Nova Scotia Health Authority

Clinicians Guide to Suicide Risk Assessment and Management

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Chapter I

Purpose and Background
Purpose

This document is developed to provide mental health clinicians with a comprehensive guide to expand their clinical understanding of suicide risk assessment and management. Clinicians are encouraged to review the literature and study other educational or competency enriching materials to improve their clinical understanding of suicide risk assessment and management.

Background

1.1 Introduction

Suicide is now understood as a multidimensional determined outcome, which results from a complex interaction of biological, genetic, psychological, sociological and environmental factors. Not all of these factors are present nor are they equally weighted in all suicides. Thus, the outcome of any one suicide may be the result of factors or weighting of factors that can be different from those related to any other suicide.

Close to 4000 people die by suicide each year in Canada. According to a Public Health Agency of Canada report in 2006, suicide accounts for the cause of 1.7% of all deaths in Canada. The reporting of death by suicide is assigned by coroner deliberation. However, this statistic does not take into consideration those suicides wrongly reported as accidental deaths or cases where it is difficult for a coroner to appropriately assess whether or not the death was intentional. While this consideration is often made with the implication that wrongful classification of suicide death may be common, there is no reliable data to currently support that interpretation and there is no evidence that in Canada, coroners are currently not correctly reporting deaths as occurring by suicide when the are actually the result of suicide.

Among Canadians, adults aged 15 years and older, about 3% will have attempted suicide in their lifetime. Suicide is a leading cause of death among young people (those between the ages of 15 and 24 years), but the rates of suicide in this age group are about half of those between ages 40 and 60 years, where suicide is not a leading cause of death. The reason that suicide is proportionally so much higher in young people is because other causes of death are low in this population. Suicide rates are much higher in some, but not all, aboriginal/first Nations communities. They are also higher in some sub-populations such as those with substance abuse and those who self-identify as LBGTQT.
Suicide is a highly emotional topic and while suicide is a rare event, (current Canadian rates are about 10-12/100,0000) the experience of suicide can touch almost every person, family and community. There exists a stigma related to suicide and this stigma may be a barrier to help-seeking for individuals who are contemplating suicide. (Ref: Health Canada www.hc-sc.gc.ca)

1.2 Epidemiology

Worldwide.
According to the World Health Organization (WHO), suicide is globally among the top 10 causes of death and the second leading cause of death in people aged 15–29 years. In 2012, about 804,000 people died by suicide globally, accounting for 1.4% of deaths worldwide with an average population rate of about 11.4/100,000..1

There are wide variations of suicide rates reported across different countries and suicide risk factors are not the same in every location. In high income Western countries (eg: Europe, Scandinavia, Australia, New Zealand, Canada, USA) suicide rates are about three times higher in males than in females, and individuals who have a mental illness are at much higher risk for suicide (table1). Risk factors that appear to be universal include youth or old age, a mental disorder, low socioeconomic status, substance use, and previous suicide attempts. Mental disorders occupy a premier position in the matrix of causation, although their relative contribution to suicide differs across countries. (Patel V. et al 2015)

The United States
In the United States, suicide is the 10th leading cause of death for all ages. More than one person dies by suicide every 15 minutes in the United States (US DHHS, 2012). In 2011, over 8 million adults reported having serious thoughts about suicide and over 1 million reported a suicide attempt (SAMSHA, NSDUH Report, 2011).

In 2015, Suicide is the third leading cause of death among persons aged 10–14, the second among persons aged 15–34 years, the fourth among persons aged 35–44 years, and the seventeenth among persons 65 years and older (CDC).

Canada

In Canada suicide is a major cause of premature and preventable death. It is estimated that in 2009 alone, there were about 100,000 years of potential life lost to Canadians under the age of 75 as a result of suicide (Statistics Canada).
In 2012, approximately 3900 death in Canada were attributed to suicide. This resulted in suicide rate of 11.3 deaths per 100,000 people. (2,972 male compared to 954 females or rate of 17.3/100,000 for males versus 5.4/100,000 for females.

Suicide rates in adolescents (ages 15 – 19) have risen from a low of about 7/100,000 in 2005 to 10/100,000 in 2012. Suicide is more common in men and the age group with the highest rates is the cohort between ages 45 – 64 years (twice the rate of youth ages 15 – 14 years). However, suicide is proportionally a more common cause of death in the younger cohort.

There are provincial differences in suicide rates, for example in 2009: Ontario rate was 9/100,000. Quebec 12.5/100,000. British Columbia 10.2/100,000

Rates of suicide and suicidal ideation are high in some First Nations communities and even higher in some Inuit communities. Among First Nations communities, suicide rates are twice the national average, and show no signs of decreasing. Suicide rates among Inuit are even higher than among First Nations, at 6 to 11 times the Canadian average. In Nunavut, rates are so high that 27% of all deaths since 1999 have been suicides. Nunavut=s suicide rate—already one of the highest in the world—continues to rise, especially among youth. (www.publichealth.gc.ca).

There are significant differences in suicide rates within aboriginal/First Nations communities with some demonstrating high rates and some with rates well below the Canadian rate. Another group of Canadians, LGBTQT, have higher suicide rates than the national average.

**Nova Scotia**

According to Statistics Canada in 2013, Nova Scotia Suicides and self-inflicted injuries, deaths rate per 100,000 population was estimated to be 9.1 (15.4 male and 3.3 female).

1.3 The Burden and cost of suicide

The psychological and social impact of suicide on the family and society is immeasurable. On average, a single suicide intimately affects at least six other people. If a suicide occurs in a school or workplace it can have an impact on many of those who are present or on site in those locations. Some high profile suicides can have substantial impact on communities as well.
The burden of suicide can be estimated in terms of DALYs (disability-adjusted life years). According to this indicator, it was responsible for 39 million disability adjusted life years in 2012.

**The Cost of Suicide**

**The United States**

The national cost of suicide and suicide attempts in 2013 was $58.4 billion based on reported numbers alone costs and the average suicide costs $1,164,499 (CDC).

**Canada**

The estimated financial cost of a suicide ranges from $433,000 to $4,131,000 per individual, depending on potential years of life lost, income level and effects on survivors. (Mental Health Commission Report, 2016. Mentalhealthcommission.ca)

**Estimating the cost of suicide**

Total cost of suicide is the combination of direct and indirect costs. Examples of direct costs include: services for ambulance, police investigation, hospital, physician, autopsy, funeral and cremation. If it is attempted suicide, but not completed, other costs may include psychotherapy, rehabilitation and drug treatments.

Indirect costs: indirect costs are productivity losses that society must bear over time: they can be thought of as discounted future earnings due to potential years of life lost. In case of suicide attempts, costs can also include: informal care, social welfare costs, and costs due to homelessness or unemployment.

**1.4. Understanding suicide risk assessment and suicide risk management**

Suicide risk assessment and suicide risk management are clinical competencies that are applied by mental health and health care providers throughout the period of patient care. Suicide risk assessment refers to the health provider’s evaluation of suicide probability for a patient that occurs at every point of patient contact. This assessment can be applied with various degrees of intensity and can be assisted by the use of certain assessment tools that can be
applied in specific situations. Not every point of patient contact requires the same degree of risk evaluation, but every point of patient contact requires a degree of risk evaluation. The degree of evaluation is based on clinical judgment, knowledge of the patient and knowledge of the patient’s circumstances. It can include information obtained directly from the patient or from collateral sources.

Over the course of clinical contact with a patient, suicide risk may change. For example: the emergence of specific symptoms (such as command hallucinations telling the person to take his/her life or the emergence of hopelessness within the context of a Depressive episode); worsening of the clinical condition (such as increasing severity of a Depressive episode or increased substance use); emergence of significant life events (such as loss of a loved one or the suicide of a friend or admired person); changes in clinical care situations (such as discharge from hospital or post emergency room visit care) can all increase suicide risk during the time course of clinical care. Thus, suicide risk assessment is an ongoing process.

The use of suicide assessment tools can assist a clinician in suicide risk assessment and when applied can also provide documentation of what the suicide risk assessment consisted of. This type of documentation may be preferred to clinical notes that make little or no mention of suicide risk assessment details. However, there are no suicide risk assessment tools that can accurately predict whether a person will or will not die by suicide and over what period of time.

A suicide risk assessment will enable a trained health care provider to determine the probability of death by suicide in the short term (usually over a period of hours to a few days). Long-term predictions are not reliable, thus suicide risk assessment is a continuous process. For some patients, increased risk for suicide can be an acute phenomenon while for others it can be a chronic phenomenon. For some patients who are at chronically elevated risk for suicide, acute exacerbations of that risk can occur.

Suicide risk assessment requires training, a good understanding of the patient, their condition and their circumstances and clinician awareness that risk is not a static phenomenon and that risk can change over time. It is the responsibility of the health care provider to conduct the most appropriate degree of suicide risk assessment at every patient contact and if information on patient status is received in periods between patient contact points.
Suicide risk assessment leads to suicide risk management. Suicide risk management is also a continuous process and is based on the clinician’s determination of the probability of suicide as an outcome – both acute and chronic. It involves application of both general and specific interventions. For example, some general interventions include provision of evidence-based treatments to individuals who have a mental illness or collaborative care approaches to the ongoing treatment of individuals with chronic and persistent mental illness. Some specific interventions may include tailored frequent post hospital or emergency room discharge contact, the advice to limit access to lethal means (such as removing guns from the home), or hospitalization (voluntary or involuntary) as the location in which treatment is provided.

Suicide risk assessment and suicide risk management are both the individual responsibility of every health care provider and the collective responsibility of the entire health care team involved with any specific patient. Communication amongst members of the health care team about patient suicide risk is an important part of ongoing care.

1.5. Does asking about suicide make a patient more likely to act on it?

In the clinical setting, asking about suicide ideation or plans does not increase the risk of suicide. On the contrary, it decreases the risk of suicide as it identifies individuals who are at higher probability of immanent death by suicide and thus is part of ongoing suicide risk assessment. However, there is no substantial data available to provide the answer to the question if outside of the clinical setting, asking people about suicide ideation or plans either decreases or increases risk of death by suicide. According to Bolton and his colleagues (2015), A barrier to assessment is the belief held by some clinicians that asking about suicidal thoughts will induce such thoughts in patients. A nonsystematic review published in 2014 examined 13 studies published between 2001 and 2013 that investigated this question and found that none reported a significant increase in suicidal ideation in patients who were asked about suicide.
Chapter 2

Understanding Suicide and self-Harm
Definitions:
Suicidal Ideation: Refers to thoughts, images or fantasies of dying or killing oneself.

Suicide Attempt: A purposeful self-inflicted act associated with the explicit or implicit intent to die.

Suicide (Completed Suicide): Death occurring as a result of a suicide attempt.

Self-Harm (Non-Suicidal Self Injury): Any self-inflicted destructive behavior that is not associated with the implicit or explicit attempt to die.

Self-harm is more commonly than suicide attempts and is found more frequently in females and in adolescents. There exists a co-relation between death and self-harm in that up to 7% of individuals who self-harm die from their self-injury. Self-harm and suicide attempts can co-occur in some mental disorders, particularly in Borderline Personality Disorder. Clinically it is important to distinguish self-harm events from suicide attempts as patient management may differ.

Difference between suicide and self-Harm
Researchers and clinicians have struggled with inconsistent terms in describing suicide-related thoughts and behaviors. However, there is some agreement that the term non-suicidal self-injury (NSSI) refers to behaviors engaged in with the purposeful intention of hurting oneself without intentionally trying to kill oneself. Several terms are used in the literature, including self-injurious behavior, non-suicidal self-injury, self-mutilation, cutting, deliberate self-harm, delicate self-cutting, self-inflicted violence, parasuicide, and autoaggression. However, many of these terms encompass more than NSSI

There is suggestion that suicide attempts and NSSI are distinct behaviours. Those who engage in NSSI typically have thoughts of temporary relief, while those who engage in suicidal behaviors have thoughts of permanent relief through death. NSSI is more common than completed suicide and attempts.

A review that included approximately 22 empirical studies that addressed NSSI in adolescents suggested that lifetime prevalence rate of NSSI ranges between 13% and 23% and that the typical reported age of onset of NSSI falls between 12 and 14 years of age (Jacobson 2007).

Some studies found that NSSI is more often undertaken for reasons such as tension reduction, emotion regulation, anger expression, self-punishment, and a decrease in dissociation, whereas suicide attempts were more often
reported as intended to make others better off. (Nock & Prinstein, 2005). A history of sexual abuse appears to be a specific risk factor for engaging in NSSI. (Zoroglu, Tuzun, Sar et al., 2003)

Several psychosocial correlates of NSSI have been identified in the literature including depression, anxiety, eating disorders, alexithymia, hostility, negative self-esteem, antisocial behavior, anger, smoking, and emotional reactivity. Suicidal ideation is predictive of later suicide attempts, but not NSSI.

Suicide attempts and NSSI are correlated with each other. Those who engage in NSSI are at increased risk for suicide compared to individuals who do not self-injure, but the risk remains very low (i.e., about 3–7% of individuals who self-injure eventually die by their self injury). The risk of death is higher for those with previous suicide attempts. It has been found that approximately half of patients who died by suicide had made at least one previous suicide attempt.

Engagement in NSSI is very common among adults with Borderline Personality Disorder (BPD) (Zanarini, Frankenburg, Hennen et al., 2005). Indeed, one of the criteria for a diagnosis of BPD is engagement in self-injurious behaviors or threats, including both suicide attempts and self-mutilation (APA, 2013).

Suicidal Behaviour and Borderline Personality Disorder (BPD)
Suicidal behavior (defined as any action that could potentially cause one to die) is found in approximately 80% of Borderline Personality disorder (BPD) patients, a substantial increase from the general population, with 60% to 70% of patients engaging in suicide attempts. A history of self-injurious behavior doubles the risk for suicide among BPD patients, but affective instability is also associated with increased suicide attempts. The risk of suicide for persons diagnosed with BPD is estimated at 8% to 10%. This suicide rate is 50 times higher than that of the general population.

Although much of the suicidal behavior in BPD does not lead to completed suicide, suicide remains a major cause of death for this population. (Dubovsky AN 2014). WHO has declared that reducing suicide-related mortality is a global imperative (Turecki 2016)
What are the diagnostic symptoms criteria of Borderline Personality Disorder?

According to DSM V (APA 2013), patient has to have a long standing pattern that started in early adulthood that causes significant impairment in function and meets 5 of the following criteria:

- An intense fear of abandonment, even going to extreme measures to avoid real or imagined rejection or abandonment
- A pattern of unstable intense relationships, sometimes seeing things as black and white or using splitting as a defense
- Rapid changes in self-identity or self-image that include shifting goals and values.
- Periods of stress-related paranoia and loss of contact with reality, lasting from a few minutes to a few hours. It can be described as micro psychotic or dissociative experience.
- Engagement in impulsive and risky behavior in at least two areas such as, reckless driving, sex, spending sprees, binge eating or drug abuse or gambling.
- Suicidal threats or behavior, gestures or self-injury, often in response to fear of separation or rejection.
- Significant and wide mood changes or swings that can happen within the same day, lasting from a few hours to a few days, which can include intense happiness, irritability, or anxiety.
- Long standing feelings of emptiness
- Inappropriate, severe anger episodes or difficulty controlling anger, such as frequently losing temper, being sarcastic or bitter, or having physical fights

For management of suicidal patients with BPD please refer to the management chapter.
Chapter 3

The Content of Suicide Risk Assessment
3.1 The Requirement For Suicide Risk Assessment

Good clinical care includes ongoing suicide risk assessment and management.

Accreditation Canada standards require that patients treated in a hospital setting are assessed and monitored for risk of suicide. (ROP 2015).

The World Health Organization recommends that all people over the age of 10 years with a mental disorder or other risk factor should be asked about thoughts or plans of self harm within the past month. Most guidelines encourage the use of standardized process for SRA. (see appendix G)

One observational UK study found that the process of assessment itself correlated with a lower likelihood of future suicidal Behavior (Olfson M.2013). This speaks to an often overlooked aspect in risk assessment: that Clinician–patient contact can provide an important therapeutic effect. (Bolton J2015)

3.2. Required Organizational Practices (ROP) Standards

Accreditation Canada requires the following organizational practices for suicide prevention (2015):

- Clients at risk of suicide are identified.
- The risk of suicide for each client is assessed at regular intervals or as needs change. The immediate safety needs of clients identified as being at risk of suicide are addressed.
- Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide.
- Implementation of the treatment and monitoring strategies is documented in the client record.

3.3 Common Challenges in suicide risk assessment

Suicide risk assessment is an inexact activity. Many people who are considered to be at high risk for suicide, never die by suicide and some who are not so considered do. There are several challenges in conducting a suicide risk assessment:

- Clinicians commonly rely on subjectively reported information, which does not always provide a full picture of the risk. Collateral information can provide a more complete picture of risk.
• Suicide risk assessment scales do not accurately predict death by suicide. They may be useful as a clinical tool or as documentation of the type of suicide risk assessment that was done but cannot be used for suicide risk assessment by individuals not trained in suicide risk assessment.

• There is a lack of consistency in the education and training of health care providers in the competencies needed to conduct a suicide risk assessment.

• Suicidal behaviour can produce intense emotional responses from clinicians. When these emotions are unrecognized, they can create negative reactions on the part of the clinician that limit their ability to work effectively with people who are acutely suicidal.

3.4 The Suicide Risk Assessment Process

**Step 1: Building a therapeutic relationship and alliance with the patient and asking about suicidal ideation and plan**

A positive therapeutic alliance is considered to be the foundation for suicide risk assessment. It is a conscious collaboration between the clinician and the patient for the purpose of a mutual exploration of the patient’s problems. Developing a therapeutic alliance involves empathy, active listening, respect, trust, support, a non-adversarial and collaborative stance, non-judgmental acceptance, transparency and a strong interest in understanding the person and the nature and cause of their pain/distress. (Bryan & Rudd, 2011).

Clinicians should also be aware of their own reactions to suicide or the patient that they are conducting a suicide risk assessment with and attempt to manage those reactions effectively.

The therapeutic alliance has been proposed to be important for a number of reasons:
1–It reduces patient anxiety during suicide risk assessments, thereby increasing honesty and accuracy in the patient self-disclosure. (Shea et al. 2002)
2–It leads to clinical improvement because the answers to the suicidal patient’s struggles lie within him or her, and better alternatives to suicide for coping with problems and life distress can be identified together with the clinician. (Jobes 2006)
3- It has been argued that a strong therapeutic alliance enables the clinician to deliver the interventions and teach the skills that enact the change required for suicide risk to resolve. (Bryan and Rudd 2011)

4- Therapeutic alliance may serve as a protective factor by encouraging a sense of hopefulness and connectedness.

Examples of approaches to develop therapeutic alliance:
The therapeutic alliance is built from the time that the clinician first makes contact with the patient. Additionally, specific questions can be used by the clinician to move from the development of the therapeutic alliance to the determination of suicide risk. The first step in that process includes confirming the challenges that the patient is having and laying the groundwork for more detailed questions about suicidal ideation and suicide plans.

For example, the clinician may say:

I can see that things have been very challenging for you lately.

OR

It seems that you have been having a difficult time lately.

OR

It must be frustrating /difficult to be going through what you are experiencing.

These types of questions provide the link between the patient’s experience, the clinician’s consideration of that experience and concurrently identify a supportive and caring concern.

Once that has been established, it is appropriate to move on to more detailed questioning, depending on the clinician’s appreciation of risk factors as they are described below.
**Step 2: Identify risk factors, noting those that can be modified to reduce risk**

A risk factor is something that increases the probability of a specific outcome. Risk factors are generally not causal, nor are they all modifiable nor are they all of equal weight in creating the determination of probability. Taken together however they can help provide the clinician with a weighted consideration as to their determination of the probability of the outcome – death by suicide. Risk factors help the clinician arrive at a risk determination.

Risk factors can be identified from information received from the patient and from collaterally sources (such as family, friends, police, other health providers, medical records, etc.). These sources of information should be used when conducting a suicide risk assessment.

The following table provides some useful risk factors to consider when conducting a suicide risk assessment.

Exemplars of Risk Factors for Suicide (adopted from Chehil and Kutcher, Suicide Risk assessment, Wiley Press)

<table>
<thead>
<tr>
<th><strong>Interview Risk Profile</strong></th>
<th><strong>Individual Risk Profile</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Suicidal thinking or Ideation</td>
<td>□ Ethnic, cultural risk group or refugee</td>
</tr>
<tr>
<td>□ Access to lethal means</td>
<td>□ Family history of suicide</td>
</tr>
<tr>
<td>□ Suicide intent or lethal plan or plan for after death (note)</td>
<td>□ Trauma: as domestic violence / sexual abuse/neglect</td>
</tr>
<tr>
<td>□ Hopelessness</td>
<td>□ Poor self-control: impulsive / violent/aggression</td>
</tr>
<tr>
<td>□ Intense Emotions: rage, anger, agitation, humiliation, revenge, panic, severe anxiety</td>
<td>□ Recent suicide attempt</td>
</tr>
<tr>
<td>□ Current Alcohol or Substance intoxication /problematic use</td>
<td>□ Other past suicide attempts, esp. with low rescue potential</td>
</tr>
<tr>
<td>□ Withdrawing from family, friends</td>
<td>□ Mental illness or addiction</td>
</tr>
<tr>
<td>□ Poor Reasoning/Judgment</td>
<td>□ Depression/anhedonia</td>
</tr>
<tr>
<td></td>
<td>□ Psychotic</td>
</tr>
<tr>
<td></td>
<td>□ Command hallucinations</td>
</tr>
<tr>
<td></td>
<td>□ Recent admission /</td>
</tr>
</tbody>
</table>
The table of risk factors is useful to assist the clinician in her/his assessment, but the clinician must apply a variety of different methods to obtain the necessary information. Each clinician must create a series of questions that will allow them to comfortably consider that they have evaluated the risk factor under consideration.

A. Ask about suicidal thinking (ideation) and understand the frequency, intensity, and duration, plans and behaviors then ask about suicidal ideation in the last 48 hours, past month and worst ever.

B. Ask about suicidal plan and behavior (e.g., loading gun), “Whether or not a plan is present, if a patient has acknowledged suicidal ideation, there should be a specific inquiry about the presence or absence of a firearm in the home.

It is also helpful to ask whether there have been recent changes in access to firearms or other weapons, including recent purchases or altered arrangements for storage. If the patient has access to a firearm, the clinician is advised to discuss with and recommend to the patient or a significant other the importance of restricting access to, securing, or removing this and other weapons. Such discussions should be documented in the medical record, including any instructions that have been given to patient and significant others about firearms or other weapons.” Excerpted from the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors

<table>
<thead>
<tr>
<th>Illness Management</th>
<th>Circle of support</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Lack of clinical support</td>
<td>□ Lack of family/friends support</td>
</tr>
<tr>
<td>□ Non compliance or poor response to treatment</td>
<td>□ Caregiver unavailable</td>
</tr>
<tr>
<td></td>
<td>□ Frequent change of home</td>
</tr>
</tbody>
</table>
**Examples of Questions about Suicidal Ideation**

The next set of questions can be relatively general, exploring the possibility of suicidal ideation. For example, the clinician can say:

Given what you are experiencing, I wonder if you have had any thoughts that you would be better off dead or that you would consider taking your own life?

OR

Sometimes in such circumstances, people may think or feel that they would be better off dead or that they may consider taking their own life. What about you?

**Examples of Questions about Suicidal Intent and Plan**

If the patient provides a positive response to any question about suicidal ideation the clinician must explore in some detail that condition. The purpose of this exploration is to determine how intense and how persistent the suicidal ideation is, to determine if there has been an attempt and to determine how and how well the patient is coping with those thoughts. For example, the clinician could say:

You say that you have thought about dying, can you tell me more about that?

Can you tell me more about the thoughts of taking your life that you are having? How often do you have those thoughts? How strong are they? How do you deal with them when they come? Can you overcome those thoughts or are you concerned that they may overcome you?

When you are having those thoughts, what do you do? Do you feel safe?

What have you done to act on those thoughts? Have you done anything that might have caused you harm or lead to death? Can you tell me about what happened?

**Examples of Questions about Suicidal Plan**

If it is established that the patient has persistent and strong suicidal ideation, the next step is to determine of the patient has a plan. The presence of a plan immediately puts the patient into a higher risk category. For example, the clinician could say:
You have shared with me your thoughts about dying or taking your life, what are you planning to do?

OR

Can you tell me what you have thought about doing to take your own life?

Once the presence of a plan has been established, the clinician should ensure that they understand all the details. When is this to happen? How lethal is the plan? How committed is the patient to carrying out the plan? What are the facilitating factors (for example: they have a gun in the house, they have obtained numerous bottles of pills, etc.).

If a plan is identified, evaluate steps taken to enact the plan (practice CO emission from the car), preparations for dying and the patient’s expectations of lethality.

Timing, location of plan, lethality of method and availability are keys to evaluating level of risk. Ask about a plan for after death like writing a suicide note or plan to give away the belongings.

At each step in the suicide risk assessment, the clinician both continues to maintain the therapeutic alliance and applies a risk evaluation strategy that includes the patient’s answers to the questions posed and a list of risk factors that should be considered in addition to the information collected from the interview.

**Important Additional Inquiries:**

1) **Past attempts:**

If there is a history of past attempts ask for when, method, what the patient understood to be the lethality of the method, outcome. A history of suicide attempts or self-harm was strongly associated with increased risk of suicide (OR=4.84, 95% CI 3.26 to 7.20).

2) **Stressors:**

If there are recent life stressors ask about impact on the person, impact on significant others, impact on financial situation.
3) **Alcohol or Substance Use:**
If there is a suggestion of substance or alcohol use, ask about problematic use or a recent increase in use. Assess for current intoxication or withdrawal.

4) **Homicidal Ideation:**
Assess for homicidal ideation, particularly in postpartum women and in patients with cluster B personality disorders or who are paranoid.

5) **Social support:**
Ask about social support and obtain collateral information from family about withdrawal and isolation from them and or from friends.

6) **Understand the psychiatric diagnosis and comorbidity (both psychiatric and physical):**
Particularly mood disorders (depressed or mixed phase), psychotic disorder, alcohol/substance use disorders, Cluster B personality disorders or traits, eating disorders and anxiety disorders. **Key Symptoms:** Anhedonia, impulsivity, hopelessness or despair, anxiety/panic, anger, agitation, global insomnia and command hallucinations.

6.1 **Mood disorders:** particularly depression, are among the strongest risk factors for suicide. More severe depressive psychopathology was associated with suicide risk (OR=2.20, 95% CI 1.05 to 4.60), severe degree of impairment was also associated with increased risk of suicide (Mattisson et al., 2007). Risk was also substantially increased where individuals had expressed feelings of hopelessness (OR=2.20, 95% CI 1.49 to 3.23). In a single study increased risk of suicide was found in people with self-neglect and also in those with impaired memory (Barraclough and Pallis, 1975)

6.2 **Schizophrenia** can contribute to an elevated risk for suicide, particularly during the initial years of the illness. Command hallucinations increase risk

6.3 **Alcohol or Substance Use:** Suicide was significantly increased in the presence of current substance misuse (i.e. alcohol and/or drug, OR=2.17, 95% CI 1.77 to 2.66). This also applied in the two studies in which alcohol (OR=2.47, 95% CI 1.40 to 4.36) or drug (OR=2.66, 95% CI 1.37 to 5.20) misuse were examined separately. Use of multiple substances can trigger suicidal behaviour. Withdrawal from cocaine, amphetamines and other addictive drugs can increase suicidal ideation and attempts. Extended use
of sedatives, hypnotics and anxiolytics can increase suicidal ideation and attempts.

6.4 **Anxiety:** The presence of symptoms of anxiety was also associated with increased risk of suicide (OR=1.59, 95% CI 1.03 to 2.45)

6.5 **Personality Disorders:** Risk of suicide was strongly associated with the presence of an Axis II (i.e. Borderline or Antisocial personality) disorder (OR 4.95, 95% CI 1.99 to 12.33).

6.6 **Medical (physical) Illness:** comorbid chronic physical illness In a single study suicide risk was associated with the presence of physical illness such as malignant neoplasms, HIV/AIDS, peptic ulcer disease, hemodialysis, SLE systemic lupus erthematosis, pain syndromes, functional impairment, diseases of nervous system, physical disorders (e.g., undiagnosed diabetes, iron/thyroid deficiency) are a common factor in suicides of individuals over 60 years old. (Brådvik et al., 2008). See appendix B for Relative risk of Suicide in Specific Psychiatric Disorders and Medical conditions.

6.7 **Suicide during Inpatient admission**
The risk of suicide while admitted as an inpatient is high. It happens particularly early during the admission (40% in the first 3 days). The rate of suicide has been reported at five per 1000 occupied beds each year in some studies and up to 860 suicides per 100 000. (BoltonJ 2015BMJ)

6.8 **Suicide after recent hospital discharge**
The risk of suicide is high in the first week after discharge from a psychiatric hospital admission, remains high for the first few months after discharge, and then slowly decreases. The risk of suicide after discharge is especially high for psychiatric patients who were admitted to hospital with a suicide attempt. (BoltonJ 2015BMJ)

6.9 **Suicide among patients presenting to the emergency department**

Rates of future suicide among people presenting to the emergency department with self harm are high: 2% of these people will kill themselves within one year, and the five year estimate of suicide is 4%. This risk is more than 50 times greater than that seen in the general population and is associated with a 40 year reduction in average life
expectancy. Rates of repeat self harm after contact with the emergency department are 10% at one month and as high as 27% at six months. (Bolton J 2015BMJ)

6.10 Past Psychiatric Hospital Admissions:
Higher risk in those with a history of previous psychiatric hospital admissions (OR=2.37, 95% CI 0.86 to 6.55)

6.11 Suicide after Visiting healthcare Professional:
Research has shown that between 40% and 60% of people who die by suicide had seen a physician in the month prior to suicide; of these, many more had seen a general physician rather than a psychiatrist. In countries where the mental health services are not well developed, the proportion of people in suicidal crisis consulting a general physician is likely to be higher. (WHO)

6.12 Understand the Social and demographic risk factors for suicide:
Suicide risk was significantly greater in males (OR=1.76, 95% CI 1.08 to 2.86), Risk increases with age; rates of suicide increase after puberty and in adults over the age of 65. Marital status: Widowed, divorced, single. Suicide seems to be much higher in certain cultural and ethnic groups. Aboriginal, Inuit and refugees have higher risk of suicide. Some researchers suggested that suicide rates are higher when patient’s caregiver is unavailable or when patients are not responding to treatment. Frequent changes of residence had been identified as a risk of suicide in adolescence.

6.13 Family history of suicide or mental illness:
Suicide risk was increased where there was a family history of mental disorder (OR=1.41, 95% CI 1.0 to 1.97) While risk was increased where there was a family history of suicide (OR=1.83, 95% CI 0.96 to 3.47).

6.14 Childhood trauma:
Sexual or physical abuse, neglect, or parental loss.

(Adopted from CAMH Suicide Prevention and Assessment Handbook 2010)
Protective factors
In addition to risk factors, and sometimes overlooked, suicide risk assessment should identify protective factors that reduce suicide risk. Although patients who exhibit protective factors do attempt and complete suicide, multiple protective factors generally contribute to patient resiliency in the face of stress and adversity. Protective factors may be considered in each of the domains of the individual, family, work and community. Important protective factors may include:

Internal: Ability to cope with stress, religious beliefs, frustration tolerance, absence of psychosis

External: Responsibility to children except among those with postpartum psychosis or beloved pets, positive therapeutic relationships, social supports

Step 3 Formulating Risk: Make a clinical judgment of the risk that a patient/client may attempt or complete suicide in the short or long term

- Integrate and prioritize all the information regarding risk and protective factors
- Assess if the patient is minimizing or escalating their stated risk
- Assess acute and imminent suicidality
- Assess chronic and ongoing suicidality
  - Assess acute exacerbation of a patient with chronic risk.

It is the combination of the information obtained from the patient and the determination of additional risk factors that are used to conduct a suicide risk assessment. For example, a patient may say that they have persistent ideation but that they have no plan and that they can push the thoughts about suicide away from their mind and can control their behavior. However, that same patient is known to have made two suicide attempts in the past year, is suffering from Depression, is feeling hopeless and has recently lost their job. It is this combination of interview information and additional risk factors that the clinician uses to determine risk for suicide.
Suicide Risk Assessment Policies and Processes
PREAMBLE

1. The purpose of this policy is to reinforce and standardize the structure and documentation of a complete Suicide Risk Assessment and Intervention plan (SRAI) process within Mental Health and Addictions (MHA).
2. Suicide risk is one of the primary concerns of MHA Staff and the completion and documentation of a SRAI is a critical function of clinical practice.

3. All MHA Staff are expected to appreciate the value and importance of suicide prevention and attempt to incorporate the knowledge of the SRAI in their routine practice.

POLICY STATEMENTS

1. Licensed Health Care Provider (LHP) must assess Patients/Clients for risk of suicide during:

   1.1. Entry into Care.

   1.2. Transfer from service area (no need for SRAI if one has been conducted in the past 24 hours and Patient/Client condition is assessed as unchanged).

   1.3. Discharge from Care; (no need for SRAI if most recent SRAI risk level is low and current suicide risk screening indicates no change in condition i.e. Patient/Client is screened as low risk).

   1.4. When otherwise clinically indicated (such as; change in presentation, change in functioning, change in life circumstances, as outlined by the Patient’s/Client’s personal monitoring plan, etc.).

   Note: If the LHP decides not to conduct a SRAI in the above situations then the rationale should be documented on the SRAI tool.

2. When Screening for Suicide risk reveals a patient is at risk of suicide then a SRAI must be completed using the SRAI Tool by, and limited to, the following Licensed Healthcare Providers (LHPs):

   - Registered Nurses
   - Physicians, including Psychiatrists
   - Psychiatry Residents
   - Social workers
   - Psychologists
Any other clinician who is a member of a self-regulated health profession who is responsible for the independent practice of MHA assessment, Treatment Planning and discharge from outpatient/community based MHA.

2.1. All LHPs (identified in #2. above) must complete a training session on the SRAI Policy and SRAI Tool.

3. A specific monitoring and management plan must be created for Patients/ Clients assessed as moderate or high risk for suicide.

3.1. The SRAI management and monitoring plan must be communicated to others involved in the Patient’s/ Client’s care and documented.

4. Patient/ Client personal health information can be disclosed without patient consent if there is reasonable grounds to believe that sharing this information will avoid or minimize an imminent and significant danger to any Patient/ Client.

4.1. All Patients/ Clients must be made aware of this at the outset of any MHA contact.

4.2. Disclosure could be to family, police, or others involved in the Patient’s/ Client’s care.

5. It is the responsibility of Managers/ Operations Managers to ensure all qualified LHPs are aware of their respective roles in communicating, documenting and accessing SRAI information.

GUIDING PRINCIPLES AND VALUES

1. Partnership with Patient/ Client and Family

1.1. Assessment and treatment take into account patient/ client’s fundamental right to freedom, dignity, and respect, as well as, the right to make their own decisions (except where this freedom is limited by legal process).

1.2. The protection of independence, self-determination and safety of the patient is a priority in decision-making.

1.3. NSHA is committed to a philosophy of least restraint and any intrusion into a Patient’s/ Client’s decision-making is limited to the least restrictive, least onerous and least intrusive intervention in the circumstances.
1.4. Whenever possible, the Patient/Client, family and Circle of Care are involved in the assessment and planning of treatment and the Suicide Risk Management strategy.

1.5. SRAI is therapeutic in intent and relies on establishment of a therapeutic relationship with the person.

1.5.1. It is based on active listening, trust, respect, empathy and the clinically informed response to the individual’s needs and concerns.

1.6. SRAI is conducted in a Trauma Informed, cultural and situational context; it is documented and relies on effective clinical judgment, and communication, as well as, Patient/Client/family and inter-professional collaboration

2. Promoting Patient Safety:

2.1. Routine clinical care includes ongoing screening and assessment of suicide risk, and appropriate documentation as required.

2.2. The SRAI tool ensures that the necessary components and follow up details are contained in a consistent location on the health record.

2.3. Clinical assessment is tailored to the developmental stage of the Patient/Client and the clinical situation.

2.3.1. The length of time utilized to assess risk is based on clinical judgment and the nature of the Patient/Client answers.

2.4. SRAI is complex, challenging, and imperfect and takes all threats, warning signs and risk factors seriously.

2.5. All decisions pertaining to SRAI/Management are based upon best available evidence.

2.6. SRAI is a collaborative process and LHPs are encouraged to consult with their colleagues.

PROCEDURE

1. Training

1.1. A LHP is responsible to complete a training session on the SRAI Policy and SRAI Tool that:

1.1.1. Is provided by MHA designated trainers in collaboration with the Department of Psychiatry for each zone.

1.1.2. Is not limited to the suicide prevention policy and will also involve:
1.1.2.1. Ability to engage the Patient/Client in a trusting, therapeutic conversation.

1.1.2.2. Ability to synthesize all clinical information into a care plan.

1.1.2.3. Ability to document and otherwise communicate the relevant information.

**Note:** Opportunities for skill development and maintenance will occur through presentations, discussions or other format in each service area across MHA.

2. **Suicide Risk Screening and Assessment**

2.1. Screening for Suicide risk can be completed by any Staff member working in a direct care role with a Patient/Client.

2.1.1. When suicide screening reveals that patient is at risk of suicide, then the person who completed the screening shall communicate the results to any of the following:

2.1.1.1. LHP who is able to conduct SRAI

2.1.1.2. The Provincial 24/7 Telephone Crisis Service delivered by the Mental Health Mobile Crisis Team (1–888–429–8167)

2.1.1.3. Local crisis response team

2.1.1.4. Emergency Services

2.1.2. Document in the health record the results of the suicide screening and the communication step #2.1.1. above.

**Note:** It is recommended that the LHP with the most knowledge of the Patient/Client at the particular time (day/event) complete the assessment if possible.

2.2. Assessment for suicide risk to be conducted by LHPs in MHA:

2.2.1. Conduct Screening for Suicide risk and if indicated, conduct SRAI during the times listed under Policy Statement #1.

2.2.2. Conduct a SRAI on Patients/ Clients with a developmental age of 10 and older using the SRAI Tool, unless otherwise clinically indicated.

2.2.3. Completing the SRAI:
2.2.3.1. Obtain (or review) a collateral history from other providers or members of the Patient’s/Client’s Circle of Care.

2.2.3.2. Review and consider the individual’s risk factors for suicide.

2.2.3.3. Determine the acuity of risk.

2.2.3.4. Document the SRAI rationale by synthesizing the known risk and protective factors with the clinical and historical knowledge of the person.

2.2.3.4.1. The SRAI rationale explains why the risk level has been selected.

2.2.3.5. Determine the risk level and the level of monitoring and management plan required as per Appendix B.

2.2.3.6. Document and appropriately communicates risk level and management plan using the SRAI Policy and SRAI Tool.

3. Suicide Risk Management and Monitoring

3.1. Where the suicide risk is assessed as low, the LHP or Treating Team will monitor for changes in Patient’s/Client’s life situation, mental status and/or care pathways that may affect clinical status and suicide risk.

3.2. Where the suicide risk is assessed as moderate to high the LHP or Treating Team will:

3.2.1. Address the Patient’s/Client’s immediate safety needs.

3.2.2. Develop and implement a suicide risk monitoring plan based on the outcomes of the SRAI and on the identified suicide risk level.

3.2.3. Develop and implement an appropriate Treatment Plan designed to reduce suicide risk.

3.2.4. Initiate the completion of a new, full SRAI tool if there change in level of suicide risk is indicated.

4. Suicide Risk Communication

4.1. The LHP completing the SRAI:

4.1.1. Communicates the SRAI level and management and monitoring plan to those who need the information to promote and maintain the safety of the Patient/Client (may be within the Circle of Care or outside the Circle of Care).
4.1.2. Documents on the SRAI Tool, when suicide risk is assessed as **low**, that:

4.1.2.1. The subjective assessment of suicide risk is **low**.

4.1.2.2. There are **no specific interventions recommended as risk is felt to be baseline/low**.

4.1.3. Communicates the risk and the safety plan when the suicide risk is assessed as **moderate** or **high**, to:

4.1.3.1. The Patient/Client.

4.1.3.2. If the Patient/Client does not have Capacity, Parent/legal guardian and/or Substitute Decision Maker (SDM).

4.1.3.3. Members of the Circle of Care/ treatment team / Provincial 24/7 Telephone Crisis Service delivered by the Mental Health Mobile Crisis Team as appropriate.

4.1.4. Discloses Patient/Client personal health information related to risk without patient consent only if there are reasonable grounds to believe that sharing this information will avoid or minimize an imminent and significant danger to any person(s).

4.1.5. Include the SRAI Tool as part of discharge from any service and/or transfer process, such as a patient going from acute care to community MHA, to:

4.1.5.1. Next Step Care Provider.

4.1.5.2. Other relevant LHPs in the community including central referral or referral office as appropriate.

5. **Suicide Risk Documentation**

5.1. It is the responsibility of the LHP working in MHA to:

5.1.1. Document the completion of the SRAI and analysis and action plan.
5.1.2. Identify a Suicide risk level as low, moderate or high.

5.1.2.1. For moderate to high risk levels:

5.1.2.1.1. Document treatments and interventions that will be undertaken to address identified risk factors and reduce the risk of harm to the Patient/Client.

5.1.2.1.2. Document that suicide risk level, immediate risk and safety plan has been communicated either verbally or in writing to:

5.1.2.1.2.1. The Patient/Client.

5.1.2.1.2.2. Parent/legal guardian and/or SDM (if the Patient/Client does not have Capacity).

5.1.2.1.2.3. Members of the Circle of Care / treatment team / mobile health crisis, as appropriate.

5.1.3. Sign the SRAI Tool.

REFERENCES


## Mental Health and Addictions

### Suicide Risk Assessment and Intervention Tool

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Assessor</th>
<th>Diagnosis</th>
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**Reason:**
- MH Assessment
- Admission/Transfer/Discharge
- Acute deterioration

### Interview Risk Profile
- Suicidal thinking or Ideation
- Access to lethal means
- Suicide intent or lethal plan or plan for after death (note)
- Hopelessness
- Intense Emotions: rage, anger, agitation, humiliation, revenge, panic, severe anxiety
- Current Alcohol or Substance intoxication /problematic use
- Withdrawing from family, friends
- Poor Reasoning/Judgment
- Clinical Intuition: assessor concerned
- Recent Dramatic Change in mood
- Recent Crisis/Conflict/ Loss

### Individual Risk Profile
- Ethnic, cultural risk group or refugee
- Family history of suicide
- Trauma: as domestic violence / sexual abuse/neglect
- Poor self-control: impulsive / violent/aggression
- Recent suicide attempt
- Other past suicide attempts, esp. with low rescue potential
- Mental illness or addiction
- Depression/ anhedonia
- Psychotic
- Command hallucinations
- Recent admission / discharge / ED visits
- Chronic medical illness/ pain
- Disability or impairment
- Collateral information supports suicide intent

### Illness Management
- Lack of clinical support
- Noncompliance or poor response to treatment

### Risk Buffers – Not to be used to determine degree of risk.
- Has reason to live/hope
- Social support
- Responsibility for family/kids/pets
- Capacity to cope/resilience
- Religion/ faith
- Strength for managing risk

### Communication Plan
- Verbal (V)
- Written/fax (W)
- Nurse:
- Physician:
- SDM/Family:
- Mobile Crisis:
- Others:
- Documentation in chart

### Management Plan
- Follow patient care plan for chronic risk
- Regular outpatient follow-up
- Removal of lethal means
- Urgent outpatient follow-up
- Admit to a psychiatric unit
  - Routine observation
  - Close observation q 15 m
  - Constant observation
Appendix A – Definitions

Circle of Care
Circle of Care may also be defined as ‘individuals and activities related to the care and treatment of a Patient. Thus, it covers the health care providers who deliver care and services for the primary therapeutic benefit of the Patient and it covers related activities such as laboratory work and professional or case consultation with other health care providers.

Capacity
The ability to understand information that is relevant to the making of a health care decision and the ability to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.

Discharge from Care
File closure or discharge from the system. Clinicians must document the level of risk before file is closed.

Entry into Care
Entry into Care is the first contact with a particular mental health and addictions service and varies depending on the structure of the particular service. Therefore, initial assessment could be an
emergency department (ED) visit, preadmission assessment, admission to a new service, admission to an inpatient unit, or new Patient to a community clinic.

| **Licensed Healthcare Provider** | Registered Nurses, Psychiatrists, Psychiatry Residents, Social Workers, Psychologists and any other clinician who is a member of a self-regulated health profession who is responsible for the independent practice of mental health and addictions assessment, Treatment Planning and discharge from outpatient/community based Mental Health and Addictions. |
| **Limits to Confidentiality** | Staff may, in accordance with the Personal Health Information Act (PHIA), disclose personal health information about an individual without the individual's consent to any person if the Staff member believes, on reasonable grounds, that the disclosure will avert or minimize an imminent and significant danger to the health or safety of any person or class of persons or for the purpose of risk management or patient safety. |

| **Next Step Care Provider** | This can be a clinician, physician or team, depending on who is involved in providing care and treatment at the point of transition. |
| **Patient/Client** | Refers to any individual receiving care in a Nova Scotia Health Authority facility or through one of Nova Scotia Health Authority’s programs. |
| **Screening for Suicide** | Refers to a process used to identify individuals who may be at risk for suicide. It involves asking questions about suicidal thoughts/wishes to be dead, plans, or suicide intent. |
| **Service Transfer** | Service Transfers take place between services within Mental Health and Addictions (e.g. Psychiatry Emergency Service to Inpatient Acute Care). |
| **Staff** | For the purposes of this policy, Staff includes any member working in a direct care role with a Patient/Client. |
Substitute Decision Maker (SDM)

"A person who is given the authority to make admission, care or treatment decisions on behalf of a Patient pursuant to the Hospitals Act, R.S.N.S. 1989, c. 208 or a Voluntary Patient; OR

A person who is given the authority to make care or treatment decisions on behalf of an Involuntary Patient."

Suicide Risk Assessment

Suicide Risk Assessment refers to the health provider’s evaluation of suicide probability for a Patient that occurs at every point of Patient contact. This assessment can be applied with various degrees of intensity and can be assisted by the use of certain assessment tools that can be applied in specific situations. Not every point of Patient contact requires the same degree of risk evaluation, but every point of Patient contact requires a degree of risk evaluation. The degree of evaluation is based on clinical judgment, knowledge of the Patient and knowledge of the Patient’s circumstances. It can include information obtained directly from the Patient or from collateral sources.

Suicide Risk Assessment is a clinical competency that is applied by mental health and addictions health care providers throughout the period of Patient care.

Suicide Risk Management

Suicide Risk Management is a continuous process and is based on the clinician’s determination of the probability of suicide as an outcome – both acute and chronic. It involves application of both general and specific interventions. For example, some general interventions include provision of evidence-based treatments to individuals who have a mental illness or collaborative care approaches to the ongoing treatment of individuals with chronic and persistent mental illness. Some specific interventions may include tailored frequent post hospital or emergency room discharge contact, the advice to limit access to lethal means (such as
removing guns from the home), or hospitalization (voluntary or involuntary) as the location in which treatment is provided.

**Trauma Informed**

A Trauma Informed context recognizes an approach to care that is sensitive to the impact of exposure to traumatic events on patients/clients and their families. It includes recognition of signs and symptoms of trauma in patients/clients and families along with responses that integrate knowledge about trauma into policies, procedures and practices.

**Treating Team**

Multidisciplinary team which may include: Counsellors, Clinical Therapists, Psychologists, Registered Nurses, Psychiatrists, Psychiatry Residents, Physicians, Social Workers, Occupational Therapists, and Licensed Practical Nurses.

**Treatment Plan**

A tool that assists psychiatrists, NSHA Staff and the Patient to define the Patient’s mental health and addictions issues, to develop and understand the goals of treatment, and to describe the interventions that will help reach the goals. A Treatment Plan is a written document and is recorded in the Patient’s chart.

**Appendix B – Suicide Risk Monitoring Level**

<table>
<thead>
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<th>Level</th>
<th>Suicide Risk Monitoring Level</th>
<th>Risk Level</th>
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| 1     | When there are no specific risk factors requiring intervention and there are few active concerns about suicide. In cases of previously established suicidal gestures or behaviours, low risk implies that there are no new, treatable risk factors to target; the Patient/Client is at ‘their baseline risk’. The Patient/Client may require follow up monitoring of clinical status and suicide risk if (but not limited to):  
- Changes in life situation and/or mental status occur that may be reasonably expected to change suicide risk.  
- Changes in care pathways or continuity occur (for example: transition from a day-hospital to a community clinic setting) | Low |
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<th>Level</th>
<th>Suicide Risk Monitoring Level</th>
<th>Risk Level</th>
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| 2     | When there are some identified risk factors that may impact risk and there is a need for a suicide plan to address risk factors. Suicide risk is present but not imminent and in the opinion of the health provider, can be managed through current supports and ongoing clinical care. In this circumstance the Patient requires ongoing monitoring of suicide risk and the following shall be implemented.  
- Suicide risk is formally assessed and the assessment outcome is appropriately documented.  
- A suicide risk monitoring and management plan is developed, documented, communicated, implemented and reviewed as clinically indicated.  
- A change in suicide risk status is documented and appropriately communicated  
- The suicide risk level is documented and appropriately communicated, as per policy | Moderate |
| 3     | When in the opinion of the health provider suicide risk is high (imminent). There are multiple risk factors that convey a strong degree of risk and that a high level of intervention or monitoring is required. Often this suggests that there is a subjective sense of urgency to address the risk factors as quickly as possible. In this case the Patient requires increased monitoring of suicide risk and the following shall be implemented:  
- The high level of suicide risk shall be appropriately documented and communicated to all relevant providers and as clinically determined within the Patient’s Circle of Care.  
- A Suicide Risk Assessment, Intervention and monitoring protocol shall be documented in the Patient’s individual care plan and other locations as deemed appropriate by the clinical care team. This may require application of constant, close or other monitoring frameworks as clinically determined.  
- The Suicide Risk Assessment and monitoring plan shall be appropriately communicated to all relevant care providers and such members of the Patient’s Circle of Care as | High |
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<td>deemed appropriate by the responsible clinician.</td>
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<td>• The responsible clinician shall determine the appropriate <strong>level and location of care</strong> based on their best clinical judgment.</td>
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<td>• Ongoing formal review of the Patient’s suicide risk status shall be undertaken as deemed appropriate by the clinical care team.</td>
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Management of Patients with Acute Suicidality
1. Medicolegal View

The law recognizes that suicide is a complex issue and cannot be attributed to a single cause. The law also recognizes that there are no standards for its prediction: However the law would consider the “foreseeability” concept. That means that when the court makes a decision in many cases, consideration is given to the clinician’s ability to take an accurate history, recognize the relevant risk factors and prepare a treatment plan that is implemented to guard against completed suicide. (Giliato M, 1999 Am. F. physician)

2. Management of Suicidal Patients

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<tbody>
<tr>
<td>A.</td>
<td>Maintain the therapeutic alliance with the patient (see previous chapter)</td>
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<tr>
<td>B.</td>
<td>Consider immediate safety needs during and after SRA assessment</td>
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<tr>
<td>C.</td>
<td>Select a treatment setting and protocol based on your SRA risk level</td>
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<tr>
<td>D.</td>
<td>Select other specific measures to manage the suicidal patient based on your clinical judgment.</td>
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B. Safety Needs to Consider in the Physical Environment (e.g. Emergency room or inpatient)

B.1 The following measures should improve safety in the physical facility:
- Having elopement precaution measures such as security staff and locked area.
- Ensuring that agitated or aggressive patients are well controlled with medications.
- Eliminating access to means of hanging, suffocation, and strangulation: Are there fixtures (shower heads, light fixtures, curtain rods, closet doors, door knobs) from which something heavy could be suspended? - Do closets and showers have break-away rods?
- Ensuring that patients who require medical equipment (e.g., beds, intravenous lines, oxygen) after a suicide attempt are properly and adequately observed.
- Ensuring that the circumstances of taking shoelaces and belts from patients (and returning them back) are well described and documented.
- Locking linen closets
- If guitars and other string instruments are allowed in inpatient units, then their use and storage should be supervised
B.2 Access to jumping as a method of suicide
- Do patients have access to windows, balconies, fire escapes, any place from which they could jump?
- Are the windows able to be opened or broken?

B.3 Access to other potentially harmful items
- Is a body/belongings search done on admission?
- Is the unit locked?
- Are items brought in by visitors searched?
- Are items such as belts/glass bottles/cigarette lighters taken from patients?
- Are cleaning supplies closely monitored by staff?
- Are there electrical outlets in the bathrooms?
- Are there blow-dyers or other electrical appliances?
- How are razors for shaving monitored?

B.4. consider safety if there is a need to transport the suicidal patient
The increased risk associated with the transport should be considered
- Consider where the patient is going. Is that facility safe? Does the patient have access to places from which to jump or hang?
- Consider a higher level of observation for the duration of the time the patient is off the more secure unit, e.g., if the patient is on 15 minute checks consider a 1:1 for the transport. If the patient is on 1:1 and in restraints consider 2:1 for the transport and having the patient restrained in transit.
- Staff responsible for the observations must be informed of the status of the patient and aware of their options and level of responsibility for intervening in a crisis.

C. Select a treatment setting and protocol based on your SRA risk level

1. Hospital Admission is generally indicated for High Risk Patients
1.1 High risk patients include but not limited to those with:
- Increased intensity of suicidal thoughts, a plan or intent
- After a serious suicide attempt or aborted suicide attempt
- Attempt was violent, near-lethal, or premeditated
Precautions were taken to avoid rescue or discovery
Persistent plan and/or intent is present
Distress is increased or patient regrets surviving
Patient is male, older than 45 years of age, especially with new onset of psychiatric illness or suicidal thinking
Patient is psychotic or responding to command hallucinations to kill self
Patient has limited family and/or social support, including lack of stable living situation
Current impulsive behavior, severe agitation, poor judgment, or refusal of help is evident
Patient has demonstrated a change in mental status with a metabolic, toxic, infectious, or other etiology requiring further workup in a structured setting
In the presence of suicidal ideation with:
Specific plan with high lethality (e.g. plans to shoot self and has a gun)
High suicidal intent (e.g. “I can’t take this any longer; I must find a way to make it stop: My family would be better off without me.”)
Severe anxiety, agitation or perturbation

1.2 Hospital admission is also generally indicated in the following circumstances
- Lack of response to or inability to cooperate with outpatient treatment
- Need for supervised setting for medication trial or ECT
- Need for skilled observation, clinical tests, or diagnostic assessments that require a structured setting
- Limited family and/or social support, including lack of stable living arrangements
- Lack of an ongoing clinician-patient relationship
- Lack of access to timely outpatient follow-up
- In the absence of suicide attempts or reported suicidal ideation/plan/intent but evidence from the psychiatric evaluation and/or history from others suggests a high level of suicide risk

1.3 Monitoring and Observation Levels of high risk patients in hospital
The monitoring of the suicidal patient includes a range of frequency of observations from 1:1 (constant observation), to 15 minute checks, to 30 minute checks.
Different categories of restrictions can also be used.

Examples of restrictions include:
- Supervised Bathroom
- Restricted to being on the unit
- Restriction to public areas
- Placement in hospital clothing
The determination of the level of observations and restrictions depends upon the acuity and suicide risk level. Clinical staff should be familiar with indications, policies for appropriate pharmacologic intervention, seclusion, restraints, body and belongings searches.

2. **Release from emergency department**

2.1 **Release from the emergency department with follow-up recommendations may be possible** After a suicide attempt or in the presence of suicidal ideation/plan when:

- Suicidality is a reaction to precipitating events (e.g., exam failure, relationship difficulties), particularly if the patient’s view of the situation has changed since coming to the emergency department
- Plan/method and intent have low lethality
- Patient has stable and supportive living situation
- Patient is able to cooperate with recommendations for follow-up, with treatment provider contacted, if possible, if applicable.
- Patient is provided with instructions on the available emergency response services and they are able to contract for safety.

2.2 **Steps required prior to leaving the hospital or facility:**

- Before the person leaves the hospital or other facility, he/she should be given a management plan including the level of support to be provided by the service, written information about how to seek further help, including a 24-hour telephone number and the name of a contact person.
- The management plan should include the date and in some cases even the time that a re-assessment of risk will be undertaken.
- The management plan should be negotiated with the person and family/support person. Information concerning the management of the person should also be conveyed when possible to the referring source, treating psychiatrist, general practitioner and other relevant health providers in contact with the person.

3. **Outpatient Suicide Management**

3.1 **Outpatient treatment may be beneficial** the following circumstances:

- Patients with borderline personality disorder with chronic suicidal behavior but with no acute exacerbation.
- Patient has chronic suicidal ideation with no intent
- Self-injury without prior attempts
• Having a safe and supportive circle of care and living situation and an ongoing outpatient psychiatric care
• If patient is determined to have no intent to die from their self-injury and their behavior is determined to be of low lethality (e.g., superficial cutting or burning) and does not require medical attention

3.2 Developing a Management plan for a person in the community (Outpatient)

When the patient is being managed in the community, the following information should be provided to the patient and the circle of support:
• The name of the clinician that patient should contact first and their phone contact should be provided.
• Time and place for the re-assessment interview according to the suicide risk level
• Detailed information about the 24-hour number of mobile crisis or emergency services.

3.3 If concern increases because suicide risk increases or the person’s situation changes and earlier re-assessment is required, the following information should be provided:

3.31. How the outpatient team will respond.
3.32. The scope and limitations of the outpatient services.
3.33. Name and contact of the clinician who should be contacted first.
   a. Name and contact of the next service that should assess the patient if the outpatient team cannot be reached such as mobile crisis, emergency services, 911, police, or going to the emergency department (use that order when possible).
   b. Information on how to manage a person with suicidal behaviour. The most important instructions are: maintaining appropriate supervision; knowing where the person is at all times and who they are with; and how to contact the team for an urgent re-assessment.
   c. Information on the next steps if a patient who has been assessed as at a medium or high risk of suicide does not attend a follow-up appointment.

(3.4 Contingency planning requires the clinician and the person at risk and/or their family or carer to anticipate likely escalations of risk such as:)

50
- deterioration of family relationships
- increase in symptoms (depression, insomnia, hallucinations, suicidal feelings)
- initial difficulty accessing the acute care service

3.41 Contingency planning is framed, communicated and documented in the following manner:
If............., then the person will.............,
the family will............., the service will.............

3.5 **Suicide Prevention Contracts (known as “no-harm contracts” or “contracts for safety”)**
- Potential utility needs to be weighed against potential limitations
- Have been used clinically in either verbal or written form to assess or manage suicide risk
- Sometimes viewed as helpful in judging the strength of the therapeutic alliance or the extent of the patient’s ambivalence about seeking help if suicidal impulses occur
- May provide an opportunity to educate patients about staff availability or about coping with suicidal impulses

However, use of suicide prevention contracts is often overvalued
- They do not act as legally binding contracts and the evidence is not clear about their effectiveness
- May inappropriately reduce clinical vigilance particularly if substituted for more detailed assessments of suicide risk
- Characteristics of the individual patient, nature of the therapeutic alliance and the treatment setting must also be considered
- “Suicide prevention contracts are only as reliable as the state of the therapeutic alliance…As a result, the use of suicide prevention contracts in emergency settings or with newly admitted and unknown inpatients is not recommended. Furthermore, patients in crisis may not be able to adhere to a contract because of the severity of their illness. Suicide prevention contracts are also ill-advised with agitated, psychotic, or impulsive patients or when the patient is under the influence of an intoxicating substance.”

---Excerpted from the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors

3.6 **Low Risk Patients include those who:**
- Have modifiable risk factors and strong protective factors
- Have thoughts of death, but do not have a plan, intent or behavior

3.7 **Interventions for low risk patients include:**
- Outpatient referral
- Symptom reduction
- Providing emergency information, including both local phone numbers mobile crisis or provincial mobile crisis number

D. Select other specific measures to manage the suicidal patient based on your clinical judgment.

1. **Assessment and Management of Chronically Suicidal Patients**
   - Detailed management plans that list both chronic and acute symptoms should be developed with the person. This assists clinicians in determining whether a person is presenting with new/greater risk than their ongoing risk. All services working with this person should have a copy of these plans, and they should be regularly reviewed and updated.
   - Emergency departments should contact mental health services (even if only by phone) when a chronically suicidal person presents. Care must be taken not to downplay the seriousness of attempts.
   - When a person who is well-known to the service arrives at the emergency department it is important that their file is obtained, their management plan consulted, and ideally their case manager or therapist contacted in case they are now experiencing from additional stressors or a significant change in their mental illness(es).
   - Inpatient admission or referral to high support services (such as crisis respite) may be necessary when the person’s suicidality is exacerbated by an acute life stressor, or if they also develop an Axis I disorder.

2. **What are some of the helpful tips for managing patients with borderline personality disorder in primary care setting?**
   - Learn about common clinical presentations and causes of undesirable behavior.
   - Validate the patient’s feelings by naming the emotion you suspect, such as fear of abandonment, anger, shame, and so on, before addressing the “facts” of the situation and acknowledge the real stresses in the patient’s situation.
   - Avoid responding to provocative behavior.
   - Schedule regular, time-limited visits that are not contingent on the patient being “sick.”
- Set clear boundaries at the beginning of the treatment relationship and do not respond to attempts to operate outside of these boundaries unless it is a true emergency.
- Make open communication with all other providers a condition of treatment.
- Avoid polypharmacy and large-volume prescriptions of potentially toxic medications in overdose (including tricyclic antidepressants, cardiac medications, and benzodiazepines).
- Avoid prescribing potentially addicting medications such as benzodiazepines or opiates. Inform patients of your policies regarding these medications early in the treatment relationship so they are aware of your limits.
- Set firm limits on manipulative behavior while avoiding being judgmental.
- Do not reward difficult behavior with more contact and attention. Provide attention based on a regular schedule rather than being contingent on behavior.
- During crisis, have a written consistent plan across providers and be ready to implement the plan.
- DBT psychotherapy is a helpful modality in managing patients with BPD (Dubovsky 2014)

3. Hospitalization of patients with Borderline Personality Disorder (BPD)
If BPD patients require admission to hospital then brief admissions to Hospital are recommended. Prolonged psychiatric hospitalization should be avoided because this is typically counter-therapeutic and may foster and increase dependency needs and cause behavior regression. Brief admission can be used to reduce repeated self-harm and suicidal crisis along with the prevention of death. It can also be used to facilitate outpatient treatment through lowering rates of treatment disruption.
A quick return to the community and facilitating community based treatment should be one of the goals of the brief admission.
Literature suggested that the duration of a brief admission ranged from 3 nights to a maximum of 14 nights depending on the study.
The interventions used during hospital admission:
- Provide active cognitive and affective support to integrate/ move away from present stressor
- Facilitate therapeutic alliance and develop a working alliance
• Help give expression to overwhelming experiences of rage, helplessness, or
decreation
• Promote insight into repetitive patterns of behavior, perception and attachment
• Address life events involving separation and loss with impaired mourning of
significant affective relationships as main target of treatment
• Interpersonal intervention with family, close friends, and especially partners to
clarify communication processes and decrease acute conflicts
• Teaching of coping behaviors to patient and family
• Psycho-education with respect to illness, treatment, and problems to be
expected following discharge and how to respond to them
• Help with organization of acute outpatient treatment following hospital
discharge (Hellman M 2014)
Chapter 6

Documentation and Communication
Documentation and Communication

6.1 Overview on Malpractice and Documentation:
An educational review published by L Sher in 2015 stated that for a physician to be found liable to a patient for malpractice, four essential elements must be proved to sustain an assertion of malpractice: duty, negligence, harm, and causation.

The abstract mentions that the incidence of malpractice litigation in the field of psychiatry is increasing and that the most common malpractice claim related to psychiatric practice is the failure to provide reasonable protection to patients from killing themselves.

It is imperative for clinicians to have a good documentation. Careful documentation of evaluations and treatment interventions with a description of changes related to the patient’s clinical condition indicates clinically and legally appropriate care. The failure to document suicide risk assessments and interventions may give the court reason to conclude they were not done. (Sher L 2015)

6.2 Documentation requirement of SRA
- Date of the assessment (included in the NS tool)
- Reasons of the assessment (included in the NS tool)
- Risk factor (included in the NS tool)
- Actions taken regarding Firearms and other means of suicide
- Protective factors (included in the NS tool)
- Risk level (included in the NS tool)
- Basis for the risk level and plan (space is available at the NS tool to document)
- The others that receive communication and consultation about patient’s risk (included in the tool)
- Management plan (included in the tool)
- Plan for patients with chronic risk particularly patients with Borderline personality disorder (space is available at the tool to document)
- For patients who are hospitalized, it is also important to document basis of involuntary treatment (must be recorded in the involuntary treatment (IPTA forms).
- Contact details for the person, relatives and treating professionals
• Sources of corroborative history and outcome from contact with each source (with consent).

6.3 Documentation on inpatient units for patients admitted for suicide related issues:

In addition to the above issues, important points of documentation include:

• Level of observation on admission (one-to-one versus every-15-minute checks, etc.)
• Changes in the level of observations, progress and outcome
• Observation level during transitions between treatment units
• The issuance of passes
• Marked changes in the clinical condition of the patient
• Discharge evaluation
• Response to clinical interventions
• Outpatient plan for follow up and monitoring (APA guidelines 2010)

6.4 Continuity of care for suicidal patients

A common factor identified by research is the failure or breakdown in the continuity of care for mental health problems (Schoenbaum et al., 2009). A summary issued by the US Center for Military Health Policy Research summarized the problem:

“Having a “chain of care” and “warm transfers” would prevent individuals from “falling through the cracks of the care system” and is seen as particularly important for individuals suffering from a mental health problem or experiencing suicidal ideation or intent.”

The center recommended smooth transitions between providers during transition times so that there is always care available.”(Ramchand et al., 2011.)

Increased occurrences of suicidal ideation or behavior appear to be associated with disruptions in patient medication access and continuity. Mosckiki (2010)

The documentation of continuity of care includes the following:

Transition from emergency room to inpatient or outpatient or home
Move to a different area
Transition from hospital to the community
Transition from child and adolescent system to an adult mental health system
Other areas of transition such as military deployments, redeployment

Communication to other treatment team members, circle of care should be documented. Exact names should be documented and the method of communication whether verbal or written should be documented.
Chapter 7

Suicide Risk Assessment Quality Monitoring
7.1 Audit Process
Clinical audit will facilitate quality improvement by ensuring adherence to the standards required around suicide risk assessment. It will also inform the system on future training needs.
Random charts are selected from each area for the scheduled audit (outpatient, Emergency room and inpatient).
An audit should be conducted at least once a year
Results of the audit should remain confidential and not directed to put blame on specific individuals. It is helpful to inform the system on areas of quality improvement.

7.2 Emergency Department Audit checklist
Date and time of assessment documented and signed on the tool
Reason for the assessment documented on the tool
Risk and Protective factors identified on the tool
Risk level identified and documented on the tool
Rationale for formulating the risk and management plan explained on the tool
Communication plan documented on the tool
Management plan documented on the tool
When patient is discharged from ED, there should be documentation of:
The date and time of the follow up appointment
Key contacts to call for emergency purposes
Information given to family and/or circle of care about key contacts such as mobile crisis number or responsible clinician when there is a concern about the patient

7.3 Psychiatric Inpatient Audit checklist
Date and time of assessment documented on the tool
Reason for the assessment documented on the tool
Risk and Protective factors identified on the tool
Risk level identified and documented on the tool
Rationale for formulating the risk and management plan explained on the tool
Communication plan documented on the tool
Management plan documented on the tool
When patient is discharged from the inpatient unit, there is documentation of:
The date and time of the follow up appointment
Key contacts to call for emergency purposes
Information given to family and/or circle of care about key contacts such as mobile crisis number or responsible clinician when there is a concern about the patient
7.4 Mental Health Outpatient Audit checklist
Date and time of assessment documented on the tool
Reason for the assessment documented on the tool
Risk and Protective factors identified on the tool
Risk level identified and documented on the tool
Rationale for formulating the risk and management plan explained on the tool
Communication plan documented on the tool
Management plan documented on the tool
When patient is discharged from ED, there is documentation of:
The date and time of the follow up appointment
Key contacts to call for emergency purposes
Information given to family and/or circle of care about key contacts such as mobile crisis number or responsible clinician when there is a concern about the patient
If patient did not attend the appointment, documentation of the next follow up appointment or safety plan should be present in the chart.
Appendix A

GLOSSARY

**Circle of Care:** Circle of care may also be defined as ‘individuals and activities related to the care and treatment of a patient. Thus, it covers the health care providers who deliver care and services for the primary therapeutic benefit of the patient and it covers related activities such as laboratory work and professional or case consultation with other health care providers.

**Discharge from Care:** File closure or discharge from the system. Clinicians must document the level of risk before file is closed.

**Entry into Care:** Entry into Care is the first contact with a particular mental health and addiction service and varies depending on the structure of the particular service. Therefore, initial assessment could be an emergency department (ED) visit, preadmission assessment, admission to a new service, admission to an inpatient unit, or new patient to a community clinic.

**Next Step Care Provider:** This can be a clinician, physician or team, depending on who is involved in providing care and treatment at the point of transition.

**Screening for Suicide:** Detecting patients/clients who require full suicide risk assessment and further evaluation by means of asking questions, obtaining history and examination of mental status.

**Trauma Informed:** A trauma informed context recognizes an approach to care that is sensitive to the impact of exposure to traumatic events on patients/clients and their families. It includes recognition of signs and symptoms of trauma in clients/patients and families along with responses that integrate knowledge about trauma into policies, procedures and practices.

**Suicidal Ideation:** Refers to thoughts, images or fantasies of dying or killing oneself.

**Suicide Attempt:** A purposeful self-inflicted act associated with the explicit or implicit intent to die.

**Suicide (Completed Suicide):** Death occurring as a result of a suicide attempt.

**Self-Harm (Non-Suicidal Self Injury):** Any self-inflicted destructive behavior that is not associated with the implicit or explicit attempt to die.
Appendix B
Suicide Risk Assessment in Children and Adolescents

Some Warning Signs in Children and Adolescents
- Making suicidal statements.
- Being preoccupied with death in conversation, writing, or drawing.
- Giving away belongings.
- Withdrawing from friends and family.
- Having aggressive or hostile behaviour.
- Neglecting personal appearance.
- Running away from home.
- Risk-taking behaviour, such as reckless driving or being sexually promiscuous.
- A change in personality (such as from upbeat to quiet).

Common RF for Suicide in Children and Adolescents
- Depression or another mental disorder
- A parent with active mental health problems.
- Previous suicide attempt
- A friend, peer, family member, or hero (such as a sports figure or musician) who recently attempted or died by suicide.
- Disruptive or abusive family life.
- History of sexual abuse.
- History of being bullied.

Other Risk Factors
- Possession or purchase of a weapon, pills, or other means of inflicting self-harm.
- Drug or alcohol use problems.
- Witnessing the suicide of a family member.
- Problems at school, such as falling grades, disruptive behaviour, or frequent absences.
- Loss of a parent or close family member through death or divorce.
- Legal or discipline problems.
- Stress caused by physical changes related to puberty, chronic illness, and/or sexually transmitted infections.
- Withdrawing from others and keeping thoughts to themselves.
- Uncertainty surrounding sexual orientation.
Appendix C
References and Suggested readings


-Patel V et al. DISEASE CONTROL PRIORITIES . THIRD EDITION, Mental, Neurological, and Substance Use Disorders, world Bank Group. 2015.


-Bolton JM, Gunnell D, Turecki G. Suicide risk assessment and intervention in people with mental illness. BMJ. 2015 Nov 9;351:h4978.


- American Association for Suicidology (AAS). Core competencies for the assessment and management of individuals at risk for suicide. Assessing and Managing Suicide Risk (AMSR): Education Development Center, Inc. (EDC).
- Substance Use and Mental Health Services Administration (SAMHSA). Preventing suicide: a toolkit for high schools. Rockville: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; 2012.
- Substance Use and Mental Health Services Administration (SAMHSA). Suicide Assessment Five-step Evaluation and Triage (SAFE-T). Substance Abuse and Mental Health Services Administration; 2009.
Suicide Prevention Contracts


Appendix D
Guidelines

VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide
Department of Veterans Affairs, Department of Defense

National Strategy for Suicide Prevention: Goals and Objectives for Action
U.S. Department of Health & Human Services

Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors
American Psychiatric Association

Technical Report: Developing Caring for Adult Patients at Risk of Suicide: A Consensus Based Guide for Emergency Departments
Suicide Prevention Resource Center

A Resource Guide for Implementing The Joint Commission 2007 Patient Safety Goals on Suicide Screening for Mental Health and Suicide Prevention Resource Center

www.ranzcp.org/Files/Resources/Publications/CPG/Clinician/CPG_Clinician_Full_DSH-pdf.aspx

Substance Abuse and Mental Health Services Administration (SAMHSA) Suicide Assessment Five-step Evaluation and Triage. 2009.

WHO Self harm and suicide. 2015.
www.who.int/mental_health/mhgap/evidence/suicide/en/


Appendix E

Other Web Resources

**Children & Adolescent**


- Pediatric and Adolescent Mental Health Emergencies in the Emergency Medical Services System Committee of Pediatric Emergency Medicine, American Academy of Pediatrics (2011). [http://pediatrics.aappublications.org/content/127/5/e1356.full.html](http://pediatrics.aappublications.org/content/127/5/e1356.full.html)


**Adults: Primary care**


**Seniors**


This resource presents a systematic examination of assessment instruments for suicidal behaviors and behaviors closely associated with suicide risk in adults and older adults

**Other Resources:**


- The Canadian Association for Suicide Prevention [http://www.suicideprevention.ca/](http://www.suicideprevention.ca/)


- Canadian mental Health Association [http://www.cmha.ca/](http://www.cmha.ca/)
Websites from Suicide Prevention Resource Centre (USA)

**Evaluation**

Screening for Suicide Risk in Adolescents, Adults, and Older Adults in Primary Care United States Preventive Services Task Force Recommendations (May 2014).
http://www.uspreventiveservicestaskforce.org/uspstf/uspssuic.htm

**Understanding Risk and Protective Factors for Suicide: A Primer for Preventing Suicide**
Suicide Prevention Resource Center

**Suicide Risk Factors and Risk Assessment Tools: A Systematic Review**
Department of Veterans Affairs

**Project BETA: Best Practices in Evaluation and Treatment of Agitation**
American Academy of Emergency Psychiatry
http://escholarship.org/uc/item/4kz5387h

**Safety Planning Guide: A Quick Guide for Clinicians**
Suicide Prevention Resource Center

**Suicide Assessment Five-Step Evaluation and Triage (SAFE-T): Pocket Card for Clinicians**
Substance Abuse and Mental Health Services Administration
http://store.samhsa.gov/product/Suicide-Assessment-Five-Step-Evaluation-and-Triage-SAFE-T-/SMA09-4432

**Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians**
American Association of Suicidology

**Screening, Brief Intervention, and Referral to Treatment**
Substance Abuse and Mental Health Services Administration
http://www.integration.samhsa.gov/clinical-practice/sbirt

**Post-Evaluation**

**SMART Discharge Protocol**
The Picker Institute
http://www.ihi.org/resources/Pages/Tools/SMARTDischargeProtocol.aspx

**Project RED (Re-engineered Discharge Planning) Toolkit**
Agency for Healthcare Research and Quality
Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version
Department of Veterans Affairs

SPRPC Emergency Department Consensus Panel
Suicide Prevention Resource Center

Patient Safety Plan template
Suicide Prevention Resource Center

Transitions of Care Resources
American College of Emergency Physicians
http://www.acep.org/transitionsofcare/

Preventing Suicide: Following up After the Crisis
Substance Abuse and Mental Health Services Administration

General Resources
Attachment-Based Family Therapy (ABFT)
National Registry of Evidence-based Programs and Practices
http://www.sprc.org/resources-programs/attachment-based-family-therapy-abft

Brief Psychological Intervention after Deliberate Self-Poisoning
Suicide Prevention Resource Center and American Foundation for Suicide Prevention
Now Matters
(Psychotherapy Using DBT for Suicidal Patients)
http://www.nowmattersnow.org/skills

NIMH Publications
National Institute of Mental Health

Suicide Attempt Survivors
American Association of Suicidology
http://www.suicidology.org/suicide-survivors/suicide-attempt-survivors
The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience
Suicide Attempt Survivors Task Force of the National Action Alliance for Suicide Prevention

Suicide Safe Mobile App
Substance Abuse and Mental Health Services Administration
Safety Plan Mobile App
New York State Office of Mental Heath

American Association of Suicidology
http://www.suicidology.org/

**EMERGENCY DEPARTMENT**

Continuity of Care for Suicide Prevention: The Role of Emergency Departments
 Suicide Prevention Resource Center

Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department. American College of Emergency Physicians
http://www.acep.org/content.aspx?id=48427

Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments — Quick Guide Version. Suicide Prevention Resource Center

After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department. Substance Abuse and Mental Health Services Administration
http://store.samhsa.gov/shin/content/SMA08-4357/SMA08-4357.pdf
Appendix F

Myth and reality about suicide

Examples:

**Myth:** Asking about suicide would plant the idea in my patient's head.

**Reality:** Asking how your patient feels doesn't create suicidal thoughts. Would asking about chest pain cause angina?

**Myth:** There are talkers and there are doers. I cannot identify people who will die by suicide because they do not talk about it.

**Reality:** Most people who die by suicide have communicated some intent. Someone who talks about suicide gives the clinician an opportunity to intervene before suicidal act or behaviors occur.

**Myth:** If somebody really wants to die by suicide, there is nothing you can do about it.

**Reality:** Not true. Many patients with suicidal intent have underlying mental disorders. Providing a safe environment for treatment of the underlying cause can change the outcome. The acute risk for suicide is often time-limited. If you can help the person survive the immediate crisis and the strong intent to die by suicide, then you will have gone a long way towards promoting a positive outcome.

**Myth:** He/she really wouldn't kill themselves since ____.

- he just made plans for a vacation
- she has young children at home
- he signed a No Harm Contract
- he knows how dearly his family loves him

**Reality:** The intent to die can override any rational thinking. In the presence of suicidal ideation or intent, the clinician should not be dissuaded from thinking that the patient is capable of acting on these thoughts and feelings.

**Myth:** Apparently manipulative self-injurious behaviors mean that the patient is just trying to get attention and are not really suicidal.

**Reality:** Suicide “gestures” require thoughtful assessment and treatment. Multiple prior suicide attempts increase the likelihood of eventually dying by suicide. The task is to empathically and non-judgmentally engage the patient in understanding the behavior and finding safer and healthier ways of asking for help.
Appendix G

Relative Risk of Suicide in Specific Disorders

(CAMH)

Relative risk (RR) is an epidemiological term that quantifies the risk of an event (or of developing a disease) relative to exposure. Relative risk is a ratio of the probability of the event occurring in the exposed group versus a non-exposed group. The following list contains the condition relative risk of suicide:

- Prior suicide attempt 38.4
- Eating disorders 23.1
- Bipolar disorder 21.7
- Major depression 20.4
- Mixed drug abuse 19.2
- Dysthymia 12.1
- Obsessive-compulsive disorder 11.5
- Panic disorder 10.0
- Schizophrenia 8.45
- Personality disorders 7.08
- Alcohol abuse 5.86
- Cancer 1.80
- General population 1.00

- A relative risk of 1 means there is no difference in risk between the two groups.
- A relative risk of < 1 means the event is less likely to occur in the experimental group than in the control group.
- A relative risk of > 1 means the event is more likely to occur in the experimental group than in the control group. (Adapted from APA Guidelines, part A, p.16. From Jacobs, 2007)
Appendix H

Suicide Risk Screening

What is the difference between suicide risk screening and suicide risk assessment?
Screening to refer to a process used to identify individuals who may be at risk for suicide. It involves asking questions about suicidal thoughts/wishes to be dead, plans, or suicide intent.
In a sense, they serve as “triage” by screening in a small set of people who may be at risk of killing themselves. The “screened-in” group then needs additional step which is standardized interview questions or consultation by a qualified mental health professional – in order to identify the seriousness of the suicide risk. This next step is called suicide risk assessment.

Suicide risk assessment usually refers to a more comprehensive full evaluation done by a qualified clinician to confirm suspected suicide risk, estimate the immediate danger to the patient, and decide on a plan for intervention and a course of treatment.

What is the task that I am requested to do?
You are requested to do suicide risk screening not assessment.

How do I conduct the screening for suicide?
Use that opening statement:
Now I’m going to ask you some questions that we ask everyone. It is part of the hospital’s policy and it helps us to make sure we are not missing anything important.

Suicide Screening

Module 1

1. In the past few weeks, have you wished you were dead or go to sleep and not wake up or even your family is better off without you?
   ___ Yes
   ___ No

2. Have you attempted to kill yourself in the past?
   ___ Yes
   ___ No

If the patient answers yes to any of the above...

3. Are you having thoughts of killing yourself right now?
   ___ Yes
   ___ No

Module 2
**Suggested Script with adults**
Sometimes people who get upset or feel bad, wish they were dead or feel they’d be better off dead. Have you ever had these type of thoughts?
When?
Do you feel that way now?
Was there ever another time you felt that way?

**Screening Questions for Suicidal Thinking in Youth**
Dr. Tyler R. Black, MD, FRCPC BC Children’s Hospital

**Suggested Script with youth:**

<table>
<thead>
<tr>
<th>Age (or Equivalent Maturity Level)</th>
<th>Suicide Screening Script</th>
</tr>
</thead>
</table>
| 12 years or older                   | Intro: “I’m going to ask you a few quick questions about how you are doing with respect to your mental health.”  
1. “Do you think that you have been under a lot of stress lately?”  
2. “Have you ever felt like life is not worth living?”  
3. **“In the past month, have you felt so bad that you have considered harming or killing yourself? *”** |
| 10 to 12 years                      | Intro: “I’m going to ask you a few quick questions about how you think and feel.”  
1. “Sometimes people find that they have too much stress. Does this sound like you?”  
2. “Sometimes when people are very upset, they think about hurting themselves. Has this happened for you?” |
| If unable to communicate directly   | To guardian: “In the past month, have you had any concerns about your child with respect to safety or self-harm?” |

* If the question is not answered by the target youth, asking the guardian is appropriate and recommended

**Do I ask everyone I meet about suicide since my employer requested that I screen people for suicide?**
No. This is not a universal screening program where everyone is asked about suicide (for example asking all first year university students about having suicidal thoughts). This is a selective screening. The people you will ask about suicide are the people whom you interact with and articulate suicidal thoughts or wishes or any indication that they may harm themselves.
Remember that suicide has many risk factors (see table A below to see examples) but it is your duty to determine if the person will do self-harm or not. Your responsibility is to pass your concerns to the next level of assessment. The duty of the assessor is to receive your concerns and formulate the suicide risk based on a full suicide risk assessment.

**What is the next step if I feel that patient/client screens positive for suicide?**

Your service will give you specific directions on the next step and whom to contact for conducting a suicide risk assessment depending on your location. Please talk to your direct supervisor about that next step. The options are:
- Contacting the treating clinician of the patient
- Calling the provincial telephone line
- Assisting the transfer to the nearest emergency department
- Calling 911

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**Table RF**

**Common Risk Factors for Suicide**

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**Circle of support**

- □ Lack of family/ friends support
- □ Caregiver unavailable
- □ Frequent change of home
Appendix I

Adopted from New Zealand SRA

Suicide Risk Assessment in the Elderly

Although suicide rates in the elderly are relatively high, their suicide risk is often overlooked. Any elderly person who is expressing suicidal ideation or has presented following a suicide attempt should be treated very seriously because:
1- Elderly people who attempt suicide usually choose more lethal means
2- Elderly people who attempt suicide often live alone therefore the chances of being discovered are decreased.
3- Elderly people may be suffering from physical frailty; therefore they are less able to survive/recover from a physically serious suicide attempt.
4- Elderly people may not seek assistance after deliberately self-harm.
5- Elderly who attempt suicide usually have a strong intent to die and are more likely to make fatal attempts.
6- Older people may be uncomfortable talking about their feelings, especially their psychological distress, to younger clinicians.

Risk Factors for Suicide in The Elderly

The general risk factors for suicide amongst elderly people are very similar to those experienced by younger people. Important risk factors include: presence of psychiatric disorder, in particular depression, early stages of dementia, physical illness (particularly painful illness), major losses, which may act as precipitating events, such as: • loss of health • loss of mobility, cognitive functioning, ability for self-care • loss of role/job (eg, retirement) • loss of means for self-support • loss of home or cherished possessions (eg, going into a nursing home) • loss of loved ones, including family/friends and pets.
Appendix J

Sample of questions during SRA

Laying the groundwork for more detailed questions about suicide, the clinician may say:

I can see that things have been very challenging for you lately.

OR

It seems that you have been having a difficult time lately.

OR

It must be frustrating /difficult to be going through what you are experiencing.

Given what you are experiencing, I wonder if you have had any thoughts that you would be better off dead or that you would consider taking your own life?

OR

Sometimes in such circumstances, people may think or feel that they would be better off dead or that they may consider taking their own life. What about you?

Examples of Questions about Suicidal Intent and Plan

The clinician could say:

You say that you have thought about dying, can you tell me more about that?

Can you tell me more about the thoughts of taking your life that you are having? How often do you have those thoughts? How strong are they? How do you deal with them when they come? Can you overcome those thoughts or are you concerned that they may overcome you?

When you are having those thoughts, what do you do? Do you feel safe?

What have you done to act on those thoughts? Have you done anything that might have caused you harm or lead to death? Can you tell me about what happened?

Examples of Questions about Suicidal Plan

If it is established that the patient has persistent and strong suicidal ideation, the next step is to determine of the patient has a plan. The presence of a plan immediately puts the patient into a higher risk category. For example, the clinician could say:

You have shared with me your thoughts about dying or taking your life, what are you planning to do?

OR

Can you tell me what you have thought about doing to take your own life?
Once the presence of a plan has been established, the clinician should ensure that they understand all the details. When is this to happen? How lethal is the plan? How committed is the patient to carrying out the plan? What are the facilitating factors (for example: they have a gun in the house, they have obtained numerous bottles of pills, etc.).

If a plan is identified, evaluate steps taken to enact the plan (practice CO emission from the car), preparations for dying and the patient’s expectations of lethality.

**Questions about past suicide attempts**

Have you ever tried to kill yourself?

**Questions about mental health conditions**

Have you had treatment for mental health problems? Do you have a mental health issue that affects your ability to do things in life?

**Questions about substance use**

Have you had four or more or more drinks on one occasion in the past month or have you used drugs or medication for non-medical reasons in the past month? Has drinking or drug use been a problem for you?
Case #1 Anna

**Identifying information:** Anna O is a 21 year old female who lives alone and works at a restaurant.

**Circumstances of referral and chief complaints:** Patient was brought by a friend to ER. Anna told her friend that she was cutting her wrists. Her friend found some blood on the floor and took her to ER.

**Stressors:** Her boyfriend left her 2 days prior to this ER visit

**Suicide related questions:** Patient said that she has been cutting since she was 13 years old. She does not wish to die. The cutting was impulsive. Anna called her friend asking for help. She does not feel like cutting now and says that she wants to go home and go to work that evening.

**History of present illness:** Patient reported a fluctuating mood every day. Now her mood is good. She reported poor concentration and attention. Her sleep has been poor for years. Has good appetite and denies feelings of guilt. She loves Yoga and soccer. She plays in 2 leagues. She also loves her job. From time to time she finds herself crying for no reason. She worries about everything and cannot control her anxiety. Her energy is good. She becomes irritable and angry very easily. She had significant anger episodes that contributed to her boyfriend left.

**Alcohol and drug use:** Drinks on weekends and smokes 1 gm of weed daily.

**Past psychiatric history:** No previous contact with mental health.

**Medical History:** Allergic to penicillin. Healthy.

**Family history:** Patient has one half-brother and one half-sister. Parents were 15 and 16 years old when they had her. Positive family history of depression, anxiety, and ADHD. She has great relationship with her parents.

**Personal history:** Her mother smoked during the pregnancy. She dropped out after grade 11 and was not attending classes. She was sexually abused by her grandfather at age 6. She failed grade 7 and 8 and had several academic and learning problems. She never kept partners for more than 6 months and had 23 boyfriends so far. She identifies herself as bisexual. She has been working in restaurants after grade 11 and has been in her current job for 2 years. Anna has many friends but she gets bored easily, stops talking to her old friends and look for new friends.

**Collateral information:** Patient agreed that clinician talk to her parents who confirmed the long term nature of the suicidal behavior. They said that she is very impulsive when it comes to drug use and spending money.

---

**What are the risk factors for suicide in this case?**

**What is the risk level in this case and how did you come up with this conclusion?**

**How are you going to manage this patient?**

For answers to these questions see NS SRA forms ANNA
Case # 2 Shawn

**Identifying information:** He is a 41 year old man who lives in Bridgewater with his brother. He works as a fisherman but was fired from his job 3 months ago.

**Circumstances of referral and chief complaints:** Patient was brought by ambulance to ER. His brother was away but decided to come back home one day early. He found his brother in the car while the engine is running and fumes all over the garage. He opened the car door, got his brother out, and called 911.

**Stressors:** Patient was fired from his job after being humiliated by his manager 3 months ago. His wife left him and took his 9 year old son with her 2 months ago. He moved in with his brother then. He discovered she was cheating on him for 2 years. He started having severe pain and difficulty breathing a year ago and after several investigations, he was diagnosed with cancer lung.

**Suicide related questions:** After spending 3 days in a medical unit, patient was seen by the psychiatrist. He said he has no suicidal thoughts and he tried to elope from the medical unit. He informed the staff that his life is his own business and does not want to discuss anything. “I just want to be left alone” he said. He refused to answer questions and looked sad and tearful.

**Past psychiatric history:** Patient had 2 documented depressive episodes in the past. He was treated successfully with antidepressants. No previous suicide attempts.

**Medical History:** NKA, has been diagnosed with lung cancer 1 year ago and currently in remission.

**Family history:** Patient has one healthy brother. Parents have been divorced for years. Father is alcoholic and grandfather had schizophrenia.

**Personal history:** Patient was born in Halifax. No abnormality documented about his development. He struggled in school but was able to finish grade 12 then worked as a fisherman. He struggled in school and failed several grades but was pushed through until he completed grade 12. Shawn had many friends as a child and continued to have friends as an adult. He was married for 11 years and had one previous long term relationship prior to this marriage.

**Collateral information:** Brother said that he found a long suicide note at home. He also found a recent will in his room. He said his brother stopped eating and was isolating himself in the room. He stopped going out and his alcohol consumption increased dramatically in the past few months. He was drinking 24 beers daily and was very sad and lonely. 2 weeks before the attempt, he told his brother that he is grateful for everything he did for him. His brother was surprised at that comment but did not consider that his younger brother is planning to kill himself.

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**What are the risk factors for suicide in this case?**

**What is the risk level in this case and how did you come up with this conclusion?**

**How are you going to manage this patient?**
Case # 3 Diane

**Identifying information:** 29 year old female who lives with her female partner and 2 children ages 2.5 and 7 month old.

**Circumstances of referral and chief complaints:** Patient was brought to ER by her partner. Patient reported the following symptoms:
- Depressed mood, poor attention, excessive guilt, anxiety attacks, forgetfulness, crying spells, excessive worry, hyperactivity and impulsivity, fatigue and irritability.

**Alcohol and drug use:** drinks twice a month. No drug use.

**Review of symptoms:** When asked about suicide, she was very vague and evasive. She said that her life has not been good. She is not a good mother. She started crying and said that she will be punished and deserves death penalty.

While waiting alone in the room, she was observed by the nursing staff attending to voices. When asked about these communication, she said that these voices know all her sins and they will “make it public” if she does not respond to their commands and requests. After long pause, she said that they want her to stab her children then herself to end this miserable life.

**Medications:** currently takes Citalopram 40 mg AM. In the past she was prescribed Zoloft, Welbutrin, an as a child she said she was given Adderrall and Ritalin for ADHD that was diagnosed by her pediatrician at age 7.

**Medical History:** NKA. Had 2 bone fractures in the past after being gang raped.

**Family history:** Patient has a half-sister, 3 half-brothers. Parents divorced when she was 3 years old. She has a positive family history of depression, anxiety, substance use disorder and ADHD. Father had schizophrenia and he died by suicide 2 years ago.

**Personal history:** Patient was born in Alberta. She came to NS at age 4 with her father and his girlfriend.

She reported normal developmental milestones.

She did not do well in school because she hated school. Teachers did not like her. She was obese and other kids called her fat kid.

She always had few friends. She had a boyfriend who left her then came with his friends and gang raped her. She started having female partners after that. She described herself as bisexual.

Her older daughter was from a one night relationship and the young one was the product of rape. Patient was receiving social assistance after being fired from her last job as a cashier in a supermarket.

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**What are the risk factors for suicide in this case?**

**What is the risk level in this case and how did you come to this conclusion?**

**How are you going to manage this patient?**
Case # 4

Christine C

Identifying information: She is a 26-year old white single female.

Circumstances of referral and chief complaints: who walked to ER on December 23. She complained that she cannot stand life anymore. She said "I will go ahead and end it all”. She was living with a boyfriend who broke up with her that evening and asked her to leave his house. She has no place to go. Her mother lives approximately 5 hours away and her father is deceased. Have no friends in town.

Review of symptoms: Patient said she has been very stressed, anxious and depressed the past month. She said "Christmas was very hard, remembering that dad used to drink a lot around that time”. He physically and sexually abused her and her only sister as kids. She talked a lot about her traumatic memories of the abuse she suffered. She kept talking about the nights she spent crying after being hit by the built and pushed on the stairs. She remembered when she was taken to hospital after one of these episodes where her father kept hitting her until she lost consciousness. Her head was open and was taken to hospital. Her mother told the nurses in the hospital that she fell from her bike.
She has been experiencing frequent nightmares for the past 10 years.
Christine reported daily panic episodes, worry about everything and inability to relax. Her appetite and sleep did not change. Her mood has been low and frustrated. She enjoys watching Netflix but she stopped that a month ago. She has been feeling guilty for her sister’s death a year ago. She did not talk to her sister and finally received a text message from her asking to meet. She ignored the text message and the next day she learnt from the police that her sister jumped in front of the train in Toronto and died immediately.
Past Psychiatric History: she was followed by her family doctor and never had any interaction with mental health. No previous admission and no history of receiving any type of psychotherapy.
Alcohol and drug use: She said she never used alcohol nor street drugs.
Medical History: She has no active medical problems other than Crohn’s disease. NKA. One abortion at age 15.
Medications: Her family doctor has kept her on Venlafaxin 75 mg daily for the past 3 years and she does not feel it is helping her.
Personal history: She is currently considering distant education or going to NSCC full time to upgrade her education. She quit school in grade 11. Currently, she works part-time at the Dollar Store.

| What are the risk factors for suicide in this case? |
| What is the risk level in this case and how did you come to this conclusion? |
| How are you going to manage this patient? |
### Table A

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**Questions about this document, please contact Dr. Joseph Sadek**  
Joseph.sadek@nshealth.ca