Direct Driver Interventions - Suicide-Specific Tools that can be imported into CAMS care

This guide will describe general clinical techniques and interventions that address the following:

1. Means Restriction
2. Crisis Card
3. Safety Planning
4. Hope Kit
5. Four-Step Problem Solving
6. Chain Analysis
7. Mindfulness (from DBT)
8. Emotion Regulation Skills
9. Distress Tolerance
10. Behavioral Activation
11. Future Planning Skills

Appendix A: Crisis Card Template
Appendix B: Safety Planning Template
MEANS RESTRICTION

A critical aspect of short-term safety planning, Means Restriction refers to procedures designed to reduce or eliminate access to or availability of methods for deliberate self-harm. Such means generally include firearms, ropes/other methods of strangulation, knives/razorblades, drug overdose, and jumping from high places. Firearms constitute both the most fatal and the most commonly used means in the United States – they account for more than half of the suicide deaths in the general US population and are more often used in suicides than in homicides. Clinicians must occasionally use creative strategies that go beyond simply “taking the weapon away” in order to ensure the patient’s safety.

Listed below are several approaches regarding restriction of firearm access as well as access to other common means. In every circumstance, the clinician is first required to acquire the patient’s permission and collaboration.

**Educate the patient’s friends and family on the importance of means restriction:** The Emergency Department Means Restriction Education program is one successful module that is currently listed in the Suicide Prevention Resource Center’s (SPRC) Best Practices Registry for Suicide Prevention: [http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=15](http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=15)

**Receipt from a 3rd party verifying delivery of the gun/other means into his/her custody:** Verification usually occurs in the form of a phone call/voicemail message from the 3rd party to the clinician. Some law enforcement departments offer temporary storage and/or permanent disposal of firearms. For additional information see [http://www.hsph.harvard.edu/means-matter/files/Questions_about_Storing_Firearms.pdf](http://www.hsph.harvard.edu/means-matter/files/Questions_about_Storing_Firearms.pdf)

**Gun locks:** A less preferable alternative to means removal is to lock all firearms, *unloaded*, in a tamper-proof, locked storage place. Keys or combinations must not be accessible to the at-risk patient and ammunition should be locked-up separately or removed from the home entirely.

**Consider the lethality of psychiatric and other medications prescribed to the patient:** Limit prescriptions of lethal medications to suicidal patients to a non-lethal quantity in coordination with the patient’s prescribing physician

**Other environment precautions:** Remove ropes, extension cords, razorblades. Physically block off access to upper-story windows/balconies. Limit quantities of alcohol available to the patient.

Ample research confirms the effectiveness of means restriction on reducing suicide rates. The Harvard Injury Control Research Center provides links to the latest research as well as additional means restriction recommendations on its website: [http://www.hsph.harvard.edu/means-matter/](http://www.hsph.harvard.edu/means-matter/).

**References:**
**Crisis Card**

The Crisis Card is often a vital component of safety planning. The card is meant to be pocket sized and is often written-in on the back of a therapist’s business card or a crisis hotline card. It lists the patient’s preferred distraction activities, including reaching out to an emergency contact, that the patient will utilize at the time of a suicidal crisis (see Appendix A).

A Crisis Card should be created collaboratively between the patient and clinician. It is the clinician’s role to guide the patient in selecting distraction activities that are likely to reduce suicidality. It is essential that the patient agree to keep the card with him/her at all times, hence the recommendation that the card be wallet/pocket-sized.

The fundamental components of a Crisis Card include the following:

**Distraction Activities:** Under the clinician’s guidance, the patient selects multiple activities that she/he believes will help reduce suicidality in the time of a crisis (i.e., reading a magazine, watching television, going for a run, lifting weights, calling a friend or family member, etc). It is recommended that four to five activities are chosen. Clinical experience indicates fewer activities are not sufficient for clients to learn self-coping strategies, particularly in the initial stages of treatment.

**Criteria for appropriate activities:** These include activities that are enjoyable, evoke emotions contrary to the current upset, are highly engaging, involve other people when possible, and are free of negative, long-term consequences (i.e., drinking, using drugs, gambling and engaging in unsafe sex do not constitute effective distracting techniques).

**The Emergency Contact:** The last item on the card should always be an emergency contact. It is the clinician’s prerogative whether or not to provide his/her personal contact information or the number for a Crisis Hotline. If the clinician chooses to disclose personal contact information, it is recommended the clinician and patient have a clear and direct conversation regarding the necessary boundaries associated with providing such information.

Clinical experience has demonstrated that Crisis Cards can successfully deter clients from engaging in suicidal behaviors at the time of crisis.

**References:**
SAFETY PLANNING

A Safety Plan is a written list of coping strategies and a list of people/sources of support that a patient can contact in order to keep him/her safe before or during a suicidal crisis (see Appendix B). The clinician and the patient work collaboratively to develop the Safety Plan. It should be brief, and written in the patients’ own words. Generally, the patient receives a copy of the plan to keep so that the patient can independently refer to and use the Safety Plan in his/her daily life.

Stanley and Brown (2008) list six steps involved in creating a Safety Plan:

1. Identify warning signs to attune the patient as to when the Safety Plan should be used

2. Assist patient in identifying risk-reducing coping strategies. For Steps 2 through 5, collaboratively consider the patient’s likelihood of engagement in the step and address potential obstacles.

3. Have patient identify several social settings capable of distracting him/her from suicidal thoughts and feelings should the Step 2 strategies fail. The patient does not need to reveal that he/she is in crisis.

4. Have patient identify a prioritized list of family members and friends with whom the patient can talk should the Step 3 distractions fail. The patient should reveal that he/she is in crisis and may benefit from role-playing this step with the clinician.

5. Help patient identify and rehearse contacting mental health professionals and/or agencies to elicit support should Step 4 fail to resolve the crisis.

6. Identify the lethal means that the patient has considered using during a suicidal crisis and collaboratively identify ways to limit access to these means.

Following the construction of a Safety Plan, the clinician and patient assess likelihood of use, identify obstacles to use, discuss where the patient will keep his/her copy so that it is easily accessible in a crisis, evaluate the appropriateness of the plan’s format, and periodically review and update the plan.

The Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version is currently listed in the SPRC’s Best Practices Registry for Suicide Prevention and is undergoing further research. The manual is available free of charge from the U.S. Department of Veteran’s Affairs.

References:
A Hope Kit is a collection of personal possessions that have meaning to the patient. In times of distress, the kit can serve as memory aid – a reminder – to the patient of various people, activities, and symbols that have been important to them, and can help maintain a connection with their reasons for living and prospects for a better future.

One of the most important elements of the cognitive-behavior approach to treating suicidality is addressing hopelessness, a well-documented risk factor for suicidal behavior. A Hope Kit can be an effective tool for patients that are struggling with this feeling.

The fundamental aspects of a Hope Kit include the following:

**Creation of the Hope Kit:** The clinician and patient should have a discussion about the purpose of a Hope Kit, what the patient feels should be included in their kit, and how the kit should be used. The process of creating the kit itself can help refresh patients’ memories of their reasons to live, as well as help them discover new ones.

**Examples of Kit contents:** These include pictures of pets, artwork made by friends or family members, awards, letters from friends or family members, faith-based items, and crisis/coping cards made during previous sessions. Smartphone applications such as PTSD Coach (T2 Health) can help patients manage certain symptoms, and a host of scrapbooking applications exist that patients can use to create a digital Hope Kit. Patients without access to applications can still be encouraged to incorporate content such as emails, voicemails, and text messages into their Hope Kits.

**Use of the Kit:** The patient is encouraged (often as part of a Safety Plan) to develop the behavioral habit of turning to the kit as a healthy coping mechanism when experiencing distress.

**Storage of the Kit:** It is important that the kit be stored in a place that is both memorable and accessible to the patient so that it can be reached easily when needed.

Patients have expressed that the process of creating a Hope Kit can be very gratifying, and researchers have documented its incorporation into the successful treatment plans of suicidal cases.

**References:***
The PTSD Coach smartphone application can be found at [http://t2health.org/apps/ptsd-coach](http://t2health.org/apps/ptsd-coach)
FOUR-STEP PROBLEM SOLVING

Problem solving in a clinical context can generally be defined as the processes by which a person attempts to find adaptive and productive ways of responding to problems encountered in everyday life.

The clinical application of problem solving is a four-step process:

1. **Problem orientation:** This step revolves around helping patients develop a healthy perspective on problems in general. How a patient conceptualizes a problem can have a major impact on what is done as a response, and the formulation of a positive and adaptive attitude towards problems is encouraged.

2. **Problem definition and formulation:** The patient is encouraged to develop a thorough understanding of the problem, and set realistic response goals. This includes discussing the details of the situation, differentiating between facts and assumptions, and describing what makes the situation an actual problem. This clarification will make it easier to formulate a set of realistic goals in response.

3. **Generation of alternative solutions:** Generating as comprehensive a list of response options as possible will help identify those most realistic and effective. Also, the potential is minimized for the patient to be discouraged if their first response is not successful. This will reinforce a sense of empowerment that can help patients feel more confident in their ability to solve problems in the future.

4. **Decision making:** This step involves helping the patient choose from the list of options that has been created. To guide the patient towards the most potentially successful responses, discussion should include both the short and long-term potential outcomes of each option, as well as both the personal and social consequences.

Developing this skill set is particularly important with suicidal patients, as research has shown that those with deficits in problem solving skills experience both more stress and more hopelessness.

References:
Chain Analysis

Chain analysis from Dialectical Behavior Therapy (DBT) is implemented to dissect a particular behavior so that the patient is able to learn more about (a) events during which the behavior tends to occur, (b) the triggers that often lead to the behavior, and (c) the consequences resulting from the behavior. Breaking-down experiences in this very specific moment-to-moment fashion allows the patient to become aware of how certain behaviors manifest and enables the patient to translate that information into healthy behavioral change.

There are four fundamental mechanisms of change associated with Chain Analysis:

Exposure: By discussing behavioral responses such as suicide attempts and their triggers in-session, a patient engages in an exposure that is not reinforced. This allows the link between the behavior and its resulting feelings to be broken down so that problem solving can take place.

Aversive contingencies: Behaviors that are often the target of chain analysis are also often behaviors that patients are reluctant to discuss. In this context, the chain analysis itself can serve as a punisher for engaging in target behaviors. The patient will eventually come to learn that sessions following such behaviors will include a long and detailed discussion of the behavior and its context.

Autobiographical memory specificity: Continued, detailed discussion of the events and circumstances surrounding a target behavior will eventually make the patient more sensitive to triggers and patterns leading to that behavior. Moving forward, the patient will be better able to recognize when a dangerous situation arises.

Practice in and learning of new skills: In addition to insight about situations during which target behaviors tend to arise, the patient is also exposed to interventions that allow them to change the ways in which they respond to their emotions using behavior. Repeated use of these new skills will increase the likelihood that a patient is able to both recognize a potentially dangerous situation and implement a more healthy set of behaviors once that awareness surfaces.

Research has demonstrated support of these elements individually and in the greater context of DBT. The worksheet found at http://www.box.net/shared/pixmr7btu can be used as a guide for both the patient and clinician when working through the analysis of a specific behavior.

References:
MINDFULNESS
(AS DISCUSSED IN DIALECTICAL BEHAVIOR THERAPY)

Mindfulness originates from ancient Eastern spiritual training, particularly Zen practices. It refers to non-judgmentally letting go and thus allowing an individual to become fully present in the moment.

Within Dialectical Behavior Therapy (DBT), mindfulness is considered an underlying skill that applies to all aspects of psychological well-being. Although it appears to be a relatively simple skill, successful mindfulness requires a new way of thinking takes time to grasp, cultivate, and apply. Though not necessary for success, clinicians who embrace mindfulness in their own lives often find they are better able to communicate and teach mindfulness skills to their patients.

The fundamental components of Mindfulness include the following:

**Three primary states of mind:** 1. *Reasonable mind* – intellectually approaches knowledge and rationally thinks/plans; 2. *Emotional mind* – emotions control thoughts and behaviors, rational thinking is difficult, and facts are amplified or distorted; 3. *Wise mind* – the integration of reasonable mind and emotional mind emphasizing the incorporation of intuition

**Three “what” skills:** 1. *Observing* – fully experiencing the moment by attending to events and emotions without attempting to change them. Often requires psychological space from event/emotion; 2. *Describing* – allows for communication, self-control, and distinguishing between feelings and reality by applying verbal labels to behavioral and environmental events; 3. *Participating* – 100% commitment to engagement in activities with alertness and awareness.

**Three “how” skills:** 1. *Nonjudgmental stance* – taking a non-evaluative approach that focuses on the consequences of behaviors rather than labeling behavior in black and white terms; 2. *Focusing on one thing in the moment* – controlling attention and focusing the mind/awareness on the current moment/activity; 3. *Being effective* – doing what works by letting go of notions of “being right” and instead focusing on achieving the goal.

Research has shown support for these elements both individually and within the greater context of DBT, particularly regarding the treatment of individuals with Borderline Personality Disorder. The worksheets provided in the manual referenced below, as well as those provided at [http://practicegroundprojects.wetpaint.com/page/Handouts,+Protocols+%26+Client+Learning+Activities](http://practicegroundprojects.wetpaint.com/page/Handouts,+Protocols+%26+Client+Learning+Activities) can be used as a guide for both the patient and the clinician when practicing mindfulness skills.

**References:**
EMOTION REGULATION

Emotion regulation is the ability to recognize, describe, and function within the realm of a wide-range of emotional states. The goals of emotion regulation training include understanding one’s own emotions, reducing emotional vulnerability, and decreasing emotional suffering.

It is essential that emotion regulation be taught and practiced in a “mindful” context, in which the patient can become empowered by his/her own ability to emotionally self-validate. The clinician starts by helping the patient to understand the complex nature of emotions while re-conceptualizing the concept of “emotion” as a tool rather than as a cause for anguish. During this process, it is helpful to acknowledge factors that interfere with observing and describing emotions including secondary emotions and ambivalence.

The fundamental skills associated with Emotion Regulation include the following:

**Understanding emotions:** 1. Recognize Emotions – body language, words, and actions; 2. Describe emotions – identify the prompting event, the interpretation of the event, the body responses, language, communications, and actions resulting from the event; 3. Naming emotions - identify different words and phrases for different emotional states.

**Enhancing Positive Emotions:** 1. Short Term Positive Experiences – increase daily positive experiences; 2. Long Term Positive Experiences – set goals and work towards them; 3. Attend to relationships – repair old relationships and cultivate new ones; 4. Avoid Avoiding - decrease avoidance behaviors; 5. Mindfulness– stay attuned to positive experiences without focusing on if/when they will end.

**Decreasing Negative Emotions:** 1. Reducing Vulnerability - acronym PLEASE MASTER (Treat PhysicaL illness, balance Eating, avoid mood-Altering drugs, balance Sleep, get Exercise, build MASTERy) 2. Let Go of Emotional Suffering – observe and experience emotions as a wave that comes and goes and is a separate entity from the client

**Take Charge of Emotions:** 1. Changing Emotions by Acting Opposite - get active, approach fearful situations continue engaging in guilt inducing behaviors, appropriately avoid trigger situations; 2. Respect your emotions – be wiling to experience whatever emotion arises and don’t assume its inherently wrong

Research has shown support for these elements both individually and within the greater context of DBT. The worksheets provided in the manual referenced below, as well as those provided at [http://practicegroundprojects.wetpaint.com/page/Handouts,+Protocols+%26+Client+Learning+Activities](http://practicegroundprojects.wetpaint.com/page/Handouts,+Protocols+%26+Client+Learning+Activities) can be used as a guide for both the patient and the clinician.

References:
DISTRESS TOLERANCE

“Distress tolerance is the ability to perceive one’s environment without putting demands on it to be different, to experience your current emotional state without attempting to change and it, and to observe your own thoughts and action patterns without attempting to stop or control them” (Linehan, 1993, p. 96). It is akin to developing a thicker psychological skin.

Distress tolerance is a key component of Dialectical Behavior Therapy (DBT) wherein the clinician emphasizes that pain and distress are an unavoidable part of life. The clinician emphasizes that it is essential for the patient to learn to cope with unpleasant emotions, sometimes by facing them head-on and sometimes by taking a step back from the problem to gain a fresh perspective. The clinician may use examples of the patient’s past avoidant behavior to demonstrate how avoidance often leads to increased distress. It should be explained that practicing the following skills and becoming tolerant of distress will enable the patient to break ongoing, unhealthy behavior cycles and see true change occur.

The fundamental skills associated with distress tolerance include the following:

**Crisis Survival Strategies:**

1. **Distraction** - acronym ACCEPTS (Activities, Contributing, Comparisons, Emotions, Pushing away, Thoughts, Sensations);
2. **Self-Soothing** – use the five senses to calm yourself;
3. **Improving the Moment** - acronym IMPROVE (Imagery, Meaning, Prayer, Relaxation, One thing in the moment, Vacation, Encouragement);
4. **Thinking of Pros and Cons** - patient asks him/herself, “What behavior will provide me with the better outcome?”

**Guidelines for Accepting Your Reality:**

1. **Observing Your Breath** - deep breathing, measuring, counting or following your breath;
2. **Half-Smiling** - adapting a serene facial expression to promote relaxation;
3. **Awareness Exercises** - awareness during every day activities

**Basic Principles of Accepting Reality:**

1. **Radical Acceptance** - complete acceptance from within;
2. **Turning the Mind** - choosing to accept reality as it is;
3. **Willingness versus Willfulness** - surrendering oneself completely instead of responding with a “yes, but” response

Research has shown support of these elements individually and in the greater context of DBT. The worksheets provided in the manual referenced below, as well as those provided at [http://practicegroundprojects.wetpaint.com/page/Handouts,+Protocols+%26+Client+Learning+Activities](http://practicegroundprojects.wetpaint.com/page/Handouts,+Protocols+%26+Client+Learning+Activities) can be used as a guide for both the patient and the clinician when practicing distress tolerance skills.

**References:**

Behavioral Activation (BA), as developed by Martell, Addis, and Jacobson (2001), is an expanded version of traditional behavior therapy that emphasizes routine use of functional analysis, activity scheduling, and rehearsal in every session in order to directly identify, decrease, and replace “avoidance” behaviors such as rumination, excessive time in bed, social withdrawal, etc.

BA theory affirms that depressed individuals engage in activities that offer them the temporary relief of avoiding or escaping from aversive thoughts, feelings, or situations. Inevitably, though, these learned avoidance responses lead the individual to develop a narrow repertoire of passive “secondary-coping” behavior, which in turn leads to poor problem-solving and decreased engagement in activities that provide a sense of pleasure or accomplishment. Thus, BA clinicians use semi-structured activities to address the avoidance behaviors that keep patients trapped in a depressive cycle and encourage “approach” behaviors that activate patients in their natural environment. The techniques used in BA can be classified as follows:

**Assessment Techniques:** Prescribed early in treatment, activity monitoring via tools such as weekly activity charts provides information about baseline and subsequent levels of involvement in pleasurable or empowering activities. BA patients are explicitly instructed to monitor behaviors that function as ways to avoid painful thoughts and feelings. Second, value and goal assessment identifies values that are deeply held by the patient and may help reinforce behaviors for which there are aversive short-term consequences and only intangible, long-term benefits.

**Activation Techniques:** Activity scheduling generally requires the patient to engage in daily activities that either discourage avoidance behavior or promote value-directed behavior. The activities should engender a sense of mastery and accomplishment, but do not necessarily need to be “pleasant” activities. One version of activity scheduling called Graded Task Assignment (originally developed by Beck et al., 1979) assigns easier tasks first, followed by increasingly more difficult tasks as the patient begins to improve. The goal of these incremental steps is to schedule activities that have a maximum likelihood of being successfully completed by the patient.

**Supplementary Techniques:** These include skills training, in-session role-plays, contingency management, and procedures targeting verbal behavior, and are only required when a depressed patient lacks the foundational abilities needed to effectively engage in scheduled activities. For example, a patient who has difficulty interacting with new people may benefit from social skills training before attempting to join a new club or invite a new friend over for dinner.

Research has shown that BA merits recognition as an empirically-validated treatment. Accordingly, BA is currently included on the American Psychological Association’s list of treatments for depression with “Strong Research Support.”

**References:**
**FUTURE PLANNING SKILLS**

Hopelessness, a well-known risk factor for suicidality, revolves around a pessimistic view of the future. Accordingly, helping suicidal patients develop the ability to plan for future events can change their outlook on the future in general and thus can be a powerful and effective intervention tool. Critically, research has shown that suicidal people have distinct deficits in their planning ability and their capacity to think about the future.

Future planning skills can benefit the patient in a variety of ways. As it relates to treatment, enhancing a patient’s planning skills can maximize the probability that the patient will attend CAMS sessions, as well as any other appointments that are incorporated into the treatment plan. Beyond treatment sessions, functional planning habits can permeate into other aspects of the patient’s life, such as professional responsibilities, social obligations, and hobbies, allowing the patient to feel more confident in his/her ability to manage these simultaneously. In the long-term, the patient’s general plans and future goals, such as marriage, parenthood, education, or certain professional accomplishments, may become some of the patient’s most motivating reasons for living.

**Suggestions for promoting future planning skills are as follow:**

**Short-term Planning:** Effective tools to complement short-term planning efforts should be discussed with the patient. “To do” lists, while sensible in theory, can leave patients with a list of tasks to accomplish that is often unfocused and difficult to approach. On the other hand, encouraging patients to use a calendar as part of their planning effort can be very effective. The key is to develop reasonable lists that can be realistically completed in reasonable time frames—this can become an acquired skill.

**Long-term Planning:** Long-term goals for the future should be discussed in-session, and revisited as often as is needed during treatment in an effort to keep the patient focused. A key piece of developing the ability to plan effectively for the future is the creation of a realistic set of goals that both the clinician and the patient are confident can be met. Otherwise the risk for failure, a sense of discouragement, and suicidal relapse can greatly increase.

Underscoring the importance of cultivating future planning skills among suicidal patients are research findings showing that a positive outlook on the future is negatively correlated with hopelessness, and that the ability to think about the future can function as a protective factor for the suicidal patient.

**References:**
APPENDIX A: CRISIS CARD TEMPLATE

Here is an example of a Crisis Card:

| 1. Watch an episode or two of my favorite comedy |
| 2. Go for a run while listening music |
| 3. Take a nap |
| 4. Call John (friend) at 111-222-3333 |
| 5. Call Dr. Smith at 222-333-4444 |

List activities you would consider including your Crisis Card:

- _______________________________________________________________
- _______________________________________________________________
- _______________________________________________________________
- _______________________________________________________________
- _______________________________________________________________
- _______________________________________________________________
- _______________________________________________________________
- _______________________________________________________________

Using a business card or other small sturdy piece of paper that will fit in your wallet, create your own Crisis Card
APPENDIX B: SAFETY PLANNING TEMPLATE

**Step 1:** 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 technique, physical activity):
1.____________________________________________________________________________
2.____________________________________________________________________________
3.____________________________________________________________________________

**Step 3:** People and social settings that provide distraction:
1. Name_____________________________________________Phone_____________________
2. Name_____________________________________________Phone_____________________
3. Place_____________________________    4. Place__________________________________

**Step 4:** People whom I can ask for help:
1. Name_____________________________________________Phone_____________________
2. Name_____________________________________________Phone_____________________
3. Name_____________________________________________Phone_____________________

**Step 5:** Professionals or agencies I can contact during a crisis:
1. Clinician Name____________________________________Phone_____________________
   Clinician Pager or Emergency Contact # _________________________________________
2. Clinician Name____________________________________Phone_____________________
   Clinician Pager or Emergency Contact # _________________________________________
3. Local Urgent Care Services_____________________________________________________
   Urgent Care Services Address___________________________________________________
   Urgent Care Services Phone_____________________________________________________
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

**Step 6:** Making the environment safe:
1.____________________________________________________________________________
2.____________________________________________________________________________