This training is sponsored by the Great Lakes (HHS Region 5) Mental Health Technology Transfer Center Network and the Ohio Association of County Behavioral Health Authorities and presented by Hazelden Publishing
Welcome!
Training Objectives

1. Learn how to promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

2. Develop strategies to fully integrate knowledge about suicide into multiple layers of the systems.

3. Identify gaps in care that suicidal individuals fall through and identify clinical evidence to close these gaps.
Training Objectives

4. Understand how to create an inclusive and safe community environment that respects and responds to diverse cultural needs and preferences when dealing with suicide

5. Recognize signs and symptoms of suicide in all individuals involved in the organization and systems

6. Cultivate open dialogue about cultural considerations in relation to suicide

7. Promote awareness of clinician burnout and offers support to those working with suicidal clients
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
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<tbody>
<tr>
<td>9:45</td>
<td><strong>Suicide: Key Information</strong></td>
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<tr>
<td>10:15</td>
<td><strong>Assessing Suicide &amp; Risk Factors:</strong> What tools are available to assist in assessing and documenting suicide?</td>
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<tr>
<td>11:00</td>
<td><strong>Break</strong></td>
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<tr>
<td>11:15</td>
<td><strong>Cultural Considerations:</strong> Cultural Factors in Suicidality</td>
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<td>12:15</td>
<td><strong>Working Lunch</strong></td>
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<td>12:45</td>
<td><strong>Small Group Activity with Toolkit and Guidance Document</strong></td>
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<tr>
<td>1:15</td>
<td><strong>Clinician Burnout:</strong> How can we measure and address clinician burnout and vicarious trauma?</td>
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<td>2:30</td>
<td><strong>Break</strong></td>
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<tr>
<td>2:45</td>
<td><strong>Breaking It All Together:</strong> Planning Session for Implementing Practices</td>
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<tr>
<td>3:15</td>
<td><strong>Wrap-Up and Evaluation</strong></td>
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Suicide: Key Information
Understanding Risk: Suicide Statistics

- Suicide was the 10th leading cause of death in 2016, claiming nearly 45,000 lives

- 2nd leading cause of death for those between the ages of 10-34

- 4th leading cause of death for those between 35-54

- Twice as many suicides in 2016 as homicides
Integrated Treatment: Prevalence of Co-occurring Disorders

• Of 19 million adults with a past year SUD diagnosis in 2016…
  • 8.2 million had any mental illness (43.3%; 3.4% of all adults)
  • 2.6 million had a serious mental illness (13.7%; 1.1% of all adults)

Source: SAMHSA
• People with drug and alcohol problems are more likely to consider and attempt suicide than the general population
  • Those struggling with BOTH alcohol and drugs having the highest overall rates within the chemically dependent population

• SUDs that co-occur with one or more mental health diagnoses can increase a person’s risk of dying from suicide

• Many suicide attempts and completions involve alcohol or other drugs
  • Intoxication impairs critical thinking, consequently, as people become sober, risk declines.
Suicidal Thoughts, Plans, and Attempts in the Past Year among Adults Aged 18 or Older, by Past Year Illicit Drug Use: Percentages, 2015 – Results from the 2015 National Survey on Drug Use and Health

<table>
<thead>
<tr>
<th>Illicit Drug</th>
<th>Suicidal Thoughts</th>
<th>Suicide Plans</th>
<th>Suicide Attempts</th>
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</thead>
<tbody>
<tr>
<td>All Adults</td>
<td>4.0</td>
<td>1.1</td>
<td>0.6</td>
</tr>
<tr>
<td>Any Illicit Drug</td>
<td>9.8*</td>
<td>3.0*</td>
<td>1.7*</td>
</tr>
<tr>
<td>Marijuana</td>
<td>9.8*</td>
<td>3.0*</td>
<td>1.7*</td>
</tr>
<tr>
<td>Misuse of Rx Pain Meds</td>
<td>14.0*</td>
<td>5.0*</td>
<td>2.7*</td>
</tr>
<tr>
<td>Misuse of Rx Stimulants</td>
<td>14.4*</td>
<td>4.8*</td>
<td>2.3*</td>
</tr>
<tr>
<td>Cocaine</td>
<td>15.0*</td>
<td>5.4*</td>
<td>3.8*</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>15.2*</td>
<td>4.4*</td>
<td>2.5*</td>
</tr>
<tr>
<td>Misuse of Rx Sedatives</td>
<td>15.9*</td>
<td>5.6*</td>
<td>3.3*</td>
</tr>
<tr>
<td>Heroin</td>
<td>17.5*</td>
<td>5.4*</td>
<td>3.0*</td>
</tr>
<tr>
<td>Misuse of Rx Tranquilizers</td>
<td>17.5*</td>
<td>7.9*</td>
<td>3.9*</td>
</tr>
<tr>
<td>Inhalants</td>
<td>19.2*</td>
<td>6.2*</td>
<td>5.6*</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>21.6*</td>
<td>7.2*</td>
<td>4.3*</td>
</tr>
</tbody>
</table>
Understanding Suicide: Static Risk Factors

• Male – ratio of about 4:1
• Single
  • Including those who have never been married, divorced, and widowed
• Age
  • Generally, suicidality increases with age and is correlated with significant medical issues and bereavement
• Family history of suicide attempts

Welton, 2007
• Gay and bisexual men are 4x as likely to attempt suicide compared to heterosexual men

• Lesbian and bisexual women are 2x as likely to attempt as heterosexual women

King et al., 2008
Understanding Suicide: Gender Minorities

• Suicide attempts amongst transgender individuals is 41%, significantly higher than the 4.6% of the overall population

• Although this number is speculative given the difficulties in recording and documenting these data

Herman, et al., 2014
Understanding Suicide: Psychological Risk Factors

• Hopelessness
• Feeling isolated
• Feeling unloved, unaccepted, or rejected
• Perfectionism
• Chronic feelings of shame or guilt
• Inadequate coping resources
Understanding Suicide: Contextual Risk Factors

- Severe relationship conflict
- Recent major loss (e.g., death, relationship ending)
- Pending incarceration, homelessness, or dire financial situation
- Life-threatening health problem
- History of sexual assault/abuse
- History of suicide attempt within the past year
- 3 or more lifetime suicide attempts
Understanding Suicide: Behavioral Warning Signs

- Isolation
- Neglected grooming
- Extreme self-denial or self-indulgence
- Giving away possessions
- Increase recklessness/impulsive behavior
- Declining interest in previously fun activities
Understanding Suicide: Protective Factors

• Future orientation – able to make plans for healthy coping, even just until next clinical contact
• Inaccessibility or removal of means
• Involved support network
• A sense of responsibility to others
• Hopefulness
• Identifying strongly with spirituality or religion
Multilevel Effects
# Gaps in Care

<table>
<thead>
<tr>
<th>Not proactively identifying intense suicide risk</th>
<th>Not acting effectively for safety</th>
<th>Not providing supportive contacts for people at risk of suicide</th>
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<tbody>
<tr>
<td>• Ask about thoughts of suicide</td>
<td>• Safety planning</td>
<td>• Timely supportive contacts (e.g., calls, texts, letters, visits)</td>
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<tr>
<td></td>
<td>• Lethal means reduction</td>
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</table>

Suicide Prevention as a Public Health Issue

• Collaboration of organizations across sectors
  • Community mental and substance use health providers
  • Hospitals
  • Schools
  • Crisis response agencies
• Use preferred language (e.g., “died by suicide” or “took his/her own life)
• Use objective, non-sensationalistic language
• Focus on the life of the person rather than the death and method
Synergistic Effects of Multilevel Efforts

• Organization training of all staff
  • Reception
  • Frontline clinical (Medical Assistants, Nurses)
  • Behavioral health
  • Physicians
  • Facilities

• Awareness campaigns (internal and external)
• Collaboration with community partners to recognize suicidality and helping at-risk people access appropriate services
• Improvement of healthcare services targeting individuals at-risk (including organizational measures)
• Training of journalists

Van der Feltz-Cornelis et. al. (2011)
An Example: Zero Suicide (ZS)

Multilevel model/systemic approach to reducing suicide risk

- 4 Clinical care components:
  - Identify
  - Engage
  - Treat
  - Transition

- 3 administrative components:
  - Lead
  - Train
  - Improve

Brodsky, Spruch-Feiner, & Stanley, 2018
Zero Suicide (ZS)

Use of Assess, Intervene, and Monitor for Suicide Prevention (AIM-SP) (Clinical care)

• **Assess** – use of screening and risk assessment to identify those at greater risk of suicide
• **Intervene** – use of suicide specific interventions to reduce overall risk and psychosocial interventions to improve outcomes
• **Monitor** – providing strategies for ongoing monitoring and increase clinical contact during periods of increased risk

Brodsky, Spruch-Feiner, & Stanley, 2018
Application of ZS/AIM

Assess

1. Inquire explicitly about suicidal ideation and behavior, past and present
2. Identify risk factors in addition to suicidal ideation and behavior
3. Implement and maintain continued focus on safety

Brodsky, Spruch-Feiner, & Stanley, 2018
Intervene

4. Introduce and develop a collaborative safety plan intervention for managing suicidality, including lethal means reduction

5. Initiate coping strategies and supports.

6. Integrate suicide-specific treatment targets in treatment planning processes
Monitor

7. Increase flexibility and contact availability
8. Initiate increased monitoring during periods of highest risk
9. Involve family and other social supports
10. Invoke clinician peer support and consultation
Community Based Interventions – MHFA

Mental Health First Aid (MHFA)

- Training for members of the public that helps individuals identify those developing mental health problems and provide assistance in crisis situations
  - 12 hours of training
  - Focus on the following mental health crises:
    - Individual with suicidal ideation
    - Panic attacks
    - Someone exposed to recent trauma
    - Individual with psychosis
    - Individual who has overdosed

Kitchener & Jorm 2005
Community Based Interventions - MHFA

The 5 Steps of MHFA

1. Assess risk of suicide or harm
2. Listen non-judgmentally
3. Give reassurance and information
4. Encourage person to get appropriate professional help

Kitchener & Jorm 2005
Community Based Interventions - MHFA

• MHFA shows reduction in “social distance and stigmatizing attitudes”
• Increased knowledge of mental health concerns and mental health treatment
• Effective in diverse community settings
  • Within Indigenous populations in Australia

Kitchener & Jorm 2005
Community Based Interventions - SOS

• Signs of Suicide (SOS)

• Prevention program aimed at high school students

• Demonstrated effectiveness with group of diverse 9th grade students

Schilling, Aseltine, & James 2016
Decrease self-reported suicide attempts
  • 64% less likely to report a suicide attempt 3 months post training (compared with control group)

Improvements in:
  • Knowledge of depression
  • Intervening with friends who are struggling
  • Help seeking behaviors when experiencing depression and suicidal ideation

Schilling, Aseltine, & James 2016
Suicide Assessment Tools

What tools are available to assist in assessing and documenting suicide?
Assessment of Suicidality

General Information/Informal Approach

• Are you having thoughts about wanting to be dead?
• Do you have thoughts about committing suicide?
• Have you thought about what you might do? (Assess plan)
• Have you started working out how you would commit suicide?
  • Assessment of means, timeframe, intent

• Assess additional risk/protective factors
Assessment of Suicidality

• While this informal approach is likely known to most clinicians, the ability to communicate concerns around suicidality within an organization is rather limited.

• If you have newer clinicians, or staff with little mental health focused experience/training, the knowledge of how to create a risk assessment may be minimal.
Consequently, certain assessment tools have been developed which facilitate more standard approach to suicidality

- Columbia Suicide Severity Rating Scale (CSSRS)
  - [http://cssrs.columbia.edu/](http://cssrs.columbia.edu/)
- Collaborative Assessment & Management of Suicidality (CAMS)
  - [https://cams-care.com/about-cams/](https://cams-care.com/about-cams/)
- Suicide Assessment Five-step Evaluation and Triage (SAFE-T)
Columbia Suicide Severity Rating Scale (CSSRS)

- Provides clear and standardized definitions of suicidal ideation and suicidal behavior that allow for greater clarity
- Low burden
- Comprehensive
  - Assesses for both suicidal ideation and behavior
CSSRS

• Scores reflect both suicidal ideation and intensity of that ideation

• Ideation:
  • 0 = No suicidal ideation
  • 1 = Passive thoughts, rather be dead
  • 2 = Thoughts of committing suicide
  • 3 = Thoughts with some plan, no intent
  • 4 = Thoughts include plan with some intent
  • 5 = Thoughts include plan, intent, and likely follow through
CSSRS

• Intensity scores (0-25)
• If Ideation scores is 1 or higher
• Address
  • Frequency
  • Duration
  • Controllability
  • Effectiveness of deterrents
  • Reasons for ideation
CSSRS Pros

• Ease of communication
  • Tool provides specific score which is informative about current status

• Allows for tracking between professionals

• Easy to administer, anyone with basic training can administer the tool
CSSRS Pros

• Protocols for
  • Communities and Healthcare
  • Families, Friends and Neighbors
  • Research

• Available in more than 100 country specific languages

• Includes triage information
CSSRS Cons

• Doesn’t consider additional contextual information (e.g., risk factors and protective factors are listed, but do not influence scores)
• Doesn’t capture all nuances of suicidal ideation
  • For instance, future focused suicidal thoughts (“If I relapse on alcohol I will likely kill myself.”)
• Doesn’t include safety plans/steps to take next
Comprehensive Assessment & Management of Suicidality (CAMS)

• Comprehensive questionnaire covering several areas of risk and protection
  • Psychological pain, stress, agitation, hopelessness, self-hate
  • Suicidal planning, impulsivity, substance use, relationship issues, health issues, legal issues

• Clinicians rate self-harm issues
• Includes Stabilization Plan
• Considers many contextual factors that can increase risk
• Includes protective factors
• Risk is rated “Low” “Medium” or “High”
• Desire to die and desire to live are both rated on a 0-5 scale
CAMS Pros

• Comprehensive

• Contextual Information

• Stabilization plan
CAMS Cons

• Clinical judgment is needed
  • Those without clinical training would not necessarily be appropriate to administer tool

• Ratings are more subjective, less concrete/specific
Suicide Assessment Five-step Evaluation and Triage (SAFE-T)

1 – Identify Risk Factors
   • Note those that can be modified to reduce risk
     • Suicidal behavior (history of suicidal attempts)
     • Mental health diagnoses (note mood disorders, cluster B PD’s, conduct/ASPD)
     • Key symptoms (anhedonia, hopelessness)
     • Precipitating factors
2 – Identify protective factors
  • Note those that can be enhanced

  • Internal: ability to cope, religious/spiritual beliefs
  • External: responsibility to others, positive therapeutic relationship
3 – Conduct suicide inquiry

• Suicidal thoughts, plans, behavior, and intent

• Ideation: frequency, intensity, duration
• Plan: timing, location, lethality, availability, preparatory acts
• Behaviors: past attempts, aborted attempts, rehearsals
• Intent: degree to which individual plans to engage in behavior
4 – Determine Risk Level/Intervention
   • Determine risk. Choose appropriate intervention to address and reduce risk
     • Risk described as low, medium, or high
     • Assessment based on clinical judgment
     • Reassess as needed

5 – Document
   • Assessment of risk, rationale, intervention, and follow-up
SAFE-T Pros

• Straightforward, easy for clinicians to use
  • Streamlined
• Recommends inclusion of safety planning and documentation
• Thorough review of relevant risk factors and protective factors
• Thorough review of associated behaviors
SAFE-T Cons

• Involves clinical judgment
  • May limit those who can use the tool

• Ratings of Low, Medium, and High are vague and subjective
Question, Persuade, Refer (QPR)

• Simple, straightforward approach to assist “gatekeepers” in recognizing risk/safety issues involving suicide

• QPR training focuses on:
  • Recognizing the warning signs of suicide
  • Know how to offer hope
  • Know how to get help and save a life
QPR (Question, Persuade, Refer)

- QPR improves overall suicidal prevention knowledge, improves self-efficacy around addressing suicide, and increases the likelihood people will offer assistance.
Cultural Considerations

Cultural Factors in Suicidality and Assessment
Cultural Competent Approach to Suicide Assessment (Chu et al., 2010)

Four factors to consider when assessing risk in different cultural groups

• **Cultural Sanctions**: values around perceived acceptability of suicide as well as the shame associated with events that may precipitate suicidal ideation
• **Idioms of Distress**: cultural differences in communicating suicidal ideation and risk
• **Minority Stress**: stress related to minority status involving pressure of acculturation, discrimination, harassment, etc.
• **Social Discord**: risk factors involving alienation and disconnection from support
• CARS includes questions from these four different domains and results indicated convergent validity with others measures of suicidal ideation/hopelessness.

• CARS total scores and subscales also were able to adequately distinguish those who had attempted suicide in the past from those who had not.
“Silent ideators” (Morrison & Downey 2000)
- Concept that some individuals from minority groups are less likely to divulge suicidal ideation unless specifically asked

Using language that normalizes suicidal ideation can be helpful
• Within the LGBTQ population, much focus is placed on community support, particularly when familial disapproval and rejection occur
  • Consequently, it is also important to assess for level of connection and engagement within the LGBTQ community when assessing overall risk
Clinician Burnout

How can we measure and address clinician burnout and vicarious trauma?
Postvention

• How do we take care of our colleagues, ourselves?
• Role of leadership
  1. Approach the situation with compassion for the bereaved
  2. Listen carefully to needs of employees
  3. Model application of applying corporate Human Resource policies
  4. Recognize their unique role
  5. Be aware of and sensitive to notable events in the future

Smith, Rivero, & Cimini (2010, June 8).
Organization Response

• Development of policies of practice or decision-making flowcharts
  • Suicide death or near fatal attempt
  • Employee suicide
    • Responses within 24 hours
    • Mourning activity
    • Support resources
  • Employee bereaved by suicide
    • Support and accommodations
    • Longer term follow up
Compassion Fatigue

“Compassion fatigue is a state experienced by those helping people or animals in distress; it is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it can create secondary traumatic stress for the helper.”

Considered two parts of compassion fatigue:
• Burnout and Secondary Trauma

Dr. Charles Figley, www.compassionfatigue.org
Compassion Fatigue: Signs in an Individual

• Excessive blaming
• Bottled up emotions
• Isolation
• Receives complaints
• Produces excessive complaints about administrative functioning
• Substance abuse used to mask feelings
• Compulsive behaviors
• Poor self-care
• Trauma symptoms
• Chronic physical ailments
Compassion Fatigue: Organizational Symptoms

- High absenteeism
- Teams having difficulties working together
- Breaking company rules
- Aggressive behaviors amongst staff
- Inability to complete assignments and tasks
- Lack of flexibility amongst team members
- Negativism towards management
- Lack of vision for the future
Compassion Fatigue: Assessment Tools

- Professional Quality of Life (ProQoL) Self-Test
- Life Stress Self-Test
- Empath Test

Professional Quality of Life (ProQoL) Self-Test

• Measures Compassion Fatigue along with the two sub components:
  • Burnout and Secondary Trauma

• Tool produces scores in these three domains

https://proqol.org/Compassion_Fatigue.html
Bringing It All Together

Planning session for implementing practices
References


References


Wrap Up and Evaluations
Post-Event Survey

Please use the QR code to access the post-event GPRA survey.

Survey link:
https://ttc-gpra.org/P?s=403299
Thank you!