

From the Cockpit to the Clinic:

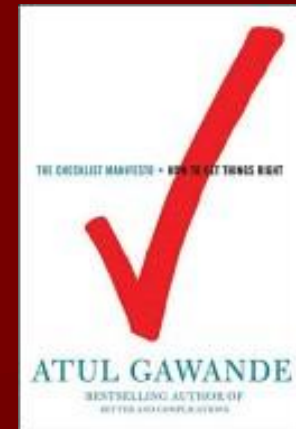
*The Use of Checklists in the Assessment and
Management of Suicide Risk*

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Why Checklists?

- The use of checklists
 - Airline industry
 - Healthcare (ER, surgery, intensive care)
 - Wal-Mart
- The utility of checklists
 - Complex tasks
 - Memory
 - Attention



Is Mental Health Really the Same?

- Evaluation of suicide crisis hotlines
 - Of 5,168 eligible callers 2,466 (47.7%) were not assessed for suicide risk
 - Why?
 - High call volume (too busy): 788
 - Risk status too high (referred): 654
 - Counselor thought not appropriate to assess: 226
 - Kalafat, Gould, Munfakh, & Kleinman (2007)

Limited Suicide-Specific Training

- Only 40% of psychology training programs offer formal training
- 45% of graduates reported no suicide-specific training
- Average of 1 hour of formal training among practicing psychologists
- Problem of core competencies, practice guidelines, standard of care
 - American Psychiatric Association
 - American Association of Suicidology
 - Suicide Prevention Resource Center

The Emergence of Core Competencies

- Attitudes and Approach
- Understanding Suicide: Conceptual Model
- Collecting Accurate Assessment Information
- Formulation of Risk
- Treatment Planning
- Management of Care

Translating to a Checklist

- Empirical Foundation has been established for critical elements of risk assessment
- Recognizing the variable nature of suicide risk
 - The persistence of intent, hopelessness
 - Issue of chronic risk
 - Need for repeated assessment

Hospital Discharge Data and Variable Intent

The Best Predictor of Suicide

- Recent discharge from inpatient facility (within month):
- | <u>Study</u> | <u>SMR</u> |
|--|------------------------------|
| ■ (the standardized mortality ratio or SMR is the ratio of observed deaths to expected deaths) | |
| ■ Ho et al. | 113 (males) |
| ■ | 178 (females) |
| ■ Goldacre et al. | 213 (males) |
| ■ | 134 (females) |
| ■ Lawrence et al. | 253 (males) within a week* |
| ■ | 350 (females) within a week* |



On the bridge, Baldwin counted to ten and stayed frozen. He counted to ten again, then vaulted over. “I still see my hands coming off the railing,” he said. As he crossed the chord in flight, Baldwin recalls, “I instantly realized that everything in my life that I’d thought was unfixable was totally fixable—except for having just jumped.”

Kevin Hines: Survived a Jump from the Golden Gate Bridge



- I took another bus to the Golden Gate Bridge. I was crying. I was just so tired, so emotionally drained. I was just looking at people, wanting someone, anyone, to say, "Are you okay?" As much as I wanted that, I was hearing these voices saying, "You have to die."
- I got off the bus at the bridge, and stood there crying. I went onto the span very slowly. Almost reluctantly. The whole time begging myself not to jump, but the voices were too strong, I just couldn't fight them.
- **There were tons of people, it was 10 in the morning, bikers, joggers, tourists, workers, cops biking around. I found my spot. And I said to myself, if just one person, just one, comes up to me and asks me if I need help, I'll tell [them] everything. And this beautiful woman walked up to me, and she goes, "Will you take my picture?" And I thought, "What? Lady, I'm going to kill myself, are you crazy?" But she had sunglasses on, her hair blowing in the wind, she was a tourist, all she could see was this guy standing right where she wanted her picture taken. I must have taken five pictures of this lady. She had no clue.**
- I thought at that moment, nobody cares. Nobody cares. So I handed her her camera. She walked away. I walked as far back to the railing closest to the traffic as I could, I ran, and I catapulted myself over the bridge. I didn't get on the ledge to have people talk me down. I just jumped.

The Checklist

Making the Complex Simple

- Engage
 - *Build a relationship*
- Evaluate
 - *Assess risk*
- Educate
 - *Provide a foundation for treatment*
- Equip
 - *Crisis management and safety planning*

Engage

Facilitating Hope (*and feeling in control*) During the First Contact

- Provide an understandable model
 - Explain why the suicide attempt(s) happened
- Contextualize/Normalize the problem
 - Sensitized to the sights, sounds, smells of war (problem is that many generalize to day to day living, particularly given the urban nature of much of this conflict)
- Label and reinforce the presence of ambivalence
 - *Reasons for living, reasons for dying*
 - *Recognize hope is embedded in ambivalence*
- Identify a common goal (reduces adversarial tension)
 - *Reduce suffering and emotional pain*

What Are Common Emotional Reactions that Limit Ability to Engage?

■ Fear/Anxiety Spectrum:

- Related to beliefs that
 - Suicidal behavior will occur
 - Will be held responsible
 - Detailed discussion will encourage suicidality

■ Anger Spectrum:

- Related to beliefs that
 - Helpless, hopeless
 - Must control

Evaluate

Assess Risk

- Understand the role and nature of intent
- Recognize the importance of
 - Specificity of questions
 - Acute versus chronic nature of risk
 - Sequencing questions
 - First and worst for multiple attempts
 - Variable themes of hopelessness
 - State versus trait elements

Elements of Intent Tell Us What We Should be Asking!

- Willingness to act (motivation to die)
 - *What are your reasons for dying?*
- Preparation to act (preparation and rehearsal behaviors)
 - Clearly differentiates ideators and attempters
 - *Have you prepared for your death in any way?*
 - *Will, letters, finances, research?*
 - *Have you rehearsed your suicide?*
- Capability to act (previous suicidality, self-harm, trauma exposure)
 - Builds over time with exposure
 - *Have you made a previous suicide attempt(s)?*
 - *Have you ever done things to harm or hurt yourself?*
 - *Have you ever experienced something you consider traumatic?*
- Barriers to act (reasons for living)
 - *What are your reasons for living?*
 - *What keeps you alive, what keeps you going?*

We Need to Differentiate Subjective and Objective Suicide Intent

■ Remember

- Always look for convergence and divergence
- Always reconcile discrepancies

■ Subjective Intent

- *What the patient says*
- *Ask for “subtle” or indirect markers of intent*

■ Objective Intent

- *What the patient does (behavioral markers)*

Critical Symptoms

- Anxiety
- Agitation
 - *Differentiate from Anxiety*
- Depression
- Hopelessness
- Sleep disturbance, nightmares
- Perceived burdensomeness

Variable and Deceptive Themes to Hopelessness

- Cognitive (Hopelessness) Themes
 - Identity-based suicide specific beliefs
 - Guilt (*I've done some bad things*) Remember the notion of “earned” and “learned” guilt (integration of history)
 - Related to behavior
 - Proactive: *I've hurt people*
 - Passive: *I should have done more.....*
 - Diffuse guilt
 - *I don't deserve to live.....*
 - Shame (*There's something wrong with me*)
 - *I'm a Failure*
 - *I'm Damaged*
 - *I'm Weak*
 - *I'm Lost*

- Burdensomeness (*My family would be better off if I were dead*)
 - Related to disruption created by behavior, financial concerns
- Helplessness (*I can't change it*)
- Distress Tolerance (*I can't stand the way I feel*)

Sequencing Assessment of Suicidal Thinking

- Comfort in asking about suicide
- Elicit past, present, and current suicidal thoughts, behaviors, plans, intent
- Sequence and word questions in effective manner
 - First attempt, past several years, past several months, current episode
 - Undermines resistance, reduces anxiety, develops trust, improves accuracy of report, differentiates suicidal and instrumental behaviors
- Address client fears about “what will happen” if suicidal thoughts are acknowledged

■ Nature of Suicidal Thinking

- Ideation: frequency, intensity/severity, duration, specificity (plans), availability/accessibility, active behaviors (preparation, rehearsal), intent (subj. vs. obj.), perceived lethality, degree of ambivalence, deterrents (family, religion, positive treatment relationship, support system)
- Severity of psychological distress pain
 - Distress tolerance

Educate

- Provide a simple model for understanding
 - Improve motivation for care, compliance
 - The importance of understanding what it means to be “in treatment”.
 - Reduce shame, guilt, self-hate
- A model with an empirical foundation

History Can
Compound the
Problem if
there is prior
abuse, etc....

Predisposing
Vulnerabilities

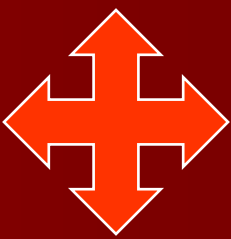


Triggers
*(Internal AND
External)*



Behavioral
*(Reduce upset/
arousal)*

Cognitive
(Why I should die)

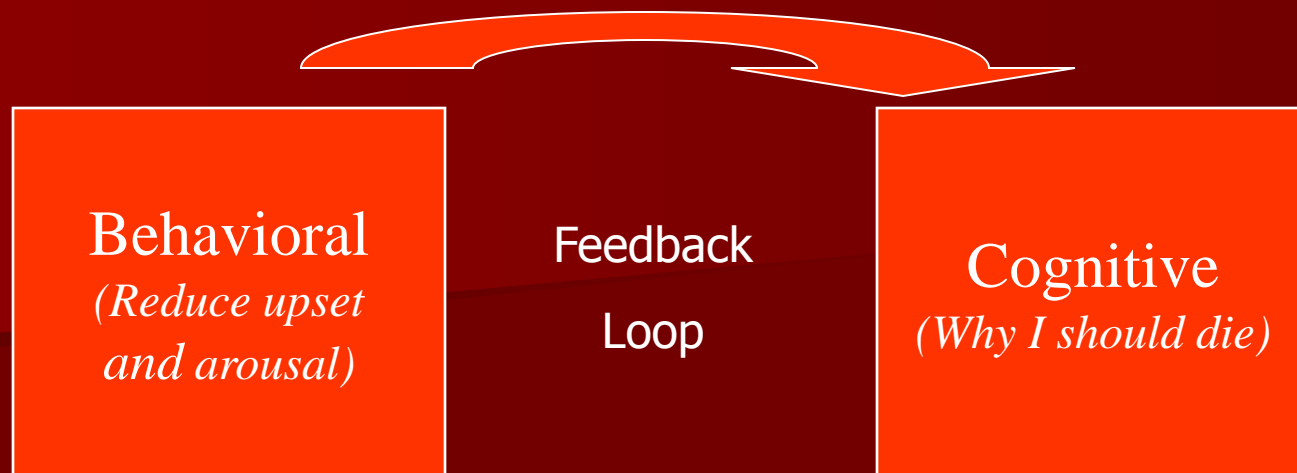


Physiological
(Arousal)

Affective
(Emotional Upset)

Behavioral Feedback Loop

- Every time there is behavior (avoidance) there is a **COGNITIVE CONSEQUENCE** that facilitates the cycle of despair and suicidality. It's almost always self-image related.
 - Alcohol Abuse...*the only way to get relief is drinking*
 - Suicide attempt....*I can't handle living, I'm a failure*



Equip

Managing Crises

- Define *crisis*
- Make it accessible!
- Identify warning signs! (for parents as well)
- Provide a simple model of suicidality---Identify trigger(s) and associated thoughts, feelings, behaviors.
- Specific goal is to reduce escalation of suicidal crisis and reduce manifest intent (increase hope)
- Moves from self-management to external intervention—improve self-efficacy.
- If not successful, access emergency care and assistance in manner that facilitates skill development (always understand the cost and consequence)



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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, 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

Are you or
someone you love
at risk of suicide?

NATIONAL
SUICIDE
PREVENTION
LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org

Get the facts and take
appropriate action.

Practice, Practice, Practice

- *When thinking about suicide, I agree to do the following:*
- *When I find myself making plans to suicide, I agree to do the following:*
 - *1. Use my hope box.*
 - *2. Review my treatment journal*
 - *4. Do things that help me feel better for about 30 minutes, including taking a bath, listening to music, and going for a walk*
 - *5. Repeat all of the above*
 - *6. If the thoughts continue, get specific, and I find myself preparing to do something, I call the emergency number XXX-XXXX*
 - *7. If I'm still feeling suicidal and don't feel like I can control my behavior, I go to the emergency room*

Creating a Hope Box

- The notion of reciprocal inhibition
- Include items that generate productive, hopeful thoughts and feelings
- Always review items individually
- Practice use of Hope Box
 - Review each item
 - Ask patient to describe item, “tell a little about it”
 - What are they thinking?
 - What are they feeling?
 - More hopeful?

Crisis Response Plan Pointers

- Be specific
 - when to use, steps to take, where to go, what numbers to call
- Be concrete
- Ensure safety, remove access, availability
- Make it accessible
 - put on a card, can be carried in a wallet or purse
- Practice, role play
- Periodically review and update
- Use of STR

- Effective intervention for suicidality facilitates hope
 - Simplify the complex
 - Make the intangible concrete