practice principles

A GUIDE FOR MENTAL HEALTH CLINICIANS WORKING WITH SUICIDAL CHILDREN AND YOUTH

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table of contents

Acknowledgements (i) 5
Advisory Committee Members (ii) 6
Clarification (iii) 6

1. Introduction 7

1.1 Child and Youth Suicidality – An Overview of the Problem 7
1.2 Learning from Experience 7
1.3 Intended Audience 8
1.4 Purpose of the Practice Principles 8
1.5 Process for Developing the Practice Principles 8
1.6 Orientation to This Guide 9
1.7 Practice Principles At-a-Glance 10

2. Child and Youth Suicidality – Principles of Clinical Care 13

2.1 Commonly Understood Terms for Suicidality 13
2.2 Child and Youth Friendly Mental Health Services 14
2.3 Therapeutic Alliance 15
2.4 Informed Consent and Confidentiality 16
2.5 Cultural Context 16
2.6 Inclusive and Accepting Language 18
2.7 Developmental Considerations 19
Table 1 - Sample Questions for Interviewing Prepubertal Children About Suicide Ideation and Behaviour 21
2.8 The Challenging Client 22
2.9 Family Involvement 23
Table 2 - Sample Psychoeducational Program for Parents of Suicidal Children 25
2.10 Clinical Consultation 26
2.11 Care for the Mental Health Clinician 27

3. Identifying and Assessing Suicide Risk 29

3.1 Identifying Risk 29
A Risk Assessment Model 29
Primary Risk Factors 30
Secondary Risk Factors 31
Situational Risk Factors 31
Protective Factors 31
3.2 The Continuum of Risk for Suicide 32
3.3 Assessing Risk 33
Situation Evaluation and Review of Presenting Difficulties 33
Ideation, Intent and Lethality 34
Table 3 - Interviewing for Suicide Ideation, Plans & Reasons for Living & Dying . . . 35
The Personal Meaning of Suicidal Behaviour 36
Protective Factors 36
Table 4 - The Personal Meaning of Suicide 37
Table 5 - Risk Assessment Matrix 38
3.4 Clinical Decision-Making 39

table of contents

4. Managing Safety and Treatment Planning 41

4.1 Safety Planning 41
Table 6 - Considerations for Monitoring Moderate to High Risk 42
Safety Contracts 43
4.2 Recommendations for Hospitalization 44
Table 7- Indicators of Need for Intensive Level of Care 45
4.3 Treatment Planning 46
4.4 Complex Psychiatric Issues 46
Major Depressive Disorder 47
Substance Abuse 48
Emerging Personality Disorder 49
Conduct Disorder 50
Psychosis 50
4.5 Brief Cognitive Behavioural Approaches 50
Problem Solving Skills Training 51
Table 8 - Competence Building Program Elements 52
Solution Focused Brief Therapy 53
Table 9 - Therapeutic Tasks of Solution-Focused Brief Therapy (SFBT) Using Shneidman's Ten Commonalities of Suicide 54
4.6 Dialectical Behavioural Therapy 55
4.7 Documentation and Evaluation of Treatment Plan 55
Documentation 56
Evaluation of Outcomes 56
4.8 Monitoring Suicidality 57

5. Enhancing Linkages Between Child and Youth Mental Health Services and the Community 59

5.1 Integrated Case Management and Wrap-Around Care 59
5.2 Protocols between Acute Care Emergency and Mental Health Services 61
5.3 Responding to Suicide Pacts: The Role of the Mental Health Clinician 62
5.4 Reintegration of Children/Youth into School Following a Suicide Attempt 63
5.5 Media Education Guidelines 64
5.6 Postvention in Schools 65
Table 10 - Suggestions for Postvention group and Individual Counselling 66
Table 11 - Elements of a Community Postvention Committee 66
5.7 “Before the Fact” Prevention in the Community 67

References 69

Suggested Reading 77

Appendices 79
1 The Acts 79
2 Consent to Treatment and Appropriate Information - Sharing Related to Treatment Planning: A Decision Tree 83
3 Designated Mental Health Facilities in BC 84
4 Case Examples 85

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(iii) CLARIFICATION

This document should be considered as a set of guiding principles only and is not to be construed or to serve as a standard of care. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advances and patterns evolve. The ultimate judgment of suicidality regarding a particular client must be made by the clinician in light of clinical data presented by the client and other available information.

1. introduction

1.1 CHILD AND YOUTH SUICIDALITY - AN OVERVIEW OF THE PROBLEM

As a practicing mental health clinician working with children and youth you are acutely aware of the seriousness of suicide and suicide behaviour in children and youth. The losses faced by families, schools, and communities as a result of child and youth deaths are enormous. Youth deaths by suicide account for more than 15,000 years of potential life lost in this country each year (National Task Force on Suicide, 1994). Suicide is the second most common cause of death among those 15 to 24 years of age in BC and across the country. Both in Canada and the United States, rates of suicide among males aged 15-19 tripled between the decades 1960 and 1980 with a plateau emerging throughout the 1990s. Many Aboriginal communities have rates of suicide that are significantly higher than the non-Aboriginal population. Based on what we know about the problem, many of these deaths are preventable.

For the three-year period from 1995-1997, there was an average of 25 suicides a year among young people aged 15-19 in BC. Among those 10-14 years old, there was an average of almost six suicides per year for the same time period. Males kill themselves three times as often as females, due in part to their use of more highly lethal methods such as firearms or hanging. Many more young people attempt suicide or consider it as an option during times of stress and crisis. According to the most recent adolescent health survey undertaken in our province, seven percent of young people in grades 7 to 12 reported making a suicide attempt in the previous year (McCreary Centre Society, 1999). Estimates from other jurisdictions suggest that among adolescent girls, the ratio of suicide attempts to completions is almost 200:1 (Bland, Newman & Dyck, 1994).

Suicidal behaviour among children and youth is complex and it needs to be understood as it arises out of the dynamic interplay between individual factors and other key socializing influences like family, school, interpersonal relationships, the economy, politics and culture. Dyck, Mishara & White (1999) suggest that a number of well-established individual factors and social conditions interact which serve to create a vulnerability to suicide and suicidal behaviour among both children and youth.

1.2 LEARNING FROM EXPERIENCE

Certainly there is a great deal to learn from the research that has been done in suicidality and from the experiences of mental health clinicians regarding the need for systems and professionals to be responsive to the challenges of child and youth suicidality. We can also learn from other voices, including those of advocates, survivors and youth themselves.

The work of the Children's Commission has produced fatality reviews, care plan audits, a complaints review process, and public reports and recommendations, all of which pay significant attention to some of the systemic weaknesses in the child and youth serving system in BC (Children's Commission, 1998). Integrated case management and planning for youth transitions to the adult mental health system have been identified as issues of particular importance.

The experiences of survivors (those who have lost a loved one to suicide) offer profound insights into the need for early detection and the

The act of suicide represents a final, desperate attempt by a child at some type of resolution to what he or she perceives to be otherwise unsolvable troubles.

Jacobs, 1999

importance of suicide prevention efforts at the school and community level; they also speak to the need for continuous care across systems and services. Youth with experience in using health care services, including mental health, have suggested ways to offer services that are more "youth friendly" and flexible. The provincial Child, Youth and Family Advocate's Office has also advanced several recommendations to improve the quality of services offered to children, youth and their families (Child, Youth & Family Advocate, 1999).

1.3 INTENDED AUDIENCE

The Practice Principles document highlights evidence-based principles and is intended for practicing mental health clinicians with established clinical competencies working with suicidal children and youth in outpatient settings. Child and youth mental health clinicians have a significant role in the assessment, clinical management, and treatment of children and youth at risk for suicide. The Practice Principles document works on the assumption that the reader is a proficient mental health clinical practitioner with a particular interest in the assessment and treatment of suicidality in children and youth.

1.4 PURPOSE OF THE PRACTICE PRINCIPLES

This document is intended as a *guide* to practice only; it is not designed as a policy document or a training tool. This resource aims to support and complement ongoing clinical training and in this spirit, contributes to the continuing professional development of mental health clinicians. The intent of this document is to support and empower mental health clinicians by highlighting the key practice principles, therapeutic tasks, and treatment strategies considered by the research literature and by experienced clinicians to be most effective in the assessment, management, and treatment of suicidal children and youth.

Empowering Clinicians and Enhancing Clinical Competency

Clinical competency in managing suicidal children and youth clients is based on sound clinical knowledge and skills combined with a caring and respectful attitude toward the young clients, and their families, and the emotional tolerance and desire to assist others in distress (Berman, 1986). A knowledge of risk factors and the capacity to respond in an effective way to clients who present a risk of suicide are distinct yet intertwined areas of clinical competency (Bongar, 1993). Additionally, it is important to be aware of specific risk populations and to understand the relation between the law and mental health practitioners and the rules and limitations regarding confidentiality and informed consent. (See Appendix 1 for further discussion of relevant legislation for clinical practice.)

The suicidology research literature and senior mental health practitioners suggest that a successful clinical practice with children and youth involves a number of interdependent variables: the mental health clinician's professional judgment, a thorough knowledge of risk factors and competency analysis, with the participation of the child or youth (and his or her family) in the planning of his or her own care to the extent possible, and documentation that provides a durable record of the assessment, intervention and treatment process. This guide will review these fundamental practices.

1.5 PROCESS FOR DEVELOPING THE PRACTICE PRINCIPLES

The Practice Principles are based on the findings of an extensive literature review, bridged with the expert opinion of senior mental health clinicians, under the guidance of a Provincial Advisory Committee. This Advisory Committee was comprised of child and youth mental health clinicians and managers, a child psychiatrist, an Aboriginal psychologist, and key government representatives.

The development and dissemination of the Practice Principles to support mental health clinicians working with individual suicidal children and youth represents an important contribution to the overall youth suicide prevention effort. As mental health clinicians, your knowledge and expertise can contribute significantly to the efforts of an entire community to reduce the risk of suicide.

A comprehensive approach to child and youth suicide prevention is characterized by multiple strategies implemented across an array of key contexts, over time. The delivery of high quality assessment and treatment services to children and youth is a central component in any youth suicide prevention effort, but must be understood as just one strategy within an overall spectrum of initiatives. Other interrelated initiatives include community education, school policy development on suicide prevention, assessment and referral protocols, the education of the media, the development of family support strategies and peer helping programs, as well as early identification of suicide ideation and depression, and the promotion of community wellness (White & Jodoin, 1998).

This guide has been reviewed by many experienced child and youth mental health clinicians in British Columbia throughout the draft phases. These thoughtful observations and comments have assisted us in shaping and fine tuning the document. Here are examples of some of their comments:

> *It is comprehensive and if I had read it having just been hired to my job, I believe I would feel more confident and informed about what to do… Having worked for nine years, I think the [Practice Principles] will assist me in the consistency of a therapeutic approach. I have never seen a document before that puts this all together…well done.*

> *Very informative and will be an excellent tool to guide mental health clinicians in their work with suicidal children and youth – up-to-date and authentic.*

1.6 ORIENTATION TO THIS GUIDE

The Practice Principles guide is organized into five main sections. Each section of the guide contains *key principles*, *discussion points*, and *illustrative tables*. These five main sections include:

1) an introduction to child and youth suicidality;

2) an overview of clinical care principles for treating child and youth suicidality;

3) a model for identifying and assessing suicide risk;

4) suggestions for safety, treatment planning, and ongoing monitoring of suicidality; and

5) a discussion and guidelines for linking child and youth mental health services with the community (e.g., 'wrap-around' care approaches, media education, management of suicide pacts, reintegration into schools after a suicide attempt, postvention, as well as suggestions for supporting community networks that respond to suicide and other critical incidents).

This guide is not intended to replace current mental health centre clinical policies and procedures. Rather, it brings together an evidence-based perspective of current 'state-of-the-art' research in child and youth suicidality thus providing you with a handy resource for reviewing the fundamentals of clinical care for suicidality, orienting new clinicians, and offering a focus for discussion among mental health clinicians who are involved in ongoing clinical consultation.

1.7 PRACTICE PRINCIPLES AT-A-GLANCE

PRINCIPLES FOR CLINICAL CARE OF CHILD & YOUTH SUICIDALITY	PRINCIPLES FOR IDENTIFYING & ASSESSING RISK	PRINCIPLES FOR SAFETY & TREATMENT PLANNING AND ONGOING MONITORING	PRINCIPLES FOR ENHANCING LINKAGES BETWEEN CHILD & YOUTH MENTAL HEALTH SERVICES & THE COMMUNITY
Use commonly understood terms for suicidality i.e., suicide, (completed suicide), instrumental suicide (also known as para suicide or deliberate self-harm), suicide attempt with injuries, suicide attempt without injuries, self-mutilation, suicidal threat, suicide ideation.	Use commonly understood terms and definitions for levels of suicidal risk, i.e., non-existent, mild, moderate, high, and imminent.	Consider the attempt or ideation from child or youth's point of view and match resources with level of risk.	Seek to establish proactive relationships to involve and work collaboratively with key service providers (school, hospitial emergency services, mental health services & child protection) families and community resources to provide integrated service delivery.
Create child-& youth-friendly mental health services.	Consider domains of risks, i.e., primary, secondary, situational, as well as protective factors.	Attend to safety planning with involvement of client & to the extent possible, the family & additional resources. N.B.: in case of high and imminent risk a 24 hour safety plan should be developed.	Establish formal agreements linkages between hospital emergency services & mental health centre for seamless referral.
Develop a therapeutic alliance, making the clinical relationship central to the treatment plan. Seek to regularly review & respond to clinicians' own reactions to suicidal clients.	Consider risk factors & presenting difficulties based on both subjective (self-reporting) & objective intent.	Conduct mental status exam to determine presence of underlying psychopathology. Seek additional testing and information for whole perspective of client's situation. Seek consultation and consider referral needs for complex psychiatric issues.	Develop guidelines for responding to suicide pacts in the community.
Seek informed consent & explain limits of confidentiality.	Assess level of suicidal intent; current ideation; current plans; lethality & availability of means; preparatory behaviour; cognitive rigidity & problem solving abilities; impulse control; degree of social isolation.	Establish criteria for determining when to recommend hospitalization.	Develop guidelines for media education on reporting suicidality in the community.
Consider the cultural context of the client.	Understand the personal meaning of suicide for individual.	Use brief cognitive-behavioural treatment approaches for suicidal ideation (particularly in the presence of Axis I disorders such as depression).	Develop guidelines for supporting the reintegration of a child or youth into the school after a suicide attempt.

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Use inclusive & accepting language.	Identify individual, family & community protective factors (subjective & objective).	Conceptualize a long-term treatment approach for chronic suicide attempts and related behaviours (particularly in the presence of Axis II disorder) such as Dialectic Behavioural Therapy.	Support "Before the Fact" suicide prevention initiatives in the community.
Consider developmental stage of child or youth.	Attend to two key variables: 1) the client's experienced & expressed distress and 2) his or her tolerance for this distress.	Document & evaluate the treatment process & outcomes.	
Respond proactively to client drop out/resistance.	Recommend level of care to match level of risk identified.	Regularly monitor suicidality.	
To the extent possible, engage parental (and other family members) as key collaborators in treatment planning. Be mindful of parents' fears & anxieties & approach family members in a supportive, non-judgmental manner.			
Seek regular clinical consultation with peers and supervisors.			
Develop and engage in personal and collective strategies to care for the Mental Health Clinician.			

2. child and youth suicidality – principles of clinical care

2.1 COMMONLY UNDERSTOOD TERMS FOR SUICIDALITY

Use clearly articulated definitions for identifying, classifying, documenting and discussing suicidal behaviours (e.g., O'Carroll et al, 1996).

There is a lack of clarity in accepted and routinely applied definitions of suicide and suicidal behaviour which has significant implications for clinical practice. O'Carroll et al (1996) suggest using a set of commonly understood, logically defined terms or nomenclature for suicidal behaviour. This set of definitions serves the mental health clinician as a kind of shorthand by which communication about suicide-related behaviour can be facilitated.

Currently, there is no one set of standardized definitions of the main types of suicidal behaviour, however, most researchers and practitioners do agree on the distinction between two main types of suicidal behaviour: fatal or nonfatal. Nonfatal outcomes are labeled suicide attempts, attempted suicides, instrumental or parasuicides, or acts of deliberate self-harm. Another distinction is made between attempted suicide, which carries the intention to die and instrumental suicidal attempts, which typically carries no intent to die but communicates other interests such as seeking help, punishing others, or attention-seeking.

Rudd and Joiner (1998) recommend using a standard nomenclature that address the most common classes of suicidal behavior. This standardization will help to improve clarity, consistency and precision between clinicians regarding the assessment of risk, ongoing management, and treatment, e.g., in cases where consultations, transfer to another service provider, or hospitalization is indicated or necessary.

Definitions

Suicide

Death from injury, poisoning, or suffocation where there is evidence (either implicit or explicit) that the injury was self-inflicted and the decedent intended to kill him/herself.

Note: the term 'completed suicide' is used interchangeably with the term 'suicide.'

Suicide Attempt With Injuries

An action resulting in non-fatal injury, poisoning, or suffocation where there is evidence (either implicit or explicit) that the injury was self-inflicted and that he/she intended at some level to kill him/herself.

Suicide Attempt Without Injuries

A potentially self-injurious behaviour with a nonfatal outcome, for which there is evidence (either implicit or explicit) that the person intended to kill him/herself.

Instrumental Suicide-Related Behaviour

Potentially self-injurious behaviour with a nonfatal outcome, for which there is evidence (either implicit or explicit) that the person did not intend to kill him/herself (i.e., zero intent to die) and the person wished to use the appearance of intending to kill him/herself in order to attain some other end (e.g., to seek help, to punish others, or to communicate pain). Instrumental suicide-related behaviour can occur with injuries, without injuries, or with fatal outcome (i.e., accidental death).

Suicidal Threat

Any interpersonal action (verbal or non-verbal) stopping short of directly self-harming that can reasonably be interpreted as communicating that a suicidal act or other suicide-related behaviour might occur in the near future.

Suicide Ideation

Any self-reported thoughts of engaging in suicide-related behaviour.

Source: O'Carroll et al, 1996

Self-Mutilation

Self-mutilation is a direct, physically damaging form of self-harm, generally of low lethality, often repetitive in nature, and commonly employing multiple methods. (Walsh & Rosen, 1988)

A Note on Self-Mutilation

Conditions associated with the emergence of self-mutilation include: physical and sexual abuse from a significant other, exposure to marital violence, loss of a parent, childhood illness or surgery, and/or familial impulsive self-destructive behaviour (e.g. alcoholism, drug abuse, suicide or acts of self-mutilation). Predisposing conditions in adolescence include: recent loss, peer isolation and conflict, body alienation, and impulse disorder.

Unlike suicide, self-mutilating acts such as self-cutting are understood as being a means for reducing tension and discomfort. The act of self-mutilation rapidly reduces feelings of alienation, tension, anger and anxiety. The acts may also reduce isolation since significant others often react with alarm and intensify their involvement with the young person.

Source: Walsh & Rosen, 1988

2.2 CHILD AND YOUTH-FRIENDLY MENTAL HEALTH SERVICES

Create the conditions for child and youth-friendly services.

Reducing Barriers to Mental Health Services

Youth tend to believe they don't require outside help with their problems, or that, while they may have problems, they can manage them without professional assistance. For many youth, it simply doesn't occur to them to seek help, even if they do feel they need it. On the other hand, fewer young people than might be expected cite reasons for failing to seek treatment as related to embarrassment to seek help or fear of what others might think (Wells et al, 1994). Concerns over cost, time schedules, or travel also seem to have little to do with the failure to seek treatment. Research indicates that major barriers are most likely to arise from the perception that symptoms or problems are not severe enough to warrant treatment. This implies that youth would be more likely to seek services if they were advised and educated in the community about mental health problems, benefits of treatment, and the importance of early treatment for mental health problems.

In a study of adolescents treated for overdoses in a hospital emergency setting, adolescents reported that the biggest single positive factor was being treated in a friendly and non-judgmental manner by staff. Burgess et al (1998 cited in Doerer, 1999) also found that in general, adolescents expected to be judged harshly for having taken an overdose or to be "told off' for wasting staff's time. Being treated in a non-judgmental manner was experienced as a great relief to many and being taken seriously provided a sense of comfort. Burgess' study found that those youths whose contact with services was most positive were less likely to have taken a further overdose. The value of being heard by someone who cares about what

had happened (to precipitate the suicidal behaviour) appears to have lasting impact. For almost one third of the adolescents in this study, contact with the services provided the adolescent with their only available opportunity to communicate their difficulties. This underscores the importance of sensitivity in the service provider's approach. The extra time afforded for psychiatric assessment and follow-up was also considered particularly helpful in this respect (Doerer, et al, 1999).

In an outpatient treatment setting, Tolan (1988) found that young clients responded most favourably (i.e., continued to attend treatment) for two main reasons: one was having repeated (consistent) contact with one mental health clinician rather than with more than one; the second was inclusion of family members in the treatment process.

2.3 THERAPEUTIC ALLIANCE

> Develop a strong therapeutic alliance with the suicidal client and make the clinical relationship central to the outpatient treatment plan (e.g., using the relationship as a source of safety and support during crises, attending to the client's sense of profound loneliness, etc.). (Rudd, et al, 1999).

As all mental health clinicians are aware, the therapeutic alliance is of central importance in the treatment approach with suicidal children and youth (Linehan, 1993). This alliance will enable you to better understand the young clients' meaning of their suicidal behaviour which is key to creating viable alternatives for problem-solving and coping (Jobes, 2000).

Butler and Strupp (1986) refer to psychotherapy as the systemic use of a human relationship for therapeutic purposes. Brent and Kolko (1998) define it as "a modality of treatment in which the therapist and patient(s) work together to ameliorate psychopathological conditions and functional impairment through a focus on (1) the therapeutic relationship; (2) the client's attitudes, thoughts, affect and behaviour; and (3) the social context and development" (p. 17).

Jobes (2000) describes the stance of the "therapist-participant" as "one who finds the capacity to truly join in the depths of suicidal despair while never losing the judgement and clinical wisdom of being a therapist" (p. 12). As you begin to work with a young suicidal client you may experience feelings of fear and anxiety that can make an otherwise competent clinician susceptible to careless errors in judgement (Jobes, 2000). Carefully monitor and respond to your own reactions as these reactions may interfere with the treatment of the suicidal client (particularly those that are chronically suicidal). Suicidal clients often present as hopeless and helpless and will transmit these feelings to their clinician, testing your healing capacities and positive wishes by provoking these negative reactions (Kernberg, 1994).

Clinicians are advised to seek clinical consultation with a peer or supervisor as part of good clinical practice. This may include scheduling regular consultations with knowledgeable colleagues and constantly reviewing your own reactions to clients to ensure that feelings such as hostility, anger or distancing behaviours are not interfering with the therapeutic process. If you are aware of such feelings, these can serve as a kind of barometer of the state of the client and aid diagnostic formulation, help you clarify how others may respond to the individual, and facilitate therapeutic intervention (Kernberg, 1994).

2.4 INFORMED CONSENT AND CONFIDENTIALITY

Under the *Infants Act*, a request for or consent or agreement to health care by the young person does not constitute consent to the health care unless the practitioner:

(a) has explained to the young person and has been satisfied that the young person understands the nature and consequences and the reasonably foreseeable benefits and risks of the health care, and

(b) has made reasonable efforts to determine and has concluded that health care or treatment is in the child/youth's best interests.

To the extent possible, work directly with the young client to elicit his or her consent for treatment. Where children or youth are refusing treatment and/or do not want their parents or guardians to be notified, a breach of confidentiality may be warranted and this is especially true in cases of young children or in cases of high or imminent risk.

As a component of informed consent, review the treatment plan, and highlight what can be expected from treatment with the client and family members, if possible (especially for multiple attempts and those evidencing chronic psychiatric problems).

It is important that the mental health clinician clarify the limits of confidentiality in relation to high and imminent suicide risk. The rationale for informed consent is that clients have a right to participate actively in the decision-making process surrounding their treatment. The process can be viewed as an opportunity to increase communication and collaboration between the clinician and the client. In the case of a young client, it is essential to determine at the onset if the client is capable of giving informed consent.

Ideally, the family and other significant supports should be included in the treatment process. Breaking confidentiality may be justified in the case of certain emergencies.

Keep in mind, too, the perspective of the family who may need to have clarification regarding their rights to know how treatment is progressing. Taking time to help parents and other concerned family members understand confidentiality constraints is invaluable for all involved. For some families this may be the first time they don't have total input/control over who their child talks to and what they are told (Ball, November, 2000, personal communication).

2.5 CULTURAL CONTEXT

To the extent possible, identify and integrate the cultural context and protective factors in intervention and treatment planning with children and youth from culturally specific populations.

Culture is broadly defined as the shared beliefs of a particular ethnic group. Culture also refers to groups with particular religious or social beliefs. The therapeutic relationship is made possible in large part as a result of the clinician's appreciation for the client's cultural values. The cultural context of a young client provides information about their behaviours, fears, and thoughts; therefore it is essential to interpret these accurately.

As is the case with all suicidal children and youth, involving parents, extended family, alternate caregivers, and community members in the short-term safety and long-term treatment planning to the extent possible is critical.

Aboriginal Children and Youth

Developmentally and culturally sensitive interventions need to be targeted to the unique needs of each child (Kaslow & Thompson, 1998). Cultural relevance of specific treatment programs and approaches must also be carefully considered. The child or adolescent's sociocultural context and the mental health clinicians' ethnicity may also affect the therapeutic alliance. Aboriginal people in Canada commit suicide two to three times more often than do non-Aboriginal people. According to a report prepared by Royal Commission on Aboriginal Peoples (RCAP), the Aboriginal youth suicide rate is five to six times higher than that of non-Aboriginal youth. Aboriginal girls are eight times more likely to commit suicide and Aboriginal boys are 4.7 times more likely to die by suicide than their non-Aboriginal cohorts (RCAP, 1995). Contributing factors for such elevated rates of suicide relate to standards of living, poverty, education, unemployment, and cultural stress. Aboriginal youth who testified before the Royal Commission stated that they believe suicide rates for their age group are so elevated because young people feel isolated from their own culture, and from the non-Aboriginal culture, which has led to a profound confusion about personal identities. Lack of meaningful activities and boredom with daily existence has led to alcohol and drug use. Racism, physical and mental abuse, family discord, loneliness, and powerlessness were also cited as contributing factors (RCAP, 1995).

Chandler and Lalonde (1998) have studied the link between personal identity and cultural continuity as an important protective factor against suicide. In Aboriginal communities studies indicate that those communities with high degrees of involvement in "collective efforts to rehabilitate and vouchsafe the cultural continuity…are shown to be [the communities] in which youth suicide rates are dramatically lower" (p. 1). Chandler and Lalonde theorize that culture has an important connection to the formation of self-identity and that when this connection between identity formation and culture is interrupted, as it has been so dramatically in Aboriginal communities, self-destructive behaviour, including suicidal behaviour, is epidemic. The extent to which Aboriginal communities engage in one or more of six markers aimed to rebuild or maintain cultural continuity contribute to decreased suicidal behaviours. These markers include the following:

- Self-government
- Land claims
- Education
- Health
- Cultural Facilities
- Police/Fire Services

The suicide rate for Aboriginal people under the age of 25 in Canada is significantly higher than the rate for non-Aboriginals in the same age group, however, this high level of mental health problems does not positively correlate to Aboriginal peoples' use of mental health services provided by the mainstream community. According to an Aboriginal psychologist (McCormick, 1999) who has carried out qualitative research on suicide prevention in Aboriginal communities, community-based, natural healing methods for Aboriginal youth hold more promise than traditional psychotherapeutic models (McCormick, 1999). This research highlights the importance of culturally specific counselling that incorporates the natural helping styles of a culture. According to this research, healing from suicide ideation for Aboriginal children and adolescents is facilitated by:

- Self-esteem/self acceptance
- Obtaining help from others
- Changing thinking
- Connection with culture/tradition
- Expressing emotion/cleansing
- Spiritual connection
- Responsibility to others

- Future goals/hope
- Learning from others/role models
- Participation in ceremonies
- Connection to nature
- Guiding vision/dreams

Source: McCormick (1999)

Treatment Implications

Depending on the client, cultural continuity may be a significant protective factor for Aboriginal youth. Each Aboriginal community will be different, as communities are shaped by variables such as the local leadership, the level of community development and participation, the local health services, and the level of cultural continuity. Mental health clinicians who take the time and energy to find out who the client is, both in terms of their particular Aboriginal community and as an individual, will increase their capacity to forge a genuine therapeutic alliance. Where possible, mental health clinicians should reach out to Aboriginal communities and explore ways to offer a culturally appropriate response to child and youth suicide. This may include clinical awareness of Aboriginal healing resources in the clients' community; and awareness and knowledge of the role of connectedness, balance, empowerment, and cleansing for Aboriginal clients.

Recommended foci for treatment includes:

- Teach positive self-image
- Encourage and assist Aboriginal youth to explore traditional healing practices, if appropriate
- Encourage and assist Aboriginal youth to explore traditional cultural activities, if appropriate
- Utilize family and community-based approaches

2.6 INCLUSIVE AND ACCEPTING LANGUAGE

Use language that demonstrates inclusiveness and acceptance of the client's presenting issues to avoid contributing to guilt, shame and fear concerning disclosure of sexual orientation, sexual behaviour, substance use, etc.

An Example: Working with Gay, Lesbian, Transgendered, Bisexual or Questioning Youth

There is evidence to suggest that the mental health problems of gay, lesbian, and bisexual youth differ from those of heterosexual youth. Increased depression, suicide, substance abuse, homelessness and school drop-out have been reported (Lock & Steiner, 1999) which place these youth at greater risk for mental health problems, sexual risk-taking, and poorer health maintenance compared with their heterosexual peers. It is well established that gay youth are two to three times more likely to attempt suicide than other young people are (Gibson, 1989). In an adolescent survey undertaken with lesbian, gay, bisexual and transgender (LGBT) youth in British Columbia, 71 percent of LGBT reported that they had seriously considered attempting suicide at some point in their lifetime, while almost half (46 percent) had attempted suicide. Thirty percent of the LGBT population reported that they had attempted suicide more than once (McCreary Centre, 1999).

Experiences of victimization and psychosocial assaults in a homophobic culture, victimization, bullying and teasing by peers in schools, and a rejection of the youth by parents, may account for findings regarding the increased levels of depression and suicide for this population (Kreiss & Patterson, 1997). One third of first suicide attempts occurred in the first year that a young person identified his or her homosexuality or bisexuality. This may indicate that the isolation and stigma associated with a homosexual identity

may be more difficult to cope with for younger adolescents compared with older persons (Remafedi et al, 1991).

Treatment Implications

Social intolerance of homosexuality in the adolescent community may be ameliorated by the initiation of gay-straight alliance groups in schools; establishing referral systems to specialized support services (i.e., Youthquest); and developing more accepting and inclusive ways of working with this population in an outpatient setting.

Lesbian, gay, bisexual and transgendered youth are at risk for a multitude of physical, emotional and social health problems. These youth have higher than average rates of depression, substance abuse, sexually transmitted diseases, school failure, family rejection and homelessness. The skills and strategies of the mental health practitioner can improve the health care experience of sexual minority youth.

2.7 DEVELOPMENTAL CONSIDERATIONS

Clinicians should not discount the risk for suicidal behaviour among children based solely on their young age (Mishara, 1999).

Assessment of suicide risk, ongoing monitoring, and treatment for prepubertal children requires developmentally appropriate approaches.

Understanding the Developmental Levels of Suicidal Children and Youth

Clinicians and researchers working with children have identified that suicidal behaviour among preadolescent children is more common than previously understood (Milling et al, 1997). Completed suicides are rare prior to puberty and yet young children do know about suicide and their understanding of the concept is related to their own development and experience with death and suicide. The literature describes their affective and behavioural characteristics as typically more depressed, hopeless and aggressive than their peers who are not suicidal (Milling et al, 1992; Pfeffer, 1989). Children who are depressed may have lower cognitive functioning, as they are more likely to suffer from concentration and energy deficits. In turn, this lower functioning can have an impact on academic success and contribute to feelings of discouragement. These factors put the depressed child with cognitive difficulties at a greater risk for suicide ideation and other suicidal behaviours than children with higher cognitive functioning (Miller et al, 1997). The challenge for the clinician is to carefully assess the child who most likely will have difficulties communicating about suicidal thoughts and feelings.

Assessing suicide ideation and suicide attempts in young children is a process fraught with fundamental complexities. Suicidal intent refers to the balance between the wish to live and the wish to die and is considered a prognosticator of future completed suicides. The level of intent and the lethality of a suicide attempt are also thought to be positively correlated. For young children (6-12 years old), the assessment of suicidal intent requires assessing three key elements: the child's understanding of the potential lethality of a given suicidal act; the actual medical lethality of the suicidal act; and the motives for the suicidal act. A child's verbal skills, concepts of time/causality and understanding of death also add to the challenge of eliciting accurate information from the child. Collateral information is essential to obtain from the caregivers, although this information requires careful consideration, as it may not agree with the child's account of the ideation and/or suicidal behaviour. (See 2.9 – Family Involvement in Treatment for further discussion).

Experienced mental health clinicians who work with children under 12 find that paying attention to providing clear rules/boundaries for behaviour and "good living" protocols helps these children.

For example:

- It is important to state in concrete terms what you mean. For example: State the "rules" of behaviour clearly, e.g., Ropes around the neck are not allowed. You may not go on the road, etc.
- Close monitoring by parents/caregivers and teachers is essential, particularly with impulsive children i.e., ADHD/FAS.
- Teach self-soothing techniques that can be built into the child's repertoire of feel-good activities, e.g., taking a bubble bath, going out for a walk, taking care of a pet, making a favorite snack, etc.
- Children use statements such as " I want to die" and "I'm going to kill myself" when often they really mean "My life sucks". Help the child find other words to describe their experiences and help them focus on what is happening, i.e., "I hate what is happening", "My life sucks", "No one is helping".

Source: (M. Carey, October, 2000, personal communication)

Treatment Implications

A key element of treatment for preadolescent children is to explore the child's fantasy of death with the goal of understanding the child's anguish and pain (Orbach, 1997). Understanding the child's conception of death can provide the clinician with clues about the particular child's crisis. The goal of treatment for children who are acting on suicidal wishes through impulsive and dangerous behaviour is to help the child see that suicidal behaviour is a way of communicating emotional pain and distress for which a solution is being sought.

A young child's suicidal behaviour is often closely linked with crises in the family. Major family crises include divorce, economic difficulties, severe illness, death and endless conflict between parents. Another goal of treatment is to understand the role the child is usually expected to play in the family or to identify the unresolvable problem with which he or she is unable to cope (Orbach, 1987).

The questions in Table 1 reflect a developmentally appropriate approach to interviewing children about suicide ideation and behaviour.

TABLE 1

SAMPLE QUESTIONS FOR INTERVIEWING PREPUBERTAL CHILDREN ABOUT SUICIDE IDEATION AND BEHAVIOUR

ASCERTAINING THE PRESENCE OF PREVIOUS OR CURRENT SUICIDAL IDEATION OR BEHAVIOUR

1. Did you ever feel so upset that you wished you were not alive or wanted to die?
2. Did you ever do something that you knew was so dangerous that you could get hurt or killed?
3. Did you ever hurt yourself or try to hurt yourself?
4. Did you ever try to kill yourself?
5. Have you ever tried to make yourself dead?

ASSESSMENT OF SUICIDAL INTENT

1. Did you tell anyone that you wanted to die or were thinking about killing yourself?
2. Did you do anything to get ready to kill yourself?
3. Was anyone near you or with you when you tried to kill yourself?
4. Did you think that what you did would kill you?
5. After you tried to kill yourself did you still want to die or did you want to live?

INTERVIEWING CHILDREN WHOSE GRASP OF THE CONCEPTS OF TIME, CAUSALITY, AND DEATH MAY NOT BE MATURE

1. Do you think about killing yourself more than once or twice a day?
2. Have you tried to kill yourself since last summer/since school began?
3. What did you think would happen when you tried to jump out of the window?
4. What would happen if you died; what would that be like?

ASSESSING THE POTENTIAL IMPACT OF THE CHILD'S CURRENT EMOTIONAL STATE UPON RECALL OF SUICIDAL IDEATION OR BEHAVIOUR

1. How do you remember feeling when you were thinking about or trying to kill yourself?
2. How is the way you feel then different from the way you feel now?

INTERVIEWING PARENTS ABOUT SUICIDAL IDEATION AND BEHAVIOUR IN THEIR CHILDREN

1. What exactly happened (step by step) on the day that your child spoke of wanting or tried to hurt him/herself?
2. How did you find out that your child was thinking about or trying to hurt him/herself?
3. What were you doing when your child was thinking about trying to hurt him/herself?
4. What happened after your child thought about or tried to hurt him/herself?

DETERMINING THE PRESENCE OF RISK FACTORS FOR SUICIDAL IDEATION AND BEHAVIOUR

1. Have you ever thought about or tried to kill yourself before?
2. How have you been getting along with your friends and family?
3. Has anything happened recently which has been upsetting to you or your family?
4. Have you had a problem with feeling sad, having trouble sleeping, not feeling hungry, losing your temper easily, or feeling tired all of the time recently?
5. Have you used alcohol or drugs recently?

Source: Jacobsen, et al, (1994)

2.8 THE CHALLENGING CLIENT

To enhance compliance and reduce risk for subsequent attempts, follow-up and assertive outreach (e.g., letters or phone calls) is recommended for clients dropping out of treatment prematurely. All efforts to re-engage the client should be documented as part of the formal record.

Responding Proactively to Client Drop Out

If a young client is assessed at high or imminent risk, actively engage parents or guardians to facilitate their support and promotion of treatment goals and to ensure client safety is maintained in the home (see Appendix 1 on informed consent and warranted breaches of confidentiality. Also refer to 5.1, Integrated Case Management and Wrap-Around Care). Many suicidal adolescents withdraw from treatment after the resolution of the immediate crisis and before formal treatment begins. This behaviour represents a manifestation of the young person's hopelessness, pessimism, and cynicism regarding the value and benefit of treatment (Rudd, Joiner & Rajab, 1995). Clients who negate help and withdraw prematurely from treatment tend to view interpersonal situations as risky and ripe for potential humiliation and emotional hurt (Rudd, Joiner & Rajab, 1995). This view calls for the mental health clinician to exhibit patience; persistence, restraint and tolerance of the client's anticipated moodiness, as well as careful monitoring for possible countertransference reactions.

Suggestions for Reducing Drop-out from Outpatient Treatment

- Client given a definite appointment for follow-up at the time of intake
- Client scheduled in a timely fashion
- Client reminded of appointment by telephone
- 24-hour clinical back-up available for crises
- No-shows pursued by phone calls and letters
- Explicit contract between client, family and clinician about treatment type and treatment plan
- Involvement of family members and other significant adults in treatment to identify 'natural helpers', the child/youth's preferred style of learning or accepting help (Murphy, 2000)

Source: Brent, 1997

Note: Assertive Follow-Up

Intensive follow-up of a suicide attempt or threat can have a significant positive impact for children and adolescent attempters and ideators. Intensive follow-up using home visits, telephone contact, and more frequent routine treatment approaches can reduce subsequent attempts over a four month period (Rudd, 1999).

2.9 FAMILY INVOLVEMENT

To the extent possible, engage parents (and other family members) as key collaborators in the planning and implementation of the treatment plan.

Be mindful of the parents' fears and anxieties and approach family members in a supportive, non-judgmental manner.

Support parents' ability to set consistent limits, engage in healthy communication with the child or youth, provide positive role modeling, offer a caring and loving relationship, and provide one-to-one supervision of the child if he or she is assessed at severe risk for suicide. This may include recommending treatment for identifiable parental mental health problems or other interventions as needed to help the parents fulfill their supportive and limit-setting functions and also to help the family members improve their communication skills and relationships with each other.

Ensure that the home is free of lethal means and that the parents understand the importance of restricting access to all lethal agents (i.e. firearms, medications).

Support and assess the family's ability to fulfill the functions of providing food, shelter, and a safe, non-abusive home environment. Concerns about the client's safety should be addressed with the caregivers, and child protection authorities must be notified if necessary.

Suicidal children and youth come from a variety of family backgrounds (White & Jodoin, 1998). In most instances, families with children who are suicidal are doing their best to respond to the complex needs of their child. Others may also be distracted by their own health concerns, family conflict and/or disorganization. Families of suicidal children tend to respond in one of two ways to their child's desperate act, whether it is a suicide attempt, gesture, or ideation. For most families it is their worst nightmare and often they can become overwhelmed with feelings of despair, helplessness, and failure. Other families become enraged at their child for what they see as the child's victimization of them. What families need more than anything is non-judgmental support. This support may involve providing education about suicide risk, warning signs of depression, and substance abuse, or using therapeutic approaches to improve family functioning. All forms of support contribute to helping the family become involved in developing a plan should another crisis situation arises, reducing risk factors, and enhancing protective factors.

Kerfoot (1980) suggests that many, not all, children and youth who are suicidal live in families where relationships are disturbed and interpersonal communication is poor. When assessment and treatment is conducted with the entire family, family members can become aware of how each individual's verbal and non-verbal communication influences others in the family. The main goal for family work is to deal with the negative reactions and psychological abandonment of the child that may first occur following a child's suicide attempt (Kernberg, 1994) or other forms of suicidality. The greatest challenge is to encourage parents to participate in treatment, which requires a respectful, non-threatening, and non-blaming approach on your part.

The perspective of families is also important. The following suggestions for mental health clinicians and other members of a case management team are based on the experiences of families who have experienced the tragedy of losing a son or daughter to suicide.

The Perspective of the Family is Important

- Validate/support family trauma. No matter what "presenting" behaviors there are, appreciate that the family probably feels like they've just been dropped into the world's worst nightmare.
- Remember both suicide and mental health are "stigma" issues, so family members may experience embarrassment and isolation. There is usually no informal network of friends who "have been there" to comfort, guide and educate. The mental health clinician may be their only source of information and support.
- Ensure that families have an opportunity to gain confidence in you as a mental health clinician. Just as you need to assess them, they have a right to assess you. You have their precious child!
- Families are the primary caregivers; investing in them is investing in the child.
- Help family members understand their rights and confidentiality constraints. For some families this may be the first time they don't have total input/control over who their child talks to, what they are told, etc.
- Help family members understand the mental health system and the types of treatment options available.
- Families need to have their experience and expertise acknowledged. Listen to parents' perceptions regarding their child. Listen for undiagnosed learning disabilities, underlying health problems, the child's preferred learning style and help acceptance style, the child's "natural" helpers, the family's previous experience with school, and/or the mental health system. The family may already feel they have tried and tried to get help from the system. Listening helps the family feel less "shut out" of the therapeutic process.
- Go beyond "suicide crisis intervention" and educate the family about the range of complex suicide risk factors. This will help diffuse guilt and stigma. Provide short list of easy-to-read, currently available brochures/books.
- Help families understand depression and any other mental illnesses, particularly as it impacts the family (i.e. a depressed person may perceive even the most loving family in a negative way).
- Listen for other stressors in family, work and health. Help family get appropriate support, i.e., employment insurance, care for aging parents, financial counseling, etc.).
- If a child will not participate in therapy, continue to meet with parents, and offer support. They are now your only link to the child.
- Help families see signs of hope without suggesting that the child isn't at risk for suicide any longer.
- Help family connect with appropriate support to reduce isolation and offer alternate sources of valid information, e.g., CMHA, support group, EAP counselors, clergy.
- Be aware that the rest of the community (i.e. school, physicians, friends, relatives) may also deny/dismiss the child's suicide attempt/ideation – particularly if the child appears to be functioning well, or if the family is respected in the community.

Adapted from: (B. Ball, October, 2000, personal communication)

Psychoeducational Programs for Families

Psyhoeducational programs for parents of suicidal children and adolescents show promise as a way to assist families quickly in the treatment of their suicidal child (see Table 2 – Sample Psychoeducational Program for Parents of Suicidal Children and Youth). Parents are a valuable resource for their children if they are informed about suicide prevention. Psychoeducational programs also provide guidance and support for those parents who are in a state of shock or distress as a result of their child's suicidality (i.e., ideation, attempt, plan, or behaviour) (Fiske, 1996). This group program approach, offered in a timely manner, serves to bridge the gap between the child and adolescent's suicidality and treatment service. For many parents who initially refused family therapy, this approach provides parents with concrete knowledge and skills, and most importantly, hope (Fiske, 1996).

TABLE 2

SAMPLE PSYCHOEDUCATIONAL PROGRAM FOR PARENTS OF SUICIDAL CHILDREN

The program is brief (three-hour duration), with 6-10 participants, led by a mental health clinician experienced in working with suicidal children and their families. Referrals are primarily from crisis workers and physicians from the hospital Emergency Room.
Basic information provided about the myths and realities of suicide, factors associated with adolescent suicide, warning signs, do's and don'ts of crisis intervention, common parental reactions, how to cope, how to get help, and signs of progress.
The story of a teenage boy gradually overwhelmed by a series of difficult life events to the point where he attempts suicide is told. Emphasis is given to the series of painful experiences that have created distress rather than one single trigger point.
A video, called Young People in Crisis, is screened. The video demonstrates helpful interventions made by various adults. A discussion follows.
Handouts are provided, including a list of local resources, list of warning signs and helpful interventions, a reading list, an article on how parents can help support positive self-esteem in their children.

Adapted from: Fiske, 1996

2.10 CLINICAL CONSULTATION

> Due to the nature of suicidality, clinical consultation with peers and supervisor in the form of regular case reviews, observation and formal discussion is vital to providing the highest quality of care.

The consulting relationship refers to the relationship between the *treating* mental health clinician and a respected and experienced clinician. When working with suicidal clients this kind of consultation can be extremely beneficial to the clinician, assisting the clinician to review their proposed plan, review risk factors and/or protective mechanisms (Bongar, 1992). Clinical consultation may take the form of formal case reviews, informal discussion, or observation and is the cornerstone of good clinical practice.

Examples of Reflective Questions for Reviewing Cases

- What can I do to increase this person's safety?
- What other people does this person see as potentially helpful?
- Who would the person choose as a helper?
- What can I do to involve others in a helping network to maintain this person's safety?
- How can my clinical expertise be helpful to those others so that they can 1) provide helpful support; 2) set appropriate and necessary boundaries and limits; and 3) focus on what they can do.
- With whom will I debrief this case?
- What can ease this person's pain and perturbation even by the slightest amount?
- How can I facilitate that?
- What can I do directly?
- Who else can I involve as part of a helping "team" for this person?
- What is one telephone call I can make right now that might be helpful?
- What does this person say will be helpful?
- If nothing will be helpful in this person's view except dying, how will that help?
- What is goal/function of suicide wish?
- What would be alternative ways to get what is needed?
- How can I help this person to get even a little bit more of what he/she wants other than by suicide?
- What is realistically and conservatively possible for me in terms of availability to clients (e.g. only scheduled sessions? Telephone calls – scheduled or as needed? During the day/evenings/weekends? Crisis sessions?)
- For occasions when I am not available, what support is? How can I work with the client to make these alternative connections real, useful, and more likely to be accessed and utilized?
- If a pattern has been identified which has led in the past to suicidal behaviour, what can interrupt the pattern? What has interrupted it in the past?
- Looking at the pattern, what is one small concrete change that would make a difference? (e.g. a contact, a comfort, a new skill, a contract, a supervisory arrangement)?
- What behaviours/cognitions/emotional skills does the client say will be useful (in his or her terms)? (e.g., "to be able to walk away when I'm angry", "to drink and have fun without getting depressed", "to not care so much when my boyfriend or girlfriend seems to like someone else?")

Source: Fiske, Personal Communication, 2000

Possible Questions for Retrospectively Reviewing Clinical Decisions

- What would you have done the same? Differently?
- What would you add?
- Did the approach consider the young person's resources, strengths, and successes?
- How else could it have done so?
- How were systemic/community resources utilized?
- How were the principles of the practice parameters applied?
- What were this person's reasons for living?

(Fiske, Personal Communication, 2000)

2.11 CARE FOR THE MENTAL HEALTH CLINICIAN

Preventing Compassion Fatigue

Child and youth mental health clinicians require individual as well as organizational and community self-care strategies (Ambrose, 2000). Working with children and youth who have experienced high levels of suffering, combined with limitations on resources, and uncertainty about the impact your work is having, all contribute to what is known as "compassion fatigue". Without adequate self-care and support, caring professionals such as mental health clinicians are vulnerable to vicarious trauma (Figley, 1995, Stamm 1995, Pearlman & Saakvitne, 1995). Following the work of Pearlman, Ambrose (2000) suggests that a mental health clinician's personal experiences with trauma play a role, both in terms of making the clinician both vulnerable to compassion fatigue and resilient in the face of stress inherent in clinical practice. Reflecting on your professional mission, taking an inventory of your sense of achievement, including whether you consider that you are making a difference in the lives of your clients, and having informal and formal clinical consultation, are key components in preventing compassion fatigue. Finding or organizing a group of trusted and like-minded clinicians can provide the necessary organizational and community support that is essential for creating a healthy balance and personal and professional resilience in this highly demanding field.

Child and youth mental health clinicians, particularly those of you working in remote communities, would also benefit from 'Telehealth' audio and video clinical conferencing, as well as by connecting with other colleagues through Internet Listserv or Web-based discussion groups.

In spite of the best clinical care and management available, there will be clients who go on to complete suicide. The effect on the mental health clinician can be devastating and each out-patient setting would benefit from having a plan in place for dealing with the aftermath of a suicide completion. This plan would provide the basis for a supportive network if, in spite of best efforts, a client does complete suicide.

Given the fact that the Children's Commission investigates all sudden and unexpected deaths of all children in BC, including suicides, mental health clinicians should be aware of the procedure in place that retrospectively reviews all of these cases. This process provides an invaluable learning opportunity for all mental health clinicians.

3. identifying and assessing suicide risk

3.1. IDENTIFYING RISK

Conduct a thorough suicide risk assessment based on a consistent use of terminology with respect to the domains of risk, protective factors, resources, and the nature and meaning of the client's suicidality, *and* continue to re-assess risk at specific intervals.

Use clearly defined and commonly understood definitions according to levels of risk, i.e., non-existent, mild, moderate, high and imminent. Assess on the basis of both subjective (self-reporting) and objective intent (clinical judgement).

A Risk Assessment Model

There are multiple views on what contributes to youth suicide. One perspective holds that child and youth suicide is an outcome of a diagnosable mental disorder, such as a major mood disorder, and that key prevention strategies should include the early detection of psychopathology in individuals and aggressive treatment for first time episodes of the disorder (Brent & Perper, 1995). Another perspective understands suicide as a complex, culturally situated response to threatening and unhealthy social circumstances. Chronic poverty, unemployment, political disempowerment, and marginalization are factors contributing to chronic stress. From this perspective suicide prevention strategies are directed toward improving social conditions and empowering communities and their members to become more self-determining (Chandler & Lalonde, 1998; Royal Commission on Aboriginal Peoples, 1995).

The move to integrate the multiple conceptions of suicide (epidemiological, philosophical, sociocultural, sociological, psychiatric, psychological, psychodynamic, and biological (Rudd & Joiner, 1998) is reflected in the framework offered by Shneidman (1993) based on his distillation of theory and research. Shneidman's view is that suicide is caused by *psychological pain in the psyche, the mind*. This explanatory framework suggests that the mental health clinician can best understand, assess, manage and treat suicidal behaviour by attending to two variables: the client's experienced (and expressed) distress *and* their tolerance for this distress (Rudd & Joiner, 1998). To understand the complexity of suicidal behaviour, Shneidman (1993) offers a simple and elegant framework organized around three main questions. These questions are at the heart of a suicide risk assessment.

- What is it about the client's current situation or context that explains, facilitates, and maintains his or her psychological distress?
- What is the client's demonstrated (or stated) distress tolerance?
- What can be done clinically to reduce the client's psychological distress in the short term and develop improved tolerance for this distress in the long term?

Child and youth suicide is a complex phenomenon, determined by multiple factors intersecting at one point in the life of the individual (Grossman & Kruesi, 2000). For this reason it can be said that there is not one single predictor of suicide. Suicidal children and youth appear to be a heterogeneous group of individuals who are affected by a combination of factors (Stoelb & Chiriboga, 1998). Within the context of balancing a demanding caseload with

multiple and competing priorities, the clinician is also called upon to assist community gatekeepers to appropriately differentiate potential mild, moderate, severe or imminent risk. Working with a risk assessment model can guide clinical decision-making in terms of judging which clients should be given priority over others, especially when more than one has been identified as potentially suicidal.

It is very important that you are able to accurately assess suicide risk in youth who seek help. An assessment process that identifies the factors that affect children and adolescents may increase the accuracy of clinical judgement regarding suicide risk (Stoelb & Chirboga, 1998). Three categories of risk in this model include:

- Primary risk factors (includes affective disorders, previous suicide attempts, and hopelessness)
- Secondary risk factors (includes substance abuse and personality disorders), and
- Situational risk factors (includes family functioning, social relationships, exposure to suicide, life stressors, and sexual orientation).

A fourth category: protective factors (includes individual, family, social, and community factors) is an important complement to this model as protective factors play an important part in the assessment safety and treatment planning. Protective factors are also significant resources from which to draw in the planning of treatment and the overall treatment process.

Primary Risk Factors

These include individual traits or characteristics that are static variables, which elevate the client's chronic risk as well as acute risk under some conditions.

Age

Escalation of suicide risk increases with age. Prior to puberty, suicide attempts or completions are rare although suicide ideation is not (Jacobs, 1999).

Sex

Risk is greater for males than females. Females are more likely to attempt suicide than are males, yet males are four times more likely to complete suicide (Blumenthal, 1990).

History of Psychiatric Disorders

A history of psychiatric disorders can signal an elevated risk for suicide.

Current Axis I diagnosis

Affective disorders play a catalytic role in the incidence of suicide. Fifteen percent of adolescents diagnosed with major depressive disorder and between 10% and 15% of adolescents diagnosed with bipolar disorder die by suicide (Stoelb & Chiriboga, 1998).

Previous history of suicidal behaviour

The predictive power of a previous attempt is supported by numerous research studies. One significant study of 1508 high school students concluded that a student who has made one suicide attempt is 18 times more likely to make another attempt within the year (Stoelb & Chiriboga, 1998).

Current markers of dysphoria

Hopelessness is highly predictive of adolescent suicide risk. Hope is a protective factor and without a sense of hope suicide is often viewed by adolescents as an acceptable escape. Anger, depression, guilt, anxiety/panic, insomnia, diminished attention-concentration are also markers.

History of abuse

(i.e., sexual, physical family violence, or punitive parenting).

Secondary Risk Factors

Substance abuse

Alcohol abuse is a commonly identified risk factor for adolescent suicide and contributes to "feelings of sadness and irritability which contribute to suicide attempts and completed suicides" (APA, 1994). Withdrawal from cocaine, amphetamines, the extended use of sedatives, hypnotic and anxiolytics also can result in increases in suicide ideation and attempts.

Current Axis II diagnosis

Personality Disorders – Adolescents with a diagnosis of an emerging personality disorder are 10 times more likely to commit suicide than those without (Jacob, 1999). In combination with substance abuse and depression, adolescents with a personality disorder are at even greater risk for suicidal behaviour.

Behavioural disorders

Conduct and oppositional defiant disorders are highly correlated with suicidal behaviour of adolescents. Children and youth that demonstrate aggressiveness, destructive, hostile, and defiant behaviour in combination with other risk factors are more likely to attempt suicide than those who do not.

Situational Risk Factors

Family Functioning and History

Family environments with divorced or single parent structures, family history of psychiatric difficulties such as depression and substance abuse, a family history of suicidal behaviour, and childhood maltreatment – violence and sexual abuse – are identified as common factors in children and youth suicides (Crespi, 1990).

Social Relationships

The child or youth's perception of the quality of friendships and family relationships is a more relevant factor in assessing suicidal behaviour than the actual number of supports. A sense of group membership is an important protective factor and helps counter-balance the effects of depression and isolation.

Negative School Experience

The child may be the victim of bullying, feel isolated, have difficulties with the academic demands of school. Any one of these factors contributes to a negative school experience.

Life Stressors

Disciplinary actions against the child or youth, incidences of rejection or humiliation by others, termination of friendships, arguments with relatives or friends, and moves to a new community or school are examples of stressful life events have been documented in adolescent suicide victims (Stoelb & Chiriboga, 1998).

Suicide Exposure

The "ripple effect" refers to the phenomena of increased youth suicides one to two weeks following media coverage of a prominent suicide or after fictional television features a youth suicide (Pfeffer, 1989).

Sexual Orientation

A disproportionately high number of gay, lesbian, bisexual, and transgender adolescents are affected by depression, substance abuse, homelessness and suicide (Nelson, 1994). One hypothesis holds that the experiences related to identifying oneself as a homosexual or bisexual in a homophobic society are confusing and painful for a young person who has limited life experiences (Garofalo, 1999). A youth is at greater risk when sexual orientation issues are combined with substance abuse and risk taking behaviours.

Protective Factors

Positive, life-oriented belief systems are held by non-suicidal individuals (Pinto et al, 1998). A strong sense of self-efficacy and optimism in coping with life's problems is a protective factor against suicidal behaviour. A sense of group membership is another important protective

factor and helps counter-balance the effects of depression and isolation. The child or youth's *perception* of the quality of relationships and support is an important predictive factor in assessing suicidal behaviour.

Individual

- Resiliency
- Personal autonomy
- Capacity to tolerate frustration
- Prior experience with self-mastery
- Adaptive coping skills
- Self-understanding
- Optimistic outlook
- Sense of humour
- Religious affiliation

Family

- Relationships characterized by warmth and belonging
- Adults modeling healthy adjustment
- High and realistic expectations

Peers/Relationships

- Social competence
- Positive peer modeling
- Acceptance and support

School

- Feeling valued as a person irrespective of academic performance
- Feeling that education is relevant
- Parent involvement
- Presence of adults who demonstrate support and encourage participation

Community

- Opportunities to participate
- Affordable, accessible resources for youth
- Hope for the future
- Community self-determination and solidarity

Adapted from: White & Jodoin (1998)

3.2 THE CONTINUUM OF RISK FOR SUICIDE

The continuum of suicidality allows the clinician to place the client more precisely in the suicide zone (Rudd & Joiner, 1998), and to respond accordingly. This is not to imply that it is possible to reliably predict suicide and suicidal behaviour in any individual case. However, competent clinical treatment and management involves knowing what information is important, what questions to ask, and integrating the responses into a treatment framework that guides clinical decision-making. The following continuum is recommended using the categories of non-existent, mild, moderate, high, and imminent risk:

Non-existent: absence of suicide ideation or other risk factors

Mild: suicide ideation of limited frequency, intensity, duration, no identifiable plans, no intent, good self-control, few risk factors and identifiable protective factors

Moderate: frequent suicidal ideation with limited intensity and duration, some specific plans, no intent, some risk factors present, identifiable protective factors

High: frequent, intense and enduring suicide ideation, specific plans, objective markers of intent (i.e., access to lethal method(s), some limited preparatory behaviour), evidence of impaired self-control, severe dysphoria/ symptomatolgoy (e.g., psychache), multiple risk factors present, few, if any, protective factors

Imminent: frequent, intense, and enduring suicide ideation, specific plans, access to methods, clear subjective (self-report) and objective (clinical judgement) intent, impaired self-control, severe dysphoria/symptomatology, many risk factors, no protective factors. (Time factor, e.g., plan with access to a method, within the next 24-48 hours).

As highlighted in Section 2, particular populations have unique characteristics that seem to elevate their risk levels and which have implications for assessment and treatment planning. A separate discussion highlights the particular issues related to Aboriginal children and youth suicidality, special issues of assessing and treating very young children; and the particular issues of gay, lesbian and bisexual youth.

3.3 ASSESSING RISK

Any child or youth who is in an identified high-risk category and has suicidal thoughts, or has harmed him or herself, needs to be taken seriously. Concommitantly, a child or youth that *does not* fit any of the risk categories but has suicidal ideation or exhibits suicidal behaviour must also be taken seriously. Predicting suicidality is complicated by the fact that many of the most lethal suicidal actions are associated with the least explicit communication of ideation, thus underlining the importance of consistent and thorough clinical assessment. For those children or youth who are *not* voicing suicidal communication (Joiner & Rudd, 1998) it is still important to assess for possible ideation, intent, and/or lethality.

The child or youth who is at the highest risk for completed suicide is one with the most risk factors occurring concurrently. For example: acute family crises, personal losses, low self-esteem and interpersonal problems combined, with social isolation and access to lethal means place the child in the highest risk category. Young people who attempt suicide may be experiencing multiple and complex psychosocial difficulties, therefore risk assessments must look beyond a focus on situational or precipitating factors, e.g., fight with parent or the break-up of a relationship (Dorer et al, 1999), and take into consideration the interaction of primary and secondary factors.

Situation Evaluation and Review of Presenting Difficulties

A comprehensive intake procedure includes an assessment of symptoms of depression, suicidal ideation, and risk factors associated with the increased risk of suicide. This information must be gathered before intervention strategies can be determined (Lewis, 1989).

The clinical interview includes:

- Identifying information
- Presenting problem
- History of presenting problem
- Medical history – Individual and Family
- Psychological history – Individual and Family
- Medications
- Social and family history
- Alcohol/ drug use
- Review of symptoms (includes screening for depression see page 34)
- Mental Status Exam

Mental Status Exam

What a young client does or says constitutes the raw data for the mental status exam. As an organizing principle it is useful to keep in mind the major categories covered in the exam. The order in which the basic information is collected is not important and not all categories need to be covered in the same amount of detail. The presenting symptoms and history will indicate what is of greatest importance. Clinical judgment and consideration for the developmental level of the client should guide the interview process. The goal of the Mental Status Exam is to be able to formulate an integrated summary of organic factors, environmental stresses, and inner conflicts, over time, of a particular child or youth.

Elements of the Mental Status Exam include:

- Physical appearance
- Separation
- Manner of relating
- Orientation to time, place, and person
- Central nervous system functioning
- Reading and writing
- Speech and language
- Intelligence
- Memory
- Quality of thinking
- Fantasies and inferred conflicts
- Affects (anxiety, depression, apathy, guilt, anger)
- Object relations (with family, friends and peers)
- Drive behaviour (sexual/aggressive)
- Defense organization (phobic, obsessive-compulsive)
- Judgment and insight
- Self-esteem
- Adaptive capacities
- Positive attributes

Source: Lewis, (1989)

Assess Depression – SIGECAPS

Not all individuals who attempt or commit suicide are depressed; however, depressive symptoms are significant risk factors and are found to be present in 54 percent to 85 percent of completed suicides. The neurovegetative symptoms of depression are identified by the following mnemonic: (SIGECAPS)

- **S**leep
- **I**nterest
- **G**uilt
- **E**nergy
- **C**oncentration
- **A**ppetite
- **P**sychomotor Retardation
- **S**uicide Ideation

SIGECAPS; Wise & Rundell, (1988) in Lewis, (1989).

Fundamental Foci for Assessing Suicide Risk: A Checklist

- Understanding of current suicidal thinking – suicide intent.
- Current ideation – intensity, duration, specificity.
- Lethality and availability of means.
- The Personal Meaning of Suicide Behaviour.
- Current plans – specificity (e.g. how, where and when).
- Preparatory behaviour (e.g., giving away possessions).
- Cognitive rigidity and poor problem solving abilities, social isolation and limited social support.
- Indication of impulse control problems (i.e., such as substance abuse, aggressive behaviour, risk-taking, sexual acting out).

Ideation, Intent and Lethality

Once the client has affirmed that he or she is experiencing suicide ideation, it is important to evaluate whether the suicidal thoughts are *active* or *passive*, that is, the level of intent; the specific plan for committing suicide; and the access to the means. The following questions in Table 3 are helpful for guiding the interview for suicide ideation, intent, and lethality. These questions can be incorporated into an assessment interview. It is important to note that these questions are a guideline only and should be woven into the rapport-building approach of the clinician.

TABLE 3
INTERVIEWING FOR SUICIDE IDEATION, PLANS & REASONS FOR LIVING & DYING

FREQUENCY, INTENSITY, DURATION OF SUICIDE IDEATION

Do you ever have thoughts of killing yourself...thoughts of suicide?

How often do you think about suicide...daily, weekly, or monthly?

Have you ever wished you were dead?

How long do these thoughts last, seconds, minutes? How severe or overwhelming are they? Could you rate the intensity on a scale from one to 10?

Have you ever thought about trying to hurt yourself?

Do you intend to hurt yourself?

Have you ever attempted suicide?

SPECIFICITY OF PLANS

When, where and how?

Do you have a plan to hurt yourself?

AVAILABILITY OF METHOD

Do you have [methods]? Do you have access to [methods]?

Self-control (subjective and objective markers)?

Do you feel in control right now?

Have you had times when you felt out of control?

What were you doing?

Were you drinking, using any substances?

Could you rate how in control you feel on a scale of one to 10? (Caution: only use the term 'in control' if the phrasing comes from the client – try to be specific, given that some children or youth feel more in control the more intent they are on dying.)

REASONS FOR LIVING AND DYING

Have you ever thought that life was not worth living?

You haven't acted on these thoughts...what keeps you alive right now? What keeps you going? What's kept you going in the past when you've had these thoughts?

INTENTION

Do you have any intention of acting on the thoughts of suicide? Could you rate your intent on a scale of one to 10?

Source: Rudd, 1998

The Personal Meaning of Suicidal Behaviour

In order to plan a clinical intervention, it is necessary to understand the particular risk factors as well as to understand the individual meaning of the suicidal act or ideation. Suicidal thoughts or acts have particular meaning for an individual and this meaning must be understood within the context of the child or youth's life. For example, for someone who feels out of control suicidal behaviour may represent a means to gain control. For a child who feels she or he has been wronged, suicide may represent a retaliatory act against the perceived perpetrators. Key themes in suicide attempts and ideation include power, control, escape, and relief. Table 4 explores some of possible personal meanings of suicide that a young client may have.

Protective Factors

Assess for the presence of protective factors at the individual, family, peers, school and community level. Assess the degree to which the child or youth feels cared for by family, peers and/or other adult(s); whether they feel supported by family and/or peers; the level of conflict with parents or peers.

TABLE 4 –THE PERSONAL MEANING OF SUICIDE

LOSS OF CONTROL LEADING TO FEELINGS OF HELPLESSNESS AND HOPELESSNESS
Experiences a combination of depressive symptoms and rage
Response to a perceived irreplaceable loss of an important relationship
Desires relief or escape from unbearable pain
Is a response to abusive treatment from another
Self-reproach
REVENGE AGAINST ANOTHER PERSON
Believes the act of suicide will cause the offending party to feel “sorry”
TO COMMUNICATE EMOTIONAL DISTRESS
REUNION WITH A DEAD LOVED ONE
Used to counter a sense of loneliness or loss
Desired to be reunited with the loved one and to escape the pain of loss
FAMILY CONTEXT
Perceives self to be family’s problem (they’re better off without me)
Attempts to distract the family from other problems (divorce)
Responding to parental wish to be rid of the child
ANTICIPATORY LOSS
Break-up of a relationship

TABLE 5 – RISK ASSESSMENT MATRIX

	MILD	MODERATE	HIGH/IMMINENT
IDEATION	Has periodic intense thoughts of death or not wanting to live that last a short while.	Regularly occuring, intense thoughts of death &/or wanting to die, that are often difficult to dispel	Thoughts of death or wanting to die are very intense & seem impossible to get rid of
IMMEDIACY OF PLANS	No immediate suicide plan No threats Does not want to die	Not sure when but soon Indirect threat Ambivalent about dying	Has imminent date, time in mind Clear threats Doesn't want to live Wants to die
METHOD	Means unavailable Unrealistic or not thought through	Lethality of method is variable with some likelihood of rescue or intervention	Lethal, available method with no chance for intervention
EMOTIONAL STATE OR MOOD	Sad, cries easily Irritable	Pattern of 'up and down' mood swings Rarely expresses any feelings	No vitality (emotionally numb) Emotional turmoil (anxious, agitated and angry)
LEVEL OF EMOTIONAL DISTRESS	Mild, emotional hurt	Moderately intense	Unbearable emotional distress or despair Feels rejected, unconnected, and with no support
SUPPORT/ PROTECTIVE FACTORS	Feels cared for by – family – peers and/or – other adult(s)	Minimal or fragile support Moderate conflict with – parents – peers	Intense conflict with – parents and/or – peers Socially isolated
PREVIOUS ATTEMPT	None	1 previous attempt Some suicidal behaviour	Previous attempts Severe self-mutilation
REASON TO LIVE/HOPE	Wants things to change and has some hope Has some future plans	Pessimistic hope Vague, negative future plans	Feels hopeless, helpless, powerless Sees future as meaningless, empty
SYMPTOMS OF DEPRESSION	Down and out; Irritable mood; Loss of interests and joy; Loss of energy; No motivation; hyper or slowed down; Eats: too much or too little; Sleeps too much or not enough; Can't concentrate; Feels extreme guilt; Feels worthless		
OTHER RISK FACTORS	Family history of suicidal behaviour; Suicidal friends; Current loss; Previous losses; Substance misuse; Current school problems; Recent criminal charges; Has a diagnosed mental health disorder; Is very impulsive; Has negative attitudes re: seeking help; Parent(s) or helpers do not take the child/youth's suicidality seriously		
OVERALL RISK			

Adapted from Regional MCF Risk Assessment Form.

3.4 CLINICAL DECISION-MAKING

The risk assessment matrix presents a number of variables that will assist you to determine suicide risk level. Consider also that girls think about and attempt suicide more often than boys; however, boys outnumber girls 5-1 in completed suicides (Jacobs, 1999). The presence of firearms in the home is also a significant risk factor (Brent et al, 1991).

Understanding categories of primary, secondary, situational risk and protective factors and assessing the risks and resources are tasks that are ideally performed with each child or youth on an individual basis. The risk level that is determined is based on the fine balance between the existence of particular risk factors, clinical judgement, and intuition. For the young client at high or imminent risk, an evaluation for hospitalization is indicated. For the child or youth considered at moderate or mild risk, outpatient treatment with the necessary levels of support in the community matching the level of risk identified is recommended. Ongoing monitoring and reassessment of risk levels is essential as situational factors may change and level of risk increases or decreases.

Suicidal behaviours are symptoms, not a specific illness, therefore interventions have to be tailored to address the identifiable factors and underlying conditions. Treatment planning will take into account the assessed level of risk, the age of the person, the availability of support, cultural considerations, and the limits of confidentiality. The key objective is to minimize risk through risk reduction approaches, consult and/or refer, manage the underlying factors, monitor and follow-up.

After careful assessment – weighing the risks and balancing them against the (protective) resources – the key clinical question is: 'what level of care is needed?' For those with a high risk/low protective factors ratio, a highly structured and protective environment like a hospital setting may be the most appropriate.

The child or youth with a moderate risk and higher number of protective factors may be maintained safely at home or in another appropriate community setting (if there is adequate support and supervision). When the risk to resources ratio is unclear, a structured and protected environment is most appropriate until a safety plan is developed. Impulsivity of the client should be assessed, as this is a factor that contributes to rapid shifts in risk status. The clinician's assessment and recommendation provides invaluable data upon which to base the decision to hospitalize.

Examples of Clinician Assessment Questions

What is the likelihood of reoccurrence of the overwhelming feelings, events or actions that led to the problem? If there is no clear answer, it is difficult to judge whether the action will recur.

Levels of safety and protection are determined on the assessment of risk and protective factors (resources) and the balance between them.

What is the personal meaning of the act or ideation? The answer to this question will inform the clinician's treatment plan.

Was the suicide act a solitary behaviour, or is it within a context of other problems that must be addressed?

4. managing safety and treatment planning

4.1 SAFETY PLANNING

High risk suicidal clients can be safely and effectively treated on an outpatient basis if family members or alternate caregivers are available to provide one-on-one supervision in the home and if 24 hour acute care is available and accessible as required.

When high risk does not dictate hospitalization, the intensity of outpatient treatment (i.e., more frequent appointments, telephone contacts, concurrent individual and group treatment) should vary in accordance with risk indicators. The availability of close supervision in the home setting must be assured in cases of high risk.

Following a suicidal crisis, clients identified as high risk will benefit from intensive follow-up treatment. Note: Multiple attempts, psychiatric history, and current diagnostic comorbidity are some of the factors that indicate high risk.

Depending on the clinician's judgement regarding degree of risk for suicide, a safety plan will be developed and intensive follow-up treatment contracted with the participation of the family. Short-term treatment for suicidal ideation or related symptomatology such as depression, hopelessness, or loneliness should focus on problem-solving approaches. Chronic suicide attempts and related behaviour, particularly in the presence of Axis II disorders should match the identified skills deficits. Regardless of therapeutic orientation, a deliberate effort should be made to articulate treatment targets, both direct targets (i.e., suicide ideation, attempts, related self-destructive and self-mutilatory behaviours) and indirect targets (depression, hopelessness, anxiety, anger, etc.).

Assessment of the young client's immediate environment may also be crucial in minimizing access to potential lethal agents or weapons. At a minimum, the clinician must check with the caregivers to ensure that the youth doesn't have access to firearms or medications. Although it is not possible to control all aspects of a client's environment, removal of easily accessible means may decrease the likelihood of an impulsive attempt of high lethality in the future (Berman, 1994).

Note: Short-term crisis intervention is aimed at protecting the client from impulsive behaviour and attenuating or eliminating factors contributing to the crisis. Activities of the clinician include conducting and documenting a suicide risk assessment, developing a safety plan (regardless of the degree of risk, a safety plan should always be developed and revisited when/if risk changes), identifying and mobilizing the necessary family and community resources, or to initiate the process of voluntary or involuntary hospitalization.

TABLE 6 CONSIDERATIONS FOR MONITORING MODERATE TO HIGH RISK

THOSE YOUNG CLIENTS WHO ARE AT HIGH AND IMMINENT RISK REQUIRE IMMEDIATE EVALUATION FOR HOSPITALIZATION. OUT-PATIENT MANAGEMENT OF THOSE AT MODERATE (AND POSSIBLY HIGH) RISK CAN BE ACCOMPLISHED WITH THE FOLLOWING CONSIDERATIONS:

Recurrent evaluation for the need for hospitalization

Increase in frequency or duration of outpatient visits

Frequent evaluation of treatment plan goals including:

- Symptom remission
- Reduction in frequency and intensity, duration or specificity of suicide ideation
- Improved hopefulness
- Reduced hopelessness
- Improved problem-solving/adaptive coping
- Improved self-control
- Establishment and mobilization of an available, accessible support system

24-hour availability of emergency or crisis services for client

Frequent re-evaluation of suicide risk

No continuing suicide ideation

Improved social support following reconciliation in a relationship (improved problem solving)

Consideration of medication if symptomatology persists or worsens

Use of telephone contacts

Professional consultation as needed

Safety Contracts

In out-patient settings a "no-suicide" or safety contract is often used as a major element of treatment, particularly in the early stages of treatment. The contract is based on a statement from the client that he or she will not harm him or herself, or will contact the mental health clinician or a specified key person, if she or he feels unable to maintain his or her own safety. It is important to note that effective contracts are always short-term, usually for no more than a week, or until the next appointment time. Contracts must be based on having established a solid therapeutic relationship with the client.

While the safety contract can be quite reassuring to the family members, the client and the clinician, there are a number of limitations to be aware of.

Limitations to Safety Contracts

The mental health clinician may not have established a sufficient therapeutic alliance with the client. This alliance provides the basis for maintaining a contract. Suicidal children and youth are especially vulnerable and struggle with creating meaningful relationships, making the therapeutic alliance difficult to establish and maintain.

- In spite of the best efforts of young clients and their families, they are not always able to adhere to a contract for various reasons (e.g., due to feeling overwhelmed, cognitive distortions and/or coexistent pathologies).
- Families may not be able to adjust their work schedules or other family commitments to provide the necessary support to the child or youth.
- Family dysfunction and distress may make it difficult to respond appropriately to the child or youth.
- While limited and not without reservations, the "no-suicide" contract has value in certain contexts. The following components can optimize its use:

Optimizing Clinical Value of Contracts

- Contract parameters are clear, are in writing, and checked and updated regularly.
- Family members and supportive others are included in negotiating the safety plan and contract. This planning is best undertaken in an open forum with all support people present.
- Access to lethal means to self-harm (i.e., guns and medications in the home) must be prevented in agreement with family members.
- Twenty-four hour availability of the mental health clinician or back up in case of a crisis situation is needed. This coverage signals to the client and his or her family that the clinician is concerned about the seriousness of the situation. (Adapted from Jacobs, 1999)

4.2 RECOMMENDATIONS FOR HOSPITALIZATION

Safety of the client is your primary concern. In the case of suicide risk, the issue of safety, or lack of it outside the hospital, is the most important factor that indicates a need to recommend in-patient hospitalization. The second major factor that suggests hospitalization is for the treatment of a serious underlying psychiatric disorder, such as psychosis or severe depression, which is better managed in an in-patient setting rather than an out-patient setting. Some examples of situations where hospitalization may be necessary:

- The client is in a psychotic state and is threatening suicide, unless there is convincing evidence to suggest that the client is not at risk.
- Suicide threats are escalating and the client is determined to be at risk to self or others.
- The client is on psychotropic medications and has a history of serious medication overdose and needs close monitoring of medications or dose.
- The suicidal client is not responding to out-patient treatment and there is severe depression or disabling anxiety.
- The client is in an overwhelming crisis and cannot cope with it alone without the risk of serious harm to him or herself, and no other safe environment can be found. The risk of suicide outweighs the risk of inappropriate hospitalization.
- There is emergent psychosis (first time episode) and the client cannot cope with such a state, the client has little or no social support, and the client is suicidal.

Adapted from: Linehan, et al (1993)

Table 7 provides a quick reference for indicators of the need for intensive levels of care.

TABLE 7 – INDICATORS OF NEED FOR INTENSIVE* LEVEL OF CARE

CHARACTERISTICS OF THE ATTEMPT/CURRENT SUICIDALITY
Active suicidal ideation (with plan and intent)
High intent and high lethality attempt
Motivation to die or to escape a painful situation or affect
Inability to maintain a no-suicide contract
PSYCHOPATHOLOGY
Depression – severe or comorbid
Bi-polar illness
Substance abuse
Psychosis
Multiple diagnoses
PAST HISTORY
Previous non-compliance or failure with out-patient treatment
Past attempt
PSYCHOLOGICAL CHARACTERISTICS
Hopelessness
Aggression/hostility
FAMILY PROBLEMS
Abuse
Severe parental psychiatric illness
Parents unable/unwilling to protect or monitor client

Adapted from: Brent (1997)

**Intensive refers to one-one supervision in the home or hospital setting.*

4.3 TREATMENT PLANNING

A treatment plan will incorporate the mental health clinicians' assessment of the strengths and weakness of the child's or youth's life situation, including the information gleaned from the mental status exam, suicide risk assessment and individual, familial, and community-based protective factors. The plan is designed on the basis of the specifics of the case. Four key elements often work synergistically.

1. Collect Data Before Treatment Planning
The reasons underlying the attempt or ideation need to be viewed and understood from the child's or youth's perspective.

2. Identify Range of Treatment Alternatives
If underlying psychopathology is suspected, a mental status assessment is required. A diagnostic assessment may also include psychological testing and additional information on the family history. Pharmacological treatment may be indicated.

3. Involve Client and Family in the Treatment Planning Process to the Degree Possible
Use individual and family therapy approaches, including psychoeducation programs to treat the underlying factors or disorder (e.g., depression education). Teaching the family what might trigger an event or how to identify risk is empowering for family members and increases their understanding and support of the child's or youth's difficulties. Acknowledge their helpful contributions. Ensure that the family is aware of the importance of restricting the child's or youth's access to lethal means (guns, medications, etc.).

4. Incorporate the Most Promising Treatment into the Plan
Focus on problem-solving and social functioning using cognitive behavioural work. Also assisting the client to engage with supportive social groups in the community is an important part of a strategy for involving the child or youth with a connected and caring environment.

Adapted from: Jacobs (1999).

4.4 COMPLEX PSYCHIATRIC ISSUES

If underlying psychopathology is suspected or if a client presents with suicide ideation, a Mental Status Exam should always be performed. Evaluation for DSM-IV Axis I and Axis II diagnoses and associated symptomatology should be documented.

A physician should be consulted concerning issues of diagnosis, treatment, and the appropriateness of medication.

When available, psychiatric consultation should be sought.

When available and appropriate, psychological assessment should be sought, even if the psychologist is with another agency, such as the school board or paid for privately by the client's family.

Regardless of the therapeutic orientation, a deliberate effort should be made to plan treatment goals in collaboration with the client and articulate the goals in such a way that the client understands both direct goals (i.e., suicidal ideation, attempts, related self-destructive and self-mutilatory behaviours) and indirect goals (i.e., depression, hopelessness, anxiety, and anger; interpersonal relationship dysfunction; low self-esteem and poor self-image; day-to-day functioning at school and home, etc.).

The mental health clinician working with a suicidal child or adolescent requires a clear diagnostic understanding of the client who is presenting suicidal behaviour (Kernberg, 1994 cited in Anderson, 1999). There is substantial evidence to show that young people who attempt suicide or eventually kill themselves are more likely to have major depression, substance abuse, or a history of suicide attempts (Brent et al,

1994; Deykin & Buka, 1994). Conduct disorder is also strongly correlated with suicidal behaviour. Children and youth in the impulsive and antisocial-behaviour spectra have a high incidence of completed suicide (Stone, cited in Kernberg, 1994). The research also points to the high incidence of suicide in schizo-affective, schizophrenic, and affective disorders. All of these risks are usually compounded by substance abuse.

Psychotic disorder is also of concern because the rates of suicide are high among the small number of people who have psychotic disorders (National Health Committee Guidelines, 1999). Risk of suicide among young people with comorbid mental disorders is high and the risk increases in direct proportion to the number of comorbid conditions. Better outcomes for young people are associated with individuals who received earlier treatment for their first serious episode of mental illness (National Health Committee Guidelines, 1999).

Major depressive disorders and alcohol abuse are positively associated with the severity of suicidal behaviour in males and females (Pfeffer et al, 1988). In a study of suicidal adolescent inpatients Brent et al (1988) reported that a large percentage of them had high rates of affective disorder and family history of affective disorder. Family functioning, in particular, communication between family members, is also an important issue in a young person's experience (Kerfoot & Huxley, 1995). Anderson (1999) suggests that children and youth that are suicidal are often living in families where relationships are disturbed and interpersonal communication is poor. (See Section 2.9, Family Involvement.)

Major Depressive Disorder (Modified from the DSM IV)

Depression is now recognized as being a common disorder of young people and there is increasing recognition that childhood depression increases the risk for reoccurrence in adolescence, for adult depression, and for future suicidal behaviour (Brent et al, 1990). Commonly identified causative and precipitating factors for major depression in young people include genetic loading and environmental stresses such as academic pressure, school bullying, relationship problems, and family pressures. There is consistent evidence linking depression and suicidality with substance abuse in young people. Research on completed suicides has found that the combination of mood disorders and substance misuse is most common in suicide victims (Zeitlin, 1999).

Outpatient Treatment Implications

Standard treatment for major depression involves the use of cognitive-behavioural therapy, plus the use of anti-depressant medication. Severe depression may require long-term psychiatric follow-up. High quality depression intervention research with children and adolescents (Lewinsohn, 1990; Lewinsohn et al, 1996) suggests that cognitive-behavioural treatment for adolescents (e.g., *Coping with Depression Program*) evidenced greater reductions in self-reported depressive and anxious symptoms and maladaptive cognition (Kaslow & Thompson, 1998).

Elements of the Coping with Depression Psychoeducational Program

- 14 session multiple component intervention
- Focus on experiential learning and skills training
- Attention given to increasing pleasant activities
- Training in relaxation, controlling depressive thoughts, improving social interaction and developing conflict resolution skills
- Booster sessions given plus follow-up assessment

Factors that limit the effectiveness of a psychoeducational approach include:

- Specific depression symptoms and severity
- Comorbid conditions
- Cognitive level
- Age
- Family constellation
- Education level
- Adherence patterns
- Expectations of therapy

Source: Kaslow & Thompson, 1998.

Substance Abuse

Substance abuse and dependence disorders (including the use of alcohol, cannabis and other drugs) are present in over 30 percent of adolescent suicide attempts. For males under the age of 25 in particular, hazardous or harmful patterns of drinking are a problem for almost 30 percent. Substance abuse disorder, according to the DSM-IV, is a maladaptive pattern of substance use that includes the following features:

- Recurrent substance use which affects performance at school, work, or home.
- Recurrent substance use in situations that are physically hazardous.
- Recurrent legal problems related to substance use.
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused by the effects of the substance.

Substance dependence disorder is defined as a maladaptive pattern of substance use, leading to significant impairment or distress and includes the occurrence of at least three of the following features within a twelve month period:

- Increased tolerance indicated by the need to increase the amounts of the substance to achieve intoxication or markedly diminished effect with continued use of the same amount of substance.
- Withdrawal patterns for a particular substance and/or the use of the substance to relieve or avoid withdrawal effects.
- The substance is often taken in larger amounts or over a longer time period than was intended.
- There is a persistent desire to decrease or stop substance use.
- A great deal of time is spent in activities necessary to obtain the substance, to use it, or to recover from its effects.
- Important social, occupational, or recreational activities are given up or reduced due to substance use.
- Use of substance continues despite knowledge of having a persistent or recurrent physical or psychological problem with the substance.

Identification of Substance Abuse or Dependence

Use of alcohol and other drugs by adolescents is quite common; however, those who have pre-existing and significant psychosocial problems, and lack family "protection," are more vulnerable to using these substances in a harmful way. Many of these "harmful users" may also have mental disorders. For other adolescents, substance use may be an attempt to "self-medicate" and reduce psychological distress and pain.

The clinician will need to determine if substance use is present and ascertain what effect the substance use has on various domains of the young person's life and psychosocial functioning (Bukstein, 1998). The primary treatment goal for adolescents with substance use disorders is to achieve and maintain abstinence from substance use. While this is the explicit, long-term goal, it is important to recognize that acceptable, interim goals may include reduction in the use and adverse effects of substances, reduction in relapses and improvement in one or more domains of the young person's life (i.e., academic performance or family functioning). Treatment goals should be matched with the client's readiness to change their use of substances. Confrontation or acceptance of "poor motivation" can lead to resistance to treatment.

The assessment interview will focus on the underlying reasons why the young client is using substances and will help to clarify the young client's pattern of use, onset, type of substances, consequences, context, and progression of the abuse and dependency.

Assessment interview questions may include:

- What do you do for fun?
- What do you do in you spare time?
- Many young people experiment with drugs, alcohol and tobacco. Have you ever tried them? What have you tried?
- How often do you use (alcohol, drugs)?
- What are some of the good things you find about using?
- What are some of the less good things?
- What worries you most about using?
- Do your friends or parents worry about you taking (alcohol, marijuana, LSD, etc.)?

Treatment Implications

The comorbidity of emotional and behavioural disorder with substance abuse and dependency place adolescent clients at risk for suicidal behaviours. Substance use should be reduced to the lowest possible level and ideally the goal is to become drug free. Self-help 12 step programs for adolescents in the community may provide additional support for the client and a referral to substance abuse treatment setting may be indicated.

Emerging Personality Disorder

Personality disorders are characterized by inflexible and enduring behaviour patterns that may impair social functioning. There is a range of personality disorders including paranoid, schizoid, schizotypal, avoidant, dependent, obsessive-compulsive, histrionic, narcissistic, borderline, and anti-social. Although hospitalization may not be effective in reducing suicide risk in the long term, it can be effective in the short term. Management of personality disorders requires long-term follow-up. Targeted psychopharmacological interventions with individuals on an outpatient basis can have positive outcomes. Linehan (1987) suggests that there are certain risks associated with medication abuse among personality disordered clients in outpatient settings. Her research indicates that Dialectical Behavioural Therapy (DBT) is an effective approach for the treatment of instrumental suicidal behaviours (parasuicidal behaviours) in adults and is also being adapted for use with adolescents with emerging personality disorders. Randomized outcome studies indicate DBT compared to treatment-as-usual are encouraging. (See 4.6 – Dialectical Behavioural Therary for further discussion).

Conduct Disorder

Conduct disorder in male adolescents is associated with suicide, especially when comorbid with substance abuse and mood disorder. The combination of conduct disorder and substance abuse should be regarded critically with respect to suicide, even in the absence of mood disorder (Renaud et al, 1999). Risk increases if the youth has a past history of physical abuse and if parents have a history of substance abuse and mood disorders. Treatment should focus not only on the adolescent, but also on their family members (Renaud et al, 1999). The management of substance abuse is the most likely means of reducing risk. Adolescents referred for the treatment of conduct disorders are least likely to continue beyond screening and attend fewer sessions. This may reflect the inappropriateness of individual psychodynamic therapy for conduct disorder (Tolan, Cromwell & Braswell, 1986, cited in Tolan, et al. 1988).

Psychosis

There is a very high suicide risk for individuals with schizophrenia and other kinds of psychotic disorders. The recommended "best practices" interventions for early psychosis includes low dose antipsychotic medication, cognitive behavioural therapy (CBT), psychoeducation, and supportive counseling. The effectiveness of CBT for psychosis has been demonstrated in several studies (Haddock et al., 1999; Sensky et al., 2000). CBT efficacy in psychosis has been demonstrated for both 1) secondary morbidity/adaptation to the illness (e.g., anxiety, depression) and 2) for the psychotic symptoms themselves (hallucinations, delusions).

Other interventions that are stressed as being perhaps more relevant to younger individuals with symptoms of early psychosis include family therapy (i.e., helping the family understand, cope, and interact appropriately with their psychotic child).

Also, it is very important to remember that treatment cannot end once the psychotic symptoms disappear. It will be essential to monitor for potential relapse of psychosis or a post-psychotic depression (very common) and to help the individual become reintegrated into his or her everyday routines (e.g., school, social life, work) which is often very difficult for the individual whose life was turned upside down by psychosis. Appropriate support groups, medication, and long-term follow-up are critical elements to treatment planning. As well, the first episode of psychosis calls for assertive treatment and active case management efforts.

Note: If young people are experiencing command hallucinations, (i.e., hearing voices telling them to kill themselves) this will most likely call for hospitalization.

4.5 BRIEF COGNITIVE BEHAVIOURAL APPROACHES

> If the target variables are suicidal ideation, or related symptomatology (particularly in the presence of an Axis I disorder), such as depression, hopelessness, or loneliness, and the treatment is brief, a problem-solving component holds the most promise as a core intervention. Note: brief approaches do not appear effective in reducing chronic attempts over enduring time frames. (Rudd, et al, 1999)

The most positive findings for suicidal children and youth offer a variant of cognitive-behavioural therapy integrating a problem-solving component as a core intervention for reducing suicide ideation, and related symptomotology such as depression, hopelessness, and loneliness (Rudd, 1999). Long-term treatment that is more intensive is indicated for repeat attempters and chronic suicidal behaviour and they appear to benefit from approaches that target specific skills deficits (i.e., anger, assertiveness, impulsivity, etc.).

Cognitive-behavioural treatment focuses on the cognitive deficits that disrupt the young person's ability to solve interpersonal problems and the capacity to regulate emotions (van der Sande, et al, 1997). If therapy is brief and the target variables are suicide ideation or related symptomatology such as depression, loneliness or hopelessness, a problem-solving treatment approach is most effective as a core intervention (Rudd et al, 1999; Joiner, Rudd & Rajab, in press).

Problem Solving Skills Training

Interpersonal problem-solving skills training (PSST) for treatment of instrumental suicidal behaviour such as self-poisoning has been shown to improve measures of interpersonal cognitive problem-solving, generate alternative courses of action, increase sensitivity to consequences of behaviour, and respond to everyday interpersonal problems (McLeavey et al, 1994). This approach is also considered effective in ameliorating deficits in problem solving skills found in adolescents prone to aggression (Brent & Kolko, 1998) and those adolescents with depression and suicidality. Depression, social isolation, and poor interpersonal skills contribute to a youth's risk for suicide. Cognitive-behavioural treatments have greater effect on older children (11-13 year olds) vs. younger children (5-7 years olds) (Rotherham-Borus, 1990).

One approach to problem-solving treatment is the *Competence Building Program* developed by the Center for Adolescent Mental Health at Washington University. This brief program of 14 sessions meets over a three-month period. Groups have five to nine members and are led by trained facilitators. Competence building groups provide psychoeducation to increase the participants' self-awareness and assist them to recognize the strong emotions that lead to an aggressive outburst, suicide attempt, or overwhelming anxiety (Rotherham-Borus, 1990). Group work was also accompanied by individualized treatment sessions.

TABLE 8 – COMPETENCE BUILDING PROGRAM ELEMENTS

PHASE ONE – EDUCATION
Provide a blueprint for understanding reactions to stress.
Interpret stressful situation then reframe as series of solvable problems.
PHASE TWO – SKILL BUILDING
Learn and rehearse behavioural and cognitive coping skills including problem solving, relaxation, role playing and social skills.
Learn to monitor thoughts, feelings and behaviours and to replace self-defeating thoughts with self-instructional statements.
PHASE THREE – SKILL PRACTICE
Exposure to a variety of stressors and role play exercises prepare adolescents for difficult situations at home, school and in the community.
KEY ELEMENTS
Intervention techniques are social skills training and cognitive therapy.
Group treatment helps members reduce their social isolation.
Cognitive approach emphasizes that individuals interpret life experiences based on their own values, beliefs, expectations and attitudes. Program instructs adolescents how to identify, evaluate, and change self-defeating cognition.
Program provides members with an opportunity to express feelings of anger, frustration, sadness and failure. Self-esteem and self-efficacy are improved through group and individual exercises.

Adapted from Rotherham-Borus (1990).

Solution Focused Brief Therapy

Solution-focused brief therapy (SFBT) emphasizes solutions, competence, and capabilities of the suicidal client. This approach marks a shift, not a complete departure, from problem solving treatment approaches. SFBT is a goal- or solution-focused approach in which the client is considered the expert in his or her treatment plan and the clinician's role is to facilitate the recognition and implementation of goals and solutions (Fiske, 1998).

Clients are invited to tell their stories; then, through reflective and careful listening, clinical judgment is made to introduce s*olution-talk* where exceptions to problems are discussed and can be used as the foundation for finding solutions. Solution-focused techniques offer a philosophy, stance, and attitude that have much to offer clinical suicide prevention work (Fiske, 1998). The therapeutic techniques address the typical concerns and issues of the suicidal person or the commonalties of suicidality (Shneidman, 1987, 1989), (i.e., decreasing perceptual constriction, working with ambivalence, facilitating early communication of intent, and developing workable solutions to suicide which are consistent with individual needs) (Fiske, 1998).

Therapeutic Techniques used in SFBT

- A question-based approach is consistent with the non-normative, individualized nature of the approach (e.g., What brings you here today? How can this meeting be helpful to you? or use of the 'miracle question' – a hypothetical solution picture for each client).
- Drawing on and utilizing the client's own competencies, strengths, resources, and successes is a fundamental principle of SFBT.
- Goals, solutions and utilizable resources are suggested by the client.
- The therapeutic stance necessary for clients to identify their own goals is one of not knowing.
- The nature of change is multidimensional. Change is defined as constantly occurring; change is generative (small changes lead to larger changes), and the client will demonstrate his or her beliefs about change through his or her behaviour (i.e., "resistant clients" may have their own understanding of how to change their lives for the better).

Adapted from Fiske (1998).

Fiske (1998) has applied the SFBT to the ten commonalties of suicide as defined by Shneidman (1997) to illustrate how the needs and challenges of the suicidal client might be addressed by SFBT.

TABLE 9 – THERAPEUTIC TASKS OF SOLUTION-FOCUSED BRIEF THERAPY (SFBT) USING SHNEIDMAN'S TEN COMMONALITIES OF SUICIDE

THE COMMON PURPOSE OF SUICIDE IS TO SEEK A SOLUTION.
Understand how the individual views suicide as a personal solution.
Find out what else could serve as a solution for the client.
THE COMMON GOAL OF SUICIDE IS CESSATION OF CONSCIOUSNESS.
Help client understand the consequence of suicide.
Help client consider alternatives to suicidal behaviour that may achieve similar consequences.
THE COMMON STIMULUS IN SUICIDE IS INTOLERABLE PSYCHOLOGICAL PAIN.
Accept the reality of the client's pain.
Help client identify anything that can help relieve pain, even slightly (even those thoughts and activities that may be undesirable or unhealthy, i.e., substance use or bingeing).
Increase awareness of small changes that make a noticeable difference.
THE COMMON STRESSOR IN SUICIDE IS FRUSTRATED PSYCHOLOGICAL NEEDS.
Understand the meaning of unmet needs in the client.
Shift the focus from the problem state to the goal picture (use of Miracle Question).
THE COMMON EMOTION IN SUICIDE IS HELPLESSNESS-HOPELESSNESS.
Seek exceptions to feelings of helplessness-hopelessness.
Explore degree to which client can behave in a non-suicidal manner.
Use presuppositional language that conveys implicit assumptions of action, efficacy, and hope (e.g., you have done things to assist your own survival; thoughts of suicide do not last indefinitely; you have the ability to modify these thoughts).
THE COMMON COGNITIVE STATE IN SUICIDE IS AMBIVALENCE.
Recognize and support the client's desire to live without trivializing their pain and distress (e.g., the use of the Reasons for Living Inventory by Linehan, Goodstein, Neilson, & Chiles, 1983, is useful in this regard).
Assist the client to identify life-affirming aspects and use qualifying questions to support the exceptions to suicidality.
THE COMMON PERCEPTUAL STATE IN SUICIDE IS CONSTRICTION.
Seek opportunities to interrupt perceptual constrictions redirecting attention from failure and disaster to consideration of accomplishments, strengths and resources.
THE COMMON INTERPERSONAL ACT IN SUICIDE IS COMMUNICATION OF INTENTION.
Communication of intention is not universal.
Communication is not always conveyed in a language understood by the recipient at the time.
Ask client about suicide intent within a context of the client as a whole person with healthy attributes as well as psychiatric symptoms and plans for suicide.
THE COMMON ACTION IN SUICIDE IS EGRESSION.
Recognize the desire to exit a painful situation and seek alternatives and goals that are more palatable than suicide.
Define goals for treatment collaboratively with client.
THE COMMON CONSISTENCY IN SUICIDE IS WITH LIFELONG COPING PATTERNS.
Even in a crisis situation seek evidence of client's coping skills.
Assume that client can learn from and rely on their own accomplishments, even in the midst of pain, fear, and apathy.

Adapted from: Fiske (1998)

4.6 DIALECTICAL BEHAVIOURAL THERAPY

> For reducing chronic suicide attempts and related behaviours (particularly in the presence of an Axis II disorder), treatment should be long-term and match identified skills deficits (e.g., emotion regulation, distress tolerance, impulsivity, problem solving, interpersonal assertiveness, anger management), in addition to other enduring problems (e.g., interpersonal relationships and self-image problems). Ongoing monitoring of suicidality is an integral part of long term treatment. (Rudd et al, 1999).

Instrumental suicidal behaviour is particularly prevalent among individuals who meet the criteria for borderline personality disorders (Linehan, 1987). Dialectical Behavioural Therapy (DBT) has been developed and evaluated as a comprehensive, behavioural treatment. DBT is based on the view that instrumental suicide is a problem-solving behaviour used to cope with or ameliorate psychic distress. At the heart of DBT is the notion that suicide and suicidal behaviour represents a basic effort to cope, albeit a limited and problematic one. Among chronically suicidal clients, distress tolerance tends to be low and coping resources and responses are limited (Jobes, 2000). For these reasons, DBT includes simultaneous individual and group treatment focusing on improving communication and assertiveness skills. Group treatment is psychoeducational and focuses on skill building rather than individual crises.

Treatment targets in individual DBT are listed in order of importance:

- Address high-risk suicidal behaviours. Although self-mutilation and other instrumental suicidal behaviour is rarely lethal, the potential for accidental death requires immediate attention. The goal is to replace instrumental suicide with more adaptive solutions.
- Reduce behaviours that interfere with the therapeutic process such as missing sessions, demanding behaviours, being admitted to hospital, inability or refusal to work in therapy, psychotic episodes, or other interruptive crises.
- Increase awareness of the destructiveness of escape behaviours that threaten any chance for a worthwhile life (substance abuse, repetitive antisocial behaviour, illness-producing behaviours).
- Integrate skills learned in group treatment into daily life such as emotion regulation, interpersonal effectiveness, distress tolerance, and self-management.

Treatment strategies guide the treatment process and include: dialectical strategies, problem-solving, irreverent communication, consultant approach directed toward the client rather than other professional, validation, capability enhancement, relationship strategies, and contingency strategies (Linehan, 1987).

4.7 DOCUMENTATION AND EVALUATION OF TREATMENT PLAN

Document and Evaluate

> Use a consistent approach for assessing risk and documenting treatment outcome, incorporating both direct (i.e., suicidal ideation, suicide attempts, instrumental behaviours) and indirect markers of suicidality (i.e., markers of symptomatology, personality traits, or general level of day-to-day functioning). (Rudd et al, 1999).

> In order to augment clinical judgement and assess treatment outcomes, use sound and reliable risk assessment scales and standardized instruments at predictable intervals (e.g., Reynolds's Suicide Ideation Questionnaire, the Beck Depression Scale, and Reasons for Living Inventory, etc.).

Documentation

Good documentation is invaluable to the mental health clinician. It helps clarify the treatment plan and communicate to other care providers across the continuum of care. Suicide risk should be documented at intake, as should any new occurrence of suicidal behaviour or ideation. Documentation should be clear, legible and brief. Suggested elements of documentation include:

Times to Assess and Document Suicide Risk

- At intake
- With the first occurrence of any suicidal behaviour or ideation
- Whenever there is any noteworthy clinical change
- Whenever suicidality is an issue
- Before treatment termination

Elements of the Suicide Risk Documentation Assessment

- Degree of risk
- Objective data
- Subjective data

Diagnosis

- Working or differential diagnosis

Treatment Plan for Addressing and Managing Suicide Risk

- Risk-benefit analysis of proposed treatment
- Basis for clinical judgement and decision-making
- Relevant medications (e.g., antidepressant, antianxiety)
- Tests ordered
- Consultations requested (e.g., second opinion on suicidality)
- Precautions
- Reassessment of suicidality

Adapted from: Jacobs, 1999

Evaluation of Outcomes

Fundamental to gauging and monitoring treatment progress of direct and indirect markers is the use of a standard set of definitions that clearly distinguish what is suicidal and what is self-mutilatory and self-destructive behaviour. (See Section 2.1 – Definitions – for a review of these definitions). Additionally, it is important to distinguish between direct markers and indirect markers of suicidality. Direct markers include suicide ideation (frequency, intensity, duration, and specificity) and suicidal behaviours (attempts and instrumental behaviours) (Rudd, et al, 1999). Indirect markers include symptomatic variables (e.g., hopelessness, depression, anxiety, and anger) as well as individual characteristics (e.g., cognitive rigidity, problem solving abilities) and personality traits (i.e., in accordance with DSM-IV). Evaluation of treatment outcomes also includes assessing subjective and objective measures using psychometric instruments (e.g., Reynolds Suicide Ideation Questionnaire, Reasons for Living Inventory, and Beck's Adolescent Depression Scale).

Clearly differentiating between acute and chronic variables in the suicidal process helps establish reasonable expectations regarding the treatment outcome and process (Rudd, et al, 1999).

4.8 MONITORING SUICIDALITY

Routinely monitor, assess, and document a client's initial and ongoing suicide risk and document interventions for maintaining outpatient safety until suicidality has clinically resolved.

For cases of chronic suicidality, monitor, assess, and document ongoing risk of suicidality and document interventions that address the chronic nature of the suicidal preoccupations. It is important to note the chronicity of some symptoms (e.g., specific suicidal thoughts with a definitive plan) indicating factors that escalate risk (i.e. emergence of intent, impulsivity) versus those that diminish risk (e.g., lack of intent).
(Rudd et al, 1999)

For younger children, ongoing monitoring of the signs and symptoms of suicide risk is essential.

The risk for repeat suicide attempts is particularly high in the first few months after discharge from treatment or hospital: approximately 10 percent (adults, youth, and children) make another attempt within the first 3 months. Repeaters who die by suicide can be as high as 8-19 percent within twelve months after a previous attempt. Suicide attempters constitute a very high risk for suicide – a rate of 50-100 times that of the general population (Jacobs, 1999). Prevention aimed specifically at attempters while they are in contact with medical services is essential. For these reasons it is clear that enhanced linkages between child and youth mental health services and other community mental health resources are invaluable.

5. enhancing linkages between child and youth mental health services and the commuunity

5.1 INTEGRATED CASE MANAGEMENT AND WRAP-AROUND CARE

Case Management and Wrap-Around Care

When a child or youth and his or her family have long-term or complex needs, and when multiple service providers are involved, integrated case management provides a structure for developing and implementing joint decision-making. Clients and their families should always be included as members of an integrated case management team to the extent possible.

The goal of the case management team is to coordinate care and to optimize opportunities for clients and family members to implement the recommendations of the case management team.

All service providers involved in treatment should be informed if treatment is discontinued prematurely and suicidal risk is high or imminent.

Information Sharing Between Systems

Establish proactive relationships among key service providers (i.e. school, hospital, mental health, and child protection) in an effort to coordinate services and provide an integrated service delivery system, keeping in mind any legislative requirements for information sharing.

Integrated case management refers to the process of developing and working collaboratively with members of a team (i.e., hospital, school, mental health, child protection) in an effort to provide coordinated care to suicidal children and youth and their families. The individual knowledge and skills of the team members contribute to the goals and outcomes of young clients. When a child or youth and his or her family have long-term and complex needs, integrated case management provides a structure for developing and implementing joint decision-making. Keep in mind that clients and their families are the most important members of an integrated care team.

Elements of Integrated Case Management

- Team approach to case management is implemented when the family has complex issues and needs.
- Joint decision-making is developed and supported.
- Roles of all team members are clarified.
- Services are coordinated across systems.
- Specific issues for diverse populations are addressed, e.g., Aboriginal families and communities.
- Case manager is responsible for coordinating a case plan.

'Wrap-Around' Care

Integrated case management is a process of building relationships with other agencies in the community to provide 'wrap-around' care of a client that cuts across organizations, the community, and families. The term is based on the philosophy in which services are highly individualized to meet the specific needs of the children and families (Burchard & Clarke,

1990). Emphasis is on the importance of mental health clinicians working collaboratively with the family, organizations and agencies, and the community to mobilize support for the child at high risk.

Providing 'wrap-around' care as an approach to case management is an important component of child and youth mental health work; however, the demands of a busy mental health clinician often make integrated case management difficult. The dilemma remains that children or youth who are considered at high or imminent level of risk for suicide require such 24 hour 'wrap-around' care. The wrap-around process extends into the community and involves helping families and communities develop individualized plans of care facilitated by a 'Wrap-around Team'. The team would be made up of four to ten people who know the child or youth best, including the young person and members of his or her family. No more than half of the team should be made up of professionals.

A wrap-around facilitator leads the process. An important aspect of this role is to discover the strengths, preferences, and cultures of the child and family through informal conversation. Some questions that may assist the process of building rapport and learning more about the children and family include:

With Children:

- If you could say one good thing about yourself, what would it be?
- I like your (hair, clothes, make-up, etc.). Did you come up with that yourself?
- What is your favorite colour? Musician? Person? Friend? Subject in school?
- Who is the coolest person you know? What is cool about this person?
- Who do you hang around with? Who would you like to hang around with?
- What do you value most in a friendship? (Loyalty, fun, etc.)
- What about your personality, are you (quiet, boisterous, private, outgoing, loyal)?

With Family Members

- What do you do for fun? When is the last time you did that?
- Who are your close friends and why are they special to you?
- What is your neighbourhood like?
- What were you like as a kid?
- Who has been the biggest influence in your life?
- What do you do to "blow off steam"?
- What are the best things about yourself? Your family? Your community?

Elements of Wrap-around Care include:

- Wrap-around efforts are based in the community.
- Services and supports should be individualized to meet the needs of children and families.
- The process should be culturally competent and build on unique values, preferences, and strengths of children and families.
- Agencies should have access to flexible non-categorized funding.
- The process should be implemented on an inter-agency basis and be owned by the larger community.
- Wrap-around plans should include a balance of formal and informal services and family resources.
- Services should be unconditional. If the needs of the child or family change, the child and family should not be rejected from services.
- Outcomes should be measured.

Adapted from: Burchard, J.D. & Clarke, R.T. (1990) & VanDenBerg, J.E., & Grealish, E.M. (1996).

5.2 PROTOCOLS BETWEEN ACUTE CARE EMERGENCY AND MENTAL HEALTH SERVICES

Adolescent suicide attempters, with or without injuries, who receive care in emergency departments, have a high rate of associated disturbances that indicate a need for mental health interventions (Rotheram-Borus et al, 1996). In spite of their need for mental health interventions, fewer than 50 percent of adolescent attempters are referred for treatment following their visit to emergency rooms. Of those who are referred, many of these are nonadherent to treatment (Piacentini et al, 1995b; Spirito et al, 1989). Children or youth who appear in emergency rooms will need psychiatric or mental health follow-up. This implies the need for very close coordination between emergency rooms and mental health teams. Ideally, children and youth who are seen in emergency rooms should be referred directly to community-based mental health programs following an assessment in an emergency room and be guaranteed a follow-up appointment within one week or sooner.

Rotheram-Borus (1996) identified a number of factors that influence adolescent attempters to adhere to treatment following an attempt. These include:

- the structure of the emergency room (e.g., lengthy evaluations, and the nature of the waiting periods)
- the quality of communication between staff, family members and the adolescent attempter
- the staff's attitudes and behaviours.

Another key influencer is the family's and adolescent's preconceptions of the suicidal behaviour and their expectations about therapy.

- Many families report feeling confused about what is happening in the emergency room, why it is happening, and what to expect from the evaluation that is being done with their child.
- Parents may feel blamed for being "bad" parents and skeptical about the goals and benefits of therapy or report feeling angry about being asked to take time off work and away from their other domestic demands in order to make treatment visits. This anger is attributed to a lack of understanding of the value of treatment (Rotheram-Borus, 1996).

The manner in which emergency room staff members communicate to families about the importance of follow-up treatment is critical. The presence of a mental health clinician in the emergency room provides an invaluable link between crisis intervention and short and long term psychotherapy, and increases the likelihood that adolescent attempters will attend their initial treatment sessions.

Elements of a Protocol Between Hospital Services & Child and Youth Mental Health Services

An agreement between the hospital psychiatric/emergency services and child and youth mental health services is essential for providing coordinated services and continuity of care for those children and youth in need of mental health services offered by the two (or more) agencies. A protocol policy provides guidelines for joint and coordinated care. This policy should include a statement regarding the sharing of personal information in agreement with the *Freedom of Information and Protection of Privacy Act*, as well as indicate the authorized mental health clinicians who will have access to their client's files in the acute care setting.

Procedures should be outlined for the Hospital Emergency Room staff, the Hospital Psychiatric Unit staff, and the Child & Youth Mental Health Clinicians in terms of the expectations for coordinating services to children and youth. The community of Powell River has developed such a protocol between the General Hospital Psychiatric Services and the MCF Child and Youth Mental Health Clinicians.

At the community level, a suicide protocol represents an agreement about the role and responsibility of each mental health agency should a child or youth become suicidal. (This is much like the 'coordinating committee' discussed in 5.6 Postvention in schools.) This protocol is used to mobilize and coordinate a response when a youth expresses suicidal ideation and/or suicidal threats, is attempting, or has just attempted suicide. Such a protocol should include representatives from the spectrum of emergency service providers, i.e., the RCMP, Adult Mental Health After-hour Program, Hospital Emergency Services, the School District, the Crisis Centre, MCF, etc.

Adapted from: Draft – Powell River Community Suicide Protocol, 2000

5.3 RESPONDING TO SUICIDE PACTS: THE ROLE OF THE MENTAL HEALTH CLINICIAN

While completed suicides by pacts are statistically rare, the *idea* that a group of young people is actively planning their own group suicide is very frightening for community gatekeepers, parents, and mental health clinicians. One of the most essential interventions in the management of a suspected pact is the active gathering of accurate and reliable information. Due to the high level of anxiety surrounding a suspected pact, managing the emotional intensity and fear being expressed by gatekeepers and other concerned community members is also critically important. Bringing a sense of calm leadership to the management of a suicide pact is valuable in and of itself.

Upon learning about a potential suicide pact in the community, mental health clinicians should work with the referring source to gather as much information as possible.

- Who is involved?
- What are the known details?
- How did news of the pact come to the attention of the referral source?

If the referring source is a school gatekeeper (i.e., teacher, principal, guidance counsellor), you can assist by collaboratively developing a plan for identifying the youth involved, assessing their individual risk levels, notifying parents, and managing the negative effects of the information (about the pact) on other students if necessary. To the extent possible, the mental health clinician's role may involve going to the school to meet with those youth who have been identified as being part of the pact, and lending ongoing support to the school-based staff. Due to the real risk of contagion, which is exacerbated by a highly charged emotional climate, those youth who have been identified (as part of a pact) should be assessed by the clinician on a one-to-one basis. Parents should be notified and counselled on how to maintain safety and vigilance in the home. Establishing a clear follow-up plan, specifying who will provide the ongoing monitoring, risk assessment, and documentation is suggested.

When news of a potential pact comes to the mental health clinician's attention by someone other than a school gatekeeper (i.e. a concerned parent or community member), the mental health clinician is advised to work with the referral source to gather as much information as possible and to determine whether any of the young people can be persuaded to make an appointment with the mental health clinician. Based on the perceived level of risk, mental health clinicians may need to actively recruit other service providers, i.e. school staff, child protection workers, to assist with contacting the youth and their parents. In cases of imminent risk, mental health clinicians should activate the appropriate emergency response, i.e. police, ambulance, etc.

5.4 REINTEGRATION OF CHILDREN/ YOUTH INTO SCHOOL FOLLOWING A SUICIDE ATTEMPT

Develop guidelines for supporting the reintegration of a child or youth into the school after a suicide attempt.

After a young person's suicide attempt or a suicidal crisis the return to school may be as difficult for staff and students as it is for the young person. Although these difficulties of reintegration are well-known, little attention is given in the research literature on how to prepare for and manage the child or youth's return to school. Coordinating this reentry process requires a team approach to ensure that the young person's needs are met (Murphy, personal communication, 2000).

In instances when the young person's attempt has received a lot of attention from other students, or when other students are considered at risk for suicide or have attempted suicide in the past, a two level response is suggested that involves both the management of the impact of the suicidal impact on the school staff and students, and the preparation for and management of the suicidal student's return to school (White, 1994). A primary concern among educators and suicide prevention experts is the potential for a suicidal act to influence further suicide acts. Following a suicidal incident, school staff need to have an opportunity to know the facts of the incident themselves and to be provided with support for their own emotional reactions. Staff also need to be advised on how to manage information when engaging with the student body. Mental health clinicians can play an important role in providing this support and advice to staff.

Suggested guidelines for handling information about suicidal incidents include:

- Refrain from sharing specific or sensational detail about the incident.
- Restrict information to the general facts as they are known.
- Diffuse anxiety by framing the suicidal act as "an unwise choice or decision" as a way of coping with problems or emotional pain.
- Provide reassurance to students, highlighting healthy coping behaviours and providing information about where additional help (i.e., counselling) is available.
- To provide the greatest degree of support for staff and students develop school policies that articulate recommended procedures and guidelines for dealing with suicidal threats, crises, and attempts, as well as completed suicides that occur on or off school property (Kalfat & Underwood, 1989).

Responding to the Needs of Students

Following a suicide incident it is important that the school staff contact students who may be potentially at risk due to their relationship with the attempter. These students should be provided with the opportunity to share their feelings and express their concern to the returning young person. However, the returning student's rights to privacy need to be respected and clear guidelines are important for maintaining confidentiality with peer support group. Again, the child and youth mental health clinician can play an important role by providing suggestions for how to initiate and facilitate such a group involving the returning student and his or her peers.

Managing the Returning Student's Reentry

There are a number of key elements that contribute to making the school environment supportive and responsive for the returning student who, understandably, may find it very stressful to fit back into school life. The most likely person to facilitate the student's reentry is the school counsellor who plays a critical role in communicating with the mental health clinician, other school personnel, and the family, and supporting the students return. (Note: not all young people who have had a suicidal crisis will have been hospitalized, taken into care, or seen in an out-patient mental health setting.) Ideally, however, the young person is involved in follow-up treatment and has a treatment plan in place. Ryerson (1986) recommends that this designated school-based person be responsible for summarizing school-related information for the treatment team, providing necessary materials, homework assignments, updates on school activities, maintaining ongoing contact with the student in his or her absence from school, and acting as a student advocate.

Typically, school-based personnel are excluded from child and youth mental health treatment planning – to the detriment of the young person. By making a concerted effort to engage with school-based personnel, you will be making them aware of the student's treatment goals in order for him or her to play an active role in supporting these goals.

Source: Adapted from White, 1994

5.5 MEDIA EDUCATION GUIDELINES

Media Education

> Responsible media coverage contributes to the reduction of suicide contagion, therefore, in the event of a child or youth suicide in the community, the mental health clinicians should suggest guidelines to the media regarding accurate and responsible reporting of a completed suicide.

One important risk factor associated with child and adolescent suicide is *contagion*, a process by which exposure to the suicide or suicidal behaviour of one or more persons influences vulnerable others to commit or attempt suicide (Center for Disease Control, 1994). The effect of contagion appears to be strongest among adolescents and is not limited to suicides that occur in a specific geographical area. Non-fictional television and print media coverage of suicide have been shown to have a statistically significant effect on subsequent occurrences of suicide (Gould, 1990 in Center for Disease Control Recommendations from a National Workshop). Mental health clinicians' concerns and perspectives on approaches to media coverage that reduce suicide contagion are important for stimulating a dialogue between the media and health professionals on responsible media reporting.

Recommendations for Media Education

- The goal is not to prevent news coverage of a suicide, but to encourage media organizations to provide accurate and responsible reporting.
- If asked to comment on a suicide, mental health clinicians have an opportunity to frame the issue and exert influence on the way the suicide is reported. Take time to formulate the response.
- Communicate the scientific basis for concern that media coverage of a suicide may contribute to the causation of contagion.

- Public officials should acknowledge that a final precipitating event was not the only cause of the suicide, (e.g., suicide is never the result of a single factor or event, but rather results from a complex history of psychosocial problems (O'Carroll, 1993).
- Repetition and excessive reporting of a suicide in the news tends to promote and maintain a preoccupation with suicide among at-risk persons (especially youth from 15-24 years old).
- The media and public officials should limit their discussion of morbid details of the suicide act or the use of photographs, (e.g., the young person's bedroom, funeral, or the site of the suicide).
- Details of the procedure and mechanisms used to complete the suicide should be avoided.
- Emphasis should be on the fact that suicide is a rare act of a troubled or depressed person and should not be presented as if it were a means of coping with personal problems. Although such precipitating factors as the break-up of a relationship or a family conflict may be seen as a trigger, other psychological problems are frequently present.
- Public eulogies and other public acts of mourning the deceased person who commits suicide should be minimized as they may suggest to at-risk persons that society is honoring the suicidal behaviour, rather than mourning the person's death.
- Focusing on the deceased person's positive characteristics without mentioning the troubles and problems she or he was experiencing may make the suicidal behaviour seem attractive to other at-risk persons, particularly those young people who seldom receive positive feedback.
- Responsible reporting of suicide will include information about: where help and support is available for suicidal people in the community; the risk factors for suicide; and how to identify a person who is suicidal.

5.6 POSTVENTION IN SCHOOLS

The provision of crisis intervention, support, and assistance for those affected by the suicide or suicidal behaviour of others contributes to reducing the negative effects of the crisis and protects at-risk students.

In communities where there are suicide clusters, the community itself takes on the characteristics of the survivor's reaction – fear, guilt, and anger can permeate. A community-based plan that involves representatives from key agencies and local leadership should form a coordinating committee responsible for developing and maintaining a response plan.

Postvention is the provision of crisis intervention, support, and assistance for those affected by a completed suicide (American Association of Suicidology, 1994). For children and adolescents who are dealing with the death of a student or friend in a school setting, the impact of a suicide can be devastating. Many signs of grief such as sorrow, fear and anger can be anticipated and vulnerable young people may be at risk of imitating the suicide act. Appropriate efforts can contribute to alleviating the crisis and protect at-risk students. The constant theme that should be communicated is that *suicide is a complex, multidimensional act by an individual, for which others cannot assume responsibility* (American Association of Suicidology, 1994, p. 8).

The purpose of a postvention plan is 1) to prevent further suicides from contagion, 2) to help students and others affected by the death to deal with the trauma and grief, and 3) to assist the school and community to return to its normal routine.

TABLE 10 – SUGGESTIONS FOR POSTVENTION GROUP AND INDIVIDUAL COUNSELLING

Explain, encourage, and normalize the expression of shock, fear, sadness, guilt, and anger at others or at the victim and provide assurance that painful feelings will subside through discussion, counselling and support.

The aim is not resolution of sorrow. Survivors will need to experience their pain to progress through grief.

Clarify the facts of the suicide.

Do not speculate on why the deceased chose to die or dwell on real or imagined guilt of the survivors. Test the common misconception that someone is to blame for the death.

Do not focus on the suicide as a romantic or heroic act, rather emphasize ways of getting attention without threatening or attempting suicide.

Focus on the suicide victim as an extremely upset and disturbed person who unfortunately did not believe he or she had other ways to resolve emotional or psychological problems.

Encourage the survivors to talk about their happy, sad, or angry memories of the victim, what they did together, what the person was like. Ask about the last time they saw the person and what they said to him or her or what they wished they would have said if they had know it was the last time they were to see him or her.

Encourage discussion of recent losses.

Acknowledge that suicidal thoughts are common but do not have to be acted on. Other options and alternatives are possible.

Rehearse possible condolence messages to the family if the young person is unsure of what to say.

Encourage discussion with parents and friends about their feelings and thoughts of suicide. Ask them who they turn to for support or help.

Provide information about available community resources for follow-up support including telephone numbers.

Assess for suicidal ideation or plans and implement safety plan as required.

Source: Adapted from Suicide Postvention Guidelines, American Association of Suicidology, 1994

A community-based plan that involves representatives from key agencies and local leaders will most likely have a *coordinating committee* responsible for developing and maintaining a response plan. Table 11 provides some suggestions about the purpose and scope of such a committee.

TABLE 11 – ELEMENTS OF A COMMUNITY POSTVENTION COMMITTEE

Roles and linkages between community resources need to be defined, e.g., community-wide crisis team.

Plan should specify the referral process to community resources.

A community forum should be organized to share information, provide guidance, and address community concerns. Opportunities for small group discussion of intense and complex feelings should be expected.

Mechanisms for identifying at-risk youth and suicide attempts need to be developed.

Long-term issues and community problems and environmental issues that impact youth suicide must be identified so that the committee can advocate on behalf of young people.

A communication plan should review process for holding a news conferences, a community-based crisis line that provides information on suicide warning signs and referral to counselling services and hotlines.

Support for the crisis team and contingency plans should be implemented if more suicides occur, (e.g., debriefing meetings for committee members).

5.7 "BEFORE THE FACT" PREVENTION IN THE COMMUNITY

Support community-based programs aimed at addressing the core known risk factors, (i.e., early detection and treatment of depression, prevention of physical/sexual abuse, prevention and treatment of substance abuse, reduction of teasing and bullying and other stigmatizing behaviour, media education and gun control).

Child and Youth Community Prevention Programs

There are 15 "before-the-fact" youth suicide prevention strategies that, taken together, show significant promise for reducing risks for suicide. Some of these strategies focus on the individual or family environment, while others are designed to be implemented within the contexts of schools and communities.

Youth/Family

- Generic skill-building
- Suicide awareness education
- Family support
- Support groups for youth
- Screening

School

- School gatekeeper training
- Peer helping
- School policy
- School climate

Community

- Community gatekeeper training
- Means restriction
- Media education
- Youth participation
- System-wide protocols
- Community development

Adapted from: White & Jodoin, 1998

references

Ambrose, J. (2000). Mental health clinician and compassion fatigue. Notes from workshop for the *Canadian Association for Suicide Prevention* (CASP) October 2000 Conference. Unpublished.

American Association of Suicidology. (no date). *Suicide prevention guidelines*. Washington, DC.

American Psychiatric Association. (1993). Practice guideline for major depressive disorder in adults. *American Journal of Psychiatry 150(suppl)*: 1-26.

Anderson, M. (1999). Waiting for harm: deliberate self-harm and suicide in young people—a review of the literature. *J Psychiatr Ment Health Nurs 6(2)*: 91-100.

Angst, J., F. Angst, et al. (1999). Suicide risk in patients with major depressive disorder. *J Clin Psychiatry 60(Suppl 2)*: 57-62; discussion 75-6: 113-6.

Appleby, L., J. Shaw, et al. (1999). Suicide within 12 months of contact with mental health services: national clinical survey. *Bmj 318 (7193)*: 1235-9.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders*. 4th edition (DSM-IV). Washington, DC: American Psychiatric Association.

American Psychiatric Press. *Ongoing treatment with suicidal adolescents*. Report 140.

Beautrais, A. (1996). Risk factors for serious suicide attempts among youths aged 13-24 years. *J. Am. Acad. Adolescence Psychiatry 35(9)*: 1174-1182.

Beck, A.T. (1972). *Depression: Causes and Treatment*. Philadelphia, PA: University of Pennsylvania Press.

Beck, A.T., Schuyler, D., & Herman, J. (1974). Development of suicidal intent scales. In: Beck, A.T., Resnick, K, Letierri, D. (Eds). *The prediction of suicide*. Bowie: Charles Press.

Beck, A.T., Steer, R.A., Kovacs, M., & Garrison, B. (1985). Hopelessness and eventual suicide. *Am J Psychiatry 142*: 559-563.

Berman, A.L. (1994). Outpatient treatment planning: The adolescent patient. *Suicide and Life Threatening Behavior 24(4)*: 406-409.

Berman, A. & Jobes, D. (1997). *Adolescent suicide: Assessment and intervention*. American Psychological Association: Washington, DC.

Berman, A. & Cohen-Sandler, R. (1982). Suicide and the standard of care: Optimal vs. acceptable. *Suicide and Life Threatening Behavior 12(2)*: 114-122.

Berman, A. & Cohen-Sandler, R. (1983). Suicide and malpractice: Expert testimony and the standard of care. *Professional Psychology: Research and Practice 14*: 6-19.

Birmaher, B., & Brent, D. (1998). Practice parameters for the assessment and treatment of children and adolescents with depressive disorders. *AACAP. J Am Acad Child Adolesc Psychiatry 37(10 Suppl)*: 63S-83S.

Bland, R., Newman, R., & Dyck, R. (1994). The epidemiology of parasuicide in Edmonton. *Canadian Journal of Psychiatry 39(2)*: 391-396.

Blumenthal, S. (1990). Youth suicide: Risk factors, assessment, and treatment of adolescent and young adult suicide patients. *Psychiatric Clinics of North America 13*: 511-556.

Boergers, J., A. Spirito, et al. (1998). Reasons for adolescent suicide attempts: Associations with psychological functioning. *J Am Acad Child Adolesc Psychiatry 37(12)*: 1287-93.

Bongar, B. (1992). *Suicide: Guidelines for assessment, management, and treatment*. New York: Oxford University Press.

Bongar, B., Maris, R., Berman, A., & Litman, R. (1992). Outpatient standards of care and the suicidal patient. *Suicide and Life Threatening Behavior 22(4)*: 453-478.

Brent, D. A. (1993). Depression and suicide in children and adolescents. *Pediatrics in Review 4(10)*: 380-388.

Brent, D. A. (1997). Practitioner review: The aftercare of adolescents with deliberate self-harm. *J Child Psychol Psychiat 38(2)*: 277-286.

Brent. D.A., Perper, J.A., Goldstein,C.E., Kolko, D.J., Allan, M.J., Allman, C. & Zelenak, J. (1988). Risk factors for adolescent suicide. *Archives of General Psychiatry 45*: 581-588.

Brent, D.A., Perper, J.A.,Allman, C., Moritz, G., Wartella, M., & Zelenak, J. (1991). The presence and accessibility of firearms in the homes of adolescent suicides: A case-control study. *Journal of the American Medical Association 266(21)*: 2989-2995.

Brent, D., Holder, D. et al (1997). A clinical psychotherapy trial for adolescent depression comparing cognitive, family and supportive therapy. *ArchGen Psychiatry (54)*: 877-885.

Brent, D., Poling, K., McKain, B. & Baugher, M. (1993). A psychoeducational program for families of affectively ill children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry 32*: 776-774.

Brent, D. & Kolko, D. (1998). Psychotherapy: Definitions, mechanisms of action, and relationship to etiological models. *Journal of Abnormal Child Psychology. 26(1)*: 17-25.

Brent, D. & Perper, J. (1995). Research in adolescent suicide: Implications for training, service delivery, and public policy. *Suicide and Life-Threatening Behavior 25(2)*: 222-230.

Brent, D. & Perper, J., Moritz, G., Liotus, L., Schweers, J., & Canobbio, R. (1994). Major depression or uncomplicated beravement: A follow-up study of youth exposed to suicide. *Journal of the American Academy of Child and Adolescent Psychiatry 3(2)*: 231-239.

Bukstein, O. (1998). Summary of the practice parameters for the assessment and treatment of children and adolescents with substance abuse disorders. *Journal of the American Academy of Child and Adolescent Psychiatry 37(1)*: 122-126.

Burchard, J.D. & Clarke, R.T. (1990) The role of individualized care in a service delivery system for children and adolescents with severely maladjusted behavior. *Journal of Mental Health Administration 1A*: 8-60.

Butler,S.F., & Strump, H.H. (1986). Specific and non-specific factors in spychotherapy: A problematic paradigm for psychotherapy research. *Psychotherapy 23*: 30-40.

Butcher, R. B. (1998). Foundations for evidence-based decision making. In *Canada health action: Building on the legacy* (Cat. No. H21-126/6-5-1997E) 5: 263-293). Ottawa, ON: Health Canada.

Byford, S., R. Harrington, et al. (1999). Cost-effectiveness analysis of a home-based social work intervention for children and adolescents who have deliberately poisoned themselves. Results of a randomised controlled trial. *Br J Psychiatry 174*: 56-62.

Canadian Task Force on the Periodic Health Examination (1990). Periodic health examination, 1990 update: 2. *Early detection of depression and prevention of suicide. Canadian Medical Association Journal 142(11)*: 1233-1238.

Cantor, C. (1994). Clinical management of parasuicides: Critical issues in the 1990s. *Australian and New Zealand Journal of Psychiatry 28*: 212-221.

Center for Disease Control. (1992). *Youth suicide prevention programs: A resource guide*. Atlanta, GA: Department of Health and Human Services.

Chandler, M. & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry 35(2)*: 191-219.

Clarke, G., Hawkins, W., Murphy, R., Sheeber, L., Lewinsohn, P., & Seeley, J. (1995). Targeted prevention of unipolar depressive disorder in an at-risk sample of high school adolescents: A randomized trial of a group cognitive intervention. *Journal of the American Academy of Child and Adolescent Psychiatry 34*: 312-321.

Clarke Institute of Psychiatry (1996). *Review of best practices in mental health service delivery*. Toronto: Health Systems Research Unit, Clarke Institute of Psychiatry.

Crespi, T.D. (1990). Approaching adolescent suicide: Queries and signposts. *The School Counsellor 27*: 256-260.

Diekstra, R. (1992). The prevention of suicidal behavior: Evidence for the efficacy of clinical and community-based programs. *International Journal of Mental Health 21(3)*: 69-7.

Dorer, C., C. Feehan, et al. (1999). Brief report. The overdose process-adolescents' experience of taking an overdose and their contact with services. *Journal of Adolescence 229 6(3)*: 413-7.

Deykin, E.Y. & Buka, S.L. (1994). Suicidal ideation and attempts among chemically dependent adolescents. *American Journal of Public Health 84*: 634-639.

Dyck, R., Mishara,B. & White, J. (1998). Suicide in children, adolescents and seniors: Key findings and policy implications, In.*Canada health action: Building on a legacy*. Ottawa, ON: Health Canada.

Elster, A. & Kuznets, N. (1994). *AMA guidelines for adolescent preventive services (GAPS): Recommendations and rationale*. Chicago, IL: American Medical Association.

Fahs, P. S., B. E. Smith, et al. (1999). Integrative research review of risk behaviors among adolescents in rural, suburban, and urban areas. *J Adolesc Health 24(4)*: 230-43.

Figley, C. (Ed.)(1995). *Compassion Fatigue*. Brunner/Mazel: New York.

Fiske,H. (1996). Including parents of suicidal adolescents in the treatment process: A psychoeducational program. *Presentation at the Canadian Association of Suicide Prevention Annual Conference*: Toronto.

Fiske, H. (1998). Applications of solution-focused therapy in suicide prevention. In D. Deleo, A. Schmidtke, & R. Diekstra (Eds.). *Suicide prevention: A holistic approach*. Dordrecht, Netherlands: Kluwer.

Flisher, A. J. (1999). Annotation: mood disorder in suicidal children and adolescents: recent developments. *J Child Psychol Psychiatry 40(3)*: 315-24.

Garofalo, R., R. C. Wolf, et al. (1999). Sexual orientation and risk of suicide attempts among a representative sample of youth. *Arch Pediatr Adolesc Med 153(5)*: 487-93.

Garrison, C., Lewinsohn, P., Marsteller, F., Langhinrichsen, J., & Lann, I. (1991). The assessment of suicidal behaviour in adolescents. *Suicide and Life-Threatening Behavior 21(3)*: 217-230.

Goldston, D. B., S. S. Daniel, et al. (1999). Suicide attempts among formerly hospitalized adolescents: a prospective naturalistic study of risk during the first 5 years after discharge. *J Am Acad Child Adolesc Psychiatry 38(6)*: 660-71.

Grossman, D. C., D. T. Reay, et al. (1999). Self-inflicted and unintentional firearm injuries among children and adolescents: the source of the firearm. *Arch Pediatr Adolesc Med 153(8)*: 875-8.

Grossman, J.A., & Kruesi, M.J.P. (2000). Innovative approaches to youth suicide prevention. In *Review of Suicidology, 2000*. (Eds). Maris, R.W., Canetto, S.S., McIntosh, J.L., Silverman, M.M. American Association of Suicidology. New York: Guilford Press: 159-169.

Gustein, S. & Rudd, D. An outpatient treatment alternative for suicidal youth. (1990). *Journal of Adolescence 13*: 265-277.

Handwerk, M.L., R.E. Larzelere, et al. (1998). The relationship between lethality of attempted suicide and prior suicidal communications in a sample of residential youth. *J Adolesc 21(4)*: 407-14.

Haddock G, Tarrier N, Morrison AP, Hopkins R, Drake R, & Lewis S. (1999). A pilot study evaluating the effectiveness of individual inpatient cognitive-behavioural therapy in early psychosis. Soc Psychiatry *Psychiatr Epidemiol 34(5)*: 254-8.

Harrington, R., Kerfoot, M., Dyer, E. et al. (1998). Randomized trial of a home-based family intervention for children who have deliberately poisoned themselves. *Journal of the American Academy of Child and Adolescent Psychiatry 37*: 512-518.

Hawton, K. (1998). Why has suicide increased in young males? *Crisis 19(3)*: 119-24.

Hengeveld, M et al. (1996) A pilot study of a short cognitive-behavioural group treatment for female recurrent suicide attempters. *Intl J Psychiatry in Medicine. 26(1)*: 83-91.

Huff, C. O. (1999). Source, recency, and degree of stress in adolescence and suicide ideation. *Adolescence 34(133)*: 81-9.

Jacobs, D. (Ed.) (1999). *The Harvard medical school guide to suicide assessment and intervention*. San Francisco: Jossey-Bass.

Jacobsen, L., Rabinowitz, I., Popper, M., Solomon, R., Sokol, M. & Pfeffer, C. (1994). Interviewing prepubertal children about suicidal ideation and behaviour. *Journal of the American Academy of Child and Adolescent Psychiatry 33(4)*: 439-451.

Jaycox, L., Reivich, K., Gillham, J., Seligman, M. (1994). The prevention of depressive symptoms in school children. *Behaviour Research and Therapy 32*: 801-816.

Jobes, D. A. (2000). Collaborating to prevent suicide: A clinical-research perspective. *Suicide and Life-Threatening Behavior 3(1)*: 8-17.

Joiner, T. E. & Rudd, M.D. (1998). Overview of special issue on adolescent suicide: Risk, assessment, and treatment. *J Adolesc 21(4)*: 355-7.

Joiner, T.E., Rudd, M.D., & Rajab. M.H. (1997). The modified scale for suicide ideation: factors of suicidality and their relation to clinical and diagnostic variables. *Jourrnal of Abnormal Psychology 106*: 260-265.

Kalfat, J. & Underwood, M. (1989) *Lifelines.* Iowa: Kendall/Hunt Publishing Company.

Kashani, J. H., L. Suarez, et al. (1998). Family characteristics and behavior problems of suicidal and non-suicidal children and adolescents. *Child Psychiatry Hum Dev 29(2)*: 157-68.

Kaslow, N.J., & Thompson, M.P. (1998). Applying the criteria for empirically suppported treatments to studies of psychosocial interventions for child and adolescent depression. *Journal of Clinical Child Psychology 27(2)*: 146-155.

Kazdin, A. (1993). Adolescent mental health: Prevention and treatment programs. *American Psychologist 48(2)*:127-141.

Klimes-Dougan, B., K. Free, et al. (1999). Suicidal ideation and attempts: A longitudinal investigation of children of depressed and well mothers. *J Am Acad Child Adolesc Psychiatry 38(6)*: 651-9.

Kerfoot, M. (1980). The family context of adolescent suicidal behavior. *Journal of Adolescence 3*: 335-346.

Kerfoot, M., Harrington, R., & Dyer, E. (1995). Brief home-based intervention with young suicide attempters and their families. *Journal of Adolescence 18*: 557-568.

Kerfoot, M. & Huxley, P. (1995). Suicide and deliberate self-harm in young people. *Current Opinion in Psychiatry 8*: 214-217.

Kernberg, P.F. (1994). Psychological interventions for the suicidal adolescent. *American Journal of Psychotherapy 48*: 52-63.

Kreiss, J. & Patterson, D. (1997). Psychosocial issues in primary care of lesbian, gay, bisexual, and transgender youth. *Journal of Pediatric Health Care 11*: 266-274.

Laederach, J., W. Fischer, et al. (1999). Common risk factors in adolescent suicide attempters revisited. *Crisis 20(1)*: 15-22.

Lee, C. J., K. A. Collins, et al. (1999). Suicide under the age of eighteen: a 10-year retrospective study. *Am J Forensic Med Pathol 20(1)*: 27-30.

Lewinsohn, P.M., Clarke, G.N., Hops, H., & Andrews, J.A. (1990). Cognitive-behavioral treatment for depressed adolescents. *Behavior Therapy 5*: 648-655.

Lewinsohn, P.M., Seeley, J.R., Hibbard, J. Rohde, P., & Sack, W.H. (1996). Cross-sectional and prospective relationships between physical morbidity and depression in older adolescents. *J Am Acad Child Adolesc Psychiatry 35*: 1120-1129.

Lewis, M. (1989). Psyciatric examination of the infant, child and adolescent. In Kaplan, H. & Saddock, B.J. (Eds). *Comprehensive textbook of psychiatry*. Baltimore: Williams & Williams.

Linehan, M., Heard, H. & Armstrong, H. (1993). Naturalistic follow-up of a behavioural treatment for chronically parasuicidal borderline patients. *Archives of General Psychiatry 50*: 971-974.

Linehan, M. (1987). Dialectical behavioral therapy: A cognitive behavioral approach to parasuicide. *Journal of Personality Disorders 1(4)*: 328-333.

Linehan, M.M., Goodstein, L.J., Nielson, S.L. & Chiles, J.A. (1983). Reasons for staying alive when you are thinking of killing yourself: The reasons for living inventory. *Journal of Consulting and Clinical Psychology 51*: 276-286.

Lock, J. and H. Steiner (1999). Gay, lesbian, and bisexual youth risks for emotional, physical, and social problems: results from a community-based survey. *J Am Acad Child Adolesc Psychiatry 38(3)*: 297-304.

Magne-Ingvar, U. and A. Ojehagen (1999). Significant others of suicide attempters: Their views at the time of the acute psychiatric consultation. *Soc Psychiatry Psychiatr Epidemiol 34(2)*: 73-9.

Mann, J. J., C. Waternaux, et al. (1999). Toward a clinical model of suicidal behavior in psychiatric patients. *Am J Psychiatry 156(2)*: 181-9.

Marttunen, M. J., M. M. Henriksson, et al. (1998). Completed suicide among adolescents with no diagnosable psychiatric disorder. *Adolescence 33(131)*: 669-81.

Miller, M, Jacobs, D., & Gutheil, T. (1998). Talisman or taboo: The controversy of the suicide-prevention contract. *Harvard Review of Psychiatry 6(2)*: 78-87.

Milling, L., Giddan, J.J., Campbell, N., Bush, E., Laughlin, A. (1997). Preadolescent suicidal behaviour: The role of cognitive functioning. *Child Psychiatry and Human Development 28(2)*: 103-115.

McCormick, R. M. (1999). Recovery from suicide ideation: Successful healing strategies as described by Aboriginal youth in Canada. (Under review) *Journal of Multicultural Counselling and Development*.

McCreary Centre Society. (1999). *Being out: Lesbian, gay, bisexual and transgender youth in BC. An adolescent health survey*. Vancouver, BC: McCreary Centre Society.

McDermott, J.S., Werry, J., Petti, T. Combinck,-Graham, L., & Char, W.F., (1989). Anxiety disorders of childhood or adolescence. In *Treatments of Psychiatric Disorders*. Vol 1 (Ed.) Karasu, T.B., Washington, D.C.: American Psychiatric Association 29: 401-446.

McLeavy, B.C.,Daly, J.D., Ludgate, J.W. & Murray, C.M. (1994). Interpersonal problem-solving skills in the treatment of self-poisoning patients. *Suicide and Life Threatening Behaviour 24*: 382-394.

Mishara, B. (1999). Conceptions of death and suicide in children ages 6-12 and their implications for suicide prevention. *Suicide and Life Threatening Behavior 29(2)*: 105-118.

Nasser, E. H. and J. C. Overholser (1999). Assessing varying degrees of lethality in depressed adolescent suicide attempters. *Acta Psychiatr Scand 99(6)*: 423-31.

O'Carroll, P. (1993). Suicide causation: Pies, paths, and pointless polemics. *Suicide and Life Threatening Behavior 23*: 27-36.

O'Carroll, P. et al. (1996) Beyond the tower of babel: A nomenclature for suicidology. *Suicide and Life Threatening Behavior 26(3)*: 237-248

Orbach, I. (1987). Assessment of suicidal behaviour in young children: Case demonstrations. In R. Diekstra & K. Hawton. (Eds.) *Suicide in adolescence* (113-123). Boston: Martinus Nijhoff.

Osman, A., W. R. Downs, et al. (1998). The Reasons for Living Inventory for Adolescents (RFL-A): development and psychometric properties. *J Clin Psychol 54(8)*: 1063-78.

Ottino, J. (1999). Suicide attempts during adolescence: systematic hospitalization and crisis treatment. *Crisis 20(1)*: 41-8.

Pfeffer, C.R. (1986) *The suicidal child*. New York: Guilford Press.

Pfeffer, C.R., (1989). Assessment of suicidal children and adolescents. *Psychiatric Clinics of North America 12*: 861-873.

Pfeffer, C.R., Newcorn, J., Kaplan, G., Mizruchi, M.S., Plutchik, R. (1988). Suicidal behavior in adolescent psychiatric patients. *Journal of American Academy of Child and Adolescent Psychiatry 27*: 357-361.

Pfeffer, C.R. (2000). Suicidal behavior in prepubertal children. I*n Review of Suicidology* (Eds.) Maris, R.W., Canetto, S.S., McIntosh, J.L., & Silverman, M.M. (159-169). American Association of Suicidology. New York: Guilford Press

Pearlman, L. & Saakvitne, K. (1995). *Trauma and the Therapist*. New York: W.W. Norton

Piacentini, J. Rotherham-borus, M.J., Cantwell, C. (1995) Brief cognitive-behavioral family therapy for suicidal adolescents. In: *Innovations in clinical practice: A source book*. (Eds.)VandeCreek L., Knapp, S., & Jackson, T., Vol 14. (151-168). Professional Resource Press, Sarasota: Florida.

Pinto, A., M. A. Whisman, et al. (1998). Reasons for living in a clinical sample of adolescents. *J Adolesc 21(4)*: 397-405.

Pulokas, J. (1993). Two models of suicide treatment: Evaluation and recommendations. *American Journal of Psychotherapy 47*: 603-612.

Reisch, T., P. Schlatter, et al. (1999). Efficacy of crisis intervention. *Crisis 20(2)*: 78-85.

Remafedi, G. Farrow, J.A., Deisher, R.W. (1991). Risk factors for attempted suicide in gay andd bisexual youth. *Pediatrics 87*: 869-875.

Remafedi, G. (1999). Sexual orientation and youth suicide. *Jama 282(13)*: 1291-2.

Renaud, J., D. A. Brent, et al. (1999). Suicide in adolescents with disruptive disorders. *J Am Acad Child Adolesc Psychiatry 38(7)*: 846-51.

Renaud, J., D. Axelson, et al. (1999). A risk-benefit assessment of pharmacotherapies for clinical depression in children and adolescents. *Drug Saf 20(1)*: 59-75.

Reynolds, W. M. (1991). A school-based procedure for the identification of adolescents at risk for suicidal behaviours. *Family Community Health 14(3)*: 64-75.

Rigby, K. and P. Slee (1999). Suicidal ideation among adolescent school children, involvement in bully-victim problems, and perceived social support. *Suicide and Life Threat Behav 29(2)*: 119-30.

Roberts, K. (1998). Best practices in the development of clinical practice guidelines. *Journal for Healthcare Quality 20(60)*: 16-20.

Rosewater, K. M. & B. H. Burr (1998). Epidemiology, risk factors, intervention, and prevention of adolescent suicide. *Curr Opin Pediatr 10(4)*: 338-43.

Rhodes, A., & Links, P.S., (1998 October) Suicide and suicidal behaviours: Implications for mental health services. *Canadian Journal of Psychiatry 43*: 785-791

Rotherham-Borus, M. (1990). Cognitive Behavioral Group Treatment. In *Planning to Live*. (Eds.) Bradley & Obolensky. Oklahoma: National Resource Centre for Youth Services.

Rotheram-Borus, et. al. (1994). Brief cognitive-behavioural treatment for adolescent suicide attempters and their families. *Journal of the American Academy of Child Psychiatry 33(4)*: 508-517.

Rotheram-Borus, M. et al. (1996). Enhancing treatment adherence with a specialized emergency room program for adolescent suicide attempters. *Journal of the American Academy of Child Psychiatry 35(5)*: 654-663.

Royal Commission on Aboriginal People. (1995). *Choosing life: Special report on suicide among aboriginal people*. Ottawa, ON: Minister of Supply and Services Canada.

Rudd, M. D., T. E. Joiner, et al. (1995). Help negation after acute suicidal crisis. *Journal of Consulting and Clinical Psychology 63(3)*: 499-503.

Rudd, M., Rajab, H., Orman, D., Stulman, D., Joiner, T., & Dixon, W. (1996). Effectiveness of an outpatient problem-solving intervention targeting suicidal young adults: Preliminary results. *Journal of Consulting and Clinical Psychology 64*: 170-190.

Rudd, M.D. (1998). An intergrative conceptual and organizational framework for treating suicidal behavior. *Psychotherapy 35*: 346-360.

Rudd, M. D.& T. E. Joiner, Jr. (1998). An integrative conceptual framework for assessing and treating suicidal behavior in adolescents. *J Adolesc 21(4)*: 489-98.

Rudd, M.D. & Joiner, T. (1998). The assessment, management, and treatment of suicidality: Toward clinically informed and balanced standards of care. *Clinical Psychology: Science and Practice. 5(2)*: 135-150.

Rudd, M.D., Joiner, T. , Jobes, D., & King, C. (1999). The outpatient treatment of suicidality: an integration of science and recognition of its limitations. *Professional Psychology: Research and Practice, 30 (5); 437-446.*

Ryerson, D. (1986). *Adolescent suicide awareness program*. New Jersey: South Bergen Mental Health Centre, Inc.

Shneidman, E. (1993). *Suicide as psychache: A clinical approach to self-destructive behaviour*. Northvale, NJ: Jason Aronson.

Sensky T, Turkington D, Kingdon D, Scott JL, Scott J, Siddle R, O'Carroll M, & Barnes TR. (2000). A randomized controlled trial of cognitive-behavioral therapy for persistent symptoms in schizophrenia resistant to medication.*Arch Gen Psychiatry 57(2)*: 165-72.

Shaffer, D. & Craft, L. (1999). Methods of adolescent suicide prevention. *J Clin Psychiatry 60(Suppl 2)*: 70-4; discussion 75-6, 113-6.

Spirito, A., Brown, L., Overholser, J., & Fritz, G. (1989). Attempted suicide in adolescence: A review and critique of the literature. *Clinical Psychological Review*. *9*: 335-363.

Stamm, B.H. (Ed.) (1995) *Secondary Traumatic Stress: Self Care Issues for Clinicians, Researchers, and Educators*. Lutherville, Md. Sidran Press.

Stoelb, M. & Chiriboga, J. (1998). A process model for assessing adolescent risk for suicide. *J Adolesc 21(4)*: 359-70.

Taylor, E. & Stansfield, S. (1984). Children who poison themselves. II. Prediction of attendance for treatment. *British Journal of Psychiatry 145*:132-135.

Tedeschi, R. & Calhoun, L. (1995). *Trauma and Transformation*. London: Sage Publishing

Tolan, P., Ryan, K., & Jaffe, C. (1988).

Adolescents' mental health service use and provider, process and recipient characteristics. *Journal of Clinical Child Psychology. 17*: 229-236.

US Public Health Service (1999). *The Surgeon General's call to action to prevent suicide*. Washington, D.C.

VanDenBerg, J.E., & Grealish, E.M. (1996). Individualized services and supports through the wraparound process: Philosophies and procedures. Journal of Child and Family Studies. **http://cecp.air/wraparound/famstren.html** Retrieved November 1, 2000.

van der Sande, R., E. Buskens, et al. (1997). Psychosocial intervention following suicide attempt: a systematic review of treatment interventions. *Acta Psychiatr Scand 96(1)*: 43-50.

Walsh, B.W. & Rosen, P.M. (1988). *Self-Mutilation: Theory, research and treatment*. New York: The Guildford Press.

Wannan, G. and E. Fombonne (1998). Gender differences in rates and correlates of suicidal behaviour amongst child psychiatric outpatients. *J Adolesc 21(4)*: 371-81.

Wehby, J., Symons, F. & Hollo, A. (1997). Promote appropriate assessment. *Journal of Emotional and Behavioural Disorders 5(1)*: 45-54.

White, J. (1994). After the crisis: Facilitating the suicidal student's return to school. *Guidance and Counselling*, 10(1): 10-13.

White, J. & Rouse, D. (1997). *Data report on the psychosocial characteristics of completed suicides in British Columbia*. CUPPL, UBC: Vancouver, BC

White, J. & Jodoin, N. (1998). *"Before the fact" interventions: A manual of best practices in youth suicide prevention*. Vancouver: Suicide Prevention Information & Resource Centre.

White, J. (2000). Science, politics, and practice: The messy landscape of implementing a best practices approach to youth suicide prevention. Community suicide prevention conference keynote address. Saint John, New Brunswick.

Wilkie, C., S. Macdonald, et al. (1998). Community case study: suicide cluster in a small Manitoba community. *Can J Psychiatry 43(8)*: 823-8.

Woolf, S, Battistat, R. Anderson, G., Logan, A., & Wang, E. (1990). Assessing the clinical effectiveness of preventive maneuvers: Analytic principles and systematic methods in reviewing evidence and developing clinical practice recommendations. *Journal of Clinical Epidemiology 43(9)*: 891-905.

Wood, A., Harrington, R. & Moore, A. (1996). Controlled trial of a brief cognitive-behavioural intervention in adolescent patients with depressive disorders. *Journal of Child Psychology and Psychiatry 37*: 737-746.

Workman, C. & Prior, M. (1997). Depression and suicide in young children. *Issues in Comprehensive Pediatric Nursing 20*: 125-132.

Wyatt, J. P., P. W. Wyatt, et al. (1998). Hanging deaths in children. *Am J Forensic Med Pathol 19(4)*: 343-6.

Young, T. L. & R. Zimmerman (1998). Clueless: Parental knowledge of risk behaviors of middle school students. *Arch Pediatr Adolesc Med 152(11)*: 1137-9.

Zeitlin, H. (1999). Psychiatric comorbidity with substance misuse in children and teenagers. *Drug Alcohol Depend 55(3)*: 225-34.

suggested reading

Brent, D. A. (1997). Practitioner review: The aftercare of adolescents with deliberate self-harm. *J ChildPsychol Psychiat 38(2)*: 277-286.

Chandler, M. & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry 35(2)*: 191-219.

Fiske, H. (1998). Applications of solution-focused therapy in suicide prevention. In D. Deleo, A. Schmidtke, & R. Diekstra (Eds.). *Suicide prevention: A holistic approach*. Dordrecht, Netherlands: Kluwer.

Jacobsen, L., Rabinowitz, I., Popper, M., Solomon, R., Sokol, M. & Pfeffer, C. (1994). Interviewing prepubertal children about suicidal ideation and behaviour. *Journal of the American Academy of Child and Adolescent Psychiatry 33(4)*: 439-451.

Linehan, M. (1987). Dialectical behavioral therapy: A cognitive behavioral approach to parasuicide. J*ournal of Personality Disorders 1(4)*: 328-333.

Rotheram-Borus, M. et al. (1996). Enhancing treatment adherence with a specialized emergency room program for adolescent suicide attempters. *Journal of the American Academy of Child Psychiatry 35(5)*: 654-663.

Rudd, M. D. & T. E. Joiner, Jr. (1998). An integrative conceptual framework for assessing and treating suicidal behavior in adolescents. *J Adolesc 21(4)*: 489-98.

Shneidman, E. (1993). *Suicide as psychache: A clinical approach to self-destructive behaviour*. Northvale, NJ: Jason Aronson.

Stoelb, M. & Chiriboga, J. (1998). A process model for assessing adolescent risk for suicide. *J Adolesc 21(4)*: 359-70.

White, J. & Jodoin, N. (1998). *"Before the fact" interventions: A manual of best practices in youth suicide prevention*. Vancouver: Suicide Prevention Information & Resource Centre.

appendices

APPENDIX 1 - THE ACTS

BACKGROUND

The cornerstone of effective clinical work with potentially suicidal children and youth rests with two distinct, yet overlapping functions: (a) making an appropriate determination regarding the level of individual suicide risk and (b) implementing an appropriate safety plan and mobilizing the necessary action to minimize the risk. On the surface, the task seems rather straightforward, yet in practice, this type of clinical decision-making is often fraught with complications, i.e. ambiguous symptom presentations, fluctuating risk levels, conflicting professional opinions, and the challenge of making connections with "hard-to-reach" youth. Several considerations and pieces of information need to be systematically assessed and weighed in order to formulate a sound clinical judgement regarding the level of suicide risk. Given the "high-stakes" character of this type of decision-making it is not surprising that clinicians often report feeling overwhelmed by their sense of professional responsibility and moral obligation to their clients. In order to guide decision-making under such circumstances, there are several pieces of provincial legislation that can help, including: the *Infants Act*, the *Child, Family, and Community Service Act*, the *Mental Health Act*, and the *Freedom of Information* and *Protection of Privacy Act* (FOIPPA). A summary and discussion of some of the relevant sections from each of these Acts is offered below, but first it is important to situate the discussion by highlighting some of the key questions and practice situations that typically give rise to consulting or invoking the legislation in the first place.

Several critical questions come to the foreground when assessing and treating suicidal children and youth including:

> Who is capable of giving consent to treatment?

> Under what circumstances are clinicians justified in breaking confidentiality?

> Under what circumstances should suicidal children or youth be admitted to the hospital as involuntary patients?

> When does a potentially suicidal child or youth constitute a "child in need of protection?"

The reason that these questions are so ethically challenging is because they often arise out of a context of competing sets of interests, e.g., the right of the young person to be "self-determining" (and reject recommended treatment) vs. the responsibility of the clinician and parents to provide protection to a young person who is at risk for self-harm. Resolving these issues requires a combination of good clinical judgement, an appreciation for the broad social context within which the suicidal behaviour is emerging, and a sound working knowledge of the relevant legislation.

While specific sections of the Acts each make a unique contribution to the overall decision-making process, it is clear that an overriding principle of all of the Acts is the promotion and maintenance of child and youth safety and well-being. Even though clinical decision-making and

treatment planning do not unfold in linear or "neat and tidy" ways in practice, it is nonetheless helpful to articulate a series of decision points that clinicians need to attend to when faced with potentially suicidal clients (see "Decision-Tree at the end of Appendix 1 Re: Consent to treatment and appropriate information sharing in treatment planning"). The most relevant sections of various Acts are listed below and are introduced through some very specific practice questions.

SUMMARY OF RELEVANT ACTS

Issue #1: Who is capable of giving consent for treatment?

Relevant Acts: *Infants Act* (section 17, "Consent to medical treatment") and *Child, Family and Community Service Act* (section 29, "Court order consenting to essential health care")

Discussion and Key Points:

- "Infant" refers to young people less than 19 years of age
- A request for or consent or agreement to health care by the young person does not constitute consent to the health care unless the practitioner:

  (a) has explained to the young person and has been satisfied that the young person understands the nature and consequences and the reasonably foreseeable benefits and risks of the health care, and

  (b) has made reasonable efforts to determine and has concluded that the health care or treatment is in the child/youth's best interests ("best interests" is understood here to mean that it will fulfill a specific therapeutic purpose with the expectation that it will improve, or prevent deterioration or impairment of the person's physical/psychological health).

If the clinician determines that the young person can give consent based on the criteria above, then the client is, by law, free to make his or her own decision. In practice though, many clinicians interpret a young person's refusal of recommended treatment as evidence of their lack of understanding of the foreseeable benefits of treatment and according to the criteria above, are hence deemed "incapable" of giving consent. Such an interpretation provides clinicians with a basis for telling parents/guardians or appropriate others about the young person's risk and need for treatment.

The principle of "proportionality" is helpful here, i.e. the more serious the consequences the higher the threshold should be for meeting the criteria of capability. A suicidal child, who is at risk for a potentially fatal outcome, should be held to the highest possible standard when making determinations about his/her capability to give consent for treatment. Under such high-risk and unpredictable circumstances, clinicians are always encouraged to err on the side of safety.

If a child or a parent refuses to give consent to health care and the health care is perceived necessary to preserve the child's health, then child and youth mental health clinicians should contact a child protection social worker. According to section 29 of the *Child, Family, and Community Service Act*, if a child or parent refuses to give consent to health care that, in the opinion of two medical practitioners, is necessary to preserve the young person's life or prevent serious or permanent impairment of the youth's health, the Director of Child Protection may apply to court for an order compelling treatment. Questions about whether and when such an application is appropriate in the circumstances may be directed to regional child protection staff. (Note: This course of action should be initiated only after the other avenues for securing consent and commencing treatment have been attempted. It is always preferable to intervene in the least intrusive manner possible, i.e. actively working with clients and families to assist them to understand that the recommended treatment is in the young person's best interests and conveying the benefits of family or parental involvement in treatment.

Issue #2: Under what circumstances are clinicians justified in breaking confidentiality?

Relevant Acts: *Freedom of Information and Protection of Privacy Act* (section 33, "Disclosure of personal information")

Discussion and Key Points:

- While it is always preferable to act with the client's full cooperation and consent, for clinicians working for a public body like the Ministry of Children and Family Development, a decision to disclose personal information is permissible – without the client's consent – under compelling circumstances that suggest a person's health or safety is at risk.[1]
- Good clinical practice demands that the rules about confidentiality are made explicit and articulated to all clients at the outset of treatment irrespective of the type of presenting problem, i.e. confidentiality will be preserved except under certain circumstances like a perceived risk of self-harm. (Other common examples where confidentiality would be broken include situations where there is a perceived harm to others, under court subpoena, reporting of communicable diseases, or when there is a legal duty to report cases of suspected child neglect or abuse).

Issue #3: Under what circumstances should children or youth be admitted to hospital as involuntary patients (i.e. without their consent)?

Relevant Acts: *Mental Health Act* (section 20, "Informal admission;" section 22, "Involuntary admissions;" and section 29 "Emergency admissions")

Discussion and Key Points:

If the child or youth is under the age of 16 and the parent/guardian requests that the young person be admitted and the young person has been examined by a physician who is of the opinion that the child/youth is a person with a mental disorder, then the client may be admitted as a voluntary patient under the *Mental Health Act*. In other words, the only person who can consent to a *voluntary* admission for a suicidal child or youth under the age of 16 is the parent or legal guardian. Further, it is recommended that such children be admitted under the *Mental Health Act* rather than the *Hospital Act*. (Note that children, teens, and adults of all ages can be certified under the *Mental Health Act* and treated as involuntary patients where appropriate. See next point below).

Where the child or youth, who is 16 years of age or older, is assessed to be at imminent risk for suicide and is refusing to be admitted into hospital as a voluntary patient, it may be appropriate to consider a committal under the *Mental Health Act*. In order to be considered for committal, the patient must be examined by a physician. The physician must be of the opinion that the patient meets *all four* of the following criteria:

- is suffering from a mental disorder that seriously impairs the person's ability to react appropriately to his or her environment or to associate with others;
- requires psychiatric treatment in or through a designated facility[2];
- requires care, supervision, and control in or through a designated facility to prevent the person's substantial mental or physical deterioration, or for the person's own protection or the protection of others; and
- is not suitable as a voluntary patient.

[1] If a clinician shares information with a third party, only information that is central to the care and treatment of the client is shared, and only on a "need-to-know" basis.

[2] A "designated facility" under the *Mental Health Act* includes inpatient provincial mental health facilities, psychiatric units, and observation units that have been designated by the Minister of Health. A complete list is provided in Appendix 2.

Child and youth mental health clinicians should also be aware that if a police officer or constable believes (based on his or her own observations or from information received from others) that a young person is acting in a manner likely to endanger his or her own safety or that of others, and is apparently suffering from mental disorder, then the police officer may take the person into custody and take the person immediately to a physician who will determine the person's eligibility for committal.

Finally, a person who has good reason to believe that someone has a mental disorder and meets the involuntary committal criteria can apply to the provincial court for a warrant. The warrant authorizes transportation to a designated psychiatric facility for an involuntary assessment. This is used when it is not otherwise possible for a physician to do an examination or for the police to exercise their powers.

Issue #4 When does a potentially suicidal child or youth constitute a "child in need of protection?"

Relevant Acts: *Child, Family, and Community Service Act* (section 13, "When protection is needed" and section 14, "Duty to report need for protection")

Discussion and Key Points:

For the purposes of this Act, "child" is defined as under 19 years of age.

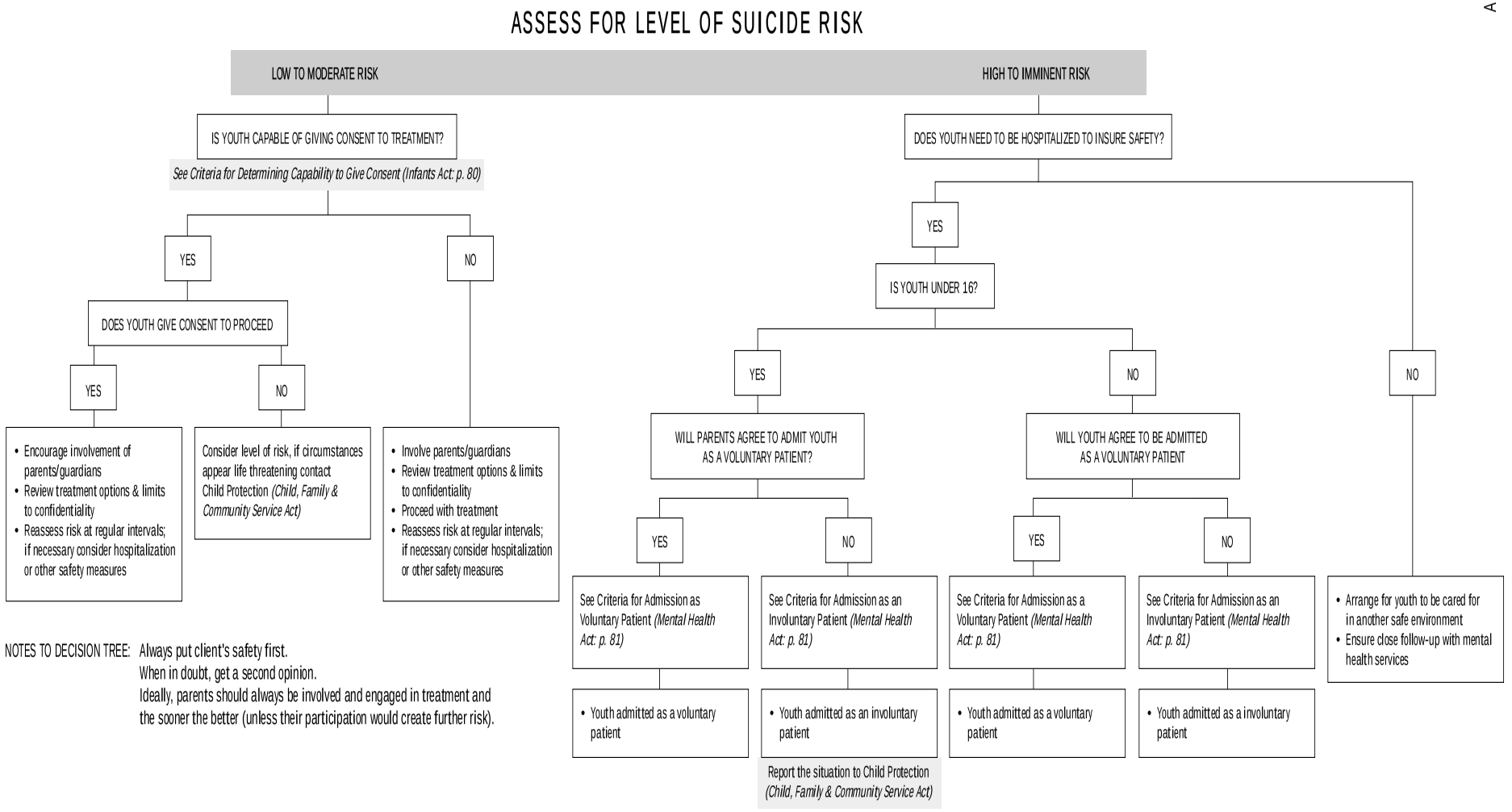
Circumstances when a young person needs protection (which are of particular relevance to the suicidal child or youth) include:

- the child is "emotionally harmed" by the parent's conduct (i.e. a child is emotionally harmed if he/she demonstrates severe anxiety, depression, withdrawal, or self-destructive or aggressive behaviour)
- the child is deprived of necessary health care
- the child's parent is unable or unwilling to care for the child and has not made adequate provision for the child's care.

Child and youth mental health clinicians who have reason to believe that a child needs protection have a duty to report this to the child protection authorities.

APPENDIX 2 – DECISION TREE

Consent to Treatment and Appropriate Information
-Sharing Related to Treatment Planning: A Decision Tree



NOTES TO DECISION TREE: Always put client's safety first.
When in doubt, get a second opinion.
Ideally, parents should always be involved and engaged in treatment and the sooner the better (unless their participation would create further risk).

APPENDIX 3 – DESIGNATED MENTAL HEALTH FACILITIES IN BC

Hospitals and Provincial Mental Health Facilities that can admit involuntary patients (Designated facilities)

A. Provincial Mental Health Facilities

The following facilities are designated as provincial mental health facilities under section 3 (1) of the *Mental Health Act*:

Burnaby Psychiatric Services sites, Burnaby

Forensic Psychiatric Institute, Port Coquitlam

Jack Ledge House, Victoria

Maples Adolescent Treatment Centre, Burnaby

Regional Health Centre, Abbotsford

Riverview Hospital, Port Coquitlam

Seven Oaks Provincial Mental Health Facility, Victoria

Vancouver Pre-Trial Service Centre sites, Vancouver

Willow Clinic (Woodlands), New Westminster

Youth Forensic Psychiatric Services Inpatient Assessment Unit, Burnaby

Source: Guide to the Mental Health Act – Hospitals and Provincial Mental Health Facilities that can admit involuntary patients.

DESIGNATED MENTAL HEALTH FACILITIES IN BC

Hospitals and Provincial Mental Health Facilities that can admit involuntary patients (Designated facilities)

B. Psychiatric Units

The following hospitals are designated as psychiatric units under section 3 (2) of the *Mental Health Act:*

British Columbia's Children's Hospital, Vancouver

Chilliwack General Hospital, Chilliwack

Cowichan District Hospital, Duncan

Cranbrook Regional Hospital, Cranbrook

Dawson Creek and District Hospital, Dawson Creek

Fort St. John General Hospital, Fort St. John

G.F. Strong Centre, Vancouver

Capital Health Region sites, Victoria

Kelowna General Hospital, Kelowna

Langley Memorial Hospital, Langley

Lions Gate Hospital, North Vancouver

Matsqui-Sumas-Abbotsford General Hospital, Abbotsford

Mills Memorial Hospital, Terrace

Mount St. Joseph Hospital, Vancouver

Nanaimo Regional General Hospital, Nanaimo

Peace Arch District Hospital, White Rock

Penticton Regional Hospital, Penticton

Powell River General Hospital, Powell River

Prince George Regional Hospital, Prince George

Prince Rupert Regional Hospital, Prince Rupert

Ridge Meadows Hospital and Health Care Centre, Maple Ridge

Royal Columbian Hospital, New Westminster

Royal Inland Hospital, Kamloops

St. Joseph's General Hospital, Comox

St. Paul's Hospital, Vancouver

St. Vincent's Hospital, Vancouver

Surrey Memorial Hospital, Surrey

Trail Regional Hospital, Trail

Vancouver Hospital and Health Sciences Centre sites, Vancouver

Vernon Jubilee Hospital, Vernon

West Coast General Hospital, Post Alberni

Source: Guide to the Mental Health Act – Hospitals and Provincial Mental Health Facilities that can admit involuntary patients

APPENDIX 4 – CASE EXAMPLES

The following cases provide examples of the challenges and dilemmas presented to mental health clinicians involving suicidal children and youth. Questions are included for reflection on the cases and provide examples of considerations about what ought to be done given the complexity of each of the cases. The questions are not meant to be an exhaustive listing but rather suggest some of the key issues that should be considered by the clinician.

CASE EXAMPLE # 1 – Supporting a Community Gatekeeper in Assessing Risk for Suicide

It is 3 PM Friday afternoon when you get a call from Sandra, the middle school counsellor. Sandra is concerned about a 12 year old male student. His teacher reported that the child has scratch marks on his wrist from cutting himself with his pocket knife. What do you do? How can you most effectively work with this counsellor to determine his risk for suicide and decide what action may be required? The following question-based approach is designed to illustrate how to gather information by working collaboratively with another professional in order to determine the child's level of risk for suicide.

Question-based Assessment

1. Does the injury require medical treatment? If an act of self-harm has already occurred, the school counsellor must quickly establish whether there is a need for medical attention (e.g. are the "scratch marks" on his wrist really just superficial or do they warrant medical follow-up? Has any other act of deliberate self-harm taken place, e.g. consumption of pills?)

2. Once the need for immediate medical intervention is ruled out, the school counsellor will need assistance to determine whether the child is at risk for further self-harm, based on a systematic consideration of risk factors, current ideation, and the availability of support (see steps below). If at any time during the telephone consultation, there is any indication that the child's suicide ideation is serious, persistent, or simply too difficult to establish, or if the school counsellor feels ill-equipped to manage the case without the direct input of the mental health clinician, arrangements should be made for a face-to-face interview with the child and his parents at the earliest possible opportunity. If risk level appears to be high, identify services that may be available to the youth and his family immediately and/or after-hours (e.g. crisis response service, hospital, etc.).

3. Have parents been notified yet? Notifying parents is essential and most often it is a requirement of the school policy. The only exception to notification is in cases where concern is high that involving the parents may increase risk-usually indicates that the child may be in need of protection, requiring the involvement of child protection social workers.

4. In collaboration with the school counsellor, develop a current risk profile of the child. (Gather information re: prior ideation/ attempt(s); mental health status and history; current stressors and support mechanisms).

   - Is there a suicide plan articulated?
   - Does the child have access to objects that could be used to self-harm?
   - Has the plan been acted on? What injury has already occurred?
   - What is the current behaviour/emotional state of the child

- What further statements/actions indicate that the child plans to harm self?

(Also see Risk Assessment Matrix on page 38.)

5. Review available support:

- Describe prior involvement with counsellors, MCF, hospital services, if any.
- If parents have been notified, what is the school counsellor's current understanding of the parents' capacity to support and protect the child?
- Are additional supports available (e.g., extended family)?
- Can significant others be actively mobilized to create a safety net, particularly over the weekend and during the evenings (i.e. maintain close vigilance, provide ongoing support and reassurance, remove any potentially lethal means, etc.)?
- Describe the current involvement of school counsellors, other support agencies, MCF or others.
- Can they provide any additional information?
- In collaboration with the school counsellor, develop a clear and time-limited safety plan for the youth that corresponds with the level of apparent risk – which in this case was determined to be low (e.g. actively involving parents, identifying alternative sources of support like the 24-hour crisis line or the local hospital in case the level of risk escalates, helping the youth to generate alternatives for coping with stress that are not harmful to self, etc.).
- If a therapeutic alliance has already been established between the youth and the school counsellor, discuss ways that you may be able to provide ongoing support and consultation to the counsellor in the coming weeks. Agree to follow-up by telephone at the start of the following week.

Questions for Reflecting on the Case: What Ought to Be Done?

- What are the key questions that need to be asked of the school counsellor that will help you decide whether you need to become directly involved or not? (consider the experience, confidence, and skill level of the counsellor and balance this against what she is telling you about the child's presenting symptoms)
- What can you say and do to reduce the school counsellor's anxiety?
- Have you taken the child's age into account? (e.g. in his own words, what were his intentions when he cut his wrist?)
- Would any of the practice parameters principles be of assistance here?

CASE EXAMPLE #2 – Substance use/suicide ideation

Jake is a 15-year old male who has been referred to you by his family physician with chronic suicide ideation. During your first session with Jake he tells you that he uses alcohol and marijuana regularly and that his substance use combined with his obsession (his word) with hard rock music often make him feel like he wants to kill himself. Based on his ideation, substance use, and impulsivity, in addition to other risk factors, you determine his risk for suicide is high. On the positive side, he has a concerned and caring mother, the Pastor from the family's church is a supportive influence, and the physician is actively committed to assisting Jake.

Jake appears quite willing to attend counselling sessions. You are concerned with his immediate safety, develop a safety plan, and schedule treatment sessions three times a week for the next three weeks. Jake has also agreed to check in by phone daily with you. You determine that Jake needs to address his substance abuse problem – which is significantly contributing to his current suicide ideation – and you inquire into the availability of outpatient drug and alcohol counselling services. The waiting list to get in to see a drug and alcohol counsellor may be several weeks. Meanwhile, how will you ensure his safety and manage his current suicide ideation?

Questions for Reflecting on This Case: What Ought to Be Done?

- How can you capitalize on the consultation services of the drug and alcohol program while Jake awaits his first appointment, i.e. can you consult by phone with the alcohol and drug counsellor regarding appropriate treatment goals and the interim management of his substance misuse?
- How might you arrange to work with the drug and alcohol counselling service in the future so that a co-managed approach is taken to working with Jake, which would include dealing with what appears to be a dual diagnosis?
- What does Jake identify as the most important thing to work on?
- Given Jake's interest and willingness to participate in counselling, how can you actively build on, and give attention to, his life-affirming choice in the sessions?
- How can you maximize the support and involvement of the physician and church pastor?
- Given that Jake's substance misuse problem may interfere with his ability to keep regular appointments and may compromise his ability to comply with treatment recommendations, what safeguards may need to be put in place to maintain ongoing and close vigilance of Jake?
- How can you help Jake to get even a little bit more of what he wants other than by suicide?
- What behaviours/cognitions/emotional skills does Jake say will be useful (in his terms)? (e.g.“ to be able to walk away when I'm angry”, “to drink and have fun without getting depressed”, “to not care so much when my girlfriend seems to like someone else”?)

CASE EXAMPLE #3: Chronic Suicidality

Jane is a 17 year old First Nations girl who lives in a small northern town. She was referred to you by her mother and the head nurse of the Aboriginal village nursing station after a suicide attempt (20-30 Tylenol, 15 ibuprofen and a number of unknown medications). Jane has a long history of suicide ideation and mood disorder. Three years ago her best friend, with whom she had a suicide pact, committed suicide, and since the death, she has had constant thoughts of suicide. Recently, she broke up from a romantic relationship, has been having academic problems, and lives away from the family home with an aunt in order to attend high school. She is using alcohol and drugs excessively and feels a constant pressure to succeed in school because she is the one of the few remaining youth from her village still in high school.

You have determined that Jane is at high to imminent risk due to her mood disorder, alcohol and drug use, her exposure to her friend's suicide, her previous involvement in a pact, and the break-up that triggered her most recent suicide attempt. Hospitalization was given serious consideration, given the recent escalation of her risk status, particularly the loss of her boyfriend and her difficulties at school. After careful consideration, you have determined that there are some considerable protective factors to capitalize on and you make the decision to see her in an out-patient counselling setting. For example, in spite of her high risk status she still maintains a strong personal commitment to finishing high school and she enjoys the support of her mother, aunt, and the village community health nurse. Although she is living away from home and staying with her aunt, her mother has called you to convey the family's interest and willingness to help her. You know from talking with the village community health nurse that the community is making substantial gains in their health care programs (including traditional healing approaches) and is involved in treaty negotiations. This complex case calls for a well thought out, multidimensional approach to treatment that will address her immediate safety, long term mental health issues and substance abuse problems, while at the same time appreciating the broader community context within which she is living.

Questions for Reflecting on This Case: What Ought to Be Done?

- What can you do to increase Jane's immediate safety?
- Are there some specific additional Aboriginal resources you can draw on? (i.e., assist Jane to benefit from her community's renewed commitment to adopting more traditional healing practices)
- How might you capitalize on the support and commitment being demonstrated by Jane's mother, aunt, and community health nurse?
- How will you know when her risk level escalates to a point that hospitalization might need to be re-considered?
- How might you draw on her future orientation towards completing high school as a significant protective factor?
- Who do you need to share information with about this case?

CASE EXAMPLE #4: Failure to Follow-Through With Treatment

Casey, a 15-year old girl, was referred to you by her high school counsellor following Casey's disclosure to a friend that she was considering suicide. Casey lives in a disruptive home environment and has repeatedly told you and her friends at school that if she has to continue to live at home she will kill herself. After probing for more details regarding her specific experience at home, you become concerned that Casey may be a "child in need of protection," based on her revelation that her mother and father are binge drinkers who become verbally abusive and physically threatening to Casey when she periodically tests the limits around her curfew. You make a report to Child Protection. They conduct a risk assessment and determine that "no protection concerns" exist, but they recommend a parenting course for mom and dad and follow-up counselling for Casey. After meeting with her father and his wife, you determine that they appear to be genuinely concerned about her welfare and appear to be committed to following through on the parenting program although they are frustrated by her repeated suicide threats. Your initial risk assessment determined that her suicide risk was low – medium. After two sessions she failed to return for a scheduled visit. What type of follow-up should be initiated?

Questions for Reflecting on This Case: What Ought to Be Done?

- Can the parents offer any information about Casey's current status? What have they been noticing at home in terms of her behaviour, affect, attitude?
- What information is available regarding parents' actual follow-through on the parenting course?
- Can the school counsellor shed any light on the situation? Has Casey been in touch with the counsellor since the initial referral?
- Who else can help? How can you work with others to share responsibility for keeping Casey safe?
- Is there any reason to think that her suicide risk status may have increased? If so, what actions need to be taken to ensure her safety?
- Are significant others aware of potential suicide warning signs and specific actions that should be undertaken if they believe her risk for self-harm has increased?
- What options are available in terms of seeing Casey "off-site," (e.g. at school)?
- What strategies exist for "maintaining contact" with Casey (e.g. leaving messages at home, at school)?
- How can you communicate your intentions to "leave the door open" for Casey to make a return visit?
- Have the repeated efforts to "make contact" been documented in the clinical record?
- Given the recent assessment by child protection, have regional child protection staff been notified of Casey's failure to follow through with her counselling appointments?

CASE EXAMPLE #5: Complex Mental Disorders/ Information Sharing Across Systems

Paula was 17 years old when she was admitted to the psychiatric unit by her family doctor. Admitting problems included mood swings, refusal to eat or come out of her bedroom, suicidal ideation, refusal to talk to anyone, and obsession with her appearance. After a full psychiatric workup she was diagnosed with Obsessive Compulsive Disorder and Major Depression. She spent one month in hospital. Upon discharge she was referred to community based mental health services where she was treated by a child and youth mental health team and a psychiatrist. Because she had recently been discharged from hospital, outpatient treatment began immediately.

Six months later Paula was involved in a series of incidents involving reckless behaviour, including shoplifting and public drunkenness. She was readmitted to hospital and treated with a number of medications, including Loxipine, Resperidone, and Paxil. A diagnosis of bipolar illness was established and she started on Lithium. She was discharged on Loxipine, Paxil, and Lithium but upon leaving hospital she discontinued taking the medication regularly. She was again referred for community mental health follow-up where she began to attend regularly. At the urging of her mental health clinician and psychiatrist, she began to take her medication on a regular basis, including having her Lithium level regularly monitored by a blood test.

Paula and her family were provided with educational materials concerning bipolar illness that included information about the risk for relapse. After three to four months however, she refused to continue at the mental health centre as she thought her problem was cured. She stopped taking her medication regularly. Six months after this she died by suicide at the age of 18.

Questions for Retrospectively Reviewing Clinical Decisions

- How did the treatment make use of Paula's resources, strengths, and successes?
- What is the role of the child and youth mental health clinician when clients refuse to continue outpatient treatment at a time when their symptoms appear to be stabilized, especially when the clinician knows that the individual has a serious and persistent mental illness?
- What is your role as a community mental health clinician in providing ongoing care for youth with serious mental illnesses?

Additional Issues to Consider

- Paula was diagnosed with a serious and persistent mental illness that required long-term psychiatric management. Ideally, she should have been seen regularly by a community-based child and youth mental health clinician until her carefully planned and facilitated transition to the adult mental health service system at age 19. Paula would have benefitted from an outreach service that could have contacted her in her home and community when she was refusing to follow through with outpatient treatment.
- The seriousness of her disorder could have been brought to the attention of the school, but she refused to allow communication between the mental health professionals and the school.
- Individuals like Paula, who have a serious and persistent mental illness – especially schizophrenia, bipolar disorder, and major depression – require regular reassessment for suicide ideation in addition to ongoing psychiatric and mental health treatment.

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