PROSPER: Module I

Proactive
Reduction
Of
Suicide in
Populations via
Evidence-based
Research

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PRINCIPAL, NATIONAL CAPITAL REGION BEHAVIORAL HEALTH

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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%.

6) Provide brief interventions to de-activate the suicide mode.

PROSPER

Pre-Course Knowledge Check

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.

SubTalk www.mta.info New York City Transit *Going your way*

George E. Pataki, Governor, State of New York — Peter S. Kalikow, Chairman, MTA

How does one “Say Something?”

Myth:

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

Reality:

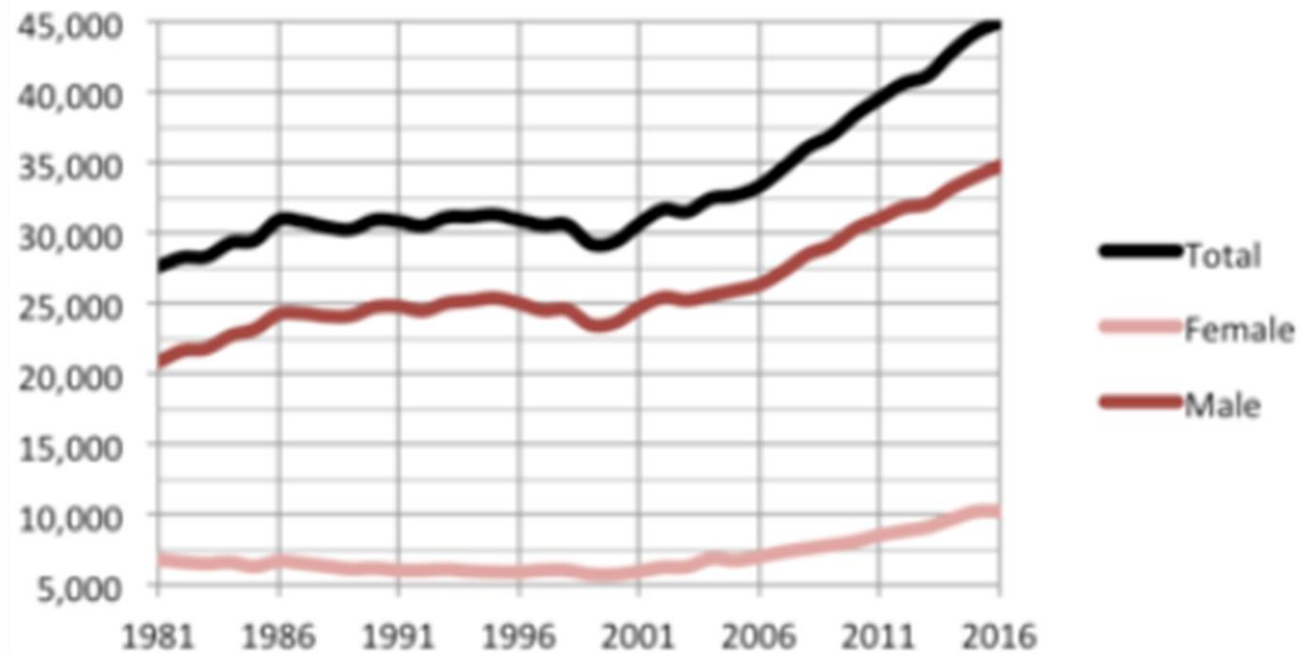
There is no evidence that asking a person if he/she/they are having suicidal thoughts results in more suicidal symptoms.

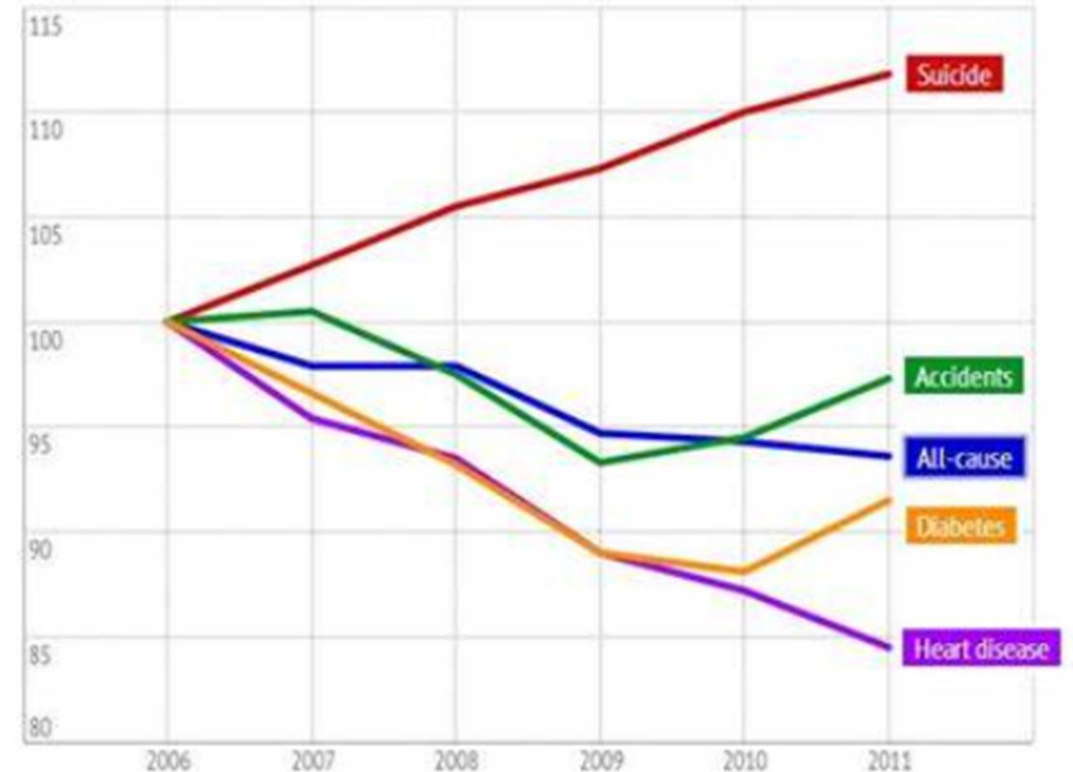
…you're not going to give someone any ideas the individual hasn't already considered.

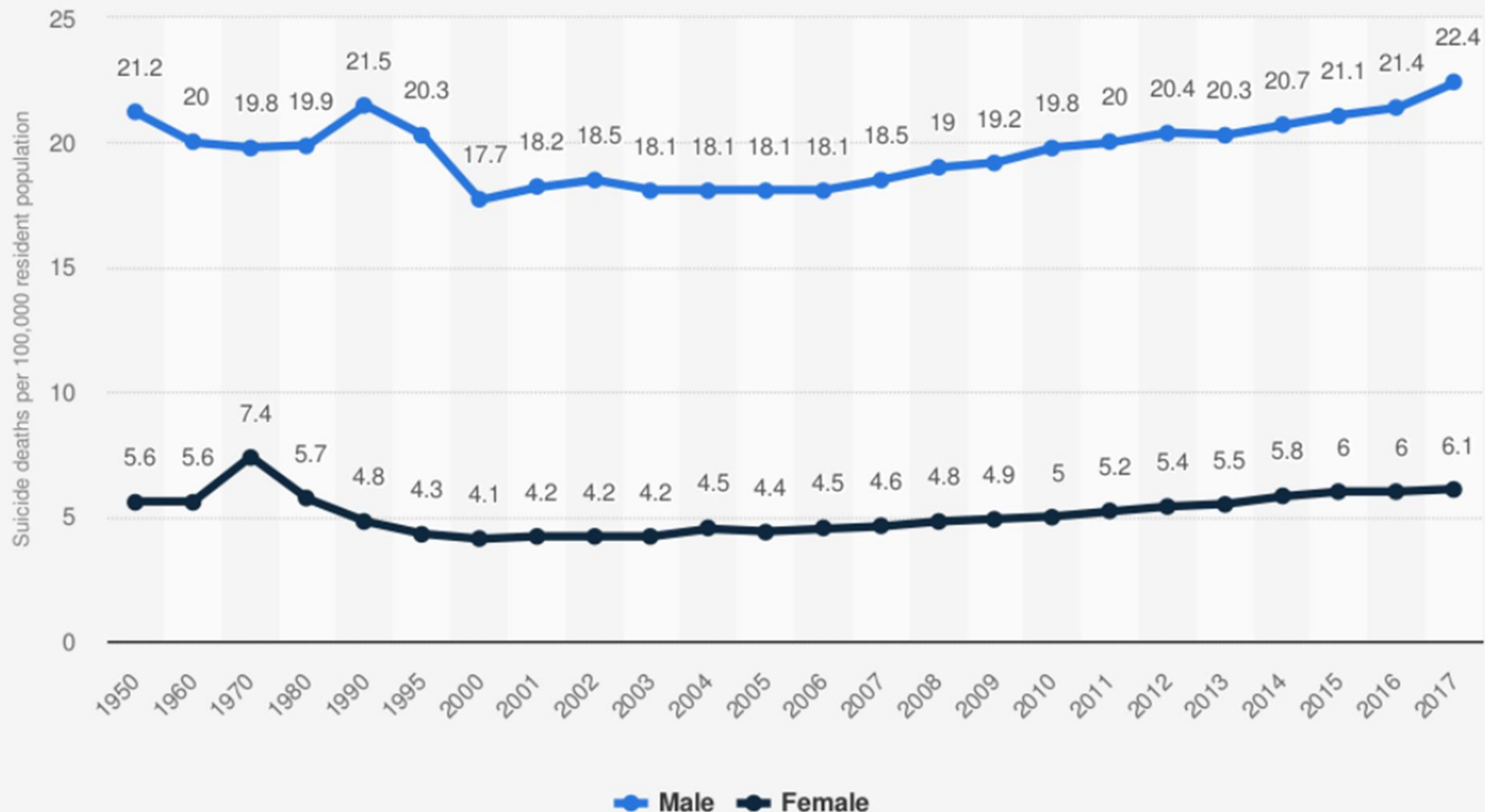
Why Do Gatekeeper Programs Sometimes Fall Short of Solving the Problem?

- Is the "right" help always available?
- Is everyone willing to help others?
- Does everyone in need want help?
- Do some cultural elements run contrary to gatekeeper theory?
- How might some people feel if another person encourages the individual to seek help?

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
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Sources
US Department of Health and Human Services; CDC
© Statista 2019
Additional Information:
United States; CDC; NCHS; all ages

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

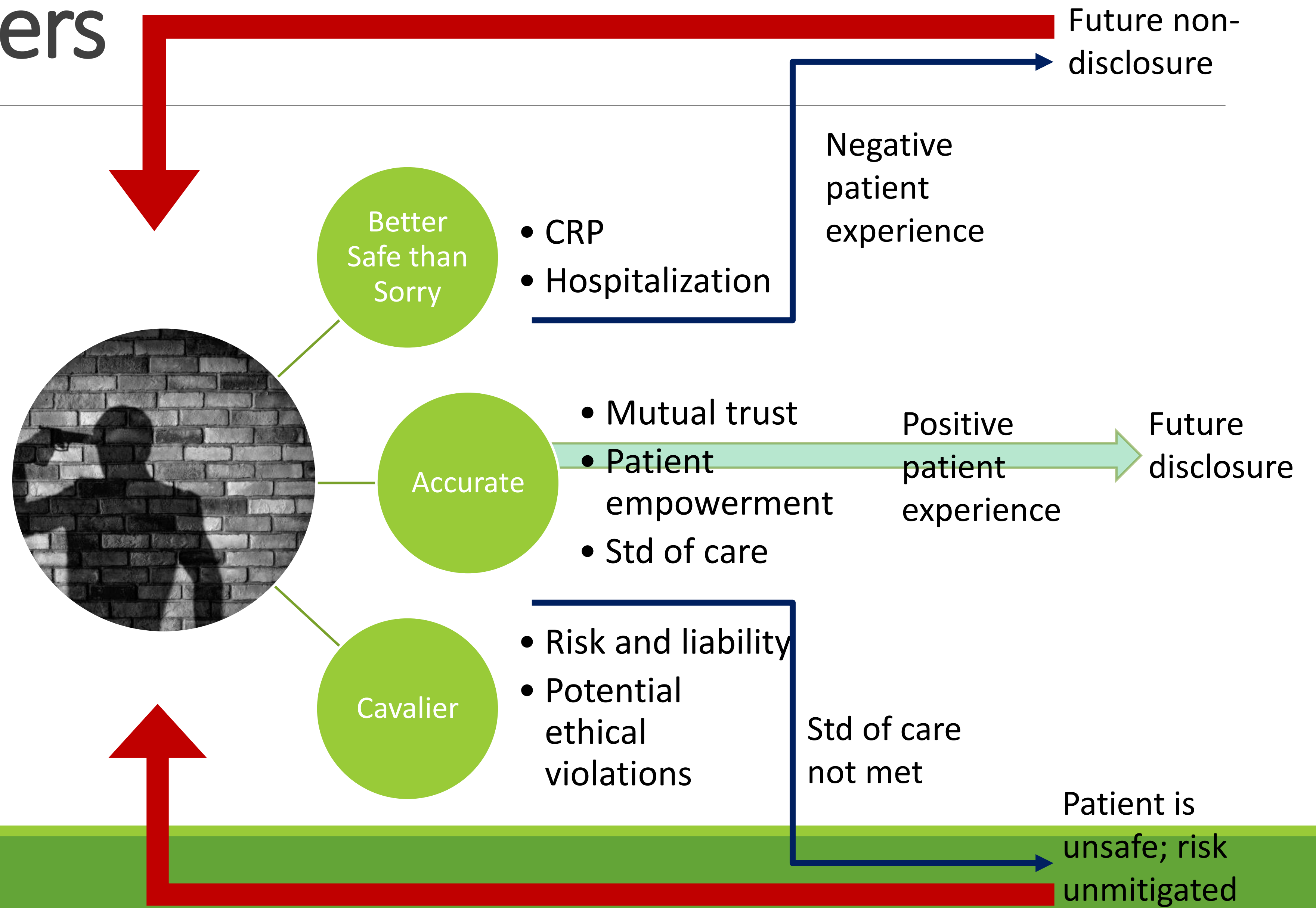
1. Risk Factors
2. Protective Factors

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

1. Ideation
2. Plans
3. Intent

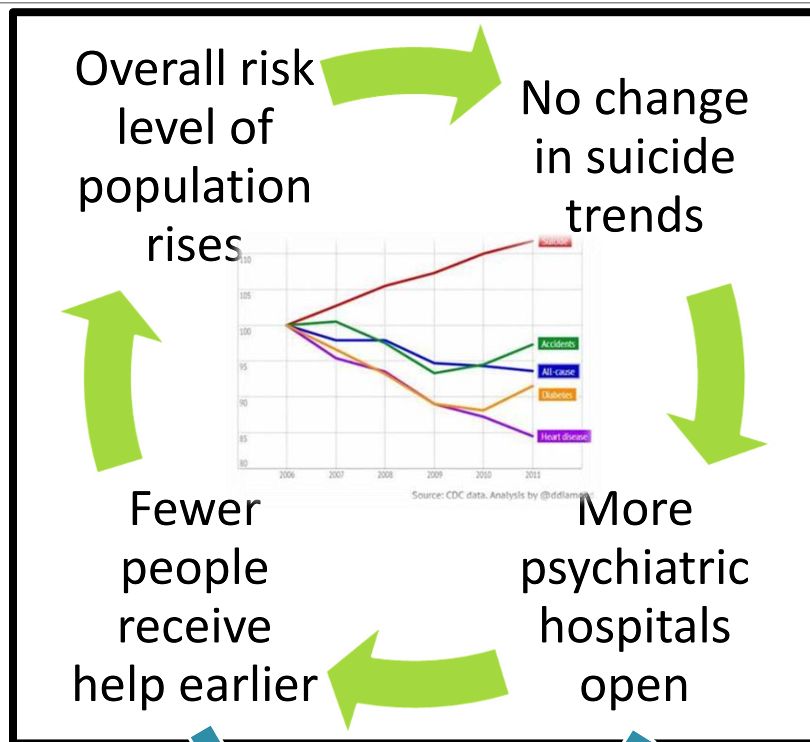
This is insufficient and antiquated.

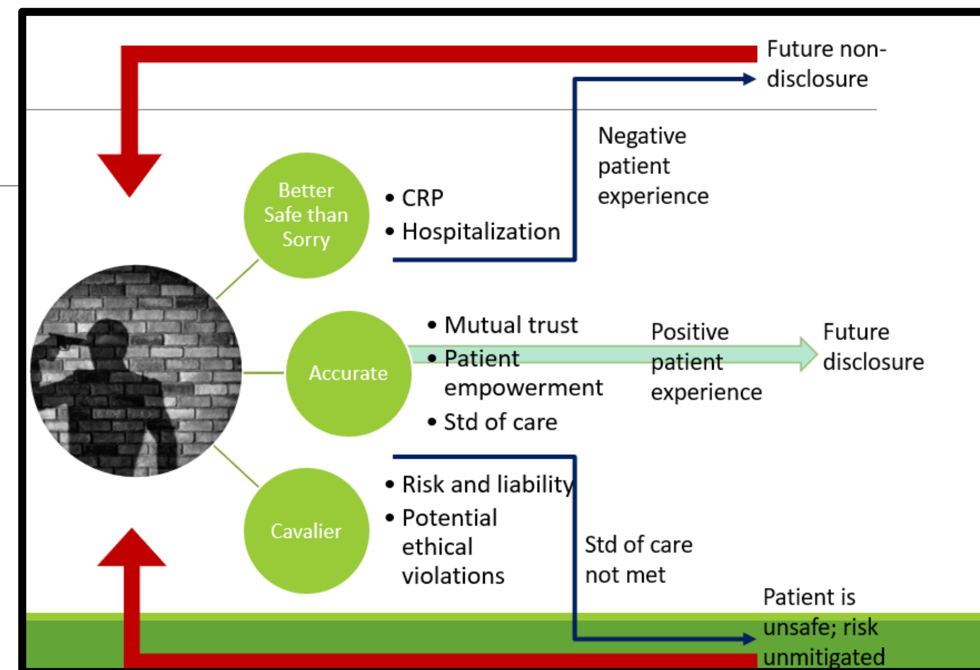
A Problematic Cycle among Providers



At the System Level…

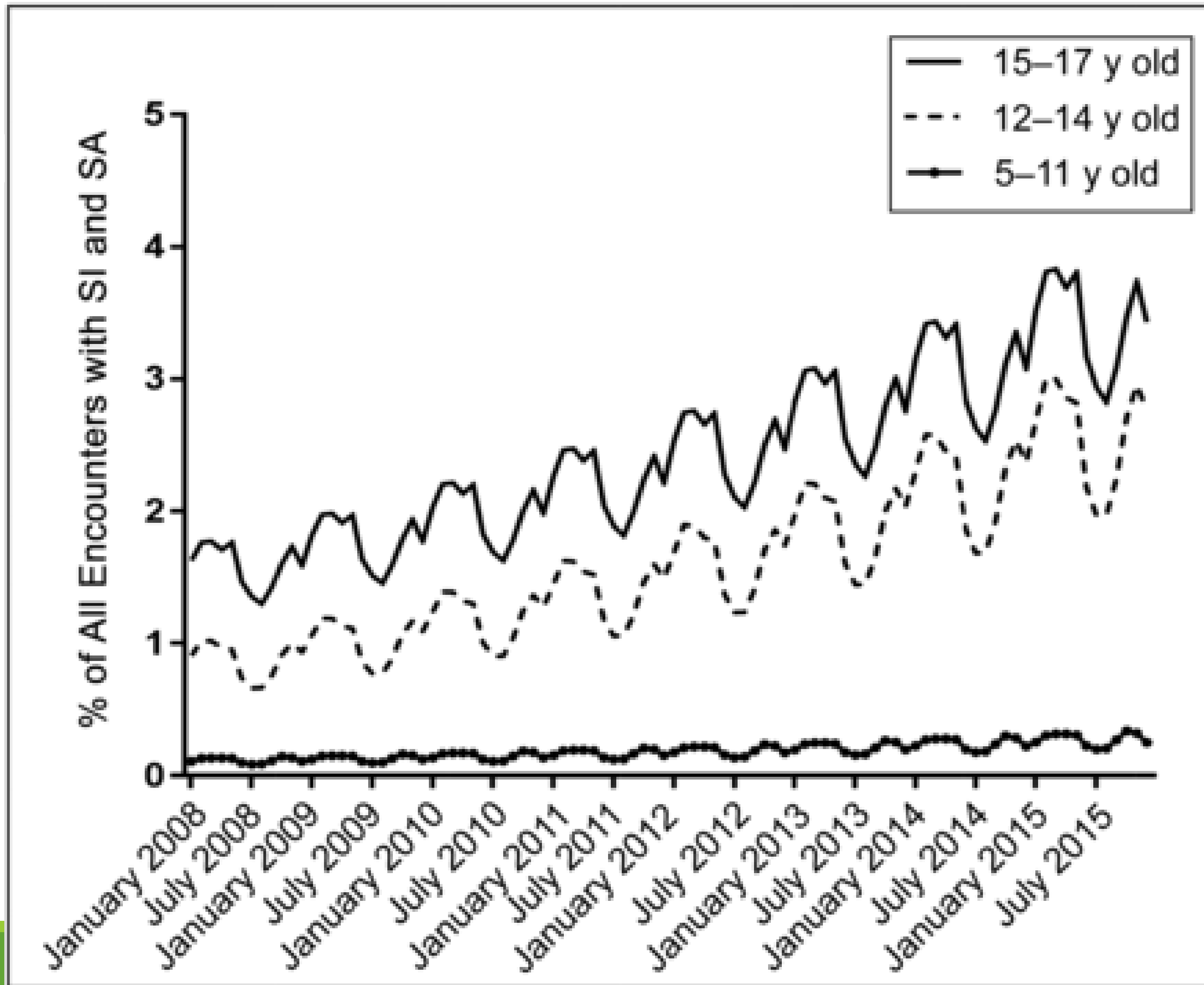
A Problematic Cycle





Outpatient MH providers' suicide management skills decline

Pediatric Hospitalizations



Plemmons et al., 2018

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).

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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.

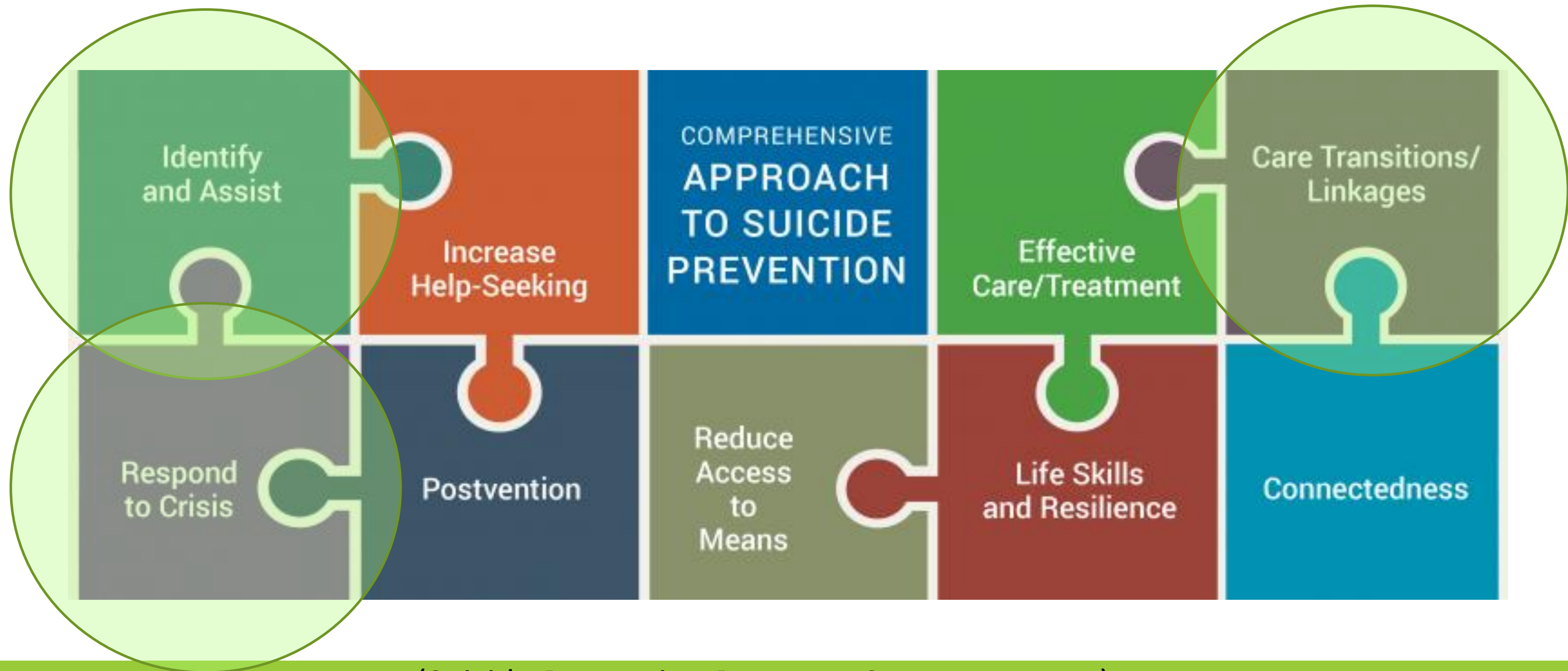
→ More than 97 percent of this cost was due to lost productivity. The remaining 3 percent were costs associated with medical treatment.

→ 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.

(Shepard et al., 2016)

A Spectrum of Suicide Prevention Actions

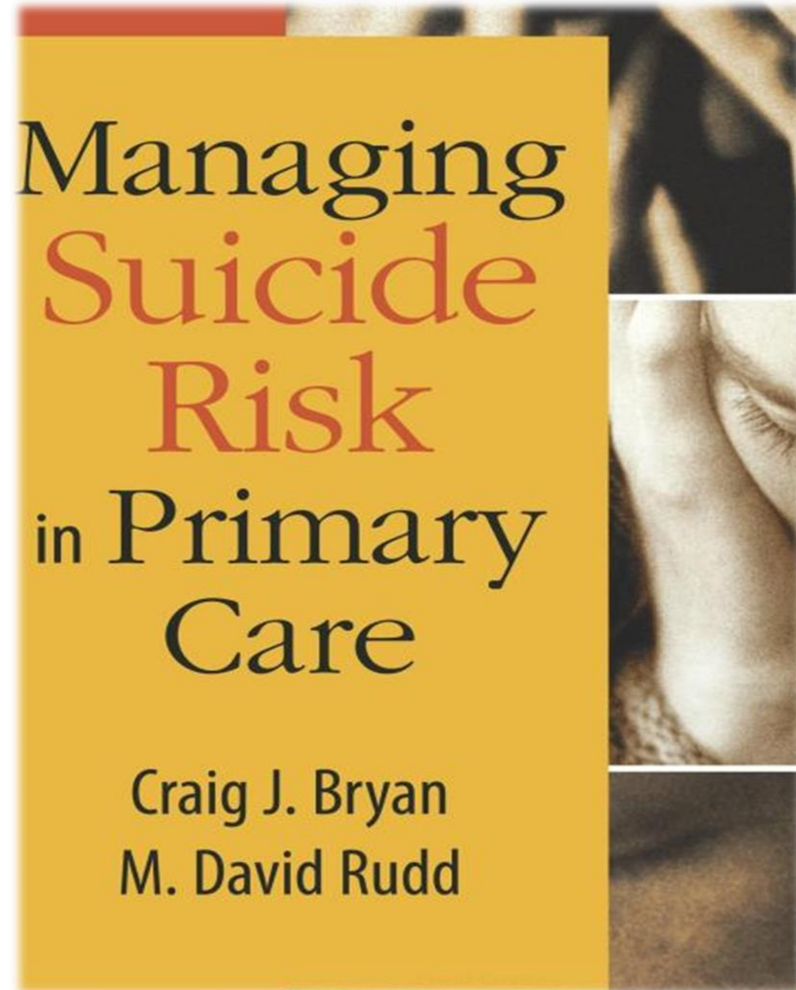


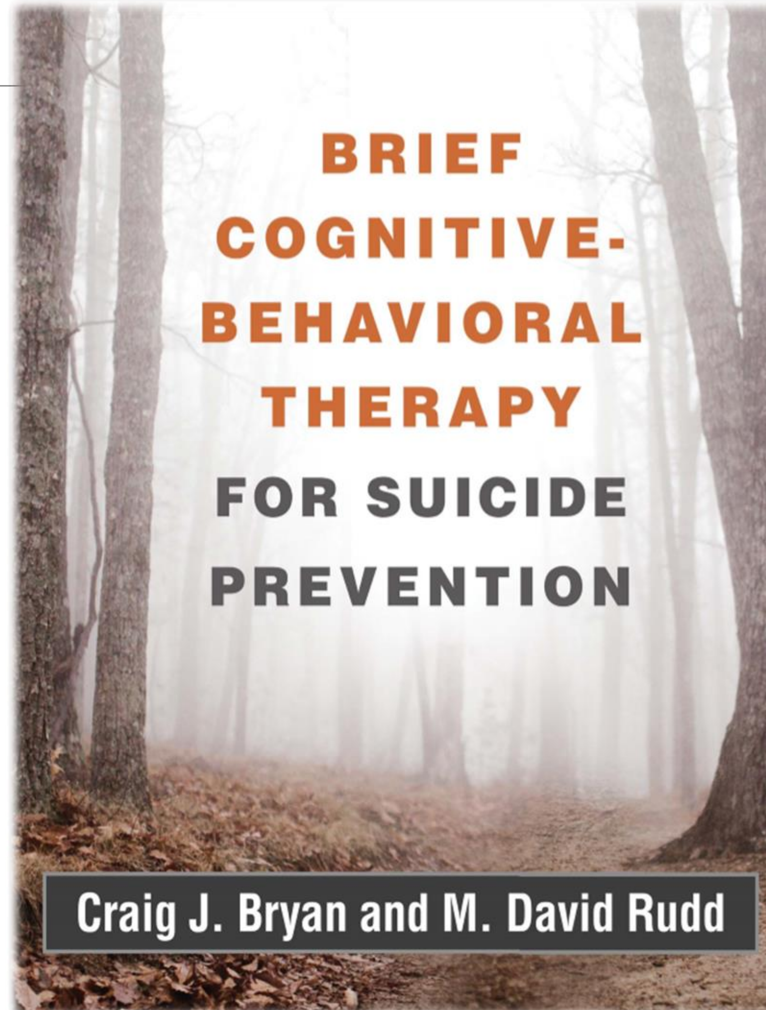
(Suicide Prevention Resource Center; sprc.org)

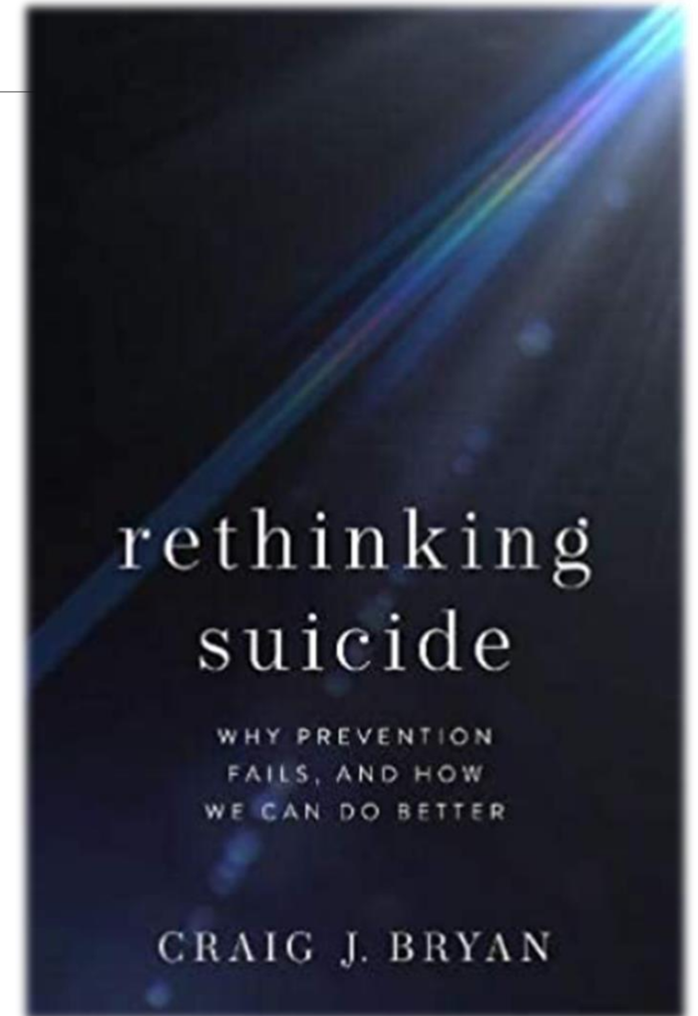
Resources

- 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/

Book Recommendations







Questions

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