Florida Center for Survivors of Torture

Suicide Precaution
How to identify when levels of sadness or depression are a concern

Suicide happens in every country, amongst every population. Individuals of all races, creeds, income and educational levels die by suicide. There is no 'typical' suicide victim. Identifying depression and suicidal ideation in refugee clients can be difficult. Although suicide is not always predictable, there are precautions that the refugee service community can take to help their clients stay safe. For example, the suicide rate amongst Bhutanese refugees resettled in the U.S. is 31.5 per 100,000 in comparison to the overall suicide rate in the U.S. which is 11.1 per 100,000.* Often the first point of contact is the Case Manager. Case Managers see their clients regularly, and are likely to become aware of changes in mood and behavior. In addition, Case Mangers are seen, by their refugee client, as their 'go to' person. Their case manager has 'fixed' everything for them so far. If a client is going to disclose suicidal thought to anyone, they may well choose their Case Manager. This can cause numerous challenges for the Case Manager. Case Mangers may wonder, 'What should I do?', How can I help my client?', 'Should I refer my client to a therapist?', 'How can I suggest therapy in a delicate and culturally acceptable manner?' What if they say no?

What Can I Do?

In Preparation: Create a suicide precaution plan. It may seem that most of your clients are not traumatized, however being prepared for the few clients who may be suicidal can help. Please see a sample plan on page 3 of this factsheet.

At Refugee Orientation: Anticipate and normalize the challenges that lay ahead. Explain to clients that it is normal to feel sad at some point during the first several months after arrival. If they cannot seem to shake that feeling, it is normal to ask for help. Ask a client what they do that makes them happy. Encourage that behavior. If it is art or music, find ways to help them express their artistic talents. Normalize mental health therapy. Reassure clients that you are a resource, and you can help them access services to help. Explain that there might come a time when a different Case Manager will work with them. Sometimes a shift in case manager can be a disruption to a client. Begin explaining the discharge plan (from the first day), detaching abruptly from their case manager, at the end of the program can be very disruptful.

When a client starts showing signs of depression As the client's 'go to' person, they may have trouble understanding why you would want to refer them to someone else. Talk to them. Explaining what mental health counseling is, and even taking them to their first appointment to introduce them to the therapist can help. If your agency does not currently partner with a mental health agency, creating that link could be important. That way, if a client needs mental health services, you can speak with authority about who they will see and how the session will go. Knowing a mental health agency before hand will also give the Refugee Service Provider confidence that their client will be treated well at the agency they are referring the client to. Often when discussing the option of mental health therapy, it can be helpful to discuss it as simply talking to someone. Who did your client talk to in their home country when they felt sad? Here in the U.S. we often talk to someone like the person I want to introduce you to.

Who is at Risk? Refugees most at risk:*

Victims of Gender Based Violence	Members of vulnerable families identified as families of 3 or more Special needs- including families who have survived torture
Individuals with untreated mental illness – which makes it important for us, as service providers, to help clients access and accept the help they need	Individuals abusing alcohol or other drugs
Individuals experiencing family separation	Individuals with immediate family members who have committed suicide

* based on a recent IOM report on Bhutanese refugees

What signs or indications might my client give if he/she is depressed or suicidal?

Feelings of helplessness or hopeless	Sudden change of mood or behavior (ex. A client who used to dress very regally now dresses poorly or a client suddenly becomes aggressive- begins acting out)	Increased use of drugs or alcohol
Exhaustion / trouble sleeping	Poor self care (sudden loss of weight, lack of hygiene)	Social Isolation or isolating from Case Manager (not taking your calls)
Pre-occupation with death or dying	Giving away possessions- saying 'good bye'	Careless behavior, not caring about the consequences
Comparing one self to others successes and feeling inadequate or shame	Talking about suicide	Client starts to need their Case manager more (starts calling more often, seeking CM's approval)
Client seems 'checked out' emotionally	Lack of motivation	Change in attitude Example: everything went bad. Client first arrived and loved their new city. Now client sees nothing of value in their new city
Client becomes self destructive (self cutting, inflicting pain)	Change in body language (covering their face, crying)	Wanting to return to home country- even the chaos they left
Family attachments are suffering	No longer participate in activities that used to bring them joy	

What should I do if my client says he/she wants to kill him/herself?

DO: If a client states that they want to kill themselves, it is important to assess the degree of seriousness that this statement holds. Talk with your client. Find out if they have a plan for how they would kill themselves. If so, by what means would they kill themselves? If they state that they want to shoot themselves, find out if they have own or have access to a gun. Find out if the person has a support system in their life, who do they talk to? Your goal is to keep your client talking so you can get as much information as possible.

DON'T Do not, do anything to undervalue what your client is telling you. DO NOT say 'You don't really want to kill yourself' or anything that might devalue their feeling. This might shutdown the conversation, wherein your goal is to keep your client talking so you can get as much information as possible.

At what point should I call for help?

If a client is a danger to himself or others, it is necessary to call for help. Calling 911 or your local Mobile Crisis Unit can ensure that your client is adequately assessed by a mental health professional and may lead to the hospitalization of your client. Although hospitalization may seem scary, it may be the only way to keep your client safe.

Self -Care

Don't forget to ensure that you and your colleagues have the support you need to do the work. Participate in regular supervision and suggest group staffing in your office. Sharing a case with colleagues can often lead to new ideas and decrease the stress or the feeling that you are the only person working on a case.

Although you are an important part of your client's life, you cannot give them your full attention if you suffer from burn out!

Suicide Protocol

Any talk of Suicide should be taken seriously and should be discussed immediately with your supervisor.
All staff should be aware of standardized, "best practice" procedures for assessing and managing suicidal individuals.

Staff will assess for clients' risk. The following questions will determine the immediate risk for suicide.
HIGH TO SEVERE RISK
Imminent Danger signs to look for:
Having suicidal thoughts
A specific plan that is highly lethal
States he/she will commit suicide
Threatening to hurt or kill oneself
Looking for a way to kill oneself
Talking or writing about death
Plans and preparations for death
Giving away possessions
Stockpiling medication
Sudden interest in weapons/having weapons
Elaborate good-byes
Have their personal plans in order
A sudden calm
Past history of suicide attempts

Questions to ask
PLAN: Do you have a suicide plan?
MEANS: Do you have what you need to carry out the plan (pills, gun, rope etc)?
TIME: Do you know when you would do it?
INTENT: Do you intend to commit suicide?
If yes to any of these questions
Staff should do the following:

- **DO not leave the person alone under any circumstances**
- **Notify your Supervisor, Program Manager or Director immediately**
- **Call 911 or take the person to an Emergency room**
- **If possible remove pills, weapons, anything lethal**

Ask for assistance if possible

Moderate Risk
Take all suicide thoughts seriously
Assess the persons Plan-Means-Time- Intent
If:
PLAN The plan may not be specific or the client may have no definite plan
MEANS-not specific- person may be weighing the odds between life and death, undecided
TIME-unsure, considering suicide but uncertain as to when
INTENT: some level of intent but not a firm conviction or commitment to suicide. States that they won't commit suicide

Staff should do the following
Make a **specific safety** plan. Try to make a specific **safety plan** with the client. A safety plan is -an undertaking to follow an agreed upon course of action if feeling suicidal. Ask the client if s/he can give an assurance that he will follow this plan and not make a suicide attempt at least for a period of time. Give client the area's mental health crisis number. As part of the suicide prevention strategy try to eliminate ready access to means of self harm, e.g. the client agrees to hand over weapons or drugs to trusted person. Call your supervisor and follow directive. Connect client with psychiatrist and counselor, if they do not have one counsel client on beginning treatment within 24 hours. Monitor client, arrange follow up appointment with client

LOW RISK

PLAN-some suicidal thoughts, no plan, and states won't commit suicide, no past history
MEANS- no means, mixed thought, ambiguous
TIME: does not know when
INTENT: Low
Staff should do the following:
1. Inform supervisor
2. Develop plan for mental health services
3. Monitor client weekly for stability
4. Bi-weekly phone contact

Continue to monitor client for signs and symptoms

All staff will be aware and trained on the warning signs
Imminent Dangers
The signs that most directly warn of suicide include:
- Threatening to hurt or kill oneself
- Looking for ways to kill oneself (weapons, pills or other means)
- Talking or writing about death, dying or suicide
- Has made plans or preparations for a potentially serious attempt
- Giving away possessions

Other warning signs include expressions or other indications of certain intense feelings in addition to depression, in particular:
- Insomnia
- Intense anxiety, usually exhibited as psychic
- pain or internal tension, as well as panic attacks
- Feeling desperate or trapped -- like there's no way out
- Feeling hopeless
- Feeling there's no reason or purpose to live
- Rage or anger

Certain behaviors can also serve as warning signs, particularly when they are not characteristic of the person's normal behavior. These include:
- Acting reckless or engaging in risky activities
- Engaging in violent or self-destructive behavior
- Increasing alcohol or drug use
- Withdrawing from friends or family

Risk Factors
- Mental illness
- Alcoholism or drug abuse
- Previous suicide attempts
- Family history of suicide
- Terminal illness or chronic pain
- Recent loss or stressful life event
- Social isolation and loneliness
- History of trauma or abuse
- Socialcultural

1. Stigma
2. Cultural and religious beliefs
3. Influence of others

* This is the Gulf Coast Jewish Family & Community Services (GCJFCS) Suicide Precaution protocol. GCJFCS is a Community Mental Health organization. Any adoption of this or similar policy should be reviewed by a licensed mental health provider.

The National Partnership for Community Training and the Florida Center for Survivors of Torture are programs of Gulf Coast Jewish Family & Community Services. This publication was funded by the Office of Refugee Resettlement. For more information on this document and for Research purposes, please contact partnership@gcjfcs.org

The views herein may not necessarily reflect the views of ORR

REFERENCES

1. Ferrada-Noli, M. & Sundbom, E. (1996). Cultural bias in suicidal behaviour among refugees with post-traumatic stress disorder. *Nordic Journal of Psychiatry*, (50) 3, 185-191.

2. Rudmin, F.W., Ferrada-Noli, M. & Skolbekken, J. (2003). Questions of culture, age and gender in the epidemiology of suicide. *Scandinavian Journal of Psychology*, (44) 4, 373-381.

3. Kennedy, M.A., Parhar, K.K., Samra, J. & Gorzalka, B. (2005). Suicide ideation in different generations of immigrants. Canadian Journal of Psychiatry, 50, 353-356.

4. Wadsworth, T. & Kubrin, C.E. (2006). *Hispanic suicide in U.S. metropolitan Areas: Examining the Effects of Immigration, Assimilation, Affluence, and Disadvantage.* American Sociological Association, Paper presented at the annual meeting of the American Sociological Association, Montreal Convention Center, Montreal, Quebec, Canada Online <PDF>. 2009-05-25 from http://www.allacademic.com/meta/p103504_index.html

5. Staehr, M.A., & Munk-Andersen, E. (2006). Suicide and suicidal behavior among asylum seekers in Denmark during the period 2001-2003: A retrospective study. *Ugeskr Laeger,* (168) 17, 1650-1653.

6. Wenzel, T., Rushiti, F., Aghani, F., Diaconu, G., Maxhuni, B., & Zitterl, W. (2009). Suicidal ideation, post-traumatic stress and suicide statistics in Kosovo: An analysis five years after the war. Suicidal ideation in Kosovo. Torture, 19 (3), 238-247.

Suicide Prevention:
In August 2004, AFSP (American Foundation for Suicide Prevention) organized a workshop that was held in Salzburg, Austria. Hosted by the Salzburg Medical Seminars, this international workshop brought together 22 representatives of countries that have developed, or are currently developing, a national suicide prevention plan, including Australia, Belgium, China, Denmark, Estonia, Finland, Germany, Hong Kong, Hungary, Israel, Japan, New Zealand, Norway, Slovenia, Sweden, Switzerland and the United States. Also attending was a senior representative of the World Health Organization. The specific goals of the workshop were to examine the evidence pointing to the effectiveness of specific components in the various national plans, and to identify specific measurable outcomes for national suicide prevention interventions. Presentations and discussions were organized into eight panels:

- Cultural Barriers to Suicide Prevention
- Creating Public Awareness of Depression as Treatable and Suicide as Preventable
- Educating Community Gatekeepers
- Reducing Access to Lethal Means and Methods of Self-Harm
- Screening Programs for Identifying Suicide Risk
- Physician Education Related to Recognizing and Treating Depression
- Improving Treatment of Depression and Other Disorders That Convey Suicide Risk

Improving Portrayal of Suicide in the Media
Report is found here:

http://www.afsp.org/files/Misc_//JAMA.National_Strategies.pdf

Standardized PPT's on suicide prevention:

http://www.afsp.org/index.cfm?page_id=598DA610-DC4C-A681-45A4701729BA0C93