Module 13a: Mental Health Care:

Preventing Suicide and Self-Harm

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Module 13a Mental Health Care: Preventing Suicide and Self Harm

PSEP Objectives	Related CPSI Safety Competencies
The knowledge elements include an understanding of:1 • the differences between suicide and self-harm; • the key risk factors and warning signs for suicide and self-harm; • how attitudes, actions, and beliefs are contributing factors to a person's risk of suicide; • the process for assessing risk of suicide and self-harm; • the specific training required of the mental health team with regard to the assessment and prevention of suicide and self-harm; and • the key elements of a suicide prevention strategy.	**Domain: Contribute to a Culture of Patient Safety** *1. Health care professionals who commit to patient and provider safety through safe, competent, high-quality daily practice:* 1.1. Are able to articulate their role as individuals, as professionals, and as health care system employees in providing safe patient care 1.3. Recognize personal limitations and ask for assistance when required 1.4. Demonstrate knowledge of policies and procedures as they relate to patient and provider safety, including disclosure 1.6. Participate actively in event and close call reporting, event analyses and process improvement initiatives 1.9. Recognize clinical situations that may be unsafe and support the empowerment of all staff to resolve unsafe situations 1.11. Advocate for improvements in system processes to support professional practice standards and the best patient care *2. Health care professionals who are able to describe the fundamental elements of patient safety, understand:* 2.1. Core theories and terminology of patient safety and the epidemiology of unsafe practices 2.2. The characteristics and capacities of organizations with respect to patient safety, namely:

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[1] Although the objectives of this module do not include specific reference to the ability to review an incident of suicide or self-harm for the purposes of quality improvement, this content is addressed within the module.

The performance elements include the ability to: • engage family members and others in the mental health care team; and • communicate effectively and producing appropriate documentation.	2.2.1. A commitment to patient safety as a major organizational or institutional goal demonstrated at the most senior levels 2.2.2. The establishment and maintenance of a just culture 2.2.3. The implementation of patient safety best practices 2.2.4. The conduct of adverse event and incident (e.g., close call) analysis 2.2.5. The involvement of patients and their families as key players in patient safety 2.2.6. The provision of an environment of support and safety for health care professionals 2.3. The use of evaluative strategies to promote safety 2.4. The risks posed by personal and professional limitations 2.5. Principles, practices and processes that have been demonstrated to promote patient safety 2.6. The nature of systems and latent failures in the trajectory of adverse events 2.7. The emotional impact of adverse events on patients, families and health care professionals[2] 2.9. The elements of a just culture for patient safety, and the role of professional and organizational accountabilities 2.10. The concept that health care is a complex adaptive system with many vulnerabilities, (e.g., space or workplace design, staffing, technology) *3. Health care professionals who maintain and enhance patient safety practices through ongoing learning:* 3.1. Identify opportunities for continuous learning and improvement for patient safety 3.3. Analyze a patient safety event and give examples on how future events can be avoided 3.4. Participate in patient and health care professional safety education

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[2] Although the objectives of this module do not include specific reference to this competency, this content is addressed within the module.

3.5. Share information on adaptations to practices and procedures that increase safety for specific individuals or situations

3.7 Participate in self and peer assessments reflecting on practice and patient outcomes

4. Health care professionals who demonstrate a questioning attitude as a fundamental aspect of safe professional practice and patient care:

4.1. Recognize that continuous improvement in patient care may require them to challenge existing methods

4.2. Identify existing procedures or policies that may be unsafe or are inconsistent with best practices and take action to address those concerns

4.3. Re-examine simplistic explanations for adverse events to facilitate optimal changes to care

4.4. Demonstrate openness to change

Domain: Work in Teams for Patient Safety

1. Health care professionals who participate effectively and appropriately in an interprofessional health care team to optimize patient safety are able to:

1.2. Describe individual and team roles and responsibilities in the context of practice and in the health care system

1.4. Work to develop a shared set of individual and team values, rights and responsibilities

1.5. Identify and act on safety issues, priorities and adverse events in the context of team practice

2. Health care professionals who meaningfully engage patients as the central participants in their health care teams:

2.1. Ensure that patients are at the centre of care

2.2. Engage patients in decision-making and the management of their own health

2.3. Provide appropriate, sufficient and clear information, and teaching to patients to support informed decision-making

2.5. Respond to individual patient needs and respect cultural and personal health beliefs and practices

3. Health care professionals who appropriately share authority, leadership, and decision-making for safer care:

3.2. Collaboratively consult with, delegate tasks to, supervise and support team members

3.3. Accept delegated tasks

3.4. Ask for support when appropriate

3.5. Encourage team members to speak up, question, challenge, advocate and be accountable to address safety issues and risks inherent in the system

3.6. Demonstrate leadership techniques appropriate to clinical situations

Domain: Communicate Effectively for Patient Safety

1. Health care professionals who demonstrate effective verbal and non-verbal communication abilities to prevent adverse events:

1.1. Show respect and empathy in communication

1.2. Explain investigations, treatments and protocols clearly and adequately to patients

1.3. Convey information with clarity appropriate to each patient (e.g., by using the Calgary-Cambridge model)

1.4. Convey information in structured communications to team members to promote understanding (e.g. ARC, CHAT, CUS, DESCscript, I'M SAFE, I PASS THE BATON, STAR)

1.5. Communicate in a manner that is sensitive to health literacy needs

1.6. Employ active listening techniques to understand the needs of others

1.7. Communicate in a manner that is respectful of cultural diversity

1.8. Respect privacy and confidentiality

1.9. Use a variety of communication tools and techniques to enhance and assess understanding on the

     part of patients and their families

2. Health care professionals who communicate effectively in special high-risk situations to ensure the safety of patients:

2.1. Engage patients or substitute decision-makers in a discussion of risks and benefits of investigations and treatments to obtain informed consent

2.2. Provide informed discharge so that patients know when and where to seek care

2.3. Communicate to others the urgency of a clinical situation

2.4. Employ communication techniques to escalate concerns across authority gradients to match the seriousness of the clinical situation

2.5. Employ appropriate communication approaches in high-risk situations, such as in clinical crises,

     emotional or distressing situations, and conflict

2.6. Use appropriate communication approaches to provide safe transfers, transitions of care and consultations among providers, including between institutions, and on discharge to community care

2.7. Demonstrate insight into their own communication styles with patients and team members in ordinary, crisis and stressful situations and adjust these styles appropriately to provide safe care

3. Health care professionals who use effective written communications for patient safety:

3.1. Provide appropriately detailed and clear written or electronic entries to the patient health record

3.2. Provide sufficient documentation to facilitate team members' comprehension of the patient's history, physical findings, diagnosis and rationale for the diagnosis, treatment and care plan at any time

3.4. Write patient care orders and prescriptions to convey the appropriate degree of urgency

3.5. Use appropriate, safe written communication approaches in consultation requests and responses, investigative, operative and other reports, and other correspondence

4. Health care professionals who apply communication technologies appropriately and effectively to provide safe patient care:

4.2. Employ critical thinking tools and structured approaches to communications (e.g., Situation-Background-Assessment-Recommendation [SBAR] and read-back of orders on the telephone) when using technology

Domain: Manage Safety Risks

1. Health care professionals who recognize routine situations and settings in which safety problems may arise:

1.1. Demonstrate situational awareness by continually observing the whole environment, thinking ahead and reviewing potential options and consequences

1.2. Recognize safety problems in real-time and respond to correct them, preventing them from reaching the patient

1.3. Employ, as appropriate, techniques such as diligent information-gathering, cross-checking of information using checklists, and investigating mismatches between the current situation and the expected state

2. Health care professionals who systematically identify, implement, and evaluate context-specific safety solutions:

2.4. Reflect on the impact of an individual intervention, including the potentially harmful or unintended consequences of a safety intervention

2.5. Evaluate the ongoing success of a safety intervention by incorporating lessons learned

2.6. Adjust policies and procedures to reflect established guidelines, if applicable

3. Health care professionals who anticipate, identify and manage high-risk situations:

3.1. Recognize health care settings that may lead to high-risk situations

3.2. Respond effectively by means of efficient task and process management, crisis team functioning, and dynamic decision-making

3.3. Participate in ongoing training, such as simulations to enhance abilities to manage high-risk situations

Domain: Optimize Human and Environmental Factors

1. Health care professionals who are able to describe the individual and environmental factors that can affect human performance understand:

1.2. The role of attitude and professional culture in clinical practice

1.5. How to evaluate the impact of organizational resource allocation, policies and procedures and culture

2. Health care professionals who apply techniques in critical thinking to make decisions safely are able to:

2.1. Describe the common types of cognitive biases

2.2. Model the behavioural characteristics that demonstrate situational awareness

2.3. Demonstrate a process of sound decision-making, understanding where the process can be challenged

and corrected

Domain: Recognize, Respond to and Disclose Adverse Events

2. Health care professionals who mitigate harm and address immediate risks for patients and others affected by adverse events and close calls:

2.3. Provide appropriate support for individual health care professionals and teams involved in adverse events and close calls[3]

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[3] Although the objectives of this module do not include specific reference to this competency, this content is addressed within the module.

Abstract

The awareness of suicide and self-harm as a serious patient safety issue in mental health has been gaining increasing focus in recent years. The World Health Organization has estimated that the global rate of death by suicide had increased by 268% among men. In Canada, Statistics Canada has reported that 3,705 people died by suicide in 2008. Suicide impacts not only the person with mental illness but also families, friends and communities.

Contrary to popular belief, most suicides take place in the community *not* on inpatient units in hospitals. What this means is that efforts to reduce these incidents should be concentrated in this area of the health care spectrum. A key to reducing and preventing the incidents of suicide and self-harm is timely and appropriate identification of risk. This module reviews best practices related to risk assessment and prevention of suicide and self-harm with an emphasis on suicide for both community and inpatient care providers. Specifically, this module discusses person and external level factors that affect suicide risk. In addition, principles and processes for risk assessment are enumerated with particular emphasis on the therapeutic rapport, communication, and documentation. Lastly, strategies for prevention, incident review, and quality improvement are also included. The factors underlying suicide and self-harm behaviours may be unique, however, the process of assessment and prevention share some important practices.

Keywords

Suicide, ideation, suicide plan, suicide attempt, self-harm, risk assessment, warning signs, therapeutic relationship, trauma informed care, environmental hazards, prevention, documentation, communication.

Teaching methods

Interactive lecture, case-study and discussion

Objectives

The objectives of this module are to understand both the individual and system factors that contribute to incidents of suicide and self-harm as well as steps that can be taken to avert them.

Knowledge requirements

The knowledge elements include an understanding of:

- the differences between suicide and self-harm;
- the key risk factors and warning signs for suicide and self-harm;

- how attitudes, actions, and beliefs are contributing factors to a person's risk of suicide;

- the process for assessing risk of suicide and self-harm;

- the specific training required of the mental health team with regard to the assessment and prevention of suicide and self-harm; and

- the key elements of a suicide prevention strategy.

Performance requirements

The performance elements include the ability to:

- engage family members and others in the mental health care team; and

- communicate effectively and producing appropriate documentation.

Introduction

The difference between suicide and self-harm is a matter of **intent to die**. *Suicide* is an intentional, self-inflicted act that results in death. *Self-harm*, while purposeful, is often repetitive behaviour that involves the infliction of harm to one's body *without suicidal intent*. Self-harm is used as a coping mechanism that provides temporary relief from psychological distress and once the person's need is satisfied, he or she will typically end a self-injury "session". Persons who engage in purposeful self-harm do not always intend to die as a consequence of their behaviour. Instances where self-injury accidently leads to suicide or serious injury may be mistakenly labeled as a death by suicide or a suicide attempt.

Demographics of suicide:

- Suicide can occur among persons of any age or gender.

- Youth may attempt suicide as a result of traumatic life experiences such as bullying or abuse while older adults may be at risk if they are experiencing chronic physical illness or pain.

- Women attempt suicide more often than men but typically use methods that are less likely to cause death. Therefore, the rate of death by suicide tends to be much higher among men compared to women.

- Men will more often choose violent and lethal methods (for example, firearms, hanging) while women tend to choose less disfiguring methods (for example, medication overdose, poisoning).

Demographics of self-harm

- Self-harming behaviours usually begin in early to middle adolescence and peak between ages 16 and 25. These behaviours may last for years, even well into adulthood.

- Occasionally, young people participate in self-harming or suicide behaviour in groups. This is sometimes referred to as a contagion effect.
- Self-harming behaviour is more common in young women.

Purposeful self-harm behaviours commonly include intentional carving, cutting, or scratching of the skin; burning the skin with cigarettes or lighters; ripping or pulling skin or hair; ingestion of toxic substances; or hitting oneself to cause bruising or fractures. Youth who engage in self-harm commonly choose methods such as skin cutting or ingesting potentially toxic levels of substances such as over the counter medication. The person often chooses a method that he or she views as an effective form of coping.

Contributing factors to suicide and self-harm

There are two categories of factors that contribute to increased risk and therefore incidents of suicide and self-harm. The first is factors related to the person i.e. intrinsic factors. The second is factors that are external to the person i.e. extrinsic factors, including human factors (e.g., human error) and health or social systems (e.g., physical environment, unit design, staffing levels, person, and organizational policies and procedures).

Factors related to the person

Person factors related to risk of suicide are those that increase, contribute or mitigate risk and can include issues related to illness, traumatic life experience, extreme loss, and social context. However, one must distinguish between factors that are associated with suicide risk versus those that are known to be predictive of or actually increase risk of suicide. This distinction becomes important when conducting a suicide risk assessment.

For example, *potentiating risk factors*, such as chronic suicidality or mental illness are factors that are associated with the potential for the development of suicide risk over the long term. Other examples of potentiating factors include:

- unemployed or recent financial loss;
- divorce, separation, loss of a spouse;
- social isolation;
- prior traumatic life events or abuse;
- previous suicidal behaviour;
- chronic mental illness; and
- chronic, debilitating physical illness.

The relationship between traumatic life experiences and self-harm and suicide cannot be underestimated. Trauma, including abuse, harassment, and extreme loss, can affect the

person's expectations, perceptions, and experiences overall, in situations that may seem completely unrelated to the trauma. There is a need for sensitivity in not re-traumatizing the person, including doing so inadvertently through systems-related issues or care that is not culturally responsive.

In contrast to potentiating factors, *warning signs* are factors that may set into motion the process of suicide over the short term. In other words, they present tangible evidence to the clinician that a person is at heightened risk of suicide in the short term. The key warning signs identified in research and best practice are as follows:

- threatening to harm or end one's life;

- seeking access to means to attempt suicide – seeking pills, weapons, or other means;

- evidence or expression of a suicide plan;

- expressing (writing or talking) ideation about suicide, the wish to die, or death;

- hopelessness;

- rage, anger, seeking revenge;

- acting recklessly, engaging impulsively in risky behaviour;

- expressing feelings of being trapped with no way out;

- increasing or excessive substance use;

- withdrawing from family, friends, society;

- anxiety, agitation, abnormal sleep (too much or too little);

- dramatic changes in mood; and

- expressing that there is no reason for living, no sense of purpose in life.

Though evidence of the first four warning signs above indicate that a person is at very high risk of suicide and immediate treatment should occur, it is also the case that persons not exhibiting those signs may equally be at risk. Therefore, it is vital that all warning signs are recognized and documented during the risk assessment process especially since persons who may be truly intent on ending their lives may conceal them. It should also be considered that potentiating risk factors in the absence of warning signs represents lower risk of suicide but nevertheless should be monitored for the development of warning signs.

The following example briefly outlines the progression of potentiating risk factors into warning signs and heighted suicide risk:

An unemployed person who is unable to attain employment becomes increasingly hopeless about his or her future, possibly due to extreme debt or inability to support family. This person may also develop thoughts that others would be better off without him and begin developing a plan to end his life through suicide.

There are also person level factors that help mitigate risk. This category of factors is called *protective factors* and can be leveraged as strengths among persons who are at risk of suicide. Protective factors include the following:

- strong connections to family and community support;

- good problem solving, coping and conflict resolution skills;

- sense of belonging, sense of identity, and good self-esteem;

- cultural, spiritual, and religious connections and beliefs;

- identification of future goals;

- constructive use of leisure time (enjoyable activities);

- support through ongoing medical and mental health care relationships;

- effective clinical care for mental, physical and substance use disorders;

- easy access to a variety of clinical interventions and support;

- restricted access to highly lethal means of suicide; and

- absence of any warning signs (e.g., presence of hope).

During the assessment process, the identification of these protective factors in the presence of warning signs should not be interpreted as minimizing risk. Instead, the identification of these factors can be used to help highlight to the person the strengths that he or she can leverage to cope with distress and alleviate feelings of wanting to hurt him or herself.

Demographic factors, such as age and gender, are not good indicators for the identification of risk for suicide or self-harm. Being male or female, young or old, does not increase risk of suicide unless in combination with other risk factors or warning signs. For instance, an adolescent male may be at risk of suicide not because he is a young man but because he has experienced intense bullying, has impulsive tendencies, and feels that he has no confidence and has no one with whom he is willing to discuss his distress.

Demographic factors are more important when considering the process of risk assessment, including the choice of risk assessment tools. For instance, older adults may downplay their feelings of distress. Men may be more likely to conceal their distress and seek out more lethal means of suicide. Adolescents may need questions that help

normalize their feelings of distress. In these examples, understanding how the person's demographics might influence how they express and share distress, these factors are useful to consider for the *process* of asking questions about suicide or self-harm but not as risk factors in and of themselves.

Mental illness

Risk of suicide and self-harm may develop among persons with a range of mental health conditions. Suicide and self-harm are not, in and of themselves, symptoms of mental illness. Instead, they are indicators of distress stemming from other symptoms that are more proximal to mental illness. For instance, hopelessness has been found to be a stronger warning sign for suicide than a diagnosis of depression. In this example, suicide is not a symptom of depression but a result of hopelessness.

Among persons who abuse alcohol or other substances, reduced inhibitory control and increased impulsivity may contribute to risk when intoxicated while guilt, isolation, and hopelessness may increase risk among persons in recovery.

It is also important to recognize that treatment of mental health symptoms does not always indicate a reduced risk for suicide or self-harm. For instance, a person who has been treated for depressive symptoms using pharmacological interventions may feel more energized but may still maintain a hopeless outlook. In this example, the person's risk for suicide may actually increase because the person has increased energy to actually engage in an attempt to die by suicide.

Family history and engagement

Research has shown that persons who have a family history of suicide are two and a half times more likely to die by suicide compared to those without a family history. The risk of suicide increases by about 50% among persons who themselves have no history of mental illness but for whom mental illness runs in their family.

Just as a family history of suicide and suicidal behavior may increase a person's risk of suicide, informed and consistent family engagement in a person's care and monitoring may decrease the risk of suicide. Families should have knowledge of the specific factors that increase their loved one's distress and thus risk of suicide. A crisis plan should also be developed in order to obtain help for the person when necessary. It should be noted that family engagement is contingent on the person's consent.

For persons who have not consented to have family engaged in care, there may be instances where, for the safety of the person, clinicians may need to breach confidentiality to engage family members. This breach should be carried out in accordance with jurisdictional law as well as professional practice and organizational standards.

External factors

External or extrinsic factors are factors outside a person's control but nonetheless can increase their risk of suicide and self-harm. These factors may do so directly or indirectly and include the attitudes of others; experiences of people close to the person; the person's social environment, as well as characteristics of healthcare providers and care settings.

Attitudes, beliefs, and stigma

The beliefs of healthcare providers about mental illness in general and suicide and self-harm in particular will influence their approach to talking with the person, supporting the person and ultimately, the person's recovery. They therefore need to understand that their feelings, attitudes and beliefs can be a direct and important contributor to a person's increased suicide risk. Specifically, they need to be aware of:

- how their own beliefs about mental illness in general and suicide and self-harm in particular can impact a person's level of distress;

- how their actions can be perceived by a person in care as an unfair exercise of power or control;

- how to manage their personal feelings of fear or anger towards persons in care;

- the importance of empathy and understanding when working with the person and families;

- the importance of remaining positive toward persons in care and their treatment and avoiding cynical attitudes and care approaches; and

- the importance of and need for grief counseling and support for themselves and families in the event of an adverse event.

Healthcare providers must also be sensitive to the issue of stigma and its impact on persons in care. Stigma is extremely important to patient safety because it impacts the person's ability to access care and influences the quality of care they receive. For example, in healthcare providers, stigma can manifest itself as a reluctance or unwillingness to openly discuss suicide. This means that they do not ask the right questions. Alternatively, stigma can manifest as attitudes and behaviours that may include dismissing suicidal behaviours as attempts to gain attention; marginalizing survivors of suicide, family and care providers of persons who have died by suicide. These attitudes affect a healthcare provider's ability to objectively assess a person and thus lead to an increased risk of suicide.

For example, less-experienced clinicians may believe certain myths about self-harm or suicide. These myths might include:

- discussing suicide will increase a person's suicide risk;

- persons who talk about suicide never follow through;

- suicide is an "irrational" and "impulsive" act;

- children and the elderly may be at risk but do not actually die by suicide;

- persons who die by suicide usually do not actively seek help beforehand;

- once depression lifts, a person is no longer at risk for suicide; and

- persons who have mixed feelings about suicide will never die by suicide.

Stigma may also be masked by seemingly good intentions such as respecting an individual's privacy (therefore not addressing warning signs) or an attempt to avoid offending someone by asking about suicide. However, not discussing or acknowledging behaviours associated with suicide and self-harm can lead the person and/or survivors of suicide to experience increased distress. Care for persons at risk of self-harm or suicide, whether at home, in the community or in inpatient settings, must be non-judgmental and allow for open expressions and discussions of suicide ideation or the loss of a loved one due to suicide.

Societal attitudes and support

Characteristics of the social environment can have an effect on rates of suicide. For example, suicide rates are 20% lower among lesbian, gay, and bisexual (LGB) youth who have supportive social environments (e.g., attend schools with anti-discrimination policies) compared to LGB youth from non-supportive environments. These kinds of social contexts help mitigate the effects of distress and prevent suicide.

Cultural attitudes towards suicide and self-harm

Depending on the particular attitude towards suicide, culture can increase an individual's suicide risk. In some cultures for instance, suicide is considered taboo and is neither acknowledged nor discussed. Therefore, a person in that community who may be struggling with suicidal thoughts may fear expressing or disclosing those thoughts or feelings to community members or to a clinician. Family members may similarly feel unable to access support or care services because of fear of disclosure. Language barriers can compound cultural attitudes and further limit the person's ability to communicate suicidal ideation.

Lack of self-care of healthcare providers

Providing care to persons at risk of suicide or self-harm demands an incredible degree of patience, insight, understanding, and empathy. If these emotional and physical demands are not managed, the risk is that the healthcare providers will be less effective in assessing and otherwise supporting persons at risk of suicide and self-harm. Therefore, healthcare providers should ensure that they are getting the support necessary to maintain their equilibrium and continue to deliver quality care.

Systemic issues

Root cause analyses have identified that a lack of risk assessment, communication, and documentation are primary factors related to deaths by suicide or attempts to die by suicide that occurred in mental health care environments. While research and best practice guides on these topics exist, there is a gap in their implementation. Therefore, there is a need for organizational policies on suicide risk assessment that include recommendations for the timing and type of risk assessment that should be done, key aspects of effective communication, the importance of a therapeutic relationship, and standards for documentation. Ongoing training on the dimensions of high quality risk assessment and the monitoring process can be embedded within the policy as an ongoing prevention framework.

Policies can also help support the care team by providing practice standards about the key processes for suicide risk assessment and prevention. These standards include the timing of risk assessment (e.g., all persons should be screened at admission), implementation of care planning and intervention (i.e., what to do if someone is a risk), and plans for monitoring (i.e., specific instructions for reassessing persons at risk). Safety for suicide and self-harm is a system process that starts with the mental health team and is supported by the organization, policy makers, and legislation.

Physical environment of care

The care environment for persons at risk of suicide or self-harm can also increase the risk of suicide of self-harm if not properly structured. These environments need to be free of hazards that pose safety risks. Objects that could be used for purposeful self-harm or suicide (e.g., toxic materials, sharp objects, belts, pills, plastic bags, etc.) should be removed. Some of the most commonly identified hazards tend to be anchor points for hanging (including those at or below the waist such as door handles), objects that could be used as weapons, and lack of a secured treatment environment. On an ongoing basis, environmental reviews should be completed to identify potential hazards using tools such as the Environment of Care Checklist.

Risk assessment process

Assessment of suicide risk begins with prior knowledge and understanding of risk factors and warning signs for suicide and self-harm. Once this knowledge is established, a person-centred risk assessment can begin. This assessment is a process about learning "what may have happened to" a person that has led to feelings of distress. This risk assessment process should engage the person and help the person feel safe in expressing his or her story by:

- establishing a therapeutic relationship,
- employing effective communication, and

- providing detailed documentation for ongoing safety.

Risk assessment tools can be used within this process but should not replace clinical judgment.

Establishing a therapeutic relationship

The need to establish a therapeutic rapport with the person can be challenged by the urgency to recognize and respond to risk factors and warning signs. However, since the primary principle for maintaining a person-centered risk assessment is the establishment of **a therapeutic relationship with the person**, the danger of forgoing this principle for the sake of expedience is that the suicide risk assessment process may become automated, or focused solely on triage or service need. Building rapport should begin in the first moments of contact between the clinician and person and continue throughout the risk assessment and care process. Healthcare providers must be highly skilled in building trust and rapport and have a high degree of expertise in eliciting information that can inform risk assessment and care planning. Strategies for building rapport can include:

- asking the person how he/she wants to be addressed;
- providing the person with an explanation of your role and the purpose of the assessment in order to minimize feelings of uncertainty and anxiety;
- respecting the person's values and beliefs;
- knowing and acknowledging one's own biases and prejudices;
- listening empathetically;
- taking the time to consider the person's story;
- highlighting the person's strengths; and
- meeting the person in a comfortable and private environment.

It is important to understand that persons who are vulnerable, scared, or from different cultures and backgrounds might not view the experience of receiving care and the care environment as necessarily positive. Clinical assessors should be aware that a person's lived experience may influence how they are perceived. In other words, the person whose lived experience may have included personal trauma may view the care provider as a controlling figure, rather than a helping figure – reducing the person's desire to be open and provide full disclosure. Integrating the practice of *trauma-informed care* that stresses understanding of how the person's story and lived experience may affect how you, as the care provider, might be perceived will enhance the establishment of a good therapeutic rapport.

Communicating and collaborating effectively

Care providers need to communicate effectively with the person, with the care team, with family members and informal supports. Effective communication and collaboration ensure that suicide risk assessment is thorough and the person's information remains current, consistent, and responsive to addressing risk throughout his or her journey through the health system. Communication and collaboration are essential for collecting and disseminating collateral information about a person's distress and maintaining a person's safety.

For persons who have attempted to die by suicide, effective communication means that they feel listened to and respected. Unfortunately, it has often been the case that these individuals, having received assessment in care settings, often report feeling directly punished or stigmatized by staff. Whether a reflection of personally held beliefs about suicide or self-harm or feelings of being overwhelmed or frustrated, care providers need to remain aware of how these kinds of feelings may make it difficult to remain empathetic and open-minded and communicate effectively. Persons in care feel unable to talk about their distress and may be made to feel that there is "something wrong" with them. Given that effective communication is a crucial tool in establishing the therapeutic relationship that underlies the person-centred risk assessment process, care providers need to continually monitor their communication style.

Effective communication with family members means acknowledging their role as partner in the risk assessment process. Families often feel left out of the risk assessment process though they are sometimes best able to provide critical information about the person at risk. Moreover, they play a crucial role in ongoing monitoring once risk is identified and the person has been discharged from the care setting – a time when persons are at heightened risk of suicide. Whenever possible, informed consent should be obtained from the person to engage family members in the risk assessment and prevention processes. In some instances where the person does not consent but a high degree of risk is suspected or established, the care team can breach the person's confidentiality and contact family in the interest of maintaining the person's safety. This process must be carried out in accordance with jurisdictional law (e.g., *Personal Health Information Protection Act* in Ontario) and professional practice standards (e.g., Provincial Nursing Practice Standards).

Between care team members and among care teams, effective communication and collaboration means that collateral information about the person and advice based on shared experience become common and collective knowledge. Especially during transitions within (e.g., during shift changes) and between (e.g., transfers between care settings) care environments, sharing information on risk factors, warning signs, protective factors, and plans to mitigate risk are essential for ensuring ongoing safety. Effective intra and inter team communication and collaboration should also continue – especially with respect to risk assessment and monitoring – in the period following the person's

discharge from a care setting as that individual will usually be at heightened risk of suicide in that period.

Carrying out detailed documentation

Documentation standards must be established within each organization caring for persons at risk of suicide and self-harm. These standards must ensure that documentation during, throughout and after the risk assessment are easily identified, transferable, and accessible between care settings. Proper risk assessment documentation should capture:

1. The overall level of suicide risk

   - The level of risk should be clearly documented along with factual information to support this assertion.

2. Prior history of suicide attempt(s) or self-harming behaviour(s)

   - Length of time since the last attempt;

   - The prior care plan/intervention plan that was in place at admission or post-incident;

   - The rationale for not being admitted to a more intensive environment or discharged to a less restrictive environment, and what safety plans were put into place; and

   - Details about family concerns and how these were addressed.

3. Details about all potentiating risk factors, warning signs, and protective factors

4. The degree of suicide intent

   - The degree of intent may include, for example, what the person thought or hoped would happen.

5. The person's feeling and reaction following suicidal behaviour

   - For example, sense of relief/regret at being alive.

6. Evidence of an escalation in potential lethality of self-harm or suicidal behaviours

   - For example, whether the person has begun to consider, plan, or use increasingly lethal means (e.g., from cutting to hanging, seeking a gun).

7. Similarity of person's current circumstances to those surrounding previous suicide attempt(s) or self-harming behaviour(s)

8. History of self-harm or suicidal behaviour(s) among family or friends or significant loss of family or friends

   - This should include anniversary dates of these events as risk may be elevated at these points.

Use of suicide risk assessment tools

Risk assessment tools should never take the place of clinical judgment since no tool can accurately predict suicide. Further, complete reliance on a single risk score as determined by a particular risk assessment tool may remove the holistic nature of clinical risk assessment. Instead, tools can be used for initial screening of suicide risk or to gather auxiliary information to further inform the clinical interview. The risk assessment tools should be used within a recovery framework where clinicians recognize the person's central role in preventing suicide.

Within this framework, the value of suicide risk assessment tools is to enable clinicians to:

- elicit and incorporate the person's perspectives on self-harm or suicide;

- gather additional information that can shed light on the person's degree of risk of suicide;

- corroborate findings from clinical interviews;

- identify discrepancy in risk, if any;

   - In some instances a person may not disclose indicators of risk in a clinical interview but may report indicators on a self-report tool.

- improve the overall quality of the suicide risk assessment process (e.g., to assist persons with less experience in risk assessment).

A wide range of risk assessment tools have been developed to help identify risk of suicide and self-harm or to guide the process of understanding risk. These tools range from self-report to interview based scales that vary from simple symptom check-lists to complex scoring approaches. A full description and critique of suicide risk assessment tools is available in the *Suicide Risk Assessment Resource: A Guide for Healthcare Organizations* published by the Ontario Hospital Association and Canadian Patient Safety Institute.

In addition to the use of tools specifically for assessment of self-harm and suicide risk, suicide risk assessment should also incorporate a complete mental status examination. This examination is important for getting a global understanding of the person's mental distress and functional deficits in order to be able to design a plan of care. This examination includes monitoring for affect, cognitive status, non-verbal behaviour, and other factors that may indicate acute agitation or the development of warning signs for suicide.

Personnel

The initial risk assessment is typically carried out by a psychiatrist or physician as part of the clinical interview with the person. However, other clinical team members including

psychologists, nurses, social workers, occupational therapists, and recreation therapists also take part in screening and ongoing monitoring of risk. Persons involved in the suicide and self-harm risk assessment should have specific training in:

- risk factors and warning signs for suicide;

- establishing a therapeutic relationship with the person;

- strategies for communicating with the person, family, and other care providers;

- proper standards for documentation of risk;

- strategies for mitigation of risk; and

- ongoing monitoring.

Training should also address stigma and staff attitudes toward suicide and self-harm. Finally, training should include information on how the care team can support each other and provide self-care.

Suicide prevention strategy

Prevention of suicide and self-harm is an interdisciplinary effort to reduce individual, environmental, and system factors that contribute to risk of suicide or self-harm. As such, the use of suicide prevention contracts or "no harm contracts" as a sole prevention strategy should not be considered.

Identification of risk

In a robust suicide prevention strategy, identification of risk for suicide and self-harm – both intrinsic and extrinsic – is the first step. As discussed previously, the process for identifying person-level factors contributing to risk should be carried out as part of a detailed clinical interview with the person using standardized instruments to assist as necessary. In addition to person-level risk factors, environmental risks should also be continually evaluated and improved. Structured checklists may help to identify environmental issues and develop a safety improvement strategy. All members of the care team should be empowered to alert the appropriate department or personnel about suicide or self-harm risks that they identify.

Mitigation of Risk

Reducing or mitigation of the risks identified through a risk assessment is the next important step in any suicide prevention strategy. Strategies that integrate information on risk into a plan of care are the easiest ways to mitigate risk. This process should take place with the person and, when appropriate, family members or other informal supports. During this stage of prevention, detailed information about the level of risk, specific risk, protective factors identified, and plans to help mitigate the risk should be clearly documented and communicated. Working with the person, establishing crisis support and

safety plans is beneficial so that the person can identify strategies for recognizing warning signs, engage in coping, and contact crisis support when needed.

Education

Targeted education is another facet of any suicide prevention program. While educational efforts should be directed to all staff, there should be a specific focus on those delivering direct patient care. Educational efforts may include in-services, one-on-one instruction by a more experienced clinician, mock exercises, and resource materials available in care environments. In-depth training resources on suicide and self-harm are available including the Applied Suicide Intervention Skills Training (ASIST) that provides robust coverage of many of the issues presented in this module. SafeTalk is also an excellent training program that is used in conjunction with ASIST.

Incident review

Though this module has focused primarily on completed suicide and self-harm, near misses or attempts should also be considered adverse patient safety events. A near miss could be an incident where a person was about to self-harm but was stopped; where a person's attempt to die by suicide was identified and halted; or when a person survived an attempt to die by suicide. These events can occur in the care environment (e.g., during a hospital admission), among persons under the care of a healthcare team (e.g., client receiving care in the community), or following discharge from care.

For learning and improvement purposes, reviewing near misses can be equally as instructive as reviewing incidents of the completed acts. An incident review should aim to discover the events and system issues that may have contributed to a incident of self-harm, a near miss, or a death by suicide that occurred while the person was under the care of the organization (either as an inpatient or community client). The review should be carried out by an incident review team established within the organization. The review process can use a variety of methods, including root cause analysis, to determine factors that contributed to the incident for purposes of quality improvement. This process enables an exploration of what happened, why it occurred, and what can be done to prevent it from happening again. These reviews are aimed at reviewing incidents from a system perspective and not geared toward identifying or placing blame at any one person. The review team may consult other clinical staff members, the person, when appropriate, the person's family.

It is important that review teams and review participants understand the context within which the review occurs. Everyone should understand that quality and patient safety thrives in a culture that promotes openness, and that full disclosure of all features pertaining to the event is encouraged. Many jurisdictions across Canada have developed legislation to promote the frank sharing of information and support the unfettered participation of all care providers in a quality care review. Under most legislation,

information provided to hospital quality of care committees and other designated committees that deal with quality improvement would be shielded from public disclosure in legal proceedings. This promotes the sharing of information and open discussion among health professionals which can lead to improved patient care and safety. It is important that healthcare organizations establish quality of care review committees that act within the bounds of any jurisdictional legislation or policies to promote open disclosure and participant discussion related to incidents of self-harm or suicide.

Post incident support

When the incident under review is one where a person has died by suicide, the organization should have a standard policy and procedure for contacting survivors of persons. Survivors include the person's family as well as staff members who would have been involved in the care of that person. Many survivors of suicide experience four stages of emotions and reactions following a suicide: shock, recoil, post-trauma, and recovery. For each stage, the appropriate kind of support will be different.

- For instance, during the initial shock that follows suicide, crisis intervention strategies are appropriate.

- During recoil, the survivor may experience guilt, anger, shame, depression, anger, and self-doubt that will need to be addressed through either group meetings such as a suicide review conference or informal peer support.

- During the post-trauma phase, specific interventions to help families or other victims of suicide experience stigma. Specific interventions to help them overcome stigmatization might be required.

For care teams it is important to have resources and training for supporting each other. Death by suicide may be the most difficult crisis a clinician or care team will encounter. Formal training in dealing with grief and loss should be provided to clinicians, particularly for coping with feelings of numbness, shock, guilt, anxiety, and helplessness that may occur following the death of a person by suicide. Informal support for care providers is also important. It is vital that team members not blame one another for adverse events such as suicide or self-harm. Health care organizations need to have structured support networks where clinicians can listen to each other, be non-judgmental, and allow each other to openly vent or mourn an event.

Quality improvement

The quality improvement process for suicide and self-harm should begin by establishing policies that support skills among all staff. These skills include:

- an understanding of a systems approach to patient safety;

- an understanding of risks associated with suicide and self-harm, a standardized approach to risk assessment and monitoring; and

- a focused strategy for prevention.

Data on the success of improvement efforts should be posted in common areas, both to educate staff about various suicide and self-harm risks and successful interventions, and to trigger further ideas for improvement. Because of the complexity of suicide and self-harm, care must be taken to avoid reallocating resources from one high-risk area to another, thereby causing increased risk. Ongoing monitoring should continue across the organization. As well, specific timelines for refresher training in suicide and self-harm risk assessment and prevention should be established for staff.

Summary

Trying to take one's life by suicide and/or attempting self-harm may stem from a person's wish to escape some form of distress related to a lived experience. Identification of risk is the first step in the care process and it is vital that healthcare providers fully engage the person at this stage and help him/her feel safe in expressing his/her story. Unlike most other patient safety incidents, care for persons at risk of suicide and self-harm, takes place along a continuum (i.e. between inpatient to community settings and potential back again). For this reason, effective communication and accessible documentation relating to the person in care become even more essential to delivering safe and quality mental health care.

Potential pitfalls

- Failing to establish a therapeutic relationship can impact the efficacy of the risk assessment process and the ability to properly care for the person;

- Ignoring the importance of communication and documentation when safely caring for the person, especially during care transitions; and

- Failing to understand how culture and traditions of diverse populations can impact the care provided.

Pearls

- Identification of intrinsic and extrinsic risk factors and warning signs for suicide and self-harm is the first step in a robust suicide prevention program; and

- In the development and implementation of a crisis and support plan, appropriate and ongoing communication with the person and family is essential.

Toolkits & outcome measures

Suicide Risk Assessment: A Resource Guide for Canadian Healthcare Organizations. Ontario Hospital Association and Canadian Patient Safety Institute. Provides details on the principles and process of risk assessment, an inventory of assessment tools, and a framework for implementing suicide risk assessment and quality monitoring.
http://www.oha.com/KnowledgeCentre/

Working with the Client Who is Suicidal: a Tool for Adult Mental Health and Addiction Services. Centre for Applied Research in Mental Health and Addiction (CARMHA) at Simon Fraser University and the British Columbia Ministry of Health, 2007.
http://www.comh.ca/publications/resources/pub_wwcwis/WWCWIS.pdf

Becoming Suicide Safer: A Guide for Service Organizations. Canadian Association for Suicide Prevention. A checklist that organizations can use to evaluate their policies, standards, and processes related to suicide prevention.
http://www.suicideprevention.ca/wp-content/uploads/2010/06/Becoming-Suicide-Safer.pdf

The Mental Health Environment of Care Checklist (MHEOCC). The MHEOCC was developed for Veterans Affairs Hospitals in the United States to use to review inpatient mental health units for environmental hazards. The purpose is to identify and abate environmental hazards that could increase the chance of patient suicide or self-harm.

United States Department of Veteran Affairs National Center for Patient Safety. http://www.patientsafety.gov/SafetyTopics.html

Resources

- **Applied Suicide Intervention Skills Training (ASIST) and SafeTALK**
  The ASIST workshop is for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. safeTALK is a training that prepares anyone over the age of 15 to identify persons with thoughts of suicide and connect them to suicide first aid resources Information available at: http://www.livingworks.net
- **Preventing Suicide: A resource guide for general physicians.**
  World Health Organization, 2000. http://www.who.int/mental_health/resources/suicide/en/index.html
- **National guidelines for seniors' mental health: The assessment of suicide risk and prevention of suicide**
  Heisel, M. J., Grek, A., Moore, S.L., Jackson, F., Vincent, G., Malach, F.M., & Mokry, J., 2006, Canadian Coalition for Senior's Mental Health. http://www.ccsmh.ca/en/natlGuidelines/suicide.cfm

- **Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour**. Registered Nurses' Association of Ontario, 2009 http://rnao.org/Storage/58/5263_Sucide_-Final-web.pdf
- **What to do when a patient commits suicide**. Hodelet, N. & Hughson, M. *Psychiatric Bulletin.* 2001;25:43-5.
- **Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care**. National Collaborating Centre for Mental Health. (2004). (CG16). London: National Institute for Clinical Excellence. http://www.nice.org.uk/CG16
- **The Aftermath of Suicide: Managing Survivors' Bereavement.** Sakinofsky I. *Canadian Journal of Psychiatry.* 2007;52[6 Suppl 1]:129S–136S.
- **SOS - Handbook for Survivors of Suicide** A pocket-sized, quick-reference booklet to help suicide survivors cope with their grief. American Association of Suicidology (AAS), 2004 http://www.suicidology.org/associations/1045/files/SOS_handbook.pdf
- **The Canadian Association for Suicide Prevention.** Works towards reducing suicide and its impact in Canada, through advocacy, support and education. www.suicideprevention.ca
- **Suicide Prevention Resource Centre**. Prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies. www.sprc.org
- **Nova Scotia DHA/IWK Quality Review: Understanding the Legal Framework.** A document that outlines legal frameworks for quality review teams. Prepared by a Working Group of Nova Scotia District Health Authorities and IWK Representatives. www.cdha.nshealth.ca
- **Quality of Care Information Protection Act, 2004 (QCIPA)** Bill 31 of the Health Information Protection Act, 2004. Outlines legislation and regulation under the quality of care information protection act in Ontario.http://www.health.gov.on.ca/english/ providers/legislation/priv_legislation/quality_info.html
- **Putting reslience theory into action: Five principles for intervention.** Ungar, M. In: Liebenberg L & Ungar M (Eds). *Resilience in action.* Toronto, ON: University of Toronto Press, 2008:17-35.
- **Mental Health Quality Improvement**. World Health Organization Mental Health Service Guidance Package. Geneva; World Health Organization, 2003.

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Mills PD, Watts BV, Miller S, Kemp J, Knox K, DeRosier JM, Bagian JP. A checklist to identify inpatient suicide hazards in veterans affairs hospitals. *Joint Commission Journal of Quality and Patient Safety*. 2010;36(2):87-93.

Principal message

The single most important message your audience should come away with is the various factors that impact a person's risk for suicide and self-harm and that the mental health team should be trained in assessment and prevention of this risk. As a part of this insight, the participant should come away with key elements of a suicide prevention strategy that can be implemented by a unit or organization.

Module overview

The awareness of suicide and self-harm as a serious patient safety issue in mental health has been gaining increasing focus in recent years. The World Health Organization has estimated that the global rate of death by suicide had increased by 268% among men. In Canada, Statistics Canada has reported that 3,705 people died by suicide in 2008. Suicide impacts not only the person with mental illness but also families, friends and communities.

Contrary to popular belief, most suicides take place in the community *not* on inpatient units in hospitals. What this means is that efforts to reduce these incidents should be concentrated in this area of the health care spectrum. The key to reducing and preventing the incidents of suicide and self-harm is timely and appropriate identification of risk.

This module reviews best practices related to risk assessment and prevention of suicide and self-harm with an emphasis on suicide for both community and inpatient care providers. Specifically, this module will discuss person and external level factors that affect suicide risk. In addition, key principles and processes for risk assessment will be enumerated with particular emphasis on the therapeutic rapport, communication, and documentation. Lastly, strategies for prevention, incident review, and quality improvement are also included. For both suicide and self-harm, the factors underlying the behaviours may be unique; however, the process of assessment and prevention may share common practice.

Preparing for a presentation

1. Assess the needs of your audience

Choose from the material provided in the syllabus according to the needs of your expected participants. It is better for participants to come away with a few new pieces of information, well learned, than to come away with a deluge of information from which they can remember little or nothing.

2. Presentation timing

Allow sufficient time to collect participants' demographic data and complete the pre-test.

The suggested timing for each part of this module is:

Introduction	2-3 minutes
Presentation	35 minutes
Debrief about teaching methods	5 minutes
Summary	2-3 minutes
Post-test & Evaluation	5 minutes
Total	49-51 minutes

3. Number of slides: 14

4. Preparing your presentation

The text in the syllabus was not designed to be used as a prepared speech. Instead, the text provides material you may want to use. The slides have been designed to trigger your presentation. Although the slides closely follow the text of the syllabus, they do not contain all of the content. Their use presumes that you have mastered the content.

You may want to make notes on the slide summary pages to help you prepare your talk in more detail and provide you with notes to follow during your presentation.

Remember that you can adjust the slides to suit your presentation content, your style, and to make it feel fully familiar and your own.

Practice your presentation using the slides you have chosen, and speaking to yourself in the kind of language you expect to use, until it is smooth and interesting and takes the right amount of time. The most accomplished presenters and teachers still practice prior to a presentation; don't miss this step.

5. Preparing a handout for participants

The syllabus text and slides in the **Participant's Handbook** were designed to be reproduced and provided to participants as a handout. Take the portion you need; they can be used in their entirety, module by module, or for just one specific topic. Please include the following in each set of handouts:

- **PSEP - Canada Front Cover Page**;
- **PSEP - Canada Acknowledgment Pages** (to acknowledge the source of the material);
- syllabus and slides for **your topic**; and
- appendix material as relevant.

6. Equipment needs

- Projector and screen
- Computer and monitor

- Flipchart and markers for recording discussion points

Test your equipment beforehand to ensure that it works.

Review your video segments to assess which trigger tapes or portions you would like to use.

Have a back-up plan so that if there is any equipment failure you can move without panic to your back-up plan. For instance, have in mind that:

- if the video fails, you can read the vignette of the trigger tape story;
- if the slides cannot be shown, you can refer to the hand out slides; and
- if flipcharts and markers are not available, you can have participants list items on their hand outs that you would have written up for all to see.

Making the presentation

1. Introduce yourself

If you have not already done so, introduce yourself. Include your name, title, and the organization(s) you work for. Briefly describe your professional experience related to the information you will be presenting.

2. Introduce the topic

Show the title slide for the module. To establish the context for the session, make a few broad statements about the importance of topic as a patient safety matter. Tell participants the format and time you will take to present the session. Identify the teaching styles that you intend to use.

3. Review the session objectives

Show the slide with the session objectives listed. Read each objective and indicate those that you are planning to emphasize.

4. Present the material

Recommended style: interactive lecture

An interactive lecture will permit you to engage your audience, yet cover your chosen material within the time. You can use as your interactive components the trigger tape stimulated discussion and an interactive exercise. To foster discussion, ask participants for examples from their institutions or experiences. Ideally, the examples could be linked to one of the major teaching points.

Alternative style: case-based teaching

Use a case you are familiar with to include some case-based teaching. To help participants feel involved and invested, you may invite them to give you a case from their institution or

experience. However, it is usually best to return to the case you know to draw out analytic points for teaching since you do not need to 'think on your feet' too much.

5. Key take-home points

1. Failing to establish a therapeutic relationship can impact the efficacy of the risk assessment process and the ability to properly care for the person;
2. Ignoring the importance of communication and documentation when safely caring for the person, especially during care transitions; and
3. Failing to understand how culture and traditions of diverse populations can impact the care provided.
4. Identification of intrinsic and extrinsic risk factors and warning signs for suicide and self-harm is the first step in a robust suicide prevention program; and
5. In the development and implementation of a crisis and support plan, appropriate and ongoing communication with the person and family is essential.

6. Summarize the discussion

Briefly, review each part of the presentation. Recap two or three of the most important points that were discussed.

7. Debrief about the teaching method

Tell the group that it is time to consider the teaching method used, how it worked and what its limitations were. Ask them what other methods might work, and what methods would work best *for the topic* in their home institutions. Ask them to consider what method would work best *for themselves as facilitators* and for their *target audience*.

8. Post-test/evaluation

Ask the participants to complete the post-test questions for this module and evaluate the session