



Suicidality and IDD

Webinar for Case Management and Support Coordination

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Objectives for Today's Webinar

- ✓ Place Suicide on the Disabilities Agenda
- ✓ Raise awareness about the nature of suicide risk among individuals with disabilities
- ✓ Acknowledge and promote suicide prevention strategies at every level





What is the Problem?

- The literature is limited on individuals with disabilities and suicidality. However, we do know that individuals with IDD and the non-IDD population share characteristics with regard to intended self-harm or death:
 - ❖ ***1/3 of respondents in a survey with intellectual disability expressed that “...life is not worth living”***
 - Unlike their non-IDD peers, persons with disability are more likely to have suicidal ideation or behaviors that are undetected and untreated



Connection between intelligence and suicidality

- Historical assumption that developmental disability acted as a buffer from suicidal behavior
- Does the person with disabilities understand the death or the concept of killing himself?
- Developmental disability is present in some form in about three percent of the population
- Developmental disability involves lower intelligence (FSIQ ≤ 69) and lifelong limitations that affect major areas of life activity such as communication, mobility, learning, self-help and independent living
- Individuals with higher IQ and disability are more likely than their lower IQ peers to experience suicidal thoughts, make suicidal attempts or commit suicide

Challenges



- Potential challenges to everyday living:
- Poor communication skills
- Difficulty responding to social or emotional cues
- Challenges to developing friendships
- Individuals may believe that they are a burden to others
- Individuals may have reduced protective factors such as coping, effective problem-solving and help-seeking skills

Risk Factors for persons with IDD

- Higher Q
- Presence of a comorbid Axis I
- Recent psychosocial stressors





Continuum of Suicidality and IDD

- Suicidal ideations including verbalizations:

I wish I were dead

Others would be better off without me...

I am going to kill myself

- Suicidal behaviors, sometimes referred to as suicidal gestures

- Non-suicidal self injury (NSSI) which refers to any behavior that results in injury to oneself without the intent of dying



Community

- Community members, including family and workers, have expressed concern that persons with IDD may not fully understand conversations about suicide or may become fixated on certain thoughts and events in response to conversations about suicide
- Although the research is limited, we do know that individuals at all levels of intellectual functioning do attempt and do commit suicide
- Individuals with disabilities with co-occurring mental health problems may be at particular risk for developing suicidal thoughts or behaviors



Suicide Risk Assessment

- Determine extent to which a person has *intent, opportunity* and *means*
- To what extent can someone contract for safety
- Take suicidal statements *seriously*, not *literally*
- A clinician who conducts suicide assessment asks about previous attempts, current stressors and current buffers
- Formal assessments might include the *Columbia Suicide Severity Scale- Revised (CSSS-R)*



Lack of Standardized Risk Assessment for the Population

- Assessment is particularly challenging for individuals with communication problems resulting in clinicians' heavy reliance on third-party informant reports
- Most existing screening measures require the capacity for abstract thought
- Due to ***diagnostic overshadowing***, which is the tendency to attribute all problems to disability and therefore overlook mental health disorders, individuals who should be assessed may be overlooked and *bona fide* suicidality dismissed
- It has been argued that individuals with disabilities and co-occurring mental health disorder, particularly depression, should be routinely assessed for suicidality because of their heightened risk for suicidal thinking and behavior



Indicators of suicidality

- Regression in functional skills
- Demonstration of behaviors that differ from usual temperament and may signal distress
- Significant increase in stereotypic and repetitive behaviors
- Threats to hurt or kill oneself
- Seeking access to pills, weapons or other means
- Talking, drawing or writing about death, dying or suicide
- Seeming preoccupation with the death of family members and friends, funerals, violent TV shows or movies



Indicators (cont'd)

- Acting recklessly or engaging in high risk activities
- Increasing alcohol or drug use which may increase impulsivity and dampen judgment
- Withdrawing from friends, family or society
- Demonstrating dramatic changes in mood
- Expressing that one has no reason for living or no sense of purpose in life
- Chronic or intractable pain conditions



Myths or Facts about Suicidality?

- All suicide attempts are a bid for attention
- A person will plan his death if he intends to commit suicide (suicidal intent and plan)
- One of the highest risk times regarding suicidality is following treatment for depression either on a psychiatric unit towards the end of inpatient stay or immediately following discharge



Truths about suicidality

- Not all suicide attempts are “bids for attention;” suicidality may, for instance, be an attempt to end physical or emotional pain for someone who cannot think of another way out...
- Not everyone has a “suicidal plan or intent” —for some individuals who are impulsive, their self-harming behavior may be opportunistic
- Yes (it may seem paradoxical): once someone is treated and depression has lifted, the person may have the energy to follow through on suicidal intent



Psychosocial stressors associated with increased risk of suicide

- Social rejection
- Stigma
- History of bullying and other forms of victimization
- Job and housing problems
- Financial problems
- Legal problems
- ***Any life situation which increases a sense of desperation and helplessness for someone with limited coping skills and social supports***



Recent Psychosocial Stressors

- A history of abuse, neglect or trauma
- Significant familial loss such as death, adoption or out-of-home placement
- Family conflict or instability including depression, psychosis, suicidality or alcoholism in the family
- Unstable or low family and social support
- Greater stress, loneliness and isolation
- Personal relationship conflicts such as peer rejection, bullying and victimization



Personal Problems associated with increased risk of suicide

- Health status changes
- Chronic pain
- Depression
- Psychiatric disorders
- Substance use
- Trauma history

Recognizing Masked Depression

SIG E CAPS

S Sleep is disturbed

I Interest is decreased

G Guilt (feelings of guilt or regret) – rumination; worthlessness

E Energy is less than usual

C Concentration is poor

A Appetite is disturbed; weight loss

P Psychomotor agitation or retardation – fatigue, anger, hostility

S Suicidal Ideation, including passive wish to die

How do clinicians assess suicidal risk?



- They conduct a suicide risk assessment
- They ask if the person has been thinking about hurting himself
- They ask if the person has any specific plans or preparations (e.g. stockpiling medication or sharp objects)
- If the person has thoughts about self-harm, how likely is the person to act upon these thoughts to end his life?
- Does the person have access to a weapon or item that can be lethal
- Does the person have the capability to execute a plan?



Suicidal Thoughts

Passive

- Death wish
- Thoughts of being better off dead
- Sign of significant distress, but no intent or plan to harm self.

Active

- Current desire to die
- Thoughts of taking action toward hurting oneself.
- Intent to harm self
- Plan to harm self

Types of Suicidal Behavior



Direct actions:

- previous attempts, wrist slashing, jumping, hanging, running out into traffic, overdose on medication, gunshot

Indirect actions:

- Refusing to eat or drink
- Refusing medications
- Refusing to follow medical advice



Protective Factors

- Sense of meaning and purpose in life
- Sense of hope and optimism
- Religious (or spiritual) practice
- Active social networks and support from family and friends
- Good health care practices
- Positive help-seeking behaviors
- Engagement in activities of personal interest
- Financial security
- Positively anticipated events (family celebrations, social gatherings)



Family and Staff Approaches

- Ask how the consumer feels or what the consumer thinks;
- Encourage consumers to talk about their issues, concerns and fears;
- Try to understand the consumer's point of view;
- Accept: sadness and other negative feelings.

A decorative graphic of a feather, rendered in a light, semi-transparent green color, is positioned on the left side of the slide. It has a central rachis with numerous fine barbs extending outwards, creating a soft, textured appearance.

Remember...

- ***Talking about suicide does not make someone suicidal!***
- *If we don't ask about it, we won't know about it!*
- *It's very rare that a person will volunteer these thoughts*
- ***Provide opportunities for the consumer to talk to a trusted staff member, clergy, a counselor or psychotherapist***



What probably doesn't help....

- “Oh, don't talk like that. You're one of our favorites.”
- “Things aren't so bad.”
- “Look on the bright side.”
- “Now don't talk such foolishness. You're doing just fine.”
- “I know you're probably not, but I just want to check—are you thinking about suicide?”

Strategies for Intervening & Managing Risk



Establish a safety plan:

- 15 minute checks or 1:1 until person is evaluated
- Restrict access to lethal means, sharp objects, call bell cords, ensure individual is on first floor, etc.
- Assist the person in identifying healthy coping skills.
- Address underlying issues:
 - *medical illness*
 - *social problems, concerns, transitions*
 - *environmental factors*
 - *Keep detailed notes*
 - ***Look for ways to foster hope and sense of meaning***



Considerations

- ❖ Recognize possible signs of depression and refer to mental health practitioner for assessment
- ❖ Discourage self-isolation such as staying in one's room, staying in bed most of the day and withdrawing from usually preferred activity
- ❖ Encourage activity
- ❖ Encourage social connection

Helpful Approaches

- Encourage continued connections with peers
- Encourage continued connections with family
- Encourage conversation with preferred staff
- Encourage participation in activities of preferred interest
- Provide adequate pain management and comfort strategies





Treatments

- Psychotherapy /counseling
- Pharmacological – use of anti-depressants
- Environmental Adjustments
 - Encourage meaningful, positive activities that create sense of mastery
 - » Schedule a predictable routine
 - » Exercise
 - » Pets
 - » Music
 - » Increase independence and sense of control
 - » Offer ways the person can contribute to the community
 - » Celebrate small successes and occasions

Whom do you call in case of psychiatric emergency?

- A **psychiatric emergency** is when a person cannot be redirected by usual means and escalates to the point of dangerousness to him/herself
- Mobile response from local Psychiatric Screening Center
- If not imminently dangerous, call appropriate CARES:
 - **1-888-393-3007** for adults 21+ with IDD



What do I bring to the Emergency Room?



- List of medications
- Information about what calms and what sets off...
- ***Do not escort someone who is dangerous to himself to the ER by yourself, call 9-1-1***
- ***You can meet the consumer at the screening center***

The Emergency Room



A decorative graphic of a feather, rendered in a light beige color, is positioned on the left side of the slide. It has a central rachis with numerous barbs extending outwards, creating a fan-like shape.

What happens when someone is referred to the ER?

- Expensive ride to Medical ER
- Wait for medical clearance
- Wait for a determination about psychiatric screening
- Will only hospitalize for dangerousness to self or others
- Determination of screening is only whether or not someone needs hospitalization; the client will generally not have treatment initiated in the ER



Role of inpatient psychiatric hospitalization

- Reduce dangerousness
- Rapid tranquilization
- Assessment
- Observation
- May be opportunity to trial intervention that can be continued in community
- Hand-off to community provider or (in the case of someone who does not stabilize) hand-off to higher level, longer-term care e.g. county or state hospitalization
- **Insist on Suicide Risk Assessment if the consumer has behaved dangerously**



Considerations for assessing risk

- Suicidal thoughts and behaviors should always be taken seriously and fully investigated
- Let the person know that you are concerned about them and want to help them
- Do not avoid using the word “suicide”
- Gain a clearer idea if the person understands death or the concept of killing themselves; in one sample, 27% of adolescents with developmental disabilities believed that their own deaths would not be permanent (Harden & Sahl 2010)
- Ask direct and to-the-point questions such as “Are you thinking about suicide?” or “Are you thinking about killing yourself”



Language considerations...

- Keep conversations simple and free of jargon
- Ask one short and specific questions or request at a time
- Speak clearly, slowly, calmly in a normal tone of voice, using non-threatening language



Confusion between NSSI and suicidality

- Unlike suicidal behavior, SIB is not accompanied by an intention to die
- Individuals self-injure for a variety of reasons including to relieve stress or numbness and because of difficulty communicating physical or emotional pain
- SIB is more likely to occur among lower intellectually functioning individuals and may be a part of their characteristic behavioral repertoire



NSSI

- May occur as a behavioral phenotype associated with certain developmental disorders such as Lesch-Nyan Syndrome and Cornelia de Lange syndrome
- May be a form of communication among individuals with limited language ability
- Medications such as Naltroxene or antipsychotics may be prescribed
- Safety measures such as helmets and mitts may be used
- Behavioral shaping (ABA) is often utilized to address reduction in SIB



Risk Management

- Short-term hospitalization to prevent death by suicide and to assess the underlying mental health of the person with disabilities
- Outpatient individual, family and group counseling to teach the individual new ways of coping
- Psychoactive medications to treat more entrenched psychiatric disorders such as depression, PTSD
- Clinical assessment to tailor unique intervention approaches that meets the needs of the individual
- Providing the consumer and his/her family with “voice” and “choice” in behavioral health services and at-home risk management



Ways that Support Coordinators can help families...

- Provide **education** about the realities of suicidality for consumers with significant depression, loneliness low self-esteem or an abuse history
- Assertively promote **evaluation** and **treatment** by a mental health professional of depression or severe anxiety
- Address diagnostic overshadowing if you become aware of same interfering with obtaining an assessment or taking action
- Make sure families take safety measures and have a **safety** plan
- Encourage families to provide opportunities for social connection and meaningful activity



How can SC help (cont'd)

- Help families address the stigma associated with mental health problems so that this does not become a barrier to obtaining help
- Educate families on the appropriate use of the ER and screening center
- Encourage families to seek opportunities for their relatives to learn healthy coping
- Encourage families to obtain supports through their faith-based communities
- Encourage families to read materials and attend workshops on the issues relevant to mental health and persons with IDD
- Encourage families to monitor television, internet use (particularly social media) regarding violence and self-harm



Questions?

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Thank you!