INTERVENTIONS FOR STUDENTS CONSIDERING SUICIDE

This material focuses on evidence-based or research-informed therapies and tools, and is not intended to be a comprehensive guide on all treatments used with clients who report suicidal thoughts.

TABLE OF CONTENTS

WHY THIS PROTOCOL MATTERS

Researchers cannot yet predict which individuals will act on their suicidal impulses and 13% of college students nationwide seriously considered suicide last year. (ACHA 2019) Today's standard of care includes first treating suicidal thinking and behaviors directly, and after the client is stabilized, then going on to treat the underlying behavioral health issue(s).

SAFETY PLANNING INTERVENTION

The Safety Planning Intervention, developed by Greg Brown and Barbara Stanley, is a collaborative process between a clinician and client. The object is to build a list of strategies the individual can use to distract themselves and keep themselves safe from the suicidal impulse.

A word about one aspect of the Safety Planning Intervention that is often not mentioned – to start the process, a detailed recounting of how the crisis happened can help the individual see what started the crisis, and when the height of it occurred. This work on the arc of the suicide crisis helps the individual to recognize what may have triggered their crisis. That knowledge can help a client anticipate when they need to turn to their safety plan.

An individual's safety plan should be treated as a daily working document – taped up on the refrigerator door or in another easy-to-access spot. The mental health provider and client should review the plan regularly for possible updating.

Safety plans have replaced no-harm contracts, after researchers found them to be ineffective.

LETHAL MEANS REDUCTION

Removing access to lethal means can be an effective way to protect the safety of a suicidal individual who has the intent to act, a plan, and access to the means they have chosen. The more lethal the means, the more critical it is to remove access. See Means Matter at the Harvard Injury Prevention Program, Safer Homes, Suicide Aware, or Counseling Against Lethal Means (CALM) for more information.

Several population-level examples of reducing access to lethal means have shown reduction of suicides. These include such actions as lessening the toxicity of domestic gas supply used in natural gas and using blister-packs for potentially lethal over-the-counter medications.

Institutions of higher education should schedule regular reviews of their physical facilities to ensure that access to locations or substances that could be used in a suicide are impeded or removed. See the Crisis Response Protocol for more information.

CARING CONTACTS

Caring Contacts are non-demand, non-judgmental messages of caring sent to an individual after a suicide attempt. Jerome Motto first used caring letters to support suicide attempt survivors after they left hospital treatment. The letters were sent over a period of two years by a health care professional who had spent time with the patient. In a randomized controlled trial were found to reduce suicide.

One of the original caring letters read:

> *Dear John –*
> *It has been some time since you were here at the hospital, and we hope things are going well for you. If you wish to drop us a note, we would be glad to hear from you.*

Texted expressions of caring also show positive results. Caring contact can be used during any care transition to encourage a patient to move into their next phase of care. Case managers and peer counselors also can help ensure clients continue to access care.

DIALECTICAL BEHAVIOR THERAPY (DBT)

DBT was developed by University of Washington psychologist Marsha Linehan as a treatment for women experiencing borderline personality disorder. Now used with individuals who struggle with suicidal thoughts or have attempted suicide, DBT is a team therapy.

One of the central dialetics in DBT involves radical acceptance and acquiring capacity for change. DBT skills include emotional regulation, distress tolerance, problem-solving, mindfulness, and interpersonal effectiveness. The skills are sometimes taught independently of

therapy; DBT-A skills are taught to secondary students and can be taught to elementary students as well.

DBT has been researched extensively and found effective in reducing suicide attempts, suicidal thinking, and non-suicidal self-injury.

COGNITIVE THERAPY FOR SUICIDE PREVENTION (CT-SP)

Cognitive Therapy for Suicide Prevention is a cognitive–behavioral psychotherapy program designed for patients who have previously attempted or thought of suicide. The intervention includes the development of a safety plan, teaches patients to use alternative ways of thinking and behaving during a suicidal crisis, and assists them in building a network of mental health services and social supports to prevent future suicide attempts.

COLLABORATIVE ASSESSMENT & MANAGEMENT OF SUICIDALITY (CAMS)

Collaborative Assessment & Management of Suicidality (CAMS) emphasizes a therapeutic alliance in which clinician and client participate in a detailed assessment process and collaborate to find the drivers of a client's suicidal thoughts or behavior. CAMS is the work of researcher David Jobes and has undergone several studies showing reductions in suicidal thinking and overall distress.

Visit Zero Suicide to learn more about these interventions.

OTHER INTERVENTIONS

Behavioral health practitioners use a variety of promising and research-informed interventions as they support postsecondary students, including those who are considering suicide.

Acceptance and Commitment Therapy (ACT)

ACT helps clients develop a psychological framework involving mindfulness, acceptance and the ability to be present. Growing understanding of personal values allows the adoption of more positive behavior.

Mandated Assessment of Suicide Risk

A small number of institutions nationally and in Washington require mandatory assessments of suicide risk for students determined to have engaged in suicidal statements or behavior.

This type of program was first developed in 1984 at the University of Illinois, Urbana-Champagne by Paul Joffe, longtime director of counseling. Over the next 20 years, the suicide rate decreased by 45%. Learn more here.

The benefits of mandatory assessments include the ability to identify students at risk for suicide and, particularly for students who reported having had suicidal thoughts at some time in their lives, the assessment/treatment was a positive experience. Concerns raised about mandated assessment or treatment challenges include concern around students' losing faith in counseling as a confidential resource.

After ten years of its mandated assessment program, the University of Puget Sound interviewed individuals who experienced the intervention. Most reported that experience was helpful, particularly those at higher risk.

University at Albany describes its CARENet program in Appendix 2 of its Crisis Response Guidelines.

Overall Recommendations

1. Safety planning should be used by any mental health professional working with students.
2. Caring contacts also should be instituted universally.
3. To the extent that funding for training is available, institutions should look for every opportunity to build capacity in among evidence-based therapies.

THANK YOU for spending time with this content. The authors' intent is to prepare you for engaging with issues outlined here, and to bring your colleagues into conversation regarding protocols that will work best for your institution and to benefit your students. You are welcome to use or adapt language from these protocols and from those that are referred here, through links. Please acknowledge the origins of any material you use.