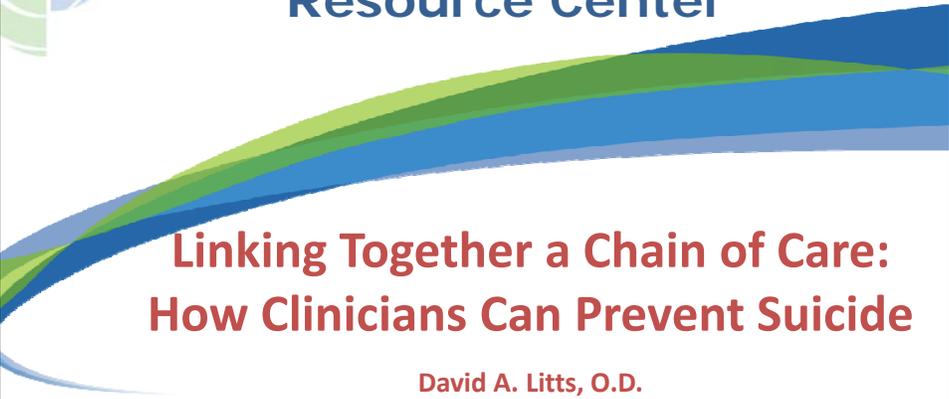




Suicide Prevention Resource Center



Linking Together a Chain of Care: How Clinicians Can Prevent Suicide

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Director Science and Policy

Suicide Prevention Resource Center

June 29, 2010



Overview

- ❖ Epidemiology
- ❖ Detecting suicide risk
- ❖ Clinical interventions and tools
- ❖ Training Implications





Epidemiology

Incidence

- ❖ ~ 1 Million suicides/year worldwide*
- ❖ >33,000 suicides/year in the U.S.**
- ❖ Suicide attempts, U.S.(adults)***
 - ◆ 1.1 M attempts
 - ◆ 678,000 attempts requiring medical care
 - ◆ 500,000 attempts resulting in an overnight hospital stay
- ❖ Suicide ideation, U.S. (adults)***
 - ◆ 8.3 M (3.7%) seriously considered suicide during past year

Source: * World Health Organization. *Suicide Prevention*. Retrieved from http://www.who.int/mental_health/prevention/en.
 ** National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. (2009). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Available from: www.cdc.gov/injury/wisqars/index.html.
 ***Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009). *The NSDUH Report: Suicidal Thoughts and Behaviors among Adults*. Rockville, MD.





Demographics

- ❖ **Suicides:**
 - ◆ Male:female = 4:1
 - ◆ Elderly white males -- highest rate
 - ◆ Working aged males – 60% of all suicides
 - ◆ American Indian/Alaskan Natives, youth and middle age
- ❖ **Attempts:**
 - ◆ Female>>male
 - ◆ Rates peak in adolescence and decline with age
 - ◆ Young Latinas and LGBT

National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. (2009). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Available from: www.cdc.gov/injury/wisqars/index.html.






Epidemiology among Patients

Prevalence of suicidal behaviors

- ❖ **Suicidal ideation at time of visit**
 - ◆ Primary care: 2- 4 percent (Olfson (1996, 2003))
 - ◆ Emergency departments: 8-12 percent*
- ❖ **Suicide attempts**
 - ◆ Pts with major depression: 10% attempted during a past major depressive episode**
- ❖ **Suicide**
 - ◆ Pts with serious mental illness: lifetime suicide risk 4-8% (1% lifetime suicide risk for general population)***

* Claassen, C.A. & Larkin, G.L. (2005). Occult suicidality in an emergency department population. *The British Journal of Psychiatry*, 186, 352-353.

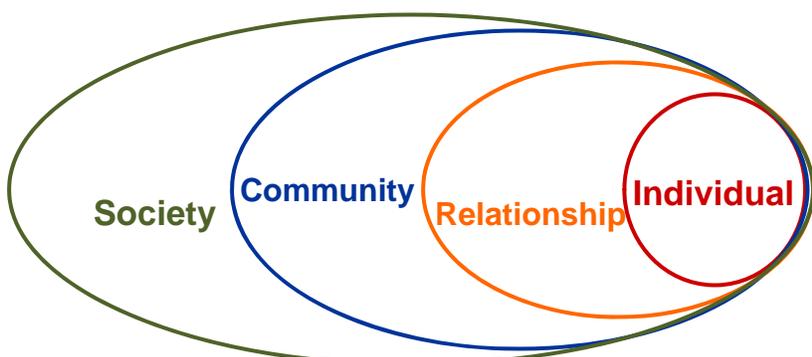
** Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009). *The NSDUH Report: Suicidal Thoughts and Behaviors among Adults*. Rockville, MD.

*** Litts, D. A., Radke, A. Q., & Silverman, M. M. (Eds.). (2008). *Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority*. Washington, D.C.: NASMHPD/SPRC.





Understanding Risk Factors



Society Community Relationship Individual






Clinically Salient Suicide Risk Factors

- ❖ Previous suicide attempt
 - ◆ Majority die on first attempt
- ❖ Suicidal ideation, plan, intent
- ❖ Major mood or anxiety disorder
- ❖ Substance abuse disorder
- ❖ Other mental illnesses
- ❖ Co morbidity (psych/SA)
- ❖ Physical illness, chronic pain
- ❖ CNS disorders/traumatic brain injury
- ❖ Insomnia

— Suicidality

— Generally:
Risk ↑'d with
1) severity of symptoms,
2) # of conditions
3) recent onset






Additional Salient Risk Factors for MHPs

- ❖ **Impulsivity**

Source: U.S. Public Health Service. (2001). *National strategy for suicide prevention: Goals and objectives for action*. Rockville, MD: U.S. Department of Health and Human Services.
- ❖ Failed belongingness
- ❖ Perceived burdensomeness
- ❖ Loss of fear of death and pain

Source: Joiner, T. (2005). *Why people die by suicide*. Cambridge, MA: Harvard University Press.






Protective Factors

- ❖ Family and community connections/support
- ❖ Clinical care (availability and accessibility)
- ❖ Resilience
- ❖ Coping/life skills
- ❖ Frustration tolerance and emotion regulation
- ❖ Cultural and religious beliefs; spirituality

Source:
 U.S. Public Health Service. (2001). *National strategy for suicide prevention: Goals and objectives for action*.
 Rockville, MD: U.S. Department of Health and Human Services.
 Cha, C., Nock, M. (2009). Emotional intelligence is a protective factor for suicidal behavior. *Journal of the American Academy of Child and Adolescent Psychiatry*, 48(4), 422-430.





Warning Signs (For the Public)

Tier 1: Call 911 or seek immediate help

- ❖ Someone threatening to hurt or kill themselves
- ❖ Someone looking for ways to kill themselves: seeking access to pills, weapons, or other means
- ❖ Someone talking or writing about death, dying, or suicide

Rudd, M. D., Berman, A. L., Joiner, T. E., Jr., Nock, M. K., Silverman, M. M., Mandrusiak, M., Van Orden, K., & Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior*, 36(3), 255-262.






Warning Signs (For the Public)

Tier 2: Seek help by contacting a mental health professional or calling 1-800-273-TALK

- ❖ Hopelessness
- ❖ Rage, anger, seeking revenge
- ❖ Acting reckless or engaging in risky activities, seemingly without thinking
- ❖ Feeling trapped—like there's no way out
- ❖ Increasing alcohol or drug use
- ❖ Withdrawing from friends, family or society
- ❖ Anxiety, agitation, unable to sleep, or sleeping all the time
- ❖ Dramatic mood changes
- ❖ No reason for living; no sense of purpose in life

Rudd, M. D., Berman, A. L., Joiner, T. E., Jr., Nock, M. K., Silverman, M. M., Mandrusiak, M., Van Orden, K., & Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior*, 36(3), 255-262.





Triggering Events

- ❖ Acute events leading to:
 - ◆ Humiliation,
 - ◆ Shame, or
 - ◆ Despair
- ❖ Includes real or anticipated loss of:
 - ◆ Relationship
 - ◆ Status: financial or health

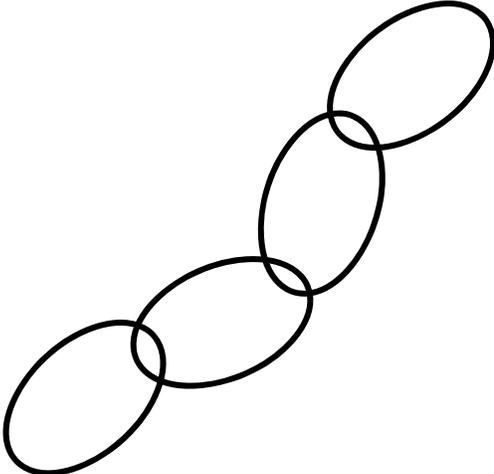
Source: Education Development Center, Inc. (2008). Suicide risk: A guide for ED evaluation and triage. Available online at: http://www.sprc.org/library/ER_SuicideRiskGuide8.pdf.




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Clinical Chain in Suicide Prevention

- ❖ Detecting potential risk
- ❖ Assessing risk
- ❖ Managing suicidality
 - ◆ Safety planning
 - ◆ Crisis support planning
 - ◆ Patient tracking
- ❖ MH Treatment
- ❖ F/U Contact



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Poll

- ❖ Look at the two clusters of conditions. Both represent conditions that in and of themselves increase risk for suicide. Which group is the more serious with regard to elevating suicide risk?
 - a. Chronic pain, traumatic brain injury, multiple sclerosis
 - b. Major depression, alcohol dependence

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Suicide Prevention Resource Center



Primary care

A Suicide Prevention Toolkit for (Rural) Primary Care
<http://www.sprc.org/pctoolkit/index.asp>



Psychosocial Problems in Primary Care

- ❖ In the United States health care system, primary care is the #1 source for mental health treatment.
- ❖ Primary care is many times a patient's only source for MH treatment of any kind.
- ❖ Approximately 70% of visits to a primary care clinic have at least some psychosocial or behavioral component contributing to the problem (Gatchel & Oordt, 2003)
- ❖ Depressive symptoms are more debilitating than diabetes, arthritis, GI disorders, back problems, and hypertension. (Wells et al, 1989)





Psychosocial Problems in Primary Care

- ❖ Comorbid psychiatric-physical disorders are more impairing than either “pure” psychiatric or “pure” physical disorders. (Kessler, Ormel, Demler & Stang, 2003)
- ❖ Less than 50% of PCPs feel competent in managing suicide (Annenberg Adolescent Mental Health Project, 2003)
- ❖ Mental health was 1 of 6 research areas primary care providers felt were important (AAP, 2002)






Why Suicide Prevention in Primary Care?

- ❖ Suicide decedents twice as likely to have seen a PC provider than a MH provider prior to suicide*
 - 70% of adolescents see their primary care provider (PCP) at least once pre year (U.S. DHHS, 2001)
 - 77% of adolescents with mental health problems go see their PCP (Schurman et al., 1985)
 - 16% of adolescents in the last year were depressed and 5% were at risk for a serious suicide attempt (Survey of pediatricians--Annenberg Adolescent Mental Health Project, 2003)
- ❖ PC acceptable to patients
 - Over 70% of adolescents willing to talk with a primary care physician about emotional distress (Good et al., 1987)

* Luoma, J.B., Martin, C.E., & Pearson, J.L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry*, 159(6), 909-916.





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Why Primary Care?

- ❖ More than 25 medical illnesses have been identified with significantly elevated risks for suicidality (Berman & Pompili, *in preparation*).
- ❖ Many at-risk subpopulations served (e.g., HIV, chronic illness, family planning)
 - ❖ Reach working-aged men
- ❖ Many key risk factors for suicide are easily observed in primary care settings
- ❖ Fits chronic disease mgmt model in pt centered medical home
- ❖ Patient education

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Prescribing in PC

Figure 1
Percentage of U.S. retail psychotropic prescriptions written from August 2006 to July 2007, by type of provider^a

Drug Class (N)	Psychiatrists and addiction specialists	General practitioners, obstetrician-gynecologists, and pediatricians	Physician assistants and nurse practitioner	All other specialties and psychologists
Total (N=472,173)	23%	59%	6%	13%
Antimania (N=4,163)	66%	22%	6%	6%
Antipsychotics (N=53,328)	49%	37%	6%	8%
Stimulants (N=35,634)	34%	52%	5%	9%
Antidepressants (N=232,660)	21%	62%	6%	11%
Anxiolytics (N=146,388)	13%	65%	5%	17%

^a Ns represent prescriptions in thousands

Mark T, et al. Psychotropic drug prescriptions by medical specialty. *Psychiatric Services* (2009). Vol 60. No 9. p. 1167.

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Contact with Primary Care and Mental Health Prior to Suicide

All Ages	Month Prior	Year Prior
Mental Health	19%	32%
Primary Care	45%	77%

Contact w/ PC by Age	Month Prior
Age <36	23%
Age >54	58%

Contact w/ MH by Gender	Month Prior	Year Prior
Men	18%	35%
Women	36%	58%



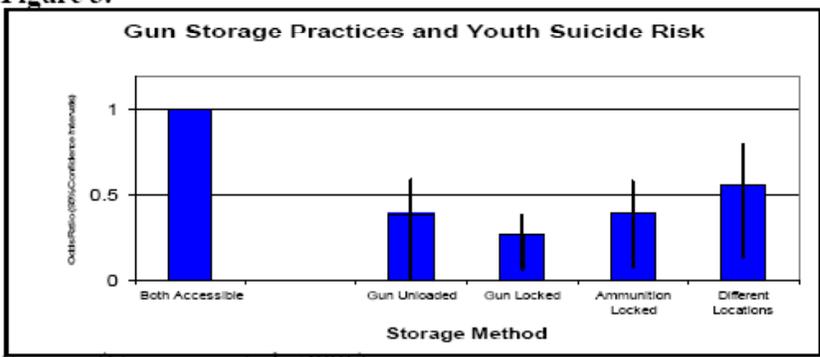
Luoma, J.B., Martin, C.E., & Pearson, J.L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry*, 159(6), 909-916.





Safe Firearm/Ammunition Storage

Figure 3.



Storage Method	Odds Ratio (95% CI)
Both Accessible	1.0
Gun Unloaded	~0.4
Gun Locked	~0.3
Ammunition Locked	~0.4
Different Locations	~0.6

Source: (Grossman et al., 2005)






PC Opportunities Missed

- ❖ Actors portrayed standardized patients with symptoms of major depression and sought help in PCP offices. *PCPs inquired about suicide in less than half (42%) of these patient encounters* (Feldman et al, 2007).
- ❖ 20% of adults who die by suicide visit their PCP within 24 hours of their death. (Pirkis & Burgess, 1998)
- ❖ Youths are more likely to die by suicide than all medical illnesses combined (CDC)





Toolkit: Primary Care Suicide Prevention Model

Prevention Practices

1. Staff vigilance for warning signs & key risk factors
2. Universal depression screening for adults and adolescents
3. Patient education:
Safe firearm storage
Suicide warning signs & 1-800-273-TALK (8255)

Intervention

Warning signs: major depression, anxiety, substance use disorder, insomnia, chronic pain, PTSD, TBI

No →

No screening necessary

↓

Screen for presence of suicidal thoughts

No →

Rescreen periodically

↓

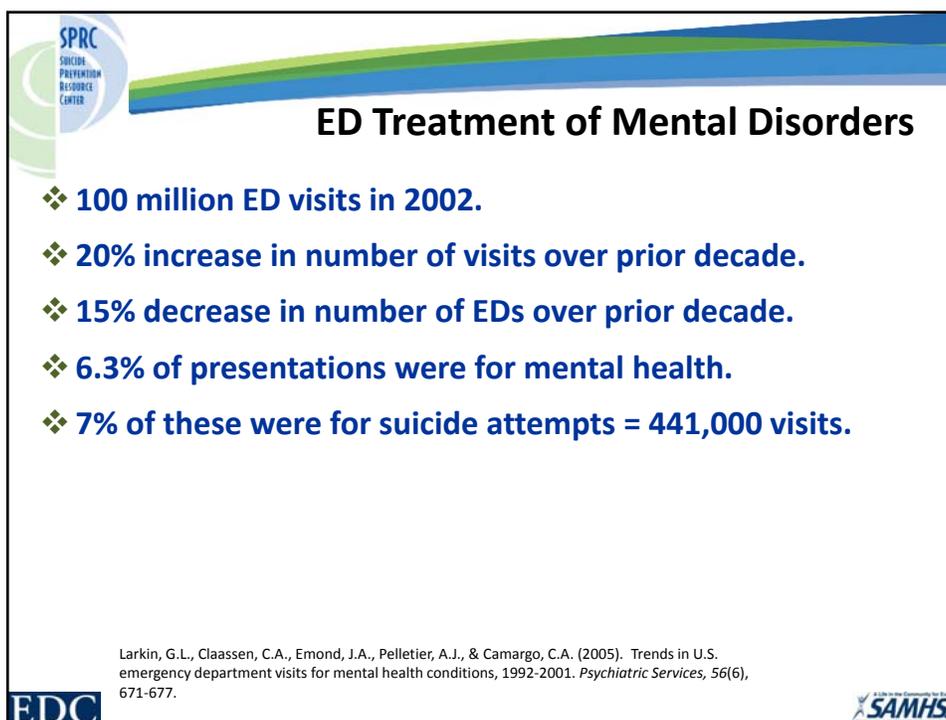
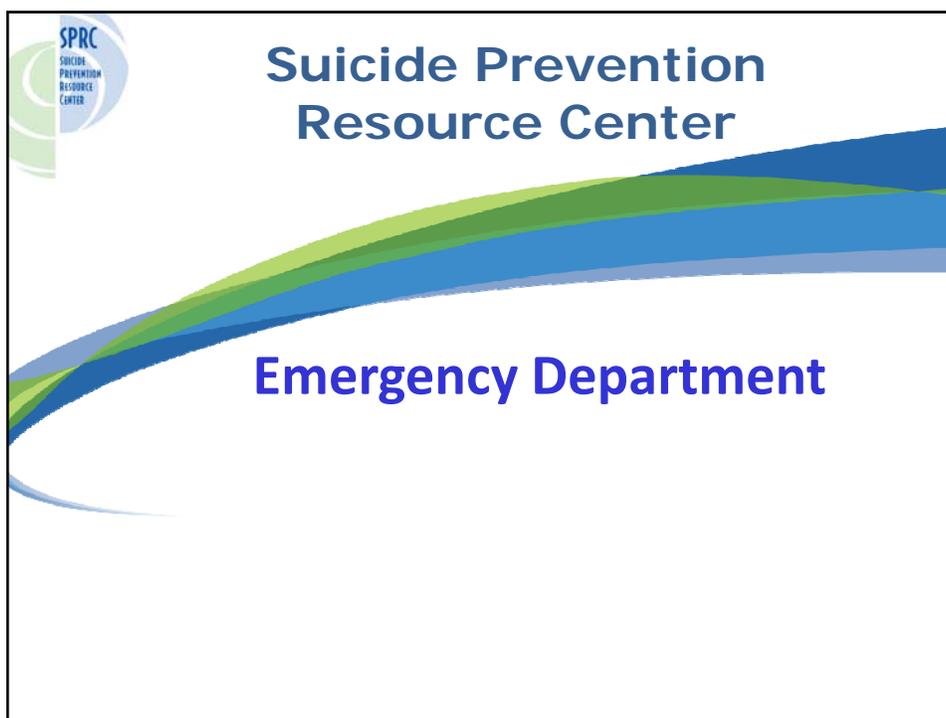
Suicide Risk Assessment

↓

Risk Management: referral, treatment initiation, safety planning, crisis support planning, documentation, tracking and follow up









ED Treatment of Mental Disorders

- ❖ Suicidal ideation (SI) common in ED patients who present for medical disorders.
- ❖ Study of 1,590 ED patients showed 11.6% with SI, 2% (n=31) with definite plans.
- ❖ 4 of those 31 attempted suicide within 45 days of ED presentation.

Source: Claassen CA, Larkin GL. Occult suicidality in an emergency department population. *British J Psychiatry*. V186, 352-353, 2005.

- ❖ 1 in 10 suicides are by people seen in an ED within 2 months of dying

Source:
Weis, M. A., Bradberry, C., Carter, L. P., Ferguson, J., & Kozareva, D. (2006). An exploration of human services system contacts prior to suicide in South Carolina: An expansion of the South Carolina Violent Death Reporting System. *Injury Prevention, 12*(Suppl. 2), ii17-ii21.
C. Bradberry, personal communication with D. Litts regarding South Carolina NVDRS-linked data. December 19, 2007.





ED Treatment of Mental Disorders

Kemball et al (2008)

- ❖ 165 ED patients with suicidal ideation self-identified on a computer screening
- ❖ Physician and nurse were informed
- ❖ Six month f/u
 - ❖ 10% were transferred to psychiatric services
 - ❖ Only 25% had any notation in the chart re suicide risk
 - ❖ 4 were seen again in the ED with suicide attempts—none were there for mental health problems on the index visit

Kemball, R.S., Gasgarth, R., Johnson, B., Patil, M., & Houry, D. (2008). Unrecognized suicidal ideation in ED patients: Are we missing an opportunity. *American Journal of Emergency Medicine, 26*(6), 701-705.






Emergency Department Guide

Evaluation and rapid triage	
<p>High risk patients include those who have:</p> <ul style="list-style-type: none"> • Made a serious or nearly lethal suicide attempt • Persistent suicide ideation or intermittent ideation with intent and/or planning • Psychosis, including command hallucinations • Other signs of acute risk • Recent onset of major psychiatric syndromes, especially depression • Been recently discharged from a psychiatric inpatient unit • History of acts/threats of aggression or impulsivity 	<p>Recommended interventions:</p> <ul style="list-style-type: none"> • Rapid evaluation by a qualified mental health professional • One-to-one constant staff observation and/or security • Locked door preventing elopement from assessment area • Inpatient admission • Administer psychotropic medications and/or apply physical restraints as clinically indicated • Other measures to guard against elopement until evaluation is complete (<i>see below</i>)
<p>Moderate risk patients include those who have:</p> <ul style="list-style-type: none"> • Suicide ideation with some level of suicide intent, but who have taken no action on the plan • No other acute risk factors • A confirmed, current and active therapeutic alliance with a mental health professional 	<p>Interventions to consider:</p> <ul style="list-style-type: none"> • Guard against elopement until evaluation is complete (<i>see below</i>) • Psychiatric/psychological evaluation soon/when sober • Use family/friend to monitor in ED if a locked door prevents elopement
<p>Low risk patients include those who have:</p> <ul style="list-style-type: none"> • Some mild or passive suicide ideation, with no intent or plan • No history of suicide attempt • Available social support 	<p>Interventions to consider:</p> <ul style="list-style-type: none"> • Allow accompanying family/friend to monitor while waiting • May wait in ED for non-urgent psychiatric/psychological evaluation

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Poll

❖ **Have you ever directly asked someone if he/she was thinking about ending his/her life?**

- Yes
- No

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Normalizing Technique

- ❖ Makes it easier for a person to disclose a highly stigmatized condition: having suicidal thoughts
- ❖ Step 1: Normalizing: Tell the person that it is not uncommon for people in their circumstances to feel hopeless, want to die, or even consider killing themselves
- ❖ Step 2: Inquiry: Have you ever had any of those feelings or thoughts?

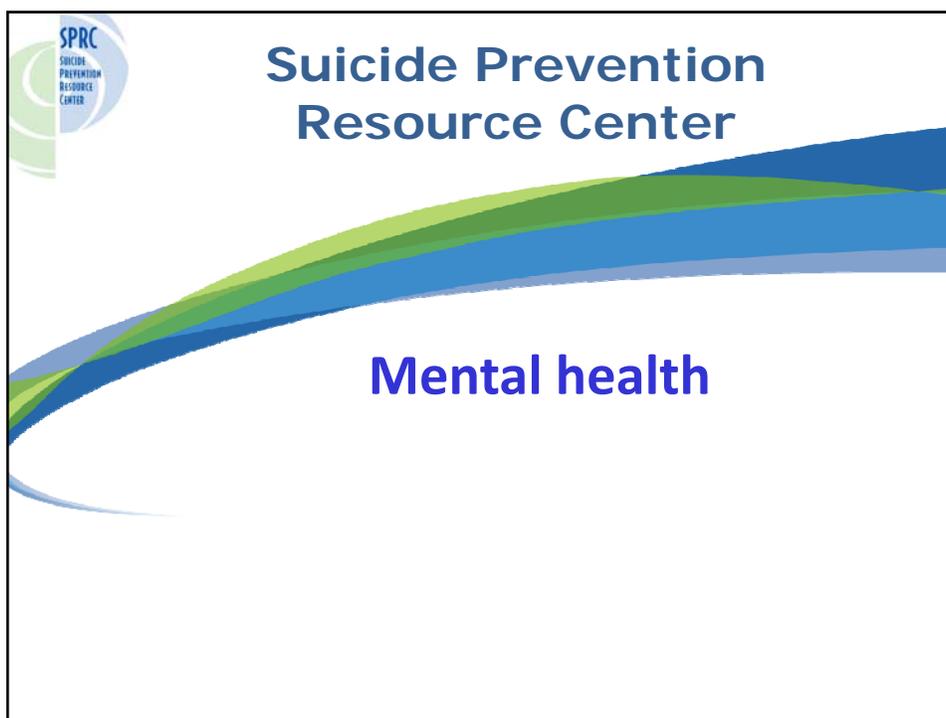
EDC 



Skill Building: Risk Detection Using Normalizing Technique

- ❖ Scenario A: 74 y/o male being treated with marginal success for severe chronic back pain associated with degenerative changes in the lumbar spine. He was recently widowed. His affect is consistent with someone who has lost hope.
- ❖ Scenario B: 24 y/o veteran of two Iraq War deployments with traumatic brain injury. After two years of rehabilitation, he is coming to terms with the magnitude of his long-term disability.
- ❖ Scenario C: 38 y/o female with debilitating panic attacks that interfere with work performance and her ability to meet her responsibilities to her family. She mentioned drinking more and more to try to “get through”.

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Mental Health Services

- ❖ ~19% of suicides had contact with MH within the past month; ~32% within the past year (Luoma, 2002)
- ❖ 41% of suicide decedents who had received inpatient psychiatric care died within one year of their discharge; 9% within one day. (Pirkis, 1998)
- ❖ Of patients admitted for attempt (Owens et al., 2002)
 - ❖ 16% repeat attempts within one year
 - ❖ 7% die by suicide within 10 years
 - ❖ Risk of suicide “hundreds of times higher” than general population

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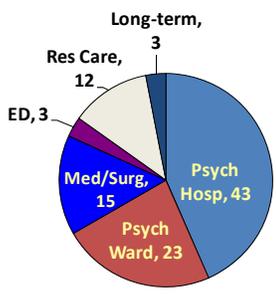


Inpatient Suicide

- ❖ **Second most common sentinel event reported to The Joint Commission (First is wrong-side surgery)**
- ❖ **Since 1996*: 416(14%)**
- ❖ **Method:**
 - ❖ **71% Hanging**
 - ❖ **14% Jumping**

Factors in Suicide

- ❖ **87% Deficiencies in physical environment**
- ❖ **83% Inadequate assessment**
- ❖ **60% Insufficient staff orientation or training**



Location	Count
Psych Hosp	43
Psych Ward	23
Med/Surg	15
Res Care	12
ED	3
Long-term	3

* Sentinel event reporting began in 1996.
Source: Joint Commission on Accreditation of Healthcare Organizations. (2005). *Reducing the Risk of Suicide*. Oak Brook, IL: JCAHO.






Trends in Suicidal Behavior 1990-1992 vs 2001-2003 National Comorbidity Survey and Replication*

Suicide	1990-1992 14.8/100k	2001-2003 13.9/100k
Ideation	2.8%	3.3%
Plan	.7%	1.0%
Gesture	.3%	.2%
Attempt	.4%	.6%

- ◆ **9708 respondents, face-to-face survey, aged 18-54**
- ◆ **Queried about past 12 months**
- ◆ **No significant changes**

* Kessler, R.C., Berglund, P., Borges, G., Nock, M., & Wang, P.S. (2005). Trends in suicide ideation, plans, gestures, and attempts in the United States, 1990-1992 to 2001-2003. *JAMA*, 293(20), 2487-2495.




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Trends in Suicidal Behavior 1990-1992 vs 2001-2003 National Comorbidity Survey and Replication*

	1990-1992	2001-2002	P
Ideators with plans	19.6%	28.6%	<i>p</i> =.04
Planners with gestures	21.4%	6.4%	<i>p</i> =.003
Tx among ideators with gestures	40.3%	92.8%	
Tx among ideators with attempts	49.6%	79.0%	

* Kessler, R.C., Berglund, P., Borges, G., Nock, M., & Wang, P.S. (2005). Trends in suicide ideation, plans, gestures, and attempts in the United States, 1990-1992 to 2001-2003. *JAMA*, 293(20), 2487-2495.

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Insufficient Treatment

“A recognition is needed that effective prevention of suicide attempts might require substantially more intensive treatment than is currently provided to the majority of people in outpatient treatment for mental disorders.”¹

¹ Kessler, R.C., Berglund, P., Borges, G., Nock, M., & Wang, P.S. (2005). Trends in suicide ideation, plans, gestures, and attempts in the United States, 1990-1992 to 2001-2003. *JAMA*, 293(20), 2487-2495.

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Suicide Prevention Resource Center



Clinical interventions



Patient Management Tools

- ❖ **Safety Plan/Crisis Response Plan**
 - ❖ Collaboratively developed with patient
 - ❖ Template that is filled out and posted
 - ❖ Includes lists of warning signs, coping strategies, distracting people/places, support network with phone numbers

Stanley, B. & Brown, G.K. (2008). *Safety plan treatment manual to reduce suicide risk: Veteran version*. Washington, DC: U.S. Department of Veterans Affairs.

Rudd, M.D., Mandrusiak, M., & Joiner Jr., T.E. (2006). The case against no-suicide contracts: The commitment to treatment statement as a practice alternative. *Journal of Clinical Psychology*, 62(2), 243-51.





Safety Planning Guide

*A Quick Guide for Clinicians
may be used in conjunction with the "Safety Plan Template"*

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?
A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is brief, is in the patient's own words, and is easy to read.

WHO SHOULD HAVE A SAFETY PLAN?
Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?
Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN
There are 6 Steps involved in the development of a Safety Plan.

URL: <http://www.sprc.org/library/SafetyPlanningGuide.pdf>

Safety Planning

Sample Safety Plan

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____

2. _____

3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (breathemaster, techniques, prayer, etc. etc.):

1. _____

2. _____

3. _____

Step 3: People and social settings that provide distraction:

1. Name _____ Phone _____

2. Name _____ Phone _____

3. Place _____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name _____ Phone _____

2. Name _____ Phone _____

3. Name _____ Phone _____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name _____ Phone _____
Clinician Pager or Emergency Contact # _____

2. Clinician Name _____ Phone _____
Clinician Pager or Emergency Contact # _____

3. Local Urgent Care Services _____
Urgent Care Services Address _____
Urgent Care Services Phone _____

4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____

2. _____

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The one thing that is most important to me and worth living for is: _____

<http://www.sprc.org/library/SafetyPlanTemplate.pdf>

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Patient Management Tools



- ❖ **Crisis Support Plan**
 - ◆ Provider collaborates with Pt and support person
 - ◆ Contract to help- includes reminders for ensuring a safe environment & contacting professionals when needed

Education Development Center, Inc. (2008). *Assessing and Managing Suicide Risk, Participant Manual*. Newton, MA: EDC, Inc.

- ❖ **Patient tracking**
 - ◆ Monitor key aspects of suicide risk at each visit

Jobes, D.A. (2006). *Managing suicidal risk: A collaborative approach*. New York, NY: Guilford Press.






Crisis Support Plan

CRISIS SUPPORT PLAN

FOR: _____ DATE: _____

I understand that suicidal risk is to be taken very seriously. I want to help _____ find new ways of managing stress in times of crisis. I realize there are no guarantees about how crises resolve, and that we are all making reasonable efforts to maintain safety for everyone. In some cases inpatient hospitalization may be necessary.

Things I can do:

- Provide encouragement and support
 - _____
 - _____
- Help _____ follow his/her Crisis Action Plan
- Ensure a safe environment:
 1. Remove all firearms & ammunition
 2. Remove or lock up:
 - knives, razors, & other sharp objects
 - prescriptions & over-the-counter drugs (including vitamins & aspirin)
 - alcohol, illegal drugs & related paraphernalia
 3. Make sure someone is available to provide personal support and monitor him/her at all times during a crisis and afterwards as needed.
 4. Pay attention to his/her stated method of suicide/self-injury and restrict



URL: <http://www.sprc.org/library/CrisisSupportPlan.pdf>





ED Patient Engagement

Brief Interventions



SAMHSA's National Registry of Evidence-based Programs and Practices

[Home](#)
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[Contact](#)

Home > Find Interventions > Find Results > Intervention Summary

Emergency Room Intervention for Adolescent Females

Date of Review: October 2007

Emergency Room Intervention for Adolescent Females is a program for teenage girls 12 to 18 years old who are admitted to the emergency room after attempting suicide. The intervention, which involves the girl and one or more family members who accompany her to the emergency room, aims to increase attendance in outpatient treatment following discharge from the emergency room and to reduce future suicide attempts. A review of the literature suggests that factors related to treatment noncompliance following a suicide attempt include family discord, maternal psychopathology, attempter depression, and negative experiences with emergency room staff. The intervention consists of three components designed to improve the emergency room experience for the adolescent and family, thereby changing the family's conceptualization of the suicidal behavior and expectations about therapy. First, a 2-hour training is conducted separately with each of the six groups of staff working with adolescents who have attempted suicide. Second, the adolescents and their families watch a 20-minute videotape, filmed in Spanish and dubbed in English, that portrays the emergency room experience of two adolescents who have attempted suicide. Last, a bilingual crisis therapist delivers a brief family treatment in the emergency room.

[Descriptive Info](#)
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[Ratings](#)
[Study Populations](#)
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Descriptive Information

Topics	Mental health treatment
Areas of Interest	Suicide prevention
Outcomes	Outcome 1: Treatment adherence Outcome 2: Adolescent symptoms of depression Outcome 3: Adolescent suicidal ideation Outcome 4: Maternal symptoms of depression Outcome 5: Maternal attitudes toward treatment



URL: http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=168



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Emergency Departments

Registry of Evidence-Based Suicide Prevention Programs **AfSP**

Emergency Department Means Restriction Education

Program Description
The goal of this intervention is to educate parents of youth at high risk for suicide about limiting access to lethal means for suicide. Education takes place in emergency departments and is conducted by department staff (an un-evaluated model has been developed for use in schools). Emergency department staff are trained to provide the education to parents of crisis who are assessed to be at risk for suicide. Lethal means covered include firearms, medications (over-the-counter and prescribed), and alcohol. To help with the safe disposal of firearms, collaboration with local law enforcement or other appropriate organizations is advised. The content of parent instruction includes:

1. Informing parents(s), apart from the crisis, that the child was at increased suicide risk and why the staff believed so;
2. Informing parents that they can reduce risk by limiting access to lethal means, especially firearms; and
3. Educating parents and problem solving with them about how to limit access to lethal means.

Evaluation Design and Outcomes
Evaluation of the program consisted of a prospective follow-up design of 103 adults whose children were seen in an emergency department for mental health assessment or treatment. Children were included in the evaluation if they received a mental health assessment, regardless of whether suicide behavior and ideation were present.

Fig. 1: Percent of Parents Restricting Access or Clipping

Category	Trained parents (%)	Controlled parents (%)
Prescribed medications	73%	45%
Over-the-counter medications	49%	27%
Alcohol	47%	1%
Firearms	67%	2%

SPRC Classification
Effective

Program Characteristics
Intervention Type Treatment
Target Age 6-19
Gender Female & Male
Ethnicity Multiple
IOM Category Universal Selective Indicated

Assignment to the treatment or no-treatment conditions was by convenience. A follow-up telephone interview of parents indicated that exposure to the means restriction education program resulted in a statistically significant increase in the self-reported restriction of means in their homes (see Figure 1).

* Catanese, A.A., John, M.S., di Battista, J., & Clarke, D.M. (2009). Acute cognitive therapy in reducing suicide risk following a presentation to an emergency department. *Behaviour Change*, 26(1), 16-26.

EDC URL: http://www.sprc.org/featured_resources/bpr/ebpp_PDF/emerg_dept.pdf **SAMHSA**

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Emergency Department

Before discharging

Check that:

- Firearms and lethal medications have been secured or made inaccessible to patient
- A supportive person is available and instructed in follow-up observation and communication regarding signs of escalating problems or acute risk
- A follow-up appointment with a mental health professional has been recommended and, if possible, scheduled
- The patient has the name and number of a local agency that can be called in a crisis, knows that the National Suicide Prevention Lifeline **1-800-273-TALK (8255)** is available at any time, and understands the conditions that would warrant a return to the ED

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Effective MH Therapies

- ❖ **Lithium (bipolar disorder)**
- ❖ **Clozapine (schizophrenia)**
- ❖ **Dialectic Behavioral Therapy (Linehan)**
 - ◆ ↓ in hospitalization and attempts for chronic suicidal behavior
- ❖ **Brief intervention, cognitive-behavioral therapy (Brown)**
 - ◆ 50% decrease in repeat attempts
 - ◆ ↓ depression
 - ◆ ↓ hopelessness
- ❖ **Brief intervention, psychodynamic interpersonal therapy (Guthrie)**

**** Quality of the therapeutic relationship a key factor**
Goldsmith, S.E., Pellmar, T.C., Kleinman, A.M., & Bunney, W.E. (Eds.) (2002). *Reducing suicide: A national imperative*. Washington, DC: The National Academies Press.





Caring Follow-up Contact

- ❖ **605 Adults d/c from ED after attempt by o/d or poisoning (Vaiva et al., 2007)**
 - ◆ Contact by phone one month after d/c ↓'d attempt by 45% during next year
- ❖ **Patients who by 30 days after hospital d/c for suicide risk had dropped out of tx (Motto, 2001)**
 - ◆ Randomized to receive f/u non-demanding post-cards
 - ◆ ↓ suicides for two years
- ❖ **394 randomized after a suicide attempt (Carter et al., 2005)**
 - ◆ Those who rec'd 8 postcards during year ↓'d repeat attempt by 45%




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Caring F/U Contact—ED

- ❖ **Brief intervention and f/u contact**
 - ◆ **Randomized controlled trial; 1867 Suicide attempt survivors from five countries (all outside US)**
 - ◆ **Brief (1 hour) intervention as close to attempt as possible**
 - ◆ **9 F/u contacts (phone calls or visits) over 18 months**

Results at 18 Month F/U

Outcome	Usual Care (%)	Brief Intervention (%)
Died of Any Cause	~2.7	~1.3
Died by Suicide	~2.2	~0.2

Fleischmann, A., Bertolote, J.M., Wasserman, D., DeLeo, D., Bolhari, J., Botega, N.J., DeSilva, D., Phillips, M., Vijayakumar, L., Schlebusch, L., & Thanh, H. (2008). Effectiveness of brief intervention and contact for suicide attempters: A randomized controlled trial in five countries. *Bulletin of the World Health Organization*, 86(9), 703-709.

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Crisis Lines

- ❖ **Seriously suicidal callers reach out to crisis lines**
- ❖ **Effective outcomes— immediately following call and continuing weeks after**
 - ◆ **Decreased distress**
 - ◆ **Decreased hopelessness**
 - ◆ **Decreased psychological pain**
 - ◆ **Majority complete some or all of plans developed during calls**
- ❖ **Suicidal callers (11%) spontaneously reported the call prevented them from killing or hurting themselves**
- ❖ **Heightened outreach needed for suicidal callers**
 - ◆ **With a history of suicide attempt**
 - ◆ **With persistent intent to die at the end of the call**

Kalafat, J., Gould, M.S., Munfakh, J.L., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 1: Non-suicidal crisis callers. *Suicide & Life-Threatening Behavior*, 37(3), 322-37.
Gould, M.S., Kalafat, J., Harrismunkfakh, J.L., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 2: Suicidal callers. *Suicide & Life-Threatening Behavior*, 37(3), 338-52.

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Fourteenth
in a Series of
Technical
Reports



Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority

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March 2008





Crisis Lines—New Roles

- ❖ Crisis hotlines can provide continuity of care for at risk persons outside of traditional BH system services
- ❖ Provide access to f/u in rural areas
- ❖ Monitor/track at risk persons after hospital discharge




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Patient Education

Firearm Locking Devices



Which one is right for you?



Suicide Warning Signs

Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1-800-273-TALK if you or someone you know exhibits any of the following signs:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities—seemingly without thinking
- Feeling trapped—like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

Sources:
<http://depts.washington.edu/lokidup/>
<http://www.suicidepreventionlifeline.org/Materials/Default.aspx>

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Poll

❖ Which of the following has been shown to be ineffective in preventing suicidal behaviors?

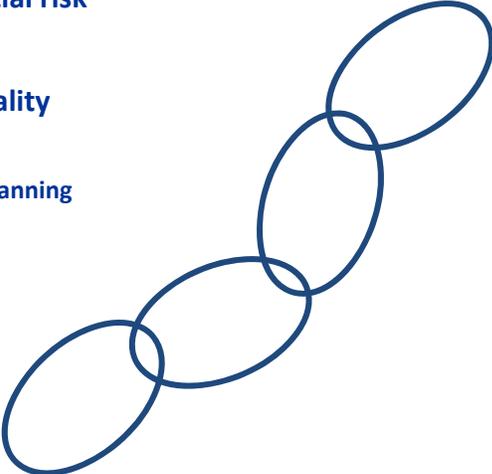
- Collaborative safety planning
- Counseling parents on safe storage of guns/ammo
- No suicide contract
- Brief cognitive therapy
- Caring follow-up contacts

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Clinical Chain in Suicide Prevention

- ❖ Detecting potential risk
- ❖ Assessing risk
- ❖ Managing suicidality
 - ◆ Safety planning
 - ◆ Crisis support planning
 - ◆ Patient tracking
- ❖ Treatment
- ❖ F/U Contact



Suicide Prevention Resource Center

Training Implications



Competency Chasm

- ❖ Large portions of mental health providers have had no formal training in the assessment and management of suicidal patients

Rudd, M.D., Cukrowicz, K.C., & Bryan, C.J. (2008). Core competencies in suicide risk assessment and management: Implications for supervision. *Training and Education in Professional Psychology, 2*(4), 219-228.





Competency Chasm

Chief Psychiatry Resident Survey

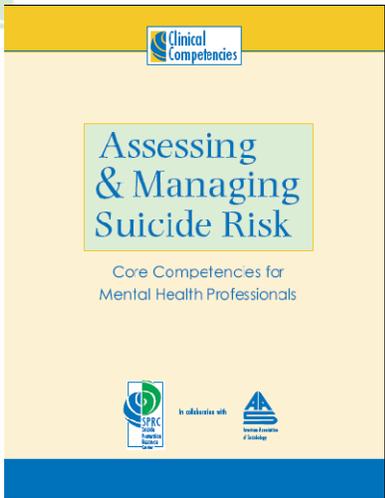
- ❖ Surveyed chief residents from all 181 U.S. residency programs (59% response rate)
- ❖ 19 of 25 topics were judged to require more attention by more than half of the respondents.

Melton, B.B. & Coverdale, J.H. (2009). What do we teach psychiatric residents about suicide? A national survey of chief residents. *Academic Psychiatry, 33*(1), 47-50.






Clinical Training for Mental Health Professionals



- ❖ One day workshop
- ❖ Developed by 9-person expert task force
- ❖ 24 Core competencies
- ❖ Skill demonstration through video of David Jobs, Ph.D.
- ❖ 175 Page Participant Manual with exhaustive bibliography
- ❖ 6.5 Hrs CE Credits
- ❖ ~100 Authorized faculty across the U.S.

Contact Isaiah Branton, AMSR Training Coordinator, SPRC Training Institute, at 202-572-3789 or ibranton@edc.org






Nationally Disseminated Curricula for MHPs

- ❖ ***Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals.***
 - ◆ A one-day workshop focusing on competencies
 - ◆ <http://www.sprc.org/traininginstitute/amr/clincomp.asp>
- ❖ ***QPRT: Suicide Risk Assessment and Management Training.***
 - ◆ A 10 - hour course available either on-line or face-to-face
 - ◆ <http://www.qprinstitute.com>
- ❖ ***Recognizing and Responding To Suicide Risk: Essential Skills for Clinicians.***
 - ◆ Two-day advanced interactive training with post-workshop mentoring.
 - ◆ <http://www.suicidology.org/web/guest/education-and-training/rrsr>
- ❖ ***Suicide Care: Aiding life alliances (Canada only)***
 - ◆ One-day seminar on advanced clinical practices
 - ◆ <http://www.livingworks.net/SC.php>






SCREENING FOR MENTAL HEALTH

*A Resource Guide
for Implementing the*

The Joint Commission
2007 Patient Safety Goals on Suicide

EDC URL: <http://www.sprc.org/library/jcsafetygoals.pdf> **SAMHSA**



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