TTTCP SUICIDE PROTOCOL

- **Do NOT leave the patient alone** if they have expressed suicidal thoughts, ideation or a plan.

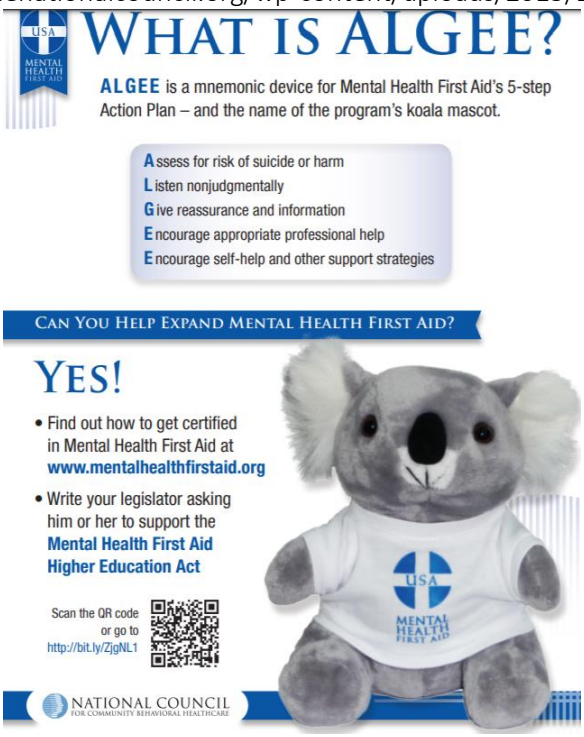
1) If a behavioral health provider IS available:

- Contact the provider responsible for suicide assessment to come into patient room to do the screening; this is often a behavioral health provider who is experienced and trained.
- When the behavioral health provider responsible arrives, give a warm hand-off, and you may leave to **notify the clinic supervisor or attending physician of the clinic** (so that they are aware and able to facilitate transport or change in clinic flow, if needed).

2) If a behavioral health provider is NOT available:

- **Start ALGEE** with the clinic supervisor or attending physician:

A: Assess for risk of suicide or harm
L: Listen nonjudgmentally
G: Give reassurance (that these thoughts are normal) and information (but it doesn't mean you have to act on them)
E: Encourage appropriate professional help
E: Encourage self-help and other strategies
(https://www.thenationalcouncil.org/wp-content/uploads/2013/10/NC-Mag-MHFA-Origami-Insert.pdf)



- **If patient shows risk of suicide or harm during ALGEE**, administer **SAFE-T** screen (https://www.integration.samhsa.gov/images/res/SAFE_T.pdf)

SAFE-T:

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity). ***Co-morbidity*** and ***recent onset of illness increase risk***
- **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- **Family history:** of suicide, attempts or Axis 1 psychiatric disorders requiring hospitalization
- **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame or despair (e.g., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation.
- **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- **Ideation:** frequency, intensity, duration--in last 48 hours, past month and worst ever
- **Plan:** timing, location, lethality, availability, preparatory acts
- **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self injurious actions
- **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live

** For Youths: ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors or disposition*
** Homicide Inquiry: when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.*

4. RISK LEVEL/INTERVENTION

- **Assessment** of risk level is based on clinical judgment, after completing steps 1-3
- **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT Risk level and rationale; treatment plan to address/reduce current risk (e.g., setting, medication, psychotherapy, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.

- STAY WITH THE PATIENT and ask another Trauma Team advocate to locate the clinic supervisor or attending physician.
- Supervisor/attending physician, Trauma Team advocate, and patient will come up with plan(s) (transport, safety plan, etc.).

Transportation Options:

- Ambulance
  - Siren free method: Ask when calling the ambulance to not use sirens.
- Cops for transportation, if requested by patient; again, request no sirens.
- Give patient the choice to come out of the clinic room to meet EMT or cops, rather than having EMT/cops come into clinic.
- Trauma Team transportation
  - A Trauma Team member goes with patient as their advocate if requested by patient (e.g. with patient riding to hospital in ambulance or police).

Other Resources:

Chat online at http://www.suicidepreventionlifeline.org/
Call 1-800-273-TALK (8255).
Text HELLO to 741741 (available 24/7).
Transgender Lifeline: 877-565-8860

Please keep in mind that TTTCP advocates are different from counselors and have a focus on education and safety rather than on treating any emotional, mental, or behavioral issues. We also can't give advice or tell people what to do because we respect the patient's right to make choices that work best for them. However, we do have many resources available, if they choose! Allow patients to pick the ones that feel right to them (patient-directed care)!