

# PRACTICE GUIDELINES FOR WORKING WITH CHILDREN AND YOUTH AT-RISK FOR SUICIDE IN COMMUNITY MENTAL HEALTH SETTINGS



Ministry of  
Children and Family  
Development

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## EXECUTIVE SUMMARY

Suicide is a leading cause of premature death among young people ages 15-24. Thoughts of suicide and suicidal behaviours are relatively common among this age group. Rates of suicide are higher among males compared with females, although recent evidence suggests the gender gap is starting to close. Other investigations have confirmed that many sexual minority (GLBTQ) youth are at heightened risk for suicidal behaviours due in part to negative social responses, peer victimization and harassment. Meanwhile, suicide rates among Indigenous youth are up to 6 times higher than the general population, even though there is great variation across communities.

*Emphasis is given to strengths-based, culturally responsive, socially just approaches, which recognize young people and their families as knowledgeable and capable collaborators*

### PURPOSE

The purpose of these practice guidelines is to provide Child and Youth Mental Health (CYMH) practitioners with up-to-date guidelines that will support their therapeutic work with children and youth at risk for suicide and suicidal behaviours. These guidelines describe recommended approaches for assessing and responding to suicidal behaviours among children and youth aged 19 and under, with a specific focus on community based prevention and treatment contexts. The guidelines have not been designed as a standalone document. They should be understood as one component of a larger set of policies, resources, and professional development training initiatives developed and implemented by the Ministry of Children and Family Development (MCFD) to advance the goals of youth suicide prevention.

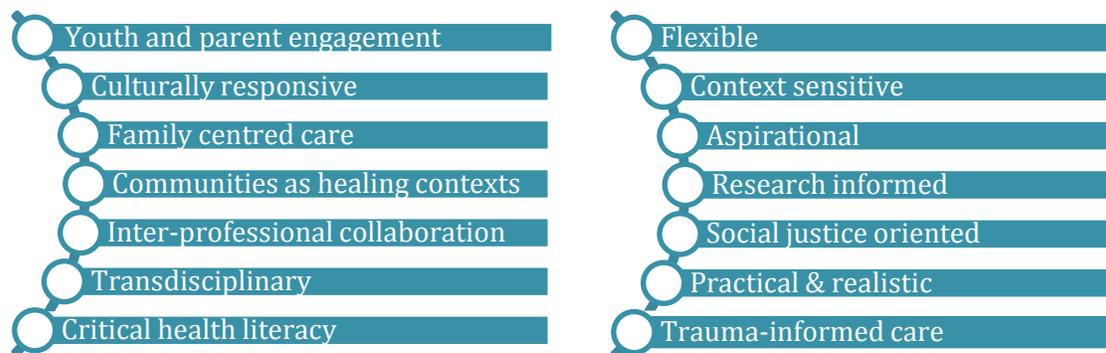
Emphasis is given to strengths-based, culturally responsive, socially just approaches, which recognize young people and their families as knowledgeable and capable collaborators. The guidelines are mutually reinforcing and several of them overlap with one another. The guidelines are not intended to replace current MCFD policies or standards, nor do they override individual clinical judgment and/or decision-making. Pharmacological interventions are not addressed here. Non-suicidal self-injuries are also considered out of scope.

What makes these guidelines unique is the specific focus on child and youth populations, the particular context of community-based mental health care, the

emphasis on collaboration with a range of formal and informal child and youth serving systems, and the active involvement of parents, caregivers, family and community members as allies in the care and treatment of suicidal youth. While the focus of these practice guidelines is on community-based treatment, a full range of services including emergency, home-based, day, and inpatient treatment programs are all important components of a continuum of services when working with children and adolescents at risk for suicide. In some cases, parental neglect and/or abuse are the conditions that may be leading a young person to experience suicidal despair. In such cases, child and youth mental health clinicians have a duty to report to a child welfare practitioner that this is a child or youth in need of protection.<sup>1</sup>

## GUIDING VALUES

A strong set of overlapping values and assumptions have guided the compilation of these practice guidelines:



## DEVELOPMENT OF THE GUIDELINES

Research on child and youth suicide and evidence-based reviews of effective approaches for working with suicidal children and youth are published on a continuous basis, attesting to a rapidly changing knowledge base. Meanwhile, CYMH practitioners routinely face complex and unprecedented practice challenges when working with suicidal children, youth and their families. It is assumed that CYMH practitioners already possess relevant skills that are of utmost importance when working with potentially suicidal youth, including: sound clinical judgment, alliance

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<sup>1</sup> Section 13 of the *Child, Family and Community Services Act* provides a detailed list of the specific circumstances that determine when a child is in need of protection.

building skills, responsiveness, flexibility, and ethical accountability. The intention is to build on this expertise by summarizing recently published research and practice literature on this topic. An advisory committee representing a diverse array of voices, including policy, practice, research, Indigenous, and non-Indigenous perspectives, as well as youth and family perspectives, has also provided input to ensure the guidelines reflect current practice realities in BC (see **Appendix A: Suicide Prevention, Intervention and Postvention Practice Guidelines Advisory Committee**).

## CONCEPTUALIZATIONS OF THE PROBLEM

While understandings of suicide and suicidal behaviours may appear to be universal, and self-evident, it can be quite useful to pay close attention to how the problem is being conceptualized within specific policy and service delivery contexts and to carefully consider the corresponding solutions that come into view as a result. When suicide is viewed exclusively as a private, individual problem that is directly linked to psychopathology or mental disorders, there is very little opportunity to see its relational, social, historical, cultural or political dimensions. Such a narrow conceptualization often invites responses or professional interventions that target the individual person for change, while neglecting many of the sociopolitical processes and structural forces that confer risks for suicide, including for example social inequity, racism, heteronormativity, or colonization. Contemporary ideas about mental health, distress, and healing are culture-bound notions, which have arisen within specific traditions and may not be appropriate for all individuals in every context.

*When suicide is viewed exclusively as a private, individual problem that is directly linked to psychopathology or mental disorders, there is very little opportunity to see its relational, social, historical, cultural or political dimensions*

## DYNAMIC PRACTICE CONTEXT

CYMH clinicians, like all human service practitioners, work in dynamic practice contexts characterized by scarce resources, changing policy goals, competing agendas, and contested knowledge. Tensions abound, including those that exist between evidence-based practice agendas and culturally responsive approaches; and those that exist between treatment and prevention initiatives. Clinicians need to engage with multiple ethical, cultural, political and professional interests and demands. This requires a reflexive, fluid and flexible approach to practice, which cannot always be specified in advance.

## PRACTICE GUIDELINES

Ten mutually reinforcing practice guidelines for working with children and youth at risk for suicide in community based mental health settings are articulated. Several of them overlap with one another. Appendices augment some of the material contained in the text.

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|---------------------------------|--|
| <b>1 Building Relationships</b> | <ul style="list-style-type: none"><li>• Develop a strong therapeutic alliance</li><li>• Attend to diversity</li><li>• Engage with communities in respectful ways</li></ul> |
|---------------------------------|--|
- 
- |                         |  |
|-------------------------|--|
| <b>2 Assessing Risk</b> | <ul style="list-style-type: none"><li>• Use a comprehensive and culturally sensitive approach</li><li>• Adopt a collaborative stance</li><li>• Estimate risk</li></ul> |
|-------------------------|--|
- 
- |                              |  |
|------------------------------|--|
| <b>3 Planning for Safety</b> | <ul style="list-style-type: none"><li>• Actively involve young people, and their parents/caregivers and community members</li><li>• Individualize the plan</li></ul> |
|------------------------------|--|
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- |                             |   |
|-----------------------------|---|
| <b>4 Treatment and Care</b> | <ul style="list-style-type: none"><li>• Tailor the treatment</li><li>• Treat and monitor suicidal behaviour</li><li>• Reduce threats to well being and prevent future suicidal behaviours</li><li>• Build on strengths and enhance resilience</li></ul> |
|-----------------------------|---|
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- |   |  |
|---|--|
| <b>5 Addressing Co-Occurring Problems</b> | <ul style="list-style-type: none"><li>• Expect the co-occurrence of problems</li><li>• Explore cultural contexts</li></ul> |
|---|--|
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- |   |   |
|---|---|
| <b>6 Providing Culturally Responsive Care</b> | <ul style="list-style-type: none"><li>• Indigenous youth and families</li><li>• Sexual minority youth</li><li>• Cultural minorities</li></ul> |
|---|---|
- 
- |  |  |
|--|--|
| <b>7 Partnering with Parents/Caregivers and Family Members</b> | <ul style="list-style-type: none"><li>• Engage parents and respect their knowledge</li><li>• Collaborate with parents in treatment, safety planning and monitoring</li></ul> |
|--|--|
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**8 Engaging Hard to Reach Young People and Families**

- Use collaborative and flexible models of care and outreach
- Work with informal and formal partners

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**9 Documentation**

- Document as soon as possible
- Record treatment and safety plans that correspond with the risk formulation
- Regularly update changes in suicide risk

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**10 Social and Systemic Interventions**

- Strengthen professional expertise and organizational capacity
  - Link emergency departments and mental health services
  - Address broad social determinants
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## INTRODUCTION

Suicide and suicidal behaviours among children and youth in BC are pressing concerns with an average of 24 suicides being recorded each year in this province among those 19 and under (BC Coroners Service, 2012). Meanwhile, the most recent version of the Adolescent Health Survey (2014), which is undertaken every five years with students in grades 7 to 12 in British Columbia, found that approximately 9% of female youth, grades seven to 12, made a suicide attempt in the previous year and 17% seriously considered it in 2013 (Smith et al., 2014). Among males of the same age, 3% made a suicide attempt and 8% seriously considered it. These findings are fairly consistent with results from a recent national survey of American adolescents, aged 13 to 17, which reported lifetime prevalence rates of suicide ideation, plans and attempts to be 12.1%, 4% and 4.1% respectively (Nock, et al. 2013).

*The low rate of help-seeking among suicidal young people is troubling and is likely the result of a number of complex factors*

While suicide is a leading cause of death among this age group and thoughts of suicide and suicidal behaviours are relatively common among young people, the number of youth who access community based mental health services following a suicidal crisis is relatively low - about 50%, according to a recent systematic review that examined community based epidemiological data from 23 published studies across North America, Europe, New Zealand and Australia (Michelmores & Hindley, 2012). For those youth who do seek mental health treatment following a suicidal crisis, the drop-out rate is very high, with half of all youth attending four sessions or less (Michelmores & Hindley, 2012). Young males are especially reluctant to seek help for their distress (Jordan, et al. 2012). Rates of help-seeking following a suicidal crisis have been reported to be less than 50% in a sample of American Indian young people (Freedenthal & Stiffman, 2007). Given the strong association between previous suicidal behaviour and future suicidal acts, it is quite likely that in the absence of a helpful response following an initial attempt, young people will remain at heightened risk for further suicidal behaviour.

The low rate of help-seeking among suicidal young people is troubling and is likely the result of a number of complex factors. For example, suicidal youth are often reluctant to seek professional support for the following reasons: they believe they do not need help, perceive that the help will not be beneficial, prefer informal sources of support, and/or they have a strong motivation to be self-reliant. Other reported barriers to help-seeking among suicidal youth include a desire to avoid the stigma of being a 'mental health client' and fears about being hospitalized (Freedenthal & Stiffman, 2007; Jordan, et al. 2012; Michelmore & Hindley, 2012). Among Indigenous youth, issues of cultural mistrust have also been reported (Gone, 2004). These concerns cannot be underestimated and serious consideration needs to be given to the way child and youth mental health services are designed and offered. For example, maximizing youth engagement at the point of first contact, offering multiple, flexible, and culturally tailored service delivery options, including home based treatments, and avoiding the potentially distancing and de-humanizing effects of standardized, 'one-size-fits-all' assessment and intervention models, are all recommendations that have been put forth in the literature (Ranahan, 2013; Rogers & Soyka, 2004; Rogers & Russell, 2013). While the focus of these practice guidelines is on community-based treatment, a full range of services including emergency, home-based, day, and inpatient treatment programs are all important aspects of the continuum of services when working with children and adolescents with suicidal behaviour (Steele & Doey, 2007).

Building on these ideas, the purpose of these practice guidelines is to provide Child and Youth Mental Health (CYMH) practitioners with up-to-date, culturally responsive, research and practice informed guidelines that will support their clinical work with children and youth at risk for suicide and suicidal behaviours. Other related initiatives, such as the Provincial Suicide Clinical Framework produced by BC Mental Health and Addictions (2011) can also provide CYMH practitioners with highly credible and useful information on suicide, risk assessment, and treatment. What makes this material unique is the specific focus on child and youth populations, the particular context of community-based treatment, the emphasis on collaboration with a range of formal and informal child and youth serving systems, and the active involvement of parents, caregivers, family and community members as allies in the care and treatment of suicidal youth. The guidelines have not been designed as a standalone document. They should be understood as one component of a larger set of policies, resources, and professional development training initiatives developed and implemented by the Ministry of Children and Family Development (MCFD) to advance the goals of youth suicide prevention.

The guidelines, which have been written to strengthen and support the existing professional resources on the MCFD website,<sup>2</sup> are not intended to replace current MCFD policies or standards on youth suicide prevention, nor do they override individual clinical judgment and/or decision-making to ensure safety.

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<sup>2</sup> A series of tools, research summaries, and resource materials have been prepared to support the work of child and youth mental health clinicians in BC in the area of youth suicide prevention. They are available at [http://www.mcf.gov.bc.ca/suicide\\_prevention/for\\_professionals.htm?WT.svl=Body](http://www.mcf.gov.bc.ca/suicide_prevention/for_professionals.htm?WT.svl=Body)

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## GUIDING VALUES

A strong set of overlapping values and assumptions have guided the compilation of these practice guidelines.

**YOUTH AND PARENT ENGAGEMENT** - Actively involving young people, and their parents and caregivers, in assessment and treatment planning decisions is increasingly recognized as an important consideration when working with youth at risk for suicide. Valuing young peoples' insights into their own experiences and recognizing parents as allies are key avenues for conveying respect and developing collaborative models of care.

*Valuing young peoples' insights into their own experiences and recognizing parents as allies are key avenues for conveying respect and developing collaborative models of care.*

**CULTURALLY RESPONSIVE** - Standard youth suicide prevention practices which make assumptions about sources of distress and which are predicated on models of expert interventions and individualized treatments can sometimes be out of step with non-western, non-European cultural conceptualizations of mental health and well-being. Being culturally responsive means being attuned to local, historical, and sociopolitical influences on mental health and well being, and developing solutions that build on local strengths and address historical and contextual realities (Wexler & Gone, 2012).

**FAMILY CENTRED CARE** - In a family-centred approach to care, young people are always viewed in the context of their families and communities. This means that family members are understood as key influencers in the lives of young people and thus they have an important role to play in decision-making. All families have strengths and assets that can be mobilized in the care of children and youth at risk for suicide.

**COMMUNITIES AS HEALING CONTEXTS** - For many young people, particularly Indigenous children and youth living on-reserve, the community is often a primary site and resource for healing. Therapeutic work with youth at risk for suicide involves knowing when and how to engage the existing resources of the local community (e.g. Elders, spiritual leaders, cultural mentors, extended kin, etc.). The existing strengths and resources of the community can be mobilized in respectful and culturally appropriate ways through ongoing relationship building with community leaders and by honoring cultural protocols.

**INTER-PROFESSIONAL COLLABORATION** - Working with youth at risk for suicide requires an integrated and collaborative approach that often involves multiple professional groups and diverse service delivery contexts. Successful inter-professional collaboration depends on many factors, including respect for others' professional expertise, proactive processes (i.e. protocol development, collaborative planning, relationship-building), policies and resources that support inter-professional collaboration, and open communication channels (Darlington, et al. 2005).

**TRANSDISCIPLINARY** - The term 'transdisciplinary' refers to multiple ways of knowing – in other words, knowledge generation that transcends traditional academic disciplinary borders (Brown, et al. 2010). Recent research findings from the field of suicidology, combined with the uniquely situated knowledge of practitioners, youth, parents and community citizens are informing these guidelines.

**CRITICAL HEALTH LITERACY** – In the context of child and youth mental health services, critical health literacy refers to an overall capacity to be attuned to dominant social practices that affect mental health. This means paying attention to language, having an understanding of the social determinants of health, and appreciating the overall political ecosystem, which collectively have a subtle and pervasive effect on health and well-being (de Leeuw, 2012; McAllister, 2008). Critically literate practitioners are more able to challenge and transform potentially limiting and/or harmful social practices.

**FLEXIBLE** - Recognizing that 'one size does *not* fit all,' the guidelines have been written with the understanding that flexibility and creative adaptations are important elements in any therapeutic context marked by change, diversity, unpredictability and unprecedented practice challenges.

**CONTEXT SENSITIVE** – The guidelines have been developed at a particular time and place with a specific end user in mind. Child and youth mental health practitioners and their allied colleagues working in community-based treatment contexts within British Columbia are envisioned as the primary beneficiaries of this material.

**ASPIRATIONAL** – These guidelines are aspirational (as opposed to binding or prescriptive) in their aims.

**RESEARCH INFORMED**- Even though the current knowledge base regarding effective interventions for preventing youth suicide is limited and many outstanding

questions still exist, staying acquainted with the empirical literature, which includes being familiar with ongoing debates in the field regarding the assessment and treatment of suicidal youth, is considered a key cornerstone of professional practice.

**SOCIAL JUSTICE ORIENTED** - It is well established that social and structural inequities have corrosive effects on the mental health and well-being of children, youth, families and communities (i.e. poverty, racism, homelessness, social exclusion, discrimination). A social justice oriented approach to mental health moves beyond the provision of individual interventions to include a focus on the fair and equitable distribution of societal resources so that all members of society can flourish (Morrow & Weisser, 2012).

**PRACTICAL & REALISTIC** - Child and youth mental health practice is characterized by high levels of complexity, ongoing change, and the emergence of novel problems. Child and youth mental health practitioners need practice frameworks that are dynamic, realistic, and in keeping with the times within which we are living.

**TRAUMA-INFORMED CARE** - Recognizing that many children and youth at risk for suicide have suffered traumatic histories (e.g. life threatening incident, sexual or physical violence, natural disaster, witnessing another person being badly harmed), a trauma-informed approach to care is a strengths-based orientation that acknowledges the ongoing impact of the trauma in the life of the young person and places an emphasis on safety (for young people and clinicians), empowerment, and the recovery of a sense of personal control (Huckshorn & Lebel, 2013). For Indigenous youth, special recognition needs to be given to attending to the multiple, pervasive and negative effects of historical trauma as a result of colonization (i.e. loss of culture, land, language, forced separation from families, multi-generational losses, and residential schools).

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## OVERVIEW OF THE ISSUE

According to Statistics Canada (2012) a total of 208 Canadian youth, aged 15 to 19, killed themselves in the year 2008. After motor vehicle fatalities, suicide is the second leading cause of death among youth aged 15 to 24 in Canada. There are typically three to four male youth suicides for every female youth suicide (Statistics Canada, 2012). Each suicide is estimated to personally affect at least seven individuals (Canadian Association for Suicide Prevention, 2004). Rates of youth

Those communities that had higher levels of “cultural continuity factors” which included self-government, land claims, education, health care, cultural facilities, police and fire service and Indigenous language use, had lower rates of youth suicide compared with those communities with fewer of these factors

suicide tripled between the 1950’s and the 1980’s with a slight decline observed in the last decade (Kutcher & Szumilas, 2008). Even though the rate of suicide is higher among males than females, a recent Canadian study noted that suicide rates among adolescent girls are increasing and the gender gap is starting to close (Skinner & McFaul, 2012).

The prevalence of suicide ideation among Canadian youth has also been studied. For example, according to the National Longitudinal Study of Children and Youth (NLSCY), 8% of youth, aged 12-15, reported thoughts of suicide in the previous year (Peter, Roberts & Buzdugan, 2008). Meanwhile, the Adolescent Health Survey, which is

undertaken every five years with students in grades 7 to 12 in British Columbia, Canada, has found self-reported rates of suicide ideation, to range from 12 to 17% (Smith et al., 2014).

Disproportionately high rates of suicidal behaviours and high profile suicide deaths among specific groups have received increased media attention in recent years. For example, rates of suicide among Indigenous<sup>3</sup> youth are estimated to be 5 or 6 times higher than the general population (Kirmayer, Brass, Holton, Paul, Simpson & Tait, 2007) even though there is great variation across communities. More specifically, in a study of youth suicide among First Nations communities in BC, those communities

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<sup>3</sup> For the purposes here, “Indigenous” is an inclusive term that refers to First Nations (“Status” and “Non-Status Indians”), Métis, and Inuit peoples.

that had higher levels of “cultural continuity factors” which included self-government, land claims, education, health care, cultural facilities, police and fire service and Indigenous language use, had lower rates of youth suicide compared with those communities with fewer of these factors (Chandler & Lalonde, 1998; Hallett, Chandler & Lalonde, 2007).

Meanwhile, there is a growing body of work that confirms that sexual minority youth (GLBTQ) are at increased risk for depression and suicidal behaviours

compared with their heterosexual peers (Marshall, et al. 2011). While the actual numbers and rates of suicide among GLBTQ youth are difficult to establish since sexual orientation is not always systematically documented by coroners at the time of death and many young people are not “out” at the time of their suicide, it is clear that sexual minority youth are at

elevated risk for suicidal behaviour. Negative social responses, peer victimization, harassment and discrimination - which are all part of a broader pattern of societal homophobia - are thought to contribute to the elevated rates of suicidal behaviours among GLBTQ youth (Russell, 2005). Again, there is great variation and diversity among GLBTQ youth and it is important not to conflate being gay with an inevitable risk for suicide (Cover, 2012).

Risk factors are those factors and social conditions that are associated with an elevated risk for suicide and suicidal behaviours. Protective factors are those factors and social conditions that serve to reduce overall risks for suicide. A summary of some of the most well-established risk and protective factors for youth suicide is presented in **Appendix B: Risk and Protective Factors for Youth Suicide.**

*There is a growing body of work that confirms that sexual minority youth (GLBTQ) are at increased risk for depression and suicidal behaviours compared with their heterosexual peers*

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## KEY TERMS AND CONCEPTS

Considerable effort has been dedicated to clarifying the terms used for describing a broad range of suicidal behaviours (Silverman, et al. 2007). While multiple perspectives continue to be debated in the field, the following definitions represent some of the current best thinking (Bridge, et al. 2006):

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<b>Suicide</b>	intentional, self-inflicted death
<b>Suicide attempt</b>	any non-fatal, self-inflicted action taken with the intention of killing oneself, regardless of lethality
<b>Suicide ideation</b>	thoughts of harming or killing oneself
<b>Suicidality/suicidal behaviours</b>	all aspects of suicidal thoughts, behaviours and actions, including death
<b>Non-suicidal self-injury</b>	behaviours which involve the deliberate destruction of body tissue, which are not socially sanctioned, and which take place in the absence of an intention to die (Klonsky & Muehlenkamp, 2007).

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At the present time, the phrase “died by suicide” is considered to be the most clear and non-judgmental way to describe a death by suicide. Many people working in the field, as well as those who have lost a loved one to suicide, recommend using “died by suicide” over other commonly used phrases, including “committed suicide” (which implies a crime), “successful suicide” (which has a positive connotation) or “completed suicide” (which implies an accomplishment). Given the changing nature of our understanding of suicide, it is very likely that over time many of these terms will undergo further shifts and transformations.

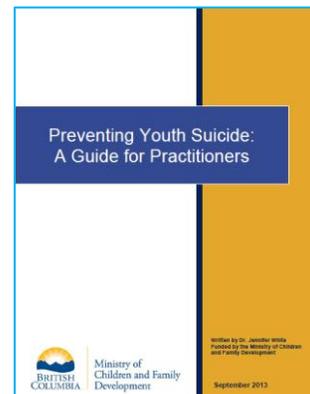
*At the present time, the phrase “died by suicide” is considered to be the most clear and non-judgmental way to describe a death by suicide*

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## DEVELOPMENT OF THE GUIDELINES

Research on child and youth suicide and evidence-based reviews of effective approaches for working with suicidal children and youth are published on a continuous basis, attesting to a rapidly changing knowledge base. Meanwhile, CYMH practitioners routinely face complex and unprecedented practice challenges when working with suicidal children, youth and families. Their practice-based knowledge represents an important source of insight. CYMH practitioners and the young people and families they work with will benefit from having access to up-to-date practice guidelines for working with suicidal children and youth that reflect the current practice context in British Columbia.

These guidelines describe recommended approaches for assessing and responding to suicidal behaviours among children and youth aged 19 and under, with a specific focus on community based prevention and treatment contexts. Emphasis is given to strengths-based, culturally responsive, socially just, and collaborative approaches, which recognize young people and their families as knowledgeable and capable. The guidelines are mutually reinforcing and several of them overlap with one another. The guidelines are specifically focused on the care and treatment of youth at risk for suicide. The content is highly compatible with the information included on the MCFD website regarding the prevention of youth suicide. The material on the website is more comprehensive in scope and addresses a broader array of audiences.



[http://www.mcf.gov.bc.ca/suicide\\_prevention/pdf/pys\\_practitioners\\_guide.pdf](http://www.mcf.gov.bc.ca/suicide_prevention/pdf/pys_practitioners_guide.pdf)

Given the diversity of youth and families living in British Columbia, the range of different treatment options and contexts, the unique cultural and professional norms governing local practices, and the variability and fluidity of suicidal behaviour, the guidelines are, by necessity, written at a fairly high level. It is assumed that CYMH practitioners already possess relevant skills that are of utmost importance when working with potentially suicidal youth, including: sound clinical judgment, alliance building skills, responsiveness, flexibility, and ethical accountability. The intention is to build on this expertise by summarizing recently published research and practice literature on this topic.

An advisory committee representing a diverse array of voices, including policy, practice, research, Indigenous, and non-Indigenous perspectives, as well as youth

and family perspectives, has also provided input to ensure the guidelines reflect current practice realities in BC (see **Appendix A** for a list of Advisory Committee members).

Pharmacological interventions are not addressed here. Non-suicidal self- injuries are also considered out of scope.

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## CONCEPTUALIZING SUICIDE AND SUICIDAL BEHAVIOURS

While understandings of suicide and suicidal behaviours may appear to be universal, and self-evident, it can be quite useful to pay close attention to how the problem is being conceptualized within specific policy and service delivery contexts and to carefully consider the corresponding solutions that come into view as a result (Morrow & Weisser, 2012; Rogers & Russell 2013; White, 2012). This type of critical reflection in and on practice can reveal important taken-for-granted assumptions about the problem of suicide and suicidal behaviour, including unspoken understandings about sources of distress, conceptualizations of change, and appropriate sites for intervention (Evans, Hanlin & Prilleltensky, 2007). This approach to practice is in keeping with the notion of critical mental health literacy (McAllister, 2008; Ranahan, 2013) and culturally responsive approaches to treatment and healing (Kirmayer, 2012a).

*When suicide is viewed exclusively as a private, individual problem that is directly linked to psychopathology or mental disorders, there is very little opportunity to see its relational, social, historical, cultural or political dimensions*

For example, when suicide is viewed exclusively as a private, individual problem that is directly linked to psychopathology or mental disorders, there is very little opportunity to see its relational, social, historical, cultural or political dimensions. Such a narrow conceptualization often invites responses or professional interventions that target the individual person for change, while neglecting many of the sociopolitical processes and structural forces that confer risks for suicide, including for example social inequity, racism, homophobia, or colonization.

In addition, it can be quite useful to critically reflect on the unspoken understandings of what counts as 'good mental health' that permeate contemporary professional mental health interventions, including suicide risk assessment and treatment practices (James & Prilleltensky, 2002; Rogers & Russell, 2013). For example, being verbally articulate, emotionally expressive, rational, self-disclosing of personal information, and cognitively congruent are just a few of the characteristics of 'good mental health' that many current treatment models appear to take as givens. Rather than conceptualizing mental health interventions as objective, universal, or value-free, it can be helpful to see them as culture-bound

products which have arisen within specific traditions and which may not be appropriate for all individuals in every context (Kirmayer, 2012a; 2012b; Rogers & Russell, 2013; Wexler & Gone, 2012).

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## DYNAMIC PRACTICE CONTEXT

These guidelines have been developed to support the work of CYMH clinicians; however, it is important to acknowledge that the goals of youth suicide prevention cannot be met through an exclusive reliance on the provision of mental health services. Given the complexity of suicide and suicidal behaviours among youth, a comprehensive, multi-pronged approach is required. This should include population level interventions and more targeted approaches.

Holistic approaches that are tailored to meet the unique needs of individuals *and* strategies which simultaneously engage with the social causes of distress (e.g. social inequalities, racism, colonization, injustice) are ideal, but not always easy to implement given the way human service systems are organized. CYMH clinicians, like all human service practitioners, work in dynamic practice contexts characterized by scarce resources, changing policy goals, competing agendas, and contested knowledge. Tensions abound, including those that exist between evidence-based practice agendas and culturally responsive approaches (Kirmayer, 2012a) and those that exist between treatment and prevention initiatives. Clinicians need to engage with multiple ethical, political, cultural and professional interests and demands. This requires a reflexive, fluid and flexible approach to practice, which cannot always be specified in advance.

*Clinicians need to engage with multiple ethical, political, cultural and professional interests and demands. This requires a reflexive, fluid and flexible approach to practice, which cannot always be specified in advance*

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## PRACTICE GUIDELINES

### 1. BUILDING RELATIONSHIPS

#### Develop a Strong Therapeutic Alliance

After several decades of investigation and several meta-analyses, it turns out that the quality and strength of the therapeutic relationship is more important than any particular technique or treatment model in determining positive mental health outcomes for youth and adult populations (Lambert, 2007; Pilgrim, et al. 2009; Shirk & Carver, 2003). When working with children or youth at risk for suicide, developing a strong working alliance with parents/caregivers is an important component of the overall relationship-building process. As Norcross and Wampold (2011) recently remarked, “Efforts to promulgate best practices or evidence-based

*When working with children or youth at risk for suicide, developing a strong working alliance with parents/caregivers is an important component of the overall relationship-building process*

practices (EBPs) without including the relationship are seriously incomplete and potentially misleading” (p. 98). Building a strong therapeutic alliance is one of the most important cornerstones of therapeutic work, and it is especially significant when working with young people at potential risk for suicide. More specifically, “...the clinical alliance is *the* essential vehicle for delivering a potentially life-saving series of clinical interventions” (Jobes, 2009, p.3).

The therapeutic alliance is an interpersonal process that has relational, cognitive and emotional dimensions (Karver, et al. 2008) and it goes beyond superficial friendliness. An international group of practicing clinicians, known as the “Aeschi Group” has put together a set of helpful guidelines for strengthening the therapeutic relationship when working with those at risk for suicide. The first guideline is perhaps the most important: “The clinician’s task is to reach, together with the person, a shared understanding of the person’s suicidality” (Michel, et al. n.d).

Additionally, the following qualities are associated with the development of a strong therapeutic alliance: credibility, warmth, genuineness, empathy, flexibility, regular solicitation of feedback, and a common understanding regarding treatment goals (Brown, et al. 2010; Norcross & Wampold, 2011). In an ideal world, young people should be given a say regarding the overall ‘fit’ with the treating clinician. Wherever

possible, and as long as it does not compromise the integrity of the treatment, young people should be allowed to exercise some choice about which clinician they work with. This can maximize the likelihood that they will be motivated to stay engaged in the therapeutic work. Of course in urgent crisis situations and/or small remote communities with limited resources, this would not be possible, nor advisable.

*Recognizing the level of emotional pain the young person is experiencing, and acknowledging the feelings of desperation that are contributing to the suicidal despair can strengthen the overall relational connection*

Finally, recognizing the level of emotional pain the young person is experiencing, and acknowledging the feelings of desperation that are contributing to the suicidal despair can strengthen the overall relational connection (Berman, Jobes & Silverman, 2006). As Jobes (2009) writes, “suicidal thinking and behaviours are often a perfectly sensible- albeit worrisome and often troubling- response to intense psychological pain and suffering” (p. 3). Acknowledging this reality is not the same as condoning suicide. On the contrary, such deep and sincerely expressed empathy can serve to enhance the therapeutic bond with young people and their families.

## Attend to Diversity

Having insight into one’s own cultural biases (which includes recognizing the unique culture of professional mental health services), valuing the unique perspective and experience of the young person and his/her family, and recognizing the role of history and culture in conceptualizations of distress and well being, are additional professional competencies that must be actively cultivated on the part of the practitioner (Kirmayer, 2012a). More specifically, proactively clarifying the young person’s expectations regarding communication style, assessing their comfort in disclosing personal information, uncovering beliefs about suicide and its causation, and understanding decision-making preferences are specific practices that can contribute to a stronger therapeutic relationship - and a more culturally sensitive suicide risk assessment process – thus greatly reducing the likelihood of misunderstandings or cultural offense (Rogers & Russell, 2013).

## Engage with Communities in Respectful Ways

Finally, the practice guideline of “building relationships,” must extend beyond the therapeutic relationship to recognize the role that many communities play in providing stability, hope, cultural connectedness, and a sense of belonging for young

people. This is particularly salient when working with Indigenous youth. By building relationships with community leaders, Elders, and cultural mentors, and recognizing the sacred connection that Indigenous people have to the Creator, the land, as well as to ancestors and future generations, child and youth mental health clinicians are making a commitment to practicing in more culturally responsive ways.

*The community is both a context and resource for healing*

While there is a great deal of diversity across communities, most Indigenous ways of knowing reflect holistic understandings, inter-connectedness, and balance. The community is both a context and resource for healing. Understanding the role of history, tradition, cultural protocols and local community norms are important aspects of building relationships with many Indigenous communities. As Vukic and colleagues (2011) acknowledge,

*The Aboriginal wellness model involves the physical, emotional, mental, and spiritual aspects of a person in connection to extended family, community, and the land. This does not fit with an understanding of mental illness that focuses on the belief that the key to curing mental illness is to determine the underlying functions of the brain (p. 69).*

## Key Principles for Building Relationships with Suicidal Children and Youth

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

## 2. ASSESSING RISK

### Use a Comprehensive and Culturally Sensitive Approach

Risk assessment is often considered the heart of clinical work with potentially suicidal adolescents. This is because, at its best, the process offers a comprehensive and research-informed framework for eliciting information in a systematic and collaborative way, enabling the clinician to formulate risk levels for potential suicide or self-harm, which in turn provides the necessary information for developing appropriate treatment strategies and corresponding safety plans (Shea, 2002). Competence in working with suicidal clients has been succinctly defined by Quinnet as follows:

*A one-to-one assessment/intervention interview... in which the distressed person is thoroughly interviewed regarding current suicidal desire/ideation, capability, intent, reasons for dying, reasons for living, and especially suicide attempt plans, past attempts and protective factors. The interview leads to a risk stratification decision, risk mitigation intervention and a collaborative risk management/safety plan, inclusive of documentation of the assessment and interventions made and/or recommended (cited in Schmitz, et al., 2012, p. 294).*

Being knowledgeable about risk and protective factors for youth suicide, understanding the dynamic and fluid nature of suicide risk, recognizing individual and sociocultural contributions to risk, systematically gathering detailed information from the young person and other collateral sources of information, formulating and documenting risk levels, and establishing clinically sound, developmentally informed, culturally safe treatment goals are just a few of the core competencies that all child and youth mental health clinicians practicing in community-based settings are expected to possess. The most significant contributor to suicide risk is previous and repetitive suicidal behaviours. Thus young people who have a history of multiple suicide attempts and who have exhausted all of their coping resources are at heightened risk.

*The most significant contributor to suicide risk is previous and repetitive suicidal behaviours*

The process of assessing for suicide risk must also be culturally safe and appropriate (Chu, et al. 2013; Rogers & Russell, 2013). By being proactive and alert to cultural differences in communication styles, comfort with self-disclosure, beliefs about suicide, and overall decision-making processes, potential barriers to the risk assessment process can be minimized (Rogers & Russell, 2013). Chu and colleagues (2013) have recently developed a tool for the culturally competent assessment of suicide risk. Recognizing the impossibility of designing a tool that could adequately accommodate every conceivable cultural variation in suicide risk, the authors have developed an instrument that integrates four streamlined concepts from the culture and suicide risk literature. The tool is designed to augment existing risk assessment approaches by prompting inquiry into a number of key domains, known to elevate risks for suicide among cultural and sexual minority clients. The domains include: social discord, minority stress, idioms of distress and cultural sanctions. These are described in more detail under the principle, “Providing culturally responsive care.”

### Adopt a Collaborative Stance

The emphasis on developing a collaborative approach to suicide risks assessment is particularly important. Such a stance invites the *active* participation of the young person in the assessment of their own risk and the development of any follow-up treatment strategies and safety plans (Jobes, 2009). In this way, the process is

*The process is relational, mutually determined, and draws on the unique strengths, knowledge and wisdom of both the practitioner and the youth*

relational, mutually determined, and draws on the unique strengths, knowledge and wisdom of both the practitioner and the youth. Understanding the meaning of the suicidal crisis from the young person’s perspective and unique context, is essential. When approached this way (i.e. in the context of a strong therapeutic bond) the process of assessment becomes part of the treatment (Granello, 2010), and might be most usefully conceptualized as

“therapeutic assessment” (Rogers & Soyka, 2004). Again, when working cross-culturally, clinicians need to be sensitive to the young person’s communication preferences (including a more directive style) and adjust accordingly (Rogers & Russell, 2013).

### Estimate Risk

A number of different frameworks have been developed to support a comprehensive and systematic approach to assessing risks for suicide. These include highly structured assessment protocols, screening tools, and clinical

interviews (Jobes, 2009; Linehan, 2012) as well as informal agency guidelines and guiding principles (Granello, 2010; Rogers & Russell, 2013). At the present time, no single instrument exists that can accurately predict a future suicidal act (Fowler, 2012). This is due in part to the fact that suicide risk is 'on the move.' In other words, risks for suicide are fluid, contextually embedded and highly variable, and we need frameworks for understanding that reflect these dynamic qualities (Rudd, 2006).

Practitioners are encouraged to think about suicide risk assessment as a dynamic and collaborative process in which information is gathered in a systematic way for the purpose of coming to a mutually informed judgment about the youth's level of suicide risk (i.e. minimal, mild moderate, severe). See **Appendix C: Levels of Suicide Risk** for a definition of these terms as outlined in current MCFD policy. Despite some differences in language and emphases, there is general agreement in the literature on a number of principles that should guide the process of suicide risk assessment (Fowler, 2012; Granello, 2010; Rogers & Russell, 2013; Rudd, 2006). They are summarized below.

## Key Principles for Assessing Risk

1. *Ensure the process is systematic, multi-faceted and holistic*
2. *Utilize research-informed approaches*
3. *Work in a collaborative and strengths-based way*
4. *Ensure the language and approach is developmentally appropriate*
5. *Be attuned to cultural differences and stressors faced by minority groups*
6. *Adopt a fluid understanding of risk , which includes an exploration of previous suicidal behaviours and other known risk factors*
7. *Focus on protective factors*
8. *Engage in a thorough exploration of current suicidal thinking*
9. *Gather input from collateral informants, including parents*
10. *Include a risk formulation*
11. *Provide clear documentation*

For a more detailed description, see **Appendix D: Principles of a Suicide Risk Assessment**

### 3. PLANNING FOR SAFETY

A safety plan (also known as a crisis response plan) (Rudd, Joiner & Rajab, 2001) is a proactive strategy, developed in collaboration with the young person that specifies what he/she will do and who they will contact when faced with suicidal thoughts. The purpose of the safety plan is to provide concrete action steps and tools that will assist the young person to cope during a suicidal crisis (Jobes, 2009; Stanley & Brown, 2012). The safety plan should specifically address the issue of restricting access to potential means (e.g. medications, firearms).

Safety planning is different from a no-suicide contract in that it includes specific practical steps for *how* to respond in a suicidal crisis (Stanley & Brown, 2012). It is not 'presented' to the young person but rather is collaboratively developed and reflects the unique circumstances of the young person's life and context. Most importantly, it emerges from the overall risk assessment process. It offers a vehicle for negotiating the action to be taken by the suicidal person depending on their level of subjective distress and suicidality. The primary purpose is to create a plan that the person will utilize when feeling suicidal, rather than providing the clinician with a sense of reassurance. Clinicians need to work with the youth to ensure that they will feel comfortable carrying out whatever safety plan is negotiated. For example, clinicians need to be curious as to whether the client would actually phone the crisis centre or go to the hospital emergency. If the client is hesitant, the clinician should follow-up and discuss the barriers to see if they can be overcome. If a client refuses to negotiate a safety plan, or seems unwilling or unable to implement it in times of distress, then other risk management strategies should be considered, such as more frequent appointments or hospitalization.

*Safety planning is different from a no-suicide contract in that it includes specific practical steps for how to respond in a suicidal crisis*

Parents and caregivers are invaluable partners in the care and treatment of youth at potential risk for suicide and they are crucial allies in establishing and maintaining safety plans. Specifically, they can provide ongoing support, validation and monitoring while also ensuring that the home environment is safe (i.e. medications are safely stored; firearms are securely locked) (Daniel & Goldston, 2009).

According to Stanley and Brown (2012), the main components of a safety plan include:

*(a) recognizing warning signs of an impending suicidal crisis; (b) employing internal coping strategies; (c) utilizing social contacts as a means of distraction from suicidal thoughts; (d) contacting family members or friends who may help to resolve the crisis; (e) contacting mental health professionals or agencies; and (f) reducing the potential use of lethal means (p. 258).*

Importantly, safety plans can be revised over time to reflect the changing circumstances of the young person's life. For example, as new coping skills are learned and as social networks are expanded, the safety plan can be changed to reflect these new realities (Stanley & Brown, 2012).

*Safety plans can be revised over time to reflect the changing circumstances of the young person's life*

The specific details of how to cope, who to call, where to seek support, and when to activate professional help should be worked out with the young person in advance of any crisis. The safety plan should also be shared with parents/ caregivers and other significant people in the young person's life. While each safety plan should be collaboratively developed and individually tailored to match the needs and resources of the individual youth, there are a number of suggested steps to be included (Stanley & Brown, 2012):

- Recognize warning signs
- Identify individual coping and/or distracting strategies
- Identify social situations and other people who can help
- Name specific people who can be asked for help (i.e. parents/caregivers)
- Identify professionals who can be contacted in a crisis
- Generate concrete strategies for making the home environment safe

## Key Principles for Developing a Safety Plan

1. *Actively involve young people in the development of the safety plan*
2. *Link the safety plan to the overall suicide risk assessment process*
3. *Recognize the important role of parents/caregivers and community members in establishing and maintaining the safety plan*
4. *Tailor the plan to reflect the individual's unique circumstances, history and cultural context*
5. *Share the safety plan with parents/ caregivers and other significant others who can support the young person*
6. *Teach parents/caregivers how to provide validation and support and educate them about the importance of keeping the home environment safe*
7. *Teach coping skills and distracting strategies that the young person can use as part of the overall safety plan*
8. *Include an explicit strategy for restricting access to potential suicide methods*
9. *Revise and modify the safety plan as circumstances change*

For an example of a Safety Plan see **Appendix E: Example of a Safety Plan**

## 4. TREATMENT & CARE

At the present time, there is insufficient evidence to support the recommendation of any one model or intervention over another for the treatment of youth at risk for

*No one singular approach could ever be considered useful for all young people, across all cultures and contexts*

suicide (Clifford, et al. 2013; DeSilva, Parker, Purcell, Callahan, Liu, & Hetrick, 2013; Muehlenkamp, Ertelt & Azure, 2008; Ougrin & Latif, 2010). Given the tremendous variation that exists among distressed adolescents, it comes as no surprise that young people exhibit

different responses to different treatment interventions. This means that no one singular approach could ever be considered useful for all young people, across all cultures and contexts (Daniel & Goldston, 2009). The way that evidence is defined also exerts a strong influence over what can be known. With these considerations in mind, a number of treatment approaches for addressing suicidality in youth have been identified as promising. These include dialectical behaviour therapy for adolescents (DBT-A), collaborative assessment and treatment (CAMS), cognitive behaviour therapy (CBT), and other problem-solving approaches (Jobes, 2009; Klomek & Stanley, 2007; Miller, Rathus & Linehan, 2007; Rudd, Joiner & Rajab, 2001).

It is important to keep in mind that very few of these recommended treatments have been specifically evaluated for their appropriateness or effectiveness with minority populations. Many questions remain about whether western forms of therapy can be usefully adapted for particular cultural groups. For example, a recent special issue of the *Australian Psychologist* (February, 2014) was dedicated to the question of whether CBT can be effective for Aboriginal peoples. On the one hand, Nelson and colleagues (2014) argue that cultural safety rests with the therapist, not the therapy. Based on the authors' own efforts to make cultural adaptations to CBT, they concluded that,

*Cultural safety rests with the therapist, not the therapy*

*...in the right hands with culturally competent practitioners, CBT "done well" is an adaptable, person-centred therapy; and as writers from other cultures have noted, it can easily be adapted for Indigenous and other non-Westernised communities (p. 26).*

On the other hand, Dudgeon and Kelly (2014) express considerable caution about the appropriateness of CBT for Indigenous peoples. Given the nature of historical

trauma faced by Indigenous peoples, they argue that therapeutic strategies that fail to engage with the broad social determinants of mental health and which obscure the sociopolitical and historical contexts of suffering, are bound to be limited. They stress that “...pathways to recovery need to include self-determination and community governance; reconnection and community life; and restoration and community resilience” (p. 10).

While it is likely that no definitive answers will be forthcoming anytime soon, and further research and thoughtful debate will hopefully continue, the main point to be

*Interventions for suicidal youth should reflect their particular life stage, diverse life experiences, and unique cultural contexts*

made here is that we always need to be alert to the potential for our preferred therapeutic practices to be experienced as culturally unsafe for some groups and be prepared to make adjustments. In the remainder of this section a number of high level principles and recommendations for treating suicidal young people in community-based contexts will be summarized. These are based on

the published literature and input from clinicians, Indigenous advisors, policy analysts, family members, and young people. In a later section, several important principles for providing culturally responsive care are highlighted.

## Tailor the Treatment

Interventions for suicidal youth should reflect their particular life stage, diverse life experiences, and unique cultural contexts. As Chu and colleagues (2010) recently noted,

*Without question, a growing body of literature on diversity and suicide confirm that the nature, expression, correlates, and behaviours of suicide are influenced by cultural variation and ethnic and sexual minority group status (p. 26).*

In addition to the wide variability within and across different ethnic groups, sexual orientations, and genders, it is also important to recognize potential differences related to age and developmental life stages. For example, young people are often more impulsive, more focused on the present, and frequently have a different sense of time compared to adults (Daniel & Goldston, 2009). Suicidal behaviour among young people often takes place in the context of a conflict with a family member or peer, in response to academic difficulties or a disciplinary crisis, or following a loss such as the break-up of a romantic relationship. Each of these stressors can become

further compounded for sexual minority youth, immigrant youth, youth with disabilities, Indigenous youth, and street involved youth, who are also quite often living with the negative effects of social disadvantage, racism, homophobia, social exclusion, and/or discrimination (Chu, et al. 2010; Clifford, et al. 2013).

Young people living with enduring and persistent psychological challenges, whose experiences and opportunities are severely compromised by the existence of deep

*Just as risk factors for suicide change across the lifespan, so too, do the factors and conditions that support the emergence of resilience*

structural inequities, and who have a history of repetitive suicidal behaviour will obviously require a different treatment approach than those without such a context or history. Older adolescents' concerns, capacities and challenges will typically

differ from those of younger adolescents. Just as risk factors for suicide change across the lifespan, so too, do the factors and conditions that support the emergence of resilience. For all of these reasons, treatment strategies should be tailored to reflect the specific histories, concerns, cultural contexts and capacities of young people, their families, and communities (Daniel & Goldston, 2009).

## Treat & Monitor Suicidal Behaviour

Within the context of a strong therapeutic relationship, the first and primary therapeutic task is to reduce suicidal behaviours (Rudd, 2006). As Muehlenkamp and colleagues (2008) put it, "A best practice approach to the treatment of suicidality will involve targeting the specifics of the suicidal crisis rather than the underlying psychiatric disorder" (p. 110). This is because ongoing suicidal behaviours interfere with the long term therapeutic goals of strengthening capacities, consolidating new learning, enhancing social support, pursuing culturally meaningful goals, and renewing the young person's commitment to living. Within some treatment modalities such as DBT, having young people and their parents/caregivers make a clear commitment to participate in the therapy is an explicit step in building and sustaining the motivation for change. For young people, this means making a commitment to building a life worth living, which by definition cannot include suicide (Miller, et al. 2007).

Since suicidal behaviours tend to fluctuate, it is also important to monitor suicide risk on an ongoing basis, which includes restricting access to firearms, medications or other potential means of suicide. Recognizing the heightened risk for future suicidal behaviour among those with a history of suicide attempts is a key aspect of

treatment planning. As Nock and colleagues (2013) recently reported following a national survey of American adolescents,

*...approximately one-third of youth with suicide ideation go on to develop a suicide plan during adolescence, approximately 60% of those with a plan will attempt suicide, and most of the adolescents who make this transition do so within the first year after onset (p. E7).*

Among adolescents who have been discharged from a hospital following psychiatric treatment for a suicide attempt or crisis, the three-month period immediately following the hospital discharge has been shown to be associated with the greatest risk for a re-attempt (Spirito, et al. 2011). Taken together, these findings underscore the importance of targeting the suicidal behaviour directly, ensuring the home environment is safe, and closely monitoring those young people who have made a suicide attempt and/or who have a suicide plan.

## Reduce Threats to Well-Being & Prevent Future Suicidal Behaviours

Once the suicidal behaviours have been addressed, the treatment can shift to addressing some of the underlying risk factors, with the goal of preventing future occurrences of suicidal behaviours. Strategies which have active skill-building and problem-solving components and include family-level interventions, have all been recommended (Muehlenkamp, Ertelt & Azure, 2008). Several therapeutic models actively incorporate many of these strategies, including for example: cognitive behaviour therapy (CBT), dialectical behaviour therapy for adolescents (DBT-A), interpersonal therapy (IPT), multisystemic family therapy (MST), and attachment based family therapy. While no definitive conclusions can be drawn regarding their effectiveness at reducing youth suicidality, and as already mentioned, these approaches may not be culturally relevant or appropriate for all groups, a handful of controlled studies suggest they hold promise (Diamond, et al. 2012; Robinson, Hetrick & Martin, 2011; Tang, et al, 2009). One example of an integrated model that combines elements of CBT, DBT and family therapy has been proposed for working with depressed and suicidal adolescents (Klomek & Stanley, 2007). It includes the following components:

*The three-month period immediately following the hospital discharge has been shown to be associated with the greatest risk for a re-attempt*

- Chain analysis of the index suicide attempt and the associated events
- Development of a safety plan and “hope kit”
- Collaborative agenda setting
- Exploration of therapy-interfering behaviours
- Skill building
- Relapse prevention
- Encourage family support, improve family problem-solving skills and communication

It is also worth reiterating that many of the biggest threats to well-being among ethno-racial and other minority groups arise from existing structural inequities that cannot be addressed through the provision of mental health services. When working with Indigenous youth specifically, approaches to treatment need to take account of the enduring negative effects of colonization and the unique role of historical trauma in the lives of individuals, families and communities. Efforts need to be directed towards strengthening social and familial support, addressing multiple forms of trauma, and providing culturally grounded healing practices (Clifford, et al. 2013; Harder, et al. 2012; Kirmayer, 2012b). This will require multiple strategies and community-wide approaches, which simultaneously engage individuals, families, communities, social policies and structures. As Harder and colleagues note,

*We agree that connection with one’s culture of origin is an important preventive factor for reducing the incidence of suicide among Indigenous peoples. However, this needs to be put into the ongoing context of the realities that Indigenous peoples face today including crippling poverty, unequal access to health and wellness services as well as ongoing issues with access to social services, and education (p. 138).*

## Build on Strengths & Enhance Resilience

Strengths-based approaches emphasize the unique resources, capacities and wisdom of youth and their families. Strengths-based strategies are in direct contrast to disease models and problem-based approaches to assessment and treatment which problematically convert “... a person into a ‘case’ to be treated by a professional expert, instead of engaging in dialog [sic] with the situation and client,

and seeking social, political, and cultural assessment of and response to predicaments” (McCammon, 2012, p. 557).

*Strengths-based strategies are in direct contrast to disease models and problem-based approaches to assessment and treatment*

By drawing on the unique strengths of the youth and family, a more balanced, hopeful and complete view of the person and his/her family is possible. This in turn sets the stage for a more trusting, affirming, mutually determined, creative therapeutic process (McCammon, 2012). Strengths and resources can be identified across a range of domains, including: mental health, family/relationships, financial, home/place to live, safety/crisis, social/recreational, vocational/education, cultural/spiritual, legal, and health/medical (Rotto, et al., 2008, cited in McCammon, 2012). These categories can be used to prompt a comprehensive inventory of specific youth and family strengths as part of the overall assessment and treatment process. Importantly a strengths-based approach must go beyond describing individual strengths towards the development of care and treatment plans that explicitly harness these strengths.

## Key Principles in the Treatment and Care of Suicidal Youth

1. *Develop a strong therapeutic alliance*
2. *Partner with parents/family member/caregivers*
3. *Tailor the treatment to fit the youth's unique needs, preferences and contexts*
4. *Actively engage youth in agenda-setting and identifying indicators of success*
5. *Treat the suicidal behaviour first*
6. *Monitor suicidal behaviour throughout the course of treatment*
7. *Restrict access to the means of suicide*
8. *Directly address therapy-interfering behaviours*
9. *Use treatment strategies that harness strengths, build skills, and support resilience*
10. *Include family interventions*
11. *Honour cultural models of healing*
12. *Recognize the role of societal factors and social inequities in the emergence of distress and suicidal despair*

## 5. ADDRESSING CO-OCCURRING PROBLEMS

Many distressed young people who access child and youth mental health services following a suicide attempt or crisis have multiple co-occurring problems and challenges, including for example: substance use problems; anxiety; intellectual disabilities; school problems; emotional and behaviour challenges; trauma; family conflict; and involvement with the child welfare and/or criminal justice system (Lichenstein, Spirito, & Zimmerman, 2010). As Effinger and Stewart (2012) note, “There is a movement in clinical practice to consider co-occurring disorders as the expectation and not the exception when working with adolescents” (p. 353). Adolescents with multiple, co-occurring mental health and substance use problems frequently drop-out of treatment prematurely, have poorer treatment outcomes, and higher rates of relapse (Lichenstein, Spirito & Zimmerman, 2010). Treatment models which offer a framework for conceptualizing suicide risk within a context of co-occurrence and which emphasize the existence of two or more distinct disorders, which vary in severity, have been recommended (for an example see Lichenstein, Spirito, & Zimmerman, 2010). Meanwhile, according to a recent Substance Abuse and Mental Health Services Association (SAMHSA) Report on Interventions for Children and Youth with Co-Occurring Disorders (2002),

*It has been estimated that up to 50% of young people who engage in suicidal behaviour have a substance abuse disorder*

*Research has found that the most effective interventions are comprehensive -integrating legal, health, recreational, and educational services- and include common elements such as group therapy, family involvement, and the recognition that recovery is a process (para 3).*

### Suicidality and Substance Abuse

It has been estimated that up to 50% of young people who engage in suicidal behaviour have a substance abuse disorder (Esposito-Smythers, et al., 2012). Substance abuse increases the risks for suicide and suicidal behaviours for a number of reasons. For example, intoxication can lead to increased emotional distress and aggressiveness towards self and others, disinhibiting effects (e.g. alcohol providing ‘courage’ to make an attempt), and can interfere with adaptive coping strategies. Over the long term, substance abuse disorders may lead to interpersonal conflicts, school or job difficulties, and/or legal problems,

*Given the high rate of co-occurrence between suicidality, depression and substance use problems, these issues need to be routinely assessed every time a young person presents for substance abuse or mental health treatment*

exacerbating the potential for future suicidal behaviours, especially among adolescents who may have pre-existing vulnerabilities. Given the high rate of co-occurrence between suicidality, depression and substance use problems, these issues need to be routinely assessed every time a young person presents for substance abuse or mental health treatment (Effinger & Stewart, 2012; Lichenstein et al. 2010).

Very few studies have been conducted to examine the effectiveness and/or the cultural appropriateness of specific therapeutic approaches for treating suicidal behaviour and substance abuse in adolescent populations. The limited evidence that does exist suggests that the following therapeutic modalities hold the most promise: CBT, DBT, ecological family therapy, and motivational interviewing (Esposito-Smythers, et al. 2012; Lichenstein et al. 2010). An integrated CBT model (CBT-I) has been developed to address co-occurring suicidality and substance abuse problems (for a full description, case example and detailed treatment outline see Esposito-Smythers, et al. 2012).

The first step in the treatment plan is to establish an understanding of the relationship between suicidality and substance use, which should include a full exploration of the context, triggers, risk and protective factors, and consequences of the suicidal or substance use behaviours (Esposito-Smythers, et al. 2012). Other elements of the therapy include "...a menu of individual adolescent, parent training, and family CBT skill building modules, which can be selected, implemented, and practiced based on the needs of each individual client" (p. 249). A motivational interview (MI) is recommended at the outset of treatment as a way to promote ongoing engagement. MI is a client-centered approach to counselling that is aimed at enhancing intrinsic motivation for behaviour change through the exploration and resolution of ambivalence toward changing behaviour and habits (Miller & Rollnick, 2002). Youth and their parents can also benefit from specific skill-building sessions including: coping, affect regulation, cognitive re-structuring, communication and parenting skills. Actively involving young people in their treatment, including the evaluation of its benefits, is also highly recommended (SAMHSA, 2002). Finally, family-based interventions offer considerable promise for Indigenous youth who are struggling with substance use problems. Such approaches are more likely to be most effective when they have been adapted with the input of Indigenous community members and when they are delivered with flexibility in mind (Calabria, et al. 2012).

## Key Principles in the Treatment of Co-Occurring Problems

1. *Expect the co-occurrence of problems*
2. *Actively involve youth and parents in the treatment process*
3. *Utilize a coherent framework for conceptualizing and treating co-occurring problems*
4. *Include motivational interviewing techniques*
5. *Assess for mental health and substance use problems as a routine part of practice*
6. *Implement research informed, integrated, and flexible models of care*
7. *Collaborate with the youth to better understand the relationship between suicidality and substance use*
8. *Explore cultural context and identify triggers, consequences and responses*
9. *Include skill-building for youth and parents*
10. *Recognize that recovery is a process*

## 6. PROVIDING CULTURALLY RESPONSIVE CARE

As others have clearly articulated,

*Suicide is not everywhere linked with pathology but represents a culturally recognized solution to certain situations. As such, understanding suicide and attempting risk prevention requires an understanding of how suicide varies with these forces and how it relates to individual, group and contextual experiences (Goldsmith, et al. 2002; p. 193).*

*We are all multiply and fluidly constituted and our identities are marked by a complex and dynamic intersection of race, gender, sexual orientation, age, ability, and class*

Given the diversity of British Columbia's youth population, it is important that any approach taken to addressing suicidal behaviour is culturally responsive. Providing culturally appropriate care to diverse groups of individuals, families and groups is considered a core competency for mental

health service providers and is an important component of effective and ethical practice. Culture, as used here does *not* refer to static or intrinsic characteristics that are assumed to be shared amongst all members of a particular group. Such a dated characterization of culture is problematic for the ways in which it reinforces stereotypes and ignores the unique and dynamic life histories, contexts and circumstances of individuals. We are all multiply and fluidly constituted and our identities are marked by a complex and dynamic intersection of race, gender, sexual orientation, age, ability, and class. This means that the term 'culture' can move beyond ethnicity and race to encompass multiple cultural identities including sexual orientation (Chu, et al. 2010).

*The term 'culture' can move beyond ethnicity and race to encompass multiple cultural identities including sexual orientation*

### Indigenous Youth and Families

Given the disproportionately high rates of suicide among Indigenous youth compared with the general population, it is important to highlight therapeutic and healing approaches that recognize the sociopolitical origins of distress, including for example, residential schools and institutional abuse, cultural disruption, historical policies of assimilation, and other forms of structural violence. The enduring

negative legacy of colonization has contributed to high levels of suicidal despair among many Indigenous peoples. This type of ‘soul wound’ requires a “postcolonial form of therapeutic intervention” (Gone, 2010 p. 196). For example, clinicians are advised to draw on conceptualizations of suicide and suicidal behaviours that are not exclusively tethered to Western, individualistic and psychological understandings of suicide, but instead take a more holistic view which recognizes the contributions of interpersonal, social, economic, political, and cultural factors in the emergence of suicidal despair (Kirmayer, Simpson & Cargo, 2003; Wexler & Gone, 2012). For many non-Indigenous mental health service providers, this will require recognizing their own complicated embeddedness in colonial relations of power. More specifically,

*Non-Aboriginal mental health professionals usually approach these problems as outsiders to the community and face complex problems of position that may undermine their credibility and effectiveness... No matter how open and unbiased practitioners try to be, they work against a backdrop of structural violence, racism and marginalisation. Only collaborative approaches that focus on the transfer of knowledge, skills, power and authority can hope to transcend these limitations (Kirmayer, Simpson, & Cargo, 2003, p. S22).*

Healing strategies which honour Indigenous ways of knowing and which reflect relational, familial, social, and spiritual dimensions of selfhood are more likely to be effective than those which are predicated on de-contextualized, expert-driven, individualistic, biomedical understandings of distress (Wexler & Gone, 2012). A

*Healing strategies which honour Indigenous ways of knowing and which reflect relational, familial, social, and spiritual dimensions of selfhood are more likely to be effective*

recent summary of culturally based approaches to Indigenous healing is offered by Vucik and colleagues (2011) who describe them as: “...wholistic, including a central role for Elders and traditional people, use of the structure of the circle and outdoor physical setting, traditional teachings and medicines, storytelling and ceremony (p. 70).

Building on local resources, respecting cultural protocols and sacred ceremonies, recognizing the importance of the land, valuing the spiritual dimension, and strengthening family and community relationships are critical components of any therapeutic endeavor when working with Indigenous youth (Gone, 2010; Rickwood, Deane & Wilson, 2007). Interventions which include families and communities, as

well as the suicidal young person are more likely to be effective. This way of working “...repositions the mental health worker as an advocate for community and family action in response to communal distress” (Wexler & Gone, 2012, p. 804).

## Sexual Minority Youth

Several decades of research have confirmed that GLBTQ youth have higher rates of suicidal behaviour than their heterosexual peers (Diamond, et al. 2012). While there is great variation, and not all sexual minority youth are at heightened risk for suicidal behaviour, there are a number of unique stressors they face that can make them especially vulnerable. These include for example: discrimination, harassment, victimization, and rejection, all of which take place within a broader culture of societal homophobia. To date there have been few studies which have evaluated the efficacy of treatment that targets GLBTQ youth who are suicidal. Given the importance of parental support, emotional closeness and positive communication in the lives of GLBTQ youth, one promising approach to working with sexual minority youth is attachment based family therapy (Diamond, et al. 2012). Key elements of the therapy include: reducing parental criticism and focusing the treatment on strengthening the parent and adolescent attachment relationship; engaging the youth in treatment and building hope for change; reducing parental distress and improving parenting practices; and providing the young person with a new experience of their parents in which they feel cared about, understood, and heard (Diamond, et al. 2012).

## Cultural Minorities

Very few research frameworks or clinical models of suicide have been developed that explicitly take culture into account. An exception is the work of Chu and colleagues (2010) who have developed a cultural theory and model of suicide. In keeping with the notion of a ‘multiple identities perspective’ their model assumes that each individual carries multiple, intersecting cultural identities. At the same time, there are some unique challenges that non-dominant groups face as a result of their minority status, which are linked to suicide risks.

*In keeping with the notion of a ‘multiple identities perspective’ ... each individual carries multiple, intersecting cultural identities*

Chu and colleagues have identified four common cultural categories of suicide risk that are important to consider when working with cultural and sexual minority groups: (1) cultural sanctions, (2) idioms of distress, (3) minority stress, and (4) social

discord (p. 27). Cultural sanctions refer to the acceptability of suicide as an option within the particular culture. Cultural sanctions also influence what is considered shameful within a particular cultural context. Both are relevant when trying to understand the context of despair and the specific response of suicide. Idioms of distress are culturally resonant forms of expressing distress (Nichter, 1981) and "...research shows differential patterns in the following idioms of distress: (1) likelihood to express suicidality, (2) the way suicide symptoms are expressed, and (3) the chosen methods or means of attempting suicide" (Chu, et al., 2010, p. 29). Minority stress refers to the challenges and stresses associated with minority status, including discrimination, stereotypes, and internalized negative beliefs about one's cultural group. Living with the effects of institutional racism and social disadvantage is also a form of minority stress. Finally, social discord refers to interpersonal conflict, lack of social support, and social alienation. This cultural model of suicide is an important resource for mental health clinicians as it shines the light on some of the unique stressors the minority groups face which can heighten risks for suicide.

## Key Principles in Providing Culturally Responsive Care

1. *Recognize cultural assumptions and biases regarding mental health, illness, healing and sources of distress*
2. *Understand that culture is a flexible and ongoing process, not a uniform or fixed entity*
3. *Appreciate that all individuals (i.e. clinicians and youth) have multiple and fluid cultural identities*
4. *Assess risks and develop treatment models with attention paid to cultural understandings of distress and healing*
5. *Explore expectations regarding communication, self-disclosure and decision-making*
6. *Be familiar with the unique stressors that can elevate risk for minority groups*
7. *Draw on healing strategies that recognize relational, familial, and spiritual dimensions of selfhood when working with Indigenous youth*
8. *Advocate for family and community empowerment*
9. *Utilize treatment strategies that strengthen the bond between parents and youth when working with GLBTQ youth*

## 7. PARTNERING WITH PARENTS/CAREGIVERS AND FAMILY MEMBERS

Parent relationships have been found to be the most consistent protective factor for adolescent suicide, even when compared to other social contexts such as peer and school relationships (Kidd, et al. 2006). Acknowledging parents/caregivers as collaborative partners in the delivery of mental health care is an important guiding principle when working with youth at risk for suicide (Slovak & Singer 2012). Several studies have demonstrated the important role of parental involvement, warmth, connection, listening and support in reducing risks for adolescent suicidal behaviour (Hooven, 2013). Conversely, high levels of family conflict, low cohesion, and punitive parenting are risk factors for suicidal behaviours. It is also important to acknowledge that in some cases, parental neglect and/or abuse are the very conditions that may be leading a young person to experience suicidal despair. In such cases, child and youth mental health clinicians have a duty to report to a child welfare practitioner that this is a child or youth in need of protection.<sup>4</sup>

*Parent relationships have been found to be the most consistent protective factor for adolescent suicide, even when compared to other social contexts such as peer and school relationships*

Parents of suicidal youth often experience high levels of distress when faced with the knowledge that their son or daughter is suicidal. Experiences of being fearful, overwhelmed, ashamed, anxious, confused, angry are not uncommon, and this can sometimes lead parents to minimize the problem or dismiss the young person's concerns, which can exacerbate the young person's feelings of hopelessness, despair and isolation. Validating parents and directly addressing their concerns, including any misperceptions they may have about suicidal behaviour is an important part of any therapeutic work with suicidal adolescents (Wells & Heilburn, 2012). Engaging parents as

*Validating parents and directly addressing their concerns, including any misperceptions they may have about suicidal behaviour is an important part of any therapeutic work with suicidal adolescents*

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<sup>4</sup> Section 13 of the *Child, Family and Community Services Act* provides a detailed list of the specific circumstances that determine when a child is in need of protection.

allies and partners in the care and treatment of suicidal adolescents also means increasing their “comfort, knowledge and competence in responding to their youth’s distress” (Hooven, 2013, p. 87).

When parents believe that the therapeutic intervention is relevant, acceptable and a good fit, they are more likely to be actively committed to the process, which in turn benefits the young person.

Parents-CARE is an example of a promising program designed for parents of at-risk, suicidal youth. It is typically offered as an adjunct to suicide prevention interventions with youth, often delivered in parents’ home (Hooven, 2013). Enhancing family communication is a central goal and several features guide the delivery of the program. These include: collaboration and respecting parents’ expertise; tailoring the program to match parents’ concerns and individual youth issues; offering social support; and teaching skills.

Other approaches, such as family-based CBT underscore the importance of hearing parents’ accounts of the young person’s suicidal crisis, collaborative agenda-setting, involving parents/caregivers in safety planning and monitoring, ensuring the home environment is safe, educating parents about CBT, and offering parents specific skill building sessions (Wells & Heilbrun, 2012).

*It is important to recognize that the notion of family may often include individuals who are not necessarily living in the same household*

Slovak and Singer (2012) add an important, but often overlooked dimension of providing culturally competent services when working with youth and families who live in rural communities. They recommend that mental health service providers working in rural communities need to understand and show respect for hunting and gun culture, while at the same time ensuring that parents take an active role in keeping the home environment safe.

When working with Indigenous young people and families, it is important to recognize that the notion of family may often include individuals who are not necessarily living in the same household (Strickland et al. 2006). This may mean engaging and mobilizing individuals who are related by blood, marriage, or adoption, across different generations to support a young person. In a study of Indigenous parents’ and Elders’ perspectives on the impact of colonization and the implications for suicide prevention, Strickland and colleagues (2006) found that “...suicide prevention for American Indian people must be aimed at strengthening family, community, and cultural values “ (p. 11).

## Key Principles for Partnering with Parents/Caregivers and Family Members

1. *View and engage parents as partners and allies*
2. *Acknowledge and validate parents' feelings and concerns*
3. *Respect parents' wisdom and expertise*
4. *Educate about suicidal behaviour and treatment*
5. *Teach skills to enhance communication and reduce conflict*
6. *Offer social support*
7. *Enlist parents' active participation in keeping the home environment safe*
8. *Collaborate with parents in treatment, safety planning and monitoring*
9. *Clarify communication and confidentiality*
10. *Provide culturally relevant support*

## 8. ENGAGING HARD-TO-REACH YOUNG PEOPLE AND FAMILIES

Numerous studies have confirmed that young people are generally reluctant to seek out professional assistance, even when they are experiencing high levels of distress (Rickwood, Deane & Wilson, 2007). Young men are even less likely to access help than young women. Cultural minorities, GLBTQ youth, and Indigenous youth may be

*When thinking about how to engage hard-to-reach youth and families, it is important to recognize that the experience of distress is not necessarily the primary factor motivating a young person to reach out for help.*

particularly reluctant to seek formal help, and this is especially likely if the care offered is not culturally appropriate. There is also some suggestion that adolescents with suicidal ideation may be less likely to seek professional help (Rickwood, et al., 2007). Other commonly experienced mental health problems among adolescents, such as anxiety, depression and substance abuse, which can exacerbate isolation and social withdrawal, may further diminish the likelihood of help-seeking. Reducing barriers to help-seeking, promoting youth engagement from the first point of contact, and offering a flexible range of service delivery options are key guidelines.

When thinking about how to engage hard-to-reach youth and families, it is important to recognize that the experience of distress is not necessarily the primary factor motivating a young person to reach out for help. In fact, “A wide range of other factors are involved, including appraisal of a problem as something to seek help for, willingness to seek help and social norms that encourage such behaviour, access to appropriate services, and choosing a source of help” (Rickwood, et al., 2007, p. S35). In other words, they have to recognize that they have a problem for which help is available and then be willing to take steps to seek help.

According to a recent systematic review investigating barriers to help-seeking, stigma and embarrassment are *the* most prominent barriers to help seeking for mental health problems (Gulliver, Griffiths, & Christensen, 2010). Other reported barriers included: worries about confidentiality and trust, lack of insight or recognition of a mental health problem, lack of access to service (time, cost, travel), concern about competence or other characteristics of the practitioner, lack of knowledge about mental health services, and fear in general.

Young people who recognize that they have a mental health problem, possess the emotional competence to express themselves, believe that the help offered will make a positive difference, have had previous positive experiences, are motivated to

change, and have the skills and knowledge to access mental health services are more likely to seek help and stay engaged in treatment (Gulliver, et al., 2010; Rickwood, et al., 2007). Many of these skills can be taught and/or bolstered. For most youth, their parents are typically the most important resource for helping them access care and navigate the system. For this reason, parents need to be seen as active partners in the care and treatment of suicidal youth. In other words, “addressing practical and psychological barriers, increasing support at multiple points of stress, showing respect and concern to families, and providing culturally competent services” are all important strategies for improving engagement (Slovak & Singer, 2012 p. 213).

Other specific strategies that may strengthen youth engagement include: providing a welcoming, non-judgmental reception, offering a range of flexible and diverse treatment options, utilizing collaborative models of care, clarifying expectations regarding confidentiality (and its limits) and actively involving young people in the treatment process from the point of first contact (Gulliver, et al., 2010; Rickwood, et al., 2007; Schley, Yuen, Fletcher, & Radovini, 2012).

*Specific strategies that may strengthen youth engagement include: providing a welcoming, non-judgmental reception, offering a range of flexible and diverse treatment options, utilizing collaborative models of care, clarifying expectations regarding confidentiality and its limits and actively involving young people in the treatment process from the point of first contact*

Pisani and colleagues (2013) discuss the importance of developing “option rich (OR) interventions” to support a range of youth preferences and needs. They emphasize approaches that strengthen emotion regulation skills and facilitate supportive connections with trusted adults.

*[Option rich] means developing interventions that offer participants ongoing options for how they will participate, in terms of content, structure, breadth and depth... [such] interventions could be especially engaging to teenagers, who prize their freedom and individuality (p. 816).*

For young people who are disconnected from traditional support networks and who are not engaged at school, relying on the assistance of more informal advocates and liaisons can be useful. For example, “Youth workers are able to engage distressed young people by being highly accessible, ‘befriending’ them, and acting as advocates. They potentially have a critical role in linking more marginalised youth with mental

health services....” (Rickwood, et al., 2007,p S38). Also, having a range of trusted adults to turn to in times of distress has been identified as an important protective factor (Pisani, et al, 2013).

*It is important for clinicians to recognize the role of the Internet in young peoples’ lives*

For those youth who are living with the effects of severe mental health problems, who have a history of limited engagement with services, and are considered high risk (i.e. suicidal), a more intensive and flexible model of treatment may be warranted. More specifically, providing outreach services to youth in the least restrictive environment of their choice (e.g. school, home, café), providing more frequent contact, and avoiding coercive management strategies are all promising strategies that have been identified in the literature (Schley, Yuen, Fletcher & Radovini, 2012).

Finally, it is important for clinicians to recognize the role of the Internet in young peoples’ lives. Many youth access help on-line and find it to be meaningful and relevant (Greidanus & Everall, 2010). Thus it is important to help direct young people to constructive and credible websites and sources of support, including for example <http://youthspace.ca> or <http://www.yourlifecounts.org> or <http://youthinbc.com>

## Key Principles for Engaging Hard-to-Reach Youth

1. *Provide a welcoming, compassionate, non-judgmental reception*
2. *Utilize collaborative and flexible models of care and outreach*
3. *Build a strong therapeutic alliance at point of first contact*
4. *Educate youth and parents about the role of mental health services*
5. *Increase confidence and hope that treatment can be of assistance*
6. *Involve parents/caregivers as key partners*
7. *Address concerns regarding confidentiality and clarify limits*
8. *Offer a diverse range of treatment options that are individually tailored and culturally appropriate*
9. *Work with informal and formal partners, including school staff, youth workers, and advocates, to connect with youth who are marginalized*
10. *Recognize and support constructive and credible Internet-based forms of self-help*

## 9. CLINICAL DOCUMENTATION

Maintaining a clear record that documents the risk assessment, estimation of risk, approach to safety planning, treatment goals and clinical consultations is an important aspect of good clinical care. Documentation is important for the following reasons (Shea, 2002):

1. To convey relevant information to other professionals
2. To serve as a quality assurance checklist
3. To provide protection against malpractice
4. Good clinical documentation rests on good clinical care
5. Even if good clinical care has been provided, if the documentation is poor, the risk for criticism and/or litigation rises

Despite the additional time involved in adequately documenting a suicide risk assessment, clinicians are strongly encouraged to document their suicide risk assessment and treatment plans as soon as possible following clinical evaluation of the child or youth. Overly simplistic “yes/no” tickable boxes (i.e. Is the person suicidal?) and subjective rating scales (from 1 to 5) are generally poor substitutes for a thorough risk assessment and a step-by-step account of subsequent clinical judgment and planning. It is also important to explicitly include documentation of interventions that are based on strengths (McCammon, 2012).

*Clinicians are strongly encouraged to document their suicide risk assessment and treatment plans as soon as possible following clinical evaluation of the child or youth*

In outpatient settings, documentation of suicide risk should be undertaken at the following points (American Psychiatric Association, 2003):

- Initial interview
- Emergence or re-emergence of suicide ideation, plans or attempts
- Significant changes in the client’s condition or treatment plans

## Key Principles to Guide Documentation Practices

1. *Use a systematic approach*
2. *Document risk assessment information as soon as possible*
3. *Ensure that the clinical record shows that the proposed treatment and safety plans correspond with the risk formulation*
4. *Include information from collateral sources*
5. *Document consultations with colleagues*
6. *Make specific note of protective factors and strengths-based interventions*
7. *Update the record to note any changes in suicide risk*

For a more detailed description see **Appendix F: How to Structure a Suicide Risk Assessment Document**

## 10. SOCIAL & SYSTEMIC INTERVENTIONS

Youth suicide and suicidal behaviours are complex. A multi-strategy, ecological approach, which is implemented across multiple systems and sectors is increasingly recommended (Alcantra & Gone, 2007; Bean & Barber, 2011). A well-functioning mental health system that is adequately resourced, governed by clear policies, supported by partner organizations and agencies (including hospitals, schools, and child welfare systems), and staffed by well trained professionals provides an important backdrop to this challenging work.

### Strengthen Professional Expertise and Organizational Capacity

Ensuring that child and youth mental health practitioners have opportunities for ongoing skill development in youth suicide risk assessment and treatment is an important element in the care of suicidal youth (Schmitz, et al. 2012). At the same time, paying attention to the broader organizational culture and policy context within which they work can provide additional reinforcement for the uptake of new skills and support the routinization of desired practices. A recent study was undertaken to determine whether professional development training in youth suicide prevention could be enhanced through the addition of an organizational design element (Donald, Dower & Bush, 2013). Preliminary findings suggest that an approach to professional development and training that includes organizational-level interventions designed to support and sustain changes to practitioner knowledge and skills is superior to a standalone focus on skill acquisition. Core aspects of the enhanced training model include:

*A well-functioning mental health system that is adequately resourced, governed by clear policies, supported by partner organizations and agencies . . . and staffed by well trained professionals provides an important backdrop to this challenging work.*

*(1) the participation of early-adopters, (2) strengthening opportunity for deep learning, (3) the opportunity to practice skills while in a supported context, (4) the creation of learning networks, (5) an extended period of support from the training team, and (6) the advancement of a supportive organizational infrastructure (p.91).*

The establishment of clear policy goals, which can focus organizational attention on key target areas are additional strategies for strengthening local youth suicide

prevention efforts. Here is an example of a set of inter-related policy goals that were developed to guide the work of one mental health team:

- To optimise the care offered to clients at risk for suicidal behaviour
- To develop networks to enable follow-up of patients at-risk
- To lend support to and share know-how/skills with other caregivers
- To advocate suicide prevention issues in local networks
- To facilitate aftercare for the bereaved by suicide (postvention)
- To participate in regional and (inter-)national suicide prevention activities (Andriessen , et al. 2002, p. 21).

## Link Emergency Departments and Mental Health Services

One of the highest risk periods for re-attempts among adolescents who have attended the Emergency Department (ED) following a suicidal crisis is the three-month period immediately following discharge (Spirito, et al. 2011). Having well-established protocols between the ED and community based child and youth mental health services, and working with EDs to develop effective interventions for suicidal youth are important elements in supporting suicidal youth. Suicide prevention protocols should be developed in advance of any crisis and should include the following elements: careful assessment, safety planning, and follow-up care (Heilbrun, et al. 2012). Specificity and clarification of roles and responsibilities are important in the development of protocols. Specifically, they should outline

*Suicide prevention protocols should be developed in advance of any crisis and should include the following elements: careful assessment, safety planning, and follow-up care*

*...who will be responsible for making decisions if such a situation were to arise, precisely what process will be in place to underlie the decision making, the documentation necessary to ensure clear communication about the youth's care, and what procedures are in place for follow-up with youth and families (p. 7).*

An example of a brief family-based intervention delivered in the ED that has been found to be effective in linking youth to follow-up care is described by Hughes and

Asarnow (2013). The purpose of this intervention is to increase the youth's motivation to attend treatment and enhance linkages with community-based mental health services. It includes the following components: work with youth and parents to ensure the home environment is safe; highlight and reinforce strengths and protective factors of the youth and family; help the youth and family to conceptualize suicidality through a discussion of triggers, thoughts, behaviours and signs of distress; collaborate on the development of a safety plan; provide the youth with concrete tools for coping; and provide emergency contact numbers (Hughes & Asarnow, 2013).

## Address Broad Social Determinants

While it is rare to read about a youth suicide prevention strategy that addresses the role of social inequities in perpetuating hopelessness, despair and suffering, the neglect of these influential macro structures, means any youth suicide prevention strategy is bound to be inadequate. The “[s]ocial determinants of health (SDH) refer to the societal factors – and the unequal distribution of these factors – that

*Given that we live in a world marked by deep social and economic inequities, understanding the role that poverty, discrimination and social injustice play in exacerbating existing vulnerabilities is essential to any youth suicide prevention effort*

contribute to both the overall health of Canadians and existing inequalities in health” (Raphael, 2009, p. 221). Accumulating research on the social determinants of health, including income distribution, education, employment, early childhood development, and housing, has convincingly established the links between inequitable social arrangements, adverse living conditions and poor health outcomes (Raphael, 2009). Given that we live in a world marked by deep social and economic inequities, understanding the role that poverty, discrimination and social injustice play in exacerbating existing vulnerabilities is essential to any youth suicide prevention effort (Li, Page, Martin & Taylor, 2011). Policy level interventions and organizational cultures that target community and social conditions represent concrete examples for expanding current approaches to youth suicide prevention.

## Key Principles for Implementing Social and Systemic Interventions

1. *Advocate for comprehensive, multi-faceted, community-wide approaches*
2. *Ensure child and youth mental health clinicians receive ongoing professional development training in youth suicide risk assessment, care and treatment*
3. *Improve organizational capacity to support new learning and uptake of new skills*
4. *Develop proactive protocols and procedures for the identification and follow-up care of suicidal adolescents*
5. *Strengthen local networks to support effective referrals and follow-up*
6. *Enhance linkages between emergency departments and child and youth mental health services*
7. *Develop clear policy goals to guide youth suicide prevention efforts*
8. *Address the social determinants of health*

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## APPENDIX B. RISK AND PROTECTIVE FACTORS FOR YOUTH SUICIDE

KEY CONTEXT	PREDISPOSING FACTORS	CONTRIBUTING FACTORS	PRECIPITATING FACTORS	PROTECTIVE FACTORS
<b>Individual</b>	<ul style="list-style-type: none"> <li>• previous suicide attempt</li> <li>• depression, substance abuse, anxiety, or other mental health problems</li> <li>• hopelessness</li> <li>• persistent and enduring suicidal thoughts</li> <li>• history of childhood neglect, sexual or physical abuse</li> </ul>	<ul style="list-style-type: none"> <li>• rigid cognitive style</li> <li>• poor coping skills</li> <li>• limited distress tolerance skills</li> <li>• substance misuse</li> <li>• impulsivity</li> <li>• aggression</li> <li>• hypersensitivity/ anxiety</li> </ul>	<ul style="list-style-type: none"> <li>• loss</li> <li>• personal failure</li> <li>• victim of cruelty, humiliation, violence</li> <li>• individual trauma</li> <li>• health crisis</li> </ul>	<ul style="list-style-type: none"> <li>• individual coping, self-soothing and problem solving skills</li> <li>• willingness to seek help</li> <li>• good physical and mental health</li> <li>• experience/feelings of success</li> <li>• strong cultural identity and spiritual beliefs</li> <li>• living in balance and harmony</li> </ul>
<b>Family</b>	<ul style="list-style-type: none"> <li>• family history of suicidal behaviour /suicide</li> <li>• family history of mental disorder</li> <li>• early childhood loss/ separation or deprivation</li> </ul>	<ul style="list-style-type: none"> <li>• family discord</li> <li>• punitive parenting</li> <li>• impaired parent-child relationships</li> <li>• invalidating interpersonal environment</li> <li>• multi-generational trauma and losses</li> </ul>	<ul style="list-style-type: none"> <li>• loss of significant family member</li> <li>• death of a family member, especially by suicide</li> <li>• recent conflict</li> </ul>	<ul style="list-style-type: none"> <li>• family cohesion and warmth</li> <li>• positive parent-child connection</li> <li>• positive role models</li> <li>• active parental supervision</li> <li>• high &amp; realistic expectations</li> <li>• support and involvement of extended family &amp; Elders</li> <li>• connection to Ancestors</li> </ul>
<b>Peers</b>	<ul style="list-style-type: none"> <li>• social isolation &amp; alienation</li> <li>• victim of peer violence</li> </ul>	<ul style="list-style-type: none"> <li>• negative attitudes toward help seeking</li> <li>• limited/conflicted peer relationships</li> <li>• suicidal behaviours among peers</li> </ul>	<ul style="list-style-type: none"> <li>• interpersonal loss or conflict</li> <li>• rejection</li> <li>• peer death by suicide</li> </ul>	<ul style="list-style-type: none"> <li>• social competence</li> <li>• healthy peer modeling</li> <li>• peer friendship, acceptance &amp; support</li> </ul>

KEY CONTEXT	PREDISPOSING FACTORS	CONTRIBUTING FACTORS	PRECIPITATING FACTORS	PROTECTIVE FACTORS
<b>School</b>	<ul style="list-style-type: none"> <li>• history of negative school experience</li> <li>• lack of meaningful connection to school</li> </ul>	<ul style="list-style-type: none"> <li>• reluctance/uncertainty about how to help among school staff</li> </ul>	<ul style="list-style-type: none"> <li>• failure</li> <li>• expulsion</li> <li>• disciplinary crisis</li> <li>• school-based harassment</li> </ul>	<ul style="list-style-type: none"> <li>• success at school</li> <li>• interpersonal connectedness/ belonging</li> <li>• supportive school climate</li> <li>• school engagement</li> <li>• anti-harassment policies and practices</li> </ul>
<b>Community</b>	<ul style="list-style-type: none"> <li>• multiple suicides</li> <li>• community marginalization</li> <li>• socioeconomic deprivation*</li> </ul>	<ul style="list-style-type: none"> <li>• sensational media portrayal of suicide</li> <li>• access to firearms or other lethal methods</li> <li>• uncertainty about how to help among key gatekeepers</li> <li>• inaccessible community resources</li> </ul>	<ul style="list-style-type: none"> <li>• high profile/ celebrity death, especially by suicide</li> <li>• conflict with the law/incarceration</li> </ul>	<ul style="list-style-type: none"> <li>• opportunities for youth participation</li> <li>• availability of resources</li> <li>• community ownership and control over local services</li> <li>• culturally safe healing practices</li> <li>• opportunities to connect to land and nature</li> </ul>
<b>Sociopolitical</b>	<ul style="list-style-type: none"> <li>• colonialism</li> <li>• historical trauma</li> <li>• cultural stress</li> <li>• interlocking oppressions</li> </ul>	<ul style="list-style-type: none"> <li>• racism</li> <li>• sexism</li> <li>• classism</li> <li>• ableism</li> <li>• heterosexism</li> </ul>	<ul style="list-style-type: none"> <li>• social exclusion</li> <li>• social injustice</li> </ul>	<ul style="list-style-type: none"> <li>• social capital</li> <li>• social justice</li> <li>• social safety net</li> <li>• social determinants of health</li> </ul>

## APPENDIX C. LEVELS OF SUICIDE RISK\*, MCFD CYMH SUICIDE PREVENTION, INTERVENTION AND POSTVENTION POLICY

<b>Minimal</b>	<ul style="list-style-type: none"> <li>Absence of active suicidal thinking</li> </ul>
<b>Mild</b>	<ul style="list-style-type: none"> <li>Suicidal thinking with no specificity, low intensity of mental health symptoms and the presence of protective factors</li> </ul>
<b>Moderate</b>	<ul style="list-style-type: none"> <li>Specific suicidal thoughts including how, when and where they will die, increased frequency and duration of these thoughts, and the presence of protective factors</li> </ul>
<b>Severe</b>	<ul style="list-style-type: none"> <li>Specific suicidal thinking with intent, increase in intensity of mental health symptoms and a reduction in protective factors</li> </ul>
<b>Extreme</b>	<ul style="list-style-type: none"> <li>As with "Severe" yet imminent with clear intention to die by suicide when there is an opportunity</li> </ul>
<b>Chronic</b>	<ul style="list-style-type: none"> <li>As with "Moderate", "Severe" or "Extreme" with an overall vulnerability and susceptibility to suicidal behaviour</li> </ul>

*\*Adapted from: Rudd (2006) and Sommers-Flanagan & Sommers-Flanagan (2005)*

## APPENDIX D. PRINCIPLES OF A SUICIDE RISK ASSESSMENT

Core Features	Key Questions
<b>Systemic, Multi-Faceted, Ecological</b>	<ul style="list-style-type: none"> <li>• Is the overall approach thorough, extensive and multifaceted?</li> <li>• Are self-report instruments always used in conjunction with a clinical interview?</li> <li>• Does the risk assessment take sufficient account of the larger ecological context and consider potential sociocultural constraints?</li> </ul>
<b>Research-Informed</b>	<ul style="list-style-type: none"> <li>• Is it informed by the current research evidence?</li> <li>• Does it reflect the most up-to-date literature?</li> </ul>
<b>Collaborative and Strengths-Based</b>	<ul style="list-style-type: none"> <li>• Is the process collaborative and strengths-based?</li> <li>• Are young people engaged as knowledgeable and capable?</li> <li>• Is there an emphasis on understanding the meaning of the suicidal despair from the young person's perspective?</li> </ul>
<b>Developmentally Appropriate</b>	<ul style="list-style-type: none"> <li>• Is it sufficiently attuned to developmental considerations?</li> <li>• Is the language matched to the child/youth's level of understanding?</li> </ul>
<b>Culturally Sensitive</b>	<ul style="list-style-type: none"> <li>• Is proactive attention paid to recognizing potential cultural barriers, including cultural biases, expectations about communication, role of self-disclosure, perceptions about the problem and causes of suicide, and preferred decision-making orientations?</li> </ul>
<b>Fluid Understanding of Risk</b>	<ul style="list-style-type: none"> <li>• Is risk understood as fluctuating and dynamic?</li> <li>• Are chronic (distal, enduring and static) and acute (proximal, episodic and variable) risk factors identified and addressed?</li> </ul>
<b>Focus on Protective Factors</b>	<ul style="list-style-type: none"> <li>• Are buffers (protective) factors against suicide thoroughly explored?</li> <li>• Is active consideration given to a range of protective factors across a number of social contexts?</li> </ul>
<b>Thorough Exploration of Current Suicidal Thinking</b>	<ul style="list-style-type: none"> <li>• Is current suicide ideation thoroughly examined beyond "yes/no" tickable boxes?</li> <li>• Does the assessment of current suicidality include an explicit consideration of suicidal desire, capability,</li> </ul>
<b>Reflects Input from Collateral Informants</b>	<ul style="list-style-type: none"> <li>• Are collateral sources of information consulted and included?</li> <li>• Is this information included in the clinical record?</li> </ul>
<b>Risk Formulation</b>	<ul style="list-style-type: none"> <li>• Does the assessment process include the explicit step of risk formulation (i.e. minimal, mild, moderate, severe, imminent)?</li> <li>• Does the proposed treatment and safety plan match the level of suicidality?</li> </ul>
<b>Clear Documentation</b>	<ul style="list-style-type: none"> <li>• Does the documentation reflect a comprehensive, multi-modal assessment?</li> <li>• Does the recommended treatment plan correspond to the level of risk identified in the risk formulation?</li> </ul>

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## APPENDIX E. EXAMPLE ELEMENTS OF A SAFETY PLAN

### STEP 1: WARNING SIGNS:

- Suicidal thoughts and feeling worthless and hopeless
- Urges to smoke weed
- Intense arguing with girlfriend

### STEP 2: INTERNAL COPING STRATEGIES - THINGS I CAN DO TO DISTRACT MYSELF WITHOUT CONTACTING ANYONE:

1. Play computer games
2. Watch TV
3. Work out at home

### STEP 3: SOCIAL SITUATIONS AND/OR PEOPLE THAT CAN HELP TO DISTRACT ME:

1. Mom
2. School gym

### STEP 4: PEOPLE WHO I CAN ASK FOR HELP:

1. Ms. Namath (teacher)
2. Joe Smith (cousin)                      Phone 333-7215

### STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. Child and Youth Mental Health Clinician  
Name \_\_\_\_\_  
Phone \_\_\_\_\_                      Emergency Contact # \_\_\_\_\_
2. School Counsellor \_\_\_\_\_                      Phone \_\_\_\_\_  
\_\_\_\_\_
3. Local Hospital Emergency Dept City Center \_\_\_\_\_  
Local Hospital Emergency Dept Address \_\_\_\_\_  
Local Hospital Emergency Dept Phone \_\_\_\_\_
4. Suicide Prevention Lifeline Phone: **1-800-SUICIDE** (784-2433)

### MAKING THE ENVIRONMENT SAFE:

1. Put mom in charge of storing medications

*(Adapted from Stanley & Brown, 2012)*

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## APPENDIX F. HOW TO STRUCTURE A SUICIDE RISK ASSESSMENT DOCUMENT

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

### I. OBJECTIVE INFORMATION

Identifying Information and Demographics  
Presenting Complaint  
History of Present Concerns  
Past Psychiatric History and Treatment  
Social and Developmental History  
Family History  
Medical History  
Mental Status

### II. SUBJECTIVE INFORMATION

DSM Diagnoses  
Clinical Summary and Formulation (includes suicide risk estimation)  
Treatment Plan

### GENERAL COMMENTS:

- Specific risk factors for suicide can be described under the various categories of **Objective Information** (e.g. *sex and age* are included under Demographics, *past history of attempts* is included under Past Psychiatric History, *current stressors and quality of interpersonal relationships* is included under Social and Developmental History, etc.)
- Information about *recent suicide ideation, planning and intent* can be included under the section History of Present Concerns
- Document the *absence of relevant risk factors*, e.g. “no history of previous attempts” and any other noteworthy protective factors
- The **Subjective Information** section provides an opportunity for you to provide an account of the *client’s current suicide risk*, including the how and why of your reasoning
- Include any *consultations with collateral informants and colleagues* under the Clinical Formulation