

# Suicide Prevention Training

Boulder Mental Health  
May 5, 2011



<b>9:00 - 10:00</b>	<b>Introductions Suicide Risk Assessment: a Medicolegal Perspective</b>	<b>Hal Wortzel, MD</b>
<b>10:00-10:45</b>	<b>Suicide Risk Assessment: Tips and Tools</b>	<b>Bridget Bulman, PsyD</b>
<b>10:45-11:00</b>	<b>Break</b>	
<b>11:00-11:30</b>	<b>Suicide and TBI</b>	<b>Gina Signoracci, PhD</b>
<b>11:30-12:00</b>	<b>Substance Use and Suicide</b>	<b>Jennifer Olson-Madden, PhD</b>
<b>12:00-1:00</b>	<b>Lunch on your own</b>	
<b>1:00-2:00</b>	<b>Safety Planning Presentation and Role-Play</b>	<b>Bridget Bulman, PsyD Patricia Alexander, PhD</b>
<b>2:00-3:00</b>	<b>Safety Planning Break-out Groups</b>	
<b>3:00-3:30</b>	<b>Final Comments and Questions</b>	



# Suicide Risk Assessment: A Medicolegal Perspective

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# Suicide statistics (2007)...

- >34,000 people die by suicide each year in the USA
- 34,598 reported suicide deaths in 2007
- 4<sup>th</sup> leading cause of death adults age 18 - 65 years in US (28,628 suicides).
- 11<sup>th</sup> leading cause of death
- A death by suicide occurs nearly every 15 minutes
- Approximately 90 Americans every day
- 90% with a diagnosable psychiatric disorder at the time of death
- 8-25 attempted suicides for every suicide death

[http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page\\_id=050FEA9F-B064-4092-B1135C3A70DE1FDA](http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=050FEA9F-B064-4092-B1135C3A70DE1FDA)



# State Statistics

Rank	State	Number of suicides	Population	Rate
1	Alaska	149	681,111	21.8
2	Montana	196	956,624	20.5
3	New Mexico	401	1,964,402	20.4
4	Wyoming	101	523,252	19.3
5	Nevada	471	2,554,344	18.4
6	Colorado	811	4,842,770	16.7

[http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page\\_id=05114FBE-E445-7831-FOC1494E2FADB8EA](http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=05114FBE-E445-7831-FOC1494E2FADB8EA)



# Veterans

- Men in the VHA population: 38.3 per 100,000
- Women in the VHA population: 14.8
- Rates appear to be on the rise (2006-2008) for OEF/OIF veterans, especially men under the age of 30
- Decreasing suicide rates in veterans under age 30 who utilize VHA services suggests that it may be life-saving to help young veterans enroll and engage in care

# We assess risk to...

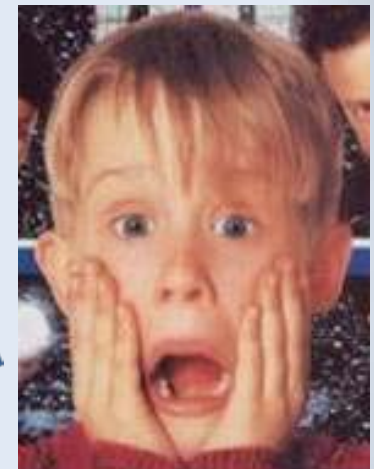
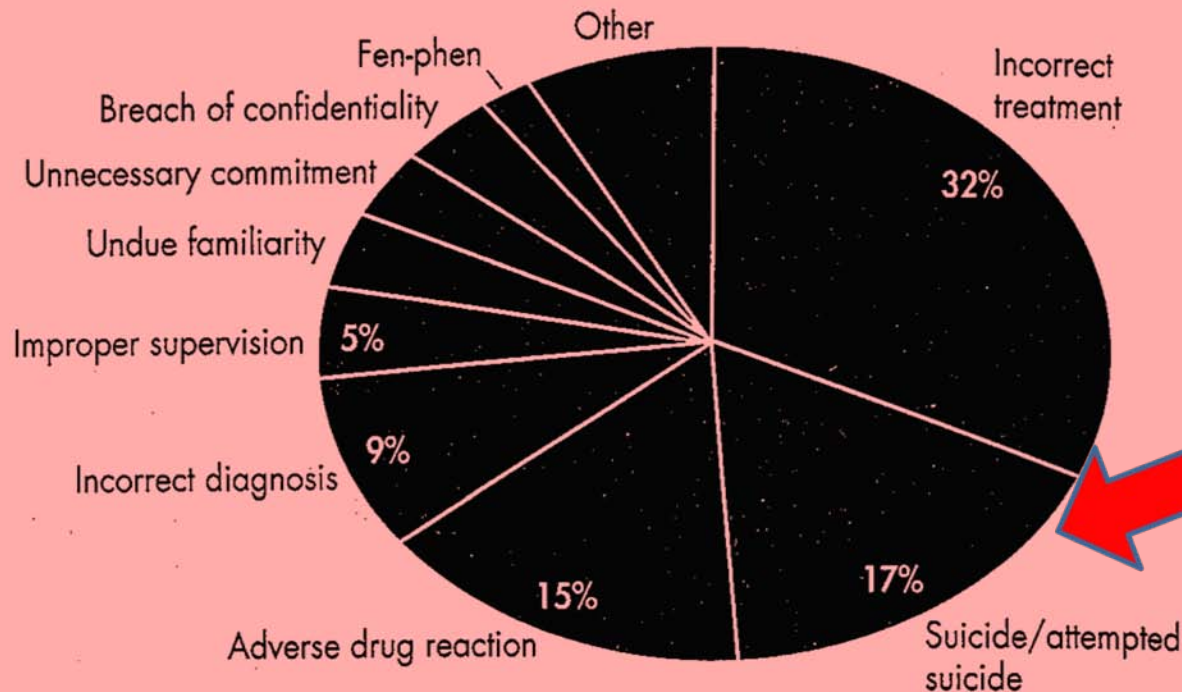
- Take good care of our patients
- The purpose of systematic suicide risk assessment is to identify modifiable and treatable risk factors that inform the patient's overall treatment and management requirements (Simon 2001)
- Suicide risk assessment is a core competency, expected to be acquired during residency training (Scheiber *et al.* 2003)

# We should also assess to...

- Take care of ourselves
- Risk management is a reality of psychiatric practice
- 15-68% of psychiatrists have experienced a patient suicide (Alexander 2000, Chemtob 1988)
- About 33% of trainees have a patient complete suicide
- 5% of residents experience >1 during training (Brown 1987)
- Paradox of psychiatric training - toughest patients often come earliest in our careers



# Shock, Disbelief, Denial, Grief, Shame, Anger, and FEAR



**FIGURE 28-1.** Most common malpractice claims against psychiatrists: United States, 1999-2003.

*Source.* The Psychiatrist's Program, the APA-Endorsed Psychiatrists' Liability Insurance Program, 2004.

# Clinically Based Risk Management

- Fortunately, the best way to care for our potential suicidal patients and ourselves are one in the same
- Clinically based risk management is patient centered
- Supports treatment process and therapeutic alliance
- Good clinical care = best risk management

# Good Clinical Practice is the Best Medicine

- Evaluation

- Accurate diagnosis
- Systematic suicide risk assessment
- Get/review prior treatment records

- Treatment

- Formulate, document, and implement a cogent treatment plan
- Continually assess risk

- Management

- Safety management (hospitalize, emergency plans, precautions, etc)
- Communicate and enlist support of others for patient's suicide crisis

***“Never worry alone.”*** (Gutheil 2002)

# Suicide Risk Assessment

- No standard of care for the prediction of suicide
- Suicide is a rare event
- Efforts at prediction yield lots of false-positives as well as some false-negatives
- Structured scales may augment, but do not replace systematic risk assessment
- Actuarial analysis does not reveal specific treatable risk factors or modifiable protective factors for individual patients

# Suicide Risk Assessment

- Standard of care does require suicide risk assessment whenever indicated
- Best assessments will attend to both risk and protective factors
- Risk assessment is not an event, it is a process
- Inductive process to generate specific patient data to guide clinical judgment, treatment, and management
- Research identifying risk and protective factors enables evidence-based treatment and safety management decision making

# APA Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors

[http://www.psychiatryonline.com/pracGuide/pracGuideChapToc\\_14.aspx](http://www.psychiatryonline.com/pracGuide/pracGuideChapToc_14.aspx)

- Quick Reference Guide
- Indications
- Risk/protective factors
- Helpful questions to uncover suicidality
- And more

# Suicide Assessment Indications...

- Emergency department or crisis evaluation
- Intake evaluation
- ***Prior to change in observation status or treatment setting***
- Abrupt change in clinical presentation
- Lack of improvement or gradual worsening with treatment
- Anticipation/experience of loss or stressor
- Onset of physical illness

# Thorough Psychiatric Evaluation

- Identify psychiatric signs and symptoms
  - In particular, sx's that might influence risk: aggression, violence, impulsivity, insomnia, hopelessness, etc.
- Assess past suicidal and self-injurious behavior
  - For each attempt document details: precipitant, timing, intent, consequences, and medical severity
  - Substances involved?
  - Investigate pt's thoughts about attempt: perception of lethality, ambivalence about living, degree of premeditation, rehearsal
- Review past treatment history and relationships
  - Gauge strength of therapeutic alliance



# Thorough Psychiatric Evaluation

- Identify family history of suicide, mental illness, and dysfunction
- Investigate current psychosocial situation and nature of any current crisis
  - Acute crisis or chronic stressors may augment risk: financial, legal, interpersonal conflict or loss, housing, employment, etc.
- Investigate strengths!
  - Coping skills, personality traits, thinking style, supportive relationships, etc

# Specific Inquiry of Thoughts, Plans, and Behaviors

- Elicit any suicidal ideation
  - Focus on nature, frequency, extent, timing
  - Assess feelings about living
- Presence or Absence of Plan
  - What are plans, what steps have been taken
  - Investigate pt's belief regarding lethality
  - Ask what circumstances might lead them to enact plan
  - Ask about GUNS and address the issue

# Specific Inquiry of Thoughts, Plans, and Behaviors

- Assess patient's degree of suicidality, including intent and lethality of the plan
  - Consider motivations, seriousness and extent of desire to die, associated behaviors and plans, lethality of method, feasibility
  - Realize that suicide assessment scales have low predictive values
- ***Strive to know your patient and their specific or idiosyncratic warning signs***

# Risk Factors v. Patient-Specific Warning Signs

## Risk Factors

- Suicidal ideas/behaviors
- Psychiatric diagnoses
- Physical illness
- Childhood trauma
- Genetic/family effects
- Psychological features (i.e. hopelessness)
- Cognitive features
- Demographic features
- Access to means
- Substance intoxication
- Poor therapeutic relationship

## Patient-Specific Warning Signs

- Any circumstance impacting risk for the individual patient
- May be intuitive or idiosyncratic
- Often extremely valuable in gauging acute risk
- Example: visit from mother protective for some, may portend potential crisis for others
- Illustrates limitations of “evidence-based” risk factors and scales

# Establish Diagnosis and Risk

- Axis I, II, III, and IV all extremely pertinent to informed determination of risk
- In estimating risk, combine all elements:
  - Psychiatric illness
  - Medical illness
  - Acute stressors
  - Risk factors and patient-specific warning signs
  - Protective factors
  - Nature, intensity, frequency of suicidal thoughts, plans, and behaviors

# Acute v. Chronic Risk

- These are very different, and each carry their own specific treatment/safety

A 29 y/o female with hx of 18 suicide attempts and chronic suicidal ideation, numerous psychiatric admissions, family hx of suicide, gun ownership, TBI, intermittent homelessness, alcohol dependence, and BPD presents to ER with c/o SOB; asked to conduct psychiatric evaluation given her well-known history. What is her risk?

- Formulation and plan for such individuals necessitates separate consideration of chronic and acute risk

# Acute v. Chronic Risk

- Acute and chronic risk are dissociable
- Document estimation for each

Although patient carries many static risk factors placing her at high chronic risk for engaging in suicidal behaviors, her present mood, stable housing, sustained sobriety, and SI below baseline suggest little acute/imminent risk for suicidal behavior.

# Psychiatric Management

- Establish/Maintain therapeutic alliance
  - Taking responsibility for patient's care is not the same as taking responsibility for the patient's life
- Attend to safety and determine treatment setting
  - Level of observation, frequency of sessions
  - Restricting access to means
  - Consider safety needs, optimal treatment setting, and patient's ability to benefit from such



# Develop a Treatment Plan

- For the suicidal patient, particular attention should be paid to modifiable risk and protective factors
- Static risk factors help stratify level of risk, but are typically of little use in treatment; can't change age, gender, or history
- Modifiable risk factors are typically many: medical illness (pain), psychiatric symptoms (psychosis), active substance abuse, cognitive styles, access to means, etc

# Don't Neglect Modifiable Protective Factors

- These are often key to addressing long-term or chronic risk
- Sense of responsibility to family
- Reality testing ability
- Positive coping skills
- Positive problem-solving skills
- Enhanced social support
- Positive therapeutic relationships

# Treatment

- Coordinate and collaborate
  - Mental health providers, other physicians, families
- Promote adherence to treatment plan
- Educate patients and families
- Reassess safety and risk
  - Risk assessment is not an event, it's a process
- Monitor status and response to treatment
- Obtain consultation if indicated
  - “Never worry alone”

# Safety Plans

- No-suicide contracts ask patients to promise to stay alive without telling them how to stay alive
- No-suicide contracts may provide a false sense of assurance to the clinician
- Safety plans offers predetermined positive steps to take to navigate a crisis

# Safety Plans

- Prioritized written list of coping strategies and resources for use during a suicidal crisis.
- Helps provide a sense of control.
- Uses a brief, easy-to-read format that uses the patients' own words.
- Involves a commitment to treatment process (and staying alive).

# Safety Plans

- Hierarchically-arranged list of coping strategies for use during a suicidal crisis or when suicidal urges emerge
- Plan is a written document
- Uses a brief, easy-to-read format
- learn more at:

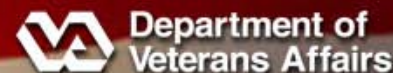
[http://www.mirecc.va.gov/visn19/2nd\\_Annual\\_Traumatic\\_Brain\\_Injury\\_TBI\\_Suicide\\_Prevention\\_Conference.asp](http://www.mirecc.va.gov/visn19/2nd_Annual_Traumatic_Brain_Injury_TBI_Suicide_Prevention_Conference.asp)



**IT  
TAKES  
THE  
COURAGE AND STRENGTH  
OF A WARRIOR  
TO ASK FOR HELP.....**

**If you're in an emotional crisis  
call 1-800-273-TALK "Press 1 for Veterans"**

[www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)



# Thank You

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[http://www.mirecc.va.gov/vi  
sn19.asp](http://www.mirecc.va.gov/vi<br/>sn19.asp)

