Wisconsin Public Psychiatry Network Teleconference (WPPNT)

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WPPNT Reminders

How to join the Zoom webinar

- **Online:** https://dhswi.zoomgov.com/j/1606358142
- **Phone:** 669-254-5252
- Enter the Webinar ID: 160 635 8142#.
  - Press # again to join. (There is no participant ID)

Reminders for participants

- Join online or by phone by 11 a.m. Central and wait for the host to start the webinar. Your camera and audio/microphone are disabled.
- Download or view the presentation materials. The evaluation survey opens at 11:59 a.m. the day of the presentation.
- Ask questions to the presenter(s) in the Zoom Q&A window. Each presenter will decide when to address questions. People who join by phone cannot ask questions.
- Use Zoom chat to communicate with the WPPNT coordinator or to share information related to the presentation.

- Participate live to earn continuing education hours (CEHs). Complete the evaluation survey within two weeks of the live presentation and confirmation of your CEH will be returned by email.
- A link to the video recording of the presentation is posted within four business days of the presentation.
- Presentation materials, evaluations, and video recordings are on the WPPNT webpage: https://www.dhs.wisconsin.gov/wppnt/2023.htm

Assessing Risk in People Who Are Chronically Suicidal

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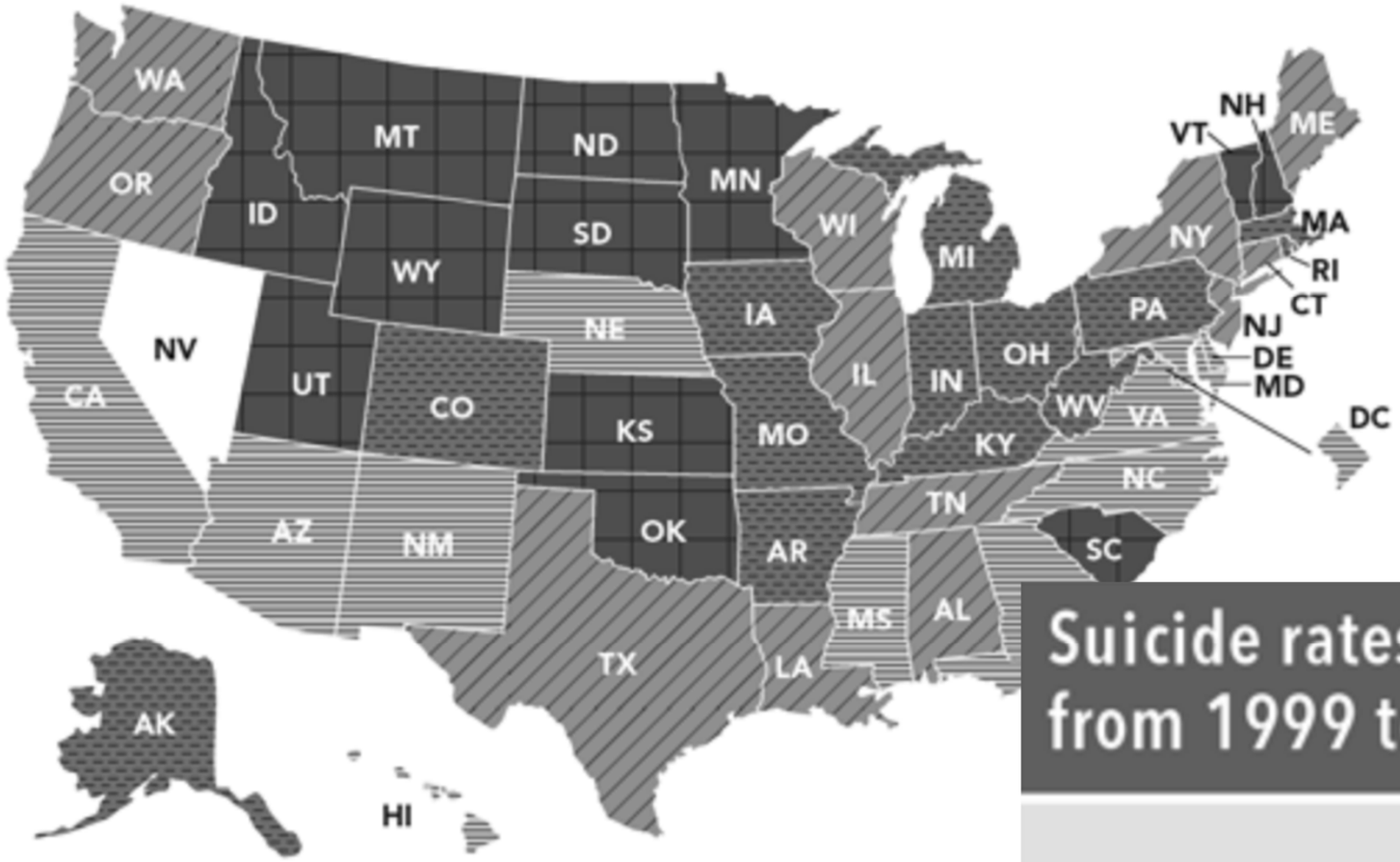
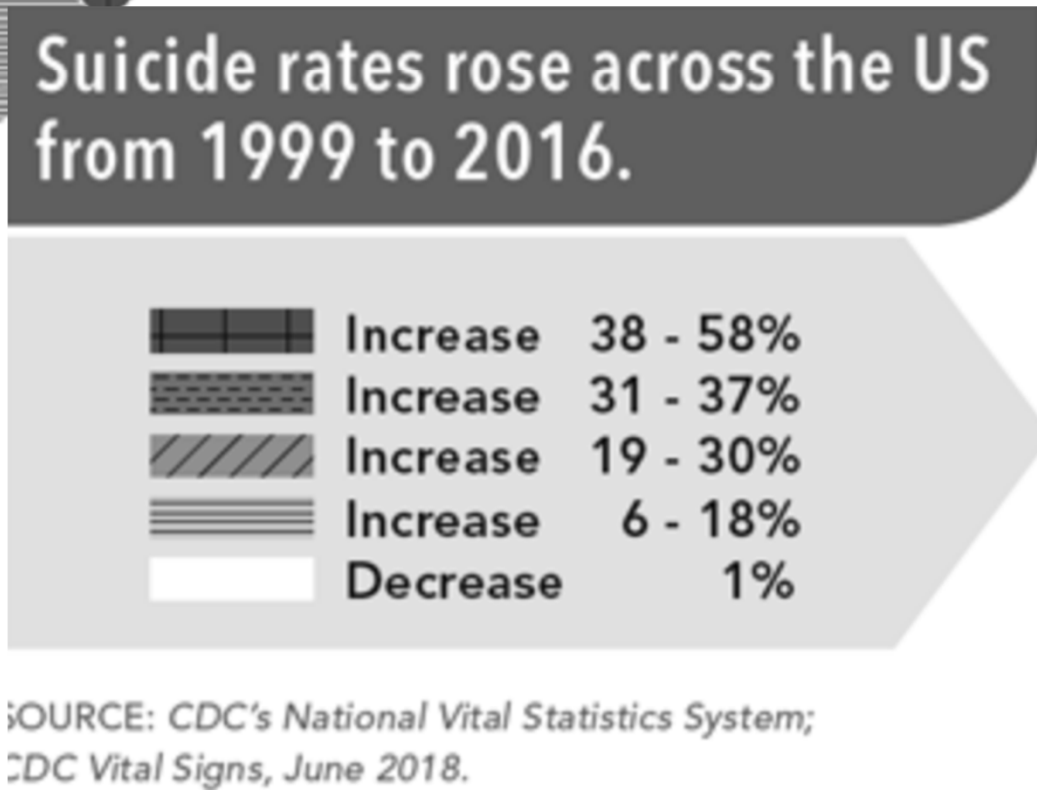
CDC Vital Statistics on Suicide





Suicide Rate in U.S. increased 30% 1999-2015

Know the 12 Suicide WARNING SIGNS

- Feeling like a burden
- Being isolated
- Increased anxiety
- Feeling trapped or in unbearable pain
- Increased substance use
- Looking for a way to access lethal means
- Increased anger or rage
- Extreme mood swings
- Expressing hopelessness
- Sleeping too little or too much
- Talking or posting about wanting to die
- Making plans for suicide

CDC Public Education Campaign on Suicide

Suicide Risk Assessment

Modifiable Risk Factors	Non-Modfiable Risk Factors	Protective Factors
Current suicide ideation Current suicide plan Intent Access to means Capacity to take action Substance abuse/dependence Intoxication Impulsivity Psychic distress Insomnia despair	Recent suicide attempts Prior suicide attempts Rehearsal behaviors Chronic illness Recent psych hospital Male Widowed, divorced, single Caucasion Unemployed Childhood abuse/neglect Exposure to suicide TBI	Children at home Religious prohibition Satisfaction with life Sense of responsibility to other Positive problem solving Capacity to self-regulate Therapeutic alliance Outpatient care in place

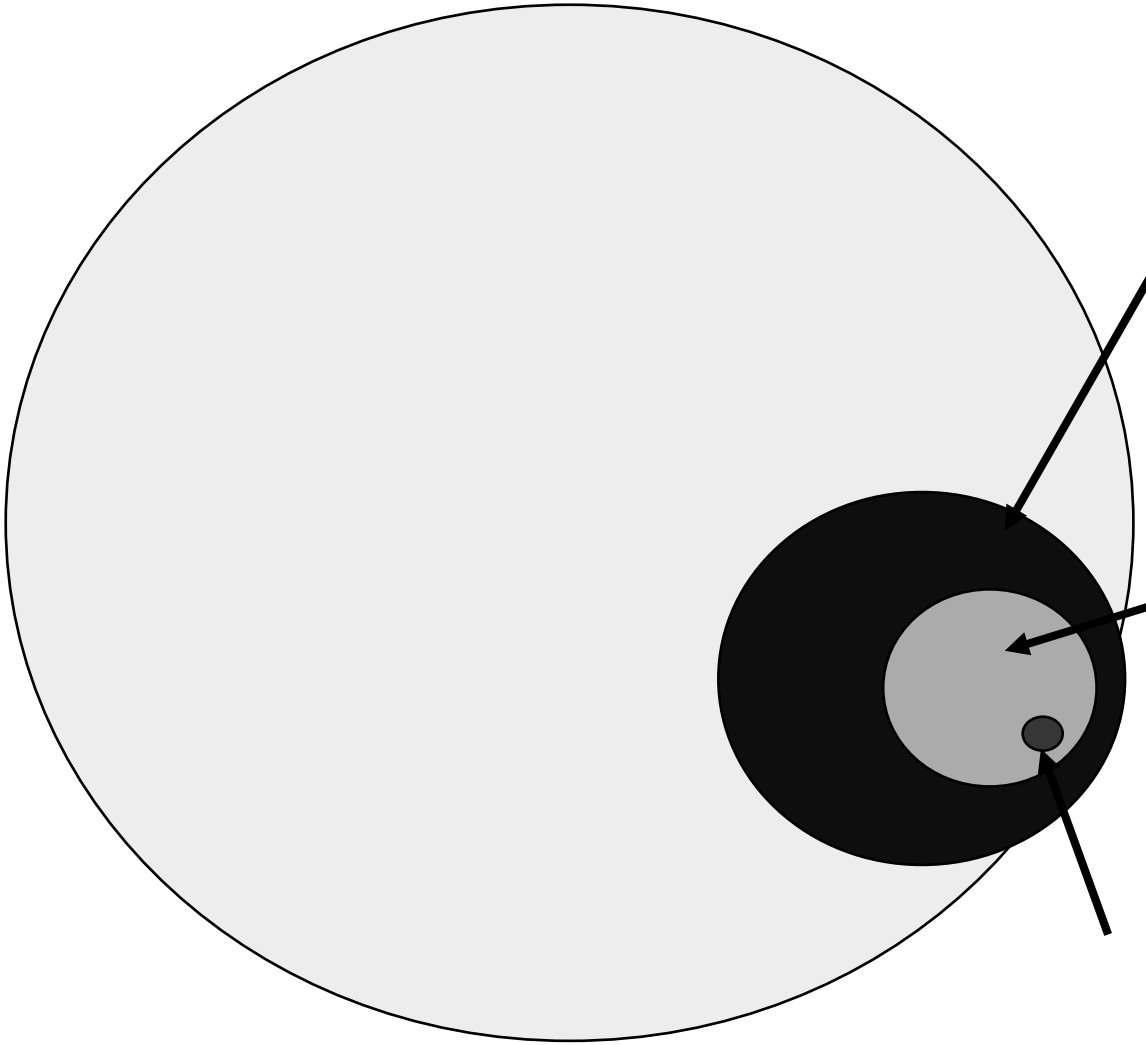
32 prospective studies of suicide

Will inevitably admit many people where this was not needed, and will not admit some people who subsequently die either in the near future or eventually

Best predictor is past attempt

- Risk Rating Scale
- Must still use clinical exam

It is extremely difficult to predict low base-rate behavior



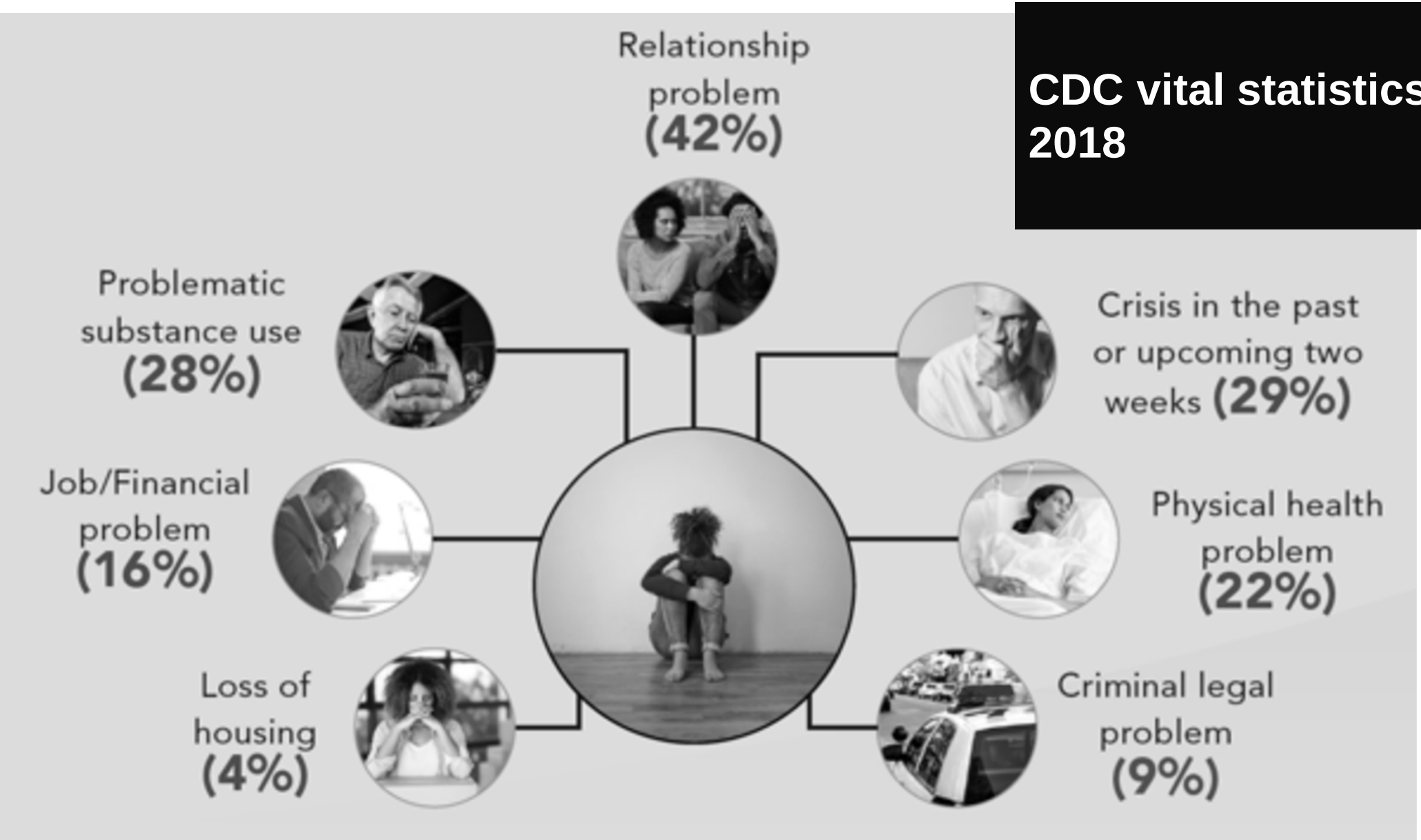
14 % lifetime prevalence of suicidal ideation

4 % lifetime prevalence of suicide plan

.01 % will complete suicide

Factors Relating to Suicide

CDC vital statistics 2018



90 % of People Who Die by Suicide Have a Mental Illness…….

BUT

- It is sometimes assumed that someone who kills themselves must be ill
- Substance “misuse” in 40% of suicides
  harmful use of alcohol, binge drinking, alcohol intoxication
- Depression in 34%--post hoc diagnosis
- Schizophrenia in 4%

Braithwaite: Suicide Prevention and Mental Illness: BMJ 2012 345; e8201
Kamerow: Can Suicide Be Prevented? BMJ 2012, Nov 7

Cumulative Incidence of Suicide by Time Since First Psychiatric Contact among Men (A) and Women (B)

- National cohort of absolute risk of suicide (Denmark)
- 36 year follow up (mean 18 years)
- N = 176,000
- People admitted to psychiatric hospital 1/1/55- 12/31/91

	Men	Women
Bipolar	7.7 %	4.8 %
Unipolar	6.7 %	7.1 %
Schizophrenia	6.6 %	4.9 %
Non-Psych Control	0.7 %	0. 3 %

Nordentoft, M. et al. Arch Gen Psychiatry 2011;68:1058-1064.

Lethality is correlated with method used

Men more likely to use more violent and lethal ways to kill themselves:

Jumping, hanging, carbon monoxide and *guns*

Women more likely to use “passive” ways to kill themselves:

Poisoning, cutting

Suicide after hospital discharge

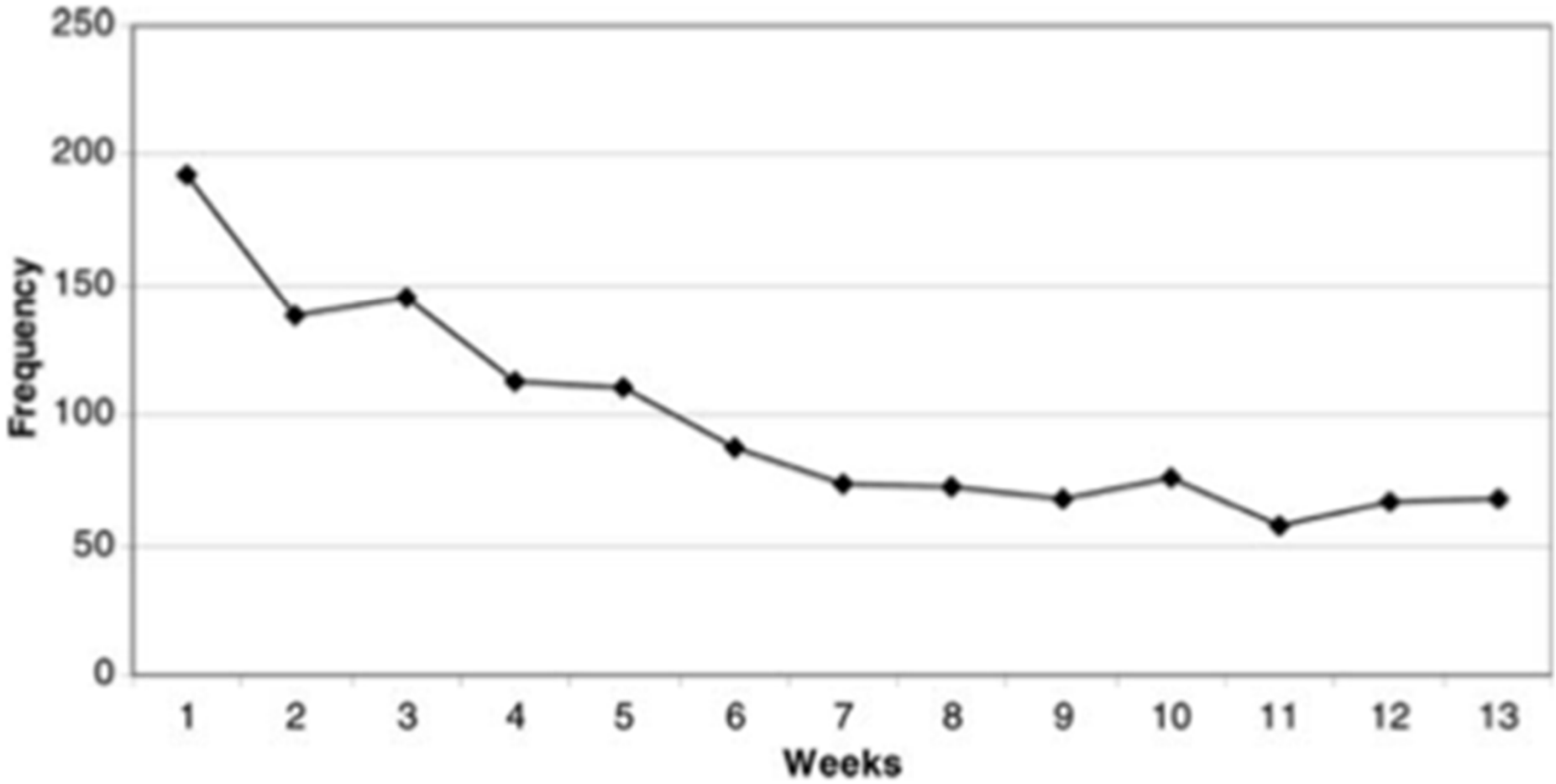
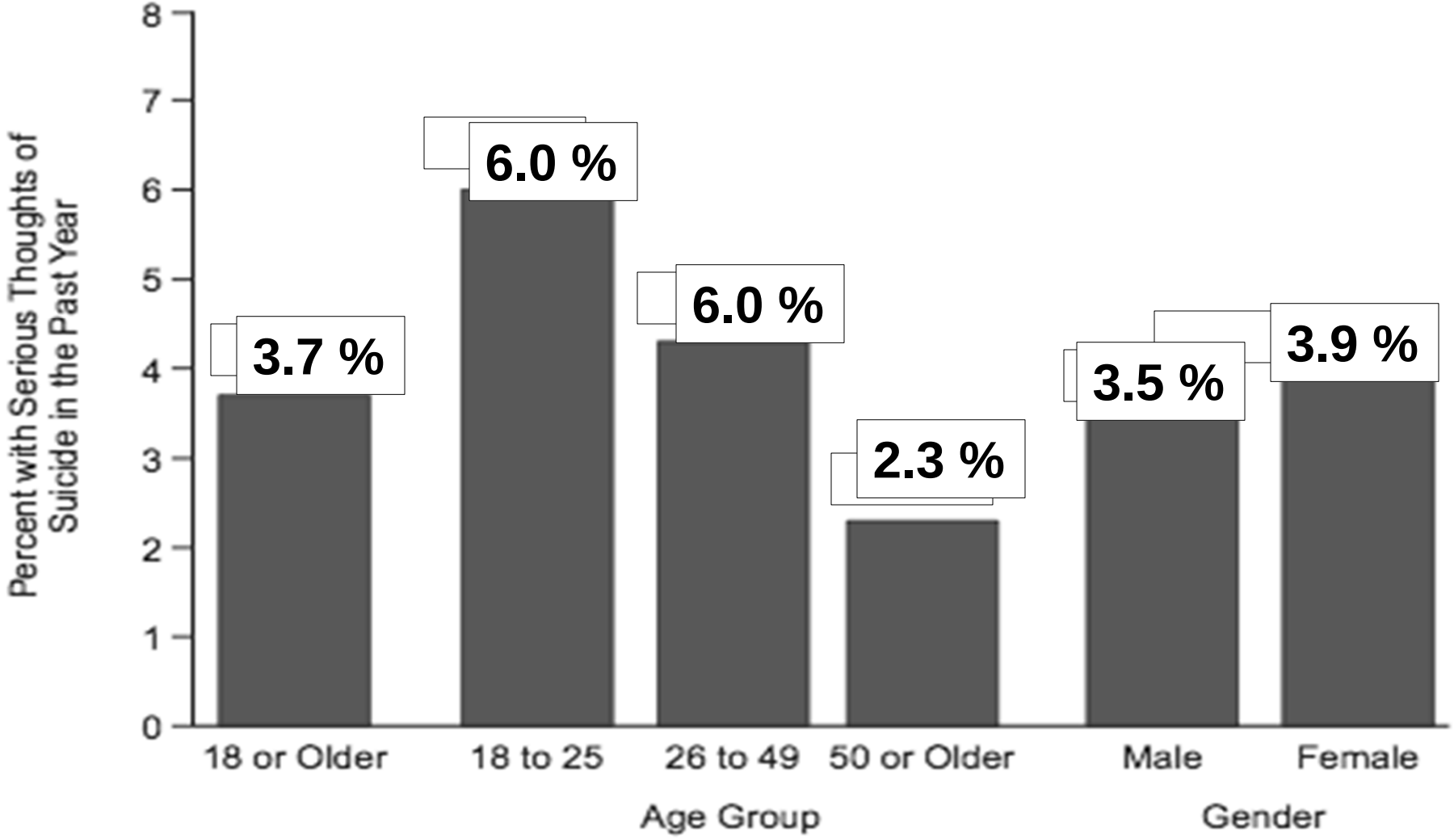


Fig. 5 Number of Inquiry suicide cases per week following discharge from an in-patient psychiatric ward. *Source*: Avoidable Deaths.[14]

The thought of suicide is a great consolation: by means of it one gets successfully through many a bad night

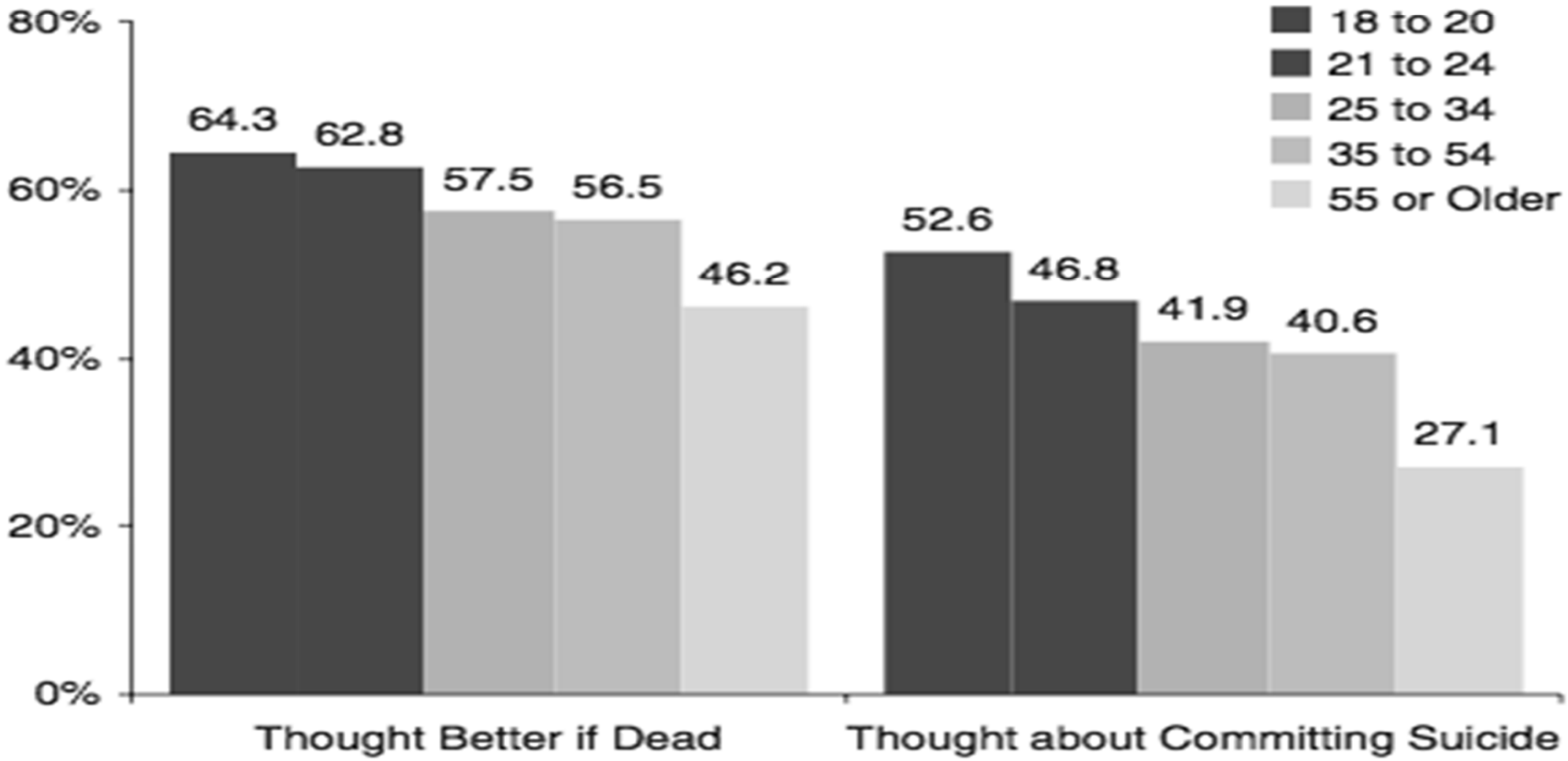
Friedrich Nietzsche

Figure 2.3 Suicidal Thoughts in the Past Year among Adults Aged 18 or Older, by Age and Gender: 2009



2009 National Survey on Drug Use and Health: Mental Health Findings: SAMHSA

Figure 2. Percentages Reporting Suicidal Thoughts among Adults Aged 18 or Older with a Past Year Major Depressive Episode, by Age Group: 2004 and 2005 NSDUHs



Source: SAMHSA, 2004 and 2005 NSDUHs

Suicide attempt:

ANY self harm attempt from someone expressing the intent to kill themselves

para-suicide (rather than suicide gesture) non-lethal suicide attempt

Vs

Self harm attempt for some other reason

Columbia Suicide Severity Rating Scale C-SSRS)

A process of structured exploration that has detailed assessment of:

- Suicidal Ideation: from wish to be deal to specific ideation with specific plan
- Intensity of ideation: frequency, duration, controllability, deterrents, reason for ideation
- Exploration of any suicidal attempt, non-suicidal self-injurious behavior, aborted attempt, or preparatory acts
- Detailed exploration of any actual attempt

Columbia Severity Rating Scale (C-SSRS)

- **Suicidal ideation (5 questions)**
- **Intensity of ideation**
- **Suicidal behavior**

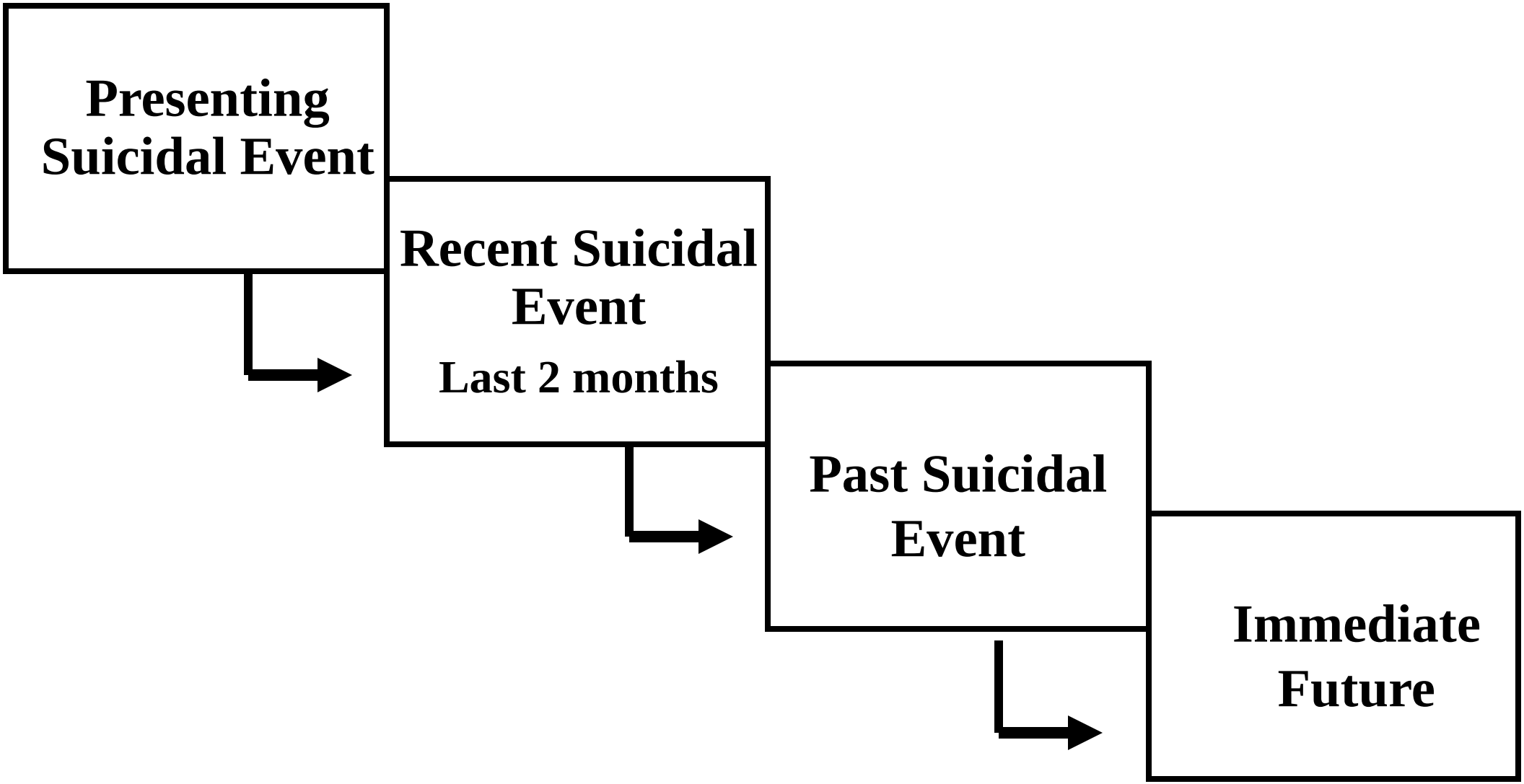
Posner et al. The Columbia–Suicide Severity Rating Scale: Initial Validity and Internal Consistency Findings From Three Multisite Studies With Adolescents and Adults. Am J Psychiatry. 2011 Dec;168(12):1266-77.

CSS-RS

1. **Wish to be dead**
2. **Non-specific suicidal thoughts**
3. **Active Suicidal Thoughts with method**
4. **Activity suicidal ideation with some intent to act**
5. **Active suicidal ideation with specific plan and intent**

CASE: Chronological Assessment of Suicidal Events

Shawn Shea 1998



CAMS: Collaborative Assessment and Management of Suicidality: David Jobes

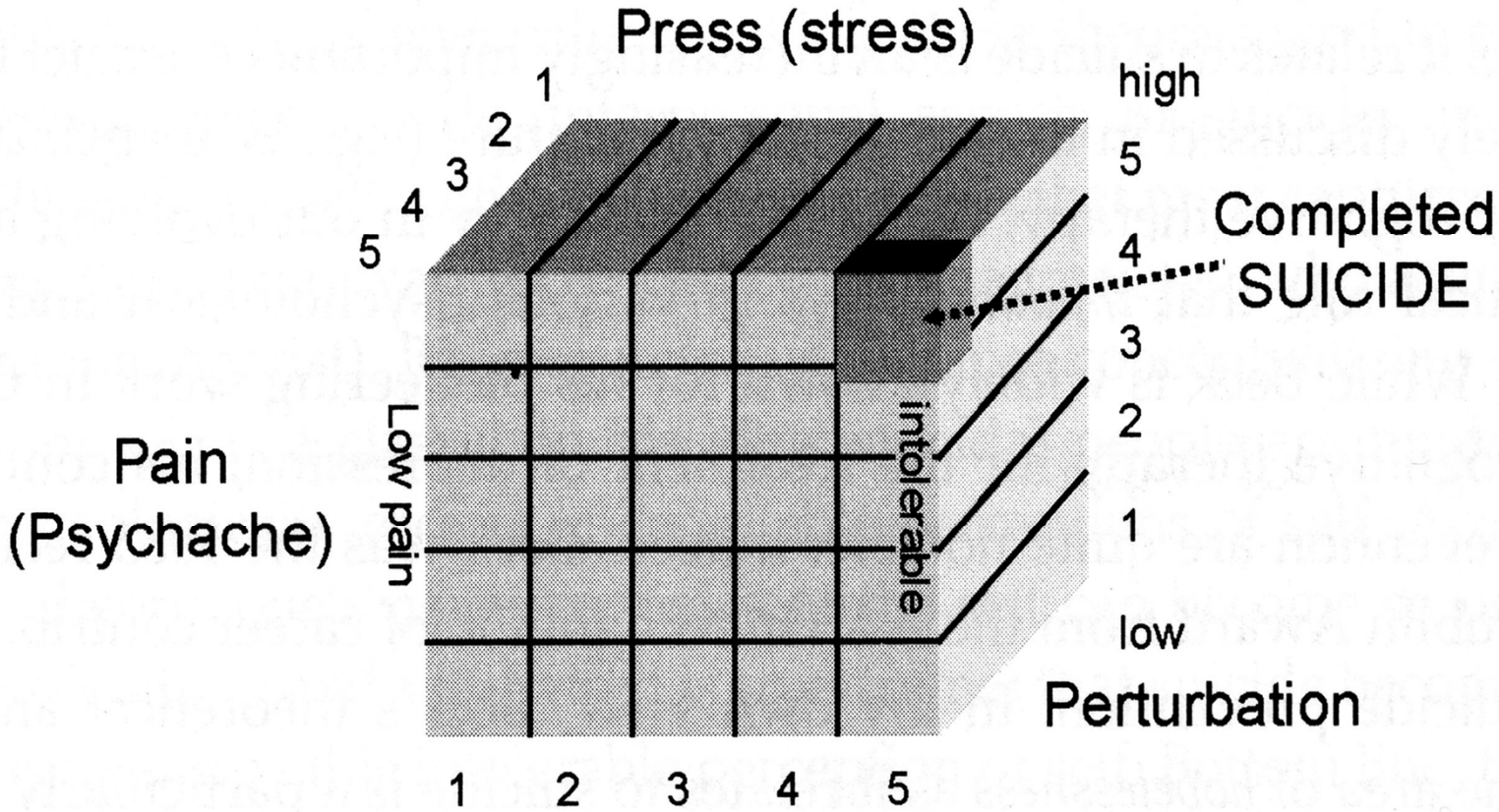


FIGURE 2.2. Shneidman's Cubic Model of Suicide. From Shneidman (1987). Copyright 1987 by the American Psychological Association. Reprinted by permission.

SSF: Suicide Status Form (Jobes)

	1) **RATE PSYCHOLOGICAL PAIN** (*hurt, anguish, or misery in your mind; **not** stress; **not** physical pain*): **Low Pain: 1 2 3 4 5 :High Pain**
_____	What I find most painful is: _____
	2) **RATE STRESS** (*your general feeling of being pressured or overwhelmed*): **Low Stress: 1 2 3 4 5 :High Stress**
_____	What I find most stressful is: _____
	3) **RATE AGITATION** (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*): **Low Agitation: 1 2 3 4 5 :High Agitation**
_____	I most need to take action when: _____
	4) **RATE HOPELESSNESS** (*your expectation that things will not get better no matter what you do*): **Low Hopelessness: 1 2 3 4 5 :High Hopelessness**
_____	I am most hopeless about: _____
	5) **RATE SELF-HATE** (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): **Low Self-Hate: 1 2 3 4 5 :High Self-Hate**
_____	What I hate most about myself is: _____
	6) **RATE OVERALL RISK OF SUICIDE:** **Extremely Low Risk: 1 2 3 4 5 :Extremely High Risk** **(will not kill self) (will kill self)**
N/A	

General considerations in crisis intervention:

- Be interested in any recent change
- Be active
- Get a DETAILED story of what happened when
  - helps organize the sense of chaos
  - Provides critical information
- Listen and give the patient permission to talk
- Make sure everyone else also has a chance to tell their story

Evaluate current suicidal ideation (cont)

Ask about preparations for death --

suicide note, giving away of possessions, etc.

There is a small slip between "gesture" and death.

The more specific and detailed the plan, the more available and lethal the method, the higher the risk.

Acute Vs. Chronic Risk

- Acute risk typically has a beginning, a precipitant, and can often benefit from active intervention
- Chronic risk may be longstanding, and acute intervention to decrease short term risk can increase long-term risk
  - Can lead to interventions that are ineffective
  - Can reinforce suicide and suicidal behaviors as a way of coping

Acute Vs Chronic Suicidal Pt

- Acutely suicidal: very detailed clinical assessment of suicide:
  - What is going on NOW
  - Context over past few weeks
  - Context over life
  - What is keeping this person alive: protective factors

- Assessment of chronically suicidal person
  - Has there been a change, in risk, in supports

Chronic Suicide Risk: different paths to suicide

- Ongoing intent to die: suicide an ongoing option
- Impulsive intent to die: someone is acutely overwhelmed
- Disinhibition impulse: intoxicated suicide
- Multiple suicide attemptor who “oversteps”: parasuicide as communication and expression of pain
- Subintentioned accident

Chronic state dependent suicide risk: The person is suicidal if…..

- Intoxicated
- In a fight with…
- Abandoned
- Overwhelmed by outside circumstance

  Medical illness, arrest, fired, etc.

The issue is not to predict risk of suicide, but to predict risk of specific circumstance occurring again

“Suicide” as shorthand for Dysregulated Affect

“I am suicidal” communicates negative emotions and confusion of what to do about them

- Being overwhelmed
- “I can’t stand it any more”
- “I need to die”

Communication style makes it hard for friends to give support, or person to receive support

Heap and Silk in Emergency Psychiatry ch 24 2008

Particular problem of cutting and other acts of low lethality with little tissue damage

- Skin cutting, burning, scab picking, suture removal, punching, …
- Cutting may, or may NOT be related to suicide or suicidal ideation
- May be a suicide attempt or a practice for suicide, but may also be an attempt to cope, to distract, to deal with overwhelming anxiety
- Cutting relieves anxiety: can be almost “addictive”

Assessment of acute risk:

- Do not dismiss suicidal feelings with casual reassurance.
- Give the patient a chance to talk about both wanting to die and wanting to live, before helping the patient decide to live.

Assessment of chronic risk:

- **Do not assume that someone with many suicide attempts will not go on to kill themselves**
- Always be alert to change in the person's life

Personal journey

- Is there a path out of current dilemma that makes sense
- Role of public humiliation
- Role of inner conflict

Expect Abrupt Transitions

- From feeling good to feeling hopeless to suicidal
- “Burn out” of chronic despair
- Assess risk of impulsivity

Management:

- GET CONSULATION: Do NOT go it alone
- When to ask about suicide, and when not?
- Document ongoing risk
- Never get complacent/never get overwhelmed
- What happens when you get tired [maybe suicide is not such a bad option]?

When do you NOT want to do a formal suicide risk

- Document why you are not doing a formal suicide assessment: Make this part of the treatment plan
- Document the formal “change” assessment
- Document changes in risk
- Assess for changes in HOPE

Always think about whatever it is that you are not thinking about that may connect with change in risk

Medical

Medication

Family/supports

Anniversaries

Symbolic moments/permissions/family/personal myths

Role of the Hospital—
What do we want to accomplish in this hospitalization?

- Time out for patient
- Time out for you and other staff/way to manage personal risk
- Way to get consultation
- Way to weather very short high risk situation
- Way to start new therapy
- Way to change dynamic issues and balance

How will the hospital help?

Is this realistic?

Manage your own personal risk

- What can you tolerate, and what not
- What risk is your back up willing to tolerate
- Do not make promises you cannot keep
- Be willing to break a promise IF there is immanent risk

Contingent Suicide

- "If you don't…I'll kill myself"
- VA sample followed 7 years
  - Contingent threateners made NO attempts
  - 10% of depressed with no threats committed suicide
- Contingent threaterns more likely to be
  - Antisocial, often with legal problems
  - Drug abusing
  - Homeless
- But expressed threats made them hard to manage

Lambert et al J Ment Health Admin 1997; 24 350-8
Report by Greist, 2008 Psych Update Conf

CBT-SP [CBT for suicide prevention]

Actively prevent dropouts

Communicate hope

A safety plan

Empathic assessment

Problem Solving

Distress tolerance

Coping cards

Hope box

Brief Cognitive Behavioral Therapy for Suicide Prvention: Bryan and Rudd
Choosing to Live by Thomas Ellis
The Carlat Report November 2018

Physician Suicide

Est 300-400 physician suicides/year

- Stigma from mental illness
- Access to lethal means
- Concerns about regulatory/license issues
- Need to “appear healthy”, be superhuman
- Limited support from colleagues
- Burnout and depression during their career

1 in 16 had SI in past 12 months

Medscape July 13, 2022

References:

DHS web page on Suicide Prevention

https://www.dhs.wisconsin.gov/prevent-suicide/index.htm

Four Strategies and 50 Opportunities for Reducing Suicide in Wisconsin

https://www.dhs.wisconsin.gov/publications/p02657.pdf