New York State Psychiatric Institute

From Lab to Clinic: Using our knowledge to advance evidence - based and best suicide prevention practices

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Disclosures

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PI: Barbara Stanley, Ph.D.


How to Grow Jobs / Higgs-terial / Chipotle's Secret
TIME
ONE A DAY
Every day, one U.S. soldier commits suicide. Why the military can't defeat its most insidious enemy


IS YOUR JOB BAD FOR YOU? | GEORGE TAKEI | DON'T CALL ME 'BABY'
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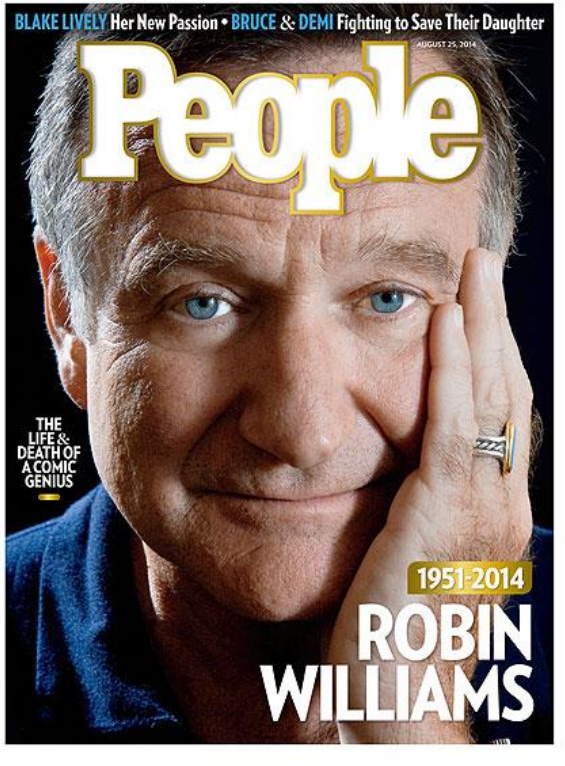
WAR'S INVISIBLE CASUALTIES
SINCE JOSHUA DIED MAKING SENSE OF A SON'S FINAL, DESPERATE ACT
BY DAVID WOOD

Christina O and Farrah: Million-dollar moms
People weekly
TEEN SUICIDE
Why are our children dying? Prompted by a powerful and troubling TV movie, an in-depth report examines:
The danger signs
How family and friends can help
What it feels like to be left behind

A TORNADO'S DEVASTATION BY ANDREW ROMANO
05.22.13
Newsweek
THE SUICIDE EPIDEMIC
WHY ARE WE KILLING OURSELVES?
HOW CAN WE STOP IT?
BY TONY DOKOUPIL


EXCLUSIVE MEL GIBSON'S EX
I THOUGHT HE WOULD KILL ME'
People
OKSANA GRIGORIEVA
TEEN SUICIDE TRAGEDIES
DEADLY BULLYING
At least three teens, tormented by classmates, have taken their own lives in the past month. Why did this happen, and how can it be stopped?
TARGET SETH WALSH, 15
TARGET ASHER BROWN, 13

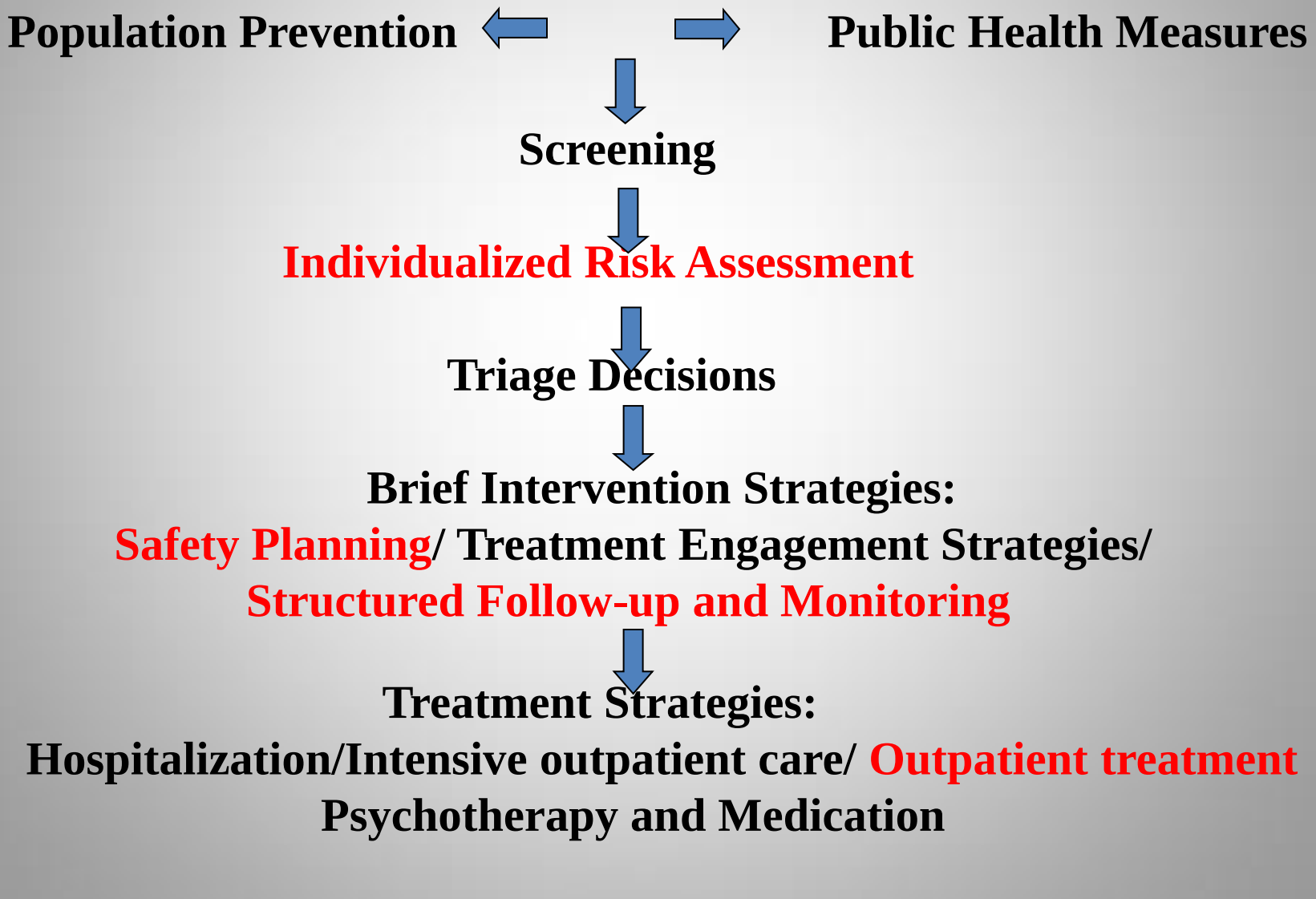

BLAKE LIVELY Her New Passion • BRUCE & DEMI Fighting to Save Their Daughter
People
THE LIFE & DEATH OF A COMIC GENIUS
1951-2014
ROBIN WILLIAMS

The problem

- Suicide rates continue to escalate
  - In the world – over 800,000 deaths/year, 10.7/100,000
  - In Israel – 409 in 2011 (7.3/100,000), 372 in 2013
  - In the U.S.- over 42,000 deaths/year, 50% increase in the last 15 years, 13.0/100,000
- Demographics changing
  - Youth (worldwide)
  - Military (US and Israel)
  - New Immigrants (Israel)

- This despite increased research and development of evidence based interventions

Points of Intervention to Prevent Suicide



Evidence-Based Suicide Prevention Strategy

10 -year systematic review of 1797 studies, and recommendations for evidence based suicide prevention strategies

- Means restriction
- Treatments: psychopharmacological and psychosocial including CBT and DBT
- Chain of care and follow-up
- Need for more RCTs that include suicidal individuals
- Population screening needs to be combined with chain of care and monitoring
- Opportunities to use social media and new technologies
- Research should lead to implementation

- Zalsman et al. Lancet Psychiatry 2016

Today's talk

- Recent research findings from a study of suicidal and non-suicidal self injurious behaviors in borderline personality disorder
- How these findings can translate to implementation: 10 common factors of evidence-based, best practices that can inform clinical practice
- Case vignette to illustrate

Study of Suicidal Ideation Using EMA

- 84 participants from a RCT study comparing two treatments for suicidal and non- suicidal self - injuring individuals with BPD

- Prior to treatment, 7 days of Ecological Momentary Assessment (EMA) to assess real time patterns of suicidal ideation, behavior and events

- Wanted to learn about patterns of suicidal ideation and factors that might increase or decrease suicidal ideation in real time

Table 1: Demographics and Psychopathology	
	Total (N=84)
Demographics	
Age (yr)	29.3±9.4
Female (%)	92%
Caucasian (%)	57%
Diagnostics	
Major Depressive Disorder (current)	68%
Current Substance Abuse (%)	49%
Childhood physical abuse (%)	40%
Childhood sexual abuse (%)	39%

Table 2: Clinical Characteristics

	Total (N=84)
Hamilton Depression Rating Scale	18.3±6.7
ZAN_BPD Total Score	16.0±5.6
Beck Depression Inventory	28.6±10.9
Global Assessment Scale	49.4±7.0
Brown-Goodwin Lifetime Aggression History	20.0±4.8
Buss-Durkee Hostility Inventory	47.7±10.7
Barratt Impulsivity Scale	68.1±18.2
Hopelessness Scale	12.1±5.4
Reasons For Living Questionnaire	141.3±32.1

Table 3: Suicidal Behavior and NSSI Characteristics at Baseline

	Total (N=84)
Scale for Suicidal Ideation- prior	9.5±9.1
History of suicide attempt (%)	71%
Maximum Lethality of Attempts	2.3±1.5
Past NSSI yes/no- SIB	96%

Ecological Momentary Assessment

- Real time assessment of affects, ideation, events, behaviors
- Assessed patients with Borderline Personality Disorder for 7 days; 6 assessments/day
- Advantages:
  - Detects fluctuations that weekly measures cannot detect
  - Allows for close evaluation of the effects of events on thoughts, affects and behaviors

Suicidal Ideation

In the past 15 minutes, how strongly have you felt or experienced the following:					
1. A wish to live	0	1	2	3	4
2. A wish to die	0	1	2	3	4
3. A wish to escape	0	1	2	3	4
4. Thoughts about dying	0	1	2	3	4
5. Thoughts about suicide	0	1	2	3	4
6. Urge to commit suicide	0	1	2	3	4
7. Thoughts about hurting self	0	1	2	3	4
8. An urge to hurt yourself	0	1	2	3	4
9. Like there were reasons for living	0	1	2	3	4

0= Very slightly or not at all; 1= a little; 2= moderately; 3= quite a bit; 4=extremely

Life Events

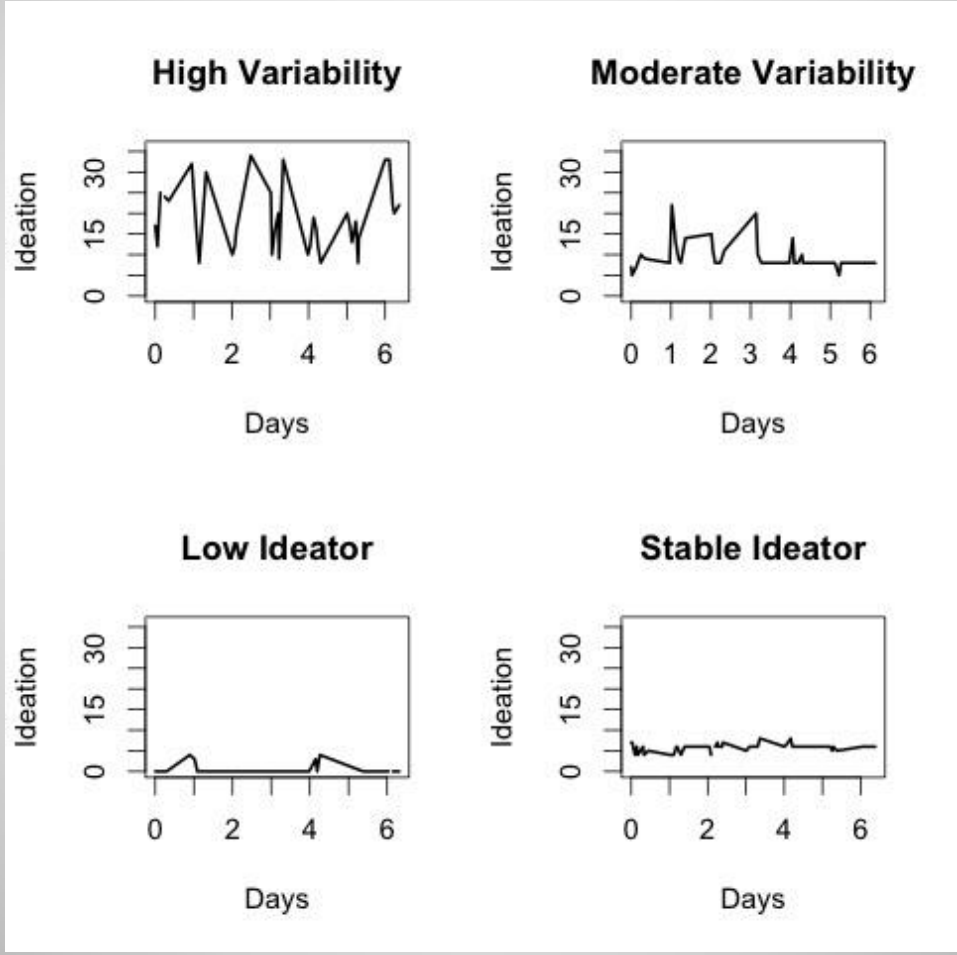
Since the last prompt, have you:	
1. Had a disagreement with someone?	Y/N
2. Been rejected by someone?	Y/N
3. Been complimented or praised by someone?	Y/N
4. Been disappointed by someone?	Y/N
5. Felt neglected by someone?	Y/N
6. Experienced a loss of some sort?	Y/N
7. Received good news?	Y/N
8. Received bad news?	Y/N
9. Been reminded of something painful from the past?	Y/N

Coping

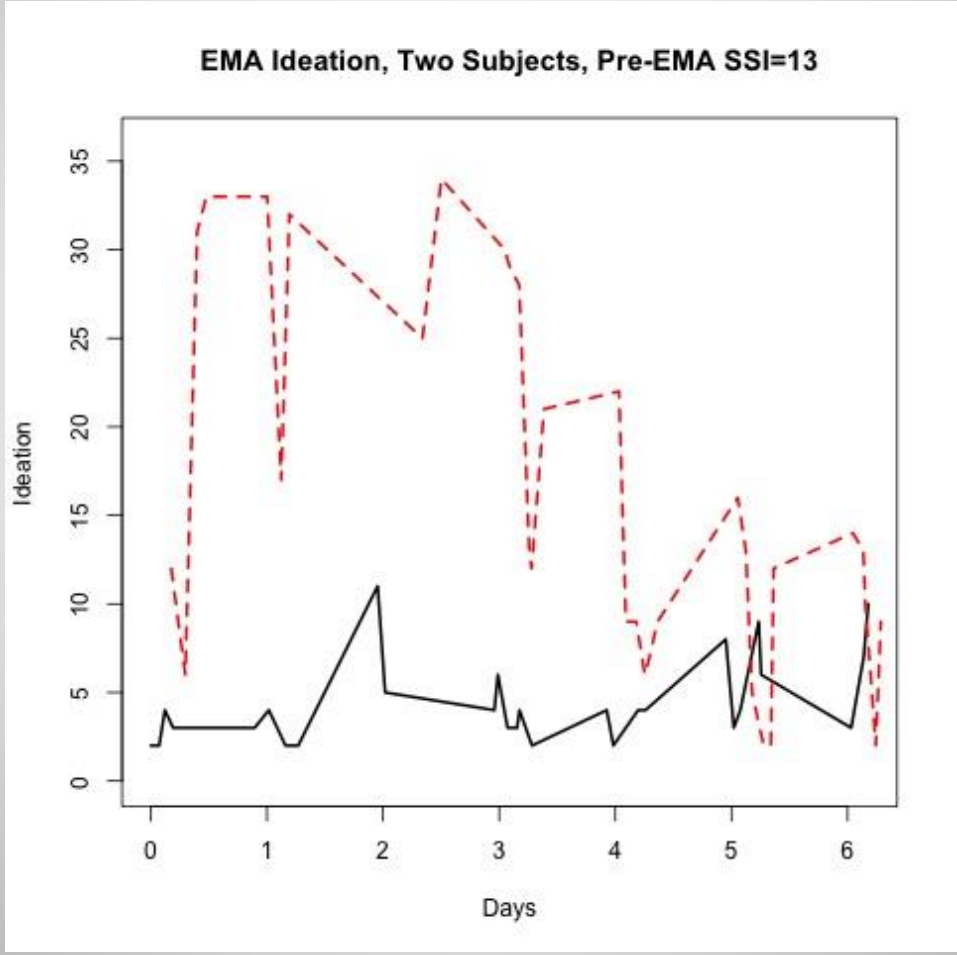
To what degree have you used the following strategies to manage any of the negative thoughts, feelings, or experiences you have had since the last prompt?					
1. Kept myself busy	0	1	2	3	4
2. Socialized with others	0	1	2	3	4
3. Focused on positive thoughts	0	1	2	3	4
4. Did something good for myself	0	1	2	3	4
5. Calmed myself down	0	1	2	3	4
6. Tried to find perspective	0	1	2	3	4
7. Sat with feelings until they passed	0	1	2	3	4
8. How effective were these strategies in dealing with these issues?	0	1	2	3	4

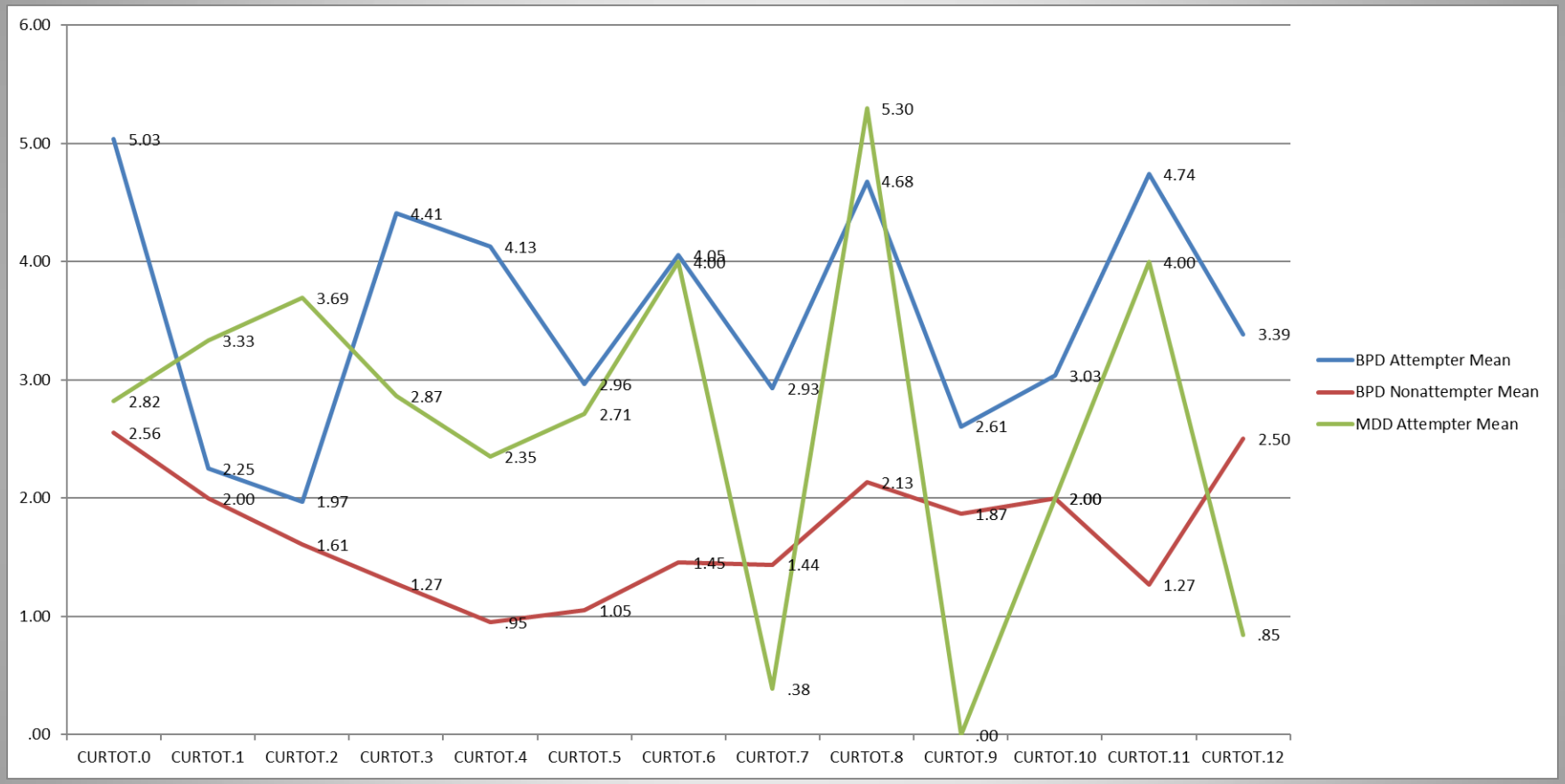
0= Very slightly or not at all; 1= a little; 2= moderately; 3= quite a bit; 4=extremely

EMA ideation scores (range 0-36) for four participants representing different ideation variability patterns, over one week.



EMA ideation score over one week for two participants with the same baseline SSI score




6.00
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2.00
1.61
1.27
.95
1.05
1.45
1.44
2.13
1.87
2.00
1.27
2.50
BPD Attempter Mean
BPD Nonattempter Mean
MDD Attempter Mean

Effect of the stressors on change in suicidal ideation

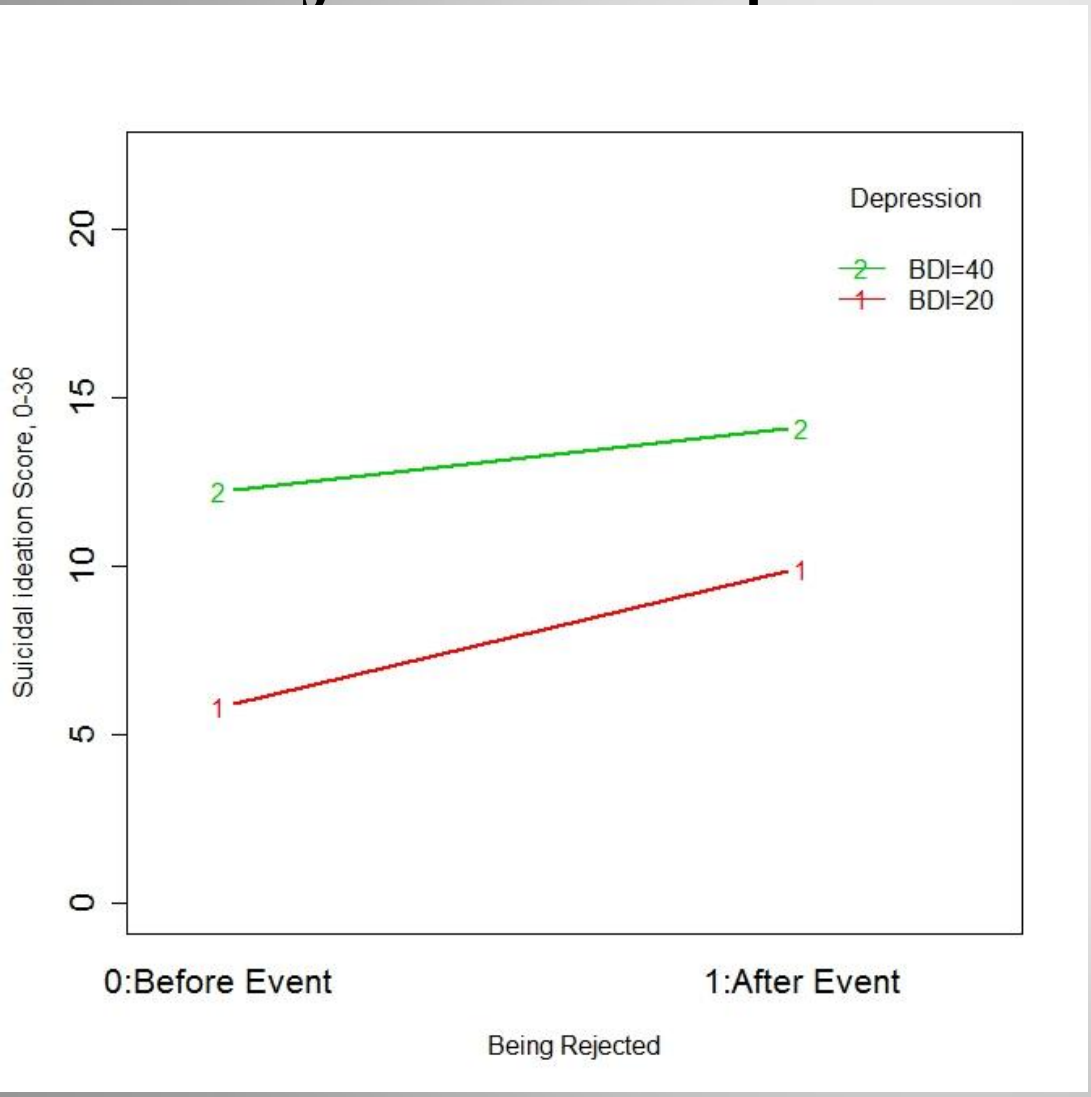
In the regression model with multiple predictors, two of the stressors, remained significant independent predictors: a disagreement (b=1.81, t=3.94, df=942, p<0.0001) and feeling neglected by someone (b=1.04, t=2.41, df=942, p=0.0160).

Stressor	Frequency	Joint Model			Individual Models		
		B	t (df=942)	p	B	t (df=950)	P
Disagreement	20%	1.9668	4.18	<.0001	2.6786	6.58	<.0001
Rejection	16%	0.2834	0.48	0.6347	2.2313	5.02	<.0001
Compliment	22%	0.2231	0.52	0.6000	0.1693	0.41	0.6798
Interpersonal disappointment	29%	-0.2460	-0.47	0.6353	1.8022	5.03	<.0001
Neglect	30%	1.0174	2.30	0.0218	1.8457	5.29	<.0001
Loss	15%	0.7563	1.49	0.1356	1.9567	4.41	<.0001
Good news	17%	-0.5106	-1.09	0.2755	-0.4806	-1.07	0.2855
Bad news	16%	0.8311	1.65	0.0999	2.0992	4.63	<.0001
Painful reminder	45%	0.04783	0.14	0.8885	0.9578	3.03	0.0025

Effect of the coping strategies on change in suicidal ideation

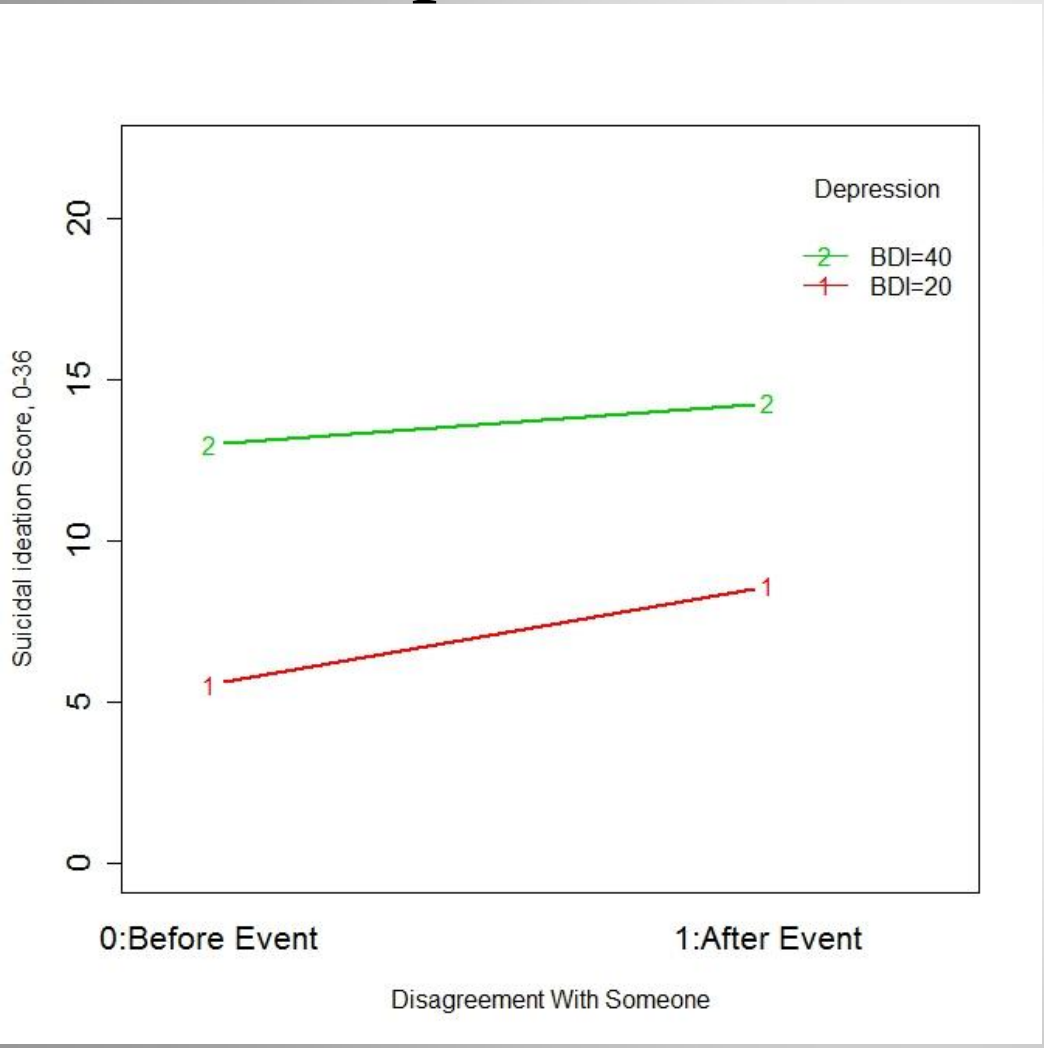
Coping Strategy	Frequency	Joint Model			Individual Models			Self-rated coping effectiveness	
		B	t (df=940)	p	B	t (df=946)	p	Coefficient	P
Keeping busy*****	79%	-0.3457	-2.65	0.0081	-0.4080	-3.67	0.0003	0.26	<.0001
Socializing	56%	0.03734	0.26	0.7919	-0.2320	-2.01	0.0446	0.08	.0001
Positive thinking	58%	-0.2845	-1.39	0.1641	-0.3146	-2.29	0.0221	0.17	<.0001
Doing something good for oneself	50%	-0.04686	-0.25	0.8004	-0.3144	-2.37	0.0182	0.11	<.0001
Calming oneself	49%	-0.3079	-1.30	0.1923	-0.1936	-1.32	0.1880	0.10	.0023
Finding perspective	60%	0.2438	1.13	0.2584	-0.0875	-0.65	0.5188	0.14	<.0001
Sitting with feelings until they pass	53%	0.2762	1.66	0.0979	0.1070	0.82	0.4125	0.06	.0084

Ideation Change Moderated by Subjective Depression After Rejection



Participants with the lower levels of depression as measured by the Beck Depression Inventory (BDI) experience a marked increase in suicidal ideation after perceived rejection (during EMA), while the increase in ideation for subjects with high BDI was to be modest or non-existent.

Ideation Change Moderated by Subjective Depression After Disagreement



Similarly, participants with the lower levels of depression, as measured by the Beck Depression Inventory, experience a marked increase in suicidal ideation after a disagreement (during EMA), while the increase in ideation for subjects with high BDI was to be modest or non-existent

Results

- Found very different, individual patterns of suicidal ideation over the week between participants who all had BPD and prior history of either SA or NSSI, and a lot of variability over the course of a week
- EMA methodology provides new window into understanding the forces that impact on suicidal ideation in the moment (triggers, coping skills)
- Supports relationship between interpersonal sensitivity/reactivity and suicidal ideation in BPD, depression not only factor
- Distraction works best as coping skill, sitting with feelings not so much

What do we do clinically with this information?

Fluctuations in suicidal ideation/risk must be at the forefront of our minds as clinicians and providers

Clinicians need training and guidance to:

- Identify fluctuating patterns of suicidal ideation and therefore suicidal risk;
- Identify individual patterns of SI in their patients;
- Anticipate and be ready to intervene around spikes in SI.

Obstacles

- We have knowledge about what works for detecting and treating suicidal thoughts and behaviors
- But, this knowledge does not always make it to clinical practice
- Gaps in clinical training to learn how to identify, monitor and treat fluctuations in suicide ideation and risk

Standard Clinical Training for Suicide Management

- Ask about current suicidal ideation as part of mental status exam
- Dimensions of suicidal ideation – passive/active, planning yes/no, intent to act yes/no
- Contract for safety
- Hospitalize yes/no
- Refer to psychiatrist

Limitations of Standard Training

Few or no guidelines for:

- Inquiry into past suicidal ideation
- Inquiry into history of suicidal behavior
- For understanding:
  - Fluctuating nature of suicide risk
  - Anticipating spikes in risk
  - Recognizing high risk periods
- No other guidelines for helping individuals stay safe
- No other guidelines for ongoing monitoring of safety outside hospital
- Leads to over-reliance on hospitalization, which is often not helpful and may not be an option
- Contracting for safety doesn't work!

10 Steps for Applying Best Practices to Everyday Clinical Care

1. Explicitly inquire about suicide ideation and behavior, past and present
2. Know about other risk factors for suicide
3. Make continued focus on safety an explicit goal
4. Develop a collaborative plan for managing suicidality: safety planning including means restriction
5. Teach coping skills
6. Increase contact and flexibility
7. Monitor and know the periods of highest risk
8. Involve family and other social supports
9. Clinician peer consultation and support
10. Documentation

AIM Model of Suicide Care

- **A**ssess----Screening and Risk Assessment
- **I**ntervene----Safety Planning and Suicide-Specific Interventions
- **M**onitor----Follow-up, Outreach, Increased Contact

Meet Paul

32 year old single male with a college degree. He lives with a roommate and is currently working as a graphic artist in a small start up company.

- Talented artist and gets jobs easily but has trouble keeping them
- Needed a medical leave in college after dropping out of sight during a final art project
- Shame and difficulty with authority often interfere with his success at work
- Non suicidal self injurious behaviors in which he uses an exacto knife to make deep cuts on his ankles.
- He has never actually tried to end his life but on numerous occasions he has had severe suicidal ideation with a plan to jump from the roof of his apartment building, and twice has actually gone to the roof and stood there contemplating jumping, and then backed away.
- Substance use – frequent alcohol use, cocaine binges
- Impulsive aggressive episodes in which he gets into verbal and once or twice physical confrontations with strangers in the subway or on the street.
- Childhood history of physical abuse by mother
- Treatment – has history of 2 ER visits and 3 years of outpatient therapy
- Suicidal ideation and urges to self-harm are chronically variable and fluctuating

ASSESS
Step 1. Direct Inquiry

- Encourage disclosure by building rapport and being collaborative
- Be matter of fact, but also warm, supportive and respectful
- Ask directly and affirmatively
  - *"Are you thinking of killing yourself?"* versus "*You aren't thinking of killing yourself, are you?"*
- Find the "sweet spot" between taking experiences seriously but not over-reacting
  - Over-reacting can lead to **non-disclosure** in the future
  - Provide **hope**, but **do not invalidate** their suicidal feelings
  - Communicate that your goal is the **least restrictive level of care** while keeping the patient safe
    - Being open and honest about suicidal thoughts can help avoid hospitalization

Talking about Suicidal Ideation

- Do not assume that if patients do not express suicide ideation that they are not suicidal
- If you don't ask, patients will think you don't care or don't want to hear about it.
- This may seem obvious, but in a 2014 survey of NYS clinicians,
- 20% reported discomfort asking about suicide, and
- 12% would not bring up the topic of suicide even if the patient's record or actions suggested the patient was at risk

Step 2: Risk Factors for Suicide Besides Suicidal Behaviors

- Demographic Background
- Psychiatric Diagnoses
- Family and Social Factors
- Precipitants: Recent Activating Events
- Treatment History
- Access To Means
- Protective Factors

Paul's General Risk/Protective Factors

- No history of suicide attempts
- Yet, history of what we call "aborted attempts" in which he started to act on a plan but then stopped himself
- Demographics: White male entering middle age
- Recurrent Major Depression
- Borderline Personality Disorder
- Substance use
- Impulsive aggression
- History of childhood physical abuse
- Access to Means: exacto knives, rooftop, pills
- Protective Factors: He is smart and talented, very likeable, charming, caring and sweet, easy to like and care about when he is not in his stormy aggressive mood. Relationships with his father and brothers reasons for living, has supportive family members in his life

Risk factors specific to Paul

- Coming to a deadline on an artistic project (feelings of inadequacy and shame about it not being good enough and having to submit it and expose himself)
- Any interpersonal interaction that triggers feelings of shame and inadequacy, self-hate
- Depressed mood in and of itself is NOT a risk factor for Paul's suicidal ideation, but it does make him more vulnerable to reacting to triggers

INTERVENE
Steps 3, 4 and 5

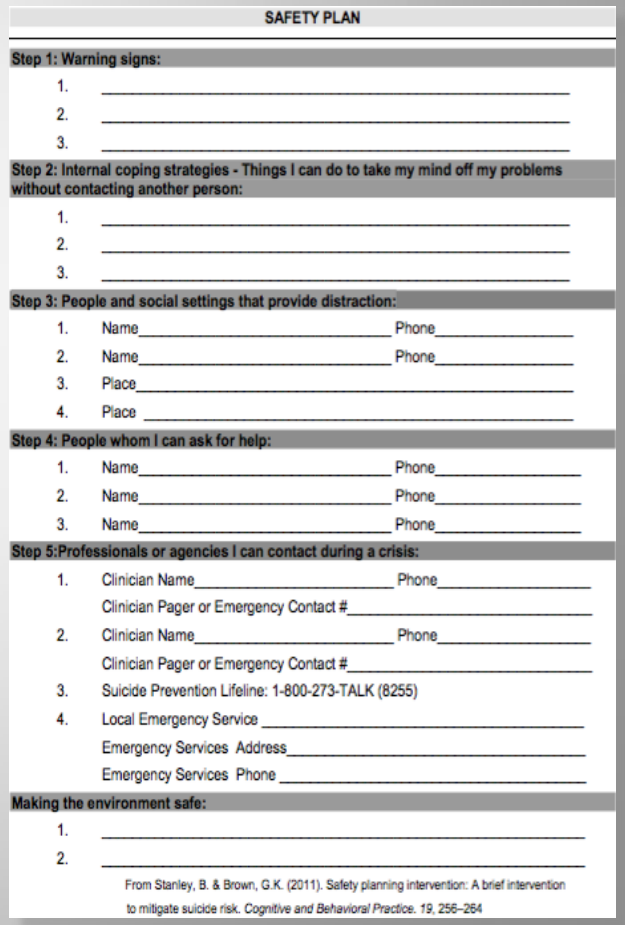
3. Make continued focus on safety an explicit goal

4. Develop a collaborative plan for managing suicidality: safety planning including means restriction

5. Teach coping skills

Brief Intervention
Safety Planning

- Suicidal urges fluctuate – They come in waves, but wax and wane, eventually go down
- Need a plan for when these urges spike
- Safety planning increases mastery and self-efficacy for coping with suicidal urges
- Can be used in one-off contacts (ER) and ongoing treatments



SAFETY PLAN

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____
4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Suicide Prevention Lifeline: 1-800-273-TALK (8255)
4. Local Emergency Service _____
   Emergency Services Address_____
   Emergency Services Phone _____

Making the environment safe:

1. _____
2. _____

From Stanley, B. & Brown, G.K. (2011). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice. 19*, 256–264

Stanley B and Brown GK, Cognitive and Behavioral Practice, 2011.

Safety Planning

- Can be done in one 30-45 minute session
- Collaboration to create an individualized, prioritized written list of coping skills
- Incorporates elements of evidence-based suicide risk reduction strategies:
  - means restriction
  - enhancing brief problem solving and coping skills (including distraction)
  - enhancing social support and identifying emergency contacts

6 Steps of Safety Planning

1. Recognizing warning signs
2. Employing Internal coping strategies without having to contact someone else
3. Socializing with others
4. Contacting family members or friends who may help resolve crisis
5. Contacting mental health professionals or agencies
6. Reducing the potential use of lethal means

Access To Means

Always inquire into access to and availability of any means and especially those that the individual is considering as part of a suicide plan:

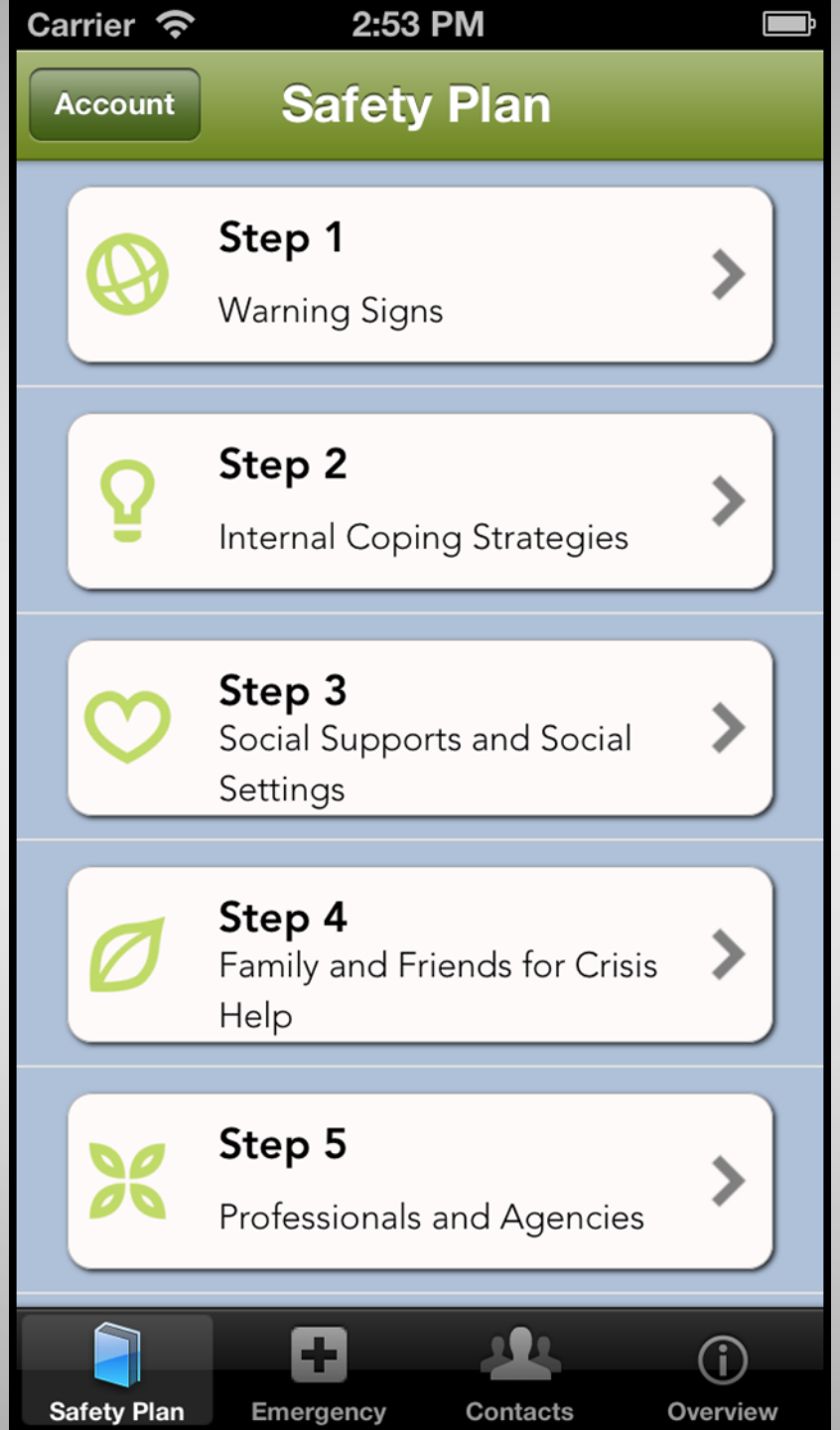
- Firearms
- Pills, ingestible poisons
- Sharps
- High places such as rooftops, bridges
- Materials/opportunity for hanging or asphyxiation

Internal Coping Strategies

58%	Watching TV
43%	Reading
29%	Music
21%	Browsing the Internet
21%	Video games
21%	Exercising/Walking
14%	Cleaning
14%	Playing with Pets
7%	Cooking

Safety Plan

Available in iTunes



Paul's Safety Plan

- Warning signs: isolating, feelings of self-hate and intense shame, urges to use cocaine
- Coping skills: video games, taking a bike ride
- Reaching out for companionship: roommate, school friends, on-line chat rooms
- Reaching out for help: father, brother, roommate
- Professional assistance: therapist, crisis hotline, ER
- Means restriction:

Paul's plan for restricting access to means

- Cleansing the environment of exacto knifes (gave them to therapist)
- Limiting the amount of medication he is prescribed at any one time
- Deleting the phone number of his drug dealer from his phone
- Having a plan in place to stay away from his rooftop when urges strike

MONITORING
Step 6: Increase contact and flexibility

- Provide for increased contact during periods of suicidal crises:
  - Increased number of appointments
  - Between session contact—phone or email
  - Encourage patient to check-in
  - Need to think outside box of traditional frame of therapy/treatment

Step 7: Know the High Risk Periods that Require Increased Monitoring

- Care transitions
  - Discharge from inpatient hospitalization
  - Discharge from ER visit
  - Transfer from one level of treatment to another (i.e., step down from intensive outpatient to once/weekly outpatient)
- Acute exacerbations

Step 8: Involving Friends and Family

- With permission, you can involve members of the patient's support network to help with safety
- Obtain ***emergency contact information*** at initial contact
- Encourage involving friends and family in treatment planning, means restriction, and safety planning

Paul's family supports

- Father was involved in Paul's safety net
- He would come to therapy sessions when he was in town
- He was made aware of Paul's safety plan
- He would check in with Paul regularly and checked about whether he was using his safety plan would contact therapist when concerned
- Therapist would call father to involve him in monitoring during higher risk periods
- Paul lived with father during a particularly high risk time

Step 9: Clinician Consultation and Support

- Seek additional support ***for yourself***
  - When in doubt, seek consultation or additional supervision for your high risk patients.
  - Make sure to have contact information of other providers
  - Take a “team” approach with other providers and reach out when necessary to coordinate safety efforts
  - During care transitions, call other providers to provide a “warm handoff”

Step 10: Documentation

Proper documentation reduces liability and improves communication with other providers

- All contacts – formal and between session
- Every time you screen
- Risk assessment – initial and ongoing, including level of risk and rationale
- Interventions and rationale
- All consultation with peers/supervisors
- Your clinical thinking and decision-making
- Other providers or emergency personnel need as much information as possible to best assist your patient.

Summary

Main clinical challenge: Suicidal ideation and risk fluctuates over time (even during the course of a day/week)

Filling the Clinical Gap:

1. Direct inquiry
2. Know risk factors – general and individual
3. Continued and explicit focus on safety – keep asking
4. Collaborative safety plan for staying safe including means restriction
5. Teach coping skills and when to use them
6. Increase therapeutic contact and flexibility
7. Monitor and know the periods of highest risk
8. Involve family and other social supports
9. Clinician peer consultation and support
10. Documentation

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