# FROM A-Z: SUICIDE ASSESSMENT, INTERVENTION, & SAFETY PLANNING

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2021

# Objectives

1

Explore the current standard of care including the collaborative approach to intervention

2

Explore and enhance their skills around safety planning including effective documentation and consultation.

3

Explore the importance of utilizing case management and ongoing relationships with the network of care providers who intervene and treat suicidality.

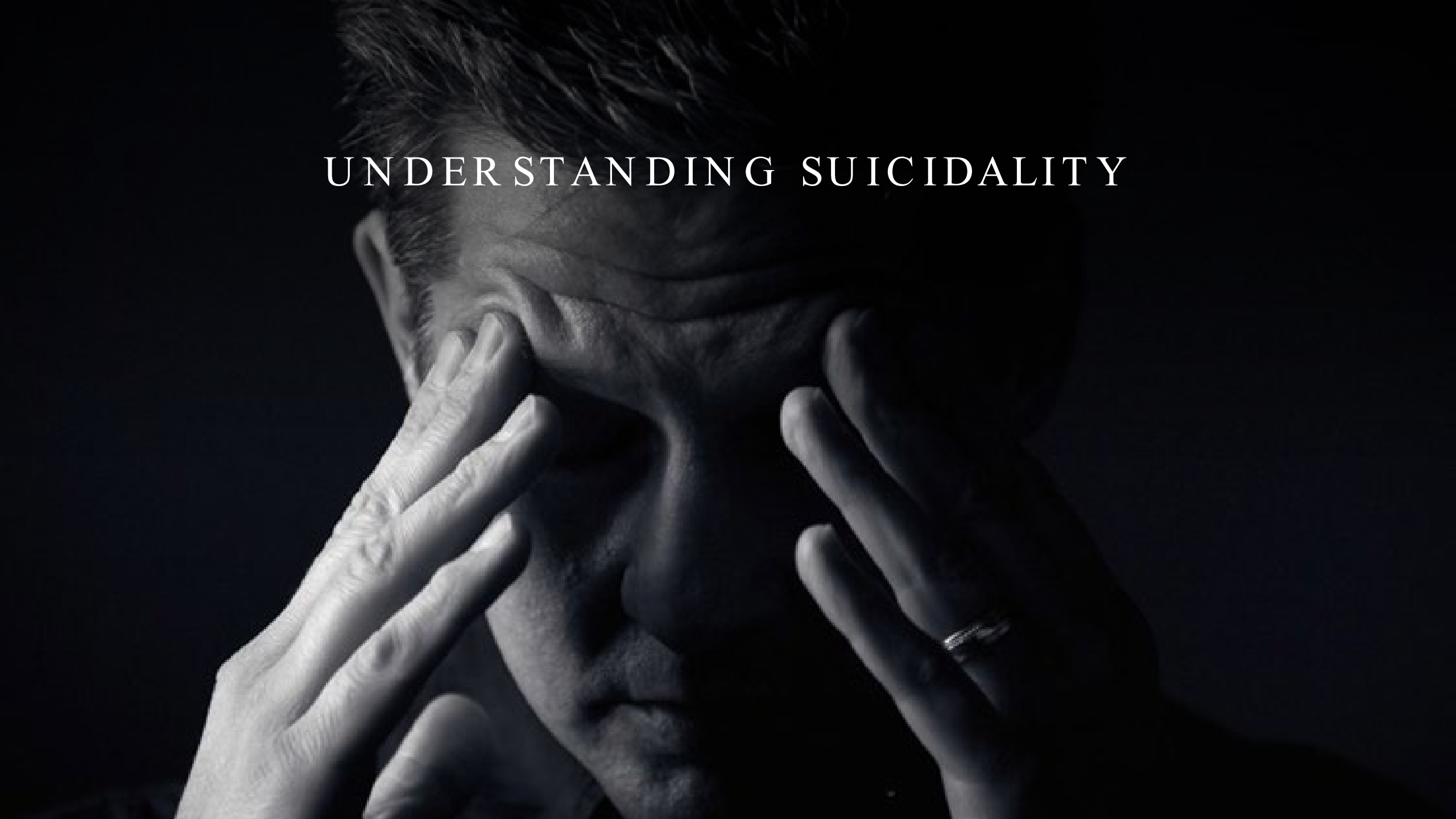
# Word Play

Suicide is like…

Treating suicide is like…

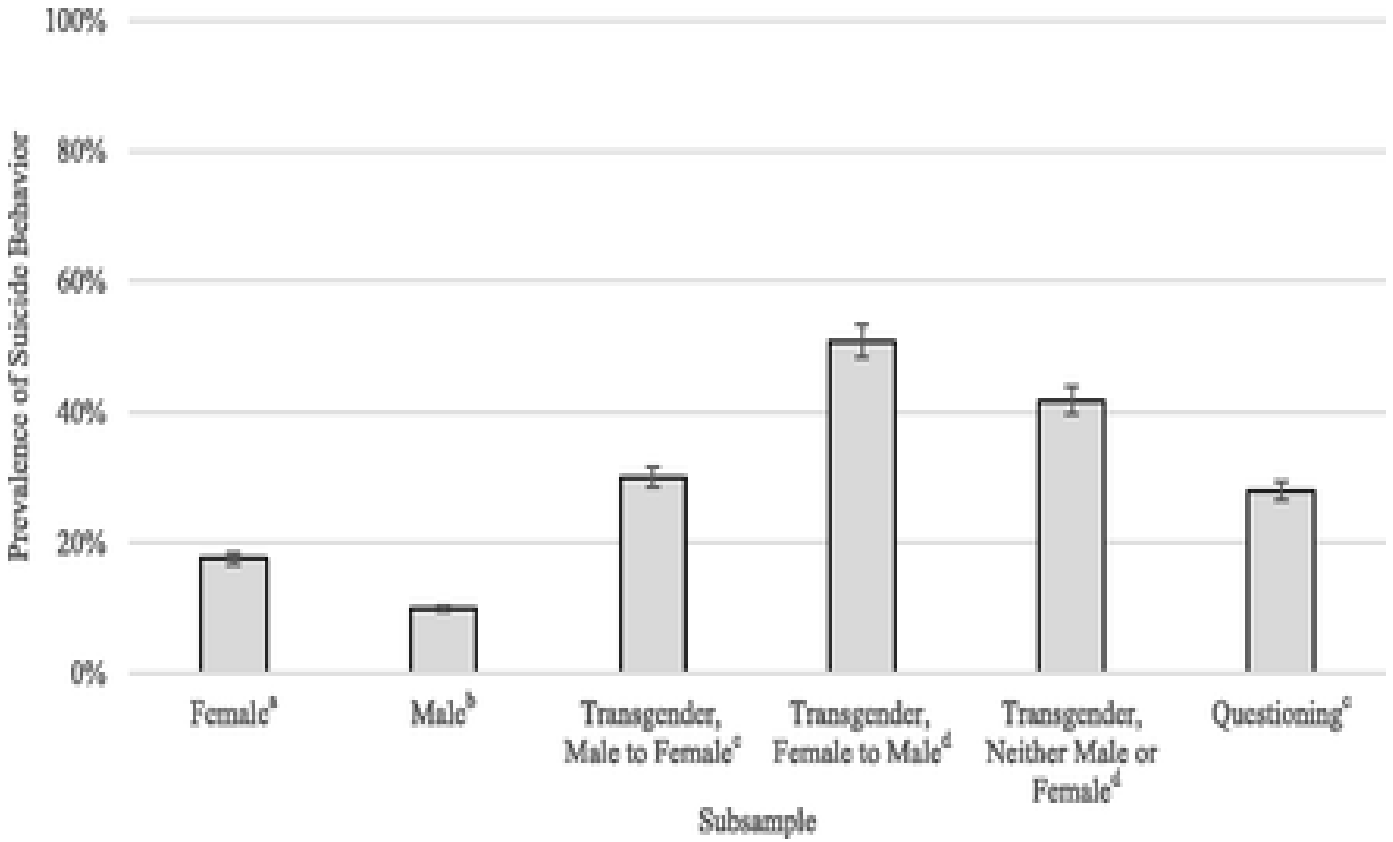
Surviving suicide is like…

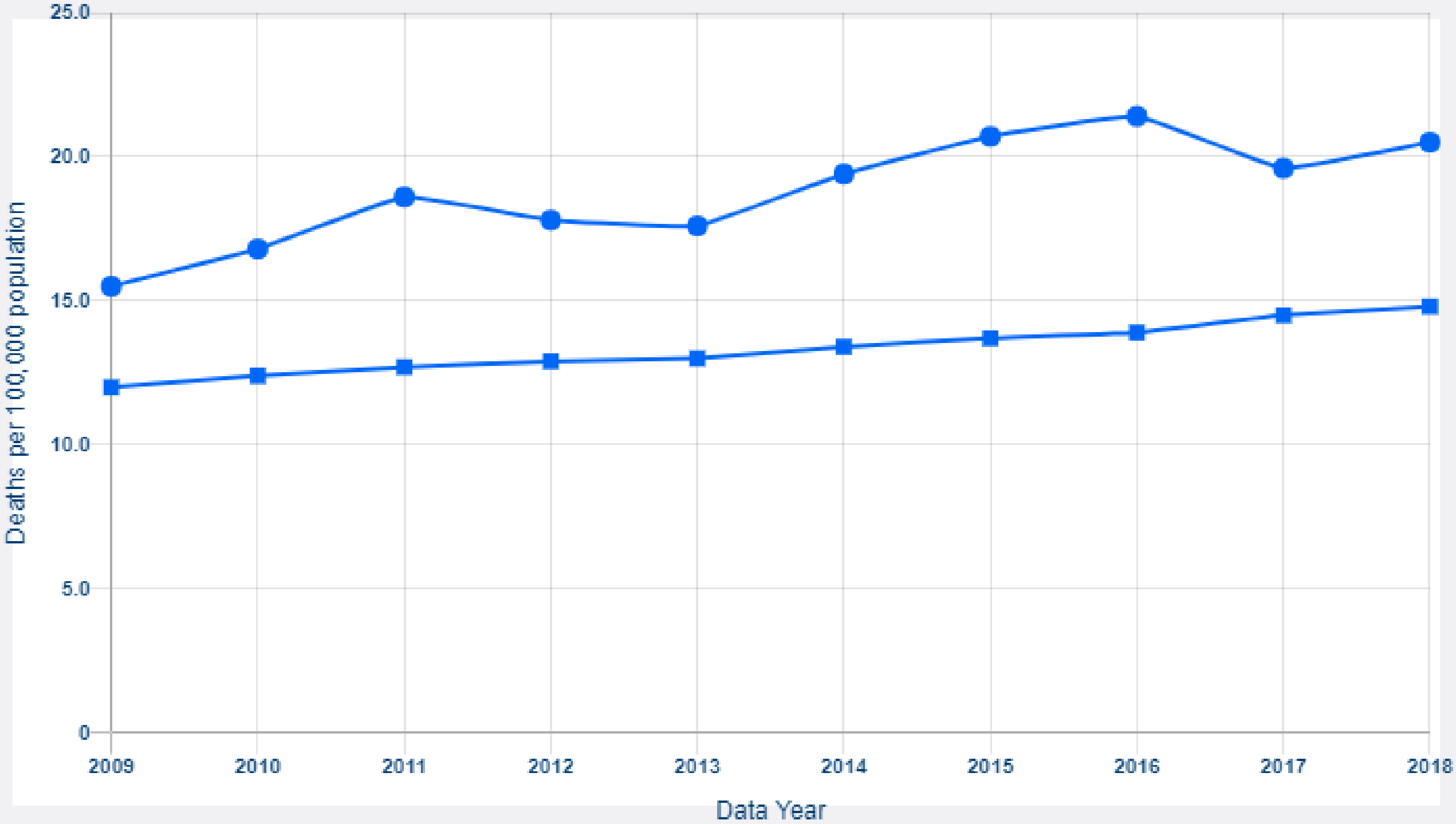
# UNDERSTANDING SUICIDALITY



# AGE & GENDER

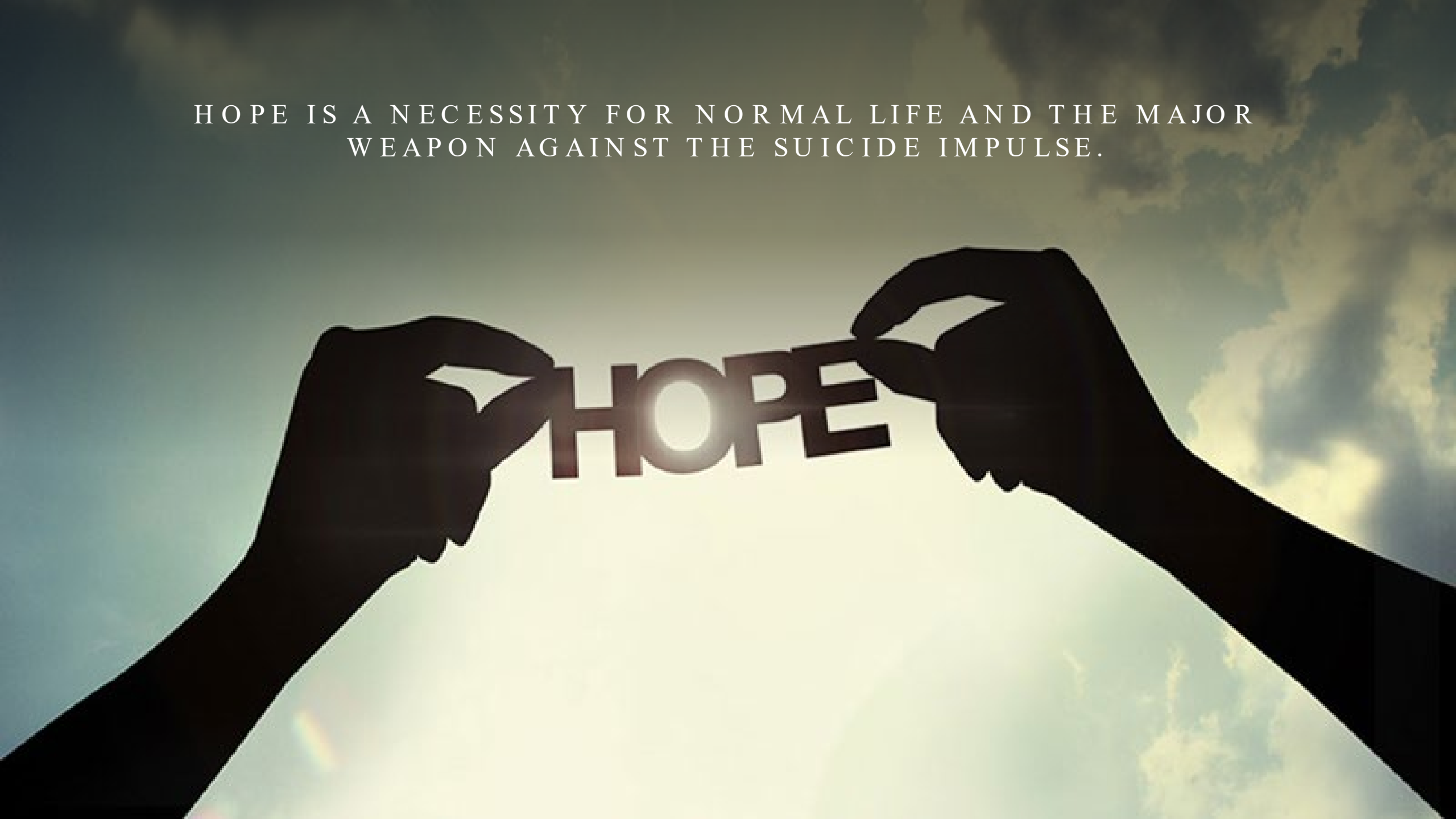
# GENDER IDENTITY & SEXUALITY

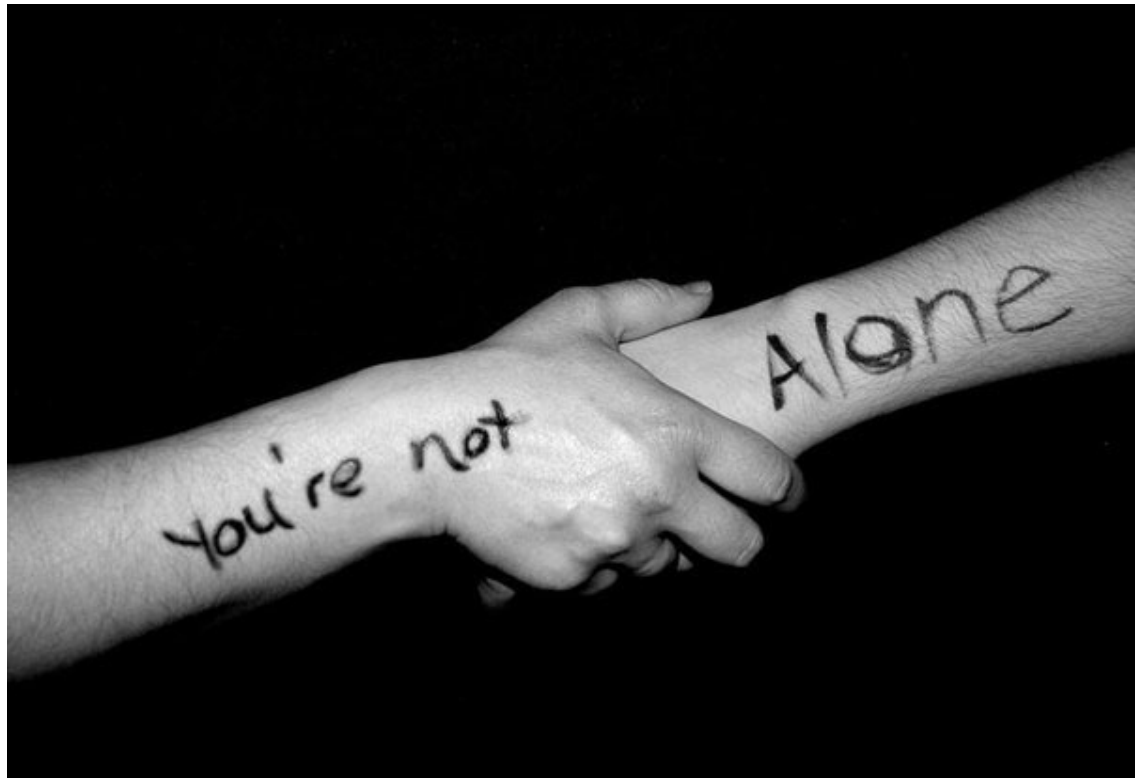



25.0
20.0
15.0
10.0
5.0
0
Deaths per 100,000 population
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Data Year

# COMMON THEMES?

HOPE IS A NECESSITY FOR NORMAL LIFE AND THE MAJOR WEAPON AGAINST THE SUICIDE IMPULSE.






"The person who completes suicide, dies once. Those left behind die a thousand deaths, trying to relive those terrible moments and understand … Why?"

# Risk Factors

What are some ways you discuss risk factors with clients?

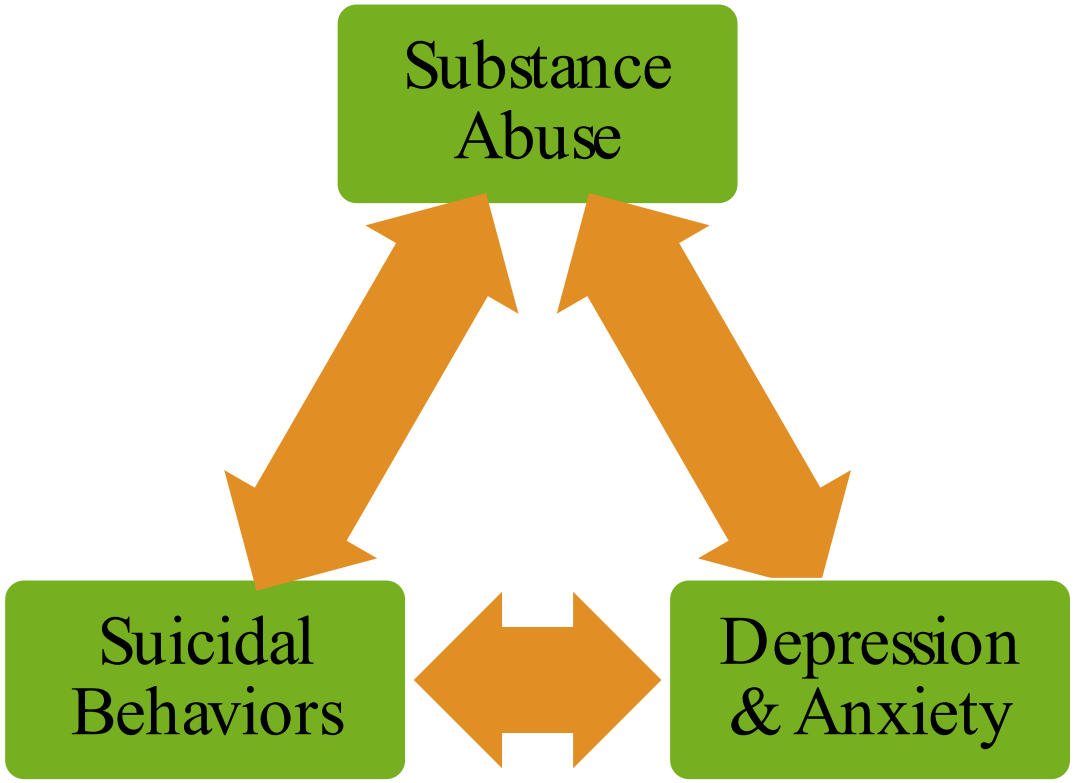
# Comorbidity

- Major Depression
- Bipolar Disorder
- Schizophrenia
- Alcohol Dependence
- Borderline Personality Disorder

# Growing Risk Factors

- Environmental stress
- Increasing isolation
- Mental Health stigma
- Marginalization of minority groups
- Specific cultural beliefs around Mental Health

# Substance Use & Suicide



# Risk Factors vs. Warning Signs

**Risk factors** tend to be static and long-standing.

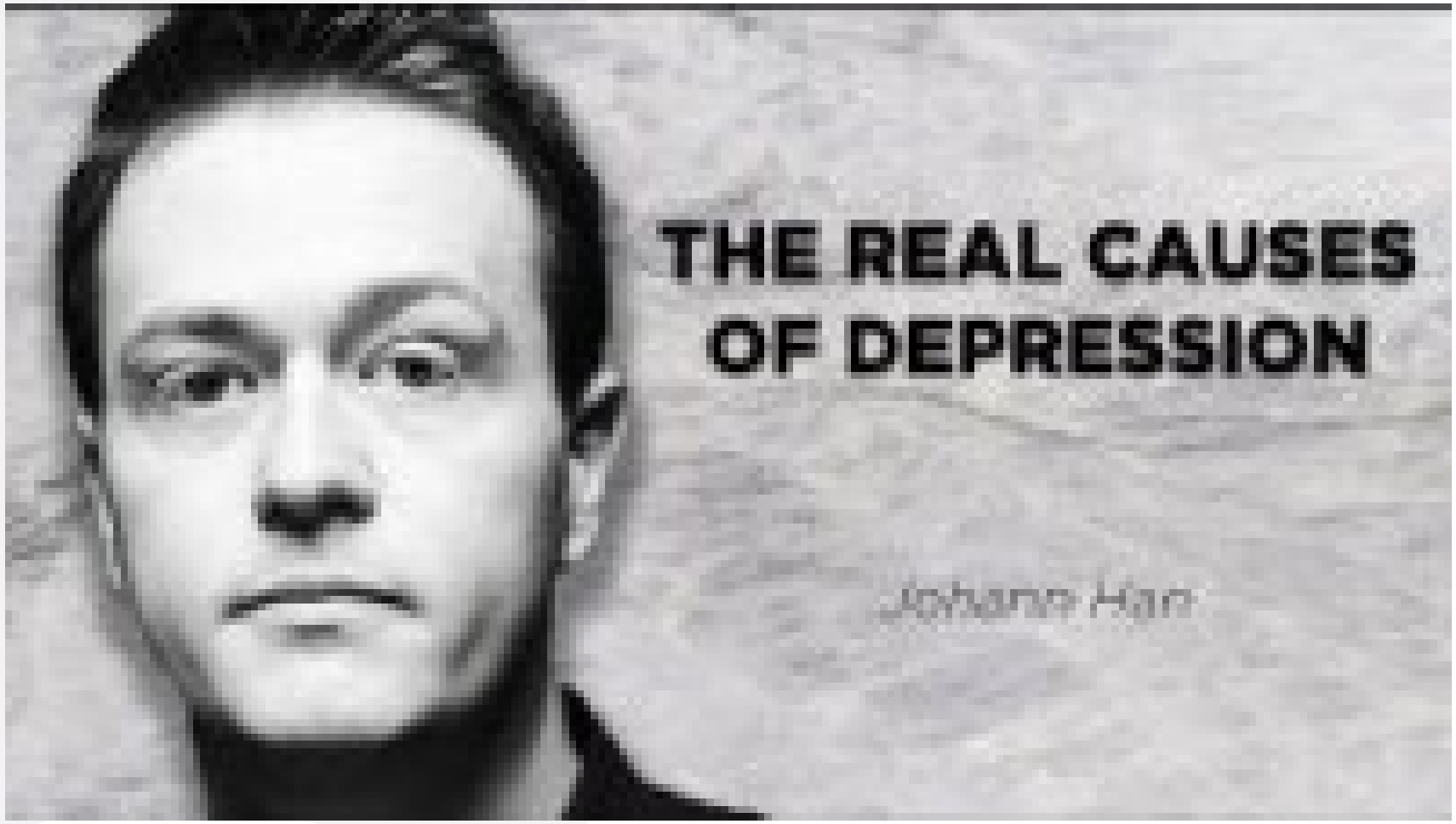
**Warning Signs** are dynamic and can be involved in acute escalation of suicide risk.

# Clinician Barriers

What have you faced in terms of barriers to treating suicidality?

How do different settings impact intervention?

How are these barriers impacting clinicians over time?


THE REAL CAUSES
OF DEPRESSION
Johann Hari

# ASSESSMENT

As physical first aid is to surgery, crisis intervention is to psychotherapy.

Some of the factors that go into consideration may include:

- Cost to purchase and resupply
- Ease in scoring
- Time needed to take for client time needed for staff to administer
- Lead time needed, or in-session assessment possible
- Thoroughness of information yielded
- Seamlessness of fit with existing policies and protocols
- Seamlessness of fit with documentation strategies
- Youth and/or adult versions available
- Reliability, validity status measured and acceptable • Other...

https://asparc.org/wp-content/uploads/2019/04/Resource-List-of-Suicide-Risk-Assessments.pdf

# Practice in Joining

Recognizing that the clinician may be seen as the enemy.

Avoiding Coercion – Collaboration is Key.

Resist the Urge to Offer Advice.

Understand and Validate the Reasons for Dying.

Acknowledge that Suicide is an option.

# Techniques for Eliciting Information

- Normalization
- Shame Attenuation
- Gentle Assumption
- Symptom Amplification
- Behavioral Incident
- Narrative Approach

# Assessing Dangers

- Suicidal Thoughts and Imagery
- Precipitants and Reasons for Dying
- Frequency, Intensity, and Duration
- Method and Means
- Preparations and Planning
- Suicidal Intent and Timing
- Controllability
- History of Suicidal Attempts
- Worst Suicidal Ideation
- History of Self-Injury (non-suicidal)

# Assessing Protective & Cultural Factors

Examine Reasons for Living

Protective Factors

Cultural Factors

Religious and Spiritual Views

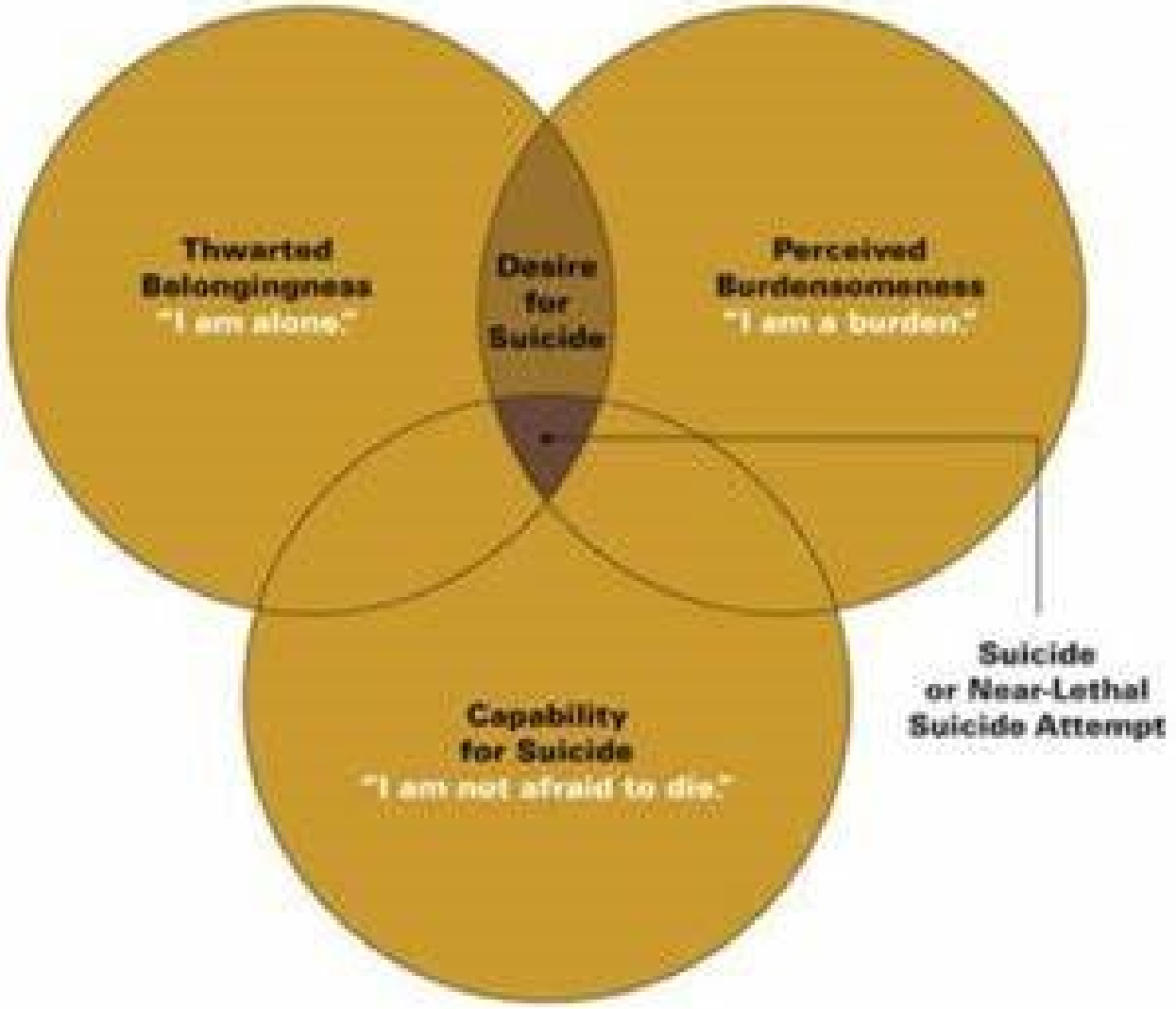
# Cultural Theory of Suicide

Four Cultural Constructs that influence Suicide risk:

- **Cultural Sanctions**
- **Idioms of Stress**
- **Minority Stress**
- **Social Discord**

*"Thinking of the cultural group that you belong to, how do they tend to view suicide?"*

# JOINER'S THEORY OF SUICIDE



# CASE Approach

## Suicide risk assessment is composed of three tasks:

- 1) gathering information related to the risk factors for suicide
- 2) gathering information related to the patient's suicidal ideation and planning
- 3) the clinical decision making that is subsequently applied to these two databases.

## Chronological Assessment of Suicidal Events

# Assessments

PHQ-9

SAFE-T

Columbia Suicide Severity Rating Scale (CSSRS)

Self-Harm Behavior Questionnaire (SHBQ; Gutierrez et al., 2001)

Suicide Cognitions Scale-Revised (SCS-R; Rudd, 2004)

Beck Scale for Suicidal Ideation (BSS; Beck, 1991)

Beck Hopelessness Scale (BHS; Beck & Steer, 1992)

# PHQ-9

A diagnostic tool for mental health disorders used by health care professionals that is quick and easy for patients to complete.

The instrument also includes a functional health assessment. This asks the patient how emotional difficulties or problems impact work, things at home, or relationships with other people.

Can be used across treatment periods to measure progress.

# SAFE-T

Suicide Assessment Five-Step Evaluation and Triage

Identifying risk and protective factors, conducting suicide inquiry, determine level risk level/ intervention, and documentation.

www.sprc.org

Originally conceived by Douglas Jacobs, MD, and developed as a collaboration between Screening for Mental Health and SPRC

American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors (www.psychiatryonline.com/ pracGuide/ pracGuideTopic_14.aspx)

# Columbia Suicide Severity Rating Scale (C-SSRS)

Consists of questions for asking people whether and when they have thought about suicide (ideation) and what actions they have taken — and when — to attempt or prepare to take their own lives (behavior).

Evidence also supports the effectiveness of the C-SSRS as an intervention tool for preventing suicides, as well as a measurement tool for treatment response.

http://cssrs.columbia.edu/wp-content/uploads/CSSRS-Supporting-Evidence-2016-11.pdf

# CSSR-S

Children ages 12 and up.

Measures Suicidal Ideation on a scale.

Questions are phrased for interview format but can be a self-report measure.

# Overview of Title 43a Mental Health Law

**Definition of a person that may require hospitalization.**

**Emergency Admission**

**Emergency Detention**

**Discharge**

# Yoga Poses

Warrior

Triangle

Bow

Table

Cobra

Lotus

Crescent

Tree


Nap


# Interventions

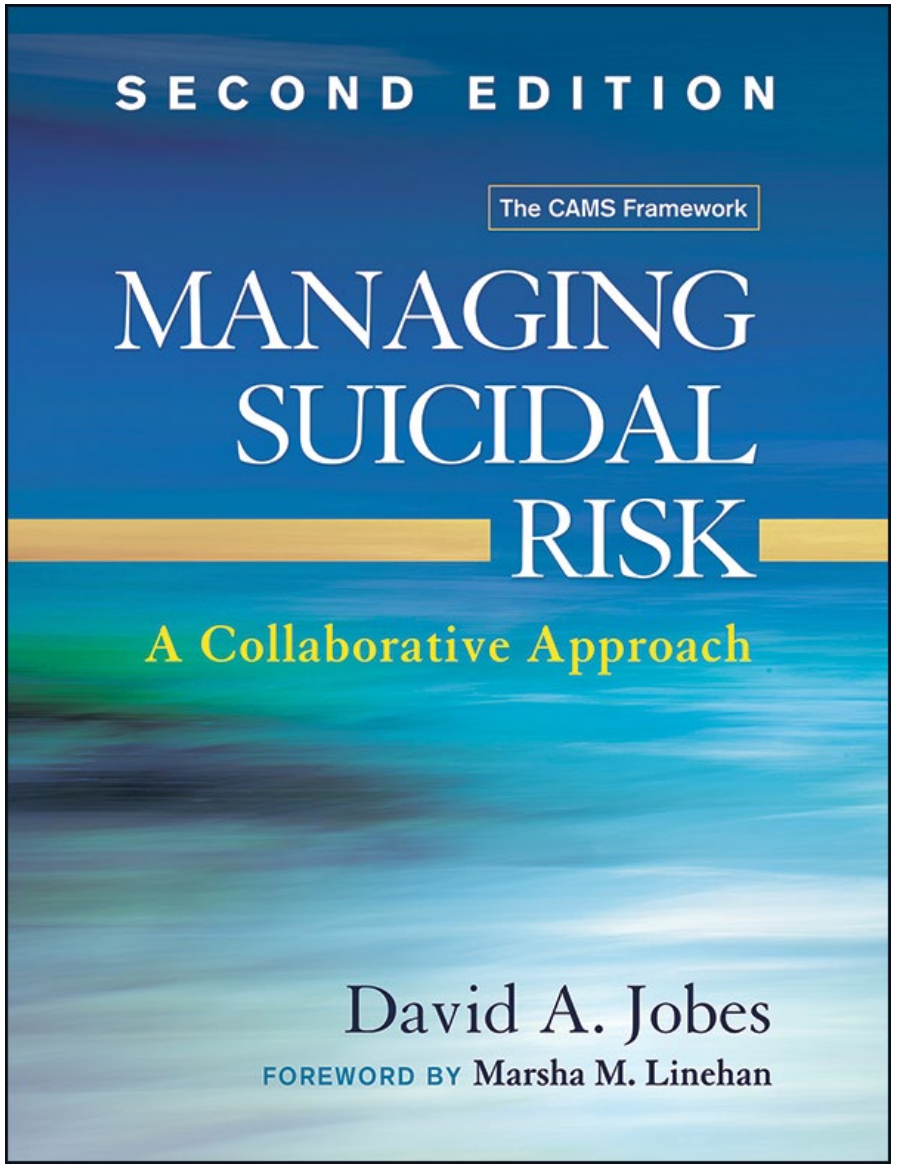
"Anyone desperate enough for suicide should be desperate enough to go to creative extremes to solve problems: elope at midnight, stow away on the boat to New Zealand and start over, do what they always wanted to do but were afraid to try." – Richard Bach

# Trouble with Data

Despite increasing public awareness and improved knowledge of risk factors, little known about interventions.

Evaluated interventions have shown limited effectiveness; most studies are underpowered.

**DBT, CBT,** Brief Home-Based Family Treatment, Group Therapy


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

# CAMS

Collaborative Assessment and Management of Suicidality (CAMS)

Emphasizes a unique collaborative assessment and treatment planning process between the suicidal patient and clinician.

Central to the CAMS approach is the use of the Suicide Status Form (SSF)

CAMS care succeeds when patients ultimately conclude that they no longer need suicide as an option for coping with pain and suffering.

Eight published correlational studies and one randomized clinical trial (RCT)

# CAMS Training

The CAMS book: Managing Suicidal Risk: A Collaborative Approach + the CAMS Online Video + CAMS Practical Role-Play Training + CAMS Consultation Calls.

# CAMS: Suicide-Specific

- CAMS is first and foremost a clinical philosophy of care.
- Clinician and client are highly interactive and client develops own treatment plan.
- Every session of CAMS intentionally involves the patient's input about what is and is not working. All assessment work in CAMS is collaborative; the patient is said to be a co-author of their own treatment plan.

# Collaborative Approach

Therapist & Patient

**SUICIDALITY**

Pain

Stress

Agitation

Hopelessness

Self-Hate

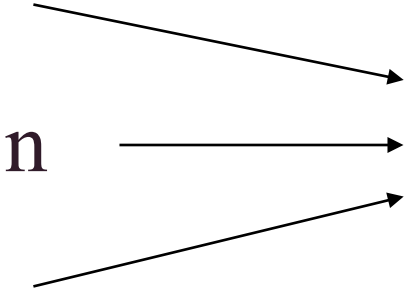
Reasons for Living vs. Reasons for Dying

# CAMS Work

CAMS Initial Session

CAMS Ongoing Session

CAMS Final Session



CAMS Treatment Planning

Stabilization Form

# CAMS TREATMENT PLANNING

Specific, Ongoing, and Collaborative

# CBT-Suicide Prevention Model

Developed by Aaron Beck and Gregory Brown

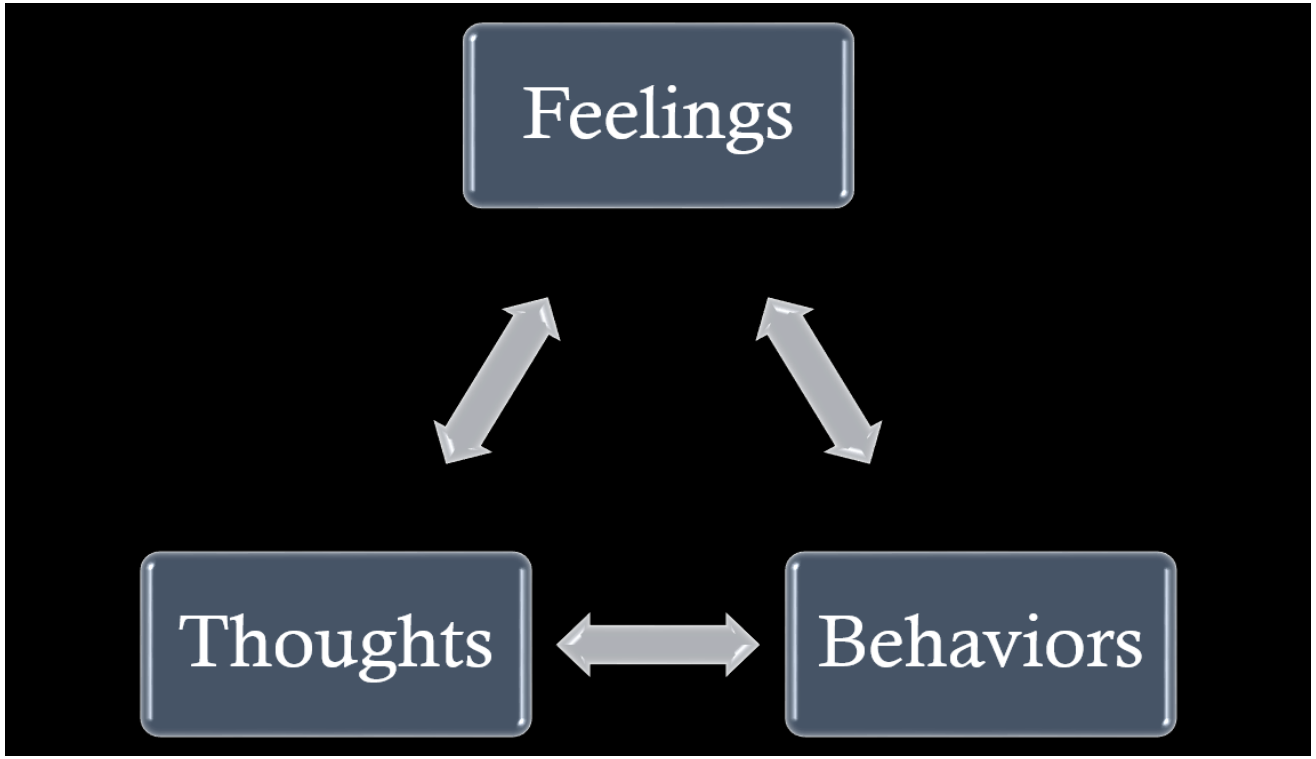
State-dependent learning – Activated vs. Non-Activated

Induction of suicidal state in-session and teaching coping skills

Goal is for the client to demonstrate the ability to use coping skills in the moment.

2013, Dr. David Rudd presented a time-limited CBT approach to treat suicidality in military personnel.

# Cognitive-Behavioral Therapy



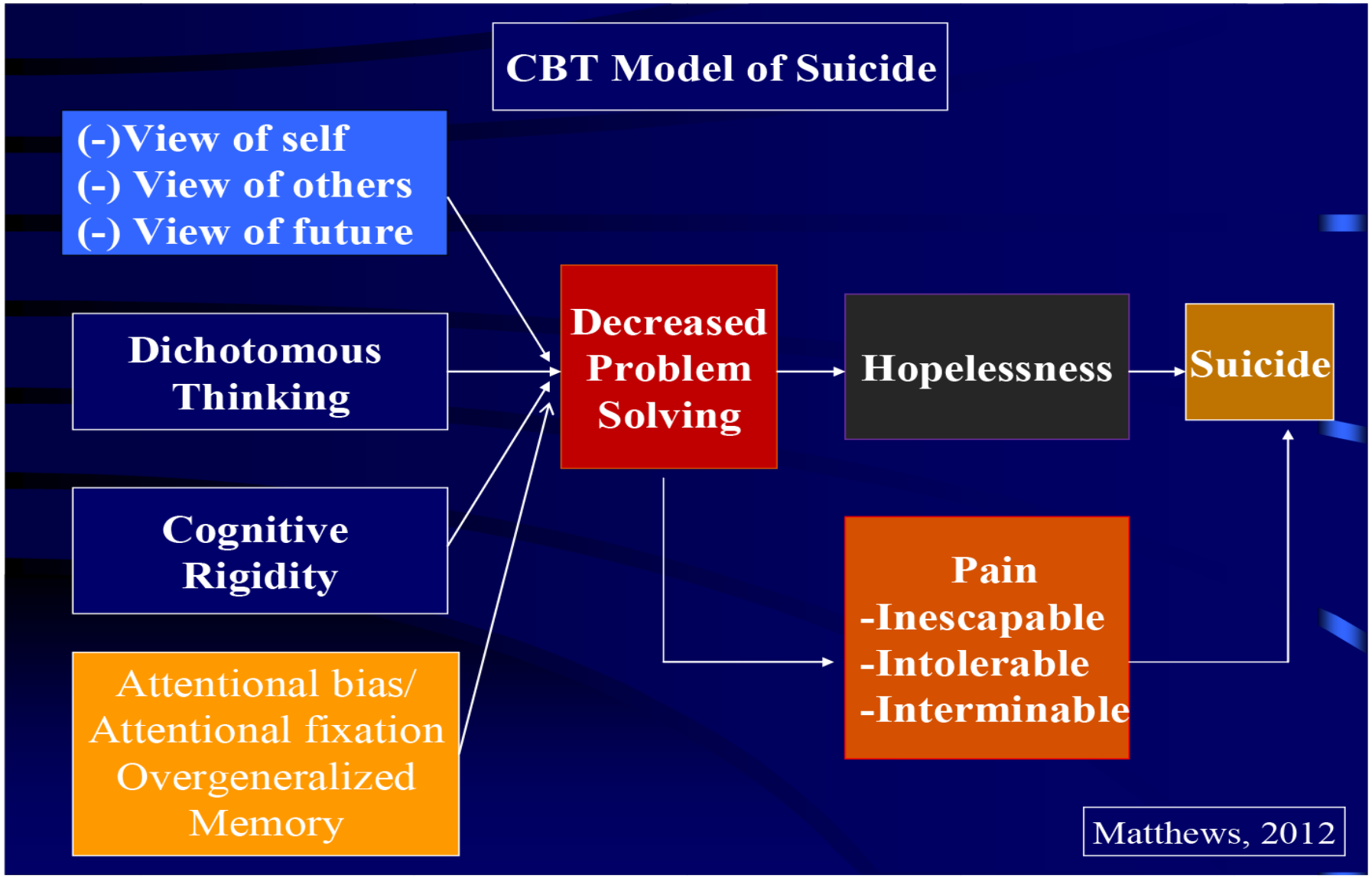
# CBT-Suicide Prevention

Based on the Stress-Diathesis Model of Suicidal behavior.

Implemented with suicide attempters

Primary goal is to reduce suicidal risk factors, warning signs, enhance coping, and to prevent suicidal behaviors.

CBT-SP acts to modify reactions to stressors both acutely and chronically in the context of vulnerability.

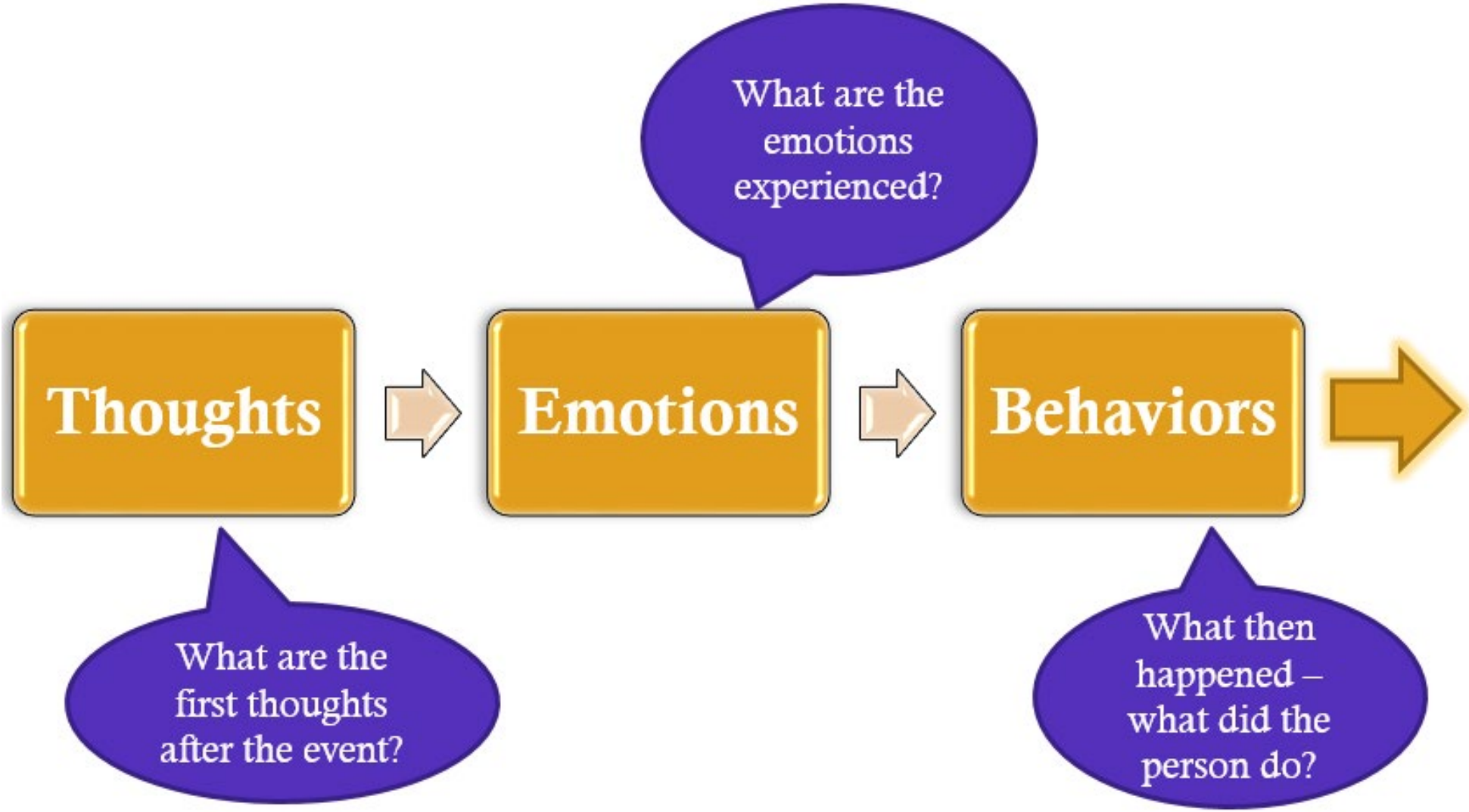

CBT Model of Suicide
(-)View of self
(-) View of others
(-) View of future
Dichotomous Thinking
Cognitive Rigidity
Attentional bias/
Attentional fixation
Overgeneralized Memory
Decreased Problem Solving
Hopelessness
Suicide
Pain
-Inescapable
-Intolerable
-Interminable
Matthews, 2012

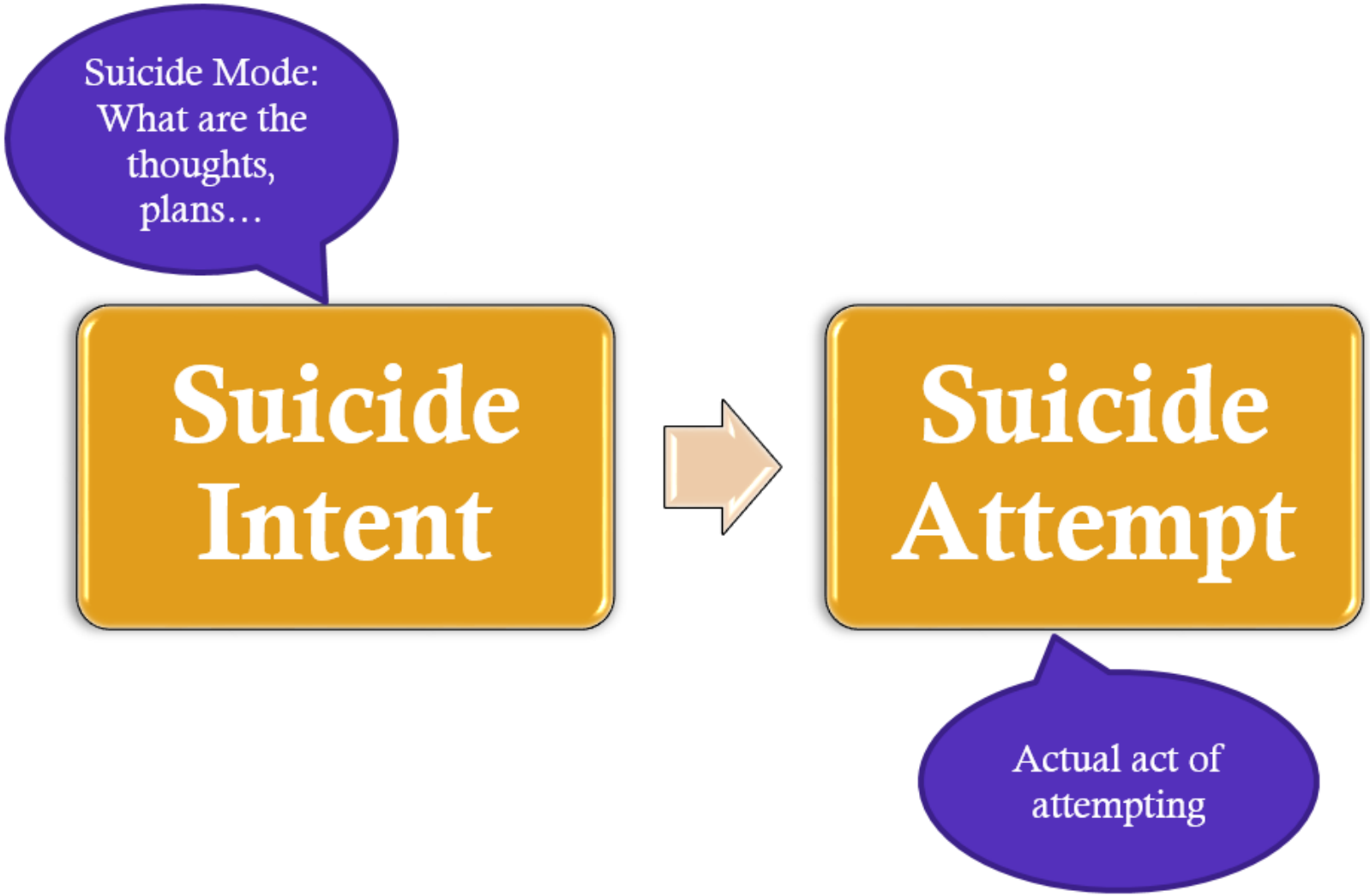
# Three Phases of CBT-SP

PHASE I: Reviewing the Narrative

PHASE II: Effective Problem-Solving and Skill Development

PHASE III: Relapse prevention


What are the emotions experienced?
Thoughts
Emotions
Behaviors
What are the first thoughts after the event?
What then happened – what did the person do?


Suicide Mode: What are the thoughts, plans…
Suicide Intent
Suicide Attempt
Actual act of attempting

**Early Experiences:**

Physically and sexually abused by father

Neglected by mother

Strict Baptist upbringing/ taught what "good girls do and don't do"

Physically and verbally abusive relationship with ex-boyfriend

**Core Beliefs:**

I am unlovable.

I am shameful.

**Conditional Beliefs:**

If other people do not love me, then I am a nobody.

If I don't protect myself, I will be taken advantage of.

**Activating Events:**

Rejection/ criticism by boyfriend or family members

Being cheated on by boyfriend Drug relapse

**Compensatory Strategies:**

Always be giving so that other people will like me and will not be disappointed in me.

Be suspicious of other people's motives.

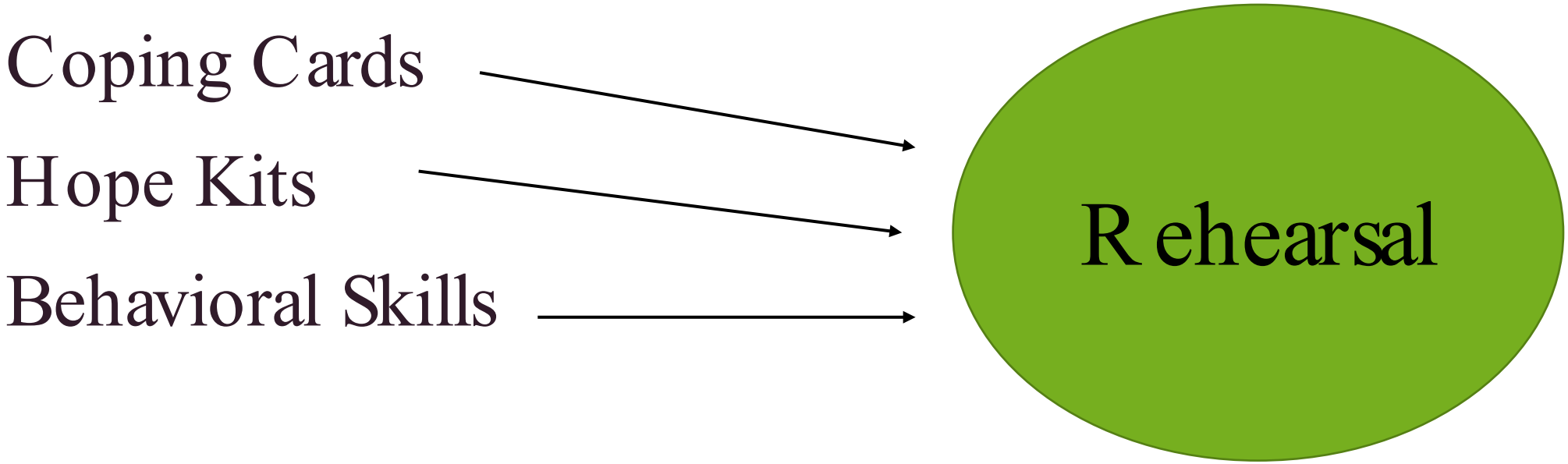
**Suicidal Automatic Thoughts:**

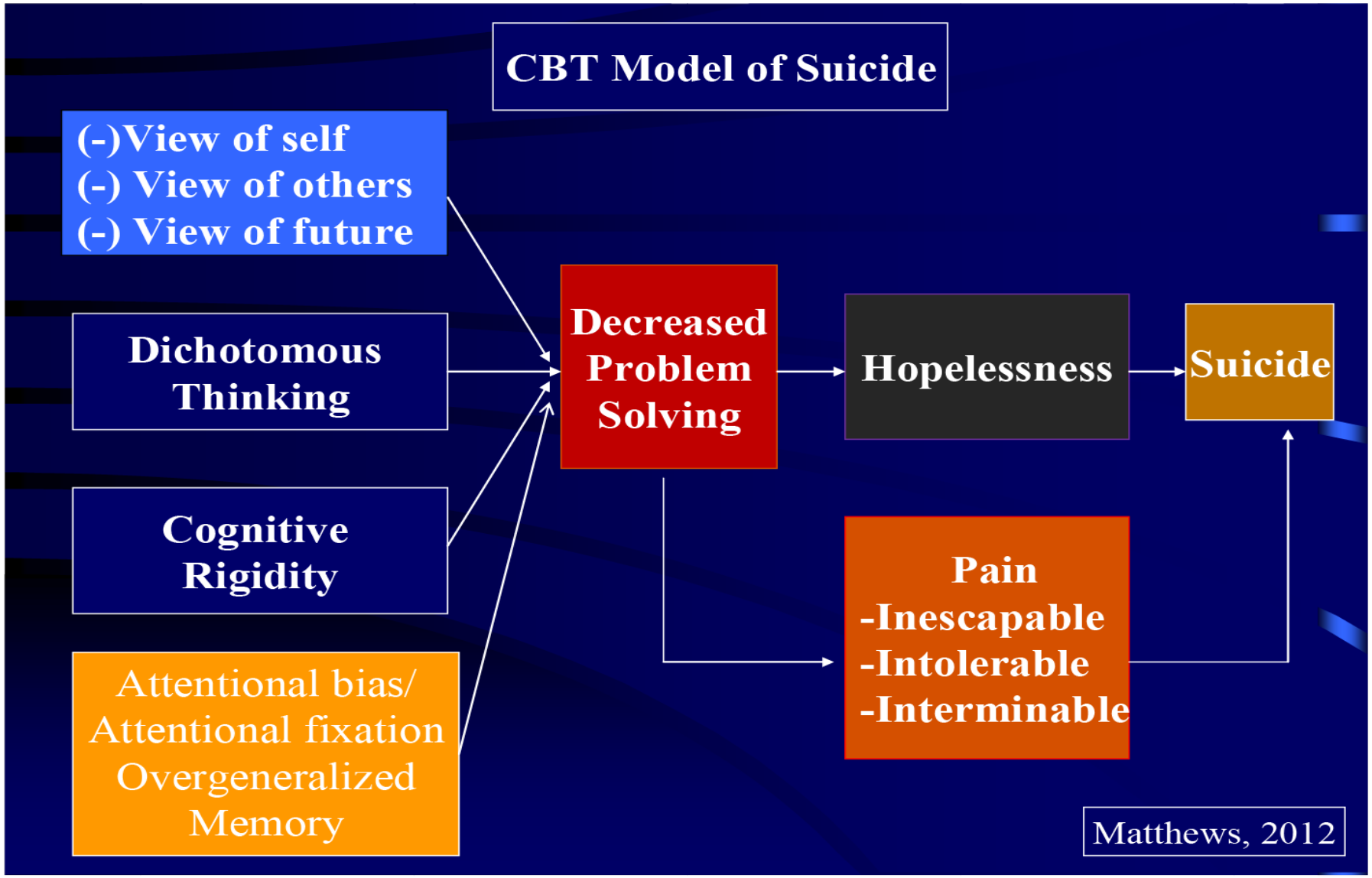
I am a horrible crack addict, I deserve to die.

I am no good to anyone. No one cares about me.

I am tired of trying. I want to escape this pain.

# Skill Development

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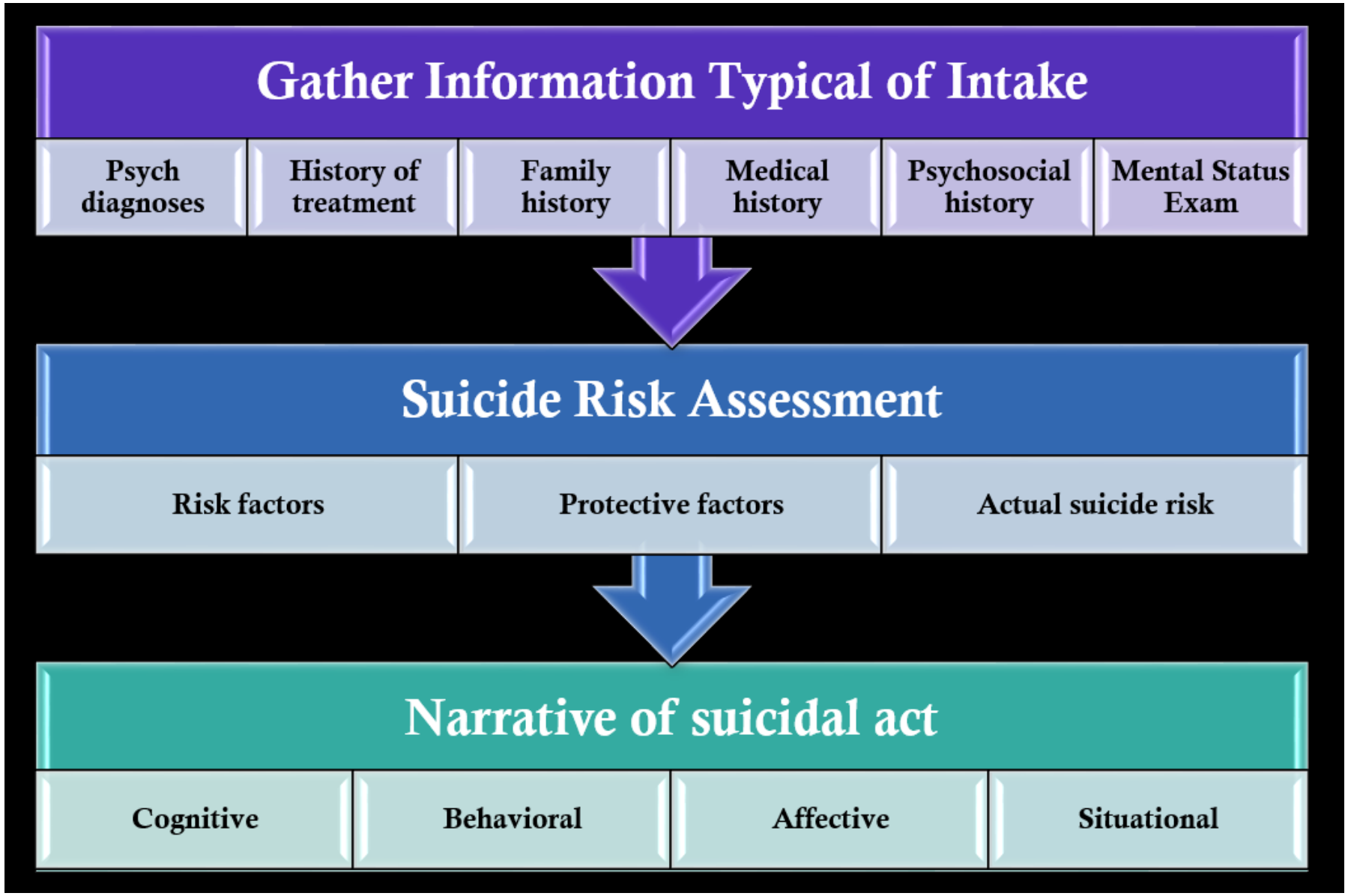
Gather Information Typical of Intake
Psych diagnoses
History of treatment
Family history
Medical history
Psychosocial history
Mental Status Exam
Suicide Risk Assessment
Risk factors
Protective factors
Actual suicide risk
Narrative of suicidal act
Cognitive
Behavioral
Affective
Situational

# Safety Planning

Warning Signs

Coping Strategies

Reducing Access

People to Call

Emergency Numbers

Resources

# Dialectical Behavioral Therapy

Marsha Linehan – Borderline Personality Disorder

Focused on resolving non-suicidal self-injury and suicidal behaviors through skill-building.

Emotional Regulation, Distress Tolerance, Mindfulness, Interpersonal Effectiveness

Individual counseling with Group counseling

http://www.dbtselfhelp.com/html/dbt_skills_list.html

# Case Management

Know your resources.

Develop contact lists: outpatient mental health & addiction clinics, inpatient and residential care facilities, detox centers, acute crisis intervention centers, hospitals, AND law enforcement resources.

Remain updated and continue education around using these resources.

# Self-Care and Consultation

The importance of continuing to check-in when encountering ongoing suicidal clients is essential to ensuring proper care.

Self-care is something we talk about often but managing it is a completely different task.

Would you believe that even therapists and clinicians can forget to take care??

# QUESTIONS?

Thank you all for your attention today!