
Suicide Risk Assessment & Intervention Course

6 Hours/Units

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Course Objectives:

In addition to the objectives described below, the following course content includes:

- Risk Assessment
- Intervention
- Professional practice issues

This course is designed to help you:

1. Identify at least two high risk suicide warning signs.
2. Discuss at least two high risk populations for suicide.
3. Describe at least two effective strategies for prevention and assessment.
4. Identify at least two high risk behaviors and circumstances.
5. Describe at least two assessment tools, scales, and/or instruments.
6. Explain at least one evidence based clinical intervention concept.
7. Describe at least one evidence based treatment and support service.

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1.0 Introduction

Suicide is a preventable public health problem and global disease burden, accounting for nearly 800,000 deaths annually (*WHO, World Health Organization*). Although significant differences exist by country, region, and access to means, suicide is a leading cause of death worldwide. The highest suicide rates occur in late life. Suicide is the second leading cause of death among 15–29-year-olds and the second leading cause of death for females aged 15–19 years. These data correspond to an overall global age-standardized suicide rate of 10.5 per 100 000 population in 2016 – 13.7 and 7.5 per 100 000 for males and females respectively (*WHO, World Health Organization*).

Suicide continues to be a serious problem in high-income countries. However, 79% of all suicides occur in low and middle-income countries which bear the larger part of the global suicide burden. Although in high-income countries three times as many men die by suicide as women, the male-to-female ratio for suicide is more even in low and middle-income countries, at 1.6 men to each woman. Suicide rates for both men and women are lowest in persons under 15 years of age and highest in persons aged 70 years or older in almost all regions of the world. In some regions, suicide rates increase steadily with age, while in others there is a peak in suicide rates in young people. In low and middle-income countries, young adults and elderly women have much higher suicide rates than their counterparts in high-income countries, while middle-aged men in high-income countries have much higher suicide rates than those in low- and middle-income countries (*WHO, World Health Organization*).

Suicide attempts far exceed the number of suicide deaths, and represent a crucial opportunity for intervention. It is estimated that for each person who dies by suicide, more than 20 others attempt suicide. In fact, suicide attempts are an important risk factor for subsequent suicide. When the family members, friends, colleagues and communities of those who attempt suicide or die by suicide are taken into consideration, many millions of people worldwide are affected by suicide every year (Pitman et al; Cerel et al.). Because suicide remains a sensitive issue, it is very likely that it is under-reported due to stigma, criminalization and weak surveillance systems.

Social, psychological, cultural and many other factors can interact to increase the risk of suicidal behavior, but the stigma attached to suicide means that many people who are in need of help feel unable to seek it. Risk factors for suicide include previous suicide attempts, mental health problems, harmful use of alcohol,

drug use, job or financial loss, relationship breakdown, trauma or abuse, violence, conflict or disaster, and chronic pain or illness (*WHO, World Health Organization*).

The United States and Suicide Prevention

Nationally. Suicide accounts for 44,193 American lives lost annually, representing 57% of all violent deaths. This figure outnumbers homicide deaths and recently surpassed annual motor vehicle accident fatalities. Males attempt suicide at approximately four times the rate of females, accounting for 77% of suicide deaths. Though suicide occurs across all demographic groups, the highest rates are observed among those aged 45-64 and 85 and older, with risk especially elevated among Whites and American Indians/Alaskan Natives. Across all ages, White males account for 7 of 10 suicides in the U.S. Regarding regional differences, higher suicide rates are observed in mountain states and rural areas with reduced access to care and increased access to firearms, resulting in national and state strategies focused on firearm safety. The Institute of Medicine (IOM) further estimates that an additional 25 suicide attempts (100-200 for youth) occur for every suicide death, accounting for nearly 500,000 emergency room visits annually.

Brief Overview

This course will discuss suicide screening, risk assessment (including warning signs and protective factors), intervention, applicable vignettes, youth suicide, additional training options, and resources. The following is a brief overview of some of the course discussion:

- ✓ “Addressing Suicidality” provides basic principles about your role in working with clients who are suicidal
- ✓ Background information concerning substance abuse and suicidality
- ✓ GATE, a four-step process (Gather information, Access supervision, Take responsible action, Extend the action) for addressing suicidal thoughts and behaviors
- ✓ Competencies for working with clients with suicidal thoughts and behaviors
- ✓ Clinical vignettes to illustrate and reinforce some of the material presented. The vignettes emphasize the GATE process and the responsible actions modeled by a clinician/counselor and his or her supervisor.
- ✓ “Master Clinician Notes” are provided to explain the thinking behind these actions.
- ✓ “How To Notes” provide instructions for specific methods and interventions.

In particular, the consensus panel recommends the following:

- ✓ Clients in 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.
- ✓ Clinicians 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, clinicians should check that referral appointments are kept and continue to monitor clients after crises have passed, through ongoing coordination with other providers practitioners, family members, and community resources, as appropriate.
- ✓ Clinicians should acquire knowledge about the role of warning signs, risk factors, and protective factors as they relate to suicide risk.
- ✓ Clinicians should be empathic and nonjudgmental with people who experience suicidal thoughts and behaviors.
- ✓ Clinicians should understand the impact of their own attitudes and experiences with suicidality on their work with clients.
- ✓ Clinicians should understand the ethical and legal principles and potential areas of conflict that exist in working with clients who have suicidal thoughts and behaviors.

2.0 Addressing Suicidality and Screening

It is important for you to be comfortable and competent when asking your clients questions about suicidal ideation and behavior. It may be challenging to balance your own comfort level with your need to obtain accurate and clear information in order to best help the client. Suggestions made by the consensus panel to ease the process follow.

Be Direct

Talking with clients about their thoughts of suicide and death is uncomfortable. However, you must overcome this discomfort, as it may lead a clinician to ask a guaranteed conversation-ending question, such as “You don’t have thoughts about killing yourself, do you?” Discomfort can also lead clinicians to avoid asking directly about suicidality, which may convey uneasiness to the client, imply that the topic is taboo, or result in confusion or lack of clarity. Instead, clinicians can learn to ask, “Are you thinking about killing yourself?” Of course, death and suicide are just two examples of taboo topics for many people. The same observations can be made in addressing issues of sexuality and sexual orientation, money and finances, and relationship fantasies and behaviors. The difference is that asking about suicidal thoughts can actually save a life, as it allows a client to

feel safe and understood enough to raise concerns and beliefs with you, the clinician. It is important to note that there is no empirical evidence to suggest that talking to a person about suicide will make them suicidal.

Increase Your Knowledge About Suicidality

One of the best ways to become more comfortable with any topic is to learn more about it. Suicide is no exception. Knowing some of the circumstances in which people become suicidal, how suicidality manifests, what warning signs might indicate possible suicidal behavior, what questions to ask to identify suicidality, and, perhaps most importantly, what the effective interventions are, can increase your competence, and as a result, your comfort in addressing this issue with clients.

Do What You Already Do Well

Good clinicians are empathic, warm, and supportive, and trust their experience and intuition. However, on encountering suicidal thoughts and behaviors, clinicians sometimes unwittingly employ countertherapeutic practices, such as aggressively questioning the client about his or her thoughts and feelings, demanding assurance of safety when a client cannot provide such assurance, becoming autocratic and failing to collaborate with the client, and/or avoiding sensitive topics so as not to engender sadness. These countertherapeutic practices can be the consequence of anxiety and unfamiliarity with the issue, along with fear of litigation if the client does make a suicidal act. Given these fears and issues, it is easy to see how otherwise highly skilled clinicians can fall into the trap of becoming “the suicide interrogator.” Your option? Deliberately choose another path. Stay grounded and make use of your therapeutic skills when dealing with suicidal behaviors, as that is the most important time to fall back on (and not veer away from) your therapeutic abilities, experience, and training. Collect objective data, just as you would collect objective data about a client’s substance use, but don’t lose your empathy or concern in the process.

Practice, Practice, Practice

Remember the first client you interviewed? Do you remember your internal reaction to that interview? Now, you’re a lot more comfortable talking with clients about their history, their current symptoms, and their plans for recovery. Nothing reduces anxiety more than practice. The same holds true about talking with your clients about suicidal thoughts and behaviors. If you need to reduce your initial discomfort on the topic, practice with another clinician or your clinical supervisor. Get feedback about how you are coming across. Start asking every one of your clients about suicidality. The more experience you have, the more comfortable you

will become. You may also consider attending a workshop or getting additional training specific to the topic of suicidality.

Get Good Clinical Supervision and Consultation

Getting clinical supervision is a great way to learn and practice new skills. Contract with your clinical supervisor to integrate skill development about suicidality into your Individual Development Plan for clinical supervision. Get feedback from your supervisor about your attitudes toward clients who are suicidal and your skills in interviewing clients. Working with a treatment team almost always increases the quality of information gathering, decisionmaking, and taking action.

Work Collaboratively With Suicidal Clients

Just as you involve clients in developing a treatment plan for recovery, so too should you involve them in suicide prevention planning. You will be most effective if you ask them about suicide with concern (but not alarm), just as you would with any other area of concern. Explain the reason(s) for your concern and any action(s) that you take, elicit their input as to what may help them be safe, and (with your supervisor), consider their input as much as possible in determining the actions that you take. Most often, the client will be willing to work collaboratively with you, particularly if you take the time to listen and to explain your actions. Informed consent should be part of collaboration with your client. Inform the client about the steps that might be taken to reduce suicide risk, steps for referral if needed, and confidentiality issues that might arise. Of course, there may be times when you and your supervisor will need to take an action over a client's objections (e.g., arrange for an immediate evaluation at a hospital), but even in these relatively rare circumstances, you can still seek your client's input, and make efforts to work collaboratively.

Realize Limitations of Confidentiality and Be Open With Your Clients About Such Limits

You should understand existing ethical and legal principles and potential areas of conflict (including the possible limits of confidentiality) because safety and protection of the client trumps confidentiality in certain crisis situations. When you first meet clients and as appropriate during the course of treatment, explain that, in the event of suicide risk, you may take steps to promote the client's safety (including the potential for breaking confidentiality, arranging for an emergency evaluation over the client's objections, and involving emergency personnel). Clients should not be given the false impression that everything is confidential or that all types of treatment are always voluntary.

Ten Points To Keep You on Track

Point 1: Almost all of your clients who are suicidal are ambivalent about living or not living.

Explanation: Wishing both to die and to live is typical of most individuals who are suicidal, even those who are seriously suicidal (see, e.g., Brown, Steer, Henniques, & Beck). For example, hesitation wounds are commonly seen on individuals who have died by suicide (e.g., hesitation scratches before a lethal cut, bruises on a temple indicating that a gun had been placed there several times before pulling the trigger). It has even been argued that the struggle between wanting to die and wanting to live is at the core of a suicidal crisis (Shneidman). Take suicidal thinking seriously and think about ways to reinforce realistic hope. Do everything you can to support the side of the client that wants to live, but do not trivialize or ignore signs of wanting to die.

Point 2: Suicidal crises can be overcome.

Explanation: Fortunately, acute suicidality is a transient state (Shneidman). Even individuals at high, long-term risk spend more time being nonsuicidal than being suicidal. Moreover, the majority of individuals who have made serious suicide attempts are relieved that they did not die after receiving acute medical and/or psychiatric care. The challenge is to help clients survive the acute, suicidal crisis period until such time as they want to live again. Moreover, treatments for suicidal clients, many with substance use disorders, including cognitive-behavioral treatment (CBT; Brown, et al.) and dialectical behavioral therapy (DBT; Linehan, Schmidt, Dimeff, Craft, Kanter, & Comtois) have shown positive results in reducing repeated suicide attempts. Interventions that successfully address major risk factors such as severe substance use, depression, and marital strife also have the potential to reduce suicidal behavior. Although data are limited, other specific interventions have been shown to prevent suicide deaths (Mann, Apter, Bertolote, Beautrais, Currier, Haas, et al.).

Point 3: Although suicide cannot be predicted with certainty, suicide risk assessment is a valuable clinical tool.

Explanation: Clinicians work with many high-risk clients. Determining with accuracy who will die by suicide using tests or clinical judgment is extremely difficult, if not impossible (Pokorny). Although precisely who may die by suicide cannot be known, suicide risk assessment is a valuable clinical tool because it can ensure that those requiring more services get the help that they need. In other words, it is not necessary to have a crystal ball if the assessment information shows

that a client fits the profile of an individual at significant risk. In such instances, appropriate actions should be taken.

Point 4: Suicide prevention actions should extend beyond the immediate crisis.

Explanation: Clients in treatment who have long-term risk factors for suicide (e.g., depression, child sexual abuse history, marital problems, repeated substance abuse relapse) require treatment of these issues, whether or not they show any indication of current risk for suicide. Individuals with a history of serious suicidal thoughts or suicide attempts, but with no recent suicidal thoughts or behaviors, may be monitored to identify any recurrence of suicidality.

Point 5: Suicide contracts are not recommended and are never sufficient.

Explanation: Contracts for safety are often used as a stand-alone intervention, but they are never sufficient to ensure the client's safety. Contracts for safety are widely used to reduce legal liability, but the consensus panel is aware of no significant evidence that such contracts offer any protection from litigation. They may, in fact, make litigation more likely if suicide prevention efforts appear to be hinged on the contract or if they provide the clinician with a false sense of security. It is misguided to predicate decisions on whether the client "can" or "can't" or "will" or "won't" contract for safety. Use this section and choose from among the many other strategies to promote safety. Use contracts sparingly, if at all.

Point 6: Some clients will be at risk of suicide, even after getting clean and sober.

Explanation: Abstinence should be a primary goal of any client with a substance use disorder and suicidal thoughts and/or behaviors (Weiss & Hufford). Indeed, risk will diminish for most clients when they achieve abstinence. Nonetheless, some individuals remain at risk even after achieving abstinence (Conner, Duberstein, Conwell, Herrmann, Jr., Cox, Barrington, et al.). For example, clients with an independent depression (one that does not resolve with abstinence or is not substance induced), those who have unresolved difficulties that promote suicidal thoughts (e.g., a deteriorating partner relationship, ongoing domestic violence, victimization, impending legal sentencing), those who have a marked personality disturbance (e.g., borderline personality disorder), those with trauma histories (e.g., sexual abuse history), and/or individuals with a major psychiatric illness may continue to show signs of risk.

Point 7: Suicide attempts always must be taken seriously.

Explanation: There is often a mismatch between the intent of the suicidal act and the lethality of the method chosen (Brown, Henriques, Sosdjan, & Beck). Therefore, clients who genuinely want to die (and expect to die) may nonetheless

survive because their method was not foolproof and/or because they were interrupted or rescued. Indeed, a prior suicide attempt is a highly potent risk factor for eventually dying by suicide (Kapur, Cooper, King-Hele, Webb, Lawlor, Rodway, et al.). Any suicide attempt must be taken seriously, including those that involve little risk of death, and any suicidal thoughts must be carefully considered in relation to the client's history and current presentation.

Point 8: Suicidal individuals generally show warning signs.

Explanation: Fortunately, suicidal individuals usually give warning signs. Such warning signs come in many forms (e.g., expressions of hopelessness, suicidal communication) and are often repeated. The difficulty is in recognizing them for what they are.

Point 9: It is best to ask clients about suicide, and ask directly.

Explanation: Available data do not support the idea that asking about suicide will put this idea in an individual's mind (Gould et al.). A clinician's power is limited and does not include the ability to place the idea of suicide in a client's head or to magically remove such an idea. You may never know about a client's suicidality unless you ask. You are encouraged to ask directly about suicide.

Point 10: The outcome does not tell the whole story.

Explanation: Suicide deaths have a much lower base rate than many other deleterious outcomes that clinicians encounter (e.g., relapse, treatment dropout). A client at significant risk may survive despite never being screened, assessed, or offered intervention for suicide simply because of the relatively low base rate of suicide. Therefore, a good outcome (survival) does not, by itself, equate to proper treatment of suicidal thoughts and behaviors. On the other hand, a clinical team may do a solid job of screening, assessing, and intervening with a high-risk client. Despite these efforts, a high-risk client may eventually die by suicide. Therefore, a tragic outcome (death) does not, by itself, equate to improper treatment of suicidality.

Maintain Positive Attitudes

Attitudes toward suicide vary widely. Some people hold religious or spiritual views that have strong sanctions against suicidal behavior. Others see suicide as a viable option for ending unmanageable pain or suffering or as an acceptable option in other circumstances. Some hold the view that it is alright to think about suicide but not to act on those thoughts. Our attitudes are influenced by our culture, childhood experiences, and especially, by our professional and personal experiences with suicidal thinking and behavior.

Before working with clients who are suicidal, clinicians are advised to conduct their own suicidal attitude inventory. The goal of the inventory is not to change your views but rather to help you understand what your views are and how those views can positively or negatively affect your interactions with clients. Some of the items you might consider in an inventory include:

- 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?
- 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?

These views may also need to be further clarified by consultation with your clinical supervisor or with your peers. As noted, your attitudes about suicide are strongly influenced by your life experiences with suicide and similar events. Needless to say, your responses to suicide and to people who are suicidal are highly susceptible to attitudinal influence, and these attitudes play a critical role in work with people who are suicidal. An empathic attitude can assist you in engaging and understanding people in a suicidal crisis. A negative attitude can cause you to miss opportunities to offer hope and help or to overreact to people in a suicidal crisis. Below are some attitudinal issues to consider in working with people who are suicidal.

Positive Attitude and Behavior 1: People in treatment settings often need additional services to ensure their safety.

Explanation: Merely receiving treatment may lessen the risk of suicide. A good working relationship with a professional is, in fact, a powerful protective factor against suicide. However, individuals who are acutely suicidal may need more services (e.g., psychiatric evaluation, short-term emergency hospitalization) to ensure their safety. In addition, certain clients, including those who are poorly connected to other clients and to treatment providers, clients who are making little progress in treatment, and clients at major transition points in care (e.g., moving from inpatient to outpatient care or being administratively discharged) may be at

increased risk. An empathic attitude can help you recognize these challenging circumstances and proactively assess and intervene.

Positive Attitude and Behavior 2: All clients should be screened for suicidal thoughts and behaviors as a matter of routine.

Explanation: “Don’t ask, don’t tell” is not an effective agency suicide policy. Take the following actions to prevent clients from being exposed to life-threatening situations and to prevent exposing yourself and/or your agency to legal risk of malpractice:

- ✓ Screen for suicide and ask followup questions.
- ✓ Follow up with a client when risk has been previously documented.
- ✓ Take appropriate action when risk is detected.
- ✓ Document suicide-related screening and interventions.
- ✓ Communicate suicide risk to another professional or agency.

Positive Attitude and Behavior 3: All expressions of suicidality indicate significant distress and heightened vulnerability that require further questioning and action.

Explanation: Even in rare circumstances where clients appear to be purposefully using reports of suicidal thoughts or plans to manipulate their treatment regimen, expressions of suicidality must be taken seriously. Thus, when clients appear to “use” suicidality, it should be recognized as a very limited approach to coping. Indeed, there is often more than one reason for an act of suicide (e.g., one may simultaneously want to die and elicit attention). You must address clients “where they are” and not impose your own agenda. If suicidal thoughts or behaviors occur, addressing suicidality must be a priority. Even if a client really does not want to die, if his or her reports of suicidal ideation are not taken seriously, the client may act on them to “save face.”

Positive Attitude and Behavior 4: Warning signs for suicide can be indirect; you need to develop a heightened sensitivity to these cues.

Explanation: Fortunately, clients often give warning signs before making a suicide attempt, and often these warning signs include expressions of suicidal thoughts or plans. More indirect signals include expressions of hopelessness, feeling trapped, or having no purpose in life, and observable signs such as withdrawal from others, mood changes, or reckless behavior. Such signs require followup. Beyond screening for current risk, clinicians should be aware of clients’ histories of suicidal thoughts and behaviors and should be on watch for indications of recurrence of suicidal thoughts or behavior and/or the emergence of warning signs, particularly when acute stressful life events (such as relapse, relationship breakup, or psychological trauma) occur.

Positive Attitude and Behavior 5: Talking about a client's past suicidal behavior can provide information about triggers for suicidal behavior.

Explanation: Discussing past suicidal thoughts or behaviors is an important part of gathering information for suicide screening. The circumstances of past suicidal ideation and attempts can provide important insights into the scenario(s) that may promote future risk. Some clients may also wish to discuss past suicidal behavior in more depth for a variety of reasons (e.g., they never talked about it before, it represented their “hitting bottom,” the spiritual implications) that should be honored.

Positive Attitude and Behavior 6: You should give clients who are at risk of suicide the telephone number of a suicide hotline; it does no harm and could actually save a life.

Explanation: It is true that some clients will never use a hotline number. However, others will use a hotline resource. It is best to give all clients who may be at risk of suicide a hotline number because you can not predict which clients will take advantage of it. In addition, always give “at risk” clients other options, including how to contact emergency resources after hours, mental health emergency services in the community, and instructions to go to the nearest hospital emergency room. The national suicide hotline, 1-800 273-TALK, and 911 can be accessed from anywhere in the United States. How to use a safety card with emergency contact information is discussed later in this chapter.

Summary

Positive, empathic attitudes toward clients experiencing suicidal thoughts and behaviors do not, by themselves, mean that clients will initiate or receive appropriate services. However, they do form the platform on which proactive, effective services can be built. It is important to remember that the thoughts, emotions, and behaviors accompanying negative attitudes toward suicidality can be a major impediment to quality care. Understanding that clients with suicidal thoughts and behaviors can benefit from intervention and treatment, that people who make verbal expressions of suicidality have needs that aren't being addressed, and that there is a relationship between a client's suicidality and his or her substance abuse can make a huge difference in a client's overcoming a suicidal crisis and staying in recovery.

There is a strong link between acute substance use and risk for suicidal behavior.

- 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 (Hufford). Other central nervous system depressants may act similarly.

- Acute alcohol intoxication is present in about 30–40 percent of suicide attempts and suicides (Cherpitel, Borges, & Wilcox).
- Intense, short-lived depression is prevalent among treatment-seeking people who abuse cocaine, methamphetamines, and alcohol, among other groups (Brown et al.; Cornelius, Salloum, Day, Thase, & Mann; Husband et al.). Even transient depression is a potent risk factor for suicidal behavior among people with substance use disorders.

The Link Between Substance Abuse and Suicidality

There is a strong link between substance use disorders and risk for suicidal behavior. Suicide is a leading cause of death among people who abuse alcohol and drugs (Wilcox et al.). Compared with the general population, individuals treated for alcohol abuse or dependence are at about 10 times greater risk for suicide; people who inject drugs are at about 14 times greater risk for suicide (Wilcox, et al.). Individuals with substance use disorders are also at increased risk for suicidal ideation and suicide attempts (Kessler et al.). Depression is a common co-occurring diagnosis among people who abuse substances that confers risk for suicidal behavior (Conner et al; Murphy, Wetzel, Robins, & McEvoy). Other mental disorders are also implicated. 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.

Overdose suicides often involve multiple drugs like alcohol, benzodiazepines, opioids, and other psychiatric medications (Darke & Ross). The risk for suicidal behavior may increase at any point in treatment.

- 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.
- 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.

Types of Suicidal Thoughts and Behaviors

Precise definitions of four types of suicide-related concepts will help clarify important nuances in the subject matter of this section.

Suicidal Thoughts

Suicidal ideation: Suicidal ideation is much more common than suicidal behavior (Conner et al.; Kessler et al.). Suicidal ideation lies on a continuum of severity from fleeting and vague thoughts of death to those that are persistent and highly specific. Serious suicidal ideation is frequent, intense, and perceived as uncontrollable.

Suicide plans: Suicide plans are important because they signal more serious risk to carry out suicidal behavior than suicidal ideation that does not involve planning (Conner et al.; Kessler et al.). Suicide planning lies on a continuum from vague and unrealistic plans to those that are highly specific and feasible. Serious suicide planning may also involve rehearsal or preparation for a suicide attempt.

Suicidal Behaviors

Suicide attempt: A suicide attempt is a deliberate act of self-harm that does not result in death and that has at least some intent to die (Silverman, Berman, Sanddal, O’Carroll, & Joiner). Attempts have two major elements: (a) the subjective level of intent to die (from the client’s subjective perspective, how intensely did he or she want to die and to what extent did he or she expect to die?); and (b) the objective lethality of the act (from a medical perspective, how likely was it that the behavior would have led to death?) (Beck, Schuyler, & Herman; Harriss, Hawton, & Zahl). Although all suicide attempts are serious, those with high intent (client clearly wanted to die and expected to die) and high lethality (behavior could have easily led to death) are the most serious.

Suicide: Suicide is an acute, deliberate act of self-harm with at least some intention to die resulting in death.

Other Suicide-Related Concepts

Suicidal intention: Suicidal intention (also called “intent”) signals high, acute risk for suicidal behavior. Having suicidal intent is always serious because it signals that the client “intends” to make a suicide attempt. Some indicators of “high intent” include drafting a suicide note or taking precautions against discovery at the time of an attempt.

Suicide preparation: Behaviors that suggest preparation signal high, acute risk for suicidal behavior. Preparation may come in many forms, such as writing a suicide note or diary entry, giving away possessions, writing a will, acquiring a method of suicide (e.g., hoarding pills, buying a weapon), making a method more available (e.g., moving a gun from the attic to beside the bed), visiting a site where suicide may be carried out (e.g., driving to a bridge), rehearsing suicide (e.g., loading and unloading a weapon), and saying goodbye to loved ones directly or symbolically.

Other harmful behaviors

Non-suicidal self-injury (NSSI): NSSI is also commonly referred to in the literature as “deliberate self-harm” and “suicidal gesture.” NSSI (for example, self-mutilation or self-injury by cutting for the purpose of self-soothing with no wish to die and no expectation of dying) is distinguished from a suicide attempt or suicide because NSSI does not include suicidal intent. This section does not focus on NSSI. Suicidal behaviors and NSSI can co-exist in the same person and both can lead to serious bodily injury.

Self-destructive behaviors: Behaviors that are repeated and may eventually lead to death (e.g., drug abuse, smoking, anorexia, pattern of reckless driving, getting into fights) are distinguished from suicidal behavior because an act of suicide is an acute action intended to bring on death in the short term.

Reasons for Suicidal Behavior

There is often more than one reason for a suicide attempt. For example, a client may want to get back at his or her estranged partner (induce guilt), demonstrate distress (cry for help), and want to die. Therefore, it is important not to trivialize suicide attempts that may involve motivations other than to die. In other words, if at least some wish to die was present at the time of the attempt, regardless of

whether there were other reasons for the act, then the behavior should be considered a suicide attempt. Some, but not all, potential reasons for a suicide attempt include:

- Desire to die.
- Hopelessness.
- Extreme or prolonged sadness.
- Perceived failure or self-hate following relapse.
- Loneliness.
- Feeling like a burden to others.
- Disinhibition while intoxicated.
- Escape from a painful emotional state.
- Escape from an entrapping situation.
- Get attention.
- Impulsive reaction to an acute stressful life event (e.g., break-up).
- Hurt another individual (e.g., make another individual feel guilty).
- Paranoia or other psychosis (e.g., command hallucination to take one's life).
- Escape a progressively deteriorating health situation (e.g., terminal disease).

GATE: Procedures

- ✓ Gather information
- ✓ Access supervision
- ✓ Take responsible action
- ✓ Extend the action

You are familiar with gathering information from clients; this skill can be translated into gathering information about suicidal thoughts and behaviors. Supervision may be a regular part of your program; with a client who is suicidal, it is a necessity. You know how to plan for the treatment of a client; this skill can be applied to planning for a client to address his or her suicidal thoughts and behaviors. You typically follow up with clients to coordinate care, check on referral appointments, monitor progress, and enlist support from family and community resources. These activities are essential when working with clients who are suicidal.

Having advanced training in a mental health discipline (such as social work, psychology, or professional counseling) along with specialized training in suicidality, might also prepare you to take on other treatment tasks with clients with suicidal thoughts and behaviors, such as specialized suicide interventions, or treatment of co-occurring mental disorders such as depression and psychological

trauma. These advanced skills, while very important, are not a primary focus of this section on addressing suicidality and screening.

Overview of Screening with GATE

G: Gather information

There are two steps to gathering information: (1) screening and spotting warning signs, and (2) asking follow up questions. Screening consists of asking very brief, uniform questions at intake to determine if further questions about suicide risk are necessary. Spotting warning signs consists of identifying telltale signs of potential risk. Ask followup questions when clients respond “yes” to one or more screening questions or any time you notice a warning sign(s). The purpose of asking follow up questions is to have as much information as possible so that you and your supervisor and/or treatment team can develop a good plan of action. You will want to provide as much information as possible to another provider should you make a referral. Examples of screening questions, warning signs, and followup questions are provided below.

As much as possible, you should avoid “stacking” questions (peppering clients with one closed-end question after the other), which will tend to generate defensiveness and/or false reassurances of safety. If you are unclear about the answer from the client or if you sense a degree of defensiveness, you might consider asking the same question in a different way somewhat later in the interview. Ambiguous or vague answers are always important to pursue further because they may be a sign of discomfort with the topic, anxiety about disclosure, evasiveness, and/or uncertainty (e.g., “I don’t know”, “I’m not sure”), with the understanding that clients will not always be able or willing to provide greater clarity.

A: Access supervision and/or consultation

With suicidal clients, two or three heads are almost always better than one. Therefore, speak with a supervisor, an experienced consultant who has been vetted by your agency, and/or your multidisciplinary treatment team when working with a client who you suspect may be dealing with suicidal concerns. It is a collective responsibility, not yours alone, to formulate a preliminary impression of the seriousness of risk and to determine the action(s) that will be taken. Accessing supervision or consultation can provide invaluable input to promote the client’s safety, give you needed support, and reduce your personal liability. Some guidelines for making effective use of supervision and consultation are provided below.

T: Take responsible action(s)

The guiding principle here is that your action(s) should make good sense in light of the seriousness of suicide risk. The phrase “make good sense” indicates that your action(s) is “responsible,” given the seriousness of risk. The next section expands on this principle and provides a list of potential actions covering a wide range of intensity and immediacy that you and your supervisor or team may take.

E: Extend the action(s)

Too often, suicide risk is dealt with acutely, on a one time basis, and then forgotten. As with substance abuse, vulnerable clients may relapse into suicidal thoughts or behaviors. This means that you will need to continue to observe and check in with the client to identify a possible return of risk. Another common problem is referring a suicidal client but failing to coordinate or even follow up with the provider. Suicide risk management requires a team approach, and you are an essential part of this team. A range of extended actions is provided below.

Documenting all the actions you have taken is important because it creates a medical and legal account of the client’s care: what information you obtained, when and what actions were taken, and how you followed up on the client’s substance abuse treatment and suicidal thoughts and behaviors. This record can be useful for your supervision or consultation, to your team, and to other providers.

Screening

The National Suicide Prevention Lifeline has produced a wallet sized card for counselors entitled: “Assessing Suicide Risk: Initial Tips for Counselors” that lists five questions counselors can ask about suicide. The card additionally provides the warning signs contained in “IS PATH WARM” and offers brief advice on actions to take with people who are at risk. The card link is available in section 3.4 *Summary of Tools, Scales and Instruments* of this course

Additional options for screening

Multi item measures that contain an item about suicidal thoughts and behaviors may also be used for screening. Items that screen for suicidal thoughts can be found on several other well validated depression measures. If a client endorses any level of suicidality on the relevant items from these measures, you will want to ask followup questions. Original and revised versions of the Beck Depression

Inventory (BDI or BDIII; Beck, Ward, Mendelsohn, Mock, & Erbaugh; Beck, Steer, & Brown) and Hamilton Depression Rating Scale (Hamilton) as well as on instruments that are administered verbally. The BDIII may be purchased.

Sample followup questions about suicidal thoughts: Asking followup questions

It is important to ask followup questions when a client answers “yes” to a screening question at intake, when you note a warning sign(s), or at any time during the course of treatment when you suspect the client is suicidal, even if you can’t pinpoint why. Followup questions and their answers enable you to have as much information as possible:

1. Can you tell me about the suicidal thoughts?
2. If the client requires more direction: For example, What brings them on? How strong are they? How long do they last?
3. If you do not already know: Have you made a plan? (If yes) What is your plan? Do you have access to a method of suicide? A gun? An overdose? Do you intend to attempt suicide?

Always ask an open-ended question first (see sample question 1). Clients may tell you spontaneously all of the information you need to know. Open-ended questions can help you avoid “grilling” the client. Information not provided by clients may be elicited with followup questions to determine characteristics such as the precipitants, strength, and duration of the suicidal thoughts (see sample question 2). Finally, if information related to planning, method, and intent does not come to light spontaneously, always gather these critical pieces of information (see sample question 3). A client’s inability or unwillingness to provide the necessary information may be an indicator of increased risk and that should be noted in any consultation.

Gathering additional information about suicide attempts is straightforward. You will want to ask the client to explain the attempt through an open-ended question such as “Please tell me about the attempt” and ask followup questions to find out more about it. If there was more than one suicide attempt, ask these questions about the most recent attempt and the most severe attempt (if it differs from the most recent act). The answers to these questions will be very helpful in characterizing the seriousness of suicidal behavior. Sample followup questions about suicide attempts:

1. Please tell me about the attempt.

2. If the client requires more direction: For example, What brought it on? Where were you? Were you drinking or high?
3. If you do not already know: To gather information about lethality: What method did you use to try to kill yourself? Did you receive emergency medical treatment? To gather information about intent: Did you want to die? How much? Afterward, were you relieved you survived, or would you rather have died?

The lessons that apply to asking about suicidal thoughts also apply here: ask an open-ended question first, ask followup questions to determine the circumstances of the attempt such as the precipitating event, setting, and the role of acute alcohol or drug use, and finally, if information related to lethality and intent does not come to light spontaneously, always continue to gather these critical pieces of information (see sample question 3).

Summary:

G: Gather information

The gathering information task consists of collecting relevant facts. Screening questions should be asked of all new clients when you note warning sign(s) and any time you have a concern about suicide, whether or not you can pinpoint the reason. Inquiries about suicidal thoughts and attempts always start with an open-ended question that invites the client to provide more information. Followup questions are then asked to gather additional, critical information. Routine monitoring of suicide risk throughout treatment should be a basic standard in all substance abuse treatment programs.

A: Access supervision or consultation

You should not make a judgment about the seriousness of suicide risk or try to manage suicide risk on your own unless you have an advanced mental health degree and specialized training in suicide risk management and you are qualified to manage such risk independently. For this step, obtaining consultation does not refer to merely getting input from a peer. Although such input may be helpful, consultation is a more formal process whereby information and advice are obtained from (a) a professional with clear supervisory responsibilities, (b) a multidisciplinary team that includes such person(s), and/or (c) a consultant experienced in managing suicidal clients. When obtaining supervision or consultation, assemble all the information you have gathered on your client's suicidal thoughts and/or suicide attempts through the screening and followup questions, as well as data from other sources of information (e.g., other providers, family members, treatment records).

In some circumstances, you will need to obtain immediate consultation. In other circumstances, obtaining consultation at regularly scheduled supervision or team meetings may be sufficient (regular consultation). The examples listed below are for illustrative purposes only; other circumstances requiring immediate consultation may exist.

Circumstances at intake requiring access to immediate supervision or consultation include:

- Direct warning signs are evident (suicidal communication, seeking access to method, making preparations).
- Followup questions to suicide screening questions suggest that there is current risk.
- Followup questions to indirect warning signs suggest that there is current risk.
- Additional information (e.g., from the referral source, family member, medical record) suggests that there is current risk.
- Circumstances during treatment that require access to immediate supervision or consultation include:
 - Emergence (or re-emergence) of direct warning signs.
 - Emergence (or re-emergence) of indirect warning signs that, on followup questioning, suggest current risk.
 - Your client's answers to suicide screening questions asked during the course of treatment suggest current risk.
 - Additional information (e.g., from another provider or family member) suggests current risk.

Circumstances at intake requiring access to regularly scheduled supervision or consultation include:

- One or more indirect warning signs are present, but followup questions indicate that there is no reason to suspect current risk for suicidal behavior per se (e.g., a client is socially isolated and abusing substances, but otherwise shows no indications of suicidality).
- One or more risk factors are present, but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior.
- During screening, your client discloses a history of suicidal thoughts or suicide attempt(s), but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior.
- Additional information (e.g., from the referral source or family member) suggests your client has a history of suicidal thoughts or attempts, but there are

no accompanying warning signs or other indications to suspect current risk for suicidal behavior.

- Circumstances during treatment that require access to regularly scheduled supervision or consultation include:
- Your client reports (or alludes to) a history of suicidal thoughts that you had not previously been aware of, but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior.
- Your client reports (or alludes to) prior suicide attempt(s) that you had not previously been aware of, but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior.
- Additional information (e.g., from another provider or family member) suggests a history of suicidal thoughts or attempts that you had not previously been aware of, but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior.
- Client with a history of suicidal thoughts or behavior experiences an acute stressful life event or a setback in treatment (e.g., substance abuse relapse), but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior.

If you suspect that information on acute suicidality might arise in a session, it is wise to alert your supervisor in advance that you might contact him or her for information, support or consultation while the client is still in your office.

Summary of A: Access supervision or consultation

Risk for suicidal behavior may be evident at intake or at any time during the course of treatment. Supervision or consultation to address risk may be obtained immediately or at a regularly scheduled time, depending on the urgency of the situation. Having a plan in place ahead of time for obtaining immediate supervision or consultation will help ensure a therapeutic response and will avoid unnecessary distress and scrambling.

Immediate supervision or consultation should be obtained when clients exhibit direct suicide warning signs or when they report at intake having made a recent suicide attempt. Substance abuse relapse during treatment is also an indication for supervisory involvement for clients who have a history of suicidal behavior or attempts.

T: Take responsible action

A useful guiding principle in taking responsible action is that your actions should make good sense in light of the seriousness of suicide risk. This section explains

this principle, applies it to taking responsible action(s), and provides a list of potential actions. In the legal system, the standard used to assess responsibility and liability is to compare a given practitioner's judgment and behavior with what another equally trained and experienced treatment practitioner would have done in the same circumstances.

The key factor, although not the only factor, in considering the action(s) to take is a judgment about the seriousness of risk. Seriousness is defined as the likelihood that a suicide attempt will occur and the potential consequences of an attempt. Briefly, if a client is judged to be likely to carry out a suicide attempt (for example, has persistent suicidal thoughts and a clear plan) and if the client expects the suicide attempt to be lethal (for example, a plan to use a gun that the client keeps at home), there is high seriousness. In contrast, if a client is judged to be unlikely to carry out an attempt (for example, has fleeting ideation, no clear plan, and no intention to act) and any attempt may be expected to be nonlethal (for example, thoughts of swallowing some aspirin if there is any in the medicine cabinet), there is lower seriousness.

The actions taken should be sensible in light of the information that has been gathered about suicidal thoughts and/or previous suicide attempts. Although the potential actions are many, they can generally be described along a continuum of intensiveness. In instances of greater seriousness, you will generally take more intensive actions. For less serious circumstances, you will be more likely to take less intensive actions. Note that "less intensive" does not equate to inaction; it merely indicates that there may be more time to formulate a response, the actions may be of lower intensity, and/or fewer individuals and resources may be involved. In some instances, an immediate response is required. In general, responses that require immediate action may be considered more intensive. Examples of immediate actions include arranging transportation to a hospital emergency department for evaluation, contacting a spouse to have him or her arrange for removal of a gun from the home and arrange safe storage. Examples of non-immediate, but important, actions include scheduling the client to see a psychiatrist for possible medication management, and ordering past mental health records from another provider.

Some interventions can be considered more intensive than others. These include interventions that reduce freedom of movement (e.g., arranging an ambulance to transport a client to a hospital emergency department), are expensive (e.g., inpatient hospitalization), compromise privacy (e.g., contacting the police to check on a high-risk client), and/or restrict autonomy (e.g., asking a spouse to arrange for

safe storage of a weapon). Other interventions in managing suicide risk, although less intensive, may also go beyond the usual care of a client and may be experienced by the client as unnecessary or intrusive. Arranging further assessment through a home visit by a mental health mobile crisis team, for instance, may be seen as burdensome to the client. Less intensive interventions do not reduce freedom of movement, do not sacrifice privacy, are comparatively inexpensive, and/or do not restrict autonomy.

Another aspect of intensiveness concerns the number of individuals involved (e.g., client, case manager, counselor, mental health professional, concerned spouse) and the number of actions taken (e.g., psychiatric medications, substance abuse counseling, family sessions, case management coordination). In other words, in general, the greater the number of interventions, and the more individuals involved, the more intensive the action(s).

What actions can you take?

The list of actions below is not exhaustive but includes the most common actions. At times, one action will suffice, whereas at other times, more than one (and perhaps many) will be required. You and your supervisor or team will strive to do things that make good sense in terms of their intensity. Your actions should match the seriousness of risk. The list below is in no particular order.

- Gather additional information from the client to assist in a more accurate clinical picture and treatment plan.
- Gather additional information from other sources (e.g., spouse, other providers).
- Arrange a referral:
 1. To an emergency provider (e.g., hospital emergency department) for acute risk assessment (see the vignette on Vince for a discussion of relevant issues).
 2. To a mental health mobile crisis team that can provide outreach to a physically inaccessible client at his or her home (or shelter) and make a timely assessment.
 3. To an intensive substance abuse treatment setting.
- Restrict access to means of suicide.
- Temporarily increase the frequency of care, including more frequent telephone check-ins.
- Temporarily increase the level of care (e.g., refer to day treatment).
- Involve a case manager (e.g., to coordinate care, to check on the client occasionally).
- Involve the primary care provider.

- Encourage the client to attend (or increase attendance) at 12-Step meetings such as Alcoholics Anonymous, Narcotics Anonymous, or Cocaine Anonymous.
- Enlist family members or significant others (selectively, depending on their health, closeness to the client, and motivation) in observing indications of a return of suicide risk.
- Observe the client for signs of a return of risk Create a safety card (see below) with the client in the event of a return of acute suicidality.

Safety Cards and Safety Plans

With all clients with suicidal risk, consider developing with the client a written safety card that includes at a minimum:

- ➔ A 24-hour crisis number (e.g., 1-800-273-TALK).
- ➔ The phone number and address of the nearest hospital emergency department.
- ➔ The clinician's contact information.
- ➔ Contact information for additional supportive individuals that the client may turn to when needed (e.g., 12 step sponsor, supportive family member).

To maximize the likelihood that the client will make use of the card, it should be personalized and created with the client (not merely handed to him or her). Discuss with the client the type(s) of signs and situations that would warrant using one or more of the resources on the card. It is ideal to create a wallet-size card with this information so clients can easily keep it with them. Have backup copies of the card available in the event that the client loses the card (which frequently happens) so that it can be quickly replaced. Consistent with this section's emphasis on Extending the action, you should check in with the client from time to time to confirm that he or she still has the card (ask the client to show it to you) and remains willing to use it if the need arises.

Clinicians with advanced mental health training and experience in work with clients who are suicidal may be in a position to formulate a more detailed safety plan. An advanced plan might emphasize helping the client recognize when direct and indirect warning signs are becoming more apparent, develop coping responses, and focus on the client's emotional regulation.

As mentioned earlier, there is little or no empirical evidence to support "suicide contracts" (an agreement from a client to contact the clinician or someone else before making a suicide attempt) as a "stand alone" intervention. However, the consensus panel strongly recommends that clinicians help clients at risk of suicidal thoughts and behaviors develop a safety card, sometimes referred to as an emergency card. Such a plan ideally identifies who a client in crisis can turn to for

immediate help, where they can go for help, other proactive behaviors the client can take (such as maintaining sobriety), and what kind of information they should give to providers so that the crisis is recognized and addressed. A related technique is a Commitment to Treatment agreement, which focuses the client's attention on the specific behaviors (such as attending treatment sessions, setting recovery goals, completing homework assignments, and taking medications as prescribed) that potentially reduce suicidal thoughts and behaviors. The difference in the two techniques is that safety cards and plans focus on preventing or intervening in crises, while the Commitment to Treatment agreement focuses on behaviors that positively support treatment outcome.

Referring a client who is ambivalent about treatment or is resisting treatment

It is common to make a referral either for further evaluation, treatment of suicide risk, treatment of a mental health condition (for example, depression), or for a combination of services. Sometimes, however, there will be times when you make a referral that a client does not agree is necessary or simply does not wish to accept. By taking the time to discuss the reasons for your actions and by listening and acknowledging their concerns, clients who are suicidal will usually soften their stance and become more willing. Eliciting a client's input as to what he or she believes would be most helpful and using these suggestions, as appropriate, can also go a long way to eliciting cooperation. Anything appropriate that you can do to give a client a sense of choice or control will be helpful.

Although a referral for emergency evaluation is usually not necessary and less intensive action(s) will typically suffice, there will be times when such an action is needed. In these instances, a resistant client may become more willing if provided some sense of control, for example, through a question such as "Would you prefer to call your family before you go to the emergency department or would you rather I call them after you get there?"

In the end, if a client refuses to cooperate with an additional evaluation, you (in close coordination with your supervisor or team) you will need to take the necessary steps to arrange for the evaluation (e.g., by arranging an ambulance or police escort). The client should not be left unaccompanied while such arrangements are being made. A note on inpatient treatment for suicidality: It is important that clinicians, clients, and their family members know what to expect from inpatient psychiatric hospitalization. Generally, the treatments are short term (5–7 days), and if the clinical team concludes that suicidality is substance-induced, the stay may be shorter (Ries, Yuodelis-Flores, Comtois, Roy-Byrne, & Russo). During hospitalization, the focus is typically on medication management and dis-

position planning, with a minimal focus on addressing ongoing stressors therapeutically. As a result, most or all of the psychosocial difficulties that prompted admission will still need to be addressed when the client returns to treatment. A study of psychiatric inpatient admissions to one large, university-based hospital showed that “substance-induced suicidality,” as rated by clinicians, represented 40 percent of all admissions, indicating the extent to which substance-related problems promote such admissions (Ries et al.).

Summary of T: Take responsible action

The intensiveness of the actions that you take in coordination with your supervisor or team should make good sense in light of the information that you have gathered, with more serious risk requiring more intensive action(s). The action(s) may include referring the client for a formal assessment or for additional treatment. Taking the time to prepare clients for a referral and providing them some sense of control will be helpful in eliciting their cooperation.

E: Extend the action

A common misconception is that suicide risk is an acute problem that, once dealt with, ends. Unfortunately, individuals who are suicidal commonly experience a return of suicide risk following any number of setbacks, including relapse to substance use, a distressing life event (e.g., break-up with a partner), increased depression, or any number of other situations. Sometimes suicidal behavior even occurs in the context of substantial improvement in mood and energy. Therefore, monitoring for signs of a return of suicidal thoughts or behavior is essential.

What extended actions can you take?

The list below mentions many common extended actions but is not exhaustive. It is in no particular order:

- Confirm that a client has kept the referral appointment with another provider such as a Psychiatrist.
- Follow up with the hospital emergency department when a client has been referred for acute assessment.
- Coordinate with a Psychiatrist (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.
- 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.

Summary of E: Extend the action

Suicide prevention efforts are not one-time actions. They should be ongoing because suicidal clients are vulnerable to a recurrence of risk. A team approach is also essential, as it requires you to follow up on referrals and coordinate with other providers in an ongoing manner. The actions listed above represent many, but not all, of the extended actions you may use to promote safety throughout treatment. Work closely with your supervisor or team in developing a plan of extended actions. Finally, document the client's eventual progress and status at the point of your treatment termination.

Documenting GATE

Documentation of suicidality is critical to promoting client safety, coordinating care among treatment professionals, and establishing a solid medical and legal record. Documentation entails providing a written summary of any steps taken pertaining to GATE, along with a statement of conclusions that shows the rationale for the resultant plan. The plan should make good sense in light of the seriousness of risk.

Examples listed below, illustrate documentation across a continuum of seriousness of suicidality. Clinicians, supervisors, or consultants may provide such documentation. Many programs or State regulatory bodies recommend or mandate a particular format in which this documentation can occur. Generally, such formats can accommodate all of the information contained in the GATE protocol. In the notes below, the italicized text is the actual note. These examples are "ideals." Notes in routine clinical practice may fall short of this level of detail and organization. Nonetheless, the notes serve as models for documentation. Agencies may implement checklists as well (e.g., warning signs, risk factors, protective

factors) to assist with documentation. Even with the use of a checklist, a conclusion statement and the articulation of the plan are always needed.

Documentation example 1

The following is from an intake evaluation of Roberta, a 40-year-old African-American woman seeking treatment for cocaine dependence. The situation was not acute, so regular supervision was used and no immediate actions were taken.

Gather information: The client made a suicide attempt at age 31 by overdosing on over-the-counter sleeping pills following a sexual assault for which she received overnight treatment in a hospital emergency department. She was ambivalent about the suicide attempt and immediately afterward was relieved that she survived.

Since that time, she has not reattempted; she reported no current or recent ideation, plan, or intent. She reported that she no longer uses sleeping pills and has none in her possession. She stated that her strong faith in God prevents her from making another attempt. No warning signs for suicidal behavior were evident.

Conclusion: There is a history of suicidal behavior but no indication of a need for action.

Access supervision: Her suicide-related history will be discussed at the next team meeting on January 14.

Documentation example 2

The following is from a progress note for Fernando, a 22-year-old Hispanic male. He is an Iraq war veteran who had been doing well in treatment for dependence on alcohol and opiates, but had missed group therapy sessions and not returned phone calls for the past 10 days. This situation occurred in a substance abuse clinic within a hospital and required accessing immediate supervision and interventions of high intensity.

Gather information: Fernando came in, unannounced, at 10:30 a.m. today and reported that he relapsed on alcohol and opiates 10 days ago and has been using daily and heavily since. Breathalyzer was .08, and he reported using two bags of heroin earlier this morning. He reported that he held his loaded rifle in his lap last night while high and drunk, contemplating suicide.

Access supervision: This writer's supervisor, Janice Davis, LMFT, was called to join the session.

Conclusion: It was determined that emergency intervention is necessary because of intense substance use, suicidal thoughts with a lethal plan, and access to a weapon.

Take action: At 11:00 a.m., a hospital security guard and this writer escorted Fernando to the emergency department where he was checked in. He was cooperative throughout the process.

Extend the action: Dr. McIntyre, the Emergency Department physician, determined that Fernando requires hospitalization. He is currently awaiting admission. This writer will follow up with the hospital unit after he is admitted and will raise the issue of his access to a gun.

3.0 Suicide Risk Assessment

While there is no way to predict with complete certainty who will attempt suicide, understanding certain imminent warning signs as well as statistically related risk factors will help providers know when to actively intervene and further assess for imminent suicide risk.

Key components of a suicide risk assessment

1. Assess warning signs and risk factors
2. Assess protective factors
3. Suicide Inquiry: thoughts/plan/intent/access to means
4. Clinical judgment

3.1 Warning Signs and Risk/Protective Factors

Warning Signs for Suicide

Warning signs are defined as acute indications of elevated risk. In other words, they signal potential risk for suicidal behavior in the near future. Warning signs may be evident at intake or may arise during the course of treatment. Warning signs always require asking followup questions. As identified by a panel of experts on suicidal behavior (Rudd et al.), warning signs can be direct or indirect. Direct indications of acute suicidality are given the highest priority. They are:

- ✓ Suicidal communication: Someone threatening to hurt or kill him or herself or talking of wanting to hurt or kill him or herself.
- ✓ Seeking access to a method: Someone looking for ways to kill him- or herself by seeking access to firearms, available pills, or other means.
- ✓ Making preparations: Someone talking or writing about death, dying, or suicide.

Additionally, the American Association of Suicidology (AAS) and American Foundation for Suicide Prevention (AFSP) have published the following warning signs of suicidal behaviors:

- ➔ Expressed or communicated ideation or plans to hurt oneself
- ➔ Increased substance use
- ➔ Espousing few reasons for living
- ➔ Anxiety, panic, or agitation
- ➔ Inability to sleep or oversleeping
- ➔ Feeling trapped
- ➔ Persistent feelings of hopelessness
- ➔ Social withdrawal
- ➔ Uncontrolled anger or rage
- ➔ Acting reckless, or engaging in risky activities
- ➔ Feelings of guilt, shame, or self-blame
- ➔ Appearing sad or depressed; or exhibiting changes in mood
- ➔ Making plans or preparations for an attempt (i.e., researching or procuring means, giving away possessions).

Though these may reflect symptoms of depression, other warning signs may be visible even when depression or a psychiatric condition is not. You may also observe indirect warning signs in clients who are not suicidal. Nonetheless, these warning signs are critical to follow up on to determine the extent to which they may signal acute risk for suicidal behavior. You can remember them by the mnemonic IS PATH WARM:

- ✓ I = Ideation
- ✓ S = Substance Abuse
- ✓ P = Purposelessness
- ✓ A = Anxiety
- ✓ T = Trapped
- ✓ H = Hopelessness
- ✓ W = Withdrawal
- ✓ A = Anger
- ✓ R = Recklessness
- ✓ M = Mood Changes

Some of the IS PATH WARM warning signs are self-evident (e.g., substance abuse); others require brief explanation. “Purposelessness” refers to a lack of a sense of purpose in life or reason for living. “Trapped” refers to perceiving a

terrible situation from which there is no escape. “Withdrawal” refers to increasing social isolation. “Anger” refers to rage, uncontrolled anger, or revenge-seeking. “Anxiety” is a broad term that refers to severe anxiety, agitation, and/or sleep disturbance. “Mood changes” refers to dramatic shifts in emotions.

Warning signs are often in evidence following acute stressful life events. Among people who abuse substances, break-up of a partner relationship is most common. It is also important to look for warning signs in your clients when relapse occurs and during acute intoxication.

Stressful life events include:

- Break-up of a partner relationship.
- Experience of trauma.
- Legal event.
- Job loss or other major employment setback.
- Financial crisis.
- Family conflict or disruption.
- Relapse.
- Intoxication.

Each of the direct warning signs indicates potential for suicidal behavior in its own right, and, if present, requires rigorous followup. The indirect warning signs may or may not signal risk for acute suicidal behavior (for example, “substance abuse” is the norm among your clients). In all cases, they require further follow up questions to determine if they may indeed indicate acute suicidality.

Suicidal behavior is associated with many different types of events, illnesses, and life circumstances. The strongest predictor of suicide is one or more previous attempts; however, most people who die by suicide die on their first attempt. A prior suicide attempt does not always mean that a person will go on to complete suicide; over 90% of individuals who have survived an attempt will not go on to later die by suicide. It is important to take all attempts seriously, however, and not interpret a patient who has had multiple attempts as solely “attention seeking”. Help, hope, and recovery are possible.

There are many factors that increase risk for suicide. A greater number of identified risk factors is suggestive of greater risk.

Risk Factors

Risk factors are defined as indicators of long-term (or ongoing) risk. They are different from warning signs, which signal immediate risk. Risk factors for suicidal thoughts and behaviors have been well researched (Conner, Beautrais, & Conwell;; Conner et al.; Darke & Ross; Ilgen et al.; Murphy et al.; Preuss et al.; Roy; Schneider et al.). The list below, although not exhaustive, is informed by these studies.

These risk factors include:

- Prior history of suicide attempts (most potent risk factor, although it should be remembered that about half of all deaths by suicide are first-time attempts).
- Family history of suicide.
- Severe substance use (e.g., dependence on multiple substances, early onset of dependence).
- Co-occurring mental disorder:
 1. Depression (including substance-induced depression).
 2. Anxiety disorders (especially PTSD).
 3. Severe mental illness (schizophrenia, bipolar disorder).
 4. Personality disorder (best researched are borderline and antisocial personality disorders).
 5. Anorexia nervosa.
- History of childhood abuse (especially sexual abuse).
- Stressful life circumstances:
 1. Unemployment and low level of education, job loss, especially when nearing retirement.
 2. Divorce or separation.
 3. Legal difficulties.
 4. Major and sudden financial losses.
 5. Social isolation, low social support.
 6. Conflicted relationships.
- Personality traits:
 1. Proneness to negative affect (sadness, anxiety, anger).
 2. Aggression and/or impulsive traits.
- Firearm ownership or access to a firearm.
- Probable risk factors (although greater certainty requires more research in people with substance use disorders):
 1. Inflexible/rigid personality characteristics.
 2. Sexual orientation (lesbian, gay, or bisexual).
 3. Chronic pain.

Additional risk factors include:

- ➔ Marital status (e.g., unmarried, divorced, separated)
- ➔ Employment status (e.g., unemployed)
- ➔ Ethnicity and cultural factors (i.e., member of underrepresented, minority, or indigenous group)
- ➔ Media exposure to graphic accounts of suicide
- ➔ Non-suicidal self injury
- ➔ Elevated pain tolerance or exposure
- ➔ Sleep disturbances (e.g., insomnia, nightmares)
- ➔ Interpersonal factors (e.g., hopelessness, low belongingness, perceiving self as burden)
- ➔ The structure of suicidal symptoms (i.e., resolved plans, intent vs. suicidal desire; symptoms that are intense, pervasive, and difficult to control).

Given that depression presents highest risk for suicide, risk factors that stand alone to confer risk (i.e., independent of depression severity) are prioritized, especially those visible, proximal to risk, and modifiable.

Protective Factors

Protective factors are defined as buffers that lower long-term risk. Unlike risk factors, factors that are protective against suicidal behavior are not well researched (Goldsmith, Pellmar, Kleinman, & Bunney). Fewer protective factors than risk factors have been identified among people who abuse substances and other populations. Reasons for living are perhaps the best researched protective factors in the literature (Linehan Goodstein, Nielsen, & Chiles,; Oquendo Dragasti et al.). The following are known and likely protective factors:

- ✓ Reasons for living.
- ✓ Being clean and sober.
- ✓ Attendance at 12-Step support groups.
- ✓ Religious attendance and/or internalized spiritual teachings against suicide.
- ✓ Presence of a child in the home and/or childrearing responsibilities.
- ✓ Intact marriage.
- ✓ Trusting relationship with a counselor, physician, or other service provider.
- ✓ Employment.
- ✓ Trait optimism (a tendency to look at the positive side of life).

Protective factors may include absence of risk, as well as increased access to care, strong connections to family/ community, non-violent ways of handling conflict, cultural or religious beliefs that may discourage suicide, and restricted access to means. Best practices in suicide risk assessment utilize a transparent and collaborative approach to safety planning, including informed consent to the risk assessment process and the use of clinical decision trees to routinize risk designations. These are based on suicide attempt history, the severity of current suicidal symptoms, and integration of risk factors (Brown & Stanley; VA Memorandum; Stanley & Brown).

A caution about protective factors: If acute suicide warning signs and/or multiple risk factors are in evidence, the presence of protective factors does not change the bottom-line assessment that preventive actions are necessary, and should not give you a false sense of security. Although protective factors may sustain someone showing ongoing signs of risk (e.g., due to chronic depression), they do not immunize clients from suicidal behavior and may afford no protection in acute crises.

Protective factors vary with cultural values. For example, in cultures where extended families are closely knit, family support can act as a protective factor. Others include a strong affiliation with a clan, tribe, or ethnic community; faith in and reliance on traditional healing methods; strong spiritual values shared among community members; and absence of cultural trauma such as that of families of Holocaust survivors and American Indians who were sent unwillingly to boarding schools to be acculturated.

Risk of Suicide and Suicide Attempts: Age, Gender, and Race or Ethnicity

Age

Adolescents and young adults are more likely to make nonfatal suicide attempts than older individuals (NCIPC). However, older individuals are more likely to die by suicide. Older adults' elevated risk for suicide deaths is attributable to their tendency to show high suicide intent, to use more deadly methods, and to their bodies' greater fragility to the effects of acts of self-harm (Conwell, Duberstein, & Caine). Because many older adults live alone, they are less likely to be rescued (Szanto et al.). The extent to which these general population patterns pertain to people treated for substance use disorders is not clear.

Gender

Women are more likely to attempt suicide than men, although the difference in prevalence of suicide attempts between men and women is not as high as once believed (Nock & Kessler). Men are more likely to die by suicide than women (NCIPC). Overall, men carry out fewer suicidal acts, but they tend to show higher intent to die (Nock & Kessler), and use more deadly methods (Goldsmith et al.). The extent to which these general population patterns pertain to people treated for substance use disorders is not clear.

Race and ethnicity

According to national statistics on suicide (NCIPC), Whites and Native Americans have higher rates of suicide than African Americans; males are at highest risk in all of these racial groups. The highest rate of suicide among White males is during older adulthood (age 70 and older), while the highest rates of suicide among Native American and African American males occur much younger—during late adolescence and young adulthood. It should be noted that suicide rates among Native Americans vary significantly depending on tribe and region of the country. Some data also suggest that risk factors differ across racial groups. For example, the presence of an anxiety disorder may be an especially important risk factor for suicide attempts among Blacks (Joe, Baser, Breeden, Neighbors, & Jackson). The extent to which these general population patterns pertain to people treated for substance use disorders is not clear. There is a particularly low prevalence of deaths by suicide among African American females, although it is unknown if this data holds true for African American females with a substance use disorder (NCIPC). Hispanics/Latinos have fairly similar rates of suicidal thoughts and behavior compared with White, non-Hispanic individuals (NCIPC). Among youth and young adults, the prevalence of suicidal thoughts and behavior increases among Hispanics/Latinos who are more acculturated to mainstream American culture, particularly among females (Zayas, Lester, Cabassa, & Fortuna). The extent to which these general population patterns pertain to people treated for substance use disorders is not clear. Additional information on race and ethnicity and substance abuse treatment can be obtained in the planned TIP, Improving Cultural Competence in Substance Abuse Treatment (CSAT, in development d) Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment

Individual Risk Factors

- ✓ Previous suicide attempt, especially within the past year
- ✓ Major physical illnesses, especially with chronic pain
- ✓ Central nervous system disorders, including TBI
- ✓ Mental illnesses, particularly:

1. Mood disorders
 2. Schizophrenia
 3. Anxiety disorders (including, PTSD)
 4. Certain alcohol and other substance use disorders
 5. Personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive PD)
 6. In youths: Attention-deficit/hyperactivity disorder (ADHD) and conduct disorders (antisocial behavior, aggression, impulsivity)
- ✓ Psychiatric symptoms/states of mind: anhedonia (diminished or inability to gain pleasure from normally pleasurable experiences or activities), severe anxiety/panic, insomnia, command hallucinations, intoxication, self-hate
 - ✓ Impulsive and/or aggressive behavior
 - ✓ History of trauma or abuse
 - ✓ Family history of suicide or exposure to suicide in social network, community, media
 - ✓ Precipitants/triggering events leading to humiliation, shame, or despair (e.g., loss of relationship, health or financial status – real or anticipated)

Social/Environmental Risk Factors

- ✓ Chaotic family history (e.g., separation or divorce, change in caretaker, change in living situation or residence, incarcerations)
- ✓ Lack of social support and increasing sense of isolation
- ✓ Easy access to/familiarity with lethal means (e.g., guns, illicit drugs, medications)
- ✓ Local clusters of suicide that can have a contagious influence
- ✓ Legal difficulties/contact with law enforcement/incarceration
- ✓ Barriers to accessing health care, especially mental health and substance abuse treatment

Societal Risk Factors

- ✓ Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- ✓ Exposure to, including through the media, and influence of others who have died by suicide

How to Assess

Risk Factors

Interviews between care providers and suicidal patients need to maintain or enhance the therapeutic alliance. All assessments should be conducted with curiosity, concern, calmness, and acceptance of the individual's current emotional

and cognitive state. Patients with suicidal ideation may feel hopeless, desperate, or cognitively overwhelmed, interfering with their ability to comprehend and convey these thoughts to others. Clinicians should stay attuned to their own reactions that may be non-therapeutic, such as hostility, avoidance of negative feelings, or the blurring of professional roles, possibly as a way to take on a savior role.

A prior suicide attempt remains the strongest predictor of future attempts and completions. There is increasing correlation between suicidal ideation and behaviors, especially for those presenting in an emergency room setting. Although most individuals who self-harm do not go on to commit suicide, repeated self-harm even without intention to end life is a predictor of suicide and is typically present within the 12 months preceding suicide in young people. It should be noted, though, that over 90% of suicides are completed on the first or second attempt.

Suicidal ideation, in contrast to a history of suicide attempts, may represent an increase in suicide risk, especially if this ideation has developed into the seeking of means to perform the action, increasing discussion about death, and rehearsal behaviors. There is no documented difference between passive or active suicidal ideation in suicide course or outcome; as such, both should hold weight in suicide assessment.

Stressful life events must be considered within the circumstance and age of the patient. Common adolescent events include bullying (either as victim or perpetrator), disciplinary actions, legal issues, school difficulties, romantic break-ups, assaults, or problems relating to home-life. For adults, financial difficulties, relationship losses, unemployment, and intimate partner violence all increase the risk for suicide attempts. These events may ultimately resolve with time and action, but during a visit with a primary care provider, they are unlikely to be modifiable.

All psychiatric disorders, with the exception of intellectual disability and later course dementias, are associated with an increased risk of suicidal ideation, attempts, and completions. This risk is significantly greater during active periods of illness and correlates with severity of illness. Hopelessness in the setting of depression increases the risk for suicide and is typically modifiable with treatment of the mental health disorder.

Physical illnesses such as pulmonary disease, cancer, stroke, diabetes, ischemic heart disease, and spine disorders are all independently associated with suicide completion. Suicide decedents tend to spend more time in the hospital for both medical and psychiatric reasons in the months prior to their death, endorse lower

global quality of life assessment scores, and suffer from more physical impairment. Similar risk for depression and suicide is also found in adolescent populations with chronic physical illnesses. While some illnesses cannot be cured, the amount of disability or functioning may be modifiable with therapy.

High-risk substance use or use disorders, including alcohol, prescription, and illicit drugs, are associated with increased suicide risk in both adult and adolescent populations. Twenty percent of suicides occur while individuals are intoxicated. Increasing substance use despite worsening mood symptoms, associated dysfunction, and increasing suicidal ideation may lead to a more acute suicide risk compared to a previous baseline level of use.

Members of the LGBTQ community may be at increased risk for suicide, especially if they have not found acceptance within their community and main support system. This risk factor should be considered within the environment of the patient.

Protective Factors

Similar to risk factors, most individuals have both modifiable and non-modifiable protective factors that may be enhanced during periods of acute distress to help prevent against suicide. The following questions can help elicit these factors:

1. What keeps you going during difficult times?
2. What are your reasons for living?
3. What has kept you from acting on those thoughts?
4. What or who do you rely on for support during times like these?

Similar to risk factors, protective factors have to be considered within the context of the patient. For example, social obligation to a spouse is protective against suicide, but the presence of high-conflict or violence within the relationship significantly increases suicide risk. Responsibility to children is felt to be protective in suicide, except in cases of postpartum mood and psychotic disorders, teen pregnancy, and extreme economic hardships. Although pregnancy and motherhood has been studied as a protective factor, suicide remains the leading cause of maternal death in industrialized countries and vigilance in assessing for ante- and postpartum depression and anxiety cannot be overemphasized.

While protective factors provide only a limited counterbalance to individuals who are high-risk for attempting suicide (i.e., someone with strong ideation, intent, a plan, preparatory behaviors, and impaired judgment) and vary greatly from

one individual to another, protective factors may mitigate risk in a person with moderate to low suicide risk. Strengthening protective factors can be a part of safety planning. Some protective factors include:

- ✓ Sense of responsibility to family
- ✓ Life satisfaction
- ✓ Social support; belongingness
- ✓ Coping skills
- ✓ Problem-solving skills
- ✓ Strong therapeutic relationship with a trusted provider
- ✓ Reality testing ability
- ✓ Religious faith

Read on for a variety of tools and sample questions that you can use to assess suicide risk. How you ask the questions affects the likelihood of getting a truthful response. Use a nonjudgmental, non-condescending, matter-of-fact approach.

NEVER ask leading questions like:

“You’re not thinking of suicide, are you?”

“I hope that you aren’t thinking about hurting yourself”

PRACTICE the questions below several times prior to a clinical encounter; again, asking about suicide for the first time may be harder than you think!

3.2 Evaluation

Part of a suicide risk assessment is gaining a very clear understanding of the individual’s desire to complete suicide, their capability to do so, and their current suicidal intent. Some questions that can help elicit this information are included below:

1. Why do you want to die?
2. Have you done anything in preparation for your death?
3. On a scale of 1–10, where would you rate your seriousness or wish to die?
4. Have you tried out any particular method or taken steps in rehearsal for suicide?

Determining Level of Risk

The overall goal at this point is that the provider has been able to adequately identify key risk factors, both modifiable and acute, and protective factors in order to rate the individuals current risk of suicide. This acute, current risk may differ

from the client's chronic level of suicide risk, the latter of which is typically based on static demographic factors that are not modifiable. There can be ambiguity around risk factors and what may define a chronic and hard to manage risk versus an acute risk that must be dealt with immediately, necessitating clinical judgement. As many assessment and screening tools do, it is proposed that overall risk be defined as a manageable three levels (low, medium, or high). Individuals at the lowest and highest risk may be easiest to identify and those at more moderate levels of risk may require greater assessment to discern the most appropriate management strategy.

Managing Level of Risk

While most providers may feel the primary purpose of a risk assessment is to determine disposition (home versus hospital), it should also be used to help guide other interventions, both pharmacologic and non-pharmacologic, and regardless of setting.

Thoughts of Suicide

Ask clients you suspect may be feeling suicidal about thoughts or feelings related to suicide. The sample questions below will help you ease into the subject in a non-threatening way.

Questions to uncover suicidal thinking:

- ❖ “Sometimes, people in your situation (describe the situation) lose hope; I’m wondering if you may have lost hope, too?”
- ❖ “Have you ever thought things would be better if you were dead?”
- ❖ “With this much stress (or hopelessness) in your life, have you thought of hurting yourself?”
- ❖ “Have you ever thought about killing yourself?”

Prior Attempts

A history of a prior attempt is the strongest predictor of future suicidal behavior. Always ask if the patient has attempted suicide in the past, even if there is no evidence of recent suicidal thinking.

Questions to assess prior attempt:

- ❖ “Have you ever tried to kill yourself or attempt suicide?”
- ❖ “Have things ever been so bad for you in the past that you thought about killing yourself or actually tried to hurt yourself or kill yourself?”

Questions to assess suicidal ideation:

- ❖ “When did you begin having suicidal thoughts?”
- ❖ “Did any event (stressor) precipitate the suicidal thoughts?”
- ❖ “How often do you have thoughts of suicide? How long do they last? How strong are they?”
- ❖ “What is the worst they have ever been?”
- ❖ “What do you do when you have suicidal thoughts? Do you find that you have them more frequently or more intensely at different times of the day or of the week?”

Plan

After discussing the character of suicidal thoughts, providers should inquire about planning. Ask whether the client has a plan and, if so, get the specifics.

Questions to assess suicidal planning:

- ❖ “Do you have a plan or have you been planning to end your life? If so, how would you do it? “Where would you do it?”
- ❖ “Do you have the (drugs, gun, rope) that you would use? Where is it right now?”
- ❖ “Do you have a timeline in mind for ending your life? Is there something (an event) that would trigger the plan?”

Intent

Determine the extent to which the client expects to carry out the plan and believes the plan or act to be lethal vs. self-injurious. Also explore the client’s reasons to die vs. reasons to live. Many clients are very ambivalent about suicide. Consider the client’s judgment and level of impulse control. Administer mental status exam if in doubt about mental status.

Questions to assess intent:

- ❖ “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?”
- ❖ “For instance, have you rehearsed what you would do (e.g., held the pills or gun, tied the rope)?”
- ❖ “Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?”
- ❖ “What makes you feel better (e.g., contact with family, use of substances)?”
- ❖ “What makes you feel worse (e.g., being alone, thinking about a situation)?”

- ❖ “How likely do you think you are to carry out your plan?”
- ❖ “What stops you from killing yourself?”

Clinical Judgment of Suicide Risk

Assessing suicide risk is complex when clients have medical illnesses, mental health and substance abuse problems, and myriad family, contextual and environmental risk and protective factors. At the low end of the risk spectrum are clients without thoughts of death or wanting to die, and without intent or a plan. Those with highly specific suicide plans, preparatory acts or suicide rehearsals, and clearly articulated intent are at the high end of the risk spectrum. Impaired judgment (intoxication, psychosis, TBI, impulsiveness) further exacerbates that heightened risk. There is no screening tool or questionnaire that can predict with complete accuracy which clients from among the many with suicidal risk will go on to make a suicide attempt, either fatal or non-fatal.

3.3 Tools, Scales, and Instruments

Columbia-Suicide Severity Rating Scale (C-SSRS)

The Columbia-Suicide Severity Rating Scale (C-SSRS) is a questionnaire used for suicide assessment developed by multiple institutions, including Columbia University, with NIMH support. The scale is evidence-supported and is part of a national and international public health initiative involving the assessment of suicidality. Available in 103 different languages, the scale has been successfully implemented across many settings, including schools, college campuses, military, fire departments, the justice system, primary care and for scientific research. Several versions of the C-SSRS have been developed for clinical practice. The Risk Assessment version is three pages long, with the initial page focusing on a checklist of all risk and protective factors that may apply. This page is designed to be completed following the client (caller) interview.

The next two pages make up the formal assessment. The C-SSRS Risk Assessment is intended to help establish a person’s immediate risk of suicide and is used in acute care settings. In order to make the C-SSRS Risk Assessment available to all Lifeline centers, the Lifeline collaborated with Kelly Posner, Ph.D., Director at the Center for Suicide Risk Assessment at Columbia University/New York State Psychiatric Institute to slightly adjust the first checklist page to meet the Lifeline’s Risk Assessment Standards. The following components were added: helplessness, feeling trapped, and engaged with phone worker. If applied, it is intended to be followed exactly according to the instructions and cannot be altered.

Training is available and recommended (though not required for clinical or center practice) before administering the C-SSRS. Training can be administered through a 30-minute interactive slide presentation followed by a question-answer session or using a DVD of the presentation. Those completing the training are then certified to administer the C-SSRS and can receive a certificate, which is valid for two years.

To access The COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS) Risk Assessment (Lifeline crisis center version), please visit <https://suicidepreventionlifeline.org/wp-content/uploads/2016/09/Suicide-Risk-Assessment-C-SSRS-Lifeline-Version-2014.pdf>

The Patient Health Questionnaire-9 (PHQ-9)

The Patient Health Questionnaire-9 (PHQ-9) is a quick, subjective reporting scale that can be incorporated into the medical record. Affirmative responses to item 9 regarding thoughts of death or self-harm have a hazard ratios of 10 and 8.5 for attempts and deaths in a community setting, respectively. It is in the public domain and available at the Stanford website https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf.

While many clinics defer to the PHQ-2 for depression screening, the cut-off for further depression assessment is typically three and can miss 50–60% of patients who would otherwise endorse suicidal ideation on item 9 of the extended version.

The Beck Scale for Suicide Ideation (BSI; Beck & Steer) is a 21-item self-report instrument for detecting and measuring the current intensity of the patients' specific attitudes, behaviors, and plans to commit suicide during the past week. The BSI was developed as a self-report version of the interviewer-administered Scale for Suicide Ideation. The first 19 items consist of three options graded according to the intensity of the suicidality and rated on a 3-point scale ranging from 0 to 2. These ratings are then summed to yield a total score, which ranges from 0 to 38. Individual items assess characteristics such as wish to die, desire to make an active or passive suicide attempt, duration and frequency of ideation, sense of control over making an attempt, number of deterrents, and amount of actual preparation for a contemplated attempt. The last two items assess the number of previous suicide attempts and the seriousness of the intent to die associated with the last attempt. As with the SSI, the BSI consists of five screening items.

If the respondent reports any active or passive desire to commit suicide, then an additional 14 items are administered. The BSI takes approximately 10 minutes to administer. Although the BSI is less widely used than the SSI, the BSI may be a viable alternative for measuring suicide ideation using a self-report format. (extract from Brown 8-9).

The 19-item Scale for Suicide Ideation – Worst (SSI-W; Beck et al.) is an interviewer-administered rating scale that measures the intensity of patients’ specific attitudes, behaviors, and plans to commit suicide during the time period that they were the most suicidal. The instrument was developed to obtain a more accurate estimate of suicide risk. As with the SSI, each SSI-W item consists of three options graded according to the suicidal intensity on a 3-point scale ranging from 0 to 2. The ratings are then summed to yield a total score, which ranges from 0 to 38. Individual items assess characteristics such as wish to die, desire to make an active or passive suicide attempt, duration and frequency of ideation, sense of control over making an attempt, number of deterrents, and amount of actual preparation for a contemplated attempt. The SSI-W takes approximately 10 minutes. Although the SSI-W has been used less frequently than the SSI, the reliability and validity of this measure have been established.

The Ask Suicide-Screening Questions (ASQ) tool is a brief validated tool for use among both youth and adults. The Joint Commission approves the use of the ASQ for all ages. Additional materials to help with suicide risk screening implementation are available in The Ask Suicide-Screening Questions (ASQ) Toolkit, a free resource for use in medical settings (emergency department, inpatient medical/surgical units, outpatient clinics/primary care) that can help providers successfully identify individuals at risk for suicide. The ASQ toolkit consists of youth and adult versions as some of the materials take into account developmental considerations.

The ASQ is a set of four screening questions. In an NIMH study, a “yes” response to one or more of the four questions identified 97% of youth (aged 10 to 21 years) at risk for suicide. Led by the NIMH, a multisite research study has now demonstrated that the ASQ is also a valid screening tool for adult medical patients. By enabling early identification and assessment of medical patients at high risk for suicide, the ASQ toolkit can play a key role in suicide prevention.

SAFE-T Pocket Card: Suicide Assessment Five-Step Evaluation and Triage for Clinicians This resource gives a brief overview on conducting a suicide

assessment using a five-step evaluation and triage plan. The five-step plan involves identifying risk factors and protective factors, conducting a suicide inquiry, determining risk level and interventions, and documenting a treatment plan. Download SAMHSA's Suicide Safe mobile app on your mobile device.

RESOURCES

- Download this card and additional resources at <http://www.sprc.org>
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide <http://www.sprc.org/library/jcsafetygoals.pdf>
- SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. *Journal of the American Academy of Child and Adolescent Psychiatry*, 2001, 40 (7 Supplement): 24s-51s

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National Suicide Prevention Lifeline
1-800-273-TALK (8255)



<http://www.sprc.org>



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SAFE-T

Suicide Assessment Five-step
Evaluation and Triage

1

IDENTIFY RISK FACTORS

Note those that can be modified to reduce risk

2

IDENTIFY PROTECTIVE FACTORS

Note those that can be enhanced

3

CONDUCT SUICIDE INQUIRY

Suicidal thoughts, plans, behavior, and intent

4

DETERMINE RISK LEVEL/INTERVENTION

Determine risk. Choose appropriate intervention to address and reduce risk

5

DOCUMENT

Assessment of risk, rationale, intervention, and follow-up



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Suicide Safe Mobile App

For individuals at risk of suicide, primary and behavioral health care settings provide unique opportunities to connect with the health care system and access effective treatment. Suicide Safe is a free mobile app that helps providers integrate suicide prevention strategies into their practice and address suicide risk among

their patients. The Suicide Safe app is based on SAMHSA's Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) card.

The Suicide Behaviors Questionnaire-Revised (SBQ-R)

The SBQ-R has 4 items, each tapping a different dimension of suicidality:

- Item 1 taps into lifetime suicide ideation and/or suicide attempt.
- Item 2 assesses the frequency of suicidal ideation over the past twelve months.
- Item 3 assesses the threat of suicide attempt.
- Item 4 evaluates self-reported likelihood of suicidal behavior in the future.

Clinical Utility: Due to the wording of the four SBQ-R items, a broad range of information is obtained in a very brief administration. Responses can be used to identify at-risk individuals and specific risk behaviors.

Patient Safety Plan Template

A fill-in-the-blank template for developing a safety plan with a patient who is at increased risk for a suicide attempt. Access this link for a copy of the Patient Safety Plan Template https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_St StanleySafetyPlanTemplate.pdf

Type: Template/Worksheet

Author: Brown G, Stanley B, Department of Veterans Affairs

Publisher: Barbara Stanley and Gregory K. Brown

(SIQ) Suicidal Ideation Questionnaire

The SIQ assesses the frequency of suicidal ideation and serves as a valuable component in a comprehensive assessment of adolescent mental health. The SIQ consists of 30 items and is appropriate for students in Grades 10-12.

The SIQ-JR consists of 15 items and is designed for students in Grades 7-9.

Reliability coefficients are .97 for the SIQ and .93 to .94 for the SIQ-JR.

For many adolescents, the SIQ and the SIQ-JR provide a mechanism for informing adults/professionals of their level of distress and suicidal intent, serving as a cry for help that doesn't involve self-injurious behavior. Adolescents who are thinking about suicide may respond to these measures with the expectation that, in telling others of their suicidal thoughts, people will take notice of their distress and act to assist them. It is therefore vital that professionals act quickly once critical SIQ or SIQ-JR scores are obtained.

BHS Beck Hopelessness Scale

The Beck Hopelessness Scale® measures negative attitudes about the future. Responding to the 20 true or false items on the (BHS®), patients can either endorse a pessimistic statement or deny an optimistic statement. Guidance on using this test in your telepractice is available.

Scoring Options: Manual Scoring or Q-global™ Scoring & Reporting
Age range: 17-80 (recommended)
Publication date: 1988, 1993
Qualification level: B

Completion time: 5 to 10 minutes; self-administered or verbally by a trained administrator

Other languages: Spanish

The Positive and Negative Suicide Ideation Inventory

A brief self-report measure for assessing the frequency of positive and negative thoughts related to suicidal behavior. The inventory is a well-developed self-report measure for assessing the frequency of positive and negative thoughts related to suicidal behavior.

The Suicide Behaviors Questionnaire-Revised (SBQ-R)

The SBQ-R has 4 items, each tapping a different dimension of suicidality:

- Item 1 taps into lifetime suicide ideation and/or suicide attempt.
- Item 2 assesses the frequency of suicidal ideation over the past twelve months.
- Item 3 assesses the threat of suicide attempt.
- Item 4 evaluates self-reported likelihood of suicidal behavior in the future.

Clinical Utility: Due to the wording of the four SBQ-R items, a broad range of information is obtained in a very brief administration. Responses can be used to identify at-risk individuals and specific risk behaviors.

3.4 Summary of Suicide Risk Assessment Tools, Instruments and Scales

The following is a summary listing of suicide risk assessment tools, instruments, and scales with corresponding links in order to promote access:

1. COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS) Risk Assessment (Lifeline crisis center version) <https://suicidepreventionlifeline.org/wp-content/uploads/2016/09/Suicide-Risk-Assessment-C-SSRS-Lifeline-Version-2014.pdf>

2. Patient Health Questionnaire PHQ-9 https://med.stanford.edu/fastlab/research/imapp/msrs/jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf
3. Beck Scale for Suicide Ideation (BSS) <https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Personality-%26-Biopsychosocial/Beck-Scale-for-Suicide-Ideation/p/100000157.html>
4. Ask Suicide-Screening Questions (ASQ) Toolkit <https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml>
5. SAFE-T Pocket Card: Suicide Assessment Five-Step Evaluation and Triage for Clinicians <https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432>
6. Suicide Safe Mobile App <https://store.samhsa.gov/product/suicide-safe>
7. The Suicide Behaviors Questionnaire-Revised {SBQ-R} <https://www.aetnabetterhealth.com/louisiana/assets/pdf/providers/communications/SDQ-Color.pdf>
8. Patient Safety Plan Template https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf
9. SIQ Suicidal Ideation Questionnaire <https://www.parinc.com/Products/Pkey/413>
10. BHS Beck Hopelessness Scale <https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Personality-%26-Biopsychosocial/Beck-Hopelessness-Scale/p/100000105.html>
11. The Positive and Negative Suicide Ideation Inventory <https://www.semanticscholar.org/paper/The-Positive-and-Negative-Suicide-Ideation-and-Osman-Gutierrez/0d9cea4c57e6ff56d88a3b59b1f171c7e18b0fb4>
12. The Suicide Behaviors Questionnaire-Revised SBQ-R <https://www.aetnabetterhealth.com/louisiana/assets/pdf/providers/communications/SDQ-Color.pdf>

4.0 Intervention

Outpatient behavioral health (BH) settings include clinics, mental health centers, day treatment or partial hospital programs, and group private practices (and as feasible, the elements of standard care are recommended for solo private practice therapists). These settings care for many individuals with suicidal thoughts and feelings and who may have been referred specifically because of their suicidality or a co-occurring substance use disorder, which increases suicide risk. While inpatient care is designed to initiate treatment, mitigate immediate risk and prepare patients for continuing care post-hospitalization, outpatient BH settings have a longer-term, ongoing role in treating individuals who may be or have been suicidal. Therefore, the ability to provide suicide safe care should be a core responsibility of outpatient BH settings, and competence and confidence in working with these individuals are essential.

Ideally, in addition to the recommended standard care elements defined in the following sections, outpatient programs or clinics should have available clinicians who can provide evidence-based treatments for suicidality, including Dialectical Behavior Therapy (DBT), Cognitive Therapy for Suicide Prevention (CT-SP), Collaborative Assessment and Management of Suicidality (CAMS), and Brief Cognitive Behavioral Therapy (BCBT).

Overview of Recommended Standard Care

Elements for People with Suicide Risk: Outpatient Behavioral Health Settings

The recommended standard care elements are the essential evidence-based and expert activities and competencies in outpatient BH settings.

They include the following:

- ➔ On intake and periodically, assess all patients for suicide risk using a standardized instrument or scale
- ➔ Stratify all patients according to the level of risk.
- ➔ For all patients with elevated risk:
 1. As part of the treatment plan, complete a collaborative safety plan during the same visit.
 2. As part of safety planning, provide information on telephone crisis lines, including the National Suicide Prevention Lifeline. Carry out steps to reduce access to lethal means.

3. Reassess risk and review and/or update the patient’s safety plan at every visit until the risk is reduced.

4.1 Safety Planning

A safety plan (also referred to as a “crisis response plan”) is developed collaboratively with the patient and is designed to decrease the probability that the patient will attempt suicide in the near future. The plan is developed in several steps and providers can help patients fill out the simple safety plan template included in Section 3.3.

The plan is to be provided to the patient to serve as a reference and support if thoughts of suicide occur.

- ✓ Recognizing warning signs that a suicide crisis may be approaching
- ✓ Identifying internal coping strategies that can be used by the patient to soothe emotions and avert the crisis
- ✓ Utilizing friends and family members that can be contacted by the client in order to distract from suicidal thoughts and urges without discussing suicidal thoughts
- ✓ Utilizing friends and family members who may help to resolve a crisis and with whom suicidal thoughts can be discussed directly
- ✓ Contacting health professionals or agencies, including dialing the National Suicide Prevention Lifeline (800-273-TALK [8255]), 911, or going to a local hospital emergency room
- ✓ Making the environment safe- reducing access to lethal means

Step 1. Warning signs and triggers

The first step in safety planning is to help patients become aware of their own triggers and the cues that signal that a suicidal crisis may be developing for them. For example, a patient might start to feel very angry, anxious, or alienated before a suicidal crisis. Patients who are familiar with their own personal triggers and cues can utilize coping strategies and may be able to prevent themselves from reaching a point where they feel out of control. To help patients determine their own unique triggers and cues you can ask patients such questions as:

- ▶ “How do you feel in the hours or days before you first notice that you are feeling suicidal?”
- ▶ “What do you notice in your thoughts and feelings, or in your body?”
- ▶ “What are your triggers? What happens just before you start feeling or thinking this way?”

- ▶ If the patient is unable to answer these questions, family members and friends have likely noticed changes that occur before the patient enters into a crisis. With permission from the patient, you may be able to involve people close to the patient (their support network) in answering these questions.

Step 2. Coping Strategies

The second step in safety planning is to help patients identify and practice coping strategies to help prevent or avert the development of a suicidal crisis. Coping techniques have different effects on different people; therefore, the provider should help the patient think through what really helps him or her feel better. Some examples of coping techniques are relaxation techniques, physical activity, moving away from a stressor or stressful person, and distraction techniques. Some sample questions to get patients thinking about effective coping techniques are:

- ▶ “What relaxes you?”
- ▶ “When was the last time you felt relaxed or peaceful? What were you doing?”
- ▶ “Are there any things that you do that help you take your mind off thinking about death and dying?”
- ▶ “Who do you spend time with that makes you feel good?”

Once coping strategies are identified, encourage patients to practice them before a crisis arises. Practicing these strategies when the patient is calm helps make them more automatic for the patient and thus easier to employ when the patient is distressed. Refer at-risk patients to the website resource below for help to identify techniques for self-soothing: <http://www.nowmattersnow.org/skill/mindfulness>

Step 3. Distracting from the crisis

Ask your patient about reaching out to family or friends, or going to specific social settings, such as a park or a coffee shop, or activities to distract them from their feelings or thoughts. Ask:

- ▶ “Where could you go or who could you call to take your mind off the crisis or off of how you are feeling?”
- ▶ “Who helps you feel better when you socialize with them?”
- ▶ “Is there anything you do that helps you feel better?”

Assess how likely it is that the patients will actually take these steps, if you suspect resistance, ask about it. Ask:

- ▶ “You’ve come up with some good options, but I’m worried that you might not follow through when you are in crisis – what steps could we take now to help make sure that you will be able to follow through?”

Step 4. Family, friends, and other supports who can help

While similar to Step 3, this step involves working with the patient to identify individuals in her/his life that s/he can turn to in a crisis who will be able to help resolve a crisis. 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?”
- ▶ “Who do you feel comfortable with discussing your thoughts of suicide?”

Encourage the use of peer supports if the patient experiences chronic struggles with any mental illness and/ or suicidal thoughts. Individuals with lived experience can help patients in ways that health care providers can’t. To find peer support specialists near you, contact your local Community Mental Health Center. Ask the patient to list more than one person, in case one contact is unreachable. They can then prioritize their list, realizing that they may be more comfortable with different people at various times. As in Step 3, assess how well you think the patient will follow through with this in a crisis, and discuss them about barriers that might come up.

Step 5. Professionals to contact for help

Add any mental health, substance abuse, health care or other types of counselors and providers such as clergy, psychiatrists or specialty providers that may be of support or assistance to the patient.

Step 6. Temporarily restricting access to lethal means of self harm

The last step in safety planning addresses the issue of access to lethal means. This step is left for last because it may be the most delicate step for many patients, and perhaps the most critical. The stronger the collaboration between the provider and the patient, the greater the likelihood the patient will relinquish his or her access to lethal means. If the patient has expressed any suicidal ideation, described a specific plan to use lethal means or has experimented with lethal means (e.g., deliberate self-cutting, loading a gun) it is essential to inquire about whether those specific means are available and to eliminate access to them while they are at risk. Lethal means may include guns (ask about all guns in the home or that a patient may have

access to elsewhere), ammunition, medications (prescription as well as over the counter), knives, razors, etc. It is important to help the patient identify whom they will entrust with these items until they can be safely returned. With the patient's permission, contact family members or other persons within the patient's support system in order to assist with temporarily limiting access.

Discussing lethal means with your patient is not a time for debating social issues around firearm ownership. Counseling on access to lethal means is a time to work with the patient to identify strategies to temporarily make their environment safe during periods of crisis.

The Harvard Means Matter Campaign and website asserts: "Means reduction" (reducing a suicidal person's access to highly lethal means) is an important part of a comprehensive approach to suicide prevention. It is based on the following understandings:

- * Many suicide attempts occur with little planning during a short-term crisis.
- * Intent isn't all that determines whether someone who attempts suicide lives or dies; means also matter.
- * 90% of attempters who survive do NOT go on to die by suicide later.
- * Access to firearms is a risk factor for suicide.
- * Firearms used in youth suicide usually belong to a parent.
- * Reducing access to lethal means saves lives.

Learn more about lethal means safety for patients of all ages: <https://www.hsph.harvard.edu/means-matter/> <http://www.sprc.org/resources-programs/calm-counseling-access-lethal-means-0>. Direct patients, parents and other concerned family members to the website below for tips on temporarily removing lethal means from the home: www.suicideproof.org. As the plan is developed write each step on a paper the patient can take home. Use the form included in Section 3 or create one of your own.

When it is clear the patient understands the plan, the patient should be able to commit to their clinician they will follow the plan, in sequence. Rehearse with the patient how he/she will use the plan:

- ▶ Where will the plan be kept?
- ▶ How will he/she know when to take the first step?
- ▶ What comes next?

When implementing the plan, the patient builds coping skills and develops confidence that they can manage future crises when they occur. Both the patient and their support person(s) should know the number for the Suicide Prevention Lifeline 1-800-273-TALK (8255).

Lethal Means Planning Among Specific Patient Groups:

Youth

Firearms remain the number one way by which young people die by suicide, although intentional deaths by prescription pain killers are on the rise among youth. It is important to find out about a youth's specific plan for suicide, if it exists, and work with family members or guardians to restrict access to means of any kind, including access to firearms, potentially lethal prescription and over the counter (OTC) medications (including containers of more than 25 acetaminophen tablets), alcohol, and even rope. Anecdotal evidence suggests young people frequently know where guns and keys to gun cabinets are kept, even though parents may think that they do not. Primary care providers should counsel parents or guardians of children and adolescents to either temporarily remove firearms from the home entirely or securely lock guns and ammunition – in separate locations. When primary care providers recommend that parents restrict access of their children to guns and medications in the home, most of them do. The websites listed above, for the Means Matter and Suicideproof.org programs, provide valuable insight on restricting and temporarily removing access to lethal means around the home.

Elderly

Along with assessing for access to firearms, providers should pay close attention to the number and nature of medication prescriptions written for older adult patients from all of their providers, and assess for any possible stockpiling. If elderly patients are not able or willing to return or destroy excess medication, family members or other friends or loved ones can hold on to excess medication until such time that the patient is not at risk of harming themselves. Providers should also be aware that smaller doses of medications can have a higher lethality when mixed with alcohol, so access to alcohol should be discussed and potentially restricted as well.

Veterans

Lethal means restriction is often more complex with patients who are Veterans or National Guardsmen. Veteran patients are more likely to have firearms in their possession, more comfortable with firearms, and more likely to use a firearm in a

suicide attempt, thus making the lethality of their attempts very high. Veterans are also typically more likely to resist relinquishing their firearms. It is crucial, therefore, when a Veteran patient is expressing or exhibiting any level of suicidality, to:

- ▶ Discuss gun storage safety with Veterans – ask your Veteran patients to commit to one or all of the following temporary measure until such time as they are no longer at risk of harming themselves (important to stress this last part to Veteran patients):
 1. Storing guns away from their homes temporarily, potentially with a trusted battle buddy
 2. Storing guns and ammunition separately, both under lock and key
 3. Storing guns with a gun lock
- ▶ Discuss whether the patient has a trusted friend or family member that would be willing to store the patient’s firearm(s), lock box keys, or gun lock key(s) until such time as the patient no longer is at risk of harming themselves.
- ▶ Have the patient commit to a plan of action for safe gun storage and follow-up with the patient or a friend or family member to ensure that they have followed through.
- ▶ Assess the number and nature of medication prescriptions written for the patient from all of their providers, and assess for any possible stockpiling
- ▶ Find a pocket card developed by the Veterans Administration to guide the development of a safety plan provided with this Toolkit and downloadable from the Department of Veterans Affairs: <http://www.mentalhealth.va.gov/docs/vasafetyplancolor.pdf>
- ▶ Additionally, find an excellent free video training for safety planning at: <http://zerosuicide.sprc.org/sites/zerosuicide.sprc.org/files/sp/course.htm>

NOTE: “No-suicide contracts” have been found to be ineffective in preventing suicidal behavior and are often done solely to alleviate anxiety on the part of the provider. It is more important to make a plan with your suicidal patients concerning what they will do in the event that they feel suicidal and are worried about their safety, rather than what they won’t do.

Referral to Evidence-Based Treatment

For patients in the moderate and high risk categories and who have symptoms of a psychiatric disorder, consider a referral to a psychiatrist for a medication evaluation (Telemedicine is increasingly becoming an option for accessing psychiatric services in rural locations). For patients with alcohol or substance use issues, consider a referral for alcohol/drug assessment and treatment. For all

patients at increased risk, be sure to provide information about the National Suicide Prevention Lifeline, 1-800-273-TALK (8255). By calling the Lifeline, patients are connected to the nearest certified crisis center, usually within the state. Counselors at these centers are skilled in suicide crisis intervention and have access to information about many local resources for individuals contemplating suicide. The centers can also activate 911 rescue when indicated.

For patients who are an imminent danger to themselves despite intervention efforts and attempts at safety planning, hospitalization is necessary. Patients can be psychiatrically hospitalized voluntarily or involuntarily. A local crisis services hotline can inform providers whether there are resources in the area to send a mobile clinician directly to your office to perform a mental health evaluation and place a patient on a mental health hold, if necessary.

Developing an office protocol for hospitalization

Having a pre-established office protocol to follow once you have determined that a patient is high risk for suicide can ease the process of hospitalization. Some important additional questions to answer in developing your office protocol are:

1. What emergency department or crisis stabilization unit is nearest to your office/clinic/facility?
2. What transportation options are available for transporting suicidal patients to the nearest emergency department?

Documentation and Follow-up Care

Thoroughly document suicide risk assessment (and rationale), management plan, actions that occurred (e.g., met with family) and any consultation (e.g., with psychiatrist). In the case of hospitalization, it will be necessary to provide this information to the admitting facility. Thorough documentation will help ensure that the patient receives appropriate care. Copying and storing the Safety Plan template included in Section 3 is a good form of documentation and will help with follow-up as well.

Close follow-up with a potentially suicidal patient is critical. Studies show that even very simple followup contacts with suicidal patients reduce their risk of repeat attempts and death. Every follow-up contact is an opportunity to assess for recurrent or increased suicidality. Flagging the records of patients at risk for suicide with color coded labels, as is frequently done for allergies or certain chronic diseases, may help insure suicide risk is reassessed on follow-up visits.

- ▶ Providers should ensure that the patient attends their next appointment(s), follows through on clinical recommendations, and discusses potential obstacles to following through on recommendations.
- ▶ Whenever possible, enlist the participation and support of the patient's loved ones to achieve this.

4.2 Pharmacologic Intervention

Because over 90% of patients who complete suicide had a mental health diagnosis at their time of death, aggressive, evidence-based treatment of mental health disorders should also be discussed during treatment planning. Despite concerns about increased suicide risk with antidepressant medications, which primarily reflects acute increases in suicidal ideation and attempts in trials of pediatric samples, multiple studies have found them protective against suicidal thoughts, behaviors, and attempts in all age groups, most strongly and consistently in adults, especially older adults, when used to treat mood and anxiety disorders. Selective serotonin-reuptake inhibitors (SSRIs) are preferred over tricyclic antidepressants (TCAs) in suicidal patients due to lower risk in overdose. TCAs and other medications with elevated risk in overdose should be prescribed in limited supplies while acute suicide risk remains elevated. When indicated, there is evidence supporting a reduction in risk of suicide for those treated with clozapine or lithium. As with psychotherapy, there is evidence that suicide attempts are increased in the month before treatment, the month after treatment, after discontinuation of medications, and after any dose change. Close follow-up and monitoring are warranted during treatment.

Some pharmacologic interventions may be harmful. After adjusting for mental health diagnoses, a current prescription for any sedative or hypnotic was associated with a four-fold increase in suicide risk, especially in patients greater than 65 years old.

4.3 Dialectical Behavior Therapy (DBT)

DBT is a multicomponent therapy for individuals at high risk for suicide and who may struggle with impulsivity and emotional regulation issues. The components of DBT include individual therapy, group skills training, between-session telephone coaching and a therapist consultation team. In a randomized controlled trial of women with recent suicidal or self-injurious behavior, those receiving DBT were half as likely to make a suicide attempt at the two-year follow-up than women receiving community treatment (23% vs 46%), required less hospitalization for

suicide ideation, and had lower medical risk across all suicide attempts and self-injurious acts combined.

4.4 Attachment-Based Family Therapy (ABFT)

ABFT is a program for adolescents aged 12–18 and is designed to treat clinically diagnosed major depressive disorder, eliminate suicidal ideation, and reduce dispositional anxiety. A randomized controlled trial of ABFT found that suicidal adolescents assigned to ABFT experienced significantly greater improvement in suicidal ideation over 24 weeks of follow-up than did adolescents assigned to enhanced usual care. Additionally, a significantly higher percentage of ABFT participants reported no suicidal ideation in the week prior to assessment at 12 weeks than did adolescents receiving enhanced usual care (69.2% vs. 34.6%) and at 24 weeks (82.1% vs. 46.2%).

4.5 The Improving Mood—Promoting Access to Collaborative Treatment (IMPACT)

The Improving Mood—Promoting Access to Collaborative Treatment (IMPACT) program aims to prevent suicide among older primary care patients by reducing suicide ideation and depression. IMPACT facilitates the development of a therapeutic alliance, a personalized treatment plan that includes patient preferences, as well as proactive follow-up (biweekly during an acute phase and monthly during continuation phase) by a depression care manager.¹⁵⁶ The program has been shown to significantly improve quality of life, and to reduce functional impairment, depression and suicidal ideation over 24-months of follow-up^{156,157} relative to patients who received care as usual.

Collaborative Assessment and Management of Suicidality (CAMS), is a therapeutic approach for suicide-specific assessment and treatment. The program's flexible approach can be used across treatment settings and clinician theoretical orientations and involves the clinician and patient working together in an interactive assessment process to develop patient-specific treatment plans. Sessions are collaborative and involve constant patient input about what is and is not working with the ultimate goal of enhancing the therapeutic alliance and increasing treatment motivation in the suicidal patient. CAMS has been tested and supported in 6 correlational studies, in a variety of inpatient and outpatient settings, and in one RCT with several additional RCTs under way. A feasibility trial with a community-based sample of suicidal outpatients randomly assigned to CAMS or enhanced care as usual (intake with a psychiatrist or psychiatric nurse practitioner

followed by 1-11 visits with a case manager and medication as needed) found better treatment retention among the CAMS group and significant improvements in suicidal ideation, overall symptom distress, and feelings of hopelessness at the 12 month follow-up.

4.6 The Veterans Affairs Translating Initiatives for Depression into Effective Solutions project (TIDES)

TIDES uses a depression care liaison to link primary care and mental health services. The depression care liaison assesses and educates patients and follows-up with both patients and providers between primary care visits to optimize treatment. This collaborative care increases the efficiency of providing mental health services by bringing mental health care to the primary care setting, where most patients are first detected and subsequently treated for many mental health conditions. An evaluation of TIDES found significant decreases in depression severity scores among 70% of primary care patients. TIDES patients also demonstrated 85% and 95% compliance with medication and follow-up visits, respectively.

4.7 Emergency Department Brief Intervention with Follow-up Visits

Several strategies that aim to prevent re-attempts have demonstrated impact on reducing suicide deaths. For example, Emergency Department Brief Intervention with Follow-up Visits is a program that involves a one-hour discharge information session that addresses suicidal ideation and attempts, distress, risk and protective factors, alternatives to self-harm, and referral options, combined with nine follow-up contacts over 18 months (at 1, 2, 4, 7, 11 weeks and 4, 6, 12, 18 months). Follow-up contacts are either conducted by phone or through home visits according to a specific timeline for up to 18 months. A randomized controlled trial that enrolled suicide attempters from eight hospital emergency departments in five countries (Brazil, India, Sri Lanka, Iran, and China) found that a brief intervention combined with nine follow-up visits over 18 months was associated with significantly fewer deaths from suicide relative to a treatment-as-usual group (0.2% versus 2.2%, respectively).

Another example of treatment to prevent re-attempts involves active follow-up contact approaches such as postcards, letters, and telephone calls intended to increase a patient's sense of connectedness with health care providers

and decrease isolation. These approaches include expression of care and support and typically invite patients to reconnect with their provider. Contacts are made periodically (e.g., monthly or every few months in the first 12 months post-discharge with some programs continuing contact for two or more years). In a meta-analysis conducted by Inagaki et al., interventions to prevent repeat suicide attempts in patients admitted to an emergency department for suicide attempt were found to reduce re-attempts by approximately 17% for up to 12 months post-discharge; however, the effects of these approaches beyond 12 months on re-attempts has not yet been demonstrated.¹⁵¹ Also, because the number of trials and associated sample sizes included in this meta-analysis were small, it was not possible to determine the effect of active contact and follow-up approaches on suicide.

4.8 Cognitive Therapy for Suicide Prevention (CT-SP)

Cognitive Behavior Therapy-Suicide Prevention (CBT-SP) is a manualized cognitive behavioral treatment for adolescents who recently attempted suicide (≤ 90 days). Although CBT-SP was implemented with suicide attempters, the theoretical approach and strategies may also apply to adolescents who experience episodes of acute suicide ideation (as opposed to chronic, unremitting ideation) in which precipitants can be identified. The primary goals of this intervention are to reduce suicidal risk factors, enhance coping and to prevent suicidal behavior. Adolescents who make suicide attempts, or who have acute or persistent suicide ideation, typically have multiple psychiatric and environmental problems. CBT-SP is narrow in focus and is not designed to address all of the adolescent's problems. This approach recognizes that the teen may need further treatment. Instead, it focuses on developing skills (cognitive, behavioral and interactional skills) that will enable the adolescent to refrain from further suicidal behavior. Thus, CBT-SP is designed to help adolescents use more effective means of coping when faced with their stressors and problems that trigger suicidal crises. Parents meet with the therapist for family sessions focused specifically on suicide risk reduction strategies.

CBT-SP is based on a stress-diathesis model of suicidal behavior. Theoretically, the diathesis for suicidal behavior includes a combination of factors, such as sex, religion, familial and genetic components, childhood experiences and psychosocial support system. In this model, stressors trigger suicidal behavior in the context of an individual who possesses the diathesis. Stressors include a variety of psychosocial events, such as interpersonal conflict, work or school-related difficulties. CBT-SP acts to modify reactions to stressors both acutely and chronically in the context of vulnerability (i.e. positive diathesis).

A central focus of CBT-SP is the identification of proximal risk factors and stressors, including emotional, cognitive, behavioral and family processes active just prior to and following the adolescent's suicide attempt or recent suicidal crisis. These processes include deficits in the adolescent's abilities or motivations to cope with suicidal crises. For example, such deficits may include the inability to regulate emotions, the inability to resolve problems, the inability to tolerate distress, the inability to address negative thoughts or beliefs such as hopelessness or worthlessness. These risk factors are identified by conducting a detailed chain analysis of the sequence of events, and their reactions to these events, that led to the suicidal crisis. A core feature of the treatment is the development of an individualized case conceptualization that identifies problem areas to be targeted and the specific interventions to be employed during periods of acute emotional distress.

4.9 Collaborative Assessment and Management of Suicidality (CAMS)

The Collaborative Assessment and Management of Suicidality (CAMS), was first developed in 1998, as a therapeutic framework that is designed to assess a patient's suicidal risk, and plan and manage suicide specific "driver-oriented" treatment. The clinical intervention can be used for a wide range of suicidal patients across outpatient and inpatient treatment settings and different treatment modalities. The framework fundamentally involves a participant's engagement and cooperation in assessing and managing suicidal thoughts and behaviors, and the therapist's understanding of the patient's suicidal thoughts, feelings, and behaviors. The duration of the CAMS treatment varies, depending on the patient's condition. A multi-purpose clinical tool, called the Suicide Status Form (SSF), guides the patient's assessment and treatment and is developed collaboratively between the patient and the practitioner throughout the course of therapy. Specifically, the SSF contains rating-scales and open-ended questions concerning six suicide-related markers including: psychological pain, stress, agitation, hopelessness, self-hate, and overall risk of suicide. The SSF is used for:

- ✓ Suicide-specific assessment
- ✓ Suicide-specific treatment planning of patient-defined suicidal drivers
- ✓ Tracking of ongoing risk
- ✓ Clinical outcomes and dispositions.

The Suicide Resource Prevention Center provides information on training and resources for CAMS <https://www.sprc.org/sites/default/files/Collaborative%20Assessment%20and%20Management%20of%20Suicidality%20%28CAMS%29.pdf>

4.10 Brief Cognitive Behavioral Therapy (BCBT)

Brief Cognitive Behavioral Therapy (BCBT) was developed and adapted to the unique treatment environment of a military setting, one that limits the ability to offer intensive and enduring psychotherapy. BCBT offers a unique alternative to traditional psychotherapy, to reduce suicidal behavior and improve the patient's ability to more fully participate in longer-term therapy for targeted Axis I and II disorders like post-traumatic stress disorder and/or major depression.

5.0 Clinical Vignettes

In this section you will meet several people with mental health/substance use disorders who are experiencing suicidal thoughts and behaviors to varying degrees. Through their dialog with clinicians, supervisors, and family members, you will see how suicidal thoughts and behaviors may manifest. You will also see that these thoughts and behaviors are typically accompanied by co-occurring mental disorders, such as depression, psychological trauma, and other anxiety disorders.

The elements of GATE (Gather Information, Access supervision, Take responsible action, Extend the action) are portrayed in different settings and situations. You will read about clinicians working with clients who are resistant to treatment for their suicidal thoughts and behaviors, about the effects of suicidal thoughts and behaviors on family members and others, and about managing suicidal crises. The consensus panel has made a significant effort to present realistic encounters with clients using clinical approaches that include motivational interviewing (MI), cognitive-behavioral therapy (CBT), supportive psychotherapy, and crisis intervention methods. In all of these therapeutic approaches, basic counseling dynamics (such as relationship building; managing rapport in stressful situations; giving feedback; assessing, understanding and responding to the needs expressed by the client; and seeking consultation and supervision as needed) are demonstrated. Please note that the panel does not intend to imply that the approach used by the clinician in the vignette is the “gold standard,” although the approach shown does represent competent practice that can be performed in real-life settings.

The vignettes begin with an overview, a substance abuse history, a suicide-related history, and a list of the learning objectives for the vignette. Each of the following additional features is also embedded in the clinician and client dialog:

- ✓ Master clinician notes are comments from an experienced counselor or a supervisor about the strategies used, possible alternative techniques, thoughts of the clinician, and other information counselors should have.
- ✓ “How-to” notes contain information on how to implement a specific intervention.
- ✓ Master clinician notes represent the combined experience and wisdom of the contributors to this section.

The notes provide insights into the cases and suggest possible approaches. Some of the techniques described in the notes may or may not be appropriate for you to use, depending on your training, certifications, and licenses. It is your responsibility to determine what services are legally and ethically appropriate for you to provide within the scope of your practice. If you are unsure, ask a supervisor.

This format was chosen to assist clinicians at all levels of mastery, including beginning counselors, those who have some experience but need more diversity and depth, and those with years of experience and training who are true master clinicians. Client scenarios are presented in vignettes in the following pages. Each client is in treatment for a substance use disorder, and is experiencing some suicidal thoughts. By way of introduction:

- * Vignette 1, Clayton, illustrates how to obtain and secure a firearm safely from a high-risk client by enlisting the help of a family member.
- * Vignette 2, Angela, shows how to work collaboratively with family in discharge planning for a high-risk client from an inpatient unit.

5.1 Vignette 1—Clayton

Overview

This case illustrates the GATE process for working with substance abuse clients with suicidal thoughts and behaviors. The vignette begins with a meeting between Clayton and his counselor (Darren) and illustrates how clinical supervision plays an important role in addressing client suicide risk. It specifically addresses working with a client who is not in an immediate suicidal crisis but has warning signs for

suicide. It also examines issues of removing a potential suicide weapon and illustrates the importance of working with family.

Participants: Clayton (client), Darren (counselor), Jill (supervisor), and Barbara (daughter).

Substance Abuse History

Clayton is a 61-year-old Caucasian man who used injection drugs as a young adult and contracted hepatitis C. He quit using injection drugs without treatment and about 10 or 15 years later developed alcohol dependence. He entered treatment 5 years ago and has been sober for 18 months. He has a cirrhotic liver but does not want to consider getting on a transplant list. He attends at least four Alcoholics Anonymous (AA) meetings a week, participates in an ongoing recovery group, and sees a substance abuse counselor individually on an as-needed basis. He lives alone, has two grown children with whom he has occasional contact, and lives on his retirement pension. He retired 3 years ago from a supervisory position at a local small manufacturing plant where he worked for 30 years.

Suicide-Related History

Clayton tried to kill himself in his twenties by overdosing on heroin. He was taken to an emergency room and released about 12 hours later. He did not follow up on treatment recommendations. He began having suicidal thoughts again following his last relapse 18 months ago. While drinking, he decided he might shoot himself but did not actually make a suicide attempt. Since stopping drinking and returning to treatment, he has had occasional thoughts of killing himself, particularly when the pain from his liver disease becomes burdensome and when he feels like he has no future. Clayton maintains that he is not acutely suicidal now but says he might act if the pain becomes worse or if he is unable to take care of himself. The suicidal thoughts arise when he feels hopeless and when he becomes afraid that he might reach a point of being physically unable to take care of himself. He took out his gun and examined it last week, an action that concerned his AA sponsor enough to urge Clayton to call his substance abuse counselor for an appointment.

Learning Objectives

1. To illustrate GATE and how this model can be applied
2. To demonstrate screening for suicide risk.
3. To highlight the role of clinical supervision in addressing the needs of the client.
4. To recognize when there are indications of continuing risk even when the client is currently denying suicidal thoughts.

5. To demonstrate three types of action:
 - ▶ Remove a potential suicide weapon.
 - ▶ Involve family in treatment.
 - ▶ Make a referral to a specialized community resource for further assessment.
6. To illustrate a followup process to ensure that the client has removed the weapon from his home and has followed through on the referral to a specialized community resource.
7. To illustrate how case management is important in helping Clayton manage a variety of life problems including substance abuse recovery, pain management, suicidality, mental health care, and physical health care.

[Clayton has requested an appointment with his counselor.]

COUNSELOR: Clayton, you said on the phone you are having some trouble and would like to see me.

CLAYTON: Well I haven't been feeling so good. I've been having a fair amount of pain for the past couple of months or so. I'm not sleeping all that great. I don't feel very well. My sponsor in the program told me to give you a call.

COUNSELOR: We'll I'm glad you did call.

CLAYTON: I've been going to the pain management clinic like you told me to. That helps—the meds and the pain management program, but sometimes the pain still gets pretty bad and I start sinking.

COUNSELOR: How much pain have you been having?

CLAYTON: I'm in pain all the time, but it flares up real bad about every other day. What happens is that the bad pain comes for several hours, sometimes four hours or so, and it makes it really hard for me to do anything. It just beats me down.

COUNSELOR: In the past we've used a scale of 1 to 10 to rate your pain. Where would you put yourself on that scale now?

CLAYTON: When it flares up, I'd say about 8 or 9. Then, after a few hours it goes down some—maybe down to a 3 or 4 or 5. It never goes away all the way. And you know, I can't take narcotic pain pills. The pain clinic gives me some meds—the non-addictive kind, but they don't help all the time.

COUNSELOR: When the pain has gotten up in that 8 to 10 level, those are the times when you feel like you're "sinking" and "feeling down?" Clayton, tell me some more about what those terms mean to you.

CLAYTON: Well, I mean it's the whole thing. You know I'm not going to go through with the liver transplant thing, even if I could get a new one. I don't want to be a burden on anybody, and I don't want to slip again. I tried working a little bit last year just to see if I could. A friend in the program let me work a few hours a day at his store. But I couldn't work all the times he wanted me to because of the pain attacks.

COUNSELOR: Sometimes in the past when those feelings of hopelessness have come up and you've had that kind of pain, I know you've had thoughts about suicide. Have those thoughts come back?

Master Clinician Note: Observe that the counselor does not wait for Clayton to bring up issues of suicide, but rather initiates the conversation in a way that normalizes the discussion and invites Clayton to provide more information. Some specific points to consider when discussing suicide with a client include:

- ▶ Use clear, direct terms, not euphemisms for suicide (for instance, say “have you thought of killing yourself?” or “Have you thought of taking your life” rather than “have you thought of doing anything foolish?”)
- ▶ Ask direct questions, but do so with care and compassion.
- ▶ Ask open-ended questions that require more than a “yes” or “no” answer.
- ▶ Acknowledge that talking about suicidal thoughts and behaviors is difficult but that having the discussion is important.

CLAYTON: Well, I think it's, like I said, not knowing what lies ahead. If I'm ever gonna get beyond this and not bother my family about the whole thing and not feel like I can't do as many things as I was able to do. All those kinds of things add up at once and I'd say those thoughts are there especially when everything collapses, when I'm not sleeping and the pain is worse, I don't know . . . it all just gets to be too much.

COUNSELOR: Yeah, it sounds pretty overwhelming and seems like you feel help would be hard to find.

CLAYTON: Well you know, I don't want to bother my family, and I really don't want to be a burden on any body. Sometimes I don't even know if I want to continue the liver treatment.

Master Clinician Note: Clayton avoids addressing the question of suicidal thoughts, except in an indirect way. Instead of grilling Clayton for the information, the counselor files away the issue temporarily and talks about pain for a few minutes, a comfortable topic for Clayton. The counselor then returns to his concerns about Clayton's suicidal thoughts. The expectation is that Clayton will feel more comfortable in talking about them if the counselor slows down a bit and goes at his pace.

COUNSELOR: Does it help to talk to anyone about your pain, like people in your AA program, or in the group here or your family when things get real bad?

CLAYTON: I don't know. I really don't want to cry on other peoples' shoulders. I don't want to tell my kids, there's nothing they can do. It helps that some people—

friends in the program—know and give me some support. And I've talked to you about it some.

COUNSELOR: It's not easy to share what you're going through with others, and I really respect how you've shared with some peers, and that you've given me your trust. What gets in the way of talking with your kids about it?

CLAYTON: Well, I see my daughter and her family some. She lives about 10 miles out of town. My son and I talk every now and then, but he lives about five hours from here. We just talk about his kids, and I ask him about his job and that's about it. We really haven't been close since he was a teenager. I was drinking the whole time he was growing up, and we never have got beyond what happened back then, what I did and what he did too.

COUNSELOR: We talked a little bit about that: the family relationship has been difficult for you. You said you've been feeling like a burden.

CLAYTON: Yeah. I haven't really told them about the liver, how bad it is. I don't really want them to get all upset. They've got their own lives now.

How To Screen for Suicide

Just a few questions about suicidal thoughts and behaviors can provide clinicians with the information they need to decide if further exploration of suicide is necessary. The five questions used in this vignette are drawn from the longer discussion of gathering information. The five questions used in this vignette are:

1. Are you thinking about killing yourself?
2. Have you ever tried to kill yourself before?
3. Do you think you might try to hurt yourself today?
4. Have you thought of ways you might kill yourself? or Do you have a plan for how you might kill yourself?
5. Do you have pills or weapons to kill yourself in your possession or in your home? or Do you have ready access to pills or a weapon that you might use to kill yourself?

When a reply indicates the presence of suicidal thoughts or behaviors, the clinician should follow up with open-ended questions that seek to obtain additional information. For instance, if a client acknowledges a prior suicide attempt, the clinician would want to know more about when the attempt occurred, what method was used, what else was happening in the person's life when the attempt occurred, and why the attempt was unsuccessful.

COUNSELOR: So you've had a sort of mixture of difficulties over the course of the last couple of weeks including thoughts about feeling hopeless and perhaps

even thoughts of taking your own life. I know it's a difficult subject, but do you mind if we talk a little bit more about this?

CLAYTON: That's okay.

COUNSELOR: Thanks. I appreciate your willingness. One concern I have is about your hopeless feelings and where they might lead, for instance, whether they lead to thoughts about killing yourself.

CLAYTON: Yeah. I've thought about it. I've had a gun for a long time.

COUNSELOR: I wonder if you could say a little bit more about the thoughts, and what you've thought of in terms of the gun.

CLAYTON: I don't do much with the gun now. I used to use it for target practice and stuff. My son and I used to take it out years ago.

COUNSELOR: Do you remember the last time you got the gun out?

CLAYTON: Yes, last week. Funny, I guess I haven't had it out of the closet in years, but I took it out the other night and just checked it out.

COUNSELOR: Were you thinking about killing yourself when you took the gun out?

CLAYTON: You know, not really. I don't know why I took it out. But later, I was feeling pretty bad, and I wondered if that was what I was doing. It bothered me enough that I told my sponsor about it, and he told me to give you a call.

COUNSELOR: I'm glad you did.

CLAYTON: Me too.

COUNSELOR: Could I ask how often the thoughts of suicide occur?

CLAYTON: I'd say about every week or so.

Master Clinician Note: Observe that the clinician occasionally asks the client's permission to continue probing, showing respect for the client and providing him with a sense of control. Also notice how the counselor picked up on hopelessness and followed it up with a more specific mention of "thoughts about killing yourself." Using this direct phrase showed Clayton that this is not a taboo subject, and indeed the counselor can handle this topic, opening the door to a revealing discussion about Clayton's suicidal thoughts and plan to use his gun. As you will see, the clinician continues to gather information, which will be necessary for deciding what actions to take. The information you want to obtain is the information that is directly relevant to treatment planning. Other information that might be useful in later treatment can be gathered at a later time. As with obtaining information about drug history, it is important to be specific and persistent, without "grilling" the client. The clinician will now obtain more specific information about suicidal thoughts.

COUNSELOR: Clayton, when the thoughts about killing yourself come up, how long do they last? How much time do you spend thinking about it? For example, does it come and go quickly or is it something that you stop and really think about?

CLAYTON: Sometimes it will stick around for a while, a couple of hours. I guess it's gotten a little worse over the past 4 or 5 months and lasting longer.

COUNSELOR: Do you mind sharing with me a little bit about what you are thinking about during that period?

CLAYTON: Just not being around and, like I said, not causing my family more grief than I've already caused them, getting out of the pain and things like that. It's not like I spend the whole time then thinking about how I'm going to shoot myself. It's more like I just think I'd be better off dead, I wouldn't feel all this pain. . . It just seems pretty reasonable when I'm in that frame of mind.

COUNSELOR: Clayton, have you thought about killing yourself today?

CLAYTON: You mean like this morning? No, it's not like it is right in front of me. It just more hangs around in the background.

COUNSELOR: Thank you for that clarification. I also wonder if you've done anything in preparation for taking your life.

CLAYTON: I don't know what you mean.

COUNSELOR: For example, giving away things, saying goodbyes, arranging affairs, making sure your gun works. Have you found yourself doing anything like this?

CLAYTON: Uh, I've made sure that possessions—things that I own and stuff—would be given out the way they should be in terms of taking care of that kind of thing but not really much beyond that.

COUNSELOR: Anything else?

CLAYTON: Well I just talked to an attorney about where whatever possessions I have will go, and I made a will. But with my physical condition, I need to do that anyway. It's not like I'm getting all the ducks in a row.

COUNSELOR: It kinda sounds like you've redone your will.

CLAYTON: Yeah.

Master Clinician Note: There is a pause in the conversation at this point. The counselor is considering that he might consult with Jill, his supervisor, about how to proceed. He is concerned particularly about letting Clayton leave the office, knowing that he has recurrent suicidal thoughts, has considered shooting himself, and has access to a gun. He decides to address the issue of getting some advice from Jill directly with Clayton.

COUNSELOR: Clayton, at this point I am going to take the opportunity to touch base with my supervisor for a few minutes. The reason I need to do that is because

some of the areas we have discussed, including your chronic pain, the hopelessness, the suicidal feelings, and your gun have me concerned about your health and safety. If Jill, my supervisor, is available, would you mind if she joins us?

CLAYTON: I knew I shouldn't have said anything. What are you going to do, lock me up?

COUNSELOR: I can appreciate that you feel nervous, but try not to jump to conclusions. I just want to get some input to make sure we're doing everything possible to help you with your struggle and keep you safe. In this instance I think she can be helpful to both of us. What I want to do is give her a call and see if she can step in.

CLAYTON: Okay, I suppose you're just trying to do the right thing.

COUNSELOR: Yes, I want as much expertise available to us as possible. Thanks for understanding.

Master Clinician Note: Darren raised the issue of involving his supervisor skillfully. First, he consulted with Clayton about it. Second, he validated Clayton's feelings. Third, he gave Clayton a rationale for the supervisor consultation. And, fourth, he kept the focus on Clayton's well-being.

[Darren telephones Jill, his clinical supervisor.]

COUNSELOR: Jill, this is Darren. Clayton, who I think you know, is in my office right now, and we're talking about his pain related to his liver disease and how he is coping with that. He's had thoughts about suicide, and I'm wondering if you could join us for a few minutes as we make some decisions about how to handle this.

SUPERVISOR: Yes, I'm glad you called, I'll be right in

[Jill, Darren's supervisor, was in a meeting with another counselor that she broke away from in order to intervene in this more urgent situation.]

How To Prepare for Suicidal Crises

Agencies should have a policy for addressing immediate crises that arise during counseling sessions. The policy should specifically state that if a clinician feels he or she needs direction in a life-threatening crisis, a supervisor or other senior staff member should be contacted for input.

[In the interim until Jill enters the office, Clayton and Darren resume their conversation, focusing primarily on Clayton's depressive symptoms.]

[Jill enters room after knocking.]

COUNSELOR: Clayton, have you met Jill?

CLAYTON: Yes. Jill, I remember you from when you were a counselor here and did the evening aftercare group.

COUNSELOR: Yes, Clayton, I remember you from the group, it's good to see you again.

[Clayton, Jill, and Darren spend a few minutes developing rapport. Darren briefly describes Clayton's reports of suicidal thoughts, the weapon in his house, his thoughts about redoing his will, and Darren's concerns that Clayton might be depressed. Jill is unaware of Clayton's suicide attempt many years ago.]

SUPERVISOR: Clayton, one other thing that I would like to ask about. Have you ever tried to kill yourself?

CLAYTON: Not really. Well, maybe, when I was doing hard drugs, in my twenties, years ago. I tried to overdose one time. I used enough heroin that it should've killed me, plus I was drinking, but I just passed out, and that was it.

SUPERVISOR: Can you tell me some more about what happened?

CLAYTON: Well, I shot up. I knew the stuff was good, pure. I tried to end it, and I just went out.

SUPERVISOR: Did someone find you?

CLAYTON: I think someone called an ambulance, and they took me to the hospital. They kept me maybe a day.

SUPERVISOR: Was there any followup?

CLAYTON: Nah.

SUPERVISOR: Okay, and you haven't made any other suicide attempts?

CLAYTON: Nah.

SUPERVISOR: Thanks, Clayton, for sharing that with me. I just needed to check that out. The issues that stand out to me are that your pain comes on pretty reliably every other day now, that you can get pretty down when this happens, and sometimes have thoughts of suicide, that you have a gun that you've thought of using, and, for the first time in a long time, you got the gun out. Would you say that's a fair summary?

CLAYTON: Yeah, that says it, I guess.

COUNSELOR: I agree, that captures the situation pretty well.

SUPERVISOR: The place I'd like to start is the gun. The reason I say that is because it's just like getting sober, it's important to get the booze out of the house, so that when the craving hits, or there is a crisis of some sort, a bottle is not right there tempting you. It's the same thing with having a gun, most of the time it's not a problem, but when the worst of the pain hits, and when the suicidal thoughts come, there is that added chance of taking action, and having the gun right there makes it more likely. What do you think of doing something about the gun, in order to make the situation safer?

Master Clinician Note: Bear in mind that Jill knows Clayton from when she did the aftercare group. She has a background in mental health counseling and has had additional training in addressing suicidality. As a result she is clear about what to do and feels confident making this intervention on the spot, rather than discussing it first with Darren, or obtaining additional input from the program director or a consulting expert.

CLAYTON: Well, I must admit when I got sober that I thought it was a little overkill to remove all the alcohol from the house, even the stuff in the liquor cabinet that I never paid any attention to, but it turned out you were right, it would've been tougher to get through those moments when the craving hit if the alcohol was right there.

SUPERVISOR: Agreed. Having a gun in the house is kind of like having alcohol in the house.

CLAYTON: I've thought about it now and then, but I haven't really had it out in a while, except that one time last week, so I'm not exactly sure, what are you suggesting I do?

SUPERVISOR: Well, what I'd like to do is have you make an agreement with me and Darren to go ahead and get rid of the weapon, not necessarily forever, but right now, given your pain and all, giving it to someone you know and trust would seem a lot safer than having it in your home. Whose help might you get in safeguarding the gun?

CLAYTON: My daughter Barbara maybe? I don't really want to get my sponsor involved in this, he's great, but he gets nervous. Truthfully, I don't really like the idea of bothering Barbara. I also don't want to burden her with my liver disease and being sick and not being able to take care of myself. But I can't think of anyone but Barbara who could take care of the gun, and I know she'd do it in a minute for me.

COUNSELOR: I can see that you're not totally comfortable asking Barbara, but if it has to be done, it sounds as if she is the best choice. Is that correct? Am I hearing you right?

CLAYTON: Yeah, that nails it pretty well.

COUNSELOR: Then Barbara it is. Thanks for working with us on that difficult decision.

SUPERVISOR: Agreed. We appreciate your working with us like this. This is difficult stuff to be sure. One more thing I'd like to ask. How would you feel about it if Darren or I confirmed with Barbara that you gave her the gun?

CLAYTON: If you gave me some time to do it.

SUPERVISOR: How much time do you think that you need?

CLAYTON: I could get it to her in the next couple days or so, and she'll have it. I'll talk to her.

SUPERVISOR: Your suggestion is very reasonable and I appreciate it a great deal. However, I think Darren and I would feel even better about it if we took care of it today. I know you might see this as pushy, but I wonder if you would mind if we gave her a call now?

CLAYTON: This feels like it is really rushing it. I mean, I'm not going to shoot myself tonight. I'm pretty sure of that.

SUPERVISOR: Yes, I thought you might feel like you were being rushed. Please let me slow down and explain. Although there is a parallel between having alcohol in the house in recovery and having a gun in the house in this situation, they are not exactly the same. What I mean by that is, with relapse, there is the opportunity to learn from the mistake and remove the alcohol, but, unfortunately, with a gun it's essential to get it right the first time. There may not come a second chance. For that reason, Darren and I tend to be a little more "pushy" and insistent with your situation than, say, if we were talking about preventing a relapse; the stakes are much higher. From our perspective, then, it makes more sense to take care of it now.

CLAYTON (reluctantly): I understand although it still feels pushy. Well . . . OK. I'm not sure we can get her, and if we do, I don't want to get her all upset. But we can try her cell phone.

COUNSELOR: Thanks for hanging in there. Before we make the call, I suggest that we make a plan for what we're going to say.

Master Clinician Note: Observe that Darren, the counselor, can clearly see where Jill is going at this point and so he steps back into the conversation and assumes the task of working with Clayton and his daughter around safeguarding the gun. Accordingly, Jill recognizes that it is ideal to empower Darren to manage the situation to the extent possible, and so she steps back and allows Darren to work with Clayton around the gun directly, while continuing to observe the interaction to ensure that the plans to remove it are made and that any other important safety issues are addressed. Darren already has a release to speak with Clayton's daughter and has spoken with her briefly on occasion about his progress.

CLAYTON: Well, I guess, I'm thinking y'all are overreacting a bit to all of this. But I understand where you're coming from.

COUNSELOR: I really appreciate you trying to see our point of view. Let's talk for just a minute before we call your daughter, about what you want to say, how you think she might react, how you want us to be involved.

CLAYTON: Yeah, probably, yeah, she doesn't know much. I mean, she knows I've been doing good in the pro gram, and it's working. And she knows that I haven't been feeling well lately but she really doesn't know much about—she knows my liver's not in great shape; but she doesn't know about the pain being so bad.

COUNSELOR: It's a fairly major thing to kind of drop on her and then to talk with you a little bit about the fact that you need to have her take the gun as well. Do you have a sense for how you're going to bring that up with her? Do we need to talk about that for a minute before we make the phone call? It would seem to make some sense for us to discuss it.

CLAYTON: Um, well, like I said, she knows I've had some liver problems but she doesn't know how bad it is. I could just tell her, you know, I don't have to get into that too much, I don't think right now, do I?

COUNSELOR: Well, I think it's up to you. I would imagine she's going to have some questions about why you're calling. You're going to tell her that you need to give her a gun, and you would like her to take it this afternoon if possible, that you've been having some difficulty. So it's really up to you how much you tell her, but I want to make sure we have thought about any kinds of questions or concerns ahead of time.

CLAYTON: Right.

COUNSELOR: So we can kind of anticipate them before you make the phone call.

CLAYTON: Yeah, I don't see any problem, I mean, as long as she can come over, which I think she can; I mean, she lives maybe 20 minutes from my apartment. I think she's visiting her mother this afternoon. I think she would do it.

COUNSELOR: Okay, all right. One thing: does Barbara have any experience handling and safely storing guns?

CLAYTON: Not much experience, but she's got an area in her attic that she keeps locked. I know that's where she'd lock up the gun.

COUNSELOR: That's really good to know. If you're okay with it, I think we're ready to make the call. CLAYTON: Are you going to be listening in to the call?

COUNSELOR: We'd be willing to, glad to in fact, if that's okay. It might come in handy if Barbara has any questions she wants to ask us. Would it be alright if we put the call on speakerphone?

CLAYTON: Yeah, that's fine, sure. I mean, if you want to. You could explain this stuff better than me, I'm sure.

COUNSELOR: Well, we'd be happy to. There may be different points where Jill or I can offer some support or say something if you're a little bit at a loss for words, and when she has a question, if you could kind of give me the nod, I'll certainly chime in and offer some help if you need it.

SUPERVISOR: Yes, that sounds excellent, I'll be happy to enter into the conversation as well if necessary, although for the most part I'll allow you and Darren to speak with Barbara.

CLAYTON: Okay.

[Clayton dials his daughter Barbara's cell phone number.]

BARBARA: Hello?

CLAYTON: Barbara, hi, it's Dad.

BARBARA: Hi, Dad, how are you?

CLAYTON: I'm, you know, I could be better. I'm sitting here with my counselor and his supervisor and they thought I should give you a call; they are actually on the speakerphone here.

BARBARA: Okay.

CLAYTON: Sorry I bothered you; I hope I'm not catching you at a bad time. I know you are probably visiting with your mom right now.

BARBARA: Oh, no, you don't bother me at all when you call, Dad, I'm glad to hear from you. I just wonder why you're calling with your counselor.

CLAYTON: Well, he thinks I should talk to you about maybe coming over and getting my gun, you know, it's . . . , he thinks that maybe it would be better if you picked it up, or whatever. What do you think?

BARBARA: I think that's pretty scary.

CLAYTON: I'm not sure we need to do it, but he thinks we need to do it, so, but, you know. Could you just keep it for awhile? And in fact, if you want to talk to him, he's here.

BARBARA: I would like to talk to him.

COUNSELOR: Barbara, this is your father's counselor, Darren. I'm imagining you may have some questions.

BARBARA: Hi, Darren. This is pretty scary. I mean, I'll be happy to come over and pick up Dad's gun, but what's going on?

COUNSELOR: Well, your dad's been doing great with sobriety, but unfortunately he's been having a lot of pain, and he feels hopeless on and off, and sometimes has thoughts of killing himself. So, we've advised your dad to get the weapon out of the house, just to be on the safe side.

BARBARA: And I certainly will be happy to come over and get the gun. Dad, do you really think that you could kill yourself? That would be really awful.

CLAYTON: No, I think I'm gonna be all right, my counselor's just being extra cautious, don't worry about me. We can talk more about it, it's a lot to talk about on the phone, but it's okay if you get the gun. It's what they want me to do, and I'm going to go along with them.

BARBARA: Okay, I'll be right over. Are you going to be home Dad?

CLAYTON: Well, I can be there in maybe a half hour.

COUNSELOR: Barbara, I understand it's a scary thing, but it seems like a really good precaution to take.

BARBARA: And I appreciate that you're doing that. And I'll certainly do anything I can to help, but, Dad, why is this happening? What's going on? I mean you've been sober for—it's just like we're getting to know each other, and now all of a sudden, I find out you're depressed. I didn't know any of this was going on.

CLAYTON: Well, it's a lot, you know, we can talk about maybe—I don't know . . . we can, well, you know, my liver's not been doing great and—

BARBARA: What do you mean your liver's not good? I knew you had some problems with your drinking, what do you mean your liver hasn't been doing great? What's that mean?

CLAYTON: Well, the doctors say my liver is pretty bad, and I've sometimes had a lot of pain with it.

BARBARA: What? We need to talk, Dad. I need to know what's going on. This is all pretty scary—you're scaring me, Dad. But I—I'll be right over.

COUNSELOR: And, Barbara, I appreciate you doing that. One of the things your dad and I can talk about is maybe it would be helpful for the three of us to sit down. This is a lot to take in, particularly over the phone. Do you think that might be a good idea?

CLAYTON: Sure.

BARBARA: I think that would be really helpful for me. I have a lot of questions, and I think I'll probably have a lot more, but the first thing is, I will be right over to get the gun.

COUNSELOR: Just two more quick things. One, do you have a safe way to store the gun? Second, after you've obtained and secured the gun, I wonder if you can call me to confirm that you've picked it up.

BARBARA: Yes, I have an area in my attic where I lock up things and I'm good about keeping the key hidden.

COUNSELOR: That's great, please confirm with me after you've locked away the gun.

BARBARA: Yes, absolutely I'll give you a call.

[Darren proceeds to give Barbara the office telephone number.]

COUNSELOR: And Barbara, the other thing I would encourage you to do is just to make a list of the questions that you have. I know this is overwhelming to have all of this dropped on you in one afternoon. So if you just make a list of the questions, you can bring those in and the three of us can sit down and go through those, and try to get you the information and the answers that you need and that your dad is comfortable with. It's likely that your dad could benefit from more treatment for his hopelessness and depression than he is getting right now, and so I think that's something we should talk about when we meet.

[Darren makes a mental note to give Barbara the 1-800-273-TALK number when she calls back.]

BARBARA: That sounds like a really good idea. I-I-I am so rattled right now, I can't even think, but I can do that and bring those in, and I think that would be helpful.

COUNSELOR: Clayton, anything else that comes to mind?

CLAYTON: No. Thanks, Barbara.

BARBARA: Okay, Dad, I'll be—

CLAYTON: Don't worry about me.

BARBARA: I can't not worry about you, Dad, but I'll be right over to get the gun.

CLAYTON: All right. Thank you. Bye.

BARBARA: Bye.

How To Work With the Family of a Client Who is Suicidal

As in treatment of substance abuse illnesses, family and significant others can be an important recovery resource. Some of the steps you, as a clinician, can take with family members include:

- ▶ Providing information about suicide, particularly dispelling misconceptions and providing accurate information.
- ▶ 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.
- ▶ 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.
- ▶ Making suggestions for how to recognize the need for and provide emotional support to a person who might be feeling overwhelmed and hopeless.
- ▶ Providing emergency resources (such as 1-800-273-TALK or local suicide hot-lines and crisis centers in a suicidal crises).
- ▶ Planning for how to access and possibly remove suicide methods, such as guns or pills, to reduce the likelihood of high-risk behaviors.

In working with family members, be sure to honor ethical and legal constraints on confidentiality and obtain appropriate consents for release of information from your client. Sometimes family members are not a positive force for suicide prevention and intervention, so care must be taken to assess how responsive the family members are to helping the client and if they possess the capacity to be a positive force in the client's life at this time.

COUNSELOR: Clayton, thanks for making the call. How do you feel about the phone call?

CLAYTON: I think it's, you know, a little too much to do all that, but I'm willing to go along with it.

COUNSELOR: Thanks for being flexible. Let's talk tomorrow by phone just to see where we are and where we need to go from here.

SUPERVISOR: I can see that you both have things under control. Thanks for allowing me to join your meeting. You did some excellent work here just now. [Jill leaves the meeting.]

Followup

Darren received a call from Barbara acknowledging that she had stored the gun in her locked attic. Ideally, firearms should be stored unloaded, but in this case, there was probably a greater risk of unintentional injury to Barbara if she attempted to unload the gun. Therefore, she simply stored it, given that she has a locked space for it and is the only person with the key. If Darren had not heard from Barbara, he would have been sure to contact her to determine if anything went wrong with the plan and, if necessary, to develop an alternative plan. A positive outgrowth of the counselor's intervention was that Barbara expressed an interest in meeting with the clinician and her dad to learn more about how she could be involved in his treatment and recovery. With Clayton's permission, a joint visit was arranged for the following week. Clayton also agreed to a psychiatric evaluation, and one was scheduled for later in the week to evaluate his depression and further assess suicide risk. Plans were also made for him to continue to visit a local pain clinic to help with pain relief. He was given the 1-800-273-TALK hotline number to call in an emergency.

Clayton was cooperative throughout, agreeing to remove the weapon that created high potential for taking a lethal action. If his daughter hadn't been available, Darren and Jill would have had a decision to make about whether or not any other immediate intervention steps were necessary. They may have wanted to get additional input concerning this question.

As shown in this vignette, family members are often willing to help and are open to coaching about the need to store guns securely and separately from ammunition. In addition, family members may decide not to return the weapon or to get rid of it. A worthy option to explore for your program is your local police department, as some police departments have special policies for receiving suicide weapons.

Darren took the time, with Jill's help, to debrief and document his actions with Clayton related to his suicidal thoughts and to gain additional guidance for the followup sessions. Some of the points they considered include:

- The information he gathered.
- How he accessed consultation with Jill and invited her into the session.
- The actions he took to contact Barbara and elicit her support in removing the gun.
- His referral of Clayton for an evaluation of his depression and Darren's support for Clayton continuing treatment at the pain clinic.
- The followup sessions he scheduled with Clayton and Barbara.

It is important to note in the documentation that Clayton and his daughter were both given the hotline number and were advised to call the number at any time if needed.

5.2 Vignette 2—Angela

Overview

Angela is a 44-year-old African-American woman with a history of chronic bipolar disorder and substance dependence. These illnesses have created numerous problems, including relationship conflicts with her family, unstable employment and housing, and poor adherence to healthcare treatment. She is currently in an inpatient psychiatric unit that specializes in the treatment of co-occurring disorders following a relapse to crack cocaine use. She made a suicide attempt by drug overdose just prior to this admission. Since being in the hospital, her psychiatric symptoms appear to be stabilized. Her counselor and the treatment staff are concerned that her stability is tenuous, and that if she relapses again following discharge, she may rapidly become suicidal. In light of her suicide attempt and her chronic history of relapse and serious mental illness, her doctor intends to keep her in the hospital for several more days of observation.

Participants: Angela (client), Lupe (counselor), Walter (brother), and Carla (sister-in-law).

Substance Abuse History

Angela has a long history of cocaine dependence with relatively brief periods of abstinence. She was hospitalized for cocaine dependence twice in the past 4 years. Her drug use is intertwined with bipolar symptoms so it is difficult for her to remain clean when hypomanic or depressive symptoms occur, and at the same time, her drug use exacerbates these symptoms. She has done well since being

hospitalized and has cooperated with treatment. The primary challenge now concerns discharge planning. Angela believes that she requires minimal aftercare treatment and intends to move back in with her brother and sister-in-law and their two children.

Suicide-Related History

Angela has made two suicide attempts, the first one as a teenager. Her most recent attempt, which precipitated her admission to the co-occurring disorders unit, was made while coming off cocaine. She had been deeply depressed for several weeks and overdosed on a variety of drugs that had been prescribed for her over the last few years. She was unconscious when discovered and taken to the emergency department. Once stabilized medically, she was admitted to the co-occurring disorders program. Although Angela denies any suicidal thoughts at this time, staff remain concerned about her potential for suicidal behavior upon initiation of cocaine use, a likelihood in light of her chronic substance dependence history. She shows poor insight into the severity of her mental illness, drug abuse, and suicide potential.

Learning Objectives

1. To illustrate treatment planning with a client at elevated risk of suicide.
2. To demonstrate family involvement in treatment planning.
3. To demonstrate case management skills in suicide prevention efforts.
4. To offer an understanding of the interaction of substance abuse, mental disorders, and suicidal behaviors.

Meeting Between Angela's Counselor and Her Clinical Supervisor

Angela's counselor, Lupe, asked that part of her weekly clinical supervision session be set aside to discuss her concerns about treatment planning for Angela. Angela's family has just notified her that they are not willing to have her return to their home and be with their children if there is a risk of drug relapse. Lupe and her supervisor discuss the complex interplay of Angela's drug use, her psychiatric illness, and the environmental stressors she faces (lack of employment, social isolation, and poverty). They conclude that this combination of forces indicates a high potential for relapse and resultant crises, and though less certain, a potential return of suicidal thoughts. They decide to recommend ongoing treatment efforts, perhaps a day hospital or a long-term mental health/substance abuse residential care program, once she leaves the intensive co-occurring disorders unit. They also agree that it would be unethical to give a false sense of optimism about her prognosis to the family to persuade them to take her back. Assuming that she cannot return to her brother's home to live in the immediate future, other

supportive housing resources need to be identified. They know that Angela will need to accept and participate in any discharge plan or she will only undermine it after discharge. They also realize that they cannot force her to accept long-term residential or day treatment after discharge, no matter how clear it is to them that such treatment is warranted.

The decisions reached in the supervision about the next steps include:

Lupe will contact Angela's brother Walter (after Angela has signed a release for Lupe to do so) and ask him to participate in Angela's discharge planning.

The staff will need to work with Angela and her family to find an alternative and more structured setting where she can be monitored for relapse of her substance abuse and psychiatric symptoms, and for a return of suicidal thoughts and behaviors. Since Walter is apparently emphatic that she cannot return to his home, this presents an opportunity to identify a more intensive treatment alternative, for example, supportive living plus day hospital treatment, options that she would never had agreed to if her brother had not forced the issue.

Lupe's objectives are to help Angela and her family with case management services to reach agreement for these arrangements. Some of the treatment goals she will try to implement include seeking to ease Angela's transition back into the community; help her develop peer support; and continue to monitor her psychiatric and substance abuse treatment needs, warning signs for suicide, and medication compliance.

Counselor and Angela's Brother

[When Lupe and Walter meet, they have an initial brief interchange focused on developing rapport. Walter seems defensive, and Lupe would like him to be more a part of the solution than an adversary.]

WALTER: Let me get straight to the point: she's gonna relapse. I mean she's come in places like this and then she uses and she shows up at our door. We take care of her and I loan her money. She takes money if I don't lend her any. We're worn out. My wife is giving me a lot of grief about how I keep taking care of my little sister. I mean she's not 18 anymore. She took pills and passed out when she was supposed to be watching our kids. I found her passed out on our sofa and had to call 911 when I couldn't wake her up. I wasn't even sure if she was alive. Just to be straight with you, Angela's not coming back to our house now. I know our kids will miss her. When she's clean, she's better to them than she was to her own kids. But when she's using, she's a real burden on me and my family. We just can't do it anymore. And then when she doesn't take her medication and gets out of treatment she gets crazy. It just keeps going on and on.

COUNSELOR: Thank you for being up front with me about this.

WALTER: Yeah, well, it's the only way we'll get anywhere. Thanks for meeting with me, by the way. It's a welcome change. Last time she was in the hospital, nobody talked to me.

COUNSELOR: Yes, it's good we're communicating. Like you, we want to be sure Angela can be in a supportive environment when she leaves, an environment that will support her abstinence and help her keep her psychiatric illness in check. It sounds like you and your wife have been fantastic in terms of supporting your sister. And I know her children are not involved, so it has fallen on you and your wife.

WALTER: I'm glad you see where I'm coming from. This is not the first time with Angela. We've been through this many times with her.

COUNSELOR: Once I learned that you wouldn't be taking Angela back to your house, I had a chance to discuss alternatives with my supervisor and our treatment team, and also discussed possibilities briefly with Angela, although we didn't come to any firm agreement. The alternative that seems to make the most sense is for Angela to first enter a halfway house program for people with co-occurring substance use and mental disorders and then, later, move toward a supportive residential housing program, which could last up to 120 days or more.

Additionally, while she's in the halfway house, she would continue to participate in intensive outpatient services here at the clinic. For starters, that outpatient treatment could be as frequent as 5 days a week, what we call "day hospital," until she achieves some success in recovery.

Master Clinician Note: It is important for counselors to be aware of ongoing residential treatment and housing options for clients who have a history of homelessness, a history of instability in obtaining and maintaining housing, and those in need of long-term supervised care. Some treatment possibilities in your community may include:

- Oxford Houses—a residential housing option found throughout the United States for people recovering from substance use disorders.
- Halfway houses for people leaving inpatient care.
- Sobriety houses, focusing on long-term supervised residential care.
- State and Federally funded long-term treatment programs.
- Supervised living.
- Group homes or other community resources.

In addition, housing options are numerous: housing funded through the HUD Homeless Assistance grants, such as Single Room Occupancy buildings, Shelter Plus Care, and Supportive Housing Programs, which are available to individuals

who are homeless and have disabilities; programs that provide rental subsidies for sober housing and supportive services; modified therapeutic communities; day treatment with abstinence-contingent housing and employment services; and emergency and transitional shelters with onsite substance abuse treatment and relapse prevention programs. For more information about substance abuse treatment and homelessness see the planned TIP Substance Abuse Treatment for People Who Are Homeless (CSAT, in development j).

WALTER: Hold on a second, I'm all for Angela doing something besides living with us, but aren't halfway house places for people who have been to jail?

COUNSELOR: Well, not everyone in halfway houses is coming from jail. The program we would like to use is specific to the needs of people who have both substance use disorders and a co-occurring mental disorder. And we hope that in a few months Angela could transition to having her own small apartment, in a supervised residential environment where there would be someone to make sure that she takes her meds and continues to participate in treatment here. When she is able, they can also help her with employment. And in the meantime, she would be responsible for helping maintain the residential housing facility, in addition to keeping her own unit maintained. And, of course, we really want to monitor her psychiatric symptoms and her potential for suicidal thoughts and behaviors. I know that Angela feels very connected to you, your wife, and your kids, and that relationship is very important to her. But I hope she can understand your position that going back to your home just isn't an option right now.

WALTER: If you can find a healthy place for her, my wife would kiss you. Angela's been a drug addict since she was in her teens, and she always has big plans. She gets an apartment or she gets a boyfriend or she goes into a program and she always ends up back on our doorstep. What am I gonna do? She's strung out. She's gonna end up on the street. We take her in, we clean her up, she makes promises and then you know what happens. If you can get her in a place where they'll be nice to her and they'll give her medications and be good to her that's great, but I got enough to take care of.

COUNSELOR: I understand, and that's why we hope this kind of step-by-step collaborative plan, between Angela, your family, and us will work. And we do hope you will remain a big part of her life. Help her to be part of the family—have her be a part of family ceremonies and special occasions because we know that is important for her. But as you say, she also needs to live apart from your family, find her own life, and build her own support system. Help her to be independent.

WALTER: About this suicide thing. You know my sister's a drama queen. Do you really think she's gonna kill herself? I mean, she's been using drugs since she was a teenager. Maybe she just went overboard when I found her.

COUNSELOR: We'll never know what would've happened if you hadn't found her, but based on my discussions with her and the report from the emergency department, we do believe that she tried to kill herself. She has a mental illness, bipolar disorder, and that has a high suicide risk. Also, as you might be aware, she tried to kill herself once as a teenager as well, also with pills. Fortunately, people like Angela who are vulnerable to becoming suicidal aren't that way all the time. I'm just getting to know Angela, and I don't have a crystal ball, but she may be vulnerable again if she relapses, and her relapses tend to happen when her mental illness is poorly controlled, especially when she's depressed. So her addiction and mental illness feed off of one another, creating a vicious cycle. Suicide potential isn't the only issue that Angela's facing, but it is an added concern that we have—one that says to us that we should keep her in the hospital a bit longer, for more observation to be sure she's safe, as well as to do everything that we can to put together a sound discharge plan. The success of that plan will ultimately depend on Angela, but we'd like to do our part to make it as realistic and supportive as possible.

WALTER: Well, to be honest, I see it your way. She always says things that are off the wall, but a few weeks ago she made a couple of remarks that were downright scary, something like "you'll be sorry when I'm gone" and "nobody cares about me so what's the difference what happens to me?" I didn't give it much thought at the time, but now it seems she was telling me something.

COUNSELOR: Yes, those statements are what we call warning signs for suicidal behavior. If she does make statements like that in the future, you should interpret it as an indication of danger for suicide, and we can work together to prevent another suicide attempt. Let's discuss this further when we meet with Angela.

Master Clinician Note: Counselors should be aware of warning signs that indicate suicidal thinking and/or acute risk for suicidal behavior. Warning signs include suicidal communications ("It's not worth it anymore," "You'd be better off without me," "Nobody cares anyway," "I might as well kill myself," "I'd be better off dead," "I might as well be dead"), seeking access to methods of suicide (for example, hoarding pills, moving a gun that has been in storage), and any actions that suggest getting prepared for suicide (for example, giving away possessions, making arrangements in case of death). Warning signs also include changes that suggest a turn for the worse, for example indications that an individual is feeling trapped or hopeless, behaving recklessly, becoming withdrawn, or experiencing dramatic swings of mood. Acute stressful life events may trigger risk for suicidal behavior, like relapsing, breaking up with a partner, losing a job, or being the victim of trauma. Additionally, as discussed below, it is important to help family

members be cognizant of warning signs and help them plan how to take action if they notice warning signs.

WALTER: I can't tell you how relieved I am that she's here right now. I sleep good at night knowing she's in this place. Worries me sick what will happen after she leaves. You were saying, there is someplace she can go?

COUNSELOR: We would like her to get into supportive residential housing, but we think first she might do better in a more structured halfway house environment until she is well stabilized with her abstinence and her mental illness. At the moment it's not a guarantee, although the sooner Angela is referred, the better, in terms of any wait.

WALTER: She's got a bed in this place?

COUNSELOR: Not at the moment, no. Getting that process started immediately is important, and for that we'll need Angela to agree to it. We want to be sure that Angela gets enough care. With too little support, her odds of maintaining the gains she started here drop. Maybe we can call Angela in now and the three of us can meet.

WALTER: Sounds good to me.

[Angela joins Lupe and Walter.]

COUNSELOR: Hi, Angela. Thanks for giving permission for Walter to talk with me today and to join us now.

ANGELA: Hi, Lupe. Hey, hi Walt!

COUNSELOR: How are you doing?

ANGELA: I'm doing fine.

WALTER: Yeah, well you best get yourself fine. I mean how many times have we done this? You get so-called fine, you get cleaned up and then you use drugs, then you show up at our door. We take care of you, and now this lady is telling me you're suicidal.

ANGELA: This is different. I'm really fine this time. I'm gonna be okay.

WALTER: Angela, you know that Carla and I love you. Our kids love you. We wouldn't have you in our lives if we didn't care about you, and we don't want to see anything happen to you. But this suicide thing is scary. I know you're an addict. You've been an addict forever. But, suicide? Angie, when I found you I thought you were dead. Your breathing was so shallow I thought you stopped breathing altogether, I thought you were gone. I was really scared.

ANGELA: This is different. I'm fine this time. I'm gonna be fine.

WALTER: Yeah. Tell it to Carla.

Master Clinician Note: Lupe recognizes that there is family anger as well as little understanding of Angela and her illnesses. She also recognizes that this may be the

first chance Walter has had to express this frustration. Rather than focus on his anger, which would likely just make him more defensive, Lupe decides to focus on his concerns and caring for Angela. She also recognizes, however, that if Walter's anger becomes an impediment to his being involved in treatment, it will need to be addressed. Encouraging family involvement in Angela's treatment may be very beneficial for both Angela and her family and will likely enhance treatment efficacy as well.

COUNSELOR: Walter, suicide is an important risk for Angela—and something we need to stay focused on, along with her abstinence and her mental illness. I know that you love your sister and she loves you. I think Angela has been working on helping herself and she's willing to continue working toward that goal. And I know you have some realistic concerns about her relapsing that need to be addressed.

ANGELA: I'm not gonna relapse.

COUNSELOR: Angela, I don't think anybody plans on relapsing. But it happens when people in early recovery aren't paying attention to the things that help them stay clean and sober. One of your goals here is to develop a personal recovery plan that identifies your triggers and looks at the opportunities and resources you have to address those triggers.

How to Incorporate Suicide Prevention in Relapse Planning

Clients who relapse with alcohol or drugs and active mental illness are at significant risk for suicidal thoughts and behaviors. As a result, planning for coping with suicidal thoughts and behaviors needs to be part of a relapse plan. Some possible elements of the plan are:

- Develop a plan for safety in the event of relapse in individuals who you have reason to believe will be at risk for suicide upon relapse (e.g., call your counselor, come to the clinic to see your counselor, call the National Suicide Prevention Lifeline at 1-800-273-TALK, go to the emergency department of your nearest hospital).
- Be aware of and address client speech that projects a suicidal result from relapse (e.g., challenge statements such as “if I use, I'll kill myself,” “if I relapse, I'll use 'til I die,” or “if I relapse, that will be the end for me”).
- Use mental health interventions to aid in relapse prevention (e.g., psychopharmacology, individual psychotherapy).
- Encourage the client to be actively involved (including a sponsor) in a 12-Step or other supportive program.

ANGELA: But I can come home later, right Walter? 'Cause I'm fine.

WALTER: I think we should do what Lupe says. I mean no treatment program has ever talked with us like this. She's taken the time to talk with us, to work with us. It sounds like they went through a lot of trouble to make a plan for you and you have a really bad addiction. I mean you've had problems and been an addict since you were 17. You need more than just coming into this hospital. You gotta go to this program like she's talking about, live there, stay sober. We can talk about you coming home later, but you have to keep going to your pro gram. You gotta start listening to these people.

ANGELA: But I'm fine, I'm fine.

WALTER: Yeah. Okay.

COUNSELOR: I know you believe you're fine right now Angela. Our goal, all three of us, you, me, and Walter, is to help you stay fine.

[Lupe outlines for Angela the housing plan that she and Walter discussed.]

LUPE: I just want to see if there were any questions that either of you might have at this point.

WALTER: I want to say I love Angela. We wouldn't have her in our lives if we didn't care about her, and we don't want to see anything happen to her. She's been an addict forever. I'm used to that, but the suicide thing frightens me.

Master Clinician Note: A concern for providers and families is that suicide risk is high after discharge for clients with a history of a previous suicide attempt and/or other significant risk factors. Families can do a number of things. They should remain watchful for warning signs. Before the patient leaves the hospital, family members should have a specific plan for whom to call and/or what to do in the event of acute warning signs (e.g., call the National Suicide Prevention Lifeline at 1-800-273-TALK, bring the individual to the psychiatric emergency department, call the clinic where the patient is being referred). Family members should not presume that, simply because a family member was just in the hospital, they are protected from suicidal behavior.

Other helpful actions are restricting access to firearms and exercising some control over the supply of medications (e.g., giving a week's supply at a time to the client and holding onto the rest, to prevent overdose). Families are also advised to be involved in inpatient and outpatient treatment of their relatives. Some common responses of family members when someone has thought about or attempted suicide include:

- ➔ Feeling angry toward the suicidal person.
- ➔ Feeling guilty.
- ➔ Wanting to punish the suicidal person.

- ➔ Hovering over the person to ensure that they don't attempt again.
- ➔ Frequently interrogating the suicidal person about their thinking.
- ➔ Emotionally withdrawing from the suicidal person.

All of these reactions can be counterproductive. Family counseling for family members and significant others can be of benefit to both the family and the client.

COUNSELOR: Well, Angela is aware that she has a number of risk factors for suicide, including her bipolar illness. She acknowledges that just a few weeks ago she took a bunch of pills in an effort to kill herself. So, it is definitely something we need to be concerned about. And Walter, let's talk for a minute about what you might notice that could mean Angela is having suicidal thoughts.

WALTER: Well, like I said, I feel bad now that Carla and I didn't pick up on her talk about maybe not being around much longer and us "being sorry when she's gone."

COUNSELOR: Well, listening for those kinds of messages is important. I think another thing is just being aware that there are times when Angela is more likely to be at high risk than other times. For instance, when she is using or when her mood is not well regulated, when she is not taking her medication, when she is avoiding treatment, and when she is depressed.

WALTER: Well, you're right. When Angie isn't too high or low and when she is clean she is okay to be around. She's good with our kids and takes care of herself.

COUNSELOR: Angela, I'm interested to hear what you have to say about this.

ANGELA: Well, I've said, I ain't gonna use, and I ain't gonna try to kill myself. Those days are over.

WALTER: Yes, yes, that's what you always say Angela.

[Pause while Angela looks away, frustrated.]

Master Clinician Note: It is common for tension to exist between clients and family or significant others over the risk of relapse and recurrence of suicidal thoughts and behaviors. While clients may deny or minimize risk, those close to them often experience distrust and anxiety (especially with a past pattern of relapse and recurrence). The counselor can address and normalize this experience and then reorient both parties back to the need for developing plans to support recovery and safety.

COUNSELOR: It's understandable that there is some tension between you about the future. This commonly occurs where the recovering person—Angela—tries to convince her family that she will be fine. What's important is to have plans in place

to support recovery and safety. It is not only helpful to you, Angela, but also helpful to your family. So let's review the plan, Walter.

WALTER: So, we should watch for when we think she's depressed or sad or hopeless or if she says she wants to kill herself. And if it sounds like she's gonna be strung out, withdrawn, or out of touch with treatment. Those kinds of things, Right?

COUNSELOR: Right. And one other thing, Walter. What will you do if you see those signs?

WALTER: Well, I'll call her on it, and I'll telephone you.

COUNSELOR: I'd be happy to hear from you in those circumstances, although my primary job is treating patients like Angela when they are here on the floor and so, after discharge, there will be other counselors working more closely with Angela on an ongoing basis. So it will be important to have their contact information and to get in touch with them.

ANGELA: How long are you expecting me to stay in this residential place?

COUNSELOR: Well, Angela, let's focus on getting in before we start planning on getting out. I'd like you to sign this release so I can start the process for you to go to a halfway house when you leave our program. Then, when you've had a chance to continue day treatment here on an outpatient basis and you are doing well, we can work on arranging a transition to a place where you can have your own apartment.

ANGELA: Okay, go ahead. I'll sign one more of those papers you're always having me sign.

COUNSELOR: Great, that sounds like a plan. I'll go get a consent form. One other thing we can do is schedule the next meeting with the three of us. Would that be okay with you Walter?

WALTER: Yes, I'm agreeable. Like I said before, nobody asked me to be part of Angie's treatment before. This is the first time I ever felt like I knew what was going on and had information about what I can do to help.

COUNSELOR: Okay, let's set something up. How would the end of the week be for you?

[The session ends with Angela signing a release and a followup session being scheduled.]

Followup at 6 Months

Angela completed the inpatient treatment program and was referred to a local halfway house. After 2 months, she was accepted to a supervised living facility. She attended an additional month of day hospital treatment following her discharge and has remained clean and sober for a longer period than any time in her adult life (7 months counting her month-long hospitalization). While in the halfway house,

she continued attending a Double Trouble support group for people with co-occurring substance use and mental disorders. She has continued in weekly outpatient counseling, where the focus remains on strengthening her commitment to abstinence, monitoring her psychiatric symptoms, and strengthening her relationships with others. She and other people in the Double Trouble group often eat at a local restaurant after meetings, and Angela expressed much satisfaction at having girlfriends in her life for the first time since she was a teenager. She had one hypomanic episode lasting about 2 weeks shortly after completing her day hospital program. This coincided with her admission to the supervised residential living facility. Her counselor worked with her residential supervisor and with Walter to continue their observation of her behavior, and her medication was readjusted. The hypomanic episode gave staff and Angela a chance to practice the relapse prevention strategies that had been developed during her inpatient stay. The staff concur with Angela's report that she has not experienced suicidal thoughts or behaviors. Angela, Walter, and her outpatient counselor have met on a monthly basis to be sure that communication has been maintained between Angela and her family, and Angela occasionally visits Walter and his family on weekends and some holidays. She feels accepted in the residential setting and has begun to see that as her home.

Resources for Family Members and Friends

The National Suicide Prevention Lifeline has published a booklet, *After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department*, with a Spanish version, *Después de un Intento de Suicidio*. These can be downloaded from <https://store.samhsa.gov/shin/content/SMA084357/SMA084357.pdf> and http://store.samhsa.gov/product/Despusdeun-intentodesuicidio_Guaparacuidarasufamiliardespusdeltratamientoenlasalade-emergencias/SMA084358, respectively. Additionally the American Association of Suicidology publishes a newsletter, *Surviving Suicide*, written by survivors for survivors. Click on the Survivors page at <http://www.suicidology.org>. Several excellent sources of information are available for those whose family member or friend has died by suicide: Suicide Prevention Resource Center (<http://www.sprc.org>). In the customized information menu, select "survivors."

- The National Organization for People of Color Against Suicide (<http://www.nopcas.com/>) has valuable information that can be accessed via it's website.
- American Foundation for Suicide Prevention (<http://www.afsp.org>). Click on the menu option "Surviving Suicide Loss."

- The American Association of Suicidology (<http://www.suicidology.org>) has a variety of print resources, including information about support groups.

6.0 Youth Suicide

Prevalence

The suicide death rate for adolescents and young adults has increased in the past two decades. In 2018, the suicide death rates for adolescents and young adults were 2.85 per 100,000 for ages 10 to 14, 11.39 per 100,000 for ages 15 to 19, and 17.4 per 100,000 for ages 20 to 24. In all age groups, males have a higher suicide death rate than females. However, from 1999 through 2018, the suicide death rate doubled for females aged 15 to 19 and 20 to 24. For youth aged 10 to 14, the suicide death rate more than tripled from 2001 to 2018. Explanations for the increase in suicide may include bullying, social isolation, increase in technology and social media, increase in mental illnesses, and economic recession.

Suicidal ideation, self-harm, and suicide attempts are significantly higher in youth compared to adults, despite adult suicide death rates being higher. In 2019, approximately 18.8 percent of high school students reported suicidal ideation in the past year, and 8.9 percent of high school students reported a suicide attempt in the past year. Rates of high school students reporting purposefully hurting themselves without wanting to die over the past 12 months ranged from 6.4 to 14.8 percent for males and 17.7 to 30.8 percent for females in 2015.

Prevalence of suicidal thoughts and behaviors is particularly high in lesbian, gay, bisexual, transgender, and questioning or queer youth and youth with other sexual and gender minority identities (LGBTQ+). Lesbian, gay, and bisexual adolescents and young adults are two to four times more likely to report suicidal ideation, self-harm, and a suicide attempt compared to their heterosexual peers. Transgender youth are four to five times more likely to attempt suicide compared to their peers who exclusively identify as their sex assigned at birth (i.e., cisgender), with about 34.6 percent reporting a suicide attempt in the past year. LGBTQ+ youth often experience unique stressors related to their identity, such as discrimination, violence, trauma, expectations of rejection, concealment of their identity, and internalized homo- and trans-negativity, that increase risk for mental disorders and suicide.

Some racial and ethnic minority youth also experience higher rates of suicidal behaviors. American Indian and Alaska Native (AI/AN) youth, as well as youth of more than one race, report the highest rates of both suicidal ideation and suicide

attempts. Differences in suicide attempt rates may be attributed to disparities in access to mental health treatment and other factors that AI/AN and Black youth disproportionately experience, including poverty, historical trauma, and adverse childhood experiences.

Importance of Prevention

While the primary focus of this section is on treatment approaches, it is necessary to highlight the importance of prevention strategies in stopping young people from engaging in suicidal behaviors. This section provides context regarding risk and protective factors and some core prevention strategies critical to treatment program planning and implementation.

The association between alcohol use and suicidal thoughts and behaviors is of concern, since more than 21 percent of youth aged 12 to 17 used alcohol in 2019, and 9.4 percent reported past month use.

Risk and Protective Factors

Risk factors are characteristics that potentially increase an individual's level of suicide risk, whereas protective factors are factors that mitigate against risk. Adolescents and young adults are in a state of transition, facing new independence, identity formation, and changing social situations at school and home. The significant physical, hormonal, and social changes of adolescence can increase the likelihood of a young person experiencing anxiety or depression. Mental and substance use disorders, including depression, anxiety, bipolar disorders, eating disorders, marijuana use, and alcohol use or misuse, also increase the likelihood and severity of suicidal ideation, as well as risk of suicide attempts and deaths. Other individual-level risk factors include but are not limited to:

- ▶ Previous suicide attempts
- ▶ Childhood trauma, such as physical, sexual, and emotional abuse
- ▶ Being in the child welfare system
- ▶ Being a victim or perpetrator of bullying
- ▶ Experiencing a stressful event
- ▶ Consistent low-level or toxic stress
- ▶ Dysregulated sleep
- ▶ Hopelessness
- ▶ A sense of losing control
- ▶ Emotional reactivity or pattern of aggressive or aggressive-impulsive behavior
- ▶ Access to non-secure firearms
- ▶ Access to lethal means of suicide, including medications

Knowledge of risk factors helps clinicians and program administrators understand chronic risks clients have. Although single risk factors are severely limited in their ability to accurately predict suicidal thoughts and behaviors, recent studies suggest that combinations of risk factors predict more effectively. Nevertheless, there is considerable heterogeneity among youth at risk for suicide, and risk levels can increase or decrease over time. Therefore, there is no one-size-fits-all approach to prevention or treatment.

Factors that reduce risk for suicidal thoughts, attempts, and deaths are referred to as protective factors. Recognizing them is just as important, if not more so, as understanding factors that increase risk. Adolescence offers a period of developmental opportunity to discover new outlooks, form positive relationships, and explore one's identity. It is also a period that can increase resilience when youth overcome challenges and thrive as they develop and mature.

Warning Signs

- ➔ Talking about or making plans for suicide
- ➔ Expressing hopelessness about the future
- ➔ Displaying severe/overwhelming emotional pain or distress
- ➔ Showing worrisome behavioral cues or marked changes in behavior, particularly in the presence of the warning signs above.

Universal screening for suicide risk using a standardized tool is an essential component of a comprehensive suicide prevention program. Screening helps providers identify individuals who may be at risk and implement appropriate care plans. Suicide screening can be done independently or as part of a more comprehensive health or behavioral health screening. The Ask Suicide-Screening Questions (ASQ), the Columbia Suicide Severity Rating Scale (C-SSRS), and the Patient Health Questionnaire-9 Modified for Teens (PHQ-A) are all validated screening tools for use in medical and other settings for youth. A positive screen is typically followed by a comprehensive suicide risk assessment and safety planning if warranted.

Common Elements of Effective Treatment

The evidence base for treatment of suicidal ideation, self-harm, and suicide attempts continues to emerge. There is no one-size-fits-all treatment approach. Care should be taken to select the program that best fits the characteristics and needs of the youth who will be served. Regardless of the specific program selected,

this guide's review of relevant research and discussions with content experts identified a set of common elements that should be strongly considered prior to treatment and within treatment programs:

- ➔ Comprehensive assessment to inform treatment
- ➔ Safety planning
- ➔ Family involvement in separate or joint sessions
- ➔ Coping skills training to match needs identified in the assessment
- ➔ Promotion of continuity of care

Prior to initiating treatment or during the first sessions, a comprehensive clinical assessment or history of a client's thoughts, behaviors, mood, previous suicide attempts, trauma, health history, and home life should be completed using a structured or semi-structured approach (e.g., using a combination of assessment tools and/or clinical interviews). This initial assessment can assist providers in identifying suicide risk, determining appropriate next steps, and tailoring specific treatment modules to meet specific needs. Clinicians should also regularly administer one or a sub-set of brief tools based on the patient's presenting problems to track the youth's progress over time and adjust the treatment plan accordingly, consistent with measurement-based care.

Measurement-based care is the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient. An example of a free assessment tool for identifying youth at risk for suicide during an initial assessment is the Ask Suicide-Screening Questions (ASQ) Toolkit. HealthMeasures include PROMIS® and the NIH Toolbox®, two free comprehensive sets of neurobehavioral measurements that assess a broad range of symptoms and risk and resilience factors that could be used at intake and to monitor patients over time. The Collaborative Assessment and Management of Suicidality (CAMS) is a therapeutic framework in which the client and provider work together to assess the client's suicidal risk and use that information to plan and manage suicide-specific treatment. CAMS is a widely used intervention but its efficacy for youth has not been tested. CAMS incorporates the Suicide Status Form (SSF) to assess the client and guide the development of a treatment plan. The SSF has been validated for use with youth aged 12 to 17.

Coping Skills Training

Skills training during treatment involves youth learning, practicing, and applying a variety of coping skills that help youth better navigate everyday challenges

and stressors. Skills training sessions may focus on emotional regulation, distress tolerance, cognitive restructuring, communication skills, help seeking, problem-solving, and/or conflict resolution. This training should be calibrated with what put that youth at risk for suicide. For example, if an adolescent male client tends to experience suicidal thoughts after interpersonal conflicts with his friends, parents, and significant other, a clinician might prioritize different coping skills than for an adolescent female who suffers from perfectionism, anxiety, depression, and feelings of failure.

Considerations

When Selecting and Implementing Programs to Treat Suicidal Ideation, Self-Harm, and Suicide Attempts

When selecting and implementing optimal interventions to address suicidal thoughts and behaviors, there are several potential factors to consider, including:

- ▶ Treatment fidelity
- ▶ Adaptation of programs
- ▶ Treatment adherence and retention in care
- ▶ Program sustainability

These factors are described in detail below, along with recommended strategies to achieve optimal implementation.

Treatment Fidelity

Consideration: Fidelity is the extent to which a practitioner adheres to the core components of the program and is crucial to reaching desired outcomes. For youth experiencing suicidal thoughts and behaviors, this consideration is particularly important given that lack of improvement could result in an attempt or death by suicide.

Strategies:

- ▶ Monitor fidelity over time – For even the most experienced clinicians, suicide can be one of the most uncomfortable and challenging presenting problems to address with clients. Without ongoing efforts to maintain it, initially high treatment fidelity can diminish, even after only a few weeks following initial implementation of a program.
- ▶ Many programs in this guide have fidelity measures that can be implemented either as a self-assessment tool, or, if funding is available, by external expert

evaluators. Practitioners should also frequently refresh their knowledge of the program by attending trainings, webinars, and other continuing education opportunities.

- ▶ Ensure the organizational environment supports fidelity - Organizations can support treatment fidelity by examining their existing systems and environment to determine whether they enable staff to carry out the program as intended. The organization must have the infrastructure needed to support correct use of evidence-based treatment, reduce clinician burden, and prevent burnout. Considerations may include current program offerings, the level of staff education, client characteristics, client intake processes, funding sources, the ability of clinicians to see clients on a regular basis (e.g., once a week or more often depending on the treatment selected), and time for clinicians to further study the treatment modules and prepare for each session. It is important for the organization and leaders to acknowledge how challenging it is to work with suicidal clients and to be transparent about the fidelity monitoring process.
- ▶ Develop in-house expertise - It is often advantageous for an organization to select staff to undergo supervision, trainings, and certification. In-house training and clinician supervision groups make professional development more easily accessible, help prevent burnout, and ensure continued treatment fidelity over time. They can also help ensure a built-in support system and more attention to self-care for clinicians working with youth experiencing suicidal thoughts or behaviors.

Suicidal ideation, self-harm, and suicide attempts among youth are significant public health concerns. This review of the research literature identified practices and programs used to treat suicidal thoughts and behaviors. The chapter provides an overview of two evidence-based programs, including a discussion of the typical settings, demographic groups, intensity and duration, and outcomes attributed to receipt of the intervention:

- * Dialectical Behavior Therapy (DBT)
- * Attachment-Based Family Therapy (ABFT)

Each program or practice description also provides a rating based on its evidence of impacting one or more of the following outcomes: suicidal ideation, self-harm, and suicide attempts among youth. The section also includes a discussion of four programs that have more limited evidence, but that show some promising results and include key elements to address suicide within a treatment system. Due to the limited number of studies available on these programs at this time, they have not been given an evidence rating. Their inclusion in this guide is meant to encourage

researchers to conduct additional studies on these programs to expand the evidence base. The programs include:

- * Multisystemic Therapy-Psychiatric (MST-Psych)
- * Safe Alternatives for Teens and Youth (SAFETY)
- * Integrated Cognitive Behavioral Therapy (I-CBT)
- * Youth-Nominated Support Team-Version II (YST-II)

Program Selection

To ensure inclusion of the most useful interventions for addressing suicidal thoughts and behaviors among youth, authors required programs meet the following criteria:

- * Clearly defined and replicable
- * Address the target outcomes of a reduction in suicidal ideation, self-harm, suicide attempts, and/or death by suicide
- * Developed or adapted specifically for youth
- * Currently in use
- * Demonstrate evidence of impact on the above targeted outcomes
- * Include accessible implementation resources

Dialectical Behavior Therapy (DBT)

Overview

DBT is a manualized, cognitive-behavioral treatment that includes concurrent individual therapy, family therapy, multifamily skills training, and telephone coaching. DBT therapists hold regular team consultation meetings to address treatment adherence, continue training, and manage caseloads and potential burnout. DBT was designed for treatment of adult patients with chronic suicidal ideation diagnosed with borderline personality disorder (BPD). Emotional dysregulation caused by BPD can result in self-harm and suicidal behaviors. The goal of DBT is to help individuals develop more effective behavioral, emotional, and interpersonal patterns. DBT emphasizes the development of four skills:

1. Mindfulness
2. Interpersonal effectiveness
3. Emotion regulation
4. Distress tolerance

Emotional dysregulation is the inability to flexibly respond to and manage emotions. Adolescents with BPD exhibit frequent suicidal ideation or behavior, and suicide attempts are common. DBT was adapted for adolescents due to the treatment's effectiveness with suicidal behaviors in adults. The intervention also focuses on retaining clients in treatment, which research shows is a challenge for youth experiencing suicidal thoughts and behaviors. As adapted for adolescents, DBT focuses on treating youth with repeated self-harm and symptoms of BPD, many of whom also meet the Diagnostic and Statistical Manual of Mental Disorders (DSM–5) diagnostic criteria for depression and other mental disorders. It includes parents in treatment through multi-family group skills training and some family sessions. These adaptations tailor the adult version for the adolescent developmental stage and typically include youth ranging from 12 to 18 years old.

Outcomes Associated with DBT

Studies included in this evidence review demonstrated that use of DBT for youth with suicidal thoughts and behaviors was associated with reductions in one or more of the following outcomes:

- Suicidal ideation
- Self-harm (non-suicidal)
- Self-harm (intent unknown)
- Suicide attempts

The studies included several additional outcomes, including improvement in BPD, reduced psychiatric hospitalizations, reduced depressive symptoms, and improved treatment completion rate.

Typical Settings

DBT has shown efficacy when delivered in an outpatient setting and has been implemented in community clinics serving primarily ethnic minority youth with low income. Some data also support particular benefits among non-white youth and Latino youth. However, DBT has been used with promising results in a wide range of settings, including intensive outpatient programs, regular outpatient care, and psychiatric inpatient units.

Demographic Groups

DBT is intended for use across all sexual and gender identities, races, and ethnicities. All DBT studies included in this review comprised adolescents aged 12 to 19. Participants were predominately female. The criteria for participant inclusion varied across all reviewed studies. However, common criteria were:

1. Suicidal thoughts or behavior
2. Meeting at least two criteria of BPD or having a previous diagnosis of BPD

Practitioner Types

DBT can be delivered by mental health practitioners, including licensed behavioral health professionals such as psychiatrists, psychologists, and therapists. At least one study included post-doctoral students, psychiatry fellows, and graduate students as DBT practitioners, in addition to licensed therapists and clinical workers.

Attachment Based Family Therapy (ABFT)

Overview

ABFT is a manualized family therapy model specifically designed to treat depression and suicidal thoughts and behaviors in adolescents. ABFT seeks to protect adolescents against suicidal ideation and risk behaviors by improving family processes and repairing or building secure parent-child bonds. ABFT is designed to be structured while also being flexible enough to address the unique challenges each family brings to treatment. The ABFT treatment manual outlines five sequential tasks the therapist will lead the client and family through during the course of treatment. To accomplish each task, the practitioner employs a primarily process-oriented, emotion-focused approach, using strategies identified for each. Each task builds on the one preceding it, leading to the desired treatment outcome. Multiple sessions may be necessary depending on the needs of the adolescent and caregivers. Initial sessions focus on repairing or building attachment bonds, and later sessions focus on promoting adolescent autonomy. ABFT's Five Treatment Tasks include:

1. Relational Reframe Task
2. Adolescent Alliance Task
3. Parental Alliance Task
4. Attachment Task
5. Autonomy Promoting Task

Typical Settings

ABFT can be administered as either an inpatient or outpatient treatment. Typical settings for conducting treatment include the family home, hospitals, outpatient clinics, community-based organizations, group or residential care facilities, and

schools. All studies included in this review administered ABFT as outpatient treatment in a research clinic setting

Outcomes Associated with ABFT

Some studies included in this evidence review demonstrated that use of ABFT for youth with suicidal thoughts and behaviors was associated with reductions in:

- Suicidal ideation

Demographic Groups

ABFT is designed to treat youth aged 12 to 25 and engages family members of all ages in treatment. The treatment has been useful for adolescents with diverse gender, sexual, racial, and cultural identities, in addition to adolescents with a history of sexual abuse.

Practitioner Types

ABFT practitioners are typically licensed and possess a minimum of a master's degree in the mental health field. If a therapist is not licensed, he or she must be practicing under a supervisor's license at their organization. ABFT has been used in teams with co-practitioners who have an undergraduate degree.

Intensity and Duration of Treatment

ABFT is designed to last approximately 12 to 16 weeks and span 10 to 20 sessions. In practice, therapists have adapted the model to the context and families with whom they work. The studies included in this review lasted from 12 to 16 weeks and averaged 8 to 12 sessions.

The remainder of this section includes short descriptions of four programs that are either newly developed or have recently been adapted to address suicidal thoughts and behaviors: Multisystemic Therapy-Psychiatric, Safe Alternatives for Teens and Youth, Integrated Cognitive Behavioral Therapy, and Youth Nominated Support Team Intervention for Suicidal Adolescents-Version II. Each program has shown positive study outcomes. Technical experts agree that these programs include key elements important for treatment of suicidal thoughts and behaviors. However, they have various limitations in their current evidence base, such as:

- * Program has not yet been studied in multiple RCTs
- * Findings of subsequent RCTs are not yet published
- * Multiple RCTs have been conducted for other outcomes, but not yet for suicidal thoughts and behavior

This section does not provide evidence ratings for the following promising interventions described below. These programs are described here to offer information to researchers and those treating youth. This information is important at a time when additional research is needed, youth suicide rates are rising, and relatively few programs are available for youth that have demonstrated well-established effectiveness for treating suicidal thoughts and behaviors.

The first of four promising programs is Multisystemic Therapy-Psychiatric (MST-Psych). MST is an intensive manualized treatment developed for youth aged 12 to 17 with serious antisocial behavior, most of whom have had involvement with the criminal justice system. Youth diagnosed with conduct disorder, the childhood disorder most associated with antisocial behaviors, have a greater rate of suicide attempts compared to youth without conduct disorder. MST provides a useful approach in that it draws from the social-ecological theory of human development, which emphasizes that treatment must address the strengths and challenges of the systems with which youth interact (e.g., family, peer, school, larger society). The social-ecological theory recognizes that all of these systems affect youth, and that youth, in turn, affect many different systems.

MST-Psych is an adaptation of MST specifically designed for adolescents with high-risk symptoms, such as suicidal, self-injurious, and aggressive behavior. Treatment focuses on improving caregiver and family functioning and working with the family to address risk factors present in the systems with which the adolescent interacts. MST-Psych has been used in both home- and community-based settings. Most families receive services for 3 to 6 months, although there is no defined length of treatment.

Some studies have demonstrated MST-Psych's effectiveness in reducing serious behaviors, such as violence, substance use, and criminal activity. One of these studies examined the use of MST-Psych with youth aged 10 to 17 presenting for emergency hospitalization for suicidal intent/planning, attempted suicide, homicidal ideation or behavior, psychosis, or other threat of harm to self or others. The majority of participating youth were African American and male. Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth

What Research Tells Us

The study demonstrated that youth who received home-based MST-Psych experienced a greater reduction in suicide attempts at 1-year follow-up compared to youth assigned to inpatient hospitalization. However, youth in the MST-Psych

group had a history of more suicide attempts on average than did youth in the hospitalization group. This difference may have affected the study results.

Additional studies that are focused on suicidal ideation, self-harm, and suicide attempt outcomes could strengthen the body of evidence for use of MST-Psych in treating suicidal thoughts and behaviors.

A second promising program is Safe Alternatives for Teens and Youth (SAFETY). SAFETY is a 12-week family-oriented treatment designed to build skills, increase safety, and reduce risk of suicide attempts. This cognitive-behavioral program is informed by DBT and grounded in social-ecological theory. It enhances protective factors and reduces risk factors within individual youth, family, and other social systems. The program is designed for adolescents aged 11 to 18 and their families. SAFETY is a community-based treatment conducted in outpatient settings and/or the client's home. It provides treatment after a suicide attempt or recent, repeated clinically significant self-harm, and is often used for youth with recent emergency, hospital, or crisis visits for suicide attempts and/or self-harm.

Elements of SAFETY include:

- * Youth work with one therapist while parents simultaneously work with a different therapist
- * Youth and family come together to practice skills identified as important to prevent repeat suicide attempts
- * When the family is not available or involvement of the young person's parents is not feasible or otherwise inadvisable, the therapist may include other protective adults in treatment.

The 12-week SAFETY program builds upon an emergency intervention called SAFETY-Acute (SAFETY-A), initially described in the literature as Family Intervention for Suicide Prevention (FISP). When delivered with community treatment as usual, SAFETY-A/FISP has demonstrated benefits for improving continuity of care after an emergency department (ED) visit for suicidal ideation and behavior, with some data supporting benefits on suicidal ideation at discharge from the ED.

SAFETY-A is included as the first session in the full SAFETY program and emphasizes a developmentally nuanced, trauma-informed, family-centered, and strengths-based approach to safety planning. Upon conclusion of the SAFETY

program, the therapist links youth and families to follow-up services and resources to encourage ongoing care.

Studies have demonstrated that use of SAFETY for youth with suicidal thoughts and behaviors was associated with reductions in suicidal ideation, self-harm (non-suicidal), and suicide attempts. In the studies reviewed, participants were primarily female and represented diverse subgroups across racial, ethnic, socioeconomic, and sexual orientation categories.

One of the studies demonstrated significant reductions in depression and hopelessness for youth and significant reductions in depression for parents involved in the intervention. An additional RCT on this program showed measurable reductions in suicide outcomes. The inclusion of more gender diverse youth would improve SAFETY's evidence base.

A third program that shows promise in reducing suicidal thoughts and behaviors among youth is Integrated Cognitive Behavioral Therapy (I-CBT). I-CBT uses cognitive, behavioral and affect regulation training to address suicidal behaviors and co-occurring substance use disorders among adolescents, as well as common comorbid conditions (e.g., depression, conduct problems) that may interfere with treatment progress. The intervention extends 12 months and consists of three treatment phases involving individual, family, and parent training sessions.

A key component of I-CBT for suicide treatment is that it targets common thought processes and behaviors that underlie substance use disorders, suicidal thoughts/behaviors, and comorbid mental health conditions. I-CBT provides a framework for teaching youth the skills needed to develop self-efficacy to manage their emotions, challenge negative thoughts, solve problems, and communicate effectively. Parents play a significant role in treatment. They learn skills to aid in their adolescent's recovery and promote supportive family relationships, such as problem-solving, communication, emotional regulation, and monitoring. I-CBT has been further adapted by its creators to a program called Family-focused Cognitive Behavioral Therapy (F-CBT) based on clinical impressions during the I-CBT study and emerging research. Additional session focus areas were added to accommodate a more heterogeneous sample of youth experiencing suicidal thoughts or behaviors. Parental involvement and support were expanded by adding parental "self-care" sessions and an emotional coaching session to improve parent-child interactions.

Preliminary research found that I-CBT for youth with suicidal thoughts and behaviors was associated with reductions in suicide attempts. The program also demonstrated reductions in the frequency of marijuana use and heavy drinking days, as well as in the number of inpatient hospitalizations, ED visits, and arrests.

To improve the field's understanding of I-CBT's effectiveness, additional studies should be conducted to:

- * Observe the treatment in a variety of settings • Include more racially, ethnically, and gender diverse youth
- * Establish stronger findings across multiple suicide outcomes (i.e., suicidal ideation, self-harm, and suicide attempts)

A fourth promising program is Youth Nominated Support Team Intervention for Suicidal Adolescents- Version II (YST-II). YST-II is a psychoeducational social support program designed for adolescents hospitalized in a psychiatric unit who have recently reported a suicide attempt or serious suicidal ideation. As a key component to suicide prevention, the intervention supplements routine treatment by strengthening existing adolescents' support networks through increasing support from caring adults. Adolescents nominate several adults (typically three to four per adolescent from family, school, and/or community settings) to serve as their support persons after hospitalization. These adults attend psychoeducational sessions to learn about:

- * The adolescent's psychiatric disorder(s) and psychosocial difficulties
- * The adolescent's treatment plan and rationale for recommended treatments
- * Risk factors for suicidal behavior and warning signs of possible acute risk
- * Strategies for communicating with adolescents
- * Availability of emergency services (e.g., crisis lines, EDs)

The adults receive weekly, supportive telephone calls from YST-II staff for 3 months. The adults are encouraged to have weekly contact with the adolescents for at least 3 months following hospital discharge. In their regular contacts with adolescents, the youth-nominated caring adults:

- * Support the young person's involvement in healthy activities
- * Inquire about and listen to the adolescent's concerns to engage in collaborative problem-solving
- * Support treatment adherence and express hopefulness about the possibility of positive change

Preliminary research demonstrated YST-II was associated with reductions in suicidal ideation. Most participants were White, and three quarters were female. Approximately 20 percent had a co-occurring alcohol or substance use disorder. YST-II resulted in more rapid decreases in suicidal ideation for youth with multiple suicide attempts during the initial 6 weeks after hospitalization. For those without multiple attempts, it was also associated with greater declines in functional impairment at 3 and 12 months. Youth who received YST-II attended more outpatient therapy and medication follow-up sessions and were more likely to participate in outpatient drug or alcohol treatment in the 12 months following their initial hospitalization.

A secondary analysis conducted more than a decade later found YST-II was associated with a reduction in mortality across all causes of death and a reduction in self-injury mortality due to either suicide or drug-related deaths with unknown intent.³⁹ Additional studies with stronger findings across multiple suicide outcomes (i.e., suicidal ideation, self-harm, and suicide attempts) and the inclusion of more racially, ethnically, and gender diverse youth would strengthen the field's understanding of YST-II's effectiveness.

The four programs described in this section have shown some positive outcomes in reducing suicidal thoughts and behaviors. In addition, each program highlights key elements to consider for the treatment system in addressing suicide. However, more research is needed to conclude that the programs are effective treatments for suicidal ideation, self-harm, and suicide attempts among youth.

7.0 Additional Training

Nationally Disseminated Information and Trainings on Suicide Prevention Models and Suicide Assessment and Management for Mental Health Professionals:

1. **Zero Suicide.** The Zero Suicide initiative is a commitment to suicide prevention in health and behavioral health care systems as well as a specific set of tools and strategies. It is both a concept and a practice. The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. It is a key concept of the National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention (Action Alliance), a project of Education Development Center's Suicide Prevention Resource Center (SPRC), and

supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). For more information on the initiative go to: <http://zerosuicide.sprc.org>. For information on training options go to: <http://zerosuicide.sprc.org/resources/suicide-care-training-options> (Offered by SPRC.)

2. **Applied Suicide Intervention Skills Training (ASIST).** A workshop designed for caregivers of individuals at risk of suicide. Training dates and locations are provided on the website. Also online are a text and audiovisual overview of the workshop, research and evaluations on the program, and suicide awareness facts. For more information go to: <http://www.livingworks.net/programs/asist> (Offered by LivingWorks.)
3. **Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals.** A one day workshop for mental health professionals and employee assistance professionals that focuses on competencies that are core to assessing and managing suicide risk. For more information go to <http://www.sprc.org/training-events/amsr> or contact the AMSR staff at amsr@edc.org. (Offered by SPRC.)
4. **Collaborative Assessment and Management of Suicidality (CAMS).** CAMS is a therapeutic framework for suicide-specific assessment and treatment of a patient's suicidal risk. It is a flexible approach that can be used across theoretical orientations and disciplines for a wide range of suicidal patients across treatment settings and different treatment modalities. Online training, practical role-play training, presentations, and consultation services are available. For more information go to: <https://cams-care.com>. (Offered by CAMScore.)
5. **QPRT: Suicide Risk Assessment and Management Training.** (QPRT stands for Question/Persuade/Refer/ Treat.) A 10-hour course available either online or face-to-face for professionals who may evaluate, assist, counsel or treat potentially suicidal persons - a tool that is uniquely designed to gather critical information about a person's status at intake and to establish a safety and intervention plan. For more information to go <http://www.qprinstitute.com> (Offered by QPR Institute.)
6. **Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians.** A two-day advanced interactive training augmented by pre-workshop, web-based assessment and post workshop mentoring. For more information go to www.suicidology.org/training-accreditation/rrsr or contact Paul at the American Association of Suicidology, prothenberg@suicidology.org. (Offered by American Association of Suicidology.)

7. **SafeTALK.** SafeTALK is a half-day training program that teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention. SafeTALK stresses safety while challenging taboos that inhibit open talk about suicide. For more information go to: <http://www.livingworks.net/programs/safetalk/> (Offered by LivingWorks.)

8.0 Resources

1. American Association of Suicidology www.suicidology.org
2. American Foundation for Suicide Prevention <https://afsp.org>
3. Commission on Accreditation of Rehabilitation Facilities: Quality Practice Notice on Suicide Prevention www.carf.org/QPN_SuicidePrevention_Sept2016
4. Sentinel Event Alert: Detecting and Treating Suicide Ideation in All Settings (The Joint Commission) www.jointcommission.org/sea_issue_56
5. Suicide Prevention and the Clinical Workforce: Guidelines for Training (National Action Alliance for Suicide Prevention) <http://actionallianceforsuicideprevention.org/resources/suicide-prevention-and-clinical-workforce-guidelines-training>
6. Centers for Disease Control and Prevention (CDC) <https://www.cdc.gov/injury/>
7. Bureau of Health Workforce <https://bhw.hrsa.gov/>
8. National Alliance on Mental Illness (NAMI) <http://www.nami.org>
9. National Rural Health Association (NRHA) <http://www.ruralhealthweb.org>
10. National Institutes of Health (NIH), National Institute on Mental Health (NIMH) <http://www.nimh.nih.gov/>
11. National Rural Recruitment and Retention Network <http://www.3rnet.org>
12. National Suicide Prevention Lifeline: 1-800-273-TALK (8255) <http://www.suicidepreventionlifeline.org/>
13. Rural Health Information Hub (RHIH) <https://www.ruralhealthinfo.org/>
14. Substance Abuse and Mental Health Services Administration (SAMHSA) <http://www.samhsa.gov/>
15. Suicide Prevention Resource Center (SPRC) <http://www.sprc.org>

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