Riverside Trauma Center

A SERVICE OF RIVERSIDE COMMUNITY CARE

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Understanding Suicide 101 Course for DDS Service Coordinators

presented by:

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Housekeeping / Logistics

- Plan for our time together
- Cell phones/texts (or mute microphone)
- Not tx focused
- Self-care for today

3

Course Objectives

- Describe the scope of the problem.
- Provide a clinically accurate definition of suicide.
- Manage personal reactions to suicidal clients.
- Review suicide warning signs and risk and protective factors.
- Identify ways to elicit suicidal ideation and history of behaviors.
- Identify strategies and tools to better understand risk, especially in the context of a person served by DDS
- Practice use of safety plan tool
- Understand ambivalence around suicide and the idea of suicide as a coping strategy.

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Adverse Childhood Experiences

- 80% of suicide attempts during childhood/adolescence were attributable to ACEs.
- Childhood and adolescent suicide attempts increased 51-fold, or 5,100% with an ACE score of 7 or more.

Dube et al. (2001)

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How Does a Suicide Occur?

Underlying Vulnerability

eg: mood disorder, substance abuse, aggression, anxiety, family history, sexual orientation, trauma, low serotonin

↓

Stress Event

(Often caused by underlying vulnerability) eg: trouble with law or school, loss, etc

↓

Acute Mood Change

eg: anxiety, dread, hopelessness, anger

Inhibition:	Facilitation:
Strong taboo, available support, slowed down mental state, presence of others	Weak taboo, method/weapon available, recent example, agitation, being alone
↓	↓
SURVIVAL	SUICIDE

Shaffer (1996); Gould (2001-2006)

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Communication of Intent

Studies have indicated that, on average, 45% of people communicate intent prior to making a suicide attempt or dying by suicide

In most cases these communications are behavioral or coded rather than direct threats.

Pompili, et.al. 2016

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WARNING SIGNS OF SUICIDE:

The behaviors listed below may be some of the signs that someone is thinking about suicide.

TALKING ABOUT:
- Wanting to die
- Great guilt or shame
- Being a burden to others

FEELING:
- Empty, hopeless, trapped, or having no reason to live
- Extremely sad, more anxious, agitated, or full of rage
- Unbearable emotional or physical pain

CHANGING BEHAVIOR, SUCH AS:
- Making a plan or researching ways to die
- Withdrawing from friends, saying good bye, giving away important items, or making a will
- Taking dangerous risks such as driving extremely fast
- Displaying extreme mood swings
- Eating or sleeping more or less
- Using drugs or alcohol more often

If these warning signs apply to you or someone you know, get help as soon as possible, particularly if the behavior is new or has increased recently.

National Suicide Prevention Lifeline 1-800-273-TALK

Crisis Text Line Text "HELLO" to 741741

www.nimh.nih.gov/suicideprevention

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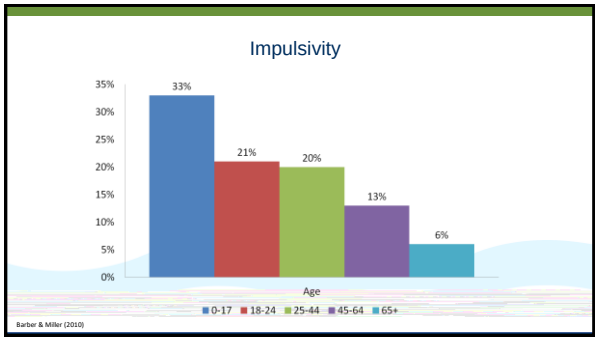
Impulsivity
35%
30%
25%
20%
15%
10%
5%
0%
33%
21%
20%
13%
6%
Age
0-17
18-24
25-44
45-64
65+
Barber & Miller (2010)

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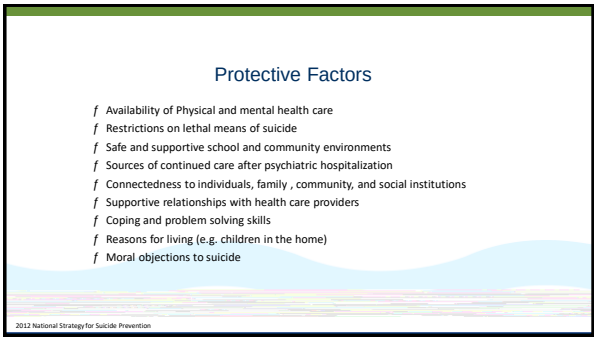
Protective Factors
Availability of Physical and mental health care
Restrictions on lethal means of suicide
Safe and supportive school and community environments
Sources of continued care after psychiatric hospitalization
Connectedness to individuals, family , community, and social institutions
Supportive relationships with health care providers
Coping and problem solving skills
Reasons for living (e.g. children in the home)
Moral objections to suicide
2012 National Strategy for Suicide Prevention

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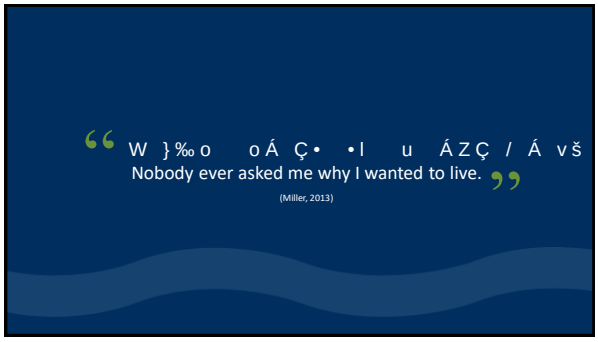
W }‰o oÁ Ç• •l u ÁZÇ / Á vš
Nobody ever asked me why I wanted to live.
(Miller, 2013)

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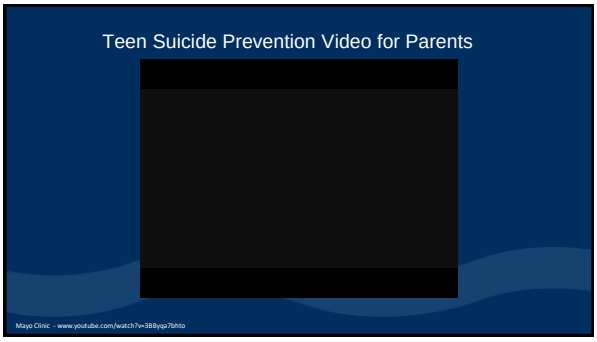
Teen Suicide Prevention Video for Parents
Mayo Clinic - www.youtube.com/watch?v=3BByqa7bhto

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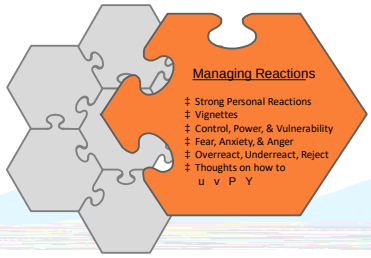
Module 3: Managing Reactions



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- oo t]o•}vU ^ u }Áv W Œ•}vU_
in Same Time Next Week: True Stories of Working Through Mental Illness,
ed. Lee Gutkind, 2015

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Suicide Engenders Strong Personal and Emotional Reactions

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Vignette

Jorge is a 25-year-old man you have known and worked with for the past two years. He works in a supported employment setting in the community. You recently spoke with his parents, with whom he lives. They mentioned that he was talking about wishing he was
U µš šZ Ç š}o Ç}µ Z [• š ol o]l šZ š (}Œ Ç Œ•X ^, i
his father said.

You set at time to visit Jorge during his lunch break, and he tells you the following:

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Case Study: Jorge

Well once again I tried to kill myself, and once again I failed. More proof I can screw anything up. When I told my family I wanted to kill myself, they all laughed. I just went to my bedroom and hit myself on my head twelve times before I started to feel better. Right now, that is the only thing that makes me feel better at all. Work is no better. It reminds me of school where I was bullied since I was in the second grade. Every day is a living hell. I try to be friendly to people at work but no one is friendly back. I love helping people so much that I would give up my life](•}u }v v]šX µš (}Œ v}Á / (o]v•] X o}vP Œ (}Œ /[u }v šZ }µš•] • Á ooX

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Vignette

Janice is a 40-year-old person who has struggled with thoughts of suicide for many years. Recently, you helped her to find a new therapist at the local mental health center, after her previous therapist moved to a private practice and stopped accepting insurance payments. You agreed to accompany Janice to the first couple of meetings with the new therapist. After about 20 minutes, the topic of suicide comes up.

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Janice

43

Managing Your Reactions

- Power and control issues
- If šZ o] vš] •]š]• šZ Á}Œl Œ[• (
- An attempt may feel like betrayal to the professionals involved t especially if long-term relationship.
- Others

Michel & Jobes (2011)

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Emotional Reactions Lead to Mistakes

- Overreact and perhaps impose unnecessary external controls or reactions.
- Underreact and perhaps deny the need for protective measures.
- Reject or abandon the person.

Bryan (2014)

45

Thoughts on How to Manage Reactions

- Affect Management tools/skills
- D]vš]v -l^Ç}Á]•‰ ••]}v š u v}Œ_ (Walsh, 2012)
- ^E}š] _ }v[š iµ P Ç}µŒ Œ š]}v•
- Pay attention to your body language
- Monitor your breathing
- }v[š Á}ŒŒtÇegulor}supervision

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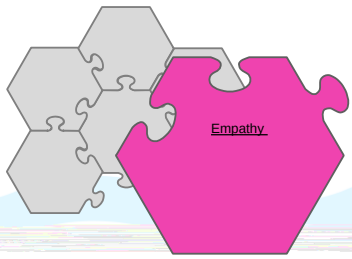
Module 4: Developing Empathy for the Suicidal Wish



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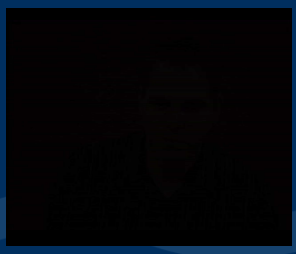
Craig Miller



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Imagine Being in So Much Pain that You Were
7 K L Q N L Q J $ E R X W (Q G L Q J < R X U

- ƒWould you tell anyone?
- ƒWhom would you tell?
- ƒHow would you tell them?
- ƒHow many times would you tell them?
- ƒt Z š](šZ Ç] v[š Œ •‰}v U Z vP
  or told you to stop being so dramatic?

Adapted from QPR Institute

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Why People Attempt Suicide

What mental health professionals have said:

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- ƒ^š} }uuµv] š Z}•š]o]šÇ_
- ƒ^š} (Œ]PZš v •}u }v _
- ƒ^š} u l •}u }v (o •}ŒŒÇ_
- ƒ^š} •Z}Á •‰ Œ š]}v_

What clients say:

- ƒ^ d} P š Œ o] ((Œ}u š ŒŒ] o •š š }(
- ƒ^ d} • ‰ (Œ}u v]u‰}••] o •]šµ š]}v_

www.aeschiconference.unibe.ch

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Different Goals

Social Worker: Keep child safe, focus on parent capacity,
‰ Œ À vš šZU }v[š P š o u

Suicidal person: Alleviate suffering/emotional distress

Adapted from Bryan (2014)

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7 K L V 'L V F U H S D Q F \ 5 H V X O W V

People not contacting providers when they are in
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Adolescents have a stronger reaction:

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- ƒ^/ Á]o o l ‰ uÇ]v v Œ šZ}µPZš• š}

www.aeschiconference.unibe.ch

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Resolving the Discrepancy

1) Understand that the person thinking of suicide
   v P P •] v Z Œ u (µ o Z À] } Œ • µ •
   • v • _ they work.
2) Recognize the functional purpose of the behaviors.
3) View the person as an individual with a unique set of issues and circumstances.
4) >] • š v š } š Z ‰ Œ • } v – • ^ • š } Œ Ç X _

Adapted from Bryan (2014)

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The Aeschi Approach

The clinician may be the expert on mental disorders but
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Æ ‰ t Œ š l and Jobes

K µ Œ š • l] • š } À o } ‰ ^ š Z Œ ‰ µ š] u ?
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Michel and Jobes (2011)

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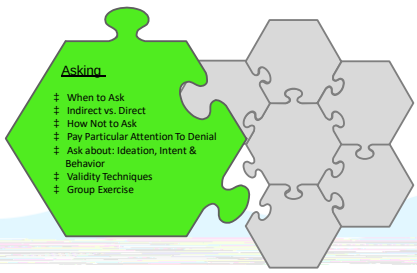
Module 5: Asking About Suicide



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When to Assess for Suicidal Thoughts/Behaviors

- ƒ At initial intake
- ƒ With any subsequent suicidal behavior
- ƒ Increased ideation
- ƒ With pertinent clinical change
- ƒ Transitions
  - ƒ Changes in living situations
  - ƒ Vacations
  - ƒ Rx Changes
- ƒ Discharge (inpatients)

Adapted from Jacobs (1999)

56

Indirect vs. Direct

Indirect:

ƒ^ } Ç}µ Á]•Z Ç}µ Á}µo P} š} •o ‰ v v
ƒ^ } Ç}µ Á]•Z Ç}µ Á Œ M_

Direct:

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Shea (2002)

57

How NOT to Ask the Question

"You're not thinking about suicide, are you?"

Quinnett (2000)

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Why Not?

"Have you thought about hurting yourself?"

Quinnett (2000)

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Looking Beyond Ideation

Why might someone deny suicidal ideation?

- ƒFear of loss of autonomy
- ƒFear of negative judgment or stigma
- ƒBelief that they cannot be helped
- ƒBelief that it is a sign of weakness
- ƒFear of disappointing others
- ƒUnclear wording of the question
- ƒPoor comprehension of the question
- ƒNot thinking of suicide at that moment

Adapted from Berman (2014)

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What to Ask: Ideation, Intent, & Behavior

Intent:

- Assess for evidence of wish to die
- Means to kill him/herself
- Understanding of the probable consequences of his/her actions

VA/DoD (2013)

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What to Ask: Ideation, Intent, & Behavior

Behavior:

Assess if the child/ adolescent has engaged in any actual behavior of preparation for engaging in self-directed violence.

VA/DoD (2013)

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Validity Techniques

- Normalization
- Gentle Assumption
- Symptom Amplification

Shea (2002)

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Validity Techniques: Normalization

^ ^ } u š] u • Á Z v ‰ } ‰ o (o • • crosses their mind to kill themselves. Have you had v Ç š Z } µ P Z š • o] l š Z š M _

^ ^ } u š] u • Á Z v ‰ } ‰ o (o • ‰ Œ do, they might feel they would rather be dead. Have Ç } µ À Œ (o š š Z š Á Ç Y M _

Shea (2002)

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Validity Techniques: Gentle Assumption

Rather than:

^, À Ç}µ šZ}µPZš }µš }šZ Œ Á Ç•

Instead:

^tZ š }šZ Œ Á Ç• Z À Ç}µ šZ}µPZš Ç}µŒ• o(M_

Shea (2002)

65

Validity Techniques: Symptom Amplification

^z}µ u vš]}v Ç}µ šZ]vl }µš •µ]]

How many times a day do you think about it?... 50

š]u • ÇM íìì š]u • ÇM_

Shea (2002)

66

3UDFWLFH $VNLQJ WKH 4XHVW

You are out for a walk with Jorge during a visit. He • u• }Áv µš ÁZ v Ç}µ •lU Z • Ç•U š]Œ X /[u š]Œ oo šZ š]u X_ , u been engaging in a few incidents of hitting himself on the head after not doing so for several months. He further says he is really getting tired of arguing with his parents and is worried he may be doing poorly at his supported work placement.

Shea (2002)

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Group Exercise

- Vignette
- Pair up t one person is Jorge, one is Service Coordinator
- Ask directly about suicide
- Employ at least two Validity Techniques:
  - Normalization
  - Gentle Assumption
  - Symptom Amplification
- Switch roles

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Collateral Sources

Try not to do your assessment in a vacuum! What are your usual sources for collateral information?

- Previous Emergency Service summary
- Contact with therapists
- Contact with PCP
- Family/friends
- Schools/Clubs/Etc Y

Possible challenges/obstacles in accessing collateral information?

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Module 7: Describing Risk and Recommendations

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When a therapist describes risk, they should be considering:

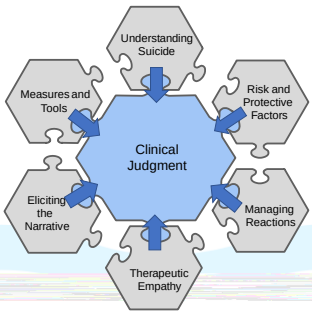
Low?

Moderate?

High?

Chronic?

Acute?



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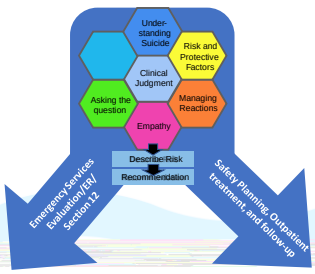
Now What? For DDS Professionals:



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Understanding Risk and Recommendations

Risk Level	Risk/Protective Factors	Suicidal Thoughts/Behaviors	Possible Interventions
High	Psychiatric disorders w/ severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan but no intent or behavior	Admission may be necessary depending on risk factors. Safety Plan.
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction, Safety Plan

This chart is intended to represent a range of risk levels and interventions, not actual determinations.

Adapted from Jacobs (2007)

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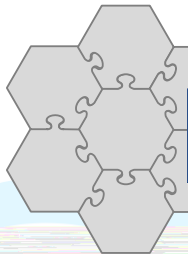
Module 8: Suicide Safety Planning



Crisis Intervention & Safety Planning

- Crisis Intervention Techniques
- Safety Planning
- Safety Planning Activity/Discussion

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Principles of Suicidal Crisis Intervention

- Restricting access
- Decreasing isolation
- Decreasing agitation
- Providing/increasing structure
- Providing hope and reality testing
- Developing a suicide safety plan (different from SDM safety plan)

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«6R SURPLVH PH \RX ZRQ·W NLO

- Safety planning vs. contracting for safety
- No-suicide contracts ask patients to promise to stay alive without telling them how to stay alive.
- No-suicide contracts may provide a false sense of assurance to the clinician.
- E} À] v ^v} •µ]] _ }všŒ š• Á}Œl

Stanley & Brown (2011)

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Suicide Safety Planning

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Suicide Safety Plan: What is It? How Can You Help Support It?

- Hierarchically-arranged list of coping strategies for use during a suicidal crisis or when suicidal urges emerge
- Written document
- Brief, easy-to-read format
- / v o] v š [• } Á v Á } Œ •
- Collaboratively developed with the client in any clinical or therapeutic setting. Families and DDS staff may provide input.

Stanley & Brown (2011); Brown & Wenzel (2011)

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Safety Planning: When is It Appropriate?

- A safety plan may be done at any point during the assessment or treatment process
- Usually follows a suicide risk assessment
- A safety plan may not be appropriate when patients are at imminent suicide risk or have profound cognitive impairment.
- ‰ š š Z ‰ ‰ Œ } Z š } š Z such as] v š [• involving family members in using the safety plan.

Stanley & Brown (2011)

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Overview of Safety Planning: 6 Steps

1. Recognizing warning signs
2. Employing internal coping strategies without needing to contact another person
3. Socializing with family members or others who may offer support as well as distraction from the crisis
4. Contacting family members or friends who may help to resolve a crisis
5. Contacting mental health professionals or agencies.
6. Reducing the potential use of lethal means

Additional question:
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Stanley & Brown (2011)

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Step 1: Recognizing Warning Signs

- A safety plan is only useful if the client can recognize the warning signs
  v • Œ] š Z ^ Œ _ } (š Z] Œ Œ] • • X
- *"How will you know when you need to use your safety plan?" How can caregivers help identify when to use?*
- *"What do you experience when you start to think about suicide or feel extremely distressed?"*
- Examples
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  - / u P • W ^ & o • Z l • _
  - D } } W ^ & o] v P ‰ Œ • • _
  - Z À] } Œ Ç] ^ v P _ ^ / u Ç o š] (v _ P ^ h Œ] µ P • _

Stanley & Brown (2011)

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Step 2: Using Internal Coping Strategies

- List activities that person can do by themselves.
- Activities function as a way to help people take their minds off their problems and promote meaning in their life.
- *"How likely do you think it is that you would be able to do this during a time of crisis?"*
- *"What might stand in the way of you thinking of these activities or doing them if you think of them?"*
- Use a collaborative, problem solving approach to address potential roadblocks.

Go for a walk	Listen to music
Take a hot shower	Walk the dog

Stanley & Brown (2011)

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Step 3: Using External Strategies: Socializing with Family Members or Others

- Coach clients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Family, friends, or acquaintances who may offer support and distraction from the crisis
- *"Who helps you take your mind off your problems at least for a little while?"*
- *"Who do you enjoy socializing with?"*
- Ask clients to list several people, in case they cannot reach the first person on the list.

Stanley & Brown (2011)

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Step 4: Seeking Support: Contacting Family Members or Friends for Help

- Coach clients to use Step 4 if Step 3 does not resolve the crisis or lower risk.
- *"How likely would you be to contact these individuals?"*
- Identify potential obstacles and problem solve ways to overcome them.

Stanley & Brown (2011)

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Step 5: Contacting Professionals and Agencies

- Coach clients or caregivers to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- *"Which clinicians should be on your safety plan?"*
- Identify potential obstacles and develop ways to overcome them.
- List names, numbers and/or locations of:
  - Clinicians
  - Local urgent care services
  - Text lines/ helplines

Stanley & Brown (2011)

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Step 6: Reducing the Potential for Use of Lethal Means

- Ask clients/ (caregivers) what means/method they would consider using during a suicidal crisis.
  - Regardless, the social worker should always ask client and caregivers whether the client has access to a firearm.
- For methods with low lethality, clinicians may ask adult clients to remove or restrict their access to these methods themselves.
  - For example, if patients are considering overdosing, discuss throwing out any unnecessary medication, using lockbox, etc.
- For methods with high lethality, collaboratively identify ways for a responsible person (eg: caregivers) to secure or limit access.
  - For example, if clients are considering shooting themselves, suggest that they ask a trusted family member to store any gun that is in the home in a secure place- preferably outside the home.

Stanley & Brown (2011)

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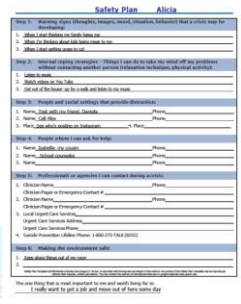
Safety Plan Alicia

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

1. When I start thinking no body takes me
2. When I'm thinking about kids being mean to me
3. When I start getting urges to cut

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

1. Listen to music
2. Watch videos on You Tube
3. Get out of the house- go for a walk and listen to my music

Step 3: People and social settings that provide distraction

1. Name: Toad- walk my friend, Daniella Phone:
2. Name: Call Alex Phone:
3. Plan: See alex's outfits on Instagram 4. Plan:

Step 4: People whom I can ask for help

1. Name: Isabella- my cousin Phone:
2. Name: School counselor 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. Keep share things out of my room
2.

Make the home environment safe by removing or locking away any lethal means (firearms, medications, sharp objects, etc.) that could be used to attempt suicide. Ask friends to remove any lethal means that they have in their homes (e.g., guns, medications) that you are unable to remove from your own home.

The one thing that is most important to me and worth living for is:
I really want to get a job and move out of here some day

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Implementation: What is the Likelihood of Use?

- *"Where will you keep your safety plan?"*
- *"How likely is it that you will use the Safety Plan when you notice the warning signs that we have discussed?"*
- *"What might get in the way or serve as a barrier to your using the safety plan?"*
  - Help the client find ways to overcome these barriers.
- May be adapted for brief crisis cards, cell phones or other portable electronic devices must be readily accessible and easy-to-use.
- As part of SDM tool- can caregiver support and keep child/adolescent safe?

Stanley & Brown (2011)

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Safety Plan Implementation

- Periodically review, discuss, and possibly revise the safety plan after each time it is used.
- The plan is not a static document.
- / š •Z}µo Œ À]• • šZ o] vš•[ ]Œ needs change over time.
- Decide with whom and how to share the safety plan. Involve DDS/ therapist/ school/ family
- Discuss the location of the safety plan.
- Discuss how it should be used during a crisis.

Stanley & Brown (2011)

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Safety Planning Practice

Jorge: is a25 year oldwho has recently been talking with you about thoughts of suicide. He was hospitalized as an adolescent for a suicide attempt.

- One person is Jorge and the other is the Service Coordinator
- Practice collaboratively developing a safety plan.
- Switch roles. (when halfway, switch but continue from where you left off)

Stanley & Brown (2011)

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Case Study: Jorge

Well once again I tried to kill myself, and once again I failed. More proof I can screw anything up. When I told my family I wanted to kill myself, they all laughed. I just went to my bedroom and hit myself on my head twelve times before I started to feel better. Right now, that is the only thing that makes me feel better at all. Work is no better. It reminds me of school where I was bullied since I was in the second grade. Every day is a living hell. I try to be friendly to people at work but no one is friendly back. I love helping people so much that I would give up my life if someone needed it. But for now / (o]v•] X /š Á}v[š o}vP Œ (}Œ /[u }v šZ }µš•] • Á ooX

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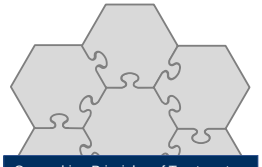
Module 9: Overarching Principles of Treatment



Overarching Principles of Treatment

- Spectrum of Intervention
- Targeting Suicide as Focus of Tx
- Symptom Matching
- Modalities: CBT, DBT, MI
- Enhancing Resilience

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Targeting Suicide as the Focus of Treatment

Traditional Treatment:

- Inpatient hospitalization
- Treating the psychiatric disorder
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Collaborative Approaches to Suicide Treatment:

- Intensive outpatient care that is suicide-specific
- Emphasizes the development of other means of coping and problem-•}oÀ]vP šZ Œ Ç •Ç•š u š] ooÇ o]u]v š]vP šZ

Jobes (2006)

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Symptom Matching / Distillation of Risk Factors

Symptom	Intervention
Insomnia	***Sleep hygiene, Stimulus control***
Anhedoniaor Sadness	***Behavioral activation***
Agitation	***Relaxation, Exercise, Benzodiazepines***
Loneliness	***Behavioral activation w/ an interpersonal focus***
Hopelessness	***Engage in pleasant activities***
Anxiety	***Exercise, Distraction***

Adapted from Joiner, et al. (2009)

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Interventions / Approaches

- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Motivational Interviewing
- Collaborative Assessment and Management of Suicidality (CAMS)
- Attachment-Based Family Therapy
- Pharmacotherapy

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Virtual Hope Box

Focuses the user on cherished memories, reminders in digital media: Photos, videos, recorded messages, music.

Distraction pieces for the user: Activity Planner, and puzzles/word search games taken from user content.

Relaxation pieces, such as a deep breathing tool, progressive muscle relaxation, etc.

User customized support contacts, hotline info.

Preloaded inspirational quotes can be supplemented or replaced by personal quotes, family aphorisms, biblical phrases, etc.

Coping Cards highlight adaptive thoughts and behaviors when in crisis or managing problematic core beliefs.

msrc.fsu.edu/funded-research/improved-virtual-hope-box

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Pharmacotherapy

- Evidence for medicine is limited: most clinical trials exclude suicidal patients
- Psychopharm interventions are helpful in managing underlying disorders
- Must be targeted to a specific diagnosis
- All medicines used by at-risk clients should be reviewed for lethality, side effects (ie t black box warning)
- Clients of all ages t esp 18-24 t started on any medicine should be monitored closely for emergence or worsening of suicidal thoughts or behaviors during the initial trial period
- Consider limiting quantities in cases where there is a risk of overdose- how do you support safety?

VA/DoD (2013)

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Pharmacotherapy

- Antidepressants may provide benefit to address suicidal behavior in clients with mood disorders
- Lithium is particularly effective in reducing suicide risk for those with bi-polar disorder
- Clozapine should be considered for those clients with schizophrenia at high risk of suicide
- Anti-anxiety agents may have the potential to decrease suicide risk for those clients with anxiety but require extreme caution (due to risk of overdose as well as possibility for disinhibition)

VA/DoD (2013)

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Key Goals for Prevention and Protection

+ PROSOCIALITY

Supportive social networks
Empathy and concern about the welfare and rights of others

- TOXIC INFLUENCES

Biological, Psychological, Social, Environmental, Cultural

+ CORE CAPABILITIES

Executive Functioning - Problem solving, response inhibition, working memory, task switching, etc.
Self-Regulation t Psychological flexibility, managing emotions, etc.

Adapted from Center on the Developing Child (2017); Biglan, et al. (2012)

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Key Goals for Prevention and Protection

- Reduce Pain
- Increase Hope
- Increase Connections
- Decrease Capability

Klonsky & May (2015)

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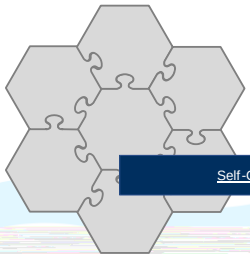
Module 12: Compassion Fatigue and Self -Care



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Self-Care as an Ethical Obligation

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- Malcolm X

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- Charlie Parker

VA/DoD (2013)

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Self-Care the 3Rs

1) Reflection
- d l š]u š} Œ G š }v šZ o] vš• Ç}µ Œ Á}ŒI]vP Á]šZU Ç}µŒ assistance that you might need
- What are they doing, and why? What is their behavior telling you?

2) Regulation
- Acknowledge and regulate the reactions that working with suicidal clients might evoke in you
- Be aware that strong emotions are contagious
- Know what your own trigger points are and what upsets you
- Take time to calm yourself when you do get angry or hurt and ask for help and debrief when necessary

3) Relaxation
- D l š]u (}Œ Ç}µŒ• o(š} Œ ›o Ç_
- Maintain/develop your social support system
- Maintain a sense of humor
- Be patient and realistic with yourself

Reminder: Take Care of Myself

Adapted from State of Victoria, Child Safety Commissioner (2007)

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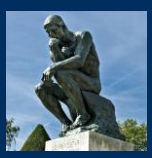
The Takeaway



Your takeaways?

New learnings?

What have you been doing that was reinforced?

Something you want to change in your work?

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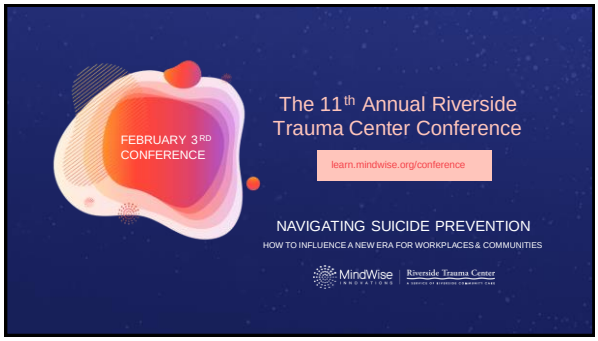
FEBRUARY 3RD
CONFERENCE
The 11th Annual Riverside
Trauma Center Conference
learn.mindwise.org/conference
NAVIGATING SUICIDE PREVENTION
HOW TO INFLUENCE A NEW ERA FOR WORKPLACES & COMMUNITIES
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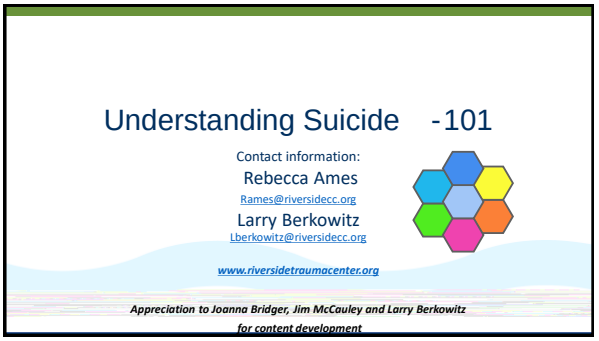
Understanding Suicide -101
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Appreciation to Joanna Bridger, Jim McCauley and Larry Berkowitz
for content development

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