Suicidal Behavior Clinical Guidelines

Developed in Collaboration with Northeast Behavioral Health Partnership, Centennial Mental Health, North Range Behavioral Health and Touchstone Health Partners

Assessing Suicidal Behaviors:

1. **Conduct a suicide assessment** initially and at regular intervals, even if the client does not present with suicidal risk. Examples of other circumstances in which a suicide assessment should be conducted include: before a change in treatment setting, e.g. hospital, when there is sudden change in clinical presentation or lack of improvement/gradual worsening, when the client experiences a significant interpersonal loss or at the onset of a serious physical illness. It is important to note that suicide risk can increase as a client begins feeling better and experiences more energy.

2. **Past suicidal behavior and self-injurious actions** should be included in the assessment**,** including precipitants, timing, intent, consequences, likelihood of interruption/rescue, and medical severity. Check whether alcohol/drugs were involved in the incident and the client's thoughts about the attempt.

3. **Other client factors to consider** in the suicide assessment include substance abuse history, strength and stability of therapeutic and/or family/social relationships, family history of suicide and circumstances of suicides in first-degree relatives, e.g. client's age and involvement.

4. **Assess the client's psychosocial stressors, psychological strengths and weaknesses and presence of protective factors,** as this information helps determine suicidal risk and aides in treatment planning (see Attachment A for list of protective factors). Consider financial issues, job or relational loss, lack of social support, and cultural and religious beliefs. Assess psychological strengths and weaknesses including: a) degree of negativistic thinking, e.g. inability to perceive positive aspects about themselves, others, and environment; b) ability to identify emotional states of different intensity and c) ability to make realistic plans without suicidal thoughts or actions.

5. **Elicit specific information about suicidal thinking, plans, and behaviors**. Overt suicidal threats or expressions and preparatory acts, such as exploring different methods or practice enacting a method, are warning signs of an immediate suicide threat. Check whether there are accessible firearms and talk with family members or friends to see if they have observed behaviors suggesting suicidal ideation, e.g. recent purchase of a gun. Whenever possible, enlist the help of family and friends in removing any potentially lethal weapons or means from the client's home. See Attachment A for Warning Signs indicating more immediate suicidal risk.

6. **Estimate suicide risk.** Keep in mind suicide assessment scales, if used, should not be considered a substitute for the clinician's assessment. The presence of a psychiatric disorder, in particular depression and/or disorders characterized by severe anxiety, agitation, and poor impulse control and previous suicide attempts are significant risk factors. In addition, characteristics such as being male, white, American Indian and/or Native Alaskan, GLBTQ, a veteran, and elderly place the client at a higher suicide risk. Those with chronic pain are also at increased risk. See Attachment A for suicide risk factors.

7. **Although adult suicide risk factors are similar for youth, there are unique issues for youth** that should be considered. First, completed suicide for children 12 years and younger is rare, although suicide rates for youth increase with age. Second, in youth, much more than for adults, suicide is an impulsive behavior commonly in the face of interpersonal discord, bullying, loss, or failure, either real or perceived. Third, youth are uniquely susceptible to suicide clustering and imitation and, in these cases; conventional risk factors are less helpful.

Interventions with Suicidal Behavior:

1. **On-going suicide assessment** should be conducted on a regular basis and be well documented even if risk factors are not present. The documentation should include the clinician's decision-making processes, changes in treatment, consultation with other clinicians, and phone calls with the client or family.

2. **An accurate diagnostic profile and treatment plan** are key to reducing suicide risk and chronic suicidal ideation**.** Suicidal thinking is a symptom shared by clients with many mental disorders, so it is important that underlying and potentially predisposing conditions be properly treated.

3. **Develop a safety plan and keep the plan current.** A safety plan is a prioritized written list of coping strategies and sources of support that clients can use during or preceding suicidal crises**.** Safety planning with the client helps to establish positive coping and problem solving skills and improves engagement in treatment. The Dept. of Veterans Affairs developed a six-step process for implementing a safety plan as a helpful guide (See Attachment B). For youth, the use of a "feeling thermometer" can help distinguish situations that are "hotter" or "cooler" depending up the level of discomfort and feelings of suicide and can assist the youth in identifying situations that require an action plan.

4. **Suicide prevention contracts** where clients agrees either verbally or in writing not to harm or kill themselves are not recommended as they may falsely lower clinical vigilance. In contrast, a safety plan, as described above, is a very useful intervention with clients who are suicidal.

5. **Establish and maintain a therapeutic alliance**. Social isolation is a strong risk factor for suicide and a strong therapeutic relationship offers a step toward reducing this risk. Be clear with your clients about the limits of confidentiality, but also ensure them that it is safe to discuss suicidal thoughts with you, before the risk becomes imminent. Fear of consequences (e.g. hospitalization) is a frequently –cited reason for clients not discussing suicide with their clinicians.

6. **Refer for psychiatric assessment.** Lithium, for clients with recurring bipolar disorder and major depression, and clozapine, for clients with schizophrenia, are associated with substantial reduction in risk of suicide and suicide attempts. Successful treatment, including medications as appropriate, of underlying and potentially predisposing conditions will likely reduce suicide risk.

7. **Assist clients in building coping and problem-solving skills,** such as learning to a) verbalize and recognize their emotional state; b) communicate effectively to obtain needed support; and c) tolerate painful emotions without resorting to suicidal thoughts. Other skills to teach include replacing suicidal behaviors with more adaptive solutions, reducing therapy-interfering behaviors, e.g. missing sessions, increasing awareness of escape behaviors, e.g. substance abuse, and learning to engage in life "in-the-moment" (See Attachment C for additional interventions).

8. **Address substance use disorders.** Increased use of substances is a significant risk factor and a warning sign indicating heightened risk. Substance use is a direct risk factor as a co-morbid condition and an indirect risk factor insofar as it reduces impulse control and behavioral inhibition.

9. **Obtain consultation and supervisory assistance,** particularly with clients that may present as chronically suicidal. Even senior clinicians should obtain consultation or supervision to assist in maintaining focus and exploring their feelings about working with these often challenging clients.

10. **Provide education and support to client's family and supports,** particularly families of youth at risk and still in the home. Involving families in the client's treatment can be complex and is not always recommended. Be clear about confidentiality and legal duties to report; obtain releases from clients as to what to share with others. Help families recognize that a range of responses to suicidality are normal

and encourage them to care for themselves. Teach families about warning signs and ways to support the client, e.g. encouraging the client to follow their crisis plan.

See Depressive Disorders Clinical Guidelines for supplementary information

Attachment A

Warning Signs: Acute/Immediate Risk of Suicide (Rudd et al, 2006)	
1st Tier (Requiring Immediate Assistance)	**2nd Tier (Less Immediate Risk)**
Threatening to hurt or kill themselves	Hopelessness
Looking for ways to kill themselves; seeking access to pills, weapons, other means	Rage, anger, seeking revenge
Talking or writing about death, dying, suicide	Acting reckless or engaging in risky activities, seemingly without thinking
Practicing enacting a suicide method	Feeling trapped or like there is no way out
	Increased alcohol or drug use
	Withdrawing from friends, family, or society
	Anxiety, agitation, unable to sleep, or sleeping all of the time
	Dramatic changes in mood
	No reason for living; no sense of purpose in life

Risk Factors: Anything that increases likelihood persons will harm themselves*
Membership in one of the following groups: male, white or American Indian; 65+ age
Previous suicide attempt(s)
History of mental disorders, particularly depression combined with anxiety
History of alcohol and substance abuse
Family history of suicide or close personal exposure to suicide
Family history of child maltreatment
Feelings of hopelessness
Impulsive or aggressive tendencies
Barriers to accessing mental health treatment
Loss (relational, social, work, or financial)
Physical illness
Easy access to lethal methods
Unwillingness to seek help because of the stigma attached to mental health issues and substance abuse disorders or suicidal thoughts
Cultural and religious beliefs
Local epidemics of suicide (more specific to youth)
Isolation, a feeling of being cut off from other people

Protective Factors*
Effective clinical care for mental, physical, and substance abuse disorders
Easy access to a variety of clinical interventions and support for help seeking
Family and community support/school connections
Support from ongoing medical and mental health care relationships
Skills in problem solving, conflict resolution, and nonviolent handling of disputes
Cultural and religious beliefs that discourage suicide and support self-preservation instincts

***http://www.cdc.gov/ncipc/factsheets/suifacts.htm**

Attachment B

VA Safety Plan: Brief Instructions*
Step 1: Recognizing Warning Signs *Ask "How will you know when this safety plan should be used?"* *Ask "What do you experience when you start to think about suicide or feel extremely distressed?* List warning signs in clients own words
Step 2: Using Internal Coping Strategies-Things I can do to take my mind off my problems without contacting another person: *Ask "What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"* *Ask "How likely do you think you would be able to do this step during a time of crisis?"* If doubt about using coping strategies is expressed, *ask "What might stand in the way of your thinking of these activities or doing them if you think of them?"* Show client Pleasant Events Schedule to help them come up with ideas.
Step 3: Social Contacts Who May Distract from the Crisis (client is not telling people that they contact that he/she is in distress at that point). Instruct clients to use Step 3 if Step 2 does not resolve the crisis or lower risk *Ask "Who or what social settings help you take your mind off your problems at least for a little while?" "Who helps you feel better when you socialize with them?"* Ask clients to list several people and social settings, in case the first option is unavailable Ask for safe places they can go to be around people, e.g. coffee shop Remember, in this step, suicidal thoughts and feelings are not revealed
Step 4: Contacting Family Members or Friends Who May offer Help to Resolve a Crisis Instruct clients to use Step 4 if Step 3 does not resolve the crisis or lower risk *Ask "Among your family or friends, who do you think you could contact for help during a crisis?" or "Who is supportive of you and who do you feel that you can talk with when you're under stress?"* Ask clients to list several people, in case they cannot reach the first person on the list. Prioritize the list. In this step, unlike the previous step, clients reveal they are in crisis. *Ask "How likely would you be willing to contact these individuals?"* If doubt expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.
Step 5: Contacting Professionals and Agencies Instruct clients to use Step 5 if Step 4 does not resolve the crisis or lower risk. *Ask "Who are the mental health professionals that we should identify to be on your safety plan?" and "Are there other health care providers?"* List names, numbers and/or locations of clinicians, local urgent care services, hotlines If doubt is expressed….
Step 6: Reducing the Potential for Use of Lethal Means The clinician should ask clients which means they would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these means. For methods with low lethality, clinicians may ask clients to remove or restrict their access to these methods themselves Restricting the client's access to a highly lethal method should be done by a designated, responsible person-usually a family member of close friend, or the police. If unable to remove means, put plan right in front of where means are kept. (e.g., tape plan to gun box)

Assess how likely it is that the client will use the safety plan. Discuss where client will keep copies of their safety plan (e.g., wallet size version) and who else they want to give a copy to.
*See Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008)

Attachment C
Specific Strategies for Working with Suicidal Clients*

When working with suicidal clients, focus on problem-solving and social functioning. Connecting clients with supportive friends, family members, and community groups, is also very important.

Other specific strategies when working with suicidal clients include:

Treatment Model	Specific Interventions or Strategies, associated with model
Cognitive Behavioral Therapy (see van der Sande et al., 1997 or Rudd et al., 1999)	Focuses on cognitive distortions and deficits that disrupt a client's ability to solve interpersonal problems and capacity to regulate emotions. 1. Goal setting 2. Self-monitoring 3. Focused skill building in areas of coping, problem solving, assertiveness, and interpersonal communication 4. Providing education about their mental disorders and suicide 5. Improving clients' ability to recognize and understand their own self-limiting and negative beliefs 6. Enabling clients to become better regulators of their own moods and experiences
Problem-Solving Therapy (see Jobes, 2000 or McLeavy et al., 1994)	Focuses on clients' ability to generate alternative courses of action, increasing their sensitivity to the consequences of their behavior, and helping them to respond to everyday interpersonal problems. 1. Educate clients regarding stress reactions. 2. Introduce and practice coping skills such as relaxation, problem-solving skills, and social skills 3. Offer opportunities to express emotions including feelings of anger, frustration, guilt, sadness, and failure 4. Promote group and individual exercises to improve self-esteem and self-efficacy (group treatment helps members to reduce their social isolation)
Solution-Focused Brief Therapy (see Fiske, 1998)	Focuses on solutions, competence, and strength capabilities of the client. Goal-focused treatment considers client to be the expert in his/her treatment plan, with clinician's role to facilitate the recognition and implementation of goals and solutions. 1. Invites client to tell their stories 2. Teaches concept of self-talk, where exceptions to problems are discussed, which is the foundation for finding solutions. 3. Question-based, individualized approach 4. Miracle question 5. Utilization of client's own competencies, strengths, resources, and successes to set goals and find solutions 6. Therapeutic stance of curiosity or 'not knowing.'
Dialectical Behavioral Therapy (see Linehan, 1993)	Includes individual and group therapy with foundation in principles of cognitive, behavioral, and interpersonal therapy. Long-term treatment with focus on building identified skills in areas of deficits (emotion regulation, distress tolerance, interpersonal effectiveness, and mindful living). 1. Address high-risk suicidal behaviors with goal of replacing with more adaptive solutions. 2. Reduce treatment-interfering behaviors (e.g. missing sessions, refusal to do therapeutic work, hospitalizations, etc) 3. Increase awareness of destructiveness of escape behaviors that threaten chances of a worthwhile life (e.g. substance abuse) 4. Integrate skills learned in group treatment into daily life through use of diary cards.

Treatment Model	Specific Interventions or Strategies, associated with model
Chain Analysis of Specific Behavior Problem, after it occurred (DBT Critical Strategy) (see Linehan, 1993)	1. Identify **THE PROBLEM BEHAVIOR** (e.g. cutting, suicide attempts, etc) 2. Identify the **PRECIPITATING EVENTS** that started the chain of behavior (e.g. fight with spouse, job loss, etc) 3. Identify **VULNERABILITY FACTORS** (e.g. unbalanced eating or sleeping, use of drugs, chronic pain, etc) 4. Identify the **CHAIN OF EVENTS** that led up to the problem behavior (e.g. SPECIFIC thoughts, feelings, actions) 5. Identify the **short- and long-term CONSEQUENCES** of the behavior (e.g. relationship ended, hospitalization, etc) 6. Identify **different SOLUTIONS** to the problem (e.g. call supportive person, work-out when angry, take a break from person involved) 7. Identify **PREVENTION STRATEGIES** for keeping the chain from starting in the future, by problem-solving the links in different ways (e.g. sticking with sleep or diet plan, calling a friend instead of going to bar, after getting bad news, etc.) 8. Identify **ways to REPAIR** negative consequences of the problem behavior (e.g. discussing the situation with boss, apologizing to loved-ones, etc.)

* adapted from:
Centre for Applied Research in Mental Health and Addictions (CARMHA) (2007). Working with the Client Who is Suicidal: A Tool for Adult Mental Health and Addiction Services. http://www.health.gov.bc.ca/library/publications/year/2007/MHA_WorkingWithSuicidalClient.pdf.

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