Navigating a Behavioral Health Crisis: Knowing the Warning Signs, Risk Factors & Evidence-Based Practices for Treating Suicidal Ideation

Presenter:

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SAMHSA
Substance Abuse and Mental Health Services Administration

Mountain Plains (HHS Region 8)
MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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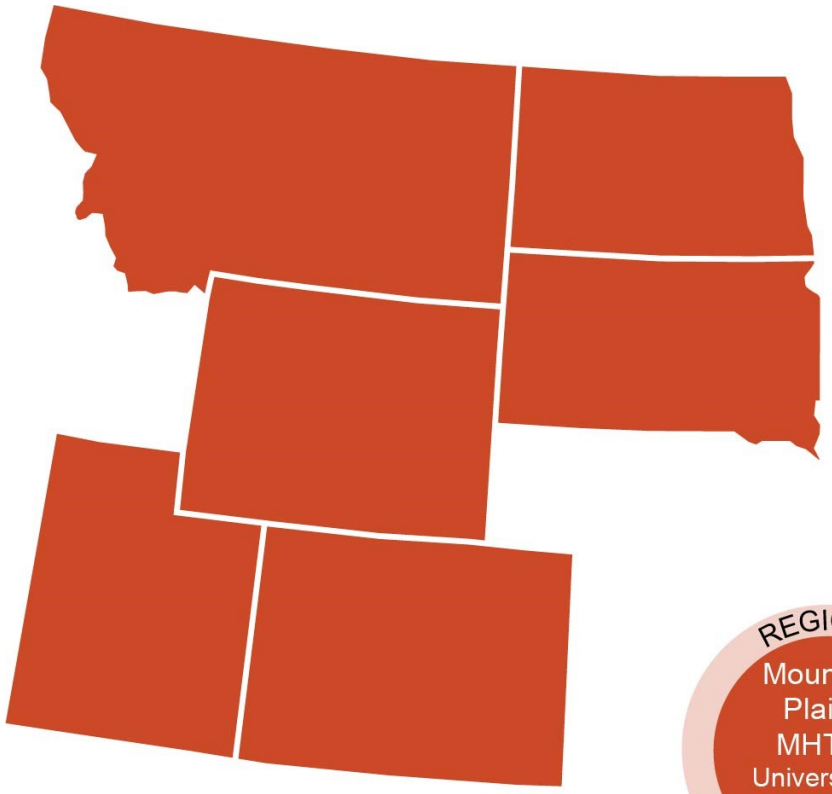
The Mountain Plains Mental Health Technology Transfer Center

The Mountain Plains Mental Health Technology Transfer Center (Mountain Plains MHTTC) provides training and technical assistance to individuals who serve persons with mental health concerns throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).



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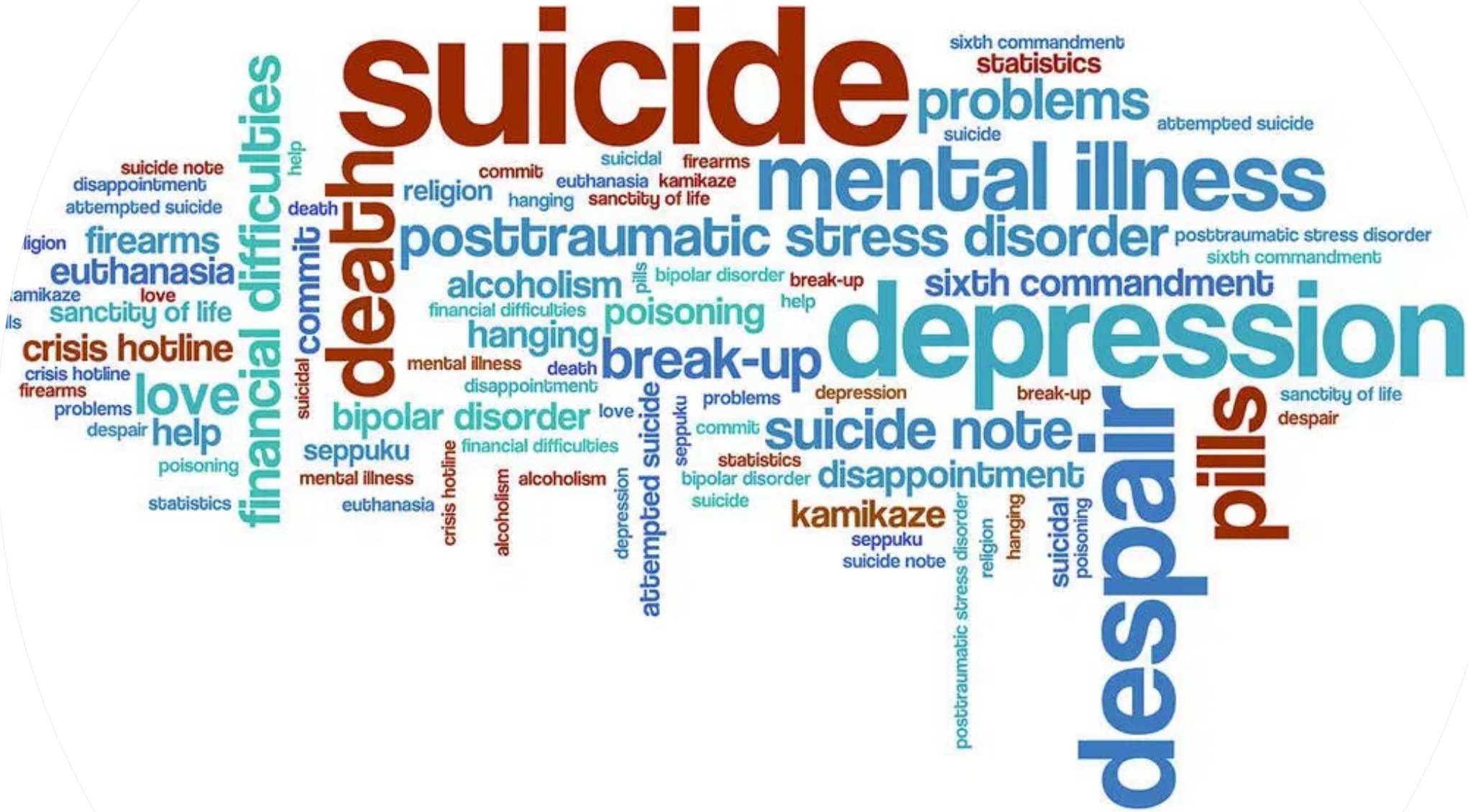
The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Healing-centered/ trauma-responsive
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf


suicide
death
depression
despair
mental illness
posttraumatic stress disorder
problems
statistics
sixth commandment
attempted suicide
financial difficulties
break-up
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pills
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Introduction

- I have had suicide prevention & assessment trainings before?
- I have a legal mandate to do an involuntary commitment.
- This is not a class on how to screen for suicidal risk. I will share one screening tool (CAMS SSF-IV-R) and the names of various other tools – and I am going to assume that you also have access to screening tools. I will share questions that need to be part of an in-depth risk assessment.
- I will focus on cultural factors/concerns as well as evidence-based practices for addressing suicidal ideation.

This training will not include …

- a refresher on all the short and long screening and assessment tools available to you.
- a refresher on mandatory disclosure laws around legally mandated breaches to confidentiality.
- a refresher on involuntary commitments/72 hour holds.
- an extensive discussion about creating suicide prevention contracts or safety plans.


I'M SCARED
BECAUSE I DON'T KNOW HOW TO HELP YOU.
BECAUSE I DON'T WANT TO DIE

"Suicide is an urgent issue –
it kills people –
but urgency need not
entail panic.
Becoming and remaining
competent is your best
antidote to panic."

- Every 40 seconds someone in the world dies by suicide, yet very few clinicians are trained to work with suicidal people using evidence-based treatments.
- 800,000 individuals across the globe die by suicide each year, 48,000 of them in the USA.
- There are over 12 million adults in the United States with serious suicidal ideation each year.
- Funding for suicide research in 2018 was $68 million versus breast cancer research funding of $709 million.
- Suicide deaths have doubled over the last 50 years while every other leading cause of death has decreased.

Definitions

- Suicide is the act of intentionally causing one's own death.
- Suicidal ideation means thinking about suicide, planning one's suicide and/or wanting to take your own life. A person can have fleeting, intermittent or ongoing thoughts about suicide.
- Passive suicidal ideation is when a person thinks they would be better off dead or that death would be a relief from current circumstances.
- Active suicidal ideation = suicidal intention – there is active intent and planning regarding how it will happen.

Definitions

- A suicidal threat is a statement without a plan or actionable intent.

- A suicidal gesture is an action that could be harmful but is done without the intent or real belief that one will die as a result, such as self-mutilation/cutting. This includes shallow cuts on a wrist or thigh without reaching any major blood vessels or a small overdose of a non-lethal medication.

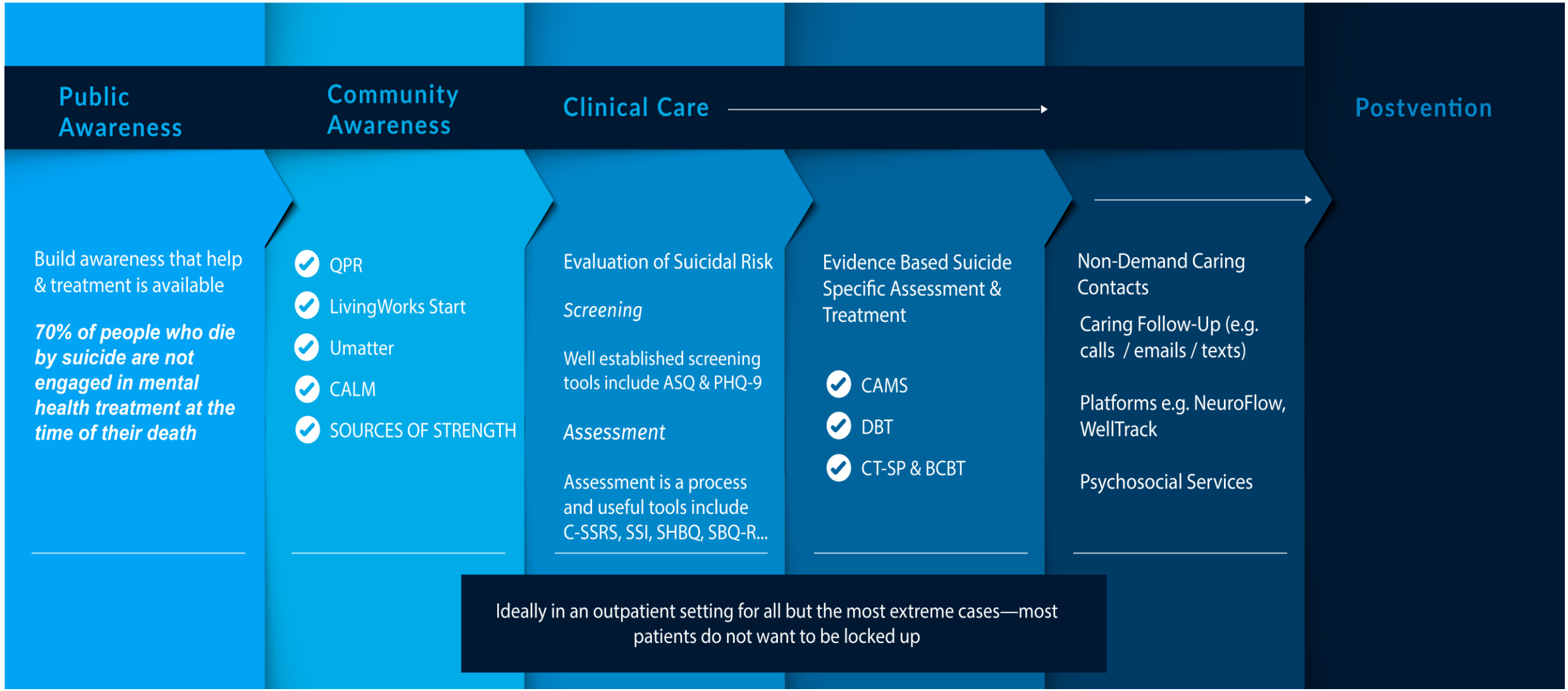
- A suicidal attempt is an action taken with the sincere belief and intent that one will die as a result – a genuine endeavor to kill oneself.

Methods & Lethality

- Suicide Methods: The most common method of attempted suicide is an attempt to overdose. Cutting (for instance, wrists) with a knife is also common.

- Lethality: Use of a firearm and hanging are the most lethal methods of suicide. The most common method of death by suicide is firearms, followed by hanging. Attempts by overdose and self-cutting are much more likely to be survived.

Suicide System of Care – Inpatient & Outpatient



- Act on the concern: all statements that hint at or directly refer to suicide need to be unpacked.
- Ask direct questions – get them talking.
- Offer understanding and encouragement.
- Make it safe to talk and share.
- Create a realistic plan. Elicit anti-self-harm statements.

CAUTION

Strengths-based, wellness-oriented, holistic principles

- Historically, suicidal ideations has been socially constructed as sinful, illegal, or a terribly frightening and bad illness.
- In contrast, Flanagan & Flanagan (2021) believe that suicidal ideation is a normal variation on human experience that typically stems from difficult environmental circumstances and excruciating emotional pain.
- Rather than fear client disclosures of suicidality, it more therapeutic to welcome these disclosures because they offer an opportunity to connect deeply with distressed clients and provide therapeutic support.

Strengths-based, wellness-oriented, holistic principles

- Although Flanagan & Flanagan(2021) and many others believe that risk factors, warning signs, protective factors, and suicide assessment instruments are important – it is more important to value relationship connections with clients over predictive formulae and technical procedures.

- Flanagan & Flanagan believe that trust, empathy, collaboration, and rapport will improve the reliability, validity, and utility of the data gathered during assessments. Consequently, Flanagan & Flanagan and many others embrace the principles of therapeutic assessment.

Strengths-based, wellness-oriented, holistic principles

- Flanagan & Flanagan and many others believe that the narrow pursuit of psychopathology causes clinicians to neglect a more complete assessment and case formulation of the whole person. To compensate, they offer a holistic seven-dimension model to create a broader understanding of what is hurting and what is helping in each individual client's life.

- Flanagan & Flanagan and many others value the positive emphasis of safety planning and coping skills development over the negative components of no suicide contracts and efforts to eliminate suicidal thoughts.

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Challenges to Clinicians working with Suicidal Ideation

- Stressful to the therapist – fear of the unknown
- Statutory requirements - 72 hr holds/involuntary commitment
- Limited hospitalization options – not always appropriate
- Limited outpatient options – not always quality
- Limitations of outpatient therapy – no guarantees
- Psych eval limitations – lack of affordable & timely access
- Medication limitations – access, effectiveness, compliance
- Concerns about suicidal completions
- Concerns about litigation – client completes suicide

A client with suicidal ideation:

- Usually doesn't want to end their life - they want an end to their psychological suffering and pain
- Tells others (including therapists) that they are thinking about suicide - as a viable option for coping with their pain
- Often has mental health and/or substance use disorders
- Is struggling with interpersonal issues & poor coping skills
- Is searching for a solution and needs help finding an alternative to suicide

Rate of Suicide by Race/Ethnicity, United States 2009-2018

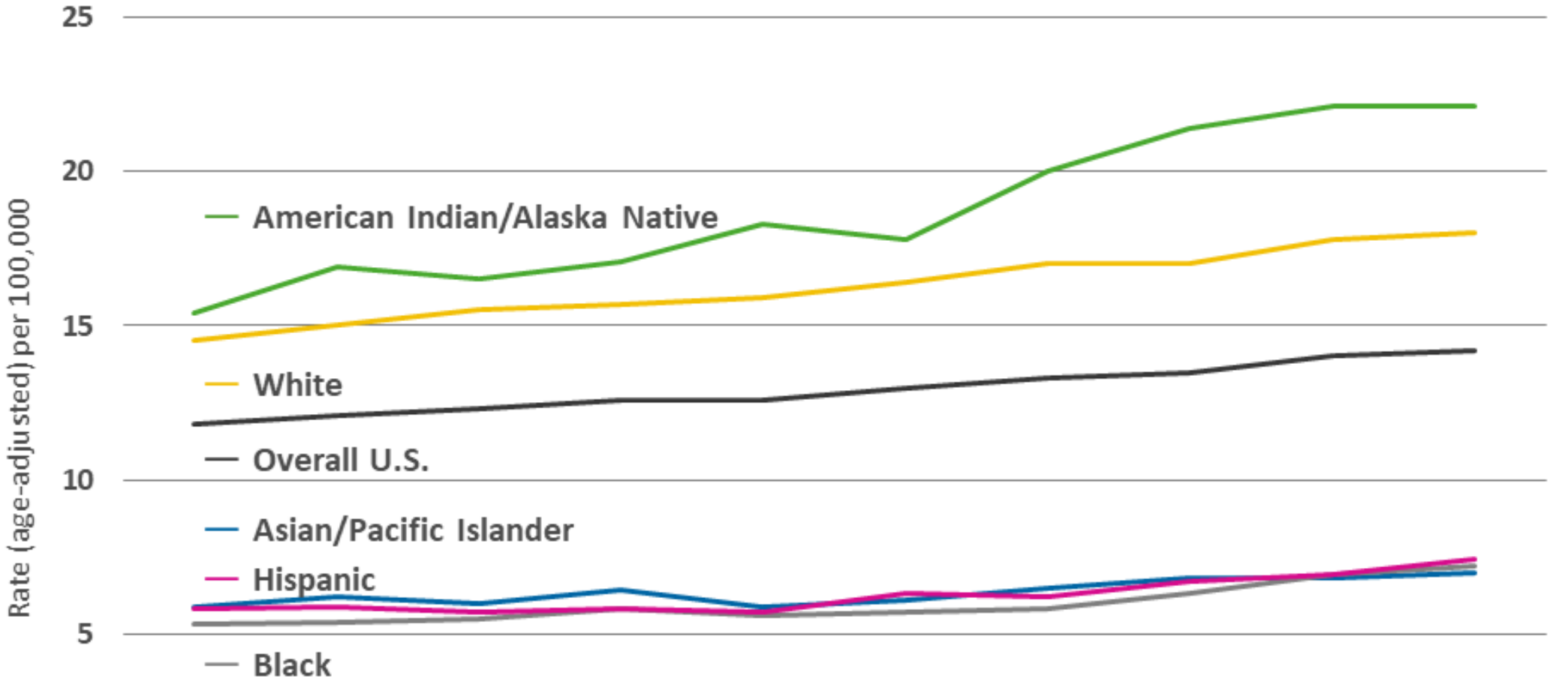
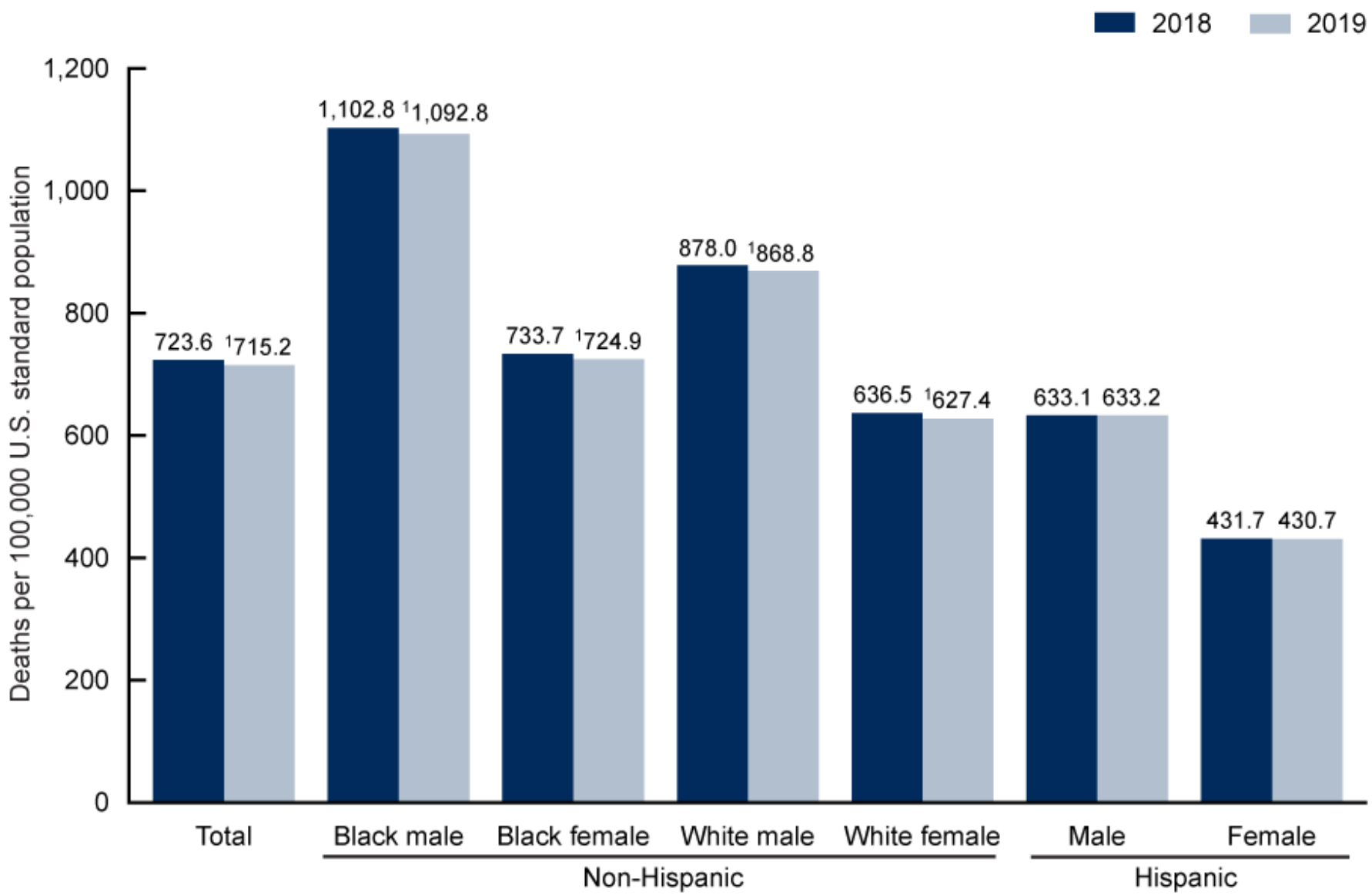


Figure 2. Age-adjusted death rates, by race and ethnicity and sex: United States, 2018 and 2019



[1]Statistically significant decrease in age-adjusted death rate from 2018 to 2019 ($p < 0.05$).
NOTES: Race groups are single race. Access data table for Figure 2 at: https://www.cdc.gov/nchs/data/databriefs/db395-tables-508.pdf#2.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

SAMHSA (2020): Good Crisis Care is:

1. an effective strategy for suicide prevention;
2. an approach that better aligns care to the unique needs of the individual;
3. a preferred strategy for the person in distress that offers services focused on resolving mental health and substance use crisis;
4. a key element to reduce psychiatric hospital bed overuse;
5. an essential resource to eliminate psychiatric traumas and issues that develop in emergency departments;
6. a viable solution to the drains on law enforcement resources in the community; and
7. crucial to reducing the fragmentation of mental health care.

Crisis

1. Crisis is time limited.
2. Crisis stimuli are typically unexpected.
3. A crisis significantly disrupts and distresses an individual and overwhelms his or her coping strategies.
4. Crisis results in psychological disequilibrium.
5. Crisis intervention models are structured and sequential, and at times, the stages may overlap.
6. RSSCIM has been found to be an effective model of crisis intervention.
7. Mental health practitioners should provide psychoeducation to family members and support networks regarding means of ensuring the safety of the individual in suicidal crisis.
8. Collaborative work with clients throughout the crisis intervention process is essential to a successful outcome.
9. Crisis intervention is not a one-session process. It requires follow-up treatment with an emphasis on treatment engagement.
10. Accessing client's strengths is important for crisis intervention, such as identifying coping strategies and building support networks.

Risk Factors

Using Suicide Risk Measures

- Suicide risk measures typically have two important goals:
  - to assess current suicidality
  - to assess the potential for future suicidal behaviors

- Some clinicians choose not to use standardized suicide risk scales due to their overconfidence in clinical interviewing, and a perception that the instruments fail to capture essential aspects of suicidality.
- However, an expert group concluded that clinicians are also unlikely to assess the suicidal person's inner state, their subjective experience of being suicidal.
- Risk assessment models can help guide and encourage professional evaluations.

Tripartite Model & Dichotomous Items

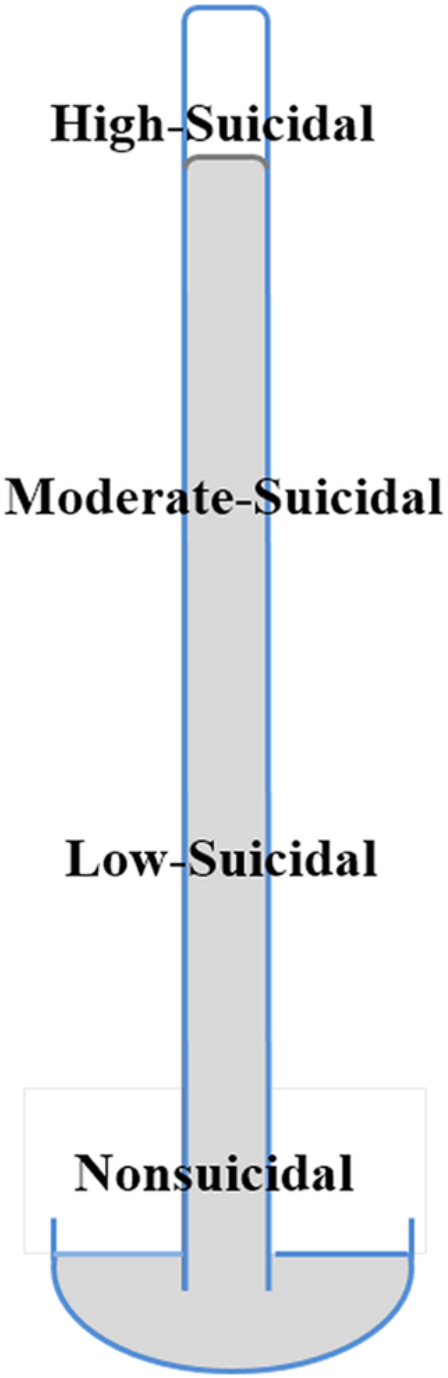
- The tripartite model postulates that an attitude (e.g., toward suicide or death) is comprised of three correlated but distinct components: affect, behavior, and cognition.
- The ABC model encompasses common suicidality factors, which might be useful for assessing suicide risk. A two-tier clinical assessment model (Kral & Sakinofsky) includes (1) sociodemographic factors to understand the client's general risk level, and (2) subjective factors (thoughts, emotions, suicidal history) to identify individual risk.
- Incorporating demographic factors may be counterproductive for standardized individual assessment.
- Many suicide risk measures, such as the SAD PERSONS and the Manchester Self Harm Rule (MSHR), use dichotomous items on demographics and select risk & protective factors.
- However, these measures have been criticized for inaccurate risk classifications, which can lead to a drain on psychiatric services.

Suicide Status Form (SSF)

- Jobes' Suicide Status Form (SSF) is a clinician-administered measure stemming from the theoretical works of:
  - Shneidman (psychological pain, agitation)
  - Beck (hopelessness), and
  - Baumeister (self-hate).

- It includes items on suicidal affect, behaviors, and cognition.
- The SSF is the most likely candidate as a gold standard in clinical evaluation.
- Unfortunately, its' length and inclusion of qualitative responses make it inconvenient for some screening and research applications.

Suicide Barometer Model



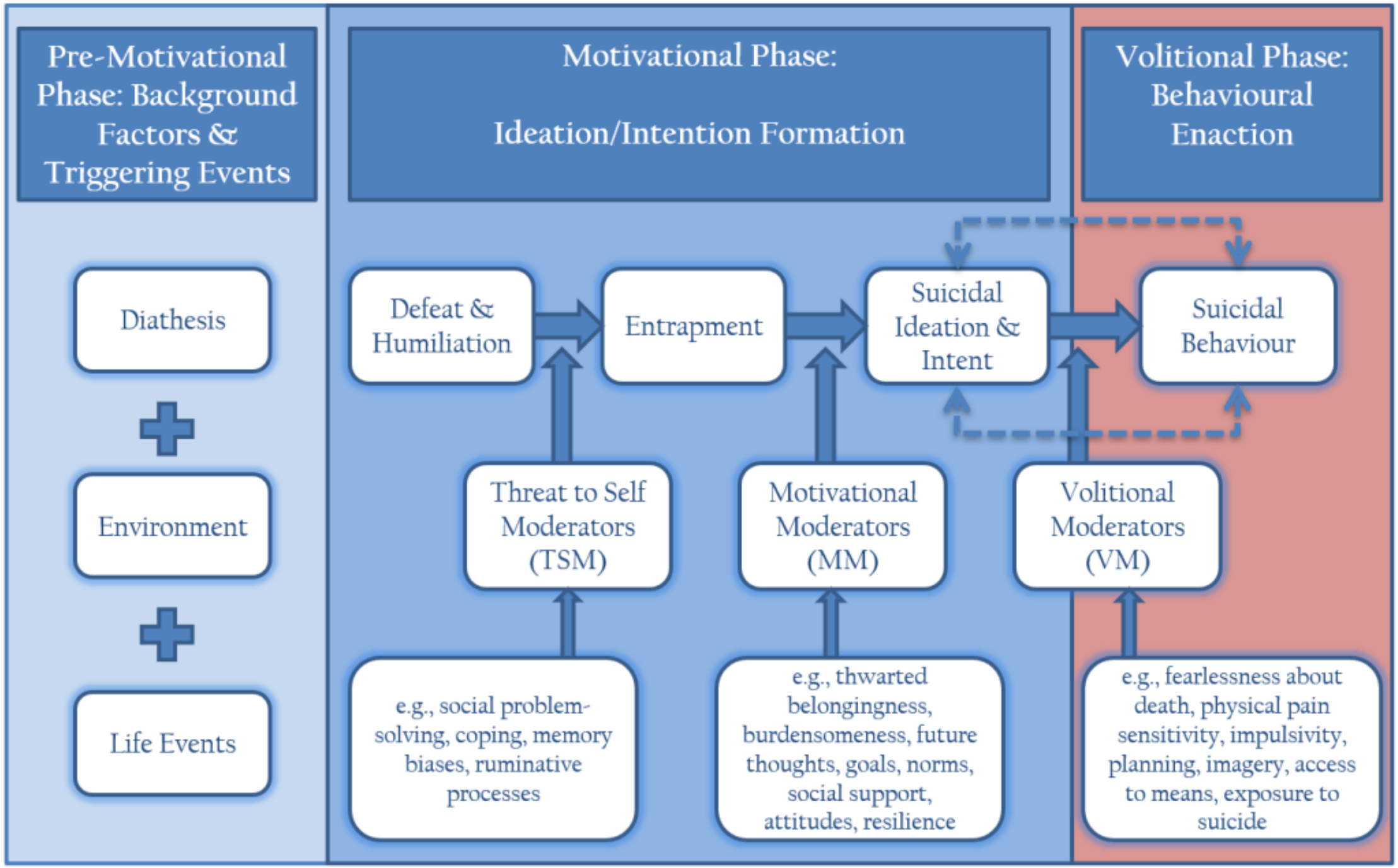
Very low WTL, very high WTD, high prediction of future suicide attempts, attempts with intent to die, frequent life/death debates.

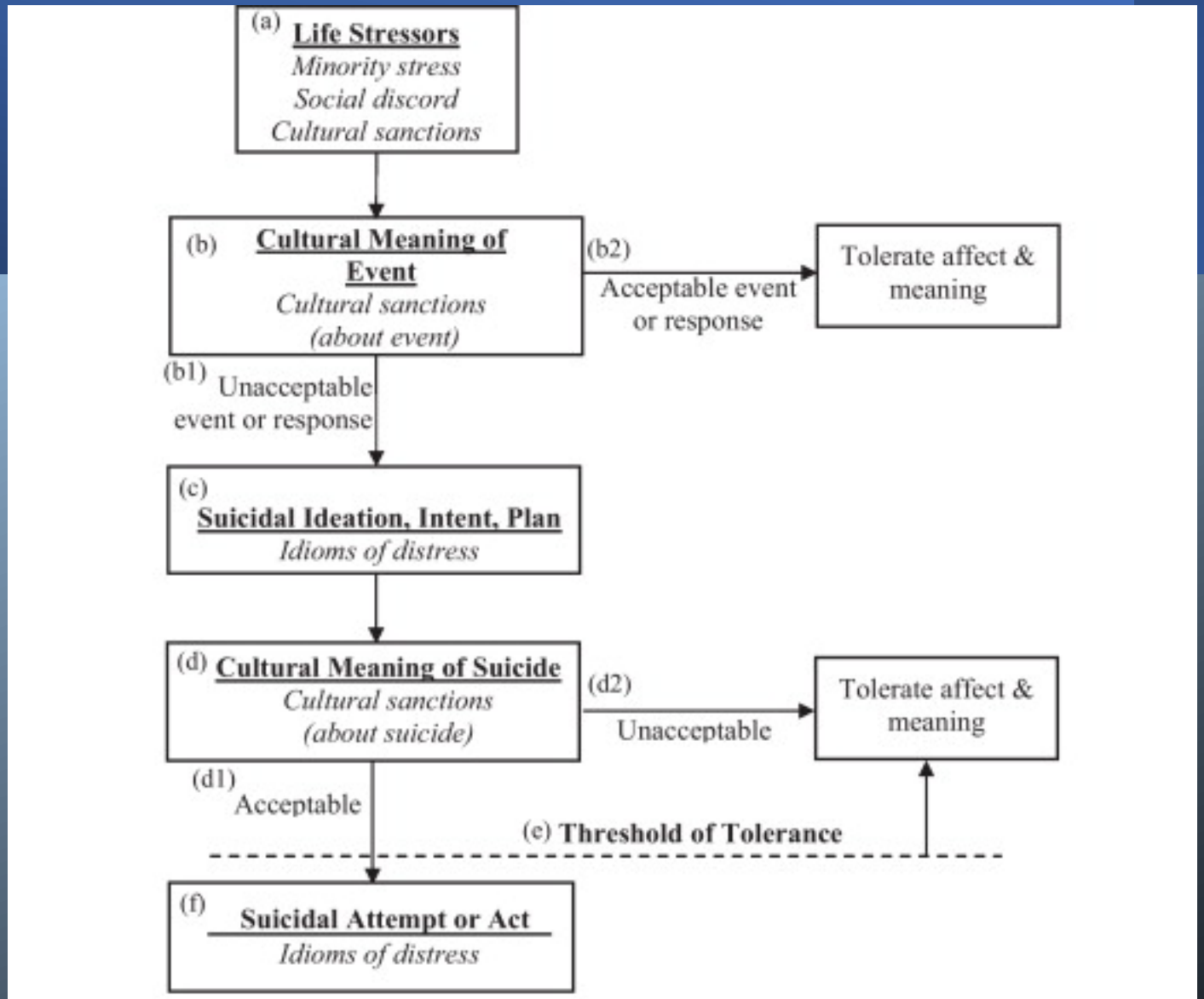
High WTD, low WTL, high prediction of future attempts, plans and attempts with intent to die, frequent life/death debates, very frequent suicidal thoughts.

Moderate suicidal thoughts, low prediction of future attempts, infrequent life/death debate, moderately high WTL, very low WTD.

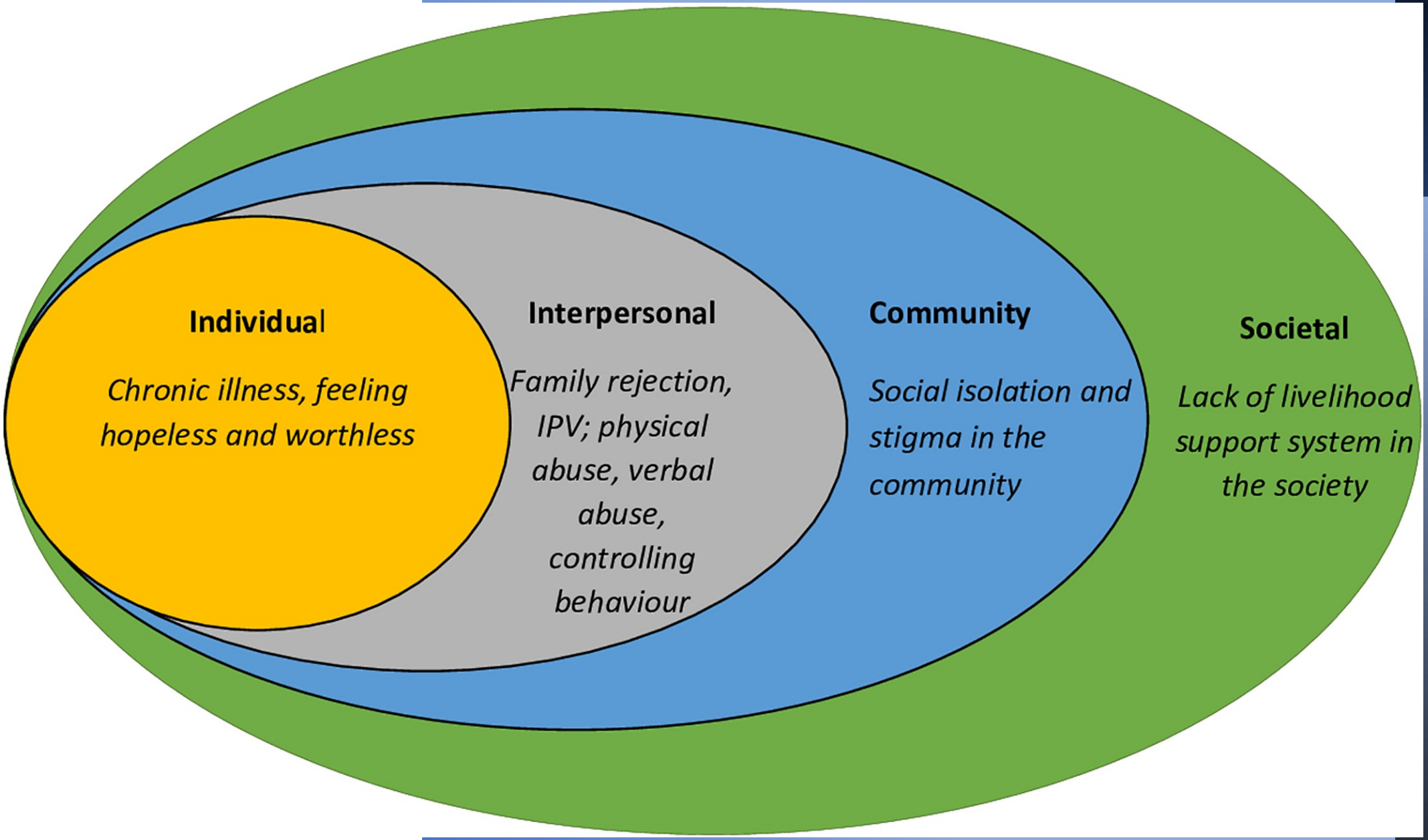
No internal life/death debate, no thoughts of suicide, prediction of no future suicide attempts.


PREVIOUS suicide ATTEMPTS
History of SUBSTANCE ABUSE
Physical DISABILITY or ILLNESS
RELATIONSHIP PROBLEMS
Some Important RISK FACTORS for suicide
Losing a FRIEND or FAMILY MEMBER to SUICIDE
ACCESS to HARMFUL MEANS
Ongoing EXPOSURE TO BULLYING behavior
Recent DEATH of a FAMILY MEMBER or a CLOSE FRIEND
History of a MENTAL HEALTH CONDITION


Pre-Motivational Phase: Background Factors & Triggering Events
Motivational Phase: Ideation/Intention Formation
Volitional Phase: Behavioural Enaction
Diathesis
Environment
Life Events
Defeat & Humiliation
Entrapment
Suicidal Ideation & Intent
Suicidal Behaviour
Threat to Self Moderators (TSM)
Motivational Moderators (MM)
Volitional Moderators (VM)
e.g., social problem-solving, coping, memory biases, ruminative processes
e.g., thwarted belongingness, burdensomeness, future thoughts, goals, norms, social support, attitudes, resilience
e.g., fearlessness about death, physical pain sensitivity, impulsivity, planning, imagery, access to means, exposure to suicide



Note: Italicized text indicates the current study's inductively-derived culturally-specific factors.


Individual
Chronic illness, feeling hopeless and worthless
Interpersonal
Family rejection, IPV; physical abuse, verbal abuse, controlling behaviour
Community
Social isolation and stigma in the community
Societal
Lack of livelihood support system in the society

SSF: Clinician's Risk Assessment

- Suicidal ideation? Suicide plan?
- Suicide preparation? Suicide rehearsal?
- History of suicidal behaviors – single or multiple attempts?
- Impulsivity?
- Substance abuse?
- Significant loss?
- Relationship problems?
- Burden to others?
- Health/pain problems?
- Sleep problems?
- Legal/financial issues?
- Shame?

Additional Areas of Exploration

- History of depression, anxiety or other mood disorder?
- Bipolar disorder, borderline pd, schizophrenia, psychosis?
- If client has history of SUDs/ADBs – recovery history? Current status of recovery?
- Family/significant other/friend history of suicide or violence?
- Physical illnesses: autoimmune disorders? chronic pain? cancers? stacked illnesses?
- Medications currently taking? Recent medication changes?
- Feelings of loneliness? emptiness? disconnected?
- Grief & loss?
- Employment? changes? wrongful termination? laid off?
- Finances? changes? loss of income? gambling? debts?
- Need for attention? paranoia? impulsivity?

Further Areas of Exploration

- Experiencing violence, abuse or neglect?
- Instability due to parental separation? marital separation?
- Household member(s) in jail or prison?
- Abuse: physical, sexual, emotional, psychological?
- Relationship where there is/was gaslighting? narcissistic pd?
- Intimate partner violence? elder abuse? bullying?
- Witnessing violence in the home or community?
- Civilian traumatic brain injury (TBI)?
- Military service? deployed? witnessed casualties? injured? TBI? personal losses? PTSD? moral injury? firearms?
- Living through natural disaster? other displacement?
- Prone to negative affect – sadness, anger, anxiety?

Teen Suicide: Risk Factors

- Depressed mood
- Substance use
- Frequent episodes of running away or being incarcerated
- Family loss or instability; significant problems with parents
- Expressions of suicidal thoughts, or talk of death or the afterlife during moments of sadness or boredom
- Withdrawal from friends and family
- Difficulties in dealing with sexual orientation
- No longer interested in or enjoying activities that once were pleasurable
- Unplanned pregnancy
- Impulsive, aggressive behavior or frequent expressions of rage

SUDs: Higher Risks

- They enter treatment at a point when their substance use is out of control, increasing a variety of risk factors for suicide.
- They enter treatment when a number of co-occurring life crises may be occurring (e.g., marital, legal, job).
- They enter treatment at peaks in depressive symptoms.
- Mental health problems (e.g., depression, post-traumatic stress disorder [PTSD], anxiety disorders, some personality disorders) associated with suicidality often co-occur among people who have been treated for substance use disorders.
- Crises can increase suicide risk, even during treatment (e.g., relapse & treatment transitions).

Strong Link SUDs & Suicide Risk

- Suicide is a leading cause of death among people who misuse alcohol and drugs.
- Compared with the general population, individuals treated for alcohol use or dependence are at about 10 times greater risk for suicide; people who inject drugs are at about 14 times greater risk for suicide.
- Individuals with substance use disorders are also at increased risk for suicidal ideation and suicide attempts.
- Depression is a common co-occurring diagnosis among people who abuse substances that confers risk for suicidal behavior.
- People with substance use disorders often seek treatment at times when their substance use difficulties are at their peak—a vulnerable period that may be accompanied by suicidal thoughts and behaviors.

Strong Link Acute Use & Suicide Risk

- Alcohol's acute effects include disinhibition, intense focus on the current situation with little appreciation for consequences, and promoting depressed mood, all of which may increase risk for suicidal behavior. Other central nervous system depressants may act similarly.
- Acute alcohol intoxication is present in about 30–40 percent of suicide attempts and suicides.
- Intense, short-lived depression is prevalent among treatment-seeking people who abuse cocaine, methamphetamines, and alcohol, among other groups. Even transient depression is a potent risk factor for suicidal behavior among people with substance use disorders.
- Overdose suicides often involve multiple drugs like alcohol, benzodiazepines, opioids, and other psychiatric medication.

Suicide Risk May Increase in Tx

- Suicide risk may increase at transition points in care (inpatient to outpatient, intensive treatment to continuing care, discharge), especially when a planned transition breaks down. Anticipating risk at such transition points should be regarded as an issue in treatment planning.
- Suicide risk may increase when a client is terminated administratively (e.g., because of poor attendance, chronic substance use) or is refused care. It is unethical to discharge a client and/or refuse care to someone who is suicidal without making appropriate alternative arrangements for treatment to address suicide risk.
- Suicide risk may increase in clients with a history of suicidal thoughts or attempts who relapse. Treatment plans for such clients should provide for this possibility.
- Suicide risk may increase in clients with a history of suicidal thoughts or attempts who imply that the worst might happen if they relapse (e.g., "I can't go through this again," "if I relapse, that's it")—especially for those who make a direct threat (e.g., "This is my last chance; if I relapse, I'm going to kill myself"). Treatment plans for such clients should provide for this possibility.
- Suicide risk may increase in clients with a history of suicidal thoughts or attempts when they are experiencing acute stressful life events. Treatment plans for such clients should provide for this possibility, for example, by adding more intensive treatment, closer observation, or additional services to manage the life crises.

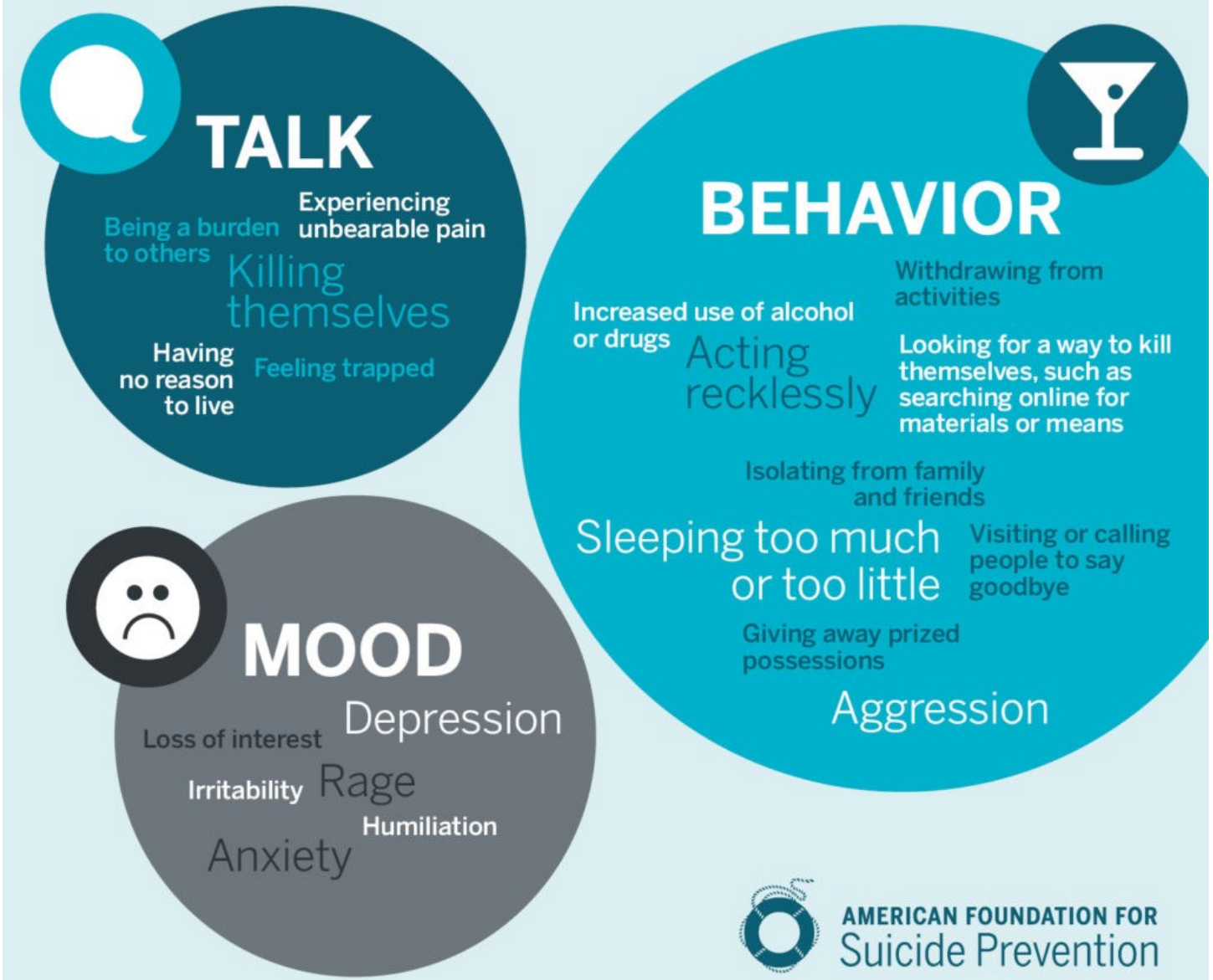
Risk Level	Risk Factors	Protective Factors	Suicide Inquiry	Intervention
High	Multiple risk factors	Protective factors are not present or not relevant at this time	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Hospital admission generally indicated, suicide precautions (e.g., observation, means reduction)
Moderate	Multiple risk factors	Few protective factors	Suicidal ideation with a plan, but not intent or behavior	Hospital admission may be necessary, develop crisis plan and suicide precautions, give emergency/ crisis numbers
Low	Few and/or modifiable risk factors	Strong protective factors	Thoughts of death with no plan, intent or behavior	Outpatient referral, symptom reduction, give emergency/crisis numbers

Warning Signs

IS PATH WARM

I	IDEATION – increased suicidal thinking, planning
S	SUBSTANCE USE
P	PURPOSELESSNESS – lack of reason for living
A	ANXIETY
T	TRAPPED – in a terrible situation where there is no escape
H	HOPELESSNESS
W	WITHDRAWAL – increasing social isolation
A	ANGER – rage, uncontrolled anger, revenge-seeking
R	RECKLESSNESS
M	MOOD CHANGES – dramatic shifts in emotions

SUICIDE **WARNING SIGNS**



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Evidence-Based Practices: Screening & Assessment

Examples of Assessment Tools

- Ask Suicide-Screening Questions (ASQ): https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/
- Columbia-Suicide Severity Rating Scale (C-SSRS): https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english
- PHQ-9: https://cde.drugabuse.gov/instrument/f226b1a0-897c-de2a-e040-bb89ad4338b9
- SAFE-T: https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432
- Suicide Risk Assessment (SRA): https://www.psychdb.com/teaching/suicide-risk-assessment-sra

CAMS

- Collaborative Assessment & Management of Suicidality
- A clinical philosophy: a way of working with client in crisis
- Suicide focused therapeutic framework: clinicians use their clinical skills & judgment, and relevant treatment tools
- Theoretically “non-denominational”
- Can be used in a wide variety of treatment settings

- Clinician uses their training & skills to convey empathy for suicidal client – no shame/blame or coercion
- Goal: to address and manage suicidality in an outpatient setting & keep client out of the hospital – IF they are willing to engage & commit to a collaborative treatment plan.

CAMS Approach

- Client is quickly engaged in the clinical assessment of their suicidal risk and in the management of their own outpatient safety and stability.
- CAMS provides both structure and process for clinician and client - to navigate the risk and crisis.
- Emphasis is placed on the quality of the therapeutic alliance.
- Clinician is honest & transparent about their professional & legal obligations to hospitalize the client - IF the client poses a clear & imminent risk of danger to themselves.

Benefits of CAMS Approach

- Enhances client motivation to find life-affirming solutions.
- Does not shame, guilt, manipulate, coerce client.
- Promotes active engagement & collaboration in treatment.
- Helps client find alternative ways of coping with their relational, situation, psychological, emotional crises.
- Client learns to rely on therapist – AND also learns to rely on self as they learn better ways to cope and solve problems.

Three Phases of CAMS

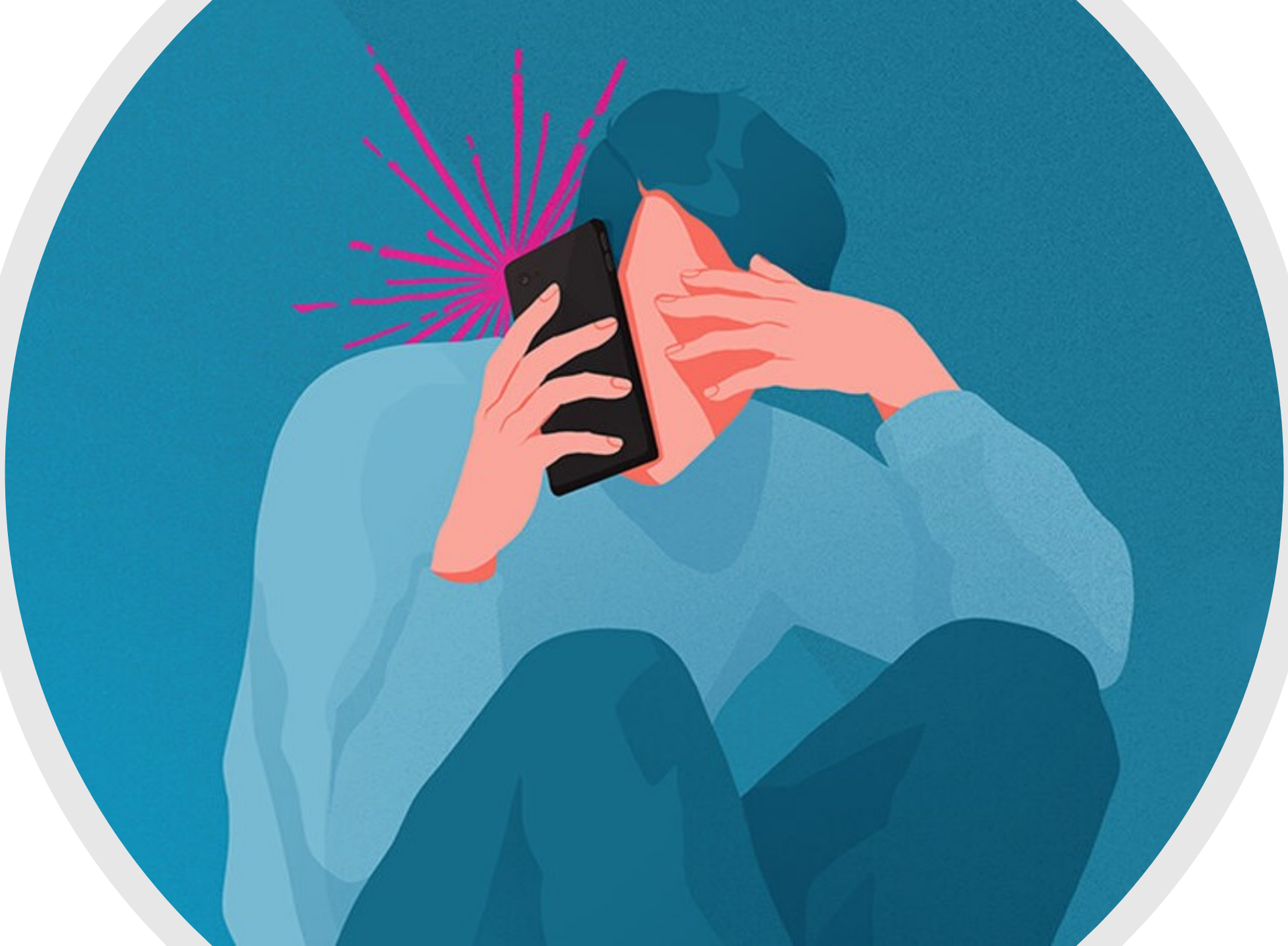
- Phase 1: Initial Assessment (SSF) & Treatment Planning
- Phase 2: Clinical Tracking
- Phase 3: Clinical Outcomes

Phase 1: Introducing CAMS to Client

- Need to focus on suicide risk within the first 5-10 minutes of session
- Transition to topic of suicide risk
- Introducing the SSF-IV-TR (Suicide Status Form)
- Ask permission to sit next to/closer to client
- Use with any currently identified suicidal client (anyone who is currently suicidal or has been in the past week)

Suicide Status Form (SSF-IV-R)

- One of the central elements of the CAMS framework is having the patient complete portions of the SSF in collaboration with the clinician.
- The SSF is used in every session, assessing suicide risk, and carefully documenting the patient's suicide-focused treatment plan.
- Clinical progress note/documentation is collaboratively completed with the client during each session and significantly reduces exposure to malpractice liability while ensuring competent clinical practice that excess most standards of care.



SSF-IV-R Section A: Client

- Rate psychological pain 1 to 5: low to high pain
- Rate stress 1 to 5: low to high stress
- Rate agitation 1 to 5: low to high agitation
- Rate hopelessness 1 to 5: low to high hopelessness
- Rate self-hate 1 to 5: low to high self-hate
- Rate overall risk of suicide from 1 to 5: extremely low risk (will not kill self) to extremely high risk (will kill self)
- How much is being suicidal related to thoughts & feelings about yourself 1 to 5: not at all to completely
- How much is being suicidal related to thoughts & feelings about others 1 to 5: not at all to completely
- List your reasons for wanting to live and your reasons for wanting to die and rank from 1 to 5.
- I wish to live to the following extent 0 to 8: not at all to very much
- I wish to die to the following extent 0 to 8: not at all to very much
- The one thing that would help me no longer feel suicidal would be __?

SSF-IV-R Section B: Clinician

- Rate psychological pain 1 to 5: low to high pain
- Rate stress 1 to 5: low to high stress
- Rate agitation 1 to 5: low to high agitation
- Rate hopelessness 1 to 5: low to high hopelessness
- Rate self-hate 1 to 5: low to high self-hate
- Rate overall risk of suicide from 1 to 5: extremely low risk (will not kill self) to extremely high risk (will kill self)
- How much is being suicidal related to thoughts & feelings about yourself 1 to 5: not at all to completely
- How much is being suicidal related to thoughts & feelings about others 1 to 5: not at all to completely
- List your reasons for wanting to live and your reasons for wanting to die and rank from 1 to 5.
- I wish to live to the following extent 0 to 8: not at all to very much
- I wish to die to the following extent 0 to 8: not at all to very much
- The one thing that would help me no longer feel suicidal would be __?

SSF-IV-R Section C (A+B): Treatment Plan

- Problem description (problems numbered #1, 2, 3…)
- Goals & Objectives (#1: stabilization)
- Interventions (#1: stabilization plan created)
- Duration of intervention for each problem itemized
- Client understands and concurs with TP – yes/no?
- Client at imminent danger of suicide (hospitalization indicated) – yes/no?

SSF-IV-R Section C: Stabilization Plan

- Ways to reduce access to lethal means
- Things client can do to cope differently when he/she is in a suicide crisis (consider crisis card)
- Life or death emergency contact number
- Attending treatment as scheduled (including list of potential barriers & solutions client will try)

SSF-IV-R Section C: Stabilization Plan - Step 1

Step 1: Reducing access to lethal means

- Therapist needs to empathetically acknowledge client's attachment to lethal means while also challenging client to substitute an alternative source of comfort
- Client willingness to remove or decrease access to lethal means is positive
- If they aren't willing to engage in lethal means reduction – outpatient therapy may not be viable & hospitalization may be needed

SSF-IV-R Section C: Stabilization Plan - Step 2

Step 2: List Coping Strategies

- "Let's come up with five things that you can do when you are in crisis…"
- Have client list these. Examples: walk; listen to music, take a bath, play with pet, watch a movie, journal, take a nap, read, call supportive friend, artwork or craft
- Therapist adds #6 – crisis counseling number
- Communicates the message to client that "*you can learn to cope when you are in crisis*"
- List can be transferred to back of therapist business card

SSF-IV-R Section C: Stabilization Plan - Step 2

Step 2 - List Coping Strategies: Potential Coping Strategies

- Going for a walk
- Writing in a journal
- Taking a hot bath
- Pedicure/manicure – other self-care
- Watching sports on TV
- Netflix, Amazon Prime
- Walking the dog
- Listening to uplifting/fun/beatful music
- Emailing or texting a supportive friend
- Taking a nap
- Doing some artwork - starting or working on craft project

SSF-IV-R Section C: Stabilization Plan - Step 2

Step 2 - List Coping Strategies: Potential Coping Strategies

- Working on a home repair project
- Painting a wall
- Reading one of my therapeutic books
- Brushing out my hair 100 times
- Going to church to pray
- Meditating
- Playing a video game
- Reading a magazine
- Watching the Animal Planet channel on TV
- Writing a letter to an old friend
- Playing Sudoku
- Watching YouTube videos

SSF-IV-R Section C: Stabilization Plan - Step 3

Step 3: List Relational Supports

- Friends, family, clergy, co-workers who are part of or can be part of a healthy support network for you
- Decrease isolation – list steps, ideas
- Develop and strengthen connection with relational supports
- Engage a peer mentor/recovery coach/ sponsor

SSF-IV-R Section C: Stabilization Plan - Step 4

Step 4: Explore potential barriers to counseling attendance

- Be proactive in identifying potential barriers & ways to manage these
- Discuss what will happen if client doesn't keep next counseling appointment

SSF-IV-R Section C: Treatment (tx) Plan

- Problems #2 & #3 = drivers of suicidal ideation/intention
- "What are the 2 problems we need to fix for you to no longer feel suicidal?"
- OR " What are the 2 things that put your life in danger?"
- Clinician helps client identify goals & objectives & suggests interventions.
- Commitment to tx plan: "Client understands & agrees to tx plan?"– Yes/No
- "Client is at imminent danger of suicide (hospitalization indicated)" - Y/N
- Client & therapist sign and date tx plan.
- Client receives a copy/takes a picture of tx plan with their phone.

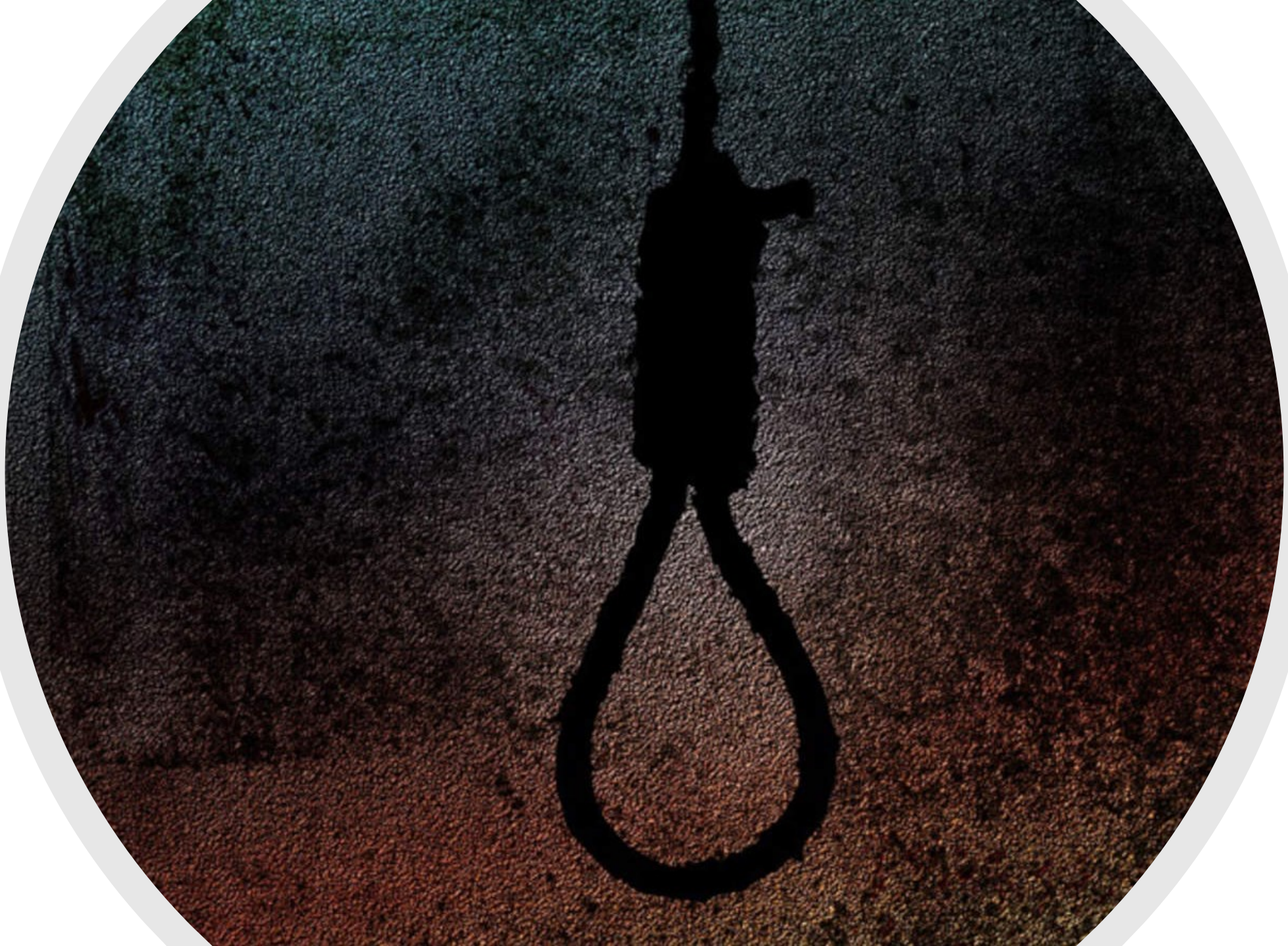
Treatment (tx) Plan

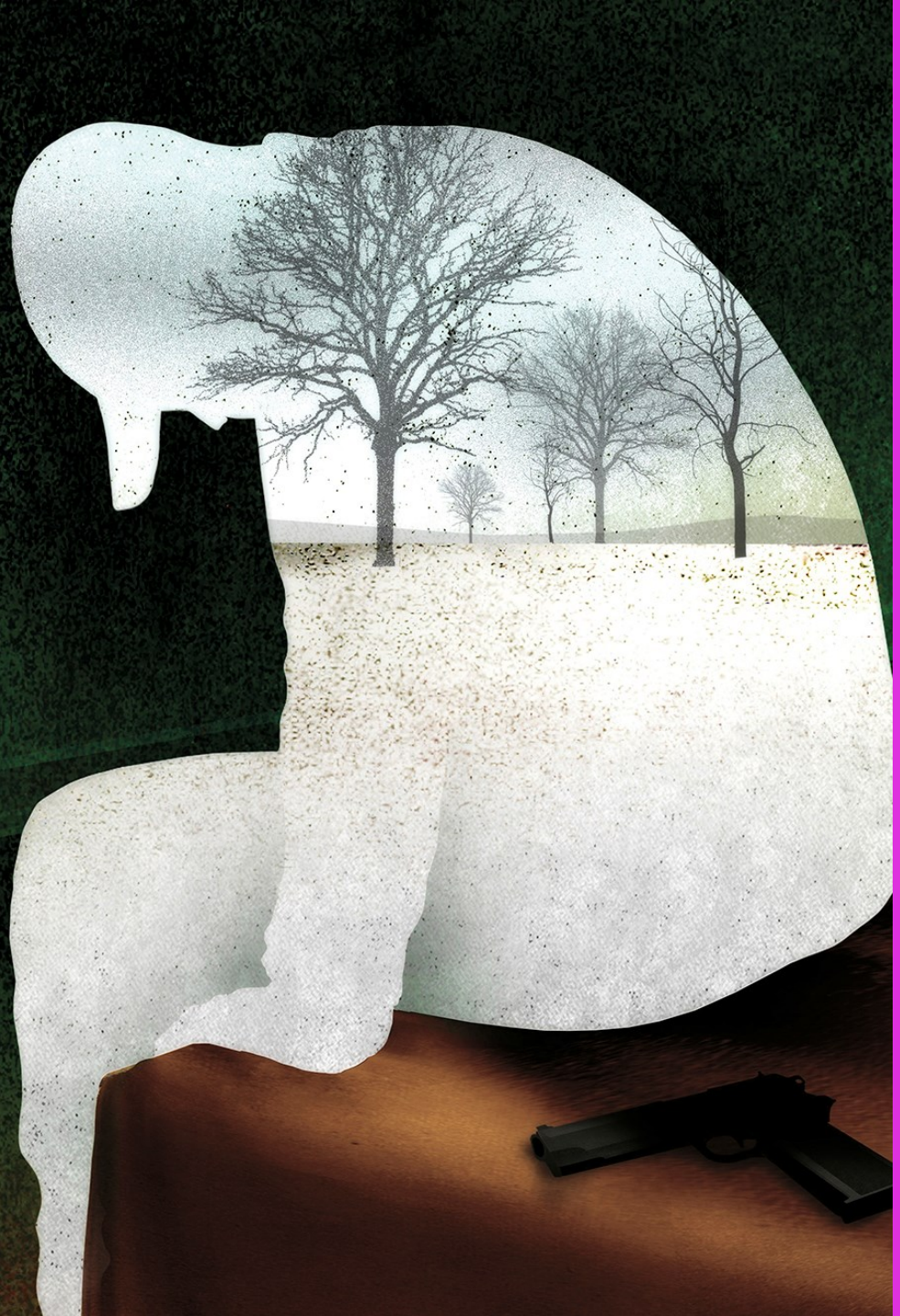
- Collaborative Assessment of Suicidal Risk
- Client must attend tx reliably as scheduled over the next 3 months
- Reduce access to lethal means
- Develop a self-oriented coping strategy/stabilization plan
- Create interpersonal supports and connectedness
- Vocational issues
- Self-related issues (self-worth/self-esteem)
- Pain & suffering – in general and in specific
- Problem-focused interventions that target drivers/problems
- Develop plan, goals, hopes for the future
- Develop guiding beliefs: post-suicidal lessons/mantras for living

SSF-IV-R Section D: Post-Session Evaluation

- Mental status exam
- Diagnostic impressions/diagnosis (DSM-5)
- Patient's Overall Suicide Risk Level
- Case Notes
- Next Appointment Scheduled date
- Treatment Modality Used
- Clinician Signature/Date

- Tracking/Update Interim Session Forms w/ Tx Plan Updates
- Outcome/Disposition Final Session w/ referrals and other recommendations, who chose to terminate/discontinue tx, discharge notes





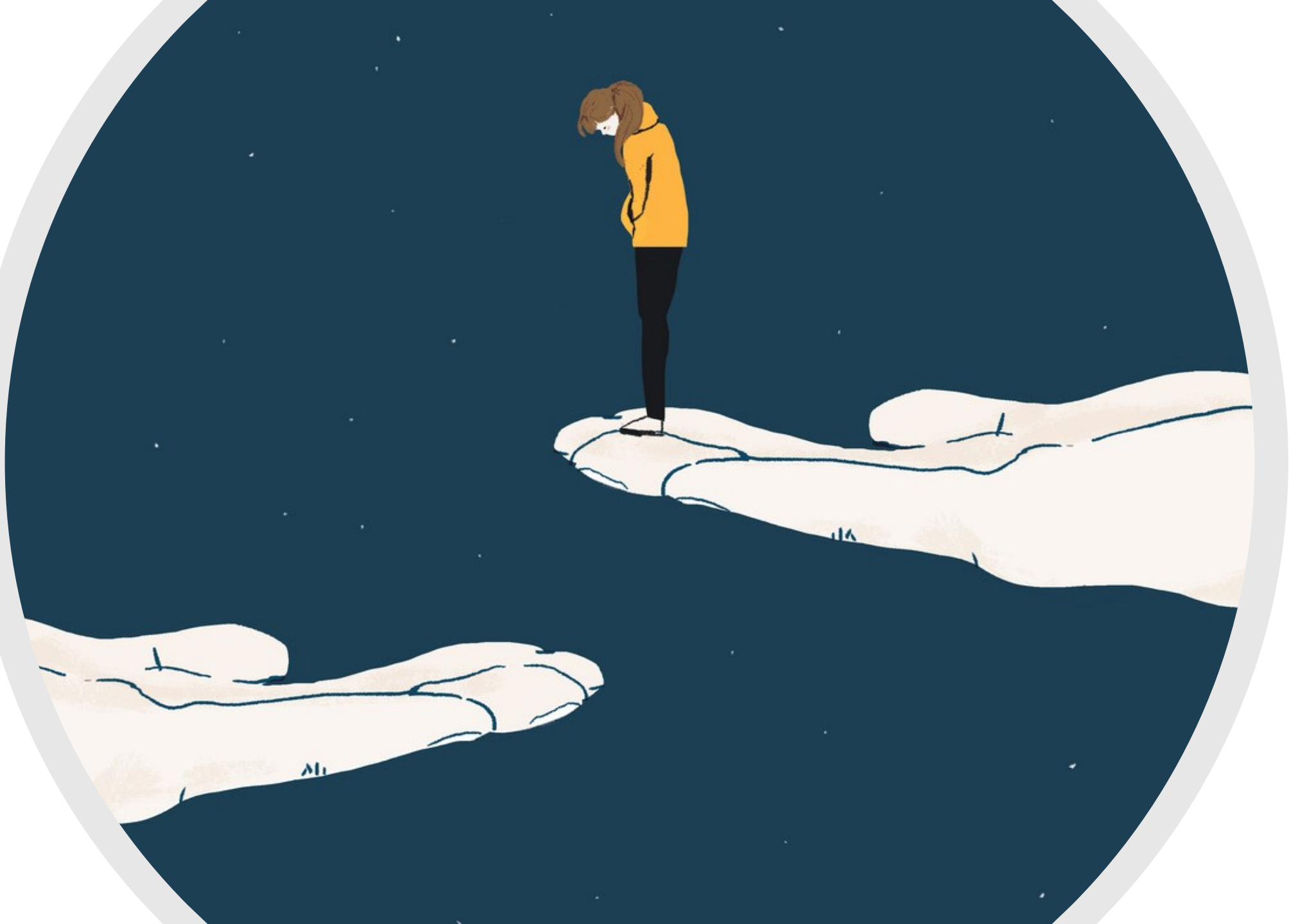
GATE

- **G**ather information
- **A**ccess Supervision
- **T**ake responsible action, i.e., engage counseling/treatment or higher level of care
- **E**xtend the action, i.e., follow-up, care-coordination

7 Dimensions of Being Human

1. Emotional Dimension
2. Cognitive Dimension
3. Interpersonal Dimension
4. Physical Dimension
5. Cultural-Spiritual Dimension
6. Behavioral Dimension
7. Contextual Dimension

Evidence-Based Practices: Treatment of Suicidal Ideation



Resources to make it through a crisis

- intrapersonal sources of resilience
- interpersonal sources of resilience
- protective beliefs
- exceptions to problems
- past successes
- current skills
- effective strategies for dealing with stressors

Building Rapport

Constructive	Destructive
• Ask one question at a time • Give the person time to respond • Repeat back the person's input as output to confirm that what you heard is what they meant • Say when you don't understand, ask for clarification • Ask open ended questions	• Interrupting • Asking questions in succession • Promising to keep a secret • "Leading the witness" • Trying to solve their problems • Rational/Philosophical arguments • Minimizing their concerns or fears

Active Listening is not Social Engineering!

All the Feels

Separate Feelings from States of Being

"I AM so lonely [and *no one* will *ever* love me]."

"I FEEL lonely right now, but I could talk to a friend."

"I AM a mess [and I *could not* change even if I wanted to]."

"I FEEL heartbroken and exhausted and furious and overwhelmed right now, but I didn't always feel this way in the past, and I won't always feel this way in the future.

I can't change what happened, but I can change how I feel about it."

Cognitive Behavioral Therapy (CBT)

- CBT stresses the connection between cognition, affect, and behavior.
- CBT focuses on active exploration of automatic thoughts, inferences and assumptions.
- Even the most overwhelming feelings can be modified by modifying one's thoughts.
- The goal of CBT is to change the way clients think by using their automatic thoughts to identify core schema and to achieve cognitive restructuring.
- Suicidality from a CBT perspective is the result of cognitive deficits such as rigidity, poor problem solving, and poor coping skills.

Cognitive Behavioral Therapy (CBT)

- CBT follows the ABC model of understanding the connection between activating events, thoughts, and resulting responses – emotions and behaviors.
- CBT has been found to be efficacious in the treatment of a number of mental disorders (i.e., depression, anxiety, and eating disorders) and other presenting problems (i.e., arthritis and insomnia).
- CBT has been demonstrated to reduce suicidal behavior in the immediate, short term, and maintain reduction in suicidal behavior for the medium term.
- CBT is significantly effective in the treatment of adults with suicidality but was not found to be significant for the treatment of adolescents with suicidality.
- For the treatment of suicidality, CBT should focus directly on the client's suicidality.

Dialectical Behavioral Therapy (DBT)

- DBT is based on a biosocial theory of borderline PD.
- DBT represents a blending together of multiple theoretical orientations and philosophies.
- There are four stages of treatment using DBT.
- There is an overarching hierarchical order of goals associated with DBT.
- DBT is skills focused.
- DBT seeks to improve the behavioral & emotional dysregulation of clients.
- DBT relies on active involvement of clinicians.
- Supervision/consultation are essential to the practice of DBT.
- DBT is typically delivered in a year-long period, and the greatest improvements are experienced in the first 4 months of treatment.
- DBT has a strong evidence base for the treatment of suicidality.

Interpersonal Psychotherapy (IPT)

- IPT has been demonstrated to be an effective, time-limited, EBP treatment for depression.
- IPT tx of depression seeks the reduction of depressive symptoms and improvement and restoration of interpersonal functioning.
- IPT uses two main overarching strategies to achieve tx goals.
- There are three main phases of IPT tx.
- IPT has been effectively adapted to the tx of depression in adolescents, adults, and older adults.
- Empirical research has supported the efficacious use of IPT in the tx of several diagnoses & presenting problems including anxiety, postpartum depression, persistent chronic depression, bipolar disorder, BPD, eating disorders and PTSD.
- IPT has not demonstrated effectiveness in the tx of some disorders and presenting problems, including substance use disorders.
- Adaptation to IPT for the treatment of suicidal older adults has been developed.

Motivational Interviewing & Suicidality

- MI is a directive, client-centered form of clinical communication.
- Clients are engaged in communication using open-ended questions, affirmations, reflections and summarizations.
- MI elicits motivational statements from the client.
- MI elicits behavioral change by helping clients explore and resolve ambivalence.
- A central principle of MI recognizes that motivation to change should be elicited from the clients, not somehow imposed on them by the clinician.
- The goal of MI is to help clients to positively change their behaviors.
- The method of MI comprises four overlapping components: engaging, focusing, evoking and planning.

Motivational Interviewing & Suicidality

- Evidence for the effectiveness of MI at increasing engagement in tx & improving tx outcomes is widespread.
- Research supports MI's effectiveness across age groups, ethnicities and socioeconomic status.
- MI is effective at engaging clients who are at risk for nonengagement in treatment.
- Preliminary research has shown that MI may support clinician's ability to work with a client's suicidal ideation by tapping into and enhancing the client's motivation to live and engage in life-enhancing activities in one brief meeting.
- Currently, MI is not an EBP treatment for client's experiencing suicidal ideation or intention.

Motivational Interviewing & Suicidality

- Expressing empathy.
- Developing discrepancy.
- Working with status quo.
- Understanding and embracing “resistance.”
- Enhancing self-efficacy.
- Open-ended questions.
- Affirmations.
- Reflective listening.
- Summaries.
- Change talk.
- Understanding the experience of “motivation.”

Extended Actions

- Confirm that a client has kept the referral appointment with a mental health provider (or other professional).
- Follow up with the hospital emergency department when a client has been referred for acute assessment.
- Coordinate with a mental health provider (or other professional) on an ongoing basis.
- Coordinate with a case manager on an ongoing basis.
- Check in with the client about any recurrence of or change in suicidal thoughts or attempts.
- Check in with family members (with the client's knowledge) about any recurrence of or change in suicidal thoughts or attempts.
- Reach out to family members to keep them engaged in the treatment process after a suicide crisis passes.

Extended Actions

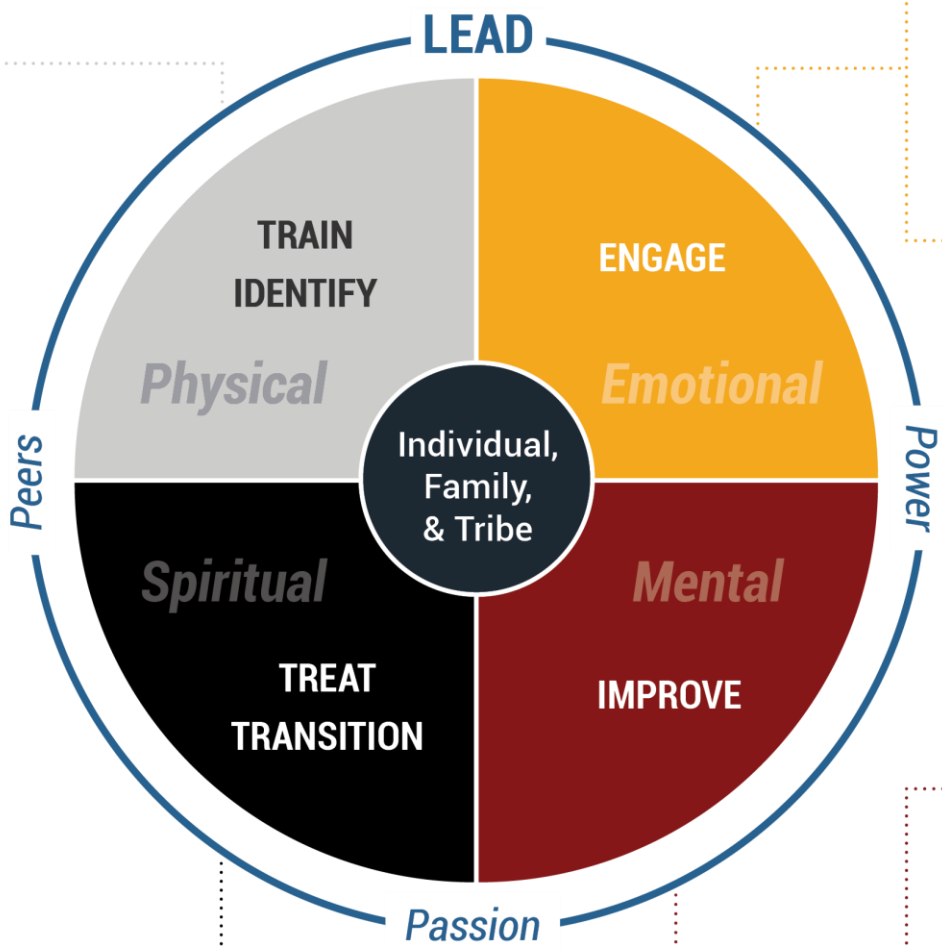
- Observe the client for signs of a return of risk.
- Confirm that the client still has a safety plan in the event of a return of suicidality.
- Confirm that the client and, where appropriate, the family, still have an emergency phone number to call in the event of a return of suicidality.
- Confirm that the client still does not have access to a major method of suicide (e.g., gun, stash of pills).
- Follow up with the client about suicidal thoughts or behaviors if a relapse (or other stressful life event) occurs.
- Monitor and update the treatment plan as it concerns suicide.
- Document all relevant information about the client's condition and your responses, including referrals made and the outcomes of the referrals.
- Complete a formal treatment termination summary when and under whatever circumstances this stage of care is reached.

ZEROSuicide | MEDICINE WHEEL

TRAIN
Train staff to understand the unique physical, emotional, and spiritual needs of Indigenous people and feel comfortable and confident working with them, their families, and their Tribes.

IDENTIFY
Identify individuals at risk using evidence-based screening vetted by members of local Tribes and ensure those at risk are assessed by culturally- and suicide prevention-savvy clinicians.

ENGAGE
Engage individuals and their support people in a collaborative safety plan that celebrates Traditional healing practices, medicines, and Healers.



TREAT
Treat suicide thoughts and behaviors using evidence-based treatments that respect the norms of local Tribes and their Traditional Healers.

TRANSITION
Transition individuals through culturally appropriate levels of care that include Traditional Healers and multilingual and symbolically relevant caring contacts.

IMPROVE
Improve policies and procedures by gathering data in ways that are culturally responsive to individuals, families, and Tribes, who may then contribute suggestions that are incorporated.

LGBTQ+: At Risk Population

- Individuals identifying as LBGTQ+ are associated with increased risk for suicidality. The increased risk has been found for both LGBTQ+ males & females; findings indicate that males have a higher risk for suicidality.
- LGBTQ adolescents are three times more likely than their heterosexual peers to consider suicide.
- The attitudes, biases, opinions of clinicians may undermine their ability to effectively work with sexual minority status individuals. Stigma remains prevalent issue for the LGBTQ+.
- Hx of being bullied in person/cyberbullying is repeatedly identified as a risk factor for the LGBTQ+ community.
- Families & school environments can serve as important protective factors for LGBTQ+ members.

Military Members

- Rates of suicide among active military personnel has sharply increased since 2008, since engagement with Iraq & Afghanistan. Suicide is the leading cause of death among the military followed by accidents & combat-related duty.
- Veterans account for 9% of our population but over 18% of all suicides.
- Many unique risk factors related to deployment, exposure to combat, timing of service, & rank exist for military members.
- Established protective factors against suicide for military personnel & veterans are very limited; social supports have been identified as especially important to decrease risk.
- Evidence-based practices to address/prevent suicide in this population are profoundly lacking.

Immigrants & Refugees

- For people migrating to the United States, stress associated with migration can be a risk factor for suicidal ideation.
- Migration poses a risk for the families who remain in the country of origin.
- Immigrants from predominantly collectivist societies may face serious problems of adaptation due to a real or perceived lack of social support, a disparity between expectations and reality, and low self-esteem.
- For immigrants from Asian countries, the risk of suicide seems generally low for men but appreciably higher for women.

- Refugees, one of the most vulnerable groups of immigrants, may be fleeing war, torture, and persecution, and suffering with PTSD, depression, and anxiety.

Working with Family

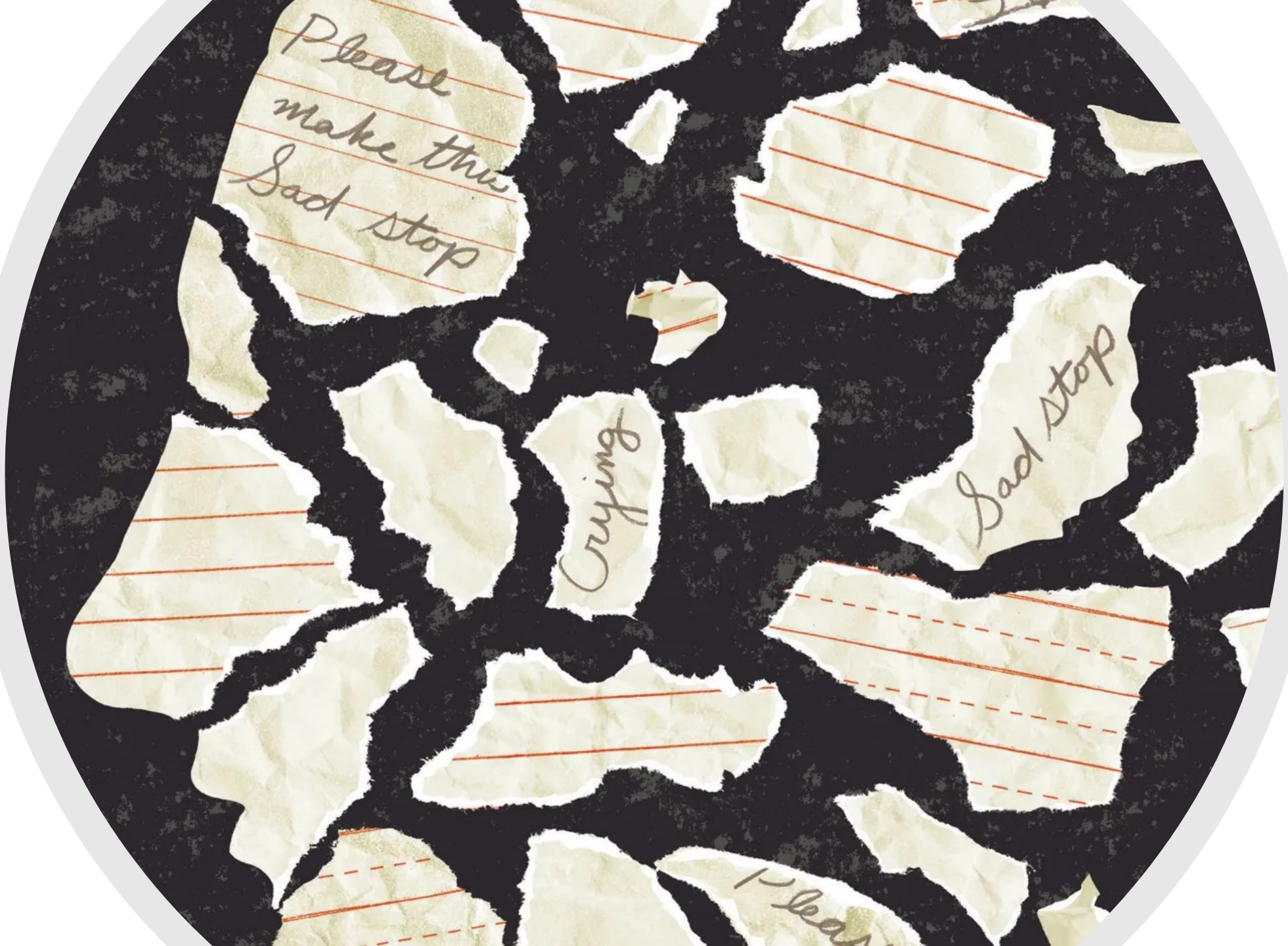
1. You have ethical/legal consents – make sure you have appropriate consents/signed ROI.
2. Providing information about suicide, particularly dispelling misconceptions and providing accurate information.
3. Increasing awareness of signs and symptoms that a loved one might be experiencing suicidal thoughts and/or behaviors, especially recognizing warning signs or a significant change in risk factors.
4. Making suggestions about how to talk to a loved one who is experiencing suicidal thoughts: what to say, and equally important, what not to say.
5. Making suggestions for how to recognize the need for and provide emotional support to a person who might be feeling overwhelmed and hopeless.
6. Providing emergency resources (such as 1-800-273-TALK or local suicide hot-lines and crisis centers in a suicidal crises).
7. Planning for how to access and possibly remove suicide methods, such as guns or pills, to reduce the likelihood of high-risk behaviors.

Surviving Suicide

- Survivors are at a higher risk of suicide.
- Postvention interventions are designed to assist survivors of suicide through the processes of grief and traumas experienced following the suicide of a family member or a friend.
- Grief reactions of suicide survivors vary according to personal and contextual characteristics.
- Survivors of suicide often suffer from complicated grief.
- The nature of the relationship with a suicide victim impacts a survivor's reaction.

Surviving Suicide

- The stigma experienced by survivors of suicide is a major cause of the severe grief reactions experienced by suicide survivors across types of relationships with the suicide victim (parents, offspring, spouse, peer, client).
- A major factor contributing to the difficulty that suicide survivors experience in resolving the grief process is the question of why their loved one completed suicide.
- Survivors of suicide often experience difficulties in returning to work.
- Following a coworker's suicide, colleagues and associates in the work environment can often experience negative reactions, including grief and anger.
- Despite the significant impact on survivors and an elevated risk of suicide, most survivors of suicide do not seek professional counseling on mental health treatment.


Please
make this
Sad stop
Crying
Sad stop

SAMHSA Consensus Panel Recommendations: 2017

- Clients in substance abuse treatment should be screened for suicidal thoughts and behaviors routinely at intake and at specific points in the course of treatment. Screening for clients with high risk factors should occur regularly throughout treatment.
- Counselors should be prepared to develop and implement a treatment plan to address suicidality and coordinate the plan with other providers.
- If a referral is made, counselors should check that referral appointments are kept and continue to monitor clients after crises have passed, through ongoing coordination with mental health providers and other practitioners, family members, and community resources, as appropriate.
- Counselors should acquire basic knowledge about the role of warning signs, risk factors, and protective factors as they relate to suicide risk.
- Counselors should be empathic and nonjudgmental with people who experience suicidal thoughts and behaviors.
- Counselors should understand the impact of their own attitudes and experiences with suicidality on their counseling work with clients.
- Substance abuse counselors should understand the ethical and legal principles and potential areas of conflict that exist in working with clients who have suicidal thoughts and behaviors.

SAMHSA Consensus Panel Recommendations: 2017

- Be direct.
- Increase your knowledge about suicidality.
- Do what you already do well – use your counseling skills. Good counselors are empathic, warm, supportive and trust their experience and intuition.
- Practice, practice, practice.
- Work collaboratively with suicidal clients.
- Realize limitations of confidentiality and be open with your clients about such limits.

SAMHSA: Ten Points to Stay on Track

- Point 1: Almost all of your clients who are suicidal are ambivalent about living or not living.
- Point 2: Suicidal crises can be overcome.
- Point 3: Although suicide cannot be predicted with certainty, suicide risk assessment is a valuable clinical tool.
- Point 4: Suicide prevention actions should extend beyond the immediate crisis.
- Point 5: Suicide contracts are not recommended and are never sufficient.

SAMHSA: Ten Points to Stay on Track *cont.*

- Point 6: Some clients will be at risk of suicide, even after getting clean and sober.
- Point 7: Suicide attempts always must be taken seriously.
- Point 8: Suicidal individuals generally show warning signs.
- Point 9: It is best to ask clients about suicide and ask directly.
- Point 10: The outcome does not tell the whole story.

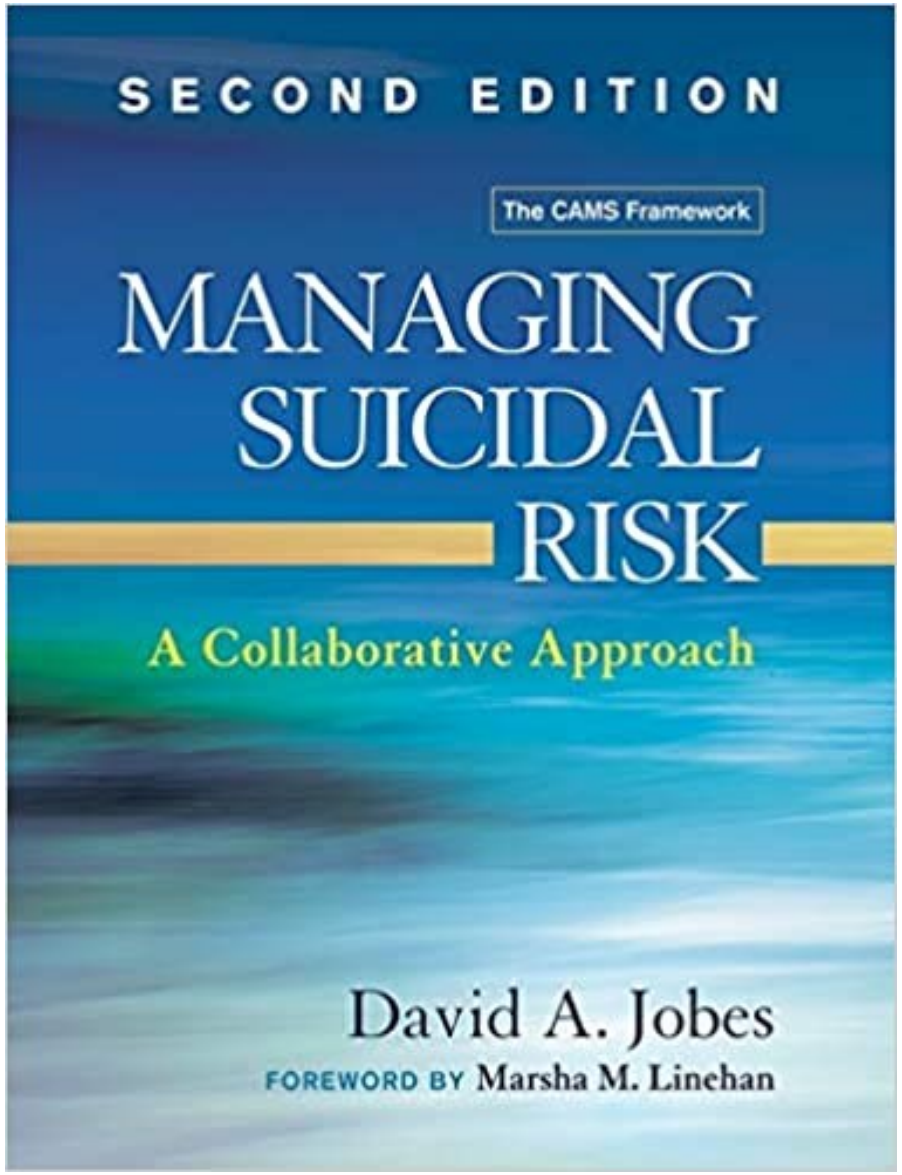
Clinicians: Suicidal Attitude Inventory

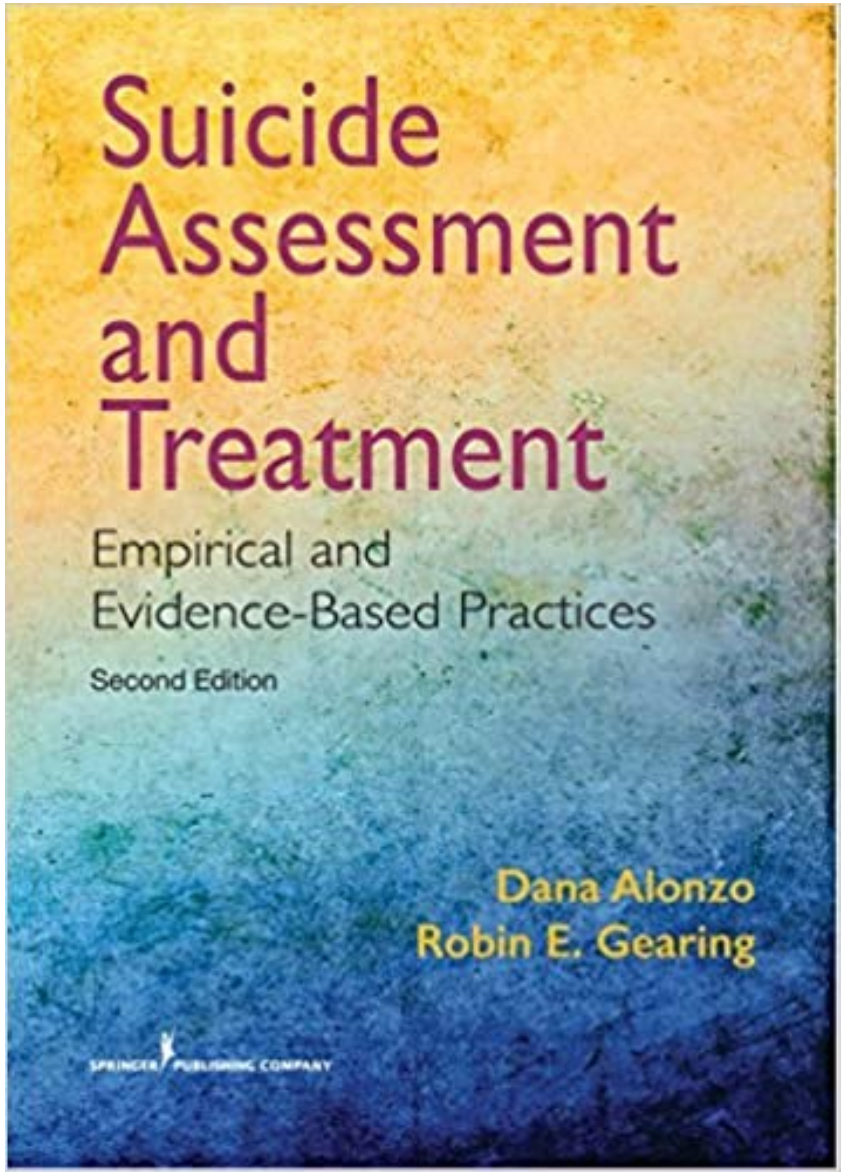
- What is my personal and family history with suicidal thoughts and behaviors?
- What personal experiences do I have with suicide or suicide attempts, and how do they affect my work with suicidal clients? How might they affect my work?
- What is my emotional reaction to clients who are suicidal?
- How do I feel when talking to clients about their suicidal thoughts and behaviors?
- What did I learn about suicide in my formative years?
- How does what I learned then affect how I relate today to people who are suicidal, and how do I feel about clients who are suicidal?
- What beliefs and attitudes do I hold today that might limit me in working with people who are suicidal?

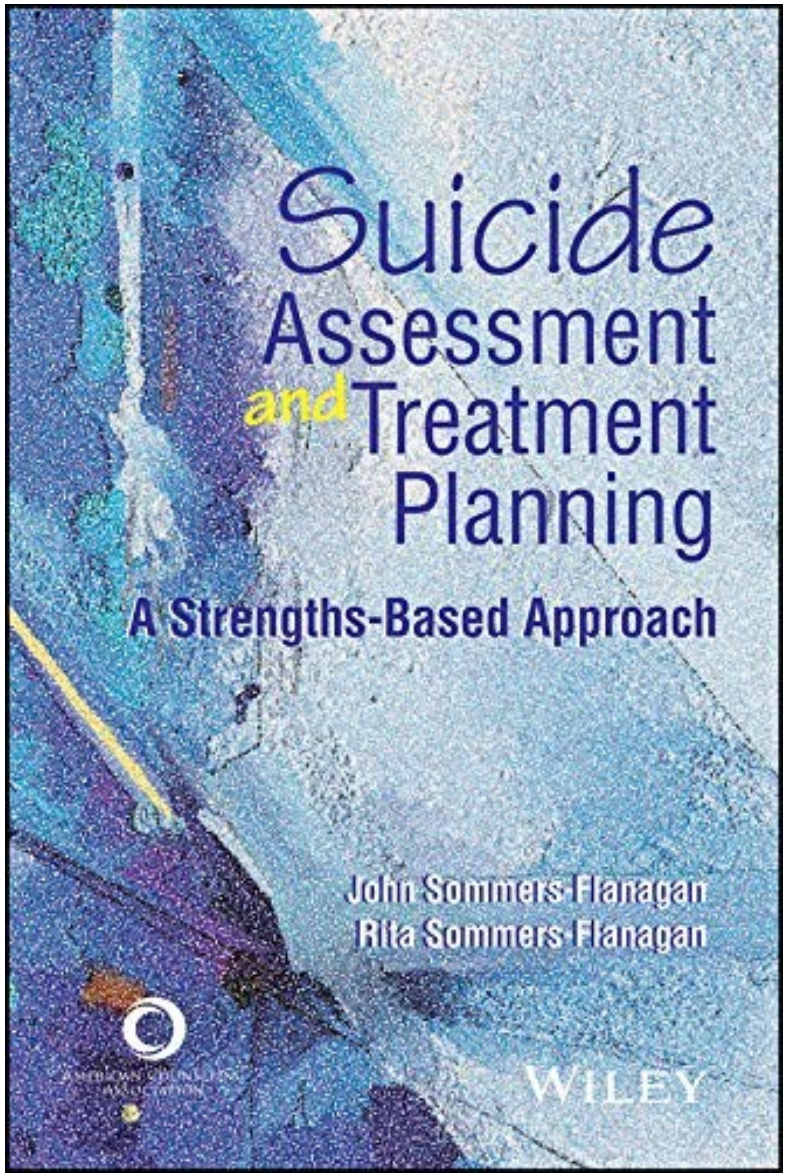
Clinicians: Positive Attitudes & Behaviors

- 1: People in substance abuse treatment settings often need additional services to ensure their safety.
- 2: All clients should be screened for suicidal thoughts and behaviors as a matter of routine.
- 3: All expressions of suicidality indicate significant distress and heightened vulnerability that require further questioning and action.
- 4: Warning signs for suicide can be indirect; you will need to develop a heightened sensitivity to these cues.
- 5: Talking about a client's past suicidal behavior can provide information about triggers for suicidal behavior.
- 6: You should give clients who are at risk of low to moderate risk for suicide the telephone number of a suicide hotline; it does no harm and could actually save a life.

References & Resources


SECOND EDITION
The CAMS Framework
MANAGING SUICIDAL RISK
A Collaborative Approach
David A. Jobes
FOREWORD BY Marsha M. Linehan


Suicide Assessment and Treatment
Empirical and Evidence-Based Practices
Second Edition
Dana Alonzo
Robin E. Gearing
SPRINGER PUBLISHING COMPANY


Suicide
Assessment
and Treatment
Planning
A Strengths-Based Approach
John Sommers-Flanagan
Rita Sommers-Flanagan
WILEY

Crisis Resources & Hotlines

- National Suicide Prevention Lifeline: This is a confidential, toll-free, 24-hour suicide prevention hotline. Call 1-800-273-TALK (800-273-8255) to receive support and local referrals.
- Crisis Text Line: This is a confidential, 24-hour suicide prevention text line. Text "HOME" to 741-741 to receive support and local referrals.
- https://www.veteranscrisisline.net/: The Veterans Crisis Line provides confidential help for Veterans, Service Members, and their families.
  - 1-800-273-8255 and Press 1 OR Text 838-255
- National Domestic Violence Hotline: The National Domestic Violence Hotline provides 24/7 counseling and support to victims of domestic violence and abuse @ 1-800-799-SAFE (7233). Client can also chat online @ the website – click on link.
- The Trevor Project (LGBTQ): The Trevor Project's trained counselors are here to support 24/7. If a young person in crisis, feeling suicidal, or in need of a safe and judgment-free place to talk, call the TrevorLifeline at 1-866-488-7386. Text and online chat is available – click on the link.
- Teen Health & Wellness Hotline List: A list of hotlines for teens facing issues ranging from bullying and abuse to drugs and eating disorders.

Online Resources for Information

- www.suicide.org
- www.suicidology.org
- www.kspope.com/ethics/index.php
- www.compassionandchoices.org
- www.deathwithdignity.org
- www.naadac.org/codeofethics
- www.kspope.com/ethcodes/index.php
- www.who.int/mental_health/resources/suicide/en
- https://afsp.org

Online Resources for Information

- www.pacificclinics.org
- http://healthymindsnetwork.org
- www.immigrationforum.org
- http://alianzas.us
- www.sprc.org/populations/Asian-pacific-islanders
- www.turtleisland.org/healing/healing-suicide.htm
- www.ahf.ca
- www.cmhsweb.org
- www.surgeongeneral.gov/library/mentalhealth/cre

Online Resources for Information

- https://www.nami.org/About-Mental-Illness/Common-with-Mental-Illness/Risk-of-Suicide
- https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Teen-Suicide-010.aspx
- https://www.hhs.gov/surgeongeneral/reports-and-publications/mental-health/index.html
- https://www.hhs.gov/about/news/2021/01/19/the-surgeon-general-releases-call-to-action-to-implement-the-national-strategy-for-suicide-prevention.html

Online Resources for Information

- www.griefnet.org
- www.bereavedparentsusa.org
- www.childsuicide.homestead.com
- www.psycom.net/depression.central.suicide.html
- www.yellowribbon.org
- www.dougy.org
- www.save.org
- http://suicideprevention.nv.gov/Youth/Myths/
- https://www.youtube.com/watch?v=ppSAlO9pmPA

Online Resources for Information

- www.samaritans.org
- www.ulifeline.org
- www.afsp.org
- www.nami.org
- www.mentalhealth.org
- www.sprc.org
- www.nmh.org
- www.spanusa.org

Online Resources for Information

- https://www.nimh.nih.gov/health/topics/bipolar-disorder/
- www.allaboutdepression.com/gen_04.html
- www.psycom.net/depression.central.suicide.html
- www.suicide.org/depression-and-suicide.html
- https://www.psychiatryadvisor.com/home/schizophrenia-advisor/suicide-prevention-in-schizophrenia-obstacles-and-awareness/
- https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3632-schizophrenia-bipolar-disorder-and-suicide

Online Resources for Information

- www.naadac.org
- www.learn-about-alcoholism.com
- www.nida.nih.gov
- www.addictionresearch.com
- www.dare.com
- www.naatp.org
- www.ncadd.org
- www.niaaa.nih.gov
- www.aa.org; www.na.org

Online Resources for Information

- www.borderlinepersonalitydisorder.com
- www.behavioraltech.org
- www.narsad.org
- www.bpddemystified.com
- www.bpdworld.org
- www.cartercenter.org/health/mental_health
- www.nmha.org
- www.psych.org
- www.dsm5.org

Online Resources for Information

- www.woundedwarriorproject.org
- www.vetfriends.com
- www.troopsupports.com
- www.theveteransvoice.com
- www.anysoldier.com
- www.road2healing.com
- https://www.ptsd.va.gov/
- https://www.ptsd.va.gov/professional/index.asp
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Questions & Thanks

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