

## 3.19 NSS – SELF-HARM/SUICIDE

**INTENT:** To identify individuals at risk for self-harm/suicide, so that prompt and appropriate intervention can be utilized to ensure the individual’s safety to the best of our ability.

### **DEFINITIONS:**

**Individual** – This refers to any person within the work environment. This may include, but is not limited to the client, family members, coworkers, other household members.

**Client** – refers specifically to the child for whom our agency is contracted for.

Certain processes may not apply to individuals for whom we are not providing contracted care. Ex Documenting in the care plan is a client specific action.

**POLICY:** Employees respond to a suspicion that an individual may be suicidal by; investigating, documenting, and reporting any concerns to primary care givers, agency management, or emergency services as necessary. If a client is at risk for self-harm/suicide, that will be documented in the Care Plan. Any risk management plan must be approved by a mental health professional or the client’s primary care physician.

### **PROCEDURE:**

1. If an individual is at immediate risk, has attempted to kill themselves, or has an imminent suicide plan
  - CALL 911, Contact parent/guardian and Nursing Supervisor/Manager (on call Supervisor if after hours).
2. If it is suspected that an individual is suicidal, it is imperative to investigate in more detail. Opening up a safe line of communication is the first step in helping someone. Document your findings in the client chart, and share information with 911, parent/guardian and your Nursing Supervisor/Manager as appropriate.
3. The ASQ tool (Fig 1.) can assist in assessing the urgency of intervention.
  - Trust your instincts
  - Believe your suspicions
  - Be a good listener, let them speak without interrupting
  - Use “I’ve noticed...” questions. Ex” I’ve noticed you seem sad lately, can you tell me about that?” Try to avoid yes/no questions to encourage communication.

- **LISTEN, don't try to fix problems or provide counselling**
  - Be direct, while showing care and concern
  - Tell the individual you are glad they told you their thoughts or feelings
  - Stay with anyone who is feeling unsafe or for whom you have safety concerns
4. If you have immediate concerns for an individual's safety, immediate assistance should be sought. Implement self-harm/suicide prevention strategies as necessary. Such as:
- Secure sharps/knives away from reach
  - Secure any other objects that may be used to cause self-harm as appropriate based on individual assessment. Keys, other pointed objects, items that the individual has identified thoughts of harming themselves with.
  - Stay with the individual to ensure their safety as much as possible, until you can get assistance from a parent/guardian, Nursing Supervisor/Manager and/or 9-1-1

### Self-harm/suicide and Children

- Suicide is the 4<sup>th</sup> leading cause of death among children 10-14y old. And is more than twice as common as drowning. (NEJM, 2018; 379:2468-2475)

### Suicide Myths and Realities

Myths	Reality
A suicide threat is just a bid for attention and should not be taken seriously.	All suicidal behavior should be taken seriously; a bid for attention may be a cry for help.
It is harmful for a person to talk about suicidal thoughts. The person's attention should be diverted when it occurs.	Not talking about it, doesn't make it any less of an issue. Of prime importance in planning care, is an accurate assessment of the lethality of the person's suicide plan.
Only psychotic persons commit suicide.	The majority of successful suicides are committed by persons who are not psychotic.
People who talk about suicide won't do it.	Most people do talk about their suicide intention before making a suicide attempt.
A nice home, good job, or an intact family prevents suicide.	Persons of all emotional and socioeconomic background may commit suicide.
A failed suicide attempt should be treated as manipulative behavior.	Failed suicide attempts are more likely to be evidence of a person's ambivalence toward killing himself or herself.

## Warning Signs

- Change in usual behavior, withdrawn, aggressive, hostile
- Risky behavior (playing the choking game, pain infliction games)
- Multiple symptoms of depression (irritability, sadness, withdrawn, prolonged boredom, loss of pleasure in normal activities, weight loss/gain, changes in sleep, new difficulties at school, thoughts of death or suicide). (Health Link BC)
- Joking about death or dying
- Writing or drawing involving death/suicide
- Neglecting personal hygiene/appearance
- Running away from home

## Resources:

- [https://www.suicideinfo.ca/wp-content/uploads/2016/08/Childrens-Toolkit\\_Print.pdf](https://www.suicideinfo.ca/wp-content/uploads/2016/08/Childrens-Toolkit_Print.pdf)
- [www.Kidshelpphone.ca/suicide](http://www.Kidshelpphone.ca/suicide)
- <https://www2.gov.bc.ca/gov/content/health/managing-your-health/mental-health-substance-use/child-teen-mental-health/child-teen-suicide-prevention>
- Kids Help Phone 1-800-668-6868
- [www.foundrybc.ca](http://www.foundrybc.ca)
- [www.keltymentalhealth.ca](http://www.keltymentalhealth.ca)
- <https://www.cps.ca/en/mental-health-screening-tools>

**asQ** **Suicide Risk Screening Tool**  
Ask Suicide-Screening Questions

NIMH TOOLKIT

**Ask the patient**

1. In the past few weeks, have you wished you were dead?  Yes  No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?  Yes  No
3. In the past week, have you been having thoughts about killing yourself?  Yes  No
4. Have you ever tried to kill yourself?  Yes  No

If yes, how? \_\_\_\_\_

\_\_\_\_\_

When? \_\_\_\_\_

\_\_\_\_\_

If the patient answers **Yes** to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now?  Yes  No

If yes, please describe: \_\_\_\_\_

**Next steps:**

- If patient answers “No” to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (\*Note: Clinical judgment can always override a negative screen).
- If patient answers “Yes” to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen**. Ask question #5 to assess acuity:
  - “Yes” to question #5 = **acute positive screen** (imminent risk identified)
    - Patient requires a **STAT safety/full mental health evaluation**.
    - **Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient’s care.
  - “No” to question #5 = **non-acute positive screen** (potential risk identified)
    - Patient requires a **brief suicide safety assessment to determine if a full mental health evaluation is needed**. **Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient’s care.

**Provide resources to all patients**

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text “HOME” to 741-741

Fig. 1

Revised June 2021