simcoe muskoka
DISTRICT HEALTH UNIT

Title	Suicide Risk Guideline		
Revised/Reviewed		Number	
Approved		Pages	

Protocol ☐	Guideline ☒	
Staff to whom the protocol applies: *(Select all those that apply from the following :)*		
☒ Customer Service Representative	☐ Family Home Visitor	☐ Public Health Promoter
☐ Dental Hygienist	☐ Program Assistant/Receptionist	☒ Physician
☐ Dentist	☐ Public Health Inspector	☒ Registered Nurse
☐ Dietitian/Nutritionist	☒ Public Health Nurse	☒ Registered Practical Nurse

Key Assessment Questions: The assessment questions in this guideline are intended to assist staff in linking clients to the appropriate health care services/provider and are not intended to determine level of risk for suicide.
The use of this guideline should never replace a thorough assessment by a qualified clinician (psychiatrist, mental health specialist). **If the individual is 18 year or younger and living in Simcoe County refer to CYFSC Suicide Risk Protocol for Youth**

1. Are you feeling hopeless about the present or your future?
2. Are you thinking about killing yourself?
3. Do you have a plan to take your life? **If yes ask:**
   Have you decided how you will kill yourself?
4. Have you taken any steps to secure the things you would need to carry out your plan? **If yes ask:**
   Have you taken/done anything already? **If yes ask:**
   Are you at home now? **If not at home ask:**
   Where are you now? (address, phone #)
5. Are you currently or have you ever received mental health care?
6. Have you attempted suicide before?
7. Have you been drinking alcohol or using drugs?

If the client answers yes to questions 2, 3, 4, or 6 they should be connected directly to the appropriate mental health crisis support line or 911. (See Suicide Risk Algorithm.)

Mental Health Crisis Lines
Simcoe Mental Health Crisis Line – Tel: 1-888-893-8333 or (705)728-5044
Simcoe County Youth Crisis Service - Tel: 705-728-5044
Muskoka Crisis Line – Tel: 1-800-461-5424
Kids Help Phone – Tel: 1-800-668-6868
Lesbian Gay Bisexual Youth Line – Tel: 1-800-268-9688
Parents Help Line – Tel: 1-888-603-9100

Interventions as per assessment:

Phone Interaction

1. Record the telephone number and name from call display in the event the client is disconnected. Calmly obtain and record the identifying information from the caller. Silently alert a second staff person, if available.
2. Establish if anyone is currently in the home with the client. Try to engage support of the other person as appropriate
3. Establish if there are children in the client's care and their ages.
4. Remain calm and establish rapport with the client letting them know that you are concerned for their well-

being.

5. If at any time you feel that the client is going to imminently harm themselves, 911 should be called either by yourself or by the second staff person. Not all questions must be asked before connecting with 911.
6. Assess if client:
    - has suicide plan in place
    - has access to means to carry out plan
    - has taken steps to carry out plan
    - has previously attempted suicide before
    - is receiving mental health care currently or has in the past
    - is or has been drinking alcohol or using drugs

(**Refer to key assessment questions**)

7. Connect client with the appropriate help based on your assessment e.g. mental health crisis line, 911 or their health care provider. You may need to connect the caller by conference call or have the second staff person make the call.
8. If you suspect (or know) there are children less than 16 years old in the home, follow the Report to Children's Aid Society Policy (LG0102).
9. Refer to CHGP G-2 Postpartum Mood Disorder Protocol if the client is postpartum.
10. Report to your supervisor/manager following the situation to debrief. You or your manager may advise HR of the situation as is appropriate.
11. After the interaction with the client is complete, document a comprehensive note in the client's record including the time and as much detail as possible. Include direct quotes taken from the conversation between the client and yourself. Document the action(s) taken, including the name of the person or agency where the client was referred, and the follow-up plan of action.

How to Conference Call for Crisis Support from SMDHU Phones

a. While you have the caller live on the line, inform them that you are going to conference them to the crisis line or 911.
b. With the caller live, push the conference button on phone (inform them they will be on hold briefly and will hear music).
c. Enter desired telephone number e.g. Simcoe Mental Health Crisis Line 705-728-5044.
d. Push conference again and you should have both caller and community agency on the same phone line.
e. Provide a brief explanation of the situation.
f. Hang up phone to disconnect from the conference call (both parties will remain connected until one of them hangs up).

Face to Face Interaction

1. Remain calm and establish/maintain rapport with the client letting them know that you are concerned for their well-being.
2. If at any time you feel that the client is going to imminently harm themselves, call 911.
3. Assess if client
    - has suicide plan in place
    - has access to means to carry out plan
    - has taken steps to carry out plan
    - has previously attempted suicide before
    - is receiving mental health care currently or has in the past

- is or has been drinking alcohol or using drugs

(**Refer to key assessment questions**)

4. Connect client with the appropriate help based on your assessment e.g. mental health crisis line, 911 or their health care provider. You may need to make the call for the client.
5. If you suspect (or know) there are children less than 16 years old in the home, follow the Report to Children's Aid Society Policy (LG0102).
6. Refer to CHGP G-2 Postpartum Mood Disorder Protocol if the client is postpartum.
7. Report to your supervisor/manager following the situation to debrief. You or your manager may advise HR of the situation as is appropriate.
8. After the interaction with the client is complete, document a comprehensive note in the client's record including the time and as much detail as possible. Include direct quotes taken from the conversation between the client and yourself. Document the action(s) taken, including the name of the person or agency where the client was referred, and the follow-up plan of action.

Email or other Electronic Interaction

1. If client phone number is know contact Mental Health Crisis Line and refer client to them for follow-up.
2. If client's phone number is unknown. Reply to clients email letting then know you are concerned for their well-being and that help is available. Urge client to seek help by phone or in-person. Provide Mental Health Crisis Lines phone numbers as well as Health Connection phone number and hours of operation.
3. After the interaction with the client is complete, document a comprehensive note in the client's record including the time and as much detail as possible. Include email conversation between the client and yourself. Document the action(s) taken, including the name of the person or agency where the client was referred, and the follow-up plan of action.

Background Information:

The presence of active suicide planning (i.e. detailed plan, available means in place) or suicide intent, places the client at risk for suicide regardless of the presence or absence of any other risk factors.[11]

Canadian Association for Suicide Prevention

- In the past three decades, more than 100,000 Canadians have died by suicide. [1]
- Suicide is a complex problem involving biological, psychological, social and spiritual factors. [1]
- Research shows that the rates of deliberate self-harming behaviours, including serious suicide attempts, may be 100 times higher than rates of suicide deaths. [1]
- Suicide is a leading cause of death for Canadians between ages 10 and 49. [1]
- Suicide is the second leading cause of death among Canadian youth aged 10-24. [1]
- Sexual minority youth are 1.5-7 times more likely to attempt suicide than their heterosexual peers. [1]
- Males are more likely to die by suicide while females are most likely to survive a suicide attempt. [1]
- 90% of people who commit suicide have a diagnosable psychiatric illness at the time of death; usually depression, substance misuse or both. [2]
- 2/3 of suicides occur in the first attempt. [2]

Warning Signs which heighten risk of suicide in the short term[11]

- Threatening to harm or end one's life
- Seeking or access to means: seeking pills, weapons or other means

Title	Suicide Risk Guideline		
Revised/Reviewed		Number	
Approved		Pages	

- Evidence or expression of a suicide plan
- Expressing (writing or talking) ideation of suicide or a wish to die
- Hopelessness
- Rage, anger, seeking revenge
- Acting reckless, engaging impulsively in risky behavior
- Expressing feelings of being trapped with no way out
- Increasing or excessive substance use
- Withdrawing from family, friends, society
- Anxiety, agitation, abnormal sleep (too much or too little)
- Dramatic changes in mood
- Expresses no reason for living, no sense of purpose in life

Risk Factors for suicide

- Chronic mental illness [11]
- Severe depressive signs and symptoms with a sense of hopelessness [2]
- Previous suicide behavior [11]
- Widowed, divorced, separated and/or social isolation [11]
- Precipitants/stressors or recent major adverse event (e.g. job loss, death of a loved one, loss of relationship – real or perceived) [2]
- Severe anxiety [2]
- Chronic, debilitating physical illness [2]
- Family history of suicide attempt or completion [2]
- Age – 65 years or older and youth aged 15-24 years [2]
- Easy access to method e.g. firearms, medication stockpile [9]
- Change in treatment: discharge from psychiatric hospital, provider or treatment change [9]

Risk factors for suicide in teenagers

- Previous suicide attempt [8]
- Mood disorder (major depressive disorder) [8]
- Substance misuse disorder (particularly in males) [8]
- Ages 16 years or older, male and living alone [8]
- Sexual minority youth experiencing discrimination, stigmatization, harassment, verbal abuse and rejection [4]
- History of physical or sexual abuse [8]
- Recent dramatic personality change [8]
- Psychosocial stressor (trouble with family or friends or a disciplinary crisis) [8]
- Writing, thinking, or talking about death or dying [8]
- Altered mental status (agitation, hearing voices, delusions, violence, intoxication) [8]

Signs and symptoms of depression

- Depressed mood most of the time
- Loss of interest or pleasure in activities
- Weight loss or gain
- Insomnia or hypersomnia

- Loss of energy
- Feelings of worthlessness
- Hopelessness toward the future
- Lack of concentration
- Recurring thoughts of death
- Complaints of psychosomatic symptoms

Protective Factors

Protective Factors even if present, may not counteract significant acute risk [9]

- Internal: ability to cope with stress, frustration, tolerance, religious beliefs [9]
- External: responsibility to children or beloved pets, positive therapeutic relationships, social supports [9]

Refer to:

- CHGP # G-2 Vers. 3 - Postpartum Mood Disorder Protocol (2009)
- LG0102 Report to Children's Aid Society

References:

Reference List

1 The CASP blueprint for a Canadian national suicide prevention strategy. Winnipeg, MB: Canadian Association for Suicide Prevention; 2007.

2 Gaynes B, West SL, Ford CA, Frame P, Klein J, Lohr KN. Screening for suicide risk in adults: a summary of the evidence for the U.S. Preventative Services Task Force. Annals of Internal Medicine. 2004;140(10).

3 Public Health Agency of Canada. Sexual orientation in schools. Ottawa, ON: Public Health Agency of Canada; 2008.

4 Public Health Agency of Canada. Gender identity in schools. Ottawa, ON: Public Health Agency of Canada; 2010.

5 Registered Nurses Association of Ontario. RNAO nursing best practice guideline: assessment and care of adults at risk for suicidal ideation and behavior. Toronto, ON: Registered Nurses Association of Ontario; 2009.

6 Suicide Risk Recognition and Prevention Task Group. High risk suicidal protocol for youth. Toronto, ON: Suicide Risk Recognition and Prevention Task Group; 2009.

7 Workplace Safety and Insurance Board. Callers in crisis: first responders protocol: responding to callers who use suicidal language. Toronto, ON: Workplace Safety and Insurance Board; 2008.

8 Zametkins AJ, Alter MR, Yemini T. Suicide in teenagers. JAMA. 2001;286(24):3120-5.

9 Suicide Prevention Resource Center. Suicide assessment five-step evaluation and triage pocket card. USA: Education Development Center Inc. And Screening for Mental Health Inc.; 2009.

10 American Association for Suicidiology. The risk factors for suicide and suicidal behaviors. Washington, D.C.: American Association for Suicidology; 2009.

Title	Suicide Risk Guideline		
Revised/Reviewed		Number	
Approved		Pages	

11 Perlman CM, Neufeld E, Martin L, Goy M, Hirdes JP. Suicide risk assessment Inventory: a resource guide for Canadian health care organizations. Toronto, ON: Ontario Hospital Association and Canadian Patient Safety Institute; 2011.

Review/Revision History