Working With the Client Who is Suicidal:

A Tool for Adult Mental Health and Addiction Services

SFU
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Working With the Client Who is Suicidal: A Tool for Adult Mental Health and Addiction Services provides an overview of recommended practices in assessing and treating suicidal behaviour in adults. This document is consistent with the goals identified in the *Blueprint for a Canadian National Suicide Prevention Strategy*, developed by the Canadian Association for Suicide Prevention (CASP) in 2004. Specifically, this document responds to the following goals as identified by CASP: to increase training for key gatekeepers, volunteers, and professionals regarding recognition of risk factors, warning signs and at-risk behaviours; to provide effective interventions; and to develop and promote effective clinical and professional practice to support clients, families and communities.

Accompanying documents include:

- ***Working with the Suicidal Patient: A Guide for Health Care Professionals***
- ***Coping with Suicidal Thoughts***
- ***Hope & Healing: A Practical Guide for Survivors of Suicide***

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Qualifying Statements

This guide is not a prescribed standard of care, and therefore cannot and does not stipulate a single correct approach for all clinical situations. This document should be used as an information and planning tool only. Decisions regarding specific procedures for specific suicidal individuals remain the responsibility of the attending professional(s). Sophisticated clinical judgment is always a requisite, and it is important to always err on the side of safety.

The text has been prepared to advance and strengthen the ongoing work of mental health and addiction practitioners. The target audience is assumed to be conversant with, and knowledgeable about, basic terms and practices in mental health and addiction settings, including: diagnostic categories, assessment procedures, therapeutic alliance, and clinical record-keeping.

Throughout this document, information on various treatment modalities and orientations is provided. It is important to acknowledge that reading this guide does not imply that a clinician is conversant in a particular treatment modality. Clinicians who are interested in further training and treatment are encouraged to pursue further continuing education activities.

The bulk of the existing empirical literature on suicide focuses on risk assessment, and there is a notable dearth of evidence-based research focused on treatment of suicidality. However, reliable risk assessment and prediction of suicide remains an elusive task: the decision-making process is difficult to describe, and is not captured by simple compilation of risk factors. To be maximally useful, assessment must always occur within the context of a therapeutic alliance. The role of the clinician is to move beyond simple assessment of risk factors, toward clinical management of risk, and therapeutic treatment of underlying contributors to suicidality.

Getting the Most out of the Document

The document is organized into 6 main sections:

1. Introduction, pp.1-4
2. General considerations for treating adult suicidality, pp.5-26
3. Identifying and assessing suicide risk, pp.27-36
4. Safety, treatment planning, and ongoing monitoring of suicidality, pp.37-57
5. Linkages between adult mental health and addiction services and the community, pp.58-64
6. Well-being issues for the clinician, pp.65-70

While it is recommended that readers thoroughly acquaint themselves with the material provided in each section, in recognition of clinicians' needs for up-to-date, clinically relevant, and timely information, this document has been designed to enable quick access to specific content areas. The next section provides a quick visual summary of each of the main content areas, and readers are encouraged to use this as a reference point to gain access to topics of specific interest quickly and efficiently.

Summary

General Considerations for Working with Suicidal Clients	Identifying & Assessing Risk	Safety & Treatment Planning and Ongoing Monitoring of Suicidality	Enhancing Linkages Between Adult Mental Health & Addiction Services and the Community
Use clear definitions for classifying, documenting and discussing suicidal behaviours (Section 2.2)	Be familiar with risk and protective factors for suicide (Section 3.1)	Develop a safety plan for all clients (Section 4.1)	Seek to establish proactive relationships and work collaboratively with key service providers, families and community resources, to provide integrated service delivery (Section 5.1)
Develop a therapeutic alliance, making the clinical relationship central to the treatment plan (Section 2.4)	Use commonly understood terms and definitions for levels of suicide risk, e.g., non-existent, mild, moderate, high, and imminent (Section 3.2)	Establish criteria for determining when to recommend hospitalization or other secure protected environment (Section 4.2)	Establish formal linkages between hospital emergency and mental health centre for seamless referral (Section 5.2)
Respond proactively to clients dropping out from treatment (Section 2.5)	Consider risk factors and presenting difficulties based on both subjective (self-reporting) and objective intent (Section 3.3)	Involve the client, family, and other resources in the development of treatment and safety plans (Section 4.3)	Develop guidelines for supporting the reintegration of a client into the workplace after a suicide attempt (Section 5.3)
To the extent possible, engage family members (spouse, parents) as key collaborators in treatment planning (Section 2.6)	Assess level of suicidal intent; current ideation; plans; lethality and availability of means; preparatory behaviour; cognitive rigidity and problem solving abilities; impulse control; social isolation; recent losses (Section 3.3)	Seek consultation and consider referral needs for complex psychiatric issues and addiction (Section 4.4)	Support local media to report responsibly on the issue of suicide through active education efforts (Section 5.4)
Seek regular clinical consultation with peers and supervisors (Section 2.7)	Understand the personal meaning of suicide for the individual (Section 3.3)	Use brief problem-solving approaches for treating suicidal ideation (particularly in the presence of Axis I disorders such as depression) (Section 4.5)	Develop guidelines for responding to potential contagion effects in the community. Provide postvention services (Section 5.5)
Create client-friendly mental health and addiction services (Section 2.8)	Recommend level of care to match level of risk identified (Section 3.4)	Conceptualize a long-term treatment approach for chronic suicide attempts (particularly in the presence of Axis II disorder) (Section 4.6)	Support suicide prevention initiatives in the community (Section 5.6)
Seek informed consent and explain limits of confidentiality (Section 2.9)	When the risk to protective factors ratio is unclear, a structured and protected environment is recommended until a safety plan is developed (Section 3.4)	Document and evaluate the treatment process and outcomes (Section 4.7)	Quality Improvement, System Analysis, and Policy Development (Section 5.7)
Consider the individual characteristics of the client, including cultural context and developmental lifespan issues (Section 2.10)	Suicidal behaviours are symptoms, not a specific illness, and interventions must be tailored to address underlying conditions (Section 3.4)	Regularly monitor suicidality (Section 4.8)	

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Section One

Introduction

- Suicide is a complex phenomenon emerging out of a dynamic interaction of biological, psychological, social, cultural, and spiritual factors.
- Suicidality is a symptom of underlying distress, and is the result of a combination of factors that cause psychological pain in the psyche, including underlying mental illness.
- Within a problem-solving conceptualization of suicidality, intervention efforts focus upon decreasing experienced suffering, while simultaneously building upon a client's capacity to cope with difficulties from an emotional, cognitive, and behavioural perspective.
- A comprehensive approach to managing suicidality includes the following 3 stages:

  1. stabilization and safety of the client;
  2. assessment of temporal and distal risk factors; and
  3. ongoing management and active problem-solving of contributing factors.

1.1. Purpose of the Document

Suicide is a complex phenomenon that emerges out of a dynamic interaction involving biological, psychological, social, cultural, and spiritual factors. Suicide is most often the result of profound pain, hopelessness and despair: it is the triumph of pain, fear and loss over hope.

Mental health and addiction clinicians (hereafter referred to as "clinicians") who work with young adult, adult and elderly populations are well aware of the potential risk for suicide and suicidal behaviour among their clients. Yet, clinical work with suicidal clients is often identified as one of the most challenging and anxiety-provoking areas of practice for many clinicians, irrespective of their level of experience.

A comprehensive approach to suicide prevention and intervention - characterized by multiple strategies implemented across an array of key contexts, over time - is likely to yield the greatest benefit in reducing the incidence of suicide and suicidal behaviour. The delivery of high quality assessment and treatment services, focused on both reducing the risk factors for suicidal behaviour, while simultaneously bolstering protective factors, is a central component in overall suicide prevention efforts.

Working With the Client Who is Suicidal: A Tool for Adult Mental Health and Addiction Services provides an overview of empirically supported assessment and intervention methods for working with suicidal adults in mental health and addiction settings. It is intended to serve as an information and planning tool. It aims to support and complement ongoing clinical training and in this spirit, contributes to the continuing professional development of clinicians. The intent is to support 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 adults.

Information provided in the document is based on:

- a review of the published empirical literature, including systematic reviews and high quality research studies;
- examination of existing clinical practice recommendations;
- consultation with experts regarding current clinical practices, including clinicians and researchers; and,
- consultation with families who have had a family member die by suicide.

Enhancing Clinical Competency

Clinical competency in managing suicidal clients requires a sound clinical knowledge and skills base, the emotional tolerance and desire to assist others in distress, and a caring and respectful attitude toward clients and their families (Berman & Cohen-Sandler, 1983). 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, 1992). Additionally, it is important to be aware of specific risk populations, to understand the relationship between the law and mental health practices, and to appreciate the process of informed consent, and associated limitations regarding confidentiality.

Clinical competency is supported and enhanced by clinician well-being (Stamm, 1995). This document also addresses specific well-being needs relevant to the clinician working with a suicidal population, including grief issues related to working with suicidal clients, burnout prevention strategies, and clinical supervision needs.

1.2 Intended Audience

Clinicians have a significant role in the assessment, clinical management, and treatment of adults who are at risk for suicide. The document works on the assumption that readers are proficient mental health and addiction practitioners who are dedicated to increasing their skill and knowledge in the assessment and treatment of suicidality in adults.

It has been designed to support local planning and practice efforts and will be of particular relevance to the following groups:

- adult mental health and addiction clinicians;
- psychiatric consultants;
- psychogeriatric assessment teams;
- mental health emergency services staff;
- outpatient psychiatry programs;
- clinical mental health and addiction program managers and supervisors;
- mental health and addiction directors of health authorities;
- public health units;
- home and community care services;
- family physicians; and
- planners of health authorities.

1.3 Models of Conceptualizing Suicidal Behaviour

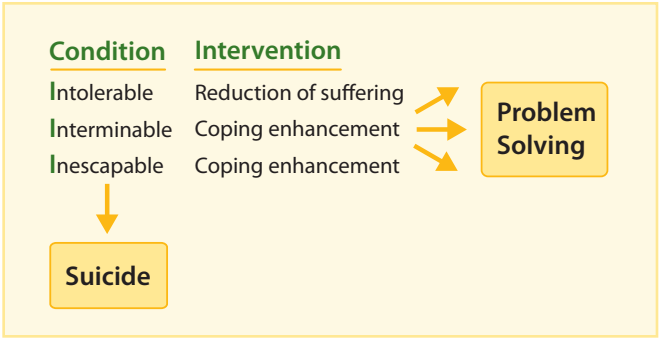
The move to integrate the multiple theories of suicide – epidemiological, philosophical, sociocultural, sociological, psychiatric, psychological, psychodynamic, and biological – is reflected in the framework offered by Schneidman (1993). Schneidman's view is that suicide is caused by psychological pain in the psyche, and he suggests that the 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. To understand the complexity of suicidal behaviour, Schneidman (1993) offers a simple framework organized around three main questions, which form the crux of suicide assessment and treatment efforts:

- 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?

Chiles and Strosahl (1995, as cited in Bilsker & Forster, 2003, p. 135) further postulate that:

> *When any one of us experiences the following cognitive conditions ("The Three I's"), we will seriously consider suicide as a coping behavior. These conditions are: (1) physical or emotional pain that is experienced as Intolerable, unbearably distressing; (2) a life situation perceived as Interminable, that is seen as continuing unchanged; (3) a life situation that is perceived as Inescapable, such that no coping action already tried or conceived will make a significant difference.*

Problem-Solving Model of Suicidal Behavior



Within the model, a client's problem-solving capacities are emphasized. Intervention efforts focus upon decreasing experienced suffering, while simultaneously building upon a client's capacity to cope with difficulties from an emotional, cognitive, and behavioural perspective.

It is important to underscore the significant effects that mental health conditions – such as depression and anxiety disorders – have on an individual's capacity to problem-solve. Acknowledging the impact of mental health conditions on an individual's capacity to problem-solve can counter client's tendencies to self-blame (Bilsker & Forster, 2003). Furthermore, it is important to assess for and treat underlying mental health conditions given their potential contribution to increasing suicidality. However, it is important to acknowledge that treatment for suicidality is not necessarily synonymous with treatment for depression. Treatment of underlying depression is often necessary but not sufficient for reduction of suicidality.

A comprehensive approach to managing suicidality includes the following 3 stages:

1. When a client is in the midst of a suicidal crisis, intervention must first focus on immediate **stabilization and safety** of the client. In cases of high or imminent risk, stabilization may take the form of inpatient hospitalization. This stage would also involve the development of a safety plan (see 4.1; also see accompanying document, *Coping with Suicidal Thoughts* which can be helpful for both clients and their families/significant others).
2. Once a client's safety has been ensured, it is important to understand the factors that contributed to the client's suicidal crisis, via a thorough **risk assessment** of factors temporally connected to the crisis (e.g., situational factors such as argument with spouse or loss of job), as well as distal risk factors (e.g., recurrent panic attacks; family history of suicide). Appropriate risk management requires more than just addressing the acute crisis, but rather targeting underlying risk factors which may elevate the risk of future crises.
3. Appropriate management of suicidality requires more than simple delineation of factors that contributed to increased risk – it requires ongoing **management** and **active problem-solving** of contributing factors, including treatment of any underlying mental illness (e.g., combination of pharmacotherapy and counselling for treatment of mental illness) and problem-solving focused on increasing coping ability.

Although there is limited evidence that conclusively establishes the efficacy of any specific intervention in reducing the likelihood of repeat suicide attempts (van der Sande, Buskens, et al., 1997; Hawton, Arensman, Townsend, et al., 1998), clients who are suffering from an acute emotional crisis that is associated with suicidal ideation or actual attempt may benefit from being presented with a problem-solving model of suicide (Bilsker & Forster, 2003). This strategy would involve providing a client with an explanation of the suicidal crisis that is framed in a manner that conveys appreciation of the client's difficulties, and promotes problem-solving, which may ultimately be used to resolve the suicidal crisis. Presentation of this type of model can help to enhance a client's sense of meaning, control, and hope, and provide a framework for which further intervention efforts can be placed (Bilsker & Forster, 2003).

Section Two

Adult Suicidality: General Considerations

- Use clear definitions to identify, classify, document, and discuss suicidal behaviours.
- Understand and challenge personal beliefs, attitudes, stigma, and myths about suicide.
- Recognize that the relationship between clinician and client is probably the most important factor in the management and treatment of suicidality.
- Actively involving families, friends, and significant others in the management and treatment of a suicidal client.
- Obtain informed consent from clients. Recognize that exceptions to confidentiality include circumstances where a client is judged to be at imminent risk of harm.
- Recognize the unique characteristics of special populations that may elevate risk for suicidality, and/or impact prevention and treatment considerations.

2.1 Suicides in B.C. – A Brief Overview

Key facts about suicide:

- The losses faced by families, friends, workplaces and communities as a result of death by suicide are enormous. Worldwide, more people die by suicide than by homicide and war.
- In B.C., suicide is the second leading cause of death among young people aged 15-24.
- There were a total of 492 suicide deaths in the province of British Columbia in 2004 and 370 (75 per cent) of these were males (B.C. Vital Statistics 2005[1,2]).
- For every death by suicide there are likely between 50 to 100 attempts (Bland, Newman & Dyck, 1994; Health Canada, 1994).
- Provincially, approximately 80 per cent of all gun deaths are suicides.
- Psychiatric disorders have been consistently identified as risk factors for suicide and suicidal behaviour.

2.2 Commonly Understood Terms for Suicidal Behaviour

Use clear definitions for identifying, classifying, documenting and discussing suicidal behaviours.

There is a lack of clarity in accepted and routinely applied definitions of suicide and suicidal behaviour, which has significant implications for clinical practice. Using a set of commonly understood, logically defined terms for suicidal behaviour will help to improve clarity, consistency and precision between clinicians and across service settings regarding the assessment of risk, ongoing management, and treatment. This includes situations where a consultation is required, when the client transfers to another service provider, or when 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 person intended to kill him/herself.

> **Note:** Expressions like "successful suicide" and "committed suicide" are strongly discouraged. Even the phrase "completed suicide," which is commonly used to refer to a death by suicide, is increasingly falling out of favour among those in the suicide prevention field, as it continues to connote an accomplishment of sorts. "Died by suicide" is the phrase that survivors of suicide (those who have lost a loved one to suicide) and practitioners in the field prefer, as it is the most neutral, clear, and straightforward way to describe this type of death.

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 the person intended to kill him/herself.

Suicide Attempt without Injuries

A potentially self-injurious behaviour where there is evidence (either implicit or explicit) that the person intended to kill him/herself.

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[1] Note, however, that due to delays in determining the exact cause of death, this number is likely to increase. Over the period 1994 to 2003, the median number of additional deaths determined to be suicide after the annual report was published was 81 (derived from B.C. Vital Statistics 2005), implying that the actual number of suicides in B.C. in 2004 might be over 500 once all the undecided causes of death are determined

[2] For a 10-year summary of suicide deaths by five-year age groups in B.C. for 1994-2003, see Appendix 1.

Instrumental Suicide-Related Behaviour/Parasuicide

Potentially self-injurious behaviour where there is evidence (either implicit or explicit) that the person did not intend to kill him/herself (e.g., no 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, also called parasuicidal behaviour, can occur with injuries, without injuries, or with fatal outcome (e.g., accidental death).

> **Note:** Interpreting parasuicidal behaviour as "just manipulation" is both counter-therapeutic and potentially very dangerous, since a person can suffer a fatal outcome with these behaviours regardless of intent. Intent can be difficult to determine since ambivalence is often a key component to suicidal behaviours.

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.[3]

Suicidal Crisis

An acute increase in suicidality, which may involve thinking about, planning, intending, or attempting suicide.

Self-Mutilation/Self-Harming Behaviours

Self-harming behaviours include "all behaviours involving deliberate infliction of direct physical harm to one's own body without any intent to die as a consequence of the behaviour."[3]

Conditions associated with the emergence of self-mutilation include: physical and sexual abuse from a significant other, exposure to marital violence, grief and loss issues, illness or surgery, and/or familial impulsive self-destructive behaviour (e.g. alcoholism, drug abuse, suicide or acts of self-mutilation). 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 (Walsh & Rosen, 1988).

2.3 Myths about Suicide

There are many misconceptions concerning suicide, both among the general public and among professionals. Clinicians need to explore their personal beliefs and attitudes, and challenge any stigma and myths that they may hold.

[3] Definitions adapted from O'Carrol et al., 1996 and Simon & Favazza, 2001.

Twelve Must-Know Myths about Suicidal Clients (Adapted from Rosenthal, 2003)

Myth 1: Suicidal people don't give warning signs.

Fact: Nearly everybody who attempts or dies by suicide communicates his or her intent. The person may talk about suicide, repeatedly joke about it, write about it, place messages on Internet chat rooms, or even draw pictures related to death. Others give away prized possessions. Research indicates that up to 75 to 80 percent of suicidal people give warning signs.

Myth 2: Suicide occurs around the holidays.

Fact: If a suicide occurs on a holiday, it is more likely to get media attention. Overall, however, December is usually the lowest month for suicide. In fact, some suicidologists have noted that all major holidays have a lower rate of suicide than other days of the year.

Myth 3: Suicide occurs more frequently in the dark, dreary days of winter.

Fact: Most suicides occur in the spring, with rates in May generally being the highest.

Myth 4: Suicide is primarily a teenage problem.

Fact: Indeed, teen suicide is a problem. The rate of teen suicide is about three times what it was in the 1960s. However, the suicide rate in women continues to rise until it peaks at about age 51 and then it plateaus. In men, the suicide rate keeps increasing with age. The rate of geriatric suicide (ages 65 and older) is nearly three times the rate of the general population.

Myth 5: Most people leave a suicide note that explains the nature of their act.

Fact: Only 15 to 25 percent of those who die by suicide leave a note. Moreover, these documents often tell us little about why the person decided to take his or her own life.

Myth 6: Clients who live in big cities are under more stress and are more likely to kill themselves.

Fact: The suicide rate is clearly higher in sparsely populated rural areas. Densely populated regions have rates that are much lower than those of regions that have fewer people per square mile.

Myth 7: Media stories about suicide and the economy do not affect the suicide rate.

Fact: Researchers have known for a long time that the suicide rate goes down during extended newspaper strikes. When a famous person dies by suicide the rate increases at a statistically significant level. Suicide is also a good barometer of the economy. In troubled economic times, such as the Great Depression of 1929, the suicide rate skyrocketed.

Myth 8: The grief surrounding a suicide is just like any other grief.

Fact: In most cases survivors (i.e., those who have lost a friend or loved one to suicide) have a tougher time coping with grief. When an individual dies by suicide, the survivors cannot blame a virus or a drunk driver. Suicide prevention centers often provide special survivors of suicide groups to help those who are grieving deal with the loss.

Myth 9: The suicide rate goes up in times of war.

Fact: In reality, the suicide rate plummets during times of war.

Myth 10: Never ask a person if he or she is suicidal as you could put the idea in his or her head.

Fact: This is one of the most pernicious myths. It is important to make it a point to ask each of your clients if he or she is suicidal.

Myth 11: Once a person's depression lifts, the situation isn't as dangerous.

Fact: It is not uncommon for individuals to attempt suicide as their depression begins lifting, as they begin having increased energy. Often changes in vegetative symptoms (e.g., energy, appetite) occur prior to changes in mood. As such, the point at which depressive symptoms begin lifting (e.g., after beginning antidepressant medication usage) may be a high risk period.

Myth 12: Don't bother giving the suicidal individual the number of the local suicide prevention hotline if the client insists he or she won't call it.

Fact: Many people who insist they would never call a hotline do decide to make the call after all. Make it a point to give all your suicidal clients the number of a suicide prevention hotline.

2.4 Therapeutic Alliance

Develop a strong therapeutic alliance with the suicidal client and make the clinical relationship central to the client 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). Explore strategies for communicating about the therapeutic alliance in treatment.

The relationship between the clinician and the client is probably the most important factor in the treatment of suicidal behaviour. Among other things, this alliance enables clinicians to better comprehend the clients' understanding of their suicidal behaviour, which is key to creating viable alternatives for problem-solving and coping (Jobes, 2000).

A requisite for the establishment of a therapeutic alliance is the development of **therapeutic rapport** – which begins from the moment a clinician has contact with the suicidal client. Rapport-building strategies that can be used in the first few minutes of an interview or assessment to reassure and engage the client include the following:

- explaining your role and the purpose of your interview/ assessment;
- asking the client their preference for how you address them;
- meeting with the client in a comfortable and private setting (e.g., if you are conducting an assessment in a hospital setting, make every attempt to speak to the client in a private setting);
- offering the client something to drink;
- using a calm, reassuring tone of voice;
- taking your time to listen to the client's story; and
- avoiding providing 'quick' solutions which may leave the client feeling misunderstood or dismissed.

Unlike therapeutic rapport, which can potentially be established within minutes, the development of a therapeutic alliance may take several treatment sessions. The therapeutic alliance is only one aspect of an effective treatment plan and therefore it also interfaces with other elements of the helping process, including risk assessment and safety planning. Essential treatment variables build on the foundation provided by the therapeutic alliance.

The therapeutic alliance is enhanced through the active cultivation of trust and mutual respect and it begins with the first encounter with the client. In their recently published *Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors*, the American Psychiatric Association (APA, 2003) acknowledged that, "… a positive and cooperative psychotherapeutic relationship can be an invaluable and even life-sustaining force for suicidal patients" (p. 30). Empathy, understanding, and recognition of one's own limits and boundaries as a clinician are central features in establishing a solid therapeutic alliance. Reflecting this balance, 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 judgment and clinical wisdom of being a therapist".

The role of the clinician is to assist a client in altering their constricted thinking, and in moving from a death-oriented position to a life-oriented position. The role of the clinician is to ultimately assist the suicidal client in untangling and addressing what is driving the suicidal feelings, and in helping them (re-) develop a sense of hope, as well as increase connections with family and community support systems, including peer support[4].

[4] See Ministry of Health's (2001) *Peer Support Resource Manual*.

Rudd and colleagues (2001) describe five key elements that collectively contribute to a strong therapeutic alliance:

1. Define a conceptual framework with the client, acknowledging the existence of the therapeutic relationship.
2. Assist the client to identify recurrent interpersonal problems, making it acceptable and expected that these problems are voiced and discussed actively in treatment.
3. Determine if any interpersonal problems have presented in previous therapeutic relationships, allowing the clinician to gauge the client's insights regarding relationship dynamics and to identify areas of sensitivity for the client.
4. Provide a framework and language for discussing the therapeutic relationship in treatment.
5. Review the treatment agenda on a routine basis, including the role of the therapeutic relationship (repetition and review are critical).

Suicidal clients typically present as hopeless and helpless and they will often transmit these feelings to their clinician (Kernberg, 1994). Clinicians need to carefully monitor and respond to their own reactions as these reactions may interfere with the treatment of the suicidal client (particularly those that are chronically suicidal). It is important to recognize that the therapeutic alliance may also be influenced by other factors such as the beliefs and attitudes held by the clinician, including beliefs about suicide, cultural beliefs and gender role expectations.

2.5 Adherence to Treatment

While many individuals who die by suicide or have suicidal behaviour have a diagnosable psychiatric disorder, it can often be years before their disorder is accurately assessed and/or effective treatment is implemented. Many clients, already emotionally vulnerable due to their (undiagnosed/untreated) psychiatric illness may have considerable frustration and discouragement related to the lack of simple or clear answers to their difficulties. In addition, clients may feel so emotionally and physically exhausted that they don't have energy to challenge or change treatment providers if they are experiencing limited therapeutic benefit. As a result, many suicidal clients withdraw from treatment after the resolution of the immediate crisis.

A client's lack of follow-through with treatment may reflect hopelessness, pessimism, and cynicism regarding the value and benefit of treatment (Rudd et al., 1995), and may be affected by the stigma of mental illness and suicide. Clients who reject help and withdraw prematurely from treatment tend to view interpersonal situations as risky and ripe for potential humiliation and emotional hurt (Rudd et al., 1995). There can be a wide range of explanations regarding a client's decision to withdraw from treatment. The clinician must exhibit patience, persistence, restraint and tolerance of their clients' anticipated moodiness; appreciation and compassion for the challenges of following a treatment plan which may have difficult side effects and be a dramatic change from the client's previous lifestyle; be alert for signs that the assessment/treatment program is incorrect; as well as do careful monitoring for possible countertransference reactions (See Section 6.1 Transference/Countertransference).

Ambivalence is a common feature of suicidal ideation and this same sense of ambivalence can often interfere with a person's desire to seek help. It is normal for people to fluctuate in their commitment to access help, especially during times of crisis and uncertainty. Nonetheless, if a client is assessed at high or imminent risk, it is important to actively engage the client in the treatment goals and ensure the client's safety is maintained.

Suggestions for Reducing Drop-out from Outpatient Treatment:

- Provide clients with follow-up appointment at time of intake.
- Schedule follow-up appointment in a timely fashion.
- Remind client of appointment by telephone.
- Provide access to 24-hour clinical back-up for crises.
- Pursue no-shows by phone calls and letters (unless this compromises client confidentiality).
- Have an explicit contract between client, family and clinician about treatment modality and treatment plan.
- Involve family members and significant others as 'natural helpers' in treatment (Source: Brent, 1997).

Follow-Up

Active follow-up is required in order to re-engage clients in treatment. This follow-up can take the form of telephone calls, letters, home visits and staying connected with the family, where appropriate. All efforts to re-engage the client should be documented as part of the formal record.

2.6 Family Involvement

Family Responses

Families[5] of suicidal individuals tend to respond in one of three ways to their loved one's suicidal behaviour, whether it is a suicide attempt, gesture, or ideation. In all cases, the clinician is reminded that they are seeing a family in overload, which may not be indicative of usual family functioning:

1. Family members may respond with shock and disbelief, and may present as distressed and overwhelmed with feelings of despair, helplessness, and failure.
   - The suicidal behaviour may be the first indication the family has that anything is wrong. The family's "assumptive world" has been shattered, and as with other traumatic loss, it takes time, education and compassion to help the family work through their reactions.
   - Even when the suicidal behaviour is a recurring theme, the family may be quite legitimately overwhelmed at seeing their loved one in such despair, likely feeling powerless to help.
   - Family members, particularly parents, may feel a sense of responsibility or guilt for their loved one's distress. They may also feel blamed by the person who is suicidal, or by other family members, friends, or professionals.

2. Family members may become enraged at their loved ones for "being selfish" and get angry that this person is considering suicide.
   - This can be complicated by anticipatory grief (resulting from fear that their loved one will eventually die by suicide) and previous family experiences with grief and loss.
   - There may be fear of loss of income or status, or apprehension due to stigma (e.g., 'what will the neighbours think?').
   - Their family member may have always been "the problem" in the family, draining the family of time and resources, and keeping the family in continual/recurring turmoil.

3. Family members may respond with apparent indifference, particularly when the client has had previous suicide attempts. Family members may feel and appear fatigued and helpless, particularly when there is persistent or repeat suicidality.
   - Family members may be suffering from compassion fatigue, possibly aggravated by real/perceived lack of support from "the system".

[5] The term "family" is used in a broad sense, and may include friends and significant others.

Regardless of the individual responses of family members, families need non-judgmental, empathic support from clinicians. This support may involve providing education about suicide risk, warning signs of depression and substance use issues, or using therapeutic approaches to improve family functioning. Living with a person who is suicidal can be challenging. Family members and friends may feel as if they are walking on eggshells, and daily boundary setting with their loved one may feel terrifying. The clinician can assist family and friends to explore options and learn new strategies for dealing with the suicidal person. Family members, similar to others living in uncontrollable high stress situations, are themselves at prime risk for mental health difficulties and comprised functioning, and may have diminished ability to effectively manage family, relationship and work issues.

The Role of Stigma

The family's response may be impacted by stigma. Due to stigma, family members may be isolated. Real or perceived stigma may keep families from utilizing their other support systems (e.g., friends, other family, neighbours, co-workers) and speaking about the suicidal behaviour of their loved one. Families may worry that they will be shunned by their family or friends if they admit they have a family member who is suicidal. They may also feel they want to protect the person who is suicidal. For example, a family member may be unlikely to request time off from work due to "my family member attempting suicide", although this may be a common request for an individual whose family member has had a heart attack. It is also important to recognize that family members may have had no previous exposure to suicide or the mental health system. As such, their knowledge of suicide may be primarily based upon myths and inaccurate information.

Working with the Family

Where possible, efforts to mobilize family support are strongly recommended. Developing a good working relationship with the family and helping them become effective partners in suicide prevention is critical. Family members can be valuable sources of information on a client's behaviours out of the clinical setting, and can also assist in helping a client maintain a safety and treatment plan (e.g., a clinician can provide family with direction on clinician and client expectations if family is used, for example, to accompany a client on an accompanied pass from hospital). The importance of involving family is underscored by research that indicates the risk of suicide is reduced by reduction of stress in clients, the family and other social systems (Richman, 1993).

Suggestions for Including and Interviewing Family Members:

- Educate family members about suicide risk and communication by discussing the relevant markers of suicide risk. In essence, the clinician needs to enlist family members in the monitoring and risk assessment process by telling them what to look for and how to recognize the importance of potentially subtle behaviours.
- Gather external information that will aid in risk assessment by asking about any recent examples of suicidal ideation or behaviour by the client.
- Respect what family members have to say. Give feedback that you have explored and/or acted on their insights whenever possible.
- The clinician will also need to clarify the limits of information sharing but should reinforce that during periods of acute and imminent suicide risk.
- Take advantage of the opportunity to activate and organize the client's social support system by routinely integrating family members into the treatment process during periods of heightened risk.

cont'd...

- Clearly define a role for the family in the treatment process. Tell family members how often they can expect to be involved and in what capacity (e.g., marital or family sessions). The clinician will also need to discuss the limits and boundaries in treatment. Chronic, multiple attempters can often be treated effectively on an outpatient basis if adequate support can be mobilized. If their role is defined, it is often easier to enlist family members in treatment. For example, the need for family or marital therapy is not uncommon as the stress of living with a chronically suicidal family member may be tremendous. If family members have been engaged from the beginning, subsequent marital or family therapy is often less threatening and more productive.

(Source: Rudd, 2001)

The following practice guidelines, adapted from the Royal College of Psychiatrists (2004) publication *Carers and Confidentiality in Mental Health: Issues Involved in Information-sharing*, provide some areas of good practice in communicating with family:

Provide general factual information, both verbal and written about:

- the mental health diagnosis
- what behaviour is likely to occur and how to manage it
- medication – benefits and possible side-effects
- local in-patient and community services
- local and national support groups

Help family to understand:

- the present situation
- any confidentiality restrictions requested by the patient
- the patient's treatment plan and its aims
- any written care plan, crisis plan or recovery programme
- the role of each professional involved in the patient's care
- how to access help, including out-of-hours services

Provide family with:

- the opportunity to see a professional on their own
- the right to their own confidentiality when talking to a professional
- encouragement to feel a valued member of the care team
- confidence to voice their views and any concerns they may have
- emotional and practical support
- an assessment of their own needs with their own written care plan (i.e., if the patient has a serious mental illness or learning disability).

Involving Families in the Therapeutic Process

Adults who are suicidal often report an absence of family and social support, leading to high levels of social isolation. This may be true, or it may be that their depression or other mental illness is distorting their perceptions. They might also be struggling with issues related to poverty, family violence, and substance use issues, which can further alienate them from both family and friends.

The challenge in mobilizing family support is that a person who is depressed may not always be able to access the love and care of friends and family, and may in fact push them away or act in ways that make it difficult for family or friends to be with the suicidal person.

"Individuals who are hurting emotionally think poorly of themselves and act in ways that will cause others to think poorly of them. As this cycle is perpetuated, they become more and more isolated and convinced of their worthlessness.... Options like reaching out and seeking help are rarely considered or are rejected outright, and as the depression evolves, the only option that promises to shut off the pain is suicide…It is typical for people with depression to perceive life in an almost totally

distorted and negative way, so that thinking and behavior become radically altered. Both one's past history and day-to-day life are rewritten and recast so that everything is seen in the bleakest terms." (Slaby & Garfinkel, 1994)

- Have family members involved as part of developing a client's treatment and safety plan. It may be helpful to share with the family member an accompanying document to this guide, *Coping with Suicidal Thoughts*
- Recommend to clients that they invite family members to accompany them to treatment session(s).
- If a client is reluctant to have you share information with the family, work with the client to specify their concerns (e.g., a 21 year old female client may not want you to share information about her sexual activities with her mother). If appropriate, attempt to obtain limited consent to communicate with families, with explicit agreements to not have discussions regarding areas that the client would like to remain private.
- Inform concerned family of your ethical and legal obligations to respect your client's privacy and confidentiality.
- Return calls promptly or immediately if possible from worried or distraught family members. If unavailable, have another clinician return the call on your behalf.
- Encourage families to connect with appropriate supports to reduce isolation, and offer alternative sources of information (e.g. brochures, websites, and books).
- If there is a death by suicide, have the client's family interviewed as part of fatality review. Also, provide the family with an accompanying document to this guide, *Hope & Healing: A Practical Guide for Survivors of Suicide*

2.7 Clinical Consultation

Participate in clinical consultation with peers and supervisors, including regular case reviews, observation, and formal discussion to ensure the highest quality of care for suicidal clients.

Routinely set aside time to reflect on clinical decision-making and case management efforts.

The consulting relationship refers to the relationship between the treating clinician and a respected and experienced clinician. Clinical consultation may take the form of formal case reviews, informal discussion, or observation and is the cornerstone of good clinical practice[6]. Maintaining regular communication with peers and supervisors can also reduce the stress and sense of isolation that sometimes accompanies the challenging work of working with suicidal adults.

In addition to participating in regular case consultations and formal case reviews, clinicians can also benefit from reflecting on their own work on a regular basis. Included below are a series of questions which are designed to facilitate thoughtful clinical reflection.

Examples of Reflective Questions for Thinking about Clinical Work with Suicidal Individuals:

- What can I do to increase this person's safety?
- Does this patient need to be hospitalized?
- Who else does this person see as potentially helpful?
- How can my clinical expertise be helpful to 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.

[6] A more thorough discussion of clinical supervision issues is provided in Section 6.4.

- 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 telephone call can I 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 the goal/function of the 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 available? 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 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")?

Examples of Questions for Retrospectively Reviewing Clinical Decisions

The following questions can guide clinical reflection following the completion/termination of treatment with a client:

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

(Source: Fiske, Personal Communication, 2000)

2.8 Client-Friendly Healthcare Services

Individuals often come to believe they don't require outside help with their problems, or think that while they may have problems, they can manage without professional assistance. Suicidal individuals sometimes report experiencing negative judgments from health care professionals when they try to access help. Stigma, or the fear of being judged harshly for accessing services, prevents some individuals from seeking help. The real or perceived threat of job loss, if they are diagnosed with a mental illness, keeps others from reaching for help. It is important that all individuals be taken seriously and treated in a non-judgmental manner. The importance of the service provider's sensitivity cannot be overstated.

In outpatient treatment settings, barriers are reduced when clients have repeated and consistent contact with one clinician rather than with multiple providers. Furthermore, clients are more apt to continue treatment when family members are included in the process (Tolan et al., 1988).

When working with clients, be cognizant of factors in the therapeutic environment that may increase the likelihood that a client will disclose that they are feeling suicidal. For example, if you are interviewing a client about their suicidality in an acute care setting, ensure that the client is seated comfortably and that measures have been taken to ensure their privacy (e.g., ensure that other patients are not within hearing range).

2.9 Informed Consent, Confidentiality and Release of Information

To the extent possible, work directly with the client to elicit his or her consent for treatment. Where a client is refusing treatment, a breach of confidentiality may be warranted and this is especially true in cases of high or imminent risk[7].

As a component of informed consent, review issues related to confidentiality and safety. Review the treatment plan, and highlight what can be expected from treatment with the client and, if possible, family members. It is particularly important to involve family for clients who have had multiple attempts and those with chronic mental health problems.

Informed Consent

The notion of informed consent is premised on the ethical and legal rights of individuals to participate actively in the decision-making process surrounding their treatment. The process of obtaining informed consent can be viewed as an opportunity to increase communication and collaboration between the clinician and the client.

Adults are generally understood to be capable of giving consent to treatment when they understand the following – based on a thorough explanation from a qualified practitioner (BC Ministry of Health, 1998):

- the nature of their condition;
- the options for their treatment; and
- the reasons for, and likely risks and benefits of, the recommended treatment.

To enable clients to be as fully informed about the treatment process as possible, clinicians are encouraged to acquaint clients with each of the following issues at the outset of treatment (Rudd et al., 2001):

1. A statement about the purpose and nature of the services provided;
2. Specific therapeutic goals and procedures to be followed;
3. Therapeutic contract;
4. Help available during crises;
5. Alternative choices;
6. Any identifiable risks and benefits;
7. The potential duration of treatment;
8. Costs and methods of payment (if relevant);
9. Procedures regarding cancellation of appointment(s);
10. Constraints on confidentiality;
11. Qualifications of the clinician;
12. Boundaries of the professional relationship, e.g. after-hours contact and how to access help during crises; and
13. Complaint procedures.

Informed consent does not have to be provided in writing; however the process must be supported with written documentation. Providing informed consent through a written document offers tangible evidence of the informed consent process. This can be signed and dated by both the clinician and the client becoming part of the clinical record and provides direction to others to act in the absence of the clinician.

[7] 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.

Ideally, the family and other significant support persons should be included in the assessment and treatment process. Be aware of the family's perspective and other supports, as they may need to have clarification regarding their rights to know how treatment is progressing and when they need to intervene. Taking time to help concerned family members understand confidentiality constraints, including when information can be shared, is invaluable for all involved[8].

Limits to Confidentiality

There are certain limits to confidentiality, which clients must be informed about when a clinician is obtaining informed consent. Specifically, the clinician should inform the client that they may break confidentiality in the following scenarios:

- if the clinician has concern that the client, or another party, is at risk of causing harm or danger to self or others (including high/imminent suicide risk, and/or after a suicide attempt);
- if the clinician has concern of a child being at risk of abuse or neglect; or
- if a clinician's records are subpoenaed by a court of law.

Breaking confidentiality may be justified in the case of certain emergencies. If a client is judged to be at imminent risk for suicide and is refusing treatment as a voluntary patient and is suffering from a mental disorder that seriously impairs his or her ability to react to his or her environment, it might be necessary to hospitalize him/her under the *Mental Health Act*.

Release of Information

The cornerstone of effective clinical work with potentially suicidal adults 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, e.g. ambiguous symptom presentations, fluctuating risk levels, conflicting professional and family/significant other opinions, and the challenge of making connections with "hard-to-reach" clients. Several considerations and pieces of information need to be systematically assessed and weighed in order to formulate a sound clinical judgment 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, particularly when considering decisions around release of information.

A difficult question to sometimes answer comes to the foreground when assessing and treating suicidal adults: Under what circumstances are clinicians justified in breaking confidentiality? The reason that this question is so ethically challenging is because it often arises out of a context of competing sets of interests, e.g., the right of the person to be "self-determining" versus the responsibility of the clinician to provide protection to a client who is at risk for self-harm. Resolving issues around release of information requires a combination of good clinical judgment, an appreciation for the broad social context within which the suicidal behaviour is emerging, and a sound working knowledge of the relevant legislation.

[8] The key sections of the FOIPP Act that may assist clinicians in talking to family members are s. 22(4)(b), and ss. 33(b), (c), (p) and (q).

It is important to consider the reasons for legislation surrounding privacy and confidentiality, and balance that with the benefits of releasing information to family members, in some cases in light of the primary client indicating the opposite. The sharing of information between clinicians and family members is important to the ongoing care of clients, many of whom will have limited or no ongoing mental health contact.

There are no definitive rules regarding the release of personal information. As such, releases of personal information need to be considered on a case-by-case basis. A client's history, their health, and the care provided by the third party are all mitigating factors which the health care provider needs to consider prior to disclosing any personal information.

Clinicians are regularly required to make decisions on disclosure of information relevant to a person's health. This includes circumstances when providers need to disclose patient information to third parties outside the provider-client relationship, such as: parents, friends, police or other health care providers.

Obtaining consent from the client is, of course, preferred when releasing any personal information to a third party. However, health care providers do encounter circumstances when consent is not viable.

The release of personal client information for clinicians in British Columbia is governed by two different Acts.

1. The *British Columbia Freedom of Information and Protection of Privacy Act* which covers any clinician who is employed by a public body (e.g. Hospital, Health Authority, University)
2. The *Personal Information Protection Act* which covers any clinician in private practice

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 client safety and well being.

Freedom of Information and Protection of Privacy Act (FOIPPA)

According to section 33.1(1)(m) of the FOIPPA, personal information about an individual may be disclosed, without the individual's consent if "(i) the head of the public body determines that compelling circumstances exist that affect anyone's health or safety, and (ii) notice of disclosure is mailed to the last known address of the individual the information is about, unless the head of the public body considers that giving this notice could harm someone's health or safety". Disclosure is permitted of information which, as per section 32(a), is "for the purpose for which that information was obtained or compiled, or for a use consistent with that purpose".

The Act relies on the words "for the purpose for which it was obtained or compiled" for the proposition that information can be disclosed to parents and other family members who are closely involved in caring for the patient and who will likely be called upon for support and assistance. The same phrase is also relied on to release information to other care providers who have been providing care to the patient and/or are likely to be in a position to provide care to the patient again, such as hospitals, physicians, mental health centres, mental health and addiction residential care facilities.

In exception 2, the head of a public body (e.g. health authority) or his or her delegate, may disclose personal information about a patient if he or she is of the view that "compelling circumstances exist that affect anyone's health or safety". This anyone can be the patient or a family member, or anyone whose health or safety is likely to be

threatened. Delegated authority for these types of decisions normally lies with the professional clinicians who are responsible for the individual patient care. Typically the individual that holds this authority is the CEO of the employing organization or health authority. It is prudent practice for health care providers to inquire who within their organization holds this authority.

In 2004 the FOIPPA was amended so that it is now no longer mandatory in all cases in which this provision is relied on to send a written notice to the patient. Notice must now be sent to the patient "unless the head of the public body considers that giving this notice could harm someone else's health or safety" (such as the health care provider who has the information and discloses it).

Personal Information Protection Act (PIPA)

According to Section 18(1)(k) of the PIPA, a clinician may disclose personal information about an individual, without the consent of the individual, if "there are reasonable grounds to believe that compelling circumstances exist that affect the health or safety of any individual and if notice of disclosure is mailed to the last known address of the individual to whom the personal information relates".

In actual clinical practice, according to legal mandates, a clinician is required to obtain a client's informed consent to participate in a clinical assessment or treatment service[9]. In the case of an individual who is presenting with suicidal ideation, it would be recommended that a clinician obtain contact information for an emergency contact (next of kin; other family member or friend). As part of the informed consent procedure, a clinician should explicitly inform the client that confidentiality may be breached if a circumstance arose whereby there was concern of the health or safety of the client (e.g., including concern about suicidal risk). If a circumstance arose whereby a clinician was faced with a compelling circumstance, whereby there was a determination of imminent threat of suicidal risk, that clinician would be permitted to disclose personal information (e.g., to that emergency contact) provided that there is a follow-up regarding notice of disclosure. A determination of imminent threat to health or safety, and an associated decision to release information to an emergency contact, could be made independent of a client's statements to not inform another party. It is legally mandated that disclosure be followed up by way of written notice to that client.

Suggestions around Informed Consent, Confidentiality and Release of Information

- As part of the intake process, obtain detailed contact information for the client, as well as contact information for family members or other significant others (e.g., friend, girlfriend/boyfriend).
- The best defence against inappropriate breaches of confidentiality is a detailed informed consent procedure.
  - Inform the client as to the limits of confidentiality. Indicate to client that you are ethically and legally obligated to release information in situations where you are concerned about the client's imminent well-being, and that this may include contacting their next of kin/significant other(s).
  - Discuss and document other parameters around release of information (e.g., you may suggest that if the client no-shows for a session, that you will first try to contact the client, and if you cannot get a hold of him/her that you will contact their next of kin).

[9] When clients are involuntary patients under the *Mental Health Act*, then informed consent by the clients is not required.

- Actively encourage client to have a trusted family member or friend involved as part of the therapeutic process. If client refuses, make discussions around involvement of family or friends an active part of the treatment process.
- In cases where a clinician's judgment suggests a client's safety or well-being is imminently at risk, the concerns about safety (and associated decisions to release information) override considerations about confidentiality.

2.10 Special Populations

2.10.1 Immigrant Populations

The clinician's appreciation for the client's cultural context and values is an integral part of establishing a therapeutic relationship. A client's social history and cultural identity, which constitutes a complex set of characteristics such as race, ethnicity, language and religion, provides important information about a client's behaviours, concerns, feelings and thoughts. It is important to identify and integrate the cultural context and knowledge of protective factors in intervention and treatment planning with suicidal clients. As is the case with all suicidal clients, it is critical to involve family members, physicians, alternate caregivers, and community members in the short-term safety and long term treatment planning.

The population of British Columbia includes many individuals and families who have migrated to Canada from diverse cultural backgrounds. Some immigrants and refugees have faced traumatic experiences such as war, living in refugee camps, seeking asylum, and isolation from family and culture. However, as a group, immigrants do not present a higher suicide risk than other Canadians.

Malenfant (2004) examined suicide rates among Canada's immigrant populations and found that suicide rates for those born outside of Canada were about half those of the Canadian-born population. Similar to trends for non-immigrants, among immigrants suicide risk was found to increase with age, with more males dying by suicide than females. Overall, the pattern of suicide among immigrants to Canada more closely resembles the pattern in their home country than Canada.

2.10.2 Aboriginal Populations

Aboriginal people in Canada die by suicide two to three times more often than non-Aboriginal people. According to reports prepared by the Royal Commission on Aboriginal Peoples (RCAP, 1995) and Advisory Group on Suicide Prevention (Health Canada, 2003), the Aboriginal youth suicide rate is 5 to 6 times higher than for that of non-Aboriginal youth. It is important to acknowledge some of the broad social factors that are understood to contribute to such elevated levels of risk among Aboriginal people, in comparison to other Canadians:

- Lower standards of living;
- Poverty (On average, Aboriginal people earn only 21.3 per cent of the Canadian average wage);
- Lower level of education (25 per cent of Aboriginal people have never been to a formal school);
- Higher unemployment rate (The unemployment rate for First Nations in Canada is ten times greater that the national average); and
- Cultural stress (Including factors such as loss of control over living conditions, suppression of beliefs and spirituality, loss of political institutions, breakdown of cultural rules and values, racism, and adoption of components of the external culture).

(Source: Royal Commission on Aboriginal Peoples, 1995)

Other social factors that contribute to higher rates of suicide in aboriginal populations include higher rates of substance use problems, physical abuse, and sexual abuse. Chandler and Lalonde (1998) have studied the link between personal identity and cultural continuity as an important protective factor against suicide. In a study of suicides in Aboriginal communities in B.C., these authors found evidence suggesting that communities that were experiencing a greater degree of self-sufficiency were associated with lower suicide rates. This research suggested that suicide rates in local communities decreased when a community was engaged in activities designed to rebuild or maintain cultural continuity, such as working towards self government, establishing land claims, developing local health and education services, supporting and developing cultural facilities, establishing local police and fire services, improving knowledge of the local aboriginal language and supporting the development of local child protection services.

Aboriginal Healing

Community-based, natural healing methods for Aboriginal individuals recovering from a suicide crisis appear to hold more promise than traditional, Western-based, psychotherapeutic models (McCormick, 1999). Research highlights the importance of culturally specific counselling approaches that incorporate and reflect the values and natural helping styles of a culture. According to McCormick (1999) healing around suicidal ideation for Aboriginal clients is enhanced through a focus on the following:

- self-esteem/self acceptance;
- obtaining help from others;
- changing thinking;
- connection with culture/tradition;
- expressing emotion (often referred to as "cleansing");
- spiritual connection;
- responsibility to others;
- future goals/hope;
- learning from others/role models;
- participation in ceremonies;
- connection to nature; and
- guiding vision/dreams.

The document *Acting on What We Know: Preventing Youth Suicide in First Nations* (2002) addresses the importance of community-driven approaches to suicide prevention in Aboriginal communities, and provides community crisis assessment guidelines.

Prevention and Treatment Considerations

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. There are varying rates of suicide between tribal groups and cultural values vary dramatically from Nation to Nation, and from Band to Band (Cooper et. al., 1991).

Clinicians who take the time and energy to find out who the client is, both in terms of their particular Aboriginal identity and as an individual, will increase their capacity to forge a genuine therapeutic alliance. Where possible, clinicians should reach out to Aboriginal individuals and communities and explore ways to offer a culturally appropriate response to suicidal behaviours. At a minimum, this can include: understanding the social and historical factors that have contributed to an increased risk of suicide among First Nations communities; awareness of Aboriginal healing resources in the suicidal individuals' community; knowledge of the role of connectedness, balance, empowerment, and cultural healing rituals for Aboriginal clients; and understanding the importance of family and community in the lives of First Nations people.

Appreciation of the impact that situational factors (e.g., unemployment) may have on the responses of a client's support system (e.g., friends, family, community) is important, particularly given the importance of family and community acceptance and support within Aboriginal communities.

Focal Points for Treatment:

- teach positive self-image;
- encourage and assist Aboriginal clients to explore traditional healing practices and to participate in cultural rituals, if appropriate; and
- utilize family and community-based approaches.

2.10.3 Lesbian, Gay, Bisexual or Transgender Clients

Lesbian, gay, bisexual and transgender clients are often at risk for a multitude of physical, emotional and social problems. These clients often have higher than average rates of depression, substance use issues, and social and family rejection.

A good portion of the available literature examining homosexuality and suicide risk focuses on youth, and young gay males in particular. The findings of this research are included here to foster an appreciation for the relevance of sexual orientation in understanding risk for suicidal behaviour.

While it is indicated that gay youth are two to three times more likely to attempt suicide compared to their heterosexual counterparts, there is currently no evidence to indicate that gay youth have a higher than expected suicide rate. It is probable that lack of social support, marginalization, and homophobic attitudes all likely contribute to an increased risk for suicidal behaviour among this population.

Evidence suggests that the mental health problems of gay, lesbian, and bisexual youth differ from those of heterosexual youth. Increased depression, suicide, substance use issues, homelessness and school dropout 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. In an adolescent survey undertaken with lesbian, gay, bisexual and transgender (LGBT) youth in British Columbia, 71 per cent of LGBT reported that they had seriously considered attempting suicide at some point in their lifetime, while almost half (46 per cent) had attempted suicide. Thirty per cent of the LGBT population reported that they had attempted suicide more than once (McCreary Centre, 1999).

Prevention and Treatment Considerations

The clinician can contribute to the overall well-being of clients who may be marginalized because of their sexual orientation by developing more accepting and inclusive ways of working with this population in acute care and outpatient settings. This may include a focus on normalizing sexual and gender diversity and actively working to reduce stigma. It is important to 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.

2.10.4 Young Adults & Students

Young adults and students comprise a population that may be vulnerable to the development of mental health disorders, particularly depression, as well as risk of suicide given a myriad of developmental, transitional, and contextual factors. Although the overall Canadian suicide rate for those aged 20 to 29 has been found to be 15.1/100,000, similar to the national rate across age groups

(Langlois & Morrison, 2002), there are a number of factors may make young adults and students vulnerable to stress, depression, and suicide risk.

Vulnerability factors for young adults and students include the following:

- Adolescence begins earlier, exposing young people to complex stressors before they have the cognitive and emotional resources to deal with them (Marano, 2004).
- Increasing numbers of young people grow up without protective buffers from stress provided by intact families, resulting in greater psychological instability and less ability to cope effectively with stress. This type of developmental context has been found to be associated with increased suicide risk (Kolb & Brodie, 1982).
- Young adults are more likely to experience major life transitions where they are moving away from family, peer and community connections, and do not have a solid adult support system, or other protective factors, in place (Potter et al., 2004). Difficulties in romantic relationships may be a precipitating factor for depression and suicidal ideation, particularly when considered in the context of lack of other supports. Establishing a sense of connectedness, therefore, has been found to be a very important suicide prevention strategy in this regard (Westfield et al, 1990).
  - Establishing a place of belonging away from home can be particularly challenging within diverse student populations being challenged with negotiating differences among ethnicities, religious groups, sexual identities and orientations, genders, and socio-economic backgrounds. Communities, colleges, and universities must become increasingly sensitive to the unique needs of these populations.
- Given the transition away from home, students and young adults are more vulnerable to erratic sleep patterns, poor nutrition, and lack of exercise at a critical time of developmental need.
- Students may experience greater cumulative stress as a result of increased competition at an earlier age and higher grades required for college and university entrance add to that stress. Self-esteem has become increasingly tied to academic achievement, resulting in increased vulnerability.
  - Helping young adults develop the skills to manage the rigors of post-secondary study can alleviate sources of distress in this regard.
- Late adolescence is characterized by a higher prevalence of onset of mental disorders (e.g., psychosis) that, if left untreated, can contribute to suicide.
  - More students with mental health disorders go to university and remain in university than before given the decreasing stigma of mental health care, and earlier diagnosis and care (Voelker, 2003). As such, ready access to treatment and continuity of care become important factors to help young adults and students manage mental health disorders.

Risk factors for the development of mental health disorders among students include: new and unfamiliar environment; academic and social pressures; feelings of failure or decreased performance; alienation; family history of mental illness; lack of adequate coping skills; and difficulties adjusting to new demands and different workloads (National Mental Health Association and the Jed Foundation, 2002). In a study of 10 large universities in the United States, student suicide risk was found to increase with age, with highest rates found among students 25 yrs old and over (Silverman et al., 1997). Graduate students were found to have higher rates than undergraduates. Women undergraduates were found to have lower rates than men (by about half) but female

suicide rates increase with years in school such that in the graduate school years, female rates were only slightly below those of their male counterparts (9.1 vs. 11.6/100,000).

National College Health Survey (NCHS) data from 2000 found 9.5% of students had seriously considered suicide and 1.5 per cent had attempted suicide in the last year. Of the students who reported attempting suicide, one-half percent reported having attempted three or more times[10]. NCHS data indicate a gradual increase in students seriously considering attempting suicide during the period 2000 to 2004 with the number of attempted suicides increasing slightly between 2000 and 2002, but decreasing slightly between 2004 and 2005 (Potter, et al., 2004).

Prevention and Treatment Considerations

An ecological approach to suicide prevention and intervention is generally thought to be most effective given the wide variety of factors that contribute to suicide in young adults and students (Potter, et al, 2004). Comprehensive programs for suicide prevention typically include the following elements:

- Screening to identify those who are potentially high risk.
- Education and social marketing to increase awareness and reduce stigma.
- Promotion of social networks to create a sense of belonging.
- Life skills development to strengthen self-management capacity (e.g., problem-solving and communication skills; distress tolerance; emotion regulation, including anger management; and healthy self-soothing).
- Development and implementation of policy to restrict potentially lethal means.
- Adequate mental health resources.
- Training gatekeepers and students to identify and refer at-risk students.
- Crisis management procedures and protocols.

2.10.5 Elderly Clients

The elderly – particularly males – are at higher risk for suicide compared to other age groups. The elderly make fewer suicide attempts compared to youth; however, older people are more likely than any other age group to die by suicide (Gallagher-Thompson & Osgood, 1997). In B.C., rates of suicide among those 65 and over are slightly higher than the overall provincial rate. For example, the provincial rate of suicide in 2004 was 11.7 deaths per 100,000[11]. For the same year, rates of suicide among those aged 75 to 79, 80 to 84, and 85 and older were 15.4, 20.4, and 17.3, respectively (B.C. Vital Statistics, 2006).

Suicidal behaviour among older people is more highly lethal than in other age groups; they are less likely to warn others of their suicidal intentions, and use more potentially lethal methods, such as guns (Conwell, 1995). Older adults are more physically vulnerable than younger people; as such, any self-injurious act is more likely to result in death. Further, older adults are more likely to live alone, so it is less likely that someone will be available to help them get medical attention following a suicide attempt. The experience of loss among older adults can be profound. They have often experienced grief resulting from the death of a spouse, family members, friends, and other losses related to life transitions, such as retirement. Loss combined with feelings of ambivalence about the future, can render an older adult vulnerable to suicide.
Suicide amongst the elderly tends to receive much less public attention than suicide among the youth. This may

[10] Note also that these suicide statistics only reflect campus suicides and not students who drop out of college or university due to depression, etc and then die by suicide outside of the college context.

[11] However, it is important to consider that the provincial rate is slightly deflated due to extreme low rates in the very young.

be a reflection of ageist values, where the lives and concerns of the young are seen as more important than the quality-of-life concerns of the elderly (White, 1997). There is also the possibility that death investigations undertaken following suicide deaths among the elderly are less thorough. The overall societal tendency to value youth over age leaves elderly people potentially vulnerable to being overlooked and hence they may not be adequately assessed for suicide risk. Further, some elderly people may avoid direct communication and may hesitate to request treatment for their suicidal thoughts (de Leo, & Ormskerk, 1991). Clinicians may discount indications of suicide by the elderly or assume that death wishes are a normal part of growing old. (Valente, 1993-94).

Risk and protective factors for suicide among the elderly have been extensively studied (Conwell, 1995; McIntosh, 1997; Richman, 1993). Knowledge of risk and protective factors can help guide suicide prevention and intervention efforts. Risk factors include:

- increasing age;
- male gender, especially for Caucasians;
- being single or divorced, or living alone;
- social isolation/closed family systems, which do not encourage discussion or help-seeking;
- generational biases against the role of clinicians and therapists;
- poor physical health or illness, particularly inadequate pain control;
- hopelessness and helplessness;
- loss of health, status, social roles, independence, significant relationships;
- grief;
- depression;
- fear of institutionalization;
- frailty of elders – injuries may cause more physical damage and their recuperative abilities may be compromised.

Prevention and Treatment Considerations

Suicide prevention rests upon detecting and reducing the factors that increase suicide risk by treating physical and psychiatric disorders, reducing social isolation, improving resources, enhancing self-esteem, and helping elderly clients find meaning or satisfaction in life (Valente, 1993-94). As with all age groups, talking about suicide with the elderly reduces barriers to accessing help. Treatment that includes ongoing assessment and monitoring, combined with interventions that improve self-esteem, manage depression, decrease negative thinking patterns, and improve social support, can decrease suicide risk (Valente, 1997).

The following are suggestions that can assist in working with the elderly:

- Include family members in treatment planning.
- Encourage family members to assist the elderly client to develop and maintain social connections, provide them tasks/responsibilities, and otherwise 'engage' in life.
- Discuss the development of interests and support networks.
- Assist seniors in securing adequate income/pensions and affordable, safe and supportive housing.
- Assist older persons to find, maintain, and/or renew meaning and purpose in life.
- Communicate with physicians about the warning signs of depression and suicide amongst the elderly, given that the elderly may have more frequent contact with a family physician for physical health problems.

2.10.6 Developmental Disabilities

Developmental disability is a condition reflecting sub-average intellectual functioning equivalent to an IQ of 70 or below, obtained on an individually administered intelligence test, as well as impaired adaptive skills, and

occurrence prior to age 18 (Byrne, Hurley and James, 2006). Individuals with a developmental disability have a much higher rate of mental health disorders than the general population. At least 30 percent of adults with developmental disability will require specialized mental health services (Hudson and Chan, 2002). However, many individuals with a developmental disability are underdiagnosed, misdiagnosed, and underserved.

Death by suicide among persons with developmental disability is considered rare. In a 35-year (1962-1998) follow-up study in Finland of a population-based cohort of 2,677 persons with developmental disability, only 10 cases of completed suicide were discovered (Patja, 2004). Among individuals who do attempt, methods of suicide in persons with developmental disability are varied and similar to those found among the general population. Suicide risk among persons with developmental disability are increase if the presence of psychiatric morbidity with challenging care needs, social problems and difficulties in adjusting and ageing. Those working with developmentally disabled individuals need to be aware of these risks in order to recognize severe depression, emotional instability and lack of will to live, possibly leading to either attempted or completed suicide (Patja, 2004).

Although death by suicide may be infrequent, suicidal thinking though can be quite common in this population and should always be inquired about. Asking if someone has ever thought about hurting themselves or killing themselves will frequently yield previously unknown information. Risk taking behaviour should also be asked about (e.g. riding a bike in traffic with eyes closed). The methods chosen may at times not have actual lethal potential, but if the person thought they would die by manual self-strangulation then that should be seen as a significant attempt and needs to be taken seriously. Assessing for and treating depression and comorbid physical conditions in people with developmental disability will result in decreased morbidity.

2.10.7 Concurrent Disorders

The co-existence of mental disorders and substance use disorders is common in persons at risk of suicide, and there is evidence that comorbidities increase the level of risk for suicide beyond the levels associated with each of the individual conditions (APA, 2003). Although estimates of the rate of comorbidity vary, there is little doubt that the prevalence of such comorbidities is sufficiently high to warrant an integrated response at both the client and system level[12].

The co-occurrence of substance use issues with other mental disorders creates unique challenges for the assessment and treatment process. The high rates of comorbidity point to the importance of routinely screening for substance use issues in clients. This issue appears to be particularly important with respect to clients who are suicidal. Suicide rates among individuals with alcoholism are six times those of the general population, and the prevalence is even higher among alcoholics who have a depressive disorder than among those with major depression or alcoholism alone. The comorbidity of disorders such as antisocial personality disorder, affective disorders, anxiety, and schizophrenia, along with substance use disorders, place clients at increased risk for suicidal behaviour (Kaplan & Sadcock, 1998). Consequently, the co-existence of substance use and mental health problems appears to escalate the risk of suicidal behaviour beyond the levels that are associated with the individual disorders. The development of integrated responses to assessment and treatment which address issues of comorbidities between mental illness and substance use disorders is an important component of effective responses to the needs of clients who are suicidal.

[12] See Ministry of Health (2004) E*very door is the right door: A British Columbia planning framework to address problematic substance use and addiction*.

Section Three

Identifying and Assessing Suicide Risk

- Be familiar with the concept of 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. Continue to re-assess risk at specific intervals.
- Use clearly defined and commonly understood categories for defining levels of risk (e.g., non-existent, mild, moderate, high and imminent). Assess risk on the basis of both subjective (self-report) and objective intent (clinical judgment).
- Recognize the need for monitoring suicidality, as suicide risk is not static and does change.

3.1 Identifying Risk

Definitions

Risk is the likelihood of an adverse event or outcome.

Risk factors are the particular features of illness, behaviour or circumstances that alone or in combination lead to an increased risk.

Risk assessment is an estimation of the likelihood of particular adverse events occurring under particular circumstances within a specified period of time.

Risk formulation is a process of summary and organization of the risk data, and identification of the risk factors. It provides the information base for risk management.

Risk management aims to minimize the likelihood of adverse events within the context of the overall management of an individual's care plan, to achieve the best possible outcome, and deliver safe, appropriate, effective care.

(Source: Ministry of Health, 1998)

Understanding Risk and Protective Factors

Suicide is a complex phenomenon, determined by multiple factors intersecting at one point in the life of the individual. There is not one single predictor of suicide. The clinician is often called upon to appropriately differentiate potential mild, moderate, severe or imminent risk.

Risk factors and protective factors are equally important to consider in the overall risk assessment process. A brief overview of three types of risk factors (Stoelb & Chirboga, 1998) is provided below, followed by a brief description of protective factors. Each of these assessment domains is elaborated in the pages that follow.

Risk Factors

These factors serve to elevate the client's chronic risk for suicide and can contribute to an escalation of acute risk under some circumstances (Stoelb & Chirboga, 1998).

Age: Suicide risk increases with age. Prior to puberty, suicide attempts or deaths by suicide are rare although suicide ideation is not (Jacobs, 1999). Suicide rates increase after puberty, and older adults (over the age of 65) have consistently shown higher rates of suicide compared to other age groups (Gallagher-Thompson & Osgood, 1997).

Sex: Risk is greater for males than females. Females are more likely to attempt suicide than are males, while males are up to four times more likely to die by suicide (Moscicki, 1999).

History of Psychiatric Disorders: A history of psychiatric disorders can signal an elevated risk for suicide.

Current Axis I Diagnosis: Mood disorders, particularly depression, as well as previous suicide attempts, are among the strongest risk factors for suicide (Henriksson, Hillevi, & Marttunen, 1993). Anxiety disorders have been associated with an increased risk for suicide and suicidal behaviour, particularly as they co-occur with mood disorders and substance use disorders. Schizophrenia can also contribute to an elevated risk for suicide, particularly during the early years of the illness (APA, 2003). Over 90% of all suicides have been associated with the presence of a psychiatric disorder (Henriksson, Hillevi, & Marttunen, 1993).

Characteristic Symptoms: Hopelessness is highly predictive of suicide risk. Hope is a protective factor. Without a sense of hope, suicide is often viewed as an acceptable escape. Anger, depression, guilt, anxiety/panic, insomnia, and diminished attention/concentration are also markers of suicide risk.

Previous History of Suicidal Behaviour: History of a suicide attempt dramatically increases future risk for suicide. Individuals who have attempted suicide constitute a very high risk for suicide – a rate of 50-100 times that of the general population (Jacobs, 1999).

History of Abuse: Physically and sexually abused individuals, both during and after the abuse, have a higher than average risk for self-destructive behaviour. Physical and sexual abuse has been related to higher rates of suicide attempts, but not higher rates of death by suicide (Hipple, 1992).

Substance Use: Intoxication is frequently a factor in suicide. Substance use issues can act as a trigger for suicidal behaviour, especially when multiple substances are used such as alcohol, cocaine and/or marijuana (Beautrias & Joyce, 1996). Withdrawal from cocaine, amphetamines, and the extended use of sedatives, hypnotic and anxiolytics can result in increases in suicide ideation and attempts (APA, 1994).

Current Axis II Diagnosis: Individuals with a personality disorder, for example borderline personality disorder, are at increased risk for suicidal behaviour.

Situational Risk Factors: Interpersonal and circumstantial factors must be thoroughly assessed as they can contribute to an increased risk for suicide (Stoelb & Chirboga, 1998). Examples include interpersonal conflict (separation or divorce), periods of change, and real or perceived humiliation or loss.

Family History – Suicide and Psychiatric Disorders: Individuals who attempt or die by suicide are more likely to come from families with a history of suicidal behaviours (Egeland & Sussex, 1985). Family history of psychiatric difficulties (e.g., depression, suicide) also increases risk for suicide (Redfield Jamison, 1999b).

Living Alone: Living alone is associated with increased risk of suicide for men (Morrant, 1999). Women typically have a stronger infrastructure of support, and unmarried women are not at increased risk of suicide, whereas unmarried men are.

Social Relationships: Social isolation is a common risk factor for depression and suicide. Individuals' perceptions of the quality of friendships and family relationships are a relevant factor in assessing risk for suicidal behaviour.

Life Stressors: Stressful life events can contribute to increased suicide risk. Stressors include legal problems, financial problems, significant losses (e.g., break-up of a relationship), loss of health, termination of employment, and the death of a loved one.

Access to Lethal Means: Easy access to firearms, large doses of medication, or other potentially lethal means can increase suicide risk considerably.

Physical Disorders: Physical disorders (e.g., un-diagnosed diabetes, iron/thyroid deficiency) have been found in approximately one third to one half of suicides of individuals greater than 60 years of age (Moscicki, 1997). A particular high risk group includes those with chronic pain.

Protective Factors

In addition to assessment of risk, a comprehensive approach to suicidality should focus on identification and fostering of protective factors, which reduce risk for suicide. For example, a strong sense of competence and optimism in coping with life's problems appears to be a protective factor against suicidal behaviour. Social connectedness is another important protective factor and helps counter-balance the effects of depression and isolation. The presence of these protective factors offers no

guarantee that a client will not attempt or complete suicide – however, in general the greater the number of protective factors, the more resilient the person will be, when faced with stress and adversity.

In conducting a thorough suicide risk assessment, the following protective factors should be taken into account (Coombs, 2001; Thompson & Brooks, 1990; White & Jodoin, 1998):

Individual Factors

- strong sense of competence
- effective interpersonal skills
- effective problem-solving skills
- adaptive coping skills
- self-understanding
- optimistic outlook
- religious affiliation

Family Factors

- sense of responsibility to family
- relationships characterized by warmth and belonging

Work Factors

- sense of accomplishment
- positive peer support and colleague relationships
- supportive, non-punitive work environment
- professional development opportunities (e.g., career development, stress management workshops)
- core values are present in the workplace (e.g., integrity, honesty)
- access to employee assistance programs

Community

- opportunities to participate
- affordable, accessible supportive resources
- hope for the future
- community self-determination and solidarity

3.2 The Continuum of Risk for Suicide

Although it is not possible to reliably predict suicide, there is value in undertaking an assessment of level of risk. 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 for conceptualizing categories of suicide risk:

Non-existent: Absence of suicidal ideation or other risk factors.

Mild: Suicidal ideation of limited frequency, intensity, or duration; no identifiable plans; no intent; good self-control; few risk factors; presence of protective factors.

Moderate: Frequent suicidal ideation with limited intensity and duration; some specific plan(s); no intent; some risk factors; presence of protective factors.

High: Frequent, intense and enduring suicidal ideation; specific plan(s); objective markers of intent (e.g., some limited preparatory behaviour); access to lethal method(s); evidence of impaired self-control; severe dysphoria/ symptomatology; multiple risk factors present; few, if any, protective factors.

Imminent: Frequent, intense, and enduring suicidal ideation; specific plan(s); access to methods; clear subjective (self-report) and objective (clinical judgment) intent; impaired self-control; severe dysphoria/ symptomatology; many risk factors; no protective factors.

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. These vulnerable populations included: First Nations, gay, lesbian, bisexual and transgender individuals, youth and the elderly.

It is important to recognize the need for monitoring suicidality, given that suicide risk is not static. It is helpful to recognize factors that may contribute to suicide risk changing. For example, a suicide risk assessment may lack confidence if the client you originally see is intoxicated, and the original suicide risk assessment was performed when the individual was under the influence of substances. It is also important to recognize factors and triggers that may impact the risk assessment (e.g., if a client has been feeling suicidal because of a relationship conflict, such as separation or divorce, and will be seeing their former partner in the next while). Good safety planning can help provide assistance with potential triggers.

3.3 Assessing Risk

In general, the client who is at the highest risk for suicide is the one with the most risk factors occurring concurrently. However, 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 (Rudd & Joiner, 1998). An open and collaborative stance on the part of the clinician during the risk assessment and management process can make a positive and significant contribution to the overall therapeutic alliance, and can improve the reliability and validity of assessment of risk.

Assessing Ideation, Intent and Lethality

The following list identifies some of the factors to consider in a comprehensive suicide risk assessment:

- Ask directly about whether the person is considering suicide. When working with suicidal clients, it is important to perform routine assessment of risk, and to ask about suicidal ideation, intent and plans during each appointment.
- Develop an accurate understanding of levels of current suicidal ideation, including intensity, duration, and specificity (see Table 1).
- Find out about the specificity of current plans (e.g. how, where and when).
- Discuss and consider the availability of means.
- Assess lethality of means (see *Lethality of Suicide Attempt Rating Scale* by Smith, Conroy & Ehler, 1984 and *Lethality Assessment Tool* by Hoff & Miller, 1987)
- Ask about any preparatory behaviour (e.g., giving away possessions).
- Assess the personal meaning of suicidal behaviour.
- Assess cognitive rigidity and problem solving abilities, and explore levels of social support and self-esteem.
- Determine whether there is a history of impulse control problems (e.g., substance use disorder, aggressive behaviour, risk-taking, sexual acting out).
- Explicitly identify any current protective factors at the individual, family, work and community level.

Table 1 provides a series of helpful questions that can guide the risk 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 1: Interviewing for Suicidal Ideation, Intent and Plan(s)

Frequency, Intensity, Duration of Suicide Ideation

- Have you ever thought about trying to hurt yourself?
- Have you ever wished you were dead?
- Do you ever have thoughts of killing yourself – thoughts of suicide?
- How often do you think about suicide – daily, weekly or monthly?
- 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?
- Do you intend to hurt yourself?
- Have you ever attempted suicide?

Intention

- Do you have any intention of acting on the thoughts of suicide?
- How strong is your intent?

Specificity of Plan(s)

- Do you have a plan to hurt yourself? Do you have a plan to kill yourself?
- When, where, and how?
- Availability of method(s): 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? How often do you feel out of control?
- When you felt out of control, what were you doing? Were you drinking, using any substances?

Reasons for Living and Dying

- Have you ever thought that life was not worth living?
- What's kept you going in the past when you've had these thoughts?
- What keeps you alive right now? What keeps you going?

(Source: Rudd, 1998)

The CASE Approach

The Chronological Assessment of Suicide Events (CASE Approach; Shea, 1998, 1999) provides a useful framework for interviewing about suicidal ideation and behaviours. The CASE Approach guides clinicians to elicit information in a manner that enhances the validity of information a client provides, across the following four time frames: presenting suicidal ideation/behaviours, recent suicidal ideation/behaviours, past suicidal ideation/behaviours, and immediate suicidal ideation.

The CASE Approach incorporates the following specific interviewing techniques to enhance the validity of elicited information: behavioural incidents; gentle assumptions; and denial of the specific.

1. **Behavioural incidents**: There is recognition that clients may be more likely to present distorted or inaccurate information when a clinician asks for opinions of events. As such, the clinician is encouraged to ask about specific behavioural descriptions, and to ask questions about specific facts, details, or trains of thoughts (e.g., "when you say you 'threw a fit', what exactly did you do?"; "exactly how many pills did you take?"; "what did you do next?") rather than opinions. Using this technique, the clinician can recreate an episode step by step, using a series of behavioural incidents.
2. **Gentle assumptions**: The use of gentle assumptions is encouraged when a clinician suspects that a client may be hesitant to disclose a specific behaviour. In this strategy, the clinician assumes that the potentially embarrassing behaviour is occurring, and frames questions accordingly (e.g., "what other ways have you thought of killing yourself?" rather than "do you think of other ways to kill yourself?"; "what types of street drugs do you like to use?" rather than "do you use street drugs").

3. **Denial of the specific**: Denial of the specific involves the use of specific questions ("have you thought of overdosing?"; "have you thought of shooting yourself") following a client's denial of a general question ("have you thought of killing yourself"). This technique is based upon the recognition that specific questions can trigger client's memories, and also that it is harder to falsely deny a specific (as opposed to generic) question.

Screening for Suicide Risk

While no clinical rating scale can predict suicide in an individual, the information that is gathered can provide a useful adjunct to overall suicide risk assessment efforts. Limited evidence suggests that the use of tools like SAD PERSONS (Patterson et al., 1983), especially modified versions which also consider hopelessness, history of psychiatric care, drug addiction, "seriousness" of attempt, and affirmative or ambivalent answers when questioned about future intent, can meaningfully contribute to decision-making about whether to hospitalize an individual at risk for suicide (Hockberger & Rothstein, 1988).

SAD PERSONS

SAD PERSONS is a commonly used tool for screening for risk for suicide (Patterson et al, 1983). A high score on this scale can serve as a signal to seek a psychiatric consultation for a more thorough risk assessment.

S Sex

Men kill themselves four times more often than women, although women make attempts three times more often than men.

A Age

High-risk groups: 15 to 24 year olds, 45 years or older, and the elderly.

D Depression

Depression is very common among those who attempt or die by suicide. A mood disorder, especially in the depressive phase, is the diagnosis most commonly associated with a death by suicide (APA, 2003).

P Previous attempts

A past suicide attempt is one of the major risk factors for future suicide attempts and deaths.

E ETOH

ETOH (alcohol) is a risk factor for suicide. Studies have found alcohol to be present in 20-50 per cent of all persons who die by suicide (APA, 2003).

R Rational thinking loss

Any mental impairment (e.g. psychosis, hallucinations or delusions) severely affects judgment and rational thought and endangers the individual.

S Social supports lacking

A suicidal person often lacks significant others (friends, relatives), meaningful employment, and community supports.

O Organized plan

The presence of a specific plan for suicide (date, place, and means) signifies a person at high risk.

N No spouse

Studies indicate that individuals who are widowed, separated, divorced, or single are at greater risk than those who are married.

S Sickness

Chronic, debilitating, and severe illness is a risk factor.

Screening for Depression

Not all individuals who attempt suicide or die by suicide are depressed; however, depressive symptoms – which are present in 54 to 85 per cent of suicides – are significant risk factors. The following mnemonic can assist in screening for depression-related symptoms:

SIGECAPS

- **S** Sleep disturbance (excessive sleeping, early morning awakening, insomnia)
- **I** Interest reduced (reduced pleasure or enjoyment in previously enjoyed activities)
- **G** Guilt and self-blame
- **E** Energy loss and fatigue (e.g., lack of energy to carry out day-to-day activities)
- **C** Concentration problems (e.g., lack of the ability to concentrate on work)
- **A** Appetite changes (e.g., reduced or increased appetite or changes in weight)
- **P** Psychomotor retardation/agitation (e.g., slowing down of the pace of normal activities, or excessive agitation)
- **S** Suicidal thoughts

Collaborative Assessment and Management of Suicidality (CAMS)

The Collaborative Assessment and Management of Suicidality (CAMS; Jobes et al., 1998; Jobes, 2000) is a clinical protocol that is structured to quickly identify and actively engage suicidal clients in their own clinical care. CAMS shifts away from the traditional (expert-driven, one-way) approach to assessing and treating suicide risk by emphasizing the collaborative nature of assessing and problem-solving treatment planning. The clinician and client find a way to organize and bring meaning to the client's various feelings, perceptions, and impulses related to suicide, and develop effective management strategies for staying safe and using coping skills and treatment to deal with underlying factors and issues.

Determining Capacity and Commitment for Future Planning

As part of the risk assessment, it is helpful to determine a client's capacity and commitment for future planning. For example, does the client have plans for the next couple of hours, the next day, and the next week? For clients with clear ideation and a plan, but unclear intent, it can be helpful to explore factors that are meaningful in the client's life, and that can reframe the focus from wanting to die to an appreciation of reasons to live (e.g., assisting in making plans to keep an appointment with a therapist, pick up a disability cheque, keep a social commitment).

The Personal Meaning of Suicidal Behaviour

In order to develop a plan for safety, 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 person's life. For example, for someone who feels out of control, suicidal behaviour may represent a means to gain control. Key themes underlying suicidal behaviour include escape, relief, power, and control. Table 2 highlights some additional motives that may contribute to suicidal behaviour.

TABLE 2: The Personal Meaning of Suicide

Loss of Control Leading to Feelings of Helplessness and Hopelessness

- Response to a perceived irreplaceable loss of an important relationship
- Desire to experience relief or escape from unbearable pain
- Response to abusive treatment from another
- Self-reproach

Revenge Against Another Person

- Belief that the act of suicide will cause the offending party to feel "sorry"

Reunion With a Dead Loved One

- Desire to counter a sense of loneliness or loss
- Desire to be reunited with the loved one and to escape the pain of loss

Family Context

- Perception of being the cause of others' problems (e.g., 'they're better off without me')
- Attempts to distract the family from other problems (e.g., divorce, legal issues)
- Response to perception that they are not wanted or needed

Anticipatory Loss

- Actual or perceived ending of a relationship
- Terminal illness (their own or someone they love)

3.4 Clinical Decision-Making Summary

A Risk Assessment Matrix is presented in Table 3. This matrix outlines a number of variables that can assist clinicians in determining level of suicide risk, and in determining 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 client 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 protective factors 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.

Assessment of primary, secondary, and situational risk factors, as well as protective factors and existing resources should be conducted with each client on an individual basis. The risk level that is determined is based on a combination of a sound knowledge of risk and protective factors and clinical judgment. At times, a clinician may rely on their "gut feeling" to partially inform risk assessment.

Suicidal behaviours are symptoms of underlying difficulties; as such, interventions must be tailored to address the identifiable factors and underlying conditions. Treatment planning will take into account the level of risk, the age of the person, the mental disorder, the availability of support, as well as cultural considerations. The key tasks are to minimize risk through risk reduction approaches, consult and/or refer, manage the underlying factors, monitor and follow-up. Ongoing monitoring and reassessment of risk levels is essential as situational factors may change and level of risk increases or decreases.

TABLE 3: Risk Assessment Matrix

	Mild	Moderate	High/Imminent
Ideation	Periodic intense thoughts of death or not wanting to live, that last a short while.	Regularly occurring, intense thoughts of death and/or wanting to die, that are often difficult to dispel.	Thoughts of death or wanting to die are very intense and 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 threats. Ambivalent about dying.	Has imminent date/time in mind. Clear threats. Doesn't want to live. Wants to die.
Method/Lethality	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, angry).
Level of Emotional Distress	Mild emotional hurt.	Moderately intense.	Unbearable emotional distress or despair. Feels rejected, unconnected and without support.
Support/ Protective Factors	Feels cared for by family, peers and/or significant others.	Minimal or fragile support. Moderate conflict with family, peers and/or significant others.	Intense conflict with family, peers and/or significant others. Socially isolated.
Previous Attempt	None.	One previous attempt. Some suicidal behaviour.	Previous attempts.
Reason to Live/Hope	Wants thing to change and has some hope. Has some future plans.	Pessimistic. Vague, negative future plans.	Feels hopeless, helpless, powerless. Sees future as meaningless, empty.
Other Risk Factors	Diagnosed mental disorder. Family history of suicidal behaviour. Suicidal friends. Current loss. Unresolved grief. Substance use. Current relationship problems. Recent criminal charges. Negative attitudes regarding help-seeking. Significant others do not take the client's suicidality seriously. Violence/homicidal ideation. Pattern of impulsive behaviour. Current impairment in thinking (psychosis).		

(Adapted from the Regional MCFD Risk Assessment Form)

Section Four

Managing Safety and Treatment 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 support and supervision in the home and if 24 hour acute care/community crisis stabilization/secure protected environment is available and accessible as required.
- When high risk does not dictate hospitalization, the intensity of outpatient treatment should vary in accordance with risk indicators (e.g., more frequent appointments, telephone contacts, concurrent individual and group treatment). 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.

4.1 Safety Planning

Suicidal crises require clinicians to make a judgment regarding the degree of risk for suicide. Risk assessment findings inform the development of a safety plan and guide subsequent treatment planning. Short-term treatment for suicidal ideation or related symptomatology such as depression, hopelessness, or loneliness should focus on problem-solving approaches. Regardless of therapeutic orientation, a deliberate effort should be made to articulate treatment targets related to both suicidality (e.g., suicide ideation, attempts, related self-destructive and self-mutilatory behaviours) and contributing factors (e.g., depression, hopelessness, anxiety, and anger; Rudd et al., 1999).

Assessment of the 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 client and family members to ensure that the person at risk does not have access to firearms, poisonous substances, or lethal doses of medications. Clinicians can play an important role in encouraging family members to reduce access to lethal methods through the safe storage and/or removal of medications and firearms from the homes of suicidal individuals. 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 (Berman, 1994).

Short-term crisis intervention is aimed at protecting the client from impulsive behaviour and reducing or eliminating factors contributing to the crisis. Regardless of the degree of risk, the clinician should develop a safety plan (and revisit when/if level of risk changes). The clinician should also be proactive in identifying, educating and mobilizing the necessary family and community resources, or initiating the process of voluntary or involuntary hospitalization if required.

Safety Plans

Safety plans are proactive strategies, typically developed in collaboration with the clinician in advance of any crises, that serve to articulate what the client will do and who the client will contact when faced with suicidal urges. A template for a safety plan, which can be copied and provided to clients (and their family significant others) is presented in Table 4. By explicitly anticipating the possibility that clients may face overwhelming feelings during the course of treatment, safety plans provide an excellent opportunity to rehearse problem-solving and proactive coping strategies. Some examples of individuals and agencies that could be included in the safety plan include professional counselors, family physician, 24-hour emergency services, friends or peers, religious or spiritual advisors, and family support systems (Paivenan, 2000).

TABLE 4: Safety Plan

Safety Plan

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

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

2. Remind myself of my reasons for living:

3. Call a friend or family member:

   Name: Phone:

4. Call a backup person if person above is not available:

   Name: Phone:

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

   Name: Phone:

6. Call my local crisis line:

   Phone:

7. Go somewhere I am safe:

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

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

No–Harm Contracts

A "no-harm" or "no-suicide" contract is based on a statement from the client that he or she will not harm him or herself, or will contact the clinician or a specified key person, if she or he feels unable to maintain his or her own safety. There is no clear empirical evidence on the effectiveness of no-harm contracts (APA, 2003). In spite of best efforts, clients are not always able to adhere to a contract for various reasons (e.g., due to feeling overwhelmed, cognitive distortions and/or co-existent pathologies). A person who is determined to kill him/herself may sign such a contract to avoid the detection of suicidal intent. The contract against suicide may thus falsely relieve the concern of the clinician and support system, and lower clinician/support system vigilance without having any beneficial effect on the client's suicidal intent. Given the above limitations, the use of no-harm or no-suicide contracts is not recommended.

Intervention Approaches for Ensuring Safety: Non-directive, Cooperative, and Directive

Based on the suicide risk assessment findings, the clinician should determine the nature and level of intervention required in order to maximize the client's safety. A clinician may take an approach that is non-directive, cooperative or directive (Ramsay et al., 1996).

Non-Directive: In this approach the primary impetus for creating the safety plan is the person at risk. The clinician may encourage this planning by saying things like: "What would you like to do now?" or "What do you see as a solution?" The clinician offers ideas and suggestions, but the client is generally taking the lead. This approach is especially effective if the client has highly developed internal resources (e.g., coping skills, problem-solving skills, cognitive abilities), which are reasserting themselves during the clinical encounter.

The non-directive approach can be used when:

- suicide risk is mild to moderate;
- stress and symptoms are low;
- thought process is clear;
- the client has identifiable internal resources (e.g., coping skills); and
- the client has identifiable external resources (e.g., supports).

Cooperative Approach: With this approach, there is a shared responsibility for deciding on a safety plan. The clinician and client may brainstorm and discuss various alternatives. This approach is conducive to supporting the client to access their own internal resources, especially when there has been evidence of these strengths and competencies during the overall assessment (both current and past) and intervention process.

The cooperative approach can be used when:

- suicide risk is moderate to high;
- stress and symptoms are moderate;
- thought process is clouded;
- internal resources are not immediately available to the client; and
- the client identifies external resources.

Directive Approach: With this approach, the clincian takes a much more active part in the safety planning because the person at risk is unable to do so. The clinician may offer specific alternatives and ask the client to pick one. In some cases, the caregiver may only offer one plan of action. Input from the client is still sought; however, the clinician takes charge of the safety plan (e.g., the clinician may need to take the person at risk to the hospital, or call the police/RCMP). Using this approach does not mean giving orders, dismissing self-determination, or acting without sensitivity, but it may mean being firm and very directive about the next steps required for the client's safety.

The directive approach should be taken when:

- suicide risk is high to imminent;
- stress and symptoms are high;
- thought process is confused; and
- internal and external resources are not identified.

4.2 Clients at High or Imminent Risk

Those clients who are at high or imminent risk (see Table 5) require immediate evaluation for secure environment or hospitalization.

TABLE 5: Factors Associated with Imminent Risk for Attempted Suicide or Suicide

Direct indices of imminent risk for suicide or attempted suicide

- Suicide threats
- Suicide planning or preparation
- Suicide attempt in the last year, especially if suicide intent expressed at time
- Suicide ideation

Indirect indices of imminent risk for suicide or attempted suicide

- Client's shift into suicide or attempted suicide risk
- Recent disruption or loss of interpersonal relationships; negative environmental changes in past month
- Indifference to or dissatisfactionwith therapy; elopements and early pass return by hospitalized patients
- Current hopelessness and/or anger; increased psychological perturbation
- Recent medical care (e.g. health problems, recent diagnosis)
- Indirect references to own death; arrangements for death

Circumstances associated with suicide or attempted suicide in the next several hours or days

- Major depression with:
  - Severe agitation, psychic anxiety, panic attacks; severe obsessive ruminating or compulsive behaviours
  - Chronic insomnia
  - Diminished concentration, indecision
  - Persistant inability to experience pleasure
- Alcohol consumption
- Suicide note written or in progress
- Methods available or easily obtained
- Isolation
- Precautions against discovery or intervention; deception or concealment about timing and place
- First twenty-four hours of jail incarceration
- Recent media publicity about suicide

(Source: Linehan, 1993)

Recommendations for Hospitalization or other Secure Protected Environments

In cases of high or imminent suicide risk, the issue of safety is paramount, and may warrant treatment of the client in an in-patient setting (e.g., in a hospital or other secure protected environment such as a community crisis stabilization unit). Recommendations for hospitalization or other secure protection may also be indicated when treatment of a serious underlying psychiatric disorder (e.g., psychosis or severe depression) is required. Additional considerations for determining the need for hospitalization include (Linehan et al., 1993):

- The client is in a psychotic state and is threatening suicide.
- 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 dosage.

- The suicidal client is not responding to outpatient 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 hospitalization.
- There is existing psychosis and the client cannot cope with such a state, the client has little or no social support, and the client is suicidal.

Table 6 provides a quick reference for indicators of the need for intensive levels of care, including hospitalization.

TABLE 6: 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/event
- inability to maintain a safety plan

Psychopathology

- depression – severe or comorbid
- bipolar illness
- substance use issues
- psychosis
- multiple diagnoses
- severe anxiety

Past History

- previous difficulty following through or failure with out-patient treatment
- past suicide attempt

Psychological Characteristics

- hopelessness
- aggression/hostility

Family Problems

- abuse, violence
- severe, acute, relationship breakdown in the family
- significant others unable/unwilling to protect or monitor client

Admission as an Involuntary Patient

When the client 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 (involuntary admission and treatment) under the *Mental Health Act*. In order to be considered for committal, a physician must examine the patient. 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[13];
- 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.

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 person is acting in a manner likely to endanger his or her own safety or that of others, and is apparently suffering from a 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.

[13] 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 Ministry of Health. A complete list is appended.

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 requires the police to apprehend and transport the person to a designated psychiatric facility for an involuntary assessment. This is used when it is not otherwise possible without unreasonable delay for a physician to do an examination or for the police to exercise their powers.

4.3 Treatment Planning

A treatment plan will incorporate the clinicians' assessment of the strengths and weakness of the client's life situation, including information on risk and protective factors. The plan is designed to address the specific requirements of each individual client and his or her situation. Four key elements should be considered in developing a treatment plan (Jacobs, 1999).

1. Collect Data before Treatment Planning

The reasons underlying the attempt or ideation need to be viewed and understood from the client's perspective. Clients benefit from an opportunity to discuss their self-destructive ideas and feelings; in fact, this is one of the most self-protective actions that a suicidal client can take (Miller et al., 1998).

2. Identify Range of Treatment Alternatives

If underlying psychopathology is suspected, a mental status assessment is required. Assessment may also include psychological testing and further information on psychosocial and family history. Pharmacological treatment may be indicated. The clinician may need to access input from other professionals (e.g., psychiatrist) and from family/significant others.

3. Involve Clients and Family in the Treatment Planning Process

Use individual and family approaches, including psychoeducation programs to treat the underlying factors or disorder (e.g., depression education, including self-management information). 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 client's difficulties. Acknowledge their helpful contributions. Ensure that the family is aware of the importance of restricting the client's access to lethal means. Provide clients and families with the accompanying document, *Coping with Suicidal Thoughts.*

4. Incorporate the Most Promising Treatment into the Plan

Focus on improving problem-solving and social functioning using empirically validated treatment approaches such as cognitive behavioural treatment. Assisting the client to engage with supportive social groups in the community is an important part of a strategy for involving the client with a connected and caring environment.

Chain Analysis: A Treatment Planning Strategy

Clients who present with suicidality often present with multiple and complex difficulties which may include mental health difficulties, substance use problems, disrupted social support systems, and poor coping skills. By definition, suicidal clients present in crisis. As such, it can be difficult for the clinician to identify and prioritize targets for treatment, given the myriad of presenting difficulties. One strategy that can assist the clinician in identifying a hierarchy of treatment targets is the use of a chain analysis of suicidal behaviour/ideation. Chain

analysis (also referred to as behavioural chain analysis; see Linehan, 1993) is an assessment strategy that helps to identify the antecedents, maintaining variables, and consequences of a particular problem behaviour. Chain analysis involves working with the client to collaboratively identify and describe in detail the following:

1. Specific **PROBLEM BEHAVIOUR** (e.g., parasuicidal behaviour such as cutting; thoughts about suicide; suicide attempt).
2. **PRECIPITATING EVENT** that started the chain of behaviour (e.g.,what prompting event in the environment resulted in the client becoming acutely suicidal?).
3. **VULNERABILITY FACTORS** that occurred before the precipitating event, and made the client more vulnerable to a problematic chain of events (e.g., unbalanced eating or sleeping; use of drugs; recent losses; chronic pain).
4. **CHAIN OF EVENTS** (thoughts, feelings and actions) that led up to the problem behaviour (e.g., what exact thought, belief, feeling, or action followed the precipitating event? what thought, feeling, or action followed that? what next?).
5. The short- and long-term **CONSEQUENCES** of the behaviour, both with respect to how others (e.g., family, friends) and the client reacted.
6. **Different SOLUTIONS** to the problem.
7. **PREVENTION STRATEGY** for keeping the chain from starting by reducing vulnerability to the chain and by problem-solving the links in different ways.
8. Ways to **REPAIR** any negative consequences of the problem behaviour.

(Adapted from Linehan, 1993)

Throughout the process of completing a chain analysis, the clinician identifies ways in which the client could have problem-solved difficulties differently, such that the chain could have either been avoided altogether, or managed in an alternate matter such that the end result was not suicidal behaviour. For example, as the clinician is working through each 'link' in the chain, he or she highlights to the client more adaptive ways of managing thoughts, feelings and actions.

The process of completing a chain analysis can assist the clinician in identifying a hierarchy of treatment targets, such that 'links' in the chain that are more proximally connected to the suicidal behaviour are assigned high priority. Completion of multiple chain analyses can also be helpful in identifying common themes and areas that treatment efforts can focus on. For example, the use of repeat chain analyses for a client with chronic suicidality can assist both the clinician and client in identifying and recognizing recurrent patterns of behaviour, ways of coping, and situations that contribute to increased suicidality.

Anticipating Treatment Disruptions

Clinicians should anticipate various disruptions during the course of treatment with suicidal clients (Rudd et al., 2001). Treatment disruptions include anything that disrupts the ability to conduct outpatient treatment in a predictable, consistent and reliable manner and include:

- frequently missed appointments;
- rescheduled appointments;
- brief appointments;
- appointments of inordinate length (e.g., a couple of hours);
- an inordinate number of phone calls;
- recurrent crises that distract from continuity in the treatment agenda;

- The need for frequent consultations (e.g. psychiatric and otherwise) and recurrent evaluations for hospitalization;
- Frequent hospitalizations;
- Persistent hostility and anger directed at the clinician (this can also be used as part of the treatment, versus a disruption); and
- Failure to complete homework assignments (also can be part of the treatment).

Treatment disruptions should be documented as part of the clinical record, noting the frequency and duration of the problem, whether or not it was discussed, and the nature of the subsequent response. **These disruptions should be addressed with the client in a non-threatening manner.**

1. State the problem clearly, making it a treatment issue, not a problem with the client individually.
2. Frame it within the context of the client's current emotional pain. The disruptions are a function of the very problems that brought the client to treatment.
3. Request any needed clarification from the client until both client and clinician agree with respect to the specific problem (e.g. maintain an alliance).
4. Offer a specific solution.
5. Request any needed clarification from the client until both client and clinician agree with respect to the solution.
6. Reinforce the client's ability to identify, discuss, and resolve the problem

(Source: Rudd et al., 2001).

4.4 Mental Disorders Associated with Suicide

The clinician working with a suicidal client requires a clear diagnostic understanding of the client (Kernberg, 1994), given that Axis I psychiatric disorders – particularly depression - comprise risk factors for suicide and suicidal behaviour (Tanney, 2000; Mann et al, 1999; Morrant, 1999; Redfield Jamison, 1999b). Axis II personality disorders, particularly borderline personality disorder, are also strongly correlated with suicidal behaviour (Linehan, 1993). Suicide risk is compounded by the presence of substance use disorders (Weiss & Hufford, 1999). Evaluation of DSM-IV Axis I and Axis II diagnoses, and associated symptomatology should be documented. Consultation with a psychologist or psychiatrist can provide clarification around diagnosis and recommended treatment. Furthermore, a qualified medical practitioner should provide a full medical examination, to assess for and to rule out medical issues which are known to have a relationship to depression and anxiety (e.g., undiagnosed diabetes, thyroid dysfunction, or iron/B12 deficiency). A qualified medical practitioner and/or psychiatrist should also be consulted concerning the appropriateness of medication.

The following disorders will be briefly addressed in the following sections:

Axis I: Clinical Disorders
Mood Disorders
Major Depressive Disorder
Bipolar Disorder
Substance Use Disorders
Psychosis

Axis II: Personality Disorders
Borderline Personality Disorder
Antisocial Personality Disorder

Axis I: Clinical Disorders

Mood Disorders

Mood disorders, especially in combination with alcohol and drug abuse, are by far the most common psychiatric conditions associated with suicide (APA, 2003, Redfield Jamison, 1999).

Major Depressive Disorder

Each year, 1 in 25 British Columbians will have a depressive illness (Ministry of Health Provincial Depression Strategy, Phase 1 Report, October, 2002). Depression is a debilitating and potentially life-threatening illness. It is estimated that up to 15 per cent of severely depressed persons will ultimately die by suicide (Stahl, 1996). Depression can be successfully treated, but it requires appropriate assessment before therapy can be initiated.

Given the high correlation between suicidal behaviour and depression, it is important for the clinician to recognize depression as part of their overall suicide prevention efforts. It is important for the clinician to routinely assess for depression. Assessment tools designed to assess depression, hopelessness, suicidal ideation and reasons for living are commercially available for use by qualified mental health professionals (see Resources). The BC Ministry of Health also has a set of clinical practice guidelines, titled the *Diagnosis and Management of Major Depressive Disorder*[14]. These assessment tools are not intended to replace a carefully conducted clinical interview; however, they can complement the overall risk assessment process.

To receive a DSM-IV diagnosis for a Major Depressive Episode, an individual must present with five (or more) of the following symptoms:

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feeling sad or empty) or observations made by others (e.g., appearing tearful). In children and adolescents, mood may present as irritable mood.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day, as indicated by either subjective reports or observations made by others.
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 per cent of body weight in a month), or decrease or increase in appetite nearly every day. In children, this may present as failure to make expected weight gains.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

[14] See www.health.gov.bc.ca/msp/protoguides/gps/depression.pdf.

The symptoms must be present during the same 2-week period, and one of the symptoms must be either depressed mood or loss of interest or pleasure.

With respect to depression, the following symptom clusters should be routinely assessed (Stahl, 1996):

- **Mood:** Assess the quality of the person's mood, the degree of mood change from the person's usual mood state, and the duration of the abnormal mood. Persons with depression generally experience a markedly depressed or indifferent mood.
- **Vegetative features:** Assess for changes in the person's sleep pattern, appetite/weight, and sex drive.
- **Cognitive features:** Assess the person's attention span, their frustration tolerance, and memory. Also assess for the presence of negative distortions and cognitive constriction. Persons with depression typically experience difficulty in their ability to concentrate and maintain attention. They may also have a pessimistic view of the future, and frequently experience low self-esteem and self-confidence. Individuals who are hurting emotionally may think poorly of themselves, and act in ways that contribute to others thinking poorly of them.
- **Impulse control:** Inquire about perceived ability to control suicidal and/or homicidal impulses. The use of alcohol or recreational drugs can increase the risk for suicide secondary to the disinhibition associated with use of substances.
- **Behavioural features:** Assess level of motivation, capacity for experiencing pleasure or enjoyment, and level of energy. Persons with depression experience a loss of interest or enjoyment, and have reduced energy that leads to fatigue.
- **Physical/somatic features:** Symptoms such as headache, stomach ache and muscle tension may be present in persons with depressive disorders.

Recommended treatment for major depression involves the use of cognitive-behavioural therapy, in combination with self-management support and antidepressant medication. Section 4.5 provides a more detailed overview of specific treatment approaches, including cognitive behavioural treatment (CBT), in the management of suicidal behaviour.

Bipolar Disorder

A DSM-IV diagnosis of Bipolar Disorder requires the presence of a distinct period of abnormally and persistently elevated, expansive, or irritable mood which lasts at least 4 days (hypomania) or 7 days (mania), and includes three (or more) of the following symptoms:

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
3. More talkative than usual, or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli).
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

At least one in four people with severe bipolar illness will attempt suicide (Goodwin & Jamison, 1990), with females being at greater risk than males (Redfield Jamison, 1999b). Not uncommonly, individuals with bipolar illness may deny their illness and/or refuse medications, leaving them at increased risk for suicide. High-risk periods for suicidal behaviour include the depressive phase of this disorder and the immediate period thereafter, where improvement can be noted (Redfield Jamison, 1999b).

Substance Use Disorders

Problematic substance use is correlated with suicide and suicide attempts. Suicide mortality rates among alcoholics are six times those of the general population. Suicide is more likely to occur among individuals with alcoholism who suffer from a depressive disorder, than in those with major depression or alcoholism alone (APA, 2003). Abuse of other substances is also associated with increased risk for suicide, particularly among young adults. Substance use disorders, in conjunction with other Axis I or II psychiatric disorders (e.g., depression, anxiety disorder, schizophrenia) can contribute to increased psychological impairment and may compromise motivation to attend treatment, both of which can exacerbate risk for suicide (Kaplan & Sadock, 1998; Tanney, 2000. As such, substance use should be reduced to the lowest possible level.

Identification of Substance Abuse or Dependence

Many substances (including recreational and inappropriate use of prescription medications) can cause neuropsychiatric symptoms similar to those of common psychiatric disorders (e.g., hallucinations, depression, euphoria, and paranoia)[15]. Alcohol and drug use can worsen or induce psychiatric symptoms. Persons may use substances to alleviate distressing symptoms of an underlying mental disorder (e.g. anxiety). There is speculation that substance use disinhibits rational protective systems against self-harm, or acts as a depressant which magnifies already disturbed emotional perspectives on a stressful situation (Tanney, 2000).

To establish an accurate diagnosis, clinicians must discriminate between psychiatric disorders and psychiatric symptoms caused by alcohol or drug use. To do so, a thorough history of substance use and psychiatric history must be completed. Information and assessment data should be obtained from multiple sources, including reports of family members/significant others, clinician observations of signs/symptoms, from standardized substance use assessment tools, and from substance use experts.

Substance abuse is defined by DSM-IV as being a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household).
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of Intoxication, physical fights).

Substance dependence is more severe than substance abuse, and requires three (or more) of the following to occur at any time during the same 12-month period:

1. Tolerance, as defined by either of the following:
   a. a need for markedly increased amounts of the substance to achieve intoxication or desired effect, or
   b. markedly diminished effect with continued use of the same amount of the substance.

[15] For example, see *Crystal Meth and Other Amphetamines: An Integrated B.C. Strategy* (Ministry of Health, 2004).

2. Withdrawal, as manifested by either of the following:
   a. the characteristic withdrawal syndrome for the substance, or
   b. the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Current best practices recommend a multi-level assessment of substance use issues (Health Canada, 2002). An initial screening for substance use issues can be undertaken using questions such as:

- Have you ever had any problems related to your use of alcohol or other drugs?
- Has a relative, friend, doctor, or other health worker been concerned about your drinking or other drug use, or suggested cutting down?
- Have you ever said to another person, "No, I don't have an alcohol (or drug problem)" when, at the same time, You questioned yourself and felt, "maybe I do have a problem"?

An affirmative answer to any of these questions should prompt more detailed interviewing, including the use of a brief screening instrument such as the Michigan Alcohol Screening Test (MAST), the Drug Abuse Screening Test (DAST), and The Medical Triggers Screening Tool (see Resources).

If there is indication of a substance use problem, a more comprehensive assessment is justified. The clinician should determine if substance use is present and ascertain what effect the substance use has on aspects of the client's life. The assessment interview should focus on the underlying reasons why the client is using substances, and should clarify details of usage (e.g., types of substances used; onset; pattern of use; context; progression; and consequences).

Treatment Implications

Motivational interviewing is an approach that acknowledges clients' readiness for change, and in combination with other psychosocial interventions, represents a promising intervention strategy for working with clients who abuse substances. In addition, self-help and 12-step programs, which are available in most communities, can serve an important role in reducing isolation and building social support. Specialized alcohol and drug services (e.g., counselling, education, residential treatment) may also be required.

When substance use disorders co-occur with mood and anxiety disorders (with the exception of posttraumatic stress disorder), it is recommended that a sequencing of interventions be used, beginning with the substance use problem but with close monitoring of the comorbid mental disorder (Health Canada, 2002). Adjustments in treatment should be made if the mood disorder does not improve following an improvement in the substance use disorder. When the co-occurring condition is posttraumatic stress disorder, it is recommended that both disorders be dealt with concurrently. In both cases, cognitive behavioural therapy (CBT) is recommended.

When the co-occurring condition is a mental disorder such as schizophrenia, it is recommended that interventions be planned and implemented concurrently, using a range of services in a staged approach which includes motivational interviewing, CBT, harm reduction, and comprehensive psychosocial rehabilitation and support.

When the co-occurring disorder is borderline personality disorder, it is recommended that treatment is planned and implemented concurrently, using dialectical behavioural therapy (DBT).

Psychotic Disorders

There is an elevated risk for suicide among individuals with schizophrenia and other psychotic disorders (Tanney, 2000). Depressive symptoms and hopelessness can exacerbate risk for suicidal behaviour among this population. Between 10 and 15 per cent of individuals with schizophrenia die by suicide, while 20-42 per cent of people with schizophrenia attempt suicide (Tsuang et al., 1999). The recommended "best practices" interventions for early psychosis include a combination of low dose antipsychotic medication, cognitive behavioural therapy, psychoeducation, supportive counselling, and family involvement (both for supportive counselling and psychoeducation (see Ministry of Health *Early Psychosis Guidelines for Mental Health Clinicians,* available at www.healthservices.gov.bc.ca/mhd and *Early Psychosis: A Care Guide* at www.carmha.ca). The effectiveness of CBT for psychosis has been demonstrated in several studies (Haddock et al., 1999; Sensky et al., 2000), and shows significant promise for both secondary morbidity and adaptation to the illness (e.g., anxiety, depression), as well as for psychotic symptoms such as hallucinations and delusions.

Clients with schizophrenia are less like than other clients to communicate their suicidal intentions (Tsuang et al., 1999). They are also at increased risk for suicide as a result of command hallucinations (e.g., hearing voices to kill themselves). It is important for the clinical care team to monitor for the presence of command hallucinations by asking questions such as "do voices ever tell you to harm yourself or kill yourself?" and "do you ever feel compelled to do so?"

Treatment Implications

The first episode of psychosis calls for assertive treatment and active case management efforts. Treatment should not end once the psychotic symptoms disappear. It is essential to monitor for potential relapse of psychosis and also to monitor for post-psychotic depression. It is also important to assist the client in becoming reintegrated into everyday social and work routines, which can be a difficult task particularly given that they may feel that their life has been turned upside down by the presence of psychosis.

A multi-disciplinary model of care, using a biopsychosocial treatment approach is strongly recommended. Appropriate support groups, medication, social and spiritual networks and long-term follow-up are also critical elements to treatment planning. Family involvement is highly recommended in treatment efforts with clients. Many clients who live with schizophrenia experience high levels of social isolation due to living alone, being unemployed, and coping with deteriorating health. Engaging family members and other existing supports in the treatment process can help protect against suicide by ensuring support and decreasing isolation during times of crisis.

Axis II: Personality Disorders

Personality disorders comprise a category of mental disorders characterized by enduring, inflexible, and maladaptive personality traits that deviate markedly from cultural expectations, are self-perpetuating, pervade a broad range of situations, and either generate subjective distress or result in significant impairments in social, occupational, or other functioning. Onset is by adolescence or early adulthood. These patterns remain stable across different life situations or circumstances.

Psychological autopsy reports indicate that 31 to 57% of those who die by suicide qualify for an Axis II personality disorder diagnosis. In combination with substance use issues and depression, individuals with a personality disorder are at even greater risk for suicidal behaviour (Tanney, 2000).

Borderline Personality Disorder

Clients diagnosed with Borderline Personality Disorder (BPD) often have recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour (Davis et al., 1999). BPD is considered very difficult to treat and is characterized by instrumental suicidal behaviours (i.e., self-destructive behaviours without lethal intent; Linehan et al., 1993). Individuals with BPD who have concurrent alcohol dependence have been found to be three times as likely to die by suicide when compared to those with BPD alone (Stone, 1993).

Dialectical behaviour therapy (DBT; discussed in section 4.6) holds promise as a treatment for recurrent suicidal and parasuicidal behaviour.

Antisocial Personality Disorder

Antisocial personality disorder, which often starts as a conduct disorder in childhood, is characterized by a pervasive pattern of disregard for the rights of others, a lack of empathy, excessive aggression, pathological lying, and little or no capacity for remorse. Antisocial personality disorder is three times more common in males than in females (Redfield Jamison, 1999).

Individuals diagnosed with antisocial personality disorder are at an increased risk for suicidal behaviours due to their markedly impulsive behaviour; uncontrollable fits of rage; frequent physical fights or unprovoked assaults; reckless behaviours, such as high-risk sexual promiscuity or substance use issues; unstable moods; and extreme irritability (Redfield Jamison, 1999). This combination of mood and behaviour often leads towards a self-destructive pattern for the individual, hence rates of suicide attempts are higher than among individuals without this diagnosis (Tanney, 2000).

Treatment Implications

Clients with personality disorders typically require long-term follow-up and care. Although hospitalization may not be effective in reducing suicide risk in the long term, it can be effective in the short term. Clients suffering from personality disorders can benefit from frequent support combined with consistent limit setting, especially those clients who present with frequent suicide risk. Psychoeducational support groups can also help clients with personality disorders.

4.5. Brief Problem-Solving Approaches

A systematic review of controlled studies examining the effects of treatment for deliberate self-harm concluded that there is insufficient evidence on which to make definitive recommendations regarding the most effective treatment for individuals who have engaged in deliberate self harm (Hawton et al., 2002). Of the few studies that did meet the criteria for methodological rigor in the Cochrane Review, promising results were found for problem-solving therapy

(Hawton et al., 2002), which holds the most promise as a core intervention for suicidal ideation or related symptoms such as depression, hopelessness or loneliness (Rudd, et al., 1999).

Cognitive Behavioural Therapy

Cognitive-behavioural therapy (CBT) integrates a problem-solving component as a core intervention for reducing suicidal ideation, and related symptomatology such as depression, hopelessness, and loneliness. Cognitive-behavioural treatment focuses on the cognitive distortions and deficits that disrupt a client's ability to solve interpersonal problems, as well as on the capacity to regulate emotions (van der Sande et al., 1997). In CBT, clients are actively challenged on their negative beliefs, and their tendency to view themselves, their circumstances and their future in unrealistically negative terms. Goal setting, self-monitoring, homework assignments, and focused skill building in the areas of coping, problem solving, assertiveness, and interpersonal communication, are all key features of this therapeutic approach (Rudd et al., 1999). By actively educating clients about mental disorders such as depression, as well as suicide, and by improving clients' ability to recognize and understand their own self-limiting and negative beliefs, CBT enables clients to become better regulators of their own moods and experiences. Bilsker and Paterson's Antidepressant Skills Workbook (available at www.carmha.ca) provides an excellent example of a user-friendly, self-management guide for clients that is based on CBT principles.

Problem-Solving Skills Training

The development of problem-solving skills aids in reducing suicidal behaviour by making suicide a less viable option (Jobes, 2000). Problem-solving skills training has been shown to improve interpersonal cognitive problem-solving skills by increasing clients' ability to generate alternative courses of action, increasing their sensitivity to the consequences of their behaviour, and assisting clients to respond to everyday interpersonal problems (McLeavy et al., 1994).

Problem-solving skills training is part of overall competency building. Treatment that aims to build client competency includes:

- Educating clients regarding stress reactions.
- Introducing and practicing coping skills such as relaxation, problem-solving skills and social skills.
- Offering opportunities to express emotions including feelings of anger, frustration, guilt, sadness and failure.
- Promoting both group and individual exercises to improve self-esteem and self-efficacy (group treatment helps members reduce their social isolation).

  (Adapted from Rotherham-Borus, 1990)

Solution-Focused Brief Therapy

Solution-focused brief therapy (SFBT) emphasizes solutions, competence, and strength capabilities of the suicidal client. SFBT is a goal-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, and through reflective and careful listening, efforts are made to introduce solution-talk where exceptions to problems are discussed, which can be used as the foundation for finding solutions.

Therapeutic Techniques used in SFBT

- A question-based, individualized approach (e.g., What brings you here today? How can this meeting be helpful to you?).
- The use of the miracle question: If a miracle happened today, and all of the problems and concerns that have brought you here today were to disappear, how would your life be different? What would you notice?

- Utilization of the client's own competencies, strengths, resources, and successes.
- Elicitation of goals, existing resources, and solutions from the client.
- A therapeutic stance necessary of curiosity or 'not knowing'.

Fiske (1998) has applied SFBT to the ten commonalities of suicide as defined by Shneidman (1996; see Table 7) to illustrate how the needs and challenges of the suicidal client might be addressed by SFBT.

TABLE 7: Therapeutic Tasks of Solution-Focused Brief Theraphy (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 the client understand the consequences of suicide.
- Help the 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 the client identify anything that can help relieve pain, even slightly (even those thoughts and activities that may be undesirable or unhealthy - e.g., substance abuse).
- 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 for the client.
- Shift the focus from a problem state to a goal picture (e.g., use of Miracle Question).

The common emotion in suicide is helplessness-hopelessness

- Seek exceptions to feelings of helplessness-hopelessness.
- Explore the degree to which client has the ability to 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.
- Identify the client's reasons to stay alive (e.g., children, spouse, family; the use of the Reasons for Living Inventory by Linehan, Goodstein, Neilson, & Chiles, 1983 may be useful in this regard).

The common perceptual state in suicide is constriction

- Seek opportunities to interrupt perceptual constrictions by redirecting attention from failure and disaster to consideration of accomplishments, strengths and resources.

The common interpersonal act in suicide is communication of intention

- Highlight that communication of intention is not universal, and that communication is not always conveyed in a manner that is understood by the recipient at the time.
- Ask the client about suicidal 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 (or escape)

- 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 pattern in suicide is consistency in lifelong coping patterns

- Even in a crisis situation, seek evidence of a client's coping skills.
- Assume that client can learn from and rely on his or her own accomplishments, even in the midst of pain, fear, and apathy.

(Adapted from: Fiske, 1998)

4.6 Dialectical Behavioural Therapy

Dialectical Behavioural Therapy (DBT) has been developed and evaluated as a comprehensive, behavioural treatment for suicidal and parasuicidal behaviour (Linehan, 1993). DBT includes simultaneous individual and group treatment modalities, and is premised in principles of cognitive, behavioural, and interpersonal therapy.

DBT is based on the view that instrumental suicide is a problem-solving behaviour used to cope with or ameliorate psychic distress. Among chronically suicidal clients, distress tolerance tends to be low and coping resources and responses are limited (Jobes, 2000). Thus, in addition to addressing enduring problems (e.g., underlying mental disorders), treatment for chronic suicide attempts and related behaviours, particularly among those with an Axis II diagnosis such as borderline personality disorder, should be long-term and target identified skills deficits (e.g., inability or reduced ability for emotion regulation, distress tolerance, managing impulsivity, problem-solving, interpersonal assertiveness, anger management; Rudd et al., 1999).

The following are the treatment targets in DBT, listed in order of importance:

- Address high-risk suicidal behaviours. Although self-mutilation and other instrumental suicidal behaviours are 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 (e.g., substance use issues, repetitive antisocial behaviour, illness-producing behaviours).
- Integrate skills learned in group treatment into daily life (e.g., emotion regulation, interpersonal effectiveness, distress tolerance, and self-management).

Treatment strategies that guide the treatment process: 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

Documentation

Good documentation is invaluable to the clinician. It helps clarify the treatment plan and assists with communication to other care providers across the continuum of care. It is important to use a consistent approach to assessing risk and documenting treatment outcomes, incorporating both direct (e.g., suicidal ideation, suicide attempts, instrumental behaviours) and indirect markers of suicidality (e.g., markers of symptomatology, personality traits, or general level of day-to-day functioning).

Suicide risk should be documented at intake, and any time a new occurrence of suicidal behaviour or ideation emerges or when there are changes in mental status, mood, or changes in life situation. Documentation should be clear, legible and detailed enough to provide a clear picture of the client's functioning. Elements of suicide risk documentation include addressing the degree of risk, with support from both objective and subjective data. In order to augment clinical judgment and measure treatment outcomes, the use of sound and reliable risk assessment scales and standardized instruments is recommended at predictable intervals (e.g., Reynolds's Suicide Ideation Questionnaire, the Beck Depression Inventory, Reasons for Living Inventory).

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 or life change
- When family/significant others provide input or concern regarding suicidality
- Whenever the level of care received by the client/patient is significantly changed
- Before treatment termination

Elements of the Suicide Risk Documentation Assessment

- Degree of risk
- Objective data (including risk indicators)
- Subjective data (including strengths)

Diagnostic Considerations

- Working or differential diagnosis

Treatment and Safety Plan for Addressing and Managing Suicide Risk

- Risk-benefit analysis of proposed treatment/options
- Basis for clinical judgment and decision-making
- Medications (e.g., antidepressant, anxiolytic)
- Tests ordered
- Consultations requested (e.g., second opinion on suicidality)
- Precautions
- Reassessment of suicidality
- Reassessment of effectiveness of treatment or options selected.

(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 behaviours with suicidal intent, versus self-mutilating and self-destructive behaviour without suicidal intent. 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 such as personality traits, cognitive rigidity, and problem-solving abilities. Clearly differentiating between acute and chronic variables in the emergence of suicidality helps establish reasonable expectations regarding the treatment outcome and process (Rudd et al., 1999).

4.8 Monitoring Suicidality

It is important to acknowledge the fluctuating nature of suicidal ideation and intent, and to routinely monitor, assess, and document a client's initial and ongoing suicide risk. It is important to note the chronicity of some symptoms (e.g., specific suicidal thoughts with a definitive plan), and to indicate factors that escalate risk

(e.g. emergence of intent, impulsivity) versus those that diminish risk (e.g., lack of intent) (Rudd, et al. 1999). Further, it is essential that the clinician document interventions for maintaining client safety until suicidality has clinically resolved.

For clients with chronic suicidality, the clinician should monitor, assess, and document ongoing risk of suicidality and provide intervention that addresses the chronic nature of the suicidal preoccupations. A detailed conceptualization of the antecedent/maintaining factors of the suicidality and a thorough understanding of the role the suicidality plays in the client's life can assist in providing targeted intervention that addresses the underlying contributors to a client's suicidality. For example, a hospital admission secondary to parasuicidal behaviour may function to 'remove' the client from a stressful home setting – intervention can then be focused on teaching the client more adaptive coping strategies.

The risk for repeat suicide attempts is particularly high in the first few months after discharge from treatment or hospital. Approximately 10% of individuals who have made one attempt make another within 3 months. Suicide attempters constitute a very high risk for suicide, having 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 adult mental health and addiction services and other community emergency resources are invaluable.

Crisis lines and other community emergency response services play a key role in the continuum of mental health and addiction care, and serve an important function in any overall suicide prevention effort, including outpatient management. These types of resources offer suicide intervention services 24 hours a day, and provide timely support to clients experiencing a mental health crisis. Monitoring suicidality can be difficult in rural and northern communities since these communities often have less staff and may also lack after-hours crisis services, including local hospitals or crisis lines. It is important to investigate other accessible resources. Northern and rural communities often rely on volunteers to help with suicide prevention work, and some communities have created their own suicide prevention teams comprised of trained volunteers.

Outpatient Management Considerations for Managing High Risk Suicidal Clients

When providing outpatient mental health and addiction services for high risk suicidal clients, careful consideration should be given to each of the following:

- Recurrent evaluation of risk, and the need for secure environment or hospitalization in circumstances of high or imminent risk.
- 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;
  - improved problem-solving/adaptive coping;
  - improved self-control;
  - improved self-esteem; and
  - establishment and mobilization of an available, accessible support system.
- 24-hour availability of emergency or crisis services for client.
- Consideration of medication if symptomatology persists or worsens.
- Use of telephone contacts.
- Professional consultation as needed.

4.9 Legal Considerations

Clinicians can understandably be concerned about liability issues arising from their work with suicidal clients. The discussion here is offered in order to provide perspective and reassurance, and to reinforce the fact that lawsuits against employees working in mental health settings are relatively rare in British Columbia.

Clinicians have a duty to act in a reasonable and prudent manner to prevent the suicide of their clients (Berman & Cohen-Sandler, 1983). This is accomplished through adherence to sound, evidence-based clinical practice standards, including: caring for the client in alliance-based, non-defensive ways; focusing on the critical elements of clinically based risk-management; clearly documenting assessment, management and intervention approaches; and consulting with other professionals (Gutheil, 1999). The use of consultants, team decision-making and carefully documented assessment of the client's competence to understand the consequences of withholding information about suicidal intent are all important components of good clinical practice (Frances & Miller, 1989). Clinicians must understand that there is no magical "right" way to act in every clinical situation and that for every decision in clinical practice, there are potential risks and benefits (Bongar et al., 1992). The clinician's role is to maximize benefits, and minimize risk to the extent possible.

Section Five

Enhancing Linkages Between Adult Mental Health and Addiction Services and the Community

- Identify the client's network of formal and informal supports.
- Establish proactive relationships among key service providers (e.g. hospital, community mental health and addiction services, physicians, police, correction services, child protection services, alcohol and drug services) and family members in an effort to coordinate services and provide an integrated service delivery system, keeping in mind any legislative requirements regarding information sharing (e.g. Freedom of Information and Protection of Privacy Act).
- To the extent possible, ensure that a seamless transition exists between services and key providers in order to reduce unnecessary disruptions for the suicidal client.

5.1 Integrated Case Management

Integrated case management (sometimes referred to as integrated care management) refers to the process of developing relationships and working collaboratively with members of a team (e.g., hospitals, physicians, clinicians and other service providers, as well as family and other care providers) for the purposes of providing comprehensive, coordinated care to suicidal clients. The individual knowledge and skills of the team members collectively contribute to the therapeutic goals and clinical outcomes of the client. When a client has long-term and complex needs, integrated case management provides a structure for developing and implementing joint decision-making. Clients and their families are the most important members of an integrated care team. Self-help groups, consumer advocacy networks, and other allied support services are also crucial members of the case management team. At times, integrated case management teams also involve multicultural translators and interpreters to support the language and cultural needs of the client. Crisis lines serve as key sources of emotional support and can be included in the case management team.

Integrated case management and collaboration across hospital, community, and other sectors is still a relatively new approach to delivering services. Communities across B.C. continue to develop strategies for successful collaboration between the various services and professionals dedicated to suicide prevention.

5.2 Protocols between Acute Care and Community Mental Health and Addiction Services

Although health authorities are responsible for the delivery of health care services, an agreement between hospital psychiatric/emergency services and adult mental health and addiction services is essential for providing co-ordinated services and continuity of care for those adults in need of services offered by multiple agencies. Development of a protocol can provide guidelines for joint and coordinated care. The agreement should indicate the community service clinicians authorized to have access to their client's files in the acute care setting, as well as community contacts for acute care staff when a suicidal client is admitted to an emergency setting.

Procedures regarding coordination of clinical services should be outlined for hospital emergency room staff, hospital psychiatric unit staff, and adult community mental health and addiction clinicians. At the community level, a suicide protocol represents an agreement about the role and responsibility of each agency should a client's suicidal risk increase. Protocols may be used to mobilize and coordinate a response when a client expresses suicidal ideation and/or suicidal threats or has already attempted suicide. Such a protocol should include representatives from the spectrum of emergency service providers (e.g., police/RCMP, adult mental health and addiction, after-hour program supports, hospital emergency services, and crisis centres). The accompanying document, *Working with the Suicidal Patient: A Guide for Health Care Professionals*, is a useful tool on assessment and management of suicidality for providers without a mental health background, including those that may be working in an acute care/emergency setting.

5.3 Suicide and the Workplace

Suicidality and suicide attempts may manifest in the workplace for a number of reasons. Accumulated workplace stressors may be a precursor to depression and burnout (Jeffrey, 1998, Monk-Cross, 1998), which can elevate risk for suicide. Furthermore, a suicidal client may choose the workplace as a locale for a suicide attempt given that the workplace may provide access to means (e.g., poisons, heavy machinery), as well as distance from family members or other significant others (Employee Assistance Newsletter, 1985).

Following a suicidal crisis, return to work may be as difficult for managers and coworkers as it is for the individual, particularly if a suicide attempt takes place onsite at the workplace. An employee may be concerned about returning to work after a suicide attempt, fearing what their colleagues will think of them (Hughes, 1991).

Workplace managers can make a valuable contribution to suicide prevention efforts by doing the following (Jones, 1996; Rickgarn, 1989):

- Develop workplace policies that articulate recommended procedures and guidelines for dealing with mental health issues, life crises, suicidal crises (threats, attempts), and deaths by suicide.
- Obtain training to recognize mental health problems, including warning signs of suicide.
- Address organizational culture factors that may contribute to elevated stress in the workplace (e.g., bullying, unexpected organizational changes).
- Provide support to employees who are experiencing stress and depression (employees are more likely to seek help if they believe they are being supported).
- Ensure that employees are aware of any special counselling services and other benefits they have available through the workplace (e.g. employee and family assistance programs). Explain that counselling services are confidential, and that information is not shared with the employer without the employee's consent.
- Develop an environment in which co-workers support each other.
- Create a safety protocol that can be utilized in the event an employee experiences a mental health crisis, to ensure their safety and the safety of their co-workers until a clinical assessment occurs.
- Develop and implement return to work and accommodation policies and protocols for employees with mental or physical health difficulties. The reintegration of employees with emotional and/or suicidal crises should be facilitated with respect and sensitivity. A non-punitive, supportive approach enables successful return to work efforts, creates a safe work environment, and contributes to an overall climate of wellness.

When an Employee Dies by Suicide

In the event of a suicide, employees should be given the opportunity to debrief this event, and should be provided with options for further support or counselling. In the human service sector, particular attention should be paid to mental health professionals who experience a peer/colleague suicide since such a loss can be especially complicated for helping professionals (Monk, 2001; Thompson & Brooks, 1990).

Suggested guidelines for handling information about suicide deaths:

- Refrain from sharing specific or sensational detail about the incident.
- Restrict information to the general facts, as they become known.
- Defuse anxiety by framing the suicidal act as a way of coping with significant, unbearable problems and emotional pain.
- Provide information to other employees about where additional help such as written resources (e.g., BC Partners for Mental Health and Addiction Information, at www.heretohelp.bc.ca) and counselling are available.
- Make crisis line numbers available.

(Adapted from Kalafat & Underwood, 1989).

As a proactive measure, the development of workplace 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 workplace property is recommended.

5.4 Media Education Guidelines

One important risk factor associated with 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, 1992). 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, especially dramatic, sensational and repetitive stories about suicide, have been shown to have a statistically significant effect on subsequent occurrences of suicide (Center for Disease Control, 1992).

Responsible media coverage contributes to the reduction of suicide contagion; therefore, in the event of a suicide in the community, clinicians should suggest guidelines to the media regarding accurate and responsible reporting of a completed suicide. While it is acknowledged that providing media commentary and education is often a function delegated to managers and media spokespeople, clinicians are encouraged to familiarize themselves with the principles of responsible media coverage in order to capitalize on any opportunities to educate others about responsible reporting practices in this area. Promoting responsible media coverage also helps prevent blaming tendencies in the media (e.g. the caregiver may be inadvertently blamed for the suicidal death).

Clinicians have the opportunity to influence what might be contained in a media report about suicide. The clinician's goal should be to assist news professionals in their efforts toward responsible and accurate reporting (MMWR, 1994). It is not the news coverage of suicide in itself that causes contagion, but rather the type of news coverage (e.g. sensational and dramatic) that is considered to contribute to the risk of contagion. Media guidelines, representing the consensus of experts based on the research literature, are available in the document *Reporting on Suicide: Recommendations for the Media* (www/afsp.org/education/recommendations/5/index.html).

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, 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.
- Encourage public officials to 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).
- 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 (e.g., 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).
- Focusing on the deceased person's positive characteristics without mentioning the troubles and problems they experienced may make the suicidal behaviour seem attractive to other at-risk persons, particularly those 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.

5.5 Postvention in Mental Health and Addiction Practice

Postvention is the provision of crisis intervention, support, and assistance for those affected by a suicide death (American Association of Suicidology, 1994). It is important to ensure the provision of crisis intervention, support, and assistance for those affected by the suicide or suicidal behaviour of others. This reduces the negative effects of the crisis and protects others who may be at-risk for suicide. Postvention is particularly critical in smaller, rural communities where suicide affects almost everyone in the community either directly or indirectly.

Many signs of grief such as sorrow, fear and anger can be part of a community response to suicide. It can be helpful to develop a community-based plan that involves representatives from key agencies and local leadership to coordinate a committee responsible for developing and maintaining a response plan. Appropriate postvention efforts can contribute to minimizing the negative effects of the crisis and can serve to identify others at-risk. For those who have been affected by the death, community meetings or local gatherings can provide an opportunity for individuals to talk about their feelings and reactions in a safe environment where they do not feel judged (Renaud, 1995). 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 those affected by the death to deal with the trauma and grief; and 3) to assist the community to return to its normal routine.

The clinician can support postvention efforts by observing the following principles:

- Healing takes time and requires patience from survivors and caregivers.
- Facing the pain of the loss and searching for meaning are common tasks and experiences following a suicide.
- Suicidal thoughts and behaviour are often present in survivors. Caregivers need to ask about suicidality and take steps to promote safety.
- There is considerable diversity in how people experience and respond to a suicide. Respecting the uniqueness of each person's grief is important.

(Source: Turley, 1999)

Further postvention guidelines are presented in Table 8.

TABLE 8: Postvention Guidelines

- 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 may be reduced through discussion, counselling and support.
- The aim is not resolution of sorrow. Survivors will need to experience their pain to progress through grief. They may also have feelings of guilt, which are common feelings related to grief caused by suicide deaths.
- Clarify the facts of the suicide, to the extent possible. Encourage and support family/friends to be open about the death being a suicide so that they may grieve appropriately.
- Challenge 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 a person in unbearable pain 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, and 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 known 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.
- Encourage discussion with family and friends (people in their natural support network) 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.

(Adapted from: American Association of Suicidology, 1994)

All communities are encouraged to develop a postvention response plan, outlining the roles and responsibilities of participating community agencies, which serves to guide community action following a death by suicide. These plans should be prepared in advance of a crisis. Table 9 summarizes some key considerations in the development of a postvention response plan.

TABLE 9: Elements of a Community Postvention Committee

- Roles and linkages between community resources need to be defined (e.g., establish a community-wide crisis team).
- The 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 included.
- Mechanisms for identifying others who are at-risk of suicide attempts need to be developed.
- Long-term issues and community problems that impact suicide must be identified so that the committee can advocate on behalf of community development initiatives that protect against suicide.
- A communication plan should describe the process for dealing with the media (e.g., holding a news conference).
- Crisis lines and other local agencies that provide service to those in crisis should be highlighted in all media stories.
- Support for the crisis team and contingency plans should be implemented if more suicides occur, (e.g., debriefing meetings for committee members).

5.6 Suicide Prevention in the Community

Community-based suicide prevention strategies show significant promise for reducing risk for suicide. A community suicide prevention plan includes:

- A community statement supporting the overall suicide prevention plan.
- Protocols and procedures for prevention, intervention, and postvention activities.
- Resource needs assessment and a strategy for acquiring needed resources.
- Evaluation plans and procedures.
- A coordination strategy.

(Source: Ramsay et al., 1997)

Some of these strategies focus on the individual or family, while others are designed to be implemented within the contexts of communities. Individual, family, and community strategies include the following (White & Jodoin, 1998):

Individual and Family Strategies

- Skill-building and support enhancement
- Suicide awareness education
- Support groups for those at risk
- Support groups for families/friends
- Screening and other early detection strategies

Community Strategies

- Community gatekeeper training
- Means restriction
- Media education
- Mental health literacy including public education[16]
- Community participation
- System-wide protocols
- Community development, including development of local resources like crisis lines and other support services, for those at risk.

The clinician can support, and provide leadership in community-based programs aimed at addressing the core known risk factors such as early detection and treatment of depression, prevention of physical/sexual abuse and family violence, prevention and treatment of substance use issues, reduction of racism and other forms of oppression, media education and gun control.

[16] See Mental Health and Addiction Information Plan for Mental Health Literacy at www.healthservices.gov.bc.ca/mhd/pdf/infoplan.pdf.

5.7 Quality Improvement, System Analysis, and Policy Development

Quality Improvement

Follow-up evaluation, research, and quality improvement activities are integral to ensuring the efficiency, effectiveness, and quality of health system interventions. Quality improvement activities can be applied across the spectrum of clinical intervention for suicidal clients (from primary prevention through to postvention). Quality improvement activities encompass quality indicator development and evaluation, as well as the broader implementation and incorporation of quality measures in mental health and addiction care related to suicidal clients.

System Analysis

A further area that warrants attention in the area of suicide prevention is the analysis of system variables – specifically, whether the system presented barriers and challenges to care that culminated in a suicide, with an associated plan to address identified barriers and challenges. Root Cause Analysis and Failure Mode and Effect Analysis are two such tools for examining system responses. Root Cause Analysis (RCA; Taylor-Adams & Vincent, 2004) is a structured process for identifying causal and/or contributing factors that underlie adverse events or critical incidents. RCA follows a defined protocol for identifying contributing factors, and involves a detailed account of events that led up to the incident. Failure Mode and Effect Analysis (FMEA; DeRosier et al., 2002) may involve either retrospective investigations (as in RCA) or prospective analysis to predict 'error modes'.

Policy Development

Organizations and broader health systems have needs for policy development within the area of suicide. *Safety First: The Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (2001) provides a number of recommendations addressing policy and practices within mental health. Key clinical recommendations are highlighted below.

Twelve Points to a Safer Service

(from *Safety First*, 2001)

1. Staff training in the management of risk "both suicide and violence" every 3 years.
2. All patients with severe mental illness and a history of self-harm or violence to receive the most intensive level of care.
3. Individual care plans to specify action to be taken if patient is non-compliant or fails to attend.
4. Prompt access to services for people in crisis and for their families.
5. Assertive outreach teams to prevent loss of contact with vulnerable and high-risk patients.
6. Atypical anti-psychotic medication to be available for all patients with severe mental illness who are non-compliant with "typical" drugs because of side-effects.
7. Strategy for dual-diagnosis covering training on the management of substance misuse, joint working with substance misuse services, and staff with specific responsibility to develop the local service.
8. In-patient wards to remove or cover all ligature points, including all non-collapsible curtain rails.
9. Follow-up within 7 days of discharge from hospital for everyone with severe mental illness or a history of self-harm in the previous 3 months.
10. Patients with a history of self-harm in the last 3 months to receive supplies of medication covering no more than 2 weeks.
11. Local arrangements for information-sharing with criminal justice agencies.
12. Policy ensuring post-incident multi-disciplinary case review and information to be given to families of involved patients.

Section Six

Care for the Clinician

- Clinicians are encouraged to recognize the unique stressors related to working with suicidal clients.
- Clinicians need to remain mindful of transference and countertransference issues within the helping relationship.
- Clinicians are encouraged to seek regular clinical consultation and supervision.
- Clinicians are encouraged to be aware of their vulnerability to various occupational hazards specific to their helping roles; these include burnout and secondary traumatic stress.

Research consistently finds that suicidal statements and behaviours are among the most stressful client behaviours for clinicians. Clinicians must consider, and in some cases adjust both their professional and personal beliefs about suicide and the value of life in order to recognize the importance of suicidal thinking for their clients. That adjustment, coupled with the ambiguity of not knowing whether someone the clinician has come to care for will be safe and alive, can take an enormous toll on the clinicians' self-capacities and spirituality (Pearlman & Saakvitne, 1995). The clinician working with suicidal clients may experience a personal existential crisis regarding the purpose of life and work, including the suicide prevention work they are doing.

6.1 Transference/Countertransference

Transference and countertransference are natural occurrences in treatment. Transference describes a process within the therapeutic encounter when a client projects strong feelings onto the clinician. Countertransference involves the clinician projecting feelings onto the client.

As a result of increasing interaction, clients typically experience specific feelings toward helpers. These feelings may range from admiration and affection to anger and rejection. Some reactions may be due to specific behaviours of the helper, but it is more likely that a transference reaction is taking place. This reaction is a common event in all human relationships where feelings once felt toward someone close to us are now projected on to the immediate helper (Brammer, 1988).

Similarly, the clinician brings his or her personal history, feelings, attitudes, defenses, unconscious processes, conscious reactions, and behaviours to the helping relationship. These characteristics represent a rich resource and serve as an important tool that can assist or interfere with the therapeutic process. The challenges of working with suicidal clients may elicit reactions in the clinician, such as fear, malice, aversion, hate, anxiety and worry. If not identified, these reactions may lead to avoidant or fear-based forms of treatment that are not in the client's best interest (Rudd et. al, 2001), nor ultimately in the clinician's best interests. Consultation with a supervisor or a senior colleague who has experience treating suicidal behaviour is highly recommended as a strategy for managing transference and countertransference issues (APA, 2003).

6.2 Clinical Consultation and Supervision

Clinicians are advised to seek clinical consultation with a peer or supervisor as part of competent clinical practice. This may include scheduling regular consultations with knowledgeable colleagues, and regularly reviewing reactions to clients to ensure that feelings such as hostility, anger or distancing behaviours are not interfering with the therapeutic process. Awareness of these feelings can serve as a barometer of the state of the client, can aid diagnostic formulation, can help clarify how others may respond to the individual, and may facilitate therapeutic intervention (Kernberg, 1994). Regularly scheduled, formal supervision is considered to be the most effective buffer to burnout (MacFadden, 1985) and enhanced clinical practice. Supervision should offer clinicians feedback regarding their performance, case review opportunities and emotional support.

Treatment of a chronically suicidal client presents many challenges to caregivers. Among the most common are anger at being manipulated, fear that the client will die, and fear of being held responsible for the client's actions via a malpractice suit (Frances & Miller, 1989). Supervision provides an opportunity for the clinician to explore and discuss these common feelings and fears.

Supervisors, or clinical consultants, should assist the clinician to separate the meaning of the suicide to him/her from its meaning to their client. A supervisor is always

supervising the therapeutic relationship, never just a client or a clinician. One of the most difficult and painful tasks for the clinician is managing the client's existential despair. It is not possible, nor would it be therapeutic, for most chronically suicidal clients to be hospitalized for the duration of their therapy process, and it is certainly not helpful for the entire treatment to be organized around crises and suicide assessments (Pearlman & Saakvitne, 1995). Recognizing the anxiety that comes from "holding the client's pain," the supervisor can be supportive by offering empathy, perspective, and support to the clinician.

6.3 Occupational Hazards

Burnout

Freudenberger (1980) suggested that burnout is a state of fatigue or frustration brought about by a devotion to a cause, a way of life, or a relationship that failed to produce the expected reward. Burnout is characterized by emotional exhaustion which is manifested by a lack of energy and a feeling that one's emotional resources are used up; depersonalization marked by the treatment of clients as objects rather than people; and diminished personal accomplishment where the clinician has the tendency to evaluate oneself negatively, experiencing a decline in feelings of job competence (Maslach, 1982). Overall, burnout is more than occupational stress: it is an erosion of the human spirit of caring.

Burnout can be a serious problem for clinicians. It becomes a crisis when individuals feel so defeated and exhausted by their environment, or the context of their caregiving work, that they take extraordinary means to find relief such as quitting a job or occupational field, developing a serious psychosomatic disease, suffering from problematic substance use or attempting suicide (Gilliland & James, 1993; Grosch & Olsen, 1995; Rothschild, 2006; Skovholt, 2001).

Common symptoms of burnout include:

Physiological

- Fatigue
- Physical depletion
- Irritability
- Headaches
- Gastrointestinal disturbances
- Back pain
- Weight changes
- Changes in sleep pattern

Behavioural

- Loss of enthusiasm
- Coming to work late
- Accomplishing little despite long hours
- Quickness to frustration and anger
- Becoming increasingly rigid
- Difficulty making decisions
- Closing out new input
- Increased dependence on drugs
- Increased withdrawal from colleagues
- Irritation with co-workers

Psychological

- Depression
- Emptiness
- Negative self-concept
- Pessimism
- Guilt
- Self-blame for not accomplishing more
- Feelings of omnipotence (Source: Grosch & Olsen, 1994).

Spiritual

- Loss of faith
- Loss of meaning
- Loss of purpose
- Feelings of alienation
- Feelings of estrangement
- Despair
- Changes in values
- Changes in religious beliefs
- Change in religious affiliation

Clinical

- Cynicism towards clients
- Daydreaming during sessions
- Hostility towards clients
- Boredom towards clients
- Quickness to diagnose
- Quickness to medicate
- Blaming clients

Burnout prevention strategies should be employed by both individual clinicians and the organizations in which they are situated (Monk-Cross, 1998). There are major personal, organizational and social costs that accrue when job stress turns into the crisis of burnout (Paine, 1982).

Secondary Traumatic Stress

Secondary traumatic stress differs from burnout. Burnout is the result of accumulated occupational stress, whereas secondary traumatic stress can occur following one traumatic incident. In contrast to burnout, which emerges gradually and is the result of emotional exhaustion, secondary traumatic stress can emerge suddenly and without much warning (Figley, 1995a). Clinicians can feel considerable strain as they engage and maintain empathetic connections with suicidal clients. Secondary traumatic stress is also referred to as vicarious traumatization.

Some of the signs of secondary traumatic stress include:

- Intrusive thoughts or images of personal or work-related trauma events
- Lowered frustration tolerance, irritability or outbursts of anger
- Dread of working with certain people/situations
- Feelings of depression, loss of hope and optimism, sadness, upset
- Decreased feelings of competence, sense of purpose/ enjoyment with career
- Feeling hardened, detached, cynical

(Source: Ambrose, 2000)

Compassion Fatigue

Figley (1995a) suggests that compassion fatigue can be used interchangeably with secondary traumatic stress. Joinson (1992) was the first to discuss compassion fatigue. Joinson examined burnout amongst nurses and discovered the fatigue that can result from offering compassion to others. Compassion fatigue refers to the behaviours and emotions that result from knowing about a traumatizing event experienced by a significant other. It is also the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1995b). The clinician is vulnerable to compassion fatigue by virtue of helping people who are struggling with their own suicidality. Professionals who listen to clients' stories of fear, pain, and suffering may feel similar fear, pain and suffering because they care (Figley, 1995b). Ultimately, these occupational risks are bound up in the emotional nature of the process of empathizing, which is a critical component of suicide intervention work.

The indicators of compassion fatigue include:

- Headaches
- Nausea
- Sleeplessness
- Intrusive imagery
- Increased feelings of vulnerability
- Difficulty trusting others
- Emotional numbing or flooding

(Source: Figley, 1995a)

The following are antidotes to secondary traumatic stress and compassion fatigue:

- Balance in life
- Knowing and living your values
- Thinking rationally
- Viewing life with humour
- Not sweating the "small stuff "
- Ability to relate assertively
- Setting limits and boundaries
- Being aware of one's own vulnerability
- Regular consultation with a trusted professional or group

(Source: Ambrose, 2000)

Personal and Professional Boundaries

The occupational hazards of burnout, secondary traumatic stress and compassion fatigue are influenced by both the professional and personal realities of clinicians' lives. A clinician's psychological and interpersonal situation will influence his/her susceptibility to burnout, secondary traumatic stress and/or compassion fatigue. Life stressors such as complex demands of relationships and family; stressful or traumatic life events such as pregnancy, illness, the death of a loved one, or a divorce; and the crises that take place in the lives of friends and families are common in the lives of helpers and can all take a toll on the clinician (Pearlman & Saakvitne, 1995).

Clinicians often find ways to buffer against the overlap of their personal and professional lives; nonetheless, working with suicidal adults can be stressful and can threaten the delicate balance sought by the professional. Furthermore, the clinician who is experiencing his or her own personal loss and grief may become overwhelmed with the themes of death and survival that permeate suicidal clients' reality.

6.4 When a Client Dies by Suicide

Most clinicians would agree that suicidal behaviour is often characterized as chaotic, unpredictable, and anxiety-provoking for both the client and the clinician (Rudd et al., 2001). The emotional impact of providing care for a suicidal client may become particularly pronounced when a client dies by suicide.

Following a death by suicide, family members may be eager to connect with treating professionals who worked with their loved one (Hendin et al., 2000; Peterson et al., 2002). However, the issue of communicating with a client's surviving family is complex. Clinicians must achieve the right balance between responding honestly and empathetically, while at the same time being mindful of legal and ethical issues (including patient confidentiality), and simultaneously managing their own grief (Hendin et al., 2000; Peterson et al., 2002). Hendin, Peterson, and their respective colleagues highlight the importance of clinicians connecting with surviving family members, and they recommend that contact take the form of expressions of condolence and sympathy, attendance at the funeral, and providing family members with a chance to discuss the difficulties and treatment of their loved one.

Losing a client to suicide is an occupational hazard for mental health and addiction clinicians. In some situations, regardless of the prevention efforts employed, clients will die by suicide. Ultimately, clinicians are faced with the reality that despite the caring work they do, clients can still die by suicide. Clinicians become suicide survivors when their client dies by suicide. Experiencing the loss of a client to suicide can cause personal and professional boundaries to overlap. Some clinicians report major disruptions in their professional and personal lives, including post-trauma symptoms (Monk-Cross, 1998).

When a client dies by suicide, mental health clinicians may find themselves manifesting some of the following behaviours and attitudes:

- Increased focus on clues related to suicide potential
- Increased collegial consultation
- Increased attention to legal-forensic matters
- Becoming more conservative in the care of clients
- Increased charting and record keeping
- Increased concern with issues of death and dying

(Source: American Association of Suicidology, 2001)

When a client dies by suicide, it is important for the clinician to acknowledge the death. The following are questions that may assist with reflecting on, and coping with, this loss:

- What was your initial response to losing your client to death by suicide?
- What was helpful to you at the time of the suicide?
- How did the experience impact you personally?
- How did the experience impact you professionally?
- What was helpful to you in the weeks and months after the suicide?
- What has been helpful to you in your healing?

- What would have been helpful to you at the time of the loss?
- How has this experience impacted the way you work with your clients?
- What have you learned from this experience?

(Source: American Association of Suicidology, 2001)

Clinicians are profoundly affected when one of their clients dies by suicide (Mishara, 1995). In responding to a client's suicide, two important issues should be considered:

- Caregivers are real people who must sometimes survive a suicide. Issues of care for bereaved caregivers are just as important as care is for family members and friends.
- Sooner or later, 'professional caregivers' impacted by suicide will encounter another person at risk. Painful lessons, learned from experience, will shape and modify their attitudes and their helping behaviours in these future encounters. Appreciating the impact allows for adjustments to be made to their caregiving practices that will ensure the effectiveness of future helping interventions.

(Source: Tanney, 1995)

Summary

"Care for the caregiver" practices and policies should be a priority for both individual clinicians and mental health and addiction agencies. When a clinician's resources are impaired, he/she is more vulnerable to being affected by his/her clients' despair (Pearlman & Saakvitne, 1995). This vulnerability can have a negative impact on the clinician's overall health and well-being, as well as having a potential harmful consequence to the therapeutic alliance between clinician and the client.

The irony of working with clients who are suicidal is that clinicians often have to visit the "dark parts" of what it is to be human, in order to create an effective therapeutic relationship. Ultimately, it is a heightened sensitivity and enhanced empathy for the suffering of victims, which results in a deeper sense of connection with others. This fosters a sense of hopefulness about the capacity of human beings to endure, overcome, and even transform their traumatic and painful experiences, thus gaining a more realistic world-view that integrates the dark side of humanity with healing images (McCann & Pearlman, 1990).

Caregiver stress can result from the repetitive process of empathizing that is required for consistent, effective and caring support with suicidal clients. The clinician must always aim for balance. Deliberately listening for clients' stories of optimism, survival, and resilience – which can emerge even in the midst of suffering – can provide much needed hope and inspiration for clinicians who are working with clients presenting with suicidal despair.

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Appendices

Appendix 1: Suicides in British Columbia 1994-2003: Frequency and Rates (per 100,000)

Frequency of Suicides:

Age	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004		
											Male	Female	Total
5-9	0	0	0	1	0	0	0	0	0	0	0	0	0
10-14	6	6	3	8	2	2	5	3	8	2	4	2	6
15-19	22	28	16	30	20	20	27	13	22	26	16	4	20
20-24	48	48	38	40	31	32	40	19	40	31	27	6	33
25-29	44	57	54	48	37	34	39	34	23	35	26	8	34
30-34	58	69	57	56	50	42	37	46	32	35	27	7	34
35-39	75	52	68	65	57	64	52	53	61	63	37	15	52
40-44	56	42	63	58	67	55	58	53	65	52	35	9	44
45-49	40	41	59	63	64	52	49	58	55	47	43	10	53
50-54	33	44	42	43	46	55	40	57	51	47	47	17	64
55-59	22	20	28	38	28	32	26	37	44	28	35	6	41
60-64	28	30	25	24	26	24	22	24	26	27	21	13	34
65-69	20	20	27	25	16	14	18	13	25	19	11	3	14
70-74	16	23	20	21	17	21	18	20	18	12	12	3	15
75-79	10	18	13	16	14	15	13	8	20	15	11	7	18
80-84	7	13	12	11	12	18	12	5	9	5	14	4	18
85+	7	9	17	11	12	5	8	14	9	14	4	8	12
BC	**492**	**520**	**542**	**558**	**499**	**485**	**464**	**457**	**508**	**458**	**370**	**122**	**492**

Suicide Rates per 100,000 BC Population:

Age	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004		
											Male	Female	Total
5-9	0.00	0.00	0.00	0.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
10-14	2.50	2.40	1.20	3.10	0.80	0.80	1.90	1.10	3.00	0.80	3.00	1.60	2.30
15-19	9.40	11.60	6.30	11.60	7.60	7.40	9.80	4.60	7.80	9.30	11.20	2.90	7.20
20-24	18.90	18.90	14.60	15.30	11.90	12.20	15.20	7.10	14.50	10.80	17.80	4.10	11.10
25-29	15.60	19.90	18.30	16.20	12.80	12.00	14.20	12.60	8.60	13.20	19.20	6.00	12.60
30-34	17.60	20.70	17.10	17.10	15.80	13.70	12.20	15.20	10.60	11.70	18.60	4.70	11.60
35-39	23.30	15.60	19.90	18.60	16.20	18.20	14.90	15.50	18.40	19.60	23.80	9.40	16.50
40-44	19.00	13.70	19.80	17.60	19.90	16.10	16.80	15.20	18.50	14.70	19.70	5.00	12.30
45-49	15.60	14.90	20.40	21.30	21.20	16.80	15.50	18.00	16.60	13.90	25.40	5.70	15.40
50-54	16.90	21.40	19.50	18.30	18.30	20.80	14.40	19.60	17.30	15.60	30.60	10.90	20.70
55-59	13.70	12.00	16.10	21.00	14.70	16.10	12.50	17.10	18.80	11.20	26.70	4.60	15.60
60-64	18.10	19.30	16.00	15.20	16.20	14.70	13.20	13.90	14.60	14.40	21.50	13.10	17.20
65-69	14.00	13.80	18.30	16.60	10.50	9.20	11.90	8.50	16.30	12.30	14.10	3.70	8.80
70-74	12.50	17.70	15.40	16.10	12.90	15.80	13.30	14.50	12.90	8.50	17.30	4.10	10.60
75-79	11.20	19.50	13.50	15.70	13.10	13.50	11.60	7.10	17.60	13.00	20.90	10.90	15.40
80-84	11.70	20.40	18.30	16.50	17.80	26.40	16.80	6.60	11.20	5.90	39.10	7.60	20.40
85+	16.40	20.20	36.50	22.50	23.30	9.10	13.70	23.00	14.20	21.20	17.50	17.20	17.30
BC	**13.40**	**13.80**	**14.00**	**14.10**	**12.50**	**12.10**	**11.50**	**11.20**	**12.30**	**11.00**	**17.80**	**5.80**	**11.70**

(Source: BC Vital Statistics, March 23, 2006)

Appendix 2: Designated Mental Health Facilities in British Columbia

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

Provincial Mental Health Facilities

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

- Forensic Psychiatric Hospital (Institute), Port Coquitlam
- Iris House, Prince George
- Jack Ledger House, Victoria
- Maples Adolescent Treatment Centre, Burnaby
- Provincial Assessment Centre for Community Living Services, Burnaby
- Riverview Hospital, Port Coquitlam
- Seven Oaks Tertiary Mental Health Facility, Victoria
- Seven Sisters Residence, Terrace
- Youth Forensic Psychiatric Services Inpatient Assessment Unit, Burnaby

B.C. 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
- British Columbia Women's Hospital and Health Centre, Vancouver
- Burnaby Hospital, Burnaby
- Chilliwack General Hospital, Chilliwack
- Cowichan District Hospital, Duncan
- Dawson Creek and District Hospital, Dawson Creek
- East Kootenay Regional Hospital, Cranbrook
- Fort St. John General Hospital, Fort St. John
- G.F. Strong Centre, Vancouver
- Kelowna General Hospital, Kelowna
- Kootenay Boundary Regional Hospital, Trail
- 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
- Regional Medical Centre (Pacific), Abbotsford
- Richmond Hospital, Richmond
- Ridge Meadows Hospital and Health Care Centre, Maple Ridge
- Royal Columbian Hospital, New Westminster
- Royal Inland Hospital, Kamloops
- Royal Jubilee Hospital, Victoria
- St. Joseph's General Hospital, Comox
- St. Mary's Hospital, Sechelt
- St. Paul's Hospital, Vancouver
- Surrey Memorial Hospital, Surrey
- UBC Hospital, Vancouver
- Vancouver General Hospital, Vancouver
- Vernon Jubilee Hospital, Vernon
- Victoria General Hospital
- West Coast General Hospital, Post Alberni

Observation Units

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

- Boundary Hospital, Grand Forks
- Fort Nelson General Hospital
- Kootenay Lake Hospital, Nelson
- Lady Minto Gulf Island Hospital, Ganges, Salt Spring Island
- Port McNeill and District Hospital
- Wrinch Memorial Hospital, Hazelton

(Source: Guide to the Mental Health Act – 2005 Edition; Hospitals and Provincial Mental Health Facilities that can admit involuntary patients)

Appendix 3: Clinical Examples

The following are examples of the challenges and dilemmas presented to mental health clinicians involving suicidal clients. Questions are included for reflection and provide examples of considerations about what ought to be done given the complexity of the clinical situation. 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.

EXAMPLE #1 – Substance Use & Suicidality

Jake is a 23-year-old male who has been referred to you by his family physician with chronic suicidal ideation. During your first session Jake 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 makes 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. You need to learn more of his recent losses and events that precipitated the escalation of suicide risk. 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 twice a week for the next three weeks. Jake has also agreed to check in by phone on a regular basis. You determine that Jake needs to address his substance use issues - which are 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. Furthermore, Jake needs a psychiatric assessment since his chronic suicide ideation could mean a need for appropriate medications after a diagnosis. 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 (e.g., can you consult by phone with the alcohol and drug counsellor regarding appropriate treatment goals and the interim management of his substance use disorder)?
- 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 area 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 use 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 identify as being useful (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")?

EXAMPLE #2: Chronic Suicidality

Jane is a 27-year-old First Nations woman who lives in a small northern town. The head nurse of the Aboriginal village nursing station referred her to you after a suicide attempt (20-30 Tylenol, 15 ibuprofen and a number of unknown medications). Jane has a lengthy history of suicidal ideation, as well as a longstanding mood disorder. Three years ago her best friend, with whom she had a suicide pact, died by suicide. Since the death, Jane has had constant thoughts of suicide. Recently, she broke off a romantic relationship, and left her home community to escape physical abuse from her former partner. Jane is now living in this new village, with her aunt, away from her immediate family community. She is using alcohol and drugs excessively and feels a constant guilt regarding her two children, who were apprehended five years ago by the Ministry for Children and Families, following allegations that Jane had failed to protect them from her abusive partner.

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 suicide pact, the break-up that triggered her most recent suicide attempt, and her guilt resulting from her separation from her children. Hospitalization was given serious consideration, given the recent escalation of her risk status, particularly the break-up from the abusive relationship, her relocation from her support and home community, and her guilt regarding her children. 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 outpatient counselling setting. For example, in spite of her high-risk status she still maintains a strong personal commitment to reunite with her children and she enjoys the support of her mother, aunt, and the village community health nurse. Although she is living away from her home village, she is staying with her aunt in the new community, and her mother has conveyed 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 Jane's immediate safety, her long term mental health and substance use issues, 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 (e.g., assisting Jane in benefiting 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 reuniting with her children as a significant protective factor?
- Who do you need to share information with about this case?

EXAMPLE #3: Failure to Follow-Through with Treatment

Casey is a 65-year-old man who was referred to you by a counsellor at the local senior's centre, following Casey's disclosure that he was considering suicide. Casey has lived alone since his wife of over 40 years died 10 months ago. Casey retired three months ago after working for an automotive plant for over 30 years. He has one daughter, who lives nearby with her husband and three children. Casey's daughter accompanied Casey to his first treatment session, but you did not obtain explicit consent to speak to her about his ongoing treatment. Casey does not have a current suicide plan; however, he has been speaking of suicide for approximately one month. The anniversary of his wife's death is in six weeks. Your initial risk assessment determined that his suicide risk was low to medium. After two treatment sessions, Casey 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 counsellor who made the initial referral offer any information about Casey's current status? What have staff at the senior's centre noticed in terms of his behaviour, affect, and attitude (assuming he is still attending the senior's centre)?
- As you do not have explicit consent to speak to Casey's daughter, can you work with the counsellor at the local senior's centre to either obtain Casey's permission to talk to his daughter, for the counsellor to have Casey's daughter phone you and provide input, or for the counsellor to talk to the daughter and relay her input to you?
- Who else can help? How can you work with others to share responsibility for keeping Casey safe?
- Is there any reason to think that his suicide risk status may have increased? If so, what actions need to be taken to ensure his safety?
- Are significant others aware of potential suicide warning signs and specific actions that should be undertaken if they believe his risk for self-harm has increased? Has he seen his physician to check for

medical issues for which depression may be a side effect (e.g., diabetes)? Are the family/counsellor aware of the specific issues that put seniors at risk for suicide (e.g., multiple losses; isolation; poor pain management)?

- Can the family and senior centre staff establish a safety plan to help Casey through this first anniversary?
- What options are available in terms of seeing Casey "off-site," (e.g. at the senior's centre)?
- What strategies exist for "maintaining contact" with Casey (e.g. leaving messages at home with his daughter)?
- 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?

EXAMPLE #4: Release of Information to Family

Jacqueline is a 23-year-old female who has been referred to you by her family physician for treatment of depression. You have seen Jacqueline for 3 treatment sessions. During your intake assessment, in which you routinely assess for past and present suicidality, Jacqueline expresses to you that she has thoughts of suicide. She reports having no specific plan, and has no history of attempts. Jacqueline describes that she has felt 'pretty depressed' for years. She indicates that she lives with her mother, with whom she experiences considerable conflict. Jacqueline states that her mom knows that she is seeing you for treatment, but that she doesn't want her mother to know anything about her treatment at all, as that would just 'make things worse'. One day, you receive 3 phone messages from Jacqueline's mother, asking you to call her back as she would like to discuss her daughter's case with you. What do you do?

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

- What would be the impact on the therapeutic relationship if you communicated with Jacqueline's mother?
- Consider the ways that you can work with Jacqueline on improving her relationship with her mother. Could you suggest joint family sessions with Jacqueline's mother to address the conflict in their relationship?
- If Jacqueline declines providing consent for you to speak to her mother, consider encouraging her to involve her mother, or another support system, as part of your therapy.
- You may want to consider phoning the mother back, and indicating that Jacqueline has indicated that she would not like her mother to be informed of her ongoing treatment. You may indicate to the mother that issues around confidentiality limit your ability to disclose to the mother information regarding the daughter, without her specific consent.
- Recognize that limits of confidentiality prevent you from disclosing information to Jacqueline's mother, but that there are not restrictions around you obtaining information from Jacqueline's mother. Consider that information you obtain from Jacqueline's mother may assist you in your ongoing treatment with Jacqueline.
- After discussion with her mother, use information that the mother has provided. Use your clinical judgment to consider your next steps.

EXAMPLE #5: Release of Information to Family

Karim is a 25-year-old male who has been admitted to the hospital where you work following a suicide attempt, by way of prescription medication overdose. You have been asked to see Karim in the few hours following his suicide attempt. You perform a suicide risk assessment of Karim while he is still in the intensive care unit. Karim indicates to you that he was at home, was 'pissed off' at life and had been drinking (approximately 5-6 beer) and that he decided to take approximately 25 antidepressant medication pills. When asked where he got these pills, he states that they were 'just lying around'. He refuses to provide you with any further information about mental health history. When you ask how he got to hospital, Karim said that he thinks his girlfriend, with whom he lives, came home and saw Karim 'out of it' so called the paramedics. He remembers seeing his father in the emergency room, and said he thought his girlfriend must have called his father as well. You ask if you can speak to his girlfriend and father. Karim says that he knows that his father is in the waiting room, but that he does not want you to speak to him as he 'feels stupid'. You are approached by his father and girlfriend as you are leaving the intensive care unit, asking questions about how they can help.

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

- As Karim is still in the intensive care unit, is he competent to provide you with consent (or lack of) to communicate with others?
- What are the potential benefits of obtaining information from Karim's family (e.g., to perform an informed and thorough risk assessment), despite his request that you not speak to his girlfriend or father?
- Be aware that legislation around release of information indicates that you are able to obtain information from family members, but not necessarily able to disclose.
- Consider that in situations where someone is at acute risk (such as being in the emergency room following a suicide attempt) it may be appropriate to break confidentiality.
- What is your assessment of Karim's level of risk while in intensive care? Is there a need for further precautions to ensure his safety?
- Consider the value in providing information on general suicide prevention and management to both his girlfriend and his father. What type of information (e.g., information on risk factors; crisis line numbers; reading materials) can you provide to Karim's girlfriend and father?
- Consider explaining to Karim's significant others that he has indicated concern about you talking to them, due to feeling embarrassed. Indicate that this is a normal response post-suicide attempt. You may want to consider speaking to Karim's father and girlfriend about ways that they can speak to Karim about his suicide attempt.

Resources

Assessment Tools

Adult Suicide Ideation Questionnaire

Purchase from Psychological Assessment Resources Inc. (www3.parinc.com/products/product.aspx?Productid=ASIQ)

- Screens for suicidal ideation in college students and adults
- Can be administered with individuals or groups
- Designed for adults

Beck Depression Inventory

Purchase from Harcourt Asseessment (www.harcourtassessment.com)

- Assesses depression
- Self-administered
- Appropriate for ages 13-80

Beck Hopelessness Scale

Purchase from Harcourt Asseessment (www.harcourtassessment.com)

- Measures negative attitudes about the future
- Self-administered
- Appropriate for ages 17-80

Patient Health Questionnaire – PHQ-9

Download from Pfizer (www.pfizer.com/pfizer/phq-9/index.jsp)

- Screens for depression

Reasons for Living Inventory

Linehan, M.M., Goodstein, J.L., Neilson, S.L., & Chiles, J.A. (1983). Reasons for staying alive when you're thinking of killing yourself. "The Reasons for Living Inventory." *Journal of Consulting and Clinical Psychology*, 51, 276-286.

- 48-item self-report measures
- Assesses beliefs and expectations for not committing suicide
- Subscales include: Survival and Coping Beliefs (24 items), Responsibility to Family (7 items), Child-Related Concerns (3 items), Fear of Suicide (7 items), Fear of Social Disapproval (3 items), and Moral Objections (4 items)

Training Institute for Suicide Assessment & Clinical Interviewing

(www.suicideassessment.com)

- A web site for mental health professionals, substance abuse counselors, school counselors, primary care physicians and psychiatric nurses who are looking for information on the development of suicide prevention skills, crisis intervention skills and advanced clinical interviewing skills.

The Michigan Alcohol Screening Test (MAST)

Description

The MAST is described as a first generation alcohol assessment instrument. It was originally developed as a 25-item instrument to assess an array of alcohol related issues including self-perception, help-seeking behaviour, and harmful consequences of drinking. Subsequently, a short form of the MAST was published. This brief 10-item scale has been shown to have similar psychometric properties to the original scale. The version of the MAST shown assesses a client's experience over the past 12 months.

Target Population

The appropriate target population for the MAST are clients who are older than 18 years of age, functionally literate in English, irrespective of presenting problem and dependency/co-dependency status.

Administration

The MAST is designed as a self-report instrument. Clients should have an opportunity to complete the form without distraction at the place of service. For clients without basic reading ability in English, an interviewer may administer the MAST. In the outpatient setting, the MAST and other scales should be given at the first formal assessment visit. In the detoxification centre, the MAST should not be given when the client is intoxicated or during the process of withdrawal. In many instances, this will mean that the scales are completed just prior to discharge. Instructions provided at the top of the scale are self-explanatory and clients circle "yes" or "no" answers to the ten MAST questions.

Scoring and Interpretation

The MAST uses a weighted scoring system in which different weights are assigned to different items. On the following page, the weights for each item are shown. Note that the score weights are not shown on the form the client completes. Item weights are summed to total scores that may range from 0 to 29. Scores of 6 or greater are considered to reflect serious problems with alcohol. Increasing scores reflect increasing severity.

The interpretation of MAST scores should occur in the context of more detailed client assessment.

The Michigan Alcohol Screening Test (MAST)

The following questions are about your use of alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question. Please answer every question. If you have difficulty with a statement then choose the response that is mostly right.

#	These Questions Refer to the last 12 Months	Circle Your Response	
1	Do you feel that you are a normal drinker?	YES	NO
2	Do friends or relatives think you are a normal drinker?	YES	NO
3	Have you attended a meeting of Alcoholics Anonymous (AA)?	YES	NO
4	Have you lost friends or girlfriends/boyfriends because of your drinking?	YES	NO
5	Have you gotten into trouble at work because of your drinking?	YES	NO
6	Have you neglected your obligations, your family or your work for two or more days in a row because you were drinking?	YES	NO
7	Have you had delirium tremens (DT's), severe shaking, heard voices or seen things that were not there after heavy drinking?	YES	NO
8	Have you gone to anyone for help about your drinking?	YES	NO
9	Have you been in a hospital because of drinking?	YES	NO
10	Have you received a 24-hour roadside suspension or have you been charged for impaired driving?	YES	NO

Scoring of the MAST

Score 2 points for a NO response to questions 1 and 2.
Score 5 points for a YES response to questions 3, 8 and 9.
Score 2 points for a YES response to questions 4, 5, 6, 7 and 10.

The Drug Abuse Screening Test (DAST)

The Drug Abuse Screening Test (DAST) is a measure of problems related to psychoactive drug use. The 20 questions on the DAST are concerned with the client's involvement with drugs only, and not alcoholic beverages. The DAST provides a reliable estimate of drug abuse severity. It can be used to monitor changes in clients over time.

Target Population

The DAST has been designed for use with an adult population. Functional literacy in English is required. Like the MAST, the DAST is given to all clients irrespective of presenting problem and dependency/ co-dependency status.

Administration

The DAST is administered as a self-report questionnaire, except with clients who have difficulty with reading comprehension. In these circumstances, the DAST may be given in an interview format. Clients are asked to circle either "yes" or "no" in response to the 20 questions.

Scoring and Interpretation

The scoring scheme for the DAST is as follows:

All "no" responses receive a score of 0, and all "yes" responses receive a score of 1, except for questions 4 and 5 where the scoring is reversed. For questions 4 and 5, a "no" response scores 1 and a "yes" response scores 0.

Individual item scores are totalled to obtain the DAST score, which may range from 0 to 20.

The total DAST scores reflect the client's severity of problems or consequences related to drug abuse. Interpretation of the DAST score should be based on the following guidelines:

DAST Score	Problem Severity
0	No Problem
1-5	Low level of problems related to drug abuse
6-10	Moderate level of problems related to drug abuse
11-15	Substantial level of problems related to drug abuse
16-20	Severe level of problems related to drug abuse

Interpretation of DAST scores is most meaningful when considered in the context of the length of time the client has been using drugs, the client's age, level of consumption, and other data collected during the assessment process.

The Drug Abuse Screening Test (DAST)

#	These Questions Refer to the last 12 Months	Circle Your Response	
1	Have you used drugs other than those required for medical reasons?	YES	NO
2	Have you abused prescription drugs?	YES	NO
3	Do you abuse more than one drug at a time?	YES	NO
4	Can you get through the week without using drugs?	YES	NO
5	Are you always able to stop using drugs when you want to?	YES	NO
6	Have had "blackouts" or "flashbacks" as a result of drug use?	YES	NO
7	Do you ever feel bad or guilty about your drug use?	YES	NO
8	Does your spouse (or parents) ever complain about your involvement with drugs?	YES	NO
9	Has drug abuse created problems between you and your spouse or your parents?	YES	NO
10	Have you lost friends because of your use of drugs?	YES	NO
11	Have you neglected your family because of your use of drugs?	YES	NO
12	Have you been in trouble at work because of drug abuse?	YES	NO
13	Have you lost a job because of drug abuse?	YES	NO
14	Have you gotten into fights when under the influence of drugs?	YES	NO
15	Have you engaged in illegal activities in order to obtain drugs?	YES	NO
16	Have you been arrested for possession of illegal drugs?	YES	NO
17	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	YES	NO
18	Have you had medical problems as a result of your drug use (i.e. memory loss, hepatitis, convulsions, bleeding, etc.)?	YES	NO
19	Have you gone to anyone for help for a drug problem?	YES	NO
20	Have you been involved in a treatment program specifically related to drug use?	YES	NO

The Medical Triggers Screening Tool (MTST)

The Medical Triggers Screening Tool (MTST)[17] was developed for use in Alcohol and Drug Services outpatient treatment agencies. The tool is designed to detect clients who may require referral to a physician for comprehensive assessment of physical health status. The ten questions on the MTST screen for health conditions and circumstances which potentially require medical assessment or intervention. In a field test of the MTST with 200 clients in two outpatient centres, nearly three-quarters had one or more positive triggers. The validity of the MTST has not been fully examined.

Target Population

The MTST is appropriate for all adult clients, irrespective of presenting problem or dependency/ co-dependency status in the outpatient setting. Physicians routinely assess clients attending detoxification services and different scales are used to evaluate and monitor medical symptoms.

Administration

The MTST is designed to be administered in an interview format. Counsellors should ask clients about each of the ten items on the form. If the client reports, or exhibits, one or more of the triggers listed on the screening form a tick should be placed in the appropriate "yes" box(es). If the client is taking a prescription drug, record the name of the drug beside that item.

Scoring and Interpretation

The number of positive items is summed to a total score. MTST scores of one or greater require consultation with or referral to a sessional physician. If a program does not have access to sessional physician services, then consultation with the client's family doctor should occur. A copy of the screening form should accompany the referral to the physician. Agencies must obtain client consent prior to contacting the physician. Clients with positive triggers for suicide risk and/or pregnancy should be considered in urgent need of attention.

[17] Anderson, J.F. & McEwan, K.L. (1994). A Medical Triggers Screening Instrument for Clients of Addiction Treatment Services. Unpublished manuscript.

The Medical Triggers Screening Tool (MTST)

#	Questions	Circle Response	
1	Was the client's last medical examination more than six months ago?	YES	NO
2	If the client has a physician, is the client's physician unaware of his/her addiction problem?	YES	NO
3	Is the client pregnant?	YES	NO
4	Is the client taking prescription medication? Name:	YES	NO
5	Does the client need detoxification?	YES	NO
6	Does the client have a history of seizures?	YES	NO
7	Does the client have a history of a serious co-existent medical condition (i.e. diabetes, hypertension, G.I. bleeding, hepatitis, HIV, anorexia/bulimia)?	YES	NO
8	Does the client have a history of a serious co-existent psychiatric condition (ie. severe depression, schizophrenia)?	YES	NO
9	Is the client at risk for suicide (i.e. persistent thoughts, planning attempts)?	YES	NO
10	Has the client ever injected drugs?	YES	NO
11	Does the client engage in unprotected sexual activity with high risk persons?	YES	NO

Enhancing the Validity of Self-Reports

Source of information about alcohol/drug use include self-reports, collateral reports and biochemical measures. While concerns may arise that the self-reports of individuals with substance use disorders may be invalid due to denial or general tendencies to underestimate use and/or problems, under appropriate conditions clients themselves are reliable sources[18]. Clients may intentionally falsify their responses on self-report instruments, if motivation exists for doing so. However, attention to factors which may influence the validity of self-reports will minimize sources of bias or error. The table shown on the following page lists situations which affect the validity of self-reported information.

Factors Influencing the Validity of Self-Reports[19]

Situations Likely to Produce Invalid Self-Reports	Situations Likely to Produce Valid Self-Reports
Patient has positive blood alcohol concentration at time of assessment.	Patient is alcohol-free at the time of assessment.
Patient is experiencing withdrawal symptoms or other acute distress.	Patient is stable and has no major symptoms.
Unstructured, general or vague items are used to obtain other information.	Structured, carefully developed items are used.
Patient is not aware that self-reports will be checked against other data.	Patient knows that self-reports will be checked against other sources of data (e.g. lab tests, collaterals, records).
Interaction with the patient is brief or minimal.	Good rapport is established with the patient.
Patient shows poor compliance with the treatment regimen.	Patient complies with other aspects of treatment.
Patient has clear motive to distort information (e.g. abstinence is a condition of parole or continued employment).	Patient has no obvious reason for distorting self-reports.
Patient doubts the confidentiality of the information provided to treatment personnel.	Patient can be validly reassured about confidentiality.
Staff has obvious expectations that certain behaviours (e.g. abstinence) will be reported.	Staff and the information-gathering processes are obviously neutral and nonpunitive.

[18] Addiction Research Foundation. (1991). Directory of Client Outcome Measures for Addiction Treatment Programs. Toronto, Ontario.

[19] From: The Institute of Medicine. (1990). Broadening the Base of Treatment for Alcohol Problems. Washington, DC; National Academy Press.

Suggested Reading for Clinicians

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Resources for Clients and Families

Useful Phone Numbers (24 hrs/day, 7 days/week)

BC Distress Line
1-800-SUICIDE (1-800-784-2433)

Provides emotional support for individuals who are in a suicide-related crisis or are looking for information about suicide. Manned by trained volunteers. No wait or busy signal. Interpreter services available.

BC Nurse Line
1-866-215-4700 (TTY for deaf/hearing impaired: 1-866-889-4700)

BC NurseLine is staffed by registered nurses who will answer questions about symptoms, health concerns, recommended course of action, when to see a health professional, and other available health resources. A pharmacist is available to answer medication-related questions from 5:00 p.m. to 9:00 a.m. daily.

BC Alcohol and Drug Information and Referral Service
1-800-663-1441 (TTY for deaf/hearing impaired: 604-875-0885)

Provides information and referral services for people needing assistance related to any kind of substance use disorder. Information and referrals provided on education, prevention, treatment, and regulatory agencies.

Problem Gambling Help Line
1-888-795-6111

A province-wide, toll-free, multilingual telephone information and referral service to community resources, including counseling, prevention and self-help resources. The service is for anyone who is adversely affected by their own, or another's gambling habits.

Youth in BC
1-866-661-3311

Offers resources and support for youth and young adults. This service is manned by trained volunteers. Service can be offered by both a telephone hotline, as well as a confidential web-based hotline (www.youthinbc.com).

Other Useful Phone Numbers

BC Mental Health Information Line
1-800-661-2121

Provides information and referral about mental health and mental illness. Not a crisis line. Office hours are Monday to Friday, 9am to 4pm; pre-recorded messages and directory of services 24 hours/day. Topics include: basic information about mental health issues; how to choose a psychotherapist; and support for caregivers.

SAFER (Suicide Attempt Follow-up, Education and Research) Counselling Services
604-879-9251

Offers short term counselling for residents of Vancouver who are in a suicidal crisis, have made a suicide attempt, or are concerned about someone who is suicidal. Also offers individual and group treatment for those grieving a suicide death. SAFER offers consultation, education and province-wide referrals.

BC Psychological Association
1-800-730-0522

Provides referrals for psychologists across British Columbia.

Canadian Mental Health Association – BC Division
1-800-555-8222

Promotes the mental health of British Columbians and supports the resilience and recovery of people experiencing mental illness. Over 20 branches throughout B.C.

www.cmha.bc.ca

Mood Disorders Association of BC
604-873-0103

Provides education, support, and friendship for people with a mood disorder, their families, and their friends.

www.mdabc.ca

Anxiety Disorders Association
604-681-3400

A non-profit organization that seeks to increase awareness about anxiety disorders; promote education of the general public, affected persons, and health care providers; and increase access to evidence-based resources and treatments.

www.anxietybc.com

Early Psychosis Intervention Program
1-866-870-7847

A treatment and education service. Provides assistance to young people who have recently developed psychosis. Provides education to a range of people, including mental health professionals, schools, community agencies, and the general public. Provides evaluation and research on psychosis.

www.psychosissucks.ca/epi

BC Schizophrenia Society
1-888-888-0029

A non-profit organization that provides support and education for people with schizophrenia and other serious and persistent mental illnesses, their families and friends. A province-wide family support system with 32 branches and over 1000.

www.bcss.org

Griefworks BC
1-877-234-3322

Provides information, grief support, and counseling for those coping with loss. Serves multiple language communities and includes resources for bereavement.

www.griefworksbc.com

Credit Counselling Society
1-888-527-8999

A non-profit service offering free credit and budget counseling, and workable strategies for reducing or eliminating debt. Services are open to anyone in Western Canada and there are no restrictions on age or income level.

Legal Services Society
1-866-577-2525

An independent, non-profit organization that provides legal aid for people with low incomes in B.C. Legal aid services range from legal information and legal advice to legal representation (e.g., a lawyer to handle your case).

Prideline
1-800-566-1170

Support, health and social services, and public education for the well being of lesbians, gay men, transgendered and bisexual people and their allies throughout B.C.

www.lgtbcentrevancouver.com

Website Resources

BC Partners for Mental Health and Addiction Information
www.heretohelp.bc.ca

This umbrella organization provides suicide-related information for mental health consumers and families. Some examples include:

- Getting Help for Mental Disorders: General Overview
  www.heretohelp.bc.ca/publications/factsheets/gettinghelp.shtml
- Suicide: Following the Warning Signs
  www.heretohelp.bc.ca/publications/factsheets/suicide.shtml
- Personal stories about suicide. From the BC Partners. Real stories of loss and hope.
  www.heretohelp.bc.ca/experiences/e_suicide.shtml
- Who are the various types of Mental Health Professionals?
  www.heretohelp.bc.ca/toolkits/md_toolkit/toolkit.php?doc=2_3_3

Suicide Prevention Resource Centre
www.sprc.org

The Suicide Prevention Resource Centre supports suicide prevention with the best of science, skills, and practice.

Centre for Suicide Prevention/Suicide Information and Education Collection
www.suicideinfo.ca

An extensive library and resource centre providing information on suicide and suicidal behaviour (not a crisis centre).

Youth Support
www.youthinbc.com

Web-based hotline for youth and young adults in B.C.

BC Health Guide
www.bchealthguide.org

Provides a range of self-management resources on physical and mental health symptoms and disorders.

Metanoia
www.metanoia.org/suicide

Contains conversations and writings for suicidal persons to read. If you're feeling at all suicidal, be sure to read this page before you take any action

Real Men Real Depression
www.menanddepression.nimh.nih.gov

An initiative of the National Institute of Mental Health, focused on increasing education and awareness about depression in men.

Resources Specific to Families

Online

HelpCard: If You Are Concerned About Someone who is Suicidal
www.suicideinfo.ca/csp/go.aspx?tabid=75

Living with Someone Who is Suicidal
www.bcmentalhealthworks.ca/files/living_suicidal.html

Family Toolkit – Living with a Family Member with Mental Illness
www.heretohelp.bc.ca/helpmewith/ftoolkit.shtml

Understanding and Coping with Mental Illness for Family & Friends
www.cmha.bc.ca/files/understanding.pdf

What Families and Friends Can Do to Help
www.heretohelp.bc.ca/publications/factsheets/families.shtml

Helping a Suicidal Friend or Relative
www.befrienders.org/support/helpAfriend.php

Books

Adamec, C. (1996). *How to Live with a Mentally Ill Person*. New York, NY: John Wiley & Sons Canada, Ltd.

Mason, P. T. & Kreger, R. (1998). *Stop Walking on Eggshells: Taking Your Life Back When Someone You Care About has Borderline Personality Disorder*. Oakland, CA: New Harbinger.

Woolis, R. (2002). *When Someone You Love Has a Mental Illness - Handbook for Family and Friends*. New York, NY: Tarcher Paper/Penguin.

Mental Health Issues in the Workplace

Antidepressant Skills at Work: Dealing with Mood Problems in the Workplace (Bilsker, Gilbert & Samra, 2007), www.carmha.ca

A self-care manual for low mood and depression in the workplace.

Mental Health Works
www.mentalhealthworks.ca

Focusing on solutions around mental health issues in the workplace to benefit employers and employees alike, such as returning to work after a mental health problem.

Global Business and Economic Roundtable on Addiction and Mental Health
www.mentalhealthroundtable.ca

The roundtable comprises business, health, and education leaders who have undersigned the proposition that mental health is a business and economic issue. It is an instrument of information analysis and ideas concerning the linkage between business, the economy, mental health and work.

BC Business and Economic Roundtable on Mental Health
www.bcmentalhealthworks.ca

The roundtable is a network of business, health leaders, and insurer leaders with a focus on mentally healthy workplaces.

National and International Organizations

Canadian Association for Suicide Prevention (CASP)
www.suicideprevention.ca

A Canadian non-profit organization dedicated to the understanding and prevention of suicide.

Centre for Suicide Prevention
www.suicideinfo.ca

The centre for Suicide Prevention includes a library and resource centre on suicide and suicidal behaviour, a training program, and research support and services.

SA\VE – Suicide Awareness \ Voices of Education
www.save.org

The mission of SA\VE is to educate about suicide prevention and to speak for suicide survivors.

American Association of Suicidology
www.suicidology.org

A non-profit organization dedicated to the understanding and prevention of suicide.

Suicide Prevention Advocacy Network
www.spanusa.org
Suicide Prevention Advocacy Network advocates a proven, effective suicide prevention program.

Canadian Network for Mood and Anxiety Treatments (CANMAT)
www.canmat.org
CANMT is an extensive network linking healthcare professionals from across Canada who have a special interest in mood and anxiety disorders. The goal of CANMAT is to improve the quality of life of persons suffering from mood and anxiety disorders.

The Samaritans
www.samaritans.org.uk
The Samaritans is a UK charity offering support to people who are suicidal or despairing and are on hand 24 hours a day every day of the year. An English language email service is available to anyone needing emotional support throughout the world.

World Health Organization
www.who.int/mental_health/resources/suicide/en
Publications on suicide prevention.

National Strategy for Suicide Prevention
www.mentalhealth.org/suicideprevention/strategy.htm
The CMHS National Strategy for Suicide Prevention website provides information for mental health professionals, health care providers, community coalitions, policymakers, survivors, and advocates.

Canadian Collaborative Mental Health Initiative
www.ccmhi.ca/en/products/toolkits/consumers.htm
Working together towards recovery: Consumers, families, caregivers and providers; developed by people who've experienced mental illness themselves, family members and caregivers.

Canadian Association for Suicide Prevention (CASP)
www.thesupportnetwork.com/CASP/main.html
"Blueprint for a Canadian National Suicide Prevention Strategy" and other Canadian references.

Canadian Health Network
www.Canadian-Health-Network.ca
Credible and practical general information about physical and mental health issues

National Network for Mental Health
www.nnmh.ca/
The purpose of the National Network for Mental Health, which is run by and for mental health consumer/survivors, is to advocate, educate and provide expertise and resources that benefit the Canadian consumer/survivor community.

Books for Clients

Arena, J. (1995). *Step Back From the Exit: 45 Reasons to Say No to Suicide*. Milwaukee, WI: Zebulon Press.

Blauner, S. R. (2002). *How I Stayed Alive When My Brain Was Trying to Kill Me: One Person's Guide to Suicide Prevention*. New York, NY: William Morrow.

Chabot, J. A. (1997). *A New Lease on Life: Facing the World After a Suicide Attempt*. Minneapolis, MN: Fairview Press.

Cobain, B. (1998). *When Nothing Matters Anymore: a Survival Guide for Depressed Teens*. Minneapolis, MN: Free Spirit Publishing Inc.

Conroy, D. L. (1991). *Out of the Nightmare: Recovery From Depression and Suicidal Pain*. New York, NY: New Liberty Press.

Ellis, T.E. & Newman, C. F. (1996). *Choosing to Live: How to Defeat Suicide Through Cognitive Therapy*. Oakland, Ca: New Harbinger.

Gordon, S. (2004). *When Living Hurts: A What to do book for Yourself or Someone You Care About Who Feels Discouraged, Sad, Lonely, Hopeless, Angry or Frustrated, Unhappy, Bored, Depressed, Suicidal*. New York, NY. RJ Press.

Jamieson, K. R. (1999). *Night Falls Fast: Understanding Suicide*. New York, NY: Alfred A. Knopf.

Quinnett, P. G. (1995). *Suicide: The Forever Decision. For Those Thinking About Suicide, and for Those Who Know, Love, or Counsel Them*. New York, NY: The Crossroad Publishing Company.

Ratey, J. J. MD, Johnson, C. PhD. (1997). *Shadow Syndromes: Recognizing and Coping with the Hidden Psychological Disorders That Can Influence Your Behaviour and Silently Determine the Course of Your Life*. New York, NY: Pantheon.

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Copies of this document can be downloaded at no cost from:

Centre for Applied Research in Mental Health and Addiction: www.carmha.ca
B.C. Ministry of Health, Mental Health and Addiction: www.healthservices.gov.bc.ca/mhd