Tri-County Batterer Intervention Provider Network Meeting Minutes July 9th, 2013

Attendance: Debbie Tomasovic (A Better Way Counseling), Sonja Miller (Multnomah County Mental), Annie Neal (Multnomah DV Coordination Office), Brian Valetski (DCJ Multnomah County DV unit), Jennifer Hopkinson (Clackamas Women's Services), Samantha Naliboff (VOA Home Free), Olga Parker (Modus Vivendi), Ella Smith (ChangePoint), Matt Johnston (Domestic Violence Safe Dialogue), Mischelle Plunkett (Life in Focus Education), Yevette Wright (Life in Focus Education), Linda Castaneda (Manley Interventions), Regina Rosann (ARMS), Wendy Viola (Portland State University), Jaime Chavez (Cedar Counseling Center), Curtis St. Denis (Allies in Change/ICE), Chris Huffine (Allies in Change)

Minutes by Wendy Viola, edited by Chris Huffine

Topic: Suicidality among BIP Participants

Chris made a mini-presentation on some information he had included on suicidality and DV. Sonja Miller, who trains people on suicidality and screening, also made substantial contributions to this discussion. She can be reached at Sonja.g.miller@multco.us.

Some people make serious attempts on their lives with the intent of dying, while others do not intend to succeed at killing themselves and attempt suicide as a gesture. But even among those who attempt suicide as a gesture, we must maintain awareness that something must be very wrong if they're willing to go that far.

Among those who we may consider to be suicidal, there's a large group who wish that they were dead and experiencing feelings of despair who are not truly suicidal. Thoughts of wishing one's life would end of wishing one were dead are come when a person is feeling despair—a hopeless depression. People feeling despair and having such thoughts have no specific plan to commit suicide, and their thoughts of wishing that they were dead are more passing, and may not be as serious. There is another group of people who actively intend to kill themselves. These are two distinct groups, who often get lumped together. Some people, perhaps especially men, may take the metaphorical thought of wishing they were dead literally, and begin to act on it. They may misinterpret their feeling of despair as an indication of their suicidality. While we want to err on the side of assuming that everyone who reports being suicidal is dangerous, we want to keep the former group from taking the emotional metaphor that they experience literally. These two groups are on different ends of a continuum, so people from the first group could work their way into the second group.

Cutting is a separate phenomenon from suicidality—it's more about pain relief than suicide attempts. But we don't really know how cutting is related to suicide, so we have to take it seriously regardless. People can die from a gesture, even if they intend for it to be a gesture. Cutting tends to be more about shame and being hidden than about getting found and rescued.

Suicide rates internationally and locally

There are conflicting statistics about rates of suicide around the world. The *New York Times* recently reported an annual rate of around 1 million suicides worldwide, but an academic journal

article that Chris located reported that 10 – 20 million people around the world commit suicide each year, noting that suicide rates differ dramatically by region. Latin America and largely Muslim countries have some of the lowest suicide rates, while Eastern European countries have some of the highest. The low rates in Latin American and Muslim countries may be related to religiosity in those countries.

There's been a significant increase in suicides in the country since 1999, especially among middle-aged people. There's some confusion about the age group with the highest rates of suicide. Currently, suicide tends to peak after the age of 85.

Oregon has a higher than average suicide rate compared to the rest of the country. Almost half of all Oregonians who have killed themselves have had a documented mental illness. However, 60% of Oregon men who have committed suicide have not received services for mental illness. Nationally, suicide among middle-aged people has increased by 28%, while Oregon's rate increased by almost 50%, moving suicide from the 8th to the 4th leading cause of death among middle aged Oregonians.

Suicide is more common in rural counties than in urban ones, perhaps due to access to fire arms and/or isolation. In rural areas in Oregon, 90% of suicides involved firearms.

Means of suicide

Following the use of firearms, the use of poison and hanging are the most common means of committing suicide. These three means account for most of the suicides.

Suicidality is typically transitory

Suicidality is usually more passing than permanent. Ninety percent of people who unsuccessfully attempt suicide do not try again. Ninety percent of people who survive suicide attempts also say that there had been less than a day between when they decided to attempt suicide and when they actually did so.

The greatest risk for attempting suicide occurs within a window of a day to two weeks. Once individuals make it through that window, they rarely attempt suicide again (though of those who do attempt suicide, many of them have made prior attempts).

Substance use

About a third of American suicides involve alcohol, though among American women, only a sixth were intoxicated at the time of death. Intoxication is more common among suicides among young people than older people. Of those who have alcohol in their system at the time of death, many more have used guns to commit suicide than other means. Between 30 and 33% of those who attempt suicide have drugs and/or alcohol in their system at the time that they do so, establishing relapse among people who have been in recovery as a risk factor.

Firearms

Many more people are killed by guns in the context of suicide, than in the context of homicide. The probability of death via suicide is 2-5 times higher for people who live in homes with

firearms. Access to guns makes a big difference in suicide rates. NY and HI are examples of states that have tighter gun control laws, and below average suicide rates. The survival rates for people who attempt suicide with guns is only 16%, while survival rates for other means of attempting suicide are much higher.

Access to guns is a substantial risk factor for completing suicide attempts, and means restrictions are effective at reducing completed suicides. The combination of gun locks, gun safes, and storing ammunition separately from guns is effective, because each of these delaying mechanisms gives the brain a chance to distract itself. Once someone is identified as being at risk of suicide, ensuring that there are no guns in their home becomes crucial, as removing guns reduces the risk of suicide attempts dramatically.

Other risk factors

Loss is a major risk factor for suicide, as are prior suicide attempts. Any prior suicide attempt is a life-long risk for future attempts. Suicide among individuals' friend and family networks also constitute lifelong risks for attempting suicide.

Most people who attempt suicide have had a crisis in the last two weeks. There's also a correlation between having made a visit to the ER in the prior two weeks, and suicide attempts. Thus, better screening for suicidality in emergency rooms could be very impactful. It is also recommended that the screening procedure involve inquiring about intentions to commit homicide, as well as suicide.

Gender issues and differences

Within the U.S., White men have higher suicide rates than every other demographic group except for Native American men. US men are 4 times as likely as US women to successfully commit suicide. Women are much more likely to attempt suicide, while men are more likely to complete suicide. In every country in the world, men are more successful in committing suicide than women, with the exception of China, where women have a higher success rate. Young men who are in same sex relationships are much more likely to commit suicide than young women in same sex relationships.

Men are more likely to use lethal means (firearms) whereas women more often poison themselves. In the U.S., about two thirds of male suicide involves firearms, which is the same proportion of domestic violence homicides in which firearms are used.

Men who commit suicide are more likely to be single, unemployed, retired, have below-average income, and are military veterans. Until the last few decades, military veterans had lower levels of suicide than the general population, a trend that is now reversed. However, this trend is not specifically associated with exposure to combat.

Clackamas County has a fatality review team as well, but it hasn't been having meetings regularly. They have been paying a lot of attention to returning veterans, which we'll hopefully talk about in September. One veteran left a suicide note explaining that he was having a hard time adjusting and didn't want to put his family through that. The shift of military service from

protective factor to a risk factor is surprising, and may be due to multiple deployments, or the way that veterans are received when they get back. This particular veteran's suicide is an example of an egotonic suicide, which stands in contrast to abusive suicides, which are meant to prove a point. Abusive suicides aren't specific to DV perpetrators, but are probably much more common among DV perpetrators.

We may need to reexamine how we address and prevent suicide, as our current conception may be very gendered, because we draw so much on information from a mental health population, which is more female than male. Losing a job, losing a romantic partner, embarrassing social disclosure, losing control, and physical illness (especially among older men) are risk factors for suicide in general. Marital status, employment status, and income are *not* risk factors for suicide among women. Among the elderly, physical disability is highly related to suicide. This all falls under the category of loss: loss of job, partner, health, house, etc., which is the biggest factor in suicide; major life transitions. Men tend to be under-identified for depression and other mental health concerns, so they often fail to receive treatment and their depression progresses. Often, boys who are identified as aggressive, oppositional-defiant, etc. are actually depressed, but misdiagnosed.

Among men who kill themselves, 84% have not tried to do so previously. However, only 68% of women who kill themselves do so on their first attempt. This difference is significant. Among women who commit suicide, 58% have a documented mental health history, while only 38% of men who commit suicide are members of a psychiatric population.

There is quite a bit of information about which men are likely to become depressed. Losing a job is a huge trigger for feelings of loss and despair, because it's experienced as ego depletion for men. Among the elderly population, changes in partners' ability to provide care may be a trigger for suicide.

There is also a layer of "accidental" deaths, which may or may not have been suicides. The assumption that men don't communicate their suicidality is a myth. They often do talk about their suicidality, but in language that we may not identify as indicative of despair, hopelessness, and loss, and we may fail to identify their concrete steps to prepare for their suicide.

<u>DV and suicidality</u>

It has been the DV Fatality Review Team's experience that, when IPV perpetrators become suicidal, their partners have stepped in to provide support, putting themselves in danger of homicide when the perpetrators do ultimately proceed with their own suicides. DV survivors are more likely to attempt suicide than women who are not battered, as a result of trauma and isolation. Thus, many women end up dead as a result of their abuser's behavior, whether or not the perpetrator is the person committing the act. This trend is well known among advocates. Among victims, the more severe the abuse they have experienced, the more likely it is that they will be suicidal.

The Washington DV Fatality Review Team has been functioning far longer than Oregon's. In 2006, Washington's team looked at all suicide cases in state, and examined their court files to

identify histories of DV. Thirteen percent of the individuals in Washington who committed suicide had documented histories of DV. Of those women who were murdered by their romantic partners in 2003, *none* of them had formal documentation of DV histories. Among the men who committed suicide in Washington at the time of the investigation, 18% had documented histories of perpetrating DV. Of the 10 DV-related murder-suicides in Washington in 2008, a restraining order had been taken out in only one case. About 18% of DV-related homicide-suicides happened in proximity to a court action that marked the ending of the relationship (family court decision, etc.). Most of the time, murder suicides happen in close proximity to the ending of the relationship, which is sometimes precipitated by police intervention. Most DV perpetrators who commit homicide have not had any intervention, and most of their victims have not had any contact with victim services.

In 2006, Washington's DV Fatality Review team published a section about suicidality, written by Knox et al. The report found that participation in a suicide prevention program lead to a moderate reduction in suicide, and a 54% reduction in severe DV among members of the Air Force.

Do we know any specifics about DV perpetrators who commit suicide? It probably isn't appropriate to apply what we know about suicide in the general population to suicide among DV perpetrators. It would be worthwhile to look at the subset of perpetrators who do commit homicides and suicides. It seems that DV perpetrators are much more focused and intentional than most people who commit suicide. About half of DV-related murder-suicides are planned, while half appear impulsive. In the case of impulsive murder-suicides, many may have been prevented had there not been firearms in the room. Among batterers who commit murder-suicides, some appear to be primarily motivated by committing homicide, while others seem to be more motivated to commit homicide by their impending suicide.

Among perpetrators who commit murder-suicide, many are facing the impending loss of relationship, and are highly enmeshed with, and dependent upon, their partners. It's important to understand not what the status of the relationship is, but what the perpetrator thinks that the status of the relationship is. It's his subjective perception of the status of the relationship that's more important than the objective status of the relationship in terms of the victim's safety.

One of the major determinants of risk is whether the victim has a new partner. Additionally, many fear that their children will call someone else dad, and have a mentality that, if they're going, they're going to take everybody else they care about with them. However, we don't have statistics about these thought-processes among perpetrators who commit suicide and murder-suicide.

We don't really know the difference between perpetrators who kill themselves, and those who kill themselves and others. In both cases, emotional collapse is a central factor, though we cannot predict which perpetrators are most likely to experience an emotional collapse and fall into despair. Relapse is similar to emotional collapse in that men who are doing good work but who fall into relapse are more prone to commit homicide-suicides. In one case, getting off of

probation and ending a program resulted in a loss of crucial support, which precipitated a former participant's double murder-suicide.

Perpetrators might also use language that refers to other cases where murder-suicide was involved, instead of talking about their own suicidality. Perpetrators' talk of suicide may take the form of threats to their partners' life. If we focus just the risk factors for murder, or just the risk factors for suicide, we'll likely miss those who are at risk of murder-suicide.

There are many more perpetrators who make threats on their partners' lives than there are perpetrators who actually commit homicide. These vague and general intimidating threats are really an attempt at power and control. We know that the proportion of perpetrators who are serious about making good on these threats to their partners' lives is small, but we cannot identify who those serious perpetrators are. As a result, we have to take all threats seriously. However, we know that perpetrators who actually commit homicide-suicide have often just lost their job and/or their relationship is ending or about to end. In general, if a perpetrator is going to kill his partner, it will likely be because she has left him or she's going to leave him. More rarely, murders appear to come out of nowhere. Sometimes, perpetrators look for excuses in their circumstances to precede the murder-suicide. Those who are more likely to go through with homicide-suicide are often more likely to go to extreme lengths to exert power and control.

Neal Websdale with the National fatality review team seemed interested in locating some funding to look more closely at DV murder suicides. Eric Mankowksi was also going to assign a grad student to do a literature review on the topic. The area of DV murder-suicide is ripe for research. There's a 2009 Dutch article that looked at murder-suicides among DV perpetrators in contrast to non-DV perpetrators, but the article was very speculative.

<u>Predicting suicide</u>

Mental health professionals do no better than chance at predicting who will commit suicide. Traditional, question-based ways of predicting which individuals will commit suicide do not work very well. The base-rate of suicide is so low that false positives are relatively common. BIP providers refer clients who they believe are suicidal for evaluation. However, receiving an evaluation often doesn't happen very quickly. It is suggested that providers screen for both suicidality and homicidal tendencies among their clients. The professionals who screen for suicidality often are not attuned to the risk that they will commit homicide as well.

Lifetime history of suicide is a life-long risk factor for another suicide attempt—people dismiss suicide attempts after a period of a few months or a couple of years. Other mental illness, DV, other circumstances compound this risk. This risk is greatest for within 2-5 years of the suicide attempt, but the risk associated with having a suicide in the friend or family network is actually lifelong. There's a difference between people who have made a half-hearted attempt at suicide or who have had suicide ideation, and those who have made a serious attempt on their lives. Suicide attempts during adolescence may not be as closely related to risk of suicide in adulthood than other attempts during adulthood. Being on the victim end of bullying in adolescence is not, in and of itself, very predictive of suicide attempts; it's the compiling of multiple stressors and victimization from different arenas.

Once individuals are identified as being at risk of attempting suicide, the evaluations to which providers refer them must be conducted that day. If it is not possible to schedule a formal evaluation, the county response center and the ER are always options. There is also a mobile crisis center, which can go anywhere, though they are usually accompanied by police back up. The Multnomah County crisis line is (503) 988-4888.

Suicide screening trainings

Applied Suicide Intervention Skills Training (ASIST) is a program that has been implemented in Multnomah County. About 800 people in the area have participated in this intensive 2-day training, which will be continuing twice a year in English and once a year in Spanish. The program has received very positive feedback, even from mental health professionals. The program teaches a strategy of developing individualized plans. Schools have been using this program's teachings extensively, and have found them very helpful for identifying youth who are at risk of suicide. The program is free to attend, and usually enrolls about 45 people per session. When fliers for the next training opportunity are released, Annie will distribute them to the network. Providers within our group who have attended ASIST believe that the program is very valuable for anyone working in mental health. You can also contact Sonja Miller at Sonja.g.miller@multco.us who provides these trainings for more information. Much shorter, less comprehensive trainings are also available, and may be conducted within a single agency, to help providers identify risk factors for suicide attempts.

The ASIST program raises participants' awareness of the risk factors and symptoms of depression among a range of people. Using the ASIST method reveals the unique stressors that individuals are experiencing, and the pile-up of stressors that increases their risk of suicide. We have no good way of predicting who will be suicidal, we can just try to stay individualized in our approach to helping people who are suicidal.

Protective factors

Having compassion for others in one's life is considered to protect against suicide. Suicide is fairly narcissistic. Those who commit suicide don't think about how it will affect the people that they love and care for. Some people are very clear that they would never "do that" to their families. However, one provider worked with a client who said he wouldn't shoot himself because of his kids, but further questioning revealed that he would take a drug that would kill himself instead. Even when participants say that they wouldn't "do that," it can't be taken at face value. You have to keep pressing about the definition of the "that" which they wouldn't do.

Having strong anti-suicide values is a protective factor against suicide, as is religion. The 40 assets, which were developed in the 1990s are vastly under-utilized. This list of 40 assets (www.search-institute.org) is a concrete list of protective factors that may help prevent suicide. The 40 assets gives you a frame to think about the family and social networks, family-, school-, and work- supports, and internal and external checks of suicidal individuals. The 40 assets helps to reinforce how we can identify the resources of people threatening suicide. It should be part of curricula to learn how to find value in participants' lives when they feel like it's lost.

Intervening with the partners

When men are screened and found to be suicidal, how do we, as providers, reach out to victims? We have to identify the appropriate support person, and ensure that we're not putting the victim in danger by asking her to be his caretaker if he's suicidal. We have to look at suicidality among both perpetrators and victims, and when we do safety planning for suicidal perpetrators, we have to think about who else, other than their partners, can be used as resources. We shouldn't prevent victims from getting involved as supports, because they may know how to help the perpetrator calm down and get out of a dangerous state of mind. However, we have to understand why victims think they need to be involved in perpetrators' safety planning.

Many programs screen for suicidality at intake, but we have to be checking in perpetually about suicidality as distinct from depression. As circumstances in perpetrators' lives change, their risk of suicidality is likely going to change. Regardless of whether or not it's legally required, we have to let perpetrators' partners know about their suicidality, especially if the couple is no longer together and the victim may be unaware of his mental state. However, we have to give victims more information than the fact that they may be in danger. Is contacting a partner about a perpetrator's suicidality a breach of confidentiality? Programs often get signed releases at intake to allow providers to contact perpetrators' current/former partners. Even in the absence of releases, we have to think about the liability involved in failing to notify a partner (i.e. Terasoff).