Responding to Suicidal Ideation

(rev. 10/06/23)

Suicidal Ideation:	Thinking about committing suicide. Passive suicidal ideation is when you wish were dead or that you could die, but you don't actually have any plan. Active suicidal ideation, on the other hand, is not only thinking about it but having the intent to commit suicide, including planning how to do it.

Overview of Responding to Suicidal Ideation:

Residents identifying that they're struggling with suicidal thoughts is one of the more intimidating and challenging situations for a residential counselor. In general, the empathic listening technique can be very useful for discussing suicidal ideation with the resident.

By way of review Empathic Listening involves:

- Mirror or match the student's general body language, speech, intensity; lead to slower and lower.
- Intense Listening.
- Asking clarifying questions in a non-judgmental fashion.
- Focusing on emotions.
- Avoid slipping into problem-solving.
- Avoid the "empathizing equals agreeing with" trap if student is being negative about others.
- Plug the student back into program structures.

The intent of Empathic Listening is for the resident to experience a feeling of being understood and supported by staff. It is not a problem-solving technique. Rather than attempting to fix *why* the resident is having suicidal thoughts, instead focus on helping the resident see those thoughts as a symptom. How often does this happen? How strong are these thoughts? How intrusive are they? When are they happening? What triggers having these sorts of thoughts?

The Columbia Protocol suggests a series of questions to determine the extent, if any, to which the resident has a plan or has taken any actions toward suicide.

1. Have you wished you were dead or wished you could go to sleep and not wake up?
2. Have you been thinking about killing yourself?
3. Have you been thinking about how you might do this?
4. Have you had these thoughts and had some intention of acting on them?
5. Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?
6. Have you done anything, started to do anything, or prepared to do anything to end your life (such as collecting pills, giving valuables away, writing a suicide note, etc.)?

Ask the resident if they have any contraband items to turn in to staff.

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Suicidal Gesture:	A non-verbal behavior expressing suicidal intent.

A common way to assess suicidal gestures or suicide plans is to evaluate both the risk factors inherent in the attempt and the rescue factors.

Risk / Rescue Assessment for suicidal gestures:

A. Method of attempt:
   1. No or questionable seriousness: nonlethal, recovery certain.
   2. Mildly serious: Death is unlikely, but possible as a secondary complication.
   3. Moderately serious: Possibility of death.
   4. Highly serious: Death is likely.
   5. Extremely serious: Death is the usual outcome; survival chance is minimal to none.

B. Rescuability:
   1. High: Most easily recused.
   2. High / Moderate: More chance of rescue.
   3. Moderate: Chance of rescue 50:50.
   4. Low / Moderate: Less chance of rescue.
   5. Low: Chance of rescue is minimal to none.

C. Physical Consequences:
   1. No or nonspecific symptoms.
   2. Mild symptoms.
   3. Moderate symptoms.
   4. Severe symptoms.
   5. Extremely severe symptoms, organ failures.

E. Medical intervention need:
   1. Medical intervention not required or observation only.
   2. First aid.
   3. Emergency care.
   4. In-patient care, specialized units.
   5. Intensive-care, life support.

F. Global impression of lethality:
   1. Subliminal: Death impossible or highly improbable.
   2. Low: Death improbable.
   3. Moderate: Death probable.
   4. High: Death highly probable.
   5. Extremely high: Death extremely probable to almost certain.

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The following chart presents a slightly different way to look at risk factors:

Talking About:	Behaviors	Mood
• Killing themselves; • Feeling hopeless; • Having no reason to live; • Being a burden to others; • Feeling trapped; • Unbearable pain.	• Increased use of alcohol or drugs; • Looking for a way to end their lives, such as searching online for methods; • Withdrawing from activities; • Isolating from family and friends; • Sleeping too much or too little; • Visiting or calling people to say goodbye; • Giving away prized possessions; • Aggression; • Fatigue.	• Depression; • Anxiety; • Loss of interest; • Irritability; • Humiliation/Shame; • Agitation/Anger; • Relief/Sudden Improvement.

Rescue factors frequently involve the person letting other people know about their suicidal ideation or gesture, or making comments or gestures in a location where their distress is going to be noticed by responsible adults.

Suicidal gestures can be related to self-injurious behaviors (such as superficial cutting or head-banging). However, self-injurious behaviors typically are not directly correlated with suicidality; instead serving a different psychological purpose. Nevertheless, self-injurious behaviors should also be reported to the Program Manager and a Clinician as soon as possible.

Qualities to look for in accessing risk factors include:

- **Excessive sadness or moodiness:** Long-lasting sadness, mood swings, and unexpected rage.
- **Hopelessness:** Feeling a deep sense of hopelessness about the future, with little expectation that circumstances can improve.
- **Sleep problems.**
- **Sudden calmness:** Suddenly becoming calm after a period of depression or moodiness can be a sign that the person has made a decision to end his or her life.
- **Withdrawal:** Choosing to be alone and avoiding friends or social activities also are possible symptoms of depression, a leading cause of suicide. This includes the loss of interest or pleasure in activities the person previously enjoyed.
- **Changes in personality and/or appearance:** A person who is considering suicide might exhibit a change in attitude or behavior, such as speaking or moving with unusual speed or slowness. In addition, the person might suddenly become less concerned about his or her personal appearance.

- **Dangerous or self-harmful behavior:** Potentially dangerous behavior, such as reckless driving, engaging in unsafe sex, and increased use of drugs and/or alcohol might indicate that the person no longer values his or her life.
- **Recent trauma or life crisis:** A major life crises might trigger a suicide attempt. Crises include the death of a loved one or pet, divorce or break-up of a relationship, diagnosis of a major illness, loss of a job, or serious financial problems.
- **Making preparations:** Often, a person considering suicide will begin to put his or her personal business in order. This might include visiting friends and family members, giving away personal possessions, making a will, and cleaning up his or her room or home. Some people will write a note before committing suicide. Some will buy a firearm or other means like poison.
- **Threatening suicide:** 50% to 75% of those considering suicide will give someone – a friend or relative – a warning sign. However, not everyone who is considering suicide will say so, and not everyone who threatens suicide will follow through with it. Every threat of suicide must be taken seriously.

After processing suicidal ideation:

Communication and Initial Documentation:

1. Contact Health Services if there is any medical follow up indicated.
2. It will be important that you verbally communicate about the incident of suicidal ideation to your shift colleagues and to staff covering the next shift.
3. Contact the On-Call Clinician.
4. Document the incident on an Incident Report Form. Your processing of the suicidal ideation may not be captured fully by the Incident Report so if indicated send a separate email to the resident's clinician and/or case manager with additional information.
5. Make note of the incident as part of the resident's Daily Shift Log.

Structural Interventions:

In general, residents should be returned to the regular program structures. However, similar to after any emotionally intense incident, it may make sense to add some additional structures.

Possibilities include:

- ☑ Scheduled Check-In's for the remainder of the shift
- ☑ Increasing structure of various activities – for example, by only giving one-step directions.
- ☑ Staff Shadowing – requiring the resident to remain in arms reach of staff.
- ☑ Re-entry Plan – requiring a meeting to facilitate the resident being reintegrated with the group.
- ☑ Relationship Repair activities and/or Restitution
- ☑ Safety Watch (see Safety Watch form).
- ☑ Safety Contract (see below).

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Safety Contracts

Safety Contracts are frequently used, in residential treatment programs and hospitals, in response to a student expressing suicidal ideation. While ultimately symbolic, they have an excellent track record for putting some positive closure on processing suicidal ideation or gestures.

Essentially a resident signs an agreement (individually crafted with the resident, rather than using a less personal-feeling standardized document) in which the resident promises to use only safe behaviors. There may be various limits built in, perhaps some scheduled check-in's, and typically an agreement to let a staff person know if suicidal ideation re-emerges. A combination of the following steps can serve as a guideline to create a safety contract with a resident:

- ♦ Identify personal warning signs. (I will use this crisis plan when…).
  - List any thoughts, behaviors, emotions, images, physical sensations, etc. that you typically experience while in crisis.
- ♦ Self-management Strategies. (Things I can do on my own…).
  - Develop coping strategies that can be done in response to warning signs.
  - Often times, these include relaxation or distraction techniques.
- ♦ Healthy Structures which serve as distraction. (My schedule for the remainder of the shift will look like…).
  - If self-management strategies do not reduce emotional distress, use a social setting as distraction.
- ♦ Social Support. (If self-management and healthy structures don't work, I will let a staff person know by…).
- ♦ Follow up. (I will speak with <therapist> at <time>.).
  - If self-management and/or social supports do not reduce emotional distress, I will let staff know by…).
- ♦ Environmental Safety. (I will turn in my shoes, etc., to increase safety…).
- ♦ Identify Reason to Not act on any Suicidal Ideation. (I agree to not harm myself because doing so would…).

Sample:

Angus has been struggling with some scary thoughts, thinking/wishing that he had never been born. Angus has identified that being around staff and peers can be helpful. When alone, reading a book and writing in a journal is helpful. Calling home to speak with his family can also be helpful.

For the rest of the night, Angus agrees to stay with the group and to fully participate in bedtime routines, including getting his laundry started. He's going to call home between 9:00 and 9:15pm. Staff will do at least a brief check-in once an hour. Angus will rate how he's doing on a scale from 1 (doing great) to 5 (totally overwhelmed). At any time tonight, if Angus is at a 4 or above, he agrees to let a staff person know the he needs a check-in.

Angus agrees to not hurt himself in reaction to how he is feeling. He wants to feel better and to be able to go home during the upcoming vacation week.

Angus	Staff	Date