Forensic Psychiatry & Suicide

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Source: Ottawa and Toronto Review courses

Forensic Psychiatry

- Any interaction between Psychiatry and the Law
- Sub-specialty of psychiatry in which scientific and clinical expertise is applied to legal issues in legal contexts embracing civil, criminal, correctional or legislative matters

01. **Criminal Law**

Fitness, NCR, violence

02. **Civil Law**

Duty to warn, privacy, consent, torts

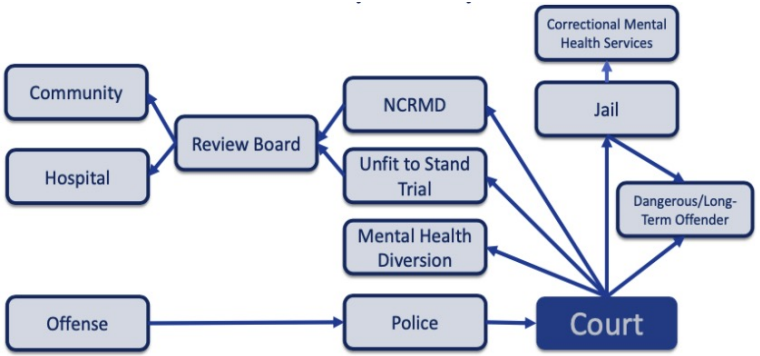
03. **Violence**

04. **Suicide**

Criminal Law & Psychiatry

Criminal law: stems from Canada's Criminal Code

- Federal legislation → applied in each province → penalties involve a loss of freedom (i.e. incarceration)
- The crimes are against the "peace" of the state
- Based on **precedence** (following higher court decisions, i.e. Supreme Court) and **prestige** (look at decisions from other provincial courts, but not follow them)



Types of medical court witnesses:

1. Fact witness: No $, tell what was seen/heard/etc.
   - **NO** opinion given
   - Testimony not optional (civic duty)
2. Expert witness: Paid for time (job is to give an opinion)
   - Can choose not to testify

Informed consent in the Forensic Context (medicolegal assessments)

Any time you are adopting the expert role, you MUST inform the evaluee of:

- **Limits of Confidentiality** → anything they tell you will be in a report, that you may disclose
- **Scope** of the assessment → sources of info that will be used
- **Role** of the evaluator → you may often have **dual duties** involving a patient
- *Honesty and objectivity* in reporting legal issues to the court
- **Purpose** of the assessment → medico-legal question

Court-ordered Assessments

The **"bread & butter"** of Forensic Psychiatry – Usually for **NCR & Fitness**

- Outlined in the ***Criminal Code of Canada***
- Psychiatrists employed as expert witnesses to perform and testify to these issues → court = employer

Assessment Orders – *Fitness to Stand Trial (sec 2)* or ***NCR on account of Mental Disorder (sec 16)***

- Duration – 5 or 30 days, but can be renewed to a maximum of 60 days total
- Assessment Orders do **not** allow treatment (only evaluation)
- Statements are **protected** & can only be used to:
  - Determine Fitness or NCR
  - Determine Disposition
  - Challenge credibility of later statements
  - Establish perjury
  - **NOT** to establish guilt

Fitness to Stand Trial

Reasons for establishing fitness:

- To safeguard the accuracy of any criminal adjudication
- To guarantee a fair trial
- To preserve the integrity and dignity of the legal process
- To be certain the accused if found guilty, know why they are being punished

Burden of proof *is on the party that raises the issue*

"Unfit to stand trial" means an accused person is unable, **on account of mental disorder,** to **conduct a defence** at any stage of the proceedings before a verdict is rendered, or to **instruct counsel** to do so.

The individual is NOT able to:

1. Understand the nature or object of the proceedings
2. Understand the possible consequences of the proceedings

Evaluation of Fitness

1. Knowledge of key **p**ersonnel, **p**rocedures and **p**urpose of the court
2. **P**ossible outcomes for the accused
3. Able and willing to **communicate** with counsel

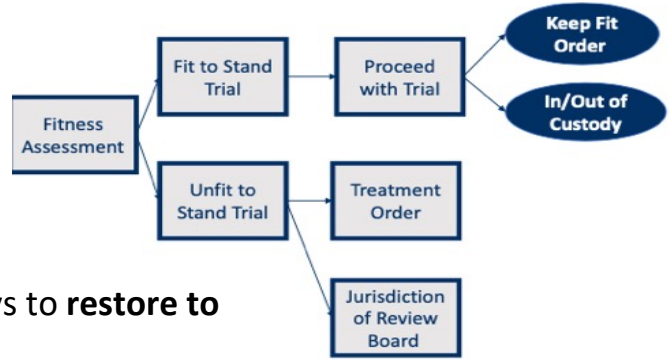
- Assessment tools: METFORS MFQ, FIT-R, *McGarry's criteria (USA)*, Nussbaum Fitness Questionnaire, Georgia Court Competency Screening Test

- Threshold to be found unfit is HIGHER in Canada, due to *Regina v Taylor (1992*)
  - Lawyer with Schizophrenia – stabbed colleague who was discussing his removal of license to practice law
  - Had delusions about courts, kept firing lawyers, trying to represent himself

- Led to the **Limited Cognitive Capacity Test** → ability to tell lawyer your version of events, and give instructions
  - Capacity to make a rational decision is **NOT** required
  - Do NOT have to be able to act in own interests

- Presence of delusions does **not** vitiate the accused's Fitness to Stand Trial unless the delusion **distorts** the accused's **rudimentary** understanding of the judicial process

Treatment Orders



- **If found Unfit → TREATMENT ORDER**
  - The Crown may request the person be treated for up to 60 days to **restore to Fitness** → then back to court
    - Cannot give ECT or psychosurgery
    - Can treat ***even if the person is competent to refuse treatment***
    - ***Right to trial > right to own body***
  - Without treatment, the accused remains unfit
  - Risk of harm is not disproportionate to the benefit
  - Treatment = least restrictive and least intrusive treatment to restore Fitness

- If not restored after 60 days → the accused comes under the Review Board's jurisdiction

Not Criminally Responsible on account of a Mental Disorder

Components of a Crime - need to prove:

- *Actus Reus* – Illegal **act** committed **consciously & voluntarily**
- *Mens Rea* – The guilty **mind**; act done **purposely, knowingly or recklessly**
- Both must be proven by the Crown beyond a reasonable doubt (~90% certainty) to ***CHARGE SOMEONE WITH A CRIME***

Why not hold ill accountable?

- Historical recognition that children, mentally ill and intellectually impaired less responsible for actions → lack *mens rea*
- Punishing does not address purposes of the law, so not serving a just purpose

NCR - Canadian standard based on "McNaughten Rule", England 1843

- **Section 16 CCC:** No person is criminally responsible for an **act committed** or an **omission made** while suffering from a mental disorder that rendered the person ***incapable of appreciating the nature and quality*** of the act or omission or of ***knowing that it was wrong***
  - Every person is presumed to not suffer from a mental disorder
  - NCRMD must be proven on a ***balance of probabilities*** (≥51%)

The ***burden of proof*** that an accused was NCRMD is on ***the party that raises the issue***

NCR Assessment

1. Is there presence of a mental disorder?

- Definition: “any illness, disorder or abnormal condition which impairs the human mind and its functioning, excluding self-induced states caused by alcohol or drugs, as well as transitory mental states such as hysteria or concussion”
- Typically: psychotic illnesses, mania with psychosis, psychotic depression

2. Due to the mental disorder, was the individual **in**capable of appreciating the **nature & quality** of the act?

- Being able to appreciate (not just know) the **material** or **physical consequences** of one’s actions
  - i.e. *when you stabbed the victim, did you **realize** they might die?*

3. Due to the mental disorder, was the individual **in**capable of knowing that it was **wrong**?

- Being able to apply **rational understanding** of right and wrong to one’s actions
- Need to consider motive – was it:
  - Irrational or psychotic vs. rational (profit, revenge/anger)
- Usually those found NCR are due to NOT knowing wrongfulness

Fate of NCR & Unfit: The Criminal Code Review Boards

- Goal is to **manage risk**, NOT TO PUNISH
- Review Board: psychiatrist, one of a doctor/psychologist/2nd psychiatrist, chair (judge/former judge), community member

Two main questions:

1. Does the person pose a significant threat? **2.** If so, how can the threat be reasonably managed?

- If there is a threat, then disposition must take into consideration:
  - the need to protect the public from dangerous persons
  - the mental condition of the accused
  - the reintegration of the accused into society
  - the other needs of the accused

DISPOSITIONS:

- If NCR and NOT a threat → **absolute discharge** – no conditions, exit forensic system
- If UNFIT and NOT a threat → assess if **permanently** unfit → if so, return to court for STAY of charges (trial stops)
- If remains a threat, then:
  - **Conditional discharge** – live in community, like "probation" with conditions
    - i.e. drug tests, come to appointments, live a certain place
  - **Detention order** – detained in hospital – like involuntary hospitalization with conditions & privileges
    - i.e. may be able to live in the community, passes to visit family, etc.

Mental Illness in Canadian Corrections

- In a study of federal inmates in 2002:
  - 84% of inmates had a current DSM-IV diagnosis → substance use disorder highest at 75%
  - Excluding substance, 43% had a psychiatric disorder

- Prevalence of mental illness:
  - Psychotic disorders in 8%
  - Mood disorders in 10-14%
  - Substance use disorders in 85-90%
  - Personality disorders in 50-60%

- Segregation of the mentally ill is rampant in prisons
  - Outcomes are poor - considered a form of torture by some researchers and human rights advocates
  - Often linked to inadequate mental health resources in corrections

- New federal legislation in 2018 to create Structured Intervention Units to replace segregation in federal corrections

- **Suicidality** - 20% of deaths in custody due to suicide (3-11x greater than in the general population)

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Civil Law & Psychiatry

- **Civil Law**
  - Regulates relationships *between individuals* (including corporations)
  - Mixture of provincial legislation and historical case law
  - Breach of civil law typically results in *allocation of damages* (i.e. monetary payment)
  - Civil plaintiff (person who suffer damage) must only prove their case on the *"balance of probabilities" (>51%)*

- **Topics:**
  - Fiduciary duty
  - Privilege and confidentiality
  - Informed consent
  - Civil Commitment
  - Medical malpractice
  - Duty to warn/protect

Fiduciary Duty

- **Definition:** Doctor must act in the patient's best interests (*legal obligation*)
  - Fiduciary duty exists because patient places *special trust and confidence* in the physician, and relies upon that person to exercise his/her *discretion or expertise* in acting for the patient
  - A doctor (the fiduciary) is in a *legal contract* with a patient (the principal or beneficiary)

- A fiduciary **at risk** when:
  - Personal interests and fiduciary duty conflict
  - Fiduciary duty conflicts with another fiduciary duty
  - Profit, benefit or gain from their fiduciary position is possible

Privilege & Confidentiality

- ***PR***ivilege - a ***P***atient's ***R***ight to decide what happens to their personal information
  - This belongs to the patient, not the doctor
- ***CO***nfidentiality - a ***C***linician's ***O***bligation to **not** disclose information
  - Legal Obligation – provincial legislation
    - Charter of Rights, The Privacy Act, Personal Information Protection and Electronic Documents Act (PIPEDA)
  - Ethical Obligation – CMA Code of Ethics
    - Sec 6 - Will keep in confidence information derived from his/her patient, or from a colleague, regarding a patient and divulge it **only with the permission of the patient** except when the law requires him/her to do so

Exceptions to Confidentiality (mandatory reporting)

- Child Abuse (provincial legislation)
  - Legal standard is usually "reasonable and probable grounds to believe" or "reasonable grounds to suspect"
  - Includes physical and sexual abuse; may include emotional abuse & neglect
- Federal occupational hazards
  - Flying - Aeronautics Act, Railway - Railway Safety Act, Maritime - Canada Shipping Act
- Elder Abuse, Professional Sexual Misconduct, Driving, Communicable diseases, Gunshot wounds, Health insurance fraud
- **Civil litigation** - if a **patient** makes their personal health information the **subject** of a lawsuit (malpractice or disability), their information becomes **available to the courts** (medical records subpoenaed)
  - Patient provides consent
  - Court ordered assessments

Capacity and Consent

Competence – the capacity to understand and act reasonably (legal term, determined by legal system)

Capacity – the ability to make a rational decision based on **understanding & appreciating** all relevant info:

- Diagnosis - describe condition/problem
- Treatment options – nature, purpose, risks & benefits of proposed treatment and alternative
- Prognosis - projected outcome with and without treatment
- **If not capable → Substitute Consent**
  - Varies by province; Decision Maker may be the court (a judge), MD, SDM (family member or PGT)
  - Decisions made based on the patient's "best interests" – what they would have wanted if they were capable

Valid Consent

- **Specific** to the issue
- **Informed** (no misrepresentation)
  - Include info on diagnosis, nature/purpose/risks/benefits of treatment and alternatives, prognosis
- **Voluntary** (no coercion or persuasion)
- **Capable** individual

Legal Basis

- Lack of consent for touching = Battery (Civil Law) or Assault (Civil & Criminal Law)
- Failure to obtain informed consent = Negligence (Civil)

Duty to Protect

Duty to Protect – Tarasoff Case

- Tarasoff I (1974) = Duty to Warn
- Tarasoff II (1976) = Duty to Protect

Duty to Protect in Canada

- **CPA** Position Paper (2002)
  - As part of the informed consent process, patients need to be warned of limits to confidentiality
  - A duty to protect (warn, or inform) exists:
    - When risk to a **clearly identifiable person** or **group** of persons is determined
    - When the risk of harm includes **severe bodily injury, death, or serious psychological harm**
    - When there is an element of **imminence**, creating a sense of urgency
- *Smith v Jones (1999)* – the Supreme Court indicated that solicitor-client privilege was the highest
  - This is **subject to breach** in the interest of public safety

Other areas of capacity

- Guardianship = ability to manage one's affairs (personal, property)
- Financial capacity = ability to manage one's finances
- Testamentary capacity = ability to make a will
  - Bounty, bequest, beneficiaries
- Contractual capacity = ability to make a contract
- Testimonial capacity = ability to be a witness
- Capability to marry or divorce

Civil Commitment

- Laws vary from province to province

- Based on both:
  - Protection of vulnerable people (mentally ill) from coming to harm *(**parens patriae**)*
  - Protection of public from the ill *(**police power**)*

- When rights taken away, must have **due process -** the variables to consider:
  - Prescence of a mental disorder
  - Not suitable for voluntary admission
  - Psychiatric treatment is needed
  - Prevent mental or physical deterioration
  - Risk of harm to self or others
- Some provinces allow treatment as part of commitment

Medical Malpractice

Tort = A civil suit involving one person wronging another – the penalty is $$$

- Based on Common Law of England
- Classified as intentional (battery, assault) vs. unintentional (negligence)

Negligence: 4 D's (must be proven):

- **Duty (fiduciary) -** i.e. see the patient, includes "hallway consultation," on-call coverage, duty to protect 3rd persons

- **Dereliction of Duty -** defined by the courts and laws of each province
  - Standard = psychiatrist must exercise a "reasonable degree of knowledge and skill exercised by other members of the profession in similar circumstances"
  - The courts have the discretion to override doctors and define the standard

- **Damages –** physical or psychological harm (usually nervous stress, includes MDD and PTSD)
  - Compensation for suffering, financial losses, or punitive

- **Direct Cause –** between dereliction and damages
  - The mistake must cause the negative outcome; has several components:
  - ***Cause in fact*** – if not for the psychiatrist's act or omission, the negative outcome wouldn't have occurred
  - ***Proximate cause*** - the act or omission was a substantial factor in bringing about the outcome
  - ***Foreseeable*** - flukes don't count, only reasonably foreseeable outcomes

Malpractice in Canada

- Failure to undertake an appropriate and thorough suicide and/or homicide risk assessment
- Wrongful confinement
- Problems arising from prescription of medication
- Sexual impropriety
- Failure to meet the expected standard of care

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Violence

Mental illness is associated with a ***small but significant increase in risk*** (this is still controversial)

- **Mostly due to concurrent substance abuse**
- Considerations:
  - Dispositional Factors – anger, impulsiveness, aggression, psychopathy
  - Clinical Factors (**our job**) – substance use, psychosis, personality disorders
  - Historical & Contextual Factors – History of violence, social supports, environment

Important Studies:

- **MacArthur Violence Risk Assessment** – 951 patients followed q10 weeks x 1 year post discharge
  - STRONG violence association: psychopathy, prior violence, male, history of childhood abuse, substances
  - Dx of SCZ had LOWER rates of violence than personality disorder
- **NIMH Epidemiological Catchment Area (ECA) study**
  - **Best** static violence predictors: substance use, major mental illness, male, young age, low SES
- **Violence and Psychiatric Disorders in the Community (Swanson et al 1990)**
  - Substance use & mental illness > substance > mental illness > controls
- **Dunedin Study (Arsenault 2000)**
  - 10% of all violence due to mental disorder

Psychiatric Risk Factors for Violence

- Risk factors associated with psychosis:
  - Positive symptoms
  - Paranoia, especially if organized (more able to plan violence)
  - Delusions of threat or control-override (by forces outside oneself)
  - Command hallucinations

- Depression

- Personality pathology:
  - Borderline PD, Antisocial PD, Paranoid PD, Narcissistic PD
    - Associated with **impulsive violence**
  - Key ingredients are **anger, impulsivity** and **hostility**
  - **Psychopathy** = glibness, grandiose self-worth, lying, manipulative, shallow affect, lack of empathy and prone to boredom
    - Assess with the **Psychopathy Checklist** (**PCL-R)**

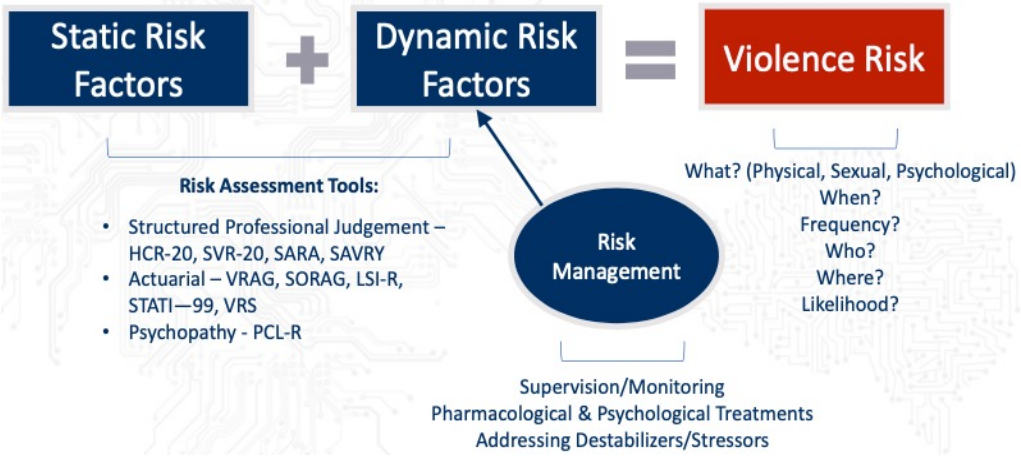
PCL-R
Factor 1 (F1)
Interpersonal
1. Glibness/superficial charm
2. Grandiose sense of self worth
4. Pathological lying
5. Conning/manipulative
Affective
6. Lack of remorse of guilt
7. Shallow affect
8. Callous/Lack of empathy
16. Failure to accept responsibility
Factor 2 (F2)
Lifestyle
3. Need for stimulation
9. Parasitic lifestyle
13. No realistic, long-term goals
14. Impulsivity
15. Irresponsibility
Antisocial
10. Poor behavioral controls
12. Early behavioral problems
18. Juvenile delinquency
19. Revoke conditional release
20. Criminal versatility

Prediction of Violence – Risk Assessment

- Accurate prediction of *rare events* is very difficult
- Prediction often → high false positives

Risk Assessment Tools

- **Actuarial** → examine large group for risk factors → correlate risks to recidivism
- **Structured professional judgement** → look at scientifically validated factors



Static Risk Factors

- **Previous violence**
- Substance use
- Age - peaks in late teens & early 20's
- Gender, IQ
- Childhood factors
- Young age of violence
- Socioeconomic status
- Psychopathy

Dynamic Risk Factors - *where we can manage violence risk*

- Current substance abuse/intoxication
- Agitation, impulsivity, poor insight
- Lack of supports
- Access to weapons, access to victims
- Stress (i.e. work, finances, relationships)
- Negative attitude towards treatment
- **Current instability of mental illness**

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Suicide

Epidemiology

- Canadian suicide rate 11/100,000
  - **Male s**uicide rate 3-4x higher
  - Women have more suicide attempts
  - **Middle aged** individuals at highest risk in both genders
  - Approximately 20-25 attempts per death
    - 100:1 attempts to death ratio in youth
    - 4:1 attempts to death ratio in elderly

Methods

- **Hanging is the commonest method** overall
- Women - #1 overdose, #2 hanging (opposite in M)

Children and Adolescents

	Children	Adolescents
Suicidal Ideation	Approximately 7-10% of children aged 10-14 have experienced suicidal ideation.[4,5]	14-20% of 15-19 year-olds have experienced suicidal thoughts in their lifetime[4,5]
Suicidal Behaviour	CDC data – 1.5/100,000 (focus only on those obtaining medical care (age 10-14)[7,8]	3-10% prevalence for high school students (includes self-harm behaviour), far less (<2%) seek ED care for same[4,5,6]
Death by Suicide	Children (age 10-14) die by suicide in North America at a rate of approximately 1/100 000 (M>F, although evidence is mixed)[1,5]	Male: 13/100 000; Female: 2/100 000 Females engage in suicidal behaviour three times more often than males[1] Hanging is most common method of dying in Canada; Firearms in the US[1,4]

Older Adults

- Highest risk in **elderly males**
- **Past attempt** is biggest risk factor
- Most have a **psychiatric disorder** (most commonly depression)
- Other associated risk factors: bereavement, alcohol abuse, living alone, physical illness, somatic pain
- Mixed evidence re: whether **dementia** is risk factor for suicide
- Nursing home residence is protective

Predictors of Suicide

- History of ***previous suicide attempts*** is the most powerful predictor for all age groups across all diagnoses
  - Predictors of **suicide death** include **number and severity** of past attempts
  - **Non-suicidal Self Injury** is also a robust predictor of death by suicide
- Family History of suicide
  - Suicide is **2-4x** more likely in 1st degree relatives of suicide victims
  - **Non-fatal suicidal behaviour in families** also increases the risk for suicide and suicidal behaviour
- Neurobiological Risk Factors
  - Suicide and suicidal behaviour are associated with **diminished central serotonin levels**
    - Lower levels of 5-HIAA in CSF via lumbar puncture
    - Low density of serotonin transporters in prefrontal cortex, brainstem
- **Mental Illness - >90%** of people who die by suicide would have met criteria for a mental illness
  - Includes substance use disorders and personality disorders
  - **Period after discharge** from the hospital is a time of increased suicide risk
- Medical illness and chronic pain

Diagnosis	Lifetime Risk	Percentage of Suicides
Affective Disorders	5-15%	50-70%
SCZ	5-10%	10-15%
Alcoholism and Substance Abuse	2-15%	15-20%
Borderline PD	3-10%	9-22%
Antisocial PD	5%	Not given

Psychosocial Risk Factors for Suicide

- **Relationship factors**
  - Single, divorced (especially for men)
  - Social **isolation**
  - **Bereavement**
  - **New loss** or **relationship rupture** is an **acute** risk factor

- **Occupational factors**
  - **Recent** job loss, financial distress, or shame and embarrassment in workplace
  - **Occupations** associated with higher rates of suicide:
    - Construction/extraction workers, physicians/dentists/veterinarians, financial service workers, military, police

- **Psychological** Factors
  - Impulsivity/history of violence
  - Hopelessness
  - Cognitive rigidity
  - Perceived burdensomeness
  - Feeling trapped

Protective Factors

- Marital status, children
- Strong social supports
- Employed
- Strong therapeutic alliance
- Religious beliefs
- Good problem-solving skills, cognitive flexibility
- Overall good self-esteem
- NO previous attempts, serious psychiatric diagnosis, history of impulsivity, serious recent losses, hopelessness
- Reality testing intact

Suicide Risk Assessment

Goals:

- Identify **risk factors** – acute vs. chronic, modifiable vs. not
- Identify **protective factors**
- Optimize the safety of the individual

- **Formalized tools** improve the **quality and predictive value** of suicide risk assessment
  - **PHQ-9** and **Columbia Suicide Severity Rating Scale (C-SSRS)** have PPV in identifying those at risk for suicide/ suicidal behaviour

S = Sex (male)
A = Age
D = Depression
P = Previous Attempt
E = Ethanol Abuse
R = Rational thinking loss
S = Social support lacking
O = Organized suicide plan
N = No spouse (for males)
S = Sickness (chronic/severe)

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screening

	Past month	
Ask questions that are in bold and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?*** Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.		
2) ***Have you had any actual thoughts of killing yourself?*** General non-specific thoughts of wanting to end one's life/die by suicide without general thoughts of methods, intent, or plan.		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** Person endorses thoughts of suicide and has thought of at least one method. e.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** Active suicidal thoughts of killing oneself and reports having some intent to act on such thoughts. e.g. "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.		
6a) ***Have you done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Lifetime**	
6b) If YES, ask: ***Was this within the past 3 months?***	**Past 3 Months**	

Response Procedure to C-SSRS Screening: **Low Risk** **Moderate Risk** **High Risk**

Suicide Risk Formulation

Integration of the suicide risk assessment to assign a level of **acute suicide risk**

- Allows clinicians to assign the **appropriate level of care** to address the patient's safety and to provide adequate treatment to reduce his or her risk, improve symptoms, and promote recovery
- Comment on **risk status** (risk relative to a population) and **risk state** (risk compared to personal baseline)

Levels of Acute Suicide Risk:

- **Low Acute Risk**: Recent suicidal ideation, but no intent to act
- **Moderate Acute Risk**: Current SI with no intent to act; some warning signs or risk factors, and limited protective factors
- **High Acute Risk**: Persistent SI, strong intention to act, well-developed plan, recent suicide attempt or prep behaviour
- **Chronically High Acute Risk**: History of multiple suicide attempts
  - Acute stressors (MDE, increasing substance use, or conflict) can increase a patient's baseline level of suicide risk
  - Use an "*Acute on Chronic*" risk assessment mode

Risk assessment should guide care planning and resource allocation

- Inform immediate, short-term and long-term management

Suicide Prevention

- Public Health Strategies → Means Restriction, School- Based Programs, Public Awareness Campaigns

- Mental Illness and Substance Use Treatment
  - Lithium, Clozapine, Antidepressants, Ketamine, ECT
  - Psychotherapy

- **Safety planning intervention**
  - Safe prescribing, eliminating alcohol or drugs from the home, brief ED intervention and rapid follow up
  - Crisis lines, mobile and internet interventions (mixed evidence)

- BEST EVIDENCE → restricting **access to lethal means**
  - Bridge and subway barriers
  - Firearms restriction
  - Restriction on sales of OTC drugs; pesticide regulation, formulation, and storage
  - Preventing hanging in hospitals

- **Physician education** in primary care

Professional Risk and Suicide

Patient suicide = Most common cause of legal action against mental health professionals

- 10% of all CMPA activities are complaints are related to suicide
- Adequately document your **assessment and intervention plan**
  - Documenting **suicidality** should be automatic **part of mental status**
  - Always document **past suicide attempts and admissions**
  - Obtain **collateral** info – document attempts to locate
- Do NOT depend on a “no-suicide contract”
- Seek **consultation**
- **Include risk assessment** at every patient encounter

If patient is lost to suicide:

- Be aware of your facility’s **standard operating procedures** following a suicide death
- Contact a **trusted mentor or colleague** for support; consider formal support pathways
- Contact **CMPA**
- Speak with the **patient’s family** and participate in grieving rituals
- **Team debriefs** should focus on ensuring that everyone has appropriate emotional support rather than assigning blame
- **Review existing processes** to see if care for suicidal patients can be improved
  - Examine the patient-, environment-, and system-related factors

Sources

- Toronto Review 2021
- Ottawa Review 2021