

From the Ledge to the Office: A Practical Approach to Suicide Intervention

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Learning Objectives

- Increased confidence to assess and intervene
- Increased awareness of ethical requirements and responsibilities
- Increased self-awareness and self-care



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Overview

- Introduction
- Learning Objectives
- Self-Awareness Check
- Ethical Requirements
- Assessment
- Intervention
- Documentation
- Self-Care
- Self-Awareness Review



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Self-Awareness Check



Self-Awareness Check

- How often do you work with clients who report suicide ideation?
☐ Never ☐ Infrequently ☐ Frequently ☐ Very frequently (more than once a week)
- How often do you work with clients who report suicide ideation?
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Ethical Requirements

- AAMFT: 1.8 **Client Autonomy in Decision Making**... respect the rights of clients to make decisions and help them to understand the consequences of these decisions. (ACA Code of Ethics Preamble)
- AAMFT: 1.10 **Referrals**... assist persons in obtaining appropriate therapeutic services if the therapist is unable or unwilling to provide professional help. (Title 46.2103.11.b; ACA Code of Ethics A.11.a)
- AAMFT: 1.11 **Non-Abandonment**... do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of treatment. (Title 46.2103.11.a; ACA Code of Ethics A.12)
- AAMFT: 2.1 **Disclosing Limits of Confidentiality**... disclose to clients and other interested parties at the outset of services the nature of confidentiality and possible limitations of the clients' right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Circumstances may necessitate repeated disclosures. (Title 46.2105.2.a; 4707.B; ACA Code of Ethics A.12)
- AAMFT: 3.1 **Maintenance of Competency**. Marriage and family therapists pursue knowledge of new developments and maintain their competence in marriage and family therapy through education, training, and/or supervised experience.
- AAMFT: 3.5 **Maintenance of Records**: ...maintain accurate and adequate clinical and financial records in accordance with applicable law.
- ACA Code of Ethics A.4. **Avoiding Harm and Imposing Values**: Counselors act to avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm.

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Test your Knowledge (True or False)

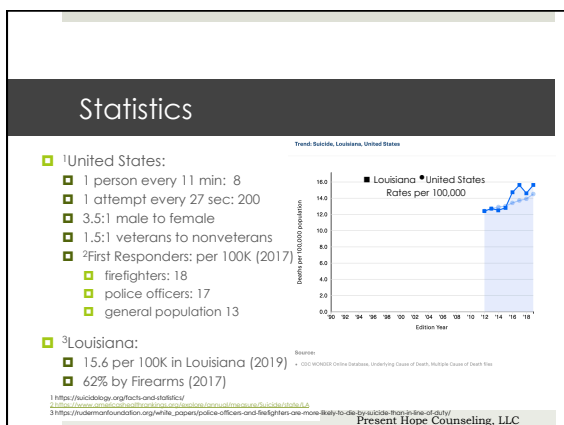
- It is estimated that in 1 in 20 psychotherapist will lose a client to suicide within their career.
 ■ False: 1 in 5 psychotherapist (1); 1 in 6 psychiatric patients will die while in treatment(2)
- Suicide Malpractice is the leading cause of legal action against behavioral healthcare providers.
 ■ True
- Suicide is the 10th cause of death in the United States?
 ■ True
- Asking a person if they are having thoughts about suicide will raise the risk.
 ■ False

(1) Task Force study of community therapists. Macintosh, J. L., Salcott, L., & Jones, F. A., Jr. (1999, April 16). "Therapists as survivors of client suicide." Presentation made at the annual meeting of the American Association of Suicideology, Houston, TX. Summary appears in the Newsletter (61), (2000), Section 99. Proceedings of American Association of Suicideology 20th annual conference, 75-76, Washington, DC, AAS.

(2) Bongio, Bruce. (1991). The Suicide Patient: Clinical and Legal Standards of Care. Washington, DC: American Psychological Association.

(3) Multiple studies summarized by Moravitch, Eve K. (1999). In The Harvard Medical School Guide to Suicide, Editor.

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Ask the Question

- Ask directly
- Ask about a plan
- Ask about lethality
- Ask about access
- Ask about availability

Be aware of your Non-verbal language!!!

"Sometimes people in your situation, with so much hurt and pain, think about suicide."

"It sounds like your burden is heavy. I am wondering if you are having thoughts of suicide."

"I'm wondering if taking your life is something you are considering."

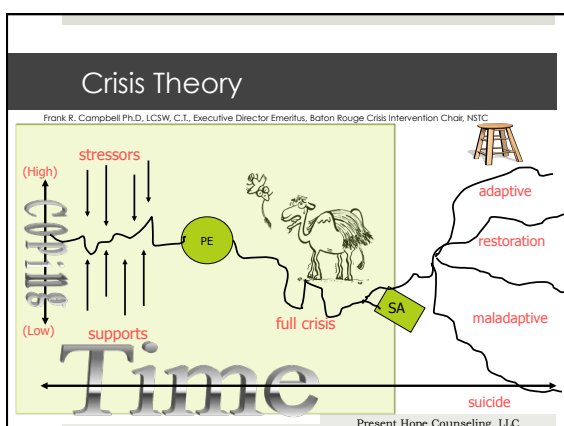
"You think there is no way out. You don't see how this situation will get any better. I am curious...are you thinking suicide is a solution?"

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Do's and Don'ts

DO empathize	DON'T freak out or panic
DO Normalize	DON'T ignore or dismiss
DO reflect	DON'T shame
DO sit with them in the emotional suffering	DON'T become adversarial or judgmental
DO remind them of your duty to protect them	DON'T be too quick to refer
	DON'T restrict the client's autonomy
	DON'T pull out a "No Suicide Contract"

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Risk Factors

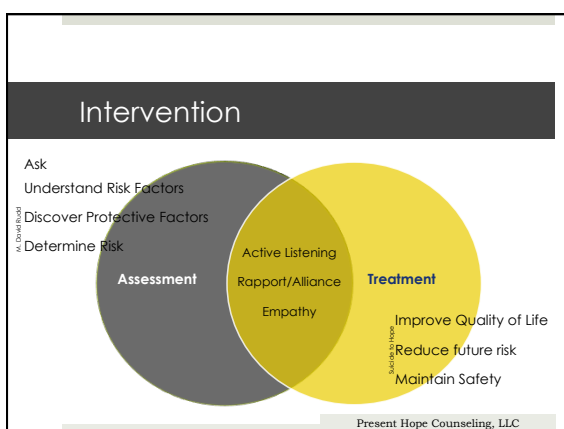
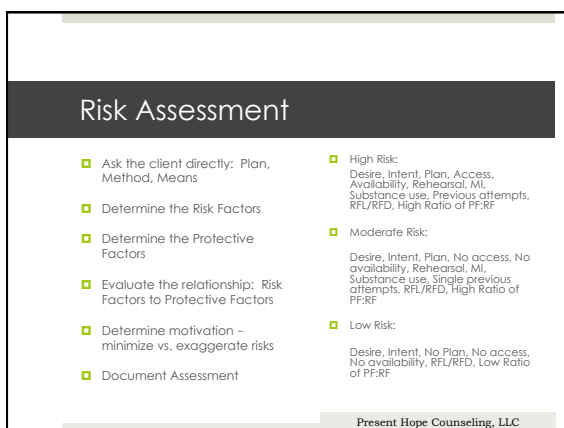
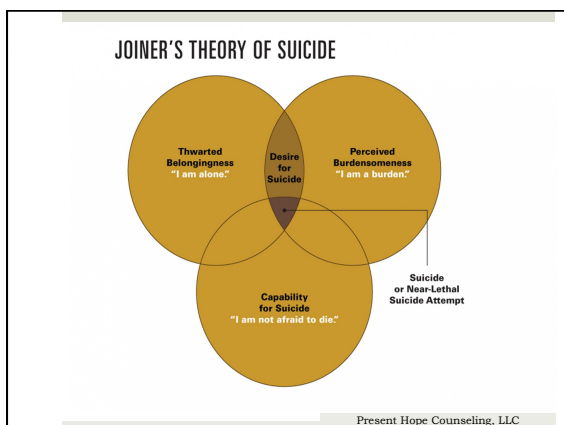
Critical

- Mental Health Illness
- Past Suicide Attempts: single vs multiple
- Substance Abuse

- Impulsivity
- Health/Pain Problems
- Sleep Problems
- Legal or Financial Issues
- Shame/Burden
- Agitation (need to take action)
- Stress
- Hopelessness
- Family History
- Means to Lethality

- Relationship problems
- Lack of Support System
- Significant Loss
- Isolation
- Psychological Pain

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Client Options for Treatment

- Join together in the journey
- Hospitalization, Inpatient care
- Intensive Out-Patient Care
- Refer to another Mental Health provider
- Right to refuse care



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Working in Ambivalence

"If someone is in the clinician's office talking about suicide, he or she is ambivalent. Suicidal people who are not ambivalent about living or dying are not talking to clinicians; they are dead."¹

Reasons for Living

- Family
- Enjoyable Things
- Hopefulness for the future
- Plans and Goals
- Beliefs
- Burdening Others

Reasons for Dying

- Relationships
- Loneliness
- Hopelessness
- General Descriptions of Self
- Escape (general, past, pain, relationships)
- Unburdening Others

1. J. J. J. David A. (2014) Managing Suicide Risk: A Collaborative Approach, 2nd Ed. 34

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"Despite best efforts at suicide assessment and treatment, suicides can and do occur in clinical practice."¹

Roles and Responsibilities

Therapist


- Competency in Assessment and Treatment Interventions
- Limits of confidentiality
- Number, location, time, length, and cost of session
- Client autonomy
- Non-abandonment & Referrals
- Follow-up
- Documentation
- Do no Harm

Client

- Commitment to Treatment
 - Compliance to Appointments
 - Motivation
- Collaboratively approach to Stabilization or Crisis Plan
- Application of Stabilization or Crisis Plan

1. Budd, M. David. (2007). Suicide Assessment & Management Standard of Care Strategies.

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Stabilization Planning

- Commitment to treatment statement- commitment to living
- Builds on a Collaborative relationship - manner of development
- Honors and Values rather than restricts the client's rights
- Individualized
- Identifies roles and responsibilities for both the therapist and the client
- Plan to reduce or remove access and availability to lethal means
- Includes a Crisis Response Plan (moves from self-management to external intervention)
- Details coping strategies and enhances skill-building
- Promotes self-management and social support
- Active and living document

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CRISIS STABILIZATION PLAN

What to reduce access to lethal means

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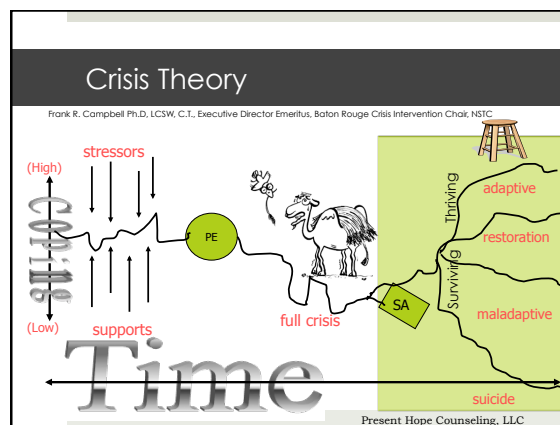
Employ Clinical Interventions that promote Change

- Build resources and systems support
- Build healthy coping strategies
- Determine Suicide "drivers" (direct and indirect)
- Working to alleviate or decrease drivers
- Help them narrate their story of suicide
- CBT, Solutions-focused, Art therapy



I am stuck... I don't see a way out.

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Intervention

In the Field

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Intervention- In the Field

- Case Study in the Field - Michael Mara, "Granddad Bandit"
 - Person of Mara - Public and Hidden
 - Plan of Escape
 - Plan of Action
 - Ambivalent
 - Overview of Intervention - Behavioral Change Stairway

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The Person of Mara- Public face

- Husband
- Step-father
- Grandpa Mike
- "Normal" employee - transport company



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The Person of Mara - Hidden Man

- Convicted Felon
- Wanted in 13 states
- 25 bank robberies
- Self-confessed Con Man



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The Plan



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Plan of Escape

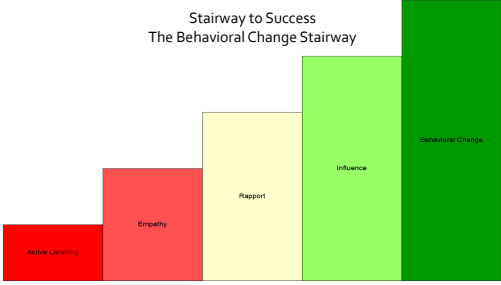
- Past Experience planned his present response
 - "Can't see another way out..."
 - "Can't see a future without pain."
 - "I'm too old to go back."
 - "I just wanted to be away from there and let her find peace."



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Plan of Action

Stairway to Success
The Behavioral Change Stairway




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Working in Ambivalence


What it sounds like...

- "I never felt this way in life."
- "I'm literally pulled in two directions."
- "I'm struggling with myself."
- "One half of me just wants to die right now..."
- "The other half of me is just... (heavy sigh)..."
- "I'm hungry... I am literally talking about killing myself, but I'm hungry."



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Ambivalence



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Working in Ambivalence

The Reasons to Die

- Felon/Con Man
- Fear of Incarceration
- Fear of dying in jail
- Unburdening spouse

We must acknowledge and connect with the person who wants to die before we can connect with and help the person who wants to live

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Working in Ambivalence

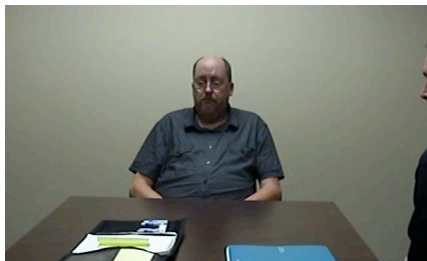


The Reasons to Live

The Reasons to Live

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What do you think now?



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From the Field to the Office

In the Field	In the Office
<ul style="list-style-type: none"> Active Listening Empathy Rapport / Connection Work in Ambivalence Consult Influence Behavioral change Refer to MHP 	<ul style="list-style-type: none"> Active Listening Empathy Rapport/ Connection (Therapeutic Relationship) Work in Ambivalence Collaborative Stabilization Plan Build resources and systems Build healthy coping strategies Employ clinical interventions to promote change Continuation of Care Consult Refer as needed

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Documentation




"...maintain accurate and adequate clinical and financial records in accordance with applicable law."

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When to Document

- Assessment at intake
- Warning signs or clinical change
- Reported thoughts of suicide
- During Treatment
- Consultations



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What to document

- Reported suicide ideation
- Risk and protective factors
- Risk level and rationale, "as evidenced by..."
- Evening and weekend emergency arrangements
- Pertinent Contact/Follow-up
- Input or attempts to employ social support
- Consultations
- Rational for or against hospitalization
- Attempts to have client voluntarily admit to hospital - reasons against, if applicable
- Treatment plan and safety plan
- Changes in care - increases or decreases in treatment
- Special precautions taken, or arrangements made
- Referrals to other Medical or mental health

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Self-care

Self-care is not selfish its "selfness," recognizing and caring for our own needs in order to care for others.

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Self-care

- Physical:
 - Exercise, Rest, Diet/Nutrition, Substance Abuse
- Emotional:
 - personal EQ, learning, personal development
- Relational: (social support)
 - Belonging, self-esteem, community
- Spiritual: belief system



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Self-Awareness Review



- Please review your previous answers on the Self-Awareness questionnaire.
- Did any of your answers change?
- Are you comfortable with your final answers?
- Is there any area you need to develop?

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Assessment Resources

- SAFE-T
 - Samhsa free pdf
 - <https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Tool-for-Clinicians/sma09-4432>
- CAMS – A Collaborative Approach to Managing Suicide Risk
 - <https://cams-care.com>
- Living Works
 - <https://shopusa.livingworks.net>
- The Assessment and Management of Suicidality, M. David Rudd
- The Columbia Lighthouse Project
 - <http://cssrs.columbia.edu/documents/safe-t-c-srs/>

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