



TITLE

SUICIDE RISK MANAGEMENT

SCOPE

Provincial Addiction & Mental Health: Ambulatory, Residential
Addiction and Detoxification Settings, Protection of Children
Abusing Drugs (PChAD) Program

DOCUMENT #

AMH-11-01

APPROVAL AUTHORITY

Vice President, Provincial Clinical Excellence

INITIAL EFFECTIVE DATE

October 30, 2020

SPONSOR

Executive Director, Provincial Addiction & Mental Health

REVISION EFFECTIVE DATE

March 24, 2022

PARENT DOCUMENT TITLE, TYPE, AND NUMBER

Suicide Risk Management Policy (#AMH-11)

SCHEDULED REVIEW DATE

October 30, 2023

NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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OBJECTIVES

- To facilitate collaborative **recovery-oriented** services for **patients** at risk of suicide in a manner that encompasses safety, respect, and best practice.
- To provide direction to Addiction & Mental Health (AMH) staff working in **ambulatory services**, residential addiction treatment and detoxification settings, and the Protection of Children Abusing Drugs (PChAD) program on screening, assessing, and supporting patients at risk of suicide and their **alternate decision-makers** and/or **families**.
- To provide direction on the appropriate actions to be taken following the attempted suicide of a patient.

APPLICABILITY

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, students, volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

ELEMENTS

1. Points of Emphasis

- 1.1 Offering a welcoming, engaging, patient-centred approach is integral to the successful support of patients at risk of suicide.

- 1.2 When managing suicide risk, **health care providers** shall consider patients' protective factors and utilize the least intrusive interventions whenever possible.
- 1.3 Working with patients at risk of suicide can be stressful and can impact staff. Staff shall be continually mindful of their emotions, attitudes, and beliefs, and are to always act in a manner that is vigilant, non-judgmental, and supportive.
- 1.4 Disclosure of health information shall be in accordance with the *Health Information Act* (Alberta).
- 1.5 Health care providers shall:
 - a) build rapport with their patients to encourage them to share information such as personal goals, recovery plans, and suicidal thoughts;
 - b) listen to patients carefully and whenever appropriate, share their clinical perspective in order to attain a common understanding with the patient;
 - c) involve families, alternate decision-makers, and other health care providers whenever possible, in gathering information while respecting patient consent and privacy, and managing suicide risk; and
 - d) discuss the limits of confidentiality with the patient (e.g., on matters directly related to safety).

2. Suicide Risk Observation, Screening, and Assessment

- 2.1 Screening for suicide risk is an ongoing responsibility for all health care providers who provide **direct care** according to their training and role, and should be done in a manner that meaningfully engages the patient.
- 2.2 **Suicide risk screening** shall be completed at service commencement by health care providers, and may be completed at other times based on clinical judgement. Findings from the suicide risk screening shall determine whether to complete a **suicide risk assessment**. Known times of increased risk include, but are not limited to, the following:
 - a) during transitions in treatment that are significant to the patient (e.g., pending discharge or transfer, changes in frequency of contact, change in treatment setting or change in health care providers);
 - b) during any significant clinical change in the patient's condition, such as improvement or deterioration in stress, behaviours, and symptoms;
 - c) whenever a patient experiences a significant stressor (e.g., change in family system/structure and/or relationships, job, finances, living arrangements, anticipating or returning from weekend pass);
 - d) relapse with reduced physical tolerance to a substance; and

- e) at the time of change in a patient's legal status under the *Mental Health Act* (Alberta).
- 2.3 In residential addiction treatment and detoxification settings, suicide risk screening shall be conducted with all patients during admission to the facility.
- 2.4 When conducting suicide risk screening or assessment, health care providers shall consider:
- a) the patient's stage of development, across the lifespan (e.g., child, youth, adult, and seniors);
 - b) the important differences of cultural values and beliefs among patients; and
 - c) that denial of suicidal ideation does not, by itself, reflect a reasonable measure of suicide risk.
- 2.5 Suicide risk screening is intended to be non-invasive, indicate whether suicide risk may exist and whether further assessment is required. It shall include an inquiry into the patient's:
- a) history of non-suicidal self-injury (self-harm) or attempted suicides;
 - b) current suicidal ideation (e.g., wish to be dead);
 - c) current thoughts and plans about killing or harming themselves; and
 - d) participation in risk-taking behaviour with the thought of causing death or self-harm (see Appendix A: *Suicide Risk Level Criteria and Examples of Risk Factors and Protective Factors*).
- 2.6 Based on the results of the suicide risk screening and, if consulted, the judgement of the clinical team, the health care provider, according to their training and role shall conduct a suicide risk assessment in collaboration with the patient.
- 2.7 Suicide risk assessment is intended to provide direction for intervention and/or treatment. The assessment shall include an inquiry into risk and protective factors (see Appendix A: *Suicide Risk Level Criteria and Examples of Risk Factors and Protective Factors*).
- a) Health care providers shall gather relevant information from all relevant sources (e.g., family) in accordance with collection and disclosure provisions within the *Health Information Act* (Alberta), while balancing the patient's risk of harm to self or others and the patient's right to privacy.
 - b) In addition to utilizing their knowledge, skills, and clinical judgement, health care providers may use suicide risk assessment tools validated for the population served.

- 2.8 If the patient is a minor or an adult without capacity, the alternate decision-maker may be included in the suicide risk screening and/or assessment based on the health care provider's clinical judgement and level of suicide risk.

3. Suicide Risk Management

- 3.1 Health care providers shall assess the patient for suicide risk (see Appendix A: *Suicide Risk Level Criteria and Examples of Risk Factors and Protective Factors*) to identify whether:
- a) the patient can safely manage their own risk;
 - b) the patient requires increased support and intervention; or
 - c) the patient requires an environment with heightened safety measures.
- 3.2 When a minor or adult without capacity is at a moderate, high/imminent risk of suicide, the alternate decision-maker shall be advised and engaged as appropriate in the **suicide risk management plan**.
- a) In the event the alternate decision-maker is unable or unwilling to protect a minor or adult without capacity, the health care provider shall:
 - (i) report concerns about a minor to the Director of Children's Services;
 - (ii) report concerns about an adult without capacity to the Office of the Public Guardian; and
 - (iii) consult with their Manager and/or Alberta Health Services (AHS) Health Law, as appropriate.
- 3.3 Health care providers may consult with their Manager/Supervisor regarding, but not limited to, the following:
- a) potential removal of **harmful and lethal means** from the patient;
 - b) roles, responsibilities, and time frames for clinical contact or level of monitoring;
 - c) explicit direction for responding to the patient's missed clinical contacts;
 - d) consideration of transfer to a higher level of care; and/or
 - e) further consultation with a **health care professional**.
- 3.4 In residential addiction treatment and detoxification settings, consideration shall be given to the facility's capacity to reasonably manage the patient's risk for suicide.

- 3.5 For patients assessed to be at a moderate or high risk of suicide, health care providers shall, in collaboration with the patient whenever possible, develop a **safety plan** to promote safety and manage patient risk. The health care provider shall:
- a) create a safety plan that is practical (e.g., understandable, realistic, sufficiently detailed) for the patient;
 - b) offer the patient (and alternate decision-maker, if any) a copy of the safety plan; and
 - c) discuss with the patient, if they would like to share the safety plan with friends and family and/or store a copy in a known location.
- 3.6 For patients assessed to be at a moderate or high risk of suicide by an unregulated health care provider, the unregulated health care provider shall consult a health care professional with appropriate competence, knowledge, and experience when:
- a) the patient demonstrates a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs:
 - (i) judgement;
 - (ii) behaviour;
 - (iii) capacity to recognize reality; or
 - (iv) the ability to meet the ordinary demands of life.
- 3.7 The safety plan shall include, but not be limited to:
- a) identified reasons for living;
 - b) personal warning signs and risk factors of an impending crisis;
 - c) ways to employ internal coping strategies and protective factors;
 - d) social and community resources that are available, including 24-hour help-lines, Health Link, and/or crisis services; and
 - e) how to access emergency services if suicide risk is unmanageable.
- 3.8 “No-suicide contracts” and “No-harm contracts” are not evidence-based practice and these agreements shall not be used.
- 3.9 Health care providers shall access local emergency services as required based on clinical judgment (e.g., Emergency Medical Services [EMS]), and if safe and appropriate to do so:
- a) stay with the patient; and

- b) prepare a copy of the file for transfer or fax to the Emergency Department.
- 3.10 If the patient, based on known information, is likely to have left to act on suicidal intention, the health care provider shall contact 911 immediately and notify the operator of the patient's location, condition, and any other relevant information. The health care provider shall also notify the Manager/Supervisor to determine next steps, including notification of relevant individuals.
- 3.11 Health care providers shall consider suicide risk management as an important component of transitions in care.
- a) In residential addiction treatment and detoxification settings, health care providers shall engage patients assessed to be at a moderate or high risk of suicide in discharge planning which includes receiving ongoing services from a health care professional.

4. Immediate Intervention of an Attempted Suicide

- 4.1 Appropriate, emergency intervention for care of a patient immediately following an attempted suicide may include:
- a) calling 911, providing first aid or further medical and/or psychiatric interventions within the health care provider's competence, and preparing the patient for transfer to an Emergency Department;
 - b) contacting the police if the patient refuses transport to a health care facility and the health care provider believes the patient meets the criteria for apprehension under the *Mental Health Act* (Alberta) (Form 10); or
 - c) notifying the Director of Children's Services if there are concerns that a minor is in need of intervention as per the *Child, Youth and Family Enhancement Act* (Alberta).
- 4.2 When responding immediately following an attempted suicide, the health care provider shall approach a patient when it is safe for both the health care provider and patient to do so. Police shall be contacted if there are safety concerns.
- 4.3 The health care provider with responsibility for the patient's care plan or the Manager/Supervisor shall:
- a) discuss the attempted suicide with the patient, the patient's alternate decision-maker, and family as appropriate to develop or revise interventions in the safety plan (see Sections 3.5, 3.6 and 3.7 above);
 - b) in collaboration with the patient, establish an appropriate follow-up plan with the patient, which may include assessing the patient's environment for risk, implementing precautions, and monitoring the patient;

- c) facilitate provision of support to family and individuals in the immediate vicinity of the patient's attempted suicide, as required; and
- d) consider the suicide risk of co-patients and others in close relationship to the patient or the incident and conduct screening as appropriate.

5. Notification and Follow-up After an Attempted Suicide

- 5.1 Utilizing a **patient and family centred care** approach, the health care provider with responsibility for the patient's care plan, or the Manager/Supervisor, may, following an attempted suicide, notify the following parties in accordance with the *Health Information Act (Alberta)* and as appropriate:
 - a) family member, unless the disclosure is contrary to the expressed request of the patient;
 - b) any person identified by the patient, including the patient's emergency contact; and
 - c) the patient's primary care provider(s) and/or alternate decision-maker, if any.
- 5.2 The health care provider:
 - a) shall review the facts of the event with their Manager/Supervisor and consider the level of review, if any, required; and
 - b) is encouraged to enter a report in the Reporting and Learning System for Patient Safety (RLS).
- 5.3 Staff shall report any attempted suicide to an identified clinical leader as per the *AHS Recognizing, Responding To, and Learning From Hazards, Close Calls, and Clinical Adverse Events Policy Suite*.
 - a) This clinical leader will be responsible for coordinating the management of the attempted suicide and may be the patient's **most responsible health practitioner**.

6. Clinical Documentation

- 6.1 Documentation in the patient's health record shall include but not be limited to:
 - a) suicide risk screening and assessments;
 - b) suicide risk management plans;
 - c) the patient's safety plan(s);
 - d) facts regarding attempted suicide and interventions;
 - e) system alerts or cautions;

- f) patient and/or family teaching;
- g) other therapeutic interventions;
- h) clinical consultations and referrals; and
- i) disclosure of information, with or without consent from the patient, in accordance with the *Health Information Act* (Alberta).

6.2 To promote patient safety, the health care provider shall communicate and transfer relevant information to other members of the patient's health care team in a timely manner.

7. Support for Staff and Physicians Following a Patient's Attempted Suicide

- 7.1 The Manager/Supervisor shall contact staff and Physicians who were directly involved to:
- a) ascertain their needs;
 - b) offer support to staff and Physicians involved as they may be emotionally impacted and should be treated with care, dignity, and respect;
 - c) provide information about assistance programs and encourage staff and Physicians to seek assistance if appropriate (see the AHS *Immediate and Ongoing Management of Clinical Adverse Events* Procedure); and
 - d) debrief with staff and Physicians in order to review the event and consider future improvements to patient care.

DEFINITIONS

Alternate decision-maker means a person who is authorized to make decisions with or on behalf of the patient. These may include, specific decision-maker, a minor's legal representative, a guardian, a 'nearest relative' in accordance with the *Mental Health Act* (Alberta), or an agent in accordance with a Personal Directive, or a person designated in accordance with the *Human Tissue and Organ Donation Act* (Alberta). This also includes what was previously known as the substitute decision-maker.

Ambulatory services means outpatient or community clinical services. Treatment in ambulatory services does not include admission to a hospital, detoxification or residential treatment facility bed, or public education services.

Direct care means the provision of therapeutic services to the patient by a health care provider without any intermediary. Direct care may be offered in face-to-face interactions or over the phone.

Family(-ies) means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers.

Harmful and lethal means means items and/or substances that have the potential to cause significant harm or death, either accidentally or deliberately. Identification of harmful and lethal means should consider multiple modes of use, including but not limited to asphyxiation, ingestion and laceration/puncture.

Health care professional means an individual who is a member of a regulated health discipline, as defined by the *Health Professions Act* (Alberta), and who practices within scope and role.

Health care provider means any person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

Most responsible health practitioner means the health practitioner who has responsibility and accountability for the specific treatment/procedure(s) provided to a patient and who is authorized by Alberta Health Services to perform the duties required to fulfill the delivery of such a treatment/procedure(s) within the scope of their practice.

Patient means an adult or child who receives or has requested health care or services from Alberta Health Services and its health care providers or individuals authorized to act on behalf of Alberta Health Services. This term is inclusive of residents, clients and outpatients.

Patient and family centred care means care provided working in partnership with patients and families by encouraging active participation of patients and families in all aspects of care, as integral members of the patient's care and support team, and as partners in planning and improving facilities and services. Patient and family centred care applies to patients of all ages and to all areas of health care.

Recovery-oriented means encompassing a broad construct that is person-centred and promotes resilience. Clinicians work in partnership with individuals and their families to build on personal strengths and skills to enhance health outcomes and quality of life.

Safety plan means a plan developed with the patient and is usually summarized as a written plan for the management of increased danger of suicide or self-harm and how to stay safe in and out of hospital. Strategies, choices, moments of control, coping strategies and contact numbers that were discussed during the intervention should be included in the safety plan.

Suicide risk assessment means the detailed exploration of risk factors and protective factors which impact the patient's risk of suicide. The purpose of the assessment is to provide direction for intervention and/or treatment.

Suicide risk management plan means a plan developed by a health care provider that is calibrated to the patient's identified degree of suicide risk. It is a clinical tool and ideally should be developed in collaboration with the patient, other health care providers and family, as appropriate. Reduction in suicidal ideation and risk reduction are key goals to the suicide risk management plan.

Suicide risk screening means inquiry into a patient's history of and current ideation, plans or behaviour related to suicide. Screening is intended to be non-invasive and to provide direction on whether further assessment is required.

REFERENCES

- Appendix A: *Suicide Risk Level Criteria and Examples of Risk Factors and Protective Factors*
- Alberta Health Services Governance Documents:
 - *Immediate and Ongoing Management of Clinical Adverse Events Procedure* (#PS-95-02)
 - *Recognizing, Responding To, and Learning From Hazards, Close Calls, and Clinical Adverse Events Policy* (#PS-95)
 - *Suicide Risk Management Policy* (#AMH-11)
- Alberta Health Services Forms:
 - *Personal Safety Plan Form* (#18600)
 - *Refusal of Care and/or Transport Form* (#09897)
 - *Safety Plan Form* (#19367)
 - *Suicide Risk Assessment Form* (#18519)
- Alberta Health Services Resources:
 - *Addiction and Mental Health Principles of Care*
- Non-Alberta Health Services Documents:
 - *Child, Youth and Family Enhancement Act* (Alberta)
 - *Health Information Act* (Alberta)
 - *Mental Health Act* (Alberta)

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APPENDIX A

Suicide Risk Level Criteria and Examples of Risk Factors and Protective Factors**Suicide Risk Level Criteria**

Suicide risk is dynamic and may change abruptly. The following examples help promote effective communication by clarifying the terms used to describe the level of risk identified at a specific point in time. A person does not need to display all criteria for the respective risk level.

Low Risk is indicated by: no apparent suicidal ideation; suicidal ideation of limited frequency, intensity, and duration; no identifiable plan(s); no apparent intent; few risk factors and multiple protective factors.

Moderate Risk is indicated by: frequent suicidal ideation with limited intensity and duration; suicide attempt(s) more than 3 months ago; limited or vague plan(s); no apparent intent; limited access to lethal means; some risk factors and some protective factors.

High/Imminent Risk is indicated by: frequent, intense, and enduring suicidal ideation; current and/or suicide attempt(s) within the last 3 months; specific plan(s); intent to act, rehearsal behaviour, or preparatory behaviour; access to lethal means; severe distress; acute precipitating event; multiple risk factors and few, if any, protective factors.

Risk Factors and Protective Factors

A person's suicide risk is influenced by factors related to circumstances, beliefs, and supports. These factors can vary widely from person to person; the importance of any one factor is subjective and based on each person's unique experience. The following lists contain common but non-exhaustive factors that can influence suicide risk.

Risk Factor Examples

*Current or past biological, psychological, or sociocultural aspects or characteristics of the person, social contacts, or environment that make it **more likely** for a person to engage in suicidal behaviour.*

- Abuse (sexual, physical, emotional, bullying)
- Addiction (substances, processes)
- Cognitive or functional limitations
- Crisis (personal, financial, relationship)
- Depression, anxiety, or hopelessness
- Discrimination, oppression, ostracism, or historical trauma (often related to race, ethnicity, gender identity, sexual orientation, physical ability, cognitive ability)
- Family history of suicide
- History of elopement, leaving against medical advice, or wandering
- History of self-harm
- History of suicide attempts
- History of violence / aggression
- Homicidal thoughts
- Legal complications
- Living situation (housing, living alone)
- Low socio-economic status
- Medical complications
- Poor insight or judgement; impulsivity
- Postpartum status
- Psychosis or command hallucinations
- Recent hospital stay or emergency department visits
- Recent loss
- Substance use
- Trauma

Protective Factor Examples

*Biological, psychological, or sociocultural aspects or characteristics of the person, social contacts, or environment that make it **less likely** for a person to engage in suicidal behaviour.*

- Ability to identify a reason(s) for living
- Access to clinical intervention or support seeking access
- Cultural, spiritual, or religious connections
- Engagement in effective clinical care for mental, physical, or substance use disorders
- Engagement in enjoyable activities
- Engagement in work or school
- Fear of death due to pain or suffering
- High self-esteem
- Problem-solving, coping, conflict resolution skills
- Sense of belonging and identity
- Sense of responsibility to people or pets; living with family
- Strong family or community connections
- Supportive social network or family
- The belief that suicide is immoral
- Willingness to access ongoing medical / mental health supports