Canadian Mental Health Association
Nova Scotia
Mental health for all

CAST
communities addressing suicide together

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Suicide Risk Assessment and Management

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True or False?

1. Suicide rates for Inuit youth are exactly the same as the rest of Canadians.
2. 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.
3. Asking about suicide make a patient act on it.
4. 60% of individuals who self-injure eventually die by their self injury.
5. One of the criteria for a diagnosis of BPD is engagement in self-injurious behaviors or threats, including both suicide attempts and self-mutilation.
6. Developing therapeutic alliance involves mistrusting the patient and getting frustrated with them.
7. Clinician should recommend to patient or a significant other restricting access to suicide means such as firearm, securing, or removing them and other weapons.
8. The risk of suicide while an inpatient is very low and happens only during the last week of admission.
9. Risk of suicide is high in the first week after discharge from a psychiatric hospital.
10. A history of suicide attempts or self-harm was strongly associated with increased risk of suicide.
11. Patients who exhibit protective factors never complete suicide.
12. Hospital Admission is never indicated for High Risk Patients.

Module 1

Provincial Suicide Risk Assessment Policy and Procedures

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Suicide Risk Assessment Policy

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.

Suicide Risk Assessment Policy

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

Suicide Risk Assessment Policy

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 a complex process, which is challenging to complete and may have outcomes that are imperfect. Nevertheless, it a process that 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.

Suicide Risk Assessment Tool

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Addressograph

Mental Health and Addictions

Suicide Risk Assessment Tool

Date _____ Time _____ Assessor _____ Diagnosis _____

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

Illness Management

- ☐ Lack of clinical support
- ☐ Non compliance or poor response to treatment

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

Circle of support

- ☐ Lack of family/ friends support
- ☐ Caregiver unavailable
- ☐ Frequent change of home

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

Suicide Risk Level: Risk assessment is based on clinical judgment and not based on number of items checked. The checklist is intended to guide the clinical decision only.

RISK LEVEL: ☐ **High** ☐ **Moderate** ☐ **Low** Signature:_____

Analysis of Risk, Comments and Collateral Information: _____

_____

_____

_____

_____

_____

For information about this form contact Dr. Joseph Sadek at joseph.sadek@nshealth.ca

Module 2

Introduction to Suicide

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Psychosocial and Economic Burden of Suicide

- The psychological and social impact of suicide on the family and society is immeasurable.
- On average, single suicide intimately affects at least six other people. If a suicide occurs in a school or workplace it has an impact on hundreds of people.
- The burden of suicide can be estimated in terms of DALYs (disability-adjusted life years).
- Suicide was responsible for 39 million disability adjusted life years in 2012.

Psychosocial and Economic Burden of Suicide

- Burden of suicide is equal to the burden due to wars and homicide.
- Twice the burden of diabetes, and equal to the burden of birth asphyxia and trauma.

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Psychosocial and Economic Burden of Suicide

The United States

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

Canada

Total costs (direct and indirect) related to suicide and self-harm in 2004 was $2,442 million. A study in New Brunswick in 1996 found the cost of suicide per death to be $849,877.80 (Clayton, 93).

Give Examples of the Estimate of Suicide Rates in Canada

- In 2012, Suicide/self-harm was the 9th leading cause of all injury (3,962). The National suicide rate in 2009 was 11.4 per 100,000.
- Nearly 4,000 Canadians die by suicide each year – an average of almost 11 suicides a day. It affects people of all ages and backgrounds.
- More than 75% of suicides involve men, but women attempt suicide 3 to 4 times more often.

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Give Examples of the Estimate of Suicide Rates in Canada

- In 2012, suicide accounted for 17% of deaths among youth aged 10 to 14.
- 28% among youth aged 15 to 19.
- 25% among young adults aged 20 to 24.
- After accidents, it is the second leading cause of death for people aged 15 to 34.

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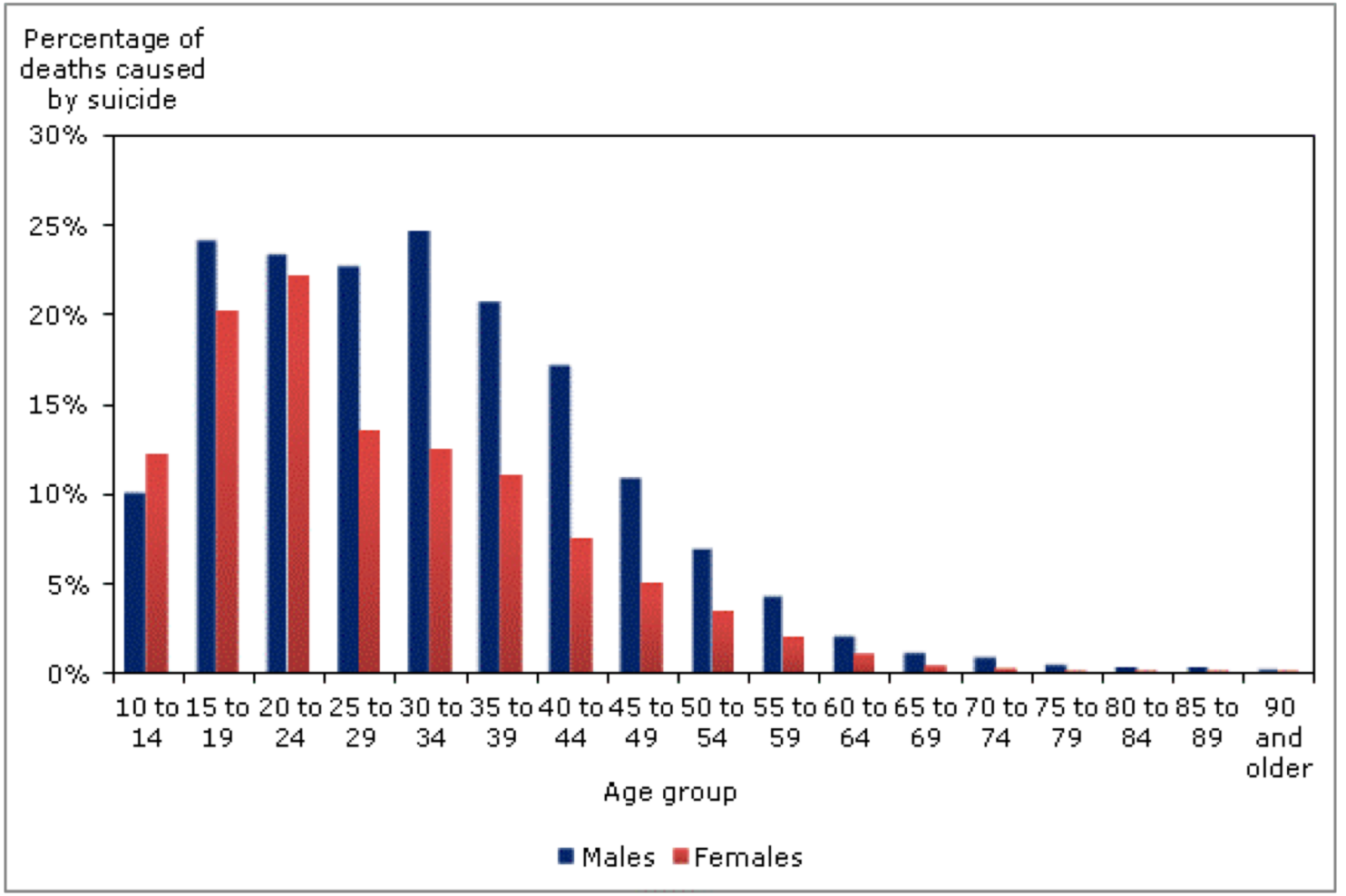
Epidemiology: Age Group



REF: Statistics Canada

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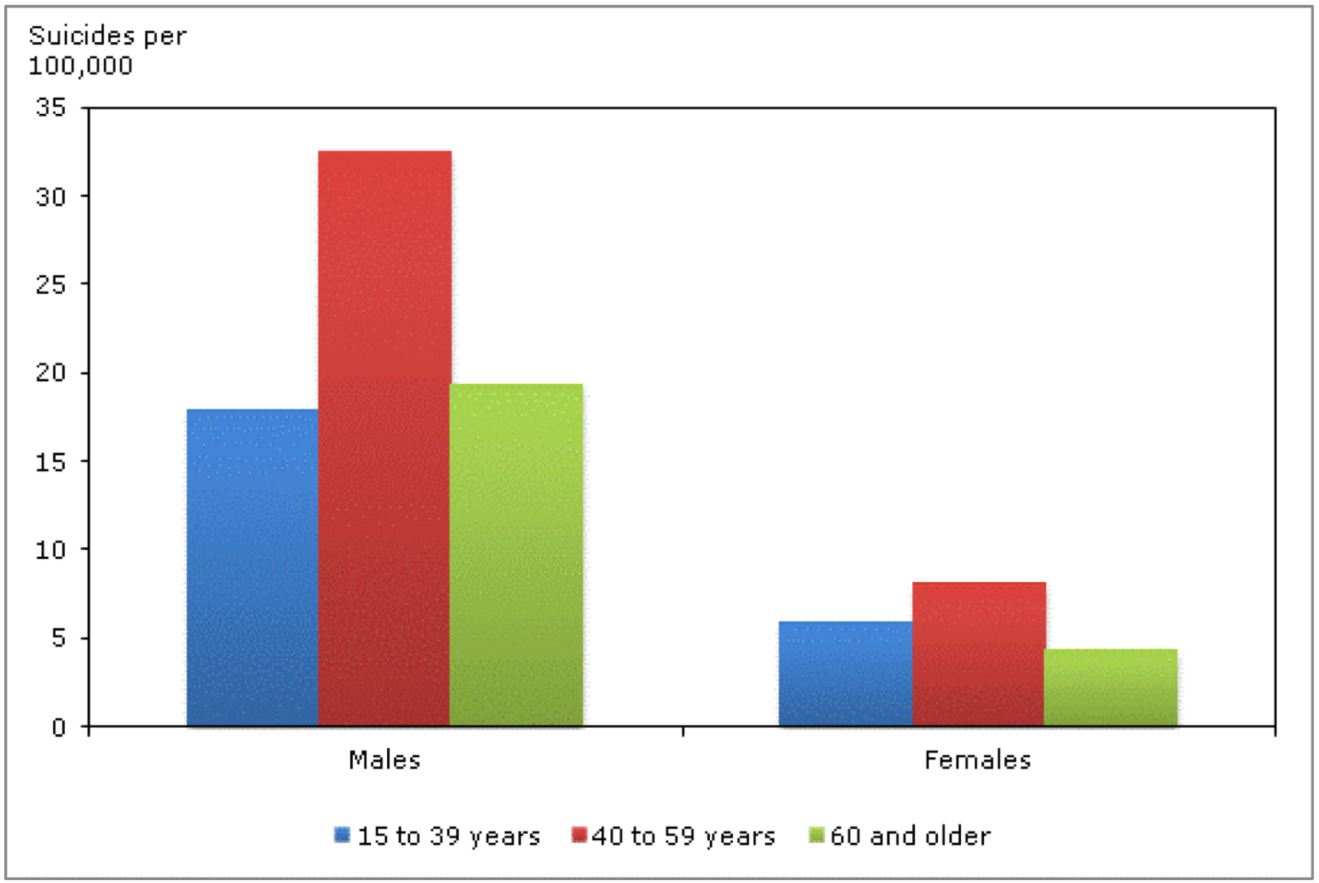
Epidemiology: Gender



REF: Statistics Canada

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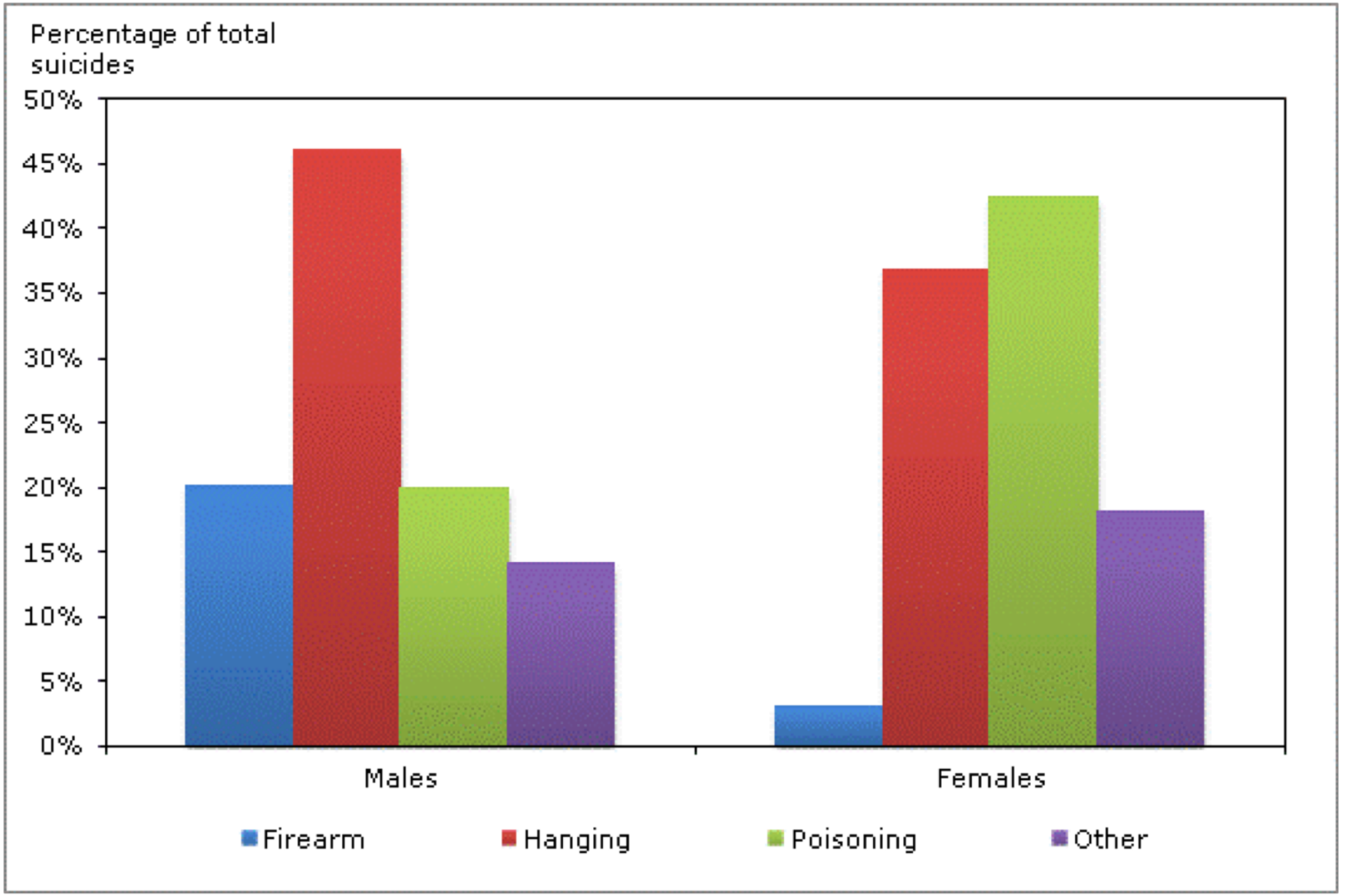
Epidemiology: Method of suicide



REF: Statistics Canada

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Give Examples of the Estimate of Suicide Rates in Canada

- First Nations youth die by suicide about 5 to 6 times more often than non-aboriginal youth.
- Suicide rates for Inuit youth are among the highest in the world, at 11 times the national average. (CAMH and HC)

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Give Examples of the Estimate of Suicide Rates in 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).

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

- No.
- A barrier to assessment is the belief held by some clinicians that asking about suicidal thoughts will induce such thoughts in patients (Bolton 2015).
- A review of 13 studies published between 2001 and 2013 that investigated this question found no evidence of increase in suicidal ideation in patients who were asked about suicide.

Is Suicide Risk Assessment the Same as the Suicide Risk Assessment Tool?

- Suicide risk assessment is a clinical encounter where a patient is asked about suicidal thoughts, plans and mental health history and assessment.

- Not considered the same as risk assessment tools or scales, as tools and scales might be used during that clinical encounter.

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Module 3

Suicide and Self Harm

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What Does the Term Non-Suicidal Self Injury Mean?

- Inconsistent terms in describing suicide-related thoughts and behaviors.

- 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.

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What Does the Term Non-Suicidal Self Injury Mean?

- 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 of 22 studies of NSSI in adolescents suggested a lifetime prevalence rate of 13% and 23% and age of onset ranges between 12 and 14 years of age (Jacobson 2007).

Is There a Correlation Between NSSI and Suicide Attempts?

- 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.
- 3-7% of individuals who self-injure eventually die by their self injury .

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Is There a Specific Mental Disorder That Has a High Risk of NSSI?

- Engagement in NSSI is very common among adults **with Borderline Personality Disorder (BPD).**

- 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).

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Is There a Specific Mental Disorder That Has a High Risk of NSSI?

- 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, 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 (BPD)?

Since BPD is associated with a chronic suicide risk, it is important to recognize the symptom criteria 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:

- Intense fear of abandonment, even going to extreme measures to avoid real or imagined rejection or abandonment.
- A pattern of unstable intense relationships.
- Rapid changes in self-identity or self-image that include shifting goals and values.

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What are the Diagnostic Symptoms Criteria of Borderline Personality Disorder (BPD)?

- Brief periods of stress-related paranoia or loss of contact with reality. 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, binge eating or substance/alcohol use.
- Suicidal threats or behavior, gestures or self-injury.
- Significant and wide mood fluctuations may occur within the same day, lasting from a few hours and rarely to a few days.
- Long standing feelings of emptiness.
- Inappropriate, severe anger episodes or difficulty controlling anger.

Would hospitalization be the most beneficial treatment for BPD?

- Not necessarily.
- If admission to hospital is required, then it should be brief with a goal of reducing repeated self-harm during crisis, along with the prevention of death.
- Can also be used to facilitate quick return to the community outpatient treatment.
- Prolonged psychiatric hospitalization should be avoided because this is typically counter-therapeutic and may foster and increase dependency needs and cause behavior regression.

Module 4

The Content and Process of Suicide Risk Assessment (SRA)

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Who Should be Asked About Suicidal Thoughts?

- WHO recommends that all people over the age of 10 years with a mental disorder should be asked about thoughts or plans of self harm within the past month.

- Most clinical practice guidelines encourage standardized process for SRA.

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Who Should be Asked About Suicidal Thoughts?

- A study found that the process of assessment itself correlated with a lower likelihood of future suicidal behavior (Olfson M. 2013).
- Clinician-patient contact can provide an important therapeutic effect. (Bolton J. 2015)

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What are the Common Challenges in Suicide Risk Assessment (SRA)?

- 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.

What are the Common Challenges in Suicide Risk Assessment?

- 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 that limit their ability to work effectively with people who are acutely suicidal.

Process and Core Competencies for Assessing Patients at Risk of Suicide

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Step 1: Build Therapeutic Alliance (TA) With the Patient and Family

- Essential and core competency.
- Developing TA involves empathy, active listening, collaboration, respect, trust, sense of warmth, non-adversarial, non-judgmental acceptance, transparency and a strong interest in understanding them and the nature and cause of their pain/distress. (Bryan & Rudd, 2011)

Step 2: Identify Risk Factors That Put the Patient at Higher Suicide Risk and Identify Protective Factors That Build Resilience in the Patient

- Questions start by asking about death wishes, suicidal thoughts, then plan and intent to die.
- Whether or not a plan is present, if a patient has acknowledged suicidal ideation, there should be: specific inquiry about the presence or absence of a firearm or access to large doses of medications or other means.

Step 2: Identify Risk Factors, Noting Those That Can be Modified to Reduce Risk and Identify Protective Factors That Build Resilience in the Patient

- Recent changes in access to firearms or other weapons, including recent purchases or altered arrangements for storage.
- Clinician should recommend to patient or a significant other restricting access to suicide means such as firearm, securing, or removing them and other weapons.

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Step 2: Identify Risk Factors, Noting Those That Can be Modified to Reduce Risk and Identify Protective Factors That Build Resilience in the Patient

- If a plan is identified, evaluate steps taken to practice 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.
- Ask about past attempts, how recent and how lethal the attempt was.

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Step 2: Identify Risk Factors, Noting Those That Can be Modified to Reduce Risk and Identify Protective Factors That Build Resilience in the Patient

Identify the following risk factors during the interview:

- 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.

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Step 2: Identify Risk Factors, Noting Those That Can be Modified to Reduce Risk and Identify Protective Factors That Build Resilience in the Patient

Identify the following risk factors during the interview:

- Poor reasoning/judgment
- Clinical intuition: assessor concerned (do not ignore)
- Recent dramatic change in mood
- Recent crisis/conflict/loss

Understand issues about illness management:

- Lack of clinical support
- Non compliance or poor response to treatment

Step 2: Identify Risk Factors, Noting Those That Can be Modified to Reduce Risk and Identify Protective Factors That Build Resilience in the Patient

Individual Risk Profile (some can obtained from the history):

- Ethnic, cultural risk group or refugee or aboriginal status
- Family history of suicide
- Trauma: as domestic violence / sexual abuse/neglect
- Poor self-control: impulsive / violent/aggressive
- Recent suicide attempt or other past suicide attempts, esp. with low rescue potential
- Mental illness or addiction
- Depression/ anhedonia (lack of interest or pleasure)
- Psychotic
- Command hallucinations

Step 2: Identify Risk Factors, Noting Those That Can be Modified to Reduce Risk and Identify Protective Factors That Build Resilience in the Patient

Individual Risk Profile:

- Recent admission / discharge / emergency department visits
- Chronic medical illness/ pain
- Disability or impairment
- Collateral information supports suicide intent
- Risk related to the circle of support
- Lack of family/ friends support
- Caregiver unavailable (particularly important in adolescents and seniors)
- Frequent change of home (particularly important in adolescents)

Understand That Suicide May Occur During Inpatient Admission

- The risk of suicide while an inpatient is high.
- 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 (Bolton, 2015, BMJ).

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Understand That Suicide May Occur After Recent Hospital Discharge

- Risk of suicide is high in the first week after discharge from a psychiatric hospital.
- Remains high for the first few months after discharge, and then slowly decreases.
- Risk of suicide after discharge is especially high for psychiatric patients who were admitted to hospital with a suicide attempt. (Bolton, 2015, BMJ)

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Suicide Among Patients Presenting to the Emergency Department

Rates are high:

- 2% will kill themselves within one year.
- Five year estimate of suicide is 4%.
- Risk is 50 times › general population and is associated with a 40 year reduction in average life expectancy.
- Rates of repeat self harm after contact with the ED are 10% at one month and as high as 27% at six months (Bolton, 2015, BMJ).

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Be Aware of the Suicide Risk With Past Psychiatric History

- Higher risk in those with a history of previous psychiatric hospital admissions (OR=2.37, 95% CI 0.86 to 6.55).
- 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).

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Be Aware of the Suicide Rates 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.
- Majority had seen a general physician rather than a psychiatrist.

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Understand Protective Factors

- Be aware that patients who exhibit protective factors **do attempt and complete suicide.**
- Multiple protective factors generally contribute to patient resiliency to stress and adversity.
- Protective factors may be considered in each of the domains of the individual, family, work and community.

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Understand Protective Factors

Important protective factors may include:

Internal: Ability to cope with stress, religious beliefs, frustration tolerance.

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

Step 3: Collect Collateral History

- Collect further information (provided that consent was obtained) to assist with formulating suicide risk assessment.
- Sources of information include other treating clinicians and health care professionals, people accompanying patient, family, circle of support, and health records.

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Step 3: Collect Collateral History

- For children and adolescents information from the school counselors should can be collected if possible.
- Direct interview or phone contact can be used.
- Consider privacy prior to obtaining collateral history.

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Step 4: Formulate The Risk

- Make clinical judgment of the risk that a patient 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.
- Consider developmental, cultural, psychosocial and gender-related issues related to suicidality.

Module 5

Management of Suicidal Patients

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What are the Steps of Management of Suicidal Patients?

a) Maintain the therapeutic alliance with the patient.

b) Consider immediate safety needs during and after SRA assessment.

c) Select a treatment setting and protocol based on risk level.

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

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A. Maintain Therapeutic Alliance With the Patient

Very important step.

B. Consider Safety Needs in the Physical Environment (e.g. Emergency room or inpatient)

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B. Consider Safety Needs in the Physical Environment (e.g. Emergency room or inpatient)

- Elopement precaution measures such as security staff and locked area
- Is observation of patients who require medical equipment (e.g., beds, IV, oxygen) adequate?
- Are agitated or aggressive patients controlled with medications?

B. Consider Safety Needs in the Physical Environment (e.g. Emergency room or inpatient)

Are the areas of potential vulnerability in the physical facility addressed? :

- Access to means of hanging, suffocation, strangulation and jumping as a method of suicide.
- Access to other potentially harmful items.

C. Select a treatment setting

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

Patients at high risk of suicide:

- Hospital admission is generally indicated for high risk patients.

High risk patients include but not limited to:

- Serious suicide thoughts, a plan or intent.
- After a serious suicide attempt or aborted suicide attempt.
- Attempt was violent, near-lethal, premeditated.

Examples of High Risk Patients

- Precautions were taken to avoid rescue or discovery.
- Persistent plan and/or intent is present.
- Distress is increased or patient regrets surviving.
- Patient is psychotic / responding to command hallucinations to kill self.
- Limited family and/or social support, including lack of stable living situation.

Examples of High Risk Patients

- Current impulsive behavior, severe agitation, poor judgment, or refusal of help is evident.
- 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 lethal plan e.g. shoot self and has a gun
    - Severe anxiety or agitation

Hospital admission is also generally indicated in the following circumstances

- Lack of response to or inability to cooperate with outpatient treatment.
- Need for skilled observation, supervision, or diagnostic assessments that require a structured setting.
- Limited clinical/family and/or social support, including lack of stable living arrangements.
- Lack of timely access to outpatient follow-up.
- Evidence from the psychiatric evaluation and/or history from others suggests a high level of suicide risk despite patient denying suicidal thoughts.

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Monitoring and Observation Levels of High Risk Patients in Hospital

Range of frequency of observations from 1:1 (constant observation), to 15 minute checks, to 30 minute checks.

Examples of restrictions include:

- Supervised bathroom.
- Unit restriction or restriction to public areas.
- Placement in hospital clothing.
- Staff should be familiar with indications for medications, seclusion, restraints, body and belongings searches.

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Release From Emergency Department With Outpatient Follow-up 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 ED.
- Plan/method and intent have low lethality.
- Patient has stable and supportive living situation and cooperative.

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Family or Circle of Care Education About Managing Their Loved One

Clinicians should give instructions about:

- Maintaining appropriate supervision.
- Knowing where the person is at all times and who they are with.
- How to contact the team for an urgent re-assessment.
- When patient does not attend a follow-up appointment, he/she must be contacted immediately to re-assess.

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Management plan for a patient with a Moderate risk of Suicide

- Support to be provided by the team.
- Written information about how to seek further help, including a 24-hour telephone number or mobile crisis number.
- The date and time of the re-assessment.
- Plan should be negotiated with the person and family/support person and conveyed to the referrer, treating psychiatrist, GP and other clinicians involved.

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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.

Interventions for low risk patients include:

- Outpatient referral.
- Providing emergency information, including phone numbers of mobile crisis.

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Assessment and Management of Chronically Suicidal People

- Detailed management plans that list both chronic and acute symptoms should be developed with the person.
- Clinicians should determine 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.

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Assessment and Management of Chronically Suicidal People

- Emergency departments should attempt to contact mental health services, obtain the file that contains the symptoms and management plan when a chronically suicidal person presents.
- Care must be taken not to downplay the seriousness of attempts.

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Assessment and Management of Chronically Suicidal People

- Patient's regular clinician should be contacted if they are now experiencing additional stressors or a significant change in their mental illness (if possible).

- Short inpatient admission or referral to high support services (such as crisis team) may be necessary when the person's suicidality is exacerbated by an acute life stressor and cannot be treated as an outpatient, or if they also develop an Axis I disorder.

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

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Suicide Prevention Contracts

- Contracts (known as “no-harm contracts” or “contracts for safety”).
- 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 clinical judgment.

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Contingency Planning

Requires the clinician and the person at risk and/or their family or care giver to anticipate likely escalations of risk such as:

- New conflict or deterioration of family relationships
- Increase symptoms (depression, hallucinations, SI)
- Difficulty accessing the service

Contingency planning is designed, communicated and documented :

If….., then the person will ……, family will……, the service will…….

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True or False?

1. Suicide rates for Inuit youth are exactly the same as the rest of Canadians.
2. 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.
3. Asking about suicide make a patient act on it.
4. 60% of individuals who self-injure eventually die by their self injury.
5. One of the criteria for a diagnosis of BPD is engagement in self-injurious behaviors or threats, including both suicide attempts and self-mutilation.
6. Developing therapeutic alliance involves mistrusting the patient and getting frustrated with them.
7. Clinician should recommend to patient or a significant other restricting access to suicide means such as firearm, securing, or removing them and other weapons.
8. The risk of suicide while an inpatient is very low and happens only during the last week of admission.
9. Risk of suicide is high in the first week after discharge from a psychiatric hospital.
10. A history of suicide attempts or self-harm was strongly associated with increased risk of suicide.
11. Patients who exhibit protective factors never complete suicide.
12. Hospital Admission is never indicated for High Risk Patients.

Thank You

Questions? Please email:

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