Best Practice in Suicide Risk Assessment and Crisis Response Planning: Current standards for all levels of care

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Agenda

• Review need to know quick facts as a group
• Epidemiology
• What PerformCare has been doing to improve the care management of Members with chronic suicidal thinking
• Standards of Care Guidelines
• What is not effective and no longer a standard of care in working with clients with suicidal thinking
• Best practices in risk assessment
• Formulating crisis response plans
• Demonstrate analysis of risk and protective factors for crisis plan development through case examples
Agree or Disagree?

• The goal of mental health workers working with clients with suicidal thinking is to work to completely eradicate suicide.

• A client with suicidal thinking is most likely to complete suicide when they have just been discharged from inpatient care.

• Adolescents have the highest rates of suicide.

• Suicide rates are increasing.

• In order to increase assurance that client’s will not complete suicide and decrease liability, it is important for a clinician to develop a “no suicide contract” with a client who has suicidal thinking.

• Using Assessment tools that identify a variable (or number), quantifying risk, is the best way to predict if a client will complete suicide.
Epidemiology

• Does not discriminate amongst any age, gender, race, or socioeconomic group
• Estimated 9.3 million will have suicidal thoughts in one year (SAMHSA, 2013)
• Suicide is still the 10th leading cause of death in the US
• Life Expectancy in the US has declined according to 2019 CDC data, seeing a decrease from 2016-2017 due to suicide a drug overdose
• A death by suicide occurs every 11 minutes
• Increases in suicide has been seen in all age groups
• Suicide is the 3rd leading cause of death among 15.-24 year olds
• Males (white males highest) complete suicide at higher rates than females
• 90% of those who complete suicide have a mental illness
• Suicide rates are highest among those 45-54
• Older adults 65+ are a particularly vulnerable group
Epidemiology

- Pennsylvania
  - 11th leading cause of death for PA
  - One person dies by suicide every 4 hours
  - In 2017, 2023 people died by suicide
  - Suicide deaths surpass alcohol related motor vehicles accidents
  - Rates amongst age and gender mirror national statistics

- PerformCare Members Reviewed by Quality of Care Counsel and Critical Incident Report Data
  - 4 completions in both 2018 and so far in 2019 varies across all levels of care
  - 30 attempts in 2018 and 19 so far in 2019 varies across all levels of care
  - In 2018, we reviewed more attempts for child and adolescent levels of care
  - In 2019, this evened out, but we have seen overall a decrease in attempts so far this year
PerformCare – Observations and Action Steps

• MCO vantage point
  • The opportunity to review cases for suicide attempts and completions across all levels of care
  • Observation has been of slow movement toward current Best Practice Standards amongst all levels of care
  • Not an uncommon phenomenon when a standard of care in any clinical area changes

• Action Steps
  • All Clinical Care Managers and Psychologist Advisors have been trained on current Best Practice Standards
    • Involved training and case presentation and practice of learned skills
    • Increase follow-up and review (i.e. more intensive care management) for Members with high risk
    • Involves review of risk assessment and crisis planning for Members
    • Increased PA review of high risk cases and recommended treatment team follow-up
    • External collaboration with counties and providers began in 2015/Multisystemic approach
Standards of Care

- There are four known Clinical Practice Guidelines related to managing suicide risk
  - American Psychiatric Association Guidelines
  - American Academy of Child and Adolescent Psychiatry
  - SPRC Assessment and Management of Suicide Risk
  - AAS Recognizing and Responding to Suicide Risk (RRSR)
  - Professionals who completed (RRSR): Essential Skills for Clinicians training demonstrated:
    - long-term improvement in attitudes toward suicide
    - confidence in their ability to work with clients who are at risk for suicide and clinical practice skills (Osteen et. al. 2012)
No Suicide Contracts

- In all cases of clinical practice guidelines “No Suicide Contracts” are either cautioned or advised against
- There has been no evidence that these contracts have been effective in the prevention of suicide
- These are not legal documents and do not stand up in court as a viable standard to managing a client’s risk of suicide completion
- A randomized controlled study of 97 Army soldiers who presented to mental health concerns confirmed showed that:
  - Crisis Response planning was more effective than utilizing safety contracts by way of:
    - Preventing suicide attempts
    - Eliminating suicidal ideation
    - Reducing inpatient hospitalizations
  (Bryan et al. 2017)
Core Competencies in Managing Suicide Risk

- See handout for discussion (Suicide Prevention Resource Center 2006; Rudd, M.D., Cukrowicz, K.C., & Bryan, C.J. 2008)
- Core competencies include more than just knowledge of risk and protective factors
- Core competencies include more than developing a strong crisis response plan
- Core competencies are a set of clinical skills that are needed by both the clinician and their supervisor to include:
  - Attitude and approach to working with the client
  - Understanding suicidal thinking
  - Collecting assessment information
  - Formulating risk
  - Develop a treatment plan
  - Managing Care
  - Understanding legal and regulatory issues
Core Competencies – Cont_ 

• Can be learned and implemented in any type of treatment approach

• Brief Cognitive Behavioral Therapy Intervention has been systematically studied and found to be more effective than non-systematic approaches

• In a study of 152 war veterans with psychiatric symptoms, suicidal thinking, and intent to die
  • Soldiers were 60% less likely to make an attempt after a the CBT interventions than those with only treatment as usual
  • Treatment gains were maintained after 24 month follow-up
    (Rudd et al. 2015)
Formulating Risk

- Involves understanding the full range of risk factors associated with suicide attempts and completions
- Identification of those that can be controlled and those that cannot
- Discussion of Risk Factors
- See handout (American Psychiatric Association, 2003)
- Use of rating scales/assessment tools
  - Can be helpful in an overall formulation of risk factors
  - Should not be used solely for risk formulation
  - Show little predictive validity in quantifying risk
  - A meta-analysis of 21 studies evaluating the ability of 15 instruments in predicting suicide risk found no instrument to be effective in quantifying risk (Runeson et al. 2017)
  - Helpful for clinical discussion and interview with client
  - Best practice is to formulate a full assessment of risk factors for the client and to collaboratively develop a crisis response plan that addresses risk that can be controlled
  - There are suggested ways to ask clients about risk, which elicit a thorough response
  - Discussion of these from (American Psychiatric Association 2003)
Crisis Response Planning/Managing Risk

- Maintaining a strong therapeutic alliance is essential in managing risk and developing effective crisis response plans.
- First step in managing risk is to consider controllable risk factors and attend to immediate safety.
- Determine the most least restrictive level of care based on the presentation of risk factors.
- Collaborate with all parties involved in the client’s care to ensure safety and incorporate natural supports into crisis response plans.
- Attend to environmental safety regardless of treatment setting.
- Collaboratively develop a systematic plan for the client to use in the event of increased suicide thinking.
- Crisis Response plans will vary by treatment setting and can change frequently depending on the presentation of risk factors.
Crisis Response Planning/ Risk Management

- Crisis Response plans should outline all risk factors identified as controllable with the client.
- They should be formulated with the client based on a thorough identification of risk protective factors.
- A written plan which identifies all possible protective factors, natural supports, and steps to be taken for each identified risk variable should be developed with the client.
- Fostering hope is a critical component in development of protective factors and development of crisis response plans.
- Each step in the plan should be assessed with the client for the likelihood of being able to execute the skill during times of heightened stress and active ideation.
- Plans should be rehearsed with clients and changed if they are not able to be executed or the step does not feel “doable” for the client.
Crisis Response Planning/ Risk Management

• Plans should be rehearsed with clients and changed if they are not able to be executed or the step does not feel “doable” for the client

• In the event of a crisis or suicide attempt crisis management plans should be reviewed for continued effectiveness and changed accordingly
  • This should be documented

• Assess risk frequently
  • Suicidal thinking is fluid which warrants frequent assessment and review of crisis response steps
  • Wish to live has been found to mediate this ebb and flow in suicidal thinking (Bryan et al. 2016)
    • Speaks to hopefulness and the importance of identifying factors to live for
    • Fluid Vulnerability theory
      • High risk states of ideation vary frequently and are due to a complex interaction between affective, physiological, cognitive and environmental factors (Bryan et. al 2019)
Kevin Hines Story

https://www.youtube.com/watch?v=WcSU9iZv-g
Case Practice

• For each case presented
  • Identify all possible risk factors to consider
  • Identify those which can be controlled and those that cannot
  • Identify all protective factors for the case
  • Using risk and protective factors, identify those that should ideally be addressed in the treatment and crisis response plan
Questions?
Care is the heart of our work.
References


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