WELCOME TO THE 2ND ANNUAL
IDAHO INTEGRATED BEHAVIORAL HEALTH NETWORK
CONFERENCE
Team and Evidence-Based Strategies to Assess Suicide Risk with Opioid Use Disorders, SUDs, MH and Chronic Disease in Primary Care: Session II – Advanced Skills

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Faculty Disclosure

The presenter of this session has received consulting and training fees during the past 12 months.
Learning Objectives

At the conclusion of this session, the participant will be able to:

1. List the interventions which demonstrate some effectiveness in helping suicidal patients.
2. Demonstrate your understanding and skill with suicidal patients in discussing ambivalence about living.
3. Demonstrate appropriate skills in intervening with suicidal patients when intentional or accidental drug overdose is likely or has occurred.
4. Apply your knowledge of evidence-based interventions to the management of suicidal patients in PCMH and in reverse integration settings.
5. Practice means restriction counseling for a patient with suicidal symptoms.


Bibliography / Reference


Advanced Suicide Prevention Training
Strategies for Managing Suicide Risk
Brief Interventions
What Works

Adaptation of empirically-supported, effective strategies for risk assessment and management from specialty MH care and applying it to the PC context
“Rules of Thumb”

▪ Eliminate psychobabble and complex theories, both for patients and for PCPs
▪ 5-10 minute rule: if it can’t be explained and taught in 5-10 minutes, then it’s too complex
▪ Strategies must be evidenced-based
▪ Intervention MUST be values-based
Interventions must target suicide risk by “deactivating” one or more components of the suicidal mode.

During acute crises, interventions should emphasize emotion regulation and crisis management skills.
Predispositions
- Prior suicide attempts
- Abuse history
- Impulsivity
- Genetic vulnerabilities

Behavior
- Substance abuse
- Social withdrawal
- Nonsuicidal self-injury
- Rehearsal behaviors

Emotion
- Shame
- Guilt
- Anger
- Anxiety
- Depression

Suicidal Mode
- Agitation
- Sleep disturbance
- Concentration problems
- Physical pain

Cognition
- “I’m a terrible person.”
- “I’m a burden on others.”
- “I can never be forgiven.”
- “I can’t take this anymore.”
- “Things will never get better.”

Trigger
- Job loss
- Relationship problem
- Financial stress
- Life transitions
Treatments

* Pharmacotherapy
* Cognitive Behavioral Therapy
* Dialectic Behavioral Therapy

Acceptance and Commitment Therapy (ACT)

Other Interventions
  ◦ Mindfulness
  ◦ Yoga

* The research is strongest for these modalities (Bryan & Rudd, 2010).
Brief Interventions

Reasons for living list
Survival kit (“Hope Box”)
Behavioral activation
Relaxation skills training
Mindfulness skills training
Cognitive restructuring
  ◦ ABC worksheets
  ◦ Coping cards
  ◦ Challenging beliefs worksheets
Brief Interventions

▪ A stronger sense of meaning in life is significantly associated with lower emotional distress, less severe suicidal ideation, and better functioning across multiple domains of life (Bryan et al., 2013).

▪ “Effective” Crisis Response Planning reduces suicide attempts up to 76% (Bryan et al., 2017 a, b)

▪ BCBT reduces suicidal behavior by 60% compared to treatment as usual (Bryan et al., 2015)
Brief Interventions

53 psychosocial clinical trials targeting suicidality (Bryan & Rudd, 2010)

- “Clinical trial” = study including both treatment and control (or comparison) condition
- Randomization not required
- 28 (53%) were cognitive-behavioral
- One RCT included military personnel
Delivering these within a PCBH Visit

Structure of the visit:

• 20-30 minute appointment
  ◦ Rapid problem identification
  ◦ Analysis of functioning
  ◦ Intervention development
  ◦ Same day feedback to the PCP
  ◦ Engage team to support disposition and treatment plan
Delivering these within a Specialty MH Visit

- Depends (slightly) on the setting...how?
- Why deviate from what works and from what’s efficient?
- Time = better outcome?
Antidepressant and the Role of BH Providers

Patients initiated on antidepressants can be followed by nurses or BHCs for PCPs

- Meets FDA recommendations and intent of warning label
- Enables psychoeducation focused on medication adherence
- Combines medication therapy with behavioral therapy, which is more effective than either alone
- Meets HEDIS requirements for antidepressant follow-up and adherence
Supporting Medication Adherence

MH providers emphasizing adherence concurrent with CBT can increase medication adherence by 10% (Kolbasovsky et al., 2005)

Talking with patients about prior experiences with antidepressants (focusing on motives and beliefs about medications) and scheduling pleasant behavioral activities increases early adherence (Lin et al., 1995)
Supporting Medication Adherence

Key messages (Bull et al., 2002; Lin et al., 1995):

1. Antidepressants must be taken consistently for 2-4 wks for noticeable effect
2. Specific instructions for resolving questions about meds
3. Take meds daily
4. Continue taking meds even if feeling better
5. Do not discontinue without first talking to prescriber
6. Keep taking meds for full 6 months despite side effects or improvement
Transitions to/within Specialty MH

The “black hole of MH”

...consult reports back from specialty MH are exceedingly rare, even when PCP made referral

Develop system to document transfer of care to specialty MH tx
  ◦ Confirm MH appt during f/u appt or phone call
  ◦ Document “proof of attendance”
Transitions to/within Specialty MH

Don’t assume patients can easily access MH care (or even know how to)

Teach patients how to find a MH provider:
- Searching for possible providers
- Rehearsing / practicing what to say on the phone
- Educating patients about the first appt
- Educating patients about the importance of therapeutic relationship
Transitions to/within Specialty MH

Follow-up with patients in-person or over the phone

Document “proof of attendance”
- Provider name
- Business card
- Release of medical information

Remember there are no “closed cases” in primary care
Recommending Hospitalization

▪ Providers tend to respond to suicide risk with “alarmist” or “better safe than sorry” attitude

▪ Inpatient hospitalization often mistakenly assumed to be “gold standard” for suicide risk

▪ Use hospitalization judiciously and appropriately

▪ PCPs should make ultimate decision about referring patient for inpatient evaluation in collaboration with BH provider and/or nurse
Post-Discharge Follow-Up

- The week immediately following discharge from inpatient hospitalization is highest risk period for suicidal patients (Qin & Nordentoft, 2005)

- Same-day / next-day walk-in appointments can be useful for risk management
Crisis Response Plan versus Safety Contract
Crisis Response Plan Literature

- Individuals who develop a CRP are 76% less likely to make a suicide attempt during the 6 month follow-up period. The CRP also contributed to faster reductions in suicidal ideation.

- The CRP was also a central component of Brief Cognitive Behavioral Therapy (BCBT), which reduces suicidal behavior by 60% as compared to treatment as usual.

- Versions of the CRP have been used in treatments shown to reduce suicidal behaviors:
  - Attempted suicide short intervention program (ASSIP);
  - Cognitive Therapy for Suicide Prevention (CT-SP); and
  - Emergency Department Safety Assessment and Follow-Up Evaluation (ED-SAFE).

- Other CRP research findings:
Crisis Response Plan

The CRP immediately reduces negative emotional distress and suicidal intent among suicidal individual (Bryan et al., 2017a).

Discussing an individual's reasons for living during the CRP increases hope, leads to larger reductions in suicidal intent, and decreases the likelihood of psychiatric hospitalization (Bryan et al., 2017b).
Crisis Response Plan

Decision-making aid

Specific instructions to follow during crisis

Developed collaboratively

Purposes:

1. Facilitate honest communication
2. Establish collaborative relationship
3. Facilitate active involvement of patient
4. Enhance patient’s commitment to treatment
5. Develop healthier coping skills

(Rudd, Mandrusiak, & Joiner, 2006)
Crisis Response Plan

Written on 3x5 card, behavioral rx pad or smartphone

Four primary components / sections:

1. Personal warning signs of emotional crises
2. Self-management strategies
3. Social support
4. Professional support & crisis management
SAMPLE

Go for a 10-15 min walk
Practice breathing exercise
Call family member to talk: xxx-xxxx
Repeat above
Contact Dr. Me at xxx-xxxx & leave message
Call hotline: 1-800-273-TALK
Go to ED or call 911
Means Restriction Counseling
Means restriction counseling is one of the only suicide prevention strategies that has consistently been found to reduce suicide death rates.

“Where the method is common, restriction of means has led to lower overall suicide rates.” (p. 2010, Mann et al., 2005)
Means Restriction Effectiveness

Reducing access to lethal methods for suicide reduces suicide rates by that method:

- Firearms (Beautrais, 2000; Beautrais et al., 2006; Leenaars et al., 2003; Loftin et al., 1991)
- Carbon monoxide (Nordentoft et al., 2006)
- Barbiturates (Nordentoft et al., 2006)
- Pesticides (Gunnell et al., 2007)
Means Restriction Counseling Effectiveness

Of those patients or parents who receive means restriction counseling following a suicide attempt (vs. no counseling):

◦ 86% vs. 32% lock up/dispose of medications (McManus et al., 1997)
◦ 75% vs. 48% removed prescription meds
◦ 48% vs. 22% removed OTC meds
◦ 47% vs. 11% restricted alcohol access
◦ 63% vs. 0% removed firearm

(Kruesi et al., 1999)
Means Restriction Counseling

Critical components:

- If complete removal of firearm is not possible, other options for storage include:
  - Remove firing pin
  - Unloaded in a tamper-proof safe
  - Lock ammunition separately
  - Ensure keys, combinations cannot be circumvented

- Hiding a firearm is not sufficient

- For children, ensure all parents with custody are aware of recommendations
# Means Receipt

<table>
<thead>
<tr>
<th>Questions? Contact your provider:</th>
<th>Dr. Me 222-222-2222</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergencies call:</td>
<td>911</td>
</tr>
</tbody>
</table>

**Patient Name:** John Doe  
**Support’s Name:** Jane Doe  
**Support’s Address:** 1234 Main St.  
**Support’s Email:** Jane.doe@email.com  
**Support’s Phone:** 555-555-5555  
**Type of means:** Firearm  
**Safety Measures:** Removed from home; stored with parent in safe  
**Release Terms:** Upon written verification by medical provider  
**Support’s signature:** (To be signed upon completion of means restriction)

*(Bryan, Rudd, & Stone, 2011)*
Practice Means Restriction Counseling
Practice Reasons for Living List
Practice Risk Assessment
Discussing Ambivalence

If a suicidal person is talking with you, there is a part of him that wants to live, even if only a little bit.

The person is suicidal because he doesn’t know how else to alleviate his psychological pain and suffering, not because he actually wants to die.

Suicide is just one solution in the person’s problem-solving repertoire.
Ask about Reasons for Living

- Addresses ambivalence...hopefully it tips the scale in the right direction
- Keeps the person future oriented

“Before, we discussed how you have ambivalence about living and dying – that you don’t really want to die, but you just can’t stand living this way. If we could help you relieve your pain, what would that allow you to enjoy in life?”

“What is keeping you alive right now?”

“Take all the pain and put it aside in your mind for a moment; what is the most important thing to you in your life?”
What do Patients Believe about their Suicidal Symptoms?

◦ I’m going crazy
◦ Since I’ve never felt this way before, I can’t relate to myself – I don’t feel like me
◦ I am losing control of myself
◦ I might not be able to stop myself from acting on my suicidal thoughts
◦ I’m not who I thought I was
Sample Questions

“What are you reasons for living?”
“I have none”

“What keeps you from killing yourself?”

“What are some things you used to enjoy doing that you no longer do?”
Practice Educating the Patient about Suicide and Discussing Ambivalence
Practice Crisis Response Plan
Crisis Response Plan: Advanced

Practice using means restriction counseling and at least one other intervention (e.g., reasons for living, survival kit/hope box; mindfulness)
PCBH Appointment Video
(as a lead in for your practice trial)
Session and Mini Break

Stretch!
Practice Full BHC Visit for Suicide (Vignette 1)
Survival Kit/Hope Box

Centralizes tangible objects to prime positive emotional states and counter suicidal beliefs

1. Obtain a container of some sort
2. Fill container with objects that have positive emotions associated with them
3. Bring survival kit to follow-up appointment
4. Patient uses this at earliest signs or antecedents of suicidal thoughts
Survival Kit/Hope Box

Common items included in survival kits:

- Pictures of vacations
- Inspirational quotes
- Scripture passages
- Trinkets or souvenirs from important events
- Letters from loved ones
- Family photos
Survival Kit/Hope Box

Patient must bring survival kit in for review with clinician

Clinician asks the patient to “tell the story” of each item, and identify items that trigger despair or hopelessness
Practice Survival Kit
Practice Full BHC Visit
(Vignette 2)
Demo of Full BHC Visit
(Vignette 3: Difficult/Complex patients)
Practice Full BHC Visit
(Vignette 4: Difficult/Complex Patient)
Book Recommendation

Managing Suicide Risk in Primary Care
Craig J. Bryan
M. David Rudd
Questions

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