PROSPER: Module II

Proactive
Reduction
Of
Suicide in
Populations via
Evidence-based
Research

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PRINCIPAL, NATIONAL CAPITAL REGION BEHAVIORAL HEALTH

NCR 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.

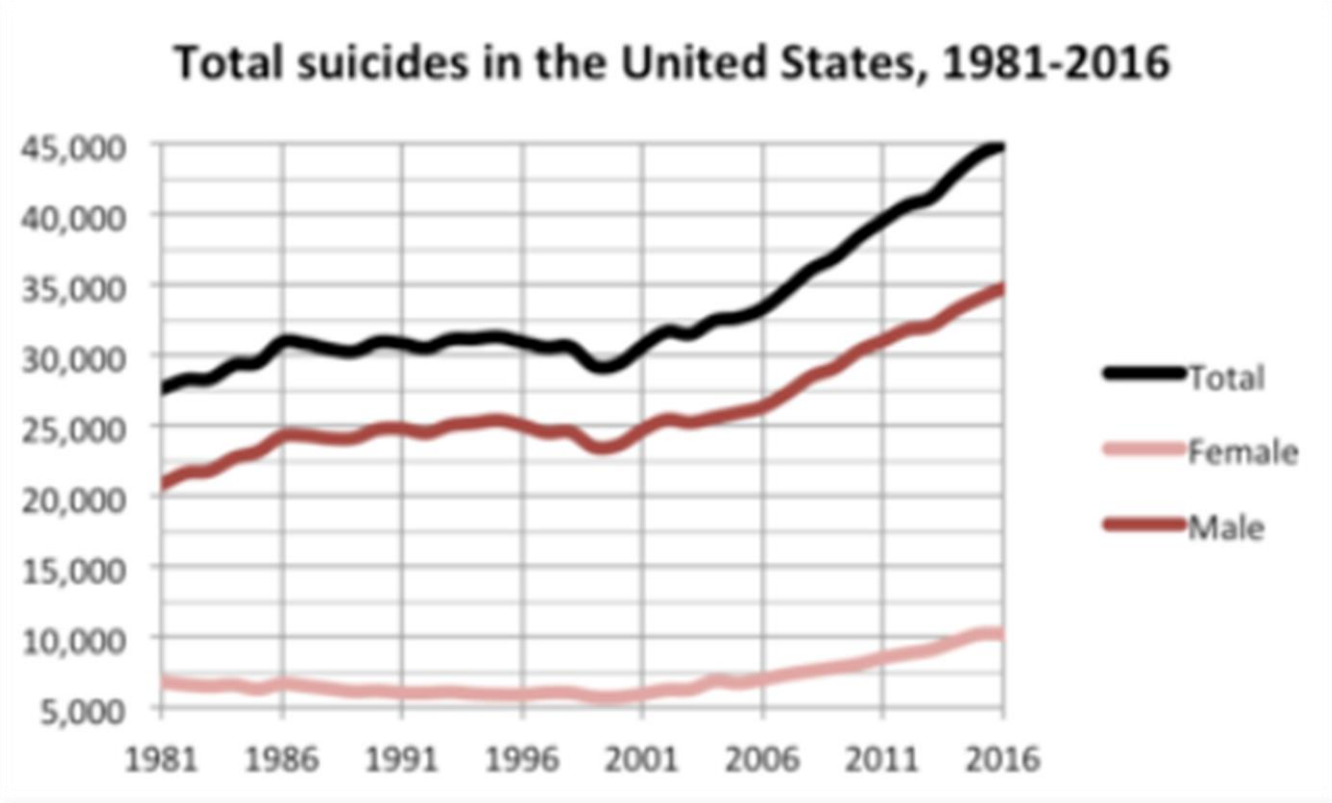
3) Assess suicide risk in 10-15 minutes.

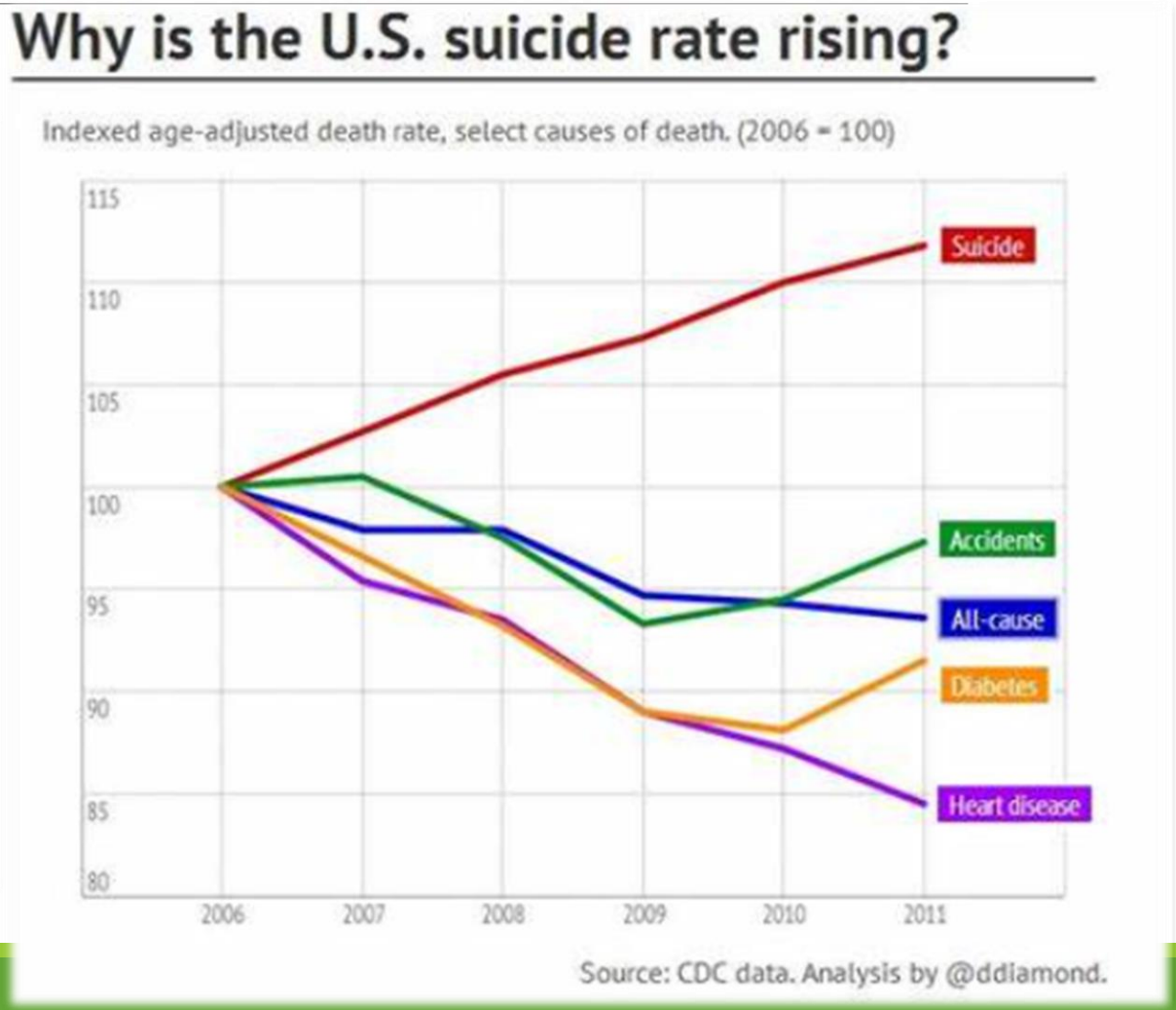
4) Discuss with patients ambivalence and reasons for living.

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

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

A Persistent Upward Trend





Traditional Suicide Risk Assessment Methods

White

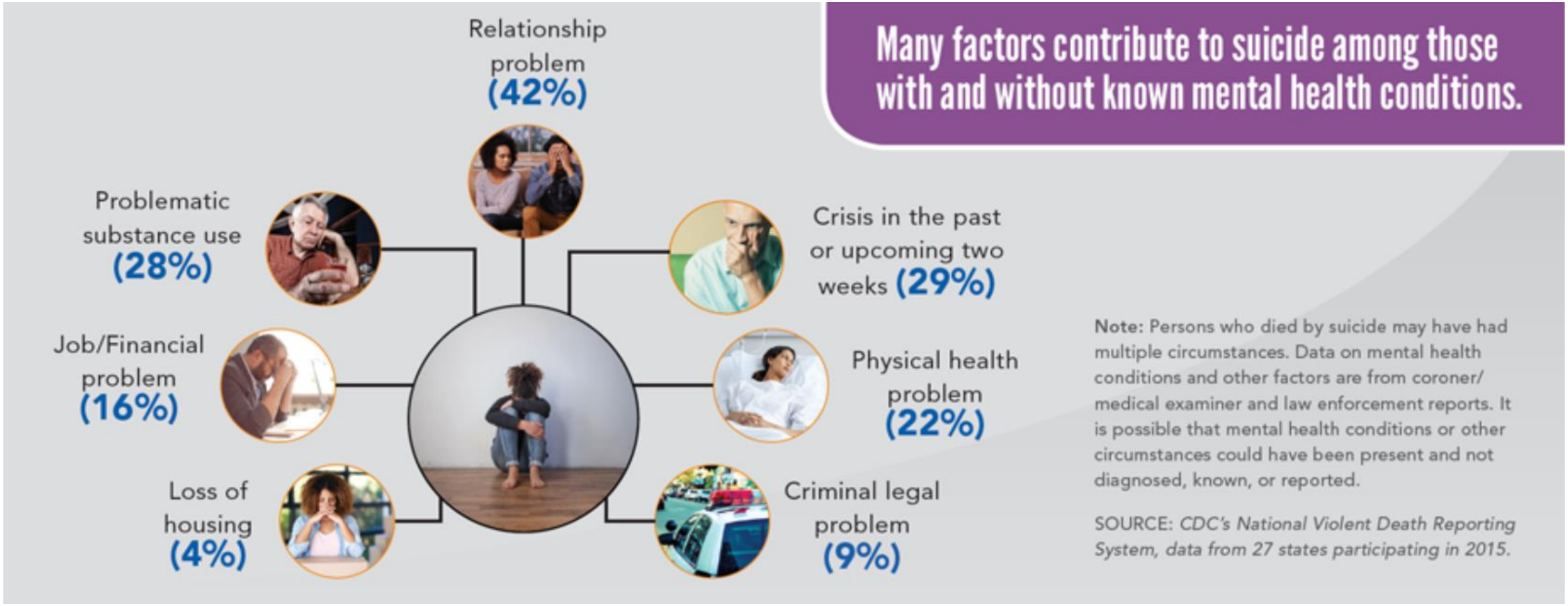
Male

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[a]
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).

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)

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

- Suicidal patients report poorer health and visit medical providers more often (Goldney et al, 2001)
  - Greater levels of bodily pain
  - Lower energy
  - More physical limitations

- Medical visits increase in frequency in weeks preceding death by suicide (Juurlink et al, 2004)
  - Up to 3 visits per month for suicidal patients

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.

Role of Nurses and Medical Assistants

- Screening for suicidal symptoms
- Care coordination and facilitation of disposition

(Bryan, Corso & Macalanda 2014)

Role of PCP

- Follow-up assessment and risk determination
- Warm hand-off
- Medication management

(Bryan, Corso & Macalanda, 2014)

Role of BHC

- Integration of MH into primary care is practical and effective approach
- Risk assessment primarily
- Additional management interventions if needed
- Transition/bridge to specialty MH services

(Bryan, Corso & Macalanda, 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 suicidal 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

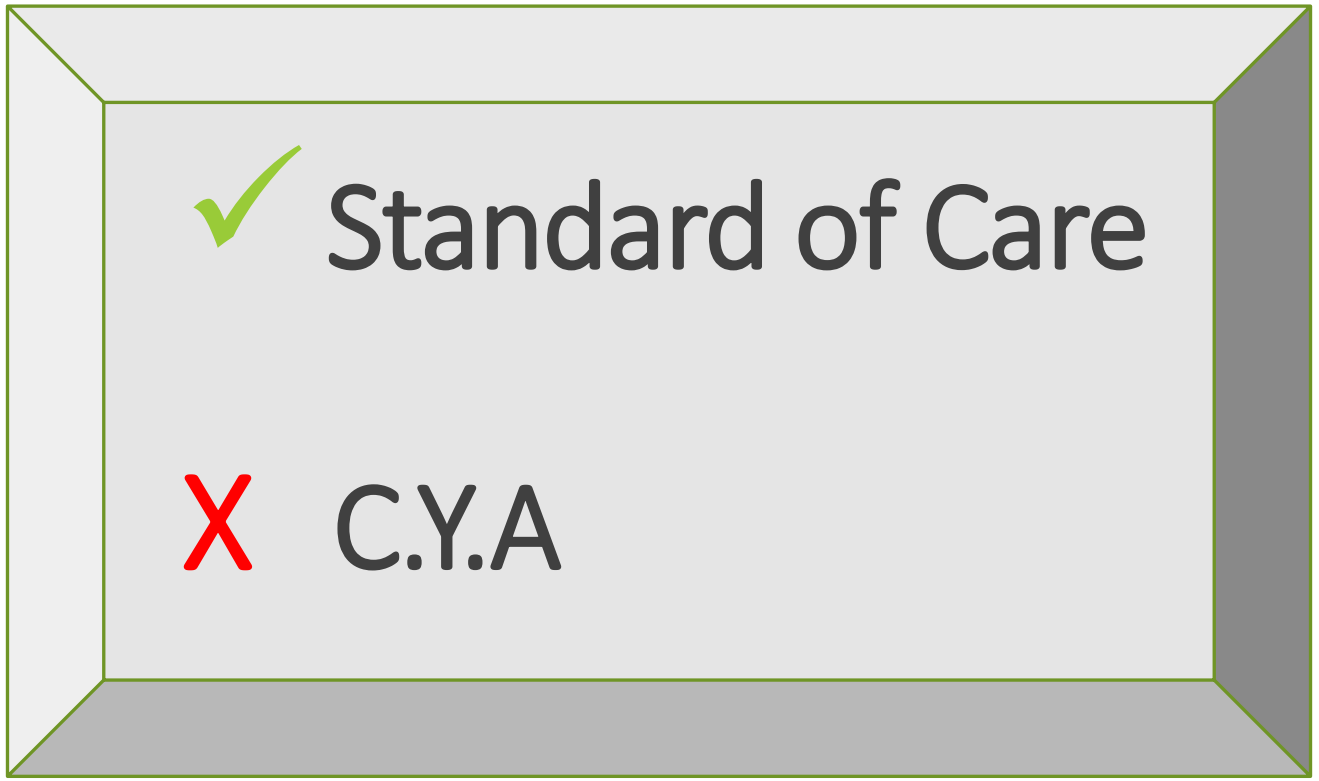
Essentially, the standard of care has been shaped more by *failures* in standard clinical practice with suicidal patients than empirical findings demonstrating what actually works (or does not work) with this population.

Standard of Care

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

- What are the implications of this?
  - Locally defined
  - Compare to a true “peer”
- What does this mean for us?
- What is our **job** when we see a patient with suicidal symptoms?


✓ 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 manipulation…isn't this still a serious problem?

Suicide is a State of…

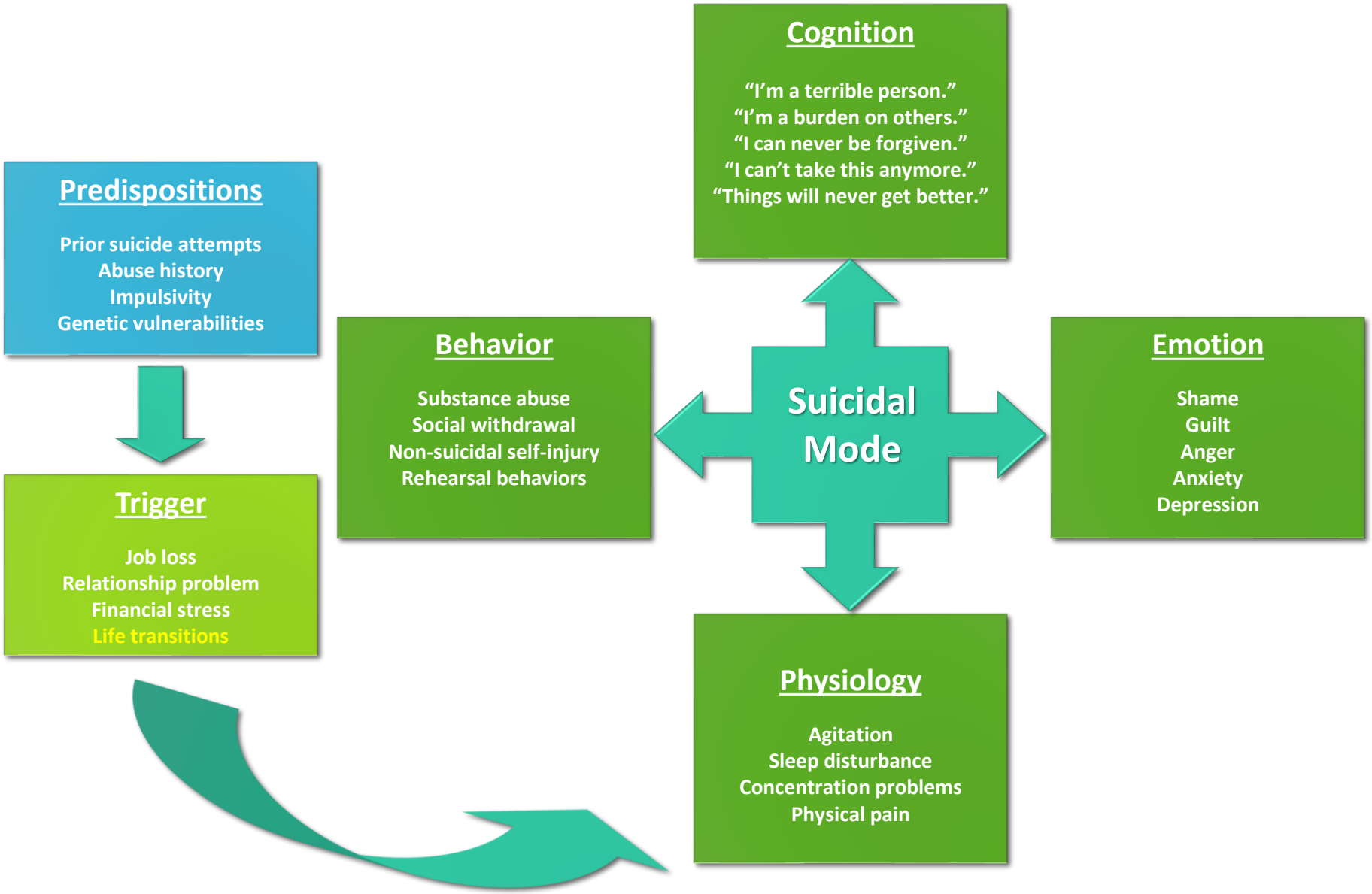
- Hopelessness
- Burdensomeness
- Powerlessness
- Thwarted Belongingness
- Ambivalence

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.


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

Observations

1. How did her affect change overtime?

2. What did you observe of her (apparent) cognitive process and speech/language as the video played on?

3. What increased or decreased as the video progressed?

What do Patients Believe about their Suicidal Symptoms?

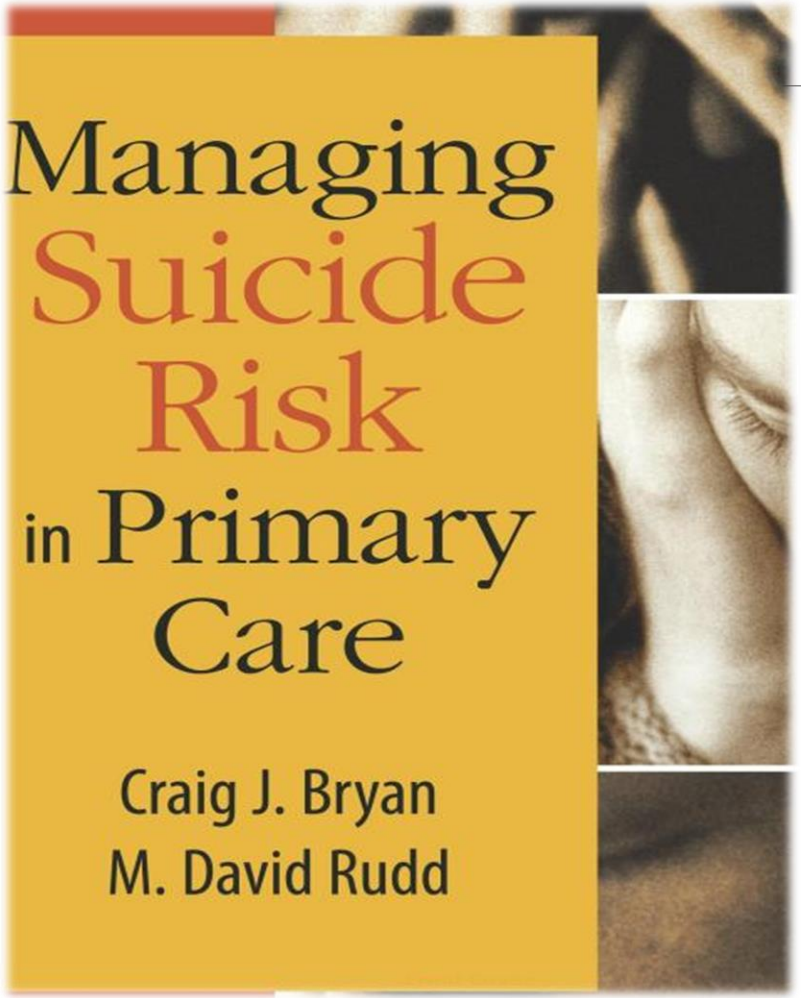
- I’m going crazy
- Since I’ve never felt this way before, I can’t relate to myself – I don’t feel like me
- I am losing control of myself
- I might not be able to stop myself from acting on my suicidal thoughts
- I’m not who I thought I was

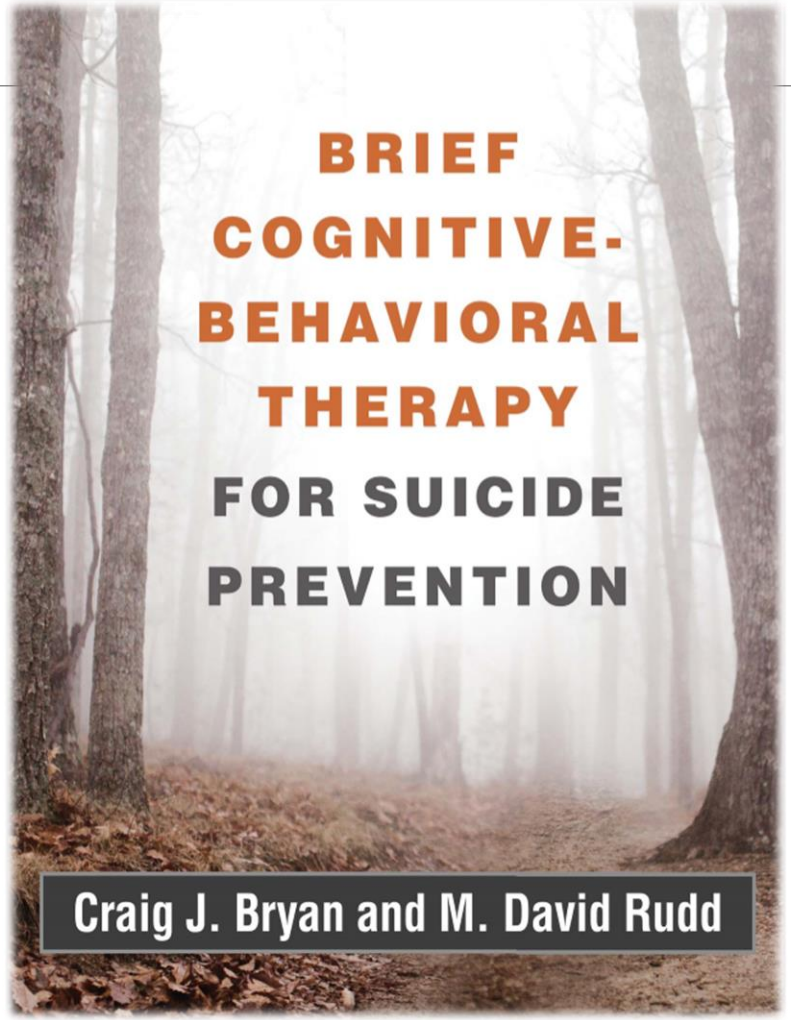
Help them avoid believing all of these!

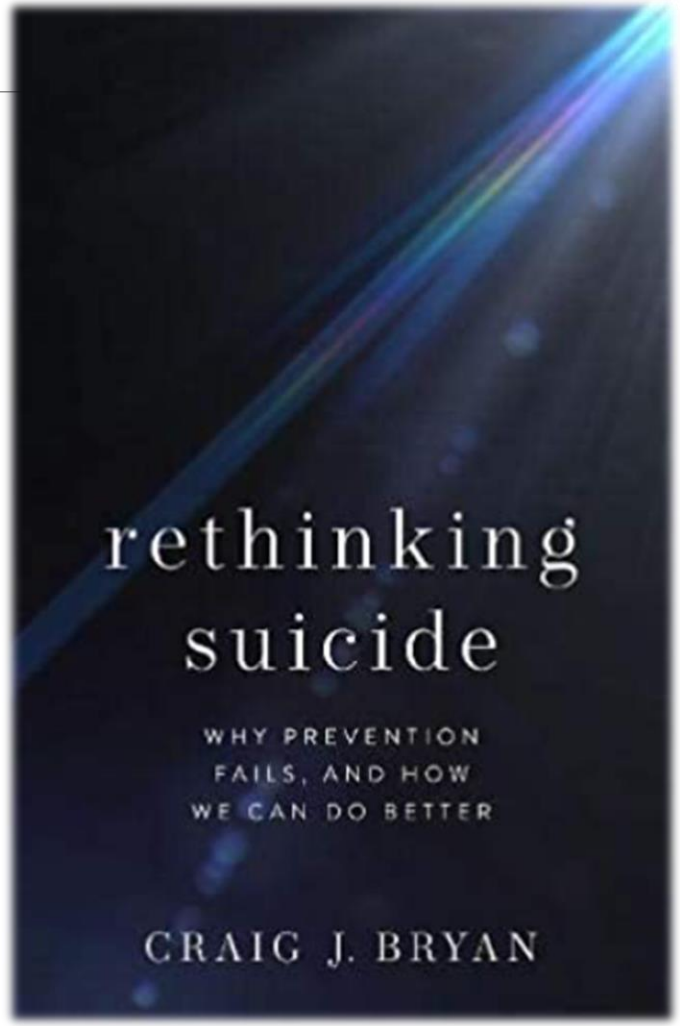
Resources

- 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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