Suicide: Risk Assessment, Prevention and Management (Community and Long-term Care)

Site Applicability

- All VCH & PHC Long-term Care homes

*for VCH Community Mental Health and Substance Use (MHSU) programs please refer to the Suicide Risk Assessment & Management: Community Mental Health & Substance Use DST

Practice Level

Basic skills for all members of the interdisciplinary team within the competencies of their respective scopes of practice or as per education, training and job description, for example:

- Nurses (RN, RPN, LPN, NP)
- Occupational Therapist (OT)
- Physiotherapist (PT)
- Registered Dietitian (RD)
- Recreational Therapist (RecT)
- Respiratory Therapist (RRT)
- Clinical Counsellor
- Vocational Counsellor
- Music Therapist
- Psychologist
- Pharmacist
- Social Worker (SW)
- Speech-Language Pathologist (S-LP)
- Spiritual Care Practitioner

Unregulated health care providers within the competencies of their employer training and job descriptions and under the supervision of appropriate regulated health care professional. Examples include but not limited to: long-term Care Aid, Rehabilitation Assistant, Activity Worker, Community Liaison Worker, etc.

Where the term individual is used through this document, it includes resident, client and patient.

Background

Suicide may be viewed as the most extreme response to overwhelming distress[5]. Death by suicide for older adults is higher than the general population particularly in men. The most common methods used in long-term care are hanging or falling from a height[3]. Completed suicide in long-term care is rare[4], however suicidal ideation can be present in up to a third of individuals[4].

The abuse of alcohol or drugs is second to depression as the most frequent risk factor for suicidal behaviour. The risks increase if Substance Use Disorder (SUD) occurs in conjunction with depression (major depressive disorder) or other mental health disorders such as Post Traumatic Stress Disorder, Anxiety Disorder, Bipolar Disorder, Schizophrenia and some personality disorders.[18]

Early recognition of suicidal ideation is key to preventing death and promoting individual safety and well-being. Recognizing when individuals are at risk requires understanding the relationship between Risk Factors, Warning Signs and Protective Factors.

Having multiple risk factors does not necessarily mean an individual is going to attempt suicide, additional information is required to a) establish whether the individual is contemplating suicide AND b) determine the individual's level of risk for suicide (low – imminent). This involves assessing for Risk Factors, Warning Signs and Protective Factors and collating this information to determine the level of risk for suicide. The Risk Assessment Matrix (Appendix B) or Suicide Risk Assessment Form (Appendix I) can be used to collate screening and assessment information in a meaningful way. Once the level of risk is identified appropriate interventions can be implemented.

This guideline's aim is to assist all staff to:

1. Identify individuals at risk for suicide
2. Understand how risk factors, warning signs and presence of protective factors can be used to determine the level of suicide risk
3. Implement interventions that maximize individual safety and promote well-being
4. Communicate suicide risk effectively with other team members, the individual and their family
5. Transfer information between care providers effectively
6. Minimize the impact of suicide on others

Quick Links

- Suicide Risk Assessment and Interventions: Long-term Care Algorithm
- Suicide Risk Assessment and Interventions: Mental Health and Substance Use Algorithm
- Appendix A: Risk Factors, Warning Signs and Protective Factors
- Appendix B: Suicide Level of Risk Assessment Matrix
- Appendix C: Developing Therapeutic Relationships
- Appendix D: Questions for Assessing Individual Risk for Suicide Tips for Health Professionals
- Appendix E: Situation Background Assessment Recommendations (SBAR) Worksheet
- Appendix F: My Safety Plan
- Appendix G: Definitions
- Appendix H: SAD PERSONS Suicide Risk Screening Tool
- Appendix I: Suicide Risk Assessment Form
- Appendix J: I.S. P.A.T.H. W.A.R.M. Suicide Risk Screening Tool

Policy Statement

1. Individuals will be screened for suicide risk factors (Appendix A). At risk individuals identified on screening will be assessed to determine the level of risk (Appendix B) for suicide. Based on the outcome of the risk assessment a care plan will be developed that promotes individual safety and well-being and minimizes risk to others (other individuals, visitors and staff) using interventions appropriate for level of risk identified.

2. Risk assessment tools must be used alongside clinical judgment.

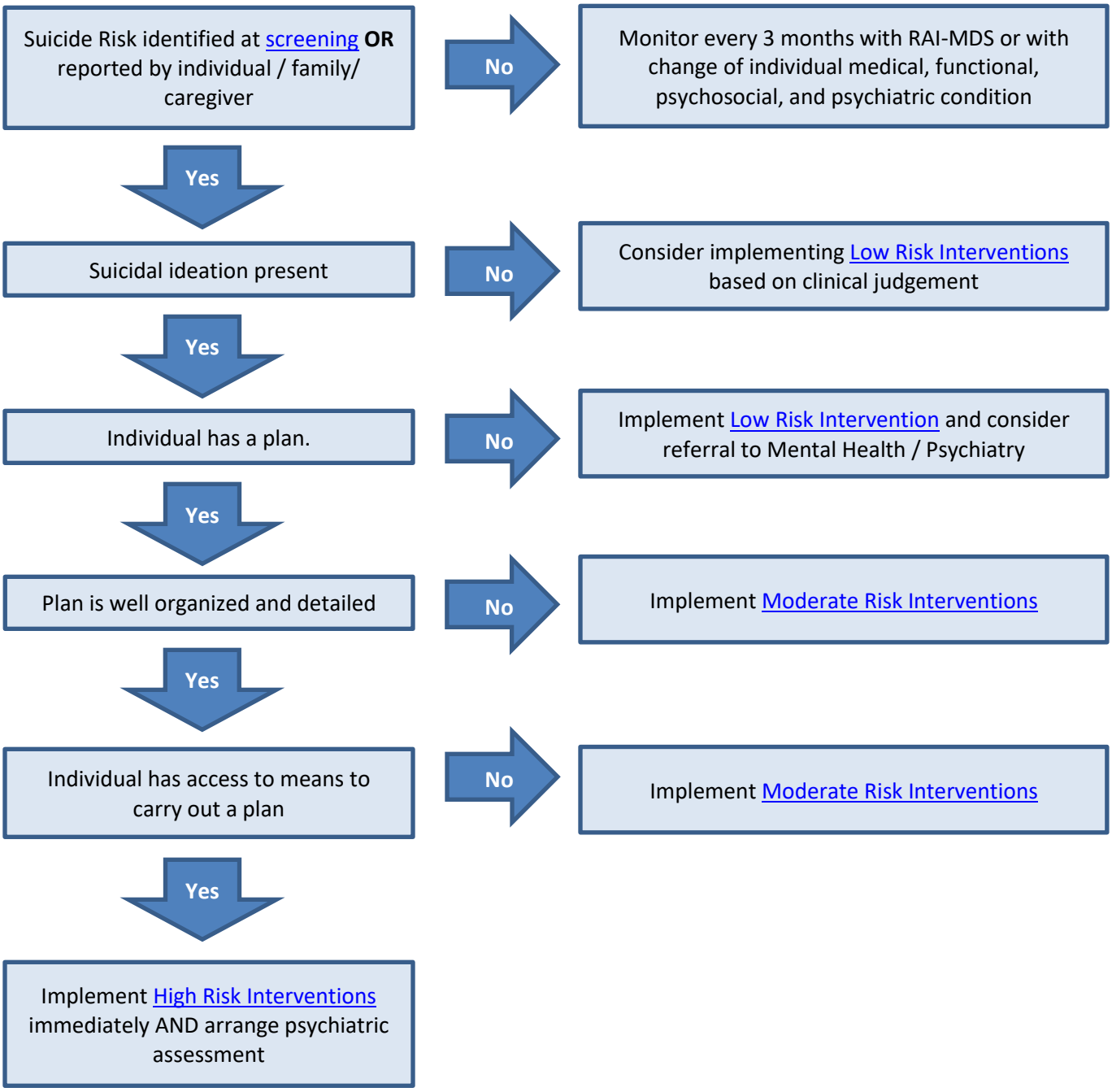
3. All information about the care plan and interventions are shared with the individual and the circle of care. Staff working with individuals at risk for suicide collaborate with other members of the interdisciplinary team to seek regular consultation and advice. Consultation includes case reviews, informal discussion and observation.

Exceptions

1. Medical Assistance in Dying (MAiD) is not considered suicide. Refer to MAiD protocol if requested by individual or Substitute Decision Maker (SDM).
    a. PHC Policy: Medical Assistance in Dying: Responding to Requests
    b. VCH Policy: Medical Assistance in Dying (Responding to Requests)
2. Choosing to decline food and fluids by mouth – refer to Risk Management and / or Ethics
3. Refusal of treatment – VCH Policy: Consent to Health Care and PHC Policy: Consent to Health Care

Suicide Risk Assessment and Interventions: Long-term care Algorithm

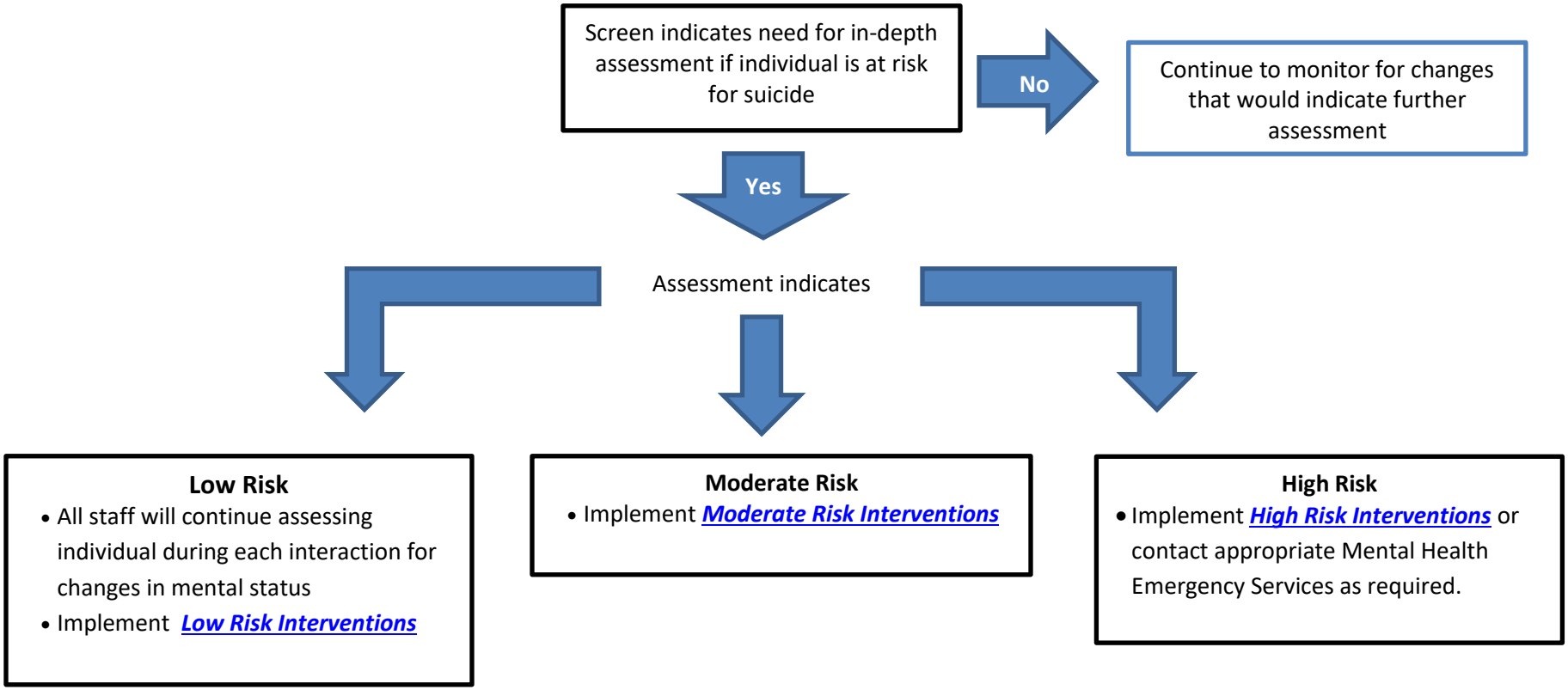
Always use clinical judgment and err on the side of caution. Implement interventions in proportion to risk identified.



Suicide Risk Assessment and Interventions: Mental Health & Substance Use Algorithm

Always use clinical judgment and err on the side of caution. Implement interventions in proportion to risk identified.

Suicide risk screening is completed with all clients accessing mental health and substance use services at point of referral, initial assessment, on an ongoing basis during treatment, and at transfer of care. See Appendix H and Appendix J for screening tools.



Need to Know

- Not all suicides are preventable[5], however death or self-harm by suicide can sometimes be prevented through careful assessment and implementation of risk reduction interventions.
- Suicide risk increases in the presence of:
    - Physical or emotional pain accompanied by feelings of hopelessness
    - Substance use
    - Behaviours e.g. aggressive or impulsive[6]
    - Suicidal ideation (previous/current)
    - Past and/or current major psychiatric illnesses
    - Social isolation
    - Major or multiple losses (economic, occupational, relational) and other stressors
    - Transitions in care for 'at risk' individuals
    - Indigenous Canadians
    - For complete list of risk factors see Appendix A
- Developing a therapeutic relationship and using a culturally sensitive, trauma informed and accepting approach is essential to prevent suicide and manage risk. (Appendix C).
- People are often relieved when asked about suicide so they can talk about suicide and how they are feeling. Asking about suicidal ideation does not increase the risk of suicide and may even reduce the risk[7]; See tips for probing questions (Appendix D).
- When in doubt, if an individual does not have all the expected Risk Factors, and Warning Signs but you still have a feeling or are concerned that they may be suicidal, err on the side of caution and always discuss with other team members who are more experienced in mental health e.g. social work, spiritual care, mental health clinician, most responsible provider, psychiatry and/or clinical leadership (supervisors, team lead, etc.).
- Individuals who deny suicidal ideation may still be at risk. Staff need to be aware of statements of suicidal denial that conflict with body language or facial expression.
- All staff must take any statements or behaviours that indicate or suggest a wish to die[2] seriously and inform the most responsible clinician who will follow this guideline to assess and initiate interventions that promote safety and well-being.

Definitions (see Appendix G)

Procedure

Screening

The screening and assessment process is viewed as part of a therapeutic approach. Building rapport before interviewing individuals regarding suicide will aid in the development of a therapeutic relationship. Throughout the process it is important to ensure the individual is informed, has an opportunity to explore and express feelings and to participate in decision making, where appropriate (refer to Therapeutic Interventions, Individual/Family Education Interventions sections below and Appendix C and Appendix D).

Screening	
Long-term Care Screening may be performed by any clinician within their competencies and professional scope of practice, e.g. Director of Care (DOC), Resident Care Coordinator (RCC), Clinical / Care Coordinator (CC), Clinical Nurse Leader (CNL), Nursing, Social Worker, Mental Health Clinician etc. For the purpose of this document RCC will be used throughout to represent RCC, CC and CNL. 1. All individuals are screened: a. On moving into Long-term care b. Quarterly (when performing the Residential Assessment Instrument Minimum Data Set RAI- MDS assessments) [1]. c. When there is a change in individual's condition that could impact their quality of life e.g. new or worsening diagnosis / loss of function. d. When there is a change in individual's psychosocial circumstances, e.g. loss of loved one, new diagnosis of depression / anxiety. 2. The clinician performing the screen reviews the following to determine the presence of risk factors (Appendix A and Appendix H) a. Most recent InterRAI-MDS[1]	**MHSU** 1. It is the responsibility of all MHSU staff to be able to identify suicide risk through screening. All community individuals are screened: a. Upon intake/ admission to entering Mental Health and Substance Use services b. Upon return from therapeutic pass or an unauthorized leave c. On an ongoing basis throughout care treatment as deemed necessary d. At any point of transfer of care when the individual is transferred from one care provider or service to another. 2. Staff will use screening tools as identified in Appendix H: Sad Persons or Appendix J: I.S. P.A.T.H W.A.R.M. 3. When an individual is deemed at moderate or high risk for suicide or self-harm on screening, a full suicide assessment is conducted immediately. Individuals will be encouraged to engage in creating a safety plan with respect to their warning signs and protective factors. It should be noted that within the mental health and substance use populations, individuals may utilize self-harm behaviours as a form of emotional

assessment - Depression Rating Scale, Mood and Behaviours and Psychosocial Well-Being Sections, individual profile, and other assessments if available e.g. Geriatric Depression Score, PHQ-9, Cornell Depression Scale. b. Medical, psychosocial history, psychiatric history and, past history suicidal ideation / attempts, family history of suicide and community suicides. c. Current mental health status or previous mental health clinician / psychiatry involvement. d. Medication list for medications that may increase risk for suicide, e.g. Serotonin Re-uptake Inhibitors (SSRIs) or indicate the presence of a psychiatric condition, depression or anxiety. e. Collateral information from substitute decision maker (SDM) / family member / friend / caregiver, if appropriate 3. When an individual is deemed at risk of suicide or self-harm on screening, a full suicide assessment is conducted immediately. 4. If suicide risk is identified on pre-screening for new individuals who have not yet moved in the most responsible provider is contacted immediately.	regulation. Therefore every effort should be made to delineate the risks associated with suicide and behaviors associated with self-harm. Assessment questions and documentation should also reflect these differences with the appropriate interventions incorporated into the individual's clinical care plan. 4. Medication list for medications that may increase risk for suicide, e.g. Serotonin Re-uptake Inhibitors (SSRIs) or indicate the presence of a psychiatric condition, depression or anxiety.

Assessment

Assessments are conducted when:

a) Individual has risk factors identified on screening
b) Individual demonstrates behaviours or verbalizes feelings suggestive of current suicidal ideation / intent / self-harm
c) Concern is raised by SDM, family member, friend, caregiver or staff member.

The purpose of the assessment is to determine level of risk for suicide and self-harm, and to identify individual's strengths and protective factors so that individualized interventions can be identified and implemented.

Assessing suicide risk is not always straightforward. Consult with other members of the health care team when determining level of risk and care planning e.g. the individual's most responsible provider/ social worker / mental health clinician / psychologist / geri-psychiatrist / psychiatrist. Use SBAR (Appendix E) to guide communication if needed.

When conducting assessments regarding suicide risk be aware that perceived stigma may affect disclosure and openness. Appendix C and Appendix D outline some practical tips for interviewing an individual about sensitive issues. Appendix I: Suicide Risk Assessment Form can be used to guide decision making and document risk assessment.

Use clinical judgment and **always** err on side of the individual's safety.

1. Develop a therapeutic relationship (Appendix C).

2. Explain to the individual the reason for the assessment, e.g. routine part of assessment, past history or risk factors identified on screening.

3. Assess Warning Signs by asking the individual about:
    a. **Suicidal ideation or behaviours**: explore how the individual feels, whether they have thoughts about self-harm, suicide or wishing to die and the frequency of these thoughts.
    b. **Intent:** is there intent to act on thoughts of self-harm or suicide and how strong are these feelings?
    c. **Plan:** explore whether the individual has thoughts about how they might take their life or if they have been researching methods. Ask the individual specific details about their plan – when, where, how, whether they have practiced and how determined they are to

plan – when, where, how, whether they have practiced and how determined they are to carry out the plan. Evaluate lethality of their plan and whether the individual has the means to carry out their plan?

d. **History:** of suicidal behaviour or self-harm.

4. Explore what would stop them from carrying out their plan (Protective Factors).

5. Assess individual's willingness and cognitive ability to participate in suicide prevention interventions, e.g. Cognitive Performance Scale (CPS) / Mini Mental State Examination MMSE.

6. Assess current mental health and substance use: depression, mood, anxiety, current stressors, psychosis, delusions, hallucinations, command hallucinations e.g. someone telling them to take their own life. Assess for recent change in baseline.

7. Long-term Care and 24 hour community MHSU sites: assess elopement risk.

8. With individual's consent, collect collateral information from family members.
Note: Consent is not always required when the individual is at risk. However, careful consideration is needed to decide whether it is appropriate to contact family members without consent. (Consent to Health Care Policy: VCH or PHC)

9. Collate information to determine level of risk: low, moderate or high, using clinical judgment and Appendix B or Appendix I as a guide and determine need for immediate Safety Interventions.

10. Determine need for psychiatric assessment.

11. Determine level of participation in care of SDM / family member / friend / caregiver. Assess their understanding of individual's risk for suicide, whether they are able or should participate in supporting the individual and promoting safety interventions.

Interventions

Interventions are **proportionate** to the level of risk for suicide. The higher the risk the more an intensive intervention can be ethically justified.

Low Risk Interventions	
Long-term Care	***MHSU***
1. Continue to develop therapeutic rapport and encourage the individual to approach staff anytime if feeling distressed, low in mood, anxious, feeling a sense of hopelessness, wanting to self-harm or having suicide thoughts. 2. Implement Safety Interventions, as appropriate. 3. Inform most responsible provider at their routine visit. Inform geri-psychiatrist / psychiatrist if individual already known. 4. Encourage individual to engage in activities that may help foster mental health and well-being. Consult OT/Recreation. 5. Monitor individual for Warning Signs as needed. 6. With individual consent (Consent to Health Care Policy: VCH or PHC), contact SDM / family member / friend / caregiver, as appropriate. 7. Consider development of "My Safety Plan" with individual, as appropriate (Appendix F). 8. Consider referral to a mental health clinician, social worker, counsellor, psychologist, spiritual care practitioner, and / or Aboriginal Patient Navigators. Remind individuals of their right to access traditional medicines and ceremony.	1. During each visit, individuals are monitored by the physician, and/or the staff for mental status changes including risk of suicide. Individuals with a history of mood disorders, may be given screening tools as a self-report outcome measure to review of any changes. Document this care in electronic health record. 2. Encourage individual to engage in activities that may help foster mental health and well-being. Clinician may support the individual in increasing coping skills e.g. mindfulness or grounding skills, distraction techniques. 3. Consult available psychosocial / spiritual services e.g. rehabilitation services (OT/Recreation), peer related services or mental health clinician, Social Worker, counsellor, psychologist, spiritual care practitioner, and / or Aboriginal Patient Navigators for further engagement. Remind individuals of their right to access traditional medicines and ceremony. 4. Consider development of "My Safety Plan" with individual, as appropriate (Appendix F).

Moderate Risk Interventions

Long-term Care	*MHSU*
1. Implement Safety Interventions in proportion to risk.	1. During each visit, individuals are monitored by the physician, and /or the staff for mental status changes including risk of suicide. Individuals with a history of mood disorders may be given screening tools as a self-report outcome measure to review any changes.
2. Contact most responsible provider use SBAR communication tool (Appendix E) to guide discussion and confirm / determine plan of care within 24 hours.	2. In all cases of moderate risk, the clinician will complete a safety plan with the individual. Clinician will provide to the individual a copy of the safety plan and along with a copy of the handout Coping with suicidal thoughts.
3. Consult geri-psychiatry / psychiatry. If already known inform individual's geri-psychiatrist / psychiatrist and mental health clinician of risk and discuss plan.	3. Encourage individual to engage in activities that may help foster mental health and well-being. Clinician may support the individual in increasing coping skills e.g. mindfulness / grounding skills, distraction techniques.
4. Consider referral to a mental health clinician, social worker, counsellor, psychologist, spiritual care practitioner and / or Aboriginal Patient Navigators. Remind individuals of their right to access traditional medicines and ceremony.	4. Consult available psychosocial / spiritual services e.g. rehabilitation services (OT/Recreation), peer related services or mental health clinician, Social Worker, counsellor, psychologist spiritual care practitioner, and/or Aboriginal Patient Navigators for further engagement. Remind individuals of their right to access traditional medicines and ceremony.
5. Continue to develop therapeutic rapport and encourage the individual to approach staff anytime if feeling distressed, low in mood, anxious, a sense of hopelessness, wanting to self-harm or having thoughts of suicide.	5. Document in electronic health record, complete suicide risk alert and notify care providers associated with individual's care.
6. Develop a care plan with the individual / SDM and implement interventions to minimize risk to the individual and others. Communicate these to all staff and make sure individual / SDM is informed and participates in implementing interventions, as appropriate. Evaluate care plan and modify interventions as needed. Where an individual does not wish to participate in interventions to minimize risk, reassess and discuss with most responsible provider.	6. With individual's consent (Consent to Health Care Policy: VCH or PHC), contact family member/friend/caregiver as per VCH Family Involvement with Mental Health & Addiction Services policy as appropriate.
7. Facilitate development of "My Safety Plan" with individual, as appropriate (Appendix F). With individual consent, (Consent to Health	7. Staff to increase visits with physician as appropriate or until risk level changes.

Care Policy: VCH or PHC) contact SDM / family member / friend / caregiver, as appropriate. 8. Monitor individual each shift for increased Warning Signs that may indicate an increasing risk of suicide.	
High Risk Interventions	
Long-term Care 1. Immediately implement Safety Interventions to minimize risk to individual and others while awaiting medical review. **Note**: These interventions must include 1:1 staff supervision of individual at all times when the individual is deemed high / imminent risk. Family members are not expected to provide one to one supervision. 2. Inform most responsible provider / geri-psychiatrist / psychiatrist immediately to determine plan. Use SBAR (Appendix E) to guide communication. 3. Confirm who will be arranging the transfer to Emergency Department (ED). 4. Explain to the individual the need to transfer to a place where care can be provided in a more supported and therapeutic environment. Under some circumstances individuals may need to be certified under the Mental Health Act. 5. Confirm who is responsible for contacting the ED to inform them the individual will be presenting to the ED imminently. 6. Ensure all documentation related to risk assessment and the 'transfer form' (see Transfer Forms) are sent to the ED on	***MHSU*** 1. Individuals are discussed by the staff and/or attending physician immediately to develop an intervention plan. 2. Depending on certification need, the following intervention is to be implemented: a) Individuals who are certified will have transportation to the nearest hospital arranged in the safest manner possible (i.e. police or ambulance). Staff will remain with the individual until transportation arrives. b) Individuals who are not assessed as certifiable will have a plan developed for increased services as deemed appropriate by the team (e.g. after-hours check-in if available, transitional/respite unit or increased follow-up with physician/staff). If it is decided that the individual is to be transported to hospital, transportation will be arranged in the safest manner possible (i.e. police or ambulance). 3. Document in electronic health record, complete suicide risk alert and notify care providers associated with individual's care. 4. With individual consent (Consent to Health Care Policy: VCH or PHC), contact family member/friend/caregiver as per VCH Family

individual transfer. 7. Follow up with a telephone call to confirm receipt of information and to clarify any questions regarding risk. 8. Assist in other arrangements to transfer the individual as required. 9. Contact SDM / family member / friend / caregiver to inform of transfer, as appropriate. 10. With consent from the individual, arrange for SDM / family member / friend / caregiver to accompany them for the transfer or to meet them at the ED, as appropriate. 11. **Note:** SDM / family member / friend / caregiver must not be asked to transport individual to ED.	Involvement with Mental Health & Addiction Services policy as appropriate. 5. Regular consultation is done to review treatment and safety plan within individual's team and referred services (e.g. AAC, MHES, emergency department and/or in-patient settings).

Long-term Care and 24 hour community MHSU sites: Safety Interventions

1. Arrange 1:1 staff supervision where risk is high and imminent; if there is risk to staff consider having two staff members to supervise.
2. Collaborate with individual and family to promote / create a safe environment.
3. In proportion to risk for suicide remove potential risks from individual's room. For example, sharp objects (razors, mirrors), plastic bags, hazardous liquids (cleaning fluids), call bell cords, ropes, belts, shoelaces, scarves, bras, linen, tubing, e.g. feeding tubes and oxygen supplies and medications. Ideally, removal of risks should be carried out in collaboration with the individual to help maintain therapeutic relationship.
4. Check for potential hanging points in room and remove. If not possible to remove, consider level of observation required and/or move individual to a safer location to promote individual safety.
5. Check items brought in by family / visitors for safety.
6. Communicate safety interventions to all team members.
7. Administer treatment medication as ordered. Monitor for response and adverse effects.

   Note: Ensure individual has taken medication and is not storing for later use.
8. Instruct family and visitors to inform nursing staff if individual expressing increasing suicidal ideation, intent or responsive behaviours.

Long-term Care: Therapeutic Interventions

1. Continue to develop therapeutic relationship.
2. Explore and emphasize individual's strengths and Protective Factors.
3. Facilitate development of 'My Safety Plan' with individual, where appropriate (Appendix F).
4. In collaboration with most responsible provider refer to mental health clinician, social work, counsellor, psychologist and/or spiritual care practitioner.
5. Encourage individual to engage in activities that help foster mental health and well-being / promote a sense of self-worth. Consult OT / Recreation/ Aboriginal Patient Navigators. Remind individuals of their right to access traditional medicines and ceremony.
6. Explore ways the individual can develop, maintain, or renew meaning and purpose in life.
7. Monitor for worsening depression and anxiety.
8. Monitor for distressing symptoms e.g. pain, other health related symptoms and other triggers for suicidal thoughts, such as social / environmental factors. Explore with the individual ways to cope with these. (See 'Coping with Suicidal Thoughts')

9. With individual's consent and, if appropriate, involve SDM / family member / friend / caregiver in supporting individual.

Individual / Family Education

Ensuring the individual is informed throughout the assessment and planning process builds trust, minimizes distress and aids development of a therapeutic relationship.

1. Explain to individual why suicide risk assessment is being conducted.
2. Explain interventions being implemented to promote safety and well-being.
3. Educate individual and family on the increased risk of suicide with alcohol and other substances that can affect judgment and reduce inhibitions.
4. Ask individual to inform staff if or when they experience increasing thoughts about suicide or feeling more hopeless, anxious or distressed.
5. Offer resources such as 'Coping with Suicidal Thoughts'.
6. If applicable, explain reasons for transfer to a mental health facility that can better provide care needed and explain the process and what to expect. Include details about transfer via ambulance / police and likely admission process.
7. Explain reasons for certification under Mental Health Act, when applicable.
8. Where family are involved in care, assess whether they are sufficiently supported. Offer support, which may include direct support from the clinician, SAFER or other resources, and/or VCH Family Support and Involvement team.

Staff Education

All staff involved in direct care should attend education as offered regarding suicide prevention.

Expected Individual Outcomes

- Individuals feel safe and are able to express suicidal thoughts and feelings without prejudice or judgment.
- Individuals experiencing suicidal thoughts receive appropriate support and care interventions to minimize risk and facilitate mental health and well-being.
- Individuals are free from harm.
- Where the individual's family are involved with care and informed about signs of suicide risk and appropriate interventions and feel supported.

Postvention

Postvention is the provision of crisis intervention, support, and assistance for those affected by a suicide death.[19] The aim is to prevent further suicides from contagion, help those affected by the death to deal with the trauma and grief, and assist the community to return to its normal routine[6]. In Long-term care and MHSU programs, it is important to ensure those affected by an individual's death by suicide feel supported.

- **Postvention for Staff:**
  A debrief for all staff is arranged by the DOC / RCC/ managers in collaboration with other interdisciplinary team members e.g. SW, Spiritual Care Practitioner, other staff involved in the individual's care.
  Employee and Family Assistance Program (EFAP) can provide additional support for staff via Critical Incident Stress Management.
  Staff are encouraged to access EFAP for additional confidential support as needed.

- **Postvention for Other Individuals Under the Care of VCH/PHC:**
  The DOC / RCC / clinical leads/ managers will determine appropriate interventions to support other individuals by consulting with other resources / SW / Spiritual Care Practitioner/ Mental Health Clinician.

- **Postvention for Family and Friends of Individual :**
  The SAFER Program offers postvention support within Vancouver Community. The DOC/ RCC / nurse/ SW / Spiritual Care Practitioner / Mental Health Clinician/ clinical leads/ staff will provide family / friends affected by suicide the contact details for S.A.F.E.R. or other resources.

Evaluation

- Programs conduct documentation audits as part of their quality improvement programs.
- Programs assess staff competency regarding suicide prevention as part of on-going staff development.
- Programs monitor suicide attempts and suicides through clinical incident reporting procedures. In addition, programs debrief clinical incidents with all staff members and implement procedures to address safety as indicated.

Documentation

Documents in individual's health record / chart as per facility policy and consider the following:

Individuals who have expressed suicidal ideation include:

- Level of risk identified
- Individual's plan details
- Interventions implemented / documented in Care Plan
- Members of team consulted and informed
- Individual Family Education
- Individual outcomes
- Information communicated on transition of individual to another care provider. (Long-term care see Transfer form)

When an individual is harmed or dies by suicide include:

- When and whether the risk was identified along with details of the risk. Actions taken and who has been informed. Follow program policy for informing manager/ on call supervisor.
- Complete incident report as per facility/ program policy.
- Long-term care: DOC / RCC follows up with clinical incident and documents outcomes as per facility policy.
- MHSU: Clinical leads and manager follow up with clinical incident

Related Documents

Suicide Risk Management Guidelines

VCH :

- Consent to Health Care Policy

VA

- Suicidal Patient: Assessment and Management of
- Suicidal Patient, Psychiatric Clearance

PHC:

- Consent to Health Care Policy

Facility Transfer forms available via Printing Services:

- Vancouver Community, Providence Health Care and Coastal
- Long-term / Acute Care Transfer Form
- Family Involvement with Mental Health & Addiction Services Policy
- Indigenous Cultural Safety Policy
- Cultural Competency and Responsiveness Policy

Resources:

- Canadian Association for Suicide Prevention
- Center for Applied Research in Mental Health and Addiction (CARMHA)
- Child and Adolescent Response Team (CART)
- CHIMO
- Coping with Suicidal Thoughts
- Counselling in the Lower Mainland
- Crisis Intervention and Suicide Prevention Centre of BC (Crisis Centre)
- Employee and Family Assistance Program
- Hope Help and Healing: A Planning Toolkit for First Nations and Aboriginal Communities to Prevent and Respond to Suicide
- Hope Centre (North Shore)
- Kelty Mental Health
- Kuu-Us
- Learning Hub video Suicide Prevention – How to talk to someone about suicide (VCH - Online) or can be accessed via –by copy and paste the following link in google chrome browser https://vimeo.com/96934836
- S.A.F.E.R.
- S.A.F.E.R Additional resources page
- Suicide Prevention among Older Adults: a guide for family members available through the Canadian Coalition for Seniors' Mental Health (CCSMH)
- Suicide: Assessment and Prevention for Older Adults (pocket sized pamphlet)

Other Grief Counselling:

  - Living Through Loss
  - Compassionate Friends
  - Bereavement Helpline

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Appendix A: Risk Factors, Warning Signs and Protective Factors

Risk Factors: Factors that predispose individuals to being at risk for suicide and include:

Demographic or Social Factors:

- Older adult
- Male gender
- Poverty
- Indigenous
- White race
- Gay, lesbian, transgender or bisexual
- Single status (widow, divorced, separated, single)
- Social isolation, including new or worsening estrangement, and rural location
- Economic or occupational stress
- Loss
- Humiliation
- History of gambling
- Easy access to firearms, access to and/or expertise in lethal means

Clinical Factors:

- Past and current major psychiatric illness, including mood (especially depression, bipolar), psychosis (schizophrenia), anxiety and/or thought disorders (severe or unremitting anxiety panic attacks) and major depressive disorder (especially depression)
- Personality disorder (borderline, narcissistic, antisocial)
- Impulsive or violent traits by history
- Current medical illness(es)
- Family history of suicide
- Previous suicide attempts or other self-injurious or impulsive acts

- Current abuse of substances e.g. alcohol or drugs
- Easy access to lethal toxins (including prescribed medication)
- Formulated plan, preparations for death or suicide note
- Low ambivalence about dying versus living
- Childhood trauma (sexual abuse, physical abuse)
- Indian Residential School or Indian Hospital experiences
- Suicidal ideation (current or previous)
- Suicidal intent
- Hopelessness
- Alcohol and substance use, or history of other addiction
- Major physical illness or chronic pain, loss of health status
- Emotional, spiritual pain
- Major or multiple losses (economic, occupational, relational) / other stressors
- Past suicide attempts or history of non-suicide self-injury
- Acquired Capability- desensitization to the natural fear of death. This can be acquired through history of traumatic experiences, previous suicide attempts or history of self-harm.

Additional Risk Factors For Older Adults:

- Generational biases regarding seeking help from professionals
- Multiple losses: loved ones, home, job, social role, independence, health
- Fear of institutionalization

Additional Risk Factor For Youth and Adults:

- Pregnancy

Recommended tools that can be used to screen for Risk Factors

- **Long-term Care: SAD PERSONS** see Appendix H.
- **MHSU: SAD PERSONS** see Appendix H. and **I.S. P.A.T.H WARM** see Appendix J

Warning Signs - factors that place individuals at high risk for acting on suicidal ideation[8] include:

- The presence of suicidal ideation. These may be overt: "I want to kill myself / I want to end my life" or more subtle: "What's the point in going on?", "Just let me die", "They'd be better off if I was dead". "It's just been getting too much", "I've had enough", "There's no use / hope anymore" "I am becoming a burden".[2]
- Frequency of suicidal ideation
- A clear / detailed plan
- The means / ability to carry out that plan
- Other warning signs includes behaviours e.g. risk taking, researching methods, obtaining sharp objects, hoarding medication or talking about being a burden.
- Other potential warning signs such as donating body to medical science / getting affairs or wills in order and giving away belongings may also be considered as expected behaviour in older adults and their relevance requires clinical judgment.

Protective Factors - factors that can help deter suicide attempts

- Intact social / Personal supports (connectedness / love / responsibility for family or others)
- Hope / goals for the future
- Absence of depression or substance abuse
- Proven effective problem-solving and coping skills
- A sense of self-worth, self-esteem, participation in hobbies
- Spiritual, cultural and religious beliefs and faith
- Women in leadership, cultural facilities and practices in community
- Therapeutic relationship with care provider
- Access to clinical care/ interventions and support
- Restricted / unable to access means of suicide e.g. living in long-term care facility can reduce risk

- Marriage and presence of dependent children
- Impulse control
- Life satisfaction
- Relief about not completing suicide
- Sense of ‘unfinished business’
- Awareness of significant others about their suicidal thoughts

Appendix B: Suicide Level of Risk Assessment Matrix

To use this matrix, assess individual for risk factors, warning signs and protective factors (Appendix A) and use clinical judgment to determine individual's level of risk for suicide by comparing with table below. The form in Appendix I can also be used as a guide and to document findings.

	Low	Moderate / Potential	High / Imminent
Ideation	Periodic thoughts of death or not wanting to live, that last a short while	Recurrent intense thoughts of death and/or wanting to die that are often difficult to dispel	Thoughts of death or wanting to die are very intense and seem impossible to get rid of
Immediacy Of Plans	No immediate suicide plan	Not sure when, but soon. Indirect threats. Ambivalent about dying	Has imminent date/time in mind, clear threats. Doesn't want to live, wants to die
Method/Lethality Of Plan	Means unavailable, unrealistic or not thought through	Plan clear, lethality of method is variable with some likelihood of rescue / intervention	Plan clear, available method, little or no chance of rescue / intervention
Emotional State Or Mood	Sad, cries easily, irritable	Pattern of 'up and down' mood swings. Rarely expresses any feelings	No vitality (emotionally numb), emotional turmoil, anxious, agitated, angry
Level Of Emotional Distress	Mild emotional hurt / distress / despair	Moderately intense emotional hurt/distress / despair	Unbearable emotional hurt / distress / despair. Feels rejected, unconnected and without support
Support Or Protective Factors	Feels cared for by family, peers and/or significant others	Minimal or fragile support. Moderate conflict with family, peers and/or significant others	Intense conflict with family, peers, and / or significant others. Socially isolated
Previous Attempt	None	One previous attempt Suicide behavior (Warning Signs)	Multiple previous attempts
Reason To Live/Hope	Wants things to change and has some hope. Has some future plans	Vague, pessimistic Negative future plans	Feels hopeless, helpless, powerless. Sees future as meaningless, empty

Appendix C: Developing Therapeutic Relationships

(Also see 15 minute video How to Talk to Someone about Suicide - best viewed using google chrome – copy and paste the following link in Google Chrome browser – https://vimeo.com/96934836)

Keys to developing a therapeutic relationship are maintaining respect, empathy and validation of feelings, beliefs and values [11].

- Maintain individual dignity and communicate respectfully by introducing yourself, explaining your role, the purpose of your interview / assessment and checking with the individual about how they prefer to be addressed.
- Meet in a comfortable and private setting without interruptions. Think about the room layout, arrange the room so that barriers to communication are removed, e.g. seated at same eye level, no table between individual and interviewer.
- Make sure the individual is able to communicate effectively, e.g. is wearing their hearing aid, use an interpreter or companion who can assist with communication if indicated. For Indigenous individuals who self-identify, offer Indigenous specific supports such as Aboriginal Patient Navigators or Elders.
- Make sure the individual is comfortable, and address any symptoms causing discomfort before conducting interview.
- Use a calm, reassuring tone of voice.
- Ask open ended questions.
- Take your time to listen to the individual's story.
- Show compassion / empathy and acknowledge the individual's feelings and concerns using active listening and reflecting skills.
- Explore and acknowledge the individual's strengths and resources.

Appendix D: Questions for Assessing Individual Risk for Suicide Tips for Health Professionals

(Also see 15 minute video How to Talk to Someone about Suicide - best viewed using google chrome – copy and paste the following link in google chrome browser – https://vimeo.com/96934836)

Always start by building the therapeutic relationship (Appendix C). Explain why you are asking the questions. Share your thoughts regarding risk factors that are present in the individual's history. If appropriate, explain that feelings of depression, hopelessness, despair or thoughts of suicide experienced in the past can re- surface when leaving their home to move into individual care. Asking about suicide intent and plans allow individuals to openly discuss feelings and is the beginning of a therapeutic intervention that will enable the individual and staff to develop a comprehensive safety plan.

Ask About Feelings

- How has your mood been lately? Have you had times where you have been feeling sad or down?
- Has anything been troubling or worrying you?
- Have you ever wished life was over?
- What are your feelings about living and dying?
- Have you ever thought about harming yourself / taking your own life / about suicide in the past?
- Have things become so bad you think killing yourself might make things better?
- People sometimes think about suicide when they are going through what you are. Are you considering suicide?
- Have you ever tried to harm yourself or take your life in the past?
- Do you wish to die or take your life now? How often do you think about taking your life?

Ask About Their Plan

- Have you thought about how you may take your life?
- What plan do you have to take your own life?
- Have you thought about when and where you will take your life?
- How determined are you about taking your life?
- Do you have access to ……? *(means identified in individual's plan e.g. sharp instruments)*

Ask About Reason to Live (Protective Factors)

- What would help prevent you from carrying the plan?
- What has kept you from harming yourself so far?
- Who or what makes your life so worth living that you would not harm yourself?

Appendix E: Situation Background Assessment Recommendations (SBAR) Worksheet

S Situation	I am calling about (individual name location)…… I have assessed the individual and I am concerned about a suicide risk because…. ……..
B Background	Have the individual's file, medications list and progress notes to hand. MRP / NP ……Date / Year Individual Moved in…….. Date of Birth…….. Risk Factors (list) …….. Current Medication
A Assessment	What is your assessment of the situation? The individual is High, Moderate or Low Risk …… Expressed suicide ideation Yes No Has strong intent to act on suicidal ideation Yes No Has a plan Yes No Has the ability to access means to complete plan Yes No Has Protective Factors (list) …….. Safety interventions currently in place (list) ……
R Recommendation	What do you need from the physician, NP or Mental Health Clinician? I recommend you …….. E.g. refer to psychiatry / geri-psychiatry, have individual transferred to mental health services, come to assess the individual now, today, tomorrow. Consider whether you need to ask the following questions. • When will you see the individual? • What parameters require on-going monitoring? • What other interventions need to be implemented? e.g. medication orders, other safety interventions? • If risk is unclear does individual require 1:1 supervision until assessed by physician, NP or mental health services? • If you are not coming to see individual when / under what circumstances should I call you again? **Before you end the call, repeat all orders back to the clinician. If individual is 'high risk' and is being transferred to ED clarify who is responsible for contacting ED and who will be informing the individual , SDM / family member / caregiver.**

Please remember that this document is meant solely as an aid for successful communication. If you are comfortable that you have all the information you need, you do not need to use this worksheet. If you do use this worksheet only fill in the blanks you need. When you have completed your call and documented the relevant facts, discard this sheet in an appropriate confidential waste bin.

Appendix F: My Safety Plan - adapted for Individual Care Version 1

For individuals who are able to leave the facility independently.

MY SAFETY PLAN
If you have thoughts of hurting yourself start at Step 1 and go through each Step until you are safe.
1. Do the following activities to calm / comfort myself:
2. Remind myself of my reasons for living:
3. Speak with a care provider looking after you today at (**Insert Name of Facility**): Name Name
4. Call a friend or family member: Name: Number:
5. Go where I feel safe OR make my room / myself safe by :
6. Call my local crisis line: 1 800 784 2433 **1800 SUICIDE** Kuu-Us 1-800-588-8717 Other:
7. If I am not at (Insert Name of Facility) go to the nearest emergency room at the nearest hospital.
8. If I am not at (Insert Name of Facility) and I feel I can't get to the hospital safely call 911 and request transportation to the hospital. They will send someone to transport me safely.

Pamphlet: Coping with Suicidal Thoughts, Other Resources

Appendix F: My Safety Plan - adapted for Individual Care Version 2

For individuals who do not leave the facility independently.

MY SAFETY PLAN
If you have thoughts of hurting yourself start at Step 1 and go through each Step until you are safe.
1. Do the following activities to calm / comfort myself:
2. Remind myself of my reasons for living:
3. Speak with a care provider looking after you today at (Insert Name of Facility): Name: Name:
4. Call a friend or family member: Name: Number:
5. Go where I feel safe OR make my room / myself safe:

Pamphlet: Coping with Suicidal Thoughts, Other Resources

Appendix G: Definitions

Individual:	Refers to a resident, client or patient
Most responsible clinician	Clinician who has overall responsibility to direct and coordinate and manage the care of an individual.
Suicide:	An intentional, self-inflicted act that results in death[2].
Suicidal ideation:	The thoughts that a person has regarding taking their own life - can be active or passive[5]. • ***Active:*** where an individual has a desire to die by suicide and has a clear plan and is able to carry out the plan. • ***Passive:*** where an individual has a desire to die by suicide however does not have a clear plan e.g. is unable to describe how, when or where they would end their life.
Risk:	The likelihood of an adverse event or outcome.
Risk factors:	The particular features of illness, behaviour or circumstances that alone or in combination lead to an increased risk.
Risk assessment:	An estimation of the likelihood of particular adverse events occurring under particular circumstances within a specified period of time[6].
Level of Risk (in the context of suicide):	The likelihood of suicidal ideation being acted upon and is a clinical judgment, arising from assessment that determines suicide risk on a continuum of low to imminent, weighed against strengths and protective factors. Appendices B and I and Suicide Risk Management Guidelines)
Therapeutic Relationship:	Planned, goal-directed, interpersonal processes occurring between staff and clients that are established for the advancement of client values, interests, and ultimately, for promotion of client health and well-being[9] (Appendix C).
Family or Family Member:	A person who has been identified by the individual, the individual's representative or the individual's Care Provider as being in a relationship of importance to the individual and who provides support or care for the individual on a regular basis.
Most Responsible Provider:	MD or Nurse practitioner

Appendix H: SAD PERSONS Suicide Risk Screening Tool

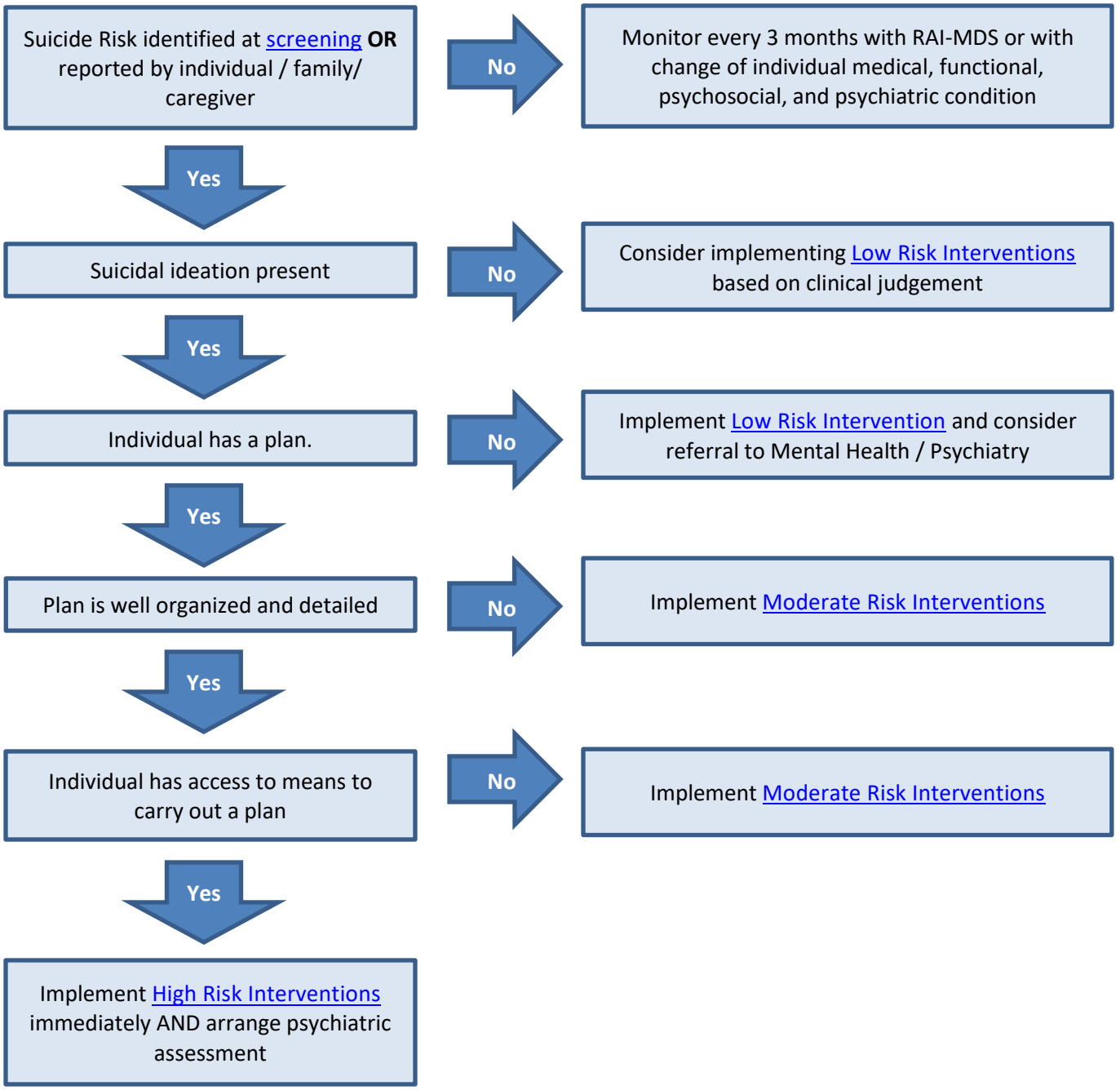
The SAD PERSONS is a Scale for determining underlying risk for suicide (Patterson et al 1983 adapted by Groulx 2001) and is useful as a reference tool when screening for risk factors. However, as with any tool, there are limitations and clinical judgment is needed to interpret scores.

One point is scored for each item present to give a total score out of 10 where 0 represents Very little risk and 10 Very High Risk.

S	**Sex** Suicide rate is 3 – 4 x higher in men than women
A	**Age** Suicide rates increase steadily with age, reaching a peak at 75 years plus
D	**Depression** Risk increases with presence of clinical or major depression
P	**Previous Attempts** Any previous attempt, even if long ago, increases risk X 10
E	**Ethanol Abuse** Use of alcohol a common contributor to suicide; either chronic alcoholism or a return to alcoholism is a very serious risk factor
R	**Rational Losses** Death of friend or family member, usefulness/role, vigor, health, self-esteem **Rational Thinking Loss** Poor judgment due to dementia, especially frontal lobe dementia
S	**Social Supports Lacking** Absence of family or community support/connections; living alone; solitude
O	**Organized Plan for Suicide** A precise and organized plan, dates, methods
N	**No Spouse** Absence of spouse or loved one a risk factor separate from Solitude
S	**Sickness** Co-existence of physical illness, in particular chronic physical illness, and even more important, chronic physical illness with pain.

Appendix I: Long-term Care Suicide Risk Assessment and Intervention- Quick Reference Guide

Use this step approach to determine Level of Risk and identify interventions. If risk is unclear, use matrix overleaf to determine level of risk. Form available through VCH forms: Form Number VCH.0540.



Note: If risk remains unclear, use matrix overleaf to determine level of risk.

Risk Assessment Matrix

(Adapted from Burnaby Mental Health Centre)

To use this matrix, circle individual's level of risk for suicide (columns B-D) for each component in column A. Then use clinical judgment based on the individual's risk factors, warning signs and protective factors to indicate level of risk. Always err on the side of caution if risk remains unclear and consult with GP/NP/mental health clinician/ clinical lead for advice. This form can also be used as a template to document findings.

A	B	C	D
	Low	**Moderate / Potential**	**High / Imminent**
Ideation	Periodic thoughts of death or not wanting to live, that last a short while	Recurrent intense thoughts of death and/or wanting to die that are often difficult to dispel	Thoughts of death or wanting to die are very intense and seem impossible to get rid of
Immediacy of plans	No immediate suicide plan	Not sure when, but soon. Indirect threats. Ambivalent about dying	Has imminent date/time in mind, clear threats. Doesn't want to live, wants to die
Method/Lethality of plan	Means unavailable, unrealistic or not thought through	Plan clear, lethality of method is variable with some likelihood of rescue / intervention	Plan clear, available method, little or no chance of rescue / intervention
Emotional State or Mood	Sad, cries easily, irritable	Pattern of 'up and down' mood swings. Rarely expresses any feelings	No vitality (emotionally numb) Emotional turmoil, anxious, agitated, angry
Level of emotional distress	Mild emotional hurt / distress / despair	Moderately intense emotional hurt/distress / despair	Unbearable emotional hurt / distress / despair. Feels rejected, unconnected and without support
Support or protective factors	Feels cared for by family, peers and/or significant others	Minimal or fragile support. Moderate conflict with family, peers and/or significant others	Intense conflict with family, peers, and / or significant others. Socially isolated
Previous Attempt	None	One previous attempt Suicide behavior	Multiple previous attempts
Reason to live/hope	Wants things to change and has some hope. Has some future plans	Vague, pessimistic Negative future plans	Feels hopeless, helpless, powerless. Sees future as meaningless, empty

Use check to indicate level of risk(√)

☐ Low ☐ Moderate ☐ High

Screened by: Name:_____ Designation:_____

Signature: Date:

Appendix J: I.S. P.A.T.H. W.A.R.M. Screening Tool

I.S. P.A.T.H. W.A.R.M. is a tool used for screening risk of suicide. This is helpful in identifying risk factors but should not be used a replacement for a clinical assessment.

I	Ideation
S	Substance Use
P	Previous history
A	Anxiety
T	Trapped (feels like there is no way out)
H	Hopelessness
W	Withdrawn from social supports
A	Anger
R	Recklessness
M	Mood Changes