# PROSPER: Module IV

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.**

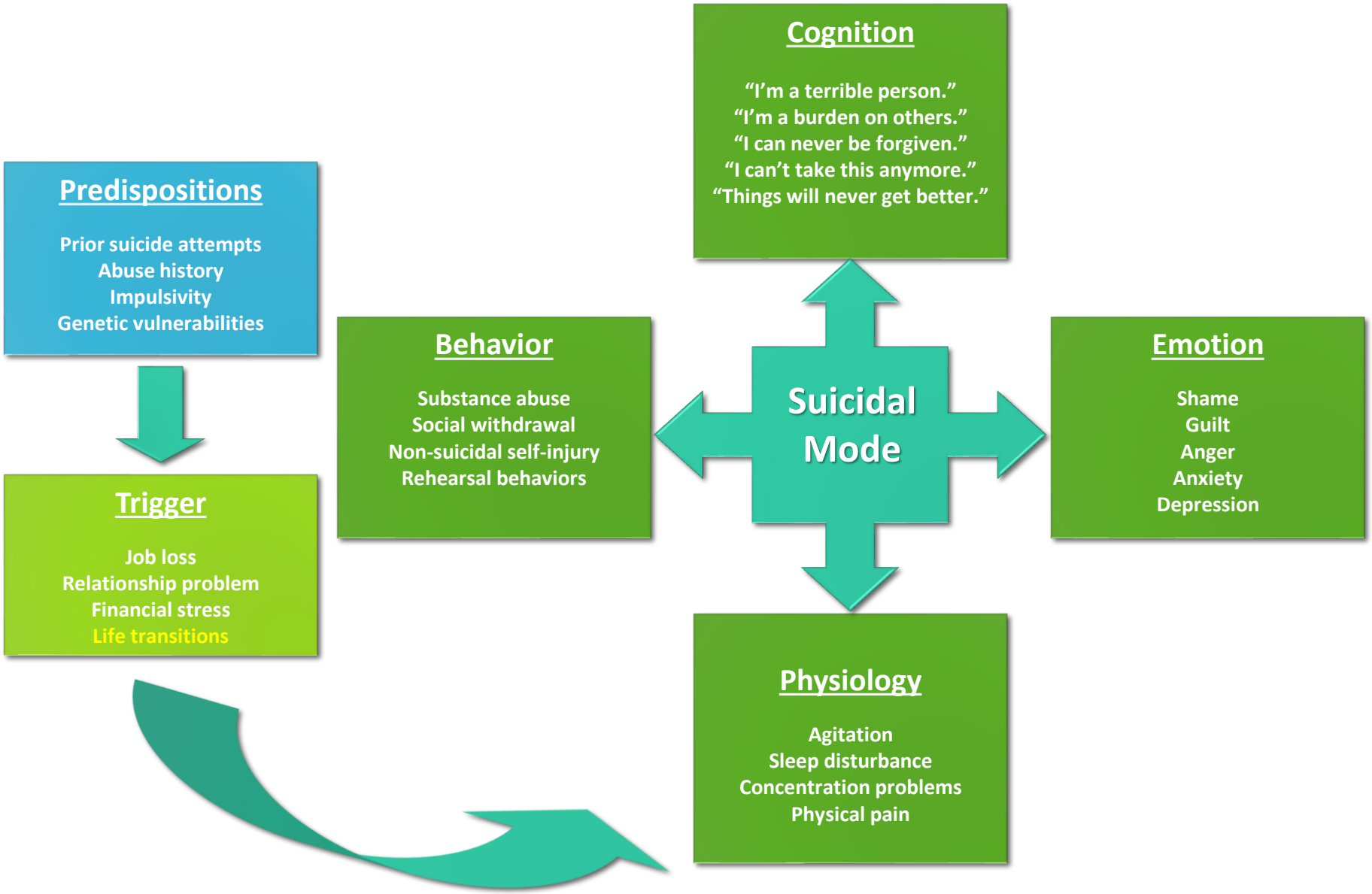
**2) Assist patients with suicidal symptoms in a collaborative, empowering way, anchored in their values and priorities.**

**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.**


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

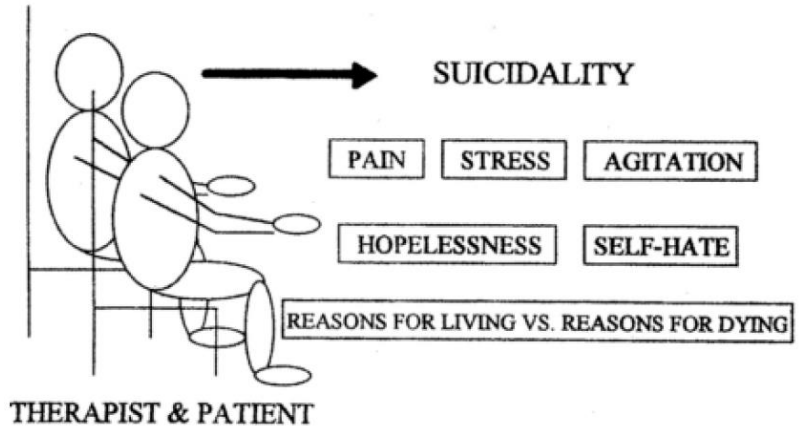
# A Collaborative Approach

**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)*

# 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

# 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

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

**Suicide screening:**

- Do things ever get so bad you think about ending your life or suicide?
- Tell me a little bit about what, specifically, you have been thinking. What is it exactly that goes through your mind?

*[Differentiate suicidal ideation from nonsuicidal morbid ideation]*

*If negative suicide screening:* Discontinue risk assessment
*If positive suicide screening:* Screen for multiple attempt status

↓

**Multiple attempter screening**

- Have you ever had thoughts like this before?
- Have you ever tried to kill yourself before?
- So you've never cut yourself, burned yourself, held a gun to your head, taken more pills than you should, or tried to kill yourself in any other way?

*If no evidence of prior attempt(s):* Assess current suicidal episode
*If positive evidence of prior attempt(s)*: Assess multiple attempt status

↓

**Assess multiple attempt status**

- How many times have you tried to kill yourself?
- Let's talk about the first time…
  a. When did this occur?
  b. What did you do?
  c. Where were you when you did this?
  d. Did you hope you would die, or did you hope something else would happen?
  e. Afterwards, were you glad to be alive or disappointed you weren't dead?
- I'd like to talk a bit about the worst time… [Repeat *a* through *e*]

↓

**Assess current suicidal episode**

- Let's talk about what's going on right now. You said you've been thinking about [content].
- Have you thought about how you might kill yourself?
- 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]?

↓

**Screen for protective factors**

- What is keeping you alive right now?

***(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

# RISK ASSESSMENT

## SKILL 2

# Assess for past suicidal behaviors and multiple attempt history

# RISK ASSESSMENT

## SKILL 3

# Assess the current suicidal episode

# 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?

# 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

# Explain that Suicide is a State 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?**

# 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 following a suicide attempt (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?"

| 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<br>2. Consider medication treatment<br>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<br>2. Routinely reevaluate suicide risk, noting specific changes that reduce or elevate risk<br>3. Consider medication change if symptoms worsen or persist<br>4. Obtain professional consultation with a colleague following each appointment<br>5. Specifically target suicidal symptoms in the treatment plan<br>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)<br>2. Obtain professional consultation with a colleague following each appointment<br>3. Specifically target suicidal symptoms in the treatment plan<br>4. Crisis response plan<br>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

# Protective Factors

- Intact reality testing
- Children in home
- Spiritual beliefs / practices
- Moral beliefs
- Social stigma
- Future-oriented thought
- Presence of positive social relationships
- Fear of death / suicide
- Problem-solving skills
- Goals / aspirations

# RISK ASSESSMENT

## SKILL 5

# 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)*

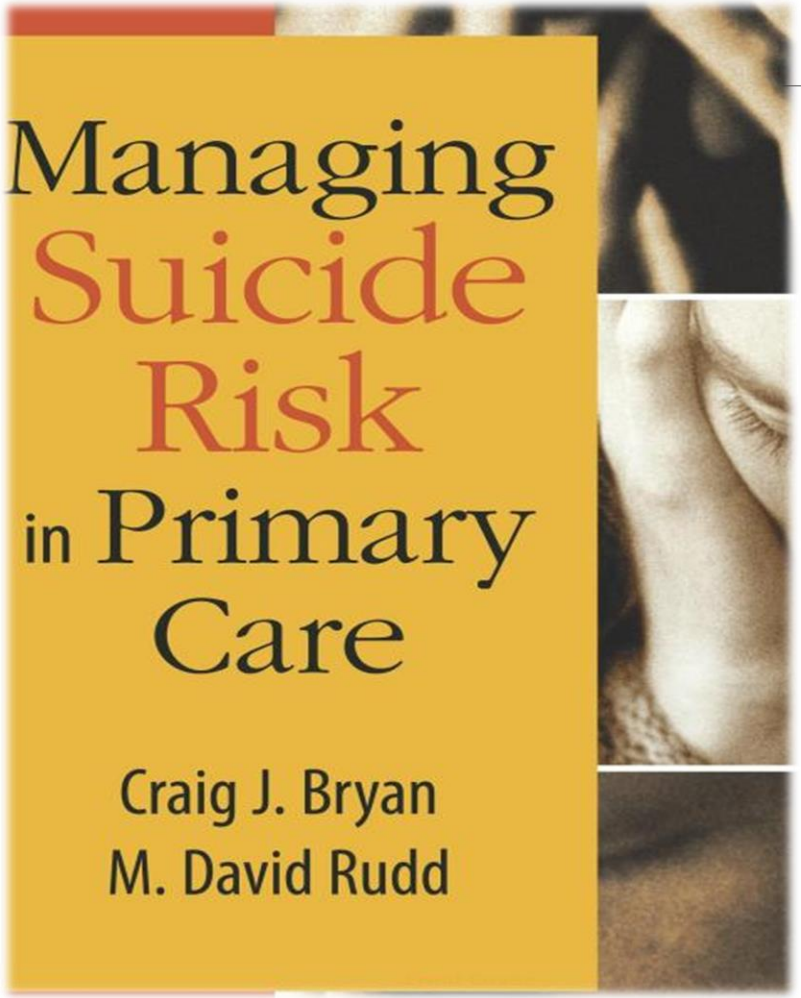
**Social Support**

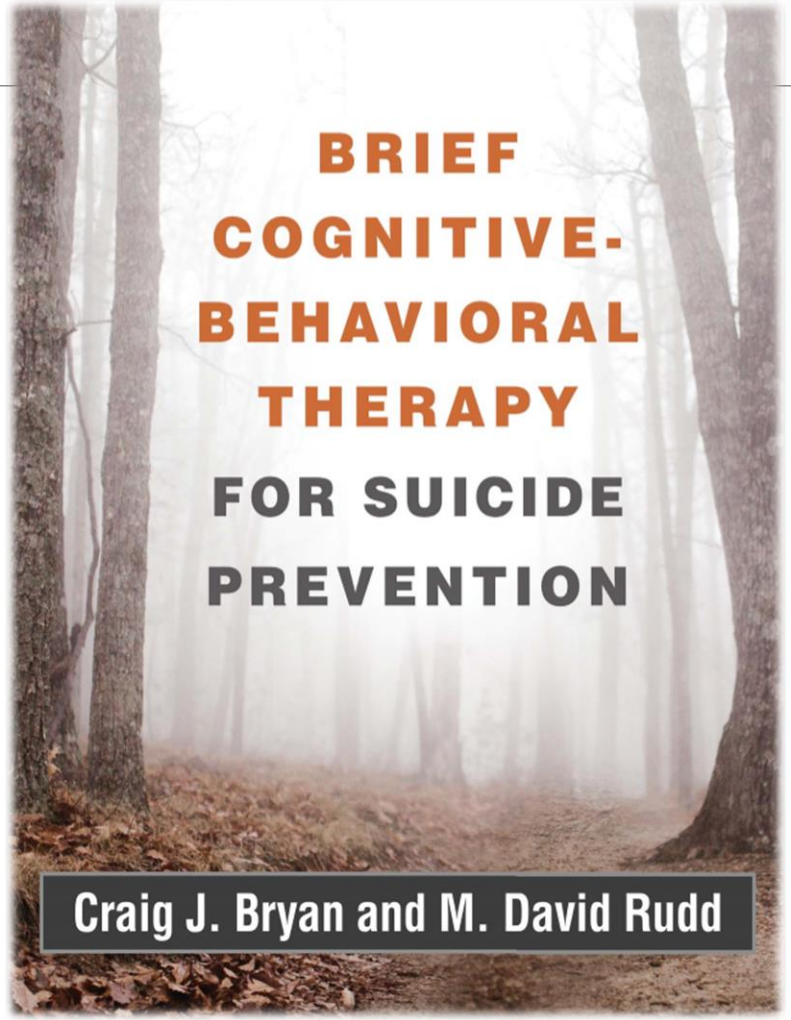
*Call Susan (wife): 555.555.5555*
*Call John (friend): 555.555.5555*

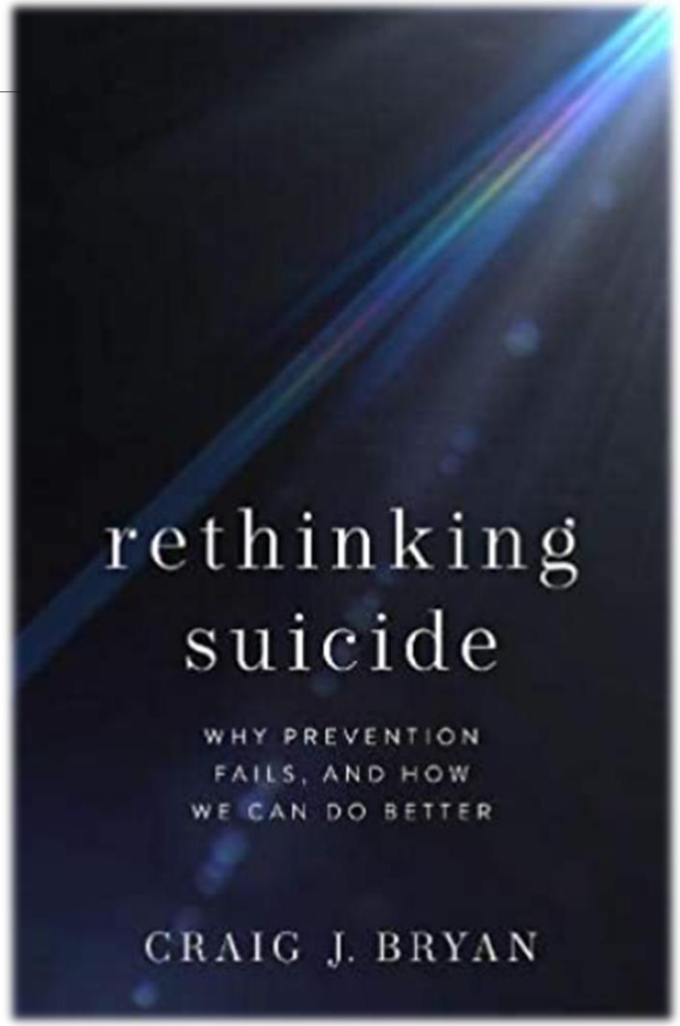
**Crisis & Professional Services**

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

# 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/

# Questions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