It is not possible to predict if someone will suicide, but we can assign a level of risk based on the known suicidal indicators.

Assessing the level of risk (i.e. low, moderate or high) over the short and long term will help in safely monitoring and intervening with individuals at risk of suicide.

**Immediate Indicators of Suicide**

**External Behavior and/or Events**

1. Direct verbal communication of intent.
2. Suicide Plan exists.
3. Suicide Plan is concrete, specific and detailed.
4. Method is selected.
5. Method is available.
6. Method is lethal.
7. Time and place are set.
8. Preparations are made for death (suicide note, giving away possessions, getting finances in order).
9. Provisions are made to avoid rescue.
10. Stimulus/Precipitant/Chance Events including contagion effect and any other significant life change. Note: contagion effect is a cumulative effect from one even setting off a chain of events such as a ripple or domino effect.

In addition to these immediate indicators, it is essential to know:

1. The number and seriousness of previous attempts.
2. The level of stress and number of concurrent stressors.
3. The intensity and duration of depression, anxiety and or inability to sleep.
4. The individual's history of coping with crisis.
5. Presence of psychosis, especially command hallucinations to harm self or others. Note: command hallucinations are voices that tell a person to behave in a particular way. The person may feel that he/she MUST obey these commands.

If the command is to harm self, always consider the flip side, i.e., person may harm others to prevent being harmed. If the command is to harm others, always consider the risk of suicide as person may harm self in order to prevent harm to others.
SUICIDE RISK ASSESSMENT

In addition to these immediate indicators, it is essential to know: (continued)

Most completed suicides in jails and in-patient psychiatric units are due to these types of psychotic symptoms.

6. The level of external support available to the individual.
7. Impulsivity.
8. Absence of protective factors.
9. The person’s physical health. Most individuals with terminal illness do not complete suicide. The suicide risk is higher in person’s coping with long term chronic illnesses.
11. Alcohol and/or drug use.
12. Your own intuition or gut level sense of the seriousness of a person’s presentation is a very valuable tool in assessing suicide risk.

If the crisis responder feels he/she will worry about the individual if left alone after the intervention that is a good indicator. Steps should be taken to provide for the recipient's safety, for example, increasing supports as needed from a friend or relative, going to a residential crisis program or hospitalization.

Key Points in Suicide Assessment

It is not possible to assess an individual for suicide risk while he/she is intoxicated or under the influence of other drugs. The person will first need to be transported to a safe place for detoxification and evaluated for suicide risk when sober.

Suicide thrives on secrecy. Encourage people (especially teens) to get professional help for a friend if a friend confides in them.

Collateral information from providers, family, friends etc. should be part of the assessment.

A history of suicide attempts is the key indicator. It’s important to get detailed information about the number of past attempts, when they took place, method, lethality of method (i.e., gun, jumping vs. scratching wrist), care or treatment required following the attempts, and injuries sustained.

Always consider evaluators gut level feeling about the level of risk—it’s reliable.

Always seek further evaluation or consultation if unsure or if the individual is not cooperative with the assessment.

Remember, 80% of individuals who complete suicide give some verbal or behavioral clues to their intent. That still leaves 20% who give no clues so it is not always possible to intervene.

Always be aware of risk of violence with individuals experiencing paranoia and/or delusions. They may be presenting with increased suicide risk, but on the flip side, may be at risk of violence. They may believe that someone will harm or kill them, and instead of harming themselves, may harm the other individual.
SUICIDE RISK ASSESSMENT

Suicide Prevention, Why it Works

Most individuals remain ambivalent until the end and may even reach out for help by placing a final phone call. The crisis intervener can use that ambivalence to help the person to consider delaying a decision while feeling highly distraught.

Highly suicidal individuals wish to end the emotional pain they are in and may not be able to think of other options. The role of the crisis intervener is to present the other options and, if necessary, to take action to get the person to a safe environment until he/she is able to cope.

Individuals do not remain highly suicidal for long periods of time. The crisis intervener can intervene at times of higher risk until the individual feels safe.

The precipitant, intent, plan, method, lethality and availability of method all have to come together at the same time for the suicide to occur. This is why suicide is a rare event. Some chance event may delay acting on the intent and then, the intent may not be as strong later or the method or opportunity may not be available.

Most people do make a particular plan with a particular method chosen. If the method is removed, most people do not immediately come up with another choice of method so the risk decreases. Crisis interveners may remove the pills or other methods for safe keeping until the crisis is over.

Suicide attempts/gestures are often a cry for help and do allow the crisis intervener to step in and intervene.

Suicide prevention does not require advanced degrees or experience. It does require the ability to be with the suicidal individual, show interest and empathy and get professional help as needed.

Intervention with Suicidal Individuals

The intervention process is determined by the person’s presentation, risk level, diagnosis, mental state and ability to engage in planning for safety.

If a crisis responder assesses the individual to be at moderate to high risk of suicide over the short term, action must be taken to protect the individual assisting with referral to needed services or involuntary hospitalization.

Establish a relationship. Introduce yourself, the agency you represent and assure the person that you are there to help. Listen well, ask simple questions and remain calm.

Stay concrete and keep the focus on the current situation, not on the ethics of suicide.

Do not agree to keep the suicidal ideation a secret.

Do not argue about the reasons the person gives for wanting to kill themselves. Instead, ask questions and seek alternatives and assure the person that you will stick with them until the needed help is available.

Evaluate the immediate risk and the person’s mental state and ability to engage in the process.

Call 911 if the person already overdosed or hurt self?
SUICIDE RISK ASSESSMENT

Intervention with Suicidal Individuals continued.

Is the person too impaired to engage in the process. Are they intoxicated, psychotic or so uncooperative with the interview that an adequate assessment cannot be made? If so, a Transportation Hold needs to be placed and 911 called so the individual can be transported to a hospital Emergency Room for further assessment.

Use active listening. Show the person that he/she is listened to and understood through active listening, paraphrasing, reflection and questioning. Use voice tone, eye contact and body language that will help the person feel less isolated and alone. View suicidal behavior as a cry for help. What help do they need?

Identify the current stressors. Sort out what is making the person feel suicidal today. What happened? What did it mean to the person? How is the person feeling? Often the suicide intent lessens once the person ventilates and feels heard and understood. Remember, most people remain ambivalent until the end. Use this as a way to buy time and delay final decisions while in state of crisis.

Establish hope for the client. Crisis responder must demonstrate a sense of competence and confidence so person feels responder is capable, knows what to do and is able to handle the person’s intense feelings. This allows the person to give up some control and decision making to the crisis responder.

Explore alternatives. How else might the person express their feelings besides killing themselves? Help the person see that their suicidal thoughts/behavior are the result of the crisis rather than some personal defect/weakness and that short term crisis treatment will help.

Develop a plan with the person. Offer choices even when you need to make the decisions, i.e., Is there someone you would like me to call to let them know where you are going? Which coat, shoes etc. do you want to bring to the hospital?

Make a clear follow-up plan. When will you check back with the recipient, who you will call/consult with or refer to?

Crisis Management of Highly Suicidal Persons

- Relieve isolation.
- Remove lethal weapons or means.
- Encourage alternative expression of anger.
- Reestablish social ties.
- Relieve extreme anxiety and sleep loss.

Legal Issues when Working with Suicidal People

If a person completes suicide after a crisis responder intervenes, it is possible that the family or friends of the individual may hold the responder responsible for the suicide.
SUICIDE RISK ASSESSMENT

Legal Issues when Working with Suicidal People continued.

Three types of suicides are most prone to this sort of blaming and/or legal suits:

1. Outpatient suicides—Should the crisis responder have hospitalized the individual?
2. Inpatient suicides—Did the institution provide a safe environment?
3. Suicide following discharge, pass or escape from a hospital—Was person ready for discharge or pass? Why was he/she able to escape from the institution?

In determining malpractice/liability, four elements must be present:

1. A professional/patient relationship must exist which creates a duty to care.
2. A deviation from the standard of care must have occurred.
3. Damage to the patient must have occurred.
4. The damage must have occurred directly as a result of the deviation from that standard of care.

Risk Management Guidelines

Know and follow agency requirements for documentation:

- Use a prescribed Suicide Assessment Tool to show that a thorough risk assessment was completed.
- Information on previous attempts and treatment.
- Involvement of family or significant others.
- Consultation on clinical presentation as needed.
- Sensitivity to medical issues/needs.
- Knowledge of and use of community resources.
- Preventive preparation and Crisis Care Plan that is based on risk assessment and meets standard of care.

Staff Issues when Working with Suicidal People

Despite the best efforts of crisis responders, suicides may occur. It is important to seek support for yourself if you have tried to help a person who then goes on to complete suicide or make a serious suicide attempt.

Suicide is a very personal decision and no one else can ever take responsibility for another's suicide.
Staff Issues when Working with Suicidal People continued

Each staff person will respond differently due to his/her individual history and relationship with the person who completes suicide. Take time to support yourself and your colleagues.

It is very common, and quite normal, for staff to experience physical, emotional, cognitive and behavioral changes after going through a traumatic event.

Some common stress reactions are:

**Physical**—fatigue, chills, nausea, vomiting, thirst, dizziness, weakness, chest pain, elevated blood pressure, rapid heart rate, sweating, difficulty breathing, grinding of teeth and sleep changes.

**Emotional**—fear, guilt, grief, panic, denial, anxiety, agitation, irritability, depression, anger, loss of emotional control, outbursts and feeling overwhelmed.

**Cognitive**—confusion, nightmares, hyper-vigilance, suspiciousness, intrusive images, blaming self or someone else, poor problem solving, concentration and ability to make decisions and disorientation of time, place or person.

**Behavioral**—withdrawal, inability to rest, pacing, increased use of alcohol or other chemicals, appetite changes and changes in social activity.

Sometimes these stress reactions appear immediately after the critical incident or they may appear a few hours, days, weeks or even months later.

The signs and symptoms of a stress reaction may last a few days, weeks or months, depending on the severity of the traumatic event. With understanding and support of others, the symptoms pass more quickly.

If a colleague is exposed to a traumatic event, you can help by:

- listening carefully
- offering support even if they have not asked for help
- telling them you are sorry the event happened
- offer to help with every day workload and
- reassure them that they did their very best with the intervention, given the situation and facts available to them.

Occasionally, the traumatic event is so painful that professional assistance is necessary. This does not imply weakness or craziness. It simply indicates that the event was too powerful for the person to manage themselves.