ASSESSMENT OF RISK OF SUICIDE

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Declaration of Interest/Disclosure

Dr. Devitt

None

Dr. Murray

None

Traditional suicide risk assessment[1]

TOOL FOR ASSESSMENT OF SUICIDE RISK (TASR)

INDIVIDUAL RISK PROFILE:	YES	NO
Demographics: Age/Gender (In Most Jurisdictions:>65/15-35yrs; M>F); Culture; Socioeconomic Status		
Family History: Suicide, Suicide Behaviours, Psychiatric Disorder		
Past/Present Psychiatric Diagnosis: Mood, Anxiety, Psychotic, Alcohol/Drug; Personality Disorders		
Medical Illness: Chronic, Disabling, Stigmatizing		
Poor Social Supports: Living Alone, Isolated, Poor Social Network, Unhealthy Relationships		
Domestic Problems: Violence/Abuse, Relationship Breakdown, Conflict, Pressure, Dysfunction		
Poor Stress Tolerance: Poor Self-Management, Coping. Problem-Solving, Decision-Making Skills		
Past Suicide Behaviours: Suicide Attempts, Aborted Attempts, Self-Harm		
Past/Present Abuse: Recent Or Current Abuse/Violence; History Of Childhood Abuse		
Exposure To Suicide: Direct/Indirect – Peers, Family, Community, Culture, Social Media		

SYMPTOM RISK PROFILE:	YES	NO
Depression/Dysphoria		
Hopelessness		
Severe Anhedonia		
Intense Emotion: Anxiety/Panic; Shame; Humiliation; Guilt; Anger; Isolation/Loneliness		
Shut Down: Emotional Withdrawal, Disengaged, Non-Communicative		
Severe Self-Reproach/Worthlessness		
Impaired Reasoning: Rigid Thinking; Poor Judgement/Problem-Solving/Decision-Making		
Poor Self-Control: Impulsivity; Poor Regulation Of Emotions & Behaviours; Violence/Aggression		
Psychosis: *Command Hallucinations		
Problematic Alcohol/Drug Use		

INTERVIEW RISK PROFILE:	YES	NO
Suicide Ideation: Frequency, Intensity, Duration, Persistence		
Suicide Intent: Degree Of Ambivalence & Expectation/Commitment To Die		
Suicide Plan: Method, Lethality, Preparation		
Concealed Suicidality: Warning signs; Verbal/Non-verbal Cues; Collateral; 'Clinical Intuition'		
Past Suicide Attempt: Number, Trigger, Context, Method, Lethality, Consequences		
Access To Lethal Means: Availability Of & Accessibility To Popular Lethal Methods		
Recent Alcohol/Drug Consumption Or Intoxication		
Suicide Trigger: Recent, Evolving Or Anticipated Crisis/Conflict/Loss; Victimization; Trauma		
Unsolvable Problem: Can't See Any Solution/Unable Or Unwilling to Search for Alternatives		
Intolerable State: Unbearable Emotional/Psychological/Physical State or Circumstance		

RISK BUFFERS:		
Reasons For Living		
Internal Strengths for Managing Risk		
External Strengths for Managing Risk		

LEVEL OF IMMEDIATE SUICIDE RISK: ☐ HIGH ☐ MODERATE ☐ LOW

1. BMJ Best Practice, Nov 29, 2016.

Effects of ***HIGH!!!!*** rating

1. Anxiety
2. Urge to eliminate risk
3. Narrowing of cognitive focus

Obscures 7 FACTS about suicide risk

Absolute risk

Lifetime risk for psychiatric patients 2 to 17%[1]

Highest suicide risk - men with bipolar disorder and a history of self harm[1]

4 of 10,000 die by suicide each month[1]

1. Nordentoft M, Mortensen PB, Pedersen CB. Absolute risk of suicide after first hospital contact in mental disorder. *Arch Gen Psychiatry*. *2011*; *68*: *1058–64.*

No Predictive Validity

Meta-analysis of 40 years of risk studies:[1]

- 95% “High risk” will die not by suicide
- 50% of suicides are from lower risk groups

No improvement in last 40 years…..

1. Large M et al. Meta-Analysis of Longitudinal Cohort Studies of Suicide Risk Assessment among Psychiatric Patients: Heterogeneity in Results and Lack of Improvement over Time. PLoS One. 2016; 11(6): e0156322, published online 2016 Jun 10. doi: 10.1371/journal.pone.0156322

No Predictive Validity

- Meta-analysis of suicide risk factors following DSH (deliberate self harm)[1]

- No useful predictors

1. Chan MKY et al . Predicting suicide following self-harm: systematic review of risk factors and risk scales . *British Journal of Psychiatry.* 2016; 1-7.

No Predictive Validity

Meta analysis of suicidal thoughts and behaviors over 50 years[1]

No useful predictors

1. Franklin J et al. Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychological Bulletin. 2017;* 143(2): 187-232.

Clinical judgements *reduce* accuracy

Statistical predictions of human behaviour are superior to clinical assessments[1]

Clinical judgements can only be trusted when[2]:

- sufficiently regular to be predictable
- learn these regularities through prolonged practice

1. Meehl P. Clinical versus statistical prediction: A theoretical analysis and a review of the evidence. 1954.
2. Kahneman D. Review: Thinking, Fast and Slow. *The Journal of Risk and Insurance.* 2012; 79(4): 1143-1145.

Was It Suicide?

- "Predictions are difficult especially about the future"[1]

- 593 deaths classified as suicide by researchers only 385 (65.4%) received a suicide verdict at inquest

1. Danish Proverb.
2. Palmer B et al. Factors influencing coroners' verdicts: an analysis of verdicts given in 12 coroners' districts to researcher-defined suicides in England in 2005. *J Public Health.* 2015; 37(1): 157-165.

Suicidal ideation[1]

- 157 patients died by suicide
- 2/3 denied suicidal ideation when last asked

SI+/- similar: diagnoses, symptoms, behaviours, environmental circumstances

1. Berman AL, Risk Factors Proximate to Suicide and Suicide Risk Assessment in the Context of Denied Suicide Ideation. Suicide and Life -Threatening Behavior. April 2017.

Suicide risk and treatment

There is no effective intervention for a “high suicide risk” patient that would be withheld from a “low suicide risk” patient

1. Large M et al. Meta-Analysis of Longitudinal Cohort Studies of Suicide Risk Assessment among Psychiatric Patients: Heterogeneity in Results and Lack of Improvement over Time. PLoS One. 2016; 11(6): e0156322, published online 2016 Jun 10. doi: 10.1371/journal.pone.0156322

So what do we do instead?

1. Manage the urge to end it all presentations

2. Universal measures to prevent suicide

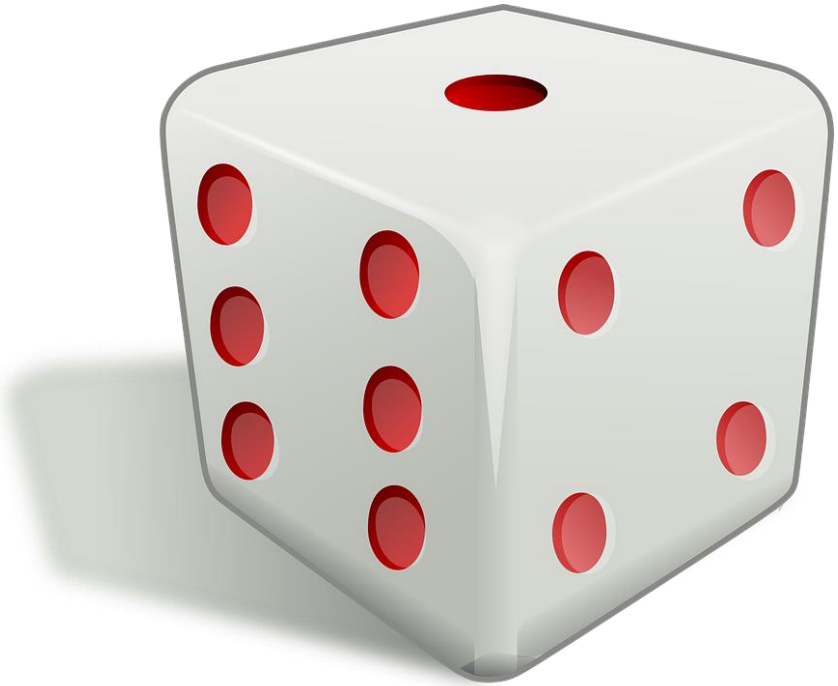
Zinc UK/ABI/1707/0111
Date of preparation: July 2017

Managing the urge to end it all

1. Think about risk in numbers
2. Framing the numbers
3. Manage staff thoughts and feelings re DSH
4. Focus on affect rather than content
5. Structured interventions

Zinc UK/ABI/1707/0111
Date of preparation: July 2017

Words or Numbers?



Zinc UK/ABI/1707/0111
Date of preparation: July 2017

Words v Numbers

“Low, Medium, High”

leads to overestimation of probability of adverse effects [1]

“1/10, 1/100, 1/1000”

more accurate estimates increase satisfaction[1]

1. Butcher R et al. Words or numbers? Communicating risk of adverse effects in written consumer health information: a systematic review and meta-analysis . *BMC Medical Informatics and Decision Making*. 2014; 14:76

Managing the urge to end it all

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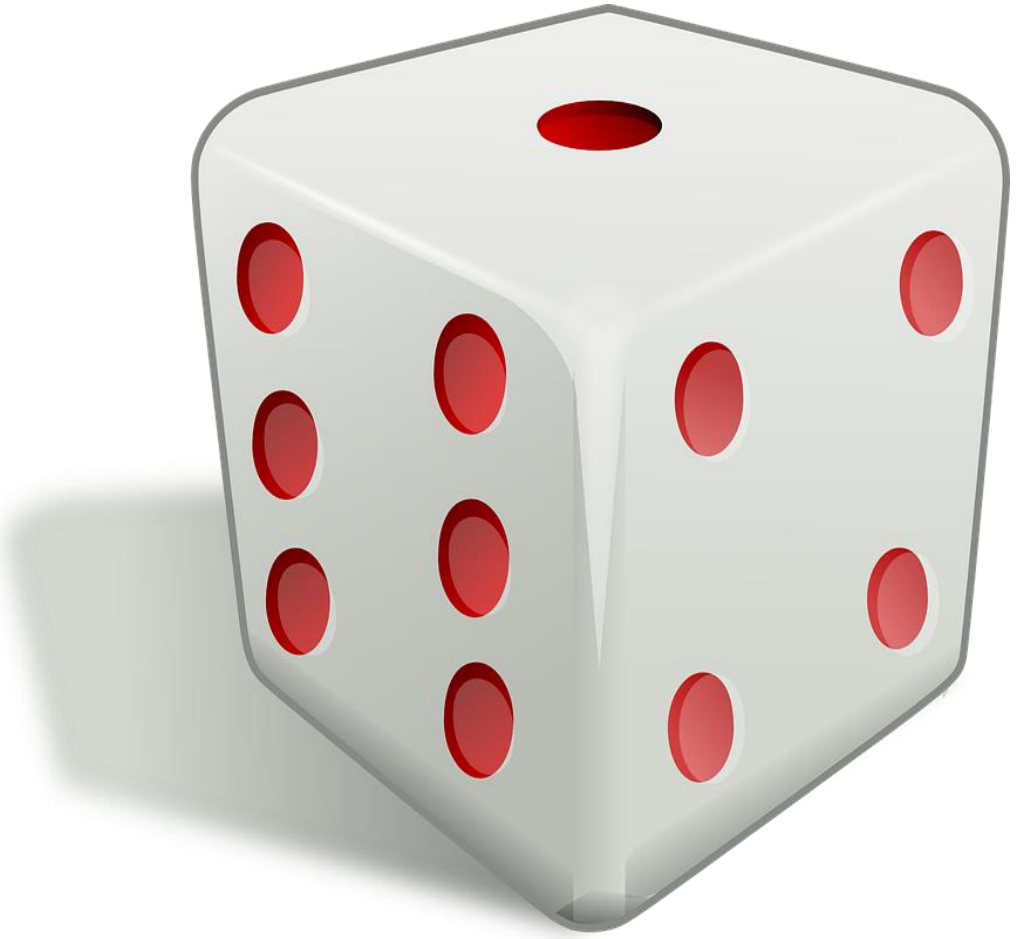
Framing the Numbers



Framing the Numbers

- One Month survival rate is 90%[1]
- 10% mortality in the first month[1]

1. McNeil B et al. On the Elicitation of Preferences for Alternative Therapies. *New England Journal of Medicine.* 1982; 306(21): 1259-1262.

Framing the Numbers

- One Month survival rate is 90%[1] 84%
- 10% mortality in the first month[1] 50%

1. McNeil B et al. On the Elicitation of Preferences for Alternative Therapies. *New England Journal of Medicine.* 1982; 306(21): 1259-1262.

Framing the Suicide Numbers

- Highest suicide risk: men with bipolar disorder and a history of self harm[1]
- 4/10,000 die by suicide each month[1]

1. Nordentoft M, Mortensen PB, Pedersen CB. Absolute risk of suicide after first hospital contact in mental disorder. *Arch Gen Psychiatry*. *2011*; *68*: *1058–64.*

Framing Suicide Numbers

- Highest suicide risk: men with bipolar disorder and a history of self harm[1]

- **4**/10,000 die by suicide each month[1]

1. Nordentoft M, Mortensen PB, Pedersen CB. Absolute risk of suicide after first hospital contact in mental disorder. *Arch Gen Psychiatry*. *2011*; *68*: *1058–64.*

Re-Framing Suicide Risk Numbers

- Highest suicide risk: men with bipolar disorder and a history of self harm[1]
- **4**/10,000 die by suicide each month[1]
- **99.96%** survive each month[1]

1. Nordentoft M, Mortensen PB, Pedersen CB. Absolute risk of suicide after first hospital contact in mental disorder. *Arch Gen Psychiatry*. *2011*; *68*: *1058–64.*

Managing the urge to end it all

1. Think about risk in numbers ✔
2. Framing the numbers ✔
3. Manage our own thoughts and feelings re DSH
4. Focus on affect rather than content
5. Structured interventions

3. Managing our thoughts and feelings about DSH

- Manipulative, attention seeking, beyond help?[1]

- Staff feelings of helplessness, rage and even revenge[2]

1. Johnstone L. Self-injury and the psychiatric response. *Feminism and Psychology. 1997;* 7: 421–426.
2. Vivekinada K. Integrating models for understanding self- injury. *Psychotherapy in Australia.* 2000; *7*(1): 18-25.
DSH = deliberate self harm.

Manipulative?

- *Skillful* in influencing or controlling others to your own advantage[1]

1. Linehan M. Cognitive-Behavioral Treatment of Borderline Personality Disorder.1993 Guilford Press New York.

Attention Seeking?

- Behaviour gets attention
- Just because behaviour gets attention does not necessarily mean that this was the purpose of the behaviour
- Behaviour occurs to relieve emotional distress

1. Linehan M. Cognitive-Behavioral Treatment of Borderline Personality Disorder.1993 Guilford Press New York.

Beyond help?

- Can be very difficult to help
- Progress can be glacial pace
- Staff burn out occurs easily

Our feeling helpless, rage and revenge

Helpful Assumptions:

- The lives of suicidal individuals are unbearable as they are currently lived
- Patients want to improve
- Patients are doing the best they can

1. Linehan M. Cognitive-Behavioral Treatment of Borderline Personality Disorder.1993 Guilford Press New York.

Managing the urge to end it all

1. Think about risk in numbers ✔
2. Framing the numbers ✔
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Free illustration / Depression, Voices, Self-Criticism - Free Image on Pixabay - 1250870

Focus on affect rather than content

3. Focus on affect rather than content

- Identify patient's feelings
- Validate the emotion
- Allow ventilation
- Find (*a manageable!*) problem to solve
- NEVER accept "being suicidal" as the problem

1. Linehan M. Cognitive-Behavioral Treatment of Borderline Personality Disorder.1993 Guilford Press New York.

Sample script

- *Most people who feel suicidal do not want to die they just want to end their emotional pain and suicide is the only way they can think of to do that. Your wife is experiencing unbearable emotional pain at the moment and as a result feels suicidal. Yes, her risk of suicide is relatively high, about 50-100 times greater than the general female population rate of 6 per 100,000 per year.*

Sample script (contd.)

- *You are bound to be very frightened by this. However, her absolute risk works out as a 99.9% likelihood that she will be alive on Monday no matter what we do. While hospitalization feels like the safe option, there is no evidence that it prevents suicide and it loses the opportunity to learn coping skills in the real world. The task is to identify the cause of your wife's emotional pain and help her find a solution for it—a combination of medication, monitoring and learning skills such as problem solving and distress tolerance.*

Sample script (Contd.)

- *If we can do that, the suicidal feelings will likely reduce. The experience will help her next time there is a crisis and reduce the likelihood of repeated hospital admissions. Although this might feel more risky in the short term, statistically it is not.*

Managing the urge to end it all

1. Think about risk in numbers ✔
2. Framing the numbers ✔
3. Manage staff thoughts and feelings re DSH ✔
4. Focus on affect rather than content ✔
5. Structured interventions

Structured Interventions

- Safety Plan[1]
- CAMS[2]
- Brief CBT[3]
- DBT[4]

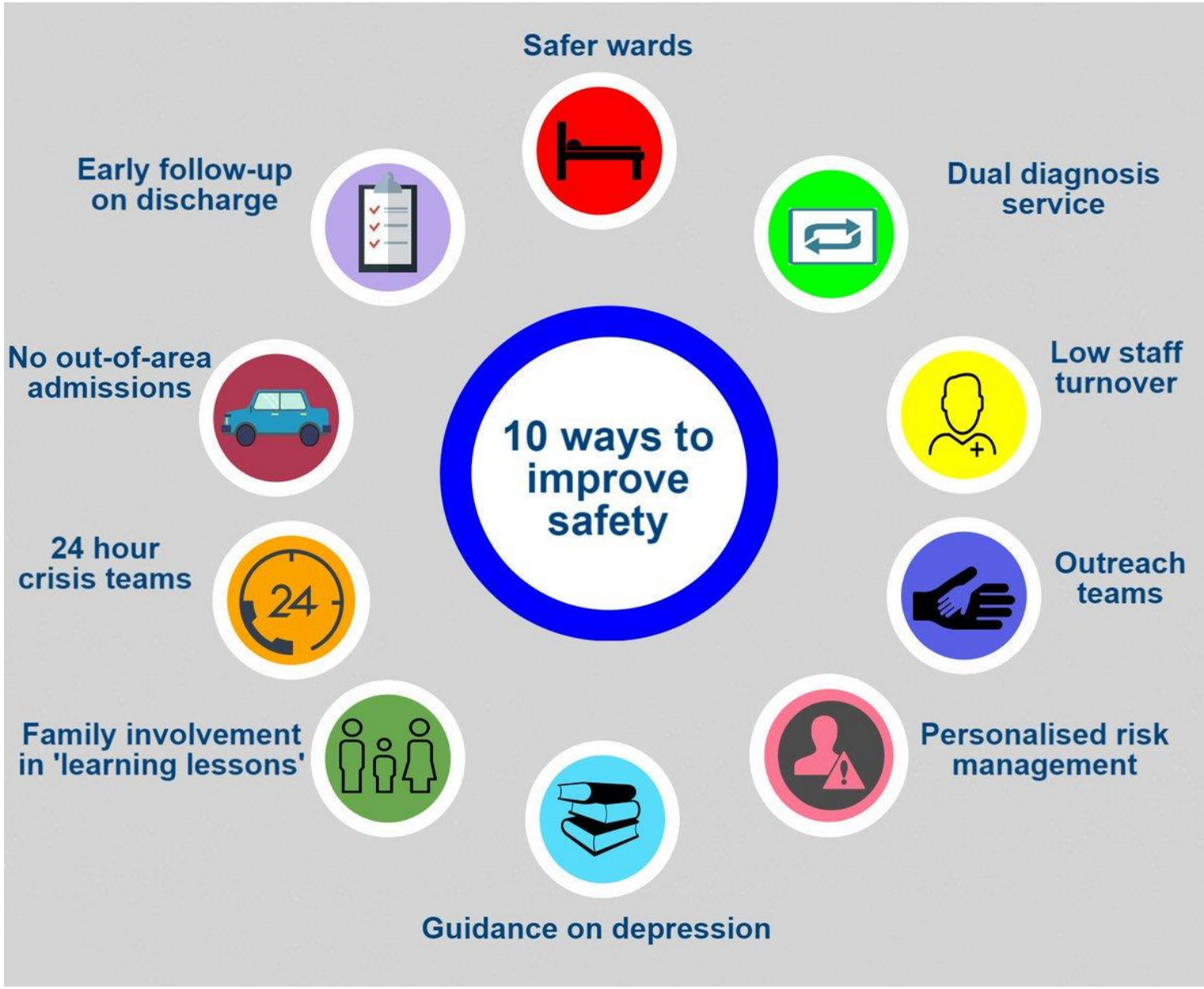
1. Safety Plan Template ©2008 Barbara Stanley and Gregory K. Brown.
2. Jobes D et al. The Collaborative Assessment and Management of Suicidality versus Treatment as Usual: A Retrospective Study with Suicidal Outpatients. Suicide and Life-Threatening Behavior . 2005; 35(5): 483-497.
3. NICE guidelines CBT
4. Linehan M. Cognitive-Behavioral Treatment of Borderline Personality Disorder.1993 Guilford Press New York.
CAMS = Collaborative assessment and management of suicidality, DBT = Dialectical Behavioural Therapy, CBT=cognitive behavioural therapy

So what do we do?

Manage the urge to end it all ✔

Universal measures to prevent suicide

Improving safety – UKNCISH evidence



Summary

Suicide risk assessment doesn't work…..

Managing Urge to end it all:

Think about risk in numbers (not words)

Manage your own thoughts and feelings

Focus on affect rather than content

Structured interventions

Preventing Suicide:

10 ways to improve safety (universal measures)