Michele Rasmussen 00:09
Welcome listeners to the NYU Langone Nursing Station Podcast. This series will highlight nurses coming together to share information about daily professional practice and initiatives to improve patient outcomes. In today's episode, we will be discussing suicide prevention and awareness. This session is eligible for contact hours and in disclosure in compliance with ANCC's Commission on Accreditation. This educational activity does not include any content that relates to the products and or services of a commercial interest that would create a conflict of interest. My name is Michele Rasmussen, Nursing Quality Specialist at Tisch Kimmel. In today's episode, we will hear from some of our psychiatry experts on suicide prevention.

Kelly Laurent 00:56
And hi everybody. My name is Kelly Laurent and I'm also a Nursing Quality Specialist here at Tisch Kimmel campus.

Michele Rasmussen 01:02
Okay, so let's kick off with some introductions. Please include your name, title, and campus. We'll start off with you Emily.

Emily Fries 01:10
My name is Emily Fries. I'm a Senior Nurse Clinician at the Manhattan Campus of NYU Langone. I'm an inpatient Psychiatric Nurse and I'm a member of the Behavioral Emergency Response Team.

Nancy Lee 01:22
Hi, my name is Nancy Lee. I'm a Recovery Firm Nurse at NYU Langone Orthopedic Hospital and I'm also a Psychiatric Nurse Practitioner.

Alessia Hughes 01:23
Hi, my name is Alessia Hughes. I am a Licensed Creative Arts Therapist and Registered Drama Therapist at the NYU Langone campus in Brooklyn. And I'm part of the Behavioral Optimization and Outcomes support team, our new boost team.

Michele Rasmussen 01:46
Welcome and thank you for joining us today. So suicide is a leading cause of death in this country and September is a time to raise awareness and discuss this highly stigmatized topic. Suicidal thoughts much like mental health conditions can affect anyone regardless of age, gender, or background. In fact, suicide is often the result of an untreated mental health condition. We use this month to spread hope and important information to people affected by suicide. It is also a good time to raise awareness across our health system. Our goal is ensuring that individuals, friends and families have access to the resources they need to discuss suicide prevention and to seek help. So, per the CDC, suicide was responsible for over 48,000 deaths in 2021. Suicide is the second leading cause of death among people aged 20 to 34. It is the third leading cause of death among those aged 10 to 19, and the fourth leading cause of death for ages 35 to 44. Did you know that although more women than men attempt suicide, men are

four times more likely to die by suicide. In fact, 79% of all people who die by suicide are male. Lesbian, gay, and bisexual youth are four times more likely to attempt suicide than straight youth. And transgender adults are nine times more likely to attempt suicide at some point in their life compared to the general population. Research supports that 90% of those who die by suicide experienced symptoms of a mental health condition. So hearing about all of these statistics, let's start off by hearing more about how we can as healthcare professionals appropriately screen our patients.

Emily Fries 03:35
So luckily, we have a lot of really great evidence based tools to use in screening patients and friends and family for suicide. The one that we use at NYU is the Columbia-Suicide Severity Rating Scale. And if you're working in the NYU system, you're probably familiar with this already. It's a series of six questions that you ask all patients according to your policy at your campus or in your practice setting. Right now in the emergency room, patients are screened when they come there, and then again when they're admitted to the unit. And the first question is just really straightforward. Have you wished that you were dead or wished that you could go to sleep and not wake up? And it's a way to just ease into that conversation with the patient? I usually start off by making it clear that I ask all of my patients these questions. You may be worried that asking someone about suicide might feel experienced as judgmental, or that it might cause someone who is not thinking about suicide to think about suicide and we know that that's simply not true. The best thing that you can do to try to prevent suicide in a patient is to ask them about whether they're thinking about suicide. So that first question is very gentle. Have you ever wished you were dead or wished you could go to sleep and not wake up? And as nurses, you're not expected to be able to provide therapy to the patient and help them feel better and feel like they want to wake up? This is really just so that you know what level of intervention is required. The following questions are about plans and intent for suicide. And then the screen ends with a question if the person has ever taken action to end their life or really worked it out how they might do it. And based on the answers to those questions, you'll need to provide an intervention, the intervention is guided by a rubric, it may simply be that you put the person immediately on one to one, it may be that you have a social worker speak with them, it may be that they may decide to see a psychiatrist, the important thing is that you complete the screen, and that you follow the interventions as guided.

Michele Rasmussen 05:37
So we just have to ask them and we have to screen our patients. How often should we actually ask these questions when patients are in the hospital?

Emily Fries 05:47
Yeah, that's a great question and again, it varies by your setting. You know, obviously, I work on inpatient psychiatry so I'm doing a mini screen of my patients every shift. In your setting that may be appropriate to just say, "Hey, are you having any thoughts of hurting yourself or ending your life or of suicide?" In your setting, you may only ask that question on your first encounter, and not again for another year. So it's really important to be up to date with your area's policies and procedures regarding suicide screening.

Michele Rasmussen 06:16
Thanks, Emily. Nancy, do you want to add anything to that?

Nancy Lee 06:20
Absolutely. When patients arrive to the hospital for surgery, each individual is screened. If there's a positive screen for suicidality or risk, patient verbalizes any thoughts or plans, the treatment team must be made aware immediately, usually an order or referral to social workers placed by an LIP, and this is the policy at NYU and it can be found on the intranet, Ellucid. Sometimes, there's also a concern nurses must be vigilant at this and escalate as needed. Remember that it does take a collaborative effort in order to keep all of our patients safe. So we identify the symptoms, the risks, any protective factors they might have, any support a person might have, as well. This includes family friends, work in the community, keeping in mind that there are also some risk factors that might place an individual at higher risk for suicidality. And this requires some screening and identification immediately.

Kelly Laurent 07:15
Alessia, do you have something to add?

Alessia Hughes 07:17
I do, yeah. So when we're talking about assessment, and I know we have all of these wonderful tools, like Emily was just sharing about these evidence based practices of how we screen for suicide, I think it's also important for providers, and if you know you're going into a space to do this assessment, practice the questions a little bit to get a feel for how they come out of your mouth, because we can talk about it. But when we're in the moment, sometimes we have our own conceptions about, preconceptions about death and about suicide. And so really figuring out how can I say these questions in a tender and caring way, that doesn't kind of put judgment in the air because there is such shame and guilt around these suicidal feelings. And I have a supervisor who always says, connection over content. The content of the screening is so important, right? We need to assess where this person is in severity of suicidal t hinking. And also, if there's not an alliance, a rapport, a trust, a comfort to be answering these questions, we're not going to get the information that we need. And so yes, we have these questions as a guide. And also, how do I say them in my own voice in a way that doesn't feel pressured or cut off in any kind of way. And so just encouraging people to practice saying those words and notice where that discomfort is for you. Maybe be curious about that. And then bringing that kind of neutral, tender space for when we're doing this kind of assessment on the floor with patients in person.

Emily Fries 08:42
I think that's fantastic advice to practice it ahead of time, so that you can really absorb what the person is saying, and also so that you can be present in that moment. Sometimes we blast through the screening questions that we have to ask, and we don't give space for the person to really settle into an answer. This may be the first time that someone was having suicidal

thoughts, has ever been asked to those questions. This may be the first opportunity we have to get someone connected to the help that they need.

Michele Rasmussen 09:16
Yeah, that's very important. So we have our patients who come to the hospital, we screen them for these suicide ideation and if they do screen in positive, what can we do to ensure that we keep them safe while they're in the hospital? You know, we want to connect them with the care that they need, but how else can we keep them safe while they're here in the hospital?

Emily Fries 09:37
So I think the most important thing to remember is that you want to stay with that person. You got to stay with the patient. That's why we have call bells, you can always say, hey, I need some help in here. But you have to stay with that person. After you get help, again, I'm just going to refer you to your locations policy about what suicide precautions entail. But until that patient can be assessed by either their primary team, or a psychiatrist, you want to err on the side of caution. So if someone says, I'm feeling suicidal, you want to assume that you're going to have to implement the suicide policy. And that generally involves keeping someone with the patient at all times, with their eyes on them at all times, staying within close range, people can do things very quickly, very, very quickly. And then after you've established that basic safety for the patient, then you want to be looking at the environment considering what in the environment might be able to be used to harm themselves. And then you want to be expressing your concern and care for that person. They have divulged to you something that may be very private. So what I usually just say is, thank you so much for telling me. This is a moment, when you don't want to freak out. This is a moment where you may be freaking out and inside your heart may be beating out of your chest. But to that person, you want to be conveying calmness and concern. Thank you for telling me that I want to help you, I'm going to get your doctor so we can talk about this more. And then that will like sort of set the tone so that they can feel comfortable, really opening up to their doctor or to the psychiatrist or to whomever comes to make that more formal assessment. And a lot of times, we will see patients who are put on suicide precautions when they are in acute pain. So this is sort of that like oncology patient, or that post op patient whose pain needs aren't being addressed and they're yelling, and they're saying, I want to kill myself with this pain. That's the kind of patient especially where it's important to return back a calmness and that expression of your genuine interest to help them. It sounds like you're really incredibly uncomfortable. I can't imagine being in the pain that you're in and I'm so sorry that it's making you feel like that I'm going to get the doctor so that we can figure this out. Those kinds of comments and statements can sometimes just help stabilize the situation.

Kelly Laurent 12:26
That's great information. So we recently actually shared in our nursing newsletters across the health system as a reminder that patients who are on suicide precaution, they must have their environment assessed and modified to remove any potential ligature risk. So for example, TV remotes connected by a cord represent a self harm risk, and they should be removed from the environment. And you can now place requests to have a cordless TV remote brought into your room through a self service ticket on InsideHealth. And as you know, patients are often awaiting

psychiatric beds while they're on medicine units. So here's the scenario that you kind of just talked about Emily, a patient's admitted for a medical condition, they never had a positive suicide screen. And then as you're caring for the patient, they say, I don't want to do this anymore. I want to die. So what would you do? How would you support a medicine nurse who's not prepared for this? And what would they do to proceed with this information.

Emily Fries 13:20
So that's, again, that's an example that we see all the time on the BERT service and with the psychiatry consult liaison team, it's establishing that rapport with the person, thank you for telling me that. I am so sorry, you're experiencing this. A lot of times, when we hear those comments about wanting to die, or suicide, it makes us afraid. And we might rush to reassure the person, or to make promises that we can't keep, like, you're not going to be in pain forever. We don't know that. I'm sure it'll be okay. We don't know that. It can't be that bad, anything like that. You really just want to meet the person in the space that they're in and acknowledge what they're experiencing. While you wait for more help. These are times where your body language also is really important. Those open hands, getting at the patient's level sitting down. Sometimes I just like lean on the bedside chair, so that I'm a little lower and I look a little more relaxed and open. Anything that makes it clear to that person that you are there to help and that you want to hear what they have to say.

Kelly Laurent 14:33
That's great. So suicide is preventable. And we all have a role to play to save lives, not only just as healthcare providers, but to our families, our friends and our community. And per the CDC suicide is rarely caused by a single circumstance or event. It's usually a range of factors, whether they're problems or situations that they'll just increase the possibility that a person may attempt suicide. So Nancy, can you share with us some risk factors?

Nancy Lee 14:59
Absolutely. There are individual risk factors that can contribute to an increased risk of previous suicide attempt. Any history of depression, other mental illness, chronic illnesses, such as pain, like we just spoke about a few moments ago, any problems in personal lives, financial situation, job situation, losses, any substance use can definitely increase this risk as well. Any relationship risk factors, history of violence, victimization, bullying, high conflict within relationships, you know, the dynamics can play a big role. And in the community, any lack of access to health care, any stress, any sort of discrimination, employment issues, there's a stigma associated with health seeking, and it's quite unsafe as media portrays suicide and, you know, we just have to ask our family and friends do they have a plan, you know, most important thing is just to ask just to check in with one another, we acknowledge each other's experience their feelings in the moment, staying in the moment with a person, especially if they're maybe showing some unsafe sort of tendencies and within the last few years, the topic of mental health has been headlined in scientific journals, internet forums, some talk shows, and we recognize the signs and symptoms of depression and the feelings of energy depletion, low self worth, exhaustion, feeling negative, which may be exacerbated due to various external stressors. So we need to check in from time to time with ourselves with one another, and just ask each other, how are we all doing. The

coping skills that we've learned that we've acquired in stressful situations, in various situations like workplace, school, family lives, in the community, they may cause an imbalance in our personal resources as well. So usually, when we think of this, we don't call to light suicide awareness, but the topic should not be taken lightly and it can affect anyone at any place any time. And because suicide awareness month is September, there's something that needs to be practiced all year round, which is raising awareness and making sure that we as healthcare providers also reach out to one another to form this sort of community and help each other help ourselves. We're at the forefront of patient care and it's important that we identify some healthy and positive coping strategies for ourselves to continue to practice in order to continue to care for our patients. So consider attending or creating wellness activities in the hospital or on your nursing unit in your department to optimize and further engagement. And know that as nurses, it's important to find a positive work life balance ourselves, setting up boundaries for ourselves too and knowing that it's okay to advocate for ourselves as well as our patients, and you are your own priority as well. So finding time to practice self care, incorporate a healthy diet for yourself, schedule a time to exercise, sleep, so important. And of course, if you know of anyone, just help them to reach out for any psychiatric or mental health resources that can link to, you know, a person to the help that they might need and also don't be afraid to ask for help when you need it to.

Emily Fries 18:13
Yeah, those are, it's really, I love what, what you say there, it's so important for us to take care of ourselves and be aware of the risk of suicide among our friends and colleagues. I know that I lost two dear friends and colleagues to suicide in the last five years, both healthcare professionals, and the risks among healthcare professionals is quite high. There are other categories of people who are at higher risk for suicide. And I do think it's important to know those categories. Anyone who's had a previous attempt is higher risk. Also, anyone who has a history of self harm, that doesn't rise to the level of a suicide attempt. Anyone who's had a close family member is automatically at higher risk for suicide. We don't know if this is because of environmental or genetic factors, but it is absolutely true. People in the LGBTQ population, as was mentioned previously, certain populations who have experienced severe stress like our Native American, our community in the United States are at higher risk for suicide. And then men in midlife and who are older are also higher risk. And in America, access to firearms dramatically increases the likelihood that if you do have a suicide attempt that it will be lethal, which is just an unfortunate fact here in the United States.

Michele Rasmussen 19:33
Thank you for all of that great information from all of you. Does anyone have any other last thoughts that they want to share with our listeners today on this very important topic? I know for me, but one thing that I learned recently is that I did learn that we should no longer really use that terminology of somebody committed suicide because using the word committed, almost seems like it is an offence or it's like a crime. it'll act and it's not that somebody committed suicide, but they died by suicide. So that was one reason takeaway that I learned during this month of suicide prevention and awareness month.

Alessia Hughes 20:12
Yeah, I think that's great to add about the language that we're using Michelle, about how we're speaking about suicide, with our colleagues, with our loved ones, and also with our patients, right, of where is my language impacting that ability for connection? And also, when Nancy was speaking about risk factors and coping strategies I was thinking about, you know, when I'm speaking with someone who is expressing some kind of suicidal ideation, I like to ask do you want out of this life or would you like out of this moment? And that's a really interesting question, because it gives you a really clear picture of where the intervention needs to go. And coming from kind of the therapeutic side, if someone is speaking about wanting out of life, then we're looking at installation of hope, universality connection, and self efficacy as an intervention. But if someone wants out of this moment, then we can get really curious about, okay, what about this moment is so uncomfortable, that we've made it to the point of not wanting to live anymore, and that kind of tension and that reality testing gives us a lot more information about what's promoting the thought pattern or the behavior pattern. And so that's something that I've been using a lot, and it gets a lot of information out and talking about where am I actually landing on this spectrum, right of suicidal thinking, and that we have to be able to tolerate the idea that people do want to die sometimes. And we have to be able to tolerate that in a shared space of giving someone insight about what makes life worth living. Both of those things, though they feel complete opposites, I personally think have to exist in the same space when we're doing suicide assessment, intervention care and prolonged treatment. Because they both exist, the tension exists within the person and that's where the discomfort comes from and when the discomfort is not tolerated, or can't be tolerated, that's when those suicidal thoughts kind of skyrocket so we have to make space for the idea that people do not want to die and make space for, okay and what makes life worth living at the same time?

Michele Rasmussen 22:22
Thank you so much for joining us today and raising awareness on suicide prevention. We hope that our listeners found this discussion helpful. The mental well being of our employees is a top priority at NYU Langone Health. We will link the life and wellness mental wellbeing web page where you can find more information on counseling services, support groups, stress management, help with substance abuse and much more. If you or someone you know is experiencing mental health related distress, or worried about a loved one who may need crisis support, contact 988 Suicide and Crisis Lifeline. For any questions or comments, please email #nursingstationpodcast. Also as a reminder, this session is eligible for .5 contact hours. A survey will be posted with the recording. Please access and complete the evaluation to obtain the certificate.