Policy and Practice Considerations:

Clinical Assessment of Suicide Risk and Clinical Documentation:

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Executive Summary

Achieving the goal of reducing suicides and suicidal behaviours among youth in BC will require the coordinated and sustained efforts of many individuals and groups. Youth, parents and caregivers, families, schools, communities, professionals, governments, researchers, media organizations and advocacy groups all have a role to play in the prevention of youth suicide. Frontline practitioners and others, such as social workers and teachers, who work directly with children, youth and families on a regular basis are very well positioned to detect, respond to, and safely intervene with young people who are exhibiting signs of potential risk for suicide. Meanwhile, given their clinical mandate and regular engagement with youth who are experiencing emotional distress, child and youth mental health clinicians have a more specific contribution to make in the overall suicide prevention effort. This paper has been informed by the professional and empirical literature as well as the clinical wisdom of practitioners in the field. Two rounds of consultation with child and youth mental health managers, consultants and clinicians, plus input from policy consultants working for the Child and Youth Mental Health Policy Team and the Aboriginal Policy and Service Support Team, MCFD, have all usefully informed this work.

The assessment of suicide risk has been identified as a core competency for health care providers and mental health clinicians practicing across multiple disciplines and jurisdictions. The purpose of the clinical risk assessment is to make a determination about the young person's current risk for suicide based on a thorough consideration of individual risks and strengths as well as social and contextual considerations. Such an ecological

approach to suicide risk assessment recognizes that suicidality is multi-faceted and multiply determined.

While individual suicides are impossible to predict, child and youth mental health clinicians can estimate a young person's current level of suicide risk (e.g. low, moderate, high, or imminent), which will then provide the basis for the corresponding safety plan and treatment goals. It is imperative that policy makers, regional managers, emergency mental health providers and child and youth mental health clinicians working for the Ministry of Child and Family Development (MCFD) have access to up-to-date, high quality, relevant information to inform their local suicide risk assessment practices and policies.

The intent of this report is not to provide an exhaustive review of the literature on youth suicide risk factors or assessment tools since many recent, high quality reviews on these topics already exist. Rather, the purpose is to synthesize the best thinking of practitioners and recommendations from the published literature in response to three very practical questions:

1) **What** information should be systematically *elicited* when assessing risks for suicidal behaviour among children and youth?
2) **What** information should be systematically *documented* in the clinical record?
3) **How** might practitioners go about engaging children, youth (and their families/caregivers/community partners) so that potential risks for suicidal behaviour can be assessed within the context of a strong, ethical and collaborative relationship?

Despite some differences in language and emphases, there is general agreement in the literature on the following points:

1. Efforts to assess potential risks for suicide should be **guided by the research** evidence.
2. **Ecological conceptualizations** of suicide risk and resilience which reflect multiple domains and move beyond narrow, individualistic understandings should be considered
3. Both **chronic and acute risk** factors should be assessed and documented.
4. **Protective factors** should always be considered alongside risks.
5. A thorough exploration of **current suicidal thinking** should be undertaken.
6. After carefully weighing all of the risk and protective factors, clinicians should make an informed judgment about the **level of risk** (mild, moderate, high, and imminent).

Meanwhile, there are a number of distinct therapeutic orientations that clinicians can usefully bring to the task of youth suicide risk assessment. These include: collaborative and strengths-based, developmentally sensitive, and inclusive of the perspectives of families/caregivers/ community partners and other sources of collateral information.

Semi-structured clinical interviews which are embedded within broader assessment frameworks, (e.g. mental status exam, collaborative assessment protocols), and/or augmented with standardized self-report instruments, are highly recommended for child and youth mental health clinicians working in community-based out-patient settings.

Being knowledgeable about risk and protective factors for youth suicide, understanding the dynamic and fluid nature of suicide risk, recognizing individual and sociocultural contributions to risk, systematically gathering detailed information from the client and other collateral sources of information, formulating and documenting risk levels, and establishing clinically sound, developmentally informed, culturally safe treatment goals are just a few of the core competencies that all child and youth mental health clinicians practicing in community-based settings are expected to possess.

Youth Suicide Risk Assessment Practices: Distillation of Core Features

Core Features	Key Questions
Systematic 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?
Developmentally Appropriate	• Is it sufficiently attuned to developmental considerations? • Is the language matched to the child/youth's level of understanding?
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?

Introduction

Achieving the goal of reducing suicides and suicidal behaviours among youth in BC will require the coordinated and sustained efforts of many individuals and groups. Youth, parents and caregivers, families, schools, communities, professionals, governments, researchers, media organizations and advocacy groups all have a role to play in the prevention of youth suicide. Frontline practitioners and others, such as social workers and teachers, who work directly with children, youth and families on a regular basis are very well positioned to detect, respond to, and safely intervene with young people who are exhibiting signs of potential risk for suicide. Meanwhile, given their clinical mandate and regular engagement with youth who are experiencing emotional distress, child and youth mental health clinicians have a more specific contribution to make in the overall suicide prevention effort. This paper has been informed by the professional and empirical literature as well as the clinical wisdom of practitioners in the field. Two rounds of consultation with child and youth mental health managers and clinicians, plus input from policy analysts working for the Child and Youth Mental Health Policy Team and the Aboriginal Services Program Team, MCFD, have all usefully informed this work.

This aim of this paper is to support child and youth mental health clinicians to adopt a systematic, research-informed, and clinically sound approach to youth suicide risk assessment and documentation. Youth suicide risk assessment is an active, collaborative, goal-directed process.[1] [2] [3] The purpose of the clinical risk assessment is to make a determination about the young person's current risk for suicide based on a thorough consideration of individual risks and strengths as well as social and contextual

considerations. Such an ecological approach to suicide risk assessment recognizes that suicidality is multi-faceted and multiply determined. While individual suicides are impossible to predict,[4] child and youth mental health clinicians can estimate a client's current level of suicide risk (e.g. low, moderate, high, or imminent), [5] which will then provide the basis for the corresponding safety plan and treatment goals. The assessment of suicide risk has been identified as a core competency for health care providers and mental health clinicians practicing across multiple disciplines and jurisdictions.[6] [7]

Given that the scholarly research about youth suicide is voluminous and new clinical guidelines for suicide risk assessment are constantly being updated, it is imperative that policy makers, regional managers, emergency mental health providers and child and youth mental health clinicians working for the Ministry of Child and Family Development (MCFD) have access to up-to-date, high quality, relevant information to inform their local suicide risk assessment practices and policies.

The primary audience for this paper is mental health clinicians, managers and policy-makers. Each of these groups is anticipated to benefit from the material in slightly different ways. For example, clinicians and managers might be expected to use this paper as a point of reference for critically reflecting on their own local suicide risk assessment and documentation practices. Managers could conceivably use this paper to prompt broader dialogues regarding local service delivery practices and organizational responses to youth at risk for suicide. Policy makers may find the information useful as they consider how to support the delivery of high quality mental health care to youth at risk for suicide

through the development of institutional practices and policies that align with the directions being proposed here.

Having identified some of the expected beneficiaries of this paper, it is also important to clarify what this document is *not* intended to do. It is not designed to replace existing MCFD policy, nor is it to be interpreted as the standard of care for treating suicidal youth. It is neither a training guide nor a set of practice guidelines. Rather, it has been written to complement existing MCFD policies and both extends and supports much of the material that has been created on the MCFD website on the topic of youth suicide prevention http://www.mcf.gov.bc.ca/suicide_prevention/index.htm

Towards this end, the paper is organized into **three distinct sections**.

1. ***Integrated Summary of the Literature.***

   Recently published (2000-2010) literature on youth suicide risk assessment and clinical documentation is synthesized to highlight the core components of a multi-modal assessment and recommended strategies for engagement.

2. ***Distillation of Core Features.***

   Recognizing that there is no singular "right way" to approach the task of suicide risk assessment and appreciating that multiple approaches to youth suicide risk assessment and documentation are currently in use throughout the province, a set of core features that can be used as reference points for judging the quality and comprehensiveness of youth suicide prevention risk assessment tools, approaches and frameworks is proposed.

3. ***Documentation Example and Recommended Websites.***

   An example of one approach to clinical documentation as well as lists of websites that include suicide risk assessment tools, approaches and frameworks developed for specific populations and contexts are included in the Appendices.

Part 1. Integrated Summary of the Literature

In addition to an astounding number of books, chapters, systematic reviews of the literature, original research, case studies, and clinical guidelines published on the topic of suicide risk assessment each year, there is also a burgeoning number of websites and other on-line resources devoted to this issue. The sheer volume of information makes it challenging for managers and practitioners to discern quality, access the most clinically relevant information and stay abreast of new developments in the field. Further, much of the material published in this area is focused on adults and it is not always clear whether the risk assessment guidelines or standardized tools are suitable for children and youth. [8]

The intent of this report is not to provide an exhaustive review of the literature on youth suicide risk factors or assessment tools since many recent, high quality reviews on these topics already exist.[9] [10] [11] [12] [13]

Rather, the purpose is to synthesize the best thinking of practitioners and recommendations from the published literature in response to three very practical questions:

1) **What** information should be systematically *elicited* when assessing risks for suicidal behaviour among children and youth?
2) **What** information should be systematically *documented* in the clinical record?
3) **How** might practitioners go about engaging children, youth (and their families/caregivers) so that potential risks for suicidal behaviour can be

assessed within the context of a strong, ethical and collaborative relationship?

The "what" question addresses the multiple domains to be addressed within any overall risk assessment process while the "how" question is primarily concerned with issues of relational engagement, including the cultivation of trust, promotion of cultural safety, recognition of developmental differences, and the ethical commitment to do no harm. These issues are explored in more detail in the following sections. First though, it is important to clarify a few key terms.

The broad terms "suicidality" or "suicidal behaviours" are typically used to reference *all* aspects of suicidal thoughts, behaviours and actions, including death.[14] *Suicide ideation* refers to thoughts of harming or killing oneself. *Suicide attempt* refers to any non-fatal, self-inflicted action taken with the intention of killing oneself, regardless of lethality. *Suicide* refers to intentional, self-inflicted death. Finally, the term *non-suicidal self-injury* is used to describe behaviours which involve the intentional destruction of body tissue which are not socially sanctioned and are undertaken in the absence of any suicidal ideation or intention to die.[15] **The focus of this paper is on suicidal behaviours.**

What Information Should be Elicited?

"… we need to know what information is important, what questions to ask, and how to integrate the information in a coherent and meaningful framework to guide subsequent clinical decision making (Rudd, Joiner & Rajib, 2001).

Despite some differences in language and emphases, there is general agreement in the literature on the following points:

1. Efforts to assess potential risks for suicide should be **guided by the research** evidence. [16] [17] [18]
2. **Ecological conceptualizations** of suicide risk and resilience which reflect multiple domains and move beyond narrow, individualistic understandings should be considered. [19] [20] [21]
3. Both **chronic and acute risk** factors should be assessed and documented. [22]
4. **Protective factors** should always be considered alongside risks.[23]
5. A thorough exploration of **current suicidal thinking** should be undertaken.[24]
6. After carefully weighing all of the risk and protective factors, clinicians should make an informed judgment about the **level of risk** (mild, moderate, high, and imminent).[25]

Research-Informed

A number of high-quality systematic reviews of the literature on risk and protective factors for youth suicide exist. Child and youth mental health clinicians are advised to stay abreast of the evolving knowledge base by accessing this literature on a regular basis. The Ministry for Children and Family Development (MCFD) website http://www.mcf.gov.bc.ca/suicide_prevention/index.htm includes brief summaries of this literature and provides links to other relevant websites. Other recommended websites on this topic are included in **Appendix A.**

Ecological Approach

While there is very little disagreement in the literature about the need to be thorough when conducting a suicide risk assessment, different authors draw from different vocabularies and/or assign different levels of significance to particular domains. Many of these differences reflect different disciplinary traditions, practice contexts and/or professional orientations. An ecological approach to suicide risk assessment recognizes young people's embeddedness in multiple, overlapping social contexts. This means that active consideration must be given to the role of families, peer groups, schools, communities and the larger sociocultural context when attempting to understand risk and protective factors for youth suicide. Each of these realms can be sources of risk and/or well-being.

What follows is one example of how a systematic, multi-modal, ecological approach to youth suicide risk assessment might be conceptualized based on an integration of the recent literature.[26] [27] [28] [29] [30] [31] Semi-structured clinical interviews which are embedded

within broader assessment frameworks, (e.g. mental status exam, collaborative assessment protocols),[32] and/or augmented with standardized self-report instruments, are highly recommended.

Example of a systematic, multi-modal, ecological approach to youth suicide risk assessment:

I. **Identify Chronic/Predisposing Risk Factors**

II. **Identify Acute Risk Factors/Warning Signs**

III. **Identify Precipitants/Stressful Life Events**

IV. **Assess Current Suicidal Thinking**

V. **Identify Protective Factors**

VI. **Formulate Current Risk Level**

VII. **Prepare Documentation**

I. Identify Chronic Risk Factors/Predisposing Vulnerabilities

Some risk factors appear to be linked to particular historical experiences and/or reflect relatively static and enduring traits. These historical experiences and qualities have been conceptualized as "chronic risk factors" (in contrast to more acute and episodic risk factors).[33] A fluid understanding of suicide risk, which recognizes that suicidal crises have both chronic and acute features, is recommended and both need to be taken into account when conducting a risk assessment.[34]

The most significant contributor to suicide risk is previous and repetitive suicidal behaviours.[35] Thus young people who have a history of multiple suicide attempts

and who have historically shown limited capacity to manage or resolve their crises are at heightened risk. [36] Additional historical factors which increase overall vulnerability to suicide include: a history of poor impulsive control, limited social problem-solving,[37] enduring maladaptive coping strategies, family history of suicide, history of childhood maltreatment, and a history of psychiatric treatment or diagnoses.[38] [39] [40]

Other broad social, "macro-level," factors that should be borne in mind when conceptualizing suicide risk include a history of marginalization, oppression/colonization, social inequality and injustice, maltreatment, lack of educational or employment opportunities, cultural, historical, and intergenerational trauma, dislocation, and poverty. [41] [42] Also known as structural determinants of risk, these sociopolitical factors underscore the importance of conceptualizing risk through a broad ecological lens. By taking sufficient account of historical, social and cultural constraints, these orientations to conceptualizing risk avoid locating risk exclusively within individuals.[43] [44]

For example, when attempting to understand the elevated rates of suicide among some groups, including males; gay, lesbian, bisexual and transgendered (GLBT) youth; or Aboriginal youth, it is important to recognize how certain social, political and historical practices, like narrow notions of masculinity, homophobia, racism, and oppression, may confer risk on these particular groups.[45] [46] When conceptualizing and responding to suicidal behaviour among Aboriginal youth, clinicians need to be aware of the multiple forms of trauma (i.e. personal, historical, cultural, and inter-generational) that Indigenous peoples have endured and continue to experience as a result of the harmful legacy of colonization. Cultivating a deep understanding of the social, historical and political origins

of problems like depression, problem drinking and suicidal behaviour helps to direct clinicians' attention to the need for individual level interventions and social change when working with Aboriginal youth.

The concept of "intersectionality" refers to the complex ways in which race, culture, gender, sexual orientation, class, and ability interact to create social advantages and benefits for some while imposing constraints on others. This concept can be helpful in understanding interlocking and structural forms of oppression and privilege. Moreover, it draws our attention to broader social, cultural, and historical contexts as both sources of distress as well as potential sites for prevention, healing and transformation.[47] [48] [49]. There is a need to recognize that mental health is viewed differently from various enthnocultural perspectives. In practical terms, this way of working explicitly recognizes that we live in a world marked by historical inequalities and unequal relations of power. By bringing a cultural safety or social justice lens to their clinical work, child and youth mental health clinicians are more likely to recognize the structural constraints that many children, youth, and families are up against and are less likely to conceptualize mental health problems in exclusively individualistic or pathologizing terms.

Specific strategies that support a cultural safety/social justice orientation to clinical practice include:[50] [51]

- Recognize your own history as culture bearers
- Reflect on your own disciplinary training and professional socialization and consider how this influences your worldview of what is good/right/normal/healthy/desirable

- Commit to a process of reflecting on your own experiences of privilege. A good document to support critical reflection in this regard can be found on the Dulwich Centre website at http://www.dulwichcentre.com.au/privilege.html
- Develop a questioning approach to your practice which invites consideration of how organizational and institutional structures might be perpetuating inequities
- Participate in efforts to improve cultural competence and enhance culturally safe practices http://www.ecdip.org/docs/pdf/Cultural%20Safety%20Poster.pdf
- Familiarize yourself with models of therapeutic change that place social justice at the centre like the Just Therapy Team in New Zealand http://www.familycentre.org.nz/Areas_of_Work/Family_Therapy/index.html
- Inspired by the ideas of narrative therapist Michael White, consider how your approach to clinical work conceptualizes persons and their problems:[52] [53]
    - What does your commitment to this professional discourse reveal about the values, beliefs, hopes and dreams you bring to your work?
    - How does your preferred approach "see" persons?
    - How does it have them "treat" and "see" and "describe" themselves?

Summary of Chronic/Predisposing Risk Factors

Previous/repetitive suicidal behaviours History of impulsivity History of poor social problem solving History of psychiatric treatment

History of childhood maltreatment History of suicide in the family History of cultural dislocation, marginalization and social disadvantage Systemic forms of oppression

II. Identify Acute Risk Factors/Warning Signs

Acute risk factors tend to be episodic and variable. Explicit consideration should be given to assessing the severity of each of the following indicators of acute suicide risk: suicide ideation, depressive symptoms, psychotic features, anxiety, panic, hopelessness, impulsivity, and agitation.[54] [55] Psychiatric diagnoses that have been strongly linked to suicidal behaviour among youth include depression, anxiety disorders, substance abuse and conduct disorders. [56] As symptom severity increases, the risk for suicide goes up.[57]

A helpful mnemonic, IS PATH WARM (see below), has been developed to describe empirically supported warning signs of suicide.[58] This mnemonic can provide an additional set of prompts for systematically assessing acute or imminent risks for suicide.

Summary of Acute Risk Factors/Warning Signs: IS PATH WARM

Ideation Substance abuse Purposelessness Anxiety Trapped Hopelessness Withdrawal Anger Recklessness Mood change

III. Identify Precipitants/Stressful Life Events

Investigations into those recent stressful events that may have triggered the suicidal crisis are important to thoroughly explore as another type of acute risk factor. Studies

indicate that the most common precipitants of suicidal behaviour among youth include: interpersonal discord, recent loss, disciplinary crisis, parental conflict, or break-up of a romantic relationship.[59] [60] Many of these stressors are unique to adolescence and are exacerbated by impulsivity, low levels of distress tolerance, and a limited capacity to regulate emotions. Other precipitants to consider include: school problems, health crises, legal problems, failure, or bullying.

Summary of Common Precipitants/Stressful Life Events

Interpersonal conflict
Recent loss
Disciplinary crisis
Parental conflict
Rejection
Break-up of a romantic relationship
Health crises
Conflict with the law/ legal problems
Failure/academic difficulties
Bullying

IV. Assess Current Suicidal Thinking

Thoroughly exploring current suicidal thinking and planning is probably the most important domain to assess.[61] As most clinicians know, the only way to establish whether a risk for suicide exists is to ask directly. For example, "*Sometimes people who are feeling as depressed and overwhelmed as you are consider suicide. I wonder if that's something that has crossed your mind at all."*

In this phase of the clinical interview it is important to get as much *specific* information as possible. A series of questions, combined with specific therapeutic strategies designed to elicit sensitive material like suicidality has been recommended in the literature.[62] These include asking questions to increase behavioural specificity and framing

them in ways that reduce potential shame or distortions. For example, *what is the nature of the person's thoughts and plans? How have they imagined killing themselves? With what means or method? Have they ever rehearsed their suicide plan? Do they have access to these means? Have they made any final arrangements like written a suicide note or prepared a will?* Clients' own attitudes and beliefs about suicide are also relevant to explore. For example, *what do they think will happen after they kill themselves? What do they hope will be achieved with their suicide? Do they have any concerns, fears or ethical qualms about it?*

Recent contributions to the literature on suicide risk assessment suggest that when assessing current suicidal thinking, there is considerable value in making conceptual distinctions between **suicidal desire, capability and intent**.[63] These three facets can be used to prompt the clinician to ask a series of questions within this portion of the clinical interview.

Suicidal ***desire*** refers to a wish to die, having no reasons for living, and may include expressions of "passive suicidality" (e.g. not caring if they live or die). Suicidal desire is relatively common particularly among those experiencing high levels of distress; however, it is when suicidal desire occurs in combination with capability and intent that suicide risk levels significantly increase.[64]

Suicide ***capability*** refers to the capacity to enact lethal self-injury, [65] fearlessness about making a suicide attempt, a feeling of competence regarding the ability to make a suicide attempt, having the means, specific plans and opportunity available to attempt suicide. Rehearsal behaviours, including previous suicide attempts, and exposure to suicidality, on the part of a family member or friend, are also associated with capability. [66]

Finally, suicidal ***intent*** refers to plans, preparatory activities and clear

communication of suicidal intentions and a wish to die to others.

Summary of Current Suicidal Thinking

Ideation – specificity, frequency, duration, intensity Desirability of suicide – no reasons for living/desire to die Capability – capacity to enact lethal self-injury, fearlessness, access to means Intent – preparatory behaviours, expressions of intent to die

V. Identify Protective Factors

A suicide risk assessment that focuses only on risk factors is incomplete.[67] Assessing protective factors or buffers against suicide provide an important balance to the focus on risks, vulnerabilities, and threats to well-being. An active and deliberate focus on eliciting strengths, capacities, and resources can assist clinicians with their risk estimation and the process serves to remind children and youth of their own assets which have often been neglected or forgotten.

Protective factors refer to those factors and experiences that appear to reduce risks for suicide and other social problems. Many of these factors are associated with child and youth resilience. Research on resilience lends justification to those practices that seek to promote change at both the individual and social environmental levels.

The concept of resilience reflects three overlapping domains:[68]

- Resilience is the capacity of individuals to navigate their way to resources that sustain well-being
- Resilience is the capacity of individuals' physical and social ecologies to provide these resources

- Resilience is the capacity of individuals and their families and communities to negotiate culturally meaningful ways for resources to be shared

Research has suggested that the following individual qualities and social experiences may provide an important counterbalance to the accumulation of risk factors in some youth: strong individual coping and problem-solving skills, experience with success and feelings of effectiveness, strong sense of belonging and connection, perceived immediate support, interpersonal competence, family warmth, support and acceptance, success at school, plans for the future, strong cultural identity, and community self-determination.[69] [70]

At the same time, it is important to recognize that the presence of protective factors or previous indicators of resilience do not serve to "cancel out" risk factors, especially when multiple imminent risk factors are present (frequent, intense ideation and strongly expressed intent to die).[71]

Summary of Protective Factors

Strong individual coping
Problem solving skills
Experience with success
Feelings of effectiveness
Strong sense of belonging and connection
Perceived immediate support
Interpersonal competence
Family warmth, support and acceptance
Success at school
Plans for the future
Strong cultural identity
Community self-determination

VI. Formulate Current Risk Level

After a careful weighing of risk and protective factors, clinicians then need to estimate the current level of suicide risk. This is based on a judicious and thoughtful understanding of the specific constellation of risk factors, the presence of certain protective factors, the particular psychosocial history of the child or youth, the unique social context and the overall strength of the therapeutic alliance. Risk levels are typically conceptualized as follows: **none, low, moderate, high or imminent**. [72] The estimation of risk is both science and art and experienced clinicians recognize the importance of attending to the whole person, understanding suicide risk within a dynamic context, and being thorough and persistent in eliciting specific information. By attending to both chronic and acute risk factors and by assessing the child's/youth's overall willingness to collaborate and engage in a treatment planning process, clinicians are recognizing the dynamic and fluid quality of suicidality as well as the importance of the therapeutic alliance for any future work together.

VII. Prepare Documentation

Maintaining a clear clinical record that documents the **risk assessment, estimation of risk, approach to safety planning, treatment goals, and clinical consultations** is a key aspect of good clinical care. Documentation provides evidence of the following:[73] conveys relevant information to other professionals; serves as a quality assurance checklist, and provides protection against malpractice.

At a minimum, the clinical record should include the following information:[74]

- Client/caregiver consent to treatment
- Risk assessment(s)
- Record of decision-making, including safety plans
- Description of any changes in treatment
- Record of consultations with supervisor and colleagues
- Record of contacts with family members
- Prescription log (if applicable)
- Medical records of previous treatment (if available)
- Availability of means (e.g. firearms)
    - If present, document instructions given to child or youth and parents/caregivers
    - If absent, document as such
- Planning for coverage in clinician absence
- Termination status

Maintaining up-to-date, high-quality clinical records is an essential component of therapeutic work with suicidal clients, regardless of the treatment setting. Ethically, the clinical record provides evidence that the young person and/or caregiver has provided consent to treatment. It also gives clinicians the chance to provide a clear record of their case conceptualization and decision-making efforts. Maintaining detailed and specific notes can also protect clinicians against potential charges of malpractice.[75] Canada is a less litigious environment than the United States, and Canadian mental health practitioners are less likely to find themselves engaged in "defensive practices" (I.e. driven by fear of malpractice). Nonetheless thorough documentation of risk assessment and clinical management decisions remains a cornerstone of any risk management strategy.

As one way to decide whether the quality and depth of information included in the clinical record is sufficient, two questions are worth considering:[76]

1. What specific information from my knowledge of the child or youth's risk factors and the extent of their suicide ideation supports the conclusion I am about to write?

2. Would these facts appear to support my conclusion to another clinician?

One way of organizing the material is to document objective information in one section while providing more subjective clinical formulations in another.[77] Objective information might include: identifying information, demographics, presenting problem, child or youth and family history, and treatment history. More subjective information would include diagnostic formulations, suicide risk estimation, as well as safety and treatment planning. See Appendix B for a more detailed example.

The treatment plan developed by the clinician needs to correspond to the estimated level of risk. At a minimum, a **treatment plan** needs to address the following, all of which should be documented in the clinical record:[78]

- Site of treatment (in-patient or out-patient)
- Members of therapeutic team (including adjunct therapies)
- Overall approach to treatment (individual, group and/or family therapy)
- Treatment goals
- Primary treatment and risk management strategies
- Safety and crisis response plans (i.e. specific, time-limited, and collaboratively developed plans that are oriented towards a no-harm decision)

Safety planning is different from a no-suicide contract in that it is built into the overall treatment plan and emerges from the overall risk assessment process. It offers a vehicle for negotiating the action to be taken by the suicidal person depending on their level of subjective distress and suicidality. The primary purpose is to create a plan that the

child or youth will utilize when feeling suicidal, rather than providing the clinician with a sense of reassurance. Practitioners need to work with the young person to ensure that they will feel comfortable carrying out whatever plan is negotiated. Wherever possible, parents/caregivers should be actively involved in the development of the safety plan and should be given explicit information about how to keep their child and the home environment safe (e.g. reducing access to medications, securely storing firearms, etc.).

Despite the additional time involved in adequately documenting a suicide risk assessment, clinicians are strongly encouraged to document their suicide risk assessment and treatment plans immediately following clinical evaluation of the client.[79] Overly simplistic "yes/no" tickable boxes (i.e. Is the client suicidal?) and/or relying exclusively on singular dimensions of client self-report (e.g." denies suicide ideation") are generally poor substitutes for a thorough risk assessment and a step-by-step account of subsequent clinical judgment and planning.

Risk assessment should be undertaken and documented at the following points:[80] [81]

- Initial interview for all new clients
- Emergence or re-emergence of suicide ideation, plans or attempts
- Significant changes in the child or youth's condition
- During increased environmental stressor-worsening symptoms
- When there exists predisposition to suicidality
- Following consultation with collateral informants suggesting increased risk

Before moving on to a discussion of *how* to engage children and youth in a collaborative and strengths-based therapeutic relationship, a brief commentary on the use of self-report and standardized suicide risk assessment tools is warranted.

Use of Standardized Instruments

Supplementing the clinical interview with self-report instruments can add to the overall comprehensiveness and make a useful contribution to the clinical record.[82] Two widely endorsed scales for assessing suicide risk among adolescents are the *Beck Suicide Ideation Scale*[83] and the *Reynolds Suicidal Ideation Questionnaire*.[84] *The Reasons for Living Inventory for Adolescents*[85] is also strongly recommended as a way to elicit hopeful attitudes and potential protective factors against suicide. [86] [87]

How **to Engage?**

> *Developing an empathic connection by explicitly recognizing the level of pain and desperation the suicidal youth is experiencing is key to developing a strong alliance.*
>
> Berman, Jobes & Silverman (2006)

Suicide risk assessment involves a number of interrelated tasks. Taken together, they provide the initial relational context for the therapeutic alliance to develop and set the stage for future treatment planning. In the sections that follow, several therapeutic orientations for guiding clinicians in their suicide risk assessment practices are described.

Collaborative and Strengths-Based

Collaborative approaches to youth suicide risk assessment are strongly endorsed in the literature.[88] Representing a departure from traditional, expert-driven assessment approaches which are "done to" young people, a collaborative stance is one in which the clinician and client "co-author" a treatment plan based on a shared understanding of the client's suicidality. In a collaborative approach, both the clinician and the client are oriented towards targeting and reducing suicidality.[89] Strengths-based approaches

recognize that children and youth all have capacities, resources and assets to mobilize despite the presence of their "problem-saturated" stories. An active, curious and engaged therapeutic stance, combined with skillfully timed questions and sensitive pacing can all strengthen the therapeutic alliance and engender feelings of hope and possibility.[90]

Developmentally Sensitive

Though statistically rare, suicide does occur among pre-pubertal children. It is important not to underestimate children's understandings of the meaning of suicide, nor to discount the possibility that children do engage in suicidal behaviour. In general though, suicide rates typically increase with age. This is due in part to the fact that risk factors for suicide, including, major depressive disorders, increase during adolescence. [91] There is also a high level of co-morbidity, especially mood, anxiety, and substance abuse disorders observed among adolescents who die by suicide. [92] Certain social stressors exacerbate suicide risk when they co-occur with other vulnerabilities and these stressors (e.g. romantic relationships, educational challenges and pressures) tend to increase during adolescence.[93] Impulsivity can further heighten risks among this age group.

Intervention strategies that attend to the multiple contexts of adolescents' lives (families, peers, school, community), and which reflect diverse developmental pathways to growth and resilience are strongly supported.[94] Recognizing the importance of peer belonging and acceptance, supporting increasing independence within the context of loving relationships, and promoting active problem-solving approaches among this age group are key strategies to keep in mind.[95]

When assessing risk for suicide in *pre-pubertal children*, clinicians should consider

the following:[96] children's cognitive development, verbal skills, concepts of time, causality, and understandings of death/suicide. Questions should always be matched to the child or youth's developmental stage and level of understanding. The suicide risk assessment interview with young children typically employs a combination of problem-solving, environmental structuring, and assessing the need for additional services.[97]

Sample Questions to Ask Young Children About Suicide[98]

Did you ever feel so upset that you wished you were not alive or wanted to die?
Did you ever do something that you knew was so dangerous that you could get hurt or killed?
Did you ever try to hurt yourself or kill yourself?
Did you tell anyone that you wanted to die or were thinking about killing yourself?
Did you do anything to get ready to kill yourself?
Did you think that what you did would kill you?
Do you think about killing yourself more than once or twice a day?
Have you tried to kill yourself since last summer/since school began?
What would happen if you died? What would that be like?
How do you remember feeling when you were thinking about trying to kill yourself?
How is the way you felt then different from the way you feel now?

Involve Family Members/Caregivers and Other Collateral Sources of Information

The success of any treatment with suicidal adolescents is heightened when parents/caregivers and other family members are actively enlisted to support the treatment goals. Depending on the context, extended family members or other key members of the community might be invited to participate in the therapeutic healing process. Learning that their child has made a suicide attempt is a frightening experience for most parents and family members and they will likely have many questions and concerns of their own. Parents should always be provided with ongoing support and education regarding depression, mental health and suicide among youth. When parents are well-supported and well-informed, and when they are included as allies in the risk assessment and treatment process they will be able to better provide care and supervision for their suicidal child.[99] All collateral sources of information that are gathered in the course of the risk assessment should be well-documented in the clinical record.

Specific strategies for involving parents/caregivers include: [100]

Enlist the family members/caregivers in the monitoring and risk assessment process by telling them what to look for and how to recognize the importance of potentially suicidal behaviours
Ensure family members/caregivers understand the importance of reducing access to potentially lethal means of suicide, e.g. medications, firearms, etc.
Clarify the limits on information-sharing and remind family members/caregivers that if suicide risk is suspected, confidentiality will be breached and parents will be told
Communicate interest in what family members/caregivers have to say
Clearly define a role for the family/caregivers

Summary

Semi-structured clinical interviews which are embedded within broader assessment frameworks, (e.g. mental status exam, collaborative assessment protocols), and/or augmented with standardized self-report instruments, are highly recommended for child and youth mental health clinicians working in community-based out-patient settings. Being knowledgeable about risk and protective factors for youth suicide, understanding the dynamic and fluid nature of suicide risk, recognizing individual and sociocultural contributions to risk, systematically gathering detailed information from the client and other collateral sources of information, formulating and documenting risk levels, and establishing clinically sound, developmentally informed, culturally safe treatment goals are just a few of the core competencies that all child and youth mental health clinicians practicing in community-based settings are expected to possess.

Part 2. Youth Suicide Risk Assessment Practices: Distillation of Core Features

Core Features	Key Questions
Systematic 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?
Developmentally Appropriate	• Is it sufficiently attuned to developmental considerations? • Is the language matched to the child/youth's level of understanding?
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?

Appendix A: Recommended Websites on Youth Suicide Risk Assessment

Several tools, guidelines and tips for practitioners on assessing and treating youth suicidal behaviour are included on the BC Ministry for Children and Family Development website at

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

Suicide risk assessment and treatment resources developed specifically for counselors and mental health practitioners can be found on the Suicide Prevention Resource Center website at http://www.sprc.org/featured_resources/customized/social_worker.asp

A number of useful clinical tools including suicide risk assessment and depression scales which have been designed for use with adolescent populations are available at http://www.teenmentalhealth.org/pros_clinical.php

A list of standardized screening and suicide risk assessment tools are included at http://www.reconnectingyouth.com/ry/pdfs/Screening_Assessment_Tools.pdf

Appendix B. How to Structure a Suicide Risk Assessment Document

Shawn Shea (2002) suggests that a standard initial assessment is typically organized around two types of information: (1) objective information and (2) subjective, clinical formulation. Listed below are several prompts and headings for guiding the preparation of a sound clinical document based on this organizational structure.

I. Objective Information

Identifying Information and Demographics

Presenting Complaint

History of Present Illness

Past Psychiatric History and Treatment

Social and Developmental History

Family History

Medical History

Mental Status

II. Subjective Information

DSM Diagnoses

Clinical Summary and Formulation (includes suicide risk estimation)

Treatment Plan

General Comments:

- Specific risk factors for suicide can be described under the various categories of **Objective Information** (e.g. sex and age are included under *Demographics*, past history of attempts is included under *Past Psychiatric History*, current stressors and quality of interpersonal relationships is included under *Social and Developmental History*, etc.)
- Information about recent suicide ideation, planning and intent (previous two months until the present) can be included under the section *History of Present Illness*
- Document the absence of relevant risk factors, e.g. "no history of previous attempts" and any other noteworthy protective factors

- The **Subjective Information** section provides an opportunity for you to provide an account of the client's current suicide risk, including the how and why of your reasoning
- Include any consultations with colleagues under the *Clinical Formulation*

Source: Shea, S. (2002). *The practical art of suicide assessment: A guide for mental health professionals and substance abuse counselors.* Hoboken, NJ: John, Wiley & Sons.

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