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SCATTT: A Suicide Intervention Plan Mnemonic for Use When Clients Present Suicide Intent

Gerald A. Juhnke, Gerald B. Juhnke, and Pei-Hsuan Hsieh

Juhnke, Gerald A., EdD, LPC, NCC, MAC, LCAS, ACS, is a Professor at The University of Texas at San Antonio. His clinical expertise is specific to Life-Threatening Behaviors.

Juhnke, Gerald B., is a Reagan High School Winners' Circle Member. His research interests include promoting positive student life decisions, and suicide and alcohol prevention.

Hsieh, Pei-Hsuan, PhD, is an Education Specialist at The University of Texas Medical School in Houston. Her research interest is evaluation of learner performance, motivation, and teaching.

Over 36,000 Americans committed suicide in 2009 (National Center for Health Statistics [NCHS], 2011). This is the most recently available U.S. mortality data and equates to approximately one suicide every 15 minutes (American Foundation for Suicide Prevention, 2011). Annually suicide is the 11th leading cause of U.S. deaths (NCHS, 2011). Suicide is also the second leading cause of death for persons ages 25 to 34; as well as the third leading cause of death for Americans ages 10 to 14 and 15 to 24; and the fourth leading cause of U.S. deaths among persons ages 35 to 44 and 44 to 54 (Centers for Disease Control [CDC], 2011). Despite these robust statistics, the numbers of annual U.S. suicides pale in comparison to those seriously considering suicide (Substance Abuse & Mental Health Services Administration [SAMSHA], 2009) and the estimated number of annual suicide attempts commonly referred to as parasuicides (Granello & Juhnke, 2009). A 2008, first-of-its-kind, SAMSHA research study found 8.3 million U.S. adults had serious thoughts of committing suicide within the preceding year; 2.3 million U.S. adults created a serious suicide plan within the preceding 12 month period (SAMHSA, 2009). Parasuicides are failed suicide attempts that may have been either intentionally or unintentionally non-lethal. Estimates suggest approximately 25 parasuicides occur for each completed suicide (American Association of Suicidology, 2007; Granello & Granello, 2007; Juhnke, Granello, & Granello, 2010). If this estimate is true, approximately 900,000 parasuicides occur annually within the U.S. Interestingly, this estimate appears supported by the 660,000 persons admitted to U.S. hospital emergency departments due to parasuicide-related behaviors in 2008 (CDC, 2009) and does not take into account the numbers of persons who parasuicide who do not seek hospital services

through emergency departments. Given the frequency of suicides and parasuicides, counselors should know how to respond to clients presenting with suicide intent.

Suicide Risk Assessment

Suicide assessment interviews and instruments such as IS PATH WARM (American Association of Suicidology, 2006; Juhnke, Granello, & Lebron-Striker, 2007), the SAD PERSONS Scale (Patterson, Dohn, Bird, & Patterson, 1983), the Adapted-SAD PERSONS Scale (Juhnke, 1996), and the Suicide Probability Scale (Cull & Gill, 2000; Valadez et al., 2009) have varying degrees of clinical utility and should be used whenever conducting suicide risk assessments. The use of these assessment methods can promote counselors' knowledge related to their clients': (a) immediate degree of suicide ideation and intent to harm self, (b) suicide and suicidal ideation histories including the frequency, duration, and intensity of suicidal thoughts, (c) intended suicide methods (e.g., gunshot, overdosing, etc.), and (d) life-circumstances actively contributing to suicide intent. If the information gathered during suicide assessments is effectively interpreted and used, counselors can increase the probability of reducing client immediate suicide risk, enhance client safety, and potentially insulate counselors' from malpractice liability. Regretfully, information gathered during suicide assessments is not always effectively used nor integrated into logical suicide treatment plans.

Suicide assessment methods augment the individual counselor's clinical perceptions. However, they merely report the presence of potential suicide risk factors or the assessed client's similarities to populations that have been hospitalized due to perceived suicide risk or serious parasuicides. Therefore, the final determination of how to intervene with clients is the counselor's responsibility.

The first author has found that many of his less experienced clinical supervisees do not fully comprehend how to utilize information gathered during suicide assessments to make effective intervention decisions. Thus, the looming question for many counselors is, "How do I respond to clients after I complete my suicide assessments and believe they present suicide intent?" Below the authors describe a basic suicide intervention plan used by the first author with his clients and reported helpful by his supervisees. The authors hope readers will familiarize themselves with the plan and adapt it as necessary to the individual settings where they work and the specific needs of their individual clients.

SCATTT: A Basic Suicide Intervention Plan

In an effort to address the first author's clinical supervisees' voiced concerns of not understanding how to respond to clients perceived as presenting suicide intent, the first and second authors developed an easily memorized mnemonic, "SCATTT." The mnemonic is a memory aid designed to help supervisees remember the specific steps necessary when intervening with clients who have suicide intent. Each letter of the mnemonic corresponds with a specific and required suicide intervention phase (i.e., **S**tay, **C**onsult, **A**pprise, **T**erminate, **T**runcate, and **T**ransport). SCATTT reminds entry-level counselors of six important suicide intervention plan phases that must occur when it is determined via the previously completed suicide assessments that clients warrant psychiatric hospitalization or another type of least restrictive, monitored, and safe

environment. Supervisees are strongly encouraged to utilize additional intervention pieces depending upon the client's specific needs. The mnemonic and each of the six intervention phases are presented below.

Phase One: Stay with the Client

Whenever a client presents suicide intent, the client should never be left alone. Thus, the counselor or another mental health professional must *stay* with the client until hospitalization or an alternative safety monitoring option that corresponds with the client's degree of danger can be arranged.

Phase Two: Consult

After stabilizing the immediate situation and insuring the client's present safety, the counselor should ask another mental health professional or appropriate designee (e.g., police officer, family member) to monitor the client while the counselor *consults* her clinical supervisor. Specifically, the counselor should contact her clinical supervisor and report her suicide assessment findings, the client's immediate degree of suicide risk, and describe how the client is being monitored. Jointly, the counselor and supervisor should develop a hospital intervention or least restrictive monitoring plan that insures the client's safety and corresponds to the client's noted degree of suicide risk. As the counselor returns to the client, and depending upon the jointly agreed upon suicide intervention plan, the supervisor or supervisor designee should begin contacting area psychiatric hospitals or other clinically appropriate options (e.g., respite care, partial hospitalization programs, psychiatric day center, etc.) to determine potential availability. Concomitantly, should it be anticipated that transportation for an involuntary hospitalization be required, the supervisor or supervisor designee should begin to secure such transportation.

If the counselor does not have a clinical supervisor, the counselor should implement the "four out of five rule." Here, the counselor consults five professional mental health peers. The professional mental health peers must have equal or greater mental health educational backgrounds (e.g., master's degrees, educational specialist degrees, or doctorates), clinical experience, and treatment licenses (e.g., Licensed Professional Clinical Counselor, Licensed Professional Counselor, etc.). Specifically, the counselor will describe the case, the findings from the suicide assessment, and present her proposed clinical recommendations for hospitalization or another least restrictive and safe monitoring option to her professional peers. The counselor will then solicit input from these professional peers in an effort to create the safest clinical intervention and to insure that the proposed clinical intervention is not overlooking important intervention factors. Should four out of the five professional peers perceive the intervention as clinically appropriate, the counselor should be able to implement the clinical intervention.

Phase Three: Apprise

The SCATTT further requires counselors to *apprise* clients of the suicide assessment findings and the counselor's treatment recommendations. A good way to start this phase is by praising clients for recognizing their suicide concerns and for entering counseling. Once counselors praise their clients, counselors then suggest the existence of hope and possibility for positive change. Next counselors apprise clients of the suicide assessment findings and treatment recommendations. Finally, if needed, counselors

describe differences between voluntary and involuntary psychiatric hospitalizations and potential benefits to voluntary hospitalization. Thus, the session might go something like this,

Counselor: Charlie, first, I want to commend you for initiating counseling. Believe it or not many people at one time or another feel like committing suicide. Yet, they fail to enter counseling to improve their lives. You on the other hand demonstrated great courage today by initiating the counseling process and seeking help. I have counseled many people who originally felt suicidal but have since learned how to take control of their lives and live a more satisfying life.

Client: Thanks, but I just do not think I have the courage to continue living.

Counselor: You know what? I believe you. During our suicide assessment earlier today, you indicated that didn't want to live. You said you just wanted to go home and shoot yourself with your gun. Is that right?

Client: Yes, life is rough. I do not think I can keep going.

Counselor: Based on what you have told me, Charlie, I believe you are at risk for suicide. I also believe you want help; otherwise, you would not have come here today. Charlie, let us get you into a safe environment where you can get the help you want. A number of my clients have voluntarily admitted themselves into St. Andrews Hospital and found the experience to be helpful. Let's get you there until things improve.

If Charlie indicates that he will voluntarily admit himself into St. Andrews hospital, we will move to the Transport Phase. However, should Charlie refuse to voluntarily enter the hospital, the counselor should explain potential differences and benefits between voluntary and involuntary hospitalization. Depending upon specific state and relevant laws, clients who voluntarily admit themselves to psychiatric hospitals can often be released if the hospital staff does not perceive the clients as an immediate danger. However, if clients are involuntarily hospitalized, some states require clients to remain for a minimum 72 hour monitoring period. Thus, clients will sometimes prefer to self-admit as a voluntary client with the hope that they will be quickly released vis-à-vis be admitted as an involuntary client and required to stay for a longer time.

Therefore, should Charlie refuse voluntarily hospitalization and the counselor believe hospitalization is warranted, the counselor should explain what she is required to do next. Here, the counselor might say something like,

> Charlie based upon what you've said to me, it is my professional belief that you need to enter into a hospital for your own safety. Because you will not voluntarily admit yourself into the hospital, I am required by law to petition the court for your safety.

Thus, the counselor has explained what her state laws require. Should the client continue to refuse hospitalization, the counselor should immediately move to Phase Four in an attempt to keep the client safe and immediately seek court involuntary hospitalization. Depending upon the state where the counselor practices, and how the mental health system interfaces with the judicial system, it is likely that the counselor will need to proceed to the county district attorney's office to petition the courts to evaluate Charlie for involuntary hospitalization.

If the suicidal client is under the age of majority and depending upon the specific laws of the state where the counselor practices, the counselor will need to apprise the client's parents or legal guardians of the child's suicide risk and hospital recommendation. In general, the first author has found most parents to be supportive of professional recommendations for hospitalization when their children present with significant suicide risk. However, should parents refuse to allow the child to continue treatment or refuse to hospitalize a child that clearly warrants hospitalization, Child Protective Services should be contacted. Because laws vary from state to state, legal counsel should be sought to insure the counselor practices in a manner congruent to state laws and guidelines.

Phases Four and Five: Terminate and Truncate the Threat

Understanding how the client plans to commit suicide is a critical component of the suicide assessment. The suicide assessment methods identified earlier in this chapter (e.g., The Adapted-SAD PERSONS Scale) should have provided such information. Phase Four of the SCATTT requires counselors to utilize this previously gathered information to *terminate* client access to the planned suicide instrument. For example, had the client intended to suicide by utilizing a gun, Phase Four of the SCATT would require the counselor to terminate the client's gun access. This can be done in a number of ways. For example, the counselor might state something like,

Counselor: Glenda, you reported that you were going to kill yourself with a .22 caliber gun. Do you have any other guns in your home or access to other guns?

Client: No, the only gun I have is my .22. I keep it next to my bed and plan on using it to shoot myself.

Counselor: Glenda, especially given that you are struggling between having thoughts of killing yourself and staying alive, do you have a trusted family member that you would be willing to give the gun and all your bullets until we complete treatment and agree it is once again safe to have your gun at home?

As you can see, the counselor first asks if the client has access to other guns. Once it is determined that Glenda has only one gun, the counselor asks the client to surrender the gun and bullets to a trusted family member. If more than one gun was identified, all guns would need to be surrendered. Once releases of confidential information are signed, the counselor, Glenda, the trusted family member, and a local law enforcement officer would then meet and establish the rules of how the weapon will be exchanged, locked, and secured until a time when Glenda's suicide intent is absent.

Some clients have plans that include suicide instruments where access cannot be terminated. For example, should a client's plan include overdosing on his antidepressant medications, Phase Five of the SCATTT encourages counselors to *truncate* access to the antidepressants and other drugs. Here, the counselor should secure a release of confidential information, contact the physician prescribing the antidepressant and inform the physician of the client's suicide plan. The counselor should request that the physician also monitor the client's safety and have the antidepressant medications dispensed in smaller quantities. Thus, instead of the client having access to a two-month antidepressant supply, the medication would be dispensed in weekly quantities.

Concomitantly, the counselor should require that the client give all current medications to a trusted family member who could then secure and dispense the medications daily. Again, releases of confidential information will need to be signed by the client. The counselor would then meet with the client and the family member dispensing the medications to establish how the medications will be dispensed.

Phase Six: Transport

This final Phase of the SCATTT is the Transport Phase. Here, counselors must insure that the client has safe and monitored *transport* to the hospital. Depending upon the client's emotional presentation, willingness to enter the hospital, and the agency's or school's transportation rules, the first author has found it best to have trusted client family members transport the client to the hospital. However, family transport should only be utilized when the client is willingly admitting herself into the hospital and poses no foreseeable risk to those transporting. Additionally, for liability reasons and to help insure everyone's safety a minimum of two, physically able, adult family members should make the transport. Depending upon the situation and immediate needs of the client, the first author has also found local police and emergency services workers helpful in transporting clients.

Conclusion

This VISTAS' manuscript provides a succinct overview of suicide frequency, commonly used suicide assessment interviews and instruments, and describes the SCATTT, a six-step, suicide intervention mnemonic. The first author and his clinical supervisees have utilized the SCATTT with clients in multiple settings including private practices, mental health and substance abuse treatment agencies, and schools. Supervisees have reported the SCATTT as an easily memorized, broad-spectrum intervention plan that has been helpful when interviewing clients who present suicide intent.

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