Suicide Risk Reduction: Assessment and Safety Planning

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MAGELLAN BEHAVIORAL HEALTH OF PA

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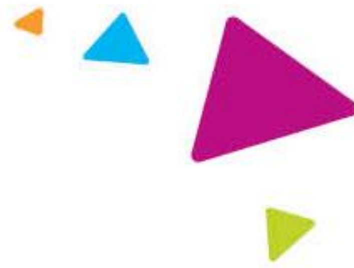
Course Outline



1. Be prepared
2. Ethical considerations
3. Psychological factors associated with suicide risk
4. Evidence-based suicide risk assessments
5. Safety planning interventions

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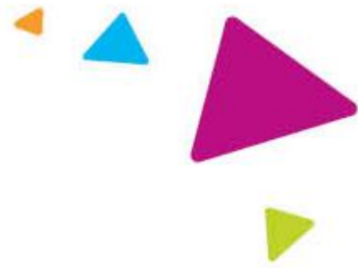
Learning Objectives



01

Describe why all clinicians must prepare to assess suicide risk

02

Describe the Duty of Care & Standard of Care

03

Describe Psychological Factors Associated With Suicide Risk

04

Describe Elements Of Evidence-based Suicide Risk Assessments

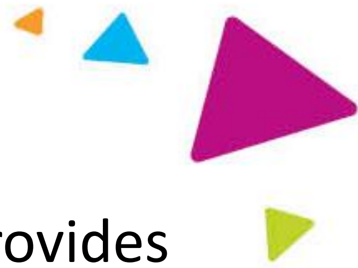
05

List 1 Risk Assessment That Support Clinical Decision Making

06

Describe Components of the Stanley Brown Safety Planning Intervention

Presenter Bio



Dr. Siegler is the Psychologist Advisor for Magellan Behavioral Health of PA. He provides consultation to the care management team and supports children's service providers striving to provide effective and accountable treatment services to the individuals and families they serve. Dr. Siegler has extensive experience providing consultation services in educational, psychiatric, and forensic settings. He has provided staff training to behavioral health providers on a variety of topics related to clinical excellence and clinical accountability. Prior to joining Magellan, Dr. Siegler has held clinical leadership positions in psychiatric inpatient, psychiatric residential treatment, extended acute care, intensive behavioral health services, and outpatient settings.

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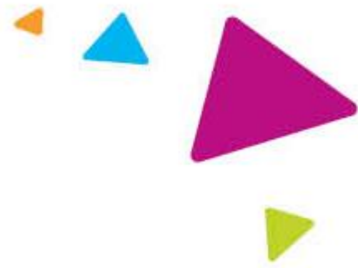
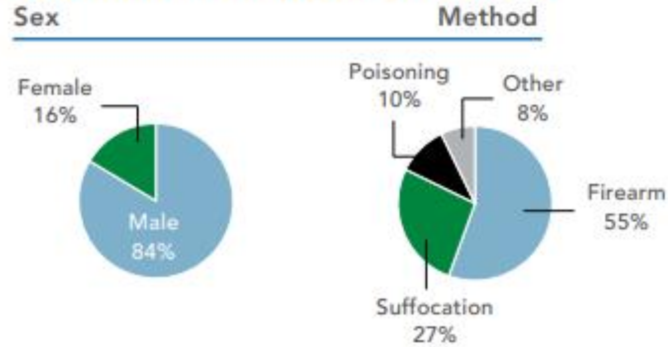
More than Half of Suicides in 2015: No Psychiatric Diagnosis



Differences exist among those with and without mental health conditions.
People without known mental health conditions were more likely to be male and to die by firearm.

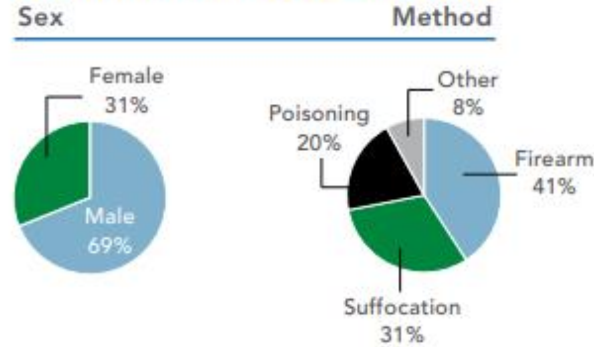
No known mental health conditions

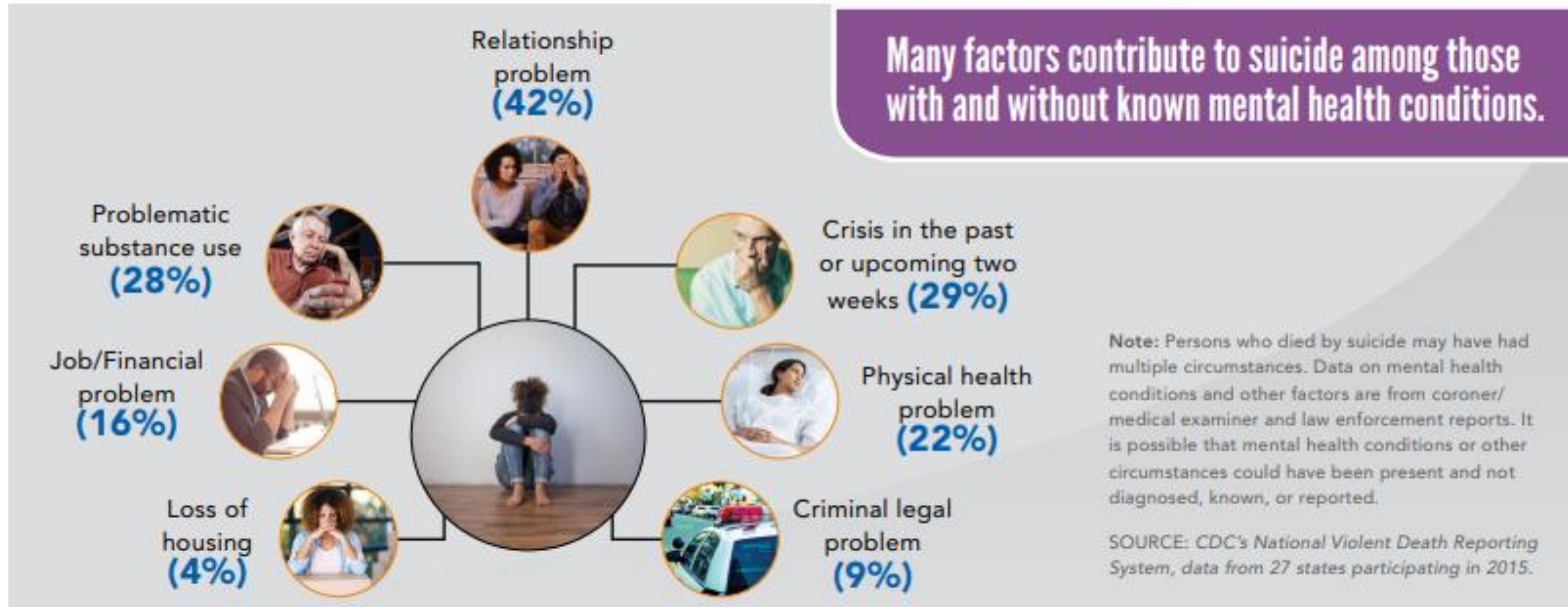
Sex | Method



Known mental health conditions

Sex | Method





Stone, D. M., Simon, T. R., Fowler, K. A., Kegler, S. R., Yuan, K., Holland, K. M., ... & Crosby, A. E. (2018). Vital signs: trends in state suicide rates—United States, 1999–2016 and circumstances contributing to suicide—27 states, 2015. Morbidity and Mortality Weekly Report, 67(22), 617.

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Suicide Risk Assessment: a Universal Precaution

Only a minority of depressed patients die by suicide

Few persons who suffer with a psychiatric disorder will attempt suicide

Large percentage of severely depressed patients never think about suicide

The risk of suicide has been estimated to be 5–8% for several mental disorders

Major depression is a risk factor for suicide attempt

Many risk factors for suicide attempt, but none are predictive.

Bachmann, S. (2018). Epidemiology of suicide and the psychiatric perspective. International journal of environmental research and public health, 15(7), 1425.
Bertolote, J. M., & Fleischmann, A. (2002). Suicide and psychiatric diagnosis: a worldwide perspective. World psychiatry, 1(3), 181.
Handley, T., Rich, J., Davies, K., Lewin, T., & Kelly, B. (2018). The challenges of predicting suicidal thoughts and behaviours in a sample of rural Australians with depression. International journal of environmental research and public health, 15(5), 928.
Pompili, M. (2019). Critical appraisal of major depression with suicidal ideation. Annals of general psychiatry, 18, 1-5.

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Is it possible to avoid treating persons at risk of suicide?

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Encountering suicidal patients is unavoidable

ED visits for suicidal ideation have increased and many people are sent home with an OP referral

Tiptoeing around the word "suicide" delays appropriate interventions.

36% of women and 18% of men had contact with a mental health professional within one month of their suicide.

Luoma, J. B., Martin, E., Pearson, J. L. (2002).Contact with mental health and primary care providers before suicide: A review of the evidence. American Journal of Psychiatry, 159(6), 909 – 916.

Brewer, A. G., Doss, W., Sheehan, K. M., Davis, M. M., Feinglass, J.M. (2022). Trends in suicidal ideation-related emergency department visits for youth in illinois: 2016–2021. *Pediatrics,* 150 (6), 39-48.

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Barriers to clinician competence and confidence?

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- Suicide focused treatment modalities not taught during formal training or internship
- Mandatory annual agency training often focus on increasing adherence with policy and procedure.
- Clinicians may not be reimbursed Continuing Education.
- Clinicians may not know about high quality, no cost training

Overcoming Barriers

Genuine desire to help patients do better.

Empirically Supported Treatments.

Directives or mandates by leadership (i.e., being forced to do it).

Fear of losing a patient to suicide and then being blamed.

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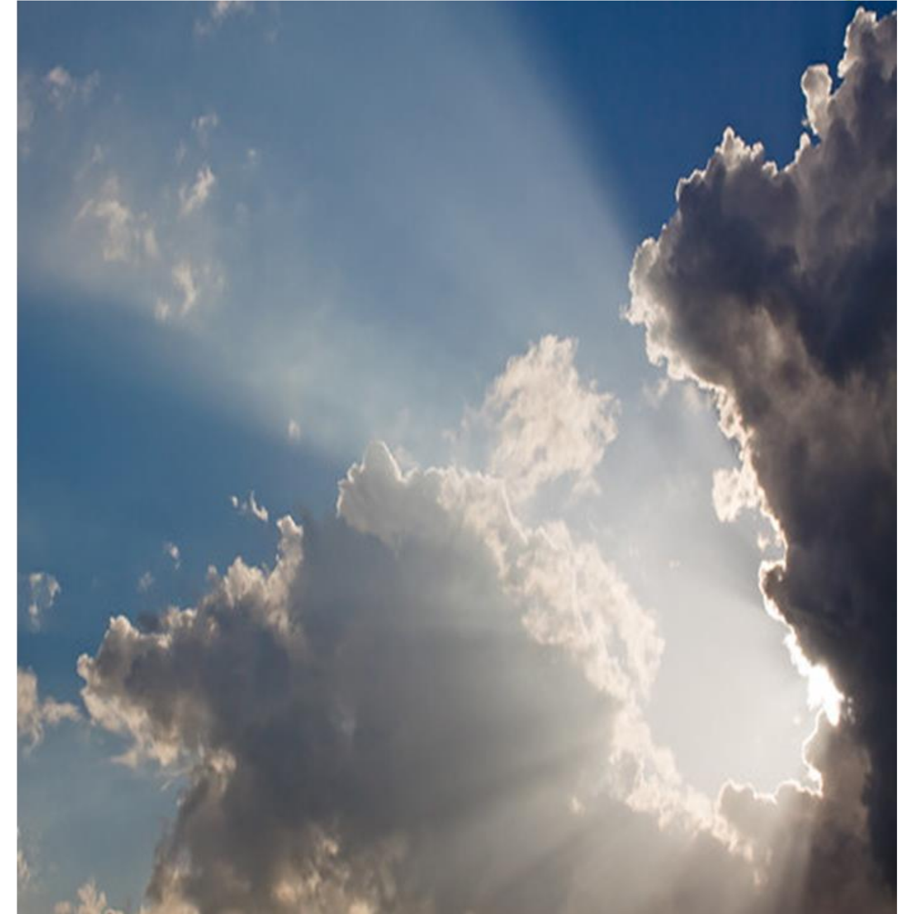
Fear of litigation for malpractice-wrongful death.

Seeing is believing. (being convinced that a treatment may actually. work.



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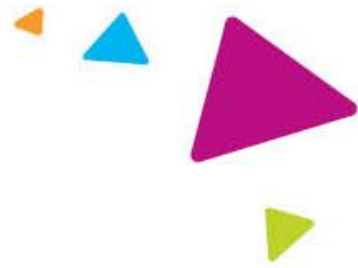
Duty of Care

Standards of Care



Duty of Care

The duty to attempt reasonably to prevent the suicide of the patient.

Standard of Care

The degree of skill and care customarily used in similar circumstances by similar clinicians.

Berman, A.L., Jobes, D.A., & Silverman, M.M. (2007). Adolescent suicide: Assessment and intervention. American Psychological Association

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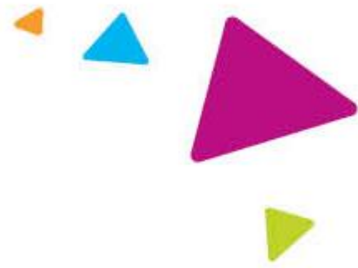
Liability – 2 factors



Foreseeability – The assessment of risk

- Suicidal thoughts
- Plans
- Intent
- Actions
- Risk factors

Reasonable care

- Treatment is provided based on the available information.
- Practice guidelines: reasonable & prudent care in the treatment of at-risk patients.

Pinals D. A. (2019). Liability and Patient Suicide. *Focus (American Psychiatric Publishing)*, *17*(4), 349–354.

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Commonly Alleged Failures In Meeting Standards Of Care : Foreseeability.

Expectation	Underlying Clinical Procedures
Appropriately diagnose patient.	Obtain history of current and past problems.
	Perform mental status exam
	Conduct assessment of suicidality to determine suicidal risk.
	Reach tentative diagnosis.
	Provide risk-benefit analysis of treatment options to support critical clinical management decisions.
	Consider least restrictive environment options.
	Develop initial treatment plan and discuss treatment plan with patient
	Obtain informed consent and discuss limits of confidentiality.
	Obtain collateral information from support network with patients consent.
Appropriately foresee future behavioral problems	Reassess regularly with diagnosis, level of suicidality. , and appropriateness of all aspects of the treatment plan.
	Obtain consultation when indicated.

Berman, A.L., Jobes, D.A., & Silverman, M.M. (2007). Adolescent suicide: Assessment and intervention. American Psychological Association

Commonly Alleged Failures In Meeting Standards Of Care: Causation.

Expectation	Underlying Clinical Activities
Provide protection against harm.	Implement treatment plan.
	Monitor treatment plan results.
	Provide. informed consent about changes in treatment plan.
	Discuss confidentiality with patient.
Treat conditions associated with suicidal behaviors.	Consider consultation when indicated.
	Provide plan specific interventions.
Carry out treatment plan as written.	Monitor adherence to treatment plan.

Berman, A.L., Jobes, D.A., & Silverman, M.M. (2007). Adolescent suicide: Assessment and intervention. American Psychological Association

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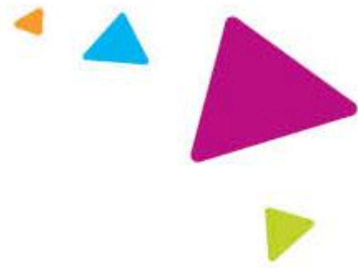
The Duty to Care includes …



Risk Assessment

Safety Planning*

Suicide Specific Treatment

*including Means Restriction Planning

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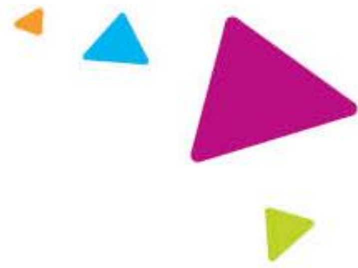
Assessing Suicidal Risk

“Why do people attempt suicide?”



Suicide is a highly complex and multifaceted phenomenon

Intrapersonal Perception (maladaptive cognitions, hopelessness, low self-esteem, meaninglessness, negative self attributions

External Environment (social status, lack of income, abuse, discrimination, poverty, unemployment)

Orsolini, L., Latini, R., Pompili, M., Serafini, G., Volpe, U., Vellante, F., Fornaro, M., Valchera, A., Tomasetti, C., Fraticelli, S., Alessandrini, M., La Rovere, R., Trotta, S., Martinotti, G., Di Giannantonio, M., & De Berardis, D. (2020). Understanding the Complex of Suicide in Depression: from Research to Clinics. *Psychiatry investigation*, *17*(3), 207–221.

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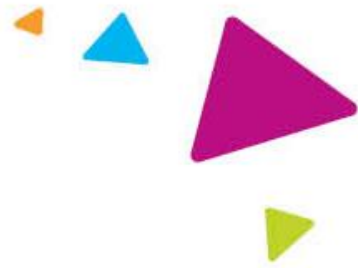
3 Theories of Suicidality



The Cubic Model

- Psychological Pain, Stress, Agitation

Hopelessness

- No hope for the future

Self-Regard

- Unacceptable perceptions of self

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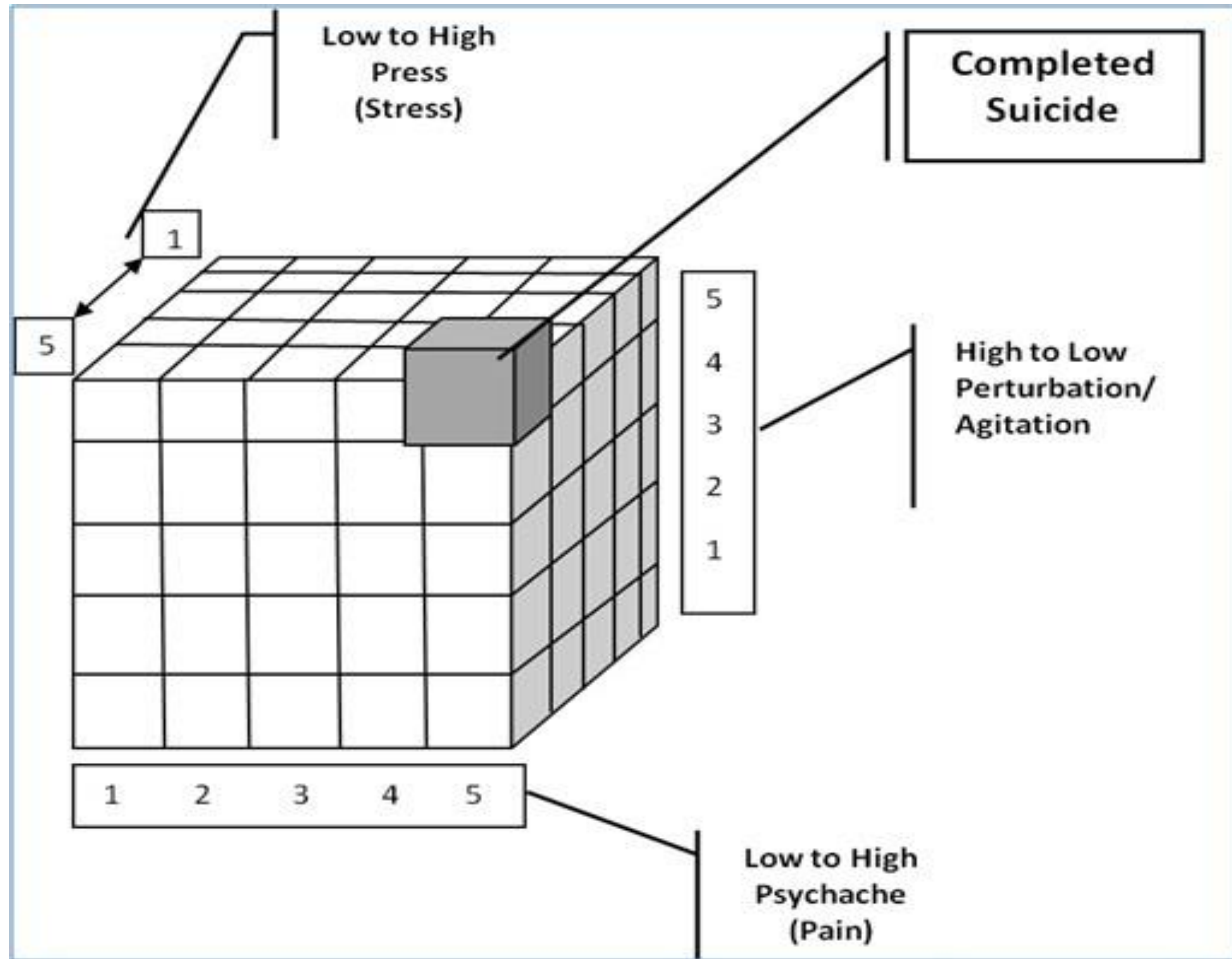
Cubic Model



Shneidman, E. S. (1999). The psychological pain assessment scale. Suicide and Life-Threatening Behavior, 29, (4), 287-294.

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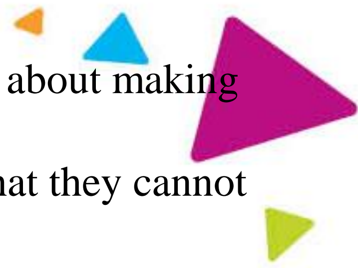
Hopelessness

- A Cognitive Style
  - negative attributions about the future
  - helplessness to improve prospects for the future
- Self-report of hopelessness may predict short-term risk for suicidal behavior
- Hopelessness is more predictive than severity of depressive symptoms.
- Assessment of Hopelessness is not sufficient to determine suicide risk.



1. I look forward to the future with hope and enthusiasm.
2. I might as well give up, because there's nothing I can do about making things better for myself.
3. When things are going badly, I am helped by knowing that they cannot stay that way forever.
4. I can't imagine what my life would be like in 10 years.
5. I have enough time to accomplish the things I want to do.
6. In the future, I expect to succeed in what concerns me most.
7. My future seems dark to me.
8. I happen to be particularly lucky, and I expect to get more of the good things in life than the average person.
9. I just can't get the brakes and there's no reason I will in the future.
10. My past experiences have prepared me well for the future.
11. All I can see ahead of me is unpleasantness rather than pleasantness.
12. I don't expect to get what I really want.
13. When I look ahead to the future, I expect what I will be happier than I am now.
14. Things just don't work out the way I want them to.
15. I have great faith in the future.
16. I never get what I want, so it's foolish to want anything.
17. It's very unlikely that I will get any real satisfaction in the future.
18. The future seems vague and uncertain to me.
19. I can look forward to more good times than bad times.
20. There's no use in really trying to get anything I want because I probably won't get it.

- For items **1, 3, 5, 6, 8, 10, 13, 15, and 19**, FALSE is equal to 1 point, TRUE equals 0 points
- For items **2, 4, 7, 9, 11, 12, 14, 16, 17, 18, and 20**, TRUE is equal to 1 point, FALSE equals 0 points

Beck, A. T., Steer, R. A., & Pompili, M. (1988). BHS, Beck hopelessness scale: manual. San Antonio, TX: Psychological corporation.

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Self-Regard: Suicide as Escape from Self

Awareness of one’s inadequacies

- events fall severely short of standards and expectations

Negative Attribution of Failures

- failures are attributed internally

Aversive State of High Self Awareness

- Acute Aware of Self as Inadequate, Incompetent, Unattractive, or Guilty

Self-awareness is painful.

- Awareness of the self's inadequacies generates negative affect

Escape from aversive self-awareness

- Avoid emotions, focus on present, not future, concrete sensation and avoid abstract thought

Impulsive response to break through thoughts and feelings

- Suicide seen as a means of escape from self and world.

Baumeister, R. F. (1990). Suicide as escape from self. Psychological Review, 97(1), 90–113.

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So, What about Trauma?

Trauma and Suicidality

Trauma has a potent impact on the risk of suicidality among individuals with PTSD

Childhood maltreatment appeared to have a remarkably strong relationship to suicidal behavior

Traumas relating to assaultive violence and peacekeeping also had similarly high rates of suicide attempt and suicidal ideation

Multiple traumas increased suicidality

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Trauma and Suicidality

Seriously neglected < 18 years by parent/caretaker
Saw serious fights at home < 18
Attacked/beaten/injured < 18 years by parent/caretaker
Attacked/beaten/injured by spouse/romantic partner
Attacked/beaten/injured by anyone else
Sexually assaulted/molested/raped
Stalked
Mugged/held up/threatened with weapon
Kidnapped/held hostage or prisoner of war
Serious/life-threatening accident
Serious/life-threatening illness
Serious fire/tornado/flood/hurricane
Active military combat
Peacekeeping/relief work in a war zone
Unarmed civilian in war/revolution/military coup
Refugee
Directly experienced terrorist attack
Injured in terrorist attack
Indirectly experienced terrorist attack
Saw someone badly injured/ killed or encountered corpse
Someone close died unexpectedly
Someone close died in terrorist attack
Someone close directly experienced terrorist attack
Someone close had other serious/life-threatening event
Someone close had other stressful/traumatic event
Other traumatic event

Rates of Suicidal Ideation and Suicide Attempt as a Function of the Number of Separate Traumas Reported

Separate	Suicidal ideation			Suicide attempt		
traumas	*n*	%	95% CI	*n*	%	95% CI
0	159	5.50	[4.5, 6.7]	24	0.9	[0.5, 1.5]
1–2	53	15.60	[11.4, 21]	13	3.3	[1.7, 6.3]
3	87	25.70	[20.5, 31.7]	18	5.8	[3.2, 10]
4	75	22.00	[17.2, 27.7]	24	7.1	[4.4, 11.2]
5	93	26.80	[21.8, 32.5]	33	8.3	[5.6, 12]
6	85	33.10	[26.8, 40.2]	27	8.7	[5.6, 13.3]
7	74	36.70	[29, 45.3]	29	14.9	[9.4, 22.7]
8	82	42.30	[34.5, 50.5]	44	21.6	[15.6, 29.2]
9	59	40.70	[31.3, 50.8]	30	19.3	[13.2, 27.3]
≥ 10	172	51.40	[44.7, 58.1]	122	36.9	[30.8, 43.6]

Note. Sample sizes are unweighted. Percentages and 95% confidence intervals (CIs) are weighted.

LeBouthillier, D. M., McMillan, K. A., Thibodeau, M. A., & Asmundson, G. J. (2015). Types and number of traumas associated with suicidal ideation and suicide attempts in PTSD: Findings from a US nationally representative sample. Journal of traumatic stress, 28(3), 183-190.

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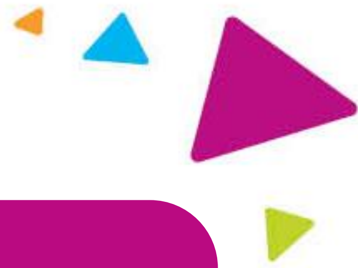
Trauma Informed Conceptualization



Seek to understand all the circumstances that contribute to the patient’s perspective on the problems that drive suicidal ideation and behavior:

- The patient’s experience of past adversity
- The patient’s current exposure to adverse circumstances
- The patient’s current capacity of emotional management
- The extent of the patient’s suffering related to difficulty regulating emotions.

Adequate Risk Assessment

Foreseeability-How much screening/assessment is enough?

Use Empirically Supported Structured Tools

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Types of Suicide Risk Assessment

2 Types of Risk Assessments

- Universal Screening
- Repeated assessment during treatment focused on reducing suicide risk

Universal Screening

- Detect elevated risk
- Low burden
- Assess ideation & behavior
- Refer to appropriate level of care for treatment

In-Depth Individualized Assessment

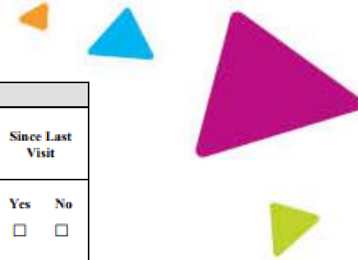
- Understanding the dimensions of a person's suicidality
- Monitoring self-report of range and extent of relevant factors
- Creating and reassessing adequacy of stabilization (safety plan)

Columba Suicide Severity Rating Scale

SUICIDAL IDEATION		
Ask questions 1 and 2. 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.	**Lifetime: Time He/She/They Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Person endorses thoughts about a wish to be dead or not alive anymore or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	**Yes No** ☐ ☐	**Yes No** ☐ ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/die by suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	**Yes No** ☐ ☐	**Yes No** ☐ ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act 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 (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"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."* ***Have you been thinking about how you might do this?*** If yes, describe:	**Yes No** ☐ ☐	**Yes No** ☐ ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and person 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."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	**Yes No** ☐ ☐	**Yes No** ☐ ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*** If yes, describe:	**Yes No** ☐ ☐	**Yes No** ☐ ☐

INTENSITY OF IDEATION		
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 5 being the most severe). Ask about time he/she/they were feeling the most suicidal. Lifetime - *Most Severe Ideation:* _______ ________________________ *Type # (1-5)* *Description of Ideation* Recent - *Most Severe Ideation:* _______ ________________________ *Type # (1-5)* *Description of Ideation*	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	____

Columba Suicide Severity Rating Scale-Pediatric Version



SUICIDAL IDEATION	
Ask questions 1 and 2. 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.	**Since Last Visit**
1. Wish to be Dead Subject endorses thoughts 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:	**Yes No** ☐ ☐
2. Non-Specific Active Suicidal Thoughts General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you thought about doing something to make yourself not alive anymore?*** ***Have you had any thoughts about killing yourself?*** If yes, describe:	**Yes No** ☐ ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject 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 (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"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."* ***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:	**Yes No** ☐ ☐
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 (or 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:	**Yes No** ☐ ☐
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 out (worked out the details of) 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:	**Yes No** ☐ ☐

INTENSITY OF IDEATION	
The following feature 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 5 being the most severe). ***Most Severe Ideation:*** _________ ______________________________ ***Type # (1-5)*** ***Description of Ideation***	Most Severe
Frequency ***How many times have you had these thoughts?*** ***Write response***______________________ (1) Only one time (2) A few times (3) A lot (4) All the time (0) Don't know/Not applicable	____

Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A.,... Mann, J. J. (2011). The Columbia Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. American Journal of Psychiatry, 168(12), 1266–1277.

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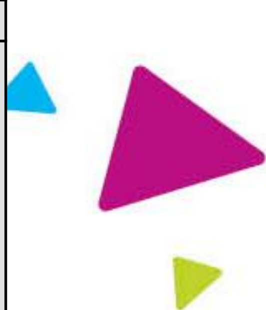
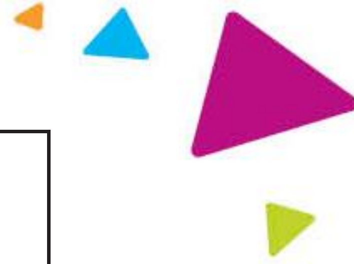


SUICIDAL BEHAVIOR *Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
Actual Attempt: A potentially self-injurious act undertaken with at least some wish to die, *as a result of act*. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth, but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent, but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you______ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** (NSSIB) If yes, describe **Has person engaged in Non-Suicidal Self-Injurious Behavior?**	**Yes No** □ □ Total # of Attempts ______ **Yes No**	**Yes No** □ □ Total # of Attempts ______ **Yes No**
Interrupted Attempt: When person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	**Yes No** □ □ Total # of interrupted	**Yes No** □ □ Total # of interrupted
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	**Yes No** □ □ Total # aborted or self-interrupted	**Yes No** □ □ Total # aborted or self-interrupted
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	**Yes No** Total # of preparatory acts	**Yes No** Total # of preparatory acts

	Most Recent Attempt	Most Lethal Attempt	Initial/First Attempt
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* ______	*Enter Code* ______	*Enter Code* ______
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over).	*Enter Code*	*Enter Code*	*Enter Code*

Assessing the Dimensions of Suicidality



________	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind,* ***not*** *stress,* ***not*** *physical pain*): **Low pain: 1 2 3 4 5 :High pain** What I find most painful is: ________________________
________	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): **Low stress: 1 2 3 4 5 :High stress** What I find most stressful is: ________________________
________	3) RATE AGITATION (*emotional urgency; feeling that you need to take action;* ***not*** *irritation;* ***not*** *annoyance*): **Low agitation: 1 2 3 4 5 :High agitation** I most need to take action when: ________________________
________	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): **Low hopelessness: 1 2 3 4 5 :High hopelessness** I am most hopeless about: ________________________
________	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): **Low self-hate: 1 2 3 4 5 :High self-hate** What I hate most about myself is: ________________________

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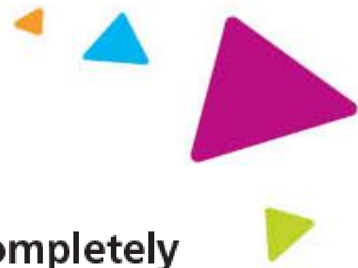
Assessing the Dimensions of Suicidality



1) How much is being suicidal related to thoughts and feelings about <u>yourself</u>? **Not at all: 1 2 3 4 5 : completely**

2) How much is being suicidal related to thoughts and feeling about <u>others</u>? **Not at all: 1 2 3 4 5 : completely**

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be: ____________________

____

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	**Rank**	REASONS FOR DYING

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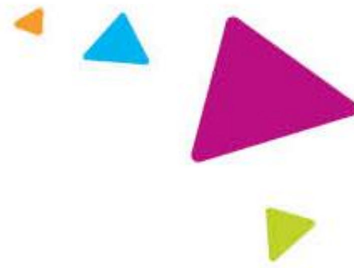
Some Suicide Risk Assessment Tools (and Training)



- The Columba Suicide Severity Rating Scale (C-SSRS): https://cssrs.columbia.edu/documents/lifetimerecent/
- The Columba Suicide Severity Rating Scale - Pediatric Version (C-SSRS-PV):

  https://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf
- Training on administering the Columba Suicide Severity Rating Scale:

  https://youtu.be/Xfddz_Yfnc4
- The Suicide Specific Form, 4th revision (SSF-4):
- https://cams-care.com/
- Training on use of the SSF-4 is available on the CAMS Care website
- Prevent Suicide PA Learning: Collecting Valid Data (assessing adolescents)

  https://youtu.be/WyxSuzWs7sw

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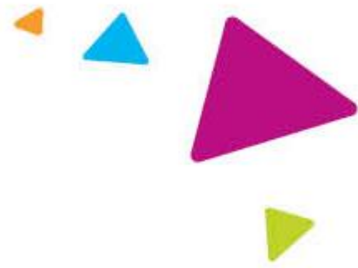
Suicide Specific Safety Planning

WHAT IS A SAFETY PLAN?



A prioritized written list of coping strategies and sources of support

Patients can use these strategies before or during a suicidal crisis.

Safety Planning is associated with reduced subsequent suicide attempts

Doupnik SK, Rudd B, Schmutte T, et al. Association of Suicide Prevention Interventions With Subsequent Suicide Attempts, Linkage to Follow-up Care, and Depression Symptoms for Acute Care Settings: A Systematic Review and Meta-analysis. *JAMA Psychiatry.* 2020;77(10):1021–1030.

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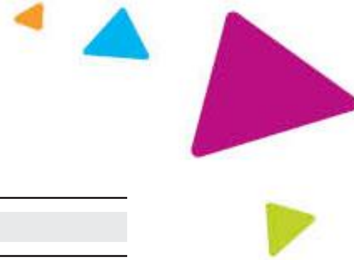
Stanley Brown Safety Planning Intervention



A brief standalone intervention that may reduce further suicidal behavior

A systematic and comprehensive approach to maintaining safety in suicidal patients.

Patients are given tools that enable them to resist or decrease suicidal urges for brief periods of time, reducing the risk for suicide.

Includes means restriction and emergency contacts, and utilizes internal coping skills and distracting strategies

SAFETY PLAN

Step 1: Warning signs:

1. Suicidal thoughts and feeling worthless and hopeless
2. Urges to drink
3. Intense arguing with girlfriend

Step 2: Internal coping strategies - Things I can do to distract myself without

1. Play the guitar
2. Watch sports on television
3. Work out

Step 3: Social situations and people that can help to distract me:

1. AA Meeting
2. Joe Smith (cousin)
3. Local Coffee Shop

Step 4: People who I can ask for help:

1. Name Mother Phone 333-8666
2. Name AA Sponsor (Frank) Phone 333-7215

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name Dr John Jones Phone 333-7000
   Clinician Pager or Emergency Contact # 555 822-9999
2. Clinician Name ______ Phone ______
   Clinician Pager or Emergency Contact # ______
3. Local Hospital ED City Hospital Center
   Local Hospital ED Address 222 Main St
   Local Hospital ED Phone 333-9000
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK

Making the environment safe:

1. Keep only a small amount of pills in home
2. Don't keep alcohol in home
3. ______

Stanley, B. & Brown, G. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk, Cognitive and Behavioral Practice, 19(2), 256-264.

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The Stanley Brown Safety Planning Intervention

A brief standalone intervention that may reduce further suicidal behavior

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Patients are given tools that enable them to resist or decrease suicidal urges for brief periods of time, reducing the risk for suicide.

Stanley, B. & Brown, G. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk, Cognitive and Behavioral Practice, 19(2), 256-264.

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The Safety Planning Intervention Process

Safety Planning is a clinical process

Takes approximately 20 to 45 minutes

A collaborative stance is most effective for developing the safety plan.

The Stanley Brown Safety Planning Intervention Resources

- The Stanley Brown Safety Planning Intervention Form can be found here:

https://bgg.11b.myftpupload.com/wp-content/uploads/2021/08/Stanley-Brown-Safety-Plan-8-6-21.pdf

- You Tube - Safety Planning with the Stanley-Brown Safety Plan: Dr. Barbara Stanley

https://youtu.be/2g6PCKJ4m9o

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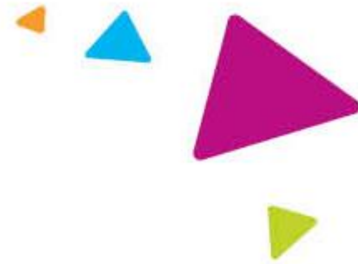
Stabilization Support Plan



To guide conversation on means restriction with Caregivers.

Things I can do to assist my ____
[child]

1. **Help reduce access to lethal means/make your home safer.** We particularly target firearms (the most common method of suicide death) and medications (the most common method of suicide attempt) until the [child/family member/friend] has recovered.

Reduce access to firearms in the following ways.

- ☐ Store all firearms away from house from now (with family member qualified to possess firearms; Gun shop; Pawn shop; Shooting range; Self storage rental; or a Police Department).
  - *Where stored:* ____.
- ☐ Lock all firearms at home in a way so that the [child/family member/friend] has no access.
  - Locked and tamper proof safe or lock box that [child/family member/friend] cannot unlock (change combination or where the key is kept).
  - Store ammunition locked up and separate from firearms.
  - Remove a key part of all firearms (i.e., bolt, slide, firing pin)
  - Use a cable lock or other external locks for added protection.
- ☐ Does this plan apply to all guns, or will a self-defense gun or work firearm be stored differently?
  - Not applicable.
  - All firearms stored as described above.
  - Storage plan for self-defense or work firearm: ______________________________

Jobes, D. A. (2023). Managing suicidal risk: A collaborative approach. Guilford Publications.

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Stabilization Support Plan

Reduce access to medications so that what is available to the [child/family member/friend] could not do serious harm, even if taken all at once.

- ☐ Discard any expired or unused prescription medications, Especially for pain.(e.g., Opioids. Like oxycodone. Were fentanyl), sleeping pills, or anxiety (e.g., Xanax, *Alprazolam*, Valium, *Diazepam*, Ativan, *Lorazepam*).
- ☐ Reduce quantities of over-the-counter pain relievers and sleeping pills to safe quantities. Dispose of or lock up the rest.
- ☐ For necessary current prescription medications, Limit to safe quantities and lock up the rest.
- ☐ Requested prescriptions be written or filled in quantities that would not cause serious harm, even if taken all at once. (e.g., Weekly or Monthly supply instead of 90 days).

Reduce access to other suicide methods if [child/family member/friend] has indicated that they would use them. Since reducing access to all means of suicide at home is impossible, focus only on those other methods that the [child/family member/friend] says they would use or have used before. For example, lock up car keys if the patient thinks about crashing the car, or using car exhaust.

For suicide methods that are harder to limit (Like cutting, hanging, or suffocation), Make a plan that the patient thinks will be helpful (Which may involve locking away certain objects or having a support person around more often).

- ☐ Not applicable.
- ☐ Plan: ____

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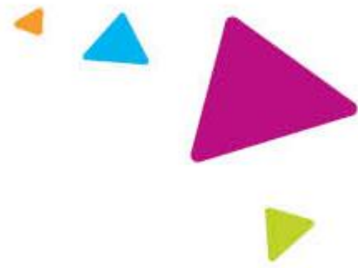
Stabilization Support Plan



Reduce access to objects [child/family member/friend] uses for non-suicidal self-harm (e.g., X-acto blades, blades from razors, makeup pencil sharpeners, lighters).

☐ Not applicable.

☐ Plan: ____

Add visual, tangible reminders of reasons for living and sources of meaning that, the [child/family member/friend] suggests could serve as positive cues for resilience in crises.

☐ Not applicable.

☐ Plan: ____

2. Things I/we can do to cope differently before providing support for a suicidal crisis.

☐ ____
☐ ____
☐ ____
☐ ____

3. Specific, encouraging, supportive words and actions I/we can choose to use in a crisis.

☐ ____
☐ ____
☐ ____
☐ ____

Stabilization Support Plan

4. Additional considerations

- ☐ People who can provide support and help keep an eye on the [child/family member/friend] when needed for extra safety.
  Names: ____

- ☐ People who increase risk for the [child/family member/friend]where I/we will discourage contact?
  Names:____

- ☐ Things I/we can do to help the [child/family member/friend] do things they have identified as life-affirming and healthy (encourage good nutrition, exercise, sleep, habits, fun activities)
  -____
  ____

If I/we cannot continue to provide these supports, or if I believe that the stabilization support plan is not helpful. Or sufficient, I will contact the patient's treatment provider to express concerns.

____

Treatment Provider *Phone#*

If I/we believe the [child/family member/friend] is in immediate danger to self or others, I/we agree to.

- ☐ Call their mental health treatment provider.
- ☐ Call the National Suicide Prevention lifeline. 988.
- ☐ Help them get to a hospital.
- ☐ Call 911 (in an emergency)

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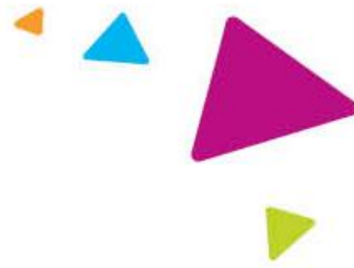
Stabilization Support Plan Resources



- The Complexities of Working with Parents On-Demand Webinar

https://cams-care.com/resources/events/cams-4teens-an-update-on-research-and-practice-webinar/?gad_source=1&gclid=CjwKCAiA8YyuBhBSEiwA5R3-E_4YoEocr4CgCRzw8i9ijOjgJoM_1IGWNrYPLAclDUcGl7-vuGbKoxoCfiAQAvD_BwE

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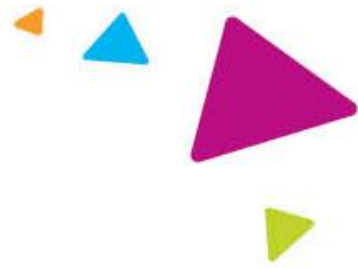
988: A Direct Link for Suicide Prevention and Crisis Support



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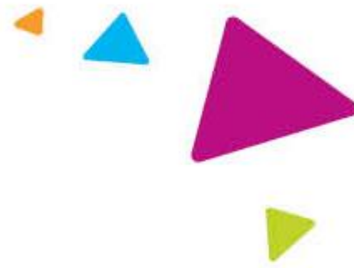

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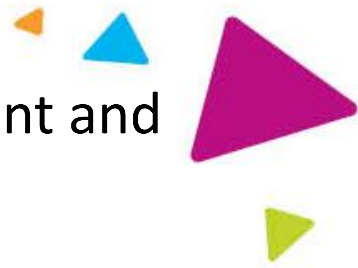

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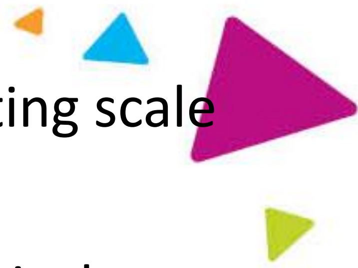

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