

Subject/Title: SUICIDE RISK ASSESSMENT and DOCUMENTATION	Former Reference:	POLICY NO. S-1
Approving Authority: Mental Health and Addictions Services Executive Team	Effective Date: 2007.04	
Classification: Quality Patient Care	Revised:	
		Page: 1 OF 4

REASON FOR POLICY

The risk of suicide increases in individuals with mental disorders. Suicide risk assessment helps the clinician identify modifiable (treatable) and non-modifiable risk factors, evaluate protective factors and implement safety management and treatment planning. Documentation of the assessment and management of suicide risk is essential to help prevent suicide: it facilitates safe, quality care and records clinical judgments based on the client's current status and review of recorded data and consultations.¹

UNDERLYING PRINCIPLES

Suicide risk is dynamic. Shifts and changes in stressors, interactions, the course of illness and treatment, and the client's ability to self regulate require on going assessment to determine risk.

Use of standardized suicide terminology promotes clarity in team communication and documentation. (See Attachment A)

Clinicians are required to possess core competencies in suicide risk assessment and to combine these with evidence-based care.² (See Attachment B: Competencies for Suicide Risk Assessment, Mental Health & Addictions Services, 2007.)

DEFINITIONS

Core Competencies are "clusters of knowledge, skills, abilities and attitudes or perceptions required for the clinical assessment, formulation of risk, treatment planning and management of individuals at risk for suicide to protect their lives and promote their well-being."²

APPLICABILITY

This policy applies to staff of CHR Mental Health & Addictions Services (which includes employees and medical staff) and students who have clinical contact with the client as caregiver, treatment team member, and consultant.

POLICY STATEMENTS

1. Consent, Safety and Risk Management

- Client involvement in decision-making and treatment choices (consent) is the optimal goal when working with clients at risk for suicide.^{3,4,5}
- The clinician must explore the client's willingness and ability to commit to the treatment process and plan.^{3,6,7}
- 'Suicide-prevention contracts', 'no-suicide contracts' and 'contracting for safety' cannot and should not take the place of a thorough suicide risk assessment and the subsequent implementation of a treatment plan, including safety planning, to reduce and manage risk.³⁻¹⁰ (see Process 1 & 2)
- When clinical judgment deems the client at such risk for self harm that assessment and care under the Mental Health Act of Alberta is required, clinical responsibilities and client rights are legislated. (Mental Health & Addictions policies M-1, M-2, M-3, M-4)
- Consent to involve or contact family, significant others and referral sources, is addressed early in discussion with the client. Family involvement, in the majority of situations, is a positive and supportive approach to care and safety.^{3,4,6,7} Having a contact person also permits notification in the event of AMA discharge.

Subject/Title: SUICIDE RISK ASSESSMENT and DOCUMENTATION	POLICY NO. S-1	Page: 2
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- Families require information and education about safety in the home.³ (Attachment C: Home Safety & Suicide Prevention card #605501)
- When suicidal ideation is present, the clinician determines if the client has access to firearms and other means of harm.^{2,3,4}
 - If firearms are accessible and there is imminent danger to the health or safety of the client, clinicians must arrange for firearms removal or disabling. In this instance, client consent is not necessary. First speak with family/significant others. If they are unable to disable the gun then contact Calgary Police Service/appropriate policing authority.
 - Client consent is required if there is no imminent danger but it is decided between the client and clinician that removal or disabling of firearms would be safer for the client.
 - The clinician documents discussion with the client and significant others and interventions taken.^{4,6}

2. Documentation

- Documentation is clear, comprehensive, accurate, legible and timely – that is, as soon as possible after interaction with the client, but within 24 hours. Documentation later than 24 hours after client contact is to be identified as a 'late entry'. (calgary health region policy #1611)
- Initial suicide risk assessments are comprehensive (see Process #1). Though some facts found in demographic data and history may appear in a different part of the health record, all relevant information is considered in the overall assessment of risk for suicide (eg-suicide survivor, family psychiatric history, substance abuse).
- Subsequent suicide risk assessments (see Process# 2) document a summary of the client's risk factors, current changes and suicidality while reflecting an assessment and plan for care.
- A client's denial of suicidal ideation does not, by itself, reflect a reasonable assessment of that client's suicide risk.^{3,4,10-14}

3. Documentation of Suicide Risk Assessment occurs at the following points in care: ^{4,6-15}

Initial assessment:

- Upon admission or first clinical contact with the client, including those admitted to Forensic Psychiatry and clients who present with substance abuse concerns.
- With the occurrence of suicidal behaviour or ideation
- In MH Services where contact occurs over the phone, staff assess the level of risk for harm in clients in distress and determine a response and course of action appropriate to the situation.

Subsequent assessment for a client at risk for suicide:

- When there is any significant clinical change in client's condition whether improvement or deterioration in stressors, behaviours and symptoms
- With changes in level of treatment and treatment setting
- At the time of change in status, e.g.-from voluntary to involuntary or when canceling certificates under the Mental Health Act
- At key points in forensic psychiatry care such as before court appearances and return to the correctional facility
- Before increasing privileges, changing frequency of observation levels or granting passes (eg-weekend safety planning for adolescent programs).
- Before discharge from any mental health service

4. Documentation of the management of chronic suicidality and parasuicidal behaviours¹⁶

Management requires:

- distinguishing suicidal impulses and behaviour from parasuicidal behaviors with non-lethal intent eg-self-cutting
- monitoring changes in self-harming behaviours
- discussing with the client the motivations and goals of self-harming behaviours
- working with the client to minimize the use of suicidal threat/self-harm as a form of communication or tension relief
- keeping in mind the factors which contribute to the clients being in a high risk group (eg-past abuse, loss and trauma)
- recognizing that that these clients are higher risk because frequent, self-harming behaviours, though not intended to be lethal, might result in serious injury

Documentation includes risk assessment, client teaching about self care and harm reduction, client involvement in treatment and safety planning.

PROCESS of ASSESSMENT and DOCUMENTATION**1. Initial Suicide Risk Assessment Fields of Inquiry include:**^{4,7,10,-12}

- **Demographic data**
- **History:** in particular, predisposition to suicidal behaviour such as previous suicide attempts, gestures, and threats; previous psychiatric diagnosis and treatment, recent discharge from hospital⁴, substance misuse, history of abuse, family psychiatric history, loss, suicide survivorship, medical illness and pain; response to prior therapeutic interventions
- **Stressors** and identifiable precipitants
- **Symptoms**-current presentation; presence of hopelessness, impulsivity, and lack of self-control
- **Ideation, motivation and plans for suicide:** explore the client's plan for specificity of details, lethality of method, access to means, chance of rescue and reasons for wanting to die.³
- **Protective factors**- client resources: strengths, coping skills, supports, ability to self regulate
- **Overall assessment of risk at this time- including** modifiable versus non-modifiable risk factors and the client's willingness and ability to commit to the treatment process and to living
- **Action taken**- the reasoning/clinical judgment for treatment interventions and changes

2. Subsequent, Ongoing Suicide Risk Assessment Fields of Inquiry include:^{3-6,11,12}

- **Changes** in client behaviour, affect, symptoms and stressors
- **High risk factors** present in the client's current situation and background
- **Protective factors** and resources currently present
- **Suicidal ideation and plans**- client responses to direct questions about suicidality
- **Overall assessment of risk at this time** including the client's willingness and ability to commit to the treatment process and to living
- **Action taken:** the reasoning/clinical judgment for treatment interventions and changes

3. Document Additional Risk Management Practices^{4,6}**I. Consultations and collateral information which may include:**

- Second opinions, team conferences
- Family meetings or discussions with the client's significant others
- Accessing previous health records and risk assessments
- Viewed (supervised) interactions

II. Coverage when primary caregiver is not available:^{3,10,11}

- Identify who has agreed to cover care, for what time periods and whether the client is aware of the plan

III. Discharge and Transition Planning:^{3,4,6}**At the time of discharge from community care and hospital, document**

- Exploration of available family and community supports
- Consent for clinician follow-up contact with the client, the next service, the client's family post discharge
- Client's willingness to engage in aftercare plan; the post hospital discharge period is associated with higher risk of suicide¹⁴
- Supportive discussion around relapse prevention with the client who, for example, may resume substance use or stop taking medications
- Proactive planning: action or safety plan including written information about who to contact and where to go if an emergency arises after discharge
- Family meetings pre-discharge including discussion/information about safety planning and relapse prevention

Against Medical Advice discharge - in this instance, document discussion with the on-call psychiatrist about the client's status and desire to leave, and, who (if anyone) was advised of the client's departure from the hospital.

- Disclosure of a client's discharge and to whom this information is disclosed requires case-by-case assessment.
- The Health Information Act of Alberta permits us to disclose, in general terms, information including the client's condition and location, without the client's consent (as long the disclosure is not contrary to the express request of the individual).
- Disclosure may be made to family members, foster parents, Child Welfare Worker, another person with whom the client is believed to have a close personal relationship (eg-caregivers or Group Home providers) or, a friend.

Subject/Title: SUICIDE RISK ASSESSMENT and DOCUMENTATION	POLICY NO. S-1	Page: 4
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REFERENCES

The Health Information Act of Alberta, Section 35
 Alberta Suicide Prevention Strategy, AMHB, 2005
 calgary health region Competency Framework, 2006
 calgary health region health information: Suicide Information & Home Safety Card # 605501
 calgary health region Policy # 1611 Clinical Responsibility for Documentation of Health Information
 calgary health region Policy #1414 Consent for Treatment
 Suicide Risk Assessment Working Group Literature Review, Mental Health & Addictions Services, 2007

Mental Health and Addictions Services Policies:

- M-1 Conveying a Person to a Facility for Examination By a Physician (Mental Health Act of Alberta, 1988, Sections 2,4,5,8,10,12)
- M-2 The Formal Patients Right to Legal Representation (Mental Health Act of Alberta, RSA 2000, Sections 14, 17)
- M-3 Admission of a Formal Patient (Mental Health Act of Alberta, 1988, Sections 2,4,5,6,7)
- M-4 Notification of Certification and Informing Formal Patients of their Legal Rights (Mental Health Act of Alberta, 1988, Sections 14,15,16,27,31)

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7. Rudd, David M., Mandrusiak, Michael, Joiner, Thomas E Jr. The Case Against No Suicide Contracts: The Commitment to Treatment Statement as a Practice Alternative. *Journal of Clinical Psychology: In Session* (2006) Vol. 62 (2), 243-251.
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11. Jacobs, Douglas, and Brewer, Margaret. APA Practice Guideline Provides Recommendations for Assessing and Treating Clients With Suicidal Behaviors. *Psychiatric Annals* (2004) 34:5, 373-379.
12. Bryan, Craig J. and Rudd, M. David. Advances in the Assessment of Suicide Risk. *Journal of Clinical Psychology: In Session* (2006) Vol. 62 (2), 185-200.
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14. Crawford, MJ. Suicide Following Discharge From Inpatient Psychiatric Care. *Advances in Psychiatric Treatment* (2004) Vol.10. 434-438.
15. Simon, Robert I. Suicide Risk Assessment: Is Clinical Experience Enough? *Journal of the American Academy of Psychiatry and the Law* (2006) 34: 276-8.
16. Chu, James A. Trauma and Suicide. In Douglas G. Jacobs (ed) *Guide to Suicide Assessment and Intervention*, Jossey-Bass Inc. Publishers, San Francisco (1999) Chapter Nineteen: 332-354.