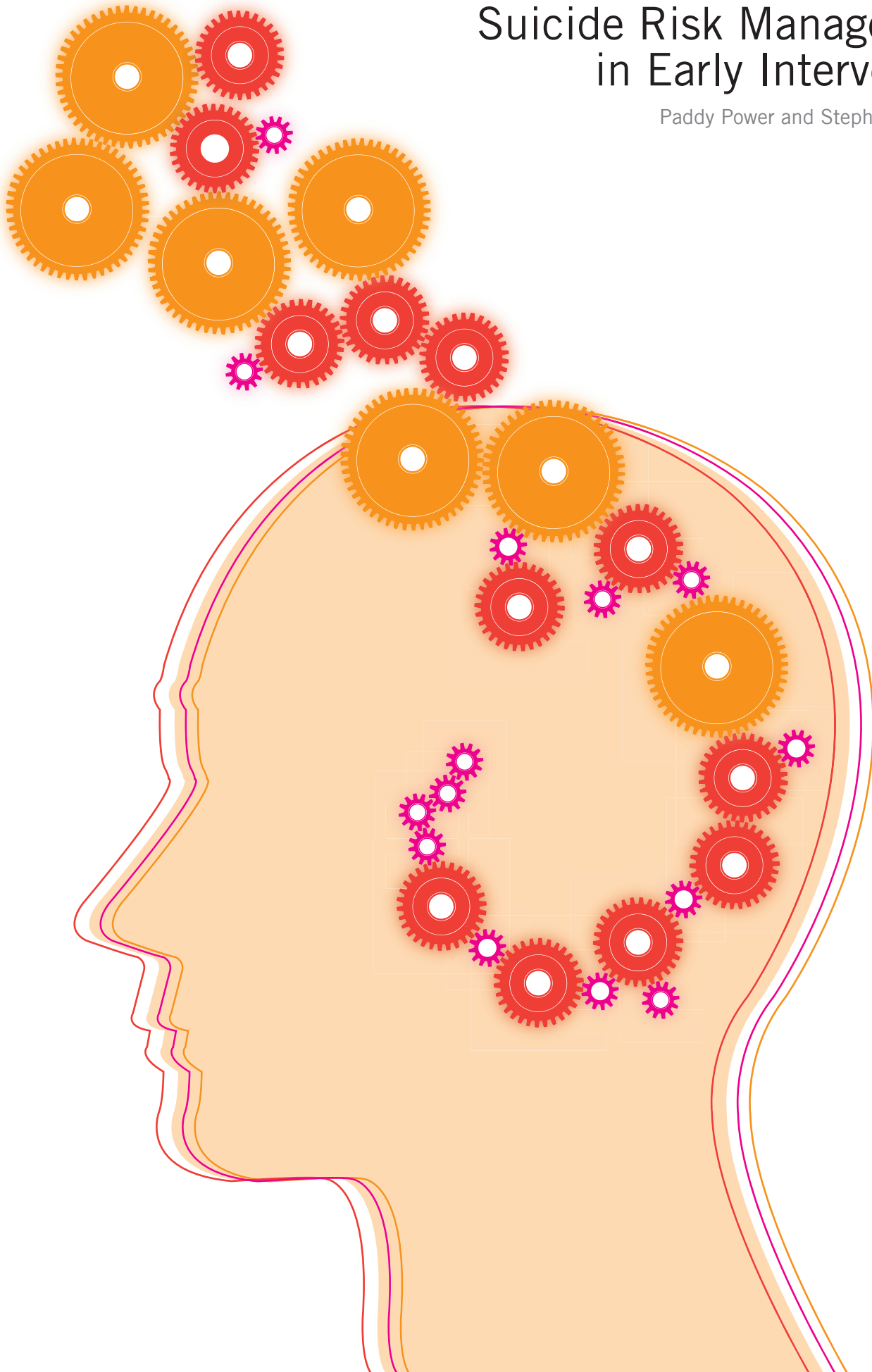
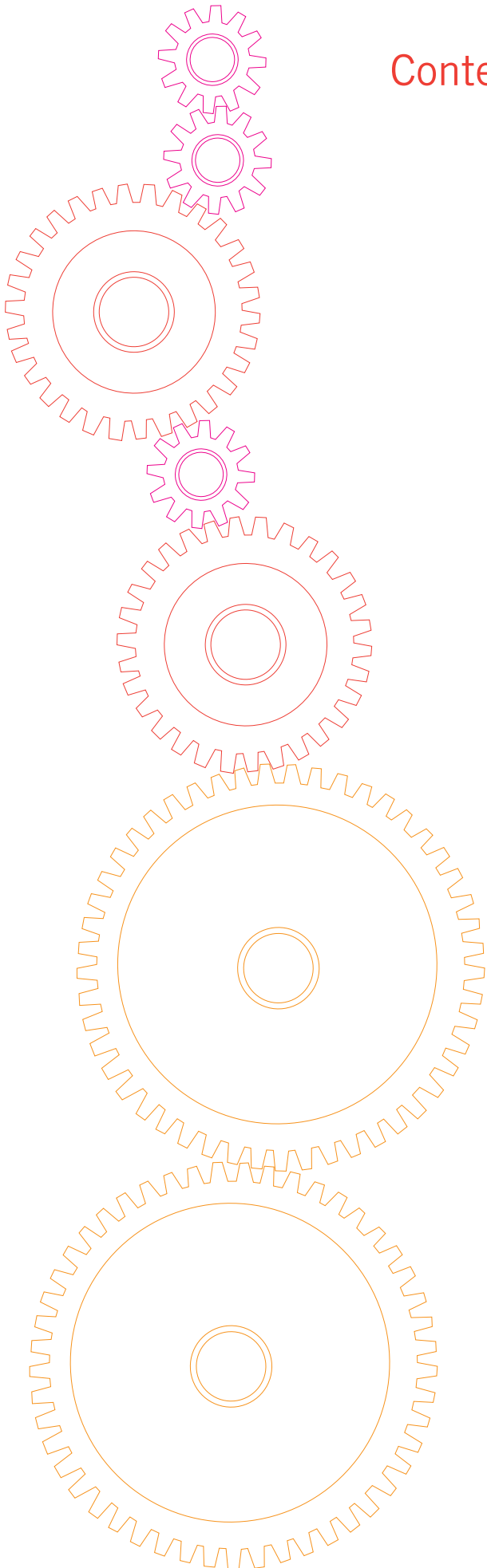


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# Suicide Risk Management in Early Intervention

Paddy Power and Stephen McGowan





# Contents

	Foreword
01	Introduction
01	Suicide and the First Episode of Psychosis
02	When Are Suicides Most Likely To Happen In Psychosis?
04	Suicide Prevention And Early Intervention Services
05	Suicide Risk Assessment
06	Early Intervention Suicide Risk Factor Check-list
11	Initial Formulation Of Suicide Risk
11	Risk Management And Suicide Prevention: General Issues
12	Involving Carers And Dealing With Confidentiality Issues
13	Suicide Risk Monitoring Systems
13	The Zoning System
14	Training In Suicide Prevention
14	Specific Interventions
16	Conclusion

## Foreword

As we embark on the next phase of development in mental health services, it is useful to reflect on what has been achieved in the last 10 years, and what improvements are still needed. From my perspective as (until recently) national director for mental health, among the most important initiatives have been the reform of community care and the prevention of suicide. Two of the successes that we can be most proud of are the introduction of Early Intervention in Psychosis services and the reduction in suicide rates among young mental health service users.

This valuable guidance brings together these two key areas. Psychosis carries a high risk of suicide; a fact that highlights the hopelessness and loss that features so prominently in the experiences of many of those affected. It represents a major challenge to services.

This publication focuses specifically on managing suicide risk in the context of a first episode of psychosis. It draws on current evidence for best practice in suicide risk management and provides practical guidance for practitioners, managers and clinical leads. It acknowledges the difficulties we face in identifying those who pose the greatest risk but promotes an optimistic, practical and purposeful approach to management.

Suicides can be avoided and Early Intervention teams are uniquely placed to prevent suicide. This guidance represents a valuable addition to our suicide prevention tool kit that I am pleased to endorse.



Louis Appleby

National Clinical Director for Health and Criminal Justice and  
Professor of Psychiatry at the University of Manchester.

# Introduction

This guidance has been developed by the National Mental Health Development Unit (NMHDU) and focuses specifically on managing suicide risk during a first episode of psychosis. It draws on current evidence for best practice in suicide prevention, informed by the expertise of the authors and contributors, and aims to provide practical guidance for practitioners, managers and clinical leads.

People experiencing psychosis are at particularly high risk of suicide. The lifetime risk of suicide is between 4 – 15% with the highest rates in affective psychoses<sup>1</sup>. These people account for 20%-37% of suicides in people with mental illness<sup>2,3,4</sup>. Most suicides occur in the early years of illness<sup>5</sup>. These first years of illness are known as the 'critical period'. It is when long-term outcome is determined. It is the period when individuals endure some of the most significant adjustments and losses. In many ways, suicide during this period can be seen as an understandable response to the difficulties people experience with these major adjustments.

[ *Psychotic illness*] is still associated with considerable stigma, fear and limited public understanding. The first few years after onset can be particularly upsetting and chaotic, and there is a higher risk of suicide. Once an acute episode is over, there are often other problems such as social exclusion, with reduced opportunities to get back to work or study, and problems making new relationships.

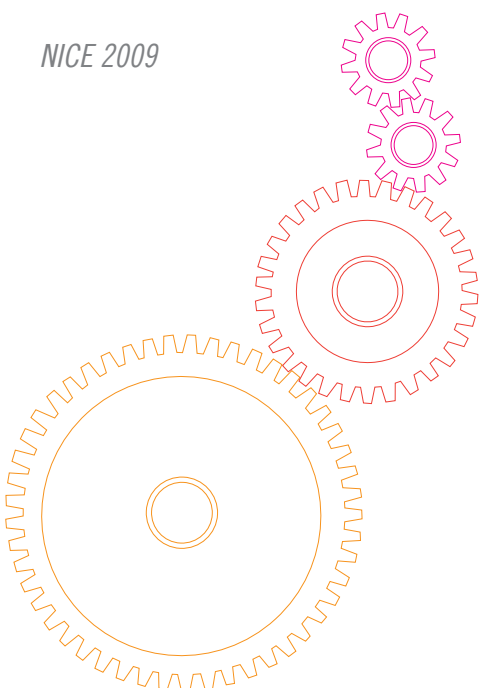
NICE 2009

## Suicide and the First Episode of Psychosis

Our understanding of suicide in psychosis has been greatly assisted by the focus in recent years on the importance of the first episode of psychosis. We now know that the first episode is one of the highest risk periods. On average **one person in a hundred will commit suicide each year in the first 5 years after their first contact with services**<sup>6</sup>. Many will have already attempted suicide before their first contact with services. Even **after their acute psychotic episode has abated, about 15% of people will continue to experience high levels of suicidality for 18 months afterwards**<sup>7</sup>. While the numbers who actually commit suicide are small, they represent a much larger group of individuals who struggle with suicidality and the impact of their deaths can have a profound impact on all involved.

[ *The devastating impact of these suicides on friends, family, fellow patients, communities and staff is a graphic reminder of the anger, regret, hopelessness and despair that many people experience with these illnesses. Their deaths can become a focus for identification for fellow patients or relatives, potentially increasing their own risk when faced with similar circumstances. Bereavement for affected families and friends is especially protracted, often complicated by intense feelings of unresolved guilt and remorse. Even staff, despite their training and support, face considerable challenges coping with such incidents with questions about their culpability and involvement. Services themselves come under considerable pressure and very public incidents can threaten their viability, particularly new services.*

Paddy Power



# When Are Suicides Most Likely To Happen In Psychosis?

Not all self inflicted fatalities in psychosis are strictly speaking suicides as individuals may not have intended to end their lives. Some fatalities may have also been accidental (road traffic accidents, falls, overdoses etc) even if due to illness factors such as delusions or acute confused behaviour. However, for the purposes of this guidance we are including these fatalities in our discussion as many of the issues overlap with true suicide.

Most suicides in psychosis actually occur during periods of remission and are not directly due to psychotic experiences. Because of the many complex and dynamic factors involved, it is helpful to distinguish what might be happening at the different phases of the illness. These phases in the first episode are the:

Prodrome/‘At Risk Mental State’ phase of emerging psychosis

Untreated Psychosis (DUP) phase

Acute psychotic treatment phase

Post-psychotic recovery phase

And for some

Early phase of relapse.

## The ‘At Risk Mental State’ phase:

Up to 90% of young people attending specialist clinics and meeting the criteria for an ‘at-risk mental state’ or ‘prodrome’ of psychosis report being suicidal<sup>8</sup>. Much of this may be directly due to the distress caused by unfamiliar emerging pre-psychotic experiences.

Most people don’t seek help during this phase of illness and on average people endure about two years of prodromal symptoms before their first episode of psychosis. How many attempt or complete suicide during this phase is unknown but it is likely to be significant.

## Untreated psychosis (DUP) phase:

This next phase of illness is when the acute psychotic episode emerges and leads up to the time that treatment starts. This phase is called the DUP (Duration of Untreated Psychosis). On average the delay in accessing treatment during this phase is one year. The longer the delay in accessing treatment the greater the level of suicidality experienced<sup>9</sup>. Most people will have become suicidal during this phase and 25% will have already made one suicide attempt before they have contact with services<sup>10</sup>. It is not known how many complete suicide during this phase but studies of coroners findings suggest that the figure is alarmingly high<sup>11</sup>.

These delays and high risks expose a very real problem with early detection and accessing services<sup>11</sup>. Trying to negotiate complicated service structures as one’s psychosis worsens can be extremely daunting for a prospective service user and their carers. Poorly coordinated, unresponsive and difficult to access services only further prolong these delays and contribute to suicide risk<sup>9</sup>. Services have a responsibility to minimise these potential barriers to care especially when spanning different directorates e.g. CAMHS and adult mental health services.

[ *The smoother the pathway into services the more likely that young people will receive the help and support they need at a time when guidance from professionals is paramount to recovery. Good engagement and a family centred plan of care ensures safe practice and will reduce the risk to the individual.*

*Fran Tummey, National CAMHS Support Service*

## Acute psychotic treatment phase:

Suicides during the acute psychotic phase may be a direct response to acute psychotic experiences such as distressing delusions, command hallucinations or passivity phenomena. In one large study, 11% of suicide attempts in the first episode were directly associated with hallucinations<sup>13</sup>. However, it's important to be aware that the majority of acutely psychotic patients maintain some degree of insight and suicides during this phase may just as easily be a response to factors such as fear, shame, stigma, guilt, loss, rejection and despair.

## Post-psychotic recovery phase:

Most suicides occur in the post psychotic recovery phase, commonly within months of discharge from hospital<sup>14,15,16</sup>. While the psychosis might have remitted, neurocognitive deficits in information processing persist and impede the ability to return to studies, work, and recreational activities. Simple activities such as watching TV, reading, conversations and social activities may be an effort to sustain for more than a few minutes. Suicide risk during this phase may relate to the realization of loss of role and function associated with the experience of psychosis. Recovery can be a slow, frustrating, disheartening process for some. This may be particularly challenging to individuals with pre-morbid difficulties (e.g. deprivations, traumas, abuse etc) that then compound their suicide risk further. Individuals are often left to get on with their own recovery with very limited support, guidance and psychosocial interventions. In addition, they are likely to be faced with returning to the very circumstances that might have led to their psychosis in the first place. At the same time, support from services and carers is being reduced in the false belief that the risks has subsided.

[ *The post psychotic recovery period is when service users emerge from their psychosis to face some of the most difficult emotional challenges of returning to a normal life. Emotional reactions such as anger, self loathing, shame, revenge, anxiety, fear, panic, emptiness, loneliness, resignation, depression, hopelessness, reckless abandon and a wish to escape what can seem like an impossible situation can precipitate a suicidal state. It can be an intensely lonely time for some people with long periods of social isolation and inactivity. Rejection, alienation, discrimination and stigmatisation will add to the sense of distress, loss, hopelessness and despair. This can be worse if individuals have had prior experience of similar illnesses e.g. through a relative and is pronounced if they have also lost a parent or significant other through suicide.*

*Paddy Power*

## Early relapse phase:

Though the majority achieve remission from psychosis within 6 months of starting treatment the risk of relapse is high. This is most likely to occur between the end of the first year and end of the third year of follow-up<sup>17</sup>. It frequently follows disengagement from services and treatment. The return of symptoms, re-entering services or treatment can have a profound psychological impact, inducing intense fear, hopelessness, and despair, carrying a particularly high risk for suicide.

# Suicide Prevention And Early Intervention Services

Suicide is a relatively infrequent event among patients managed by individual teams. A first episode psychosis service (with a case load of about 150 patients) can expect about one person to die by suicide each year. These suicides are very difficult to prevent and identifying those at greatest risk can be extremely challenging. The complex changing dynamic between individual and circumstantial factors make timely risk formulations difficult. No single factor can be relied upon and it is important to take into account the very individual dynamic nature of each person's risk. It is, therefore, unrealistic to expect services to prevent all suicides (or, indeed, homicides). However, studies suggest that it is not unrealistic to aim for a 50% reduction in suicide rates through the introduction of Early Intervention services<sup>18</sup>.

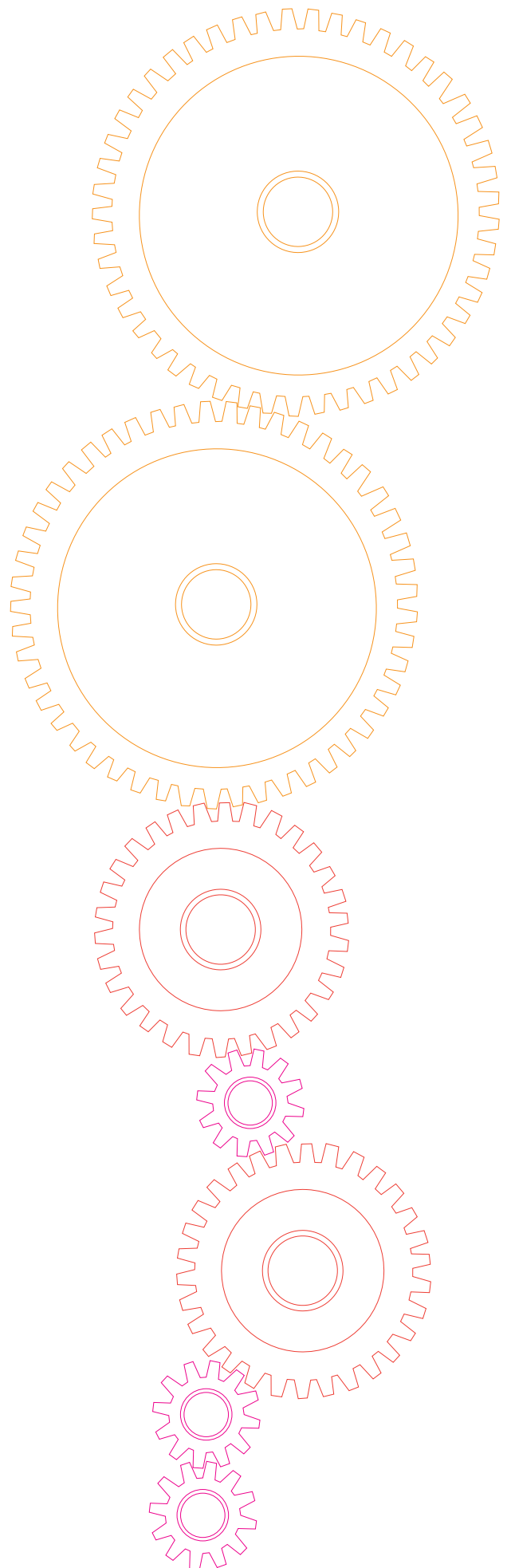
[ *One of the most difficult challenges in Early Intervention is achieving a balance between the inevitability of suicide and the preventability of suicide. As a manager I have to reassure staff that some suicides are unavoidable, whilst simultaneously raising the teams' sensitivity to suicide risk and driving up standards of practice aimed at minimising suicide.*

*Moggie McGowan*

Most first episode service users will experience some level of suicidal thinking but less than half will act upon this and very few will die as a result. However, one can never afford to be complacent. There is plenty of evidence from inquiries that failures in service provision contribute to many suicides<sup>19</sup>. Suicide can be preventable and there is encouraging evidence that Early Intervention services may protect against suicide in psychosis<sup>20,18,21,22,23</sup> through strategies such as reducing initial delays in treatment<sup>9</sup> and providing more intensive help during the recovery phase<sup>13</sup>.

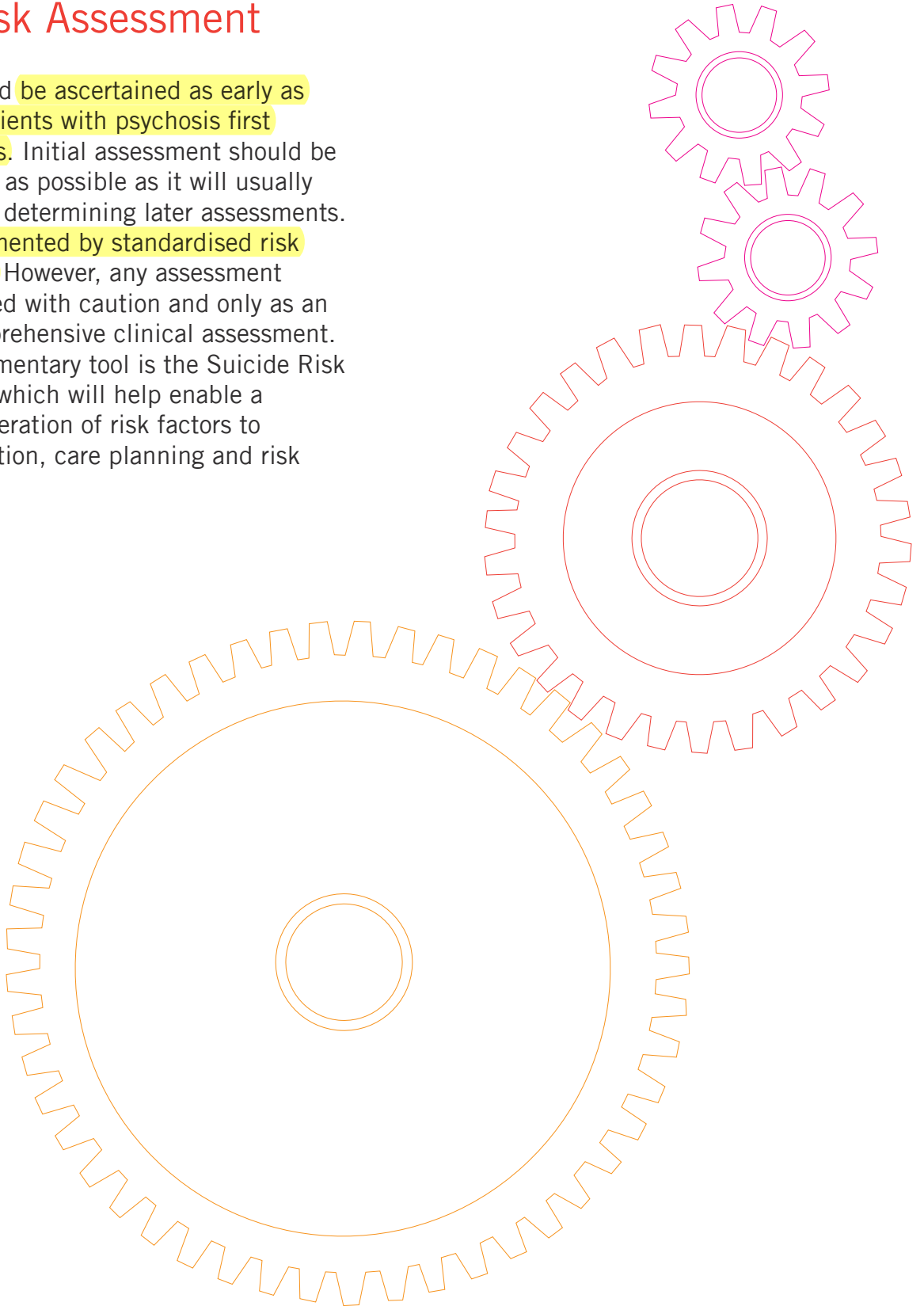
[ *'It is time to change the widespread view that individual deaths are inevitable – such a view is bound to discourage staff from taking steps to improve safety'*

*(National Patient Safety Agency/University of Manchester, 2006).*



# Suicide Risk Assessment

Suicide risk should be ascertained as early as possible when patients with psychosis first present to services. Initial assessment should be as comprehensive as possible as it will usually form the basis for determining later assessments. It can be complemented by standardised risk assessment tools. However, any assessment tool should be used with caution and only as an adjunct to a comprehensive clinical assessment. One such complementary tool is the Suicide Risk Factor Check-list which will help enable a systematic consideration of risk factors to support a formulation, care planning and risk management:





# Early Intervention Suicide Risk Factor Check-list

Name :

Date :

Current Risk Factors	Y/N
Preoccupation with morbid/suicidal thoughts	<input type="checkbox"/>
Suicidal intent/plans	<input type="checkbox"/>
Suicidal behaviour: e.g. researching the subject, storing up medication	<input type="checkbox"/>
Hallucinatory content/commands	<input type="checkbox"/>
Distressing symptoms/experiences	<input type="checkbox"/>
Prominent guilt, hopelessness and self reproach	<input type="checkbox"/>
Acutely depressed or labile mood	<input type="checkbox"/>
Agitation or motor restlessness	<input type="checkbox"/>
Impulsive/unpredictable behaviour or bizarre risk taking decisions	<input type="checkbox"/>
Recently admitted or discharged from hospital	<input type="checkbox"/>
Relapse/first relapse of psychosis	<input type="checkbox"/>
Slow or incomplete recovery/poor treatment response/fear of mental disintegration	<input type="checkbox"/>
Poor/non concordance with prescribed medication	<input type="checkbox"/>
Problematic engagement and refusing help	<input type="checkbox"/>
Significant personal stress or loss e.g. debts, job, relationship, abuse	<input type="checkbox"/>
Critical family environment/high expressed emotion	<input type="checkbox"/>
Social isolation: single/separated/living alone	<input type="checkbox"/>
Unemployment/inactivity	<input type="checkbox"/>
Recent contact with police/criminal justice system	<input type="checkbox"/>
Serious physical health problems, terminal illness, pain, intolerable side effects	<input type="checkbox"/>
Harmful/persistent substance misuse	<input type="checkbox"/>
Access to lethal means	<input type="checkbox"/>

Historical Risk Factors	Y/N
Previous suicide ideation	<input type="checkbox"/>
Previous suicide attempts or serious self injury	<input type="checkbox"/>
Long duration of untreated psychosis (DUP)	<input type="checkbox"/>
Previous depressive episodes	<input type="checkbox"/>
History of abuse or bullying	<input type="checkbox"/>
History of impulsiveness and/or other high risk behaviour	<input type="checkbox"/>
History of harmful/persistent substance misuse	<input type="checkbox"/>
Family History of suicide	<input type="checkbox"/>
Friend or acquaintance committed suicide	<input type="checkbox"/>

Future/Potential Risk Factors	Y/N
Service disengagement and refusing help	<input type="checkbox"/>
Service transitions or transfer of staff	<input type="checkbox"/>
Protracted recovery	<input type="checkbox"/>
Depression	<input type="checkbox"/>
Social rejection/loss of relationship	<input type="checkbox"/>
Relapse of psychosis	<input type="checkbox"/>

**RISK STATUS :**

**HIGH**

Assertive action to reduce immediate suicide risks and MDT review of care plan

**MODERATE**

Care plan for current risk factors and remain vigilant for future risk factors

**LOW**

Remain vigilant for future risk factors

In addition to the checklist included here, there are a number of clinical tools, assessment schedules and other packages developed to support best practice in suicide risk management. A selection (taken from Best Practice in Managing Risk, DH, 2007) is included in the appendix. Responsibility for managing the process of suicide risk assessments in a service rests with senior mental health professionals. However, all members of the multidisciplinary team are expected to be proficient in standard suicide risk assessments and there is little excuse for neglecting this crucial area during an initial clinical assessment<sup>24</sup>.

Assessors should ideally work in pairs and gather as much information as possible about historical and current suicide risk factors at the point of referral. Agreement should be reached with the referrer regarding the urgency of the referral in relation to suicide risk; whilst acknowledging that there is often very little history upon which to rely. Problematic engagement of a new referral should be regarded as a risk factor for suicide and clinicians should seek the advice and support of colleagues when considering a 'watchful waiting' strategy with a difficult to engage client, where risks remain un-assessed<sup>25</sup>.

[ *Failure to engage the client is in itself a significant risk factor and the multidisciplinary team must take into account potential suicide risk factors when deciding upon management plans during a prolonged and difficult engagement process.*

*Alyson Leeks, Nottingham City Early Intervention in Psychosis Team*

Information should be sought from the client, family, carers, referrer, and any previous contacts with health and social care agencies in order to build up as complete a picture as possible. The risks should be reviewed regularly, given the transient nature of suicidality and one should maintain a forward-looking awareness of potential risk-factors for the future if circumstances change. Transition points e.g. from at-risk/ prodrome to psychosis or the early phase of recovery are recognised as particularly high risk times<sup>18</sup>. A comprehensive reassessment of suicide risk should therefore be undertaken in the event of the following:

In the event of suicide threats

Following any behaviour suggestive of a suicide attempt

Marked deterioration in psychosis, mood, anxiety or substance use

Major stressful life event e.g. serious rejection or loss

Service disengagement and refusing help

Admission to and discharge from hospital

Commencement of leave from hospital

Transfer from one community team/service to another.

Practitioners must explore the unique reasons behind suicidal feelings or a suicide attempt and timing and trust is important when enquiring about suicide risk. Ideally, one should give enough time first to develop rapport and an understanding of some of the issues, no matter how unusual the speech content, before asking whether the person has considered suicide.

[ One way of introducing the question of suicidal feelings is to ask how the person is being affected by what has been happening, whether it is getting them down, how desperate they feel, and if they have ever thought of ending it all? If they have been thinking of, researching, planning or have actually attempted suicide, one should try to identify what has made them feel this way, what emotions they are experiencing, whether it is driven by psychotic features, what their rationale for suicide is, what plans they have made, and what is stopping them from doing it.

Paddy Power

Some will be very cautious about disclosing their true feelings at the initial assessment, perhaps ashamed or afraid that if they reveal suicidal feelings they will be hospitalised. To prevent this it is helpful to promote optimism and normalise the experience, explaining that some transient suicidal thoughts are an understandable reaction to a difficult situation and that these feelings are common and likely to subside when they get the help and treatment they need.

[ Fleeting thoughts of suicide can be common in people experiencing psychosis. It is important that these feelings are understood, worked through, and in many cases normalised as an understandable reaction to the difficult circumstances that people can find themselves in. It is vital that service users are reassured that these feelings can subside with the right help and treatment.

Paul French, Associate Director for Early Intervention, Greater Manchester West Mental Health NHS Foundation Trust

If a person does disclose that he/she has felt or is feeling suicidal, one should take the opportunity to provide some initial counselling, exploring the underlying reasons for suicide and identifying possible ways of alleviating the causes, thereby, cultivating a sense of hope. One should try to determine the acuteness of suicidality by identifying where someone might be on the continuum of suicidality.

## Continuum of Suicidality

Risk Factors →

IDEATION → INTENT → PLANS → ACTIONS

← Protective Factors

This continuum ranges from ambivalence about living to actual serious physical attempts to kill oneself. It is important to identify the drivers pushing someone to consider suicide and the protective factors preventing them from completing it. One should ask why they feel they can't go on and why they can't live with themselves, their psychosis, or the situation they find themselves in. One should also ask what they expect to achieve by killing themselves, what fantasies they might entertain about death and what the imagined consequences might be.

It's essential to inquire about influencing psychotic experiences like command hallucinations, morbid guilt, terrifying delusions or hallucinations, delusions of control, grandiose delusions that might prompt life threatening behaviour, or highly vulnerable levels of thought disorder and confusion. There may also be pre-existing contextual factors, e.g. previous traumatic life events, such as loss or abuse, underpinning a person's suicidal thinking as well as fears about outcomes e.g. the future implications of their illnesses.

[ *We no longer regard psychosis as simply a biological condition that derives from inherited faulty brain chemistry, but acknowledge the trauma, loss and abuse that so often precedes it. It is important to remember this when a person's distress manifests as suicidal thinking and behaviour. Psychotic expression represents an opportunity to recognise and address deep-seated and powerful psychological distress and any suicide management plan needs to acknowledge this and not dismiss psychotic expression simply as unfounded madness.*

*Guy Dodgson, Consultant Clinical Psychologist  
Northumberland Tyne and Wear NHS Trust*

Factors that might be fuelling/driving a person's suicidality include:

Acute psychotic symptoms/experiences

Mood disturbance

Pre-existing or co-morbid conditions such as. depression, personality disorder and substance misuse/dependence

The individual's psychological reaction to the impact of their illness

External factors such as the death of a significant other, sexual abuse and the reactions of others

PTSD features related to earlier trauma or prior suicide attempt

Trauma associated with an unsatisfactory pathway to care

Suicide pacts with others

Previous suicidality should be sensitively explored and recorded in detail to provide a baseline. You will need to catalogue each episode, recording dates and times, reasons, chosen methods, outcomes and how the person feels about it now, i.e. do they wish they had been successful or do they regret it? Perhaps they learned something positive about themselves from it or it helped to bring their problems to the attention of others. The history of events should be confirmed wherever possible with family, friends, carers and any other agencies to build as complete a picture as possible.

[ *Not all suicide attempts are completely negative. It may be a life affirming experience for some people, a test of fate and resolve to survive overwhelming adversity. It may prompt help-seeking and elicit empathic reactions in others. It can also be an opportunity for engaging in psychotherapeutic interventions and, in the most difficult to engage, a rationale for assertive engagement or the use of mental health legislation.*

*Paddy Power*

It is also important that protective or resilience factors are taken into consideration when assessing suicide risk. These include:

At least one close relationship/confidante

Family support

Things to live for, e.g. plans for the future, children, pets etc.

Strong positive cultural/religious/personal values and anti-suicide attitudes

Social stability

Good service engagement and optimism about recovery

[ *To every action there is a reaction. I think sometimes we underestimate the capacity of people to deal with intolerable situations and survive - much of this comes from protective factors (internal factors such as survival instinct, personal resilience, capacity to tolerate difficult feelings, personal belief systems and external factors, particularly those things which motivate us to keep going in the face of adversity such as people and things that are important to us or when we believe we may be important to them) as well as personal coping strengths. Sometimes these aspects can be overshadowed by concerns about risk and we need to draw these out for the person (and ourselves as workers) identifying survival factors that can offset risk and keep the scales tipped towards living.*

*Jo Smith, Consultant Clinical Psychologist, Worcestershire EI Service Lead*

At the end of the interview enough time must be left for service users to 'debrief' with staff; to readjust after discussing suicide, as such intimate investigation can trigger memories of previous suicidal states, feelings of hopelessness, and might inadvertently increase suicide risk.

## Initial Formulation Of Suicide Risk

At the end of the assessment process the assessors should combine all the relevant information into a summary; a biopsychosocial formulation of the person's condition and suicide risk. This should determine not only the nature, severity and acuteness of risk but also their rationale for wanting to end their lives. More specifically, this might identify 'when', 'where', and 'how' and in 'what' circumstances a person might become acutely suicidal. It should determine whether the person could be relied upon to seek help in such situations and engage effectively in any preventative strategies on offer. If not, then the alternative safeguarding options should be explored and identified. It is important that this process is concluded collaboratively with the patient and carer so that a mutual understanding and agreement can be reached about the risk formulation. This then forms the basis and rationale for developing a positive risk management plan.

## Risk Management And Suicide Prevention: General Issues

Once the formulation is concluded, the lead clinician should sum up the key issues and, in collaboration with all of those involved, develop a pragmatic plan for managing risks over the next few days. Contingencies such as hospitalisation should also be discussed and 24-hour emergency contact details provided. Potentially harmful medications and other means such as blades, flammable materials and ligatures, should be stowed away safely. Levels of supervision and precautions should be agreed upon and communicated to all involved. Extra staff may need to be called upon for assistance e.g. for one to one observations in hospital.

The initial risk management plan should ideally be agreed upon promptly with everyone involved, including the service user and carers. Occasionally, this may prove difficult if emotions are running high. In such situations it's best to involve lead clinicians early as they are likely to be called upon anyway if agreement can't be reached. The principle of the 'least restrictive intervention needed to achieve a safe and effective outcome' should apply. The plan should always be put in place before the patient leaves the immediate supervision of the clinicians involved. If the patient or carer cannot be persuaded of the minimum safeguards necessary and the suicide risk is acute then clinicians may have to resort to ensuring the immediate safety of the patient even if it means resorting to 'common law' or mental health legislation.

[ *Positive risk management is to be encouraged and the improper use of disproportionately heavy-handed interventions should be avoided. The disempowering and potentially traumatising impact of forced treatment and interventions must be recognised: The involvement of police, use of the mental health act, forced admission, treatment by compulsion and physical restraint can all lead to trauma and may in fact increase the suicide risk.*

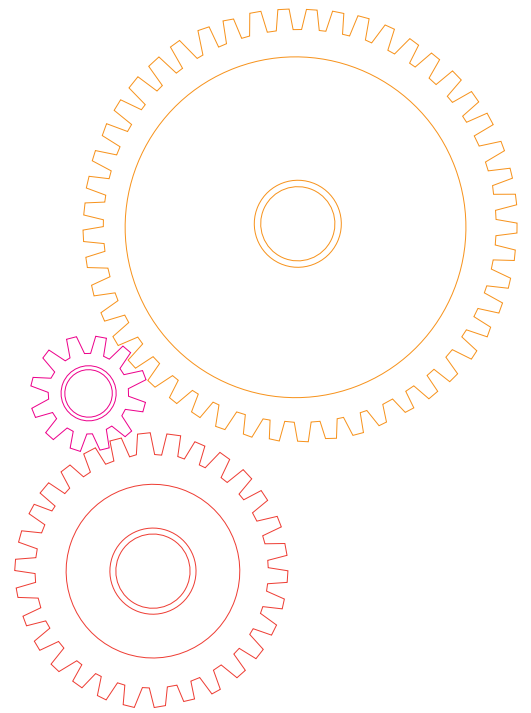
*Moggie McGowan*

If you think that a suicidal person can be looked after at home, it is vital to assess their capacity to comply with agreements that they will inform their family/carers or staff if their circumstances change. Professionals should be reminded that young people increasingly have access to instant communication media that might be used to express suicide intentions. These include Facebook, mobile phones, text messaging, emails and more worryingly internet 'chat rooms' and websites dedicated to suicide. The treating team needs to feel confident that they will be informed immediately the client becomes actively suicidal so that support can be increased or contingencies put in place.

Those who are extremely guarded, mute or partly catatonic should be managed with great caution, particularly if they display high levels of anxiety, agitation, confusion, and impulsiveness. In addition to suicide risk, their confused or frightened behaviour may put them at risk of injury through dangerous behaviour e.g. in traffic, with home utilities or with fire.

Safeguarding and child protection procedures must be followed if the individual is a minor or if there are minors who may be affected. Responsible carers will need to be identified and agree with any care/crisis plan that is recommended<sup>26</sup>.

If the conclusion is that suicide risk remains high, this should then trigger a more comprehensive ongoing risk assessment with the service user, carer, treating team and any other agencies involved. Ideally, this should prompt a multi-agency care planning (CPA) meeting with if necessary a second opinion if there are major concerns. Increased risk should trigger more frequent contact and all contacts should remain on high alert until the risk has subsided. Full risk assessments should be reviewed again and communicated to all involved whenever a transfer occurs from one team to another, especially on discharge from hospital<sup>14,15,16</sup>.



## Involving Carers And Dealing With Confidentiality Issues

Ideally, carers should always be involved in any risk management plan. Some individuals will, however, insist that their carers are not informed. One should never assume that family members and carers are aware of the risks or know what to do as studies reveal that they often have no knowledge of their loved ones' suicidal thinking or even attempts<sup>27</sup>. If a carer is to be given any responsibility for managing the safety of a suicidal person they must be informed of the risks and be part of the care planning and risk management process. This should be the same whenever any individual, team or partner agency is required to play a part in the care of a suicidal service user.

[ *If one wishes to respect the person's confidence then one should never at the same time place another person (carer or professional) unwittingly in a position of having to supervise that risk without appropriate knowledge.*

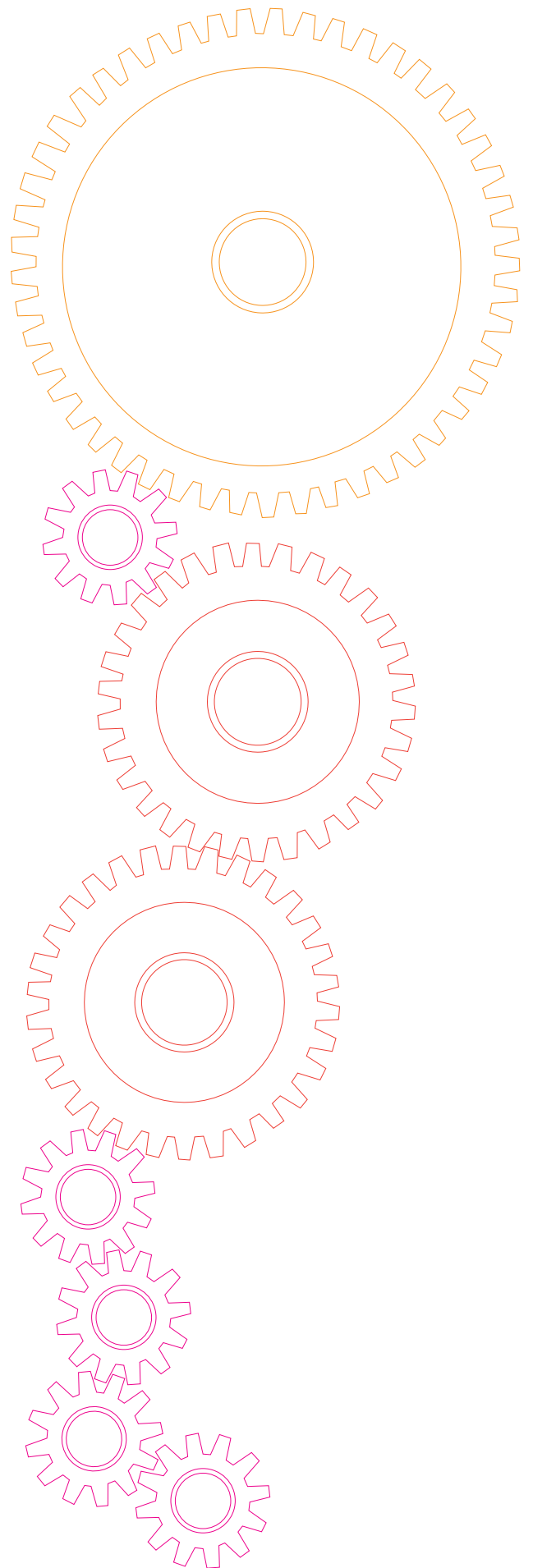
*Paddy Power*

# Suicide Risk Monitoring Systems

Effective risk assessment and management systems should be a fundamental part of any Early Intervention service. The system should be clear and simple. Communication is vital. Any service user assessed to be an acute suicide risk should be highlighted immediately and the service should stay vigilant to such risk until formal multidisciplinary review has agreed that the risk has abated. Teams should ensure that such alerts are communicated, updated and recorded at staff handovers (e.g. on whiteboards, handover sheets, and electronic patient records). Any observed worsening of this risk should automatically trigger an immediate review of the risk management plan by the senior clinician on duty. Early Intervention teams are expected to provide flexible assertive follow-up in the community, in order to maintain good engagement in treatment /services<sup>28, 29</sup>. Depending on resources some Early Intervention teams may have the capacity for daily monitoring of an individuals suicide risk in the community. However, many will need to co-work with the home treatment team to achieve this level of community supervision.

## The Zoning System

The Zoning System<sup>30,31</sup> is one of a number of risk management systems available in mental health services. It is recommended because of its ease of administration and usefulness in clinical practice. It has been successfully introduced in Early Intervention services such as the Lambeth Early Onset (LEO) service in London. Service users are categorised into three levels of risk (low = green, moderate = amber, high = red). New service users are usually placed in the red zone until sufficient information has been gathered and the multidisciplinary team decides otherwise. A highly visible board/chart or a 'handover sheet' is kept in each team base and





shows clearly each service user's risk status/zone. Any clinician may move a service user up into a higher risk zone at any time if they are concerned, but a service user may not be downgraded until the team has made a decision to do so at a multidisciplinary clinical review meeting. The zoning system is linked to a patient management protocol that determines the intensity of supervision and frequency of observations/contact/reviews required. Red zone service users are frequently evaluated and discussed at each team meeting. These protocols can be adapted to inpatient and community team settings. They are a useful audit and management tool for evaluating service demand, incidents, caseloads, and staffing levels.

For more information on the Zoning System see 'Zoning: A system for managing case work and targeting resources in community mental health teams'<sup>30</sup>.

## Training In Suicide Prevention

Staff training in suicide prevention has been shown to significantly reduce suicide rates and basic 'first aid' training for staff (including reception staff), families and, indeed, service users, brings obvious benefits<sup>27</sup>. Recognised suicide prevention training programs available in the UK include ASIST ([www.asist.org.uk](http://www.asist.org.uk)), and Chooselife ([www.chooselife.net](http://www.chooselife.net)). Mental Health First Aid training and Youth Mental Health First Aid training is now available to families, employers, care agencies and the emergency services, and both include a substantial suicide prevention component ([www.mhfaengland.org](http://www.mhfaengland.org) <<http://www.mhfaengland.org/>> ).

## Specific Interventions

### Medications

There is evidence that choice of medication can reduce the suicide risk in psychosis. Atypical antipsychotics appear more protective than conventional antipsychotics<sup>32,33</sup> (and Clozapine may specifically reduce suicidal ideation)<sup>34</sup>. Antidepressants appear to provide some benefit in post-psychotic depression<sup>35</sup> and are recommended in acute depressive psychosis<sup>36</sup> but not in acute phases of schizophrenia or schizoaffective disorders<sup>37</sup>. Lithium may reduce suicide risk in affective disorders<sup>38</sup>. Prescribing neuroleptic medication to young people for the first time should only be undertaken by experts experienced in this field. There is a high risk of unwanted side-effects and a negative first experience of psychotropic medication can have consequences for future concordance and may even lead to an increased risk of suicide.

Electroconvulsive therapy (ECT) is recommended in severe affective psychosis<sup>39</sup> and severe suicidal depression complicating schizophrenia spectrum disorders<sup>40</sup>.

### Psychological interventions

Debriefing after suicide attempts may help reduce subsequent morbidity<sup>41</sup>. Even where the attempt is not recent it may still be helpful to provide a form of debriefing to assist the person with coming to terms with what happened, understanding the reasons behind it and hopefully learning ways of preventing it happening again. However, it is essential to respect the healthy level of denial that some patients need to maintain. Repeatedly reigniting memories might in itself be potentially traumatizing.

Some cognitive interventions have been shown to reduce the rate of suicide in controlled trials. However, such findings are few and their effect appears to be small<sup>7</sup>. One cognitive oriented intervention, called LifeSPAN, has been specifically designed to address the issues

underpinning suicidality in early psychosis<sup>7</sup>. The therapy is designed for acutely suicidal patients and provided on an individual basis over a minimum of 10 weekly sessions. It begins with an explorative risk assessment with the service user in order to collaboratively formulate the person's rationale for considering suicide.

The remaining sessions target the underpinning factors as well as addressing hopelessness, psychoeducation about recovery and relapse prevention, obstacles to help seeking, and reasons for living. A randomised controlled trial of LifeSPAN suggests that such programmes may add to the benefits of standard care in reducing suicide risk<sup>7</sup>. Such forms of cognitive therapy should only be provided by specially trained therapists as it is possible that some standard cognitive interventions for psychosis may aggravate suicidality in some people.

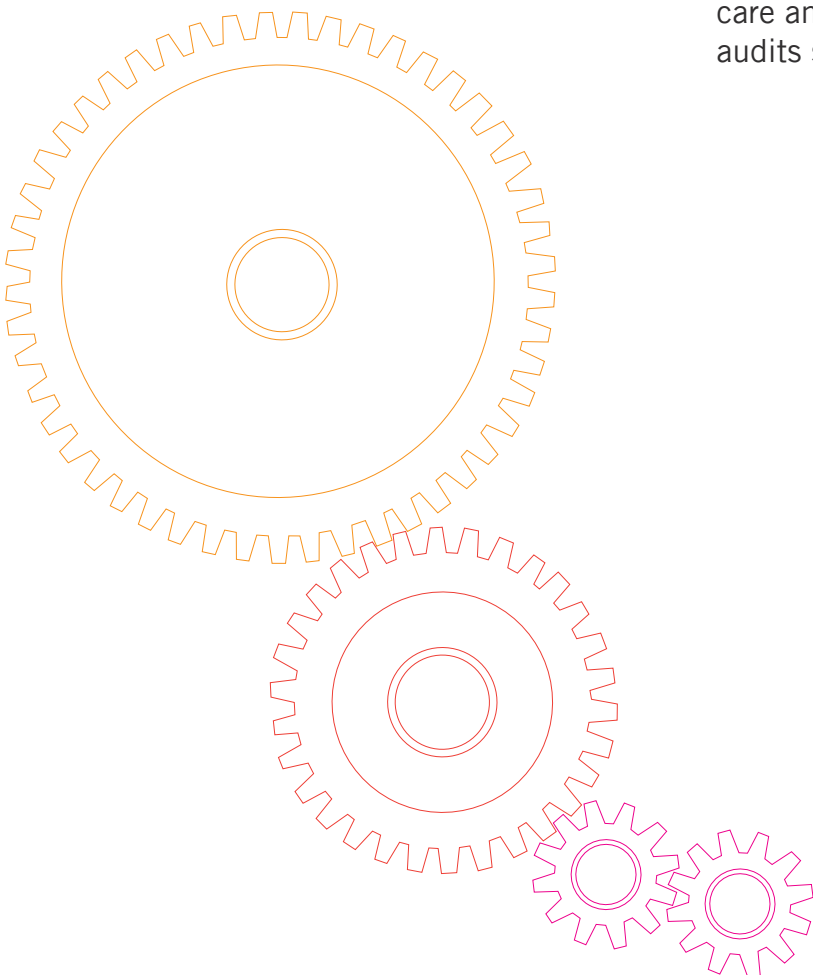
Other psychological interventions may reduce the risk of suicide in psychosis by addressing co-morbid conditions such as social anxiety, substance and alcohol use disorders. As yet there is no evidence of their impact on suicidality in patients with psychosis.

## Psychosocial interventions

Young people with psychosis are at high risk of dislocation from their normal course of personal and social development. Psychosocial interventions that support growth and instill hope and optimism are crucial to recovery<sup>42</sup>. Rehabilitative, vocational/educational and social interventions that address deprivation and exclusion and that restore confidence, social integration and a sense of purpose are likely to improve quality of life and reduce levels of secondary morbidity and suicidality. Practical support for housing and finances and parenting support can all help to reduce stress and social exclusion. In addition, family interventions such as psycho-education may reduce burden, 'high expressed emotion', family disintegration, and rejection, thereby protecting against the risk of suicide<sup>43</sup>.

## Preventable Issues

Preventable issues such as unchecked dispensing practices, medication storage, inadequate systems for the management of high risk clients, record keeping, staff supervision, cover for staff on leave, obstructive pathways to care and lack of adequate incident reporting/ audits should also be remedied.



# Conclusion

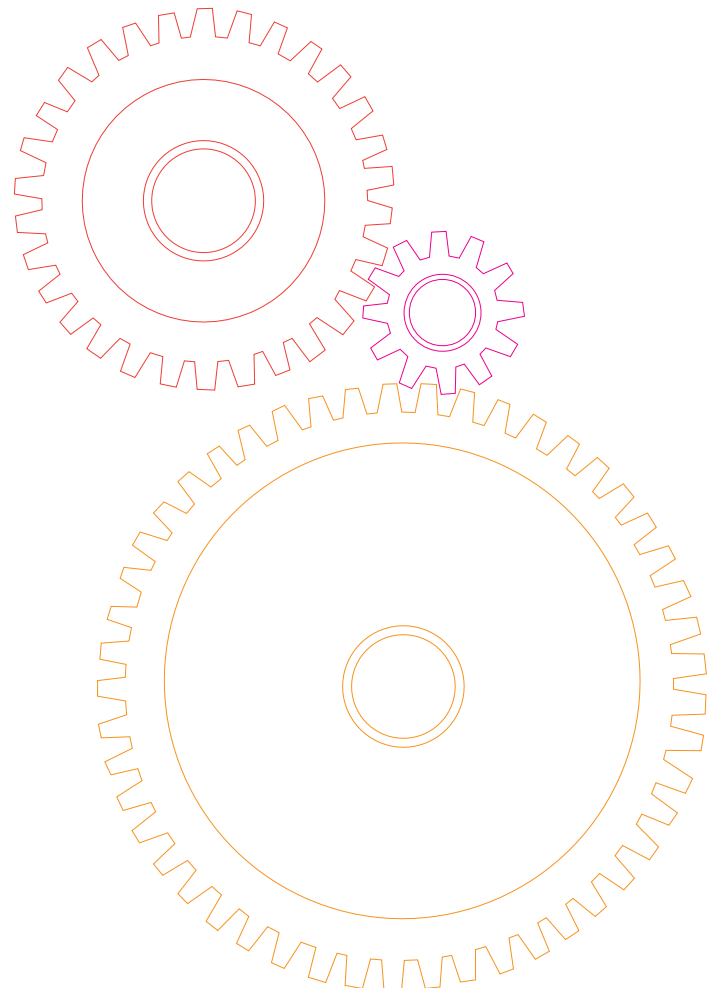
Suicide risk is one of the greatest challenges facing Early Intervention in Psychosis teams. The risk is particularly high and prediction is problematic. However, there is encouraging evidence that Early Intervention strategies can significantly reduce the risk. Suicide rates appear to be lower in patients attending Early Intervention services for follow-up compared to generic services though the effect may be lost once contact with the Early Intervention service is finished (usually after 3 years of follow-up). This suggests that for the benefits to be sustained, Early Intervention strategies need to be maintained through and possibly beyond the 'critical period' of follow-up.

The mainstay of suicide prevention in first episode psychosis is good, evidence based practice. This includes earlier detection, sustained engagement, individually tailored treatment plans, comprehensive psychosocial interventions during the critical phase of recovery with flexible risk management and systems of care. More specialised treatment interventions for suicide prevention may only have a limited additive effect.

There is still much to learn about suicide prevention in early psychosis. Our limited skills in prediction and targeted interventions for suicide prevention cannot be underestimated. In addition, the extent of unmet need and risk remains high not only in those already attending services but also in the as yet undetected population with emerging psychosis. In the early stages of psychosis we have the greatest opportunity for prevention and timely interventions can effect better recoveries and restore a sense of self. This might be the most challenging time in these young peoples' lives. We have a responsibility to them and their families and perhaps one of our most important roles, as Sue Estroff<sup>44</sup> says, is to be their 'guardians of hope'.

[ *Engaging service users in Early Intervention services reduces the risk of suicide. Early Intervention provides hope for a better future for many people and extra protection against these tragic incidents.*

*Dr David Shiers, GP Advisor on Early Intervention in Psychosis National Mental Health Development Unit*



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## Resources

Self-help books and for both suicidal service users and survivors of suicide:

**Choosing to Live**  
(Ellis & Newman, 1996)

**Stronger than Death: When Suicide Touches Your Life**  
(Chance, 1997)

**Questions and Answers about Suicide**  
(Lester, 1989).

**Help is at Hand**  
(Department of Health, 2008)

**After a Suicide**  
(Scottish Association for Mental Health, 2004:  
[www.samh.org.uk](http://www.samh.org.uk))

## Websites

**Friends for Survival:**  
<http://www.friendsforsurvival.org>

**Cruse Bereavement Centre:**  
[www.crusebereavementcare.org.uk](http://www.crusebereavementcare.org.uk)

**SAVE (Suicide Awareness Voices of Education):**  
[www.save.org/coping](http://www.save.org/coping)

**Mind:**  
[www.mind.org.uk](http://www.mind.org.uk)

**Child Bereavement Trust:**  
[www.childbereavement.org.uk](http://www.childbereavement.org.uk)

**The Compassionate Friends:**  
[www.tcf.org.uk](http://www.tcf.org.uk)

**SOBS (Survivors of Bereavement by Suicide):**  
[www.sobs.admin.care4free.net](http://www.sobs.admin.care4free.net)

**Interfaith Seminary – serves the spiritual needs of people from all faiths and none:**  
[www.theinterfaithseminary.com](http://www.theinterfaithseminary.com)

**American Association of Suicidology:**  
[www.suicidology.org/web/guest/home](http://www.suicidology.org/web/guest/home)

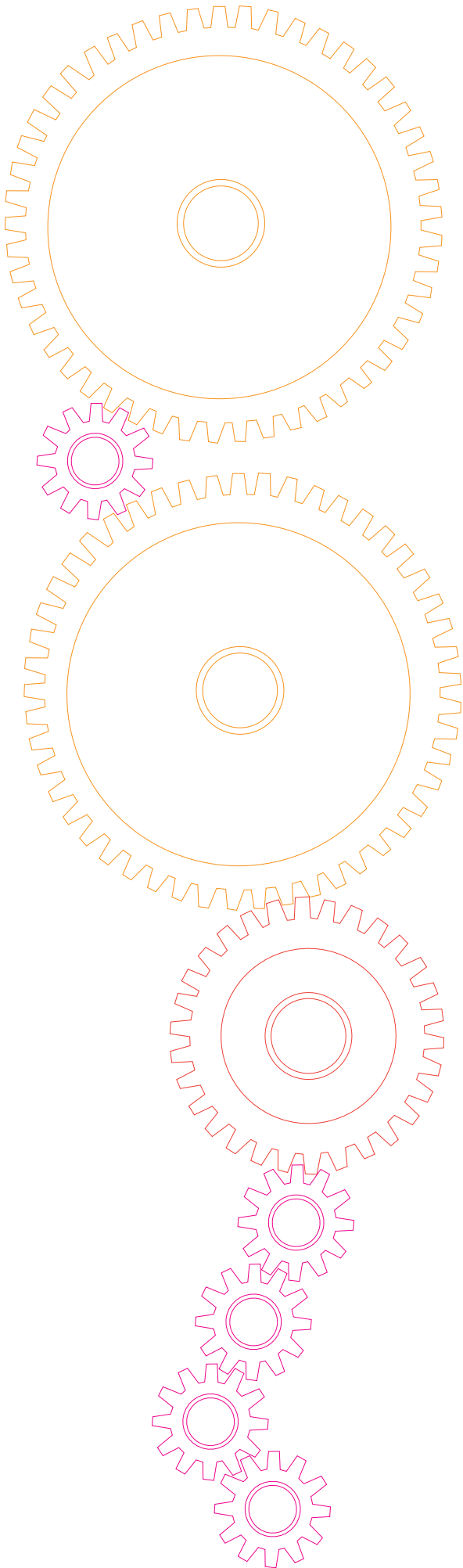
**The Suicide Education and Information Centre (Canada):**  
[www.suicideinfo.ca](http://www.suicideinfo.ca)

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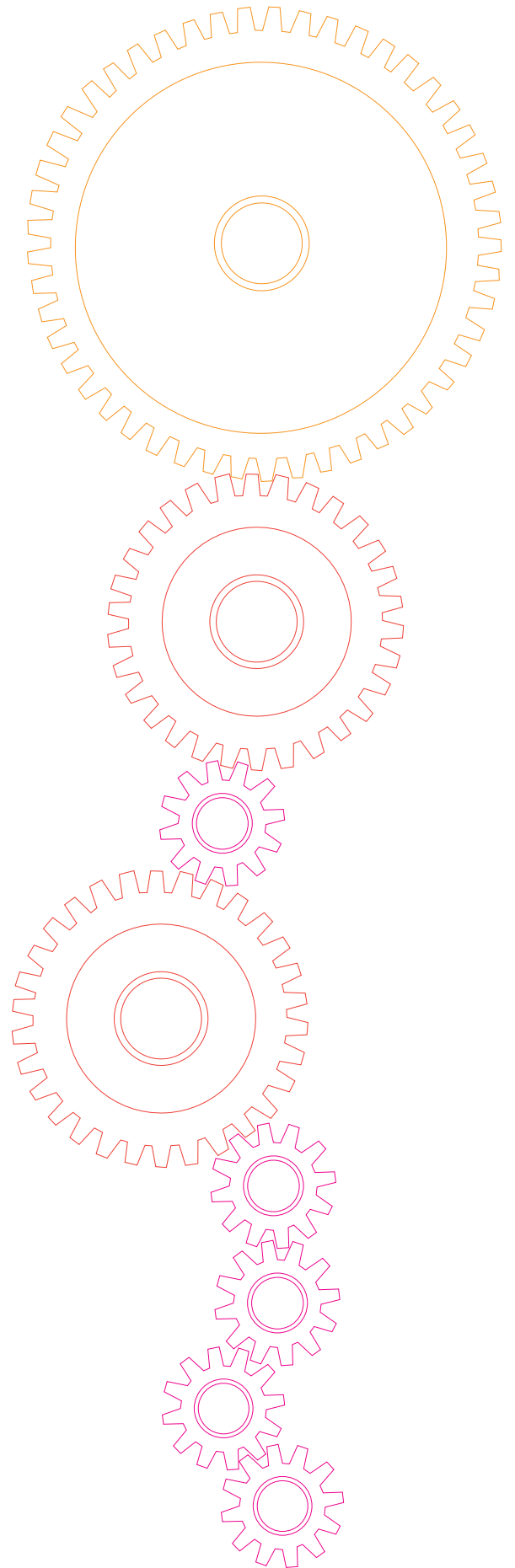
# Authors

Paddy Power

Child and Adolescent, Adult Consultant  
Psychiatrist & Honorary Senior Lecturer, Young  
Adult Service, St Patrick's University Hospital,  
James Street, Dublin 8, Ireland.

Stephen (Moggie) McGowan

Bradford District Care Trust Lead for Early  
Intervention in Psychosis and Early Intervention  
Lead, Yorkshire and the Humber Improvement  
Partnership.



# Appendix

## SIS: Suicidal Intent Scale

This interview-based or self-administered scale was designed to assess the intention to die among people who have attempted suicide. It has 15 items separated into circumstances related to the suicide attempt (e.g. presence of a suicide note) and self-report items (e.g. expectations of fatality). The first group of items can be completed retrospectively from case notes. Each item is scored on a three-point scale and cut-offs for severity are provided. Five additional items do not contribute to the overall score. There are no specific cut-offs and a positive response to any item should be a cause for concern.

[www.beckinstitute.org/](http://www.beckinstitute.org/)

## BHS: Beck Hopelessness Scale

This is a self-report scale, measuring an important suicide/self-harm risk factor that takes less than ten minutes to complete. There are 20 items assessing feelings about the future. Each item is a true/false statement and scored 0 or 1. Negative responses on each item are added together to give a total score out of 20.

[www.harcourt-uk.com/](http://www.harcourt-uk.com/)

## SSI: Scale for Suicide Ideation

This is a 21-item scale that can be self-administered or completed via an interview in about ten minutes. It is designed to assess the intensity of a person's attitudes with regard to suicide and their behaviours and plans to complete suicide during the past week. Some 19 test items are each rated between 0 and 2 and added together to yield a total score ranging from 0–38. Two additional items ask about previous suicide attempts and the seriousness of intent in the most recent attempt. The first 5 of the 19 items act as a screening filter. While a higher score is associated with a higher risk, there are no specific cut-offs, and a positive response to any item should be a cause for concern.

[www.harcourt-uk.com/](http://www.harcourt-uk.com/)

## STORM: Skills-based Training on Risk Management

STORM is a suicide prevention training package bought as part of an overall suicide prevention strategy by organisations or partnerships of organisations in statutory and voluntary sectors. It can be delivered on-site either in a short modular format or over one or two days. The package covers assessment, crisis management, crisis prevention and problem solving when working with potentially suicidal service users. A Children's & Young Person's version is available as well as the adult version. Facilitators are professionals, non-professionals or service users with relevant experience who have been trained to deliver the package in a cascade model.

[www.medicine.manchester.ac.uk/storm/](http://www.medicine.manchester.ac.uk/storm/)

## ASIST: Applied Suicide Intervention Skills Training

ASIST is a training programme developed in Canada that is designed to prepare caregivers from a wide range of settings in suicide 'first aid'. It consists of a two-day package on suicide risk management for caregivers which is interactive, intensive and closely related to practice. The aim is to prepare caregivers to recognise risk and develop skills to intervene to reduce the immediate risk. Awareness is raised on the importance of attitudes in this area and the resources available within local communities. The course includes learning about intervening to prevent the immediate risk of suicide. The programme has been run in a number of countries worldwide and has been adopted as a national suicide intervention training programme by the Scottish Executive.

[www.livingworks.net](http://www.livingworks.net)

