



# Emergency/Crisis Coverage of a Suicidal Patient

**DECISION SUPPORT OUTLINE**

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crico

Dear Clinician:

We offer this outline to support your efforts when evaluating a patient's suicide risk in a crisis setting or when you are providing coverage for another clinician. The patient may or may not be in psychiatric treatment. The patient contact may be face-to-face or by telephone.

The chief purpose of the outline is to aid your memory, since one cannot possibly remember all categories of information that might be useful for making clinical judgments or for treatment planning. Some of the items may appear quite basic, but have been included for the sake of completeness. While this outline provides areas of inquiry that might be useful for risk assessment and clinical decisions, you will often be required to make judgments based on partial or incomplete information, and without information that might not come to light until after contact with other informants (e.g., subsequent caregivers, family members).

This document is not a substitute for clinical judgment and it should not be construed as a standard of care. Every clinical situation is unique and not all areas of this outline will be relevant to every case.

The outline is a practical extension of the *Guidelines for the Identification, Assessment, and Treatment Planning for Suicidality* published by CRICO in 1996. Please refer to those Guidelines for more detail about specific areas of inquiry.

#### Definition: "Patients with Chronic Suicide Ideation"

- Recurrent and persistent suicidal thoughts provide an ongoing psychological mechanism for coping with distress.
- Suicidality is a frequent, usual response to life stresses and disappointments, and represents a chronic condition rather than an emergent response to an acute crisis of mood and despair.
- For such patients, suicide is not the only risk. Premature, unnecessary, and often lengthy hospitalizations may have negative effects, such as undermining autonomy, interfering with a patient's assumption of responsibility, interrupting important relationships, and promoting regression.

#### Implications for Treatment

Treatment of these patients requires an acknowledgment that suicidality represents a chronic condition usually best managed by increasing the patient's coping skills and assumption of responsibility for her/his own behavior.

Treatment on an outpatient basis has the advantage of fostering realistic adjustment to the environment. Documentation should outline the realistic goals of outpatient treatment, such as enhanced independent functioning, better coping with external stress, or improved self-maintenance, rather than the ultimate and perhaps unrealistic goal of having "no more suicidal thoughts."

Treaters should explain the risks and goals of outpatient treatment to the patient. With the patient's permission, include family or significant others in the discussion, with the goal of educating them and eliciting their help and support for the patient.

## Consider the following while conducting an evaluation...

### A. IDENTIFY SOURCES OF INFORMATION

1. Patient
2. “On-call book” or sign out information
3. Medical records
4. Treating physician/therapist  
*Note:* Since it is often not possible to reach relevant treating clinicians immediately, one may document attempts to notify them or discuss the case with them.
5. Family or friends (if present/available, with patient’s permission)  
*Note:* Some patients are reluctant to grant permission for you to speak to others. Remember that the value of honoring the right to confidentiality may be outweighed by actions that reduce risk to the patient.

### B. DETERMINE THE CHIEF COMPLAINT

1. Why is the patient asking for help now?
2. Solicit/identify third-party concerns (e.g., family, friends, other clinicians, etc.).

### C. ESTABLISH RAPPORT

1. Ask open-ended questions about the patient’s current state of mind.
2. Advance your questioning from general to specific. (Also consider beginning with less emotionally charged questions before focusing on details of the current crisis.)

### D. ESTABLISH CONTEXT

1. When did this crisis begin?
2. What were the precipitants, losses, and stresses (actual or anticipated)?
3. What is the current treatment (therapy & medications)?
4. Obtain permission to talk with relevant clinicians.

5. Has the patient experienced prior similar crises, or is current suicidality unique? If so, how does this episode compare to previous episodes? How is this episode different (e.g., loss of support or progression of behaviors)?

### E. DETERMINE CURRENT SUICIDE RISK

1. Does the patient have an acute change in health status or a new medical/neurological diagnosis that requires evaluation?
2. Were there prior suicide ideas, plans, or attempts?
3. Are there depressive symptoms/vegetative symptoms (especially hopelessness)?
4. Are there psychotic symptoms/thought disorder?
5. Are there anxiety or panic symptoms?
6. Is there a history of alcohol or substance use/current intoxication?
7. Is there a family history of suicides or suicide attempts?
8. Does the patient have access to weapons, particularly firearms?
9. Does the patient have access to dangerous or lethal medications or chemicals?
10. What are the patient’s current supports?
  - a. Family/community
  - b. Treatment team
  - c. What are the patient’s perceptions of those supports?
11. What is the patient’s employment status?
12. What is the patient’s marital/relationship status (married/partnered, single, alone, living with someone, recent break-up vs. ongoing relationship)?
13. Does the patient have children? Are appropriate childcare arrangements in place during the crisis? How does the patient perceive the impact on the children of the psychological distress (including possible suicide)? Might the patient be thinking about “taking the kids with” him or her?

## F. PROBE FOR CURRENT SUICIDAL THOUGHTS

1. What is the patient's intent?
2. What is the patient's motive (relief, mobilize supports, revenge, reunion)?
3. How often and for how long does the patient think about suicide?
4. Does the patient have a suicide plan?
  - a. method contemplated (lethality)
  - b. extent of planning
  - c. likelihood of being discovered
  - d. presence or absence of hope, and of various deterrents to suicide, including religion

## G. ASSESS ABILITY TO ESTABLISH TREATMENT PLAN

1. Ability to comprehend current problems
2. Ability to understand risks and benefits of treatment options
3. Ability to trust caregivers
4. Ability to cooperate with assessment and intervention
5. Ability to act in the interest of his/her safety

## H. EVALUATE THE LEVEL OF CARE REQUIRED

1. The following may lead you to consider a *more intensive* or conservative level of care (requiring greater patient supervision):
  - a. a new, acute presentation
  - b. a lack of confirmation that the current presentation is part of a chronic or repetitive pattern
  - c. the presence of multiple risk factors
  - d. the presence of a suicide plan (especially with a lethal method and access to the means to carry it out)
  - e. evidence of substance abuse
  - f. presence of psychosis
  - g. a relative absence of historical data
  - h. limited access to medical records
  - i. unavailability of current treating clinicians
  - j. the absence of an ongoing relationship with the patient, especially if the patient is new to you, and you are unable to consult with the current treating clinician
  - k. reduced capacity to understand the nature of the illness or of a proposed plan for managing the crisis
  - l. reduced ability to cooperate in the evaluation of the current problem or in making a plan for managing the current crisis

2. The following may lead you to consider a *less intensive* level of care (requiring less patient supervision):
  - a. the patient exhibits a chronic, repetitive cycle, especially if the patient is aware of the chronicity (*refer to the definition "Patients with Chronic Suicide Ideation" on the next page*)
  - b. available, independent confirmation of the chronicity, based on direct knowledge of the patient, medical records, sign out, discussion with current therapists, etc.
  - c. confirmation of history of ideation without action
  - d. you already have an ongoing positive, working relationship with the patient in crisis
  - e. the patient demonstrates the ability to understand risks and benefits of various approaches to managing the crisis and participates in making a plan
  - f. the patient understands what to do if things worsen (for example, what resources to use, what numbers to call)
  - g. the clear presence of responsible support that is positively regarded by the patient (family, friend, roommate)

## I. COMMUNICATION

1. With the patient's permission,
  - a. discuss treatment plan with family or significant others
  - b. discuss treatment plan with the patient's current or future treatment team

## J. PROVIDE DOCUMENTATION

1. Data collected, including the patient's reason for the call, symptoms reported, context of the call, risk factors, the nature of suicidal thoughts, and the patient's state of mind as described by the patient and perceived by the clinician
2. Any discussions with supervisors or consultants
3. A description of the patient's willingness or ability to understand and follow a treatment plan
4. A summary of assessment in plain language, including diagnostic considerations and a relative risk assessment
5. The treatment plan: state how you and the patient (together) and any others (professional or family) made the decision regarding management, noting the inherent uncertainty in decision making about levels of risk

6. The clinical rationale for that plan: what are the benefits/risks to the patient of taking one approach to management over another (e.g., advantages and disadvantages of more or less restrictive plans)
7. Clinical rationale for not taking more conservative action (e.g., reasons for not hospitalizing the patient)
8. Plans for future access to care for the patient and follow-up, including communication with ongoing treatment team

#### K. OPTIONS IF INITIAL SCREENING LEAVES QUESTIONS

1. Encourage the patient to dispose of any acknowledged means for committing suicide
2. Meet with the patient within a time frame dictated by your clinical judgment
3. Contact other informants and supports, if available (obtaining permission as appropriate)
4. Discuss with supervisors or colleagues for a consultation or second opinion
5. Notify police or security personnel if the risk to the patient appears acute/imminent
6. Consider Section 12 (*involuntary admission to a mental health facility under M.G.L. c. 123, s. 12*) if the patient poses a danger to self or others

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