CAMH

Suicide

PREVENTION AND ASSESSMENT

HANDBOOK

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

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Preface

The impetus for this project was a new Accreditation Canada Required Organizational Practice (ROP) that requires all mental health services to "assess and monitor clients for risk of suicide" (Accreditation Canada, 2010). An interdisciplinary group of CAMH clinical staff came together to develop methods to meet and exceed this standard. Tests for compliance for this ROP include that the organization:

- assesses each client for risk of suicide at regular intervals, or as needs change
- identifies clients at risk of suicide
- addresses the client's immediate safety needs
- identifies treatment and monitoring strategies to ensure client safety
- documents the treatment and monitoring strategies in the client's health record (Accreditation Canada, 2010).

The *CAMH Suicide Prevention and Assessment Handbook* is a quick, comprehensive and interactive starting point for staff across all clinical programs on the subject of suicide assessment and management. It provides key clinical information, current CAMH tools and resources, and further population-specific resources.

Suicides can and do occur in clinical practice and when clients are in treatment, despite the best efforts at suicide assessment and treatment. Most CAMH clinical staff have either worked directly with or known clients who have completed suicide. Work with suicidal clients and their families and loved ones often presents emotionally difficult experiences for clinicians. In this context, a significant portion of this handbook is devoted to providing staff with suggestions for caring for themselves.

Because CAMH provides services to a highly diverse population of clients, many of whom have specific concerns and needs in regard to suicide assessment and management, readers are encouraged and directed to review the bibliography for further direction and education.

Introduction

It is tempting when looking at the life of anyone who has committed suicide to read into the decision to die a vastly complex web of reasons; and, of course, such complexity is warranted. No one illness or event causes suicide; and certainly no one knows all, or perhaps even most, of the motivations behind the killing of the self. But psychopathology is almost always there, and its deadliness is fierce. Love, success, and friendship are not always enough to counter the pain and destructiveness of severe mental illness.

— *Kay Redfield Jamison (*Night Falls Fast: Understanding Suicide, *1999)*

CAMH clinicians frequently carry responsibility for identifying and preventing suicide. Ninety per cent of people who commit suicide have been diagnosed with a serious mental illness; psychiatric disorders and substance abuse problems have been consistently identified as risk factors for suicide and suicidal ideation (Centre for Applied Research in Mental Health and Addiction, 2007; Jacobs, 2007). In general, the more diagnoses present, the higher the risk of suicide. In a psychological autopsy of 229 suicides: 44 per cent had two or more Axis I diagnoses; 31 per cent had Axis I and Axis II diagnoses; 50 per cent had Axis I and at least one Axis III diagnoses and only 12 per cent had an Axis I diagnosis with no co-morbidity (Jacobs, 2007).

Relative risk (RR) is an epidemiological term that quantifies the risk of an event (or of developing a disease) relative to exposure. Relative risk is a ratio of the probability of the event occurring in the exposed group versus a non-exposed group.

Relative Risk of Suicide in Specific Disorders

CONDITION	RELATIVE RISK OF SUICIDE
Prior suicide attempt	38.4
Eating disorders	23.1
Bipolar disorder	21.7
Major depression	20.4
Mixed drug abuse	19.2
Dysthymia	12.1
Obsessive-compulsive disorder	11.5
Panic disorder	10.0
Schizophrenia	8.45
Personality disorders	7.08
Alcohol abuse	5.86
Cancer	1.80
General population	1.00

- A relative risk of 1 means there is no difference in risk between the two groups.
- A relative risk of < 1 means the event is less likely to occur in the experimental group than in the control group.
- A relative risk of > 1 means the event is more likely to occur in the experimental group than in the control group.

(Adapted from APA Guidelines, part A, p.16. From Jacobs, 2007)

Part I: Suicide Risk Assessment and Prevention

Because of the high incidence of suicidality among clients with mental health and substance use problems, all CAMH clinicians, regardless of discipline, should be able to conduct a suicide assessment and to develop safety and treatment plans and/or be aware of program- and service-specific processes to assess and manage suicidality. Screening, assessment and treatment for suicidality need to be considered at all points of entry into the health care system, in day-to-day clinical practice, or at frequent intervals of care, depending on the treatment setting. The severity of suicide risk assessed should inform the care interventions, levels of observation, ongoing screening and treatment approaches (RNAO, 2009). Health care professionals who lack training and competence in the assessment and treatment of individuals with suicidality have been shown to hinder recovery and the disclosure of suicidality, and to contribute to stigma and poor outcomes (Meerwijk et al., 2010; RNAO, 2009; Pauley, 2008). Therefore, it is essential for professionals to receive adequate training on the screening and assessment of suicidal individuals and for such training to be informed by best practice guidelines (RNAO, 2009).

Suicide risk assessment is critical to the establishment of a clinical judgment of suicide risk over short periods in the very immediate future. It is a necessary and ongoing exercise in the treatment and management of suicidal clients. Suicide risk assessment is a reasoned and inductive process rather than an intuitive one. It is conducted systematically and based on the analysis of available clinical detail (Jacobs, 2007). Information is gathered

through interviews with the client, family members or significant others, other helping professionals involved in care, and by reviewing of available clinical records (Jacobs, 2007).

The assessment of potentially suicidal clients begins with a comprehensive psychiatric evaluation that usually includes a mental status examination, and relevant history and physical and/or laboratory examinations (Risk Management Foundation of the Harvard Medical Institutions (RMFHMI), 1996). In a suicide assessment, the clinician:

1. identifies risk factors that contribute to suicidality, distinguishing those that can be modified from those that cannot be changed
2. identifies protective factors
3. conducts an open and detailed inquiry into the client's suicidal ideation
4. uses information gathered in and for the assessment to distinguish the client's level of risk, and a treatment and/or safety plan. (Jacobs, 2007; RMFHMI, 1996).

Critical areas to explore in a suicide assessment include (Jacobs, 2007):

Psychiatric illness	Co-morbidity, mood disorders, alcohol and other substance use, schizophrenia, personality disorders
History	Prior suicide attempts, aborted attempts or self harm, medical diagnoses, family history of suicide attempts, family history of mental illness
Individual strengths/ vulnerabilities	Coping skills, personality traits, past responses to stress, capacity for reality testing, tolerance of psychological pain
Psychosocial situation	Acute and chronic stressors, changes in status, quality of support, religious beliefs
Suicidality and symptoms	Past and present suicidal ideation, plans, behaviours, intent, methods; presence of overt suicidal and/or self-destructive behaviour; hopelessness, anhedonia, anxiety symptoms; reasons for living; associated substance use; homicidal ideation

When to conduct suicide assessments

Suicide risk assessments should be conducted:
- at first psychiatric assessment or admission
- with occurrence of any suicidal behaviour or ideation
- whenever there is a significant clinical change.

Additionally, inpatients should be assessed:
- before increasing privileges / giving passes
- before discharge.

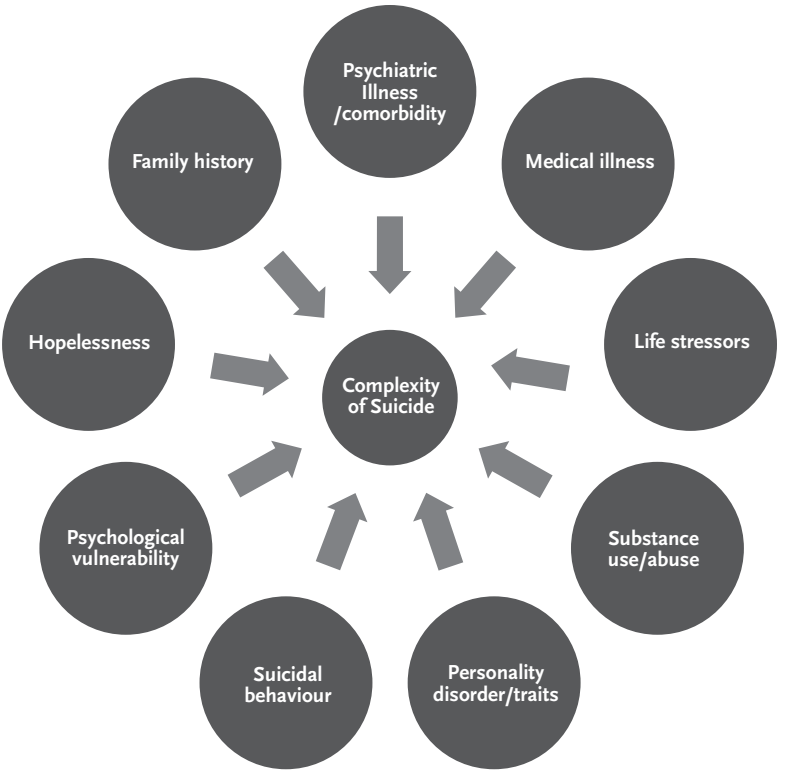
(Jacobs, 2007; RMFHMI, 1996)

In some settings, like the Emergency Department or with some populations, such as clients with borderline personality disorder or mood disorders, especially depression, clinicians conduct suicide assessments on a daily basis. In outpatient treatment of any duration, assessments should be routinely conducted when there is significant clinical change to warrant concern (i.e., depressive symptoms or substance use, especially when there is a known history or family history of suicidal ideation or attempts). As well, suicide risk should be reassessed at various points throughout treatment, as a client's risk level will increase and decrease over time (Jacobs, 2007; RMFHMI, 1996).

All clinicians who work at entry points to CAMH, such as intake, assessment or consultation services, should pay particular attention to the identification of this form of risk. Such identification can occur within mental status examinations and through the collection of previous medical records.

SUICIDE RISK FACTORS

Suicide is a complex phenomenon, determined by multiple factors intersecting at one point in the life of the individual:



(Adapted from Jacobs, 2007)

There is not one single predictor of suicide. A central purpose of a suicide assessment is to appreciate the complexity of risk factors that contribute to suicidality and increase the client's acute and chronic risk for suicide (Jacobs, 2007; CARMHA, 2007). As a general rule, clients with multiple risk factors occurring concurrently are at highest risk for suicide; however, any estimation of risk is complicated by the fact that the most lethal suicidal actions are often associated with the least explicit communication of ideation (Jacobs, 2007; CARMHA, 2007). The clinician's open and collaborative stance during the assessment can enhance the reliability and validity of the

risk assessment. In the suicide assessment, the clinician identifies risk factors and distinguishes those that can be modified from those that cannot be changed (Jacobs, 2007).

Risk Factors for Suicide

(***bold italics*** = modifiable)

Demographic	Age: Risk increases with age; rates of suicide increase after puberty and in adults over the age of 65. Sex: Risk is greater for males than females; men are more likely to die by suicide while women are more likely to attempt suicide. Marital status: Widowed, divorced, single.
Access to lethal means	***Possession of firearms.*** ***Access to large doses of medications.***
Psychosocial	Recent severe, stressful life events such as interpersonal loss (break-up or death of a loved one) or conflict, job loss, financial problems, legal problems, moving.
Psychiatric	Mood disorders, particularly depression, are among the strongest risk factors for suicide. Anxiety disorders, especially those co-occurring with mood disorders and substance use disorders, are associated with an increased risk for suicide and suicidal ideation. Schizophrenia can contribute to an elevated risk for suicide, particularly during the initial years of the illness. Borderline personality disorder. Co-morbidity of psychiatric illnesses.
Substance use	***Intoxication*** is a common factor in suicides. ***Use of multiple substances*** can trigger suicidal behaviour. ***Withdrawal from cocaine, amphetamines and other addictive drugs*** can increase suicidal ideation and attempts. ***Extended use of sedatives, hypnotics and anxiolytics*** can increase suicidal ideation and attempts.

Physical illness	Malignant neoplasms, HIV/AIDS, peptic ulcer disease, hemodialysis, systemic lupus erthematosis, pain syndromes, functional impairment, diseases of nervous system, physical disorders (e.g., undiagnosed diabetes, iron/thyroid deficiency) are a common factor in suicides of individuals over 60 years old.
Psychological dimensions	***Hopelessness, psychic pain/anxiety, psychological turmoil, decreased self-esteem, fragile narcissism, perfectionism.***
Behavioural dimensions	***Impulsivity, aggression, severe anxiety, panic attacks, agitation.*** Prior suicide attempt: History of a suicide attempt dramatically increases future risk for suicide.
Cognitive dimensions	***Thought constriction.*** ***Polarized thinking.***
Childhood trauma	Sexual/physical abuse, neglect, parental loss/ separations.
Genetic and familial	Family history of suicide, mental illness or abuse.

(Jacobs, 2007; CARMHA, 2007; RMFHMI, 1996)

PROTECTIVE FACTORS

In addition to risk factors, and sometimes overlooked, suicide risk assessment should identify protective factors that reduce suicide risk. Although clients who exhibit protective factors do attempt and complete suicide, multiple protective factors generally contribute to client resiliency in the face of stress and adversity. Protective factors may be considered in each of the domains of the individual, family, work and community. Important protective factors may include:

- children in the home, except among those with postpartum psychosis
- responsibility to others
- pregnancy
- deterrent religious beliefs, high spirituality and/or belief that suicide is immoral
- life satisfaction
- reality testing ability

- positive coping skills
- positive social support
- positive therapeutic relationship
- attachment to therapy, social or family support
- hope for future
- self-efficacy
- supportive living arrangements
- fear of act of suicide
- fear of social disapproval (Jacobs, 2007; CARMHA, 2007; RMFHMI, 1996).

Suggested reflective questions about risk and protective factors

Does the client have the capacity to act?

Suicide requires the ability to organize and the energy to implement a plan.

Suicide potential may be heightened when there is greater energy (early recovery from depression) or lowered inhibition (with intoxication or rage).

Have suicidal behaviours occurred in the past?

Is the client hopeless?

Hopelessness is a key factor in suicidal intent and behaviour and it is often accompanied by pervasive negative expectations.

Are depression and/or despair present?

Depression is a mood state associated with vegetative symptoms.

Despair is a cognitive state that is characterized by a sense of futility about alternatives, the absence of a sense of a future role, and a lack of social connections for support.

Is a diagnosable psychiatric disorder present that is correlated with suicidality?

Does the client's physiological state (illness, intoxication, pain) increase the potential for suicide?

Are intoxicants present?

Acute intoxication or withdrawal can lead to an acute increase in suicide risk.

Evaluation is difficult when the client is intoxicated. A safe place should be provided until the client becomes sober and the client should be reassessed for suicide risk when sober.

Chronic substance use or dependence may result in chronic risk.

Suicide risk can be elevated when a relapse occurs.

Has the client recently experienced loss, disappointment, humiliation, failure (real or imagined)? Is the client facing loss, disappointment, humiliation, failure (real or imagined)?

Interpersonal loss can be an important precipitant.

Has the client lost or does he or she anticipate losing his or her main reason for living?

Is there any disruption in the client's support system?

Is the client vulnerable to painful affects such as isolation, self-contempt, shame or panic?

What are the client's capacities for self-regulation?

Does the client have any history of impulsive behaviour?

Does he or she have the ability to use external resources to regulate self-esteem?

Is the client able to participate in treatment?

Does the client verbalize his or her willingness to comply with the treatment plan?

Does he or she have the capacity to make an alliance?

(Adapted from RNAO, 2009; RMFHMI, 1996)

SUICIDE INQUIRY

In the assessment, it is essential that the client is asked directly about suicidal ideation, including any plans to commit suicide, the availability of means to kill himself or herself and deterrents (Jacobs, 2007). In this context, added concern and consideration should be given when the client has a history of previous suicide attempts, both actual and aborted, when the client is experiencing his or her first episode of suicidality, when the client expresses feelings of hopelessness, and when the client has a history of psychological pain. Also, it is worth noting whether the client is ambivalent about such an action, as ambivalence represents an important opportunity for intervention.

Components of suicidal ideation

- Intent: subjection, expectation and desire for a self-destructive act to end in death
- Lethality: objective danger to life associated with a suicide method or action. Lethality is distinct from and may not always coincide with an individual's expectation of what is medically dangerous
- Degree of ambivalence: wish to live, wish to die
- Intensity
- Frequency
- Rehearsal; availability of method
- Presence or absence of suicide note
- Deterrents (e.g., family, religion, positive therapeutic relationship, positive support system, including work)

(Jacobs, 2007; CARMHA, 2007; RMFHMI, 1996)

Suggested reflective suicide-specific questions

Are suicidal thoughts and/or feelings present?

What form does the client's wish for suicide take?

What does suicide mean to the client?

Is a suicide plan present?

How far has the suicide planning process proceeded?

- specific method, place, time
- available means
- planned sequence of events
- intended goal (e.g., death, self-injury, or another outcome).

Does the client have access to weapons?

Document any conversation about access to guns or other lethal weapons.

Has the client engaged in self-mutilating behaviours?

When a history of trauma or abuse is present, it may be valuable to assess the presence of a mood disorder.

Although self-mutilation is frequently an act of self-soothing rather than an attempt to die, clients who self-mutilate do sometimes commit suicide.

How lethal are any planned actions?

Objectively assess danger to the client's life.

Avoid terms such as gesture or manipulation since they imply a motive that may be absent or irrelevant to lethality.

Bizarre methods have less predictable results and may therefore carry greater risk.

Pay attention to violent, irreversible methods such as shooting or jumping.

Is there likelihood of rescue?

Clients who contemplate a plan likely to end in discovery may be more ambivalent than others who plan their suicidal behaviour to occur in an isolated setting.

What preparations has the client made?

Obtaining pills, preparing suicide note, making financial arrangements.

Has the client rehearsed for suicide?

Rigging a noose, driving near a bridge.

Is there a history of overt suicidal and/or self-destructive behaviour?

Explore the circumstances of any past suicide attempts. Absence of previous suicidality does NOT eliminate the risk of current or future attempts.

(Adapted from RNAO, 2009; RMFHMI, 1996)

Statistical Relationships of Suicide Attempts to Suicide Completion (RMFHMI, 1996)

- Attempters are at a seven to 10 per cent increased risk for suicide over the general population.
- Eighteen to 38 per cent of those who completed suicide have made a prior attempt.
- Ninety per cent of attempters do not go on to complete suicide.
- One per cent of past attempters kill themselves each year.

LEVEL OF RISK AND TREATMENT PLANS

Through discussion and exploration of risk and protective factors and suicidal ideation, the clinician determines level of risk (low, medium, high) and develops a treatment plan (Jacobs, 2007). Once an assessment of the client's suicide risk has been made, an individual treatment plan must be designed (RMFHMI, 1996). Whenever possible, treatment planning should be developed in collaboration between providers and clients (RMFHMI, 1996). Sometimes it may be possible and/or necessary to include significant others in treatment planning. At CAMH, involvement in the development and implementation of treatment plans is highly dependent on the discipline of involved clinicians and the nature of the service. Psychiatrists will most often recommend and initiate somatic treatment

modalities; however, discussions with team members and colleagues of other disciplines may be critical to the generation of these plans. Moreover, professionals in nursing and social work may be central to the development and implementation of other elements of the plan such as family education or ongoing monitoring of the client. Generally, treatment plans should address the clients' immediate safety, the most appropriate setting for immediate treatment, the strength of the alliance between the clinician and client, long- and short-term goals, and client and family education. For clients with high or imminent risk, inpatient hospitalization is frequently necessary and may need to be imposed involuntarily (Jacobs, 2007; CARMHA, 2007; RMFHMI, 1996).

Forms of treatment for suicidality

- Somatic treatment modalities:
  - ECT: Used to treat acute suicidal behaviour. Evidence for short-term reduction of suicide, but not long-term.
  - Benzodiazepines: May reduce risk by treating anxiety.
  - Antidepressants: A mainstay treatment of suicidal clients with depressive illness and symptoms. No conclusive evidence of suicide reduction.
  - Lithium, anticonvulsants: Lithium has a demonstrated anti-suicide effect; anticonvulsants do not have an anti-suicide effect.
  - Antipsychotics: Evidence for Clozapine reducing suicidality in schizophrenia and schizo-affective disorders.
- Psychotherapeutic intervention.
- Education for client and family.
- Monitoring of psychiatric status and response to treatment.
- Frequent reassessment for safety and suicide risk. (Jacobs, 2007)

SCREENING TOOLS

There is limited evidence to suggest that clinical rating scales predict suicide; however, information gathered from these scales may add to the overall information from the suicide risk assessment. Because depressive symptoms and depression are significant risk factors for suicide, clinicians may also want to consider the use of depression screening tools in some cases.

The SAD PERSONS Scale for Assessing the Risk of Suicide and the Nurses' Global Assessment of Suicide Risk are given as examples of screening tools in the *RNAO Guideline for the Assessment and Care of Adults with Suicidal Ideation and Behaviour* (2009). These and further screening tools can be found in Appendix II of this handbook.

SAFETY PLANS

When clients exhibit suicidal ideation, regardless of estimated risk, teams and/or clinicians 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, 1996).

Safety plans are most frequently used in outpatient and community settings but they may also be implemented in inpatient environments, particularly when granting privileges and passes. Multiple individuals and agencies and their contact information may be identified in safety or crisis plans including family physicians, 24-hour crisis services, friends or peers, religious or spiritual advisors, and family support systems. Individuals and/or agencies that are listed in such plans should be involved in their development and familiar with their role in facilitating client safety. Ideally, copies of the plan should be circulated to individuals and agencies who are identified within it (CARMHA, 1996).

See Appendix IV for a sample safety plan template from *Working with the Client who is Suicidal: A Tool for Mental Health and Addictions Services* (CARMHA, 2007).

Suicide contracts or no harm contracts

These contracts are statements from clients that they will not harm themselves, or will contact the clinician or a specified person, if they feel unable to maintain their own safety.

While suicide contracts are commonly used, there are no studies to demonstrate their ability to reduce suicide. Furthermore, suicide contracts are discouraged because they:

- may be signed to avoid the detection of suicidal intent
- are not a legal document, whether signed or not
- are sometimes used without evaluation by psychiatrist or assessment, a practice that is not suggested (Sakinofsky, 2010; Jacob, 2003).

Documentation of suicide risk assessment

Documentation of the risk for suicide is every clinician's responsibility!

Documentation is a standard of practice for all regulated health care professionals and is an integral part of the assessment and care of clients who are at risk of suicide (RNAO, 2009). Clear and complete documentation of suicide risk assessment helps to ensure:

- communication among the team of health care providers (CRAG, 2002)
- ongoing assessment of the need for observation of the client (CRAG, 2002)
- development, clarification and promotion of an appropriate plan of care (Monk & Samra, 2004; Sullivan et al., 2005)
- evaluation of the client's progress toward desired outcomes (Horrocks et al., 2004)
- quality monitoring (Horrocks et al., 2004)

Additionally, documentation helps clinicians to sharpen their focus and provide rationale for their decisions. In essence, documentation helps clinicians to demonstrate accountability for the care that they are providing (Simon, 2004).

When to document the assessment of risk for suicide:

1. At first psychiatric assessment and/or triage (including intake to a service or admission to an inpatient unit).
2. Whenever there is a change with the client's clinical state (e.g., change in mood, new occurrence of suicidal ideation or behaviour, change in life situation).

3. When a family member, significant other, friend or staff member expresses concern of suicidality.
4. With any major shift in the treatment plan.
5. With any incident of suicidal behaviour or ideation.
6. At any change in the level of care (e.g., change in precautions or observation, including before increasing inpatient privileges).
7. Before terminating a relationship (including at discharge from the inpatient unit), with consideration for both immediate and chronic risk.

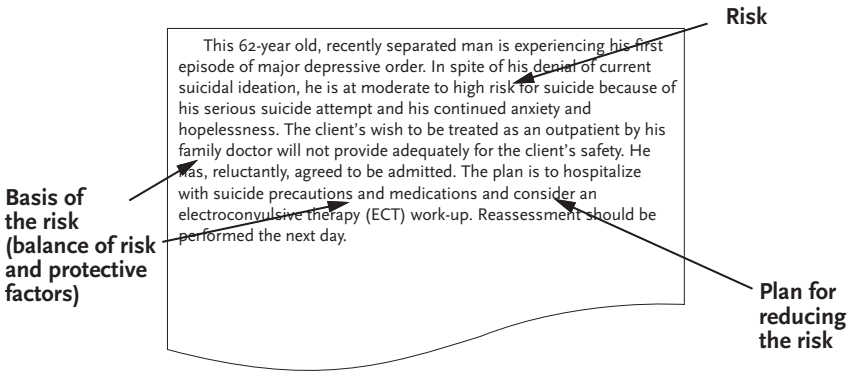
Documentation of any suicide risk assessment is expected to be in accordance with the documentation standards established by relevant regulatory bodies and/or professional associations, as well as those of CAMH.

Elements of the Suicide Risk Assessment for Documentation

- Risk level
- Basis of the risk, including:
  - risk factors
  - protective factors.
- Treatment planning process and plan for reducing the risk level, including:
  - the range of options considered and why one was chosen over others
  - any interventions or consultation, including changes made to the previous plan and the rationale for the changes
  - any changes that were considered but rejected, and why
  - communications with the client
  - discharge planning to include:
    - living arrangements, work, communication with significant others
    - follow-up appointments or contact with outpatient provider
    - medications (including prescriptions)
    - current suicide assessment.

Suicide risk assessment occurs within the context of a comprehensive Mental Status Examination and documentation reflects this. The reason for the assessment, consultation with other professionals (e.g., physician, nurse, peer), communication with the client, and any tools used in the assessment are included in the documentation. For the suicide risk assessment in particular, documentation incorporates both direct and indirect markers of suicidality (Monk & Samra, 2004). It also reflects the basis for clinical judgment and decision making through the plan of action in relation to the degree of risk for suicide that the client presents.

Example (Jacobs, 2007)



While documentation is an essential step in communicating an assessment, clinicians will also need to share their findings with their teams through verbal reports. Practically speaking, it is difficult to predict when all health care professionals will be able to review the documentation. The timing and number of verbal reports to team members will depend on the urgency of the risk assessment. With high and/or medium levels of risk, staff should consider contacting the treating physician or physician on call (duty doctor), charge nurse and other team members to discuss a second opinion and a plan for safety. Additionally, the risk assessment should be discussed in shift report, team/clinical review, transfer, etc. Generally, in shift change and transfer reports, clinicians should ensure that they communicate:

- level of risk
- pertinent demographics
- observation status
- risk factors

- mental status
- medications
- plan.

For more information on verbal reports, refer to *CAMH's Guidelines for Verbal Reports: Change of Shift or Transfer* (http://insite.camh.ca/files/Verbal%20Reports.pdf).

CAMH-SPECIFIC REQUIREMENTS AND TOOLS

CAMH has a hybrid health record, meaning that there are both electronic and hard-copy elements to clinical documentation. Elements of the suicide risk assessment and action plan may be captured in a variety of places; some are mandatory while others are optional.

A. Mandatory documentation

Elements of the sucide risk assessment and plan for intervention must be documented in the following tools in TREAT:

1. RAI-MH (Resident Assessment Instrument—Mental Health)
   - An interdisiplinary assesssement that must be completed within 72 hours of admission, at discharge, and every three months between

   - Areas of the assessment that are relevant to suicide include questions related to:
     - threat or danger to self
     - self-injurious attempt(s)
     - whether intent of any self-injurious attempt was to kill self
     - consideration of performing a self-injurious act in the last 30 days
     - expressed concerns by family, caregiver, friend, or staff member that client is at risk for self-injury.

2. eIPCC (Electronic Interdisciplinary Plan of Client Care)
   - An interdisciplinary plan of care that outlines identified problems and treatment goals.

- Sections available to document client input (client participation), protective factors (strengths) and risk factors (challenges).
- MHAPs (Mental Health Assessment Protocols) are generated from the RAI or goals can be identified separately.
- The eIPCC includes specific sections and automatic prompts to help clinicians to organize the details, goals and intervention related to the care of suicidal clients, suicide and self-harm.

3. Progress Notes
   - Documentation must be detailed enough to provide a clear picture of the client's functioning. CAMH *Health Record Documentation Guidelines* (http://insite.camh.ca/files/Guidelines_for_Documenting_against_Referring_Service_Encounters.pdf) provides general guidelines for clinicians to follow.

4. Some health care professionals on the interdisciplinary team may also complete assessment reports that are filed to the health record. These reports may be filed directly to the chart or submitted through tools such as Chartscript. They are available to be viewed in Chartmaxx.

B. Optional documentation

- CAMH clinical forms: Separate clinical programs have developed templates for clinicans to both guide and document their assessment of risk for suicide.
- Validated scales/screening tools: Many scales have been developed for clinicians to use in the assessment of suicide risk. Some scales have been validated for use with specific populations while others can be used more generally:
  - SAD Persons Scale for Suicidal Risk (see Appendix I)
  - Beck Scale for Suicidal Ideation (BSS)
  - Beck Hopelessness Scale (BHS).

CAMH resources for documentation of suicide risk assessment

- Mental Status Exam Green Card
- Suicide Assessment Yellow Card
- Documentation Guidelines for the Health Record (http://insite.camh.ca/files/2-1_CAMH_Minimum_Doc_guidelines.pdf)

- Mental Status Exam Review
- Suicide Risk Assessment and Management

INVOLVEMENT OF FAMILY, SIGNIFICANT OTHERS AND FRIENDS

Family members, significant others and friends will need to be educated about suicide risk by thorough discussion of what to look for and how to recognize more subtle behaviours. One purpose of such discussion may be to enlist family members, significant others and friends in the ongoing monitoring of risk (CARMHA, 2007). Essentially, family members and/or significant others may be integrated into the treatment plan and process, especially during periods of heightened risk (Jacobs, 2007; CARMHA, 2007). These roles should be made explicit both in the treatment plan and to family members and significant others. They should be clear about how (i.e., monitoring risks outside of appointments or on passes from hospital) and when they should be involved (i.e., attendance at sessions, marital or family therapy) (Jacobs, 2007; CARMHA, 2007).

Tips for communicating with families

The following points have been adapted from the Centre for Applied Research in Mental Health and Addiction (2007). Provide family members, significant others and friends with basic information about:

- mental health diagnosis
- behaviours and their management
- medication benefits and possible side-effects
- inpatient and community services
- local and national support groups.

Then help family and friends to understand their loved one's own circumstances:

- the current situation
- confidentiality restrictions
- the treatment plan
- crisis or safety plans

- the roles of involved professionals
- how to access help, including out-of-regular-hours services.

SUPERVISION AND CONSULTATION

For each suicide assessment and over the course of work with suicidal clients, it is especially important to formally and informally consult with team members and professional colleagues and to seek supervision through regular case reviews, observation and/or formal discussion (RNAO, 2009; CARMHA, 2007). These consultations can reflect on decision making such as the designation of risk, the need for a client to be hospitalized, or ways to increase client safety in the community (CARMHA, 2007).

Since work with suicidal clients can be both professionally and emotionally challenging, clinicians should pay attention to their own reactions because these reactions may interfere with their treatment of the suicidal client (particularly those that are chronically suicidal). For example, clients' feelings of hopeless may be transmitted to clinicians and/or clinicians may be influenced by their clients' beliefs about suicide. In this context, informal and formal conversations with colleagues may provide important opportunities to obtain both advice and support. These discussions may help to reduce the isolation and stress that is often a component of work with suicidal clients (CARMHA, 2007).

Where to get help

Depending on the setting, there are many avenues for clinical consultation and supervision at CAMH:

- Many areas have advanced practice nurses and clinicians who provide regular supervision to staff and who should be consulted in challenging cases.
- Team reviews and meetings should be used to review and discuss cases.
- Experienced colleagues can be approached for advice in particularly challenging cases or can be asked to conduct formal consultations.
- Informal discussions with team members are often the most frequent source of debriefing support and advice for clinicians in all of their casework.
- Depending on their background, managers sometimes provide clinical

supervision: they should also be approached if regular clinical supervision is required but not currently available.

What to ask

The following are some questions to consider prior to and during clinical consultation and supervision (CARMHA, 2007):

- How can I be more effective in caring for a suicidal client?
- What can I do to increase this person's safety?
- Does this client need to be hospitalized?
- What can ease this person's pain and perturbation even by the slightest amount and how can I facilitate that?
- What is realistically and conservatively possible for me to be available to the client? Only scheduled sessions? Telephone calls (scheduled or as needed)? During the day, evenings, weekends? Crisis sessions?
- For occasions when I am not available, what supports are there?
- If a pattern has been identified as leading to suicidal behaviour in the past, what can interrupt the pattern? What has interrupted it in the past?
- What skills does the client say will be useful to him or her?

RESTRICTION OF THE HEALTH RECORD

In the event of a completed suicide, the client health record will be restricted. Details are outlined in CAMH's policy Restriction of Health Records. This means that any hard-copy clinical documents from the health record (e.g., inpatient binder) will be removed from the unit or program and will be held in health records with limited access. While clinicians are able to continue to include necessary documentation in TREAT, any entries will be dated contemporaneously; no entries can be backdated or altered. Additionally, electronic access to the record will be audited.

Treatment and Management of Suicidal Patients

THE THERAPEUTIC RELATIONSHIP BETWEEN CLIENT AND CLINICIAN

CAMH clinicians serve in a variety of capacities with clients and on teams. Regardless of role or discipline, it is essential to attempt to understand and appreciate the client's situation and to treat the client with respect and openness. The alliance between the clinician and client is essential to the treatment and management of suicidal clients and should be considered and addressed in any treatment plans (Sakinofsky, 2010; CARMHA, 2007).

When clinicians have the opportunity to develop therapeutic alliances with clients over time, clients can be assisted in identifying recurrent interpersonal problems, including those that may have occurred in previous therapeutic relationships (Jacobs, 2007; CARMHA, 2007). This relationship can also be used to target issues such as the denial of symptoms or a lack of insight and/or to manage high risk symptoms such as hopelessness and anxiety (CARMHA, 2007).

Suggestions for reducing dropouts in outpatient treatment

- Provide clients with follow-up appointment at time of intake.
- Schedule timely follow-up appointments.
- Remind client of appointment by telephone.
- Provide access to 24-hour clinical back-up for crises which may include identification of a specific Emergency Department.
- Pursue no-shows by phone calls and letters (unless this compromises client confidentiality).
- Involve family members and significant others in treatment. (CARMHA, 2007)

PRIVACY AND CONFIDENTIALITY

Ensuring a client's right to privacy is respected is extremely important. The Mental Health Act (MHA, 1990), Public Hospitals Act (PHA, 1990) and the Personal Health Information Privacy Act (PHIPA, 2004) work together to outline required practices in relation to privacy, consent and confidentiality; however, the obligation to intervene if a client's well-being is at risk outweighs his or her right to privacy. Both the MHA and PHIPA allow for several exceptions related to release of personal health information, including allowing disclosure if it is required to "eliminate or reduce a significant risk of bodily harm to a person or group of persons."

Weighing the risks and benefits of breaking confidentiality can present a significant ethical dilemma for clinicians. In order to ensure that a client is truly informed, tell him or her from the initial contact about the limits of confidentiality and your ethical and legal obligation to release information. Outline that this obligation may include the release of information to next of kin, significant others and police when you are concerned about their imminent well-being.

In cases in which a clinician's judgment suggests that a client's safety or well-being is imminently at risk, the concerns about safety (and associated decisions to release information) override considerations about confidentiality.

PREVENTING SUICIDES IN THE INPATIENT ENVIRONMENT: MANAGEMENT OF AWOL AND VOLUNTARY PATIENTS

Inpatient care is seen to be effective in the treatment of acute rather than chronic suicidality, offering safety, support, and hope (RMFHMI, 1996). Most often, the inpatient treatment of suicidal clients progresses through a hierarchy of observation and privilege levels to therapeutic passes (RMFHMI, 1996). Although suicidality may persist, privileges are increased and levels of observation are decreased as suicidal risk is reduced. Levels of observation and privileges are discussed in CAMH's policy, Client/Patient Monitoring and Activity.

Observation and privileges

In inpatient settings, levels of observation, supervision and privileges should "parallel the clients' potential for suicidal behaviour" (RMFHMI, 1996).

Examples of observation levels are:

- continuous observation (1:1 or remaining in sight of staff members)
- restricting the client to an area where he or she can be seen at all times by staff
- restricting the client to public areas; not allowing him or her to be alone in room
- checks at intervals of five, 15 or 30 minutes
- periodic checks at intervals greater than every 30 minutes (RMFHMI, 1996).

Examples of privilege levels:

- restricted to unit
- accompanied off-unit by staff (specify 1:1 versus group, and legal status of client when relevant)
- accompanied off-unit by non-staff (reliable family member or friend)
- unaccompanied off-unit (RMFHMI, 1996).

Voluntary Clients

"I'm not allowed to ask a voluntary client where she is going when she leaves the unit."

"Voluntary clients all have privileges to be in the community all day every day."

These are not facts; these are common misconceptions about voluntary clients.

While Ontario's Mental Health Act (1990) says that voluntary clients are capable of making the decision either to stay or leave the hospital, it allows some room for staff to intervene if the client is at risk for suicide. A voluntary client agrees to be in the hospital for the purposes of observation,

care and treatment. Part of the treatment plan may include limitations on the time that clients are able to leave the unit or restrictions on access to the community (much like privileges). Part of implementing the client's treatment plan is abiding by the passes and privileges that the client has agreed to comply with as part of his or her care; voluntary or not, staff are accountable for knowing the whereabouts of their clients. Voluntary clients are able to decide to leave the hospital and cannot be detained against their wishes. However, staff may attempt to intervene prior to the client's departure if there is reason to suspect that he or she may pose a risk of harm to himself or herself. If the client meets criteria for involuntary admission, the doctor may put him or her on a Form 3, Certificate of Involuntary Admission, in order to ensure that he or she stays in hospital. If the client leaves despite concerns or does not return when agreed, the team may consider the need to compel the client to return to the hospital. The doctor may issue a Form 1, an Application for Psychiatric Assessment, if he or she feels that the client meets the criteria for continued assessment. A Form 1 allows police to intervene and return the client to CAMH.

AWOL and Suicide

"The first steps in reducing suicide rates in inpatient settings are to increase focus on AWOL and tighten the mental status assessment completed prior to letting clients leave on passes" (Sakinofsky, 2010).

The majority of inpatients who commit suicide do so outside of hospital during either an authorized leave or AWOL (Gordon, 2002). AWOL is "a common feature within psychiatric wards" and a "significant risk factor for suicide" (Hunt et al., 2010). In this context, clinicians, and teams' management of and approach to AWOL may assist in the prevention of suicide.

The following are suggested methods to prevent and manage absconding behaviour:

- *Identify those at risk for AWOL*: One of the strongest predictors for AWOL is previous absconding behaviour. Review a new client's history to identify a high risk for AWOL.
- *Identify and document AWOL when it occurs*: It has been well established that clients who AWOL for shorter periods, who are voluntary, or who are

not perceived as being at risk for suicide are not reported as absconding (Muir-Cochrane & Mosel, 2008; Bowers et al., 2005; Dickens & Campbell, 2001; Bowers et al., 2000). SCORE reports from CAMH seem to indicate a similar trend. Failure to identify AWOL is problematic because:

- It has a negative impact on predicting future outcomes and understanding treatment needs.
- It may limit our ability to identify those who are at risk. Gordon (2002) summarized a British Department of Health study that found that 80 per cent of the inpatients who completed suicide were thought to have been at low risk at the time of death.

- *AWOL isn't just escaping in the middle of the night*: The majority of absconding occurs in the daytime, after clients have been given permission to leave the ward unaccompanied, after clients have become more organized and with many considered ready for discharge (Bowers et al., 2010; Khisty et al., 2008; Bowers et al., 1998).
- *It is important to document AWOL when it happens*: Muir-Cochrane and Mosel (2008) described quality documentation related to AWOL as including previous incidents, outcomes of AWOL incidents, and risk assessment and harm minimization specific to AWOL.
- *Follow up with the client after AWOL and consider if changes to the treatment plan are needed*: Bowers et al. (1999b) found that in 73 per cent of cases, no changes were made to management plans for clients following returns from AWOL; Dickens & Campbell (2001) added that no special measures were taken with clients known to be repeat absconders compared to single-event absconders. Given that we know that past AWOL is a significant risk factor for suicide, it is prudent to assess the need to refine the client's treatment plan following AWOL events, based on individual risk factors, known stressors and increased needs for support.

REMOVING RISKS IN THE ENVIRONMENT

Suicide affects all programs within the context of hospital care. When working with clients in the mental health spectrum, it is imperative to take all measures in providing the safest environments. When informed precautions are made on an inpatient unit, staff have greater control over the safety of a client's environment; in the outpatient setting this is a more difficult task. When assessing for suicidal risk, it is important to assess the physical environment.

Inpatient

The goal of environmental safeguards in psychiatric institutions is two-fold: (a) to limit the means that inpatients may use to physically harm themselves, and (b) to provide external control for inpatients through staff interventions until the inpatients are able to re-establish internal control over their suicidal impulses. Environmental safeguards involve the elimination or restructuring of physical features that may be used by inpatients to engage in self-injurious behaviour (Cardell et al., 2009).

The physical environment must be inspected and evaluated to ensure safety without negative impact on the treatment capabilities (Farberow, 1981). The most frequent method of attempts—jumping and hanging—influence the safeguards recommended in the literature on suicide prevention.

Safeguards in all patient areas include:

- safety glass in all windows
- restricted window openings
- stairwells secured and no access to the roof
- elimination of articles or materials for hanging including:
  - shower curtain rods
  - clothes hooks (if used should not able to support the weight of a person)
  - rails in bathrooms
  - exposed pipes
  - telephone cords.

Staff supervision may be necessary during the suicidal client's use of:

- sharps (nail cutters, razors, scissors)
- cigarettes and matches
- cleaning supplies
- bathroom
- kitchen (RMFHMI, 1996).

Creating and reviewing policies and procedures regarding the storage of clients' belongings and their access to non-patient areas may help to address the changing risk of the clients' environment. When monitoring the traffic in and out of the unit, one can better control dangerous items that could be brought in by clients or visitors and that pose a safety risk to clients on the

unit. When a unit has patients who are AWOL risks, a sign could alert staff and visitors.

The RNAO guideline, The Assessment and Care of Adults with Suicidal Ideation and Behaviour, includes monitoring of items used within the daily functioning of the unit in addition to protecting and storing these items appropriately when not in use (2009). For example, a common linen hamper could be dismantled and used as a weapon; cabinets can be taken apart and removable headboards inspected to ensure no safety risks are present.

The inpatient unit can also implement safeguards in clients' personal rooms, as in dining rooms and occupational therapy kitchens by removing all articles easily used for self-harm including belts, suspenders, bathrobe cords, shoe laces, glass, ashtrays, vases, razors, nail clippers, knitting needles, bottle openers, can openers, etc. (Matakas & Rohrbach, 2007).

Outpatient

Once a client leaves a clinician's office and returns to the community, there is minimal ability to "remove risks from their environment" and, therefore, there are no real safeguards for control. While there is a suggestion that environmental safeguards do decrease the incidence of suicide, these safeguards should not be depended upon solely. Instead, they should be combined with observation and supportive, caring therapeutic interventions focused on increasing clients' self-esteem and decreasing a sense of hopelessness (Cardell et al., 2009).

According to the Canadian Association for Suicide Prevention, environmental risks in the outpatient setting include job loss, problems with interpersonal relationships, access to lethal means and local clusters of suicide.

Part II:
The Aftermath of Client Suicide

Supporting staff in the aftermath of client suicide

The completed suicide of a client has a strong emotional impact on staff involved in his or her care. The event is particularly catastrophic when it occurs on an inpatient unit. As Bartels (1987) points out, the survivors include not only the family of the deceased but also fellow clients, the therapist, the staff and the institution with its culture and norms. A client's suicide evokes a range of emotions that include denial, shock, disbelief, guilt, a sense of failure and loss in professional confidence.

A study conducted by Ruskin et al. (2004) surveyed the impact of suicide on medical residents. One-half reported at least one suicide during their training, indicating the need for preparation and support. The findings also showed that more than two-thirds of respondents mentioned that they kept to themselves after the tragic event. This draws attention to the need for active outreach to individuals and teams. The study found that there was a group of practitioners that was more vulnerable and experienced signs of acute stress disorder and post-traumatic stress disorder. This finding highlights the importance of a range of resources and supportive organizational practices.

Unlike surgical or palliative care units, client death by suicide is not an expected occurrence in mental health settings. While mental health

practitioners are aware of the morbidity associated with mental illness, "mastery by repetition" is less likely. This means that we may continuously anticipate a client death by suicide but are less likely to be faced with a death. Bartels (1987) notes that this may, in fact, create a false sense of mastery and the illusion that all suicides can be prevented. In this respect, ongoing training of staff and students around assessment of suicide risk is essential. This training would also include a discussion about the eventuality of suicide despite good clinical care. Bartels (1987) concludes that without a climate of anticipation, a suicide on a unit is severely traumatic.

PHASES OF RECOVERY

Following a client suicide, individual staff members and teams are faced with a number of challenges that require specific responses to facilitate recovery. If the suicide occurs on an inpatient unit, the acute needs of fellow patients are a priority to help contain the crisis and prevent further self-destructive acts.

The time immediately following a suicide is a critical period as the initial response by staff and clients is characterized by shock, disbelief, confusion and disorientation. Some clients may experience panic and emotional flooding. To help contain staff and client reactions, a number of tasks, outlined here, are helpful.

Initial responses

An initial staff meeting is essential to ensure all staff are informed and a practical management plan is established. This includes assignment of tasks, such as discussion of observation levels, need for additional staff, review of passes and transfer requests from other units. The latter may need to be put on hold until the immediate crisis is contained. The focus of the initial staff meeting, therefore, should not focus on emotional processing of the event, which could in fact be harmful.

Another essential component of the immediate aftermath of suicide is to ensure that the appropriate steps are taken to document and inform all

essential stakeholders. This includes family, risk management, and hospital administration. Further details regarding this process are to follow. For guidelines in working with families, this handbook contains a separate section, "Supporting Families in the Aftermath of Suicide" (see page 38). Other parties to be informed may include community therapists or case managers.

In addition to the initial staff meeting, a staff–client community meeting is essential. It is recommended that this happen in a timely fashion to accomplish the goals of containment, support and crisis intervention. The "Supporting Clients in the Aftermath of Suicide" section of this handbook (see page 35) provides further details and practical suggestions.

Processing of the event

Following the immediate shock and disbelief, staff members often experience a host of emotions, including feelings of guilt, and fears of recrimination, shame or despair. This often is followed by feelings of anger at the client, the family or the institution. Finally, this may be followed by self-doubt, depression and search for meaning. Clinicians may feel that they can no longer rely on their clinical judgment. Outpatient staff may feel a sense of isolation and loneliness. Bartels (1987) notes that staff may be painfully aware of the silent accusation by others or oversimplified explanations.

It is during this period of "recoil" that the focus shifts to the need to process the event. There are a number of activities that will assist in this working through. These include debriefing meetings, clinical and peer supervision, and ward meetings. In facilitating such process meetings it is important to let staff express painful feelings while containing accusatory or blaming remarks. The Ontario Nursing Association suggests that bringing in an outside consultant to assist in the debriefing can be helpful (ONA).

Involvement in formal "rituals of death" can also be a step in the recovery process. This refers to practices such as attendance at the funeral, sending of cards or flowers and memorial services for staff and clients. The section on supporting families will further elaborate on these issues and include boundary and confidentiality issues.

Bartels (1987) suggests that a suicide review conference may be an important component of bringing closure to the processing phase. This idea was initially called "psychological autopsy," a term coined by E.S. Shneidman. The conference aims at discussing the possible underlying dynamics of the event. As mentioned earlier, this task is to be undertaken once staff has regained equilibrium.

Recovery and renewal

The final phase of recovery following a client suicide is to move away from processing the event to be able to anticipate the possibility of future losses. Staff members will have regained confidence and are once again able to work effectively with suicidal clients. It is also a time to review existing processes of assessment, communication and unit structure.

CAMH has a number of important guidelines that assist teams and individuals in the event of a client suicide. A comprehensive summary of practices can be accessed through CAMH's policy, Death of an Inpatient. This policy provides step-by step guidelines, definitions and references to assist teams in all practical aspects of dealing with a death on the unit. It outlines the reporting structure, documentation guidelines and responsibility of all stakeholders. It is helpful if teams periodically review these guidelines in an effort to be crisis prepared.

The Registered Nursing Association of Ontario (RNAO, 2007) offers a number of practical suggestions to assist teams in the event of a suicide. These are summarized in the *Nursing Best Practice Guideline: Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour*. The RNAO suggests that helpful postvention (an intervention held after a suicide) strategies include a package of written information covering grief and coping strategies, a reading list, contact information for staff on local bereavement services and related matters. The document also summarizes a list of staff debriefing strategies, such as using existing traumatic incident response plans, and bringing in an external consultant. As well, the use of existing risk management procedures should be implemented to identify those at risk for severe grief responses and suicidal behaviour.

Some staff members will experience the suicide of a client, directly or indirectly, at some point in their career. Various support mechanisms need to be in place to address unique needs of staff. Few, if any, training programs prepare staff to anticipate and cope with client suicide. Hence, it is helpful to address this topic openly during clinical orientations and during individual supervision. Staff support also needs to include a list of resources individual staff can access during times of distress. Choices can include information on the CAMH employee assistance program and community therapy options. First and foremost, it is important to realize that increased social support and decreased isolation will act as protective factors.

Supporting clients in the aftermath of suicide

Inpatient suicides occur at a rate of five to 30 times that of the general population. Those most at risk are typically younger clients (35 years of age and younger) with mood disorders and functional psychoses. Clients who are 65 years and older comprise four per cent of inpatient suicides. Suicides can occur in those who have been identified as being at risk; however, many take place without any warning and often occur in those who have been judged by their psychiatrists as clinically improved and/or stable (Bartels, 1987).

According to the literature, a client is most at risk for suicide during his or her first month of admission, with the risk decreasing as length of stay increases.

The suicide of an inpatient can be an extremely difficult and sometimes catastrophic event for the inpatient unit (Bartels, 1987). The administrators, staff members and the client's surviving family are inevitably affected by the event, but fellow inpatients will also experience a range of emotions and behavioural reactions. The other clients must therefore be deemed among the survivors and special steps should be taken to assist them in working through the traumatic event (Sakinofsky, 2007). Similar reactions may occur among outpatient clients who knew the deceased, so risk assessment, containment and supportive interventions may be warranted in specific

cases. However, as with the inpatient setting, standard privacy and confidentiality guidelines must be adhered to.

EMOTIONAL REACTIONS OF INPATIENT SURVIVORS

Fellow inpatients, similar to other survivors of the suicide, will undergo a range of emotions immediately following the suicide and in the weeks that follow (Bartels, 1987).

The initial response is one of shock, disbelief, confusion and disorientation, which can coincide with emotional flooding and panic.

Fear is another commonly expressed emotion following a suicide of a co-patient. Inpatients might identify with the victim and worry that they too may be unable to control their own impulsivity. They might also begin to perceive the unit as unsafe.

Anger and blame might be directed toward the staff and/or the person's clinician, as the clients may feel they should have been able to intervene and prevent the suicide. Anger toward the victim for taking his or her own life might also surface.

Those who are actively psychotic may experience primitive guilt since they may claim responsibility for the suicide or identify with an imagined aggressor; they may also have delusional beliefs that they have somehow caused the suicide (Bartels, 1987).

Steps to help surviving clients

Sakinofsky (2007) and Bartels (2007) outline the importance of an immediate focus on containment of self-destructive behaviours, followed by enhancement and support to assist with mourning and recovery. Right after a suicide of an inpatient, the following is recommended:

- defer new admissions until the environment has stabilized
- temporarily suspend off-unit passes to clients
- flag clients suspected of being a particular risk

- put appropriate interventions and precautions into place, such as increased observation for those who were close to the deceased
- assess physical structure and design of the unit and review environmental safeguards
- assess need for additional staff
- ensure that staff who are present cancel off-unit responsibilities
- delegate tasks to each staff member with checks to ensure they're carried out
- ensure that unit leaders provide clear information, direction and support to inpatients
- direct attention toward remaining clients and to the containment of any potentially dangerous behaviours and any copycat events.

According to Bartels (2007), a mandatory staff-client meeting should be called within a few hours of the event with the focus on containment. The goals of this meeting are to inform the clients of the incident in a controlled manner, to assess their reactions, to address their anxieties and safety concerns and to support the emotional recovery of those affected by the loss. Brief crisis-oriented group therapy can occur in this meeting to deal with the aforementioned range of emotional reactions of the surviving clients.

It is important for staff facilitating the meeting to:

- communicate a clear overview of the situation and a readiness to respond to any dangerous behaviours or crises that could ensue
- answer questions openly, directly and calmly without providing excessive details about the suicidal act that took place (RNAO, 2009)
- validate the emotional responses of the clients
- discuss the range of emotions that suicide evokes and discuss methods to cope with them
- attend closely to client behaviours to determine who might be at risk (i.e., a client who acts out or leaves the meeting abruptly)
- document observations made during the meeting and inform other team members (Bartels, 2007).

Clients who may be at risk and require closer monitoring and supervision are those who:

- have already been struggling with suicidal thoughts and feelings
- have a history of previous suicide attempts

- are depressed
- have formed close relationships with the victim or have shared similar psychiatric histories
- are actively psychotic, particularly with impaired reality testing (Bartels, 2007).

Following the immediate crisis and containment period clinicians should:

- continue to provide support and enhancement to assist clients in the mourning and recovery process
- initially implement an increase in frequency of check-ins and regular visits with clients
- emphasize the therapeutic alliance and continued adoption of a calm, supportive, client-centred, culturally competent and empathic approach
- provide ongoing awareness and reassessment of risk
- eventually return to the "basics of client care" with attention to the practical issues and needs of the clients (Bartels 2007).

Supporting families in the aftermath of suicide

Survivors of suicide are not only grieving the loss of a loved one, but are also dealing with several other factors pertaining to the loss of a loved one through suicide. Along with the normal grief reactions, they may be experiencing a sense of shame, embarrassment and isolation. Staff working with families who are grieving a family member who has completed suicide need to be mindful of what the family may be experiencing, what their current needs may be, and how they can best be supported.

NORMAL AND COMPLICATED GRIEF REACTIONS

A normal grief reaction may include both psychological and somatic symptoms. The psychological symptoms include:

- shock
- denial
- anger

- disbelief
- intense sadness and loss
- emptiness
- fear
- anxiety
- confusion
- panic.

People may experience physical reactions such as:

- tightness in their chest
- nausea
- fatigue
- sleep disturbances
- headaches
- numbness
- changes in appetite.

In addition to a normal grief reaction, those grieving the loss of a loved one by suicide may experience intense feelings of:

- abandonment
- bewilderment
- guilt
- shame
- being overwhelmed
- embarrassment
- humiliation
- failure.

Losing someone to suicide may also be complicated by a person's spiritual or cultural beliefs and the stigma attached to suicide. These can lead to denial or a wish to hide the event, causing families to become isolated with their grief, and withdrawn from others or their usual support systems. Staff may be able to provide support to these families that otherwise may be unavailable. If staff recognizes a family withdrawing into themselves in the aftermath of suicide, the family may need support in reconnecting with family and friends (Sakinofsky, 2007).

A CLINICIAN'S ROLE IN SUPPORTING THE FAMILY

Whether dealing with an inpatient or outpatient suicide, Sakinofsky (2007) suggests contacting the family as early as possible to arrange a meeting and offer support. A family meeting may be helpful in clarifying the current needs of the family who has lost a member due to suicide. When conducting the family meeting, being aware of one's role and communicating that role to the family is essential because it provides structure to the session. The clinician's role is to support the family with their grief. The family is now becoming the client and they need a space to vent their thoughts and feelings. It may be helpful for the clinician to consult with management prior to holding a family meeting since the clinician is not responsible for risk management decisions. Administration may consult with risk management if there are any concerns. The CAMH policy "Death of an Inpatient" (http://insite.camh.net/policies/death_of_an_inpatient-37166.pdf) is also a helpful resource when working with a family.

CONFIDENTIALITY AFTER A SUICIDE

Confidentiality must continue to be maintained even after the person's death. Information the client would not want shared with their family can not be divulged. Families can be supported in telling their story and can provide staff with information, even if confidentiality laws prevent staff from providing information to the family.

CONDUCTING THE FAMILY MEETING

During the family meeting, staff can provide support to families in the aftermath of suicide by listening and not judging their reactions. Staff should make every effort to respect cultural and spiritual customs. Families must be encouraged to grieve in their own way.

Allowing the family to grieve and normalizing their grief reactions may help the family process their loss. Staff can help families understand that it is the death, not the form it takes, that must be grieved.

Support regarding religious services and funeral arrangements can be offered to the family. Staff may offer psychoeducation around grief reactions and provide families with tools for coping with their intense emotions (i.e., grounding exercises). Families should be offered longer-term supports to assist them in resolving their grief. For example, grief support groups or grief websites specific to suicide survivors may help families feel less alone in their grief.

Dealing with anger

Family meetings may be particularly challenging depending on the families reaction to the suicide. In a study completed by Van Dongen, 89 per cent of participants reported feeling anger, usually directed toward the deceased, the mental health system, God, or the world in general. Anger is part of the grieving process, "as survivors search for a reason why the suicide has occurred, believing that someone or something must be to blame" (Van Dongen, 1991). The family may express anger directed at themselves, the deceased or the institution in which the client was being treated. In this situation, it is important to ensure the family has a space to vent their anger and that they feel heard and understood. Allowing them to express their anger in a supportive manner does not require staff to accept responsibility for the person's death. Listening and allowing them to talk can often defuse some of the anger.

ATTENDING FUNERAL AND MEMORIAL SERVICES

Staff may have questions around the appropriateness of attending funeral or memorial services for the deceased. Sakinofsky (2007) suggested that staff members who have worked with the deceased should consider attending the memorial service, so long as the family has deemed this to be acceptable. Obtaining the families permission to attend is pivotal in the decision-making process.

Toronto Area Suicide Resources

For a comprehensive list of Toronto area mental health services, download *Making Choices*, a guide to mental health services, supports and resources in the City of Toronto. The guide has been produced by Community Resource Connections of Toronto and can be found at:

www.crct.org/choices/index.cfm

Bereaved Families of Ontario, Toronto

www.bfotoronto.ca/

416 440-0290

Dedicated to bereavement support through self-help and mutual aid.

Canadian Mental Health Association Toronto

www.toronto.cmha.ca/ct_workshops/asist.asp

Lawrence Avenue West site:
700 Lawrence Avenue West, Suite 480, Toronto, ON M6A 3B4.
Tel: 416 789-7957

Markham Road site:
1200 Markham Road, Suite 500, Scarborough, ON M1H 3C3.
Tel: 416 289-6285

Offers a variety of suicide prevention workshops for professionals and caregivers.

Distress Centres

416 408-HELP (4357)

24-hour distress and crisis lines. Distress Centres offer emotional support, crisis intervention, suicide prevention and linkage to emergency help when necessary. Access to a confidential interpreter for callers in crisis, offered in 151 languages. TTY service for the hearing impaired.

Family Association for Mental Health Everywhere (FAME)

www.fameforfamilies.com/index.php

Main office:
4214 Dundas St. West, Ste. 209, Etobicoke, ON M8X 1Y6.
Tel: 416 207-5032

Mississauga office:
2600 Edenhurst Dr., Ste. 101, Mississauga, ON L5A 3Z8.
Tel: 905 276-8316

Scarborough office:
4155 Sheppard Ave. East, Suite 100, Toronto, ON M1S 1T4.
Tel: 416 913-2144

Brampton office:
71 West Dr., Unit 21, Brampton, ON L6T 5E2.
Tel: 905 488-7716

The Family Association for Mental Health Everywhere (F.A.M.E.) offers support to families where any mental illness is an issue by providing education, resources and coping strategies.

Gerstein Crisis Centre

100 Charles Street East, Toronto, ON M4Y 1V3.

Tel: 416 929-5200

Non-medical crisis intervention for individuals experiencing a mental health crisis who either do not need hospitalization or do not want hospitalization. Twenty-four hour phone-line, mobile team and a 10-bed house for a short stay, three to five days.

Kids Help Phone

1 800 668-6868

Provides immediate help to young people 24 hours a day, 365 days a year.

Mood Disorder Association of Ontario

www.mooddisorders.on.ca/index.html

Main support line: 416 406-8046
Toll free: 1 888 486-8236
Family support line: 416 486-4011

Serves Ontario communities by providing awareness, education and training, family and youth clinical support, recovery programs and peer support.

Ontario Association for Suicide Prevention

http://ospn.ca/pages/home.html

Tel: 905 897-9183

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Appendix I: Suicide, Mental Illness and Substance Abuse

Suicide and children and youth: Facts

Suicide rates in Canada rise dramatically between the childhood and teen years, from 1.5 per 100,000 in girls aged 10 to 14, to 5.0 per 100,000 in girls aged 15 to 19. In boys, the rate rises from 1.7 per 100,000 in the younger group to 11.4 per 100,000 in the 15-to-19 age group (Statistics Canada, 2007). These numbers are exclusive of suicide attempts and ideations.

According to the Public Health Agency of Canada, suicide is the second highest cause of death for the age group 15 to 19, following unintentional injuries. Suicide was the third leading cause of death for the age group 10 to 14 (in 2005), after unintentional deaths and cancer.

In the *Canadian Journal of Psychiatry,* Steele and Doey outline key risk factors for suicide in children and youth, including increasing age. In Canada, boys are more likely to commit suicide, though girls are more likely to attempt suicide. Aboriginal youth are more likely to commit suicide; some studies have found an increased risk for gay, lesbian and bisexual youth as well. As with adults, psychiatric disorders including mood (especially depression) and substance use disorders are risk factors for suicide. Previous suicide attempts also appear to increase the risk of completed suicide. Other risk factors for suicide include a family history of suicide, impaired parent-child relationships, life stressors such as interpersonal losses, legal or disciplinary crises, and gang involvement. Positive family relationships may have a protective effect.

As Lizardi and Gearing describe in the chapter "Child and Adolescent Suicide" in *Suicide Assessment and Treatment: Empirical and Evidence-Based Practices,* intervention approaches for child and adolescent suicide prevention

need to include crisis management, psychosocial evidence-based practices and psychopharmacology. Crisis management must include thorough assessment and appropriate planning and disposition. Evidence-based practices that have been found to be effective for children and youth at risk for suicide include cognitive-behavioural therapy, dialectical behaviour therapy, interpersonal therapy for adolescents, psychodynamic therapy and family therapy. Psychopharmacology may mitigate the risk of suicide when used in the treatment of appropriate disorders and symptoms.

Family, friends and other caregivers are important and usually indispensable in the assessment and treatment of children and youth.

Suicide and mood disorders: Facts

The strong association of mood disorders with suicide will formally be recognized for the first time in the fifth edition of the *Diagnostic and Statistical Manual* (*DSM-V*) by the inclusion of a suicide assessment dimension across all types of mood disorders (American Psychiatric Association, 2010). The mood disorders comprise a group of diagnostic entities linked together by the core symptom of a disturbance in mood. The main mood disorders in the *DSM-V* are major depressive disorder (single episode or recurrent), dysthymic disorder, bipolar I or II disorders, and mood disorder or bipolar disorder NOS. Mood disorders not currently in the *DSM-IV* but to be listed in the *DSM-V* are mixed anxiety depression, mixed features specifier, and premenstrual dysphoric disorder. Psychological autopsy studies show that any *DSM* formal diagnosis is present in 90 per cent of suicides, but the largest proportion of suicide deaths (60 per cent) are in people with mood disorders (Cavanagh et al., 2003). In cases of suicide, dysphoria must clearly be accompanied by at least some degree of hopelessness and the belief that alternative solutions are either untenable or not feasible.

It is inconceivable that no element of depressed mood (i.e., dysphoria, mental pain or "psychache") would accompany suicidal thinking or acts—even among people who deliberately harm themselves without actually intending to cause death (Sakinofsky, 2010). Suicide attempters are 26 to 33 times more prevalent than people who complete suicide (Sakinofsky & Webster, 2010) and suicide attempters include a high proportion of people with depressed mood who do not meet the full criteria for major depressive disorder (i.e., are cases of "subthreshold" depression) (Bethell & Rhodes, 2007).

Early pooled analyses of observational follow-up studies of affective disorder estimated suicide risk as 15 to 19 per cent, based on the proportion of all *deaths* in the cohort attributable to suicide (Goodwin & Jamison, 1990; Guze & Robins, 1970; Miles, 1977). More recently, Bostwick & Pankratz (2000) applied case fatality prevalences (the proportion of the original cohort ultimately succumbing to suicide) to these data and calculated lifetime risks of 8.6 per cent in cases of people with mood disorder hospitalized for suicide risk, compared with four per cent for those hospitalized without specification of suicidality. Another way of understanding the relative im-

portance of mood disorders in suicide is to note that the standardized mortality rates for major depression are more than 20 times that in the general public, bipolar disorder more than 15 times, dysthymia more than 12 times, and mood disorders NOS more than 16 (Harris & Barraclough, 1997).

We have come to understand the psychopathology of mood disorders as coming from both a state of altered brain neurochemistry and from dire human predicament, so that caregivers must clearly pay proper attention to both these aspects (Sakinofsky, 2005). Even with the significant proportions of mood-disordered patients at risk mentioned above, the low base rate of suicide in the population and in research samples makes it difficult to evaluate treatments intended to prevent suicide; there are ethical dilemmas and sample sizes must be huge (Gunnell & Frankel, 1994). Prospective studies of suicide prevention have begun only recently and so far much of our knowledge about effective suicide prevention in mood disorders is based on retrospective analysis of investigations where treatment of depressed mood was the original primary objective. The most robust evidence for a specific effect of pharmacological treatment on suicidality is with bipolar disorder (Sakinofsky, 2010).

Clients with bipolar disorder spend considerably more time depressed than manic and the vast majority of suicides in people with bipolar disorder occur during depressive or mixed episodes. Hawton et al. (2005) noted that the predictors for completed suicide in people with bipolar disorder included being male, having a positive family history of suicide or mood disorder, having made a previous suicide attempt, and expressing hopelessness at the admission to hospital. There was no association with rapid cycling or the presence of a psychotic element. A past history of a suicide attempt is probably the strongest predictor, together with having recurrent or refractory depressions and a high percentage of days spent being depressed over the past year. An Australian study found that 60 per cent of bipolar disorder suicide cases in its sample had not received treatment at or above the benchmark standard because of less than optimal biological or social treatment or the patient's failure to adhere to treatment (Keks et al., 2009).

The best evidence for pharmacological prevention of suicide in people with bipolar disorders is lithium (in patients who persist with it for at least two

years) but lithium prescriptions have been overtaken by those for anti-convulsants and antipsychotics, possibly because of fear of the potential side-effects of lithium and also because of differential marketing. Although manic episodes are more attention-grabbing, clinicians need to remain focused on bipolar depression and mixed states since they carry the highest risk of suicide. Clients are often admitted while manic and discharged while in the depressed phase, when suicidal ideation is less obvious than it is during manic overactivity. Careful monitoring and energetic psychosocial support should be maintained after patients are discharged from hospital.

Depressive disorders are found in 45 to 70 per cent of suicides and the highest risk of suicide is during the first episode. Comorbid problem substance use and personality disorders increase the suicide risk in depressive illness. For five decades, antidepressants have been the cornerstone of the management of depressive illness, but in the last decade important questions have been raised about their safety and efficacy (Sakinofsky, 2007; Thase, 2008). The effect size of antidepressants (i.e., advantage of the active drug over placebo), is greater when the clients are more severely ill, suggesting that psychosocial support for both clients on the placebo and the experimental drugs is a large factor in reducing the gap between them in less severe cases of depression. Illness severity that persists in spite of psychosocial support indicates the need for more emphasis on biological treatment.

There has been much debate in recent years about antidepressants giving rise to emergent suicidality (non-fatal suicidal behaviour), particularly in young people. The U.S. Federal Drug Administration (FDA) sponsored a meta-analysis of 372 trials comprising more than 99,000 people. The study showed that the risk for emergent suicidality associated with antidepressants is age-related and decreases in older age groups. In the study, the odds of emergent suicidality doubled in those under 25 years old, changing to less than one in those aged 25 to 64 years (possibly protective), while antidepressants were clearly protective in those more than 65 years of age (Stone et al., 2009).

The Treatment for Adolescents with Depression Study (TADS) showed better results for treating people with suicidal ideation with a combination of a selective seratonin reuptake inhibitor (SSRI) with cognitive-behavioural

therapy (CBT) rather than from either alone (March et al., 2004). Current consensus is that antidepressants should not be used in young people as a first-line treatment but only if psychosocial methods are ineffective or severity does not permit a trial of psychosocial treatment only.

The PROSPECT study (Prevention of Suicide in Primary Care Elderly—Collaborative Trial) showed that suicidal ideation declined faster where primary physicians were able to collaborate with trained geriatric "health specialists" who also applied a treatment algorithm for antidepressant use and psychotherapy (Alexopoulos et al., 2009; Mulsant, 2001).

Aboriginal suicide: Facts

Suicide was rare among First Nations people before the arrival of Europeans (Canadian Mental Health Association, 2003). White and Jodoin (2003) noted that Aboriginal suicide has increased within the last few decades. Although suicide rates vary enormously across First Nation communities, the overall suicide rate among First Nation communities is higher than the total Canadian population. According to the Royal Commission on Aboriginal Peoples (1995), suicide rates among registered Aboriginal peoples were three times higher than the general Canadian population. In more recent studies, suicide has been reported as the leading cause of death among youth and adults up to the age of 44 (Health Canada, First Nations Inuit Health Branch, 2003; Health Canada, 2003). These reports noted that Native youth between the ages of 15 and 30 were five to six times more likely to commit suicide than non-Aboriginals. Kirmayer (1994) suggested that Aboriginals take their lives more than any identified culture group in the world. However, while suicide rates among Aboriginal peoples are higher than non-Aboriginals some evidence suggests that some First Nation communities have no suicide, and that these communities appeared to have developed community protective factors such as controlling and managing self-government, land claims, education, policing and have developed and supported cultural facilities (Chandler and Lalonde, 1998).

Not all communities have this ability or the resources to achieve non-suicidal behaviour in their communities. Chenier (1995) suggested that Aboriginal suicide may be the result of communities in poverty, low levels of education, high rates of unemployment and poor housing conditions, which may contribute to feelings of helplessness and hopelessness. She further noted that culture stress, "loss of land and control over living conditions, suppression of belief systems and spirituality, weakening of social and political institutions, and racial discrimination have seriously damaged their confidence and thus predisposed them to suicide, self-injury and other self-destructive behaviours" (p. 3). A Health Canada conference report, "Lifting the silence on suicide: Together we can make a difference" (2002), noted that other risk factors for suicide include a family history of addictions and suicide, previous suicide attempts, interpersonal conflicts, physical illness or disability, depression, unemployment, unresolved personal issues, sexual

orientation, family violence, living alone, and the loss of a friend or relative. Other risk factors identified by White et al. (2003) included alcohol and substance abuse, social isolation and access to firearms.

Suicide is a behaviour or action. It should not be seen as a distinct psychiatric disorder, but as a reaction to the state that First Nations peoples find themselves trapped in—a colonist and pro-colonist reality. Therapists need to be mindful of this reality when providing intervention to First Nation peoples.

Schizophrenia and suicide: Facts

Schizophrenia is a disturbance of the brain's functioning that can seriously alter the way people think, feel and relate to others. About one person in 100 develops schizophrenia. Men and women are affected equally; however, men tend to have their first episode of schizophrenia in their late teens or early 20s and women experience this first onset a few years later. The symptoms of schizophrenia fall into two categories: "positive" and "negative" symptoms. Positive symptoms (sometimes called psychotic symptoms) refer to symptoms that appear, while negative symptoms refer to elements that are taken away from a person. Positive symptoms include delusions, hallucinations, disorganized thinking, mood and behaviour, and changes in sensitivity. Negative symptoms include lowering of physical activity levels, reduced motivation, loss of interest in the feelings and lives of others, and loss of concern for personal appearance. Schizophrenia has three phases: prodromal (or beginning), active and residual. These phases tend to happen in order and appear in cycles throughout the course of the illness. During a lifetime, people with schizophrenia may become actively ill once or twice, or have many more episodes. No single cause has been found for schizophrenia, although there is a clear genetic link. Research has given us clues in the search for better ways to diagnose and treat the illness. It is impossible to predict how well a person will recover after the onset of the disorder: some will recover almost totally, while others will need medication and support for the rest of their lives (Patterson et al., 1999).

Some interesting facts and statistics about schizophrenia and suicide:

- Although a historic misconception, it is possible for individuals with schizophrenia to live meaningful lives that include having a job, family, home and a circle of close friends.
- At least five to 13 per cent of individuals with schizophrenia die by suicide; it is cited that the higher end range is a more accurate estimate (Pompili et al., 2007).
- According to the Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviours, 40 to 53 per cent of clients with schizophrenia think about suicide at some point in their lives (American Psychiatric Association, 2003).

- The suicide rate in inpatient cohorts of individuals with schizophrenia, who were followed up post one-year hospitalization, for periods of one to 26 years, was 6.8 per cent (Pompili et al., 2005).
- Meta-analyses have found that the risk of suicide in individuals with schizophrenia is eight times that of the general population (Harris & Barraclough, 1997).
- It is estimated that about 20 to 55 per cent of individuals with schizophrenia make a suicide attempt at some time in their lives (Drake, 2006; American Psychiatric Association, 2003; Landmark et al., 1987; Plansky & Johnston, 1971).
- Compared with suicide attempts among people without schizophrenia, attempts by people with schizophrenia are serious and intent is generally strong: therefore, these attempts typically require medical attention (Pompili, et al., 2007).
- Suicide attempts in individuals living with schizophrenia have been associated with the number of lifetime depressive episodes. In this context, depression has been recognized as a major risk factor among people with schizophrenia who have attempted suicide (Gupta et al., 1998).

RISK FACTORS

Identifying of risk factors for suicide in individuals living with schizophrenia is important in preventing the risk and severity of outcomes. Confusing of the negative symptoms or medication side-effects with depression has been cited as a contributing factor for poor outcomes. This confusion highlights the need for health care providers to be better trained and to have a better understanding of illness symptomology (Jones et al., 1994; Pickar et al., 1986).

Five significant variables for suicide have been indicated in this population:

- past suicidal ideation
- previous deliberate self-harm
- previous depressive episodes
- drug abuse or dependence
- higher number of psychiatric admissions (Pompili et al., 2007).

Review of the literature points to a consensus that the key risk factors related to schizophrenia and suicide include individuals who are young, male and Caucasian, have never married and:

- have good premorbid functioning
- have high aspirations
- were first hospitalized at a late age
- have a higher IQ
- are aware of the illness trajectory and its potential impact on their lives
- are experiencing post psychotic depression
- are experiencing deteriorating health due to co-morbid conditions (Pompili et al., 2007; Fenton et al., 2000; Fenton et al., 1997).

Other significant risk factors for suicide in individuals living with schizophrenia include:

- hopelessness
- social isolation
- recent loss or rejection
- limited external support
- family stress and instability (Pompili et al., 2007; Fenton et al., 2000; Fenton et al., 1997).

An association of positive symptoms with suicide, specifically in the acute phase of the illness, with the presence of psychotic symptoms, paranoid delusions and thought disorder has also been found (De Hert et al., 2001; Kruplinski et al., 2000; Fenton et al., 1997; Saarinen et al., 1999; Heila et al., 1997; Hu et al., 1991; Westermeyer et al., 1991; Roy, 1982).

Command hallucinations resulting in a suicide, although atypical, have been reported in the literature. According to the literature, command hallucinations occur more than recognized and assessed for in clinical settings. These hallucinations frequently hold imperative clinical significance and should therefore be carefully assessed and treated in individuals with schizophrenia (Pompili et al., 2007).

Despite the finding above, suicide has been found to be less associated with core symptoms of psychosis, and more with affective symptoms, agitation,

and an awareness that the illness is disturbing mental function (Pompili et al., 2007).

Anxiety has been found to be a contributing factor to suicidality in post psychotic depression. Co-morbidity with panic attacks has been associated with higher suicide rates in individuals with schizophrenia (Goodwin et al., 2002; Saarinen et al., 1999).

Akathisia awareness manifested subjectively as an insufferable feeling of inner tension and restlessness, in combination with hopelessness, has been associated with higher rates of suicidality in individuals with schizophrenia (Cem Atbasoglu et al., 2001).

These risk factors for suicide and schizophrenia are commonly compounded and exasperated by deficits in adequate access to the social determinants of health (Pauley, 2008). An understanding of the social determinants of health and health equity in the context of harm reduction and recovery must inform a clinician's approach to care. Lack of equity, or of these determinants or assistance in facilitating them, must be considered as a fundamental gap in a care delivery model (Meerwijk et al., 2010; Pauley, 2008; RNAO, 2009).

The suicide risk for adolescents or young adults with schizophrenia has been found to be three times higher than for adults living with the illness (Pompili, 2007).

SUBSTANCE USE AND YOUTH WITH SCHIZOPHRENIA

It is estimated that 40 to 60 per cent of individuals with schizophrenia will develop a substance use disorder in their lifetime (Ptaszik, 2009; Ptaszik, 2008).

Individuals living with schizophrenia who use substances have been found to be at an increased risk for suicide (Ptaszik, 2008). In particular, youth living with schizophrenia who use substances are cited to be at greater risk (RNAO, 2009; Pompili et al., 2007; Rich et al., 1988; Fowler et al., 1986).

TRANSITIONS AND PHASES OF CARE

A high-risk period for suicidality includes situations in which the treatment regimen is altered in a significant way (Drake et al., 2006; Pompili et al., 2004; Burgess et al., 2000; Saarinen et al., 1999; Cotton et al., 1985; Crammer, 1984; Farberow et al., 1976; Virkkunen, 1976; Farberow et al., 1965; Cohen et al., 1964). Approximately one third of suicides in individuals with schizophrenia occur during admission or during the first week after discharge. These high-risk periods are important factors to consider when conducting an assessment, and when establishing, planning and considering the next phases of care (RNAO, 2009; Drake et al., 2006; Pompili et al., 2004; Burgess et al., 2000; Saarinen et al., 1999; Cotton et al., 1985; Crammer, 1984; Farberow et al., 1976; Virkkunen, 1976; Farberow et al., 1965; Cohen et al., 1964). The post-discharge period is an important phase for individuals with schizophrenia, because this time may represent a period of separation from an environment that was central to their lives. This period is of greater concern if the individual is experiencing hopelessness and a sense of demoralization related to the illness (Pompili et al., 2007).

INSIGHT

Research suggests that awareness of illness is associated with increased risk of suicide in this population, but only if this awareness leads to hopelessness (Pompili et al., 2007). It is imperative that individuals with schizophrenia be carefully assessed for hopelessness and suicidal ideation throughout the course of their illness, especially if there is a distinct improvement in their awareness of any element of the illness symptoms (Pompili et al., 2007; RNAO, 2009).

PROTECTIVE FACTORS AND PREVENTION

Above and beyond the other protective factors and preventative measures for suicidality, non-pharmacological treatments such as social skills training, vocational rehabilitation and supportive employment are key protective factors in suicide prevention in individuals living with schizophrenia (Nyman et al., 1986; Cotton et al., 1985; Roy et al., 1982). Strength-based programs that focus on suicide prevention, early detection, in addition to

treatment options tailored to meet the unique needs of individuals with schizophrenia and support their families, are crucial. Supportive, reality-oriented therapies, including supportive psychotherapy and cognitive-behavioural approaches need to be considered as part of the treatment approach and as preventative measures for individuals experiencing suicidality and schizophrenia (RNAO, 2009; Pompili et al., 2007; Cotton et al., 1985; Nyman et al., 1986; Roy, 1982). Clinicians need to be able to accurately screen, diagnose and treat suicidality in individuals with schizophrenia. Screening and treatment must be combined with adequate screening and treatment for other risk factors. Screening and treatment must take place at all points of entry into the health care system and continued at intervals determined by the level of risk assessed (Pompili et al., 2007). In light of the multi-factorial risk factors associated with suicide and schizophrenia, an understanding of screening for substance use and dependence, and other co-morbid conditions is also critical.

Suicide and substance use: Facts

In 2002, Statistics Canada estimated that approximately 90 per cent of Canadians who committed suicide were suffering from depression, another mental illness, or a substance use disorder at the time (Canadian Social Trends). A 2002 study by the Canadian Centre on Substance Abuse found that a total of 603 deaths from suicides/self-inflicted injuries (493 males and 109 females) were associated with alcohol use and another 295 completed suicides (146 males and 149 females) were attributable to the use of illegal drugs in that year (Rehm et al., 2006).

Many researchers and clinicians have attempted to clarify the nature of the relationship between substance use and suicidal risk:

- In a study of 527 abstinent opiate-dependent clients, Roy found that almost 40 per cent had a history of suicide attempts and that family history of suicidal behaviour, alcohol dependence, cocaine dependence and treatment with antidepressant medication were significant predictors of these attempts (Roy, 2010).
- In their study of a sample of 990 drug users with criminal justice histories, Cottler and colleagues found that alcohol use disorder and depression were significant predictors of suicidal ideation for both males and females. They highlighted "the need to discuss suicidal thoughts among depressed drug users for early treatment and prevention" (2005).
- Flensborg-Madsen and colleagues concluded that alcohol use disorders were associated with a "highly increased risk of completed suicide" among 18,146 subjects in the Copenhagen City Heart Study in Denmark (Flensborg-Madsen et al., 2009).
- In Canada, Mann and colleagues (2008) studied male and female suicide mortality rates in Manitoba between 1976 and 1997 and found that alcohol consumption was related to both male and female suicide mortality rates.

Suicide and the elderly: Facts

Older adults (those over 65) made up 13.7 per cent of the Canadian population in 2006. The Canadian population continues to age and in 2026 it is expected that 20 per cent, or one in five Canadians, will be aged 65 or older (PHAC, 2008).

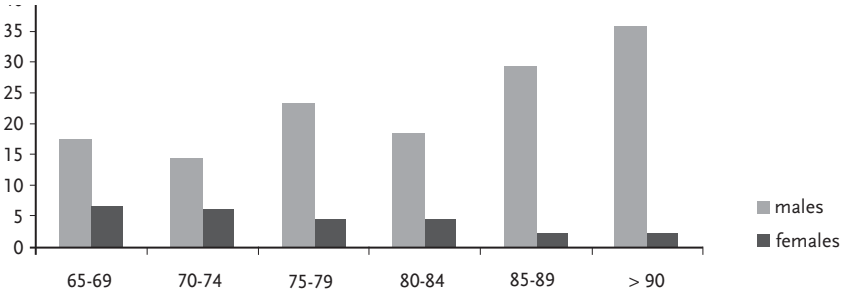
Men aged 85 and older, labelled "old-old," were at the greatest risk for suicide of all Canadians. In 2006, the suicide rate for men aged 85 and older ranged from 29 to 35.7 per cent per 100,000 population. That was twice the current rate for all ages (16.7 per 100,000).

Every day 1.3 seniors die by suicide in Canada (23 in 100,000).

While older adults attempt suicide less often than those in other age groups, they have a higher rate of death by suicide (15 to 24 year olds: one death per 100 to 200 attempts, versus those people who are over 65: one death per four attempts).

One of the leading causes of suicide among the elderly is depression, which is often undiagnosed and/or untreated.

Suicides and suicide rate per 100,000 population, by sex and age group in Canada, 2006.



(Statistics Canada, 2007)

In the elderly, common risk factors include:

- recent death of a loved one
- physical illness
- uncontrollable pain
- perceived poor health
- social isolation and loneliness
- major changes in social roles
- suicidal ideation/behaviour
- family history of suicide
- mental illness
- substance use
- personality factors (American Association of Suicidology, 2007).

Protective factors include:

- resiliency
- sense of meaning and purpose in life
- sense of hope
- sense of optimism
- religious (or spiritual) practice
- active social networks
- good health practices
- positive health-seeking behaviours
- engagement in activities of interest (American Association of Suicidology, 2007).

Appendix II: eIPCC for Suicidal Clients

Safety Domain is generated if any of the following **issues** are identified:

- Client at risk of self-harm.
- Client is at risk for suicide.
- Client has suicidal ideation.

Issue Needs/Detail provides the clinician with an opportunity to elaborate on the client's particular circumstances, for example:

- Client has history of harming self.
- Client hospitalized for injuries related to self-harm.
- Client has attempted suicide in the past.
- Client expressed current thoughts of suicide.

Based on the issues and needs identified for the client, **Goals** are generated:

- Prevent self-harm.
- Identify factors that contribute to incidents of self-harm.
- Discuss triggers for harming self.
- Collaborate with client to develop a written plan to manage the intense feelings that lead to suicidal thinking and/or actions.

Client specific **Interventions/Plans** are developed based on issues, needs and goals, for example:

- Assess immediate factors that pose a risk to safety (modify environment as needed).
- Increase level of observation to _____ for _____ hrs/days.
- Identify factors that place the client at risk for suicide (recent loss, age, chronic medical condition, loss of hope, substance use, past suicide attempts, family history, thoughts of suicide) (this is different than the above immediate risk factors).
- Identify protective factors (children, culture, pets).
- Assess suicidal ideation (plan, intent, means, lethality, protective factors, previous attempts; include active ideation, include passive ideation.

- Assess triggers for level of distress (mild, moderate, severe).
- List and encourage the use of coping strategies (talking, sensory, alternative).
- Identify modifiable and specific factors that will increase or decrease risk (access to means to attempt, potential hazards).
- Create and discuss client safety plan located on _____.
- Review with client plan for safety when clients are coping with intense feelings.
- Reflect on events, thoughts and feelings that immediately precede suicidal thoughts to help understand triggers.
- Explore reasons for living and reasons for dying.
- Consultation with spiritual and religious service.

Appendix III: Screening Tools

How do you Remember the Warning Signs of Suicide?
Here's an Easy-to-Remember Mnemonic:

IS PATH WARM?

I	Ideation
S	Substance Abuse
P	Purposelessness
A	Anxiety
T	Trapped
H	Hopelessness
W	Withdrawal
A	Anger
R	Recklessness
M	Mood Change

A person in acute risk for suicidal behavior most often will show:

Warning Signs of Acute Risk:

- Threatening to hurt or kill him or herself, or talking of wanting to hurt or kill him/herself; and/or,
- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or,
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary.

These might be remembered as expressed or communicated **IDEATION**. If observed, seek help as soon as possible by contacting a mental health professional.

Additional Warning Signs:

Increased **SUBSTANCE** (alcohol or drug) use
No reason for living; no sense of **PURPOSE** in life
ANXIETY, agitation, unable to sleep or sleeping all the time
Feeling **TRAPPED** - like there's no way out
HOPELESSNESS
WITHDRAWING from friends, family and society
Rage, uncontrolled **ANGER**, seeking revenge
Acting **RECKLESS** or engaging in risky activities, seemingly without thinking
Dramatic **MOOD** changes

If observed, seek help as soon as possible by contacting a mental health professional.

These warning signs were compiled by a task force of expert clinical-researchers and 'translated' for the general public.

American Association of Suicidology (2010).

Suicide Prevention Resource Centre. (2009).

SAD PERSONS Scale

The following is an assessment tool used to determine the risk of an individual for suicide. Each area is a risk factor for suicide. The theory is that the more areas that an individual fits into, the higher risk the individual would be considered.

S	**Sex -** Females are more likely to attempt suicide, but males are more likely to choose a more deadly means
A	**Age** - 15-24 years old or men 75 and older are high risk groups
D	**Depression**
P	**Previous attempts**
E	**Ethanol and other drug use**
R	**Rational thinking loss**
S	**Social support lacking**
O	**Organized plan** - The more specific the greater the risk
N	**No spouse**
S	**Sickness**

(RNAO, 2009; Patterson, W. M., Dohn, H. H., Bird, J., & Patterson, G. A., 1983).

(RNAO, 2009; Patterson, W. M., Dohn, H. H., Bird, J., & Patterson, G. A., 1983).

Appendix IV: Sample Safety Plan Template

Safety Plan

If you have thoughts of hurting yourself, start at Step 1. Go through each step until you are safe. Remember: Suicidal thoughts can be very strong. It may seem that they will last forever. With support and time, these thoughts will usually pass, you can put energy into sorting out problems that have contributed to you feeling so badly. The hopelessness you may feel now will not last forever. It is important to reach out for help and support. You can get through this difficult time. Since it can be hard to focus and think clearly when you feel suicidal, please copy this and put it in places where you can easily use it such as your purse, wallet, or by the phone.

1. Do the following activities to calm/comfort myself:

2. Remind myself of my reasons for living.

3. Call a friend or family member.
   Name: Number:

4. Call a back-up person if person above is not available.
   Name: Number:

5. Call a care provider (psychologist, psychiatrist, therapist):
   Name: Number:

6. Call my local crisis line:
   Number:

7. Go somewhere I am safe:

8. Go to the Emergency Room at the nearest hospital.

9. If I feel that I cannot get to the hospital safety, call 911 and request transportation to the hospital. They will send someone to transport me safely.

(CARMHA, 2007: 39)

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