Suicidal Patient: Assessment and Management of

Site Applicability

VGH, UBCH, GFS

Practice Level

RN, RPN, PW, LPN, MD, SW, OT, AW, Recreational Therapist, R.Psych

Goal

- Identify the patient's level of risk for suicide.
- Determine appropriate treatment and monitoring strategies to ensure patient safety.
- Identify protective factors and address aspects of risk that may be modified.

Policy Statements

There is a common strategy for suicide prevention for patients assessed to be at risk recognizing that suicidal behavior cannot always be predicted and cannot always be prevented. The strategy use resources of the interdisciplinary team to provide a multimodal approach to assessment and treatment.

Need to Know

The following is a list of factors to consider when assessing your patient to be at risk for suicide.

THE PRESENCE OR ABSENCE OF ANY OF THESE RISK FACTORS DOES NOT ACCURATELY "PREDICT" THE POSSIBILITY OF A SUICIDE. TREATMENT DECISIONS SHOULD BE MADE AFTER A THOROUGH ASSESSMENT ON THE BASIS OF THE OVERALL UNDERSTANDING OF THE PATIENT, THEIR HISTORY, RISK AND PROTECTIVE FACTORS AND INDIVIDUAL CIRCUMSTANCES.

Risk Indicators

Historical	Current
• previous suicide attempts, including the perceived and actual lethality of method • history of suicide in family and/or friends • chronic illnesses • history of gambling, substance abuse • poor impulse control • traumatic experience	• depressed mood • anger, agitation or elevated anxiety • feelings of helplessness/ hopelessness • psychosis e.g. persons who hear voices telling them to kill themselves, delusional beliefs or fears that they will be killed or tortured, especially if accompanied by distress • acute confusion/delirium • sudden, marked change in behavior and personality • substance abuse, especially when experiencing transitions in treatment, relapses, legal events.
Vulnerability	**Suicidal Thinking**
• loss: real or perceived, anniversaries of losses • separated, divorced, widowed • lack of social support systems • nature and prognosis of disease/illness • substance abuse • under-managed chronic pain • **demographics (higher risk categories: male, white, aboriginal, sexual orientation: gay, lesbian, bisexual, unemployment, poverty, living alone/social isolation)** • life transitions • age: adolescent, older adult	• verbalization of suicidal ideation • verbalization of suicidal plan • giving away of personal items • frequent requests for sleeping pills • Access to firearms or lethal methods, medications.

Risk Indicators

- Sense of belonging: having a significant emotional attachment to or sense of responsibility for (children, spouse/partner, and pets)
- Ongoing supportive relationship with caregiver
- Active religious affiliation or faith
- Positive therapeutic relationship
- Marriage, presence of dependent children
- Absence of substance abuse, depression
- Access to medical and mental health resources
- Impulse control, proven problem-solving and coping skills
- Life satisfaction
- Pregnancy
- Relief about not completing suicide
- Good self-esteem, self confidence
- Willingness to communicate about their suicidal thoughts
- Intact social supports

Practice Guideline

ASSESSMENT

ASKING A SUICIDAL PATIENT DIRECT QUESTIONS ABOUT SUICIDAL THOUGHTS OR PLANS DOES NOT INCREASE THE RISK AND IS ESSENTIAL TO ASSESSING RISK.

- **Ask the following questions:**
  - How do you see the future?
  - Do you ever feel hopeless, like giving up?
  - Have you ever made a plan to take your own life? (Have you ever considered suicide?)
  - Can you tell me about the plan and how you would have done it?
  - Did you act on that plan? (Have you ever attempted suicide?)
  - Do you have access to the means/methods to carry out the plan?
  - What has stopped you from acting on suicidal thoughts/urges to this point?

- **Assessment of replies to interview questions:**
  - If the patient has a plan, how detailed is it?
  - What is the lethality of the method chosen?
  - Will the reason identified as a deterrent continue to be a protective factor?
  - Were previous suicide attempts carried out in an environment where the patient was likely to be found?
  - What is the patient's perception of support/lack of support?
  - Is there a risk of elopement?

RECOGNIZE THAT AN IMPROVEMENT IN MOOD AND/OR AN INCREASE IN ENERGY MAY INDICATE THE PATIENT TO BE AT GREATER RISK, ESPECIALLY IF NONE OF THE STRESSORS IN THE PATIENT'S LIFE HAVE CHANGED OR IMPROVED. RISK FACTORS SERVE AS A GUIDE ONLY. LOW RISK IS NEVER NO RISK

Risk Assessment Matrix

	Lower	Potential	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 No threats Does not want to die	Not sure when, but soon indirect threats. Ambivalent about dying	Has imminent date/time in mind. Clear threats
Method / Lethality	Means unavailable, unrealistic or not thought through	Lethality of method is variable with some likelihood of rescue or intervention	Doesn't want to live Wants to die
Emotional State or Mood	Sad, cries easily, irritable	Pattern of 'up and down' mood swings Rarely expresses any feelings	Lethal, available method with no chance for intervention
Level of Emotional Distress	Mild emotional hurt	Moderately intense	No vitality (emotionally numb)
Support/ 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	Emotional turmoil (anxious, agitated, angry)
Previous Attempt	None	One previous attempt Some suicidal behavior	Unbearable emotional distress or despair Feels rejected, unconnected and without support
Reason to Live/Hope	Wants things to change and has some hope. Has some future plans	Vague, Pessimistic negative future plans	Intense conflict with family, peers and/or significant others

INTERVENTIONS

ENSURE THAT ASSESSMENT AND MANAGEMENT FINDINGS ARE DOCUMENTED AND COMMUNICATED TO THE INTER-DISCIPLINARY TEAM

Imminent Risk

- Arrange for psychiatric consult if patient in area other than Psychiatry/Short Term Assessment and Treatment (STAT) Unit
- A transfer of patient to Acute Psychiatry may be considered by the consulting psychiatrist
- Consider placing patient on Constant Observation (see Guideline Observation Levels for Patients in Acute Mental Health [D-00-07-30280])
- Consider risk prior to placing patient in seclusion or quiet room. Remove belts, ties, string, brassieres that can be used for self-harm.
- Be aware of patient's whereabouts at all times, 24 hours a day
- Take measures to reduce risk of unauthorized absences by patient (hospital pyjamas/housecoat/slippers, no off ward privileges, lock up belongings)
- Consider whether patient can be safely cared for in the open ward setting or whether a locked facility is needed

Potential Risk

- Place patient on Close Observation (D-00-07-30280)
- Stagger observations of the patient within 15 minutes
- Take measures to reduce risk of unauthorized absences by patient (hospital pyjamas/housecoat/slippers, no off ward privileges, lock up belongings)
- **FOR IMMINENT AND POTENTIAL RISK, PAY SPECIAL ATTENTION AND PLAN AROUND LOW STAFFING TIMES, e.g. SHIFT CHANGE AND MEAL BREAKS**

Lower Risk

- Place patient on Standard Observation (see Observation Levels for Patients in Acute Mental Health [D-00-07-30280])
- Observe patient every 30 - 60 minutes
- Carefully assess before allowing patient to leave hospital on Therapeutic Leave. Assess whether patient has access to weapons or medications that may need removing from home situation before authorizing passes.
- Carefully assess patient on return from Therapeutic Leave

FOR ALL PATIENTS, REGARDLESS OF RISK LEVEL

- Assess patient's room at least once every shift for presence of potentially dangerous articles and remove as appropriate, e.g. plastic bags, sharps, cleaning agents, drugs
- Consider placing the patient in a room close to the nursing station
- Inform patient of precautions being taken
- Consider developing a safety plan with the patient and whether they can follow through
- Work with the patient to develop and practice coping strategies that manage suicidal thoughts and impulses
- **If appropriate, inform family of precautions being taken (note - inform patient that family will be notified prior to doing so)**

Patient / Client / Resident Education:

Coping with Suicidal Thoughts, by Dr. Jotic Samra, R Psych and Dr. Dan Bilsker, R.Psych. (Lead Authors; 2007) Consortium for Organizational Mental Health (COMH; http://www.comh.ca), Faculty of Health Sciences, Simon Fraser University, Vancouver, BC. Inquiries may be directed to; info@comh.ca

Documentation

Admission Assessment

- According to unit specific assessment forms (all disciplines)
- Include factors indicating suicide risk and protective factors

Ongoing Assessment

- Include behaviours leading to need for suicide assessment or indicating an increased risk

Patient Care Plan

- Problem related to suicide risk
- Interventions

Progress Notes

- Ongoing assessment of suicide risk
- Patient's response to interventions
- Maintenance of observation level
- Family/significant other concerns

Related Documents

- Observation Levels for Patients in Acute Mental Health [D-00-07-30280]
- Therapeutic leave[D-00-12-30325]
- Restraints: Care of the Patient at Risk for or Requiring Restraint[D-00-07-30281]
- Emergency Response – Code White

Resources

- Psychiatry Consultation and Liaison Service
- Clinical Educators, Psychiatry
- Department of Spiritual Care and Multifaith Services
- The Provincial Suicide Clinical Framework, draft June 2008
- Suicide Attempt Follow Up Education and Research (SAFER) Program

Revised By

PROGRAM/UNIT: Psychiatry

Task Group / Individual Names:

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Final SharePoint Sign-Off by VA Operations Directors

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