Hope and Recovery in Suicide Care

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Hope and Recovery in Suicide Care

8:30am Registration
9:00–10:30am Overview and Rationale
10:30–10:45am Morning Break: 15min
10:45am–12:00noon Management of Suicide Risk
12 noon–1:00pm Lunch
1:00-1:45pm Management of Suicide Risk
1:45–2:30pm Treatment of Suicide Risk
2:30–2:45pm Afternoon Break: 15min
2:45–4:30pm Treatment of Suicide Risk

Chronic Suicidality: Respondent vs. Operant Suicidality
Summary

Suicide is preventable.
Suicide is not inevitable.
Suicide care includes screening, assessment and risk formulation followed by management and treatment of suicide risk.
Treatment of suicide risk involves a collaborative relationship to facilitate self-awareness and self-management of suicide risk.

Hope and Recovery in Suicide Care

Working with Suicidal Clients: Hope and Recovery in Suicide Care
Jeffrey C. Sung, M.D.

<table>
<thead>
<tr>
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<th>Event</th>
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Suicide Risk Assessment & Management

Predisposing and Historical (Demographic)
Situational
Symptomatic
Suicide-specific
Protective factors
Risk Stratification
Conceptualization
Interventions
Justification for Care
Consultants

Hope and Recovery in Suicide Care

Handout p. 13

Handout p. 1-2

Working with Suicidal Clients: Hope and Recovery in Suicide Care
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Example: Hope and Recovery in Suicide Care

Risk and protective factors
- Demographic
- Situational
- Symptomatic
- Suicide-specific
- Protective factors

Management of suicide risk
- Connectedness
- MH & SUD
- Lethal means safety
- Safety planning

Man Therapy Testimonials: Tony

Suicide Risk Assessment

Predisposing and Historical (Demographic)
- Situational
- Symptomatic
- Suicide-specific
- Protective factors

Risk Assessment vs. Prediction
- Suicide risk assessment does not, cannot and is not intended to predict suicide or suicidal behavior in clinically relevant time frames.
- Suicide risk assessment is intended to identify modifiable targets for management and treatment and to guide clinical decision-making.

Suicide Care in Medical Systems

TJC NPSG 15.01.01: Suicide Prevention Portal
The Bree Collaborative: Suicide Care Recommendations

PHQ-9 (Patient Health Questionnaire) Question 9.
C-SSRS (Columbia Suicide Severity Rating Scale) first two questions.
SAFE-T (Suicide Assessment Five-step Evaluation and Triage) with C-SSRS.

Screening

Assessment and Risk Formulation

Safety Planning on Discharge

Patient Safety Plan Template

Handout p. 3-4
Handout p. 4-6
Handout p. 7

Cultural Factors and Suicide Risk

Cultural sanctions: Shameful events or prohibitions on suicide
- Suicide would bring shame to my family.
- I consider suicide to be morally wrong.

Idioms of distress: Ways of expressing distress, including suicidality
- When I get angry at something or someone, it takes me a long time to get over it.
- There is something in my life I feel ashamed of.

Minority stress: Negative experiences based on minority status
- The decision to hide my sexual or gender orientation to others causes me significant distress.
- Adjusting to America has been difficult for me.

Social discord: Relationship conflict, especially with family
- There is conflict between myself and members of my family.

Cultural Factors and Suicide Risk

Suicide rates vary across gender, ethnic, age, sexual minority and other cultural groups.

Certain situational factors may be more relevant in some cultural groups:
- Minority stress (i.e. LGBT)
- Social discord (i.e. Asian Americans)
- Cultural sanctions

The expression of distress or acceptability of suicide will differ among cultural groups:
- Cultural sanctions (i.e. African Americans)
- Idioms of distress (i.e. Latinos)

Cultural Factors and Suicide Risk

Minority stress: Stress related to minority status - i.e. negative experiences of exclusion, persecution, discrimination, prejudice.

Social discord: Family or social conflict.

Cultural sanctions: Actions or circumstances that have cultural meaning regarding acceptability or non-acceptability (shamefulness).

Idioms of distress: Culturally influenced ways of expressing distress or suicidality.

Make the Connection:
Healing through support groups and counseling

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Suicide Care in MH and SUD Treatment

**Screening**
- PHQ-9 C-SSRS, 1-2
- SAFE-T with C-SSRS
- Connectedness MH & SUD
- Lethal means Safety Planning

**Assessment**
- Clinician Patient
- Clinical judgment Risk & Protective Factors Suicide-specific

**Risk Formulation**

**Management**
- Suicide
- Treatment
- Life worth living

**Recovery**

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### Indicated Screening: When and How

**How to screen**
- Attitudes and approach
- Create context and ask directly
- Screening tools

**What to screen**
- Risk factors
- Situational Symptomatic Suicide-specific Warning signs

Continue with suicide-specific assessment using C-SSRS for a positive screen.

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### Attitudes and Approach: Barriers to Assessment

**Why did you not report SI?**

1. No suicidal ideation
2. Alcohol use
3. Fear of consequences
   - Stigma
   - Over-reaction
   - Loss of autonomy/control

**Clinician**
- PHQ-9: Suicide?
- Patient, ~25% attempters

- Non-judgmental listening and caring without over-reaction.
- Engage patients in their treatment plans.
- Ensure racial and ethnic diversity among clinicians.
- Provide proactive outreach based on history.

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### Indicated Screening when Risk Factors Are Present

**How to Ask: Create Context and Ask Directly**

**Create context**
- I've noticed that you've...
- With everything that's been happening...
- It sounds like you feel trapped...
- I can hear how defeated you feel...

**Listen for risk factors.**
- Say what you have seen or heard that leads you to believe that the person might be at risk of suicide.

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### Asking Directly about Suicide Risk

**Normalization:** Others have had similar experiences.

*Sometimes when people feel overwhelmed like this, they might start to wish they could be dead or think about suicide. What about you? Have you had those thoughts?*

**Shame attenuation:** Suicidal thoughts make sense, given the circumstances.

*Just to be safe, I try to check in with people I know are having a tough time to see whether it ever gets so bad they start thinking they’d be better off dead.*

**Ask directly:** Use the words suicide, killing yourself, or end your life.
Columbia Suicide Severity Rating Scale: 
Suicidal Ideation

- **Passive**: Have you ever wished you were dead or that you wouldn’t wake up from sleep?
- **Active**: Have you had actual thoughts of killing yourself?
- **With method**: Have you thought about how you would do it?
- **With intent**: Do you intend to act on your suicidal thoughts?
- **With plan**: Have you worked out the details of a plan for how you might kill yourself?

Columbia Suicide Severity Rating Scale: 
Suicidal Behavior

- **Aborted (self-interrupted) attempt**: Potentially self-injurious act that was stopped by the person before any injury could occur. Have you ever started to do something to end your life and then stopped yourself before you did anything?
- **Preparatory behavior**: Acts or preparation towards imminently making a suicide attempt. Have you prepared or rehearsed in way for your death? Have you taken any steps towards killing yourself?

Columbia Suicide Severity Rating Scale: 
Suicidal Behavior

- **Non-suicidal self-injury**: Self-injurious acts done with NO intent to die (i.e. to feel different, to influence someone else, or end emotional pain). Have you ever injured yourself without wanting to die?

- **Emotion regulation**: “I couldn’t take the [emotional] pain anymore. Anything was better than how I was feeling.”
- **Problem-solving**: “I was so overwhelmed, I didn’t know what else to do. I don’t know what I wanted.”
- **Communication**: “If you can’t give me anything for the pain, I should just kill myself.”

Indicated Screening: When and How

- **When to screen**: Risk factors
  - **Physician Patient Screening**
  - **Risk factors**
  - **PHQ-9**
  - **C-SSRS**
  - **1-2**

- **Warning signs**
  - **When to screen**
  - **Risk factors**
  - **Physician Patient Screening**
  - **PHQ-9**
  - **C-SSRS**
  - **1-2**

Functions of NSSI
More on this later

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21
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23
24
### Warning Signs for Suicide

- **S**uicidal Ideation
- **S**ubstance use
- **P**urposelessness
- **A**nxiety
- **T**hinking about or planning suicide
- **H**opelessness
- **W**ithdrawal
- **A**nger
- **R**ecklessness
- **M**ood changes

**? You must ask**

### More immediate action:
- Emergency assessment
  - 911 for transport or welfare check.
  - Family transport to ED.
- Immediate care coordination

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### Breakout Group: Screening and suicide-specific assessment

**Role Play**
- Enter the **breakout group** with other participants.
- Decide who will be the **Clinician** and who will be the **Patient**.
- The **Clinician** will conduct screening and assessment by asking all questions in italics:
  - Creating context and asking directly
  - Transitioning to suicide-specific assessment.
  - Assessing suicidal ideation and behavior using the C-SSRS questions.
- The **Patient** will answer yes to all questions and provide more information – suggestions are in italics.

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### Suicide Risk Formulation (Stratification)

"The estimation of suicide risk, at the culmination of the suicide assessment, is the **quintessential clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior." AJP, 2003

<table>
<thead>
<tr>
<th>Risk level</th>
<th>Predicting suicide attempts or suicide death</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No</strong></td>
<td>Predicting suicide attempts or suicide death</td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td>Guide clinical judgment</td>
</tr>
<tr>
<td></td>
<td>Select a level of care</td>
</tr>
<tr>
<td></td>
<td>Select timing of care</td>
</tr>
<tr>
<td></td>
<td>Select interventions</td>
</tr>
</tbody>
</table>

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### Suicide Risk Formulation/Stratification

<table>
<thead>
<tr>
<th>Risk level</th>
<th>Suicidal ideation</th>
<th>Suicidal behavior</th>
<th>Risk &amp; Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>SI with intent or intent with plan in the past month</td>
<td>Suicidal behavior within the past 3 mon</td>
<td>Multiple risk factors and few protective factors</td>
</tr>
<tr>
<td>Moderate</td>
<td>SI with method WITHOUT intent, plan or behavior</td>
<td>Suicidal behavior more than 3mon ago</td>
<td>Modifiable risk factors and strong protective factors</td>
</tr>
<tr>
<td>Low</td>
<td>Wish to die or SI WITHOUT method, intent, plan or behavior OR no h/o SI or behavior</td>
<td>No reported history of SI or behavior</td>
<td>Modifiable risk factors and strong protective factors</td>
</tr>
</tbody>
</table>

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Breakout Group: Suicide Risk Stratification

• Enter the breakout group with other participants.
• Review the examples with (limited) clinical information about suicidal ideation and behavior.
• Assign a level of risk using the risk stratification scheme of the C-SSRS.
• What additional information would you want to make a clinical judgment about risk?

Suicide Risk Formulation/Stratification

<table>
<thead>
<tr>
<th>Risk level</th>
<th>Suggested interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Immediate consultation with behavioral health.</td>
</tr>
<tr>
<td></td>
<td>Consider referral for inpatient hospitalization.</td>
</tr>
<tr>
<td></td>
<td>Immediate referral for behavioral health.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Immediate consultation and referral for behavioral health.</td>
</tr>
<tr>
<td></td>
<td>Referral for outpatient behavioral health.</td>
</tr>
<tr>
<td></td>
<td>Suicide-specific management strategies.</td>
</tr>
<tr>
<td>Low</td>
<td>Discretionary outpatient referral.</td>
</tr>
<tr>
<td></td>
<td>Provide crisis resources: NSPL, Crisis Text Line.</td>
</tr>
</tbody>
</table>

Management of Suicide Risk

- Screening
- Assessment
- Risk Formulation
- Management
- Treatment
- Follow-up

Management of suicide risk

- Foster connectedness
- Treat mental health and substance use disorders
- Reduce access to lethal means
- Develop a safety plan

Suicide Risk Management: Emergency Care

- Level of risk: Immediate high risk
- Outpatient plan: Not feasible or insufficient
- Future circumstances: No foreseeable changes

Emergency Care: Call 911 or arrange emergency assessment

Hospital?

You can call the National Suicide Prevention Lifeline for consultation.
800-273-TALK
800-273-8255

Breaking Confidentiality

- Consider contacting family members when:
  - Risk is judged to be high.
  - Family members are likely unaware of the risk.
  - Family members are likely to be able to intervene to reduce risk.

Breaking Confidentiality: HIPAA Privacy Rule: 45 CFR § 164.512(j)

A covered entity may disclose PHI consistent with laws and ethical standards and in good faith if the use of the disclosure:
(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and
(B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

- Document the basis for the risk being serious and imminent based on your risk assessment – i.e. findings from your suicide risk assessment and management plan.
- Document the basis for contacting the person who could lessen the risk – i.e. how this person might prevent or lessen the threat.
Suicide Risk Management
What is the theory behind this?

- Suicidal desire
- Emotional distress
- Suicide attempt
- Suicide method
- Fatal or non-fatal

• Connectedness
  - Trusting relationship with platoon sergeant.
  - Immediate access to mental health services.
  - Army crisis line.
• Depression treatment
  - Medication treatment for depression.
  - Psychiatrist and psychologist for ongoing care.
• Lethal means safety
  - “They took away my weapon.”
  - “They took my bolt away for a while – like a week.”
• Safety planning
  - Plan for how to respond to suicidal thoughts: “If I felt like hurting myself, did I tell anybody?”

Outpatient Management of Suicide Risk

U.S. Department of Veterans Affairs
Make the Connection

• Connectedness
• Depression treatment (co-occurring mental disorders)
• Lethal means safety
• Safety planning
• Other modifiable risk factors

Veterans and Suicide Risk

Knowledge about suicide
- 22% of suicide deaths are veterans.
- Firearm suicide is more common among veterans: 70% for men and 35% for women.

Suicide risk assessment
- Ask: Have you ever served in the armed forces, guard or reserves?
- Demographic and situational factors: TBI, PTSD, transitions (deployment, re-integration).

Suicide risk management
- Veterans Crisis Line: 800-273-8255, Press 1
- Veterans crisis chat: veteranscrisischat.net
- VHA: mentalheaalth.va.gov

For clinicians: U.S. DVA Suicide Risk Management Consultation Program (SRM) - free one-time consultation, resources and support for working with veterans.

Connectedness

Motto and Bostrom (2001) identified 3005 persons in the San Francisco area hospitalized because of a depressive or suicidal state and contacted them 30 days after discharge about follow-up treatment.

Caring Letters: Connectedness

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Caring Letters: Connectedness

3005 admitted for depressed or suicidal state

1939 (64%) accepted treatment

454 received no further contact

843 (28%) refused treatment

389 were sent caring letters

Treatment (TAU): Therapeutic work with a professional from a field such as psychiatry, psychology, social work and pastoral counseling.

Contact (Caring letter): “Dear X, it has been some time since you were here at the hospital, and we hope things are going well for you. If you wish to drop us a note we would be glad to hear from you.”

• Addressed from the person who had spoken with the patient in the hospital.
• Included a response to any previous contact.
• Q mo x 4mo; Q 2mo x 8mo; then 4x/yr x 4yrs.

Over 5y, the caring letters group had the lowest suicide rate every year.

Cumulative percentage of suicides

Treatment: N=1939

No contact: N=454

Caring letters: N=389

Rates converge over the next 10y

Conclusion: A systematic program of contact with persons who are at risk of suicide and who refuse to remain in the health care system appears to exert a significant preventive influence for at least 2y.

“I always think someone cares about me, even if my family did kick me out.”

“You are the most persistent son of a bitch I’ve ever encountered, so you must really be sincere in your interest in me.”

Reach Out: Ways to help a loved one at risk of suicide – Chatterjee for NPR, 2019

The Best Way to Save People from Suicide – Cherkis for The Huffington Post, 2018

329 standard care

329 standard care + caring text messages (11 over 1 year)

658 military service members all with suicidal ideation, 44% with h/o SA

This is [x] from the MC Project. Hope this week is going well for you.

Hey [x], hope you’re having a good day today.

It’s your birthday! Hope you have a great one.

Comtois, et al., 2019 in JAMA Psychiatry

Results: Inconsistent findings

• No difference in SI.
• No difference in suicide risk incidents or ED.
• Fewer SAs among caring text subjects.

...Caring Contacts in this study were extremely brief and focused solely on expressing care, interest and support. It may be that the crucial ingredient...is regular and long-term contact with another person who expresses caring and concern without demands or expectations, as was originally proposed in 1976.
**Connectedness: Building Therapeutic Alliance**

**Thwarted belongingness:** Convey belonging.
Thank you for talking to me about this. I'm glad you're here. I want to work on this with you.

**Perceived burdensomeness:** Convey value.
You're doing a lot of things right. What's happened doesn't need to define you.

**Hopelessness:** Convey hope.
I have hope for you. You're going to get better – it's already started.

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**Connectedness: Access to Crisis Support**

- **National Suicide Prevention Lifeline**: 1-800-273-8255
- **Crisis Text Line**: Text HELLO to 741741
- **SPRC Crisis Support Plan**: Template for family members to support a person at risk of suicide

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**Suicide Risk Management: Connectedness**

- **Screening**
- **Assessment**
- **Risk Formulation**
- **Management**
- **Treatment**
- **Follow-up**

- **MH & SUD treatment**
- **Lethal means safety**
- **Safety planning**

- **Build the therapeutic alliance by conveying belonging, value and hope.**
- **Facilitate access to ongoing care and crisis services.**

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**Depression Treatment: Antidepressants & Suicide Risk**

**FDA Black Box Warning (2007)**

- **Children, adolescents and young adults < 24:** Increased risk of suicidality (ideation and behavior not suicide death). 4% vs. 2%.
- **Adults 25-64:** No difference in risk.
- **Adults 65+:** Protective effect.

<table>
<thead>
<tr>
<th>Cases of Suicidality in Drug Group per 1000 Patients</th>
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<tbody>
<tr>
<td>&lt;18yo</td>
</tr>
<tr>
<td>14 more per 1000</td>
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**Intranasal Esketamine for Treatment Resistant Depression**

- **History of use:** Ketamine was developed in 1962 as an alternative to PCP for dissociative anesthesia and has been FDA approved since 1970 for this use in adults and children.
- **Novel mechanism of action:** Antidepressant actions of ketamine are believed to relate to effects on glutamate transmission at NMDA and AMPA receptors. These differ from monoamine neurotransmitters (serotonin, norepinephrine, dopamine) implicated in the effects of conventional antidepressants.
- **Rapid effects:** Single doses of intravenous ketamine have been shown to have rapid antidepressant effects, including reductions in suicidality, that may begin within an hour peak at 24 hrs and dissipate by 1 wk.
- **FDA approval:** In 2019, the FDA approved the use of intranasal esketamine (an enantiomer of ketamine) as an adjunct to antidepressant medication for treatment resistant depression (unresponsive to 2+ adequate AD trials).
Intranasal Esketamine for Treatment Resistant Depression

• **Administration:** Intranasal esketamine may only be administered through a Risk Evaluation and Mitigation Strategy (REMS) program by a certified medical clinic with patients enrolled in a registry. The patient self-administers the nasal spray at the clinic, is observed for at least 2 hours and may not drive until the next day after restful sleep.

• **Side effects:** Increased BP, dissociation, dizziness, nausea, sedation, others.

• **Uncertainties:** Addictive and abuse potential, optimal dosing duration, optimal dosing frequency, suicide risk.

  Park, et al. in Focus, Winter 2019; FDA SPRAVATO prescribing information

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Suicide Risk Management: **MH & SUD Treatment**

**Screening** → **Assessment** → **Risk Formulation** → **Management** → **Treatment** → **Follow-up**

- Connectedness
- MH & SUD treatment
- Lethal means safety
- Safety planning

- **Suicide Risk Management:**
  - Identify and treat co-occurring MH and SUD problems.
  - Antidepressants alone appear insufficient to resolve suicide risk.

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Suicide Risk Management: **Lethal Means Safety**

- Counseling on access to lethal means.

- Harvard School of Public Health: Means Matter
  hsph.harvard.edu/means-matter

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**Suicide Risk Management:**

- **Lethal Means Safety**
  - Emotional distress
  - Suicidal desire
  - Suicide method
  - Suicide attempt

- Have people forgo the attempt or make the attempt less lethal.

- Lethal Means Safety: Reduce the lethality of the method (firearm, OD) by modifying access to or lethality of the means.

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**Firearm Suicide:** 23,854 deaths in 2017 (CDC)

- ~265,000,000 firearms in the U.S.
- Firearm type: Handgun (73%), Shotgun (15%), Rifle (12%)
  NVDRS data on firearm suicide from 13 states, 2005-2015
  (Hanlon, et al., 2019 in *J Adolesc Health*)
- Suicide with recent firearm purchase or rental: 11/144 (8%)
  (Vriniotis, et al., 2015 in *SL TB*)
- Interval between handgun purchase and firearm suicide:
  Median of 11 years (Cummings, et al., 1997 in *AJPH*)
- Would have passed a background check on the date of death:
  92% (Barber, et al, 2019 in *Health Affairs*)

- Adult men with pre-existing, longstanding firearm ownership

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Cultural Competence: Firearms and Suicide

Culture: “...the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group.” (Cross, et al., 1989)

Disparities: Health and health care delivery

Cultural competency
• Attitudes
• Knowledge
• Skills

Outcomes: Health and health care delivery

Cultural factors
• Values
• Beliefs
• Practices

National Standards for CLAS in Health and Health Care (U.S. DHHS, 2013)

Multiple Sub-Populations

Values: Safety and Protection

% of gun owners saying each is a major reason they personally own a gun

Protection / Self-defense
Hunting 38%
Sport shooting 30%
Gun collection 13%
Professional use / Job 3%

Values: Freedom

% saying the right to own guns is essential to their own sense of freedom

Gun owner, grew up w/guns 79%
Gun owner, didn’t grow up w/guns 65%
Non-gun owner, grew up w/guns 44%
Non-gun owner, didn’t grow up w/guns 30%

Beliefs: Prevalence of Suicide, Inevitability & Method Substitution

Prevalence: Survey of firearm retailers
Q: What proportion of firearm fatalities in WA are suicides?
A: “Less than two thirds”
Actual % which are suicides: ~75%
Walton & Stuber, 2020

Inevitability & Method Substitution: Survey of gun owners
Q: If blocked from jumping from the Golden Gate Bridge, how many people would kill themselves another way?
A: “All of them”
Actual % of later suicide deaths: ~12%
Miller, et al., 2006

Values: Responsibility, Protection & The Rifleman’s Creed

This is my rifle. There are many like it, but this one is mine. My rifle is my best friend. It is my life. I must master it as I must master my life.

Without me, my rifle is useless. Without my rifle, I am useless. I must fire my rifle true. I must shoot straighter than my enemy who is trying to kill me. I must shoot him before he shoots me. I will...

My rifle and I know that what counts in war is not the rounds we fire, the noise of our burst, nor the smoke we make. We know that it is the hits that count. We will hit...

My rifle is human, even as I, because it is my life. Thus, I will learn it as a brother. I will learn its weaknesses, its strength, its parts, its accessories, its sights and its barrel. I will keep my rifle clean and ready, even as I am clean and ready. We will become part of each other. We will...

Before God, I swear this creed. My rifle and I are the defenders of my country. We are the masters of our enemy. We are the saviors of my life.

So be it, until victory is America's and there is no enemy, but peace!
Firearms Culture and Suicide Care

Values, Beliefs and Practices: What is “safety”?

Suicide
Unloaded
Locked
Ammunition separate
Temporary off-site storage
Inaccessible to the owner and others at risk

Home defense
Readily accessible

Accidents
Unloaded
Locked
Ammunition separate
Inaccessible to others, esp. children

Clinician
gun owner

Are your firearms stored safely?

Yes

Type of Firearm Used in Suicides
NVDRS: 13 States, N=44,540 (Hanlon, et al., 2019)

All firearm suicides

Shotgun 15%
Rifle 12%
Urban handgun: 57% of all firearm suicides

Handgun 73%
Handgun 49%
Rural male adolescent: Long gun 51%

Lethal Means Safety: Firearms

Securing Firearms

Unlock? Limit? Remove?

Clinician

Patient

Grossman et al. (2005). Gun storage. JAMA

Firearms Culture and Suicide Care

Values:

- I’m thinking about how protecting yourself and your family might also mean protection against suicide.

- In the state of Washington, about 75% of all gun deaths are suicides. Sometimes people don’t know that the most common safety issue with firearms is suicide risk.

- A common myth is that if someone doesn’t have access to a gun for suicide, they’ll just find another way. Instead what we find is when people don’t have immediate access to a lethal method of suicide, almost everyone overcomes the crisis and makes it through to live.

Beliefs:

- When someone is going through a hard time, temporarily reducing access to the firearms can give some time to work through the crisis. Do you have some ideas about what would make sense for you? Someone who could hold your guns until things get better?

Practices:

Collaborate on storage practices

Utah Suicide Prevention Coalition on Vimeo

Working with Suicidal Clients: Hope and Recovery in Suicide Care
Jeffrey C. Sung, M.D.
Mr. A is a 29 year old man presents for mental health evaluation after being prompted by his wife. He reports depressed mood and irritability in the setting of conflict with his wife over finances. He endorses suicidal ideation, stating that, "When I'm driving, I sometimes think about going into the other lane," and follows this with, "but I think suicide is a coward’s way out – I don’t think I'd ever do it". When asked about firearms, he reports having a rifle for hunting that he purchased to go hunting with his brother-in-law and no other firearms. He states that his rifle is unlocked and unloaded in a bag on a shelf in his basement and that he has no ammunition in the home.

The therapist suggests, “You’ve had thoughts about suicide, and we know that firearms are the most lethal suicide method. While we’re working things out and getting you feeling better, what do you think about having someone else hold onto your rifle or locking it up more securely in your home?” Mr. A replies, “I don’t know what you mean. There’s no ammunition in the house, so it’s not like I could shoot myself anyway. Besides, there’s a lot of other ways people kill themselves.”

- What would you say to align with values?
- What would you say to provide information on beliefs?
- How would you collaborate on storage practices?
Suicide Risk Management: Safety Planning

- Engage patients in a process to recognize and manage suicidal crises.
- Provide contact information for crisis resources.

Follow-up

Can you promise that you won't...

Suicide prevention contracts can create the illusion of patient safety, reducing staff anxiety without achieving the intended purpose of effective safety management for the suicidal patient. Simon. (2004). Assessing and managing suicide risk. American Psychiatric Publishing

Perform a risk assessment and establish a therapeutic alliance. Use a commitment to treatment statement (Rudd, 2006) whereby the clinician explains the treatment and the patient agrees to participate. Safety planning is more effective than extracting a promise for no self-harm.

Documentation: Justification for Level of Care

Why did you not hospitalize or refer for emergency evaluation?

- Risk is judged to be low
- Detrimental to clinical status.
- Detrimental to treatment.
- Risk likely to decrease due to future events.
- Addressing current problems more likely to be effective.
- Suicidality appears operant.

Five Components of Documentation

1. Database: Risk factors, protective factors, warning signs
2. Overall level of risk
3. Interventions for suicide risk
4. Justification for care
5. Consultants

Interventions for suicide risk: Foster connectedness with ongoing mental health appointments; target depression with medication treatment; motivational interviewing for alcohol use; pt. has confirmed no firearm access; selection of medications of lower toxicity in overdose; pt. given contact information for NSPL and after-hours crisis services.

Breakout Group: Management of Suicide Risk

- Connectedness
- Mental health and substance use disorders
- Lethal means safety
- Safety planning
- Other modifiable risk factors

Questions?

U.S. Department of Veterans Affairs
Make the Connection
Suicide Care: Treatment of Suicide Risk

Management vs. Treatment

Treatment: Therapist and client engage in a collaborative relationship to resolve internal factors that are unique/intrinsic to suicide risk (i.e. "drivers" of suicide).

Working together so that the client learns over time how to self-manage suicide risk.


Meaningful engagement:
• Regular schedule.
• Prioritize suicide risk.
• Hold off on suicide.
• Reduce lethal means.
• Safety planning.
• Emergency contacts.

Indirect drivers:
External life circumstances, stressors and mental health conditions that relate to suicide risk.

Direct drivers of Suicide
Internal factors and characteristics that are intrinsic to suicide risk and distinguish between suicidal and non-suicidal individuals. Direct drivers are emotional and psychological ways of experiencing or interpreting indirect drivers such that people consider suicide.

Jobes DA. Managing Suicidal Risk, 2016

Indirect vs. Direct Drivers of Suicide

Treatment of Direct Drivers
Why do people die by suicide?

Indirect vs. Direct Drivers of Suicide

Indirect vs. Direct Drivers of Suicide

What does [indirect driver] mean to you?
What is it about [indirect driver] that makes you want to end your life?
To what extent do you feel or think [direct driver]?
Ms. A is a 37yo single woman who works as a project manager for a sales company. For the past 2 years she has been having an affair with her supervisor who is married with two children. When she reveals to him that she is pregnant, he appears to look right through her as he states, “It’s fine. I’ll pay for the abortion.” Ms. A, who has “always wanted a family,” reports to her therapist that her supervisor has suggested that if she raises any concerns about his behavior, he will arrange for her to be laid off due to his knowledge of her unethical behavior on a previous work project. She states, “I’m the only one to blame. I’m going to end this hopeless pregnancy, and then I’m going to end this hopeless life.”

I need to:
- not have nightmares...
- get married...
- not have cancer...
- have a girlfriend...
  to not kill myself.

I have heard the extent of your suffering and propose we work simultaneously on the problems in your life and the way of responding to the problems that has led to suicide as an option.
Suicide has a storyline: Interpersonal Theory

Lowered fear of death
Increased pain tolerance

Capability for lethal self-injury

Acquired capability

Previous attempts
Military experience
Abuse history
NSSI
Substance use
Severe psychiatric symptoms

Desire for death

Direct drivers
Thwarted belongingness
Hopelessness
Perceived burdensomeness

Capability for lethal self-injury

High lethality attempt or death

Example: Thwarted Belongingness

Mr. B is a 39yo man who lives alone in an apartment and works for a software company. He has experienced long-standing depression and SI dating to the suicide death of his mother when he was 6yo. Throughout his life he has experienced painful loneliness as he misses his mother and longs to join her in death. His therapist, focusing on thwarted belongingness as the most relevant direct driver of suicide, discusses with the patient a plan for Mr. B to light candles each evening while calling to mind a positive, loving memory of his mother. With some consistency, Mr. B follows through with this and reports no improvement for months, stating that this only makes him feel more sadness and loss. Appointments are spent discussing the pain of the loneliness in his life.

After six months, Mr. B arrives for an appointment stating that over the past week he fell asleep on his couch one night while watching television. In a dream, he is awakened from sleep on the couch by his mother smiling while seated next to him. He awakens from the dream to find that he has been crying while asleep. As he and his therapist discuss the dream, Mr. B states, “I don’t know. I feel different. I feel like my mother wants me to live – like she wouldn’t want me to be so sad all the time.” The therapist conceptualizes the shift as the development of a living, internal presence of Mr. B’s mother that resolved the unbearable loneliness of thwarted belongingness.

Cognitive Content: Suicide Has a Story Line

Problem-solving: Fostering development of connections.
Cognitive restructuring
- Address the validity of thoughts
- Address the utility of thoughts
Mindfulness
- Noticing thoughts and letting these go
- ACT: Defusion from thoughts
Processing grief: Grieving to restore an inner relationship.
Addressing hopelessness: Behavioral activation, cognitive restructuring – “Hope is a skill” that is practiced continuously rather than achieved entirely.

Breakout Group: Indirect and Direct Drivers of Suicide

1. What are the indirect drivers – i.e. mental health conditions and life stressors?
2. What are the direct drivers – i.e. the suicidal storyline? What did you hear to indicate thwarted belongingness, perceived burdensomeness and hopelessness?
3. How were the direct drivers targeted in a way that resolved suicide risk?
4. What other interventions would you consider?
Suicide is an intoxicant: Cognitive Theory
Tunnel vision, suicide as the only escape from pain and hopelessness

Hopelessness and cognitive constriction
Wenzel & Beck (2008)
A cognitive model of suicidal behavior

Direct Drivers: Cognitive Model of Suicide

Trigger (Loss)

Hopelessness

Nothing will ever change. It's over.

Selective attention

Attentional fixation

Suicide is the only escape from this pain and hopelessness.

Selective Attention

Suicidal Ideation

Maybe I'll kill myself.

Nothing ever changes. It will never get better.

Everything in my life is wrong.
Attentional Fixation

I can't keep doing this. I need this to end.

Hopelessness

Suicide is an intoxicant: Cognitive Model of Suicide

Selective attention

Attentive Fixation and Racing Thoughts

Suicide is an intoxicant: Cognitive Theory

Selective attention

Attentional fixation

Direct Drivers of Suicide: Hopelessness & Selective Attention

Baseline

Gratitude journal

Hope kit

Selective attention

Assemble a box with photos of loved ones, inspirational sayings, encouraging messages.


Keep a journal and list 3 items each day for which you feel gratitude.

Keep a journal and be specific in listing 3 events that occurred each day related to...what happened...health...time of day (Celano, et al., 2017)

Better organization?

Department of Defense Virtual Hope Box

1. Distraction techniques
2. Guided relaxation
3. Photos and videos
4. Inspiring statements
5. Coping cards
6. Activity planner
7. Emergency contacts

t2health.dcoe.mil/apps

DoD Virtual Hope Box

Stories of Hope and Recovery: A Video Guide for Suicide Attempt Survivors

The David Lilley Story

SAMHSA Stories of Hope and Recovery: David's Story

Working with Suicidal Clients: Hope and Recovery in Suicide Care

Jeffrey C. Sung, M.D.
Example: Selective Attention and Attentional Fixation

Ms. C is a 24 yo graduate student whose research has been complicated by departmental politics. Her boyfriend recently ended the relationship with Ms. C after their mutual advisor made sexual advances towards him — which he rejected. Simultaneously, Ms. C’s mother has been calling Ms. C on the phone repeatedly, telling Ms. C that “should not have gone into that useless field” and that “your father is sick and needs you to help take care of him.” Ms. C tells her therapist that she has been living in fear of her advisor while enraged with her mother. Ms. C reports having fantasies of killing herself while on the phone with her mother. The therapist engages Ms. C in the safety planning intervention — during which Ms. C states repeatedly, “I know this already” and “this won’t work.”

Three months later, Ms. C presents to her appointment, stating “something happened that I wanted to talk to you about.” Ms. C reports that she was on the phone with her mother while driving on the highway. Ms. C hung up on her mother in a rage, after which, “I was literally screaming in my car and felt completely out of control. I was either going to drive into another car or pull over. I pulled over, and I couldn’t think of a single thing to do to calm myself down. Then I remembered that we had written down ‘listen to music’ on that safety plan so I turned on the music full blast to block out all my thoughts. I was shocked that it only took 15 minutes to feel like I was in better control. Is that what you meant by ‘the feelings go up and down?’” The therapist uses the experience to reinforce successful coping and discuss the emerging ability to observe and describe suicide-related stressors, thoughts and feelings.

Suicide is an action, often with multiple motivations:

Emotion Dysregulation

- Overwhelming emotions.
- Lack of skills.
- Suicidal ideation and behavior functioning as emotion regulation, problem-solving and communication.


Direct Drivers: Emotion Dysregulation

Dialectical Behavior Therapy Theory of Emotions

Can’t stand this anymore

Prompting event: Relationship conflict

Unbearable emotional pain

Direct Drivers: Emotion Dysregulation

Dialectical Behavior Therapy

I hate him

Anger

Punination

Emotion regulation

Problem solving

Communication

I hate how I feel.

What else could I do?

No one cares anyway.

Suicide attempt or NSSI

Emotion regulation

Problem solving

Distress tolerance

Suicide attempt or NSSI
Suicide is an action, often with multiple motivations. Find a different action to fulfill the same motivation.

Motivation: Emotion regulation
Action: Emotion regulation skill
Mindfulness of current emotions
- Stay in the present
- Redirect from thoughts
- Focus on body sensations

I hate her... She has no right...

nowmattersnow.org

Suicide is an action, often with multiple motivations. Find a different action to fulfill the same motivation.

Motivation: Problem-solving
Action: Remoralization

Vulnerability vs. Resilience
- Identify existential stances related to vulnerability and demoralization
- Access strengths to build resilience

Griffith & Gaby on Demoralization (2005)

Vulnerability Resilience
Confusion Coherence
Isolation Communion
Despair Hope
Helplessness Agency
Meaninglessness Purpose
Cowardice Courage
Resentment Gratitude

Example: Indirect and Direct Drivers of Suicide

Suicide has a storyline
- Alone, worthless, hopeless
- Defeated and trapped

Suicide is an intoxicant
- Selective attention and attentional fixation

Suicide is an action, often with multiple motivations
- Emotion regulation, problem-solving, communication

Make the Connection: I absolutely love what I do

Handout p. 14

Treatment to Resolve Suicide Risk: Questions?

Tell me the story. Can we work together? What is making you suicidal?

Narrative interview
Invitation to collaborate
Collaborative assessment

Let’s review a safety plan. We’ll work on what matters the most to you.

Management plan
Treatment plan

What is making you want to die?

Respondent and Operant Suicidality

Respondent: Suicidality controlled by preceding events; more typical of acute suicide risk.

Operant: Suicidality controlled by consequences; chronic suicidality that might require treatment to facilitate self-management of suicide risk.

Antecedent: Preceding event
Behavior: SI or behavior
Consequence: Internal or external

- Emotion regulation
- Problem solving
- Communication

Chronic Suicidality: Respondent vs. Operant Suicidality

If I can’t get ___ done by my ___th birthday, I will kill myself.

Knowing that I could kill myself is what gets me through life.

I know you won’t give me what actually works for sleep. It’s like you want me to kill myself.

Operant suicidality?

Clinician

Client
Suicide Care with Operant Suicidality

**Assessment and Formulation:**
Which aspects of the client’s suicidality are respondent? Which are operant?
If some aspects are operant, what is the function of the suicidal ideation or behavior—i.e., how does the behavior function to regulate emotion, solve problems or communicate distress?

- **Respondent:** It started to seem hopeless, and I thought, “I’ll kill myself.”
- **Operant:** It was a relief to have a way out. Eventually that thought would come even with smaller problems.

**Management vs. Treatment: Operant Suicidality**

**Treatment of Operant Suicidality:** A consultative and collaborative approach whereby the client grows in self-awareness and self-management of suicide risk.

**Insight, orientation and commitment:** Use of communication strategies to provide an explainable model of suicidality to the client—i.e., describe how suicidal behavior can function to regulate emotion, solve problems and communicate distress.

**Skills training:** Propose alternative strategies to regulate emotion, solve problems and communicate distress—i.e., review mindfulness, distress tolerance, emotion regulation, problem-solving and interpersonal effectiveness skills.

**Suicide Care with Operant Suicidality**

**Emotion regulation:**
- **Negative reinforcement:** I did it because I couldn’t stand the pain anymore. Knowing I’ll always have a way out gives me some relief.
- **Positive reinforcement:** I wanted to feel something, anything, even if it meant feeling pain.

**Problem solving:**
I need more pain medication. If you don’t give me something, I’ll kill myself. There’s no way I’m going back to the street. I’ll kill myself if I have to be homeless again.

**Communication:**
No one was listening to me. Do I have to kill myself to get you to hear me?

**Follow-up:**
Clients with chronic suicidality that is operant will likely need longer term outpatient treatment to resolve suicide risk over time. Options will depend on the client’s ability and willingness to participate in treatment and the availability of treatment. If treatment is not possible, clients may be referred for outpatient care that provides management of suicide risk.
Case Management to Facilitate Treatment (CT-SP)

- Coordination with contacts and facilities
- Community voicemail
- Scheduled and unscheduled contact
- Birthday and holiday cards
- Reminder calls
- Subway tokens
- Outreach visits
- Flexible session times

Pilot: No case management

Study: Case management

Berk, et al., 2004; Brown, et al., 2005; Gibbons, et al., 2010

Breakout Group: Respondent and Operant Suicidality

- Review the chart and discuss the direct drivers of suicide.
- Which direct drivers would you prioritize in treatment?
- Did you hear additional drivers or have different ideas about which drivers are present?
- How would you use management or treatment interventions to address the direct drivers that appear to be the highest priority?

Handout p. 15

Respondent and Operant Suicidality: Questions?

- Thwarted belongingness
- Perceived burdensomeness
- Hopelessness
- Emotion dysregulation

Respondent: Suicidality controlled by preceding events; more typical of acute suicide risk.

Antecedent: Preceding event

Behavior: SI or behavior

Consequence: Internal or external

Operant: Suicidality controlled by consequences; chronic suicidality that might require treatment to facilitate self-management of suicide risk.

- Emotion regulation
- Problem solving
- Communication

Suicide Care: Summary

Screening, Assessment & Risk Formulation

- Risk assessment does not predict suicide; instead, it is intended to identify modifiable targets for management and treatment.
- Risk formulation similarly does not predict suicide; instead, it is intended to guide clinical decision-making.

Screening, Assessment, Risk Formulation

- PHQ-9
- C-SSRS
- SAFE-T

Management of Suicide Risk

Four categories of intervention have evidence for reducing suicide risk:

- Fostering connectedness
- Treating mental health and substance use conditions
- Lethal means safety
- Crisis/Safety planning
Suicide Care: Summary

Treatment of suicide risk requires a management plan to keep the client alive while then seeking to foster self-awareness and self-management of suicide risk.

Treatment targets direct drivers of suicide as the psychological and emotional experiences of life circumstances that drive people to consider suicide.

Hope and Recovery in Suicide Care

- Suicide is **preventable**.
- Suicide is **not inevitable**.
- **Suicide care** includes screening, assessment and risk formulation followed by management and treatment of suicide risk.
- **Treatment of suicide risk** involves a collaborative relationship to facilitate self-awareness and self-management of suicide risk.