

Aspiring to a Zero-Suicide Mindset

By Sally Spencer-Thomas

When it comes to suicide prevention, bold leadership makes all the difference. EAP managers who understand this can make a big difference in the behavior of their counselors, their affiliate network providers, and the workplaces they serve. Leaders must push back on the idea that suicide is inevitable. Instead they can aspire to achieving zero suicide.

There is magic in aspiring to zero suicide – it ignites and provokes conversation and thinking. If we don't have an ambitious model, we are not going to achieve it. While it may be true that if someone wants to die by suicide strongly enough they may find a way, EAP managers have an opportunity to implement training for both their counselors and the companies they serve to ensure that employees are not going to complete a suicide on their watch.

Applying a zero-defect standard of care to suicide means that the entire organization reviews adverse outcomes related to suicide and adjusts performance accordingly. Robust performance improvement focused on the goal of zero suicides must become a central ingredient to managing EAP systems.

The following are specific recommendations regarding suicide prevention that EA professionals can help implement in the workplace.

❖ **Offer suicide prevention training and programming.** Throughout the year, EAPs can offer outreach programming that helps workplaces be partners in suicide prevention. One new tool EAPs can provide to help clients is to have employees complete the new gap analysis tool by Resilience at Work (www.ResilienceAtWork.net) called, "Is Your Workplace Mentally Fit?"

The site features a free, 24-point quiz that ranks an organization's state of mental fitness. Statements include, "Mental health benefits are accessible, offered to all employees and are covered at the same level as physical health." Participants are then asked to choose from the responses "not at all", "partially true", or "completely true." Results will indicate the level of mental fitness of a client company, and thus the degree to which the EAP may be able to assist in incorporating suicide prevention training in the workplace.

❖ **Oversee peer support programs.** EAPs can also help workplaces develop and supervise peer support programs. A peer supporter acts as a trained and empathic liaison to EAPs. An example of a peer supporter would be an employee leader passionate about wellness willing to advocate for their co-workers' mental health. Peer supporters act as trained and empathic liaisons to EAPs. They do not serve as counselors, but they can offer to accompany the employee to their first EAP session or in making the initial call to EAP.

EAPs can provide guidance on the selection processes of workplace peer supporters, helping to ensure that nominated peers understand the role of the EAP, which can also provide training on the need for boundaries and confidentiality.

❖ **Ask the suicide question effectively.** Most mental health professionals have not been trained in what Dr. Shawn Shea describes as the "practical art" of asking the suicide question (Shea, 2011). Thus, many ask indirect questions in a way that communicates they really don't want to know the truth.

Instead of, "Are you thinking of harming yourself" or, "You are not suicidal, are you?" EA professionals can learn to ask direct questions that are much more likely to elicit truthful answers.

Starting the conversation with observations and empathy is always a good step. For instance, “I’ve noticed (insert observed mood, behavior or life circumstance changes), and I’m concerned. Sometimes when people experience these things they think about suicide. I am wondering if you are thinking about suicide.”

Using the word “suicide” is important because when clinicians use direct language they model comfort and confidence, and are more effective at opening the door to the conversation.

Dr. Shea offers additional tactics:

- *Self-normalization*: “If I was going through this I might consider...”
- *Behavioral incident* (frame by frame): “Describe to me your worst point when you were overwhelmed, and walk me through step-by-step how your thinking changed. Tell me what happened when you experienced thoughts of suicide, even if just fleeting in nature...and then what happens...and then what...”
- *Shame attenuation* (learned behavior for survival): “Given your past (insert specific childhood trauma or neglect), I wonder if you ever found it necessary to (insert judged behavior like lying, stealing, exaggerating) to...just get through.”
- *Gentle assumption*: “What other ways have you thought of killing yourself?”
- *Symptom amplification*: Set upper limits of quantity in question at a high level, for example, “Do you think about suicide 1,000 times a day?”
- *Denial of the specific*: List specific means one by one, for instance, “Have you thought of killing yourself by jumping? By hanging? By firearms? Etc.”

What should anyone do if they say “yes”? The first words out of the counselor’s mouth should

be, “Thank you.” Expressing gratitude for the client in trusting the relationship and for being courageous are important steps in reassurance. Then offer collaboration, “We will figure this out together” or, “I have some ideas that might help.”

❖ Say “no” to “no-suicide” contracts.

“No-suicide contracts” “attempt to assure that the client makes a commitment not to inflict self-injurious behavior while in the care of the provider. Almost every mental health provider has been trained to do this when a client expresses suicidality.

Yet there is no evidence that “no-suicide” contracts actually work. In fact, evidence exists that they *don’t* work. In one study of people who attempted suicide in an inpatient mental health facility, 65 percent had signed a “no-suicide contract”. A survey of psychiatrists who used “no-suicide contracts” found that 40 percent had a patient die or make a serious attempt after signing one.

Clients who receive such contracts often become mistrustful of clinicians because the contracts are seen as being more about protecting the clinician rather than serving the client. By engaging a client in a “no-suicide contract” a dynamic sometimes emerges whereby the client becomes hesitant to bring up the issue of suicidal thoughts or behaviors for fear of breaking the contract.

❖ Collaborate in safety and wellness

planning. Instead of a “no-suicide contract,” clinicians should become familiar with structured safety and wellness planning. There are several tools that can help in this process. One is my3app (<http://my3app.org/>), another is SAMHSA’s Suicide Safe (<https://store.samhsa.gov/apps/suicidesafe/>), and a third is the Virtual Hope Box (t2health.dcoe.mil/apps/virtual-hope-box), which reminds people of their reasons for living. (Editor’s note: For additional resources, see the accompanying sidebar.)

Each of these tools walk people through a graduated hierarchy of things they can do instead

of attempting suicide, beginning with low-level self-soothing, distracting, or behavioral strategies. The next stage is reaching out to friends and family or trained peer supporters. If these efforts are not effective, individuals should seek professional or crisis support. Each of these steps is spelled out in great detail, with names and numbers for easy access.

When talking to people who are living with suicidal thoughts, many have told me their goal isn't to be "safe" – that is the goal of the clinician – rather, their goal is to live fully-engaged lives. Once the white hot crisis of suicide has passed, working on wellness planning can help the person transition from staying safe to rebuilding his or her life.

❖ **Recognize that predictive suicide risk assessment is a fallacy.** How good are clinicians at predicting suicide risk? Not very good, according to suicide risk researchers. Two recent studies concluded that 95 percent of so-called "high-risk patients" will *not* die from suicide, while roughly 50 percent of suicide deaths were among people in the lower-risk categories.

Researchers found that multiple risk factors were no more predictive than a single risk factor. In fact, they concluded that relying on these instruments to predict risk may even be a harmful practice, as it takes the focus off of rapport building and treatment formulation. Instead of trying to predict behavior, assessments should be used to help develop treatments.

Summary

EA counselors need to avoid relying on out-of-date suicide risk assessment protocols, and instead be offered training in state-of-the-art interventions. Together with our client companies we must aspire to "zero suicide". ■

Dr. Sally Spencer-Thomas is a clinical psychologist, inspirational international speaker, impact entrepreneur, and survivor of suicide loss. For a list of references used in this article, contact Sally at sallyspencerthomas@gmail.com.

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Resources include...

American Association of Suicidology – Suicide is everyone's business. Learn more at <http://www.suicidology.org/>

Calm Harm – Calm Harm is an app that provides tasks to help resist or manage the urge to self-harm. Visit <http://calmharm.co.uk/>

Columbia Lighthouse Project – The Project's mission is to light the way to ending suicide. Check out <http://cssrs.columbia.edu>

Crisis Text Line – This is a free crisis support line. Text HOME to 741741. Learn more at <https://www.crisistextline.org/>

Kevin Hines Story – A heartfelt video from a man who survived a suicide attempt off the Golden Gate Bridge. See <http://www.kevinhinesstory.com/video/>

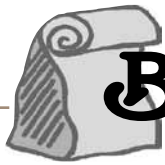
Man Therapy – Working-aged men (25-54 years old) account for the largest number of suicide deaths in the U.S. These men are also the least likely to receive any kind of support. Check out <http://mantherapy.org/about>

National Suicide Prevention Lifeline – 1-800-273-8255

Patient Safety Plan Template – A very useful template, courtesy of the National Suicide Prevention Lifeline. Go to https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf. (The URL is case sensitive.)

Suicide Prevention App – A step-by-step free tool to help prevent suicide. Check out <https://www.suicidepreventionapp.com/>

Suicide Prevention Resource Center – Self-paced online courses will improve your knowledge and skills in suicide prevention. Learn more at <https://training.sprc.org/> ■



Tips for Preventing Suicide ...

Suicide risk increases for those who have had a previous suicide attempt, those who suffer from one or more psychiatric disorders, such as depression, or use drugs or alcohol, and those who have ready access to methods of harming themselves (guns, medications).

The most effective way to prevent someone from taking his or her life is to recognize the factors that put them at increased risk for suicide, take warning signs seriously, and know how to respond.

Early Warning Signs

- Intense feelings or dramatic changes in mood such as hopelessness, rage, agitation.
- Sudden, unexplained improvement in mood with carefree appearance.
- Inability to sleep or sleeping all the time.

- Behaviors uncharacteristic of the individual (e.g. acting recklessly, increase alcohol/drug use).

Warnings of Immediate Danger

- Threatening to hurt or kill oneself (always take such comments seriously) .
- Looking for ways to kill oneself (weapons, pills, or other means).
- Talking or writing about death, dying, or suicide.
- Making plans for a serious attempt including practicing a suicide method, putting affairs in order, or giving away possessions.

Source: "Suicide Prevention Tips – Mental Health Partners."

... and Facts about Veterans at Risk

Among deployed and non-deployed active duty veterans who served during the Iraq or Afghanistan wars between 2001 and 2007, the rate of suicide was greatest the first three years after leaving service, according to a recent study.

Compared to the U.S. population, both deployed and non-deployed veterans had a higher risk of suicide, but a lower risk of death from other causes. Deployed veterans also had a lower risk of suicide compared to non-deployed veterans. Some key statistics include:

- Deployed veterans had a 41% higher suicide risk compared to the general U.S. population.
- Non-deployed veterans had a 61% higher suicide risk compared to the general U.S. population.

- Within 3 years since discharge, 33.1 suicide rate by non-deployed veterans, 29.7 suicide rate by deployed veterans.
- Regardless of deployment status, the suicide risk was higher among younger, male, white, unmarried, enlisted, and Army/Marine veterans; however, predictors of suicide were similar between male and female veterans.
- Veterans Crisis Line – 1-800-273-8255, press 1.

Source: U.S. Department of Veterans Affairs. To find out more, go to <https://www.publichealth.va.gov/epidemiology/studies/suicide-risk-death-risk-recent-veterans.asp>