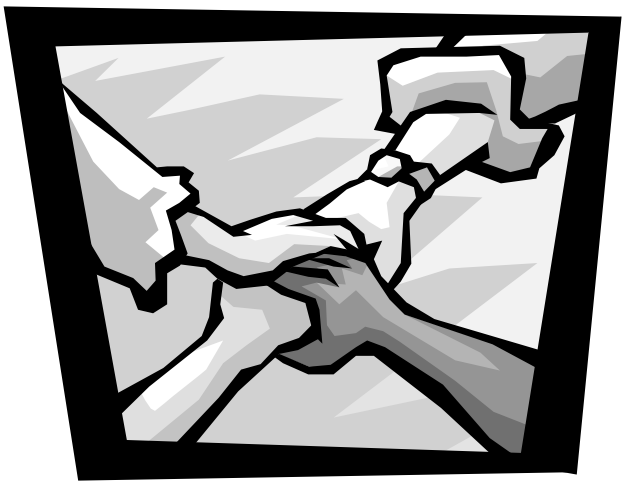
Suicide Prevention for Peer Specialists



Tony Salvatore

Montgomery County Emergency Service, Inc.
Norristown, PA

September 2009

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What is this booklet all about?

In 2006, Kathryn Power, the Director, Center for Mental Health Services, stated that "suicide prevention is a mental health system transformation imperative**.**"[1] Two years earlier she said:

> In a transformed system consumers…will act as gatekeepers. They will recognize the warning signs of suicide and be able to encourage people at risk to seek treatment. It is important to understand that achieving the vision of a transformed system is crucial to suicide prevention…and vice versa.[2]

This view of a transformed system embracing suicide prevention has not yet come to be.

This booklet is about engaging peer specialists in appropriate suicide prevention roles in a transforming community behavioral health system.

As you read on please keep these realities of suicide in mind:

- It is produces trauma in all those who experience it in any way.
- It happens in families and support systems not in a vacuum.
- It is the most abnormal form of death.
- It is always a premature death.
- It is preventable.

If you have comments about this booklet please call 610-279-6100 or send an e-mail to tsalvatore@mces.org. The references used in preparing this booklet are available on request.

Tony Salvatore
Norristown, PA
September 2009

"Actively involve suicide attempt survivors and mental health consumers in planning, implementing, and evaluating all suicide prevention efforts."

First National Conference for Survivors of Suicide Attempts, Heath Care Professionals, and Clergy and Laity (2008)

[1] *http://mentalhealth.samhsa.gov/newsroom/speeches/062206.asp*
[2] *http://mentalhealth.samhsa.gov/newsroom/speeches/102804.asp*

1) What are some key terms?

Suicide prevention, at the individual level, is helping someone avoid the onset of suicide risk or to get help if suicide risk is present. Here are definitions of some of the terms and phrases used in this booklet:

Aborted Suicide - A suicide attempt that is terminated by the individual before physical harm occurs.

Lethal Means – The act, process, or instrument by which suicide is completed.

Suicidal Behavior – Ideation, planning, acquiring means, an attempt, or a suicide completion.

Suicidal Ideation – Thoughts of self-harm or completing suicide.

Suicidality – Any level of suicidal behavior from ideation to making a plan to an attempt

Suicide Attempt –Deliberate self-harm intended to be fatal that does not result in death.

Suicide Completion – A suicide attempt that results in death.

Suicide Plan – An individual determination of when and how suicide will be completed.

Suicide Postvention – Aid following a suicide attempt or a suicide loss.

2) What about stigma and suicide?

It is well-known that mental illness is stigmatized and that this negatively impacts consumers. Stigma is an equal, if not greater, problem with suicide too. Stigma colors how people think about suicide. Stigma shapes feelings towards suicide attempters, suicide victims, and those bereaved by a suicide loss. Stigma influences how individuals struggling with suicidality or with a suicide loss see themselves, and how they deal with their problem.

Suicide stigma is expressed in language. Think about "committed suicide." What comes to mind? Does "committed" conveys a strong sense of criminality or illegality and immorality? Suicide was decriminalized decades ago and most religions (but not all) do not regard it as a sin. Nonetheless these changes have been slow in being picked up by the media and general public.

An alternative phrase is "completed suicide." Another is to say that the victim "died by suicide." Such nonjudgmental phrasing reduces the stigma and disapproval that is often felt by the family and close friends of a suicide victim. It also lessens the stigma felt by those who have attempted suicide or come very close and may make them more open to seeking help and support.

Some descriptions of suicidal behavior minimize the risk and danger inherent to the act. "Failed attempts" or "unsuccessful attempts" are two common examples. Why not just say "suicide attempt" which indicates that the individual survived? Then there is "suicide gesture" which sounds harmless though all suicidal behaviors increase risk and vulnerability.

Negative references to suicide abound after one has occurred. The victim at a high school in Montgomery County (PA) was repeatedly called "the shooter" by officials and the media despite no evidence of homicidality or any effort to harm anyone but himself. Criminalizing such tragedies may deter others at-risk from admitting that they are suicidal and from seeking help.

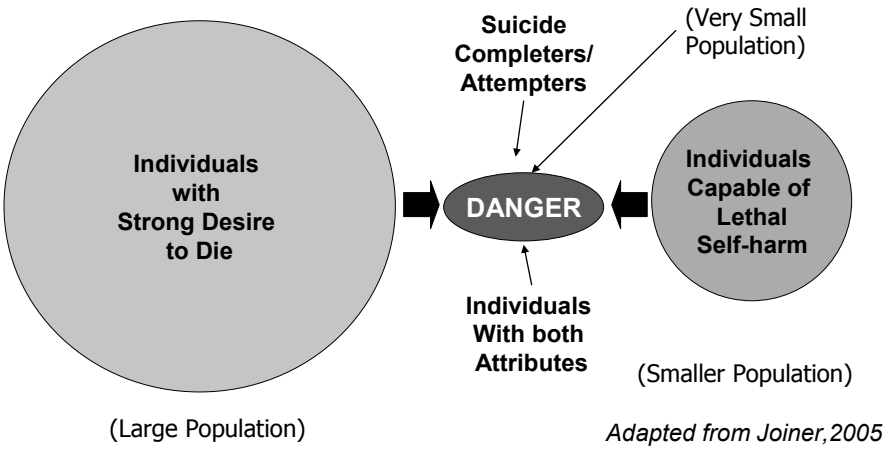
"While the stigma attached to mental illness and addiction prevents persons at risk of suicide from seeking help for treatable problems, the stigma of suicide itself may also reduce the number of people who seek help, while adding to emotional burdens. Family members of suicide attempters often hide the behavior from friends and relatives, since they may believe that it reflects badly on their own relationship with the suicide attempter or that suicidal behavior itself is shameful or sinful. Persons who attempt suicide may have many of these same feelings."

National Strategy for Suicide Prevention (2001)

3) Why do people die by suicide?

In *Why People Die by Suicide* (2005), Thomas Joiner notes that two conditions must be present to overcome the instinct for self-preservation. The first is a desire to die caused by a strong belief that one is a burden and does not belong. The other is a capacity for lethal self-harm due to exposure to abuse, pain, suicidality, violence, and other factors. Here's how they interact:

Joiner Model:



From time to time, many people may desire to die and have thoughts of self-harm, but few go further. This is because they do not have the ability for lethal self-harm. When the two coincide, a suicide attempt may occur. This can happen to consumers.

This model shows that suicide is not an impulsive act but that "…individuals advance along a trajectory of advancing capability for self-injury by engaging in activities that foster fearlessness and competence for suicide."[3] Suicide is the outcome of a process and a plan.

[3] *Smith, A. et al. (2008) "Revisiting Impulsivity in Suicide"* ***Behavioral Science Law*** *26(6) 779-797.*

4) How is suicide connected to mental illness?

Mental illness does not cause suicide. It plays a part in some suicides, but it is not a cause. About 5% of people with mental illness complete suicide.

The National Violent Death Reporting System (NVDRS)[4] compiled detailed data on over 8000 suicides in 16 states in 2005. It found that just over 40% of the victims had a known psychiatric diagnosis at the time of their death. If we apply this percentage to the average number of US suicides yearly, it suggests that almost 13000 individuals with a diagnosed mental illness may take their lives annually.

In Joiner's theory a desire to die is a prerequisite for suicide and this state of mind is can be brought about by major depression, bipolar disorder, and schizophrenia. There is a high incidence of suicide in those with these disorders, but according to the theory they also needed to acquire the capability for lethal self-harm and that does not come from mental illness alone.

Mental illness may cause someone to feel that they do not belong and are a burden. This may lead to thinking about death. Suicide becomes a possibility with a history of attempts, alcohol use, trauma, violence, abuse, self-injury, severe physical or emotional pain, or access to firearms. These factors increase "suicide competence." The melding of intent and capacity may be fatal.

Mental illness contributes to suicidality in those that it afflicts. Mental illness is a strong risk factor for suicide (see page 12). It plays a big part in acquiring multiple risk factors for suicide. This means that individuals with mental illness will usually have many problems that bear on their risk for suicide. One of the most common is alcohol and drug use.

Studies of outpatients with depressive disorders found that about 2% complete suicide. 50% of those with bipolar disorder will attempt suicide at least once. Research in schizophrenia found 20%-40% of sufferers attempt suicide and 6%-10% complete suicide.

[4] *http://www.cdc.gov/ncipc/profiles/nvdrs/publications.htm*

5) What about co-occurring disorders and suicide?

Co-occurring disorders (COD) significantly increases the risk of suicidal behavior. COD increases exposure to more risk factors and weakens protective factors. It is linked to history of past attempts. Misuse of alcohol and street or prescription drugs drives up the risk of suicide.

Here are some aspects of co-occurring disorders that increase suicide risk:

- Mood instability and chronic hopelessness
- Impulsiveness and disinhibition
- Poor self image; low self-esteem; loss of support system
- Less likelihood of seeking/getting help and intervention.
- Low sensitivity to negative consequences of actions
- Limited temporal outlook; little future orientation; "all or nothing thinking"
- High exposure to abuse, violence, suicide loss, and other trauma
- Frequent hospitalizations
- High criminal justice system contact and incarcerations (jail suicide risk)

Alcohol is involved in about 20% of all US suicides. Alcohol misuse raises stress levels and induces a lessened range of perception, reduced inferential thought, and decreased awareness of optional problem solutions. This creates a "slippery slope" towards suicidality.

Suicide is a leading cause of death among people who abuse alcohol, drugs, and other substances. Alcohol and drug use disorders elevate risk for suicide ideation and attempts.

Depression has many negative consequences in regard to suicide risk in those with COD. It decreases self-esteem and increases feelings of hopelessness and helplessness. It increases social isolation and anxiety. It adds or worsens psychological pain, agitation, and panic attacks.

In blending mental health and substance abuse services both systems must better address suicide risk. COD raises risk far beyond that accompanying either disorder alone. Systems integration must proceed with an awareness of the pervasiveness of suicide risk in the COD population.

6) What about suicide attempts?

An attempted suicide is the closest thing to a completed suicide:

- The intent to die was present.
- A doable plan was present
- Lethal means were present.
- The ability to lethally harm one's self was present.
- The warning signs were missed or ignored.

Surviving an attempt is not a benign event. An attempt is highly traumatizing and many attempters experience post-traumatic stress disorder (which is often overlooked). Attempters may be re-traumatized if they again become suicidal. This also is not generally recognized.

Suicide attempts create a life-long risk of suicide. About half of all suicide victims made at least one previous attempt. Greatest risk is within 3 months of the first attempt. 10% of attempters complete suicide within 10 years of the first attempt. 40% of these deaths occur within one year.

Individuals with psychiatric disorders have significantly higher rates of attempts compared to the general community, 29% versus 5%. There are 500 attempts per 100,000 people in the general population. This suggests that the attempt rate among consumers may approximate 3000 per 100,000 people or 3 out of every 100 persons. Or it may be far more.

Consumer attempters are in great jeopardy of repeat attempts. They must be singled out for care recognizing the trauma, stigma, and elevated risk that they acquired by attempting. They need clinical and peer postvention. If they are hospitalized because of the attempt, aftercare should start during the inpatient stay and continue in the community.

Individuals with co-occurring alcohol misuse are at high risk of attempting suicide. Studies show that alcohol plays a significant role in suicide attempts:

7) What about people who are always talking about suicide?

One of the most frustrating suicidal behaviors is when someone frequently threatens suicide or voices intent. This is called "chronic suicidality" because of its repetitive nature and because it tends to go on for a long time.

Individuals who do this are known as "chronic suiciders." Their suicide threats are usually contingent in nature (e.g., "I'll kill myself if I don't get into rehab tonight") and may have a manipulative or control element. The threats can be dramatic and often involve "setting terms."

Suicide threats may be used to evade criminal justice issues or to get shelter. Most cases seem to involve a low intent to die and are limited to vague or non-specific threats.

Chronically suicidal persons seem to be troubled by hopelessness, emptiness, and a need for control. It is a coping strategy. Suicide threats get attention and open doors.

There is an inherent problem. Overtime "chronic suiciders" may raise their threat level while they are getting more used to the idea of suicide. Despite their low desire to die they may have some very real risk factors for suicide and a weakening set of protective factors.

The risk of suicide can rise. Repeated suicide threats can increase the capability for suicide by lowering resistance to self-harm over time. There may be little insight that suicide risk is growing as suicidal behavior grows. Given the right combination of stressors and triggers there may be a shift from threatening suicide to attempting suicide.

Individuals with a history of chronic suicidality are very vulnerable when this happens. Their support system may not note the change in risk level that has taken place. They may be less vigilant because of "false alarms" in the past. Heightened suicide risk may be minimized.

Chronic suiciders need help to be free of this type of suicidal behavior. They must learn other ways to cope, manage stress, and how to use self-help and to build supports. This may require various types of help, but peer specialists should be partners in the process.

"Suicidality always has to be taken seriously. That is because suicidal thoughts and actions communicate profound suffering and hopelessness. This is a message that has to be received, understood, and acknowledged."[5]

[5] *Paris, Joel (2007) Half in Love With Death. Mahwah, NJ: Lawrence Erlbaum Associates*

8) How are people who experience a suicide affected?

Every suicide leaves several people severely affected. Suicide loss is a serious but unrecognized concern among consumers. There are many consumer and family member "suicide survivors."

Suicide loss upsets well-being, overrides coping, and causes extreme distress[6]. It alters functioning, brings on anxiety, depression, and panic, and has significant behavioral consequences. It generates severe emotional pain and shatters feelings of control and safety.

Worst of all it creates a sense of vulnerability to suicide and can even lead to suicidality. Complicated grief and depressive symptoms may occur and further heighten the risk for suicidal ideation, which may pose a risk for subsequent increased suicidality in suicide survivors.

Suicide loss affects recovery. Extreme guilt may arise because the bereaved individual didn't see the danger or do anything to prevent the death. There may be intense anger towards the deceased for abandoning those left behind. Suicide leaves a numbing and disabling shock because of the suddenness, unexpectedness, and violence involved. Fear, stigma, shame, and a total lack of understanding may spur denial and helplessness.

Other factors can worsen the effects of a suicide. These include witnessing the suicide or finding the body, losing a child (at any age), being estranged from the victim, being away from where the death occurred, or being unable to go to the services. Police or media involvement after a suicide can distress suicide survivors.

Those close to the victim may experience relief after the death. Often this lasts only briefly, but it can be troubling. It may be an issue when the victim frequently threatened suicide or made many attempts. Relief may give way to guilt or it may be overcome by the gravity of the loss.

The impact of a suicide loss is amplified when it is unacknowledged. This is known as marginalizing or disenfranchising grief. This sometimes occurs when the victim is a common-law spouse, a gay or lesbian partner, or an estranged or divorced spouse. The survivors of such victims may be denied the chance to share their loss with others, such as the victim's family.

Problems may occur if a suicide survivor is in a setting where it is difficult to grieve openly, such as a residential rehab program or a prison. Such highly structured environments are not bereavement friendly, particularly in regard to the intensely emotional aftermath of a suicide.

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[6] *See "Recovering from Suicide Loss: Self-help for Consumers who have Lost Someone to Suicide" (Norristown, PA: Montgomery County Emergency Service, June 2009).*

9) What are the risk factors for suicide?

Risk factors are variables strongly associated with suicide and found in victims. Risk factors facilitate but do not *cause* suicide. Some risk factors (e.g., a past attempt or abuse) are permanent. Others may be eliminated or reduced (e.g., removing firearms). The main risk factors for consumers are:

- Young age and early stage of illness
- Good pre-illness functioning, good intellectual functioning
- Frequent relapses/remissions, post-recurrence improvement periods
- Depressive episode/hopelessness

Several conditions act as short-term risk factors: impulsivity, instability, agitation, panic, anxiety; relational conflict, aggression, violence, and co-occurring alcohol/substance abuse. A past attempt is the closest thing we have to a predictor of suicide. Additional risk factors are:

- White male, Native American, veteran
- Poor coping, problem-solving, help-seeking
- Intimate partner conflict, social isolation
- Family history of suicide, mental disorder or substance abuse
- Family violence, including physical or sexual abuse
- Firearms in the home or otherwise accessible
- Legal charges, financial problems, incarceration
- Physical illness and disability

Bisexual and homosexual men are at elevated risk for suicide attempts, with such risk clustered earlier in life. Gay men, lesbians, and bisexual persons have higher rates of suicidal ideation attempts, and completions than do heterosexual individuals.

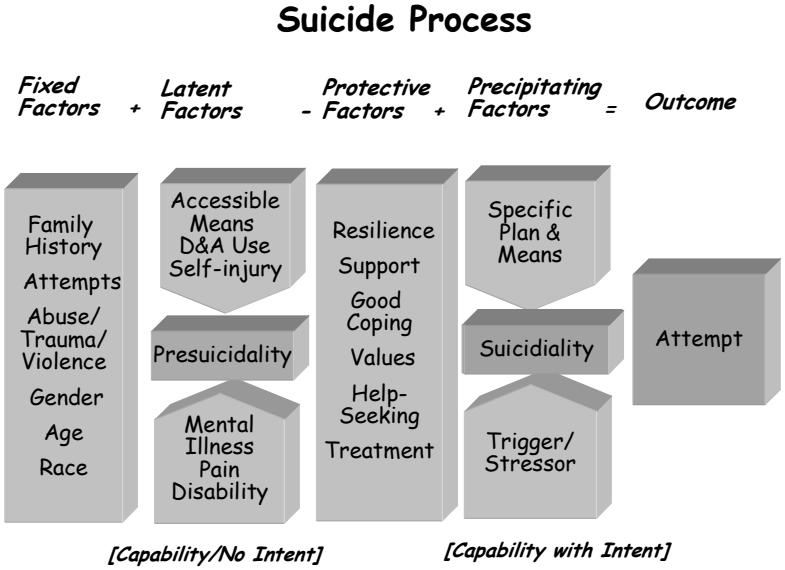
Risk factors cluster and interact. Generally speaking, more risk factors means more risk, but serious risk may be present in individuals with only a few known risk factors.

10) What are the protective factors?

Protective factors are behaviors, characteristics, and other variables found to offset risk factors of suicide and precipitants of suicidal behavior. They contribute to feeling that life is worth living. Some can be developed and enhanced. Here are the main protective factors for suicide:

- Strong family, social ties, support sources
- Optimism, resilience, life satisfaction, emotional stability
- Strong self-esteem, sense of self-worth
- Good problem-solving, coping skills, and willingness to seek help
- Religiosity, spirituality
- No firearms in household
- No alcohol or drug use

Female gender and being non-white are protective factors against completed suicide. Recovery is a protective factor. Social support increases self-esteem and self-efficacy. The buffering role of protective factors is shown in this diagram:



Adhering to treatment is a protective factor. Yet suicidality may persist, arise, or worsen in those who faithfully follow care regimens. Suicidality and mental illness are not the same. Treating the latter does not always impact the former. Suicide can occur after the return to sobriety and the easing of depression. Ongoing risk monitoring and follow-up are necessary.

11) What are the danger signs and warning signs?

The Danger Signs: These are early indications of emerging risk that should result in the individual having immediate contact with a health care provider. These include:

- Hopelessness ("There's no way that I can make things better")
- Feeling trapped ("I feel like there's no way out")
- Withdrawal from family or friends
- Anxiety, agitation, sleep problems
- Dramatic mood changes
- No reason for living ("Life isn't worth living")
- Reckless, risk-taking behavior

The Warning Signs: These are indicators of heightened suicide risk in the near-term, and should trigger an immediate crisis intervention response (calling a crisis center or 9-1-1). They include:

- Threatening to hurt or kill self
- Looking for ways to kill self
- Talking or writing about death, dying, or suicide

These are the most specific warning signs but there are others. Among them are:

- Citing a doable plan specifying how and when
- Giving away valued possessions
- Making unexpected visits or calls to family members or friends
- Settling up affairs, making a will, dictating funeral arrangements

"Any person has the potential to become suicidal when confronted with a situation that produces emotional pain and is believed to be inescapable, interminable, and intolerable." [7]

[7] *Chiles, J. A., & Strosahl, K. D. (1995). The suicidal patient: Principles of assessment, treatment, and case management. Washington, DC: American Psychiatric Press.*

12) What are some of the myths of suicide?

Misconception	Reality
Those who talk about suicide are "all talk" and won't complete suicide.	Talking about suicide is a warning sign and many who talk about it do complete suicide.
Those who have attempted suicide are single-mindedly dedicated to dying.	Suicidal people only want to be free of hurt and would go on if their pain could be ended.
Asking someone if they are thinking about suicide will only give them "ideas."	Asking is often the only way to determine risk and to show that you care.
Those who have attempted suicide are at very low risk of actually completing suicide.	Many suicide victims have made one or more previous suicide attempts.
If someone says that he is suicidal, telling him to "do it" will snap him out of it.	This may be the single worst thing that anyone can do. Never say "go ahead and do it."
Surviving a suicide attempt shows that the individual wasn't really serious about dying.	An attempt always involves the intent to die.
Most suicides occur with little or no warning	Most people do mention what they are feeling and show signs of suicide
Improvement following a suicidal crisis means that the suicidal risk is over.	Many suicides occur following 'improvement'. Suicidal feelings can return.
Non-fatal acts are only attention-getting behaviors or only attempts to be manipulative	For some, suicidal behaviors are pleas for help. It is always better to err on the side of safety.
Once a person is suicidal, he or she will be suicidal forever.	Most suicidal crises are temporary, and will pass if help is provided.

13) How does recovery relate to suicidal behavior?

Recovery promotes hope, self-help, help-seeking, problem-solving skills, and improved treatment adherence. Suicidality does the opposite:

Attributes of Recovery	Attributes of Suicidality
• Hope, optimism, positiveness • Adaptability • Capacity to change	• More hopelessness, fear • Maladaptive and negative • Resistance to change
• Autonomy, empowerment, confidence • Self-respect • Sense of value as a person	• Decreased self-control • Decreased self-respect • Decreased self-esteem/self-worth
• Wellness • Self-awareness	• Increased illness and symptoms • Less self-awareness/greater denial
• Peer/family/other supports • Community living	• Loss of peer/family support • Increased risk of hospitalization

It is not enough to only promote recovery. It is also necessary to prevent the onset or return of suicidality in those working on recovery. This is why suicide prevention and postvention must be features of a transformed system.

Suicide loss negatively affects recovery. It undoes wellness, overrides coping mechanisms, and causes extreme stress. It brings anxiety, depression, and panic, and has significant affective and behavioral consequences. It generates emotional pain and shatters feelings of control and safety.

Experiencing a suicide, like experiencing suicidal behavior, changes those that it affects. This change cannot be undone, but it is possible to return to a sense of things being normal that you felt before. This is a different normal, a "new normal." That is what recovery is all about.

14) What can you do to help as a peer specialist?

This chart shows how peer specialist training and skills apply to suicide prevention:

Core Competencies[8] - What You Know	Prevention/Postvention Competencies
• Orientation to Peer Specialist Program - Program Orientation - The Emergence of Recovery Concepts	• Orientation to, basic concepts of suicide prevention and suicide loss, incidence of suicide among consumers
• Recovery and Peer Support - Visioning Our Recovery Module - Exploring Peer Support	• Application of recovery and peer support concepts to coping with aftermath of an attempt, suicide loss, or suicidal behavior
• Introduction to WRAP: The Wellness Recovery Action Plan - Key Recovery Concepts - Developing a Wellness Toolbox - Daily Maintenance Plan - Identifying Triggers - Early Warning Signs - When Things Are Breaking Down - Crisis Planning Post Crisis Planning	• Use of WRAP concepts and methods to help others develop: (i) "personal safety action plans" (triggers, signs, crisis what-to-do, etc.) for avoiding future suicide attempts, episodes of suicidal behavior, or using suicide threats to control; and (ii) "personal grief recovery action plans" for coping with the traumatic aftereffects of experiencing a suicide
• Communication Skills - Active Listening -Active Listening Skills Practice	• Understanding myths of suicide, the stigma associated with suicide completions and attempts, and what not to say
• Managing Our Differences - Cultural Competency. - Group Facilitation	• Cultural/ethnic perspectives on suicide and dealing with suicide loss • Suicide prevention/postvention groups
• Working With People Who Appear Unmotivated - The Cycle of Engagement - Problem Solving	• Working with "survivors of suicide attempts," "chronic suiciders," and "suicide survivors" and applying problem-solving/coping skills to their needs
• Co-occurring Disorders and Boundary Issues in Peer Support - Introduction to Co-Occurring Disorders -Boundary Issues in Peer Support	• Co-occurring disorders, serious mental illness, trauma as risk factors for suicide • Suicide crisis intervention and complicated grief treatment boundary issues
• Workplace Issues and Practices -Workplace Practice	• No change

[8] *"Institute for Recovery and Community Integration" in Katz, J. and Salzer, M.* ***Certified Peer Specialist Training Program Descriptions*** *(Phila., PA: UPenn Collaborative on Community Integration, ND).*

Eligibility Criteria	Prevention/Postvention Criteria
• Must be self identified current or former, mental health consumer or co-occurring consumer who can relate with others with similar experiences	• Must be self-identified as a consumer who has made a suicide attempt, experienced chronic suicidality, or suicide loss and can relate to others with similar experiences
• High School diploma or GED	• No change
• Verbal/written communication proficiency	• No change
• Have maintained, within the last 3 years, at least 12 months of successful full/part time paid/voluntary work experience or one year post secondary education experience totaling 24 credit hours.	• No change
• Ability to demonstrate recovery expertise (knowledge of approaches to support others in recovery) and has the ability to demonstrate own efforts at self-directed recovery	• Ability to apply recovery concepts to support others who have made a suicide attempt, experienced chronic suicidality, or suicide loss and demonstrate efforts at self-directed recovery from such experiences.
• Commitment to consumer choice and empowerment	• Understanding that suicidality often leads to reoccurrence, crisis, including suicide attempts and that consumers in such situations must receive professional assessment and treatment as necessary.
	• Understanding that suicide prevention and postvention does not recognize suicide as a personal right but as a maladaptive outcome to illness, an adverse life event, or other severe stressor(s).
	• Understanding that suicidal individuals may feel empowered and that this represents a potentially life-threatening situation
• Ability to establish relationships with peers	• Ability to establish relationships with individuals who have recently been suicidal or bereaved as a result of suicide.

15) What are some peer specialist roles in suicide prevention?

Here are some things that anyone troubled by suicidality should know

- How to maintain an optimal level of wellness
- Be aware of ongoing risk and the possible recurrence of suicidality
- An ability to meet needs and solve problems
- How to mobilize and utilize supports
- How to manage/minimize effects of suicidality
- How to change patterns and get "unstuck" from negative behaviors

These are the kinds of outcomes that a peer specialist will be able to assist in bringing these outcomes about.

Peer Specialist Activity
Outpatient peer assisted W.R.A.P. (or other self- help or safety plan) development for consumers coping with persistent suicidal ideation or other chronic suicidality.
Education of family/support system members on risk factors, danger/warning signs of suicide (counseling, groups, printed/on-line materials).
Peer gatekeeper program (Consumers QPR[9]-trained to recognize danger signs of suicide and facilitate appropriate intervention).
Peer-run warm lines for consumers coping with chronic suicidality, recovery from suicide loss, and related needs.

These roles and the roles listed on the next two pages were identified by the Regional Mental Health Suicide Prevention Work Group as part of a strategy for consumer-focused suicide prevention in the community mental health system in southeastern Pennsylvania.

Chronic suicidal behavior can be compulsive (even addictive) in nature. As such the 12-step concept might be applicable. "Suicide Anonymous" is such a program[10]. SA's mission is to "solve our common problem and help others to recover from suicidal ideation and behavior." It may serve as a model peer-led support groups for those with persistent suicidality.

[9] "*Question/Persuade/Refer" – A gatekeeper training program (see www.qprinstitute.com).*
[10] *See www.suicideanonymous.org*

16) What are some peer specialists roles in suicide attempt postvention?

Suicide attempters get too little help and what they do get is often alienating, judgmental, insensitive, controlling, rescuing, and disempowering.

Among the recommendations and proposals from the First National Conference for Survivors of Suicide Attempts in 2008 were some that speak directly to roles for peer specialists:

- Validating and normalizing similar experiences
- Increase supportive community-based networks
- Communicate suicide risk/prevention info to families at hospital discharge
- Develop volunteer support systems
- Track patients to assure follow-up and aftercare

This chart lists some ways to put these recommendations into effect:

Peer Specialist Activity
Inpatient/outpatient/community psychoeducation peer-led/co-led group on suicide prevention.
W.R.A.P. (or other self- help plan) development for recovery from a suicide attempt or occurrence of severe suicidality without attempt.
Education of family/peers on risk factors, / warning signs (e.g., National Suicide Prevention Lifeline's "After a Suicide Attempt" booklet[11]).
Maintain daily contact with at-risk consumers during post-D/C period until engagement with outpatient care provider.
Open-ended peer-facilitated mutual self-help support group for post-attempters and those who experienced an acute episode of suicidality.
Open-ended family member-led support group for relatives of post-attempters and those who experienced an acute episode of suicidality.

Peer suicide attempt postvention services can promote recovery, empowerment, and timely interventions to help at-risk consumers avoid crisis and maintain or regain wellness.

[11] *Available at http://download.ncadi.samhsa.gov/ken/pdf/SVP-0157/SVP-0157.pdf*

17) What are some peer specialist roles in suicide loss postvention?

Postvention is a special form of crisis intervention. In regard to suicide loss it tries to reduce the negative consequences that may affect those close to the victim after a suicide. It provides immediate emotional support and lessens the distress brought on by the loss.

The objectives of suicide loss postvention are: a) to ease the trauma and related effects of the loss; b) to prevent the onset of adverse grief complications; c) to minimize risk of suicidal behavior; and d) to encourage resilience and coping. Peer specialists can make these things happen.

Peer Specialist Activity
Peer-run warm lines for consumers coping with chronic suicidality, recovery from suicide loss, and related needs.
Quarterly regional suicide bereavement support group for consumers who have experienced a suicide loss (Facilitated by peer suicide survivor).
Open-ended peer-facilitated mutual self-help support groups for (i) consumers coping with chronic suicidality; (ii) acute bereavement.

Recovery is the goal of the journey through suicide grief. Recovery from a suicide loss like recovery from serious mental illness is not just a matter of letting things take their course. It is an active process; it has to be worked at. It requires help and support and having someone to look to as a model of what can be accomplished. These are things that peer specialists can provide through formal roles designed to help consumers dealing with suicide loss.

18) How do you help someone who's suicidal?

A suicidal person may not ask for help, but that doesn't mean that help isn't wanted. Most suicidal people are ambivalent – they don't want to die - they just want to stop hurting.

Here are some "Don'ts" that apply to anyone who might be suicidal:

- Do not leave him/her alone or let him/her go off alone
- Do not be judgmental
- Do not argue, debate, analyze, or moralize
- Do not try to cheer him/her up
- Do not try to shock or challenge (i.e., say "Oh, go ahead and do it if you want to!")
- Do not accept "I'm okay now." (Nobody recovers immediately from suicidality.)
- Do not be sworn to secrecy

Here are some "Do's":

- Ask if he/she is thinking about suicide
- Take the intent or threat very seriously
- L-I-S-T-E-N !!!
- Show that you care and <u>say</u> <u>it</u>

If there is no apparent immediate danger (and no lethal means in view):

- Tell her/him that help is available and you can see that he/she gets it.
- Let her/him have some space.
- Try to get her/him to another area in case there are hidden means.
- Remove car keys, if possible.
- Call the local crisis center or 9-1-1.

If there is apparent immediate danger - <u>ACT</u>:

- Say that you are getting help
- Call 9-1-1

The information given above is not meant to substitute for crisis or emergency services.

19) What about personal suicide safety plans?

A personal suicide safety plan is a written list of coping strategies and sources of support that a consumer can use in a suicide crisis. It lists individuals, agencies, and other resources, such as hot lines or warm lines, that a consumer can contact to help them lower the risk of suicidal behavior. It is a proactive individualized suicide prevention plan for the consumer.

The personal suicide safety plan is a practical and meaningful joint provider-consumer-family suicide prevention effort. It is useful with consumers at risk of increasing suicidality as well as those trying to recover from recent suicidal behavior. A personal safety plan consists of:

- Warning signs – Thoughts, feelings, moods, behaviors, etc. that the individual identifies as indicators of emerging suicidality.
- Coping strategies – Self-help measures to avert suicidality.
- Social supports – Friends and social settings (e.g., Drop-in Center) that can serve as distractions if self-help efforts do not abate suicidality.
- Family supports – Relatives who would be willing to serve as supports if necessary.
- Providers – Physicians, therapists, crisis lines, etc. that can be contacted for help.
- Means restriction – Identification of possible means of lethal self-harm and what can be done to block access (e.g., disposing of unused meds).

Self-help prevention plans can be developed by the consumer or with the help of a peer specialist. An example is the Depression and Bipolar Support Alliance's "plan for life" which lists warning signs and actions to take if suicidal ideation cannot be deterred such as personal or provider contacts as well as diagnosis, medications, hospital preferences, and insurance information.[12] Another example appears as an appendix to this booklet.

A personal suicide safety plan involves the person at-risk in managing that risk by anticipating the possible crisis and delineating an action plan. The consumer gains a sense of control (ownership), and her or his support system is made aware of the risk and how help can be given.

Family members can contribute to personal suicide safety plans. They can help develop and maintain such plans. They may be contacts to turn to when signs of suicidality appear.

[12] *www.dbsalliance.org/site/PageServer?pagename=crisis_suicide_suicide#plan*

20) What are some of the boundary issues?

Boundaries most matter between people and between roles. Peer specialist training generally addresses person-to-person boundaries so here the focus will be on role boundaries.

Roles are inter-related sets of responsibilities and tasks. A role boundary is where one role ends and another role begins. Peer specialists have two natural roles in suicide prevention and postvention: (i) identifying individuals who are potentially at risk of suicide (i.e., danger or warning signs) and directing them to professional or emergency help; and (ii) providing recovery support services to help initiate and sustain recovery from suicidal behavior or suicide loss.

These roles are supportive and may include: (i) showing empathy, caring, and concern; (ii) giving information and help in acquiring new life skills; (iii) concrete assistance in getting something necessary done; and (iv) helping people feel connected with others. Peer specialists may "own" these tasks and roles.

Role boundary issues may occur if a peer specialist plays a role that belongs to someone else. There are three roles in suicide prevention and postvention that already belong to other staff in the community behavioral health system.

- Risk Evaluator – It is a psychiatrist's role to assess the level of suicide risk, identify treatable risk factors, and assure safety. It requires professional skill and judgment.

- Crisis Intervention – It is a crisis center role to assure the safety and stabilization of a person preoccupied with thoughts of suicide, threatening suicide, or voicing a plan or seeking the means for completing suicide. (If peer specialists encounter such individuals they must immediately contact a crisis center or call 9-1-1).

- Therapist/Counselor – It is a clinical role to do diagnosis, care planning, and treatment. Individuals struggling with suicidal behavior or suicide loss may need such services.

The urgency that is present when suicide is a concern can cause those close to the situation to get involved inappropriately. Role boundaries create a safety zone for all parties. Peer specialists can most effectively play a role in suicide prevention and postvention by knowing the boundaries of their roles and maintaining a "fix" on support activities and recovery solutions.

Appendix A: Sample Personal Safety Plan

Name:_____ **Date**_____

My warning signs:_____

_____

_____

_____

_____

My coping strategies:_____

_____

_____

_____

_____

My social supports:

Name_____ Phone_____

Name_____ Phone_____

Name_____ Phone_____

My family supports:

Name_____ Phone_____

Name_____ Phone_____

Name_____ Phone_____

Name_____ Phone_____

My providers:

Peer Specialist:_____ Phone_____

Physician:_____ Phone_____

Therapist:_____ Phone_____

Case Manager:_____ Phone_____

Crisis Center:_____ Phone_____

Warm Line:_____ Phone_____

My means restrictions:_____

_____

_____

_____

_____