The Next Step in Suicide Prevention

Continually improving quality care to save lives

Mental Health
Risk Retention Group, Inc.

Suicide deaths increase

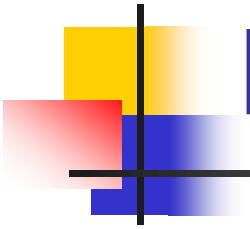
- Despite:
  - Significant effort by the behavioral healthcare industry
  - Widespread use of the Columbia screening instrument

Suicide rate increase in the United States

- From 1999 to 2017
- 33% increase

Suicide deaths in the United States

- 2018 – 48,344
- 2019 – 47,511
- 2020 – 45,979
- 2021 – 48,183
- 2022 - 49,449



Each death is a tragedy

- Which we strive to avoid

A critical challenge for behavioral healthcare

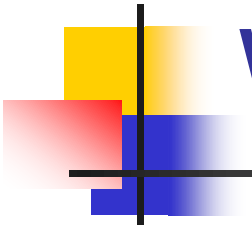
- Keep moving the needle to improve quality care

The next step in suicide prevention & quality care

- 3 parts
  - 1. Grow our understanding of why people die by suicide
  - 2. Continually improve our ability to recognize risk
  - 3. Systematically utilize practical tools and strategies for prevention

The next step

- May be different than what you are doing now



Why listen to us?

How do we know & why do we care?

- 50+ year database of claims
  - Negley Associates
  - Mental Health Risk Retention Group
    - Provider CEOs

How do we know & why do we care?

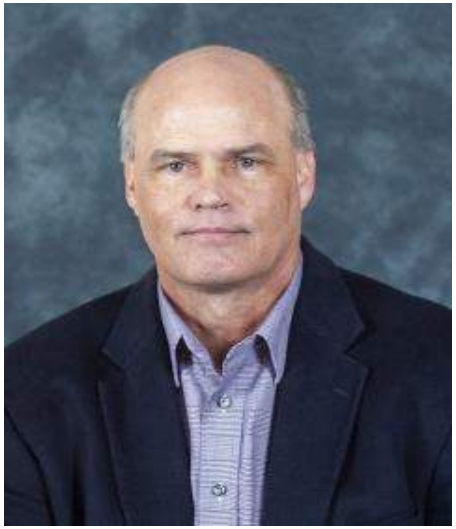
- 50+ year database of claims
  - Litigation analysis - thousands of cases
  - Risk management practice analysis
  - Experts

The next step in suicide prevention & quality care

- What can we do to help the industry save lives?

Dr. Thomas Joiner

- Free training and resources from:
  - The country's preeminent expert on suicide risk assessment & prevention



Dr. Thomas Joiner

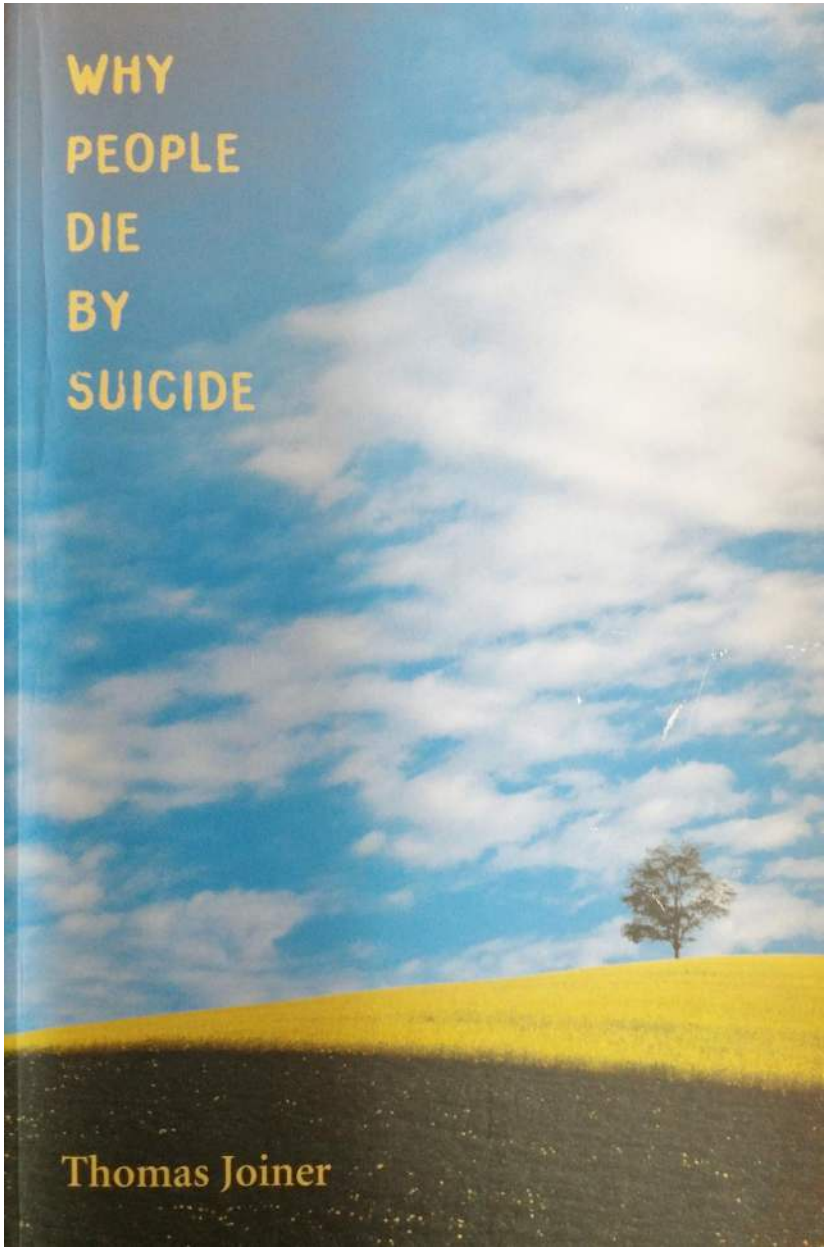
- Educational video modules
- Clinical tools & practical strategies

Dr. Thomas Joiner

- Prof. of Psychology, Florida State University
- FSU teaching clinic

Dr. Thomas Joiner

- Many books, articles, research projects
  - *Why People Die by Suicide,*
  - *Myths about Suicide,*
  - *The Interpersonal Theory of Suicide,*
  - *The Varieties of Suicidal Experience - A New Theory of Suicidal Violence*


WHY
PEOPLE
DIE
BY
SUICIDE
Thomas Joiner

Dr. Thomas Joiner

- The Interpersonal Theory of Suicide
  - The foundation for the 988 Lifeline protocol

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1. Grow our understanding of why people die by suicide

The next step

- 1. Grow our understanding of why people die by suicide
  - So we know where to focus risk assessment & treatment efforts

The next step

- Commonalities of the lethally suicidal mind despite clear diversities between people?

Let's listen in to Dr. Joiner

- Suicide prevention & the Interpersonal Theory of Suicide

Let's listen in to Dr. Joiner

- 3 especially important factors identified by ITS
  - Commonalities of the lethally suicidal mind
  - None of which should be missed on a risk assessment

Poll #1

- Which is NOT a facet of suicidal capacity?
  - A. reduced fear of death
  - B. talking about suicide
  - C. greater pain tolerance
  - D. practical capability

Poll #1 answer

- Talking about suicide

Suicidal capacity

- Practical capability
  - Accessibility and knowledge of lethal means
    - E.g. knowing how to operate a firearm

Suicidal capacity

- Acquired from repeated exposure to painful and provocative events (e.g. child abuse)

Suicidal capacity

- Acquired Capability for Suicide Scale – Fearlessness about Death (ACSS-FAD)
  - Self-report measure available on the website

Suicidal capacity

- The interplay of these facets comprise overall capability.
- There is "emerging literature that suicide capability is not static…" but fluctuates over time.
  - Bayliss et.al. *Fluidity in capability: Longitudinal assessments of suicide capability using ecological momentary assessments, Suicide Life Threat Behav. 2023; 00:1-16*

Risk = Acquired capability +

- Acquired capability alone does not equal risk
- Acquired capability + desire creates risk

Desire

- Sustained
  - Perceived burdensomeness +
  - Failed belongingness +
  - Feeling that it's permanent

Desire

- Interpersonal Needs Questionnaire (INQ)
  - Self-report measure available on the website

Combining factors

- "…I am prepared to defend the view that 100% of suicides are characterized by the combination of learned fearlessness, perceived burdensomeness, and profound alienation from others…"
  - Joiner, *Myths about Suicide*, Harvard University Press, 2010, p.193

Address those factors in treatment

Include treatment elements

- 1. Emphasize a sense of belonging in the therapeutic relationship
  - "We're in this together."
  - "We'll work through this together."

Include treatment elements

- 2. Behavior activation to increase social support
- 3. Address thoughts about acquired capability & behaviors

Include treatment elements

- 4. Address erroneous thinking about burdensomeness
- 5. Address underlying psychopathology
- 6. Address identified risk factors
  - Match risk factors & treatment

2. Recognizing risk

The next step

- 2. Continually improve our ability to recognize risk
  - Especially *imminent* risk

Recognizing the risk

- Short times between last contact with a provider and a suicide death

Recognizing the risk

- During a hospital or CSU admission
  - How closely to monitor?
  - Deaths using ligatures

Recognizing the risk

- Discharge from a psychiatric hospital or CSU

Recognizing the risk

- "This study demonstrates that there are 2 sharp peaks of risk for suicide around psychiatric hospitalization, one in the first week before admission and another in the first week after discharge…"
  - Quin & Nordentoft, Suicide Risk in Relation to Psychiatric Hospitalization, Arch Gen Psychiatry, 62: 427- 432, 2005

Recognizing the risk

- Discharge after an ER evaluation

Recognizing the risk

- No decision to admit after an intake evaluation

Recognizing the risk

- No reevaluation or discussion during a treatment session or a case management appointment despite signs of risk

Poll #2

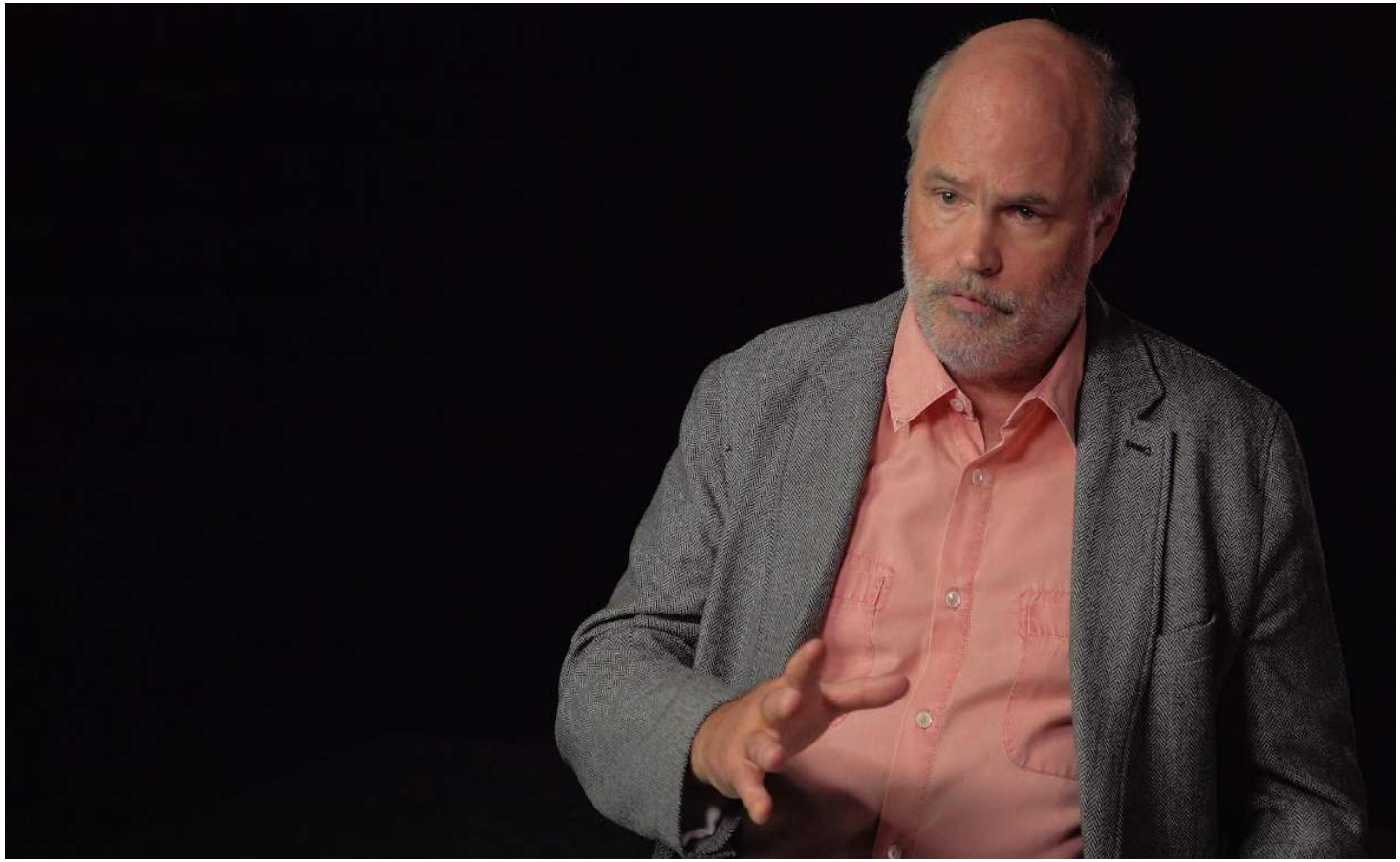
- Which is NOT a danger sign of imminent risk?
  - A. Agitation
  - B. Thinking about suicide
  - C. Insomnia
  - D. Nightmares
  - E. Unhealthy weight loss
  - F. Talking about suicide

Poll #2 answer

- Thinking about suicide is not a danger sign of imminent risk
  - Not a good predictor of attempts or death
  - Surveys estimate 10% of the population have serious ideation – 33 million
  - 2022 deaths - 49,449

Let's listen in to Dr. Joiner

- Analysis of commonalities shared by people in the few days before death from suicide
  - Including factors suggesting imminent risk



Risk assessment

- "Although the assessment of desire, plans, preparations, and intent is essential, evidence suggests that a significant percentage of suicide decedents deny suicidal ideation at their final mental health encounter."
  - Chu, Joiner et al. *Routinized Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update*, Journal of clinical psychology 1-15 (2015)

Risk assessment

- "Additionally, reliance on chronic risk factors (e.g. psychopathology, past suicidal behavior, family history of suicide) limits our ability to determine whether an individual is at imminent risk."
  - Chu, Joiner et al. *Routinized Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update*, Journal of clinical psychology 1-15 (2015)

Risk assessment

- "Therefore, it is imperative to assess acute and objective risk factors, which are time-limited and associated with an increased risk for suicide over a period of hours to days, not months or years."
  - Chu, Joiner et al. *Routinized Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update*, Journal of clinical psychology 1-15 (2015)

Danger signs

- Don’t miss any of these 8 danger signs of imminent risk when your client’s life is at stake

Danger signs of imminent risk

- Agitation
- Social withdrawal
- Unhealthy weight loss
- Marked irritability

Danger signs of imminent risk

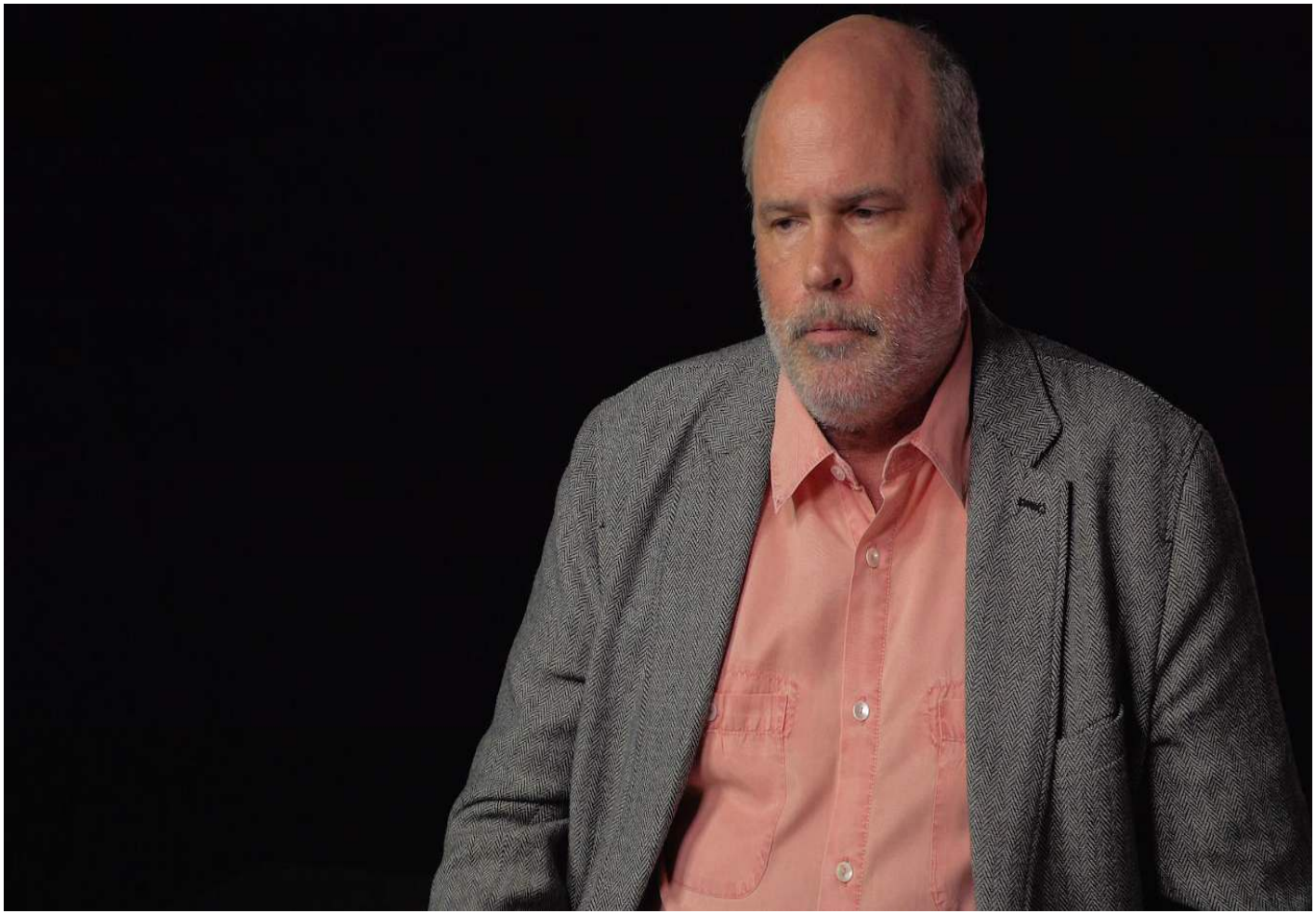
- Nightmares
- Insomnia
- Severe affective states
- Talking about suicide

Let's listen in to Dr. Joiner

- As he identifies "intent to die" as measured on a 10 point scale as an information rich risk parameter
- **But**

Let's listen in to Dr. Joiner

- Pay attention to more than one risk parameter
- Multiple channels of information
  - Important aid to recognizing risk



Multiple channels

- Chart review of 76 patients who died by suicide in the hospital or immediately after discharge
  - "…78% denied suicidal ideation at their last communication about this…"

    - Fawcettt, et.al. *Clinical Correlates of Inpatient Suicide*, The Journal of Clinical Psychiatry, February, 2003

Multiple channels

- Chart review of 76 patients who died by suicide in the hospital or immediately after discharge
  - "Standard risk assessments and standard precautions used were of limited value in protecting this group from suicide."

    - Fawcettt, et.al. *Clinical Correlates of Inpatient Suicide*, The Journal of Clinical Psychiatry, February, 2003

Multiple channels

- Chart review of 76 patients who committed suicide in the hospital or immediately after discharge
  - "Adding severity of anxiety and agitation to our current assessments may help identify patients at acute risk…"
    - Fawcettt, et.al. *Clinical Correlates of Inpatient Suicide*, The Journal of Clinical Psychiatry, February, 2003

Multiple channels

- Cited by courts related to negligence findings
  - Reasonably needed & available sources

3. Practical tools for prevention

The next step

- 3. Systematically utilize practical tools and strategies for prevention including:
  - Caring contacts
  - CBTI
  - Imagery rehearsal therapy for nightmares

The next step

- 3. Systematically utilize practical tools and strategies for prevention including:
  - Means safety negotiation
  - Behavioral activation & walking outside

Let's listen in to Dr. Joiner

- As he talks about means safety
  - One of the very few things we know for sure that works in suicide prevention

Let's listen in to Dr. Joiner

- The common sense idea across all methods, create
  - distance & obstacles
  - between the at-risk individual and the dangerous means or methods

Let's listen in to Dr. Joiner

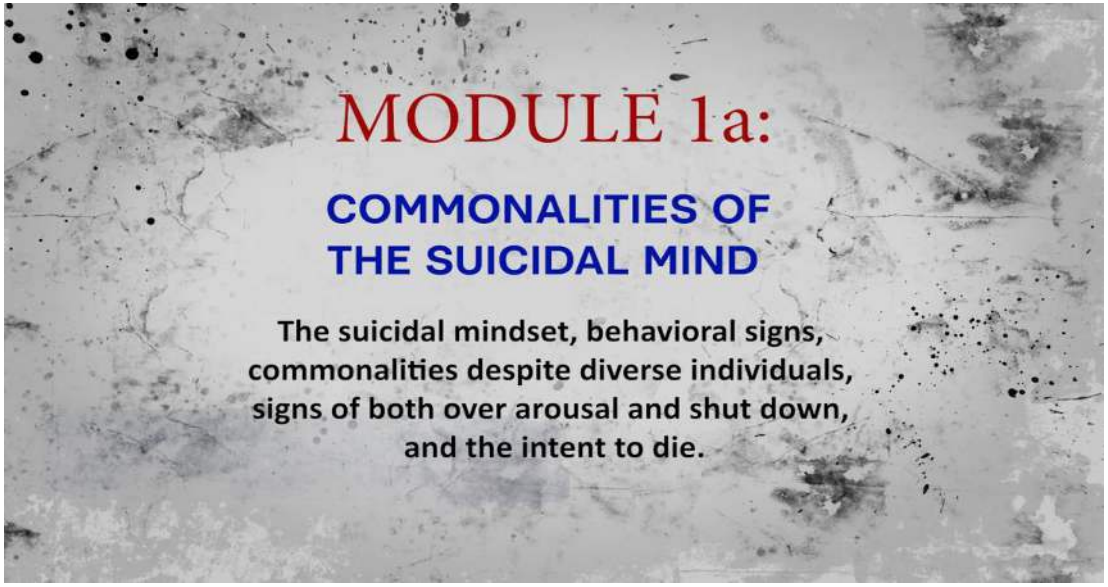
- An especially important point about means safety


T-LOCK
Means
Safety

Free resources

The next step

- Educational videos
  - 12 videos
  - 4 hours CEU



Video modules

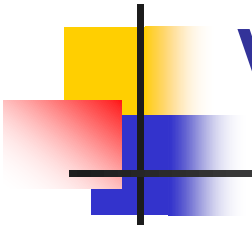
- Why people die by suicide
- Commonalities of the suicidal mind
- Evaluating risk
- Children & suicide

Video modules

- Myths about suicide
- Clinical tools
- Surprising data about alcohol use

Video modules

- Practical approaches to reducing risk
- CBTI
- Critical importance of caring contacts



Video modules

- Negotiating means safety
  - Identifying specific objects and places

Clinical tools

- Risk assessment form/protocol
- Decision tree to help determine risk level
- Risk categories guidance

SUICIDE RISK ASSESSMENT

****DANGER SIGNS****

Talking about Suicide Social withdrawal	Agitation Weight loss	Insomnia Marked Irritability	Nightmares Extreme emotional states (e.g. rage)

Assess Suicidal DESIRE and IDEATION	Assess RESOLVED PLANS and PREPARATIONS	Assess OTHER SIGNIFICANT FINDINGS
• Have you been having thoughts or images of suicide (thoughts of images of killing yourself)? Tell me about that. • Do you think about wanting to be dead? • **THWARTED BELONGINGNESS**: Do you feel connected to other people? Do you live alone? Do you have someone you can call when you are feeling bad? (Are supporting relationships completely absent?) • **PERCEIVED BURDENSOMENESS**: Sometimes people think, "The people in my life would be better off if I were gone." Do you think that?	• **Duration** (look for pre-occupation): When you have these thoughts, how long do they last? • **Intensity**: How strong is your intent to kill yourself? 0 = not intense at all, 10 = very intense. • **Past suicidal behavior**: Have you attempted suicide in the past? How many times? Methods used? What happened (e.g., admitted to hospital?). Non-suicidal self-injury? Family history? • **Specified plan** (look for vividness, detail): Do you have a plan for how you would kill yourself? • **Means and opportunity**: Do you have the pills (or a gun, etc.)? Do you think you'll have an opportunity to do this? • Have you made preparations for a suicide attempt (e.g., buying pills) • Do you know when you expect to use your plan? • **Fearlessness**: **Thinking about suicide, do you feel afraid**? 0 = very afraid; 10 = not afraid at all	• **Precipitant Stressors**: Has anything especially stressful happened to you recently? (e.g., death of a loved one, divorce, major break-up, job loss)? • **Hopelessness**: Do you feel hopeless? • **Impulsivity**: When you are feeling badly, how do you cope? Sometimes when people feel badly, they do impulsive things to feel better. Has this ever happened to you? (e.g., cutting your skin, drinking alcohol, running away, binge eating, promiscuous sex, physical aggression, or shoplifting)? • **Presence of psychopathology:** (rated by interviewer)

Depressive Symptom Index – Suicidality Subscale
Acquired Capability Scale (ACSS) **Interpersonal Needs Questionnaire (INQ)**

****RISK CATEGORY****

LOW	MODERATE	SEVERE	EXTREME

ACTIONS TAKEN:

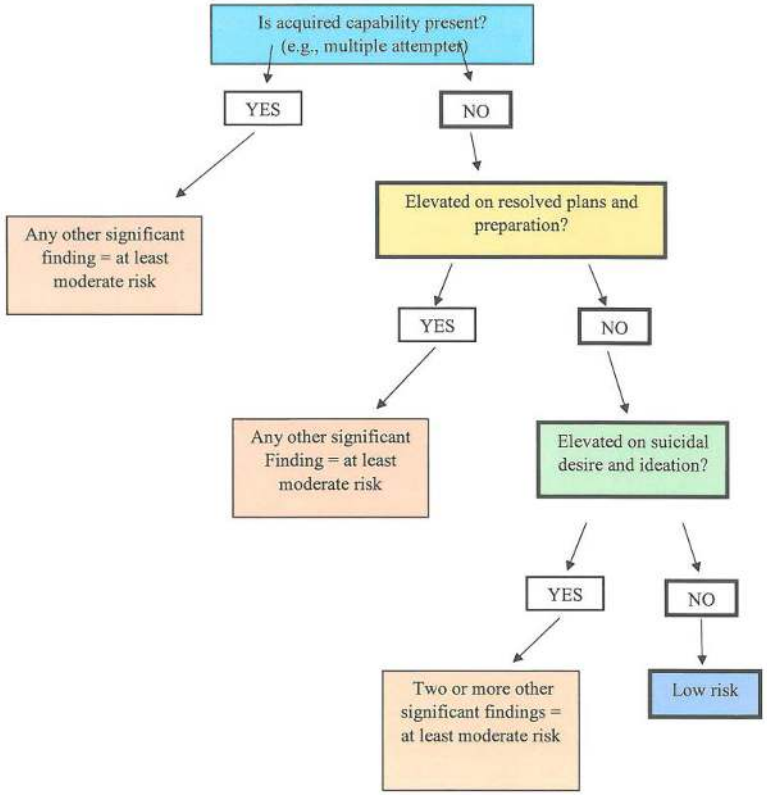
- Continue to monitor regularly
- Given Emergency numbers
- Scheduled mid-week phone check-in
- Provided info about adjunctive treatment
- Coping Card/Safety Plan
- Consulted Supervisor
- Other

Form Provided by Dr. Thomas Joiner, Florida State University, Dept. of Psychology

Suicide Risk Assessment

DECISION TREE

(Joiner, Walker, Rudd, & Jobes (1999). Scientizing and routinizing the assessment of suicidality in outpatient practice. Professional Psychology: Research and Practice, 30, 1-7)



Suicide Risk Assessment
RISK CATEGORIES

LOW:

- A person with no identifiable suicidal symptoms
- A multiple attempter with NO other risk factors OR
- A non-multiple attempter with suicide ideation of limited intensity and duration, no or mild symptoms of the Resolved Plans and Preparation factor AND no or few other risk factors

What to do if no current suicidal ideation:

- *Tell the client a variant on the following: "In the event that you begin to develop suicidal feelings, here's what I want you to do: First, use the strategies for self-control that we will discuss, including seeking social support. Then, if suicidal feelings remain, call [the emergency call person]. If, for whatever reason, you are unable to access help, or, if you feel that things just won't wait, call 9-1-1 or go to the ER."*
- *Give emergency numbers: including 1-800-273-TALK*
- *Continue to monitor risk in subsequent sessions (in case severity changes).*
- *Document activities in progress notes*

What to do if there is current suicidal ideation:

- Give emergency numbers
- Create a coping card (a crisis response plan)
- Symptom-matching hierarchy
- Document activities in progress notes

MODERATE:

- A multiple attempter with any other notable finding OR
- A non-multiple attempter with moderate to severe symptoms of the Resolved Plans and Preparation factor OR
- A non-multiple attempter with moderate to severe symptoms of the Suicidal Desire and Ideation factor (but mild or no Resolved Plans and Preparation) AND at least two other notable risk factors

What to do:

- *Give emergency numbers*
- *Create a coping card (a crisis response plan)*
- *Symptom-matching hierarchy*
- *Consider mid-week phone check-in's*
- *Inform about existence of adjunctive treatments (e.g., medication)*
- *Increase social support:*
  - *Encourage client to seek support from friends/family;*
  - *Plan with client for someone to check-in on him/her regularly;*
  - *Get client's permission for you to contact the person who will be checking-in*
- *Document activities in progress notes*

[Severe] HIGH [Extreme]

- A multiple attempter with any two or more other notable findings, OR
- A non-multiple attempter with moderate to severe symptoms of the Resolved Plans and Preparation factor and at least one other risk factor
- A multiple attempter with severe symptoms of the Resolved Plans and Preparation factor, OR
- A non-multiple attempter with severe symptoms of the Resolved Plans and Preparation factor and two or more other risk factors

What to do:

- ***CONSULT a supervisor***
- *Consider emergency mental health options with supervisor*
- *Client should be accompanied and monitored at all times*
- *If hospitalization is not warranted, use steps from "moderate" category*
- *Document activities in progress notes*

Form Provided by Dr. Thomas Joiner, Florida State University, Dept. of Psychology

Clinical tools

- Interpersonal Needs Questionnaire
  - Thwarted belongingness & perceived burdensomeness
- Acquired Capability for Suicide Scale – Fearlessness about Death

INQ

The following questions ask you to think about yourself and other people. Please respond to each question by using your own current beliefs and experiences, NOT what you think is true in general, or what might be true for other people. Please base your responses on how you've been feeling recently. Use the rating scale to find the number that best matches how you feel and circle that number. There are no right or wrong answers: we are interested in what you think and feel.

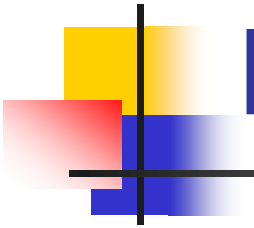
		Not at all true for me						Very true for me
1.	These days, the people in my life would be better off if I were gone	1	2	3	4	5	6	7
2.	These days, the people in my life would be happier without me	1	2	3	4	5	6	7
3.	These days, I think I am a burden on society	1	2	3	4	5	6	7
4.	These days, I think my death would be a relief to the people in my life	1	2	3	4	5	6	7
5.	These days, I think the people in my life wish they could be rid of me	1	2	3	4	5	6	7
6.	These days, I think I make things worse for the people in my life	1	2	3	4	5	6	7
7.	These days, other people care about me	1	2	3	4	5	6	7
8.	These days, I feel like I belong	1	2	3	4	5	6	7
9.	These days, I rarely interact with people who care about me	1	2	3	4	5	6	7
10.	These days, I am fortunate to have many caring and supportive friends	1	2	3	4	5	6	7
11.	These days, I feel disconnected from other people	1	2	3	4	5	6	7
12.	These days, I often feel like an outsider in social gatherings	1	2	3	4	5	6	7
13.	These days, I feel that there are people I can turn to in times of need	1	2	3	4	5	6	7
14.	These days, I am close to other people	1	2	3	4	5	6	7
15.	These days, I have at least one satisfying interaction every day	1	2	3	4	5	6	7

Note: Items 7, 8, 10, 13, 14, and 15 are reverse coded.

ACSS-FAD

Please read each item below and indicate to what extent you feel the statement describes you. Rate each statement using the scale below and indicate your responses on your answer sheet.

		0 Not at all like me	1	2	3	4 Very much like me
1	The fact that I am going to die does not affect me.	0	1	2	3	4
2	The pain involved in dying frightens me.	0	1	2	3	4
3	I am very much afraid to die.	0	1	2	3	4
4	It does not make me nervous when people talk about death.	0	1	2	3	4
5	The prospect of my own death arouses anxiety in me.	0	1	2	3	4
6	I am not disturbed by death being the end of life as I know it.	0	1	2	3	4
7	I am not at all afraid to die.	0	1	2	3	4



Relias course template

Why this theory?

- Interpersonal Theory of Suicide
- "In science, including psychology, a **theory** is a principle or idea that explains or solves a problem"
  - Like the Theory of Relativity
  - Not used in the sense of "conjecture" or "speculation"

Poll #3

- During an intake assessment, the client is asked to respond to Columbia scale questions as follows:

Poll #3

- Have you wished you were dead or wished you could go to sleep and not wake up?
- Have you actually had any thoughts of killing yourself?
  - The client responds “no” to both questions

Poll #3

- What is the client's risk of suicide?
  - A. the client is at no risk of suicide
  - B. there is inadequate information to assign a risk level
  - C. the client is at low risk of suicide

Poll #3

- Answer: inadequate information
- "…when faced with a difficult question, we often answer an easy one instead, usually without noticing the substitution."
  - Daniel Kahneman, *Thinking, Fast and Slow,* Farrar, Straus, Giroux, 2011

Why this theory?

- Complex question:
  - Is this individual at (imminent) risk of suicide?
- Easier question:
  - Does this individual admit to thoughts of suicide?

Why this theory?

- The complex question
  - Is this individual at (imminent) risk of suicide?
    - In the moment **&** future oriented
    - Is the client's response reliable?
    - Uncertainty or ambivalence about suicidal thoughts
    - Temporal instability

Why this theory?

- 1. Suicidal thoughts are not good predictors of attempts & death
  - 33,000,000 – 49,449
- 2. Unwise to rely on one risk parameter

Why this theory?

- 3. People reluctant to disclose suicidal thoughts, may be less reluctant to disclose:
  - Feelings of burdensomeness
  - Failed belongingness
  - Experiences leading to acquired capacity

Why this theory?

- Where to focus risk assessment & treatment
  - Without leaving out important evidence-based factors

Combining factors

- "…I am prepared to defend the view that 100% of suicides are characterized by the combination of learned fearlessness, perceived burdensomeness, and profound alienation from others…"
  - Joiner, *Myths about Suicide*, Harvard University Press, 2010, p.193

Why this theory?

- Recognizing imminent risk
  - Danger signs

Why this theory?

- Suicide deaths keep increasing
- 988

Columbia scale?

- Contractual & regulatory requirements to use the scale
- All the questions in the screening version of the Columbia scale are in the ITS risk assessment form
  - Add the ITS questions to your assessment

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The Next Step in Suicide Prevention

April 16, 11:30 a.m. – 12:30 p.m. CT
Room C22

Learning Objectives:

- Examine the principles of the Interpersonal Theory of Suicide.
- Describe ways to use the theory in assessments and management of individuals with suicidal behavior.
- Explore the clinical tools that accompany the theory.

Register for NatCon24

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Questions & Comments

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