ADDITIONAL INFORMATION FOR CLINICIANS

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American Foundation for Suicide Prevention

SUICIDE DECLARED A SERIOUS PUBLIC HEALTH PROBLEM.

–SURGEON GENERAL DAVID SATCHER
1999

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RISK REDUCING CARE

Even in Non-Mental Health Settings, it is now recommended to:

1. Detect Suicide Risk

- ✓ 1. Screen for depression & other changes in mental health
- ✓ 2. If pt endorses SI, probe its history, **intent/plan**
- ✓ 3. If **+** plan & intent, ask abt means
- ✓ 4. Ask about supports & other protective factors

https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf

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RISK REDUCING CARE

Goal of Suicide Risk Assessment

- The goal of suicide risk assessment is NOT to predict whether a person will die by suicide, but to continue to care and support
- Actions depend on present risk, available supports, foreseeable changes

RISK REDUCING CARE

2. Suicide Risk Assessment

Formal SRA is ideally done by a MH professional.
Must go further than asking about current SI.

- ✓SI, planning, access to means, gathering means
- ✓Past or current suicidal behavior
- ✓Other Risk and Protective Factors (Family Hx, Reasons for living/dying)
- ✓Treatment history including therapy & medications
  - Pt perceptions, adherence, impact, side effects
- ✓Social supports
- ✓Substance use history, recent escalation?
- ✓Hopes and aspirations for the future
- ✓Consider need for hospitalization or other crisis intervention

RISK REDUCING CARE

3. Take Action: Continue to Care

Acute suicidal crisis

- ✓ Do not leave unattended
- ✓ Immed access care (ED, mobile crisis, 911, respite)
- ✓ Involve family when possible

Risk is present but not acute

- ✓ Express concern
- ✓ Refer to psych (ideally within 1-2 weeks)
- ✓ Give **Lifeline # 1-800-273-TALK** (pt & family)
- ✓ Conduct Safety Plan
- ✓ Urge removal of lethal means
- ✓ Follow-up

Consider consulting a colleague
Consider suicide-specific treatment intervention

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NOT RECOMMENDED

"Contracting for Safety"

- Use of patient promise/agreement to not harm
- Despite lack of empirical support, commonly used by mental health professionals (up to 79%)
- **Not recommended** for multiple reasons
  - No medicolegal protection
  - Negatively influences provider behavior
  - Not patient-centered

Rudd et al., 2006; Simon, 1999

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Safety Planning Intervention

(Stanley & Brown, 2008; 2012)

Similar to other emergency plans (e.g., do x, y, z in a certain order in case of low cabin pressure…)
Evidenced-based strategies (e.g., means restriction, social support)
A ***collaboratively*** developed, ***prioritized,*** written plan that can be used during or preceding crisis

- **Person-centered- triggers & warning signs for suicidal crises**
- **Internal & external coping strategies**
- **Identifies sources of support**
- **Keeps environment safe**

Conveys that suicidal feelings and urges can be "survived" and controlled!

ROLE OF HC SYSTEM

Steps Healthcare Systems can take

- Systematic follow-up: CONTACT & COMMUNICATION
- Educ- all staff: SP, language, Safety Planning, Lethal Means Counseling
- Ask pt for consent to involve family/peer at the start of treatment
- Routine screening/assessment
- Document actions taken
  - Referral to BH, communication w family
  - Safety Plan completed, provided Lifeline #
  - Counseled on lethal means removal

Providing good care & doc = medicolegal protection

INNOVATION
IN CLINICAL TREATMENT

RISK REDUCING CARE

Innovation in Treatment

- Suicide-specific treatments
- Brief interventions
- The increasing role of technology
- Least restrictive, evidence-based, and cost-effective

RISK REDUCING CARE

Suicide Specific Interventions

- Dialectic Behavioral Therapy **DBT** *(Linehan)*
- Cognitive Behavioral Therapy **CBT-SP** *(Beck, Brown)*
- Collaborative Assessmt & Mngemt of Suicidality **CAMS** *(Jobes, Comtois)*
- Attachment Based Family Therapy **ABFT** *(Diamond)*
- Attempted Suicide Short Intervention **ASSIP** *(Michel, Gysin-Maillart)*
- Safety Planning Intervention **SPI** *(Stanley, Brown)*
- Online and tech resources
  - ***nowmattersnow.org*** online **DBT** *(Whiteside)*
  - CBT video games *(Christensen)*
  - SPI apps *(Stanley, Brown)*

RISK REDUCING CARE

Clinical Pearls

- **Clinicians can learn to filter and "dial in" information that informs suicide risk**
  - Consider patient's "logic" for their triggers and language
- **Suicide Risk Assessment** goes further than SI/plan
  - **Consider other factors** – past hx, prior attempt, support, hope/pain, FH, ambivalence
- **Prioritize contact & ongoing communication between visits**
- Consider **suicide-specific therapy options**
- Consider **medications** to reduce suicide risk