# Module 17

## Prevention of Suicide; Assessment and Treatment of the Suicidal Patient

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CANADIAN HEALTH CARE AGENCY

EXPERIENCE THE NORTH



1. Discuss the CHN role in Suicide Prevention
2. Risk Factors/Protective Factors
3. Warning Signs
4. Understand the importance of “No Show” follow up

## Objectives-Suicide Prevention

1. History Taking
2. Physical Findings
3. Suicide Risk Assessment Tool (SAD PERSONS)
4. Non Pharmacological Interventions
5. Attempted Suicide
6. Referral: Including Medevac Criteria
7. Recognize available community resources

## Objectives: Assessment & Intervention



- Teaching youth coping strategies, problem solving skills and life skills
- Reducing access to lethal means
- Ensuring adequate treatment for mental health
- Addressing determinants of health
- Family support
- Support groups for youth
- Increase awareness of mental health and suicide

## CHN Role in Suicide Prevention

## Risk Factors

- Social isolation
- Major disruption in life
- Mental Illness
- Family History
- Substance abuse
- Peer teasing
- Poor school attendance
- Previous attempts

## Protective Factors

- Good physical and mental health
- Strong problem solving, communication, conflict resolution abilities
- Positive family and friend relationships
- Positive attitude towards school

**Risk Factors & Protective Factors**



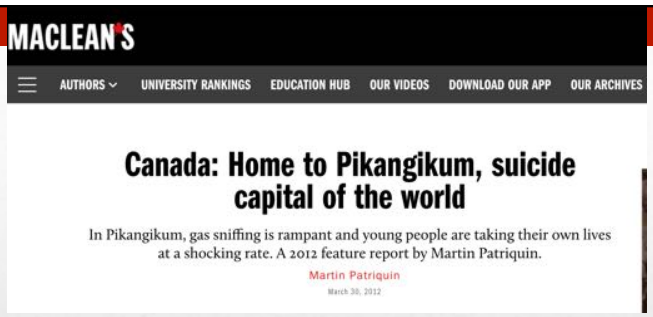
- Sudden change in behaviour
- Increased use of ETOH or drugs
- Recent loss of friend or family member
- Many mood swings, outbursts, irritability or aggression
- Feeling hopeless, worthless, in despair
- Giving away valued possessions, putting affairs in order
- Purchasing items to be used for suicide
- Having a plan for suicide
- Preoccupation with death
- Talking about suicide directly
- Threatening to commit suicide


**Warning Signs**

- The jury from a coroner's inquest into the suicide of 15 year old Selena Sakanee from Neskantaga First Nation delivered 41 recommendations on suicide prevention for First Nations in 1999.
- Recommendation #23: Service providers should develop a protocol on how to deal with a "no show" patient who needs follow up.

## Coroner's Inquest: Selena Sakanee






- Review of 16 Pikangikum First Nation youth ages 10 to 19 between 2006-2008
- Report includes a total of 100 recommendations in the areas of education, policing, child welfare and health care, with a particular focus on the development of suicide prevention strategies.

## Coroner's Inquest: Youth Suicides, Pikangikum First Nation

"Suicide is the leading cause of death for First Nations under the age of 44."

"The suicide rates for First Nations youth (10-19 years) are 4.3 times greater than the rest of Canada."

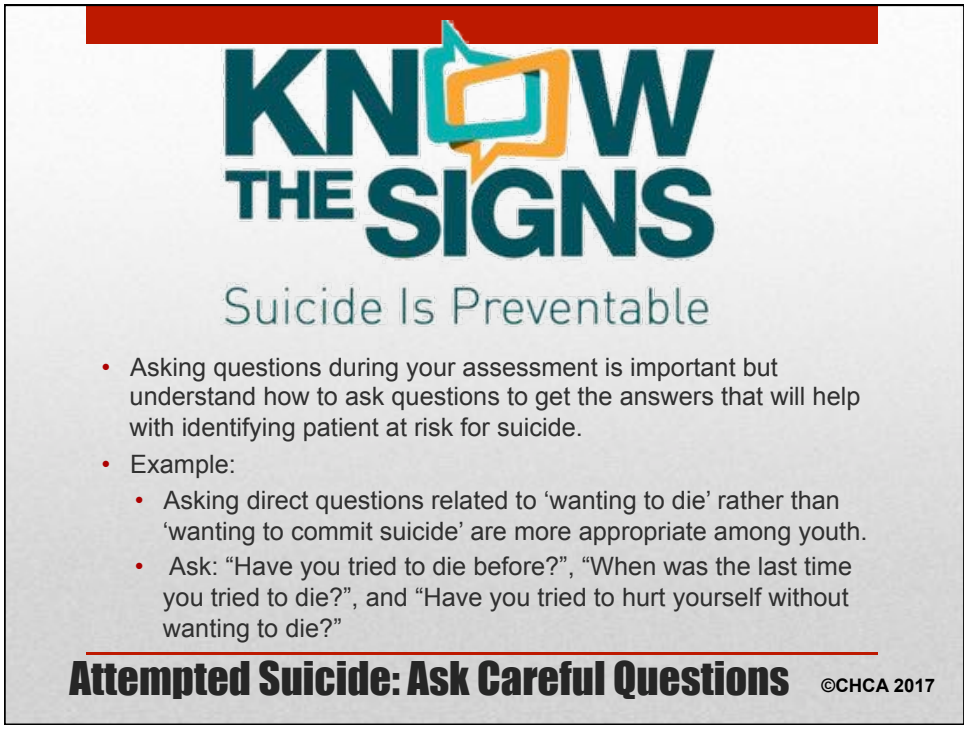
## Suicidal Behaviour



## History

- BATHE
- Therapeutic relationship
- Assure confidentiality
- Suicidal ideation?
- "Does client have a plan?"
- Suicide risk assessment
- Triggers
- Previous attempts?
- Mood
- Substance use
- "Does client want help?"


## Suicidal Behaviour: History


KNOW
THE SIGNS
Suicide Is Preventable
• Asking questions during your assessment is important but understand how to ask questions to get the answers that will help with identifying patient at risk for suicide.
• Example:
• Asking direct questions related to 'wanting to die' rather than 'wanting to commit suicide' are more appropriate among youth.
• Ask: "Have you tried to die before?", "When was the last time you tried to die?", and "Have you tried to hurt yourself without wanting to die?"
Attempted Suicide: Ask Careful Questions
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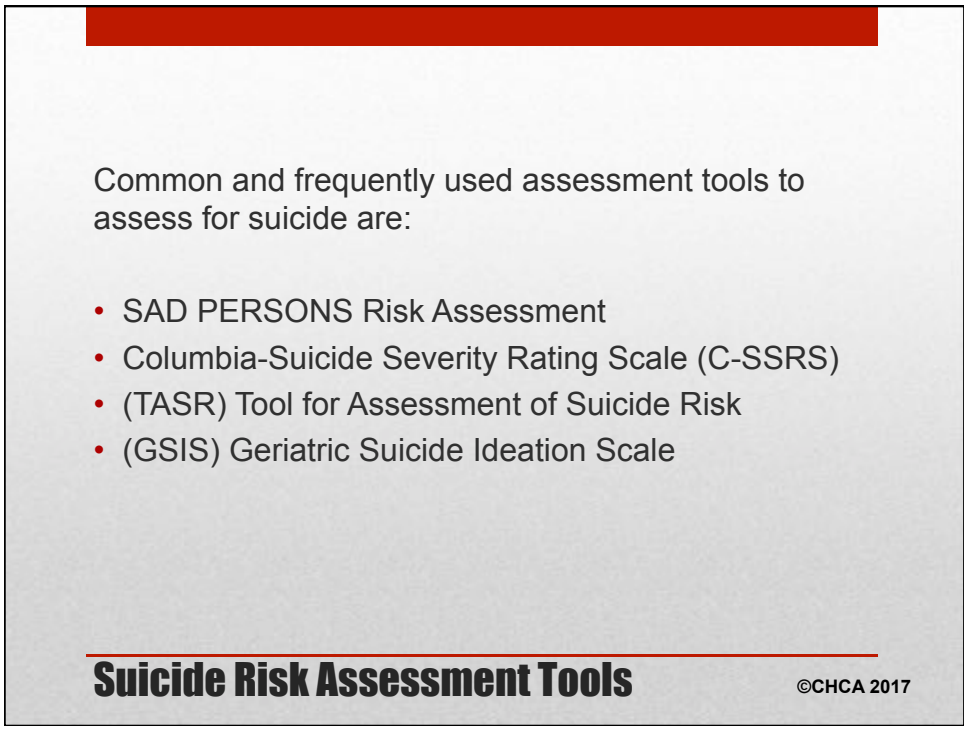

Common and frequently used assessment tools to assess for suicide are:
• SAD PERSONS Risk Assessment
• Columbia-Suicide Severity Rating Scale (C-SSRS)
• (TASR) Tool for Assessment of Suicide Risk
• (GSIS) Geriatric Suicide Ideation Scale
Suicide Risk Assessment Tools
©CHCA 2017

- The score is calculated from TEN yes/no questions, with points given for each affirmative answer as follows:
  - **S**: Male sex → 1
  - **A**: Age <19 or >45 years → 1
  - **D**: Depression or hopelessness → 2
  - **P**: Previous suicidal attempts or psychiatric care → 1
  - **E**: Excessive ethanol or drug use → 1
  - **R**: Rational thinking loss (psychotic or organic illness) → 2
  - **S**: Single, widowed or divorced → 1
  - **O**: Organized or serious attempt → 2
  - **N**: No social support → 1
  - **A**: Availability of Lethal means 2 points
  - **S**: Stated future intent (determined to repeat or ambivalent) → 2

## Suicide Risk Assessment: SAD PERSONAS



This score is then mapped onto a risk assessment scale as follows:

- 0–5: May be safe to discharge (depending upon circumstances)
- 6-8: Probably requires psychiatric consultation
- >8: Probably requires hospital admission

## SAD PERSONAS: Scoring

- Feasible; low burden- short administration time
- Assesses both behavioral and ideation: Uniquely addressing the need for a summary measure of suicidality
- Comprehensive measure that includes only the most necessary suicidality characteristics (low burden)
- Evidence-based (developed by leading experts)

VIDEO: CSSRS

**Columbia-Suicide Severity Rating Scale** ©CHCA 2017

## KEY QUESTIONS AREAS FOR SUICIDAL IDEATION

1) **Wish to be Dead**
   - Have you wished you were dead or wished that you could go to sleep and not wake up?
2) **Non-specific Active Suicidal Thoughts**
   - Have you actually had thoughts of killing yourself?

   ****If NO to #1 and #2, Suicidal Ideation Section completed**

   ****If NO to #1 and YES to #2, ask the following 3 questions**
3) **Associated Thoughts of Methods**
   - Have you been thinking about how you might do this?
4) **Some Intent**
   - Have you had these thoughts and had some intension of acting on them?
5) **Plan and Intent**
   - Have you started to work out or have worked out the details of how to kill yourself? Do you intend to carry out this plan?

**Columbia-Suicide Severity Rating Scale** ©CHCA 2017

## Physical Exam

- MSE
- General appearance
- Attitude and interaction
- Activity level
- Speech
- Thought process
- Perceptions
- Cognition
- Insight
- Impulse control
- Affect
- Family interaction

## Diagnostic Tests

Consider following test after consultation with physician

- Serum toxicology
- Urine pregnancy screen
- Serum drug and ETOH level
- TSH
- Random glucose

**Suicidal Behaviour**

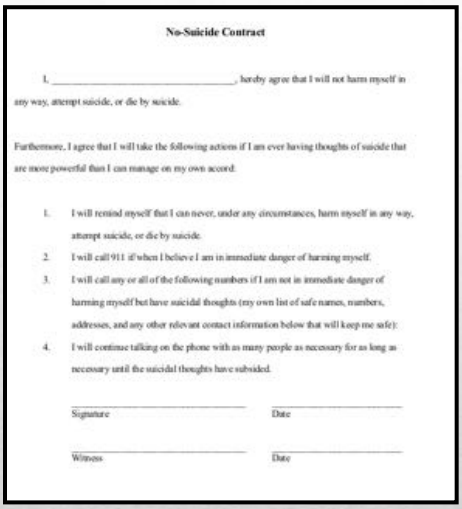


1. Safety First
2. Assess patient for any physical injuries and treat.
3. Choose the appropriate suicide risk assessment tool
4. Contact MD on-call for Medevac, call Nodin to send patient out and arrange escort.
5. Sign a **SAFETY CONTRACT** if remains in the community.
6. Form 1 if patient refuses admission, with assistance of MD via video conference or if MD onsite.

**Management of the Suicidal Patient**

## No-Suicide Contracts

- Contract between client and clinician
- May be written or verbal
- Not a stand alone intervention
- Components
  - Promise not to hurt or kill themselves
  - May have a specific duration
  - Actions for suicide prevention
  - Signature and date
- Lack of evidence



**No-Suicide Contract**

I, _____, hereby agree that I will not harm myself in any way, attempt suicide, or die by suicide.

Furthermore, I agree that I will take the following actions if I am ever having thoughts of suicide that are more powerful than I can manage on my own accord:

1. I will remind myself that I can never, under any circumstances, harm myself in any way, attempt suicide, or die by suicide.
2. I will call 911 if/when I believe I am in immediate danger of harming myself.
3. I will call any or all of the following numbers if I am not in immediate danger of harming myself but have suicidal thoughts (my own list of safe names, numbers, addresses, and any other relevant contact information below that will keep me safe):
4. I will continue talking on the phone with as many people as necessary for as long as necessary until the suicidal thoughts have subsided.

_____ _____
Signature Date

_____ _____
Witness Date



## Suicidal Behaviour

### Non pharmacological

- Educate about suicide
- Establish a written safety plan
- Crisis intervention services
- Family interventions
- Establish a treatment plan
- Verbal or written safety agreement

### Pharmacological

- Treat co-existing and/or misdiagnosed medical or psychiatric concerns
- Treat chronic medical conditions
- Tetanus vaccination
- Antibiotics
- Poison control instructions

## Form 1

- Authorizes the detention and assessment of an individual who meets the criteria in the Act for a 72 hour period
- Physician assessment within the past 1/52
- Reasons under the Mental Health Act

Ministry of Health — Form 1 — Mental Health Act

**Application by Physician for Psychiatric Assessment**

Clear Form

Name of physician _____

Physician address _____

Telephone number (___) _____ Fax number (___) _____

On _____ I personally examined _____

whose address is _____

*You may only sign this **Form 1** if you have personally examined the person within the past seven days. In deciding if a Form 1 is appropriate, you must complete **either** Box A (serious harm test) **or** Box B (persons who are incapable of consenting to treatment and meet the specified criteria test) below.*

**Box A – Section 15(1) of the Mental Health Act**
**Serious Harm Test**

**The Past / Present Test** *(check one or more)*

I have reasonable cause to believe that the person:

- ☐ has threatened or is threatening to cause bodily harm to himself or herself
- ☐ has attempted or is attempting to cause bodily harm to himself or herself
- ☐ has behaved or is behaving violently towards another person
- ☐ has caused or is causing another person to fear bodily harm from him or her; or
- ☐ has shown or is showing a lack of competence to care for himself or herself

I base this belief on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations:

Facts communicated to me by others:

**The Future Test** *(check one or more)*

I am of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in:

- ☐ serious bodily harm to himself or herself,
- ☐ serious bodily harm to another person,
- ☐ serious physical impairment of himself or herself

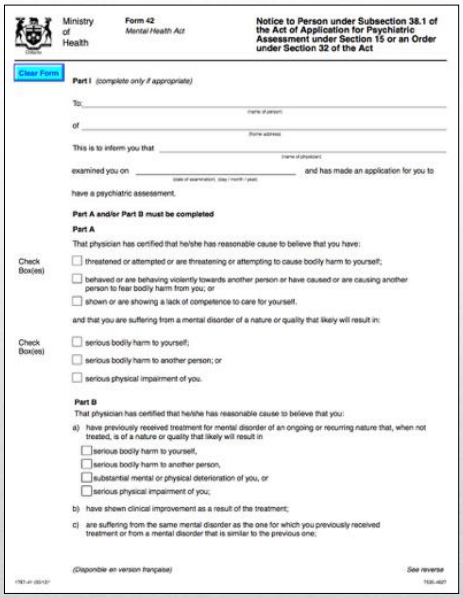
*(Disponible en version française)* *See reverse*

**FORMS**



## Form 42

- Informed the reason for Form 1 initiation



Ministry of Health — Form 42 — Mental Health Act

**Notice to Person under Subsection 38.1 of the Act of Application for Psychiatric Assessment under Section 15 or an Order under Section 32 of the Act**

Clear Form

**Part I** *(complete only if appropriate)*

To: _____

of _____

This is to inform you that _____

examined you on _____ and has made an application for you to have a psychiatric assessment.

**Part A and/or Part B must be completed**

**Part A**

That physician has certified that he/she has reasonable cause to believe that you have:

Check Box(es)

- ☐ threatened or attempted or are threatening or attempting to cause bodily harm to yourself;
- ☐ behaved or are behaving violently towards another person or have caused or are causing another person to fear bodily harm from you; or
- ☐ shown or are showing a lack of competence to care for yourself.

and that you are suffering from a mental disorder of a nature or quality that likely will result in:

Check Box(es)

- ☐ serious bodily harm to yourself;
- ☐ serious bodily harm to another person; or
- ☐ serious physical impairment of you.

**Part B**

That physician has certified that he/she has reasonable cause to believe that you:

a) have previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in
   - ☐ serious bodily harm to yourself,
   - ☐ serious bodily harm to another person,
   - ☐ substantial mental or physical deterioration of you, or
   - ☐ serious physical impairment of you;

b) have shown clinical improvement as a result of the treatment;

c) are suffering from the same mental disorder as the one for which you previously received treatment or from a mental disorder that is similar to the previous one;

*(Disponible en version française)* *See reverse*

**FORMS**

- Management and Follow up
  - Medevac
  - Within 48 hours and at least weekly until client is stable to assess coping strategies, social supports, resolution to acute crisis phase, education, and further referrals.
  - Safety agreement can be renewed as needed
  - Ongoing Prevention

**Suicidal Behaviour – Management and Follow up**



- Exhibiting destructive behaviours and is willing to attend counselling.
- Exhibiting Suicidal behaviours and is willing to attend counselling.
- Is a victim of Sexual Assault/physical abuse and is at imminent danger if remains in the community and is willing to attend counselling.
- Physical condition warrants further medical attention

**Medevac Criteria for Admission of Suicidal Patient**

**Suicide attempt by hanging:**

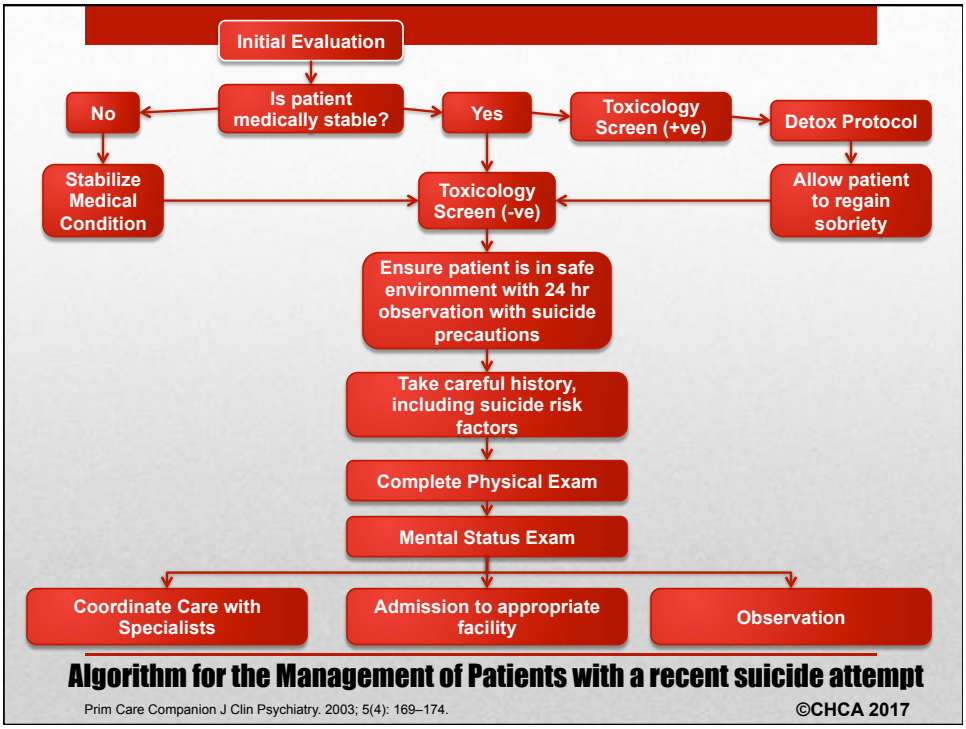
- Ensure cervical spine precautions are engaged on-scene, although C-spine injuries are uncommon in cases of self-hanging.
- Morbidity is primarily due to asphyxiation with cerebral anoxia or soft tissue injury – maintain a patent airway, monitor for laryngeal edema and provide oxygen.
- The heads of kids under eight years of age are somewhat large in proportion to their bodies, resulting in neck flexion when they are placed supine on a standard backboard – use a towel roll under the shoulders.

**Suicide attempt by overdose:**

- Brief initial screening performed to identify immediate measures required to stabilize and prevent deterioration
- Vital signs, mental status, and pupil size, skin temperature and moisture, and perform pulse oximetry, continuous cardiac monitoring, and an ECG.
- Obtain intravenous access and a finger-stick glucose measurement.
- Search clothing, wallets, and pocket books for pills, pill bottles, or drug related equipment to try and identify etiology of the poisoning, but take care when doing so to avoid a needle stick.
- Call poison control for guidance and consult MD.

## Initial Emergency Management






## Algorithm for the Management of Patients with a recent suicide attempt

Prim Care Companion J Clin Psychiatry. 2003; 5(4): 169–174.

- Visit www.suicideinfo.ca for resources surrounding Aboriginal Youth, and suicide prevention strategies.

Available at: http://suicideinfo.ca/Store/ProductDetail/tabid/520/ProductId/6/Default.aspx

## Resources



Kutcher, S & Chehil S. (2007) Suicide risk management: A manual for health professionals. Malden, MN: Blackwell Publishing Ltd.

Juhnke, G.A & Hovestadt A. J (1995) Using the SADERSONS Scale to promote supervisee suicide assessment knowledge. The Clinical Supervisor, 13(2), 31-40.

Heisel, M.J., & Flett, G.L (2006). The development and initial validation of the Geriatric Suicide Ideation Scale. The American Journal of Geriatric Psychiatry, 14 (9), 742-751.

Bullard, M. J (1993). The problem of suicidal risk management in the emergency department without fixed, full time emergency physicians. Changgeng Yi Xue Za Zhi, 16, 30-38.

## References