ESMI TTA CENTER

SAMHSA's National Training and Technical Assistance Center for Early Serious Mental Illness

Suicide Prevention Best Practices for Individuals at Clinical High Risk for Psychosis or Experiencing First Episode Psychosis

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Webinar Overview

I. Opening Remarks
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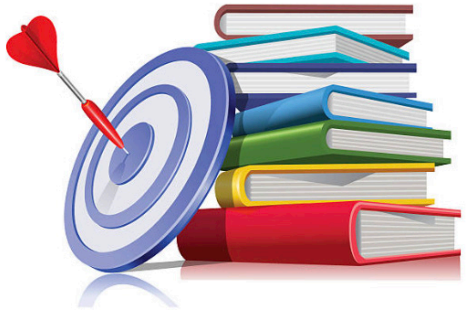
Learning Objectives

- Guidance for mental health providers and clinical supervisors on implementing effective, evidence-based suicide prevention interventions for individuals at clinical high risk for psychosis (CHR-P) or experiencing first episode psychosis (FEP)
- Development of suicide prevention protocols
- Information on universal screening, assessment, and monitoring, the 988 Suicide and Crisis Lifeline, and other resources



Definition: Clinical High Risk for Psychosis

Risk for developing FEP is the time preceding threshold levels of psychosis

Genetic vulnerability

- Presence of certain genes (dopaminergic or glutamate functioning, brain development, polygenic)
- First degree relative(s) who have experienced psychosis
- Genetic risk and deterioration syndrome: Genetic risk AND recent functional deterioration

Basic symptoms or cognitive disturbances

- Subjectively experienced disturbances in thought, affect, motor functioning, bodily sensation, perception, and tolerance of stress

Sources: Andreou et al., 2023; Fusar-Poli et al., 2013, Fusar-Poli et al., 2016; Schultze-Lutter et al., 2015)

Definition: Clinical High Risk for Psychosis (continued)

Attenuated positive symptoms:

- Positive symptoms of subthreshold severity (e.g., speaking in a confusing manner, hearing faint noises, or seeing fleeting shadows)

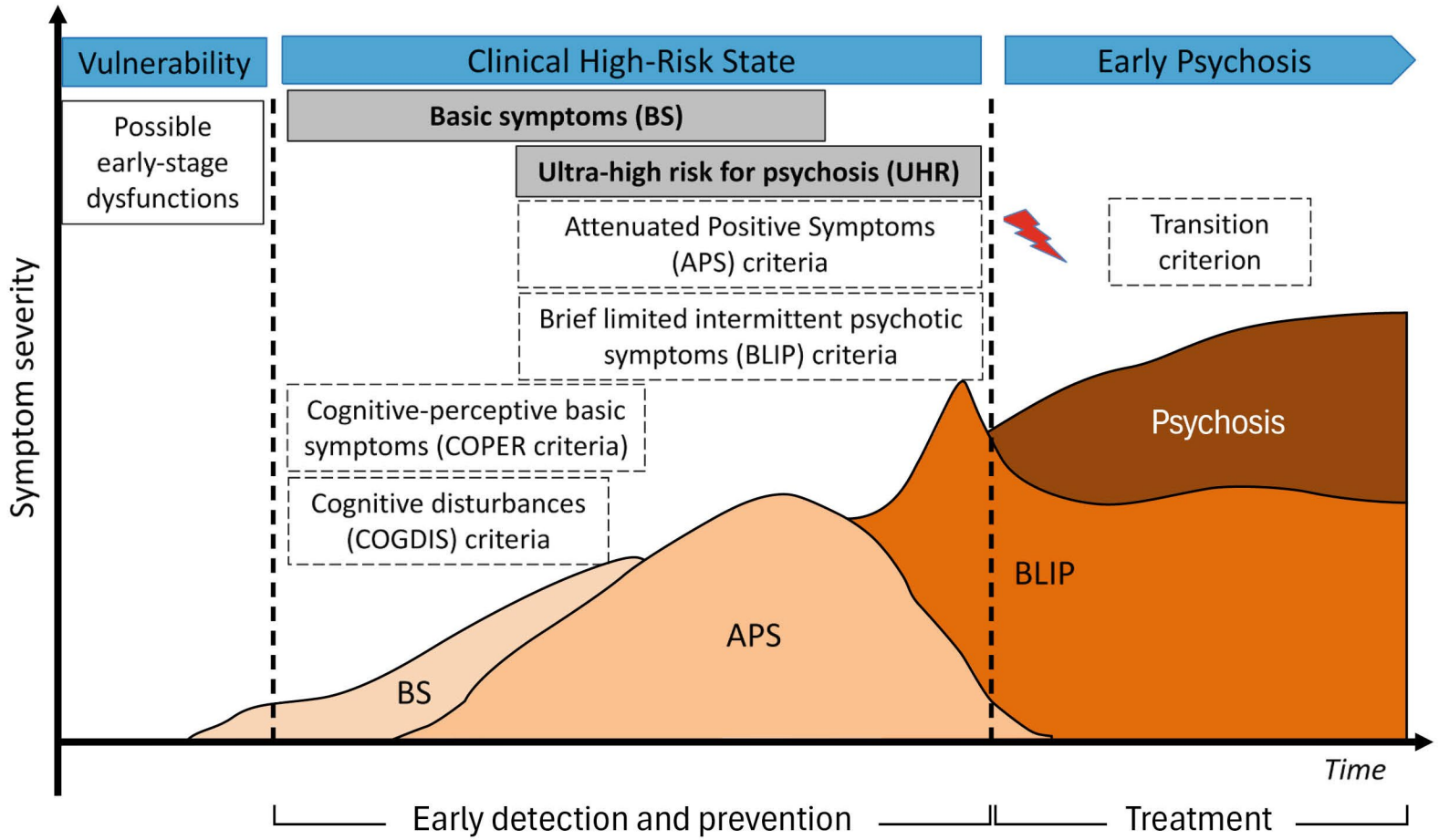
Brief (and limited) intermittent symptoms:

- Typical symptoms of psychosis of short duration that remit spontaneously (e.g., symptoms that are less intense or frequent)

Definition: First Episode Psychosis

Individuals experiencing their first episode of threshold symptoms and/or meeting diagnostic criteria for a psychotic disorder for the first time

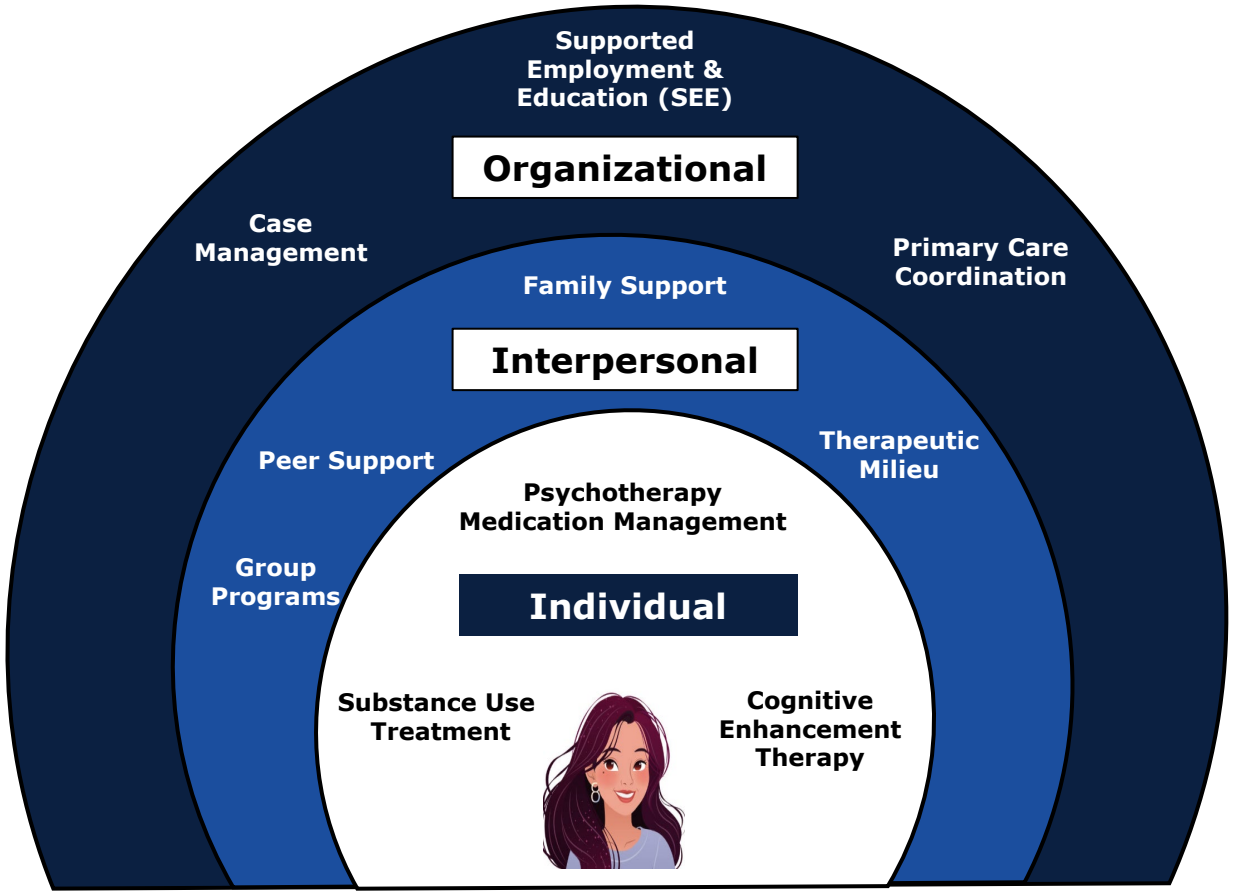
Clinical High Risk for Psychosis and First Episode Psychosis Vary in Severity and Time Course



Model of the severity- and time-specific course of psychosis including basic symptoms and ultra-high-risk states. (Smiegielski et al. adapted the figure from Fusar-Poli et al. (2013) and used it with the authors' permission. Some modifications were made to the figure for Section 508 compliance.)

Sources: Fusar-Poli et al., 2013; Smiegielski et al. 2022

Why the Interest in Clinical High Risk for Psychosis and First Episode Psychosis?



Components of Care for Early Psychosis

- CHR-P period represents an opportunity for **prevention and early intervention**
- FEP period represents an opportunity for **early identification** and **treatment**

- **Goal:** Improve the psychosocial trajectory of vulnerable individuals
  - Longer duration of untreated illness is associated with greater negative outcomes

Sources: Massachusetts Psychosis Network for Early Treatment (MAPNET); Howes et al., 2021

Suicide Risk in Clinical High Risk for Psychosis and First Episode Psychosis (1 of 2)

- Individuals diagnosed with a psychotic disorder have a nearly **5-fold increase in dying by suicide**
  - 25 percent to 50 percent attempt suicide
  - 5 percent to 13 percent die by suicide
  - Highest risk is during illness onset

- Suicide risk for young people at CHR-P or experiencing FEP is **2.7 times higher** than older adults diagnosed with a psychotic disorder
  - Up to 65 percent of individuals at CHR-P and 75 percent of individuals experiencing FEP endorse current suicidal ideation; typically related to negative symptoms and level of functioning
  - 22 percent of individuals at CHR-P report at least one lifetime suicide attempt
  - 8 percent to 10 percent of individuals experiencing FEP attempt suicide during early stages of treatment

Sources: Olfson et al., 2021; Moe et al., 2022; Palmer et al., 2005; Pompili et al., 2007; Power et al., 2003; Gill et., 2015; Haining et al., 2020; Pfluger et al., 2025

Definitions: Suicide and Unintended Self-Harm

Suicide

Suicidal behavior: Any action taken toward ending one's life

- **Suicide attempt:** A deliberate action taken with at least some intention to end one's life
- **Preparatory behavior:** Obtaining access to means, writing a suicide note or will, saying goodbye, giving away prized possessions
- **Interrupted attempt:** When someone engages in behavior to end their life, but they either stop themselves or someone or something stops them

Unintended Self-Harm

(Potentially) dangerous behavior *without* the intention of ending one's life but a result of psychotic symptoms

- Jumping off a building due to delusional beliefs about being able to fly
- Drinking bleach to cleanse oneself due to delusional beliefs about being dirty or having sinned
- Hurting oneself because the voices say it is the only way to keep your family safe
- Cutting oneself due to believing that one has an implanted recording device
- Walking into traffic due to disorganization

Suicide Risk in Clinical High Risk for Psychosis and First Episode Psychosis (2 of 2)

The earliest phases of psychosis are a **particularly** vulnerable time for suicide

Early Psychosis-Specific Risk Factors

- Not yet on effective medication or medication changes or discontinuation
- Escalation of psychotic symptoms that could lead to dangerous behavior
- Desire to escape intolerable symptoms
- Agitation or panic as a result of symptoms
- Feeling as though they cannot live with the consequences or aftermath of their behavior while they were experiencing symptoms of psychosis
- Feeling hopeless

Traditional Risk Factors for Suicide Particularly Pertinent for CHR-P/FEP

- History of self-harm
- Substance misuse
- Comorbid mental health conditions (depression, anxiety)
- Care transitions
- Trauma
- Agitation
- Sleep disturbance
- Isolation
- Hopelessness
- Perceived burdensomeness
- Feeling trapped

Best Practices for Suicide Prevention in Clinical High Risk for Psychosis and First Episode Psychosis

Despite the high suicide risk for individuals at CHR-P or experiencing FEP:

- Most suicide prevention best practices were *not* developed with or for persons at risk for psychosis
- Interventions for suicide prevention in early psychosis are understudied
- Evidence-based suicide prevention protocols do not typically include guidance on important adaptations for psychosis

Assess, Intervene, and Monitor (AIM) for Suicide Prevention:

Adaptations to suicide prevention best practices for individuals at CHR-P or experiencing FEP

What Should an Early Psychosis Suicide Prevention Protocol Include?

To identify best practices for suicide prevention among individuals:

- Reviewed extant literature on suicide prevention in early psychosis
- Reviewed evidence-based suicide prevention protocols, including the Zero Suicide model and coordinated specialty care protocols
- Held discussions with experts
  - Coordinated specialty care team leaders, clinical and peer support specialist trainers, and team members
  - Doctoral-level clinicians and researchers with expertise in both FEP and suicidality
- Conducted qualitative interviews via teleconference with:
  - 13 clinicians who treat clients experiencing FEP throughout the OnTrackNY network
  - 4 peer specialists who work with clients experiencing FEP
  - 12 individuals experiencing FEP who made a suicide attempt or experienced significant ideation
- Interview participants were sought until themes reached saturation; interviews were transcribed, and all data were coded using a grounded theory approach

Assess: Universal Screening and Assessment

- Due to heightened risk for suicide and unintended self-harm (SUSH), **universal screening and comprehensive risk assessment are critical**
  - Screen everyone in behavioral health settings for SUSH thoughts and behaviors and symptoms of psychosis
  - Do not rely on spontaneous self-report
  - Typical suicide screening tools are insufficient (do not assess for unintended self-harm)
- **Important components of suicide risk screening and risk assessment for early psychosis:**
  - Encourage disclosure by building rapport, being collaborative, and adopting a direct, matter-of-fact style when asking about suicidal thoughts and behaviors and unintended self-harm
  - Provide a rationale for why and how often the screening or assessment is being done
  - Be prepared to break down concepts to ensure the individual understands the questions
  - Get collateral information whenever possible (e.g., treatment providers, family, records)

Assess: Universal Screening and Assessment (continued)

- **Include questions about unintended self-harm, in addition to screening for suicide risk**
  - *Example:* At any point in your life, have you had thoughts of doing something where you could end up getting hurt without meaning to end your life? (This may include behaviors where others thought you may get hurt even if you didn't think so.)

Assess: Comprehensive Suicide Risk Assessment (CSRA)

- If someone denies recent suicidal or unintended self-harm thoughts and behaviors, it does **NOT** necessarily mean they are not at risk → Need a broader case conceptualization to optimally determine risk
  - For those who **do not** endorse ideation, **ONLY** a comprehensive assessment can detect elevated risk
  - Not all clients are willing or able to disclose their thoughts
  - Individuals not experiencing SUSH thoughts today could be one acute stressor away from having them tomorrow
- Risk fluctuates over time, so assessment must be **ongoing**
- **Comprehensive** means assessing *all* categories of risk factors and protective factors, not just screening
- Information gleaned from CSRA can help providers:
  - Anticipate crises and establish measures to maintain safety
  - Make better shared decisions about triage and treatment planning
  - Work with clients to reduce modifiable risk factors and enhance modifiable protective factors

Assess: Risk Level Determinations

- Individuals at CHR-P or experiencing FEP are at elevated **chronic risk** relative to the general population, but that is not always a great predictor of who is at highest risk and needs support in the short term
- Recommended to avoid high-medium-low risk determinations and instead focus on **acute risk** (not currently elevated vs. currently elevated)

Not Currently Elevated Risk:

- Few proximal or acute risk factors present or anticipated
- **No acute warning signs** present or anticipated
- **No suicidal ideation** or intent
- **No symptoms of psychosis** likely to result in **dangerous behavior or unintended self-harm** (e.g., command hallucinations to hurt self or others, delusions that could increase the likelihood of dangerous behavior, severe disorganization)
- Strong **protective factors**
- Symptoms of psychosis that are **not prominent or are manageable**

Risk Level: Currently Elevated Risk

- Numerous acute/imminent proximal risk factors or warning signs
- Risk factors outweigh protective factors
- Protective factors either absent or not prominent
- Presence of SUSH ideation with intent (with or without plan)
- Recent SUSH behavior
- Has access to means (or could easily obtain access)
- Increased substance use, agitation, or sleep disturbance
- Recent traumatic event or victimization
- Recent or anticipated shifts in care (e.g., emergency department/ inpatient discharge, clinician change, end of programming)
- Recent or anticipated life stressor or loss

Presence of multiple **FEP-specific risk factors**

- Command auditory hallucinations related to suicide or dangerous behavior
- Delusions that could increase the likelihood of dangerous behavior or unintended self-harm
- Severe disorganization that could lead to risk for unintended self-harm
- Increased erratic behavior or agitation
- Significant distress from symptoms of psychosis or desire to escape psychotic symptoms
- Shame, hopelessness, or perceived burdensomeness (particularly related to consequences of their early psychosis diagnosis or behavior while symptomatic)

Universal Interventions: What Everyone at Risk Should Receive (1 of 2)

Psychoeducation: Provide information to all individuals *and* their family/supports regarding:

- Warning signs of SUSH and how SUSH risk fluctuates
- What symptoms of psychosis are and signs of escalating episodes
- Treatment options for managing risk, including risk escalation
- Rationale that understanding warning signs and triggers can help prevent crises and establish measures to maintain safety

Provide crisis information to all individuals *and* their supports, regardless of risk status:

- Include helpful contacts that can be used during a mental health crisis, such as provider's crisis number, location of a local comprehensive psychiatric emergency program or emergency department, contact information for mobile crisis or emergency drop-in care if available
- National 24/7 resources such as the **988 Suicide and Crisis Lifeline**

Case Management: Connect individuals to additional community supports (e.g., financial or housing assistance) for a comprehensive approach to recovery

Universal Interventions: What Everyone at Risk Should Receive (2 of 2)

Engagement of Family and Other Supports: Enhance safety by providing support to both the individual *and* the treatment team

- Encourage family and supports to be involved in psychoeducation, means reduction, and treatment
- Educate family on what to expect regarding suicide risk, how to best support the participant, de-escalation techniques, and when to contact emergency services

Integration of Peer Specialists (if available): Peer specialists have a valuable role

- Inspiring hope
- Validating complex emotions and experiences
- Providing instrumental and emotional support in navigating health care
- Teaching coping skills and identifying reasons for living
- Enhancing social connections

Development of Distress Tolerance and Coping Skills: Improve quality of life and ability to manage mental health crises

- Social, academic, or occupational achievement as "reasons for living"

Universal Monitoring: What Everyone at Risk Should Receive

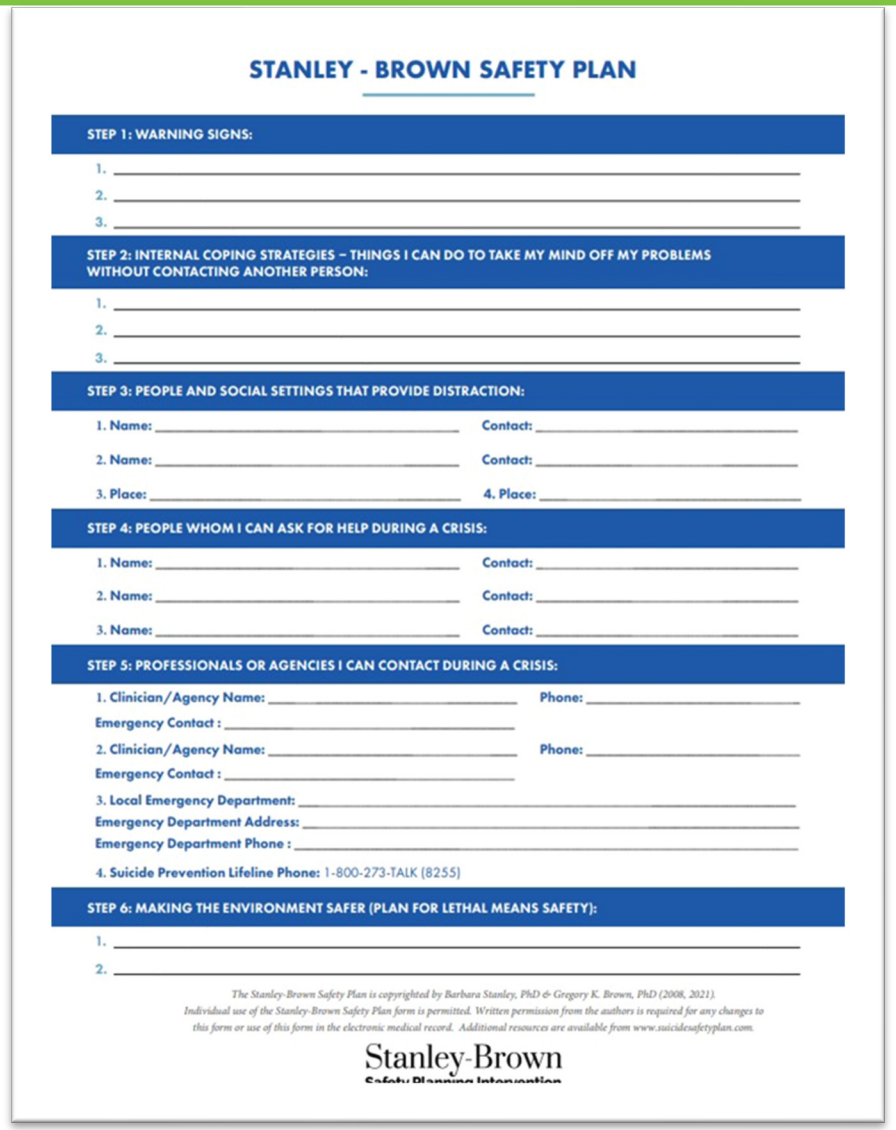
Rescreen all individuals at least quarterly (and according to clinical judgment):

- Include questions about SUSH
- Remember that all individuals experiencing FEP are at elevated **chronic risk** relative to the general population and other mental health outpatients; risk is not static
- Give all individuals an equal opportunity to disclose
- Maintain ongoing vigilance throughout treatment; cannot allow other goals to take precedence over safety

Increase clinical contact during high-risk periods (i.e., within 48–72 hours of):

- **Shifts in care** (discharge from an inpatient unit, comprehensive psychiatric emergency program, or emergency department) are a particularly high-risk period for SUSH
- **Large life stressors**, such as pending incarceration, disciplinary problems, or homelessness; anniversaries; medication changes; loss of employment or educational opportunities; unintended pregnancy; loss of an important relationship; and death of a loved one

Interventions for Elevated Risk: Safety Planning



STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Place: _____ 4. Place: _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Name: _____ Contact: _____

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
2. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
3. Local Emergency Department: _____
Emergency Department Address: _____
Emergency Department Phone : _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. _____
2. _____

Stanley-Brown

Source: Stanley-Brown Safety Plan

- Written prioritized list of coping strategies and sources of support to help prevent or de-escalate suicidal or unintended self-harm behavior
  - Includes counseling on access to lethal means
- Although the standard use of the safety plan is for suicidal crises, it can be modified to address symptoms of psychosis, unintended self-harm, and FEP-specific warning signs similar to psychiatric advance directives
- Emphasis on obtaining crisis narrative and providing psychoeducation on the suicide risk curve
- Focus on family and social support involvement in all aspects of safety planning

Interventions for Elevated Risk: Suicide-Specific Treatment Planning

- Treating underlying psychopathology like psychosis or depression is not enough to reduce suicide or unintended self-harm risk
- Focus on developing goals, treatment targets, and interventions to target suicidal ideation and unintended self-harm **directly**
- Reach shared decisions with the individual (and ideally with family or other supports)
- Directly target suicidal and unintended self-harm thoughts and behaviors
- Reduce risk factors and drivers of suicidal and unintended self-harm thoughts and behaviors
- Enhance protective factors and reasons for living

Interventions for Currently Elevated Risk

Increased Clinical Contact

- At least weekly sessions with the primary clinician
- More frequent and/or longer sessions
- Multiple contacts per week with the primary clinician and/or other team members
- More frequent planned "check-ins"
  - In person, via text, or over the phone
  - Evenings, between sessions, over the weekend, on "anniversaries," after care transitions
- Encouraged participation in other supports
  - Group therapy or support groups
  - Peer support
  - Respite care
- Outreach to family or other supports (with consent)
- Home or community visits

Optimizing Psychotropic Interventions

- Psychiatric care providers should be cognizant of SUSH risk and alter prescribing practices to reduce potential for self-harm

  Examples: Prescribing clozapine, prescribing smaller quantities, switching to long-acting injectables, etc.

Monitoring for Currently Elevated Risk

Screen Every Session

- **Why?** If an individual is not suicidal today, it does not mean they will not be suicidal tomorrow; ongoing vigilance is required for those at elevated risk
- Screening should be a clinical interaction in a conversational manner, such as a weekly check-in about concerning or important symptoms

Same-Day Phone Contact for No-Show

- **Why?** Individuals are at a significantly heightened risk for harm anytime there is a break in continuity of care, including missed appointments
- If an individual at currently elevated risk misses an appointment without calling to cancel or reschedule, use **structured follow-up and monitoring** outreach:
  - **Step 1:** Mood check and risk assessment
  - **Step 2:** Review and revise safety plan
  - **Step 3:** Treatment engagement and motivation
  - **Step 4:** Obtain consent/willingness for additional follow-up

General Recommendations

- Care for individuals at CHR-P or experiencing FEP often includes several approaches beyond what is typically provided in outpatient behavioral health settings
  - Case management and care coordination services
  - Multidisciplinary teams (e.g., supported employment or education services, peer support, medication management and psychotherapeutic interventions all in the same place)
  - Engagement of family and other supports
  - Peer support
  - Frequent clinical contact and monitoring of high-risk clients
- "Regular" outpatient behavioral health settings may need to provide additional supports to those at risk or experiencing early psychosis
- Even among coordinated specialty care, "what works" needs to be systematized across programs (e.g., substantial variance in procedures between and within programs)
- Even excellent programs can benefit from:
  - More emphasis on "upstream" prevention, family engagement, and coordination
  - Additional training for clinicians in risk assessment, safety planning, trauma-informed care, cognitive behavioral therapy for psychosis, or dialectical behavior therapy principles
  - Role-specific guidelines, including those for optimal prescribing practices

Summary

We need more training and nuance in screening and risk assessment

- Screening for suicidal thoughts and behaviors with standard tools (e.g., Columbia Suicide Severity Rating Scale) is not enough
- Greater awareness of **FEP-specific risk factors**, as well as traditional risk factors that are particularly pertinent for this population
- Ongoing risk assessment **throughout treatment**
- **Relationship building** is vital—without good rapport and trust, clients will not disclose symptoms

Helping individuals develop protective factors and reasons for living is integral to prevention services and recovery-oriented care

- Different roles and team members have varied but equally important skill sets to share
- Framing educational, occupational, and social goals as "reasons for living" connects suicide prevention to client-centered goals

Suicide prevention must be the bedrock of recovery-oriented, client-centered care

- Empowering individuals to develop mastery over their symptoms promotes recovery
- Although individuals may have many goals for treatment, keeping them safe needs to be the primary concern and cannot "take a backseat" to educational or occupational attainment; safety **must** be maintained to achieve other goals
- Providers need to maintain vigilance regarding suicide prevention throughout treatment

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ESMI TTA CENTER

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