Suicide Risk Assessment: Overview of Best Practices and Considerations Webinar

Mental Health Commission of Canada
Commission de la santé mentale du Canada

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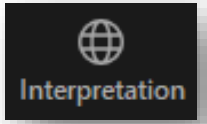
Audio and Video Reminders

Simultaneous Interpretation

French interpretation is available through a computer. To listen, click on the Interpretation button at the bottom of your screen and select your preferred language.

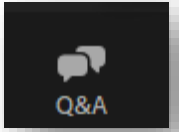


English and French Slides

If you would like to follow along to the slides in French, please select the view “Speaker”. The slider between the speaker’s camera and the English slides can be adjusted and moved to the left in order to view better view the French Slides.

There will be a Q&A period at the end of the presentation

Please feel free to type in any questions for the presenters in the Q&A box.



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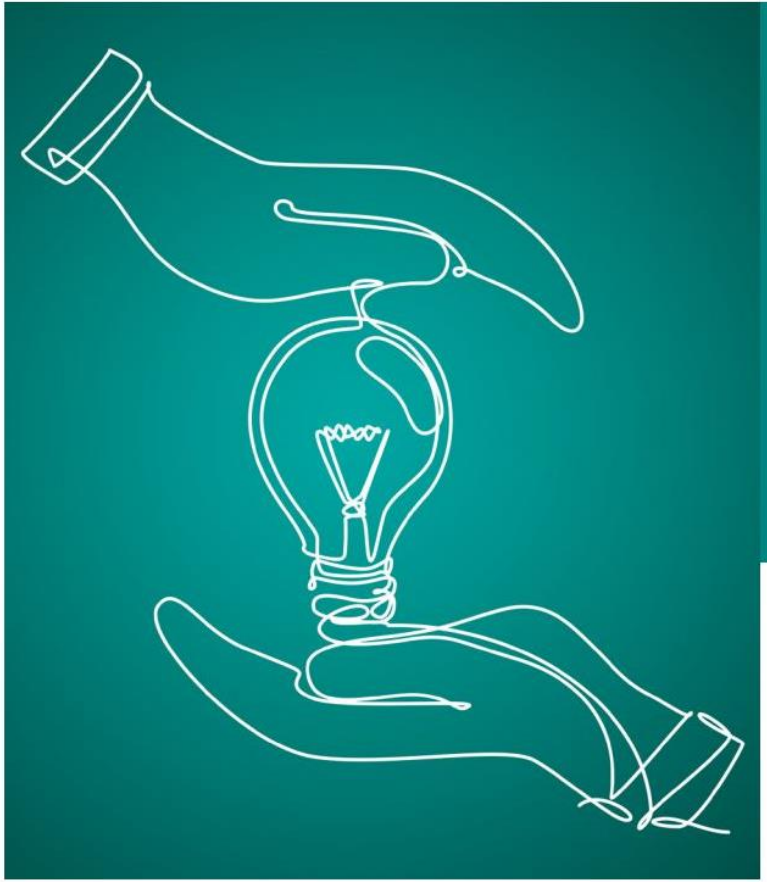


Suicide Risk Assessment Toolkit

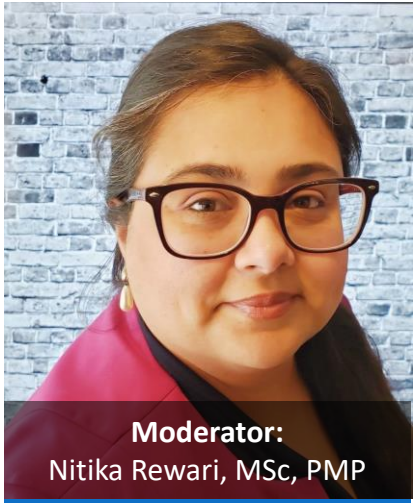
A Resource for Healthcare Workers and Organizations

January 2021

cpsi icsp
Canadian Patient Safety Institute / Institut canadien pour la sécurité des patients

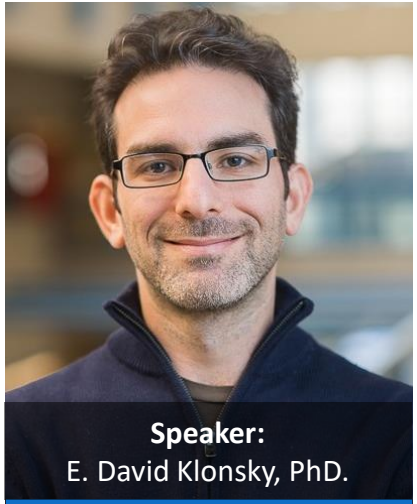
Mental Health Commission of Canada / Commission de la santé mentale du Canada

Presenters



Moderator:
Nitika Rewari, MSc, PMP

Acting Director
Prevention and Promotion Initiatives
Mental Health Commission of Canada



Speaker:
E. David Klonsky, PhD.

Professor
Department of Psychology
University of British Columbia

Speaker:
Allison Crawford, MD, PhD.

Clinician Scientist
Centre for Addiction and Mental Health (CAMH)

Associate Professor
Department of Psychiatry,
University of Toronto

Speaker:
Joseph Sadek, MD.

Associate Professor Department of Psychiatry *Dalhousie University*

Clinical and Academic Leader
Nova Scotia Hospital, Acute Care

UNDERSTANDING SUICIDE RISK

E. David Klonsky, PhD
University of British Columbia
@KlonskyLab

CONDITIONS FOR SUICIDE

1) Pain

2) Hopelessness

3) Connection

4) Capability for Suicide

PAIN AND HOPELESSNESS

Motivate Suicide

CONNECTEDNESS

Makes life worth living

CAPABILITY FOR SUICIDE

Makes suicide feasible

CONDITIONS FOR SUICIDE

1) Pain

2) Hopelessness

3) Connection

4) Capability for Suicide

Organizing Model for Suicide Risk

Organizing Model for Suicide Risk

Pain	Hopelessness	Connectedness	Capability

Organizing Model for Suicide Risk

Pain	Hopelessness	Connectedness	Capability
Psychache			
Depression			
Anxiety			
Emotion Dysregulation			
Mental Disorders			
General Distress			

Organizing Model for Suicide Risk

Pain	Hopelessness	Connectedness	Capability
Psychache	Hopelessness		
Depression	Pessimistic Outlooks		
Anxiety	External Locus		
Emotion Dysregulation	Learned Helplessness		
Mental Disorders	Self-Efficacy		
General Distress	Future Orientation		

Organizing Model for Suicide Risk

Pain	Hopelessness	Connectedness	Capability
Psychache	Hopelessness	Social Isolation	
Depression	Pessimistic Outlooks	Loneliness	
Anxiety	External Locus	Poor Social Support	
Emotion Dysregulation	Learned Helplessness	Low Belongingness	
Mental Disorders	Self-Efficacy	Burdensomeness	
General Distress	Future Orientation		

Organizing Model for Suicide Risk

Pain	Hopelessness	Connectedness	Capability
Psychache	Hopelessness	Social Isolation	Acquired Capability
Depression	Pessimistic Outlooks	Loneliness	Access to Means
Anxiety	External Locus	Poor Social Support	Knowledge of Means
Emotion Dysregulation	Learned Helplessness	Low Belongingness	Dispositional Capability
Mental Disorders	Self-Efficacy	Burdensomeness	
General Distress	Future Orientation		

CONDITIONS FOR SUICIDE

1) Pain

2) Hopelessness

3) Connection

4) Capability for Suicide

CANNOT ACCURATELY PREDICT THE FUTURE!

1) Pain

2) Hopelessness

3) Connection

4) Capability for Suicide

SNAPSHOT OF SUICIDE RISK

1) Pain

2) Hopelessness

3) Connection

4) Capability for Suicide

BROAD CATEGORIZATION OF SUICIDE RISK

1) Pain

2) Hopelessness

3) Connection

4) Capability for Suicide

POINTS OF INTERVENTION

1) Pain

2) Hopelessness

3) Connection

4) Capability for Suicide

MULTIPLE LEVELS OF INTERVENTION

1) Individual (psychotherapy, medication, safety plans)

2) Emergency (crisis lines, hospitals, 911)

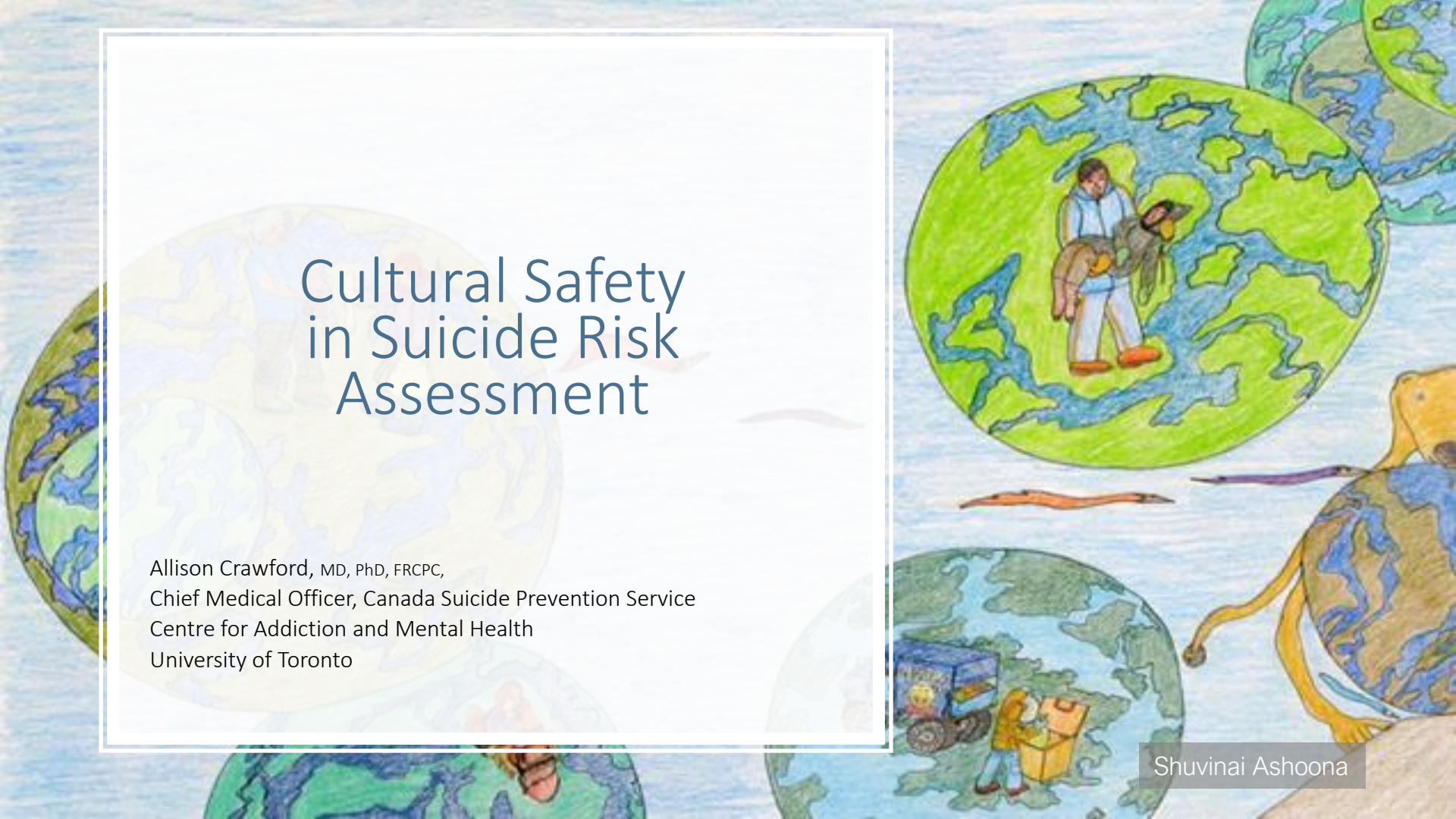
3) Communities (schools, Indigenous)

4) Population/Government (discrimination, healthcare, poverty, guns)


THANK YOU!!
QUESTIONS??

Cultural Safety in Suicide Risk Assessment

Allison Crawford, MD, PhD, FRCPC,
Chief Medical Officer, Canada Suicide Prevention Service
Centre for Addiction and Mental Health
University of Toronto



Disclosures

- **Presenter Disclosures**
  - **Presenter:** Allison Crawford
  - No relationships with financial sponsors to disclose
- **Potential for conflict(s) of interest:**
  - None to disclose

Thank you to Dr. Rene Linklater for her collaboration in the development of some of these materials.

Thank you also to the Project CREATeS team and to the youth participants.
www.ProjectCREATeS.com

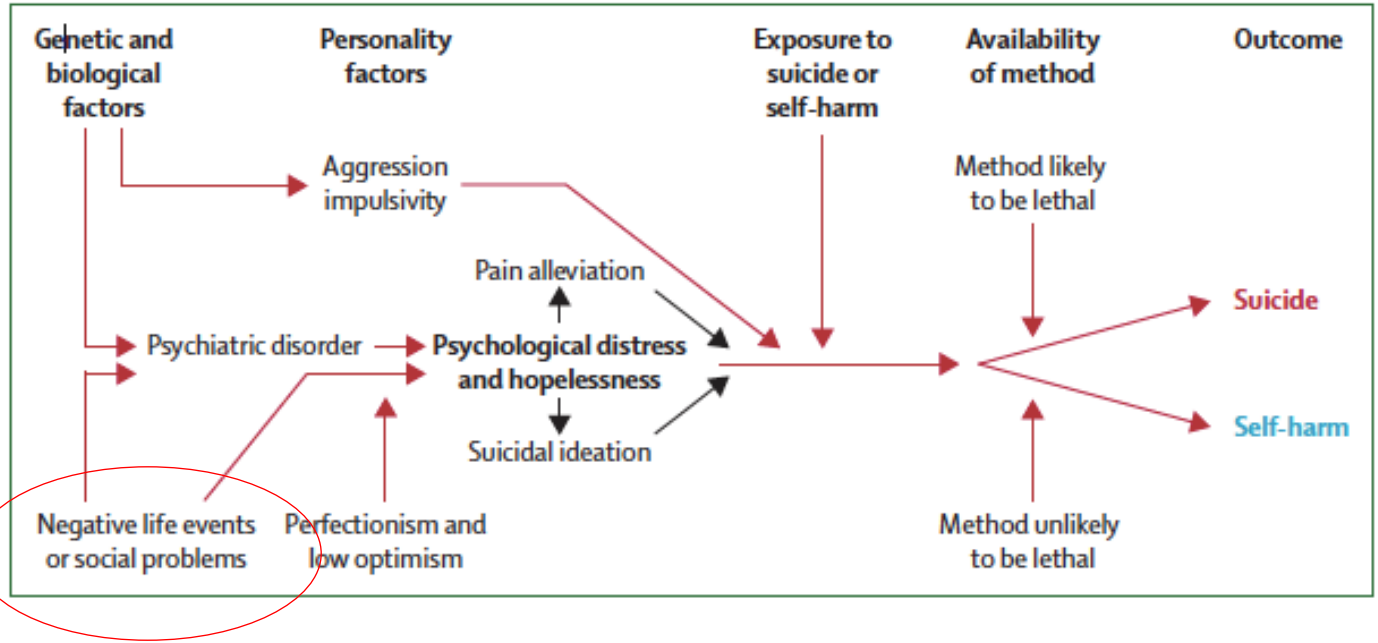
Learning objectives

At the end of this session, participants will be able to:

1. Consider how suicide risk assessment practices “fit” within diverse contexts and for equity-seeking communities.

2. Apply a cultural safety when identifying strengths and risk factors at community and individual levels.

Pathways of Risk



Hawton, Saunders, O'Connor 2012

Attempts to Quantify Risk

EMNote

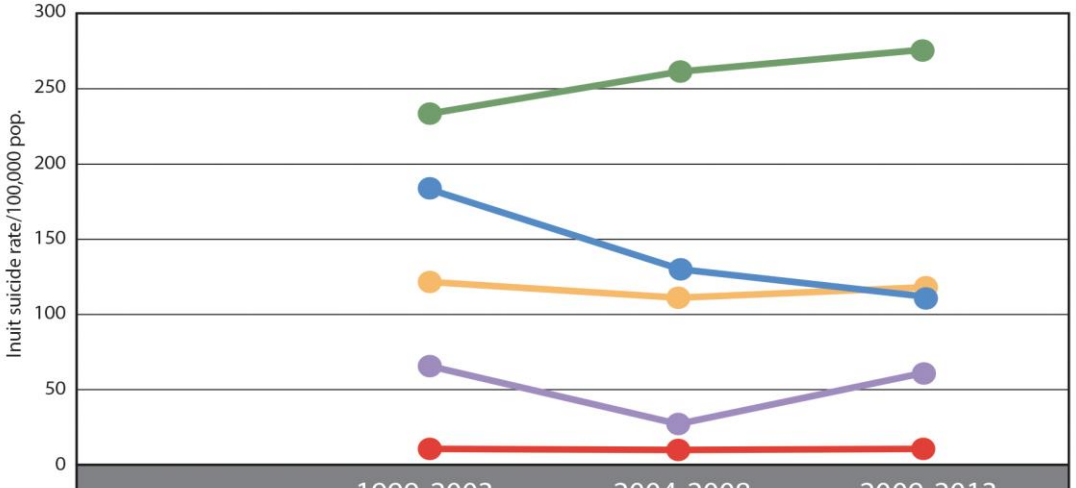
The modified SADPERSONS score

	Meaning	Points Assigned
S	Sex: Male	1
A	Age: <19 or >45	1
D	Depression or hopelessness	2
P	Previous attempts or psychiatric care	1
E	Excessive alcohol or drug use	1
R	Rational thinking loss	2
S	Separated/divorced/widowed	1
O	Organized or serious attempt	2
N	No social support	1
S	Stated future intent	2

Score ≥ 6: high suicide risk, need psychiatry directed hospitalization

@ jackcfchong

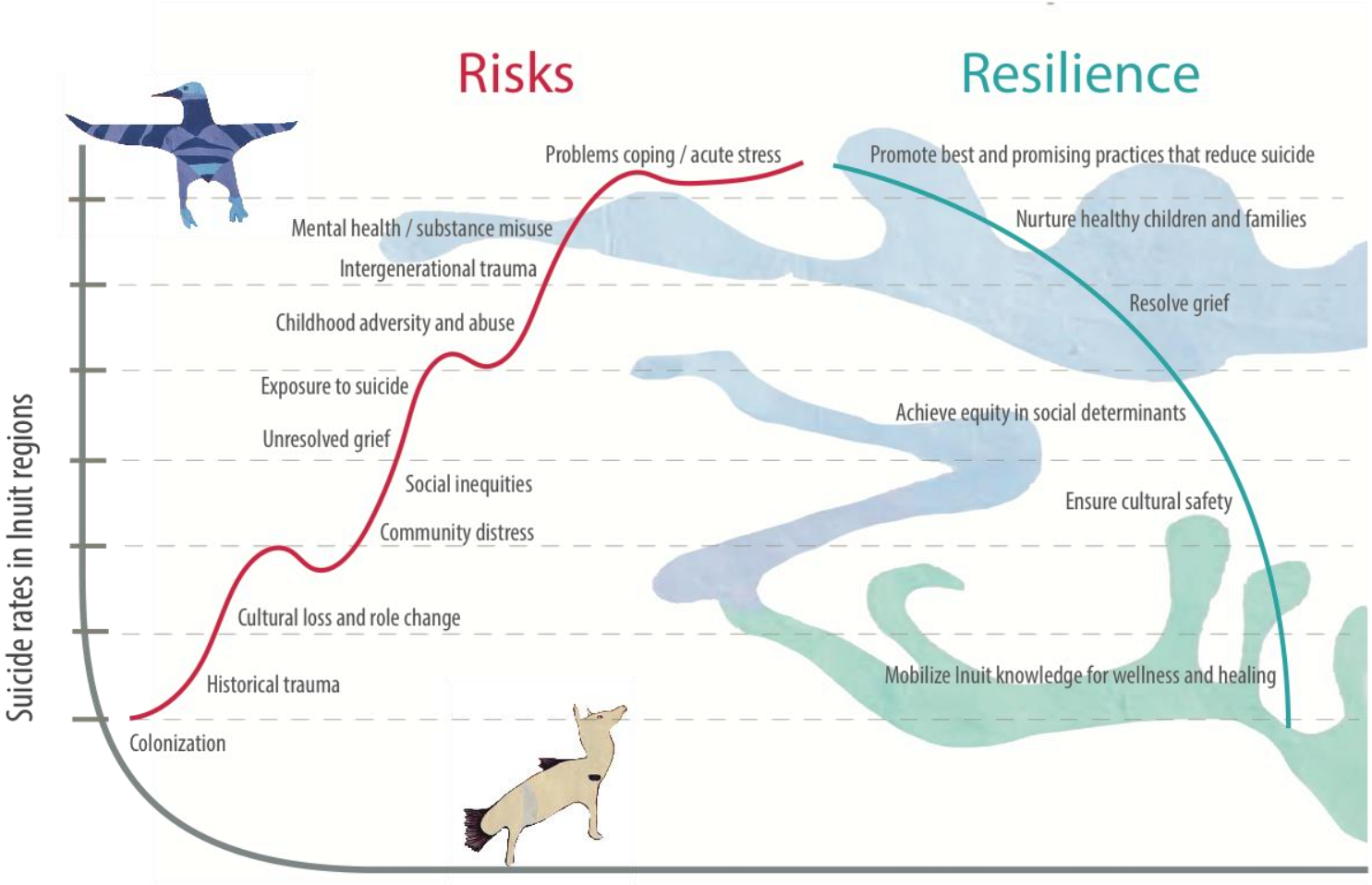
Warden et al. 2014

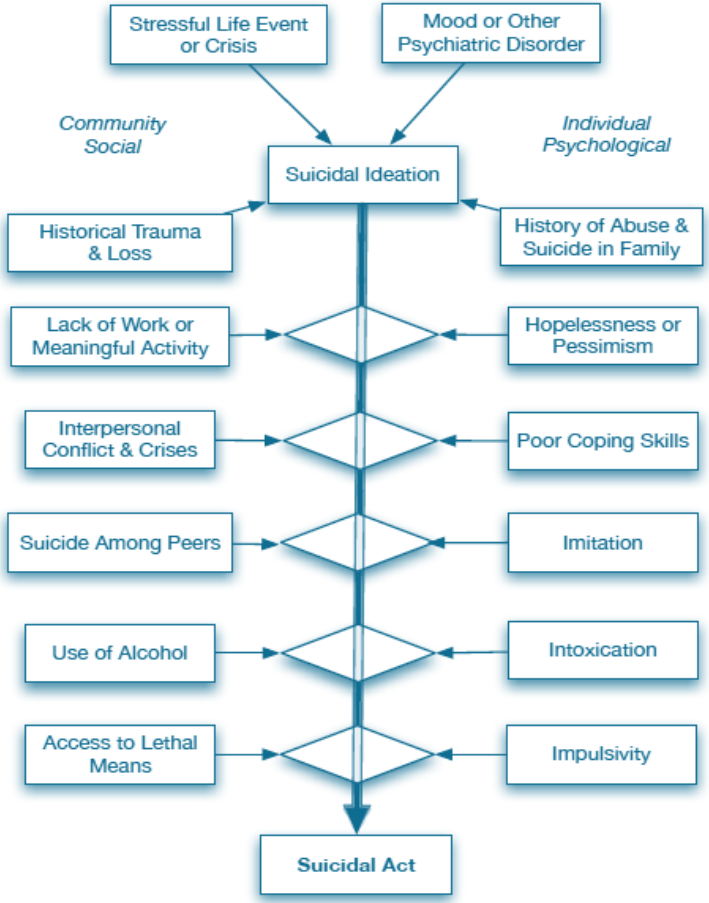


	1999-2003	2004-2008	2009-2013
Inuvialuit Region	61.4	32.1	60.4
Nunavut	119.7	109.6	116.7
Nunavik	181.2	129.2	113.5
Nunatsiavut	238.8	259.3	275.3
Total Canada	11.9	10.8	11.3

Note: Rates for all populations are crude. Total Canada rates are for 2001, 2006 and 2011.
Sources: a) Inuit data prepared for ITK by J. Hicks; b) Total Canada data – Statistics Canada, Table 102-0552 – Deaths and mortality rate, by selected grouped causes and sex, Canada, provinces and territories, annual.

National Inuit Suicide Prevention Strategy 2016


Risks
Resilience
Suicide rates in Inuit regions
Problems coping / acute stress
Mental health / substance misuse
Intergenerational trauma
Childhood adversity and abuse
Exposure to suicide
Unresolved grief
Social inequities
Community distress
Cultural loss and role change
Historical trauma
Colonization
Promote best and promising practices that reduce suicide
Nurture healthy children and families
Resolve grief
Achieve equity in social determinants
Ensure cultural safety
Mobilize Inuit knowledge for wellness and healing

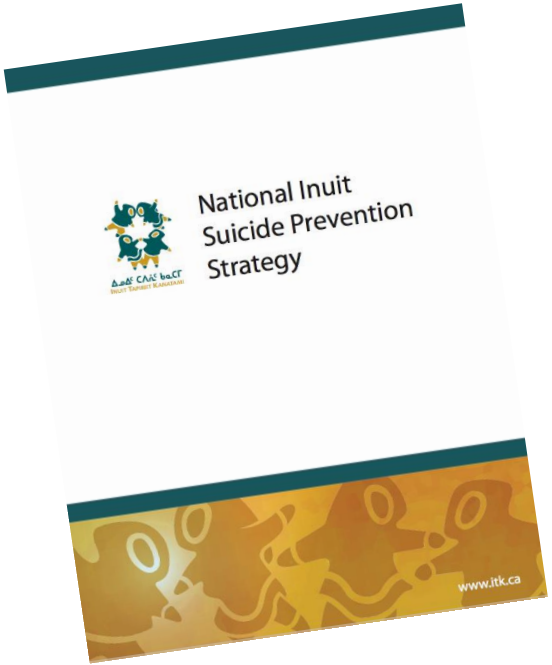


Kirmayer et al., 2009

Cultural Continuity

- Measure of self-government*
- Litigated land claims
- Local control over education
- Local control over health
- Local control over policing and fire services
- Community facilities for preservation of culture
- Local control over child protection system
- Presence of women in leadership roles

Chandler, M.J., and Lalonde, C.E., 2008



SUICIDE RISK AND PROTECTIVE FACTORS FOR INUIT IN CANADA

RISK FACTORS

Historical Trauma
Impacts of colonialism, residential schools, relocations, dog slaughter

Community Distress
Social inequities including crowded housing, food insecurity, lack of access to services

Wounded Family
Intergenerational trauma, family violence, family history of suicide

Traumatic Stress and Early Adversity
Experiencing acute or toxic stress in the womb, witnessing or experiencing physical or sexual abuse

Mental Distress
Depression, substance misuse, mental health disorder, self-harm

Acute Stress or Loss
Recent loss, intoxication, access to means, hopelessness, isolation

PROTECTIVE FACTORS

Cultural Continuity
Strongly grounded in Inuit language, culture and history

Social Equity
Adequate economic, educational, health and other resources support and foster resilience

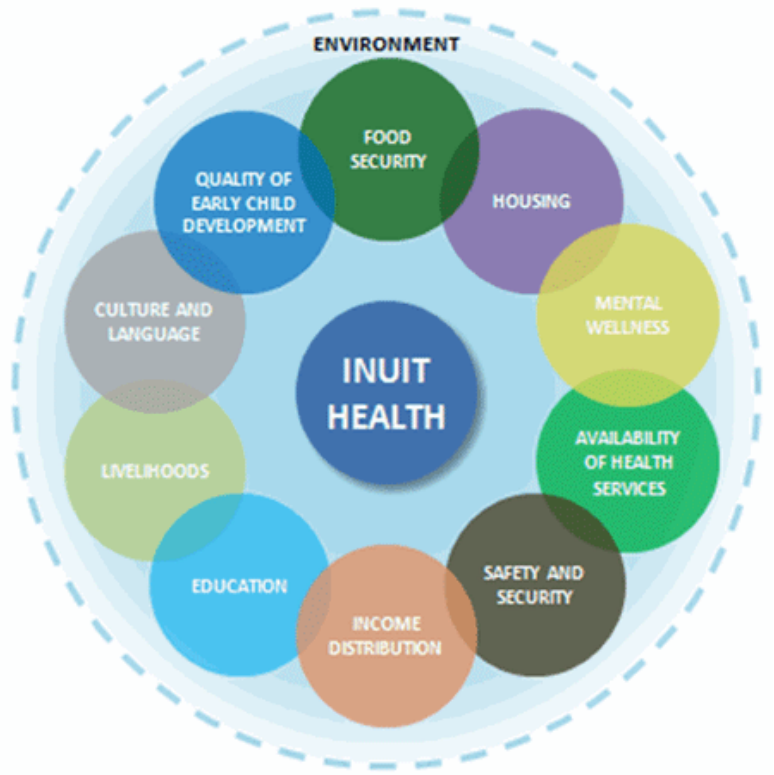
Family Strength
Safe, supportive and nurturing homes

Healthy Development
Providing children with safe environments that nurture social and emotional development

Mental Wellness
Access to Inuit-specific mental health services and supports

Coping with Acute Stress
Ability to regulate and cope with distress, access to social supports and resources

Social Determinants of Health



Inuit Tapiriit Kanatami, 2014

ARCTIC COUNCIL

ABOUT EXPLORE NEWS CALENDAR RESOURCES CONTACT

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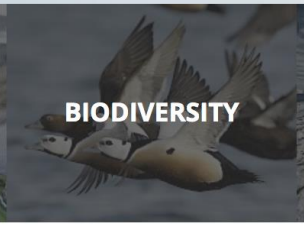
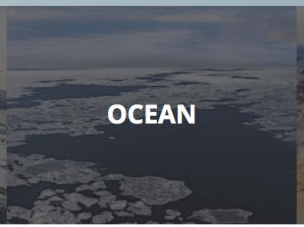
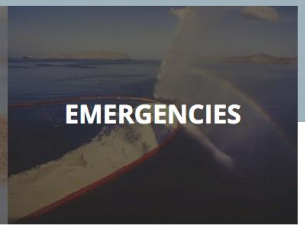
ARCTIC COUNCIL

The leading intergovernmental forum promoting cooperation in the Arctic.

Learn more







RISING SUN: Prioritized Outcomes for Suicide Prevention in the Arctic

Pamela Y. Collins, M.D., M.P.H., Roberto A. Delgado, Jr., Ph.D., Charlene Apok, M.A., Laura Baez, L.C.S.W., M.S.W., Peter Bjerregaard, M.D., Ph.D., Susan Chatwood, Ph.D., M.Sc., Cody Chipp, Ph.D., Allison Crawford, M.D., Ph.D., Alex Crosby, M.D., M.P.H., Denise Dillard, Ph.D., David Driscoll, Ph.D., Heidi Ericksen, M.D., Ph.D., Jack Hicks, Christina V. L. Larsen, Ph.D., Richard McKeon, Ph.D., M.P.H., Per Jonas Partapuoli, B.Sc., Anthony Phillips, Ph.D., Beverly Pringle, Ph.D., Stacy Rasmus, Ph.D., Sigrún Sigurðardóttir, Ph.D., Anne Silviken, Ph.D. (Cand. Psychol.), Jon Petter Stoor, M.Sc., Yury Sumarokov, M.D., Ph.D., Lisa Wexler, M.S.W., Ph.D.

The Arctic Council, a collaborative forum among governments and Arctic communities, has highlighted the problem of suicide and potential solutions. The mental health initiative during the United States chairmanship, Reducing the Incidence of Suicide in Indigenous Groups: Strengths United Through Networks (RISING SUN), used a Delphi methodology complemented by face-to-face stakeholder discussions to identify outcomes to evaluate suicide prevention interventions. RISING SUN underscored that multilevel suicide prevention initiatives require mobilizing resources and enacting policies that promote the capacity for wellness, for example, by reducing adverse childhood experiences, increasing social equity, and mitigating the effects of colonization and poverty.

Psychiatric Services 2019; 70:152–155; doi: 10.1176/appi.ps.201700505

Approximately 500,000 indigenous people inhabit the circumpolar North, and suicide rates in Arctic communities, particularly for young people, typically exceed national averages (1). The high rates of suicide among indigenous youths in the Arctic are a relatively recent phenomenon, coinciding with colonial intrusions into traditional lifestyles, rapid modernization, cultural disruption, and policies of cultural assimilation (2). Lack of service system infrastructure, distrust of formal services, systemic discrimination, underemployment, and collective disempowerment increase suicide risk for Arctic indigenous youths (1, 3). Yet the holistic perspectives (i.e., connections with land and spirituality) reflected in the traditional culture of many circumpolar indigenous communities can support mental health (4).

Suicide prevention efforts should be tied to identified strengths and vulnerabilities, but the challenges of conducting rigorous research and evaluation in the Arctic hinder the development and implementation of best practices. Suicide prevention research in these locations is constrained by geography, lack of culturally relevant measures with thorough psychometric testing, small populations, and research strategies that prioritize local control and cultural relevance over generalizability and rigor-enhancing scientific conventions (5). Another constraint is the definition of evidence, which has often limited the criteria for determining intervention effectiveness to randomized controlled trials at the expense of evidence from other knowledge systems. Arctic mental health researchers have called for a "circumpolar comparative framework . . . to design, conduct and interpret interventions [to] enable lessons to be learned and shared" (5). Such a framework will better enable indigenous communities, service providers, researchers, and policymakers to address the critical health disparities that affect indigenous youths across the Arctic.

Over the past decade, the Arctic Council, the intergovernmental forum of Arctic states and permanent participants (representing indigenous peoples' organizations), has become a forum for collaborative efforts to highlight the problem of suicide and potential solutions. The 2011 Arctic Health Declaration in Nuuk, Greenland, focused on enhancing mental health and the prevention of substance abuse and suicide. Under the 2013–2015 Canadian chairmanship of the Arctic Council, the Sharing Hope initiative supported international teams of Arctic researchers to identify evidence-based interventions that increase mental wellness and prevent suicide among circumpolar indigenous communities (5). The final report revealed a dearth of rigorously tested interventions for these communities. More recently, under the United States chairmanship (2015–2017), a multicountry team built on this work with a new mental health initiative called Reducing the Incidence of Suicide in Indigenous Groups: Strengths United Through Networks (RISING SUN). The


PROJECT CREATES
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STORY
ABOUT TEAM STORIES
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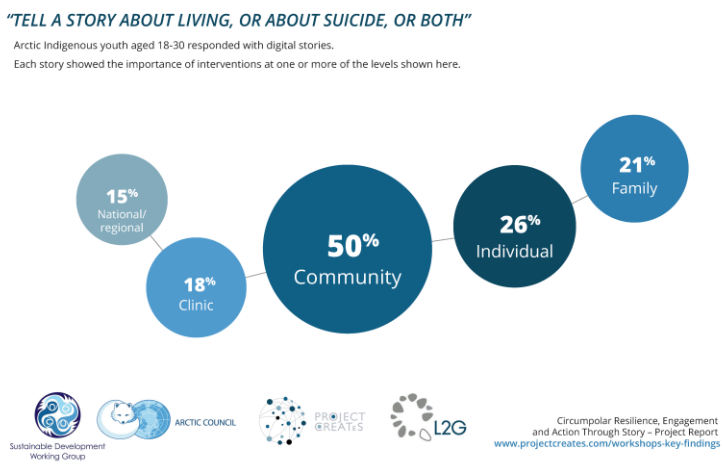
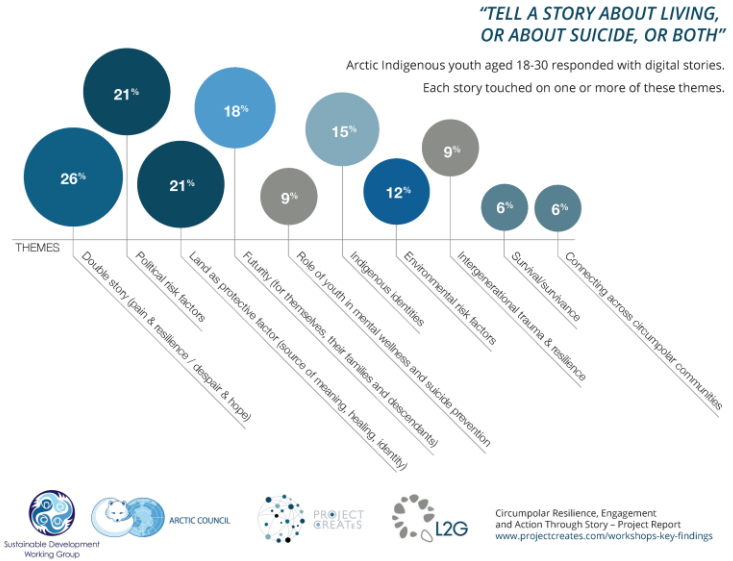
VIDEO SLIDE

https://www.dropbox.com/s/hqljsgpz050uwky/A01%20Byron%20Nicholai.mov?dl=0





www.ProjectCREATeS.com

Crawford 2019

Cultural safety in suicide risk assessment

What is cultural safety?

Cultural safety is about fostering a climate where the unique history of Indigenous peoples is recognized and respected in order to provide appropriate care and services in an equitable and safe way, without discrimination. (San'yas 2021)

Trust is established and maintained in the treatment relationship
Clients are treated with respect
Clients have their cultural location, values and preferences taken into account in the health service encounter

Cultural humility

A process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust.

Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience.

Cultural Safety and Indigenous Knowledges

Believing that health is a wholistic concept.

Knowing that Peoples' ways of thinking and being are important to wellness and healing, while also taking a distinctions-based approach

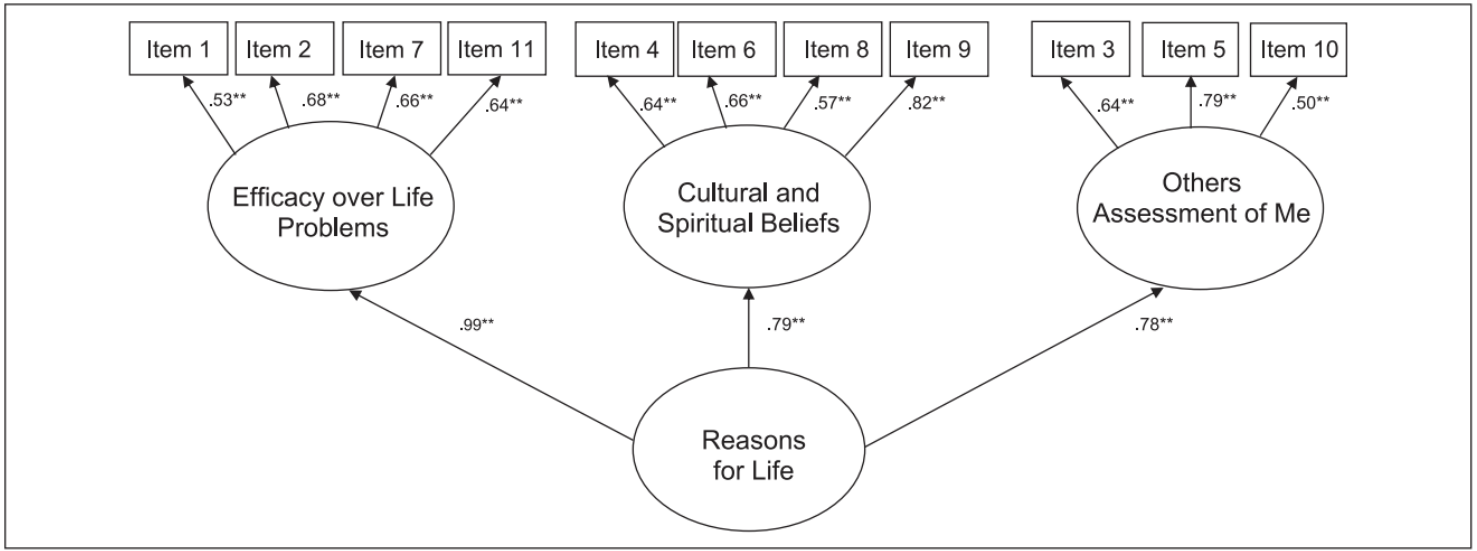
Recognizing that mental health is developed and is maintained through connectedness with family, community and the environment.

Understanding how history may influence experience, including individual and community history.

Accepting that different healing processes exist for different people, and respecting each other's strengths and abilities in helping.

Adapted from: http://www.naho.ca/documents/it/2009_Cultural_Safety_Knowledge_poster.pdf

Reasons for living scale



Allen et al. 2021

Reasons for living scale

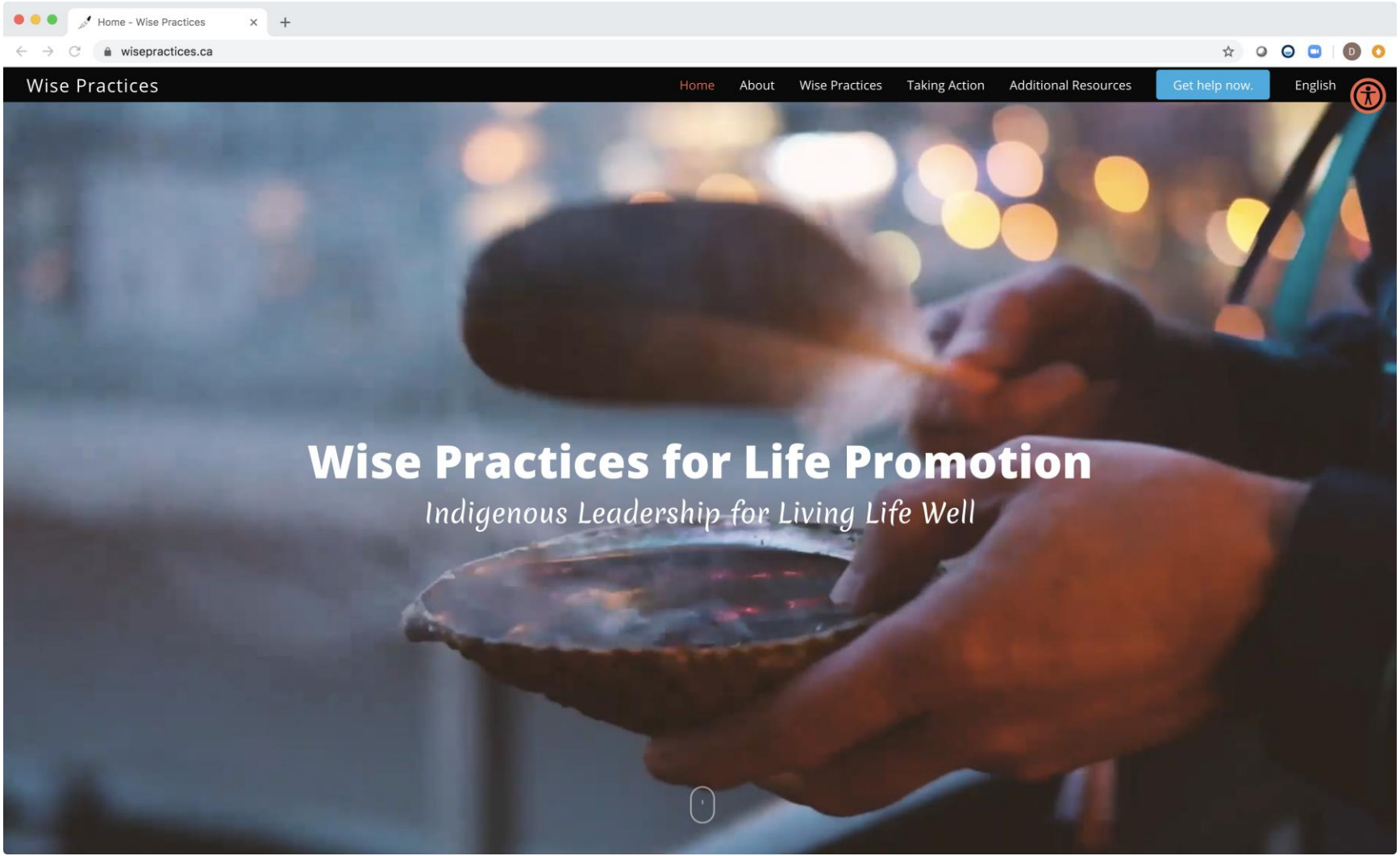
Table 2. Item Parameters for Five-Category and Four-Category Calibrations.

Item		Five-category calibration					Four-category calibration			
		a	b_1	b_2	b_3	b_4	a	b_1	b_2	b_3
	Efficacy Over Life Problems									
1	I believed I can help others fix their problems	1.00	−3.30	−0.54	0.01	1.22	1.00	−3.32	−0.55	1.22
2	I believed I can make things work out for the best even when life gets difficult	1.93	−2.26	−0.78	−0.38	0.82	1.78	−2.35	−0.79	0.85
7	I believed I can fix my problems	1.54	−2.76	−1.30	−0.89	0.30	1.57	−2.73	−1.28	0.30
11	I had the courage to face life's hardest moments	1.47	−2.86	−0.89	−0.49	0.44	1.41	−2.93	−0.89	0.45
	Cultural and Spiritual Beliefs									
4	No matter how hard things got, I believed God wanted me to live	1.07	−4.52	−2.75	−1.69	−1.29	1.03	−4.64	−2.91	−1.32
6	My Yup'ik Elders taught me that my life is valuable	1.93	−2.21	−1.20	−0.93	−0.13	1.84	−2.25	−1.22	−0.14
8	I believed I must live to be an Elder	1.25	−3.87	−2.04	−1.66	−0.51	1.23	−3.92	−2.06	−0.52
9	My religion taught me that my life is valuable	2.32	−2.09	−0.90	−0.56	0.10	2.42	−2.06	−0.89	0.10
	Others' Assessment of Me									
3	People saw me do good things to help others	1.62	−2.40	−0.74	−0.29	0.69	1.51	−2.49	−0.75	0.70
5	People saw that I am strong and care about others	2.70	−2.27	−1.16	−0.74	0.20	2.92	−2.22	−1.13	0.19
10	People saw I live my life in a good way	0.88	−4.37	−1.58	0.05	0.57	0.83	−4.55	−1.81	0.60

Allen et al. 2021

What does this mean for our work?

- Stance of cultural humility
- Assume strengths
- Trauma-informed care
- Wholism
- Evaluate cultural safety
- Know resources
- Partnership
- Indigenous leadership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HOPE FOR WELLNESS HELPLINE

Welcome to the Hope for Wellness Helpline – On-Line Chat Counseling Service

Call the toll-free Help Line at 1-855-242-3310, 24 hours a day, 7 days a week, **or use the chat box below to connect with a counsellor on-line**

The Hope for Wellness Help Line offers immediate mental health counselling and crisis intervention to all Indigenous peoples across Canada.

Experienced and culturally competent Help Line counsellors can help if you:

- want to talk
- are distressed
- have strong emotional reactions
- are triggered by painful memories

If asked, counsellors can also work with you to find other wellness supports that are available near you

Phone and chat counselling is available in English and French. On request, phone counselling is also available in:

- Cree
- Ojibway
- Inuktitut

CHAT NOW

Name (Real name optional)

Your Question

Connect with a counsellor

Services provided by Donna Cona. To understand how your personal information is managed, please click Donna Cona's privacy policies and terms and condition policy.

References

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Inuit Tapiriit Kanatami National Inuit Suicide Prevention Strategy
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Clinical Approach to Suicide Risk Assessment

Dr. Joseph Sadek, MD, MBA, B.Sc. Pharm, FRCPC.
Diplomat American Board of Psychiatry and Neurology
Associate Professor, Department of Psychiatry, Dalhousie University
Chaired the NS Suicide Prevention Task Force

Objectives

- By the end of this presentation, participants will be able to recognize the clinical approach to suicide risk assessment and management with focus on NS experience.

WHY Suicide Prevention is Important?

The psychological and social impact of suicide on the family and society is immeasurable

On average, a single suicide affects at least six other people. If a suicide occurs in a school or work place it has an impact on hundreds of people (Bolton J, 2015, BMJ)

The burden of suicide is twice the burden of diabetes, and equal to the burden of birth asphyxia and trauma (WHO. Preventing suicide—a global imperative. 2014)

Epidemiology

In 2019, the number of suicides in Canada was around 4012.

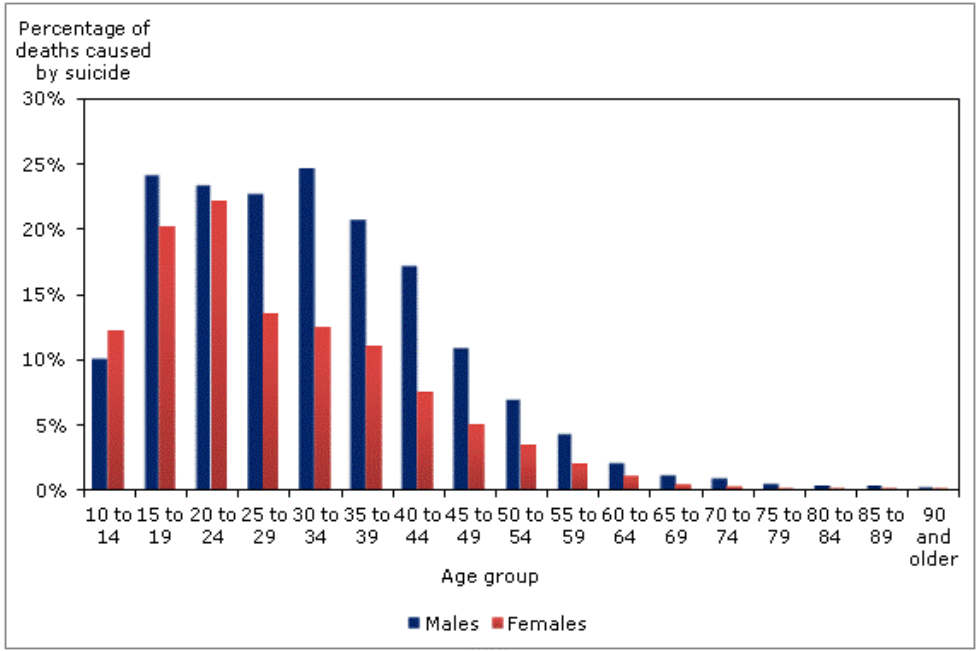
The suicide rate for males was three times higher than the rate for females (17.9 versus 5.3 per 100,000).

Although suicide deaths affect almost all age groups, those aged 40 to 59 had the highest rates.

Suicide rates for Indigenous youth are among the highest in the world, at 11 times the national average.

REF: Statistics Canada

Epidemiology



REF: Statistics Canada

Suicide Prevention Task Force in NS

The task force had to:

Meet Accreditation Canada standards

Review or current and past morbidity and mortality cases

Review the literature related to Suicide

Identify challenges in SRA and propose solutions

Design a tool that assist in clinical judgment and provide training

Required Organizational Practices (ROP) Standards for Suicide Prevention

Accreditation Canada (2015) states following requirements:

- Clients at risk of suicide are identified.
- The risk of suicide for each client is assessed at regular intervals or as needs change. The immediate safety needs of clients identified as being at risk of suicide are addressed.
- Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide.
- Implementation of the treatment and monitoring strategies is documented in the client record.
- REF: http://accreditation.ca/sites/default/files/rop-handbook-2014-en.pdf

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.

- Designed a tool that allows for including collateral information

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

- Suicide risk assessment scales do not accurately predict death by suicide and cannot be used for suicide risk assessment by individuals not trained in suicide risk assessment

- Designed a tool that relies on clinical judgment but allows for inclusion of all the relevant information to make a sound judgment

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

- Lack of consistency in the education and training of health care providers in the competencies needed to conduct a suicide risk assessment

- Developed a training program to all clinicians and allied health professionals with video modules, book, e-book, case studies and face to face training.

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

- Suicidal behavior 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.

- Allowed for extra training for clinicians who react negatively to suicidal patients

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

- Sometimes suicide risk is not documented
- Suicide risk not communicated with others involved in patient care

- Developed a tool that allows for documentation and communication among other clinicians involved in patient care

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

- Acute risk sometimes not differentiated from chronic risk.
- Patients who self harm are not diagnosed and managed adequately

- Designed one of the training modules to discuss self harm and disorders that may be related to self harm such as Borderline Personality Disorder

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

- Some people argues that suicide prevention is not the responsibility of the mental health system

- Several researchers found that majority of patients who died by suicide had a mental disorder preexisted. Mood disorders (predominantly depression) and substance use disorders (particularly alcohol abuse and dependence) were found in about two-thirds of people who died from suicide, with personality disorders accounting for an additional 15% .
- Social dimensions cannot be ignored. (Turecki, Lancet 2016)

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

Some argue: “No evidence that suicide prevention can be successful”.

We know of several programs that had evidence of success:

Akita University, in Japan’s with 50% reduction in suicide in a town in 4 years.

In the UK, improvements in service delivery achieved up to a 20% reduction in completed suicide by service users.

Nurmberg, Germany: after two years, a program resulted in a 24% reduction in suicides and suicide attempts


国際教養大学
Akita International University

DO WE HAVE EVIDENCE THAT SUICIDE PREVENTION CAN BE SUCCESSFUL ?

- There is some evidence that thorough assessments after self-harm may on their own improve outcomes. (Kapur N, 2008, Bergen H, 2010).

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.

NS Suicide Prevention Training

1. Suicide Risk Assessment Policy
2. Introduction to Suicide Literature and background
3. Suicide, Self Harm, BPD and other disorders
4. <u>The Content and Process of SRA:</u>

- Developing Core Competencies such as therapeutic alliance
- Identify Risk Factors and Factors That Build Resilience
- Collecting collateral history
- Formulating the risk

5. Management of suicidal patient
6. Documentation, Communication and Quality Monitoring

nova scotia health authority

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: _____

_____

_____

_____

_____

_____

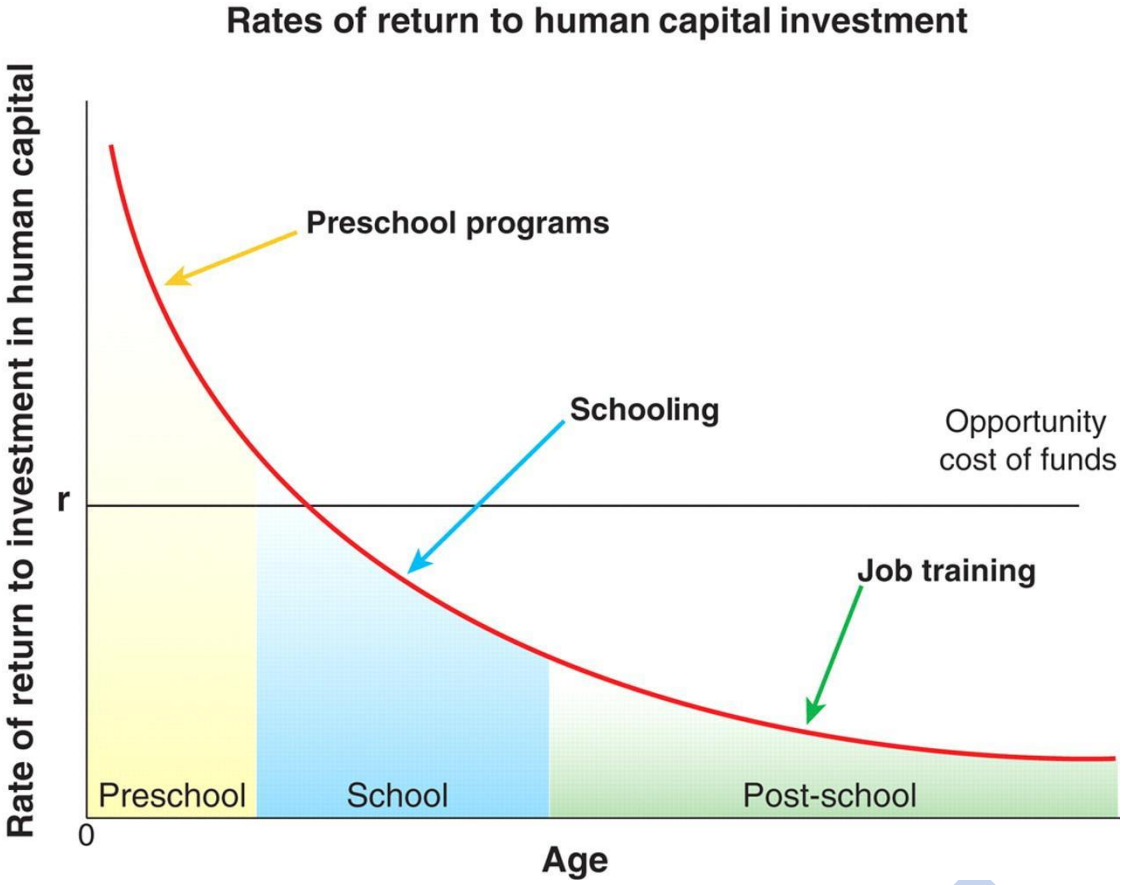
For information about this form contact Dr. Joseph Sadek at joseph.sadek@nshealth.ca

A Fresh Look at the Future

Start at an Early Age and Think Prevention

It is useful to recall the overall estimation of return of investment in human capital proposed by Heckman: the earlier the age of exposition (or investment), the higher the return

Considering the trend towards a progressively younger average age when suicidal behaviors occur, Heckman's proposal assumes even greater importance.


Rates of return to human capital investment
Rate of return to investment in human capital
Preschool programs
Schooling
Opportunity cost of funds
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Job training
Preschool
School
Post-school
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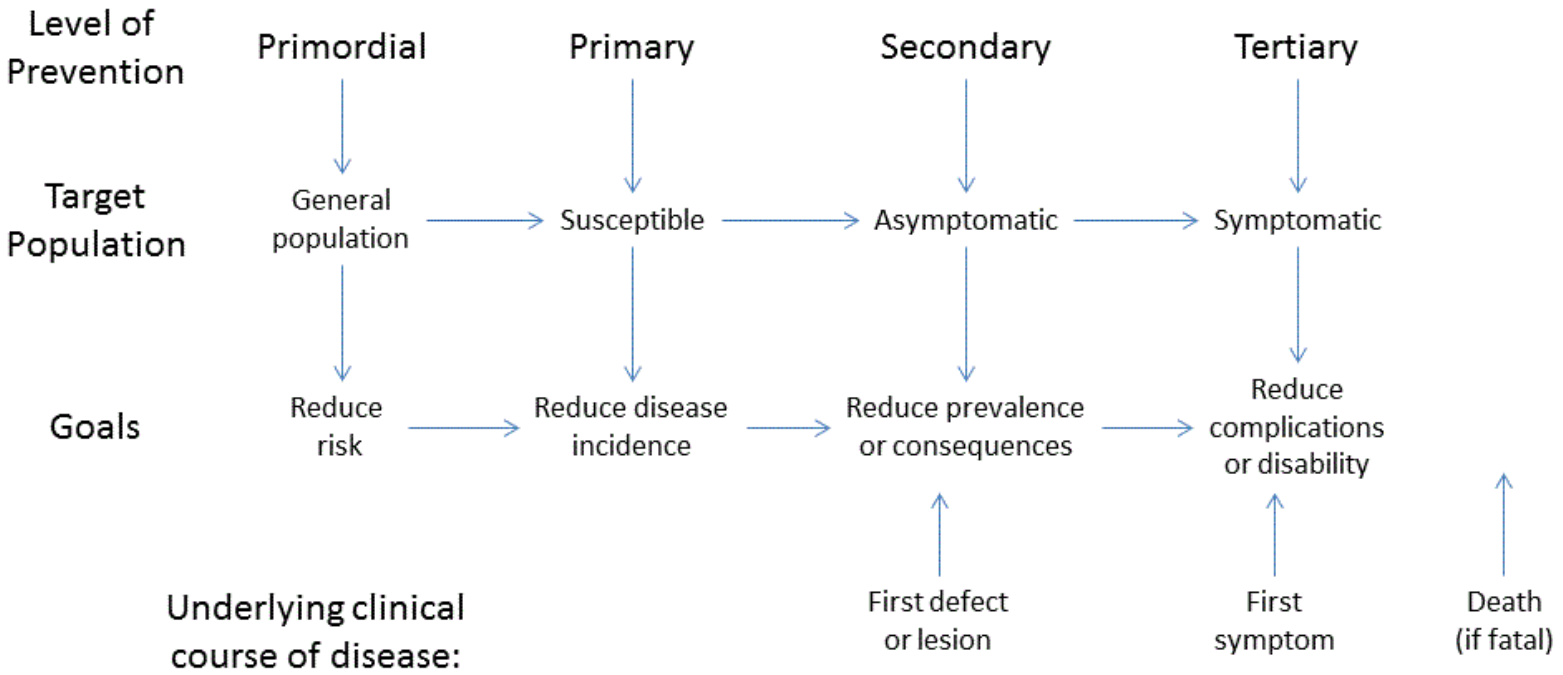
Age

A Classification of Preventive Strategies



Words to Remember

If patients have mental disorder, perhaps they might later recover and change their mind. Many people are relieved to have survived suicide

We usually conclude to give the patient the benefit of the doubt, and that whatever we do, should assist in the preserving of life, not the opposite. (*The Lancet, Vol 383 March 8, 2014)*

Thank You

Questions? Please email: joseph.sadek@nshealth.ca

THANK YOU!

Questions?

Mental Health Commission of Canada
Commission de la santé mentale du Canada

camh
mental health is health

UBC

DALHOUSIE UNIVERSITY
Inspiring Minds

THANK YOU!

If you have any other questions, please email Meagan Barrett-Bernstein at mbarrett-bernstein@mentalhealthcommision.ca

MERCI!

Si vous avez d'autres questions, veuillez s'il vous plait envoyé un courriel à Meagan Barrett-Bernstein à mbarrett-bernstein@mentalhealthcommission.ca

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