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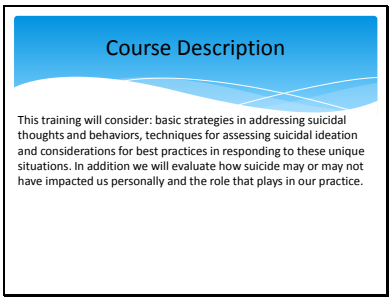

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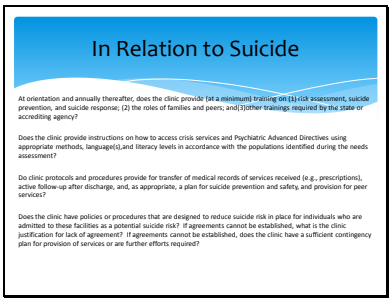

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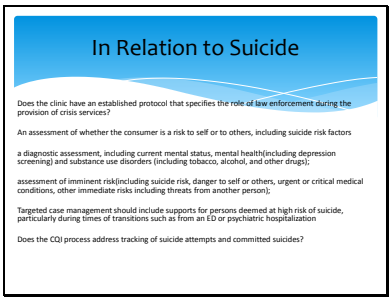

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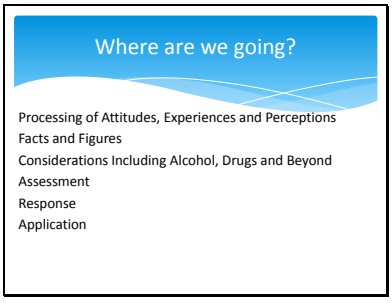

Slide 7

Practice, Practice, Practice

Remember the first substance abuse client you interviewed? Do you remember your internal reaction to that interview? Now, you're a lot more comfortable talking with clients about their drug history, their current symptoms, and their plans for recovery. Nothing reduces anxiety more than practice. The same holds true about talking with your clients about suicidal thoughts and behaviors. If you need to reduce your initial discomfort on the topic, practice with another counselor or your clinical supervisor. Get feedback about how you are coming across. Start asking every one of your clients about suicidality. The more experience you have, the more comfortable you will become.(TIP 50)

Slide 8

Processing

Why this matters…

Slide 9

Attitude Considerations:

…your attitudes about suicide are strongly influenced by your life experiences with suicide and similar events. Needless to say, your responses to suicide and to people who are suicidal are highly susceptible to attitudinal influence, and these attitudes play a critical role in work with people who are suicidal. An empathic attitude can assist you in engaging and understanding people in a suicidal crisis. A negative attitude can cause you to miss opportunities to offer hope and help or to overreact to people in a suicidal crisis. (TIP 50)

Slide 10

Processing of Attitudes, Experiences and Perceptions

Objectives: Minimize anxiety about discussing suicide.

Explore attitude toward suicide and potential for personal and professional impact.

What is my personal and family history with suicidal thoughts and behaviors?

What personal experiences do I have with suicide or suicide attempts, and how do they affect my work with suicidal clients?

What is my emotional reaction to clients who are suicidal?

How do I feel when talking to clients about their suicidal thoughts and behaviors?

What did I learn about suicide in my formative years?

How does what I learned then affect how I relate today to people who are suicidal, and how do I feel about clients who are suicidal?

What beliefs and attitudes do I hold today that might limit me in working with people who are suicidal?

Slide 11

TIP 50's 6 Positive Attitudes and Behaviors to Consider

Positive Attitude and Behavior 1: People in substance abuse treatment settings often need additional services to ensure their safety.

Positive Attitude and Behavior 2: All clients should be screened for suicidal thoughts and behaviors as a matter of routine.

Positive Attitude and Behavior 3: All expressions of suicidality indicate significant distress and heightened vulnerability that require further questioning and action.

Slide 12

TIP 50's 6 Positive Attitudes and Behaviors to Consider

Positive Attitude and Behavior 4: Warning signs for suicide can be indirect; you need to develop a heightened sensitivity to these cues.

Positive Attitude and Behavior 5: Talking about a client's past suicidal behavior can provide information about triggers for suicidal behavior.

Positive Attitude and Behavior 6: You should give clients who are at risk of suicide the telephone number of a suicide hotline; it does no harm and could actually save a life.

Slide 13

Application

Now that we have processed attitudes, experiences and perceptions what is a professional consideration for you moving forward?

Slide 14

Facts and Figures

Objectives:

Consider intentionality when working with all clients and unique risk factors for specific populations.

Create awareness of the number of suicides and the impact on society and others.

Slide 15

Facts and Figures

Suicide is a leading cause of death among people who abuse alcohol and drugs (Wilcox, Conner, & Caine, 2004).

Compared to the general population, individuals treated for alcohol abuse or dependence are at about 10 times greater risk to eventually die by suicide compared with the general population, and people who inject drugs are at about 14 times greater risk for eventual suicide (Wilcox et al., 2004).

Individuals with substance use disorders are also at elevated risk for suicidal ideation and suicide attempts (Kessler, Borges, & Walters, 1999).

Slide 16

People with substance use disorders who are in treatment are at especially high risk of suicidal behavior for many reasons, including:

They enter treatment at a point when their substance abuse is out of control, increasing a variety of risk factors for suicide (Ross, Teesson, Darke, Lynskey, Ali, Ritter, et al., 2005).

They enter treatment when a number of co-occurring life crises may be occurring (e.g., marital, legal, job) (Ross et al., 2005).

They enter treatment at peaks in depressive symptoms (Ross et al., 2005).

Slide 17

People with substance use disorders who are in treatment are at especially high risk of suicidal behavior for many reasons, including:

Mental health problems (e.g., depression, posttraumatic stress disorder [PTSD], anxiety disorders, some personality disorders) associated with suicidality often co-occur among people who have been treated for substance use disorders.

Crises that are known to increase suicide risk sometimes occur during treatment (e.g., relapse and treatment transitions).

What else might increase suicide risk among people with substance use disorders?

Slide 18

Additional Facts and Figures About Suicide

Suicide is the 10th leading cause of death, claiming more than twice as many lives each year as does homicide.[1]

On average, between 2001 and 2009, more than 33,000 Americans died each year as a result of suicide, which is more than 1 person every 15 minutes.[1]

More than 8 million adults report having serious thoughts of suicide in the past year, 2.5 million report making a suicide plan in the past year, and 1.1 million report a suicide attempt in the past year.[3]

Almost 16 percent of students in grades 9 to 12 report having seriously considered suicide, and 7.8 percent report having attempted suicide one or more times in the past 12 months.[4]

Slide 19

Additional Facts and Figures About Suicide

Despite these very personal experiences, most Americans are surprised to learn that between 2001 and 2009, an average of 33,000 suicide deaths occurred each year in the United States. Suicide is among the top five causes of death for adults under age 45 in the United States, and in 2009, more Americans died from suicide than from motor vehicle traffic-related injuries. (U.S. Dept of HHS)

After a decade of advancements in suicide prevention, we National Council for Suicide Prevention (NCSP) remain concerned that the nation is still in a period of rising suicide rates. Therefore, we believe that the timing for a revised National Strategy is right and that it offers an improved framework for achieving our ultimate goal of saving lives. (U.S. Dept of HHS)

Slide 20

Additional Facts and Figures About Suicide

The effect of suicide on communities across our nation goes beyond the personal. Suicide affects some of the most important concerns of our time. Suicide among those who serve in our Armed Forces and among our veterans has been a matter of national concern. The largest number of suicidal deaths each year occurs among middle-aged men and women, sapping the workforce we need to grow our economy. The fact that suicidal behavior occurs among some of our most marginalized citizens is a call to action we must embrace. (U.S. Dept HHS)

Slide 21

Application

Is there something you didn't know?

Is there something that surprised you?

Is there something that increased your awareness that could be used in professional application?

Slide 22

Considerations including alcohol, drugs and beyond.

Objectives:

Consider specific populations identified as being at higher risk for suicide.

Consider specific life events that may create a higher risk for suicide.

Slide 23

Except as noted, the following information on suicide risks in specific populations is from the:

2012 National Strategy for Suicide Prevention: GOALS AND OBJECTIVES FOR ACTION A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention

Emphasis has been added.

Slide 24

American Indians/Alaska Natives

In 2009, the suicide rate among American Indians/Alaska Natives (AI/AN) was 11.91 per 100,000, which is similar to the overall U.S. rate of 11.77. *However, suicide rates are much higher among AI/AN youth than among youth overall.* In 2009, the rate of suicide among AI/AN youth aged 10 to 18 years was 10.37 per 100,000, compared with an overall rate of 3.95 per 100,000. Suicide is the second leading cause of death among AI/AN youth aged 10 to 34 years, with young Native men aged 20 to 24 having the highest rate of suicide in the AI/AN population: 40.79 deaths per 100,000. Although suicide rates vary widely among individual tribes, it is estimated that 14 to 27 percent of AI/AN adolescents have attempted suicide.

Slide 25

American Indians/Alaska Natives

Research indicates that cultural continuity, high levels of cultural spiritual orientation, and connectedness to family and friends are protective factors for suicidal behaviors among AI/AN populations. *Specific risk factors particular to this group include alcohol and other substance use, discrimination, limited mental health services access and use, and historical trauma.* Findings from the Adverse Childhood Experiences (ACE) study suggest that there is a strong and positive correlation between the number of adverse events in a child's life and the probability for negative outcomes during adulthood. *In reservation settings, AI/AN youth have considerable exposure to suicide and may be at particular risk for contagion.* Much of the research available on AI/AN racial and ethnic disparities does not include urban (non-reservation) areas, where a majority (78 percent) of Native people in the United States live. Compared with other racial and ethnic groups, few resources are devoted to the health needs of the urban AI/AN population, and many have experienced losses of community, language, and ethnic identity.

Slide 26

Individuals Bereaved by Suicide

The impact of suicide can be profound and sometimes devastating for those who are left behind. *Each year, more than 13 million people in the United States report that they have known someone who died by suicide that year.* Conservative estimates suggest that there are typically at least five or six family members who are affected when a family member takes his or her life, and perhaps as many as 30 to 60 people in the larger social network who also may be affected. Moreover, exposure to suicide carries risks for elevated rates of guilt, depression, and other psychiatric symptoms, complicated grief, and social isolation. Alarmingly, there is also compelling evidence that individuals bereaved by suicide (also referred to as "survivors of suicide loss") may have an increased risk for suicide completion themselves. Therefore, to paraphrase Edwin Shneidman, helping those who have been bereaved by suicide is a direct form of suicide prevention with a population known to be at risk.

Slide 27

Individuals in Justice and Child Welfare Settings

Suicide is often the single most common cause of death in secure justice settings. More than 400 suicides occur annually in local jails at a rate three times greater than among the general population, and suicide is the third leading cause of death in prisons. Youth involved in the juvenile justice and child welfare systems have a high prevalence of many risk factors for suicide. Although statistics on prevalence are unavailable, juveniles in confinement have life histories that put them at higher suicide risk, including experiences such as mental disorders and substance abuse; physical, sexual, and emotional abuse; and current and prior self-injurious behavior. Youth in foster care share many of these traumatic experiences. In one study, children in foster care were almost three times more likely to have considered suicide and almost four times more likely to have attempted suicide than those who had never been in foster care. Suicide among youth in contact with the juvenile justice system occurs at a rate about four times greater than the rate among youth in the general population. Research suggests that youth engage in more than 17,000 incidents each year in juvenile facilities, that more than half of all detained youth reported current suicidal ideation, and that one-third also had a history of suicidal behaviors.

Slide 28

Individuals Who Engage in Nonsuicidal Self-Injury

Research of NSSI and DSH populations shows a relatively strong relationship between self-injury and suicidal behaviors. An Australian study found that approximately 30 percent of patients presenting with self-poisoning to an emergency department (ED) reported previous episodes of self-harm. Of patients who presented to the ED on more than one occasion, 3 percent died by suicide within 5 years and 4 percent within 10 years. In a follow-up study of deliberate self-harm conducted in the United Kingdom, death by suicide was 17 times more frequent than expected in those who had previously presented to a general hospital with deliberate self-harm. In another U.K. follow-up study of deliberate self-harm, there was an approximately 30-fold increase in risk of suicide compared with the general population. **Suicide rates were highest within the first 6 months after the first self-harm episode.** A systematic review of the international literature on fatal and nonfatal repetition of self-harm found that after 1 year, nonfatal repetition of self-harm behaviors was approximately 15 percent. The review found that suicide risk was hundreds of times higher among self-harm patients than in the general population.

Slide 29

Individuals Who Have Attempted Suicide

A previous suicide attempt is a known predictor of suicide death. A study of individuals who had survived a serious suicide attempt, conducted in New Zealand, found that almost half made another attempt or subsequently died by suicide within 5 years. Many individuals do not receive ongoing treatment or mental health care after an attempt, although they may continue to experience suicidal thoughts. In addition, a study conducted in the United Kingdom found that many people who die by suicide do so within 30 days of having been discharged from a hospital for a previous attempt, often before an appointment for services.

Slide 30

Individuals with Mental Disorders: Mood Disorders

More than 60 percent of suicidal deaths occur among individuals with mood disorders. Suicide risk is particularly high among individuals with bipolar disorders, which is strongly associated with suicide thoughts and behaviors. Over their lifetime, the vast majority (80 percent) of patients with bipolar disorders have either suicidal ideation or ideation plus suicide attempts. In clinical samples, 14 to 59 percent of the patients have suicide ideation, and 25 to 56 percent attempt suicide at least once in their lifetime. Approximately 15 to 19 percent of patients with bipolar disorders die from suicide. The suicide rate among patients with bipolar disorders is estimated to be more than 25 times higher than the rate in the general population.

Several factors can increase the risk for suicide among patients who have mood disorders. These factors include a recent suicide attempt and a severe major depressive episode, often accompanied by feelings of hopelessness and guilt, a belief that that are few reasons for living, thoughts of suicide, agitation, insomnia, appetite and weight loss, and psychotic features. Suicidal behaviors among mood disorder patients occur almost exclusively during an acute, severe, major depressive episode.

Slide 31

Individuals with Mental Disorders: Anxiety Disorder

The presence of any anxiety disorder is significantly associated with suicidal ideation and suicide attempts. Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance abuse, which may mask anxiety symptoms or make them worse. The presence of any anxiety disorder in combination with a mood disorder is associated with a higher likelihood of suicide attempts in comparison with a mood disorder alone. Among adults in the general population (i.e., not in the Armed Forces or veterans), panic disorder and PTSD have been found to be more strongly associated with suicide attempts when there is a co-occurring personality disorder.

Slide 32

Individuals with Mental Disorders: Borderline Personality Disorder

It has been estimated that between 3 and 10 percent of patients with BPD die by suicide. Recurrent suicide attempts, self-injury, and impulsive aggressive acts are often associated with BPD and often result in emergency and inpatient treatment. Suicides in BPD often occur late in the course of the illness and follow long courses of unsuccessful treatment.

Slide 33

Individuals with Mental Disorders: Schizophrenia

The risk for suicide in individuals suffering from schizophrenia is particularly high in the early stages of the illness (first 3–5 years of onset). A meta-analysis of more than 60 studies found that almost 5 percent of schizophrenic patients will die by suicide during their lifetimes, usually near the onset of the illness. Surviving the initial period of heightened risk results in a lesser, although still considerable, risk of death by suicide.

The greatest indicator of suicide risk among people with schizophrenia is active psychotic illness (e.g., delusions) combined with symptoms of depression. Greater insight into the psychotic illness itself, the need for treatment, and the consequences of the disorder are strongly related to suicide risk. Increased risk for suicide is also associated with higher levels of education and higher socioeconomic status. Alcohol abuse has been reported in studies examining suicide attempts.

Slide 34

Lesbian, Gay, Bisexual, and Transgender Populations

Studies over the last four decades suggest that LGBT individuals may have an elevated risk for suicide ideation and attempts. Attention to this disparity has been limited, in part because neither the U.S. death certificate nor the NVDRS identify decedents' sexual orientation or gender identity. Thus, it is not known whether LGBT people die by suicide at higher rates than comparable heterosexual people.

Slide 35

Lesbian, Gay, Bisexual, and Transgender Populations

Across many different countries, a strong and consistent relationship between sexual orientation and nonfatal suicidal behavior has been observed. A meta-analysis of 25 international population-based studies found the lifetime prevalence of suicide attempts in gay and bisexual male adolescents and adults was four times that of comparable heterosexual males. Lifetime suicide attempt rates among lesbian and bisexual females were almost twice those of heterosexual females. Lesbian, gay, and bisexual (LGB) adolescents and adults were also found to be almost twice as likely as heterosexuals to report a suicide attempt in the past year. A later meta-analysis of adolescent studies concluded that LGB youth were three times more likely to report a lifetime suicide attempt than heterosexual youth, and four times as likely to make a medically serious attempt. Across studies, 12 to 19 percent of LGB adults report making a suicide attempt, compared with less than 5 percent of all U.S. adults; and at least 30 percent of LGB adolescents report attempts, compared with 8 to 10 percent of all adolescents. To date, population-based studies have not identified transgender participants, but numerous nonrandom surveys show high rates of suicidal behavior in that population, with 41 percent of adult respondents to the 2009 National Transgender Discrimination Survey reporting lifetime suicide attempts.

Slide 36

Lesbian, Gay, Bisexual, and Transgender Populations

Most studies have found suicide attempt rates to be higher in gay/bisexual males than in lesbian/bisexual women, which is the opposite of the gender pattern found in the general population. As in the overall population, there is some evidence that the frequency of suicide attempts may decrease as LGB adolescents move into adulthood, although patterns of suicide attempts across the lifespan of sexual minority people have not been conclusively studied. Within LGB samples, especially high suicide attempt rates have been reported among African American, Latino, Native American, and Asian American subgroups.

Slide 37

Members of the Armed Forces and Veterans

The suicide rate for active duty military personnel has historically been significantly lower than the rate for a comparable population of Americans. However, both the numbers and rates of suicide have been increasing over the past decade. In 2001, the U.S. Department of Defense (DoD) recorded 160 total suicides for a rate of 10.3 per 100,000. Suicide rates began to increase in 2006, driven primarily by a steady upward trend in the number of suicides in the Army and Marine Corps. In 2009, the DoD identified 309 total active duty suicides, for a rate of 18.3 per 100,000. The number of suicides has been on the rise in the Reserve Component (RC) as well. In 2009, there were 104 suicides of service members who were in the RC and not on active duty at the time of the event. In 2010, this number increased to 180, with the Army National Guard having the largest increase in the total number of suicides from 48 in 2009 to 101 in 2010.

Slide 38

Members of the Armed Forces and Veterans

For calendar year 2010, service members who were white and under the age of 25, junior enlisted (E1–E4), or high school educated were at increased risk for suicide relative to comparison groups in the general population. Service members most frequently used firearms as the means for suicide. Drug overdose was the most frequent method for suicide attempts, and the misuse of prescription medication was more frequent than illegal drugs. Most service members were not known to have communicated their potential for self-harm with others prior to suicide or attempted suicide. The majority of service members who died by suicide did not have a known history of a mental or substance use disorder. Finally, the overwhelming majority of suicides occurred in a nondeployed setting, and more than half of those who died by suicide did not have a history of deployment.

Slide 39

Members of the Armed Forces and Veterans

The Centers for Disease Control and Prevention (CDC) estimates that veterans account for approximately 20 percent of the deaths from suicide in America. There is controversy in the scientific literature about whether suicide rates are higher among veterans than among other Americans after controlling for sex, age, and minority status. However, rates appear to be increased among two important groups: veterans who have recently returned from service in Afghanistan and Iraq, and those who receive health care services from the Veterans Health Administration (VHA), the health care system operated by the U.S. Department of Veterans Affairs (VA). In the most recent years for which data are available, suicide rates for male VHA patients were approximately 1.4 times greater than for other American men. For female VHA patients, rates were approximately twice as high as among American women. Both increases reflect the higher rates of medical and mental health conditions, disability, and other risk factors for suicide that occur among VHA patients. In VHA, as in DoD, firearms represented the most common means for suicide and overdoses represented the most common means for attempts. Approximately half of all suicides in VHA occurred among patients known to have mental health conditions. An increase in the suicide rate among returning veterans first appeared in 2006, and rates continue to be monitored closely. The rates as observed echo the increase that occurred for the first few years after veterans returned from service in Vietnam.

Slide 40

Men in Midlife

While suicide rates have tended to decrease or remain stable for most age groups in the past two decades, suicides in middle adulthood have increased. Men in their adult years, from their early 20s through their 50s, account for the bulk of suicides and the majority of years of life lost due to suicide. Yet there has been little research on this demographic group, when compared with the number of studies conducted with adolescents and older adults.

Slide 41

Men in Midlife

Although research exploring the recent surge in suicide in midlife is lacking, existing studies suggest that the factors that may increase the risk for suicidal behaviors in this group are similar to those among other age groups and in both sexes: mental illness that can be discerned from retrospective analyses (particularly mood disorders), substance use disorders (particularly alcohol abuse), and access to lethal means. However, these factors are likely to be exacerbated by other risk-related characteristics that occur more frequently among males, such as the underreporting of mental health problems, a reluctance to seek help, engagement in interpersonal violence, distress from economic hardship (e.g., unemployment), and dissolution of intimate relationships.

Slide 42

Older Men

Older men, in particular those who are white, have disproportionately high rates of death by suicide. In 2009, the rate of death by suicide among older white men was 30.15 per 100,000—almost three times the rate among the general population (11.77 per 100,000). Several factors can increase the risk for suicidal behaviors among older men, including the presence of a mental disorder. Research suggests that older adults who die by suicide are more likely to meet criteria for affective disorders (especially major depressive disorder) than younger adults. Other important risk factors include physical illness and functional decline. Finally, an extensive body of literature indicates that social disconnection increases risk for death by suicide in older men.

Slide 43

Older Men

Suicide in late life is qualitatively different than in younger adults. Older adults are more likely than younger adults to die by suicide as a result of their first suicide attempt, in part because older adults are more likely than younger adults to use highly lethal means to attempt suicide. Another important difference is that older adults are less likely than younger adults either to have reported suicidal ideation or to have sought mental health treatment prior to their deaths. Interestingly, however, research suggests that most older adults who die by suicide are seen by primary care physicians in the last three months of life.

Although many suicide prevention efforts have targeted youth, older adults have also become a focus of suicide prevention. Since 2001, many national and regional conferences have featured the topic, and many states have broadened or are in the process of broadening their suicide prevention strategies to include older adults. Some states (e.g., Oregon and Maine) have separate plans for this age group. Mental health parity for Medicare is now being phased in so that seniors in the United States will have the same copay (20 percent) for mental health care as for physical health care.

Slide 44

Individuals With Medical Conditions

Several physical illnesses are associated with an increased risk for suicidal behaviors. The factors that may help explain this increased risk vary by medical condition but can include chronic pain, cognitive changes that make it difficult to make decisions and solve problems, and the challenges and emotional toll that can be associated with long-term conditions and limitations.

Slide 45

Individuals With Medical Conditions

Cancer is one of the most common physical illnesses associated with elevated suicide risk. The National Cancer Institute has identified cancers of the mouth, throat, and lung as risk factors for suicidal behaviors. While suicide risk tends to be highest in the first few months after diagnosis, risk remains elevated in the first 5 years. Fear associated with how the disease is perceived and managed, rather than the fear of death itself, is a frequent precipitator of suicidal behaviors. The consequences or side effects of treatment can also result in psychological problems. Fatigue and/or exhaustion, some of the most frequently reported side effects of cancer treatments, can be a risk factor for suicidal behaviors. In addition, depression and anxiety are common in cancer patients. About 63 to 85 percent of individuals with cancer who die by suicide meet criteria for severe depression, anxiety, and thought disorder. It is not always clear whether these types of mental disorders are triggered by the disease, occur as a consequence of the disease, or are an adverse effect of the treatment itself.

Slide 46

Individuals With Medical Conditions

Overall there is strong evidence that psychological and social factors (e.g. comorbid depression, hopelessness, loss of dignity, and the impact of spiritual beliefs), rather than the physical ones (e.g. functional status and level of pain control), are the chief determinants of the desire to hasten death. (Maytal and Stern 2006)

Slide 47

Individuals With Medical Conditions

Degenerative Diseases of the Central Nervous System

The prevalence of suicide is believed to be two to four times greater in individuals with Huntington disease than among the general population. The lifetime history of suicide attempts ranges from 4.8 to 17.7 percent. Major depressive disorder may be present in up to half of patients with Huntington's disease and is thought to be a consequence of the disease itself, rather than a psychological reaction to having a serious illness. In addition, anxiety disorders, obsessive-compulsive disorders, psychosis, mania, aggression, irritability, impulsivity, and personality changes have all been reported in patients with the disease.

Slide 48

Individuals With Medical Conditions

Multiple Sclerosis: Studies confirm an increased risk of suicide among patients with multiple sclerosis. Lifetime prevalence rates of depression range from 37 to 54 percent, and the prevalence rate of depression is almost three times the lifetime prevalence reported in the general population. Generalized anxiety disorder, panic disorder, and bipolar affective disorder (manic episodes) are also present more frequently in these patients.

Slide 49

Individuals With Medical Conditions

Parkinson's disease is often associated with one or more psychiatric or cognitive disorders, such as depression, psychosis, and dementia. Most of the observations support the hypothesis that depression is a primary consequence of brain dysfunction, although situational factors may contribute to mood changes to some extent. Suicide and suicide attempts are uncommon despite the fact that the rates of suicidal ideation are elevated. Depression seems to be the most important predictor of suicide ideation.

Slide 50

Individuals With Medical Conditions

Traumatic Injuries of the Central Nervous System: Suicide and suicide attempts occur more frequently in those with spinal cord injuries (SCI) than in the general population. People with SCI are five times as likely to experience depression compared with the general population, and the rates of depression following a traumatic spinal cord injury may be as high as 45 percent. Others have found that 10 to 13 percent of SCI patients suffer from anxiety and high levels of post-traumatic stress disorder.

Traumatic Brain Injury: People with moderate to severe traumatic brain injury (TBI) may have widespread cognitive impairment that can affect attention, memory, executive functioning, language and communication, visual-spatial skills, and processing speed. TBI survivors may also have perceptual deficits and motor deficits. Executive brain dysfunction is a contributing factor related to suicidal behaviors. A review of the literature found that on the whole, there is an increased risk of death by suicide(three to four times greater for those with severe TBI), a higher frequency of attempts, and clinically significant suicidal ideation in 21 to 22 percent of the TBI population.

Slide 51

Individuals With Medical Conditions

In general, patients with migraine are two to four times more likely to develop depression, two to six times more likely to develop general anxiety disorder, five times more likely to develop obsessive-compulsive disorder, and up to seven times more likely to develop panic disorder than the general population. Furthermore, depressed patients are about three times more likely to develop migraine in their lifetime. Migraine with an aura is believed to have a stronger association with psychiatric conditions than migraine without an aura. The relationship between migraine and depression and anxiety appears to be bidirectional, with each increasing the risk of the other condition. The risk of suicide ideation and attempts is higher among migraine patients, especially in those who have migraine with aura.

Slide 52

Individuals With Medical Conditions

HIV/AIDS Most studies among individuals living with HIV report lifetime prevalence of suicide attempts that range from 22 to 50 percent. Individuals with AIDS were 44 times more likely to attempt suicide than those without AIDS.

While most studies report that persons living with HIV/AIDS have much higher suicide rates than the general population or those with other life-threatening illnesses, studies have reported no significant differences in suicide rates between HIV-infected individuals and other groups at risk for suicide, such as injection drug users and psychiatric patients. Hence, HIV status may not be the most relevant factor related to suicide, but rather that other suicide risk factors that are common among HIV-infected individuals play a more important role. Studies have shown that suicide attempts and suicide ideation among people with HIV occur most often in those who have a previous psychiatric history and other social and environmental risk factors for suicide. Mood, anxiety, substance abuse, and personality disorders are prevalent among those with HIV.

Slide 53

Individuals With Medical Conditions

Chronic Kidney Disease

The following psychiatric disorders have been frequently observed in patients with severe end-stage kidney disease who require hemodialysis: affective disorders, dementia and delirium, drug-related disorders (e.g., alcohol dependence), schizophrenia and other psychoses, and personality disorders. The prevalence of depressive disorders in hemodialysis patients is estimated at 20 to 30 percent, with a rate of 10 percent for major depression. Hemodialysis patients with major depressive disorder commonly demonstrate a sense of hopelessness, as well as lack of pleasure and energy, and other depressive symptoms. This subset of patients has been noted to be the most likely to request withdrawal from hemodialysis.

Slide 54

Individuals With Medical Conditions

Arthritis

Arthritic disorders often co-occur with other physical conditions, especially chronic pain conditions including back pain, migraine, and other chronic headaches. The association between arthritis and problems such as anxiety, substance use, and personality disorders has been demonstrated in large, population-based studies. The relationship between arthritis and suicidal behavior may be largely explained by comorbid mental health disorders alone or in combination with other factors such as level of pain and/or disability that are associated with a lower quality of life.

Slide 55

Individuals With Medical Conditions

Asthma

Adolescents with asthma are more likely to report depressive symptoms, panic attacks, suicide ideation and behavior, and substance abuse when compared with those without asthma. It is not clear whether the association between asthma and depressive and anxiety disorders, as well as with suicidal ideation and behavior, results from a shared underlying process or from shared risk factors.

Slide 56

Substance Use Disorders

About 8.5 percent of U.S. adults are estimated to have an alcohol use disorder, which includes alcohol dependence and alcohol abuse. About one-fourth of all the suicides in the United States are estimated to occur among individuals with alcohol use disorders. Acute (e.g., binge drinking episodes) and chronic use of alcohol are associated with suicidal behaviors. Among individuals with alcohol use disorders, suicide frequently takes place within the context of a major depression and interpersonal stressors. Aggression, impulsivity, hopelessness, and partner-relationship disruptions are also risk factors. Studies have shown that depression is present in 45 percent to more than 70 percent of those with alcohol and substance use disorders who die by suicide.

Although less is known about the relationship between suicide risk and other drug use, the number of substances used seems to be more predictive of suicide than the types of substances used. Findings from a few initial studies suggest that treatment of drug abuse may help reduce the risk for future suicidal behaviors.

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Substance Use Disorders

SUDs and chronic substance use can lead to consequences and losses that contribute to suicide risk factors. Individuals in treatment for substance use disorders and/or transitioning between levels of care may be especially vulnerable. A large number of people in treatment have co-occurring mental disorders that increase suicide risk, particularly mood disorders. At the time these individuals enter treatment, their substance abuse may be out of control, they may be experiencing a number of life crises, and they may be at peaks in depressive symptoms. In addition, mental disorders associated with suicidal behaviors, such as mood disorders, PTSD, anxiety disorders, and some personality disorders, often co-occur among people who have been treated for substance use disorders. Crises that are known to increase suicide risk, such as relapse and treatment transitions, may occur during treatment. According to one study, compared with the general population, individuals treated for alcohol abuse or dependence have a 10 times greater risk of eventually dying by suicide. Among those who inject drugs, the risk is about 14 times greater than in the general population.

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Substance Use Disorders

Alcohol and drug abuse are second only to depression and other mood disorders as the most frequent risk factors for suicide. According to data from the National Violent Death Reporting System (NVDRS), in 2008 alcohol was a factor in approximately one-third of suicides reported in 16 states. Opiates, including heroin and prescription painkillers, were present in 25.5 percent of suicide deaths, antidepressants in 20.2 percent, cocaine in 10.5 percent, marijuana in 11.3 percent, and amphetamines in 3.4 percent.

Suicide is a leading cause of death among people with substance use disorders (SUDs). Substance use may increase the risk for suicide by intensifying depressive thoughts or feelings of hopelessness while at the same time reducing inhibitions to hurting oneself. Alcohol and some drugs can cause a "transient depression," heighten impulsivity, and cloud judgment about long-term consequences of one's actions.

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Substance Use Disorders

Research consistently shows a high prevalence of suicidal thoughts and suicide attempts among persons with substance abuse problems who are in treatment (Ilgen, Harris, Moos, & Tiet, 2007) and a significant prevalence of death-by-suicide among those who have at one time been in substance abuse treatment when compared with those who do not have a diagnosis of substance use disorder (Wilcox et al., 2004).

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Substance Use Disorders

As a result, substance abuse treatment providers must be prepared to gather information routinely from, refer, and participate in the treatment of clients at risk for suicidal behavior. Suicidal thoughts and behaviors are also a significant indicator of other co-occurring disorders (such as major depression, bipolar disorder, PTSD, schizophrenia, and some personality disorders) that will need to be explored, diagnosed, and addressed to improve outcomes of substance abuse treatment.

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Assessment

Objectives:

Review/introduce common assessment tools.

Slide 62

Intentionality

There is no substitute for direct questioning. Clinicians must be willing to address suicide directly, confidently and with intentionality in assessment and response. All while using therapeutic skills including empathy and care.

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Expert Recommendations

- Clients in substance abuse treatment should be screened for suicidal thoughts and behaviors routinely at intake and at specific points in the course of treatment. Screening for clients with high risk factors should occur regularly throughout treatment.
- Counselors should be prepared to develop and implement a treatment plan to address suicidality and coordinate the plan with other providers.

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Expert Recommendations

- If a referral is made, counselors should check that referral appointments are kept and continue to monitor clients after crises have passed, through ongoing coordination with mental health providers and other practitioners, family members, and community resources, as appropriate.
- Counselors should acquire basic knowledge about the role of warning signs, risk factors, and protective factors as they relate to suicide risk.

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Expert Recommendations

- Counselors should be empathic and nonjudgmental with people who experience suicidal thoughts and behaviors.
- Counselors should understand the impact of their own attitudes and experiences with suicidality on their counseling work with clients.
- Substance abuse counselors should understand the ethical and legal principles and potential areas of conflict that exist in working with clients who have suicidal thoughts and behaviors.

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Application

Practice, practice, practice.

What strategy would you use to introduce the topic of suicide?

What assessment strategy would you use to assess for suicide?

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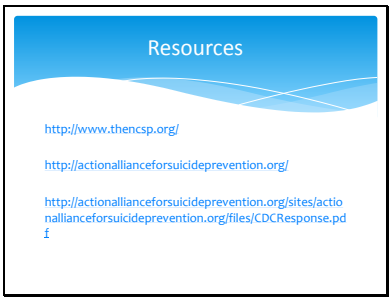

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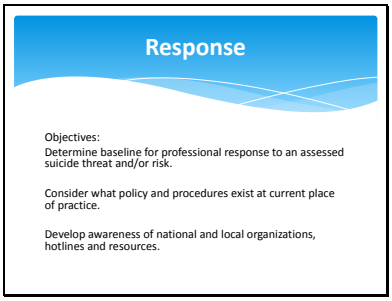

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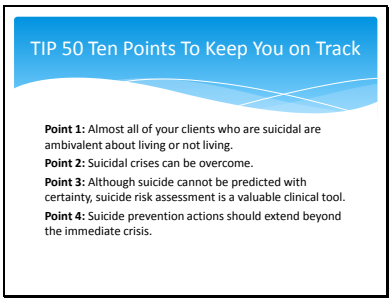

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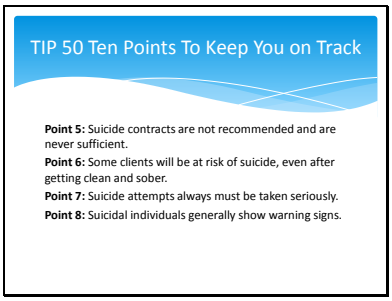

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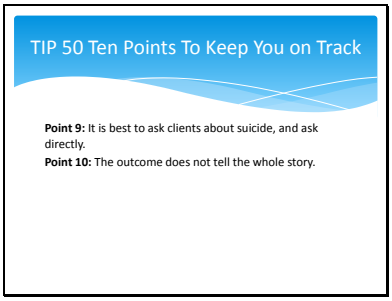

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After an Attempt

Research suggests that even simple efforts to challenge isolation and provide follow-up support to people living in the community after an attempt can have a powerful impact and reduce future attempts. A program that used hand-written postcards with brief personal messages showed remarkable results in reducing reattempt hospital admissions, revealing that a small amount of effort in the area of social support may be very powerful. In addition, a growing number of programs that provide suicide attempt survivors with self-help tools and social support show great promise in reducing isolation and empowering people to manage their own suicide risk and mental health.

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Application

At what point and how would you intervene if you assessed for suicide risk?

Are you aware of the policy and procedures at your current place of practice in regard to suicide assessment and response? If not how could you find out?

What resources would you consider providing your client?

Slide 75

Assessment

Objectives:

Review/introduce common assessment tools.

Brainstorm other considerations.

Slide 76

Risk Factors

Social:
Availability of lethal means of suicide
Unsafe media portrayals of suicide
Community:
Few available sources of supportive relationships
Barriers to health care
Relationship:
High conflict or violent relationships
Family history of suicide
Individual :
Mental illness
Substance abuse
Previous suicide attempts

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Protective Factors

Social:
Availability of physical and mental health care.
Restrictions on lethal means of suicide
Community:
Safe and supportive school and community environments
Sources of continued care after psychiatric hospitalization
Relationship:
Connectedness to individuals, family, community and social institutions
Supportive relationships with health care providers
Individual:
Coping and problem solving skills
Reasons for living
Moral objections to suicide

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Intentionality

There is no substitute for direct questioning. Clinicians must be willing to address suicide directly, confidently and with intentionality in assessment and response. All while using therapeutic skills including empathy and care.

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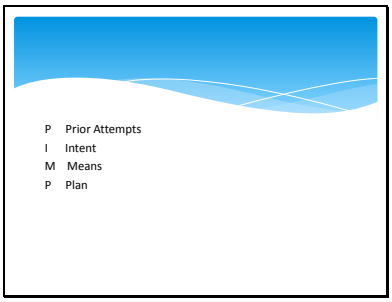

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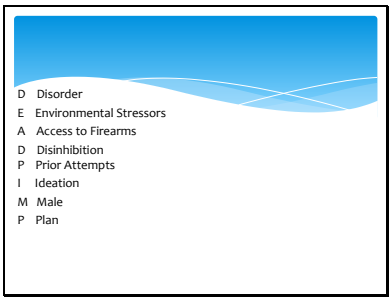

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"There is no generally accepted and standardized instrument that can accurately measure suicide potential. **Suicide screening and assessment scales can be used as aids, but if a client shows signs of being at risk of suicide, these scales are not a substitute for a thorough clinical interview by a qualified mental health clinician, during which client and counselor can talk openly about suicidality.** Any client showing warning signs or risk factors for suicidality should be assessed by a mental health professional specifically trained in conducting suicidal risk evaluations (APA, 2000)." (TIP 48)

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Application

Practice, practice, practice.

What strategy would you use to introduce the topic of suicide?

What assessment strategy would you use to assess for suicide?