S.C.I.P.S.

tool

Guidelines & Resources for Youth Suicide Prevention

Accompanying Guide

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Introduction

As a primary care provider you play an important role in preventing death by suicide in our community especially among your patients. This guideline will assist you in being able to identify individuals at risk and in navigating the appropriate systems with mental health partners. We also hope to increase your level of comfort and interest in addressing this issue.

It is important to note that asking about suicidal ideation has not been shown to increase rates of suicide. Patients may come presenting with many different concerns but may not spontaneously share that they are having thoughts of suicide. The question is not about predicting suicidal acts but more about when and how to get a second opinion (Specific intervention and Resources). Therefore, the intent is to support you in your role and not to train you to become a crisis counselor or a therapist.

MYTH:
Someone who is suicidal is determined to die

FACT:
On the contrary, a person thinking about suicide is ambivalent about living or dying; as they really want to kill the pain! Access to emotional support can prevent suicide.

Gender differences

Among those who die by suicide gender differences are almost universally found and it is important to note that help-seeking behaviours differ between males and females.

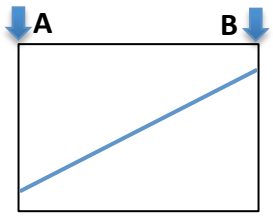
Specifically women have a greater propensity to seek and use supports from help when in need, whereas men tend to keep their worries to themselves and wait until they are experiencing a crisis, which compounds the urgency of their situation. Men tend to indirectly seek help by mainly reporting physical symptoms, and are less likely to report psychosocial problems or distress during their appointments.

Socially, men generally feel competent when they are in control of their own situation, and as a result may be reluctant to open up. Normalizing symptoms in a context of the difficult situation and asking directly about those is appropriate and can be supportive.
Women generally want to understand more about their situation (causes, symptoms, feelings, etc.), whereas men are more problem/solution focused and just want to know what to do. Therefore, using words that respect that point of view will help engage your patient in the referral/resource seeking process.

Understanding suicidality

It is important to remember that it is not death that a person with suicidal thoughts seeks, but the end of their suffering. For that person, there seem to be no other solutions. They still experience ambivalence until the end.

Every person has a part that wants to live and a part that wants to die. When the person is doing very well (see A in graphic), they are completely on the left side of the graph: a great part of them wants to live and a tiny portion wants to die (Freud would say "death instinct") which makes us not always take very good care of ourselves! The more the suffering increases, the part that wants to die grows larger to the detriment of the part that wants to live. When a person is about to take action (see B, in graphic), they are completely on the right side of the graph: then a great part of them wants to die and a tiny portion wants to live, which they might not be aware of at that time. Therefore, ambivalence is there until the end.



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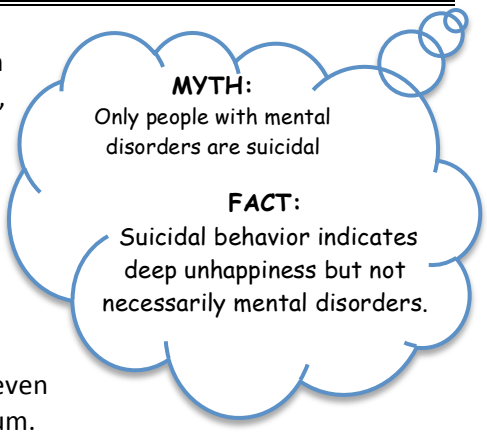
This ambivalence will be seen in a person with suicidal thoughts as the "dying part" might not open up easily about the distress and the "living part" will most likely give some hints and signs of distress in an attempt to get help. It is crucial to acknowledge both parts to make the person feel understood and create space for the part that wants to live to grow larger again.

Note that this document is not a rating tool; it is intended to serve as a guide to aid with your professional judgment when screening patients.

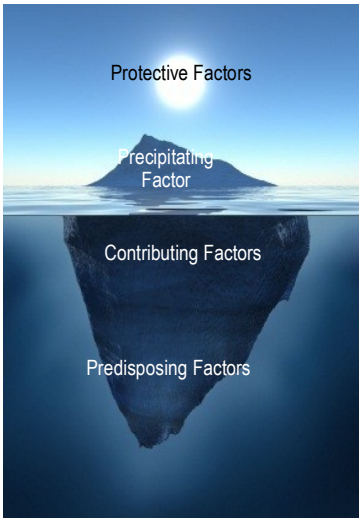
Risk factors and Warning signs

"Suicidal behaviour is not a disease, but the result of a complex interaction among various neuro-biological, psychological, cultural and social factors, which have marked the person at different levels, but taken in isolation are not enough to explain suicide". [a] These are the risk factors.



To properly understand suicidal behaviour, it is important to take into consideration a group of risk factors; they include **predisposing, contributing, precipitating, as well as protective factors.**

The presence of risk factors creates vulnerability or fragility in a person even before any incident has occurred to perturb their state of balance/equilibrium.



The **predisposing factors** render the person more vulnerable to suicide. They are related to their life history and constitute, in some ways, the foundation on which the person develops. Some pre-disposing factors emerge from the family network (family history of suicidal behaviour, history of abuse and violence, early loss experiences...) and from the surrounding/environment (isolation, lack of significant relationships, trivializing suicide…). They also include all individual factors (psychiatric disorders, depression, non-resolved grief issues…).

The **contributing factors** are the behaviours and events that increase the current risk level. Contributing factors include substance abuse of all kinds, a lack of coping abilities, instability in the family, previous suicidal attempts, work/school stresses, a lack of resources in the face of adversity, etc.

The **precipitating factors** are the ones that could act as triggers of a crisis. Failure, humiliation, rejection, broken heart, disciplinary crisis or any other recent and difficult life events, unbalance the person's way of looking at and understanding "things". Taking into consideration each person's life history, the precipitating factors may create, at times, a disorganized state or condition (the straw that broke the camel's back).

The **protective factors** are the conditions that reduce the impact of the contributing and pre-disposition factors. The presence of healthy role models, the availability of resources, a strong network of support from family and friends, competency in social skills and adequate coping skills are some of the factors that protect the person, expanding their range of alternatives when faced with difficult situations.

Finally, various **environmental factors** also play a major role in this area, like poverty or easy access to means.

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While the factors associated with suicide can be divided into four main groups, their relative importance also varies with age group. A distinction must therefore be made between the factors that affect children, young people, adults and the elderly[1].

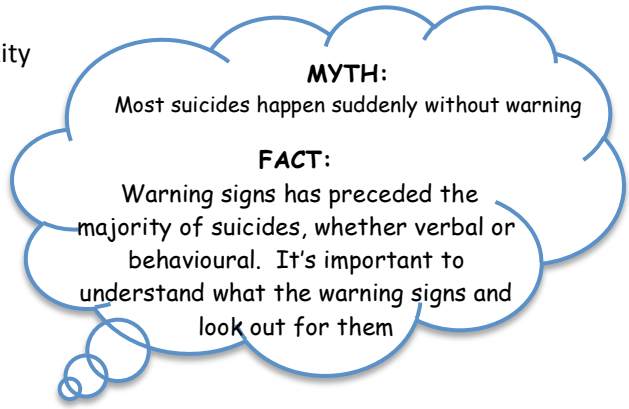
Common risk factors associated with suicide and suicidal behaviour [1]

	CHILDREN (under 12)	YOUTH (12 to 24 years old)
Predisposing	• Psychiatric disorders • Family history of alcohol and drug abuse • Psychopatholigical parents • Suicide or suicide attempt by parent	• Psychiatric disorders including depression, conduct disorders, substance use disorders • Parents-Youth relationship problems • Parents presenting psychopatholigical problems • Loss of parent early in life • History of suicide in the family • Poor coping mechanisms
Contributing	• Lack of understanding of death (specially irreversibility, and finality (but also universality, causality, imprevibility) • Lack of problem-solving ability • Parental violence or sexual abuse	• Alcohol or drug use • Prior suicide attempt • Learning difficulties and impulsivity • Parental violence or sexual abuse • Serious & ongoing difficulty with peer relations • Serious conflict with family member • Social isolation and lack of social integration
Precipitating	• Separation, divorce of parents • Death of a parent	• Separation, divorce of parents • Death of a parent • Rejection by peers or break-up of relationship
Environment	• Trivialization of suicide by the media • High unemployment rate & poverty of family	• Sensational coverage of suicide by the media • High unemployment rate & poverty among youth • Easy access to means of suicide • Family's inability to support suicidal youth

Note: For more information about risk factors for Adults and elderly, refer to the appendix 1.

These lists of factors contribute to help understand the complexity of suicide. However, it is not the most useful tool to screen or assess people. **Risk factors are identified through epidemiology, yet the patient in front of you is a unique individual and not a statistic.**

They can be at risk without presenting any of those risk factors. Therefore, it is essential to extract from that information, what is more likely to be an indication that the patient is in distress or at risk of putting themself in danger.



Warning signs

Despite commonly known ones, these can be very individual as personality and temperament is. It is important to note that some level of pain is common to everyone and hopelessness is more indicative of suicidal ideation regardless of other symptoms or illness. It is important to note that any individual may present with some level of risk and there is no such thing as a "suicide type". Warning signs involve changes in the individual's usual way of being or a new behaviour. Signs can be categorized into:

- Verbal messages
- Behaviours
- Feelings & Emotions
- Physical & biological signs
- Cognitive signs

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There is a wide range of possible warning signs that someone may be thinking about or planning to die by suicide. The type and quantity of these will vary from one person to another (Verbal messages are NOT always the most present ones). Therefore, any signs should prompt a conversation around emotional distress and question about suicide. **The only way to really know whether a person is contemplating suicide or not, is to ask them directly.**

WARNINGS SIGNS	
Messages	*Direct verbal messages* • "I'll kill myself" • "I'll die by suicide" *Indirect verbal messages* • Talks above all of death, of being "fed up", out of breath/juice • "I can't take this anymore" or "I'll never get through this" • "I am a burden to everyone" or "They'd be better without me" • "What's the point? or "It doesn't matter anymore." • "They'll miss me when I'm gone." • "…I wish I could die." or "Life isn't worth it" • "I'm totally useless" • Talks about an event to come, some kind of obscure plan • Talks often of a long term departure, some nebulous kind of trip in the planning • Talking about the value and courage of people that died by suicide
Behaviours	• Increased substance use (alcohol, drugs or medication) • Impulsivity, engaging in reckless activities • Social withdrawal, isolation • Putting affairs into order • Sudden interest in fire arms, medications (or any other…) • Giving away belongings which they held dear • Demonstrates disproportionate signs of affection for the situation
Feelings & Emotions	• Purposelessness • **Hopelessness** • Irritabily, uncontrolled anger • Loneliness • Extreme anxiety • Sadness • Shame and-or guilt • Significant decrease in self-esteem • Inability to enjoy anything or boredom • Unexplained and sudden euphoria after a period of struggle
Physical & Biological	• Sleep disorder (wakes up very early, sleeps too much or very badly) • Eating disorder (eats too much or not enough) • General stress symptoms • Hyperactive, unable to stay in on place • Lack of energy, extreme sluggishness • Poor hygiene or disheveled appearance
Cognitive	• Memory loss, • Indecision • Lack of concentration, of attention • Dichotomous thinking (may look like incoherent speech)

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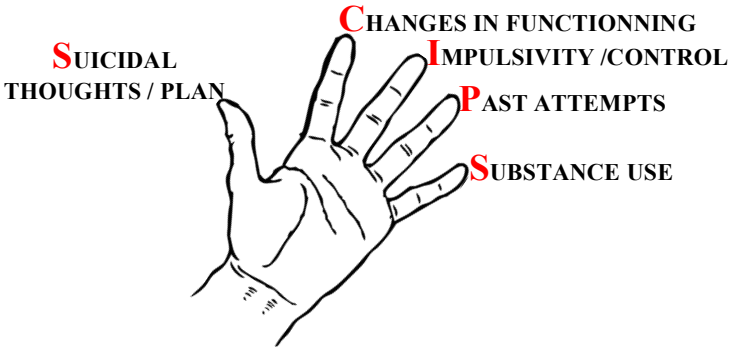
MYTH:
Talking about suicide is a bad idea and can be interpreted as encouragement

FACT:
Given the widespread stigma around suicide, most people who are contemplating suicide do not know who to speak to. Talking openly about suicide can give more options and hope.

Again, this document is not a rating tool; it is intended to serve as a guide to aid with your professional judgment when seeing patients. It is meant to help you discern when to reach out for a second opinion, specialized resources and how to do it.

To facilitate remembering the principal items to investigate, we created a five letter acronym – SCIPS, that matches the five fingers. Like the thumb of the hand works on its own, suicidal thoughts /plan is a category in itself in screening for Suicide and could be enough to move on to get emergency support or at least a second opinion. Additionally, like the four other fingers works together, the four other categories influence each other and increase the importance of the information collected around Suicidal thoughts/plan.



Each element is presented with a series of questions to ask, a section on "Red Flags" answers you may receive that must get your special attention, accompanied by some specific intervention guidelines and resources if you do get those answers. A synthesis of the S.C.I.P.S. can be found, in an easy to consult chart form.

But before all that, there are some intervention guidelines for ANY situation (no matter the answers). This is not about referral or no referral. If there was some sort of distress that brought up the subject (any warning signs), then youth needs support of some sort. Therefore, it is about which intervention (or referral) will be the most appropriate (natural social network and family, you as their doctor, community resources, hospital, 911) – someone will NEED to take care of the trigger, the pain, the problems that underlie the suicidal crisis or distress. The earlier help is provided, the better…

Generic Distress Intervention Guidelines

It is important to remember that most people that struggle with suicide thoughts are quite distressed by those thoughts (sense of losing control). They are also scared of being judged, stigmatized or ridiculed. Your attitude (tone of voice, body language and words used) will help create a safe atmosphere to open up discussion on this sensitive subject.

- Approach the youth in a **calm and nonjudgmental** manner – **take them seriously**
- **Use respectful and age appropriate language** that is easily understood by the youth you are working with

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and at the same time still involves suicide and death as to not reinforce the taboo around suicide. Most youth understand the meaning of suicide, for those who do asking "have you ever thought of killing yourself, or making yourself dead".

- **Include parent(s)/adult** role models whom the youth identifies as a support. Including them in the conversation can help build the safety net of support for the youth.

- **Explain your role**: You care, you'll work to help but you are not a therapist or a mental health professional.

- **Empathy & Validation** (Showing compassion and acknowledging personal feeling will make them feel heard and less alone):
  - ✓ Being in distress or in crisis is not comfortable
  - ✓ The first best move is to talk about it (which they did)
  - ✓ It might be scary and confusing but there are alternate positive ways out
  - ✓ Acknowledge ambivalence (part that wants to die, part that wants to live – that confided in you)

- **Avoid giving advice and making well-meaning statements** such as: *"You are so young, you have your whole life ahead of you.", "Think about how this would affect those around you", "You'll feel better tomorrow", "You should appreciate how lucky you are".* These types of comments can deepen feelings of shame and guilt and don't make a person feel heard.

- **Encourage social support** (isolation amplifies the risk): Support to talk about the pain but also just compassionate presence that spend time with the Youth & give a sense of belonging. Don't assume who is the best social support for the person, ask and include at least one adult (sometimes parents ARE part of the problem) relative or School or leisure staff.

- **Provide crisis information & Education**
  - ✓ Crisis happens to everybody at some point, to some degree
  - ✓ It's a "signal" that tells you that something needs to be taken care of, that needs to change – some positive action toward the problem needs to be taken
  - ✓ It didn't happen over night, it won't go away over night. Give yourself some time but something needs to be done
  - ✓ Crisis happens when the pain goes beyond our current ways of coping. It's an opportunity to get coaching (like in sports) and to learn other, new ways of coping.

- **Give lifestyle advice as you would with any other patients** (exercise, meditation & mindfulness, nutrition, sleep, etc.) congruent with their actual state. Insisting on the well known link between physical & mental & mood (Healthy body, Healthy mind!).

- **Promote Mental Health (and other) resources in the region to help on specifics issues.** Referral is good but in a crisis situation, a **caring transfer** is better, meaning:
  - ✓ Stay involved with the patient until they are connected with the appropriate resource
  - ✓ Provide the Resource with a letter outlining (or phone call in some cases) your concerns and how you can be contacted (cc your patient).

⇒ **See the Resources p.14**

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Suicidal thoughts/plan

As for any event in our lives (marriage, trip, etc.), suicide is more or less planned. Therefore, the more the patient has thought about it and planned it in their head, the closer or easier it is to act on it. Questioning about those thoughts and the "preparations" is therefore very important.

Questions to ask

Patients may not spontaneously report suicidal ideation. Asking directly about suicide will not increase their risk. In fact, chances are, it will be a relief to find an open ear to share them (some people may be ashamed to open up and meeting a non-judgmental professional that shows openness to discuss their distress can be very supportive). Not asking directly prevents open communication and reinforces stigma. Your concern and willingness to discuss this topic will show that you do not judge the individual for having those thoughts and feelings and will help the patient to open up.

Introduction questions:
Sometimes, it is easier to start the conversation indirectly. Introduction questions are meant to start the conversation and any YES to these questions indicate you need to ask the direct questions too. Here some examples of introduction questions:

- Other people with similar problems sometimes lose hope; have you?
- Have you ever thought things would be better if you were dead?
- Have you ever thought that things were so bad that life was not worth living? Is it what you think now?

You can even use introduction and direct questions together, using words that the patient used like:

- "When you say (indirect message) (introduction), …are you telling me you are thinking about suicide? (Suicidal thought question)

Direct Suicidal thoughts questions:

- Are you thinking about making yourself dead (for young children)?
- Are you thinking about killing yourself?
- Are you thinking of suicide?

If your patient answer YES to any of these three direct questions, you HAVE to ask ALL the questions about planning:
Direct questions about planning (What, where, when):

- How often do you think about suicide (weekly, daily or hourly)?
- Do you have a plan or have you been planning to kill yourself?
  - Do you know (have thought about) **how (or what)** you would kill yourself?
  - Do you know (have thought about) **where**?
  - Do you know (have thought about) **when**?
  - Do you have a timeline in mind for ending your life?
- Have you been making preparations?
- Do you have the (drugs, gun, other means) that you would use?
- Where is it right now?

Have you ever rehearsed a plan? (in your head or for real)

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Red flags and specific intervention

Frequent (every day) thoughts of suicide:

Hospital and emergency services are meant to keep people safe. If the person does NOT have a specific/organised plan AND doesn't have any Red Flags from the other elements (C.I.P.S.), they don't need to be kept safe in that present moment; they need support in working through their problems and pain:

- Make sure NOT to provide access to means (see section on Means restriction on p.13)
- Encourage connection to community resources to prevent an escalation of the distress situation
- Create a plan that includes safety and action toward solutions with the person (What they'll do, when, where) and provide information (phone numbers, description of resources, etc.). Be sure the patient agrees to implement it.
- If the situation starts to escalate, they need to call the crisis lines (available 24/7) and come back to see you (then, you go through the SCIPS chart again).

A person that has a plan (Where, when, with what) organized/prepared, needs to be kept safe. Therefore, the emergency services are in order.

- Share your worries (that the part that wants to die takes too much space) & that you will help (keep them safe)
- See for immediate follow-up with a **caring and safe transfer** to emergency services. Do not let the patient go home
  - ✓ You really need to trust the parent (or significant adult) is taking the situation seriously to let them bring the youth to hospital by them selves.
  - ✓ If you feel like the adult may not take it seriously or the youth is alone (or with another minor), you might need to issue a form 1 (see Appendix 2) and contact the police/ambulance for transportation.

Resources

A note about resources: Even if the immediate resource is determined to be hospital, as discussed above, connection to community resources can be an important step for increasing safety, reducing pain, and preventing further hospitalizations. It is best in such cases to facilitate a **safe and caring transfer (see p.7)** to appropriate emergency resources by contacting the resource with the patient, or creating an action plan for them to do so with clear time frames and/or with a person to assist them if need be. A follow up conversation about how it went with resources can then take place at the next appointment to continue the support/address any further needs.

Anyone with suicidal thoughts should be connected to a support that is easily accessible, available 24/7 and able to support the person through their thoughts of suicide, and provide intervention if needed. Crisis lines should always be provided as a way to support the pain and be part of the action plan to help increase safety. Crisis lines can provide immediate support for the patient's concerns as well as can help assess for the need for further services or intervention that will help the individual with their thoughts of suicide, but also to address the precipitating factors.

⇒ **See Crisis line services p.14**

In talking to the youth you may also discover personal resources that the patient might have, including family, friends, teachers, coaches, spirituality or activities such as hobbies or sports. These personal resources represent connections to the part of them that wants to live and should also be encouraged in addition to resources to help address the pain. It is important that these personal resources are ones that the youth identifies with (and not suggested externally) as the stronger the personal tie they have, the greater is the connection to life.

If the Suicidal thoughts are NOT a worry in the short term, it is still essential to explore the following elements that, alone or combined, could contribute to exacerbating the suicidal thoughts or have an impact on triggering a suicidal act. Those elements are Changes in functioning, Impulsivity, Past suicide attempts and Substance use.

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Change in functioning

The biggest change to have in mind is that we usually have faith in life that things will get better. Losing that faith is very dangerous: hopelessness is, as mentioned, a high risk indicator. As seen in the warning signs, changes in regular habits and routine, is a sign of disorganization that could put people at risk.

Questions to ask

- Do you believe things can/will get better?
- How is your *_(each element listed below)_* lately?
  - ✓ Sleep
  - ✓ Appetite
  - ✓ Emotions or moods
  - ✓ Self-care (hygiene, appearance, compliance to medication and appointments)
  - ✓ Concentration/memory/attention
  - ✓ Work/school attendance and performance
  - ✓ Social life (friends, leisure, sports, family connection, etc.)
- How different from your usual self is this?

Red flags and specific intervention

HOPELESSNESS:

- Especially with serious suicidal thoughts, a youth that feels hopeless will need to be kept safe. Therefore, the emergency services will be necessary (going with an adult or form 1).
- Share your worries (that the part that wants to die takes too much space) & that you will help (keep them safe)
- See for immediate follow-up with a caring and safe transfer to emergency OR Mental Health services (not just a referral but a clear commitment from them that they take over)
- Do not let the patient go home without a clear and safe action plan. If you decide to send them to emergency:
  - ✓ You really need to trust the parent (or significant adult) to let them bring the youth to hospital or the mental health professional by themselves – meaning they take the situation seriously.
  - ✓ If you feel like the adult may not take it seriously or the youth is alone (or with another minor), you might need to issue a form 1 (see Appendix 2) and contact the police/ambulance for transportation.

Depression, Severe anxiety or significant changes in usual self, over a significant period of time:

- Medications & psychotherapy (caring safe transfer)
- Encourage involvement of significant others in support (identified with the patient)
- Follow-up appointments (where you will re-ask the SCIPS questions again)

Resources

In addition to possible medication needs the individual may require varying levels of support to address their changes in functioning and mental health needs. Your role is to link them to a service that will then help explore those needs further and go through the process of determining the most appropriate service for their needs to then connect them to that service in the community. These services could range from psychotherapy, group counseling, case management etc.

⇒ **See Mental Health services p.14**

Some individuals may prefer more immediate face-to-face support, and thus walk in options have been included below for those wishing to start there for support.

⇒ **See Walk-in Counseling services p.14**

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Impulsivity

With most suicidal behaviour there is often a lot of thought and planning before action. However in cases impulsivity is present, this may not be the case and thus impulsivity poses a more immediate level of risk that requires attention and most often an intervention or immediate resource.

Questions to ask

- Are you more impulsive recently (we tend to be more, when in crisis)?
- Do you find that you are making bad decisions on the spur of the moment?
- Do you ever do things without thinking them through?
- Do you fear that you could lose control?
- Do you feel irritable? Angry?
  - What do you do when you are…?

Red flags and specific intervention

Aggressive / violence; No self-control (very impulsive):

- Reflect that this has some degree of negative impact in their life and their relationships. Working on this and getting help could really improve their quality of life. (NOTE: that some aggression & violence can be pre-meditated and not impulsive, which is a different issue).
- Especially with some serious suicidal thoughts, a youth that is very impulsive might need to be kept safe. Therefore, the emergency services could be in order.

Hallucinations (telling to kill oneself or others):

- Share your worries (that the part that wants to die takes too much space) & that you will help (keep them safe)
- See for immediate intervention with a caring and safe transfer to emergency services. Do not let the patient go home
  - ✓ You really need to trust the parent (or significant adult) to let them bring the youth to hospital or the mental health professional by themselves – meaning they take the situation seriously.
  - ✓ If you feel like the adult may not take it seriously or the youth is alone (or with another minor), you might need to issue a form 1 (see Appendix 2) and contact the police/ambulance for transportation.

Resources

If there is a level of impulsivity present with suicidal ideation, immediate hospitalization may be required to prevent the individual from acting on their thoughts. This could be especially true in cases where judgment and insight are impaired. Thus the guidelines above for safe transfer to emergency services via a Form 1 (see Appendix 2) or responsible adult may be the preferred approach.

In situations that do not require emergency services, there may also be a need for further evaluation, especially in the case of hallucinations or delusions. Thus a psychiatric follow up appointment should be arranged to allow for further assessment and treatment where appropriate.

Guardians, family members, and the school may also need to be involved to monitor for later signs of impulsive behavior and thus should be included in the action plan where appropriate.

Depending on the patient's level of impulsivity and capacity of judgment, Crisis lines may be appropriate for those who feel able to reach out in times of need as they are easily available, in non-imminent risk situations.

⇒ **See Crisis line services p.14**

Longer term supports can also be accessed to work on mental health concerns related to the impulsivity.

⇒ **See Mental Health services p.14**

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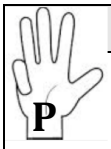

Past (suicide) attempts

As with many things in life, exposure to past experiences can make us more prepared and/or more likely to act in the future. The first time someone rides the tallest rollercoaster at the amusement park there is a lot of fear of the unknown, but each subsequent time the fear decreases as there is more familiarity and the individual knows what to expect. The same is true for suicide attempts, and thus it is important to determine the youth's familiarity with suicide attempts, the present perception of it and the impact on their present situation.

Questions to ask

- Have you ever tried to kill yourself or intentionally harmed yourself?
- Did you go to hospital
- When did that happened?
- What do you think about it now? And how do you feel compered with then?
- What was the trigger then?

Red flags and specific intervention

1) Recent (in the last 6 months) attempt, 2) Disappointed to be alive or 3) Similarities with current situation:

- Especially with ANY suicidal thoughts, a youth that attempted suicide in the past and presents with any of these 3 red flags, needs to be kept safe. Therefore, the emergency services are in order.

Resources

The youth may have existing resources from past attempts- it is important to determine if they are currently helpful and should be continued, as some of these resources may be what has helped the youth continue to live. Or, if the past resources were unhelpful, alternative resources should be sought.

Crisis lines again should be offered as a support to talk about the current and past thoughts of suicide as well as the pain involved. Crisis lines can act as a safety net while long term or ongoing supports continue to address the deeper issues.

⇒ **See Crisis line services p.14**

If there is a pattern or history of attempts having a stable, ongoing support can be important for providing consistency and working through the contributing factors the youth is dealing with. A child and youth worker or mental health professional could meet this need and hopefully prevent future attempts.

⇒ **See Mental Health services & Walk-in Counseling services p.14**

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Substance use

Substance use may exacerbate suffering and crisis situations. However it is also important to take into account that the youth uses it to answer some needs (and sometimes, self medication). Insisting on completely giving up substance use at this point may create more distress and may also shut down the communication.

Questions to ask

- How do you describe your alcohol/drug use? (amount, Frequency)
- Have you been using drugs or alcohol more than you usually do?
- How would someone close to you describe it?
- Do you find your thoughts of suicide increase when you are using substances (during or not long after)?

Red flags and specific intervention

Current intoxication:

- If there are current medical concerns due to intoxication or withdrawal, emergency services should be considered.

Increase of consumption or Relapse (Specially with consequences):

- Share your worries (that the part that wants to die takes too much space) & that you will help (keep them safe)
- See for immediate follow-up with a caring and safe transfer to addictions services OR Mental Health services (not just a referral but a clear commitment from them that they take over)

Lack of concern for wellbeing or safety:

- Beside that it is jeopardizing their life, this is a sign of suicidal ideation. If not congruent with the answers you got when questioning about those thoughts, reflect that incongruence to the youth and re-open the conversation about it (maybe the part that wants to die is bigger than they were ready to admit in the first place).

Resources

If your professional judgment indicates that there is medical concern about the quantity of use and withdrawal symptoms then hospitalization may be in order as indicated above.

The next consideration relates to how the youth is willing to receive support and assistance for their substance use at this time. This could determine what type of substance use support is needed. This is something that does not need to be determined in your role, as other services can take more time to explore this in a therapeutic relationship. Your role is to connect them to the services that can help with that determination.
See Addictions services p.14

Personal supports may also be helpful in reducing substance use with support, or by providing alternatives to use with other activities or connections. This could be involvement with family or friends, or with activities, social groups or clubs.

- Those looking for different activities available in the community can contact **inCommunities** by dialing 211 or at http://www.incommunities.ca/ for information.

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Means restriction

Means restriction is where highly lethal, commonly used suicide methods are made less accessible or less lethal.

Most of the time, by restricting the means, the attempt is temporarily or permanently delayed; this sometimes results in the suicidal individual substituting another, on average, less lethal method. But even that, gives a chance to the "living" part of the person, or the resources to find another way to ease the pain.

For highly lethal methods restricting or removing access should be done by a designated person, usually a family member, close friend or the police (firearm for example).

As a practioner, you also have many opportunities to reduce the risk of medication misuse by:

- Prescribe in limited amounts.
- Monitor prescriptions of at-risk individuals to keep total supply below toxic dose.
- Substitute less toxic medications when possible.
- Ask about stockpiling/hoarding medications.
- Ask about medication compliance and where extra medication is kept.
- Have a family member safely store the medication and dispense it appropriately
- Ask about and advise regarding the proper disposal of old and unused medicines.
- Ask about whether there are other lethal means in the home, such as firearms (have them removed or at least safely locked up – ammunition being kept separately and safely locked up too).

In general, advise parents/caregivers to safely store all medication (not in bathroom where everyone has access and can lock the door, and to keep firearms inaccessible (locked & ammunition in different location) and inoperative (remove a necessary part for use such as bolt and bolt carriers), move the item to another location outside of the home, or turn it to local police.

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Resources

Crisis line services (available 24/7)

Crisis Outreach and Support Team (COAST) Niagara (16 and over)– 24/7 crisis line available, as well as a mobile outreach team to provide assessment and support in the community

- **1-866-550-5205 Press 1**

Distress Centre Niagara (ALL ages) – confidential and anonymous telephone support for any concern

- St-Catharines/Niagara Falls: **905-688-3711**
- Welland/Port Colborne/ Wainfleet: **905-734-1212**
- Grimsby/Beamsville/West Lincoln: **905-563-6674**
- Fort Erie and area: **905-382-0689**

Kid's Help Phone (under 20)

- **1-800-668-6868**
- www.kidshelpphone.ca (chat or ask questions online)

Pathstone Crisis Services (under 18) 24/7 Crisis Line available for youth

- **1-800-263-4944**

Mental Health Services

Contact Niagara (up to 18)- Provides connection to information and services for children with emotional and/or behavioural difficulties or impacted by a developmental disability.

- **905-684-3407**

Mental Health and Addictions Access Line (16 and up- with some exceptions) 24/7 service available to provide system navigation and direct connection to local mental health and addiction services, while providing immediate telephone support. Follow ups provided to ensure individuals are connected to service.

- **1-866-550-5205 Press 2**

The youth's school board may be able to provide in school supports

If the youth's family have the means, private therapy services could also be accessed

Addictions

Community Addiction Services of Niagara (CASON) Range of addictions services including counseling and support within some schools.

- **905-684-1183**

Mental Health and Addictions Access Line 24/7 service available to provide system navigation and direct connection to local mental health and addiction services, while providing immediate telephone support. Follow ups provided to ensure individuals are connected to service.

- **1-866-550-5205 Press 2**

Walk-in Mental Health services

Family Counselling Centre Walk-in Counselling (all ages)

- **905-937-7731 x3345**;
  Tues and Thurs 1:00 – 4:30
- **5017 Victoria Avenue, Niagara Falls**

Canadian Mental Health Association Urgent Support Services (16+) Mental health counsellors are available to assist individuals in meeting immediate non-emergency and non-medical needs for problem solving, goal setting, and linking to appropriate community supports.

- **905-641-5222 x231**;
  Mon – Fri.11:30 am – 7pm (last apt. at 6:30pm)
- **15 Wellington St. St Catharines**
- **6760 Morrison St. Niagara Falls**

Canadian Mental Health Association One Session at A Time (16+) Walk in- single session available for emotional difficulties with opportunities for immediate problem solving and therapeutic conversation. (Not a crisis service).

- **6760 Morrison St. Niagara Falls**
  Wednesdays 11:30 am - 7:00pm
- **20 Jarvis St. Fort Erie**
  Thursdays 11:30 am – 7:00 pm

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APPENDIX 1

Common risk factors associated with suicide and suicidal behaviour [1]

	ADULTS	ELDERLY
Predisposing	• Major loss in early years (as a child) • Incest, violence as a child	• Same as Adults
Contributing	• Alcohol and drug abuse • Lack of problem-solving ability • Violence or sexual abuse • Absence of social network and isolation • Prior suicide attempt • Psychiatric disorders	• Same as adults • Social isolation • Poverty • Chronic illness (dependence, pain) • Abuse or improper use of medication
Precipitating	• Separation, divorce • Serious interpersonal problems • Humiliating event	• Same as adults • Widowerhood • Placement in a nursing home
Environment	• Trivialization of suicide by the media • Suicide perceived as acceptable behaviour • High unemployment rate	• Same as adult

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Appendix 2:

Find the original at http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/ 014-6427-41~1/$File/6427-41_.pdf

Ministry of Health
Ontario

Form 1
Mental Health Act

Application by Physician for Psychiatric Assessment

Clear Form

Name of physician _____
(print name of physician)

Physician address _____
(address of physician)

Telephone number ( ) _____ Fax number ( ) _____

On _____ I personally examined _____
(date) (print full name of person)

whose address is _____
(home address)

*You may only sign this **Form 1** if you have personally examined the person within the past seven days. In deciding if a Form 1 is appropriate, you must complete **either** Box A (serious harm test) **or** Box B (persons who are incapable of consenting to treatment and meet the specified criteria test) below.*

Box A – Section 15(1) of the Mental Health Act
Serious Harm Test

The Past / Present Test *(check one or more)*

I have reasonable cause to believe that the person:

- ☐ has threatened or is threatening to cause bodily harm to himself or herself
- ☐ has attempted or is attempting to cause bodily harm to himself or herself
- ☐ has behaved or is behaving violently towards another person
- ☐ has caused or is causing another person to fear bodily harm from him or her; or
- ☐ has shown or is showing a lack of competence to care for himself or herself

I base this belief on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations:

Facts communicated to me by others:

The Future Test *(check one or more)*

I am of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in:

- ☐ serious bodily harm to himself or herself,
- ☐ serious bodily harm to another person,
- ☐ serious physical impairment of himself or herself

6427–41 (00/12) *(Disponible en version française)* *See reverse* 7530–4972

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Clear Form

Box A – Section 15(1) of the Mental Health Act
Serious Harm Test *(continued)*

I base this opinion on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations:

Facts communicated by others:

Box B – Section 15(1.1) of the Mental Health Act
Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria

Note: The patient *must* meet the criteria set out in *each* of the following conditions.

I have reasonable cause to believe that the person:

1. Has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in one or more of the following: *(please indicate one or more)*
   - ☐ serious bodily harm to himself or herself,
   - ☐ serious bodily harm to another person,
   - ☐ substantial mental or physical deterioration of himself or herself, or
   - ☐ serious physical impairment of himself or herself;

AND

2. Has shown clinical improvement as a result of the treatment.

AND

I am of the opinion that the person,

3. Is incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained;

AND

4. Is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

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Clear Form

Box B – Section 15(1.1) of the Mental Health Act
Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria
(continued)

AND

5. Given the person's history of mental disorder and current mental or physical condition, is likely to: *(choose one or more of the following)*

- ☐ cause serious bodily harm to himself or herself, or
- ☐ cause serious bodily harm to another person, or
- ☐ suffer substantial mental or physical deterioration, or
- ☐ suffer serious physical impairment

I base this opinion on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations:

Facts communicated by others:

I have made careful inquiry into all the facts necessary for me to form my opinion as to the nature and quality of the person's mental disorder. I hereby make application for a psychiatric assessment of the person named.

Today's date _____ Today's time _____

Examining physician's signature _____
(signature of physician)

This form authorizes, for a period of 7 days including the date of signature, the apprehension of the person named and his or her detention in a psychiatric facility for a maximum of 72 hours.

For Use at the Psychiatric Facility

Once the period of detention at the psychiatric facility begins, the attending physician should note the date and time this occurs and must promptly give the person a Form 42.

_____ _____
(Date and time detention commences) (signature of physician)

_____ _____
(Date and time Form 42 delivered) (signature of physician)

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