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Management of a Suicidal Patient: A Practitioner's Perspective

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ABSTRACT

According to the Centers for Disease Control and Prevention, 2018, suicide is a leading cause of death in the United States. Suicide rates have increased in almost every state in the United States from 1999 through 2016. For many individuals with suicidal ideations, mental health disorders are often seen as the cause of suicide; however, suicide is not only caused by a single factor. Studies have shown several factors contribute to suicide which may include but is not limited to relationship issues, substance use, physical health, job-related issues, money, legal, and/or housing stressors (CDC, 2018). Suicide is a public health crisis reaching epidemic proportions and has claimed the lives of more than 45, 000 individuals in the U.S. (Brodsky, Spruch-Feiner, & Stanley, 2018). Due to the increasing number of suicides, mental health practitioners must be clinically prepared to provide appropriate interventions to help prevent suicide. Thus, this paper aims to share some guidelines and/or tips for managing an individual with suicidal ideation from a practitioner's perspective.

Keywords: suicide, prevention, risks, management interventions

Introduction

As a private practitioner for over 22 years, I have seen many individuals in my clinical practice that have experienced depression which often leads to suicide ideation. Most patients in my practice have been Hispanics. According to research, there has been a drastic increase in suicide rates among Hispanics in the U.S. primarily Hispanic females (Silva & Van Orden, 2018). Often, treating individuals with depression can be very taxing due to concerns that suicide ideation may compound the treatment of depression. When suicide ideation occurs, mental health practitioners must be clinically well prepared to offer the necessary help to minimize the risk of a fatal suicide. Due to suicide being a leading cause of death in the United States (CDC, 2018), practitioners have to be able to recognize suicide warning signs to be able to prevent suicide. Preventing suicide is not only the responsibility of a mental health practitioner but involves everyone in the community intending to save a life. People in every community need to be educated about the warning signs of suicide. This merits for leaders of any community to foster education on the prevention of suicide. According to the CDC (2018), communities can help identify people at risk of suicide, promote safe and supportive environments, connect people at risk to community resources, teach problem-solving skills to help people manage their daily challenges, and offer activities that bring people together so they can feel connected and not alone. Due to suicide reaching epidemic proportions worldwide, suicide prevention efforts require a comprehensive approach, and research must lead to effective implementation across public and mental health systems (Brodsky, Spruch-Feiner, & Stanley, 2018). Thus, the following information is designed to give the reader an overview of suicide, the prevalence of suicide, tips on how to recognize warning signs of suicide, and how to manage a suicidal patient to help save a life from a clinical practitioner's perspective.

Suicide Awareness

According to the CDC, suicide rates are climbing at alarming rates and have become more than a mental health concern. According to Silva and Van Orden (2018), Hispanics have historically had decreased rates of suicide ideation, attempts, and death, compared to other ethnic groups. However, in recent years, suicide rates have risen among U.S. Hispanics, and suicide among Hispanics remains understudied and little information is known about how to help this population, (Silva & Van Orden, 2018). Due to suicide being a leading cause of death in the United States, mental health conditions such as depression are often seen as the major cause of death. Despite this notion, research has shown multiple factors contribute to suicide and many people that have died by suicide were never known to have a mental health diagnosis (CDC, 2018). However, psychological autopsies have revealed that most people who have died by suicide have suffered from a mental health disorder. A recent figure suggests this number could be at least 90%. Yet, on the other hand, most people with mental disorders do not die by their hand. The risk of suicide has been estimated to be approximately 5 to 8% for several mental health disorders which include depression, alcoholism, and schizophrenia. Research on the risk factors among people with mental disorders is urgent in efforts to predict and prevent fatal suicide (Bradvik, 2018). Additionally, for Hispanics, other risk factors such as facing a very stressful life due to poverty, migration, cultural issues, ethnic identity, and

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discrimination may place them at a higher risk for mental health problems, (Silva & Van Orden, (2018).

Many times, suicide prevention efforts depend on the disclosure of suicidal ideation (SI) which is considered an early step in the suicide process (Bradvik, 2018). According to the CDC (2018), recognizing the warning signs is an essential step in the prevention of suicide. These may include the client feeling a burden, being isolated, feeling trapped or in unbearable pain, increased anxiety, increased use of alcohol and/or other substances, increased anger or rage, extreme mood swings, expressing hopelessness, sleeping too much or too little, talking or posting about wanting to die, looking for a way to access lethal means, and making plans for suicide. When an individual is known to be at risk, there are 5 basic steps to help them. These include asking if they are thinking about suicide, keeping them safe, being there with them and listening to what they need, helping them connect with ongoing support, and following up to see how they are doing. These steps will be discussed further in this paper.

Suicide rates

According to the CDC (2018), suicide rates in the United States have risen in almost every state. The only state in the U. S. that has reported a decrease in suicide by 1% is the state of Nevada. The increase reported by the CDC has been from 18% to 38%. A major increase has been reported in the states of Montana, Idaho, Wyoming, Utah, North Dakota, South Dakota, Minnesota, Kansas, Oklahoma, South Carolina, Vermont, and New Hampshire. The CDC also reported that there was a difference between those with and without mental health conditions. Additionally, it was reported that individuals without known mental health conditions were more apt to be males. The causes of suicide reported were poisoning (10%), suffocation (27%), firearms (55%), and others (8%). Suicide death by firearms was primarily among males. Gender differences were reported as 16% females and 84% males. The statistics reported for individuals with known mental health conditions were different. The gender differences in individuals with known mental health disorders were 31% females and 69% males. The method used to die from suicide were poisoning (20%), suffocation (31%), firearms (41%), and others (8%).

Factors Contributing to Suicide

Research has shown that numerous factors can contribute to death by suicide. Louise Bradvik, 2018, discovered through a review of an article dealing with suicide, that depression was a common thread throughout the articles and was known to be the most common disorder among individuals who died by suicide. Additionally, in a subsequent review, the risk factors in depression were family history of psychiatric disorders, male gender, suicide attempts, more severe depression, hopelessness, and comorbidity. While depression is strongly related to both suicidal ideation and attempt, it lacks some specificity as a predictor, and little is known about the characteristics that increase the risk of suicide among people with depression (Bradvik, 2018).

According to the CDC (2018), other factors contribute to suicide among individuals with or without known mental health conditions. These factors include relationship problems (42%), the crisis in the past or upcoming two weeks (29%), problems with substance use (28%), physical health problems (22%), job/financial problems (16%), criminal legal problems (9%), and loss of housing (4%). As mental health practitioners, it is always imperative to conduct a thorough clinical assessment to cover all areas of concern to ensure the risk of suicide is minimized.

Managing a Suicidal Client

Often, in the profession of social work, social work practitioners are employed in mental health settings that serve populations at risk. As a mental health practitioner, it has been my experience that suicidal clients require a lot of special care and empathy to reduce the risk of suicide. It is critical to always assess the safety and well-being of our clients. However, according to Frances Brenes (2019), research shows that when presented with suicidal patients, healthcare providers often avoid caring for suicidal patients due to a lack of knowledge on mental health, stigma, and misconceptions about suicidal patients; therefore, neglecting the needs of the mental health patient. One of the first steps in managing a client who is expressing suicide ideation is to screen and validate their suicide ideation. This merits for the practitioner to ask if they are thinking about suicide. If the client confirms they are thinking about suicide, the practitioner has an ethical and professional obligation to ensure the safety of the client. According to the NASW Code of Ethics, it is a social worker's ethical responsibility to promote the well-being of clients (National Association of Social Workers, 2017). Practitioners are obligated to keep them safe and reduce the risk of harm to themselves or others by displaying genuine concern and empathy. Therefore, this merits for practitioners to know what action to take to reduce this possible harm.

According to Brodsky, Spruch-Feiner, and Stanley, 2018, there are several approaches to assessing the risk of suicide. During the assessment of suicide, the practitioner must consider the risk factors besides suicidal ideation which include demographics, psychiatric and family history, diagnosis, trauma, and protective factors. Rudd, Joiner, and Rajab (2001) offer eight essential components of a good clinical risk assessment interview. These include predisposition to suicidal behavior, precipitants of stressors (triggers), symptomatic presentation (effective system), presence of hopelessness (cognitive system, suicidal belief system), nature of suicidal thinking (cognitive system, suicidal belief system), previous suicidal behaviors (behavior system), impulsivity and self-control (behavioral system), and protective factors. Additionally, Rudd, Joiner, and Rajab (2001) delineate four risk categories with criteria to assess for suicide. The first is at baseline with the absence of acuity (crisis). The second

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category is "acute" with acute crisis overlay, significant stressors, and prominent symptomatology. The third category is chronic high risk for multiple attempters, with the absence of the above-mentioned criteria. The fourth category is chronic high with acute exacerbation. In this category, there is the presence of acute (crisis), overlay significant stressors, and/or prominent symptomatology. Once it has been established that the client has suicide ideation, practitioners must gather information regarding the thoughts and if they have a lethal plan. The social work practitioner must gather information about the frequency of the suicidal ideations, the plan to carry out the suicide, ascertain the lethality of the plan, and how much time has been spent on planning the suicide. Additionally, the practitioner must discuss the history and/or recent attempts (Cooper & Lesser, 2015).

In keeping the client safe, the practitioner must do everything possible to ensure the safety of the client. The practitioner must be there with them and listen to what they are needing. If the client needs to be connected to a referral source such as a psychiatric facility or a medical facility to have the client's mental stability assessed, the practitioner must make the contact with the agency or facility that is warranted (Johnson, 2004). By doing this, it will help determine what level of treatment may be required for the client which could be either immediate inpatient admission and hospitalization or an outpatient treatment center. In either case, the risk of suicide must be addressed and prioritized. By engaging in this process of referring the client for help, confidentiality may be or will be breached as the need to contact the client's family, police authority, or a crisis stabilization facility takes precedence (Cooper & Lesser, 2015). This merits for the practitioner to address the limits to confidentiality and the circumstances under which confidentiality will be breached before beginning their work. This requires the practitioner to review these conditions with the client. Additionally, the practitioner must be ready to confront the conflict that may arise with the client who may feel his/her confidentiality and trust have been violated by the practitioner. The practitioner must also document the client's assessment of the suicidal thoughts and the steps the practitioner took to keep the client safe and prevent suicide. By doing this, the practitioner's professional accountability prevents any conflicts that may arise in ascertaining the practitioner's ethical and professional duties to keep the client safe were followed (Cooper & Lesser, 2015).

There are situations where the client does not meet the criteria for inpatient hospitalization and must be returned to their home environment. When this occurs, the practitioner must educate the family on monitoring and assessing the client's safety at home. This may require the practitioner to formulate a safety plan or contract with the client and involve family members and friends if necessary. According to Cooper and Lesser, 2015, a safety plan will provide important insights and allow the practitioner to further explore the client's thoughts about suicide, identify any plans for suicide, deter these suicidal thoughts and ideations, and delineate for the client how they may choose to seek help in emergency cases. The client must be advised who to contact in case of emergency, which includes the practitioner, law enforcement officials, or crisis centers. Clients need to be linked to crisis centers that operate on a 24-hour basis, 7 days a week. According to Brodsky, Spruch-Feiner, and Stanley (2018), the safety plan intervention is a best practice brief intervention that incorporates evidenced-based suicide risk reduction strategies such as lethal means reduction, brief problem solving and coping skills, increasing social support, and identifying emergency contacts to use during a suicide crisis. However, it must be noted that while safety contracts/plans are important deterrents, they do not guarantee that a client will not commit suicide.

Practitioners need to ensure that clients who are at risk of suicide need to be referred for a thorough psychiatric evaluation. According to Cooper and Lesser, 2015, a psychiatrist's knowledge and expertise in this area support our own, and many psychotropic medications that only psychiatrists can prescribe help stem the depressive course. In addition, the social work practitioner can provide techniques that can initiate building a support system to keep the client from isolating, removing potential hazards that can be utilized in their suicide attempts, or validating the client's feelings while reminding them of the facts of the situation. Additionally, a practitioner can empower a client by educating them to help identify irrational and negative beliefs which will guide them toward the best self-care.

Conclusion

Suicide is a leading cause of death in the United States with alarming increasing rates yearly. As a result, many lives have been lost and continue to be at risk. According to the Centers for Disease Control and Prevention (2018), suicide is more than just a mental health concern that merits a lot of attention not only from mental health practitioners but from everyone in each community to help save a life. To reduce rates of suicide among Hispanics, research indicates that common suicide risk factors (e.g. psychiatric problems) and culturally unique factors need to be addressed (Silva & Van Orden, 2018). Suicide prevention is the responsibility of everyone and the key to decreasing rates of suicide. Prevention of suicide can be achieved by learning about mental health, recognizing warning signs, and providing additional services from the federal government, state agencies, healthcare systems, schools, employers, media, and everyone. Additionally, social work practitioners as well as other healthcare practitioners require formal suicide training to meet the needs of suicidal patients. This requires everyone in communities to work together to promote safe and supportive environments, teach coping and problem-solving skills, identify and support people at risk of suicide, provide activities that can bring together people so they can feel connected and not isolated, connect

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people at risk to effective and coordinated mental and physical healthcare, provide services to those struggling to make ends meet, and prevent future risk of suicide among those who have lost a loved one or friend to suicide.

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