



American Mental Health Counselors Association White Paper Series

Understanding Suicide Prevention

This white paper is a preliminary look at the needs of persons at-risk for suicide or suicide attempts. Readers are encouraged to pursue the plentiful evidence-based practices and best practices that are reviewed in widely available publications and sites.

Top 10 Things to Know about Suicide Prevention and Intervention

- 1. Core Competencies, Best Practices, and Evidence-based Practices:** SAMHSA, the Suicide Prevention Resource Center (SPRC), the American Association of Suicidology (AAS), and many experts provide extensive information about standards of care, core competencies best practices and evidence-based treatment. CMHCs should not be led by personal thoughts, feelings, attitudes, or beliefs rooted in unexamined opinion, religion, moral values, or philosophy that are in contradiction to best practices when caring for an at-risk client. CMHCs should seek to align their standards of care with the SPRC/AAS Core Competencies for Assessing and Managing Suicidal Risk in a variety of clinical settings (see www.sprc.org).
- 2. Risk Factors, Protective Factors, and Warning Signs:** CMHCs should become and remain familiar with risk factors, protective factors and warning signs in order to identify potential vulnerability in a client, even if the client does not state or clearly reveal his or her thoughts of suicidality. Warning signs signal that more direct behavioral indicators are manifested by the at-risk individual and more intervention is warranted. See www.suicidology.org for resources on these risk formulation indicators.
- 3. Debilitation with Intent to Die:** Suicidality encompasses suicidal thoughts, ideation, plans for carrying out an attempt, an actual suicide attempt or a completed suicide with **intent to die** by using a method which does or could result in death. Suicide is *not* regarded by experts as a *rational* "choice" (or a decision to "commit" suicide). Rather, it is considered to be a process of debilitation, perhaps acute or chronic, that can become a psychiatric emergency. The burden for knowledge about suicidal risk is on the professional. Clients, even high-functioning ones, should not be presumed to know in depth about suicide risk and preventive management. This is even more true if the client is experiencing disabling depression or symptoms of bipolar disorder, mood dysregulation, sleep deprivation, agitation, unclear thinking, and symptoms concurrent with other psychiatric difficulties. To learn more, read Jamison, 1999; Powell, 2004; and Slaby, 2004, found in the references below.

In 2010, the United States lost 38,364 persons to suicide, now the 10th cause of death in the nation. A suicidal individual or a concerned third party can call the National Suicide Prevention Lifeline (NSPL) at **1-800-273-TALK** (8255) or **1-800-SUICIDE** for immediate assistance.

4. **Acute or Chronic, Low, Moderate, or High:** CMHCs are expected to appropriately assess for and use responsive clinical judgment in order to determine whether a client's risk is Acute or Chronic, and whether this risk is Low, Moderate, or High. Acute risk, or imminent or emergent risk, suggestive that the client could be injured, permanently disabled or die within 24 hours or less (many clinicians may interpret circumstances to be acute even if harm could happen in several days). Chronic risk can become acute, but usually is considered to allow for more time for intervention. Assessment should be done more than one time over the course of a counseling episode, and can be done through best-practice interview techniques by using acronyms such as IS PATH WARM (see www.suicidology.org) or SIMPLE STEPS (McGothlin, 2008) or Shea's researched interview technique known as the CASE Method (2009). Further, there are dozens of paper and pencil assessments such as the Positive and Negative Suicide Ideation Inventory (PANSI) , Sad Persons Scale, the Hamilton Rating Scale for Depression, the Collaborative Assessment and Management of Suicide ([CAMS] Jobes, 2006) and many more. (A search on the internet or with psychological assessment catalogs and/or publishing companies will yield many authenticated tools from which to choose.)
5. **What constitutes acute risk?:** CMHCs should be trained and ready, when conducting an assessment, to evaluate specifically whether the client has the presence of a plan to attempt suicide (a method, the specificity of the plan, the availability of means, when the attempt is scheduled), the degree to which there could be chance of intervention, whether intoxication is present, the degree to which the client feels ambivalent about dying (no ambivalence equals greater risk) and if there are any warning signs (as contrasted with risk factors) of acute risk. These factors assist in the formulation of risk and whether or not the CMHC should provide immediate directives, safety planning, and interventions.
6. **One size does not fit all:** Not all persons at risk for suicide can be or should be hospitalized. CMHCs should become familiar with formulation of risk assessment and appropriate interventions to match risk. For example, low risk of a chronic nature may not warrant hospitalization or inpatient observation. Instead, increased care from the private practice and/or community mental health setting may be a better response to manage suicide risk over time. Interventions may include increased frequency of sessions, recurring assessment and safety plan "tweaking," development of a vigilance "syllabus" for the client so as to plan for vulnerable times, etc. Other interventions can be obtained by consulting Rudd (2006), McKeon (2009), Jobes, (2006), and other evidenced based practice experts.
7. **Risk Groups:** Persons who have attempted suicide in the past are considered one of the very highest risk groups for a repeat attempt. Their thoughts of suicide should be taken very seriously even if they deny the seriousness of their thoughts. Other high risk categories of concern would be persons who have lost a family member to suicide or were impacted by a family member's attempt, along with persons who recently (hours, days, weeks, months) have been discharged from the hospital for a psychiatric inpatient visit with suicidal risk. Persons who have begun to take medication recently for depression (3 months or so, as medication may provide energy to attempt suicide without the presence of

Internet Resources and National Call Center

- American Association of Suicidology: <http://www.suicidology.org>
- American Foundation for Suicide Prevention: <http://www.afsp.org>
- Suicide Prevention Resource Center: <http://www.sprc.org>
- National Suicide Prevention Lifeline, **1-800-273-TALK** (8255) Free, confidential, 24/7, available to civilians, military and veterans, and concerned third party persons. NSPL also manages the **1-800-SUICIDE** helpline. Callers to these lines are linked with nearest NSPL-network crisis centers and local resources.

insight and new coping skills that become possible with longer therapy + medication). A myth about suicide is that asking someone if he or she is suicidal can "make" a person become so; persons who are *not* asked are actually at greater risk. Finally, while the client in one's office is a "one-person sample" and could be at risk for suicide independent of what is known about large risk group categories, CMHCs should know that there are higher rates of suicide among these risk groups: military personnel and veterans, Native Americans, persons older than age 65, youth and young adults, LGBTQ persons, victims of bullying and bullies themselves, victims of trauma and more. See www.afsp.org, www.suicidology.org, www.cdc.org, or SAMHSA (2009) for extensive information about facts and statistics of suicide incidence.

8. **Safety Planning:** CMHCs who were trained to use a "no-harm contract" should seek re-training and professional literature immediately about the now preferred "Safety Plan." Implementation of a Safety Plan is considered a standard of practice and should be formed and customized specifically with each client at risk, perhaps multiple times as conditions change. Safety plans should address specific, behavioral strategies for how the client, perhaps with the help of the clinician, and/or family members or other agents, will restrict access to means, soothe self during times of distress, attend to self-care, involve family members or trusted allies, what to do in a crisis, and more attentive care if necessary. See the writings from Stanley and Brown, Jobes (2006), and others for current safety planning design and use. Although some authors use alternative language to describe the many issues that safety plans address (such as crisis response plan, or self-care plan), the preferred term is **safety plan**. Other verbiage diminishes the importance comprehensive safety planning; self-care, crisis plan, etc., are considered components of a thorough safety plan.
9. **Public Health and Mental Health as a Team:** The current National Strategy for Suicide Prevention (2012) along with many states' strategic initiatives are rooted in a public health model. Many, perhaps all members of society, are encouraged to share in prevention by recognizing warning signs, facilitating access to appropriate help, and by caring for rather than judging an at-risk person. CMHCs may note that the mental health field alone cannot prevent all suicides and should adopt a multi-systemic view of and engage the multiple team players available to assist in its prevention including families, communities, schools, employers, faith communities, law enforcement and corrective institutions, first responders, emergency departments, primary care physicians, crisis centers and call in helplines, and community mental health supports, and more. See the National Strategy for Suicide Prevention at www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/.
10. **Current Nomenclature:** Terminology about suicide prefers the use of these terms: a. Preferred: *Died from suicide* or *Completed suicide* over the old Antiquated: *Committed suicide* or *Chose to end life*; b. Preferred: *Survivor* or *survivor of suicide loss* not to be confused with survivor of an attempt; c. Someone who has attempted suicide is more commonly referred to as an Attempter or Attempt survivor. Finally, persons who cut or injure themselves may or may not be suicidal. The most important clarifying variable for clients who injure themselves is the intent to die. Appropriate treatment decisions should be applied to either class of clients who have or do not have intent.

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Developing white papers on current topics of interest to mental health clinicians is a responsibility of the Professional Development Committee of the American Mental Health Counselors Association (AMHCA). The white papers give a brief orientation to clinical mental health counselors about topics relevant to current practice. Current AMHCA white papers address technology in counseling, trauma-informed practices, and responding to suicide risk.

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