Suicide Prevention and Management in Hospice;
Supporting Challenging Conversations at the End of Life

Greg A Marley, LCSW

Maine Suicide Prevention Program

In Partnership with NAMI Maine

Education, Resources, and Support-It's Up to All of Us

Maine Suicide Prevention Program

A program of the Maine Center for Disease Control and Prevention since 1998

Statewide Activities Include:

- **Data** collection, analysis & dissemination of **information**
- **Training** on suicide prevention and management to a wide range of partners statewide.
- **Technical Assistance** for schools, healthcare providers and others in protocol implementation and support after a loss.
- Annual Beyond the Basics Conference Spring, 2024

NAMI Maine

- Education Advocacy and Support for people affected by mental illness.
  - Education for peers, family and professionals
  - Support groups for peers, veterans and family
  - Information and Referral advocacy HELPLINE
  - Crisis Intervention Team Training for Law Enforcement
  - NAMI-Maine Family Respite Program
  - Mental Health First Aid Trainings
  - Outreach partner for National Institute of Mental Health
  - NAMI Maine Annual Conference
  - **NAMI Maine Annual Walk: October 2023**

www.namimaine.org

1-800-464-5767

Today's Agenda

- Role of suicide prevention at the end of life
- Attitudes and Ethics in Suicide Prevention
- The Facts; suicide risk trends
- Warning Signs and Risk Factors in suicide
- Supporting Protective Factors; building resilience
- Responding to Suicidal Behavior, assessing risk
- Resources for Help
- Bereavement needs and support after a suicide

Introduction

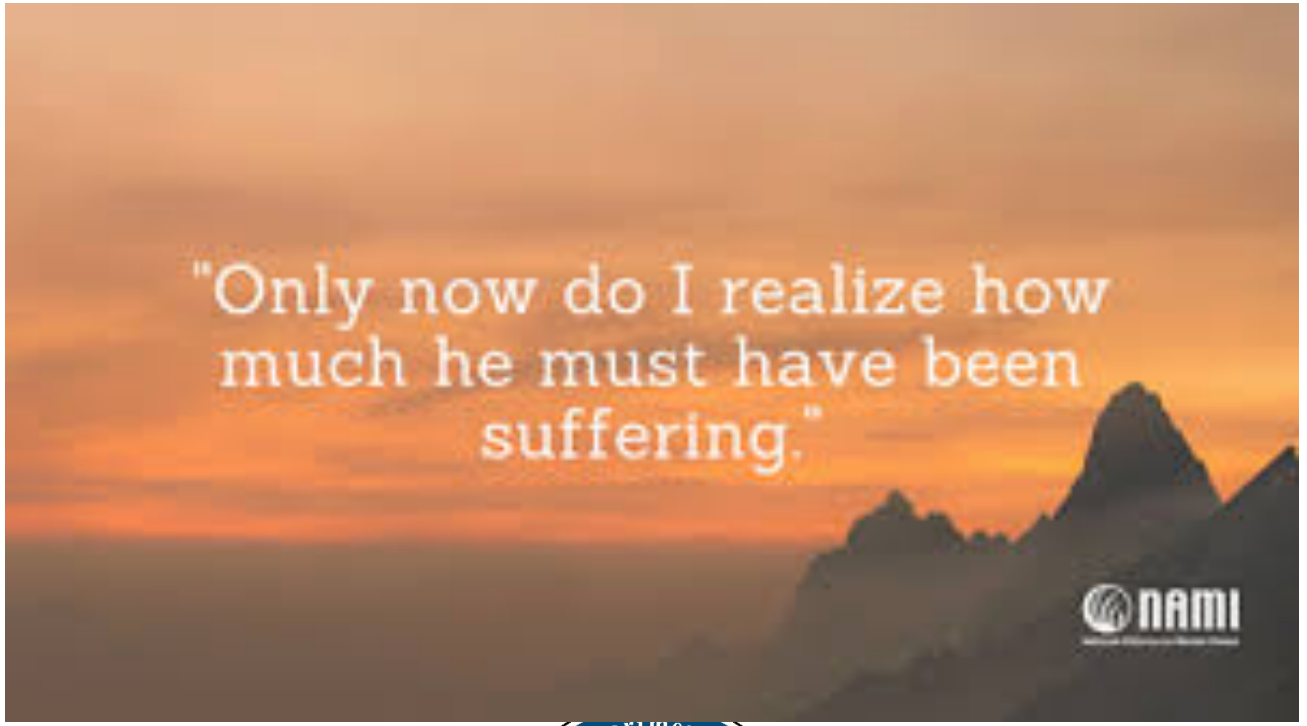
When a suicide occurs, it is a shocking and devastating loss of life, deeply impacting family, friends, co-workers and the community.

- A suicidal crisis is almost always transient and treatable;
  - ***This is less consistent in a hospice or palliative care setting***.

- Suicide is “the most preventable form of death in the US today.” (David Sacher, former US Surgeon General)

- Having the tools and processes in place prepares you to be a prevention and intervention resource. Having an attitude of prevention is equally important.

Suicide Carries a Stigma



Our Ease with Talking About Suicide is Shaped by:

- Personal and family history
- Cultural background
- Personal, regional and community values
- Religious beliefs
- Professional ethics
- Organizational/school culture and history
- Our role and relationship with the person
- Other?

Discussion

What feelings/thoughts come up when you think about suicide?

Values Clarification Worksheet

Talking About Suicide

Preventing suicide starts with our comfort in acknowledging and talking about suicide

Preferred:

Simply use the word

- “suicide”
- “died by/of suicide”
- “suicide attempt”

Use clear language that is age appropriate for your audience

What is Your Reaction When Someone Talks About Suicide?

- Personal
- Professional
  - What are your concerns?
  - How do you know when you've done enough?
- When I ask her about suicide, I'm thinking…
- How do you take care of yourself?

Asking About Suicide
Overcoming Societal Reluctance

- Talk about suicide directly and without hesitation; it becomes part of the conversation with someone at risk.
- Ask using concrete and direct language.
  - **Are you having thoughts of your suicide?**
  - **Are you thinking about dying today**
  - **How often do you consider killing yourself?**

- Vague or indirect questions elicit vague responses:
  - **Are you thinking of hurting yourself?**
  - **Do you feel safe?**

- When in doubt about the answer, repeat the question differently.

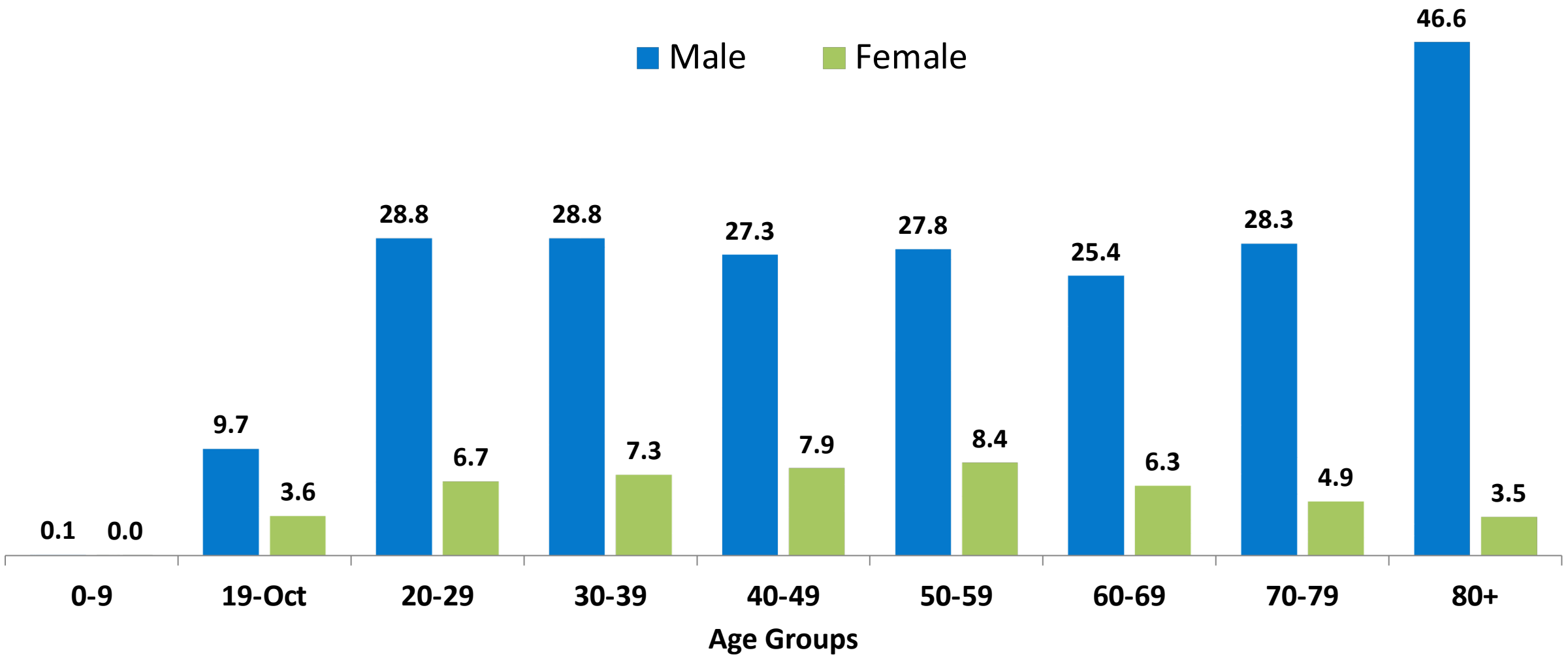
The Burden of Suicide

Suicide in The United States, 2020

- **45,979** Americans died by suicide in 2020; about 1 person every 11 minutes[1]
- Suicide deaths are **1.9 times** the number of homicides (homicides=24,576) [1]
- **2nd** leading cause of death for **10-14** and **25–34**-year olds[1]
  - **3rd** leading cause of death for **15–24**-year-olds
- Males account for **79%** of suicide deaths[1]
- Approximately 6,000 Veterans die by suicide each year; accounting for **13.7%** of all suicides annually[2]
- Since 2009, suicides have **exceeded** motor vehicle crash related deaths[1]

1. U.S. CDC WISQARS Fatal Injury Data, 2020 update. Accessed April 2022; https://www.cdc.gov/injury/wisqars/index.html
2. '2021 National Veteran Suicide Prevention Annual Report', September 2021, U.S. Department of Veteran Affairs.

Suicide Death Rates, by Age & Sex, United States, 2020
(rates per 100,000 population)



Data source: U.S. CDC WISQARS Fatal Injury Data, 2020 update.

Suicide in Maine, 2018-2020

- **9th** leading cause of death among all ages[1]
  - **2nd** leading cause of death ages 15-34
  - **4th** leading cause of death ages 35-54
- Suicide deaths are **12.4x** higher than homicide deaths
- Every **1.5 days** someone dies by suicide in Maine
- **Every other week** a young person (10-24) dies by suicide
- **260** suicide deaths per year on average
- **Firearms** are the most prevalent method for suicide deaths (**54.1%**)
- Of attempts resulting in hospitalization, there are **3** female attempts per every **2** male attempts[2]

1. U.S. CDC WISQARS Fatal Injury Data, 2018-2020. Accessed April 2022; https://www.cdc.gov/injury/wisqars/index.html
2. Maine Hospital Inpatient Database, Maine Health Data Organization

Suicide Attempts

- A suicide attempt may be the first overt sign that someone is struggling!
  - A call for Help
  - Often trigger being seen by a provider!

- Estimates 25 attempts for every suicide death across the lifespan
  - 200:1 for adolescents
  - **4:1 for older adults! Older adults may be more secretive, more intentional and choose means of more certain lethality.**

- ***A past suicide attempt is most predictive of future suicide behavior. A more recent and severe attempt, increases risk.***
  - Good practice includes a query of historic suicidality.

Maine's Death With Dignity- 2021 Report

- In 2021 67 individuals met all criteria and qualified for DWD services

- **Demographics**
  - No statistical difference between female & male
  - Age range from 52-97 with <50% over age 75
  - 98% were non-Hispanic white
  - 62% college educated, 22% High school or GED

- 63 of those individuals had a verified death: Their deaths are not classified as suicides
  - 46 died by patient choice
  - 17 died from underlying medical illness

Warning Signs
Risk Factors
Protective Factors

Definitions

Risk Factors- Stressful events or situations that may increase the likelihood of a suicide attempt or death. (Not predictive!)

Protective Factors- Personal and social resources that promote resiliency and reduce the potential of suicide and other high-risk behaviors.

Warning Signs- the early *observable signs* that indicate increased risk of suicide for someone in the near-term. (Within hours or days.)

Gender Differences in Suicide Risk

Males

- 80% of suicides
- Suicide rates increase in oldest adults
- Poor help-seeking
  - Men less likely to talk to someone
  - Less emotional literacy
- Increased substance abuse
- Use more lethal means
- Feeling like a burden
- Struggle between belongingness and independence

Females

- 20% of suicides
- Higher rate of suicide attempts
- Suicide rates decrease after age 55
- Depression rates 2 times higher
- Improved Help Seeking Behavior
  - More social connectedness
  - Higher emotional literacy
  - More likely to seek help
- Lower substance abuse rates
- Higher increases in rates of suicidality and suicide over the past decade!

Medical Comorbidity Issues in Suicidality

- In a home health and hospice practice, the suicide risk in someone with a chronic, progressive and debilitating illness must be considered. Those with cancer Dx have 2X risk of suicide.
  - Certain cancers
  - ALS
  - Progressive neurological disorders
  - COPD
  - …
- This can be a factor in any illness severely affecting quality of life and/or where there is significant unmanaged pain (or fear thereof).

RISK FACTORS For Suicide in Hospice / Palliative Care

A patient in hospice care is considering their death; it is what they face.

- *Typical that a patient will consider suicide as an option; especially when:*
  - Unresolved adverse medial issues related to primary Dx.
  - Anger/aggressiveness to family and care givers
  - Adverse physical/emotional consequences to treatment
  - Loss of, or fear of loss of autonomy/ fear of being a burden
  - Loss of quality of life

The most common reasons *patients* give for wanting to end their own Life

- Current pain and suffering;
- Fear of pain and suffering yet to come.
- Loss of control over what is happening.
- Fear of becoming even more dependent.
- Fear of abandonment, isolation, dying alone.
- Inability to cope with the impact of the illness on family and friends.
- Loss of personal integrity, fear of disfigurement.
- Economic impact of further expensive care; exhausted financial resources.
- Desire to “join” previously deceased spouse, parent, child.

How often are these kept inside?

Dr. Saul Ebema in Hospice Chaplaincy

Protective Factors

Protective Factors across the lifespan

- **Skills** to manage illness, communicate, manage anxiety & anger; coping skills
- **Purpose & value** in life; family connections and support; feeling of use in your world
- **Personal characteristics-** health and access to healthcare, positive outlook, healthy lifestyle choices, spirituality or religious belief
- **Supports**- family, friends and caring connected people including healthcare
- **Safe Environment –** restricted access to lethal means; personal safety

Warning Signs

These are changes in behavior or appearance that indicate someone is in crisis!

Clear Signs Of A Suicidal Crisis

1. Someone threatening to hurt or kill themselves
2. Someone looking for the means (gun, pills, rope etc.) to kill themselves; has a clear plan.
3. Someone showing signs of distress/ agitation/ anxiety

Get the facts and take action!

Call **911** if lethal means is present

Call **Crisis Hotline** if no means present

Warning Signs

I	***Ideation / threatened or communicated***
S	***Substance abuse / excessive or increased?***
P	***Purposelessness / no reasons for living***
A	***Anxiety /agitation / insomnia***
T	***Trapped / feeling no way out***
H	***Hopelessness / nothing will ever change***
W	***Withdrawal from friends, family, society***
A	***Anger (uncontrolled)/ rage / seeking revenge***
R	***Recklessness/ risky acts / unthinking***
M	***Mood changes (dramatic)***

Keep Your Eyes and Ears Open

Direct clues:

- I wish I was dead
- I'm going to end it all
- I'm going to kill myself

Less Direct clues:

- Life's just too hard
- You'd be better off without me
- Not sure if I can last
- What's the point?

From a Suicidal Person's Point of View

- Crisis point has been reached. (or a point of acceptance)
- Pain is unbearable
- Solutions to problems seem unavailable
- Thinking is affected

HOWEVER:

- Ambivalence exists (less common at end of life)
- Communicating distress is common
- Invitations to help are often extended

Why People Hesitate to Ask for Help

Why People Hesitate to Ask for Help

- Unwilling to admit needing help
- Afraid to upset/anger others
- Unsure of available help or resources
- Struggling with symptoms of depression/despair
- Afraid of what will happen if they acknowledge need
- Shame, fear of stigma
- May be quite comfortable with the decision
- May not want to be stopped!

Intervention: A bridge to help

Intervention

- **It all starts with a conversation**
- **Active intervention** is needed d/t stigma of suicide; you must ask!
- **Engagement** is essential
- Importance of connections/ **breaking isolation**
- Reduce the level of risk by removing **lethal means**
- **Invitations** are often extended to people based on fit

Where have you seen the interventions occur?

What IS Helpful

1) **Show You Care—Listen carefully—Be genuine**

"I'm concerned about you . . . about how you feel."

2) **Ask the Question—Be direct, caring and non-confrontational**

"Are you thinking about suicide?"

3) **Get Help—Do not leave him/her alone**

"You're not alone. Let me help you."

Assessing Suicidal Risk

- Use of a structured assessment instrument is recommended
- The MSPP supports the use of the Columbia Suicide Severity Rating Scale (C-SSRS) as a tool for screening for and evaluating suicide risk
- C-SSRS An evidence-based screening tool with applications as an assessment instrument; enables more nuanced estimation of risk
- Valid and reliable across a wide range of populations and settings

Assessing Risk for Suicide
(C-SSRS; Screen Version)

- **Suicidal Ideation**
  - *"Have you wished you were dead or wished you could go to sleep and not wake up?"*
  - *"Have you actually had any thoughts of killing yourself?"*
- **Planning**
  - *"Have you been thinking about how you might kill yourself?"*
- **Intent**
  - *"Have you had these thoughts and had some intention of acting on them?"*
  - *"Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?"*
- **History of suicidal Behavior**
  - *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"*
  - "If yes, when, how long ago and details of the event(s)?"

***Over the past week or the past month**

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

Using the C-SSRS Screen

- If the answer to the first 2 questions is ***NO***:
  - Ask the final question about Suicide Behavior to rule out history.
  - A NO answer on Q-6 finishes the screen.
- If ***YES*** *on questions 1 or 2*, ask questions 3,4,5 and 6.

- An increase in yes answers indicates an increased risk. Presence of current or recent intent and plan indicates a full risk assessment is needed.
  - Refer for crisis assessment

How to Work with C-SSRS Results

- Though asking about risk may often be done by an individual, management of safety, level of care decisions and ongoing management is a team sport.
  - ***Decisions on how to respond are best done with consultation.***
  - ***Who can you access for consultation?***
  - ***Do you include the family? (ar when…)***

- Always consult and follow your protocols

- ***Always err on the side of safety and caution.***

- If in ***any*** doubt, seek a full crisis assessment.

Examples and Discussion

Resources for Help

What are YOUR resources?

Resources for Help

To address the Crisis

- **Statewide Crisis Line (888-568-1112) 988**
- **National Suicide prevention Lifeline 800-273-8255**
- Hospital emergency room
- 911

For follow-up, support & information

- Evaluation for medication management or adjustment
- Referral to social work and chaplaincy
- Other…. ?

With whom can you consult for questions and concerns?

When to Call or Text Crisis. 988

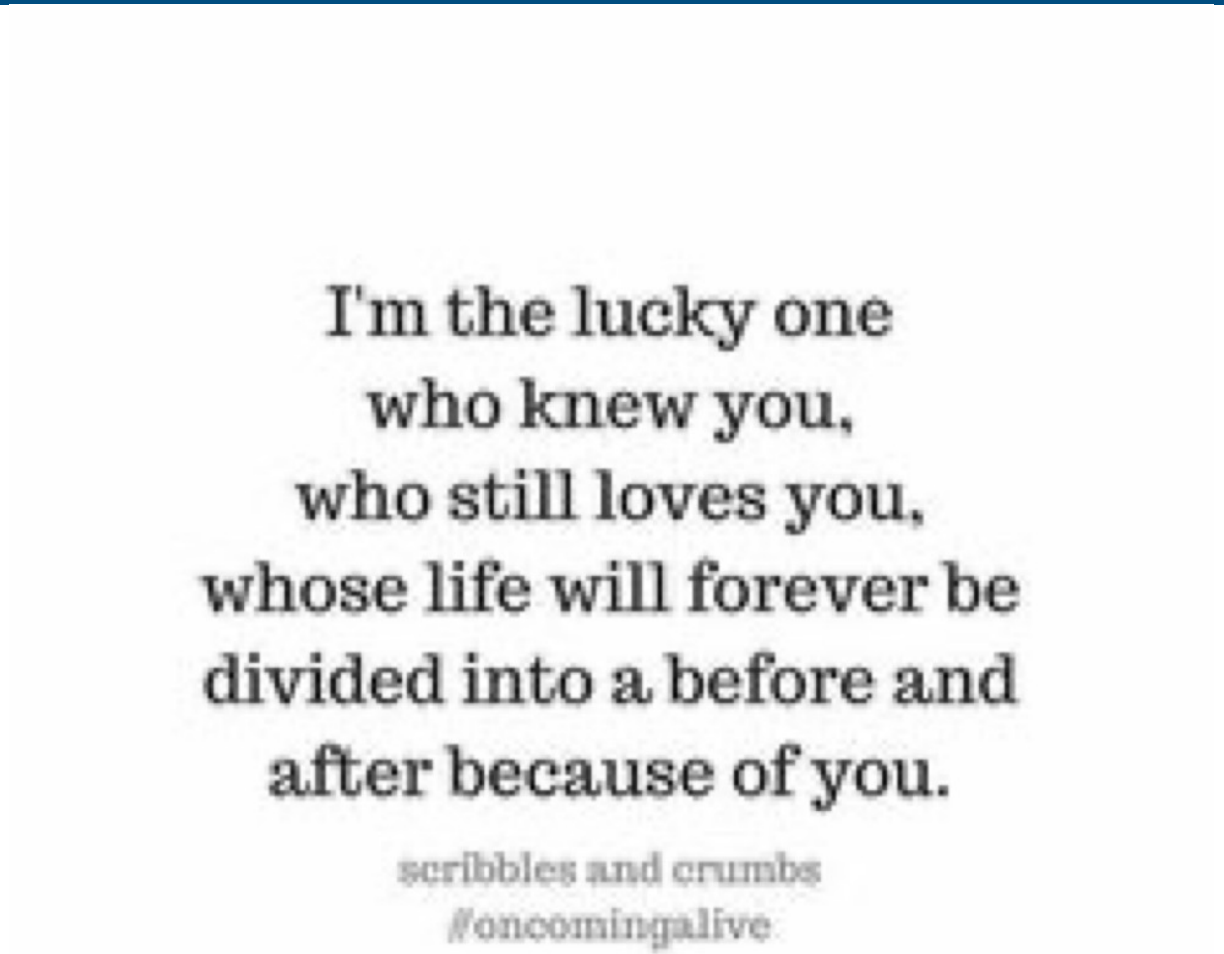
- “Call early, call often”
- Crisis clinicians are:
  - Available 24 / 7 by phone call or text through a statewide center.
  - Clinicians available regionally to come to your location or meet in a safe place for an assessment
  - Gatekeepers for admission into a hospital
- Call or Text for a phone consult when you are:
  - Concerned about someone’s mental health
  - Need advice about how to help someone in distress
  - Worried about someone and need another opinion
- The initial contact is free

1-888-568-1112

MAINE CRISIS LINE

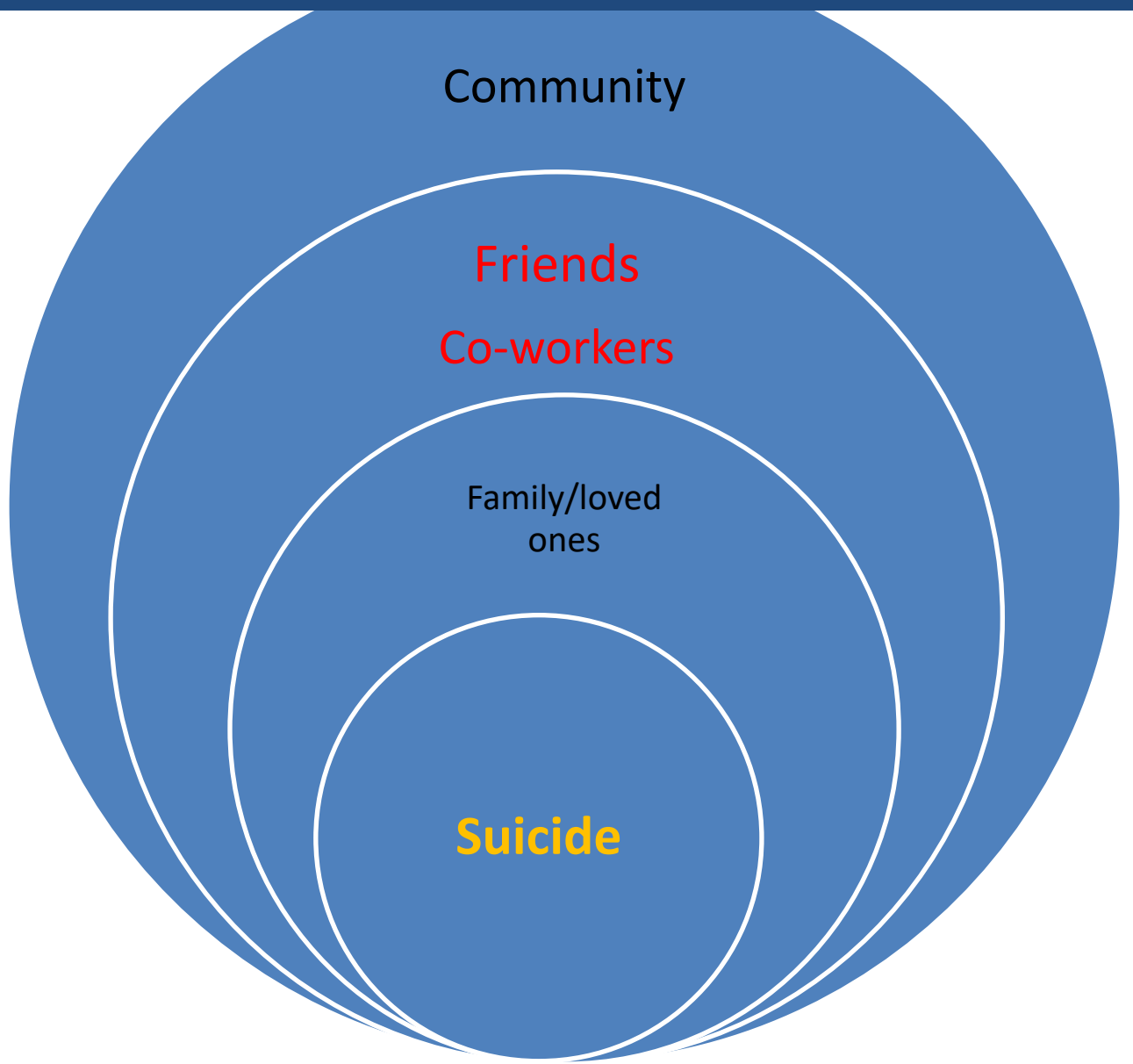
CALL. TEXT. CHAT.

Grief Following a Suicide



Effect of Suicide

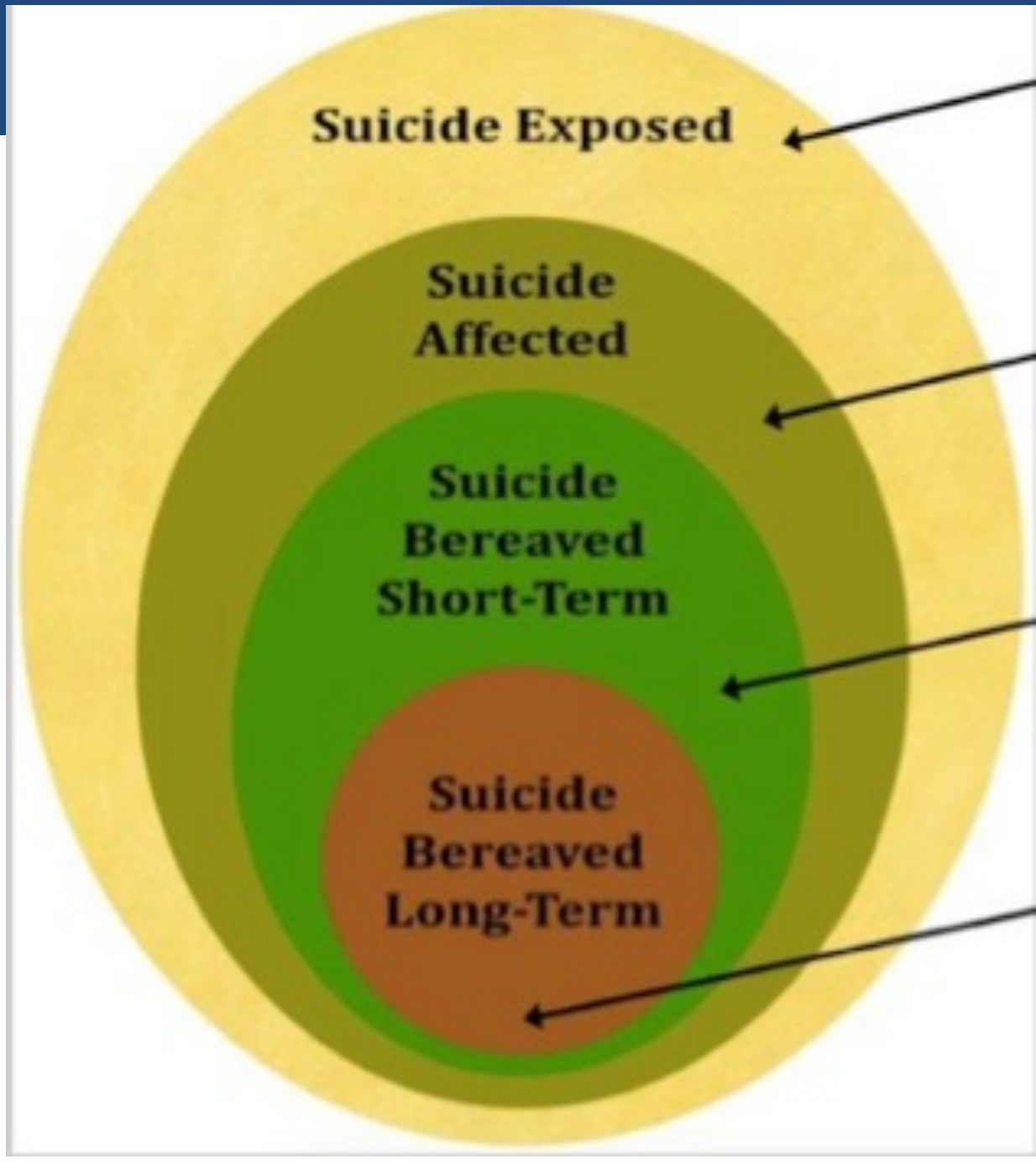
- **The Loss is:**
  - Sudden
  - Unexpected
  - Premature
  - Self-inflicted
- **The Reaction is:**
  - Shock, hurt, anger
  - Questions & torment
  - Loss and grief
  - Guilt and regret



Effect of Suicide on Others

- **After a suicide:**
  - Everyone is affected
  - For some it is intense & impactful
  - For a few, the impacts is deep and long
  - Triage support accordingly

Grief is also impacted by the stigma surrounding suicide and is especially strong among older adults



Who You Lose Matters

- **Friend;** acquaintance**,** close friend, best friend
- **Mentor or role model, or celebrity**
- **Sibling;** lost while young, or as an adult
- **Spouse;** lifelong spouse, estranged spouse, former spouse
- **Parent;** lost as a child, lost while an adolescent, or adult
- **Child;** lost while young or adolescent, lost as an adult, …

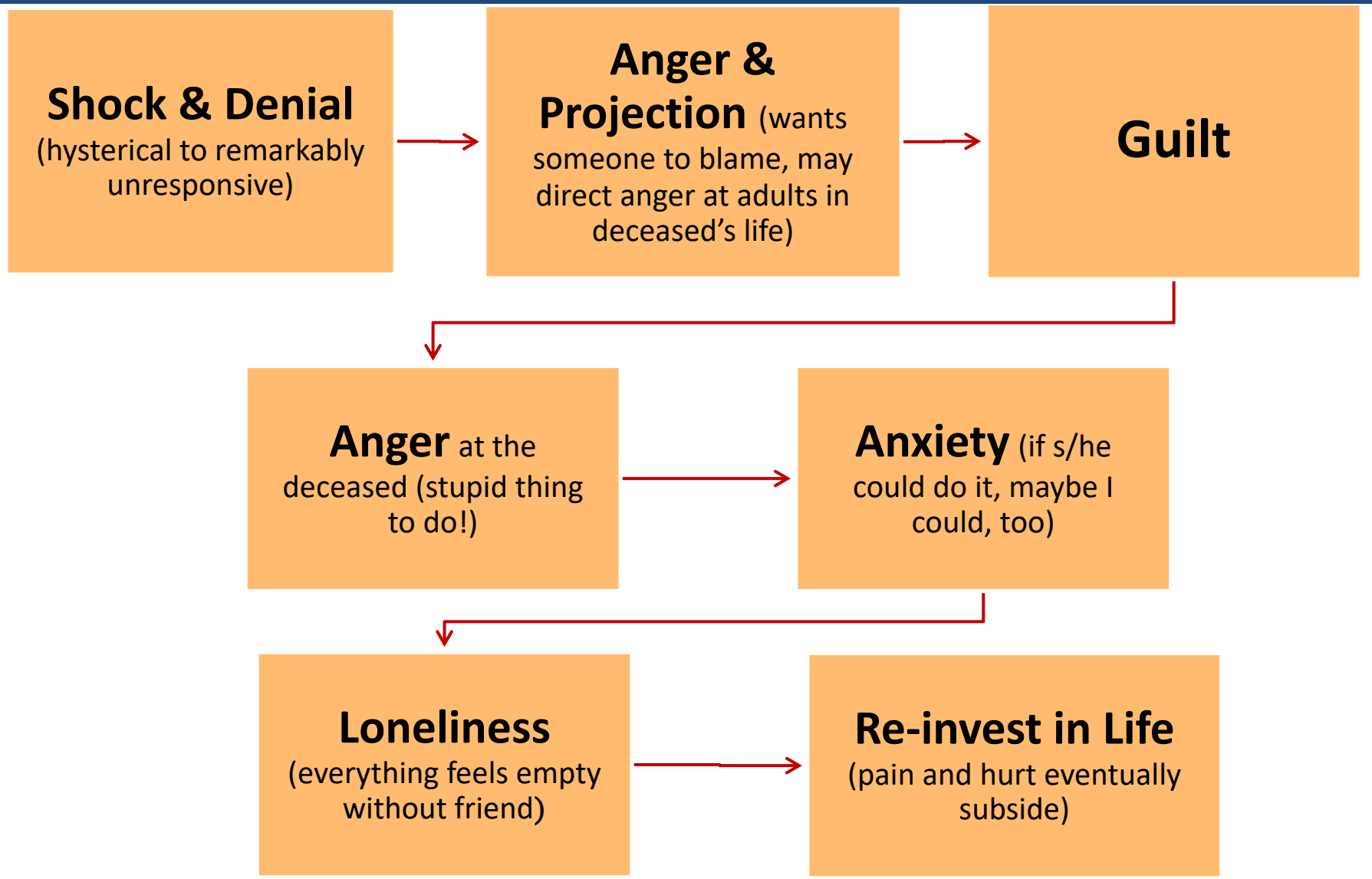
Normal Grief Reactions

- **Grief is the natural reaction to a loss or death**
  - This may be the first suicide death in their life
  - Suicide brings up their own mortality and sense of safety
  - *Stigma can isolate people in their grief*
- **Each person's grief experience is unique and their own**
  - The strong emotions may be scary as they feel out of control
  - Males and females often grieve differently
  - Couples may struggle to support each other's grief
- **Reactions can be powerful and even overwhelming and include:**

Suicide Bereavement

- **A Tsunami of Emotion**
  - All feelings are normal
  - Guilt is almost inevitable
  - Denial is common as a response to the stigma
  - It takes time, lots of time
  - The first months might be the easiest for family

Common Reactions to Suicide



The Range of Normal Grief Reactions

- **There are no “right” and “wrong” ways to grieve; each person follows their own pathway.**
  - But there can be behaviors that are not healthy
  - Be concerned re. isolation, rumination or depression, suicidality
  - Emotional reactivity or explosions can occur
  - Watch for high-risk reactions! ETOH, drugs, running away. starting a new life direction abruptly…
- **Grief after a suicide takes time; 3 to 5 times longer…**
  - No appropriate or “right” timeline, but some will try to hurry you
  - The grief following a suicide takes much longer…
  - The initial year of firsts…

How to Support Suicide Bereaved; Holding the Conversation

- *Acknowledge the elephant in the room!*
  - *Talk about the person and the death; use their name.*
  - *Acknowledge the nature of the death (?)*
  - Share your presence; none of us can "fix" grief
- Be prepared to mostly listen and accept… grief is about rewriting the narrative of the person's life and their death in the psyche of the bereaved.
- The grieving process is influenced by many issues
    - Relationship and role of the loss survivor in the deceased's life,
    - Their level of functioning in the world and reliance on the deceased
    - Past history of loss or of other trauma,
    - Resilience and coping
    - Supports present and engaged…

Coping With the Immediate Aftermath

- Signs of a stress reaction:
  - Hypervigilance
  - Emotional roller coaster
  - Sleep disturbance
  - Persistent thoughts of the deceased
  - Reminders or re-awakening of other losses
- All these are normal reactions to an extraordinary event
- They should diminish over time
- But be alert for suicidality or significant depression Sx.

Work to not pathologize grief!

Do you Tell the Kids?

- Or, when do you tell,
  - How do you tell
  - What do you tell.
- Support parents and caregivers with:
  - Appropriate language
  - How much to share
  - Age-appropriate levels
- We find that kids usually know!

Look to Maine Center for Grieving Children, NAMI Maine or NACG for resources

What Hospice Caregivers Experience After a Loss

- **Guilt is common:**
  - "Guilt was the biggest part. Could I have done more?"
  - "I felt guilty that I had missed something during my visit. I went over and over how I could have missed the suicidal ideation."
  - "The experience made me question my clinical judgment and ability to successfully perform my job."
  - "I felt I had failed to do my job of helping her die peacefully."
- **Thoughts and images can intrude**
  - "When someone brings up the topic of suicide, I have a visual memory of the event—particularly the visual image

What Hospice Caregivers Experience After a Loss

- **Changes in attitudes about patient suicide are also common**
  - "It made me view suicide differently in terms of it being a choice by the patient rather than pathology. I can now see how for some patients it is a choice rather than the absence of alternatives, mental illness, etc."
  - "I now see it as the ultimate act of patient autonomy. Death is what we do, and suicides will ultimately be a part of that."
- **And ultimately it grew into acceptance…**
  - "I found it important to not take full responsibility for a suicide. "
  - "It reaffirmed that I did all I could, and that we cannot control outcomes when people don't ask for help."
- **And growth:**
  - "It made me more attuned to what patients and their families are not saying or doing; looking for more clues and signs of suicidal ideation."

What Survivors Need

- Acceptance (and a space to feel accepted)
- Acknowledgment of the loss and the person who died
- Support for the very dark nights ahead
- A place to grieve in safety
- Other survivors who can share the story theme (often)
- Time
- More Time

MSPP Postvention Booklet Handout

Good Self-care Supports Ongoing Work!

If you are working with someone at risk for suicide….

- Acknowledge the intensity of **your** feelings
- Seek support from others, **debrief**
- Share your feelings with family/friends
- *Avoid over-involvement*. Never act in isolation
- Develop your support/referral team
- Maintain your hobbies! Have fun! Love your family.
- Know that you are not responsible for another person's choice to end their life

Resources to Support Grief

- Maine Center for Grieving Children: 207-775-521 www.cgcmaine.org resources, Cumberland and York Co.
- Local Hospice organizations with bereavement support
- Faith or pastoral leaders
- Camp Kita: info@campkita.com
- Grief Support Groups: http://www.state.me.us/suicide/survivors/index.htm

Questions or Discussion

MSPP Contact Information

- Training Program Inquiries: Julianne McLaughlin ; 207-622-5767 x 2318
  mspp@namimaine.org

- Greg Marley, LCSW, Clinical Director; 207-622-5767 x 2302
  gmarley@namimaine.org

- Rebecca Kurtz, Suicide Prevention Trainer; 207-622-5767 ext 2310

- MSPP Program Coordinator: Sheila Nelson, 207-287-3856
  Sheila.Nelson@maine.gov

Before you leave . . . .

Any Questions??

Thank you for learning about suicide prevention . . .