GUIDELINES ON SUICIDAL RISK

Warning Signs and risk factors

It is crucial that we make every effort to spot potential warning signs, even if the patient is not overtly presenting with issues around potential suicide risks.

The following actions can help identify risk factors or vulnerabilities:

- Carefully reading a patient's history from the referral source or asking for any medical reports if self-referred;
- Further investigations with relatives;
- Asking when a patient is referred to your clinic about any history of suicide attempts or suicide history in the family;
- Observing their behaviour when they move in;
- Listening well in all conversations.

WARNING SIGNS SCALE

- Previous suicide attempts: the patient has a family history of suicide, which may indicate familiarity with suicide as a problem-solving technique. (Score 10)
- The patient has a family history of mental health problems and a current mental health diagnosis (including a personality disorder with/without self-harming behaviour). (Score 9)
- The patient has a history of chaotic substance misuse (drugs and alcohol can prevent a patient from thinking logically and can act as a depressant). (Score 8)
- Depression, signs of hopelessness and helplessness about the future in particular. (Score 7)
- History of childhood abuse or severe trauma. (Score 6)
- Social isolation, alienation from peers, poor or no family relationship. (Score 5)
- Life-threatening or chronic physical illness (terminal cancer, HIV, Alzheimer). (Score 4)
- Bereavement or loss, or recent separation or relationship breakdown. (Score 3)
- Financial problems. (Score 2)
- Unemployment. (Score 1)

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To help you identify the level of suicidal intent score each of the risks as appropriate 1, 2… or 10. **Add** all the above points that the patient had highlighted for you or which you had observed or read about in the medical history

A score above 9 should certainly suggest to you a potential suicide risk and therefore you should make sure that an explicit discussion about suicidal ideas and plans is initiated!

WHAT TO DO NEXT?

1. INVESTIGATE AND ENCOURAGE A DIALOGUE. ASK VERY DIRECT QUESTIONS ABOUT PLANS.
2. CALL LOCAL COMMUNITY MENTAL HEATLH TEAM.
3. ALTERNATIVELY CALL 999 IF RISK IS VERY HIGH or CALL ACCIDENT AND EMERGENCY at local hospital and speak with the PSYCHIATRIC LIAISON TEAM on site, who would advise you (if appropriate) to come to hospital straight away. Answer all their questions accurately.
4. INFORM REFERRING SOURCE
5. INFORM FAMILY (as per consent)
6. INFORM GP

ALL MENTAL HEALTH CLINICS (WHETHER PRIVATE OR STATUTORY) SHOULD HAVE A LIST OF RESOURCES. PHONE NUMBERS FOR LOCAL CMHT, ACCIDENT AND EMERGENCY AND GP OR OTHER MENTAL HEALTH CLINICS WITHIN EASY REACH.

A possible course of action:

Once you have established and entered into a discussion and dialogue about suicidal intent, remember to make detailed notes both for yourself and concerned third parties.

You will need to ask questions about the suicide plan, method and intended outcome to determine lethality, or the potential to cause death. The more dangerous the method or plan the more serious the intent.

An example of a question here might be:

'Have you made any plans about hurting yourself or thought about how you might go about it?'

If you get a response which shows the patient has no plans, they may answer:

'I have not thought about it to that extent*.**' If this is the case, continue to talk about it, ***'So, to what extent have you thought about it…?' allow the patient to explore their thoughts and feelings, assure him it is OK or safe to talk about it. ***'I'd really like to help if I can…'***

If you get a response which indicates a **specific method** has been considered, for example:

'***I think about hanging myself'***, ask him/ her ***'how, when or what would they use'*** – the specifics of their plan are very important; you will need to find out when the patient last experienced thoughts of harming themselves and how often these thoughts occur.

Before an act of suicide, a patient may become more comfortable with the thought of dying and communicate no fear; they may communicate that **death is seen as a happy release** from suffering, or as an opportunity for reunion with a dead parent or spouse.

A precise plan with a lethal method arranged for the next 24 to 48 hours also constitutes a high risk.

In this case, immediate intervention is suggested, by calling the local Community Mental Health Team or 999 or by taking the patient to Accident and Emergency. Supervision is required to prevent a suicide attempt by high risk patients. This level of supervision may depend upon the setting in which you work. You may be able to arrange for a psychiatric assessment immediately from within your own clinic, or you may need to take the patient yourself to their own general practitioner, or to your local accident and emergency unit for an assessment by a psychiatric doctor. Occasionally your patient may live with reliable and willing relatives who understand the responsibilities and are able to fulfil them. A safe environment is vital. As a therapist your responsibility is to assess and report (refer to duty of care for mental health practitioners). Patients with an immediate, lethal and precise suicide plan will immediately require a safe environment or hospitalisation. You may need to go outside the realms of the

confidential relationship to prevent suicidal ideation becoming reality.

FURTHER TIPS:

1. During any assessments, if your patient is talking of suicide you will need to take this seriously.

2. Your patient may convey these messages in various ways such as in behaviour, writing, pictures or verbally.

3. Asking the patient about suicidal ideation does not make suicidal behaviour more likely: the contrary is true. This open discussion and frankness will enable the client to feel understood and less alienated.

4. It is important for you to assess whether your patient is entertaining suicidal ideas at the present time. Use open questions such as '**How do you feel about the future?**' The patient's response may be verbal and indirect, for example '**I wish I could go to sleep and never have to wake up'**, or more direct: '**I wish I was dead**'.

5. Be aware of the non-verbal indications that your patient is suicidal such as the giving away of personal possessions, or tidying-up of personal affairs.

6. Cessation of eating or drinking or both may be other non-verbal indications of suicide. You should be alert to any expressions of hopelessness, helplessness or pessimism about the patient's future or current situation.

7. As highlighted above, if you have access to previous notes, pay attention to them! This will enable you to ascertain if your patient has told someone before that they were thinking of hurting themselves or if there is a clear history of attempts.

8. If your patient has made an attempt on their life previously, whether dangerous or not, this is an important predictor that they may contemplate suicide in the near future. Assess if this is viewed as a solution to their current problems.