CASBHC Suicide Webinar

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Training Agenda

- Understand the influences that impact youth mental health - Adolescent suicide trends
- Learn strategies to talk to young people about the negative and positive influences on their mental health – Crisis intervention principles
- Differentiation of self injury and suicide
- Assessment of lethality/determine risk and response indicated
- Identify how SBHC's can coordinate with existing school and community based suicide prevention efforts

Factors Influencing Youth Mental Health – World Health Org 2018

‘Good Mental Health ‘– is not merely the absence of mental illness but is comprised of many variables

Self Esteem

Confidence

Coping Skills/ Resilience

Connection/Feeling Loved

Family Stability/Family Loss

Physical Health/Illness

Challenging Behavior

Safety/Abuse

Factors Influencing Youth Mental Health

Colorado Health Institute 2017

Suicide is most common in the 45-64 age group and men are three times as likely to die by suicide as women.

Suicide was leading cause of death in 10-24 age group.

1175 lives lost in Colorado (2017)

- Firearms 50.3%
- Hanging 28.7%
- Drugs 12.9%
- Gas/Vapors 2.8%

Colorado's SW corner faced highest rates of suicide and rates doubling along the eastern plains

Colorado Executive Summary

2018 Colorado Conversations to Inform Youth Suicide Prevention: A study of youth suicide in four Colorado Counties – El Paso, La Plata, Mesa, Pueblo

Colorado Office of Attorney General under the leadership of Attorney General Cynthia Coffman provided funding to Health Management Associates (HMA) to conduct the 'community conversations' work in 4 counties with . Office of Suicide Prevention and CDPHE also partnered and provided guidance.

42 stakeholder interviews

34 focus groups

To view full report follow this link

https://coag.gov/sites/default/files/final_youth_suicide_in_colorado_report_10.01.18.pdf

Scope of the Problem Colorado- Exec Summary

- In 2009 There were 940 suicide deaths in total across Colorado
- In 2016 suicide deaths hit a new high of 1156 (20.3 per 100,000)
- In 2016 Colorado ranked 5th in the nation for suicide deaths and has made the top 10 list since 2009.
- Between 2014-2015 the number of hospitalizations in Colorado residents ages 10-18 shows that 816 females were hospitalized due to a suicide attempt, while 249 males were hospitalized during this same period.
  - More females attempting but more males successfully completing
- Between 2015-2017 in Colorado there were 222 suicide deaths of young people between ages of 10-18
  - Of those deaths 67.6% male (150 deaths) and 32.4% female (72 deaths)

Scope of the Problem Colorado- Exec Summary

In the 2017 Health Kids Colorado Survey (HKCS)- survey conducted every two years…

- 17% of middle and high school youth reported considering suicide and 7% reporting making at least one attempt in the last 12 months – similar to national data

- LGBTQ+ youth reported 44.8% considered suicide and 19.9% attempted suicide in previous 12 months – highlighting the health disparities in this group

Scope of the Problem Colorado- Exec Summary

Risk Factors

- Pressure and anxiety about failing
- Social Media and Cyberbullying
- Lack of prosocial activities
- Lack of connection to a caring adult
- Judgement and lack of acceptance in the community
- Substance abuse/mental health disorders/trauma history
- Lack of behavioral health providers
- Adult suicide in family/community

Scope of the Problem Colorado- Exec Summary

- Factors that increase protection against youth suicide
  - Trained school staff
  - Boys and Girls clubs
  - Safe2Tell – Crisis Hotlines
  - Supportive safe family environment
  - Sense of belonging
  - Church/Faith based activities
  - Case management support – system navigation
  - Sports/Band/Clubs – after school activities
  - Youth suicide prevention programming
  - Groups not tied to academic achievement
  - Nature is a resource although access to hiking, skiing, camping can be expensive and hard to access

Scope of the Problem Colorado- Exec Summary

- Recommendations:
  - Prioritize relationship building between adults and youth
  - Create a culture of support for youth in crisis/post-crisis
  - Implement programs that build resilience and coping skills
  - Increase access to prosocial activities in supportive environments
  - Increase flexible funding to primary prevention of youth suicide
  - Leverage current public awareness campaigns to destigmatize getting help for mental health and suicidal ideation
  - Create coalitions of providers and foster relationships between providers and youth serving organizations
  - Train media professionals on how to cover suicide safely

Adolescent Suicide

Additional Risk Factors:

- LGB Youth - In past 12 months, 60.4% of LGB youth felt sad or hopeless everyday for 2+ weeks compared to 26.4% of heterosexual youth
  - In past 12 months, 42.8% of LGB youth seriously considered suicide, compared to 14.8% of heterosexual youth
  - In past 12 months, 38.2% of LGB youth made a suicide plan, compared to 11.9% of heterosexual youth
  - In past 12 months, 29.4% of LGB youth attempted suicide, compared to 6.4% of heterosexual youth
  - In past 12 months, 9.4% of LGB made a suicide attempt that required medical attention compared to 2% of heterosexual youth.

(American Association of Suicidology 2016)

Adolescent Suicide

Rates are the highest for suicidal ideation/attempts in Transgender Youth

- Fifty-one percent of transgender male adolescents reported at least one suicide attempt — the highest rate in the study. The second highest was among young people who are nonbinary — those who do not identify exclusively as male or female — at 42 percent, while 30 percent of transgender female adolescents reported attempting suicide.

(Pediatrics Oct 2018, Volume 142 Issue 4- transgender adolescent suicidal behavior, Toomey et al.)

Crisis Intervention Skills

Key Principles to working with suicidal patients

- Take time to understand what is going on?
- Provide undivided attention
- Listen carefully and strive to form an empathic bond
- During the process of listening and forming a bond assess risk and protective factors
- Focus interventions on process over content
- System management
- Chart documentation/risk management

Crisis Intervention Skills

Counseling Principles Condensed

- Listen carefully (with the 3rd ear)
- Be fully present
- Reflect back the feelings you are hearing
- Emphasis is not initially on problem solving – its on being with your student
- Need nothing from your student – no attachment to outcome
- Develop secondary professional ego – one that can delay gratification and needs no gratification from the student
- Sequence – Compassion, Information gathering, Problem solving

Crisis Intervention Skills

Counseling Principles Condensed

- If you find yourself asking a lot of “Have you tried this/that?” questions you’re probably getting yourself tied up in knots
- When you feel lost or stuck just reflect the last feeling you have heard
- Learn the therapeutic value of limits, boundaries, saying no
- Don’t try so hard – if nothing seems to be ‘working’ stop trying to ‘do’ and focus on ‘being with’
- Develop inner quietness – learn to be with suffering while centered and grounded
- Develop self awareness, especially awareness of your own needs, vulnerabilities, sensitives, and triggers

Crisis Intervention Skills

Counseling Principles Condensed

- Don’t be afraid of silence
- Be clear about what your role is and isn’t
- Don’ts
  - Ignore, avoid, minimize, make fun of, get angry, judge, impose your world view, tell the patient what to do, impose guilt, make promises you can’t keep, try to trick them, lie to them, or say you understand if you don’t.

Crisis Intervention Skills

What a suicidal student may feel or experience

- Can’t stop the pain
- Can’t feel anything
- Can’t get rid of voices telling me to kill myself
- Can’t make decisions
- Can’t stop feelings of hopelessness/helplessness
- Can’t see a way out
- Can’t see a future without pain
- Can’s sleep, eat, work
- Can’t cope with overwhelming anxiety
- Can’t live with the loneliness/isolation
- Can’t live like ‘this’ (whatever ‘this’ is)

Crisis Intervention Skills

Challenges unique to adolescents

- Highly vulnerable to peer influence
- Often feel out of control
- Decrease in dopamine – often report feeling bored/empty
- Struggle with delayed gratification
- Digital relationships
- Hyper-rationalization – overemphasis on pro's and de-emphasizes cons
- Impulsivity – most suicidal acts by youth are impulsive and unplanned.
- Often eager to imitate role models as they seek to develop their own identity.

Crisis Intervention Skills

Additional Risk Factors to be aware of

Recent loss

Access to firearms

Anger/Rage/Revenge seeking

Anxiety/Panic

Insomnia

Withdraw/Isolation

Paranoia

Feeling trapped

Reckless/Excessive risk taking

Legal Problems

ACE score

Drug/Alcohol

Crisis Intervention Skills

Tips for assessing psychological intent

- Ask the question – Are you thinking about hurting or killing yourself?

- What does the option of suicide mean to the youth?
  - Motive among young people is often interpersonal and instrumental
- What is the intended goal of suicide –
  - to escape pain
  - escape helplessness/hopelessness
  - escape emotions and thoughts associated with suicidal state

Crisis Intervention Skills

Tips for assessing suicidal plan

- Presence or absence of a plan?
- Inquire directly about the plan?
- Is there intent to carry out the plan – timing?
- How lethal is the plan?
- Is the plan carefully thought through?
- Are lethal means available to carry out the plan?
- How impulsive is the student?
- Are they under the influence/using drugs or alcohol?
- Are they reporting command hallucinations?
- What does support system look like?
- Is there a precipitating event? – recent loss, rejection, humiliation?

Crisis Intervention Skills

Tips for assessing suicidal plan

- Hopelessness is one of the best indicators of suicide risk
- Youth are sensitive to interpersonal pressures/expectations
- Suicidal youth often have conflict with peers and family members
- Social media impact – the bathroom wall follows you home
- Have they made a previous attempt?
- What keeps them going?

Crisis Intervention Skills

Clinical Considerations

- Essential for clinician to be empathic and to connect with the youths subjective experience of pain
- Pain can be experienced quite intensely
- Explore possible options and alternative coping strategies
- Evaluate negative and positive forces in a youths life
- Ask directly about the pressure and overwhelm they feel
- If chronically suicidal ask them what keeps them going?
- Ask specifically about the youths perceived ‘fit’ with their family
- Is there juvenile justice/child welfare involvement?
- Are they in facility or foster home – risk is high in first 24 hours of placement.

Suicide vs Self Injury

"Self Injury is intentional, non-life threatening, self effected bodily harm or disfigurement of a socially unacceptable nature, performed to reduce psychological distress."

(Walsh & Rosen, 1988)

Suicide vs Self Injury

Basic beliefs about self injury

- Because of stigma, shame, and risk attached to disclosing self injury many people who struggle with it are reluctant to discuss their experiences.
- Self Injury is more prevalent among females then males 65-70% female
- There is a high correlation between self injury and a history of interpersonal trauma (past or present) i.e. sexual, physical, and emotional abuse, neglect, abandonment, serious illness, being removed from the home, witnessing family violence or chaos, ritual abuse, isolation and captivity.

Suicide vs Self Injury

Cont…

- Self Injury is a coping mechanism; it is an attempt to survive and manage the affect of an overwhelming experience.
- Self Injury spans all races, religions, and socio-economic classes.
- Self Injury is generally not life threatening. Often the injury represents the least possible amount of damage and represents extreme self restraint. Many people who self injure are able to articulate the intention behind the behavior.

Suicide vs Self Injury

Common functions of self injury

- Tension Reduction
  - To focus the pain and distract from psychic pain
  - To provide “relief” or “release”
  - To regain a sense of control
- Expression of feelings & needs
  - Rage, frustration, hurt, emotional pain, guilt etc.
  - Self punishment for having feelings and needs
  - In response to triggers

Suicide vs Self Injury

- Reenactment
  - To communicate or show the abuse
  - To gain mastery of experience
  - In response to programming (ritual abuse)
- To manage dissociation
  - To keep from dissociating
  - To feel re-grounded and present
  - Reassurance about being alive
  - To keep memories away

Suicide vs Self Injury

Responding to disclosures of self injury – Do's

- It is important to attend to disclosure with empathy and respect.
- Encourage open communication.
- Validate changes that have already been made (breaking the isolation, talking with others etc.)
- Understand the function it serves.
- Attend to the underlying wound for which self injury is a "solution"

Suicide vs Self Injury

Responding to disclosures of self injury – DON'T's

- Label self injury as manipulative or crazy
- Forcing client to stop self injury instead of working to understand it
- Hospitalizing solely because of self injury
- Contracting with your client to stop self injury or making the cessation of cutting a condition of continued treatment
- Withholding clinical attention after client self injures
- Labeling self injury as a suicide attempt. Only 0.02% of self injury results in death.

Suicide vs Self Injury

Assessment Focus

- What was the expressed and unexpressed intent of the act?
  - Suicide Attempt –To escape pain; terminate consciousness
  - Self Injury- Relief from unpleasant affect (anger, emptiness)
- What was the level of physical damage?
  - (SA) Serious physical damage, lethal means of self-injury
  - (SI) Minimal physical damage, non lethal means
- What is the level of psychological pain?
  - (SA) Unendurable, persistent
  - (SI) Uncomfortable, intermittent

Suicide vs Self Injury

- Is there a chronic, repetitive pattern of self injurious acts?
  - (SA) – rarely a chronic repetition; some repeatedly overdose
  - (SI) – Frequently a chronic, high rate pattern
- Do they feel helpless and hopeless?
  - (SA) – Hopelessness and helplessness are central
  - (SI)- Periods of optimism and some sense of control
- Is there constriction of cognition?
  - (SA) – Extreme constriction; suicide is the only way out, tunnel vision, seeking a final solution
  - (SI) – Little to no constriction; choices available; seeking a temporary solution

Suicide vs Self Injury

The Informal response

- Keep suicidal terminology out of it
- Use clients own language as a joining strategy
- Use low key dispassionate demeanor
- Don’t condemn behavior or contract for it to stop
- Be respectfully curious “How does cutting help you feel better?”

Suicide vs Self Injury

Crisis Intervention

- Levels of physical damage
- Bodily location – Face, eyes, breast, genitals. Most people don't injure face – these four areas are the most serious
- Injury to breasts or genitals is almost always primitive trauma reenactment
- Most injure wrists, hands, arms, legs

Suicide vs Self Injury

Replacement skills training

- Negative replacement behaviors – snapping a rubber band on arm, art work of self injury marking spot on the skin, ice packs, carving into piece of word. Always ask what could go wrong with these replacement behaviors.
- Mindful breathing – skill of deliberate calm
- Visualization – reality based or fantasy based
- Physical exercise – walking, sports, repetitive activity
- Writing
- Artistic Expression
- Playing or listening to music
- Communicating with others

- Transfer misery disclosure to skills practice

Suicide vs Self Injury

How can parents/teachers help?

- Listen to your child and acknowledge their feelings are valid.
- Be available, non judgmental, and encourage open communication.
- Model positive coping skills.
- Don’t avoid the subject of self injury or threaten to withdraw love or support from the child.
- Work to understand the function self injury serves.
- Don’t label them as crazy or manipulative.
- Provide distractions if necessary.
- Link child to a trained mental health professional for an assessment / treatment.
- Calm Harm APP – manages self harm

3 Key Components of Completed Suicide – Joiner (2005)

1st Key - Acquired capability to enact lethal self injury – accrues with repeated and escalating experiences involving pain and provocation such as:

- Past suicidal behavior
- Repeated injuries
- Repeated witnessing pain, violence, or injury
- Any repeated exposure to pain and provocation

With repeated exposure one habituates:

- Serves to squelch the powerful instinct to live
- The 'taboo' and prohibitive quality of suicidal behavior diminishes and so may the fear and pain associated with it

3 Key Components of Completed Suicide – Joiner (2005)

- 1st Key - Acquired capability to enact lethal self injury – cont
  - The opponent process may also be involved:
    - Opponent process theory (Solomon 1980) predicts that, with repetition, the effects of a provocative stimulus diminish, and the opposite effect, or opponent process, becomes amplified and strengthened.
    - The opponent process for suicidal people may be that they become more competent and courageous, and may even experience increasing reinforcement, with repeated practice at suicidal behavior

3 Key Components of Completed Suicide – Joiner (2005)

- 2nd Key - Perceived Burdensomeness

Feeling ineffective to the degree that others are burdened is among the strongest sources of all for the desire to die by suicide.

3 Key Components of Completed Suicide – Joiner (2005)

- 3rd Key – Thwarted Belongingness
- The need to belong to valued groups or relationships is powerful, and fundamental and extremely pervasive human motivation – when this is thwarted numerous negative effects on health, adjustment, and well being have been documented
- This need is so powerful that , when satisfied, it can prevent suicide even when perceived burdensomeness and the acquired ability to enact lethal self injury are in place. By same token, when the need is thwarted, risk for suicide is increased.
- Belongingness may be the most malleable

M1 – Mental Health Hold

- A person is considered to be a danger to self if he or she poses a substantial risk of self harm, as evidenced by recent threats of or attempts at suicide or serious bodily harm.

- A 72-hour mental health hold can be initiated by an intervening professional, including a certified peace officer, medical professional, registered professional nurse with training in psychiatric or mental health nursing, licensed marriage and family therapist or counselor with training in mental health, or licensed clinical social worker.

- Additionally, a hold can be initiated upon an affidavit sworn to or affirmed before a judge that establish that a person appears to have a mental illness and, as a result of such illness, appears to be an imminent danger to himself or herself or others, or gravely disabled.

M1 – Mental Health Holds

- Suicide Risk Review process occurs in school district to identify and evaluate concerns for risk for suicide – develops and implements action and intervention plan

- When? – Any time a student talks about harming/killing themselves or having thoughts of harming/killing themselves. In some cases this is done in the moment and other times its completed when the student returns from inpatient hospitalization or emergency room evaluation.

- Know your schools protocol and process for responding to suicide risk in the school. You are not alone!

No Suicide Contracts

- No evidence that no-suicide contracts work
- Of those who used no suicide contracts over 40% report they had a patient die by suicide or make a near lethal attempt while under contract
- Contracts assume the person is competent and able to follow instructions
- Overvalued in the field, creates false sense of security
- May distract from careful assessment
- Usually motivated by fear of litigation (caregivers stress vs. patients)
- Safety plans are something different and can help remind students of coping skills/resources/numbers to call if suicidal

Documentation tips

Clear and comprehensive documentation

- Detailed, accurate, and thorough notes are key.
- Go beyond reporting “no SI/ HI” (suicidal ideation/homicidal ideation).
- Report what the patient said and how she (he) said it. If the patient denies current suicidal ideation, ask when her (his) last suicidal thought occurred. How did the patient respond to that thought? Why?
- Avoid using a suicide contract—it is not a substitute for a thorough suicide assessment; it isn’t a legal document; it does not protect against legal liability; and it is ineffective.

Provider challenges

- Sitting with uncertainty and worry – how can we increase our tolerance for distress and stay present with the student when they aren't going to be hospitalized?
  - Are we trying to fix?
  - Are we really seeing their capacity to heal?
  - Are we feeling pity, fear, moral distress or attachment to outcome?
- Challenge of knowing home environment is not supportive to recovery?
  - Role of relationships in SBHC/school become even that much more important and may serve as a psychological lifeline for youth.

Suicide Postvention

- Intervention conducted after suicide – largely taking form of support for the bereaved
- Friends and family may be at increased risk for suicide themselves
- Postvention – coined by Shneidman (1972) – he used to describe “appropriate and helpful acts that come after a dire event.”
- In Shneidmans view “the largest public health problem is neither the prevention of suicide nor the management of suicide attempts, but the alleviation of the effects of stress in the survivors whose lives are forever altered.”
  - Reduces copycat suicide and complicated grief reactions
  - For every suicide death its estimated 147 people exposed (6.9 million annually. (AAS 2017)

Suicide Postvention

- Suicidal grief
  - Can be intense, complex, long term
  - Shocking, painful, and often unexpected
  - Individual process - experienced in own way at own pace
  - Grief does not follow a linear path – does not always move forward direction
  - There is no time frame for grief – survivors can't expect life to feel the same again
  - Common emotions experience are: shock, denial, pain, guilt, despair, disbelief, hopelessness, numbness, sadness, stress, shame, anger, rejection, loneliness, abandonment, self blame, anxiety, confusion, helplessness, depression,

Suicide Postvention

- Survivors often struggle with the “Why’s? “If Only’s?” And feelings of guilt often ensue as they believe their loved ones suicide could have been prevented
- At times if loved one had a serious mental disorder or addiction the survivor may experience relief – the suffering is over
- Shame/Stigma/Embarrassment prevent people from reaching out for support – others may rely on survivors initiative to talk about loved one or to ask for help
- When time is right survivors can find joy in life again and healing is possible
- Local support groups are a helpful resource to move through healing process

Suicide Aftermath

- **Tips When Speaking with Family Members of deceased patient**
- Express sympathy and support for the family
- Listen and respond to the emotional needs of the grieving family rather than talking
- Focus on the sadness of the death and the needs of the family rather than the details of the treatment
- Provide information about suicide in general rather than specific information about the client
- Explain confidentiality laws, if needed
- Provide any resources or referrals for individual therapy, if needed
- Prepare a list of suicide survivor resources to give to the family if they want them
- Avoid engaging in therapeutic work with the family, since this may create a dual relationship

SBHC Opportunities

We are uniquely positioned to make a difference in the lives of suicidal students

- Know the school protocol for response in the event of a suicidal student and know the back up resources available in the event front line staff are out of the building.
- Know the school's process for getting student to hospital psychiatric emergency evaluation – M1's, police/ambulance/parent transport?
- Determine how can your SBHC partner with youth and suicide prevention programming already in place? Student champions?
- Become familiar with community resources and state/national helplines if local resources in your area are sparse.
  - How can we leverage current public awareness campaigns to destigmatize getting help for mental health and suicidal ideation?
  - How can we create coalitions of providers and foster relationships between providers and youth serving organizations?

Resources and More Information

- **Suicides can be prevented, and many people who think about or attempt suicide go on to thrive.** Identifying which groups and regions have higher rates of suicide can help point to areas in need of support.

- If you are in crisis, call the Colorado Crisis & Support Line at **1-844-493-TALK (8255)** to connect with a trained counselor in your area.
- Or reach the toll-free National Suicide Prevention Lifeline at **1-800-273-TALK (8255)** 24 hours a day, 7 days a week. The service is available to anyone. All calls are confidential.

Resources and More Information

- For more information on what's happening to prevent suicides in Colorado, see:
- The Colorado Department of Public Health and Environment's Office of Suicide Prevention
- The Gun Shop Project
- Man Therapy
- The Suicide Prevention Coalition of Colorado.
- Zero Suicide
- Mental Health First Aid
- Sources of Strength
- For more detail on suicides in Colorado, including substance use and suicide and trends among first responders, LGBTQ-identified Coloradans, construction workers, veterans and adolescents, visit CDPHE's vital statistics department and check out its data dashboard.

References

- American Association of Suicidology (2016). Facts and Statistics. Retrieved from www.suicidology.org
- American Association of Suicidology (2017). Facts and Statistics. Retrieved from www.suicidology.org
- American Association of Suicidology (2018). Facts and Statistics. Retrieved from www.suicidology.org
- Colorado Department of Public Health Environment (2017). Health Kids Colorado Survey. Retrieved from www.colorado.gov
- Colorado Health Institute (2017). Retrieved from https://www.coloradohealthinstitute.org/research/suicides-colorado-reach-all-time-high
- Colorado Office of the Attorney General (2018). Community Conversations to Inform Youth Suicide Prevention. Retrieved from www.coag.gov
- Joiner, T. (2005). *Why people die by suicide.* Cambridge, MA: Harvard University Press.
- National Association of Social Work (2015). Legal Considerations When a Client Dies by Suicide. Retrieved from www.nasw-michiganblog.weebly.com

References

- Miller, D. (1994). *Women who hurt themselves: A book of hope and understanding.* New York, NY: Basic Books.
- Shneidman, E.S. (1985) *Definition of suicide*. New York, NY: Wiley
- Simeon, D. & Favazza, A. (2001). *Self Injury behaviors: Phenomenology and assessment.* Washington, DC: American Psychiatric Association.
- Solomon, R.L. (1980). The opponent process theory of acquired motivation: The cost of pleasure and the benefits of pain. *American Psychologist*, *35* (8), 691-712.
- Toomey et al (2018). Transgender adolescent suicidal behavior. *Pediatrics, 142* (4),
- Walsh, B.W. & Rosen, P. (1988). *Self mutilation: Theory, research, and treatment.* New York, NY: Guilford Press.
- Walsh, B. W. (2006). *Treating self injury: A practical guide*. New York, NY: Guilford Press.
- World Health Organization (2018, September 18). Adolescent Mental Health. Retrieved from www.whi.int/news-room/fact