

Working Well with the Suicidal Patient: Research-Informed Approaches to Ethical Suicide Assessment and Management

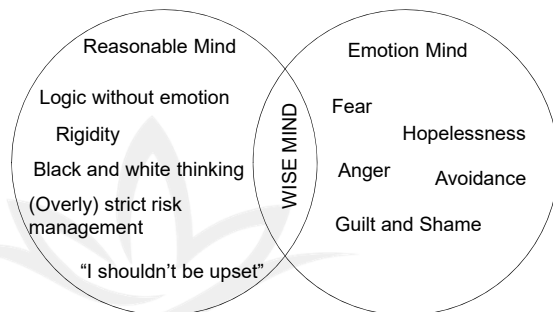
Presented by: Andrew White, PhD
5200 SW Macadam Portland OR 97239 | (503) 231-7854

Topics for Today

- Suicide data in the US
- Populations at risk for suicide
- Risk Factors for Suicide
- Suicide Research and Hospitalization
- Legal and Ethical Considerations
- Documentation Strategies
- Postvention

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The Principle of Wise Mind



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Mindfulness

- The quality or state of being mindful (attentive, thoughtful, intentional).
- A particular way of paying attention and directing one's focus, in the present moment, without judgment.
- Awake and flexible
- The repetitive act of directing and redirecting one's attention to only one thing moment by moment.
- Attention control.

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Mindfulness Practice

Observe



- Non judgmentally
- Effectively
- One mindfully

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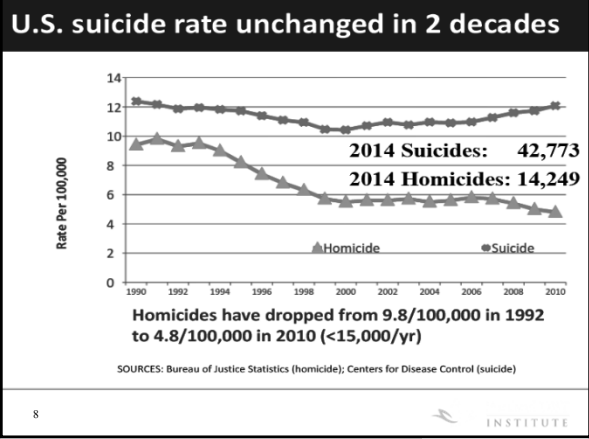
Emotion Regulation

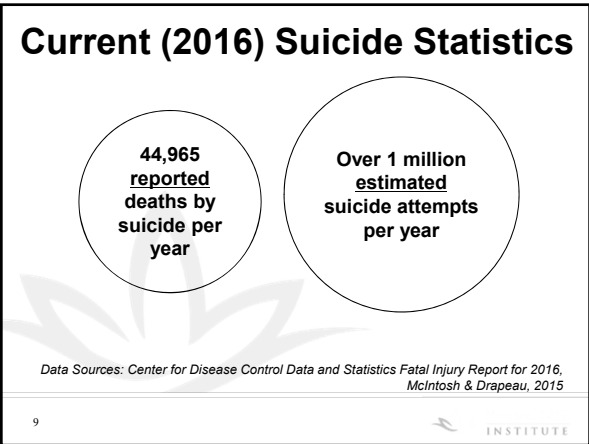


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Suicide Statistics and Data





Current (2016) Suicide Statistics

Suicide is the 10th leading cause of death in the US...

..and the 2nd leading cause of death in individuals aged 15 to 34

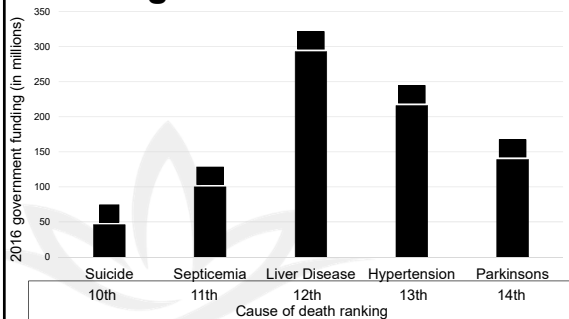
The estimated economic cost of suicide deaths is **\$50.8 billion dollars**

Data Source: Center for Disease Control Data and Statistics Fatal Injury Report for 2016

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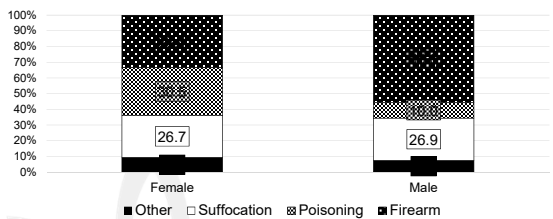
Funding and Suicide Research



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Suicide Methods and Rates



The rate (per 100,000 individuals) of death by suicide for the general population is 13. For men, this rate is 20.7, while for women it is 5.8.

Data Source: Center for Disease Control Data and Statistics Fatal Injury Report for 2016

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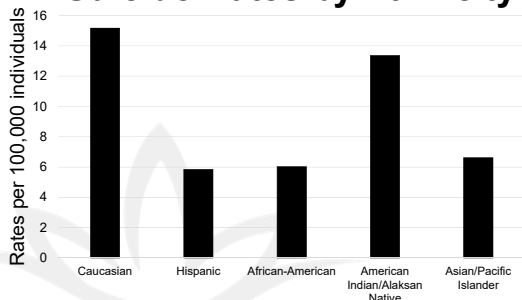
Suicide and Adolescents

- Second leading cause of death (CDC, 2016).
- Alaska Native/Native American youth have the highest rate of suicide, 1.5 times greater than the national average. (CDC, 2015)
- Gay and lesbian youth (age 15-24) suicide attempt rate: 29.4%. (vs. 6.4 %for heterosexual youth) (Center for Disease Control and Prevention, 2015)
- 45% of transgender youth age 18-24 have attempted suicide. (Haas, Rodgers, Herman, 2014)

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Suicide Rates by Ethnicity



Data Source: Center for Disease Control Data and Statistics Fatal Injury Report for 2016

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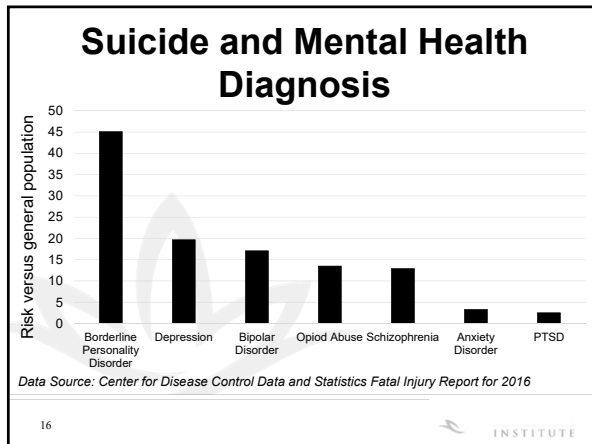
Veteran Suicide Statistics

- In 2016, the VA reviewed 50 million patient records ranging from 1979 to 2014. They found:
- Veterans accounted for 18% of all deaths from suicide in the US, but veterans only account for 8.5% of the US population.
- 65% of all veterans who completed suicide were over 65 years old.
- Veterans have a 21% increased risk of suicide from the general population.
- 66% of suicides resulted from firearms

Data source: VA Suicide Prevention Program, 2016

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Suicide and Borderline Personality Disorder

- Between 8-10% mortality.
- Close to 50 times greater than general population. (Hoffman et al., 2010; CDC, 2016)
- Histories of suicide attempts in population reported as high as 73%. (Soloff et al., 2000)

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Risk Factors for Suicide

General Factors Related to Long Term Risk For Suicide

- Family discord/domestic violence
 - In justice or child welfare setting (APA, 2003; National Strategy for Suicide Prevention, 2012)
- Environmental Characteristics
 - Life changes - losses, disrupted relationships, discharge from psychiatric hospital within 6 – 12 months (Linehan, 1993, 2014)
- Social Support
 - Unemployed, single, less available family, limited social support network (Linehan, 1993, 2014)
- Access to lethal methods
 - Leading methods in USA are firearms, suffocation/hanging, and poisoning (CDC, 2016)

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Social Factors Related to Long Term Risk For Suicide

- Modeling
 - Family history of suicide (Linehan, 1994, 2014)
 - High profile suicide publicity
 - Family history of mental illness or substance use (APA, 2003)
- Cultural or religious beliefs about death or suicide

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Cognitive/Behavioral Factors Related to Long Term Risk

- Cognitive
 - Rigid, impulsive, poor and/or passive problem solving, hopeless, powerless, and negative self concept.
- Physiological/Affective
 - Apathetic, depressed, panic attacks, anxiety, anhedonic, and indifference to treatment (Linehan, 1993, 2014)

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Medical Factors Related to Long Term Risk For Suicide

- Somatic- Poor health, low pain tolerance.
- Serotonergic system abnormality (Chesin & Stanley, 2013; Mann, 2013)
- Major Medical conditions (National Strategy for suicide prevention, 2012)

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Factors Related to Imminent Risk For Suicide

- Fits into high risk population
- Rapid mood cycling
- Alcohol consumption
- Access to lethal means
- Isolation
- Provisions to prevent discovery
- Recent loss of relationship/s
- Negative environmental change in previous month
- deterioration of relationship between client and treaters due to negative perceptions of behavior
- Recent discharge from psychiatric hospital
- Indifference to/Dissatisfaction with therapy
- Hopelessness Ruminative flooding
- Anger/Agitation
- Indirect references toward own death
- Sudden clinical change, positive or negative
- Unusually calm and placid affect
- Suicide attempt or NSSI in past year

Data Sources: Borges et al, 2006; Cassells et al, 2005; Galynker et al., 2014; Galynker, Yaseen & Briggs, 2014; Linehan 1993, 2014)

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Areas to Reflect on

- Do I see individuals who fall into these areas in my practice?
- Do I have systems in place to assist me in working effectively with these individuals?
- Who could I consult with in these situations?

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And... How Much do we Really Know?

- A recent review of 365 studies over 50 years on suicide found poor ability to predict suicidal behaviors (or ideation) using previously identified risk factors.

Take home points:

- More work is needed in the area of suicide prediction
- Know the risk factors, and know your patients better
 - What is their unique baseline and changes from baseline?
 - What drives the current urge to die, and what can be done right now to instill hope?
 - Assess deeply, generate reasons for living.
 - **Assess and block lethal means access**

Data Source: Franklin et al., 2017

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Lethal Means Access

- Means restriction in England/Wales (detoxification of gas), Sri Lanka (ban on pesticides), and Israeli Defense Force (locking firearms on base for weekends) resulted in substantial decreases in suicide
- 71% of individuals attempting suicide reported less than an hour between the initial thought and the attempt
- **83% of all deaths from firearms in Oregon from 2010-2014 were from suicide (national number is 61%)**

Data Sources: Bryan et al (2011); Gunnell et al (2007); Lubin et al (2010); Simon et al, 2001; Simon, 2005

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Counseling on Lethal Means Access

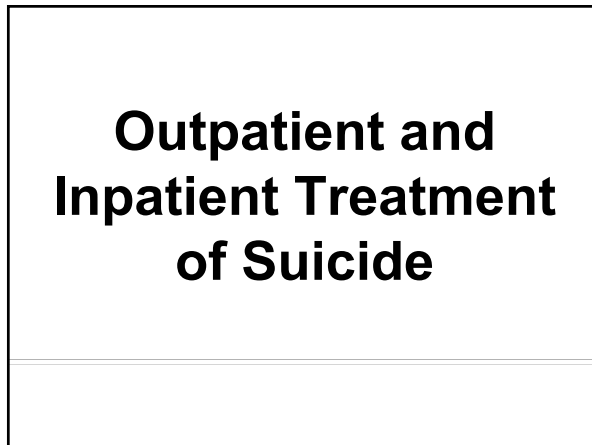
- Alliance: I am concerned about your safety and would like to talk about what we can do to protect you and your family
- Education: We know that removing or reducing access to lethal means for suicide is one of the most effective ways to prevent suicide (similar to removing alcohol while trying to stay sober)
- Therapeutic Task: Can we find a way to temporarily remove or find a safer way to store means with someone you trust while we together on helping you feel better?

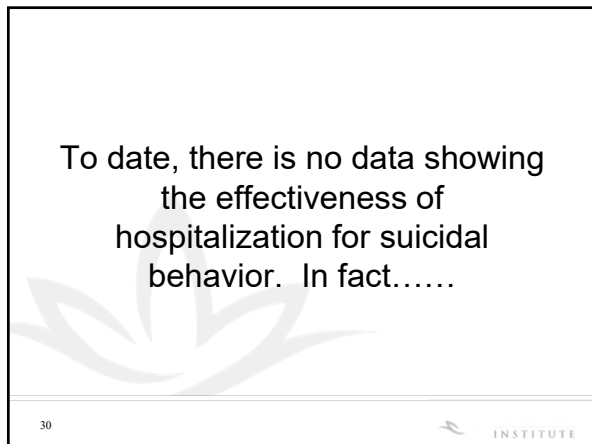
Data Source: Bryan et al (2011)

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Hospitalization and Suicide

- Several studies show risk in suicidal behaviors during or following hospitalization.
- The risk of suicide is higher during the period immediately following discharge from inpatient psychiatric care than at any other time in a service user's life.
- Suicide is one of most common events in inpatient setting.

Data source: Tishler, 2008; Crawford, 2004

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Hospitalization and Suicide

Researchers of a 16 year longitudinal study found to 2 peaks of risk after hospitalization:

- First week after admission.
- First week following discharge.
- Risk was found to increase with number of psych hospitalizations, especially for women.

Data Source: Qin and Nordentoft, 2005

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Borderline Personality Disorder and Hospitalization

- A recent study found admissions to the psychiatric emergency room while in treatment for women with BPD was a strong predictor of subsequent suicide attempts.
- People with BPD are approximately 28% more likely to complete suicide if they have had any ER contact.

Data Source: Coyle, Shaver & Linehan, 2018

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When to Hospitalize

- Acute psychosis
- Insomnia
- Medication Stabilization
- When you need a break (in collaboration with the client)

Data Sources: McCall, et al, 2010; Nadorff, et al, 2013; Woznica et al, 2015; Bernert and Joiner, 2007)

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When to try to avoid hospitalization

All other times

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“Hospitalize Well”

- Client exerts as much control as possible
- Voluntary over Involuntary
- Wise Mind
- Targets are clear
- More functional, less reinforcing
- Not vacation, more “boot camp”
- Consultation to the client
- Discuss with the client, expectations

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So if hospitalization is not as effective as we would like it to be, where do we go from here in outpatient care?

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Use Validated Risk Assessment and Management Protocols

Examples:

- Linehan Risk Assessment and Management Protocol (LRAMP)
- Collaborative Assessment and Management of Suicidality (CAMS)
- Mood Improvement Protocol
- Crisis Response Plans (Bryan et al, 2017; Fleischmann, et al, 2008; Stanley & Brown, 2012)

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Crisis Response Plan (CRP)

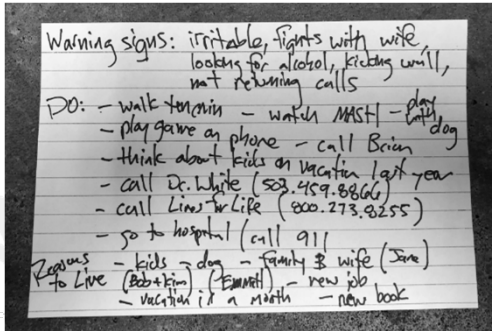
- Is not a contract for safety!
- Use index card/sheet of paper, write out:
 - Personal warning signs for suicide
 - Self management strategies
 - Reasons for living
 - Social Supports
 - Crisis/Emergency Steps
- Verbally review card and seek commitment.

Data source: Bryan et al, 2017

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Crisis Response Plan (CRP)



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Let's Practice

- Assess the current suicidal impulse or attempt- try to really get "the story of what happened". (Bryan et al, 2017)
- Use the previous slide to generate a CRP.
- Remember the Franklin et al (2017) study!
 - Understand what drives the current urge to die, and what can be done right now to instill hope and generate reasons for living.

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Last Note: Know When to Refer and Seek Consultation

- Have access to expert consultation set up ahead of time.
- Know your own limits for individuals you seek in your practice.
 - Who can you effectively treat?
 - Are there limitations in what you offer which could affect individuals you see?

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Ethics and the Treatment of Suicide

Comment Aspects of Ethical Standards

- Avoid Harm
- Base your practice in evidence, increase competencies
- Protect civil rights
- Lifelong commitment to learning
- Consult!

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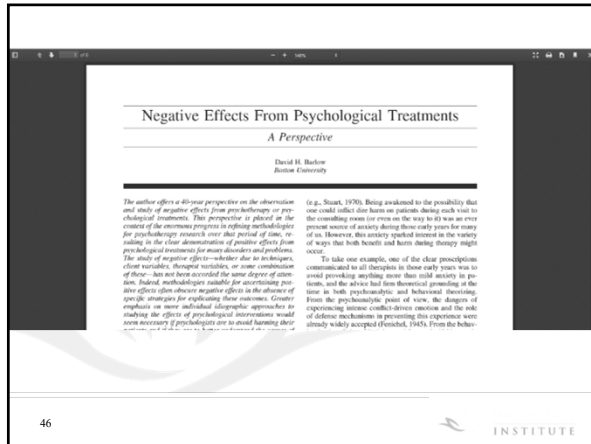
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Ethics Codes: Avoid Harm

- “APA: Safeguard the welfare and rights of those with whom they interact with professionally..”
- ACA: “Do not use.. modalities when substantial evidence suggests harm, even if such services are requested”
- NASW: “..primary responsibility is to promote the well being of clients”

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Ethics Codes: Competence

- APA: Practice within competence, stay competent, know your own issues. Get training.
- NASW: When standards do not exist, do research and seek consultation. Routinely review the literature.
- ACA: Practice within boundaries of competence, monitor effectiveness, seek supervision. Use scientific basis for treatment.

Ethics Codes: Civil Rights

- APA: Do not exploit. Safeguard welfare. Respect self-determination and patient rights.
- NASW: Challenge social injustice, address social problems, respect dignity of the person.
- ACA: Remove barriers to access of services, revise plans to respect client freedom of choice.

Ethics in Practice- Structural

- Create structure setup to allow for expedient consultation and supervision if needed.
- Find a way to stay current on clinical research (e.g. journal club, mailing lists, learning communities).
- Obtain materials needed to implement evidence based practice and reduce barriers.
- Have guidelines (and resources) for when to refer out.
- Be familiar with local resources.

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Ethics in Practice- Stylistic

- Radical Humility: Knowing and accepting what we don't know.
- Effective Compassion (Pema Chodron): Focus and movement towards long term goals without stiffening in fear.
- Rehearse, rehearse, rehearse to increase effectiveness in risky situations.

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Documentation Strategies

Traditional Pitfalls in Documentation

If it isn't written down, it didn't happen"- Thomas Gutheil, MD

- Patient records are an enduring document which may be used by future providers, as well as in legal proceedings.
- Avoid the temptation to use "lazy" language, stock phrases, judgmental language, and things you would not want to have read on a stand in court.
- Be familiar with generally accepted medical/legal standards for documentation.

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Risk Benefit Notes

- Whenever a moderate to high risk event is occurring, and you are using your own (and your colleagues!) clinical judgment to not hospitalize the client.
- In these situations, a risk benefit note is needed so anyone reviewing the chart can understand your justification for not hospitalizing.

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What is in Risk Benefit Notes?

- An accurate, complete assessment of risk
- Risk factors current present vs. historically present
- Factors which may lower the risk of death
- How information was obtained (e.g. in person, phone, collaterals, etc)
- Pros/cons of utilizing emergency/hospital services
- Notes about any consultations obtained
- A summary of how the relevant information has lead to the decision not to hospitalize

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One Example: LRAMP

Linehan Risk Assessment and Management Protocol

- Protocol to reduce anxiety about malpractice lawsuits for assessors and providers.
- Standardized protocol to manage suicide risk during clinical research assessments that could be documented and applied by blinded assessors.
- Generic crisis protocol that guide good clinical care across treatment conditions.

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Case Vignette

- 24 year old single Caucasian male
- Baseline is using self-harm (cutting) and alcohol as coping skills, then posts suicidal threats on social media until friends call police. ER has been a (short term) reinforcing situation in past
- Prompts for dysregulation are often interpersonal rejection.
- You create a plan to increase coping skills and block posts on social media, obtain commitment in session to a life worth living and increased effectiveness
- Client texts you at 10pm on Friday night stating they have “had enough and are going to die”

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Case Vignette- Application of Principles

How would you apply principles such as..

- Do no harm
 - Short term vs. long term harm?
- Maintenance of civil rights and client choice
 - Choice in the moment vs during previous therapy session
- Accurate document
 - How would you write the risk benefit note?

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Case Vignette- What do you need to know?

- To make an informed decision (and write an effective risk benefit summary), what do you need to know that is not listed in the summary?
- What would the LRAMP (or a similar instrument) remind you to look for?

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Postvention

Clinician Survivors of Suicide Loss

Number of suicide deaths annually in US:

44,965

Percent of suicidal patients receiving mental health treatment is **31.45%**

So: $44,965 \times 31.45 =$

About **14,142** clinicians lose patients to suicide on annual basis.

Data sources: CDC, 2016; NVDRS, 2009; Sung, 2016

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Clinician Survivors of Suicide

- Psychiatrists: 53%
- Psychologists: 25%
- Psychiatry Trainees: 33%
- Counselors: 23%

Data Sources: Chemtob et al, 1988; McAdams & Foster, 2000; Brown, 1987

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Dialectical Dilemma for Clinics After Suicide

Risk & liability management



Supporting clinician, staff, clients following suicide

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Dialectical Dilemma for Clinician Survivors After Suicide

Meet clinical & admin responsibilities



Tend to own emotions; protect self

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Risk & Risk Management

The death of a patient to suicide may have legal consequences for the clinician(s) and clinic.

and...

Discussion of treatment details may become evidence in event of litigation

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While conversations with attorney or personal therapist about patient suicide is **legally protected...**

...discussions with team, supervisor, clinic director are **not.**

Clinician Risk Management Steps Immediately Following Suicide

- Notify supervisor
- Notify malpractice insurance provider
- Create WiseMind game plan with supervisor and/or clinic director; follow game plan and stay in close contact.
 - Plan should include taking care of family
- Focus on *emotional effect* of suicide, not treatment details.
- Develop plan for emotional support

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Supporting our Colleagues after a Suicide (Sung, 2016)

- Peer Support: family, friends, colleagues (Alexander et al., 2000)
- Team Support
- Clinician Survivors of Suicide Support groups (Kolodny, 1979; AAS Clinician Survivors list serv)
- Supervision (Schultz, 2005)

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Supporting our Colleagues after a Suicide: What's Helpful

- Validation of emotional experience
- Empathic listening
- Sharing of personal experiences
- Validating the valid
- *"How can I support you?"*

Experienced as Supportive & Responsive

Data Sources: Sung, 2016; Hendin et al., 2000

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Supporting our Colleagues after a Suicide: What's Not So Helpful

- Offering up **false assurance**
 - *It's not your fault.*
 - *Death was inevitable.*
- **Leaping into Action** too Quickly (and expecting same of clinician survivor)
- **"Fragilizing"** clinician survivor
- Willful **refusal to hear** clinician survivor's concerns about missteps/mistakes

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Suicide Case Review:
Psychological Autopsy (Sung, 2016)

Function: Retrospective review to learn from and improve care of others; emotional support & resolution

Timing: Higher order targets addressed (e.g., immediate activities resolved; family's acute emotional needs addressed; negative emotion of clinician survivors resolved)

Tone:

- Non-judgmental, open-minded, earnest dedication
- Ask: **What can we learn from this?** and **Where can we do better in the future?**
(verses *What did we do wrong?*)


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Suicide Case Review
Be Clear From Start

Even if treatment wasn't followed, areas of improvement are discovered, or the best therapist in the world provided treatment...

The **outcome**
may have still been the same


Data Sources: Hendin et al., 2006; Sung, 2016

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Principles for Explaining Suicide

- Explain the suicide as one resulting from many events, not from a single event.
- Avoid excessive details on method used.
- Do not portray as a successful means to an end or a viable option.
- Minimize public expressions of grief so as not to glorify the suicide
- Be mindful of contagion.

Data Sources: Jobes et. al, 2000, CDC, 1994

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Principles for Talking with Family

- Develop game plan with supervisor or designated person.
 - Know what is/isn't confidential
- Rehearse call (to "clear" emotions and anticipate call).
- Offer condolences, convey concern
 - Do they have support? From whom?
 - How can you be of service?
 - Help establish plan for emotional support
- Offer to meet with them (their home? your office?)
- If needed, stay close (briefly)

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Principles for Talking with Family

- Protect patient confidentiality
- If confidentiality is lifted, work to honor what would nonetheless matter to patient (based on what you know)
- Help family heal
- **Remember:** Most families of chronically suicidal patients know their loved one was high risk for suicide (well before they got to you)

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Suggestions for the call:

- Sympathy and needs
- Pain focus, not treatment details
- Contact information and referral resources
- Offer to meeting
- Avoid saying "I am sorry"
- Ask about privacy preferences; document call and consent
- If no contact, follow up 1-3 weeks later

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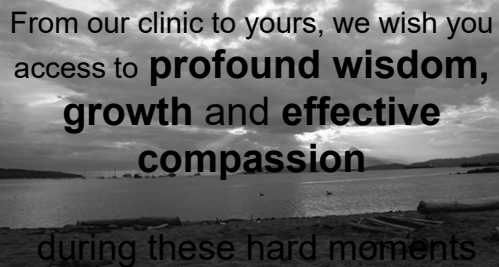
Questions to consider

- What worries you most about losing a client to suicide?
- What do you anticipate being the hardest part afterwards?
- What would you be most likely to avoid?
- What forms of self-care would be most helpful for you?
- How could your colleagues support you?
- How would you support a colleague?
- How might your previous experiences with suicide interfere with engaging in effective postvention steps/ behaviors?

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Contemplating Your Next Steps



From our clinic to yours, we wish you access to **profound wisdom, growth and effective compassion** during these hard moments

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Portland DBT Institute
Phone: 503.290.3295
