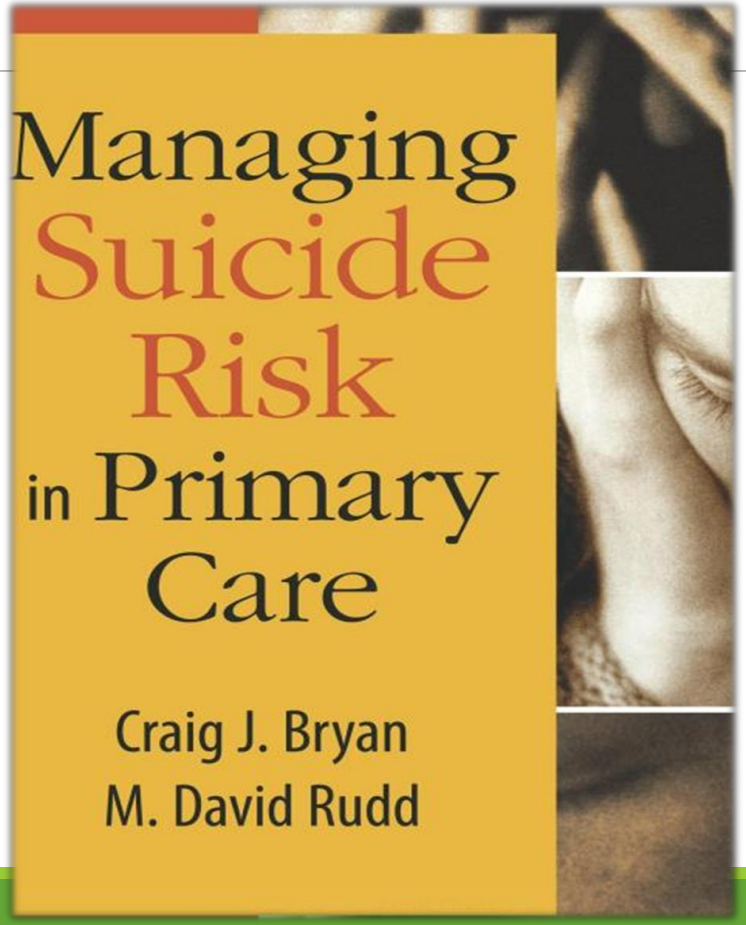
- ❑ Document presence/absence of suicidal thoughts vs. death ideation
- ❑ Document number of prior suicide attempts
- ❑ Document presence/absence any plans and access to means
- ❑ Document static and dynamic risk factors; **protective factors;** frequency duration and intensity of current suicidal thoughts, plans and intent
- ❑ Document your explicit discussion of ambivalence and the patient's response
- ❑ Document your discussion of reasons for living
- ❑ Document that patient agreed to outpatient treatment (insert type) with use of a crisis response plan

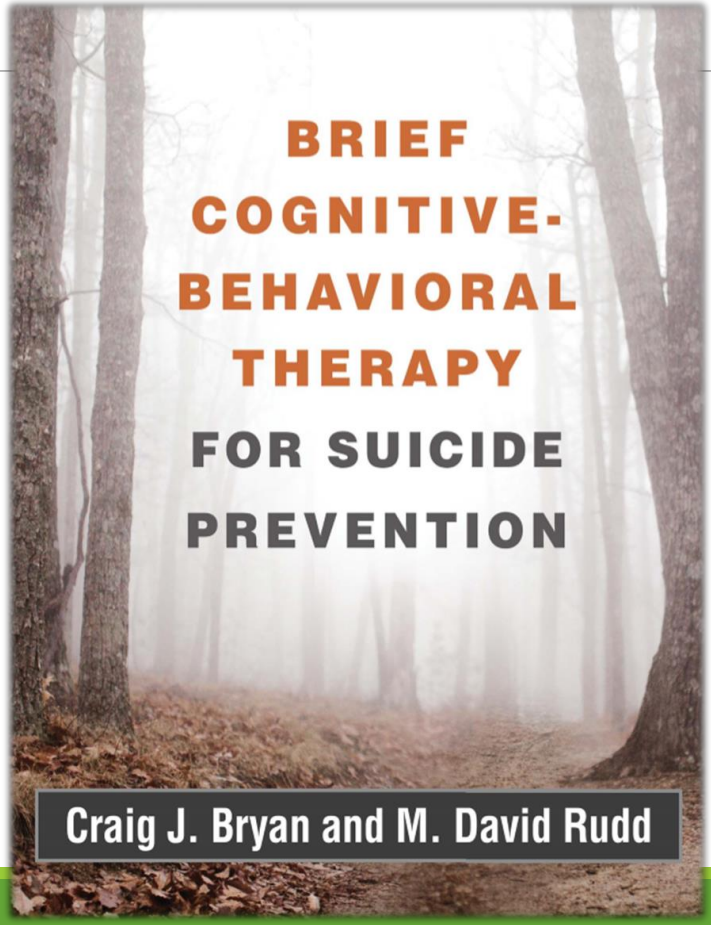
Postvention

Postvention is psychological first aid, crisis intervention, and other support offered after a suicide to affected individuals, a community or organization as a whole to alleviate possible negative effects of the event.

(Smith, Rivero, & Cimini. (2010, June 8). Postvention as a Prevention Tool: Developing a Comprehensive Postvention Response for Your Campus. A webinar of the Suicide Prevention Resource Center. http://www.sprc.org/news-events/events/postvention-prevention-tool-developing-comprehensive-postventionresponse-your-ca)

Book Recommendations





Resources

- National Suicide Hotline: 1-800-273-TALK
- www.suicidology.org
- www.sprc.org/library/SafeMessagingfinal.pdf
- https://afsp.org/ (local chapters exist in almost every state)
- https://www.crisisconnections.org/get-training/schools/
- https://www.sprc.org/resources-programs/youth-suicide-prevention-program-yspp
- https://www.crisisconnections.org/teen-link/

Arkansas Resources

Arkansas Lifeline Call Center—1-800-273-TALK or http://www.suicidepreventionlifeline.org/ are the places to go for those who are in immediate crisis. The line is answered 24/7 in-state, and has a separate line for veterans who are in crisis, pressing #1.

Arkansas Crisis Center
1-888-274-7472
https://www.arcrisis.org/

AFSP (American Foundation for Suicide Prevention)- Arkansas
(888) 274-7472

NAMI Arkansas
(800) 844-038

Mental Health Council of Arkansas
(501) 372-7062

In the event of an emergent situation please call 911 or go to your nearest emergency room.

Questions

ARKANSAS BEHAVIORAL HEALTH INTEGRATION NETWORK (ABHIN)

Questions? Please email: kent@ncrbehavioralhealth.com