Working with Patients Presenting Suicidal Ideation

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BACKGROUND

Suicide is a major cause of premature death. Approximately 4,000 Canadians die by suicide each year, averaging nearly 11 lives claimed by suicide each day[1]. 90% of individuals that die by suicide have a previous diagnosis of psychiatric illness, and the most common risk factors for suicidal ideation and suicide include mental illness and substance use disorders[1, 2].

Relative Risk of Suicide in Specific Disorders[3]:

Condition	Relative Risk (RR)*
Previous suicide attempt	38.4
Major depression	20.4
Bipolar disorder	15.0
Dysthymia	12.1
Mixed drug abuse	19.2
Alcohol abuse	5.86

**compared to individuals without the condition*

What does this mean?

- A relative risk of **1** means the risk of suicide is equally as likely to occur in both case and control groups.
- A relative risk of **< 1** means the risk of suicide is ***x*** times less likely to occur in the case group than the control group.
- A relative risk of **>1** means the risk of suicide is ***x*** times more likely to occur in the case group than the control group.

Smoking and Suicidal Behaviour

A 2016 meta-analysis found an association between smoking and suicidal behaviour in both current and past smokers[4]. Compared to non-smokers, current smokers were **more likely** to have:

- **Suicidal ideation** (OR = 2.05; 95% CI: 1.53, 2.58) [4]
- **Suicide plan** (OR = 2.36; 95% CI: 1.69, 3.02) [4]
- **Suicide attempt** (OR = 2.84; 95% CI: 1.49, 4.19) [4]
- **Death by suicide** (RR = 1.83; 95% CI: 1.64, 2.02) [4]

Odds Ratio (OR) **> 1** means the occurrence of suicidal behaviour is ***x*** times more likely in smokers vs. non-smokers.
Odds Ratio (OR) **< 1** means the occurrence of suicidal behaviour is ***x*** times less likely in smokers vs. non-smokers.

It is important to note that while evidence confirms an *association* between smoking and suicidal behaviour, smoking does not *cause* suicidality[4]. In addition, whether smoking influences suicidal behaviour through direct biological mechanisms, or works with other risk factors of suicide to increase this association remains unclear[4].

SCREENING AND ASSESSING SUICIDE RISK

Evidence has found that individuals who smoke are more likely to experience depression, and have an increased risk of suicidal behaviour, including suicidal ideation[4]. Therefore, it is important for healthcare professionals to be appropriately trained to screen and assess patients for suicidality as part of smoking cessation programming. Research suggests that when healthcare practitioners do not have adequate training in suicide risk assessments, they are less likely to report potential suicidal behaviour, which may interfere with appropriate treatment plans and health outcomes[5, 6].

Screening for Suicidality

There is often a false perception that asking someone about suicidality will "trigger" an individual and increase their risk of suicidal behaviour. However, evidence has found that asking about suicide does **not** increase one's risk of suicidal ideation[7]. In fact, addressing suicidal ideation can help reduce these thoughts and may increase motivation for seeking treatment and improving overall mental health[7].

There are several validated screening tools that can be used to help identify and assess the presence and risk of suicidality among patients. Some screening tools are listed below:

Single-Item Measures from Depression Rating Scales

Patient Health Questionnaire (PHQ) 9, item 9: The PHQ-9 is a self-reported screening tool used to screen for, and measure the severity of, depression[8]. Item 9 of this screening tool asks the client if they have had, "Thoughts that you would be better off dead or hurting yourself in some way[8]."

- **Note:** While item-9 of the PHQ-9 can be an initial screen for the presence of suicidal ideation, the item asks about thoughts of *death* and *self-harm* in one question, which can lead to false-positives for risk of suicidality[9]. Therefore, the PHQ-9 is not recommended as a stand-alone tool and clinical consideration must be taken[9]

Hamilton Scale for Depression (HAM-D17), item 3: The HAM-D is a 17-item scale used to assess a series of depressive symptoms[10, 11]. Items on the HAM-D17 are rated on a scale of 0-2 or 0-4; the higher an individual's score, the more severe the depressive symptoms are[10, 11].

- Item 3 of this screening tool assesses the presence of suicidal ideation[10, 11]:
  - 0 = absent,
  - 1= feels life is not worth living,
  - 2 = wishes he/she were dead or any thoughts of possible death to self,
  - 3 = ideas of gestures of suicide,
  - 4 = attempts at suicide

Screening Tools for Suicidal Ideation:

The Scale for Suicidal Ideation (SSI) is a 19-item scale used to assess suicidality on three levels, each rated in intensity from 0-2[11, 12]:

1.) Active desire to commit suicide
2.) Plan for suicide
3.) Passive thoughts of suicide

The SSI can be administered by a clinician during a semi-structured interview with the patient during their initial intake session, as well as follow-up visits, in order to measure changes in suicidal behaviour[11, 12].

The Beck Scale for Suicidal Ideation (BSSI) is a self-reported version of the clinician-administered SSI, and has shown to be a reliable measure of suicidal ideation among various outpatient settings[13, 14].

Columbia-Suicide Severity Rating Scale (C-SSRS) is intended to measure the presence of suicidal ideation and suicidal behaviour through four domains[15]:

- Severity
- Intensity
- Behaviour
- Lethality

This questionnaire can be administered in an interview format with the patient. The C-SSRS is available for download here: http://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf [16].

Conducting a Risk Assessment

Suicide is a complex phenomenon, involving a number of factors[17, 18]. There is no single predictor of suicide, therefore it is important for healthcare providers to identify risk factors and assess the patient's risk of suicide in order to determine the appropriate course of action[18]. Some of the screening tools mentioned above contain questions for identifying suicide risk; however, in general, a risk assessment should consider the following core principles[18]:

Desire

- Frequency,
- Intensity and,
- Duration of suicidal ideation

Capability:

- Does the individual have a history of suicide attempt(s)?
- Does the individual's behaviour indicate capability of suicide?

Intent:

- Has the individual expressed intent to commit suicide?
- Does the individual have a plan? Do they have the means/access to act on their plan?

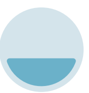
- Does the individual know *when, where* and *how* they will carry out their plan?
- Is the individual displaying any additional preparatory behaviour?

Buffers:

- Does the individual have any immediate supports (i.e. family, friends, 24/7 crisis-line)?
- Are there any meaningful components of the individual's life identified (i.e. pets, job, children)?
- Does the individual have any core beliefs/values and/or sense of purpose?
- Is the individual future-oriented (talking about plans or goals in the near future)?

Levels of Risk[18]

When conducting a risk assessment, healthcare practitioners often classify suicide risk into one of three levels:



Mild

- Fleeting thoughts of suicide.

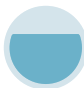
- No plan.

- Means are unavailable.

- No previous attempts.

- Support and protective factors present.

- Sense of purpose and plans for future.



Moderate

- Recurring thoughts of death and/or wanting to die.

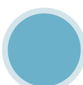
- Has a plan but does not know when.

- Ambivalence about dying.

- Means available but there is possibility of intervening/saving life.

- Some support/protective factors present.

- Negative, elusive plans for future.



High/Imminent

- Intense thoughts about death and wanting to die.

- Known plan, including when, where and how.

- Preparatory behaviour (goodbyes, settling finances etc.).

- Means available and no possibility of intervening.

- Disconnected; no social supports present. Conflict with family/friends.

- Feels hopeless, no sense of purpose or plans for future.

Keep in mind…

While screening and risk assessment tools can help determine the presence and risk of suicide, it is still imperative to use your clinical judgement as patients may choose not to express their suicidal thoughts and behaviour[18, 19].

Risk Factors for Suicide

As mentioned above, there are several risk factors that can influence an individual's thoughts and desire to commit suicide. Some common risk factors are listed below[18, 19, 20]:

- Mental Illness and/or Substance Use
- History of Pyschiatric Illness
- Hopelessness
- Age and/or Sex
- Previous Suicidal Behaviour
- Cirumstances & Life Stressors
- Social Isolation
- Physical Disorders

Protective Factors against Suicide

In addition to assessing risk factors, healthcare providers should also identify protective factors in the patient's life that can help reduce the risk of suicidal behaviour[18, 19]. Below is a list of protective factors that should be considered when developing a treatment plan[18, 20]:

Individual Factors

- sense of competence
- strong interpersonal skills
- effective coping strategies and problem solving skills
- optimistic
- religious/spiritual beliefs
- life satisfaction

Social Factors

- strong family relationship and support system
- social networks
- responsibility to others (children, pets etc.)
- supportive living arrangements

Work Factors

- sense of accomplishment
- support from colleagues and peers

DEVELOPING A TREATMENT PLAN

Once a risk assessment has been conducted, you can work with your patient to develop a treatment plan. Depending on the role at your organization, as well as your patient's level of risk, it may be necessary to work with clinicians from other disciplines, or refer your patient to another healthcare provider, such as a social worker or psychiatrist, for a more thorough assessment[18, 19, 21].

In general treatment plans should consider[18, 19]:

- Patient's immediate safety
- Involvement of significant others and/or family members (if appropriate)
- Patient and family education on mental health and suicide prevention
- Reducing risk factors and increasing protective factors
- Any co-occurring disorders and psychiatric history
- Cultural considerations

Patients at Imminent Risk

For patients deemed to be at imminent risk, immediate assessment of a safe environment is required and may involve treatment in an in-patient setting, including hospitalization or a community crisis stabilization unit[18].

- If a patient refuses to receive treatment after considered to be at imminent risk, it may be necessary to contact 9-1-1 and emergency services[18].
- The *Ontario Mental Health Act* allows clinicians to admit patients into in-patient settings involuntarily if they believe the individual is at risk of harming themselves[22].

In some cases, hospitalization may not be required. Consider whether your patient has family members or other supportive persons to provide appropriate care and close monitoring[18, 19].

Treatment Approaches for Clients with Suicidal Ideation

Treatment for suicidality will vary depending on your patients risk level, as well as additional internal and external factors[18]. Some treatment approaches are listed below:

- **Pharmacotherapy**[18, 20]:
    - Benzodiazepines
    - Antidepressants
    - Lithium
    - Antipsychotics

- **Psychotherapy**[18,20, 23]:
    - Cognitive Behavioural Therapy (CBT)
    - Dialectical Behaviour Therapy (DBT)
        - Mindfulness
        - Distress tolerance
        - Interpersonal effectiveness
        - Emotional regulation
    - Psychoeducation

When working with clients with suicidal ideation, *consider the following*[18, 20]***:***

- ✓ It is important to frequently reassess the patient's safety and risk of suicidality.
- ✓ Increase the frequency of follow-up visits.
- ✓ Continuously monitor patient's psychiatric status and response to treatment.

Developing a Safety Plan

While immediate safety assessment and treatment planning is required when working with individuals with suicidal ideation, it is also important to plan ahead and determine what your patient will do and who they will contact if the desire to act on their suicidal thoughts occurs[18, 19]. Work together with your patient, and other clinical team members, to develop a safety plan that your patient can refer to when faced with high-risk situations and suicidal ideation[18].

Safety plans can allow individuals to acquire effective problem solving skills and coping strategies for managing risk-factors and depressive episodes. When helping your patient develop a safety plan, consider including internal and external supports that patients can contact, including family members and friends, as well as a 24/7 crisis centre[18].

The **Self-Awareness Managing Your Mood** workbook contains a list of internal and external supports, as well as several relapse prevention and stress management techniques. Consider reviewing this workbook together with your patient when developing their safety plan.

The "Additional Resources" section includes a safety plan template that you can refer to *(adapted from the Centre for Applied Research in Mental Health and Addiction)*[18].

GENERAL TIPS AND CLINICAL CONSIDERATIONS

- ✓ Healthcare providers should consider the level of suicide risk when determining treatment interventions, including the frequency of follow-ups, continuous screening and re-assessments[24].
- ✓ Establishing a therapeutic alliance with patients at risk of suicide can reduce feelings of guilt or shame, and can improve a patient's readiness to seek help[19].
- ✓ Maintain a patient-centered approach to care[18, 19].
    - Listen empathetically
    - Affirm the patient of their strengths and validate his/her feelings
    - Consider the patient's experiences and story
- ✓ Use plain language and clear definitions when discussing suicidal behaviours with patients[18].
- ✓ Documentation and evaluation of treatment and safety plans should be done regularly and communicated between team members and care settings to ensure consistency in treatment [18, 19].
- ✓ Supportive networks can significantly benefit individuals in crisis. If appropriate, ask permission from your patient to involve family, friends and/or supportive persons as part of their treatment and safety plan[19].
- ✓ Screening tools and assessments should never replace the need for clinical judgement [18, 20].
- ✓ In circumstances where individuals are deemed to be at imminent risk, the patient's safety takes priority over confidentiality [18, 22].
- ✓ Not all individuals expressing suicidal ideation have a history of mental illness. *Predicament suicide* refers to suicide that occurs when an individual's circumstances are perceived to be so unbearable they have no alternative means of coping[25].

Remember to Practice Self-Care!

Working with patients presenting suicidal ideation can be stressful and often overwhelming. Therefore, it is important to consider your own needs and safety to ensure your mental health is not neglected[27]. Some strategies for practicing self–care are listed below[27]:

- Following an encounter with a suicidal patient, it is helpful to debrief with team members and managers to reduce feelings of anxiety and work through any unresolved issues.
- Engage in educational trainings about working with suicidal patients to strengthen your skills and increase your confidence in managing these types of cases.
- Recognize your own well-being and safety and understand your limits to avoid burnout.
- Participate in self-care activities, such as exercise, planning a vacation and spending time with loved ones.

ADDITIONAL RESOURCES

Resources for Patients and Families:

1. **Centre for Addiction and Mental Health – Mental Illness and Addiction Index:** https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/suicide
    - Provides information on the signs and symptoms of suicidal behaviour, risk factors, frequently asked questions, and programs and services for those in crisis.
2. **Treatment at the Centre for Addiction and Mental Health - Access CAMH:** https://www.camh.ca/en/your-care/access-camh
3. **Centre for Addiction and Mental Health – Support for families:** https://www.camh.ca/en/your-care/planning-your-care/for-families
4. **Ontario Association of Distress Centres:** http://www.dcontario.org/centres.html
    - Includes a list of distress centres across Ontario
5. **Ontario Association for Suicide Prevention:** http://ospn.ca/
    - Offers information and resources for individuals experiencing suicidal ideation, as well as support persons.
6. **Connex Ontario**: http://www.connexontario.ca/
    - Provides information on mental health services across Ontario.

Resources for Healthcare Providers:

1. **Suicide Prevention Toolkit for Primary Care Practices:** https://www.sprc.org/settings/primary-care/toolkit
2. **Mental Health First Aid Canada:** https://www.mhfa.ca/en/course-types
    - Courses on how to appropriately offer help to individuals in crisis.

Safety Plan

1. What activities can I complete to calm/comfort myself?

2. Remind myself of my reasons for living:

3. What can I do to reduce the risk of acting on suicidal thoughts?

4. Are there certain signs or triggers that make me feel like acting on suicidal thoughts?

5. List coping skills I have used in the past, or can use now, to help manage my thoughts:

6. What would I like others to do to help?

7. These are a list of friends/family members I can call:
   Name:
   Phone Number:

8. This is a backup person I will call if no one above is available:
   Name:
   Phone Number:

9. Care provider I can contact (physician, psychologist, psychiatrist, therapist):
   Name:
   Phone Number:

10. Call my local 24/7 distress/crisis line

11. This is a safe place I can go:

12. Call 9-1-1 and/or go to the nearest emergency room

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