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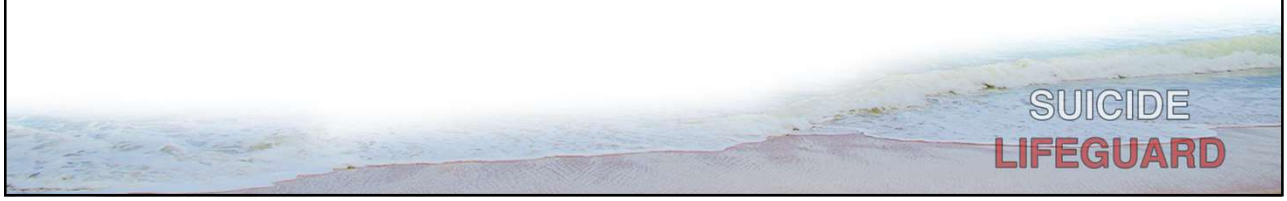
Suicide Lifeguard

Recognizing, Assessing, & Intervening with Suicide to Empower Clients:



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Katie Ellison

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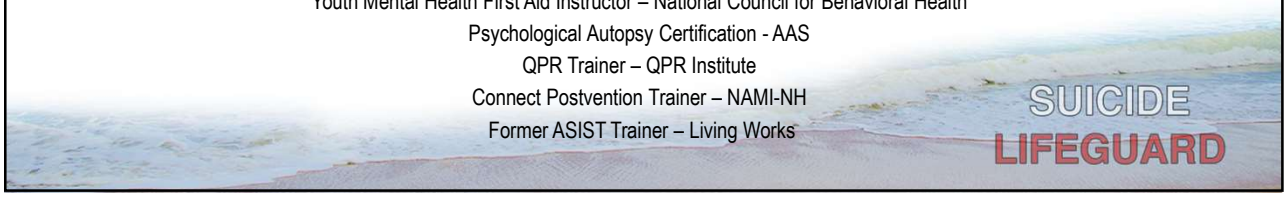
Family & Human Development, BA
Psychology, MS
Professional School Counseling, MA

Suicide Attempt Survivor
Safer Homes Collaborative Project Director – MIMH-UMSL
School Suicide Prevention Specialist Certification– AAS
Youth Mental Health First Aid Instructor – National Council for Behavioral Health
Psychological Autopsy Certification - AAS
QPR Trainer – QPR Institute
Connect Postvention Trainer – NAMI-NH
Former ASIST Trainer – Living Works



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LEARNING OUTCOMES

- Develop skills to ask clients about suicide
- Assess for suicide using evidence-based tools
- Collaborative with clients in the development of a safety plan, treatment plan and lethal means reduction

This training is developed for behavioral health professionals who are required to meet licensure and re-licensure continuing education hours in suicide assessment, referral, intervention and management skills.

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ETHICAL CONSIDERATIONS

- Responsibility for client welfare
  - Beneficence vs. nonmaleficence
  - Client autonomy and decision making, rights and dignity
- Responsibility to confidentiality and the limits of confidentiality
  - Serious and foreseeable harm to self and others
  - Need for professional supervision
- Client autonomy through Informed Consent
  - Limitations of practice
- Professional competence
  - Practicing within the scope of training

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SUICIDE SPECIFIC INTERVENTIONS

- Dialectic Behavior Therapy DBT (Linehan) (NowMattersNow.Org– Free DBT skills training for professions)
- Cognitive Behavioral Therapy for Suicidal Patients CBT-SP (Beck, Brown)
- Collaborative Assessment and Management of Suicidality CAMS (Jobes, Comtois)
- Attachment Based Family Therapy ABFT (Diamond)
- Safety Planning Intervention SPI (Stanley, Brown)
- Recommended Standard Care for People with Suicide Risk: MAKING HEALTH CARE SUICIDE SAFE – National Action Alliance for Suicide Prevention

SUICIDE LIFEGUARD

American Foundation for Suicide Prevention, 2017

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RECOGNIZING:

SUICIDE DEATH AND IDEATION RATES
RISK FACTORS
WARNING SIGNS
METHODS

ASSESSING & INTERVENING FOR SUICIDE:

ASSESSES YOUR SUICIDE BIAS,
ASKING THE QUESTION,
ASSESSING THE RISK FOR SUICIDE,
TOOLS & RATING SCALES

EMPOWERING CLIENTS:

STABILIZATION
SAFETY PLANNING
LETHAL MEANS REDUCTION

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RECOGNIZING:

SUICIDE RATES
RISK FACTORS
WARNING SIGNS
METHODS

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SUICIDE DECLARED A PUBLIC HEALTH ISSUE

"The nation must address suicide as a significant public health problem and put into place national strategies to prevent the loss of life and the suffering suicide causes. We must act now."

U.S. Surgeon General, Dr. David Satcher
Quoted in the New York Times July 29, 1999

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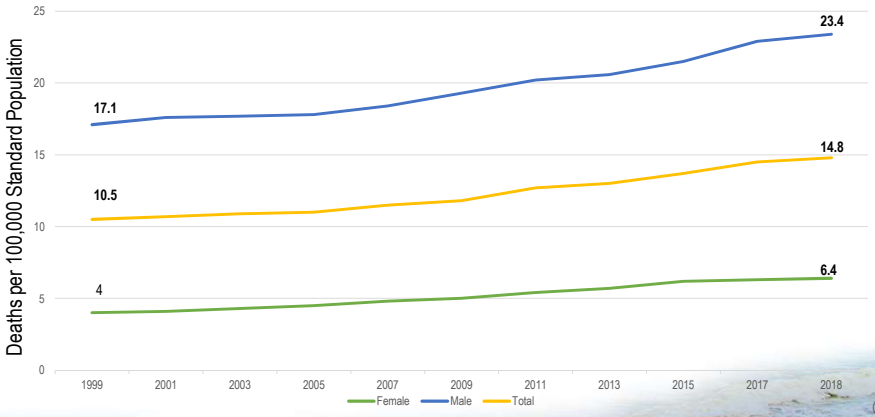
US Suicide Rates (1999-2018)
Age Adjusted Rates by Gender



CDC Wonder, 2019

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US Leading Causes of Death by Age, 2018

Rank	10 to 17	18 to 24	25 to 34	35 to 44	45 to 64	65+	Total
1	Accidents	Accidents	Accidents	Accidents	Cancer	Heart disease	Heart disease
2	Suicide	Suicide	Suicide	Cancer	Heart disease	Cancer	Cancer
3	Homicide	Homicide	Homicide	Heart Disease	Accidents	Chronic lower respiratory disease	Accidents
4	Cancer	Cancer	Cancer	Suicide	Chronic lower respiratory disease	Stroke	Chronic lower respiratory disease
5	Congenital anomalies	Heart disease	Heart Disease	Homicide	Chronic Liver Disease	Alzheimer's disease	Stroke
6	Heart disease	Congenital anomalies[3]	HIV	Liver disease	Diabetes	Diabetes	Alzheimer's disease
7	Chronic lower respiratory disease	Diabetes	Diabetes	Diabetes	Stroke	Accidents	Diabetes
8	Influenza and pneumonia	Influenza and Pneumonia	Stroke	Stroke	Suicide	Influenza and pneumonia	Influenza and pneumonia
9	Stroke	Pregnancy and childbirth	Chronic Liver Disease	Influenza and pneumonia	Septicemia	Kidney disease	Kidney disease
10	Benign/in situ neoplasms[2]	Chronic Lower Respiratory Disease	Congenital anomalies	Septicemia	Influenza and pneumonia	Parkinson's disease	Suicide

- 9th leading cause of death for all age groups

CDC, Wonder 2018

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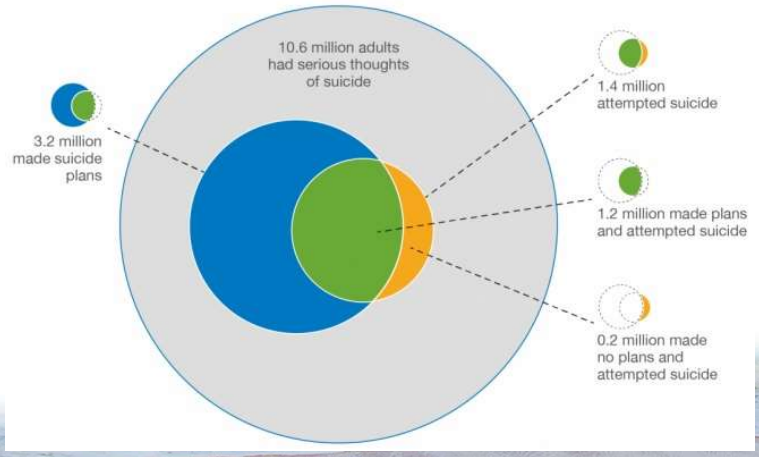
PREVENLANCE OF SI & BEHAVIOR



National Survey on Drug Use and Health, 2017

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IMPLICATIONS FOR PROFESSIONALS

7 out of 10 mental health professionals will work with a client who has attempted suicide

1 out of 4 mental health professionals will work with a client who will die by suicide

1 in 3 who suicide will have had contact with a mental health professional in the last year

1 in 5 who suicide will have been in services in the previous month

Counselor Training in Suicide Assessment, Prevention and Management (2016)

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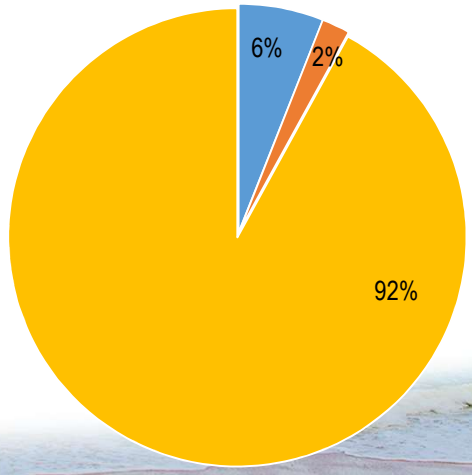
PROFESSIONALS IN TRAINING

- COAMFTE- programs offered suicide assessment/interventions in their curriculum
- CACREP- programs offered suicide assessment/interventions in their curriculum
- COAMFTE & CACREP programs without suicide assessment/intervention in their curriculum



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Counselor Training in Suicide Assessment, Prevention and Management (2016)

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RISK FACTORS

Lack of Access to Health Care
Violence
School Difficulties
Isolation
Religious Beliefs
Finances
Impulsive Tendencies
Family History of Suicide
Hopelessness
Divorce
Previous Suicide Attempt
Family History of Child Maltreatment
Aggressive Tendencies
LGBTQ
Trauma
Alcohol Abuse
History of Mental Health
Loss
Clinical Depression
Unemployment
Substance Abuse
Death of a Loved One
Helplessness
Cultural Beliefs
Chronic Disease and Disability
Contagion
Bullying
Easy Access to Lethal Means
Legal Matters

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American Association of Suicidology, American Foundation for Suicide Prevention


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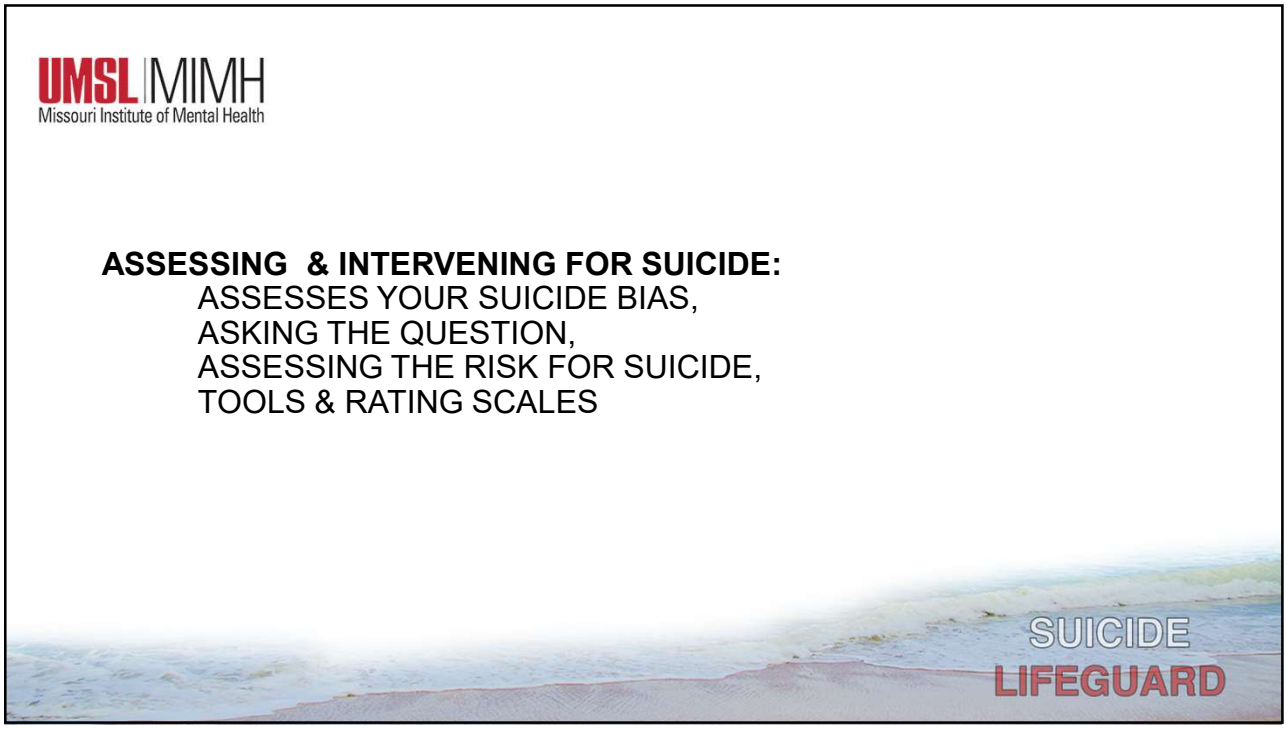
Recent Trauma
Seeking Revenge
Recent Life Crisis
Putting Affairs in Order
Extreme Mood Swings
Sense of Relief
Giving away Prized Possessions
Withdrawing
Increased Use of Alcohol
Expressing a Want to Die
Looking for a means to kill oneself
Sudden Improvement in Mood
Increased Use of Drugs
Describing Unbearable Pain
Acting Agitated
WARNING SIGNS
Irritability
Shame
Sleeping Too Little
Talking, Writing, Drawing About Suicide
Acting Anxious
Expressing Hopelessness
Talking About Being Purposeless
Feeling Trapped
Isolating
Making Preparations
Posting Intent on Social Media
Feeling Like a Burden to Others
Acting Reckless
Sleeping Too Much
Saying Good-bye
Changes in personality
Expressing Rage
SUICIDE
LIFEGUARD
American Association of Suicidology, American Foundation for Suicide Prevention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ASSESSING & INTERVENING FOR SUICIDE:
ASSESSES YOUR SUICIDE BIAS,
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ASSESSES YOUR SUICIDE BIAS

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WHERE HAVE I LEARNED ABOUT SUICIDE?

NEWS

SOCIAL MEDIA

LIVED EXPERIENCE

PROFESSIONAL TRAINING

RELIGION

EDUCATION

FAMILY

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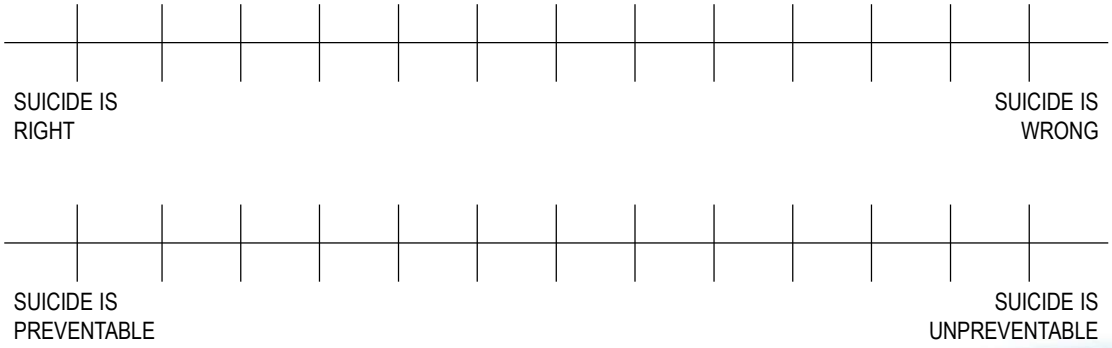
WHAT ARE MY BELIEFS ABOUT SUICIDE?



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Applied Suicide Intervention Skills Training, 2014

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ASKING THE QUESTION

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TIPS FOR ASKING THE QUESTIONS

- It is Important to Ask the Question
- Practice Asking the Question Before You Are in a Life and Death Situation.
- How You Ask is Just as Important
- Avoid Euphemisms
- Be Direct, Be Specific
- Listen beyond “NO”

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THE IMPORTANCE OF ASKING THE QUESTION

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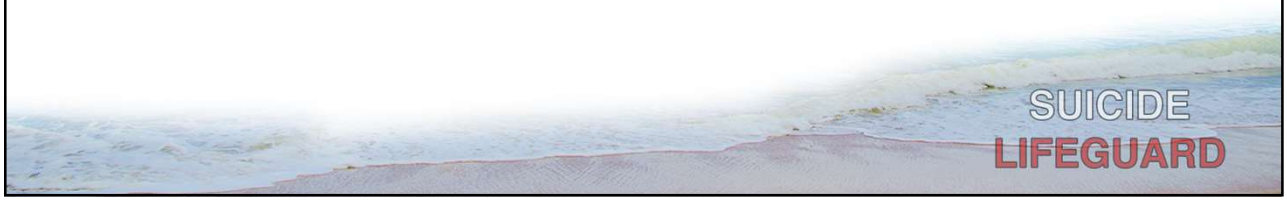
HOW YOU ASK IS AS IMPORTANT AS ASKING

- You're not thinking of killing yourself, are you?
- Are you going to commit suicide?
- You're not thinking of doing something stupid, are you?
- Have you ever made an unsuccessful suicide attempt before?



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AVOID EUPHEMISMS

- Are you thinking of hurting yourself?
- Have you ever tried to harm yourself?
- Have you ever wanted to go to sleep and not wake up?
- Do you ever wish something bad would happen to change your circumstances?

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BE DIRECT, BE SPECIFIC

- Are you thinking of suicide?
- Do you want to kill yourself?
- Do you have a plan for suicide?
- What you are saying sounds to me like suicide.
- Are we talking about suicide?

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ROLE PLAY – ASK THE QUESTION

- Are you thinking of suicide?
- Do you want to kill yourself?
- Do you have a plan for suicide?
- What you are saying sounds to me like suicide.
- Are we talking about suicide?

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TAKE A STRETCH

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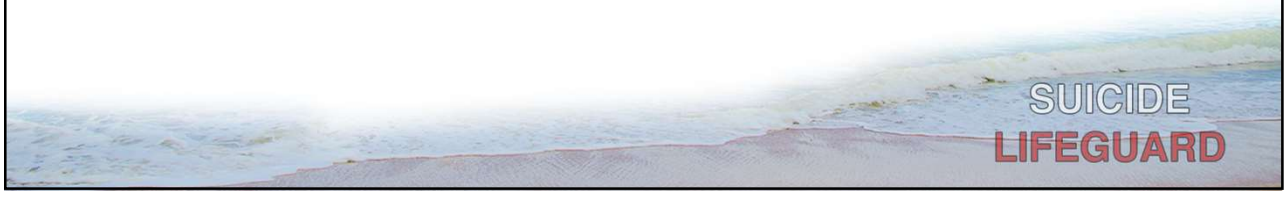
ASSESSMENT TOOLS AND RATING SCALES



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PHQ-9

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Columbia University, 1999

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CASE SCENARIO

The school you work in implemented a suicide prevention-educational program for all students in 6-8 grade. Each student was asked to take the PHQ-9 and turn them in. You're reviewing your student's assessments when you come across Sarah's PHQ-9; a student whose mother was diagnosed with stage 4 breast cancer the previous term.

You note that she answers that she is having difficulty nearly every day has little interest or finding pleasure in doing things, feeling down and hopeless, sleeping, appetite, low energy, and concentrating. She indicates that she has not had thoughts that she would be better off dead or of hurting herself in some way.

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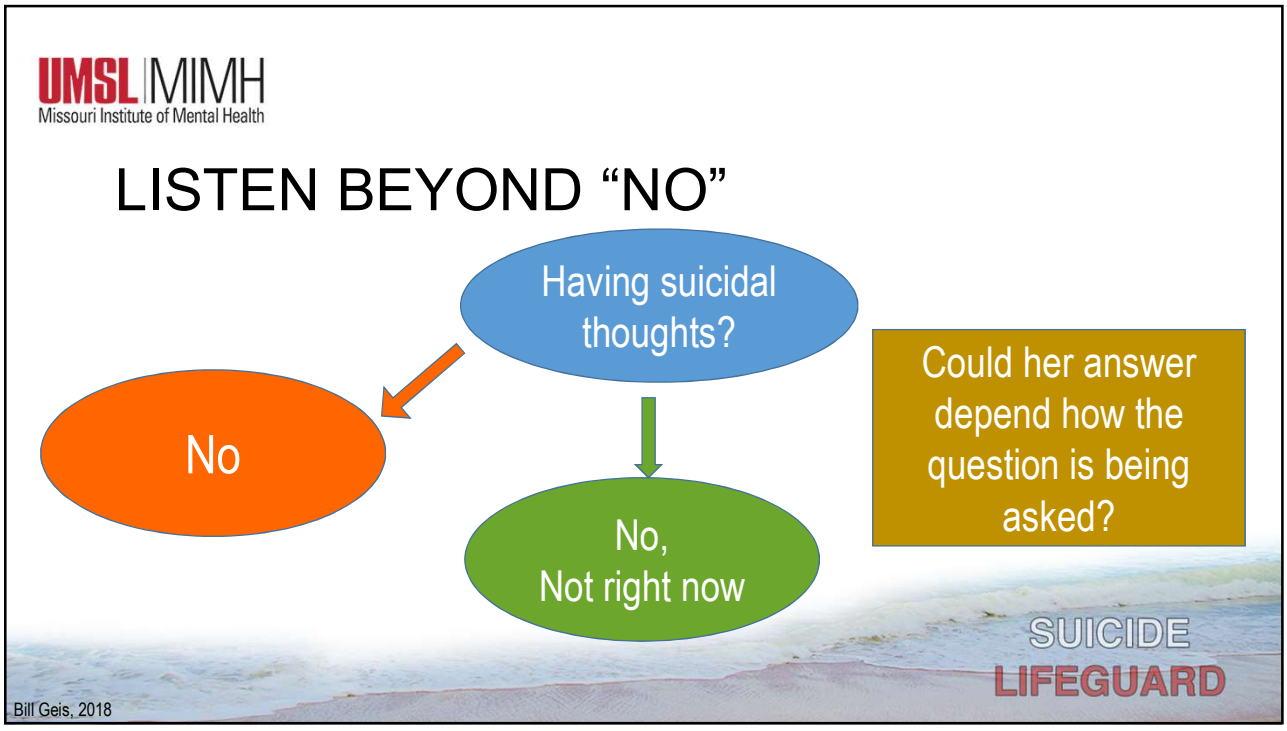
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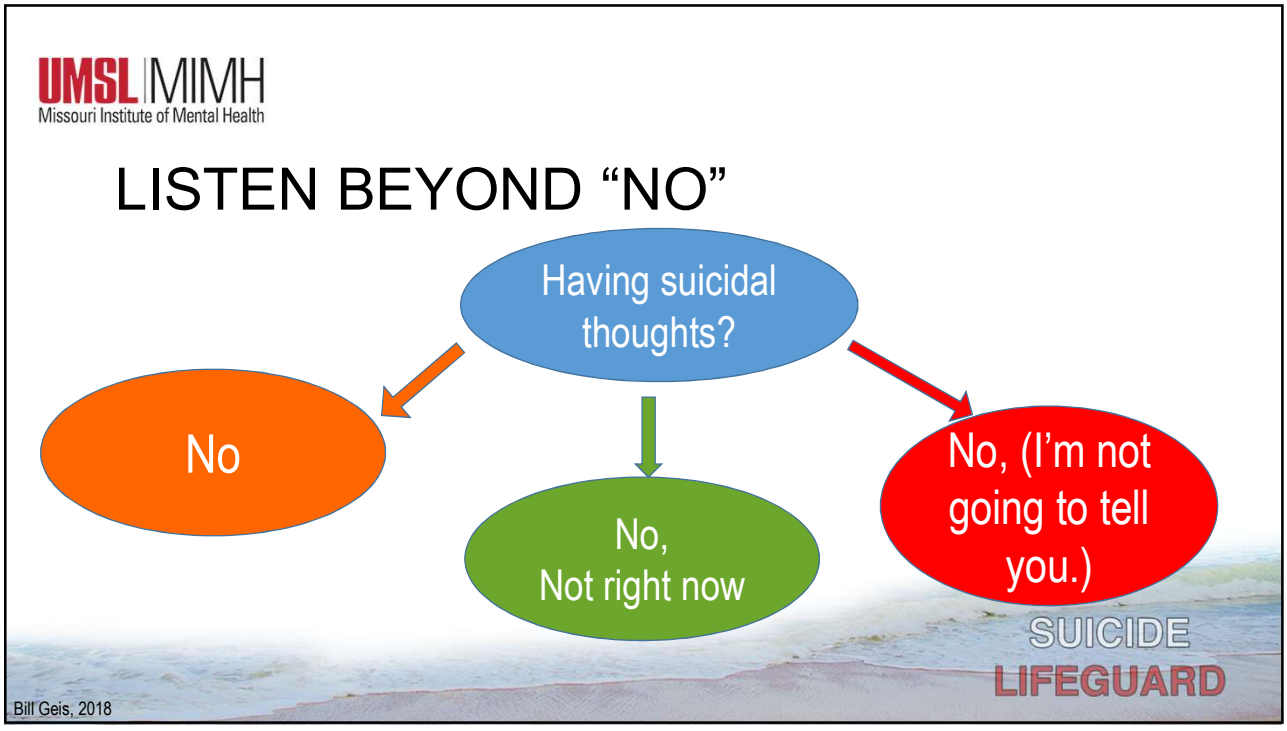
LISTEN BEYOND "NO"
Having suicidal thoughts?
No
No, Not right now
Could her answer depend how the question is being asked?
SUICIDE LIFEGUARD
Bill Geis, 2018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LISTEN BEYOND "NO"
Having suicidal thoughts?
No
No, Not right now
No, (I'm not going to tell you.)
SUICIDE LIFEGUARD
Bill Geis, 2018

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IS PATH WARM

I	IDEATION	Threatening to hurt or kill self; looking for ways to die
S	SUBSTANCE ABUSE	Increased or excessive substance use (alcohol or drugs)
P	PURPOSELESSNESS	No reason for living; no sense of purpose in life
A	ANXIETY	Anxiety, agitation; unable to sleep
T	TRAPPED	Feeling trapped - like there's no way out; resistance to help
H	HOPELESSNESS	Hopelessness about the future
W	WITHDRAWAL	Withdrawing from friends, family and society; sleeping all the time
A	ANGER	Rage, uncontrolled anger; seeking revenge
R	RECKLESSNESS	Acting recklessly or engaging in risky activities, seemingly without thinking
M	MOOD CHANGES	Dramatic mood changes

American Association of Suicidology, 2003

SAFE-T

Suicide **A**ssessment **F**ive-step **E**valuation and **T**riage

for Mental Health Professionals

1. IDENTIFY RISK FACTORS
   Note those that can be modified to reduce risk
2. IDENTIFY PROTECTIVE FACTORS
   Note those that can be enhanced
3. CONDUCT SUICIDE INQUIRY
   Suicidal thoughts, plans behavior and intent
4. DETERMINE RISK LEVEL/INTERVENTION
   Determine risk. Choose appropriate intervention to address and reduce risk
5. DOCUMENT
   Assessment of risk, rationale, intervention and follow-up

NATIONAL SUICIDE PREVENTION LIFELINE
1.800.273.TALK (8255)

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- Suicidal behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- Current/past psychiatric disorders: especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity).
  Co-morbidity and recent onset of illness increase risk
- Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- Family history: of suicide, attempts or Axis 1 psychiatric disorders requiring hospitalization
- Precipitants/Stressors/Interpersonal: triggering events leading to humiliation, shame or despair (e.g., loss of relationship, financial or health status–real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation.
- Change in treatment: discharge from psychiatric hospital, provider or treatment change
- Access to firearms

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- Internal: ability to cope with stress, religious beliefs, frustration tolerance
- External: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- Ideation: frequency, intensity, duration--in last 48 hours, past month and worst ever
- Plan: timing, location, lethality, availability, preparatory acts
- Behaviors: past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self injurious actions
- Intent: extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live

** For Youths: ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors or disposition*
** Homicide Inquiry: when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.*

4. RISK LEVEL/INTERVENTION

- Assessment of risk level is based on clinical judgment, after completing steps 1-3
- Reassess as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT Risk level and rationale; treatment plan to address/reduce current risk (e.g., setting, medication, psychotherapy, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.

SPRC, 2009

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CASE SCENARIO

A 63-year-old male has been referred to a counselor for counseling by his primary care physician because of a recent diagnosis of depression.

He has had a successful 40-year career in the entertainment industry. He is currently married, but has been divorced twice before. His previous divorces have caused him to have financial difficulties, as well as precipitated past episodes of depression. He has three grown children who live in the area, whom he is devoted to.

He reports that in his 20's he abused cocaine but sought treatment in his early 30's and has been abstinent from illegal drugs since. He's had two additional stints in rehab for alcohol; most recently in the past 12 months.

He indicates that he has been diagnosed with depression and anxiety and is currently taking Remeron and Seroquel as prescribed by his doctor. At a recent doctor appointment, he was diagnosed with an incurable health condition.

SUICIDE LIFEGUARD

Tohid, 2016

SAFE-T

Suicide **A**ssessment **F**ive-step **E**valuation and **T**riage

for Mental Health Professionals

1. IDENTIFY RISK FACTORS — Note those that can be modified to reduce risk
2. IDENTIFY PROTECTIVE FACTORS — Note those that can be enhanced
3. CONDUCT SUICIDE INQUIRY — Suicidal thoughts, plans behavior and intent
4. DETERMINE RISK LEVEL/INTERVENTION — Determine risk. Choose appropriate intervention to address and reduce risk
5. DOCUMENT — Assessment of risk, rationale, intervention and follow-up

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SPRC, 2009

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Upon meeting with the our 63-year-old male and his wife, you learn that with each subsequent divorce he has experienced financial hardships. His divorce settlements cost him roughly tens of millions of dollars and he had to sell his multi-million-dollar ranch to settle. The client and his wife describe their marriage as having had its ups and downs, due to the client's struggles with alcohol and depression.

Professionally he is struggling. Recently, he received news that the television program he was staring in had been canceled after one season. He is uncertain about his ability to continue to work given his physical health concerns.

A few years ago, he had extensive heart surgery to replace the aortic heart valve. He has experienced several other health issues over the years and has recently been experiencing tremors, which resulted in seeing a specialist.

SUICIDE LIFEGUARD

Tohid, 2016

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

for Mental Health Professionals

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Note those that can be modified to reduce risk

2 IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3 CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans behavior and intent

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- Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- Family history: of suicide, attempts or Axis 1 psychiatric disorders requiring hospitalization
- Precipitants/Stressors/Interpersonal: triggering events leading to humiliation, shame or despair (e.g., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation.
- Change in treatment: discharge from psychiatric hospital, provider or treatment change
- Access to firearms

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- Internal: ability to cope with stress, religious beliefs, frustration tolerance
- External: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- Ideation: frequency, intensity, duration--in last 48 hours, past month and worst ever
- Plan: timing, location, lethality, availability, preparatory acts
- Behaviors: past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self injurious actions
- Intent: extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live

** For Youths: ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors or disposition*
** Homicide Inquiry: when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.*

4. RISK LEVEL/INTERVENTION

- Assessment of risk level is based on clinical judgment, after completing steps 1-3
- Reassess as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT Risk level and rationale; treatment plan to address/reduce current risk (e.g., setting, medication, psychotherapy, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.

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His wife discloses that the specialist has diagnosed with Parkinson's-like symptoms. She is concerned because he is being treated for depression by his doctor but has also been paranoid and experiencing hallucinations and bizarre behavior. Recently, he placed his collection of watches in a sock and gave them to his wife for safe keeping because he was concerned someone would steal them.

He and his wife indicate that he has been sober of illegal drugs and alcohol since his most recent treatment episode.

The counselor notes that there appears to be cut marks on his wrists. His wife indicates that despite a long history of depression the client has never expressed suicidal thoughts or behaviors to her. When the counselor asks about past suicide attempts he relates an experience while filming a movie in which he played the father to a son who committed suicide and how distressed he was by that scene.

He makes the comment that he just isn't sure he wants to go on living with a disease there is no recovery from.

SUICIDE LIFEGUARD

Tohid, 2016

SAFE-T

Suicide **A**ssessment **F**ive-step **E**valuation and **T**riage

for Mental Health Professionals

1. IDENTIFY RISK FACTORS — Note those that can be modified to reduce risk
2. IDENTIFY PROTECTIVE FACTORS — Note those that can be enhanced
3. CONDUCT SUICIDE INQUIRY — Suicidal thoughts, plans behavior and intent
4. DETERMINE RISK LEVEL/INTERVENTION — Determine risk. Choose appropriate intervention to address and reduce risk
5. DOCUMENT — Assessment of risk, rationale, intervention and follow-up

NATIONAL SUICIDE PREVENTION LIFELINE
1.800.273.TALK (8255)

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- Suicidal behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- Current/past psychiatric disorders: especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity). *Co-morbidity and recent onset of illness increase risk*
- Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- Family history: of suicide, attempts or Axis 1 psychiatric disorders requiring hospitalization
- Precipitants/Stressors/Interpersonal: triggering events leading to humiliation, shame or despair (e.g., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation.
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SPRC, 2009

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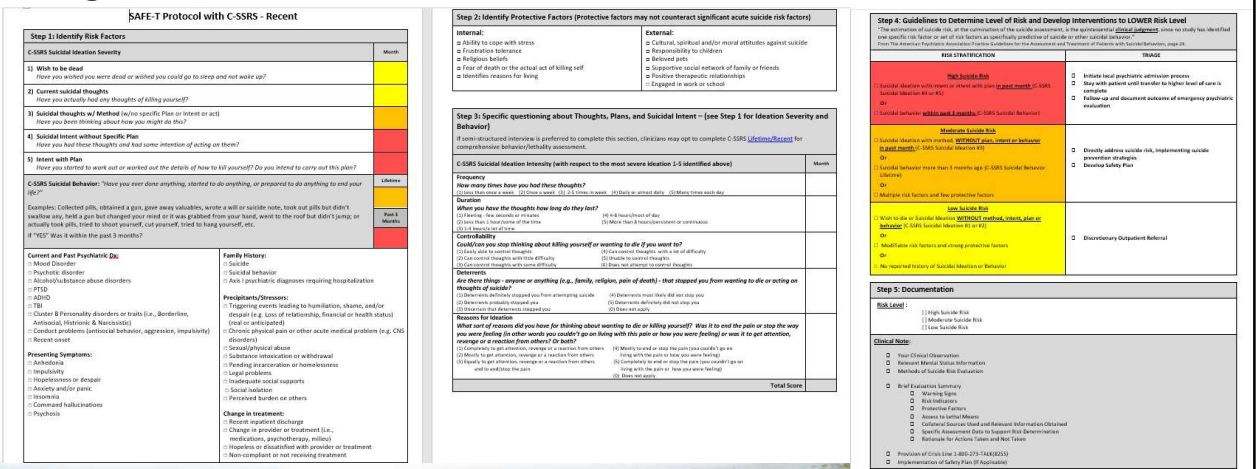
C-SSRS WITH SAFE-T EMBEDDED



LIFEGUARD
Columbia Lighthouse Project, 2016

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C-SSRS with SAFE-T Protocol Embedded

Step 1: Identify Risk Factors	
C-SSRS Suicidal Ideation Severity	**Month**
1) Wish to be dead *Have you wished you were dead or wished you could go to sleep and not wake up?*	
2) Current suicidal thoughts *Have you actually had any thoughts of killing yourself?*	
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) *Have you been thinking about how you might do this?*	
4) Suicidal Intent without Specific Plan *Have you had these thoughts and had some intention of acting on them?*	
5) Intent with Plan *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*	
C-SSRS Suicidal Behavior: *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"*	**Lifetime**
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. If "YES" Was it within the past 3 months?	**Past 3 Months**

Current and Past Psychiatric Dx: □ Mood Disorder □ Psychotic disorder □ Alcohol/substance abuse disorders □ PTSD □ ADHD □ TBI □ Cluster B Personality disorders or traits (i.e., Borderline, Antisocial, Histrionic & Narcissistic) □ Conduct problems (antisocial behavior, aggression, impulsivity) □ Recent onset **Presenting Symptoms:** □ Anhedonia □ Impulsivity □ Hopelessness or despair □ Anxiety and/or panic □ Insomnia □ Command hallucinations □ Psychosis	**Family History:** □ Suicide □ Suicidal behavior □ Axis I psychiatric diagnoses requiring hospitalization **Precipitants/Stressors:** □ Triggering events leading to humiliation, shame, and/or despair (e.g. Loss of relationship, financial or health status) (real or anticipated) □ Chronic physical pain or other acute medical problem (e.g. CNS disorders) □ Sexual/physical abuse □ Substance intoxication or withdrawal □ Pending incarceration or homelessness □ Legal problems □ Inadequate social supports □ Social isolation □ Perceived burden on others **Change in treatment:** □ Recent inpatient discharge □ Change in provider or treatment (i.e., medications, psychotherapy, milieu) □ Hopeless or dissatisfied with provider or treatment □ Non-compliant or not receiving treatment

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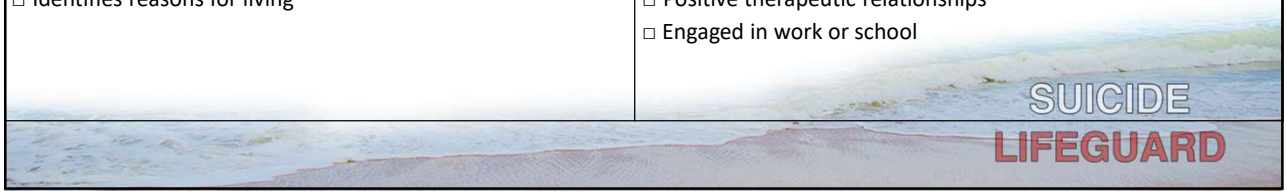
□ **Access to lethal methods:** Ask <u>specifically</u> about presence or absence of a firearm in the home or ease of accessing

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)

Internal: □ Ability to cope with stress □ Frustration tolerance □ Religious beliefs □ Fear of death or the actual act of killing self □ Identifies reasons for living	**External:** □ Cultural, spiritual and/or moral attitudes against suicide □ Responsibility to children □ Beloved pets □ Supportive social network of family or friends □ Positive therapeutic relationships □ Engaged in work or school



Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior) If semi-structured interview is preferred to complete this section, clinicians may opt to complete C-SSRS Lifetime/Recent for comprehensive behavior/lethality assessment.	
C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 1-5 identified above)	**Month**
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	
Total Score	

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential **clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."
From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

RISK STRATIFICATION	TRIAGE
High Suicide Risk □ Suicidal ideation with intent or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5) **Or** □ Suicidal behavior **within past 3 months** (C-SSRS Suicidal Behavior)	□ **Initiate local psychiatric admission process** □ **Stay with patient until transfer to higher level of care is complete** □ **Follow-up and document outcome of emergency psychiatric evaluation**
Moderate Suicide Risk □ Suicidal ideation with method, **WITHOUT plan, intent or behavior in past month** (C-SSRS Suicidal Ideation #3) **Or** □ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) **Or** □ Multiple risk factors and few protective factors	□ **Directly address suicide risk, implementing suicide prevention strategies** □ **Develop Safety Plan**
Low Suicide Risk □ Wish to die or Suicidal Ideation **WITHOUT method, intent, plan or behavior** (C-SSRS Suicidal Ideation #1 or #2) **Or** □ Modifiable risk factors and strong protective factors **Or** □ No reported history of Suicidal Ideation or Behavior	□ **Discretionary Outpatient Referral**

Step 5: Documentation

Risk Level :

[ ] High Suicide Risk
[ ] Moderate Suicide Risk
[ ] Low Suicide Risk

Clinical Note:

□ Your Clinical Observation
□ Relevant Mental Status Information
□ Methods of Suicide Risk Evaluation

□ Brief Evaluation Summary
□ Warning Signs
□ Risk Indicators
□ Protective Factors
□ Access to Lethal Means
□ Collateral Sources Used and Relevant Information Obtained
□ Specific Assessment Data to Support Risk Determination
□ Rationale for Actions Taken and Not Taken

□ Provision of Crisis Line 1-800-273-TALK(8255)
□ Implementation of Safety Plan (If Applicable)

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TAKE A STRETCH

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INTERVENING WITH SUICIDE

I ASKED, THEY SAID YES – NOW WHAT?

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TRADITIONAL DIRECTIVE APPROACH TO SUICIDE

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A COLLABORATIVE INTERVENTION FOR SUICIDE

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Jobes & Linehan, 2016

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LISTEN TO THEIR STORY

What Is Their Why?

- Reasons for dying
  - Psychological Pain
  - Stress
  - Hopelessness
  - Self-Hate
  - Rate the extent they wish to die 0-5
- Reasons for living
  - Protective factors
  - Connections to life
  - Hopefulness
  - Resiliency
  - Ambivalence
  - Rate the extent they wish to live 0-5

SUICIDE LIFEGUARD

Applied Suicide Intervention Skills Training (2014), Jobes (2016)

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LISTEN FOR THE PLAN

- Ideation: when, where, how
- Triggers for thoughts or behavior
- Frequency of thoughts
- Duration of thoughts – fleeing versus ruminating
- Preparation – obtaining or access to means
- Rehearsal
- History of suicidal behaviors – single or multiple attempts

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Applied Suicide Intervention Skills Training (2014), Jobes (2016)

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LISTEN FOR INCREASED RISK FACTORS

- Impulsivity
- Substance use/abuse
- Significant loss
- Relationship problems
- Burden on others
- Health or chronic pain concerns
- Sleep problems
- Legal/financial issues
- Shame

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HELPFUL QUESTIONS

- When did you first notice you were having these thoughts? (duration)
- What led up to the thoughts? (triggers)
- How often have those thoughts occurred? (frequency)
- How close have you come to acting on those thoughts? (preparation)
- How likely do you think it is that you will act on them in the future?
- Have you ever started to harm (or kill) yourself but stopped before doing something? (rehearsal)
- What do you envision happening if you actually killed yourself?

SUICIDE LIFEGUARD

Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors (2010)

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HELPFUL QUESTIONS

- What do you envision happening if you actually killed yourself?
- Have you made a specific plan to kill yourself? Is so, what does the plan include?
- Do you have guns or other weapons available to you? (access to means)
- How does the future look to you? (reasons for living/dying)
- What things would lead you to feel more (or less) hopeful about the future? (magic question)
- What things would make it more (or less) likely that you would try to kill yourself? (triggers)
- What things in your life would lead you to want to escape from life or to be dead? (pain)
- What things in your life make you want to go on living? (connections to life)
- If you began to have thoughts of harming or killing yourself again, what would you do? (resources/supports)

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Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors (2010)

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HELPFUL QUESTIONS

When there's been a past attempt:

- Can you describe what happened?
- What thoughts were you having beforehand that led up to the attempt?
- What did you think would happen?
- Did you seek help afterward yourself, or did someone get help for you?
- Had you planned to be discovered, or were you found accidentally?
- How did you feel afterward?
- Did you receive treatment afterward?
- Has your view of things changed, or is anything different for you since the attempt?
- Are there other times in the past when you've tried to harm (or kill) yourself?

SUICIDE LIFEGUARD

Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors (2010)

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HELPFUL QUESTIONS

Individuals with repeated suicidal thoughts or attempts

- About how often have you tried to harm (or kill) yourself?
- When was the most recent time?
- Can you describe your thoughts at the time you were thinking mostly about suicide?
- When was your most serious attempt at harming or killing yourself?
- What led up to it, and what happened afterward?

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EMPOWERING CLIENTS

Stabilization
Safety Planning
Lethal Means Reduction

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Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

Safety Plan Template ©2008 Barbara Stanley and Gregory K. Brown

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THE TRUTH IS THAT SUICIDAL PEOPLE ONLY REALLY GIVE UP ON SUICIDE WHEN THE PURPOSE AND VALUE OF SUICIDE IN THEIR LIVES IS MADE OBSOLETE, NOT BECAUSE WE HAVE TOLD THEM THEY CANNOT HAVE IT.

Dr. David Jobes,
Managing Suicidal Risk:
A Collaborative Approach, 2016

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LETHAL MEANS REDUCTION

SUICIDE LIFEGUARD

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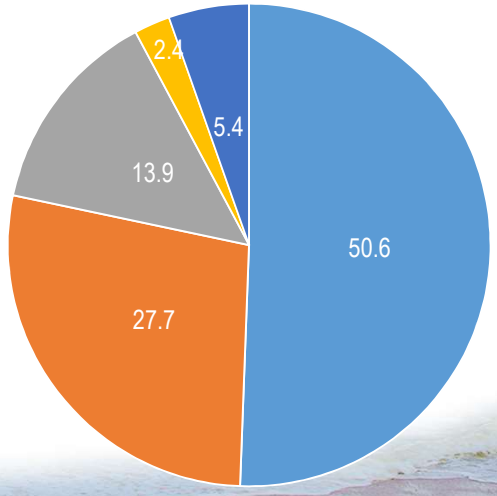
LETHAL METHODS: U.S. - 2017

CDC - WISQARS



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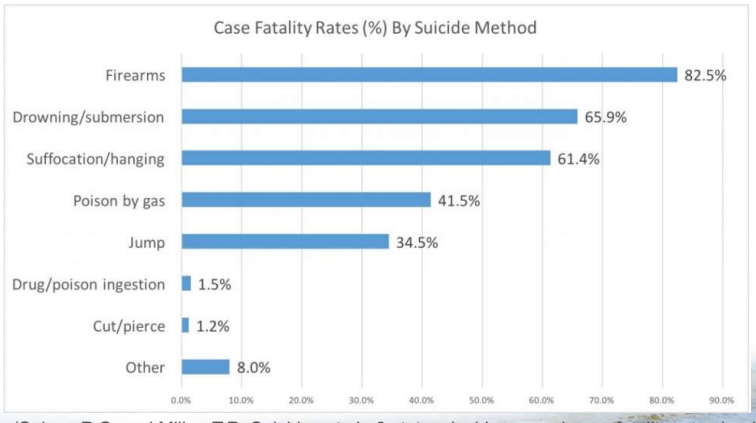
LETHALITY OF METHODS



(Spicer, R.S. and Miller, T.R. Suicide acts in 8 states: incidence and case fatality rates by demographics and method. American Journal of Public Health. 2000:90(12);1885.)

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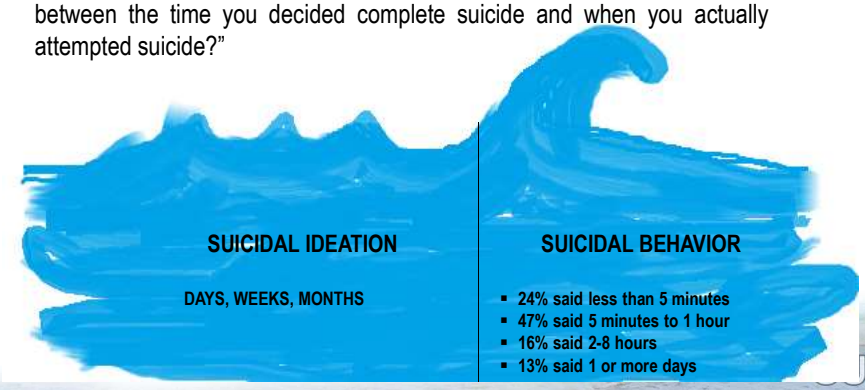
BREVITY OF SUICIDE CRISIS

A 2005 study of suicide attempt survivors asked, "How much time passed between the time you decided complete suicide and when you actually attempted suicide?"



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LETHAL MEANS REDUCTION

- Remove highly lethal means from the home
  - Store all firearms away from the home.
  - Don't keep lethal doses of medications/poisons in the home.
  - Remove access to other means when indicated as the identified method by the person at-risk.

- Off-site storage options for firearms
  - Storing with friends or family
  - Gun shops and shooting ranges
  - Self-Storage Facilities
  - Pawn shops
  - Some law enforcement department

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LETHAL MEANS REDUCTION

- Safely dispose of all out-of-date, unused and excess medications and over the counter remedies.
  - Don't flush or pour medications down the sink.
  - Drug take back at local law enforcement agencies
  - Utilize drug deactivation/medical disposal kits.
- Be Creative
  - Keep a picture of loved ones in the gun safe.
  - Adhere a NSPL magnet to the gun safe.
  - After locking guns in a gun safe, store the key in a bank safety deposit box.
  - After locking guns in a gun safe, freeze the key in a bucket of ice.

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WHAT ELSE?

- Follow-up, check in by phone, send a card or email
- Get others involved
  - Release of Information
  - Confidentiality
  - Limits of confidentiality
- Use law enforcement when necessary (welfare checks)
- Supervision/consult with colleagues/supervisors
- Review the policies within your organization
- Attend suicide specific trainings and conferences
- At-Risk populations – Youth, LGBTQ, Elderly
- Implement suicide policies within your organization
- Have referral resources at your disposal
- Join local suicide prevention coalitions

SUICIDE LIFEGUARD

Resources

National Suicide Prevention Lifeline	1-800-273-TALK (8255) www.suicidepreventionlifeline.org
Veterans Suicide Prevention Lifeline	1-800-273-CHAT (8255) www.suicidepreventionlifeline.org/help-yourself/veterans/
LGBT Youth Suicide Hotline	1-866-4-U-TREVOR
Crisis Text Line	Text 741-741
Missouri Suicide Prevention Hotlines	http://www.suicide.org/hotlines/missouri-suicide-hotlines.html
Missouri Department of Mental Health	dmh.mo.gov/mentalillness/suicide/
Suicide Prevention Resource Center	www.sprc.org
SAMHSA - Substance Abuse and Mental Health Services Administration	www.samhsa.gov
CDC - Center for Disease Control	www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html
AFSP - American Foundation for Suicide Prevention	www.afsp.org
AAS - American Association for Suicidology	www.suicidology.org
NAMI - National Alliance on Mental Illness	www.nami.org
The Trevor Project (LGBTQ)	www.thetrevorproject.org
Indian Health Services Suicide Prevention and Care Program	https://www.ihs.gov/suicideprevention/
Recommended Standard Care for People with Suicide Risk: MAKING HEALTH CARE SUICIDE SAFE	https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf

Books and Trainings

Managing Suicidal Risk: A Collaborative Approach	David Jobes & Marsha Linehan
Preventing Suicide: A Toolkit for High Schools	SAMHSA
After a Suicide: A Toolkit for Schools 2nd Edition	Suicide Prevention Resource Center
Suicide in Schools: A Practitioner's Guide to Multi-level Prevention, Assessment, Intervention, and Postvention	Terri Erbacher, Jonathon Singer, & Scott Poland
Helping the Suicidal Person	Stacey Freedenthal
Guns and Suicide: An American Epidemic	Michael Anestis
Recommended Standard Care for People with Suicide Risk: MAKING HEALTH CARE SUICIDE SAFE	https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf
(CAMS) Collaborative Assessment and Management of Suicidology	www.cams-care.com
(ASIST) Applied Suicide Intervention Skills Training	www.livingworks.net/programs/asist/
(RRSR) Recognizing & Responding to Suicide Risk	www.suicidology.org/training-accreditation/rrsr
School Suicide Prevention Accreditation Program	www.suicidology.org/training-accreditation/school-suicide-prevention-accreditation
(CALM) Counseling on Access to Lethal Means	www.sprc.org/resources-programs/calm-counseling-access-lethal-means
Connect Suicide Prevention, Intervention and Postvention Training	www.theconnectprogram.org
Now Matters Now	Nowmattersnow.org

Links to Professional Organization Ethical Standards

American Association for Marriage and Family Therapy	www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx
American Counseling Association	www.counseling.org/knowledge-center/ethics
American Psychiatric Association	www.psychiatry.org/psychiatrists/practice/ethics
American Psychiatric Nurses Association	www.apna.org/i4a/pages/index.cfm?pageid=5684
American Psychological Association	www.apa.org/ethics/code/
American School Counseling Association	www.schoolcounselor.org/school-counselors-members/legal-ethical
Missouri Credentialing Board for Substance Use Disorder Professionals	www.missouricb.com
National Association of Alcoholism and Drug Abuse Counselors	www.naadac.org/code-of-ethics
National Association of School Psychologists	www.nasponline.org/standards-and-certification/professional-ethics
National Association of Social Workers	www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

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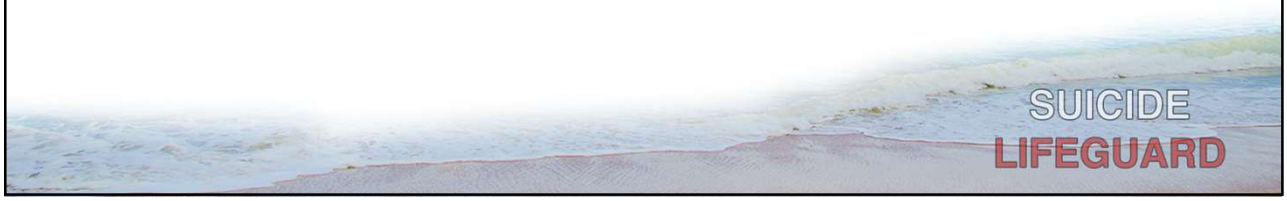
QUESTIONS?



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