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THE PROVINCIAL SUICIDE CLINICAL FRAMEWORK
SUMMARY DOCUMENT

A common strategy for assessing, treating, monitoring and documenting suicide prevention activities across British Columbia Health Authorities

VERSION 1.0

January 2011

PREPARED BY:

BC Mental Health & Addiction Services

An agency of the Provincial Health Services Authority

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Acknowledgements

BC Mental Health & Addiction Services, an agency of the Provincial Health Services Authority, gratefully acknowledges the commitment and contribution of the Provincial Suicide Clinical Framework Steering Committee. We thank the leadership within each of the Regional Health Authorities and the Ministry of Health for providing committed representation on the Steering Committee.

A large and diverse group of stakeholders were involved in the development and refinement of the Framework. First, 921 clinical and administrative leaders, managers, health care professionals and direct care staff from across the health authorities responded to an environmental scan in January 2010. Respondents represented a full range of services, levels of care and service populations. Information from this feedback was used to develop the structure of the current document. In June 2010, a draft of the report was distributed widely to a full range of health authority, Ministry of Health and Ministry of Children and Family Development service providers, staff, and physicians for their feedback and input.

We thank all these stakeholders for their time and thoughtful suggestions, which strengthen the integrity of the document. We also thank the Provincial Mental Health and Substance Use Planning Council and its members for their review and endorsement of this Framework.

Sincerely,

Leslie Arnold, *President*
BC Mental Health and Addiction Services
An Agency of the Provincial Health Services Authority

Disclaimer: This document is intended for health service providers to develop and implement an evidence-based suicide risk management protocol. It is not intended to prescribe a standard of care. Nothing contained in this document should be construed as providing professional advice. If professional advice is required, the services of a competent and qualified professional should be sought. Clinical decision making in a specific context remains the responsibility of attending professionals. Nothing contained herein should in any way be construed as being either official or unofficial policy of the British Columbia Mental Health Society Branch or the Provincial Health Services Authority

Provincial Suicide Clinical Framework Steering Committee

AGENCY	REPRESENTATIVE	ROLE	POSITION
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	Shannon Griffin	Co-Chair	Director, Planning & Strategy Development, BCMHAS
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Providence Health	Alice Chan	Committee Member	Clinical Nurse Specialist, Mental Health
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Northern Health Authority	Debbie Strang	Committee Member	Area Director, Northern Interior Community Programs
Vancouver Island Health Authority	Janet Dorland	Committee Member	Manager, Education & Program Support
	Dr. Robert Miller	Committee Member	Medical Director, Mental Health & Addiction Services

Background

A call for a standardized, best practice approach to suicide risk management

The importance of preventing suicide and self-harm as a strategic priority in the enhancement of patient safety is demonstrated by its prominence in the planning and priorities of health organizations worldwide. Recently, the Canadian Patient Safety Institute (CPSI) and Ontario Hospital Association (OHA) commissioned BC Mental Health and Addiction Services to develop a background paper outlining current issues in patient safety across mental health settings (paper released in July, 2009). One of the key findings in that review was the need for a standardized approach in assessing suicide risk and implementation of evidence-based interventions; including the identification of empirically-validated suicide risk assessment tools and training.

The Provincial Suicide Clinical Framework is intended to provide a common strategy for mental health and addiction services to align with best practice standards for suicide risk management. The Framework and its accompanying template is structured to provide clinical and administrative leaders across BC's Health Authorities (HA) with the background information and steps for developing a protocol that incorporates best practice standards in suicide assessment, treatment, monitoring and documentation. These components are part of a new Accreditation Canada's Required Organizational Practice (ROP).

In 2009, Accreditation Canada rolled out a new patient safety goal: Organizations are to identify safety risks inherent in its client population. Similarly, reducing patient suicide was identified as a patient safety goal by the United States' Joint Commission on Accreditation of Healthcare Organizations (JCAHCO, 2008). The Australian National Mental Health Working Group (2005) set the reduction of suicide and deliberate self-harm as a priority area for improving patient safety in Australia. They described suicide as "catastrophic system failures" that undermine confidence in the mental health care system.

The new Required Organizational Practice (ROP) for meeting Accreditation Canada's new safety goal is to assess all clients for risk of suicide at regular intervals, or as needs change, to address immediate safety needs, to identify and document treatment and monitoring strategies to ensure client safety. As such, the Regional and Provincial Health Authorities have a common interest in developing a framework that:

1. Aligns with best/promising practice,
2. Conforms to Accreditation Canada's tests of compliance for the new ROP, and
3. Responds to the unique risks and needs of diverse regions, sites, agencies and populations.

Purpose of this Summary Document

This summary document provides readers with a brief overview of the complete Provincial Suicide Clinical Framework. Those who are developing a clinical protocol for their service should refer to the longer document for a more in-depth review of best practice. Reference to the "Framework" in this summary document refers to the long document.

Provincial Suicide Clinical Framework Development

The complete Framework was developed using the following information sources:

- Peer-reviewed research literature
- Best practice guidelines and practice parameters from the American Psychiatric Association, The Canadian Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the Canadian Coalition of Seniors' Mental Health, The Registered Nurses Association of Ontario, National Centre for Clinical Excellence, Centre for Substance Abuse Treatment and the New Zealand Guidelines Group.
- Gray literature from similarly situated mental health and addiction services
- Accreditation Canada
- Commission on Accreditation of Rehabilitation Facilities
- British Columbia Ministry of Health
- British Columbia Ministry of Child and Family Services
- General Practice Services Committee (a joint committee of the BC Ministry of Health, the BC Medical Association, and the Society of General Practitioners of BC)
- The Centre for Applied Research in Mental Health and Addiction (CARMHA)
- The Canadian Medical Protection Agency (CMPA)
- The Prevention/Intervention/Postvention Initiative (Ministry of Health)
- Data from a Province-wide environmental scan, initiated by the Provincial Suicide Clinical Framework Steering Committee, eliciting service provider input (including direct care providers, physicians, managers and directors)

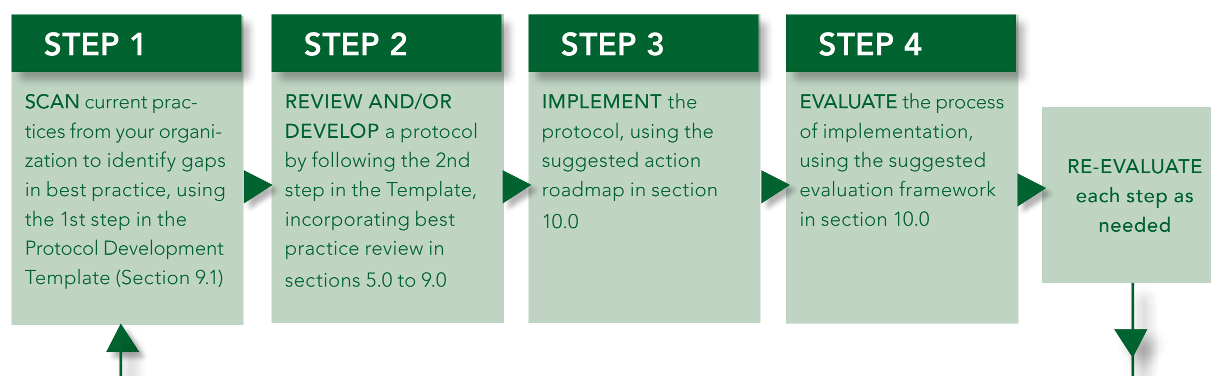
Drivers for Action

In response to the call for a standardized, best practice approach to suicide risk management, Accreditation Canada's Required Organizational Practice (ROP) requires that appropriately-trained staff assess all clients for risk of suicide or self-harm at intake to the service, and monitor and treat those clients at a level appropriate to their needs. Clients are reassessed regularly throughout that client's contact with services, and the monitoring/treatment plan adjusted as required. All assessments, monitoring and treatment responses must be documented in clients' health records.

The ROP tests for compliance:

1. The organization assess each client for risk of suicide at regular intervals, or as needs change
2. The organization identifies clients at risk for suicide
3. The organization addresses the clients immediate safety needs
4. The organization identifies treatment and monitoring strategies to ensure client safety
5. The organization documents the treatment and monitoring strategies in the client's health record.

Use the longer Framework document to take the following steps in order to align a service to the Suicide Risk Management ROP.



Assessment

Services are expected to align themselves to best practice in suicide assessment by the following ROP tests for compliance:

1. The organization assesses each client for risk of suicide at regular intervals, or as needs change
2. The organization identifies clients for risk of suicide

This Framework does not endorse a specific tool or method of assessing risk for suicide. Instead, psychiatric and nursing practice guidelines are summarized to provide a common foundation for HA representatives to select the best assessment protocol for their population. Representatives will ultimately need to weigh the risks, costs and benefits of selecting and using an instrument as part of a suicide risk management protocol for their respective sites and programs.

There is general agreement that, regardless of the individual approach a program may follow, the approach should have the following key points: The approach should be guided by peer reviewed, published research, risk and resilience should be considered in the context of multiple domains, both chronic and acute risk factors should be assessed, protective factors should be taken into account, current suicidal thinking should be thoroughly explored, and all these pieces should be considered in the context of making an informed judgment of an individual's level of risk.

The gold standard for a psychiatric assessment of suicide risk is a clinical assessment. This assessment should: Assess suicidal ideation, assess suicide plan, assess current or previous attempts, establish a multiaxial diagnosis, and estimate the suicide risk via acute, chronic and protective risk factors. A standardized tool may be used to aid the assessment, but should not replace it. The three steps recommended for suicide risk management for nurses and other health care providers are: 1) ensure safety of self and client, 2) conduct comprehensive risk assessment, and 3) mobilize resources for monitoring and treatment. For individuals with chronic or recurring self-injurious behaviours, each act needs to be re-assessed considering the context in which it occurred and the situational factors that may have led to the recent behaviours.

These steps for assessing suicide risk should be adapted as needed depending on the population at hand. For example, special considerations should be made for populations across various levels of care, (emergency, inpatient and outpatient groups), children and youth, geriatrics, and clients with co-occurring mental health and substance use problems. Unique issues in each of these populations are reviewed.

General Risk & Protective Factors for Suicide [1]

Demographic or Social Factors:

- Older adult
- Male gender
- Poverty
- Aboriginal, especially youth aged 12-24
- White race (APA, 2003)
- Gay, lesbian or bisexual orientation (APA, 2003)
- Single status (widow, divorced, separated, single)
- Social isolation, including new or worsening estrangement, and rural location
- Economic or occupational stress, loss, or humiliation
- New incarceration
- History of gambling
- Easy access to firearms

1 Source: Murray & Hauenstein (2008), in RNAO, 2008 *Adaptations by RNAO in italics

Clinical Factors:

- Past and current major psychiatric illness, including bipolar, schizophrenia and major depressive disorder (especially depression)
- Personality disorder (borderline, narcissistic, antisocial)
- Impulsive or violent traits by history
- Current medical illness
- Family history of suicide
- Previous suicide attempts or other self-injurious or impulsive acts
- Current anger, agitation, or constricted preoccupation
- Current abuse of alcohol or drugs (including solvents)
- Easy access to lethal toxins (including prescribed medication)
- Formulated plan, preparations for death or suicide note
- Low ambivalence about dying versus living
- Childhood trauma (sexual abuse, physical abuse) (APA, 2003)
- Suicidal Ideas (current or previous)
- Suicidal intent (APA, 2003)
- Hopelessness (APA, 2003)
- Severe or unremitting anxiety (APA, 2003)
- Panic Attacks (APA, 2003)
- Impulsiveness (APA, 2003)
- Aggression (APA, 2003)

Precipitants:

- Recent stressors (especially losses of emotional, social, physical, or financial security)

Protective Factors:

- Intact social supports
- Active religious affiliation or faith (may be a risk factor if shame/guilt about behaviour is involved)
- Marriage and presence of dependent children
- Ongoing supportive relationship with a caregiver
- Positive therapeutic relationship (APA, 2003)
- Absence of depression or substance abuse
- Access to medical and mental health resources
- Impulse control
- Proven problem-solving and coping skills
- Pregnancy (APA, 2003)
- Life satisfaction (APA, 2003)
- Relief about not completing suicide (NZGG, 2003)
- Sense of 'unfinished business' (NZGG, 2003)
- Good self-esteem, self-confidence (NZGG, 2003)
- Awareness of significant others about their suicidal thoughts (NZGG, 2003)
- Sense of belonging (Sargent, Williams, Hagerty, Lynch-Sauer & Hoyle., 2002)

Presence of risk and protective factors should be noted in the patient's chart as part of the risk assessment. The assessment of risk should always take place within the context of a comprehensive exam.

Risk Factors & Checklist: Adolescents

HIGH-RISK FACTORS FOR SUICIDE IN ADOLESCENTS				
Immediate risk predicted by agitation and major depressive disorder				
Males HIgher Risk	Overall	Previous suicide attempts Age 16 or older Associated mood disorder Associated substance abuse	Females	Mood disorders Previous suicide attempts

CHECKLIST FOR ASSESSING CHILD OR ADOLESCENT SUICIDE ATTEMPTERS IN AN EMERGENCY ROOM OR CRISIS CENTER	
Suicidal history	Still thinking about suicide
	Made a prior suicide attempt
Demographics	Male
	Lives alone
Mental state	Depressed, manic, hypomanic, severely anxious, or mixture of these states
	Substance abuse alone or in association with a mood disorder
	Irritable, agitated, threatening violence to others, delusional, or hallucinating

Do not discharge such patients without psychiatric evaluation.

Look for:

SIGNS OF CLINICAL DEPRESSION	SIGNS OF MANIA OR HYPOMANIA
Depressed mood most of the time	Depressed mood most of the time
Loss of interest or pleasure in usual activities	Elated, expansive, or irritable mood
Weight loss or gain	Inflated self-esteem, grandiosity
Can't sleep or sleeps too much	Decreased need for sleep
Restless or slowed-down	More talkative than usual, pressured speech
Fatigue, loss of energy	Racing thoughts
Feels worthless or guilty	Abrupt topic changes when talking
Low self-esteem, disappointed with self	Distractible
Feels hopeless about future	Excessive participation in multiple activities
Can't concentrate, indecisive	Agitated or restless
Recurring thoughts of death	Hypersexual, spends foolishly, uninhibited remarks
Irritable, upset by little things	

Interview Questions for the Assessment of Suicidal Ideation and Plan (Adults and Older Adults [2])

Here are some suggested questions (APA, 2003, NZGG, 2003, in RNAO, 2008) that a mental health clinician might use to ask about a person's suicidal thoughts, plans and behaviours. Always be attentive to and assess both verbal and non-verbal communication, and 'cues' from the person. Not all questions may need to be asked. Although this list of questions is presented in a linear fashion, they are intended to be utilized within an assessment, as a process within a conversation or discussion that flows in the context of the nurse-patient relationship.

A general question about a person's thoughts and feelings about living is frequently a recommended start to this discussion:

- *Sometimes people feel that life is not worth living. Can you tell me how you feel about your own life?*
- *What are some of the aspects of your life that make it worth living?*
- *What are some of the aspects of your life that may make you feel or think that your life is not worth living?*
- *Do you find yourself wishing for a permanent escape from life?*
- *How would that happen for you? What might you do to achieve that?*

It is important to continue with additional questions that are actually about self-harm, suicide and death. Even if the response to the previous questions tend to affirm the person's value for his/her own life, those responses may not be consistent or congruent with other assessment information you have for this person, so assess for suicidal ideation and behaviour more specifically:

- *Do you think about your own death or about dying?*
- *Have you ever thought of harming yourself or trying to take your own life?*
- *Do you think or feel this way presently?*

If the person expresses thoughts of self-harm, and/or suicide, or even if he/she seems ambivalent (e.g. says "I don't know," or "I don't remember" or "maybe, I'm not sure"), continue with these questions as ambivalence between wanting to live and die is very common in suicidal ideation and behaviour and does not necessarily equate to no thoughts or behaviours. Be attentive to the person's cues, as not all questions may need to be asked.

- *When did you begin to experience these thoughts and feelings?*
- *What happened before you had them?*
- *Were there events in your life that preceded this such as a sudden loss or feelings of depression?*
- *How frequently have you had these thoughts and feelings?*
- *Do these thoughts intrude into your thinking and activities?*
- *How strong are they?*
- *Can you describe them?*
- *Can you stop yourself from having them by distracting yourself with an activity or other more positive thoughts?*
- *Have you ever acted upon these thoughts?*
- *If not, what stopped you from acting on them?*
- *Do you think you might act on these thoughts of self-harm or suicide in the future?*

2 A more comprehensive review of geriatric assessment issues is provided in the longer Framework document.

- *What might help you from acting on them?*
- *If you did take your own life, what do you imagine would happen after you die to those people who are important to you?*
- *Do you have a plan to harm yourself or take your own life? If so – describe your plan*
- *Do you have those methods available to you to take your life, such as over the counter pills, prescription pills, knives or proximity to a balcony, bridge or subway?*
- *Have you prepared for your death by writing a note, making a will, practicing the plan, putting your affairs such as your finances in order, or ensuring privacy such that you would unlikely be discovered?*
- *Have you told anyone that you are thinking about taking your own life or are planning to do this?*

If a person has attempted suicide or engaged in self-harm behaviour(s), ask additional questions to assess circumstances surrounding the event(s):

- *What happened in your previous attempts to self-harm or take your life? What led up to it? Were you using alcohol or other substances? What method did you use? Sometimes people have many reasons for harming themselves in addition to wanting to die. What might have been some of your reasons for self-harm or suicide? How severe were your injuries?*
- *What were your thoughts just before you harmed yourself?*
- *What did you anticipate would be the outcome of your self-harm or suicide attempt? Did you think you would die?*
- *Were other people present when you did this?*
- *How did you get help afterward? Did you look for it by yourself or did someone else help you?*
- *Did you anticipate that you might be discovered? If not, were you found accidentally?*
- *How did you feel after your attempt? Did you feel relief or regret at being alive?*
- *Did you receive treatment after your attempt? Did you get medical and/or psychiatric, emergency help?*
- *Were you assessed in an emergency department? Were you cared for in an inpatient/outpatient department?*
- *How do you think and feel about your life now? Have things changed for you? Do you see your life in the same way or differently?*
- *Are there other times in the past when you've tried to harm (or kill) yourself?*

For individuals with repeated suicidal thoughts or attempts:

- *How many times have you tried to harm yourself, or tried to take your own life?*
- *When was the most recent time?*
- *What were your thoughts and feelings at the time that you were most serious about suicide?*

Assess reasons for living or protective factors for this person:

- *How do you feel about your own future?*
- *What would help you to feel or think more positively, optimistically or hopefully about your future?*
- *What would make it more (or less) likely that you would try to take your own life?*
- *What happens in your life to make you wish to die or escape from life?*
- *What happens in your life to help you to want to live?*
- *If you began to have thoughts of harming or killing yourself again, what would you do to prevent them?*

For individuals with psychosis, ask specifically about hallucinations and delusions:

- *Can you describe the voices you hear?*
- *Can you tell if they are male or female?*
- *Can you stop the voices?*
- *What do the voices say to you? Do they say anything positive, or do they say negative or hurtful things to you? Do they threaten you or anyone else?*
- *How do you cope with the voices? Do you do anything about them?*
- *Have there been times when the voices told you to hurt or kill yourself? How frequently has this happened? What happened?*

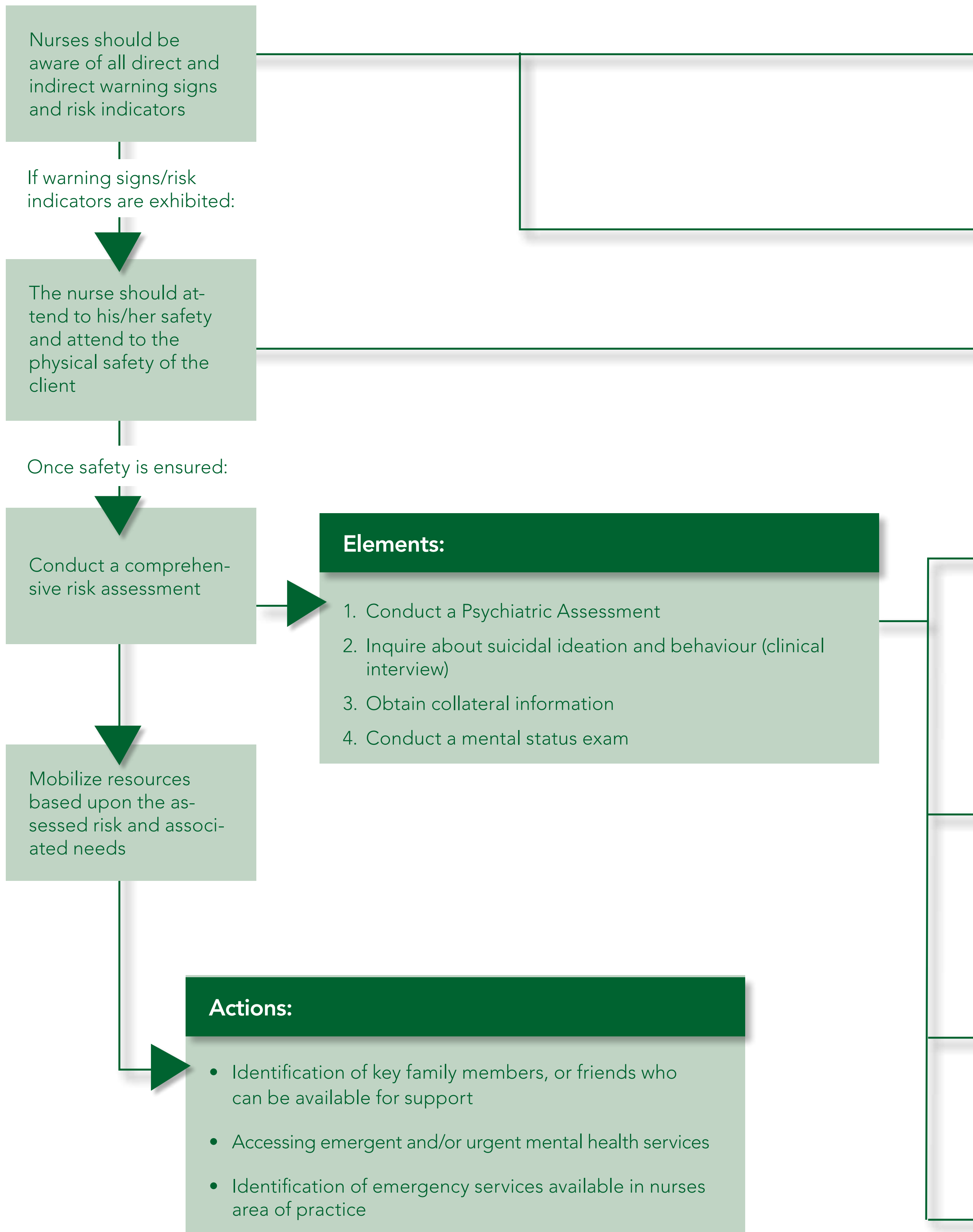
Key Questions for the Assessment of Suicidal Ideation and Plan (Children and Youth [3])

The AACAP give a list of key questions to ask children and adolescents who may be considering suicide. Questions include:

- *Did you ever feel so upset that you wished you were not alive or wanted to die?*
- *Did you ever do something that you knew was so dangerous that you could get hurt or killed doing it?*
- *Did you ever hurt yourself or try to hurt yourself?*
- *Did you ever try to kill yourself?*
- *Did you ever think about or try to commit suicide?*

3 A more comprehensive review of child and adolescent assessment issues is provided in the longer Framework document.

COMPLETE NURSING ASSESSMENT (RNAO Best Practice Guidelines, 2009)



Warning Signs May Include:

- Talking about suicide or death directly (e.g. I wish I was dead)
- Talking about suicide or death indirectly (e.g. "What's the point of going on?")
- Formation of suicide plan
- Putting affairs in order
- Purchasing or stockpiling medications, firearms, razors
- Exploring balconies, bridges, rooftops

Risk indicators:

include being male, elderly, hopeless, previous suicide attempts, substance use, past and current psychiatric illness.

Potential Hazards:

clothing, cords, plastic bags, sharp or glass objects, medications, oxygen therapy devices

1. Psychiatric assessment components:

- Presenting Problem – from the patient's perspective
- History of present illness (duration, severity)
- Past psychiatric history (hospitalizations, dates, diagnoses)
- Current and past medications, drug allergies
- Substance use, forensic, psychosocial and family history
- Nursing Diagnosis

2. Example clinical interview questions:

- Has anything been troubling you?
- Have you ever felt like life is just getting on top of you?
- Do you sometimes wish you could just make it all stop?
- Have you ever wished you were dead?
- Have you ever thought about taking your own life?

3. Examples of questions for acquiring collateral information:

- Are they their usual self?
- Have they made any comments that they would be 'better off dead'? Any statements about 'things getting better'?
- Have you been worried about them? Do they seem depressed?
- Are they drinking more than usual?

4. Conduct a mental status exam:

Include appearance, behaviour, attitude, affect, mood, psychomotor activity, speech, thought content, thought process, perception, orientation, insight, judgment, cognition

Mental Status Assessment

APPEARANCE	
Age, Sex, Race	Grooming
Body Build	Manner
Position	Attentiveness to examiner
Posture	Distinguishing features
Eye contact	Prominent physical irregularity
Dress	Emotional facial expression
Alertness	

MOTOR BEHAVIOUR	
Retardation	Gait
Agitation	Catatonia
Unusual Movements	

SPEECH	
Rate	Amount
Rhythm	Articulation
Volume	Spontaneity

MOOD/AFFECT	
Stability	Intensity
Range	Affect
Appropriateness	Mood

THOUGHT CONTENT	
Suicidal or homicidal ideations	Paranoid ideation
Depressive cognition	Magical ideation
Obsessions	Delusions
Ruminations	Overvalued ideas
Phobias	Thought broadcasting, insertion or withdrawal
Ideas of reference	Other major themes discussed by patient/client

THOUGHT PROCESS	
Perseveration	Neologism
Logic	Blocking
Stream	Attention
Coherence	

PERCEPTION	
Hallucinations	Depersonalization
Illusions	Déjà vu, Jamais Vu

COGNITION	
Orientation	Abstract Thought
Memory	Capacity to read and write
Intellect	Level of consciousness

INSIGHT/JUDGEMENT	
Ability to make a decision wisely considering the pros and cons for a course of action	Awareness of illness

In order to develop the most appropriate clinical protocol for a service site, clinical and administrative leaders will need to select the best suicide risk management assessment and treatment tools. The following matrices provide summary overviews of brief assessment tools, and in-depth assessment and treatment protocols, broken down by service level and population. A more complete listing of brief assessment tools are found in Appendix A and B of the longer Provincial Suicide Clinical Framework document.

Brief Assessment Tool Decision Support Matrix

<table>
<tr><th></th><th>CHILDREN</th><th>ADOLESCENTS</th><th>ADULTS</th><th>GERIATRIC</th></tr>
<tr><td>Urgent/Emergency</td><td rowspan="3">Child Hopelessness Scale</td><td rowspan="3">Beck Hopelessness Scale

Risk of Suicide Questionnaire

Beck Suicide Intent Scale**</td><td rowspan="3">Beck Hopelessness Scale

Scale for Suicide Ideation

Beck Suicide Intent Scale**

Linehan Reasons for Living Inventory++</td><td>None identified</td></tr>
<tr><td>Inpatient/Day</td><td rowspan="2">Hamilton Rating Scale for Depression (Suicide Item)#

Geriatric Suicidal Ideation Scale

(Heisel & Flett, 2006) ##</td></tr>
<tr><td>Tertiary Care</td></tr>
<tr><td>Outpatient/ Community</td><td>Child Suicide Potential Scales

Hopelessness Scale for Children</td><td>Beck Hopelessness Scale

Hopelessness Scale for Children

IS PATH WARM</td><td>Scale for Suicide Ideation

IS PATH WARM

SAD PERSONS</td><td>ung Depression Scale ##

Geriatric Suicidal Ideation Scale

SAD PERSONS</td></tr>
<tr><td>Withdrawal Management</td><td>None identified</td><td>IS PATH WARM</td><td>Beck Hopelessness Scale

IS PATH WARM</td><td>None identified</td></tr>
<tr><td>Residential Programs</td><td>Identified</td><td>Suicide Probability Scale*

IS PATH WARM</td><td>Scale for Suicide Ideation</td><td>Geriatric Suicidal Ideation Scale</td></tr>
</table>

* Tested on group home adolescents but the properties are not strong; see complete review in Appendix A.

**Only for those who have attempted suicide.

++ Not tested in an emergency environment.

The properties are not strong, see complete review in Appendix B.

Not reviewed in appendices; see reference list for sources.

Assessment Protocol Decision Support Matrix

<table>
<tr><th></th><th>CHILDREN/ADOLESCENTS</th><th>ADULTS</th><th>GERIATRIC</th></tr>
<tr><td>Urgent/Emergency</td><td rowspan="4">AACAP Protocol</td><td rowspan="3">APA Protocol
St. Michael’s Hospital Protocol
NZGG Clinical Toolkit (Assessment)
RNAO Protocol</td><td rowspan="4">CCSMH Protocol</td></tr>
<tr><td>Inpatient/Day</td></tr>
<tr><td>Tertiary Care</td></tr>
<tr><td>Outpatient/ Community</td><td>APA Protocol
CARMHA Clinical Toolkit (Assessment)</td></tr>
<tr><td>Withdrawal Management</td><td rowspan="2">None identified</td><td rowspan="2">Treatment Improvement Protocol (CSAT) (Assessment)</td><td rowspan="2">None identified</td></tr>
<tr><td>Residential Programs</td></tr>
</table>

Treatment

A treatment plan should include level of care (e.g., inpatient, outpatient and day treatment), level of observation (levels of care and observation are reviewed in the Monitoring section, below), diagnosis, medications, privileges, discharge planning and follow-up to community services. The appropriate steps for treatment planning are: Collect data, identify range of treatment alternatives and select based on assessment and judgment of the individual circumstances, involve client and caregiver perspectives into the plan, and include existing treatment modalities. Next, review family and individual treatments, incorporate the most promising treatment into the process, choose appropriate levels of observation, supervision and privileges, and document the process. Nurses and other health care providers should utilize effective communication and mutual problem-solving techniques.

Therapeutic approaches should target the Axis I and Axis II diagnoses (as appropriate) and their specific symptoms using a combination of somatic therapies and psychosocial interventions when appropriate. Approaches can include psychotropic medications and electroconvulsive therapies. There is a substantial evidence base to support the use of psychotherapy in the treatment of non-psychotic depressive disorder and borderline personality disorder, both of which are associated with increased suicide risk.

Special population considerations need to be made across diagnostic categories, including concurrent disorders, and various populations, including youth and geriatrics. The AACAP (2001, p.28S) qualify that: …”it is the impression of many clinicians that the majority of (youth) suicide attempters and their families benefit from straightforward interventions dictated by the child or adolescent’s mental state and family circumstances.” For children and youth, family therapy is often advocated as the most appropriate means for intervening in suicidal behaviour and depression in youth. Psychotherapy should be considered and tailored to the child’s needs, and Selective Serotonin Reuptake Inhibitors [SSRIs]) or lithium may be helpful for some children and youth.

Research suggests that the best way to decrease suicide risk among elderly individuals is to treat the underlying psychiatric disorder, which is typically depression. Research supports the use of SSRIs (e.g., Citalopram) and psychotherapy in the context of collaborative care for the treatment of major depressive symptoms in older adu*lts*.

Treatment Protocol Matrix

<table>
<tr><th></th><th>CHILDREN/ADOLESCENTS</th><th>ADULTS</th><th>GERIATRIC</th></tr>
<tr><td>Urgent/Emergency</td><td rowspan="4">Medication
Cognitive Behavioural Therapy (CBT)
Dialectical Behavioural Therapy (DBT)
Family Support
Interpersonal Therapy (IPT)
Skills Training</td><td rowspan="4">Medication
RNAO client-centred problem solving
CBT
Gatekeeper Training
Skills Training
DBT</td><td rowspan="4">Medication
RNAO client-centred problem solving
CBT
Gatekeeper Training
IPT</td></tr>
<tr><td>Inpatient/Day</td></tr>
<tr><td>Tertiary Care</td></tr>
<tr><td>Outpatient/ Community</td></tr>
<tr><td>Withdrawal Management</td><td>None identified</td><td>CSAT Treatment Improvement Protocol (Treatment)</td><td>None identified</td></tr>
<tr><td>Residential Programs</td><td>None identified</td><td>None identified</td><td>None identified</td></tr>
</table>

Monitoring

Monitoring includes hospital environmental safeguards (features on the unit that limit patients' access to the means for self-harm), observation policies and procedures, interdisciplinary management and education. For patients identified at risk for suicide, the clinical team needs to determine the appropriate setting (e.g., outpatient, inpatient) and address immediate safety needs through safety interventions (e.g., specialized unit, level of observation). After ensuring the patient's immediate safety needs, the recommended steps are to establish therapeutic alliance, coordinate treatment planning with multiple clinicians and patient, monitor patient progress and response to treatment plan, re-assess (as needed) the patient's safety, psychiatric status and functioning, and initiate education to patients, family and significant others.

Nurses and other health care providers require effective communication and interviewing skills, awareness of warning signs, risk and protective factors, knowledge and use of a problem-solving approach, collaboration with the health care team (including knowing when experts should be consulted), standardized documentation, clear communication and guided decision-making. The organization should provide support and education for direct care staff to stay current with best and promising practice and develop professional competencies. In addition to basic education, other tools such as clinical supervision, mentoring and observation should be utilized to actively support novice direct care staff.

British Columbia Mental Health and Addiction Services (BCMHAS) recommends that inpatient units adopt a common observation policy and procedure. A suggested observation policy is presented in the longer Framework document using terminology from the New Zealand Guidelines Group (2003) and the National Institute for Clinical Excellence (2005, 2006). Having a common and standardized language regarding levels of observation should improve clarity regarding who can initiate changes to a patient's level, as well as explicitly link each level of observation to levels of risk.

Children and adolescents with acute suicidal ideation or attempts are frequently first evaluated and treated in an emergency setting, which provides an important triage function for subsequent inpatient or outpatient treatment. Discharge from an emergency setting can be considered if the clinician is satisfied that adequate supervision and support will be available in the home environment, and a referral is made to community mental health services. Older adults with more severe suicidal ideation and/or a history of self-harm behaviours have symptoms that are resolved more slowly, less completely and are more prone to relapse. As such, continued vigilance is needed for geriatric patients (and indeed, patients of all ages) throughout the period of recovery from depression.

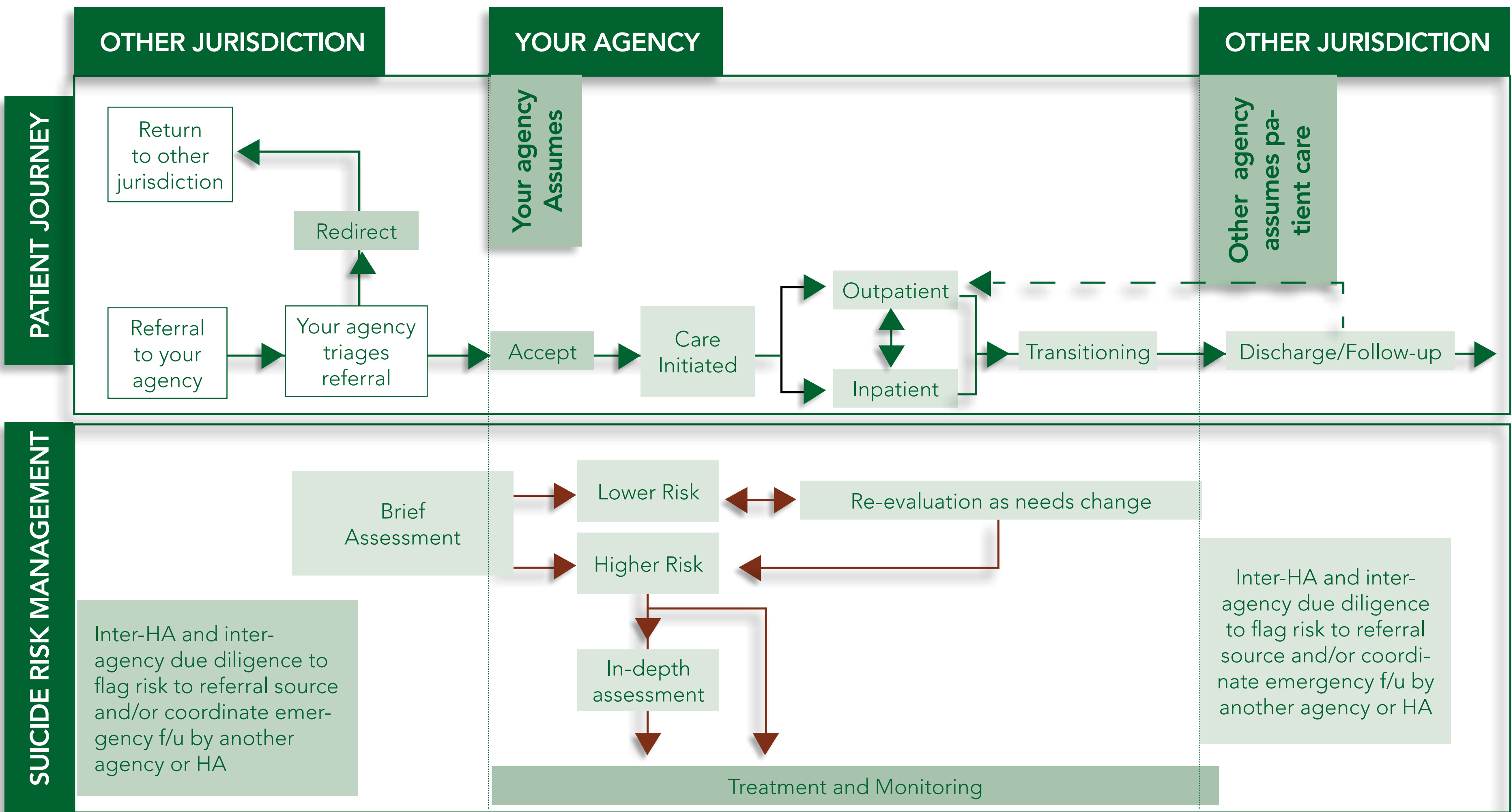
Continuity & Transfer of Care

Effective suicide risk management requires explicit documentation policies and procedures at each stage of the patient journey, including transfer of care within and across agencies. Documentation is a standard of clinical practice and is an integral part of the assessment and care of clients at risk for suicidal ideation and behaviour. Clear documentation facilitates communication within the team and during transfer of care to another agency or organization. Transfer of care documentation practices and policies should include the degree of suicide risk, and treatment and monitoring strategies when appropriate. Policies and procedures related to these issues should be routinely audited to ensure compliance.

Although there is no consensus on a standardized way to document suicide risk management strategies, it is recommended that organizations develop policies to ensure that a systematic process is adopted. Each service will need to ensure that they have documentation policies and practices that cover screening results for every patient in contact with services, and when appropriate, the program's response to immediate safety needs (e.g., observation/security levels), clinical assessment results and treatment plan and on-going monitoring activities.

The Chart below provides an overview of how organizations are required to respond to suicide risk at each stage of the patient journey.

Patient Journey and Required Organizational Response



Putting it Together

The full Provincial Suicide Clinical Framework is intended to provide mental health and addiction services leaders with the background information and steps for developing a suicide risk management clinical protocol that aligns with best practice and complies with Accreditation Canada's new ROP. This next section provides the practical steps to develop a clinical protocol for use in a particular site or service (e.g., adult concurrent disorder outpatient clinic, adolescent inpatient unit).

Accreditation Canada provides latitude for services to conduct suicide risk management activities that best meets the needs of the clients they serve (e.g. youth, adults). Organizations should be able to provide evidence to the Surveyors that they are regularly assessing for risk and a rationale for why they are using a particular approach.

Protocol Development Template

Best practice in suicide risk management is to assess, treat and monitor all clients in mental health and addiction for risk of suicide, and document those activities in the patients' charts. An inter-Health Authority Steering Committee was struck to develop a Framework and companion Template to assist clinical programs across the province to standardize their risk management protocols. Since no single protocol would be appropriate across all patient populations, clinical and administrative program leaders will need to develop a clinical protocol that is appropriate for the population they serve. This clinical protocol can be developed by using the following template.

Instructions:

This template has four sections (assessment, treatment, monitoring, and continuity/transfer of care) with two steps each. In each section the user conducts a gap analysis by comparing the target service to the ROP test for compliance. Second, the user should refer to the best and promising practice literature review in the Framework to identify the most appropriate response for the service.

Assessment

Protocol Development Template

STEP 1: GAP ANALYSIS

ROP Tests for Compliance	Current Practice	Analysis
The organization assesses each client for risk of suicide at regular intervals, or as needs change The organization identifies clients for risk of suicide	What assessment protocol(s) are already in place?	Does the current protocol meet the test for compliance?
	When are those at risk of suicide re-assessed?	
	List policy numbers	
	Where in the patient chart is the assessment information documented?	Fill in areas of action, where applicable

STEP 2: AREAS OF ACTION

	Brief Assessment	In-Depth Assessment
WHO	Who will perform and document the brief assessment?	Who will perform the in-depth assessment?
WHERE	Where in the chart will the brief assessment be documented?	Where in the chart will the brief assessment be documented?
WHEN	How is suicide risk communicated within the agency? How is suicide risk communicated across agencies?	When will an in-depth assessment be required? If other, describe:
WHAT	List relevant continuity/ ToC policies	What physician assessment will be used, if any?

Treatment

Protocol Development Template

STEP 1: GAP ANALYSIS

ROP Tests for Compliance	Current Practice	Analysis
The organization identifies treatment and monitoring strategies to ensure client safety The organization documents the treatment and monitoring strategies in the client's health record.	What treatment protocol(s) are already in place?	Does the current protocol meet the test for compliance?
	List policy numbers	
	Where in the patient chart is the treatment information documented?	Fill in areas of action, where applicable

STEP 2: AREAS OF ACTION

	Brief Assessment
WHO	Who will document the treatment plan?
WHERE	Where in the chart will the treatment plan be documented?
WHEN	What are the best practice options or clinical pathways for your population?

Monitoring

Protocol Development Template

STEP 1: GAP ANALYSIS		
ROP Tests for Compliance	**Current Practice**	**Analysis**
The organization assesses clientts' immediate safety needs.	What treatment monitoring protocol(s) are already in place?	Does the current protocol meet the test for compliance?
The organization identifies treatment and monitoring strategies in the client's health record.	What observation policies/ protocols are already in place?	Fill in areas of action, where applicable
	List monitoring policy numbers	
	Where in the patient chart is the monitoring information documented?	

STEP 2: AREAS OF ACTION	
	Monitoring
WHO	Who can initiate or change an observation level? Who will document monitoring activities (select up to two)?
WHERE	WWhere in the chart will monitoring activities be documented?
HOW	How will patient progress or decompensation be re-assessed / monitored?
WHEN	When will patients be re-assessed for risk?
WHAT	List monitoring policies

Continuity & Transfer of Care

Protocol Development Template

STEP 1: GAP ANALYSIS		
ROP Tests for Compliance	**Current Practice**	**Analysis**
The organization identifies clients for risk of suicide	How is suicide risk communicated within the agency?	Does the current protocol/ policy related to documentation ensure patient safety in regards to suicide risk management?
The organization documents the treatment and monitoring strategies in the client's health record.	How is suicide risk communicated across agencies?	
	List policy numbers	Fill in areas of action, where applicable

STEP 2: AREAS OF ACTION	
	Continuity/Transfer of Care
WHO	Who is responsible for communicating suicide risk within the agency? Who is responsible for communicating suicide risk across agencies?
WHERE	Where in the chart will continuity/ToC communication be documented?
HOW	How is suicide risk communicated within the agency? How is suicide risk communicated across agencies?
WHAT	List relevant continuity/ToC policies

Online Clinical Toolkits

There are a number of excellent resources that mental health and addiction service providers may wish to draw upon for developing a clinical protocol. The following clinical toolkits cover a broad range of service levels (emergency, outpatient, inpatient), but are only applicable for adult services. Youth service providers may find helpful the family handout published by the NZGG (item #7 below). These resources are publicly available and online.

Government of British Columbia Resources

The Ministry of Health (MoH), the Ministry of Child and Family Development (MCFD) and the Centre for Applied Research in Mental Health and Addiction (CARMHA) have developed a number of publicly-available resources that provide excellent suicide risk management information and tools for use in a health care setting. These are useful resources that service providers may choose to incorporate into a suicide risk management protocol. Implementing these resources alone, however, would not ensure a service is compliant with Accreditation Canada's ROP related to suicide risk management. To ensure compliance, a service should follow the steps provided in the longer Framework document.

1. "Working with a Client who is Suicidal" is a comprehensive document that provides planners and direct care providers with recommended assessment and treatment practices for working with adults at risk for suicide. The complete tool kit is available for download from here:

   http://www.health.gov.bc.ca/library/publications/year/2007/MHA_WorkingWithSuicidalClient.pdf

2. MCFD developed the Preventing Youth Suicide website, which is updated annually following a review of the literature. It is a great source of recent, relevant literature and written specifically for child and youth mental health practitioners.

   http://www.mcf.gov.bc.ca/suicide_prevention/index.htm

3. "Working with the Suicidal Patient: A Guide for Health Care Professionals" is a 2-page tool for the assessment and management of suicidality in adults, available here:

   http://www.comh.ca/publications/resources/pub_wwsp/WWSP.pdf

4. "Coping with Suicidal Thoughts" is a brief worksheet intended for those who are experiencing suicidal thoughts, have a suicide plan, or who have recently attempted suicide. The worksheet is available here:

   http://www.comh.ca/publications/resources/pub_cwst/CWST.pdf

New Zealand Guidelines Group Resources

The New Zealand Guidelines Group has similarly published some helpful tools for mental health and addiction service providers, related to suicide risk management.

1. The Rapid Assessment of Patients in Distress a brief assessment tool for use in a general emergency room:

   http://www.nzgg.org.nz/guidelines/0005/Appendix_1_RAPID_Tool.pdf

2. The Assessment and Management of Suicidal clients in an Emergency Department includes helpful suggestions for assessment, sedation, discharge and handover procedures, and a triage protocol:

   http://www.nzgg.org.nz/guidelines/0005/Suicide_Summary.pdf

3. An assessment and management algorithm is available for acute assessment settings:

   http://www.nzgg.org.nz/guidelines/0005/ACF67B.pdf

4. An assessment tool for general use in mental health services is available here:

   http://www.nzgg.org.nz/guidelines/0005/Appendix_2_Assessment_Risk.pdf

5. A tool for examining a person's mental state is available here:

   http://www.nzgg.org.nz/guidelines/0005/Appendix_3_Mental_State_Examination.pdf

6. The Psychiatric/Psychosocial Assessment Tool is intended to assist psychiatrists and psychologists as part of a clinical assessment:

   http://www.nzgg.org.nz/guidelines/0005/Appendix_4_Psychiatric_Psychosocial.pdf

7. A handout for families and caregivers of a person who may be at risk for suicide, to ensure a safe home environment:

   http://www.nzgg.org.nz/guidelines/0005/Appendix_5_Safe_Home.pdf

8. A helpful list of risk factors for clinicians to consider:

   http://www.nzgg.org.nz/guidelines/0005/Appendix_7_Risk_Factors.pdf

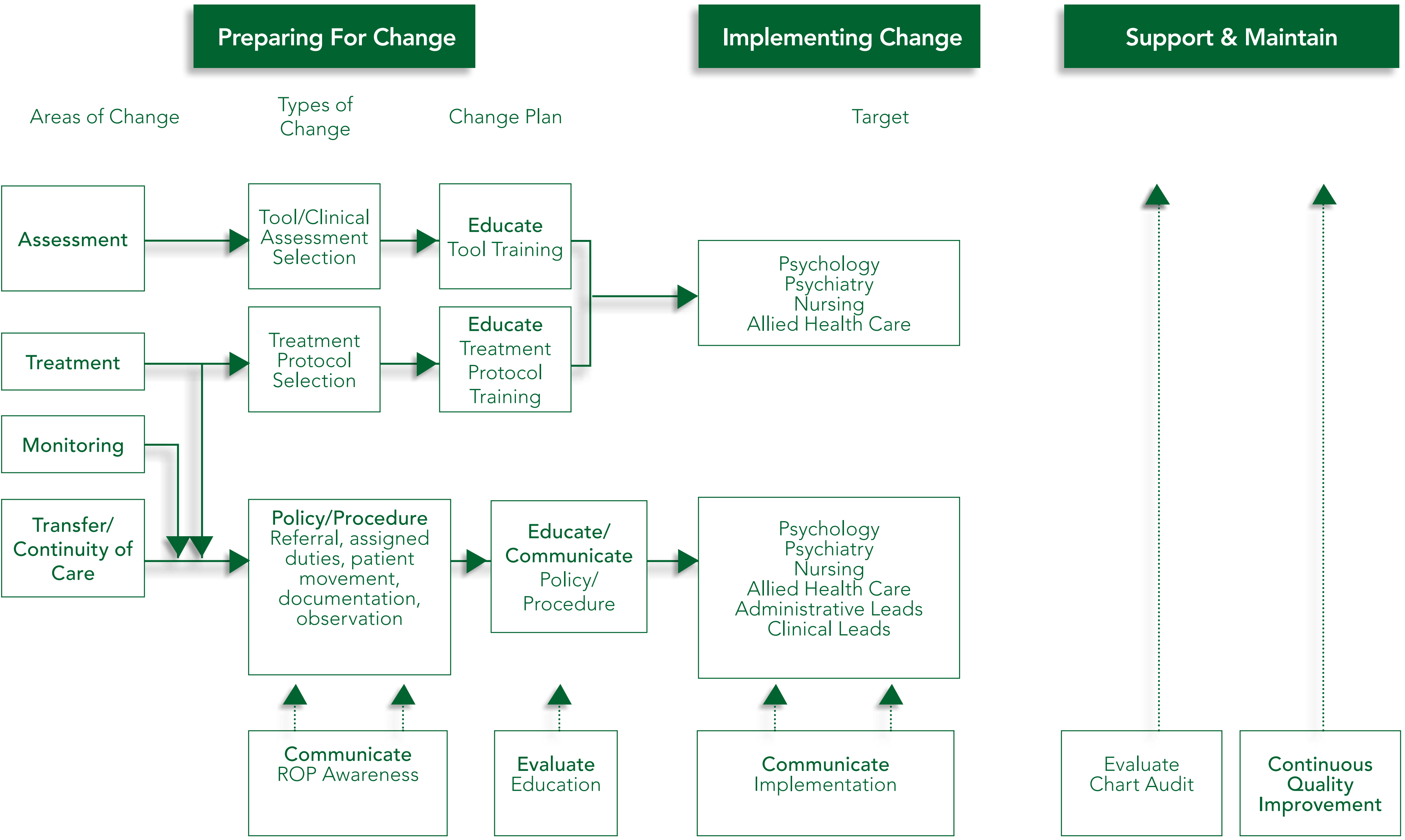
Action Roadmap

The action plan developed for the Framework is intentionally broad so that it can be adapted for use at heterogeneous sites. It is an evidence-informed roadmap of the steps to implementation for those developing a clinical protocol for a specific population.

BC Mental Health and Addiction Services has developed a Change Management Model. This application centres on preparing, implementing and maintaining changes in the context of suicide risk management. The first four steps suggested by the model (consent to change, understanding current context, specifying outcomes and assessing readiness for change) are required pieces that each program undertakes within the organization. The application of the final three steps is illustrated in the chart on page 26.

As part of understanding the change context, a program conducts a gap analysis and develops a clinical protocol using the Protocol Development Template. The areas of action that emerge in assessment, treatment, monitoring and documenting (continuity and transfer of care) provide the types of change to be implemented. For example, a change in the area of treatment requires protocol and policy changes, as well as clinical education for staff. The target of the change will depend on the areas and types of change. The action roadmap stresses the importance of evaluation and continuous quality improvement to ensure that changes are maintained over time.

Implementing & Maintaining Change



Evaluation Template

The ROP requirements related to suicide risk management are to assess, treat, and monitor all patients in contact with mental health services, and to document those activities in a designated place in the patient chart. It is expected that some services have many or all of these ROP components in place, and others will need to implement numerous changes to their service. Those changes should be rolled out via an education plan, and the evaluation outcomes should be linked with the goals of that plan.

This evaluation template is comprehensive in scope so that sites and programs can select the components that are targeted for change and disregard the components that are already in place within the service. For example, if a service already has an observation policy related to suicide risk, but no defined clinical pathway for severe depression, the evaluation should only target the implementation and outcomes related to a new clinical pathway.

In summary, the evaluation should:

1. Assess the degree of compliance to the Required Organizational Practices through auditing procedures,
2. Assess the process of the implementation and uptake of any change related to the current initiative, through auditing procedures and staff interviews as needed, and
3. Assess the degree to which initiative achieved its project and education goals, through auditing procedures and monitoring outcome indicators.

The studies are reviewed in greater detail in Appendix G of the longer Framework document, and the common themes are summarized in the table below.

Suicide Risk Management Program Outcomes and Methods

OUTCOMES	METHOD / MEASURE	REFERENCE
Staff Knowledge	Focus groups Self-developed scale	Chan et al., 2008 Chan et al., 2009 Simpson et al., 2003 McAuliffe & Perry, 2007 Shim & Compton, 2009 Chan et al., 2009
Intermittent Observation	Attitudes to Suicide Prevention Scale (ASP) Focus groups Self-developed scale Semi-structured interview – telephone – face-to-face Suicide Opinion Questionnaire (SOQ)	Appleby et al., 2000 Gask et al., 2006 Chan et al., 2008 Chan et al., 2009 Simpson et al., 2003 Fenwick et al., 2004 Shim & Compton, 2009 Ramberg & Wasserman, 2004b Gask et al., 2006 Chan et al., 2009

OUTCOMES	METHOD / MEASURE	REFERENCE
Staff Skills	Face-to-face interviews Focus groups Self-developed scale Suicide Intervention Response Inventory Form 2 (SIRI-2) Videotaped role-played interviews	Gask et al., 2006 Chan et al., 2008 Chan et al., 2009 Simpson et al., 2003 McAuliffe & Perry, 2007 Chan et al., 2009 Morriss et al., 1999 Appleby et al., 2000 Fenwick et al., 2004 Gask et al., 2006 Morriss et al., 1999 Appleby et al., 2000 Gask et al., 2006
Staff Confidence and Self-efficacy	Face-to-face interviews Self-developed scale Visual analogue scale	Gask et al., 2006 Fenwick et al., 2004 Ramberg & Wasserman, 2004a McAuliffe & Perry, 2007 Shim & Compton, 2009 Morriss et al., 1999 Appleby et al., 2000 Gask et al., 2006
Impact of Policy/ Protocol on Rates of Suicide and Self-Harm	Quantitative measures Semi-structured telephone interviews	McAuliffe & Perry, 2007 Ramberg & Wasserman, 2004b
Staff	Self-developed scale	Appleby et al., 2000
Satisfaction with Training		Gask et al., 2006

Proposed Logic Model:

Evaluation of the education and clinical components of a Suicide Risk Management Initiative

Project Goal	**Project Objectives**	**Inputs** (resources/ budget lines)	**Activities** (activities, tasks, strategies)	**Outputs** (deliverables)	**Short-Term Outcomes**	**Long-Term Outcomes**
Identify safety risks inherent in client population	To assess each client for risk of suicide at regular intervals, or as needs change To identify clients at risk of suicide To address clients' immediate safety needs To identify treatment and monitoring strategies to ensure client safety To document treatment and monitoring strategies in client's health record	Planning staff resources: executive leadership, project leader, quality analyst, communications, change management & learning and development representatives, sub-committee leads/experts & members, administrative support Implementation staff resources: Planning staff, plus all direct care staff time Material resources: assessment tools	Development and implementation of a suicide risk management protocol for each site/ population Communication initiative developed and implemented	# of sites with developed and implemented protocols % of clients assessed for risk of suicide at intake % of clients assessed for risk at regular intervals, or as needs change % of clients with appropriate documentations of treatment strategies % of clients with appropriate documentations of monitoring strategies	Improved clinical consistency in suicide risk assessment Improved clinical consistency in suicide treatment strategies. Improved consistency of suicide monitoring strategies Improved consistency in documentation practices related to suicide risk management.	Reduction of suicide/self-harm-related safety events within the service

Education Goal	**Education Objectives**	**Inputs** (resources/ budget lines)	**Activities** (activities, tasks, strategies)	**Outputs** (deliverables)	**Short-Term Outcomes**	**Long-Term Outcomes**
Provide staff with the appropriate training to meet project objectives	To increase knowledge related to suicide risk management To increase skills related to suicide risk management To increase confidence related to suicide risk management To demonstrate satisfaction with suicide risk management training	Planning: Learning & development staff time Implementation: L&D staff plus all direct care staff time	Education initiative developed and implemented	# of education sessions % of direct care staff trained	Increased knowledge related to suicide assessment, treatment and monitoring Increased skills related to suicide assessment, treatment and monitoring Increased confidence to assess, treat & monitor suicide risk Satisfaction with training related to suicide risk management	Reduction of suicide/ self-harm-related safety events within the service