Suicide Risk Assessment and Prevention

Presented by
Charlton Hall, MMFT, LMFT/S, RPT-S, CHt
Mindful Ecotherapy Center
PO Box 102
Cleveland SC 29635
www.mindfulecotherapy.org

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- Resources

About this Course

ABOUT THIS COURSE

In this presentation…

- This is a FREE continuing education course for licensed mental health care professionals
- Downloads included in this course:
  - Suicide Prevention Action Plan
  - No Harm Contract & Action Plan
  - Suicide/Homicide Ideation Decision Flowchart
  - PDF of this presentation
  - Citations and references for course materials/studies
  - List of Course Objectives
  - Instructor Credentials & Contact Information

ABOUT THIS COURSE

Getting continuing education credit

- Download the handouts
- Watch the video presentation
- Take the post-test
- When you pass with 80% or higher, a pdf certificate of completion will be found on the main course page where you registered for this free course

Myths about Suicide

Myths about Suicide

There are many misconceptions about the realm of suicide. Contrary to helping, these myths can actually do more harm than good by preventing a suicidal person from getting much needed help.

By being aware of these myths and the actual facts surrounding suicide, you can more effectively help someone who has expressed suicidal thoughts.

SOURCES:

- National Mental Health Association http://www.mentalhealthamerica.net
- Youth Suicide Prevention Education Program https://crisisclinic.org/education/community-training-opportunities/school-curriculum
- The Trevor Project https://www.thetrevorproject.org

Myth: Talking about suicide or asking someone if they feel suicidal will encourage suicide attempts.

FACT

- Talking about suicide provides the opportunity for communication. Fears that are shared are more likely to diminish.
- The first step in encouraging a suicidal person to live comes from talking about those feelings.
- That first step can be the simple inquiry about whether or not the person is intending to end their life.
- However, talking about suicide should be carefully managed.

Myth: Young people who talk about suicide never attempt or complete suicide.

FACT

Talking about suicide can be a plea for help and it can be a late sign in the progression towards a suicide attempt.

Those who are most at risk will show other signs apart from talking about suicide.

Myth: A promise to keep a note unopened and unread should always be kept.

FACT

Where the potential for harm, or actual harm, is disclosed then confidentiality cannot be maintained.

- A sealed note with the request for the note not to be opened is a very strong indicator that something is seriously amiss.
- A sealed note is a late sign in the progression towards suicide.

Myth: Attempted or completed suicides happen without warning.

FACT

The survivors of a suicide often say that the intention was hidden from them. It is more likely that the intention was just not recognized. These warning signs include:

- The recent suicide, or death by other means, of a friend or relative.
- Previous suicide attempts.
- Preoccupation with themes of death or expressing suicidal thoughts.
- Depression, conduct disorder and problems with adjustment such as substance abuse, particularly when two or more of these are present.

Myth: Attempted or completed suicides happen without warning.

FACT – EARLY WARNING SIGNS

- Giving away prized possessions / making a will or other final arrangements.
- Major changes in sleep patterns - too much or too little.
- Sudden and extreme changes in eating habits / losing or gaining weight.

Myth: Attempted or completed suicides happen without warning.

FACT – EARLY WARNING SIGNS

- Withdrawal from friends / family or other major behavioral changes.
- Dropping out of group activities.
- Personality changes such as nervousness, outbursts of anger, impulsive or reckless behavior, or apathy about appearance or health.
- Frequent irritability or unexplained crying.
- Lingering expressions of unworthiness or failure.
- Lack of interest in the future.
- A sudden lifting of spirits, when there have been other indicators, may point to a decision to end the pain of life through suicide.

Myth: If a person attempts suicide and survives, they will never make a further attempt.

FACT

- A suicide attempt is regarded as an indicator of further attempts.
- It is likely that the level of danger will increase with each further suicide attempt.
- A recent analysis of studies that examined successful suicides among those who made prior attempts found that one person in 25 had a fatal repeat attempt within five years.

SOURCE: Metcalfe & Gunnell (2014): *Hospital Presenting Self-Harm and Risk of Fatal and Non-Fatal Repetition: Systematic Review and Meta-Analysis*

Myth: Once a person is intent on suicide, there is no way of stopping them.

FACT

- Suicides can be prevented. People can be helped.
- Suicidal crises can be relatively short-lived.
- Immediate practical help such as staying with the person, encouraging them to talk and helping them build plans for the future, can avert the intention to attempt or complete suicide.
- Such immediate help is valuable at a time of crisis, but appropriate counselling will then be required.

Myth: People who threaten suicide are just seeking attention.

FACT

- All suicide *attempts* must be treated as though the person has the intent to die.
- Do not dismiss a suicide attempt as simply being an attention-gaining device.
- It is likely that the young person has tried to gain attention in the past and failed; therefore, this attention is needed.
- The attention that they get may well save their lives.

Myth: Suicide is hereditary.

FACT

- Although suicide can be over-represented in families, it is not genetically inherited.
- Members of families share the same emotional environment, and the completed suicide of one family member may well raise the awareness of suicide as an option for other family members.
- “Nature vs. Nurture”
- Increased suicide history in a family is a “nurture” problem

Myth: Only certain types of people become suicidal.

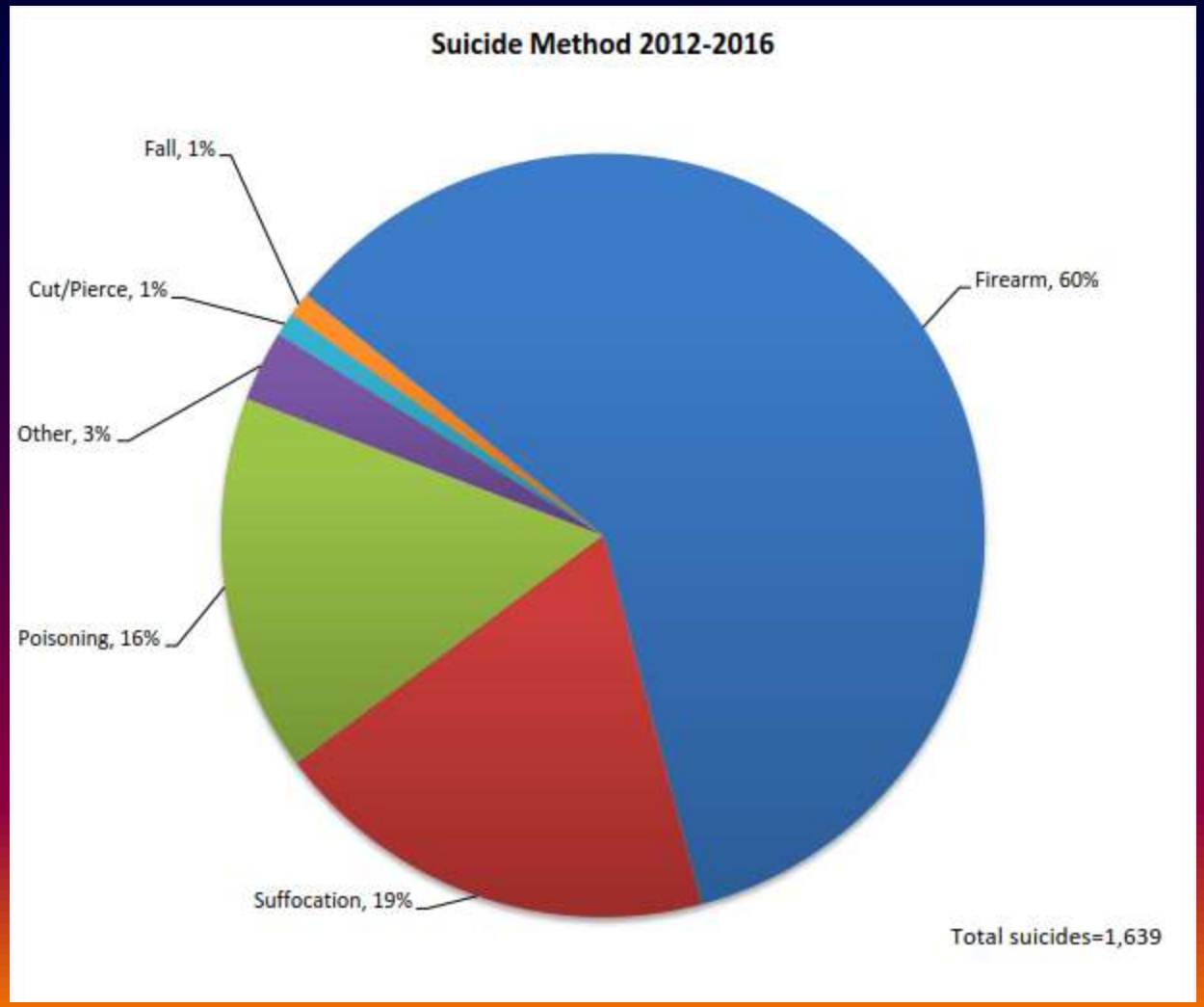
FACT

- Everyone has the potential for suicide.
- The evidence shows that there are some predisposing conditions that may lead to either attempted or completed suicides.
- It is unlikely (but not impossible) that those who do not have the predisposing conditions (for example, depression, conduct disorder, substance abuse, feelings of rejection, rage, emotional pain and anger) will complete suicide.

Myth: Suicide is painless.

FACT

- Many suicide methods are very painful.
- Fictional portrayals of suicide do not usually include the reality of the pain.



Myth: Depression and self-destructive behavior are rare in young people.

FACT

- Both forms of behavior are common in adolescents.
- Depression may manifest itself in ways which are different from its manifestation in adults but it is prevalent in children and adolescents.
- Self-destructive behavior is most likely to be shown for the first time in adolescence and its incidence is on the rise.

Myth: All suicidal young people are depressed.

FACT

- While depression is a contributory factor in most suicides, it need not be present for suicide to be attempted or completed.
- Suicide is often premeditated, but it may also be an impulsive act.

Myth: Marked and sudden improvement in the mental state of an attempter following a suicidal crisis or depressive period signifies that the suicide risk is over.

FACT

- The opposite may be true. In the three months following an attempt, a young person is at most risk of completing suicide.
- The apparent lifting of the problems could mean the person has made a firm decision to commit suicide and feels better because of this decision.

Myth: Once a young person is suicidal, they will be suicidal forever.

FACT

- Most young people who are considering suicide will only be that way for a limited period of their lives.
- Given proper assistance and support, they will probably recover and continue to lead meaningful and happy lives unhindered by suicidal concerns.

Myth: Suicidal young people cannot help themselves.

FACT

- While contemplating suicide, young people may have a distorted perception of their actual life situation and what solutions are appropriate for them to take.
- However, with support and constructive assistance from caring and informed people around them, young people can gain full self-direction and self-management in their lives.

Myth: The only effective intervention for suicide comes from professional psychotherapists with extensive experience in the area.

FACT

- All people who interact with suicidal adolescents can help them by way of emotional support and encouragement.
- Psychotherapeutic interventions also rely heavily on family, and friends providing a network of support.
- This *doesn't* mean that a suicidal person *would not* benefit from mental health treatment!

Myth: Most suicidal young people never seek or ask for help with their problems.

FACT

- Evidence shows that they often tell their school peers of their thoughts and plans.
- Most suicidal adults visit a medical doctor during the three months prior to killing themselves.
- Adolescents are more likely to ask for help through non-verbal gestures than to express their situation verbally to others.

Myth: Suicidal young people are always angry when someone intervenes and they will resent that person afterwards.

FACT

- While it is common for young people to be defensive and resist help at first, these behaviors are often barriers imposed to test how much people care and are prepared to help.
- For most adolescents considering suicide, it is a relief to have someone genuinely care about them and to be able to share the emotional burden of their plight with another person.
- When questioned some time later, the vast majority express gratitude for the intervention.

Myth: Break-ups in relationships happen so frequently, they do not cause suicide.

FACT

- Suicide can be precipitated by the loss of a relationship.
- In one study, 28% of teen suicide attempts were related to a break-up.

SOURCE: Del Palacio-González, A., Clark, D. A., & O'Sullivan, L. F. (in press). Distress severity following a romantic breakup is associated with positive relationship memories among emerging adults. *Emerging Adulthood.*

Myth: Most suicidal young people are insane or mentally ill.

FACT

- Although suicidal adolescents are likely to be extremely unhappy and may be classified as having a mood disorder, such as depression, most are not legally insane.
- However, there are small numbers of individuals whose mental state meets psychiatric criteria for mental illness and who need psychiatric help.

Myth: Most suicides occur in winter months when the weather is poor.

FACT

- Seasonal variation data are essentially based on adult suicides, with limited adolescent data available.
- However, it seems adolescent suicidal behavior is most common during the spring and early summer months.

Myth: Suicide is much more common in young people from higher (or lower) socioeconomic status (SES) areas.

FACT

- The causes of suicidal behavior cut across SES boundaries.
- While the literature in the area is incomplete, there is no definitive link between SES and suicide.
- This does not preclude localized tendencies nor trends in a population during a certain period of time.

Myth: Some people are always suicidal.

FACT

- Nobody is suicidal at all times.
- The risk of suicide for any individual varies across time, as circumstances change.
- This is why it is important for regular assessments of the level of risk in individuals who are at risk.

Myth: Every death is preventable.

FACT

- No matter how well intentioned, alert and diligent people's efforts may be, there is no way of preventing all suicides from occurring.
- Be aware of “survivor guilt.” Symptoms of survivor guilt include:
  - Nightmares
  - Difficulty sleeping
  - Flashbacks to the traumatic event
  - Loss of motivation
  - Irritability
  - Sense of numbness
  - Thoughts about the meaning of life

Suicide Statistics

Suicide Statistics

- There were 41,149 suicides in 2013 in the United States—a rate of 12.6 per 100,000 is equal to 113 suicides each day or one every 13 minutes
- Suicide was the tenth leading cause of death for all ages in 2013.
- Based on data about suicides in 16 National Violent Death Reporting System states in 2010, 33.4% of suicide decedents tested positive for alcohol, 23.8% for antidepressants, and 20.0% for opiates, including heroin and prescription pain killers.

SOURCE: CDC - NCHS - National Center for Health Statistics

https://www.cdc.gov/nchs/

Suicide Statistics

- 17.0% of students seriously considered attempting suicide in the previous 12 months (22.4% of females and 11.6% of males)
- 13.6% of students made a plan about how they would attempt suicide in the previous 12 months (16.9% of females and 10.3% of males).
- 8.0% of students attempted suicide one or more times in the previous 12 months (10.6% of females and 5.4% of males).
- 2.7% of students made a suicide attempt that resulted in an injury, poisoning, or an overdose that required medical attention (3.6% of females and 1.8% of males).

Gender Disparities

- Males take their own lives at nearly four times the rate of females and represent 77.9% of all suicides
- Females are more likely than males to have suicidal thoughts
- Suicide is the seventh leading cause of death for males and the fourteenth leading cause for females
- Firearms are the most commonly used method of suicide among males (56.9%)
- Poisoning is the most common method of suicide for females (34.8%)

Nonfatal Suicidal Thoughts and Behavior

Among adults aged ≥18 years in the United States during 2013:

- An estimated 9.3 million adults (3.9% of the adult U.S. population) reported having suicidal thoughts in the past year
- The percentage of adults having serious thoughts about suicide was highest among adults aged 18 to 25 (7.4%), followed by adults aged 26 to 49 (4.0%), then by adults aged 50 or older (2.7%)
- An estimated 2.7 million people (1.1%) made a plan about how they would attempt suicide in the past year

SOURCE: CDC - NCHS - National Center for Health Statistics

https://www.cdc.gov/nchs/

Nonfatal Suicidal Thoughts and Behavior

- The percentage of adults who made a suicide plan in the past year was higher among adults aged 18 to 25 (2.5%) than among adults aged 26 to 49 (1.35%) and those aged 50 or older (0.6%)
- An estimated 1.3 million adults aged 18 or older (0.6%) attempted suicide in the past year. Among these adults who attempted suicide, 1.1 million also reported making suicide plans (0.2 million did not make suicide plans)

Age Group Differences

- Suicide is the third leading cause of death among persons aged 10-14, the second among persons aged 15-34 years, the fourth among persons aged 35-44 years, the fifth among persons aged 45-54 years, the eighth among person 55-64 years, and the seventeenth among persons 65 years and older
- In 2011, middle-aged adults accounted for the largest proportion of suicides (56%), and from 1999-2010, the suicide rate among this group increased by nearly 30%

Age Group Differences

- Among adults aged 18-22 years, similar percentages of full-time college students and other adults in this age group had suicidal thoughts (8.0 and 8.7%, respectively) or made suicide plans (2.4 and 3.1%)
- Full-time college students aged 18-22 years were less likely to attempt suicide (0.9 vs. 1.9%) or receive medical attention as a result of a suicide attempt in the previous 12 months (0.3 vs. 0.7%)

Nonfatal Self-Inflicted Injuries

- In 2013, 494,169 people were treated in emergency departments for self-inflicted injuries.
- Nonfatal, self-inflicted injuries (including hospitalized and emergency department treated and released) resulted in an estimated $10.4 billion in combined medical and work loss costs.

SOURCE: CDC - NCHS - National Center for Health Statistics

https://www.cdc.gov/nchs/

Suicide Statistics

Complete reports with references and citations at www.cdc.gov/violenceprevention

Suicide Risk Assessment

Suicide Risk Assessment

- Think “PPI:” Purpose, Plan, and Intent
- Purpose – Definite active and present desire to commit suicide as opposed to, “Sometimes I just wish I weren’t alive”
- Plan – Lethal means (gun, pills, driving car into a tree, etc.)
- Intent – Have they taken steps to make a plan happen? (e.g. bought a gun, written a suicide note, said “goodbye” to family and friends)

Suicide Risk Assessment

PURPOSE

- Patient has demonstrated through thoughts, words, or deeds that they have an active ideation to harm self or others.
- Take all threats of suicide, homicide, self-harm, or harming others seriously.

Suicide Risk Assessment

PLAN

- Patient has demonstrated a plan to harm self or others (bought a gun, gotten pills, thought about how they'd do it).
- A high number of people contemplate suicide by automobile (insurance reasons), so include this information in your assessment by asking, "Have you ever thought of hurting or killing yourself in an automobile crash?"

Suicide Risk Assessment

INTENT

- Patient has demonstrated intent through thoughts, words, or deeds
  - e.g. given away possessions, written a suicide note, said “goodbye” to family members, made arrangements for care of pets/children.

Suicide Risk Assessment

"NO HARM" CONTRACT

- If patient is suicidal, complete "Suicide Prevention Action Plan."
  - Can be downloaded from this course's home page
- If patient is homicidal, complete "No Harm" contract.
  - Can be downloaded from this course's home page
- If patient refuses to sign, and is not a minor, then emergency services must be called.

Suicide Prevention Action Plan

Suicide Prevention Action Plan

- Downloadable from the course page
- Different than a “no suicide” contract in that it includes:
  - Action Plan Support Network (people to call)
  - Positive Affirmations (reasons to live)
  - Plan to remove lethal means

Suicide Risk Assessment

SPECIAL CONSIDERATIONS FOR MINORS

- If patient is a minor, or otherwise incompetent or incapacitated, a parent, guardian, or other legally responsible adult can sign for them, with the understanding that if the suicide/homicide ideation returns the patient must immediately be taken to the emergency room.

Suicide Risk Assessment

SPECIAL CONSIDERATIONS FOR MINORS

- If the patient is a minor or otherwise unable to sign for themselves, and a parent/guardian refuses to sign, Child Protective Services must be notified, and the child must be sent to emergency services.
- Refusal to protect a minor child or a vulnerable adult who has a suicide/homicide ideation constitutes abuse and/or neglect and a mandated report is required.

If you have concerns about a young person who talks about suicide:

- Encourage him/her to talk further and help them to find appropriate counseling assistance.
- Ask if the person is thinking about making a suicide attempt.
- Ask if the person has a plan.

If you have concerns about a young person who talks about suicide:

- Think about the completeness of the plan and how dangerous it is.
- Do not trivialize plans that seem less complete or less dangerous.
- All suicidal intentions are serious and must be acknowledged as such.
- Encourage the young person to develop a personal safety plan.
- This can include time spent with others, check-in points with significant adults and plans for the future.

Suicide Risk Assessment

REFER TO A MENTAL HEALTH PROFESSIONAL

- Only if patient is not actively suicidal/homicidal as defined by the flow chart.
- Otherwise, send patient to emergency services.
  - Call “911” or law enforcement to escort patient to the emergency room
  - Don’t assume patient will go on their own in a crisis situation

Suicide Risk Assessment

REFER TO A MENTAL HEALTH PROFESSIONAL

- If the patient is actively suicidal/homicidal but is willing to sign the “no harm” contract, then referral to emergency services is not necessary; however, they would still need to be seen by a mental health professional, preferably on the same day.
- **USE YOUR BEST CLINICAL JUDGMENT!** When in doubt, refer to emergency services, regardless of flow chart results.

Suicide Risk Assessment

REFER TO A MENTAL HEALTH PROFESSIONAL

- If a same-day appointment is not available, then the patient would need to be seen by behavioral health within 24 hours.
- When in doubt, rely on your own clinical judgment and refer to emergency services as necessary.

Suicide Risk Assessment

REFER TO A MENTAL HEALTH PROFESSIONAL

- If a same-day appointment is not available, then the patient would need to be seen by behavioral health within 24 hours.

Suicide Risk Assessment

REFER TO A MENTAL HEALTH PROFESSIONAL

- Crisis appointments take precedence over all other behavioral health appointments.
- If on a Friday or holiday and an appointment is not available within 24 hours, refer the patient to emergency services.

Suicide Risk Assessment

WHEN IN DOUBT…

- Err on the side of caution.
- If patient is evasive, uncooperative or non-responsive, contact emergency services.
- Use your best clinical judgment.

Suicide Risk Assessment

"If they're drowning, don't try to teach them how to swim"

- If they're in a full crisis mode, asking a lot of questions can escalate their fight or flight response
- Try to get PPI answers if possible, but don't do lengthy assessments until they're more stable
- Refer to behavioral health if possible; if not call 911 and follow up to make sure they got to the emergency room

Suicide/Homicide Ideation Decision Flowchart

No Harm Contract & Action Plan

No Harm Contract & Action Plan

- Downloadable from the course page
- Different than a “no harm” contract in that it includes:
  - Action Plan Support Network (people to call)
  - Positive Affirmations (reasons not to harm)
  - Plan to remove lethal means

De-Escalation Strategies

The Importance of De-escalation

- In a crisis situation such as assessing a person with an active suicide/homicide ideation, de-escalation strategies are crucial
- Well-meaning people with poor de-escalation skills can unintentionally make a bad situation worse
- De-escalation strategies can help to de-fuse a crisis situation, potentially saving lives

The Importance of De-escalation

De-escalation refers to behavior that is intended to escape escalations of conflicts. Escalations of problem thoughts and behaviors are often hard to keep from spiraling out of control into a crisis situation without specific measures being taken.

The Importance of De-escalation

RESOURCE: The LEAP Approach to De-escalation

http://mhr4c.com.au/coping-strategies/the-leap-approach/

The Importance of De-escalation

- The LEAP approach (Listen, Empathize, Agree, Partner), developed by Dr Xavier Amador, is an approach that can be useful when dealing with people who have poor insight.

- LEAP is a way of communicating that encourages a person in a crisis situation to accept treatment and/or intervention.

The LEAP Method of De-escalation

LISTEN

- Listen with only one goal: to understand the other person’s point of view and reflect your understanding back to him or her.

The LEAP Method of De-escalation

LISTEN

- Effective listening involves listening to the frustrations, fears, hopes and dreams of the person in your care, and repeating back your understanding of what has been said.
- You can use effective listening to stop yourself from offering your opinion or advice.

The LEAP Method of De-escalation

LISTEN

- Sometimes they don’t need a solution as much as they need someone to understand what they’re saying and how they’re feeling.

The LEAP Method of De-escalation

EMPATHIZE

- If you want someone to seriously consider your own advice or point of view, be certain that first they feel you have seriously considered their point of view.
- If you're not willing to listen to them, why should they be willing to listen to you?

The LEAP Method of De-escalation

EMPATHIZE

- To empathize is to identify with their feelings, thoughts and attitudes.
- To empathize with another you can acknowledge:
  - That their feelings may be frightening
  - That they want to understand their feelings are okay in context
  - The reasons they resist treatment

The LEAP Method of De-escalation

AGREE

When you're facing someone who rigidly holds irrational beliefs, you gain nothing by disagreeing; instead, you run the risk of alienating them even further and making the situation worse.

The LEAP Method of De-escalation

AGREE

To reach agreement:

- Discuss only problems or symptoms perceived by the person in your care, without adding to them
- Review advantages and disadvantages of treatment
- Reflect back and highlight the perceived benefits
- Agree to disagree on some things

The LEAP Method of De-escalation

PARTNER

- When you share the same goals, you can work together instead of being at odds.
- Try to find mutual goals while taking the patient's safety and wellbeing into consideration.

The LEAP Method of De-escalation

PARTNER

- You can partner by moving towards goals you both agree can be worked on together.
- You can also partner by agreeing on goals that challenge the person in your care to step outside their comfort zone but that are still within their ability to achieve.

The LEAP Method of De-escalation

PARTNER

- Practice a patient-centered approach
- Their goals may not be the same as your goals; that’s okay as long as you can keep them safe and work together to achieve safety

TO LEARN MORE…

National Suicide Prevention Lifeline

Call 1-800-273-8255

Available 24 hours everyday

Suicide Prevention Resource Center

www.sprc.org

Centers for Disease Control Suicide Statistics and Information

https://www.cdc.gov/violenceprevention/suicide/statistics/index.html

COURSE SUMMARY

COURSE SUMMARY

- Suicidal ideations are very rarely if ever attention-seeking strategies. Take all threats of suicide seriously.
- Sudden improvement in mood after a suicide risk or suicide attempt does not necessarily mean that the patient is getting better. Sometimes mood improves after a patient has decided to commit suicide, because they see it as a way to end the pain.

COURSE SUMMARY

Early warning signs of a potential suicide attempt include:

- The recent suicide, or death by other means, of a friend or relative
- history of previous suicide attempts
- preoccupation with themes of death and dying
- talking about wanting to die or to kill oneself
- looking for a way to kill oneself (lethal means)
- talking about feeling hopeless or having no purpose; talking about feeling trapped or being in unbearable pain

COURSE SUMMARY

Early warning signs of a potential suicide attempt include:

- talking about being a burden to others
- increasing substance abuse; acting anxious, agitated, or reckless
- sleeping too little or too much
- withdrawing or feeling isolated
- showing rage or talking about seeking revenge
- displaying extreme mood swings

COURSE SUMMARY

- Suicide was the tenth leading cause of death for all ages in 2013
- Firearms are the most common lethal means among males committing suicide
- Poisoning (drug overdose, etc.) is the most common lethal means among females committing suicide

COURSE SUMMARY

- Preliminary studies seem to indicate that as firearms become more prevalent in our society, more women are committing suicide with firearms, but for now poisoning is still the most common lethal means on average among females.

COURSE SUMMARY

Purpose, Plan, and Intent (PPI) is a quick way to determine risk of suicide

- Purpose
- Plan
- Intent

COURSE SUMMARY

A Suicide Prevention Action Plan can help reduce risk.

Such a plan contains:

1. a plan to remove lethal means
2. an identified support network
3. positive affirmations (reasons to live)

COURSE SUMMARY

If a parent or other guardian/caretaker of a minor child refuses to engage in suicide prevention planning, a report to Child Protective Services is warranted, as this could constitute abuse/neglect

COURSE SUMMARY

If the guardian of a vulnerable adult who is suicidal refuses to engage in suicide prevention planning, a report to Adult Protective Services is warranted, as this could constitute abuse/neglect of a vulnerable adult

COURSE SUMMARY

- “If they’re drowning, don’t try to teach them how to swim”
- In a crisis, use PPI to determine level of risk, refer to emergency services
- Save the full assessment until after the crisis is over.

COURSE SUMMARY

- The Suicide/Homicide Ideation Decision Flowchart contained within the course materials helps to do a brief and accurate suicide risk assessment

COURSE SUMMARY

- De-escalation is important during suicide risk assessment so that the situation isn't exacerbated
- A quick and simple method of de-escalation during a crisis is "LEAP"

COURSE SUMMARY

Listen

Empathize

Agree

Partner

COURSE SUMMARY

- Mental health professionals are not the only effective intervention for suicide
- Sometimes all it takes is a person willing to listen
- Build support for your patient by linking them to community resources or friends and family

YOU ARE NOW READY TO TAKE THE POST-TEST

- Click on the post-test link
- When you pass the post-test with a score of 80% or higher, you will receive a certificate of completion in pdf format
- You have a total of three attempts to pass the quiz with a score of 80% or higher

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