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ONLINE CONTINUING EDUCATION FOR THE LIFE OF YOUR CAREER

Suicide Awareness, Assessment and Intervention

Nika Ball, MOT, OTR/L, ATP;
Angela Moss, PhD, RN, APRN-BC

Moderated by:
Amy Natho, MS, CCC-SLP, CEU Administrator, SpeechPathology.com

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Suicide Awareness, Assessment and Intervention

Angela Moss, PhD, RN, APRN-BC
Nika Ball, MOT, OTR/L, ATP

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Learning Outcomes

After this course, participants will be able to:

- Identify suicide definitions, concepts and epidemiology.
- Describe how to differentiate suicide risk factors, comorbidities and warning signs of suicidal behavior.
- Identify appropriate assessment strategies and resources for use in clinical settings.
- Identify state of the science regarding suicide prevention, research, and resources for additional information.

5

Myth or Fact?

Once a person decides they want to die by suicide, there is nothing anyone can do to stop them.

6

Facts About Myth #1

- Suicide can be prevented
- Most people who are suicidal do not want to die - they want to stop their pain
- There are almost always warning signs
- Asking people if they are thinking about suicide does not give them the idea for suicide - it is important to talk about suicide with people who are suicidal because you will learn more about their mindset and intentions

7

Myth or Fact?

Suicide only strikes people who are depressed or "weak".

8

Facts About Myth #2

- Untreated depression is the number one cause of suicide - BUT - there are usually several causes, not just one, for suicide
- Many people die by suicide because a depression is triggered by several negative life experiences and the person does not receive treatment
- Suicide can affect anyone
- Many people who are very “strong” die by suicide

9

Myth or Fact?

A person who talks about suicide isn’t really going to do anything – they just want attention from other people.

10

Facts About Myth #3

- People who die by suicide usually talk about it first
- Suicidal people often reach out for help because they do not know what to do and have lost hope
- Talking about suicide isn't just "manipulation" or "attention seeking" by a person - assuming so is insensitive and uninformed
- Always take talk about suicide seriously

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Myth or Fact?

Young people never think about suicide because they have their whole life ahead of them.

12

Facts About Myth #4

- Suicide is the second leading cause of death for young people aged 10-34
- Though less common, sometimes children under age 10 die by suicide
- Most people are suicidal for a limited period of time - though suicidal feelings can recur

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Definitions

- Suicide:
  The act or instance of taking one's own life voluntarily and intentionally
- Suicide Attempt:
  A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior; might not result in injury to oneself

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Definitions

- Suicidal Ideation (SI):
  Thinking about, considering, or planning suicide
- Self-directed violence (SDV):
  A range of violent behaviors, including acts of fatal and non-fatal suicidal behavior, and non-suicidal intentional harm
- Suicide Survivor:
  A family member or friend of a person who died by suicide

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The Stigma

The stigma surrounding suicide is rooted in:

-Fear of social rejection
-Misunderstanding
-Ridicule
-Discrimination
-Judgement

The people responsible for perpetuating suicidal stigma engage in behaviors such as distrust, stereotyping, shunning, and avoidance toward those affected by suicide

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CONTINUED

Incidence

- Suicide is the 10th leading cause of death in the United States
- 2nd leading cause of death between ages 10-34, and 4th leading cause between ages 35-54
- Suicide was responsible for nearly 45,000 deaths in 2016, with approximately one death every 12 minutes or 123 suicides per day
- More than twice as many suicides (44,965) in the U.S. as there were homicides (19,362) in 2016

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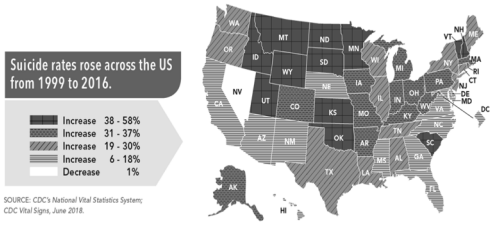
CONTINUED

Incidence

Distribution:

- 30% increase in suicide rates since 1999 across all racial and ethnic groups, in men and women, in cities and rural areas, and across ALL age groups



54% of people who died by suicide did not have a known mental health condition

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CONTINUED

Demographics

- Suicide rates vary by race and ethnicity, age, and other demographics - but in general the highest rates are among:
  - non-Hispanic White populations
  - non-Hispanic American Indian/Alaska Native
- Other groups disproportionately impacted by suicide include:
  - Veterans and other military personnel
  - The ”Triple-F” occupational groups - farming (agricultural workers), fishing, and forestry
  - Sexual minority youth, LGBTQ

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CONTINUED

Demographics

- Men die by suicide 3.53 times more often than women
- White males accounted for 7 of 10 suicides in 2016
- Rate of suicide is highest in middle age - white men in particular - and suicide rates for whites have been climbing faster than those for other racial and ethnic groups

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Methods

- Firearms is the most common method of suicide among males (56.6%)
- Poisoning is the most common among females (33.0%)
- Suicide accounted for $50.8 billion (24%) of fatal injury cost

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Risk Factors

- Risk factors are characteristics or conditions that increase the chance that a person may try to take their life
- Risk factors include:
  - Mental health conditions
  - Physical health conditions
  - Environmental factors
  - Historical factors

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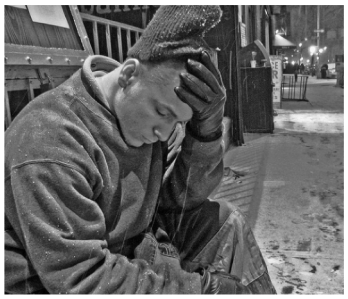
Personal Health Risk Factors

Mental Health Conditions:

- Depression
- Anxiety
- Substance abuse
- Post Traumatic Stress Disorder (PTSD)
- Bipolar
- Schizophrenia
- Aggression, mood swings, poor social skills/relationships
- Conduct disorder



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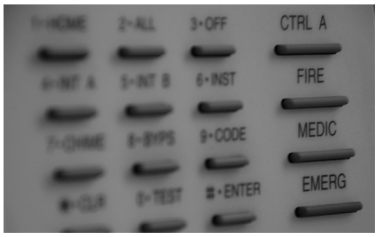
Personal Health Risk Factors

Physical Health Conditions:

- Chronic physical health conditions such as cardiovascular disease, diabetes, obesity, cancer, arthritis
- Chronic pain and functional disability
- Traumatic injuries including traumatic brain injury
- Spinal cord injury
- Postpartum depression



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CONTINUED

Personal Health Risk Factors

Environmental Conditions:

- Access to lethal items such as firearms, drugs, etc.
- Prolonged stress such as homelessness, incarceration, etc.
- Victim of harassment, bullying, rape, abuse, domestic violence, or chronic childhood adversity
- Stressful life events such as death of a loved one, divorce or relationship instability, financial crisis, unemployment
- Lack of social support, isolation or institutionalization
- Exposure to sensationalized accounts of suicide

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CONTINUED

Historical Risk Factors

- Previous suicide attempts
- Family history of suicide or suicidal ideation
- Family history of mental illness - particularly bipolar, alcoholism
- Childhood abuse, neglect, trauma
- Prolonged trauma or stress at any time in past
- Poor problem solving skills
- Surviving the loss by suicide of a loved one

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Warning Signs

- Warning signs = Change in behavior or sudden occurrence of completely new behaviors
- Could be related to a sudden change in life, some type of loss or painful event
- Things to look for:
  - Change in the way a person talks
  - Change in behavior
  - Change in mood

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Warning Signs

Talk of:

- Killing themselves
- Feeling hopeless
- Having no reason to live
- Being a burden to others
- Feeling trapped
- Unbearable pain

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Behavior Warning Signs

- Increased use of drugs or alcohol
- Looking for/researching a way to end their life
- Withdrawing from activities
- Isolating themselves from family and friends
- Sleeping too much or too little
- Visiting or calling people to say goodbye
- Giving away prized possessions
- Aggression
- Fatigue

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Mood Warning Signs

- Depression
- Anxiety
- Loss of interest
- Irritability
- Humiliation/shame
- Agitation/anger
- Relief/sudden improvement

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General Assessment

- General clinical assessment - risk factors and warning signs, might also use a screening tool
- Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)
  - Constructed as an assessment and triage tool for healthcare professionals
  - Contains guidelines on risk factors to explore
  - Presents stratified risk levels with accompanying recommendations
  - Downloadable pocket card

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Screening Tools

- Useful for:
  - Implementing standardized screening practices within specific groups or across populations
  - Quantifying an individual's suicide risk
  - Assessing individuals with risk factors but who are not displaying obvious warning signs

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Screening Tools

- A number of screening tools exist:
  - Some are for general purposes, while others are designed for use with specific clinical populations or settings
  - Some are psychometrically tested and widely disseminated, while others are not
  - Some are available in the public domain, others are proprietary or used primarily in research
  - Many focus on assessing depressive symptoms and do not assess risk factors
- Screening tools should not replace simple assessment questions such as "are you thinking of harming yourself?" - particularly in acute situations

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CONTINUED

Screening Tools

The Patient Health Questionnaire-2 (PHQ-2):

- Contains 2 questions assessing depression
- Questions are answered "yes/no"
- Answering "yes" to either of the two questions indicates risk warranting further investigation
- Screen with the complete PHQ-9 if a PHQ-2 is positive

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things

2. Feeling down, depressed, or hopeless

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CONTINUED

Screening Tools

The Patient Health Questionnaire-9 (PHQ-9):

- Contains 9 questions assessing depression
- Score ranges from 0 to 3 for each question
- Maximum score of 27
- Score of 10 or higher is considered to indicate mild major depression
- Score of 15 or higher indicates moderate major depression
- Score of 20 or higher indicates severe major depression
- Longer version of the PHQ-2

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CONTINUED

Screening Tools

Columbia-Suicide Severity Rating Scale (C-SSRS):

- 6-item, plain-language questions used for suicide assessment
- Available in 114 country-specific languages
- Mental health training is not required to administer
- Take a few minutes
- Decisions about hospitalization, counseling, referrals, and other actions are informed by the “yes/no” answers

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Screening Tools

- Depressive Symptom Inventory-Suicidality Subscale (DSI-SS)
- Suicide Behavior questionnaire-Revised (SBQ-R)
- Beck Depression Inventory (BDI)
- Beck Hopelessness Scale (HS)
- Suicide Ideation Scale (SIS)
- Ask Suicide-Screening Questions (ASQ) Toolkit for Youth
- Tool for Assessment of Suicide Risk Adolescent Version Modified (TASR-AM)
- The Edinburgh Postnatal Depression Scale (EPDS)
- The Geriatric Depression Scale (GDS)
- The Cultural Assessment of Risk for Suicide-Shortened (CARS-S)

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Assessment for Acute Situations

- Consider whether the individual has risk factors in addition to warning signs
- Perform a quick assessment - NOTE - using a formal screening tool may be less useful in acute situations

  IF YOU SUSPECT SOMEONE MAY BE AT RISK FOR SUICIDE, IT IS IMPORTANT TO ASK DIRECTLY ABOUT SUICIDAL THOUGHTS
- To assess them, directly ask:
  - "Are you having thoughts of suicide?"
  - "Are you thinking about killing yourself?"
- Ask the question(s) without dread and without expressing a negative judgement
- Clearly state that thoughts of suicide are often associated with a treatable mental disorder - this may instill a sense of hope

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CONTINUED

Assessment for Acute Situations

How to keep a person safe in acute situations:

- AN ACTIVELY SUICIDAL PERSON SHOULD NOT BE LEFT ALONE
- If you cannot stay with the person, arrange for someone else to do so
- Give the person a safety contact available at all times, such as the National Suicide Prevention Hotline
- Call 9-1-1 if you are concerned about the person's immediate safety
- Help the person think about people or things that have helped in the past - possibly other healthcare providers, family or friends, church or support groups
- Seek assistance from law enforcement (call 9-1-1) if the person has a weapon or is behaving aggressively toward you

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CONTINUED

When to Refer

- ALWAYS!! when you encounter a patient with:
  - multiple risk factors
  - who is displaying warning signs
  - screens positive
  - whom you assess is acutely at risk
- To whom to refer:
  - Primary care provider
  - Psychologist or psychiatrist
  - Therapist
  - Case manager
  - Social worker
  - Emergency services (9-1-1 or ED)

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CONTINUED

Outpatient Referral Options

- Primary care provider
- Mental health professional
  - Clinical social workers (and counselors), clinical psychologists, marriage and family therapists, psychiatrists, and advanced practice psychiatric nurses
- Suicide hotline

OF NOTE:

- Access to mental health care depends on the number of practicing mental health providers relative to the population
- Currently the U.S. is experiencing a critical shortage of both primary care and mental health care providers

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CONTINUED

Outpatient Referral Options

Suicide Hotline:

- Staffed by nurses, social workers, or other trained operators
- Typically the 1-800 call is routed to a local trained counselor located in the area from which the call was placed
- Telephone calls are available, but also online chat, email and text messaging are options
- Decide whether to call together or have the patient call independently
- Available 24/7 and trained counselors staffing the phones will have locally-based resources

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CONTINUED

Inpatient Referral Options

- Local Emergency Department for hospital admission
- Direct admission to an inpatient mental health facility
- Secondary resources include:
  - -Local police
  - -Ambulance
  - -Call 9-1-1

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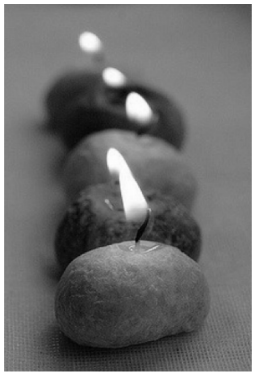
CONTINUED

Treatment

- Often involves a combination of multiple methods used concurrently or consecutively
  - Psychotherapies
  - Medication
  - Inpatient hospitalization
  - Electroconvulsive therapy
- Treating the underlying cause is important, however:

ALL TREATMENTS MUST INCLUDE TEACHING SKILLS THAT HELP THE PERSON REGULATE AND TOLERATE THEIR EMOTIONS



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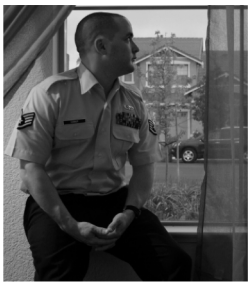
Suicide Survivors

- In the immediate aftermath of the loss, suicide survivors are at higher risk for self-harm or attempting suicide themselves
- Must be evaluated for immediate suicide risk



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Suicide Survivors

- Distinctive bereavement issues:
  - -Significant bewilderment, surprise, shock
  - -Overwhelming guilt
  - -Self-blame
  - -Anger, rage
  - -Disappointment
- Due to the stigma, many people have trouble discussing suicide and therefore might not reach out to support a suicide survivor
- At high risk for feelings of isolation or abandonment

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Prevention & Advocacy

- Reduce social stigma around suicide and mental illness
  - Plain and simple language free of judgment is the simplest method
  - Examine your own feelings about suicide and mental illness
  - If you have the sense someone may be struggling, have the courage to ask them how they are doing
- Improve protective factors like social connectedness and easy access to health care

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Prevention & Advocacy

- Improve coverage of mental health conditions in health insurance plans
- Reduce access to lethal means such as firearms
- Improve education in health professions to recognize “non-mental health factors further upstream”, risk factors and warning signs before a person is in suicide crisis

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Prevention & Advocacy

- Survivor Outreach Program (AFSP) provides resources to suicide survivors experiencing distinctive bereavement issues:
  - Significant bewilderment, surprise, shock
  - Overwhelming guilt
  - Self-blame
  - Anger, rage
  - Disappointment

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Prevention Team Members

!!EVERYONE!!

- Family
- Friends
- Co-workers
- Neighbors
- Community leaders
- Politicians
- Media
- Healthcare providers

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Impact of Societal Change

American rapper Logic released a song in 2017 titled "1-800-273-8255" which is the phone number for the American National Suicide Prevention Lifeline

- Calls increased by 27%
- Increase of 100,000 visits to the website

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British Coal Gas Story

- Prior to 1970, homes in Great Britain were heated with coal-gas furnaces which had high levels of toxic carbon monoxide
- Poisoning by gas inhalation was the leading means of suicide in the U.K.
  - "Sticking one's head in the oven" became a preferred method of suicide
- The government began phasing out coal-gas for natural gas as it was cleaner, by 1971 nearly 70% of homes were using natural gas
- The overall suicide rate dropped by roughly 30% after the conversion and the numbers haven't changed since

WHY?

- Public policy change removed the "easy means"

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CONTINUED

Washington D.C. Bridges

- There are two bridges located in Washington, D.C. that are within a couple hundred years of each other, both are ~125 feet tall - The Duke Ellington Bridge and the Taft Bridge
- In 1985 the Duke Ellington Bridge averaged 4 suicides per year while the Taft Bridge averaged 1.7 suicides per year
- Three suicides in a 10-day period in 1985 at the Duke Ellington Bridge resulted in the construction of an anti-suicide barrier in January 1986
- This eliminated suicides at the Duke Ellington Bridge and the Taft Bridge had only a slight increase to an average of 2 suicides per year

WHY?

- Prior to 1986 the Duke Ellington Bridge had a knee-high barrier while the Taft Bridge had a chest-high barrier. The low height provided potentially suicidal people the opportunity in an impulsive moment.

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CONTINUED

New Initiatives

- Sip of Hope: The world's first coffee bar that will donate 100% of its proceeds to mental health awareness and suicide prevention
- Project 2025: AFSP goal to reduce suicide rate 25% by 2025 through strategic partnerships with other organizations including accrediting bodies, professional associations and leaders in other industry sectors

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Current Research

- A meta-analysis of 18 studies from 2000 to 2017 found that exposure to suicide-related content in research studies led to significant ***reductions*** in suicidal ideation and a lower likelihood of suicidal behavior
  - adolescents showed twice as large a reduction from pre to post exposure as adults
- Studies suggests the two major barriers preventing persons with suicidal ideation from seeking help are (1) stigma and (2) geographical isolation
- Some studies suggest that adolescents who spent more time on new media were more likely to report mental health issues, and adolescents who spent more time on non-screen activities were less likely
- The opioid and suicide epidemics are intermingled - studies suggest persons with opioid use disorder (OUD) are about 75% more likely to make suicide plans and twice as likely to attempt suicide

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Your Role in Suicide Prevention

- Approximately 50% of persons who died by suicide saw a healthcare provider *who was not a mental health specialist* within 30 days of completing suicide
- 54% did not have a known mental health disorder when they died by suicide - BUT - it is estimated 90% of people who die by suicide have a mental disorder at the time of their deaths
- Mental health treatment prevents suicide
- Professionals with specialized training are best equipped to provide mental health treatment for persons at risk or displaying warning signs of suicide

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CONTINUED

Your Role in Suicide Prevention

- Healthcare professionals are often the front line person to screen and assess for suicide risk
- To provide informed, evidence-based, and best practice care to all patients, ALL healthcare professionals must become educated to:
  - Differentiate between risk factors and warning signs of suicide
  - Develop a systematic suicide risk assessment strategy for all patient populations
  - Develop a plan to practically manage acute suicidal crises in their clinical settings
- Healthcare professionals can advocate for suicide screening and assessment policies and procedures within their organizations - for example using EHRs as an "early warning system" to alert clinicians about patients who should be assessed for suicide

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CONTINUED

Case Study

Ms. A is a 19-yr-old college student who recently moved out of her family home at the beginning of this semester and is living in her own apartment. She is struggling with gender identity. She states that she "ignored" her thoughts about self-identity but realizes that she may have had these gender identity issues for many years. She recently confided in a close friend who has now rejected her. She feels closed off from her family as she believes they wouldn't be supportive. She has started skipping classes and not going to work at her part-time job on-campus. She is in danger of losing her scholarship if she is unable to maintain good grades. She presents at the student center health clinic as her roommate encouraged her to "go to the nurse" as she was thought to be sick due to her staying in bed for three days and not leaving the apartment.

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CONTINUED

Case Study

Mrs. G is an 93-yr-old female who recently suffered a stroke with right upper extremity deficits and impaired ambulation. She previously had driven, completed her own grocery shopping and errands, completed her own housework, and attended religious services every week. She is using a walker and is homebound. She has difficulty cooking and completing housework but is able to manage all other home management tasks. She lives alone as her spouse recently passed away and she reports that they had just celebrated their 71st wedding anniversary. She has a large family and she states that they are very supportive but no one lives locally so she has no assistance with day-to-day needs. She reports she's very lonely during the week as she only sees family on the weekend when they are not working. She states that members from her church have offered to pick her up and take her to activities but she "doesn't want to be a burden on anyone" and wants to be able to drive herself again. Her family is worried that she may have suffered another stroke as she seems increasingly forgetful and now is having trouble managing her medications.

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CONTINUED

Case Study

Mr. L is an immigrant worker from Mexico residing in a large metropolitan city in the United States. He is employed full-time at the airport in a food service position. He presents to his employer-provided health clinic at the airport for a routine physical and you discover that he's lost 25 lbs. in the past three months. You question Mr. L about his sudden weight-loss and he reports that he's had increased stress related to marital problems. He states that his wife moved out and took the children with her one day while he was gone at work. He's tried to reconcile but his wife is adamant that she wants a divorce and she is moving back to Mexico where the rest of their family resides. Mr. L reports that he can't sleep at night and has no appetite. He states that he misses his children and doesn't see the point of living if he can't be with his family.

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CONTINUED

Points to Consider

- Multiple significant changes recently
- Limited support network present
- Limited knowledge of local resources
- Financial strain
- Emotional strain
- Fear of the unknown
- Fear of rejection
- Unwillingness to seek out help because of the stigma

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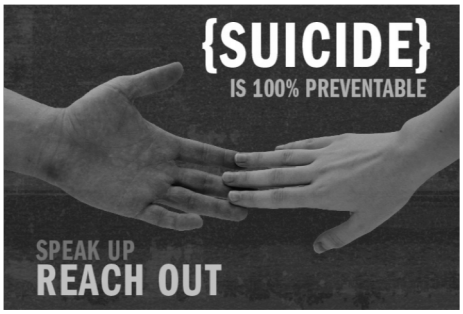
Summary



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Summary

- Suicide is often described as a multifactorial "perfect storm" causing feelings of hopelessness, despair and intense pain
- There are almost always warning signs

SUICIDE CAN BE PREVENTED

- Always take talk of suicide seriously
- Suicide affects all people regardless of age, race/ethnicity, socioeconomic status, geography, educational attainment
- Responsible healthcare professionals must examine their own perceptions of suicide and mental illness in general in order to become effective advocates for their patients, and advocates for social change related to suicide and mental health awareness

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Resources

- National Suicide Prevention Lifeline

  1-800-273-TALK (8255)

  A national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week
- Text **741-741** if in crisis to talk to a trained counselor 24 hours a day, 7 days a week

- Online Resources

  www.Suicide.org

  www.CDC.gov
- Local Resources

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Resources

- American Foundation for Suicide Prevention (AFSP)
- American Association of Suicidology
- Substance Abuse and Mental Health Services Administration Suicide Prevention Program (SAMHSA)

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Resources

- Indian Health Service Suicide Prevention Program
- National Alliance for Suicide Prevention
- National Child Traumatic Stress Network
- National Institute of Mental Health
- U.S Department of Defense Suicide Prevention Office
- U.S. Department of Veterans Affairs (VA) Suicide Prevention

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THANK YOU!

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Nika Ball - nball@occupationaltherapy.com

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