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Best Practices for Suicide Prevention to Postvention

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Today's Presenters

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A Moment to Arrive

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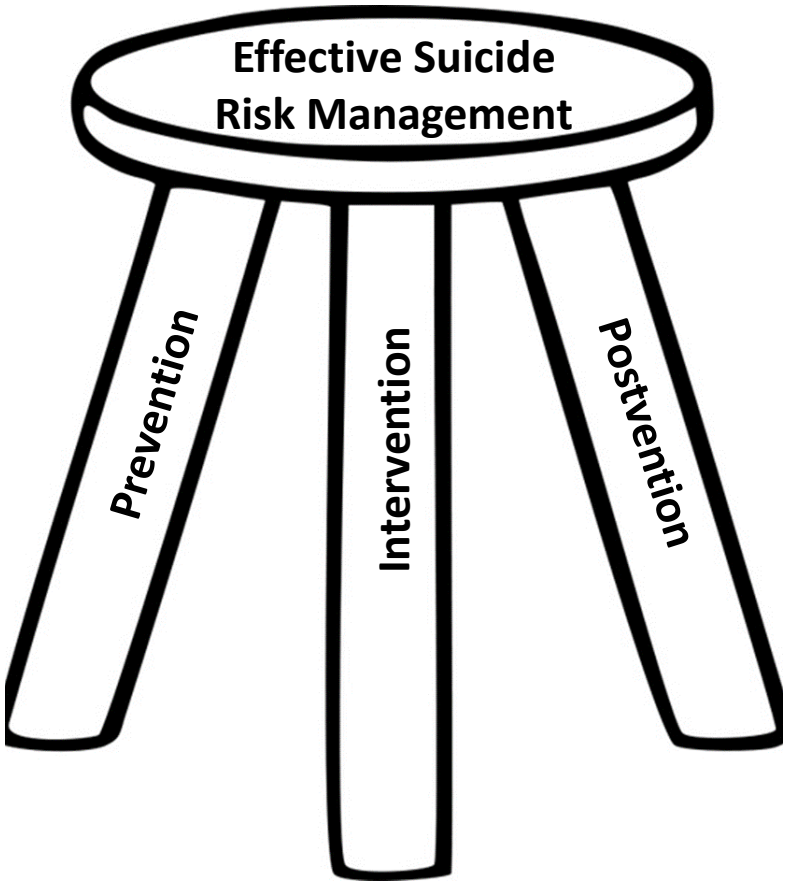
Objectives

By the end of this session, participants will be able to:

- Review suicide prevention best practices
- Explore a framework to provide support around building internal and external capacity for suicide prevention with practical interventions.
- Discuss postvention strategies when providing services to those directly affected by or bereaved by {someone else's} suicide.
- Discuss training and skills application best practices for putting suicide prevention into action.

Estimates suggest that in any given year, 1 in 20 people will lose someone they know to suicide, and 1 in 5 will lose someone to suicide at some point in their lifetime.

Andriessen et al., 2019



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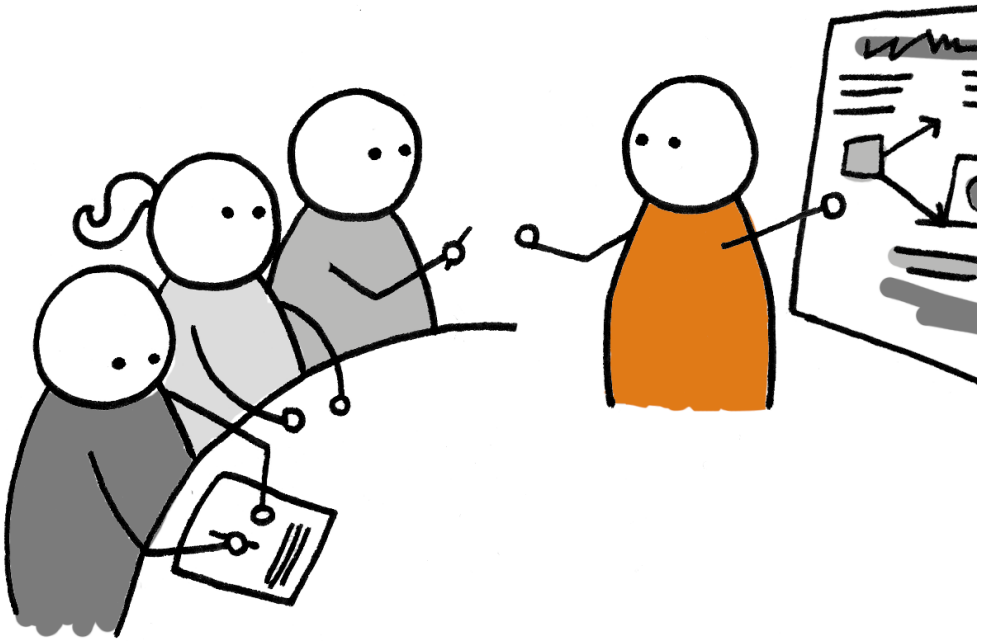
Identify Leadership, Champions, and Task Force

Lead the Charge!



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Educate and Inspire Change

Suicide Experiences

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Joint Commission Sentinel Event Alert 56

Sentinel Event Alert

EMBARGOED UNTIL FEB. 24

A complimentary publication of The Joint Commission
Issue 56, February 24, 2016

Detecting and treating suicide ideation in all settings

Published for Joint Commission-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

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The rate of suicide is increasing in America.[1] Now the 10th leading cause of death,[2] suicide claims more lives than traffic accidents[3] and more than twice as many as homicides.[4] At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,[5] usually for reasons unrelated to suicide or mental health.[6-7] Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.[8]

Through this alert, The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely fashion following discharge from emergency departments and inpatient psychiatric settings.[6] The risk of suicide is three times as likely (200 percent higher) the first week after discharge from a psychiatric facility[9] and continues to be high especially within the first year[6,10] and through the first four years[11] after discharge.

This alert replaces two previous alerts on suicide (issues 46 and 7). The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care.

Some organizations are making significant progress in suicide prevention.[12] The "Perfect Depression Care Initiative" of the Behavioral Health Services Division of the Henry Ford Health System achieved 10 consecutive calendar quarters without an instance of suicide among patients participating in the program. The U.S. Air Force's suicide prevention initiative reduced suicides by one-third over a six-year period. Over a period of 12 years, Asker and Bærum Hospital near Oslo, Norway implemented continuity-of-care strategies and achieved a 54 percent decline in suicide attempts in a high-risk population with a history of poor compliance with follow-up. Additionally, the hospital's multidisciplinary suicide prevention team accomplished an 88 percent success rate for getting patients to the aftercare program to which they were referred.[8] Dallas' Parkland Memorial Hospital became the first U.S. hospital to implement universal screenings to assess whether patients are at risk for suicide. Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk.[13]

The Joint Commission

www.jointcommission.org

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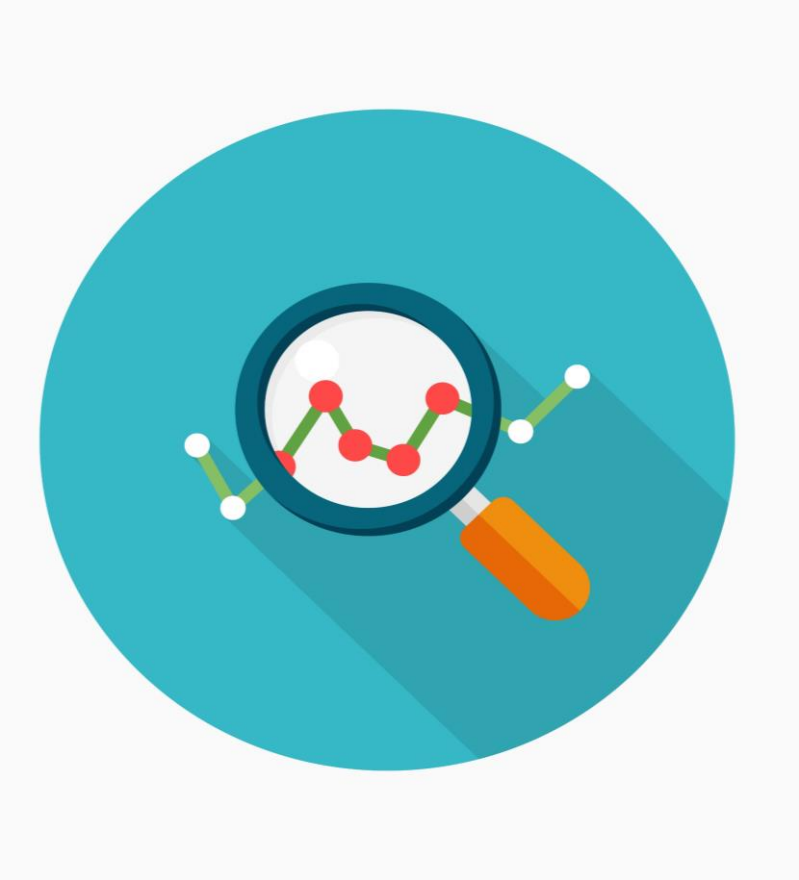
Gauge the Current Organizational Landscape

Find the Baselines



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Times of High Risk

- Post hospitalization or emergency room visit
- New antidepressant medication start
- Antidepressant dose change

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Practice Improvement

Language about Suicide

Former Term	Replacement Term
Commit suicide	Died by suicide
Successful suicide	Died by suicide
Completed suicide	Suicide
Unsuccessful suicide	Non-fatal attempt / Suicide attempt
Hurt yourself	Kill yourself
Suicidal person	Person with thoughts of suicide
Suicide gesture, manipulative act, suicide threat	Describe what you mean…

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Detecting Suicide Risk

- Screening: Identifies who may be at risk, using a standardized tool
- Assessment: Comprehensive evaluation conducted by clinician to confirm risk and plan for treatment
- What instruments? When? How often?

Risk Factors for Increased Risk of Suicide during COVID

- Health Related Factors
- Identifiable Stressors
- Environmental Factors
- Past Suicide Behavior

*According to the American Foundation for Suicide Prevention

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Additional Risk Factors for Increased Risk of Suicide

- Health Conditions:
  - Mental health conditions
  - Substance abuse disorders
  - Alcohol abuse disorders
  - Serious chronic health conditions
  - Chronic pain
  - Limited access to healthcare
  - Sleeping difficulties
- Identifiable Stressors:
  - Relationship loss or challenges such as death, divorce, separation
  - Job loss
  - Harassment, bullying, relationship problems
  - Financial or school difficulties
- *According to the American Foundation for Suicide Prevention

Additional Risk Factors for Increased Risk of Suicide

- Environmental Factors:
  - Access to lethal means including firearms and drugs
  - Exposure to suicide in the media or community
- Past Suicide Behavior:
  - Previous suicide attempts
  - Family history of suicide attempts
  - History of self-harm
  - Recent hospitalization
  - Cultural beliefs that support suicide

*According to the American Foundation for Suicide Prevention

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Suicide Inquiry

- Ideation / Thoughts
- Plans / Methods
- Intent
- Protective Factors

https://www.sprc.org/sites/default/files/PrimerModule4.pdf

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Screening for Depression

- Patient Health Questionnaire 2
- Patient Health Questionnaire 9
- Q9: Thoughts you would be better off dead or hurting yourself

Patient Health Questionnaire- 9

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

US Preventive Services Task Force

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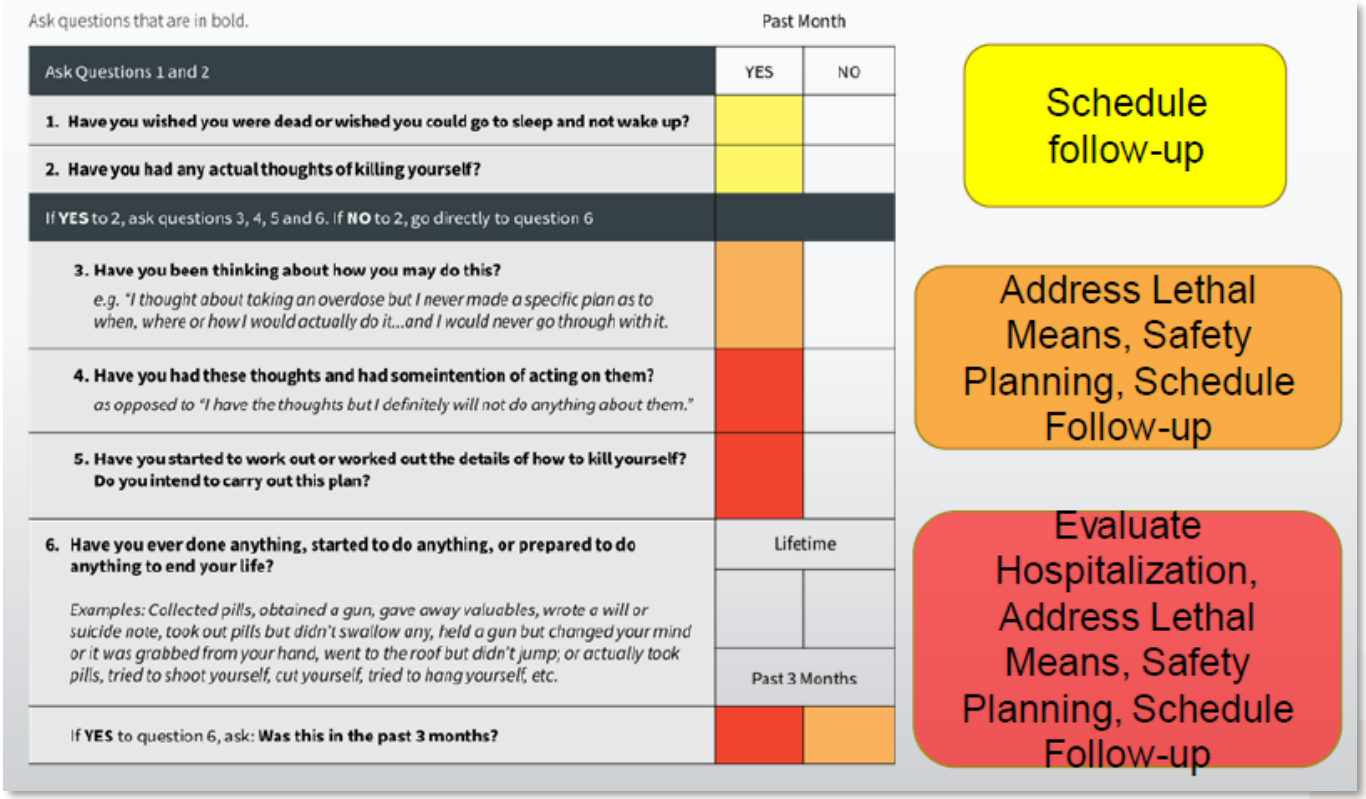
Columbia Suicide Severity Rating Scale Screener



Ask questions that are in bold.

Ask Questions 1 and 2	Past Month YES	Past Month NO
1. Have you wished you were dead or wished you could go to sleep and not wake up?		
2. Have you had any actual thoughts of killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, go directly to question 6		
3. Have you been thinking about how you may do this? *e.g. "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it.*		
4. Have you had these thoughts and had someintention of acting on them? *as opposed to "I have the thoughts but I definitely will not do anything about them."*		
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?		
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? *Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.*	Lifetime	
	Past 3 Months	
If **YES** to question 6, ask: **Was this in the past 3 months?**		

https://cssrs.columbia.edu/training/training-options/

Suicide Risk Formulation

- Background:
  - Long-term Risk Factors:
  - Impulsivity/Self-control:
  - Past/Present Suicide Ideation/Behavior:
  - Identifiable Stressor:
  - Clinical Presentation:
  - Engagement/Reliability:
- Synthesis of:
  - Risk Status (related to stated population:
  - Risk State (compared to person's baseline):
  - Internal and Social Strengths/Supports:
  - Hypothetical Changes That Could Increase Risk:

Appropriate Levels of Care

- Not everyone needs an alternate level of care
- There is no “emergency room“ magic

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Safety Planning Intervention

- Safety planning intervention consists of an often written/documented, prioritized list of coping strategies and sources of support that patients can use to alleviate a suicidal crisis.
- There are different types
- Who is safety planning for?

Stanley, B., & Brown, G. (2012). Safety Planning Intervention: A brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice, 19(2), 256–264.

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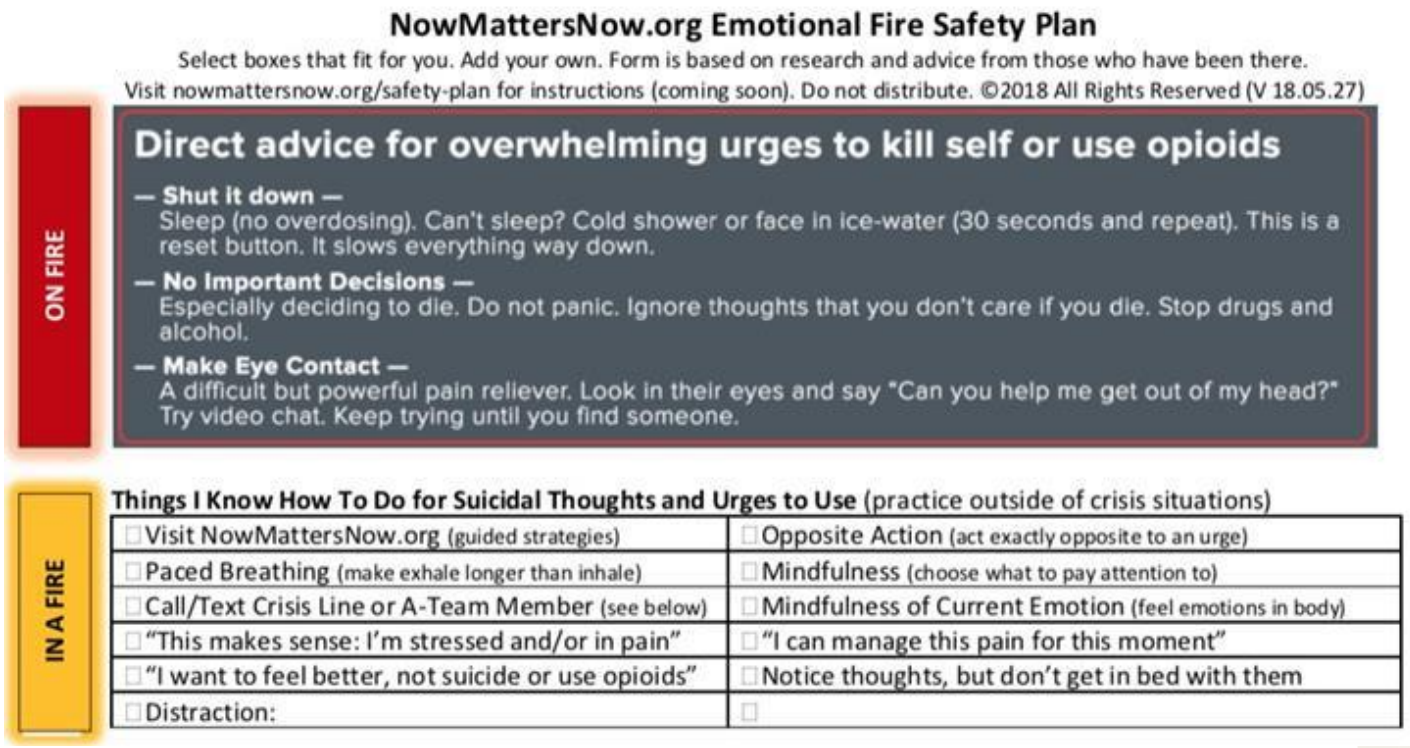
Emotional Fire Safety Plan



NowMattersNow.org Emotional Fire Safety Plan

Select boxes that fit for you. Add your own. Form is based on research and advice from those who have been there.

Visit nowmattersnow.org/safety-plan for instructions (coming soon). Do not distribute. ©2018 All Rights Reserved (V 18.05.27)

ON FIRE

Direct advice for overwhelming urges to kill self or use opioids

— **Shut it down** —
Sleep (no overdosing). Can't sleep? Cold shower or face in ice-water (30 seconds and repeat). This is a reset button. It slows everything way down.

— **No Important Decisions** —
Especially deciding to die. Do not panic. Ignore thoughts that you don't care if you die. Stop drugs and alcohol.

— **Make Eye Contact** —
A difficult but powerful pain reliever. Look in their eyes and say "Can you help me get out of my head?" Try video chat. Keep trying until you find someone.

IN A FIRE

Things I Know How To Do for Suicidal Thoughts and Urges to Use (practice outside of crisis situations)

☐ Visit NowMattersNow.org (guided strategies)	☐ Opposite Action (act exactly opposite to an urge)
☐ Paced Breathing (make exhale longer than inhale)	☐ Mindfulness (choose what to pay attention to)
☐ Call/Text Crisis Line or A-Team Member (see below)	☐ Mindfulness of Current Emotion (feel emotions in body)
☐ "This makes sense: I'm stressed and/or in pain"	☐ "I can manage this pain for this moment"
☐ "I want to feel better, not suicide or use opioids"	☐ Notice thoughts, but don't get in bed with them
☐ Distraction:	☐

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Stanley and Brown Safety Plan

- Recognizing warning signs
- Using internal coping strategies
- Socializing distractions
- Contacting friends or family members
- Contacting professionals
- Reducing access to lethal means

Stanley, B., & Brown, G. (2012). Safety Planning Intervention: A brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice, 19(2), 256–264.

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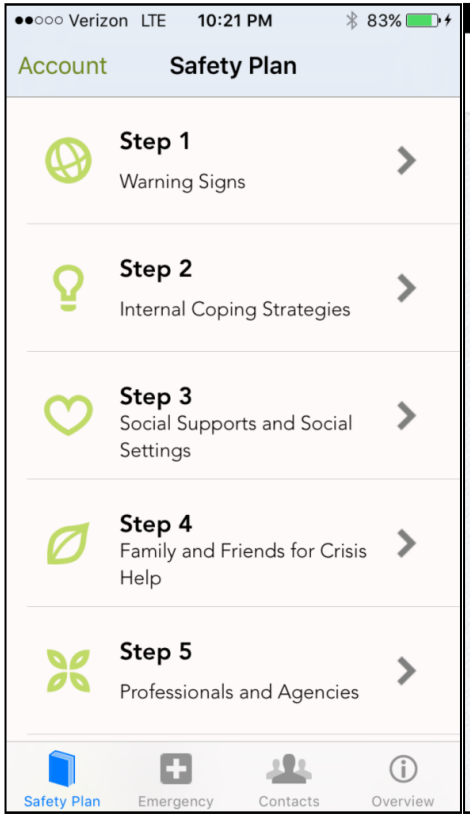
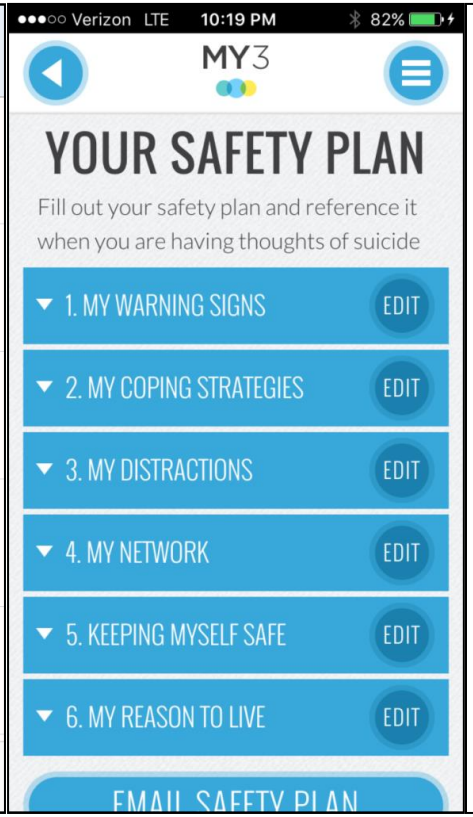
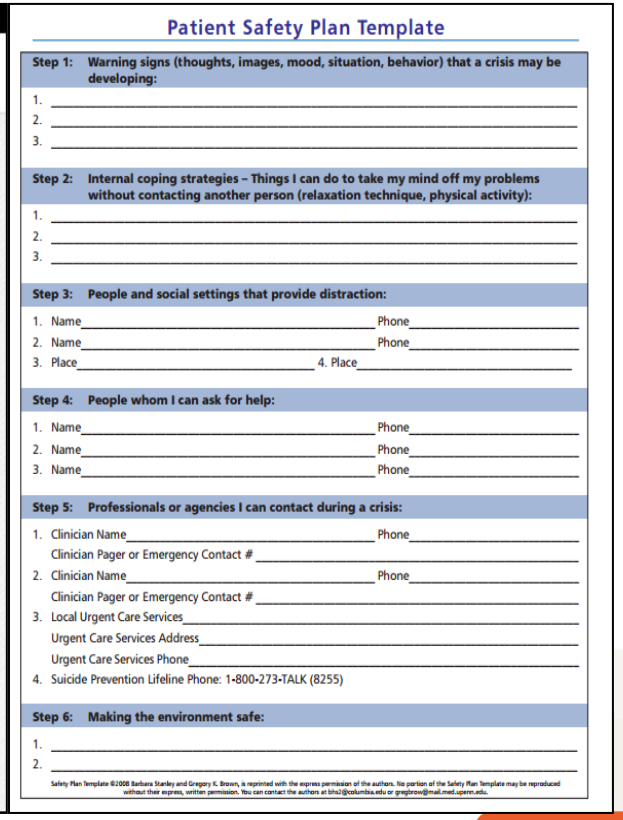
Documenting the Plan







Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

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Means Restriction Counseling

- Ask your patients/clients about their access to lethal means.
- Work with your patients/clients on reducing access to lethal means, particularly firearms and medications, including:
  - Communicate effectively with your patients/clients about this issue.
  - Set goals for reducing access and develop a plan that is acceptable to both you and your patients/clients.

SPRC. (2018). Means restriction counseling. Retrieved from https://training.sprc.org/enrol/index.php?id=3

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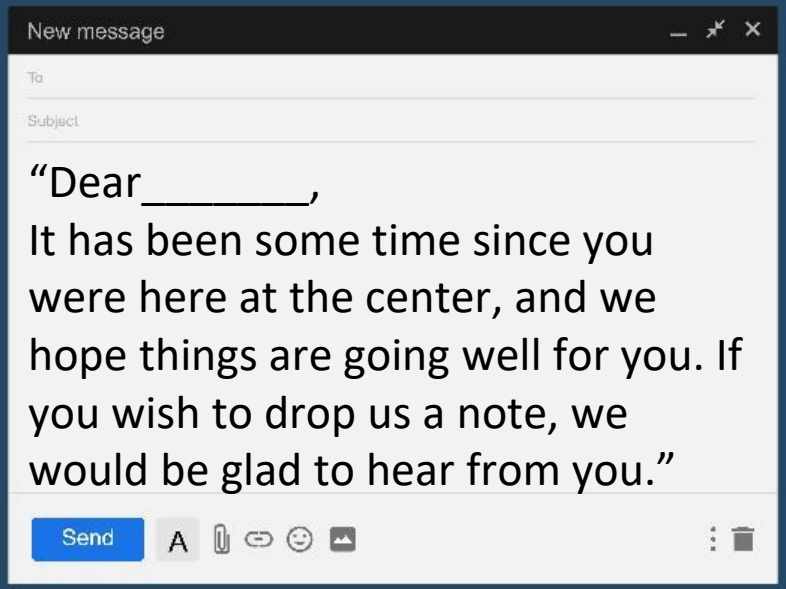
Non-Demand Caring Contacts / Messages

- Letter, phone call, email, or text message
- Nonpunitive
- Doesn't expect or require action from recipient



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Other Interventions

- Micro-interventions
- Opposite action
- Dialectical behavioral therapy skills (DBT)
- Cognitive therapy for suicide prevention (CT-SP)
- Collaborative assessment and management of suicidality (CAMS)
- Problem-solving therapy
- Medication intervention with clozapine

Symptom Improvement

Policy and procedures

Team Meeting / Case conference / Supervision

Remain consistent

Restart process when symptoms emerge

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Wellness Planning

- This is an important part of the treatment process
- Review with the patient the reasons it is important
- Discuss the warning signs of relapse
- Review what strategies have worked previously with the patient

- It should be completed when:
- The Patient suicidality subsides
- Transitions of care/end of treatment

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Imbed Throughout Organization

Suicide and Electronic Health Records

- Address suicide in all sites, services, and programs
- Multiple areas in chart
- Need different workflows and tools for different providers
- Use Decision Support

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Suicide on the Problem List

- Will show in all encounters
- Readily seen by providers of all disciplines
- Ability to report on characteristics of suicidal patients

Data Driven Care

- Population Health Management perspective
- Standardized screening tools, rescreening in a predictable way
- Helps to predict costs and outcomes
- Clinical pathways: standardize what we can, to leave space for what we can't.

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Suicide Postvention

Postvention is Prevention in the Truest Sense

- What is postvention?
- Who are suicide loss survivors?
- What are the primary goals of suicide postvention?

- **It is important to have an effective suicide postvention protocol in place before an individual dies by suicide**

Primary Strategies of Postvention

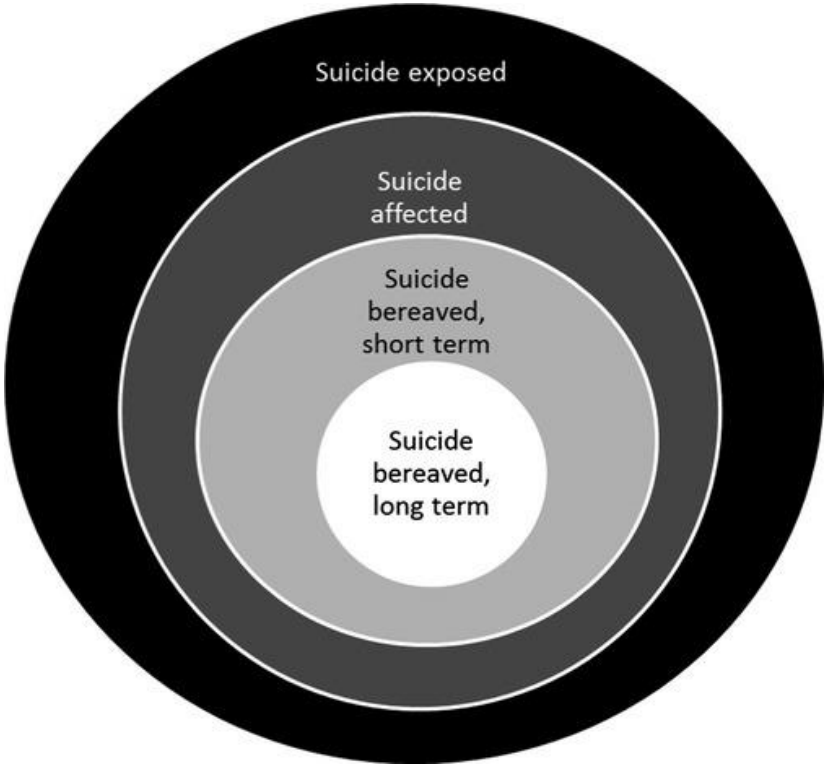
- Facilitate safe reporting and communication about suicide
- Support those affected by suicide to mourn their loss in ways that reduce the risk of contagion
- Provide support and treatment, both short-term and long-term
- Help supportive friends, family members, and community members to assist individuals who have been impacted by suicide loss

Continuum Model of Exposure Scenario

- Theresa was the principal of a local elementary school and a respected figure in her community. She died by suicide last year. She was found in her car in the back parking lot of a local park. Theresa had used a firearm to end her life. Her injury was extensive, and paramedics pronounced her dead within minutes of their arrival.

Continuum Model of Exposure

- Individuals within Theresa's community may be affected by their exposure to her suicide in the following ways:
  - Exposed
  - Affected
  - Bereaved, short term
  - Bereaved, long term



Adapted from Cerel, J., McIntosh, J. L., Neimeyer, R. A., Maple, M., & Marshall, D. (2014). The Continuum of "survivorship": Definitional issues in the aftermath of suicide. *Suicide and Life-Threatening Behavior, 10.*1111/sltb.12093

RELIAS

A Cautionary Note

- ***Perception*** of closeness to the deceased is more important to understand than objective relationship
- Perception of relationship can exist even in situations where there is no familial or other form of obvious direct relationship

Community Healing and Support

Suicide postvention efforts must extend beyond direct clinical work to be most effective

- Meeting the needs of the larger community
- Individuals may not seek out professional services

RELIAS

Organization Healing and Support

- The risk of adverse outcomes tends to be higher for those who:
  - Have a perceived close relationship with the deceased
  - Were already experiencing psychiatric issues
  - Feel responsible for the death through their actions or inactions
  - Identify with the deceased in some way
  - Are younger, especially teens and young adults

(Berkowitz et al., 2015)

Therapeutic Intervention

- Use best practices
- Be person-centered
- Be trauma-informed
- Focus on integration of the loss
- Support client's exploration
- Don't try to rush in with solutions

RELIAS

Therapy Session

- Address emotional reactions
- Prepare for increased safety risks
- Clearly understand confidentiality
- Understand their narrative
- Educate about resources and evidence-based treatment

It is imperative to routinely assess for risk of suicide when working with suicide loss survivors for this reason

Cultural Variations and Suicide Loss

Ignoring cultural variations can result in pathologizing normal grief responses or mourning customs or trying to impose treatment approaches that are biased toward your own culture

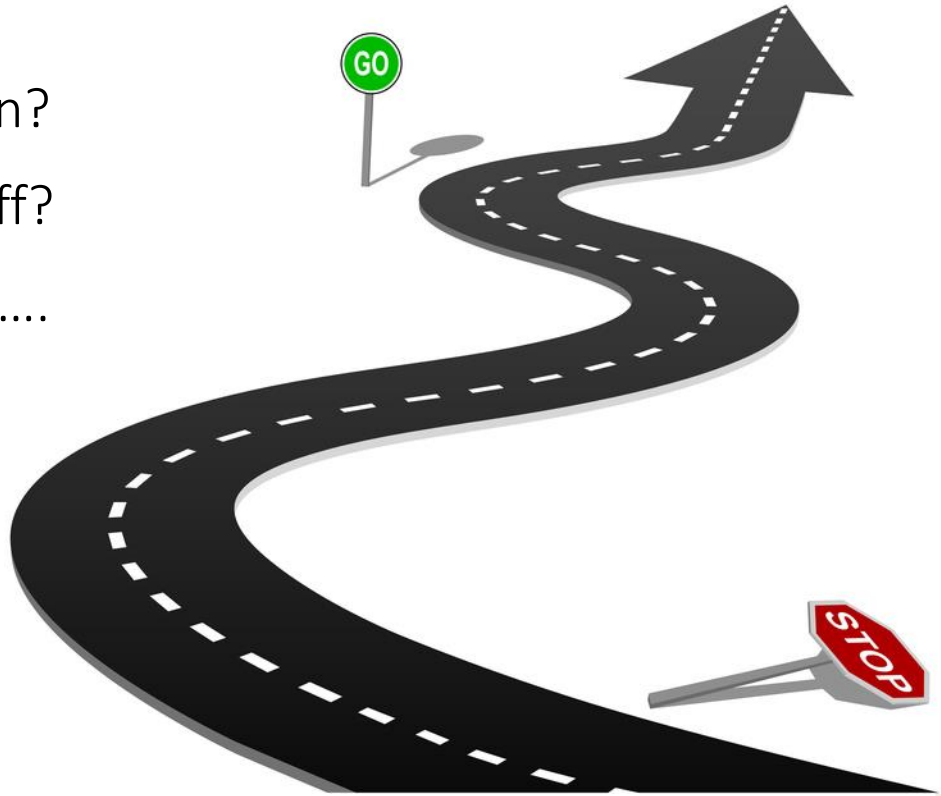
- Culture is a key variable that impacts the experience and expression of grief, as well as mourning rituals
- The degree of emphasis on trying to maintain connections with the deceased also varies by culture

RELIAS

Training and Skills Application Best Practices

Create a Pathway

- How does one get on?
- How does one get off?
- Exceptions / What if….



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Knowledge of Suicide Prevention Skills

Train everyone to respond to suicide	Clinical staff should be trained and skilled	Create a protocol

Relias provides a full suite of courses related to suicide

RELIAS

Practical Application of Suicide Prevention Skills

Training provides knowledge, but skill takes practice to build

- Research suggests active methods of learning may better facilitate skill development than training alone (Gryglewicz et al., 2020)
- Simulation-based learning allows learners to practice with a simulated client, improving skill in a safe environment and with immediate feedback (Kourgiantakis & Lee, 2021)

RELIAS

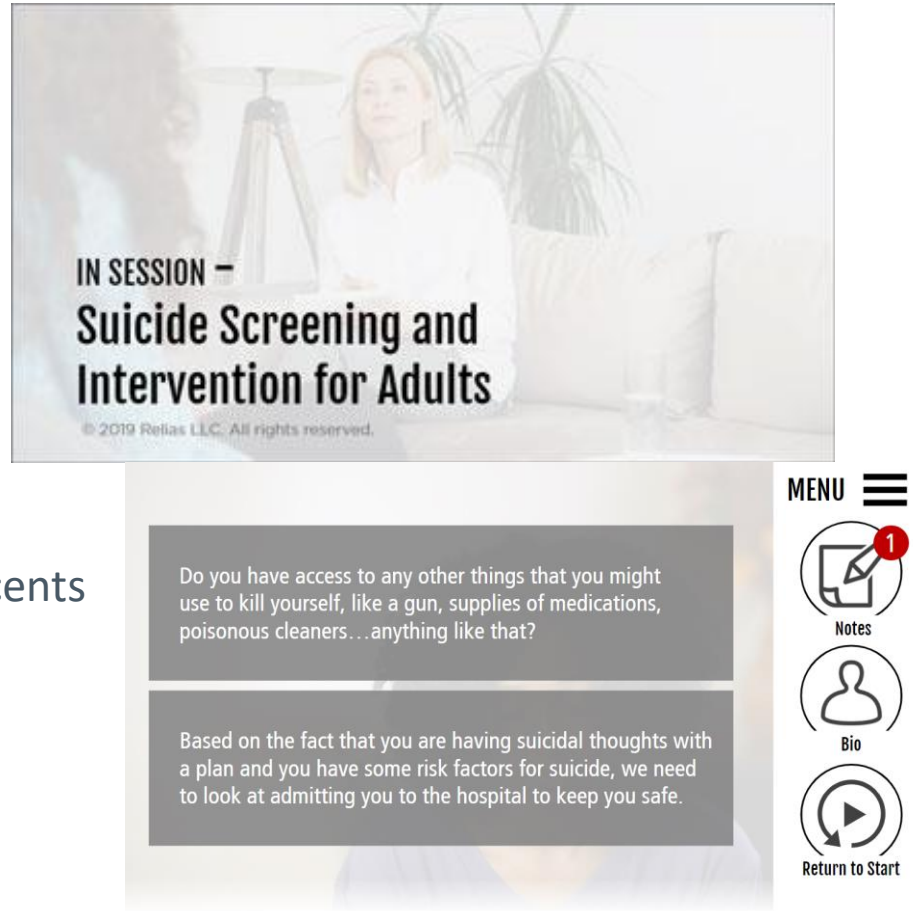
Relias' *In Session* Simulation Training

- Relias *In Session* simulations provide clinicians with an ***opportunity to apply existing knowledge*** to assess and intervene with a client in a simulated therapy session
- They will see how their selection of responses impacts the client's level of risk and outcomes
- Supervisory input will also help guide them through this simulation exercise

Relias *In Session* Simulations

Currently Available

- In Session: Suicide Assessment and Intervention in Adults (Young adult)
- In Session: Practicing Clinical Skills to Prevent Suicide (Middle-aged adult)
- In Session: Practicing Clinical Skills to Prevent Suicide in Children and Adolescents



RELIAS

Relias *In Session* Simulations

Coming Soon!

- In Session: Practicing Clinical Skills to Prevent Suicide in Older Adults
- In Session: Practicing Clinical Skills to Prevent Other-Directed Violence in Adults
- In Session: Practicing Clinical Skills to Prevent Other-Directed Violence in Children and Adolescents

Coming in 2022

- In Session: Practicing Clinical Skills to Prevent Non-suicidal Self Injury in Children and Adolescents
- In Session: Practicing Clinical Skills to Prevent Non-suicidal Self Injury in Adults

RELIAS

Learn More About *In Session* Simulations

Sample an In Session Simulation Course

- In Session: Suicide Assessment and Intervention for Adults

Attend the upcoming webinar

- Introduction to Relias' Suicide Prevention Simulation Training Courses- September 9

Recap of Steps from Prevention to Postvention…

- Identify Leadership, Champions, and Task Force
- Educate and Inspire Change
- Gauge the Current Organizational Landscape
- Practice Improvement
- Imbed Throughout Organization
- Resources and Collaboration with the Community and Stakeholders
- Suicide Postvention
- Practice and importance of skill application

Discussion and Questions

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Additional Resources

What Resources Exist?

- Everytown for Gun Safety https://everytown.org/
- National Council for Mental Wellbeing https://www.thenationalcouncil.org/BH365/2015/05/08/treatment-toolbox-clinical-interventions-prevent-suicidal-behavior/
- Now Matters Now https://www.nowmattersnow.org/
- Suicide is Different https://www.suicideisdifferent.org/
- Suicide Prevention Resource Center https://www.sprc.org/
- Zero Suicide https://zerosuicide.sprc.org/

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Asking about Ideation

- Sometimes people in your situation (describe the situation) lose hope and I'm wondering if you may have lost hope too?
- Have you ever thought things would be better if you were dead?
- With this much stress (or hopelessness) in your life, have you thought of dying?
- Have you ever thought about killing yourself?
- When did you begin having suicidal thoughts?
- Did any event (stressor) precipitate the suicidal thoughts?
- How often do you have thoughts of suicide? How long do they last? How strong are they?
- What is the worst they have ever been?
- What do you do when you have suicidal thoughts?
- What did you do when they were the strongest?

https://www.sprc.org/sites/adefault/files/PrimerModule4.pdf

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Asking about Plan

- Do you have a plan, or have you been planning to end your life? If so, how would you do it? Where would you do it?
- Do you have the (drugs, gun, rope) that you would use? Where is it right now?
- Do you have a timeline in mind for ending your life? Is there something (an event) that would trigger the plan?

https://www.sprc.org/sites/default/files/PrimerModule4.pdf

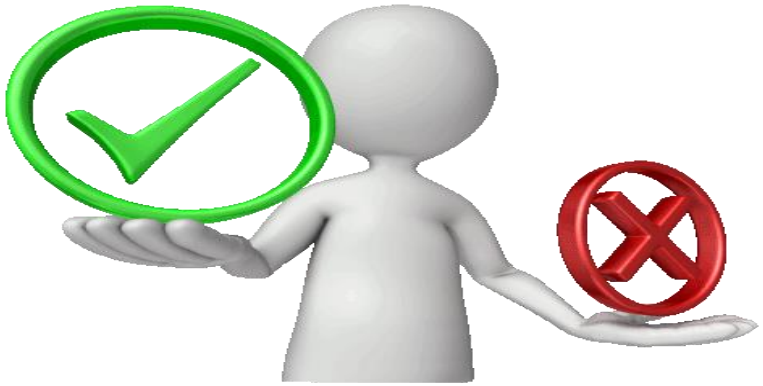
Asking about Intent

- What would it accomplish if you were to end your life?
- Do you feel as if you're a burden to others?
- How confident are you that this plan would actually end your life?
- What have you done to begin to carry out the plan? For instance, have you rehearsed what you would do (e.g., held the pills or gun, tied the rope)?
- Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?
- What makes you feel better (e.g., contact with family, use of substances)?
- What makes you feel worse (e.g., being alone, thinking about a situation)?
- How likely do you think you are to carry out your plan?
- What stops you from killing yourself?

https://www.sprc.org/sites/default/files/PrimerModule4.pdf

Asking about Protective Factors

- Sense of responsibility to family
- Life satisfaction
- Social support; belongingness
- Coping skills
- Problem-solving skills
- Reality testing ability
- Religious faith
- Strong therapeutic relationship



https://www.sprc.org/sites/default/files/PrimerModule4.pdf

NATIONAL COUNCIL for Mental Wellbeing

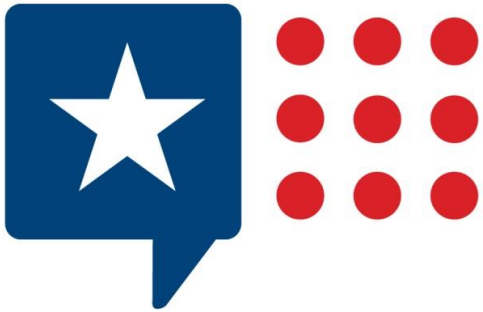
NATIONAL

SUICIDE PREVENTION LIFELINE™

1-800-273-TALK (8255)

suicidepreventionlifeline.org

Veterans Crisis Line



1-800-273-8255

PRESS 1

Other hotlines

- **Crisis Text Line: Text hello to 741741**
- **Trevor Project: 1-866-488-7386**
  - **For LGBTQ Youth**
- **TRANS LIFELINE: 1-877-565-8860**
  - **Best under step 4, not step 5**

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