Suicide Risk in San Francisco: Assessment, Management, & Resources

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Questions

• What are your needs in the assessment and management of patients with suicide risk?
• What are your biggest frustrations?
• Uncertainties?
Suicide Risk Project

- Empower myself and others in suicide risk assessment & management
- Three email resource directories
- *Suicide Risk in the San Francisco Bay Area: A Guide for Families, Physicians, Therapists, and Other Professionals* (June, 2015)
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Talk About It
SUICIDE
If there is any one secret of success it lies in the ability to get the other person’s point of view and to see things from their angle as well as your own.

Henry Ford
Fear

- Suicide as the #1 fear of mental health professionals
- Shame, guilt, helplessness
- Anxiety, control, denial
- Blame
- Malpractice liability
- Inadequate training & confidence
Countertransference Hate in the Treatment of Suicidal Patients

John T. Maltsberger, MD, Dan H. Buie, MD, Cambridge, Mass

The countertransference hatred (feelings of malice and aversion) that suicidal patients arouse in the psychotherapist is a major obstacle in treatment; its management through full awareness and self-restraint is essential for successful results. The therapist’s repression, turning against himself, reaction formation, projection, distortion, and denial of countertransference hatred increase the danger of suicide. Such antitherapeutic stances, their recognition, and the related potential for constructive or destructive action are the subject of this paper.

Countertransference is inevitable in all psychotherapies. Taken in the broader sense of the term, it comprises the therapist’s emotional response to his patient’s way of relating to him, and to transference which the therapist may form in relation to his patient. Some of the therapist’s countertransference response may specifically arise from the way the patient behaves in the specific therapeutic relationship, and some of it may stem from treatment of “borderline” and psychotic patients, especially those who are prone to suicide. 

Repeated experience has taught that borderline and psychotic patients have great difficulty with aloneness, hostility, and sadism. Klein has described the mechanism of projective identification encountered in such individuals, and Kernberg, their personality organization and primitive defenses. Searles has emphasized the cannibal instincts as well as the role of an attacking, raging posture as a defense against sadness. The contributions of Winnicott and Guntrip have helped better to understand the aloneness, separation, and fears of abandonment that torture such patients. While no review of this complex subject can be attempted here, we take it as understood that the transference hate manifested by borderline and psychotic suicidal patients relates to a deep sense of abandonment (or expectation thereof), an intense craving for yet horror of closeness (it threatens annihilation through engulfment),
Kids Dying By Suicide

- Ages 15-19 in U.S., 7.47 deaths per 100,000
- Second leading cause of death, after accidents
- *The most dramatic increase in suicide occurs during the teenage years (after age 14)*

CDC, 2009
High School Students
(Female versus male)

- **Considered suicide:**
  - 17.4% versus 10.5%
- **Planned suicide:**
  - 13.2% versus 8.6%
- **Attempted suicide:**
  - 8.1% versus 4.6%

CDC, 2009
26-Year-Old Male

- Brown graduate
- Bipolar Disorder
- Alcohol and marijuana abuse
- Golden Gate Bridge
32-Year-Old Female

- Married, mother of three
- Bipolar Disorder
- Daughter of an alcoholic
- 22 rifle
SUICIDE COMPLEX
SUICIDE COMPLEX

stigma
anger
dread

horror
sin
disgust

selfish
crazy
shame

secrecy
fear
blame
Suicide Risk: Assessment & Management
Prevention Research
JAMA 2005

- Means restriction
- Physician education
- Screening
- Pharmacotherapy
- Psychotherapy
- Media
SUICIDAL BEHAVIOR

Stressful Life Event

Mood or Other Psychiatric Disorder

Suicidal Ideation

FACTORS INVOLVED IN SUICIDAL BEHAVIOR

Impulsivity

Hopelessness and/or Pessimism

Access to Lethal Means

Imitation

Suicidal Act

PREVENTION INTERVENTIONS

A. Education and Awareness Programs
   - Primary Care Physicians
   - General Public
   - Community or Organizational Gatekeepers

B. Screening for Individuals at High Risk

Treatment

C. Pharmacotherapy
   - Antidepressants, Including Selective Serotonin Reuptake Inhibitors
   - Antipsychotics

D. Psychotherapy
   - Alcoholism Programs
   - Cognitive Behavioral Therapy

E. Follow-up Care for Suicide Attempts

F. Restriction of Access to Lethal Means

G. Media Reporting Guidelines for Suicide

Mann, 2005
CAMS

Collaborative Assessment and Management of Suicidality
Elements of Assessment and Management

- Screening
- Formal assessment
- Risk formulation
- Treatment planning
- Treatment
- Plan review and revision
- Ongoing assessment
Ongoing Assessment

“Continue to monitor suicidal ideation at every session, no matter how well the therapy appears to be progressing, until it is clear that the patient is no longer having any suicidal ideation.”

Shea, The Practical Art of Suicide Assessment, 2011
Screening

- Sometimes when people are in this much pain they have thoughts of suicide. Have you been having thoughts like that?
Screening

- In the past week, how many days did you have thoughts of killing yourself, even if fleeting in nature?
- On your worst day in the past two weeks, how many times did you think of killing yourself—five times, ten times, more?
My Initial Screening Method

- Inquire about past periods of depression or hopelessness
- Assess the lowest point in the past
- Did you have thoughts of killing yourself or make a suicide attempt? Plan, intent, preparation, decision to die?
- Assess the present
Screening: Brief Outline

Step 1: Screen for low points
Step 2: Identify lowest point
Step 3: Screen past for risk
Step 4: Screen present for risk
Step 5: Formulate present risk
Step 6: Formulate immediate plan
Relationship

- Treatment begins at greeting
- Comfort with suicide risk
- Empathy, listening
- A hopeful interpersonal connection
- Acceptance and collaboration
- Normalization
Relationship

- Talk about it
- Push in
- Past, present and future
- Candor
- Reassurance
- Alliance building
CAMS

Alliance → Alternative ways of coping

Alliance → Finding a life worth living
Assessment

- Suicidal ideation
- Plan, preparation & intent
- History of suicide risk/behavior
- Alcohol and drug use disorder
- Negative life events
- Acute & chronic risk factors
The Future

- Hopelessness about the future as red flag
- Beck’s hopelessness triad
- Capacity to think about the future with hope is protective
- Golden Gate Bridge Patrol
Risk Formulation

• No significant suicide risk
• Low risk
• Moderate risk
• High risk
• Imminent risk
Management

• Safety
• Appropriate level of care
• Removal of access to means
• Crisis stabilization
• A suicide-specific treatment plan
• Psychotherapy & pharmacology
• Suicide risk tracking
Management

- Interventions to lessen major stressors
- Alternative ways of coping
- Relational safety network
- Family involvement
- Reasons for living
- Engagement in life
Behavioral Activation

As clinicians we must do our best to light a fire under the patient to get them engaged in life.

Jobes, 2006
Medications & Neurostimulation

- Lithium & clozapine
- Antidepressants
- Atypical antipsychotics
- ECT & TMS
- Ketamine

Griffiths, 2014
Crisis Plan for Patient

• What will you do (not not do)?
• Activities to lessen intensity/risk
• Contact friend, family member, clinician, hotlines, 911.
• Emergency department

Jobes, 2006; King 2013
Crisis Card

- Activities to diminish hopelessness, stress, agitation
- Relational safety net
- Access to clinician
- 911, emergency department
Crisis Plan for Clinician

• The “crisis” within the patient
• The “crisis” within the clinician
• Panic and fear
• How to gain calm, confidence, and mastery over risk?
• Determining the best plan
Crisis Plan for Clinician

- Resources & logistics
- EDs and inpatient units
- Involuntary v. voluntary
- 911, police, 5150
- Accompaniment & transportation
1. Safety

2. Humanity

3. Liability
Suicide Risk: Resources
Resources

- Family members
- Friends
- Teachers, employers
- Primary care doctors
- Therapists
- Psychiatrists
- Case Managers
Resources

- 911
- Emergency departments
- Mobile crisis
- Hotlines and text lines
- Inpatient units
- Crisis stabilization units
- Partial hospitalization programs
Resources

- Intensive outpatient programs
- Crisis clinics
- DBT programs
- Group practices
- Wellness committees
- Support groups
- Trainings
Telephone

- Consult with colleagues
- Get help
- Ask questions
- Check your thinking
- Talk about it until you feel confident and calm
Suicide Safe

- Mobile app released 03/04/15
- Created by SAMHSA
- Utilizes the SAFE-T assessment approach
- For clinicians, not patients
- App store
San Francisco Suicide Prevention

• 415-781-0500
• First U.S. suicide hotline
• Guidance
• Crisis card
• Trainings
911

- Life-threatening circumstances or Immediate evaluation required
- Efficient, swift, experienced
- 5-15 minutes
- 5150s
- Transport to SF General
Mobile Crisis Treatment Team

- 415-970-4000
- Phone assessments
- Safety checks, 5150s
- Call and present case if not immediately life-threatening
Comprehensive Child Crisis Service

- 415-970-3800
- All 5150s
- 24/7, phone assessments, field visits, walk-ins, family work,
- Short-term stabilization program
- Crisis stabilization unit (CSU)
- Hospital discharge planner
Crisis Stabilization Units

- Child and Adolescent Crisis Stabilization Unit (CSU)
- Edgewood Residential Center
- Dore Center
EDs & Inpatient Units

- SF General PES
- CPMC Pacific Campus
- St. Francis
- UCSF Parnassus
- VA Hospital
- St. Mary’s
Same-Day Assessment Resources

- San Francisco Mental Health Access Line: 415-255-3737
- Community clinics for MediCal and Healthy SF patients
- Emergency departments
- Mobile crisis
- Westside Crisis Clinic
Private Insurance Practices & Networks

- Community Psychiatry
- Pacific Coast Psychiatric Associates
- Well Clinic
- Baywell Psychiatry
Same-Day Assessment: Telephone

• San Francisco Suicide Prevention
• Mobile Crisis
• Comprehensive Child Crisis
DBT

- UCSF Young Adult and Family Center
- Downtown DBT
- Center for Emotional Regulation Disorders
- San Francisco DBT Center
PHPs and IOPs

- Langley Porter
- Kaiser IOP
- Mind Therapy Clinic (youth & adult)
- Edgewood (youth)
- City programs
Recommendation

- Your own evidence-informed, systematic approach is the best approach
- Have a written procedural roadmap at your fingertips ready to review and use at short notice
Summary

- Talk about it
- Past, present, & future
- Suicide complex
- Written roadmap
- Two crisis plans
- Consultation
In Memory of Michael Kirsch, M.D.
Talk About It
Contact

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Suicide Risk Research Page
Search online “Merritt Suicide Risk”