Suicide Risk Assessment
Hospitalized Trauma Patients

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Suicide in Québec

- Québec is the Canadian province with the highest suicide rate
- Affects all age groups and all social classes
- One of the major causes of premature death in Québec
- Causes more deaths than road accidents
- Each day, 3 Quebecers die by suicide
- 1068 persons died by suicide in 2009
- More men than women die by suicide (4:1)
- Men use more lethal methods
- More women than men attempt suicide (2:1)
- 20 suicide attempts for every suicide
Suicidal Patients on the Trauma Unit
Who are they?

- Patients admitted for injuries caused by a suicide attempt
- Patients who become suicidal after a traumatic injury
Barriers to effective communication

- What do you think about suicide and those who consider suicide as an option?
- What do you think and feel when you care for someone who is suicidal?
- How do your thoughts and feelings affect your behaviour?
Bring down the barriers

- Learn more about mental illness and suicidality
- Examine your thoughts and feelings and be willing to reshape them
- Available, open minded, curious, compassionate
  - Listen to your pt’s story first
  - Do not judge or draw quick conclusions
- A suicidal person needs your understanding and support
- Share the information with your colleagues
Talking about suicide does not cause someone to be suicidal, does not « give a person new ideas » or increase the risk!!! So ASK!!!

Opportunity to discuss distressing thoughts
Decrease isolation & initiate problem solving
If not identified and dealt with, suicide risk may turn into injury or death
The most powerful nursing intervention
Prerequisite to trust and open communication
Built on empathy, genuine concern, interest, and respect
Patient is more likely to:
- Confide suicidal thoughts, plans and/or command hallucinations
- Be hopeful and receptive to supportive interventions
Suicidal behaviour

- Call for help
- Communication of distress and despair in a person who is unable to resolve what is perceived as a desperate situation (state of mind)
- Most suicidal individuals want to live but are unable to see alternatives to their problems
- It is not death that is sought but relief, the end of suffering
Detect suicide risk

Watch for red flags:

- Warning signs of suicide
- Presence of risk factors
Admitted post suicide attempt = HIGH RISK
Direct or indirect statements about death or suicide
Feeling hopeless/helpless/trapped
Loss of interest, withdrawn from family, friends, society
Changes in mood (depression, anxiety, sudden improvement)
Guilt, shame, sense of failure, anger, rage, seeking revenge
Risky behavior (increased substance abuse, reckless driving)
Seeking access to means
Etc.
Risk Factors

- Previous suicide attempt(s)
- Mental illness
- Death of a spouse or child
- Separation divorce
- Feeling alone, isolated
- Physical problem / Pain
- Drug or alcohol abuse
- Loss of employment, financial difficulties
- Traumatic life events physical/sexual abuse
- Family history of suicide or attempt
Assess suicide risk

1. Current thoughts about suicide
2. Self-destructive command hallucinations
3. Suicide plan
4. Suicidal intent
5. Current experience / reasons for dying
6. Protective factors / reasons for living
1. Current thoughts about suicide

- Share your observations (I saw, I heard) and ask directly if the patient is thinking about suicide
  - I heard you say that life isn’t worth living anymore; are you thinking about suicide?

- If the patient is admitted after a suicide attempt
  - How do you feel about being alive (anger, regret, failure, relief, thankful)?
  - Are you still thinking about ending your life?

- Some patients wish they were dead but would not harm or kill themselves
  - Have you wished you were dead or wished you could go to sleep and not wake up? Would you do anything to harm yourself?
2. Command hallucinations

Is the patient hearing one or more voices giving commands e.g. “kill yourself”, “stab yourself”, “jump off the bridge”

- Command hallucinations are difficult to ignore
- Put the patient at high risk for suicide

- Are you hearing voices other than yours and mine?
- What do the voices say?
- Do they command you to hurt yourself?
- Are you able to ignore the voices or do you feel you have to obey?
3. Suicide plan

- Has the patient thought of a plan?
  - method (how)
  - timeframe (when)
  - place (where)
- Does the patient have access to the chosen method in the hospital, at home, elsewhere?
- Has the patient made preparations (collecting pills, buying a rope, putting affairs in order, writing a suicide note)?
- Lethality of the suicide plan i.e. how serious would the injury be if the person's plan were carried out?
4. Suicidal intent

Does the patient intend to carry out the suicide plan, is the patient ambivalent?
➢ *Do you intend to carry out this plan?*

Does the patient intend to die or is the patient ambivalent?
➢ *Are you certain that dying is what you want?*
5. Current experience / reasons for dying

What’s going on? Why is the patient considering suicide as an option?

- Are there concerns / events / circumstances that triggered your thoughts about suicide?

Suicidal thoughts can be strongly influenced by delusional thoughts (psychosis)

- Secret agents are looking for me. They want to kill me because I know things. I better kill myself before they find me.
- I have been chosen by God to spill my blood to save the world.
6. Protective factors / reasons for living

- Supportive family and/or community
- Responsibility to family or others (e.g. children in the home)
- Skills in problem solving, coping, and conflict resolution
- Sense of belonging, sense of identity, good self-esteem
- Cultural, spiritual, and religious connections and beliefs
- Future goals (family, school, work)
- Enjoyable leisure activities
- Supportive medical and/or mental health care relationships

- Are there things, anyone or anything, that stop you from taking your life or acting on these thoughts?
- What has kept you from acting on your thoughts thus far?