Podcast Transcript

Suicide Prevention: Identifying and Intervention with the At-Risk Person

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Guest

David J Denino, LPC, NCC

- Experienced educator and an expert in mental health first response, suicide prevention, and mental health interventions.
- Presented at many state and national conferences and has provided consulting services to a variety of both national and state organizations.
- Master trainer of Question Persuade Refer (QPR), having taught the QPR curriculum for several years, and was the key person in bringing the QPR model to the state university system in Connecticut.
- Certified clinical trauma professional and a Red Cross mental health first responder
- Mental health lead for the states of Connecticut and Rhode Island. As such, has assisted with relief efforts for hurricanes Katrina, Sandy, and Harvey as well as provided mental health support at the Sandy Hook and Las Vegas shootings

Host

Jannah Amiel MS, BSN, RN

- Visionary nurse leader with extensive clinical experience in high-acuity hospital settings.
- Education expertise in pre- and post-licensure nursing education, and leading organizational teams in building and developing products and talent.
- Founder and nurse educator of an online bootcamp-style course experience that prepared pre-licensure nursing graduates pass the NCLEX-RN and enter the workforce.
- Currently the Head of Healthcare Learning at Colibri Group.

Transcript

Episode 1 – It's Everyone's Business

Hi, and welcome to another episode of our NP Clinical Series. I am Jannah Amiel. I'll be your host today. And joining me, we have a very special guest, Mr. David Denino. And, David, I'm gonna let you introduce yourself, but you are a lot of things, right? There's a lot of work that you do looking at your bio, director emeritus, is that right? You work for counseling services, I think you're an adjunct professor, work with the Red Cross, tons of stuff. Tell us a little bit about yourself.

Sure. Well, thanks for the introduction. And all of those accolades come with just getting old, so they build up over time. As you said, I was a director of counseling at a university for almost 40 years, before I left to go on and do some consulting. I also taught at a graduate school for clinical mental health, and I still do that as an adjunct, so those were the mainstays of my career, if you will. My work with the Red Cross has been as a disaster, mental health first responder, and that's insurance with crisis and trauma work, and I've been around the block over the last lot of years. I started doing that work when the Twin Towers went down in New York. I got qualified, certified and vetted to be on scene to do that kind of work, and I've been at the large scale and small scale.

I do, in Connecticut here where I live, I do, you know, the small responses, which are usually fires and smaller storms, but I've done Hurricane Harvey, Katrina, I've been at mass shootings like Sandy Hook, which happened in our home state here, as well as the Las Vegas shootings, doing that mental health work that we have to do right on the scene, essentially, so a number of roles in terms of academic background, and in terms of counseling. I don't practice anymore as a therapist, but I teach as a therapist, though. And of course, let's get to the main point here, we're going to talk about suicide today. I have a lot of experience, obviously, in that area, working at the college where the second leading cause of death for college students is caused by, so that's important that we have prevention programs in place, and that we have all kinds of feelers out there to get people the assistance and help that they need. So that's me in a nutshell.

Very good, very good. So you're not busy at all. Well, I'm gonna open us up here, because you're right, we're going to talk about suicide prevention, and really kind of get down to, you know, why we're talking about this, right, and what's the actual data around it, and then really get into the health care provider's role. But I wanted to share a story, you know, as I was preparing for this particular podcast, I was thinking about, one, I'm super excited that we continue to have these conversations around mental health and mental wellness in our podcast series that we're having.

And then I was thinking particularly about this episode today, and thinking about suicide in the sense of reflecting "have I been affected directly by suicide?" in the sense of, was it a friend or family, you know, how has that shown up in my own life? And the one thing that I think about often, and it was interesting, because I thought "I don't think I've got a story in this way", but I actually do. And it's one

of those things that you realize you don't think about until you think about and then you realize you think about it all the time.

I'm a registered nurse and in one of my very first roles, this was more than a decade ago, I was working in the pediatric ICU, and I was a very new nurse in there, I want to say it was less than even a year. And one of, you know, a patient I was assigned, we had a new admit that was coming into the ICU. He was a 12-year-old boy, and he was coming in post-suicide attempt. And I still think about that today. And that was more than 10 years ago, and I really think about that today because for me, it was the first real was a child. And I remember, it felt like this very one-off thing, this like, isolated incident that never happens, I would probably never see it again. But obviously, we know that's not true. And I've really, you know, thought about that and thought, "oh jeez, I've carried this with me for a long time", because I think about it, you know, really often and now that I feel like we're all having these conversations more in the healthcare space as it relates to us as providers, as it relates just to the world, you know, this is a really important opportunity, I think, to start to frame up. This really isn't everybody's type of problem, if we will, this is something that everybody should be, you know, aware of, and educated, if you will. So I'm wondering if you can talk to us a little bit about just the basics, you know, on suicide, and why really it's a bigger issue than just someone who happens to encounter a patient.

Sure, sure. Thank you. First of all, thank you for sharing that story. I think it exemplifies the walk in life that we all have, the journey, and suicide affects us in many different ways. It could be professionally or personally. But I think when we talk about suicide, we talk about degrees of separation, whether you're directly involved in that, or more closely involved, and then as those kind of, I describe it as the rock into the pond, you have the epicenter where you get the burst of water coming up, but then the concentric circles that move out, that's how suicide affects people, those closest than a little bit further out. Best example is when we have a celebrity death by suicide, it affects everybody because they're high profile. Kate Spade for example, Anthony Bourdain recently, Robin Williams, etc. So it affects everybody and we all have a story where we at least maybe touched it. So that's why it's an important topic.

The other thing you mentioned, that's really critical in the last two and a half years with the nation having its ills, and with COVID, you know, impacting so abruptly and changing everyone's life and stress and all those kinds of things that impacted us, we're going to see if suicide rates were affected, or at least contemplation of suicide ideation, or if actual suicides take a bump. My guess is they probably will take a bump, because it's been a very difficult two and a half years. So with that being said, you know, and I know in the healthcare field, for providers, it's critical because your eyes and ears are on patients of all sizes, shapes, ages, etc, different populations that you see. And like other professions, it could be a quick-pace profession and do we skip over this question on an intake or in an annual exam? Or when we're talking to somebody and they say, "I am upset or I am depressed", are we asking the suicide question?

So today, you know, the hope is to give you an overview of why suicide is everyone's business, including all of those folks in healthcare, and whatever role they do play, and then we hope you take the second part of this which we'll drill down into a little more information, which we'll talk about at

the close so to get back to your question about the basic concepts, we absolutely want to know the foundation of why we have to be aware of what suicide means and is. And one of the first things I usually discuss when I teach this in graduate school, or I'm teaching suicide prevention programs to people who are non-clinically oriented, is that people know that suicide is multi-determined, it's usually not one thing, one focused, one item. That means there's lots of input as to why people go on to contemplate suicide, or then unfortunately, actually die by suicide. And the fact that it's multi-determined, it also means that we have to have multiple approaches to counteract thoughts for suicides to get involved in people who might be in the early stages of contemplation by looking at signs, symptoms, signals. And the grand thing when we're looking, regardless of role in life, healthcare professional or personal life, is to ask the question, and we're going to talk about that much more in Part 2 of this, how do we go ask the question, and what do we do with the answer.

So suicide is contemplated, because there's multiple things generally in a person's life that are going on that become very difficult, unable to handle. There might be a mental health issue attached with that, we'll talk about that statistic in a little bit. So if you have those kinds of things kind of going in and becoming a burden, let's say, that's heavier, much like it has been on all of us for two and a half years, people contemplate maybe more frequently about "what is life, why do I belong here, maybe I should not be here, this might be my exit strategy", which we don't want to have happen. So multiple approaches in terms of the person contemplating and then multiple approaches for the eyes and ears of the community to be on that person and listen and hear what people are saying, and ask the right questions.

We also want to remember that most suicidal people really don't want to die. It's just a solution to a problem that can be solved with intervention if they don't isolate and take it alone. So, one of the one of the stories I tell about that, you're all familiar with the Golden Gate Bridge, it became really known as the Suicide Bridge for a period of time. Yeah, so people would walk and they would get to the top of it and go over the side. Not many survivors. In terms of survivors, I don't know, maybe five or six in the whole lifetime of people jumping. But one person went on to make his living doing suicide prevention, and he said what shows in the data when other people have attempted in other ways, is that after he left the bridge, he decided he didn't want to die but it was too late. When that final moment was inside of him, and he was falling, he said, "I don't want to die". But he went down, they pulled him out unconscious, but he lived, had many issues, had mental health issues in his past. But it can be a very spontaneous decision within a window of several to 24-36hours where the crescendo, almost like a bell curve goes up and then a person's impacted and makes that fatal decision.

With intervention before the peak of that happening when we can bring that bell curve back down, maybe it would involve medication if there's a mental health issue, but it certainly would involve counseling so we have to access the person so they really can give themselves permission at times to get help. A lot of times people won't do that, because there might be a religious issue, it's embarrassing, it's sad, I don't want to bother anybody. But we'll see as we go through this, this two-part series, when you asked the question of someone, mostly they're going to be candid in their answer, because it's an "aha" moment that people digest and say, "you got me, you know where I'm coming from so let's talk, let's do something, let's do the next step". But your question to me would be, what is my next step? And we're gonna get to that eventually. So, and that just kind of

encapsulates that most suicidal people want to live and that they generally are in a position where they can get out of it with help, that we can solve the issues that are going on, but they might have been trying to solve those problems alone. But the other thing that kind of ties into this is, I mentioned it with a fellow who jumped off the Golden Gate Bridge, but the ambivalence - "Do I want to die? Do I not want to die?" and the build up to that. There's a lot of people in my practice, over 35 plus years, there's a lot of people who contemplate suicide all the time.

Not unlike depression, setting in and living with depression and medicating depression, but the depression never goes away, more dysthymic over time. They're ambivalent, and they're going back and forth, should I, shouldn't I, they're watching the world, they're watching people around them, they're watching what's happening to them, did another crisis event happen, did I just get fired from my job, did I get divorced, did I have a sudden death in my family, that is probably a factor, that would be the last straw on top of the haystack, if you will. So as they're doing that, they're contemplating options, to live or not to live.

Us, as healthcare professionals certainly at the top of the list, and then us as just fellow human beings want to be looking, listening and watching for whatever that is, you know, and later on, in this two-part series, we'll talk about those signs that we should be looking for that we might overlook and how we deal with them. One of them obviously, being you know, when people give stuff away, you know, that's the old adage, like oh, they're giving their stereo, I say stereo, they don't give stereos away anymore. They give their music collection away, they give their iPhone away, they give their computer away, they gave up on Facebook, they gave up on Instagram after being totally, totally and wholly involved with it forever. So it's the disconnection that we're looking for.

Now, as a provider, you're not going to see that every day unless you're in a hospital or you're in an in-patient unit, or you're in a center that sees your patients regularly. More than likely you see your patients when they're ill, or they're doing their annual exam in terms of "I've got health care". So the other thing we need to know and this is important, and it's important to know that the final decision rests with the individual all the time. And I say that to people because there are times where we can do everything, everything under the sun, to get the person treatment, help, in-patient, out-patient medication, counseling, support, financial support, you can do everything and a person still will go on to die by suicide. The chances are very, very much mitigated if they have that intervention and go on to live and have a productive, healthy life. But we can't catch everyone all the time, because we don't want people to think that they did an intervention, either from health care purposes or on a personal side of life, and that they failed at it because they didn't do something right. You're always doing something right.

And one of the key features about suicidality is that you can never inject the thought of suicide into somebody that is not contemplating suicide, and that's critical. So it's just never said like, "are you thinking about suicide?", and somebody would respond like you would respond to me Jannah by saying, "yeah, wow, what a great idea. I'm glad you brought that up with me". Doesn't happen. People are either in that realm of thinking about it, or they're not and if they are and you ask the question, you can get some input back and then our whole thing is, what do we do with that input?

So there's risk factors, a little bit more about basic concepts, there's risk factors that are involved and we're really gonna cover those I think, in part two of this, what do we look for in terms of risk factors. But more than more than risk factors, what are the protective factors that help people stay alive and not think about suicide and not ideate for a long period of time. So when we look at those protective factors, what can we do as healthcare providers, regardless of what your role is in the healthcare industry, when we're talking to patients, and we're talking to clients, whether they're as early as kindergarten, young people, right to our gerontologists, and working with geriatrics and older folks. And by the way, that suicide rate is quite high for older folks, so you need to know that people in geriatric care, home care, hospices, obviously, you know, those end-of-life stuff people contemplate before going to hospice, "I don't want to go, so maybe I'll take my own life", and a lot of issues for the elderly, for sure. And we'll talk about those populations that are at risk in a moment or two.

So that's an overview of what I wanted to present at the beginning to kind of set the tempo. We're going to talk a little bit today about the populations, the numbers, and health care providers and then in part two, we'll get into all those kind of warning signs in what we do. So, kinds of questions that might have generated for you, Jannah? Do you have any?

Yeah, Absolutely! That was great, great framing that up. You know one of the things that you said I'm curious. Before we kind of talked about the numbers, I want to hear that, like what is the prevalence of suicide, really. But you know you talked about contemplating suicide, and it makes me think of training that I've even had, as a nurse, just a brand new nurse, the first year, we kind of learned about how we screen for suicide, you know, ideations and things of that nature and what the risk is. But I wonder if you can talk a little bit about, you know, how do we know, and maybe it's just part of the provider's role, but, you know, sometimes you feel like this, this person, they're not really gonna do anything, right?

Like, they're just saying this expression or saying, "I want to kill myself", just because it was a really bad week, it was just a crummy week, I don't really think this is a real thing, I shouldn't be concerned about it, or should I be concerned about it? Do we take everything? Do you know what I'm saying? What is that... how do we know? Or is it going to be "hey, if someone says it, if they express it in any way, we must act on it?"

Yeah, that is insightful and a great question. Because all of the suicide trainings and what you're, you know, those of you listening now, you might have an organization that goes through routinely some kind of training, and mental health first aid, safe talk QPR, there's lots of trainings out to look at suicide, and do that prevention model. They all talk about this in capital letters of the beginning, take all signs and talk about suicide seriously. Exclamation point, period.

So especially I think, when you're providing services as a mental health provider or as a health care provider, you've got to listen to the patient because we are, like, bigger gatekeepers of health, right? So you've got to take all signs seriously . In terms of that, being a friend who's lamenting over like, "ah, she's lost a job, and then you know, the divorce is going poorly and they have an alcohol issue, and they have weapons in the house, and the kids don't talk to them anymore", that kind of picture has to be kind of placed around the person, and then you have to ask the question, you know, "I want

to ask you about what you just said about maybe I should just die or maybe I should just kill myself. Are you having that thought? And here, this is a great thing if they look at you, and they say, "what are you thinking about? Like, where did you get that?" Good answer from the person because then we can identify that we maybe read into it too much. But you go, "whew, I was worried about you. So that makes me feel better" or perhaps they would say, "yeah, I'm thinking about it" so what? And then what do you do with the answer? Friend or as a healthcare provider, you know. But yeah, you have to take all signs and all talk about suicide seriously, so it's important that you do that."

Okay, excellent. Yeah, excellent, excellent. So let's talk a little bit about those numbers then. You know, what is the prevalence of suicide? And I feel like to your point earlier, you talked about, you know, us just kind of coming out of this pandemic, the world's ills, I mean, you're totally right in that way, so I feel like, when we are watching, you know, the news, when we're interacting out in our profession, in our spaces, even as our patients are coming through, as we're engaging in different types of continuing education, we're seeing a lot more suicide, you know, the concept and the topic come into our own reality, and so what is those numbers, really?

Yeah, and you know, and I think we're gonna see a bump in it but when we do data on that, it's all post-mortem, and then it's all done by State Department of Health, and then fed into the federal numbers, and those that are actually identified by dying by suicide with the identified cause being, you know, self-inflicted, if you will. So the data sets are every two to three years, because that's how data rolls out so we're looking at 2019, 2020, there's a little data from 2022. But generally speaking, the numbers are that suicide is ranked among the top 10 leading causes of death in the nation overall. You can imagine the other nine are all health-related cancers, etc, right?

But suicide has a number, it's a powerful number that is up there. I know that COVID just bumped to number 3 in that list of 1-10 of the cause of death, so that's a big number right now, hopefully, that'll dissipate quickly. So the 10th leading cause of death, and in 2019, 2020, there were about one and a half million people that died by suicide, so that's a big number. And for those of you that deal with kids, it's the second leading cause for youth and young adults aged. So people, kids, and I've heard these stories, I don't deal with a lot of children, I didn't deal with a lot of children in my career, but there's young children as early as 6, 7, 8, 9 that have died by suicide, and contemplate it and have access to look at the internet and figure out how to do that, and a lot of that is done by pill-taking or unfortunately sometimes hanging, it's very sad.

Almost 37% of the people in the last survey, so we're getting up there to about a third of the people who are 55 and older to make that determination, and it's also important to know, inside of those numbers, that was reported back to DPH by the coroner's office postmortem, is that 90% had a diagnosable mental health condition at the time of their death of some kind. That doesn't mean that they were schizophrenic, bipolar, or off on the very heavy end of having mental health issues. That could be, as I talked before about it, the depression, part of their life that they carry with them, but something that was diagnosed, and I'll talk about the numbers in a minute that have seen actually medical professionals prior to their death, either the year before or some point in time prior to their death taking place by suicide.

So 45,000 deaths, give or take, and what the methodology is, and you could probably just easily guess at this, firearms are number one. Access to firearms and so on, I spoke before, if a person is having a bad time, and they turn to alcohol, and they have firearms, that's kind of a very lethal triangle where we have to look at like, will a person act on what they might want to do, and we know anytime you have a substance abuse issue, or cloud judgement, right, that's the worst part because then you're doing things impulsively, and something can happen that could be tragic, so firearms. The second is suffocation, there's poisoning, and other's. So that access to weapons in our society, unfortunately, is the root of lots of things that happen, so access is an issue there. So it's big numbers. I think that, you know, I can kind of roll that over probably into the next topic, which is the populations that are at risk.

So I said before, adults over 45, that's a very large group, that's a large number of people that die by suicide, so we want to keep that point in mind. Then we have, you know, this is in no specific order, but these are higher-risk groups, if you will. Certainly we're concerned about veterans. You read about that regularly, a lot of you might work for the VA or agencies that work with veterans, so we want to be concerned about our veterans and I know that they have rolled out a terrific, robust suicide-prevention program inside of the military.

I've been part of those trainings here in Connecticut with the National Guard, and how they look out and they teach other reservists and other military people to look out for their folks that they work with. So older adults, veterans, a myriad of racial and ethnic groups, you could list those down, you know, American Indians, for those of you that work out where there are larger populations, or Alaskan, Native Alaskans, African American black population, Hispanic, Latino, and then we also have Asian and Pacific Islanders. So these are pockets, but if you look at the pockets, each has its own constituent area, and each of those areas gets larger and larger as you build out. So you want to describe, and we'll do this a little bit in part two, what's at risk and why is that risk higher. So what I just mentioned to you, and I want to include here, most specifically, because your antennas should go up when you're talking about persons of color, veterans, those racial and ethnic groups I've talked about, but I can't be remiss and not mention the LGBTQ+ population is very large-risk, and inside of that, the transgender healthcare part of it for anybody that is dealing with the LGBTQ population, is incredibly high. The risk factor doubles and triples, so that's important that we know that with a person that we're providing health services to, either mental health services or physical health care services, that the risk is higher. And we have an obligation to know that in the field we're in.

Generally, as a person, you should know that, it's just higher than heterosexuals' experience, so that's really critical that we look at that for the populations. Let's talk a little bit, because we wanted to talk a little bit, oh, any questions about that popped into your head or we can move on to healthcare provider role? Yeah, you know, what popped into my head as I'm thinking about this is, and we'll talk a little bit about this, I think, in Part 2, you know, of our podcast, but thinking about the question, right? You mentioned that things like history of mental illness, for instance, certainly could factor into this, but I'm wondering, a history of familial suicide attempts, if that factors into that? And I wonder if we even ask that question as part of like, our role as a health care provider, you know. Is that one of the history questions that we ask? Should we? Is that something that we should ask if there is a risk? Yes and yes. Yeah. I mean, absolutely. I mean, because if a family has a history of suicide, you're gonna

see generally there might be an issue with mental health. That might be an undercurrent. And we know that that can be hereditary in terms of depression and other kinds of things that kind of, you know, leak into our lives. So yeah, it is a question to ask. People who have been impacted directly by familial history, it's important to ask that question.

And these are, you know, in healthcare, we ask a lot of hard questions all the time about a lot of different topics and some of them are embarrassing for people, right? This shouldn't be embarrassing, it should be one of those check-off things like, you know, "have you thought about suicide in the past? Are you currently thinking about suicide? Did anybody in your family die by suicide? How recently did they die by suicide?" You know, those kinds of things because it's part of the package of assessment, right? So yes and yes to your question.

All right. Thank you for that. So talk to us a little bit about the healthcare provider's role here. Yeah, and this is, I think we're gonna end with this and a couple of final comments, but it's important because, you know, in addressing healthcare providers, anybody who has a license to, that is working with patients from LPN, up to whatever you want to be, if you have patient care and patient contact, you have a responsibility. And you all know, our level of responsibility is higher than the general population, you know, just by our training and certainly, we're ethically and legally obligated to do that.

But here's some telling statistics I would just put forward, and that is that whenever I talk about a provider role, I give you some data on that. So we're in a unique position as a provider, we get to see patients and clients in front of us maybe not so frequently, that's why we have to be thorough in our assessment of what we're asking and what we're doing. But I mentioned before that there were some data that was recovered by some researchers that said, around 45% of people who had contact with their primary care provider, about 45% of suicides had contact with that provider within a month. So that's closely aligned for that person taking their life and then when they do that post-mortem, they see that they had a healthcare visit somewhere. It could have been for a cold, it could have been an annual physical, it could have been anything. It could mean nothing. It could mean something. It depends on how the patient presented, and then what questions you asked to find out about what happened, what was going on in that person's life. The number's higher when you roll it back a year, it could be up to three quarters at 77% of people who saw somebody in a primary care position before their death.

Now, when you drill down to the data, that could have been an annual checkup, right. So it could be half meaningless, but it might not be meaningless. I think the point I take away from that is that if they see us, we want to be asking the questions, as you do about mental health issues or sexual health issues, you want to ask the questions in a same way. They're not threatening, they're not judgmental, they're just open-ended questions so that you can get a read on what your patient, either in-patient, out-patient, or whatever that person is seeing you for health care purposes. So we see people who have mental health issues, we know that, it could be low-level, it could be high-level, and that depends on your role and what your treatment is with them, but we want to check for that risk of suicide in our role.

I said, at the beginning, we're larger, bigger gatekeepers than an average person encountering someone, we know that, we carry that with us as part of the role that we provide. So what we're trying to do here is to provide some education on suicides. Specific skills, understanding ideation, understanding suicide death, and then looking at risk factors, and how do we make a determination of everything we're looking at to judge how low is this level or how high is this level, and ultimately, especially for mental health clinicians, do I let the person walk out the door at this point or not? And that's the ultimate decision, it's if you're going to hospitalize, which is a very serious thing for the patient, and for you to do, but appropriate, if necessary, for sure. So we are already seeing people, we should be in a position to do some work with that.

The last thing that I'll say, and then we could have some final comments, maybe if we're at about that point. The part I want to reiterate, is the part about 90% of the people having a diagnosable mental health disorder at the time of their death. The sub-bullet point there is that, again, they come into contact with some kind of a health professional during the time of their suicide risk. Did we know that? Did we ask about it? Did they tell us about it? Do people also, and we know this in mental health as well as healthcare services, we know that people can be pretty good at playing their life out in front of us, and they're not always honest but they appear to be honest. And it's not unlike other things where people have substance abuse problems, and they try to hide the fact that they have that problem. They get really good at it, you know, and that's why we get extra training to understand, to hopefully understand and penetrate that show, that is like, everything's really good but we know it's not, so how do we tear down or peel back the layers of that so we can get some help for the person. So that becomes the important thing. So follow-up question and maybe some closing points?

Yeah, that was excellent, actually. This has been very, very insightful and I'm really looking forward to diving into some of these concepts here in Part 2, really getting into those warning signs and things we can do about it and the risk factors.

Good. I'm glad to hear that and I hope people watch it and you know, it's not something that we deal with all the time. Every person that's watching this, they may never even entertain the suicide part based on their role, but you should be aware of it, you should be able to manage it, you should be able to recognize it. That's critical and then, as Jannah said, then we will talk about in the next chapter, the next 30 minutes, what suicide talk is, what the behavior is, risk factors, and then the key part about the last 10 minutes of that will be "what do I do for an intervention?", so Jannah asked, you know, asked me the question today, "are you thinking about suicide?" And I say "yes, I have thought about it", what's your next question? Usually people freeze and go, "I didn't want that answer. Because now I have to deal with the answer and have to have an intervention", now as healthcare providers, we should be ready to do that. If you're a layperson, you got to have some skill set to say "okay, what's my next step?" with this person who just told me they're contemplating that they want to die by suicide.

Yeah, looking forward to exploring that with you. David, thank you so much. I appreciate you for joining me today for this dialogue. This has been great.

Great. Hopefully you see everyone in Part 2.

Absolutely, and thank you all for tuning in to podcast. We absolutely hope you'll join us for Part 2 of this conversation. I am Jannah Amiel and on behalf of myself and David, thank you so much for joining us. Goodbye for now.

Episode 2 – It's OK to Ask the Questions

Hello everyone and welcome to part two of our very special clinical series episode. We're talking about suicide prevention and going through some of the things that we actually have spoken about last time: the health care provider's role, the basics. And now we're going to expand a little bit more on that. And of course, joining me is David Denino, who's with me for our first part. You want to give us a little intro and say hello again to our listeners?

Yeah, sure. And if you're joining us, thanks for doing part two. It's a real critical part of everything that we're talking about. So again, just briefly, my name is Dave Denino. I'm a licensed professional counselor. I was the director of counseling at a state university for about 38 years. Done a lot of work in prevention, particularly suicide prevention and suicide postvention over the last several decades. The other part of my work involves crisis and trauma. I'm a first responder for the—with the Red Cross as a disaster mental health worker. I'm the state lead for Connecticut and Rhode Island, but I've done—do a lot of local work for both states. But I've done such national events since the Sandy Hook school shooting, which happened in our home state, the Las Vegas shootings, Hurricane Katrina, Harvey floods to numerous dimension across the United States frequently. So that's, that's a bit of my background. And certainly, my passion is in training people both in the, in the healthcare field, as well as people who don't have credentials, just regular folks to understand signs of suicide and how to do an intervention.

So we're going to talk about that today. Not everybody in healthcare, either in mental health care, or healthcare services provided by nurse practitioners and MDs, PAs, etc. We don't touch suicide a lot. So it's always good to have a refresher about it. So that's what we're doing for you today.

Yeah, absolutely. I love that you said, even for the non-licensed folks. Because one of the things that we spoke about in part one, is really how suicide prevention—these conversations that we're having—is for everybody. It is everybody's business. So of course, we know that we are speaking to our audience, right, our audience of providers and healthcare workers and clinicians. But really something I wanted to make sure that we kind of underscore right, because it is an everybody issue.

You're totally right in saying that. Now, one of the last things we left off with in our first podcast, part one, was the health care provider's role. So I was hoping we can just pick up with that, and just a review on what that role is, and then get down some of these deeper concepts.

Right, yeah. And just to kind of go over when we left off in part one, that was about what health—why and how health care providers should be included. You know, research and some studies have shown obviously, that all primary care providers and people in all aspects of healthcare and delivering services are in a good and unique position to help identify people at risk. Do we ask the question always? Probably not. Should we? Probably so.

And then what do we do when that question is asked and the answer comes back as a yes? So we need to know the intervention methods— not that you have to do a whole suicide evaluation of the person

because it might not be your direct field of psych or counseling. But what do you do with the answer? And how do you hand that off? And how do you help the person with that issue? So that's really important. So it's about the proper education for all of us on using suicides specific skills to do an intervention and not missing warning signs and risk factors. And they're not unlike asking other questions when you talk to patients. You ask about lots of other things in life. You ask about physical health, sexual health, home environment. It's in the same vein as that. And it should be asked in the same way. It's not an alarming question and we'll talk about that in a moment. So that's kind of a little bit of an overview.

Excellent. Yeah. And the question, I'm excited to get to that point because when we do talk about it, it is like an awkward question. It does feel a little strange. But I mean, quite honestly, we ask people if they've ever had an STI before? How many sexual partners do you have? And that's an awkward question in itself, but we'll talk more about that. What about some of the warning signs? Can you start to kind of talk to us a little bit more about those pieces?

We'll talk about what the talk about suicide is, what the behavior and the mood might be with the person. But in terms of warning signs, there's no single cause. There's not one thing that that will lead to suicide, generally. It might be a culminating thing and a history of things that happen to a person. So we know that suicide can occur when stress comes into people's lives. That's important, obviously. And there's another thing that kind of sits on top of those things we're going to talk about, and that's the issue of depression. And I think we mentioned that in the first 30-minute podcast we did. Depression can be an underlying theme. In and of itself doesn't necessarily lead to a person wanting to die by suicide. But it is a factor. And it's a big factor when people suffer from depressive illnesses.

So and I said this leaving off last time, we want to take all signs seriously. So and we know depression affects people differently. Lots of ways depression can impact people. And you probably—when your screening people are asking about that: what is your mental health like? Are you depressed? Anxiety? And certainly, in the United States today, most especially stressors are on the rise around everything. The economy, civil unrest, the COVID issues—really have heightened everybody's level of anxiety, and sometimes depression. So—For sure. So that's a little bit about, about the background to take all signs seriously. But I think, you know, we want to jump into kind of four areas, which is, you know, when people talk the talk about suicide first, and then we'll look at behavior and mood after that. And it's pretty clear if people talk about suicide, you should be listening. So if they talk about killing themselves in any way, shape, or form, if people talk about being hopeless or the helplessness—I can't deal with this. The struggle is too hard. There's too many things. Too many things, the confluence of everything coming into my life is just—it's too heavy to bear. I can't take it. They talk about having no reason to live, perhaps. There's nothing to look forward to last this much in life, that much in life.

And even if we look at natural disasters, as a pinpoint, you might lose your business, your house, you might lose loved ones, and then you know, the feeling to go on might become very minimal for some people, particularly those that were compromised with maybe prior mental health issues, or don't have the resiliency to kind of go on. And if people talk about being like a burden to others. I don't want to, I don't want you know, I don't want people to have to come to see me in a hospital. I don't want this disease or this, this injury to last forever. I'm too old to care for. I don't want to burden my kids or

my family. So if they, if they talk about those things, we want to listen to each and every one of them when people start to talk about it. So a good question, obviously, if somebody says something is like, would you. You know, tell me a little bit more about that. When certainly as providers, you know, we're on schedules every day, we gotta get to the next thing. When someone starts to talk about these issues that I just mentioned, when you're talking the talk, you've got it, you've got to push the pause button on your day for at least a period of time to investigate that it's really critical and important. I said in the first 30-minute podcast we did that it was about 40% of people die by suicide had seen some kind of provider in a prior year. It could have been for a check-up. It could have been for a rash. It could have been anything, but they had been in to see a medical provider. So it's important that we listen carefully. So talk is really critical.

The second thing, if we start to look at the behaviors that people exhibit, so talk behavior and behavior and mood. The behavior and I think we look for this as we deal with patients and clients—looking at an increased use in alcohol or drug use. Any substance abuse issue needs to be monitored. You would do that for general health care anyway. But when you put that inside of someone who—oh, the target alcohol, substance abuse issue, they put that tucked inside of somebody wanting to die, drinking and acting spontaneously and wanting to die is—can be a very lethal combination.

So if people talk about wanting to end their lives, and they talk about processes that they might do that, searching for methods to do that. We want to be careful of that as well. So that's a behavior. Unfortunately, in behaviors, we find out post-mortem. When we look at emails or website searches and what people collected, we look back. We don't look forward. But we need to be looking forward and asking those questions. And then the other things, you know, when people withdraw from activities and a behavior can be like giving things away, which is kind of cliche, I gave all my stuff away. But it does happen. And people do start to park parts of their lives with people that they want to have items that they had to leave legacy or meaning for them. So it's important if they're doing that we want to know that behavior as well. And the other thing is like when we're interviewing patients or clients, are they isolated from family? What's their social network like? Did it shrink incredibly? Are they on all social media forums and then they quit them all suddenly? That's a change in behavior, again, that we want to take a look at. So talking about things, the kind of behavior that they would present.

And then, you know, the third thing that kind of dovetails into this is mood. And I think we're asking, regardless of the healthcare profession we're in, whether it's in the physical health side or the mental health side, we always ask patients and clients, how are you doing today? That's a good lead question, right? And it's an open-ended question. But "fine", is a great answer for everybody. But it might not be the real answer. So at times you want to, we want to maybe, well, what do you mean by fine? How about family life? How about work life? How about relationship life? You know, those kinds of things. Being more targeted. As you would be if you were conducting an interview or a session with a person who was had suicidal ideation and you're a clinician. You drill down into many different levels. But in teaching the masses, that's not your job. Your job is to identify whether they are suicidal, and then to get to the point, which we won't today, but how to make a referral and get them help. So the mood, the mood issues, certainly, we talked about depression and anxiety, the private number one and two leading factors for mental health issues in the United States.

Sometimes depression is number one, sometimes anxiety is number one, but they're kind of—sometimes went together. So loss of interest again, in a mood. Again, withdrawing from social media, social circles that you have. Irritability that wasn't there before. And if you see your patient once every year, you know, you have your notes, but you know, sometimes you remember their demeanor. And you know, if they, for example, is usually upbeat.

When he comes in, he talks about, you know, his dogs, the Red Cross, and things that are going on, but now he's not doing that. And I look forward to his Red Cross stories and he's not telling them anymore, whatever that might be. So being irritable, anger, maybe agitation in their life. And then, you know, kind of a giving up in the mood or relief that don't worry about me, everything's okay. You know, that's a statement. But what is reflecting? So you have to do a little more. And we're going to take a look at that in a minute or two, what it sounds like and what it looks like. So any other questions that pique your curiosity there?

Yeah, you know, certainly one of the things that I'm thinking about, you kind of ended with this, but I am thinking about when does the patient historian or someone's—anybody, individual's historian come in, right. So to your point, I imagine that as a provider, and even as a registered nurse, right, thinking about some of the patients that I've come across, sometimes this could be maybe your first or second, you know, brief encounter with this person. You don't feel like you know them quite well. It's not a patient that you really know well, in that way. But you've got that—that feeling right. And maybe it's something that they said. Or maybe it was their behavior. You know, there was something about it and you feel like—I don't, I don't know, something just seems different, right? And so, in saying that, you know, in my own perspective, I think about where, you know, I was working, I think about pediatrics. I had patients that had parents that had older siblings, you know, aunts, uncles that I could pull on to talk to and say, "Is this—is this normally how they behave? This is normally something that they say?" But in cases where you feel like, you know what, I'm just, I'm not sure and there isn't a historian here. There's almost a part of you that feels like I don't want to be judgmental, or freak them out and say, "I don't know. I'm really worried about you. You're not behaving like I think you might be." You know, how does how does that play in?

Yeah, great question. You know, the word is, how much do you want to pry? And do we what do we want? Exactly. Really deeply? And my answer to that is yes. And I think it can be done comfortably by saying, "I'm not—I'm not really feeling your answer. You know, I'm sensing something else. You know, is there anything going on? Would you like to kind of expand on that answer a little bit? But I'm not feeling it. Is there anything happening in life that you really want to talk about?" Just to be non-judgmental and to be comfortable when you wade into it, you don't have to get to the suicide question immediately. But if your inner feeling is telling you that something's there, it does not hurt to get to the question and be direct and like, take all signs seriously. Take your intuition as a healthcare provider seriously and say, "I'm just getting a sense of something here. Are you thinking about—and we'll talk about this momentarily— but the language has to be “are you thinking about suicide? Or are you thinking about killing yourself?" And we'll talk a little bit in in toward the end of this about how not to ask the question.

Yeah. Direct and get the correct answer. But yeah, I think you got to wait into it and pry a little more if your gut feeling's telling you. Especially when you meet a patient for the first time or second time, you don't really have the whole grip on who they are. They've been a patient for 10 years, you kind of know. But new, new people, you got to you know, if you're feeling it as a professional, you're feeling it. So go with it. Okay, that's good. That's good advice. And I'm interested to hear—asking the question, right, because as we kind of talked about that, right, I think about saying, "You know, I'm not feeling that answer. And I'm a little concerned. Let's explore this together more."

Yeah. And I have to be honest, I have absolutely had—especially as a brand new nurse—absolutely had the experience of going through a screening questionnaire, working in the ED, asking the question and getting a yes. And quite honestly thinking, "Where's my manager?" Where, you know, I didn't know what to do because I wasn't prepared with any rebuttal. I wasn't prepared in that way.

Yeah. And then you prepare to say, "Okay, thank you for that answer and being so honest with me." And then move on to the next step, but the next step is, because you're not going to do a, a clinical overview of are they actively suicidal or not?

Right. That's when you're gonna have to impart help. Even in healthcare professionals, you got to look toward other professionals. And we're going to talk about how you should be prepared on your worksite. And know those kinds of connections and regulations, if you will, if there are suicidal patients.

So yes, talk to us about that. About, you know, asking that question, because I absolutely have felt the fear of this is a yes. And I don't feel prepared to help.

Yeah, and we'll, and we're gonna go through some other some direct clues and indirect clues when people are actually indicating directly or indirectly their thoughts about suicide. And then we get to that big one that are really centers itself. How do you answer a yes answer? When yes comes, it's like you sit back and go, "Oh, I didn't want that answer. What do I do now?"

You're totally right. Healthcare providers do it on people in all walks of life say, "I don't want that answer. What do I do now?" This is about preparing for it and getting training. These two podcasts will help you, but then it's a muscle more training and how to deal with it. So let me let me talk about the direct verbal clues, which are easy and then the decoded, or indirect ones. And the direct ones, you know, this is this is pretty easy. If you're looking at a person's health, and you ask about the suicide question: depression, suicide? And they say yes, that's obviously an answer you have to react to. But clues that people give up in language to other people, maybe to providers, you know, I decided to kill myself, but not in a forceful way. I decided to kill myself. It's like, well, I just I decided to kill myself, or I wish I were dead. I have no business being here. I'm going to die by suicide. People will say commit suicide.

The term we like to use is I'm going to die by suicide. But I'm going to end that all. And a really big one is if such and such doesn't happen in my life, I've decided I'm going to kill myself. So whatever that—that factor is in life, like if my divorce goes through, if my divorce doesn't go through, if I don't

get custody of the kids, if I get fired from my job, if I get kicked out of the school—a litany of things that compound other things that lead people to things that would make them think about suicide. So if they're direct, you can hone in on that.

The other areas are like more indirect, where someone says I'm tired of life. I don't think I can go on anymore. There's too much stress. And really, in the last couple of years here in the United States, a lot of people lament about that. Like how am I going to get through my financial well-being, my job, COVID, civil unrest, shootings, you know, so much for everybody to carry. So it wouldn't be an uncommon thing for a person to say I'm tired of life. But if you're a healthcare provider, well, you've got to dig a little deeper and see where that's coming from. Things like my family would be better off without me—again, going back to being a and agony to my family because of my behavior, what I'm doing, I should just check out. Who cares if I'm dead anyway and things like that. People who become socially isolated and don't have connections. I just want out of all this. These are indirect clues you're listening to now. Or I won't be around much longer, so you won't have to be, you won't really have to worry about me. Those are things that when people say that, you want to say, "What do you mean by that? Can you tell me more about that?" Because it could be benign. I'm tired of life. I just can't go on with this. And then you ask the question, you know, please tell me more about it. “Well, you know, my401k tanked. I think I'm getting laid off. I don't know what to do with the kids during the day anymore.” So it's a compounded bunch of issues that then would lead to like, "Well, how do you feel about that? And are you thinking about like suicide, or you're thinking about killing yourself?" Most likely the person is going away to say, "No, I just don't have the capacity right now to deal with all this. I don't have the resiliency. I don't have the bounce back." So it's really—direct and indirect is about listening.

That makes sense. And in that way, right? Those direct and indirect verbal cues, right? So in this scenario, just kind of that you named, someone's just kind of like airing out their feelings. And absolutely, I get that, right. And they said, "No, no, no. Like, I'm not really thinking about suicide. I'm just, I'm complaining out loud. You're hearing me." But maybe you hear that person do it all the time. And again, I think it's bringing me back to my pry. Like, at what point do I say, "Hey, you know, this is the fourth time this week that you said something like that?" Is it as easy as you know, me saying, "I'm just—I'm just concerned. You're saying it a lot. And I know you said no, that you really are not thinking about killing yourself or dying by suicide. But I am concerned that you're saying this a lot."

Yeah. And you can say that comfortably I think, by indicating that I'm really concerned about you. You said that several times. That means things aren't getting better. So maybe you can open up the discussion about how can we help things get better? What kinds of resources would you need to get better at what is not working? So and you can only go so far, and we know this being health providers because people can be very closeted about what they reveal. And they can be very, very good at it.

Because they've learned through their life to hide things. Lots of people that have issues in life tuck them away. And people, unfortunately, if they do die by suicide, say I never saw that coming. Because—and truly, they may not have because people tuck it away, and they get good at it. I guess a kind of an analogy is a person who has a substance abuse issue that hides it for many years from people

they live with, from kids, from family, at parties and social functions. They hide it, but it's there. And then eventually it catches up. But they're good at making up the excuses as to why their behavior is off. But it's not about alcohol or substance abuse.

Yeah, good analogy there. Difficult.

Yeah, difficult. So. So that's, you know, the behavioral and situational clues are important.

There's many more of them. If you do get some suicide training, at some point, some more in-depth training about that at your agency or your practices, you'll learn a little more about that. But that'll pop us into the thing you're really excited about—is the ask —getting the yes answer. And, and I say excited about because you want to have some tools to be able to bounce back. And that put that look on your face that goes, "Oh my gosh, what do I do with this?" You know, because if a person says, "Yes, I have thought about suicide." Or they say, "Well, I tried last week, but it didn't work." You know, maybe they just took not enough medication to OD. So. So if they say yes, what do you do with that? That is that's this is an important part of this. So how do you get comfortable asking the question?

The first thing you need to know, and it's a giant misnomer for everyone, whether you're in healthcare or not, is that asking the question will not put the thought of suicide into somebody's head. You cannot present that. It's just not true. If I were to say to you today, "Jannah, are you're thinking about suicide?" And you never had, the answer wouldn't be from you, "I never thought about that. What a great idea. I think I will try that." It just doesn't happen. So the thought of wanting to die is either there or it's not there. So you have to be comfortable asking the question, knowing that you're not going to precipitate some action that might lead to somebody thinking about suicide. You have to remember this in asking the question, that not asking the question might have more dire consequences that you didn't ask when you had the opportunity and the person went on to die by suicide. So asking is overall a better option for sure.

The other thing I can tell you, and if there's clinicians that are listening to this that provide therapy, psychiatric nurses, psychiatric nurse practitioners, etc., they will tell you, and in my career I dealt with a lot of students that were, that were, I would say, on a borderline actively suicidal for a long period of time. But every time he asked a question about suicide, and somebody has it placed in front of them, you'll see their eyes go to the ground generally, and kind of like the shoulders go down. And this is a sense of relief that people have. That somebody pinpointed what they're struggling with, but hasn't asked the question directly. And I know, for the students that I've asked, they were almost like, "Thank goodness, somebody understands where I'm at, and they can help me work with this." That's where you want to be. So it often leads to a sense of relief when you ask the question, not a sense of anxiety, not a ratcheting up of like, "Yeah, I'm gonna go out and do it today." Because they're struggling, they don't know how to deal with it. They don't know how to ask about it. And they're just in this bad place, if you will. So overall, we're going to have some direct and indirect approaches here in a moment. But overall, how you ask the question is, is less important than you actually ask it. You got to get to it. And that's the key part. So a couple of things here. Less direct approach, getting to the direct approach, kind of warming up to it. So you don't go, "Are you thinking about suicide?"

Like you're saying before, right out of the gate. Or do a little more gauging here. Do I engage them in a different way? So maybe, you know, have you been very unhappy lately? And you've been so unhappy that you thought about, about ending your life? We're still not saying, 'Are you thinking about dying by suicide?' Do you ever wish you went to sleep and didn't wake up? These are some kind of introductory questions that kind of soften for people.

The next question, which becomes the direct approach. And the direct approach is just that. Are you thinking about killing yourself? Are you thinking about suicide? I prefer using, "Are you thinking about suicide? Have you thought about dying by suicide?" And it's direct and if the person was and wants to be candid and unload that, they will. That's the hope. And most people do because they're waiting for that opportunity, for the door to open and say, "I need help." So less direct approach warming up to it, and kind of a more direct. Actually, so, so the direct stuff, "Have you had thoughts of suicide or thinking about killing yourself? Do you wish you were dead there, right there?" And it's really important to know that kind of as a secondary check. And again, if a person acknowledges that they're thinking about suicide, or they have tried suicide, and now they're in your office, this is an alarm to get more help. You don't have to be there to do everything.

So if you're, if you're able to, you can go a little bit further and have that conversation about do you have a plan? How have you thought about suicide? And maybe they'll express, "I thought about stockpiling my pills. I have a weapon at home, which is very dangerous. I thought about hanging myself. I'm not sure how I'll do it. But I know I could look it up. I've had that answer online and figure it out. And I know it'll be painless. So this is some rumination about how we're going to get there. That's an important signal that the person is in trouble for sure, whether they have a plan or not. And they thought about it. You know, the other big question is like, "Have you decided about when you think you might kill yourself? Like, is it like, a month away?" Because people plan the event to get things in order. Sometimes, sometimes not. But it's a little more drilling down, If you will. Not that you have to ask these questions, but you've got to get somebody who's going to get more information about that.

Kind of other things that are common to ask, you know, "Have you collected things to carry out your plan?" Pills, rope, weapons, etc.? So did I get anything ready to make the next, the next, jump into that, that foray of really, really dying by suicide. So directly and indirectly, you should be comfortable enough to have a conversation. If it's telling, and again, your intuition is telling you should ask more questions. But remember, by discussing all this you're not going to plant the seed of suicide in someone's mind. They either have it or they don't.

Yeah, and that's an important piece. Certainly, that is something I have even heard in my own profession and in practice, that, you know, you think somebody might, might be on the edge, so to speak, for lack of better term. And asking them there is a real concern that you feel like I'm presenting the idea to someone who already is in distress. And I don't want to put that idea on them. That is a very real thing.

It is a very real feeling. And that's why people are afraid to ask it. And that's why we have such programs. And for those of you listening, you should think about your agency or the hospital where you work, and do they have any kind of suicide prevention training. And there's a multitude of national programs that are available. I happen to teach in one called QPR: Question, Persuade, Refer. And these are evidence-based programs. There's mental health, first aid, which I heard a lot about during the Obama administration. You know, there's Safe Talk. There's lots of them. Some are long, some are short, but they're all evidence-based. And they help us think about asking that question for both licensed medical providers and laypeople. Remember, we're all licensed professionals. We have a higher level to establish in terms of safety for any patient you're working with.

That's right. So that's critical to understand.

That's right. So you know, get to the question, I think, a key part here, too—and this is the next thing. And we'll talk about risk and, and protective, and then just your intervention. But how do you not ask the question, in capital letters? How do you not ask the question? And I can relate to you a story of a mom and daughter that were interviewed about the mom's son and the daughter's brother who was in the military, died by suicide. And they both asked, "And we wouldn't do anything stupid, would you?" They wanted to ask, "You are thinking of killing yourself, or you're not thinking about dying by suicide or committing suicide"—as they probably would put it. And the answer, in hindsight, unfortunately, for them was that it wasn't a stupid plan for her brother or her son. It was a good plan for him to relieve himself of whatever, that, those problems were that were so, so terrible that he thought he had to die by suicide.

So, so here's ways not to ask the question. "You're not suicidal, are you?" You know, because no. The answer for sure is gonna be no, right? Yeah, right. Yeah. You're not suicidal, are you? And again, I'll reiterate, you wouldn't do something stupid, would you? Suicide is a dumb idea. You're not thinking about killing yourself, are you? These are closed then questions. You want open ended and they have to you have to be direct in asking about are you're thinking about dying by suicide or are you thinking about killing yourself. And the key thing is, if you can't get to the point where you can ask the question, find somebody who can. I understand that's not always possible. If you don't work in an environment where you have colleagues you could turn to, other providers that you can turn to, that's difficult. If you're in a single person practice, and you can't get to it, get some consultation when that patient leaves. But be sure that the patient is leaving in a safe way, you know. You're—again, you want to always leave in a safe way. So it's important you get to the question. And again, I want you to just kind of think back to the point I made before when I asked the question, people find relief in it, generally. So it's okay. And you said before, you ask them about sexual health, you ask them about very intimate parts of their lives when they present certain things. So you can go there with the same degree of compassion and care with the suicide question as you can everything else.

So I want to move on a little bit. And the risk and protective factors, just say a little bit about that, and then intervention. So major risk factors. And this all part of having the history, you know. If you have a new patient, you're developing that. If you have an older patient that you've had with you for a while, you'll know some of those things. But if they had a prior suicide attempt, that's a risk factor. It doesn't mean they'll go on to complete suicide after that attempt. Often people with treatment and

intervention go on and live healthy and productive, productive lives because suicide is it's contemplated in a window of time when everything gets heavy. And that kind of timeframe that exists can be—and I think of it as a bell curve—something leading up to the crisis. And if we can catch it before it gets to the top of the bell curve, we can start to de-escalate it with therapy and with intervention and kind of reconciling what they can't deal with. So prior suicide attempts, drug or alcohol abuse is a factor.

Prior mental health conditions or current mental health conditions. A lot of people who are going to die by suicide have an existing mental health problem. Access to lethal means you learn that in school. If they have access to guns, most especially, which is the number one way to die by suicide, you've got to get those weapons out of the home. Or have somebody secure them eventually.
And then, you know, the linkage to if you know someone who died by suicide, or if you have family history is a bit of a factor as well. So those are some risk factors.

Protective factors become important. And I call this kind of like, after my training in suicide prevention, this is the wall of resistance. You got all those major risk things going on, then you get the protective factors. So here is suicide over here. Here's the protective factor wall. The protective factor wall is how people cope with their problems, problem solving skills, resiliency, connection to religion, perhaps and faith. That could be religion for hope and care or it could be religion that says, "My religion doesn't really recognize suicide. And it's a bad thing if I die by suicide, so I won't kill myself."

Family connections, social connections, supportive relationships with care providers, of all kinds. And we know this is difficult in the United States for sure, but availability of physical and mental health care, if they have access to that or not. And then again, the limited access to lethal means. So those are protective factors. That's the wall that we want to set up to help people not to die by suicide. If you have a question, you can interject or I'll go on to the last part, which is intervention.

Yeah. I mean, I think this question really might lean into the intervention. Because, you know, as we're talking through this, and I'm learning a ton, I have to tell you, David, after practicing as an RN, and even asking these questions, a lot of this is like breath of fresh air to me. But I wonder, just even in your opinion, in your practice, and your your experience, you can certainly talk to this in our intervention section here. But you know, how have you handled patients? How can we handle individuals, patients who won't be forthcoming and say, "Yes, yes, I am thinking about this." Because there's a real fear that if I say yes, you're gonna do something to me. You're gonna lock me up. I'm gonna go to jail, or in that room in the ED, or something's gonna happen to me and I'm not gonna say it, because then I don't want that to happen. I'm curious about that, as we're talking.

Yeah. And there's an approach that you could use, that's more gentle than that. Like, because some people do have that fear of, like, if I say I'm suicidal, you're gonna get me an ambulance, and I gotta do a three day stay at the hospital, right? And generally, that does, even with people who provide mental health services, that doesn't happen but a small percentage of the time. It's all about getting intervention in the plan to be well. So it's more about imminent risk versus risk. Imminent risk is like I have a plan, I have a gun, I'm gonna kill myself. I don't, I don't care anymore. Then we have to ratchet it up and say, "Well, look, I've got to call. And I've got to help protect you. And I want to be

there for you and with you." So meaning that support, even from any of—any provider is critical, because they don't have other linkages at that point that are helping them with this. And it really is about coaching, the fact that, look, we want to keep you safe. And this is part of keeping you safe. If you go to the hospital, it's for a further assessment. It doesn't mean that we might stay there, necessarily. You might be released, but we want to make sure that you're okay for now. And I want to help you look for those resources to be well. So it's about the longer term plan. Clinicians do this all the time, that work with patients or clients that are suicidal.

So it's about the gentle approach to it. And you know, sometimes you just have to make that gut feeling. And I've done this in my career. I mean, it spans, like 40 years now. But I have had people hospitalized through, in our state, we have to do it through the police. There's special categories that can, can do that directly in the state of Connecticut. So and I do that in a gentle way, walking the person through, being in touch with them, but they have to go to the hospital because I can't let them go. Because I've determined through my background check about their ideation level, that they are in line of direct harm. That they are going to die by suicide. It's kind of like they're gonna go off and they could actually kill themselves.

That makes sense.

So you have to make it comfortable—that it's not you're going to be hospitalized. You're not crazy. It's normal process, you know. And often, you know, I know it's kind of a silly analogy, but I said if you were having a heart attack right now, would you like to go to the hospital and have them help you with it? And maybe in a day or two, you'll be out and you'll be better physically? So the analogy is, this is your mental health versus your physical health, but it's like we want to take care of that, you know?

Absolutely. Like, yeah, go to the hospital for a seminar. That's a good analogy. That's good.

So, so let's talk about intervention before we go toward the end here. And my word to you is whoever's listening to this, wherever you work, think about a person. A person that would help you with, with a person that might be suicidal, who could you call at this moment that would help deal with that fact, that factor. And we'll talk about other helplines and so forth in a moment, but if you're in an agency and a hospital, you should be able to look to the left or the right and say, I need some assistance with this. And I've done that. I mean, I've had colleagues call me in to a session and say, they'll say, look, I want to get our director in here, and make sure you're safe. And then I'll get involved within a conversation. And we'll have two heads instead of one, say, this is what we're going to do with this patient or this client.

So think about somebody who could help you. It's imperative that you know your agency's roles for intervention, because somewhere buried in a policy and procedural manual is something about dealing with suicidal patients, for clients. So you better know what the agency policy is. So we might want to think about checking that out. What kind of screenings are available, and how you let people walk out the door from your agency or your facility. And be prepared to ask the question, and be ready to refer. Referral becomes an important thing. If you're in a mental health field, that, you know, you're

working with that, but you might utilize other resources. If you're in another type of health field, you would connect with mental health to have those assessment done and you probably will work collaboratively with that.

So here's what you need to know for the intervention. And the key part is about getting help so know your resources in your community, who do I call in our state, in Connecticut, we have a 211 system. So that can be as far as information for getting help, long-term mental health treatment into medical facilities, that can be helpful. You know, how you get help immediately, which is obviously 911, if that's necessary, and that is really at the top tier of calling anyone. And I mentioned before just about using your community resources, we certainly have the 1-800 Suicide Hotline. It's 1-800-273-8255, 1-800-SUICIDE but, but wait, there's more—like the commercial. We now have 988, which was unveiled in July 2022. So it's a new—and this is important. We had a suicide hotline 1-800-SUICIDE. 988 is for suicide prevention and mental health crisis.

So not only suicide. So if you have a person in crisis in front of you, don't be afraid to call 988 and start to get some assistance and referrals from them in your home state. It also deals with substance abuse issues. So if somebody's having a severe substance abuse problem, 988 is the number to call. Federal mandate, every state in the United States to get help differently trained than just the info line of 211. So differently trained to deal with suicide and mental health crisis. So that becomes important. Both of those have, when you call in, also have immediately a link for veterans, that is kind of ticked up, if you will, because you know, veteran suicides clearly are of concern. So that, you know, if it's acute, get a person to help. Get somebody on the line, make the next step. If it's less acute, maybe you can engage other family or their clergy or someone in that person's life, to help help get them that help, if you will. So it's really imperative that we make the linkage. And in Connecticut you know, I sat in the Connecticut State suicide advisory board for years. And we have a bit of a marketing campaign, both for suicide prevention, and now 988. But our promo, if you will, was, is really linked or linked to one word, one voice, one life. So if you're there for that person at that time, and you could link them, you might be able to do that intervention and save someone from dying by suicide. So any questions that you have at this point, maybe we can wrap up?

Yeah, you know, this is fantastic. We've covered a ton of great information. I think this has been fantastic. And really, really, I mean, informational for me, and I've been in practice for 15 years, right? So this is an important thing. I think it continues to evolve. And I'm glad that we continue to surface these conversations because it's for everybody. And you brought up in perfect examples of what's happening now in the world that really is just causing a lot of stress and contributing to a lot of—maybe new feelings, right that we haven't really dove into. So thank you so much, David for that. Is there anything that you want to leave our audience with before we wrap-up?

No, I just hope you've got the you know the tip of the iceberg here and pique your curiosity. And you might look around to see if either your community's providing training that's free or if your agency or hospital is providing any training that could be minimal in terms of your time out of your day. Some programs run an hour to 90 minutes, some run eight hours, like mental health first aid, but they all will help you be better equipped for dealing with mental health crisis and suicide, so do what you can. Excellent. David, appreciate you so much for joining me today for this amazing dialogue.

And thank you everyone for tuning into our podcast. We certainly hope you'll join us again for another discussion. I'm Jannah Amiel, and on behalf of myself and David, thanks for joining us and goodbye for now.