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Acknowledgements

This document was originally produced by the NSW Department of Health. It was later revised for the Saskatchewan Ministry of Health. We thank the NSW Department of Health for granting permission to reproduce copyright material. Additionally, we would like to thank the New Zealand Frameworks Group and Ministry of Health for use of their material.
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Foreword

Statement from the Regional Directors and Ministry of Health Table

Suicide is a devastating event for those close to the person who died with enduring emotional consequences. It also affects the wider community both emotionally and economically. Effective treatment of mental illness can reduce or abolish the risk of suicide. Effective treatment requires recognition and a reduction in the barriers to appropriate care. These barriers include: stigma against mental illness, limited public knowledge about symptoms indicating mental illness, difficulties accessing affordable services and suitably trained individuals. Such services need to interface with other relevant organizations and people to provide a full range of appropriate interventions. Services need to be continued for long enough to reduce suicide risk and improve mental health in the long-term.

Developing a framework is, in many ways, the easy part of the task of improving practice. Achieving commitment to changes in practice and changes in systems of care requires effective implementation. These changes must be backed by quality educational measures which are maintained over time and supported by adequate supervision on a regular basis. Adequate supervision includes clinical audit and quality improvement processes. These strategies require appropriate piloting, evaluation and adequate resources if the promise of this document is to be achieved. The Regional Directors of Mental Health and Addiction Services and the Ministry of Health are committed to reducing the rate of suicide and suicide attempts. We hope these frameworks are implemented by Regional Health Authorities to achieve a common goal.
A Historic Background

Ensuring the safety of patients at risk for suicide has been identified as a significant issue at the provincial and national level. In June 2008, the Ministry of Health issued a provincial “Alert ensuring the safety of patients at risk for suicide” which provided recommendations for addressing areas of concern.

In response to the Ministry recommendations, a provincial Safety Alert Working Group was formed. The findings and recommendations of this group were tabled in a report to the Regional Directors of Mental Health & Addictions Services. See Final Report: *Provincial Response to Saskatchewan Health Safety Alert: Patients at Risk of Suicide (September 2009).*

At the national level, Accreditation Canada introduced a required organizational practice (ROP) which came into effect in May 2008. This ROP requires provincial Regional Health Authorities to assess and monitor clients at risk of suicide and has developed specific actions to test for compliance in this area. Accreditation Canada’s sector and service-based standards help organizations assess quality at the point of service delivery. They are based upon five key elements of service excellence: clinical leadership, people, process, information, and performance. This framework is organized around the required organizational practice established by Accreditation Canada.

In 2010, a Suicide Task Committee was formed at the provincial level. As a first step, the committee conducted a survey of practices across Health Regions. This survey informed that there was not a consistent approach to the assessment and management of suicide across the province. The goal of this committee was to move recommendations forward into frameworks and protocols that would guide individuals working within the health system in the appropriate assessment and management of suicidal people.

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Saskatchewan Statistics

The rates of suicide are gathered yearly and reported every 5 years. The rates of suicide continue to be a concern in Saskatchewan. The rates in Northern Saskatchewan are twice the provincial average and have increased during the most recent 5 year average. (Ministry of Health, 2010).

RATES OF SUICIDE BY AGE GROUP (2004 - 2008)

RATES OF SUICIDE BY HEALTH REGION (2004 – 2008)
The Saskatchewan Regional Health Authorities (RHAs) are tasked with accreditation every 4 years from Accreditation Canada. This document was written to assist the RHAs to comply with the Required Organizational Practice (ROP) associated with obtaining accreditation. Compliancy with the ROP entails the RHAs, seeking &/or maintaining accreditation, assess and monitor clients for risk of suicide. Various factors are considered when testing for compliance including:

- Each client is assessed for risk of suicide at regular intervals, or as needs change.
- Clients are identified at risk of suicide.
- The client’s immediate safety needs are addressed.
- Treatment and monitoring strategies are identified to ensure client safety.
- Treatment and monitoring strategies are documented in the client’s health record.

[Accreditation Canada, 2010]

To be considered compliant, all Regional Health Authorities should ensure:

- Regional policies and procedures are developed and utilized for the prevention, assessment and treatment of suicidal behaviors.
- Staff are aware of, educated to and has easy access to all current policies and frameworks in relation to suicide assessment and prevention.
- There are clear regional protocols for consultation with mental health services.
- Relevant to the health care setting, staff are proficient in performing standardized procedures and protocols for assessing, managing and providing follow-up for people who are at risk of suicide.
- Training in suicide risk assessment and management is available to staff to ensure proficiency in role performance. Training is reviewed and updated on a regular basis.
- A standardized multi-departmental response across the health continuum is adopted within regions for persons at risk of suicide.
Summary of Suicide Management Principles

- Anyone who talks about suicide should be taken seriously. People who die by suicide have often previously expressed suicidal thoughts or displayed warning signs. All people who report self-harm or suicidal intent should be treated as being in a state of potential emergency until convinced otherwise.

- When a health care provider remains uncertain after a clinical assessment, it is important to consult with a senior colleague, supervisor or psychiatrist.

- Whenever possible, support people, including families and significant others, should be involved when working with a suicidal person. A collaborative partnership is equally relevant for the assessment component, crisis management and subsequent treatment. At any time, support people can give information without compromising privacy. If a suicidal person declines involvement of others, their refusal may be circumvented to keep them safe.

- Any person at risk of suicide should be re-assessed regularly, particularly if their circumstances have changed. A suicidal person’s mental state and suicide risk can fluctuate considerably over time. Changeability of risk status should be assessed and high changeability should be identified. More vigilant management is adopted, with respect to the safety of the person, in light of the identified risk of high changeability.

- Thorough and timely documentation should be structured and include: relevant suicide risk assessments; a comprehensive physical assessment if appropriate; support people’s concerns; previous psychiatric history; previous treatment received including key clinical decisions; and discharge plan including who is providing follow up services.

- Training in suicide assessments improves staff performance, encourages appropriate referrals and advances the overall care provided. Provincial consensus recognizes Applied Suicide Intervention Skills Training (ASIST) as the foundational training for staff coming in contact with suicidal individuals.

- Emergency department staff should be able to contact a trained mental health clinician to assist a patient following an act of deliberate self-harm, irrespective of intent or lethality, or if suicidal ideation is expressed.

- Access to appropriate and timely clinical supervision is important for all mental health clinicians. This should also include discussion regarding high-risk persons and the opportunity for debriefing on management interventions.

- Culturally appropriate services should be offered to the suicidal person whenever possible.

- Information for persons at risk of suicide, and their support people, should be provided. Material should contain information regarding: actions being taken to minimize suicide risk, contact information for 24-hour services and options for treatment and management.
Other Considerations

Informed Consent

There is an ethical and legal requirement that a person give informed consent to any treatment offered to them. Informed consent includes information about:

- The type of assessment and/or treatment;
- Details about its known efficacy and any side-effects;
- Estimation (if possible) of the likely duration of treatment; and
- Any alternative options.

This information should be presented in jargon-free language so that the person can understand the different options available.

Mental Health Service Act & Involuntary Detainment

At times, a suicidal person may not be able to exercise their usual degree of judgment and autonomy in making such a decision. Persons assessed at high risk of suicide, who refuse to see a psychiatrist or attend a hospital emergency department, will require a health care provider to act in his/her client’s best interests. When it is necessary to act against a person’s wishes, in order to prevent them from killing or seriously harming themselves or others, it is necessary to utilize The Mental Health Services Act.

Please contact a mental health service for further information about involuntary treatment and utilizing The Mental Health Service Act.

Health Information Protection Act & Confidentiality

Health care providers have professional and legal obligations to keep client information confidential. However, there are circumstances when it will be appropriate to disclose information including:

- When the person is capable of giving consent and consents to the information being disclosed to specific person(s);
- When failure to disclose information could place the individual at serious risk of physical harm or death and disclosure is justified in order to avoid this risk;
- When failure to disclose information could place other members of the community at serious risk of physical harm or death and disclosure is justified in order to avoid this risk;
- When there is a need to consult a supervisor or a colleague; and
- When the person is less than 16 years of age and the information is disclosed for the purposes of notification under child protection legislation.
**Information Sharing**

Information about the outcome of a suicide risk assessment and the management plan may need to be communicated to a range of other people including: parent(s) &/or guardian(s), support people, a general practitioner, other members of a treatment team including mental health & addiction services. Information about a person may be passed to someone else:

- With the person’s explicit consent;
- On a ‘need to know’ basis when the recipient needs the information because he/she will be involved with the person’s care or treatment; or
- If the need to protect the person at risk or others outweighs the duty of confidentiality to the person.

When staff from more than one agency are involved, the person at risk needs to be informed that some sharing of information will or may occur during the course of treatment.

**Documentation**

- All details of risk assessment, management plans and observations are to be clearly documented in the person’s medical/clinical record.
- Regular reviews, including re-assessment of risks and response to clinical interventions, should be noted.
- The rationale, including the reasons for the decision to manage a person in the community, and the management plan to support the decision should be documented.
- Contact details for the person at risk, family, support people and treating professionals should also be noted.
- If family, support people or other health professionals contact a health care provider regarding a person at risk, all information, including their concerns, should be documented.

**Audits**

A systematic review, using audit tools to ensure compliance to the framework, will need to be implemented in each Regional Health Authority and within each practice setting.

See appendix C for a sample of an audit template.
Introduction to Framework

Suicidal behavior is one of the most common and stressful psychiatric emergencies. There is neither a single explanation for suicide attempts nor any simple solutions to treatment. Suicide prevention is the concern of all health care providers and the whole community. Health care providers play a key role in early detection and intervention with people who are at risk of suicide. The aim of this document is to assist health care staff to make informed judgments about risk by providing a framework and information on best practices and evidenced based outcomes. Research has shown that, if properly developed, communicated and implemented, frameworks can improve care.

The Framework for Assessment and Management of People at Risk of Suicide for Saskatchewan Health Care Providers outlines a comprehensive framework to guide the suicide risk assessment and management process. The framework contains protocols which outline standards of practice that must be implemented in key treatment settings throughout all health services. These protocols describe the responsibilities and requirements for health care professionals, across the health continuum, in the assessment and management of suicide risk. While the framework represents a statement of best practice, based on the latest available evidence at the time of publishing, it is not intended to replace the health care professional's judgment in each individual case.

Protocols for Suicide Risk Assessment and Management for specific settings are identified in appendixes to this document. Supplementary information, in regards to specific populations, is also included.

Implementing the Framework

The goal of a suicide risk assessment is to determine the level of suicide risk at a given time and to provide the appropriate clinical care and management. Assessment is a continuing process, occurring along a pathway of care, from the person’s first presentation to a health service to the provision of treatment leading to discharge.

The assessment and management of suicide risk is conducted within a collaborative partnership between the person at risk of suicide, their support people and relevant health care services.

A suicide risk assessment generates a rating of the risk that the person will attempt suicide in the immediate future. The person’s immediate and short term suicide risk can be assigned to one of four broad categories including: high risk, medium risk, low risk, no (foreseeable) risk. The level of changeability of the person, and confidence in the assessment rating, should be taken into account.
**Figure 1: Four Categories of Suicide Risk**

<table>
<thead>
<tr>
<th>NO (FORESEEABLE) RISK</th>
<th>LOW RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Following a comprehensive suicide risk assessment, there is no evidence of current risk to the person. There are no thoughts of suicide, or history of attempts, and they have a good social support network.</td>
<td>Definite but low risk of suicide. A person at this level of risk is considered to require review at least monthly. The time frame for review should be determined based on clinical judgment. After discharge from an in-patient unit, the review is to be conducted within one week. The person at risk should be provided with written information on 24-hour access to suitable clinical care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDIUM RISK</th>
<th>HIGH RISK, HIGH CHANGEABILITY &amp;/or LOW ASSESSMENT CONFIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant but moderate risk of suicide. The clinician ensures that a person at this level of risk receives a re-assessment within one week. Contingency plans are in place for rapid re-assessment if distress or symptoms escalate.</td>
<td>Steps are taken to ensure that the person is in an appropriate, safe and secure environment. A Mental Health Clinician organizes a re-assessment within 24 hours. Ongoing management and close monitoring occurs. Contingency plans are in place for rapid re-assessment if distress or symptoms escalate.</td>
</tr>
</tbody>
</table>
Engagement is crucial to detection, assessment and management of suicide risk. Engagement is a continuous process throughout all interactions with the suicidal person. Health care providers take responsibility for maximizing engagement. Level of engagement is assessed. Limits of confidentiality are discussed. Detection is about identifying risk factors. Most people seek help prior to a suicide attempt. Documentation of care is completed in a thorough and timely manner. It is important and safe to ask about suicide risk.

**Figure 2: Framework for Suicide Risk Assessment and Management for Saskatchewan Healthcare Providers**

In practice, the progressive steps described below might not necessarily be carried out in this order.

- Engagement
- Preliminary Suicide Screening
- Suicide Risk Level Assessment
- Management of Suicide Risk by Protocols
- Reassessment of Suicide Risk
- Discharge

- All persons accessing health care services need to be screened for suicide.
- Health care providers, at all access points, need to be trained to screen patients for suicide.
- All access points must have procedures in place to screen for suicide.

- Determine the level of risk.
- Assess multiple factors including protective factors.
- Determine impulsivity.
- Determine changeability of risk status and assessment confidence.
- Determine validity of information through corroborative information.
- Consult with team &/or senior colleagues.

- Determine appropriate clinical interventions and clinical setting.
- Refer to management protocols for specific clinical settings.
- Inclusion of person at risk, family and other service providers in plan.
- Contingency planning.

- Level of risk will determine time frame for reassessment.
- New risk levels determines further treatment.
- If required, review with consultant.
- Reassessment of risk at every transition point of care.
- Ensure continuity of clinical care.
- Obtain collateral information.

- Suicide risk is low or no foreseeable risk.
- Discharge from hospital.
- Information regarding accessing services after discharge.
- Educational material for families & other support people.
- Re-entry pathway.
Components of the Framework

<table>
<thead>
<tr>
<th>Engagement</th>
<th>Health care providers take responsibility for maximizing engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage is crucial to detection, assessment and management of suicide risk</td>
<td>Level of engagement is assessed</td>
</tr>
<tr>
<td>Engagement is a continuous process throughout all interactions with the suicidal person</td>
<td>Limits to confidentiality are discussed</td>
</tr>
</tbody>
</table>

Engagement is crucial to detection, assessment and management of suicide risk and is a continuous process throughout all interactions with the suicidal person

Engagement and detection are interdependent. Engagement is often crucial to detecting a person’s suicide risk and is the first task once suicide risk is suspected. The level of engagement is an important determinant of the degree to which the person is willing to participate in the assessment by revealing their issues. The level of engagement is also an indicator of the likelihood of the person’s participation in the management plan.

Health care providers take responsibility for maximizing engagement

To assist in the engagement process, the health care provider should:

- Be professional, non-judgmental, non-threatening;
- Show genuine interest and concern for the person’s situation;
- Be empathic by providing reassurance and hope;
- Offer an ability and willingness to provide practical assistance;
- Invite an appropriate level of partnership; and
- Listen to the family and/or support person’s reactions (such as distress, anger, confusion, fear) without taking sides.

It is important that attempts be made to engage the person’s family and/or support people. Engagement of support people is vital in many cultures. Cultural aspects of engagement need to be considered including:

- How does the person differ from their peers?
- What might be considered good rapport or evasive behavior in their culture?
- What are their common cultural beliefs or prior experiences that may interfere with engagement?

Strong personal reactions often occur when assessing an individual with suicidal or self-harming behavior. The health care provider needs to have a capacity to observe and manage their feelings. Clinical supervision and consultation are important supports to ensure all health care providers gain experience in managing such situations.
Level of engagement is assessed

The capacity of the person to establish rapport and trust will provide important information on the level of alliance and partnership which is likely to develop in the immediate future. Engagement is a key indicator in the prospect of influencing the person in a positive and safety-enhancing manner. Therefore, consideration should be given to the level of confidence in the quality of the connection established between the health care provider and the suicidal person.

Limits of confidentiality are discussed

At some stage of the assessment, often in the initial stages, the issue of confidentiality will need to be discussed. This will include informing the person of the need to contact other relevant people to acquire further information to assist in determining the current suicide risk status. On matters directly relevant to safety, complete confidentiality cannot be guaranteed. For further information, please review page 10 of this document entitled Information Sharing.

Detection

- Detection is about identifying risk factors
- Most people seek help prior to a suicide attempt
- Documentation of care is important
- It is important to ask about suicide risk

Detection is about identifying risk factors

Certain risk factors should elicit a high index of suspicion. Conducting comprehensive suicide risk assessment should occur in certain situations including:

- The first 28 days following a discharge from in-patient mental health care is a critical time. Particularly attention should be paid following a suicide attempt, noted suicidal ideation and/or depression.
- People, who return for services after a recent suicide attempt, or after self-harming behavior, require careful reassessment. Premature closure should be avoided.
- A significant portion of people who die by suicide suffer from a diagnosable mental health disorder. Linking those at risk of suicide with mental health care is essential.

Most people seek help prior to a suicide attempt

The majority of people who die by suicide have consulted a primary health care professional in the few weeks prior to their death.

Preliminary Suicide Screening

- All persons accessing health care services need to be screened for suicide
- Health care providers, at all access points, need to be trained to screen patients for suicide
- All access points to health care services must have procedures in place to screen for suicide
All persons accessing health care services need to be screened for suicide

A hierarchy of screening questions, which gently leads to asking about suicidal ideas, is a generally accepted procedure for all health care professionals.

Figure 3: Screening Questions for Suicide

1. Are you having any feelings of hopelessness, helplessness or depression?
2. Have you had any thoughts, urges or behaviors related to harming yourself?
3. Have you recently engaged in any reckless behavior such as; abusing alcohol or drugs, reckless driving or impulsive actions?
4. Have things been so bad lately that you have thought you would rather not be here?
5. Are you thinking of suicide?
6. Have you made any current plans?
7. Do you have the means to act on your plan?

It is important to clarify the answer and watch for answers that avoid directly answering the questions! If any of the above questions are answered “YES” an assessment of risk level must be done.

Health care providers need to be trained and all access points must have procedures in place for suicide

As noted earlier, Regional Health Authorities (RHAs) should ensure all services are compliant with Accreditation Canada’s required organizational practice. Utilizing the tests for compliance, as provided by Accreditation Canada, will enhance the prevention, assessment and treatment of suicidal behaviors.

- Training in suicide assessments improves staff performance, encourages appropriate and timely referrals and improves overall care. Provincial consensus recognizes Applied Suicide Intervention Skills Training (ASIST) as the foundational training for staff coming in contact with suicidal individuals.

- Relevant to the type of health care services, staff should be proficient in performing standardized procedures and protocols for assessing, managing and providing follow-up for people who are at risk of suicide.

- Training in suicide risk assessment and management is available to staff to ensure proficiency in role performance. Training is reviewed and updated on a regular basis.

- Staff are aware of, educated to and have easy access to this framework and protocols and other relevant policies in relation to suicide assessment and prevention (including future changes and amendments to this document).
Suicide Risk Level Assessment

- Determine the level of risk
- Assess multiple factors including protective factors
- Determine impulsivity
- Determine changeability of suicide risk status
- Determine assessment confidence
- Determine validity of information through collateral & corroborative information
- Consult with team &/or senior colleagues

**Determine the level of risk**

The goal of a suicide risk assessment is to determine the level of suicide risk at a given time, and to determine the next step of care and management. Literature indicates there is not a definite predictor of suicide. However, a rating scale, in combination with good clinical judgment, provides a means to determine management protocols.

The suicide risk assessment is a tool that assists all health care providers in rating the risk that a person will attempt suicide in the immediate future. The suicide risk assessment tool is a reliable tool, with proven validity, that will enable confidence in the rating that is generated. The rating generated will determine what actions need to occur to ensure the persons immediate and longer term safety and suggest the next steps of a management plan.

The Suicide Risk Assessment is meant to be used as a guide only and not to replace clinical decision-making and practice. The health care provider must use his/her experience, knowledge and skill in estimating the current level of suicide risk. A reflective practice approach is important. All available information should be evaluated for its quality and be appropriately weighed.

**Assess multiple factors including protective factors**

Risk factors, specifically associated with a higher risk of dying from suicide, can be classified into three categories: demographic factors, groups at higher risk and current personal risk factors.
Figure 4: Examples of demographic, group and personal risk factors for dying from suicide

<table>
<thead>
<tr>
<th>Demographic Factors</th>
<th>Groups at Higher Risk</th>
<th>Current Personal Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Male</td>
<td>▪ Previous history of attempts or self-harm</td>
<td>▪ At risk mental health status</td>
</tr>
<tr>
<td>▪ Between 19-45 years of age</td>
<td>▪ History of a mental illness, particularly depression, schizophrenia, other psychotic illness, personality disorder</td>
<td></td>
</tr>
<tr>
<td>▪ Older people</td>
<td>▪ History of sexual or physical abuse or neglect</td>
<td>▪ Recent interpersonal crisis, especially rejection &amp;/or humiliation</td>
</tr>
<tr>
<td>▪ Living in rural area</td>
<td>▪ History of trauma</td>
<td>▪ Recent major loss, trauma or anniversary</td>
</tr>
<tr>
<td>▪ Members of minority groups</td>
<td>▪ First presentations of mental illness</td>
<td>▪ Post-Partum depression</td>
</tr>
<tr>
<td>▪ People with sexual identity conflicts</td>
<td>▪ Victims of domestic violence</td>
<td>▪ Alcohol intoxication</td>
</tr>
<tr>
<td>▪ Immigrants, refugees, asylum seekers</td>
<td>▪ Alcohol and other substance abuse; co-morbidity</td>
<td>▪ Drug withdrawal state</td>
</tr>
<tr>
<td>▪ Homelessness</td>
<td>▪ Marginalized populations</td>
<td>▪ Chronic pain or illness</td>
</tr>
<tr>
<td></td>
<td>▪ Serious physical illness or disability</td>
<td>▪ Financial difficulties, unemployment</td>
</tr>
<tr>
<td></td>
<td>▪ People in prison or police custody</td>
<td>▪ Impending legal prosecution</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Family breakdown, child custody issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Lack of social support network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Unwillingness to accept help</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Cultural or religious conflicts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Difficulty accessing help due to; language barriers, lack of information &amp;/or support, negative experiences with mental health services</td>
</tr>
</tbody>
</table>
Protective factors have been identified that may protect a person from suicide. These include:

- Strong perceived social supports
- Family cohesion
- Peer group affiliation
- Good coping and problem-solving skills
- Positive values and beliefs
- Ability to seek and access help

Research suggests that suicidal behavior commonly results from a convergence of multiple, predisposing and concurrent, risk factors that combine to elevate the risk of suicide. A broad view of all of the risk factors associated with suicidal behavior is important to consider during the assessment. However, the most important risk factors for estimating the current and immediate risk are the personal risk factors. Specifically, the current mental state that is impacting on the individual’s life at the present time is significant.

Important personal risk factors include how depressed an individual is and whether they have made suicidal plans as opposed to having passive suicidal thoughts. It is also important to note that a person might not reveal their plans and might try to hide their suicidal intent.

Other current personal risk factors include:

- At risk mental health state especially hopelessness, despair, agitation, shame, guilt, anger, psychosis etc.
- Recent suicide attempt
- Personal vulnerability, challenges to dependency &/or impulsivity

Hopelessness is one of the main factors mediating the relationship between depression and suicidal intent. Some people experiencing hopelessness may conclude that death is a better alternative than living a life in which they believe there is no hope for a positive future. Hopelessness can be determined by exploring how a person feels about his/her future. Lack of positive expectancies and a negative view on life are important factors in suicidal behavior.

Distinguishing between “self-harm without suicidal intent” and “attempted suicide” can be difficult. Regardless of motivation or intention, both are dangerous behaviors associated with a heightened risk of dying. Self-harm is a maladaptive behavior that reflects severe internal distress which may not always be evident in the external demeanor. Self-harming behavior also reflects a limited ability to develop effective coping strategies to deal with difficulties. While some of the management principles described in these frameworks may be helpful, additional measures are necessary and a referral to an appropriate mental health service is needed.
Impulsivity

Impulsivity is a personality trait characterized by the inclination of an individual to initiate behavior without adequate forethought as to the consequences of their actions. Impulsivity is related to risk-taking, lack of planning and making up one's mind quickly. Impulsivity has been shown to be a major component of various neuropsychiatric disorders such as ADHD, substance abuse disorders and bipolar disorder. Impulsivity has been shown to increase in the presence of alcohol and other substances including street or prescription drugs.

Please note that intoxication delays the immediate assessment of a suicidal person. If suicide risk is identified in an intoxicated person, they should be detained in a safe setting until a full assessment is conducted. Determining risk cannot occur until after the person is detoxified.

Changeability

Risk status is changeable and requires regular re-assessment. For people identified as having highly changeable risk status, more vigilant or frequent management may be required. Changeability of risk status, especially in the immediate future, should be assessed and high changeability should be identified. When high changeability is identified, the need for careful re-assessment and consideration as to when the re-assessment should occur is important. More vigilant management is adopted with respect to the safety of the person in light of the identified risk of high changeability.

Confidence of assessment

A number of factors may indicate low (poor) assessment confidence including:

- Factors in the person at risk, such as; impulsivity, likelihood of drug or alcohol abuse, present intoxication and inability to engage.
- Factors in the social environment, such as; impending court case, divorce with child custody dispute
- Factors in the assessment, such as; incomplete assessment, inability to obtain collateral information.
- Health factors in the person at risk.

If a low assessment confidence is present, careful consideration for re-assessment should occur (ex. within 24 hours). With respect to the safety of the person, and in light of gaps of information or rapport, a more vigilant management style is adopted. Careful consideration into the quality of the assessment is encouraged in relation to:

- The likelihood of the person’s suicide risk changing in the next 24 hours;
- The quality of alliance between the health care provider and the person at risk;
- Confidence that all the required information is provided;
Given the current level of suicide risk assessed, consideration for the most appropriate management plan; and

- A plan of when to review the suicide risk with the person

**Collateral & corroborative information**

Corroboration helps to provide accuracy around the changeability of suicide risk status, enhances the confidence of the assessment, provides opportunities to assess supports and assists with collaboration about management and discharge planning. The purpose of a corroborative history is to confirm the assessment, confirm the level of support available to the person and promote collaboration with the suicidal individual and their support person/s.

All means for accessing information, to assist with the risk assessment, must be actively sought.

- Due to stigma and shame, support people may not reveal the extent of the suicidal person’s problems for fear of repercussions. For example, a mother might fear having her children taken away.
- It’s important to assess the support person’s belief about the current presentation of the person at risk and determine their response to the situation. Family &/or support people might indicate that the suicidal individual is in distress, attention seeking, etc. and is worried, angry, etc.
- Assess the family or support person’s willingness and capacity to facilitate a protective environment for the at-risk individual upon discharge (ex. monitoring safety, removal of means, etc.).
- Corroboration can also provide an opportunity for engagement with the family or other support people where appropriate.
- Careful consideration of the person’s privacy, prior to obtaining corroborative history, must occur. For further information, see page nine of this document entitled *Health Information Protection Act & Confidentiality*.

**Consultation with team or senior colleague**

Assessment of people at risk of suicide is a complex and demanding task that requires involvement of an experienced health care provider at some level. Wherever possible, all assessments of suicide should be discussed with a senior colleague or supervisor.

- Consideration of the time of consultation should be based on the degree of concern for the person at risk. The greater the concern, the sooner the consultation should be sought.
- For persons from culturally and linguistically diverse backgrounds, consideration needs to be given to obtaining information from a cultural consultant.
- All team members involved in the assessment of persons at risk should ideally have access to regular (daily or weekly) clinical forums, such as a clinical case review, where all cases are presented and discussed.
Management Of Suicide Risk By Protocols

- Determine appropriate clinical interventions and clinical setting
- Refer to management protocols for specific clinical settings
- Inclusion of person at risk, family and other service providers in plan
- Contingency planning

A comprehensive mental health assessment

All people at risk of suicide are to receive a comprehensive mental health assessment that includes a psychiatric assessment, psychosocial assessment and a corroborative detailed suicide risk assessment. In some settings and services, comprehensive suicide risk assessment may be conducted by general health professionals in consultation with a mental health clinician.

A comprehensive mental health assessment requires a medical assessment and physical examination. Additionally, an investigation may be required to detect illnesses. Most frequently, suicidal behaviours are symptoms of underlying mental health problems or disorders. Therefore, a suicide risk assessment cannot be undertaken in isolation from an overall mental health assessment. The clinician needs to assess for the following illnesses:

- Depression
- Schizophrenia or other psychosis
- Bi-polar disorder
- Anxiety
- The patient’s personality style
- Command hallucinations
- Current/ previous drug & alcohol use

Exploration of these areas will provide further information on the changeability of risk status. For example, a person with a history of impulsivity under stress would be assessed as having a high level of changeability. Determine the plausibility of suicidal ideation denial in the context of a patient’s recent psychotic experiences or with the current severity of their depression. Assess whether the person is psychologically competent to enter into a therapeutic alliance. For example, a person who is distressed and believes that they are responsible for the AIDS epidemic cannot give a meaningful reassurance they have no intention of harming themselves.

A comprehensive mental health assessment goes beyond a suicide risk assessment. As such it should identify the following elements:

- Person: name, age, marital status, employment status, family history of mental illness and other professional(s) they are currently, or recently, involved with.
- Problem: determine why the assessment is being completed at this time; determine the events leading up to their present state.
- Perpetuating factors: determine what in their life is maintaining the problem; determine if alcohol &/or drug abuse is an issue.
- Past history: determine if they experienced a similar problem in the past and how have they dealt with it in the past.
- Power: explore the individual’s belief regarding how much of the solution is within their power to control. Help them to see how much power they have to engage the problem.
- Plan: based on all the information, determine a recommended course of action. Complete a suicide risk assessment.

**Presence of risks &/or other factors**

A comprehensive mental health assessment may also explore various risks &/or factors that will increase the risk of suicide.

The presence of certain at-risk mental states escalates the level of suicide risk. These would include: hopelessness, despair, agitation, shame, anger, guilt and psychosis. These emotions may be exhibited and the level of distress they cause should be identified.

Lethality and intent are very important to explore. Sometimes the intent of the suicidal individual may be obvious from his or her account. However, more complex issues may need to be explored. Consider the following questions:

- What is the person’s degree of suicidal intent? How determined were/are they?
- Was ‘rescue’ anticipated or likely? Were there elaborate preparations and measures taken to ensure death was likely?
- Did the person believe they would die? Question the person’s perception of lethality.

Lethality and intent may also be more complex with people from culturally and linguistically diverse backgrounds. For example, planning would be of a lower lethality in an extended family due to likelihood of discovery. Planning may not be apart of the culture’s script, due to the likelihood of discovery, but may be very lethal for those more isolated.

The presence of a suicide plan, or preparation for death, may indicate serious suicidal intent. It is important to consider:

- How far has the suicide planning process proceeded
- Is there a specific method, place, time
- How long has the person had the plans and/or thought about the plans
- How realistic are the plans

Additionally, it is important to consider if the person has finalized personal business. Consider if they made a will, made arrangements for pets, said goodbyes or gave away possessions.

In most cases, the chances of dying from a suicide attempt are much higher if a person has developed a potentially fatal plan and has the means and knowledge to carry it out. It is important to corroborate the information with a support person.
Consider if a person at high risk of suicide has access to firearms. The police should be contacted to discuss the possibility of removing the firearms.

Consider if poison and/or lethal medication is available to the suicidal person. Consider such medication as insulin, cardiovascular medications, antidepressants etc.

Consider if the method chosen by the suicidal person is irreversible. For example, does the method include shooting, jumping, etc.?

Has the person made a special effort to find out information about methods of suicide? Does the person have particular knowledge about using lethal means?

Consider the suicidal person’s type of occupation. For example, is he/she a police officer, farmer (access to guns), health worker (access to drugs), etc?

Consider the safety of others. When possible, corroborate the information with others.

Has the person’s thoughts ever included harming someone else?

Has the person harmed anyone else? If so, what is their rationale for harming another?

Is there a risk of murder-suicide? Is the person psychotic?

Are there issues regarding custody of children? Is there evidence of postnatal depression? If so, are the children safe?

Consider the motivation of the suicidal person. Explore cultural aspects of meaning and motivation with persons from culturally and linguistically diverse backgrounds.

What is the person’s understanding of their predicament? What is the meaning of recent events for them?

What is motivating the person to harm him/her self? Has the person lost his/her main reason for living?

Does the person believe that it might be possible for their predicament to change?

Explore the coping potential and capacity of the suicidal person.

Does the person have the capacity to enter into a therapeutic alliance/partnership?

Does the person recognize any personal strengths or effective coping strategies?

How has the person managed previous life events and stressors? What problem-solving strategies are they open to?

Are there social or community supports? Consider; family, friends, church, general practitioner, etc. Can the person use these supports?

Can the person acknowledge self-destructive behaviour and identify it as a risk? Can the person agree to abstain from or limit alcohol &/or drug consumption?

Can the clinician assist the person to manage the risk of impulsive behaviour?
Management protocols for specific clinical settings

The first management decision in treating a person at risk of suicide is to determine the most appropriate and available treatment setting. Specific protocols have been developed that contain the standards of practice that must be implemented in key treatment settings.

- Appendix A: Community Mental Health Services
- Appendix B: Mental Health In-patient Units
- Appendix C: Facility Checklists & Access to Means
- Appendix D: Emergency Department (under construction)
- Appendix E: General Hospital Ward (under construction)
- Appendix F: Primary Health Care Service (under construction)
- Appendix G: Health Services in Justice Settings (under construction)

Determine appropriate clinical interventions

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<td>▪ De-escalation &amp; issues of environmental safety</td>
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<td>▪ Symptom control, treatment of mental illness &amp;/or use of medication</td>
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<td>▪ Caring &amp; empathic responses to foster a therapeutic alliance, Instilling hope</td>
<td>▪ Referral to other services to further clarify &amp; address risk factors</td>
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<td>▪ Exploring incidents, motivation &amp; circumstances</td>
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<td>▪ Identifying individual risk and protective factors</td>
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<td>▪ If person is intoxicated, exploring detox services</td>
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<td>▪ If necessary, utilization of the Mental Health Services Act</td>
<td>▪ Education on illness and risk management for person and support people</td>
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<td>▪ Addressing apparent risks, including possible removal of firearms by police</td>
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<td>▪ Assess family &amp;/or other support, ensure support is provided and coordinated</td>
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<tr>
<td>▪ Develop a contingency plan that includes family &amp;/or other support</td>
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<td>▪ Follow-up arrangements</td>
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Re-assessment of Suicide Risk

- Level of risk will determine time frame for reassessment
- New risk levels determines further treatment
- If required, review with consultant

- Reassessment of risk at every transition point of care
- Ensure continuity of clinical care
- Obtain collateral information

Level of risk will determine time frame for reassessment

A mandatory component of managing a person at risk of suicide is the re-assessment of that risk. The management plan should include the date, and in some cases even the time, that a re-assessment of risk will be undertaken. This will depend on the level of risk determined at the previous assessment and at every transition point of care.

This step also facilitates the re-assessment of the changeability of risk. The re-assessment also allows for the re-appraisal of the assessment confidence in the current risk status. If feasible utilizing the same health care provider for the re-assessment facilitates engagement and generally enhances the accuracy of the assessment.

In addition to reviewing the person’s state of mind, the re-assessment of risk needs to include:

- Circumstances in the social environment that may have changed.
- Collateral information, particularly from the family or support person, is sought as part of the re-assessment of suicide risk.

Reassessment of risk needs to happen at every transition point of care

At any transition point, the new health care provider must be made aware of the person’s level of risk and the current management plan. The person’s family, support people, general practitioner, psychiatrist or other professionals involved in their care should be kept informed of changes in management.

Discharge

- Suicide risk is low or no foreseeable risk
- Discharge from hospital
- Information regarding accessing services after discharge

- Educational material for families and other support people
- Re-entry pathway

Suicide risk is low or no foreseeable risk

The assessment and management of suicide risk aims to assist the person through a period of immediate or imminent risk of suicide. When the person’s risk can be revised down to low or no foreseeable risk, levels of care can be safely reduced. The person can be assessed for routine follow-up care and/or discharged from the care of the mental health services.
Discharge from hospital

Key areas to address at the time of discharge are:

- Reassessment of suicide risk
- The person’s current mental state
- Resolution of precipitating, or perpetuating, factors &/or events
- Significant relationships and social circumstances including accommodation, employment and financial situation
- Follow-up or re-entry arrangements made and communicated to the person.

People who have been at risk of suicide require close follow-up when discharged from hospital. The first 28 days after discharge from hospital has been identified as a period of elevated risk of suicide. The management plan for people being discharged from hospital or acute care is to be documented and includes:

- A booked appointment within the first week with a Mental Health Clinician who has responsibility for the person’s community management and will complete a risk re-assessment at that first appointment;
- Confirmation that the person and his/her family, or support person(s), have been provided with contact details for rapid response re-assessment; and
- Communication with a general practitioner as appropriate.

Accessing services after discharge

When a person is discharged from a mental health service, there are precautions that should be in place and documented in the discharge plan. The person, and their family or support person(s), should:

- Know how to re-enter the appropriate level of care through a re-assessment process;
- Have confidence that there are no barriers to re-assessment and, where necessary, re-entry to the appropriate level of care;
- Understand that, wherever possible, the preferred point of contact is a Mental Health Clinician who knows the person;
- Be provided with phone contact numbers to use in the case of emergency and to get support in the moment re-entry may be required.

Education for families, caregivers, supports

On discharge, it is important to provide patients/clients, and their family or support person(s), with written documentation about the illness they were being treated for, their follow up treatment plan including appointment dates and times, information on suicide and how to maintain their safety plan.
Assessment & Crisis Management with Special Populations

Children & Adolescents

In 1997, the Canadian suicide rate for children, under 14 years of age, was 0.9 per 100,000 and for adolescents, aged 15 – 19 years, was 12.9 per 100,000. As the data shows, a steep escalation of suicide is evident during the middle teens. In Canada, suicide is the second leading cause of death in both sexes for youth aged 10 – 19 years of age and is the third leading cause of death among children aged 10 to 14 years of age. In Canada, the methods of suicide used by youth 10 to 19 years old were firearms, drugs, carbon monoxide poisoning and hanging. Suicide can occur at any age; however developmental factors can modify the clinical presentation of suicidal behavior in children and youth. Before puberty, the prevalence of suicidal behavior is rare; it increases steeply with age, peaking between the ages of 19 and 23 years. Suicide is unusual in young children, in part owing to their cognitive immaturity, which prevents them from planning and executing a lethal suicide attempt; the younger the child, the less complex and more immediately available the method.

Precipitants of suicidal behavior vary with age, with discordant family relationships being a common precipitant for pre-pubertal children and peer conflicts for adolescents. Having certain psychiatric disorders (for example, major depressive disorder) is a risk factor for suicidal behavior at any age, but the frequency of onset of some of these disorders increases with age, becoming more common in older adolescents and adulthood. A complex interplay of risk factors facilitates suicidal behavior among children and youth. These factors include age, sex, ethnicity, psychiatric disorders, prior attempts, a preexisting cognitive profile (rigidity, poor problem solving, pessimism, impulsivity), abuse during childhood, dysfunctional family backgrounds, firearm availability and stressful life events.

The roles of caregivers and schools are more salient in the assessment, management and prevention of suicidal behavior in children and youth, as compared with an adult population. Steele, M., Doey, T. (2007)

Elderly

Adults 65 years or older have high rates of suicide worldwide. Approximately 1.3 seniors die by suicide in Canada every day. Older men are at especially high risk of suicide. The 1997 suicide rate for older Canadian men (23.0 in 1000,000) was nearly twice that of the nation as a whole (12.3 in 1000,000) and nearly five times that of older Canadian women (4.5 in 100,000). In 2002, 430 Canadians 65 years of age or older (361 men and 69 women) died as a result of “intentional self-harm”. This is likely a low estimate as it is widely believed that published mortality statistics underestimate the total number of deaths by suicide, owing, in part to the stigma of suicide and other social pressures that may lead family members and health professionals to avoid labeling deaths as suicides.
The lethal potential of self-harm behavior increases with advancing age, partly owing to the lethality of the means used. Other possible contributing factors to the lethality of late-life self-harm behavior may include lessened physical resiliency and the relative physical or social isolation of older adults who engage in self-harm behavior (Heisel, Grek, et al., 2006).

The general risk factors for suicide among the elderly people are very similar to those experienced by younger people. Suicidal ideation is closely linked with the presence of psychiatric disorder, in particular depression and the early stages of dementia. In addition, there is a marked association between physical illness (particularly painful illness), depression and suicide among older people. Additionally, elderly people have often experienced a number of major losses, which may act as precipitating events such as loss of health, loss of mobility, cognitive functioning, ability for self-care, loss of role/job, loss of means for self-support, loss of home or cherished possessions (New Zealand Guidelines Group, 2003). Although multiple risk factors commonly coexist in suicidal older adults, clinicians should not judge an older adult’s suicide risk to be low simply owing to the presence of only one or two risk factors or absence of a specific risk factor. It can be very helpful to contextualize risk factors within the older adult’s life experiences.

Assessment of suicide risk requires sensitive and careful evaluation, clinical judgment, and experience and is best conducted in the context of good clinical rapport. Use of well-constructed assessment tools, developed &/or carefully validated among older adult populations, can aid in the detection of suicide risk or resiliency by mental health professionals with appropriate training in the selection, administration, scoring and interpretation of psychological assessment measures. Measures designed to assess suicidal features among older adults include The Harmful Behaviors scale, The Reasons for Living Scale Older-Adult version, and the Geriatric Suicide Ideation Scale (Heisel, Grek, et al., 2006).

**Aboriginal Peoples**

Suicide was rare among Aboriginal Peoples in Canada in pre-European contact times. However the suicide rate has increased since that time, particularly within the past few decades (White and Jodoin, 2003). The suicide rate for Aboriginal Peoples is three times that of the general Canadian population (Royal Commission on Aboriginal Peoples, 1995). There are strong reasons to believe the elevated suicide rate of Aboriginal people is a reflection of the overall health and well being of the communities within which Aboriginal people are living.

Aboriginal youth suicide appears to reflect a range of inequities in access to services that promote the appropriate development of children & youth. These factors include poorer access to health, recreation, education and employment opportunities. Of particular concern is the exposure of young Aboriginal people to racism, substance abuse, violence and sexual assault.

Although Aboriginal people are subject to many of the same risk factors for suicide that apply to non-Aboriginal people, it appears many of these risk factors are concentrated in Aboriginal communities. In relation to Aboriginal youth suicide, the high proportion of suicidal behavior...
that occurs in rapid response to negative events requires particular recognition. Services need to address and assist young Aboriginal people who have poor coping abilities, impulsive response styles and elevated stress responses resulting from early and prolonged exposure to trauma and grief. Additionally, the exposure of Aboriginal people to suicide in their families and communities and to representations of Aboriginal suicide in the media requires that services work with Aboriginal communities to target the perception that suicide is a culturally appropriate response to distress and negative events.

Many Aboriginal suicidal crises are precipitated by conflict or offence within family or community. These may be surrounded with shame and reluctance to engage with services that require extensive, albeit sensitive, probing by the health care provider. Equally there may be cultural violations or breaches of cultural law that may be significant in individual cases. Elders tend to know what to do and how to resolve these issues. The strength of Aboriginal family and community ties are significant protective factors against suicide.

Whenever possible, the involvement of Aboriginal mental health workers in all stages of assessment and management and, in particular, at time of discharge, is essential to the effective engagement of Aboriginal clients (Royal Commission on Aboriginal Peoples, 1995).

**Culturally and linguistically diverse communities**

A culturally sensitive approach to working within a multicultural society requires health professionals to be aware of their own cultural values and beliefs. It is recommended that when working cross-culturally, staff approach the person with sensitivity to and respect for the social and cultural context of the client’s problems and their personal and social history. It is important to understand the personal meaning of the illness and suffering for the individual, their family and their community.

A comprehensive suicide risk assessment will take into account the diverse issues facing migrants, refugees and refugee claimants. Factors that are associated with increased risk of suicide for immigrants and refugees, from non-English speaking backgrounds, include low levels of English language proficiency and the resulting difficulties in accessing health services.

Accessing mental health service might be complicated by stigma about mental illness and lack of knowledge about how services operate in Saskatchewan. Stressors are frequently experienced during the process of adjusting to mainstream culture and, in the case of refugees, may be superimposed on a background of pre-arrival experiences of torture or trauma. Other factors that might be experienced following immigration include a decrease in socio-economic status, lack of recognition of overseas qualifications and separation from social, religious and cultural networks. Immigrants and refugees might also experience prejudice, discrimination and breakdown of traditional family structures with inter-cultural conflict between generations being a major feature.
Consideration needs to be given to cultural context when exploring assessment issues, in particular the possible meaning of an act of suicide to the individual, their family and their community. Clinicians need to give attention to cultural differences in the expression of emotions and symptoms and how these differences are interpreted. In relation to management, when a situation involves a person from a culturally and linguistically diverse community, consideration needs to be given to how family members and culture-specific community support services will be involved. Health staff are encouraged to network more widely than traditional avenues when providing services to individuals from different cultures to incorporate their community supports (e.g. church, community leaders, Migrant Resource Centers, etc.) Where complex or unknown cultural dynamics are involved, consideration needs to be given to the use of a cultural consultant. This should be considered irrespective of the need for an interpreter.

Wherever possible, culturally and linguistically diverse people and their family should have the same accessibility as English-speaking communities to mental health services. They must be informed, in their own language, of the 24-hour telephone interpreter service and how to access it. They must be provided with the 24-hour interpreter service telephone number, together with the 24-hour contact number for the mental health services.

**Chronically Suicidal People**

There are some people who repeatedly seek assistance from mental health or emergency services for suicidal ideation or episodes of deliberate self-harm. These chronically suicidal people often suffer from personality disorders (Beautrais, AL, Joyce, PR, 1996).

There appears to be a link between suicide and personality disorder. People with these diagnoses are often impulsive and have difficulty managing their emotional state, including sadness and anger. They are also more likely to get into interpersonal conflicts and then lack the skills to solve these issues. These factors in turn increase the likelihood of self-harm and suicidal behavior.

People with personality disorders are also at an elevated risk of developing a secondary Axis 1 disorder such as depression or psychosis, which in turn places the person at elevated risk of suicide. A clinician must be cautious about downplaying the seriousness of such a person’s attempt at suicide on the grounds that they are “attention-seeking”. Although these people’s suicidal crises may resolve relatively quickly, they remain at high risk and even higher risk if they have developed an Axis 1 disorder. A careful assessment is always warranted and emergency departments should always contact mental health services whenever such a person presents (Beautrais etal, 1996).

For these individuals, it is critical that a detailed management plan is developed in conjunction with the person at risk of suicide so that all parties know how to respond and what to reasonably expect. Management plans should include both a list of chronic symptoms and also acute symptoms. This assists clinicians in determining whether a person is presenting with new/
greater risk than their ongoing chronic risk. These management plans should ideally be developed when the person is relatively well, should be kept current and have an expiry date (New Zealand Guideline Group, 2003).

**Maternal Mental Health**

Maternal mental health is an increasingly urgent health concern. The prevalence of depression and anxiety among women peaks during childbearing years. Every woman is vulnerable to mental health problems during pregnancy or postpartum but the following factors increase the risk including: poverty, single status, minority ethnicity, and a history of depression.

Untreated maternal depression and anxiety can impact all aspects of an entire family and is associated with significant personal, social, and economic costs. There is increased risk of pregnancy complications, preterm birth, impaired breastfeeding, and attachment problems. Additionally, the child of a mother who has struggled with mental health problems can experience developmental and cognitive difficulties.

The World Health Organization identifies depression as the number one cause of disability in women worldwide. Depression during pregnancy is more prevalent than common physical issues such as gestational diabetes. Up to one in five pregnant and postpartum women suffer from depression related to pregnancy and childbirth, meaning approximately 2,800 Saskatchewan women and their families are affected each year. It has been reported that up to 29.5% of socially high-risk pregnant women in Saskatchewan are depressed.

Approximately 0.1 – 0.2% of postpartum women experience postpartum psychosis which is characterized by agitation, hallucinations, mood swings &/or bizarre perceptions. Postpartum psychosis usually occurs within the first few weeks following childbirth but can also present later in the postpartum year. Postpartum psychosis is a serious problem that can lead to self-harm, infanticide or homicide. It is probable that maternal suicides and attempted infanticides happen in Saskatchewan however these are largely unknown due to lack of public reporting of such events out of respect for the family.

(Maternal Mental Health Strategy, 2010)
Summary

This document provides both a framework and protocols for the assessment and management of people at risk of suicide. The content of the framework, as well as the protocols, are in response to the Suicide Alert issued by the Province of Saskatchewan in 2008 and the standards outlined in the 2009 Accreditation Canada Required Operating Practice (ROP). The framework is a blend of practice, both provincially and internationally, and has been written in a format that satisfies the mandate of the Provincial Alert as well as the Accreditation Canada ROP.

While it is recognized that some health regions in the province have developed tools and policy, regarding the assessment and management of suicide, others have not. No one health region has developed an all-inclusive policy/procedure document that addresses all components of the Alert or ROP. The framework and protocols in this document are intended to be a resource to strengthen existing practices and process.

As with most things in the health care industry, Suicide is not a static issue; neither is the framework and protocols outlined in this document. It is recognized that ongoing yearly work will need to take place to review the contents so that the framework and protocols can be relevant and current. The Regional Executive Directors will need to ensure that this is adopted and communicated to the Provincial working groups.

Regional Executive Directors of Mental Health and Addiction services will need to use the framework to measure their region’s compliance to both the Alert and the ROP. The framework and protocols are not mental health specific rather should be considered an all-inclusive process that guides regional health staff where ever an intake of a client into the system exists.

The framework is intended to be used by the Regional Executive Directors to start conversations with other departments providing services in the health care continuum. While there may be existing protocols, for example in the Emergency Departments, this document is intended to be a starting place that guides the personalization of the framework and protocol in the local region.

To launch the framework provincially, the Suicide Task Team will present the content of the framework and the protocols via Telehealth. Following this initial step, Regional Executive Directors will use the contents of the framework to provide ongoing in-service training opportunities for mental health and addiction staff. Going forward, other departments within the health regions will be educated as agreement is reached on how the contents of the documents can be introduced into their specific departments. Should clarification be required, members of the provincial Suicide Task team may be available to provide content expertise.
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