Managing Suicidality and Inpatient Hospitalization Procedures

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Preface

This manual was adapted from a number of sources including the American Journal of Psychiatry Practice Guidelines for the Assessment and Treatment of Patients With Suicidal Behaviors, the Suicide Protocol from the Psychosocial Research Program at Butler Hospital, the NIMH Treatment of Resistant Depression in Adolescents (TORDIA) study and the NIMH Skills Based Treatment for Suicidal Adolescents (START) study with permission.

Overview of Clinical Assessment of Suicidality

Assessment of suicidal patients requires an evaluation of the suicidal behavior and determination of risk for death or repetition as well as of the underlying diagnosis or promoting factors. Evaluating the presence and degree of suicide intent is a complicated matter. Suicide intent involves a balance between the wish to die and the wish to live. Some aspects of this address severity of the behavior, the efforts made to conceal the behavior and avoid discovery, and also the formulation of specific plans (e.g., "Did you do anything to get ready to kill yourself? Did you think what you did would kill you?").

Another approach in assessing suicidal intent is to evaluate motivating feelings, for example, the wish to gain attention, to effect a change in interpersonal relationships, to rejoin a dead relative, to avoid an intolerable situation, or to get revenge. If these motivations have not been satisfied by the time of the evaluation, serious suicidal intent may still be present. Similarly, it is important to determine the type of method employed in the suicide attempt (more unusual attempts, i.e., method other than cutting or small ingestion, carry a worse prognosis), potential medical lethality, the degree of planning involved, and the degree to which the chance of intervention or discovery was minimized (signifying higher intent). Previous suicide attempts make a further attempt more likely; a pervasive and frequent degree of current suicidal ideation also denotes greater seriousness and a greater likelihood of an associated mental illness.

Availability of firearms or lethal medications should be ascertained, and, if available, a recommendation for removal or more secure storage should be made as an imperative part of assessment. Likewise, drugs/ alcohol increase suicide risk increasing dysphoria and impulsivity.

Finally, the capability of the environment to insure safekeeping is critical in the evaluation of the suicidal patients. Of specific importance are the presence of abuse, significan other mental illness, family conflict/hostility and willingness to negotiate and agree to a verbal "No Suicide Contract."

Clinical Guidelines for Working with Suicidal Patients

Be very attentive.

Patients need to have someone listen and take their suicidal ideation seriously. The belief that someone is paying close attention and is trying to understand their level of distress may be sufficient to decrease the immediate threat. Attentive listening can also help dispel stigma and fear that having suicidal thoughts is "crazy" or shameful. Lack of attention may lead the patient to believe that people are ignoring or minimizing the threat and that no one cares if they do die. The patient may escalate the danger in order to communicate the seriousness of his or her pain.

Remain calm and non-threatened.

The threat of suicide by a patient does not mean that you have lost control of the situation. It may indicate that the patient is trying desperately to communicate how badly he or she feels. If the provider appears confident in the face of such a crisis, it can have a stabilizing effect for a labile patient.

Give the patient some space and time to vent.

If you assess for suicidality (or follow up on suicidal hints) early in the contact, you will provide yourself and the patient with enough time to fully describe how he or she is feeling. By allowing enough time to hear the patient's whole story (and not just jumping in to try and solve the problem), you will assist the patient to feel an important sense of validation. Empathic listening (e.g., "It sounds like you must be going through a really tough time right now" with appropriate eye contact) will also help to validate the patient's feelings. These techniques often facilitate the patient to be more receptive to your feedback.

Stress a team approach to the problem.

Freely use the collaborative pronoun "we" when discussing the suicidality, e.g., "We have to find a way for you to get some relief when you feel deeply depressed." Let the patients know that the responsibility for how treatment progresses is a shared responsibility between you and the patient, and that there are a number of treatment alternatives that can be tried.

Be willing to say the word "suicide" without flinching.

Do not avoid the word "suicide," as that gives the impression that we find the concept stigmatic. To the contrary, it is important to discuss the issue directly, without dread or negative judgment, in order to promote an open discussion. Clearly stating that feelings of suicide are symptoms of a treatable illness or disorder may also give the patient a sense of hope.

Monitoring of Suicidality and Contracting for Safety

Any patient in the study must be able to negotiate a No-suicide contract at every contact. This is an essential aspect of assessing suicidal risk and safety. If a patient has endorsed aggressive or homicidal ideation, this contract should be modified to focus on this behavior. The patient must be able to agree 100% to the following in negotiating a "No Suicide Contract":

- That he/she will not attempt suicide/harm another between now and the next contact.
- If the patient feels in danger of acting upon suicidal/aggressive thoughts, the patient will phone his/her mental health provider (or doctor on call after hours), or present himself/herself to the nearest emergency room.
- The patient will try to avoid activities/situations, which he/she believes, may increase the chance of feeling suicidal/aggressive.
- If the patient had endorsed significant current suicidal or homicidal ideation and is hesitant to agree to the no-suicide contract, the assessment may need to be abbreviated so that you can consult as soon as possible with the doctor on call and evaluate the necessity of inpatient hospitalization **(SEE INPATIENT HOSPITALIZATION EVALUATION PROCEDURES BELOW).**

How to Evaluate a Suicidal Patient

The following steps are procedures when possible suicidality is suspected and/or the patient is unable to agree to a No-Suicide contract.

Step 1: Administer the Modified Scale for Suicide Ideation (attached below)

Step 2: Complete a suicide interview (follow the suicide interview outline presented below).

Step 3: Arrange an appropriate intervention dictated by the patient's clinical circumstances (follow the intervention outline below).

Step 4: Complete Adverse Events and Severe Adverse Event forms as required.

The Suicide Interview

Specific topics to be covered during the evaluation of the suicidal patient include the following.

1. **What is the degree of suicide risk?**

   Determine the extent of suicidality by asking about ideation, method/plan, the presence of threats (e.g. suicide note, giving away belongings) and actual behaviors. A suicidal gesture means the method is in hand, but the patient didn't actually do anything (e.g. threatened to take pills he/she was holding but didn't actually do it). An attempt means acted on suicidal ideation (e.g., took pills). In an ideator, determine the risk that patient will move from low to higher risk. If an attempt has already occurred, determine its nature and assess future risk.

2. **Was a precipitant present?**

   Ask whether anything triggered the suicidal ideation or behavior (e.g. break up with romatic partner, death of a loved one, fight with family member). Carefully, ask whether the primary motivation was to escape the pain associated with this stressor, to communicate distress, ask for help, make someone change his/her mind or to exact revenge. Determine whether these circumstances still hold.

3. **Irrespective of intent, what is preferred method for suicide?**

   Begin with an open-ended question, but consider asking hanging, jumping, drowning, stabbing, carbon monoxide, car accident and cutting. Always ask about the availability of firearms and pills not only at home but also at relatives' and friends' houses. When asking about firearms or pills, ask specifically about type, how many, how stored (e.g. locked up or not) and for, firearms, availability of ammunition.

4. **Suicidal intent?**

   Ask specifically about whether the patient has a desire to die. If yes, consider the degree and type of motivation: actually wants to die, doesn't particularly want to die but rather wants to escape an intolerable situation or wants to communicate something, such as asking for help, getting attention, making someone feel sorry or change their mind. In the patient has made an attempt or gesture, ask whether these motivating factors still exist. If yes, this indicates increased risk. In this context, inquire specifically about the extent of hopelessness and irritability/anger. Both increase risk before an attempt and, if not resolved by or after an attempt, increase risk of another attempt or completed suicide. Ask about what the patient thinks will happen after he/she dies. Ask about personal fate and impact of suicide of family and friends. Ask specifically, what keeps him/her from committing suicide, including reasons for living and adverse impact on other people. Ask about regret for what happened. Finally, ask about the chances that the patient will make a suicide attempt: less than 50%, equal or more than 50%.

5. **Intoxication?**

   In the context of the patient's drug and alcohol history, ask whether drugs or alcohol are involved either through worsening mood or decreasing behavioral self-control (e.g. impulsivity). If present, ask about future intent to use and availability.

6. **How lethal is/was the method used or proposed?**

   Irrespective of intent or the patient's judgment about lethality, how dangerous is/was the patient's preferred method?

7. What is/was the potential for discovery?

Inquire about whether or not early intervention for suicidality is/was possible in the context of whether or not a suicide attempt will be discovered in time to do something to preserve life.

8. If an attempt was made, was the attempt planned or impulsive?

If the patient made a suicide gesture or attempt, to what extent was it planned versus impulsive. Inquire about how long she/he had been thinking about it. Ask about indicators about planning such as leaving a suicide note or making preparations for what would happen after she/he dies. Determine insight into vulnerability to act impulsively again and intent to avoid precipitants that might provoke impulsive actions.

9. How effective is the environment for keeping the patient safe?

In the context of negotiating and adhering to a verbal "No Suicide Contract", including the contract negotiated at the start of treatment and the renewal or renegotiation of this contract, can the significant other or other family members, provide for safekeeping? Consider availability to the patient, the quality of their relationship, whether abuse/neglect, family mental illness or substance abuse is present and the ease of working out the "No Suicide Contract".

The Intervention

It is impossible to pre-determine the outcome of an evaluation of a suicidal patient. However, the patient's safety is the paramount consideration.

The following conditions should be met before ending contact with a suicidal patient.

1. **There is a supportive and responsible person at home.**
2. **A verbal "No Suicide Contract" is in place.**
3. **Firearms and lethal medications are effectively secured or removed.**
4. **Patient and family have been cautioned about the disinhibiting effects of drugs or alcohol.**
5. **A follow-up appointment with a mental health provider has been scheduled and patient/family members understand how to contact crisis management resources at any time for emergencies.**

If these five conditions cannot be met, then hospitalization for safekeeping should be considered:

SEE PROCEDURES FOR INPATIENT HOSPITALIZATION EVALUATION BELOW

<u>If the above conditions can be met</u>:

With the patient:

- Help the patient develop a concrete coping plan to get through the rest of the evening.
- Have the patient contact his/her mental health provider to schedule an immediate appointment.
- Contact the clinician to inform him/her of the situation and confirm he appointment

With the significant other/family member:

- Review the patient's coping plan and elicit support.
- Review the importance of close supervision at this time.

- Review limiting access to suicide means (e.g. pills, firearms).
- Review treatment plan (i.e., contact clinician ASAP to schedule appt.).
- Review safety procedure – if patient appears to escalate and/or cannot follow through with the coping plan, bring the patient directly to a local ER.

If above conditions cannot be met and/or if the staff feels uncomfortable with issue of patient safety:

- Attempt to speak with a significant other/family member and instruct him/her to bring the patient to a local emergency room for an evaluation.
- If a significant other/family member cannot be reached, ask the patient for the number of a relative or family friend. Then contact that person and ask him/her to bring the patient to a local emergency room for an evaluation.
- If a significant other/family member cannot be reached or if the patient seems disoriented and/or hangs up and will not answer when called back, contact rescue immediately at 911.

How to Handle a Completed Suicide

Although every precaution will be taken to avoid a suicide, it is always possible that a patient may commit suicide over the course of treatment. Should that occur, following are specific procedures that should be followed.

- The suicide will be recorded as an adverse event and the PI will follow institutional IRB procedures for reporting adverse events. The PI will also immediately alert the Data and Safety Monitoring Board.
- The PI with the help of other investigators will debrief study staff members about the circumstances surrounding the suicide and address any distress among staff members.
- The PI and therapist who was treating the deceased patient will discuss the suicide with significant others/ family members. In doing so, the suicide will be presented from a disease model rather than any fault of the patient or family members. Discussion of beliefs surrounding the death will be facilitated and erroneous perceptions corrected. Family members will be strongly discouraged from believing that the death was due to any failure on their part. Referrals for grief counseling will be made on behalf of family members as needed.
- The PI and Data Safety and Monitoring Board will hold a meeting to discuss the suicide and determine whether there were any errors in the study procedure that need to be corrected/changed.

Inpatient Hospitalization Procedures

Therapist procedures: to be followed when patient is judged to be a significant risk and is likely to require hospitalization.

Outpatient in-person session

- Call ahead to the nearest 24 hour inpatient evaluation service, then escort patient (and his/her significant other) there.
- Depending on your current location, there are several options:

Butler Hospital
345 Blackstone Boulevard, Providence
Patient Assessment Services (PAS) and is located on the 1st Floor to the left of Butler's main lobby entrance; the receptionist in the lobby can provide directions to PAS.
401-455-6214/5

Rhode Island Hospital
Psychiatric Emergency Services (PES)
Rhode Island Hospital, Main Building 038
593 Eddy Street
Providence, RI 02903
Phone: 401- 444-4PSY (4779)

Roger Williams Medical Center
825 Chalkstone Avenue, Providence, Rhode Island 02908
Emergency Services 401-456-2000

Brown University Psychological Services- hotline for emergencies
J Walter Wilson Room 516, 69 Brown St (corner of Brown and Waterman)
M-F business hours: 401-863-3476
After hours: 401-863-3953 for nights (between 5pm and 8:30am), weekends (from 5pm Friday to 8:30am Monday) or holidays.

Johnson and Wales Psychological Services:
If a J&W student is coping with a psychiatric emergency during our regular business hours they are to call our office and meet with an on-call urgent clinician, if the students primary clinician is unavailable. We are open from 8:30am-4:30pm Mon-Fri. For after hours emergencies there are two options. Students (and providers, community members, concerned parents etc.) can call our Safety and Security office who will either transfer the call to our after hours on-call clinicians or complete a wellness check on a student. Students can also call our after hours on-call line directly if they would like to bypass Safety and Security. Lastly, we ask our clients to fill out an ROI with RI Hospital and Gateway Healthcare (the company that provides the psychiatric assessments at RI Hospital) so that we may triage with the ER if necessary.

JWU Counseling Services: 401-598-1016
Campus Safety and Security: 401-598-1103
After Hours On-Call: 1-888-222-4805

- Procedure: Explain to the assessment clinician that you are treating the patient on an outpatient basis through a research study but the patient requires an inpatient evaluation due to his/her current level of suicidality. Provide a rationale for the evaluation and fill out any necessary paperwork. Wait there for the final decision. In almost all cases, the patient will be admitted to the inpatient unit. If the patient is not admitted, consult with the assessment clinician and then contact the supervisor on call.
- Contact supervisor on call to confirm the patient's disposition.

Telephone Contact

- If a call is received during office hours, ask the patient and his/her significant other or family member to come in for an in-person evaluation. If after conducting a suicide evaluation, you deem that the patient requires an inpatient hospitalization evaluation, follow the procedures listed above (therapist procedures - outpatient setting). If a subject becomes suicidal after office hours or on weekends, they should call 911 or present at nearest emergency room.
- If a patient calls during office hours and cannot come in for a session (or you cannot immediately get hold of a significant other/family member to bring him/her in for a session), conduct a suicide evaluation by phone and attempt to negotiate a no-suicide contract. Then tell the patient that you need to hang up to contact a supervisor and will call him/her right back. If the patient seems disoriented, and/or patient hangs up and will not answer when called back, contact rescue immediately at 911.

Assessment Contact Procedures:

- If the patient's score on the Modified Scale for Suicide Ideation reflects suicide risk the IE should contact a study clinician or PI (during office hours) or the doctor on call (after office hours). The IE should explain to the patient and his/her significant other/family member that it is standard protocol to contact a clinician when scores on any of the assessments reflect potential suicide risk. Ask the patient and his/her significant other/family member to maintain contact with you until the study clinician or doctor on call returns your call.

The Modified Scale for Suicidal Ideation

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ID_____ Total Score_____
Date_____

Instructions
The purpose of this scale is to assess the presence or absence of suicide ideation and the degree of severity of suicidal ideas. The time frame is from the point of interview and the previous 48 hours.

1. Wish to die
Over the past day or two have you thought about wanting to die?
Do you want to die now?
(If the patient wants to die ask: Over the past day or two how often have
you had the thought that you wanted to die? A little? Quite often? a lot?
When you have wished for death, how strong has the desire been? Weak?
Moderately strong? Very strong?)

0. None - no current wish to die, hasn't had any thought about wanting to die.
1. Weak - unsure about whether he/she wants to die, seldom thinks about death, or intensity seems low.
2. Moderate - current desire to die, may be preoccupied with ideas about death, or intensity seems greater than a rating of 1.
3. Strong - current death wish, high frequency or high intensity during the past day or two.

2. Wish to live
Over the past day or two have you thought that you want to live?
Do you care if you live or die?
(If the patient wants to live ask: Over the past day or two how often have you thought about wanting to live? A little? Quite often? A lot? How sure are you that you really want to live?)

0. Strong - current desire to live, high frequency or high intensity.
1. Moderate - current desire to live, thinks about wanting to live quite often, can easily turn his/her thoughts away from death or intensity seems more than a rating of 2.
2. Weak - unsure about whether he/she wants to live, occasional thoughts about living or intensity seems low.
3. None - patient has no wish to live.

3. Desire to make an active suicide attempt
Over the past day or two when you have thought about suicide
did you want to kill yourself? How often? A little? Quite often? A lot?
Do you want to kill yourself now?
0. None - patient may have had thoughts but does not want to make an attempt.
1. Weak - patient isn't sure whether he/she wants to make an attempt.
2. Moderate - wanted to act on thoughts at least once in the last 48 hours.
3. Strong - wanted to act on thoughts several times and/or almost certain he wants to kill self.

4. Passive suicide attempt
Right now would you deliberately ignore taking care of your health?
Do you feel like trying to die by eating too much (too little), drinking too
much (too little), or by not taking needed medications?
Have you felt like doing any of these things over the past day or two?
Over the past day or two, have you thought it might be good to leave life or
death to chance, for example, carelessly crossing a busy street, driving
recklessly, or even walking alone at night in a rough part of town?

0. None - would take precautions to maintain life.
1. Weak - not sure whether he/she would leave life/death to chance, or has thought about gambling with fate at least once in the last two days.
2. Moderate - would leave life/death to chance, almost sure he/she would gamble.
3. Strong - avoided steps necessary to maintain or save life, e.g., stopped taking needed medications.

5. Duration of thoughts
Over the past day or two when you have thought about suicide how long did the thoughts last?
Were they fleeting, e.g., a few seconds?
Did they occur for a while, then stop, e.g., a few minutes?
Did they occur for longer periods, e.g., an hour at a time?
Is it to the point where you can't seem to get them out of your mind?

0. Brief - fleeting periods.
1. Short duration - several minutes.
2. Longer - an hour of more.
3. Almost continuous - patient finds it hard to turn attention away from
suicidal thoughts, can't seem to get them out of his/her mind.

6. Frequency of ideation
Over the last day or two how often have you thought about suicide? Once a
day? Once an hour? More than that? All the time?
0. Rare - once in the past 48 hours.
1. Low frequency - twice or more over the last 48 hours.
2. Intermittent -approximately every hour
3. Persistent - several times an hour.

7. Intensity of thoughts
Over the past day or two, when you have thought about suicide, have they been
intense (powerful)?
How intense have they been? Weak? Somewhat strong? Moderately strong? Very strong?
0. Very weak.
1. Weak.
2. Moderate.
3. Strong.

CUT-OFF INSTRUCTIONS - If Item 1 and Item 2 are scored less than "2" and
Items 3 and 4 are scored 0, then STOP. Otherwise continue with full scale.
Modified Scale for Suicidal Ideation

8. Deterrent to active attempt
Can you think of anything that would keep you from killing yourself?
(Your religion, consequences for your family, chance that you may injure yourself seriously if unsuccessful).
0. Definite deterrent - wouldn't attempt suicide because of deterrents.
Patient must name one deterrent.
1. Probable deterrent -can name at least one deterrent, but does not definitely rule out suicide.
2. Questionable deterrent - patient has trouble naming any deterrents,
seems focused on the advantages to suicide, minimal concern over deterrents.
3. No deterrents - no concern over consequences to self or others.

9. Reasons for living and dying
Right now can you think of any reasons why you should stay alive?
What about over the past day or two?
Over the past day or two have you thought that there are things happening in your life that make you want to die? (If the patient says there are clear reasons for living and dying, ask what they are and write them verbatim in the section provided. Ask the remaining questions)
Living Dying
Do you think that your reasons for dying are better than your reasons for living?
Would you say that your reasons for living are better than your reasons for dying?

Are your reasons for living and dying about equal in strength, 50-50?
0. Patient has no reasons for dying, never occurred to him/her to weigh reasons.
1. Has reasons for living and occasionally has thought about reasons for dying.
2. Not sure about which reasons are more powerful, living and dying are about equal, or those for dying slightly outweigh those for living.
3. Reasons for dying strongly outweigh those for living, can't think of any reasons for living.

Method:
Over the last day or two have you been thinking about a way to kill yourself, the method you might use?
Do you know where to get these materials?
Have you thought about jumping from a high place? Where would you jump?
Have you thought about using a car to kill yourself? Your own? Someone else's?
What highway or road would you use?
When would you try to kill yourself? Is there a special event (e.g., anniversary, birthday with which you would like to associate your suicide?
Have you thought of any other ways you might kill yourself? (note details verbatim).
(The interviewer should try to get as detailed a description as possible about the patient's plan and degree of specificity - Record this information in narrative fashion below and then rate item 10)

_____
_____
_____
_____
_____
_____
_____
_____

10. Degree of specificity/planning
0. Not considered, method not thought about.
1. Minimal consideration.
2. Moderate consideration.
3. Details worked out, plans well formulated.

11. Method: Availability/opportunity
Over the past day or two have you thought methods are available to you to commit suicide?
Would it take time/effort to create an opportunity to kill yourself?
Do you foresee opportunities being available to you in the near future (e.g., leaving hospital)?
0. Method not available, no opportunity.
1. Method would take time/effort, opportunity not readily available, e.g., would have to purchase poisons, get prescription, borrow or buy a gun.
2. Future opportunity or availability anticipated - if in hospital when patient got home, pills or gun available.
3. Method/opportunity available – pills, gun, car available, patient may have selected a specific time.

12. Sense of courage to carry out attempt
Do you think you have the courage to commit suicide?
0. No courage, too weak, afraid.
1. Unsure of courage.
2. Quite sure.
3. Very sure.

13. Competence

Do you think you have the ability to carry out your suicide?
Can you carry out the necessary steps to insure a successful suicide?
How convinced are you that you would be effective in bringing an end to your life?
0. Not competent.
1. Unsure.
2. Somewhat sure.
3. Convinced that he/she can do it.

14. Expectancy of actual attempt
Over the last day or two have you thought that suicide is something you really might do sometime?
Right now what are the chances you would try to kill yourself if left alone to your own devices?
Would you say the chances are less than 50%? About equal? More than 50%?
0. Patient says he/she definitely would not make an attempt.
1. Unsure - might make an attempt but chances are less than 50% or about equal, 50-50.
2. Almost certain - chances are greater than 50% that he/she would try to commit suicide?
3. Certain - patient will make an attempt if left by self (i.e., if not in hospital or not watched).

15. Talk about death/suicide
Over the last day or two have you noticed yourself talking about death more than usual?
Can you recall whether or not you spoke to anybody, even jokingly, that you might welcome death or try to kill yourself?
Have you confided in a close friend, religious person, or professional helper that you intend to commit suicide?
0. No talk of death/suicide.
1. Probably talked about death more than usual but no specific mention of death wish. May have alluded to suicide using humour.
2. Specifically said that he/she wants to die.
3. Confided that he/she plans to commit suicide.

16. Writing about death/suicide
Have you written about death/suicide e.g. poetry, in a personal diary?
0. No written material.
1. General comments regarding death.
2. Specific reference to death wish.
3. Specific reference to plans for suicide.

17. Suicide note
Over the last day or two have you thought about leaving a note or writing a letter to somebody about your suicide?
Do you know what you'd say? Who would you leave it for? Have you written it out yet?
Where did you leave it?
0. None - hasn't thought about a suicide note.
1. "Mental note" - has thought about a suicide note, those he/she might give it to, possibly worked out general themes which would be put in the note (e.g., being a burden to others, etc.)

2. Started - suicide note partially written, may have misplaced it.
3. Completed note - written out, definite plans about content, addressee.

18. Actual preparation

Over the past day or two have you actually done anything to prepare for your suicide, e.g., collected material, pills, guns, etc.?

0. None - no preparation.
1. Probable preparation - patient not sure, may have started to collect materials.
2. Partial preparation - definitely started to organize method of suicide.
3. Complete - has pills, gun, or other devices that he needs to kill self.