Suicide Assessment and Crisis Intervention in Children and Adolescents

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Objectives

• List vulnerability factors for risk of suicide using the Columbia Suicide Severity Rating Scale

• Recognize when a safety plan is indicated and how to help patient construct safety plan

• Incorporate knowledge of suicide screening and safety planning into care in behavioral health and medical settings
Questions

1. The following are warning signs of potential suicide except:
   a. Delusions or hallucinations
   b. Past suicide attempt
   c. Recent loss
   d. Loss of appetite

2. True or false:
The term “suicide gesture” is recommended because it confounds lethality with intent

3. The following statements are true:
   a) Any or all suicidal statements or behaviors, regardless of how extreme, must be taken very seriously
   b) Never use the term “successful suicide”
   c) The Columbia Suicide Severity Rating Scale must be conducted by those with mental health background
   d) a & b
Agenda

• Terminology Related to Suicide
• Epidemiology of Suicide in Children and Adolescents
• Assessment and Columbia Suicide Severity Rating Scale
• Safety Plan
• How to Incorporate into Health Care Setting
Terminology Related to Suicide

- **Suicide** means killing oneself.
  - The act constitutes a person willingly, perhaps ambivalently, taking his or her own life.
  - Several forms of suicidal behavior fall within the self-destructive spectrum.

- **Completed suicide** means the person has died.
  - NEVER use term successful suicide
  - GOAL to prevent suicide and provide treatment.

- **Suicide attempt** involves a serious act
  - Taking fatal dose of medication, shooting self
  - Someone intervening accidentally.
  - Without the accidental discovery, the individual would be dead.
Terminology Related to Suicide

- **Suicide gesture** denotes a person undertaking an unusual, but not fatal, behavior as a cry for help or to get attention.
- **Suicide gamble** is one in which patients gamble their lives that they will be found in time and that the discoverer will save them.
  - For example, an individual ingests a fatal amount of drugs with the belief that family members will be home before death occurs.
- **Suicide equivalent** involves a situation in which the person does not attempt suicide. Instead, he or she uses behavior to get some of the reactions that suicide would have caused.
  - For example, an adolescent boy runs away from home, wanting to see how his parents respond. (Do they care? Are they sorry for the way that they have been treating him?)
  - The action can be seen as an indirect cry for help.
Terminology Related to Suicide

- **Suicidality**
  - All suicide-related behaviors and thoughts

- **Suicidal Ideation**
  - Can be on continuum from passive to nonspecific ideation (e.g., “I wish I had never been born”) to active specific ideation with intent and/or plan.

- **Nonsuicidal self-injurious behavior (NSIB)**
  - Any self-inflicted destructive act
  - Performed without intent to die
  - Full intent of inflicting physical harm to oneself (viewed as distinct from suicidal behavior)
  - The term “suicide gesture” is **NOT recommended** by the National Institute of Mental Health task force, nor is it included among the operational definitions because it confounds lethality with intent

- **Parasuicidal Behavior**
  - Suicidal gestures or self-harming behaviors in the context of suicidal ideation
  - For the purpose of alerting others to their emotional pain
  - Not typically behaviors which could have led to completed suicide.
## U.S.A. Suicide: 2011 Official Final Data

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Per Day</th>
<th>Rate</th>
<th>% of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nation</td>
<td>39,518</td>
<td>108.3</td>
<td>12.7</td>
<td>1.6</td>
</tr>
<tr>
<td>Males</td>
<td>31,003</td>
<td>84.9</td>
<td>20.2</td>
<td>2.5</td>
</tr>
<tr>
<td>Females</td>
<td>8,515</td>
<td>23.3</td>
<td>5.4</td>
<td>0.7</td>
</tr>
<tr>
<td>Whites</td>
<td>35,775</td>
<td>98.0</td>
<td>14.5</td>
<td>1.7</td>
</tr>
<tr>
<td>Nonwhites</td>
<td>3,743</td>
<td>10.3</td>
<td>5.8</td>
<td>1.0</td>
</tr>
<tr>
<td>Blacks</td>
<td>2,241</td>
<td>6.1</td>
<td>5.3</td>
<td>0.8</td>
</tr>
<tr>
<td>Elderly (65+ yrs.)</td>
<td>6,321</td>
<td>17.3</td>
<td>15.3</td>
<td>0.3</td>
</tr>
<tr>
<td>Young (15-24 yrs.)</td>
<td>4,822</td>
<td>13.2</td>
<td>11.0</td>
<td>16.3</td>
</tr>
<tr>
<td>Middle Aged (45-64 yrs.)</td>
<td>15,379</td>
<td>42.1</td>
<td>18.6</td>
<td>3.0</td>
</tr>
</tbody>
</table>

Epidemiology of Suicide in Children and Adolescents

- **10th** leading cause of death in the United States
- **3rd** leading cause of death for children, adolescents, and young adults
- Western states have highest suicide rates, with the exception of Vermont.
- Rural areas carries a higher risk of suicide than living in urban areas

Epidemiology of Suicide in Children and Adolescents

- 15 to 25% of adolescents **endorse some degree** of suicidal ideation
  - 2-6% specific and **active ideation**
- **3rd leading cause** of death among youth and young adults
  - 13% of mortality in this age group in 2005
- The **suicide rate in this age group increased** by 8% from 2003 to 2004 (the largest single-year increase since 1990)
  - Rate **decreased** in last 10 years
Epidemiology of suicide in children and adolescents

Rates of attempted and completed suicide increase dramatically with age throughout childhood into adolescence due to:

* Elevated risk for psychopathology incurred during adolescence
* Increased capacity to prepare and execute a suicide plan with cognitive maturity
* Decreased supervision with age

Prepubertal children do endorse suicidal ideation but:

* Cognitive immaturity appears to limit ability to plan and execute lethal suicide attempts

Preschool children:

* Suicidal behavior is rare
* When present in this age group, physical and/or sexual abuse is common
EPIDEMIOLOGY of Suicide in Children and Adolescents

• **Females** 10% vs 4% more likely to attempt suicide and have *specific ideation*

• **Males** 6:1 more likely to complete suicide
  • use *more lethal* means such as hanging or firearms
  • substance use and antisocial behaviors

• **Adoptees** 4 x more likely to attempt suicide than those not adopted *(Keyes, Malone, Sharma, Iacono, McGue, 2013)*

• **Children with parent who has attempted suicide** almost 5x risk of attempting suicide *(Brent, et al. 2015)*
Ethnicity and Suicide in Children and Adolescents

- Suicide is prevalent in all ethnic groups
- Higher among non white
- American Indian highest rate
- Completed suicide in young African American males growing
- Hispanic higher rates and attempts
- Little known about Asian American youth who do not disclose suicidal ideation and underutilize mental health services
- LOWER SES except for African American males as completed suicide associated with higher SES
Why do they suicide?
Precipitating Circumstances of Suicide Among Youth Aged 10–17 Years by Sex: Data From the National Violent Death Reporting system 16 States 2005-2008

Most Common

• Relationship problems
• Recent crises
• Mental health problems
• Intimate partner violence
• School problems 25% of decedents
  30.3% drop in grades
  12.4% bullying related
• Died in a house or an apartment (82.5%).
Most Common Co-Morbid Psychiatric Disorders in children and adolescents who attempt suicide

- Mood (61-76%)
- Substance Abuse (27-62%)
- Conduct/Disruptive Behavior
- Borderline or Antisocial Personality
- Post Traumatic Stress (PTSD)
- Chronic Medical Illnesses

- 90% of individuals who commit suicide have untreated mental illness---60% depression
- 50-75% of children with depression go undiagnosed and untreated
- < 20% of adolescent suicides receive any consistent treatment prior to their death.
Populations Most vulnerable to suicide

Higher risk for suicide or suicide attempts than the general population:

• American Indians and Alaska Natives
• People bereaved by suicide
• People in justice and child welfare settings
• People who intentionally hurt themselves (non-suicidal self-injury)
• People who have previously attempted suicide
• People with medical conditions
• People with mental and/or substance use disorders
• People who are lesbian, gay, bisexual, or transgender
• Members of the military and veterans
• Men in midlife and older men
Take home message

• Any or all suicidal statements or behaviors, regardless of how extreme, must be taken very seriously!
• **ALL** of our patients need to be screened for suicidality, even if we do not expect it in the least
How to Identify

Suicidal Children and Adolescents
Why Assess Suicide Risk?

- **Increases** awareness
- **Provides a** common language about suicide
- **Provides** guidance for developing an action plan
- **Helps to ensure that all staff are following a standardized, evidence based protocol to identify individuals at risk of suicide**
Why Assess Suicide Risk?

- Evidence exists that screening actually
  - **DECREASES** referrals to behavioral health
  - Provides behavioral health resources to those **who truly need them**, not to those who weren’t actually at high risk
  - May actually **save lives**
Alicia

• 15 yr AA/Hispanic female. Father in service for years. High achiever, straight A’s, attends parochial school. Likes to be ‘unique’ but inwardly low self esteem.

• Met older teen at driver’s ed in the summertime and began hanging out with him and his friends. Just prior to breakup began cutting on wrist. After breakup attempted suicide by overdose.
Assisting Potential Suicidal Patients

✓ Be attentive
✓ Remain calm and do not appear threatened
✓ Stress a partnership approach
✓ Discuss suicide in a calm, reasoned manner
✓ Listen to the patient
✓ Emphasize that suicide causes a great deal of pain to family members
Warning signs or signs of vulnerability to suicide

- History of Impulsive Aggression
- Prior Suicide Attempts
- Hopelessness/Helplessness
- No Future Orientation
- Exposure to Recent Suicide
- Psychiatric Disorders

- Comorbid psychiatric disorders (e.g., disruptive disorders, substance abuse)
- Availability of lethal, agents (e.g., firearms), exposure to negative events (e.g., physical or sexual abuse, violence)
- Family history of suicidal behavior
Suicide Assessment: Warning Signs

✓ Pacing
✓ Agitated behavior
✓ Frequent mood changes
✓ Chronic episodes of sleeplessness
✓ Actions or threats of assault, physical harm or violence
✓ Delusions or hallucinations
✓ Past suicide attempt
✓ Recent loss

✓ Threats or talk of death (e.g., "I don't care anymore," or "You won't have to worry about me much longer.")
✓ Putting affairs in order, such as giving possessions away
✓ Unusually risky behavior (e.g., unsafe driving, abuse of alcohol or other drugs)
Columbia Suicide Severity Rating Scale (CSSRS)

A semi-structured interview used to assess suicide risk

The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes.

Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.
Center for Suicide Risk Assessment

Video
Why use the Columbia suicide severity rating scale? (CSSRS)

- Don’t need mental health training
- Comes in multiple formats
  - Screener version appropriate for First Responders, gatekeepers, peer counselors
  - Full version appropriate for behavioral health clinicians
  - Versions for children, intellectually disabled
- Available in 100+ languages
- Versions to assess lifetime/recent/since last visit
- Used for research, and clinically
- Flexible format, don’t need to ask all the questions if not necessary
- Integrate information given by collateral sources family, caregivers
Versions of **Columbia Suicide Severity Rating Scale**

**The Lifetime/Recent version**

- Practitioners **gather lifetime history** of suicidality
  - any **recent suicidal ideation** and/or behavior.
- For behavior it is used to capture **all lifetime occurrences**, 
- For ideation (which is hard to average throughout a lifetime) the reference point used is **“the time the person felt most suicidal.”** which has been shown to be the **most predictive** of completed suicide in the future (Beck, A.T., et al., 1999).

**The Since Last Visit version**

- **Assesses suicidality since the patient’s last visit.**
- Meant to assess patients who have completed at least one Lifetime/Recent C-SSRS assessment.
- Asks about **any suicidal thoughts or behaviors** the patient/participant may have had since the **last time** you have administered the C-SSRS.
Versions of Columbia Suicide Severity Rating Scale

The Screener version

• Shortened form of the Full Version.
• 3-6 questions long.
• Commonly used for clinical triage by first responders, in ER settings and crisis call centers, for non-mental health users like teachers or clergy or in situations where frequent monitoring is required (e.g. inpatient shift monitoring, day programs).
• Includes all the information necessary to make a decision about next steps.
• 1-5 questions about the severity of suicidal ideation (thoughts of suicide).
• 1 question on the full range of suicidal behaviors that is collapsed from the Full Version.

The

• Provides a checklist for protective and risk factors for suicidality.
• Developed to better account for common risk and protective factors in assessing suicidal ideation and behavior clinically.
• Designed to include all suicide-relevant variables and risk and protective factors on one page to assist the clinician in weighing these factors for determining overall risk and treatment planning.
• Used in conjunction with the Full or Screener versions of the scale.
### INSTRUCTIONS

Ask questions 1 and 2 and if both are negative proceed to “suicidal behavior” section (next page),

If answer to question 2 is “yes”, ask questions 3, 4, and 5.

If answer to question 1 and/or 2 is “yes”, complete “intensity of Ideation” section below

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### IDEATION

**Pediatric/cognitively impaired**

#### Lifetime: Time He/She First Made Suicide Attempt

**Recent: Ideation**

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**Ask MINIMUM of 3 Questions**
SUICIDAL BEHAVIOR

(Should you apply, as long as there are separate event: must ask about all types)

<table>
<thead>
<tr>
<th>Actual Attempt</th>
<th>Lifetime</th>
<th>Past 3 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you ever do anything to try to kill yourself or make yourself not alive anymore?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Did you ever hurt yourself on purpose? Why did you do that?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Real attempt? (not an accidental, unplanned violation of a protective order)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Did you ever feel like you were going to or you did (even a little) when you were making your attempt?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Were you trying to make yourself not alive anymore when you did it?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Or did you think it was possible you could live and die?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

No

Actual Attempt

Interrupted Attempt

Aborted or Self-Interrupted Attempt

Preparatory Acts or Behavior

Potential Lethality: Only Answer if Actual Lethality 0

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**Potential Lethality: Only Answer if Actual Lethality 0**

**Lethality:** Likelihood of actual attempt on medical diagnosis (the following example above having an actual medical diagnosis, had potential for very serious lethality; put gun in magazine and pulled the trigger but gun fails to fire so no medical damage; laying on trays with 12-gauge gun but pulled away before round entered).
INSTRUCTIONS:
Ask questions 1 and 2 and if both are negative proceed to “Suicidal Behavior” section.

If the answer to question 2 is “yes” ask questions 3, 4, and 5.

If the answer to question 1 and/or 2 is “yes”, complete “intensity of Ideation” section below.

<table>
<thead>
<tr>
<th><strong>SUICIDAL IDEATION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask questions 1 and 2.</strong> If both are negative, proceed to “Suicidal Behavior” section. If the answer to question 2 is “yes”, ask questions 3, 4, and 5. If the answer to question 1 and/or 2 is “yes”, complete “Intensity of Ideation” section below.</td>
</tr>
</tbody>
</table>

1. **Wish to be Dead**
   - Subject either thought about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.
   - Have you thought about being dead or what it would be like to be dead?
   - Have you wished you were dead or wished you could go to sleep and never wake up?
   - Do you wish you weren’t alive anymore?
   - If yes, describe.

2. **Non-Specific Active Suicidal Thoughts**
   - General, non-specific thoughts of wanting to end one’s life (e.g., “I’ve thought about killing myself”) without thoughts of ways to kill oneself
   - Have you thought about doing something to make yourself not alive anymore?
   - Have you had any thoughts about killing yourself?
   - If yes, describe.

3. **Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act**
   - Subject endures thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan).
   - Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?
   - If yes, describe.

4. **Active Suicidal Ideation with Some Intent to Act, without Specific Plan**
   - Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to “I have the thoughts but I definitely will not do anything about them.”
   - When you thought about making yourself not alive anymore (killing yourself), did you think that this was something you might actually do?
   - This is different from (as opposed to having the thoughts but knowing you wouldn’t do anything about it)
   - If yes, describe.

5. **Active Suicidal Ideation with Specific Plan and Intent**
   - Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.
   - Have you decided how or when you would make yourself not alive anymore (kill yourself)? Have you planned it out (worked out the details off how you would do it)?
   - What was your plan?
   - When you made this plan (or worked out these details), was any part of you thinking about actually doing it?
   - If yes, describe.

<table>
<thead>
<tr>
<th><strong>INTENSITY OF IDEATION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 3 being the most severe).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Most Severe Ideation:</strong></th>
<th><strong>Type # (1-5)</strong></th>
<th><strong>Description of Ideation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many times have you had these thoughts?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Write response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Only once (2) A few times (3) A lot (4) All the time (5) Don’t know/Not applicable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If 1 and 2 are no, ideation section is done.

### Columbia Suicide Severity Rating Scale

**Screening Version**

Minimum of 3 Questions

#### Columbia Suicide Severity Rating Scale

**Screening Version - Recent**

<table>
<thead>
<tr>
<th>Question</th>
<th>Part 3 Months</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask questions that are bold and underlined</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ask Questions 1 and 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Wish to be Dead:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.</td>
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<tr>
<td>Have you wished you were dead or wished you could go to sleep and not wake up?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2) Suicidal Thoughts:</td>
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<tr>
<td>General non-specific thoughts of wanting to end one’s life/care by suicide, “I’ve thought about killing myself” without general thoughts of ways to kill oneself/associated methods, intent, or plan.</td>
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<tr>
<td>Have you actually had any thoughts of killing yourself?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):</td>
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<tr>
<td>Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it.”</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Have you been thinking about how you might kill yourself?</td>
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<td></td>
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<tr>
<td>4) Suicidal Intent (without Specific Plan):</td>
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</tr>
<tr>
<td>Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to “I have the thoughts but I definitely will not do anything about them.”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had these thoughts and had some intention of acting on them?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Suicide Intent with Specific Plan:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6) Suicide Behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you done anything, started to do anything, or prepared to do anything to end your life?</td>
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</tr>
<tr>
<td>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.</td>
<td></td>
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</tr>
</tbody>
</table>
When to Refer for further Psychiatric Evaluation or more restrictive treatment?

• Ideation: 4 or 5 in the past month
• Behaviors: any behavior in the past 3 months
• Score of 4 indicate some suicidal intent
• Risk doubles from 3 to 4
Reasons for Safety Planning

• Suicide risk fluctuates over time
• Problem solving capacity is lower during times of crisis so it helps to plan ahead
• Cognitive behavioral approaches reduce impulsive behaviors
• Learning to cope with suicidal crises without hospitalization helps increase a person’s self-efficacy and self confidence
• Safety planning helps to instill hope!
Who Is Appropriate for Safety Planning & What Does it Do?

• Patients at increased risk for suicide who do not require immediate hospitalization
• Fills the gap between hospital or ED discharge and follow-up
• Provides an alternative for those who don’t want or don’t receive outpatient care
Safety Plan *if suicidal and outpatient*

Are all of your ducks in a row?

- Get your **ducks** in a row LONG before client becomes suicidal!
- When initial assessment of child/adolescent, have baseline conversation about suicidality and how you and parent would keep child/adolescent safe.
- Collaborate with parent if good, reasonable protector
- If suicidal, depending on severity and intensity of ideation, and parents feel they can keep child/adolescent safe 24 hour monitoring, sleep with parent
- If parent does not feel they can keep child safe or the child will not cooperate at home, need for more restrictive setting (hospitalization)
- Speak with parent about removing potentially lethal weapons, poisons, ropes, knives from the home and document the conversation
How to Help Patient Construct Written SAFETY PLAN What is Included?

• This is an essential step in treating any patient in the community for whom suicide is or has been a concern
  • Lock up potentially hazardous materials
  • Increase family and peer supervision and support
  • Engage in treatment with easy access to providers
  • Emergency Plan: know when to call 911 or come to the emergency for an urgent evaluation
SAFETY PLAN What to include

Common questions that should be answered when creating a safety plan:

• What are common triggers for you?
• What is the first sign that you may be entering a crisis (thoughts, feelings, body sensations)?
• Which coping skills have been most useful in crisis?
• Who can you call when feeling upset (create a support network)?
• How do you know when things are getting out of control and you need help?
Safety Plan in Action

• Rehearse the safety plan
• Agreed upon location of safety plan
• Cues for patient to recall they have a safety plan
• Explore confidence of client that she or he will use the safety plan
• Discuss barriers to use, and ways to overcome these
Safety Plan in action

• Safety planning needs to be collaborative not coerced
• Needs to include items that have meaning to the individual and which she or he is likely to use
• When involving family/friends, the patient needs to have control over how/when they are told
• Safety plans change over time as people change/social support systems change
• Important to instill hope
SPECIAL ISSUES

• Copycat Suicides
  • Typically occur after a suicide
  • Peer to peer groups have been incredibly helpful

• Social Networking
  • New forum for bullying
  • Can be a trigger, but also can alert others to cries of help and even suicidal thoughts and attempts

• Ethnic, Socioeconomic, and Sexual Minorities
  • At risk for targeting by peers
Potential emergency

• Thought changes represent areas for major focus and concern.
  • Command hallucinations telling the patient to kill himself or herself. These are usually auditory in nature and often take the form of the deity's voice (e.g., "I hear God commanding me to kill myself, because I am bad").
  • Delusions - e.g., "The world and my family would be better off with me dead" or "If I take my life, I will be reunited in heaven with my mother."
• Obsession of a patient wanting to take his or her own life. Some patients focus their lives on their suicide.
TREATMENT

Treatment of Co-Morbid Psychiatric Conditions
  • Psychotherapies aimed at specific conditions
  • Medications aimed at symptom reduction (SSRI’s for depression)
  • Lithium has shown some benefit in adults for reducing persistent suicidality

Dialectical Behavior Therapy
  • The only therapy to date which has been shown to reduce suicidal and self harming behaviors in adolescents
How to incorporate suicide screening and safety planning into Primary care and behavioral health care settings

• **ZERO Suicide** is one program that advocates the screening of **every patient** that walks into the clinic.

• Provides **short and long term view** of client’s suicidal features

• **Quality assurance tool**

• **Buy in** by staff, clinicians and administration

• Must have **good referral list and appropriate resources**-emergency room/hospital

• Agency **emergency crisis plan** developed by staff, clinicians, administrators

• **Re-evaluate** effectiveness
Questions

1. The following are warning signs of potential suicide except:
   a. Delusions or hallucinations
   b. Past suicide attempt
   c. Recent loss
   d. Loss of appetite

2. True or false:
   d) a & b

3. The following statements are true:
   a) Any or all suicidal statements or behaviors, regardless of how extreme, must be taken very seriously
   b) Never use the term “successful suicide”
   c) The Columbia Suicide Severity Rating Scale must be conducted by those with mental health background
   d) a & b
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• Laura Rombach, LPCC, Jeanne Bereiter, MD, Shawn Sidhu, MD
Resources

- Suicide Prevention Resource Center - [http://www.sprc.org/](http://www.sprc.org/)
  - American Indian and Alaska Native Suicide Prevention Programs
  - Garrett Lee Smith State/Tribal Suicide Prevention Program
- Action Alliance for Suicide Prevention- [http://zerosuicide.actionallianceforsuicideprevention.org/](http://zerosuicide.actionallianceforsuicideprevention.org/)
- Suicide Prevention Life Line 1-800-273-TALK (8255)
- SAMHSA – Substance Abuse and Mental Health Services Administration
Resources


• Safety Plan template, manual and other resources: [www.suicidesafetyplan.com](http://www.suicidesafetyplan.com)