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)

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**Suicide Prevention, Intervention and Postvention Practice Guidelines**

<table>
<thead>
<tr>
<th>Quick Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Develop a shared understanding of the young person’s suicidality</td>
</tr>
<tr>
<td><strong>2.</strong> Acknowledge emotional pain and recognize that thoughts of suicide are understandable under the circumstances</td>
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<tr>
<td><strong>3.</strong> Convey empathy and instill hope to young people and their parents/caregivers</td>
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<td><strong>4.</strong> Create opportunities for ongoing feedback</td>
</tr>
<tr>
<td><strong>5.</strong> Wherever possible, provide young people with some say about which clinician they work with</td>
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<tr>
<td><strong>6.</strong> Recognize the role of culture in understandings of distress and healing</td>
</tr>
<tr>
<td><strong>7.</strong> Clarify expectations about the treatment process, communication, and decision-making with youth and parents</td>
</tr>
<tr>
<td><strong>8.</strong> Understand the importance of the community as a context and resource for healing for Indigenous youth</td>
</tr>
<tr>
<td><strong>9.</strong> Respect and follow cultural protocols</td>
</tr>
<tr>
<td><strong>10.</strong> Build strong and respectful relationships with individuals, families, and communities</td>
</tr>
</tbody>
</table>

**Building Relationships**

1. Ensure the process is systematic, multi-faceted and holistic
2. Utilise 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

**Assessing Risk**

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

**Planning for Safety**

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 inequalities in the emergence of distress and suicidal despair

**Treatmeent and Care**

1. Expect the co-occurrence of problems
2. Actively involve youth and parents in the treatment process
3. Utilise 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

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*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](http://www.mcf.gov.bc.ca/suicide_prevention/index.htm)
## Core Features

### 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
- 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?

## Key Questions

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## Principles of a Suicide Risk Assessment

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