

# SUICIDE PREVENTION PART II

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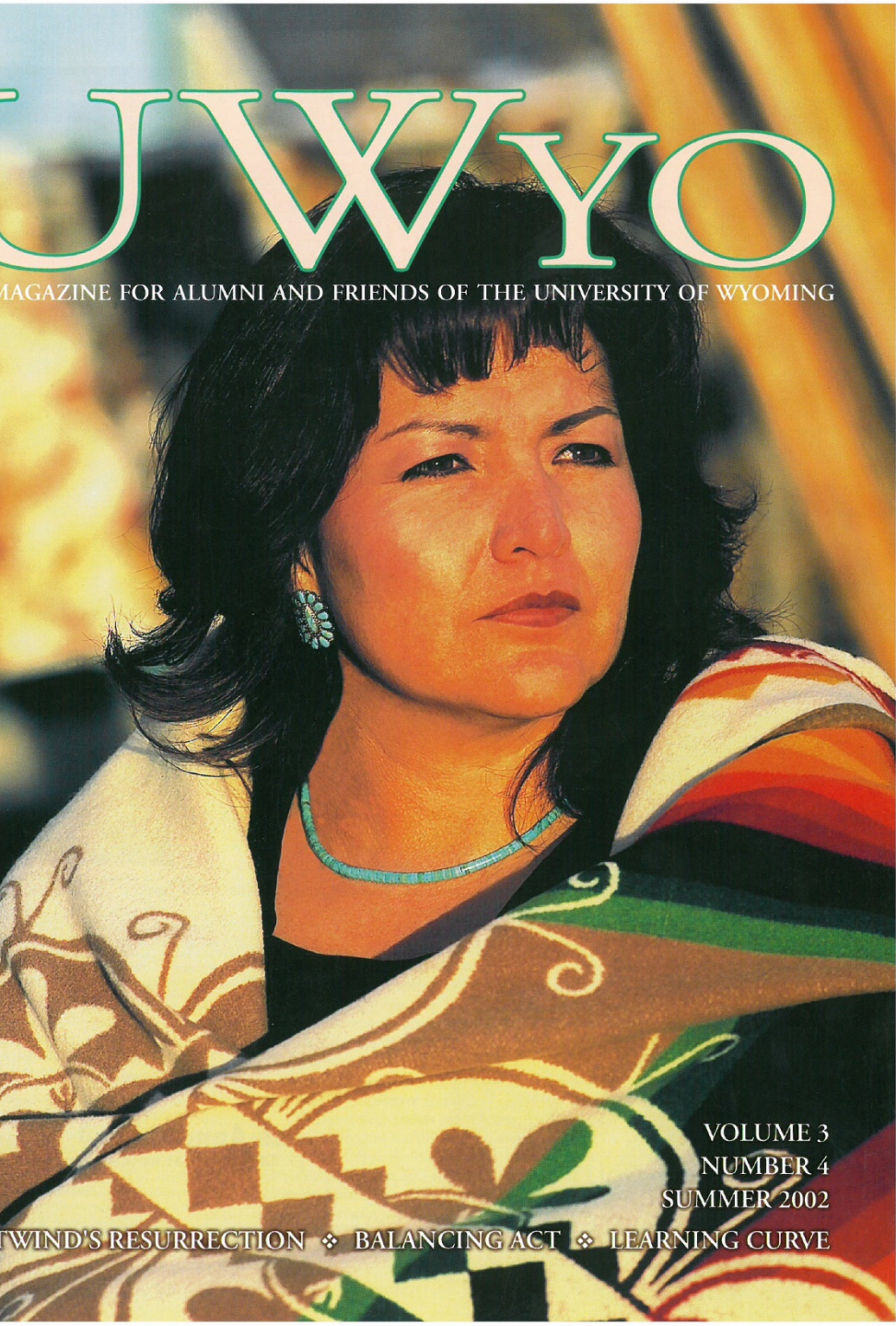
AUGUST 12, 2020

# ACKNOWLEDGEMENT OF COUNTRY

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- Lived Expertise
- Gratitude
- Self-care
- Preface





# WHO AM I?

TWINN'S RESURRECTION ♦ BALANCING ACT ♦ LEARNING CURVE



# LITTLE EAGLE/ JOHN DESHAW III 1968-1985

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# INTRODUCTIONS

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- Name
- Role/organization
- Tribal affiliation
- (Optional) How has the issue of suicide shown up in your life?
- Burning Question



# GOALS

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1. Risk Formulation
2. Eliciting Information
3. Managing Safety and Promoting Well-being
4. Reducing Access to lethal means
5. Treatment
6. Suicide grief & Trauma Support
7. Making Meaning



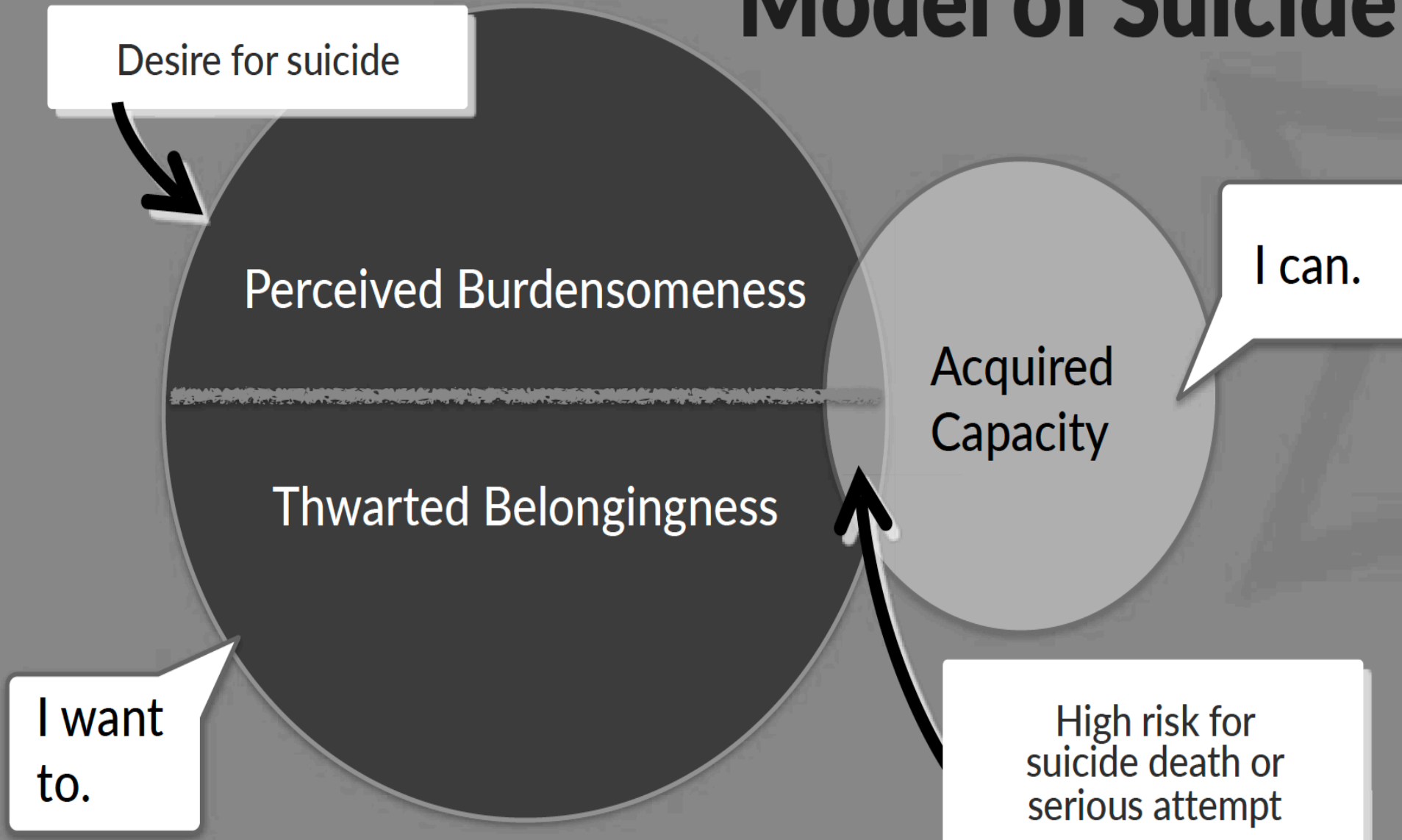
# STARTING WITH OURSELVES

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- #1 FEAR = SUICIDE OF CLIENT, 97% OF CLINICIANS
- ONE OUT OF EVERY FIVE MENTAL HEALTH SERVICE PROVIDERS WILL EXPERIENCE A CLIENT SUICIDE EACH YEAR



# Model of Suicide Risk



# ASSESSMENT CONSTRUCTS (JOBES)

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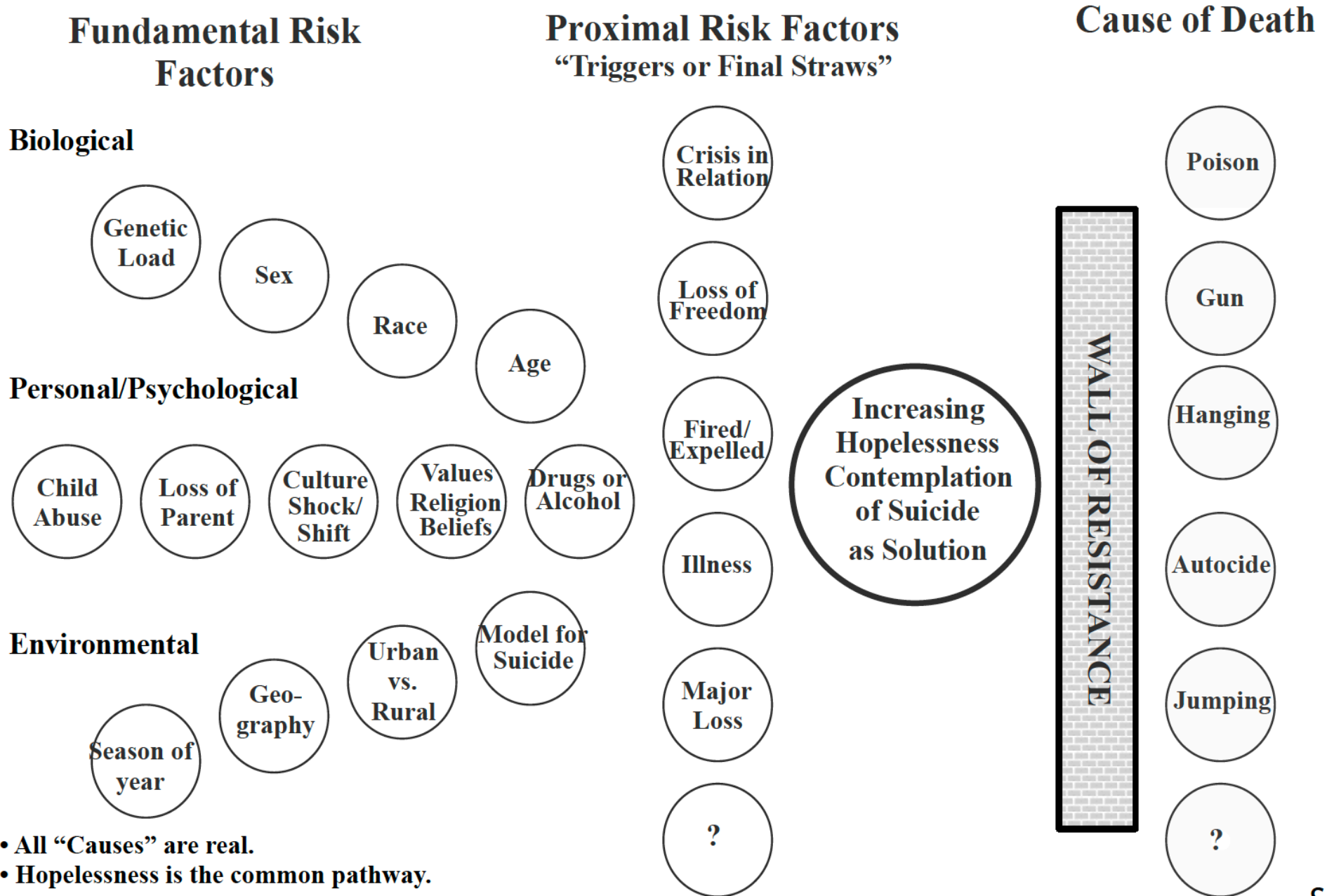
- Psychological pain (despair, misery)
- Stress (overwhelmed)
- Agitation (need to take action)
- Hopelessness
- Self-hate

# PSYCHACHE

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- Profound emotional pain is experienced as inescapable, interminable, and intolerable. Pain tolerance is exceeded.
- ~Ed Shneidman

# The Many Paths to Suicide



# Wall of Resistance to Suicide

Counselor or therapist	Duty to others	Others?	
Good health	Medication Compliance	Fear	
Job Security or Job Skills	Responsibility for children	Support of significant other(s)	
Difficult Access to means	A sense of HOPE	Positive Self-esteem	
Pet(s)	Religious Prohibition	Calm Environment	AA or NA Sponsor
Best Friend(s)	Safety Agreement	Treatment Availability	
-- Sobriety --			

## Protective Factors



# 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

# 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

- **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 \*

## ADDITIONAL INQUIRY

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- **For Youth:** 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.

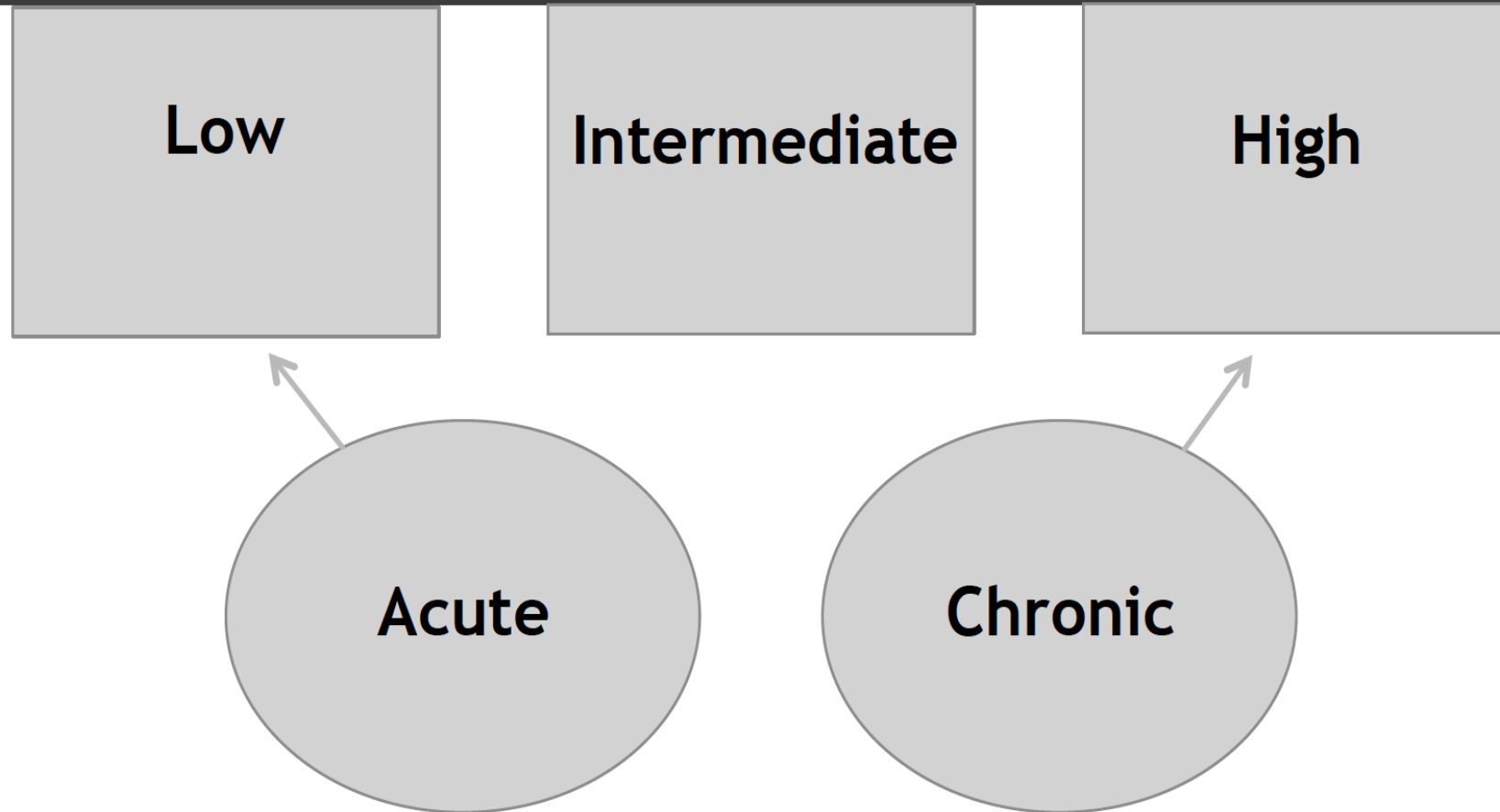
# *Risk Formulation and Intervention*

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.)

- Assessment of risk level is based on clinical judgment, after completing risk and protective factors analysis
- Reassess as patient or environmental circumstances change

# STRATIFY RISK – SEVERITY & TEMPORALITY





# STANDARDIZED ASSESSMENT TOOLS TO AUGMENT CLINICAL JUDGEMENT

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- Beck Hopelessness Scale (BHS)
  - Assesses hopelessness within the past week
  - 5 minutes
- Reasons for Living Inventory
  - Reasons for living that may serve a protective function or someone contemplating suicide
  - 10 minutes
- Beck Scale for Suicidal Ideation (BSS)
  - One of the few measures that has shown an association with death by suicide
  - 5 minutes

# ELICITING INFORMATION ABOUT SUICIDE

ASK THE QUESTION

I've noticed

"I noticed changes, and I am concerned. Tell me more." (Active Listening)

Is this true for you?

Empathy

"I can't imagine what you are going through. I am so glad you told me..."

"Sometimes suicidal thinking helps them temporarily escape overwhelming emotional pain."

I'm wondering

Open door to discuss suicidal thoughts

"Sometimes people in your situation think about suicide."

# TYPES OF QUESTIONS TO UNCOVER SUICIDAL IDEATION

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1. **Normalization**, self-normalization “If I was going through this I might consider ...”
2. **Behavioral Incident** (frame by frame)
3. **Shame attenuation** (learned behavior for survival)  
“Given your past, I wonder if you ever found it necessary ...”

## QUESTIONS CONTINUED...

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- **Gentle Assumption** “What other ways have you thought of killing yourself?”
- **Symptom Amplification**: setting upper limits of quantity in question at high level
- **Denial of the Specific**: list specific means one by one

# WHAT IF THEY SAY “YES”?

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- **Don't:**

- Over-medicate
- Whip out a “no suicide contract”
- Try to convince them life is worth living
- Hot potato

- **Do:**

- Gratitude: Thank you
- Collaborate: I am on your team, we will figure this out together
- Provide Hope: I have some ideas



# WHY “NO-SUICIDE CONTRACTS” ARE DEAD

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- Typically entails a patient agreeing to not harm themselves
- Despite a lack of empirical support, commonly used by mental health professionals
- Not recommended for multiple reasons
  - No medicolegal protection
  - Negatively influences provider behavior
  - Not patient-centered

# TIPS FOR DEVELOPING SAFETY PLAN COLLABORATIVELY

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Ways to increase collaboration

- Sit side-by-side
- Use paper form
- Have the individual write
- Provide brief instructions using client's words
- Controversial approach
- Jointly address barriers and use problem-solving.

# SAFETY AGREEMENT

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1. Warning signs
2. Hope Kit – reasons for living
3. Self-soothing/coping strategies
4. Distracting, behavioral activation
5. Social connections/Peer support
6. Professional & Crisis Support

***”How likely would you be able to do this during a time of crisis?”***

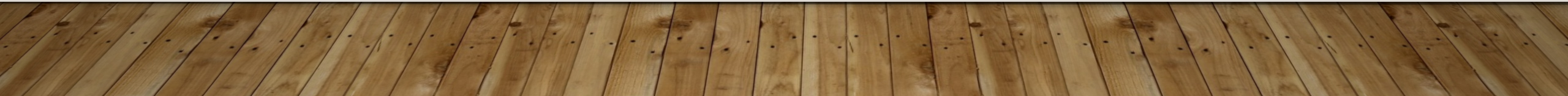
## STEP 1: WARNING SIGNS

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Ask:

“How will you know when to use your safety plan?”

“What are your personal red flags?”





## STEP 2: REASONS FOR LIVING

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Ask:

“There is a part of you that wants to die and a part that wants to live. Tell me about your reasons for living.”



## STEP 3: SELF-SOOTHING, INTERNAL COPING STRATEGIES

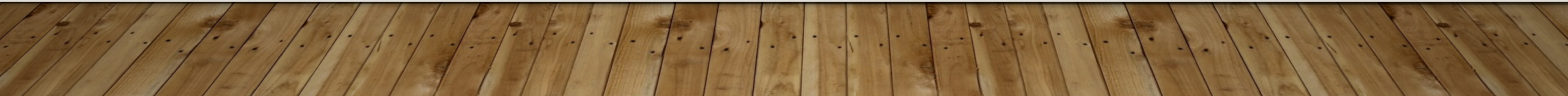
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Ask:

“What can you do on your own to prevent yourself from acting on suicidal thoughts or urges?”

”What helps you calm down?”

“When life has been really hard before, what helped you get through?”



## STEP 4: DISTRACTIONS

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Ask:

“What things help you take your mind off your problems at least for a little while?”

## STEP 5: SOCIAL CONNECTIONS, FAMILY, FRIENDS & PEER SUPPORT

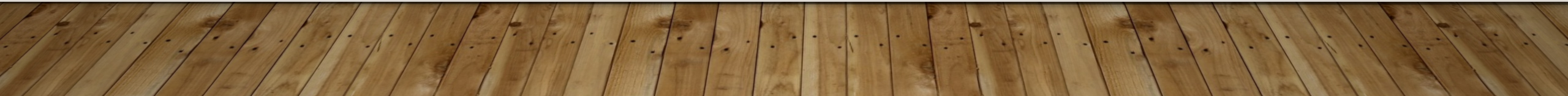
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Ask:

“Among your family and friends, who do you think you could contact for help during a crisis?”

”Who helps you feel better when you socialize with them?”

“Who is supportive of you and who do you feel that you can talk with when you’re under stress?”



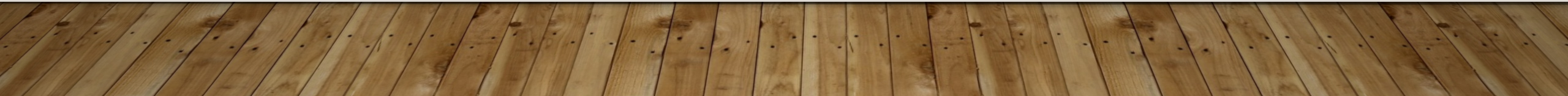
## STEP 6: PROVIDERS AND CRISIS RESOURCES

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Ask:

“Who are the mental health professionals that we should identify to be on your safety plan?”

“What crisis resources should we add?”





# NATIONAL SUICIDE PREVENTION LIFELINE & CRISIS TEXT LINE

THE NATIONAL SUICIDE PREVENTION LIFELINE & CRISIS TEXT LINE



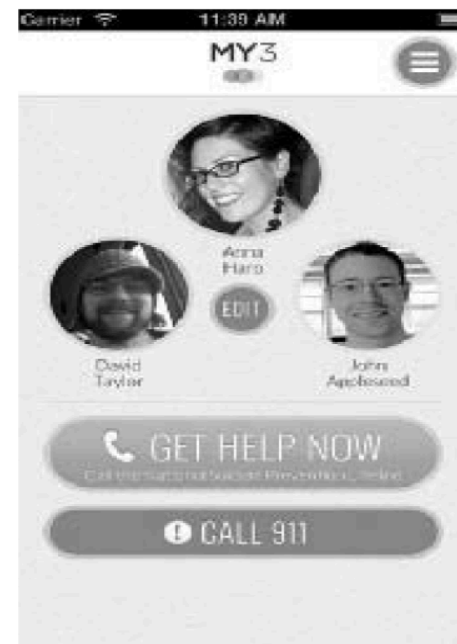
- 1-800-273-8255/Chat
- Certified crisis counselors
- 24/7, free
- Routes locally
- Veteran's option
- Spanish speaking
- They work!





# TOOLS FOR RECOVERY

## TOOLS FOR RECOVERY



NATIONAL SUICIDE PREVENTION LIFELINE

1-800-273-8255

CRISIS TEXT LINE

TEXT "HOME" TO 741741

ONLINE RESOURCES

[SUICIDEPREVENTIONLIFELINE.ORG](https://suicidepreventionlifeline.org)

# DOCUMENTATION

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- Risk factors, Ideation, planning, intent, buffers “as evidenced by...” (the how and why of your decision)
- Do not use the word “suicidal” (unless describing thoughts verbatim)
- Write down pertinent negatives (“client denies...” “was unable to locate file”)
- Update safety agreement – support system, means restriction, coping; track changes in risk each session (like taking vitals)
- Collaborative sources, consultation, referrals, follow-up
- Peer review

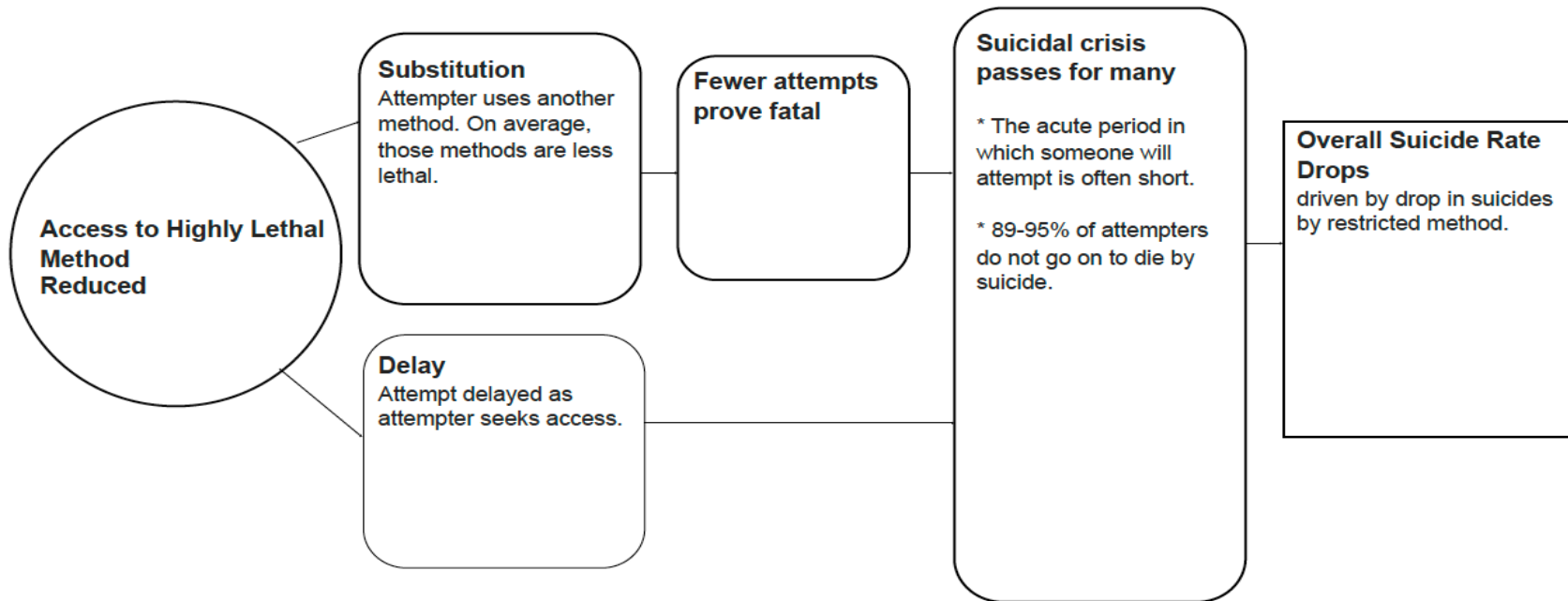
# REDUCE ACCESS TO LETHAL MEANS

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## Means Restriction Theory

How means restriction saves lives at the population level





# IMPULSIVITY AND SUICIDE

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Time between decision to act and action:

- 24% said less than 5 minutes
- 47% an hour or less

# C.A.L.M. (COUNSELING FOR ACCESS TO LETHAL MEANS)

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- Negotiation
- Express concern, ask about plan, explore all means
- Reduce availability
- On hand? Familiar? Temporary? Permanent?
- Advise others/Supervision 24-hour
- Safety Planning

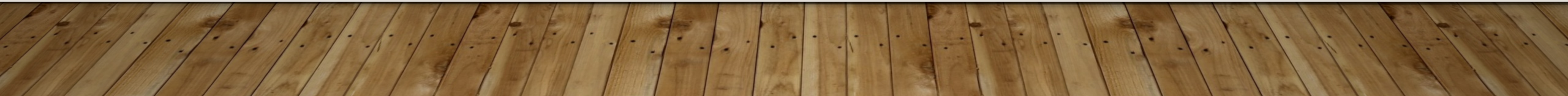
# KEEP ENVIRONMENT SAFE

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Ask:

“What means do you have to access to and are likely to use to make a suicide attempt?”

“How can we develop a plan to limit your access to these means?”



TREAT WITH DIGNITY, COMPASSION, &  
EMPOWERMENT

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Lethal Means Counseling



# IMPORTANCE OF COLLABORATION

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**Hope and Collaboration:** “Do you think you would be suicidal if you were less miserable? Let’s work together to make you less miserable”

~ Ursula Whiteside

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“Before you take our life to end your pain and suffering, let’s try to give clinical treatment a **reasonable chance** to help you find other ways of coping – obviously, there are many options – like suicide- that you can reflect on later without my help...”

# IMPORTANCE OF PRESERVING CHOICE AND DIGNITY

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People are experiencing suicidal thoughts feel they are at the “mercy of life,” ”but there remains one aspect of life over which they can maintain total control:

They can decide whether they live or die. The choice for suicide thus provides a chance for dignity via the conduit of self-determination.” p.43 (Shawn, Shea)

# ADDITIONAL BEST PRACTICES IN SUICIDE MANAGEMENT

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1. Suicide-specific
2. Time-limited (but often increased contact)
3. Goals:
  - Keep out of hospital
  - Increasing tolerance and improving coping to psychological pain
  - Make life worth living





Restraint + Isolation + Loss of Civil Rights = Trauma not treatment

Inhumane waiting time = Loss of self-worth + increased hopelessness



**“Living room” models are welcoming and accepting environments, conveying hope, empowerment, choice, and higher purpose.**

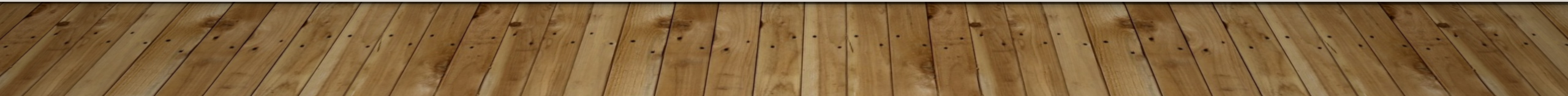
“Guests” not “patients”  
“Sanctuary” not “Psych Ward”

# RECOVERY WHEN OUT OF CRISIS

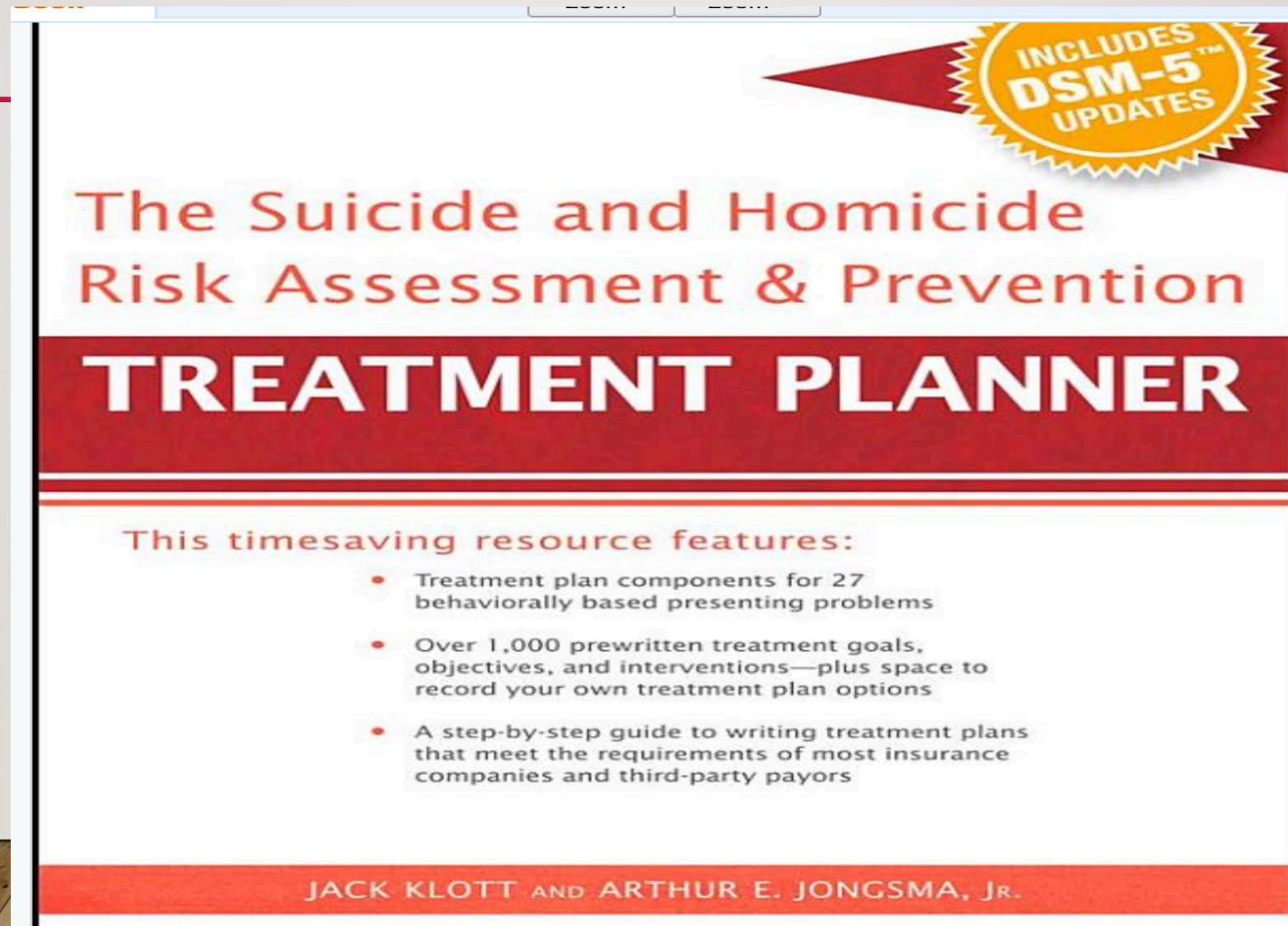
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1. Dialectical behavior therapy
2. Peer Support
3. Motivational Interviewing
4. “Suicide 2 Hope”
5. WRAP (Wellness Recovery Action Plan)
6. Ceremony: sweat lodge, NAC, what fits with your tribal culture for healing

GOALS: Understanding the meaning behind suicide (what purpose did it serve) and building a fully engaged life.



# BOOK I HIGHLY RECOMMEND

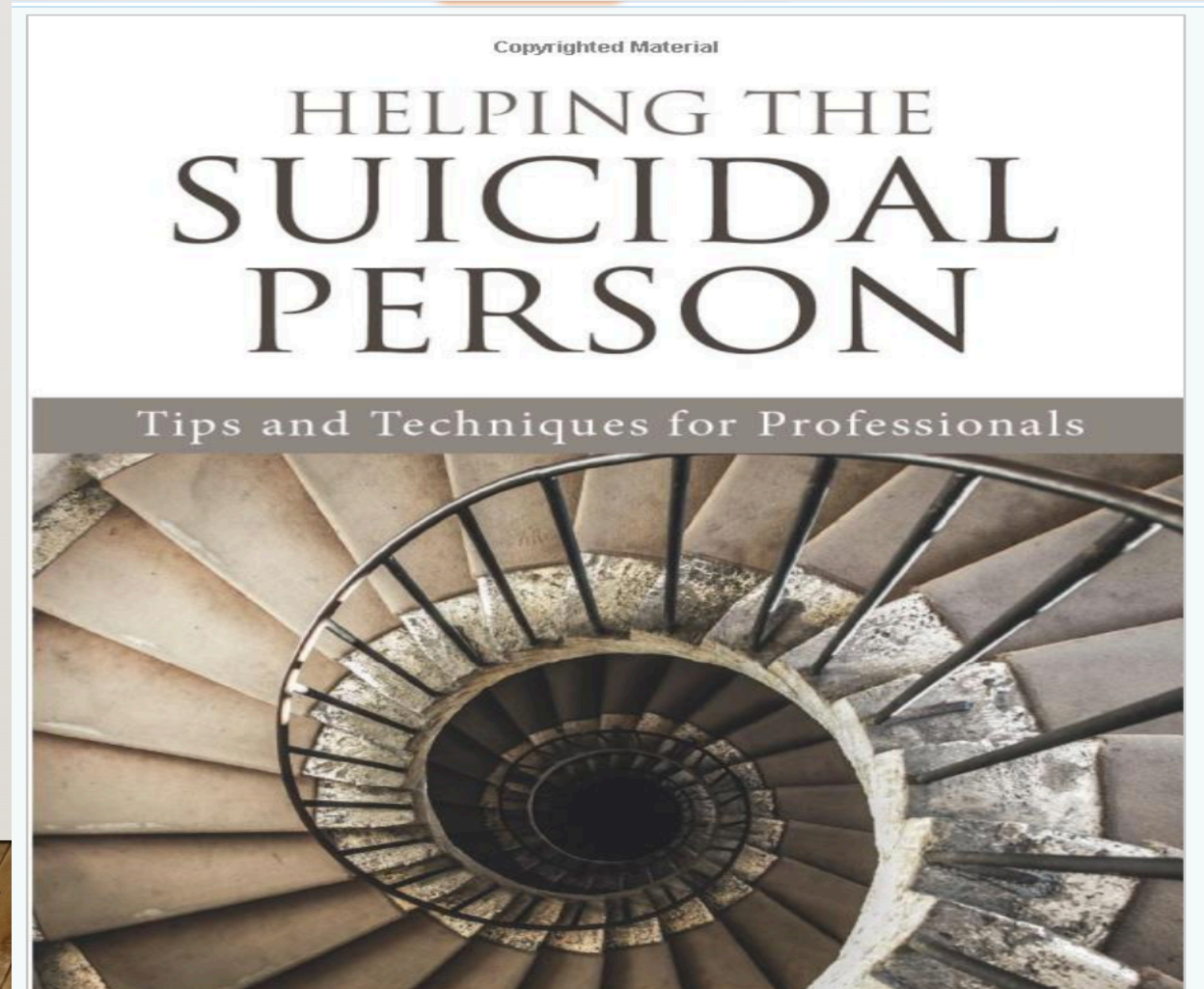


ment plan components for 27 behaviorally based presenting problems



# STATE OF THE ART INTERVENTION

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# TENSIONS IN POSTVENTION

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## **Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines**

Survivors of Suicide Loss Task Force  
April 2015

# INTERPERSONAL REGULATION

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- Non-demand caring contacts (TEXT)
- Increase scheduled check-in meetings (Internet, facetime)
- Plan for voluntary hospitalization

# QUESTIONS?

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- Don't forget to practice your self-care
- And join us in the next segment when I will get into prevention more and some treatment briefly.
- Ha hou for your time to listen. And please share and take action in your community.
- Help our people, they need you