Suicide Prevention Best Practices
Warning Signs
Risk & Protective Factors

Chronological Assessment Suicide Events
(Case Approach)

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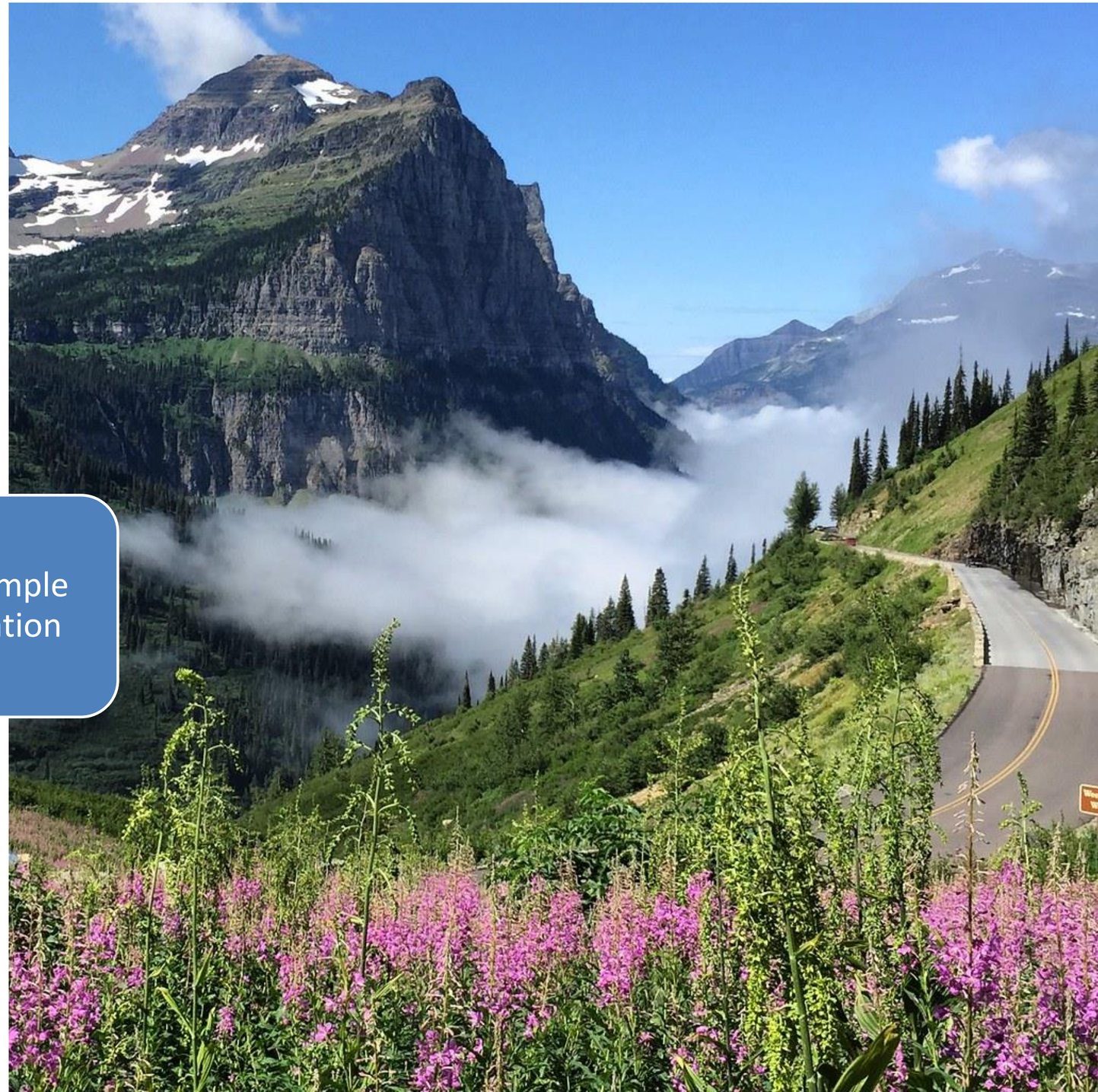
Suicide is a complex issue.

There is not one reason why someone dies by suicide.

Does not have a simple answer or explanation

Involves mental health, social factors, environmental factors

Only death that if NOT handled with best practices can put others who are vulnerable at risk



Best Practice Terms

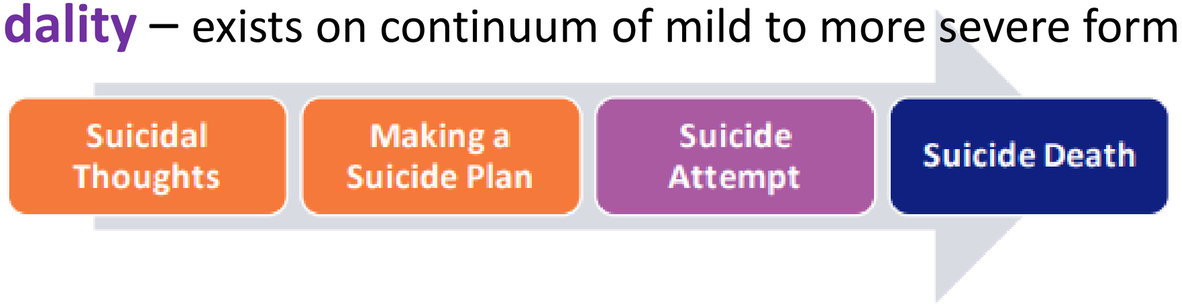
- **Suicidal Ideation** – the consideration or desire to end one's own life (passive to active)

- **Suicide Attempt** - action to deliberately end one's own life
  - instead of "failed or successful"

- **Died by Suicide** - instead of committed or completed suicide
  reduces stigma and shame, judgement

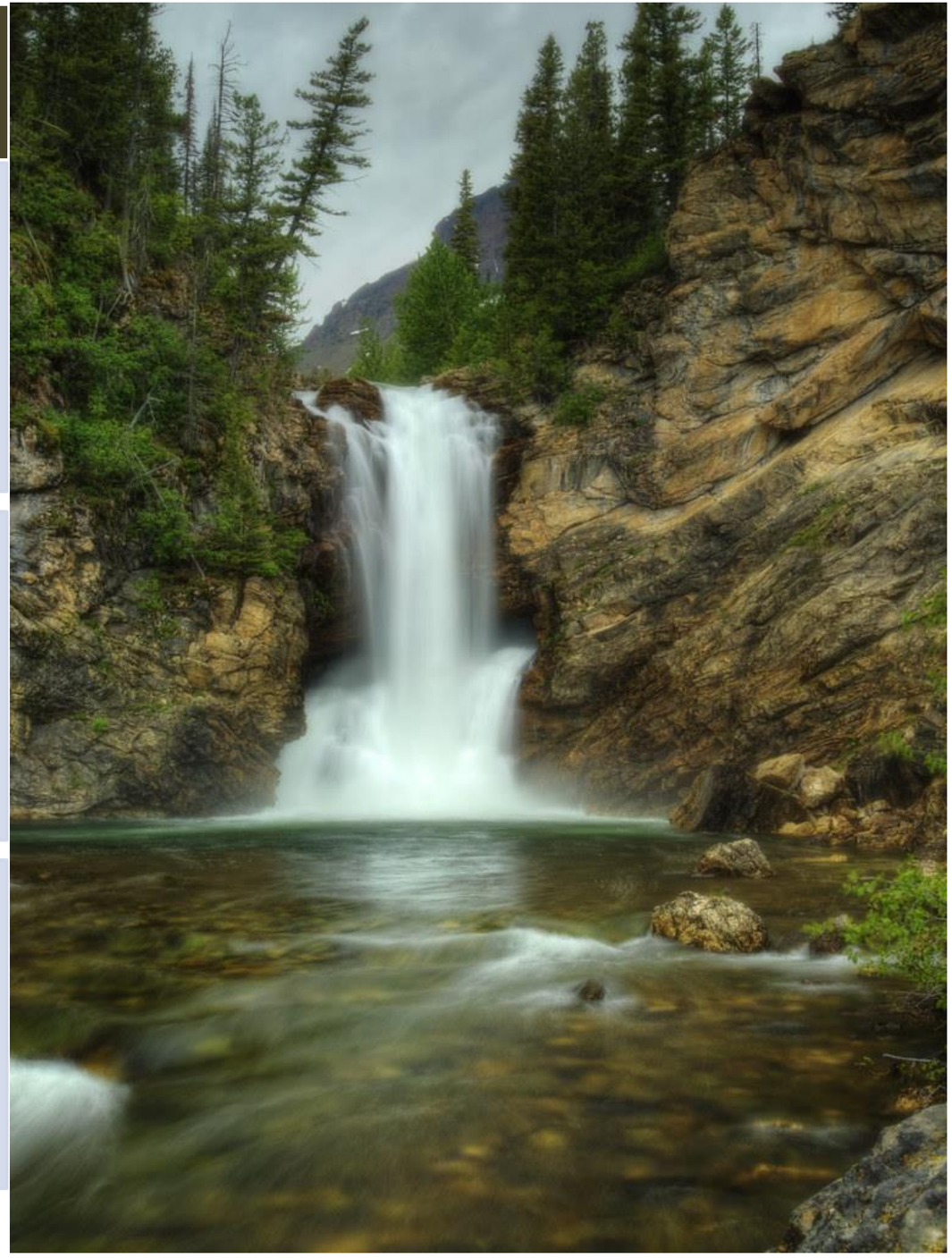
- **Survivor** – person who has experienced the death of a friend, family member or colleague by suicide

Suicidality – exists on continuum of mild to more severe forms with stages:



Best Practice Terms

Suicide Prevention	Programs/interventions to create awareness, knowledge, enhance protective factors to inhibit someone from dying by suicide
Suicide Postvention	Programs or interventions for those impacted by a death by suicide • Help with emotional distress, suffering • Prevent suicide contagion by following best practices (how we talk about, honor, not memorialize or sensationalize the death)
Suicide Contagion	Suicide Contagion – How a suicide or suicidal behavior of one or more persons influences others to die by or attempt suicide. “copycat deaths” Fellow student or famous actor



Examples

Suicide Prevention

Adult Trainings

- Media Training on Reporting Best Practices
- QPR (Question, Persuade, Refer)

Youth Trainings

Hult Center's Youth Mental Health Matters Program

K - 5th grades, 9th grade

Suicide Prevention – Seize the Awkward Campaign

"Upstream" suicide prevention (social-emotional learning)

HMHN – Healthy Minds Healthy Neighborhoods

resiliency, coping, emotional regulation, stress management

Suicide Postvention

Advise/Consult best practices schools, community, families

MYTH [illegible]

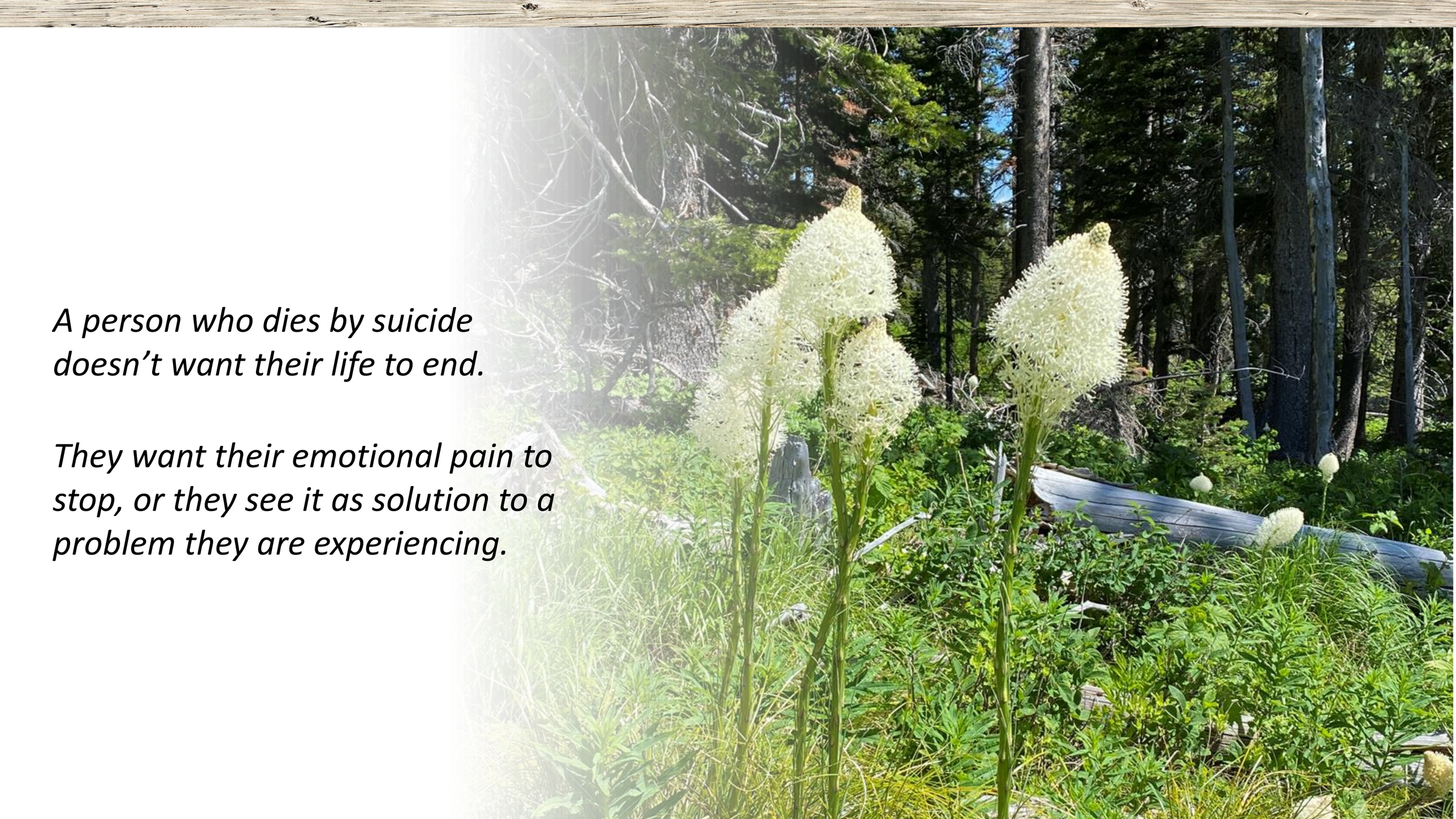
[illegible]

suicide.

FACT [illegible]

[illegible]

suicide attempt.



A person who dies by suicide doesn’t want their life to end.

They want their emotional pain to stop, or they see it as solution to a problem they are experiencing.

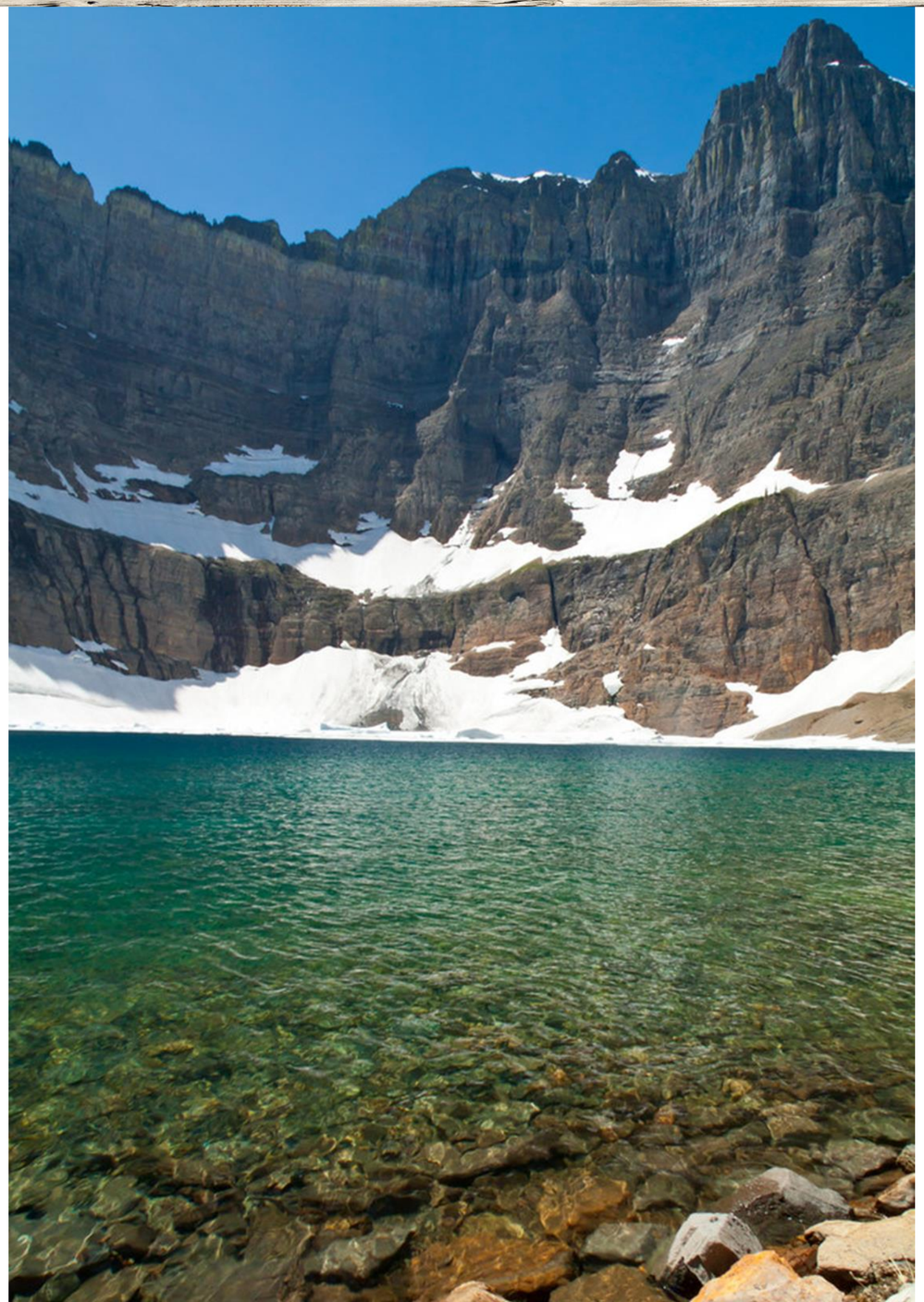
Circumstances that Increase Suicide Risk

Individual Risk Factors

Relationship Risk Factors

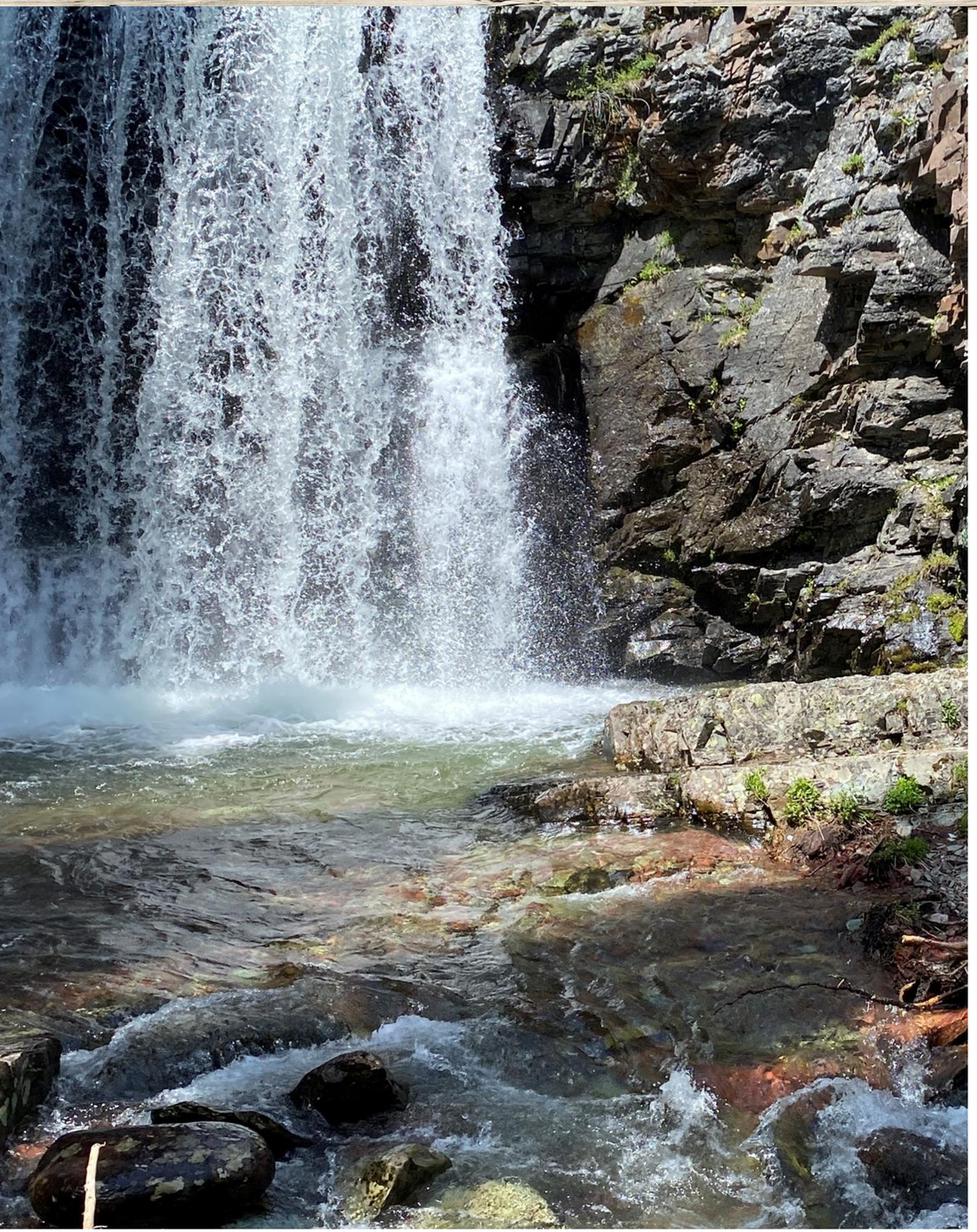
Community Risk Factors

Societal Risk Factors



Individual Risk Factors

These personal factors contribute to risk:	Previous suicide attempt
	History of depression or other mental illness
	Serious illness such as chronic pain or terminal illness
	Criminal/legal problems Fear of punishment
	Job/financial problems or loss
	Impulsive or aggressive tendencies
	Substance abuse
	Current or prior history of adverse childhood experiences
	Sense of hopelessness
	Violence victimization and/or perpetration



Relationship Risk Factors

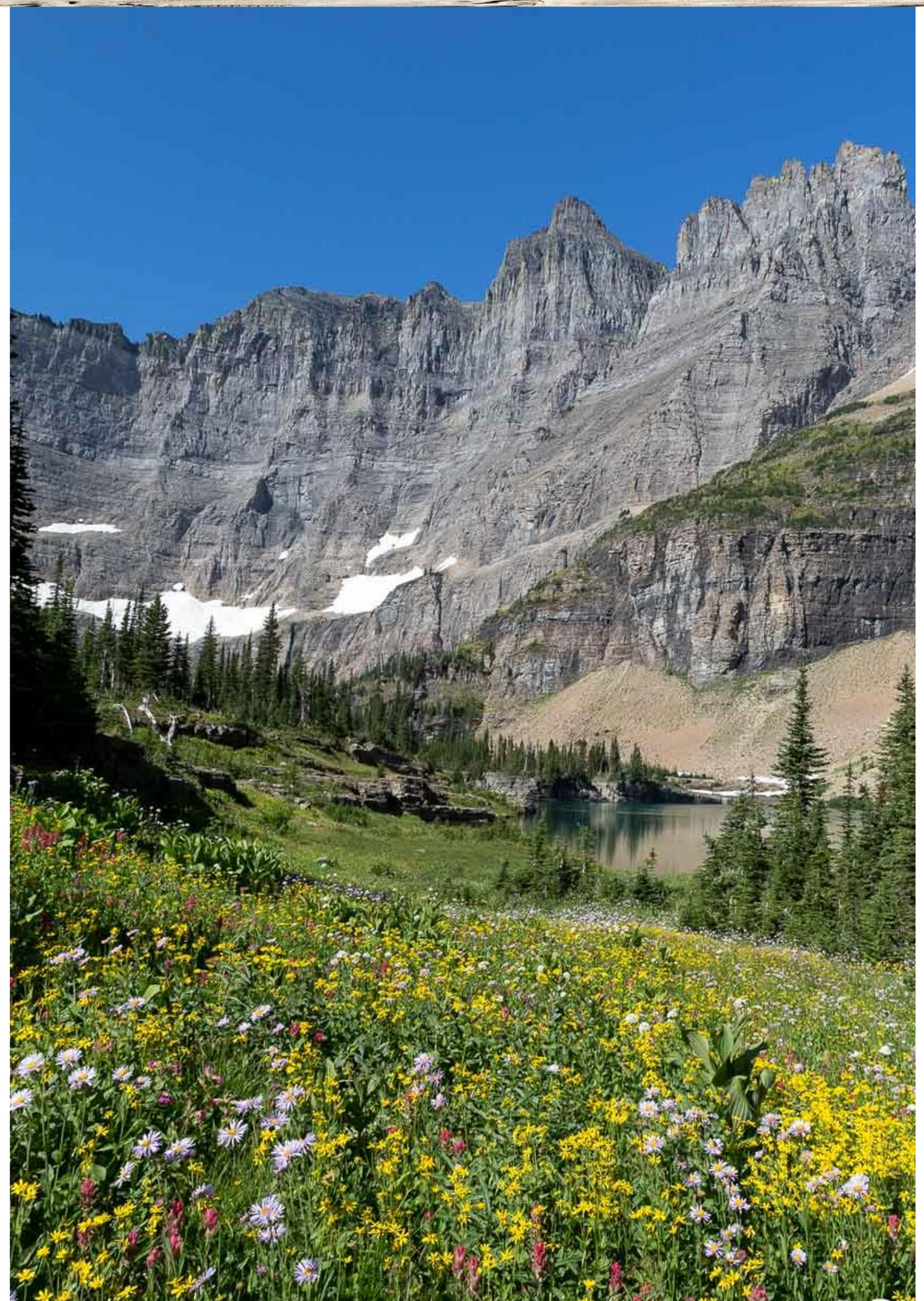
These harmful or hurtful experiences within relationships contribute to risk:

- Bullying
- High conflict or violent relationship
- Loss of Relationships
- Social Isolation
- Fear of becoming a burden
- Family or loved one’s history of suicide

Community Risk Factors

These challenging issues with a person's community contribute to risk:

- Lack of access to healthcare
- Suicide cluster in community
- Stress of acculturation
- Community violence
- Historical trauma
- Discrimination



Societal Risk Factors

These cultural and environmental factors within the larger society contribute to risk:

- Stigma associated with help-seeking and mental illness
- Easy access to lethal means of suicide among people at risk
- Unsafe media portrayals of suicide

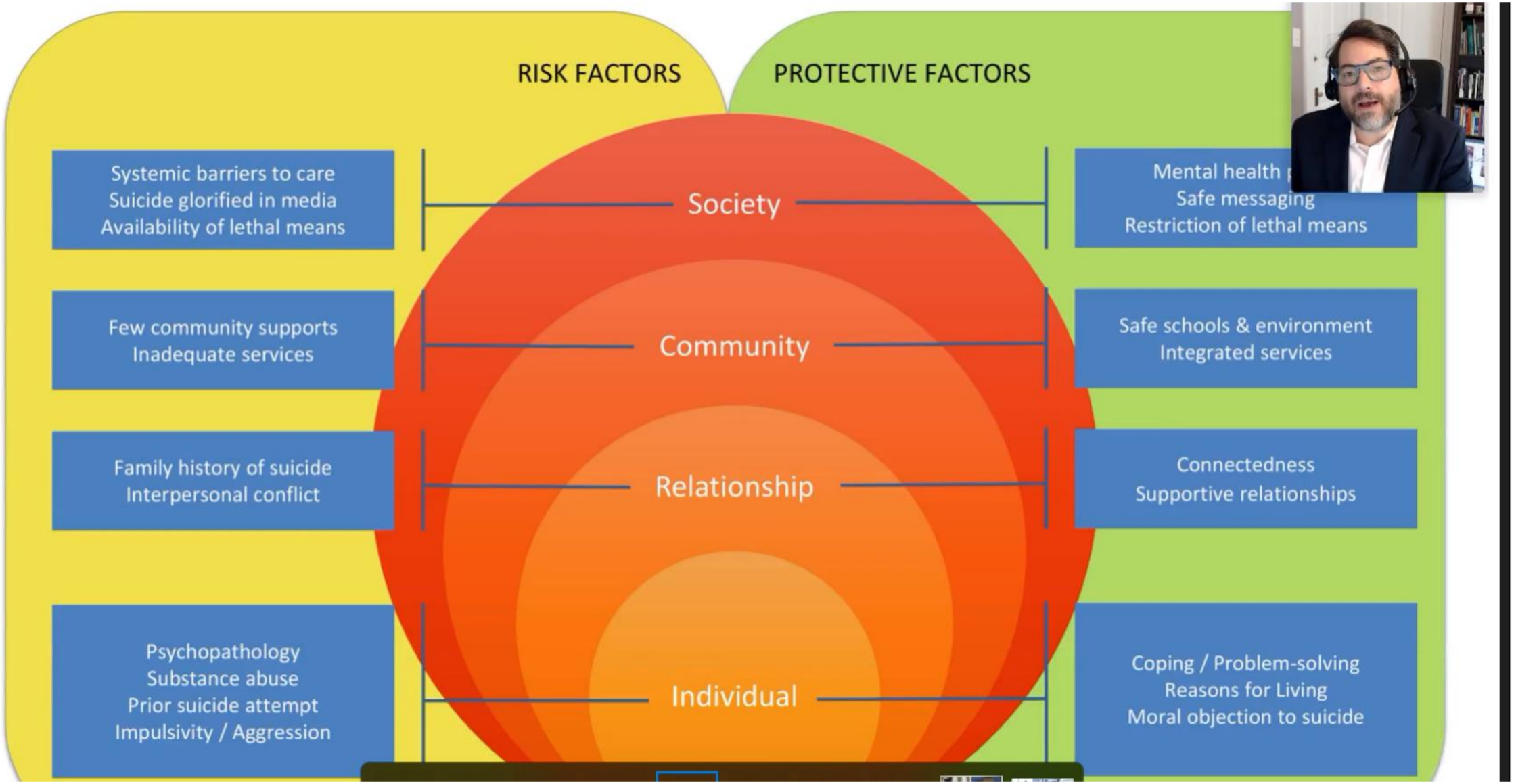
Assess for Protective Factors

Individual Factors

Relationship Factors

Community Factors

Societal Factors


RISK FACTORS
PROTECTIVE FACTORS
Systemic barriers to care
Suicide glorified in media
Availability of lethal means
Society
Mental health
Safe messaging
Restriction of lethal means
Few community supports
Inadequate services
Community
Safe schools & environment
Integrated services
Family history of suicide
Interpersonal conflict
Relationship
Connectedness
Supportive relationships
Psychopathology
Substance abuse
Prior suicide attempt
Impulsivity / Aggression
Individual
Coping / Problem-solving
Reasons for Living
Moral objection to suicide

Circumstances that Protect against Suicide Risk

Individual Protective Factors

These personal factors protect against suicide risk:

- Effective coping and problem-solving skills
- Reasons for living (family, friends, pets, etc.)
- Strong sense of cultural identity

Relationship Protective Factors

These healthy relationship experiences protect against suicide risk:

Support from:

- Partners
- Family
- Friends

Feeling connected to others

- Work Colleagues
- School Mates
- Church Members

Community Protective Factors

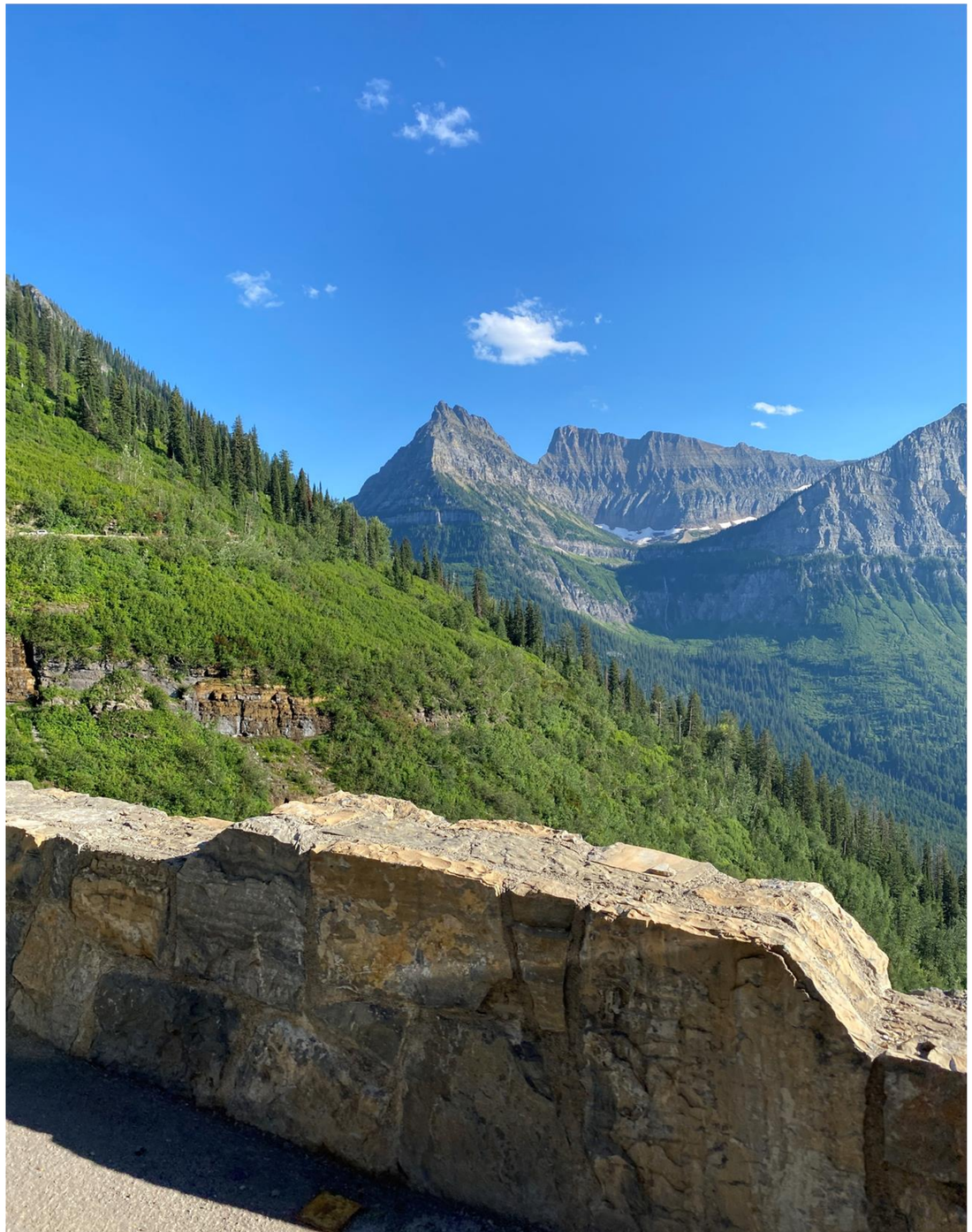
These supportive community experiences protect against suicide risk:

- Feeling connected to school, community, and other social institutions
- Availability of consistent and high quality physical and behavioral healthcare

Societal Protective Factors

These cultural and environmental factors within the larger society protect against suicide risk:

- Reduced access to lethal means of suicide among people at risk
- Cultural, religious, or moral objections to suicide



Sound Suicide Assessment Approach

3 Components

Gathering information related to risk & protective factors and warning signs of suicide

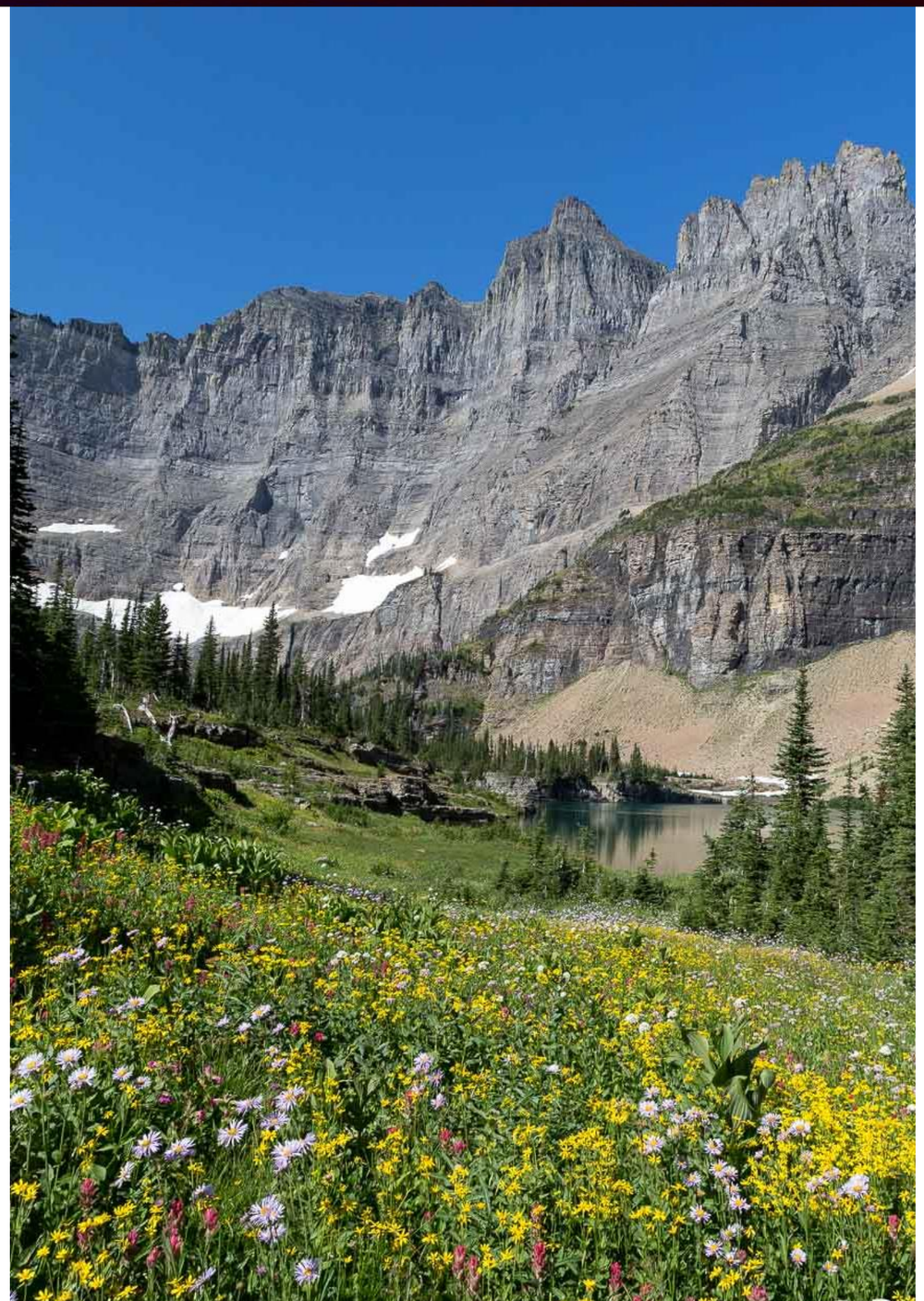
Collecting information related to suicidal ideation, planning, behaviors, desires and intent

Making a clinical formulation of risked based on these 2 databases

Chronological Assessment Suicide Events (CASE Approach)

- Flexible, practical, and easily learned
- Interviewing strategy eliciting:
  - Suicidal ideation
  - Planning
  - Behavior
  - Desire
  - Intent

- Not the *right or only* way to elicit S.I.
- Not a standard of care
- Way to help clinicians develop own methodology for interviewing



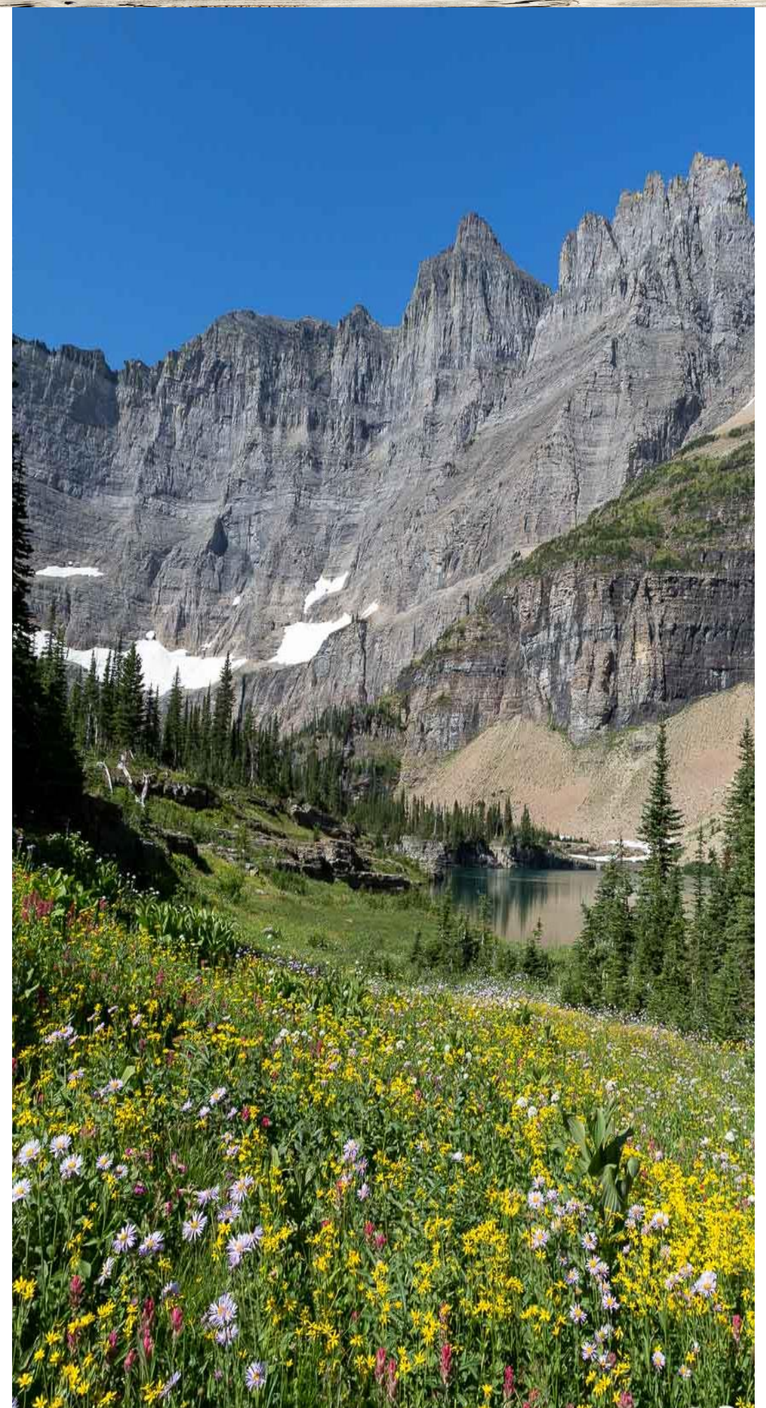
Normalization

(Validity Technique – Raising topic of suicide)

Unobtrusive method to raise to topic of suicide

Client asked to look at what other people have felt

Clinician relates they have had other clients with similar pains or stresses – share these clients experienced suicidal thoughts



Normalization Examples

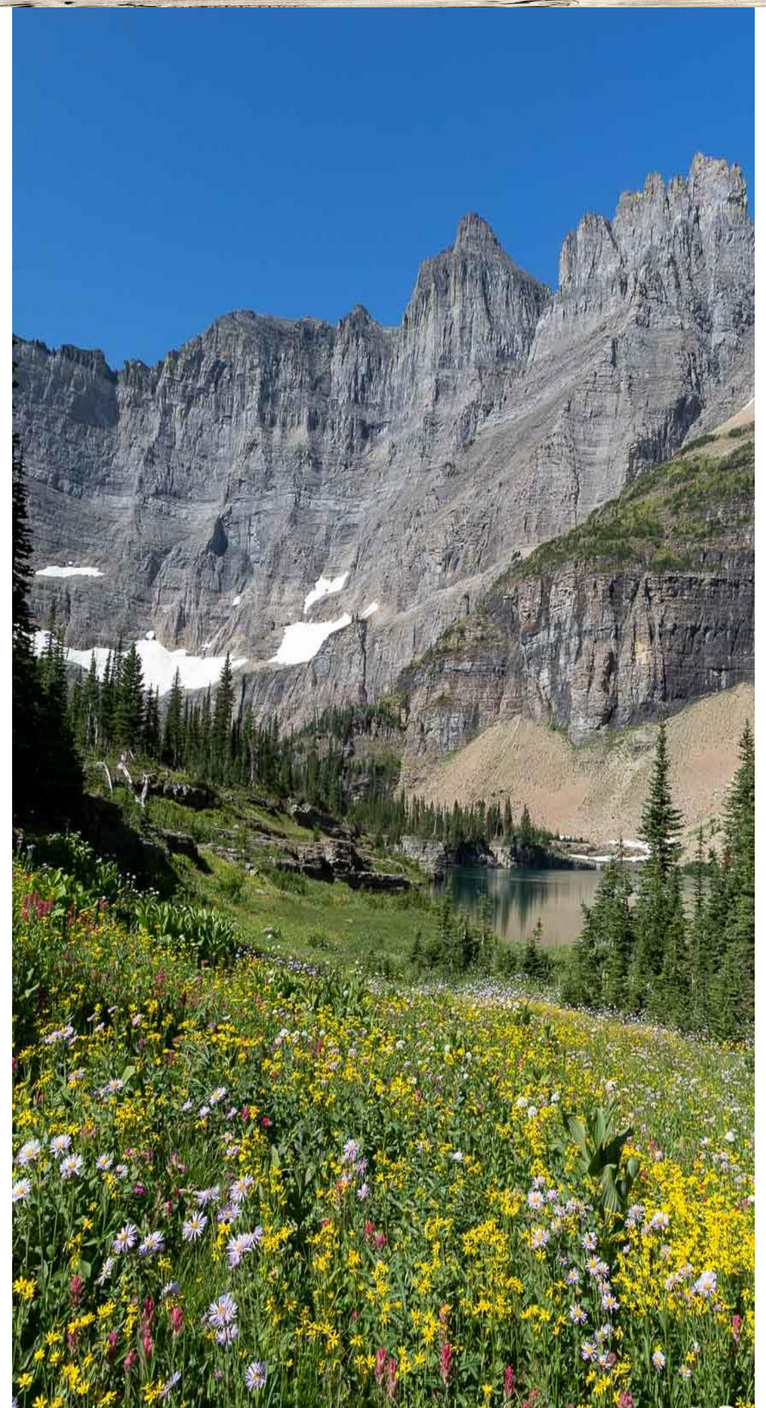
1. You know, Ben, some of my other teens, when they are feeling as stressed and depressed as you have been feeling, tell me that they sometimes gets thoughts of killing themselves. I'm wondering if you've been having any thoughts like that recently?

2. Sometimes when people feel as much pain as you are feeling, they have thoughts of killing themselves, has that happened to you?

3. Sometimes when teen feel the way you are feeling, they wish that they could just go to sleep and never wake up, has that happened to you?
4. Yes response:

5. Sometimes people feel like they just want to go to sleep and wake up on an island or someplace else where they feel better, and all their problems are gone.

6. Or… sometimes people want everything to end. Their heart to stop, their brain to stop.



Normalization Examples

1. Sometimes when people get really angry, they say things that they later regret, has this ever happened to you?

2. Sometime when teens are really worried about their weight, they will do things to make sure they don’t gain weight like force themselves to vomit after a meal, have you ever tried that?

3. Many of the teens that I work with have told me that when they are feeling really down, they find themselves crying, or at least feeling like crying, have you noticed anything like that?

4. Others often tell me that sometimes the pain of their depression is so great that they have thoughts of wanting to kill themselves, have you had any thoughts like that?

Shame Attenuation

Similar to Normalization

Client's own pain used as a gateway to topic of suicide

Considering all the pain you have been feeling the past couple of weeks, I'm wondering if you have had any thoughts of killing yourself?

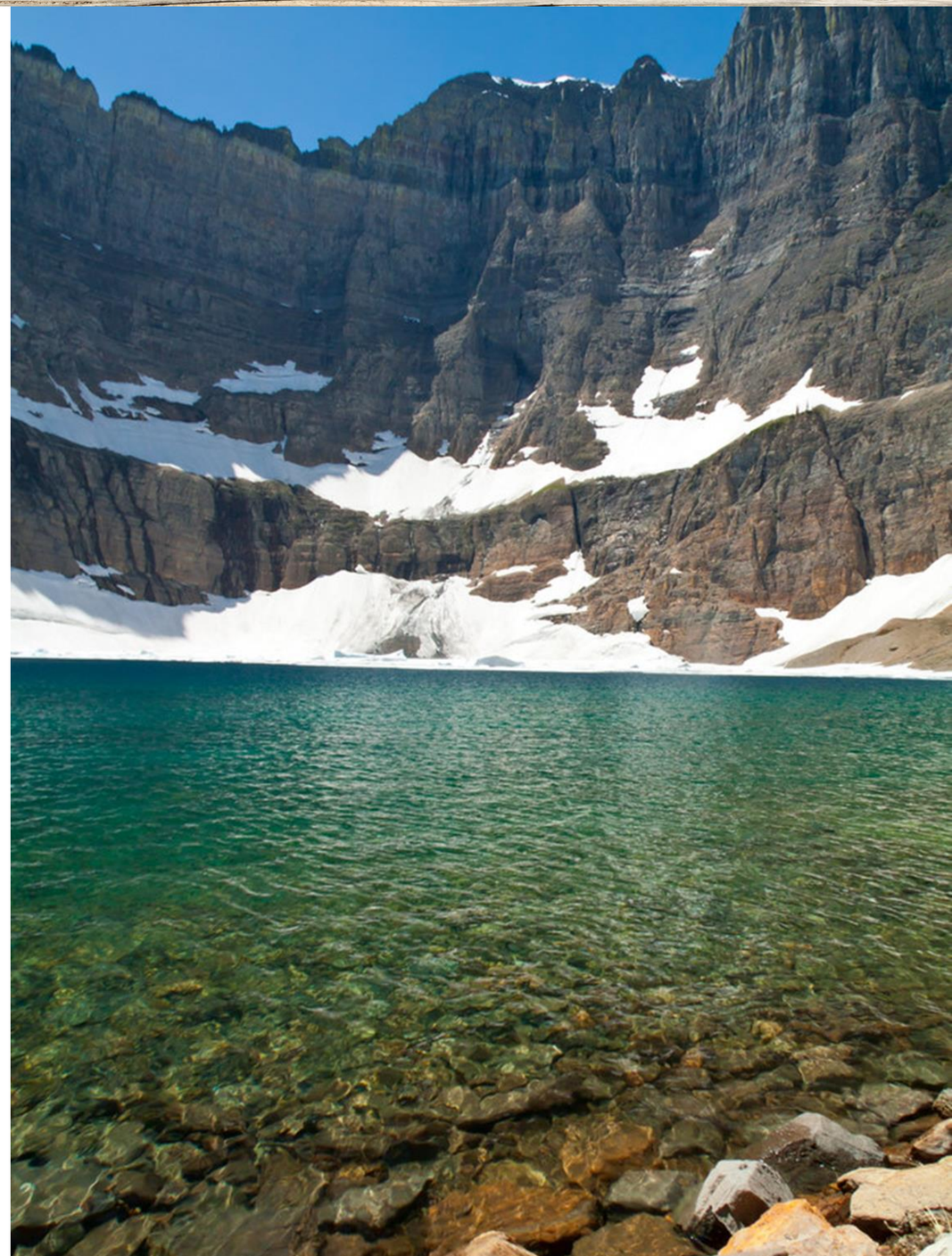
- Both techniques are effective & engaging
- Use whatever feels most comfortable to you

Those feel awkward about having S.I. may respond well to reassurance that others have these feelings.

If client DENIES:

- Ask a second time, soften inquiry,
- Ask for even subtle suicide ideation
- Helps hesitant clients

Have you had fleeting thoughts of suicide, even for a moment or two?



4 Cornerstone –Validity Techniques

Behavioral Incident

Gentle Assumption

Symptom Amplification

Denial of Specific

- Created for clinicians to increase getting a valid response with question that raise sensitive or taboo material such as:
  - Sexual abuse
  - Physical or psychological abuse
  - Alcohol and drug use
  - Violence
  - Antisocial behavior

Behavioral Incident

Clients may provide distorted information for many reasons:

- Anxiety
- Embarrassment
- Protecting Family Secrets
- Unconscious Defense Mechanisms
- Conscious Attempts at Deception

Distortions more likely when ask opinions rather than behavioral descriptions of events.

Behavioral Incident Questions

Asked for specific facts, behavioral details, or trains of thought (Fact Finding)

Can be asking what happened sequentially. (Sequencing Behavior Incidents)

How many pills did you take?

What did she say next?

What did your father do then?

Help client recreate, step by step, the unfolding of potentially taboo topic like suicide attempt

Behavioral Incident Questions

Originally created by Gerald Pasal. Great for uncovering hidden information.

Caution: Time consuming. Best to use with sensitive areas: drug abuse, domestic violence, suicide assessment

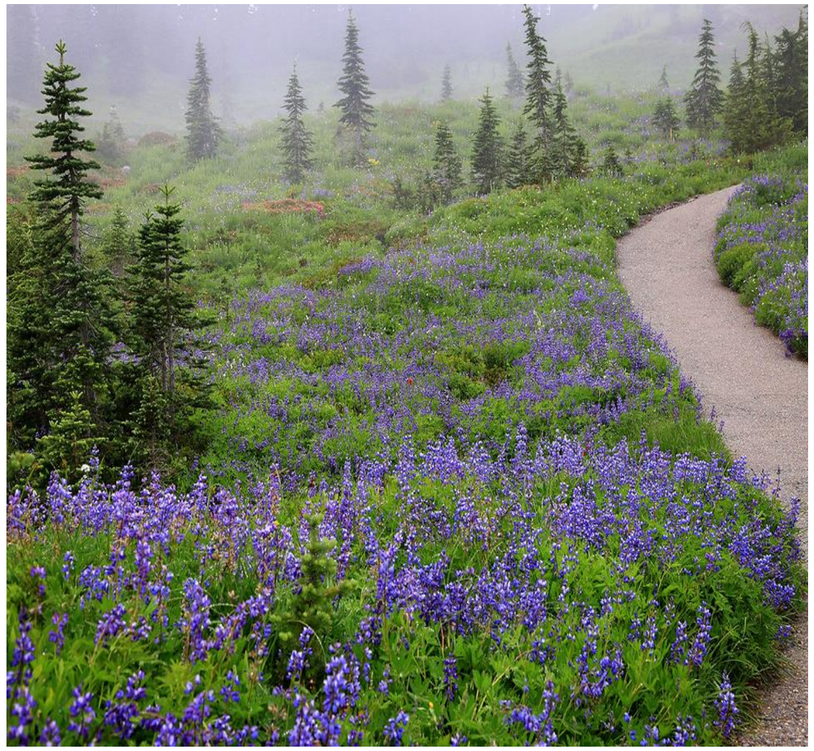
Did you put the razor blade up to your wrist?

Tell me what happened next?

What did your father say right after he hit you?

How many bottles of pills did you actually store up?

When you say you, “were going to show your friends” what did you actually do?



Gentle Assumption Questions

Originally created by Pomeroy & colleagues for eliciting valid sex history when client is hesitant to discuss taboo behavior.

Clinician assumes potentially embarrassing or incriminating behavior is occurring and frames question with gentle tone

What do you experience when you masturbate?
How frequently do you find yourself masturbating?

VS

Do you masturbate?

Clinician can also soften question and add “if at all?”

1. What other street drugs have you tried?
2. What other types of vandalism have you been involved in?
3. What kind of problems have you ever had at work?
4. What other ways have you thought of killing yourself?

Gentle Assumption Questions

Caution: Powerful examples of a leading questions. Use care.

Do not use if client feels intimidated or if you think clients are trying to tell you what you want to hear.
Inappropriate for uncovering abuse histories – can lead to false memories of abuse.

Denial of Specific Questions

After a client has denied a generic questions, more information is learned if client is asked a series of specific questions.

Technique appears to “jar the memory”
Makes it harder to falsify or deny a specific as opposed to a general question

Have you thought of shooting yourself?

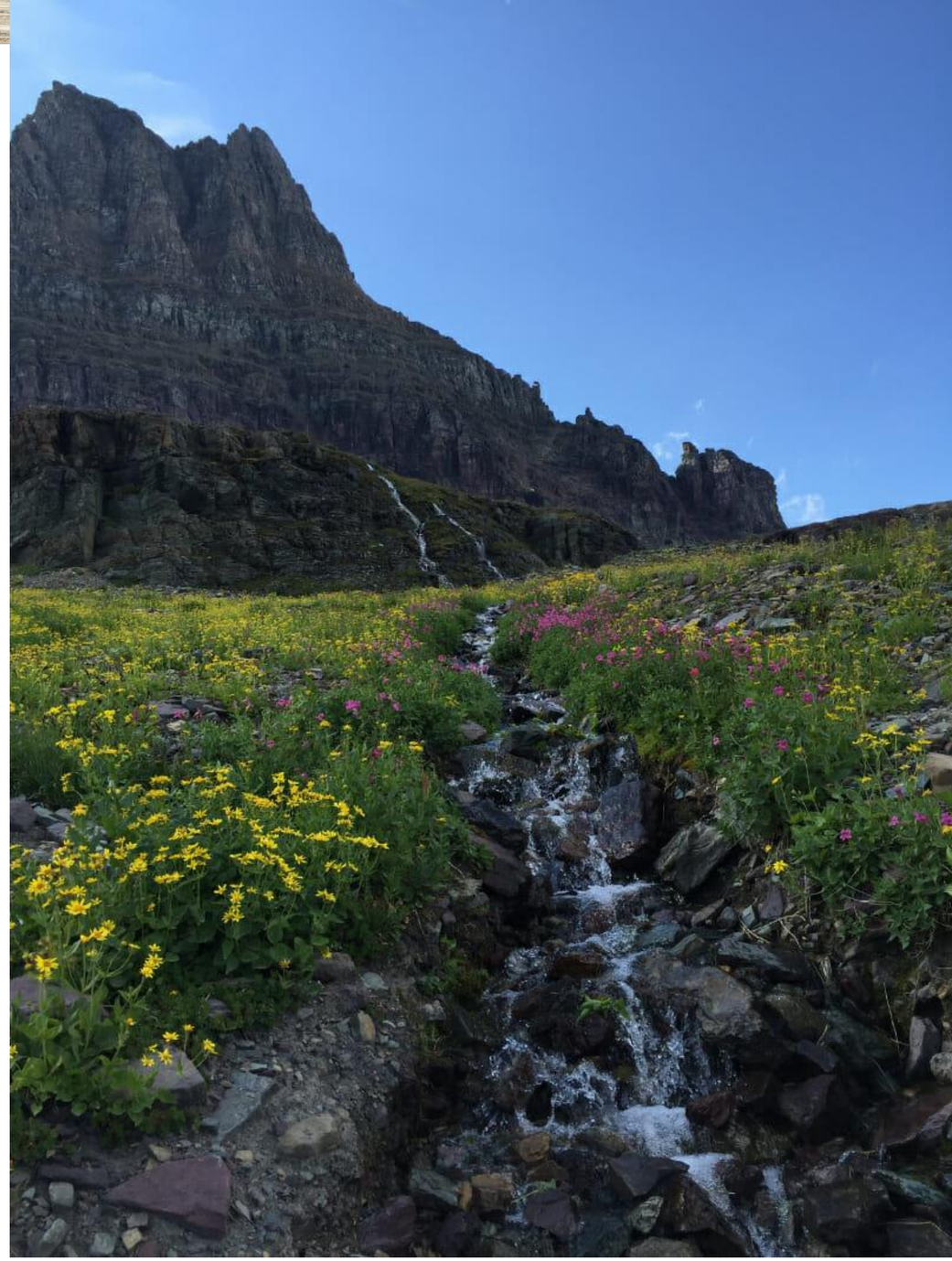
Have you thought of overdosing?

Have you thought of hanging yourself?”

Caution: make each a separate question, pause in between.

Don’t make one long question – “cannon question”

Leads to invalid info – omit, or only answer last item.



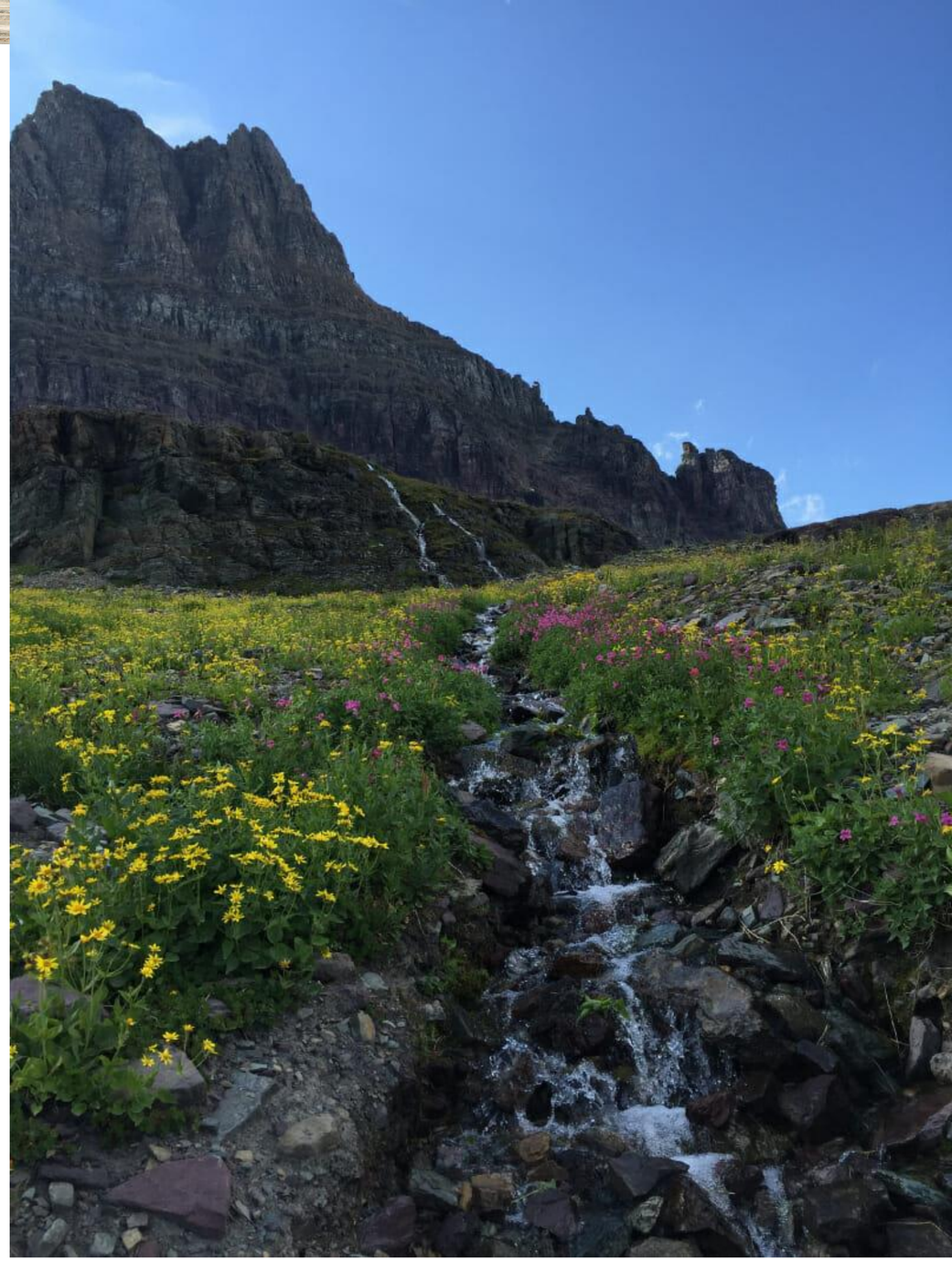
Responding to “I don’t know” Answer

If a client answers with: “I don’t know”

Try using:

If you did know the answer to the question, what do you think it would be?

I often use when trying to understand if client has thought about different methods for suicide.



Symptom Amplification

This technique based on observation that clients often minimize frequency or amount of disturbing behaviors (drink, gamble)

Clinician sets the upper limit of quantity in question – still aware it's a significant problem - Must ask a specific high number
Reason it works: Avoids a confrontational atmosphere

Example:

How much liquor can you hold in a single night… a pint? A fifth?

Client:

Oh no, not a fifth, I don't know, maybe a pint.

Use when client wants to minimize behavior.

Caution: don't use with client wants to "maximize"

i.e. Teen wants to show they are "big time drinker"

Symptom Amplification Examples

How many physical fights have you had in your whole life… 25, 40, 50?

On a day when the thoughts of suicide are most intense, how much of your time do you spend thinking about killing yourself… 70% of the day, 80%, 90%?

Caution: don’t set the upper limit so high that is seems absurd or creates the appearance you don’t know what you are talking about.

How to avoid Errors of Omission Interviewing for Suicide Ideation

CASE Approach Questions
4 Chronological Regions

1. Presenting suicide events
(past 48hrs.)

2. Recent suicide events
(over preceding 2 months)

3. Past suicide events
(from 2 months ago back in time)

4. Immediate suicide events – arise during interview
    - Suicidal feelings
    - Ideation
    - Intent

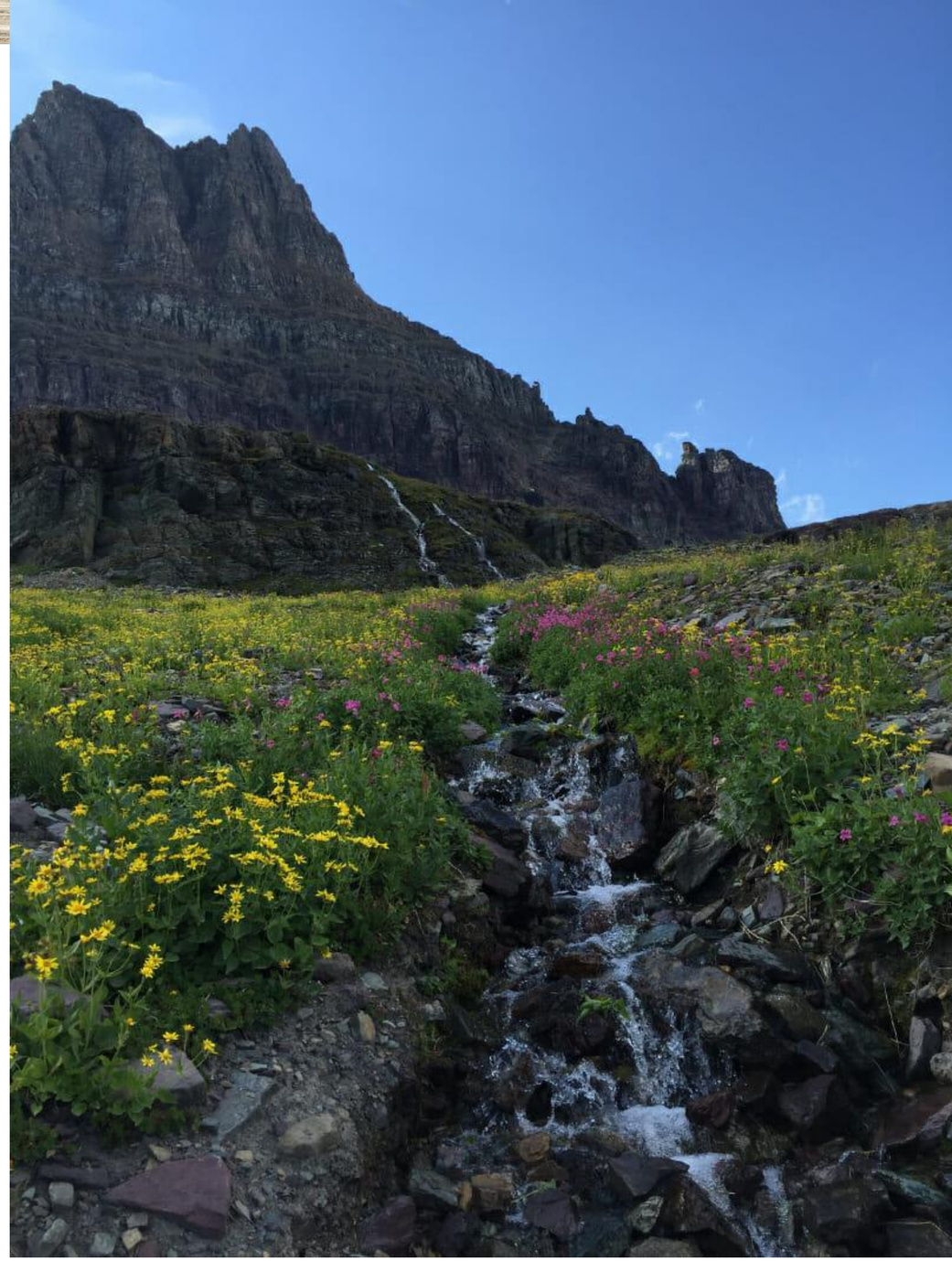
Using Anchoring Questions: CBT

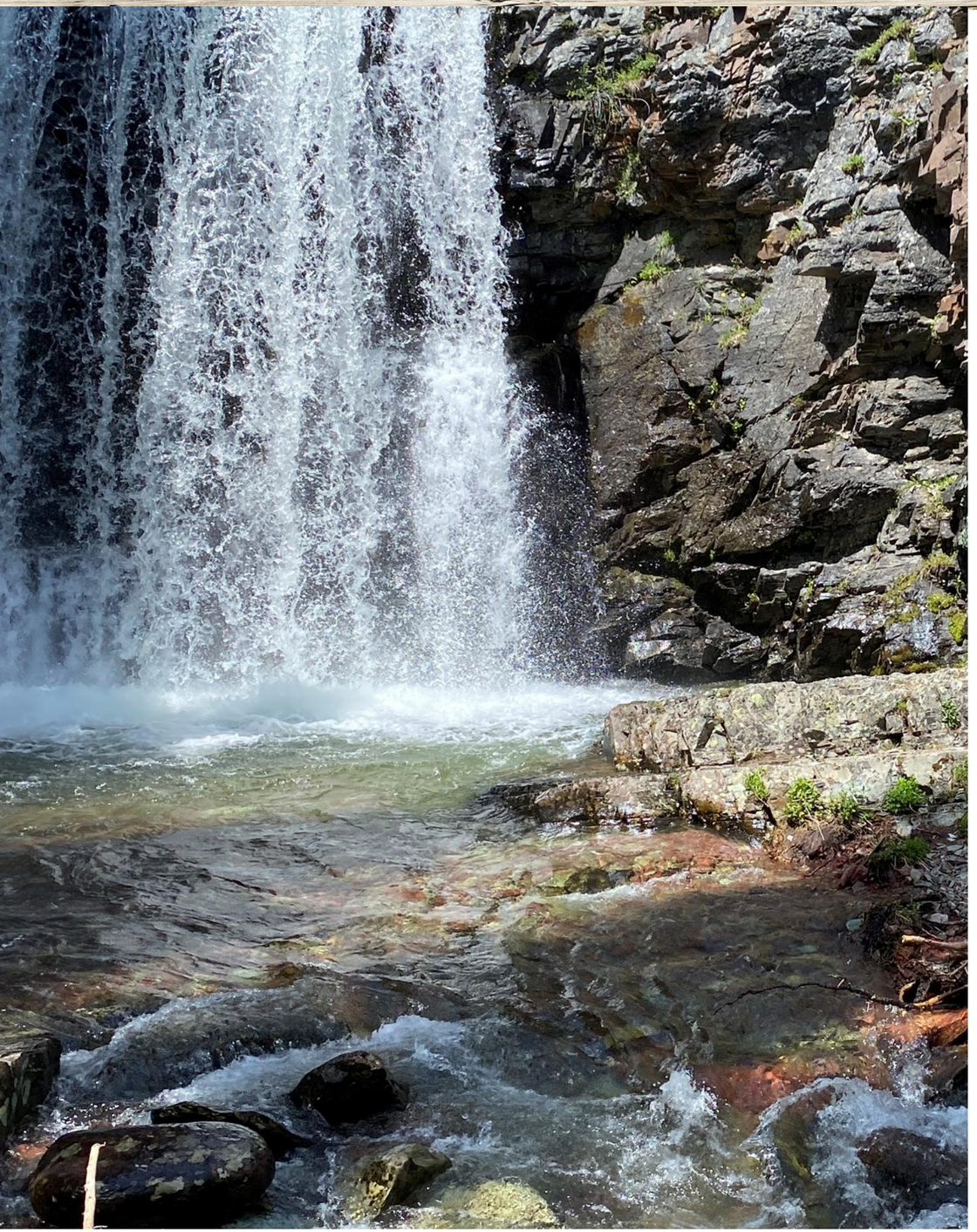
Type of question that anchors client to specific memory vs feelings

Create a “verbal video tape”

1. Start with 1 or 2 anchoring questions
2. May use shame attenuation – bring up topic suicide
3. Follow with behavioral incident questions
4. Use gentle assumptions to bridge (present, recent, past) and for other methods tried

Where you when you …. What kind… How many….
What other ways have you … Have you ever gotten out a ….





Step 1 – Exploration of presenting suicide events

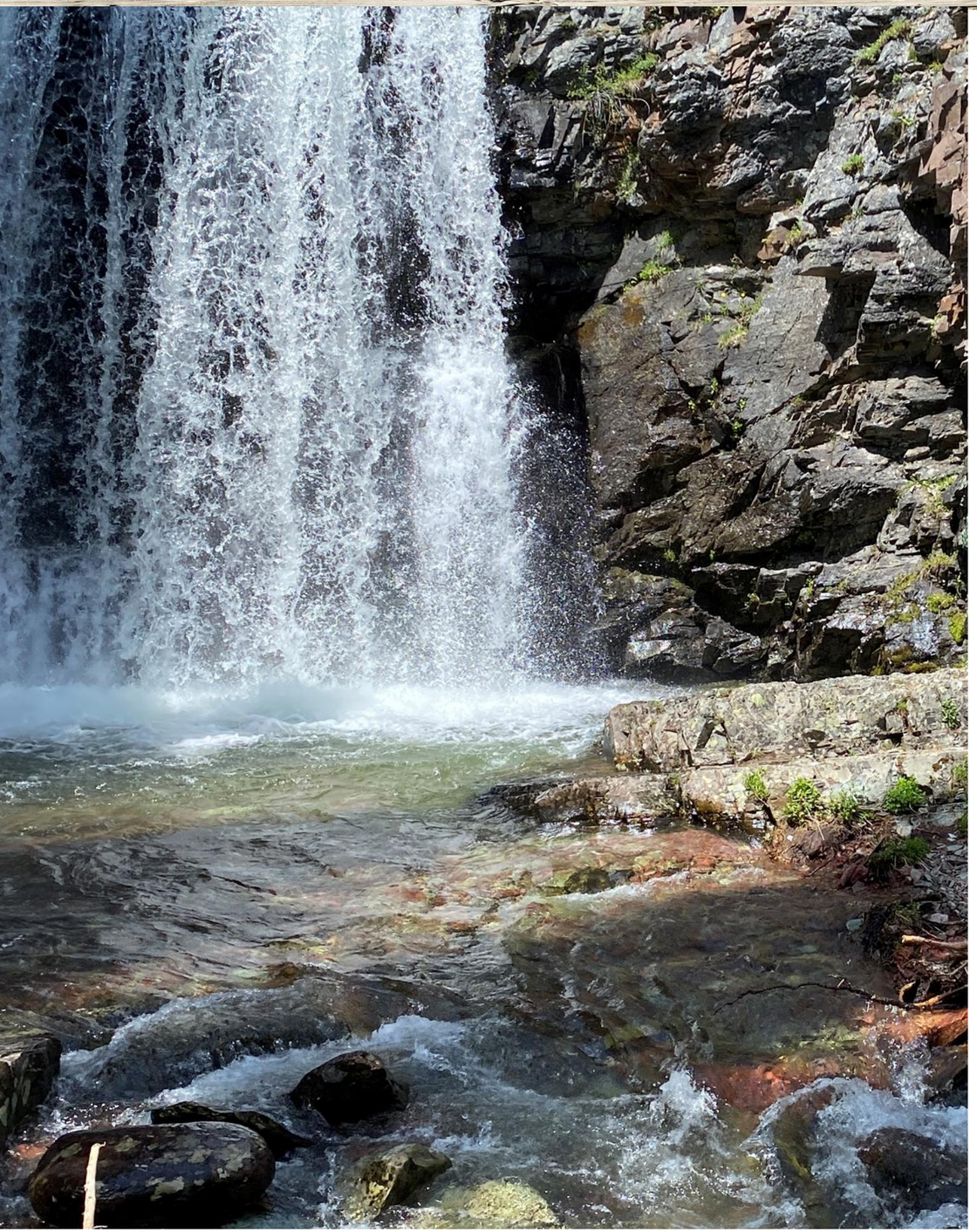
Presenting events – “currently” previous 2-day timeframe
Must determine severity = triage (ED, crisis hotline, follow-up)

Questions that provide valuable information:

1. How did patient try to commit suicide? (Method)

2. How serious was action taken with the method?
   Overdose: What pills, how many taken?
   Cut self: Where was the cut, and did it require stiches?

3. How serious were client’s intentions?
   - Did they tell anyone afterwards?
   - Where was attempt made – isolated area or where thought they’d be found?
   - Did client write a note, check on insurance, say goodbye to significant others?
   - How many pills were left in the bottle?



Step 1 – Exploration of presenting suicide events

4. How good does client feel about attempt didn't result in death?

Good question:

What are some thoughts about the fact that you are still alive?

5. Was the attempt well planned or impulsive?

6. Did alcohol or drugs play a role in the attempt?

7. Were interpersonal factors a major role in the attempt?

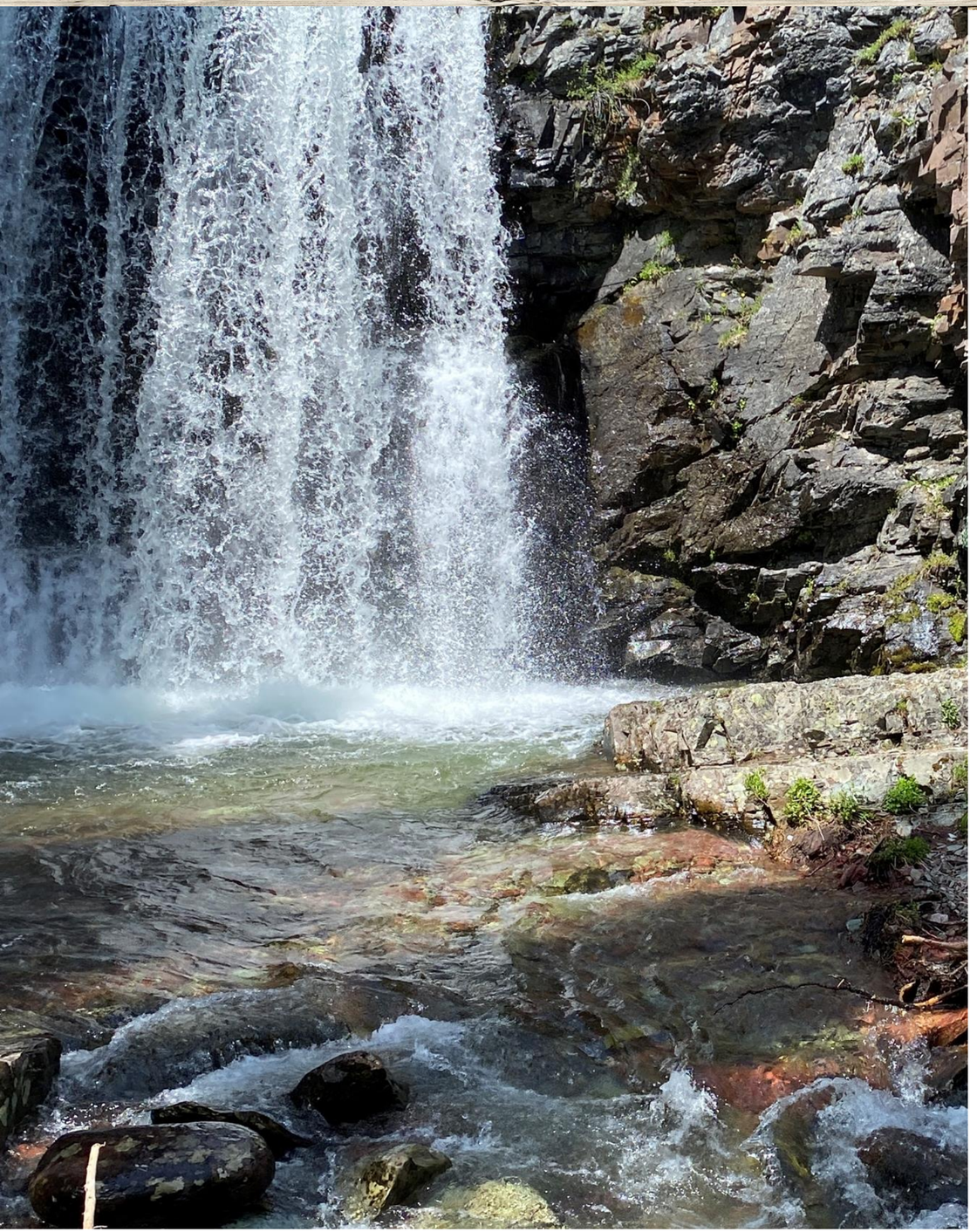
Including:

feelings of failure

view world better off without them

anger towards others - was suicide attempt to make others feel pain or guilt

8. Did a specific stressor or set of stressors prompt the attempt?



Step 1 – Exploration of presenting suicide events

7. Were interpersonal factors a major role in the attempt?

Including:

feelings of failure

view world better off without them

anger towards others - was suicide attempt to make others feel pain or guilt

8. Did a specific stressor or set of stressors prompt the attempt?

9. At time of attempt, how hopeless did patient feel?

10. Why did attempt fail?
    Disclosure?
    Discovery?
    Stopped self?

Step 1 – Exploration of immediate desire & intent

Desire = the intensity of client's pain and desire to die

Intent = the degree to which client has decided to actually proceed with suicide

Clinician must explore the relationship between the two

Client may have great pain and strong desire

but

couldn't do that to their family

(Note: over time the pain can override these defenses)

Questions to explore pain and desire to die:

1. Right now are you having any thoughts about wanting to kill yourself?
    1. How would you describe how bad the pain is for you from your breakup?
        1. “It’s sorta rough but I can handle it” to “If it doesn’t let up, I don’t think I can go on.”
        2. “In the coming week, how will you handle your pain if it worsens?”

Questions to explore intent:

1. I realize that you can’t know for sure, but what is your best guess as to how likely it is that you will try to kill yourself during the next week from highly unlikely to very likely?

2. What keeps you from killing yourself?

Import to explore:

- current level of hopelessness
- productive plans for future
- Concrete plans for dealing with problems/stresses

1. How hopeful are you about the future?
2. How does the future look to you?
3. What things in your life make you want to go on living?

Developing a safety plan

1. What would you do later tonight if you begin have suicidal thoughts?
    1. Helps give insight how serious client about ensuring their safety.

Safety Plan Consists of:

Series of steps client will take to distract, and/or control suicidal thoughts

List support people to contact

List crisis line supports

List distractions –

Coping items

Vibrant Mental Health Website

music, hang out with friends, take a shower

Go to hospital – call 911

Suicide contracts and controversial

Let's practice…

Interviewing client: suicidal ideation, mentioned they would use a gun they have access to….

Role Play. Pick a partner. One person client. One person interviewer. Client is reluctant/embarassed

Want interviewer to ask the question:

"Did you come close to actually using the gun?"

Discussion: Results?

Let’s try again…

Serial use of behavioral incidents are powerful in uncovering intent of actions when client minimize.

Where… When… Do you…. Did you.. What did you do next? Where were you sitting? What time of day?

Redo role play: So, you have a gun in your house.

Have you ever gotten the gun out while thinking of using it to kill yourself?

You can also try gentle assumption. “Often when people are feeling the way you are and have a gun, they….”

Don’t forget anchor questions: Where were you sitting?

Remember: CASE Approach is interview strategy

It is NOT a complete interview

3 Components

Gathering information related to risk & protective factors and warning signs of suicide

(CASE component)
Collecting information related to suicidal ideation, planning, behaviors, desires and intent

Making a clinical formulation of risked based on these 2 databases

Safety Plan Resources

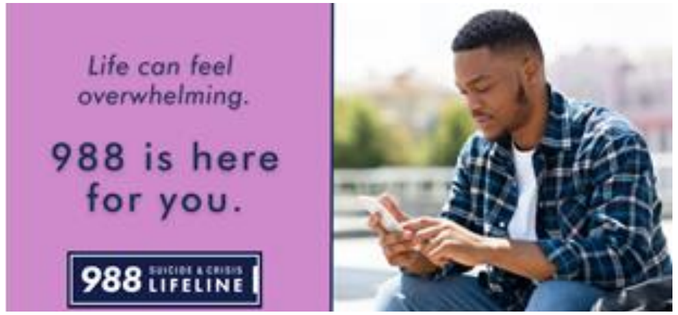
- **Trans Lifeline 1-877-565-8860**
- **Trevor Project 1-866-488-7386** (GLBTQ support)
- **911 – Wellness Check** (give city, State)
- **Mental Health Counseling**

Resources

National Suicide Prevention Lifeline is now **988 LIFELINE**

1-800-273-TALK is now **988 LIFELINE**

CHAT 988lifeline.org



Reasons to Connect with the 988 Lifeline

We continue to see a need to let people know that the 988 Lifeline is available for people to connect around many emotional struggles, including:

- Thoughts of suicide
- Drinking too much
- Anxiety
- Sexual orientation
- Drug use
- Feeling depressed
- Mental and physical illness
- Loneliness
- Trauma
- Relationships
- Economic worries, and more

Other Resources

- **Trans Lifeline 1-877-565-8860**
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- **911 – Wellness Check** (give city, State)
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Questions
&
Comments