Assessment Of Suicidal Risk

Is there a plan? How specific is the planning?
Access to means of completing the plan?
History of similar ideations or attempts?
What is the precipitating factor(s)?
Are there social supports in life currently? (and - Who could monitor pt?)
Presence of symptoms related to personality disorder?
Current use of drugs or alcohol?
Compliance with medications and other treatment?
Willingness to go to hospital?
Willingness to access crisis lines?
Things keeping them from suicide? Things to live for?
What things might "push them over the edge" and lead to an attempt?

Action Steps for Prevention

Is pt willing to commit to a safely or crisis plan? (Help pt write out their plan.)
Is pt willing to give up access to plan? (such as medications; firearms)
Use identified risk factors to guide treatment (social isolation, anger, intoxication)
Increase # and frequency of therapeutic contacts
Develop coping skills, anxiety-reduction strategies, positive thinking

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CLINICAL GUIDELINES FOR RESPONDING TO RECENT SUICIDE-RELATED ISSUES WITHIN NMS SERVICES

Suicide attempts and ideation are an unfortunate and scary reality for many NM Solutions' patients. A history of mental illnesses such as bipolar disorder, and substance use issues are two very common high-risk factors associate with suicidality. In addition, social isolation, sleep disturbance and difficulties accessing healthcare services are also very common social factors which contribute significantly to risk of suicide ideation and/or attempts.

All of these factors, particularly substance use problems and social isolation, are very common in the patients seen in various NM Solutions' programs. Socially isolated, older (above 45) white males with substance use issues and access to firearms are the highest risk population, related to suicide.

As a result, we must be thoughtful, careful and organized in our response to suicide-related concerns, when identified in the course of treatment. The below is intended to a guide to assist clinicians in responding effectively, carefully and in a client-centered manner. These guidelines are not expected to be comprehensive, as clinical presentations may vary. Clinicians are encouraged to use their best clinical judgment in such cases, and to seek supervision and clinical support in dealing with these difficult situations.

These guidelines are NOT meant to replace or supplant training in assessing, intervening or treating suicidality. Documentation of assessment, interventions, responses and clinical reasoning regarding suicidality is extremely important, to support therapeutic continuity, liability prevention, and risk management.

Assessment:
Patients may reveal/report suicidality in a variety of different overt and covert ways. In some cases, this information may come to clinical attention through police or medical/EMS response to a patient, hospitalization or other direct responses to a discovered suicide attempt. In many cases however, patients may reveal thoughts of

suicide during the course of clinical interaction. Because so many of our patients have high-risk factors for suicide, NMS clinicians should be constantly attending to both subtle and overt signs of suicidality.

These signs may include, but are not limited to:

- Disclosure of thoughts of active suicide or a suicide plan;
- Thoughts of going to sleep and never waking up, wishes that they had never been born;
- Statements such as "dealing with problems once and for all," or "You won't have to deal with me any longer;"
- Expressing feelings of hopelessness (hopelessness is THE number one predictor of thoughts of suicide;
- Feelings of anger, loss, rejection from social support system and feeling of social isolation;
- Stockpiling weapons, pills or other suicide means;
- Engaging in "hypothetical" discussions of suicide;
- Researching methods of suicide;
- Significant changes in mental status, such as onset of psychosis, acute depression, or mania;
- Agitated depressive symptoms: high energy depressive states are a very high-risk time for suicidality;
- Chronic anxiety or brooding;
- Disclosure of hallucinations of death or dying, or auditory command hallucinations related to suicide or self-harm, or statements of worthlessness;
- Feelings of worthlessness;
- Severe social embarrassment or humiliation related to a recent event;
- Conflict or shame or isolation with family/friends over sexual orientation;
- Current or past history of abuse;
- Current flashbacks or intrusive thoughts related to history of trauma or abuse;
- Report of severe, chronic sleep disturbance;
- Sudden life disruptions such as divorce, relationship dissolutions, jobloss, financial disruptions such as eviction or bankruptcy;
- Diagnosis of serious medical illness or sudden loss of physical/medical health, creating life impairment or loss of function;
- Giving personal items away, or otherwise seeking some unexpected resolution or closure to relationships;
- Disclosure of an upcoming negative anniversary, such as the loss of a loved or parent, especially if that loss was related to suicide.

Clinicians are strongly encouraged to "trust your gut," on risk to suicide. If you have an inkling that suicide issues may be at play, it is always best to investigate, even if you cannot formulate a reasoning for that intuitive thought.

Simply ask! Many people, even clinicians, are afraid to ask about suicidality, worried that it may create problems, offend people, or even create suicidality. Instead, extensive

research indicates that asking someone if they are suicidal actually often REDUCES anxiety. Suicidality can be investigated in many ways, but the simplest is: "Are you thinking of suicide or self-harm?"

While clinical assessment measures for suicide risk do exist, none hold a demonstrated superiority over clinical interview, and many have very high false positives, leading to people at low-risk being treated as though are at high risk for suicide. As a result, thorough clinical assessment informed by knowledge of risk factors is recommended at this time.

In the event of a patient disclosing or acknowledging thoughts of suicide, clinicians should assess:

- Current specificity of planning;
- Access to means (especially firearms or stockpiled medications);
- History of similar attempts/ideation;
- Precipitating factors;
- Any social supports in life currently;
- Presence of symptoms related to personality disorder;
- Current use of drugs or alcohol;
- Compliance with medications and treatment;
- Willingness to go to hospital;
- Willingness to access crisis lines;
- Things keeping them from suicide;
- Things which might "push them over the edge" and lead to an attempt;

Clinical Response to Suicidality:
Clinical treatment of suicidality is, in many ways, a developing field. One of the things it's very important to know, is that while as many as 10 million adults may think of suicide each year in the United States, only around one million attempt (that we know about) and fewer than about 40,000 are lost to completed suicides. So, the base rates of suicides are very low, and most people who think of suicide, do not attempt, even without receiving therapeutic support. The good news is that suicide is very preventable, most people with thoughts of suicide are unlikely to complete suicide, and that suicide assessment, intervention and treatment work. The hard news is that there are no magic bullets, or quick-fixes, and that therapeutic treatment of suicidality is a process which must be carefully individualized to patients.

The below recommendations are not comprehensive, but are based upon literature to date. Clinicians are referred to Jobes' excellent book Managing Suicidal Risk; to Quinnet's book Counseling Suicidal People; and to Linehan's work with DBT treatment with individuals with borderline personality disorder. Quinnett also has a book intended for patients struggling with thoughts of suicide, called The Forever Decision. It is an accessible book, pragmatic and non-shaming in approach. It is available for free at: http://www.ryanpatrickhalligan.org/documents/Forever_Decision.pdf

Referral to hospital/Emergency Room/911:

- Appropriate when a patient is unwilling to commit to safety or a crisis plan;
- When a suicide attempt is in progress, or a patient has physically harmed themselves and requires medical treatment;
- When a patient actively resists assessment or assistance;
- When a patient is intoxicated, or mentally impaired and is unable to disclose information.

Unfortunately, referral to emergency room/hospitalization is often merely a start. Many people are not hospitalized when suicidal, for a variety of reasons. Even when hospitalized, this treatment rarely "cures" suicidality, but merely starts a process of healing which must be continued outpatient. Periods following hospitalization are high-risk times, due to social disruptions, new medications, and because often, precipitating events/problems still exist.

Clinical response to suicidality in outpatient treatment:

- When suicidality is identified and becomes a component of treatment, it is important to document this in the treatment plan and in clinical documentation;
- In many cases, suicidality resolves/reduces in a period of 1-2 weeks, and on average, after about 7 therapy sessions. This is good news. While chronic suicidality is a challenging issue, most episodes of acute suicidal risk reduce over time. As a result, it is often a matter of helping a person stay alive for long enough for life's problems to change, work themselves out, or for new solutions to emerge.
- When addressing issues of suicidality, therapists and clinicians should ALWAYS seek support, supervision and assistance. Effectively dealing with suicidality truly "takes a village," or at least a team. People who are suicidal are often isolated, and clinicians supporting them must resist any tendency to become isolated as well.
- When dealing with suicidality, clinicians must resist, but empathize, with a patient's desire to keep things secret. Privacy is of course appropriate and respectful. But, when dealing with suicidality, clinicians MUST encourage that patients open up to their social support system about their need for help. This is the time to "activate" a social support system, or to create one, if none exists, through accessing family, clergy, neighbors, friends, coworkers, etc. Appropriate releases of information are important, but when dealing with potential imminent risk, HIPAA makes clear allowances for us to disclose information as needed and appropriate.
- Clinicians cannot and MUST NOT take on the sole responsibility of preventing suicide.
- Restrict access to means. Encourage patients to give up things like firearms or medications. It is best to have such items given to family members to hold or dispose of. THIS IS ONE OF THE MOST EFFECTIVE METHODS OF SUICIDE PREVENTION
- Invite/assist patients to develop a safety plan. Where possible, have patients write out a crisis/safety plan of their own, including names and phone numbers of people/resources they will call in moments of dire needs, and outlining things they will do to reduce their feelings of hopelessness. Make a copy of this for the

file, and have the patient keep a copy with them - I've laminated them for patients at times, for them to carry in their wallet/purse. I discourage use of pre-printed fill-in-the-blank safety agreements/no-harm contracts. They serve little real purpose;

- Use the risk factors identified in the assessment process, as guide to treatment. Reducing risk factors (such as social isolation, anger, agitation, intoxication, etc.) is a proven means of reducing suicides;
- Clinicians should never shame or condemn a patient's thoughts of suicide. Instead, we can do best by treating thoughts of suicide as a problem-solving strategy, and by helping the patient to identify other, more-effective solutions;
- Encourage patients to increase social interactions and to reach out to social supports. Patients should try not to be alone, when possible, especially during very high-risk periods.
- Increase therapeutic interventions/contacts as needed. Sometimes, multiple brief contacts in a week are better than longer less-frequent sessions. Follow-up phone calls, even over the weekend, can be extremely helpful and positive, making a patient feel valued and connected;
- When dealing with risk of suicide, issues related to suicidality should become the priority focus in treatment. While issues related to relationship, etc., are often important, and affect suicidality, dealing with, and reducing suicidality must be the absolute priority in treatment. Some issues may have to become "back-burner" until suicidality is reduced;
- Help patients to recognize and endorse the critical importance of continuing treatment and especially medication compliance;
- Help patients recognize the importance of maintaining sobriety. Drug and alcohol intoxication is absolutely something for patients to avoid, in service to staying alive;
- When doing therapeutic interventions with patients dealing with suicidality, assessing current risk factors, thoughts of suicide, plans, or changes should be the FIRST thing done in every clinical interaction. This is NOT the thing to ask at the end of a therapy session;
- Helping patients to learn and practice coping skills, anxiety-reduction strategies, and helping them to interrupt brooding are all effective means of reducing suicidality. CBT strategies such as teaching people relaxation skills, mindfulness, meditation and thought-shifting from negative, to positive thoughts are all critical interventions.
- Remember that hopelessness is the chief factor in suicide. As a result, a central focus in treatment should be building and nurturing hope. One useful strategy is often helping patients to create "Hope Kits," like a miniature "hope chest" that they can carry around, and look at in times of need. These should include things that make them feel hopeful, or remind them of things that make them want to live. I encourage such things to be multi-sensory, especially things that have smells that remind them of hopeful things.

Suicide issues in children/adolescents:

Children and adolescents in our programs may be at high risk, particularly when they are:

- Isolated or separated from family
- Find out their parents' rights are being terminated;
- Are socially isolated/rejected at school;
- Have parents or family members or friends who have attempted or completed suicide;
- Recently started an SSRI;
- Need/desire help and aren't getting it or feel their needs are ignored/neglected;
- Are struggling with their sexual orientation in conflict with family/cultural values (Note, LGBTQ orientation is not itself a risk factor, except where that orientation is rejected/shamed by an individual's family/social system);
- Is a Native American struggling with issues of acculturation;

Suicide plans in children often involve things which may not seem as life-threatening as adult methods, but the thoughts and risks are real, nonetheless. Suicidal children often talk about strategies such as jumping out of a moving car, walking into traffic or other, more "environmental" plans. As a result, the best prevention strategy is close monitoring and avoidance of high-risk situations.

Suicidality in children and youth is almost always related to social or familial conflicts. Sudden suicidality in young people is often a very strong indicator of some recent stressor or trauma, such as abuse, public shaming, rape, loss of a relationship, etc. Young people don't have the neurological ability that adults have, to see that in the future, things may feel better. So, it's very easy for things which seem less serious to us as adults, can seem like the "end of the world." It's desperately important that we empathize with these feelings in youth, and never ever dismiss the seriousness of their feelings.

Response to suicide ideation/intent in children/adolescents should often involve increased parental/caregiver monitoring, removal of means and offering increased social and therapeutic support. When young people are dealing with issues of suicidality, it is important for teams to support the youth in coping and stress reduction. For instance, when a kid uses music to calm down and self-soothe, it's okay to let them have their MP3 player back, even if it gotten taken away because they were breaking a rule. It's important to make sure that we don't let rigid rules or consequences stand in the way of a young person dealing with loss and emotional struggles.

Medication-assisted treatment for suicidality:
Psychiatric medications are often an important part of treatment for suicidality. Unfortunately, they are also often a complex and individualized factor. As a result, when dealing with a suicidal patient, prescribers should always function as part of a team, gathering information about side-effects and treatment response. The below information is not intended to replace clinical guidelines and is offered merely as limited information related to the role of medications in treating suicide;

- In adolescents, some SSRI's may increase suicidal ideation and behaviors, especially in first weeks of treatment. While this is not necessarily an outright contraindication to such prescriptions, clinicians rendering an SSRI prescription to an adolescent with possible suicidality should be extremely thoughtful of these

risks and engage in thorough safety planning;

- The period of time between beginning an SSRI prescription and reaching therapeutic effect/blood levels is often a high-risk time. Therapeutic monitoring and safety planning should be a focus in such periods;
- Lithium is one of the only psychiatric medications with a proven anti-suicide effect. However, as lithium can be hard to tolerate, it may not be appropriate for everyone. However, interrupting, or discontinuing lithium in a suicidal individual may be something to hold off on, when possible, until suicidality resolves;
- Changing medications during times of suicidality is something to be very thoughtful and cautious with. While it may offer the ability to attempt to address symptoms, times of changing medication are known high-risk periods for suicide. These may also be times when patients may accidentally stockpile medications and end up with more unused doses;
- Psychiatric medications may be very helpful in dealing with sleep and anxiety problems, two key risk factors for suicide. Prescribers are encouraged to pay careful attention to these symptoms, as medications may often hold useful strategies to temporarily reducing these symptoms during the duration of the suicidal episode. Concerns about long-term effects or dependency are reasonable, but should be weighed against the possible current efficacy of reducing critically distressing symptoms.

Resolving therapeutic concerns about suicidality:
Hopefully, over the course of treatment, interventions, social engagement, CBT strategies, medication interventions, and other therapeutic means, patients report a decrease in suicidality. They often report a gradual, almost unnoticed reduction in the frequency of thoughts of suicide, and a decreased desire, often unnoticed until you, the clinician enquire. When this occurs, it's a great time to point out and highlight the success and effect of their recent efforts. Help them to put these successful strategies "in their back pocket" for future use, if they need them again.

I recommend monitoring such issues for period of 4-8 weeks, and allowing for future stresses or problems to trigger thoughts of suicide again. If thoughts/ideation/intent recurs, it is time to renew assessment, planning, intervention and treatment.

<u>When, over the course of treatment, issues of suicidality resolve or reduce, treatment plans and clinical documentation should be updated to reflect this.</u>

In the event: Tragically, sometimes suicides do occur in the people we serve. In such event:

- Immediately offer support and assistance to family members or caregivers. In these circumstances, it is critical we offer these people what we can. They, in that period are also at risk, and our support can sometimes make all the difference.
- Supervisors and managers should be notified immediately.
- Ensure law enforcement is notified as needed.
- Treatment records should be secured. Additional documentation may be created after the fact, but nothing should be amended or removed in any circumstances.

- Ensure that team members are supported themselves, in this challenging time.
- While there may be an understandable tendency to second-guess treatment decisions or strategies, now is not the time to discuss possible lapses or errors. Such a process will occur in our agency's Sentinel Incident Review process, where such issues can be explored objectively and carefully.

These guidelines are intended to be an evolving best of ideas and strategies, reflecting what is known in best practices. Remember that each case is individual, and some things may work for one person, which don't work for others. Use your best clinical judgment, access resources and support, most importantly: Feel HOPE that we can help our patients deal with the scary issues of suicide. If we don't feel hopeful, we can't help them to be hopeful.

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