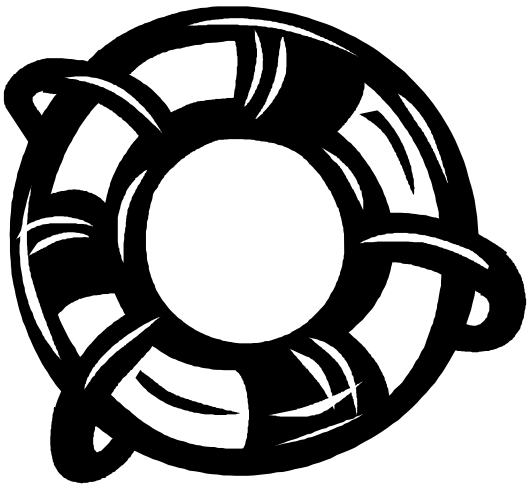
Suicide Prevention for Behavioral Health Providers



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What is this publication about?

Suicidality figures in most psychiatric hospitalizations. It is a leading cause of death among those with serious mental illness. Attempts and completions exact a great emotional toll on consumers, families, and providers.

A 2003 background paper to the President's New Freedom Commission on Mental Health noted that "Mental health and suicide prevention are not national priorities." Little has changed, but suicide prevention must move up on the community behavioral health agenda.

In 2006, A. Kathryn Power, Director, Center for Mental Health Services, stated that "suicide prevention is a mental health system transformation imperative**.**"[1] Earlier she said: "It is important to understand that achieving the vision of a transformed system is crucial to suicide prevention…and vice versa."[2] It is time that view caught on because:

> Most suicides, although by no means all, can be prevented. The breach between what we know and what we do is lethal.[3]

This booklet is about applying what we know about suicide to what we do in the behavioral health system. Comments about this publication may be directed to tsalvatore@mces.org. A bibliography is available on request.

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[1] *http://mentalhealth.samhsa.gov/newsroom/speeches/062206.asp*
[2] *http://mentalhealth.samhsa.gov/newsroom/speeches/102804.asp*
[3] *Jamison, K. (1999)* ***Night Falls Fast: Understanding Suicide*** *New York, Alfred A. Knopf.*

1) What is the language?

Suicide prevention, at the individual level, is helping someone avoid the onset of suicide risk or to get help if suicide risk is present. This the focus of much of what follows. Some other key terms and phrases are:

Aborted Suicide – An attempt terminated by the individual before physical harm occurs.

Lethal Means – The act, process, or instrument by which suicide is completed.

Suicidal Behavior – Ideation, planning, acquiring means, an attempt, or a completion.

Suicidal Ideation – Thoughts of self-harm or completing suicide.

Suicidality – Any level of suicidal behavior from ideation to making a plan to an attempt

Suicide Attempt –Deliberate self-harm intended to be fatal that does not result in death.

Suicide Completion – A suicide attempt that results in death.

Suicide Plan – An individual determination of when and how suicide will be completed.

Suicide Postvention –Aid following a suicide attempt or a suicide loss.

Suicide and Stigma

Stigma is expressed in everyday language. "Committed suicide" conveys criminality or sinfulness. It implies that suicide is a voluntary act or decision rather than the outcome of a process. "Completed suicide" or "died by suicide" are more neutral.

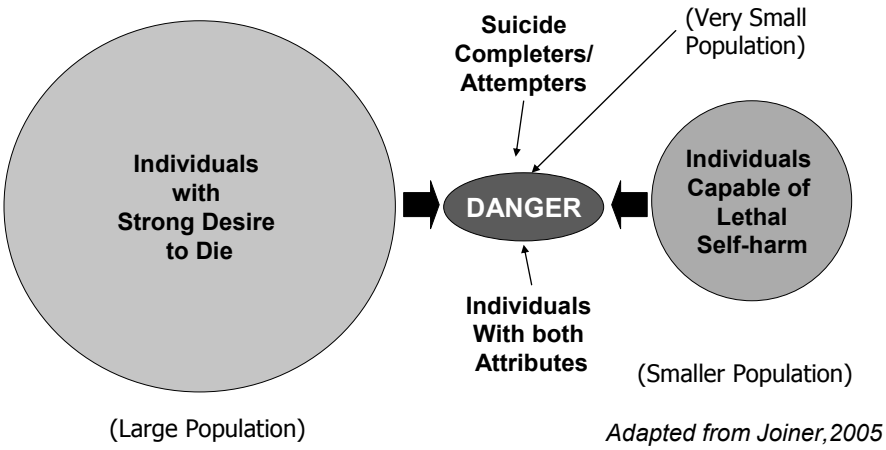
Other commonly used terms are stigmatizing and minimize the inherent risk or danger. "Failed attempts" or "unsuccessful attempts" are two examples. Why not just say "attempt"?

Suicidal consumers bear the stigma of suicide and the stigma of mental illness. Stigma deters asking for help. It increases feelings of shame, isolation, and helplessness. These raise risk. Stigma seems to be most felt by attempters. Stigma towards victims is felt by their survivors.

2) Why do people die by suicide?

In *Why People Die by Suicide* (2005), Thomas Joiner notes that two conditions must be present to overcome the instinct for self-preservation. The first is a desire to die caused by a strong belief that one is a burden and does not belong. The other is a capacity for lethal self-harm due to exposure to abuse, pain, suicidality, violence, and other factors. Here's how they interact:

Joiner Model:



From time to time, many people may desire to die and have thoughts of self-harm, but few go further. This is because they do not have the ability for lethal self-harm. When the two coincide, a suicide attempt may occur. This can happen to consumers.

This model shows that suicide is not an impulsive act but that "…individuals advance along a trajectory of advancing capability for self-injury by engaging in activities that foster fearlessness and competence for suicide."[4] Suicide is the outcome of a process and a plan.

[4] *Smith, A. et al. (2008) "Revisiting Impulsivity in Suicide"* ***Behavioral Science Law*** *26(6) 779-797.*

3) How is suicide connected to mental illness?

Mental illness does not cause suicide. It plays a part in some suicides. It is a risk factor, but it is not a cause. About 5% of people with mental illness complete suicide.

The National Violent Death Reporting System (NVDRS)[5] compiled detailed data on over 8000 suicides in 16 states in 2005. It found that just over 40% of the victims had a known psychiatric diagnosis at the time of their death. If we apply this percentage to the average number of US suicides yearly, it suggests that almost 13000 individuals with a diagnosed mental illness may take their lives annually.

In Joiner's theory (see above) a desire to die is a prerequisite for suicide and this state of mind is can be brought about by major depression, bipolar disorder, and schizophrenia. There is a high incidence of suicide in those with these disorders, but according to the theory they also needed to acquire the capability for lethal self-harm and that does not come from mental illness alone.

Mental illness may cause someone to feel that they do not belong and are a burden. This may lead to thinking about death. Suicide becomes a possibility with a history of attempts, alcohol use, trauma, violence, abuse, self-injury, severe physical or emotional pain, or access to firearms. These factors increase "suicide competence." The melding of intent and capacity may be fatal.

Mental illness contributes to suicidality in those that it afflicts but it is not a cause. Mental illness is a strong risk factor for suicide (see page 11). It plays a big part in acquiring multiple risk factors for suicide. This means that individuals with mental illness will usually have many problems that bear on their risk for suicide. One of the most common is alcohol and drug use.

Studies of outpatients with depressive disorders found that about 2% complete suicide. 50% of those with bipolar disorder will attempt suicide at least once. Research of suicide and schizophrenia found 20%-40% of sufferers attempt suicide and 6% - 10% complete suicide.

Suicide accounts for most premature deaths in people with schizophrenia. It cuts life average expectancy by about 10 years.

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[5] *http://www.cdc.gov/ncipc/profiles/nvdrs/publications.htm*

4) What about co-occurring disorders and suicide?

Co-occurring disorders (COD) significantly increases the risk of suicidal behavior. COD increases exposure to more risk factors and weakens protective factors. It is linked to history of past attempts. Misuse of alcohol and street or prescription drugs drives up the risk of suicide.

Here are some aspects of co-occurring disorders that increase suicide risk:

- Mood instability and chronic hopelessness
- Impulsiveness and disinhibition
- Poor self image; low self-esteem; loss of support system
- Less likelihood of seeking/getting help and intervention.
- Low sensitivity to negative consequences of actions
- Limited temporal outlook; little future orientation; "all or nothing thinking"
- High exposure to abuse, violence, suicide loss, and other trauma
- Frequent hospitalizations
- High criminal justice system contact and incarcerations (jail suicide risk)

Alcohol is involved in about 20% of all US suicides. Alcohol misuse raises stress levels and induces a lessened range of perception, reduced inferential thought, and decreased awareness of optional problem solutions. This creates a "slippery slope" towards suicidality.

Suicide is a leading cause of death among people who abuse alcohol, drugs, and other substances. Alcohol and drug use disorders elevate risk for suicide ideation and attempts.

Depression has many negative consequences in regard to suicide risk in those with COD. It decreases self-esteem and increases feelings of hopelessness and helplessness. It increases social isolation and anxiety. It adds or worsens psychological pain, agitation, and panic attacks.

In blending mental health and substance abuse services both systems must do a better job of addressing suicide risk. COD raises suicide risk far beyond that which accompanies either disorder alone. Systems integration must proceed with an awareness of the pervasiveness of suicide risk in the COD population.

5) What about suicide attempts?

An attempted suicide is the closest thing to a completed suicide:

- The intent to die was present.
- A doable plan was present
- Lethal means were present.
- The ability to lethally harm one's self was present.
- The warning signs were missed or ignored.

The only difference is that death did not occur. Surviving a suicide attempt is not a benign event. An attempt is highly traumatizing and many attempters experience post-traumatic stress disorder (which is often overlooked). Suicide attempters may be re-traumatized if they again become suicidal. This also is not generally recognized.

Suicide attempts create a life-long risk of suicide. About half of all suicide victims made at least one previous attempt. Greatest risk is within 3 months of the first attempt. 10% of attempters complete suicide within 10 years of the first attempt. 40% of these deaths occur within one year.

Individuals with psychiatric disorders have significantly higher rates of attempts compared to the general community, 29% versus 5%. There are 500 attempts per 100,000 people in the general population. This suggests that the attempt rate among consumers may approximate 3000 per 100,000 people or 3 out of every 100 persons. Or it may be far more.

Consumer attempters are in great jeopardy of repeat attempts. They must be singled out for care recognizing the trauma, stigma, and elevated risk that they acquired by attempting. They need clinical and peer postvention. If they are hospitalized because of the attempt, aftercare should start during the inpatient stay and continue in the community.

Individuals with co-occurring alcohol misuse are at high risk of attempting suicide. Studies show that alcohol plays a significant role in suicide attempts:

6) What about people who are always talking about suicide?

One of the most frustrating suicidal behaviors is when someone frequently or habitually threatens suicide or voices suicide intent. This is called "chronic suicidality" because of its repetitive nature and because it tends to go on for a long time.

Individuals who do this are known as "chronic suiciders." Their suicide threats are usually contingent in nature (e.g., "I'll kill myself if I don't get into rehab tonight") and may have a manipulative or control element. The threats can be dramatic and often involve "setting terms."

Suicide threats may be used to evade criminal justice issues or to get shelter. Most cases seem to involve a low intent to die and vague or non-specific threats. Some individuals go suicide talk and engage in potentially dangerous acts (e.g., lying in the street to have the police take them to an ER or crisis center). Despite a low intent to die, some may die unintentionally.

Chronically suicidal persons seem to be troubled by hopelessness, emptiness, and a need for control. This behavior is a coping strategy. Chronic suiciders learn that suicide threats get attention, open doors, and compel others to care.

There is an inherent problem with this tactic. Overtime "chronic suiciders" may raise their threat level while they are getting more used to the idea of suicide. Despite their low desire to die they may have many very real risk factors for suicide and a weakening set of protective factors.

Repeated threats (and pseudo-attempts) can increase suicide capability by lowering resistance to self-harm over time. Those with a history of chronic suicidality are very vulnerable when this happens. Family and friends may not see that a change in risk level that has taken place. They may be less vigilant because of many "false alarms" in the past. "Chronic suiciders" can get on a "suicide competence" track and become suicide victims.

"Suicidality always has to be taken seriously. That is because suicidal thoughts and actions communicate profound suffering and hopelessness. This is a message that has to be received, understood, and acknowledged."[6]

[6] *Paris, J. (2007)* ***Half in Love with Death****. Mahwah, NJ: Lawrence Erlbaum Associates*

7) How are people who experience a suicide affected?

Every suicide leaves several people severely affected. Suicide loss is a serious but unrecognized concern among consumers. There are many consumer and family member "suicide survivors."

Suicide loss upsets well-being, overrides coping, and causes extreme distress[7]. It alters functioning, brings on anxiety, depression, and panic, and has significant behavioral consequences. It generates severe emotional pain and shatters feelings of control and safety.

Worst of all it creates a sense of vulnerability to suicide and can even lead to suicidality. Complicated grief and depressive symptoms may occur and further heighten the risk for suicidal ideation, which may pose a risk for subsequent increased suicidality in suicide survivors.

Suicide loss can affect recovery. Extreme guilt may arise because the bereaved individual didn't see the danger or do anything to prevent the death. There may be intense anger towards the deceased for abandoning those left behind. Suicide leaves a numbing and disabling shock because of the suddenness, unexpectedness, and violence involved. Fear, stigma, shame, and a total lack of understanding may spur denial and helplessness.

Other factors can worsen the effects of a suicide. These include witnessing the suicide or finding the body, losing a child (at any age), being estranged from the victim, being away from where the death occurred, or being unable to go to the services. Police or media involvement after a suicide can distress suicide survivors.

Those close to the victim may experience relief after the death. Often this lasts only briefly, but it can be troubling. It may be an issue when the victim frequently threatened suicide or made many attempts. Relief may give way to guilt or it may be overcome by the gravity of the loss.

The impact of a suicide loss is amplified when it is unacknowledged. This is known as marginalizing or disenfranchising grief. This sometimes occurs when the victim is a common-law spouse, a gay or lesbian partner, or an estranged or divorced spouse. The survivors of such victims may be denied the chance to share their loss with others, such as the victim's family.

Problems may occur if a suicide survivor is in a setting where it is difficult to grieve openly, such as a residential rehab program or a prison. Such highly structured environments are not bereavement friendly, particularly in regard to the intensely emotional aftermath of a suicide.

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[7] *See "Recovering from Suicide Loss: Self-help for Consumers who have Lost Someone to Suicide" (Norristown, PA: Montgomery County Emergency Service, June 2009).*

8) What are the risk factors for suicide?

Risk factors are variables strongly associated with suicide. Risk factors do not cause suicide. Some risk factors (e.g., a past attempt) are permanent. Others may be reduced (e.g., removing firearms). The main risk factors for consumers are:

- Young age and early stage of illness
- Good pre-illness functioning, good intellectual functioning
- Frequent relapses/remissions, post-recurrence improvement periods
- Depressive episode/hopelessness/co-occurring alcohol/substance abuse

Several conditions act as short-term risk factors: instability, agitation, panic, anxiety; relational conflict, aggression, and violence. Impulsivity is linked to suicide risk because it makes it more likely that individuals will take on behaviors that increase the capability for lethal self-harm.

A past suicide attempt and alcohol use are such strong risk factors that they almost qualify as "predictors" of suicide. They are present in many victims. Additional risk factors are:

- Adult/elder white male, Native American, veteran, Latina teen
- Poor coping, problem-solving, help-seeking
- Intimate partner conflict, social isolation
- Family history of suicide, mental disorder or substance abuse
- Family violence, including physical or sexual abuse
- Firearms in the home or otherwise accessible
- Legal charges, financial problems, incarceration
- Physical illness and disability

Bisexual and homosexual men are at elevated risk for suicide attempts, with such risk clustered earlier in life. Gay men, lesbians, and bisexual persons have higher rates of suicidal ideation attempts, and completions than do heterosexual individuals.

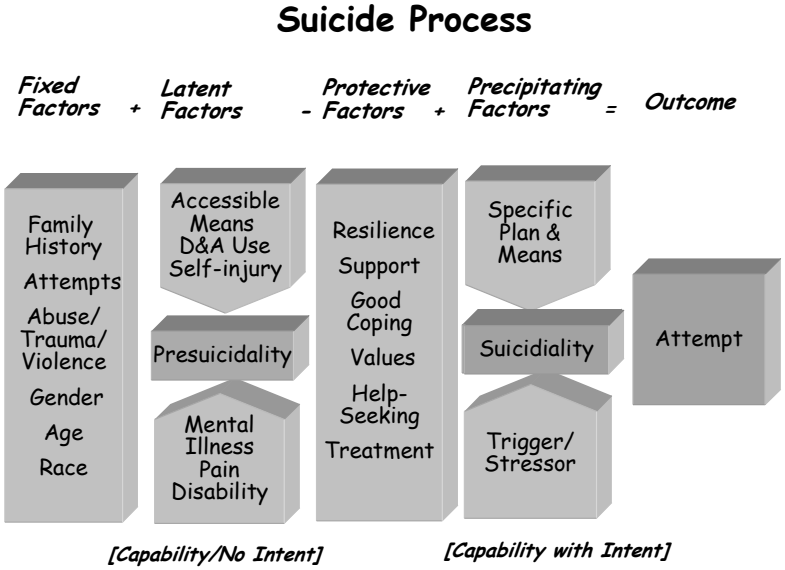
Some risk factors facilitate attempts (e.g., alcohol use, gun access). Risk factors may cluster and interact. Generally speaking, more risk factors means more risk, but serious risk may be present in individuals with only a few known risk factors.

9) What are the protective factors?

Protective factors are behaviors, characteristics, and other variables found to offset risk factors of suicide and precipitants of suicidal behavior. They contribute to feeling that life is worth living. Some can be developed and enhanced. Here are the main protective factors for suicide:

- Strong family, social ties, support sources
- Optimism, resilience, life satisfaction, emotional stability
- Strong self-esteem, sense of self-worth
- Good problem-solving, coping skills, and willingness to seek help
- Religiosity, spirituality
- No firearms in household
- No alcohol or drug use

Female gender and being non-white are protective factors against completed suicide. Recovery is a protective factor. Social support increases self-esteem and self-efficacy. The buffering role of protective factors is shown in this diagram:



Adhering to treatment is a protective factor. Yet suicidality may persist, arise, or worsen in those who faithfully follow care regimens. Suicidality and mental illness are not the same. Treating the latter does not always impact the former. Suicide can occur after the return to sobriety and the easing of depression. Ongoing risk monitoring and follow-up are necessary.

10) What are the danger signs and warning signs?

The Danger Signs: These are early indications of emerging risk that should result in immediate contact with a health care provider. They include:

- Hopelessness ("There's no way that I can make things better")
- Feeling trapped ("I feel like there's no way out")
- Withdrawal from family or friends
- Anxiety, agitation, sleep problems (too much or too little)
- Dramatic mood changes
- No reason for living ("Life isn't worth living")
- Reckless, risk-taking behavior

The Warning Signs: These are indicators of heightened suicide risk in the near-term, and should trigger an immediate crisis intervention response (calling a crisis center or 9-1-1). They include:

- Threatening to hurt or kill self
- Looking for ways to kill self
- Talking or writing about death, dying, or suicide

These are the most specific warning signs but there are others. Among them are:

- Citing a doable plan specifying how and when
- Giving away valued possessions (e.g., pets, CDs, books, tools, money, etc.)
- Making unexpected visits or calls to family members or friends
- Settling up affairs, making a will, dictating funeral arrangements

Suicide warning signs are fairly clear-cut but they are not always visible or voiced. Suicide danger signs are often missed because they are similar to signs of acute depression.

"Any person has the potential to become suicidal when confronted with a situation that produces emotional pain and is believed to be inescapable, interminable, and intolerable." [8]

[8] *Chiles, J. & Strosahl, K. (1995).* ***The Suicidal Patient: Principles of Assessment, Treatment, and Case Management****. Washington, DC: American Psychiatric Press.*

11) How is suicide risk identified?

Screening identifies suicide risk. It is conducted at points of contact with potential at-risk individuals (e.g., in crisis centers, at admission or intake). It involves simple direct questioning. It requires training but not clinical skill or judgment. It does not evaluate the level of risk.

Some screening questions are:

- Are you thinking about suicide right now?
- Do you have a plan on how to kill yourself?
- Do you have the means to carry out this plan?
- Have you tried out or rehearsed your plan?
- Have you ever attempted suicide?

After screening an individual may be referred for a suicide risk assessment to identify treatable risk factors and to assure safety. An assessment determines the degree of suicide risk. It is usually performed by a psychiatrist and requires clinical skill and judgment. It is based on an interview, observation, and other sources. It weighs both risk and protective factors.

Assessments try to establish the foresee-ability of a possible suicide through the reasonable determination of suicide risk. They cannot predict when an individual will complete suicide. Assessments have short shelf lives because of the transience and volatility of suicide risk.

New clients should be screened for risk. Those with multiple risk factors should be assessed. Those presenting with threats, ideation, or attempts must be assessed. Clients should be reassessed at discharge or transfer, and with clinical changes or after significant life events

A pre-discharge assessment should look for protective factors such as hopefulness and optimism, inaccessibility of firearms, availability of family and community supports, articulation of reasons for living, and self-help efforts such as personal suicide safety plans (see p. 21).

12) What are some of the myths of suicide?

Misconception	Reality
Those who talk about suicide are "all talk" and won't complete suicide.	Talking about suicide is a warning sign and many who talk about it do complete suicide.
Those who have attempted suicide are single-mindedly dedicated to dying.	Suicidal people only want to be free of hurt and would go on if their pain could be ended.
Asking someone if they are thinking about suicide will only give them "ideas."	Asking is often the only way to determine risk and to show that you care.
Those who have attempted suicide are at very low risk of actually completing suicide.	Many suicide victims have made one or more previous suicide attempts.
If someone says that he is suicidal, telling him to "do it" will snap him out of it.	This may be the single worst thing that anyone can do. Never say "go ahead and do it."
Surviving a suicide attempt shows that the individual wasn't really serious about dying.	An attempt always involves the intent to die.
Most suicides occur with little or no warning	Most people do mention what they are feeling and show signs of suicide
Improvement following a suicidal crisis means that the suicidal risk is over.	Many suicides occur following 'improvement'. Suicidal feelings can return.
Non-fatal acts are only attention-getting behaviors or only attempts to be manipulative	For some, suicidal behaviors are pleas for help. It is always better to err on the side of safety.
Once a person is suicidal, he or she will be suicidal forever.	Most suicidal crises are temporary, and will pass if help is provided.

13) How does recovery relate to suicidal behavior?

Recovery is a powerful suicide prevention tool. It is the best way to escape the cycle of suicidal behavior. Here is how recovery and suicidality relate to each other:

Attributes of Recovery	Attributes of Suicidality
• Hope, optimism, positiveness • Adaptability • Capacity to change	• More hopelessness, fear • Maladaptive and negative • Resistance to change
• Autonomy, empowerment, confidence • Self-respect • Sense of value as a person	• Decreased self-control • Decreased self-respect • Decreased self-esteem/self-worth
• Wellness • Self-awareness	• Increased illness and symptoms • Less self-awareness/greater denial
• Peer/family/other supports • Community living	• Loss of peer/family support • Increased risk of hospitalization

It is not enough to only promote recovery. It is also necessary to prevent the onset or return of suicidality in those working for recovery. This is why suicide prevention and postvention must be essential features of a transformed community behavioral health system.

Suicide loss negatively affects recovery. It undoes wellness, overrides coping mechanisms, and causes extreme stress. It brings anxiety, depression, and panic, and has significant affective and behavioral consequences. It generates emotional pain and shatters feelings of control and safety.

Experiencing a suicide, like experiencing suicidal behavior, changes those that it affects. This change cannot be undone, but it is possible to return to a sense of things being normal that you felt before. This is a different normal, a "new normal." That is what recovery is all about.

14) What is the role of peer support in suicide prevention[9]?

Peer support can play two roles: (i) identifying consumers who are at risk of suicide and directing them to help; and (ii) providing support to help initiate and sustain recovery from suicidal behavior or suicide loss.

Peer support can help consumers at-risk of suicidal behavior to minimize its occurrence, help those who have made attempts avoid recurrence, and help those who have suffered a suicide loss to cope with its affects on wellness and recovery. Peer specialists who have experienced suicidal behavior and/or suicide loss can serve as models for recovery from exposure to suicide.

Consumers troubled by suicidality need to know how to maintain wellness, be aware of risk and possible recurrence of suicidality, know how to mobilize supports, and be able to cope with the effects of suicidality. Peer specialists can help consumers develop suicide prevention self-help plans, act as "gatekeepers" who can recognize emerging signs of risk in peers, staff peer-run non-crisis warm lines, and educate consumers and families about suicide risk.

Consumers who have made attempts need support. Peer-led inpatient suicide prevention support groups, follow-up during the high risk period after discharge from inpatient care, and peer-facilitated post-attempt support groups are appropriate peer specialist functions.

Suicide loss postvention reduces the consequences that affect those close to the victim. It provides immediate emotional support to: a) ease the trauma of the loss; b) prevent the onset of grief complications; c) minimize risk of suicidal behavior; and d) encourage resilience and coping. Peer specialists can help make these things happen.

Peer support has proven itself in suicide postvention. Survivors of Suicide (SOS) uses self-help support groups facilitated by individuals who had a suicide loss to help those bereaved by a suicide. Consumers need peer-led support on the SOS model. Suicide Anonymous (SA) uses the 12-step model to support chronic suiciders through peer-led mutual self-help groups.

Peer specialist involvement in suicide prevention and postvention is do-able with training and clarification of roles. Peer specialists can broaden the range of services available to consumers.

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[9] *See Salvatore, T. (2009) "Suicide Prevention for Peer Specialists" Norristown, PA, Montgomery County Emergency Service*

15) What role does trauma play in suicidality and suicide loss?

Trauma is a psychological reaction to a harmful or life-threatening occurrence outside normal experience and control. Those with histories of trauma may be troubled by thoughts of suicide and some may attempt or complete suicide. Trauma is insidious and enduring. It influences responses to future stressors.

Trauma can result from victimization and abuse, assault, injury, exposure to homicide, suicide, serious accidents, interpersonal losses, as well as disasters. Suicide attempts and suicide loss can induce trauma and Post-Traumatic Stress Disorder (PTSD):

> People who suffered suicidal conditions, particularly conditions that were chronic, recurrent, or included one or more attempts, may also be victims of PTSD. Suicidal people meet the formal criteria for PTSD. Severe and prolonged suicidal pain is not something that most people suffer.[10]

The effects of trauma that may increase suicide risk are anxiety, depression, hopelessness, despair, anger, hostility, isolation, impulsiveness, substance abuse, humiliation, shame, guilt, lessened self-esteem, a loss of personal beliefs, and feeling ineffective, distrustful, or threatened.

Trauma makes those affected feel less connected or that they are burdens to their families and friends. This generates hopelessness and depression, which may produce a desire to die. Trauma weakens resistance to serious self-harm. Risk factors of suicide interact with trauma.

Trauma is prevalent in individuals with severe mental illness. Other trauma sufferers with a risk of suicide include self-injurers, "chronic suiciders", veterans and active members of the military, physicians, emergency responders, sexual assault victims, individuals with brain injury, and physically and developmentally disabled persons.

Re-traumatization can be an outcome of recurrent suicidal behavior or a suicide loss. Suicidal ideation may trigger a trauma response in an individual who survived a past serious attempt. Subsequent suicidality or loss may cause the earlier suicide-related trauma to be revisited, and raise vulnerability to recurrence, crisis, or suicide.

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[10] *Conroy, D. (N.D.) "Why is it so hard for us to recover from being suicidal" at www.metanoia.org/suicide/ptsd.htm*

16) What are some crisis intervention basics with a suicidal individual?

Here are some "Don'ts" that apply to anyone who might be suicidal:

- Do not leave him/her alone or let him/her go off alone
- Do not be judgmental; do not argue, debate, analyze, or moralize
- Do not try to cheer him/her up
- Do not try to shock or challenge (i.e., say "Oh, go ahead and do it if you want to!")
- Do not accept "I'm okay now." (Nobody recovers immediately from suicidality.)
- Do not be sworn to secrecy

Here are some "Do's":

- Ask if he/she is thinking about suicide
- If yes, go on to screen for risk
- Take the intent or threat very seriously
- L-I-S-T-E-N !!!
- Show that you care and <u>say</u> <u>it</u>

If there is no apparent immediate danger (and no lethal means in view):

- Tell her/him that help is available and you can see that he/she gets it.
- Let her/him have some space.
- Try to get her/him to another area in case there are hidden means.
- Remove car keys, if possible.
- Call the local crisis center or 9-1-1.

If there is apparent immediate danger - <u>ACT</u>:

- Say that you are getting help
- Call 9-1-1
- See that the person receives a psychiatric evaluation

This information is not a substitute for crisis services. However, providers must know the basics of dealing with a suicide emergency.

17) What about hospitalization and suicide?

Many consumers and their families confront hospitalization because of suicidality. It accounts for most voluntary and involuntary admissions. Many consumers incur multiple readmissions because of suicidal behavior, especially those with chronic suicidality.

Inpatient care is indicated if an attempt is violent, near-lethal, or premeditated, if precautions are taken to avoid rescue or discovery, or if the individual regrets surviving.[11] Other indicators are limited family and/or social support, the lack of stable living situation, and impulsive behavior, severe agitation, poor judgment, or refusal of help. Inpatient care is ordered for those with a specific plan with high lethality (e.g. plans to shoot self and has a gun), high suicidal intent (e.g. "I can't take this any longer, I just want to die."), or severe anxiety, agitation or perturbation.

Hospitalization does not assure the non-recurrence of suicidality. It can try to reduce "suicide competence" by giving more attention to factors that enhance capability for lethal self-harm. It is an opportunity to engage an at-risk individual in psychoeducation about suicidality, self-help and support.

Suicide risk is very high for the thirty days after discharge from a psychiatric hospital irrespective of the reason for admission because:

- Anyone admitted to a psychiatric hospital will have a set of strong risk factors
- Discharge plans focus on psychiatric diagnosis rather than suicidality
- Patients and families are not adequately informed of post-discharge risk
- There may be delays or disconnects for patients moving to outpatient care
- Consumers may fear rehospitalization if they acknowledge ongoing suicidality

Hospital can lessen this risk by doing pre-discharge risk assessments, addressing suicidality in discharge plans, educating patients and family members about ongoing risk, and maintaining contact with former patients during the service gap after discharge. Hospitals should involve consumers and families in developing personal suicide safety plans (see next section).

[11] ***Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors*** *(www.psych.org/psych_pract/treatg/pg/suicidalbehavior_05-15-06.pdf)*

18) What about personal suicide safety plans?

A personal suicide safety plan is a written list of coping strategies and sources of support that a consumer can use in a suicide crisis. It lists individuals, agencies, and other resources, such as hot lines or warm lines, that a consumer can contact to help them lower the risk of suicidal behavior. It is a proactive individualized suicide prevention plan for the consumer.

The personal suicide safety plan is a practical and meaningful joint provider-consumer-family suicide prevention effort. It is useful with consumers at risk of increasing suicidality as well as those trying to recover from recent suicidal behavior. A personal safety plan consists of:

- Warning signs – Thoughts, feelings, moods, behaviors, etc. that the individual identifies as indicators of emerging suicidality.
- Coping strategies – Self-help measures to avert suicidality.
- Social supports – Friends and social settings (e.g., Drop-in Center) that can serve as distractions if self-help efforts do not abate suicidality.
- Family supports – Relatives who would be willing to serve as supports if necessary.
- Providers – Physicians, therapists, crisis lines, etc. that can be contacted for help.
- Means restriction – Identification of possible means of lethal self-harm and what can be done to block access (e.g., disposing of unused meds).

Self-help prevention plans can be developed by the consumer or with the help of a peer specialist. An example is the Depression and Bipolar Support Alliance's "plan for life" which lists warning signs and actions to take if suicidal ideation cannot be deterred such as personal or provider contacts as well as diagnosis, medications, hospital preferences, and insurance information.[12] Another example appears as an appendix to this booklet.

A personal suicide safety plan involves the person at-risk in managing that risk by anticipating the possible crisis and delineating an action plan. The consumer gains a sense of control (ownership), and her or his support system is made aware of the risk and how help can be given.

Family members can contribute to personal suicide safety plans. They can help develop and maintain such plans. They may be contacts to turn to when signs of suicidality appear.

[12] *www.dbsalliance.org/site/PageServer?pagename=crisis_suicide_suicide#plan*

19) How can care become suicide aware?

The community behavioral health system must be more suicide prevention oriented. Values, philosophy, policies, and services will need to change to meet the needs of consumers affected by suicidality or suicide loss on a day-to-day basis.

Suicide prevention represents a paradigm shift or system-wide initiative like the recovery model. The new paradigm would have two principal elements.

The first is to mobilize service, support, and advocacy resources to promote consumer, family, and provider knowledge of suicide risk, and suicide prevention as follows:

- Integrate an understanding of suicide risk into all behavioral health programs.
- Recognize the impact of exposure to suicide risk and suicide loss on wellness, interpersonal relationships, and help-seeking and acceptance among consumers.
- Consumer and provider collaboration to promote suicide prevention and postvention.
- Appropriately involve peer specialists in consumer-focused suicide prevention.

The second entails new services of all types in various settings (i.e., peer-led and provider-based, hospital and community-based, clinical and nonclinical, etc.) to address the negative effects of suicidality and suicide loss on consumers and family members as follows:

- Services that enhance protective factors as a preventive measure among consumers.
- Services that target manageable/modifiable risk factors to reduce their effect on consumer susceptibility to suicidal behavior.
- Services that help consumers with persistent or recurrent episodes of suicidal ideation to limit their risk of moving on to more active or dangerous suicidal behaviors.
- Services that enable consumers caught up in chronic suicidality to escape and free themselves of the growing risk of an attempt or completion.
- Services that specifically facilitate regaining wellness after a suicide attempt.
- Services that assist and support consumers to recover from a suicide loss.

This is a basic blueprint for suicide prevention in the community behavioral health system.

20) What can be done to get started?

Some consumer-focused suicide prevention and postvention activities are outlined below. Most involve education or peer support. This is not an exhaustive listing.

Postvention Measures After a Suicide Attempt or Episode of Acute Suicidality	Consumer Community-based Prevention Measures
Inpatient psychoeducation peer-led/co-led group on suicide prevention.	Mandatory annual suicide prevention and basic crisis intervention in-service for peer support specialists.
Inpatient peer assisted self- help plan development for recovery from a suicide attempt or episode of severe suicidality without attempt.	Outpatient peer assisted self- help plan development for consumers coping with persistent suicidal ideation or other chronic suicidality.
Education of family on risk factors, danger/warning signs (e.g., National Suicide Prevention Lifeline's "After a Suicide Attempt"[13]).	Education of family/support system members on risk factors, danger/warning signs of suicide (counseling, groups, printed/on-line materials).
Routine objective (e.g., high/moderate/low) suicide risk assessment/evaluation prior to discharge from inpatient care.	Provider suicide prevention policy (Formal statement of organization's commitment to prevention and applicable procedures).
Communication of risk information between inpatient and outpatient providers and whenever consumers' treatment settings change.	Provider suicide prevention training (e.g., mandatory annual education for all staff with consumer service responsibility).
Routine instructions to patients, family/support system members on dealing with occurrence/ recurrence of suicidality.	Peer gatekeeper program (Consumers QPR[14]-trained to recognize danger signs of suicide and facilitate appropriate intervention).
Maintain daily contact with at-risk consumers during post-discharge period until engagement with outpatient care provider.	Peer-run warm lines for consumers coping with chronic suicidality, recovery from suicide loss, and related needs.
Intensive Outpatient Program (IOP) for consumers recovering from suicide attempt/acute episode of suicidality.	Quarterly regional peer suicide survivor-led suicide bereavement support group for consumers who have experienced a suicide loss.
Open-ended peer-facilitated mutual self-help support group for post-attempters and those who experienced an acute episode of suicidality.	Open-ended peer-facilitated mutual self-help support groups for (i) consumers coping with chronic suicidality; (ii) acute bereavement.
Open-ended family member-led support group for relatives of post-attempters and those who experienced an acute episode of suicidality.	Open-ended family member-led support group for relatives of consumers coping with chronic suicidality.

[13] *Available at http://mentalhealth.samhsa.gov/publications/allpubs/SVP-0159/*

[14] *Question/Persuade/Refer – Gatekeeper training program (see www.qprinstitute.com).*

Appendix A: Sample Personal Safety Plan

Name:_____ **Date**_____

My warning signs:_____

_____

_____

_____

_____

My coping strategies:_____

_____

_____

_____

_____

My social supports:

Name_____ Phone_____

Name_____ Phone_____

Name_____ Phone_____

My family supports:

Name_____ Phone_____

Name_____ Phone_____

Name_____ Phone_____

Name_____ Phone_____

My providers:

Peer Specialist:_____ Phone_____

Physician:_____ Phone_____

Therapist:_____ Phone_____

Case Manager:_____ Phone_____

Crisis Center:_____ Phone_____

Warm Line:_____ Phone_____

My means restrictions:_____

_____

_____

_____

_____