Suicide Risk Assessment, Prevention, Intervention and Management

QPRT: Question, Persuade, Refer, Treat

Overview

- Welcome & Introductions
- Current Data and Trends
- Risk Factors & At-Risk Groups
- Non-suicidal Self-Injury Behaviors
- Behavioral Health & Suicide Risk
- Protective Factors
- Assessing Risk:
  - Weighing Risk and Protective Factors
- The QPRT Process
- Safety Planning
- Closing & Evaluation

Training Needs Assessment

- Stand up
- Find two others you do not know well
- Introduce yourselves
- Have a brief conversation about:

1. What are your strengths regarding suicide prevention & intervention?
2. Where do you still have questions or need more information and training?

Who is here?

- Primarily MH
- Primarily SUD
- Primarily BOTH (integrated)
- Primarily Youth
- Primarily Adults
- Elderly focus
- Other special populations
- School-based
- In-patient/Residential
- Outpatient
- Eastern WA
- Western WA
- Not WA

SAFE: Suicide Awareness for Everyone

Surgeon General's Report (1999)

– David Satcher, Former U.S. Surgeon General

- Suicide is a serious public health problem.
- Suicide is an enormous trauma for millions of Americans who experience the loss of someone close to them.
- The nation must address suicide as a significant public health problem and put into place national strategies to prevent the loss of life and the suffering suicide causes.
- Resulted in National Strategy for Suicide Prevention (2012 latest revision).

Leading Cause of Death

- Do more Americans die of homicide or suicide?

SUICIDE

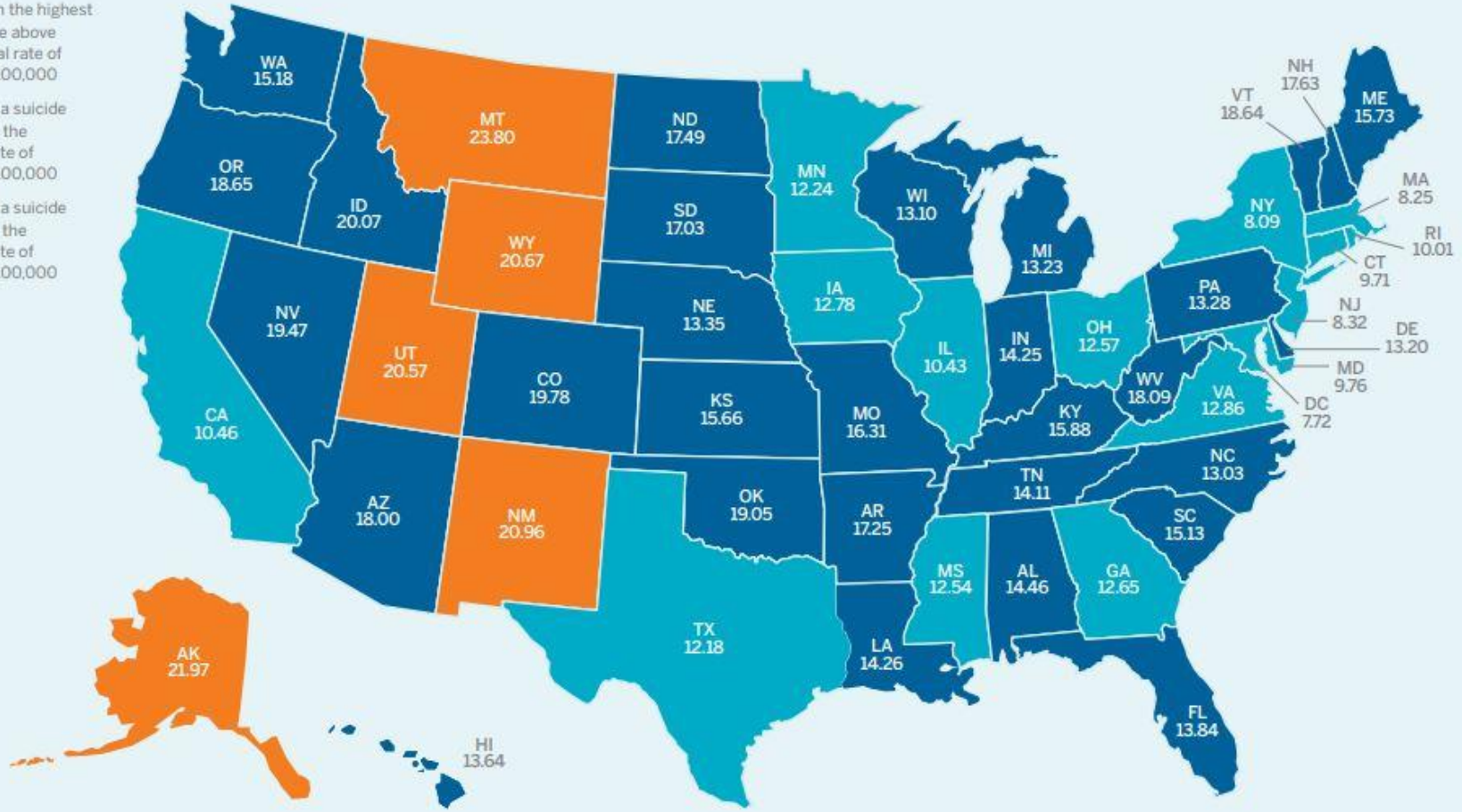
- Suicide ranks **10th** overall in causes of death, homicide 16th.
- Over TWICE as many Americans die by suicide as by homicide each year.
- We know suicide and suicide attempts are underreported (single car fatalities, other accidents, overdoses, etc.)

National Data

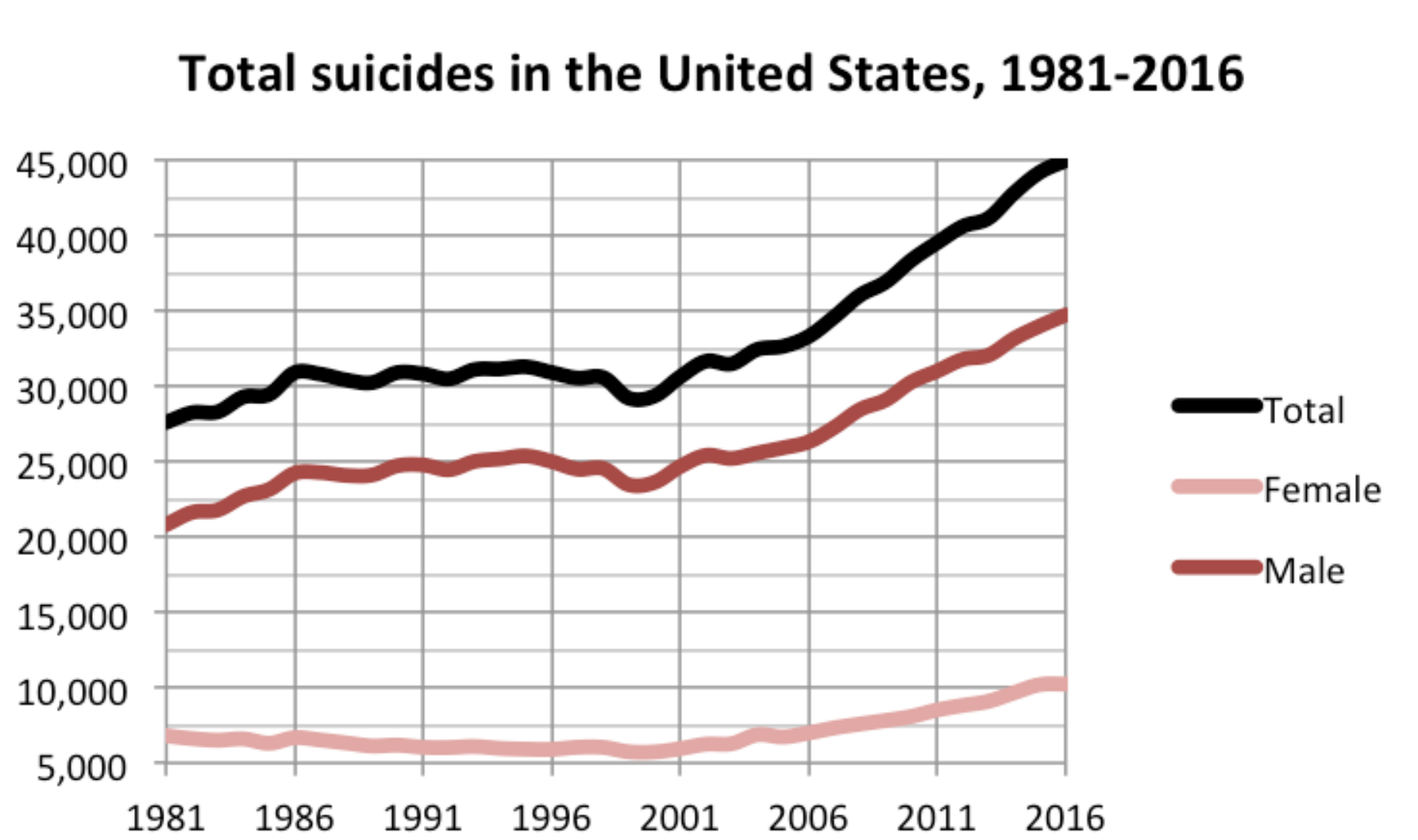
- 10 million adults have serious thoughts of suicide each year
- 2.7 million adults make a plan
- **1.3 million** attempt (minimum count)
- In 2017, **47,173** people died by suicide
  - Rate of 13.4 per 100,000 people
- Every day, 129 suicides and 3,000 attempts
  - One attempt every **28** seconds
  - One death every **12** minutes
- Plus the pain, suffering, and disability caused by attempts

SUICIDE DEATH RATES

- States with the highest suicide rate above the national rate of 12.93 per 100,000
- State with a suicide rate above the national rate of 12.93 per 100,000
- State with a suicide rate below the national rate of 12.93 per 100,000

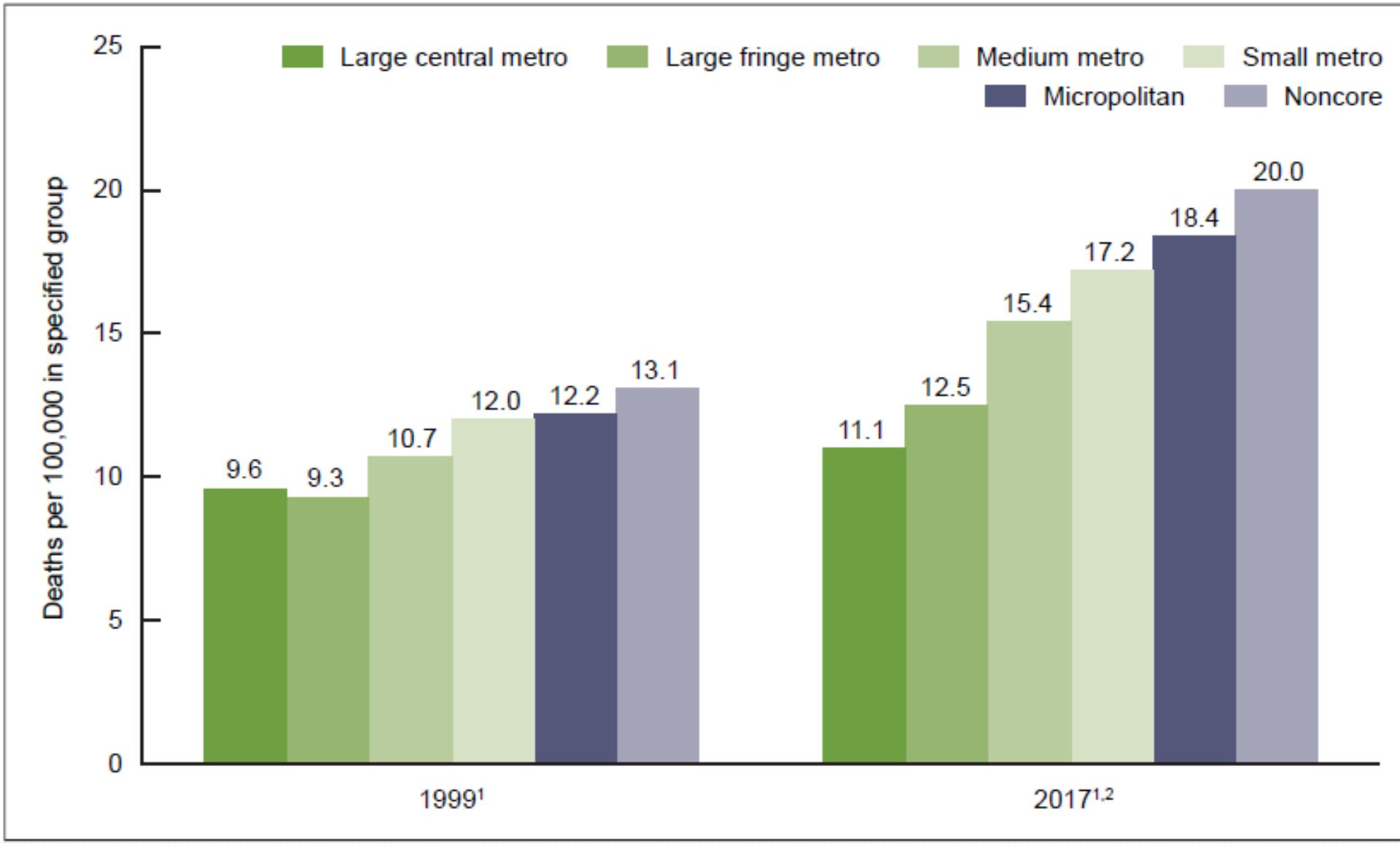


2014 data, released December 2015, CDC Web Based Injury Statistics Query and Reporting System (WISQARS)


Total suicides in the United States, 1981-2016
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
1981
1986
1991
1996
2001
2006
2011
2016
Total
Female
Male

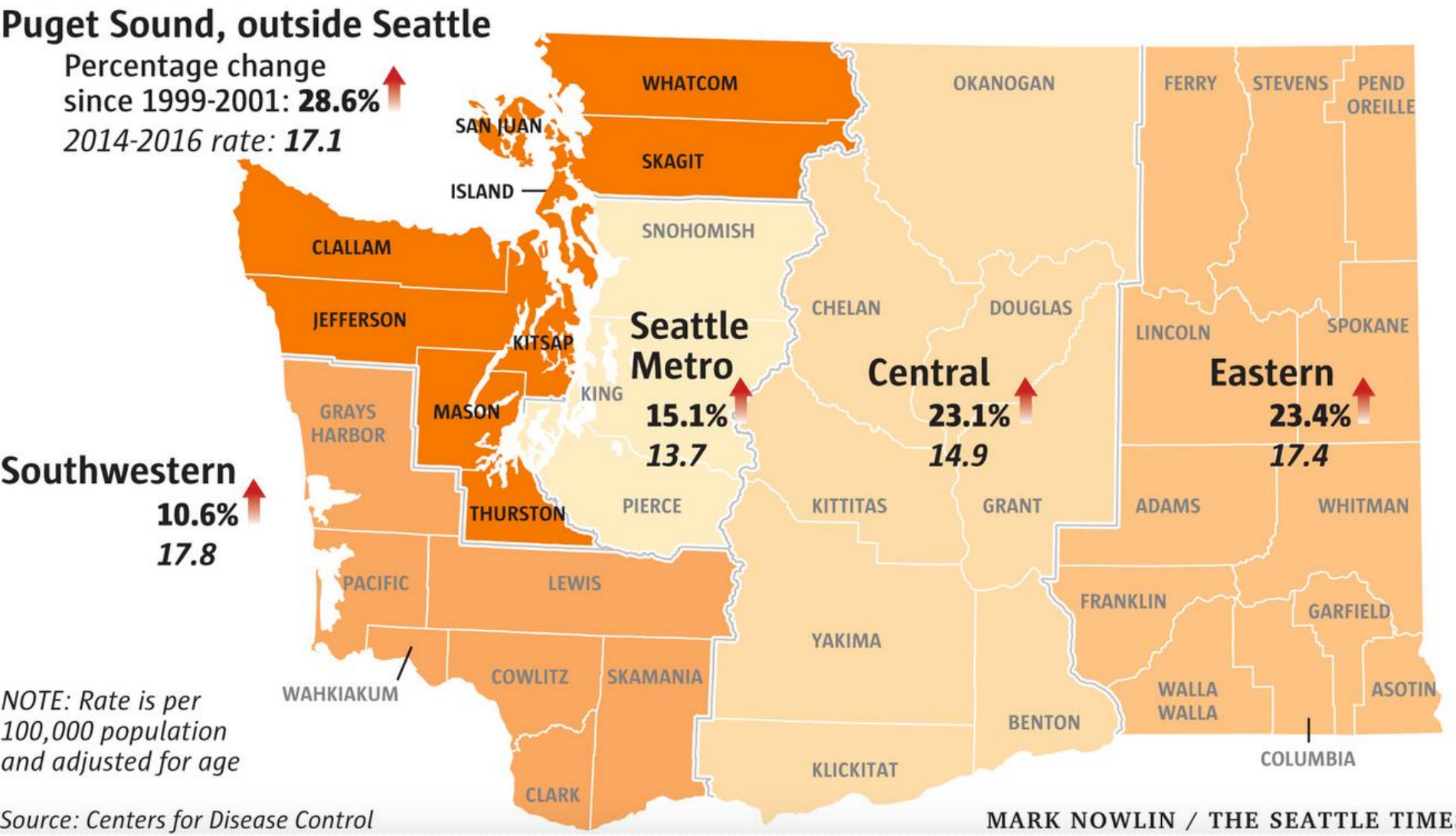
Suicide in Washington State

- 15.7 suicides per 100,000 people
  - 3.0 homicides per 100,000
- 1141 died by suicide vs. 210 by homicide
- Approximately 2-3 Washingtonians a day
- 1st leading cause of death for ages **10-14**
- 2nd leading cause of death for ages **15-34**
- 8th leading cause of death in the state overall
- 36,000 attempts per year
- Washington ranks 26th in the US in suicides
- Suicide rate ↑ 19% since 1999 (US ↑ 25%)


Large central metro
Large fringe metro
Medium metro
Small metro
Micropolitan
Noncore
Deaths per 100,000 in specified group
25
20
15
10
5
0
9.6
9.3
10.7
12.0
12.2
13.1
11.1
12.5
15.4
17.2
18.4
20.0
1999[1]
2017[1,2]

Suicide rates rise across state

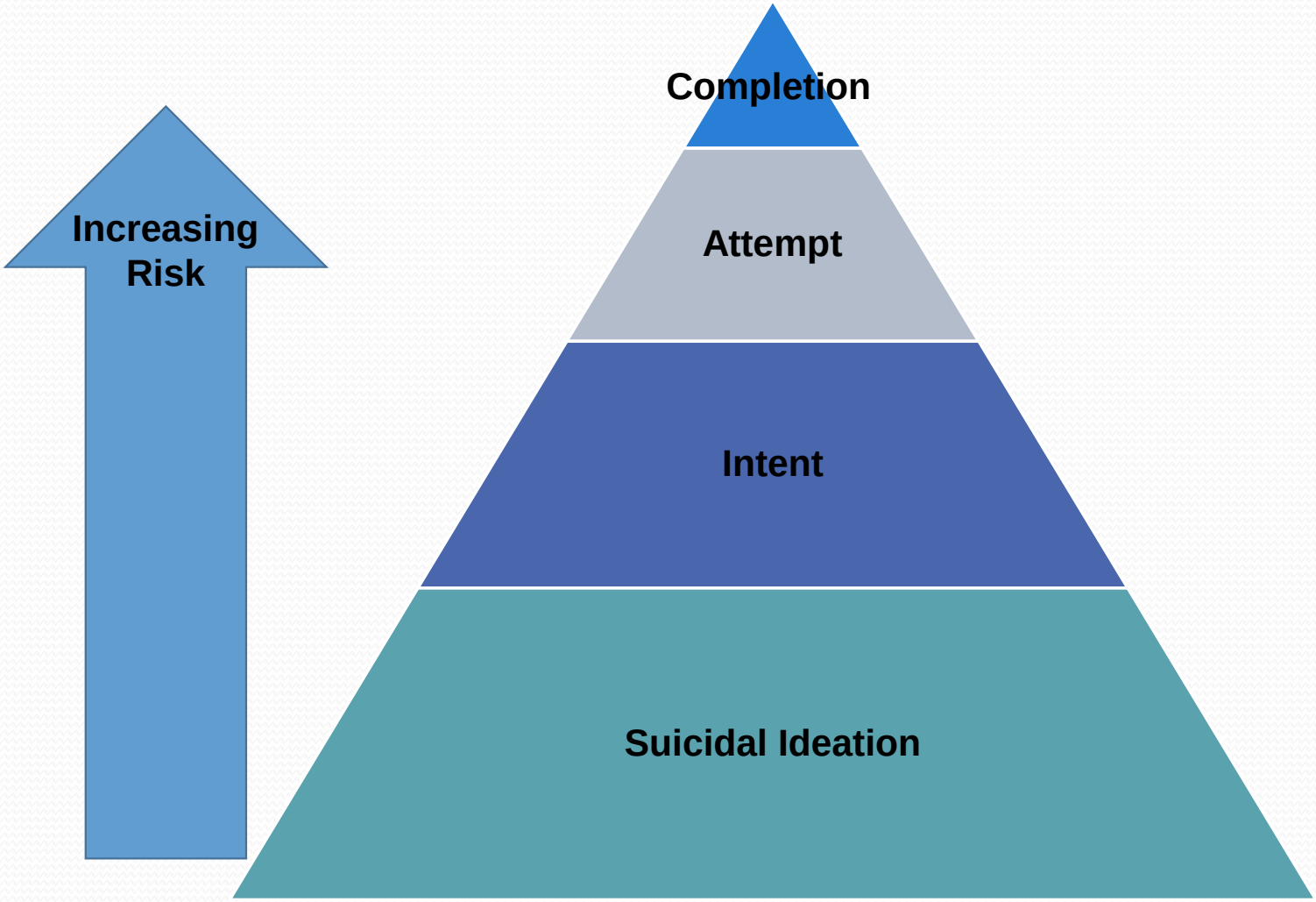
The suicide rate in Washington has increased in every region of the state since 1999.



Where do we start?

- Suicide is a complex behavior usually caused by a combination of factors
- Almost all people who kill themselves have a diagnosable mental or substance use disorder or both—and the majority have depressive illness.
- Studies indicate that the most promising way to prevent suicide and suicidal behavior is through the early recognition and treatment of depression and other mental illnesses.

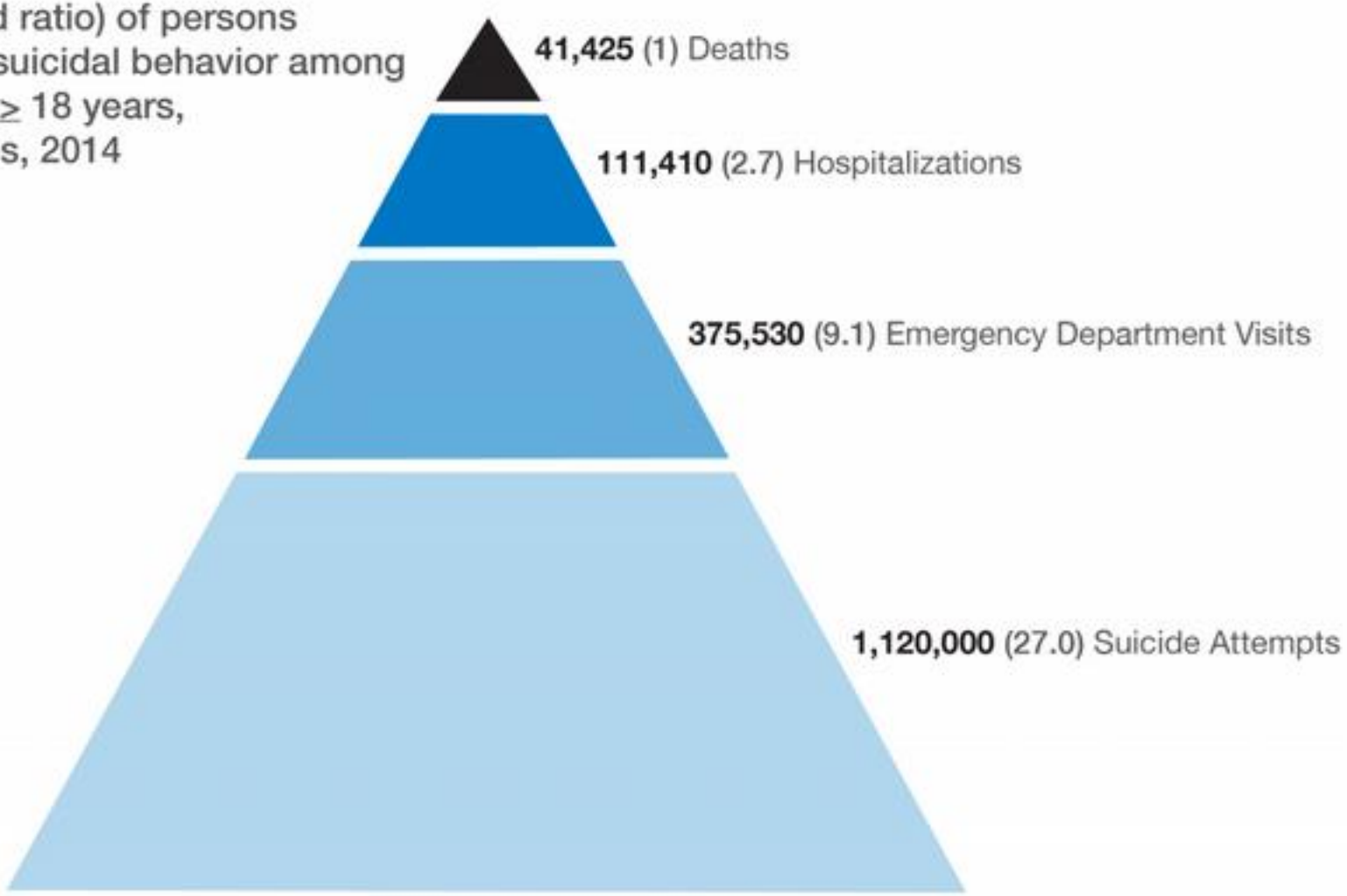
Suicidal Behavior Continuum



from James Mazza, PhD

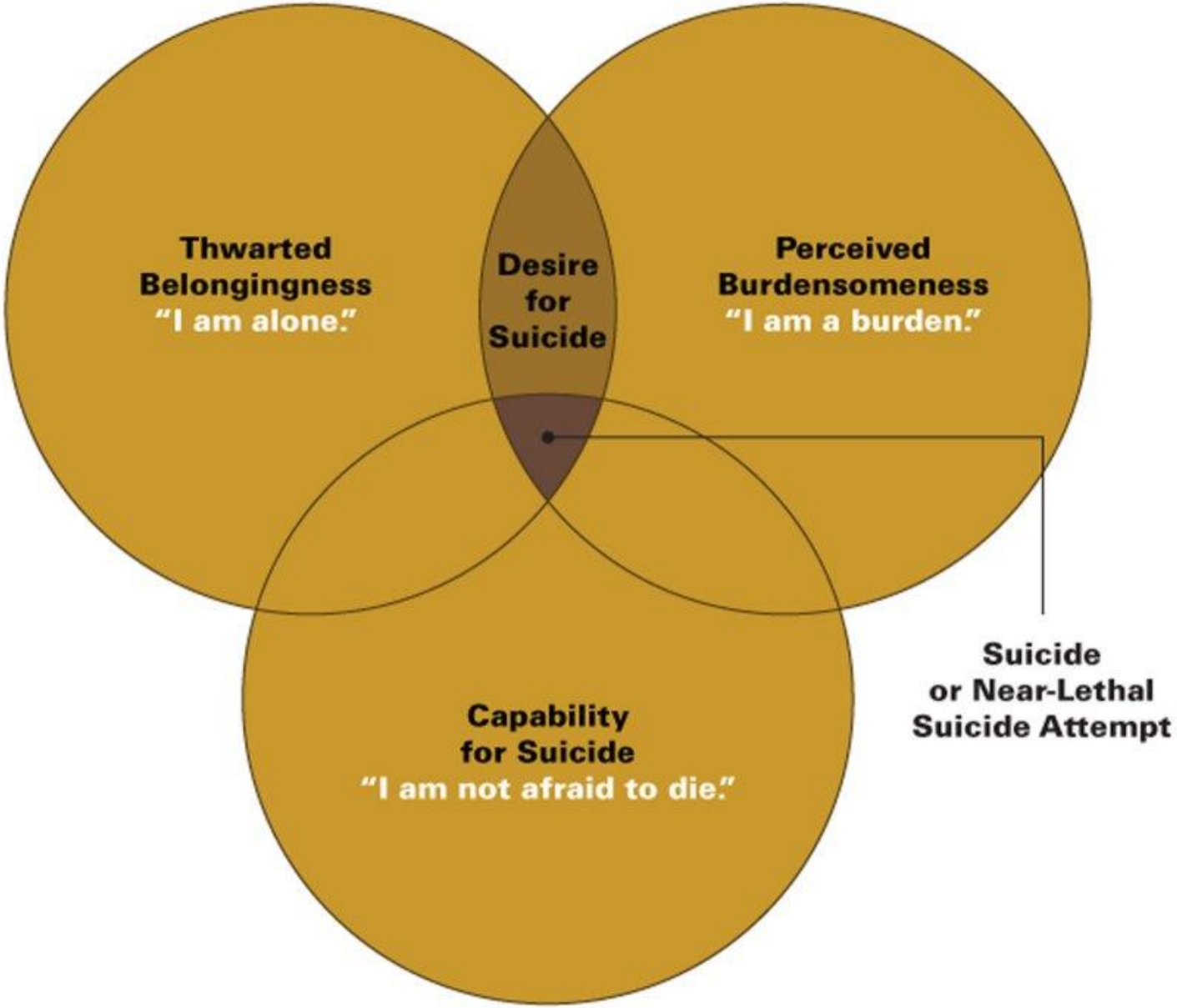
Suicidal Behavior Among Adults in the United States, 2014 (≥18 years of age)

Number (and ratio) of persons affected by suicidal behavior among adults aged ≥ 18 years, United States, 2014



Source: Personal communication, Alex Crosby, CDC, 2017

JOINER'S THEORY OF SUICIDE



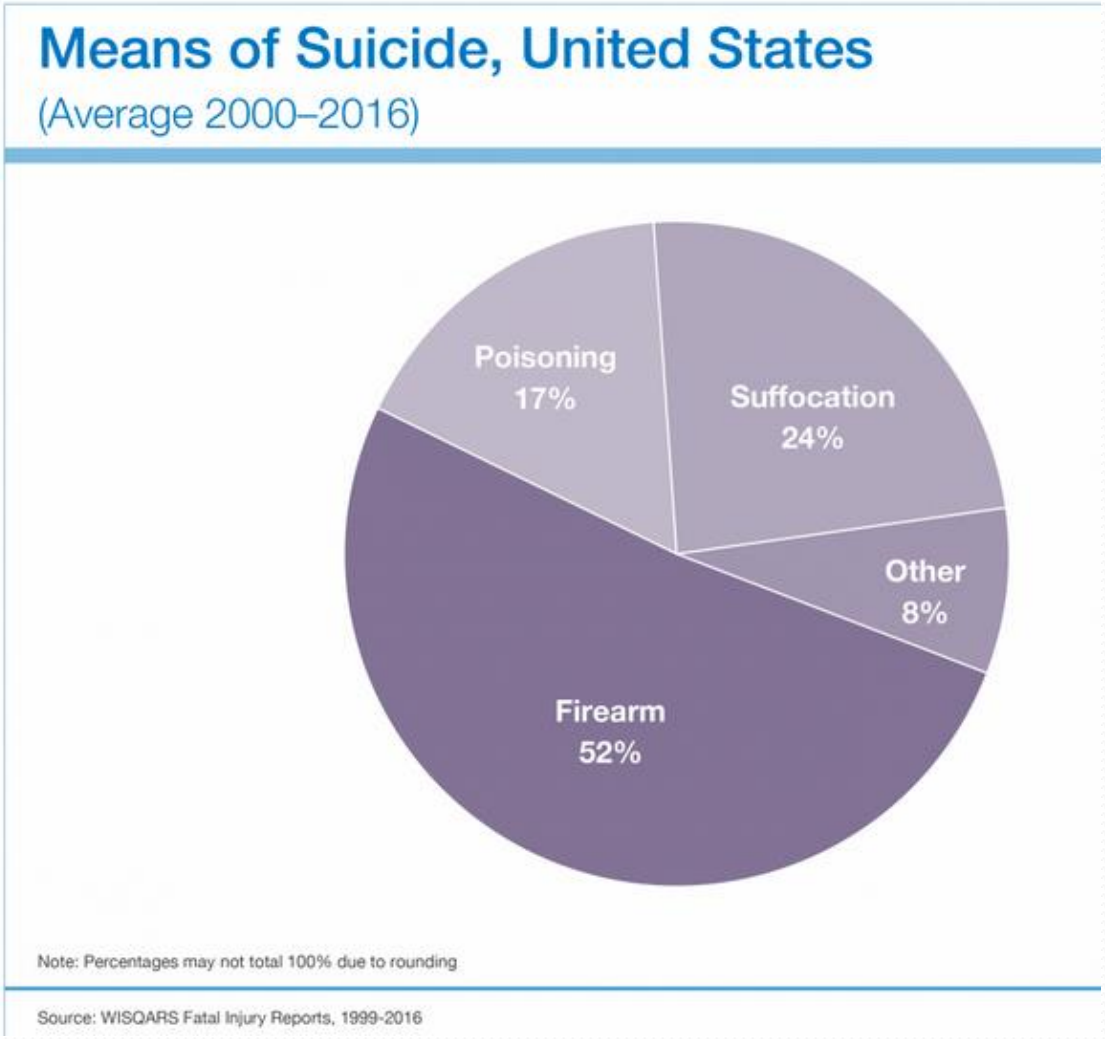
Risk & Protective Factor Case Study – Part 1

- Identify risk and protective factors (Questions 1 & 2)
- Ask follow-up questions to become risk and protective factor detectives (Question 3)

Primary Method: Firearms

- Easy access to a gun is a significant risk factor.
  - Presence of a gun in the home increases risk by **2-10** times depending on person's age and how the gun is stored
- In 2017: 47,173 suicides in US
  - of those 51% were by firearms
- Because the impulse to attempt suicide is frequently short-lived, the method is important:
  - Firearm: instantaneous
  - Pills: 15 minutes or more
  - Car Exhaust: 20 minutes or more

Firearms vs. Other Methods



- The rate of suicide by firearms is more than double the next closest method
- The longer it takes to complete a suicide, the better the chance of survival

No Second Chance

- It is important to note that it is estimated that **90%** of those who **attempt suicide** go on to **die of something else** — they do not subsequently kill themselves.
- However, for those who use a gun on their first attempt, there generally is not a second chance.
  - Lethality of guns as method: 85 to 90%
  - Poison as method: 1-2%
- Removal of firearms from the home, or securing them properly, decreases risk significantly.

Assessing Overall Suicide Risk

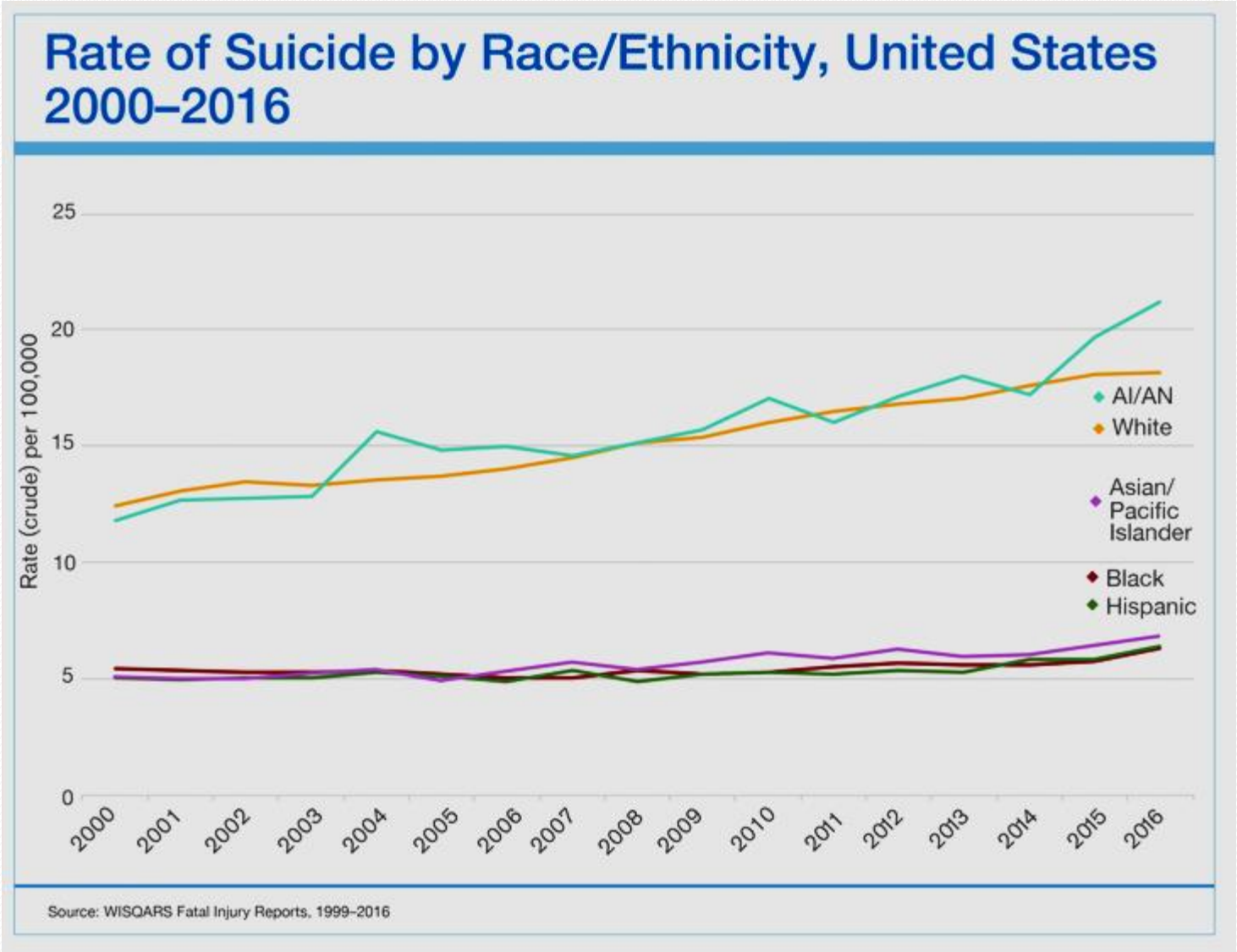
When assessing an individual's suicide risk, consider:

- Environmental factors
- High risk groups
- Risk factors
  - Including mental health diagnosis
- Protective factors

Environmental Factors

- Seasonal variations
  - lowest in December, peaks in the spring and fall
- Weekly variation
  - Mondays are the highest, Saturdays lowest
- Geography
  - highest in the west (see earlier map)
- Urban versus Rural
  - highest in rural areas
- Times of war
  - inverse effect (general population)
- Contagion Effect
  - local clusters, ‘copy cat’ deaths
- Unemployment
  - Chronic - No increased risk
  - Acute/sudden - Increased risk
- Homelessness (same pattern)

Suicide & Ethnicity



Native American Suicide

- Highest ethic rate in US
  - 21/100,000, lowest group 3.5/100,000
- Younger
  - 10-24, 35% of completions, whites, 11%
  - Over 50, 2.7%, whites 17%
- More alcohol involvement
  - 53%, whites 35%

Suicide & Ethnicity Washington State

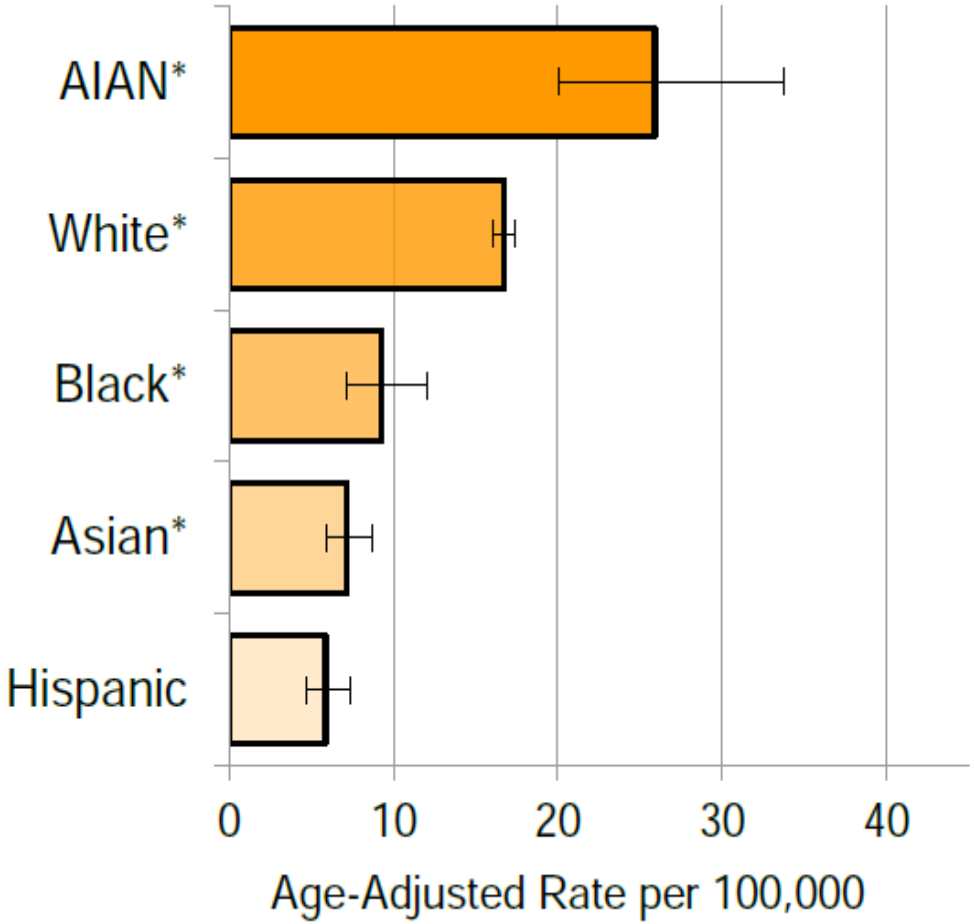


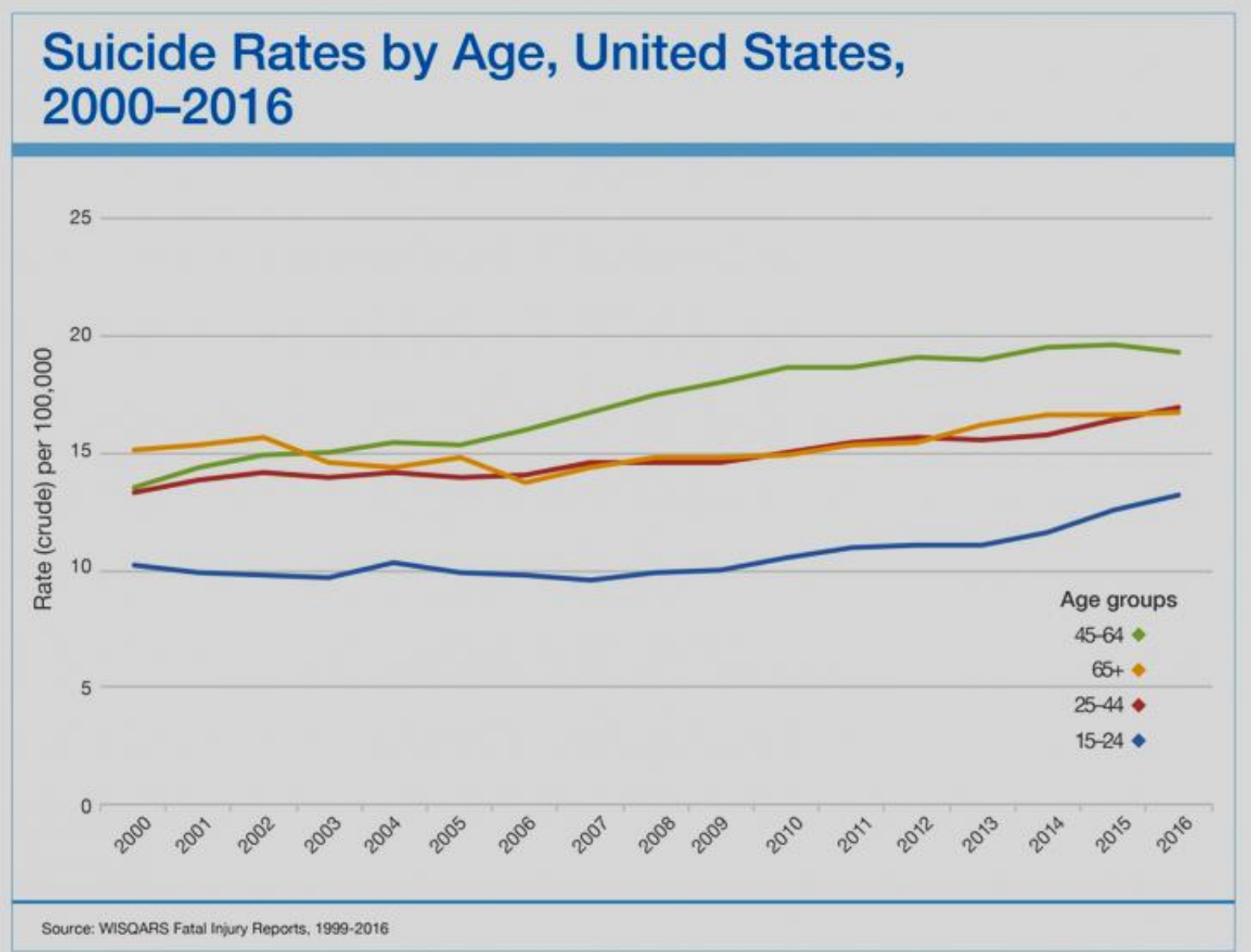
Figure 7:
Suicide rates by race and Hispanic origin in Washington, 2012–2014

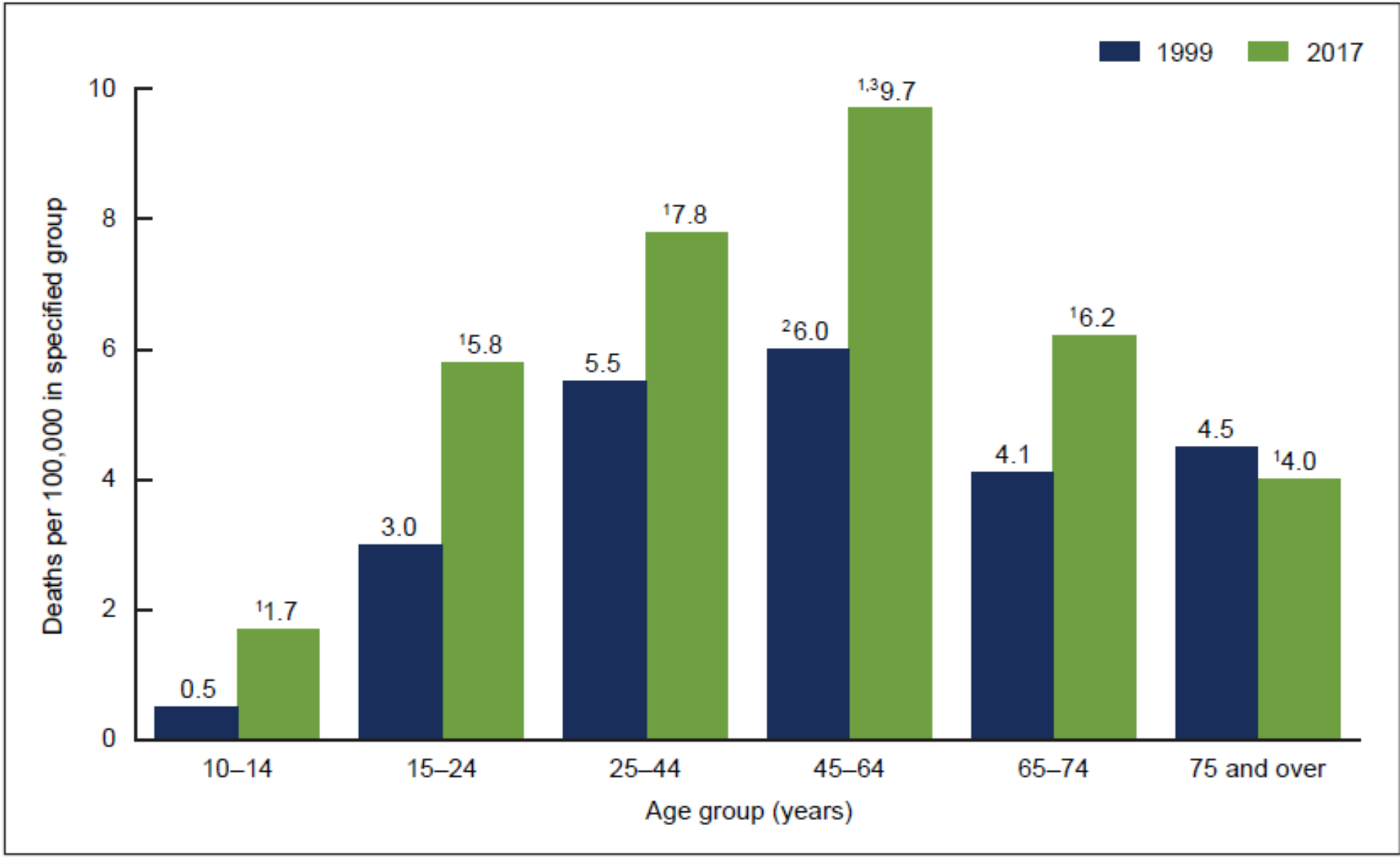
* Non-Hispanic, single race only

AIAN = American Indian/Alaska Native

Native Hawaiian/Other Pacific Islander not included (unreliable rates due to small numbers)

Suicide & Age


Suicide Rates by Age, United States, 2000–2016
Rate (crude) per 100,000
25
20
15
10
5
0
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
Age groups
45-64
65+
25-44
15-24
Source: WISQARS Fatal Injury Reports, 1999-2016


1999
2017
Deaths per 100,000 in specified group
10
8
6
4
2
0
0.5
[1]1.7
3.0
[1]5.8
5.5
[1]7.8
[2]6.0
[1,3]9.7
4.1
[1]6.2
4.5
[1]4.0
10–14
15–24
25–44
45–64
65–74
75 and over
Age group (years)

Late-Life Suicide

- Older adults often lack past psychiatric history
- Are less likely to have made previous suicide attempts
- Are more likely to complete:
  - 25:1 attempts per completion in general population
  - 4:1 in older population
- More planned and determined
- Fewer warnings
- More violent and lethal
  - #1 = firearm (72.9%), a higher proportion than any other age group

Late Life Suicide & Primary Care Visits

- 70% of older suicide victims have visited a PCP within 1 month of the suicide
  - 1/3 within 1 week
- They are typically not asking for mental health care
  - Anxious (#1 reported symptom)
  - Guilty
  - Decreased energy
  - Change in personal care and appearance
  - Memory problems
  - Back pain
  - Feeling inadequate
  - Complaining of being a burden

Middle Aged (aged 35-65) Suicide Trends U.S.

- 28% increase for individuals aged 35-65
- Now account for about 57 percent of suicides
- Moved from 8th leading cause of death to 4th (behind cancer, heart disease and accidents)
- 40% increase for white middle aged individuals
- Flat for most other ethnic groups
- Except American Indian/Native Alaskan group, increased 65% (small numbers can cause large changes)

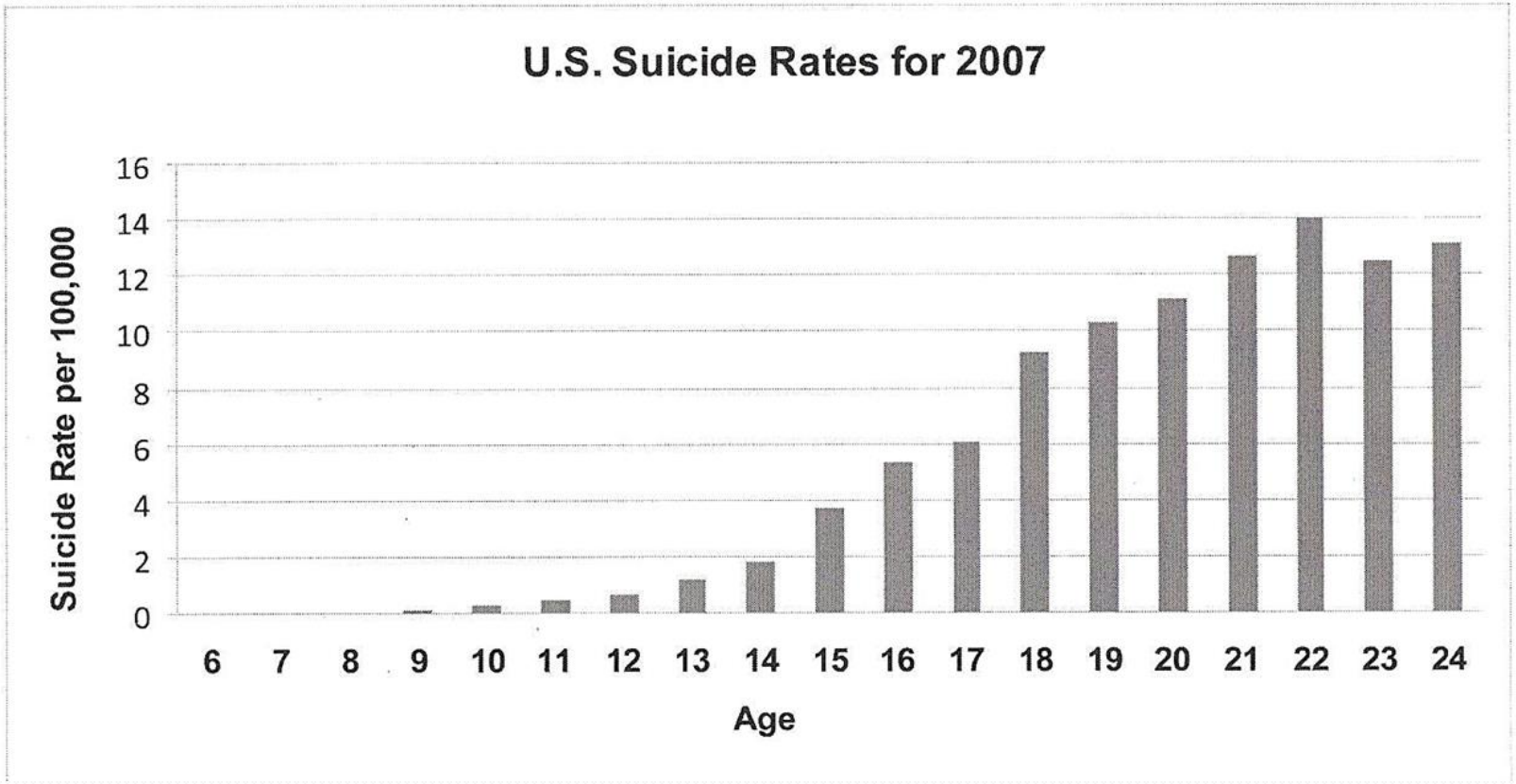
Youth Data Summary (ages 10-24)

- Second-leading cause of death
- 2 per week in Washington State
- 4600+ lives lost each year nationally
- The top three methods used are firearm (45%), suffocation (40%), and poisoning (8%)
- Boys are more likely than girls to die from suicide (81% young men vs 19% young women)
- Girls are about 3 times more likely to attempt suicide than boys

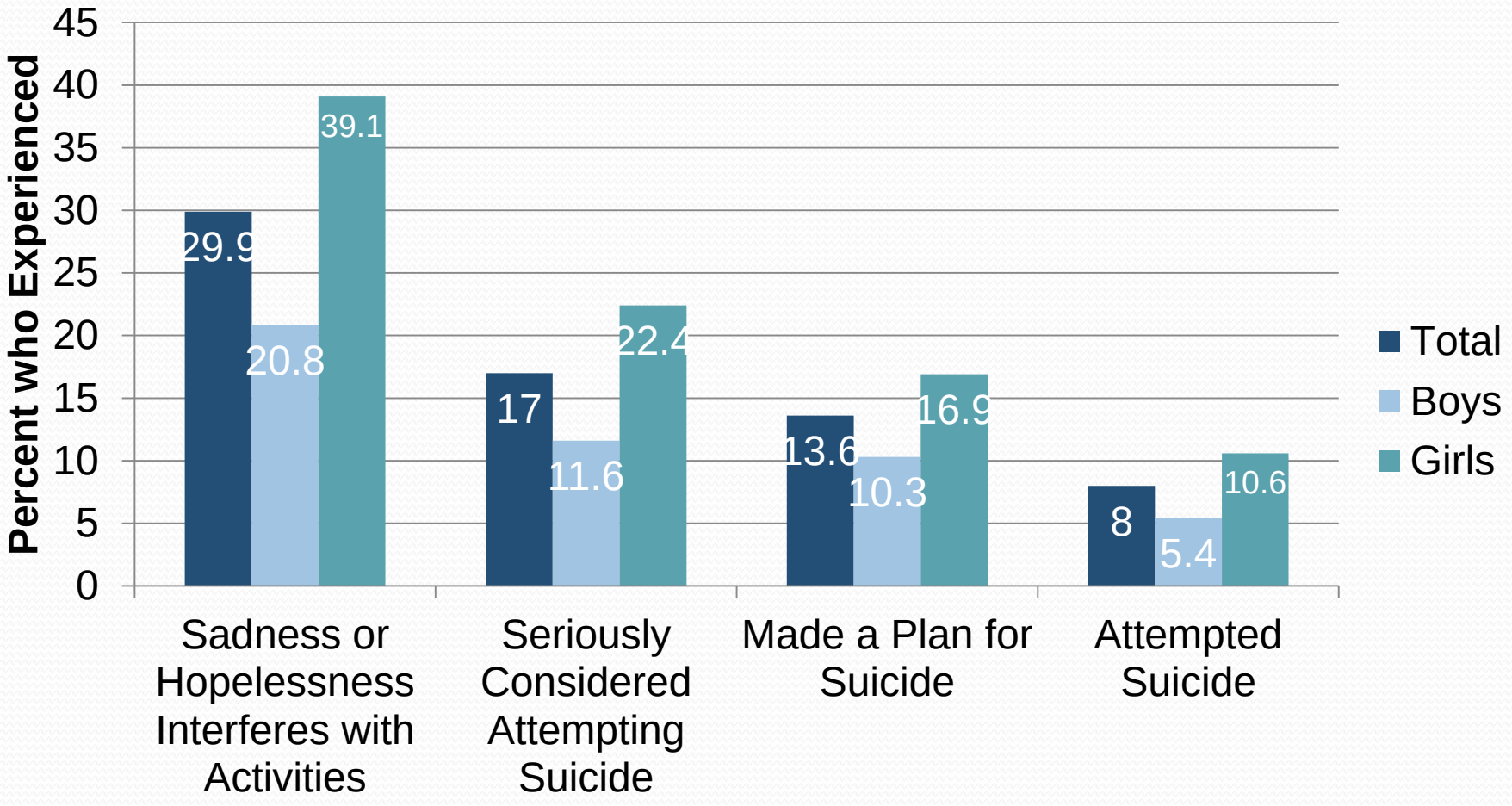
Challenges in Youth Suicide Prevention

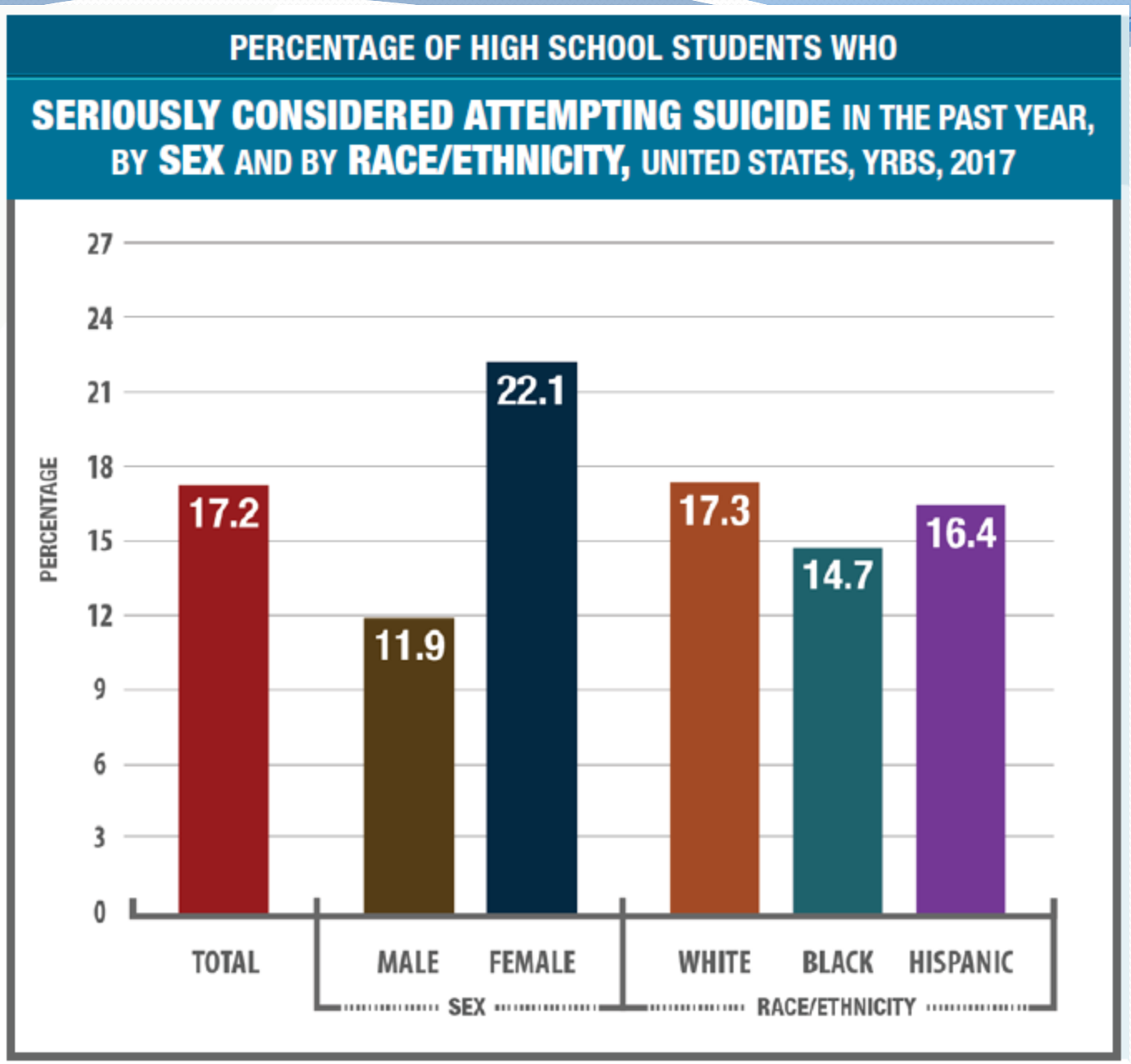
- Early stages of brain development
- Inability to express self emotionally
- More impulsive, aggressive, quick-tempered
- Lack of trust in adults
- Highly influenced by peers and peer groups
- 20% of youth have a mental illness
  - Only 80% receive treatment

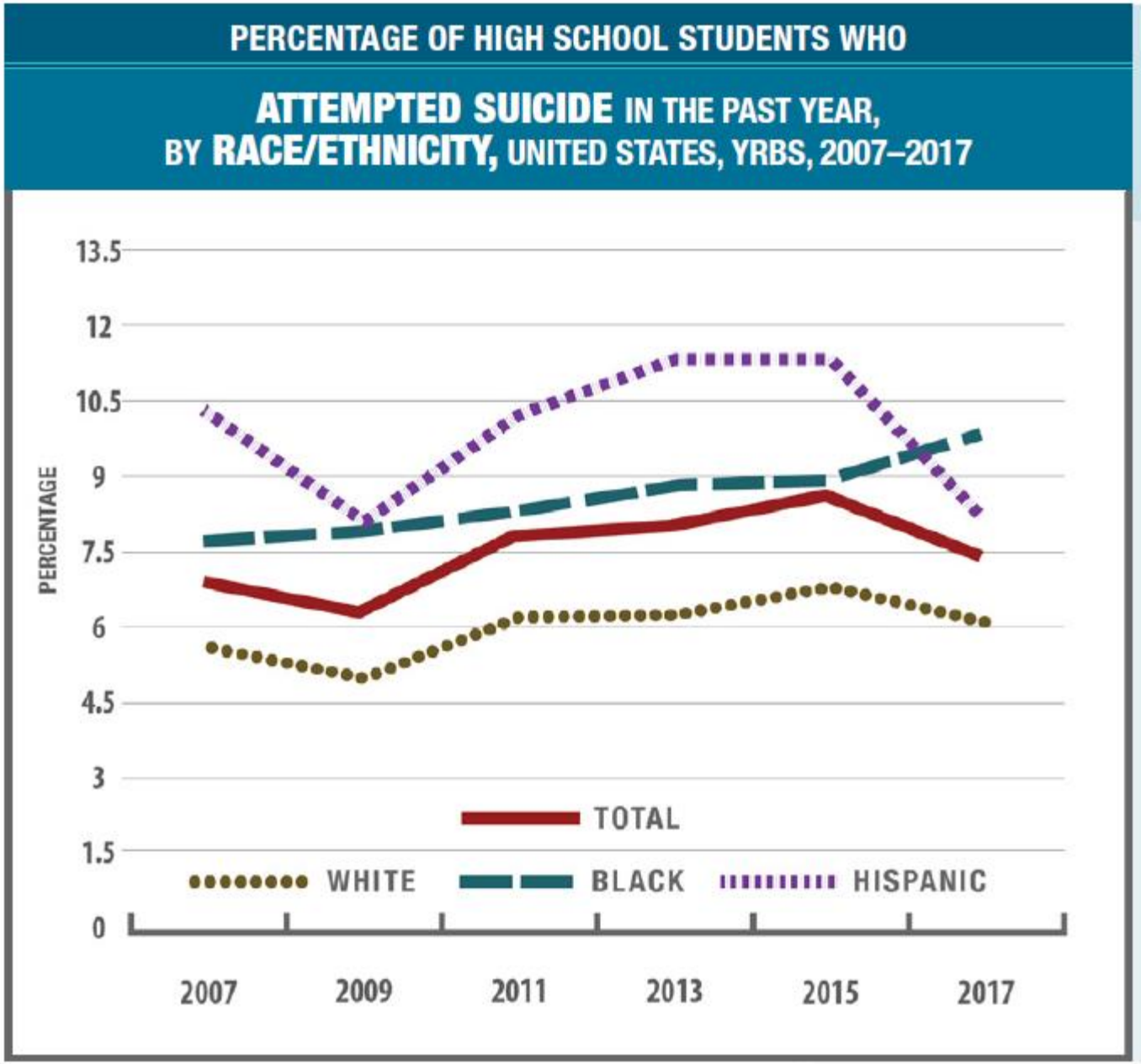
Youth Suicide Rates by Age (Ages 6-24)

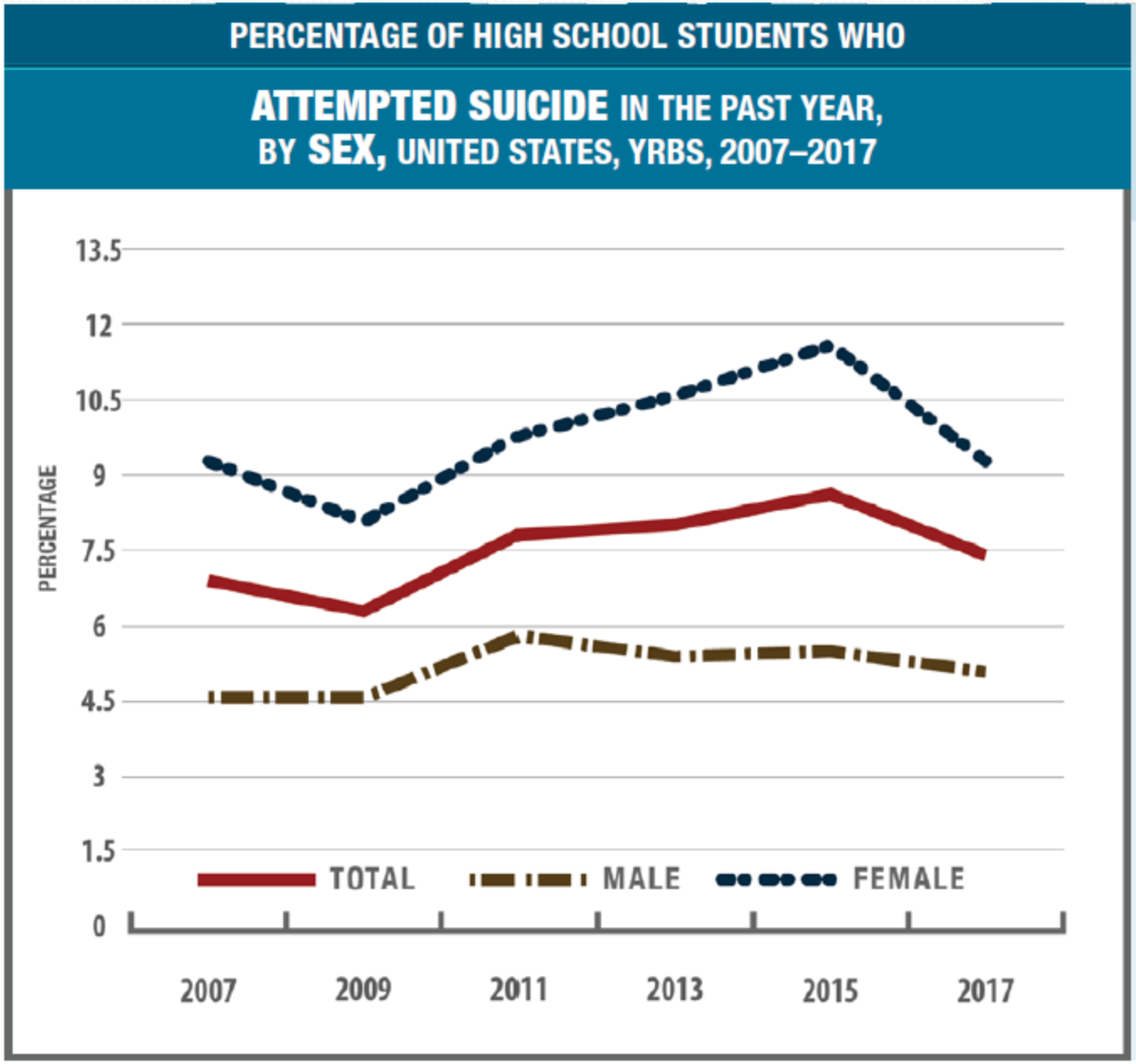


Youth Suicidal Behaviors




PERCENTAGE OF HIGH SCHOOL STUDENTS WHO
SERIOUSLY CONSIDERED ATTEMPTING SUICIDE IN THE PAST YEAR, BY SEX AND BY RACE/ETHNICITY, UNITED STATES, YRBS, 2017
PERCENTAGE
27
24
21
18
15
12
9
6
3
0
17.2
11.9
22.1
17.3
14.7
16.4
TOTAL
MALE
FEMALE
WHITE
BLACK
HISPANIC
SEX
RACE/ETHNICITY


PERCENTAGE OF HIGH SCHOOL STUDENTS WHO
ATTEMPTED SUICIDE IN THE PAST YEAR,
BY RACE/ETHNICITY, UNITED STATES, YRBS, 2007–2017
PERCENTAGE
13.5
12
10.5
9
7.5
6
4.5
3
1.5
0
TOTAL
WHITE
BLACK
HISPANIC
2007
2009
2011
2013
2015
2017


PERCENTAGE OF HIGH SCHOOL STUDENTS WHO
ATTEMPTED SUICIDE IN THE PAST YEAR,
BY SEX, UNITED STATES, YRBS, 2007–2017
PERCENTAGE
13.5
12
10.5
9
7.5
6
4.5
3
1.5
0
TOTAL
MALE
FEMALE
2007
2009
2011
2013
2015
2017

Adverse Childhood Experiences (ACEs)

1. Child physical abuse
2. Child sexual abuse
3. Child emotional abuse
4. Neglect
5. Mentally ill, depressed or suicidal person in the home
6. Drug addicted or alcoholic family member
7. Witnessing domestic violence against the mother
8. Loss of a parent to death or abandonment, including abandonment by divorce
9. Incarceration of any family member

FAMILY • POLICY • COUNCIL
A FAMILY, COMMUNITY & STATE PARTNERSHIP

ACEs & Suicide: Probability of Sample Outcomes Given 1,000 U.S. Adults

330
Report No ACEs

WITH 0 ACEs

1 in 16 smokes

1 in 69 are alcoholic

1 in 480 uses IV drugs

1 in 14 has heart disease

1 in 96 attempts suicide

510
Report 1-3 ACES

WITH 3 ACEs

1 in 9 smokes

1 in 9 are alcoholic

1 in 43 uses IV drugs

1 in 7 has heart disease

1 in 10 attempts suicide

160
Report 4-8 ACEs

WITH 7+ ACEs

1 in 6 smokes

1 in 6 are alcoholic

1 in 30 use IV drugs

1 in 6 has heart disease

1 in 5 attempts suicide

FAMILY • POLICY • COUNCIL
A FAMILY, COMMUNITY & STATE PARTNERSHIP

Non-Suicidal Self-Injury

Adapted from Paul Quinnett, Ph.D., President & CEO, QPR Institute

Terminology

- At different times, this behavior has been called different things: self-injury, self-mutilation, self-harm, non-fatal suicide attempt, and more.
- The term used currently is:

non-suicidal self-injury

What is non-suicidal self-injury?

- Non-suicidal self-injury (NSSI) is the deliberate, self-inflicted destruction of body tissue resulting in immediate damage, without suicidal intent and for purposes not culturally sanctioned.

Definition of Suicide Attempt

- “Any potentially self-injurious action, with a nonfatal outcome, for which there is evidence, either explicit or implicit, that the individual intended to kill himself or herself.”
  - From Carol, Berman, Maris, et. al., *Journal of Suicide and Life-Threatening Behavior*, 1996
- Notice: the key word is “intended” – it’s not always easy to determine, since some people can’t really decide if they want to live or die.

Potential Self-injurious Behaviors

- Intentional carving or cutting of the skin
- Subdermal tissue scratching
- Burning
- Banging, hitting
- Biting
- Excessive rubbing
- Embedding objects under the skin
- Ingesting objects
- Causing third parties to injure you
- Interfering with healing of wounds
  - “Self-mutilation” is usually reserved for severe self-injury, like cutting off a limb

Body Modifications

- Tattoos and body piercing are not typically considered self-injurious unless undertaken with the intention to harm the body.
- Rather, tattoos are often culturally approved.

What does NSSI look like?

- What defines self-injury has less to do with what it looks like than it does with the intention a person has when doing it.
- NSSI might look like a suicide attempt, so it can be confusing.
- More often, NSSI is frightening to those who see it but who do not know what it means.

NSSI and Alternate States

- The major purpose of NSSI appears to be to affect regulation and management of psychological and emotional distress.
- NSSI can bring an abrupt return to the reality of the moment or to an increased sense of “being alive.”
- NSSI may also help create a dissociative state.

Age Groups and NSSI

- Non-suicidal self-injury is more common in adolescent and young adult populations than previously thought.
- The most common ages that NSSI begins is between 10 and 24 years old.
- As more and varied research takes place, this will become clearer.

Adolescents and NSSI

- Almost 1 in 5 adolescents (17.2%) report some (at least one episode of) NSSI.
- Diminishing prevalence among older ages:
  - 17.2% of adolescents
  - 13.4% among young adults
  - 5.5% among adults
- In the US, the lifetime prevalence is 12% to 37.2% among secondary schoolers, and 12% to 20% in young adults.

Facts About NSSI

- Mostly goes untreated
- Usually an indicator of more serious problems
- Can cause substantial physical damage
- Can lead to “accidental” death
- May worsen over time (behavior on a continuum, more damage)
- May become addictive, as in a form of self-medication
- There is a contagion effect, as in suicide (copycat risk among youth)

Does NSSI increase the risk of suicide?

- Yes, studies show that suicidal intent at the time of deliberate self-injury is known to be associated with risk of future suicide in NSSI patients.
- Among those with a history of NSSI, 70% have attempted suicide at least once and 55% several times (Nock, Joiner, Gordon, et al, *Psychiatry Research, 2006).*
- Lowered inhibition, increased capacity
- Bottom line: if you know someone who is engaged in NSSI, they should be screened and assessed for suicide risk.

What do people who engage in NSSI have in common?

- High levels of depression, suicidal ideation and hopelessness are often characteristic of people who engage in NSSI.
- While NSSI is prevalent among girls and young women, there is no single profile.
- ACEs are a known risk factor

Known Acute Risk Factors

Current experiences:

- Rape/sexual abuse
- Domestic violence
- Psychiatric diagnoses
- Substance use (both alcohol and drugs)

Note: Not everyone who experiences these events goes on to self-harm, but anyone experiencing these problems should be screened for NSSI.

Hospitalizations: Tip of the Iceberg

- Those people who show up at hospitals for NSSI represent only a fraction of all those who self-injure.
- And then there is intentional life-threatening behavior (ILTB) in which people engage in behavior that may cause death, but their intention to die is not clear or stated.

NSSI and Pain

- Physical pain may not be present during some NSSI.
- Overdoses produce no immediate physical pain.
- Pain thresholds vary from person to person and from episode to episode.
- Some individuals report little or no pain at the time of the injury but do so later.
- Others experience pain at the time, but the physical pain relieves the emotional pain.
- For many, handling physical pain (in the short run) is described as “easier” than dealing with the enormity of their emotional pain.
- Pain offset, removal/reduction effect for physical and emotional pain

Youth are Very Reluctant to Seek Help

- 50% do not seek help at all; 30% contact social workers; and only 20% ask for medical treatment.
  - This care is often performed by people who are not knowledgeable/trained about NSSI.
- We must keep our eyes open to the possibility of NSSI, watch for warning signs, and be ready with our compassion, our trained support, and our questions.
- Practice “respectful curiosity”

LGBTQ Suicide

- No **inherent** risk related to sexual orientation
- LGBTQ people experience higher rates of violence, bullying, verbal abuse, peer rejection, family rejection, and social isolation than heterosexuals
  - Higher rates of depression, anxiety, and co-occurring disorders
- As a group, gay/lesbian/bisexual **youth** are at a higher risk for suicidal behavior
- Social environment plays a key role

LGBTQ Suicide

- 50% of trans gender and bi sexual youths seriously considered suicide last year
- 33% of trans gender and bi sexual youths attempted suicide last year

College/University Students

- 6.5 to 7.5 per 100,000
  - Fewer firearms
  - More female than male
  - 77% do not want to disappoint family
  - 40% want to complete their degree
  - Approximately half the rate of nonstudent college-aged adults

College/University Students

- 31% report anxiety symptoms
- 37% report depression symptoms
- 45% report binge drinking in last 30 days
- 13% considered suicide
- 6% made a plan
- 2% attempted

STUDENTS IN WASHINGTON

80%
Emotional stress hurt academics in last month

28%
Students screened positive for depression

4%
Students developed suicide plan in last year

Healthy Minds Study WA, 2017, 13 WA Campuses

Veteran Suicide

- Suicide rate:
  - Active military: 20 per 100,000 (2018)
  - Deployed military: 30 per 100,000 (2014)
  - 3-4x lifetime risk
- Suicide rates decrease among veterans aged 18-29 who use VA health care services
  - Only 20% of vets receive VA services
- Veterans are more likely than the general population to use firearms as a means for suicide

Veteran Suicide

Compared to the general population, veterans have additional risk factors:

- Higher poverty
- Higher unemployment
- More often live in rural areas
- Less likely to ask for help
- Combat & training consequences
  - Fearlessness
  - Avoidance of feelings; toughness
  - Comfortable with firearms
  - Traumatic brain injury
  - Emotional trauma

Suicide & Incarceration

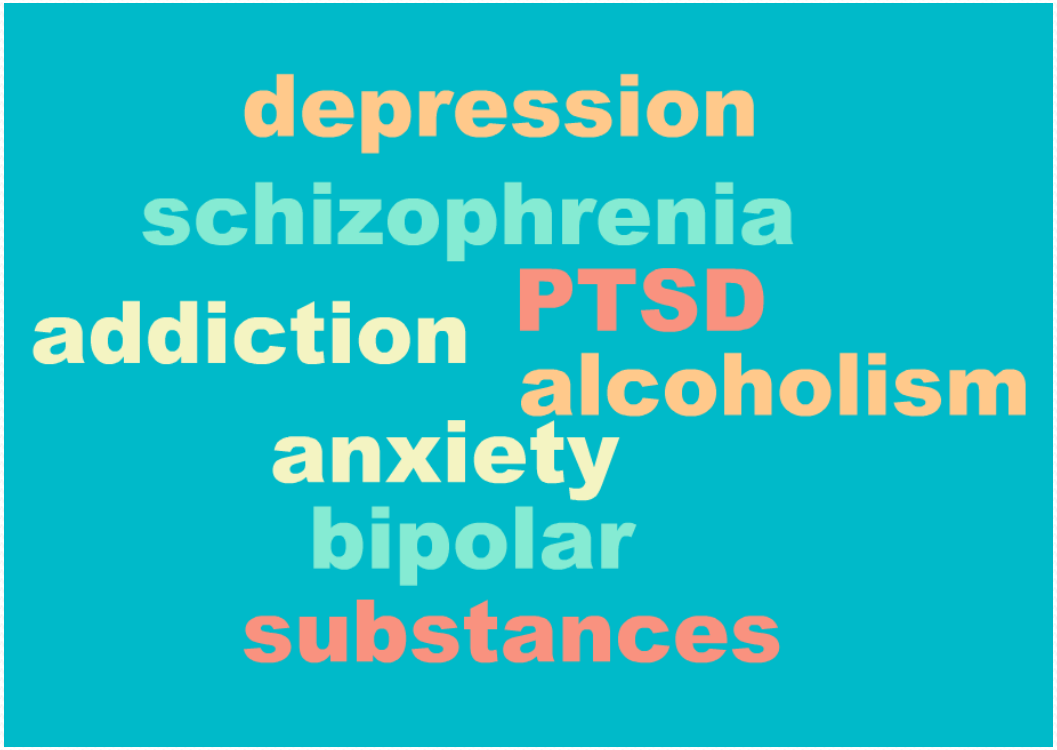
- 47 per 100,000 (jails), 14 (prisons)
- High risk after being booked into jail and upon release
- #2 cause of death in jails, #3 in prisons
  - 51% of suicides occur within first 24 hours of confinement
  - 60% of victims intoxicated at time of confinement
  - 2 out of 3 suicides occur in isolation
- Violent offenders have a rate over twice that of non-violent offenders
- State prison, local jail suicide rates have fallen sharply since the 1980's

Suicide Survivors

A “suicide survivor” is someone who has lost a loved one to death by suicide.

- For every death by suicide, approximately 6 survivors are left grieving
- That’s 775 people per day—283,000 people per year
- As a group, suicide survivors are at elevated risk for suicide
- Individuals with a family history of suicide have a 4 times greater risk of suicide

Suicide Risk & Behavioral Health Conditions



Suicide & Major Depression

- The estimated lifetime risk of suicide from untreated major depressive disorders is approximately **15%**.
- Signs and symptoms of depression are leading indicators for suicides and suicidal behaviors.
- Compliance with medication and treatment regimes is essential to safety – most attempts take place when person is off their medication.
- ***Individuals and family members need to be counseled that death by suicide is a real risk when discontinuing anti-depression medications.***

Post-Partum Depression

- 40% of postpartum women suffer a mood disorder (weeks or even months after birth)
- 10-15% of postpartum women suffer from postpartum depression
- Depression is a major risk factor for suicide; any indication of self-harm, harm, or suicidal ideation should be taken seriously
- Postpartum depression relapses at a higher incidence with each subsequent birth
- Overall, depression is twice as common in women as it is in men

Bipolar Disorder & Suicide

- Suicide is the number one cause of death
- Suicide attempt rates:
  - Major depressive disorder 20%
  - Bipolar disorder 24%
  - General population 1%
- High risk windows:
  - Early phases of the illness
  - When the individual is resistant to accepting the diagnosis
  - During mixed states
- A combination of psychotherapy and medications is more effective than either treatment alone
- Lithium has pronounced anti-suicide effect
  - Lithium works best for those who won't take it!
    - Decreases aggression and impulsivity

Schizophrenia & Suicide

- Major risk factors:
  - Young age (ages 15-40 / first 5 to 10 years of illness)
  - Early in the course of the illness
  - Substance use
  - Multiple episodes of psychosis / current psychotic symptoms
  - Command auditory hallucinations for suicide
  - Depressed mood / major depressive episode
  - Inadequate pharmacology / symptom control
  - Recent hospital discharge (especially initial hospitalization)
  - Living alone
  - History of previous attempt(s) / Family history

Schizophrenia & Suicide

- 10-15% will die by suicide
  - Leading cause of death for those under 35
- 20-40% of those with a diagnosis of schizophrenia will make a suicide attempt
- CBT and antipsychotic medications have been associated with lower risk
- Improving on medications is often one of the most dangerous times for someone with a diagnosis of schizophrenia.

Borderline Personality Disorder & Suicide

- Individuals with a diagnosis of BPD experience high levels of self-harm, threats & non-lethal attempts
- Have a lifetime suicide rate of 8.5%
  - With alcohol problems: increases to 19.0%
  - With alcohol problems and major affective disorder: increases to 38.0%
- A comorbid condition in over 30% of the suicides.
- Nearly 75% of patients with borderline personality disorder have made at least one suicide attempt in their lives

Substance Use & Suicide

- No safety without sobriety.
- People with substance use disorders are over **six times** more likely to die by suicide than the general population
- Between 40-60% of those who die by suicide are intoxicated at the time of death (typically prescription opiates, heroin, or alcohol)
- Individuals who use opiates, cocaine, and sedatives may have a noticeably higher risk of suicide than those who use other drugs
- Substance use combined with clinical depression creates the greatest risk
  - The rate of major depression is 2-4x higher among individuals with severe substance use disorders than in the general population

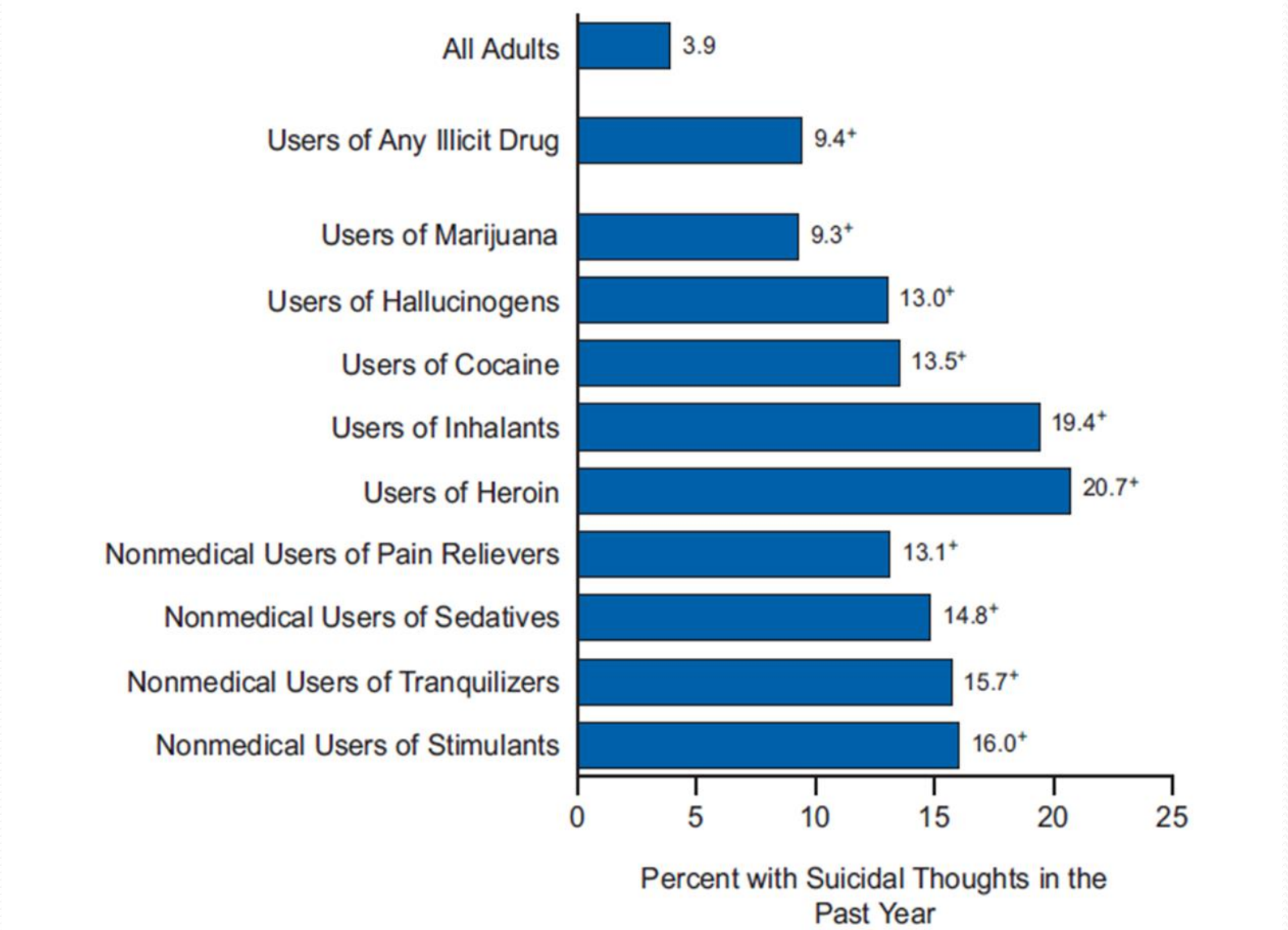
Alcohol and Suicide

- Highest risk group: major depression and alcoholism.
- 24-33% of individuals were legally drunk at the time of the suicide (consistent across ethnic groups, higher rates for men than women).
- Alcoholism may be the strongest single predictor of subsequent completed suicide after an initial attempted.
- Suicide rates are 8% higher in 18-20 year olds in states with lower minimum age limits for purchasing alcohol.
- During *perestroika* in Russia (1984-90) when the cost of alcohol substantially increased, suicide rates dropped 31% for men & 19% for women.
- 25%-30% suicides are by those with a diagnosis of alcohol abuse or dependence.

Alcohol & Suicide

- Alcohol impairs judgment, decreases inhibition, and increases impulsivity & aggressiveness
- Major risk factors: male, long-term drinker, co-morbid psychiatric disorder
- Alcoholism erodes protective factors: loss of job, health, home, money, family & friends
- Alcohol myopia: increased concentration on immediate events, reduced awareness of events which are distant (consequences)
- Alcohol increases the lethality of some medications, making an attempt via overdose more likely lethal

Suicidal Thoughts among Adults (2013)



Addiction Treatment Works

Suicide Attempts

Age	Year Prior to Treatment	Year After Treatment
25 and up (n=3524)	23%	4%
18-25 (n=651)	28%	4%
Adolescents (n=236)	23%	7%

Source: National Treatment Improvement Evaluation Study

Residential - Inpatient

1. Severe psychiatric anxiety or agitation
   - Unable to settle, crawling out of their skin, mix bipolar state
2. Ruminations
   - Unable to redirect, may be combined with #4 below
3. Global insomnia
   - Significant risk factor, exacerbates other symptoms, fatigue, disorientation, mania
4. Delusions of gloom and doom
   - Especially end of the world, no way out, increases hopelessness
5. Recent alcohol use
   - Not necessarily alcoholic, drinking to medicate the above, numbing of psych-ache

The Many Paths to Suicide

Fundamental Risk Factors

Biological

- Genetic Load
- Sex
- Race
- Age

Personal/Psychological

- Child Abuse
- Loss of Parent
- Culture Shock/ Shift
- Values Religion Beliefs
- Drugs or Alcohol

Environmental

- Season of year
- Geo-graphy
- Urban vs. Rural
- Model for Suicide

Proximal Risk Factors

"Triggers or Final Straws"

- Crisis in Relation
- Loss of Freedom
- Fired/ Expelled
- Illness
- Major Loss
- ?

Increasing Hopelessness Contemplation of Suicide as Solution

WALL OF RESISTANCE

Cause of Death

- Poison
- Gun
- Hanging
- Autocide
- Jumping
- ?

- All "causes" are real.
- Hopelessness is the common state.
- Break the chain anywhere = prevention.

QPR For Suicide Prevention

Hopelessness & Risk

Hopelessness corrupts.

Absolute hopelessness corrupts absolutely.

"Suicide prevention…is the restoration of hope in the hopeless."

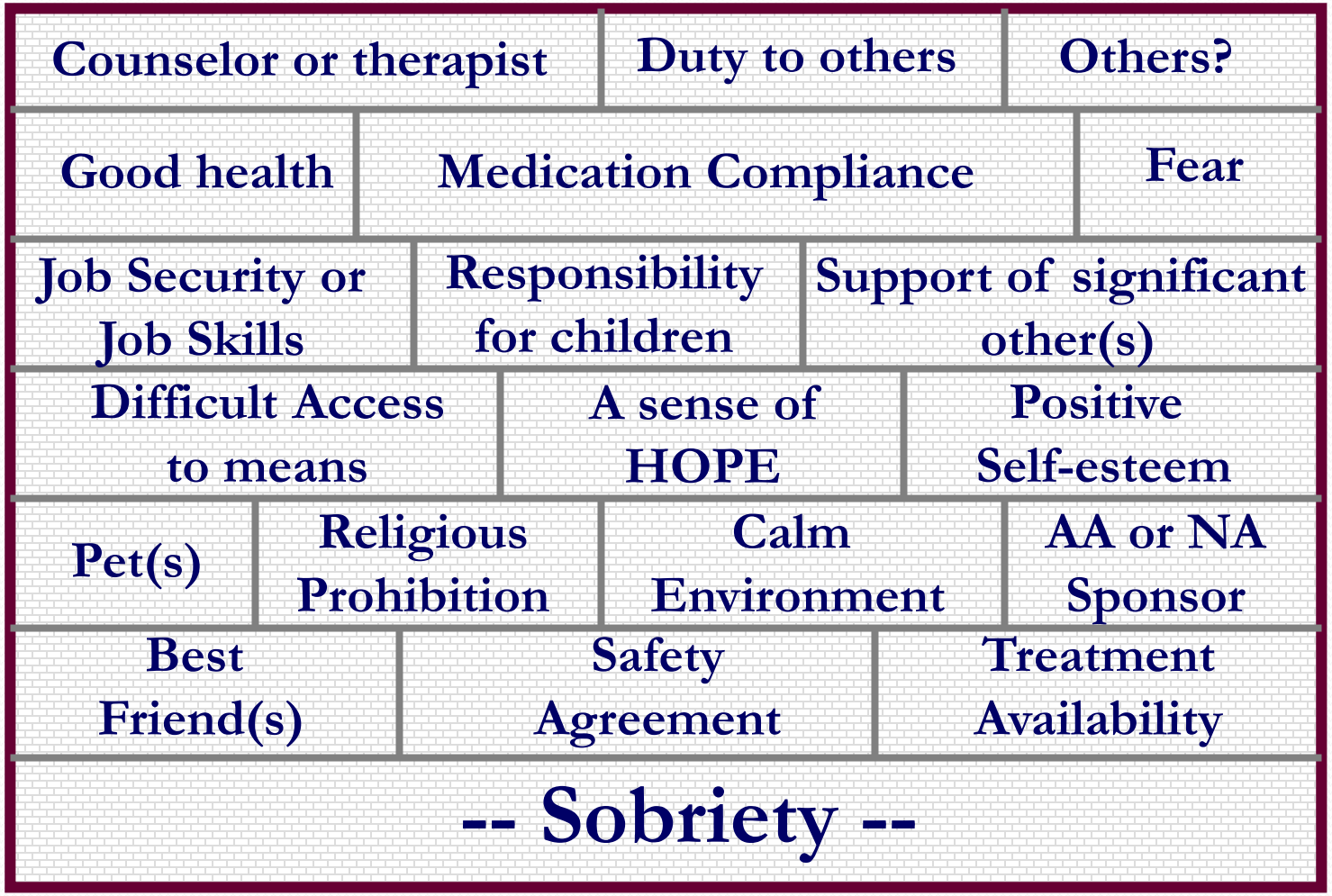
Protective Factors

- Clean & sober
- Active in treatment
  - Mental health, chemical dependency, medication
- Support network
- Duties or responsibilities to others (children, pets, work, etc.)
  - Responsibility for a child is the best protective factor for women
- Safe environment
- Access to resources
  - Community, treatment, basic needs

Protective Factors (cont.)

- Self-care skills
- Emotional management & regulation skills
- Decision making & problem solving skills
- Clear plan of action (safety planning)
- Difficult access to means (lethal means restriction)
- Positive self-esteem
- Commitment to choose life
- A sense of hope

Wall of Resistance to Suicide



QPR For Suicide Prevention

Suicide Intervention & Prevention: The QPRT Process

Paul Quinnett, Ph.D.,
QPR Institute

QPR For Suicide Prevention

The Challenge

- There is **no psychological** test for predicting suicide.
- The suicide rate for people receiving mental health services is **385 per 100,000** (compared to 12 per 100,000 for general population).
- **About 90%** of all individuals who died by suicide had **communicated explicit intent** to a significant other during the period prior to their death.
- The absence of suicidal ideation ≠ no suicide risk.
- The denial of suicidal ideation ≠ no suicide risk.
- A sudden improvement in symptoms and mood should not be interpreted as a resolution of the suicidal crisis.

Recovery & Suicide Prevention

- Brain disorders are treatable
- Depression is highly treatable
- Alcoholism and substance abuse are highly treatable
- Medications work
- Psychotherapy works (50% reduction)
- Medications and therapy work best

"If recovery is possible, suicide is preventable!"

The Four Cornerstones of the QPRT Approach

Those who most need help in a suicidal crisis are the least likely to ask for it.	*Therefore, we must find our at-risk citizens and go to them with help without requiring that they ask for it first.*

The person most likely to prevent you from dying by suicide is someone you already know.	*Therefore, those around us must know what to do if we become suicidal.*

The Four Cornerstones of the QPRT Approach

Prior to making a suicide attempt, those in a suicidal crisis are likely to send warning signs of their distress and suicidal intent to those around them.	*Therefore, learning these warning signs and taking quick, bold action during these windows of opportunity can save lives*.
When we solve the problems people kill themselves to solve, the reasons for suicide disappear.	*Therefore, crisis intervention, problem resolution and treatment save lives*.

Why QPR?

- QPR stands for Question, Persuade and Refer:
  - An emergency intervention that teaches lay people and professionals the skills to recognize and respond positively to someone exhibiting suicide warning signs and behaviors, and make appropriate referrals.
- Each letter in QPR represents an idea and an action step
- Asking Questions, Persuading people to act, and making a Referral are established adult skills
  - These are not new skills
- QPR intentionally rhymes with CPR – another universal emergency intervention – making it easy to remember

QPRT as a Risk Assessment Tool

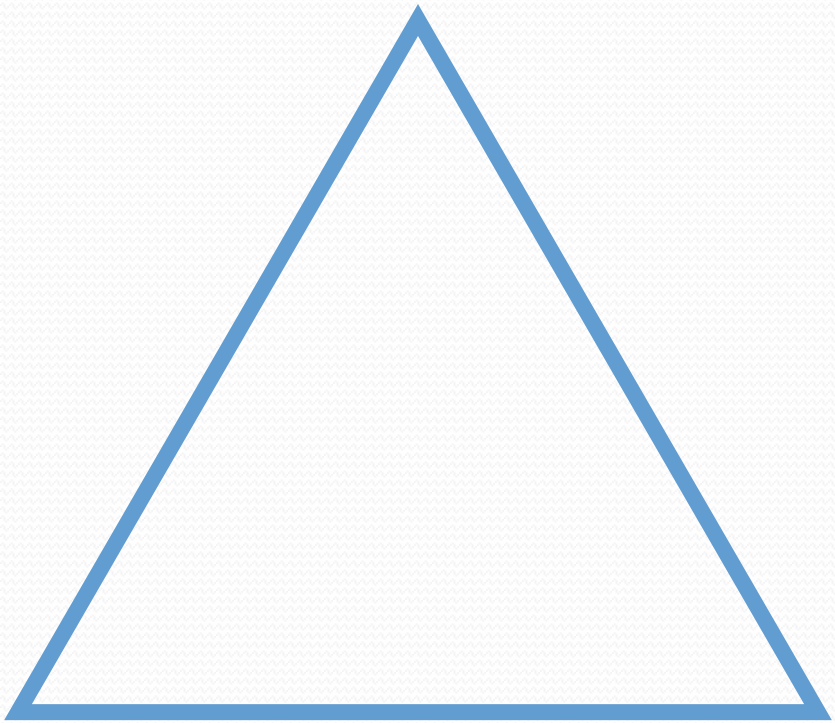
- The QPRT process encourages routine suicide risk assessment
- QPRT contains no number or score.
- QRPT is not a substitute for:
  - A proper diagnostic work-up
  - A thorough mental status exam
  - A comprehensive psychological exam
  - A detailed social or medical history
  - Good clinical judgment

QPRT as a Risk Assessment Tool

- QPRT effectiveness depends upon the quality of the therapeutic relationship
- The QPRT inventory can help build rapport, understanding and trust
- Was developed for ages 15 and above
  - A pediatric version has been developed for ages 12-15 and under
- QPRT is effective for periodic monitoring and for the re-assessment of risk

The Lethal Triad

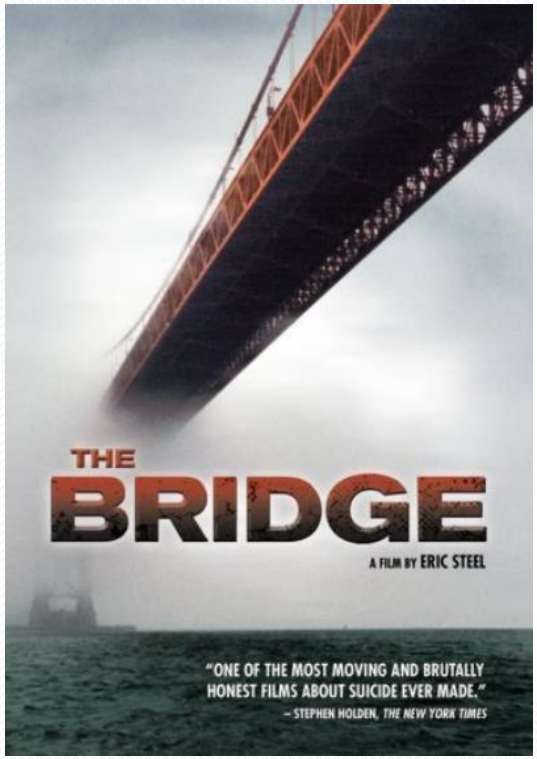
UPSET PERSON

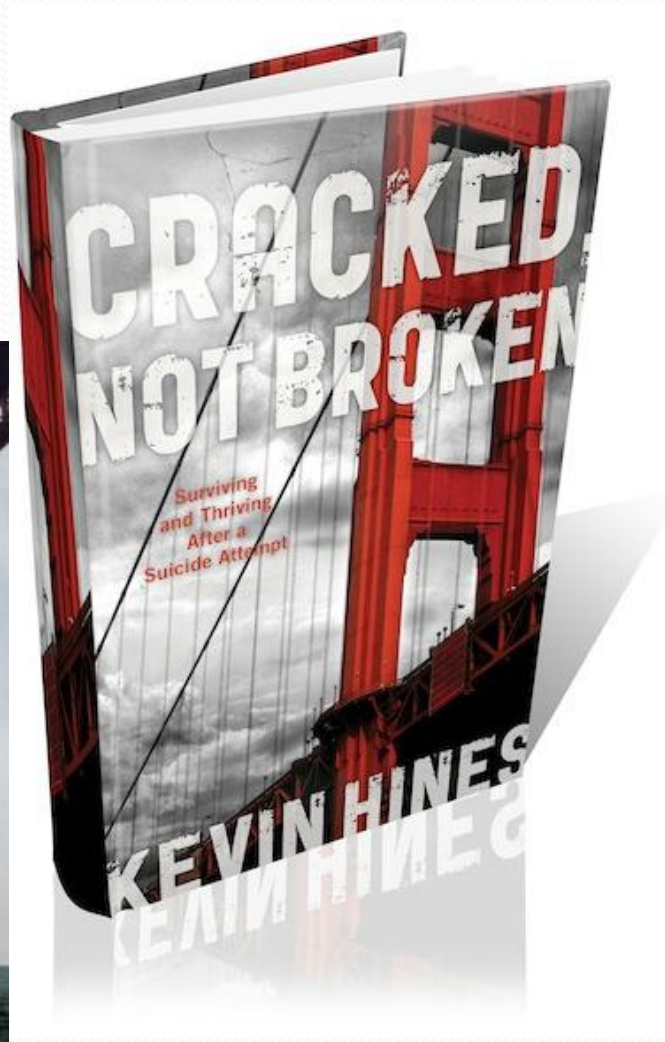


WEAPON **ALCOHOL/DRUGS**

When these three are present – the risk of violence is <u>very high</u>.

Kevin Hines' Story





Suicide Clues & Warning Signs

- Types of signs or clues:
  - Verbal
  - Behavioral
  - Emotional
  - Situational

The more clues and signs observed, the greater the risk. Take all signs seriously.

Direct Verbal Clues

- “I’ve decided to kill myself.”
- “I wish I were dead.”
- “I’m going to commit suicide.”
- “I’m going to end it all.”
- “If (such and such) doesn’t happen, I’ll kill myself.”

Indirect Verbal Clues

- “I’m tired of life, I just can’t go on.”
- “My family would be better off without me.”
- “Who cares if I’m dead anyway.”
- “I just want out.”
- “Nobody needs me anymore.”
- “I won’t be around much longer.”
- “Pretty soon you won’t have to worry about me.”

Behavioral Clues

- Any previous suicide attempt
- Acquiring a gun or stockpiling pills
- Co-occurring depression, moodiness, hopelessness
- Putting personal affairs in order
- Giving away prized possessions
- Sudden interest or disinterest in religion
- Drug or alcohol abuse, or relapse after a period of recovery
- Unexplained anger, aggression and irritability

Situational Clues

- Financial problems (their own or within the family)
- Sudden loss of freedom/fear of punishment
- Feeling embarrassed or humiliated in front of peers
- Victim of assault or bullying
- Being fired or being expelled from school
- A recent unwanted move
- Loss of any major relationship
- Death of a loved one, especially if by suicide

Other Signs of Distress

- Change in interaction with family & friends
- Recent disappointment or rejection
- Sudden decline or improvement in academic or job performance
- Increased apathy
- Physical symptoms: eating disturbances, changes in sleep patterns, chronic headaches, stomach problems, sleeplessness

Warning Signs of Suicidal Risk

I - IDEATION - Threats to hurt or kill him or herself, or talking of wanting to hurt or kill him/herself. Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means. Talking or writing about death, dying or suicide, when these actions are out of the ordinary.

S - SUBSTANCE - Increased alcohol or other drug use

P - PURPOSE - No reason for living; no sense of PURPOSE in life

A - ANXIETY - Agitation and unable to sleep or sleeping all the time

T - TRAPPED - Feeling TRAPPED, like there's no way out

H - HOPELESSNESS

W - WITHDRAWING from friends, family and society

A - ANGER - Rage, uncontrolled ANGER, seeking revenge

R - RECKLESS - Acting RECKLESS or engaging in risky activities, seemingly without thinking*

M - MOOD - Dramatic mood changes

* Sometimes referred to as intentional life threatening behavior (ILTB)

The “Q” of QPRT

- Stands for?

Question!

The “Q” of QPRT – Question

Ask the **“S” Q**UESTION

- Are you thinking of committing suicide?
- Have you ever wished you were dead or wished you could go to sleep and not wake up?
- Have you had any thoughts about killing yourself?
- When people are as upset as you seem to be, they sometimes wish they were dead. I’m wondering if you’re feeling that way, too?”
- Are thinking of harming yourself?
- Do you ever think about killing yourself?
- When was the last time you thought about suicide?
- Others?

Simply asking the question may lower the risk for suicide.

The “Q” of QPRT – Question

What prevents us from asking?

- Fear of being wrong
- Fear of being right
- Fear of being embarrassed or uncomfortable
- Fear you may plant the seed or cause it to happen
- Not knowing how/inexperience

Asking is difficult, not asking is dangerous.

The “Q” of QPRT – Question

- If the answer to the “S” question is YES, then assess the immediate risk:
  - Have you thought about how you would kill yourself?
  - Do you have a plan?
  - How are you thinking of doing it? With what?
  - Have you tried to kill yourself before?
  - When and where?
  - How far have you gone to work out the details?
  - Is there anyone else involved?
  - Why now?
  - What’s wrong?
  - If you leave here, do you think you will follow through with your plan?
  - **What prevents you from following through? Why haven’t you followed through on your plans yet?**
    - ALWAYS end on this question (find reasons for hope)

Assessing for Intensity

- **Frequency** – How often do you have these thoughts?
- **Duration** – How long do these thoughts usually last?
- **Controllability** – Can you stop thinking these thoughts?
- **Deterrents** – Are there things that have stopped you from acting on these thoughts?
- **Reasons** – What sort of reasons do you have for wanting to die or kill yourself?

Evaluating Intent

- Do you really want to die, or do you just want _____ (pain, voices, depression, etc.) to stop?
- What would it accomplish if you were to end your life?
- Do you feel as if you're a burden to others?
- How confident are you that this plan would actually end your life?
- What have you done to begin to carry out the plan?
  - Have you rehearsed what you would do (e.g., opened the pill bottle, held [loaded] the gun, tied the rope, visited the place were you'll carry out the plan)?
- Have you made other preparations?
  - Updated life insurance or will, written notes, made arrangements for pets?
- On a scale from 1 to 10 (1 being not sure, 10 being certain), how likely do you think you are to carry out your plan?
- Assessing for how detailed, realistic, clear and ready the plan is to implement.
- Assessing for "capacity" – how capable is the person of implementing this plan?

Effective Risk Assessment

- Do not rely on a single reporter.
- Do not rely on a single data source.
- **DO** rely on multiple observers.
- Interview everyone possible—be thorough.
- What you don't bother to learn now, you may have to learn later (either in court or after the fact from the family).
- Rely more on what the person is doing versus what he or she is saying.

Effective Risk Assessment

- Shawn Shea, The Practical Art of Suicide Assessment

"In my experience, most errors in suicide assessment do not result from a poor clinical decision. They result from a good clinical decision being made from a poor or incomplete database."

Knock Knock!
-Who's there?
HIPAA!
-HIPAA who?

I can't tell you that.

someecards
user card

The “Q” of QPRT – Question

- If the consumer denies thoughts of suicide:
  - Provider writes a progress note similar to the language provided below, or s/he initials that such a prewritten statement is true of the individual at the time of the evaluation.
- “Client/patient appears to be oriented, alert, and sober. Client’s/ patient’s risk and protective factors were reviewed. He/She denies any suicidal thoughts or feelings at this time. He/She understands current treatment recommendations and knows what to do in the event of increased distress or crisis. Community resource and crisis line numbers were given if emergency assistance is needed.”

The “P” of QPRT

- Stands for?

Persuade!

The “P” of QPRT – Persuade

- The final decision rests with the individual
- Most people experiencing suicidal thoughts and feelings want to find a way to live:
  - Most suicidal people do NOT want to die
  - Suicidal people DO want to find a way to live
  - Ambivalence exists until the moment of death
- Persuading a person to get help begins with listening.
- Listen for the problem(s) suicide is intended to solve.
  - Suggest that suicide is not a good option.
  - Suggest better alternatives (problem solving).
  - Find reasons for hope.
    - Draw on “What prevents you from following through?” responses from “Q”

The “P” of QPRT – Persuade

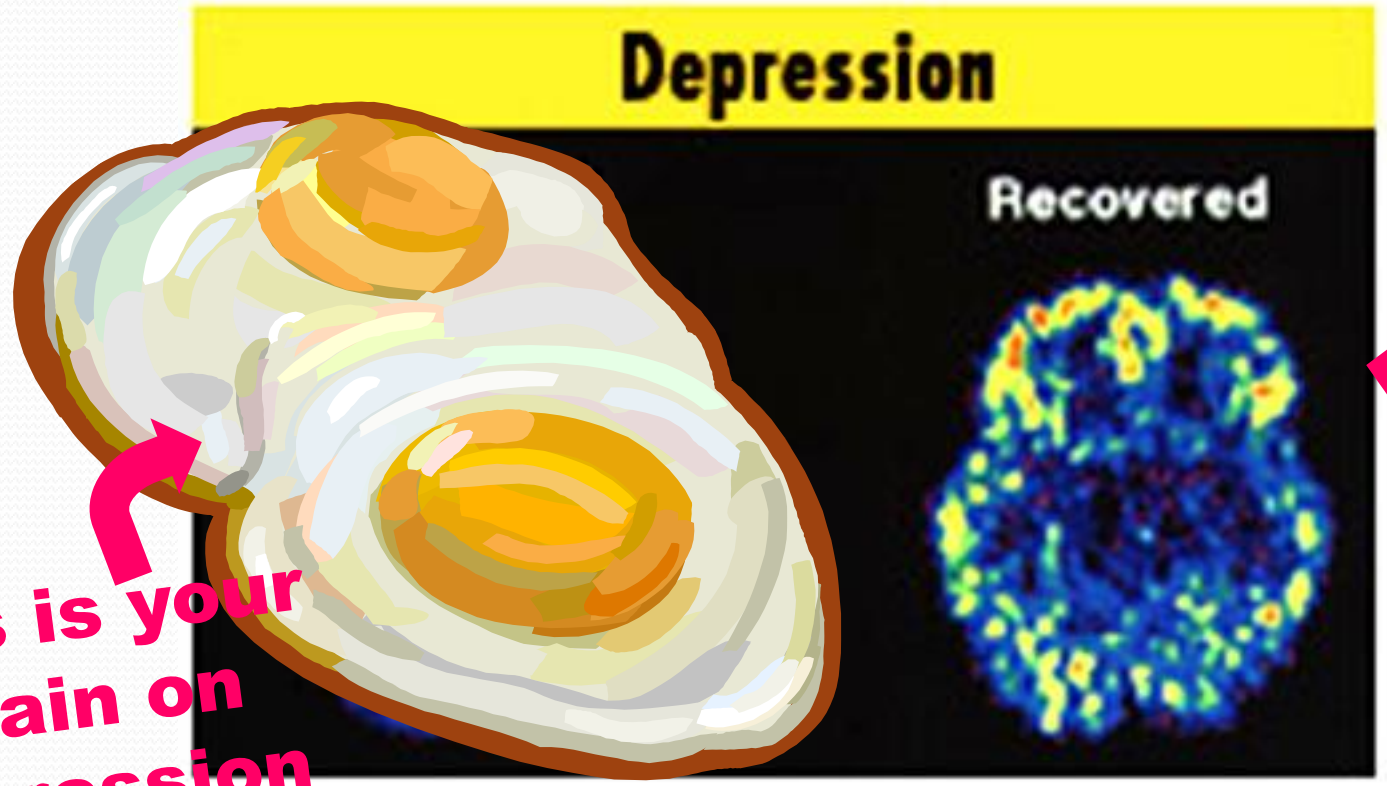
- Persuading a person to get help begins with compassionate listening:
  - Be a friend, supporter, listening ear
  - Give your full attention
  - Do not interrupt
  - Do not judge
  - Avoid condemnation
  - Listen for the problem(s) suicide is intended to solve

Suggesting that suicide is not a good option +

giving suggestions for better alternatives =

HOPE

A Depressed Brain is an Impaired Brain



Warning: Do not use the brain on the left to make a life or death decision.

The “R” of QPRT

- Stands for?

Refer!

The “R” of QPRT – Refer

Once you have persuaded the person to take a different path, what are your referral resources?

- Yourself
- 911
- Local Designated Crisis Responders (DCR)
- Supervisor / Clinical Director
- Other clinicians on your team
- Psychiatrist/Prescriber
- Crisis Lines (local, national)
- Primary Physician
- Family members
- Community supports
- Church/faith groups
- Sponsor
- Community support groups (AA, NA, NAMI)
- Friends
- Others?

Referrals

- Referrals should always be accompanied by some emergency response information (e.g. phone numbers, business cards, Safety Plan, or other printed materials)
- If person is being referred, the individual should be accompanied, when possible, by a responsible adult to the next provider.
- Make sure the person knows what the next steps are in the process.
- Follow up to see if the plan was followed.

Calling for Backup

- How do you know when it is time to call for help?
- When do you call 911?
- When do you refer to a DCR?
- Know your local system, process and contact numbers

Role of DCRs

- What is the role of the DCR?
- What is their responsibility?
- How are they protected by state law?
- What information do they need from:
  - You
  - The client
  - Family members or natural supports

The “T” of QPRT

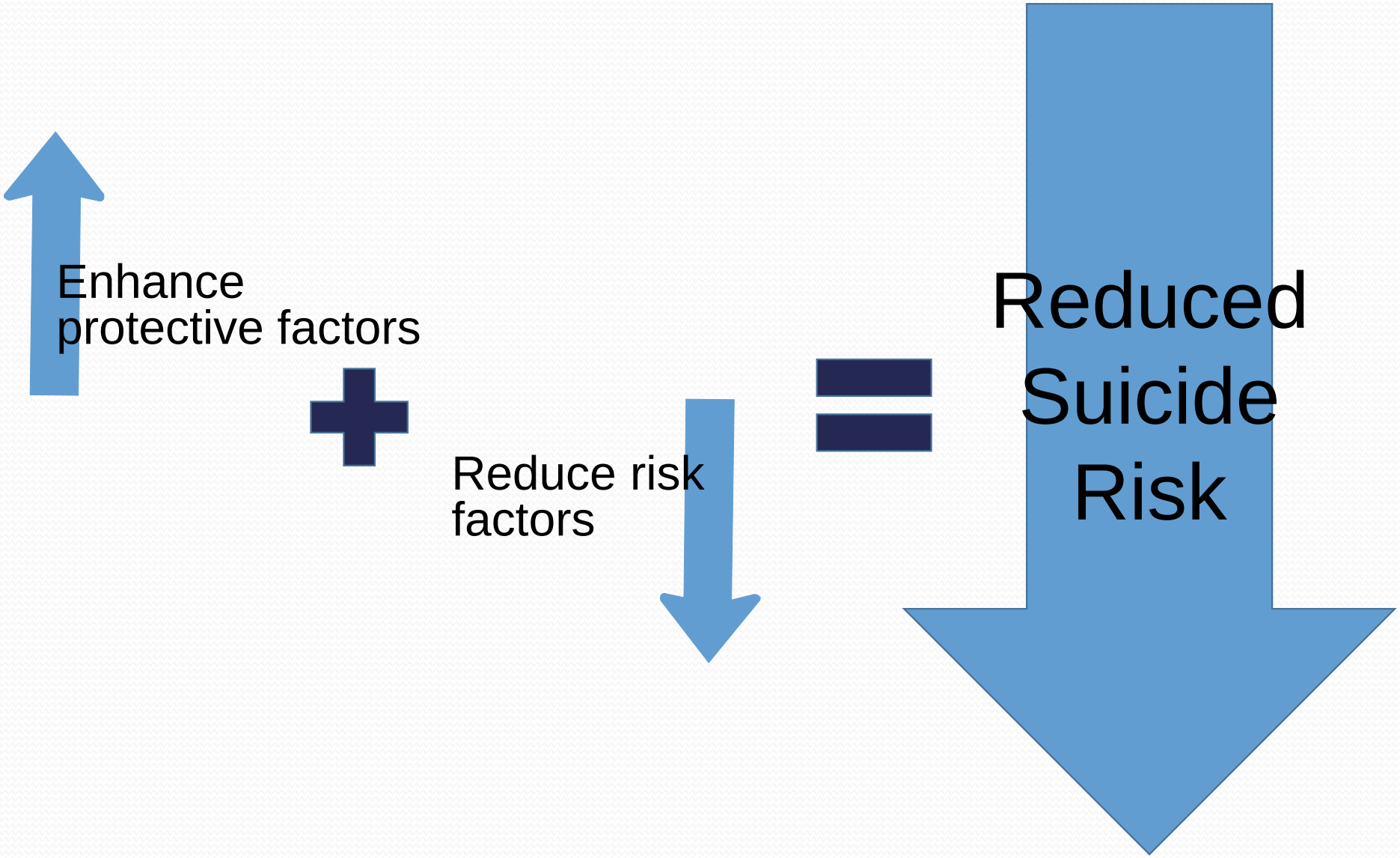
- Stands for?

Treat!

The “T” of QPRT – Treat

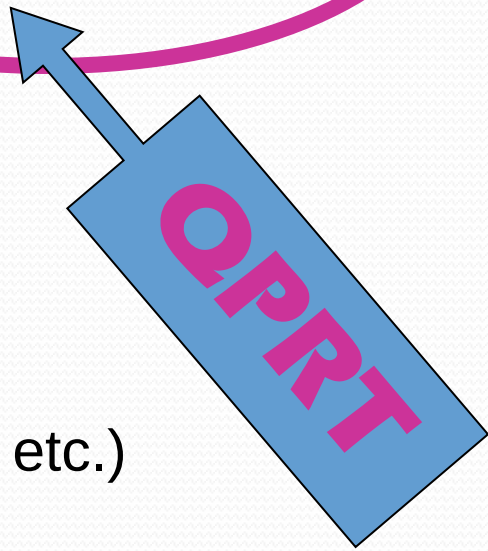
- Crisis intervention
  - Crisis Line
  - You & your team
  - DCRs / Crisis Outreach Professionals / Acute Care
- Detox placement
- Crisis or stabilization beds
- Safety planning
- Counseling
- Medication
- Support
- Family involvement

Safety Planning



Imminent Versus Overall Risk

- Imminent Risk:
  - Right now
  - Suicidal Desire
  - Suicidal Capability
  - Suicidal Intent
  - Intensity (Frequency, Duration, Controllability, etc.)



- Overall Risk Assessment:
  - Takes into consideration all of the above
  - Plus all contemporaneous and historical risk factors
  - Combined with a review of relevant personal protective factors

Can be LOW imminent risk and still be HIGH overall risk.

Suicide Risk Assessment Rating

- **Low**
- **Moderate** → **Develop Safety Plan**
- **High** → **Develop Safety Plan**

  - Adult manual: Pages 19-21
  - Pediatric manual: Pages 15-18

  - Know your organization's policy

Documenting Risk Assessment

- No SI/HI. X
- Client denies suicidal ideation, no plan, or thoughts to harm others. X

No Suicidal Ideation ≠ No Risk

- This is NOT a risk assessment.
- Low predictive value.

Sample Risk Assessment

Jean is at a moderate overall risk for suicide. She has a diagnosis of depression and is in early recovery from alcohol use disorder. She is responding well to medication and is an active participant in treatment. She has limited family support, but has strong peer support where she is living and has recently obtained a sponsor. She is currently unemployed, but plans to return to school next quarter. She has a safety plan and actively participated in its development.

Risk & Protective Factor Case Study – Part 2

- Rate client's risk (Question 4)
- Document your risk assessment (Question 5)

Risk Assessment Confidence

- Before selecting Low, Moderate or High, an indication of assessment confidence should be made. If confidence in the assessment is low, a note should be made to this effect in the documentation such as:
- *Confidence in this assessment is **low** because the client…*
  - ***Has been uncooperative and refused to collaborate in the assessment.***
  - ***Is suspected of being deceitful or guarded in answering questions.***
  - ***Presents information inconsistent with collateral reports.***
  - ***Has or may have psychotic symptoms, especially paranoia.***
  - ***Is or has been recently intoxicated.***
  - ***Has a history of impulsivity.***

Effective Safety Planning

Using the Stanley & Brown Safety Plan Format

Safety Planning

- Reduce suicide risk, ease psychological pain, and enhance coping
- Support the client in learning to manage a suicidal crisis on his or her own, in the moment, while it is happening
- Identify opportunities to prevent a crisis from escalating (prevention)
- Increase treatment motivation, enhance linkages, and build client ownership of the Safety Plan

Origin of Stanley & Brown Safety Plan

- To maintain safety of high risk patients in outpatient treatment trials
- Department of Psychiatry at the University of Pennsylvania, cognitive therapy study for adults
- Treatment of Adolescent Suicide Attempters Study (TASA) with suicidal adolescents
- Expanded and modified as a stand alone intervention for:
  - The Veterans Administration
  - Civilian application in emergency departments
- Widespread use in behavioral health settings as evidence based practice

Theoretical Approaches Underlying the Safety Plan Intervention

Three theoretical perspectives:

1. Suicide risk fluctuates over time (e.g., Diathesis-Stress Model of Suicidal Behavior, Mann et al., 1999)
2. Problem solving capacity diminishes during crises – over-practicing and a specific template enhances coping (e.g., Stop-Drop-Roll)
3. Cognitive behavioral approaches to behavior change (emphasis on behavioral):
   - Behavioral strategies to identify individual stressors that have precipitated suicidal behavior in the past.
   - Client and staff member collaborate to determine cognitive-behavioral strategies patient can use to manage suicidal crises.

It is Critical to Communicate…

- that ending the individual's emotional pain is an important goal and it is possible.
- that coping skills, strategies and support can be identified and used effectively.
- that preserving the person's life is essential.
- support and encouragement that accessing or continuing in services will be helpful.

What is a Safety Plan?

- A brief clinical intervention
- Follows the QPRT risk assessment
- A hierarchical and prioritized list of coping strategies and resources for support during a suicidal crisis
- Helps provide a sense of control
- To be used during, or preceding, a suicidal crisis
- Uses a brief, easy-to-read format that uses the clients' own words
- Provides a way to survive and actively counteract suicidal crisis (teaches the client what 'to do,' an alternative to the 'white knuckle' approach)
- Encourages a commitment to coping (and staying alive)
- Involves close collaboration between the client and clinician

Stanley, B., & Brown, G.K. (with Karlin, B., Kemp, J.E., & VonBergen. H.A.). (2008).
Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version.

“No-Suicide” or “Safety” Contracts

- “No-suicide” or “safety” contracts ask clients to promise to stay alive without telling them **how** to stay alive.
- No-suicide contracts provide a false sense of assurance to the clinician without increasing safety for the client.
- DON’T USE THEM!
- **Do** use a SAFETY PLAN

What Do Clinicians Need to Know Before Starting a Safety Plan?

- The Stanley & Brown Safety Plan format is relatively easy to learn and easy to implement

BUT…

- It is important to remember that the Safety Plan is **NOT** simply a form to complete
- It is designed as a collaborative intervention
- The format provides a framework for a safety discussion
- To do safety plan well involves training, practice, resources, and a willingness to listen to & learn from the client

When Is It Appropriate?

- A safety plan may be done at any point during the assessment or treatment process.
- It follows a QPRT risk and protective factor assessment.
- Safety Plan may **not** be appropriate when patients are at imminent suicide risk or have profound cognitive impairment.
- The clinician should adapt the approach to the client and family's specific needs, and involve family members or other natural supports when appropriate.

Safety Planning

- The Safety Plan is based on the client's willingness to:
  - Remain clean and sober
  - Follow medical/clinical advice
  - Remain active and engaged in treatment
  - See to the removal of the means of suicide to make the environment more safe
  - Be responsible for personal safety & practice self-management of the crisis
  - If that does not work, then seek support and assistance
- Family or support network is also involved and educated.

Safety Planning (cont.)

- Shared safety plan builds trust
- Often provides individual with a sense of relief (a clear plan of action is a protective factor)
- Can also serve as effective test of suicidal person's sense of personal control and safety:
  - Sincere willingness to postpone suicide is a sign of lower risk
  - Unwillingness to postpone, or inability to make good faith commitment to stay alive, is a sign of high risk

6 Steps of Safety Planning

Step 1: Recognizing Warning Signs

Step 2: Using Coping Strategies

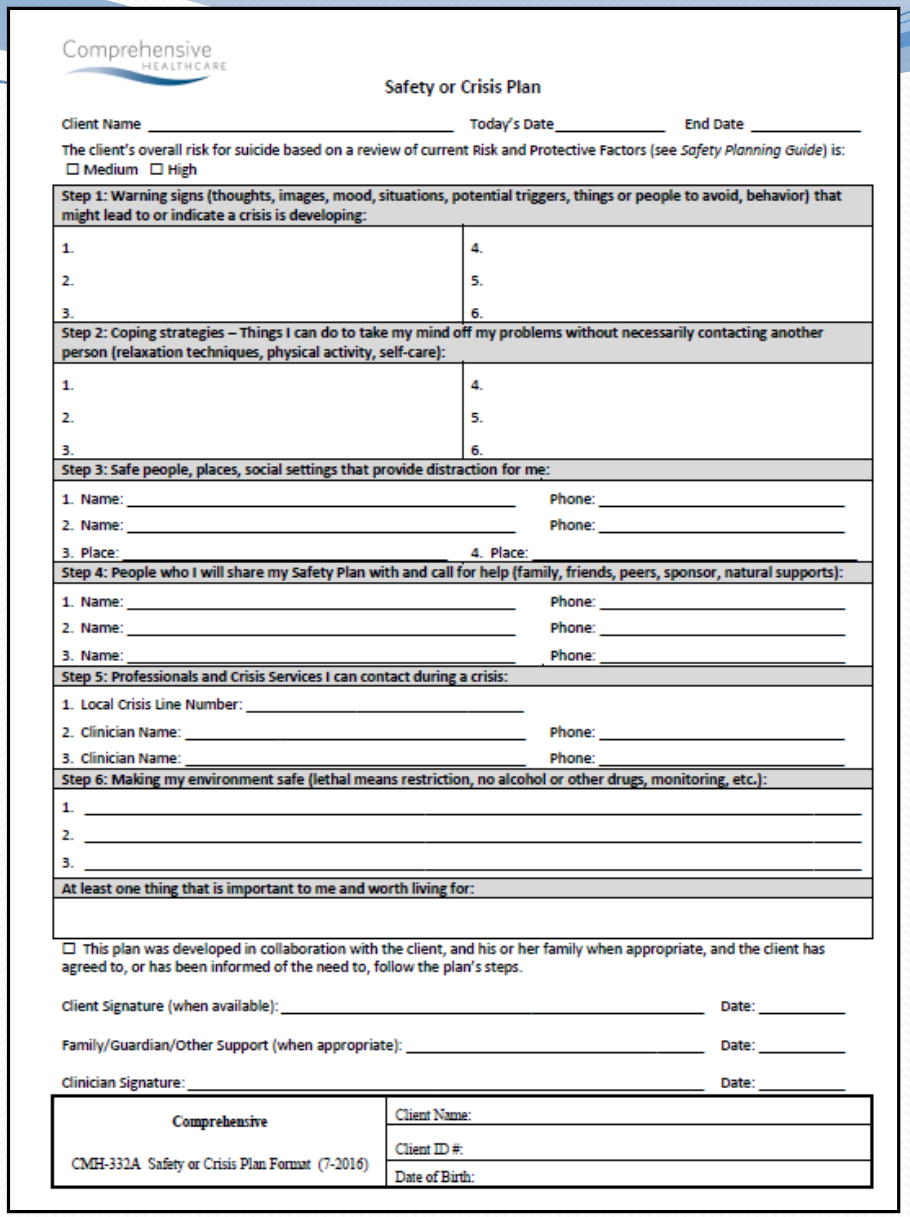
Step 3: Utilizing Social Contacts that Can Serve as a Distraction from Suicidal Thoughts and Who May Offer Support

Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve the Crisis

Step 5: Contacting Professionals and Crisis Support

Step 6: Making the Environment More Safe (including lethal means restriction)

Safety Plan Format



Comprehensive HEALTHCARE

Safety or Crisis Plan

Client Name _____ Today's Date_____ End Date _____

The client's overall risk for suicide based on a review of current Risk and Protective Factors (see *Safety Planning Guide*) is:
☐ Medium ☐ High

Step 1: Warning signs (thoughts, images, mood, situations, potential triggers, things or people to avoid, behavior) that might lead to or indicate a crisis is developing:	
1.	4.
2.	5.
3.	6.

Step 2: Coping strategies – Things I can do to take my mind off my problems without necessarily contacting another person (relaxation techniques, physical activity, self-care):	
1.	4.
2.	5.
3.	6.

Step 3: Safe people, places, social settings that provide distraction for me:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Place: _____ 4. Place: _____

Step 4: People who I will share my Safety Plan with and call for help (family, friends, peers, sponsor, natural supports):

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____

Step 5: Professionals and Crisis Services I can contact during a crisis:

1. Local Crisis Line Number: _____
2. Clinician Name: _____ Phone: _____
3. Clinician Name: _____ Phone: _____

Step 6: Making my environment safe (lethal means restriction, no alcohol or other drugs, monitoring, etc.):

1. _____
2. _____
3. _____

At least one thing that is important to me and worth living for:

☐ This plan was developed in collaboration with the client, and his or her family when appropriate, and the client has agreed to, or has been informed of the need to, follow the plan's steps.

Client Signature (when available): _____ Date: _____

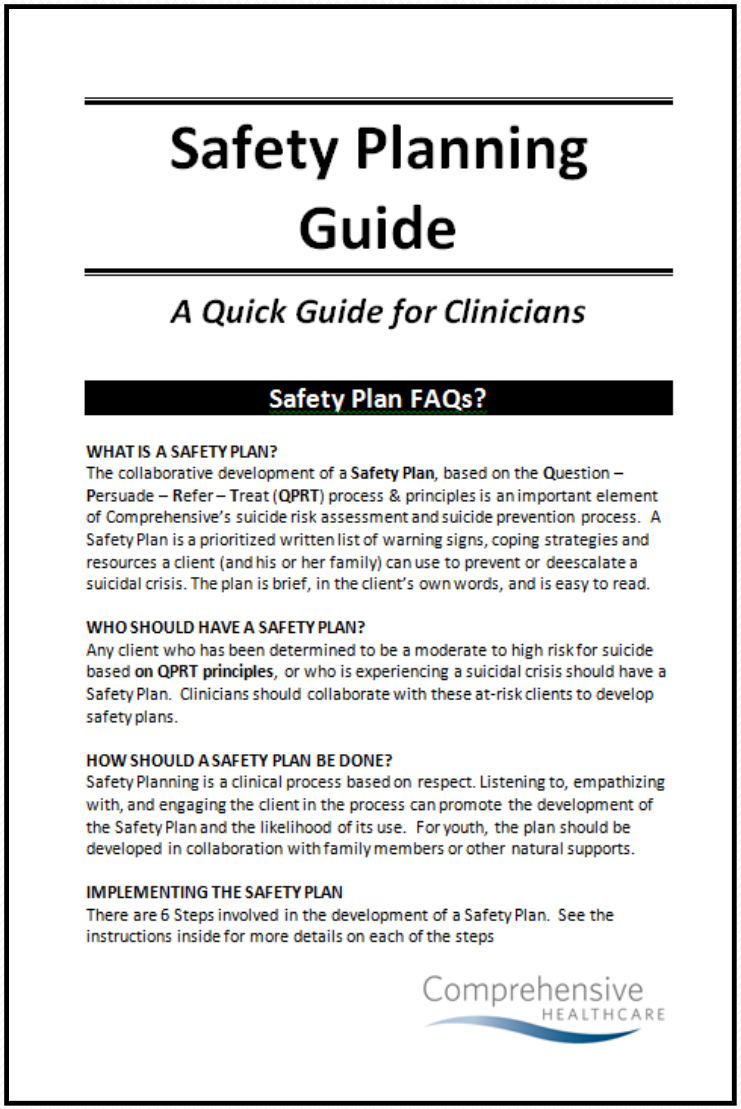
Family/Guardian/Other Support (when appropriate): _____ Date: _____

Clinician Signature: _____ Date: _____

Comprehensive	Client Name:
CMH-332A Safety or Crisis Plan Format (7-2016)	Client ID #:
	Date of Birth:

http://www.sprc.org/sites/default/files/Brown_StanleySafetyPlanTemplate.pdf

Safety Planning Quick Guide



Safety Planning Guide

A Quick Guide for Clinicians

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?
The collaborative development of a **Safety Plan**, based on the **Q**uestion – **P**ersuade – **R**efer – **T**reat (**QPRT**) process & principles is an important element of Comprehensive's suicide risk assessment and suicide prevention process. A Safety Plan is a prioritized written list of warning signs, coping strategies and resources a client (and his or her family) can use to prevent or deescalate a suicidal crisis. The plan is brief, in the client's own words, and is easy to read.

WHO SHOULD HAVE A SAFETY PLAN?
Any client who has been determined to be a moderate to high risk for suicide based **on QPRT principles**, or who is experiencing a suicidal crisis should have a Safety Plan. Clinicians should collaborate with these at-risk clients to develop safety plans.

HOW SHOULD A SAFETY PLAN BE DONE?
Safety Planning is a clinical process based on respect. Listening to, empathizing with, and engaging the client in the process can promote the development of the Safety Plan and the likelihood of its use. For youth, the plan should be developed in collaboration with family members or other natural supports.

IMPLEMENTING THE SAFETY PLAN
There are 6 Steps involved in the development of a Safety Plan. See the instructions inside for more details on each of the steps

Comprehensive HEALTHCARE

Step 1: Recognize Warning Signs

- **Purpose:** To help the client and family, or other natural supports, identify and pay attention to the client's warning signs
- Recognize the signs that immediately precede a suicidal crisis – prevention/early intervention focus
- Personal situations, thoughts, images, thinking styles, mood or behavior
- Ask: "How will you know when the Safety Plan should be used?"
- Specific and personalized examples

Step 1: Recognize Warning Signs

Ask:

- “What do you experience when you start to think about suicide or feel extremely distressed?”
- “How does your body tell you that you are feeling stress?”
- “Are there places or people that are stressful to be around?”

- List warning signs (thoughts, images, mood, situations, potential triggers, things or people to avoid, and/or behaviors) using the client’s own words.

Step 1: Recognize Warning Signs

Automatic Thoughts

- "I am a nobody."
- "I am a failure."
- "I don't make a difference."
- "I am worthless."
- "I can't cope with my problems."
- "Things aren't going to get better."

Images

- "Intrusive images"
- "Flashbacks"

Thinking Processes

- "Having racing thoughts"
- "Thinking about a whole bunch of problems"

Mood

- "Feeling depressed"
- "Feeling hopeless"
- "Intense worry"
- "Intense anger"

Behavior

- "Crying"
- "Not answering the phone"
- "Isolating myself"
- "Using drugs"

Learning Application & Practice

- Volunteer to play a client
- Create a role based on a client or case with which you are familiar
- Observe role play of Step 1
- Look for opportunities for partnering and engagement
- Use the “Quick Guide” for support

Tips for Developing a Safety Plan

- Ways to increase collaboration
  - Sit side-by-side
  - Allow the client to write down his or her own ideas
  - Brainstorm & prioritize first, then transfer to the Safety Plan
- Use motivational interviewing principles & skills
- Brief instructions using the client's own words
- Easy to read
- Address barriers and use a problem-solving approach
- It is the client's plan, only the things they agree to go on the plan

Hierarchy of Action Steps

1
- Know your warning signs
- When will you implement the plan?

2
- Try this first
- If this does not work…

3
- Try this next
- If this does not work…

…
- Try the next step
- Etc.

Step 2: Using Coping Strategies

- **Purpose:** To take the client's mind off of problems to prevent escalation of suicidal thoughts
  - **NOT** to solve the client's problems
- Identify & list activities the client can do without contacting another person
- Activities function as a way to help individuals take their minds off their problems and regulate emotions
- This step helps clients see that they can cope with their suicidal thoughts on their own, even if only for a brief period of time
- Prevents suicidal ideation from escalating

Step 2: Using Coping Strategies

- It is useful to have clients try to cope on their own with their suicidal feelings, even if it is just for a brief time

Ask:

- “What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?”
- “What kinds of things do you find helpful in reducing your stress?”

Step 2: Using Coping Strategies

Examples:

- Go for a walk
- Listen to music
- Emotional regulation skills
- Deep breathing
- Take a hot shower or bath
- Play with a pet
- Journal writing
- Reading
- Praying, meditation, mindfulness
- Cleaning
- Engaging in a hobby
- Practice relaxation techniques
- Physical activity
- Other self-care strategies (eating, sleeping, etc.)

- **Use a collaborative, problem solving approach to address potential roadblocks and identify alternative coping strategies.**
- **List on the plan only things the client is willing to do.**

Step 2: Using Coping Strategies

Assess likelihood of use:

- "How likely do you think you would be able to do this step during a time of crisis?"

If doubt about use is expressed, ask:

- "What might stand in the way of you thinking of these activities or doing them if you think of them?"

Learning Application & Practice

- Find a partner
- Create a role based on a client or case with which you are familiar
- Practice Step 2 only
- One person is the client, the other is the clinician
- Use the “Quick Guide” for support
- Remember to:
  - Assess for likelihood of use
  - Discuss potential barriers and problem-solve

Hierarchy of Action Steps

1
- Know your warning signs
- When will you implement the plan?

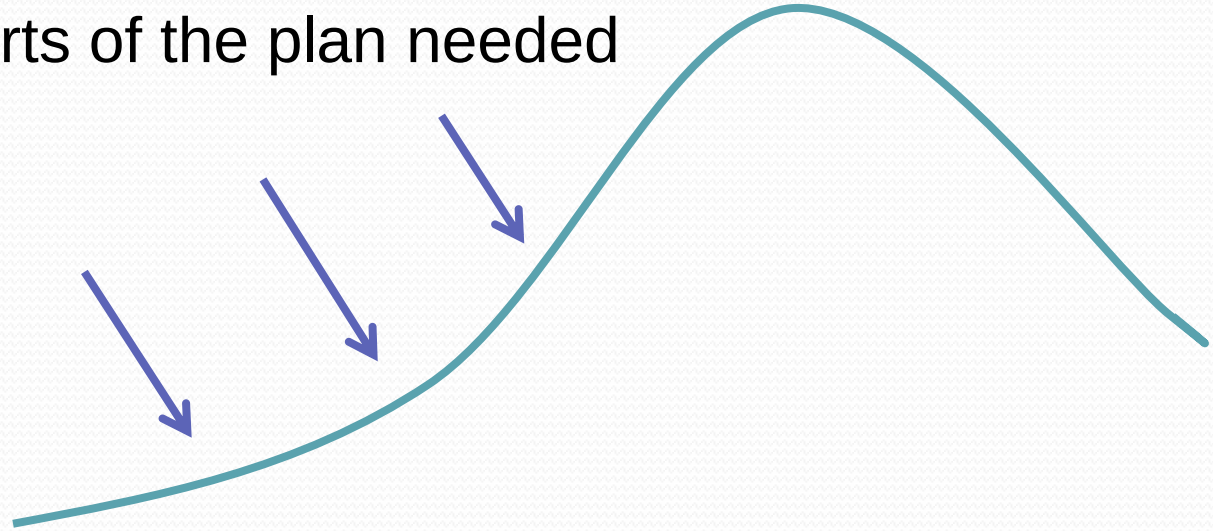
2
- Try this first
- If this does not work…

3
- Try this next
- If this does not work…

…
- Try the next step
- Etc.

The Suicidal Crisis

- Use Safety Planning to prevent the risk from rising too high
- Begins with prevention
- Builds from there
- Multiple intervention points
- Only use the parts of the plan needed



Step 3: Social Contacts Who May Distract from the Crisis

- **Purpose:** To engage with people and social settings that will provide distraction.
- Also increases social connection.
- The client is not telling someone they are in distress during this step.
- Include family, friends, acquaintances, or other natural supports who may offer support & distraction from the crisis.
- Include safe social settings that provide support & distraction, ones that help clients focus outside of themselves.

Step 3: Social Contacts Who May Distract from the Crisis

Ask:

- “Who or what social settings help you take your mind off your problems at least for a little while?”
- “Who helps you feel better when you socialize with them?”
- “Who do you enjoy socializing with?”
- “Where can you go where you’ll have the opportunity to be around people in a safe environment?”
- *Remind*: “You don’t have to tell anyone at this step about your suicidal feelings or distress.”

Step 3: Social Contacts Who May Distract from the Crisis

- Ask the client to list several people and social settings in case the first option is unavailable.
- Include phone numbers on the plan to make it easy to implement this step of the plan.
- Avoid listing any controversial relationships (family conflicts, peers who use, etc.).
- Avoid listing unsafe or risky settings such as bars.
- Use places the client is already familiar (coffee house, clubhouse, library, AA or other self-help meeting, etc.).

Step 3: Social Contacts Who May Distract from the Crisis

- As in the previous step, assess the likelihood that the client will engage in this step.
  - “How likely are you to actually call your mother?”
  - “You suggested your sister, but you have not talked with her in some time. How likely is it that you will contact her when you notice your warning signs?”
- Identify any potential obstacles and problem-solve, as appropriate.
- Only list on the plan the people and places the client will commit to reaching out to for support and distraction.

Learning Application & Practice

- Switch roles
- The person who was the client last time is now the clinician and vice versa
- Can use the same client role or create a new role based on a client or case
- Practice Step 3
- Use the “Quick Guide” for support
- Remember to:
  - Assess for likelihood
  - Discuss potential barriers and problem-solve

Step 4: Contacting Family Members or Friends Who May Offer Help

- Coach clients to use Step 4 if Step 3 does not resolve the crisis or lower risk.
- **Purpose:** To explicitly tell a family member, friend, or other natural support that he or she is in crisis and needs support.
- Can be the same people as Step 3, but different purpose (distraction versus support).
- If possible, include a family member or friend in the process by sharing the Safety Plan with them.

Step 4: Contacting Family Members or Friends Who May Offer Help

Ask:

- “Among your family or friends, who do you think you could contact for help during a crisis?”
- “Who is supportive of you and who do you feel that you can talk with when you’re under stress?”

- Ask clients to list several people (family, friends, peer, teacher, sponsor, natural supports) in case one contact is unreachable.

Step 4: Contacting Family Members or Friends Who May Offer Help

- Prioritize the list ("Who would you call first?").
- In this step, unlike the previous step, clients will reveal they are in crisis to others and are in need of support.
- Assess likelihood the client will engage in this step; identify any potential obstacles, and problem-solve.
- Role play and rehearsal can be very useful in this step:
  - Don't assume your client knows how to ask for support.

Learning Application & Practice

- What are some challenges you might expect to run into at this step?
- How might you address these challenges?
- Why might someone need to role-play asking for help?
- How can we help set the client, and their support people, up for success?

Step 5: Contacting Professionals & Crisis Services for Help

- Coach clients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- **Purpose:** The client should contact a professional if the previous steps do not work to resolve the crisis.

Ask:

- “Who are your treatment team staff that we should identify to be on your Safety Plan?”
- “Are there other professionals or health care providers we should list?”

Step 5: Contacting Professionals & Crisis Services for Help

- List names and contact numbers of clinician or treatment team
- Local Crisis Line number.
- Assess likelihood the client will engage in this step; identify any potential obstacles, and problem-solve.
- Explain protocols and what will likely happen if the client calls the crisis line.
- Role play and rehearsal can be very useful in this step as well.

Step 6 : Making the Environment Safe

- Ask: “How can we make your living environment safer?” It may be necessary to remove alcohol or other drugs from the environment.
- Ask: “Do you think you need to stay with someone for a while?” Ongoing monitoring by a friend or family member can increase safety.
- Ask the client what means they would consider using during a suicidal crisis to take their own life.
- Ask: “Do you own a firearm, such as a gun or rifle?” and “What other means do you have access to and may use to attempt to kill yourself?”

Step 6 : Making the Environment Safe

- Collaboratively identify ways to secure or limit access to lethal means.
- Ask: “How can we go about developing a plan to limit your access to these means?”
- For methods with low lethality, clinicians may ask clients to remove or limit their access to these methods themselves.
- Restricting the client’s access to a highly lethal method, such as a firearm, should be done by a designated, responsible person – usually a family member or close friend, or the police.

Learning Application & Practice

- Switch roles back again
- Practice Step 6
- Use the “Quick Guide” for support
- Remember to inquire about firearms

Step 6 : Making the Environment Safe

- Complete this step even if the client has not identified a suicide plan.
- Eliminate or limit access to any potential lethal means.
- Always ask about access to firearms (locked and unloaded, removed from the house, etc.).
- Discuss medications (including over the counter medications) and how they are stored and managed (smaller quantities, daily pick up).
- Secure keys to vehicles.
- Consider alcohol and drugs as a conduit to lethal means.

Counseling on Access to Lethal Means (CALM)

Site: http://training.sprc.org/

At least one thing that is important to me and worth living for…

- What is the purpose of this portion of the Safety Plan?
- Strategies for soliciting ideas

Implementation: What is the Likelihood of Use?

- Ask: “Where will you keep your safety plan?”
- Ask: “How likely is it that you will use the Safety Plan when you notice the warning signs that we have discussed?”

- Needs to be readily accessible and easy-to-use
- Discuss where the client will keep the safety plan:
  - Multiple copies, put information in cell phone, etc.
- Who to share the plan with:
  - “How many copies of your Safety Plan would you like to share?”
  - Not, “Do you want any copies to share?”

Implementation: What is the Likelihood of Use?

Ask:

- “What might get in the way or serve as a barrier to your using the safety plan?”

- Potential barriers:
  - Difficult reaching out for help (role play)
  - Embarrassment
  - Etc.

- Help the individual find ways to overcome any identified barriers.

Implementation: Review the Safety Plan Periodically

- The plan is not a static document
- Periodically review, discuss, and revise if needed after each time it is used
  - What worked, what didn't work, how can it be improved?
- The plan should be revised as circumstances and needs change over time.

It's Always About the Relationship

- Creating a Safety Plan can help you to build your relationship with the client.
- The plan is an outline for a conversation you have with the client as you develop the plan.
- Use the "Safety Planning Guide" but become familiar with the steps so you can focus on the person.
- Recognize strengths and skills and incorporate them into the Safety Plan.

Persuade & Treat = Hope

- Most people experiencing suicidal thoughts and feelings want to find a way to live:
  - Most suicidal people do NOT want to die
  - Suicidal people DO want to find a way to live
  - Ambivalence exists until the moment of death
- They do not want to end their lives, they want an end to their psychological pain and suffering
- Validate that they are thinking about suicide as an option for coping with pain, but suggest alternatives
- As behavioral health professionals we are well-trained to help solve problems, increase coping skills, and build social connections.

The “T” of QPRT – Treat

The safety plan is a tool to engage the client in a discussion about safety and is only one part of a comprehensive suicide care plan.

Additional components may include:

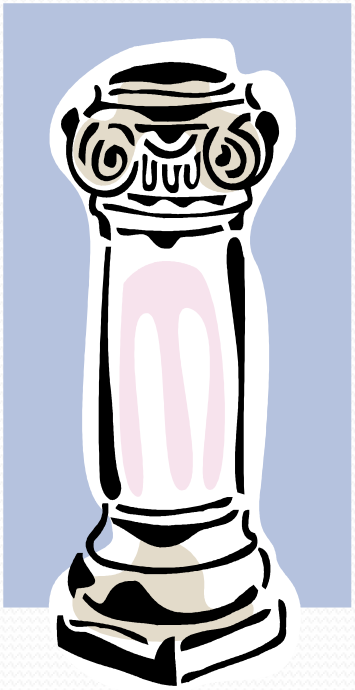
- increasing frequency of contacts
- temporary modified living arrangements (supervision)
- family involvement
- attending all treatment appointments
- following medical advice & taking medications as prescribed
- connecting with other community & natural supports

Guidelines for Suicide Risk Reassessment

- When a major loss occurs, REASSESS!
- If a third party reports concern for safety, REASSESS!
- If the person relapses, REASSESS!
- If the provider feels treatment is not going well, REASSESS!
- If a transfer from inpatient to outpatient or to another provider agency occurs, or a loss of services, or a loss of benefits is in the offing, REASSESS!
- Client's mood improves or declines dramatically, REASSESS!
- If in doubt, uncertain, or concerned, REASSESS!

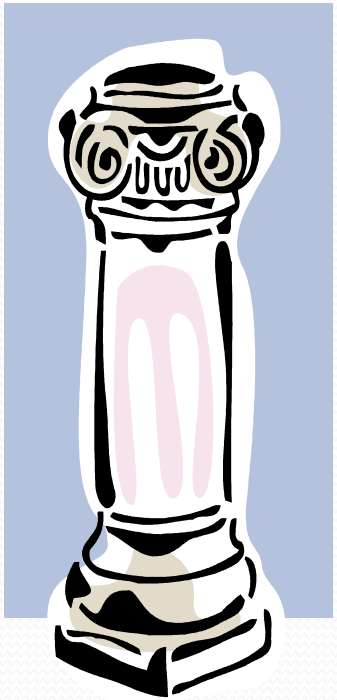
How to Avoid a Malpractice Suit

Detect risk, be a caring, well-trained professional, and stand on the twin pillars of defense:



Consultation

- Seek assistance and professional consultation regarding every suicidal consumer
- The best meeting involves you, your team, the client and family, thoroughly discussing all possible interventions, treatments and conducted a shared risk-benefit assessment.
- The meeting and its outcome should be recorded in the client's health record.



Documentation

The Best Defense

- BE a caring professional.
- BE properly trained.
- BE reasonable and prudent and write things down!
  - **If it isn’t written down, it didn’t happen**.

Suicide Post-Intervention and Review Process

- Know your organization's policy
- Outreach to family
  - Immediate contact (48-72 hours)
  - Offer to meet, provide support, assess needs
  - Follow-up contact (3-4 weeks)
- Case Review/Root Cause Analysis

Staff as Survivors

- Be supportive
- Time off as appropriate
- Team support
- CISM intervention with treatment team
- Individual support through Employee Assistance Program
- Ongoing monitoring through clinical supervision

One Step Down a Different Path

- Community suicide prevention is everyone's responsibility
- As behavioral health experts, we must take the lead in suicide prevention and intervention
- Take **BOLD** action and trust that the person's ambivalence will allow you to help them find another choice
- Then connect the person with the resources needed to take the next step, receive help, and plan for a safe future

Online Resources

- NAMI, National Alliance on Mental Illness
  www.namiyakima.org
- SPRC, Suicide Prevention Resource Center
  www.sprc.org
- AFSP, American Foundation for Suicide Prevention
  www.afsp.org
- American Society of Suicidology
  http://suicidology.org/
- Youth Suicide Prevention Program (Washington)
  www.yspp.org

Closing and Evaluation

- Final questions or comments?
- Needs assessment review
- What does QPRT stand for?
- Program evaluation

Prevention Works!