B5 Suicide Prevention with Youth: Implementing Suicide Prevention Protocols in Your Agency, Part 1

Wednesday, June 15, 2016, 1:30-3:00 p.m.

C5 Suicide Prevention with Youth: Implementing Suicide Prevention Protocols in Your Agency, Part 2

Wednesday, June 15, 2016, 3:30-5:00 p.m.

Jessica Holzer, Melissa Geiger

Salon 6

SUICIDE PREVENTION PROTOCOL

Jessica Holzer, M.A., LMFT
Melissa Geiger, M.S., IMF
Sonia Gligian, M.S.W., LCSW

Developed for all the children and families we have served
and continue to serve, especially those in San Diego.

Overview

This protocol will provide specific implementation of suicide psychoeducation, assessment, prevention, and intervention including safety planning in a manner that will both empower direct service providers and individuals in the community, including caregivers, to appropriately and confidently address suicide with all client populations, though this protocol centers on practices with youth and families. Within a protocol created by the authors, this protocol is introducing the Columbia Suicide Severity Rating Scale (C-SSRS) developed by Dr. Kelly Posner at the New York Psychiatric Institute. These assessments were created to be utilized by anyone, anywhere and has been adopted by the CDC as a comprehensive and universal assessment for suicide. The authors hope to normalize the conversation around suicide while also illustrating the importance of being direct and efficient in assessment and implementation of interventions for suicide prevention.

Table of Contents

Introduction

As direct care providers to a very special population of children and families, the authors of this protocol quickly noticed that suicide prevention was not an adequately discussed topic among clients or providers. Trainings were short and lacked detail on how to work with children and families specifically when suicidal ideation or behaviors became a focus of treatment. Additionally, current protocols simply instructed professionals and paraprofessionals to call local psychiatric teams to take the child to be assessed at an Emergency Screening Unit and then safety plan after the child "agreed to safety."

These first order interventions allowed for a momentary relief from the crisis at hand. However, as the authors experienced, a pattern emerged where youth were being hospitalized up to several times a month. Clearly, second order change was needed. As a result, this team of authors actively engaged in additional trainings on suicide prevention, joined the local Suicide Prevention Committee in San Diego, and began identifying the needs of clients who were experiencing suicidal thoughts and behaviors. These actions initiated active and normalizing conversations about how the authors' current program was working with these high risk children and families, leading to the development of this protocol.

The purpose of developing this protocol was clear. The authors wanted to develop a protocol that targeted children and families who were experiencing suicidal thoughts and behaviors in order to reduce hospitalizations and screenings (experiences many children and families described as "traumatic") and ultimately, to educate and empower parents to help their children. As a result, the goal became to develop this protocol to share with as many providers as possible to standardize the practice of working with high risk children and families and promote safety.

Recognizing that every county, every program, and every client is different, the authors hoped that this protocol could be applied to many populations. However, these interventions are meant to be edited and altered in order to fit individualized needs as well. Due to the fact that many trainings the authors attended were not focused on children, the authors developed additional tools to assist providers in having efficient and effective conversations with children

and families about suicide. This protocol is simply a guide for crisis management of suicide for all levels of professionals. The authors strongly feel providers should attend their own trainings to learn more about suicide and prevention.

This is just one example of a suicide prevention triage plan that was specifically developed for Mental Health Systems, Families Forward Wraparound Program, but there are many more examples that have utilized and published. Several examples can be found on the C-SSRS website. The authors hope that this protocol is helpful and effective and would like to hear feedback on the implementation of this protocol in your own programs or practice. Please contact us with your questions, concerns, or comments. Our contact information is listed in the back of this protocol.

Thank you for helping our communities understand suicide better and contributing to the reduction of suicide,

Jessica, Melissa, and Sonia

2016

How to Implement This Protocol

**Use your clinical judgement; this is simply a helpful guide.

**At any step of this process, consider the safety of the client and yourself first.

**Additional information on these steps, the assessment, and the tools are provided in this protocol.

At Intake:

1. Within the intake/assessment period, complete the C-SSRS regardless. Every person *needs* to be asked.
    - Ages 12 and younger or Cognitively Impaired: Use the C-SSRS Lifetime Pediatric Version
    - Ages 12 and older: Use the C-SSRS Lifetime Version
2. Complete the Youth/Adolescent Risk Assessment for Clinical Use (located on the back of the C-SSRS) to document and assist in determining risk level.
3. Initiate safety planning tools with client and family.

Continuing Assessment:

1. Throughout services, use the C-SSRS Last Visit Scale each time client is discharged from the hospital or as needed.
    - Face to face follow up with client should be within 72 hours from discharge.
2. Utilize the Weekly Check In worksheet to facilitate conversation as an informal assessment.
3. Initiate the C-SSRS Screener as needed.

Safety Planning Tools:

1. If a client endorses suicidal thoughts or behaviors, create and complete the following tools to safety plan with the client and (if possible) family or other informal supports.
    1. Individual Safety Plan
    2. Crisis Thermometer
    3. Emergency Response Plan
    4. Provide Resources
    5. Additional required program safety and prevention plans
2. Share safety planning tools with other providers if applicable to increase communication and continuity of care among services to better support the client.

Psychoeducation:

1. When client is safe and calm, provide psychoeducation on suicide and suicide prevention.
2. Utilize Parent Fact Sheets with families and caregivers.
3. Educate client on where information can be found about suicide.

Follow Up

1. Follow up with clients to ensure safety and continued care.

Assessments

"Screening normalizes the conversation...We need to change the culture so that it becomes like taking your blood pressure — everybody gets asked and everybody deals with it."

—Dr. Kelly Posner

Dr. Posner was reported to say this statement following the Germanwings Flight 9525 in March 2015 after the pilot intentionally crashed the carrier plane (Reuters, 2015). The essential assessments utilized in this protocol, the Columbia Suicide Severity Rating Scales (C-SSRS), Risk Assessment, and Screener, were developed by Dr. Kelly Posner from the New York State Psychiatric Institute. The majority of the training of the authors participated in were also facilitated by Dr. Posner and her associates. Dr. Posner stated that she developed these assessments in a way that anyone, anywhere can use the tools developed. **No mental health training is needed to administer these scales.** Her goal was also to normalize the conversations and universalize assessment of suicide among all providers using the same tools. At this time, hospitals, schools, jails, public health settings, and the military are utilizing these scales and assessments for suicide risk assessment. Many states have adopted these scales as part of their standard practice in assessing for a suicide risk and the Center for Disease Control and Prevention (CDC) is using the same language in their own protocols. For additional information, training, and copies of all the scales including translations of these assessments developed by Dr. Posner, please visit http://www.cssrs.columbia.edu.

The other assessment included in this section, the "Weekly Check In", was developed by the authors of this protocol. This was added to help providers and caregivers facilitate conversation about risk factors related to suicidal ideations and behaviors as well as give clients a different way to communicate their needs and concerns.

The following section reviews the assessments included in this protocol as well as copies of the assessments.

C-SSRS LIFETIME SCALE

The C-SSRS Lifetime Scale allows the practitioners to gather lifetime of suicidality, as well as suicidal ideation and behavior within the past three months. In assessing behavior, the scale is used to capture all the lifetime experiences. However, for ideation, which is difficult to average throughout a lifetime, the scale creates a point of reference of "the time the person felt most suicidal," which has been shown to be the most predictive of completed suicide in the future. This scale should be utilized at the assessment or intake phase when working with all clients. Again, these questions are suggested probes, as indicated on the scale, and ultimately the presence of suicidal ideation and/or behavior should depend of the clinical judgement of the person administrating the scale. While there is no specific scoring, scaling is included to assist in assessment and documentation. When working with children, you may be asking these questions to the child individually based on maturity/ability or to the caregiver.

The scale included here is the Pediatric/Cognitively Impaired English version. Other versions, including the Adult scale, Military Specific, and other language translations can be found on the C-SSRS website http://www.cssrs.columbia.edu.

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Pediatric/Cognitively Impaired – Lifetime Recent - Clinical

Version 6/23/10

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in ***The Columbia Suicide History Form****, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.]* Standardized Evaluation in Clinical Practice, *pp. 103 -130, 2003.)*

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact *posnerk@nyspi.columbia.edu*

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 Felt Most Suicidal		Past 1 month	
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 ever wish you weren't alive anymore?*** If yes, describe:	Yes ☐	No ☐	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 ☐	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 ☐	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 ☐	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 ever decided how or when you would make yourself not alive anymore/kill yourself? Have you ever 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 ☐	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	Most Severe
Lifetime - Most Severe Ideation: _____ *Type # (1-5)* _____ *Description of Ideation*		
Recent - Most Severe Ideation: _____ *Type # (1-5)* _____ *Description of Ideation*		
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	____	____

SUICIDAL BEHAVIOR

(Check all that apply, so long as these are separate events; must ask about all types)

	Lifetime	Past 3 Months
Actual Attempt:	Yes No	Yes No
A potentially self-injurious act committed 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.		
Did you ever <u>do anything</u> to try to kill yourself or make yourself not alive anymore? What did you do?		
Did you ever hurt yourself on purpose? Why did you do that?	Total # of Attempts	Total # of Attempts
Did you_____ as a way to end your life?		
Did you want to die (even a little) when you_____?		
Were you trying to make yourself not alive anymore when you _____?	_____	_____
Or did you think it was possible you could have died from_____?		
Or did you do it purely for other reasons, <u>not at all</u> to end your life or kill yourself (like to make yourself feel better, or get something else to happen)? (Self-Injurious Behavior without suicidal intent)		
If yes, describe:		
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	Yes No ☐ ☐	Yes No ☐ ☐
Has subject engaged in Self-Injurious Behavior, intent unknown?	Yes No ☐ ☐	Yes No ☐ ☐
Interrupted Attempt:	Yes No	Yes No
When the 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 make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?	Total # of interrupted	Total # of interrupted
If yes, describe:	_____	_____
Aborted or Self-Interrupted Attempt:	Yes No	Yes No
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 make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?	Total # of aborted or self-interrupted	Total # of aborted or self-interrupted
If yes, describe:	_____	_____
Preparatory Acts or Behavior:	Yes No	Yes No
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 done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?	Total # of preparatory acts	Total # of preparatory acts
If yes, describe:	_____	_____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage:	*Enter Code*	*Enter Code*	*Enter Code*
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			
Potential Lethality: Only Answer if Actual Lethality=0	*Enter Code*	*Enter Code*	*Enter Code*
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).			
0 = Behavior not likely to result in injury			
1 = Behavior likely to result in injury but not likely to cause death			
2 = Behavior likely to result in death despite available medical care			

C-SSRS SINCE LAST VISIT SCALE

This version of the scale is to be used assess suicidality since the client's last visit, either from the hospital or since the last time someone assessed the client. This should be used after the Lifetime scale was completed. In effect, this scale may be administered multiple times and/or consistently with clients. As always, these questions are suggested probes, as indicated on the scale, and ultimately the presence of suicidal ideation and/or behavior should depend of the clinical judgement of the person administrating the scale. While there is no specific scoring, scaling is included to assist in assessment and documentation. When working with children, you may be asking these questions to the child individually based on maturity/ability or to the caregiver. Additionally, a protocol should be identified for a face to face visit with a client after a suicide attempt and/or hospitalization (e.g. San Diego country requires a provider to have a face to face meeting within 72 hours after a client is hospitalized).

The scale included here is the Pediatric/Cognitively Impaired English version. Other versions, including the Adult scale, Military Specific, and other language translations can be found on the C-SSRS website http://www.cssrs.columbia.edu.

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Pediatric/Cognitively Impaired - Since Last Visit - Clinical

Version 6/23/10

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in ***The Columbia Suicide History Form****, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.]* Standardized Evaluation in Clinical Practice, *pp. 103 -130, 2003.)*

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact *posnerk@nyspi.columbia.edu*

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

Most Severe Ideation: _____ _____

Type # (1-5) ***Description of Ideation***

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

____

SUICIDAL BEHAVIOR

(Check all that apply, so long as these are separate events; must ask about all types)

Since Last Visit

Actual Attempt:

A potentially self-injurious act committed 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.

Did you <u>do anything</u> to try to kill yourself or make yourself not alive anymore? What did you do?

Did you hurt yourself on purpose? Why did you do that?

Did you_____ as a way to end your life?

Did you want to die (even a little) when you_____?

Were you trying to make yourself not alive anymore when you _____?

Or did you think it was possible you could have died from_____?

Or did you do it purely for other reasons, <u>not at all</u> to end your life or kill yourself (like to make yourself feel better, or get something else to happen)? (Self-Injurious Behavior without suicidal intent)

If yes, describe:

Yes ☐ No ☐

Total # of Attempts _____

Has subject engaged in Non-Suicidal Self-Injurious Behavior?

Yes ☐ No ☐

Has subject engaged in Self-Injurious Behavior, intent unknown?

Yes ☐ No ☐

Interrupted Attempt:

When the 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 make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?

If yes, describe:

Yes ☐ No ☐

Total # of interrupted _____

Aborted Attempt 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 make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?

If yes, describe:

Yes ☐ No ☐

Total # of 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 done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?

If yes, describe:

Yes ☐ No ☐

Total # of preparatory acts _____

Suicide:

Death by suicide occurred since last assessment.

Yes ☐ No ☐

Most Lethal Attempt Date:

Actual Lethality/Medical Damage:

Enter Code

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

Potential Lethality: Only Answer if Actual Lethality=0

Enter Code

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).

0 = Behavior not likely to result in injury
1 = Behavior likely to result in injury but not likely to cause death
2 = Behavior likely to result in death despite available medical care

SCREENER

The Screener is a shortened version of the C-SSRS Lifetime and Since Last Visit Scale. This Screener has a total of six questions. The intention of this screener is to triage clients (or anyone!) immediately if suicidal ideation is suspected or reported. Used in emergency room settings and crisis centers, the screener is intended to be utilized for non-mental health providers. The Screener includes the information necessary to make an assessment regarding a person's feelings of suicidality. There are five questions about the severity of suicidal ideation and one question about suicidal behaviors. It is recommended for all professionals and paraprofessionals to memorize these questions in order to be ready for any situation that needs triage. Additionally, this is a helpful tool to teach caregivers (and other members of the community) on assessing for suicide. This tool can be used to empower caregivers to be direct when ensuring the safety of their children (and others).

Additional information about the Screener can be found on the C-SSRS website http://www.cssrs.columbia.edu.

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
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?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: 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? Do you intend to carry out this plan?***		
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *How long ago did you do any of these?*** · Over a year ago? · Between three months and a year ago? · Within the last three months?		

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

RISK ASSESSMENT

The Risk Assessment Page is not as much as an assessment, but rather a checklist for risk and protective factors for suicidality. The goal of this Risk Assessment is to increase accountability for suicide-relevant variables as well as other risk and protective factors in place to assist the professional to weigh these factors for determining overall risk and treatment planning. The risk factors and protective factors listed have been empirically researched. This page can be utilized in several ways including clearer communication between providers, better documentation, and suggestions for safety plans, treatment plans, etc. This page should be completed after the Lifetime Scale is completed and consistently updated as necessary.

There is a youth version as well as an adult version. The youth version takes in to account additional factors such as bullying, exposure to a peer's suicide, and disciplinary crises into account.

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

RISK ASSESSMENT

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Past 3 Months	Suicidal and Self-Injurious Behavior	Lifetime
☐	Actual suicide attempt	☐
☐	Interrupted attempt	☐
☐	Aborted or Self-Interrupted attempt	☐
☐	Other preparatory acts to kill self	☐
☐	Self-injurious behavior ***without*** suicidal intent	☐

Suicidal Ideation
Check Most Severe in Past Month

☐	Wish to be dead
☐	Suicidal thoughts
☐	Suicidal thoughts with method (but without specific plan or intent to act)
☐	Suicidal intent (without specific plan)
☐	Suicidal intent with specific plan

Activating Events (Recent)

☐	Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)

Describe:

☐	Pending incarceration or homelessness
☐	Current or pending isolation or feeling alone

Treatment History

☐	Previous psychiatric diagnoses and treatments
☐	Hopeless or dissatisfied with treatment
☐	Non-compliant with treatment
☐	Not receiving treatment

Other Risk Factors

☐	
☐	
☐	

Clinical Status (Recent)

☐	Hopelessness
☐	Major depressive episode
☐	Mixed affective episode (e.g. Bipolar)
☐	Command hallucinations to hurt self
☐	Highly impulsive behavior
☐	Substance abuse or dependence
☐	Agitation or severe anxiety
☐	Perceived burden on family or others
☐	Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.)
☐	Homicidal ideation
☐	Aggressive behavior towards others
☐	Method for suicide available (gun, pills, etc.)
☐	Refuses or feels unable to agree to safety plan
☐	Sexual abuse (lifetime)
☐	Family history of suicide (lifetime)

Protective Factors (Recent)

☐	Identifies reasons for living
☐	Responsibility to family or others; living with family
☐	Supportive social network or family
☐	Fear of death or dying due to pain and suffering
☐	Belief that suicide is immoral; high spirituality
☐	Engaged in work or school

Other Protective Factors

☐	
☐	
☐	

Describe any suicidal, self-injurious or aggressive behavior (include dates)

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

RISK ASSESSMENT – YOUTH/ADOLESCENT

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Past 3 Months	Suicidal and Self-Injurious Behavior	Lifetime
☐	Actual suicide attempt	☐
☐	Interrupted attempt	☐
☐	Aborted or Self-Interrupted attempt	☐
☐	Other preparatory acts to kill self	☐
☐	Self-injurious behavior ***without*** suicidal intent	☐

Suicidal Ideation: Check Most Severe in Past Month	
☐	Wish to be dead (1)
☐	Suicidal thoughts (2)
☐	Suicidal thoughts with method (but without specific plan or intent to act) (3)
☐	Suicidal intent (without specific plan) (4)
☐	Suicidal intent with specific plan (5)

Activating Events	
☐	Significant negative event(s) resulting in loss, conflict or humiliation/shame (legal, financial, relationship, familial, occupational, health, etc.)
Describe:	
☐	Current or pending homelessness
☐	Current or pending isolation or feeling alone
☐	Exposure to suicide of peer
☐	Disciplinary crisis (incarceration or expulsion)
☐	Victim of Bullying or Cyberbullying
☐	Truancy or runaway behaviors

Treatment History	
☐	Not receiving treatment
☐	Previous psychiatric diagnoses and treatments
☐	Hopeless or dissatisfied with treatment
☐	Non-compliant with treatment
☐	Refuses or feels unable to agree to safety plan

Other Risk Factors	
☐	

Clinical Status (Current)	
☐	Hopelessness
☐	Major depressive episode
☐	Mixed affective episode (e.g. Bipolar)
☐	Command hallucinations to hurt self
☐	Highly impulsive behavior, recklessness
☐	Substance abuse or dependence, cigarettes
☐	Agitation or severe anxiety (panic symptoms)
☐	Perceived burden on family or others
☐	Chronic physical pain or other acute medical problem (e.g. HIV/AIDS, cancer, etc.)
☐	Homicidal ideation, perpetrator of violence
☐	Aggressive/Disruptive behavior (Conduct DO)
☐	Method for suicide available (gun, pills, etc.)
☐	History of physical abuse, sexual abuse or dating violence
☐	Sleep Disturbance
☐	Eating Disorder

Parent and Family	
☐	Parent with mood disorder symptoms
☐	Parent with legal problems
☐	Family history of suicide ideation or bx (lifetime)
☐	Poor attachment/lack of communication with parent

Protective Factors (Current)	
☐	Identifies reasons for living
☐	Responsibility to others; living with family
☐	Supportive social network or family
☐	Fear of death or dying due to pain and suffering
☐	Belief that suicide is immoral; high spirituality
☐	Engaged in work, school or sports
☐	High academic achievement

Describe any suicidal, self-injurious or aggressive behavior (include dates):

WEEKLY CHECK IN

The Weekly Check In assessment was developed by the authors in response to working with children (particularly adolescents!) who struggled to express their thoughts and feelings verbally, especially in front of others. The questions included should be direct and related to the current risk and protective factors that were identified. Other questions can be included as well (i.e. taking current prescribed medications, drug and alcohol use, etc.) that may be of clinical interest. This assessment is meant to be a template and encouraged to be modified and edited to meet the needs of the client. This Weekly Check In can be used weekly or as needed. The response from families and children using the scale has been positive and has been reported to increase self awareness by expanding emotional vocabulary and helping children practice self monitoring skills. The authors' hope is to use the Weekly Check In to contribute to a conversation about risk and protective factors with clients and that it will be an individualized process for each client during this assessment and safety planning process.

Where Am I At?

[Client's name]_____ **[Date]**_____

1. Have you actually had any thoughts of killing yourself?

   Yes__ No___

2. Have you self-harmed in the last 7 days?

   Yes__ No___

3. Have you ever done anything, started to do anything, or prepared to do anything to end your life?

   Yes__ No___

4. Have you made any suicidal attempts within the last 7 days?

   Yes__ No___

5. Do you want to kill yourself?

   Yes__ No__

6. Do I have a plan? If yes, what is it:

When using this form for the first time discover "non-negotiable" number. If client reports that number during future check-ins---immediate hospitalization

7. On a scale of 1-10, at what number do I need to go to the hospital?(non-negotiable)

   My non-negotiable number is:

   - Ex: 1-----5----8----10

Where Am I At?

8. Have I used [SUBSTANCE] within the last 7 days?

   Yes___ No___

   If yes, how often_____.

9. Have I consumed alcohol within the last 7 days?

   Yes__ No__

   If yes, how often_____.

10. Am I taking my medication like the doctor prescribed?

    Yes___ No___

11. On a scale of 1-10 (10 being the highest) how happy am I today?

    1---------- 5 ---------- 10

12. Today I am feeling_____.

DECISION TREE FOR CLINICIANS

As discussed previously, the C-SSRS does not provide direct quantitative results that gives specific direction to the clinician. Instead, results from the C-SSRS were intended to be interpreted by the clinician at the time of administration. The authors found clinicians struggled with the openness of the results at times and struggled to decide what to do next should a client endorse the items on the C-SSRS. As a result, the authors developed a Decision Tree for providers based on the Wraparound Model and specific to their current program.

The Decision Tree here can be used as a template for other programs and should be modified to fit protocols set by the clinician's program or practice. There are many examples of these decision trees developed by hospitals, other mental health programs, and even entire states. These other examples can be found in Dr. Posner's materials on the C-SSRS website http://www.cssrs.columbia.edu.

Clinician Decision Tree

After completing the Columbia-Suicide Severity Rating Scale, either Lifetime, Recent, or Screener, review the following decision tree to determine the next steps.

NOTE Endorsement of any question on the scale could also indicate a need for further evaluation or clinical management depending on the population or context, however, a positive answer to Question 4 or 5 in the past month or any behavior in the past 3 months indicate a more emergent clinical situation.

Level of Risk	Triage/Policy	Possible Interventions
High Risk ☐ Suicidal Ideation with intent or intent with plan in the past month *(C-SSRS Suicidal Ideation Question #4 or #5)* **OR** ☐ Suicidal Behavior within past 3 months *(C-SSRS Suicidal Behavior)*	Refer to the Emergency Screening Unit (ESU) for Evaluation Develop plan and follow up with ESU to coordinate care Notify other team members of possible hospitalization Complete/Review Suicide Prevention Protocol Safety Planning tools Update High Risk Assessment (HRA) in Cerner	☐ Family/Caregiver meetings to plan for client's discharge ☐ Other referrals for increased support (i.e. CAC) ☐ Update Behavioral Health Assessment (BHA) ☐ Increase contact with client ☐ Review and utilize interventions below if not previously initiated
Moderate Risk ☐ Suicidal Ideation WITHOUT plan, intent, or behavior in past month *(C-SSRS Suicidal Ideation Question #2 or #3)* **OR** ☐ Suicidal Behavior more than 3 months ago *(C-SSRS Suicidal Behavior)* **OR** ☐ Multiple Risk Factors and Few Protective Factors	Continue Wraparound services Ensure clinician has assessed client to evaluate risk factors and determine appropriate treatment plan Notify other team members of ideation Complete/Review Suicide Prevention Protocol Safety Planning tools	☐ Explore other treatment options (i.e. psychiatry, group therapy) if not already in treatment plan ☐ Educate parent/family/caregivers on warning signs and encourage to use Safety Planning Tools with clinician support ☐ Review and utilize interventions below if not previously initiated
Low Risk ☐ Wish to die with no plan, intent, or behavior *(C-SSRS Question #1)* **OR** ☐ Suicidal Ideation more than one month ago WITHOUT plan, intent, or behavior *(C-SSRS #2 or #3)* **OR** ☐ Modifiable Risk Factors and Strong Protective Factors **OR** ☐ No reported history of Suicidal Ideation or Behavior	Continue Wraparound services Notify other team members of ideation Complete/Review Suicide Prevention Protocol Safety Planning tools	☐ Provide information about warning signs ☐ Provide Suicide Prevention Resources ☐ Re-assess treatment plan if not a previous focus of treatment ☐ Document plan for safety in progress note ☐ Discuss in Case Consults/Supervision ☐ Develop a check in plan throughout the week in between next wrap meeting ☐ Review Connect-O-Gram for possible supports ☐ Review/Modify current safety plan

Severity of Ideation Subscale: Consists of 5 questions that reflect five types of ideation in increasing severity

Suicidal Behavior Subscale: Includes questions about 4 suicidal behaviors and non-suicidal self-injurious behavior.

Intensity of Ideation Subscale: Includes 5 questions about Frequency, Duration, Controllability, Deterrents, and Reasons for Ideation for the most severe level of ideation endorsed on the Severity Subscale (i.e. highest endorsed from 1 to 5).

- The total score ranges from 2 to 25, with a higher number indicating more intense ideation and greater risk.

Suicidal Behavior Lethality: Inquires about the level of actual medical damage or potential for it

- Greater lethality or potential lethality of the behavior indicates greater risk

Safety Planning

After assessing a client, safety planning will be needed. Research shows that "No Suicide Contracts" are not effective, but thorough planning with a client can be life or death. In this section we have several crisis prevention planning tools were developed and adapted by the authors. Safety planning should be done when client and family is in a calm, regulated state so that they may open for suggestions and brainstorming. Additionally, it will be important to include many informal supports to help the client follow through with the safety plan. However, these informal supports also need to agree to be an active participant if needed.

These plans should be shared among other providers as well as they encourage collaboration for the client, the family, and providers as well as promote continuity of care. Additionally, providers should create multiple copies for the client and other supports and possibly laminate copies for families. When developing the plans, providers should take the time to deeply explore client's responses. For example, instead of simply excepting a response of a family member as someone to call if help is needed, the provider should explore when was the last time the client spoke with this person, how far away does this person live, or does the client have accurate contact information. Thorough exploration of the client's responses to the prompts on the safety plans assist clients and providers to develop effective safety planning tools that could save their life.

INDIVIDUAL SAFETY PLAN

This Individual Safety Plan was adapted by the authors from a safety plan that was already developed by the Suicide Prevention Resources Center and the WICHE Mental Health Program. The example in this protocol is adapted for a specific program, but should be adapted to the program using the safety plan. The authors also added a list of examples of triggers, warning signs, and interventions to assist clients and family develop ideas that may contribute to the safety plan.

The safety plan here has seven sections. The first section helps clients identify triggers and warning signs to suicidal feelings. The provider can help by reminding client of past behaviors or events, but should also look and feelings in the body and consider risk factors previously identified. The second section looks at internal coping strategies that the client can do on their own, *without* help from others. This section is a great way to help a client explore strengths, interests, and motivators by including things that will help the client take their mind off problems. Section three identifies people and places that provide distraction. This is the section where youth can write in their friends as support: people that cannot specifically take action to help the client if they are in trouble, but people they can call to talk to about the problem or something to distract from thoughts or problems. Safe places are also good to identify, but explore transportation and access to resources if the crisis escalates. The fourth section identifies people the client can ask for help i.e. people that will take action should the crisis escalate. Section five lists the providers and/or professional that can be called for emergency assistance. The last step has ways to make the environment safe. For example, this may mean locking up knives, taking guns out of the home, someone else managing the client's pills, etc.

The last point on the safety plan is asking the client the one thing that is worth living for. Clients have responded positively to this question, especially when not pressured to respond in a certain way. The original template for this plan can be found on the Suicide Prevention Resources Center website here: http://www.sprc.org/sites/sprc.org/files/SafetyPlanTemplate.pdf

_____'S SAFETY PLAN

Step 1: Triggers and Warning Signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal Coping Strategies – Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity):

1. _____
2. _____
3. _____

Step 3: People and Places that provide distraction:

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____

Step 4: People whom I can ask for help:

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____

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

1. Wrap Facilitator: _____ Phone: _____
2. Wrap Coach: _____ Phone: _____
3. Family Support Partner: _____ Phone: _____
4. Therapist: _____ Phone: _____
4. Psychiatrist: _____ Phone: _____
5. Access & Crisis Line: Phone: 1.888.724.7240
6. Suicide Prevention Lifeline: Phone: 1.800.273.8255
7. Psychiatric Emergency Response Team (PERT)/Sheriff: Phone: 911
8. Emergency Screening Unit: Phone: 619.421.6900

Step 6: Making the Environment Safe:

1. _____
2. _____

The one thing that is important to me and worth living for is:

TRIGGERS:	WARNING SIGNS:	INTERVENTIONS:
• Not Being Listened To • Loud Noises • Darkness • Upsetting Memories • Being Isolated • Being Touched • Feeling Pressured • Feeling Lonely • Being Stared At • People Yelling • Not Having Control • Arguments • Being Teased/Bullied • Lack of Privacy • Particular Person ... • Particular time of ... day/season/year	• Sweating • Red Faced • Acting Hyper • Being Rude • Eating More • Singing Inappropriately • Clenching Fists • Breathing Hard • Wringing Hands • Swearing • Isolating/Avoiding People • Pacing • Eating Less • Becoming Very Quiet • Racing Heart • Loud Voice • Bouncing Legs • Crying • Not Taking Care of Myself • Can't Sit Still • Clenching Teeth • Sleeping a Lot • Rocking • Squatting • Laughing Loudly/Giddy • Sleeping Less • Damaging Things	• Time out in my room • Talking with friends • Exercising • Listening to music • Talking to an adult • A cold cloth on face • Reading a book • Coloring • Writing in a journal • Punching a pillow • Video games • Getting a hug • Take a hot or cold shower • Ripping paper • Bouncing ball • Drawing • Screaming into a pillow • Being read a story • Doing chores/jobs • Playing cards • Holding ice on hands • Making a collage • Deep breathing • Crying • Drinking hot herb tea • Using a rocking chair

CRISIS THERMOMETER

This safety planning tool was exclusively developed by the authors of this protocol. The idea came from a conference discussing another county's crisis response protocol as well as from the experience of the authors of families struggling to identify the appropriate action step to take. In effect, the goal to the Crisis Thermometer is to assist and empower clients and families in understanding their treatment and practicing the skills taught to stay safe on their own.

The thermometer essentially helps clients and families identify the level of crisis and the appropriate action step for that level of crisis. This is easiest to complete once the individual safety plan has been completed with the client. To complete the Crisis Thermometer, first educate clients and families on how to assess (located on the back of the sheet). Teaching clients and families the appropriate times to assess for level of crisis can empower and educate, and ultimately change the possible culture of crisis within families and/or clients. With the actual thermometer, providers should encourage clients and families to recognize the scaling number of the crisis. The bottom of the sheet starts the lowest level of crisis with the prompt "Had a bad day." Clients and families may then brainstorm additional low level crises that impact the family and client. These types of crises should be able to resolved by the client alone. The second level of crisis is prompted with "Has erratic behavior and/or escalating mood" as an example. Other examples may be becoming verbally aggressive, throwing things, becoming extremely unfocused, etc. These types of crises should need assistance of informal supports or paraprofessionals. Caregivers may need to help client use the coping skills that have been identified. The third level is reached when the client is engaging in thoughts of suicide or hurting others, using drugs and alcohol, running away, self harm behaviors, etc. At this point, intervention should be following a safety plan and calling a professional to help the client and/or family through the crisis. The provider may help assess the accurate level of crisis at this point. Lastly, the highest level of risk includes imminent risk of harm toward self or others. The intervention here is to call 911. It is also encouraged to find an informal support who may help with childcare or other needs the family has while coping with a crisis of this risk level.

Overall, this tool is used to guide families and clients in identifying risk level of the crisis and make a decision tree available. Sharing this tool with other providers working with the family and client also increases collaboration and continuity of care.

Risk Thermometer

What To Do If _____ Is In Crisis

First, determine the level of risk by →

Risk Level

	If your child is...	You need to ...
10	• Is at imminent risk of harm to self or others • Has a weapon • Is physically assaultive or destroying valuable property • _____	1. Call 911 immediately and request a PERT officer; use EPR for officer 2. Call your informal support to help with other needs my family may have: _____ Ph. No._____
9		
8		
7	• Threatening to harm/kill self/ others • Engaging in risky behaviors (running away, using drugs/ alcohol, etc.) • _____	1. Refer to Safety Plan and follow steps to attempt to regulate 2. Call your Wrap Facilitator or Therapist WF:_____ Therapist:_____
6		
5	• Has erratic behavior/escalating mood • _____ • _____ • _____	1. Help use/use coping skills _____ _____ 1. Call your Wrap Coach or Family Support Partner WC: _____ FSP:_____
4		
3		
2	• Had a bad day • _____ • _____ • _____	1. Encourage use/use coping skills _____ _____ 2. Call an Informal Support _____ 3. Go to a safe, calm place
1		

To Assess Risk Level

1. Stop and evaluate how **YOU** are feeling. Are you calm? Anxious? Upset?
2. If you are not calm, find a way to feel more relaxed so you can be in control of the situation. Four deep breaths is a great place to start!
3. Once you are calm, you can really think about the risk. Think about what may be happening and why it may be happening. Use the 1-10 scale to plan your action steps.
4. Be **DIRECT** with your child. Ask clearly, "Have you thought about hurting or killing yourself?" "Do you have a plan to hurt/kill yourself?"
5. Stay calm and react appropriately by following your plan you have created with your providers or your family.

EMERGENCY RESPONSE PLAN (ERP)

San Diego County uses the PERT Team in psychiatric emergencies. The following safety planning tool is developed by the county and used by PERT. Other counties may have other emergency response teams when dealing with crises. The authors encourage providers to explore the resources of the county and see if there are similar tools available.

The authors decided to include this in the protocol for several reasons. Due to the high risk clients the authors served, some families were calling 911 several times a month for various reasons. When the police or PERT would arrive, families and clients were disregulated and upset. As a result, pertinent information would not be communicated to responders or to the Emergency Room staff to screen properly. The solution was to have this form filled out prior to a crisis. Should a crisis occur the family could simply hand over the form with all of the client's information the emergency response team would need and professionals they could contact that are working with the client currently.

Families found this extremely useful and also gave a way for providers to discuss what families and the client could expect if the police or emergency responders should arrive for a crisis. This tool assists with safety planning and contributes to collaboration and effective care when other systems become involved.

Behavioral Health
Emergency Response Plan (ERP)

Date Completed: _____

First Name: _____ Middle Initial: _____ Last Name: _____ Gender: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ Date of Birth: _____ Primary Language: _____

Special Instructions (such as: housing, contact information or care of minor children, access codes, pet care, cultural/religious considerations, service dog information, dietary needs, WRAP plan and Advance Directive etc.)

_____

_____

_____

_____

_____

_____

Emergency Contact Information ***(Consent to release information must be obtained by treatment providers)***

Name: _____ Relationship: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Case Manager Name: _____ Phone #: _____

Conservator Name: (LPS-attach copies of documentation) _____ Phone #: _____

Medical Information ***(For use by First Responders and emergency medical personnel only)***

Mental Health and/or Substance Use: _____

Medical Conditions: _____

Allergies: _____

Current Medications: List name, dosage & frequency (including herbal and over-the-counter):

_____ _____

_____ _____

_____ _____

Health Insurance Provider: _____ Insurance Phone #: _____

Subscriber's Name: _____ Insurance ID #: _____

Counselor/Therapist: _____ Phone #: _____

Psychiatrist: _____ Phone #: _____

Primary Care: _____ Phone #: _____

Preferred Hospital: _____ Phone #: _____

Preferred Crisis House: _____ Phone #: _____

I, _____, authorize this form to be used and released to First Responders and emergency medical personnel.

Signature: _____ Date: _____

Information Submitted by (*print name*): _____

Relationship to Consumer (*if applicable*): _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Signature: _____ Date Signed: _____

The ERP form is to be shared with First Responders and emergency medical providers and returned to the person presenting the form once the information has been obtained. The ERP should not be placed in the consumer's medical record without his/her consent.

7/19/11

When should I call Police/Emergency Services or 911?

There are many reasons why you might call 911. The following is a partial list of the primary mental health and psychological emergencies that 911, police and EMS handle.

Self-Assessment:

- I am feeling in need of urgent mental health assistance.
- I am feeling suicidal and I am at risk for attempting suicide.
- I feel I am at risk of harming others, or am having difficulty controlling impulses to harm others

When observing others:

- Exhibiting strange, unusual or disorganized behavior. When the behavior may be dangerous, a medical emergency or a mental health related problem.
- Exhibiting violent behavior. When there has been violence or there is evidence of an immediate risk of violence towards self or others.

When calling police for assistance: Things I might be asked.

When calling for yourself:

- What is your name?
- What is your location?
- How old are you?
- What is going on, or occurring now?
- Do you have any weapons?
- Are you or anyone else injured? If so, do you need the paramedics?
- What is your description? (What color is your hair? How tall are you and how much do you weigh?)
- What are you wearing?
- Is there anyone else in the house with you?
- Are there any pets on the property?
- Have you been drinking, or using prescribed or non-prescribed medication or drugs?

When calling for someone else:

- What is the person's name?
- What is going on, or occurring now?
- Does he/she have any weapons now, or immediate access to weapons? (Keep in mind a weapon can be any object, tool or device that can be used to hurt themselves or someone else.
- What is the person doing now?
- Where is the person now? (Be specific. i.e. if the person is in the house tell the dispatcher which part of the house the person last seen.
- How old is the person?
- How tall is the person and how much do you think the person weighs?
- What is the person wearing now? (Be prepared to provide an accurate description.)
- Has the person been drinking (alcohol), using prescribed or non-prescribed medication, or drugs?
- Is the person violent now or does the person have a history of violence?
- Is the person injured, and if so, does the person need paramedics?
- Are there any pets on the property.
- Is there anyone else in the residence?

Things I need to remember when police arrive:

- Remain Calm
- Be patient
- Identify yourself
- Secure any knives, guns or other weapons in a safe place prior to officers arriving.
- Have hands free and visible
- If possible, wait in front of residence
- Ask emergency dispatcher for special instructions
- Have lights turned on if dark or nighttime
- Secure Pets
- Identify a primary contact person to communicate with arriving officers
- Be prepared to answer many of the same questions asked by dispatchers
- Let officers know what kind of help you are requesting

Parent Fact Sheets,Fact Sheets, & Further Resources

The last piece the authors included in this protocol is what should be done first and foremost: educating clients and families about suicide. Included here are a few fact sheets from the Society for the Prevention of Teen Suicide (website found here: http://www.sptsusa.org). These have been effective in educating parents about suicide in children with the goal of empowering parents to manage their own crises. While these few sheets have been effective with most parents, it is encouraged to explore additional resources with caregivers.

Below are some additional resources that providers can explore to expand their own knowledge as well as share these resources with clients and families.

- **QPR Training**: a training anyone can take for suicide prevention and crisis management https://www.qprinstitute.com/
- **Suicide Prevention Resource Center**: a website full of information about suicide prevention that could be helpful for both providers and clients http://www.sprc.org/
- **C-SSRS Website**: includes the scales, research on suicide prevention, as well as trainings and webinars on the C-SSRS http://cssrs.columbia.edu/index.html
- **It's Up To Us**: an organization full of tools and resources for clients http://www.up2sd.org/index.php
- **Society for the Prevention of Teen Suicide**: includes many tools and a lot of information for caregivers about suicide prevention http://www.sptsusa.org/

Suicide "FACTS"

Warning Signs of Teen Suicide

Feelings

- Major changes in mood and emotions
- Hopelessness: feeling like things are bad and won't get any better
- Fear of losing control, going crazy, harming himself/herself or others
- Helplessness: a belief that there's nothing that can be done to make life better
- Worthlessness: feeling like an awful person and that people would be better off if he/she were dead
- Hating himself/herself, feeling guilty or ashamed
- Being extremely sad and lonely
- Feeling anxious, worried, or angry all the time

Actions

- Drug or alcohol abuse
- Talking or writing about death or destruction
- Aggression: getting into fights or having arguments with other people
- Recklessness: doing risky or dangerous things

Changes

- Personality: behaving like a different person, becoming withdrawn, tired all the time, not caring about anything, or becoming more talkative or outgoing
- Behavior: can't concentrate on school or regular tasks
- Sleeping pattern: sleeping all the time or not being able to sleep at all, or waking up in the middle of the night or early in the morning and not being able to get back to sleep
- Eating habits: loss of appetite and/or overeating and gaining weight
- Losing interest in friends, hobbies, and appearance or in activities or sports previously enjoyed
- Sudden improvement after a period of being down or withdrawn
- Environmental risks including: family stress/dysfunction; presence of firearm in the home
- Situational Crises (i.e. traumatic death a loved one, physical or sexual abuse, family violence, etc.)

Threats

- Statements like "How long does it take to bleed to death?"
- Threats like "I won't be around much longer" or "Don't tell anyone else… you won't be my friend if you tell!"
- Prior suicidal behavior
- Plans like giving away favorite things, studying about ways to die, obtaining a weapon or a stash of pills; the risk is very high if a person has a plan and the way to do it (writing suicide notes).
- Suicide attempts like overdosing, wrist cutting

Situations

- Getting into trouble at school, at home, or with the law
- Recent loss through death, divorce, or separation; the breakup of a relationship; losing an opportunity or a dream; losing self-esteem
- Changes in life that feel overwhelming
- Being exposed to suicide or the death of a peer or family member under any circumstances
- Family history of suicide or mental illness

Resiliency Factors

- Coping Strategies and Problem Solving Skills
- Support availability
- Family support and cohesion
- Positive family communication
- Peer support and close social networks
- School and community connectedness
- Cultural or religious beliefs that discourage suicide and promote healthy living
- Adaptive coping and problem-solving skills, including conflict-resolution
- General life satisfaction, good self-esteem and a sense of purpose; personal control
- Easy access to effective medical and mental health resources

What To Do

- Remain Calm
- Ask the youth directly if he or she is thinking about suicide
- Focus on your concern for their wellbeing and avoid being accusatory
- Listen
- Do not judge
- Provide constant supervision. Do not leave the youth alone.
- Remove means for self-harm
- Get help: Peers should not agree to keep the suicidal thoughts a secret and instead should tell an adult, such as a parent, teacher, or school psychologist. Parents should seek help from school or community mental health resources as soon as possible. School staff should take the student to the designated school mental that professional or administrator.

Websites For More Information

National Association of School Psychologists:

www.nasponline.org

American Academy for Child and Adolescent Psychiatry:

www.aacap.org

American Association of Suicidology:

http://www.suicidology.org

Depression and Bipolar Support Alliance (DBSA):

www.dbsalliance.org

Light for Life Program:

http://www.yellowribbon.org/

National Institute of Mental Health Suicide Prevention:

http://www.nimh.nih.gov/suicideprevention/index.cfm

National Mental Health Association:

www.nmha.org

U.S. Department of Health and Human Services, National Strategy on Suicide Prevention:

http://www.mentalhealth.samhsa.gov/suicideprevention/

SOCIETY for the PREVENTION of TEEN SUICIDE

PARENT AWARENESS SERIES:

Talking to your Kids About Suicide

Every parent would like to believe that suicide is not relevant to them or their family or friends. Unfortunately, it's all too relevant for all of us. It's the 3rd leading cause of death in adolescents and the 2nd for college aged students. Even more disturbing are national surveys that tell us that 16% of high school students admit to thinking about suicide and almost 8% acknowledge actually making an attempt. The unfortunate truth is that suicide can happen to ANY kid in ANY family at ANY time!

So how do you deal with this reality? Once you acknowledge that suicide is as much risk for your child as not wearing a seat belt while driving, or using alcohol or drugs, or engaging in risky sexual behavior, you've taken the first step in prevention. You talk to your children about these other behaviors which can put them at personal risk, and suicide is no different. It's something you CAN and SHOULD talk about with your children!

Contrary to myth, talking about suicide CANNOT plant the idea in someone's head! It actually can open up communication about a topic that is often kept a secret. And secrets that are exposed to the rational light of day often become less powerful and scary. You also give your child permission to bring up the subject again in the future.

If it isn't prompted by something your kid is saying or doing that worries you, approach this topic in the same way as other subjects that are important to you, but may or may not be important to your child:

- Timing is everything! Pick a time when you have the best chance of getting your child's attention. Sometimes a car ride, for example, assures you of a captive, attentive audience. Or a suicide that has received media attention can provide the perfect opportunity to bring up the topic.

- Think about what you want to say ahead of time and rehearse a script if necessary. It always helps to have a reference point: ("I was reading in the paper that youth suicide has been increasing..." or "I saw that your school is having a program for teachers on suicide prevention.")

- Be honest. It this is a hard subject for you to talk about, admit it! ("You know, I never thought this was something I'd be talking with you about, but I think it's really important"). By acknowledging your discomfort, you give your child permission to acknowledge his/her discomfort, too.

- Ask for your child's response. Be direct! ("What do you think about suicide?"; "Is it something that any of your friends talk about?"; "The statistics make it sound pretty common. Have you ever thought about it? What about your friends?")

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- Listen to what your child has to say. You've asked the questions, so simply consider your child's answers. If you hear something that worries you, be honest about that too."What you're telling me has really gotten my attention and I need to think about it some more. Let's talk about this again, okay?"

- Don't overreact or under react. Overreaction will close off any future communication on the subject. Under reacting, especially in relation to suicide, is often just a way to make ourselves feel better. ANY thoughts or talk of suicide ("I felt that way awhile ago but don't any more") should ALWAYS be revisited. Remember that suicide is an attempt to solve a problem that seems impossible to solve in any other way. Ask about the problem that created the suicidal thoughts. This can make it easier to bring up again in the future ("I wanted to ask you again about the situation you were telling me about...")

Here are some possible warning signs that can be organized around the word "FACTS":

FEELINGS that, again, seem different from the past, like hopelessness; fear of losing control; helplessness; worthlessness; feeling anxious, worried or angry often

ACTIONS that are different from the way your child acted in the past, especially things like talking about death or suicide, taking dangerous risks, withdrawing from activities or sports or using alcohol or drugs

CHANGES in personality, behavior, sleeping patterns, eating habits; loss of interest in friends or activities or sudden improvement after a period of being down or withdrawn

THREATS that convey a sense of hopelessness, worthlessness, or preoccupation with death ("Life doesn't seem worth it sometimes"; "I wish I were dead"; "Heaven's got to be better than this"); plans like giving away favorite things, studying ways to die, obtaining a weapon or stash of pills; suicide attempts like overdosing or cutting

SITUATIONS that can serve as "trigger points" for suicidal behaviors. These include things like loss or death; getting in trouble at home, in school or with the law; a break-up; or impending changes for which your child feels scared or unprepared

If you notice any of these things in kids who have always been impulsive, made previous suicide attempts or threats or seem vulnerable in any way, you really should get consultation from a mental health professional.

NATIONAL
SUICIDE
PREVENTION
LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

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SOCIETY for the PREVENTION of TEEN SUICIDE

HIGH FOCUS CENTERS

PARENT AWARENESS SERIES:
I am Worried About My Child

Prepared By: Dara Gasior, PsyD, Director of Freehold High Focus Centers and Maureen Underwood, LCSW, SPTS Clinical Director

I am worried about my child, but a little embarrassed to talk about it with anyone and have no clue how to get help. Where do I start?

There is no need to be embarrassed about asking questions or reaching out for help. It is okay to be concerned about your child and it is your job as a parent to make sure that you are doing everything you can to get them the support they need. As a parent, you have instincts about your child, and if your instinct tells you that something is wrong and this is not "just a phase" then you should listen to yourself. Sometimes our embarrassment comes from not knowing where to turn. The mental health system can be confusing for people who are reaching out to get help and the goal of this article is to assist you in better knowing what resources are available and then finding out how to access them.

The first thing you need to do is get some clarity about what is worrying you. One of the best ways to try to pinpoint the specific behaviors or feelings that have you concerned is to think about the ways in which these behaviors are 'changes' from the way your child normally acts. Are things different just at home or also at school? How about with friends? siblings? Listing examples of the behaviors that have fueled your concerns is a concrete and objective place to start.

The next question is to determine just how concerned you are. How intense are the behavior and mood changes that you are seeing? Using a 1 to 10 scale can help you get specific. For example, if you think your child is mildly depressed you might consider a 3-5 score on the scale; if you are concerned that they are at risk to harm themselves your score would be in the 8-10 range. The reality is that the clearer you can be about both the specific behaviors that concern you and the level of your concern, the easier it will be to get your child into the correct level of care.

Once you are a little clearer about your concerns, you'll want to have your child evaluated for mental health treatment. A 'mental health evaluation" means an assessment by a mental health professional to determine whether or not your child has an issue or problem that would benefit from mental health treatment. The mental health system, unfortunately, can seem a bit confusing because it consists of a number of different tiers of treatment, from the least restrictive to the most restrictive. Here's some information to help you get a clearer understanding of the different levels of care.

Outpatient Therapists

The outpatient therapist is someone who can not only make that initial mental health assessment but can also treat mild to moderate symptoms of depression, anxiety, some experimentation with drugs or alcohol, attentional issues, acting out behaviors and family conflict. Just as portrayed in movies or on television.

the therapist usually sits across from an individual patient or client, and asks questions or makes comments. These meetings or sessions typically last from 45-60 minutes and take place about once a week. The frequency can vary, though, from 2-3 times per week to once every other week depending on the therapists' availability and the severity of the problems.

Therapists can have any number of different degrees and credentials, which can be confusing when you are trying to figure out which professional to see. A licensed social worker (LSW or LCSW), licensed family counselor (LMFT), licensed associate or professional counselor (LAC, LPC) all have Masters Degrees in the mental health field. A psychologist (PhD or PsyD) has advanced training and a doctorate in the mental health field. Psychologists are the only mental health professionals qualified to administer and interpret psychological tests that can be helpful in diagnosing and understanding complex cases. From a practical viewpoint, it does not matter which degree or letters therapists have after their names; they are all trained to provide clinical care in the community. What matters is how comfortable you and your family member feel with them.

Outpatient therapists also may provide group therapy that is designed to allow individuals of similar ages and problems to be treated within a group setting. Many of these groups occur for 1-1.5 hours a week and generally deal with specific topics. Some of the most common groups for adolescents include social skills groups, and groups to assist teenagers with attentional difficulties .For example, if you are concerned that your child is struggling socially, group therapy can be a great resource to assist with development of these skills in an appropriate and therapeutic setting.

Psychiatrists

These are medical doctors (MD) with advanced training in dealing with serious mental illness. Most psychiatrists primarily prescribe and monitor medications. Often the psychiatrist will see individuals for an initial evaluation, and then follow up monthly for medication management sessions. Some psychiatrists will see patients weekly while others will provide both individual talk therapy sessions and medication management sessions. However, this varies from doctor to doctor.

Many people who are seeking help for the first time will try to make their initial appointment with a psychiatrist. In general, psychiatrists often do not take insurance and usually have longer waiting- lists for appointments than other therapists. So if you are concerned about a family member, it can be easier and quicker to get them in to see an outpatient clinician first. They can begin talk therapy and if the clinician believes that medication is necessary or should be considered, they can assist with making a referral to a psychiatrist.

Intensive Outpatient Programs (IOP)

These programs, which meet for multiple hours, multiple days per week have higher levels of care and are designed to treat individuals who are experiencing moderate to severe symptoms. Most IOP's are scheduled from 3 – 5 times per week and typically run for about 3-4 hours per treatment day for approximately 2-3 months. However, all IOPs are designed with a strong emphasis on group work to assist clients in developing specific skills to improve their level of functioning. There are usually a variety of groups that address particular problems like substance abuse, eating disorder or psychiatric disorders (such as mood, anxiety and psychotic disorders).If your child is using drugs or alcohol on a semi-regular to regular basis, then this is most likely the appropriate level of care for them. Similarly, many individuals who are struggling with eating disordered symptoms are often referred to this level of care.

If you have a child who has been in therapy with an outpatient clinician and has not made the progress you were hoping for, then an IOP may be the next step. Conversely, if your family member has not been in treatment before, but their symptoms are raising safety concerns (for example, you have recently discovered that they are harming themselves through cutting or burning) or if they are struggling with suicidal thoughts, then an IOP may be a more appropriate level of care for them than just outpatient therapy.

Partial Care Programs/Partial Hospitalization Programs (PCP/PHP)

This level of care is the step between an IOP and an inpatient hospitalization program. This program is designed for individuals who are not at immediate risk of harming themselves, but are experiencing significant symptoms which make it difficult for them to function in their daily lives. PCPs usually run 5 days a week for 5-6 hours. Like IOP's, they are group based programs but also provide family work, individual work as well as medication management with a psychiatrist. Patients usually attend these programs from 2- 4 weeks, with the specific goals of getting their medications adjusted, improving level of functioning, addressing any safety concerns and creating an appropriate aftercare plan. Many Partial Care patients will go directly to an IOP once they are more stable. If your child is not attending school, not functioning well, having severe depressive symptoms, self injuring, or expressing suicidal thoughts with regularity, then this may be the appropriate level of care for them.

Inpatient Hospitalization

Just like you'd do if your child broke an arm or leg, when you are worried that your child is in immediate danger the best thing to do is take them to the emergency room for an evaluation. Any suicide gesture or attempt should be taken seriously, so if your child is telling you or someone else that they want to die or have a plan to harm themselves, this is the level of care you may need. When you take your child to the emergency room, they will be medically cleared first, and then evaluated by a therapist/social worker who will determine the next step. Many times children who are suicidal will be recommended for admission to the hospital for a week or so. Although this recommendation may sound scary, it really is the best course of action for someone who is in crisis. As an inpatient, your child will attend groups, family sessions and be seen regularly by the psychiatrist for medication management. Once your child is more stable and no longer at high risk for self-harm, there will be an assessment by the clinician to assist you with determining what level of care is appropriate for follow up.

What's the Next Step??

If you have insurance, the best thing to do first is to call your insurance company and find out what type of mental health benefits you have. You want to know if you need something called 'preauthorization' and whether or not you have "out-of-network' coverage. If you have this type of coverage, your choice of providers will greatly increase. Almost all plans have outpatient coverage as well as coverage for inpatient hospitalizations. However, not all insurance packages have IOP or PCP benefits, so it is good to ask about this. If you have the benefit, then the next step is to get a list from the insurance company of in-network providers that meet the level of care you are seeking.

BEFORE you make an appointment, do not hesitate to call ahead and ask questions about the program or the therapist, the types of services rendered, as well as the way in which initial appointments are scheduled. Remember, you are technically a consumer who will be purchasing an important service for your child. It helps, of course, to frame your request in a courteous way. For example, "I don't know much about mental health counseling and I'm trying to approach this process as an educated consumer. I'd like to ask you a few questions to help me better understand how you work."

While you probably already have a list of questions in your head, here's a few more that you may want to include:

- My child has been having some problems in the following areas...(briefly provide examples of the behaviors that concern you). Can you give me an idea of what your approach to dealing with these types of problems might be?
- Do you involve parents (or guardians) in the counseling process?
- Do you provide family therapy? How do you decide if this is needed?
- What criteria do you use to determine whether or not my child needs medication?
- To whom do you refer for this type of assessment?
- If my child needs special accommodations at school, do you assist in making these arrangements?
- How flexible is your appointment schedule? Do you offer after school/ evening/Saturday appointments?
- If you or I decide that you and my child might not work well together, will you be able to suggest other referrals?
- You should also ask about that initial appointment: who will it be with, how long will it take, what will happen during it and how long after that initial evaluation will services start? You, as the consumer, have a right to make sure that the people you are calling will meet your needs, so ask them.

If you do not have insurance, most counties and states provide services to adolescents through county and state programs. In New Jersey, the provider of these services is Perform Care, and the best way to get help for the uninsured is to call them. The phone number to call is 877-652-7624. When you call them, you will give them basic information and get your child registered. You will be given a number that is your registration number. Once this first step is completed, they will assign a counselor to complete a needs assessment, which consists of a professional coming out to the home to interview you and your child and gather information to create a treatment plan. This treatment plan could include in-home therapies, a behavioral assistant who comes over consistently to assist with parenting, or possibly a mentor (someone to take your child out on social gatherings). They can also provide referrals to programs out of the home if that seems necessary. Many parents are reluctant to call Perform Care due to concerns about having strangers come to their homes. Please keep in mind that these people are professionals who are there to help you, not judge you or cause you additional stress. Reaching out to them for help is a sign that you are doing the best thing you can for your child, and they will respect that, so please allow them to opportunity to help.

Prepared By: Dara Gasior, PsyD, Director of Freehold High Focus Centers and Maureen Underwood, LCSW, SPTS Clinical Director

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SOCIETY for the PREVENTION of TEEN SUICIDE

After An Attempt:
When Your Child is Released from the Hospital

Having a child released from the hospital after a suicide attempt can be an unsettling experience for parents and guardians. Although many parents report being shocked that their child needed to be hospitalized at all, there is often a momentary sense of relief during the hospital stay that at least their child is safe and in good hands. As planning for discharge from the hospital begins, parents may be unprepared for their mounting anxiety about how to maintain a safe environment for their child once he or she returns home.

Treatment options after hospital discharge often include something called "Intensive Outpatient Treatment" or IOP. This usually includes a prescribed number of hours in an outpatient treatment facility like a mental health clinic where individual and group counseling focuses on helping the child develop healthier coping strategies. If the child was prescribed medication during his or her hospital stay, the IOP staff also monitors the drugs for evidence of effectiveness, side effects, etc. At the conclusion of the IOP treatment, the child is usually referred to a mental health provider in the community. This person continues to work with your child to address the issues that led to his or her suicidality.

In other instances, the hospital may decide to skip the IOP and directly refer your child to an outpatient therapist. Sometimes this happens when a child was in treatment with a mental health professional prior to his or her attempt, and then he or she is simply referred back to that original person to continue counseling after hospital discharge. In some parts of the country, an appropriate IOP may not be accessible so intensive outpatient treatment with a private practitioner may be suggested as a substitute.

It is really important for you to be involved in your child's treatment after hospital discharge. What is essential is a conversation with the counselor about what is called a safety plan for your child. Since your child is designated by insurance as the "identified patient" there may be confidentiality issues. The therapist may be reluctant to share details of the treatment but should be able to talk with you, as a key member of your child's support system, about specific ways you can help maintain his or her safety. Unfortunately, because the clinical picture for each child is unique, there is really no one set of prescribed guidelines to help you in this process. The safety plan would include helping him or her identify situations that may trigger thoughts of suicide and coming up with alternative responses. You should also get clear instructions about what to do and whom to call in a mental health emergency.

Remember, you are a critical member of your child's support system and need to understand the goals of counseling, what measures the counselor will use to assess progress and the specific ways in which you can work with your child to increase his or her feelings of safety. SPTS has produced a video which models how to address questions to mental health providers and how to keep asking questions until you understand and are comfortable with the answers. *Not My Kid: What Every Parent Should Know About Teen Suicide* can be viewed on the SPTS website, www.sptsusa.org

Conclusion

When the authors of this protocol decided to collaborate and pull together all the training and tools from different protocols and assessments, the goal was to create something practical, logical, and easy for both providers and clients. With backgrounds in attachment theory, the authors wanted to ultimately entrust caregivers to work with their children to create safer homes and stronger relationships. Caregivers should feel like they can keep their children safe and providers should promote resiliency and empowerment among caregivers and clients.

Thus far, utilizing the protocol in a Wraparound program, where coordination is a big part of the Wraparound model, has been highly effective. Feedback has been very positive from both providers working with teams who have shared the safety planning and assessments with other involved providers and systems of care as well as with clients. Caregivers have reported understanding more about the process of suicide prevention and report less anxiety when crisis occurs. While quantitative or official qualitative research has not yet been explored, this would be a the next step the authors would like to take this protocol to explore if this process reduces hospitalizations due to suicidal ideation.

The authors hope that these tools and protocol are not only useful, but adaptable. Recognizing the need to individualize assessment and treatment, these tools created and developed by the authors are meant to be edited and changed. Again, the authors would like to hear feedback from those that utilize this protocol. Please send your questions, comments, or thoughts to the authors.

Thank you,

Jessica, Melissa, and Sonia

About the Authors

Jessica Holzer, M.A., LMFT

Jessica Holzer received her Bachelor of Arts in Psychology and Cognitive Science from the University of California, San Diego and her Masters of Arts in Marriage and Family Therapy from Alliant International University. With eight years of experience in the mental health field and a focus on crisis management, Jessica focuses on attachment related interventions and therapy, suicide prevention, and working with children and their families.

Email: jessicanholzer@gmail.com

Melissa Geiger, M.S., IMF

Melissa Geiger has her Bachelor of Arts in Psychology from San Diego State University and her Masters of Science in Counseling from University of Phoenix. Melissa, for the past nine years, has worked with SED children and teenagers in multiple settings such as in home, community, and residential. Melissa's areas of special interest are Suicide Prevention and Attachment.

Email: mkgeiger07@gmail.com

Sonia Gligan, MSW, LCSW

Sonia Gligan received her Bachelor's Degree in Psychology at the University of Southern California, San Diego and a Master's Degree of Social Work with a concentration in health. She is a Licensed Clinical Social Worker with extensive experience in crisis management and working with SED youth. Additionally, Sonia's experience includes participation in research focusing on development and working with children, families and adults in mental health and health settings.

Email: srgligan@gmail.com