Resources & Recommendations for Working with Suicidal Patients

CRISIS INTERVENTION AND RESPONSE PROCEDURE

When considering the type of resolution, staff should consider the following:

1. If an emergency, follow the SUICIDE ASSESSMENT ACTION PLAN.
2. Determine this is a non-emergent situation that can be resolved using problem-solving resources and skills.
3. Identify the type of crisis.
4. Develop an action plan.
5. Attempt to defuse the situation and/or reassure the individual and family.

Once the situation is calm:

6. Identify and contact available community resources in your service area that may be able to assist the individual and/or family through the identified crisis.
7. Document events to the extent possible, maintaining confidentiality when required.

Maintain professional skills and resources:

8. Identify and post information about available community resources.
9. Keep all community resource information updated.
10. Seek additional opportunities when available to empower individuals and/or families.

Best practice and trauma-informed recommendations

To support individuals in a crisis situation.

- ✔ Ensure safety of self and others. Seek medical and emergency services if needed.
- ✔ Ask to meet in private and escort to a safe and private location.
- ✔ Listen empathetically and avoid minimizing the situation.
- ✔ Demonstrate cultural humility and sensitivity
- ✔ Discuss concerns and instill hope.
- ✔ Be open and non-judgmental.
- ✔ Be direct and specific.

- ✔ Be respectful even if there is personal disagreement with circumstances and choices.
- ✔ Maintain clear and consistent boundaries and expectations.
- ✔ Communication understanding and be honest about responsibility to their safety.
- ✔ Recognize risk factors, signs and or symptoms that increase risk for safety well-being.
- ✔ Offer options for health care support
- ✔ Provide reassurance and encouragement.
- ✔ Connect individuals to health care professionals by accompanying them to health care destinations.

BE DIRECT:

While it can be challenging, we must ask direct questions around thoughts of suicide and/or self-injury, to include:

1. Do you ever feel so badly that you have thoughts of suicide?
2. Do you have a plan?
3. Do you know when you would do it?
4. Do you have access to what you would use?

Information from these questions is important to make the best connection with health care professionals. For any situation where an ***individual is reluctant to seek professional care for suicide, homicide, self-injury, or other necessary medical attention, use emergency procedures and contact 911 for immediate assistance***. We have an ethical and legal responsibility for safety of individual actively expressing thoughts or plans of suicide, homicide and/or injury/harm.

RISK FACTORS

- Prior suicide or history of attempt
- Depression or other mental health disorder
- Substance use disorder
- Family history of mental health or substance use disorder
- Family history of suicide
- Family violence, including physical or sexual abuse
- Access to guns or other firearms in the home
- Being in prison or jail
- Being exposed to other's suicidal behavior, such as family member, peer, or media figure
- Medical illness

- Ages between 15 and 24 or over 60
- Trauma history including military combat exposure, rape, childhood family violence

WARNING SIGNS

- Talking about wanting to die or wanting to kill themselves
- Talking about feeling empty, hopeless, or having no reason to live
- Planning or looking for a way to kill themselves, such as searching online, stockpiling pills, or newly acquiring potentially lethal items (e.g. firearms, ropes)
- Talking about great guilt or shame
- Talking about feeling trapped or feeling that there are no solutions
- Feeling unbearable pain, both physically and emotionally
- Talking about being a burden to others
- Using alcohol or drugs more often
- Acting anxious or agitated
- Withdrawing from family and friends
- Changing eating and sleeping habits
- Showing rage or talking about seeking revenge
- Taking risks that could lead to death, such as reckless driving
- Talking or thinking about death often
- Displaying extreme mood swings, suddenly changing from very sad to very calm
- Giving away important possessions
- Saying goodbye to friends or family
- Putting affairs in order, making a will
- Self-injury or harming behaviors (e.g. cutting, burning or branding, etc.

CRISIS INTERVENTION AND RESPONSE TRIAGE GUIDE

Address the crisis situation by utilizing community social support programs and or linkage to resources. Case staff if necessary with clinical staff support to assist in resolving patient/client related crisis situation(s).

Risk Factor Screening Questions

Consider the following screening questions to determine risk factor(s) related to prioritizing intervention(s) and connecting individuals to health care professionals.

- *Is there an immediate risk of serious bodily harm or death?*
- *Is there a possible risk of safety to self or others?*
- *Is the individual having thoughts of suicide, homicide, or self-injury?*
- *Is the individual in need of immediate medical attention?*
- *Is the individual responsive to questions in a coherent manner?*

If the answer is **YES** to any of these questions, ***use emergency procedures and contact 911 for immediate assistance***.

Additional considerations:

1. Lethality of situation (e.g. weapons involved, access to weapons, or other lethal means)
2. Attempt history (e.g. does the individual have a history of suicide attempt(s)?)
3. Planning (e.g. does the individual have a plan whether active or have a previous plan?)
4. Timing (e.g. does the individual identify when or how soon they intend to end their life?)
5. Mental health (e.g. does the individual have a mental health disorder?)
6. Medications (e.g. does the individual take medications for a mental health disorder?)
7. Substance use (e.g. does the individual use or abuse substance as self-medication?)
8. Survivor (e.g. is the individual a survivor of suicide or a combat war veteran?)

Mandatory Reporting:

The Montana Code Annotated requires all individuals to report instances of suspected child abuse and /or neglect, elder and persons with developmental disabilities abuse and/or neglect to the Montana Department of Public Health and Human Services. **(For child abuse/neglect concerns, contact Centralized intake 866-820-5437. For elder or persons with developmental disabilities concerns of abuse/neglect contact Adult Protective Services at 800-551-3191.)**

Not every abuse/neglect report requires emergency medical services. However, in the event that a child, elder, or individual with a developmental disability requires emergency medical attention, ***use emergency procedures and contact 911 for immediate assistance***.

Incident Reports and Record-keeping:

An operational incident report in addition to any clinical incident reports should be documented in a patient record.

The typical timeline for an Emergency and Critical Incident Management Incident Report Form to be completed is 24-hours following the incident. The Clinical Director may provide an extended time frame based on the severity of the emergency situation and impact on staff.

Emergency and Critical Incident Management Incident Reports are stored hardcopy and may be electronically archived. These records are confidential and stored in a double locking system.

Medical Records Entry:

Any emergency situations, critical incident, or crisis situation involving a patient must be documented within the patient's medical record. The medical record entry should only contain patient specific information such as presentation, symptoms observed or reported, behavioral risk factors, statements about medications, presence of weapons, body posturing or verbal threats of harm to self or others, safety planning, and/or emergency medical services required. This information is crucial to patient care in the event of involuntary hospitalization or criminal detainment. Documentation of patient incidents must meet adherence with the Board of Behavioral Health monitoring requirements.

SUICIDE ASSESSMENT ACTION PLAN

If you suspect a client may be contemplating suicide, follow these action steps:

STEP 1: Check for suicide ideation

Ask client if they are thinking about suicide: **Be Clear, Concise, and Direct.**

Ex. *"Are you thinking about hurting yourself? Are you having suicidal thoughts?"*

Do **NOT** try to cheer him/her up, accept, "I'm okay now," or be sworn to secrecy.

Do **NOT** be judgmental; do not argue, debate, analyze, or moralize.

DO confirm to the client that he/she is safe, no longer alone and that you will help access help.

DO establish rapport by engaging in dialogue using active listening skills to Identify the main problem, provide reframing to enhance pieces of strength and resiliency, and support emotions.

DO generate and explore alternatives, support systems, and resources.

DO implement client directed treatment plan and follow-up.

ASSESS THROUGH SLAP

1) **Specific plan** – has client thought about how, where and when he would commit suicide? A plan that is specific is much closer to being carried out than one that is only general.
2) **Lethality** – How deadly is the plan?
3) **Availability (of means)** – Does client have or can easily gain access to what he/she needs to carry out his/her plan?
4) **Proximity (of help)** – Does client have a social support system?

STEP 2: If the person's plan is lethal, concrete, specific, and available, get the client to emergency psychiatric services immediately-**TAKE IMMEDIATE ACTION:**

1) Tell the client that you are getting help.
2) Do not leave client alone, remove possible lethal means and remove car keys, if possible.
3) Until help is on its way: **LISTEN**, take the intent or threat very seriously, show and say you care.
4) ***Use emergency procedures and contact 911 for immediate assistance***.

STEP 3: If the client has no plan or if it is not specific, available, or immediate, proceed as follows:

1) Do not leave client alone.
2) Reassure client that help is available and you can see that he/she gets it.
3) Ask about medications and dosages to determine if suicidal ideation may be related to a drop in the therapeutic level of a prescribed medication or an over the counter drug reaction.
4) Proceed to contact the appropriate supports:
   police Department Non-Emergency
   (888) 866-0328 Montana Mental Health Services Helpline
   (800) 273-8255 MT State Suicide Hotline
   (877) 688-3377 MT Mental Health Warmline
   (800) 784-2433 National Suicide Hotline

5) If client remains at risk, ***use emergency procedures and contact 911 for immediate assistance***.