“Are you uncomfortable discussing this because I’m a man or because I’m your husband?”
Here's something I've always wondered: are people supposed to automatically know how to kiss?

Everyone does it but no one teaches it. My dad taught me to ride a bike. My mom taught me to cook, but no one's ever said, "Here's how to kiss."

I have no idea if I'm a good kisser or even if I'm doing it right. I don't know if kissing's all about the lips or if it includes other body parts. And how long should a kiss last? What do you do with your hands? Where do—

I'm a school counselor, not a psychotherapist.

Yeah, so many certificates, so little real use.
YOU THINK YOU GOT IT BAD? TRY LIVING WITH A PROCEEDING HAIRLINE.
AND SO THE DAY BEGINS
HAVE YOU SEEN PETER? HE'S SUPPOSED TO BE PREPPING FOR FINALS.

HE'S OUTSIDE LOOKING AT STARS WITH JASON.

IS THAT FOR HIS PHYSICS CLASS, OR SOMETHING?

I ASSUME SO. I CAN'T IMAGINE WHY ELSE HE'D BE DOING IT.

SO TELL ME AGAIN HOW SMALL AND INSIGNIFICANT MY REPORT CARD IS ON A COSMIC SCALE.

WELL, IF WE BEGIN WITH THE ESTIMATE OF 170 BILLION GALAXIES IN THE UNIVERSE...
WHERE ARE YOU TWO GOING?

TO YOUR DAD’S ANNUAL RETAINER AWARDS BANQUET.

CAN I GO?

OH, SWEETIE, I’M AFRAID NOT.

THIS IS THE BIGGEST NIGHT IN MIDWEST ORTHODONTIA! IT’S COMPLETELY SOLD OUT!

BUT I WANTED TO SPEND QUALITY TIME WITH YOU.

YOU KNOW... UNO... CHARADES... DOMINOES...

I’M SORRY, HONEY. WE'RE COMMITTED.

WELL, OKAY.

BYE.

HAVE FUN.

(SIGH!) I HATE TO MISS THE CHANCE TO PLAY GAMES WITH HIM.

DON’T WORRY, YOU DIDN’T.
A COMPREHENSIVE OVERVIEW OF SUICIDE RISK ASSESSMENT, INCLUDING POLICIES AND PROCEDURES FOR ADDRESSING RISK

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OBJECTIVES
The attendee should be able to:

- Identify the multiple risk factors contributing to suicidal thinking/behavior in students.
- Identify level of risk for student suicidal behavior.
- Identify policies that address management of suicidal risk.
- Describe treatment strategies for the safety of students at risk for suicide.
“We’re ready to begin the next phase of keeping things exactly the way they are.”
Rationale
Summary of Committee Process
I'm sure you had a hard day, but I don't think there is such a thing as a chocolate I.V.

Well, there should be.
Benefits of Comprehensive Suicide Risk Assessment

- Client welfare
- Clinical care improvement
- Continuity / Communication
- CYA (Liability)
Template Design

- Risk Factors
- Protective Factors
- Determine Level of Risk
"Your kid throws up a lot."
RISK FACTORS / PROTECTIVE FACTORS

- Demographic Information
- Mental Health Factors
- Psychosocial-Environmental Factors
- Medical Factors
- Additional Personal Factors
- Additional Clinical Factors
Demographic Information

- Financial/security problems
- Living alone
- Never married, separated, divorced
- Cultural minority/International student
- Sexual Minority (i.e., LGBTQ)
- Other
Mental Health Factors

- Current suicidal behavior (ideas/plans/threats/attempts)
- History of suicidal behavior (ideas/plans/threats/attempts)
- Mental disorder (major depression/bipolar/substance abuse/schizophrenia/Borderline Personality Disorder)
- Concurrent presence of significant anxiety
- Family history of suicidal behavior/mental illness
- Prior mental health treatment – inpt or outpt
- Other
Psychosocial-Environmental Factors

- Loss of autonomy/independence
- Significant loss (e.g., job, relationship)
- History of violence/aggressive behavior/harm to others/temper outbursts)
- Death of family member/significant other
- Lack of significant relationships
- Negative social interactions
- Social isolation
- Victim of physical/sexual assault
- Academic problems
- Major/recent life stressors
- Family conflict
- Breakdown of client’s support system
- Access to weapons
- Other
AHEM!

WELL?

WELL WHAT?

DOESN'T ANYBODY NOTICE ANYTHING?

NOTICE WHAT?

I SHAVED!
Medical Factors

- Recent and/or chronic health/medical problems (e.g., STDs/seizures/cancer)
- Head injury
- Severe or chronic pain
- Family member illness/medical problems
- Other
Additional Personal Factors

- Low self-esteem
- Feelings of hopelessness/helplessness
- Emotional instability/agitation
- Impulsivity or aggression
- Irrational beliefs/distorted thinking/rigid thinking
- Low stress tolerance
- Poor judgment/insight
- Poor coping skills
- Poor problem-solving skills
- Other
Additional Clinical Factors

- Recent use of/increase in substance abuse
- Changes in behavior
- Changes in mental status
- Changes in mood
- Changes in attitude
- Lack of compliance with treatment
- Other
Demographic Information

- Relative financial security
- Married or significant relationship
- Employed or involved in a structured program (e.g., education)
- Other
Mental Health Factors

- Involved in mental health treatment
- Medication compliance
- Effective cognitive functioning
- Good insight
- Healthy family functioning
- Other
Psychosocial-Environmental Factors

- Support system (e.g., family, friends, church, social clubs, institution)
- Emotional, informational, and tangible support
- Sense of belonging
- Best friend(s)
- Constructive use of leisure time/enjoyable activities
- Duty to others
- Responsibility to children
- Pets
- Religious prohibition
- Calm environment
- Difficult access to means
- Other
Medical Factors

- Good health
- Family history negative for major medical Dx
- Healthy nutritional habits
- Regular exercise
- Awareness of/access to available medical care
- Medical insurance
Additional Personal Factors

- General purpose in living
- Effective problem-solving skills
- Sense of hope
- Feeling loved/valued
- Positive self-esteem
- Stable identity & role development
- Personal sense of competence
- Perception of acceptance by others
LIFE IS SWELL

I NEED LOVE.

I NEED SWEETNESS.

I NEED INTIMACY.

I NEED PATIENCE.

I NEED HONESTY.

I NEED UNDERSTANDING.

I NEED HAPPINESS.

I NEED LAUGHTER.

HA HA HA HA

HA HA HA

HA

HA

HA
Additional Clinical Factors

- Safety plan
- Therapeutic alliance
- Sobriety
- Adaptive behaviors
- Normal mental status
Policies & Procedures
Suicidality Risk Hierarchy

- **Not Suicidal** – may have fleeting and/or intermittent ideation/thoughts, no plan, no intent
- **Mild** – some passive or active suicidal thoughts, no plan, no intent
- **Moderate** – passive or active suicidal thoughts, vague plans, no clear intent
- **High** – active suicidal thoughts, specific plan, and/or clear intent
If student’s safety can be established, following action is recommended:

- **Not Suicidal** – No specific response is required
- **Mild** – F/U at discretion of provider
- **Moderate** – Consider consult*, F/U within 1 week
- **High** – Seek consult, create safety plan, consider hospitalization or other protective environment

* with all suicidal risk, consultation is encouraged
ONE OF YOU IS HERE TO DELIVER A PIZZA.
If student’s safety cannot be established, following action is recommended:

- **Not Suicidal** – No specific response is required
- **Mild** – F/U at discretion of provider
- **Moderate** – Within 72 hours, provider will:
  - Attempt contact and/or
  - Consult with colleague(s) and/or
  - Seek supervision and/or
  - Call police for a wellness check
- **High** – Within 24 hours, provider will:
  - Attempt contact and/or
  - Consult with colleague(s) and/or
  - Seek supervision and/or
  - Call police for a wellness check and/or
  - Initiate other appropriate action based on specifics of case
- Action taken
- Action not taken
- Rationale
Peer Review / Staff Compliance with Policies & Procedures

VISIT TYPES REVIEWED

Triage
Initial Visit
Continuing Visit
Peer Review / Staff Compliance with Policies & Procedures

- TRIAGE*
  - Suicidality assessed (100%)
  - For all levels of suicidality
    - Template utilized (100%)
    - Narrative explanation provided (100%)
  - Plan noted (location w/in note varied)

* 17% of Triage Sample assessed at High Suicidal Risk
INITIAL VIST*

- Suicidal risk level documented in Template (88%)
- Suicidal risk level documented elsewhere (4%)
- Suicidal risk level not documented (8%)

When assessed to be “Not Suicidal”
- Explanation provided (58%)
- Explanation not provided (42%)

For all levels of suicidal risk:
- Used Template to determine risk level (75%)
- F/U plan was consistent w/ P&P (75%)
- Explanation provided for assessment of risk (100%)

* 15% of Initial Visit Sample had Some Suicidality Risk Level
CONTINUING VISITS*

- Suicidal risk level documented (81%)
- Suicidal risk level not documented (19%)

When assessed to be “Not Suicidal”
- Explanation provided (48%)
- Explanation not provided (52%)

* 4% of Continuing Visits Sample had Some Suicidality Risk Level
Triage

- 17% High Suicidality
- 83% Not Suicidal
Initial Visit

- Some Suicidality: 15%
- Not Suicidal: 85%
Continuing Visits

- 4% Some Suicidality
- 96% Not Suicidal
“They’re great with kids, but not all of the defects have been bred out of them yet.”
Action Taken After Peer Review

- Template Revision
  - Expanded Risk & Protective Factors
  - Add text box for “negative” Risk/Protective Factors
  - Added recommended action prompts into P&P

- Staff Training
  - Other than “Not Suicidal” – use Template to document Risk & Protective Factors
  - If any SI present at previous session, must assess SI at subsequent visit
REVIEW

- Incident
- Review
- QI Issue Identification
- Formation of Committee
- Research
- Template Design
- P & P Review & Revision
- Staff Training
- Implementation
- Compliance Review
REVIEW OF OBJECTIVES
The attendee should be able to:

- Identify the multiple risk factors contributing to suicidal thinking/behavior in students.
- Identify level of risk for student suicidal behavior.
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Questions / Comments?

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Western Interstate Commission on Higher Education (WICHE) and Suicide Prevention Resource Center (SPRC). (2009) Suicide Prevention Toolkit for Rural Primary Care: A Primer for Primary Care Providers. Boulder, Colorado: Western Interstate Commission on Higher Education.
Twelve Core Principles of Suicide Risk Assessment

Suicide risk assessment:
  of each person is unique,
  is compelling and challenging,
  is an ongoing process,
  errs on the side of caution,
  is collaborative,
  relies on clinical judgment.
  takes all threats, warning signs, and risk factors seriously.
  asks the tough questions.
  is treatment.
  tries to uncover the underlying message.
  is done in a cultural context.
  is documented.
Suggestions for Documentation of Risk Assessment

These statements reflect points from various authors, based on literature review.

The record should include a complete and detailed report of what happened and support for the therapist's actions.

Assess risk, including client's background.

Identify information which alerted the therapist to the risk.

Record risk factors which were present.

Record protective factors which were present.

Specify questions asked and replies given.

Indicate how the data, including the therapist's clinical and evaluative judgments, led to actions taken or not taken.

Include name and credentials of those consulted.

Specify the actions recommended. Record the time of the consult or decisions or interventions. Establish a timeline.

Indicate the rationale for all following recommendations provided.

State source of differences of opinions between consultants and the provider.

Record communications contemporaneously.

Add to the record as facts become known.

Re-assess for suicidality at each meeting.

The goal: to behave in a reasonable professional manner given the information possessed at the time.

Consider that the competent client has a right to participate in decisions.

Is it in the best interest of the client to involve others in open communication of the risk and benefits of a course of action?

Inform the client of the availability of a "second opinion."

"In the absence of research, breach of duty and failure to follow professional standards has occurred."