LEVELS OF SUICIDE RISK*

Minimal	• Absence of active suicidal thinking
Mild	• Suicidal thinking with no specificity, low intensity of mental health symptoms and the presence of protective factors
Moderate	• Specific suicidal thoughts including how, when and where they will die, increased frequency and duration of these thoughts, and the presence of protective factors
Severe	• Specific suicidal thinking with intent (as above) and increase in intensity of mental health symptoms and a reduction in protective factors
Extreme	• As with "Severe" yet imminent with clear intention to die by suicide when there is an opportunity
Chronic	• As with "Moderate", "Severe" or "Extreme" with an overall vulnerability and susceptibility to suicidal behaviour

Adapted from: Rudd (2006) and Sommers-Flanagan & Sommers-Flanagan (2005)

EXAMPLE ELEMENTS OF A SAFETY PLAN*

Identify elements such as the following specific to the context and needs of the child/youth and their families/caregivers:

STEP 1:
Warning signs
STEP 2:
Internal coping strategies i.e., distraction techniques that can be done alone
STEP 3:
Social situations and/or people that can help with distraction
STEP 4:
People who can help
STEP 5:
Professionals or agencies who can be contacted during a crisis
STEP 6:
How to make the environment safe

Adapted from Stanley & Brown (2012)

*The *Practice Guidelines for Working with Children and Youth at-risk for Suicide in Community Mental Health Settings* (2014) and other resources can be found on the MCFD Preventing Youth Suicide website: http://www.mcf.gov.bc.ca/suicide_prevention/index.htm

SUICIDE PREVENTION, INTERVENTION AND POSTVENTION PRACTICE GUIDELINES*

QUICK REFERENCE

Building Relationships	1. Develop a shared understanding of the young person's suicidality 2. Acknowledge emotional pain and recognize that thoughts of suicide are understandable under the circumstances 3. Convey empathy and instill hope to young people and their parents/caregivers 4. Create opportunities for ongoing feedback 5. Wherever possible, provide young people with some say about which clinician they work with 6. Recognize the role of culture in understandings of distress and healing 7. Clarify expectations about the treatment process, communication, and decision-making with youth and parents 8. Understand the importance of the community as a context and resource for healing for Indigenous youth 9. Respect and follow cultural protocols 10. Build strong and respectful relationships with individuals, families, and communities
Assessing Risk	1. Ensure the process is systematic, multi-faceted and holistic 2. Utilize research–informed approaches 3. Work in a collaborative and strengths-based way 4. Ensure the language and approach is developmentally appropriate 5. Be attuned to cultural differences and stressors faced by minority groups 6. Adopt a fluid understanding of risk, which includes an exploration of previous suicidal behaviours and other known risk factors 7. Focus on protective factors 8. Engage in a thorough exploration of current suicidal thinking 9. Gather input from collateral informants, including parents 10. Include a risk formulation
Safety Planning for	1. Actively involve young people in the development of the safety plan 2. Link the safety plan to the overall suicide risk assessment process 3. Recognize important role of parents/caregivers and community members in establishing and maintaining safety plan 4. Tailor the plan to reflect the individual's unique circumstances, history and cultural context 5. Share the safety plan with parents/ caregivers and other significant others who can support the young person 6. Teach parents/caregivers to provide validation and support and educate about importance of keeping home safe 7. Teach coping skills and distracting strategies that the young person can use as part of the overall safety plan 8. Include an explicit strategy for restricting access to potential suicide methods 9. Revise/modify the safety plan as circumstances change
Treatment and Care	1. Develop a strong therapeutic alliance 2. Partner with parents/family member/caregivers 3. Tailor the treatment to fit the youth's unique needs, preferences and contexts 4. Actively engage youth in agenda-setting and identifying indicators of success 5. Treat the suicidal behaviour first 6. Monitor suicidal behaviour throughout the course of treatment 7. Restrict access to the means of suicide 8. Directly address therapy-interfering behaviours 9. Use treatment strategies that harness strengths, build skills, and support resilience 10. Include family interventions 11. Honour cultural models of healing 12. Recognize the role of societal factors and social inequities in the emergence of distress and suicidal despair
Addressing Co-Occurring Problems	1. Expect the co-occurrence of problems 2. Actively involve youth and parents in the treatment process 3. Utilize a coherent framework for conceptualizing and treating co-occurring problems 4. Include motivational interviewing techniques 5. Assess for mental health and substance use problems as a routine part of practice 6. Implement research informed, integrated models of care 7. Collaborate with the youth to better understand the relationship between suicidality and substance use 8. Explore context and identify triggers, consequences and responses 9. Include skill-building for youth and parents 10. Recognize that recovery is a process

Prepared by Jennifer White, EdD in collaboration with MCFD and Community Partner Advisory Committee

Providing Culturally Responsive Care	1. Recognize cultural assumptions and biases regarding mental health, illness, healing and sources of distress 2. Understand that culture is a flexible and ongoing process, not a uniform or fixed entity 3. Appreciate that all individuals (i.e. clinicians and youth) have multiple and fluid cultural identities 4. Assess risks and develop treatment models with attention paid to cultural understandings of distress and healing 5. Explore expectations regarding communication, self-disclosure and decision-making	6. Be familiar with the unique stressors that can elevate risk for minority groups 7. Draw on healing strategies that recognize relational, familial, and spiritual dimensions of selfhood when working with Indigenous youth 8. Advocate for family and community empowerment 9. Utilize treatment strategies that strengthen the bond between parents and youth when working with GLBTQ youth
Partnering with Parents/Caregivers and Family Members	1. View and engage parents as partners and allies 2. Acknowledge and validate parents' feelings and concerns 3. Respect parents' wisdom and expertise 4. Educate about suicidal behaviour and treatment 5. Teach skills to enhance communication and reduce conflict	6. Offer social support 7. Enlist parents' active participation in keeping the home environment safe 8. Collaborate with parents in treatment, safety planning and monitoring 9. Clarify communication and confidentiality 10. Provide culturally relevant support
Engaging Hard to Reach Young People and Families	1. Provide a welcoming, compassionate, non-judgmental reception 2. Utilize collaborative and flexible models of care and outreach 3. Build a strong therapeutic alliance at point of first contact 4. Educate youth and parents about the role of mental health services 5. Increase confidence and hope that treatment can be of assistance	6. Involve parents/caregivers as key partners 7. Address concerns regarding confidentiality and clarify limits 8. Offer a diverse range of treatment options that are individually tailored and culturally appropriate 9. Work with informal and formal partners, including school staff, youth workers, and advocates, to connect with youth who are marginalized 10. Recognize and support constructive and credible Internet-based forms of self-help
Clinical Documentation	1. Use a systematic approach 2. Document risk assessment information as soon as possible 3. Ensure that the clinical record shows that the proposed treatment and safety plans correspond with the risk formulation 4. Include information from collateral sources	5. Document consultations with colleagues 6. Make specific note of protective factors and strengths-based interventions 7. Update the record to note any changes in suicide risk
Social and Systemic Interventions	1. Advocate for comprehensive, multi-faceted, community-wide approaches 2. Ensure child and youth mental health clinicians receive ongoing professional development training in youth suicide risk assessment, care and treatment 3. Improve organizational capacity to support new learning and uptake of new skills	4. Develop proactive protocols and procedures for the identification and follow-up care of suicidal adolescents 5. Strengthen local networks to support effective referrals and follow-up 6. Enhance linkages between emergency departments and child and youth mental health services 7. Develop clear policy goals to guide youth suicide prevention efforts 8. Address the social determinants of health

PRINCIPLES OF A SUICIDE RISK ASSESSMENT *

Core Features	Key Questions
Systemic, Multi-Faceted, Ecological	• Is the overall approach thorough, extensive and multifaceted? • Are self-report instruments always used in conjunction with a clinical interview? • Does the risk assessment take sufficient account of the larger ecological context and consider potential sociocultural constraints?
Research-Informed	• Is it informed by the current research evidence? • Does it reflect the most up-to-date literature?
Collaborative and Strengths-Based	• Is the process collaborative and strengths-based? • Are young people engaged as knowledgeable and capable? • Is there an emphasis on understanding the meaning of the suicidal despair from the young person's perspective?
Developmentally Appropriate	• Is it sufficiently attuned to developmental considerations? • Is the language matched to the child/youth's level of understanding?
Culturally Sensitive	• Is proactive attention paid to recognizing potential cultural barriers, including cultural biases, expectations about communication, role of self-disclosure, perceptions about the problem and causes of suicide, and preferred decision–making orientations?
Fluid Understanding of Risk	• Is risk understood as fluctuating and dynamic? • Are chronic (distal, enduring and static) and acute (proximal, episodic and variable) risk factors identified and addressed?
Focus on Protective Factors	• Are buffers (protective) factors against suicide thoroughly explored? • Is active consideration given to a range of protective factors across a number of social contexts?
Thorough Exploration of Current Suicidal Thinking	• Is current suicide ideation thoroughly examined beyond "yes/no" tickable boxes? • Does the assessment of current suicidality include an explicit consideration of suicidal desire, capability and intent?
Reflects Input from Collateral Informants	• Are collateral sources of information consulted and included? • Is this information included in the clinical record?
Risk Formulation	• Does the assessment process include the explicit step of risk formulation (i.e. minimal, mild, moderate, severe, imminent)? • Does the proposed treatment and safety plan match the level of suicidality?
Clear Documentation	• Does the documentation reflect a comprehensive, multi-modal assessment? • Does the recommended treatment plan correspond to the level of risk identified in the risk formulation?