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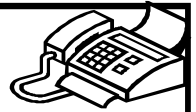

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DIRECTIONS TO COMPLETE THIS COURSE:

Step One: Please use the above address and telephone numbers for ALL correspondence with our office. Our old address may still be on some of the handout pages, and mailing to the wrong address will delay your certificates.

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On the following pages you should find an **Outline**, an **Evaluation of Learning Quiz** form, and a **Grade This Course** form, as well as the **Course Content** itself. Many courses will require that you also listen to an Audio lecture or watch a Video lecture, which you will access on our website in the same place where you obtained this document. Some courses may require that you read sections from the DSM-IV or your Professional Code of Ethics — and in such cases you must provide your own DSM and find your own Code.

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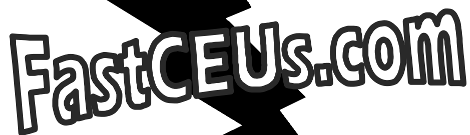

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"SUICIDE Intervention and Prevention"

3 Continuing Education Clock / Credit Hours

Instructor: Richard K. Nongard, LMFT/CCH

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Purpose of this Course:

The purpose of this continuing education course is to provide professionals in mental health, education and criminal justice settings with strategies and ideas designed to assess clients at risk for suicide and to create interventions minimizing the risk for suicidal actions.

At times we may think that "suicide" is not an issue that "changes" over time, and so we likely already know everything there is to know about the subject of intervention and prevention. However, not only is staying current on effective procedure and assessment tools a professional obligation, but unfortunately you just never know when you may be faced with a crisis situation when it is vital that your knowledge and skills are fresh and confident.

Course Objectives:

At the conclusion of this course, the professional will be able to:

1) Identify the common risk factors for suicidal ideation
2) Understand the 4 primary motivations for suicide
3) Perform a suicidal ideation interview and create a safety plan
4) Develop targeted intervention strategies designed to help to alter negative ideation and curb destructive behaviors

Course Outline:

10 Minutes: Course organization and introduction
90 Minutes: Audio lecture
35 Minutes: Reading and synthesis of handout materials
35 Minutes: Completion of required Evaluation of Learning Quiz
10 Minutes: Documentation and preparation
===========
180 Minutes (3 Hours)

If you ever have any questions concerning this course, please do not hesitate to contact PeachTree at (800) 390-9536.

COURSE NOTES: "SUICIDE INTERVENTION"

PeachTree Professional Education, Inc.
(800) 390-9536 Fax (888) 877-6020

INSTRUCTOR: Richard K. Nongard, LMFT/CCH

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Introduction:

Suicide. We may shudder simply at the sound of the word. Taking one's own life. Murdering your self. We the Living, or rather the 'currently not at risk', often have very differing philosophies about Suicide, primarily negative. To some, it's an inconceivable, totally unacceptable damnation against Religion. To others it's more of a moral issue—the ultimate act of selfishness—how could they do that to the survivors? And still to others, it's an individual choice—a tragedy, yet perhaps 'understandable' if not 'justifiable'—all depending on the 'motive' and 'circumstances at hand'.

For the "At Risk" the various above thoughts will probably come into play at one time or another as they consider and/or plan their potential actions. They may mull over these concepts for years, months, or only milliseconds before they actually 'pull the trigger'.

Despite their philosophical ponderings however (which is often where a key intervention strategy be found), their final decision to act will likely ultimately be based on their Primary Motivation.

Is Suicide a Choice?

"No. Choice implies that a suicidal person can reasonably look at alternatives and select among them. If they could rationally choose, it would not be suicide. Suicide happens when all other alternatives are exhausted -- when no other choices are seen."

Adina Wrobleski ~ *Suicide: Why?* (1995)

NOTE: Throughout these materials you will read a lot of the words 'often', 'usually', 'generally', 'frequently', 'may' and so on. This is because there is never a pat answer to any of the questions concerning suicide. To give broad statements of fact would be erroneous and perhaps even dangerous. The information provided is as accurate as possible, but please remember that every case is different, and that is why it is so important that each person is thoroughly interviewed and evaluated individually without bias or any pre-suppositions. As you read along, these concepts should become obvious.

HIGH RISK * DEMOGRAPHICS * STATISTICS

While certainly anyone can commit suicide, there are some groups of people who are more likely than others to make the attempt and/or succeed.

ADOLESCENTS

- Nationwide, suicide is the 3rd leading cause of death for Adolescents (those aged 15-19). Homicide is 2nd, accidents are first. (By comparison, suicide is the 8th leading cause of death among adults—however, while most people have suicidal thoughts or feelings at some point in their lives—less than 2% of all deaths are suicides.)
- Between 1960 - 1988 the Adolescent suicide rate rose at 200%, compared with an increase of 17% for the general population.
- Between 6-13% of adolescents say they have attempted suicide at least once .
- Adolescents and young adults with sexual identity questions are at great risk for suicide.

UNDERREPORTING

- Suicide is often under-reported. This is for many reasons, including stigma, difficulty in determination if no 'note' is left, religious prohibitions, and insurance payout concerns.

SUICIDE ATTEMPTS

- Males successfully complete suicide at 4 times the rate females do (18 compared to 4 per 100,000).
- Females attempt suicide at least 3 times as often as males—they just do not succeed as often.
- Difference in methods - Females generally use less lethal methods like pills & gas, Males typically use more lethal methods, such as guns & ropes.
- Difference in case-finding. Most attempts are made in mental health facilities which are used more often by females. If case-finding included detention facilities some say gender differences would diminish. (Males attempt suicide while in jail.)
- Native Americans have highest rate of suicide of any ethnic group, although it varies by tribe.

"RISK FACTORS" FOR SUICIDE

- Prior suicide attempt - 80% of those who complete suicide have tried before - up to 40% of attempters will try again.
- Age. The Elderly (particularly white males over age 65) are more likely even than adolescents to commit suicide—primarily for health and/or financial reasons. However, this is often underreported. (See 'Underreported' above.)
- Drug and alcohol abuse (often committed while under the influence) - Alcoholics are 8 times more likely to attempt suicide.
- Affective illness such as depression or manic depression/bi-polar disorder, or personality disorder.
- Antisocial or aggressive behavior pattern.
- Family history of suicidal (or homicidal) behavior.
- Availability of firearms - positive correlation between gun ownership rates & suicide rates can be seen by geographical region.
- Protestant Religious Faith, or other Faith without strong admonishments against suicide, or with compassion for those who do.

- ♦ Contagion effects. A well-publicized suicide often leads to more suicides, especially with adolescents. They may even attempt "copy-cat suicides / homicides", with ideas stemming from media reports, books or magazines.
- ♦ ***** Remember that these risk indicators are general & may not predict well at the individual level. The more risk factors present however, the greater the chance for a person engaging in this behavior.

WARNING SIGNS Conditions associated with increased risk of suicide

- Death or terminal illness of relative or friend.
- Divorce, separation, broken relationship, stress on family.
- Loss of health (real or imaginary).
- Loss of job, home, money, status, self-esteem, personal security.
- Alcohol or drug abuse.
- Knowing of someone else who committed suicide, especially family or close friends.
- Depression. In the young depression may be masked by hyperactivity or acting out behavior. In the elderly it may be incorrectly attributed to the natural effects of aging. Depression that seems to quickly disappear for no apparent reason is cause for concern. The early stages of recovery from depression can be a high risk period.
- Anxiety. Recent studies have associated anxiety disorders with increased risk for attempted suicide.

Emotional and behavioral changes associated with suicide

- Overwhelming Pain: pain that threatens to exceed the person's pain coping capacities. Suicidal feelings are often the result of longstanding problems that have been exacerbated by recent precipitating events. The precipitating factors may be new pain or the loss of pain coping resources.
- Hopelessness: the feeling that the pain will continue or get worse; things will never get better.
- Powerlessness: the feeling that one's resources for reducing pain are exhausted.
- Feelings of worthlessness, shame, guilt, self-hatred, “no one cares”. Fears of losing control, harming self or others.
- Personality becomes sad, withdrawn, tired, apathetic, anxious, irritable, or prone to angry outbursts.
- Declining performance in school, work, or other activities. (Occasionally the reverse: someone who volunteers for extra duties because they need to fill up their time.)
- Social isolation; or association with a group that has different moral standards than those of the family.
- Declining interest in sex, friends, or activities previously enjoyed.
- Neglect of personal welfare, deteriorating physical appearance.
- Alterations in either direction in sleeping or eating habits.
- (Particularly in the elderly) Self-starvation, dietary mismanagement, disobeying medical instructions.
- Difficult times: holidays, anniversaries, and the first week after discharge from a hospital; just before and after diagnosis of a major illness; just before and during disciplinary proceedings. Undocumented status adds to the stress of a crisis.

SUICIDAL IDEATION ASSESSMENT INTERVIEW

1.) Do you have recurring or frequent thoughts about death, dying, going to sleep and never waking up, or of killing yourself or others??
(*Obsessive or passing thoughts??*)

2.) Do you intend to die, or do you really just want to communicate a message to someone??
(*Lethality of Intent??*)

3.) Do you have a plan for dying or killing yourself??
(*Is is well thought out and detailed, or vague??*)

4.) What method(s) have you considered using??
(*Is it Lethal??*)

5.) Do you have access to this method or weapon>>
(*Easy or difficult to access??*)

6.) Do you have a specific time or day in mind to carry out this act>>
(*Immanency??*)

7.) To whom would you be trying to impact or communicate what message, if you killed yourself??
(Lack of connectedness or just want to die??)

PRIOR SUICIDE ATTEMPT INTERVIEW

1.) How many times have you tried to kill yourself before?? (*History*)

2.) When did you last try to kill yourself??

3.) Did you have a plan, or was your attempt impulsive?? (*Immanency*)

4.) Did you really want to die, or to communicate a message to someone?? (*Motivation*)

5.) What method did you use, and did you believe it would kill you?? (*Lethality*)

6.) What happened to you, and why did you survive??

7.) Were you relieved that you survived?? (*Lethality of Intent*)

8.) Do you think you will try to kill yourself again?? (*Future Orientation*)

9.) GO TO THE ABOVE ‘SUICIDAL IDEATION’ INTERVIEW QUESTIONS

Suicidal Behavior

- Previous suicide attempts, "mini-attempts".
- Explicit statements of suicidal ideation or feelings—or homicidal ideation.
- Threats - take them seriously. People generally do not make a threat that they cant in some way see themselves following through on.
- Development of suicidal plan, acquiring the means, "rehearsal" behavior, setting a time for the attempt.
- Self-inflicted injuries, such as cuts, burns, or head banging.
- Reckless behavior. (Besides suicide, other leading causes of death among young people in New York City are homicide, accidents, drug overdose, and AIDS.) Unexplained accidents among children and the elderly.
- Making out a will, organizing business and financial affairs or giving away favorite possessions.
- Inappropriately saying goodbye.
- Verbal behavior that is ambiguous or indirect: "I'm going away on a real long trip.", "You won't have to worry about me anymore.", "I want to go to sleep and never wake up.", "I'm so depressed, I just can't go on.", "Does God punish suicides?", "Voices are telling me to do bad things.", requests for euthanasia information, inappropriate joking, stories or essays on morbid themes.

A WARNING ABOUT WARNING SIGNS

The majority of the population at any one time does not have many of the warning signs and has a lower suicide risk rate. But a lower rate in a larger population is still a lot of people - and many completed suicides had only a few of the conditions listed above. In a one person to another person situation, all indications of suicidal ideation need to be taken seriously.

SUICIDE ASSESSMENT INTERVIEW DISCUSSION INFORMATION

Motivation (or Intent), History (Suicidal and Homicidal), Method, Lethality, the Plan, Availability, and Immanency (and Future Orientation) are all key components to a thorough Suicide Ideation Assessment Interview. While each section has its own value, all sections are interrelated and any conclusions should be based on results from the entire interview as a whole.

EVALUATE THE FOUR PRIMARY MOTIVATIONS FOR SUICIDE

1. **HEALTH.**

One of the key risk factors for suicide is failing health, especially in the elderly. Persons with HIV/AIDS, terminal cancer, and various other terminal or 'severe' medical conditions, or simply the inability to care for oneself due to natural aging affects— are at substantially higher risk for suicide than the general 'healthy' population.

Why? Two primary 'common sense' reasons: They themselves do not wish to physically and emotionally prolong their own suffering, and, they do not wish to prolong the suffering and/or demands required of their loved ones, emotionally and often financially. They know/believe they are 'doomed to die', and, rather

than wait out the indefinite duration of pain and expense, they 'nobly' choose to speed up the inevitable end via suicide.

2. **COMMUNICATING A MESSAGE.**

Sometimes, and too often, those who attempt and/or succeed at suicide do not really *want* to die, but instead really just want to communicate a message to someone. Frequently the message intended is a cry for help and/or attention. They may feel they do not receive the love, attention or respect they deserve. Their depression may appear to go ignored. Their behavioral acting out may not seem solicit the response they desire. Perhaps they are being abused and no one appears to care or try to help them. They ultimately believe they cannot devise any other way to effectively get their point across to the people who need to know, and so the goal of their suicide attempt is to dramatically draw attention to their pain and suffering.

Unfortunately, here is where we find numerous cases of those who likely "accidentally died trying to kill themselves", meaning that they really didn't think that many sleeping pills would kill them– not knowing they were allergic to them or that they would react adversely to their cold medicine; or they accidentally hit their head on the sink on the way down when cutting on themselves in the bathroom, when secretly hoping to only cause a messy scene; or when they wave the gun around and point it at their head, truly believing it is unloaded when it isn't, etc.

The majority of people who make a suicide attempt are those who wish to communicate a message. They are also the most likely to fail at their attempt. And, they are the most likely to be reached with adequate prevention intervention. The key however, is in accurate assessment and treatment.

3. TO IMPACT OTHER PEOPLE

These kinds of suicides can be very shocking and ... messy. The motivation/ intent often comes from a last resort effort to deeply impact other people—'see what you made me do?' or 'what will you do now, without me?' The attempt designed to create embarrassment, transfer guilt and blame, or are done simply out of deep seeded anger and revenge.

Here is where you find the stories of the son who blew his brains out on his mother's stark white carpet, leaving behind a jug of carpet cleaner and a note to mom which read, "See how clean your house will be now!" and the disenfranchised ex-husband who shot himself on the front lawn of his ex-wife's house at 3pm, just before she returned home with the children from school.

4. JUST WANT TO DIE.

Sometimes a person simply wants to die. In their minds there is no haggling, no moralizing, no option searching. They are determined that this is what they want, and the likelihood of anyone or anything changing their mind is slim to none. They are sick and tired of being sick and tired. They simply do not have any desire to live another day. They generally have a very concise plan, and rarely fail in their attempt. If they do fail, they are usually extremely angry at themselves and the world, and will likely attempt again as soon as they are able.

History.

Any prior History of a suicide attempt, suicidal ideation, homicidal ideation, or history of suicide or homicide in the family or among close friends should be explored thoroughly, as prior history is always a key risk indicator of future behavior.

People often tend to stick with ideas that they are comfortable with, and if they tried it once before, they may be more tempted to try it again. Depending on their motivation, they may intentionally fail again, may accidentally die trying to kill themselves this time, or may be more intent on succeeding this time. If a close friend or family member committed suicide, the person may feel that the option apparently worked for them, and so it will work for themselves as well.

Homicide is brought up here because there is a very fine line between Suicide and Homicide. And more and more frequently people are deciding to take others out with them when they commit suicide. It is felt that if a person has the capacity to kill themselves, they likely have the ability to kill others as well, or vice versa. It is a question not to skirt or ignore during a complete interview.

All details concerning motivation, methodology, lethality, and social factors should be noted and carefully considered for future plans.

Method.

What Method did they use for any past attempt? Or what methods have they considered using in a future attempt? Gun? Hanging? Knife? Pills? Car Wreck? Drinking Drano? Cyanide? Carbon Monoxide? Or have they not even given it any thought at all yet?

It is not uncommon for people to use the same (failing) method more than once—depending on the motivation of their ideation—their intent. However, if they are serious about dying, and a previous attempt failed them, they may restructure their plan and be careful to choose a more lethal method in the future.

If they have not yet chosen any particular method, then the immanency is most likely greatly reduced, as well as is the likelihood of their success. They are still in the 'pre-planning' stage of ideation, and offer a far greater chance for effective prevention intervention.

Also, they may have decided, for instance, that next time they will shoot themselves. But, do they own a gun? Or do they have reasonable Access to one? These questions, and any similarities or changes from previous attempts and their overall thought processes need to be carefully noted, and may provide keys to prevention intervention strategies.

Lethality.

Is their chosen method Lethal? Some methods of suicide attempt are simply more lethal than others, and men usually try more lethal methods than women. For instance, hanging yourself or shooting yourself in the head with a gun is usually far more lethal than shooting yourself in the shoulder with a crossbow. This also lends itself to motivation. If you intentionally shoot yourself in the shoulder, perhaps you really didn't wish to die, but instead really wished to communicate a message or gain attention.

Shooting yourself with a gun is usually more lethal than taking pills, or

cutting on your wrists. Cutting is generally not so lethal, as the blood will usually clot long before you would bleed to death, unless you actually cut a main artery (which is usually accidental in suicide attempts). Pills, unless taken in a particularly lethal combination, will usually take a very long time and often do not cause death, but instead unconsciousness and/or organ damage, and the person is often found by others before death could occur. Overdosing on Tylenol, for instance, will generally cause great damage to liver and kidneys, but most often is not lethal.

The question is—does the person *believe* that their chosen method *will be* lethal ?? We professionals may know that Tylenol is usually not lethal, but does the client know that? Or do they truly believe that 20 Tylenol will actually kill them? This is an important question because here again, it leads to motivation and intent, and can open up key prevention intervention points.

Also, time and location of the attempt are very important to consider for motivation, intent, and intervention strategies. If you shoot yourself in the shoulder, outside, in the middle of the afternoon, 3 blocks from a trauma center, the odds are pretty good that you will receive help and survive. However, if you overdose on 60 sleeping pills at home 10 minutes after everyone has left for work in the morning, rather than 10 minutes before they return home in the evening, the odds are greater that you will not be discovered in time to be saved.

Availability.

Does the client have Access to their chosen method? Deciding to shoot oneself becomes far less lethal and immanent if the client has no access to a gun, or no knowledge of how to load or use a gun. Sure, they could perhaps acquire one in the near future, and they might be able to figure out how to load it eventually, but if they do not have one now that they know how to use, the risk is slightly reduced, and there is more time for prevention intervention.

Does the client have access to the kinds of drugs they mentioned using? Is the person capable of tying a noose correctly in order to hang themselves? Is the person tall enough to use the selected shotgun on themselves the way they had hoped? Does the person have the knowledge of where to cut themselves and how in order to actually bleed to death before they risk being discovered?

Availability leads to immanency. If they have reasonable ability and access to their chosen method today, then the risk for their attempt is far greater, sooner, rather than later.

Plan.

Does the client have a Plan of Action for attempting suicide? Are their thoughts organized, specific, detailed? Are they clear in their Motivation? Do they have a selected Method? Is their Method potentially Lethal? Do they have Access to their Method and the Ability to carry out the Plan as chosen?

Have they started putting things in order to carry out the plan? Have they started or do they have a plan for taking care of financial paperwork or their will? Are they giving things away? Do they know the 'who, what, where, when, why and how' of their intended actions?

Are they suddenly more relaxed or even cheerful than in recent days?

A person with a detailed plan is usually far more likely to actually take

action and attempt suicide than is a person who has not yet developed a firm plan. There are occasions of course where the suicide attempt is more spontaneous, but generally, the person who is intent on dying will at least attempt to develop a thorough plan in advance.

And once the plan is firmed up, once they believe they have all the bases covered, they will likely experience a dramatic positive change in their demeanor. This is another key indicator to watch for, as it also leads to the Immanency factor.

Immanency

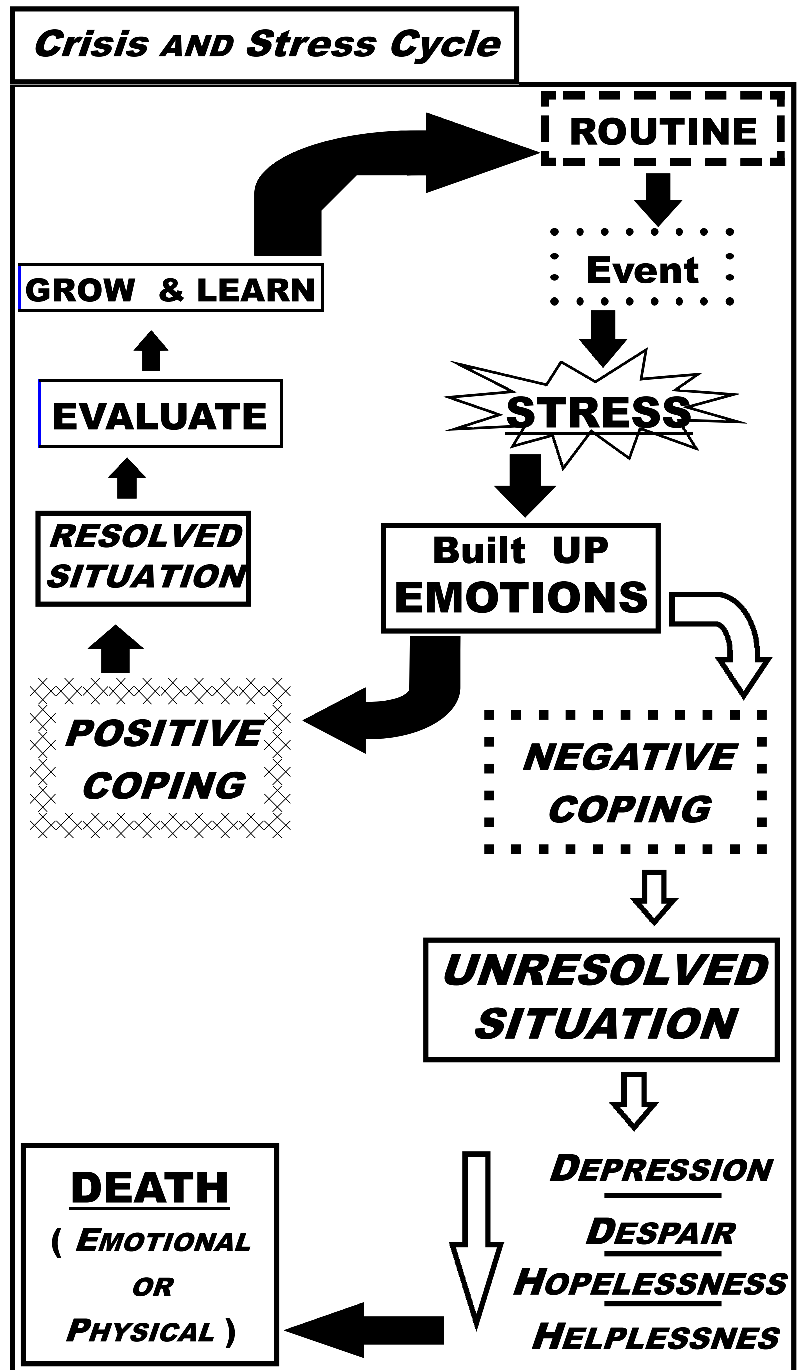
Is the client in danger of going through with a suicide attempt in the very near future? In the next 4 Hours? 24 Hours? In the next Week? Month?

What is their Future Orientation? When you ask what they plan to do next Saturday night, do they say, "*Probably go to a movie*" — or do they respond with, "*Nothing, cause I'll be dead*" ??

This assessment section is probably one of the most important for health care and mental health professionals to try to accurately answer. This is where the majority of the liability comes into play. The conclusions you draw from this section of the interview, and the subsequent actions you take (referral for medication, treatment for depression, hospitalization, or perhaps nothing if not felt to be warranted) can possibly hold life or death consequences for your client.

The more firm their plan is, the more lethal and available their chosen method is, the more convicted they are with their motivation and intent, and especially if their demeanor has suddenly changed to one of calmness and even cheerfulness after a long period of depression and despair——the far more immanent their risk is for actually going through with a suicidal attempt in the very near future.

Crisis, Stress and Depression



- ♦ As we can see on the chart, we all have a fairly routine "Routine" that we each follow day by day.
- ♦ Something that happens to alter that routine, whether positive or negative, is called an "Event".
- ♦ All events, whether positive or negative will cause "Stress", since the event is a change in our routine.
- ♦ Stress, whether positive or negative, causes "Built Up Emotions".
- ♦ When we have built up emotions, we have to cope. Here we have a Choice to take "Positive Coping" or "Negative Coping" Actions.

- P If we take Positive Coping Actions, we will likely have a Healthy and "Resolved Situation".
- P We now can pause to "Evaluate" what has happened to us.
- P We can now "Grow and Learn" from the Experience, and return to our old-- or perhaps create a new "Routine".

- N If we were to choose "Negative Coping" Actions to deal with our built up emotions, we would likely have an UnHealthy, "Unresolved Situation".
- N UnResolved situations lead us to "Depression".
- N Depression left untreated leads to "Despair".
- N Despair left untreated leads to "Hopelessness".
- N Hopeless left untreated leads to "Helplessness".
- N Helplessness, left untreated, if even treatable at all, leads to "Death"—either physical or emotional.

Obviously this cycle chart is a summation of emotional and behavioral cycles, and one single event handled with negative coping actions will not likely lead a person straight to depression and ultimately to death. However, when there is an ongoing pattern of stressful events and more negative coping than positive coping, and numerous situations that seem to never get resolved in a positive

or healthy manner, the weight builds and builds, and depression does set in, and then grow greater. Left unresolved and untreated, despair does begin to creep in, followed eventually by hopelessness and then helplessness, and then eventually Death, in one form or another.

If nothing else, this chart should be a clear indicator for the importance of Teaching our clients Positive Coping Strategies, and Assessing and Treating Depression—before it leads to Despair.

SUICIDAL MYTHS and OTHER THOUGHTS — for everyone

***Myth*: "The people who talk about it don't do it."** Studies have found that more than 75% of all completed suicides did things in the few weeks or months prior to their deaths to indicate to others that they were in deep despair. Anyone expressing suicidal feelings needs immediate attention.

***Myth*: "Anyone who tries to kill himself has got to be crazy."** Perhaps 10% of all suicidal people are psychotic or have delusional beliefs about reality. Most suicidal people suffer from the recognized mental illness of depression; but many depressed people adequately manage their daily affairs. The absence of "craziness" does not mean the absence of suicide risk.

"Those problems weren't enough to commit suicide over," is often said by people who knew a completed suicide. You cannot assume that because you feel something is not worth being suicidal about, that the person you are with feels the same way. It is not how bad the problem is, but how badly it's hurting the person who has it.

***Myth*: "If a someone is going to kill himself, nothing can stop him."** The fact that a person is still alive is sufficient proof that part of him wants to remain alive. The suicidal person is ambivalent - part of him wants to live and part of him wants not so much death—as he wants the pain to end. It is the part that wants to live that tells another "I feel suicidal." If a suicidal person turns to you it is likely that he believes that you are more caring, more informed about coping with misfortune, and more willing to protect his confidentiality. No matter how negative the manner and content of his talk, he is doing a positive thing and has a positive view of you.

Be willing to give and get help sooner rather than later.

Suicide prevention is not a last minute activity. All textbooks on depression say it should be reached as soon as possible. Unfortunately, suicidal people are afraid that trying to get help may bring them more pain: being told they are stupid, foolish, sinful, or manipulative; rejection; punishment; suspension from school or job; written records of their condition; or involuntary commitment. You need to do everything you can to reduce pain, rather than increase or prolong it. Constructively involving yourself on the side of life as early as possible will reduce the risk of suicide.

Listen.

Give the person every opportunity to unburden his troubles and ventilate his feelings. You don't need to say much and there are no magic words. If you are concerned, your voice and manner will show it. Give him relief from being alone with his pain; let him know you are glad he turned to you. Patience, sympathy, acceptance. Avoid arguments and advice giving.

ASK: "Are you having thoughts of suicide?"

Myth: "Talking about it may give someone the idea." People already have the idea; suicide is constantly in the news media. If you ask a despairing person this question you are doing a good thing for them: you are showing him that you care about him, that you take him seriously, and that you are willing to let him share his pain with you. You are giving him further opportunity to discharge pent up and painful feelings. **If the person is having thoughts of suicide, find out how far along his ideation has progressed.**

If the person is acutely suicidal, do not leave him alone.

If the means are present, try to get rid of them. Detoxify the home.

Urge professional help.

Persistence and patience may be needed to seek, engage and continue with as many options as possible. In any referral situation, let the person know you care and want to maintain contact.

No secrets.

It is the part of the person that is afraid of more pain that says "Don't tell anyone." It is the part that wants to stay alive that tells you about it. Respond to that part of the person and persistently seek out a mature and compassionate person with whom you can review the situation. (You can get outside help and still protect the person from pain causing breaches of privacy.) Do not try to go it alone. Get help for the person and for yourself. Distributing the anxieties and responsibilities of suicide prevention makes it easier and much more effective.

<u>**SUICIDE AND DEPRESSION ASSESSMENT RESOURCES**</u>

Psychological Assessment Resources (P.A.R.) (800) 331—TEST — A Supplier of all sorts of Assessment Tools and Valuable Resources. www.parinc.com

The ASIQ : Adult Suicidal Ideation Questionnaire — An Effective Assessment Tool for Suicidal Ideation among college students and other adults

The Beck Depression Inventory — An industry standard.

<u>**Alternatives or Supplements to the Beck Depression Inventory**</u>**:**

(From Psychological Assessment Resources, Inc. www.PARinc.com)
- **Reynolds Depression Screening Inventory™ (RDSI)**
  Quickly screen for symptoms of depression for ages 18-89 years
- **Reynolds Child Depression Scale (RCDS)**
  Screen for depressive symptoms in children for grades 3-6
- **Reynolds Adolescent Depression Scale (RADS)**
  Screen for depressive symptoms in adolescents for grades 7-12
- **Hamilton Depression Inventory (HDI)**
  Comprehensively screen for symptoms of depression
- **Hamilton Depression Inventory Software System (HDI)**
  Comprehensively screen for symptoms of depression
- **State Trait-Depression Adjective Check Lists (ST-DACL)**
  Measure both state and trait feelings of depression for ages 14-89 years
- **Adolescent Psychopathology Scale–Short Form™ (APS-SF™)**
  Target high incidence psychopathology in adolescents

The Depression Adjective Checklist — Allows for the quick assessment of depression without he need to choose multiple choice answers like the Beck. Easy to administer, and can be used as a progress checker at each session.

The Inventory of Suicide Orientation-30 (ISO-30) Assessment — An instrument from NCS, is designed to help identify adolescents at risk for suicide. It provides an overall suicide risk classification based on measurements of hopelessness and suicide ideation.

The ISO-30 assessment can be given to adolescents in a variety of situations where the assessment of suicide risk is essential. It is appropriate for use by psychologists, licensed social workers, and licensed counselors in outpatient and inpatient mental health facilities, juvenile justice evaluations, and school settings. The ISO-30 assessment can help identify

adolescents at risk for attempting suicide and for facilitating objective communication with the family, other counseling professionals, and insurance providers about diagnostic and treatment decisions.

The NDI: Nongard Depression Index — Plain, non-threatening language. Mark the statements you personally Identify with. Follows the DSM-IV in layout and interpretation. Adult and Adolescent Versions, Use Manual and Copy Agreement License Included.

⇒ If you would like to **order** a copy of the *NDI: Nongard Depression Index* for **$49.95**, including the License to Copy Agreement (*so you never have to reorder forms*) - or any of our other Professional Resource Materials such as the *NSAS: Nongard Substance Addiction Screening* or the *NCCQ: Nongard Couples Conflict Questionnaire*, or the *NSRI: Nongard Strengths and Resources Inventory*, please call **PeachTree @ (800) 390-9536**.

HANDLING A CALL FROM A SUICIDAL PERSON

⇒ **Be yourself.** "The right words" are unimportant. If you are truly concerned about the caller, your voice and manner will show it.

⇒ **Listen.** Let the person unload despair, ventilate anger. If given an opportunity to do this, he or she will feel better by the end of the call. No matter how negative the call seems, the fact that it exists is a positive sign, a cry for help.

⇒ **Be sympathetic, non-judgmental, patient, calm, accepting.** The caller has done the right thing by getting in touch with another person.

⇒ If the caller is saying "I'm so depressed, I can't go on," ask **The Question:** "*Are you having thoughts of suicide?*" You are not putting ideas in his head, you are doing a good thing for him. You are showing him that you are concerned, that you take him seriously, that it is OK for him to share his pain with you.

⇒ If the answer is yes, you can begin asking a series of further questions: Have you thought about how you would do it (PLAN); Have you got what you need (MEANS); Have you thought about when you would do it (TIME SET). 95% of all suicidal callers will answer No at some point in this series or indicate that the time is set for some date in the future. This will be a relief for both of you.

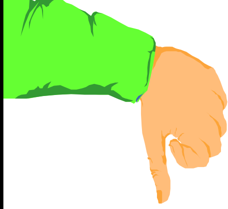
⇒ Simply talking about their problems for a length of time will give suicidal people relief from loneliness and pent up feelings, awareness that another person cares, and a feeling of being understood. They also get tired -- their body chemistry changes. These things take the edge off their agitated state and help them get through a bad night.

⇒ Avoid arguments, problem solving, advice giving, quick referrals, belittling and making the caller feel that has to justify his suicidal feelings. It is not how bad the problem is, but how badly it's hurting the person who has it.

⇒ If the person is ingesting drugs, get the details (what, how much, alcohol, other medications, last meal, general health) and call Poison Control at ________________. A shift partner can call while you continue to talk to the person, or you can get the caller's permission and do it yourself on another phone while the caller listens to your side of the conversation. If Poison Control recommends immediate medical assistance, ask if the caller has a nearby relative, friend, or neighbor who can assist with transportation or the ambulance. In a few cases the person will initially refuse needed medical assistance. Remember that the call is still a cry for help and stay with him in a sympathetic and non-judgmental way. Ask for his address and phone number in case he changes his mind. (Call the number to make sure it's busy.) If your organization does not trace calls, be sure to tell him that.

⇒ Do not go it alone. Get help during the call and debrief afterwards.

⇒ Your caller may be concerned about someone else who is suicidal. Just listen, reassure him that he is doing the right thing by taking the situation seriously, and sympathize with his stressful situation. With some support, many third parties will work out reasonable courses of action on their own. In the rare case where the third party is really a first party, just listening will enable you to move toward his problems. You can ask, "Have *you* ever been in a situation where you had thoughts of suicide?"



Potential Lethality Indicators

Prior History of Violence
Blackouts When Angry * Substance Abuse
Threats of Violence / Suicide / Homicide
The Depressing Triad
Weapons Available * Separation Violence
Increased Risk to Self * Copycat Behavior
Repeated Law Enforcement Contacts

SUICIDE CONTRACT

I, ____, AGREE TO CONTACT THIS

PERSON ____ AT THE FOLOWING

TELEPHONE NUMBER _(__________)________________________ IF I AM FEELING LIKE HURTING OR KILLING MYSELF OR OTHERS.

I WILL SAY TO THEM THAT, "*I AM FEELING LIKE KILLING MYSELF—OR HURTING OTHERS—AND I NEED HELP*."

SIGNED,

____
(signature)

SIX INSTRUCTIONS FOR THE SUICIDAL PERSON

1.) Stop Drinking Alcohol and/or Using Drugs.

2.) Exit by going outside or to another room. Take three *deep* breaths.

3.) Call _____________________________ @ (_______)_________________________.
Talk for 5 minutes.

4.) Write out what is bothering you on a piece of paper.

5.) If you are still feeling angry, go to this place: ___________________________.

6.) If you still feel like killing yourself or others, call __________________________ at this number (_________) _________________________ and tell them, "*I feel like killing myself, or others and I want help now.*"

DEVELOPING OPTIONS AND ALTERNATIVES

Fill in the following sentence identifying your typical unhealthy behavior and as well as a new behavior that you think may help you to deal with your anxiety or depression distress in a healthy manner.

Use the space below to brain-storm and strategize ten more alternative healthy behaviors that may be useful to you when you are feeling distressed, depressed or anxious.

Do not leave any portion blank. If you are having a hard time coming up with ten ideas, talk to others, group members or your therapist.

BEFORE I DO THIS: ______________________________,

I CAN DO THIS : ______________________________.

1.)

2.)

3.)

4.)

5.)

6.)

7.)

8.)

9.)

10.)

We Have What You Need

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EVALUATION OF LEARNING QUIZ   PAGE 1 of 2

PRINT and FAX or MAIL THIS PAGE AND THE ANSWERS PAGE TO OUR OFFICE
*** * * * OR * * * ***
>>> You may complete and submit this Evaluation and your payment Online by following the 'Quiz & Pay' link for this course on our website at www.FastCEUs.com.

PLEASE NEATLY PRINT THE FOLLOWING INFORMATION:

NAME as you want it on your CEU Certificate: ____________________________________

Professional cert/license type with numbers: ______________________________________

ADDRESS to keep in our board records: Street: __________________________________

City: _____________________________________

State: __________ Zip: ____________________

DAYTIME TELEPHONE Number: (_________)____

NEATLY Print YOUR FAX Number OR EMAIL Address to receive your CEU Certificate — Certificates will NOT be mailed:

(If you FAX us your Evaluations do NOT also mail them. Please WRITE NEATLY !!)

CREDIT CARD and BILLING INFORMATION:

(Certificates will not be provided until payment is received by our office.)

"SUICIDE INTERVENTION AND PREVENTION"

This 3 Hour CEU Course is $49.95

Please make checks out to PeachTree Professional Education and mail to the address above.

***Circle*:** MC Visa Discover Amex Check Enclosed

Credit Card Number: ____

Credit Card Expiration Date: __________________ 3-4 Digit Code: ____________

Signature: ____

EVALUATION OF LEARNING QUIZ — page 2 of 2

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Course Title: "SUICIDE Intervention & Prevention"

3 Hours of Approved Continuing Education Credit

The purpose of the following Evaluation of Learning questions is to:

A.) Verify that you have read and/or listened to the required course materials,
B.) Demonstrate an understanding of the practical application of the course materials,
C.) Officially document your participation and completion of this course.

ANSWER THE FOLLOWING 20 T/F EVALUATION OF LEARNING QUESTIONS

T F 1.) I have read the required course notes that accompany this class.

T F 2.) I have listened to the entire audio lecture presentation for this course.

T F 3.) The goal in crisis counseling is the same as any other counseling, to help the client function at their best level.

T F 4.) Services are provided based on immanency and lethality.

T F 5.) There is a key counseling method that ends suicidal ideation among all clients.

T F 6.) We can create interventions that can help a client do something other than take a suicidal action.

T F 7.) Suicide contracts always limit liability.

T F 8.) Suicide risk increases with each year of life, with those in their 60's and 70's being at greatest risk.

T F 9.) Caucasians are at greatest risk for suicide because they have access to the means to commit suicide.

T F 10.) If a family member or friend commits suicide, it increases suicidal risk.

T F 11.) Financial security comes from having a lot of money.

T F 12.) The assessment of major depression is so easy that professionals have no problem accurately diagnosing the condition.

T F 13.) Pscyhomotor agitation can be a sign of major depression.

T F 14.) Ambivalence about life is an indicator for suicide risk.

T F 15.) The person who attempts suicide to communicate a message has a strong desire to die.

T F 16.) It is a myth that nothing can stop a suicidal person.

T F 17.) Obsessional thoughts increase risk for lethality.

T F 18.) The best indicator or future behavior is past behavior.

T F 19.) Instructions for the suicidal client are useful tools for taking proactive action.

T F 20.) The Crisis and Stress Cycle always ends in Despair.

"Blue Sheet"

Grade This Class!

Please complete this short course evaluation.

Please mail or fax this page to us along with your completed course documentation.

DATE: ____________ Homestudy Course Title: ____

On a scale of 1-5 (5 being "highest" and 1 being "lowest) please answer the following questions:

	LOW		--->		HIGH
1) The instruction appeared knowledgeable of the materials:	**1**	**2**	**3**	**4**	**5**
2) The course objectives for this class were met:	**1**	**2**	**3**	**4**	**5**
3) Appropriate teaching methods were utilized:	**1**	**2**	**3**	**4**	**5**
4) The handout materials were useful:	**1**	**2**	**3**	**4**	**5**
5) Sound / Video quality was acceptable:	**1**	**2**	**3**	**4**	**5**
6) How much of this material was new to you:	**1**	**2**	**3**	**4**	**5**
7) The overall quality of this course was:	**1**	**2**	**3**	**4**	**5**

8) Please feel free to make any additional comments below:

____

____

____

____

____

Thank you for your participation! *Please sign here if you give permission for your comments to be used on our website or other advertising materials.*

______________________________ ______________________________

Name or Initials *City, State*