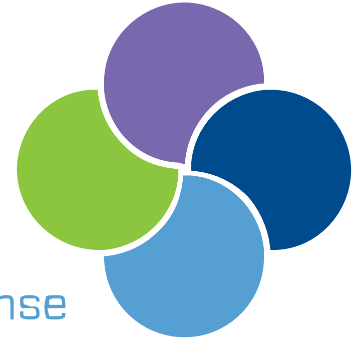
We Care, We Listen, We Respond…24 Hours a Day

Suicide & Care



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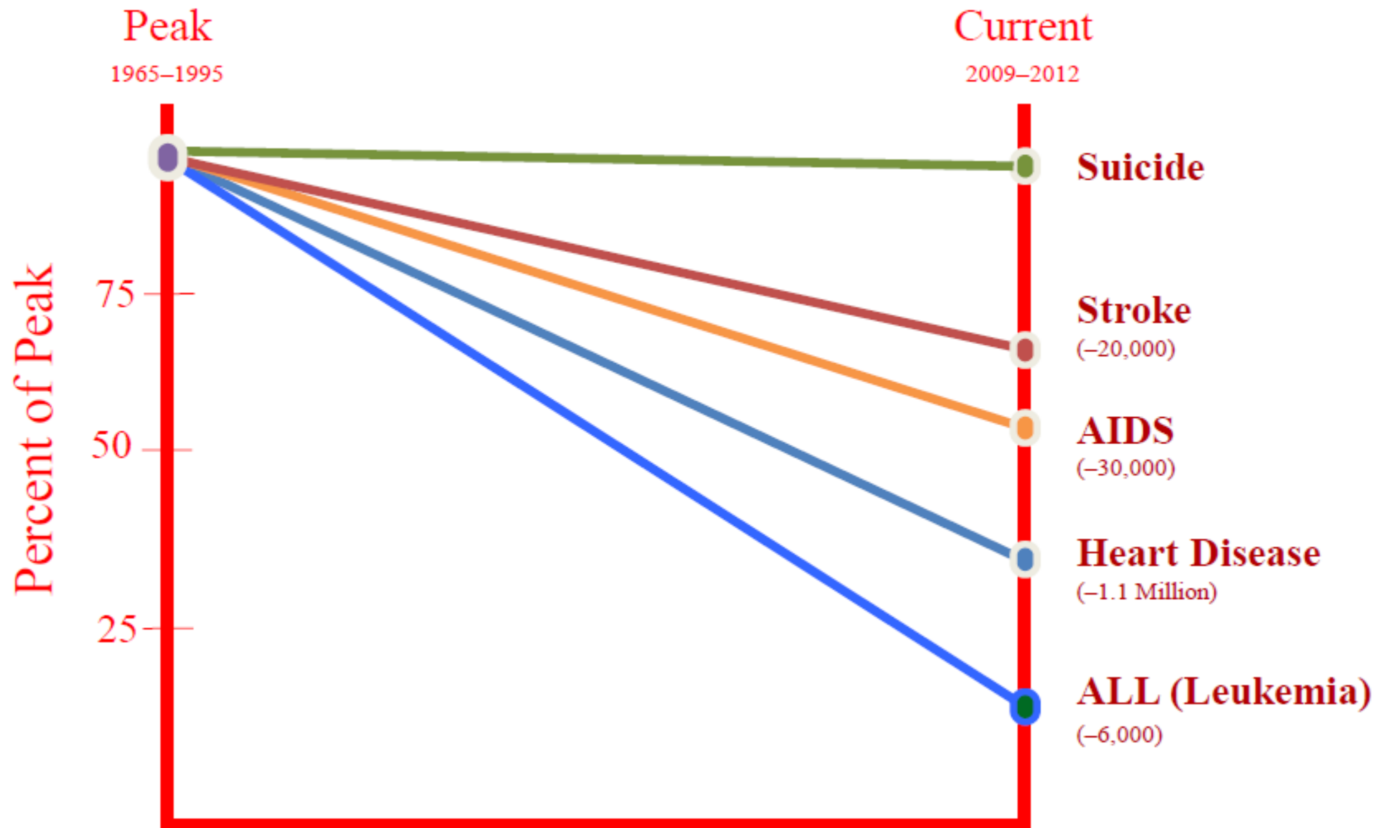
Dr. Bart Andrews
Clinical Director

Behavioral Health Response

Mortality from Medical Causes



The Quest for the Cure: The Science of Mental Illness, Thomas Insel, MD, Director of NIMH, 2014 National Council for Behavioral Health.

Who am I, why am I here?

– Admiral Stockdale, 1992

- Father/husband
- Psychologist
- PhD
- Vice President Clinical Operations-BHR
- In Long Term Recovery-Substance Use
- Suicide Attempt Survivor
- @bartandrews

Quiz, Quizzer and Quizzest

True or False:

- If you restrict a frequent means of suicide, the utilization of other methods increases.
- Rates of suicide vary greatly by culture, gender and occupation.
- 4 out of the last 60 Tour De France winners have suicided.
- Most persons who suicide leave a note.

U.S. 2014 Data

- Population: 318,900,000
- Reported suicides: 42,773
- Rate of suicide: 13.4 per 100,000 population
- People with thoughts of suicide per year: 15,932,250

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Youth Depression and Suicide

2013 High School Risk Behavior Survey

- 27% felt sad/hopeless everyday
- 14% seriously considered suicide
- 12% planned how they would suicide
- 7% attempted suicide
- 2% attempted suicide and required medical treatment

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U.S. Military-Active Military

Military suicides-2013: Frequency(RATE)*

- US Army – 115 suicides (23)
- US Marines Corps – 45 suicides (23.1)
- US Navy – 43 suicides (13.4)
- US Air Force – 42 suicides (14.4)

- VETERANS- More than 22 suicides A DAY

Another Quiz-YES

In Missouri, licensed psychologists, social workers, counselors, nurses and psychiatrists are required to have _____ hours in suicide assessment and intervention training:

a) 15 Hours
b) 12 Hours
c) 6 Hours
d) 3 Hours
e) 0 Hours

Understanding Suicide

Once detected, they have to be understood. And full understanding requires an acceptance of the qualitatively distinct viewpoint from which suicidal people see death. – Thomas Joiner

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Habituation to Self Harm

- Higher Pain Tolerance OR habituation
- Lethality increases with attempt number
- High habituation groups = High Suicide

  BPD and Anorexia
- Heroin addicts: 14x rate of suicide to peers
- Strong relationship between rehearsal and ruminative death imagery and suicide

Myth-It is Easy to Kill Yourself

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Belonging

- Social exclusion triggers physical pain system
- Mothers and number of children
- Connection between depression and disconnection from others
- Living alone/relationship loss strong predictor
- Divorced suicide rate 3x married rate

SYSTEM FAILURE

Burdensomeness

- Cultures of Honor and Suicide Rate
- Social effectiveness and mental illness
- Strong relationship between burdensomeness and suicide thoughts
- Burdensomeness successfully differentiates suicide deaths over and above other factors

Customers cannot fail, but providers and systems fail

LANGUAGE

Implicit Bias	Patient Centered
Commit Suicide	Attempted or Died by Suicide
Non Compliant	TX is not adhering
Axis II/PD	Emotional dysregulation
Resistant	Engaged/assertive/strong
Manipulative/gamey	Needful, help seeking, persistent, engaged

*Client-centered language is Evidence Based

I AM NOT DEFINED BY MY DIAGNOSIS, THAT IS JUST A LABEL A STRANGER GAVE ME

DESE'RAE L. STAGE
WWW.LIVETHROUGHTHIS.ORG

mematic.net

Getting Started

- A helping professional should view suicide risk screening the same way a primary care physician views listening to a heart beat or taking blood pressure
- Regardless of how a client presents, suicide screening should be a basic part of all clinical screenings.

Initial Screening

Three questions should always be asked:

1. Are you thinking about suicide
2. Have you thought about suicide in the last two months?
3. Have you ever attempted to suicide?

Initial Screening

- Affirmative answer to any of the questions prompts a full suicide risk screening.
- Complete screening based on the quality of denial to the questions.
- "No," can really mean "I don't want to tell you-yet!."

Full Suicide Risk Screening

Suicide is more similar to a convergence of distinct and mostly independent factors:

1. Desire
2. Capability
3. Intent
4. Barriers/Deterrents

Desire

- Thoughts about suicide/death/dying
- Hopelessness/helplessness
- Psychological pain
- Perceived burdensomeness
- Trapped/cornered cognition
- Escape

Capability

- History of suicide attempts
- Exposure to other's death by suicide
- History of violence
- Intoxication
- Acute symptoms
- Extreme agitation/rage
- Availability of Means

Intent to Die

- Attempt in process
- Plan to hurt self with method known
- Preparatory Behaviors:
  - Giving away possessions
  - Tying up loose ends
  - Suicide note
  - Acquiring/gathering means
- Internal commitment to dying

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Buffers/Deterrents

- Immediate support present with client?
- Strength of social support network?
- Future oriented thinking?
- Engagement with mental health worker?
- Ambivalence for living/reasons not to die?
- Values/Beliefs (spiritual, philosophical)?
- Sense of life purpose?

Determining Risk-Basic Skills

- Good rapport
- Interviewing with follow-up
- Reflection and active listening
- Screening across all four factors
- Significance of responses given
- Knowledge of the risk factors

Determining Risk-Elevating Factors

- Elevating Factors:
  - Desire
  - Capability
  - Intent
- There is an additive effect
- Buffers/Deterrents – help with planning

Buffers/Deterrents

Protective

- Immediate support present
- Engaged with long term social supports
- Active engagement with mental health worker
- Has future oriented thinking
- Has reason for living, even if ambivalent
- Has strong belief against suicide
- Has sense of purpose

Predictive

- Currently alone
- No social support
- Not linked with services OR lacks rapport
- Focused on past
- Little or no ambivalence about dying
- Lacks religious/ philosophical belief against suicide
- Lacks of a sense of purpose

Screening Review

- Review includes current/recent SI and history of suicide attempts.
- Affirmative response triggers full risk screening
- Risk screening does not need to be linear
- Screening must cover the four core factors

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Intervention at the Beginning

- Ask directly
- Ambivalence-Motivational Interviewing
- Identify stressors
- Avoid minimizing nature of threat
- Explore barriers and sources of support
- Develop Safe Plan

COLLABORATIVE Safe Plans

- Immediate safety and antecedents
- Plan must be disabled
- Get guns out of home
- Family/Peer involvement
- Clear chain of custody
- Coping strategies

Outpatient Plan vs Inpatient Referral

- Can we develop a safety plan?
- Can symptoms be TX w/ outpatient services?
- Has mood, engagement, life/future focus changed during intervention?
- Do all involved think plan will keep person safe?

Documentation

- Ideation and risk factors have been thoroughly assessed
- Include explanation of risk and reasons for treatment decisions made
- Address inconsistencies in report
- Detail treatment plan
- Accurately record peer/supervisory consults

SOCIAL MEDIA-GET OUT THERE

@againstsuicide

@lttphoto

@twloha

TO
WRITE
LOVE
ON HER
ARMS.

Lived Experience/Peers -Veterans

@pos_rep

@TCruz76

facebook.com/pages/Silent-Warrior/

SOLDIERS LOOK OUT FOR SOLDIERS

PEERS HELP PEERS

We Care, We Listen, We Respond...24 Hours a Day

#spsm 9pm CT

TWEETS 8,401 FOLLOWING 430 FOLLOWERS 1,215 FAVORITES 5,018

Following

SPSMChat
@SPSMChat FOLLOWS YOU

Suicide Prevention Social Media: Weekly chats, expert guests

Sundays 9pm CST

spsmchat.com

Tweet to | Message

285 Followers you know

Tweets | Tweets & replies | Photos & videos

SPSMChat retweeted

Dese'Rae L. Stage @deseraestage · May 24

That's really not how it works, bro. #depression #SPSM

Who to follow · Refresh · View all

Wade Concienne @wadelik...
Follow

Austin Carlile @austinc...
Follow

Scott Lloyd @ScottMTM
Follow

Find friends

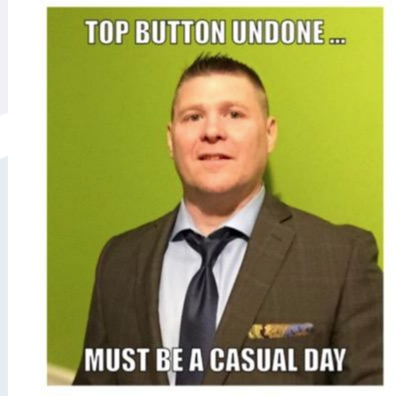
Trends · Change

FIFA
FIFA: A soulless, stinking scourge finally gets its comeuppance

Contact Info

bandrews@bhrworldwide.com

@bartandrews



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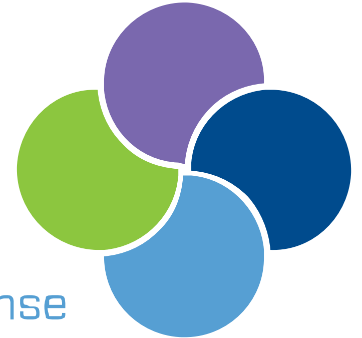

Thank you

Questions/comments