

Working with the Suicidal Patient

A Guide for Health Care Professionals

Summary

- *Assess/Ensure Safety*
 - *Build Rapport – introduce yourself, your role, your goals*
 - *Assess Current Suicidal Ideation*
 - *Obtain Details on Current Attempt (if applicable)*
 - *Obtain History*
 - *Communicate with Family/Friends*
 - *Connect with Primary Healthcare Provider(s)*
 - *Advise Patient – instill hope, obtain information on existing supports, provide a safety plan*
 - *Provide Referrals at Time of Discharge*
 - *Follow-up Post-Discharge*
- ◆ **Refer to Mental Health/Psychiatry if high risk** ◆

Task One: ASSESS

1. Assess current suicidal ideation

Is suicidal ideation present now?

Have you gotten to the point where you did not want to go on? Have you had thoughts of not wanting to be alive? What about right now?

Passive Ideation: The patient would rather not be alive, but does not indicate a plan that involves an act of initiation = **LOWER RISK** (e.g., *I'd rather not wake up in the morning; I wouldn't mind if a car hit me when I was crossing the road*)

Active Ideation: The patient has acute thoughts of completing suicide = **HIGHER RISK** (e.g., *I do think about killing myself; I feel like throwing myself into traffic*)

Intense, continuous ideation = HIGHER RISK

Is there a plan?

Do you have a plan as to how you would end your life?

Detailed, carefully thought-out plan = HIGHER RISK

Is there intent?

You talk about wanting to die, and have even considered [taking pills] but are you intending to do this?

Low Intent: Suicidal thoughts and fantasies about plans, with absolutely no intent to put these plans into action. Fantasizing about suicide can provide some comfort to those in distress to know there is always a way out = **LOWER RISK** (e.g., *Oh no, I could never do that, I have children*)

High Intent: Expression of specific intent to end life = **HIGHER RISK** (e.g., *I intend to do this as soon as my daughter's graduation is over*)

Ambivalent or Unclear Intent: Ask about what has helped in past.

What has stopped you from ending your life to this point? What has helped in the past when/if you've had these thoughts?

2. Obtain details if there is a suicide plan

How lethal is the plan?

How lethal does the patient believe the method(s) to be?

Is there access to means?

Obtain specific details.

What pills do you have or would you take to overdose? Exactly where would you get a gun from?

Has patient chosen a time and/or place?

How isolated is the patient? What preparations have been made (e.g., buying rope)?

Has patient made final arrangements?

Has patient prepared a suicide note, settled their affairs or communicated to others?

Higher lethality, access to means, preparations and arrangements = HIGHER RISK

Note: This document is intended to be a guide to working with the suicidal adult, and should not replace a psychiatric consultation. When suicide risk exists, an expert opinion should be sought to determine the need for hospitalization and clarification of diagnosis.

3. Gather details on current and previous attempts

Previous attempts, especially in past year = HIGHER RISK

Triggers of Present Attempt

Walk me through the last 24 hours. At what point did you consider suicide?

Triggers of Past Attempts

Tell me about other times you have seriously considered suicide or made an attempt. What chain of events led up to attempts you've made in the past?

Lethality

Assess the lethality of the method(s). What was the likelihood that the patient would be found after they made the attempt?

Impulsivity

Was attempt carried out in the heat of anger (impulsive) or was it carefully thought-out (planned), with day and time picked in advance? What was the direction of hostility (goal to hurt self or others)?

Intoxication

Was patient intoxicated at time of attempt (substance use can lead to disinhibition and can contribute to individuals acting in atypical ways)?

Expectations of Dying

What did you think would happen to you when you [cut your wrists/took an overdose]? How did you think others would respond? Did you truly think you would die?

Outcome

Was medical intervention required? How was this accessed (e.g., patient called for help vs. being found unresponsive by others)?

Feelings about Survival

Guilt, remorse, embarrassment = LOWER RISK

Disappointment, self-blame = HIGHER RISK
(e.g., I couldn't even get this right and kill myself properly)

4. Obtain information on psychiatric and other history

Obtain information on psychiatric history (e.g., depression, psychosis), including symptoms that may suggest undiagnosed mental illness; substance use/abuse (alcohol, drugs); and past/current mental health treatment, including all current and past psychiatric medications.

Obtain information on other chronic and acute stressors (e.g., loss of relationship, loved one, job; gambling/financial stressors; trauma/abuse; struggle with sexual identity issues; changes/discontinuation of medications).

Assess for protective factors, such as family, friends, pets, religion, and therapist.

Ask about any other relevant and contributory factors.
Is there anything else I should know about?

5. Conduct mental status examination

Emotional State

What is the patient's self-reported mood vs. their observed affect?

Extremes in emotional state/mood (no vitality, emotionally numb or unbearable emotional pain/turmoil) = HIGHER RISK

Behaviour & Appearance

How is the patient behaving (agitated, alert, cooperative)?
How do they appear (hygiene, speech)?

Thought Process

Is the patient oriented? Are attention, concentration and memory intact? Assess thought process (logical, organized), thought content (paranoid, delusional), and judgment and reasoning.

Problem-Solving Capacity

Can the patient generate strategies and options for problem-solving through their difficulties?

Reasons for Living & Level of Hope

What reasons do you have for living? How hopeful do you feel that your current situation could change? What is needed to change to help you feel not so hopeless?

Feelings of hopelessness, helplessness, and view of future as empty or meaningless = HIGHER RISK

6. Communicate with families/ significant other(s)

Obtain contact information for, and consent to speak with, family/significant other(s). Connecting with family and friends demystifies what's happening, and allows the patient's support system to develop confidence in the assessment and treatment process.

Inform next of kin/emergency contact if patient has made suicide attempt.

Note: In an emergency, consent is not required to release information to family/significant other(s), although it is a courtesy to inform the patient of disclosure of information. Consent is also not required to obtain information from family/significant other(s).

Solicit input from family or significant others, as this is helpful for risk assessment and safety planning. Inquire about changes in behaviour, signs of depression, hopelessness, past attempts, any communication of intent, difficulties adhering to treatment, and examples of risky behaviour (important when decisions are made about certification).

Include family/significant other(s) in discussions regarding safety and treatment planning (discuss ways family/friends can implement support in the patient's home environment).

Acknowledge feelings of family/friends (e.g., fear, anger). Guide them to seek psycho-educational and emotional supports for themselves. Provide referrals for support agencies.

7. When to make a specialist referral

Refer patients with a psychiatric history to mental health/psychiatry.

The high-risk patient should be admitted to hospital or provided a high-priority referral for a mental health or psychiatric assessment to provide recommendations about management.

SAD PERSONS provides a useful screening acronym to identify the high risk patient:

Sex (male)

Age (adolescent or elderly)

Depression

Previous attempt

Ethanol abuse

Rational thinking loss (psychosis)

Social supports lacking

Organized plan

No spouse/partner

Sickness – especially chronic/uncontrolled pain

Other factors suggesting high risk are: multiple risk factors; profound hopelessness; lack of protective factors; high lethality; premeditation of present attempt; and/or family history of suicide, depression or substance abuse.

8. Communicate with primary care provider(s)

Obtain information from patient and/or their family about the patient's current health and mental health care provider(s). Communicate with patient's primary care provider(s) to ensure continuity of care.

Task Two: ADVISE

1. Provide meaning and support

Explain a Model of Suicide

Provide a model to help the patient understand their suicidality, and to normalize their feelings. People think seriously about suicide when they experience the **3 I's** in their life situation: **Intolerable** (meaning their life situation is so painful that it seems unbearable), **Interminable** (it seems like it's going to go on like this forever), and **Inescapable** (it seems like nothing they've tried has changed or will change their experience).

Provide Coping Strategies

Provide strategies for coping that target the 3 I's: Intolerable (distress reduction/tolerance strategies); Interminable (cognitive challenging techniques); and Inescapable (effective problem-solving). Provide **Coping with Suicidal Thoughts**, a document to help individuals decrease thoughts of suicide, develop a safety plan and connect with helpful resources.

Reinforce the Value of Treatment

Treatment (both therapy and medication) can help to reduce your suffering. Therapy can help you to identify and address underlying issues that are contributing to you feeling this way, and provide you new ways of dealing with your life problems. Medication can help you with difficulties you are having with [depressed mood, anxiety, sleep, appetite].

Address Ambivalence in Order to Instill Hope

Many people have mixed feelings about suicide, and are just looking for some way to get out of the pain they are feeling. There are ways you can find support to help with that pain that don't include ending your life.

Reinforce Positive Coping Used in the Past

What has helped in the past when you've had these thoughts?

2. Develop a safety plan

Develop an interim, written safety plan with the patient to help them stay safe until they secure longer-term professional supports. Provide written safety plan to patient, primary care provider and family/significant other(s).

Discuss with the patient how to make their environment safe (remove risky means of self-harm; have friend or family on-site for the short-term).

Generate with the patient adaptive means of self-soothing and coping with distress (calling a friend, going for a walk).

Generate with the patient reasons they have for living, and methods they have used to cope in the past. Work with the patient on completing the Safety Plan provided in the patient handout, *Coping with Suicidal Thoughts*.

Indicate to patient that if they try these steps and still do not feel safe, they should go to a hospital emergency room or call 911.

3. Provide information

Provide a written copy of a treatment plan, including details of medications (if applicable) and dates of follow-up appointments to patient, primary care provider and family/significant other(s).

If the patient is prescribed antidepressants, explain that there may be temporary increased risk as symptoms of depression resolve at different rates, and improvement of mood may be delayed in comparison to improvement in physical symptoms such as energy or sleep.

Provide contact numbers of primary care providers (family physician, psychiatrist, psychologist), local crisis lines (1-800-SUICIDE) and mental health centres.

Instill hope. Most importantly, let the patient and their family/friends know that there is help available. Indicate that although you cannot guarantee that there will be no further attempts or difficult feelings, prognosis will be much better if the patient adheres to the treatment plan. Indicate that it may take time to find the right diagnosis and treatment, and time for patient to make accompanying changes.

4. Follow-up

Follow-up with the patient and/or family or significant other(s) within 48 hours to answer any questions they have, and to offer further information, including providing referrals.