BEST PRACTICE GUIDELINES FOR ASSESSMENT AND MANAGEMENT OF RISK OF SUICIDE IN YORK REGION

This Best Practice Guide is intended to help standardize suicide risk assessment and safety planning practices across York Region’s child, youth and family serving organizations

York Region Mental Health Collaborative & York ASD Partnership Crisis Intervention Suicide Prevention Committee 2017

BEST PRACTICE GUIDELINES/PRINCIPLES FOR ASSESSMENT AND MANAGEMENT OF RISK OF SUICIDE IN YORK REGION 2017

Introduction

Suicide is one of the leading causes of death among our youth. Suicide is the #1 or leading cause of non-accidental death among youth[1]. We lose 2 young Canadians each day to suicide[2]. Suicide is a tragic and distressing phenomenon. The negative effects on families, friends and communities following a suicide reinforce the urgency for a better understanding and prevention of suicide. The loss of these young Canadians is often too hard to bear. Focusing on suicide risk assessment is a first step in improving suicide prevention.

This *Best Practice Guide* is intended to help standardize suicide risk assessment practice across York Region's child, youth and family serving organizations. Its goal is to highlight all factors that should be considered for performing high-quality suicide risk assessments to ensure the safety and well-being of the children, youth, and their families served. This document includes the background history of the development of the guide, important principles to be aware of while assessing suicide risk, and recommendations for organizations.

Background

In 2014, York Region, through the joint auspices of the Mental Health Collaborative (MHC) and the York ASD Partnership commissioned a Scan of Crisis Services and Suicide Prevention Services for Children and Youth in York Region. The report (available at www.yorkasdpartnership.org/ (Working Groups –Crisis Response) was distributed in 2015 to all child, youth and family services in York Region and the Crisis Response Working Group took on the coordination of implementing the recommendations. There were three actions early on:

1. Commitment at the MHC to adopt the Applied Suicide Prevention Skills Training (ASIST) as our suicide prevention training program across the community as a whole;
2. Creation of the Risk Assessment and Safety Planning subcommittee to explore the possibility of a common approach to risk assessment and safety planning across York Region; and
3. Development of training for first responders and ASIST trained staff intervening with children and youth on the Autism Spectrum Disorder (ASD) spectrum.

[1] Navaneelan, T. Statistics Canada – Catalogue no. 82-624-X. Suicide rates: An overview. July 2012

[2] Statistics Canada 2009

Risk Assessment and Safety Planning Sub-Committee3

The Risk Assessment and Safety Planning subcommittee issued a survey to all child, youth and family serving organizations to ascertain what practices existed in this area. The results from the 20 that responded demonstrated that there was not a uniformed response across the region. The group set about to explore best practices and general principles that would guide our collective response. This short paper reflects their work.

Clinical Framework for Risk Assessment

Suicide risk assessment should be viewed as an integral part of a holistic therapeutic process that creates an opportunity for discussion between the person and service provider, and his or her family and other supports.

The goal of a suicide assessment is not to predict suicide, but rather to...appreciate the basis for suicidality, and to allow for a more informed intervention".

- (Jacobs, Brewer, & Klein-Benheim, 1999, p. 6).

The assessment of suicide risk is commonly based on the identification and appraisal of warning signs as well as risk and protective factors that are present. Information relevant to the individual's history, chronic experience, acute condition, present plans, current ideation, and available support networks can be used to understand the degree of risk.

Suicide risk assessment is a multifaceted process for learning about an individual, recognizing and addressing his or her needs and stressors, and working with him or her to mobilize strengths and supports. While suicide risk assessment tools are a part of this process, these should be used to support the assessment process, rather than to guide it.

Suicidality vs Self Harm

As an introductory point, it is important to distinguish between the terms "self-harm" and "suicide". Often the terms "self-harm" and "suicide" are used interchangeably, yet they are different on both a conceptual and treatment level.

Suicide is an intentional, self-inflicted act that results in death. The difficulty in distinguishing suicidal behaviours from purposeful self-harm is in determining the person's intent. For example, was the intention of the behaviour to end the person's life, a call for help, or a means of temporary escape? Suicidal behaviours that do not result in death are considered "non-fatal," or more commonly, "suicide attempts".

Self-harm is an intentional and often repetitive behaviour that involves the infliction of harm to one's body for purposes not socially condoned (excluding culturally accepted aesthetic modifications such as piercing) and without suicidal intent (see Neufeld, Hirdes, Rabinowitz, 2011).

It may be very difficult to distinguish between self-harm and suicide-related behaviour as both are self-directed and dangerous. However, the majority of individuals who engage in self-harm do not wish to

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[3] Membership: Blue Hills Child and Family Centre, Catholic Community Services York Region; Cedar Centre; Children's Treatment Network, 310 COPE (YSSN), 360^0 Kids, Family Services York Region, Kinark Child and Family Services, Kerry's Place Autism Services, Mackenzie Health, Reena, The York Centre for Children, Youth and Families, York ASD Partnership, York CAS.

die. Rather, they use self-harm as a coping mechanism that provides temporary relief from psychological distress. Although seemingly extreme in nature, these methods represent an effective form of coping for some individuals. Though most people will know when to cease a session of self-harm (i.e., when their need is satisfied), accidental death may also result for example, if the person cuts into a vein and cannot stop the bleeding. Such cases of self-harm may be mistakenly labelled as a suicide or non-fatal suicide attempt by health care professionals.

Risk Factors

Risk factors may be associated with an individual contemplating suicide at one point in time over the long term, whereas warning signs are those factors that, in the immediate future (i.e., minutes and days), may set into motion the process of suicide (Rudd, 2008). Warning signs present tangible evidence to the service provider that a person is at heightened risk of suicide in the short term; and may be experienced in the absence of potentiating risk factors.

It is important to recognize that risk may still be high in persons who are not explicitly expressing ideation or plans, searching for means, or threatening suicidal behaviour. Persons who may be truly intent on ending their lives may conceal warning signs. Thus, it is vital that all warning signs are recognized and documented during the risk assessment process. The most significant contributor to suicide risk is previous and repetitive suicidal behaviours.

Protective Factors[4]

The identification of protective factors is a necessary component of suicide risk assessment in order to identify potential strengths and resiliency that can be used to buffer suicide risk. Recognizing protective factors can be a means to encourage hope among persons at risk. Responsibility and love for one's family or children, strong ties to friends or the community, or personal hobbies or interests may foster a sense of self-worth and should be considered during suicide risk assessment. However, the protective nature of some factors may be temporary (e.g., a person may not attempt suicide while their children are still living at home). Protective factors should never supersede evidence of warning signs when assessing risk. The presence of protective factors does not reduce the risk associated with the presence of severe warning signs. Instead, these factors should be used in the care process with the person to attempt to alter risk.

- Strong connections to family and community support
- Skills in problem solving, coping and conflict resolution
- Sense of belonging, sense of identity, and good self-esteem
- Cultural, spiritual, and religious connections and beliefs
- Identification of future goals
- Constructive use of leisure time (enjoyable activities)

[4] **Protective factors** are conditions or attributes (skills, strengths, resources, supports or coping strategies) in individuals, families, communities or the larger society that help people deal more effectively with stressful events and mitigate or eliminate risk in families and communities.

• Support through ongoing medical and mental health care relationships

• Effective clinical care for mental, physical and substance use disorders

• Easy access to a variety of clinical interventions and support for seeking help

• Restricted access to highly lethal means of suicide

Definition Potentiating risk factors are associated with a person contemplating suicide at one point in time over the long term. Warning signs are factors that may set into motion the process of suicide in the short term (i.e., minutes and days)

Fact: In general, there is consensus that it is the combination of warning signs and potentiating risk factors that increases a person's risk of suicide (Jacobs et al., 1999).

Definition Predicament suicide refers to "suicide that occurs when the individual without mental illness/disorder is in unacceptable circumstances from which they cannot find an acceptable alternative means of escape". (Pridmore, 2009, p 113)

Risk Management

Risk management must be built on the recognition of the client's strengths, their capacity to change over time and recognition that each service user requires a consistent and individualized approach.

GUIDING PRINCIPLES FOR SUICIDE RISK ASSESSMENT (adapted from Granello, 2010).

Suicide Risk Assessment:	**Explanation**
1. Is Treatment and Occurs in the Context of a Therapeutic Relationship	• The process of the risk assessment, itself, could be a therapeutic process for persons, helping them feel that that their story can be heard in a safe and confidential environment. • Empathy and helping the person feel valued in the assessment process is important. • This process can help establish the therapeutic relationship with the person.
2. Is Unique for Each Individual	• Regardless of risk profile an individual may have unique circumstances that precipitate suicide ideation or behaviours. • To help the individual, it is important to learn about these circumstances from the person's perspective.

Suicide Risk Assessment:	Explanation
3. Is Complex and Challenging	• Suicide thoughts or behaviours may be an attempt to escape distress rather than a direct desire to seek out death. • The distinction between wanting to escape vs. wanting to die may create opportunities for intervention. • Each individual may have their own specific reasons for escape or distress that may fluctuate over time.
4. Is an Ongoing Process	• Ongoing assessment is needed due to the fluctuations of risk factors and warning signs over time. • Important assessment points include times of transition, elevated stress, and changes to supports. • Assessments can use brief questions about frequency and timing of ideations (e.g., last day, week, month, etc.) to determine the acuity or chronicity of ideation.
5. Errs on the Side of Caution	• Assessment of risk needs to balance between identifying all possible persons at risk of suicide (sensitivity) while identifying only individuals actually at risk of suicide (specificity). • While over estimating individuals who may be at risk (false positives) may be burdensome, underestimating those actually at risk (false negatives) can be detrimental. • Risk factors and warning signs are to be used to balance this assessment, but cautious clinical judgement is required to ensure safety.
6. Is Collaborative and Relies on Effective Communication	• Multiple sources of information can provide corroboration to the risk assessment. • Collaboration and consultation with other clinical team members as well as others familiar with the person in different environments (e.g., at home, school, or work) can inform this process. • Communication of risk factors and warning signs among all individuals involved in care is essential to monitoring and preventing risk.

Further to the above Guiding Principles the four additional Principles below can guide our collective work and reflect Best Practices:

1. The Therapeutic Relationship
2. Communication and Collaboration
3. Documentation in the Assessment Process
4. Cultural Awareness

PRINCIPLE ONE – THE THERAPEUTIC RELATIONSHIP

The primary principle for maintaining a person-centered risk assessment is the establishment of a therapeutic relationship with the individual, based on active listening, trust, respect, genuineness, empathy, and response to the concerns of the individual. Maintenance of openness, acceptance, and willingness to discuss his or her distress can help minimize feelings of shame, guilt, and stigma that the person may experience

The way that questions are asked may help convey a sense of empathy and normalization, and help the individual feel more comfortable. This may be particularly important among youth, who may be afraid to disclose their feelings for fear of repercussions. One approach is to let the person know that it is not uncommon for some people to think about hurting themselves when in distress, and then ask him or her if that is how he or she feels. The person may then feel reassured that he or she is not alone in his or her feelings, and that the support provider is there to listen and provide support.

Successful strategies for building the therapeutic rapport (Heaton, 1998)

The primary principle for maintaining a person-centered risk assessment is the establishment of a therapeutic relationship with the person, based on active listening, trust, respect, genuineness, empathy, and response to the concerns of the individual.

• Ask the person how he/she wants to be addressed

• Provide the person with an explanation of your role and the purpose of the assessment which will minimize feelings of uncertainty and anxiety

• Listen empathetically

• Take the time to consider the person's story

• Highlight the person's strengths

• Meet the person in a comfortable and private environment

Building rapport should begin in the first moments of contact between the service provider and client and continue throughout the risk assessment process; this can reassure the person and improve his or her engagement.

PRINCIPLE TWO – COMMUNICATION AND COLLABORATION

Effective communication and collaboration are crucial for ensuring that suicide risk assessment remains thorough, consistent, and effective in addressing a person's risk throughout his or her journey through the system (e.g., from the emergency room to the community, from one professional to another). Communication and collaboration are essential for obtaining collateral information about a person's

distress and maintaining his or her safety. To support the person throughout his or her recovery process, it is essential to maintain good communication and collaboration:

• With the person;

• With the person's informal support network; and

• Within and between the care teams supporting the person.

While efforts to include informal supports in the process of risk assessment and treatment can enhance the overall care provided, this involvement is not always maximized. Some family members describe having very little opportunity for genuine participation in mental health care and treatment at either a systemic or individual level, and have little encouragement to do so (Goodwin & Happell, 2007). However, a family/parent-centered approach to the treatment of suicide-related behaviour views family members as partners in providing care for the person (Buila & Swanke, 2010).

A risk management plan is only as good as the time and effort put into communicating its findings to others. Responsibility for implementation of a risk management plan must be clearly defined.

PRINCIPLE THREE – DOCUMENTATION IN THE ASSESSMENT PROCESS

Documentation is key to suicide risk assessment and are every service provider's responsibility.

Clear notes are needed for:

- Level of risk (based on warning signs, potentiating risk factors and protective factors);
- Person's thoughts and observed behaviours;
- Psychiatric history;
- Previous treatments;
- Plans for treatment and preventive care;
- Current and previous suicidal behaviour (timing, method, level of risk).
- Concerns expressed by the informal support network (including intent and consequences).

This is by no means an exhaustive list. Organizations should develop standard protocols for identifying the location of information in the person's record related to suicide risk.

Documentation is a key process for ensuring the efficacy of suicide risk assessment. After initial and ongoing assessments, notes should clearly identify the person's level of risk (based on warning signs, potentiating factors, history, safety plans and community supports.

Documentation should include:

1. The overall level of suicide risk: The level of risk should be clearly documented along with information to support this assertion. This can include information about:

• The types of assessment tools used to inform risk assessment;

• Details from clinical interviews and details from communication with others (e.g., the person's family and friends, other professionals). Including:

i. The circumstances and timing of the event;

ii. Method chosen for suicide;

iii. Degree of intent; and

iv. Consequences.

2. Prior history of suicide attempt(s) and self-harming behaviour.

This should include:

• The prior care plan/intervention plan and Safety Plan that was in place;

• The length of time since previous suicide attempt(s) or self-harming behavior(s);

- The rationale for not being admitted to a more intensive environment or discharged to a less restrictive environment, and what safety plans were put into place; and

• Details about family concerns and how these were addressed.

3. Details about all potentiating risk factors, warning signs, and protective factors

4. The degree of suicide intent

The degree of intent may include, for example, what the person thought or hoped would happen.

5. The person's feeling and reaction following suicidal behaviour For example, sense of relief, regret at being alive.

6. Evidence of an escalation in potential lethality of self-harm or suicidal behaviours Document whether the person has begun to consider, plan, or use increasingly lethal means (e.g., from cutting to hanging, seeking a gun).

7. Similarity of person's current circumstances to those surrounding previous suicide attempt(s) or self-harming behaviour(s)

8. History of self-harm or suicidal behaviour(s) among family or friends or significant loss of family or friends. This should include anniversary dates of these events as risk may be elevated at these anniversary points.

Organizations should also develop standard protocols for identifying the location of documentation regarding suicide risk within the persons' record. The location of documentation should be consistent and easily identified by others within the organization or those involved in providing service to the person.

PRINCIPLE FOUR – CULTURAL AWARENESS

Service provider professionals performing suicide risk assessments need to be aware of culture and its potential influence on suicide. In some cultures for instance, suicide is considered taboo and is neither acknowledged nor discussed. This creates a challenge not only for the service provider assessing for suicidality, but also for the person of that culture who may be struggling with suicidal thoughts and unable to discuss or disclose those thoughts or feelings to members of their same ethnic community. It should be considered a sign of strength for persons whose culture does not accept or discuss suicide to disclose suicidal ideation.

Intra-cultural beliefs regarding suicide can be further confounded by age (e.g., youth, adult, elder), sex, and/or religious beliefs. It is important to consider and be aware of this diversity in beliefs and the potential impact on risk of suicide. Whenever possible, talking with the person, family, or others about specific cultural beliefs toward suicide will aid the risk assessment process. It would also help develop an approach to prevention with the person that is in line with his or her beliefs. We are all multiply and fluidly constituted and our identities are marked by a complex and dynamic intersection of race, gender, sexual orientation, age, ability, and class.

SAFETY PLANNING

When clients exhibit suicidal ideation, regardless of estimated risk, service providers should develop crisis or safety plans in collaboration with clients, and they should revisit these plans whenever there is a change in risk level. Safety or crisis plans are distinct from treatment plans. They typically outline how clients should respond to their suicidal urge by outlining coping and problem-solving skills and abilities (CARMHA, 2007).

Safety plans are formulated in response to a client at risk for suicide, regardless of level of risk. Ideally, these plans are developed in conjunction with the service provider (s) and the client. They include potential triggers, coping strategies, resources and protective factors, such as family and friends who can be contacted for support. Multiple individuals and agencies may be identified in safety plans, including family physicians, 24-hour crisis services, friends, religious or spiritual advisers and family support systems. Individuals and agencies listed in these plans should be involved in developing them and should be familiar with their role in facilitating client safety. Ideally, copies of the plan should be circulated to individuals and agencies identified within it (CARMHA, 2007).

The specific details of how to cope, who to call, where to seek support, and when to activate professional help should be worked out with the young person in advance of any crisis. The safety plan should also be shared with parents/ caregivers and other significant people in the young person's life. While each safety plan should be collaboratively developed and individually tailored to match the needs and resources of the individual youth, there are a number of suggested steps to be included (Stanley & Brown, 2012):

- Recognize warning signs
- Identify individual coping and/or distracting strategies
- Identify social situations and other people who can help
- Name specific people who can be asked for help (i.e. parents/caregivers)
- Identify professionals who can be contacted in a crisis
- Generate concrete strategies for making the home environment safe

RECOMMENDATIONS FOR YORK REGION:

That all Organizations serving children, youth and families[5] that are part of the Mental Health Collaborative and the ASD Partnership aim to integrate the following in their practices:

1. Wherever possible to Identify clients at risk of suicide (either at the front door and/or in service);
2. Assess each client for risk of suicide at regular intervals, or as needs change;
3. Address the client's immediate safety needs through the development of a Safety Plan that is regularly monitored and/or ensure referral is made to an agency/professional that can help complete a Safety Plan;
4. Identify treatment and monitoring strategies to ensure client safety if within their scope of practice;
5. Document the treatment and monitoring strategies in the client's record;
6. Ensure that all relevant staff that engage in risk management should receive training (ASIST) which must be updated at least every three years;
7. Reach out to other relevant service agencies that may have previous history or information to inform an updated support plan for the individual;
8. That all organizations continue to support ASIST as the suicide prevention training program across the community as a whole;
9. That the Crisis Response Committee encourage participating organizations to make use of the material in this Guide.

Reference Materials:

- Suicide Risk Assessment-Procedures and other Information/development/Suicide Risk Assessment-FSYR-updated April 2016
- Visual Brief Suicide Risk Assessment- Procedures and other Information/development/Suicide Risk Assessment-FSYR-updated April 2016
- Suicide Risk Protocol: A Coordinated Community Response for Youth at High Risk For Suicide- The Child, Youth and Family Services Coalition of Simcoe County 2012
- Scan of Crisis Services for Children and Youth in York Region –Literature Review and Themes for Consideration- 2015
- Summary of Recommendations- 2015

The material in this document was liberally borrowed from the:

1. Suicide Risk Assessment Guide: A Resource for Health Care Organizations- Ontario Hospital Association (OHA)and Canadian Patient Safety Institute (CPSI)
2. Risk Management in Mental Health Services, Guidance Document – Health Service Executive (HSE)
3. CAMH Suicide Prevention and Assessment Handbook-2015
4. Practice Guidelines for Working with Children and Youth At-Risk For Suicide In Community Mental Health Settings- Prepared by Jennifer White, EdD for the Ministry of Children and Family Development (MCFD) British Columbia.

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[5] Not all organizations will be able to implement all of these recommendations given their scope of practice, the services they provide and their lack of direct contact with children/youth, among other factors. It is nevertheless recommended that all staff have an appreciation this issue and are trained in ASIST.