

Understanding Suicide Risk in Mental Illness

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NVDRS* Findings (2008):

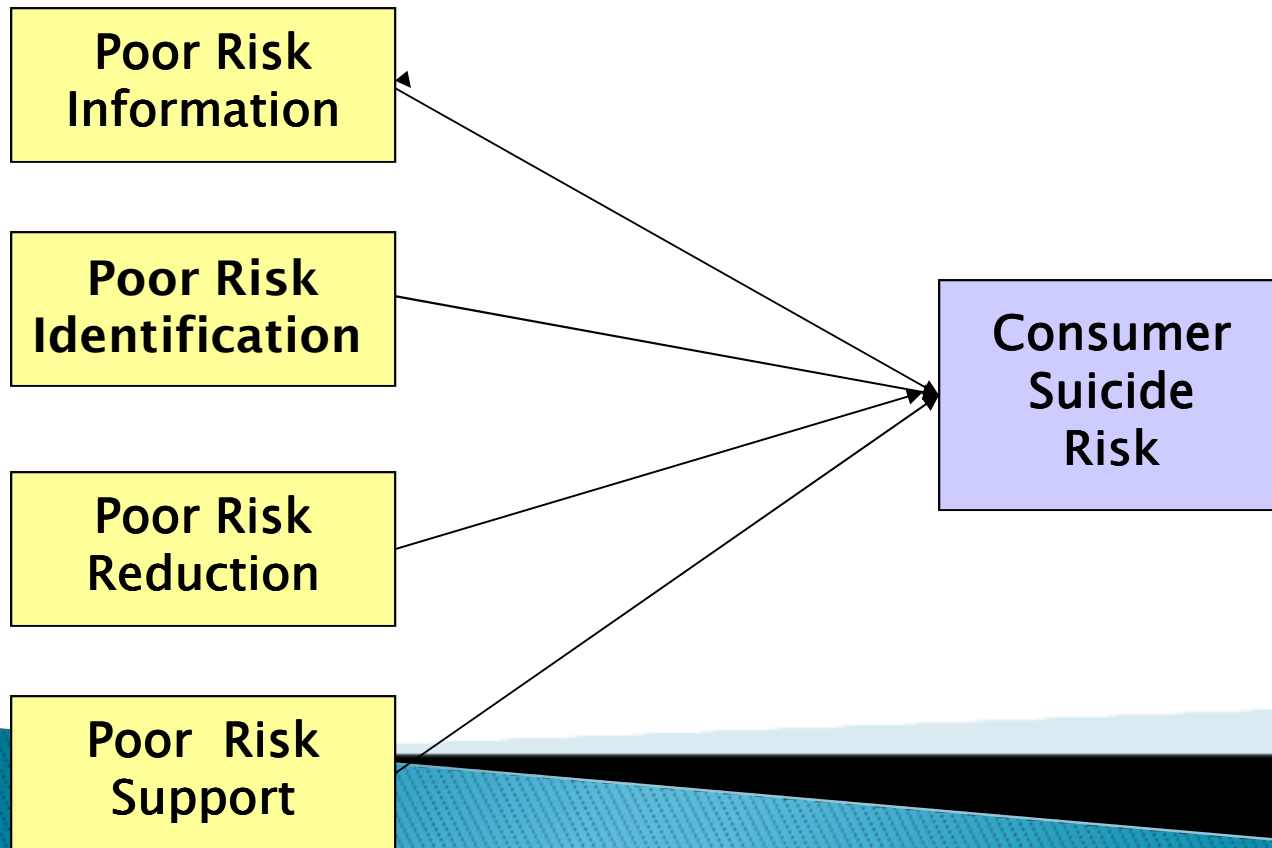
9245 Victims in 16 States:

- ▶ 42% had a depressed mood at the time of death
- ▶ 45% had a current mental health problem
- ▶ 32% were under treatment
- ▶ 90% of those with a current mental health had a mood disorder
- ▶ 24% on antidepressant at time of suicide

**National Violent Death Reporting System*



Root Causes:



Risk Information:

- ▶ What does suicide risk mean?
- ▶ What are the myths regarding suicide risk?
- ▶ Where does suicide risk come from?
- ▶ What are the risk factors for suicide in mental illness?
- ▶ What is the incidence of suicide risk in persons with mental illness?
- ▶ When is suicide risk the greatest?



What does suicide risk mean?

- ▶ Suicide risk is the foreseeable and fluctuating likelihood of a completed suicide
 - It is predictable (and can be anticipated)
 - It is measurable
 - It can be changed
 - It can be present without behavior
- ▶ It is generally life-long once acquired but may recede to a very low level



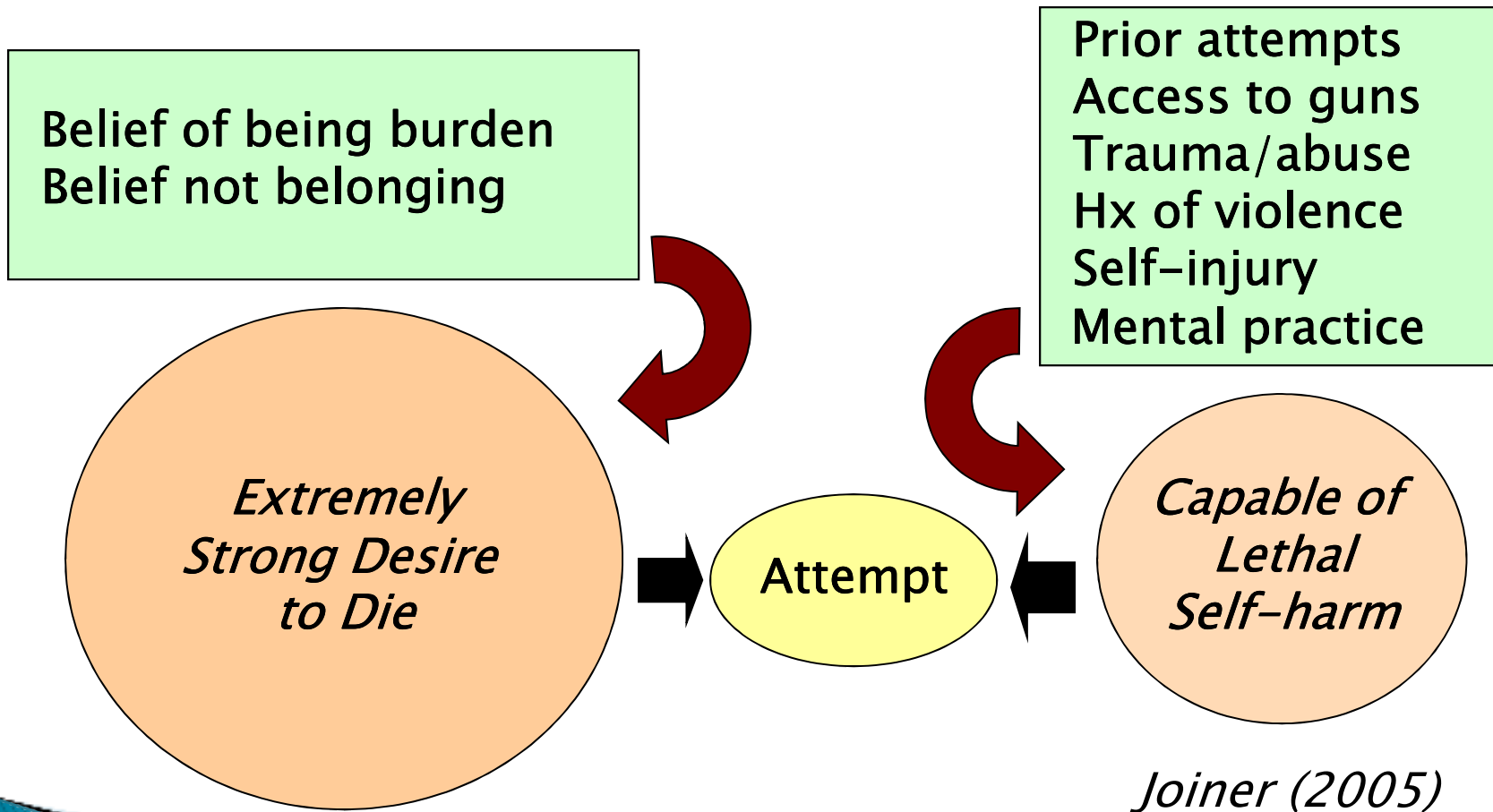
What are the myths of suicide risk?

- ▶ Only persons with mental illness complete suicide
- ▶ Mental illness causes suicide
- ▶ Surviving a suicide attempt indicates that the person was not serious about completing suicide
- ▶ Improvement following a suicidal crisis means that suicide risk has abated
- ▶ Persons who only make threats are manipulative and at very low risk
- ▶ “Contracting for safety” demonstrates low risk



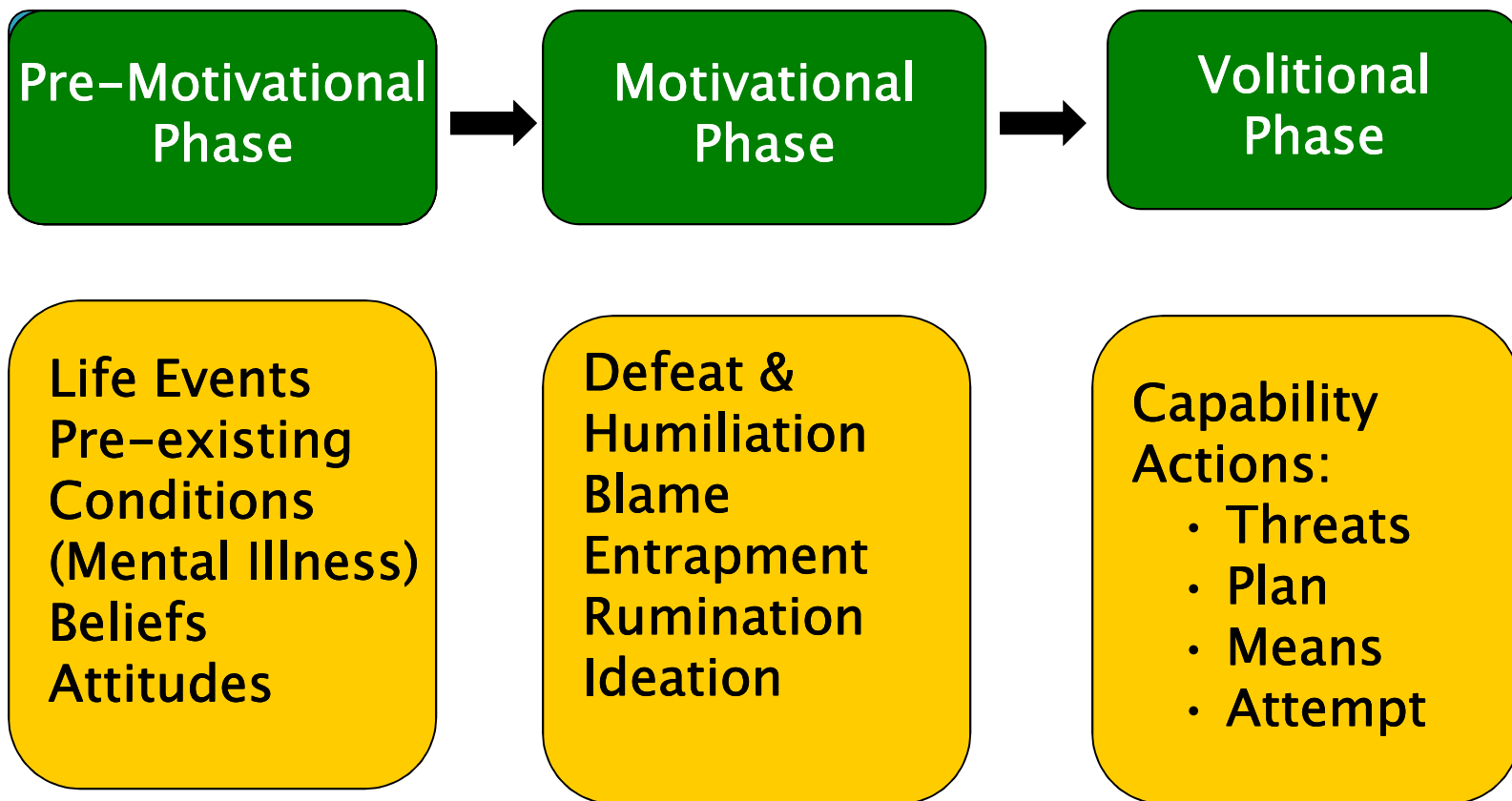
Where does suicide risk come from?

Interpersonal Psychological Theory



Where does suicide risk come from?

Integrated Motivation-Volitional Theory



O'Connor (2011)

Rumination:

- ▶ Frequent, sometimes negative, persistent self-focused thoughts involving:
 - Reflection – Introspective problem-solving
 - Brooding – Passive problem-focused thought concentrated on the concern rather than on any possible solution.
- ▶ Amplifies/mediates any unrealistic self-expectations or exaggerated self-criticism

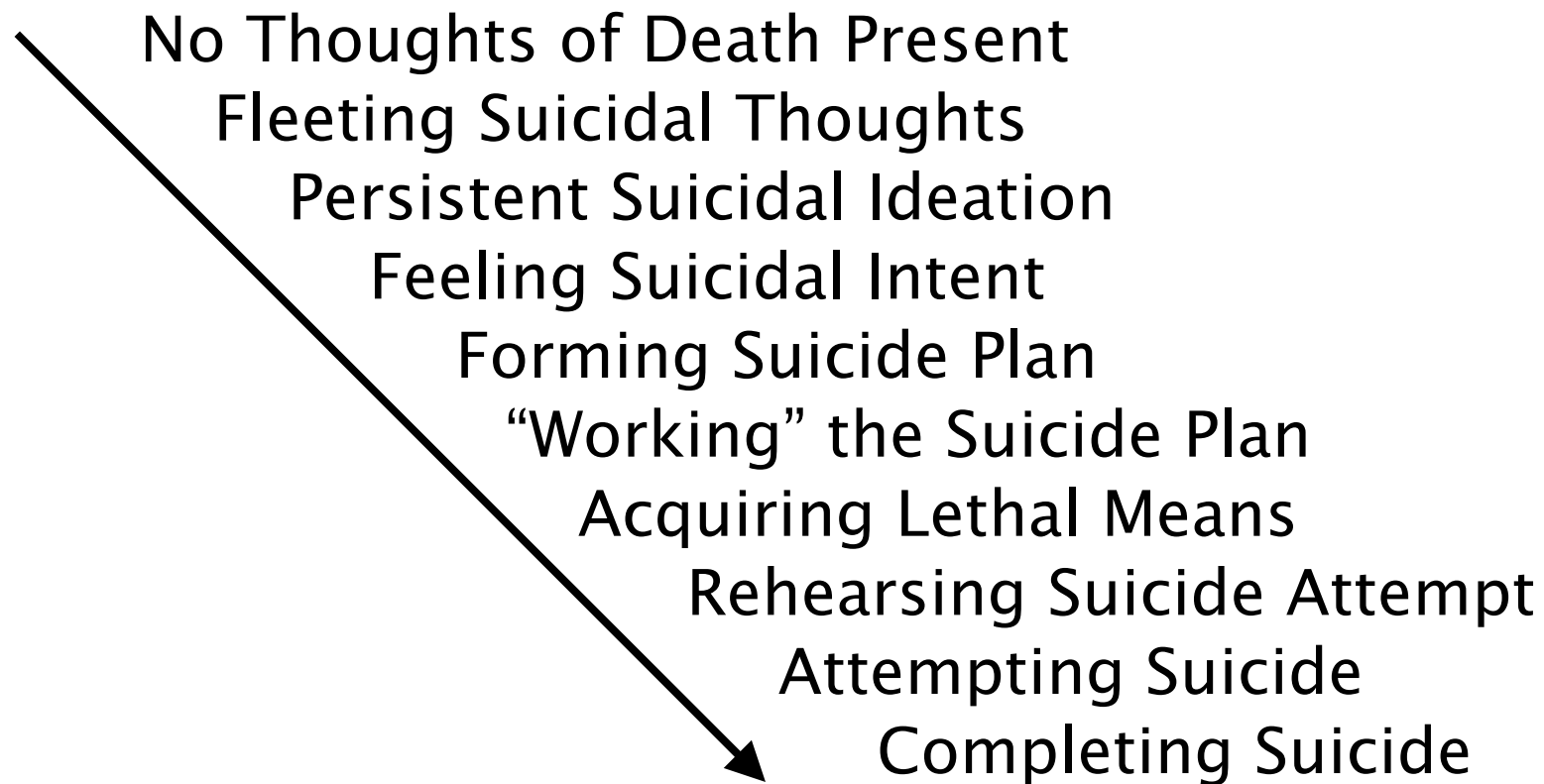


Suicide Risk Clustering:

- ▶ Suicide contagion refers to suicidal behavior by 1 /more persons related to similar acts in others
- ▶ A suicide cluster is the occurrence of 3 /more suicide attempts in the same area at the same time
- ▶ McKenzie et al. (2005) found “suicide imitation” in for 10% of the suicides among patients of Mental Health Trusts in the UK
- ▶ “Low mood and low self-esteem may render an individual less able to resist copying a behavior that seems to offer a way out.”



“Down Escalator”



SMI-Specific Risk Factors:

- ▶ Young age and early stage of illness
- ▶ Good pre-illness functioning
- ▶ Good intellectual functioning
- ▶ Frequent exacerbations/remissions
- ▶ Post-relapse improvement periods
- ▶ Depressive episode/hopelessness

Bongar (1992)



What is the incidence of suicide risk?

- ▶ 5% of people with mental illness complete suicide
- ▶ About 4% of those hospitalized for a depressive disorder will complete suicide (*Bostwick & Pankratz, 2000*)
- ▶ 5% of schizophrenia sufferers complete suicide (about 3800 deaths yearly in US)
- ▶ As many as 1 in 5 people with bipolar disorder eventually complete suicide (*Cowan & Kandel, 2001*).
- ▶ At least 25% to 50% of patients attempt suicide at least once (*Jamison, 2000*)



Disorders and Suicide Risk:

| Disorder | Lifetime Risk | Risk Drivers | Risk Periods |
|------------------------|---------------|---------------------------------|----------------------------------|
| Mood Disorders | 5%–15% | Panic, anxiety, substance use | Symptoms abating |
| Panic Disorder | 7%–15% | Demoralization; co-morbidities | Periods of agitation |
| Schizophrenia | 5%–15% | Early onset; good function | Post-psychosis; Early in illness |
| Borderline Personality | 7% | Mood disorders Substance use | Impulsivity & hopelessness |
| Alcoholism | 3% | Co-morbid depression | Recent/ expected loss |

When is suicide risk the greatest?

- ▶ Periods of very high suicide risk:
 - 30 days after psychiatric hospital discharge
 - Within 180 days after a suicide attempt
 - After experiencing a suicide
 - Post-recurrence improvement periods (i.e., after psychosis, after severe depression)
 - Following re-traumatization



Risk Identification:

- ▶ Risk Determination Intercepts:
 - Calls to Hot Lines/Warm Lines
 - Contact with Crisis Centers/Mobile Crisis
 - Inpatient/Outpatient Admission
 - Psychiatric Hospital Discharge
 - Provider/Treatment Mode/Setting Changes
 - Critical Incidents (e.g., loss, trauma, relapse)
 - Re-engaging after Non-compliance



Risk Screening:

If signs of pre-suicidality are present ask:

- ▶ Are you thinking about suicide right now?
- ▶ Have you had thoughts about suicide in the last two months?
- ▶ Have you ever attempted to kill yourself?

If 1 /more “YES” responses arrange assessment.



Protective Factor Failure:

- ▶ Changes in features deterring suicidality and sustaining resilience:
 - Weakening relationships with family, friends
 - Decreased problem resolution ability
 - Deteriorating confidence, optimism, self-worth
 - Failing health, exacerbation of disability
 - Diminished spirituality
 - Acquires firearms



Risk Support:

Short-term

- ▶ Increase awareness of reasons for living
- ▶ Include reasons for living as part of assessment
- ▶ Instill hope in course of treatment

Malone et al. (2010)

Long-term

- ▶ Build strong social supports
- ▶ Build positive coping skills
- ▶ Build life satisfaction
- ▶ Build resiliency

Montrose et al. (2005)



Risk Reduction:

- ▶ Consumer/family/CPS/provider education
- ▶ Post-hospital discharge follow-up
- ▶ Post-attempt support groups (peer/provider-led)
- ▶ 12-step group (e.g., “Suicide Anonymous”)
- ▶ Peer support/counseling
- ▶ Personal suicide safety plans and W.R.A.P.
- ▶ Adherence to treatment statements
- ▶ Peer-run warm lines
- ▶ CBT/DBT for chronic suiciders



Three Risk Groups:

1. Persons who deal with a problem by making threats until they get an acceptable solution.
2. Persons who make threats to relieve overwhelming emotions (and who may show symptoms of borderline personality disorder).
3. Persons who are severely depressed and hopeless and manifest strong intent to die.

Bonner (2001)



Risk Assessment:

| <i>Problem-solving Threateners</i> | <i>Emotional Relief Threateners</i> | <i>Hopeless Threateners</i> |
|--|--|---|
| <input checked="" type="checkbox"/> Ideation <input checked="" type="checkbox"/> Voicing Threats <input checked="" type="checkbox"/> Risk Factors <input checked="" type="checkbox"/> Low Protective Factors <input type="checkbox"/> Plan/Mean <input type="checkbox"/> Desire to Die <input type="checkbox"/> Danger to Self | <input checked="" type="checkbox"/> Ideation <input checked="" type="checkbox"/> Voicing Threats <input checked="" type="checkbox"/> Risk Factors <input checked="" type="checkbox"/> Low Protective Factors <input type="checkbox"/> Plan/Mean <input type="checkbox"/> Desire to Die <input type="checkbox"/> Danger to Self | <input checked="" type="checkbox"/> Ideation <input checked="" type="checkbox"/> Voicing Threats <input checked="" type="checkbox"/> Risk Factors <input checked="" type="checkbox"/> Low Protective Factors <input checked="" type="checkbox"/> Plan/Mean <input checked="" type="checkbox"/> Desire to Die <input checked="" type="checkbox"/> Danger to Self |

Suicide Risk & Recovery:

| <i>Recovery Asset</i> | <i>When Present</i> | <i>When Absent</i> |
|-----------------------|---------------------|--------------------|
| Hope | Less Risk | More Risk |
| Self-respect | Less Risk | More Risk |
| Control | Less Risk | More Risk |
| Autonomy | Less Risk | More Risk |
| Dignity | Less Risk | More Risk |
| Support | Less Risk | More Risk |

Signs of pre-suicidality:

- ▶ Talking about being trapped, losing control
- ▶ Withdrawing from family/friends/supports
- ▶ Increasing alcohol/drug use
- ▶ Disengaging from treatment, less contact
- ▶ Manifesting anxiety/agitation/sleep problems
- ▶ Mood changes, anger, growing pessimism
- ▶ Increasing recklessness/risk-taking
- ▶ Sleep disturbances, nightmares



Paradigm Shift:

Devolving Paradigm

- ▶ Suicide is “committed” (i.e., voluntary decision)
- ▶ Suicide is an impulsive act
- ▶ Suicide is driven by mental illness
- ▶ Suicide is a complex, bio-
psychosocial phenomena

Emerging Paradigm

- ▶ Suicide is “completed”
- ▶ Suicide is the outcome of a process
- ▶ Mental illness is one risk factor for suicide
- ▶ Suicide is predominantly a psychosocial phenomena



Suicidality as Process:

Fixed Factors + Latent Factors - Protective Factors + Precipitating Factors = Outcome



Tony's Five Commandments:

- I. Thou shalt know that suicide risk can arise in anyone.
- II. Thou shalt believe that when someone is suicidal it is her or his *only* problem.
- III. Thou shalt give those who say that they are suicidal the benefit of the doubt.
- IV. Thou shalt get a suicidal individual a psychiatric evaluation ASAP.
- V. Thou shalt not assume that voiced suicidality will just pass.

